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**Issues Surrounding  
Mental Health Benefits**

*Introduction*

The Clinton administration's inclusion of mental health benefits as part of the standard health care package has sparked a national debate on mental health care. Many oppose the expansion of mental health benefits because they fear an increase in their mental health care costs. However, some health analysts argue that expanded mental health benefits can ultimately save employers money by reducing the use of other medical services and raising employee productivity. A second issue concerns the quality of mental health services under managed care. A recent study by the RAND Corporation suggests that care of severely mentally ill patients may be of lower quality under health maintenance organizations (HMOs) and independent practitioner associations (IPAs), two models of managed care that may become more prominent under managed competition.<sup>1</sup>

<sup>1</sup> W.H. Rogers et al., "Outcomes for Adult Outpatients with Depression under Prepaid or Fee-for-Service Financing," Archives of General Psychiatry (July 1993): 517-525.

<sup>2</sup> Data on psychological conditions commonly categorized as problems in living, such as marital difficulties and narcissism, are not counted among major mental disorders and therefore were not included in the estimate of the total economic costs of mental illness.

*The Current System*

*Costs*—The consequences of mental illness impose a significant economic burden on society. The total economic cost of alcohol, drug, and mental disorders was estimated to be \$147.8 billion in 1990. Approximately 45 percent of this cost was treatment-related, with the remaining costs resulting from lost and reduced productivity, death, law enforcement, social welfare administration, and other related costs.<sup>2</sup> In addition, approximately one-third of the nation's 600,000 homeless adults suffer from a severe mental illness.<sup>3</sup>

Psychological conditions may be increasingly hampering the quality of employees' work. The New York Business Group on Health estimates that one out of four employees now has stress-related problems.<sup>4</sup> According to the Mental Health Policy Resource Center, mental illness is the most limiting disease in the context of the ability to work. Employers can expect employees with untreated mental health problems to have a higher

<sup>3</sup> See Donald M. Steinwachs, Judith D. Kasper, and Elizabeth A. Skinner, "Patterns of Use and Costs Among Severely Mentally Ill People," Health Affairs (Fall 1992): 179-185.

<sup>4</sup> New York Business Group on Health, Stress, Anxiety and Depression in the Workplace: Report of the New York Business Group on Health/ Gallup Survey (New York, NY: New York Business Group on Health, 1990).

turnover rate and to be absent 15 percent to 30 percent more frequently than healthy employees.

*Coverage*—Ninety-nine percent of the full-time participants in medium and large private businesses with medical benefits had inpatient mental health coverage and 98 percent had outpatient coverage in 1991 (table 1). However, coverage for mental health benefits is currently more restrictive than that for general medical illnesses. Only 18 percent of these employees had hospital care for mental health illnesses commensurate with nonmental health hospital care, and 2 percent had mental health care outpatient benefits commensurate with those for other medical conditions (table 1).

Health insurance plans typically limited hospital stays for mental illness to 30 or 60 days per year and frequently imposed a separate, lower dollar maximum on covered hospital expenses. Outpatient visits for mental health care were commonly covered at a coinsurance rate of 50 percent, while other illnesses were typically covered at a 20 percent coinsurance rate. In addition, plans usually covered fewer outpatient mental health care visits per year than other outpatient services, placed special maximum dollar limits on annual

Table 1  
Percentage of Full-Time Participants in Plans with Mental Health Benefits by Extent of Benefits, Medium and Large Establishments, 1991

Coverage Limitations	Hospital Care <sup>a</sup>	Outpatient Care <sup>b</sup>
Total	100	100
With coverage	99	98
covered the same as other illnesses	18	2
subject to separate limitations <sup>c</sup>	81	95
limit on days	54	35
per year	45	35
per confinement	9	1
per lifetime	2	(d)
limit on number of treatments	1	(d)
limit on dollars	39	68
per day	1	21
per year	9	48
per lifetime	33	32
per other period <sup>1</sup>	(d)	
coinsurance limit	10	56
50 percent	3	42
other <sup>e</sup>	7	14
ceiling on out-of-pocket expenses does not apply	16	39
separate copayment or deductible	3	12
other limitations	1	1
Without coverage	1	2

Source: U.S. Department of Labor, Bureau of Labor Statistics. *Employee Benefits in Medium and Large Private Establishments, 1991* (Washington, DC: U.S. Government Printing Office, 1993).

<sup>a</sup>Excludes doctor's charges in the hospital.

<sup>b</sup>Includes treatment in one or more of the following: Outpatient department of a hospital, residential treatment center, organized outpatient clinic, day-night treatment center, or doctor's office. If benefits differ by location of treatment, doctor's office was tabulated.

<sup>c</sup>Separate limitations indicate that mental health care benefits are more restrictive than benefits for other treatments. For example, if a plan limits inpatient mental health care to 30 days per year, but the limit on inpatient mental health care for any other type of illness is greater than 30 days per year, than plan contains separate limits. The total is less than the sum of the individual items because many plans had more than one type of limitation on mental health coverage.

<sup>d</sup>Less than 0.5 percent.

<sup>e</sup>Includes plans with reduced coinsurance other than 50 percent and plans where the rate of reimbursement varied during the treatment period.

payment, and often did not allow outpatient mental health costs to be counted toward the employee's maximum out-of-pocket expense limit (table 1).

More restrictive coverage of mental health illnesses reflects employers' and insurers' concern over the lack of "science" in diagnosis

and treatment of mental conditions relative to general medical illnesses. The development of a standardized methodology for the measurement of mental health has lagged far behind that of physical health. To some extent, the nature of psychology prevents scientifically objective evaluation of outcomes. With limited funding for health care, employers and insurers have been hesitant to provide coverage for mental health services when their efficacy is in doubt.

### ***Mental Health Coverage—How Generous?***

Experts disagree on whether mental health benefits should be equivalent to or less generous than those for general medical conditions. Many mental health experts argue that commensurate coverage can be provided at little or no extra cost through the utilization of less costly mental health treatment alternatives and reduced use of medical services. However, others

question whether broader coverage will produce savings large enough to offset a potential cost increase in the provision of mental health benefits.

*Commensurate Coverage*—Proponents of commensurate coverage contend that differential treatment of mental health and non mental

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health medical coverage reinforces the stigma of mental illness. They believe this stigma is a major reason many people fail to seek care for their psychological problems.<sup>5</sup> Proponents also contend that a higher coinsurance rate for mental health services deters many people who need care from seeking treatment.

The mental health community also points to growing evidence that negates the belief that treatment for mental disorders is not effective. According to the National Institute for Mental Health (NIMH), 60 percent of schizophrenic patients and 80 percent of manic-depressive patients improve with treatment, while the success rate for angioplasty is 41 percent and for atherectomy, 52 percent. In the long term, only 25 percent of schizophrenics and 34 percent of manic-depressives receiving treatment suffer a relapse, compared with 80 percent of those treated with a placebo.

Proponents of commensurate coverage of mental health also argue that such coverage can be provided at little or no additional cost to employers. Several studies suggest that current benefit designs, which provide more generous coverage for inpatient mental health services, may

cause people to seek mental health care in more intensive and expensive inpatient settings. For example, a Coopers and Lybrand study found that the savings gained from lowering outpatient mental health coverage from 45 to 30 visits per year are offset by an increase in inpatient costs.

Some experts believe that savings can be gained by altering mental health benefit design to include a continuum-of-care approach. This would give individuals access to a full continuum of mental health services such as inpatient, outpatient, intensive outpatient, partial hospitalization, residential treatment, medical management, and in-home care programs.<sup>6</sup> Through a continuum-of-care approach, the money now spent on costly intensive procedures could be redirected toward less costly but equally effective alternative treatments, according to Saul Feldman of The Travelers' U.S. Behavioral Health.<sup>7</sup> For example, American Biodyne, an HMO specializing in mental health benefits, found that plans that encourage shifting mental health care services to the outpatient arena can substitute \$1 million in outpatient psychotherapy for

\$4 million in hospitalization costs. Other managed care organizations using a continuum-of-care approach have had savings as high as 25 percent to 40 percent compared with traditional approaches.<sup>8</sup>

Proponents of commensurate mental health coverage contend that further savings may come from a lower utilization of medical services following the initiation of psychiatric services, or an offset effect. Several studies suggest that mental illness may either cause physical ailments or cause persons to seek medical services inappropriately for their mental health problems. Psychological intervention may reduce these problems. In addition, further savings can be gained through a reduction in indirect costs. The staff of the administration's health care task force concluded that treatment for depression and other emotional disorders ultimately saves money by increasing workers' productivity and reducing homelessness, crime, and the need for costly hospitalization. In addition, a study by NIMH concluded that providing commensurate coverage for adults and children with severe mental illnesses would yield an annual savings of \$2.2 billion.<sup>9</sup>

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<sup>5</sup> In a survey of 20,000 adults, the National Institute of Mental Health (NIMH) found that, among the 28 percent of all adult Americans affected by a mental disorder (5 million persons), only 3 in 10 of all mentally ill persons, and 6 in 10 of severely mentally ill persons, seek treatment.

<sup>6</sup> Alternatives to inpatient and psychotherapy treatments are typically not reimbursed. See Frederick C. Lee, "Managing Mental Health Care," *Benefits Quarterly* (Fourth Quarter, 1991): 91-100.

<sup>7</sup> As cited by David Albertson, "Experts Consider Mental Health Key Ingredient in Reform Mix," *Behavioral Health, supplement included in Employee Benefit News* (March 1993).

<sup>8</sup> Hay/Huggins Company, Inc., *Psychiatric Benefits in Employer-provided Healthcare Plans: 1992 Report* (Washington, DC: Hay Huggins Company, 1992).

<sup>9</sup> NIMH assumed a utilization increase from the current 60 percent to 80 percent, with total treatment costs increasing \$6.5 billion. They predict this increase would be offset by a \$7.5 billion decrease in indirect costs and a \$1.2 billion decrease in utilization of other medical services, for a net offset of \$2.2 billion. See *National Institute of Health, Health Care Reform for Americans with Severe Mental Illnesses: Report to the National Advisory Mental Health Council* (Bethesda, MD: National Institute of Mental Health, 1993).

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*Differential Benefits*—Because mental health coverage has in general been a limited benefit in private insurance policies, accurate calculation of its costs and benefits has proven difficult. Although the analysis conducted by the Clinton administration's health care reform task force included some managed care firms that successfully held down costs while providing virtually open-ended mental health benefits, the data covered less than a decade and came from companies specializing in mental health services. Therefore, proponents of differential coverage conclude that cost savings data cannot necessarily be applied to the entire national health care system.

Of particular concern to proponents of differential coverage is moral hazard, or the extent to which people will begin to use mental health services if more generous insurance coverage is made available. A 1986 RAND Corporation study found that outpatient mental health care is more responsive to price than is outpatient medical use. Participants without insurance coverage for ambulatory mental health services spent one-quarter as much on mental health care as those with no copayment, and those with 50 percent coinsurance and no limit

on cost sharing spent approximately two-fifths as much as those with no copayment.<sup>10</sup> No significant difference in mental health status among participants in the various cost sharing plans was found.

Many supporters of differential treatment also express doubt over the efficacy of mental health services. Although recent NIMH studies suggest that favorable treatment outcomes for severe mental illnesses range from 60 percent to 80 percent, an NIMH epidemiological study found that only 55 percent of mental health patients meet official diagnostic criteria for a mental illness. Treatment efficacy for those seeking help for moderate and/or temporary conditions is not well documented. Proponents of differential coverage fear that broader mental health benefits will cause many health dollars to be spent on services that have not been proven cost effective.

### ***Mental Health Benefits Under Managed Care***

If health reform results in an acceleration of the growth of managed care, the administration and delivery of mental health benefits for some people may be altered. Because current managed care organizations, such as HMOs, are likely to be

encouraged under managed competition, they serve as the best model for predicting the future of mental health care under managed competition.

*Cost*—Numerous managed care organizations have reported savings in mental health care costs of between 25 percent and 35 percent.<sup>11</sup> Some studies have suggested that lower costs were due to fewer outpatient visits per user of mental health services, greater reliance on group rather than on individual therapy, and greater utilization of nonphysician mental health providers. However, many claim that managed care organizations have controlled costs not by providing better coordinated and more cost-efficient treatment but by limiting care. They contend that a restrictive mental health benefit design has been responsible for HMO cost savings. Relative to other plans, HMOs have more restrictive limits, limiting inpatient days to 34 days per year on average and outpatient visits to 21 visits per year on average.<sup>12</sup>

*Quality*—Because prepayment plans give providers incentives to reduce the intensity of services provided, some argue that this incentive has

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<sup>10</sup> Emmett B. Keeler et al., *The Demand for Episodes of Mental Health Services* (Santa Monica, CA: The RAND Corporation, 1986). Although the study found large proportional changes in the use of mental health care as copayments rates decrease, there is a small absolute difference in costs. The average enrollee with no copayment spent \$37 per person per year (in 1986 dollars) on outpatient psychotherapy, while those in plans with a coinsurance rate of 50 percent (and no out-of-pocket limit) spent \$14 per person per year.

<sup>11</sup> Ronald Bachman, Georgia Commission on Health Care Presentation on Mental Health Pricing Model (Atlanta, GA: Coopers and Lybrand, 1993).

<sup>12</sup> National Institute of Mental Health, *Health Care Reform for Americans with Severe Mental Illnesses: Report to the National Advisory Mental Health Council* (Bethesda, MD: National Institute of Mental Health, 1993).

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caused managed care organizations to compromise the quality and outcomes of their mental health services. A recent RAND Corporation study found that, among patients of prepaid HMO and IPA plans, those suffering from severe depression acquired over time new limitations in role/physical functioning, such as being prevented from working around the house or at a paying job. Those receiving fee-for-service care did not acquire new limitations. This result may be related to the finding that depressed patients under prepaid care were one-half as likely as those with fee-for-service care to be receiving ongoing care by a psychiatrist. There were no significant differences in outcome by plan type for patients with less severe forms of depression. An earlier study found similar results for schizophrenia.<sup>13</sup>

In general, little information is available to answer quality ques-

tions about managed mental health services because the measurement of mental health outcomes has proven very difficult. It may be premature to generalize about the circumstances under which the administration of mental health care would work best.

### **Conclusion**

Many businesses, particularly small businesses, have expressed concern over the cost of mandated mental health benefits. It remains unclear whether expanded mental health benefits can sufficiently offset treatment costs through savings from lower inpatient mental health care costs, general medical costs, and indirect costs. Concern about the quality of mental health services under managed care organizations is also difficult to answer.

—*Jessica Lind, EBRI*

## **Internal Revenue Service Data Provide a Look at Plan Creations and Terminations**

### **Introduction**

In 1993, the Internal Revenue Service (IRS) issued 12,000 application letters for new qualified pension plans and 15,000 applications for termination of qualified pension plans. The IRS Office of Employee Plans and Exempt Organizations issues determination letters regarding the tax-favored status of private plans when they are established, amended, and terminated. Plans are not required by law to apply for these letters, and their issuance may precede (or more commonly follow) the relevant plan transactions by a year or more. While IRS determination letter activity is at best an imperfect measure of plan starts and terminations, it provides additional and more current insight into pension plan and participant trends.

While many sources provide data on the number of pension plans and participants as well as pension plan coverage rates and participation rates,<sup>14</sup> little is

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<sup>13</sup> W.H. Rogers et al., "Outcomes for Adult Outpatients with Depression Under Prepaid or Fee-for-Service Financing," *Archives of General Psychiatry* (July 1993): 517-525.

<sup>14</sup> These sources include data from Form 5500 annual reports filed with the Internal Revenue Service, as well as household surveys such as the Current Population Survey and the Survey of Income and Program Participation.

Table 2  
**Internal Revenue Service Determination Letter Statistics,  
 Qualified Initial Applications and Termination Applications<sup>a,b</sup>**

Initial Applications Qualified	Defined Contribution							
	Total	Defined Benefit	Total	Stock bonus	Money purchase	Target benefit	Profit sharing	ESOP <sup>c</sup>
	(thousands)							
1976-1977	61 <sup>d</sup>	10 <sup>d</sup>	47 <sup>d</sup>	2 <sup>d</sup>	16 <sup>d</sup>	e	28 <sup>d</sup>	f
1978	66	10	56	1	22	e	33	f
1979	57	15	41	1	16	e	24	f
1980	69	19	50	1	20	e	30	f
1981	82	24	58 <sup>g</sup>	g,h	21 <sup>g</sup>	e	32 <sup>g</sup>	h
1982	85	28	57	h	23	g	34	h
1983	64	22	42	h	16	g	25	h
1984	41	13	28	h	9	g	19	h
1985	48	17	30	h	9	1	21	h
1986	67	22	45	1	12	1	32	h
1987	56 <sup>j</sup>	16 <sup>i</sup>	40 <sup>i</sup>	h,i	10 <sup>i</sup>	1 <sup>i</sup>	29 <sup>i</sup>	h,i
1988	63 <sup>j</sup>	17 <sup>f</sup>	46 <sup>f</sup>	h,j	12 <sup>j</sup>	1 <sup>j</sup>	34 <sup>j</sup>	h,j
1989	28 <sup>j</sup>	5 <sup>j</sup>	23 <sup>f</sup>	h,j	5 <sup>j</sup>	1 <sup>j</sup>	17 <sup>j</sup>	h,j
1990	13 <sup>j</sup>	2 <sup>j</sup>	11 <sup>ff</sup>	h,j	2 <sup>j</sup>	h,j	8 <sup>j</sup>	h,j
1991	12 <sup>j</sup>	h,j	12 <sup>j</sup>	h,j	2 <sup>j</sup>	h,j	10 <sup>j</sup>	h,j
1992	14 <sup>j</sup>	h,j	14 <sup>j</sup>	h,j	2 <sup>j</sup>	h,j	11 <sup>j</sup>	h,j
1993	12 <sup>j</sup>	h,j	12 <sup>j</sup>	h,j	2 <sup>j</sup>	h,j	10 <sup>j</sup>	h,j

  

Termination Applications Qualified	Defined Contribution						
	Total	Defined Benefit	Total	Stock bonus and ESOP <sup>k</sup>	Money purchase	Target benefit	Profit sharing
	(thousands)						
1976-1977	16 <sup>d</sup>	5 <sup>d</sup>	10 <sup>d</sup>	d,h	3 <sup>d</sup>	e	8 <sup>d</sup>
1978	15	5	11	h	3	e	7
1979	11	3	8	h	2	e	5
1980	13	4	9	h	3	e	6
1981	13	5	9 <sup>g</sup>	g,h	3 <sup>g</sup>	e	5 <sup>g</sup>
1982	15	5	10	h	4	h	6
1983	19	7	11	h	4	h	7
1984	20	9	11	h	5	h	6
1985	26	12	14	h	6	h	8
1986	25	11	15	h	6	h	8
1987	24 <sup>j</sup>	11 <sup>i</sup>	13 <sup>i</sup>	h,i	5 <sup>i</sup>	h,i	8 <sup>i</sup>
1988	24 <sup>j</sup>	12 <sup>j</sup>	13 <sup>j</sup>	h,j	4 <sup>j</sup>	h,j	8 <sup>j</sup>
1989	29 <sup>j</sup>	16 <sup>j</sup>	13 <sup>j</sup>	h,j	4 <sup>j</sup>	h,j	9 <sup>j</sup>
1990	33 <sup>j</sup>	16 <sup>j</sup>	17 <sup>j</sup>	h,j	6 <sup>j</sup>	h,j	11 <sup>j</sup>
1991	22 <sup>j</sup>	10 <sup>j</sup>	12 <sup>j</sup>	h,j	4 <sup>j</sup>	h,j	8 <sup>j</sup>
1992	19 <sup>j</sup>	9 <sup>j</sup>	11 <sup>j</sup>	h,j	3 <sup>j</sup>	h,j	7 <sup>j</sup>
1993	15 <sup>j</sup>	7 <sup>j</sup>	8 <sup>j</sup>	h,j	2 <sup>j</sup>	h,j	5 <sup>j</sup>

Source: Department of the Treasury, Internal Revenue Service, Public Affairs Division, IRS determination letter statistics obtained from various IRS news releases, 1976-1994.

Note: The IRS's Office of Employee Plans and Exempt Organizations issues determination letters regarding the legality of private plans and plan transactions. IRS determination letter activity may be used as an imperfect, but useful, measure of plan starts and terminations.

<sup>a</sup>Fiscal years of plans vary.

<sup>b</sup>Determination data do not accurately reflect actual plan and participant changes. Plans are not legally required to file for determination letters.

The date of IRS issuance of determination letters may not coincide with the date of plan establishment or termination. Moreover, participation figures may include employees who are counted as participants in more than one plan.

<sup>c</sup>Employee Stock Ownership Plan.

<sup>d</sup>Totals include letters issued under pre-ERISA procedures. Data on these letters by plan type are not available. Therefore, data reported here by plan type include only letters issued under post-ERISA procedures.

<sup>e</sup>No plans in this category before 1982.

<sup>f</sup>No plans in this category before 1981.

<sup>g</sup>Stock bonus, money purchase, and profit-sharing subtotals for 1981 include data from February through December. Stock bonus, money purchase, and profit-sharing data cannot be categorized for January and have the following aggregate values: 4,310 initial qualifications; 1,942 qualified amendments; and 642 qualified terminations. Total applications, defined benefit and defined contribution application totals for 1981 include data for January.

<sup>h</sup>Less than 500.

<sup>i</sup>Transitional year comprised of first three quarters of calendar 1987 only.

<sup>j</sup>Fiscal years beginning on October 1 of prior calendar year, concluding on September 30 of calendar year indicated.

<sup>k</sup>The termination reporting system does not distinguish between stock bonus and ESOP plans.

known about the number of plan terminations and plan creations. Since 1976, the IRS has issued favorable letters approving tax qualified status for 838,000 new pension plans and issued 339,000 letters approving plan terminations. This represents a ratio of new to terminated plans of 2.5 (calculated from table 2). Defined benefit plans account for 221,000 of the new plan applications and 147,000 of plan termination applications. This represents a ratio of new to terminated defined benefit plans of 1.5. At the same time, IRS issued favorable letters for 612,000 new defined contribution plans and 195,000 defined contribution terminations, for a ratio of new to terminated plans of 3.1. IRS determination letter statistics indicate that pension plan growth has occurred in both defined benefit and defined contribution plans, with defined contribution plans increasing faster on a net basis than defined benefit plans.

### **Recent Activity**

Most recently, IRS statistics indicate that the net growth in defined contribution plans may be slowing. In fiscal 1990, the number

of favorable letters issued regarding defined contribution terminations exceeded the number issued in response to initial defined contribution applications for the first time since the passage of the Employee Retirement Income Security Act of 1974 (table 2). The two were equal in fiscal 1991. However, since then the number of favorable applications for defined contribution plans has slightly exceeded the number of termination applications, with 14,000 initial applications and 11,000 termination applications in 1992 and 12,000 initial applications and 8,000 termination applications in 1993.

IRS determination letter statistics also indicate that the decline in the number of defined benefit plans may be flattening. Since 1989, the number of defined benefit initial applications has decreased and remained far lower than the number of termination applications, indicating a decrease in the net number of defined benefit plans. While the number of favorable letters issued regarding defined benefit plan applications has been declining since 1989, the number of termination applications decreased from 16,000 in 1990 to 7,000 in 1993.

—*Celia Silverman, EBRI*

## **Americans Have More Confidence in Pensions and Savings than in Social Security, According to New EBRI/Gallup Survey**

Americans are more confident about the availability throughout their retirement years of an employer pension plan and personal savings than Social Security, according to a recent public opinion survey conducted by EBRI and The Gallup Organization, Inc. On a scale of one to five, with five extremely confident and one not at all confident, the mean confidence score for personal savings was 3.6, 3.4 for employer pension or savings plan, and 2.8 for Social Security.

More than two-thirds of Americans (69 percent) said they expect the level of Social Security benefits to decrease (38 percent) or be eliminated (31 percent) in the future. One-quarter of Americans (25 percent) said they expect benefits to increase in the future, and 4 percent said benefits will stay the same. Lower income individuals were more likely than higher income individuals to say Social Security benefits would increase, while higher income individuals were more likely than lower income individuals to say benefits would decrease.

“These survey results are particularly disturbing as we see

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that individuals at the lower income end, who are probably least likely to have started saving now to supplement Social Security, are the people who believe Social Security benefits will increase,” says EBRI President Dallas Salisbury.

When respondents were asked to indicate what sources from a list of options provided they used to learn about Social Security, 64 percent of Americans said newspapers contributed to their understanding of the program, with higher income individuals significantly more likely than lower income individuals to cite learning from a newspaper. Of the other responses, 60 percent said television; 56 percent said friends, neighbors, or coworkers; 27 percent said an employer, and 19 percent said a financial advisor, banker, or investment counselor.

“Employers and financial advisors, who were cited the least frequently, are the sources that are best positioned to educate people about Social Security’s role in retirement income security. Education by employers is particularly important in a less paternalistic work environment,” comments Salisbury.

In addition, results from a series of questions about how Social Security is designed and administered showed that Americans’ understanding of the program is quite good.

The survey also asked Americans to rate the trustworthiness of a variety of institutions; state the level of credibility they believe a variety of professions have; tell how much they agree or disagree with a list of statements concerning the federal government; and indicate what sources of income they believe retired people will depend on if Social Security retirement income is not available in the future.

The 1994 survey on Social Security was conducted in February 1994 and is the fifty-sixth in a series of national public opinion surveys EBRI is conducting on public attitudes toward work force and economic security issues. The surveys, conducted monthly for EBRI by The Gallup Organization, Inc., question 1,000 Americans by telephone. The maximum expected error range at the 95 percent level is  $\pm 3.1$  percent.

Copies of the survey report, *Public Attitudes on Social Security, Part I, 1994*, (G-56) may be ordered from Malaika Barnes, (202) 775-6338, for the following prices: EBRI member prices: summary—\$25; full report—\$50; nonmember prices: summary—\$50; full report—\$100. Annual subscriptions are available for a 25 percent discount. Call Carolyn Piucci Pemberton, (202) 775-6341, for more information on an annual subscription.

—Carolyn Piucci Pemberton, EBRI

## Washington Update

**Health Reform**—The House Education and Labor Committee Subcommittee on Labor-Management Relations on Apr. 21 began markup on health reform legislation. The subcommittee will ultimately vote on both a version of the Clinton plan (H.R. 3600) and the single payer bill (H.R. 1200). Subcommittee Chairman Pat Williams (D-MT) began consideration of a revised form of H.R. 3600 that replaces mandatory alliances with a requirement for states to perform the functions previously assigned to alliances; provides more subsidies for small businesses and individuals; and provides a more generous benefits package.

House Ways and Means Committee Democrats have continued to caucus since returning from recess in anticipation of markup on health reform legislation in early or mid-May. Ways and Means Republicans are not likely to support the provisions with which Chairman Dan Rostenkowski (D-IL) will likely begin markup, so he will need 20 of the committee’s 24 Democrats to pass a bill. Chairman Rostenkowski says he is ultimately looking for “universal coverage, cost controls, and 218 votes”—the number of votes needed to pass a bill in the full House of Representatives.

House Energy and Commerce Chairman John Dingell (D-MI) is having difficulty shoring up the

needed 23 votes for passage of a health plan from his committee. No Republicans are expected to vote for the plan he has crafted (*Notes*, 4/94). Of the 27 Democrats on the panel, four members, Reps. Ralph Hall (TX), Billy Tauzin (LA), J. Roy Rowland (GA), and Jim Cooper (TN), have said they also will not vote for his plan. Rep. Jim Slattery (D-KS), who is considered a swing vote, is currently drafting his own plan that contains no mandates but would automatically force Congress to implement a mandate or perhaps increase the subsidy program by the year 2000 if universal coverage has not been achieved by then. This concept of “triggering” a mandate in the future is gaining some momentum with moderate lawmakers in the Senate. In addition, the incremental bill introduced by Reps. J. Roy Rowland (D-GA) and Mike Bilirakis (R-FL) (H.R. 3955) has garnered more cosponsors in recent weeks (*Notes*, 3/94). Of the 62 cosponsors to H.R. 3955, 13 are on the Energy and Commerce Committee.

Forty-five of the 56 Senate Democrats held a retreat Apr. 16–17 to discuss how to forge a compromise on health reform. Majority Leader George Mitchell (D-ME) outlined three less costly alternative reform plans during the retreat, all of which would guarantee universal coverage and mandate that employers pay some portion of their employees’ health coverage costs. Sen. Mitchell proposed additional options at an Apr. 26 policy meeting of Democratic

senators. The Finance Committee will likely begin drafting legislation on completion of hearings in mid-May. The Senate Labor and Human Resources Committee will likely begin markup shortly thereafter.

On May 4, Congressional Budget Office (CBO) Director Robert Reischauer discussed CBO’s analysis of the Managed Competition Act of 1993 (H.R. 3222/S. 1579) at a Senate Finance Committee hearing (*Notes* 10/93). CBO estimates that the number of uninsured people would decrease 40 percent by 1996 under the proposal. However, with a comprehensive standard benefits package, costs would greatly exceed the funds designated for subsidies. CBO also estimates the average annual shortfall between 1996 and 2000 would exceed 30 percent of the subsidies for premiums for non-Medicare enrollees.

#### **Individual Retirement Accounts**

—Sens. Bill Roth (R-DE) and John Breaux (D-LA) are expected soon to introduce legislation dubbed the “Super IRA” bill. The legislation would restore full deductibility for regular IRA contributions and create a new type of back-ended IRA in which contributions would not be deductible, but distributions would be tax free. The bill would allow penalty free early IRA distributions for college education expenses, first-time home purchases, catastrophic medical expenses, and long-term unemployment.

**Outlook:** The bill’s sponsors intend

to introduce the measure as revenue neutral, increasing the chance that the bill will receive serious consideration. However, given the time constraints on the remainder of this congressional term, floor action on the bill is not likely.

**Pensions**—Rep. Robert Borski (D-PA) will introduce a bill this month that would allow workers who lose their jobs to maintain \$2,000 or more in their defined contribution plans and still be eligible for certain types of federal assistance. Current law governing eligibility for federal assistance programs requires recipients to reduce their pension savings to \$2,000 to qualify for these programs. They are eligible for unemployment assistance without having to use up their savings.

**Outlook:** The Congressional Budget Office will soon release a cost estimate of the bill. Since it is a revenue loser, Rep. Borski hopes to attach the bill to another measure that could pay for it. Such a vehicle is not likely to present itself this year.

**Pension Reform (PBGC)**—The House Ways and Means Committee held a hearing Apr. 19 on the administration’s Pension Benefit Guaranty Corporation (PBGC) reform proposal (H.R. 3396). Representatives from the Treasury and Labor Departments, the General Accounting Office, and PBGC testified at the hearing. In addition, a variety of witnesses

from unions and business coalitions also presented testimony.

The bill contains a controversial provision that would eliminate the cross-testing of defined contribution plans on a benefits basis. Treasury Assistant Secretary for Tax Policy Leslie Samuels indicated at the hearing that the department wants only to target “abusive” plans and is interested in working with the Ways and Means Committee to achieve that objective.

**Outlook:** No further hearings on the bill have yet been scheduled. With the pending retirement of Rep. J.J. Pickle (D-TX)—a long-time advocate of PBGC reform—lawmakers may push to get the bill passed as a tribute to him. House Ways and Means Chairman Dan Rostenkowski (D-IL) may further push for passage in an effort to gain Pickle’s vote on health reform. However, given the preoccupation with health legislation in both chambers, PBGC reform may not see floor action by the end of the year.

**Bankruptcy**—The Senate on Apr. 21 passed S. 540, the Bankruptcy Amendments Act of 1993. The bill is aimed at reforming personal and corporate bankruptcy law to alleviate some of the backlog in the judicial system. The bill includes provisions dealing with the status of pension benefits in personal bankruptcy and how participant loans are to be administered when an employee declares bankruptcy. An amendment to the Senate-passed

## Keeping On Track

The following items are listed to keep you up-to-date on issues that were not specifically addressed in *Washington Update*.

### Compensation Deduction Limit

The Department of the Treasury may release guidance this year on particular issues relating to the \$1 million cap on executive compensation deductions (*Notes*, 4/94). The guidance may address specifically the definition of “outside directors” and the timing for compensation committee approvals of performance goals. Comprehensive regulations will not likely be issued until next year.

### Economically Targeted Investments

The administration in a low-keyed fashion is promoting economically targeted investments (ETIs) of pension assets as a means to strengthen the U.S. economy. The administration has set up an interagency work group to consider ways to structure acceptable ETIs. Pension and Welfare Benefits Administration Assistant Secretary Olena Berg recently discussed the Department of Labor’s keen interest in pursuing ETIs for pension investments during a conference of employee benefits professionals.

### Medicaid/Medicare Data Bank

Employer guidance on reporting responsibilities continues to be delayed by the Health Care Financing Administration (*Notes*, 3/94). The guidance, originally slated for release in March, will probably not be available until sometime in May.

### Retirement Income Security

Speaking at a recent employee benefits conference, a senior Senate staff aide predicted that the retiree health care provision in the Clinton administration health reform bill will be the first thing removed in the Senate’s markup process. The aide noted the provision’s \$11 billion price tag as the reason.

### Stock Options

The Financial Accounting Standards Board (FASB) met Apr. 18 with 23 university professors, investment bankers, and others to continue deliberations on proposed rules on accounting for stock compensation (*Notes*, 4/94). FASB originally expected to issue a formal standard on stock-based compensation later this year, but the contentiousness of the issue may delay action. FASB is expected to announce in May whether financial statement preparers should plan to disclose stock options granted in 1994.

Separately, Securities and Exchange Commission (SEC) Chairman Arthur Levitt recently predicted that FASB will modify the controversial exposure draft. FASB’s final rule will be subject to SEC review.

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bill would prohibit states from taxing certain pensions received from qualified pension plans. Another provision that made it into the bill would give PBGC and state and local pension plans seats on the creditors' committees in corporate bankruptcies. A measure that was defeated would have forced companies reorganizing under Chapter 11 of the Bankruptcy Code to divert borrowed funds from operations into payments for retiree health benefits.

**Outlook:** The bill now proceeds to the House, where lawmakers are expected to act quickly on a more narrow version of the legislation. Passage of final legislation is likely this year.

**Social Security**—House Ways and Means Chairman Dan Rostenkowski (D-IL) introduced a bill (H.R. 4245) Apr. 19 to bolster the Social Security system. The bill would ensure the long-term solvency of the Social Security system by reducing the generosity of the benefit formula, increasing the normal retirement age, reducing cost-of-living adjustments, reducing income thresholds at which 85 percent of benefits are subject to income tax, and raising the Social Security payroll tax beginning in the year 2020. On Apr. 21, Rep. J.J. Pickle (D-TX) introduced his own Social Security solvency bill (H.R. 4275), which would reduce spousal benefits, extend the normal retirement age to 70, and make

cost-of-living adjustments every two years instead of annually. On a related matter, the House Ways and Means Committee passed the Social Security Act Amendments of 1994 (H.R. 4278), which would simplify employment taxes for domestic services (i.e., the “nanny tax”) and reallocate a portion of the Social Security tax to the Disability Insurance Trust Fund.

Also on the Social Security front, Rep. Andy Jacobs (D-IN) introduced a bill (H.R. 4277) on Apr. 21 to make the Social Security Administration an independent agency. The bill also includes miscellaneous administrative provisions that were dropped from the Senate version of the bill (S. 1560) that passed Mar. 2.

**Outlook:** Rep. Rostenkowski says his intention on introducing H.R. 4245 is to start debate on the long-term health of the Social Security trust fund. Rep. Pickle says he introduced H.R. 4275 in an effort to offer alternatives to Rep. Rostenkowski's bill and to alert future Social Security recipients to some changes that may be necessary to keep the system solvent. Neither bill is expected to see action this year.

Markup of the independent agency bill was held Apr. 28 in the full Ways and Means Committee. No final action was taken. House passage is likely by session's end. The administration has recently reversed its opposi-

tion to the legislation, virtually guaranteeing the bill will be signed into law this year.

**ERISA Preemption**—On Apr. 13, the Senate Labor and Human Resources Committee approved without amendment a bill (H.R. 1036/S. 1580) that would limit ERISA preemption of state prevailing wage laws, apprenticeship training programs, and mechanics' liens (*Notes*, 4/94). The House passed H.R. 1036 on Nov. 9, 1993.

**Outlook:** The bill was sent to the Senate legislative calendar, where no floor action has yet been scheduled.

—Kathy Stokes Murray, *EBRI*

## At EBRI

### *Fellows Program Being Expanded*

The Fellows Program, part of the EBRI Education and Research Fund, allows individuals from the government, private sector, academia, and media to undertake projects on health, retirement, and other economic security issues. The program is designed to aid in carrying out a mission of research and education.

EBRI is increasing its effort to expand awareness of the Fellows Program. On May 4, EBRI held a luncheon with a group of distinguished academics in the retirement field to introduce the Fellows Program to them. A similar luncheon is planned for health care researchers in the fall. For more information on the Fellows Program, call Nora Super Jones at 703/876-9124.

### *EBRI Board To Meet in June*

The EBRI Board of Trustees will meet on June 7-8 at the Watergate Hotel in

Washington, DC. The meeting will focus on the present and future direction of EBRI's research and education programs. In addition, several government and private sector officials have been invited to discuss health care, economic security, and pension public policy issues and the areas in which new data and research are needed.

### *EBRI Policy Forum Held on Retirement Security Prospects*

More than 125 people attended the May 4 EBRI Policy Forum, "Retirement in the 21st Century: Ready or Not?" organized by the EBRI Education and Research Fund. Participants at the forum explored the baby boomers' retirement income prospects; individual and employer attitudes toward planning, saving, and preparedness; initiatives by employers and investment organizations to encourage greater savings and more informed investing; and, what changes in individual savings and investment behavior may be expected in the years ahead. Proceedings from the forum will be published in an upcoming EBRI/ERF report.

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