EBRI
EMPLOYEE BENEFIT RESEARCH INSTITUTE®

Notes

February 2004, Vol. 25, No. 2

IRA and Keogh Assets

by Craig Copeland, EBRI

Individual retirement accounts (IRAs) are a critically important component of the assets that will be available to fund retirees' expenses. In recent years, they have increasingly become important vehicles for holding assets rolled over from employment-based retirement plans.[1] Thus, they play an intricate part in preserving assets generated in the employment-based retirement system as well as in accumulating retirement savings through direct contributions. A Keogh plan allows self-employed workers to contribute more on a tax-deferred basis than they could do in an IRA, giving them an option similar to an employment-based retirement plan for accumulating assets for retirement. The combined assets held in these accounts surpass those of both private-sector defined contribution and defined benefit plans.[2] Thus, the level of these assets will have a significant impact on retirees' ability to have a financially secure retirement.

This article examines the level of assets in these accounts, the type of financial institution in which they are held, the breakdown of the assets into Keogh and various IRA types, tax-deductible contributions to these plans, and the percentage of Americans age 21 or older who have one of these accounts. The analysis uses various data sources, including the Federal Reserve's *Flow of Funds* report; the Survey of Consumer Finances (SCF) conducted by the Federal Reserve; the Internal Revenue Service's *SOI Bulletin*; and the Survey of Income and Program Participation (SIPP) conducted by the U.S. Census Bureau.[3]

These data show how the IRA market currently stands, where deductible contributions and the taxing of withdrawals have been the norm. The data also show the relative value of assets in Roth IRAs, which are the closest currently available savings vehicle to President Bush's proposed Retirement Savings Accounts (which would replace existing IRAs) and Lifetime Savings Accounts, and thereby provide context for debate surrounding this proposal.

Total Assets

Total IRA assets decreased for the third consecutive year in 2002, falling from $2.651 trillion in 1999 to $2.333 trillion in 2002 (Figures 1 and 2).[4] The decline in 2002 was the largest of the three years at 8.1 percent, compared with the 3.4 percent and 0.8 percent declines in 2001 and 2000, respectively. These three years of declines follow significant gains in every year since 1981, with only one year (1994) having less than a double-digit percentage increase.

Where Assets Are Held

As the level of IRA assets has declined, the percentage of these assets held at bank and thrift institutions and life insurance companies has increased (Figure 2). The percentage of assets held in bank and thrift institutions increased from 9.2 percent in 1999 to 11.3 percent in 2002, while the percentage held with insurance companies increased from 9.3 percent to 10.7 percent. Even with this increase, the percentage of IRA assets held in bank and thrift institutions in 2002 pales in comparison with its historic highs of above 70 percent, as mutual funds became the primary investment vehicle for this money in recent years, accounting for 44.0 percent in 2002. Brokerage self-directed accounts followed mutual funds as the second most-frequently chosen place for holding IRA assets, accounting for 34.1 percent in 2002. However, both had declines in the percentage of IRA assets held from 1999 to 2002 that corresponded to the increases in the assets held in other institutions

IRA Asset Type

The *Flow of Funds* report does not break IRA assets into plan types such as regular, rollover, or Roth. The SCF does this to a certain extent by asking for the total amount of assets held in IRAs and Keoghs and then asking whether any of these assets are in Keoghs or in education, rollover, Roth, or regular IRAs, but the relative portion of these assets among the types is not provided. In this study, the breakdown of assets by IRA type is conducted two ways: 1) individuals reporting having IRA assets and *no* Keogh assets, and 2) individuals reporting either IRA or Keogh assets.[5]

For those with IRA assets and *no* Keogh assets, the largest percentage of assets were owned by individuals who had only a regular IRA, at 34.5 percent, with individuals having a rollover IRA only following closely behind at 33.9 percent (Figure 3). The third largest percentage of assets (16.4 percent) was owned by individuals who had both regular and rollover IRAs. The remaining 15.2 percent of assets were owned by IRA holders with a Roth IRA, an education IRA, or some combination of those with another IRA type.

The addition of individuals with Keogh assets does not change the category leaders but reduces the percentage of their assets. Individuals with only a regular IRA account for 30.6 percent of the assets, those with only a rollover IRA account for 30.1 percent, and those with regular and rollover IRAs account for 14.5 percent (Figure 4). Those with only a Keogh account for just 3.6 percent of the total IRA and Keogh assets, and those with rollover IRAs and Keoghs account for 4.8 percent of these assets.

Contributions

The Internal Revenue Service (IRS) tracks deductible contributions to IRAs and Keogh/Self-Employed Plans in their *SOI Bulletin*.[6] Tax-deductible contributions to IRAs declined from $9.858 billion in 1990 to $7.407 billion in 2001, with a period of increase from 1995 to 1997 followed by a decline through 2001 (Figure 5). In contrast, tax-deductible contributions to Keogh plans increased steadily from $6.778 billion in 1990 to $13.114 billion in 2001. This decline in tax-deductible contributions occurred despite legislation in 1997 easing the restrictions on who can make these contributions, but it does not account for the creation of the Roth IRA from that same legislation, as to date the IRS does not track contribution data for Roth IRAs.[7] Consequently, on a total IRA

contribution basis, it cannot be determined yet if more individuals found the Roth IRA a better option than a regular IRA or if, in the aggregate, contributions to IRAs have decreased.

Ownership of IRAs and Keoghs

According to the 2001 SIPP Waves 3 and 6, approximately 21 percent of Americans age 21 or older were found to own an IRA, a Keogh, or both in September of 2001 and 2002 (Figure 6).[8] The likelihood of owning one of these accounts increased with age, family income, and educational attainment. For example, in September 2002, 6.8 percent of Americans age 21 or older who had less than $10,000 in family income owned an IRA or a Keogh, compared with 31.8 percent of those with $60,000 or more in family income.[9] Furthermore, males and whites were more likely to own these accounts than their comparison groups.

Conclusion

The decline in IRA assets from 1999 through 2002 coincides with the steep declines in the equity markets, as capital gains (or losses) have been one of the most important drivers of the change in the asset level of IRAs.[10] Annual deductible contributions to IRAs are also down, but these constitute only a very small portion of the total assets. The impact of nondeductible contributions, such as contributions to Roth IRAs, cannot be assessed from this data, but their impact on the total is likely to be quite small as the 2001 deductible contributions accounted for less than 1 percent of total IRA assets in 2001.[11] However, the percentage of Americans owning an IRA or Keogh held relatively constant from 2001 to 2002. Thus, assets are likely to have grown significantly in 2003 as the equity markets made back a significant percentage of what they had lost over the prior three years. This growth is likely to continue if the value of the equity markets remains at its current levels or increases, as many in the baby-boom generation are preparing for retirement with contributions to these types of plans or contributions to employment-based retirement plans that are likely to be rolled over to IRAs as these individuals retire or change jobs.

IRA Types

The major types of individual retirement accounts are:

- ***Regular IRA:*** Interest earnings are tax-deferred until withdrawn at retirement; contributions may be tax deductible or not, depending on the account owner's income and employment-based retirement plan participation status.
- ***Roth IRA:*** Contributions are on an after tax-basis with account accruals and contributions being tax-free when withdrawn at retirement.
- ***Rollover IRA:*** An IRA created by transfer of assets from another tax-qualified retirement plan, typically from a 401(k)-type plan.
- ***Education IRA:*** Accounts established to fund educational expenses using non-deductible contributions that grow tax-free and withdraws are federal income tax exemption when used for qualified educational expenses. They were subsequently renamed Coverdell Education Savings Accounts.
- ***Keogh:*** A retirement savings account vehicle for self-employed workers.

Endnotes

[1] See John Sabelhaus, "Projecting IRA Balances and Withdrawals," *EBRI Notes*, no. 5 (Employee Benefit Research Institute, May 1999): 1–4 shows that percentage increase of IRA assets that represent rollovers.

[2] Craig Copeland, "IRA Assets and Characteristics of IRA Owners," *EBRI Notes*, no. 12 (Employee Benefit Research Institute, December 2002): 1–9, shows that IRA assets account for 22 percent of retirement account

assets while private-sector defined contribution plans represent 20 percent and defined benefit plans 17 percent.

[3] For the most recent Board of Governors of the Federal Reserve's *Flow of Funds* report, see www.federalreserve.gov/releases/Z1/Current/ (viewed December 2003). For more information on the Survey of Consumer Finances, see www.federalreserve.gov/pubs/oss/oss2/scfindex.html (viewed December 2003). For the Internal Revenue Service's *SOI Bulletin*, see www.irs.gov/taxstats/article/0,,id=117514,00.html (viewed December 2003). For more information on the Survey of Income and Program Participation, see www.bls.census.gov/sipp/overview.html (viewed December 2003).

[4] The total individual retirement account (IRA) assets from the *Flow of Funds* report includes Keogh assets with the assets reported for IRAs in depositories (bank and thrift institutions).

[5] These numbers are different from Craig Copeland, "Individual Account Retirement Plans: An Analysis of the 2001 Survey of Consumer Finances," *EBRI Issue Brief* no. 259 (Employee Benefit Research Institute, July 2003), where only the assets of the family heads were studied. This article examines all of the IRA/Keogh assets of family heads, spouses, and other family members.

[6] *SOI Bulletin*, op cit.

[7] See Paul Yakoboski and Bill Pierron, "IRAs: It's a Whole New Ballgame," *EBRI Notes,* no. 9 (Employee Benefit Research Institute, September 1997): 1–4 for an explanation of the expansion in deductible contribution eligibility as well as the creation of the Roth IRA under the Tax Reform Act of 1997. The increases in the contribution limits to IRAs and the catch-up contributions from the Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA) are not reflected in these numbers, as they were not effective until 2002—the year after the data on contributions in this article end.

[8] These numbers are not comparable with the 17.2 percent of Americans owning an IRA in November 1999–February 2000 from Copeland, 2002, *op. cit.*, as that number is for IRAs only, whereas in this article the percentage is for those owning either an IRA or a Keogh.

[9] SIPP interviews respondents every four months on a rotating basis. The common month encompassed in the interviews for Waves 3 and 6 is September, so the data for these results are for September. The family income reported for September is only the income received in that month. Therefore, the monthly amount was multiplied by 12 to arrive at an annual number. This obviously creates issues for those who receive uneven streams of income, but the qualitative results still hold, as the monthly income is adjusted by a fixed factor.

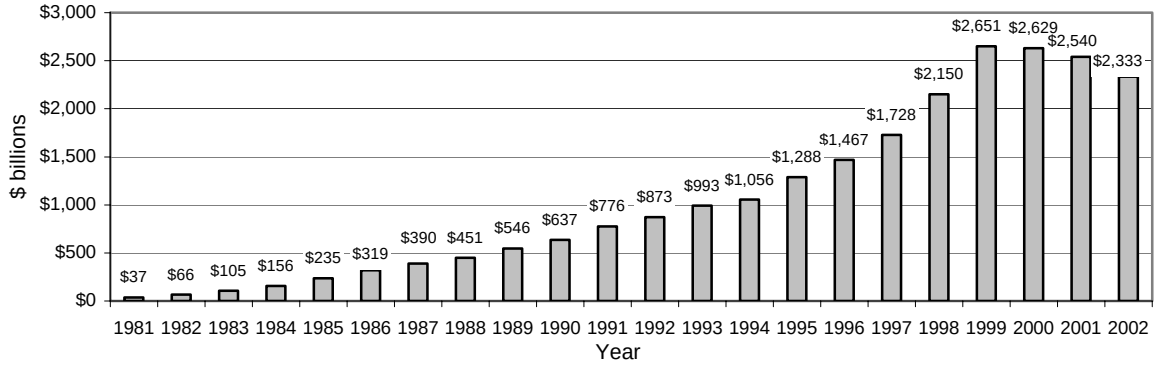
[10] See Sabelhaus, 1999, *op. cit.*

[11] The contributions to Keoghs are growing and may become more integral to the retirement savings market, but, as Figure 4 shows, they currently only account for at the most 11 percent of total IRA and Keogh assets.

Figure 1

Total Individual Retirement Account (IRA) Assets,[a] 1981–2002

($ billions)



Source: Board of Governors of the Federal Reserve, *Flow Funds Accounts of the United States: Flows and Outstandings Second Quarter 2003,* September 9, 2003; Employee Benefit Research Institute.

[a] The asset level of IRAs for depositories include Keogh accounts held there.

Figure 2

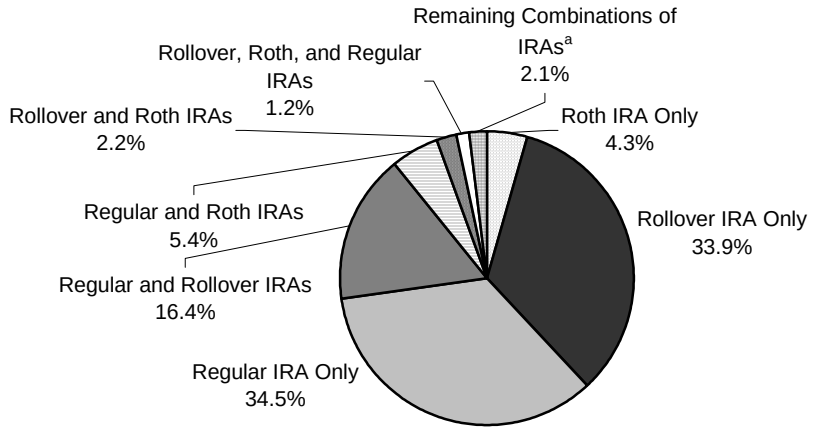
Distribution of Individual Retirement Account (IRA) Assets, by Financial Institution, 1981–2002

Year	Total Assets	Bank and Thrift Deposits[a]	Mutual Funds	Life Insurance	Brokerage Self-Directed Accounts	Percentage Increase
			(billions)			
1981	$37.0	$27.0	$3.0	$3.0	$4.0	
1982	66.0	47.0	6.0	6.0	8.0	78.4%
1983	105.0	72.0	11.0	9.0	13.0	59.1
1984	156.0	104.0	18.0	12.0	23.0	48.6
1985	235.0	140.0	34.0	16.0	45.0	50.6
1986	319.0	171.0	59.0	21.0	69.0	35.7
1987	390.0	194.0	80.0	26.0	91.0	22.3
1988	451.0	217.0	96.0	33.0	105.0	15.6
1989	546.0	244.2	120.9	37.9	143.1	21.1
1990	637.0	266.4	138.6	42.0	190.0	16.7
1991	776.0	282.8	183.8	49.7	259.6	21.8
1992	873.0	274.9	231.8	55.6	310.6	12.5
1993	993.0	262.7	314.7	69.5	346.2	13.7
1994	1,056.0	255.4	341.2	78.7	380.8	6.3
1995	1,288.0	261.0	462.5	94.3	470.2	22.0
1996	1,467.0	258.7	579.0	110.3	518.9	13.9
1997	1,728.0	254.0	751.0	160.0	563.0	17.8
1998	2,150.0	248.6	942.0	190.1	769.3	24.4
1999	2,651.0	243.0	1,220.0	245.5	942.5	23.3
2000	2,629.0	250.1	1,203.0	245.5	930.4	-0.8
2001	2,540.0	254.6	1,148.0	251.0	886.4	-3.4
2002	2,333.0	262.8	1,027.0	248.8	794.4	-8.1
			(percentage of total assets)			
1981	100%	73.0%	8.1%	8.1%	10.8%	
1982	100	71.2	9.1	9.1	12.1	
1983	100	68.6	10.5	8.6	12.4	
1984	100	66.7	11.5	7.7	14.7	
1985	100	59.6	14.5	6.8	19.1	
1986	100	53.6	18.5	6.6	21.6	
1987	100	49.7	20.5	6.7	23.3	
1988	100	48.1	21.3	7.3	23.3	
1989	100	44.7	22.1	6.9	26.2	
1990	100	41.8	21.8	6.6	29.8	
1991	100	36.4	23.7	6.4	33.5	
1992	100	31.5	26.6	6.4	35.6	
1993	100	26.5	31.7	7.0	34.9	
1994	100	24.2	32.3	7.5	36.1	
1995	100	20.3	35.9	7.3	36.5	
1996	100	17.6	39.5	7.5	35.4	
1997	100	14.7	43.5	9.3	32.6	
1998	100	11.6	43.8	8.8	35.8	
1999	100	9.2	46.0	9.3	35.6	
2000	100	9.5	45.8	9.3	35.4	
2001	100	10.0	45.2	9.9	34.9	
2002	100	11.3	44.0	10.7	34.1	

Source: Board of Governors of the Federal Reserve Board, *Flow of Funds Accounts of the United States: Flows and Outstandings Second Quarter 2003,* Sept. 9, 2003; Employee Benefit Research Institute.

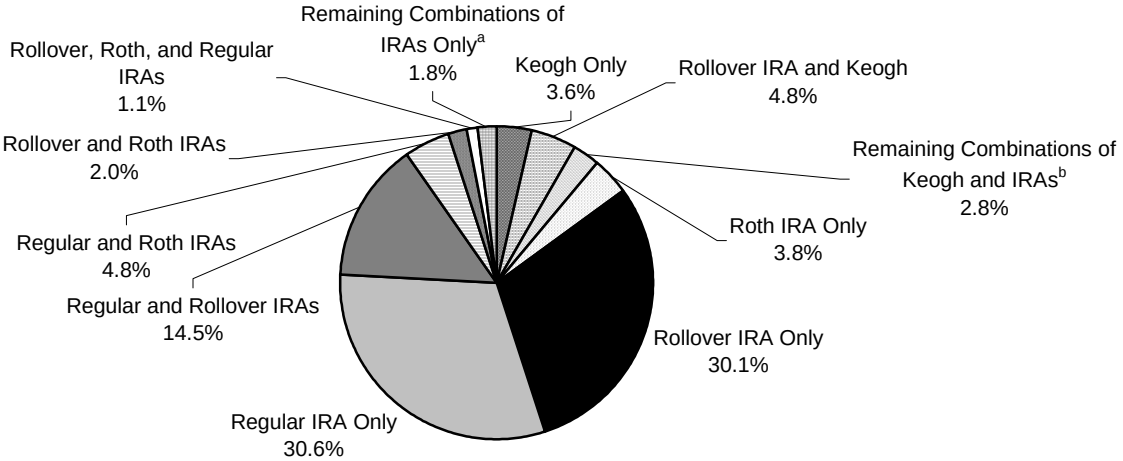
[a] These asset levels include Keogh account assets.

Figure 3
Percentage of Individual Retirement Account (IRA) Assets, by Type or Combination of Types, 2001 (Excluding Those With a Keogh Plan)



Source: Employee Benefit Research Institute estimates of the 2001 Survey of Consumer Finances.
[a] The remaining combinations include any combination of IRAs with an Education IRA.

Figure 4
Percentage of Individual Retirement Account and Keogh Plan Assets, by Type or Combination of Types, 2001



Source: Employee Benefit Research Institute estimates of the 2001 Survey of Consumer Finances.
[a] Remaining combinations of IRAs only include any combination of IRAs with an Education IRA but no Keogh.
[b] Remaining combinations of Keogh and IRAs include any combination of IRAs with a Keogh not shown in the figure.

Figure 5
Individual Retirement Accounts (IRAs) and Keogh/Self-Employment Deductible Contributions, 1990–2001

	IRAs		Keogh	
Year	No. of Returns	Amount	No. of Returns	Amount
	(thousands)	(millions)	(thousands)	(millions)
1990	5,224	$9,858	824	$6,778
1991	4,666	9,030	840	6,913
1992	4,478	8,696	919	7,592
1993	4,385	8,527	948	8,160
1994	4,319	8,389	996	8,195
1995	4,301	8,338	1,032	8,734
1996	4,374	8,628	1,079	8,979
1997	4,069	8,663	1,190	10,238
1998	3,868	8,188	1,177	11,040
1999	3,687	7,883	1,264	11,928
2000	3,505	7,477	1,288	12,475
2001	3,448	7,407	1,290	13,114

Source: Internal Revenue Serivce, *SOI Bulletin,* Historical Tables, various years.

Figure 6
Percentage of Americans 21 or Older With An Individual Retirement Account or Keogh Plan by Various Characteristics, 2001–2002

	September 2001	September 2002
Total	21.2%	20.9%
Age		
21–24	3.0	2.4
25–34	13.0	12.5
35–44	20.4	20.3
45–54	26.0	25.5
55–64	32.8	32.5
65 or older	24.9	24.4
Gender		
Male	22.0	21.7
Female	20.4	20.1
Race/Origin		
White	26.2	25.9
Black	5.7	5.2
Hispanic	5.4	5.4
Other	16.7	16.5
Total Family Income (Annualized)		
Less than $10,000	7.3	6.8
$10,000–$19,999	10.7	10.0
$20,000–$29,999	15.7	14.4
$30,000–$39,999	18.0	17.6
$40,000–$59,999	22.7	21.8
$60,000 or more	32.5	31.8
Educational Level		
No HS diploma	5.0	5.4
HS diploma	14.4	14.5
Some college	20.6	19.7
Bachelor's degree	36.5	34.7
Graduate/profnl degree	48.3	46.6

Source: Employee Benefit Research Institute estimates of Waves 3 and 6 of the 2001 Survey of Income and Program Participation (SIPP).

■ Evidenced Based Medicine: Putting Research Into Practice

by Jim Jaffe, EBRI

While few would characterize America's health care delivery system as efficient, there's a growing belief that there is an optimal way to deliver care for a specific diagnosis—and that finding and publicizing that path to a point where it became the norm could lead to better medical outcomes at less cost.

There's an equally broad consensus that achieving this radical goal would be very difficult. A key question is who should be the targets of this push for what is generally termed *evidence-based medicine*, popularly known as EBM. Obviously, the arguments and terminology vary from one group to another, but three target groups are suggested:

- Integrated medical systems: a group of physicians make a commitment to use common protocols, or all the patients within a given health care system use a formulary for their drug needs.
- Practitioners: efforts are made to educate and win the commitment of individual doctors or others who deliver care on the best medical practice for a given condition.
- Patients: individuals use resources to decide on what treatment options should be used in their particular case.

There's little argument about inclusion of the first two. The existence of a structured group like a health maintenance organization (HMO) virtually presupposes the use of common standards or rules. Physicians are generally perceived as scientists and it is assumed that their work has an experimental and changing basis. The systems and physician groups may have differing levels of sophistication that require different types of communication, but they both have a public commitment to an evidence-based system.

But the question of whether patients should be included is a more provocative one. Traditionally, many patients have been told that their duty lies in selecting a good doctor and then doing what their physician recommends, at least until something goes awry. Americans are accustomed to hiring expertise in many areas, including medicine. Suggesting they behave otherwise implies a major cultural shift.

Whether this would be a positive change—assuming it is possible—is a big question that raises a number of issues, including whether it justifies the diversion of resources from other components of the medical system: How would these constituencies get along? What happens, for instance, when the patient does research and finds out that the remedies selected are not included among his physician's protocols or his insurance plan's formulary? Even if physicians agree a standard treatment is best, what if the patient does not?

Similar questions were often the basis of tensions that have led to the rejection of rigid managed care (as measured by the decline of HMOs and the growth of less restrictive preferred provider organizations, or PPOs), and will have to be resolved before the potential patient impact of EBM becomes significant.

And there's an even more basic cultural question. Since the time of Flexner[1] at least, patients have been told that their physicians are men (and women) of science and assumed that they were being treated in a fashion characterized by a scientific approach, notwithstanding ample evidence to the contrary gathered by insiders. Is the medical establishment ready to tell the patient population that much of what is practiced today is not evidence based? And if so, will people believe them?

Selling the public on this threshold question opens the door to a series of other complex issues. One involves rules that make sense for large groups, but not necessarily for individuals; for instance, it might be a waste of resources for an insurer of a million people to pay for mammograms for young women—but nonetheless, the test would be advantageous to a few women who took it. Can and should evidence-based medicine be used as a tool to provide the best outcomes for the group at the cost of some disadvantage (and potential risk) to individual members? This question, too, echoes the managed care debate.

EBM could get a major boost when new Medicare drug insurance becomes available in 2006, as called for by the Medicare prescription drug law enacted by Congress in 2003 (P.L. 108–173). Insurers will rely on formularies of favored drugs, and drawing up such lists could create increasing demands for data on which drugs are most effective.

While generally agreed upon protocols exist for some chronic and expensive conditions that now eat up a disproportionate share of America's health dollars, they have yet to be created for most problems that patients bring to the system. Logically, the initial focus has been on big-ticket items.

Such questions were the focus of the 11th annual ECRI[2] Conference on Healthcare Policy, Law and Methodology held in October 2003 in suburban Philadelphia and cosponsored by EBRI, Kaiser Permanente, the Leonard Davis Institute of the University of Pennsylvania, the Milbank Memorial Fund, and the U.S. Food and Drug Administration. The topic was "From Populations to Persons: Putting EBM Research Into Practice." Presiding were Jeffrey Lerner, ECRI's CEO, and Dr. Yank Coble, a Jacksonville, FL, endocrinologist and immediate past president of the American Medical Association.

Slow Progress With EBM

Dr. Richard Roberts, a family physician practicing in Belleville, WI, who teaches at the University of Wisconsin's Medical School, suggested EBM was making slow progress because the concerns of the academic experts in the field were different from those of the community-based physicians most patients relied on.

Noting that the average family physician sees more than 125 patients weekly and that many patients have multiple complaints, he concluded that there was seldom time for physicians to update themselves on the favored way of dealing with a problem before actually confronting it. He was the first of many speakers to note that, in many instances and for many conditions, no quality evidence exists on optimal care. But, he noted, newer physicians were most likely to use practice guidelines and believe that they had a positive impact.

A contrasting perspective came from Dr. Sharon Levine, associate executive director for physician and professional services for the Permanente Medical Group, which includes 5,000 physicians serving 3.3 million patients in Kaiser HMOs in California. Her group has made a substantial investment in creating patterns of practice and installing technology that allows physicians—and their patients—immediate access to current research on numerous medical problems. An initiative to improve care for those with cardiovascular disease led to a 15 percent decrease in the death rate between 1996 and 2001 and included such low-tech innovations as the use of preprinted orders for emergency room and hospital care, Dr. Levine said.

Dr. Katrina Armstrong, an assistant professor of medicine and primary care physician in the University of Pennsylvania Health System who directs its evidence-based medicine course, discussed semantic and linguistic differences between patients and practitioners. Unhappy patients, for instance, accused doctors of dishonesty when a recommended medicine didn't work, she said. When combined with anomalies that patients view as evidence (such as the 95-year-old smoker or a young jogger who drops dead), along with confusing or misleading media reports and low levels of patient numeracy, and you've got the elements of a serious communication problem, Dr. Armstrong said.

Finally, she added, there's a need not to oversell the power of EBM: Inevitably, it will prove the wrong answer in certain instances, and patients will distrust and dismiss the value of evidence-based medicine if they are told that it is always right.

Dallas Salisbury, president and CEO of the Employee Benefit Research Institute, provided some context with data about the rising cost of health insurance and the increasing efforts by employers to moderate increases, sometimes by shifting more financial and care decisions to workers. He noted that health insurance remains the most popular employment benefit among workers, and that for various reasons employers backed away from the managed care model used during the 1990s and are now actively experimenting with new approaches, including consumer-choice plans.

Some see EBM as a tool that could make such managed care plans work, he said, but there's a case to be made that it will actually impede progress in this area.

EBM Success Stories

Not surprisingly, progress comes easiest when there's a captive audience, as is the case with public programs. Dr. Jeffery Thompson, chief medical officer for the Washington state Medicaid Program and Head of the Division of Medical Management, presented a glowing report on how the Washington State Medicaid program has slashed drug prices for Medicaid patients by creating a formulary of drugs that are the first choice in dealing with a given diagnosis.

Another prescription success story came from Kevin Conconnan, director of human services for the state of Iowa, who earlier helped create a plan that gives low-income residents in Maine discounts on drugs, using the purchasing power of that state's Medicaid program.

In illustrating how evidence counts, Conconnan recounted his experiences with the Oregon Medicaid program, which is one of the very few care providers in America that explicitly acknowledges it is rationing health care. When the Oregon program began, state residents said they'd be willing to pay higher taxes to support such a program if they were confident the dollars were spent right. The priorities set by the state provides some assurance.

He also recalled how Maine legislators reversed themselves and agreed to bar smoking in restaurants after becoming familiar with the evidence about the dangers of second-hand smoke. Conconnan's conclusion was that evidence-based medicine is working.

Cautionary Tales

A cautionary counterpoint came from Cindy Pearson, executive director of the National Women's Health Network, who discussed the checkered trajectory of estrogen replacement therapy. Pearson argued that the drugs were used more commonly than evidence would suggest was appropriate, largely because of aggressive marketing that went beyond evidence the medical community would find compelling.

Despite the fact that the Food and Drug Administration decided there was inadequate evidence that estrogen reduces cardiac problems, there's a wide public belief that it does, she said, and a more general sense that it is a tonic that will help women age more gracefully; implicit was a suggestion that if women knew a bit more about the drug, they'd use it a bit less.

After Pearson argued that women were failing to use the information available to make prudent decisions, a drug firm executive suggested that physicians have been slow to adopt good information that's already available to them.

Making better information available doesn't guarantee that it will be used. Merck Vice President Marc Berger argued that the best way to make a lasting impact on physicians is to provide "just-in-time information" when it is required in a particular case. At the opposite end of the spectrum is old-fashioned low technology, he added, such as traditional continuing medical education events like the ECRI event he was participating in when these remarks were delivered.

Providing context for his views were comments by Dr. Carolyn Clancy, director of the Agency for Healthcare Research and Quality, who documented imperfections in today's medical system and talked about her agency's efforts to encourage better outcomes. She cited studies concluding that patients wanted more information and would like to be more involved in decision-making about their care.

Some participants suggested that an unquantified but significant portion of patients prefer the old model—termed *paternalistic* in this discussion—where they simply and unquestioningly relied on the expertise of their physician and other practitioners.

Dr. George Isham, chief health officer of HealthPartners of Minneapolis, saw this traditional perspective as a declining one. Employers are increasingly pushing workers they insure to make their own health care decisions as part of a cost-containment strategy, he said. In a world where workers are

increasingly told that their insurance won't fully pay for whatever they want, whenever and wherever they want it, patients are being asked to decide on personal priorities. What's needed, he concluded, is a system that allows patients to make rational choices.

Another speaker from Minneapolis, which has been the hotbed of any health insurance innovations, was Dr. Lee Newcomer, who described the new consumer-based system as buying health insurance "a la carte." Newcomer is with Vivius, a new health plan that basically allows consumers to create their own preferred provider organizations. He stressed the need to provide accessible information to patients about efficiency and outcomes, so as to promote informed decision-making. Newcomer noted that "best evidence" was a shifting target, and that decisions—however well-informed—were inevitably and ultimately made on the basis of incomplete information. Vivius requires a series of decisions from covered consumers, even if they have no health problems.

Near the opposite end of the patient option spectrum is a closed-panel HMO, which imposes its own standards about how best to deal with any given problem, but is nonetheless making increasing efforts to involve patients in the decision-making process. Kaiser Permanente has sponsored a variety of initiatives—ranging from a high-tech effort to put patient files online to rearranging furniture in examining rooms so patients can also view the computer monitors used by their physicians. A recurring question in such discussions is whether Kaiser's patients are typical and whether techniques Kaiser developed can be used with equal success in a broader environment.

Another challenging question is how to translate data about large groups into guidance for individuals. What do and should patients construe as good news? Should they embrace a drug that merely slows an inevitable deterioration, rather than providing a cure? How can they calculate the cumulative impact of several drugs, each of which promises modest improvement at the cost of some uncomfortable side effects?

What's the Evidence?

Putting the evidence into medicine isn't an easy task. A few weeks after the ECRI conference, a new 18-year study of 88,000 women taking daily aspirin found that some had an elevated rate of pancreatic cancer. Millions of people take low-dose aspirin daily because evidence shows low-dose daily aspirin helps prevent heart attacks. There was no speculation in the study whether the reported elevated risk of pancreatic cancer was relevant to men.

Sponsors of the new study advised aspirin-taking women not to change their habits. A single study isn't conclusive, they counseled, and an educated decision would weigh the odds of heart attacks (which are relatively common) and pancreatic cancer (which is not).

What's an informed patient to do?

These are questions the Food and Drug Administration wrestles with as it tries to refine drug-testing procedures. Already sensitive to complaints that tests done on white males of a particular weight might not be directly relevant to patients with other characteristics, the agency is trying to come up with results helpful to different types of patients at various disease stages.

An interactive model created by Kaiser is one way of dealing with this issue. As explained by Dr. David Eddy of Kaiser-Permanente, it combines various reliable sources of information in an effort to extrapolate existing research to fill in "dead spots" where such there's no strong, directly relevant research.

Inevitably, any discussion about changes in the way medicine is practiced and insurance policies that reimburse for those practices leads to difficult legal questions. Some of these were discussed by Arnold Rossoff of the Legal Studies Department of the Wharton School of Economics in Philadelphia, who noted that medical protocols could be used as either a sword (by an unhappy litigant claiming that a bad outcome was the result of failure to follow usual procedures) or a shield (by a practitioner to argue that everything that *should* have been done *was* done).

In fact, Rossoff said, relatively few cases involving evidence-based medicine have yet found their way into the legal literature, and at this point there is no clear sign that either use has been typically effective.

Endnotes

[1] Funded by the Carnegie Foundation, Abraham Flexner in 1910 published a comprehensive, independent, and groundbreaking report on major problems with the quality of American medical education. His report, "Medical Education in the United States and Canada," revealed the discrepancies between school catalogue descriptions of courses and clinical opportunities and the realities of medical training in schools throughout the nation. He strongly advocated truly academic training, with clinical teaching in close geographical association with university science departments, and his report had a huge impact on the way medical education is currently conducted in the United States.

[2] ECRI (formerly the Emergency Care Research Institute) is an independent nonprofit health services research agency that focuses on health care technology, health care risk and quality management, and health care environmental management. Its Web site is www.ecri.org

Washington Update

by Jim Jaffe, EBRI

Bush Proposes Priorities for 2004 Session of Congress

President Bush has issued his priorities for the year, first in his State of the Union speech to Congress and later in his fiscal 2005 budget submission. Now the serious bargaining begins. As legislators are fond of saying, "The president proposes, but Congress disposes." That's particularly true this election year, when political concerns play an even greater role in legislative actions (or inactions).

The White House revived its proposal for an expanded version of Roth IRA accounts, termed Lifetime Savings Accounts when they were initially proposed last year. Basically, they'd allow everyone to create such accounts and make annual contributions of money that had already been taxed. Subsequent earnings wouldn't be taxed. Virtually no one in Congress showed any interest in the plan last year and it quickly disappeared. There's no evidence that the White House has ignited any new legislative enthusiasm since.

And the president revived a proposal initially made by his father more than a decade ago to significantly expand the nation's space exploration effort. In its initial outing, this idea too was ignored by Congress. There's little basis for a judgment yet on whether lawmakers will be more enthusiastic this time.

Even though this is an election year, adding expensive new programs will be a tough sell at a time when a growing number of legislators are concerned about big deficits and polls show many voters would be willing to have promised tax cuts curtailed in order to bring the government's books into balance.

Despite that, Bush is suggesting that many of the temporary tax cuts enacted earlier in his term be made permanent. On that issue he has significant support from Republicans in Congress, regardless of the impact on deficits. And waiting in the wings is a major corporate income tax cut, the first since Bush took office.

Pension Issues Pending

Congress will confront two pension issues carried over from last year and will resolve at least one of them. A temporary pension benchmark interest rate expired at the end of 2003, and is likely to soon be replaced by another temporary fix, this one based on a blended corporate bond rate.

Discussions will continue about how to protect older workers when an existing pension plan is converted to a cash balance plan, but there's no clear compromise in sight. Employers are asking for

guidance, but Congress seems content for the moment to preclude the administration from providing regulatory direction on the issue, so lawmakers can continue to debate a resolution.

Employer Provided Retiree Health Coverage Seen at Risk

One large employer in five will probably stop providing health insurance to retirees within the next three years, according to a new study released by the Henry J. Kaiser Family Foundation and Hewitt Associates. They surveyed 408 firms in mid-2003, before enactment of the Medicare drug bill that will offer a subsidy to employers who continue such coverage.

Confirmation of this trend came when bankrupt Kaiser Aluminum (no current relation to the Kaiser Family Foundation) asked a federal court in Delaware for permission to slash benefits, including health insurance, originally promised to retirees. Subsequently, troubled United Airlines said it would make a similar request to its bankruptcy court if unions weren't amenable to reducing health benefits for 35,000 retirees.

The Kaiser/Hewitt report (*Retiree Health Benefits in 2003: Employer Survey*) is available on the Internet at www.kff.org/medicare/011404package.cfm

Universal Health Insurance Proposed

The Institute of Medicine recently concluded a three-year study by recommending that Washington make universal health insurance a goal to be achieved by 2010. While that goal won bipartisan support, including applause from former GOP presidential candidate Bob Dole, President Bush's Secretary of Health and Human Services, former Wisconsin Gov. Tommy Thompson, called it unrealistic. One measure of the administration's interest in the idea: This proposal was made public during a week when President Bush was calling for missions to the moon and Mars.

The IOM report (*Insuring America's Health: Principles and Recommendations*) is on the Internet at www.iom.edu/report.asp?id=17632

■ EBRI in Focus

EBRI Cosponsoring ASA Conference

EBRI is cosponsoring the "Managing Retirement Assets Symposium" with the Society of Actuaries, to be held March 31–April 2 at the Flamingo Hilton in Las Vegas. More information and a registration form are available at the SOA Web site at www.soa.org

EBRI Education on the Road

EBRI staff took to the road early in 2004 to carry forward the EBRI mission of education on financial security issues. In January, Jack VanDerhei, Temple University and research director of the EBRI Fellows Program presented recent EBRI research at the Securities Industry Association's 2004 Savings and Retirement Symposium, focusing on the EBRI-ERF Retirement Security Projection Model results as contained in the November 2003 *EBRI Issue Brief.* That topic was also the subject of congressional testimony he presented Jan. 27 before the Senate Aging Committee, and a "virtual seminar" he presented on the Internet for the Financial Planning Association.

And in February, Dallas Salisbury, EBRI president and CEO, gave speeches on economic security issues to the Deere Management Meeting in Moline, IL; implications of employee health benefit trends to the North Carolina Hospital Association in Raleigh, NC; and on health issues to the Society for Human Resources Management in Washington, DC.

New Publications & Web Sites

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

Employee Benefits

Allen, Jennifer. *Cost Benefits of Child Care for Extended Hours Operations*. $400. Circadian Technologies, Inc., 24 Hartwell Ave., Lexington, MA 02421, (800) 284-5001 or (781) 676-6900, www.circadian.com.

International Group Program. *IGP Country Profiles*. For further information, contact Rita Distel, John Hancock Financial Services, Inc., John Hancock Place, Boston, MA 02117, (617) 572-8661.

Society for Human Resource Management. *SHRM 2003 Eldercare Survey*. $99.95; SHRM members, $79.95. Society for Human Resource Management, 1800 Duke St., Alexandria, VA 22314-3499, (800) 444-5006.

Health Care

Healthcare Distribution Management Association. *2003 Industry Profile and Healthcare Factbook*. Hardcopy of book only: HDMA members, $149; nonmembers, $349. Hardcopy w/CD of Excel files: HDMA members, $250, nonmembers, $450. Healthcare Distribution Management Association, 1821 Michael Faraday Dr., Suite 400, Reston, VA 20190-5348, (703) 885-0214, fax: (703) 787-6930.

Isaacs, Stephen L., and James R. Knickman. *To Improve Health and Health Care: Volume VII*. $24. Jossey-Bass Publishers, 350 Sansome St., Fifth Floor, San Francisco, CA 94104, (800) 956-7739.

National Committee for Quality Assurance. *The State of Health Care Quality: 2003*. $50. National Committee for Quality Assurance, 2000 L St., NW, Suite 500, Washington, DC 20036, (202) 955-3500.

U.S. National Center for Health Statistics. *United States, 2003 With Chartbook on Trends in the Health of Americans*. Order from GPO.

Pension Plans/Retirement

CRA RogersCasey and Institute of Management and Administration. *CRA RogersCasey / IOMA Annual Defined Contribution Survey*. For cost and other information, phone CRA RogersCasey, Donna Zaleski, (203) 656-5900.

International Social Security Association and International Network of Pension Regulators and Supervisors. *Complementary & Private Pensions Throughout the World 2003*. $110. ISSA Publications, International Social Security Association, Case postale 1, CH-1211 Geneva 22, Switzerland.

Mitchell, Olivia S., and Kent Smetters. *The Pension Challenge: Risk Transfers and Retirement Income Security*. $65. Oxford University Press, Oxford University Press, 2001 Evans Rd., Cary, NC 27513, (800) 451-7556.

Social Security
Diamond, Peter. *Taxation, Incomplete Markets, and Social Security: The 2000 Munich Lectures*. $27.95. The MIT Press, c/o Triliteral, 100 Maple Ridge Dr., Cumberland, RI 02864, (800) 405-1619 or (401) 658-4226, fax: (401) 531-2801.

Tax Policy
Poterba, James M., and Lawrence H. Summers. *Tax Policy and the Economy*. $25. The MIT Press, c/o Triliteral, 100 Maple Ridge Dr., Cumberland, RI 02864, (800) 405-1619 or (401) 658-4226, fax: (401) 531-2801.

Web Documents

Are H & P [Health & Productivity] Programs for You?
Www.imanet.org/ima/docs/2000/1976.pdf

Building Futures: Plan Options and Participant Choices in Workplace Savings
buildingfutures.fidelity.com/president.html

Electronic Symposium: The US Transition to Hybrid Pensions
rider.wharton.upenn.edu/~prc/wpcashbalance.html

Medicare Drug Benefit Calculator
www.kaisernetwork.org/static/kncalc.cfm

National Small Business Poll: Health Insurance
www.nfib.com/PDFs/sbpoll/sbpoll102703.pdf

Private Insurance and End-of-Life Care
www.lastacts.org/files/resources/Private_Insurance.pdf

Progressivity and Government Incentives to Save
www.brookings.org/dybdocroot/views/papers/orszag/20031008.pdf

Reporting and Disclosure Guide for Employee Benefit Plans
www.dol.gov/ebsa/pdf/rdguide.pdf

Retirement Plan Management for Small Business
www.sba.gov/nationwide/index.htm

Social Insurance Sourcebook
www.nasi.org/publications3901/publications.htm

Top 10 Health Policy Stories/Issues of 2003
www.cmwf.org/programs/topten_2ndpg.asp

U.S. Household Ownership of Mutual Funds in 2003
www.ici.org/pdf/fm-v12n4.pdf

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EBRI Notes (ISSN 1085–4452) is published monthly at $300 per year or is included as part of a membership subscription by the Employee Benefit Research Institute, 2121 K Street, NW, Suite 600, Washington, DC 20037-1896. Periodicals postage rate paid in Washington, DC. POSTMASTER: Send address changes to: *EBRI Notes*, 2121 K Street, NW, Suite 600, Washington, DC 20037-1896. Vol. 25, no. 2.

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