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Tax Reform Enters Decisive Phase

By a roll call vote of 97 to 3, the Senate June 24 approved its version of tax reform (H.R. 3838). The bill now goes to a conference committee, where Senate and House conferees will attempt to reach agreement on provisions acceptable to both the House and the Senate.

The Senate debate of H.R. 3838 was marked by supporters' success in fending off almost all amendments that would have substantially altered the balance of tax rates and the distribution of the tax burden among individuals and corporations. Recognizing early on that few amendments would succeed, various lobbying organizations, including employee benefit lobbying groups, opted to concentrate their efforts on the conference committee, hoping to win improvements in the bill for the groups they represent.

The conference is also where the Reagan administration will strive to achieve any modifications it desires, although President Reagan has hailed the Senate bill as "an excellent bill that would shift the balance of power to productive enterprises."

The employee benefit provisions of the Senate version of H.R. 3838 remain as described in the "Tax Reform Update" in the May 1986 issue of Employee Benefit Notes; the House provisions are described in the January 1986 EBRI Issue Brief.

Several key Senate provisions, such as five-year vesting, changes in pension integration and coverage rules, elimination of deductible individual retirement account (IRA) contributions for pension-covered workers, reduction of the maximum benefit payable to early retirees under section 415, and retention of current law for 403(b) annuities and ESOPs, are not found in the House bill. Despite important differences in the two bills, their basic thrust is very similar in the employee benefit provisions: for example, a $7,000 cap on cash or deferred arrangements; new penalties on preretirement lump-sum distributions; repeal of 10-year forward averaging; a 10 percent excise tax on asset reversions; and new uniform nondiscrimination rules in the welfare benefit area.

Senator John Heinz (R-PA), Chairman of the Finance Subcommittee on Savings, Pensions and Investment Policy, spoke in favor of the bill's employee benefit provisions (see box), many of which reflect proposals he had sponsored in the Retirement Income Policy Act (S. 1784, H.R. 3594). Heinz noted the broad endorsement the tax reform benefit provisions had received from numerous groups, ranging from the Women's Equity Action League and the United Auto Workers to the ERISA Industry Committee and the U.S. Chamber of Commerce.

During the debate, the Senate June 11 agreed 96 to 4 to a nonbinding resolution addressing IRAs, which expressed that "Senate conferees on the Tax Reform Act give highest priority to retaining maximum possible tax benefits for individual retirement accounts to encourage their use as a principal vehicle for ensuring retirement security." The amendment also said that the IRA deduction should be retained "in a manner which does not adversely affect the tax rates or distribution by income class of tax reduction otherwise provided for" in the bill.

The Senate then went on to defeat other amendments designed to restore IRA deductibility at the 15 percent tax credit level. The Senate also defeated
Senate Phases Out Life Insurance Loan Deduction

Before passing H.R. 3838 June 24, the Senate agreed to an amendment which would phase out the deduction for interest on loans from individual life insurance policies over a four-year period. Sen. Majority Leader Robert Dole (R-KS) sponsored the proposal, telling colleagues, "Under the committee bill, no interest paid on loans on a life insurance contract purchased by an individual will be deductible after a four-year phase-out period. That is because interest paid on these loans is treated as consumer interest and that itemized deduction is phased out.

"However, if an employer purchases a life insurance policy for an employee and then borrows on the cash value, the interest paid on the loan will be deductible.

"This amendment modifies the treatment of interest paid on loans related to life insurance contracts purchased by businesses covering the lives of their employees. It would limit the employer's interest deduction to interest on life insurance related to loans aggregating no more than $50,000 per employee.

"Unlike the rule for life insurance policy loans taken out by individuals, the interest paid deduction for these loans will not be phased out, only capped at $50,000 of indebtedness. This will allow small businesses to use loans on life insurance policies for their employees as a source of short-term capital when necessary. But it will not allow these loans to be an unlimited tax shelter as under present law. Of course, businesses could borrow more than $50,000 per employee if necessary. This amendment only affects the amount of interest paid that could be deducted."

From the June 20, 1986, Congressional Record.

Gradison on Congressional Health Issues

[Editor's Note: The following is an edited version of Rep. Bill Gradison, Jr.'s (R-OH) remarks at EBRI's June 3 Policy Forum on "The Changing Health Care Market."]

Obviously, government health policies have many goals. The ones we talk the most about are cost containment, access, and quality. Today, the present stress is obviously on cost containment, which brings into sharp focus the inherent conflict among these three goals.

At some point, insistence on any one goal impinges on the other two. In the past, tough choices have been minimized by simply adding more dollars or starting new programs. However difficult such health policy choices may once have been, they're far tougher in what I would describe as the Gramm-Rudman-Hollings revenue-neutral, budget-neutral world.

Health Care Versus the Budget

While Gramm-Rudman-Hollings was very controversial, there seems to be a consensus with regard to two goals, both among those who voted for it and those who opposed it. They seem to be what we called at Harvard Business School "a currently useful generalization."

One is that we want to hit the $144 billion target for the next fiscal year and no more. The second is that we do not want sequestration [i.e., automatic across-the-board spending reductions under Gramm-Rudman-Hollings]. We want the budget cuts to be made in a more rational manner.

To accomplish that, both on the tax side and the spending side, we've got to do something the federal government is not accustomed to doing: taking from Peter to pay Paul.

For the last four years, there have been impasses between the executive branch, which favors defense and foreign aid over domestic spending programs, and Congress, which is more supportive of domestic spending programs.

These impasses have been resolved by compromises only a politician can love, which is spending money for both. This is no longer possible or easy to accomplish, so health care spending must compete with other public or private spending. Treatment competes with research, prevention with care, the old with the young. Vexing issues that once perhaps could have been put aside and handled by just throwing some more money into the pot have intensified and have to be discussed.

Some of those issues important to Congress are: How far can costs be reduced without impacting quality? Doesn't the present diagnosis-related group (DRG) payment mechanism for hospitals provide a fair distribution of adequate care among patients of different hospitals? Does the DRG system require hospitals and physicians to make decisions that
are not in the best interest of their patients?

Does fee-for-service reimbursement encourage overutilization of physician services? Do health maintenance organizations (HMOs) and comprehensive medical plans (CMPs) encourage underutilization? How is quality to be measured, and by whom?

Now, the Congress, following the plan of the founding fathers, is a responsive, not an anticipatory, body. You can't have both. Crises, real and imagined, that show up on the nightly news tend to move us to action. Right now, we have anecdotal information that suggests that there has been a negative impact on quality. It's difficult to tell how serious, since the DRG system has only been on the books for about three years.

This has an impact on policy, and it has an impact on legislation. In the most recent budget reconciliation bill, which covered a wide range of departments and activities of the federal government, there were, by one count, 51 separate provisions involving Medicare. That bill, by the way, is known by an acronym. It is the Consolidated Omnibus Budget Reconciliation Act, but it's called COBRA, and those in the field believe that has a definite double meaning, because of some of the provisions we've included here. Certainly some of the providers feel that way.

In a broad sense, what we were trying to do was to fine-tune the DRGs. We did this in many respects. For example, wage indexes were modified to try to provide greater equity between rural and urban hospitals. The direct and indirect medical education add-ons were revised. We increased payments to hospitals serving a disproportionate share of low-income patients, and provided a timetable—which I think will hold up—for transition to national DRG rates. As a matter of fact, Oregon is already there.

We increased payments to participating physicians as an incentive for them to remain or begin to participate on that basis. Hopefully, we clarified the responsibilities of Medicare hospitals in emergency cases, which is a matter of patient transfers, or so-called "dumping."

We also dealt with an issue that I want to use as a point of departure here, which is the matter of continued health coverage. One of these 51 items in COBRA amends the Internal Revenue Code, ERISA, and the Public Health Service Act to require that an employer with 20 or more employees who maintains an employer-provided group health plan must provide a continuation option to certain qualified beneficiaries [see "Continuation of Health Insurance Coverage under COBRA" in this issue].

These beneficiaries are widows, divorced spouses, and spouses of Medicare-eligible employees, as well as dependent children of such beneficiaries. They must have the option to continue group health coverage for up to three years. They will pay for this, but payment is limited to a maximum of 102 percent of what a similar group of people covered by the same plan would pay.

We also have an 18-month continuation financed in a similar way for terminated employees. That includes voluntary and involuntary terminations, except those whose termination resulted from gross misconduct.

**Improved Access**

This leads me to comment briefly on the Improved Access to Health Care Initiative (H.R. 4742), a bill of which I'm a cosponsor. This is a highly controversial piece of legislation, which I suppose I don't have to tell you, but it builds upon some of the steps recently taken, and, in particular, on the continuation item I referred to.

It is also an outgrowth of statistics that suggest 75 percent of all Americans without health insurance are employed or are the dependents of employees. That's different from what I would have expected years ago. It may help explain why some of us in Congress are looking at the employment relationship to see what can be done to encourage, force, or Dragoon employers into broadening their coverage for some of these now uncovered groups.

We would extend coverage of employment-based health insurance to laid-off workers and their dependents. We would follow the example of nine states that now have subsidized health insurance pools by requiring the other states to set up such pools.

We would require that states establish a mechanism to fund hospital charity care or develop a plan to provide health insurance to all uninsured residents. In certain respects, this builds on what is already being done in New York, New Jersey, and Florida, which have funding mechanisms for uncompensated medical care. We also would attempt to find some way to encourage the self-employed to take a more positive view toward covering their employees, because about half of the employed, but uninsured, people work for self-employed individuals or small businesses, so that's a special problem.

**Medicare Reforms**

Another related bill is the Medicare Quality Protection Act (S. 2331 and H.R. 4638) [see May 1986 Employee Benefit Notes]. It's probably less controversial, and, to me, the most important provision would require the Department of Health and Human Services to develop within the next 18 months a legislative recommendation to refine the prospective payment system to better account for variations in severity of illness and case complexity.

I personally think that the greatest weakness in the DRG system today is the lack of a severity or intensity factor. I also am not aware of any hard data on which to base action right now, so this is an attempt to get such information. I say an "attempt," because those of us in the Congress who are concerned about these issues have had a chronic problem, particularly during this administration, trying to get timely reports from the Health Care Financing Administration (HCFA) on very important issues. We set deadlines that often are not met, or the reports have been completed but the Office of Management
and Budget (OMB) won't let them out.

I mention this because some of us thought that it may be necessary to turn to other groups to get timely reports. HCFA isn't the only crowd around to do a study, and they often contract these out, so it may be possible for us to turn to the Office of Technology Assessment, or the Library of Congress, or the General Accounting Office, or directly to consultants, if necessary, to get information we may need.

**Government Attitudes Toward Health Care**

Let me summarize what I think reflect the current government attitudes toward health care. First of all, I think we're going to be in a period of continued uncertainty, and that will be the most important thing to keep in mind when viewing government policy toward health care finance.

I think that's going to be true not only in direct health issues, such as Medicare, Medicaid, and medical research, but in the very broad context of fiscal policy. Putting it another way, federal dollars are soft dollars, not hard dollars, and if I were a recipient of federal funds, I certainly would view them in that way.

The second point, following the lead of the private sector, is that the federal government will try to become a more prudent buyer of health services, perhaps a downright stingy buyer, if it utilizes its potential market clout.

Greater emphasis will be placed on HMOs and capitation in general. That will tend to reduce the federal role in defining the required scope of services. It will also mean we will increasingly look to outside groups to measure quality.

Now, what that says to me is that as pressure from both the private and the public sectors reduce implicit subsidies for uncompensated care, some more explicit means of payment will be required.

It also says to me that if the federal government truly utilizes its market potential through, let's say, a preferred provider arrangement, it's probably going to make it more expensive or more difficult for nongovernmental groups to figure out how to pay for health care. That's because the federal government, which pays something like 40 percent of all hospital bills, won't be paying as much as had been anticipated.

The third point is that Congress is near the end of the road of legislated health budget cuts. You can see that in both the House- and Senate-passed budget resolutions, but don't rest comfortably at that thought. Attention, therefore, is shifting to budget restraints through regulatory, rather than legislative, action with occasional expressions of congressional outrage, as in the case of the administration plan for capital reimbursement under Medicare. The squeeze will continue to be on providers, not beneficiaries. I'll give you a few examples of what I'm talking about, and these are "big buck" examples.

For two years in a row, HCFA has proposed virtually no increase in that pool of money which is divided up under the DRGs. For the current fiscal year, the Prospective Payment Assessment Commission (PROPAC) proposed a little over 2 percent. HCFA proposed zero.

For the fiscal year that will begin October 1, the president's budget included a 2 percent increase described by a word I never heard of before, and I haven't heard of it in any other context: a "place holder." That 2 percent increase was called a place holder.

I thought there was some consensus developing, because PROPAC suggested 2.2 percent, but HCFA very graciously proposed regulations calling for an increase of one-half of 1 percent [see "HHS Proposes Small Increase in Hospital Medicare Payments" in Legislation and Litigation section], and that was done only after a heated meeting between Secretary Bowen and some of the hospital groups.

Probably even more important in dollars, HCFA announced its intention to terminate the periodic interim payment (PIP) programs for hospitals. If this is approved, institutions are going to have to increase their borrowing.

I'm very disturbed about slow payment to the institutions. After all, they're just providing a service the government promised to beneficiaries. I'm putting the finishing touches on a piece of legislation to apply the concept of the Prompt Payment Act to Medicare reimbursement (H.R. 5053).

It would simply say that "clean" bills presented to carriers and fiscal intermediaries not paid within 30 days would carry interest after the 30th day. I also intend to include a provision in the bill to maintain the present PIP arrangements and try to stop the regulations from taking effect.

The fourth point is that as federal funds for new programs become harder to find, the private sector will be required to carry the costs of activities previously financed by the government. Medicare, for example, is now the secondary payer for the working elderly. I've already mentioned that employers who maintain an employer-provided group health plan must provide a continuation option for certain groups.

I know this is controversial, but it is not especially revolutionary. Look at the wide range of state laws that mandate insurance coverage of a wide range of services, providers, dependents, and diseases. I think that trend is going to grow, and has already spread to the federal level.

Fifth point: there may not be many bills passed by Congress limited to health, limited to Medicare. We are in an era of what I call "megabills."

The tax bill is a perfect example of what I'm talking about. Who would have ever thought that the entire revenue code, as it applies to both individuals and corporations, would be put on the table and proposals for change incorporated in one single bill? Continuing resolutions for appropriations are another example. We're supposed to have 13 appropriations bills. Last year,
and valuable debate and analysis cover them up. It will stimulate needed the trust fund for these programs is estimates, reported in the of ethical dilemmas that have been Under the intermediate set of economic two years earlier than projected in the stringency will heighten the awareness sound basis for \_

My final point, and this is probably the cates that the O Medicare trust fund faces possible depletion The 1986 Annual Social Security Old- Medicare Trust Funds—Hospital Insur- Funds Security increases automatically each

The OASDI payroll tax rate is scheduled to increase in 1988 to 6.06 percent, up from the current 5.7 percent. Both employers and employees are taxed by this amount. In 1986, the ceiling on the amount of earnings subject to the Social Security payroll tax is $42,000. After 1986, the maximum amount of earnings taxable by Social Security increases automatically each year by the rate of growth in average wages nationwide.

| Table 1 |
|------------------|------------------|------------------|------------------|------------------|
| **Financial Status of Social Security Trust Funds, Selected Calendar Years**<sup>a</sup> (dollars in billions) | | | | |
| Calendar | Total Income | Total Disbursements | Interfund Transfers | Net Increase in Fund | End-of-Year Fund Status |
| Year | | | | | |
| Old-Age and Survivors, and Disability Insurance | | | | | |
| Trust Funds | 1985 | $203.5 | $190.7 | $-1.8 | $11.7 | $42.2 |
| | 1986 | 215.3 | 202.4 | -10.6 | 2.3 | 44.4 |
| | 1990 | 318.0 | 263.2 | b | 54.8 | 106.4 |
| Medicare Hospital Insurance Trust Fund | 1985 | $51.4 | $48.4 | $1.8 | 4.8 | 20.5 |
| | 1986 | 59.6 | 50.1 | 10.6 | 20.1 | 40.6 |
| | 1990 | 77.6 | 74.8 | b | 2.8 | 63.6 |
| | 1996 | 106.6 | 129.9 | b | -23.2 | c |
| Medicare Supplementary | 1985 | $25.1 | $23.9 | b | b | $10.9 |
| Medical Insurance Trust Fund | 1986 | 24.3 | 27.5 | b | b | 7.7 |
| | 1988 | 35.8 | 35.4 | b | b | 8.1 |

Source: 1986 Annual Reports of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, the Federal Hospital Insurance Trust Fund, and the Federal Supplementary Medical Insurance Trust Fund. (OASDI, p. 39, Table 13; HI, p. 48, Table 11; SMI, p. 25, Table 6.)

<sup>a</sup> 1985 operations are based on actual experience. All other estimates based on Social Security II-B actuarial assumptions.

<sup>b</sup> Data unavailable.

<sup>c</sup> Trust fund depleted in calendar year 1996.
Federal Hospital Insurance Fund, also are based on Social Security's intermediate II-B demographic and economic assumptions. The deterioration in Medicare's projected solvency, relative to last year's estimates, is due to revisions made in calculating factors influencing the trust fund balance. These factors include overall performance of the economy, as well as assumptions about future demographic changes.

The HI payroll tax rate (for employees and employers) is scheduled to remain at 1.45 percent of taxable earnings. The amount of earnings subject to the tax is the same as the OASDI ceiling amount.

The Supplementary Medical Insurance (SMI) trust fund is expected to remain financially sound, because the federal government provides support through general revenues. By law, the federal government contribution makes up the difference between enrollee premiums and program costs. However, the Board of Trustees expressed concern over the rapid increases in the cost of the program.

### AMA Recommends Medicare Financing Reforms

Warning that Medicare will face bankruptcy during the next decade, the American Medical Association (AMA) is proposing establishment of a new system of financing the elderly's health care, in part through the provision of medical individual retirement accounts (medical IRAs).

The proposal won approval by the AMA's 388-member House of Delegates at the association's annual meeting in Chicago last month.

Medicare, the federal program that finances health care for the elderly and long-term disabled, currently uses payroll taxes from workers and employers to pay out present benefits from its Hospital Insurance Trust Fund. In contrast, the AMA plan would finance the trust fund through a flat tax on adjusted gross income. An independent government agency would manage the fund and invest its assets similarly to the way pension funds are invested.

In addition to using medical IRAs to cover deductibles and copayments, the plan would cover catastrophic illness, currently not covered by Medicare. (See January 1986 Employee Benefit Notes for an analysis of the feasibility of medical IRAs.)

The age of eligibility for Medicare benefits would rise from 65 to 67 years in three-month increments over an eight-year period. Instead of having the government pay for health care directly, beneficiaries would receive annual vouchers with which to buy individual private health insurance. A similar proposal by the Department of Health and Human Services, which oversees Medicare, is pending before Congress (see June 1986 Employee Benefit Notes).

### Continuation of Health Insurance Coverage under COBRA

(Para appears to be cut off)

[Editor's Note: Because of a large number of inquiries regarding the provisions of the new legislation mandating continuation of health coverage for terminated employees and their spouses and dependents, we are publishing this summary of the provisions of the bill. For more detail, consult the legislative language in the Congressional Record for April 8, 1986, pp. 53841-53845, and in the Conference Report Accompanying H.R. 3128, Consolidated Omnibus Budget Reconciliation Act of 1985, 99th Congress, 1st Session, Report 99-453, available through the U.S. Government Printing Office.)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), P.L. 99-272, requires that employers continue to offer health insurance coverage to a covered employee and the spouse and dependent children of the covered employee if their coverage would otherwise cease for one of five "qualifying events":

- death of the covered employee;
- termination or reduction of hours of the covered employee, for reasons other than gross misconduct;
- divorce or legal separation of the covered employee and spouse;
the benefits covered employee be-
keh as dependent entitled to Medicare; or
covered as a dependent under the plan.

The required coverage must be identi-
cal, as of the time it is being provided, to the coverage provided under the plan to similarly situated beneficiaries who have not experienced a qualifying event.

The offer of continued coverage must be made for three years from the qualifying event for widows, divorced spouses, spouses of Medicare-eligible employees and dependent children who become ineligible under the plan. For workers who are terminated or lose coverage because of a reduction in hours, the coverage must be offered for 18 months.

Coverage may cease earlier if the employer ceases health coverage for all employees, or if the qualified beneficiary fails to pay the required premiums or is reemployed with group health coverage, becomes eligible for Medicare, or is a spouse and qualifies under another group plan through remarriage.

Within 180 days after the continued coverage expires, the qualified beneficiary must be provided the option of enrollment under a conversion health plan otherwise generally available under the plan.

For the continued coverage, the employer may charge an applicable premium, equivalent to the cost of similarly situated beneficiaries under insured plans and, for self-insured plans, a reasonable estimate of the cost for similarly situated beneficiaries. The charge to the beneficiary cannot exceed 102 percent of the applicable premium.

The new continuation provisions apply to taxable and tax-exempt employers with 20 or more employees, including state and local governments. They do not apply to churches, federal agency employees, or the government of the District of Columbia. They are effective for plan years beginning on or after July 1, 1986, but a special rule exists for collectively bargained plans, requiring them to comply by the latter of January 1, 1987, or the date on which the last collectively bargained agreement relating to the plan terminates.

A private employer who fails to provide continued coverage under any of its health plans loses the tax deduction for contributions to all health plans the employer maintains. In addition, any highly compensated individual—defined as one of the five highest paid officers, a 10 percent shareholder, or one of the 25 percent highest paid employees—covered by any insured or self-insured group health plan would be denied the income exclusion for employer contributions to the plan if that plan, or any other group health plan maintained by the employer, fails to provide qualified beneficiaries a continuation coverage election. The only sanction imposed on state and local governments is suits for equitable relief.

Employers must notify all current employees and spouses in writing for the plan year beginning after July 1, 1986. The employer must notify the plan administrator if an employee qualifies for the continuation for reason of death of the covered employee, termination or reduction of hours, or entitlement to Medicare benefits.

Employees must notify the plan administrator if the qualifying event is divorce or legal separation, or the dependent child ceases to be a dependent under the plan.

Three federal agencies will be issuing regulations: the Department of Labor on reporting and disclosure; the Department of the Treasury on the definition of the required coverage; deductions and income exclusions; and the Department of Health and Human Services regarding the continuation offered by state and local governments. The Conference Report specifies that any regulations issued pursuant to these changes are to be effective after the date they are issued. In the meantime, employers are required to operate "in good faith with a reasonable interpretation of these substantive rules, notice requirements, etc."

Pickle Says More Legislation Needed for Pension Plan Underfunding

In the course of a joint Oversight/Social Security Subcommittee hearing June 24 on pension plan underfunding, Oversight Chairman J.J. Pickle (D-TX) said "some drastic changes" will be needed in the single-employer termination insurance program. Pickle went on to describe what he saw as a "crisis in the funding program" and said he expects the Oversight Committee to take further action.

The strong comments came after hearing testimony from the U.S. General Accounting Office (GAO), the Pension Benefit Guaranty Corporation (PBGC), and the Internal Revenue Service. PBGC Executive Director Kathleen Ut-goff said that despite the recent premium hike, PBGC has a deficit of $1.7 billion that will grow to $3 billion by 1990. She now estimates that at the end of 1985, a premium of $13.50 per participant would have been needed to cover future claims and retire the PBGC deficit. GAO reported that it found PBGC's forecasts of the escalating deficit to be "reasonable."

"I am concerned that we are all facing an endless series of premium increases," said Pickle. "Such increases would let PBGC meet its financial obligations, but they would not resolve the real problem. Furthermore, they could undermine support for the entire voluntary defined benefit pension system."

GAO provided four alternatives for legislative remedy; require more rapid payment of unfunded benefits, especially those resulting from benefit increases; require employers to make minimum contribution payments to their underfunded plans sooner than 8 1/2 months after the end of the plan year; further limit the guarantee of benefit increases; and raise the premium to provide the revenue needed to retire the program's deficit and pay for estimated future claims.
Allis-Chalmers

"The history of the Allis-Chalmers UAW Pension Plan, which terminated on July 26, 1985, with virtually no assets on hand, strikingly illustrates the inability of ERISA's minimum funding standards to assure adequate funding—or even mere solvency—in all cases. At termination, the present value of the Allis-Chalmers plan's liabilities exceeded the value of its assets by $170 million. The termination resulted in the second largest claim in PBGC's history.

"During the existence of the Allis-Chalmers plan, the sponsor requested no minimum funding waivers for the plan. The plan actuary utilized a 'middle of the road' actuarial method (frozen initial liability) and assumptions (e.g., 7 percent investment return) throughout the period during which the minimum funding standards were in effect.

"The plan's problems can be traced to the fact that the minimum funding standards permit 'unfunded past service liability' to be amortized over relatively long periods, even where the plan is top heavy with retirees. On January 1, 1977, the Allis-Chalmers plan had 4,700 active participants and 6,500 retired and separated vested participants. The active lives decreased steadily over the next few years. At the time of termination, they constituted only 15 percent of the participant population (1,300 actives out of 8,500 total). Due to the large proportion of retirees, the plan's minimum funding requirement was, from 1977 on, always less than its annual benefit payments.

"The depletion of the plan's assets was slowed somewhat by an agreement between the plan sponsor and the union that contributions would be made in excess of minimum funding requirements (though even these additional amounts did not result in contributions to revert to the ERISA minimum. Because of the 'excess' contributed in earlier years, the plan's funding standard account had a substantial positive credit at this point; the minimum funding requirement was zero.

"From 1982 on, the plan's assets dwindled rapidly. When it terminated in July 1985, funds on hand were sufficient for only two months of benefit payments. Clearly, ERISA's minimum funding standards failed to achieve their purposes in this case."

From testimony of Kathleen P. Utgoff, executive director, Pension Benefit Guaranty Corporation, before the Subcommittees on Oversight and Social Security, Committee on Ways and Means, June 24, 1986.

Utgoff recited the facts in the recent Allis-Chalmers termination (see box), in which PBGC suffered its second largest loss, as justifying the need for changes in the minimum funding standards. The three possible approaches she outlined are as follows.

Special minimum funding standards for plans that fail to meet specified financial criteria could be established. For example, sponsors could be required to fund unfunded vested benefits over specified periods, with a shorter funding period required for benefits in pay status than for other benefits.

Sponsors of underfunded plans could be required to make contributions at least equal to annual benefit payments or to the amount needed to prevent the unfunded vested benefit liability from increasing.

ERISA's definition of "reasonable funding method" could be amended to require that the method chosen assures plan solvency over some reasonable future period of time, based on realistic projections employing a variety of scenarios for future interest rates and employment patterns.

Dallas Salisbury, EBRI president, told the subcommittees that "whether you believe the private pension system is underfunded or not will depend on the manner in which you choose to view the liabilities associated with pension plans." He noted that the adequacy of funding can be measured in two ways: against liabilities present if the plan were to be terminated, and against additional liabilities that will accumulate if the plan is maintained on an ongoing basis.

"Congress imposed funding standards upon employers to improve the security of the pension benefit promise. Overall, the standards adopted by Congress have achieved that goal," Salisbury said.

"Despite the generally favorable picture, the current rules still allow a minority of individual firms to underfund their plans. Basically, this is because ERISA allows considerable flexibility in choosing the period for amortizing funding of plan liabilities, which is, in turn, closely related to funding levels. Funding waivers available to firms experiencing substantial business hardship also allow plans to underfund," Salisbury concluded.

Salisbury emphasized that the recent dramatic declines in interest rates could force up the size of the current PBGC deficit by a wide margin, and he emphasized that despite recent gains in assets due to strong stock market performance, the declining interest rates are in some cases creating even greater increases in plan liabilities. "For the first time in the postwar period," he said, "we are facing a situation where interest rates and actuarial assumptions are no longer going up. And the implications of the interest rate reversal make the subcommittees' inquiry especially timely."

Other witnesses at the hearing were Norman S. Losk representing the American Academy of Actuaries; Kenneth W. Porter representing the ERISA Industry Committee; Vance J. Anderson representing the Association of Private Pension and Welfare Plans; Thomas A. Jorgensen representing the U.S. Chamber of Commerce; and Alan V. Reuther of the United Auto Workers.
Legislation and Litigation

Federal Budget Approved

The House and Senate June 27 approved the fiscal 1987 budget resolution. The spending plan calls for $995 billion in outlays, balanced against anticipated revenues of $852 billion. The remaining $143 billion deficit is just under the limit set by Gramm-Rudman-Hollings.

Both chambers agreed to a 2 percent cost-of-living increase for Social Security recipients, as well as civil service and military retirees. In the area of economic medical malpractice damages to both chambers agreed to a 2 percent more employees to provide up to 43 billion deficit is just under the committee, would require private, federal, and state and local employers with 15 or more employees to provide up to 18 weeks of unpaid parental leave within a 24-month period to any full-time employee or any permanent part-time employee who had worked at least 3 months with the employer. Unpaid leave would also be allowed for care of a seriously ill dependent parent. A worker with serious medical problems would be allowed 26 weeks of unpaid leave in a 12-month period.

In all cases, the worker would have the right to the same or equivalent job with continued benefits upon return to work. The committee-approved bill was a substitute offered by committee Chairman William Clay (D-MO) in response to concerns voiced about his original version, which exempted employers with five or fewer employees and did not include the provision for care of dependent parents.

The committee defeated a proposal by Rep. Marge Roukema (R-NJ) that would have (1) limited the leave policy to full-time workers who had worked at least one year with a firm employing more than 50 employees, (2) reduced to 8 the number of weeks permitted for parental leave, and (3) exempted employees among the top 20 percent in salary.

The House Post Office and Civil Service Committee, the second committee of jurisdiction, passed the bill without amendments June 11.

The bill now moves to full House consideration. There is no floor schedule for the bill yet, but one committee aide expects floor action in early fall.

Although there is little opposition from most House members to parental leave in general, some find particular provisions objectionable. Chairman Clay suggested there may be more compromises on the House floor.

Military Pensions Reform

President Reagan July 1 signed legislation approved by Congress June 26 to reduce military pensions for future military personnel who retire after 20 years of service from the current 50 percent of pay. The legislation would limit the 20-year pension to 40 percent of base pay in their three highest-paid years. The pension would increase by 2.5 percent of base pay for each additional year of service up to 30 years, when it would reach 75 percent of base pay. (H.R. 4420).

House Bill Would Curb U.S. Investment in South Africa

All U.S. investments in South Africa would be banned under terms of H.R. 4868. Originally introduced by Rep. Bill Gray (D-PA) with more than 40 cosponsors, H.R. 4868 was amended by Rep. Ronald Dellums (D-CA) to impose much stronger sanctions against South Africa unless its government begins "good faith" efforts to end apartheid in that country.

H.R. 4868 would require total U.S. disinvestment from South Africa 180 days after enactment and impose a strict trade policy with that country. Recent surveys indicate that an increasing number of U.S. banks and companies are curbing operations and investments in South Africa because of its economic problems and political pressures.

Parental Leave Bill Advances

Workers with newborn, newly adopted, or seriously ill children would be entitled to extended time off without pay under a bill passed June 25 by the House Education and Labor Committee.

The Parental and Medical Leave Act of 1986 (H.R. 4300), as approved by the committee, would require private, federal, and state and local employers with 15 or more employees to provide up to 18 weeks of unpaid parental leave within a 24-month period to any full-time employee or any permanent part-time employee who had worked at least 3 months with the employer. Unpaid leave would also be allowed for care of a seriously ill dependent parent. A worker with serious medical problems would be allowed 26 weeks of unpaid leave in a 12-month period.

In all cases, the worker would have the right to the same or equivalent job with continued benefits upon return to work. The committee-approved bill was a substitute offered by committee Chairman William Clay (D-MO) in response to concerns voiced about his original version, which exempted employers with five or fewer employees and did not include the provision for care of dependent parents.

The committee defeated a proposal by Rep. Marge Roukema (R-NJ) that would have (1) limited the leave policy to full-time workers who had worked at least one year with a firm employing more than 50 employees, (2) reduced to 8 the number of weeks permitted for parental leave, and (3) exempted employees among the top 20 percent in salary.

The House Post Office and Civil Service Committee, the second committee of jurisdiction, passed the bill without amendments June 11.

The bill now moves to full House consideration. There is no floor schedule for the bill yet, but one committee aide expects floor action in early fall.

Although there is little opposition from most House members to parental leave in general, some find particular provisions objectionable. Chairman Clay suggested there may be more compromises on the House floor.

Bill to Limit Malpractice Awards Introduced

Federal legislation to limit medical malpractice awards and attorneys' fees by awarding federal grants to states that have established tort reforms is pending in the Senate Labor and Human Resources Committee.

Sponsored by Sens. Orrin Hatch (R-UT), Daniel K. Inouye (D-HI), and James Abdnor (R-SD), the National Professional Liability Reform Act of 1985 (S.B. 1804) would limit noneconomic medical malpractice damages to $250,000; eliminate the "collateral source" rule that allows a plaintiff to collect present and future medical costs from more than one source, such as the patient's and the physician's insurers; require periodic rather than lump-sum awards; and set a decreasing sliding scale for lawyers' contingency fees.

The bill would require that states adopt doctors' peer review and disciplinary reforms, such as strengthening medical licensing boards' authority and funding, to qualify for the federal grant.

House Panel Hears Health Care Cost Issues

The Committee on Ways and Means' Subcommittee on Health heard testimony on two health care cost issues June 9 and 10. The first day of testimony covered the Health Care Improved Access Act of 1986 (H.R. 4742), which is designed to extend health care coverage to the poor and uninsured (see June 1986 Employee Benefit Notes for details of the bill).

Subcommittee Chairman Fortney "Pete" Stark (D-CA) told the committee that the number of Americans without health insurance coverage has grown from 25 to 37 million during the past five years, with indications that the situation is worsening. Stark told the committee that while the bill "doesn't close all the gaps, it takes a vital step and keeps us moving in the right direction."

Among those testifying were Jack Owen, executive vice president of the American Hospital Association, who...
told the committee that the proposal to establish statewide insurance pools has several advantages in that it would spread the cost over a wide base and insure not just high-risk individuals, but anyone willing to pay for coverage. The major disadvantage, Owen said, would be that companies who insure their employees could be subsidizing those who do not, and insurers could be subsidizing a product that competes with their own.

Bert Seidman, director of Social Security for the American Federation of Labor and Congress of Industrial Organizations (AFL-CIO), testified in support of the bill, suggesting it would reduce federal and state health care spending and help avoid cost shifting.

Richard H. Fay, a partner in the law firm Reed Smith Shaw & McClay and chairman of the U.S. Chamber of Commerce's Employee Benefits Council, said the Chamber supports tax incentives for self-employed individuals to purchase health insurance, but oppose health coverage mandates. Fay warned that imposition of such mandates may force some employers to diminish or eliminate their health insurance plans. He said the legislation should address the more fundamental issues of how to provide incentives for those who do not or are unable to provide coverage.

Several of those testifying told the committee that until Congress addressed the "ERISA issue" by removing the provision that exempts self-insurers from state law, many of the health insurance coverage problems would not be resolved.

Medicare Out-of-Pocket Expenses—The Health Subcommittee June 10 reviewed another health care cost issue—that of increasing out-of-pocket expenses for physician services under Medicare Part B. Stark suggested that Congress should have two priorities in reforming Medicare payment for physician services: (1) the elderly and disabled must be assured continued access to affordable care of the highest quality, and (2) taxpayers should pay no more than necessary. The purpose of the hearing, he said, was to review options to strengthen the participating physician program and to consider other means for protecting Medicare beneficiaries from excessive charges on unassigned claims.

Among those testifying was Karen Davis, chairman of the Department of Health Policy and Management, Johns Hopkins School of Hygiene and Public Health. Davis told the subcommittee, "It's clear that Medicare alone is insufficient to protect the elderly from rising medical costs." She said that the participating physician program "had a remarkable effect on limiting costs to patients," and suggested expanding the program. Failure of physicians to accept Medicare assignment is a serious problem that needs to be addressed, Davis added.

Lucille Thornburg, regional board member of the National Council of Senior Citizens, told the subcommittee that often Medicare beneficiaries don't have a choice of which doctor they see, such as in the emergency room. She also said that Gramm-Rudman-Hollings' 1 percent cuts in the doctor reimbursement rate had resulted in some participating physicians billing their patients for the portion not paid by Medicare. She suggested that Congress look at three areas: protection of Medicare beneficiaries against excess charges, mandatory assignment for physicians, and improving the mechanism used to inform Medicare beneficiaries about which physicians accept assignment.

Rep. Bill Gradison (R-OH) pointed out that "if we mandate assignment but don't pay enough, there won't be anyone to take assignment."

Richard Rowland, secretary of the Executive Office of Elder Affairs for the Commonwealth of Massachusetts, said that the state had resolved the problem by making assignment a condition of physician licensure. He said that, contrary to popular belief, physicians had not left Massachusetts in droves. He said that a June 6 Massachusetts federal district court ruling upheld the constitutionality of the new state law, but that physicians would likely appeal the decision.

Another witness, Harold Cohen, executive director of the Maryland Health Services Cost Review Commission, recommended several methods to reduce out-of-pocket Medicare expenses, including federal action to regulate doctors. Paul Ginsburg, senior economist for The Rand Corporation, suggested careful monitoring of costs combined with the use of a "trigger" to mandate assignment when necessary.

John Dawson, a member of the board of trustees for the American Medical Association (AMA), testified that the participating physician program should be repealed. Dawson said that the program has confused beneficiaries and failed to deliver on its promises to physicians. Other witnesses from the panel of physicians told the subcommittee that the proposal to mandate that physicians accept Medicare assignment is not necessary, but that Congress should improve the current program so that concrete benefits exist for physicians who wish to participate. The physician witnesses agreed that Congress should not legislate abrupt changes in the payment method for physician services until studies of the proposed reforms are completed.

Finance Committee Reviews Medicare Issues

The Senate Finance Committee June 2 heard testimony on the quality of care delivered under the Medicare program in response to increasing concerns that Medicare patients are being discharged from hospitals "quicker and sicker." 

Sen. Bob Packwood (R-OR) said that
he was concerned about allegations that because of the prospective payment system (PPS), Medicare beneficiaries are being released before their need for acute inpatient care has been met. He also expressed concern about reports that posthospital care is frequently not available.

Among those testifying was Sen. John Heinz (R-PA), chief sponsor of the Medicare Quality Protection Act of 1986 (S. 2331) and a long-standing critic of early discharges of Medicare beneficiaries under the DRG system.

Provisions of S. 2331 call for redesigning DRGs to account for severity of illness, informing Medicare patients of their right to appeal hospital discharges, requiring the Department of Health and Human Services (HHS) to study the issue, and improve access to posthospital care.

William Roper, administrator of the Health Care Financing Administration (HCFA) testified that "Medicare patients are appropriately discharged from the hospital earlier, but this is a process that began before PPS. Just as before, patients are in a medically stable condition when discharged, but may still require some care to assist them with daily activities. . . . Care of this nature is not considered skilled and is not covered by the Medicare program."

Roper said there is room for improvement in the program, but doubted that more studies were needed to determine the effectiveness of PPS. He cited several areas where HCFA has proposed or implemented improvements in PPS.

HCFA opposes many of the provisions of S. 2331, arguing they could be accomplished under current legislative authority, would expand program benefits, increase administrative expenditures, and add to the burden of mandated studies. (For details of the legislation, see June 1986 Employee Benefit Notes.)

"Working Americans: Equality At Any Age" Subject of Senate Hearing

Legislation to abolish mandatory retirement was the subject of a June 19 hearing before the Senate Special Committee on Aging. Sen. John Heinz (R-PA), chairman of the committee, noted that "the poverty rate among seniors who don't work is three times that of those who do. Social Security benefits for the average couple over age 65 are less than $10,000 annually." Heinz pointed out that many such couples have no additional income from pensions or savings.

Heinz said that passage of his legislation in the Senate (S. 1054) and Rep. Claude Pepper's (D-FL) in the House (H.R. 4154) would remove the maximum age limit for employees covered by the Age Discrimination in Employment Act (ADEA), which is designed to prohibit forced retirement until age 70.

Among those testifying was Raymond Fay, an attorney with the Washington, DC, firm of Haley, Bader and Ports, who supported elimination of the mandatory retirement age at age 70 provision and stressed the need to "resist the entreaties of some segments of the business community to weaken the ADEA in other respects." Fay referred to the effort by the U.S. Chamber of Commerce to remove ADEA provisions calling for jury trials and liquidated (double) damages in age discrimination cases.

Mark A. de Bernardo, manager of labor law and special counsel for domestic policy at the U.S. Chamber, told the committee: "While the Chamber recognizes and appreciates the substantial contributions, experience, and loyalty of our country's most senior workers, it also recognizes the need for consistent, definite, and rational human resource planning and pension policies." He said that lifting the mandatory retirement age would unnecessarily disrupt personnel and pension practices and, ultimately, hurt employers and employees.

Both House and Senate bills are pending in committee. Pepper announced at the Senate hearing, however, that Rep. Matthew Martinez (D-CA), Chairman of the Employment Opportunities Subcommittee of House Education and Labor, has agreed to discharge H.R. 4154 to the full committee. Pepper also stated that Education and Labor Committee Chairman Rep. Augustus Hawkins (D-CA) has promised him the bill will be reported out soon.

Testimony on Organ Transplants before Labor Committee

The Senate Labor and Human Resources Committee June 11 heard testimony on new legislation designed to remove a major financial obstacle that restricts access to organ transplant surgery.

S. 2536, sponsored by Sen. Orrin Hatch (R-UT), chairman of the committee, would amend Medicaid laws to authorize federal payment for immunosuppressive medications that are needed by transplant recipients who either lack health insurance or are underinsured. The measure also establishes a three-year, $15 million annual grant to states for the immunsuppressive drug program.

Hatch noted that the Task Force on Organ Procurement and Transplantation, created under legislation approved in 1984, is scheduled to issue a report on organ transplants this summer. In addition, he said that President Reagan is working on a reassessment of the administration position on organ transplantation.

Meanwhile, HHS Secretary Bowen June 27 announced that the Medicare program will begin paying for heart transplants for Medicare beneficiaries.

Ways and Means Hears Proposal on Use of Wage Data

The House Ways and Means Committee June 25 heard testimony on a proposal from the Department of Housing and Urban Development (HUD) to require states to make quarterly wage data available for use in verifying an individual's eligibility for subsidized housing.

Most states currently collect wage data from employers to determine an individual's eligibility for unemployment insurance compensation. HUD's proposal is intended to provide a more systematic method of discovering underreported income of tenants and applicants for HUD's various rent subsidy programs.
Senate Subcommittees Begin
Hearings on "Work and Welfare"

The Senate Finance Committee's Sub-
committee on Social Security and In-
come Maintenance Programs and the
Labor and Human Resources Com-
mittee's Subcommittee on Employment and
Productivity are scheduled to hold joint
hearings July 17 and 22 on "work and
welfare."

The hearings will examine how, and to
what extent, employment training can
lead to economic independence for re-
cipients of benefits under the Aid to
Families with Dependent Children
(AFDC) Program. Among the issues to
be addressed will be the value of educa-
tion, training, and employment ser-
dices, the targeting of programs to
particular groups of recipients, the
availability of and financing for child
education, and the use of other economic or
tax policies to reduce welfare depen-
dency. The hearings will begin at 9:30
a.m. in room 430 of the Dirksen Senate
Office Building.

DOL Panel Approves Plan on
Excess Assets

The Department of Labor (DOL) Advi-
sory Council on Employee Welfare and
Pension Plans June 12 recommended
that employers with defined benefit
plans be permitted to withdraw excess
assets without terminating the plans.

The action followed similar recom-
dinations made by the council's Task
Force on Terminations (see June 1986
Employee Benefit Notes).

After the council approves its final re-
port, it will be sent to DOL Secretary
William Brock.

Regulations

HHS Proposes Small Increase in
Hospital Medicare Payments

The Department of Health and Human
Services (HHS) has proposed to in-
crease Medicare payments to hospitals
by one-half of 1 percent beginning next
fiscal year for reimbursement for the

treatment of elderly or disabled

patients.

The Prospective Payment Assessment
Commission "PROPAC," a special
study group established by Congress,
June 27 recommended a 2.2 percent in-
crease in Medicare payment rates to
hospitals.

The June 3 proposal is part of the con-
tinuing implementation by HHS of the
Medicare prospective payment system.
In addition to the prospective payment
rates for Medicare inpatient hospital
services, HHS proposed changes in the
factors necessary to determine prospec-
tive payment rates. HHS also proposed
incorporating capital payments (such as
construction and equipment costs) into
the prospective payment rates.

A final notice making changes in the
diagnosis-related group (DRG) classifi-
cation system was also published June 3,
and final regulations governing the con-
ditions of hospital participation in the
Medicare and Medicaid program were
published June 17. In addition, HHS
announced May 6 an interim rule to
implement various sections of the new
Consolidated Omnibus Budget Reconcil-
iation Act of 1985 (COBRA).

For more information, see the 1986
Federal Register, vol. 51, no. 116,
pp. 22010-22052; no. 106, pp. 19970-
20202; and no. 87, pp. 16772-16789.

Rules on Disability Benefits

The Department of Health and Human
Services May 21 proposed regulations
specifying under what conditions dis-
ability benefits may be paid pending the
outcome of an appeal of a determina-
tion by the Social Security Administra-
tion that such benefits are not
warranted.

The proposed rule appears in the May
21, 1986, Federal Register, vol. 51,
no. 98, 18611-18620.

In a related action, the Social Security
Administration (SSA) May 29 pub-
lished a cumulative list of medical diag-
nostic and evaluative techniques that
have come into use since 1970 and may
be used by SSA to determine a person's
continued eligibility for Social Security
disability benefits and/or Supplemental

Security Income benefits based on dis-
ability.

The notice states that the techniques
may permit a more accurate diagnosis in
a particular case than those previously
used; it also says that such techniques
may disclose that a person on the bene-
fit rolls has a less severe or more severe
impairment than previously thought.

The list appears in the May 29, 1986,
Federal Register, vol. 51, no. 103,
19413-19417. Those wishing to com-
ment should contact the Commissioner
of Social Security, Department of
Health and Human Services, P.O. Box
1585, Baltimore, MD 21203. (See
"Court Grants Right to Sue for Disabil-
ity Benefits" in this section.)

SSA Revises Public Employee
Coverage Rules

The Social Security Administration
May 29 issued a proposed rule to revise
existing regulations on Social Security
coverage for employees of state and lo-
cal governments.

The revisions are intended to expand
and update existing rules, make them
clearer and easier for the public to use,
and reflect legislative changes made by
the Social Security Amendments of
1983.

The proposed rules are published in the
May 29, 1986, Federal Register, vol. 51,
no. 103, pp. 19468-19487. Those wish-
ing to comment should submit state-
ments in writing by September 26,
1986, to the Commissioner of Social
Security, Department of Health and
Human Services, P.O. Box 1585, Balti-
more, MD 21203.

IRS Suspends Approvals for Certain
Plan Asset Transfers

The Internal Revenue Service (IRS) in
June announced it had put a hold on
approving asset transfers from a defined
benefit plan to a defined contribution
plan. The IRS recently made public a
February 18 memo to all assistant re-
gional commissioners announcing the
policy.

The memo noted that the IRS is con-
sidering the effect, if any, upon plan
qualification of transferring assets from defined benefit plans, including terminating plans, to defined contribution plans. The memo instructed local IRS offices to use only information provided on the application, plan document, and attachments to determine whether an asset transfer is involved. If appropriate, the applicant will be notified of Revenue Ruling 85-19, which announced that the IRS, the Pension Benefit Guaranty Corporation, and the Department of Labor are reviewing legal and policy implications of asset transfers from over-funded defined benefit plans without terminating the plan or complying with interagency asset reversion guidelines.

Ruling on Social Security Integration
The IRS May 27 issued Revenue Ruling 86-74 reflecting changes made by the Social Security Amendments of 1983 and addressing the inclusion of deferred compensation under sections 401(k) and 403(b) in the definition of taxable wages. The ruling also addresses changes made by the act to increase the normal retirement age to 67 for reduced Social Security benefits for persons born after January 1, 1938. For copies of the ruling, contact the IRS at 1111 Constitution Avenue, NW, Washington, DC 20224, (202) 566-4024.

Litigation

Supreme Court Rules States Must Stay in Social Security Program
The U.S. Supreme Court June 19 ruled that states may not elect to pull their employees out of the Social Security program.

After hearing warnings that such action could cost the program $1 billion annually, the Court reversed a lower court ruling that found that a 1983 congressional amendment to the Social Security Act “affected a taking of property without providing the requisite just compensation” on the part of the federal government and was unconstitutional.

The Supreme Court noted Congress’ extensive power to amend the Social Security Act and said that “courts should be reluctant to construe [Social Security Act] agreements in a manner that forecloses Congress’ exercise of that authority” (Otis R. Bowen, Secretary of Health and Human Services, et al., appellants v. Public Agencies Opposed to Social Security Entrapment et al., no. 85-521).

Supreme Court Upholds Medicare Judicial Review
The U.S. Supreme Court June 9 rejected the Department of Health and Human Services’ argument that Congress has forbidden judicial review of all questions affecting the amount of benefits payable under Medicare Part B.

A physicians’ association and several individual doctors challenged the validity of Medicare regulations that authorize payment of benefits in different amounts for similar services. The Court ruled there is a strong presumption that Congress intends judicial review of administrative action, and there is no evidence that Congress has barred such review of regulations promulgated under Medicare Part B (Bowen, Secretary of Health and Human Services, et al v. Michigan Academy of Family Physicians et al., no. 85-225).

Court Grants Right to Sue for Disability Benefits
The U.S. Supreme Court June 2 ruled unanimously that thousands of mentally disabled persons in New York had a right to sue the government for illegal use of a clandestine policy to deny them benefits.

The Court rejected the Department of Health and Human Services’ argument that those who lost their benefits did so for failure to comply with appeal deadlines and administrative procedures.

The substance of the New York respondents’ suit was that the administration had adopted an unlawful, unpublished policy under which countless deserving claimants were denied benefits. Lower federal courts found that the administration had adopted the illegal policy and ordered HHS to reopen the decisions denying or terminating benefits and re-determine eligibility. The courts also directed HHS to reinstate benefits of all class members—who previously had been entitled to benefits but were subsequently terminated—until eligibility is properly determined.

In affirming the lower court rulings, the Supreme Court wrote: “the [HHS] Secretary had the capability and the duty to prevent the illegal policy found to exist by the District Court. The claimants here were denied the fair and neutral procedure required by the statute and regulations, and they are now entitled to pursue that procedure” (Bowen, Secretary of Health and Human Services, et al v. City of New York et al., no. 84-1923).

Court Declines to Hear Maryland Teachers’ Pension Case
The U.S. Supreme Court declined to hear an appeal of a lower court ruling that imposes a 5 percent cap on cost-of-living increases in Maryland state employees’ retirement benefits.

The Maryland State Teachers’ Association and the American Federation of State, County and Municipal Employees (AFSCME) asked the Court to overturn a decision that prevents unlimited cost-of-living adjustments in their pension plans without increases in employee contributions. The state had argued that benefits had not been retroactively reduced and that only benefits earned in the future would be affected. In addition, supporters of the law argued that it was needed to prevent imbalances in the state budget. The Court’s decision not to hear the case in effect upholds the constitutionality of the Maryland law. (See March 1986 Employee Benefit Notes.)

Supreme Court Agrees to Review Health Tax Deductions
The U.S. Supreme Court June 16 agreed to review a lower court ruling upholding a St. Louis firm’s accounting technique for employee health benefits.

At issue is how self-insured companies calculate for tax deduction purposes health benefits that may be due employees but are not yet paid. The Justice Department argues that General Dy-
EBRI submitted testimony for the record on “Statistical Policy in an Aging America” before the Senate Labor and Human Resources Subcommittee on Aging and the Senate Governmental Affairs Subcommittee on Energy, Nuclear Proliferation, and Government Processes June 3.

In a statement submitted by Emily Andrews, research director, EBRI noted its reliance on quality government data and focused on several areas of concern with regard to timeliness and availability.

Some of the other issues addressed at the hearing included the effect of budget cuts on statistics, uses of the information, and new methods to assist researchers. John Cornman, executive director of the Gerontological Society of America, said that recent budget cuts have reduced the number of people surveyed, having serious consequences on how the data can be used. Jane Ross, director of the Office of Research, Statistics and International Policy for the Social Security Administration, pointed out that studies on how employers respond to the changing age of the work force will have an impact on Social Security. One of the areas addressed by Manning Fenkleib, director of the National Center for Health Statistics, Public Health Service, of the Department of Health and Human Services, covered state-of-the-art systems that measure the quality of information gathered in surveys.


Pension Underfunding
The birth rate in 1984 was the lowest so far this decade—about 65.8 births per 1,000 women age 18 to 44, down from 72.2 in 1984, according to the Census Bureau's latest report. The report indicates, however, that for women age 30 to 34, the birth rate continued to rise. In addition, more mothers with infants are in the labor force.

The report notes that the needs of working mothers for childcare services has grown, since the number of working women with children under age five increased from 4.7 million in June 1977 to 6 million in June 1982. Contact Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402. (202) 783-3238. Ask for Series P-20, No. 401.

Nongovernment Publications

For-Profit Enterprise in Health Care, Institute of Medicine, Committee on Implications of For-Profit Enterprise in Health Care

This book examines for-profit health care and the effects it has had on the entire health care system. Among its findings: the rise in investor-owned hospitals has increased health care costs to payers; the expected ability of investor-owned for-profit organizations to produce the same services at a lower cost than their not-for-profit counterparts has not been demonstrated; and for-profit hospitals provide less uncompensated care than their not-for-profit counterparts, although there are variations in the magnitude of this difference. In the area of quality of care, the committee found no overall pattern of either inferior or superior quality in investor-owned chain hospitals when compared with not-for-profit hospitals.

Contact National Academy Press, 2101 Constitution Ave., NW, Washington, DC 20418. (202) 334-3318. Cost $39.50 in U.S., Canada, and Mexico; $47.50 in other countries.

Managing Employee Health Benefits, Dow Jones-Irwin

CEOs and benefit managers must play an active role to ensure that they get the most for their health benefit dollars, say authors Jay Wolfson and Peter J. Levin. They suggest that health benefits and employee health are substantial and directly controllable investments, which, like any other asset, can and should be properly managed rather than merely financed.

Wolfson and Levin assert that U.S. corporations, as the chief health care financiers through employee health benefit plans, have the greatest potential to curb spiraling health care costs, through aggressive participation in the health care arena. The authors guide the reader through the marketplace and suggest how managers can participate effectively. The book is available from Dow Jones-Irwin, 1818 Ridge Road, Homewood, IL 60430, telephone (312) 798-6000. Price: $25.00.

Medical Selection of Life Risks, R.D.C. Brackenridge

This comprehensive handbook on a wide variety of medical conditions also includes a section on the historical development of mortality tables and the principles of risk classification. Updated and revised since it was first published in 1977, it contains new data, studies, tables and charts. It is a reference volume for medical directors, actuaries, life underwriters, pension boards and clinical investigators. Contact Stockton Press, 15 E. 26th Street, New York, NY 10010. (212) 481-1334. Cost $100.

The Flat Tax, Robert E. Hall and Alvin Rabushka

Reforming and simplifying the federal income tax has been one of the most important issues in national policy throughout the 1980s, according to the authors of this book. They review key standards by which tax systems can be evaluated, discuss the reasons the federal tax system needs reform, present their proposal and compare it to other major tax reform plans. Contact Hoover Institution Press, Stanford University, Stanford, CA. Cost $7.95.

Pension Funds and Their Advisors, AP Informational Services Ltd.

The first section of this book contains 14 editorial articles describing the roles of various kinds of pension advisors. The second section includes information on nearly all the major U.K. and U.S. pension funds, major U.S. money managers and other financial advisors and insurance companies. Contact AP Informational Services Ltd., 33 Ashbourne Avenue, London NW11 ODT. Telephone (01) 458-1607.

Surveys


Hewitt Associates has published its annual "factbook" of employee benefits for salaried workers, which provides statistics on major benefit areas—retirement, death, disability, health care, and time off. In addition, for the first time, information on temporary disability, medical cost containment features, and flexible benefits is included.


The rate of health care costs may be increasing in general across the U.S., but in Connecticut, New Jersey, and New York the annual rate of increases is slowing down, according to this new study.

The survey, based on 300 employers from a variety of industries, revealed that a wide range of cost containment approaches are being implemented. Most of these approaches are voluntary, the report states, but added that such may not be the case much longer.

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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