

notes

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◆ Observations on the Differences and Similarities in the Japanese and U.S. Benefits Systems

EDITOR'S NOTE: The following article is a recap of remarks from EBRI Fellow Tomomi Kodama made to the EBRI Board of Trustees at their June 1992 meeting. Ms. Kodama works for the Japanese Ministry of Health and Welfare (Japan's counterpart to the U.S. Department of Health and Human Services) and joined EBRI as a fellow from July 1991 to June 1992 to study human service issues in the United States. She spoke about what she learned at EBRI and what ideas she would take home.

From my work at EBRI, the first lesson I learned was the fact that the structure of the U.S. employee benefit system is considerably different from that of the Japanese system. The U.S. structure of employee benefits seems to be based on diversity and individualism. Companies have a real choice in selecting and planning their employee benefit plans. In order to attract and retain capable workers, each company tries hard to find some way to provide appealing benefits for its employees at affordable costs. In this sense, employee benefit issues are closely related to a company's management strategy.

However, what explains the structure of Japanese employee benefits is equity and uniformity for everyone. The Japanese priority has been to assure equal access to benefits for everyone, even if it sometimes means providing mediocre services. For example, in health care, Japanese employees are covered by employment-based health insurance, just as in the United States, and are assured free choice of their physicians and hospitals. However, in order to provide equal access to all employees, health insurance is strictly regulated across the board by the Japanese government. In other words, employees of a small company on the verge of bankruptcy are provided basically the same coverage as employees of a well-known big company such as Honda or Toyota. For example, while the health plans of these two companies cover mental illness without any limit, neither covers a heart transplant. And, even if a conscientious manager believes that his or her company's health care costs are

too high, law prohibits the company from introducing an HMO-type of health plan. The same type of equity and uniformity in health insurance is more or less a common feature among other Japanese employee benefits such as pension plans and child care.

As a result, Japanese companies seem to pay much less attention to employee benefit issues than their American counterparts do. And for better or worse, it is not the companies but the central government that has consistently taken the key role in planning and implementing the employee benefit system. To put it rather dramatically, employee benefits in Japan are not what each company individually designs but what the government uniformly imposes on companies.

So, it is not surprising that there is no Japanese equivalent of EBRI. In fact, I could not imagine or understand what a "nonprofit, nonpartisan, public policy research organization" did before I came to EBRI. After I learned what an important role EBRI plays in the human resource field in the United States, I believe that the existence of EBRI itself exemplifies the outstanding features of the U.S. employee benefit system. And,

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I have come to understand EBRI's rationale and to believe that the type of analysis EBRI does can challenge the present employee benefit system in Japan. That is the second lesson I learned from EBRI.

I want to explain more about the second lesson. It is generally thought that the Japanese benefit system has been working well up to now. However, the future presents a different story. While Japan's rising standard of living has diversified the Japanese people's lifestyle, they have become dissatisfied with the existing benefit system. Japan now needs more tailored benefits to help meet varying individual demands. In short, our goal in this area has been shifting from uniformity to diversity.

An example of this shift can be seen in child care benefits. The Japanese child care policy has focused on equal benefits for everyone, but the country needs more flexible and tailored care, such as day care for sick infants and children as well as extended day care for mothers who work overtime. Consequently, the government is encouraging employers to individually design their own child care programs to meet their employees' needs.

As shown in this example, Japan needs ideas for creative and innovative programs that can be shared with companies, local governments, and communities. In this sense, what EBRI is doing in the United States is quite helpful to future policymaking in Japan. EBRI is the very organization providing such information. Actually, in order to learn more about EBRI and the strengths of the U.S. employee benefit system, some Japanese public organizations have become EBRI members and the Ministry of Health and Welfare has decided to send another Fellow to EBRI next year.

While there are major differences between the employee benefit systems in the United States and Japan, they have something in common.

Japanese society has recently been experiencing a kind of underground revolution. First, because of its severe baby bust and growing life expectancy, there is a higher proportion of elderly Japanese. In 1990, the number of people aged 65 and over represented 12 percent of the Japanese population. While this proportion of elderly is currently the lowest among developed countries, by 2020 it will reach 25 percent and will be the highest proportion. Secondly, the Japanese family has been changing. The stereotypical Japanese family was the extended

family with a full-time housewife, but today there is a clear trend toward nuclear families with more elderly people living independently. Due to the increasing number of working women, one out of five families with children is a dual-income family. At the same time all these changes have been taking place, the values and needs of the Japanese society have been changing.

Both U.S. and Japanese policymakers know that health care and pension benefits costs will continue to rise steadily; the demand for long-term care will increase tremendously; and families will need more and more outside support in terms of caring for children and the elderly. I used to think that these issues were somewhat peculiar to Japan. But, through my work at EBRI, I have learned they are common phenomena in both societies. In order to respond to these changes, a new approach will become even more important than ever before in both Japan and the United States.

Of course, the approach to these changes will differ in the two countries, and it is impossible to directly apply successful U.S. programs in Japan and vice versa because human service issues are closely connected with a country's traditions, culture, and values. However, I strongly believe both societies can be better off if we are able to share each other's experiences in these areas. We will be able to more objectively analyze what is going on in our society by knowing that there can be a different approach to a similar situation.

Finally, I owe special gratitude to Mr. Salisbury and all members of the EBRI team, who have kindly accepted me at EBRI. I cannot thank them enough. With their great help, I have certainly learned a lot and enjoyed my stay in this wonderful country.

—Tomomi Kodama, EBRI Fellow

◆ Workers' Compensation Medical Costs Continue to Rise

Cost Management Practices Are Increasing

Between 1980 and 1990, the cost to employers of providing workers' compensation increased from \$19.3 billion to \$45.9 billion.¹ Medical expenses are the fastest

¹U.S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business*, January 1992 (Washington, DC: U.S.

Chart 1
Annual U.S. Cost Growth: Workers' Compensation Medical Costs Versus Non-Workers' Compensation Medical Costs



	Medical Cost Growth (annual average percentage change)			
	1965– 1970	1970– 1975	1975– 1980	1980– 1985
	(percentage)			
Workers' Compensation	9.3%	11.9%	14.1%	14.7%
Non-Workers' Compensation	11.5	11.2	12.2	9.8

growing component of workers' compensation, representing 44 percent of total workers' compensation costs as of 1990, up from 38 percent in 1981.² Historically, cost management strategies have not been used extensively to control workers' compensation medical costs. Since 1974, workers' compensation medical costs have been growing at a faster rate than non-workers' compensation medical costs. In order to contain these costs, employers are adopting cost containment strategies, and states have increasingly implemented cost containment mandates, often utilizing strategies commonly used in health care benefit plans.

Workers' compensation is a state mandated employee benefit requiring employers to provide medical benefits, indemnity benefits (i.e., income replacement), and

compensation.³ Employers finance workers' compensation coverage through private insurance, state funds, or self-insurance, depending on state law and employer preference. The employer pays premiums (in the case of private insurance and state funds) that are based on risk factors attributed to the industry and are calculated as a percentage of payroll. Additionally, most states require that premiums be experience rated (i.e., based on incidence of prior injuries).

Between 1975 and 1980, the medical cost component of workers' compensation rose by 14.1 percent, compared with a 12.2 percent increase in non-workers' compensation medical costs (chart 1). Between 1980 and 1985, the medical costs component of workers' compensation and nonworkers' compensation increased 14.7 percent

Government Printing Office, 1992); and U.S. Department of Commerce, Bureau of Economic Analysis, *The National Income and Product Accounts of the United States: Statistical Supplement, 1959-1988*, Vol. 2 (Washington, DC: U.S. Government Printing Office, 1992).

²National Council of Compensation Insurance, personal communication, July 26, 1992.

³Laws pertaining to workers' compensation were enacted in response to an increase in work-related injuries after the industrial revolution and were designed to provide comprehensive and efficient coverage to employees for occupational injuries and diseases and to encourage safety in the workplace. Workers' compensation is a form of social insurance developed on the principle of providing full coverage regardless of fault.

Table 1
Comparative Cost Indices

	Cumulative Change Since 1980		
	Workers' Compensation Medical ^a Costs	Average Weekly Wage	Medical Consumer Price Index
1980	1.000	1.000	1.000
1981	1.283	1.087	1.107
1982	1.414	1.154	1.235
1983	1.675	1.198	1.343
1984	2.039	1.264	1.426
1985	2.101	1.322	1.515
1985	2.201	1.373	1.629
1987	2.584	1.430	1.737
1988	2.979	1.487	1.850
1989	3.354	1.545	1.993
1990	3.782	1.624	2.174

Source: National Council on Compensation Insurance, personal communication, 1992.

^aBased on the average medical cost per case for workers' compensation lost time claims as sampled in the National Council on Compensation Insurance's *Call for Detailed Claim Information* (Boca Raton, FL: National Council on Compensation Insurance).

and 9.8 percent, respectively.⁴ Additional data indicate that this trend is continuing. Between 1980 and 1990, workers' compensation medical costs rose more than 278 percent, compared with an approximate 117 percent increase in the medical consumer price index (M-CPI) (table 1).⁵

The increase in workers' compensation medical costs has resulted from many of the same forces that are driving medical costs in employer-sponsored benefit plans, such as the introduction of new technology, the spread of insurance (which lowers the relative price of medical services to insured individuals, increasing patient demand for health care services), and the rapid expansion of treatment options without concurrent research on their relative efficacy.⁶ However, dissimilarities between workers' compensation and employer-sponsored benefit programs also may affect costs.

Workers' compensation provides indemnity and vocational rehabilitation benefits in addition to medical care.

⁴Leslie Boden and Charles A. Fleischman, *Medical Costs in Workers' Compensation: Trends and Interstate Comparisons* (Cambridge, MA: Workers' Compensation Research Institute, 1989).

⁵National Council on Compensation Insurance, personal communication, July 26, 1992.

⁶William Custer, "Issues in Health Care Cost Management," *EBRI Issue Brief* no. 118 (Employee Benefit Research Institute, September 1991).

Legal disputes over these nonmedical benefits may influence the quality, quantity, timeliness, and cost of medical care under workers' compensation. Both the employer and employee typically hire experts to determine if the employee has a disabling condition, the degree of disability, and if the condition is work related. Expert evaluations add to medical costs and may delay disbursement of benefits, particularly if the evaluations diverge. Furthermore, as the definition of work-related injuries has broadened (i.e., to include injuries such as carpal tunnel syndrome and stress-related injuries), the litigious environment of workers' compensation claims has increased, complicating care, delaying recovery, and ultimately increasing medical costs. In addition, some analysts believe that health care providers are charging higher rates for workers' compensation claims because of the lack of cost management strategies used in these programs. One study indicates that the rates paid for back treatment under workers' compensation can be almost double those charged under Blue Cross for non-workers' compensation claims.⁷

Cost management strategies used by employer health plans have not been used as extensively to control workers' compensation medical costs. In some states, employers' ability to use these cost containment methods is limited by state law. Thirty-one states and the District of Columbia prohibit employer selection of medical providers, making it difficult to utilize managed care provider networks.^{8, 9} Furthermore, workers' compensation programs provide first-dollar coverage, thereby precluding the use of cost sharing through the use of premiums, deductibles, or coinsurance.

However, states are increasingly overturning these barriers by mandating cost containment strategies similar to those used in other health care programs. A study by

⁷Minnesota Department of Labor and Industry, Report to the Legislature on Health Care Costs and Cost Containment in Minnesota Worker's Compensation (St. Paul, MN: Minnesota Department of Labor and Industry, 1990).

⁸Workers' Compensation Research Institute, *Medical Cost Containment in Workers' Compensation, A National Inventory, 1991-1992* (Washington, DC: Workers' Compensation Research Institute, 1992).

⁹Nineteen states allow employers to select providers, including four jurisdictions where the employee selects from an employer list. Not included in the total are Arizona, which only allows employer selection of providers in limited instances (i.e., self-insured employers), and California, which lets the employee choose the treating provider by notifying the employer in writing before an accident occurs.

the Workers' Compensation Research Institute shows that, between July 1, 1990 and July 1, 1991, 16 of the 51 workers' compensation jurisdictions surveyed¹⁰ had added or were developing cost containment strategies.¹¹ The most common means states use to contain workers' compensation medical costs are mandates limiting provider choice. Forty states and the District of Columbia limit employees' ability to change health care providers, and 21 states limit employees' initial provider choices (table 2).

Other cost containment strategies include fee schedules, hospital charge regulations, utilization review (UR), and bill review. Twenty-seven states have set fee schedules listing maximum reimbursement levels for medical procedures. Twenty-two states require regulation of hospital charges, and an additional seven are developing regulations. Thirteen states and the District of Columbia mandate UR, requiring payers or exclusive state workers' compensation funds to review claims to determine if medical care was utilized properly for all worker's compensation claims or for those in which costs exceeded an established level. Thirteen states enforce their medical fee schedules through a bill review program. In these states, the workers' compensation agency or the state fund examines all medical bills to verify the charges.

¹⁰Includes the 50 states and the District of Columbia.

¹¹Workers' Compensation Research Institute, *Medical Cost Containment in Workers' Compensation, A National Inventory, 1991-1992* (Washington, DC: Workers' Compensation Research Institute, 1992).

Table 2
Cost Containment Mandates in the 51 Workers' Compensation Jurisdictions

Cost Containment Strategy	July 1990	July 1991
Limited Initial Provider Choice	21	21
Limited Provider Change	39	40
Medical Fee Schedule	26	27
Hospital Charge Regulation	17	22
Utilization Review	10	14
Bill Review	11	13

Source: Workers' Compensation Research Institute, *Medical Cost Containment in Workers' Compensation, A National Inventory, 1991-1992* (Washington, DC: Workers' Compensation Research Institute, 1992).

^aArizona lets self-insured employers select the provider; California lets the employee choose the treating provider by notifying the employer in writing before an accident occurs. In New Mexico, the employer/insurer can control provider choice during the 60 days following the injury or after that period.

State mandates related to workers' compensation implemented most frequently between July 1990 and July 1991 include mandates for added hospital charge regulation (five states), UR mandates (four states), and bill review mandates (two states).¹² Furthermore, 13 states encourage managed care delivery systems, which are new to workers' compensation. These states authorize workers' compensation insurers to contract with selected provider groups at discounted rates. In addition, some proposals would integrate employer health care benefit programs with workers' compensation to provide what is referred to as "24-hour coverage" in order to contain workers' compensation costs.

Although both states and employers are implementing cost management strategies for workers' compensation, workers' compensation medical costs are growing faster each year and continue to outpace the M-CPI. Because these costs continue to increase, it is likely that cost containment strategies will continue to be developed and implemented. However, adopting a strategy that solely minimizes medical costs in workers' compensation may be insufficient from a public policy standpoint. Emphasis must also be placed on the effectiveness, timeliness, and quality of medical care in order to facilitate the recipients' return to work, thereby reducing indemnity and vocational rehabilitation costs. Furthermore, the goals of workers' compensation medical care are different from those of employer-sponsored health care plans. Employer-sponsored health care plans are provided at the discretion of employers, in large part as a form of compensation to recruit and retain qualified workers. Workers' compensation is a social insurance program that focuses on reducing injury and lost productivity in the workplace. Concentrating on reducing workers' compensation medical costs without consideration of these goals may not be desirable.

—Sarah Snider and Celia Silverman, EBRI

◆ Americans Value Having Choice in Benefit Programs, According to Recent EBRI/Gallup Survey

Most Americans say having choice in the employee benefits offered by prospective employers would influ-

¹²*Ibid.*

ence their decision on whether or not to work for an employer, according to a recent public opinion survey conducted by EBRI and The Gallup Organization, Inc. Given the choice between two jobs with the same salary and benefit level, one that provides choice in selecting benefit options and one that does not, 40 percent of Americans who are employed or whose spouse is employed said the choice in benefits provided by the first employer would have a great deal of influence on their selection of employers, 44 percent said some influence, 12 percent said very little influence, and 4 percent said the choice in benefits would have no influence.

Working Americans most likely to say the choice in benefits would have either a great deal of influence on their selection of employers were those with incomes less than \$20,000 (53 percent), minorities (49 percent), and those with less than a 12th grade education (46 percent). Individuals most likely to say the choice in benefits would have very little influence on their job decision were those with incomes of \$75,000 and over (17 percent), post-graduates (17 percent), and males (14 percent).

The survey also showed that 61 percent of Americans with employer-sponsored benefits are satisfied with their benefit package, compared with 70 percent in a similar EBRI/Gallup survey conducted in 1991. In 1992, the higher the individuals' incomes the more likely they were to say they were satisfied with their existing benefit package—70 percent of individuals with incomes of \$75,000 and over were satisfied with their benefits, compared with 56 percent of those with incomes less than \$20,000.

In 1992, 13 percent of those with employer-sponsored benefits said they would rather have additional benefits and less cash, while 7 percent said they would rather have additional cash and fewer benefits. Seventeen percent said they would rather have the same level of benefits but a different mix.

Nearly one-half (46 percent) of workers with employer-sponsored benefits said their employer offers a flexible plan. About two-thirds (63 percent) of those who stated their employer did *not* offer a flexible benefits plan said they would prefer to have a flexible benefits plan. Among individuals who said they did not have flexible benefits, those most likely to say they would prefer to

have such benefits were individuals between the ages 18–34 (74 percent), minorities (69 percent), and those with incomes between \$20,000 and \$75,000 (66 percent).

Health insurance is clearly the most important program in benefit plans. When all those who are employed or whose spouse is employed were asked which three employee benefits they would most likely include in their benefit package if they were given a choice of benefits, 62 percent said they would select a health plan, 32 percent said they would select a pension plan (not including a 401(k) plan), followed by vacation (27 percent), 401(k) plan (24 percent), life insurance (21 percent), disability insurance (18 percent), cash above their regular salary (15 percent), health care reimbursement account (12 percent), dependent care assistance plan (8 percent), dependent care reimbursement account (6 percent), and some other benefit (5 percent).

When individuals with employer-sponsored benefits were asked if they would participate in a benefit program that allowed them to set aside money before taxes to pay for health or child care expenses, 73 percent said they would participate. In the 1991 survey, 70 percent of individuals with benefits expressed interest in participating in such a program. The average contribution individuals said they would make to the plan from their annual income was 7.4 percent in 1992 and 8.3 percent in 1991.

The 1992 survey on flexible benefits was conducted in May and is the thirty-sixth in a series of national public opinion surveys EBRI is undertaking on public attitudes toward economic security issues. The surveys are conducted monthly for EBRI by The Gallup Organization, Inc., which questions 1,000 Americans by telephone. The maximum expected error range at the 95 percent confidence level is ± 3.1 percent.

Copies of *Public Attitudes on Flexible Benefits, 1992* (G-36) and the 1991 survey (G-19) can be ordered from Kim Thorpe, (202) 775-6315, for the following prices: summary—\$75 each; full report—\$275 each; EBRI member prices: summary—\$25 each; full report—\$75 each.

—Carolyn Piucci, EBRI

◆ Washington Update

As we reported last month, much significant tax, pension, and health care legislation has remained pending as Congress prepares for its August recess. While Congress has moved forward on legislation relating to pension simplification, ERISA preemption, expiring tax provisions, health care reform, and family and medical leave, it has still not completed final action on any of these items as this issue went to press. The Internal Revenue Service (IRS) did announce further delays in the effective dates of the nondiscrimination rules.

Pensions—IRS announced August 7 that the effective date of the nondiscrimination rules will be delayed until the first day of plan years beginning on or after January 1, 1994, under a proposed rule (EE-6-92). The effective date for tax-exempt organizations is delayed until the first day of plan years beginning on or after January 1, 1996, and for governmental plans is delayed until the later of the first day of plan years beginning on or after January 1, 1996 or 90 days after the opening of the first legislative session beginning on or after January 1, 1996. The delay applies to regulations under sections 401(a)(4), 401(a)(5), 401(a)(17), 401(l), 410(b), 414(r), and 414(s). For governmental plans *only*, the delay also applies to sections 401(a)(26), 401(k), and 401(m).

Evelyn Petschek, deputy benefits tax counsel for the U.S. Department of Treasury, has stated that the department will soon issue proposed changes to the 401(a)(4) nondiscrimination regulations designed to increase the flexibility of the general test and to increase the stability of results under the test. In addition, the department plans to issue a model notice in the fall for employers to use in complying with new pension plan distribution requirements enacted under the unemployment compensation bill.

The Senate Finance Committee reported out July 29 its version of the House-passed Revenue Act of 1992 (H.R. 11)—a major urban relief tax package that also contains a number of benefit-related provisions, including pension simplification and tax extenders. The bill incorporates much of the pension simplification language included in the House version, as well as in H.R. 4210—a comprehensive tax bill that was ultimately vetoed by President Bush earlier this year (*Notes*, March 1992). Differences

between the two bills relate to their treatment of leased employee rules, minimum participation rules, uniform retirement age, vesting schedules for multiemployer plans, and minimum distribution rules. In addition, the Senate version includes provisions relating to IRAs, SEPs, and PRIME accounts that are not included in the House version. It also contains a number of technical corrections and clarifications to the new retirement plan withholding/rollover distribution rules. The full Senate is scheduled to begin debate on the bill the week of August 10. While the House/Senate conference is not expected before September, a tax bill is expected to be signed into law this year.

Meanwhile, Congress has been holding a number of hearings on the U.S. private pension system and on the PBGC. The Senate Labor and Human Resources Subcommittee on Labor held a hearing August 4 on the health of the U.S. private pension system. EBRI President Dallas Salisbury testified on the strength of the system. The House Ways and Means Subcommittee on Oversight conducted a hearing August 11 to review the financial condition of PBGC and to consider proposals for reducing the growth in federal contingent liabilities under the defined benefit pension program. The subcommittee will also examine continuing problems with the information systems used by PBGC to account for and collect premiums and to estimate its liability for future benefits. The Senate Finance Subcommittee on Private Retirement Plans and Oversight will hold a hearing on the PBGC September 25.

Tax Extenders— Also included in the Senate version of H.R. 11 are provisions to extend or make permanent several tax provisions that expired June 30, 1992. The bill would extend for 18 months the exclusions for employer-provided education assistance and group legal assistance as well as the 25 percent deduction for health insurance expenses for self-employed individuals (extended only for six months in the House version).

ERISA Preemption— The House Education and Labor Committee favorably reported out legislation July 30 (H.R. 1602) relating to ERISA preemption. The committee voted to adopt a substitute version of the bill, offered by Rep. Pat Williams (D-MT), that would establish new federal standards under ERISA relating to insurance claims procedures. The new standard would apply to all plans except collectively bargained plans that

have a dispute resolution procedure in place at the time of the bill's enactment. In addition, named fiduciaries of multiemployer plans would be exempt from liability for punitive and compensatory damages.

The substitute would require plans to adopt an accelerated review process for the approval or denial of claims, provide for an alternative dispute resolution process under ERISA, and expand damages available to participants or beneficiaries under ERISA (except for multiemployer plans that are self-administered and self-insured).

Additionally, the House passed legislation August 4 (H.R. 2782) that would exempt state prevailing wage, apprenticeship, and contribution collection laws from ERISA preemption.

Health Care Reform— Senate Democrats are working on a compromise health care reform package as a possible replacement for S. 1227 (*Notes*, June 1991) in an attempt to gain the support of all Democrats. Details of the plan's contents were not available at press time. Reportedly, however, the proposal includes a strict cost containment measure and a provision that differentiates between the types of health care benefits package small (less than 100 employees) and large employers would be required to offer to their employees.

Meanwhile, Governor Clinton (D-AR) laid out his preliminary plans for reforming the nation's health care system at the Democratic National Convention. According to campaign literature, his plan would institute a type of "play-or-pay" approach, establish a national health care spending cap, prohibit insurers from denying coverage to individuals with preexisting conditions, and create a core benefits package with guaranteed access for all Americans. The package can be expected to be significantly modified as time passes. It is expected to include an emphasis on mandated provisions, with less opportunity to opt out. It is also likely to contain market reforms such as Health Insurance Purchasing Cooperatives.

Separately, the U.S. Department of Health and Human Services (HHS) denied Oregon's Medicaid waiver request August 3 because of its potential conflict with the Americans with Disabilities Act (ADA). HHS Secretary Sullivan stated that Oregon's request could not be granted "until [its] proposal is altered to protect

persons with disabilities." HHS found fault in the development of the plan's "quality of life" rankings, noting, "[there is] considerable evidence that it was based...on the premise that the value of a life of a person with a disability is less than the value of a life of a person without a disability." Sullivan asked Oregon to address the ADA concerns and then resubmit the proposal.

Family Leave— Congress reported out August 5 a compromise version of the Family and Medical Leave Act of 1991. The Senate passed the bill August 11 and the House is expected to vote on it in time to send it to the President before the election. The legislation is similar to the version passed by the Senate last October. The legislation would require employers with 50 or more employees to grant unpaid leave to employees for the birth or adoption of a child or for the serious illness of the employee or employee's family member (child, spouse, or parent). The bill would restrict leave to employees who have worked at least 1,250 hours a year for the employer. In addition, an employer would be able to deny leave to an employee who is among the highest paid 10 percent of the employer's work force. He is expected to veto the bill.

Retiree Health— The Senate passed a comprehensive energy bill July 30 (H.R. 776) that includes a provision to provide new funding for the UMWA coal miners' retiree health fund. Under this provision, all companies that were party to labor agreements with the UMWA would be required to contribute to the payment of retiree health costs (regardless of their current relationship with the union). Additionally, up to \$220 million in pension funds, as well as interest on monies in the abandoned mine land reclamation fund, would be transferred to the union retiree health fund.

◆ New Publications

[*Note: To order publications from the U.S. Government Printing Office (GPO), call (202) 783-3238; to order congressional publications, call (202) 275-3030. To order U.S. General Accounting Office (GAO) publications, call (202) 275-6241.*]

Boudreau, John W. **EXTMOV: A Computer Spreadsheet Program for Analyzing Staffing Costs and Benefits**. \$5. ILR Press, Cornell University, Ithaca, NY 14853-3901, (607) 255-3061.

- Canan, Michael. **Qualified Retirement and Other Employee Benefit Plans: 1992 Edition.** \$60.50. West Publishing Company, 610 Opperman Drive, P.O. Box 64833, St. Paul, MN 55164-9752, (800) 328-9352.
- Center for Health Policy Studies. **Impact of Uncompensated Maternity and Infant Care Costs on Employers: Final Report.** \$10. Center for Health Policy Studies, 9700 Patuxent Drive, Suite 100, Columbia, MD 21046, (301) 596-7775.
- Chollet, Deborah J., John F. Newman, and Andrew T. Sumner. **The Corporate Cost of Poor Birth Outcomes.** \$10. Georgia State University, College of Business, RMI Research Center, P.O. Box 4036, Atlanta GA 30302-4036, (404) 651-4250.
- Coberly, Sally. **An Employer's Guide to Older Worker Employment and Retirement Transition Programs.** \$18. Washington Business Group on Health, Institute on Aging, 777 North Capitol St., NE, Suite 800, Washington, DC 20002, (202) 408-9320.
- Cook, Mary F. **The Human Resources Yearbook: 1992/1993 Edition.** \$79.95. Prentice Hall Inc., 200 Old Tappan Road, Old Tappan, NJ 07675, (515) 284-6751.
- Families USA. **The Medicare Buy-in: Still a Government Secret.** \$5. Families USA, 1334 G St., NW, Washington, DC 20005, (202) 628-3030.
- Ghilarducci, Teresa. **Labor's Capital: The Economics and Politics of Private Pensions.** \$35. MIT Press, 55 Hayward St., Cambridge, MA 02142, (617) 253-5643.
- Hager, J. Lawrence, et al. **Flex Plan Handbook.** \$303. Thompson Publishing Group, 1725 K St., NW, Suite 200, Washington, DC 20006, (800) 677-3789.
- Hyclak, Thomas, and Geraint Johnes. **Wage Flexibility and Unemployment Dynamics in Regional Labor Markets.** \$11. W.E. Upjohn Institute for Employment Research, 300 S. Westnedge Ave., Kalamazoo, MI 49007-4686, (616) 343-5541.
- Jehle, Faustin F. **The Complete & Easy Guide to Social Security & Medicare.** 1992 edition. \$13.45. Williamson Publishing Company, Church Hill Road, P.O. Box 185, Charlotte, VT 05445, (802) 425-2102.
- Jones, Lawrence K., ed. **The Encyclopedia of Career Change and Work Issues.** \$67.50. Oryx Press, 4041 North Central at Indian School Road, Phoenix, AZ 85012, (602) 265-2651.
- Kushner, Mike, ed. **ERISA Regulations: Including Final, Temporary, and Proposed Rulemaking from DOL, PBGC, IRS, SEC, and Other Agencies, Current Through November 1, 1991.** \$96. BNA Books, P.O. Box 6036, Rockville, MD 20850-9914, (800) 372-1033.
- McKenzie, Richard B. **The Retreat of the Elderly Welfare State.** One copy free; additional copies \$2. Center for the Study of American Business, Washington University, Campus Box 1208, One Brookings Drive, St. Louis, MO 63130-4899, (314) 935-5630.
- NFIB Foundation. **Rescuing American Health Care: Market Rx's.** \$15. National Federation of Independent Business Foundation, 600 Maryland Ave, SW, Suite 700, Washington, DC 20024, (202) 554-9000.
- Robbins, Gary. **Capital, Taxes and Growth.** \$10. National Center for Policy Analysis, 12655 North Central Expressway, Suite 720, Dallas, TX 75243, (214) 386-6272.
- Rosen, Robert H. **The Healthy Company: Eight Strategies to Develop People, Productivity, and Profits.** \$22.95. Jeremy P. Tarcher, Inc., 5858 Wilshire Blvd., Suite 200, Los Angeles, CA 90036, (213) 935-9980.
- Rosenbloom, Jerry S. **The Handbook of Employee Benefits: Design, Funding and Administration.** Third edition. \$75. Business One Irwin, 1818 Ridge Road, Homewood, IL 60430, (708) 798-6000.
- Sack, Steven Mitchell. **The Employee Rights Handbook: Answers to Legal Questions—From Interview to Pink Slip.** \$24.95. Facts on File, Inc., 460 Park Avenue South, New York, NY 10016-7382, (212) 683-2244.
- U.S. Congress. House Committee on Energy and Commerce. **Health Care Fraud and Waste.** Order from GPO.
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