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Health care cost management techniques, state mandates, impending retiree health accounting rules, and a growing number of pension regulations add to the complexity of employee benefit packages, which continue to represent a significant part of workers' total compensation.

Questions and Answers on Employee Benefit Issues

- Since 1980, employer spending for retirement income benefits has declined as a proportion of total compensation, while spending for medical benefits has grown.
- The number of pension plan terminations with asset reversions dropped to an annual low of 99 in 1989, with $586 million recovered in excess assets—down from a high in 1985 of 582 plans and $6.1 billion in recovered assets.
- Among participants in medium-sized and large private group health plans, the proportion required to contribute for individual coverage increased from 26 percent in 1980 to 45 percent in 1988. The proportion required to contribute for family coverage increased from 46 percent to 63 percent over the same period.
- The proportion of participants in employer-sponsored health plans in medium-sized and large private establishments who were eligible for partially or wholly employer-financed health benefits continuing into retirement up to age 65 declined by 14 percent from 1986 to 1988; the proportion with benefits that continue through Medicare eligibility dropped 22 percent over the same period.
- At least 23 percent of full-time employees in medium-sized and large private establishments were eligible for some type of flexible benefits arrangement in 1989, up from 13 percent in 1988.
- In 1989, 37 percent of full-time employees of medium-sized and large private establishments were eligible for maternity leave, and 18 percent of employees were eligible for unpaid paternity leave.

◆ Introduction

Employee benefits continue to represent a significant part of total compensation. In 1988, U.S. employers spent $474 billion for noncash benefits, representing more than 16 percent of total compensation. Since 1980, employer spending for retirement income benefits has declined as a proportion of total compensation, while spending for medical benefits has grown. As the demographic characteristics of the work force have changed, the range of benefits has changed in response to new needs. Pension plans are often tied to company profits, giving employees a stake in company success. The high cost of medical care has led many employers to reevaluate health benefits and to share the cost with their employees. Companies have begun to offer flexible benefits and child care benefits, which accommodate workers in two-worker households and working parents. Health care cost management techniques, state insurance mandates, impending retiree health accounting rules, and continuing pension regulations add to the complexity of benefit packages.

This *Issue Brief* addresses 15 topics in the areas of pensions, health insurance, and other benefits. Using a question-and-answer format, the discussion draws largely on Employee Benefit Research Institute (EBRI) research and the forthcoming *EBRI Databook on Employee Benefits*, which will be a comprehensive collection of current and historical information on pensions and retirement income, health insurance, and other employee benefits.

1. *How much do employers spend on employee benefits?*

Public and private employer spending for employee benefit programs exceeded $474 billion in 1988. This represented an absolute increase of $37.5 billion, or 8.6 percent, from 1987. However, as a percentage of total compensation ($2.9 trillion), outlays for employee benefits have remained essentially constant since 1980, at somewhat more than 16 percent (table 1).

Tabulations of the U.S. Department of Commerce's National Income and Product Accounts (NIPA) show that in 1988, employers spent $132.8 billion for group health insurance, up $12.7 billion from 1987. In both 1987 and 1988, spending for group health insurance constituted the largest single component of nonwage compensation. Although employer outlays for group health insurance as a proportion of total compensation have increased since 1980, in the last several years they have leveled off somewhat, at between 4.3 percent and 4.6 percent.

In 1988, spending for public and private retirement plans (other than Social Security) totaled $119.1 billion.

In total, outlays for all health-related benefits amounted to $163.7 billion in 1988, including Medicare (HI) expenditures of $29.7 billion and military medical insurance of $1.2 billion.

In 1988, spending for public and private retirement plans (other than Social Security) totaled $119.1 billion. Before 1987, these components collectively represented the largest element of nonwage compensation. On the other hand, employer contributions to public and private retirement plans is the only component of compensation to decline as a percentage of the total every year since 1982 (not shown in table 1). Peaking at 5.8 percent in 1980, the percentage dropped to 4.1 in 1988. This decline is predominantly due to the reduction in private pension contributions from $57.4 billion (or 3.0 percent of total compensation) in 1982 (not shown) to $50.0 billion (1.7 percent of total compensation) in 1988. This decline may be attributable to a number of factors. Higher-than-expected returns on investments during this period may have enabled companies to reduce annual pension contributions. In addition, companies may have been required

Table 1
Cost of Employee Benefits

Employer Outlays for Employee Compensation, Selected Years, 1960–1988

Component of Compensation	1960	1970	1980	1985	1986	1987	1988
				(in billions of nominal dollars)			
Total Compensation	$296.8	$618.2	$1,638.1	$2,367.4	$2,511.1	$2,689.9	$2,907.4
Wages and salaries	272.8	551.5	1,372.0	1,975.2	2,094.8	2,249.4	2,429.0
All benefits	23.7	66.1	264.3	389.0	412.7	436.6	474.1
Other labor income[a]	0.3	0.6	1.9	3.3	3.6	3.9	4.3
Retirement Income Benefits	14.2	40.3	150.5	205.5	213.8	220.7	237.9
Social Security OASDI[b]	5.6	16.2	55.6	91.5	98.1	103.9	118.8
Public and private retirement plans	8.6	24.1	94.9	114.0	115.7	116.8	119.1
private pension and profit sharing	4.9	13.1	54.2	54.6	53.5	51.6	50.0
public retirement plans[c]	3.7	11.0	40.7	59.4	62.2	65.2	69.1
Health Benefits	3.4	14.6	71.6	124.3	135.9	148.9	163.7
Social Security HI[d]	e	2.3	11.6	22.7	26.0	27.7	29.7
Group health insurance[f]	3.4	12.1	59.6	100.8	109.0	120.1	132.8
Military medical insurance	0.0	0.2	0.4	0.8	0.9	1.1	1.2
Other Employee Benefits	6.1	11.3	42.2	59.1	63.0	67.0	72.5
Unemployment insurance	3.0	3.8	16.4	26.0	24.7	24.1	24.2
Workers' compensation	2.0	4.6	19.2	24.4	28.8	33.5	38.2
Group life insurance	1.1	2.9	6.6	8.7	9.4	9.5	10.0
				(as a percentage of total compensation)			
Total Compensation	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Wages and salaries	91.9	89.2	83.8	83.4	83.4	83.6	83.5
All benefits	8.0	10.7	16.1	16.4	16.4	16.2	16.3
Other labor income[a]	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Retirement Income Benefits	4.8	6.5	9.2	8.7	8.5	8.2	8.2
Social Security OASDI[b]	1.9	2.6	3.4	3.9	3.9	3.9	4.1
Public and private retirement plans	2.8	3.9	5.8	4.8	4.6	4.3	4.1
private pension and profit sharing	1.6	2.1	3.3	2.3	2.1	1.9	1.7
public retirement plans[c]	1.2	1.8	2.5	2.5	2.5	2.4	2.4
Health Benefits	1.1	2.4	4.4	5.3	5.4	5.5	5.6
Social Security HI[d]	e	0.4	0.7	1.0	1.0	1.0	1.0
Group health insurance[f]	1.1	2.0	3.6	4.3	4.3	4.5	4.6
Military medical insurance	0.0	g	g	g	g	g	g
Other Employee Benefits	2.1	1.8	2.6	2.5	2.5	2.5	2.5
Unemployment insurance	1.0	0.6	1.0	1.1	1.0	0.9	0.8
Workers' compensation	0.7	0.7	1.2	1.0	1.1	1.2	1.3
Group life insurance	0.4	0.5	0.4	0.4	0.4	0.4	0.3

Source: EBRI tabulations of U.S. Department of Commerce, Bureau of Economic Analysis, National Income and Product Accounts, *Survey of Current Business,* selected years.

[a]Primarily directors' fees.
[b]Old-Age, Survivors, and Disability Insurance payments.
[c]Includes employer contributions to federal civilian and military retirement, railroad retirement, and state and local retirement plans.
[d]Medicare Hospital Insurance payments.
[e]Not applicable. Program not in existence.
[f]Public and private employer costs.
[g]Less than 0.1 percent.

to reduce contributions due to maximum funding limits that were enacted in 1987 and became effective the following year. The rules prohibit tax-deductible contributions once a pension plan's assets reach a certain level (related to the obligation to participants that the employer would incur if the plan were terminated).

Employer payroll taxes for the Social Security retirement and disability program (OASDI) have grown steadily since 1960 to reach $118.8 billion in 1988, approaching outlays for public and private retirement plans. Moreover, OASDI spending grew faster than any other component of compensation in 1988, climbing 14.3 percent above 1987 spending. This increase was due in part to an OASDI payroll tax increase and to an increase in the Social Security wage base (earnings subject to taxes).

Total participation in private pension plans grew to 78.2 million in 1987, up 1.5 million from the prior year.

Employer outlays for workers' compensation in 1988 ($38.2 billion) increased 14.0 percent—just behind Social Security increases. Until 1988, annual increases in workers' compensation costs outpaced all other benefit increases, as premiums in many states rose. Much of the premium increase has been attributed to increases in medical claim costs (Thompson, 1990).

Employer spending for unemployment insurance increased relatively little in absolute terms ($100 million) in 1988, but dropped as a percentage of compensation.

The NIPA data implicitly include as a component of wages and salaries payment for time not worked—vacation leave, holiday leave, sick leave, and personal leave—but do not separate the amount paid for such leave. Survey data from the U.S. Department of Labor estimate that the value of paid leave represented 7.0 percent of total compensation in 1988, up from 6.9 percent in March 1987 (U.S. Department of Labor, 1988b).

◆ Pensions and Retirement Income

2. How many workers participate in employer-sponsored pension plans? In what types of plans do they participate?

Total participation in private pension plans grew to 78.2 million in 1987, up 1.5 million from the prior year (table 2). Since 1975, pension plan participation has experienced a net increase of 33.7 million. These figures include active, retired, and separated-from-service participants and do not adjust for double counting of employees participating in multiple plans.

Because participants are counted once for each plan in which they participated, the above figures inflate the actual *number* of individuals participating in a retirement plan. Many participants are in a primary plan—a defined benefit plan or a defined contribution plan—and are also in one or more secondary plans—usually a defined contribution plan. Adjusting the numbers for duplication and to include only active participants, the data show a total of 41.9 million active *participants* in 1987. A closer look at the distribution of these participants among plans shows that 28.6 million were in primary defined benefit plans and 13.4 million were in primary defined contribution plans. (Numbers do not add to total due to rounding.)

Since 1975, participation in primary defined contribution plans has grown from 3.9 million to 13.4 million—more than a threefold increase. At the same time, the number of participants in primary defined benefit plans increased from 26.8 million in 1975 to a high of 29.8 million in 1984 but has dropped each year since then.

Table 2
Penslon Plan Participants

Participants[a] in Public and Private Single-Employer and Multiemployer Plans, Selected Years, 1975–1987

Plan	1975	1980	1981	1982	1983	1984	1985	1986	1987
All Private Plans[b]					(in millions)				
Total	44.5	57.9	60.6	63.2	69.1	73.9	74.7	76.7	78.2
defined benefit	33.0	38.0	38.9	38.6	40.0	41.0	39.7	40.0	40.0
defined contribution	11.5	19.9	21.7	24.6	29.1	32.9	35.0	36.7	38.3
Private Single-Employer Plans[c]									
Total	35.7	48.9	51.3	54.1	59.6	64.2	65.4	67.1	68.6
defined benefit	24.5	29.6	30.3	30.3	31.4	32.3	31.4	31.7	31.7
defined contribution	11.2	19.4	21.0	23.8	28.2	31.9	34.0	35.4	36.9
Private Multiemployer Plans[d]									
Total	8.8	9.0	9.2	9.1	9.5	9.7	9.3	9.6	9.7
defined benefit	8.5	8.4	8.6	8.3	8.6	8.7	8.3	8.3	8.3
defined contribution	0.3	0.6	0.7	0.8	0.9	1.0	1.0	1.3	1.4
Unduplicated Active Primary Plan Participants[e]									
Total	30.7	35.9	36.9	37.5	39.0	39.7	40.4	41.3	41.9
defined benefit	26.8	29.7	29.7	29.4	29.6	29.8	28.9	28.6	28.6
defined contribution	3.9	6.2	7.2	8.1	9.4	9.9	11.6	12.7	13.4
Public Plans									
Total	16.9	20.0	f	20.5	20.6	21.0	21.4	21.6	f
federal plans	4.1	4.5	f	4.6	4.7	4.8	4.9	4.9	f
U.S. civil service[g]	4.1	4.5	f	4.6	4.7	4.8	4.9	4.9	f
FERS[h]	i	i	i	i	i	i	i	i	0.8
railroad retirement system	1.6	1.5	1.4	1.4	1.4	1.4	1.3	1.3	f
military retirement system[j]	5.9	6.5	6.7	6.7	6.8	6.9	7.1	7.2	f
state and local plans	11.2	14.0	14.2	14.5	14.5	14.8	15.2	15.4	f

Source: John A. Turner and Daniel J. Beller, eds., *Trends in Pensions* (Washington, DC: U.S. Department of Labor, 1989); Richard Ippolito and Walter Kolodrubetz, eds.,*The Handbook of Pension Statistics, 1985* (Chicago: Commerce Clearing House, Inc., 1986); unpublished data from the U.S. Department of Labor, Pension and Welfare Benefits Administration; American Council of Life Insurance, *Pension Facts 1987 (*Washington, DC: American Council of Life Insurance, 1987); and U.S. Office of Personnel Management, *Civil Service Retirement and Disability Fund, Annual Report,1987* (Washington DC: Office of Personnel Management, n.d.).
[a]Unless otherwise noted, includes active, separated, and vested participants and beneficiaries.
[b]Data based on IRS Form 5500 series. Individuals participating in more than one plan are counted once for each plan in which they participate.
[c]Includes single-employer plans of controlled groups of corporations and multiple-employer noncollectively bargained plans.
[d]Includes multiemployer plans and multiple-employer collectively bargained plans.
[e]Data tor 1986 and 1987 are based on preliminary estimates.
[f]Data unavailable.
[g]Includes U.S. Civil Service Retirement System (CSRS), Federal Reserve, Foreign Service, and Tennessee Valley Authority employees. CSRS accounts for more than 95 percent of participants in all years.
[h]Federal Employee Retirement System. Second tier of federal plan for workers hired after January 1, 1984. Became operational January 1, 1987. Number as of September.
[i]Not applicable.
[j]Includes all active duty and reserve members of the U.S. armed forces.

The growth of participants in primary defined contribution plans, combined with a growth in secondary defined contribution plan participation, has propelled the growth in total plan participation previously noted.

In 1975, there were 7.2 million active participants in secondary defined contribution plans (Cerino and Owen, 1989). By 1987, participation had tripled to 22.1 million.[1] Very few defined benefit plans are secondary.

The number of pension plans has also grown significantly. In 1975, there were 340,000 plans. By 1987, the number reached 872,000 (Piacentini and Cerino, forthcoming). Defined contribution plans outnumbered defined benefit plans in 1987 by almost 3 to 1 (638,000 and 234,000, respectively). As a proportion of all plans, defined contribution plans have increased since 1981, while defined benefit plans have decreased.

Defined contribution plans can take a variety of forms. Profit sharing and thrift/savings plans are the most common type of defined contribution plan (table 3). In 1985, these plans collectively represented 63 percent (or 363,333 plans) of all defined contribution plans (580,931). Money purchase plans followed, accounting for 32 percent, or 188,174 plans. Other types of defined contribution plans—including target benefit plans, stock bonus, 403(b) tax-deferred annuities, and simplified employee pensions—made up the other 5 percent.

Furthermore, many of these plans can be structured to include 401(k) arrangements or employee stock ownership plans (ESOPs), both of which are becoming increasingly popular. In 1985, there were 31,658 defined contribution plans with a 401(k) feature and 10,307 plans with an ESOP feature. Most 401(k)s are part of a profit sharing or thrift plan. ESOPs are often part of a combination stock bonus and money purchase pension plan (Turner and Beller, 1989).

Participation is heavier in private single-employer plans than in multiemployer plans by more than 6 to 1 and has grown steadily since 1975. (Multiemployer plans are pension plans maintained under a collective bargaining agreement that cover employees of more than one employer. The employers are often in the same or related industries.) In 1987, 68.6 million pension participants were in single-employer plans, up from 35.7 million in 1975 (table 2). In contrast, there were 9.7 million pension participants in multiemployer plans in 1987, up from 8.8 million in 1975. The majority (8.3 million) of participants in multiemployer plans are in defined benefit plans. Participants in single-employer plans are more evenly distributed between defined benefit (31.7 million) and defined contribution (36.9 million) plans.

Table 3
Types of Defined Contribution Plans

Number of Defined Contribution Plans by Plan Type, Number with 401(k) Feature, Number with ESOP Feature, 1985

Type of Plan	Total Number of Plans	Number with 401(k) Feature	Number with ESOP Feature
Total Defined Contribution	580,931	31,658	10,307
Profit Sharing and Thrift	363,333	29,710	3,148
Stock Bonus	4,647	457	3,451
Target Benefit	8171	78	26
Money Purchase	188,174	1,357	1,316
403(b)	6,263	a	a
Simplified Employee Pension	1,948	a	a
Other Defined Contribution	8,396	55	2,365

Source: John A. Turner and Daniel J. Beller, eds., *Trends in Pensions* (Washington, DC: U.S. Department of Labor, 1989).
[a]Data unavailable.

Participation in public-sector pensions has grown more slowly than private-sector plan participation. In 1986 (the latest year for which data are available), there were more than 21 million participants in public-sector plans, up from 16.9 million in 1975. Public plans include those in the federal government—Civil Service retirement plans, the Federal Employee Retirement System, and the railroad and military retirement systems—and those in state and local governments. The bulk of public-sector retirement plan participants are in state and local plans.

[1]These numbers are not adjusted to reflected double counting of participants in more than one supplemental plan.

3. *How much do pension plans hold in assets? Where are the funds invested?*

Private and public pension funds held more than $2.8 trillion in assets at the end of 1989, up $286 billion from year-end 1988 and more than double the level at the beginning of the decade (table 4).

Assets in private pension plans include trusteed and insured funds. Trusteed funds are managed by a trustee, which may be an employee of the plan sponsor, a bank, or a trust company. Insured funds are managed by a life insurance company, which receives premiums from the plan sponsor and guarantees payment of future benefits.

At the end of 1989, private pension funds made up somewhat more than 66 percent of all pension assets, 48 percent of which were in trusteed funds and 18 percent in insured funds. A further breakdown of private trusteed funds shows that assets in single-employer defined benefit plans represented more than one-half (55 percent) of the total, and single-employer

Table 4
Pension Plan Assets

Assets[a] of Private and Public Pension Funds, 1982–1989

	Private Trusteed				Public		
	Single-employer						
Year	defined benefit	defined contribution	Multi-employer	Private Insured	Federal government retirement	State & local government	Total
	($ billions)						
1982	$399	$196	$ 61	$211	$ 98	$262	$1,227
1983	449	239	72	246	112	311	1,429
1984	460	256	79	286	130	357	1,568
1985	545	325	98	343	149	404	1,864
1986	588	359	114	407	170	469	2,107
1987	598	386	117	460	188	517	2,266
1988	661	422	129	517	208	606	2,543
1989	752	463	147	517[b]	229	721	2,829
	(as a percentage of total pension assets)						
1982	32.5%	16.0%	5.0%	17.2%	8.0%	21.4%	100.0%
1983	31.4	16.7	5.0	17.2	7.8	21.8	100.0
1984	29.3	16.3	5.0	18.2	8.3	22.8	100.0
1985	29.2	17.4	5.3	18.4	8.0	21.7	100.0
1986	27.9	17.0	5.4	19.3	8.1	22.3	100.0
1987	26.3	17.0	5.2	20.3	8.3	22.8	100.0
1988	26.0	16.6	5.1	20.3	8.2	23.8	100.0
1989	26.6	16.4	5.2	18.3[b]	8.1	25.5	100.0

Source: Employee Benefit Research Institute, *Quarterly Pension Investment Report*, fourth quarter 1989 (Washington, DC: EBRI, 1990); Board of Governors of the Federal Reserve System, *Flow of Funds Accounts, Assets and Liabilities Outstanding 1982–1989* (Washington, DC: Board of Governors of the Federal Reserve System, December 1989).

[a]Data for private trusteed funds include all assets. Due to reporting differences among the sources, public fund data include only financial assets, not real estate, physical property, or receivables. Private insured numbers exclude real estate. All assets are at market value, except state and local government funds, which (except for equity) are at book value.

[b]Data for 1988.

defined contribution plans represented 34 percent. Multiemployer plans represented the remaining 11 percent of private trusteed funds, most of which are estimated to be in defined benefit plans (U.S. Department of Labor, unpublished). No data are available to show the split of insured fund assets between defined benefit and defined contribution plans.

Assets in state and local retirement funds totaled $721 billion at the end of 1989, representing 25.5 percent of all pension fund assets. Assets in the federal government pension funds amounted to $229 billion at the end of 1989, repesenting 8 percent of total pension assets.[2] Data to show the defined benefit/defined contribution plan split for these assets are also unavailable.

While single-employer defined contribution plans invest the greatest proportion of assets in equity relative to other plans, differences in asset allocation are lessening.

Investment—While some observers view pension fund assets as one "lump" of money, in practice, pension funds are diverse in their management, investment policies, and investment allocation. Some of this diversity can be seen in the portfolio allocations of various types of plans.

At the end of 1989, private single-employer defined contribution plans held 44.5 percent of their assets in equity, 7.2 percent in bonds, 13.3 percent in cash, and 35.0 percent in other asset categories, including bank pooled funds, real estate holdings, mortgage-backed securities, guaranteed investment contracts, and mutual funds. In comparison, defined benefit plans held 40.2 percent of their assets in equity, 17.3 percent in bonds, 4 percent in cash, and 38.5 percent in other assets. Multiemployer plans held 29 percent in equity, 40.5 percent in bonds, 7.4 percent in cash, and 23.1 in other assets. (These data are for trusteed funds only; most insured pension funds are in insurance company general accounts, which are commingled with nonpension assets.) State and local government funds are proportionately more heavily invested in bonds than other plans, with 55 percent of assets in bonds, 39 percent in equity, 4 percent in cash, and 2 percent in other investments.

While single-employer defined contribution plans invest the greatest proportion of assets in equity relative to other plans, differences in asset allocation are lessening. In 1982, defined benefit plans held about 36 percent of assets in equity and 22 percent in bonds; state and local plans held less than 23 percent in equity and 69 percent in bonds. In 1950, state and local plans held nearly all (95 percent) of their assets in bonds (EBRI, 1990).

The motivation behind differences in asset allocation among plan types is not entirely clear. Work force demographics and certain constraints on contributions may have some significance.[3] In particular, state and local government pension funds are often encouraged to invest in certain state or municipal projects (usually funded by the issuance of bonds) or are limited under state laws to a maximum investment in certain vehicles, particularly equities.

In general, state and local government pension funds appear to be more active as shareholders than their private counterparts. The continued buildup of equity holdings could further induce shareholder activism in corporate governance issues. Several of the nation's largest public pension funds—generally including the California and Florida public employees' retirement

[2]Assets in public pension funds are reported somewhat differently than private pension fund assets. See footnote a to table 4 for definitions.

[3]See VanDerhei, 1990, for an examination of the relationship between work force demographics and pension asset allocation.

systems and the New York City pension fund—have recently been involved in controversial proxy votes at General Motors, Exxon, and Lockheed.

4. *What are asset reversions and why are they a public policy issue?*

The term asset reversion refers to the recovery by an employer of surplus pension assets following termination of a defined benefit plan. Surplus assets are any assets in excess of those required to pay all accrued benefits to retirees and participants.

Asset reversions became a focus of public attention in the mid-1980s, when a number of large and well-known companies terminated their defined benefit plans and took reversions. In 1985, the number of reversions[4] and the amount recovered reached an annual peak of 582 plans and $6.1 billion in recovered assets.

The U.S. Congress has held numerous hearings since then and has passed several laws modifying the treatment of asset reversions. The Tax Reform Act of 1986 applied a 10 percent excise tax on the amount recovered by the employer upon termination of a defined benefit plan, which was increased to 15 percent by the Technical and Miscellaneous Revenue Act of 1988. The Omnibus Budget Reconciliation Act of 1987 modified a previous provision in the law to prevent an employer from amending its pension plan to permit a reversion immediately before it terminated the plan. Furthermore, in 1989 the U.S. Treasury Department imposed a moratorium until May of that year on the issuance of determination letters for overfunded pension plans with asset reversions.[5] Further legislation has been introduced to curb or eliminate reversions.

The issue revolves around the question of whether excess assets from terminated pension plans should be recovered by employers or distributed to employees.

[4]Limited to reversions in excess of $1 million per plan.

[5]An employer usually files with the Internal Revenue Service for plan termination. IRS reviews the application for satisfaction of certain conditions, and, if approved, issues a determination letter.

Underlying this is the fundamental question of who "owns" these assets. Companies argue that because employers assume investment risk and in some cases fund more than the minium required contribution, they should be entitled to any accumulation of excess assets. Others believe that all pension assets belong to participants because the assets represent compensation deferred by participants in return for pensions.

Policymakers have several concerns about pension asset reversions. One is the potential benefit losses to workers resulting from the type of plan, if any, established to replace the original plan. Another concern is the decreased funding levels in the successor plan (compared with the original plan's overfunded status), which could threaten benefit security. There is also some concern for the tax arbitrage potential by employers who overfund a plan in years of high profitability only to terminate it and revert the excess assets when the effective rate is reduced.[6]

Since 1980, more than 2,000 companies have terminated their overfunded plans, recapturing a combined total of almost $21 billion (table 5). Following the peak in 1985, the number of reversions has decreased considerably. Between 1985 and 1988, the number of reversions dropped to an annual level of around 250 before declining further in 1989 to 99 plans with $545.9 million in recovered assets. The moratorium on determination letters may have had some effect on the lower 1989 level, but because the processing of plan terminations takes several months, officials suggest the effect would be minimal (VanDerhei, 1989).

Most of these terminated plans are replaced by a successor plan, which could be a new defined benefit or defined contribution plan, or a "spin-off" plan, in which active participants are separated from the original plan and placed in a new plan. The original plan, which then includes only retirees, is terminated and annuities are purchased to cover the benefits.

[6]A detailed discussion of the issues involved in asset reversions and their public policy implications is presented in VanDerhei, 1989.

Table 5
Asset Reversions

Pension Plan Terminations with Asset Reversions in Excess of $1 Million per Plan, 1980–1989

Termination Year	Number of Plans	Number of Participants	Assets	Benefits	Reversion
				($ millions)	
1980	9	22,242	$ 58.5	$ 40.0	$ 18.5
1981	35	30,512	341.6	183.0	158.6
1982	82	123,587	1,136.8	732.9	403.9
1983	166	168,314	3,429.4	1,822.6	1,606.8
1984	329	379,716	7,402.3	3,845.0	3,557.3
1985	582	708,595	13,654.1	7,548.1	6,106.0
1986	258	261,769	8,912.6	4,628.3	4,284.3
1987	277	236,060	4,931.7	2,975.3	1,956.4
1988	252	266,376	6,076.4	3,888.1	2,188.3
1989	99	108,926	1,616.3	1,070.4	545.9
Total	2,089	2,306,097	$47,559.7	$26,733.7	$20,826.0

Source: Pension Benefit Guaranty Corporation.

Most participants in terminated defined benefit plans with reversions have been covered by another defined benefit plan (VanDerhei, 1989). More than one-half of all reversions (on a participant-weighted basis) involved defined benefit replacement plans for active participants until 1987. However, data through the third quarter of 1988 suggest that the proportion is dropping.

Recent policy attention to overfunded pension plans has focused on the use of excess assets to fund retiree health liabilities and the security of insurance company annuities purchased to cover pension benefits upon plan termination. Concerning the former, Congress is considering various proposals that would allow excess pension assets to be reallocated to meet companies' retiree medical obligations. With regard to the latter, the soundness of certain insurance companies is being questioned amid indications that several are heavily invested in junk bonds. In response, in late February of this year, the Senate Labor and Human Resources Committee approved legislation (S. 685), sponsored by Sens. Howard Metzenbaum (D-OH) and Nancy Kassebaum (R-KS), that would make asset reversions subject to ERISA fiduciary standards. The bill would require that in the case of a termination a plan would not be allowed to distribute residual assets to an employer, purchase annuities for participants and beneficiaries, or transfer excess pension assets to a 401(h) retiree health account unless the fiduciary determines that such action is in the interest of the plan participants and their beneficiaries.

5. *What other ways can individuals save for retirement on a tax-effective basis? How can the self-employed save for retirement?*

Individuals can save for retirement in the same ways they save for personal uses: regular savings plans, certificates of deposit, mutual funds, stocks, bonds, etc. However, there are fewer savings vehicles (nonemployer-based) designed exclusively for retirement. One is an individual retirement account (IRA).

IRAs were originally established in 1974 for workers who did not have a pension plan at their job. Eligibility was extended to all workers and their nonworking spouses in 1981. But the Tax Reform Act of 1986 (TRA '86) changed the rules again, eliminating IRA deductions for workers who have incomes above a

certain threshold amount and who also participate in an employer-sponsored pension plan. (See EBRI, forthcoming, for a complete description of the rules.)

IRA usage grew in the early 1980s as a result of the expansion of eligibility. In 1980, 2.6 million taxpayers—representing 2.7 percent of all returns filed that year—claimed IRA deductions amounting to $3.4 billion dollars (Piacentini and Cerino, forthcoming). By 1985, a record 16.2 million taxpayers, or 15.9 percent of all returns, claimed IRA deductions totaling $38.2 billion. In 1986, the number claiming deductions dropped to 15.5 million and to 15 percent of all returns. Preliminary data for 1987 show steep declines: the number of taxpayers reporting a deduction dropped to 7.4 million and to 6.9 percent of total returns. The amount claimed dropped to $14.1 billion.

A majority of taxpayers are probably still eligible to claim full IRA deductions. EBRI estimates that 93 percent of single taxpayers, 94 percent of one-earner couples, and 77 percent of two-earner couples were still eligible to take advantage of fully deductible IRA contributions after TRA '86 became effective. But the complexity of the rules, less advertising, and the perception that the law fully eliminated IRAs for those with employer pensions may have inhibited potential new IRA contributors. In addition, former IRA contributors tended to have higher earnings and pension coverage, precluding further tax-deductible IRA contributions. (See Andrews, 1987, for a further explanation of the impact of TRA '86 on IRAs.)

Even for those who are unable to make deductible contributions to IRAs, the vehicles are still tax effective because the interest on the assets remains untaxed until distribution—unlike a regular savings account. Nondeductible IRA contributions may be more popular than first expected. New EBRI survey data reveal that some 14 million respondents reported IRA contributions in 1987—higher than IRS' preliminary 1987 figure of 7.4 million taxpayers. Many of the 14 million respondents to the EBRI survey were participants in retirement plans who earned more than the threshold limit and therefore were ineligible to make deductible IRA contributions. However, they *were* eligible for nondeductible IRA contributions.

The self-employed can save through IRAs but not through typical corporate retirement plans. Instead, unincorporated self-employed individuals can establish Keogh plans, named after Rep. Eugene J. Keogh of New York, who sponsored legislation that created the plans in the early 1960s. Although when they were first established Keogh plans were more restrictive than corporate retirement plans and had lower contribution and benefit limits, the current rules essentially parallel those for corporate plans.

Few self-employed persons take advantage of Keogh plans. In 1986 (the latest year for which comparative data are available), 772,476 unincorporated self-employed persons contributed $6.2 billion in deductions to Keoghs (Turner and Beller, 1989), which is less than 10 percent of those eligible (U.S. Department of Commerce, 1989). Amounts contributed to Keoghs are, on average, larger on a per return basis than those contributed to IRAs, reflecting the higher individual Keogh plan limits. In 1986, the average amount deducted on income tax returns was $2,361 for IRA contributions and $7,998 for Keogh contributions. Analysis of earlier data suggests that the workers who are most likely to take advantage of the available tax incentives are older workers or people who have been self-employed for many years (Andrews, 1985).

Assets held in IRA and Keogh accounts reached $455 billion by June 1989—or almost one-sixth as much as assets in all private and public pension funds (table 6). Assets in these accounts have grown substantially every year since 1981, when they totaled $39 billion. The growth in IRA and Keogh assets first slowed in 1987 (from a $74.5 billion increase to a $61.3 billion increase) and again in 1988 (dropping to a $60.6 billion increase).

Growth for the first half of 1989 was slower than for the same period in 1988 (EBRI, 1988), and therefore the year-end 1989 growth rate may drop again.

Table 6
IRA and Keogh Assets

Assets in IRA and Keogh Accounts and Distribution by Financial Institution, 1981–1989

Financial Institution	1981	1982	1983	1984	1985	1986	1987	1988	1989[a]
Total Assets ($ billions)	$38.6	$68.0	$113.0	$163.1	$230.4	$304.9	$366.2	$426.8	$454.5
					(percentage of market)				
Commercial Banks	21.0%	25.7%	26.5%	27.3%	26.3%	23.8%	22.6%	22.0%	22.6%
Savings and Loans	32.9	27.6	25.1	24.5	22.9	20.8	19.2	18.5	18.3
Mutual Savings Banks	12.4	9.1	7.7	7.1	5.1	4.9	4.2	4.9	4.8
Mutual Funds	16.1	16.0	14.9	14.3	17.1	20.8	22.5	22.7	24.1
Credit Unions[b]	0.5	2.4	4.3	5.3	6.0	6.4	6.1	5.7	5.5
Life Insurance	15.8	12.6	10.7	9.7	8.8	8.6	9.3	10.3	9.7[c]
Brokerage SDAs[b]	1.3	6.5	10.7	11.7	13.8	14.7	16.1	15.9	15.0[c]

Source: Employee Benefit Research Institute, tabulations of data collected from the *Federal Reserve Board Weekly Statistical Release*, the Federal Home Loan Bank Board, the National Council of Savings Institutions, the Investment Company Institute, the Credit Union National Association, the American Council of Life Insurance, and *The IRA Reporter*.
[a]Numbers for 1989 are as of June 30; unless noted, all other years are as of December 31.
[b]Figures represent IRA assets only.
[c]As of December 1988, the latest data available.

Nearly 50 percent of IRA and Keogh assets are invested with commercial banks and mutual funds. Savings and loans and brokerage self-directed accounts follow with 18.3 percent and 15.0 percent of assets, respectively.

◆ Health Benefits

6. How much do group health benefits cost, and how much do employees contribute to this cost?

The average cost per employee of a group health insurance plan was $2,748 in 1989, up from $2,354 in 1988 ($2,467 in 1989 dollars) and $1,645 in 1984 ($1,963 in 1989 dollars) (A. Foster Higgins & Co., Inc., 1989 and 1990). This amounts to 25.7 percent real growth in average plan cost between 1984 and 1988. But aggregate *employer contributions* per worker toward the cost of group health insurance plans experienced only 16.6 percent real growth (from $1,648 to $1,921) over the same period (Barber and Horkitz, 1990). The slower growth in aggregate employer outlays may reflect an overall reduction in coverage and increased cost sharing with employees.

At one extreme, employers may be controlling their outlays for group health insurance by eliminating it as a benefit for some or all employees. According to the 1988 U.S. Department of Labor Bureau of Labor Statistics (BLS) survey of employee benefits in medium-sized and large establishments, the proportion of full-time employees of such establishments who received employer-sponsored health insurance as an employee benefit declined from 97 percent in 1980 to 92 percent in 1988 (U.S. Department of Labor, 1989).[7] Likewise, employers may eliminate coverage for de-

[7]The BLS survey represents U.S. private-sector establishments employing at least 50, 100, or 250 workers, depending on the industry, and includes a broad representation of industries. The 1988 BLS survey represented a significant expansion in the survey coverage over previous years and, specifically, included more establishments with 100 to 250 employees (smaller establishments). The original survey data were representative of approximately 21 million full-time employees in a cross-section of private industries. The expanded survey (beginning in 1988) provides representative data for 31 million full-time employees. Because of the change in survey scope, the BLS published "old-scope" data from the 1988 survey as well as data representing the expanded survey. For purposes of comparison, measurements used in the older survey will be used for 1988 except as noted.

pendents of employees: according to the same survey, in 1988, 92 percent of participants in employer-sponsored health plans received family coverage, down from 97 percent in 1984.

More commonly, however, employers have reduced their own costs by requiring employees to contribute to individual and/or family health insurance premiums. Among participants in medium-sized and large group health plans, the proportion required to contribute to premiums for individual coverage increased from 26 percent in 1980 to 45 percent in 1988, and the proportion required to contribute for family coverage increased from 46 percent to 63 percent over the same period (table 7) (U.S. Department of Labor, 1989). Not only has the prevalence of contributory health plans increased, the average contribution for both individual and family coverage has more than doubled since 1982 (table 8). The increased prevalence of contributory plans, coupled with the increased employee dollar contribution, have resulted in employee contributions to group health premiums which, in aggregate, outgrew employer contributions to premiums by an estimated four times for individual coverage and three times for family coverage from 1982 to 1988 (Barber and Horkitz, 1990). Currently, however, employee contributions to group health premiums still average less than one-quarter of total health insurance premiums.

Insurance premium contributions are not employees' only contribution to health care costs. Employers have increasingly elected to sponsor health insurance plans requiring deductibles, copayments, and coverage limitations. In 1988, a typical indemnity insurance plan for employees of medium-sized and large establish-

Table 7
Participation in Employer Health Plans

Percentage of Full-Time Employees Participating in Employer-Sponsored Group Health Plans, by Type of Plan: Medium-Sized and Large Establishments 1980–1988; State and Local Governments, 1987

	Medium-Sized and Large Establishments							State and Local Governments[e]
	Old scope[d]					Expanded scope[d]		
Type of Coverage	1980	1982	1984	1986	1988[a]	1988[b]	1989	1987
Individual Coverage	97%	97%	97%	95%	92%	90%[c]	92%[c]	93%
Total participants	100	100	100	100	100	100	100	100
Wholly employer financed	74	73	64	57	55	57	52	65
Contributory	26	27	36	43	45	43	48	35
Family Coverage	94	93	97	95	92	c	c	93
Total participants	100	100	100	100	100	100	100	100
Wholly employer financed	54	49	42	37	37	36	34	29
Contributory	46	51	58	63	63	64	66	71

Source: U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms*, 1980–1986 and 1988 (Washington, DC: U.S. Government Printing Office, 1981–1987 and 1989); and U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in State and Local Governments, 1987* (Washington, DC: U.S. Government Printing Office, 1988).
[a]Figures represent old survey scope and can be compared with prior years.
[b]Figures represent expanded survey and can be compared with 1989 figures.
[c]Overall medical insurance coverage was not divided between individual and family coverage, but the two have been the same in recent years and can be treated as such.
[d]Old-scope figures are representative of 21 million full-time workers in establishments with at least 50, 100, or 250 employees, depending on the industry.
[e]These tabulations provide representative data for 13 million workers in state and local government establishments with 50 or more employees, excluding Alaska and Hawaii.

Table 8
Employee Contributions to Health Insurance Premiums

Average Monthly Employee Contribution, by Type of Coverage: Medium-Sized and Large Establishments, 1982–1986 and 1988–1989; State and Local Governments, 1987

Type of Coverage	Medium-Sized and Large Establishments: Old scope						Expanded scope		State and Local Governments
Year	1982	1983	1984	1985	1986	1988[a]	1988[b]	1989	1987
Individual Coverage	$ 8.97	$10.13	$11.90	$12.05	$12.80	$17.94	$19.29	$25	$15.74
Family Coverage	27.32	32.51	35.84	38.33	41.40	51.72	60.07	72	71.89

Source: U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms*, 1980–1986 and 1988, and *Employee Benefits in State and Local Governments*, *1987* (Washington, DC: U.S. Government Printing Office, 1981–1987, 1989, and 1988, respectively); and U.S. Department of Labor, Bureau of Labor Statistics, USDL 90-160 news release, 30 March 1990.
[a]Figures represent old survey scope and can be compared with prior years.
[b]Figures represent expanded survey and can be compared with 1989 figures.

ments specified a $150 deductible to be paid by the beneficiary, after which most services became reimbursable at a coinsurance rate of 80 percent. For 82 percent of fee-for-service plan participants, insurance reverted to 100 percent after a certain out-of-pocket maximum was spent (an average of $957 for individuals and $2,004 for families) (U.S. Department of Labor, 1989).

In addition to these overall limitations, cost sharing for certain medical services with costs that are considered difficult to control, such as mental health care, is often more severe. In 1988, 97 percent of plan participants in the BLS survey with outpatient mental health coverage and 74 percent of those with inpatient mental health coverage were subject to separate limitations on that coverage, including dollar maximums (67 percent and 47 percent, respectively) and limits on days and/or visits (38 percent and 32 percent, respectively). In addition to defined maximums, 50 percent coinsurance was common for outpatient mental health care (49 percent of plan participants). Benefits for the treatment of substance abuse are similar to mental health benefits in that they often are subject to special limits as well. To the extent that health plans with overall and specific limitations have less expensive premiums, these limitations are another way in which employees contribute to the cost of employer-sponsored health benefits. While employee payments for premium contributions, deductibles, copayments, and uncovered services may control *employer* expenditures, they do not necessarily reduce the total dollars spent on health care.[8]

7. *What initiatives have employers and insurers undertaken to reduce health care costs, and which have been successful?*

Employers and insurers continue to implement various measures in an effort to manage health care costs. Cost containment initiatives include alternative delivery systems such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs), utilization review techniques, expanded coverages for services or settings believed to be more cost effective, and health promotion programs. Cost management programs may be voluntary or there may be a financial

[8]Deductibles and copayments have been found to reduce participants' demand for health care services, thereby containing expenditures for all payers in the short run (Custer, 1989). The long-term cost effect of these features is not easily quantified.

incentive for participation. While some employers have reported success with specific initiatives, others remain dissatisfied, and most continue to search for ways to control their increasing costs.

HMOs give providers financial incentives to provide cost effective care and are therefore generally identified with cost containment. Annual HMO premiums were lower, on average, than fee-for-service premiums in 1989 ($2,319 versus $2,600, respectively). These figures represent a 16.5 percent increase from 1988 for HMOs, compared with 20.4 percent growth for fee-for-service plans (A. Foster Higgins & Co., Inc., 1989 and 1990). However, many employers feel that HMOs have been unsuccessful in reducing costs. Their reasons include a 17 percent annual increase in premiums, coupled with the increased costs associated with offering HMO options, including the added administrative costs of multiple plans and possible increases in indemnity rates associated with adverse selection.[9] Employers are cutting back on the number of HMO options they offer and negotiating harder for rate cuts by pressing for increased experience rating (group rates based on actual historical claims experience from the group itself). According to BLS, HMO enrollment among employees with employer-sponsored health plans grew steadily from 2 percent in 1980 to 19 percent in 1988 (U.S. Department of Labor, 1989).[10]

PPOs are a relatively new type of health care delivery network in which an organization, generally an insurer, contracts with a network of doctors, hospitals, and other health care providers to provide services at a discounted price schedule. Providers enter these agreements hoping to generate a higher volume of business. PPOs may be offered on a stand-alone basis or as an option within a traditional indemnity plan. In the latter case, insurers usually encourage participants to use the preferred providers by waiving deductibles or offering more attractive coinsurance provisions. PPOs appear to be gaining popularity: in 1989, 10 percent of participants in medium-sized and large employer health plans were enrolled in PPOs, compared with only 1 percent in 1986 (U.S. Department of Labor, 1990).[11] Employers are divided in their responses to PPO effectiveness at controlling costs. A. Foster Higgins & Co., Inc., found that 55 percent of employers surveyed said they were unable to measure the effect of PPOs on medical costs, while 24 percent said they reduced costs, 17 percent said there was no effect, and 4 percent said PPOs increased medical costs (A. Foster Higgins & Co., Inc., 1989).

Since Americans have long been accustomed to fee-for-service medicine, many place a high value on freedom of choice.

From the participant's perspective, the relative attractiveness of the various types of plans often depends on the value the individual assigns to freedom of choice in the selection of providers. Since Americans have long been accustomed to fee-for-service medicine, many place a high value on freedom of choice. For this reason, some insurers have found that plans that preserve the ultimate right to choose while giving powerful incentives to use an identifiable group of providers are more successful in the market. These plans allow the employee to choose a fee-for-service delivery mode or an HMO or PPO option within a single plan at the point of service. In these plans,

[9]Various studies indicate that when there is a choice between an HMO and a traditional indemnity plan, younger, healthier employees may be more likely to opt for the HMO, leaving a higher-risk group in the indemnity plan and thereby causing indemnity premiums to increase.

[10]Preliminary 1989 DOL data find that HMO enrollment declined to 17 percent of health plan participants in 1989, but the difference between 1989 and 1988 is not statistically significant at the 95 percent level. Moreover, data from the Group Health Association of America indicate that nearly 35 million Americans were enrolled in HMOs at the end of 1989, 6.4 percent more than in 1988.

[11]Data are not strictly comparable due to the expanded scope of the 1988 and subsequent survey; growth in PPO participation may be slightly understated.

participants incur fewer out-of-pocket expenses when using designated HMO or PPO providers than when they choose fee-for-service delivery. Allied-Signal and Southwestern Bell are notable among companies that have implemented such plans. AT&T plans to implement a point-of-service managed care network that will have the nation's largest enrollment and will be unique in that the company's unions have agreed to help write the standards and select the bidders. While they are a relatively new phenomenon, point-of-service plans are gaining in popularity. A recent study found that enrollment in open-ended HMOs, which allow enrollees to opt for care from nonnetwork providers, rose 47 percent (from 476, 788 enrollees to 702,648 enrollees) from July 1988 to July 1989, compared with 4 percent growth in "pure" HMO enrollment (InterStudy, 1990).

While HMO and PPO networks are organized to give providers financial incentives to provide cost-effective care and control utilization, neither providers nor participants in traditional indemnity plans have a natural financial interest in doing so.[12] Cost management techniques employed in indemnity plans are intended to create such incentives. Indemnity plan provisions to encourage cost-effective care include coverage for services that are believed to promote health, such as routine physical examinations, and coverage for medical care in alternative service settings that may be more cost effective, such as extended care facilities, home health care, and hospice care. More aggressive cost management strategies include lower or no insurance coverage for nonemergency weekend hospital admissions and higher coverage for prehospitalization testing, delivery at a birthing center, and mail order drugs. Programs to reduce health care costs by controlling utilization include lower or no coverage for failure to obtain prehospitalization certification, failure to obtain a second surgical opinion, and failure to submit hospital bills for review.

[12]In fact, if the provider faces any economic incentive, it is the opposite: to provide more, and more expensive, care (because his or her revenues will increase) and to provide more care to defend against malpractice litigation.

In addition to offering plans with cost management features, some employers have begun to sponsor corporate programs that may help to manage health care costs (and possibly boost productivity) by promoting wellness. The 1988 Wyatt *Group Benefits Survey* (a survey of 2,271 employers employing nearly 10 million workers and varying in size and industry) identified the following common wellness programs: smoking cessation (41 percent of surveyed employers), weight control (31 percent), fitness (27 percent), stress management (25 percent), hypertension (14 percent), health risk appraisal (12 percent), and back care (10 percent) (The Wyatt Company 1988a). While programs to promote wellness are generally voluntary, several companies—U-Haul International and Baker Hughes, Inc., among them—have established programs that require employees who smoke or who are significantly overweight or underweight to pay more than other employees toward the cost of health insurance.

8. *How many employees will receive employer-based postemployment health benefits, and how are retiree health benefits different from those for active employees?*

Because Medicare provides health benefits to individuals aged 65 and over, it is important to distinguish between employer-provided health benefits for retirees under age 65 and those for Medicare-eligible retirees. Health coverage for retirees under age 65 is typically similar to that for active employees and is therefore quite expensive, since on average older group members are sicker than younger employees. Coverage for Medicare-eligible retirees, however, tends to coordinate with or supplement the benefits provided by Medicare and should be less expensive. In 1988, 54 percent of participants in employer-sponsored health plans (private medium-sized and large establishments) were eligible for partially or wholly employer-financed health benefits continuing into retirement up to age 65, a 14 percent decline from 1986. The percentage of participants with employer-financed health benefits that continue through Medicare eligibility (that is, who were aged 65 and over) dropped nearly 22 percent over

the same period, from 58 percent in 1986 to 45 percent in 1988 (table 9) (Barber and Horkitz, 1990).[13] State and local government employees are less likely than employees of private medium-sized and large establishments to receive employer-financed retiree health coverage. In 1987, 48 percent of government employees participated in medical plans with employer-financed coverage upon retirement up to age 65, and 44 percent were in medical plans with employer-financed coverage after retirement through Medicare eligibility (U.S. Department of Labor, 1988). According to a recent study by the U.S. General Accounting Office, small employers are less likely to extend health coverage into retirement than are larger employers.

Plan design is generally the same for retirees under age 65 as for active employees. The 1988 A. Foster Higgins *Health Care Benefits Survey* (a survey of more than 1,600 private and public employers varying in size and industry whose benefit programs cover more than 10 million employees) found that 84 percent of employer-sponsored plans covering retirees under age 65 had coverage identical to that for active employees; 6 percent dropped coverage for vision, prescription drug, or other "noncore" medical benefits for retirees; 4 percent required higher deductibles and/or copayments; and 6 percent made other changes in plan design.

Health plans designed for Medicare-eligible retirees (Medigap plans) are quite different from plans for noneligible retirees. Employers that provide health coverage for Medicare-eligible retirees offer one of three types of Medigap plans: Medicare carve-out plans, in which benefits are determined and reduced by Medicare payments (43 percent); plans that coordinate benefits with Medicare so that beneficiaries may receive up to 100 percent of expenses from a combination of Medicare and employer plan benefits (33 percent); or plans that specify supplemental benefits to Medicare (24 percent) (A. Foster Higgins & Co., Inc., 1988).

[13]In addition, some employers may offer a retiree health plan that requires the retiree to pay 100 percent of the premium. In 1986 (the latest year for which BLS reported the number of participants in medium-sized and large establishments with such an option), 12 percent of plan participants were eligible for such coverage for pre-Medicare-eligibility retirement, and 11 percent of plan participants were offered such coverage after age 65.

Table 9
Health Insurance for Retirees

Percentage of Health Insurance Plan Participants with Wholly or Partially Employer-Financed Retiree Medical Coverage, Medicare Eligible and Ineligible Retirees: Private Medium-Sized and Large Establishments, 1986 vs. 1988; State and Local Governments, 1987

Provision for Coverage	Medium-Sized and Large Private Employer Plans		State and Local Public Plans
	1986	1988	1987
Retirement before Age 65 (Medicare ineligible)	63%	54%	48%
Wholly employer-financed	40	29	23
Partially employer-financed	23	25	25
Retirement at Age 65 and over (Medicare eligible)	58	45	44
Wholly employer financed	40	26	17
Partially employer financed	19	19	27

Source: Estimates based on U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms*, 1980–1986 and 1988 (Washington, DC: U.S. Government Printing Office, 1981–1987 and 1989); and U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in State and Local Governments, 1987* (Washington, DC: U.S. Government Printing Office, 1988).

Employers that provide retiree medical benefits have been more likely to increase retiree contributions to premiums in order to control costs than they have been to reduce health coverage.[14] The Wyatt Company found that the average annual contribution for individual health care coverage under a comprehensive plan was $390 for a retiree under age 65, compared with $272 for an active employee (The Wyatt Company, 1988b). In many instances, health plans that are noncontributory for active employees become contributory on retirement. The Wyatt survey calculated that 44 percent to 47 percent of group plans that are noncontributory for active employees require retirees who are under age 65 to contribute to premiums. The percentage of contributory Medigap plans is increasing as well. The survey found that 59 percent of Medigap plans required contributions in 1987, compared with 53 percent in 1985 (The Wyatt Company, 1988).

9. How are employers responding to proposed accounting rules for retiree health benefit liabilities, and what are the implications for future retiree health benefits?

Few employers prefund future liabilities for postretirement (life and health) benefits. Eighty-five percent of the U.S. corporations surveyed recently by Godwins, Inc., currently account for postretirement benefits on a pay-as-you-go basis (Godwins, Inc., 1990). This funding method may have relatively little cost implication when companies have few retirees, but as the ratio of retirees to workers grows, the productivity of relatively few workers must support benefits for relatively many retirees, and the burden of unfunded future obligations grows. Some employers have consequently found themselves faced with postretirement benefit obligations they cannot afford to meet and legal precedent that places into question their ability to terminate or curtail the plans.[15]

The Financial Accounting Standards Board (FASB) 1989 proposal on accounting standards for postretirement benefits has caused employers to reevaluate their retiree health plans.

Aside from the legal issues, the Financial Accounting Standards Board (FASB) 1989 proposal on accounting standards for postretirement benefits has caused employers to reevaluate their retiree health benefits. The proposal would require employers to account for future retiree health liabilities (and other postretirement benefits other than pensions) on an accrual basis, obligating them to record unfunded liabilities on their balance sheets. Hearings held in October and November 1989 revealed three general areas of contention that must be resolved before the final rules can be issued: identifying the attribution period over which the cost of the benefits should be recognized; measur-

[14]Changes in plan design that reduce and/or limit coverage appear to be increasing in prevalence since the Financial Accounting Standards Board (FASB) proposed accounting rules in February 1989. See question 9 in this *Issue Brief* for a discussion of the proposed FASB rules.

[15]Postretirement welfare benefits, unlike pension benefits, are not subject to vesting standards or other Employee Retirement Income Security Act (ERISA) protections. Thus, under federal statute, employees and/or retirees would forfeit these benefits upon employer discontinuance of a plan. Nevertheless, the ability of employers to take such action has been tested numerous times by the courts, which commonly apply contract law in an attempt to interpret employer intentions in plan documents. The courts have tended to find an employer "promise" in the provision of postretirement welfare benefits and that the benefits must continue until an employee's death. But there is still considerable uncertainty about the nature of the employer's commitment. The U.S. Congress has intervened when bankruptcy is an issue, requiring in a 1988 law that these benefits be paid by companies filing for chapter 11 bankruptcy. See Schmidt, 1989, for a full discussion of the legal issues.

ing the retiree health care benefits expected to be paid in the future; and identifying the transition obligation (that is, how the unfunded and unrecognized accumulated postretirement benefit obligation that is measured when the new accounting method is adopted should be recognized). FASB expects to issue the final rules by the end of 1990.

While these rules do not themselves change employers' obligations, they force employers to acknowledge the magnitude of unfunded liabilities for the first time. EBRI estimates that the present value of of employers' liability for retiree health insurance obligations (taking into account the repeal of the Medicare Catastrophic Coverage Act of 1988 was $399 billion in 1988 (table 10). Furthermore, these liabilities could reduce stock prices: a survey of employers by Towers, Perrin, Forster & Crosby, Inc., found that the proposed FASB rules could reduce pretax earnings by an average of 10 percent (Davis, 1989a). The response to the proposed accounting requirements has been limited so far but, as table 9 illustrates, there has been some movement toward dropping retiree health benefits entirely. Some companies wishing to continue retiree health benefits have redesigned them to limit employer liability.

Companies can arrange health benefits as either defined contribution plans, defined dollar benefit plans, or defined benefit plans. A defined contribution medical plan acts like a defined contribution retirement plan, providing a fixed contribution to a fund from which retiree medical costs are later paid. In this type of plan, the employer has no liability: the risk of medical costs beyond the accumulation in the fund is borne by the employees. Several companies have opted for this approach. Among them, National Intergroup enlarged its 401(k) plan to accommodate savings for retiree medical expenses. Under the plan, which has a five-year vesting requirement, the company makes a monthly deposit in each employee's account. Ralston Purina and Whitman Corp. of Chicago are phasing out their retiree medical plans and replacing them with increased contributions to their ESOPs through their 401(k) plans. An important consideration for these two companies and any others amending a retirement plan to accommodate retiree health contributions is that retirement income holdings vest throughout employment while retiree medical benefits vest only at retirement.

A defined dollar benefit approach promises a maximum annual dollar amount toward the cost of retiree medical

Table 10
Employer Retiree Health Insurance Liabilities

Public and Private Employer Liability for Retiree Health Insurance Benefits before and after Repeal of MCCA[a] (Intermediate Estimate, Discounted Present Value, 1988)

Worker/Retiree Status	Total	Private Employees	Public Employees
With Savings Associated with MCAA[b]		($ billions)	
Total	$279.4	$168.7	$110.7
current retirees	91.2	68.2	23.0
current workers	188.2	100.5	87.7
Without Savings Associated with MCAA			
Total	$399.1	$241.0	$158.1
current retirees	130.3	97.4	32.9
current workers	268.9	143.6	125.3

Source: Employee Benefit Research Institute, preliminary estimates.
[a]Medicare Catastrophic Coverage Act of 1988.
[b]These estimates include reductions in plan cost associated with MCCA before its repeal. Prior to the repeal of MCCA, corporate and public employer liabilities were an estimated 30 percent lower due to the expanded Medicare benefits.

coverage, beyond which the employee would be responsible for medical costs. In this type of plan, the employer must prefund a fixed dollar benefit but need not consider liabilities that may result from medical cost inflation or other uncertainties. TRW established a defined dollar approach, with contributions for each employee indexed to the medical consumer price index. Retirees with fewer than 20 years of service will be required to make contributions to the total cost of the medical plan, but TRW will pay the entire amount for those with 20 or more years of service.

Some employers prefer to retain a medical service benefit plan, which promises the full cost of medical coverage throughout retirement. In this type of plan, the employer must prefund the future cost of retiree health benefits and bear the risk of medical inflation and other uncertainties. 3M is among the companies that have chosen a medical service benefit. Its plan covers the full cost of one year of medical insurance for each year of service and covers for life retirees with 15 or more years of service. Tying postretirement medical benefits to years of service is a strategy for limiting employer liability in medical service benefit plans as well as other medical plans.

Employers who choose to prefund defined dollar benefit plans and medical service benefit plans must identify appropriate vehicles for investment. Because future retiree medical liabilities suffer from the unknowns of medical inflation, medical innovations, and technology, employers face a difficult challenge in deciding how to fund these liabilities to best correspond with future cashflow needs and tax consequences.[16]

10. What kinds of health coverages are mandated by the states, and what effect do they have on employees?

State-mandated benefit requirements prescribe the content of health insurance purchased from Blue Cross and Blue Shield and commercial insurers. There are currently more than 800 laws requiring insurers to include specific benefits or coverages for types of providers, services or diseases, and persons who might otherwise have difficulty in finding coverage (Crenshaw, 1990). State mandates do not extend to businesses that self-fund their health insurance plans, because ERISA preempts state law in employee benefit plans.

Proponents of state mandates claim that they help to assure a minimum level of health benefits to the insured population, that they encourage lower-cost health care providers within the health care delivery system, and that they protect chronically ill individuals by guarding against adverse selection for plans offering extensive coverage.[17] However, mandated health coverages have been found to increase health insurance premiums, thereby discouraging small employers from providing health insurance coverage and encouraging employers to self-fund their health plans if they can afford to do so (that is, predominantly large employers, who are better able to bear the risk associated with self-funding) (Gabel and Jensen, 1989).[18]

While the majority of state mandates are for fairly traditional services (table 11), several states mandate relatively unusual coverages. For example, Minnesota mandates coverage for hair transplants, Arkansas and Connecticut mandate that insurers cover the services of naturopaths (who specialize in prescribing herbs), three states require that insurers cover acupuncture, five states mandate coverage for in-vitro fertilization, and seven states have mandates against coverage for abortion (Blue Cross and Blue Shield Association, 1989).

[16]For a detailed discussion of investment strategies and funding vehicles for retiree medical funds, see Davis, 1989a.

[17]Some believe that if health insurers were free to sell plans covering minimal benefits, these plans would attract healthier groups, while plans with broader coverage would attract higher-risk groups, resulting in excessively high premiums for broad coverage plans.

[18]As seen earlier, coverages that are likely to provide cost-effective alternatives to medical care are being adopted by insurers and plan sponsors on their own because they do, in fact, save money.

Table 11
Mandated Benefits

10 Most Common State-Mandated Coverages, 1988

Mandate	Number of States
Newborns	46
Psychologists	37
Chiropractors	35
Mental/Physical Handicap	33
Conversion Privilege	33
Optometrists	31
Alcoholism	29
Dentists	27
Continuation of Dependent Coverage	27
Podiatrists	26

Source: Jon R. Gabel and Gail A. Jensen, "The Price of State Mandated Benefits," *Inquiry* (Winter 1989): 419–431.

As the effects of state-mandated health insurance coverages have been questioned, several states have passed legislation to require that mandate proposals be subject to an objective evaluation based on the social and financial impact of the new benefits. In 1984, Virginia became the first state to require mandate evaluation, followed by Arizona and Oregon in 1985, Nebraska and Pennsylvania in 1986, Florida and Hawaii in 1987, Rhode Island and Wisconsin in 1988, and Georgia and Maine in 1989. Oregon, Virginia, and Washington recently enacted laws that specifically address the negative impact of health insurance mandates on small business' ability to afford group health insurance. The Virginia law, effective July 1, 1990, allows insurers to sell policies that are exempt from certain state-mandated benefits to employers with fewer than 50 workers that have not offered health insurance in the past year. Mental health, alcohol and drug abuse treatment, and mammography screening are among the benefits that may be exempted for small employer policies. Although states adopted 79 new mandates in 1988 (more than in any previous year), the increasing prevalence of mandate evaluation laws and the recent introduction of laws to exempt insurers from state mandates in small employer plans (which are less likely to be able to effectively exempt themselves by opting to self-insure) indicate some recognition of the tradeoffs involved in such mandates.

◆ Other Employee Benefits

11. How prevalent are parental leave benefits, and what are other family-supportive employee benefits?

Economic necessity and increased opportunities for women in the labor force have influenced more mothers to work and to remain in the work force after childbearing; in the mid-1980s, only about 10 percent of families were so-called traditional families in which the husband was the sole wage earner (Charles D. Spencer and Associates, 1988). The changing demographics of the work force have created pressure on employers to consider new "family" benefits, including child care, parental leave, and flexible schedules for working parents.

Pregnancy disability leave, generally covered under employers' short-term disability insurance, requires certification of disability by a physician, usually lasts from six to eight weeks, and includes some salary replacement. The Pregnancy Discrimination Act of 1978 (PDA), which covers employers with 15 or more employees, requires employers that offer disability plans to treat pregnancy and childbirth the same as any other disability with regard to benefit programs. Under PDA, if states mandate the provision of short-term disability plans, they must also include coverage for pregnancy and childbirth. States are not required to adopt such laws, however, and only five states—California, Hawaii, New Jersey, New York, and Rhode Island—and Puerto Rico have done so. Seven states —California, Connecticut, Iowa, Louisiana, Massachusetts, Montana, and Tennessee—have mandated maternity disability leave. Five states—Oregon, Hawaii, Kansas, New Hampshire, and Washington—provide maternity leave through state antidiscrimination laws. A recent study by the National Council of Jewish Women Center for the Child found that 72 percent of larger employers (20 or more workers) and 51 percent of smaller employers (fewer than 20 workers) offered employees at least eight weeks of job-protected maternity medical leave (time off for mater-

nity-related disability) for full-time workers (Charles D. Spencer and Associates, 1988). The study found that 36 percent of the larger employers and 11 percent of the smaller employers offered the leave with some wage replacement, and 41 percent of the larger employers and 23 percent of the smaller employers continued paying for group medical coverage (contributory and noncontributory) during medical leave.

In addition to medical leave for disability associated with pregnancy, some employers offer parental leave, a benefit that provides time off for parents to care for newborn or adopted children. However, unlike medical leave, parental leave is almost exclusively unpaid and may not include job protection. The U.S. Department of Labor (DOL) found that in 1989, 37 percent of full-time employees of medium-sized and large establishments were eligible for unpaid maternity leave, and 18 percent of employees were eligible for unpaid paternity leave as an employee benefit (table 12). The maximum leave available was 20 weeks for maternity leave and 19 weeks for paternity leave (U.S. Department of Labor, 1990). Paid parental leave was rare: 3 percent of employees were eligible for paid maternity leave, and 1 percent were eligible for paid paternity leave (an average of one to three days for both).

Unpaid parental leave was more common among full-time state and local government employees. In 1987, 57 percent of these government employees were eligible for maternity leave, and 30 percent were eligible for paternity leave (U.S. Department of Labor, 1988a). In addition to being more prevalent among government employees, time available for parental leave was substantially longer: available maternity leave averaged 50.7 weeks for state and local government employees, and available paternity leave averaged 64.6 weeks. Employees on unpaid parental leave could usually continue coverage under employer-sponsored health and life insurance but often at their own expense. In some cases, however, the employer paid the premium for an initial period, after which the employee was responsible (U.S. Department of Labor, 1989).

Some states have mandated parental leave. Maine, Minnesota, Oregon, Rhode Island, Wisconsin, and Vermont require employers to provide a specified duration of unpaid parental leave for both male and female private-sector employees. Duration of the mandated leave ranges from 6 to 13 weeks. These states also have laws requiring that an employee be assigned to his or her former job or a similar job on returning from parental leave. The laws also prohibit

Table 12
Parental Leave

Percentage of Full-Time Employees Eligible for Parental Leave and Average Length of Leave, Medium-Sized and Large Establishments, 1989; State and Local Governments, 1987

	Medium-Sized and Large Private Employer Plans		State and Local Government Plans	
Program	Percentage of employees	Maximum leave available	Percentage of employees	Maximum leave available
Paid Parental Leave				
Maternity leave	3%	a	1%	a
Paternity leave	1	a	b	a
Unpaid Parental Leave				
Maternity leave	37	20 weeks	57	50.7 weeks
Paternity leave	18	19 weeks	30	64.6 weeks

Source: U.S. Department of Labor, Bureau of Labor Statistics, "Employee Benefits Focus on Family Concerns in 1989," USDL news release 90-160, 30 March 1990.
[a]Data unavailable.
[b]Less than 0.5 percent.

employers from reducing the compensation or seniority of an employee who returns from leave within the legally required time. The National Conference of State Legislatures reports that approximately 24 states had parental and family leave bills pending in legislative sessions in early 1989 (Saltford and Heck, 1990). Federal attempts to mandate that employers provide a minimum amount of maternity and paternity leave have failed.[19] Opposition to such legislation frequently centers around claims that it would be costly and disruptive for employers. This has not been the experience of some employers, however. Aetna Life & Casualty Co., for example, reports that its family leave program, introducted in 1988, has been successful in increasing employee retention and aiding in recruitment. Employees may take up to six months of unpaid leave with continued health coverage, but of the 1,323 women who took maternity disability leave during the first 12 months of the program, 214 took advantage of the family leave policy, with the average leave taken at just under one month (Bureau of National Affairs, 1989). Likewise, a survey by Oregon's state commissioner found that 88 percent of employers did not find compliance with the state's 1988 family leave statute difficult (Johnson, 1990).

Child care benefits have also become more important to many families. Some employers have established programs such as on-site or near-site day care centers and assistance with child care expenses. DOL reports that 5 percent of full-time employees working for medium-sized and large private establishments were eligible for these employer-subsidized child care benefits in 1989, up from 1 percent in 1985 (U.S. Department of Labor, 1990).[20] Direct financial assistance for child care was also rare for state and local government employees; only 2 percent were eligible for employer-subsidized benefits in 1987 (U.S. Department of Labor, 1988). Small businesses are even less likely to offer child care assistance (Saltford and Heck, 1990). More common programs for assisting employees with child care have been information and referral services; reimbursement accounts, which allow employees to make pretax salary reductions to pay for child care and other qualified expenses; and flexible work schedules, including policies allowing flextime, part-time work, job sharing, work at home, and flexible leave policies.[21]

In 1988, federal spending for child care assistance totaled an estimated $6.9 billion through direct outlays, tax credits, and deductions (Braymen, 1990). Many argue, however, that these funds are insufficient to meet child care needs and support further federal involvement not only through direct financial assistance but through the expansion of day care programs and standardized health and safety regulations. Currently, each of the 50 states regulates child care through separate licensing and certification procedures. Child care, like parental leave, has been on the congressional agenda since the mid-1980s. Both the Senate and the House have approved bills to expand federal assistance for child care, but these bills have significantly different provisions. A conference committee must meet to resolve the differences before a bill is presented to President Bush. Bush has threatened to veto the legislation, citing the cost of the proposed assistance and of the requirements for minimum health and safety standards.[22]

12. How common are flexible benefit plans, and what types of benefits are typically included?

Flexible benefit plans, also known as cafeteria plans, allow employees some choice in their employee benefits package. Employees can select the benefits they value

[19]Parental leave legislation does not distinguish between time off for medical leave associated with maternity and time off for nonmedical parental leave.

[20]Data are not strictly comparable due to the expanded scope of the 1988 and the subsequent survey; growth in child care benefits may be slightly understated.

[21]For a full discussion of employee benefits supportive of families, their prevalence, and their effect on worker productivity, see Saltford and Heck, 1990.

[22]For a review of recent legislative initiaives in the child care area, see Braymen, 1990.

the most and that meet their specific family or lifestyle needs and forgo benefits that are less important to them.

Established under section 125 of the Internal Revenue Code in 1978, flexible benefit plans did not experience much growth until 1981, when regulations interpreting the legislation were released. Since then, they have generated increasing attention, and many large companies have established them. More than 1,000 of the largest U.S. employers surveyed by Hewitt Associates—including almost one-half of top 100 industrial companies and 26 percent of the top 500 companies ranked by *Fortune* magazine—had established flexible benefit programs by 1989 (Hewitt Associates, 1990). These programs were most prevalent in commercial banks (53 percent of the top 100) and in life insurance companies (38 percent of the top 50), followed by utilities (24 percent of the top 50).

Among other employers, flexible benefits are less widespread but are growing rapidly. In 1989, at least 23 percent of full-time employees in private medium-sized and large establishments were eligible for some type of flexible benefits arrangements, up from 13 percent in 1988 (table 13) (U.S. Department of Labor, 1990).

The establishment and growth of flexible benefits plans has been driven by a number of factors. In particular, the changing demographic profile of the work force—more women, more dual husband-and-wife wage earners, and more working families with children—has led to changing benefits needs. In traditional benefits packages, dual-earner couples may experience duplicate coverage for some benefits, such as health care, and may lack other benefits, such as child care or extra time off. In a flexible benefits plan, duplicate benefits may be reduced and benefit options broadened.

Table 13
Flexible Benefits Arrangements

Full-Time Employees Eligible for Flexible Benefits Plans and Reimbursement Accounts, Private-Sector Medium-Sized and Large Establishments, 1986, 1988, and 1989; State and Local Governments, 1987

	Private, 1988[a] (former survey scope)	Private, 1986	Private, 1989	Private, 1988[a] (expanded scope)	State and Local, 1987
Total Eligible for Flexible Benefits Plan and/or Reimbursement Account	15%	5%	b	13%	9%
Flexible Benefits Plan	6	2	9%	5	5
with Reimbursement Account	5	2	b	4	1
Total with Reimbursement Account	14	5	23	12	5
Free standing Account	9	3	b	8	3

Source: U.S. Department of Labor, Bureau of Labor Statistics, "Employee Benefits Focus on Family Concerns in 1989," USDL news release 90-160, 30 March 1990; and U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms,* 1988 and 1986, and *Employee Benefits in State and Local Governments, 1987* (Washington, DC: U.S. Government Printing Office, 1989, 1987, and 1988, respectively).

[a]The 1988 survey increased the minimum establishment size of covered firms, thus expanding the survey scope and making the1988 data not strictly comparable with 1986 data. For comparison purposes, the data in column 1 are limited to the scope of earlier surveys and can be compared with 1986 data. The data in column 4 include the establishments newly covered by the survey in its expanded scope and can be compared with the 1989 and the 1987 state and local data.

[b]Unavailable.

The rising cost of health care has also been a force driving flexible benefit plan growth. Often a flexible benefits plan is designed to allow employees to choose certain cost-saving provisions that in turn generate extra credits that the employee can use to purchase coverages otherwise not obtainable. In addition, when flexible benefits plans are first implemented, cost control mechanisms are usually added or increased at the same time, which can shift some costs from employer to employee.

In a flexible benefits plan, an employer typically allocates a specified amount of money to each employee with which to "buy" benefits. Each type of benefit or benefit level has a value, or cost, associated with it. If the cost exceeds employer contributions, many plans permit employee contributions—usually pretax—to help purchase the benefit.

Reimbursement accounts (either freestanding or as part of flexible benefits plans) appear to be more common than flexible benefits plans alone.

Benefit areas most commonly offered in flexible benefits plans include a variety of health options, such as indemnity plans, health maintenance organizations and preferred provider organizations; dental care; life insurance; long-term disability; accidental death and dismemberment; and paid time off (Hewitt Associates, 1989). Some employers include short-term disability, sick leave, dependent care, and legal assistance (Meisenheimer and Wiatrowski, 1989).

Another type of flexible benefits arrangement is a reimbursement account (also called a flexible spending account) which may supplement a flexible benefits plan or stand alone. Reimbursement accounts provide a way for employees to pay for expenses not covered by their existing benefit plan, such as health insurance copayments, deductibles, coinsurance, or other out-of-pocket expenses; dependent care expenses; or health insurance premium contributions. Accounts are usually funded through employee pretax contributions, which are designated prior to the plan year and withheld in equal amounts from employee paychecks. When the employee incurs an expense, he or she is reimbursed with pretax dollars. Some employers also contribute to these accounts.

Reimbursement accounts (either freestanding or as part of flexible benefits plans) appear to be more common than flexible benefits plans alone. DOL reports that in 1989, 23 percent of employees were eligible for reimbursement accounts, while 9 percent were eligible for flexible benefits plans alone. Most flexible spending accounts are established independently of a flex plan, but they may also be established as part of a plan. In the latter case, employers may contribute part of the flexible benefits plan credit to the reimbursement account.

There is no statutory limit on annual contributions to flexible benefits arrangements, unless an individual benefit has its own limit or the plan has an established limit. Child care, for example, has a statutory $5,000 annual limit, so the plan could not allow more than this amount to be funded through a reimbursement account or flexible benefits plan. In practice, most employers set an upper limit. Employees must be careful when designating annual contributions, because unused portions are forfeitable at the end of the plan year. The Hewitt Associates 1989 survey reports that average annual employee contributions to reimbursement accounts that are part of a full flexible benefits plan averaged $524 for health care accounts and $2,426 for dependent care accounts (Hewitt Associates, 1989). Another survey by A. Foster Higgins showed a similar average contribution for dependent care—$2,395—but a somewhat higher amount—$670—for health care (A. Foster Higgins & Co., Inc., n.d.)

13. *What are other common employee benefits?*

Life insurance and disability benefits in the form of sick leave, sickness and accident insurance, and long-term disability insurance also represent a portion of the 16.3 percent of total compensation that employers spend on employee benefits. In 1988, 89 percent of employees of medium-sized and large establishments were covered by an income protection plan in the event of a short-term disability—either sickness and accident insurance, sick leave, or both (U.S. Department of Labor, 1989) (table 14).

Life insurance plans covered 92 percent of full-time employees in medium-sized and large establishments in 1988, and 85 percent of state and local government employees in 1987.

Other benefits include paid leave, severance pay, transportation benefits, gifts and cash bonuses, financial and legal services, health promotion programs, and education assistance programs. In general, employees of private medium-sized and large establishments were more likely to participate in these benefit programs than were government employees.

14. *Are employee benefits less common for employees of small businesses?*

Larger employers are more likely to offer health insurance and/or other nonwage benefits than are smaller ones (table 15). An analysis conducted by ICF Incorporated of the U.S. Small Business Administration's (SBA) Health Benefits Data Base provides information on the number of firms that offered various employee benefits in 1986. Health benefits were offered by 100 percent of firms with more than 500 employees, by 78 percent of employers with between 10 and 24 employees, and by only 46 percent of those with 1 to 9 employees. Similarly, employees in larger firms were more likely to have vacation and sick leave, life insurance, retirement savings plans, and disability insurance. These findings are consistent with those of the National Federation of Independent Business (NFIB) 1985 survey of small business benefits, which measured the number of *employees* working for small employers with individual benefits.

Health insurance for employees of small firms is of special concern to policymakers. Small businesses account for a disproportionately large proportion of employed individuals who lack health insurance. According to the 1987 SBA annual report, 73 percent of the employed uninsured worked for small businesses having fewer than 100 employees. (However, only 38 percent of U.S. private-sector workers were employed in small businesses with fewer than 100 employees in 1988 (Piacentini, 1990).) Small businesses face higher group health insurance premiums than larger employers and are often unable to qualify for group rates (or are required to exclude certain individuals in order to do so), leading small business advocates and policymakers to call for insurance reform in the small group market. The 1989 NFIB Health Care Benefit Survey (a random survey of NFIB members,)[23] indicates that 22 percent of the businesses that reported having no health plan said they could not qualify for group health insurance rates. Among employers that sponsored group health plans, 16 percent of indicated that employees were excluded on the basis of preexisting health conditions or older age.

The U.S. Bipartisan Commission on Comprehensive Health Care (Pepper Commission) recommended reforming the small group insurance market, prohibiting the exclusion of persons with preexisting conditions and/or individual group members from health plans, and guaranteeing small groups access to community rated policies (U.S. Bipartisan Commission on Comprehensive Health Care, 1990). While many parts of the report have been criticized, these provisions have some support, and many observers feel that they may be the only recommendations that Congress addresses this year. The Health Insurance Association of America, in

[23]NFIB members are generally representative of the total business population on a variety of demographic characteristics, but are somewhat larger and older than the general small business population.

Table 14
Types of Employee Benefits

Percentage of Full-Time Employees Participating[a] in Employee Benefit Programs:[b] Medium-Sized and Large Private Establishments, 1988; State and Local Governments, 1987

Employee Benefit Program	Medium-Sized and Large Private Employer Plans[a]	State and Local Government Plans[b]
Paid Leave		
Holidays	96%	81%
Vacations	98	72
Personal leave	24	38
Lunch period	11	17
Rest time	72	58
Funeral leave	85	56
Jury duty leave	91	98
Military leave	55	80
Sick leave	69	97
Insurance Programs		
Sickness and accident insurance	46	14
wholly employer financed	37	12
partly employer financed	9	2
Long-term disability insurance	42	31
wholly employer financed	33	28
partly employer financed	9	3
Life insurance	92	85
wholly employer financed	80	69
partly employer financed	12	16
accidental death and dismemberment included	76	67
Other Benefits		
Income continuation plans		
severance pay	42	6
supplemental unemployment benefits	6	1
Transportation benefits		
free or subsidized employee parking	84	73
subsidized commuting	5	5
job-related travel accident insurance	49	16
Gifts and cash bonuses		
gifts	16	c
nonproduction bonuses	22	7
Financial and legal services		
financial counseling	10	10
prepaid legal services	4	6
Health promotion programs		
in-house infirmary	35	19
wellness programs	17	c
employee assistance programs	43	c
Employer-subsidized recreation facilities	25	11
Employee discounts	52	c
Subsidized meals	21	12
Relocation allowance	33	15
Education assistance		
job related	70	53
not job related	18	15
Sabbatical leave	c	21

Source: Derived from U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms*, *1988* (Washington, DC: U.S. Government Printing Office, 1989); and U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in State and Local Governments*, *1987* (Washington, DC: U.S. Government Printing Office, 1988).
[a]Includes workers covered but not yet participating due to minimum service requirements. Does not include workers offered but not electing contributory benefits.
[b]Includes only benefits that are partly or wholly employer paid.
[c]Data unavailable.

Table 15
Employee Benefits in Small Firms
Percentage of Firms that Offer Different Employee Benefits, by Firm Size, 1986

		Number of Employees				
Employee Benefit	Total	1–9	10–24	25–99	100–499	500+
Percentage Offering:						
Vacation	59%	52%	75%	83%	91%	95%
Health	56	46	78	92	98	100
Sick leave	37	32	42	59	77	91
Life insurance	30	22	45	62	80	94
Pension/401(k)	17	11	22	41	66	79
Bonus plan	12	10	13	17	17	29
Short-term disability	10	7	12	26	37	55
Long-term disability	9	6	14	21	47	69
Savings plan	2	a	3	12	17	29
Cafeteria-style health benefits	1	a	1	2	1	12
Vacation, sick leave, health, life, and pension or 401(k)	8	3	14	25	50	75
No answer	19	20	14	14	7	33

Source: ICF Incorporated analysis of Small Business Administration, Office of Advocacy, Health Benefits Data Base, 1986.
Note: While each of the other benefits categories listed above may be somewhat low due to missing data, there were no missing data for health benefits. Consequently, the ratio of health benefits to other employee benefits listed above may be somewhat high.
[a]Less than 0.5 percent.

its own proposal for small employer market reform, would guarantee small employers (those with fewer than 25 employees) "relatively affordable" group coverage but would permit medical underwriting and establish a privately funded and administered reinsurance mechanism through which insurers could reinsure high-risk persons.

Aside from the costs, the decision not to provide health insurance may reflect employee preferences for wages over noncash benefits (theoretically, smaller employers can better reflect group preferences than larger employers). The NFIB survey found that 74 percent of employers (including those who sponsor and those who do not sponsor group health insurance) agreed with the statement, "employees prefer wage increases to health insurance." Likewise, when asked how they would increase compensation by $100 if they wanted to do so, 76 percent of employers surveyed responded that they would increase wages, 11 percent said they would provide an additional $100 per month in health benefits, and 8 percent said they would provide other nonwage compensation. It may be the case that even if every small employer were guaranteed "relatively affordable health insurance coverage," many still would not choose to offer health insurance as an employee benefit. But the choice to forgo health insurance has some troubling implications beyond the exposure of the uninsured individual. Those who are not covered by health insurance are at personal financial risk, but they may also impose an external cost on others who *do* pay for health insurance (including taxpayers).[24]

15. How do social expenditures in the United States compare with expenditures for similar programs in other countries?

[24]Uninsured individuals risk receiving care for which they cannot afford to pay, but many of these people will receive care anyway. The cost of care for the medically indigent may be largely passed on to those who can pay in the form of higher prices and insurance premiums. This may contribute to a spiral in which the higher cost of health insurance increases the number of individuals and employers who cease to purchase the insurance, thereby increasing the number of uninsured and exacerbating the problem.

To facilitate comparison of social expenditures among various countries, a broad definition of the concept is often used. The Organization for Economic Cooperation and Development defines social expenditure to include both direct public expenditure on social services, such as health, education, and welfare and transfer payments from the government to households in the form of social security, unemployment compensation, and other income support schemes (Organization for Economic Cooperation and Development, 1988). According to this definition, in 1985, the United States spent 18.2 percent of its gross domestic product (GDP) on social programs—less than any other country studied except Japan (16.2 percent) (table 16). France had the highest level of spending, 34 percent of GDP, followed by Sweden and the Netherlands, which spent 32 percent and 31 percent, respectively. Between 1980 and 1985, social expenditures increased nearly 16 percent in Canada (from 19.5 percent to 22.6 percent) and 11 percent in France (from 30.4 percent to 34.2 percent). Sweden, Germany, and the Netherlands exhibited a net total decrease in social expenditures of about 3.5 percent during the same period. Japan, the United States, and the United Kingdom experienced relatively slow growth in these expenditures (table 16).

Public expenditure for social security cost between 5 percent and 13 percent of countries' GDP in 1985. France spent the most (13 percent), followed by Germany (12 percent) and Sweden (11 percent). Contributing to the high cost in these countries are a preretirement earnings replacement rate of more than 65 percent in France and Sweden and a large proportion of the population aged 65 or over in all three. The countries spending the least for social security—the United Kingdom, Canada, and Japan—have lower average preretirement earnings replacement rates of 31 percent, 34 percent, and 54 percent, respectively. Also, Canada and Japan have the smallest proportion of population aged 65 or over relative to the other countries studied.[25] Finally, an additional cost saving feature in Canada, the United Kingdom, and the United States is the lack of partial disability pension provisions available in other countries (Gordon, 1988).

[25]Japan's population aged or over 65 is projected to increase rapidly in the next century. The Japanese government has already begun searching for ways public and private programs can cope with this demographic change. The results may change public and private spending for retirement and health and welfare programs. For further discussion, see Martin, 1989.

Table 16
Public Spending on Social Programs in Various Countries

Social Program Expenditures as Percentage of Gross Domestic Product, 1980 and 1985, Selected Countries

	Proportion of GDP Spent on Social Programs		Proportion of GDP Spent in 1985 for Specific Programs			
Country	1980	1985	Education[b]	Health	Social Security	Unemployment
Japan	16.1%	16.2%	5.1%	4.8%	5.3%	0.4%
United States	18.0	18.2	5.0	4.4	7.2	0.4
United Kingdom	20.0	20.9	5.0	5.2	6.7	1.8
Canada	19.5	22.6	6.6	6.4	5.4	3.3
Germany	26.6	25.8	4.3	6.4	11.8	1.5
Netherlands	31.8	30.7	6.6	6.5	10.5	3.3
Sweden[a]	33.2	32.0	7.5	8.5	11.2	0.7
France	30.9	34.2	5.6	6.8	12.7	2.8

Sources: Organization for Economic Cooperation and Development, *The Future of Social Protection 1988* (Paris: OECD, 1988); Organization for Economic Cooperation and Development, *Education in OECD Countries* (Paris: OECD, 1989).
[a]All data (except education) are for 1984.
[b]Data are for 1986.

The United States government spends far less proportionately than most other countries on public health care programs. In 1987, only 4.6 percent of GDP was allocated to public health expenditures in the United States, compared with 8.2 percent in Sweden and 6.7 percent in France. This does not mean that Americans spend less overall on health care, however. In 1985, the total health expenditure in the United States was higher than that of any other country—at 11.2 percent of GDP (Schieber and Poullier, 1989). The governments in each country, with the exception of the United States, pay a minimum of 74 percent of the total health bill. In comparison, the United States government pays only 41 percent of the total health bill, while the remaining 59 percent is paid for by private insurance and out of pocket by individuals. This cost places a proportionately greater burden on individuals and employers in the United States.

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