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CBO Releases Retirement Policy Study

The Congressional Budget Office (CBO) recently released its long-awaited report on Tax Policy for Pensions and Other Retirement Saving. The study was requested by Sen. Robert Dole in 1983 during his tenure as chairman of the Senate Finance Committee. At the time, there were many in the private sector who asked that pension tax changes be deferred until the Congress had established a “comprehensive national retirement income policy.”

Dole requested a more comprehensive study than the CBO actually conducted, apparently because tax law revisions since 1983 made significant changes in many of Dole’s areas of interest (e.g., lump-sum distributions). The CBO report drew heavily from the EBRI/HHS 1983 Current Population Survey pension supplement, and made use of a data base developed for EBRI to assess the incidence of tax preferences.

The CBO report contains chapters on (1) the tax advantages of saving in qualified plans and their effect on revenues; (2) employer plans and individual retirement accounts (IRAs); (3) use of tax advantages; (4) incentives, incidence, and unintended uses; (5) recent changes in qualified plans; and (6) the size and distribution of gains from qualified plans: options for further legislation.

Retirement Income and Tax Preferences

The report notes that “along with Social Security and other measures, they [qualified plans] are intended to help assure adequate retirement incomes for as many workers as possible. They are also intended to stimulate national saving and economic growth.” It finds that “qualified plans and IRAs account for the largest annual revenue loss of all the preferences in the individual income tax structure.” The report also focuses on the degree that those who have no pension coverage pay higher taxes to support a program they do not receive benefits from.

The report concludes that “the tax advantages of qualified pensions and IRAs can raise after-tax retirement incomes substantially.” It notes, however, that “projections of the retirement incomes of today’s workers indicate that the gains will be distributed somewhat unevenly by income and even more unevenly by job tenure. This pattern of distribution results from a number of factors: not all workers participate in such plans; some plan rules exclude certain classes of employees and delay vesting; and people who change jobs are likely to lose much of the value of their defined benefits through preretirement inflation.”

Retirement Saving

CBO reaches the conclusion that while the tax advantages of qualified plans will increase retirement income, such plans do not appear to “reflect much increase in personal saving.” The report continues: “Though pensions may not cause people to save more, their higher retirement wealth represents greater national saving unless the revenue loss from the tax advantage has been financed by greater federal borrowing or offsetting taxes on capital income.”

CBO concludes that effects of the Tax Reform Act of 1986 will vary: “Large plans in the industrial and unionized sectors of the economy will probably not be affected, while those of medium- and smaller-sized employers may. Shrinking the gains available to finance redistribution, and by making redistribution harder to avoid, the act may result in fewer traditional pension plans—with their fixed employer commitments—being established or continued in firms where demand for retirement saving is weak. Thrift and salary-reduction plans, which allow rank-
and-file workers to sort themselves according to their saving preferences, may become increasingly attractive in firms where the demand for retirement income is not very uniform."

Legislative Options

While the CBO study notes at the beginning that "in accordance with the mandate of CBO to provide objective analysis, the report offers no recommendations," it does offer legislative options. The summary discussion of the options is quoted here so that the reader can assess the balance and "objectivity" of the presentation:

"The tax advantages for qualified plans and IRAs constitute the largest tax preference in the individual income tax. Yet, though these advantages boost retirement incomes, they probably do not significantly raise personal saving rates. In addition, the retirement income gains traceable to these advantages are skewed to highly-paid workers and, even more so, to workers who spend 20 years or more under one pension plan. Yet all other taxpayers—including workers who are never covered by a plan or who change jobs relatively often—bear the costs of these gains in retirement income in the form of higher tax rates, lower government spending, or increased federal debt. Because of the questionable saving effects and uneven distributional outcomes, the Congress might decide to alter further the size and distribution of these tax advantages. The paper examines the following measures that the Congress might consider.

"First, the Congress could reduce the tax advantages either by imposing even tighter limits on contributions to qualified plans or by subjecting the investment income of qualified plan trusts and IRAs to a special income tax rate of, for example, 5 percent. The resulting reductions in retirement income would be borne by workers mostly in the upper half of the income distribution.

"Second, as it has already done in legislation about vesting and the like, the Congress could further alter the distribution of the gains in income traceable to the tax advantages. In particular, the Congress could impose new requirements to limit the extent to which inflation erodes the value of deferred annuities in defined benefit plans. Additionally, by expanding salary reduction arrangements or tax-favored individual saving in ways beneficial to middle-income earners, the Congress could bring about a more even distribution of tax advantages among all workers.


IRA Assets Reach $262 Billion; Keogh Assets Nearly $42 Billion

Financial assets held in individual retirement accounts (IRAs) and Keogh accounts (for the self-employed) reached an estimated $303.9 billion in calendar year 1986, up from $230.4 billion in 1985. This represents a 31.9 percent increase in total IRA and Keogh assets in calendar 1986, which compares with a 41.3 percent increase in 1985, and a
Table 1
Distribution of Estimated IRA and Keogh Assets by Financial Institution
1981-1986

<table>
<thead>
<tr>
<th>Financial Institutions</th>
<th>12/31/86</th>
<th>12/31/85</th>
<th>12/31/84</th>
<th>12/31/83</th>
<th>12/31/82</th>
<th>12/31/81</th>
</tr>
</thead>
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<tr>
<td>Commercial banks</td>
<td>$72.8</td>
<td>$60.6</td>
<td>$44.5</td>
<td>$30.0</td>
<td>$17.5</td>
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<td>Savings and loans</td>
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<td>$40.0</td>
<td>$28.4</td>
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<td>Mutual savings banks</td>
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<td>Life insurance^b</td>
<td>$25.9</td>
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<td>Stock brokerage SDA^a</td>
<td>$44.9</td>
<td>$31.7</td>
<td>$19.1</td>
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<tr>
<td>Total</td>
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<td>$230.4</td>
<td>$163.1</td>
<td>$113.0</td>
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</table>

percent of market

<table>
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<tr>
<th>Financial Institutions</th>
<th>Commercial banks</th>
<th>Savings and loans</th>
<th>Mutual savings banks</th>
<th>Mutual funds</th>
<th>Credit unions^a</th>
<th>Life Insurance^b</th>
<th>Stock brokerage SDA^a</th>
<th>Total</th>
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<tr>
<td>12/31/86</td>
<td>24.0%</td>
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<tr>
<td>12/31/85</td>
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<td>25.1%</td>
<td>27.6%</td>
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<td>12/31/84</td>
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<td>7.1%</td>
<td>7.7%</td>
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<tr>
<td>12/31/83</td>
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<td>14.3%</td>
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<td>16.1%</td>
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</tr>
<tr>
<td>12/31/82</td>
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<td>8.8%</td>
<td>100.0%</td>
</tr>
<tr>
<td>12/31/81</td>
<td>8.5%</td>
<td>8.8%</td>
<td>9.7%</td>
<td>10.7%</td>
<td>12.6%</td>
<td>15.8%</td>
<td>13.8%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

^a Figures represent IRA assets only.
^b EBRI estimate based on 1984 and 1985 data from the American Council of Life Insurance.

Source: EBRI 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.

44.3 percent increase in 1984. This declining growth rate may indicate that the total number of IRA users had begun to level off even before Congress changed the rules restricting eligibility for IRAs.

Distribution of these IRA/Keogh funds among financial institutions continues to show an investment adjustment aiming for higher total rates of return. Investment in mutual funds grew by $24.0 billion, to reach a total of $63.4 billion, or a 20.9 percent of market share, compared to a 17.1 percent share in 1985. Stock brokerage self-directed accounts grew at a slightly lower rate than they had previously, gaining 1.0 percent of the total market share in 1986, as compared to 2.1 percent in 1985. Total assets in stock brokerage self-directed accounts reached $44.9 billion. Mutual savings banks lost 0.4 percent of the market, and credit unions showed a modest increase of 0.4 percent of the market (table 1).

Commercial banks and savings and loan institutions hold the largest dollar amounts of IRA and Keogh funds at $136.0 billion, but their market share has declined from 49.2 percent in 1985 to 45.6 percent in 1986.

In 1986, total IRA assets were estimated to equal $262 billion, and Keogh assets were an estimated $42 billion. Keogh assets accounted for an estimated 14 percent of the total IRA/Keogh market among all financial institutions in 1986 (chart 1). Among the various financial institutions, mutual funds and mutual savings banks both provide separate figures for IRA and Keogh investments. In 1986, Keogh assets held by mutual funds accounted for 15 percent of total IRA and Keogh holdings, while Keogh funds in mutual savings banks accounted for 12 percent of total IRA/Keogh assets. In 1981, before IRA eligibility was expanded, mutual funds held a much higher percentage of their...
total IRA/Keogh assets in Keogh plans (58 percent) than mutual savings banks did (29 percent).

The increasing importance of IRA assets in the IRA/Keogh market is also apparent based on Internal Revenue Service (IRS) statistics on individual tax returns for 1981–1985. In 1981, approximately 30 percent of all IRA and Keogh contributions of $6.8 billion represented Keogh plan investments. By contrast, in 1985 only 11 percent of IRA/Keogh contributions totalling $43.5 billion stemmed from Keogh plans (chart 2). This 11 percent Keogh contribution share is close to the 14 percent estimate of the proportion of 1986 IRA/Keogh assets held by Keogh plans and indicates that expanded IRA eligibility gave individual employee investments a much more significant share of the IRA/Keogh market within a relatively short period of time.

### Insurance Companies and Fiduciary Responsibility

[Editor's note: This article was prepared by the law firm of Arnold and Porter, EBRI's counsel, and is a regular feature of Employee Benefit Notes.]

A federal district court in Connecticut has joined the Seventh Circuit Court of Appeals in its earlier finding that an insurance company can become an ERISA fiduciary by virtue of its authority and control over assets in the insurance company's general account.1 (See Jacobsen v. The John Hancock Mutual Life Insurance Company, no. N-84-663, slip opinion, March 16, 1987.)

The decision is significant for at least the following reasons: (1) it demonstrates that the earlier holding of the Seventh Circuit on this issue will not be limited to courts in that jurisdiction; and (2) it represents an interpretation of the prior administrative guidance on this issue that, if not an outright repudiation thereof, is still fundamentally at odds with the interpretation previously accorded it by the insurance industry.
Because ERISA imposes fiduciary responsibility on those with discretionary authority or control over plan assets, analysis of whether the fiduciary responsibility (and prohibited transaction) rules apply to the managers of entities in which plans invest has generally begun by determining whether the assets of such entity constitute plan assets. ERISA Section 401(b)(2) states the following regarding assets owned or managed by insurance companies:

In the case of a plan to which a guarantee benefit policy is issued by an insurer, the assets of such plan shall be deemed to include such policy, but shall not, solely by reason of the issuance of such policy, be deemed to include any assets of such insurer. For purposes of this paragraph...

The term “guaranteed benefit policy” means an insurance policy or contract to the extent that such policy or contract provides for benefits the amount of which is guaranteed by the insurer. Such term includes any surplus in a separate account, but excludes any other portion of a separate account.

Under this definition, a fully guaranteed general account product, e.g., a guaranteed investment contract, will clearly not involve plan assets. However, an insurance company general account product may involve a combination of guaranteed and other benefits, and the phrase “to the extent of” in the quotation set forth above creates significant ambiguity regarding such products.

It might be argued, as some in the industry have, that a general account product with any guaranteed features is a guaranteed benefit policy within the meaning of the statutory definition. Relying in part on the following statement from the Conference Report on ERISA, however, the Jacobson case appears to have come to exactly the opposite conclusion, i.e., that only a product not dependent in any way on investment return will in all respects constitute a “guaranteed benefit policy”:

If the policy guarantees basic payments but other payments may vary with, e.g., investment performance, then the variable part of the policy and assets attributable there - to are not to be considered as guaranteed, and are to be considered as plan assets subject to the fiduciary rules.

The court stated that section 401(b)(2) “must be read as written, vis [sic], to cover only that phase of a contract in which the obligation of the insurer to guarantee the benefits payable to plan participants is fixed.”

In reaching this conclusion, the court considered DOL Interpretive Bulletin 75-2, 29 C.F.R. 2509.75-2 (1985), which states the following:

If an insurance company issues a contract or policy of insurance to a plan and places the consideration for such contract or policy in its general asset account, the assets in such account shall not be considered to be plan assets.

The court also noted statements that then-Assistant Secretary of Labor, Paul J. Fasser, Jr., made when this interpretive bulletin was issued, which strongly suggest that insurance company general account assets do not constitute plan assets by virtue of policies or contracts issued by the company.

Apparently for the most part accepting defendant’s assertion that the Labor Department pronouncements supported defendant’s position, the court nonetheless dismissed such pronouncements:

The DOL’s interpretation of the statutory language and legislative intent and defendant’s reliance thereon is simply unsupportable.

The court also rejected defendant’s argument that, if held to be a fiduciary, its duties would conflict with the nature of general accounts. An insurance company generally has multiple contractual obligations with varying goals and responsibi-
ties, depending on the type of policy or contract. Assets in the general account are commingled, and investment decisions are made on the basis of all the assets, not on an individual, segregated basis. The court, however, cited the general purposes of ERISA's fiduciary rules, and stated:

*An insurer may not use a general account to harbor a plan's assets, create a potential conflict, and thus claim relief from a fiduciary's obligations.*

Whether the Second Circuit Court of Appeals will affirm this decision remains to be seen. However, if this decision, and its underlying rationale, become generally accepted law, fundamental changes may well be required in 1) the law itself; 2) the nature of insurance company policies and contracts with employee benefit plans; or 3) the manner in which insurance companies manage their general account assets.

**The Changing Environment of Mandated Benefits**

[Editor's note: The following was prepared by Greg Scandlen, director of the State Services Research Department, Blue Cross and Blue Shield Association.]

Over the past year there has been a meteoric rise in concern by employer and business organizations over the topic of mandated employer-paid health benefits.

The Employee Benefit Research Institute (EBRI) in late 1985 began planning for a day-long policy forum on mandated benefits held in April 1987.

The White House Conference on Small Business has named elimination of mandated benefits as the second most important priority out of 60 recommendations sent to the president in November 1986.

The National Association of Manufacturers, in conjunction with the Washington Business Group on Health, made mandated benefits a primary topic at their third annual Health Agenda Conference in January 1987.

The National Chamber Foundation commissioned a major study for 1987 of mandated benefits and mental health and substance abuse benefits.

The National Federation of Independent Business has become increasingly concerned about mandates, devoting most of one newsletter edition to it and lobbying vigorously against certain mandated proposals.

Two events have sparked this sudden increase of interest over an issue that has existed for over 20 years.

First was the U.S. Supreme Court Decision *Metropolitan Life Insurance Company v. the Commonwealth of Massachusetts*, June 3, 1985. This decision dashed the hopes of many in the business community that the Employee Retirement Income Security Act (ERISA) meant what it said when it preempted state laws relating to employee benefits plans—that the content of such a plan could not be regulated by the states. Unfortunately for those in the business community, the Court placed more emphasis on the "saving clause" which allowed the states to continue to regulate insurance, while prohibiting them from regulating employee benefits plans. The upshot of this decision is that insured health benefits would remain subject to state mandates, while self-funded health benefits would not.

The second event was enactment of COBRA [the Consolidated Omnibus Budget Reconciliation Act] in 1985, with its federal continuation-of-coverage mandate. Unlike previous state mandates on the same topic, the federal mandate made no exception for self-funded health benefits, but included all health programs. Buried in a congressional omnibus budget bill [now P.L. 99-272], this provision did not cause a great stir until after it became law and employers were faced with trying to understand it, and then with trying to comply with it. Employers demanded to know how this was allowed to happen. And their Washington representatives have answered: "Never again."

**State Mandates**

It is ironic that this heightened awareness is coming at a time when the popularity of mandating health insurance benefits appears to be tapering off at the state level. In fact, in 1986, there were fewer mandate laws enacted by the states (26) than any year since 1972, when only six were enacted. Several states have passed legislation to require that mandating proposals be subject to an objective evaluation. It remains to be seen how effective these evaluations, based on the social and financial impact of the new benefits,
will be. But the fact that they have become law indicates a new skepticism on the part of state legislatures.

Mandated coverage laws fall into four categories roughly equivalent to "who, what, when and where." These may be explained as follows:

Benefits (what)— These mandates expand the kind of services covered under a health insurance contract. Examples would be alcoholism treatment or in vitro fertilization.

Dependents (who)— These mandates expand the numbers of people to be covered under a contract. Typically, these may be applied to handicapped children upon reaching the age of majority or to adopted children and newborns.

Provider (where)— These expand the numbers and types of providers eligible to perform and be reimbursed for the covered services. Examples are requirements that birthing centers be covered as are hospital maternity units, or that social workers be reimbursed for covered services that are within the scope of their license.

Continuation/Conversion (when)— These expand the length of time the coverage will be in effect. Like COBRA, these may require that a worker may continue participating in the group contract for a certain period after termination.

The actual increase in claims cost is the subject of vitriolic debate. Insurance companies and employer groups maintain the costs of mandates are high and getting higher.

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Chart 1

The Square Balloon of Mandated Coverage Laws

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Chart 2

Number of Health Mandates Enacted by 50 States Each Year Since 1965

Source: Blue Cross and Blue Shield Association
Providers and advocates for certain disease victims argue that the costs are not high, and that in any event, the money spent on one service is offset by eventual savings in the cost of traditional services.

Whatever the actual cost in terms of claims submitted, there can be little doubt that if one expands the services covered, and the number of people providing the services, and the number of people receiving the services, and the length of time in which they are eligible to receive them, the exposure to cost increases must be large.

The argument then becomes a question of whether the social need justifies the potential cost—precisely the question that increasing numbers of state legislatures are asking. Indeed, the most recent trends with respect to mandates in the states, have been a slowing down of further enactments, and interest in developing objective criteria to measure the social and financial impact of new mandates.

Chart 2 illustrates the number of mandates enacted by all the states for each year since 1965. Prior to 1965, only two such laws existed. 1975 was the peak year, with 75 mandated coverage laws being enacted in that year alone. In 1986, only 26 new laws were enacted—fewer than any year since 1972.

The chart is remarkably similar to the traditional product life cycle as taught in basic marketing courses. There is an introduction period (1965-1970) in which the product is just becoming known; a market acceptance period (1971-1975) characterized by a large growth in "sales;" a maturity period (1976-1983) in which sales level off; and a period of decline (1984-1986) in which the market has become saturated and new customers are hard to find. This type of cycle applies to everything from Hula Hoops and Wacky Wall Walkers to video cassette recorders and compact discs. Unfortunately, unlike Wacky Wall Walkers, when the "customers" become bored with these products (state mandates) they cannot toss them in the back of the closet. They are laws and continue as laws until they are repealed. Thus we get a situation like that demonstrated in chart 3, which shows the aggregate number of mandating laws throughout the country. The total has climbed from two prior to 1965 to 645 at the end of 1986.

It remains to be seen whether the decline in mandates will continue. It
is possible there could be a resurgence as there has been in other years. In fact, during 1987 there have been as many or more mandate bills introduced as other years. The 70th session of the Texas legislature, for instance, is considering 36 separate pieces of legislation mandating some form of expanded coverage on employer-based health insurance.

There are numerous reasons, however, for believing these bills will not be successful.

States appear to be less enamored of mandates than they used to be. One indicator is the decreasing numbers of laws enacted for three years in a row. More significant, however, may be the "mandate evaluation" laws enacted in four states and being considered by several others. These laws were inspired by criteria developed by the NAIC [National Association of Insurance Commissioners] in 1983 and recommended for adoption by state legislators and insurance commissioners. To date, Washington, Oregon, Arizona and Pennsylvania have enacted some form of the criteria, which amount to a social and financial impact statement.

The growth in self-funding and the concomitant escape from state regulation has made mandating benefits ever less effective in securing services for the general population. A recent Johnson & Higgins Health Group survey of more than 1,300 employers reported 46 percent were self-funding their health benefits (Johnson & Higgins. Corporate Health Care Benefits Survey. Princeton, New Jersey: Johnson & Higgins Health Group, 1986). The larger the group, the more likely they were to self fund. Seventy percent of the employers with 10,000-19,999 employees self-funded, as did 85 percent of those with more than 40,000 employees. [Nationally, 42 percent of health plan participants in medium and large establishments had all or part of their plans self-funded by their employers. See November 1986 EBRI Issue Brief]. Given the usual variation between states, there may be some states in which 70-75 percent of the population escapes mandated coverages. Thus, even the most desirable of mandates may have very little effect.

Recognizing the diminished effect of state-level mandates and increasing resistance from state legislators, provider groups have begun turning to Congress to achieve their purposes. Congressional action has the very attractive advantage of one-stop shopping for lobbying new mandates. Not only will one law affect all 50 states, but one law will also cover all employer health plans, not just insured ones. Congress has a traditional reluctance to tamper with insurance issues, but like state legislators, members of Congress may be drawn to the possibility of achieving some social good without spending any taxpayer money. Mandates make that easy. If substance abuse is a national problem, Congress can require that all employers provide benefits for the treatment of substance abuse. A noble purpose is served, without spending a penny of direct federal revenues.

Proponents of mandates like this approach so much that some have begun to believe they are wasting time attempting to enact mandates at the state level. This may be particularly true of certain patient advocacy organizations with limited budgets and national constituencies.

The fourth reason state mandates are less likely to become law is the sudden interest by employers. The COBRA continuation law shocked employer organizations into heeding the threat posed by mandates, both to those still insured (at the state level) and to all employers providing health benefits (at the federal level). Suddenly, like minimum wage increases and unemployment compensation hikes, mandates have become a red flag for all employers. Business coalitions have been developing a marketplace model for health care throughout the country, and "let the market decide" is a slogan easily applied to mandates as well as to hospital rate-setting or cumbersome health planning regulations.

The primary arena for discussion of mandates has clearly shifted from the state to the federal level. It remains to be seen whether Congress will heed the lessons learned at the state level—that mandates never end. Once one is enacted, other provider groups are encouraged to seek more. Possibly the product life cycle will be replicated by Congress, until they, too, become saturated and decide to evaluate these proposals objectively. Meanwhile, however, employer and business groups are on the alert and will strive to dissuade Congress from continuing very far along this path.

Legislation and Litigation
Kennedy Bill Would Mandate Employer Health Coverage

The formal debate over mandated health insurance opened on Capitol Hill as Sen. Edward Kennedy (D-MA) introduced a bill (S. 1265) to require all employers, regardless of size, to provide a basic employee health insurance package. Similar legislation (H.R. 2509) has been introduced in the House by Rep. Henry Waxman (D-CA), chairman of the House Energy and Commerce Health Subcommittee.

At a May 19 news conference, Kennedy said he expects the Senate Labor and Human Resources Committee—of which he is chairman—to approve S. 1265 by July. At a hearing the same day, Kennedy received testimony from uninsured individuals, health economists, and representatives of organizations supporting the proposal. A June 24 hearing will include witnesses from the employer community and insurance industry.

The National Association of Manufacturers and the U.S. Chamber of Commerce claim the proposal would impair firms’ competitiveness in foreign markets. Kennedy counters that most employers affected by the proposal—smaller firms—do not compete abroad and that employers already providing health coverage actually would see their costs reduced when they cease “subsidizing” the uninsured.

The Kennedy proposal would require all employers to provide coverage for physician and hospital services, diagnostic tests, prenatal/ well-baby care, and stop-loss catastrophic coverage for out-of-pocket expenses exceeding $3,000 annually. Employees would pay up to 20 percent of the premium and deductibles of $250 for an individual and $500 for a family. Prenatal/ well-baby care would carry no copayments or deductibles.

Kennedy estimated the total cost would be $25 billion, with employers financing four-fifths of the expense. He said the program would bring coverage to some 24 million of the nation’s 37 million uninsured people.

Contractors would bid to provide coverage to small businesses within regions. The economies of scale resulting from the regional pools, Kenedy said, would allow small employers to purchase coverage at premiums 30 percent below their current cost. In his oral statement (but apparently not in the bill itself), Kennedy added that establishments less than two years old with fewer than 10 employees would be permitted to provide only the catastrophic benefit. Other planned legislation would extend the tax-deductibility of health insurance purchased by the self-employed from the current 25 percent deductible to 80 percent.

Kennedy was joined at the news conference by Waxman, Sen. Lowell Weicker (R-CT), and representatives William Clay (D-MO) and Austin Murphy (D-PA). The measure has drawn the support of a number of health care and consumer groups and labor unions. EBRI’s May 1987 Issue Brief gives a profile of the nonelderly population without health insurance and the June 1987 Issue Brief discusses public policy options for expanding health insurance coverage among the nonelderly population.

Medicare Catastrophic Bill Advances

Both the House and Senate tax-writing committees have approved similar legislation designed to protect Medicare beneficiaries against catastrophic medical bills.

Senate Action

The Senate Finance Committee May 29 approved S. 1127, sponsored by Senate Finance Committee Chairman Lloyd Bentsen (D-TX). As reported, the following provisions are included in the bill.

Eligibility—All individuals enrolled in Medicare Part B would be automatically covered under the catastrophic insurance program.

Cap—Out-of-pocket expenses incurred under Part A or Part B for Medicare-covered services would be limited to $1,700 annually. The cap would be indexed to the Social Security cost-of-living adjustment.

Part A Benefits—All hospital coinsurance and the current limit on the number of hospital days covered by Medicare are eliminated. Liability is limited to one hospital deductible annually, but the indexation of the deductible is not changed. Coverage for skilled nursing days and the number of days that beneficiaries receive daily home health care are increased. The 210-day limit on hospice coverage is eliminated, and for those who enroll in Part B, the “spell of illness” concept of benefit a period is eliminated.

Part B Benefits—Beneficiary costs for immunosuppressive drugs, mammography, and colorectal examinations are counted toward the
expense cap.

Financing — Catastrophic benefits would be financed through a combination of a basic monthly premium of $4.00 per month and an income-related supplemental premium. The premiums would be indexed to increases in the per capita costs of the catastrophic benefits. After 1988, the premium increase would be limited so that no beneficiary’s monthly premium would increase by more than the cost-of-living increase in his or her monthly Social Security benefit. The supplemental premium would be based on the tax liability of the beneficiary. The Senate Finance Committee says that approximately 35 percent of the elderly would be subject to the supplemental premium. On average, a couple on Medicare with income of $17,500 or less would have a basic premium increase of $4.00 per month and would not pay the supplemental premium.

Medigap — Changes to the model standards made within 90 days by state insurance commissioners to reflect this bill would be automatically adopted. If the state insurance commissioners do not amend standards to reflect these changes within 90 days, the Secretary of Health and Human Services (HHS) must issue revised standards, which would then become effective in one year. The current standards are modified to expand the “free look” period for policies sold by agents, and to require states to adopt report standards relating to loss ratios. The secretary is required to provide information for consumers relating to Medigap policies and Medicare benefits.

The legislation also calls for HHS and the Secretary of the Treasury to conduct studies on options and tax incentives for long-term care insurance. The Secretary of the Treasury is required to seek the views of the insurance industry providers of long-term care.

House Action

The House Ways and Means Committee May 7, approved legislation (H.R. 2470) designed to ensure that no Medicare beneficiary would pay more than about $1,700 out-of-pocket annually for Medicare-covered services and financed through a new double-premium mechanism. Like the Senate bill, there is a flat premium increase combined with an income-based premium for those in specified income levels. The optional Part B supplemental medical insurance premium would increase by $1 in 1990 and by $1.50 in 1991 and 1992. The income-related premium would come on top of that and would vary with income. As originally introduced by Reps. Fortney “Pete” Stark (D-CA) and Willis Gradison (R-OH), the legislation would have required Medicare beneficiaries to pay taxes on the insurance value of Medicare coverage.

Outpatient Prescription Drugs

Though neither bill in its current form expands Medicare coverage of outpatient prescription drugs, some such expansion is expected to be included in the final legislation. Ways and Means has a markup scheduled to approve a prescription drug amendment, and the Senate Finance Committee is also developing one, after hearings are held in the Health Subcommittee soon.

Catastrophic Coverage under Employer Plans — Rep. Willis Gradison (R-OH) has also introduced a bill (H.R. 2300) that would require that employers offer catastrophic health coverage as part of their health benefit package, and the Ways and Means Subcommittee on Health held hearings on the legislation May 12. (See April and May 1987 Employee Benefit Notes). As drafted, the legislation would require employers with 20 or more employees to include catastrophic health insurance coverage as part of their group health plans or lose the tax exclusion. The insurance would limit employee liability for payment for physician and hospital services to out-of-pocket costs of $2,000 per individual and $3,500 for families per year. In remarks to colleagues, Gradison said that “most employer plans already meet this standard.”

President Signs S. 903

President Ronald Reagan May 15 approved S. 903, which extends until September 15, 1987 the requirement that companies that have filed for reorganization under Chapter 11 of the Bankruptcy Code continue to pay retiree health, life, and disability benefits (P.L. 100-41). The original measure, approved last year, expired May 15. (For more information, see the May 1987 Employee Benefit Notes.)

Chandler Announces Retiree Health Legislation

Legislation designed to encourage companies to prefund retiree health and long-term care benefits by creating tax-exempt Voluntary Retiree Health Plans (VRHPs) has
been announced by Rep. Rod Chandler (R-WA). In general, employer contributions to the plans would be deductible and earnings on plan assets would not be subject to tax. Employees would not be taxed at any time on amounts in the plan, including upon distribution. In return for the tax-favored treatment, employers would be required to make contributions for post-retirement health and long-term care coverage to a broad group of employees.

Chandler’s legislation would repeal current special rules that allow qualified retirement plans to provide retiree health benefits (401(h) trusts). Rules relating to the funding of benefits under welfare benefit plans—voluntary employee beneficiary associations (VEBAs) would be amended to prohibit reserves for retiree health benefits. These changes would ensure consistent tax-favored treatment for the prefunding of retiree health benefits.

Existing pension rules regarding vesting and participation would generally apply to the tax-favored fund. The plan could be maintained by an employer who has no regular pension plan, or as part of an existing pension plan, providing that the retiree health and long-term care accounts were kept separately. In either situation, a separate limit on contributions would apply, so that even employees receiving the maximum contribution under a pension plan could receive contributions under a retiree health and long-term care plan.

Employees would not be promised a specific health benefit or level of benefits, but employers would be obligated to make contributions to the accounts of participating employees. Contributions would be the same amount for each employee. The level of the contribution would be based on a “target benefit” approach, which would enable employers to fund for a projected dollar level of benefits at an employee’s retirement age.

Also included in the proposal is a requirement that employers continue to contribute to VRHPs for employees working beyond the normal retirement age and a portability provision that allows workers who leave employment prior to retirement to retain funds that have been contributed on their behalf. Access to the VRHP before retirement is prohibited under the legislation, except in the case of workers who qualify as disabled under Social Security rules.

From the Record

"There are... large differences in the assumed savings for the Pension Benefit Guaranty Corporation (PBGC) between the House and Senate resolutions. The House assumed savings of $34 million for fiscal years 1988 through 1990, while the Senate assumes savings of over $2.7 billion. The Senate numbers assume a three-fold increase in the premiums. This simply is too large an increase to be politically feasible or substantially defensible. Increases as large as those proposed by the Senate could prove to be counterproductive to the purposes of ERISA and the PBGC since it could lead to increasing termination of defined benefit plans. Furthermore, any legislation considered by the committee dealing with increases in PBGC premiums will involve increases in funding standards in order to ensure that solvent plans are not bailing out insolvent plans. However, increasing these funding standards will reduce tax revenues. Thus, the path assumed in the House resolution is the correct one and further savings are simply not advisable."
Dole Aide Outlines Options for Medicare Reform

The rising economic status of the elderly may lead Congress to focus on means testing as a way to relieve Medicare's overburdened Hospital Insurance Trust Fund, a key Capitol Hill aide said at a conference, "Medicare Reform and the Baby Boom Generation," sponsored by Americans for Generational Equity.

Medicare, the federal program that provides health coverage to the nation's elderly and long-term disabled, will fail to meet the needs of tomorrow's older Americans "unless we reexamine the fundamental underpinnings of the program," said Sheila Burke, chief of staff for Senate Minority Leader Bob Dole (R-KS).

As the oldest members of the baby-boom generation retire in 21 years, there will be progressively fewer active workers to support each retiree. The Medicare program is expanding its role as secondary payer, placing a greater share of the health care burden on employer-provided retiree health plans and on retirees themselves.

As it seeks ways to ensure Medicare's solvency, said Burke, Congress will consider reforms in eligibility, benefits, and/or reimbursement, and will approach reform incrementally. "Short-term fixes are sometimes necessary pending availability of data," she said.

EBRI President Dallas Salisbury told the conference it is unlikely Congress will expand tax incentives for employers to prefund retiree health benefits. Congress may, however, explore medical individual retirement accounts as an option for financing retirees' health care.

Copies of the conference proceedings are available from Americans for Generational Equity, 318 4th St., NE, Washington, DC 20002.

Access to Excess Assets

Legislation prohibiting employer access to excess assets has been introduced in the House by Rep. Edward Roybal (D-CA). The "Pension Plan Assets Protection Act of 1987" (H.R. 1942) would require that following any defined benefit pension plan termination, all residual assets be distributed to plan participants and beneficiaries in the same proportions as plan assets are allocated in satisfying plan liabilities.

Roybal's bill is designed to protect workers' and retirees' benefits in the event of pension plan terminations. He has introduced similar legislation in the 98th and 99th Congresses (see March/April 1984, January/February 1985, and July/August 1985 Employee Benefit Notes). In introducing the legislation, Roybal cited a Department of Labor (DOL) study. It concluded that the difference to workers between an expected real benefit—had the plan continued until the worker reached retirement age—and a terminated nominal benefit—benefits accrued only up until the termination date and unadjusted for inflation up to retirement age—where there is no replacement plan, could represent a benefit loss of approximately 45 percent of the expected benefit.

Roybal said that "the Pension Plan Asset Protection Act does nothing more than recognize that the favorable tax treatment accorded defined benefit pension plans can only be justified from a policy perspective if they are treated as irrevocable trusts. Workers forego current wages in exchange for plan contributions eventually repaid in the form of pension annuities. This would simply prohibit employers from reclaiming funds otherwise contributed to fund current and future pension benefits."

Antitakeover Bill Introduced

Legislation designed to reform securities trading laws and takeovers has been introduced by Rep. John Dingell (D-MI), chairman of the House Energy and Commerce Committee. Dingell explained that the "Tender Offer Reform Act" (H.R. 2172) "allows for prompt disclosure of a bidder's intentions, and extends to corporate management a more reasonable time period in which to respond to such bids. It also restricts abusive defenses that can be used by management to fend off unfriendly offers such as greenmail and poison pills, unless approved by shareholders. The bill also limits "golden parachutes."

In addition, the bill increases shareholder rights by requiring a one-share, one-vote standard for certain securities and improving shareholder access to the corporate proxy machinery. The legislation also extends and clarifies the definition of "group" to alert the marketplace, at an early stage, of concerted acquisition activities and permits trading halts in all markets when necessary.
Regulations

Federal Agencies Announce
Regulatory Agendas

HHS — The Department of Health
and Human Services (HHS) has
issued its regulatory agenda for the
next 12 months. Among rules that
the Social Security Administration
(SSA) are developing are those
affecting medical criteria for deter-
mining various disabilities, and
continued payment during appeals
by beneficiaries whose continuing
eligibility has been denied. The
Health Care Financing Administra-
tion (HCFA) is developing rules
covering health maintenance orga-
nizations (HMOs) and competitive
medical plans, changes to the
diagnosis-related group (DRG)
classification system, and standards
for organ procurement agencies. (See
the April 27, 1987 Federal Register,
vol. 52, no. 80, pp. 14269–14359.)

IRS — The Internal Revenue Service
(IRs) April 27, issued its semiannual
agenda of regulations in the process
of being developed between April 1,

Among those at the prerule stage are
rules covering the procedure and
administration of the excise tax on
reversions of qualified pension plan
assets; included at the proposed rule
stage are regulations relating to
restrictions on golden parachute
payments, rules on defined benefit
plans and reversion of assets, and
rules on cash or deferred arrange-
ments; at the final rule stage are
regulations covering tax treatment of
cafeteria plans, rules covering
individual retirement plans (IRAs)
and simplified employee pensions
(SEPs), and rules covering the tax
treatment of lump-sum distribu-
tions. (For more information, see the
April 27, 1987 Federal Register ,
vol. 52, no. 80, pp. 14704–14842.)

DOL — The Department of Labor’s
(DOL’s) Office of Pension and
Welfare Benefit Administration
(PWBA) has published its regulatory
agenda for the next 12 months.
Among regulations the agency is
developing are those covering the
definition of pension plan assets
(employee contributions). The
proposed regulations are currently
at the final rule stage and are
expected to be completed by August
1987. (For more information, see the
April 27, 1987 Federal Register ,
vol. 52, no. 80, pp. 14704–14842.)

PBGC — The Pension Benefit Guar-
anty Corporation (PBGC) April 27
published its agenda of regulations
covering rules currently under
development during the next year.
Among those are implementation
guidelines for processing defined
benefit pension plan asset rever-
sions, the payment of benefits in
PBGC-trusteed plans, Retirement
Equity Act amendments, and
distress terminations of single-
employer pension plans. (For more
information, see the April 27, 1987
Federal Register , vol. 52, no. 80,
pp. 15027–15035.)

HHS Issues Notice on Medical
Services Coverage Decisions

The Department of Health and
Human Services April 29 issued a
notice requesting comments on
Health Care Financing Administra-
tion (HCFA) procedures for making
determinations regarding Medicare
coverage for special services and
items. The Social Security Act
prohibits Medicare payment for
expenses incurred for items and
services that are “not reasonable
and necessary for the diagnosis or
treatment of illness or injury or to
improve the functioning of a mal-
formed body member.” The notice
requests comments on procedures
used to make determinations under
that provision by June 29, 1987.
Comments should be addressed to
HCFA, Department of Health and
Human Services, Attention: BERC-
21, 432-N, P.O. Box 26676, Baltimore,
MD 21207. (See the April 27, 1987
Federal Register , vol. 52, no. 82, pp.
15560–15563.)

IRS Issues 401(k) Prototype Regs

Prototype Regulations — The Internal
Revenue Service has issued a notice
containing a model amendment and
procedures designed to speed up
processing for sponsors of master
and prototype plans who add a cash
or deferred arrangement (CODA) to
an approved profit-sharing plan.

IRS says that by using the amend-
ment and procedures, sponsors and
adopting employers can add CODA
provisions to their plan quickly and
efficiently, with minimum paper-
work and with the assurance of
compliance with the requirements of
section 401(k) of the Internal Re-
vene Code. IRS added that a sponsor
of a previously approved master or
prototype profit-sharing plan may
adopt the model CODA; plan
sponsors may also request a new
opinion letter on the CODA. The
agency said that it will give the
highest priority to all such model
CODA applications. The IRS held a
seminar on the use of CODAs in
master and prototype employee plans on June 5, and answered questions related to the notice (See the May 4, 1987 Internal Revenue Service Bulletin 1987-18, notice 87-33.)

Litigation

Supreme Court Rules on Estimated Medical Liability Tax Deduction

The Supreme Court April 22 ruled that companies may not deduct from federal income tax estimated liabilities for medical claims incurred, but not yet claimed. The ruling preserves a tax advantage that leads many companies to purchase health care from an insurer rather than self-insure.

In U.S. v. General Dynamics (no. 85-1385), the Court ruled in a 6-3 decision that an employer cannot take a tax deduction for a reserve set aside based on actuarial estimates of its anticipated liabilities for unreported employee claims under its self-insured medical benefit plan. Although such expenses may be deductible before they have become due and payable, liability must be firmly established, the Court ruled. An estimate of liability based on events that have not occurred before the end of the taxable year does not pass this test, since claims filing "is not a mere technicality" but is "crucial" to establishing taxpayer liability. The U.S. Court of Appeals for the Federal Circuit had extended tax-free treatment of such reserves to employers who self-insure.

Supreme Court Upholds Indiana Shareholder Laws

The U.S. Supreme Court April 23 voted to uphold an Indiana law giving shareholders of companies in the state more than double the time allowed under federal law to vote on takeover offers. The ruling is seen as a victory for states that are trying to regulate corporations and could result in a sharp reduction in hostile takeover activity.

The Indiana law says that an investor who buys more than 20 percent of a company's shares cannot vote that stake unless he wins approval from a majority of "disinterested" shareholders. Disinterested shareholders are defined as everyone except officers, inside directors, and the takeover investor. One of the more controversial provisions of the law gives a company 50 days to schedule a stockholders' meeting to decide to ratify or reject the investor's voting rights. Lower federal courts had ruled that the Indiana law hindered interstate commerce, and unfairly favored stockholders by delaying tender offers 50 days, rather than the 20 days required under federal law. But the Supreme Court upheld the Indiana law, ruling that it is not inconsistent with federal statute. In writing the majority opinion, Justice Lewis Powell wrote: "A state has an interest in promoting stable relationships among parties involved in the corporations it charters, as well as ensuring that investors in such corporations have an effective voice in corporate affairs."

Supreme Court Hears Multiemployer Pension Plan Case

The U.S. Supreme Court April 27 heard arguments on the constitutionality of the Multiemployer Pension Plan Amendments Act's (MPPAA) provisions for resolving disputes over the amount of withdrawal liability imposed on certain employers.

In United Retail and Wholesale Employees Teamsters Pension Fund v. Yahn & McDonnell, Inc., a lower federal court held that under MPPAA, employers who withdraw from a pension plan are denied a fair opportunity to challenge the pension plan's withdrawal liability determination, and that the federal pension statute therefore violates the due process clause of the Fifth Amendment to the Constitution. The lower court also held that multiemployer plan trustees are "biased decisionmakers" because of the legal requirement that they act in the best interests of the pension plan.

After the lower federal court ruling, the PBGC intervened in the case to prosecute an appeal to the Supreme Court. The PBGC argued that the "biased decisionmaker" analysis was inappropriate because plan trustees are like civil plaintiffs rather than judges. "The employer is entitled to a full evidentiary hearing before a neutral arbitrator, and consequently, it is the arbitrator, not the trustees, who adjudicate withdrawal liability disputes," PBGC General Counsel Gary M. Ford argued. He also stressed that the possible increase in the number and scope of arbitration proceedings likely to result from the lower court ruling threatens the resources of multiemployer plans and the PBGC.

Appeals Court Upholds State Tax on Value of Self-Insured Health Benefits

The United States Court of Appeals
for the Ninth Circuit has reversed a district court ruling and upheld a California law that taxes premiums received by insurance companies doing business in the state. The decision follows several federal and state court rulings giving broad interpretation to the preemption clause contained in the Employee Retirement Income Security Act of 1974 (ERISA).

*General Motors v. California State Board of Equalization* concerns several appellees, including General Motors (GM), that are fiduciaries of employee welfare benefit plans and fund the plan benefits through company assets and excess risk policies from Metropolitan Life Insurance Company. By paying a portion of the claims themselves and depending on Metropolitan for larger risks, the premiums that GM paid to Metropolitan were lower than those under a traditional arrangement.

In calculating the gross premiums tax assessed Metropolitan, however, California included premiums paid by GM to Metropolitan, plus benefits paid directly to GM employees under both the self-insured and insured portions of the plans. (This method of calculation was upheld by the California State Supreme Court.) A contractual requirement that Metropolitan be reimbursed for premium taxes led to GM's action in federal court, seeking an opinion that California's interpretation of "gross premiums... received" was preempted by ERISA.

The court did not address California's method of calculating "gross premiums received," but disagreed with GM and a federal district court on the issue of ERISA preemption, noting that "the second step in preemption involves the insurance saving clause, which provides that any state law that regulates insurance, banking, or securities shall remain in force. This clause must be interpreted broadly, . . . and must be construed to cover taxation of insurance. . . . The final step in preemption analysis requires consideration of the deemer clause, which prevents a plan from being deemed to be an insurance company to prevent states from regulating benefit plans simply because they provide insurance. . . . But the tax here is imposed on the insurance companies, not the benefit plans."

**Pension Accrual Stay for EEOC**

The U.S. Court of Appeals for the District of Columbia May 12 granted the Equal Employment Opportunity Commission (EEOC) a stay of a district court order directing the EEOC to issue final regulations to require that employers continue to pay contributions and accruals to pension and retirement plans for employees who continue to work beyond the normal retirement age. The U.S. district court order required the EEOC to issue regulations on post-65 pension accruals by May 18. The EEOC has said it will not issue final regulations pending the outcome of its appeal; but the EEOC has rescinded a 1979 interpretive bulletin that supported employers' right to cease pension contributions for employees who work beyond the normal retirement age as a result of the same district court ruling (see May 1987 *Employee Benefit Notes*).

**At EBRI**

*America in Transition: Benefits for the Future*

Few aspects of American life have been undisturbed in the last 30 years—we live differently, work in different jobs with different work schedules, goals, values, and spend our leisure time differently. In addition, the population is aging, American business is experiencing intense foreign and domestic competition, and government policy is assuming a greater role in the work place. These changes have important ramifications for individuals, businesses, and government policy. What changes are predicted for employee benefits in forthcoming decades and how will those changes affect Americans and the business community? In EBRI's newly released book based on October 1986 policy forum proceedings, experts in demographics, survey research, public policy, and benefits design present their views of what the future holds for employee benefits. Contact EBRI, 2121 K Street, N.W., Suite 860, Washington, DC 20037-2121. (202) 659-0670. Cost $15 (softcover) or $30 (hardbound). Add $1.50 for UPS shipment.

*Fundamentals of Employee Benefit Programs*, third edition

Widely acclaimed as a thorough, accurate, and readable primer on the entire range of employee benefits, *Fundamentals* has been expanded and updated in a new third edition to include 1986 tax law and regulatory changes. In addition, new chapters on how to evaluate a
Small Business entitled “The Erosion of Health Insurance Coverage Among the Nonelderly Population: Public Policy Issues and Options.” The hearing was one of a series held to review insurance costs for small business (see the May 1987 EBRI Issue Brief for more information).

Presentations

EBRI President Dallas Salisbury made a number of presentations during the month of June. These included a presentation to Hewitt Associates June 2; the Sherwin Williams Company June 9; the Columbia University School of Social Work June 12; and the Geneva Association General Assembly June 15.

Emily Andrews, EBRI research director, made a presentation on pension plans and small employers to the American Association of Retired Persons’ (AARP’s) National Planning Meeting on “Worker Equity Initiatives” June 23.

Deborah Chollet, EBRI senior research associate, served on the U.S. Chamber’s Health Care Council for a discussion on mandated benefits May 7, and was invited to participate in the Department of Health and Human Services’ (HHS) upcoming conference on retiree health benefits (see below) June 25 and 26.

Robert Friedland, EBRI research associate, was a speaker at the National Conference on Long-Term Care Data Bases, sponsored by the Office of the Assistant Secretary for Planning and Evaluation and the Office of the Assistant Secretary for Health, HHS, May 21 and 22.

Announcements and Publications

HHS to Hold Health Care Conference

The Department of Health and Human Services (HHS) June 25 and 26, 1987, will hold an invitational conference on retiree health care benefits. Participants will examine the vital issues confronting Americans regarding retiree health benefits, with emphasis on cooperative efforts of the federal government and the private sector to solve this emerging national problem. HHS Secretary Otis Bowen, in announcing the conference, noted that: “Providers, consumers, and payors all have a stake in solving the problems posed by retiree health care.”

Bowen said that a number of issues will be discussed by leaders in the private sector and high-ranking government officials. “Both large and small corporations are facing ever-increasing unfunded liabilities for the health benefits of their retired workers. These unfunded liabilities are undermining the competitiveness of many of these firms. The dilemma we face is how to maintain and fund quality health care for retirees without placing a crippling burden on the productive capacity of American business,” Bowen said. For more information, contact Carol Cronin, vice president, Washington Business Group on Health at (202) 547–6644.
Government Reports

General Explanation of the Tax Reform Act of 1986, Joint Committee on Taxation


Nongovernment Reports

Public Employee Retirement Systems: The Structure and Politics of Teacher Pensions, Suzanne Saunders Taylor

According to this report, pension assets are the fastest growing source of capital in the United States today, and retirement funds for public employees constitutes one of the nation's largest pools of capital—about $300 billion. This book provides a comprehensive view of the retirement systems for teachers that control a significant portion of those funds. The author outlines their organizational schemes and relationships to state government, and defines the roles of trustees, pension professionals, and teacher unions. Contact ILR Press, NYSSILR, Cornell University, Ithaca, NY 14851-0952. (607) 255-2264. Cost $14.95 for paperbound, $26 for clothbound.

prepaid. Add $2 handling charge for orders not accompanied by full payment.

Liberty, Equality, Maternity, Dana E. Friedman

"Women should not be asked to put their jobs at risk in order to produce the next generation," according to the author of this report, prepared for The Conference Board’s March 1987 issue of Across the Board. The report notes that "How women—and companies—face the problems posed by maternity leave will have a tremendous bearing on the future hiring and advancement of women. It will also be a crucial test of society's commitment to children and families." The author points out that company policy in the area of parental leave is often driven by law, and notes a 1984 survey indicating that companies may actually reduce maternity leave because they see no reason to offer more than is legally required. Contact The Conference Board, 845 Third Avenue, New York, NY 10022. (212) 759-0900. Cost $2.

Surveys

Corporate Defined Contribution Plans, Bankers Trust Company

The 1987 survey includes information on defined contribution plans that qualify for tax advantages under section 401(k) and section 401(a) of the Code and includes profit sharing and voluntary contribution plans.

The majority of surveyed companies (67 percent) extend defined contribution pension plan coverage to substantially all employees. Seventy-three percent of surveyed plans have a service-only provision for participation. The most common requirement is one year of service (52 percent).

Eighty-nine percent of the surveyed plans have a 401(k) provision and permit pretax employee contributions. Twenty percent of the plans permit pretax contributions only; another twenty-one percent require the employee to contribute a minimum pretax rate prior to making any post-tax contributions. The median, and the most common, basic contribution rate continues to be 6 percent of compensation (49 percent of plans).

The median basic matching contribution rate is 50 percent of employee contributions (48 percent of plans). Twenty-four percent match at a rate higher than 50 percent, and 15 percent at a lower rate.

Ninety-six percent of plans allow employees to choose how to invest at least part of their funds, with three options being the most common (38 percent of plans). Forty-one percent offer more than three choices and 15 percent fewer than three. Company stock is the most common required option.

The trend is toward faster vesting, with 25 percent now offering immediate vesting.

Eighty-six percent of plans contained a hardship withdrawal provision, and 43 percent have a loan provision. Eighty-eight percent of the plans offer alternative forms of distribution upon termination of employment, in addition to an immediate lump-sum distribution.
The study makes it clear that defined contribution plans continue to be popular and that design trends continue to move in the direction of allowing employees choice in all areas allowed by law. Contact Sook Chang at Bankers Trust Company, 280 Park Avenue, 84 M, New York, NY 10015. (212) 850-20220. Cost $200.

*Coopers & Lybrand 1986 Executive Compensation Survey, Coopers & Lybrand*

This survey of more than 600 mid-sized and large U.S. companies indicates that they are moving quickly to adopt 401(k) plans to offset the lessened availability of individual retirement accounts (IRAs). The companies are also absorbing higher pension costs brought on by changes resulting from the Tax Reform Act of 1986. For a free copy, contact Arlene Ickes, National ABC, 400 Renaissance Center, Detroit, MI 48243.

*Employee Participation in Wholly Voluntary Retirement Plans, Teachers Insurance and Annuity Association-College Retirement Equities Fund*

This survey conducted by TIAA-CREF determines the extent to which eligible employees choose to join their retirement plan when participation is wholly voluntary. The survey includes data from 394 respondents—152 colleges and universities and 103 independent schools with wholly voluntary participation for all classes of employees, and 72 colleges and universities and 67 independent schools with wholly voluntary participation for some classes of employees and required participation for others. The results of the survey are reported in TIAA-CREF's January 1987 issue of *Research Dialogues, no. 12. Contact TIAA-CREF Educational Research Unit, 730 Third Avenue, New York, NY 10017. (212) 490-9000.*

*Looking to the Future of Retiree Health Benefits, EQUICOR*

The main purpose of this survey is to provide baseline information about the presence of employer-provided retiree health plans; how much of a problem their current costs present to employers, and how great a problem these costs may become. This national survey addresses the subject of employer-provided retiree health benefits through interviews with corporate employers, retirees, and current employees. Contact EQUICOR, Equitable HCA Corporation, 195 Broadway, New York, NY 10007. (212) 618-5252.


This report summarizes the principal benefit plans provided during 1981 through 1986 for the salaried employees of 256 major U.S. employers. Each year's data represents the same constant sample of 256 employers. Among industrial companies, the study includes 75 percent of Fortune 100 and 68 percent of the Fortune 250. The study also includes 38 percent of the Fortune 50 commercial banking companies and 46 percent of the Fortune 50 life insurance companies. Benefit information in areas such as pensions, health care, group life insurance, disability, time off with pay, and capital accumulation is included. Contact Hewitt Associates, 100 Half Day Road, Lincolnshire, IL 60015. (312) 295-5000. Cost $25.

*1986 Survey of Flexible Compensation Programs and Practice, Hewitt Associates*

This survey, which supports the premise that flexible compensation can be a powerful tool for employers seeking to curb health care costs, contains information from 198 organizations. Only those companies with either a flexible spending account or choices in at least one benefit area were invited to participate. Sections of this report discuss plan objectives, design, requirements, administration, and communication. Contact Cathy Schmidt at Hewitt Associates, 100 Half Day Road, Lincolnshire, IL 60015. (312) 295-5000. Cost $100.

*401(k) Plans After Tax Reform, Hewitt Associates*

Employee Participation in 401(k) plans continues to be strong, according to this new survey from Hewitt. Responses from over 200 employers indicate that employers expect a significant number of employees to be effected by the new 401(k) limits, but few employers intend to make up for the reductions. Information about plan design issues, plan experience, and possible makeups for contribution cutbacks is also covered in this report. Contact Cathy Schmidt, Hewitt Associates, 100 Half Day Road, Lincolnshire, IL 60015. (312) 295-5000. Cost $25.
The Employee Benefit Research Institute (EBRI) is a nonprofit, nonpartisan public policy research organization based in Washington, DC. Established in 1978, EBRI provides educational and research materials to employers, employees, retired workers, public officials, members of the press, academics, and the general public. Through its books, policy forums, and monthly subscription service, EBRI contributes to the formulation of effective and responsible health, welfare and retirement policies. The Institute has—and seeks—a broad base of support among interested individuals and organizations, as well as among private-sector companies with interests in employee benefits education, research, and public policy.

Employee Benefit Notes and EBRI Issue Brief (a monthly periodical devoted to expert evaluations of a single benefit issue) are written, edited, and published by the staff of the Employee Benefit Research Institute and its Education and Research Fund (ERF). For information on periodical subscriptions and other EBRI publications, contact EBRI-ERF subscription service, 2121 K Street, NW, Suite 860, Washington, DC 20037-2121. (202) 659-0670.

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