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Making Coverage Decisions

By Paul Fronstin, EBRI,
and Diane Robertson, ECRI¹

Introduction

A return to double-digit increases in health benefit costs is fueling interest in new structures for employment-based health benefits. It is also fueling discussions about whether the best available evidence, based on rigorous evidence reviews, is used in making coverage decisions and how these decisions affect the cost of providing health benefits. Evidence reviews based on the relatively new science of research synthesis will play an increasingly important role not only in the practice of medicine but also in the business of health care, according to speakers at ECRI's 10th Annual Conference on Healthcare Policy, Law, and Methodology on October 29 and 30, 2002, in Plymouth Meeting, PA. Conference cosponsors included the Consumer Health Education Council, the Employee Benefit Research Institute, the Leonard Davis Institute of the University of Pennsylvania, and the Milbank Memorial Fund. Employers, insurers, providers, and regulators questioned whether the health care debate would focus more on cost—at the expense of quality and value in health care—as costs continue to rise, particularly during a foundering economy.

Evidence-Based Medicine

“Traditionally, mention of cost-effectiveness in health care decision making was heresy, but cost always filters into the question,” said Grant P. Bagley, M.D., J.D., former director of the coverage and analysis group in the Health Care Financing Administration (now Centers for Medicare & Medicaid Services, or CMS) and now a partner in the law firm of Arnold and Porter. Evidence is required to make these decisions, and a major obstacle is first overcoming antagonism to evidence-based medicine (EBM), he noted. “Everyone is in favor of evidence-based medicine as long as you use *their* evidence and come to *their* conclusions,” said Bagley. To further the acceptance of EBM, Bagley called for greater inclusion of all interested parties—perhaps patients and beneficiaries themselves—in EBM and the coverage process.

“What is the business case for worrying about value in health care?” asked Dallas L. Salisbury, president and chief executive officer, Employee Benefit Research Institute. To date, the business case for health care quality has not been made, said Salisbury, and most employers have based their health care purchases on issues of cost and satisfaction. Although using evidence could help guide health care purchasing based on quality, most employers have little experience evaluating research evidence and putting evidence-based conclusions into practice, he noted.

As the largest health care purchasers in many jurisdictions, state governments are turning to EBM to make rational health care decisions while also providing political cover, said John M. Colmers, program officer for the Milbank Memorial Fund. "Private payers observe states to see if some health care policy and its coverage aspects work," he noted. "Private payers observe what the public response is to state coverage decisions, such as repealing coverage of a certain technology or adding prescription drug coverage," said Colmers.

Sharon Levine, M.D., a pediatrician and associate executive director for physician and professional services, The Permanente Medical Group, Inc., explained that Kaiser Permanente uses evidence in making coverage decisions but places the locus of authority on the treating physician rather than on insurance executives. "We've created as much autonomy as is available in U.S. health care—Kaiser puts the responsibility on doctors to be accountable for both the quality and cost of health care," said Levine.

Kaiser uses evidence-based technology assessments "not to deny the use of new technology, but to use new technology in the most practical and clinically appropriate way," said Levine. In one evidence-based example, Kaiser determined that Cox II inhibitors (prescription drugs) offered limited, if any, benefit for relieving arthritis pain and inflammation compared with other nonsteroidal anti-inflammatory

drugs (NSAIDs), which cost substantially less. Because evidence failed to show that Cox II inhibitors did not eliminate the risk of gastrointestinal bleeding, were not proven safe in high-risk patients, and offered no benefit in low-risk patients, Cox II inhibitors are prescribed for only about 5 percent of Kaiser Permanente patients, compared with about 46 percent of patients nationally.

Levine believes that improving the evidence base for making coverage decisions can help relieve cost pressures. "It's easy where there is clear evidence of harm or lack of benefit," she noted. However, evidence often does not exist for new technology, and if available, evidence frequently does not address the cost of new technology and drugs, said Levine.

Among the proposals that panelists suggested for improving the dearth of available evidence on emerging technologies, where it is often most needed, were:

- Shifting more National Institutes of Health funding from basic laboratory research to applied clinical research, to enable better coverage decision-making.
- Creating a national procedure for studying emerging technologies and collecting evidence to inform decision making on these technologies.

Methods of Medicare Coverage Policymaking Create Inconsistencies

Discrepancies in Medicare coverage

policies exist because of the different ways in which local and national coverage policies are made (Medicare is the federal health care insurance program for the elderly and disabled). A panel of speakers involved in different aspects of Medicare coverage decision making and implementation at both levels reviewed the problems that these discrepancies can create and proposed solutions.

Panel moderator Susan Bartlett Foote, J.D., division head and associate professor, Division of Health Services Research and Policy, University of Minnesota School of Public Health, said that national coverage decisions tend to focus on the effectiveness of a particular medical technology and the equity in extending national coverage to that technology to make it available to a wider patient population. Local medical review policy (LMRP), on the other hand, deals with the timeliness and flexibility of extending coverage and the responsiveness to local conditions, said Foote.

She also reviewed findings from a recent survey of LMRP contractors that found that 87 percent of responding contractors had no written process for making policy, while 92 percent had no process for reviewing data on technology. While manufacturers try to influence LMRPs the most, they have the least influence with them, and patients in large part were not active in trying to influence local policies, she said.

LMRPs and national coverage decisions (NCDs) tend to be developed from very divergent positions,

said Sean Tunis, M.D., M.Sc., acting deputy director, Office of Clinical Standards and Quality, and acting chief clinical officer for CMS. Technologies are considered for NCDs when companies file a request for consideration of their technology or when local Medicare carriers request that an NCD be made. Under Medicare's "reasonable and necessary" statutory requirement for coverage, CMS considers the evidence on new technologies with the following goals in mind before making an NCD, Tunis explained:

- Having sufficient knowledge and data about how well a technology works.
- Avoiding the promotion of procedures that are ineffective or may harm Medicare beneficiaries.
- Directing limited resources so that they produce a net health benefit.

LMRPs tend to be enacted first, with the intention of studying the technology later, said Tunis. In practice, such studies are difficult to conduct once a technology has been diffused, and adequate evaluations are rarely done because prospective studies require time and funding. If manufacturers obtain coverage on a local level for new technologies, there is little incentive to carry out further studies. Moreover, manufacturers can put together funding from numerous localities, allowing them to diffuse the technology more broadly even in the absence of an NCD. And if studies are carried out after coverage is granted and a technology is found to be less effective than first believed, it is very

difficult to remove coverage, Tunis explained.

Charlotte S. Yeh, M.D., medical director for Medicare policy at National Heritage Insurance Company, the local Medicare carrier for New England and California, described the difficulties of carrier medical directors (CMDs) in making local policy, but also noted benefits to making LMRPs. Yeh is one of two people (the other is a nurse) who review technologies and make LMRPs for two large regions in which the carrier provides Medicare coverage. The carrier in these regions covers five states, 2.4 million beneficiaries and 80,000 providers, and processes more than 25 million beneficiary claims annually.

"When CMDs started in 1993, they were to assure program integrity and utilization review, not to make coverage policy," she explained. Yeh said that CMDs lack the resources and time to carefully weigh the available evidence. "We are given no budget for technology assessment activities even though we'd love to have those kinds of resources," she said. Instead, they rely on consensus from their 200 care advisory committee (CAC) members, who represent all the medical specialties and states in the two regions, and on input from public hearings. Relevant CAC members have periodic teleconferences to discuss what they know about particular technologies and make recommendations to the CMD. LMRPs give local CMDs the ability to make flexible coverage decisions that consider geography (i.e., cover-

age area), local practice patterns and culture, and the volume of patients. Once an LMRP is made, CAC members carry that message to providers. LMRPs, however, cannot conflict with statutory requirements, regulations, or national coverage determinations.

To balance the flexibility of local decisions and national coverage consistency, Yeh suggested setting a threshold for converting local decisions to national ones. "If perhaps 40 percent to 50 percent of local carriers cover a certain procedure, then perhaps we should set a standard national coverage policy for this technology," said Yeh. However, she believes LMRPs are necessary because they allow the flexibility that she feels the system needs due to differences in laws, licensure, and scope of practice across states; local standards of practice; the rate of adoption of new technology; beneficiary demand; and provider interest in and capability of using technologies.

Less May Be More

Douglas L. Wood, M.D., vice chair of the department of internal medicine at the Mayo Clinic and chair of both the Minnesota Medicare Carrier Advisory Committee and the Department of Health and Human Services' Secretary's Advisory Committee on Regulatory Reform, expressed dismay at the variation in Medicare coverage and reinforcement of practice created by 9,000 LMRPs. "LMRPs have many unintended consequences and much unfulfilled

promise,” he declared.

Although LMRPs ostensibly are intended to improve health care quality while containing costs, there is no direct evidence that LMRPs actually reduce aggregate health care spending or utilization, said Wood. In fact, he believes that LMRPs discriminate against beneficiaries by increasing out-of-pocket expenses for some, create burdens on physicians through significant paperwork, and have no effect on spending and quality of care. “If we could devise LMRPs that would improve and standardize care, then that would be beneficial,” said Wood. “That seldom occurs in reality, however, so we need to figure out a way to achieve those goals.”

Wood noted, for example, that Minnesota has relatively few LMRPs, relatively low overall Medicare beneficiary spending per capita, and ranks fourth-highest in the nation in quality-of-care ratings. In contrast, Missouri has hundreds of LMRPs, higher spending, and much lower quality-of-care ratings. To streamline the coverage-review process, Wood recommended that CMS develop a simple, understandable, consistent, and nondiscriminatory preauthorization system to alert physicians and beneficiaries about what services would likely be covered. He believes that CMS should eliminate most LMRPs and restrict them to new medical technology or important local delivery system or policy needs. “What is not local is the scientific basis for medical practices and the require-

ments for training,” he asserted. Furthermore, Wood advised that CMS establish an effective appeals process to complement NCDs or create templates for payment policies that all CMDs would follow.

Reconciling LMRP and NCD Policymaking

In the continuing policy debate over the proper balance between national and local Medicare coverage, Foote recommended that coverage decisions maximize value on both sides by allocating coverage decisions to national, local, and shared areas based on the technology under review and needs of beneficiaries.

Foote suggested that coverage of breakthrough medical technologies would best be addressed through NCDs for which technical expertise would be more readily available to consider questions of equity among beneficiaries and efficiency. Coverage issues that deal with managing how various medical technologies are used would be handled locally, Foote noted. Local and national coverage policy would converge when product extensions, new clinical indications, and process improvements come under review, Foote proposed. Under this combined approach, LMRPs would be flexible enough to respond to local needs while encouraging innovation. In cases in which wider coverage for an evolving technology becomes appropriate, LMRPs could prompt development of NCDs when certain conditions are met, Foote said.

Opportunities for Stakeholders to Collaborate on Health Policy

Who has what interest in improving the quality and cost of health care in this country, and who can benefit in the future? This was the cross-cutting issue, noted Daniel Fox, Ph.D., president of the Milbank Memorial Fund. Fox synthesized the panel presentations and described the opportunities for collaboration to solve the problems identified by stakeholders.

The two main areas that Fox identified for collaboration among businesses, employers, the government, private payers, and consumers center around issues of how to apply “evidence” for health technologies and assess the best mix of spending by employers, the government, and consumers. “‘Best mix’ means achieving the optimal affordable health of the populations that make up this country,” said Fox.

“Dallas Salisbury introduced this issue by asking if there is a ‘business case’ for health. That is, do firms benefit from what they spend for employees’ health coverage? Is there a return on a firm’s investment in health care and health promotion?” said Fox, who then added his own questions. “What if evidence shows that there is a business case for spending on health for large firms in some industries but hardly ever for small firms and never for very small ones?”

“Put another way,” he continued, “what if employer spending for coverage benefits society because it contributes to the health of employ-

ees and their dependents in our highly mobile society but doesn't do much for firms' earnings? What if health coverage is like defense and domestic security—something that is more efficiently paid for by taxes? What if it turns out that it is better for the economy—that is, better for employment and earnings—to use taxes and consumer spending to pay for health care? On the other hand, what if the opposite is true—that coverage based on employment combined with public programs for particular populations is the most effective way to serve the public interest?"

As he urged the audience to collaborate, Fox noted, "We have talked about coverage in this country for a long time. We have, however, never had a national discussion that is based on good evidence about the effects on the national economy and health status of particular policy approaches to coverage. The second major opportunity for collaboration is to use evidence in ways that maximize quality and outcomes in ways that are cost effective."

Fox cited six general issues for collaboration that would enhance the interests of business, labor, and government. The sixth issue, he warned, was very controversial. These issues are as follows:

1. Determining what health services different populations require.
2. Learning more about the determinants of health, an area of research in which he said the research community has not yet been asked to listen hard to policymakers in the public and

private sectors.

3. Evaluating the quality of plans and providers. (Evaluation should include how plans and provider organizations appraise evidence about both new and accepted interventions, how they implement the results of their appraisal, and the results of implementation for patients.)
4. Studying the effects of various types of cost shifting and cost sharing on access, cost, and, most important, patient outcomes.
5. Evaluating the effectiveness of interventions. (Immediate value would be added by setting standards of evidence; setting standards for evaluating the quality of evidence reviews; defining processes by which reviews inform clinical policymaking on local, regional, and national levels; finding ways for federal and state regulators to create incentives for professionals and systems to use the best evidence in everyday health care practice; and pressing for federal funding for the infrastructure that is needed to speed the production of evidence, especially well-designed clinical trials and evidence reviews that meet high international scientific standards.)
6. Addressing antagonism and resistance to the use of the evidence to inform policy.

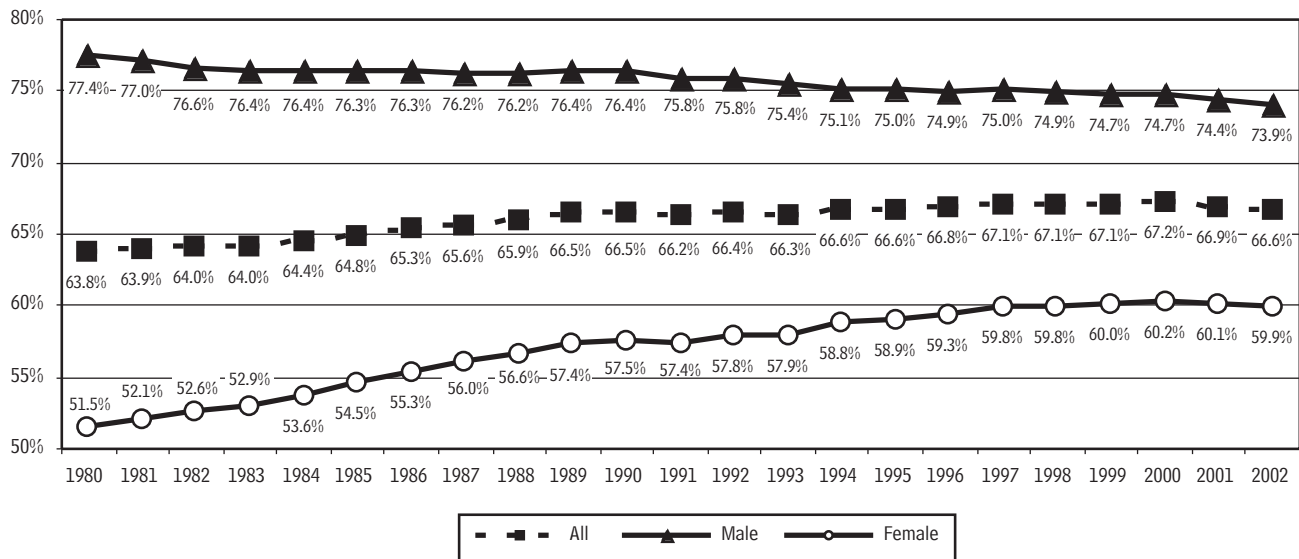
"Collaboration is essential on the sixth issue because the antagonists of the use of best evidence to inform clinical and finance policy are

powerful, often wealthy, and always very smart," said Fox. "The work before us requires attention to manufacturers, professionals, and consumers. We need to reduce or neutralize resistance from manufacturers of drugs and devices. We must address resistance of health professionals by aligning incentives, provoking the emulation of appropriate peers, and supporting innovators in education, especially of physicians. Finally, we must help consumers understand that the best evidence is the best guide to their care, just as it is the best guide to clinical and reimbursement policies. The best way to get this message to consumers may be to improve how the media covers the announcement of alleged advances in medicine—that is, to work with health reporters and editors to communicate the practical power of evidence."

Endnotes

¹ ECRI (formerly the Emergency Care Research Institute) is an independent nonprofit health services research agency based in Plymouth Meeting, PA.

Figure 1
CIVILIAN LABOR FORCE PARTICIPATION RATE, AMERICANS AGES 16 OR OLDER, BY GENDER, 1980-2002



Source: U.S. Department of Labor, Bureau of Labor Statistics, "Labor Force Statistics from the Current Population Survey—Civilian Labor Force and Population," www.bls.gov/data/home.htm

Social Security Actuarial Balance and the Labor Force Participation Rate

by Craig Copeland, EBRI

Introduction

The 2003 Trustees Report of the Old Age, Survivors Insurance and Disability Insurance Trust Funds reports that the OASDI trust funds' projected 75-year actuarial balance currently shows a deficit of 1.92 percent of OASDI taxable payroll.¹ Furthermore, the programs' annual costs are expected to exceed their annual income for the first time in 2018. In comparison, the 2001 Trustees Report² projected a deficit of 1.86 percent of OASDI taxable payroll and 2016 as the year the program would first exceed its annual income. The projection of the OASDI's actuarial balance entails numerous assumptions concerning

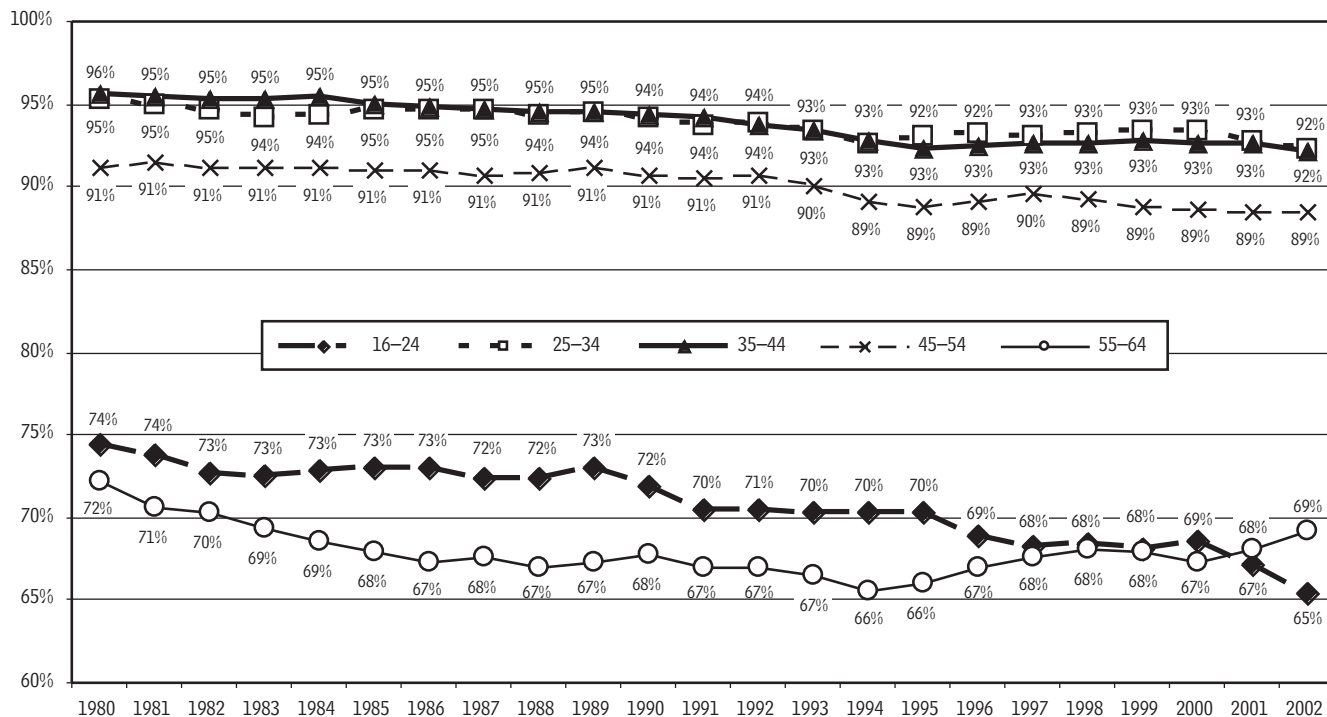
various demographic and economic conditions over the next 75 years that are all important to the projection outcome. As with any projections, the chosen assumption values used in the analysis determine the projection's ultimate outcome, and it is inherently impossible to predict the future. Thus, the values of the assumptions can be chosen from a reasonably large distribution of possibilities.

Previous EBRI publications examined a range of values of the mortality rate, the productivity rate, the level of immigration, and the unemployment rate to determine their impact on the OASDI trust funds' actuarial balance.³ This study investigates the impact of the assumed value of the labor force participation rate (percentage of all civilian Americans age 16 or older who are in the labor force) on the OASDI trust funds' actuarial balance. The labor force participation rate is studied since there are

different projections for this rate and also because the rate of participation among the near elderly (55–64 year olds) has changed significantly in recent years. Quinn (1999) showed that the labor force participation rate among the near elderly was increasing and discussed how these individuals are using "bridge jobs" from career jobs to retirement.⁴ The increase in the near elderly labor force participation rate has subsequently accelerated, possibly making this change a more significant trend to consider in evaluating the actuarial balance of the OASDI program.

After presenting these latest trends in the labor force participation rates and discussing their future directions, their impact on the actuarial balance of the OASDI program is estimated using the SSASIM model. SSASIM closely replicates the results of the actuarial model used for projections in the Trustees report.⁵ Thus, this

Figure 2
MALE CIVILIAN LABOR FORCE PARTICIPATION, AGES 16-64, 1980-2002



Source: U.S. Department of Labor, Bureau of Labor Statistics, "Labor Force Statistics from the Current Population Survey—Civilian Labor Force and Population," www.bls.gov/data/home.htm

study's results would be similar to those produced by the model used by the Social Security Administration's Office of the Actuary in the Trustees' report.

Labor Force Participation Rate Trends

The civilian labor force participation rate for Americans age 16 or older increased from 63.8 percent in 1980 to 66.5 percent in 1989 (Figure 1). From 1989 through 2002, this rate was virtually constant, reaching a high of 67.2 percent in 2000 before settling at 66.6 percent in 2002. The male labor force participation rate declined modestly but steadily from 77.4 percent in 1980 to 73.9 percent in 2002. In contrast, the female labor force participation rate increased significantly, from

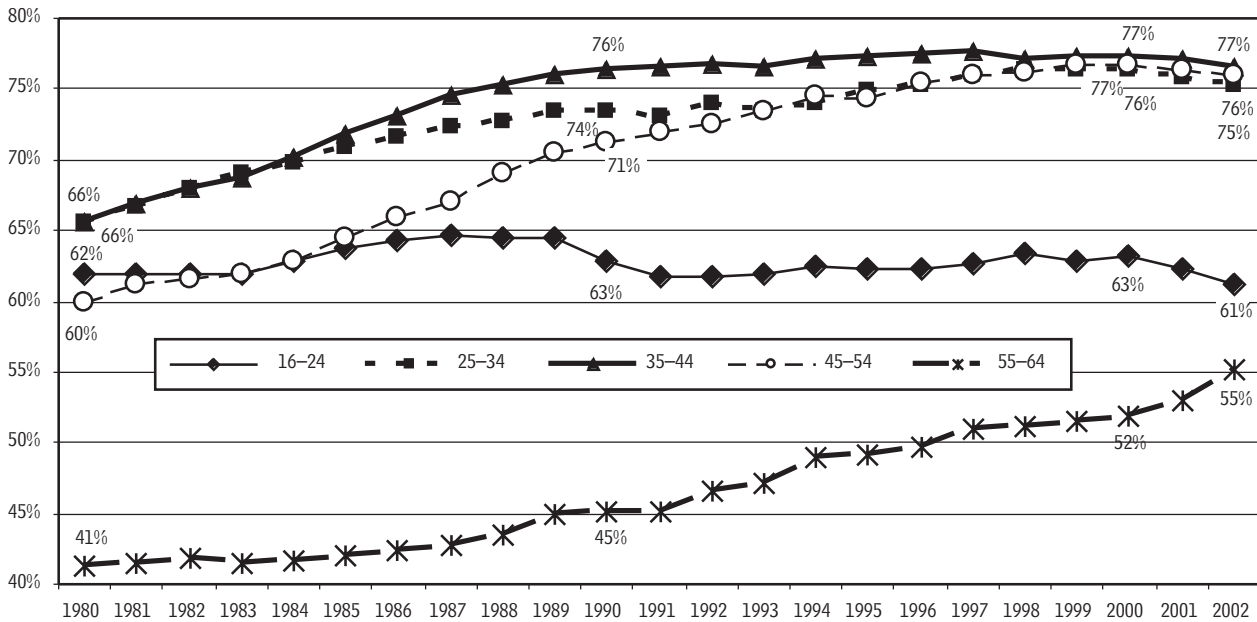
51.5 percent in 1980 to 60.2 percent in 2000, then decreased slightly to 59.9 percent in 2002.

Males by Age—All male age groups, with the exception of 55–64 year olds, have experienced steady declines in their labor force participation rates (Figure 2). The largest decline was among males ages 16–24, whose rate fell from 74.4 percent in 1980 to 65.3 percent in 2002. The rates for groups ages 25–34, 35–44, and 45–54 all decreased approximately 3 percentage points. The one exception, the group ages 55–64, experienced a declining rate from 1980 through 1994, followed by a rising trend and an accelerated increase in 2001 and 2002 (67.3 percent in 2000 to 69.2 percent in 2002).

Females by Age—Female middle age groups had continual increases in labor force participation rates from 1980 through 1997, before the rates leveled off and decreased somewhat by 2002 (Figure 3). The participation rate among females ages 16–24 increased from 61.9 percent in 1980 to 64.4 percent in 1989, before sharply dropping to 61.7 percent by 1991 and remaining relatively constant through 2002, when it was 61.2 percent. The labor force participation rate of females ages 55–64 increased sharply, from 41.3 percent in 1980 to 55.1 percent in 2002. There was a particularly sharp increase from 2000 to 2002, which also occurred among males of this age.

Summary of Trends—Overall, the labor force participation rate has

Figure 3
FEMALE CIVILIAN LABOR FORCE PARTICIPATION RATES, AGES 16-64, 1980-2002



Source: U.S. Department of Labor, Bureau of Labor Statistics, "Labor Force Statistics from the Current Population Survey--Civilian Labor Force and Population," www.bls.gov/data/home.htm

been constant to falling over the last 10 years. Males' labor force participation rate has been in steady decline since 1980, while the rate among females, after having steadily increased through the mid-1990s, has leveled off. However, there have been significant trends within age groups. Younger Americans experienced a decline in their participation rate, while the rate among 55-64 year olds increased—sharply in 2001 and 2002.

Labor Force Participation and Actuarial Balance

To investigate the impact of the labor force participation rate on the OASDI trust funds' actuarial balance, the SSASIM policy simulation model is used. This model is benchmarked with the intermediate assumption values from the 2001 report of the Trustees of the OASDI program. In this report, the inter-

mediate assumption value of the male labor force participation rate is expected to reach 73.4 percent by 2075, and the female labor force participation rate is expected to reach 60.6 percent.⁶ In the 2003 report, the labor force participation rate intermediate assumptions were adjusted upward. The male rate was increased to 74.2 percent by 2080 and the female rate to 61.1 percent.⁷ While the Trustees of OASDI raised their assumption values for the labor force participation rates, the U.S. Department of Labor's Bureau of Labor Statistics' projections for 2010-2050 show a decrease in labor force participation rate from 67.5 percent in 2010 to 61.4 percent by 2050.⁸ Thus, expectations differ on the future direction of the labor force participation rate.

The SSASIM model is used to estimate the impact of these different projections and the

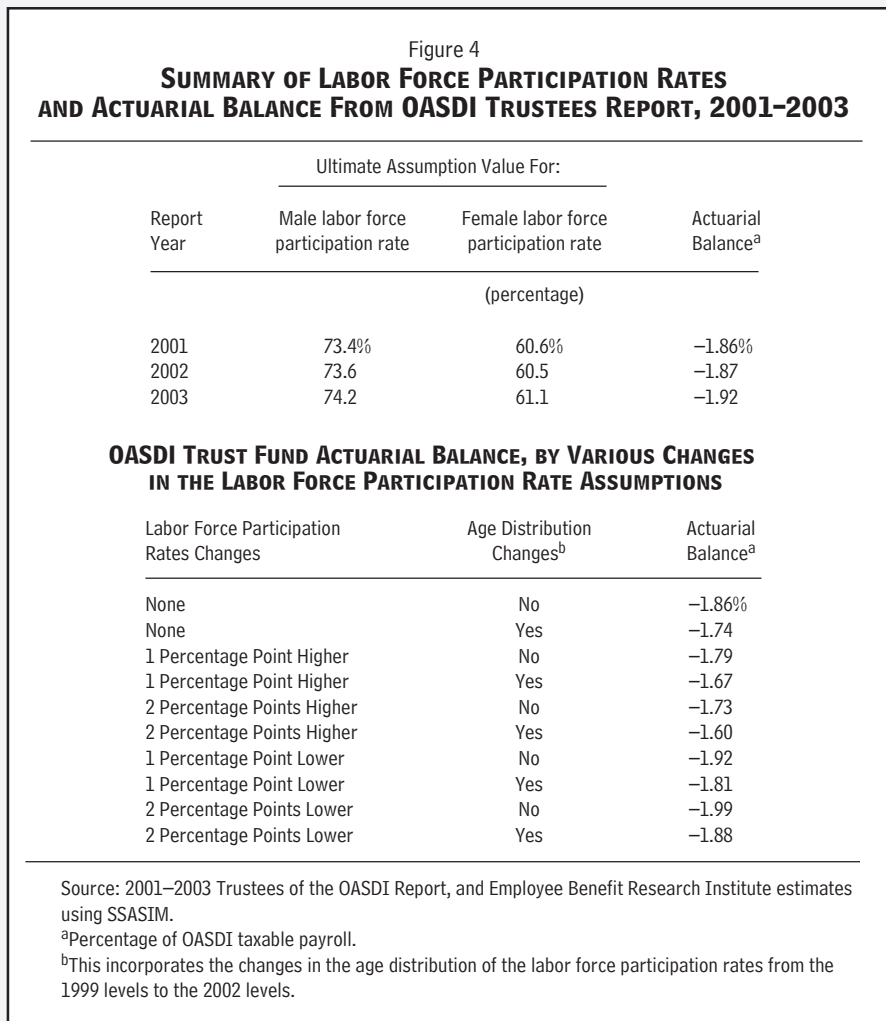
accelerated labor force participation rate among 55-64 year olds on the actuarial balance of the OASDI trust funds.⁹ Without any changes in the labor force participation rate, the actuarial balance is a 1.86 percent deficit of OASDI taxable payroll.¹⁰ When just the acceleration in the 55-64 year olds' rate is considered, the actuarial balance improves to a 1.74 percent deficit (Figure 4).¹¹ Furthermore, assuming no acceleration of the labor force participation rate among the near elderly and a 1 percentage point participation rate increase from the intermediate value in the 2001 Trustees' report for both the male and female labor force participation rates, the actuarial balance improves to a 1.79 percent deficit. Assuming a 2 percentage point increase from the 2001 participation rates and the acceleration in the near elderly's rates, the deficit is lowered to 1.60 percent.

If the labor force participation rates are decreased by 1 percentage point with no changes across the ages, the actuarial balance worsens to a 1.92 percent of OASDI taxable payroll deficit. The actuarial balance is basically unchanged—at a 1.88 percent deficit—with a 2 percentage point decrease in each labor force participation rate and accounting for the older Americans' increased participation in the labor force.

Conclusion

The labor force participation rates of both male and female 55–64 year olds in 2001 and 2002 built on their previous increases, while younger Americans had declining labor force participation rates in 2001 and 2002. Furthermore, expectations differ on the future of the labor force participation rates, with the Trustees of the OASDI program increasing their assumption values for these rates in the 2003 report over those in their 2001 report. The value that is eventually realized will affect the financial status of the OASDI program.

A 1 percentage point increase (decrease) in the male and female labor force participation rates leads to a 0.06–0.07 percentage point increase (decrease) in the actuarial balance of the OASDI's trust funds. Altering the age distribution of the labor force participation rates (increasing the older Americans' rates and decreasing the younger Americans' rates to reflect the distribution in 2002) improves the



actuarial balance by 0.12 percentage points.

Having a higher percentage of Americans in the labor force and prolonged working careers has a positive impact on the OASDI program's financial status. However, making reasonable changes to the assumptions used by the Trustees of the OASDI program results in a relatively small improvement in the OASDI financial status. Even if labor force participation rates increased to record highs, the program's financial status—although it would be improved more than shown in this study—would not be enough to eliminate the need for further changes to the OASDI program to

achieve a sustainable funding level. Consequently, while encouragement of labor force participation would be beneficial, other changes will be needed to either increase the program's revenue or to reduce its costs.

Endnotes

¹ See Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, *The 2003 Annual Report of the Board of the Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds* (Washington, DC: Board of Trustees of the Federal Old-Age and Survivors

Insurance and Disability Insurance Trust Funds, 2003) available at www.ssa.gov/OACT/TR/TR03/index.html

² See Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, *The 2001 Annual Report of the Board of the Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds* (Washington, DC: Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, 2001) available at www.ssa.gov/OACT/TR/TR01/index.html

³ See Neil Howe and Richard Jackson, “Do the Social Security Projections Underestimate Future Longevity?” *EBRI Notes* no. 11 (Employee Benefit Research Institute, November 1999): 1–4; Craig Copeland, “Productivity Growth and The Actuarial Balance of the Social Security Program,” *EBRI Notes*, no. 11 (Employee Benefit Research Institute, November 2001): 7–10; Craig Copeland, “Social Security: Unemployment and Immigration,” *EBRI Notes*, no. 4 (Employee Benefit Research Institute, April 2002): 1–4.

⁴ See Joseph F. Quinn, “Retirement Patterns and Bridge Jobs in the 1990s.” *EBRI Issue Brief* no. 206 (Employee Benefit Research Institute, February 1999).

⁵ For more details on the model, see Martin Holmer, *Introductory Guide*

to *SSASIM* (Washington, DC: Policy Simulation Group, February 2003) available at www.radix.net/~holmer/guide.pdf

⁶ See Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, 2001, op. cit.

⁷ See Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, 2003, op. cit.

⁸ See U.S. Department of Labor, Bureau of Labor Statistics, “Labor Force (Demographic) Data—Labor Force Projections, 2010–2050.” www.bls.gov/emp/emplab1.htm, viewed March 2003.

⁹ The model contains a labor force participation rate for each age 16 or older for each gender. The rates used initially in the model are from the 1999 age distribution of the labor force participation rates used in the 2001 Board of Trustees’ report. A new distribution was created that reflected the 2002 age distribution of the labor force participation rates shown in this study. Thus, as the labor force participation rate figures show, the participation rates were increased for the older Americans while they were decreased for the younger Americans. The 2003 Board of Trustees’ report incorporated some of these changes as they used the 2001 age distribution of the labor force participation rates.

The male and female overall labor

participation rates are increased and decreased by 1 and 2 percentage points, respectively, in this study. The 1 percentage point increase from 2001 Trustees’ report level is almost equal to the level used in the 2003 Trustees’ report.

¹⁰ OASDI taxable payroll is the amount of wages and salary that is subject to the Old-Age and Survivors Insurance and Disability Insurance (OASDI) payroll tax, which in 2003 is 6.20 percent on both the employee and employer on the first \$87,000 of an employee’s wages and salary.

¹¹ In this study, only the specified labor force participation rates will be changed, no other assumptions are changed from the intermediate assumptions of the 2001 Trustees’ report. While a change in the labor force participation rate in a real economic situation would be correlated with changes elsewhere in the economy, this analysis is intended to examine the effects of changes in the labor force participation rates in isolation. In a real economic situation, the effects found in this study would be either mitigated or enhanced by the changes elsewhere in the economy.

Washington Update

by Jim Jaffe, EBRI

The Congressional Schedule

The 108th Congress is currently in the preliminary stages of its annual budget debate, holding hearings and working toward an overall budget plan that will later guide the specifics of the 13 regular appropriations bills that finance government operations. But with quick passage last month of a nearly \$80 billion downpayment on the war with Iraq, and lawmakers still planning to cut taxes (see tax cut story below), the major question about next year's budget is just how big the record-setting deficit will be (see debt limit story, below).

Lawmakers recently returned to Washington from their weeklong Easter break, and are in session until similar weeklong breaks over Memorial Day and Independence Day. They take a month-long summer recess in August, returning after Labor Day. The target adjournment date this year is Oct. 3; last year's "target" was missed by a mile, as budget fights and campaign politics dragged out the session and delayed enactment of a final budget until halfway through the new fiscal year.

Tax Cut Size Creates Continuing Controversy

Concerns about unpredictable war costs and a growing projected deficit have caused Congress to back away from endorsement of President Bush's 10-year, \$726 billion proposed

tax cut. After voting for nearly \$80 billion to finance combat in Iraq and finance homeland security costs, the Senate decided to reduce the tax cut to \$350 billion. The House subsequently indicated some doubts about the large spending cuts that would be required to allow the tax cuts, which it initially endorsed, without creating explosive deficit growth. The two chambers are moving toward a compromise figure.

Once the size of the tax cut is resolved, the debate will begin about specific priorities and taxes to cut. Washington pundits rated the White House retirement incentive reform plan as dead, and the proposal to end shareholder taxation of some dividend payments as vulnerable, because of the initial high cost (which has risen as the White House broadened proposed relief to include annuity payments). But it remains probable that some elements of dividend tax relief will be enacted.

Debt Limit Squeezes Treasury

Treasury Secretary John Snow used an accounting maneuver—diverting federal workers' retirement savings—to free billions of dollars to finance government operations through mid-April without breaching the current \$6.4 trillion debt ceiling. A flood of anticipated revenue as taxpayers pay prior to the April 15 tax deadline could buy additional weeks of solvency.

By suspending new investments in Treasury securities that would be credited to the Civil Service Retirement and Disability Fund

(CSRDF), the maneuver (and other steps) frees up around \$12 billion that will allow the government to continue to pay its bills. Treasury officials promise the maneuver does not threaten the stability of the CSRDF or jeopardize tax refunds now being mailed out.

While conventional wisdom has it that a federal default is unthinkable, the political brinksmanship over voting to raise the debt limit is serious. Democrats blame the government's surging deficits on President Bush's tax cuts and handling of the economy and remember well that Republicans provided little help on the issue when increases were needed during Democratic presidencies, while significant numbers of Republicans always vote against debt ceiling increases to protect their image as fiscal conservatives. Snow's accounting gymnastics reflect the ever-growing difficulty that congressional leaders face in rounding up the votes to pass an ever-growing debt limit.

Replacing the Long-Bond Benchmark

The latest pension reform legislative proposal from Reps. Rob Portman (R-OH) and Ben Cardin (D-MD) would use long-term corporate bond rates as the benchmark interest rate for defined benefit plans and lump-sum distributions. Their draft language would solve one problem by providing a replacement for the 30-year Treasury rate. A decision by the government to stop issuing such debt set off the search for a substi-

Keeping on Track

Treasury Pulls Proposed Cash Balance Reg—In a surprise move, the Treasury Department last month withdrew a key—and controversial—element of its proposed antidiscrimination regulation, designed to protect older workers whose employers convert their traditional defined benefit plan into a cash balance plan.

Treasury officials said the proposed regulation designed to block disproportionate benefits to highly compensated employees had the unintended consequence of also blocking transitional benefits to older, non-highly compensated workers. “When the effect was identified, Treasury and IRS decided to withdraw the proposed antidiscrimination regulations immediately so they do not prevent employers from reducing the impact of cash balance conversions on their employees,” stated Treasury Assistant Secretary for Tax Policy Pamela Olson, who set a new deadline of July 27 for comments on what the policy should be.

The Treasury press release announcing the action is available on the department’s Web site at www.treasury.gov/press/releases/js161.htm

Meanwhile on the legislative front, Reps. Bernie Sanders (I-VT) and Sen. Tom Harkin (D-IA) have introduced identical legislation in the House and Senate that is aimed at protecting older workers whose companies convert their pensions to cash balance plans. Their proposal would require companies that convert to cash balance plans to allow workers who are age 40 or have at least 10 years of service the choice of receiving the benefit they would have accrued under the traditional pension plan at retirement. The Sanders/Harkin bills are supported by the AARP, the AFL-CIO, CWA, and employee groups.

“Any Willing Provider” Law Affirmed—The Supreme Court last month unanimously affirmed that the state of Kentucky may require health maintenance organizations to accept any medical provider willing to comply with the HMO’s rules. Several states have laws similar to the one initially enacted by Kentucky in 1994 in an attempt to guarantee health plan participants a wider choice of providers. The decision focused on whether Kentucky was in compliance with ERISA language allowing continuing state regulation of insurance companies.

But the decision may have broader policy implications about the ability of health insurance companies to limit provider choices. It will probably be months before any judgments can be made about the broad impact of the Supreme Court decision.

Medicare Physician Reimbursement May Drop Again—Within a month after Congress voted to reverse cuts in Medicare physician payment rates that were scheduled to become effective this year, program administrators raised the possibility that such rates would be cut by more than 4 percent next year.

Even if physicians are paid less, beneficiaries may have to pay more. The Medicare actuary is projecting a 12 percent increase in the Part B monthly premium next year, to \$66 a month. Nearly all Medicare beneficiaries participate in this program that reimburses providers for outpatient care and is mostly funded by general revenues.

Medicare Financial Crisis Seen Closer; Social Security Unchanged—The trustees who project whether Medicare and Social Security will have adequate funding to pay promised benefits have delivered a split decision, projecting continued stability for Social Security but deterioration for Medicare.

During the past year, they report, Social Security has gained an extra year of projected solvency and is now seen as having adequate funds to pay promised benefits until 2042.

(see next page)

tute. Congress must agree on a replacement by the end of this year.

The proposed change would provide relief for pension funds but simultaneously make significant cuts in projected lump-sum payments. The draft bill includes transition

rules designed to protect older workers from drastic cuts.

Many in Washington believe that this bill, rather than the pension reform package proposed by the White House earlier this year, will become the basis of action later

this year. The bill also is expected to accelerate the higher limits for contributions to tax-qualified savings plans (notably 401(k)s and IRAs) that were enacted as part of the EGTRRA tax-cut law of 2001.

Keeping on Track (continued)

But Medicare's predicted time of troubles moved four years nearer, from 2030 to 2026. Despite President Bush's commitment to control costs and reform the program, what little attention the issue has garnered in Congress involves adding a prescription drug benefit that would cost a minimum of \$400 billion during the first decade. The idea of addressing the fiscal problems of either program by raising taxes or cutting benefits is getting no attention so far.

New Proposal for Medicare Drug Aid—And speaking of a Medicare prescription drug benefit: Two Democratic congressmen, Reps. Cal Dooley (CA) and Rahm Emmanuel (IL), have come up with a new proposal to spend the \$400 billion President Bush has tentatively allocated for a Medicare prescription drug benefit over the next 10 years. Their plan would have Medicare reimburse 80 percent of drug charges once Medicare recipients have spent \$4,000 a year on prescription drugs. The deductible would be lower for beneficiaries with incomes below twice the poverty level (approximately \$24,000 for a couple). The White House wants to include any such benefit expansion in a broader package that includes cost-saving Medicare reforms, but has yet to unveil a specific plan.

FASB Considers Pension Accounting Issues—A Federal Accounting Standards Board decision to seek ways to improve pension disclosure won new attention after two researchers from the Federal Reserve concluded that current "smoothing" rules result in overvaluation of shares in the firms using the procedure. At issue is a technique introduced in the 1980s that divorces funds from market volatility by "smoothing" changes in asset values over several years. Critics say the flaws in this procedure have become clearer over the past five years and that the judgment calls involved in such adjustments allow corporate executives to influence the results.

The two Fed researchers, Julia Coronado and Steven Sharpe, concluded that use of smoothing results in a modest overstatement of true share values. Their report, *Did Pension Plan Accounting Contribute to a Stock Market Bubble?* will be published by the Brookings Institution.

EBRI in Focus

EBRI Education on the Road

Presentations by EBRI President Dallas Salisbury in May included:

- May 2 at Rutgers University, NJ, where he led off and participated in a session of the Rutgers Center for HR Strategies Corporate Advisory Committee with a presentation on "strategic retirement income and health issues for HR executives."
- May 6 in Florida, where he keynoted the Institutional Investor Defined Contribution Forum with the topic: *The 401(k) Promise—Myth or Reality?* He reviewed EBRI data and studies and answered many questions, including: Can the 401(k) deliver on its promise? What changes will have to be made to secure the comfortable retirement of millions of Americans?
- May 7 in Washington, DC, where he met with the EBRI Board of Trustees for committee meetings and a semi-annual business meeting.
- May 8, also in Washington, where he participated in an EBRI-ERF policy forum on health issues, held in Washington, DC.
- May 15–16, in Orange County, CA, where he presented a keynote address to the local chapter of the Western Pension and Benefits Council on *Bridging the Gap: Cost vs. Realities of an Individual Choice World—An Insider View on Pension Reform*.
- May 17, in Scottsdale, AZ, where he met with 50 senior HR executives

who constitute the “Personnel Roundtable” to discuss strategic retirement income and health issues for HR executives. The discussion focused on the financial, worker, and public policy implications of alternative courses of action by employers.

- May 21, in Washington, where he represented the general public on the Advisory Panel on Medicare Education established by Secretary of Health and Human Services Tommy Thompson. EBRI member Bruce Taylor of Verizon was also a member of the panel.

Among other staff presentations, EBRI Senior Researcher Paul Fronstin spoke on national health care issues May 6 in Myrtle Beach, SC, to the NRECA Human Resource Management and Benefit Update Conference; on health benefit decision making May 14 in Flint, MI, to the HealthPlus Purchasers Summit; and on consumer-driven health benefits May 19 in Washington to CBI’s Second Annual Employer Summit on Managing Healthcare Costs and Quality, where he also led a workshop.

2003 RCS Released

The 2003 Retirement Confidence Survey (RCS) was released in April. Among the key findings: Americans’ overall confidence in their ability to retire comfortably has decreased only slightly from last year, yet there are strong indications of

growing anxiety because of stock market losses and continuing economic turmoil. And as previous waves of the survey have consistently found, the 2003 RCS shows that there continues to be widespread lack of knowledge and apathy about key money management issues that could prevent millions of Americans from properly preparing for their financial future.

Full results of the survey are available online at www.ebri.org/rcs

National Save For Your Future Kick-Off May 1

The American Savings Education Council (ASEC), an EBRI-ERF program, kicked off the national Save for Your Future (SFYF) campaign on May 1, in conjunction with the Social Security Administration.

SFYF is a national, regional, and local initiative designed to educate Americans on the need to plan and save for their future, using the personal Social Security Statement they receive from the SSA each year as the touchstone for annual financial planning and review. The national campaign kicked off at an event on May 1 at the National Press Club in Washington, DC, and will be mirrored later that month by up to 12 regional SFYF events around the country. Local SSA field offices will emphasize the Save For Your Future campaign initiative and

distribute SFYF campaign materials during the course of their ongoing and regular public information activities (i.e., preretirement seminars, fairs, exhibits, speeches, etc.).

The campaign has three main objectives:

- To make Americans aware of the need for savings and financial planning.
- To make Americans aware of the tools available to help them save and plan.
- To urge Americans to use their *Social Security Statement* as a starting point to begin their financial planning.

Participation of the Social Security Administration in the Save For Your Future campaign does not constitute its endorsement, authorization, or approval of any services or products of any partner.

For additional information, contact ASEC President Don Blandin at blandin@asec.org

EBRI Cosponsors TIPS Seminar

EBRI is cosponsoring a daylong seminar May 30 on “Emerging Roles for Inflation-Linked Bonds in Pension Funds and Endowments,” to be held at the National Press Club in Washington, DC. Other sponsors include the Pension Research Council of the University of Pennsylvania’s Wharton School, the Stanford Institute for Economic Policy Research (SIEPR), and TIAA-

CREF. Support for this seminar is provided by a grant from Barclays Capital.

Specific topics of interest include the future of the U.S. TIPS program; the structure and behavior of inflation-linked bonds; their characteristics as an asset class; their uses (including pros and cons) in defined contribution and defined benefit pensions and endowments; institutional experience with TIPS; and foreign inflation-linked bonds. For registration information, contact Gladys Bolella of TIAA-CREF at 212/916-5385 or gbolella@tiaa-cref.org

McMahon Memorial Service

May 10, EBRI President Dallas Salisbury and Trustee Joe Miniaci (Pacific Maritime Association) represented the EBRI family at a memorial service held in Napa Valley for deceased EBRI Trustee, Secretary and Executive Committee member Tom McMahon. Tom passed away May 3, 2002, after a short but critical illness. Remembrances of Tom can still be viewed at www.tmcMahon.info

Tom made significant contributions to EBRI and the world of financial security in his too short life. He spent a great deal of time during his last two years of life on the Advisory Council to the U.S. secretary of labor, dealing with ERISA issues. He is and will continue to be missed.

New Publications & Internet Resources

[*Note: To order publications from the U.S. Government Printing Office (GPO), call (202) 512-1800; to order congressional publications published by GPO, call (202) 512-1808. To order U.S. General Accounting Office (GAO) publications, call (202) 512-6000; to order from the Congressional Budget Office (CBO), call (202) 226-2809.*]

Collective Bargaining

Clark, Paul F., John T. Delaney, and Ann C. Frost. *Collective Bargaining in the Private Sector*. \$29.95. Industrial Relations Research Association, University of Illinois at Urbana-Champaign, 121 Labor and Industrial Relations Building, 504 E. Armonry Ave., Champaign, IL 61820, (217) 333-0072, fax: (217) 265-5130.

Employee Benefits

Hewitt Associates. *Salaried Employee Benefits Provided by Major U.S. Employers: 2002–2003*. \$375. Hewitt Associates LLC, Attn: Publications Desk, 100 Half Day Rd., Lincolnshire, IL 60069, (847) 295-5000, was.hewitt.com/hewitt.

International Personnel Management Association. *Workers' Compensation*. IPMA members, \$25; nonmembers, \$50. International Personnel Management Association, 1617 Duke St., Alexandria, VA 22314, (703) 549-7100, fax: (703) 684-0948, e-mail: publications@ipma-hr.org.

Health Care

Communicating for Agriculture & the Self-Employed. Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis: Includes Operating Statistics, Model Bill, Current Premiums, Funding Mechanisms, State Contacts. \$29.95. *Communicating for Agriculture*, 112 E. Lincoln Ave., Fergus Falls, MN 56537, (218) 739-3241; (800) 432-3276, ext. 3500; fax: (218) 739-3832.

Henry J. Kaiser Family Foundation and Hewitt Associates. *The Current State of Retiree Health Benefits: Findings from the Kaiser/Hewitt 2002 Retiree Health Survey*. Free. Henry J. Kaiser Family Foundation, 2400 Sand Hill Rd., Menlo Park, CA 94025, (800) 656-4533, www.kff.org.

Institute of Medicine (U.S.). *Committee on the Consequences of Uninsurance. Health Insurance Is a Family Matter*. \$29 (prepaid) + \$4.50 S&H. National Academy Press, 2101 Constitution Ave., NW, Box 285, Washington, DC 20055, (888) 624-8373 or (202) 334-3313, fax: (202) 334-2451.

National Health Information. *2003 Disease Management Directory & Guidebook*. \$299 + S&H. National Health Information, P.O. Box 15429, Atlanta, GA 30333-0429, (800) 597-6300, fax: (404) 607-0095, www.nhionline.net.

Weissert, Carol S., and William G. Weissert. *Governing Health: The Politics of Health Policy*. \$27.50. The Johns Hopkins University Press, 2715 N. Charles St., Baltimore, MD 21218-4319, (410) 516-6956.

Public Policy

Heritage Foundation. *The Insider Guide to Policy Experts*. \$29.95. Heritage Foundation, 214 Massachusetts Ave., NE, Washington, DC 20002, (202) 546-4400.

Reference

Insurance Information Institute. *The Fact Book 2003* [Property/Casualty Insurance Facts]. III members, \$5 + \$2.50 S&H; nonmembers, \$27.50 + \$2.50 S&H. Insurance Information Institute, Attn: Publications Dept., 110 William St., 24th Floor, New York, NY 10038, (212) 669-9200, fax: (212) 732-1916.

Insurance Information Institute and Financial Services Roundtable. *The Financial Services Fact Book 2003*. \$27.50 + \$3.50 S&H. Insurance Information Institute, Attn: Publications Dept., 110 William St., 24th Floor, New York, NY 10038, (212) 669-9200, fax: (212) 732-1916.

Taxation

Haritan, Mancuso & Jones, P.C. *2003 RIA Federal Tax Handbook*. \$54.50. Research Institute of

America, 117 E. Stevens Ave., Valhalla, NY 10595-1264, (800) 950-1216.

Work Patterns

Boston College. Center for Work & Family. *Bringing Work Home: Advantages and Challenges of Telecommuting*. \$40. Boston College Center for Work & Family, St. Clement's Hall, 140 Commonwealth Ave., Chestnut Hill, MA 02467-3862, (617) 552-2844, fax (617) 552-2859.

Worker Displacement

Kuhn, Peter J. *Losing Work, Moving On: International Perspectives on Worker Displacement*. \$28. W.E. Upjohn Institute for Employment Research, 300 S. Westnedge Ave., Kalamazoo, MI 49007-4686, (616) 343-5541.

Internet Documents

529 Plans Directory
www.529directory.com/

2001 Service Annual Survey: Health Care and Social Assistance Services
www.census.gov/svsd/www/sas62.html

2003 Wilshire Report on State Retirement Systems: Funding Levels and Asset Allocation
www.wilshire.com/Company/2003_State_Retirement_Funding_Report.pdf

America's Health: United Health Foundation State Health Rankings
www.unitedhealthfoundation.org/shr2002/index.html

A Consumer Guide to Handling Disputes with Your Employer or Private Health Plan, 2003 Update
www.kff.org/consumerguide/

Health Plan Administrative Cost Trends
news.bcbs.com/relatives/20445.pdf

National Compensation Survey: Employee Benefits in Private Industry in the United States, 2000
stats.bls.gov/ncs/ebs/sp/ebbl0019.pdf

Participant Report Card for 2002: The Impact of the Bear Market on Retirement Savings Plans
institutional.vanguard.com/pdf/Report_Card.pdf

The Pension Crisis Revealed
www.ebri.org/WhatsNew/RyanLabs-PensionCrisisRevealed.pdf

Proposed "Savings Incentives" Would Cause Revenue Hemorrhage in Future Decades
www.cbpp.org/2-5-03tax.htm

Spendthrift Nation
www.theatlantic.com/issues/2003/01/calabrese.htm

Statistical Abstract of the United States
www.census.gov/prod/www/statistical-abstract-02.html

Top 100 Defined Contribution Plans by Participation Rate
www.plansponsor.com/survey_type1/?RECORD_ID=19017

What's Whipsaw? Why Is It a Problem?
www.actuary.org/pdf/pension/whipsaw_feb03.pdf

Online Investment Sites

Alliance Capital
www.alliancecapital.com/

American Century Investments
www.americancentury.com/

Ameritrade, Inc.
www.ameritrade.com/

Bank of America
www.bankofamerica.com/

E*TRADE Financial
www.etrade.com/

Fidelity Investments
www.fid-inv.com/

Merrill Lynch
www.ml.com/

Nationwide Financial
www.nationwidefinancial.com/

OppenheimerFunds
www.oppenheimerfunds.com

Principal Financial Group
www.principal.com/

Quicken.com
www.quicken.com/

SmartMoney.com
www.smartmoney.com/

T. Rowe Price
www.troweprice.com/

Vanguard Group
www.vanguard.com/

Wachovia
www.wachovia.com/

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