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Notes

Defined Contribution Health Benefits: The Next Evolution?

by Stephen Blakely, EBRI

Introduction

The U.S. employment-based health benefits system has changed dramatically over the past century, as reflected most recently in the political battle over patients' rights in managed care plans. Shifting economic and work-place forces may be moving the employment-based benefits system into another evolutionary phase that could significantly change the way that workers and their families deal with their health insurance and health care providers.

Historically, the lumber and railroad industries pioneered the use of company medical services during the 1800s, a time when many workers labored in remote areas and employers had a practical interest in caring for ill or injured employees. Between World War II and the 1970s, health benefits provided by employment-based plans were typified by "traditional" fee-for-service health insurance with limited benefits; beneficiaries chose their health care providers, and claims for reimbursement were filed after services had already been provided. In the 1970s, benefits became more comprehensive and virtually "open-ended"; however, health benefits were defined in terms of dollar amounts (i.e., "defined benefit" plans) for inpatient and outpatient care.

Soaring medical inflation made the period of the mid-1980s (lasting into the mid-1990s) one of the major turning points in the evolution of the employment-based system, as managed care arrangements became the dominant form of health care coverage in America: This movement fundamentally altered the way health insurance worked, frequently resulting in benefit decisions being made *before* health care services were provided, rather than *after*. The movement to managed care resulted in declines in health care cost inflation, at least temporarily.

With the return of health care cost inflation in 1998, employers once again are examining options in order to control their cost increases. One emerging alternative that is starting to receive a great deal of attention is a way of designing and financing health benefits often referred to as "defined contribution" (DC) health benefits. Similar to the terminology used for retirement benefits, shifting from a "defined benefit" to a "defined contribution" changes the focus from the *service* to the *subsidy* provided by an employer.

Potentially, DC health benefits could result in major changes in the way employers provide and workers receive health coverage through the work place. Even though some employers say they

currently are providing DC-type health benefits, it is apparent that widespread confusion exists over what the term "DC health" actually means—and so far, at least, employers seem to be watching and waiting (rather than acting) on the concept.

But major questions remain: If DC health benefit arrangements become widely adopted by employers, will individuals get more choice and control over their health coverage and health care, as proponents argue? Or, as critics warn, will DC health benefits result in major cost-shifting of health expenses onto workers, resulting in a surge in the uninsured? And will the DC health concept, unlike managed care, actually lead to long-term control of health benefit costs for employers?

Policymakers, leading thinkers on benefits, employers, and labor representatives examined these questions during the May 3, 2001, policy forum on "Defined Contribution Health Benefits: The Next Evolution?" sponsored by Employee Benefit Research Institute Education and Research Fund (EBRI-ERF). Attended by about a hundred invited experts, the policy forum examined the research that has been done on DC health benefits, and the implications for consumers, business, and government. Presentations by various speakers at the policy forum will be available at *EBRI Online,* at www.ebri.org

"The really bad news is that the tools employers developed and used to stabilize inflation in the past will not have much effect on the underlying drivers of this latest round of inflation, such as the cost of pharmaceuticals and technological advances," said Ray Werntz, president and chief operating officer of the Consumer Health Education Council (CHEC). "Human resources professionals are both skeptical and curious about the attributes and prospects for DC health benefits. For now, it is not clear whether DC health benefits are inevitable—or whether this approach is merely a curiosity."

DC Health: What and Why

There are a number of generally similar terms that have also been used to describe defined contribution health benefits: c*onsumer-driven health care*, c*onsumer-centric health care*, *defined care*, or *e-health*. In what might be described as the "pure" form of DC health benefits, employers would make a fixed periodic contribution to a worker's health care account, but would exercise no control over factors in which they currently are heavily involved: plan design, risk pooling, and inflation drivers. Instead, the participant would assume full responsibility for self-insuring the care he or she needs, by acquiring commercial insurance individually or through other groups. This also has been described in some quarters as "cashing out" the value of a worker's health insurance benefit, thereby removing the employer from health coverage decisions and letting workers choose and control their own health insurance directly.

DC health benefits are often described as being similar to defined contribution *retirement* benefits (such as a 401(k) retirement plan), in which an employer sends a contribution, performs various clerical duties, and lets the worker make investment decisions. However, many commentators using this analogy often get it wrong, since employers actually determine some of the most crucial issues in DC retirement plans: whether to sponsor a plan in the first place, who the plan provider will be, what investment options are to be made available to workers, how much the company will contribute, and other major determinations.

"It's a false comparison to say DC *health* benefits are like DC *retirement* benefits, because there are significant dissimilarities," said Paul Fronstin, senior research associate at the Employee Benefit Research Institute. "In a DC retirement plan—and a 401(k) is just one of them—workers have only 'residual control,' after the employer sets up the framework." Not only do health and retirement benefits differ from each other in many crucial ways, Fronstin added, but there is no common definition among benefits professionals of the term *DC health*. This widespread confusion extends to public opinion surveys of employers and the public about DC health benefits, which Fronstin described as being "all over the map."[1]

Among the important differences between DC *retirement* and DC *health* plans:

- *Experience.* Adverse selection (covering too many high-risk consumers) is not an issue in the

pension world, but it is an enormous concern in health care. DC retirement plans have been around for a long time, but DC health plans are undeveloped and under-tested.

- *Pricing.* Employer contributions to DC retirement plans are generally wage-related, which means contributions automatically increase with salary. But health-care contributions are not wage-related, and future employer contributions are not guaranteed. Employers face a difficult challenge in translating average per capita premiums that are controlled by a known risk pool into a per-person equivalent—especially one that is affordable and relevant to that person's health care needs and risk profile.
- *Planning.* It is not as easy to plan for medical emergencies as it is to plan for post-retirement needs; many individuals may be unable to save enough money on their own for an unexpected catastrophic illness.
- *Information.* In the DC retirement market, there is an over-abundance of information about mutual funds, financial performance, fund managers, and other relevant topics. But there is no corresponding infrastructure in health care that offers, informs, and secures the choices individuals would be faced with if they were required to choose individual insurance or pay providers directly with money from their accounts.
- *Blended benefits.* For retirement benefits, most larger companies blend defined contribution and defined benefit plans to form an arrangement that has a guaranteed floor benefit (DB) with an employee-controlled supplement (DC). But with DC health benefits, it is an all-or-nothing proposition.

Although there are various models characterized as DC health benefits, probably a more workable description (as some employers are currently describing their DC health-type benefits) typically has the plan sponsor contributing most (but not all) of the premium for a group of plans or a single plan that covers defined and medically necessary services. Significantly, the employer continues either to design the plan or choose a plan designed by other sponsors.

"This is fairly commonplace today, and, frankly, is really just cost-sharing [with workers], with a new moniker and probably some more definition and rigidity," said Ray Werntz of the Consumer Health Education Council (CHEC). But he added that since employers still determine the plan benefits and the risk pool, they will never completely escape the financial and participant-relations consequences of medical cost inflation.

Why are employers considering DC health benefits? Three major reasons are generally cited:

- *Money.* Employers are seeking to manage their health benefit cost increases as annual medical cost inflation again soars into the double-digit range. The Health Care Financing Administration (HCFA) predicts that national costs will double before this decade ends.
- *Regulation and liability.* In addition to the possibility of new liability risks for employers if Congress enacts a patients' rights law, there are sweeping (and expensive) new regulations coming out on medical privacy and medical insurance claims. Health benefits already are subject to numerous complex regulations and rules, and many employers voice a concern about the growing burden and expense.
- *Employee choice.* Defined contribution health benefits are consistent with changes made to other types of benefits in recent years, and may be facilitated by the growth of the Internet's information technologies. Employees have voiced demands for more influence over care decisions with respect to plans and providers, as can be seen in the shifts in workers' participation away from the more restrictive health maintenance organizations (HMOs) and into more flexible preferred provider organizations (PPOs).

"High costs and the hassle associated with the regulatory environment, and employee unrest, may cause sponsors to throw up their hands in despair and declare enough is enough," said Ray Werntz. "Businesses exist to make money for

their investors, not to provide social services like retirement and health benefits."

For employers, the major advantage of providing DC health benefits would be the limit on health care costs and liability exposure, compared with the current managed care model of providing health coverage to their workers. As plan sponsors, employers would no longer have to invest the considerable effort and cost in finding a health plan, negotiating coverage contracts with health insurers or providers, or handling disputes between workers and insurers over noncoverage. Perhaps most importantly, the defined contributions that employers would make to their workers' health care accounts would insulate them from the effects of medical cost inflation and potential litigation over medical decisions if Congress were to enact a federal patients' rights law.

For workers, the major advantage is that they would have greater individual control over how their health care resources were spent, and—in theory—would be able to choose their own health provider rather than be limited to those selected by their employer. Those who wanted to purchase a more extensive coverage option would be able to do so, again without being limited by their employer's choices.

The major drawback for workers is that they would be stuck with paying the extra costs from medical inflation that their employer's contribution did not cover. Also, workers currently benefit from their employer's insurance pool and administrative support in buying health insurance, which generally gives them better coverage at lower rates; finding affordable coverage on their own, in the individual market, may be difficult if not impossible. Many critics warn that if a "pure" form of DC health benefits ever does become widely adopted, the ultimate result would be massive numbers of workers dropping their health coverage and a potentially calamitous surge in the number of uninsured—with ripple effects that would be felt by the insurance industry, the federal government, and the national economy.

Health Care Cost Drivers

Since the shift to managed care did not produce long-term health care cost control, a key question is whether DC health benefits would be able to do so. According to Len Nichols, a health economist with the Urban Institute, that requires an understanding of the major "drivers" that are forcing health costs to escalate and how a DC health benefits system could control them.

Current research strongly indicates that the main factors behind higher health costs are advances in medical technology, such as new diagnostic techniques, and treatment options like pharmaceutical drugs, Nichols said. And even though technology may lower the cost a particular procedure or treatment, its dissemination throughout the health care industry drives up costs because more patients utilize it. For example, in 1984 only 11 percent of Medicare patients who had experienced a heart attack underwent surgery, rather than being medically managed; by 1997, that had risen to 47 percent. Research also shows that medical cost inflation appears to be a worldwide phenomenon, and that per capita health care costs are going up at pretty much the same rate worldwide, regardless of the type of health care system.

Also, Nichols suggests that the shift to managed care merely hid medical cost increases, as employers shifted away from more expensive indemnity plans. Since the majority of workers are now covered by managed care plans, the true costs are again emerging. DC health benefits could control costs if the employer contribution covered the basic low-cost plan and employees would have to bear the extra cost for any plan above that, thereby making the true cost of health care apparent and "economically effective," he said. However, since health costs are driven primarily by technology, DC health benefits would also have to slow the diffusion and development of new medical technologies and devices. Even if that happened, DC health benefits would not be able to stop cost growth, but would merely slow it, he added.

Since private health insurance pays for only about a third of total national health care spending, a shift to DC health benefits would be unable to control cost growth unless costs are also controlled in the much larger government Medicare

and Medicaid programs. "You are never going to make real progress [in health care cost control] in the long run using incentives unless you get Medicare reformed," Nichols said. "We're not going to get there with defined contribution alone."

The Perspective of Purchasers

Some employers currently provide benefits that they describe as DC health, in that they offer workers more choice over how their health care money is spent and more flexibility in choosing their providers. One such firm is Medtronics, a medical technology company with 25,000 employees that operates in 120 countries, and which just this year started offering a "consumer-driven health care" plan as an alternative to its traditional plans. The plan gives individual participants control over a certain amount of dollars in their health care plan, and far greater freedom to select health care providers than traditional managed care plans. About 13 percent of eligible employees have selected the plan, according to Roger Chizek of Medtronics.

One notable feature of the plan is that it provides quarterly statements showing the total cost of the medical care participants have received, including what they, their employer, and their health plan have paid for. "It's time to make the total cost of health care visible for employees," Chizek said. "Far too many of our employees believe that the $10 co-pay they pay when they go to the doctor is the total cost of health care. Very few people realize that the prescription that they pay $5 for really costs $80, or whatever it may be."

Many firms remain interested but skeptical of DC health benefits. For the 5.5 million small businesses in the United States, which tend to offer health coverage far less often than large businesses, DC health benefits may offer another option—an important factor, since small-business owners need flexibility and must control costs. "The DC health-type plan does present an option for smaller firms, and options are critical because the variety in the small business population is enormous," said William J. Dennis, Jr., executive director of the National Federation of Independent Business. Small employers, especially, are fearful of lawsuits and would respond positively to DC health plans if they protect employers from liability under a new patients' rights law, he added.

But for those small firms that do offer health coverage, the current employment-based system remains quite popular with both management and labor, and any shift away from that will not happen quickly, Dennis added. "I don't see any mad dash by small firms to a defined contribution health care system," he said.

Large firms also are watching and waiting. Motorola, Inc., a very large technology employer that must compete intensely for talent, uses its extensive health benefits as a major recruiting and retention tool. The company has been actively involved in seeking to improve the quality and control the costs of its health care benefits. While Motorola is studying the DC health benefits issue, it remains skeptical of the concept, according to Randall Johnson of Motorola. "How can the DC model improve the clinical quality of care? How can the DC model improve cost effectiveness, and will the DC model—if it fails—lead to a government-run health system?" Johnson asked. But if Motorola's competitors move in the direction of DC health benefits, he added, "we will have to consider that alternative as well."

Labor unions, which both sponsor and negotiate benefits plans, tend to deal mostly with defined benefit plans for both retirement and health benefits. One such union is the American Federation of Teachers (AFT), which has about a million members and negotiates more than 2,000 benefit contracts a year, typically for three-year periods. AFT's John Abraham notes that school managers constantly search for a "silver bullet" to deal with rising costs, access and service, but "in the end of the bargaining process, workers typically give up wage increases in order to maintain benefits for three more years."

Abraham suggested that the consolidation currently sweeping through the health and insurance sectors would make it unlikely that individuals have much of a choice under a DC health benefits system. "One looming trend that will affect all of this is the consolidation of the health care industry into regional

and local monopolies that will give insurers and other providers even more control over the purchasing decision in the days ahead," Abraham said. "In the past, we could put out a bid and get four or five insurers to respond. In some parts of the country today, we are lucky if we can get two bids."

How Insurers View DC Health

One company that has created a DC health-type plan is Highmark Blue Cross Blue Shield of western Pennsylvania, which rolled out the "Blue-e Choice" program in July 2000. Highmark is the major health insurer in its region, covering about 3 million members. As of the first quarter 2001, Highmark's Blue-e Choice program had 14 accounts covering about 20,000 members, with employers ranging in size from between 70 and 4,000 workers.

According to Kim Bellard of Highmark, Blue-e Choice is the nation's first fully online health insurance market product, with everything from pre-enrollment to benefit booklets to post-enrollment activities handled online; the only paper that employees get from the program is their health insurance ID card. The program offers up to 16 different plan choices, and is designed to provide a variety of interactive tools that allow participants to pick the level (and cost) of health coverage they want, with workers who select broader coverage paying more for the benefit. Among other things, the tools allow workers to conduct side-by-side health plan comparisons.

Among the early lessons learned with the programs, according to Bellard: It does not work with employers that are not "technologically efficient"; it must be part of an employer's overall benefit strategy; workers respond to and use the choices they are offered in the program; and workers seem to like the technology and actively use the tools that are offered.

Bellard noted that the Blue-e Choice program is just one option the company offers, and that "we don't see that the employer-based system is going to go away, at least not in the short term." But he added that the program will help employers control their costs while giving workers the ability to choose the level of health coverage they want. "Employees can buy up, or buy down, to the plan choice that fits their needs," Bellard said. "They really have to understand that you can get more, but in some cases you are going to pay more—but at the end of the day, you went for the plan you want."

At UnitedHealthcare Group, one of the most successful new features on the managed care company's Web site is a pilot program that allows patients to describe their experiences with doctors in the health plan (such as waiting times) and to give feedback to the doctors. Jay Silverstein of UnitedHealthcare noted that the site does not attempt to provide a rating of the doctors' "quality" of care—since that is difficult to define—but is rather designed to provide consumer information. Even though their consumer Web page is not marketed, Silverstein said, it is the most frequently visited part of the company's Web site, and the comments that patients are sharing are "overwhelmingly positive."

At CIGNA Corp., a major health insurer with more than 14 million members, the company also is investing heavily in computer and Internet technology because "the marketplace is shifting and the end consumer is the one who will be driving this marketplace increasingly, whether or not we change any of the public policy that underlies the system," according to CIGNA's Arthur Lifson.

CIGNA's health insurance business is roughly evenly divided between indemnity and managed care types of health plans. While the company is also moving to "empower" its consumers in ways that describe DC health benefits, he cautioned that the group insurance principles that currently drive the employment-based health system would be lost under a "pure" individual-based DC health system. The result, he suggested, could be much higher administrative costs and insurance risk to carriers, unequal tax treatment of health benefits for younger and older workers, and more people without health insurance. He also noted that employers and health insurers are reacting to worker complaints about managed care by making their current health benefit plans more user-friendly: "The employer-based system is already responding in many ways to

the types of changes we attribute to an individual-based system," Lifson said.

Providers' Point of View

Within the health care provider sector—where managed care is widely unpopular—opinion is divided over the prospects of a shift to DC health benefits. Doctors, many of whom have private practices, see managed care as wrongly interfering with the doctor-patient relationship and strongly advocate individual-based health insurance such as DC health benefits. But hospitals fear the potential loss of the employment-based structure in maintaining a financially viable health insurance system.

For instance, the American Medical Association (AMA), the largest professional organization of American doctors, favors the DC health benefits concept as a form of individually selected, consumer-driven health care. The AMA is critical of the employment-based health care system, arguing that it has bred a structure that is anti-competitive and focused exclusively on cost at the expense of quality.

"In most industries there is no need for a 'consumerism' movement because competition naturally breeds it," said Donald Palmisano of the AMA. "In U.S. health care today the situation is quite different—we have 'employerism,' where competition may not always benefit patients."

Palmisano said that managed care as developed by the employment system is unresponsive, produces excessive patient churning, and denies patients the medical choices they want and need. He predicted that patients would be more cost conscious under DC health benefits, since they would be allowed to make their own choices and know what the costs are. "Health benefits are earned compensation. They are not gifts from the employer," he said. "Defined contribution programs would monetize the health benefits transaction."

However, the American Hospital Association (AHA) sees DC health benefits as potentially leading to a government takeover of health insurance.

James Bentley of AHA notes that the "80-20 rule" applies to the health care sector: 20 percent of the population consumes 80 percent of the health care resources. Hospitals are far more likely to deal with that 20 percent, which is subsidized, in three ways:

- *Cost-shifting,* in which the "routine" or healthy patients pay more than the high-cost patient.
- *Insurance pooling* through employment-based group health insurance.
- *The government tax structure,* which provides favorable treatment for employment-based health insurance benefits, especially compared with individually purchased insurance.

Bentley said hospitals are concerned that if the employment-based insurance pooling system is dismantled, "do we move down to a system in which the only way to pool and cover the high-cost patient is with some new or expanded government health care program?"

AHA's strategic planning committee has studied the DC health benefits concept, and concluded there are three basic options for health plan sponsors:

- *A fixed payment to selected options,* which would keep the employer in the role of a sponsor deciding what plans to offer, negotiating with those plans for the premium and the benefit structure, and deciding on a fixed payment that the employer would make regardless of which plan the individual enrolled in.
- *Getting out of the selection and negotiation* of a health plan, but still providing a payment for health care coverage.
- *Pure compensation,* under which workers' salaries would simply be increased by some amount to represent the monetary value of a health insurance premium, and workers would be entirely on their own to buy (or not buy) health insurance in the individual market.

AHA's analysis concluded that almost nowhere in the United States is there a stable individual-based insurance market, and that under the second two options workers would be unable to find coverage. Bentley noted that if just 10 percent of the people currently covered through employment-based health insurance moved to a DC health

system and dropped their coverage, the number of uninsured would go up by 35 percent—"Not an attractive state of affairs for the hospitals."

Also, even though workers might be able to choose from different tiers of coverage under a DC health system, hospitals are required by the state and federal governments to provide a common standard of care regardless of the sponsorship of the patient. The result: "From the hospital point of view we will see more uncompensated care" in a DC health benefits framework, Bentley said.

Public Policy Issues

If the U.S. work force does adopt some form of "pure" DC health benefits, shifting away from employment-based group health coverage to individual coverage, a number of major policy issues will be raised one way or another. These include:

- *Adverse selection/lack of choice.* Under the "pure" DC health benefit scenario, where employers give workers the cash equivalent of their health benefits, insurance companies would lose the group-health insurance pool provided by employers and have to rate a worker's health risks on an individual basis. Experience has shown that, as a matter of financial survival, insurers will either raise prices sharply or refuse to underwrite bad risks on an individual basis; state governments that have attempted to force individual coverage have found that insurers will leave the state. "The states that have attempted to [force] those choices have had pretty unqualified disasters: They have virtually no market left because the individual market is fragile, volatile, and does not lend itself well to regulatory oversight," said Kathleen Sebelius, Kansas state insurance commissioner and president of the National Association of Insurance Commissioners (NAIC). "The individual market is not protected by the same kind of tax laws, guaranteed issue, or portability that protect the group market."
- *Equity.* If employers were simply to provide cash as a health benefit, fairness between younger and older workers would become a contentious issue. For instance, if an employer is spending $5,000 a year per worker on health coverage, does each worker get $5,000—or do younger (and healthier) workers get less, while older (and less healthy) workers get more? If so, how much?
- *Recruiting and retention.* The major reason why employers currently offer health benefits directly is to recruit and retain qualified workers. If those benefits were "cashed out" under a DC health system, employers would be left to compete largely on salary levels.
- *Replacement dollars.* If employers pull out of sponsoring health care benefits and providing the cross subsidy between younger and older workers, will the federal government have the political will or financial resources to step in and take over? "An enormous, very valuable, cross subsidy goes on behind the employee right now that is a major public good," said Mary Nell Lehnhard of the Blue Cross Blue Shield Association, "and we should not walk away from it lightly."
- *Regulation.* The individual health insurance market is highly regulated because of the high risk of insurance failure and the potential for fraud. Shifting the working population from the employment-based system (where employers handle most of the administrative functions) to an individual-based system (such as DC health benefits) would require vastly greater government resources and subject both workers and health insurers to far more government rules and restrictions. If the shift to DC health benefits occurs, warned NAIC's Sebelius, "I think what will happen very quickly is a lot of policymaker involvement."
- *Capitalization.* The individual insurance market would have to be capitalized, since state insurance regulators require the individual market to have enough money to pay outstanding claims if insurers go bankrupt. The employment-based system is not required to

have those kinds of reserves, and billions of dollars would be needed (from insurers and ultimately from participants) to capitalize an individual insurance market.

- *Education.* Tom Beauregard of Sageo, Inc., a benefits outsourcing firm, pointed out that 63 percent of Americans do not know what kind of health plan they are in, which suggests that any movement toward consumer-driven health care will require a lot of education for plan participants: "We've got a very uninformed base of buyers, and that is the single biggest challenge." Adds NAIC's Sebelius: "From my perspective, I don't think that the systems are in place to educate people about their choices, or that the marketplace exists to purchase the choices."
- *Uninsured.* In an individual-based market, with workers bearing the full brunt of health care cost inflation without support from their employers, chances are that large numbers of people will drop their coverage and become uninsured. Currently, about 42 million people, or more than 17 percent of the working-age population in the United States, has no health insurance. "The uninsured rate goes up dramatically if you move to an individual, voluntary market. We know this very well from our own experience in the individual market, and we are in it in every state," said Lehnhard of BCBS. "As much as we would like to test our brand in the individual market, we don't think it is good public policy for American workers to move away from the employment-based system."

On Capitol Hill, DC health benefits are beginning to get attention from some lawmakers involved in setting health policy, although for very different reasons. One factor that may drive employers to a DC health system is the current debate on patients' rights legislation, which would create new legal liabilities for managed care health plans—and possibly the employers who sponsor them. By using DC health benefits to distance themselves from any role in medical decision-making, employers might be able to avoid any liability under the patients' rights bill currently being voted on in Congress.

"Republicans who are trying to hold health maintenance organizations accountable but not destroy the employment-based system through litigation have seized on defined contribution as a kind of 'exit ramp on the highway to hell,'" said Dean Clancy, health policy analyst to House Majority Leader Richard Armey (R-TX). "We want to be able to say to the employer: 'Look, if you don't actually pick the plan for your employees, and you don't pick the benefits, and you are basically just writing a check, then you should not be held liable for the things those plans do.'"

But John Gilman, health policy advisor to Sen. Paul Wellstone (D-MN), noted that employers are unlikely to start shifting to a DC health system until the labor market softens and is not as tight as it is today, with unemployment at historically low levels. When and if that happens, it will occur when the numbers of both unemployed and uninsured are rising; the higher costs to workers from a DC health system would likely hasten the end of the employment-based benefits system, he predicted.

"As an advocate of government programs that would ensure universal health care for all, I think that sort of move plays right into expanding government's role," Gilman said. "In my view, the only value of moving to defined contribution health plans is that it would move us a lot closer to government insured health care a lot quicker."

Endnotes

[1] *See Paul Fronstin, "Defined Contribution Health Benefits,"* EBRI Issue Brief *no. 231 (Employee Benefit Research Institute: March 2001).*

Washington Update

by Teresa Turyn, EBRI

Social Security Commission Issues Draft Report

President Bush's 16-member Commission to Strengthen Social Security issued a draft report July 18, and as expected it amounted to a public education effort designed to increase understanding of the financial problems facing the Social Security program. Also as expected, the draft report called for the creation of voluntary "individual accounts" that workers could use to invest a portion of their payroll taxes for retirement. The commission will issue a final report later this year.

While not making specific recommendations for change, the draft report said the 66-year-old Social Security program "has itself reached retirement age," and that economic and demographic forces leave no choice but to restructure the program to allow individual investments in the stock market. The report said that doing nothing would inevitably lead to big tax increases, deep benefit cuts, a sharp rise in the national debt, or some combination of these results. It described the system as often unfair to minority groups (who tend to receive less because of shorter life spans) and women (who tend to spend less time in the work force but live longer than men).

Inevitably, with an issue as controversial as Social Security reform, supporters of individual accounts hailed the report as a step forward, while critics dismissed it as alarmist and factually flawed.

Although the commission released its interim report publicly, it has declined to post the document on its Web site. However, *The Washington Post* has made an electronic version of the full report available, and EBRI Members can access it at the "What's New" page of *EBRI Online* at www.ebri.org/whatsnew/current.htm by scrolling down to postings for July 20, 2001: "The Washington Post has posted the Staff Draft (revised July 18, 2001) of The President's Commission to Strengthen Social Security's report."

Patients' Rights Bills in Conference

The House of Representatives Aug. 2 approved legislation (H.R. 2563) that would create federal rights for millions of Americans in managed health care plans, after revising the legislation to limit lawsuits against insurance companies. The 226–203 vote, without a single GOP defection, represented a political victory for President Bush, who had argued that earlier versions of the bill would encourage frivolous lawsuits.

The bill now goes to a House-Senate conference committee, where lawmakers will try to iron out differences with the Senate-passed version (S. 1052), which contains broader liability provisions than what was approved by the House. This conference on patients' rights legislation is expected to be one of the most contentious issues facing Congress when it returns this fall.

Under both the House and Senate versions of the legislation, health insurance plans would have to, among other things, provide patients prompt access to medical specialists, allow women to visit obstetricians and gynecologists without a referral, and permit patients to obtain emergency care at the nearest hospital, even if it is not affiliated with a specific health plan. The one key issue of difference between the two bills is the degree to which patients would be allowed to sue their health plans (and in which jurisdiction) for alleged denial of access or health care. The House bill has more restricted liability provisions, the Senate bill less so.

Under the House measure, patients could enforce their rights by suing health maintenance organizations (HMOs) in state court for medical decisions, and could collect up to $1.5 million in damages for pain and suffering. They could also collect up to $1.5 million in punitive damages, but only where a plan had been ordered by an outside appeals board to provide more care and refused. The federal rules would also pre-empt states' laws that allow larger damage awards, but states with lower caps could keep their own limits. Aggrieved patients could also sue their employers, but only in federal court and only if their

Keeping on Track

HHS Issues Guidance on Privacy Regulations—The Department of Health and Human Services (HHS) July 6 issued guidance pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Presented in a question-and-answer format, the HHS privacy guidance comes in response to the need for clarification and instruction with respect to the final regulations issued by HHS, which went into effect April 14, 2001. In general, the guidance covers topics including timelines for compliance; clarification of procedures and acceptable practices for health plans and employers in administering plans and handling individually identifiable health information; the treatment of third-party vendors and associates in health plan administration; and the interaction of the regulations with medical research initiatives and projects. The guidance may be viewed at www.hhs.gov/ocr/hipaa/

DOL Delays Compliance Date for Claims Procedure Final Regulation—The Department of Labor (DOL) July 9 published final rules in the *Federal Register* delaying for up to one year the compliance date of the new claims and appeal procedure rules for group health plans. The delay does not apply to pension plans, disability plans, and other types of welfare benefit plans. The claims procedure rules were originally scheduled to apply to claims filed on or after Jan. 1, 2002, but have now been changed to the earlier of the first day of the first plan year beginning on or after July 1, 2002, or Jan. 1, 2003. However, group health plans can choose to comply with the new rules prior to the delayed effective date. According to DOL, one of the reasons for the delay is that there is a "significant likelihood" that patients' rights legislation will be enacted before or shortly after the regulation was scheduled to take effect, a development that might require additional changes to the same procedures.

Judge Rules Viagra Coverage Not Mandatory—In a ruling that may affect prescription coverage at every health maintenance organization (HMO) in California, a Sacramento Superior Court judge has ruled that state regulators cannot force Kaiser Permanente to pay for Viagra, a male sexual-dysfunction drug. Although the state Department of Managed Health Care had originally required the HMO to provide coverage of Viagra, the Superior Court ruling stated that nothing in state law requires health plans to "provide coverage for all medically necessary prescription drugs, including drugs for sexual dysfunction." In addition, the ruling found no law obligating HMOs to authorize the use of drugs that treat conditions excluded from coverage in the insurance contracts signed by health plan members. Although the ruling applies only to Viagra, some experts said it could affect coverage of other so-called "lifestyle" drugs for conditions such as baldness or obesity (*Kaiser Foundation Health Plan v. Director, Department of Managed Care*).

Eleventh Circuit Rules Against Disparate Impact ADEA Claims—The U.S. Eleventh Circuit Court of Appeals recently held that disparate impact claims may not be brought under the Age Discrimination in Employment Act (ADEA). In taking this position, the court joins the First, Third, Sixth, Seventh, and Tenth circuit courts (the Second, Eighth, and Ninth Circuits have allowed ADEA disparate impact claims). A disparate impact claim involves employment practices that appear to be neutral but in fact fall more harshly on protected group members and cannot be justified by business necessity (*Adams v. Florida Power Corp.*, 2001 U.S. App. LEXIS 15063, 7/05/01).

employer made health-care decisions directly.

Bush Promotes Medicare Overhaul

President Bush July 12 announced a set of general principles for Medicare reform to guide Congress in crafting an overhaul this year of the financially troubled federal health care insurance program for the elderly and disabled. The principles include maintaining current benefits as well as creating plan options that beneficiaries can select.

As a first step, Bush said that the government would use the program's bulk purchasing power to work with private companies on a plan to offer every older American a

pharmacy discount card. Under the plan, which the administration says can be adopted by January without congressional approval, the government would set standards for companies that manage pharmacy benefits to negotiate discounted prices with pharmaceutical manufacturers and drug stores and pass on those savings to Medicare beneficiaries. To be allowed to offer the cards, private companies would have to show that they would negotiate discounts with numerous pharmacies and that drugs from every major class would be included under their cards.

Investment Advice Hearing

Rep. John Boehner's "investment advice" bill (H.R. 2269) received a hearing July 17 by the House Education and the Workforce Subcommittee on Employer-Employee Relations, as an initial step toward expected passage of that measure by the full House. Boehner (R-OH), chairman of the full Education and the Workforce Committee, first introduced the measure last year. His current bill, largely unchanged from the last Congress, would allow employers to provide retirement plan participants with access to professional investment advice concerning their 401(k) retirement plans and pensions if adviser fees and conflicts of interest are disclosed. Ann Combs, assistant secretary for the Pension and Welfare Benefits Administration, testified on behalf of the Department of Labor (DOL). Testimony from the hearing may be viewed at www.house.gov/ed_workforce/hearings/107th/eer/eerhearings.htm

Tax Cut Interpretations in the Works

When President Bush signed into law the sweeping $1.35 trillion, 10-year tax-cut law in June, it did not mark the end of the battle over the issue. Congress is already working on a "technical corrections" bill to fix legislative mistakes and unintended problems with the law, and the Treasury Department is working on regulatory clarifications of how it will interpret the law's application in practice. The law, the Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA), includes $49.6 billion in pension reforms and incentives designed to increase retirement savings.

A Treasury Department official July 12 reaffirmed the Treasury's plans to issue regulatory guidance before the end of this year regarding disclosure of benefit accrual reductions, catch-up contributions for individuals over age 50, and deferred compensation plans for tax-exempt organizations or government employees under Sec. 457 of the tax code.

EBRI in Focus

EBRI Part of GAO's Retirement Study

At the request of the General Accounting Office (GAO), EBRI has joined GAO's 2001 Retirement Advisory Panel, and EBRI President Dallas Salisbury attended its July 11 meeting in Washington, DC. The panel provides GAO with comments and advice on the agency's work involving Social Security and retirement, and helps target GAO research toward retirement income security issues. In addition to Salisbury, the GAO Retirement Advisory Panel includes William Gale, Brookings Institution; Teresa Ghilarducci, Notre Dame University; and C. Eugene Steuerle and Lawrence Thompson, Urban Institute.

EBRI Participates in Coverage Conference

EBRI President Dallas Salisbury and Jack VanDerhei, Temple University and EBRI Fellow, participated in a two-day conference July 24–25, *Conversation on Coverage,* sponsored by the Pension Rights Center and underwritten by the Ford Foundation and the W.K. Kellogg Foundation and cosponsored by a variety of organizations involved in retirement issues, including EBRI. The conference brought together 50 experts from diverse organizations to discuss strategies to increase pension coverage for working Americans. Proceedings of the conference will be published by The Century Foundation.

Oregon Retirement Project Briefing

Results of EBRI's Oregon Future Retirement Income Project were presented to a group of about two dozen retirement specialists in New York City July 26 by EBRI President Dallas Salisbury and Jack VanDerhei, Temple University and EBRI Fellow. The study, conducted in collaboration with the Milbank Memorial Fund and the Oregon governor's office, is designed to estimate the future retirement income for all currently employed individuals and families in a single state. The study then uses the estimates to begin assessing the adequacy of retirement income at different levels of health and housing cost.

Health Confidence Survey Funders' Briefing

A special briefing was held July 18 for organizations underwriting the 2001 Health Confidence Survey (HCS), which will be publicly released in September. Some findings related to Medicare were released in late July, to coincide with commemorations related to the program's 35th anniversary. The HCS, conducted annually since 1998 and cosponsored by EBRI, the Consumer Health Education Council, and Mathew Greenwald and Associates, looks at public attitudes toward health insurance, managed care, and other health care issues and programs. For more information about the HCS, contact Paul Fronstin at (202) 775-6352 or fronstin@ebri.org

Choose to Save® Update

The second 30-minute Choose to Save® television special program for Phase IV of CTS will air in the Washington, DC, media market on WJLA-TV Sept. 6 at 8:30 p.m. The show is to feature an interview with Treasury Secretary Paul O'Neill and Raul Yzaguirre, president of the Latino group La Raza. The CTS Special will focus on retirement savings issues in minority populations.

Also, three additional 30-second television public service announcements (PSAs) are being filmed in August, to begin airing in the Washington media market in September. CTS also recently released a new radio PSA package that is doing well at radio stations across the country. New radio spots are being recorded featuring Rep. Ben Cardin (D-MD) speaking to the need for retirement savings. Along with Rep. Rob Portman (R-OH), Cardin co-authored most of the "Portman-Cardin" retirement savings provisions in the recently enacted tax-cut law.

ASEC Summer 2001 Partners' Meeting

ASEC held its Summer 2001 Policy Board and Partners' meetings July 12–13 in Washington, DC. The Partners' meeting, held at the U.S. Securities and Exchange Commission, covered a wide array of topics including: the next White House/ Congressional National Summit on Retirement Savings; financial education initiatives of the U.S. Department of the Treasury; an update of the national "Save for Your Future" education campaign with the Social Security Commission; the upcoming RetireMint conference in New York City on Oct. 19–20; and other updates from various partners. For more information, please contact ASEC President Don Blandin at (202) 775-6321 or by e-mail at blandin@asec.org

CHEC Policy Board Meets

The EBRI-ERF Consumer Health Education Council (CHEC) Policy Board met July 11 to review progress on CHEC's *Knowledge Base* (a compendium of facts and evidence pertinent to employer support for providing health care benefits to America's 42 million uninsured) and plans for outreach and partner development. Currently, CHEC is focused on building the business case for community-level, private/ public partnerships to expand coverage, and accordingly is establishing organizational relationships with all key stakeholders.

CHEC was instrumental in the development of a conference—the first of its kind—entitled *Business Perspectives on the Uninsured*, held June 13 in Chicago. The purpose was to provide input from the state's business community to the Illinois Assembly, a recipient of a coverage-expansion planning grant from the Health Resources and Services Administration—a government liaison to CHEC's Policy Board. The conference served as a forum on the role of employers in

addressing the problem of the nation's uninsured and particularly the 1.8 million uninsured in Illinois. For more information, contact CHEC President Ray Werntz at (202) 775-6302 or werntz@healthchec.org

New Publications & Internet Sites

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

Aging Policies

U.S. Administration on Aging. Resources and Information about the Older Americans Act Amendments of 2000. www.aoa.gov/Oaa/status/default.htm

U.S. Congress. Senate Special Committee on Aging. Living Longer, Living Better: The Challenge to Policymakers. Order from GPO.

Disability

Bloch, Frank S., and Rienk Prins. Who Returns To Work & Why?: A Six-Country Study on Work Incapacity & Reintegration. $29.95. Transaction Publishers, 390 Campus Drive, Somerset, NJ 08873, (732) 445-1245, (888) 999-6778, fax: (732) 748-9801.

Economic Security

AARP. Beyond 50: A Report to the Nation on Economic Security. Free. AARP, 601 E St., NW, Washington, DC 20049, (202) 434-2277.

Sullivan, Teresa A., Elizabeth Warren, and Jay Lawrence Westbrook. The Fragile Middle Class: Americans in Debt. $35. Yale University Press, P.O. Box 209040, New Haven, CT 06520-9040, (800) 987-7323.

Employee Benefits

Society for Human Resource Management. 2001 SHRM Benefits Survey. $59.95; SHRM members, $49.95. Society for Human Resource Management, 1800 Duke St., Alexandria, VA 22314-3499, (800) 444-5006.

Workplace Economics. State Employee Benefits Survey: Benefits in Effect January 1, 2001. $135. Workplace Economics, P.O. Box 33367, Washington, DC 20033-0367, Phone/fax: (202) 223-9191.

Health Care

Academy for Health Services Research and Health Policy, et al. Mapping State Health Insurance Markets: Structure and Change in the States' Group and Individual Health Insurance Markets, 1995–1997. Free at www.statecoverage.net/mapping.pdf.

Watson Wyatt Worldwide, Washington Business Group on Health, and Healthcare Financial Management Association. Changing Role of Health Care Benefits: A Survey of Employers, Providers and Health Care Plans: Sixth

Annual Survey Report on Purchasing Value in Health Care. $20. Watson Wyatt Worldwide, Attn: Marketing, 6707 Democracy Blvd., Suite 800, Bethesda, MD 20817, (800) 388-9868.

Pension Plans/Retirement

Barclays Global Investors. Mind the Gap!: Why DC Plans Underperform DB Plans, and How to Fix Them. Free at www.barclaysglobal.com/knowledge/

Greenwich Associates. United States Investment Management, 2000: Market Dynamics Report. Contact Ryan Randolph for cost. Greenwich Associates, 8 Greenwich Office Park, Greenwich, CT 06831-5195, (203) 625-5158.

HR Investment Consultants. 401(k) Provider Directory Averages Book. $95 + S&H. HR Investment Consultants, 305 W. Chesapeake Ave., Baltimore, MD 21204-4421, (888) 401-3089.

John Hancock Financial Services. Defined Contribution Plan Survey: Insight into Participant Investment Knowledge & Behavior. Free. John Hancock Life Ins. Co., Attn: Christine Gerardi, P.O. Box 111, Boston, MA 02117, (617) 572-9456.

National Association of Pension Funds. Twenty-Sixth Annual Survey of Occupational Pension Schemes: 2000. About $226 for nonmembers. National Association of Pension Funds, Sue Dean, 44-207-808-1300, fax: 44-207-7585, e-mail: sue.dean@napf.co.uk.

National Defined Contribution Council and Spectrem Group. Defined Contribution Market Insights. Free. National Defined Contribution Council, Attn: Albert Brust, P.O. Box 370467, Denver, CO 80237, (303) 770-5353.

OppenheimerFunds, Inc., et al. Gen X Retirement Study. Free. (800) 944-9464.

Organization for Economic Co-Operation and Development. Private Pensions Systems: Administrative Costs and Reforms. $48. Organisation for Economic Co-operation and Development, Publications and Information Center, 2001 L St., NW, Suite 650, Washington, DC 20036-4910, (800) 456-6323.

Towers Perrin. Managing Global Pension Assets: Key Survey Findings. Free. Towers Perrin, 100 Summit Lake Dr., Valhalla, NY 10595, (800) 525-6741, fax: (914) 745-4199.

U.S. Congress. Senate Special Committee on Aging. The Cash Balance Conundrum: How to Promote Pensions Without Harming Participants. Order from GPO.

Documents Available on the Internet

The 2001 401(k) Providers Buyer's Guide
www.cfo.com/401kguide/1,4858,,00.html

Charging Participants Plan Expenses
www.westanley.com/binsight/06_2001.html

Comparison of State Managed Care Liability Laws
www.kff.org/content/2001/3155/

Employee Plans News
www.irs.gov/bus_info/ep/current.html

Mutual Funds and the Retirement Market in 2000
www.ici.org/pdf/fm-v10n2.pdf

NCQA's Health Plan Report Card
hprc.ncqa.org/index.asp

Overview of Title VI of HR 1836 (EGTRRA), as Passed by Congress
www.segalco.com/compalert52901.html

Washington Insider: Track Patients' Bill of Rights Legislation
www.plansponsor.com/content/news/opinions/billofrights

Legal Portals

FedLaw
www.legal.gsa.gov/

FindLaw
www.findlaw.com/

Guide to Law Online
www.loc.gov/law/guide/

Heiros Gamos
www.hg.org/

Internet Law Library
www.qlamerica.com/library/

Legal Information Institute
www.law.cornell.edu/

WashLaw Web
www.washlaw.edu/

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EBRI's work advances knowledge and understanding of employee benefits and their importance to the nation's economy among policymakers, the news media and the public. It does this by conducting and publishing policy research, analysis, and special reports on employee benefits issues; holding educational briefings for EBRI members, congressional and federal agency staff, and the news media; and sponsoring public opinion surveys on employee benefit issues. **EBRI's Education and Research Fund** (EBRI-ERF) performs the charitable, educational, and scientific functions of the Institute. EBRI-ERF is a tax-exempt organization supported by contributions and grants. The **American Savings Education Council** (ASEC) and the **Consumer Health Education Council** (CHEC) are programs of EBRI-ERF. They are coalitions of private- and public-sector institutions with the goals of public education on saving, retirement planning, health insurance, and health quality.

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