Tax Reform Continues to Move Forward

The major tax reform proposals being considered share major common elements. These include some form of taxation of health insurance, imposition of nondiscrimination rules on all benefits, limitations on 401(k) plans and greater taxes and restrictions on the use of lump-sum distributions.

"Even if we do tax reform with small employee benefit changes, there will still be a push to totally revamp ERISA [Employee Retirement Income Security Act]. You're kidding yourselves if you think that there won't be any change in ERISA for a decade—there's too much money in employee benefits not to touch it."

Anne Moran, counsel to the Senate Finance Committee, added: "The main reason employee benefits were hit under tax reform is because those plans receive lots of federal tax dollars. When there's that much money in pension plans, no matter how noble the purpose, people look toward it."

IRA/Keogh Assets Surpass $200 Billion

Individual retirement account (IRA) and Keogh plan assets rose by $60.2 billion between June 30, 1984, and June 30, 1985: Total assets in June 1985 were $202.4 billion, up from $142.2 billion in June 1984—a 42.3 percent increase. Total dollars contributed to these plans have continued to increase since 1981, while the annual percentage increase has remained relatively stable.

IRA and Keogh assets are equivalent to nearly 60 percent of assets held in state and local government pension plans ($346.9 billion) and 22 percent of private plan assets ($935.5 billion) held at year-end 1984. IRA and Keogh assets are 72 percent as large as assets held in private-sector defined contribution plans ($280.7 billion).

"Even if Congress fails to approve a tax reform measure, regulatory legislation—such as rules governing 401(k)s—is always a possibility."

There's anything to do. It's really up to the House. If they give it to us, we'll pass it."
Market shares of IRA and Keogh funds held among financial institutions changed little during the 12 months prior to June 30, 1985. Four of the seven assetholding institutions experienced a decrease in market share. While the decreases are not large, savings and loans registered the largest decline, with a 1.7-percent drop in market share, and commercial banks lost 0.6 percent of the market. Mutual savings banks reported a decline of nearly 1 percent of market share, while life insurance companies lost just over 0.5 percent of market share.

Mutual funds registered a 2-percent gain in market share. Credit unions gained 1 percent of the market, and self-directed accounts (SDAs) at stock brokerages also gained 1 percent of the market.

### Two States Respond to Rising Health Care Costs

With rapid increases in health care costs during the past several years, legislation proposing various solutions has appeared in several states, as well as at the federal level. But drafting reforms that are accepted by both health care providers and those who pay for their services is a challenge that often results in health care cost containment programs that have little in common beyond the name.

Over 30 states have passed laws affecting the availability and design of health care coverage. As of 1984, 11 states had some form of a mandatory rate-setting commission, and four states—Maryland, Massachusetts, New Jersey and New York—set all payers' rates. (Two of those states—New York and Massachusetts—have decided not to renew the federal waivers that allowed them to set Medicare rates.)

Two states that have passed or revised laws concerning health care costs during the past year are Maryland and Illinois. Illinois' new law initially called for hospital rate caps, but was revised so that its thrust was competitive, rather than...
regulatory. Maryland has taken a regulatory approach.

**Maryland's Regulatory Approach**

Earlier this year, Maryland passed a package of bills aimed at strengthening regulations imposed in the 1970s. And while Maryland's new cost containment program imposes further regulations on health care providers, it is still considered to be a voluntary program, although virtually every nonfederal hospital in the state participates in the system.

Reasons for such widespread participation in the Maryland program can be traced to the financial difficulties experienced by many of the state's hospitals during the last decade. Such difficulties were partially the result of treating large numbers of indigent patients, so when the state legislature approved a measure guaranteeing that hospitals would receive payment for their services, hospitals agreed to participate in the program.

**Maryland Allowed to Set Medicaid, Medicare Rates**—Maryland was granted a waiver from the federal government, which allowed the state to set hospital rates for Medicaid and Medicare. The waiver, combined with the new law, enabled the costs of treating charity and had debt cases to be absorbed by all payers, since the State Health Resources Planning Commission was allowed to factor such costs into the rates.

The program was successful until recently, when the combination of federal budget cuts and excess hospital capacity led Maryland Governor Harry Hughes to appoint a task force on health care cost containment. Charged with exploring ways to further trim health care costs, the panel made 36 recommendations that were incorporated into a package of bills and introduced into both houses of the Maryland General Assembly.

While Maryland's new program differs substantially from the original proposals, the package adopted this past April includes a moratorium on "certificates of need" issued to hospitals for expensive equipment purchases or building projects, regulations covering the use of major medical equipment by both doctors and hospitals, establishment of utilization review programs, incentives for hospitals to reduce excess capacity, preferred provider regulation and stronger regulatory authority for two state commissions.

One of the more controversial bills approved by the General Assembly required a suspension of the certificate-of-need process for hospitals until October 1, 1985. The moratorium was intended to give the state time to develop a plan to reduce excess hospital bed capacity and to streamline the regulatory process governing major expenditures by hospitals. Exceptions to the moratorium include equipment replacement, hospitals that are the sole community provider of services, services designed to enhance efficiency and not directly related to patient care and hospitals reducing their capacity.

**New Regulations Apply to Hospitals, Physicians for Equipment Purchase**—Since the moratorium was lifted on October 1, the certificates of need will still apply to certain projects, such as hospital expansion. But the legislature repealed certificate of need requirements for purchases of major medical equipment by hospitals. Instead, the Maryland General Assembly approved a bill that requires both doctors and hospitals to comply with regulations governing utilization, safety and "reasonableness of charges" of medical equipment valued in excess of $6,000.

Hospitals in Maryland are also now required to implement utilization review programs, including predmission review, second opinions on nonemergency surgery, continued stay review and discharge planning review. Utilization review by hospitals is not required for a patient whose insurer has a utilization review program that meets state standards. But hospitals are encouraged to arrange for independent reviews; previously, many reviews had been done by hospital staff.

**Fourteen Hospitals Recommended for Closure**—Another measure approved allows the Secretary of Health and Mental Hygiene to partially or totally revoke the license of a hospital upon petition from the State Health Resources Planning Commission and the State Health Services Cost Review Commission. As a result, 14 Maryland hospitals are currently scheduled for closure at the recommendation of a study commissioned by the state. But before licenses can be revoked, the state must hold public hearings and prove that all efforts have been made to encourage hospitals to become more efficient, reduce excess capacity, merge or consolidate.

A bond program to refinance public bonds of hospitals that have been closed or had their licenses revoked is also established by the legislation. The program refines such bonds by assessing a fee on remaining hospitals, which is to be included in the rates charged to patients.

In addition, the new law allows hospital privileges to be granted to physicians who have lost privileges or a position because of a merger or hospital closing and allows fees to be assessed to establish retraining programs for hospital employees affected in a similar manner. The State Health Resources Planning Commission is required to develop a plan to guide hospitals in reducing excess capacity and requires that future plans give priority to excess capacity to other uses, such as alcohol or drug rehabilitation programs.

**Incentives for Hospitals to Reduce Size**—Incentives for hospitals to reduce excess capacity include favorable rate adjustments and exemptions from the certificate-of-need process. Exemptions from antitrust statutes are also granted for mergers, consolidations and joint-ownership of major medical equipment.

**Preferred Providers**—Maryland's new law prevents preferred provider arrangements from including the costs of medical education, uncompensated care, undergraduate nursing education and
Illinois Takes Competitive Approach

Illinois last year passed the Health Finance Reform Act. Although the legislation initially called for hospital rate caps, the proposal was changed so that the thrust of the law was competitive, rather than regulatory. The law requires the state to negotiate competitive contracts with hospitals to provide inpatient services to the medically indigent and to establish a comprehensive data base containing price and other financial information from hospitals. This information can then be used to determine the best cost-effective care available.

PPOs Allowed—Just recently, Illinois Governor James Thompson approved legislation to allow insurance companies and employers to negotiate "preferred provider organization" contracts (PPOs) with doctors as well as hospitals and other health care providers. The new law is expected to result in further savings for both Illinois employers and employees.

As with Maryland’s legislation, Illinois’ Health Finance Reform Act was initiated in 1983, when the state’s health care price tag became enough of a concern that the question of legislative remedy changed from “if” to “when.” Strong opposition from the state’s health care providers blocked proposals favoring a government controlled and regulated system from passing the General Assembly. Ultimately, a task force appointed by the Illinois State Chamber of Commerce drafted many of the elements that were incorporated into the law.

Cost Containment Council Created—The result was the establishment of the Illinois Health Care Cost Containment Council in the fall of 1984. The group studies, recommends and implements measures to control costs and encourages innovative methods of financing health care. Its goal is to limit increases in the cost of health care to no more than the rate of inflation in the general economy.

Law Requires Hospitals to Make Prices Available—As a first step in keeping health care costs under control, the new law requires that nearly all Illinois hospitals submit to the council various financial information, such as total assets, revenues, liabilities, Medicare and Medicaid data, admissions, discharges, bad debts and charity cases. In addition, hospitals must provide the council with a list of rates charged for rooms and services, such as chest x-rays and EKGs (electrocardiograms).

The council also monitors the extent to which hospitals individually and as a group limit their price increases to the general inflation rate. Certain considerations are noted by the council, such as the hospital’s role, the quality of care provided, the effectiveness of capital improvement planning, the approval process, financial hardship of hospitals serving the poor and a reduction of cost shifting.

After hospital financial information and patient charge data are collected and analyzed, they are distributed within certain confidentiality limitations to providers, patients, third-party payers and the public. This is the first time hospitals in Illinois are making such information available to consumers.

Prices May Vary Substantially—Published information shows, for example, that prices for rooms may vary by as much as $60 per day for hospitals in the same city, and operating room charges vary by more than $150 for the first 15 minutes of service. The report warns, however, that "prices reflect both those services which you are actually using as well as services necessary to maintain the hospital’s overall operation, such as emergency services." In conjunction with the reporting system, the law established a Health Care Consumer Adviser to assist consumers with cost disputes.

Besides making prices for various services available to consumers, the new law allows the Illinois Department of Public Aid to contract in advance for services for the poor, and sets criteria when negotiating contracts. In addition, the provision requires that hospitals securing such contracts must grant admitting and clinical privileges to all practitioners who meet hospital standards. This method is intended to reduce the amount of cost shifting to private payers by allowing Medicaid patients to be treated by their own physicians. Transfers of Medicaid patients to hospitals that do not accept predetermined fees for services as payment in full are expected to be reduced.

The uniform billing system for Medicare patients, which is the key to the mandatory uniform price reporting system, was adopted for all patient charges statewide. Information collected by the council is used to determine the actual average charges for all major diagnoses, the length of stay and the costs of various hospital services. Currently, all patient records are used to establish comparative price information, which is necessary for the state's competitive approach.

The new law grants employers and insurers the right to require that hospitals cooperate in implementing concurrent utilization review programs and allows the benefits to be discontinued, after notifying the patient, if further medical services are not justified. Costs of the
utilization review are to be paid by the party ordering the review, such as employers or insurance companies.

Several reports on health care cost trends and recommendations for preventing excessive price increases have already been prepared by the council for the General Assembly; hospitals are permitted to verify the accuracy of data used in reports before they are published.

Success of Illinois Law Depends on Business—Meanwhile, the success of Illinois' new law depends directly on the involvement of business. As the March 1, 1985 report by the council to the general assembly noted: "The regulatory approach to containing hospital price increases addresses only a symptom of rising health care costs. The council's agenda will focus on more effective competition by promoting an understanding and ability to address the underlying causes that affect health care costs." The Illinois State Chamber of Commerce, which was instrumental in getting the legislation drafted and passed by the general assembly, is currently assisting businesses across the state in setting up their own cost containment programs.

As health care prices continue to rise, legislation will be proposed at both the state and federal levels in an effort to control costs. In addition, many employers have begun to implement their own forms of controlling the amount of money they pay for their employees' health care.

Although Maryland and Illinois have embarked on cost containment programs that are very different, each has made an attempt to reinforce efforts made by employers to curtail expenditures for health services.

**Health Care Costs: One Company's Experience**

At a 1985 employee benefits conference, Eugene G. Michael, health care manager of the Mobil Oil Corporation, shared some of Mobil's recent experience in health care cost management. The following piece is an adaptation of his remarks.

Mobil got off to an early start in the 1970s in its efforts to stem the rise in health care costs. We became self-insured, redesigned our medical plan, installed several cost containment features, and also established nine geographic areas for determining monthly premiums. I'll discuss these efforts briefly, and I will focus on one recent experience that holds some significance for all of us.

We seem to be witnessing some distinct changes in the way medicine is practiced in this country. Although much of this change is generated by medical research and new technology, a great deal of it occurs as a result of external pressures from public- and private-sector initiatives to manage health care costs more effectively. We need to understand these developments, and we need to communicate them to employees.

The change in health benefits is a prime example. Not long ago, we were concerned with how to improve coverage and keep pace with our competitors. Today, companies are recouping from first-dollar coverage, asking employees to share more of the costs and attending conferences, in hopes of finding more effective ways to control costs.

A few short years ago, we would not have dreamed of interfering with the practice of medicine. Today, we are creating financial incentives to get people to question their physician's opinion and to take a more active part in their health care. We are also trying to get doctors to think twice about whether to recommend surgery or a more conservative medical regimen; whether to hospitalize patients or treat them as outpatients; whether to order tests and x-rays or not; and to decide on an appropriate length of hospital stay.

As a result of these incentives, we hear concerns that efforts to reduce costs may jeopardize the quality of care. Some have raised the possibility of "rationing" health care. They imply that we may be forced to make the inevitable life-and-death decisions and, in effect, play God.

**Mobil's Early Efforts**

In 1977, Mobil introduced several plan design features to keep medical plan costs under control: second opinions on nonemergency surgery, 100 percent reimbursement of ambulatory surgery (instead of the normal 80 percent), outpatient preadmission testing, home health care, extended care and alcohol and drug abuse rehabilitation facilities. These were voluntary programs, offered with 100 percent coverage and no deductibles to encourage less costly alternatives to expensive surgery and inpatient hospital care. We also set a maximum contribution to the medical plan premium on a company-wide basis. The actual premium is based on experience in each of the nine geographic areas that Mobil established.

We have communicated with employees at least three times each year, keeping them posted on (1) changes in the company contribution, (2) how their plan costs were doing and (3) whether or not they would receive a bonus, or have to contribute the monthly premium.

With assistance from Metropolitan Life Insurance Company, our claims administrator, we kept track of the utilization and savings from the cost containment features. Although we saved over $1 million in a recent two-year period, we find that use of these features tends to be low, primarily because they are voluntary. Early efforts have kept Mobil's per-employee costs low compared with other major oil companies, but our costs have been increasing at an unacceptable rate.

We now believe it is critical to change the behavior of physicians and hospitals, to intervene at the source where decisions are made to use surgery, inpatient care, laboratory procedures, etc. We believe that information is the key to this new approach.
Provider Negotiations

One of our recent projects involves a moderate-size community in which Mobil has significant representation. We contracted with Corporate Health Strategies (CHS), a data consulting firm, to analyze hospital use patterns and charges for Mobil employees and dependents (about 9,800 covered lives) over a period of 18 months in 1982 and 1983. CHS used its diagnosis-related group (DRG) technology, in which data is adjusted for age, sex and severity of illness, and CHS compared Mobil's utilization to Southern regional norms in the U.S. The results were startling. We found high rates of admissions for surgical procedures usually performed on an ambulatory basis; high percentages of short-stay diagnostic admissions that could have been handled safely out of the hospital; a problem of weekend admissions and preoperative length of stay; high ancillary charges and a rate of tonsillectomies that was more than twice the national average. All this accounted for 13.5 percent of nearly $6 million in total charges.

We decided we had to do something about this, so we formulated a medical action plan to bring us face to face with the medical providers in that community. A joint Mobil-Metropolitan team of medical and benefits personnel was formed. Three major hospitals were contacted, as well as the medical society and a group of ear, nose and throat specialists.

Our intent was to share our findings with each hospital and discuss voluntary methods of controlling utilization. We provided handouts with data specific to each provider; we discussed changes in local medical practice, especially in the past year; and we asked for specific action to reduce unnecessary hospital and surgical care. We also indicated that Mobil would be monitoring performance over the next six months.

Discussions were lively and productive. There was no attempt to deny the data. Initially, there were expressions of concern about legal issues and complaints about employees "demanding" hospital and surgical care. In one case, a physician who chaired a hospital utilization review committee lectured us, suggesting that we [the employer] had nerve expecting physicians to control something that we had caused with our generous benefit plans and first-dollar coverage, which encourage employees to demand more and more. We agreed with him and let him know that things were changing, that we were doing our part and hoped he would do his part. By the end of the meeting, this physician told us that he knew which of his peers were contributing to the problem and that this would give him the leverage he needed to deal with them.

This was the first time many of these providers had received such specific feedback on their performance. The hospitals have agreed to review the medical necessity of admissions within 24 hours (one hospital even offered to review proposed surgery prior to admission), to perform quality assurance studies, and also to use physician education programs in support of our objectives. We came away with voluntary commitments from the three hospitals to reduce the "excess" care by 75 percent immediately and by 100 percent as soon as possible.

Medical Practice Variations

The following experiences confirm what medical researchers are telling us about variations in medical practice and hospital use.

Consider the findings of two studies reported in 1982 and 1984 on small area variations in New England by Dr. John Wennberg of Dartmouth Medical School. The rates of three of the most common surgical procedures—hysterectomy, tonsillectomy and prostate surgery—varied by as much as six times from one community to the next. The overall rate of surgery varied more than two times and correlated with the number of surgeons in each area and the number of hospital beds per capita. Ninety percent of all medical and surgical admissions in 30 areas of Maine had high or very high variations. The Rand Corporation's health insurance experiment found that hospital admissions in health maintenance organizations (HMOs) were about 40 percent less than fee-for-service groups, even when patients were randomly assigned to either HMOs or a fee-for-service physician. Also, at the Mayo Clinic in Minnesota, hospital days per 1,000 are 38 percent less than the national average.

Consider the comments of Dr. David M. Eddy, from Duke University, who addressed the Washington Business Group on Health last year on the inexactitude of medical science. For most medical procedures, he said, "we do not know the effects on benefits, cost, and risks, and we do not have quantifiable estimates of which procedures are the most cost-effective." He went on to say that the average medical practitioner "does not know the effect on mortality of any given procedure."

If good medical practice varies this widely without correlation to outcomes, then it appears that we have an opportunity to encourage a more conservative style of practice, and to seek out more efficient practitioners, especially for preferred provider networks. In this new and changing environment, our challenge is to find more effective ways of communicating this information to employees and to deal with concerns about safety and quality, as well as cost.

Legislation and Litigation

Employee Benefit Tax Reform Resolutions Introduced

Ever since the specifics of President Reagan's tax reform proposal became known, resolutions urging the inclusion or exclusion of certain aspects of his initial plan and its successors have surfaced in Congress. None, however, appears to have as much support as H. Res. 268, introduced September 20 by Rep. Augustus Hawkins (D-CA), chairman of the House Education and Labor Committee.
Hawkins' resolution states "that it is the sense of the House of Representatives that employee benefits not be taxed." The measure currently has more than 240 cosponsors.

A House concurrent resolution limited to 401(k) plans has also been introduced. Sponsored by Rep. Frederick Boucher (D-VA), H.C.R. 197 states "that it is the sense of Congress that 401(k) retirement savings plans should be preserved for all organizations and should remain structured to allow widespread participation." Boucher's measure currently has 21 cosponsors.

Concurrent resolutions are used to express facts, principles, opinions and purposes affecting the two houses of Congress. Upon approval by both houses, they are published in the Statutes at Large. Simple resolutions, such as H. Res. 268, are considered only by the body in which they were introduced, and upon adoption, are published in the Congressional Record.

Ways and Means Subcommittee Proposes to Take Social Security Out of Budget

The House Ways and Means Social Security Subcommittee September 19 approved a proposal to remove Social Security Old Age and Survivors and Disability Insurance (OASDI) from the federal budget in fiscal year 1987, which began October 1.

The committee plan, based on a bill sponsored by Reps. J.J. Pickle (D-TX), Dan Rostenkowski (D-IL), and B. Archer (R-TX), would create an independent agency to administer OASDI and the Supplemental Security Income (SSI) program. The committee does not have jurisdiction over Medicare, but Rep. Fortney H. "Pete" Stark (D-CA), chairman of the Ways and Means Health Subcommittee, is expected to call for the removal of that program as well from the budget process.

Sen. John Heinz (R-PA), chairman of the Senate Special Committee on Aging and a member of the Senate Finance Committee, has introduced legislation similar to the House proposal. In addition, Heinz convinced his colleagues to order the Budget and Finance Committees to draft new rules and legislation by early November to assure that Social Security cuts can no longer be used to reduce federal budget deficits.

Since 1967, Social Security trust funds have been included in the unified budget. Any surplus in Social Security revenues over program spending has resulted in the appearance of a reduction in the federal deficit. The reduction is misleading, however, since Social Security revenues can only be spent for Social Security programs.

Currently, the Social Security Administration is a part of the Department of Health and Human Services (HHS) and administers the Social Security program, the Supplemental Security Income program, the Aid to Families with Dependent Children (AFDC) program and several smaller social welfare programs. The bill would establish an independent agency headed by a three-member, bipartisan board, appointed by the president with the consent of the Senate. The agency would have the responsibility for administering the Social Security and SSI programs. Other programs would remain under HHS jurisdiction.

Former HHS Secretary Margaret Heckler voiced her opposition to the proposal in a September 18 letter to Rep. Archer, ranking minority member on the Ways and Means Committee. She claimed that the "divestiture of the Social Security Administration from the executive branch would break up an integrated system of service delivery for income maintenance, human service and health programs that would create enormous problems for beneficiaries and the administrators who serve them."

Despite her opposition, the Social Security Subcommittee sent the legislation to Ways and Means for further action.

National Retirement Policy

Although our present retirement system is working fairly well, there is room for improvement, witnesses told the House Ways and Means Subcommittees on Social Security and Oversight September 5 and 6.

The hearings, the second in a series on retirement income policy, were intended to address the questions of: What is retirement? What are the major sources of retirement income today? How can we define "adequate" retirement income security? What role does federal tax policy play? Since, however, the hearing was less than a week after the administration announced its new decision to again abolish 401(k) plans, much of the testimony centered on the value and use of 401(k) programs.

EBRI President Dallas Salisbury was the first to testify and noted that while employer-provided pensions currently provide benefit accruals to over 70 percent of full-time workers, nearly 68 percent of all noncovered employees work for firms with fewer than 100 employees. That, Salisbury said, is where Congress should focus its attention.

Salisbury pointed out that many small firms do not have the finances and expertise to offer defined benefit plans. The 401(k) may be their only alternative in providing their workers with retirement benefits. Even larger companies are turning more frequently to defined contribution plans, Salisbury told the panel. This, he said, is because of the new types of defined contribution plans that Congress has made available to employers, as well as the effect of the economy on employers' ability to budget plan costs from year to year.

Other witnesses suggested that the changing trends in the work force have resulted in a shift from defined benefit plans toward defined contribution plans. James Short, vice president of U.S. Steel's benefits administration and representing the ERISA Industry Committee (ERIC) told the panel that,
historically, the defined benefit plan was a reward for long service. Over time, that service period has been shortened to about 10 years. "Employers are going to find it advantageous to use defined contribution plans more and defined benefit plans less," Short said.

Short also explained that one of the advantages that 401(k) plans have over individual retirement accounts (IRAs) is the payroll deduction process. If employees are given the money, rather than having it deducted from their salaries, they are not as inclined to save it to purchase IRAs, Short said.

Rep. Beryl Anthony, Jr. (D-AR) noted the apparent success of 401(k) programs, and commented on the Treasury Department’s reasoning for the elimination of 401(k)s. "If I understand their reasoning, they basically said 401(k)s have been too successful and forced too many people to save. Therefore, it is costing Treasury too much money and therefore we have got to stop them from saving." It was sort of like the dog chasing its tail in the street. It did not make any sense to me at all," Anthony asked witnesses to address the issue of availability of 401(k) programs.

Salisbury responded, saying that according to a 1983 EBRI survey, "of those earning between $5,000 and $10,000 a year, 8 percent chose to put money into an individual retirement account. In the case where their employer offered a 401(k) program, 21 percent of those earning $5,000 to $10,000 a year used the 401(k)."

"Approximately 19 million employees are eligible for 401(k)s because their employers have provided them, and 50 percent of those employees are choosing to participate in the 401(k) program," Salisbury said.

G. David Hurd, chairman of the Association of Private Pension and Welfare Plans (APPWP), pointed out that "these plans have not been around for a long time. Only recently, government rules have become clear enough that employers felt safe in adopting a program, and the adoption of 401(k) programs are spreading like wildfire throughout the country."

Rep. Barbara Kennelly (D-CT) asked witnesses whether the former $8,000 cap that the second Treasury tax proposal placed on 401(k)s would be preferable to total elimination of the plan. Hurd answered that while an $8,000 cap would not be a mortal wound to the viability of the concept, dollar limits have a tendency to weaken benefits for executives, which weakens benefits for rank-and-file employees.

Witnesses also urged Congress to avoid frequent changes in laws affecting retirement programs and to carefully study proposed changes. Rep. Bill Frenzel (R-MN) told the witnesses that he agreed Congress should not "lose sight of the goals" when considering retirement benefits and tax reform. He also noted that Congress’ "situation is further complicated by the fact that jurisdiction is split between a number of committees, and between the House and the Senate."

Lawrence Smedley, associate director of the AFL-CIO Department of Occupational Safety, Health and Social Security, told the panel that "it is essential for Congress to develop a clear and consistent national retirement income policy. Too often, tax considerations have been the primary basis for pension policy."

Smedley also addressed the need for reform of the private pension system, such as preventing employers from diverting pension fund assets and from dumping unfunded liabilities onto the Pension Benefit Guaranty Corporation. He also proposed removing the Social Security program from the budget and introducing "new retirement income security."

"Since most Americans rely heavily on Social Security, the United Auto Workers (UAW) believes that more emphasis should be placed on making benefits under the program sufficient so that retirees can live in dignity, rather than on the brink of poverty," William Hoffman, the director of UAW’s Social Security Department of the International Union, told the committee. Hoffman also urged reform of the single-employer pension plan termination program, and like the AFL-CIO, voiced concern over IRAs and 401(k) plans. Cost-of-living adjustments should be preserved, Hoffman said.

"Overall, the current body of tax code provisions are achieving their social goals," Harry Smith of Sun Company told the group. He suggested that benefits be viewed in two tiers—basic benefits that fulfill basic needs and newer forms of benefits, which can be used to pay inflation protection. Smith forecast a return by both employees and employers to basic benefits and said that if tax incentives must be changed, he would not disagree with changes in some of the benefits that aren’t absolutely necessary.

Smith warned, however, that the tax incentives supporting the basic core of retirement and welfare plan benefits should not be undercut. If such benefits are cut, he said, "then tax reform will end up hurting American workers, retirees and their families—instead of helping them."

New Retirement Income Security Bill Introduced

The third major piece of legislation in the 99th Congress dealing with the retirement income system was recently introduced. The Retirement Income Policy Act, sponsored by Sen. John Heinz (R-PA) and Rep. William Clay (D-MO), follows the lead taken by the Economic Equity Act and the Retirement Universal Security Arrangements
Act (Retirement-USA) earlier this year. (See May/June and July/August issues of Employee Benefit Notes for descriptions of these bills.)

The Retirement Income Policy Act appears more broad in its intent than the other two bills. It would make new distinctions between qualified plans, separating retirement plans and nonretirement (capital accumulation) plans. It would substitute five-year cliff vesting for the current vesting options and would limit the extent to which a plan may be integrated with Social Security. Plans would have to cover 100 percent of all employees (except those subject to collective bargaining agreements and those who do not meet minimum participation standards). And finally, contribution limits for defined benefit plans would be lowered to the lesser of 100 percent of compensation or 200 percent of the Social Security taxable wage base and for defined contribution plans, the lesser of 20 percent of compensation or 50 percent of the Social Security taxable wage base. Special 401(k) limits would be set at 25 percent of the Social Security taxable wage base.

Retirement plans would be defined as plans which pay benefits in a retirement income form (no lump-sum benefits before age 59 1/2), while nonretirement plans may pay benefits in any form at any time without penalty. Employers would not be able to institute a nonretirement plan if they did not have a "meaningful" retirement plan. (A meaningful benefit as defined in the draft bill is an accrued benefit equal to at least 0.5 percent of compensation per year of service for a defined benefit plan or an employer contribution of no less than 3 percent of compensation per year for a defined contribution plan.) If an employer wants to continue its practice of providing lump sums upon separation from service, however, the plan must rollover the amount directly to an individual retirement account.

In a memo circulated to pension experts and others interested in pension issues asking for comment on the draft legislation, Sen. Hinch and Rep. Clay stated that their goal is to enhance retirement security by broadening retirement benefit delivery, strengthening support for the present system of employer-sponsored pensions, and simplifying the rules and administration for pension plans. Although the impact of their legislation and ability of it to meet their goals is not definitively known at this time, some provisions have been analyzed.

The concept of five-year vesting has been discussed prior to this legislation. Rep. Geraldine Ferraro (D-NY) supported more liberal vesting standards in 1984 because "many industries, particularly high tech industries, encourage workers to change employment every few years." Some fear, however, that changes in ERISA vesting standards would produce few additional benefits at considerable additional cost, causing some plan sponsors to terminate their plans. EBRI research indicates that a move to five-year vesting in 1985 would have led to an additional 1.9 million vested pension-plan participants at an increased cost of between 2 and 7 percent of current plan costs.

Expanding plan coverage to meet new nondiscrimination standards might affect approximately the same number of individuals. EBRI tabulations of the May 1983 Current Population Survey sponsored by EBRI and the Department of Health and Human Services indicate that an additional 1.8 million workers would become included in their employer pension plan under 100 percent coverage.

Federal Worker Retirement Plan Revised

Sens. William Roth (R-DE) and Ted Stevens (R-AK) have announced a revised version of their retirement plan for federal employees.

S. 1527, as amended early in October, would allow federal employees hired after January 1, 1984 and postal workers to pick from two retirement plans. The first option would be identical to the plan Roth/Stevens introduced earlier this year. That plan would combine a basic mandatory defined benefit plan with an optional savings plan, along with the required Social Security coverage. Participants in the savings plan would be allowed to contribute, on a pre-tax basis, up to 10 percent of their pay with the government contributing $50 for every dollar up to a maximum of 5 percent.

The second option would also include a mandatory defined benefit plan but with larger government contributions. It would, however, reduce to 6 percent the maximum amount that a participant could contribute to the savings plan and reduce the maximum government matching contribution to 3 percent. In addition, the worker would have to contribute 1.3 percent of salary toward the defined benefit plan, whereas he would contribute nothing if they elected the first option.

As a result of the 1983 Social Security Amendments, federal employees hired after January 1, 1984 contribute to Social Security and make small payments into the current civil service retirement system. Workers hired before January 1, 1984 contribute 7 percent of their salary to the current civil service system and pay only for their Medicare coverage. They are not covered under Social Security. Unless a new plan is in place before the start of next year—Congress' self-imposed deadline—new federal workers would be required to make the full 7 percent contributions to the civil service plan in addition to Social Security payments.

Under any new plan, workers hired before January 1, 1984 would have the option to join the new plan or stay in the current civil service program. In the revised Stevens/Roth plan, these workers would thus have three retirement plan options.

Federal and postal unions objected to the original Roth/Stevens plan because employees would have to work until age 62 to get unreduced benefits. Currently, an employee can retire at age 55 with 30 years of service on about 53 percent of his original salary. The revised Stevens/Roth plan would allow unreduced benefits at 55 provided employees contribute 1.3 percent of salary to the defined benefit plan.
Reporting Requirements for State and Local Pension Plans

State and local governments would have to comply with standards similar to those established by ERISA under Public Employee Pension Plan Reporting and Accountability Act (PEPPRA) legislation recently introduced into Congress.

H.R. 3126 by Rep. William Clay (D-MO) and H.R. 3127 by Rep. Marge Roukema (R-NJ) are similar to PEPPRA legislation introduced last year which would require minimum reporting, disclosure and fiduciary standards for state and local government pension plans. The bills would exempt from the reporting requirements any plans in states that impose similar reporting and disclosure rules.

The legislation would also require that summary plan descriptions be provided to plan participants and beneficiaries and that a report containing plan operation and financial information be prepared annually. Actuarial statements would have to be included in the annual reports of defined benefit plans, and either an accountant or government auditor would have to review the plan on behalf of the participants. In addition, the bills address requirements relating to fiduciary functions and establish administration and enforcement provisions.

Roybal Introduces ESOP Bill

Rep. Edward R. Roybal (D-CA), chairman of the House Select Committee on Aging, has introduced the Employee Stock Ownership Plan Improvements Act of 1985 (H.R. 3203), which is designed to prevent the conversion of defined benefit pension plans into employee stock ownership plans (ESOPs) during or after hostile corporate takeover attempts. Roybal said that in some cases, "ESOPs have become tools in boardroom acquisition strategies. They can be used as a poison pill to discourage hostile takeovers."

To defeat a takeover attempt, a company sometimes terminates its defined benefit plan, and after satisfying retirement plan liabilities, uses the reversion of excess assets to buy back company stock. A large block of stock is thus taken off the market and out of the grasp of outsiders hostile to current management. "Since the employer now has no defined benefit plan in place," Roybal said, "a successor ESOP is usually created to serve as a reservoir for the repurchased stock and the principal retirement vehicle for workers."

ESOPs are also popular among companies that successfully complete a hostile takeover, Roybal asserted. In several recent cases, he said, the target company's overfunded pension plan was terminated, and the reversion was used to reduce the acquiring company's debts. The target company's workers were without a pension plan, and an ESOP was adopted in its place, said Roybal.

Roybal argues that "in both these cases employees and retirees are forced to suffer a loss of retirement income security so that management can manipulate the form of the company's pension arrangements to management's own advantage." Stocks purchased by or for an ESOP during a hostile takeover attempt are typically bought at substantially inflated prices, which usually decline immediately after the completion or failure of the takeover attempt, said Roybal.

He argued that the loss of benefits and detrimental impact on workers' retirement income security can be severe.

H.R. 3203 would limit the use of ESOPs in the following ways:

- adoption of an ESOP would be subject to the vote of an absolute majority of employees in addition to any vote of shareholders;
- all benefits accrued by workers under the ESOP would have to vest immediately;
- voting rights for stock held by the ESOP would have to be passed through to employees, and any unallocated shares would have to be voted by plan trustees in the same proportion as those actually voted by employees; and
- an ESOP could not be created within one year of the termination of a defined benefit plan.

Supplemental Pension Benefits

Legislation designed to protect employees' pensions from inflation has been introduced into Congress by Rep. Barbara Kennelly (D-CT).

H.R. 3179, according to Kennelly, "permits employees and employers to jointly fund supplemental retirement benefits through an employer's existing tax qualified pension plan or plans using employer contributions and employee accumulations in company savings-type programs."

Specifically, the bill would allow employees and employers to share costs in providing supplemental retirement benefits, enable employers to contribute to supplemental retirement benefits with the understanding that employees would share a portion of the cost, ensure that additional employer contributions would not be considered taxable income to the employee until benefits are received, permit an employer to fund its contributions over the employee's career through its established defined benefit plan, and protect joint and survivor benefits under current law provisions.

PBGC Files to Become Wheeling-Pittsburgh Trustee

The Pension Benefit Guaranty Corporation (PBGC) filed suit September 5 in U.S. District Court in Pittsburgh, Pennsylvania, seeking to become interim trustee of Wheeling-Pittsburgh pension fund.

The first major move by the PBGC's new Executive Director, Kathleen Utgoff, was also the first such action ever taken by the agency. The PBGC asked the court to issue an order requiring plan administrators to show cause why the PBGC should not be appointed trustee for at least 30 days.

In filing the suit, Utgoff said: "In light of the Wheeling-Pittsburgh plans' recent failure to meet ERISA's minimum funding standards, as well as the company's unsettled financial situation, inac-
tion by the PBGC would expose the insurance system to substantial additional risk. However, the corporation also believes that preemptive termination of the plans would not serve the interests of participants, the company or the PBGC.

Wheeling-Pittsburgh has attempted to settle its financial difficulties under protection of the bankruptcy code. Although the PBGC is authorized under ERISA to take immediate action to terminate the pension plan since it has not met minimum funding requirements, Utgoff said the PBGC elected to become interim trustee to give Wheeling-Pittsburgh a chance to reach agreement with its labor unions and avoid termination.

The agency also asked the court to require Wheeling-Pittsburgh to turn over pension fund records so that it can act quickly to adjust benefit payments and transfer the plan's assets to PBGC investment funds if it does terminate.

If the Wheeling-Pittsburgh plan does terminate, it will increase the PBGC's deficit in liabilities from all terminated pension plans to about $1 billion. The PBGC's current deficit is approximately $600 million.

Action to help reduce the PBGC's current deficit may come from Congress' work on the budget resolution. The Senate Finance Committee in mid-September approved a premium increase, and the House Education and Labor Committee included a premium increase and single-employer termination insurance reforms in its budget reconciliation measure.

Congress Considers Various Health Care Proposals

While there are points of disagreement between the Senate Finance and House Ways and Means Committees, the budget proposals they approved contain many identical—or nearly identical—provisions affecting Medicare, Medicaid and employer health plans.

At the same time, the House Energy and Commerce Committee and the chairman of the House Ways and Means Subcommittee on Health have proposed legislation aimed at reconciling the budget and expanding access to health care.

Medicare—It appears likely that Congress will extend the Medicare payroll tax to state and local government employees and hold increases in payments to hospitals under the prospective payment system (PPS) to 1 percent or less in fiscal year 1986.

As part of a budget reconciliation package, the Finance Committee voted Sept. 18 to make Medicare coverage mandatory for all state and local government employees beginning September 30, 1986. Ways and Means in July voted to bring workers hired after 1985 into the system. The Finance provision would provide $5.1 billion in new revenues over three years; the Ways and Means plan would generate $490 million.

Finance voted to raise the Medicare PPS payment rate to hospitals by 0.5 percent in FY 1986, while Ways and Means approved a 1-percent rise. Payment levels for fiscal years 1987 and 1988 would be tied to increases in the hospital market basket under the Finance Committee's proposal.

Provisions common to all three proposals include:

- an increase in payments to hospitals that serve a disproportionately large number of poor patients;
- removal of the age limit for allowing Medicare beneficiaries who continue to work to elect their employer-provided health coverage as primary;
- maintenance of the Medicare Part B premium for 1988 at 25 percent of program costs;
- a requirement that the Department of Health and Human Services (HHS) conduct demonstration projects to evaluate the effectiveness of providing Medicare coverage for preventive care;
- continuation of end-stage renal disease networks; and
- continuation of a freeze on Medicare payments to nonparticipating physicians.

The Energy and Commerce Committee's proposal, known as the "Medicare and Medicaid Budget Reconciliation Amendments of 1985," requires second opinions as a condition of payment for certain surgical procedures. HHS establish a task force on long-term health care policies and the Congressional Office of Technology Assessment establish a Physician Payment Review Commission to make recommendations to Congress regarding Medicare payments to physicians.

Meanwhile, H. R. 3210, introduced by Fortney H. (Pete) Stark (D-CA), chairman of the Ways and Means Subcommittee on Health, and entitled the "Medicare Payment Reform and Health Care Improved Access Act of 1985," would increase accessibility to health insurance for employees of small firms, the self-employed and dependents of laid-off, deceased, or divorced workers; provide tax incentives for the formation of statewide health insurance pools; and increase Medicare payments to disproportionate-share hospitals.

Medicaid—Ways and Means approved a $650-million spending increase in the Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) programs, while Finance and Energy and Commerce passed similar measures. All three committees voted to implement changes aimed at strengthening quality control in the Medicaid program.

In an effort to lower the infant mortality rate, the Energy and Commerce Committee voted to increase benefits for pregnant women. Ways and Means voted to mandate states to provide AFDC benefits to needy two-parent families in which the principal earner is unemployed.

Employer Plans: Sponsor Flexibility Would Decrease—In addition to making employer health plans primary for the working aged and their spouses over age 69, both Finance and Ways and Means
agreed to disallow tax breaks for employer contributions to health plans if employers fail to provide a coverage option to former spouses and dependents of covered employees, Medicare-ineligible spouses of covered employees, covered employees who lose their jobs, and employees' children that would otherwise lose coverage because they have reached majority age. The individual would pay the full premium and could be charged a small additional amount. The reconciliation report of the Senate Labor Committee contains a similar provision. This provision would become effective July 1, 1986. The key difference between the two proposals is that Finance's and Labor's proposals would mandate coverage for 18 months while the Ways and Means plan would require coverage for five years.

The House and Senate are each expected to approve their budget packages shortly; congressional leaders will appoint a conference committee to reconcile budget differences.

Committee Heats Pros and Cons of Mandated Preventive Pediatric Care

Legislation that would penalize employers who fail to provide well-child coverage in their group health insurance plans was the subject of a Senate committee hearing September 16.

S. 376, sponsored by Sen. John Chafee (R-RI), would require employers to offer well-child coverage or lose tax deductions for contributions to group health plans. The bill would set specific provisions that must be included in plans, such as vision and hearing tests, and immunizations. It does not address whether the employee or the employer is responsible for the payment of additional premiums.

Among those testifying in the Senate Finance Subcommittee on Taxation and Debt Management was Frederick Hunt, executive director of the Society of Professional Benefit Administrators. Hunt told the panel that while preventive pediatric care is good, there are also hundreds of other desirable health protections. "The question then is whether Uncle Sam should dictate and mandate this ever-growing list of hundreds of coverages." He also pointed out that while many Congressmen on one hand criticize the high costs of health care, they are often the same ones who ironically "force workers to take more expensive coverage."

Health care professionals praised the bill, contending that preventive measures may cost more initially, but would save high costs and frequent visits to a doctor or hospital later.

Veterans to Share Health Insurance Costs

Veterans with family incomes greater than $25,000 annually would have to pay a portion of their costs of treatment at Veterans Administration (VA) hospitals under a House Veterans Affairs Committee measure.

The proposal is an effort to produce $300 million in Veterans Administration savings to reach fiscal 1986 budget goals. It would require that veterans with family incomes exceeding $25,000 annually and whose ailment is not directly related to military service pay up to $476 per year for VA medical care.

The Reagan administration has proposed requiring that those families with income greater than $15,000 pay for a portion of their VA medical care. Current law allows veterans over the age of 65 to receive VA care at no charge.

The largest part of the savings—about $204 million—would be generated by allowing the Veterans Administration to bill veterans' insurance companies for treatment.

IRS Reverses Spousal Consent Rule

The Internal Revenue Service (IRS), pressured by complaints from pension plan managers, announced it will not require the consent of a spouse before a worker can retire early and receive pension benefits.

In July the IRS issued temporary regulations dealing with the qualified joint and survivor annuity (QSA) and preretirement survivor annuity (PSA) requirements under the Retirement Equity Act of 1984. Comments on the spousal consent rule suggested that an employee might be forced to keep working if a spouse refused to consent in writing to an early plan distribution.

IRS said in a news release (85-99) that it would drop the spousal consent rule when it issues final regulations.

Issues covered by the temporary regulations also include:

- plans subject to survivor annuity requirements
- benefits affected by survivor annuity requirements
- written explanation of the survivor coverage and the right to waive coverage
- spousal consent to waive survivor coverage
- effect of survivor annuity requirements on loans made by the plan
- consent requirements for distributions prior to normal retirement age
- calculation of $3,500 cash out voluntary cash outs in excess of $3,500
- calculating service for maternity/paternity leave
- break-in-service rule for class year plans

Other comments submitted to IRS posed objections to requirements that the PBGC interest rate be used for valuing lump-sum options and the inability to cash out terminated employees.

The temporary regulations generally apply to plan years beginning after December 31, 1984 and are generally effective July 19, 1985. See Federal Register 19 July 1985, pp. 29371-29379 for the text.

Compliance Date for TEFRA, DEFRA and REA Extended

The Internal Revenue Service (IRS) announced an extension, until November 1, 1985, of the time for compliance with the requirements of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the Deficit Reduction Act of 1984 (DEFRA), and the Retirement Equity Act of 1984 (REA) that relate
to pension, profit-sharing, stock bonus, and annuity plans.

IRS said in a news release issued August 30 that because a large number of plans have a compliance date of September 15, 1985, there may not have been enough time to complete all work necessary to submit a determination letter request by that date.

In order to quality for this extended compliance, a determination letter request must be filed with the appropriate IRS key district office no later than November 1. IRS emphasized that under the usual rules for processing determination letter requests, applicants have additional time after submitting a determination letter request to make corrective amendments if the plan provisions submitted in good faith are deficient.

IRS said that there will be no further extension of these deadlines. IRS also said that tax sanctions apply to plans that do not meet applicable compliance dates. For more information, call IRS public affairs division, (202) 566-4024.

HHS Issues New Medicare Rate Rules

Former Department of Health and Human Services Secretary Margaret Heckler has announced approval of final rules freezing fiscal 1986 Medicare reimbursement rates to hospitals, but her decision could be overturned by Congress.

The freeze, designed to save more than $1.8 billion in spending during the next fiscal year, means that the prospective payment system (PPS) rates for hospitals will be held at current levels. Hospitals had been seeking at least a 2 percent increase to compensate for inflation; the House Ways and Means Committee compromised by approving a 1 percent increase before adjourning in August.

The rules also carry out the scheduled provision that sets Medicare reimbursement rates at levels based 75 percent on the federal rate and 25 percent on the hospital's historic costs. This represents a shift from the current 50-50 reimbursement rate. The Ways and Means Committee also voted to retain the 50-50 split for another year.

In addition, the rules revise the schedule of diagnosis-related groups (DRGs) for the first time since the PPS was implemented in 1983. The new rates reflect technological changes, newer medical practice methods, and regroup certain diagnoses. DRGs are used to classify reimbursement rates for the treatment of various conditions.

The rules do not provide for increases in target limitations on reimbursement for hospitals now excluded from the PPS system, such as rehabilitation and psychiatric hospitals, but do establish a new wage index retroactive to 1983, based on Health Care Financing Administration survey data that account for area differences in part-time hospital employment practices. They also revise the method used to count interns and residents in determining payments to teaching hospitals.

The rules are published in the September 3 Federal Register, vol. 50, no. 170, pp. 35645-35759.

Limits on Reimbursement of Nonphysician Medical Services Proposed

The Health Care Financing Administration (HCFA) has announced that the method for determining reimbursement rates for nonphysician services under Medicare's Supplementary Medical Insurance Program (SMI) be changed.

HCFA is proposing that an additional charge factor be added to those currently taken into consideration by carriers in determining reasonable charges for nonphysician services under SMI, or Medicare Part B. The new factor, the "inflation-indexed charge," would represent the reasonable charge from the preceding plan year plus an inflation adjustment factor. For plan years beginning on or after October 1, 1986, the inflation adjustment factor would be the annual change in the level of the consumer price index (CPI) for urban consumers, as compiled by the Bureau of Labor Statistics, for the 12-month period ending on March 31. For the plan year beginning on October 1, 1985, the inflation adjustment factor would be zero.

Medicare Part B payments for medical services, supplies and equipment that generally do not vary significantly in quality from one supplier to another must be based on a customary and prevailing "reasonable charge." The Deficit Reduction Act of 1984 imposed reimbursement limits on Part B physician and clinical diagnostic laboratory services, but not on other nonphysician services.

HCFA maintains that reimbursement for nonphysician services has been unconstrained. "It is our view that increases in the level of reimbursement for nonphysician services, supplies, and equipment beyond the general level of increase in the CPI (that is beyond increases justified by a supplier's or provider's costs) are not reasonable despite increases in customary or prevailing charges." The proposed change in reimbursements would save $750 million over the next five years, estimates HCFA.

The items and services that would be affected by the proposed changes include:

- Durable medical equipment such as oxygen, oxygen equipment, wheelchairs and hospital beds;
- Ambulance services;
- Prosthetic devises, braces and artificial limbs and eyes;
- Outpatient physical therapy and speech pathology services;
- Portable x-ray services; and
- Certain medical supplies used in connection with home dialysis delivery systems.

The proposed rule is published in the August 16 Federal Register pp. 33324-33328.

At EBRI

EBRI Policy Forum on Tax Reform

"What is the tax policy future for employee benefits?" "Where does tax re-
form legislation currently stand?” These were some of the topics addressed at EBRI’s October 24 policy forum, “Tax Reform and Employee Benefits.” Speakers included Richard Citron of the Frank B. Hall Consulting Company, Edward Davey of Johnson & Higgins, Judith Mazo of the Martin E. Segal Company, Donald Harrington of AT&T, John Riordan of Nossaman, Guthner, Knox & Elliott (formerly with the House Ways and Means Committee), Melvyn Rodrigues of the Atlantic Richfield Company, and John Fleming of the Bakery and Confectionery Union and Industry International Health Benefits and Pension Funds.

Consultants, analysts and plan sponsors discussed such issues as the new Heinz/Clay retirement income policy bill, PBGC reform, the future of flexible spending accounts, defined benefit and defined contribution plans, and plan design for a changing work force.

Salisbury Briefs National Press Club on Tax Reform and Employee Benefits

Employee benefits fulfill valuable social goals but are an attractive tax reform target for Congress because they are a potentially lucrative source of revenue, EBRI President Dallas L. Salisbury told members of the National Press Club at its “Morning Newsmaker” briefing September 4.

The briefing came on the heels of the Reagan administration’s recommendations to Congress that section 401(k) plans be abolished to raise revenues. Many reporters’ questions centered on the 401(k) issue. Salisbury pointed out that the participation rate for 401(k) plans is greater than that for individual retirement accounts (IRAs)—39.1 percent versus 16.5 percent, respectively—but IRAs have not been targeted for elimination.

New EBRI Publications

Major Pension Study Published

The Changing Profile of Pensions in America puts the U.S. retirement income system into full perspective by examining the role of private-sector and public-sector programs. Author Emily S. Andrews presents an analysis of the largest and most recent survey of retirement programs in America—the May 1983 pension supplement to the Current Population Survey, sponsored by EBRI and the Department of Health and Human Services and undertaken by the U.S. Census Bureau. More than 50 million Americans have retirement programs other than Social Security, and this study analyzes the more traditional defined benefit plans as well as newer programs, such as 401(k) plans and IRAs. Current and proposed reforms of the U.S. pension system are also discussed.

This new study, fully indexed, is available for $18 in softbound and $30 hardbound by sending a check to EBRI-ERF Publications, P.O. Box 753, Waldorf, MD 20601.

Impact of Medicare Reform Analyzed

As the baby boom generation reaches retirement, increasing demands will be placed on Medicare, a program whose financial health is in question. In the new book Medicare Reform: The Private-Sector Impact, based on the proceedings of EBRI’s June 1985 policy forum, experts from government and the private sector share their concerns about the future of Medicare—and the future of health care for our nation’s elderly.

Representatives of government, Congress, health insurance companies, benefit consultants, consumer groups and the academic community discuss options for reforming Medicare and the potential effects on individuals, health care providers, employers and insurers. Related issues, such as uncompensated health care and Medicare’s role in reducing the federal budget deficit, are also analyzed.

The forum featured Rep. Fortney H. (Pete) Stark (D-CA), chairman, Health Subcommittee, Committee on Ways and Means; Sheila P. Burke, deputy chief of staff, Office of Senate Majority Leader Robert J. Dole (R-KS); Cynthia K. Hosay, national director for health care cost management, Martin E. Segal Company; Stephen H. Long, deputy assistant director for health and income security, Congressional Budget Office; John Rother, associate director for legislation and public policy, American Association of Retired Persons; John Troy, vice president, corporate communications department, The Travelers Insurance Companies; and Karen Williams, director of research and policy development, Health Insurance Association of America.

The book is fully indexed and includes the 1982 Advisory Council on Social Security’s recommendations, the summary of the Medicare Board of Trustees 1985 annual report and the section on entitlements and mandatory spending from the Congressional Budget Office’s 1985 annual report on federal deficit reduction.

Copies of Medicare Reform: The Private-Sector Impact are available for $15 softbound and $28 hardbound by sending a check to EBRI-ERF Publications, P.O. Box 753, Waldorf, MD 20601.

Presentations

During September and October, EBRI President Dallas Salisbury made a number of presentations on a variety of employee benefit topics, including: in Washington, DC, on Sept. 11, a speech on Current Trends in Employee Benefits before the National Employee Benefits Institute; a presentation on Pension Policy and the Marketplace on Sept. 12, before the American Bankers Association in Hot Springs, VA; in New York on Oct. 8, a presentation on Washington Versus the U.S. Pension Funds: What’s Going On, before Manufacturers Hanover Client Investment Seminar; in Washington, DC, on Oct. 25, a speech to the Association for Public Policy Analysis and Management Annual Meeting on The Role of Employee Benefits in the Social Protection System; in Hot Springs, VA, on Oct.
28, a speech to the Citibank Employee Benefit Funds Client Conference on legislative matters; a speech on the Taxation of Employee Benefits before the Boston University Human Resources Policy Institute in Boston on Oct. 31; and also in Boston on Oct. 31, a speech on “Legislative Developments in the Defined Contribution Area” before Fidelity Investments National Performance Review and Workshop.

Emily Andrews, EBRI research director, testified Oct. 17 on post-65 accruals before the Senate Labor and Human Resources Subcommittee on Aging; and she addressed the 7th Annual Research Conference of the Association for Public Policy Analysis and Management on “The Current and Future Role of Pensions in Old Age Economic Security,” Oct. 25 in Washington, DC.


Frank McArdle, EBRI director of Education and Communications, addressed the 36th Annual Meeting of the Conference of Actuaries in Public Practice on “The Crisis in Medicare” Sept. 30 in Honolulu, Hawaii. He also delivered a speech on “Benefit Implications of Tax Reform Proposals” at the same conference on Oct. 1.

Announcements and Publications

Benefits Information Network
The Employee Benefit Information Network (EBIN), developed by Personnel Research Associates, is now available for employee benefit professionals to improve their access to timely information on all aspects of employee benefits.

EBIN, a private computer-based bulletin board system accessed by personal computer users, includes information about the latest developments in benefits, conferences and meetings, products and services available, and research being conducted in the benefits field.

System users may post their own bulletins, and conduct mini-surveys.

A user identification and password for six months are available for $50.00 by contacting Personnel Research Associates, 49 Oakridge Road, Verona, NJ 07044, (201) 239-6154.

Government Reports and Publications


An estimated 5.5 million Americans were receiving periodic private employee pension benefits at the end of 1978. This report examines the level of benefits they received, giving special attention to recent retirees. It discusses the characteristics of retirees and pension plans and their effects on benefit levels and earnings replacement rates. The survey data describe the pension benefits and related information for over 300,000 recipients from 357 pension plans.


Surveys

A Fifty-Year Report Card on the Social Security System, The Attitudes of the American Public, A national survey conducted by Yankelovich, Skelly and White, Inc. for the American Association of Retired Persons

This report presents the findings that emerged from research on how the American public thinks and feels about the Social Security system. The study focuses primarily on retirement benefits. Findings show that Social Security’s perceived importance has increased for many Americans. It is seen as a successful government program, but not without flaws. Some of the concerns about the system are the adequacy of payments, fairness of the system and government mismanagement. Retirees polled were the group most satisfied with the system.


Healthcare Cost Containment in the Public Sector, William M. Mercer-Meidinger, Incorporated

Public-sector employers—among them, state, city and county agencies and school boards and district—are making progress in containing the costs of the health coverage they provide to their employees, but at a markedly slower pace than their private-sector counterparts. This is one of the findings of a new survey of 256 public employers by the benefit consulting group, William M. Mercer-Meidinger in cooperation with the Public Risk and Insurance Management Association.

Copies of the survey report are available at no charge by writing William M. Mercer-Meidinger, Incorporated, Marketing Department, 2600 Meidinger Tower, Louisville, KY 40202-3415.

Articles

Frank McArdle, EBRI’s education and communications director, wrote a feature article on “The U.S. Budget and Employee Benefits” which appeared in the July issue of Internben, The World of International Benefits.
The Employee Benefit Research Institute (EBRI) is a nonprofit, nonpartisan public policy research organization based in Washington, DC. Established in 1978, EBRI provides educational and research materials to employers, employees, retired workers, public officials, members of the press, academics and the general public. Through its books, policy forums and monthly subscription service, EBRI contributes to the formulation of effective and responsible health, welfare and retirement policies. The Institute has—and seeks—a broad base of support among interested individuals and organizations, as well as among private-sector companies with interests in employee benefits education, research and public policy.

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

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