

# Defined Contribution Health Benefits, *p. 1*

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Notes

### Two Views on Defined Contribution Health Benefits

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

The EBRI Education and Research Fund (EBRI-ERF) held a daylong policy forum on DC health benefits May 3, 2001, which was highlighted in the August 2001 *EBRI Notes*. A detailed examination of the issue was published in the March 2001 *EBRI Issue Brief*. This article follows up on that earlier work by presenting contrasting views of the issue, presented by an outspoken advocate and an equally forthright critic of DC health.

**PRO:**

**Dr. Donald Palmisano, AMA**

Dr. Palmisano, a general and vascular surgeon from New Orleans, LA, is secretary-treasurer of the American Medical

Association (AMA), the national professional organization representing physicians. He is in the private practice of surgery in New Orleans with five other surgeons, and is clinical professor of surgery and clinical professor of medical jurisprudence at Tulane University. He also is president of Intrepid Resources®/The Medical Risk Manager Company, which provides professional liability claims handling, risk management consultation, and patient safety advice to physicians, clinics, and hospitals.

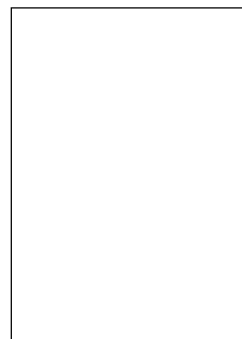


**CON:**

**Dr. James Bentley, AHA**

Dr. James Bentley is senior vice president for strategic policy planning of the American Hospital Association (AHA),

the national organization that represents and serves all types of hospitals. He was previously vice president of clinical services for the Association of American Medical Colleges, and has been on the faculty of George Washington University in Washington, DC, teaching medical sociology and health care administration. A former board member of Holy Cross Health of Silver Spring, MD, he continues to serve on its Mission and Planning Committee.



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**PRO** [Palmisano]

For all its outstanding successes, there is a problem in American medicine, and the American Medical Association (AMA) believes that it lies in the paradigm of insurance financing. We believe that the system is under severe stress right now, and, although dedicated professionals are working very hard to keep it in place, it is near the breaking point. Our support for the concept of defined contribution health benefits is one major element of our proposal for health insurance reform.

**Overview**

AMA policy favors consumer-driven health care. That is the guiding light

in our pursuit of health care system changes. Such changes are sorely needed because today's situation is one of misdirected competition and dissatisfaction among patients, physicians, and even health insurers. We are in favor of competition, but with everybody on an equal playing field. Put everything out there—managed care, health maintenance organizations, preferred provider organizations, indemnity, medical savings accounts (MSAs)—and let the competition begin.

Normally, throughout our economy, competition breeds “consumerism.” But in U.S. health care today, the situation is quite different: We have “employerism,” where competition may not always benefit

patients. Insurers compete primarily on price for *employer* contracts—they do not compete on price and patient satisfaction for *patient* contracts.

The AMA believes that defined contribution health benefits are an essential ingredient of a consumer-driven system. AMA policy favors individually selected and owned health insurance; defined contribution health benefits; ending the federal income tax exclusion for health benefits compensation; and income-related, refundable tax credits as a package of reforms that will greatly improve the U.S. system. (This proposal is explained at length on the AMA Web site at [www.ama-assn.org/ama/pub/category/3037.html](http://www.ama-assn.org/ama/pub/category/3037.html))

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**CON** [Bentley]

The AHA's Strategic Policy Planning Committee undertook a project to examine defined contribution health benefits, and the results are revealing. In looking at the health insurance system, it seemed useful to think of the insurance product as composed of two components: in the first, the population is prepaying a rather predictable part of their coverage. The second component, the insurance piece, is the pooling of risk to pay for the small group of people who have a large expenditure. Judging from what consumers express in various polls, there is some mixing together of the two insurance components.

Almost everyone who has looked at any health care population

finds that 20 percent of the population consumes 80 percent of the health care resources. From our perspective, that 20 percent is very heavily concentrated in hospitals. As a society, we have supported the high cost of that 20 percent with three subsidy approaches.

- Historically, there was cost shifting. In my view, it is really not *cost* shifting—it is *revenue* shifting, but cost shifting is the commonly used term. It describes the arrangement in which some patients—the routine patients—pay more than their costs in order to subsidize the high-cost patient. In recent years, the ability of hospitals to cost shift has declined.
- Next, the high-cost patient was

supported by pooling risk at the level of the employer with group-sponsored health insurance. Those who were fortunate in their health paid more in premiums than they received in benefits. Those who were unfortunate in terms of their health needs received more in benefits than they paid in premiums.

- When neither cost shifting nor employment-based group coverage worked, we wound up using a government tax structure to subsidize the high-cost patient. From the hospital point of view, one of the concerns about defined contribution coverage is: if you separate out the insurance pooling that happens at the employer level, are we moving to

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**PRO** [Palmisano] (continued)

### **Employee Satisfaction**

A major problem we see in today's health care system is that employers do not give employee satisfaction a high priority. A recent Milliman & Robertson survey of benefit managers asked respondents their most important criterion for selecting health plans, and the number one response was price, mentioned by 43 percent (87 percent of surveyed employers said they would look for a new plan if premiums increased by more than 3 percent). Only 4.5 percent of respondents listed employee satisfaction as most important.

The result is that we have an unresponsive system with excessive patient churning. Too often

patients are forced to switch plans/doctors. Half of workers switch health plans over three years due to their employer switching plans or their own change in employment. And 41 percent of those who switch plans also switch doctors. This means severed patient-physician relationships and reduced continuity of care and added costs due to otherwise unnecessary new patient testing. I have personally lost patients who didn't want to leave because their health plan changed, and I can tell you there is a lot of material that is not on the record because you can't put every living moment down on the record—nuances, the family situations. The result, with the patient's new physician, is added cost due to

otherwise unnecessary new patient testing.

We at the AMA believe the solution must be health insurance that meets individual needs. This includes defined contributions with individually selected and owned health insurance that allows patients to make their own choices. This will allow better matches between patient preferences and plan offerings. Such a system also will generate more products, including MSAs and other innovative approaches for health expense protection. And we should allow patients to leave unsatisfactory plans. Under the competition model, a health plan should go out of business if enough patients simply walk away.

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**CON** [Bentley] (continued)

a system in which the only way to pool and cover the high-cost patient becomes some new or expanded government health care program?

### **Types of Defined Contribution Health Benefits**

The AHA Strategic Policy Planning Committee next looked at what is meant by defined contribution health benefits. It wasn't as clear to us as it seemed. We looked every place we could to find information on defined contribution health benefits. EBRI provides some definitions in its recent publication on the issue.<sup>1</sup> But since we could find no common terminology, we created the follow-

ing three basic options for DC health benefits:

- Fixed payment to selected options.
- Fixed payment with no selection.
- Cash compensation without benefits.

The first type of DC health arrangement (the fixed payment to selected options) keeps the employer in the role of a health plan sponsor, deciding what plans to offer, negotiating with those plans for the premium and the benefit structure, and deciding on a fixed payment that the employer would make regardless of which plan the individual enrolls in.

The second type of defined contribution arrangement we could

identify was one in which the employer goes a step further and withdraws from the selection and negotiation processes but still provides a payment for health care coverage. This is more analogous to what happens if you have been so unfortunate as to be in an auto wreck, where you have to sign the check and the body shop has to sign the check and only then is it a valid check. That is, the employer says, in one way or another, "We'll provide money that can only be spent for health care coverage." But you, the employee, have to go to Kaiser or BlueCross/BlueShield or Nationwide or whomever you want, and buy a policy for yourself. The people who write about this approach are considering the advantages not only

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**PRO** [Palmisano] (continued)

**Characteristics of DC Health Plans**

Defined contribution health benefits are earned compensation, not a gift from the employer. Defined contribution programs simply monetize the health benefits transaction between management and labor—neither side is necessarily worse off. With respect to the “employer share,” there is no greater likelihood of deterioration over time under defined contributions than under defined benefits. Defined contributions clarify for patients the out-of-pocket consequences of health plan choices.

One often-cited option for defined contribution health plans involves employers “cashing out” health plan costs in higher wages for workers, who then are on their own

to find, evaluate, and purchase health coverage. This is not the only option, nor is it a particularly effective one for employers. For example, one alternative might be for defined contributions from employers, along with employee premium payments, to be conveyed to Internet-based Health Insurance Marts.

What changes would we expect to see under a defined contribution health benefit program? Initially, patients would be more cost-conscious about plans; ultimately, they would be more cost-conscious about physician services, referrals, prescriptions, etc. Health insurance would be less likely to be first-dollar coverage, more likely to require higher deductibles. Patients would come to

expect value from all of their health care transactions. Performance measures for individual physicians would emerge for both cost and quality.

Won't patients make bad choices, and how can the system prevent that? Well, patients already choose houses, colleges, cars, and other insurance products. The economy is already well geared to help consumers make informed choices. When the choice is given to patients, the market will respond with consumer information in user-friendly forms. The important thing we need is not only knowledge and information but also rapid and accessible retrieval of knowledge. While some patients may initially choose “cheap plans,” they will learn that inexpensive coverage may not

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**CON** [Bentley] (continued)

for the employer in terms of constraining cost but also for the individual who can increase portability and contingency of coverage.

The third use of defined contribution we could find was discussed from the economist's viewpoint. If benefits are just another form of compensation, some people take the position that employers ought to move to cash contribution and get out of the benefit business. Employers would increase employee compensation by some amount, but the employee would be back to negotiating his or her own coverage with the insurance companies.

As the AHA Strategic Policy Planning Committee looked at these three tiers, the fixed payment to selected options did not seem to us to offer nearly the difficulties or adverse consequences as the two options in which the employer stops being a plan sponsor and essentially says, “I will provide some level of contribution or adjusted payment but I'm getting out of the plan selection and pooling role. You're on your own.”

We have four major concerns with the two approaches that eliminate the employer roles in plan selection and pooling:

- First, almost nowhere can we find a healthy, stable individual

insurance market. Although a number of states have made efforts to structure one, when faced with the behavior of some consumers who sign up only when they think they have a high probability of need, insurers respond with measures that will avoid adverse risk. Individuals and insurers engage in a set of behaviors that “spiral” the marketplace when adverse selection occurs.

- Second, no one has studied what would happen if people were not in a group structure and some percentage of employees did not chose to purchase the available coverage, especially if they could

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**PRO** [Palmisano] (continued)

be the coverage they want. In a system where unsatisfactory choices don't have to be repeated the next time around, patients as consumers will find the health plans that best meet their own needs.

What would happen with more cost-conscious/quality conscious patients? Switching to defined contribution programs would break "job-lock," hence patient preferences would become more important. Losses (or gains) in patient volume would be more a result of a physician's own performance than of changes in patients' employers' choices. Therefore, physicians would compete on price and quality. Physicians who have trained hard and who have good quality work would retain patients.

**Conclusion**

The AMA believes that defined contribution health benefits allowing patient choice would be good for patient care. This kind of approach allows patients to continue with a trusted physician regardless of changes in their employment circumstances. The patient-physician bond would be stronger, which would be good for both patients and physicians. This would lead to improved continuity of care and more patient-tailored care based on physicians' continuing experience with individual patients. Good patient skills would be rewarded, accelerating improvement in these skills.

Enhanced cost-consciousness on the part of both patients and

physicians would act to restrain cost increases across the health sector. From the employer perspective, improved continuity of care should lead to healthier workers with fewer days lost from work. Across the board, more competition for patients would lead to new insurance products that may offer advantages to patients who otherwise might be uninsured.

The bottom line is that we think defined contribution is the way to go. We also think that both competition and information retrieval are essential. Don't tilt the marketplace to either managed care or indemnity insurance. Let all known options be in the mix, and let patients have the choice.

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**CON** [Bentley] (continued)

use that money for some other kind of good or service in which they were interested. I would note that if just 10 percent of the people currently covered through employment-based health insurance moved to defined contribution but did not replace their employer coverage, the number of uninsured in the United States would rise by 35 percent. That is not an attractive state of affairs for the hospitals.

- Third, everything we can observe suggests that moving from group policies to individual policies through defined contribution health benefits would increase

uncompensated care. Unlike the defined contribution *retirement* plan, which does not guarantee you living quarters in retirement, or a given diet, or a given automobile, the health care provider is put in the position of not being able to deny services because the patient in a defined contribution *health* plan has made a poor selection and now wishes he or she had purchased a plan that provided the services needed for a newly discovered illness.

- Lastly, while we can theoretically have multiple tiers of health care in this country, historically—whether it is the federal government, the state govern-

ment, or the private accreditation agencies—hospitals have to provide a common standard of care regardless of the sponsorship of the patient. In a defined contribution world, where individuals would select different levels of coverage, the hospital has to provide the same product. The hospital winds up subsidizing anyone who elects low in that coverage market.

**Endnote**

<sup>1</sup> See Paul Fronstin, "Defined Contribution Health Benefits," EBRI Issue Brief no. 231 (Employee Benefit Research Institute, March 2001).

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## Washington Update

by Teresa Turyn, EBRI

### ***The New Dynamics in Congress***

Among the aftershocks of the attacks in New York and Washington last month are vastly changed priorities in Congress, as the United States opens its war on terrorism. Virtually all benefits-related issues are now off the table until at least next year, and the previous debate over Social Security has been practically silenced for now. Instead of the bitter partisanship anticipated in Congress this fall, Republicans and Democrats worked cooperatively to enact disaster aid packages for New York City, the Pentagon, and the airline industry. At this writing, an economic stimulus package is under debate to deal with the recession.

Also gone (at least for now) is the acrimonious budget battle that was expected on Capitol Hill this fall. Technically, the government's fiscal year ended Sept. 30, but lawmakers quickly enacted stopgap legislation to carry the budget into mid-October. At this writing, lawmakers were working on a package to quickly wrap up work on all of the 13 regular funding bills by the end of the month.

While key Republican lawmakers have been pushing for a stimulus tax package that would, among other things, include a cut in the corporate capital gains tax rate for businesses and individuals,

economic experts such as Federal Reserve Chairman Alan Greenspan and former Treasury Secretary Robert Rubin have advised lawmakers that they should wait for additional economic information before making any final decisions. Senate Finance Committee Chairman Max Baucus (D-MT) and ranking Republican Charles Grassley (R-IA) said Sept. 25 they would heed the advice of Greenspan and Rubin, while House Majority Leader Richard Armey (R-TX) Sept. 25 reiterated his commitment to ensuring House passage of an economic stimulus plan before year-end.

### ***Tax Relief Bill for Attack Victims***

The House and Senate late last month were working on a bill (H.R. 2884) that would provide immediate income and estate tax relief to victims of the Sept. 11 terrorist attacks on the United States. The bill, co-sponsored by House Ways and Means Chairman William Thomas (R-CA) and ranking Democrat Rep. Charles Rangel (D-NY), would give families of victims of the Sept. 11 attacks the same tax benefits that apply to the families of soldiers, sailors, and civilian government employees killed in war zones or in terrorist attacks abroad. The bill would provide a one-year exemption from federal income taxes for families of individuals who were killed or died of injuries sustained in the attacks.

The House acted quickly, passing the bill Sept. 13. At this writing, the Senate was modifying the bill's provisions to address death and disability concerns and technical issues related to estate taxes and how original-law tax provisions that apply to the military can also apply to civilians.

### ***Insurance Liability of Attacks to Be Largest Ever***

Preliminary estimates of the financial cost to the nation's insurance industry in the aftermath of the Sept. 11 terrorist attacks put the total losses in the range of \$10–\$15 billion. Property damage, workers' compensation, accident insurance, business-interruption coverage, business liability coverage, and life insurance claims are expected to add up to the largest insurance industry price tag in U.S. history. *The New York Times*, however, reported that claims could be much higher than these estimates, when factoring in coverage for the cost of the World Trade Center itself.

### ***PBGC Advisory Committee Gets Employer Member***

President Bush has appointed Betsy S. Atkins of Miami, FL, to the Advisory Committee of the Pension Benefit Guaranty Corporation (PBGC), for a term that expires in 2003. Atkins will represent the interest of employers on the seven-member PBGC Advisory Committee, which carries out several specific

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## Keeping on Track

*Treasury Cash Balance Guidance, EGTRRA Pension Clarifications Due Soon*—The Treasury Department is preparing guidance on cash balance plans that will address both conversions to cash balance plans and employers that want to establish such plans from scratch, which should be “helpful for small employers who want to set up cash balance plans for the first time,” Treasury Benefits Tax Counsel Bill Sweetnam said Sept. 25. The Treasury Department also expects to release in October guidance under the Economic Growth and Tax Relief Reconciliation Act (EGTRRA) (P.L. 107-16) on the following issues: (1) a clarification on the disclosure notice provision under Internal Revenue Code (IRC) Sec. 204(h); (2) how the “sunset” provision of EGTRRA—which calls for a return to prior laws in September 2011—should be handled with regard to lump-sum distributions and defined benefit plan funding; (3) how to reflect increases in IRC Sec. 415 amounts with regard to EGTRRA changes, which increased maximum annual benefits under defined benefit plans and maximum annual additions to defined contribution plans; (4) guidance on the new EGTRRA catch-up provisions; and (5) various other technical corrections.

*San Francisco Domestic Partner Ordinance Upheld*—The U.S. Ninth Circuit Court of Appeals Sept. 11 ruled a San Francisco ordinance requiring contractors to provide the same benefits to domestic partners that are provided to spouses is consistent with the Airline Deregulation Act and the Railway Labor Act. According to the court, the airlines are free to set whatever terms, conditions and prices they want on the travel benefits and discounts they provide to employees and their families, as long as they do not discriminate on the basis of race, color, creed, religion, national origin, ancestry, age, sex, sexual orientation, gender identity, disability, HIV/AIDS status, domestic partner status or marital status (*Air Transport Association of America v. City and County of San Francisco*, 9<sup>th</sup> Cir., 2001 U.S. App. LEXIS 20156, (9/1/01)).

*Court Rejects IRS Position on Partial Terminations*—The U.S. Seventh Circuit Court of Appeals recently held that only nonvested participants should be counted in determining whether a retirement plan has undergone a partial termination. In this case, the plaintiff and other employees lost their jobs when their employer sold off various subsidiaries. After the layoff, participants who were not fully vested at the time of discharge forfeited the nonvested portion of their matching contribution accounts. The plaintiff argued that these accounts should have been fully vested because the plan had undergone a partial termination. In making the ruling that only nonvested participants be counted in the partial termination analysis, the Seventh Circuit reversed its original decision from last year, where it had adopted the Internal Revenue Service view that all vested and nonvested participants must be considered in the partial termination analysis (*Matz v. Household International Tax Reduction Investment Plan*, 2001 US App. LEXIS 19786 (9/7/01)).

responsibilities outlined by ERISA. Those include advising on PBGC investment policies and procedures for the more than \$20 billion in

assets, the trusteeship of terminated plans, and other matters as determined by the PBGC. Atkins is president and CEO of Baja LLC, an

independent venture capital firm that focuses on early-stage, high-tech companies.

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## EBRI in Focus

### **CEO Activities**

EBRI President and CEO Dallas Salisbury had the following events in September:

- On Sept. 7, he met with Sheila Bair, assistant secretary for financial institutions at the U.S. Treasury Department, regarding financial literacy and the department's use of EBRI's library for financial institution research. Treasury officials have undertaken a project regarding the existing financial educational resources available on a broad basis, anticipating that this will be an issue in the context of Social Security reform, individual accounts, and types of financial education available to the millions of potential new investors.
- On Sept. 10, he was a plenary speaker at the ISCEBS Symposium, held in Boston, where he spoke on "HR and Organizational Strategies: Where Will Benefits Fit in the Future?" Also speaking at the symposium were Jack VanDerhei, Temple University and EBRI Fellow, and Sarah Holden of the Investment Company Institute, on 1999 results from the EBRI/ICI 401(k) database.
- Salisbury also will have an article in the upcoming issue of the ISCEBS *Benefits Quarterly* on the prospects for Social Security and retirement reform in the years ahead. (EBRI Senior Associate

Paul Fronstin is co-author of another article in the same issue of *Benefits Quarterly* on "Medicare in the 21<sup>st</sup> Century.") In addition, he will have an article in the October *WorldatWork Journal* on the role of employment-based benefits in an aging and aged America.

- On Sept. 19, he spoke at the Northern Virginia Chapter of the Worldwide Employee Benefits Network on human resources business strategies and priorities.

On the international front, Salisbury was interviewed by the top-rated news program in Japan on the U.S. 401(k) system (that nation has recently created a type of defined contribution retirement savings system). And later in the month, EBRI staff met with officials from the NLI Research Institute in Japan to discuss possible Social Security reform in the United States and developments in private pension plans after the stock market's decline.

### **Choose to Save<sup>®</sup> Moves To Phase V**

EBRI announced Sept. 28 that the success of the Choose to Save<sup>®</sup> public service education campaign continued to be proven by quantitative measures, and that it would join with metro Washington underwriter Fidelity Investments for a Phase V to run from Oct. 1, 2001 to Sept. 28, 2002. Phase V will include new public service announcements and a

new one-half hour special, as well as special programs surrounding the 2002 SAVER Summit to be held in the spring.

During September, the half-hour CTS *Savings Game* TV special aired twice on WJLA in the Washington, DC, metro market: first on Sept. 5, which did a 3.6 household rating with a 6 share (the number translates to 72,000 households or 151,200 adults age 18 and over) and again on Sept. 23 (which did a 1.4 household rating with a 3 share, meaning 28,700 households or 57,500 adults 18 and over).

### **ASEC Participates in Military Financial Wellness Day**

At the request of the U.S. Navy, the American Savings Education Council (ASEC) participated in the first Financial Wellness Day sponsored last month by the Navy Fleet & Family Support Center, held on the Fort Myer army base in Arlington, VA. ASEC hosted an exhibit, along with a number of other ASEC partners. The goal of the event was to educate military personnel and their family members about how to prepare for major financial life events such as retirement and purchasing a home.



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## New Publications & Internet Sites

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

### ***Aging***

Schulz, James H. *The Economics of Aging*. \$24.95. Greenwood Publishing Group, Inc., Attn: Customer Service, 88 Post Road West, P.O. Box 5007, Westport, CT 06881-5007, (203) 226-3571 or (800) 225-5800, fax: (203) 222-1502, www.greenwood.com.

### ***Employee Benefits***

Hay Group. (1) 2001 Hay Benefits Report: Prevalence of Benefits Practices and Executive Summary. \$935. Call Carrie Nocentino, (215) 861-2890. (2) *The Hay Report: Compensation and Benefits Strategies for 2001 and Beyond*. \$400. Hay Group, 100 Penn Square East, Philadelphia, PA 19107-3388, (800) 721-4429.

Hewitt Associates. *Work/Life Benefits Provided by Major U.S. Employers: 2000-2001*. \$100. Hewitt Associates LLC, Attn:

Publications Desk, 100 Half Day Rd., Lincolnshire, IL 60069, (847) 295-5000.

### ***ESOPs***

The ESOP Association. 2000 ESOP Survey. Free. The ESOP Association, 1726 M St., NW, Suite 501, Washington, DC 20036, (202) 293-2971.

### ***Family Leave***

U.S. Congress. House Committee on Ways and Means. *Unemployment Compensation and the Family and Medical Leave Act*. Order from GPO.

### ***Health Care***

International Personnel Management Association. *Retiree Health Benefits*. \$20. IPMA members; \$40, nonmembers. International Personnel Management Association, 1617 Duke St., Alexandria, VA 22314, (703) 549-7100.

Merck-Medco. *The Merck-Medco Drug Trend Report 2001*. Free. Merck-Medco, 100 Parsons Pond Dr., Mailstop: E3-16, Franklin Lakes, NJ 07417-9991, (201) 269-6400 or (800) 879-7140.

National Health Care Purchasing Institute. *Corporate Health Care Purchasing Among the Fortune 500*. Free. National Health Care Purchasing Insti-

tute, 1801 K St., NW, Suite 701L, Washington, DC 20006, (202) 291-6700, www.nhcpi.net.

Silow-Carroll, Sharon, Todd Kutyla, and Jack A. Meyer. *The State of Employment-Based Health Coverage and Business Attitudes About Its Future*. Free. Economic and Social Research Institute, 1015 18th St., NW, Suite 210, Washington, DC 20036, (202) 833-8877, fax: (202) 833-8932.

U.S. Congress. House Committee on Ways and Means. (1) *Additional Medicare Refinements to the Balanced Budget Act of 1997*. (2) *Legislation to Cover Prescription Drugs Under Medicare*. Order from GPO.

Zhou, Huizhong. *The Political Economy of Health Care Reforms*. \$15. W.E. Upjohn Institute for Employment Research, 300 S. Westnedge Ave., Kalamazoo, MI 49007-4686, (616) 343-5541.

### ***Human Resource and Organizational Development***

Gilley, Jerry W., et al. *The Manager As Change Agent: A Practical Guide for Developing High-Performance People and Organizations*. \$30. Perseus Publishing, Eleven Cambridge Ct., Cambridge, MA 02142, (617) 252-5200. For bulk orders, call (800) 255-1514.

Gilley, Jerry W., Peter J. Dean, and Laura L. Bierema. *Philosophy and Practice of Organizational Learning, Performance, and Change*. \$30. Perseus Publishing, Eleven Cambridge Ct., Cambridge, MA 02142, (617) 252-5200. For bulk orders, call (800) 255-1514.

Swanson, Richard A. *Assessing the Financial Benefits of Human Resource Development*. \$30. Perseus Publishing, Eleven Cambridge Ct., Cambridge, MA 02142, (617) 252-5200. For bulk orders, call (800) 255-1514.

Walker, Alfred J. *Web-Based Human Resources: The Technologies and Trends That Are Transforming HR*. \$34.95. McGraw-Hill Inc., 1221 Avenue of the Americas, New York, NY 10020, (212) 512-2000, (800) 422-9685.

### ***Labor Markets***

Turner, John A. *Pay at Risk: Compensation and Employment Risk in the United States and Canada*. \$19. W.E. Upjohn Institute for Employment Research, 300 S. Westnedge Ave., Kalamazoo, MI 49007-4686, (616) 343-5541.

### ***Pension Plans/Retirement***

Aon Consulting and Georgia State University. *Replacement Ratio Study*. Free. Aon Consulting, 200

E. Randolph St., Chicago, IL 60601, (800) 438-6487.

Clark, Gordon L. *Pension Fund Capitalism*. \$29.95. Oxford University Press, 2001 Evans Rd., Cary, NC 27513, (800) 451-7556.

Hackleman, Paul, and Bill Tugaw. *Deferred Compensation/Defined Contribution – New Rules/New Game for Public and Private Plans*. IFEBP members, \$36; nonmembers, \$40 + S&H. International Foundation of Employee Benefit Plans, Publications Department, P.O. Box 68-9953, Milwaukee, WI 53268-9953, (888) 33-IFEBP, fax: (262) 786-8780, e-mail: books@ifebp.org.

Rodrick, Scott S. *Section 401(k) Plans and Employee Ownership*. \$25, NCEO members; \$35, nonmembers. National Center for Employee Ownership, 1201 Martin Luther King Jr. Way, Oakland, CA 94612-1217, (510) 272-9461.

### ***Tax Reform***

U.S. Congress. House Committee on Ways and Means. *Fundamental Tax Reform*. Order from GPO.

### ***GAO Reports***

U.S. General Accounting Office. (1) *Medigap Insurance: Plans Are*

Widely Available But Have Limited Benefits and May Have High Costs. (2) *Telecommuting: Overview of Potential Barriers Facing Employers*. Order from GAO.

### **Documents Available on the Internet**

*Are Americans Saving Enough for Retirement?*

[http://www.actuary.org/pdf/pension/cori\\_brief\\_0701.pdf](http://www.actuary.org/pdf/pension/cori_brief_0701.pdf)

*The Challenge of Managed Care Regulation: Making Markets Work?*

<http://hcfo.net/pdf/managedcare.pdf>

*Employers' Attitudes Toward Patients' Rights*

<http://www.kff.org/content/2001/3173/>

*Financial Education and Retirement Savings*

<http://www.tiaa-crefinstitute.org/Publications/wkpapers/wp06-27-01.htm>

*Increasing Pension Coverage & Benefits and Preparing for Retirement*

[http://www.actuary.org/pdf/pension/ERISA\\_071701.pdf](http://www.actuary.org/pdf/pension/ERISA_071701.pdf)

*Interim Report of the President's Commission to Strengthen Social Security*

<http://>

[www.commtostrengthensocsec.gov/reports/Report-Final.pdf](http://www.commtostrengthensocsec.gov/reports/Report-Final.pdf)

**Pension Insurance Data Book 2000**

<http://www.pbgc.gov/publications/databooks/DATABOOK.htm>

**Pension Liberation for Oregon: A Proposal to Reform PERS**

[http://www.cascadepolicy.org/pdf/fiscal/I\\_117.pdf](http://www.cascadepolicy.org/pdf/fiscal/I_117.pdf)

**Productive Workforce Survey: Report of Findings, Private Employer/Public Agency**

[http://www.thap.net/downloads/public\\_private\\_survey.pdf](http://www.thap.net/downloads/public_private_survey.pdf)

**Data Sets Sites**

**American FactFinder**

[factfinder.census.gov/servlet/BasicFactsServlet](http://factfinder.census.gov/servlet/BasicFactsServlet)

**Bureau of Labor Statistics Data**

[stats.bls.gov/datahome.htm](http://stats.bls.gov/datahome.htm)

**Current Population Survey Data**

[www.bls.census.gov/cps/datamain.htm](http://www.bls.census.gov/cps/datamain.htm)

**Data on the Net**

[odwin.ucsd.edu/idata/](http://odwin.ucsd.edu/idata/)

**Data Sources for Research in Aging**

[www.ssc.wisc.edu/cdha/resources.htm](http://www.ssc.wisc.edu/cdha/resources.htm)

**Health and Retirement Study and Asset and Health Dynamics Among the Oldest Old**

[www.umich.edu/~hrswww/](http://www.umich.edu/~hrswww/)

**Health Care Financing Administration**  
[www.hcfa.gov/stats/pufiles.htm](http://www.hcfa.gov/stats/pufiles.htm)

**Medical Expenditure Panel Survey**  
[www.meps.ahrp.gov/Data\\_Public.htm](http://www.meps.ahrp.gov/Data_Public.htm)

**Panel Study of Income Dynamics**  
[www.isr.umich.edu/src/psid/](http://www.isr.umich.edu/src/psid/)

**Social Security Program Data**  
[www.ssa.gov/OACT/ProgData/progData.html](http://www.ssa.gov/OACT/ProgData/progData.html)

**U.S. Census Data**  
[www.FreeDemographics.com/](http://www.FreeDemographics.com/)

**World Gazetteer**  
[www.gazetteer.de/](http://www.gazetteer.de/)

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