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**Tax Reform Becomes Law**

The recently enacted tax reform legislation, P.L. 99-514, makes dramatic changes in employee benefits both through numerous provisions directly affecting benefits and through the overall reduction in individual income tax rates. (For a detailed analysis of tax reform and employee benefits, see the October 1986 *EBRI Issue Brief*.) In all, the new law anticipates savings of $44 billion over five years due to changes in tax preferences for employee benefits—total savings that are greater than otherwise would have resulted from either the Senate or the House version of H.R. 3838.

The changes in the pension and welfare benefit area are intended to produce more comparable employee benefit coverage of rank and file employees and of highly-compensated employees. Pension changes, assuming that plans are maintained, increase the number of vested workers through faster vesting schedules, increase pension amounts by limiting the coordination with Social Security benefits, and mandate broader and more comparable coverage of rank and file employees. Higher-paid employees, however, suffer potential losses in benefits: restrictions on 401(k) salary reduction contributions ($7,000 cap, tighter nondiscrimination rules and inclusion of all after-tax contributions as annual additions under section 415 limits); a new limit of $200,000 on the amount of compensation that may be taken into account under all qualified plans; a new excess benefit tax of 15 percent on annual benefits over $112,500; and sharply reduced maximum benefits payable to early retirees under defined benefit plans.

Changes in welfare benefit areas aim for the same effect: an intended broadening of benefits because of tighter nondiscrimination rules that also could reduce benefits payable to the higher paid. Government staff have argued that reduced tax-favored benefits for the highly paid employees may be viewed as more comparable coverage of rank and file and highly paid when considered in terms of dollars, versus percent of compensation.

Overall, the employee benefit changes are far less punitive than those originally contained in the 1984 Treasury proposal. Favorable tax treatment is retained for most benefits, except education assistance, group legal services, and van pooling, which lose the income tax exclusion. Also, nondiscrimination rules for medical and group life insurance coverage are much more flexible than the original Treasury proposal, and permit a greater disparity between highly paid and rank and file employees.

Still, dramatic effects may be anticipated. The reduction in marginal tax rates will remove a significant force that historically contributed to the growth in employee benefits, and future growth will be slowed; coverage may not improve and may actually decline in the small business sector, where a top rate of 28 percent for the owners and a 15 percent rate for 80 percent of taxpayers may make cash a lot more attractive than benefits, which are more difficult to administer under the new rules. The desirability of deferring compensation is also called into question, because of new penalties on early withdrawals and the expectation that future tax rates may be higher than current rates. Finally, because of new restrictions on the higher-paid, many employers will face the option of removing the higher-paid from their general qualified benefit plans, which could result in deterioration in benefits for rank and file employees. As more of their compensation is provided through nonqualified plans, the higher compensated might "lose their stake" in the general benefit plan. Obviously, whether nondiscrimination rules cause expanded and more comparable coverage of rank and file employees, or reduce tax-favored benefits for the highly paid, will differ from employer to employer.

Employee benefits will remain an important piece of total compensation, but the changes in their tax effectiveness may prompt a reevaluation of overall benefits and a return to the basic purposes employee benefits were intended to fulfill: the promotion of economic security and human resource needs.
Effective Dates Approaching

The changes in employee benefits have varying effective dates. Some of them are effective January 1, 1987. The Internal Revenue Service is expected to come out with a series of notices bringing to employers' and practitioners' attention deadlines that need to be met right away. For example, to meet the new 401(k) participation rules that are effective after December 31, 1986, participants must be enrolled in plans before the end of 1986. A plan that calls for three years of service for eligibility must be changed to require one year of service. For provisions effective in 1988, however, the law cannot be applied sooner than the effective dates.

Congress Fails to Approve New Tax Law Corrections

Congress adjourned without approving technical corrections to P.L. 99-514, the new tax reform law. H. Con. Res. 395 would have corrected many of the errors found in the drafting of the massive new legislation. There will certainly be a technical corrections bill in 1987 when the 100th Congress begins its work.

Already the battle lines are being drawn between those who view the technical corrections as a vehicle for substantive changes in the tax law and Ways and Means Chairman Dan Rostenkowski, who has stated publicly that he will oppose any efforts to use the technical corrections measure to restore tax preferences that were reduced in the Tax Reform Act.

IRA, Keogh Assets Jump $70 Billion; Future Growth May Slow Because of Tax Reform

Financial assets held in IRA and Keogh accounts reached $268.7 billion as of June 30, 1986—up from $198.6 billion in June 1985 (chart 1). This represents a 35.3 percent increase in total IRA and Keogh assets over last year at this time and a 21.9 percent increase year-to-date.

Distribution of these IRA/Keogh funds among financial institutions (table 1) continues to show an investment adjustment aiming for higher total rates of return. A shift continues to the more popular mutual funds and self-directed brokerage accounts (SDAs) which each gained 4.2 percent and 1.5 percent, respectively, of total IRA and Keogh market share. Credit unions were the only other financial institution registering a gain—0.7 percent of market share.

Commercial banks and savings and loan institutions still hold the largest dollar amounts of IRA and Keogh funds—$124.2 billion. However, market share for these institutions continues to drop—from 50.7 percent in June 1985 to 46.2 percent in June 1986 (chart 2).

Life insurance companies lost ground in their share of the total IRA and Keogh market, declining by 0.4 percent of the market since June 1985. The market share lost by mutual savings banks is more difficult to assess, because the number of these institutions is shrinking as many of them register as federal savings and loans institutions. Therefore, IRA/Keogh assets held by these institutions are probably affected by this registration change.

Although assets in IRA and Keogh accounts increased by $70.1 billion between 1985 and 1986, future growth may not be as large due to limits placed on IRAs by tax reform.

There were an estimated 24.4 million IRA holders by the end of the 1985 tax year. Of these individuals, 73 percent, or 17.8 million, had employer-sponsored pension coverage. Within this group of all IRA holders, 73 percent, or 17.8 million individuals, would still have been allowed to make fully deductible IRA contributions had the new tax reform bill been effective in 1985; 12 percent, or 2.9 million, would have been
able to make partial deductible contributions; and 15 percent, or 3.7 million, would only have been eligible to make nondeductible IRA contributions.

Among IRA holders participating in an employer-sponsored retirement plan, EBRI estimates that those individuals allowed to make partial deductible contributions would, on average, have reduced contributions by $1,000 per person, resulting in an overall loss of $2.9 billion in new IRA money were all to contribute. (Internal Revenue Service data indicate that about 75 percent of those with IRAs contribute in each tax year.) From those individuals no longer allowed to make tax-deductible contributions, whose contribution
averaged $2,000 per person, approximately $7.4 billion in deductible IRA contributions would have been lost, although a portion of the losses might be replaced by nondeductible IRA contributions. Thus, total deductible contributions in 1985 might have fallen by an estimated $10.3 billion in the first year solely because of the new eligibility rules. Further reductions might result from the lower tax rates under tax reform, which diminish the tax value of a deductible contribution.

To put these losses in perspective, EBRI has also estimated the effect of the tax reform eligibility change on all wage earners in 1985. An estimated 89 percent, or 94.4 million workers, would still have been eligible to make a full IRA deduction. About 6 percent—6.4 million workers—would have been eligible for a partial deduction; and 5 percent, or 5.3 million workers, would have been restricted to a nondeductible IRA. (For more information on IRAs, see the October 1986 EBRI Issue Brief.)

Health Care Management at Xerox

[Editor's note: The following is an edited version of Pat Nazemetz's remarks at EBRI-ERF's policy forum on The Changing Health Care Market. Ms. Nazemetz is manager of benefits development at Xerox Corporation, and president of the National Association of Employers on Health Care Alternatives.]

Concerning the role of employers in the changing health care market, I would like to give you the Xerox perspective; many of the problems are similar to those of other major corporations. I will discuss the Xerox environment and business conditions before turning to health care.

Business conditions often trigger the way we view health care expenditures. Health care expenditures at Xerox, as for most large companies, are a major expense. Something in excess of $150 million annually is used to provide health care benefits for our employees. This is the full spectrum of benefits—disability benefits, workers compensation, health care benefits. Even in terms of a major corporation—a $10 billion corporation—this is a big expenditure; and we need to focus on that expenditure in much the same way as we do other business expenses. We haven't done that in the past.

In the last seven or eight years, Xerox has had a rude awakening. We've gone from a significant market share in the copier/duplicator business—over 75 percent in 1975—to less than 40 percent of that market share today. So the way that we did business ten years ago is not the way we do business today. It's not the way we will do business in the future.

As a result of the increase in competition, we've had to take an inward look at our priorities and our philosophy. We've begun to articulate some very specific philosophical directions and priorities for the business, and many of those things have a good application within the health care environment as well.

Quality, Customer Satisfaction and Employee Relations are Top Priorities

Our primary emphasis is on quality, and you hear that from most major manufacturers today—in fact from most major American businesses. Quality is very critical—quality products and a quality approach to the way we do business.

Customer satisfaction is also important. When you're fighting for market share, it's very important to make sure you're meeting your customers' needs.

Return on assets (ROA) is also a priority. We need to improve that ROA picture, which historically had been very strong, but has weakened somewhat in the last several years.

Employee relations is also a key priority at Xerox. Employees are a critical asset to the company.

Community responsibility has always been a strong priority, and remains one, even in more difficult financial times.

And, of course, market share— increase and improvement in market share—is critical to us.

There are some human resource implications for these particular priorities. What we have found is that people like me, in the human resource environment, need to take a look at how you balance the human resources and the financial resources of the business.

In a tough competitive environment, as we are beginning to see in the health care environment, cost becomes a major driver. What we need to assure through the human resource function is that the cost requirements, i.e., requirements to contain and manage the cost of the business, are not overshadowing the needs to balance or manage the human resources.

The common link is productivity. To the extent that you can make productivity improvements, you manage your costs more effectively. On the other hand, to the extent that your employees are appropriately motivated and healthy, they are more likely to be productive.
So, the whole issue of making sure that the health programs are intact and that the human resource programs are working will ultimately find its way to the bottom line, if managed appropriately. This is something that we've never really had to focus on before, with cost never being a major issue for companies like ours until recently.

Changes in Work Force Cause Program Reassessment

The human resource environment in which we work is changing. We have a less traditional work force today, in much the same way as most American companies do. We have employees with much greater mobility than they've ever had before. We are seeing a significant increase in retirees. Still a relatively young company with 60,000 active people, we have fewer than 4,000 retirees. But, as recently as seven or eight years ago, we had fewer than a thousand retirees. So we're seeing an increase and a trend that is obviously going to continue.

Our employee population is also aging somewhat, though not as fast as many other areas of the work force. But our population is aging, and that has health implications.

Probably the most important change in our human resource environment is that business conditions have driven us to less permanence in the work force. We don't have the same level of job security anymore that we've had in the past. As a result, one of the things that we have to look at is the concept of a buffer work force, patterning that in much the same way the Japanese have done. To maintain some stability in the work force, you may bring on some buffer people to deal with your peak and valley times. The consequence for human resource programs and human resource managers is that very often, to contain costs, these buffer people do not participate in benefit programs.

We have not instituted that level of buffer strategy at this point in Xerox. It's something we have under consideration. As we develop this strategy further, we must ensure that we don't neglect a major segment of the population in terms of health care and other financial security that we've assured the rest of our work force through our benefits package.

Through the evolving human resource environment, we have had to reassess our human resource programs, particularly the health care programs, to balance and meet the needs of the changing work force, and at the same time, meet the long term needs of the company. The role of health care programs at Xerox in this evolving environment has been articulated in this way. Essentially, we want the programs to help employees and their families to have appropriate access to health care, to remove the significant financial barriers to that access, and to make sure that they have not only appropriate care, but protection against financial catastrophe as a result of major health care expenses.

We also want employees to maximize their health care potential to whatever extent possible. This starts to move us out of the realm of mere reimbursement programs, and into the realm of things like wellness and prevention programs, and employee assistance.

Finally, and certainly not last on the list in importance, is the fact that we need to provide a safe and healthy work place and a safe and healthy community environment. That is the goal of our occupational safety and health staff and other people within the corporation.

Our goal now is to try to integrate some of these programs.

As in our business priorities and philosophy, in the area of health care, we are driving toward quality, customer satisfaction (employees and their families being end users and key customers of these products, and hopefully, the recipients of better health in the long term), and toward improvement in return on assets ("assets" being human resource assets as well as the financial assets, i.e., the dollars that we're spending). Employee relations are also important, and this takes into account the union as well as the salaried employee pieces, to make sure we maintain some level of harmony, keep employees productive, and make sure that they're on board with the corporation.

Finally, there is community responsibility: "community" being the source of care for our employees and our social responsibility in terms of things like indigent care. Even in a cost-competitive environment, we still maintain that social responsibility is a very important goal.

Cost Sharing Has Positive Results

What we've done so far has been somewhat typical. When we embarked on our strategy four years ago, it was not quite as typical as it is today. What we did then was to redesign our health care programs, primarily to introduce cost sharing, or, as I'm often corrected, "cost shifting" back to the employee population. We did this through plan redesign that essentially eliminated our old first-dollar coverage for hospital and surgery and subjected those expenses, as well as major medical types of expenses, to cost-sharing requirements.
We introduced pay-related deductibles and pay-related "stop loss" features in our program. We also introduced a flexible spending account, first of all, to help us with the transition from the old plan to the new, and, secondly, to make sure that employees did not feel that they had an inappropriate barrier to access to health care as a result of the cost-sharing features.

The results have been very positive to date. Hospital use has seen the biggest decrease. Overall, we've seen a decrease in hospital utilization of more than 20 percent in one year and another six or seven percent the following year. Our overall health care utilization has decreased somewhat less. Surgical procedures, particularly elective surgical procedures, have decreased dramatically, in excess of 30 percent. We've changed the way people are using the system, and that clearly was one of our goals.

The redesign was cost-driven, and we'll continue to emphasize cost. We don't want to pay for unnecessary care. Inappropriate expenditures, whether they are for health care or for other services, are simply inappropriate.

Movement Toward A Risk-Management Approach

While cost will continue to be an emphasis, we are moving beyond that now. While we have been driven by and focused on cost up until this point, we have begun to move forward to other areas, in terms of quality and access, but more importantly, in terms of health management in the broadest sense.

What we're embarking on now is in its earliest stages and so far, still on an internal basis. We have not engaged the provider community yet. What we're hoping to do is to work toward a "select provider process," essentially moving from the fee-for-service system (we now have about 60 percent fee-for-service, about 40 percent health maintenance organizations in terms of our employee participation in Xerox health care benefits) to more of a managed care system. Our goal is to maintain or manage the whole process. We have not done a good job at that in the past.

We want to move toward a risk-sharing approach where the corporation, the providers and the employees share in the risk of maintaining the employee's health status and in the cost of providing care in the event that employees or their dependents need care. In other words, we want to move toward a risk-management approach.

To do that, we know we need to move from negotiating insurance contracts and HMO agreements (and at this point, we don't really negotiate HMO agreements), toward negotiating provider contracts. The thrust is toward purchaser-driven competition, payer-driven competition, and that's the area in which we need to become more active.

To do this, we need to assess customer requirements. One of our key customer populations is our employees. Company and union representatives are also customers in this process, since we are spending company money, union dollars, and to some extent employee "wages" to provide these benefits. The community also becomes a customer, and the provider community as well may be a customer in this process.

After we have identified customer requirements—we're in the process of doing that right now—we need to translate those into provider specifications. Once we get to provider specifications, we'll get requirements and levels for provider service and performance.

A key issue is that of quality. How do we begin? Who measures quality? Who's responsible for quality? Our contention at this point is that the responsibility for assuring quality care rests with the provider community. We know that we have a role in helping them with that, and they have a role in helping us establish provider specifications that will govern quality measurement.

Essentially, what we're going to do is to say that we will work in collaboration with the provider community to develop provider specifications to provide the whole continuum of health care benefits to our employees, and then subject those specifications to bid within the provider community.

Once providers have agreed to conform to those specifications and to provide services within those specifications, it becomes their responsibility to assure adherence to them. Then, our role becomes one of monitoring, of establishing, a measurement system to assure that the providers live up to the specifications they've agreed to.

We're a long way from completing this project. We've just begun to talk about it. We realize there are a lot of problems facing us. It's a two- to five-year process before we're going to have the whole system up and running. But it's the direction that we think is important because it will help give us management control. We can then start to buy the products that we want to buy, the services that we want to buy, at a price that we think is the appropriate price.

We'll be working in collaboration with the provider community so that everybody is on board early on, at the onset of the process. We have begun to draw in our health care people internally, sitting down with them, talking with
From The Record

[Editor’s Note: The following excerpt of an interview with Rep. Dan Rostenkowski (D-IL) is from the September 1986 edition of Council Review, published by the American Council of Life Insurance, and reprinted with their permission.]

Council Review (CR): Two Ways and Means Subcommittees—Oversight and Social Security—are engaged in a joint review of national retirement income policy. What do you think the outcome is likely to be?

Rostenkowski: I don't want to prejudge the issue and will await their findings with interest. My suspicion is that they'll decide that we don't have a rational national retirement income policy, but are operating with a mishmash of bits and pieces that have been thrown together over the years.

Clearly, the experts would like a more comprehensive policy—as long as they don't have to make sacrifices. The situation is unlike what we have seen in the tax reform debate. Everyone knows how to make the system better, but no one wants to volunteer to sacrifice his special interests.

CR: Some people have criticized Ways and Means for its pension proposals, saying that the proposals seem to be revenue-driven and haven't always provided incentives for people to save for retirement. What is your response to that criticism?

Rostenkowski: The thrust of the entire tax reform debate reflects a waning interest in providing tax incentives for anything—including retirement. Our efforts at leading people into righteous paths have yielded mixed results. While we do retain some incentives, notably home mortgage interest and IRAs for some, we are turning away from the idea of making social policy in the tax code.

CR: A problem of increasing concern to insurers and their group clients is how to pay for the cost of health care in retirement, especially in light of Medicare's decreasing role. Shouldn't the tax code offer employers tax incentives similar to those offered for private pension plans?

Rostenkowski: The interests have an apparently insatiable appetite for new tax incentives. Given the fiscal realities, I cannot see a situation in the foreseeable future where we will provide new tax benefits to employers who do what we believe is good social policy.

If the ongoing debate about continuation of coverage is an indication of where we are going—and I don't know whether that's true—you might instead see tax penalties for those who don't move in directions that are seen as positive. The current debate over whether to tie obligations to the tax deduction for employer-purchased health insurance reflects this orientation.

CR: The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) mandating continuation of health care coverage highlighted the growing conflict between federal and state law. As Congress moves more into the regulation of health care benefits, are we going to see federal preemption or clarification of the respective roles of federal and state law?

Rostenkowski: Congress typically doesn't act until it has to. There isn't a clear need yet to clarify the state and federal responsibilities in the insurance area. When the industry comes in and says there is, I suspect we'll listen. But I doubt that we'll move until there is agreement within the industry.

It seems that insurance companies no longer view any federal role as negative, but that position hasn't been defined into something that would provide the basis for a broader policy.

Legislation and Litigation

Legislation
Congress Approves Budget Reconciliation

Two weeks after its planned adjournment date, Congress approved budget reconciliation legislation—H.R. 5300, now P.L. 99-509—that includes a reduction in the deficit of $11.7 billion. The deficit reduction is an attempt to meet the target allowed under the Gramm-Rudman-Hollings law approved last year, and is expected to bring the deficit to $154 billion—within the target range for the employee community in the process.
of $144 to $154 billion to avoid further budget cuts called for under the Gramm-Rudman-Hollings law.

Among the many provisions in the budget reconciliation law are several that affect benefits. One is the repeal of the current-law 3 percent inflation rate trigger for Social Security cost-of-living increases. Social Security beneficiaries will now receive cost-of-living increases even if inflation is less than 3 percent.

**Medicare**—The new law also makes several changes in Medicare. Under Medicare Part A, which covers hospital costs, hospital prospective payment rates are increased by 1.15 percent, compared to the administration's recommended 0.5 percent increase. The new law limits the increase in hospital capital costs to 3.5 percent in 1987, 7 percent in 1988, and 10 percent in 1989.

Medicare periodic interim payments (PIP) for reimbursements to hospitals are eliminated, except for rural hospitals and hospitals serving a large portion of low-income beneficiares. For Medicare beneficiaries generally, P.L. 99-509 also limits the 1987 increase in the Hospital Insurance deductible that beneficiaries pay to $520, instead of the $572 deductible that would otherwise have resulted from the indexing under current law. The deductible will be indexed to Medicare hospital prospective payment rates in the future.

The new law requires prompt payment of Medicare claims—in 26 days—beginning October 1, 1987. It makes Medicare the secondary payor for disabled beneficiaries eligible for employment-based health benefits. It prohibits the Reagan administration from issuing before September 1, 1987, final regulations or notices regarding hospital payments or physician payments that would achieve Medicare savings of more than $50 million in fiscal year 1988.

Under Medicare Part B, payments for cataract surgery are reduced, and criteria that the administration must consider before making inherent "reasonableness" decisions to reduce payments to providers are specified. P.L. 99-509 reduces end-stage renal dialysis payments by $2 per service, compared to the administration's regulatory reduction of $11. The new law limits payments for clinical labs and nutrition supplies, and allows Medicare reimbursement for vision care services offered by optometrists if the services are among those already covered by Medicare when furnished by a physician, and if the optometrist is authorized by state law to provide the services, effective beginning April 1, 1987. The new law also provides a 3.2 percent increase in Medicare physician prevailing charges, effective January 1, 1987. Future year increases would be tied to percentage increases in the Medicare Economic Index. (The MEI, expressed as a maximum allowable percentage increase, has been tied to economic indexes reflecting changes in physician operating expenses and earnings levels. An August 1986 HHS regulation revised the calculation to account for an adjustment to the housing cost component, which the administration believes to be historically overstated.)

**Medicaid**—In addition, states would be allowed to expand Medicaid coverage to pregnant women, infants, elderly, and disabled, with income below the poverty line but who do not meet federal welfare requirements. It "holds harmless" those states adversely affected by a change in the Medicaid formula made under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

**COBRA**—The budget reconciliation law also amends the continuation of health care provisions under COBRA. It makes loss of retiree health coverage because of a firm's filing of chapter 11 bankruptcy a qualifying event for continuation of coverage for retirees and their dependents. Effective July 1, 1986, retirees and their dependents in that situation will be eligible for continued coverage, provided they pay the required premium, for as long as the retiree lives. Upon the death of the retiree, dependents are eligible for 36 months of continuation coverage. (For more action relating to LTV's retiree health and pension plans, see "LTV Receives Congressional/Judicial Attention" in this issue.)

**Post-65 Pension Accruals**—The budget reconciliation measure also requires that employers provide pension accruals or allocations for those working beyond age 65, and for newly hired employees who are within five years of normal retirement age. In the latter situation, however, employers may delay the individual's normal retirement age by five years beyond the age of the newly-hired employee.

EBRI estimates that, in 1985, out of an estimated 365,000 nonfarm plan participants age 65 and over, only 151,000 would have been helped by post-65 accruals. In addition, EBRI has estimated actuarial costs for post-65 accruals in 1985 would have ranged from $638 million to $1.3 billion.

**Other Federal Retiree Benefits**—The budget reconciliation measure also exempts federal civilian, military, and related retirement COLAs, as well as railroad retirement so-called "windfall benefits" from programs subject to cutback under the Gramm-Rudman-Hollings law. A 1.3 percent increase will be paid effective January 1, 1987, to low-income aged, blind, and disabled persons receiving Supplemental Security Income (SSI) benefits; to former federal
civilian and military employees
receiving civil service and military
retirement pensions; to railroad
retirement annuitants (whose increase
will be calculated only on the Social
Security portion of the benefit); and to
low-income persons receiving veteran's
pensions not based on service-connected
disabilities.

Risk Pools, Medicare for State and
Locals Dropped from Bill—Two
controversial provisions were dropped
from budget reconciliation: (1) the
Senate-passed provision to extend
Medicare coverage on a mandatory basis
to all state and local government
employees, instead of just those hired
after March 31, 1986 (current law); and
(2) the House-passed provision to require
states to establish health insurance pools
for uninsured individuals. Congressional
staff report that the risk-pool provision
included health insurance coverage for
abortion, making the legislation too
too controversial for approval in the last
hours of the 99th Congress.

Risk-pool legislation, along with a host
of other mandated benefits, will certainly
be reintroduced in the next Congress.
Medicare coverage for all state and local
government employees will also be
reconsidered in the overall context of
Medicare's financing problems.

Regan Expects Budget Overhaul Attempt
Next Year—White House Chief of Staff,
Donald Regan, said that he expects
overhauling the federal budget process to
be a major policy initiative for the rest
of President Reagan's term. Regan said
that a possible reform package put forth
by the Reagan administration might
remove trust funds from the federal
budget, allow presidential line-item
vetos, include a balanced-budget
constitutional amendment, and move to
a "capital" budget, which would spread
payment of building costs over a period
of time, rather than in a lump sum at the
start of a project. The administration
might also seek a two-year budget
process. Another proposal that the
administration is considering would
require the president's signature on the
joint budget resolution that is passed by
Congress. Currently, the resolution
does not require the president's approval.
Congress is unlikely to accept all of the
administration's recommendations for
budget reform.

Mandatory Retirement Abolished
One of the last actions of the 99th
Congress was to approve H.R. 4154, the
bill to eliminate mandatory retirement at
age 70, sponsored by Rep. Claude
Pepper (D-FL), and Sens. John Heinz (R-
PA) and Howard Metzenbaum (D-OH).
The legislation also recodifies the
COBRA provision that requires
employers to continue group health
coverage for workers over age 70.

The new law amends the Age
Discrimination in Employment Act of
1967, which originally prohibited
employers from establishing a retirement
age lower than 65. Congress raised the
age to 70 in 1978. As passed by
Congress on October 17, 1986, H.R.
4154 exempts police, firefighters, and
tenured academic faculty from the
provisions for seven years, pending
studies of the impact of the legislation.
It also continues a current-law exception,
allowing mandatory retirement at age 65
for senior executives, i.e., individuals
eligible to receive an annual annuity
equal to $44,000 or more. The new law,
which applies to firms employing 20 or
more employees, will become effective
January 1, 1987, with an exception for
collectively bargained plans. Where a
collective bargaining agreement was in
effect on June 30, 1986, the new
retirement age is effective upon the
earlier of the following two dates: (1) the
date of termination of the agreement or
(2) January 1, 1990.

EBRI estimates that between 41,000 to
77,000 more men and women would
have been in the labor force in 1985 had
mandatory retirement been abolished.
This would represent an average 2.3
percent increase in employment among
those age 70 and over. Since these
estimated labor force effects are so small,
the new law primarily represents a civil
rights measure to require the equal
treatment of all older workers, and not a
measure that would significantly change
work and retirement behavior (see the
August 1986 EBRI Issue Brief for more
information).

South Africa Sanctions Now
Law
Congress overrode President Reagan's
veto of H.R. 4868, which imposes
sanctions on South Africa until that
country begins measures to end
apartheid. One of the provisions of the
H.R. 4868—now P.L. 99-440—bans
new public and private loans and
investments in South Africa, except for
reinvestment of profits from South
African enterprises, short-term credits,
and rescheduling of existing debt.

The congressional override came shortly
after Reagan extended for one year
limited sanctions issued last September,
and offered to impose further limits on
South African investments and imports.
Provisions in Reagan's offer were less
stringent than the measures approved by
Congress.

Other provisions of the new law include
a ban on South African imports and
restrictions on certain U.S. exports to
the country. Corporations violating the
sanctions could be fined; individuals
could also be fined and imprisoned for up
to five years (see Employee Benefit
Administration Drafts Nursing Home Rules

Reversing its previous efforts to loosen federal regulation of nursing homes, the administration has apparently developed new rules designed to protect patients' rights, according to a New York Times report.

The October 13 edition of The Times described a confidential 48-page summary of proposed rules drafted by the Department of Health and Human Services in response to recommendations made earlier this year by the National Academy of Sciences.

In addition to guaranteeing every nursing home resident a "dignified existence," the proposed new rules would require nursing homes to inform patients how to obtain their own medical records, legal aid, and information about state nursing home regulations. The rules also would call for stepped-up regulation of homes that have histories of deficiencies.

Although the administration reportedly is embracing many of the academy's proposals, it is rejecting others, including one to bar nursing homes from discriminating against Medicaid recipients.

PBGC, DOL, and IRS Propose Changes in 5500 Forms

The Pension Benefit Guaranty Corporation (PBGC), together with the Internal Revenue Service and DOL, September 19 proposed revisions in the annual return/report forms (form 5500) filed by administrators of employee pension and welfare benefit plans under terms of the Employee Retirement Income Security Act of 1974 (ERISA). The revisions are intended to reduce reporting burdens and increase efficiency.

The Office of Management and Budget has not yet approved the revised forms.

If adopted, the revised forms will be effective for plan years beginning on or after January 1, 1987 (for more information, see the Federal Register, September 19, 1986, vol. 51, no. 182 pp. 33500-33557).

DOL Proposed Penalties for Illegal Transactions

The Department of Labor (DOL) Pension and Welfare Benefits Administration (PWBA) has proposed a regulation that authorizes the secretary of labor to assess civil penalties against parties in interest who engage in prohibited transactions with certain welfare plans and nonqualified pension plans. It provides for the imposition of an initial penalty of up to 5 percent of the "amount involved" in the underlying prohibited transaction, and allows a 100 percent penalty if the prohibited transaction is not corrected within 90 days. If adopted, the regulation would be effective 30 days from the date of its publication as a final regulation (Federal Register, August 27, 1986, vol. 51, no. 166, pp. 30518-30522).

Litigation

Supreme Court to Decide Pregnancy Leave

The U.S. Supreme Court October 8 heard arguments over whether states can require employers to provide more generous disability leave for pregnant employees.

At issue is whether a California state law mandating that employers grant up to four months of unpaid leave to pregnant women discriminates in favor of pregnant workers and violates a 1978 federal law designed to ensure equal treatment of disabled employees.

In California Federal Savings and Loan v. Guerra (Cal Fed), no. 85-494, the Court is asked to determine whether Congress, in passing the 1978 law, intended to not only prohibit discrimination against pregnant women, but also discrimination in their favor.

The Justice Department filed a suit urging the Court to rule such laws unconstitutional, arguing that they violate the 1978 Pregnancy Discrimination Act. Several other states require employers to grant special leave for pregnancy-related conditions. Should the Court agree with the Justice Department, such states may be required to review their laws. The Court is expected to rule on the case by next summer (see February 1986 Employee Benefit Notes for more background information).

AARP Files Older Worker Discrimination Suit

The new law that requires employers to provide pension accruals or allocations for workers over age 65 will not affect a suit recently filed by the American Association for Retired Persons (AARP).

Chris Mackaronis, head of AARP's advocacy program, said that it is AARP's position that current law requires post-65 pension accruals, and furthermore, the pension accrual provision approved as part of the budget reconciliation law does not require employers to provide retroactive payments.

AARP September 23 filed a lawsuit against Farmers Group, Inc., alleging that the organization discriminates against its older workers by discontinuing pension and profit-sharing.
civilian and military employees receiving civil service and military retirement pensions; to railroad retirement annuitants (whose increase will be calculated only on the Social Security portion of the benefit); and to low-income persons receiving veteran's pensions not based on service-connected disabilities.

Risk Pools, Medicare for State and Locals Dropped from Bill—Two controversial provisions were dropped from budget reconciliation: (1) the Senate-passed provision to extend Medicare coverage on a mandatory basis to all state and local government employees, instead of just those hired after March 31, 1986 (current law); and (2) the House-passed provision to require states to establish health insurance pools for uninsured individuals. Congressional staff report that the risk-pool provision included health insurance coverage for abortion, making the legislation too controversial for approval in the last hours of the 99th Congress.

Risk-pool legislation, along with a host of other mandated benefits, will certainly be reintroduced in the next Congress. Medicare coverage for all state and local government employees will also be reconsidered in the overall context of Medicare's financing problems.

Regan Expects Budget Overhaul Attempt Next Year—White House Chief of Staff, Donald Regan, said that he expects overhauling the federal budget process to be a major policy initiative for the rest of President Reagan's term. Regan said that a possible reform package put forth by the Reagan administration might remove trust funds from the federal budget, allow presidential line-item vetoes, include a balanced-budget constitutional amendment, and move to a "capital" budget, which would spread payment of building costs over a period of time, rather than in a lump sum at the start of a project. The administration might also seek a two-year budget process. Another proposal that the administration is considering would require the president's signature on the joint budget resolution that is passed by Congress. Currently, the resolution does not require the president's approval. Congress is unlikely to accept all of the administration's recommendations for budget reform.

Mandatory Retirement Abolished

One of the last actions of the 99th Congress was to approve H.R. 4154, the bill to eliminate mandatory retirement at age 70, sponsored by Rep. Claude Pepper (D-FL), and Sens. John Heinz (R-PA) and Howard Metzenbaum (D-OH). The legislation also recodifies the COBRA provision that requires employers to continue group health coverage for workers over age 70.

The new law amends the Age Discrimination in Employment Act of 1967, which originally prohibited employers from establishing a retirement age lower than 65. Congress raised the age to 70 in 1978. As passed by Congress on October 17, 1986, H.R. 4154 exempts police, firefighters, and tenured academic faculty from the provisions for seven years, pending studies of the impact of the legislation. It also continues a current-law exception, allowing mandatory retirement at age 65 for senior executives, i.e., individuals eligible to receive an annual annuity equal to $44,000 or more. The new law, which applies to firms employing 20 or more employees, will become effective January 1, 1987, with an exception for collectively bargained plans. Where a collective bargaining agreement was in effect on June 30, 1986, the new retirement age is effective upon the earlier of the following two dates: (1) the date of termination of the agreement or (2) January 1, 1990.

EBRI estimates that between 41,000 to 77,000 more men and women would have been in the labor force in 1985 had mandatory retirement been abolished. This would represent an average 2.3 percent increase in employment among those age 70 and over. Since these estimated labor force effects are so small, the new law primarily represents a civil rights measure to require the equal treatment of all older workers, and not a measure that would significantly change work and retirement behavior (see the August 1986 EBRI Issue Brief for more information).

South Africa Sanctions Now Law

Congress overrode President Reagan's veto of H.R. 4868, which imposes sanctions on South Africa until that country begins measures to end apartheid. One of the provisions of the H.R. 4868—now P.L. 99-440—bans new public and private loans and investments in South Africa, except for reinvestment of profits from South African enterprises, short-term credits, and rescheduling of existing debt.

The congressional override came shortly after Reagan extended for one year limited sanctions issued last September, and offered to impose further limits on South African investments and imports. Provisions in Reagan's offer were less stringent than the measures approved by Congress.

Other provisions of the new law include a ban on South African imports and restrictions on certain U.S. exports to the country. Corporations violating the sanctions could be fined; individuals could also be fined and imprisoned for up to five years (see Employee Benefit Notes 1986).

LTV Receives Congressional/Judicial Attention

In addition to the COBRA amendment for retiree health benefits continuation in chapter 11 situations (see "Budget Reconciliation" story above), the continuing resolution for fiscal year 1987 (H.J. Res. 738) contains a provision, inspired by the LTV situation, which says if a firm is in chapter 11 bankruptcy proceedings as of October 2, 1986, or later, and is paying retiree health benefits as of October 2, 1986, or later, then retiree health benefits must be continued until May 15, 1987.

The amendment to the continuing resolution, offered by Sens. Howard Metzenbaum (D-OH) and John Heinz (R-PA), was a stopgap measure, pending action in the 100th Congress to resolve the issue of an employer's legal obligation to continue retiree health benefits under section 1113 of the bankruptcy code. For example, H.R. 5490, a House-approved bill sponsored by Rep. Peter Rodino (D-NJ), would have clarified that section 1113 of the bankruptcy code explicitly applies to retiree health benefits that are included in collective bargaining agreements.

Meanwhile, a U.S. district court judge has ruled that LTV Corporation may continue paying retired workers benefits for a six-month grace period while it reorganizes under federal bankruptcy laws. Twenty-two banks had appealed the bankruptcy court order in July.

The Congressional Research Service (CRS) issued another report addressing the issue of whether the LTV corporation, which is filing for reorganization under bankruptcy law, may halt nonunion retirees' right to benefit payments (see September 1986 Employee Benefit Notes for the first CRS report on LTV).

The new CRS report concludes that "the Bankruptcy Code appears to be flexible enough to accommodate the continuation of nonunion retiree benefits in appropriate circumstances. As in matters relating to an individual debtor's rights and obligations, determinations must be made on a case-by-case basis. Hence, even though a debtor may be legally justified in suspending payment of retiree benefits not covered by a collective bargaining agreement simultaneous with a filing under chapter 11, it cannot be said that the code itself clearly, unambiguously, and consistently necessitates that result in all instances."

In related action, the Pension Benefit Guaranty Corporation (PBGC) September 26 filed for an order in the U.S district court for the southern district of New York to terminate LTV's Republic Retirement Plan and appoint the PBGC as plan trustee. PBGC said that the action is designed to protect the pensions of 9,000 LTV workers and retirees. The PBGC is required to initiate termination of such pension plans under the Employee Retirement Income Security Act of 1974 (ERISA) when a plan does not have assets available to pay benefits currently due. The action involves the largest PBGC-initiated termination and the second largest claim in PBGC's history.

According to the PBGC, LTV's Republic plan currently has a monthly pension obligation of $2 million, and will represent an additional unfunded liability for PBGC-guaranteed benefits of approximately $250 million. PBGC Executive Director, Kathleen Utgoff, noted that "this LTV plan will add another heavy burden to an already financially troubled agency." As of June 1986, the PBGC's deficit was estimated at $1.7 billion, reflecting $1.5 billion in assets versus long-term liabilities of $3.2 billion.

Senate Panel Holds Third Hearing on Medical Malpractice

The Senate Labor and Human Resources Committee held its third oversight hearing on "The Impact of the Medical Malpractice Insurance Crisis on Health Care in America" September 11. Although the 99th Congress did not pass legislation addressing malpractice insurance, the issue is expected to carry over to the 100th Congress.

HHS Secretary Otis Bowen told the panel that he had named a task force to examine the issues involved: Daniel P. Baroque, president of the National Committee for Quality Health Care, is the task force chairman, and Dennis DeWitt of HHS' Health Care Financing Administration (HCFA) is the executive director.

Bowen also suggested the Senate committee review a report issued by the White House Domestic Policy Council, that includes several recommendations designed to improve liability law.

Bowen said that "there are no comprehensive national data on whether rising malpractice premium costs are affecting access to care. However, we recently completed a survey that found a number of specific examples which suggested there may be problems in some geographic areas and certain population subgroups with access to care.

"In general, our survey shows that low-income patients, rural residents, those living in midwestern and southeastern states and those considered to be high risk—either because of their medical condition or because they are likely to sue—are more likely to encounter access problems that may be attributed to the
current malpractice situation. Of course, these are many of the same groups that have traditionally had more access problems." Bowen said that the number of examples collected—over 150 in 33 states—provides cause for concern.

Bowen also addressed legislation before the Senate committee—S. 1804, sponsored by Sen. Orrin Hatch (R-UT). The bill would establish financial incentives to encourage states to adopt reforms in liability insurance and tort law, including limits on noneconomic damages and on attorneys' fees.

Bowen expressed concern over the cost of the legislation in light of current budget restraints. He also said that the bill limits itself to too narrow a set of reforms. Bowen said that his task force would attempt to resolve some of the issues by looking at five areas.

Examine the impact of existing compensation systems on the delivery of medical services.

Examine applicable laws governing compensation for medically caused injuries.

Examine development of structures and procedures to ensure the quality of medical practice.

Examine roles of the insurance industry, public and private, as it attempts to protect both provider and beneficiary.

Identify a national research agenda, including a national survey of physicians, to find out how liability coverage has changed since 1983.

In addition, Rep. Robert Mrazek (D-NY), sponsor of a bill (H.R. 2659), which is also intended to reform medical malpractice laws, noted the similarity of his bill and S. 1804 in a statement submitted to the panel.

"The main difference in my approach is the creation of arbitration panels to hear and decide all claims resulting from medical malpractice," Mrazek said. "Truly effective reform will require, in my view, an alternative mechanism to the judicial system," he added.

Portability Legislation Likely

With the ink barely dry on the new tax reform act, congressional staff and others are already talking about employee benefit issues that might arise in 1987. One issue of long-standing concern is the issue of pension portability (see July 1986 EBRI Issue Brief). In an earlier issue of Notes, we also published a discussion of the portability arrangement that existed under the breakup of the Bell Telephone System (March 1986 Employee Benefit Notes).

Another portability model has been brought to our attention, and merits further study. Associated Benefits Corporation serves 146 individual employers (agricultural cooperatives) and has a portability arrangement for vesting purposes with other cooperative plan providers covering approximately 600 similar employers. Each is a totally independent employer with the only tie being a common industry.

An employee who works his entire career within the cooperative system in the midwest could work under as many as 16 separate plans with each recognizing the other 15 for vesting service. Since the plans all have different provisions, credited service is calculated and paid by each plan as earned. Since an employee transferring within the cooperative world is treated as a "transfer" by any one plan (rather than a termination), each plan continues to hold the assets for the benefit payable by that plan until the employee retires, dies, becomes disabled, or leaves the cooperative system. This is an arrangement that has been in operation for more than 15 years and Associated Benefits Corporation reports that it works well.

Regulations

HCFA Announces Medicare Premium Increase

The Health Care Financing Administration (HCFA) October 2 announced that the monthly premium to be paid for Part B of Medicare will increase to $17.90 from $15.50, effective January 1, 1987. The increase reflects the amount needed to cover 25 percent of the program's cost. In addition, the HCFA regulation explains calculations of new monthly actuarial rates for aged and disabled enrollees in the Medicare Supplemental Medical Insurance (SMI) program. (For more information, see the Federal Register, October 2, 1986, vol. 51, no. 191, pp. 35291-35298.)

HCFA Proposes Final Medicare PPS Rule

The Department of Health and Human Services' (HHS) Health Care Financing Administration (HCFA) September 3 issued a final rule to implement changes in the Medicare prospective payment system, as a result of legislation and continuing experience with the system. The changes include revisions in the method used to calculate prospective payment rates. One proposal, however, to incorporate capital-related costs into the prospective payment system, was dropped. HCFA says they will continue to deliberate the issue. The rule is effective October 1, 1986 (Federal Register, September 3, 1986, vol. 51, no. 170, pp. 31454-31603). For more information on the prospective payment system, see July 1986 Employee Benefit Notes.
Administration Drafts Nursing Home Rules

Reversing its previous efforts to loosen federal regulation of nursing homes, the administration has apparently developed new rules designed to protect patients' rights, according to a New York Times report.

The October 13 edition of The Times described a confidential 48-page summary of proposed rules drafted by the Department of Health and Human Services in response to recommendations made earlier this year by the National Academy of Sciences.

In addition to guaranteeing every nursing home resident a "dignified existence," the proposed new rules would require nursing homes to inform patients how to obtain their own medical records, legal aid, and information about state nursing home regulations. The rules also would call for stepped-up regulation of homes that have histories of deficiencies.

Although the administration reportedly is embracing many of the academy's proposals, it is rejecting others, including one to bar nursing homes from discriminating against Medicaid recipients.

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AARP September 23 filed a lawsuit against Farmers Group, Inc., alleging that the organization discriminates against its older workers by discontinuing pension and profit-sharing
contributions at age 65.

Filed in federal district court in Los Angeles, the suit charges that Farmers Group, Inc. violated the Age Discrimination in Employment Act (ADEA) by "freezing" pension and profit sharing for all employees working beyond age 65. AARP is asking the court to order pension and profit sharing credits for post-65 employment, liquidated damages, and attorneys' fees.

At EBRI

Policy Forum Explores Benefits for the Future

"America in Transition: Benefits for the Future" was the subject of EBRI's fall policy forum October 15.

The forum was a roundtable discussion of the demographic and economic situation of the American worker, and how those changes will affect employee benefits in the years to come. More than 100 EBRI sponsors, congressional and executive branch staff, benefits experts, and representatives from academia, labor and the press discussed trends in the work force, employer and employee views of benefits, the federal role in providing retirement and economic security, and the employer's response to benefit provision changes under tax reform.

Panelists included Tom Espenshade, senior research associate, The Urban Institute; Deborah Chollet, senior research associate, EBRI; Florence Skelly, president, Telematics; John Parkinson, practice director, organization research and analysis, The Wyatt Company; Mathew Greenwald, Mathew Greenwald and Associates, Inc.; David Lindeman, analyst, Congressional Budget Office; Anna Rappaport, principal, William M. Mercer-Meidinger, Inc.; Richard Velloney, director, personnel-administration department, The Travelers Insurance Companies; Margaret Gagliardi, vice president, compensation and benefits, American Express Travel-Related Services Company, Inc.; and Robert Paul, vice chairman, Martin E. Segal Company. Proceedings from the forum will be published early next year.

EBRI Cosponsors American Pension Conference Meeting

EBRI October 28 cosponsored a workshop with the American Pension Conference, designed to address changes affecting employee benefits that are the result of tax reform. Panelists included Paul T. Shultz, vice president, Towers, Perrin, Forster & Crosby; William M. Leiber, pension tax counsel, Joint Committee on Taxation; Kent Mason, attorney-advisor, Department of Treasury; and Robert H. Masnick, group chief employee plans, projects branch, Internal Revenue Service.

EBRI Conducts Financial Planner Survey

A major change in our system of taxation has been enacted into law. The new law will have an enormous impact on the way Americans accumulate wealth and prepare for retirement. Because the way that individuals should react to the changes in the tax code is not clear, EBRI is conducting a survey of financial planners in an effort to determine what impact the changes will have on pension plans and other benefit systems.

Survey results will be analyzed by the research firm of Mathew Greenwald and Associates, and should soon be available.

EBRI to Study Long-Term Care Issues

The American Association of Retired Persons, Atlantic Richfield Foundation, and Southwestern Bell Foundation have together contributed a total of $120,000 to help finance an Employee Benefit Research Institute (EBRI) Education and Research Fund study of options for financing and delivering long-term care—health and social services provided to the chronically ill and functionally impaired.

The growing need for better long-term care options has prompted the federal government to place long-term and catastrophic health care high on its policy agenda. The Health Care Financing Administration's new Task Force on Long-Term Health Care Policies met September 25 and 26 to begin developing guidelines for private long-term care insurance.

Another advisory group at the Department of Health and Human Services is considering a number of policy options for financing catastrophic illness and long-term care expenses for a report due to the president later this year.

EBRI's study, scheduled for completion in late 1987, will evaluate delivery and financing options in light of the elderly's projected financial and insurance resources. Headed by Robert Friedland, EBRI research associate, it will explore such options as funding through employer-based insurance plans, private long-term care insurance, and greater Medicare financing of long-term care.

The study also will evaluate how long-term care is provided and weigh the alternatives to institutional care, including social health maintenance.
organizations, continuing care communities, transition units outside hospitals, and community-based programs.

Presentations

EBRI President Dallas Salisbury made a number of presentations during the month of October. These included a speech October 2 before General Foods Personnel Forum on the "Background and Implications of the Tax Reform Act;" October 6 before the American Bankers Association on "Trends in the Employee Benefits Business;" October 10 before the American Association of Retired Persons' United States Canadian Expert Group Meeting on Policies for Midlife and Older Women, on the subject of "Issues in the Coverage of Women under Private Pension Plans in the United States;" October 20 before the Citibank Employee Benefit Funds Client Conference on "The Outlook from Washington: A Legislative Update;" October 27 before the Health Insurance Association of America Individual Insurance Forum on "What Lies Ahead;" and October 28 before the Norwest Bank Client Seminar on "Employee Benefits and Tax Reform."


Deborah Chollet, senior research associate, delivered a speech October 14 before the National Health Policy Forum on "Retiree Health Insurance Benefits: The Impact of Vesting Rules."

Announcements and Publications

Social Security Benefits, Medicare Premiums to Increase

Health and Human Services (HHS) Secretary Otis Bowen October 23 announced that the nation's Social Security beneficiaries will get a 1.3 percent cost-of-living increase in January.

The Social Security wage base will increase from the current $42,000 annually to $43,800. As a result, the maximum tax payable by a worker in 1987 will increase from $3,003 to $3,131.70.

The maximum amount that a retired worker under age 65 can earn without a reduction of Social Security benefits will increase from $5,760 to $6,000 in 1987; those age 65 to 69 can earn $8,160 in 1987, up from the current $7,800 annually. There is no limit on earnings for Social Security Beneficiaries age 70 and over.

The hospital insurance deductible expenses Medicare beneficiaries must pay under Part A will increase from $492 to $520 (see "Budget Reconciliation" story in this issue). Monthly Medicare premiums for Part B will increase from the current $15.50 to $17.90 (see "HCFA Announces Medicare Premium Increase" story in this issue). The Medicare premium increase, however, will not apply for those beneficiaries whose monthly benefits are so low that the $2.40 per month increase would wipe out their Social Security cost-of-living increase and reduce their net Social Security monthly benefit.

Pentagon Reviews Health Care Proposals

The Department of Defense (DOD) is currently evaluating industry comments on its proposal to shift its $1.8 billion medical care program to private insurers and medical care providers; DOD hopes to release a request for a proposal shortly.

Congress approved funding for the plan before adjourning, but recommended phasing the program in over a three-year period. Initially, private providers were to have assumed complete control of the federally-funded Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) by October 1987. The first stage of the plan is expected to begin next October.

The plan is designed to take advantage of the private-sector marketplace by using provider networks to buy better care for some 6 million DOD beneficiaries and the government in the hope that it would result in more efficient use of military facilities.

UMW to Develop Prepaid Health Plan For Retirees Under HCFA Grant

Affirming its interest in capitation as a payment mechanism for Medicare-covered health services, HCFA has awarded a grant to the United Mine Workers of America (UMW) for development of a prepaid health plan demonstration project for its Medicare-eligible retirees.

The project is one of nine which together are to receive first-year funding of $1.8 million. Other recipients include the University of Colorado, which will investigate the impact of the Medicare prospective payment system (PPS) on posthospital quality of care, and Yale and Brandeis universities, each of which will develop potential refinements for PPS diagnosis-related
In addition, HCFA is holding discussions with several companies and labor unions on the Medicare system. HCFA, the companies, and the unions are studying whether Medicare benefits can be administered more cost-effectively by industry. The "risk-contract" program, proposed on a demonstration basis by HCFA, would give an employer a fee based on the number of the employer's Medicare-eligible retirees and dependents. In exchange for the fee, the employer would provide health benefits equal to those the retiree is entitled to under Medicare. Several employers are now collecting data to determine the feasibility of such a contract (see "Michigan Employers Establish Health Insurance Database").

Michigan Employers Establish Health Insurance Database

The Greater Detroit Area Health Council in September announced that Michigan employers, including two of the nation's big three automakers, will create a common database from their employees' health insurance claims. Data from the claims of approximately 1.2 million Michigan residents will be included in the initial phase of the project.

The goal of the project, which is partially funded by a $50,000 grant from the CIGNA foundation, is to help participating corporations get a handle on how their health care benefit dollars are being spent. Project participants will receive data on utilization and costs of health care services, as well as comparative aggregate information. The information can then be analyzed by project participants to determine how their health care dollars are spent, and, if possible, implement ways to control costs.

Final Plan Asset Regulations

The U.S. Department of Labor (DOL) is expected to issue final plan asset regulations during the first week in November. The long-awaited regulations have been in the works for nearly 11 years. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) instructs DOL to adopt final rules by December 31, 1986. The forthcoming rules will likely be substantially different from 1985 proposed regulations, which establish guidelines for determining who is a fiduciary, and define plan assets for purposes of fiduciary duty and prohibited transaction rules.

Opinions Issued on Performance-Based Compensation to Investment Managers

The Department of Labor's Pension and Welfare Benefits Administration (PWBA) September 2 issued two advisory opinions concerning payment by plans of performance-based compensation to investment managers.

Issued to BDN Advisers, Inc., of New York, and Batterymarch Financial Management of Boston, PWBA noted common features in the proposals.

The investment management arrangement will comply with the terms and conditions of securities law governing performance compensation arrangements.

The investment manager's performance will be measured by a formula that takes into account both realized and unrealized gains and losses during a preestablished valuation period.

Investment of plan assets generally will be made in securities for which market quotations are readily available, and persons appointed by a plan and independent of the investment manager will independently value the small portion of the securities under management for which the market quotations are not readily available.

The performance-based compensation arrangement will only be entered into with plans having aggregate assets of at least $50 million.

The advisory opinions clarify that the payment of performance-based compensation in accordance with the arrangements described by BDN and Batterymarch would not necessarily constitute a violation of the self-dealing prohibitions of the Employee Retirement Income Security Act (ERISA). Such a violation, however, could occur in the course of the provision of services by the investment manager.

The opinions also cautioned that ERISA's general standards of fiduciary conduct require a plan fiduciary to act prudently with respect to the decision to retain an investment manager pursuant to a performance-based compensation arrangement, as well as to the negotiation of the specific formula under which compensation will be paid.

The DOL announcement also said that it expects plan fiduciaries entering into performance compensation arrangements to fully understand the compensation formula and risks associated with the arrangement, following disclosure by the investment manager of all relevant information. Moreover, the announcement says, the plan fiduciary must be capable of monitoring the manager's performance of its investment duties.

Questions regarding specific performance-based compensation arrangements should be addressed to Janet Laufer, Office of Regulations and Interpretations, Pension and Welfare Benefits Administration, Room NS669, 200 Constitution Avenue.
NW, Washington, DC 20210, (202) 523-7910; or Shelby J. Hoover, Plan
Benefits Security Division, Office of the Solicitor, Room C4508, 200

NYSE Asks SEC for Voting Rights Revisions

The Securities and Exchange Commission (SEC) October 16 voted to
hold public hearings on the New York Stock Exchange's proposal to drop its requirement that each share of its listed companies' common stock carry one vote. The hearings could be scheduled by December.

The New York Stock Exchange September 16 filed proposed modifications to the "one share/one vote" voting rights standards, which prohibit creation of a class of stock with unusual voting provisions that would nullify or restrict voting, or that has voting power not in proportion to the equity interests of the class.

The proposed rule change, filed with the Securities and Exchange Commission (SEC), establishes approval requirements that would allow a class or classes of common stock to have other than one vote per share, or a class or classes of voting equity securities that would otherwise be objectionable under existing policy.

National Teleconference Debates Economic, Ethical Issues of High-Tech Medicine

Panelists and participants throughout the country discussed the difficult economic and ethical choices surrounding the use of high technology medicine in a nationwide video teleconference, "Who Lives, Who Dies, Who Decides?", held September 24 at the U.S. Chamber of Commerce in Washington, DC.

Panelists included Thomas Ferris, University of Minnesota Medical School; Donald Fredrickson, Howard Hughes Medical Institute; Sen. Albert Gore (D-TN); William B. Schwartz, Tufts University Medical School; Joseph Califano, former Secretary of Health, Education, and Welfare under President Jimmy Carter; Rep. George Miller (D-CA); Barbara Sklar, National Council on the Aging; Samuel O. Thier, Institute of Medicine; James S. Todd, American Medical Association; Alexander Capron, University of Southern California Law Center; Leah Curburn, Nursing Management magazine; Albert Jonsen, University of California, San Francisco, Medical School; John J. Llacos, Supreme Judicial Court of Massachusetts; and Mitchell Rabkin, Boston Beth Israel Hospital. Final summary and comment were provided by Koppel, Sen. Paul Simon (D-IL), and Rep. John Seuer (R-NY).

Government Publications

The Catastrophe of Uninsured and Underinsured Americans: In Search of a U.S. Health Plan, Select Committee on Aging

More than 85 percent of Americans lack adequate insurance protection against catastrophic medical expenses or long-term illness, and more than 13 percent have no health insurance at all, according to a report issued by the House Select Committee on Aging.

Committee Chairman Edward R. Roybal (D-CA) issued the eight-page report in conjunction with a September 12 hearing. Roybal is sponsor of the USHealth Act of 1986 (H.R. 5070), which if enacted would establish a broad national health care program (see Employee Benefit Notes, August 1986).

According to the report, more than 31 million Americans are uninsured, representing over 13 percent of all Americans and over 15 percent of Americans under age 65. Most of the uninsured are employed.

[Numbers cited in the report are somewhat lower than those recently released by EBRI. EBRI tabulations of data from the March 1985 Current Population Survey indicate 34.7 million Americans under age 65 and not living in the families of military or agricultural workers were uninsured in 1984. See the September 1986 EBRI Issue Brief, "Employer-Sponsored Health Insurance Coverage."]

Free copies of the committee's report are available from the Select Committee on Aging, U.S. House of Representatives, 300 New Jersey Ave., SE, Room 712, Washington, DC 20515.

Employment in Health Services: Long-Term Trends and Projections, Anne Kahl and Donald E. Clark

Hospital Employment Under Revised Medicare Payment Schedules, Eileen Appelbaum and Charlyn S. Granrose

Changes in demand for health services from a growing elderly population and from increasing pressure from public and private payers to control health care costs are predicted to affect employment in the health services industry, according to two new studies reported in the August 1986 issue of Monthly Labor Review. Authors of the study entitled "Employment in Health Services: Long-
Term Trends and Projections projects employment among wage and salary workers in the health care industry in 1995 could range from 7.3 million to 10.5 million workers, up from 7.2 million actual employment in 1984. The wide variation in the estimate reflects the great degree of uncertainty in the response of providers, consumers, and payers to the conflicting pressures of changing demographics and cost containment. Even the most optimistic estimate, however, anticipates that employment in the health services sector would increase at a slower rate than it has in the past. Much of this slowdown in the growth rate of health services employment is dependent upon the responses of hospitals to demands to reduce admission rates and duration of hospitalization. Increased amounts of care will be provided on an ambulatory rather than an inpatient basis, resulting in faster-than-average employment growth in physicians’ offices, home health agencies, and other types of ambulatory care facilities. Hospitals, provided that they have adequate access to capital, may diversify into providing more care on an outpatient basis.

The response of hospitals in one area to the recent imposition of DRG reimbursement under Medicare is described in the study entitled, "Hospital Employment Under Revised Medicare Payment Schedules."

In interviewing hospital managers in the Philadelphia area, the authors focused on several common responses to the constraints of Medicare prospective payment, one of which involved human resource strategies. Among the human resource strategies used to cut costs in general, hospitals attempted to develop a smaller, more flexible work force, through hiring more highly skilled personnel and creating pools of workers with flexible job descriptions. Registered nurses were preferred to licensed practical nurses, for example, because they could perform a wider range of duties.


Nongovernment Publications

Study of the Investment Performance of ERISA Plans, U.S. Department of Labor

ERISA plans hold over $1 trillion in assets and are projected to hold $2.2 trillion (in 1984 dollars) in 15 years. Although they could control 50 percent of corporate bonds and equity by the year 2000, to date there has been no systematic study of pension portfolio allocation and performance. This study, prepared for the Office of Pension and Welfare Benefits, Department of Labor, by Berkowitz, Logue and Associates, Inc., evaluates the investment performance of corporate pension plans with data from several sources. Among the findings are that: average risk-adjusted performance of ERISA plans (excluding management fees and expenses) over the entire 1968-1983 period was lower than the returns experienced by diversified portfolios invested in U.S. financial markets. Performance in the 1976-1983 post-ERISA period exceeded market indices, but performance in 1973 and 1974 was found to be sufficiently below the benchmark to cause the cumulative performance for the period to be substandard. Contact National Technical Information Service (NTIS) 5285 Port Royal Road, Springfield, VA 22161. (703) 487-4650. Cost $16.95, plus $3.00 for shipping and handling.

The Challenge of Private Pension Funds, edited by Gilberto Gabrielli and Daniele Fano

Pension funds, according to the editors of this book, were described ten years ago as the unseen revolution. Since then, pension funds in the United States and Great Britain have increased in size by 500 percent. The chapters of this report are working papers prepared for a conference held in April 1986 on the development of capital markets and the role of pension funds, organized by Future Organization Resources, the research unit of the Montedison Group. Montedison has announced its intention to begin a private-sector pension plan in Italy, and the conference was held to explore issues and information relevant to that effort. Contact The Economist Intelligence Unit, 10 Rockefeller Plaza, New York, NY 10020. (212) 541-5730.


Developed as a reference for human resources professionals, personnel executives, benefit managers, corporate officers, and financial executives, this guide by the publishers of the "Employers' Health Cost Savings Letter" covers such topics as health care cost containment, business health coalitions, alternative health care plans, and health promotion. It includes a bibliography targeted for health plan managers and directories of employer coalitions and other resources.

Copies are available from American Business Publishing, Brinley Plaza, Highway 38, P.O. Box 1442, Wall Township, NJ 07719. Cost $51.50.
Pension Lump-Sum Distributions and Tax Reform

Tax reform bills would increase the taxes owed by individuals receiving a lump-sum distribution from a pension plan in an attempt to encourage saving for retirement. This study published by the Employee Benefit Research Institute (EBRI) shows that there is generally a less than 5 percent probability that a preretirement lump-sum distribution will be rolled over into retirement savings, and there is only a 30 percent chance that it will be saved in any form.

Spend It or Save It? Pension Lump-Sum Distributions and Tax Reform, by Dr. G. Lawrence Atkins, explores the policy question of whether allowing people access to their pension money when they change jobs enhances or diminishes their eventual retirement income. Atkins, the deputy staff director for the Senate Special Committee on Aging, estimates that 71 percent - 35.5 million -- of the nonfederal pension-covered work force can receive some form of cash payment upon leaving their job, and 30 percent -- 15 million -- can receive a preretirement lump-sum distribution from their primary pension plan.

Under tax reform proposals, amounts not rolled over into an IRA or taken as an annuity would (1) be subject to a penalty tax and (2) no longer qualify for 10-year forward averaging (one-time five-year forward averaging would be available for those over age 59 1/2).

The EBRI study finds that more than 9 million workers have access to a full lump sum, although a lump-sum payment of the pension accrual is not generally available for most workers. Most receiving them are covered under a pension plan sponsored by a single, private-sector employer, but availability varies depending on the type of plan.

Only 10 percent -- 2.6 million -- of the workers covered under single-employer defined benefit plans can receive an unlimited lump-sum payment, and another 20 percent -- 4.9 million -- can receive a lump sum only in the case of a small accrual. By contrast, nearly 81 percent -- 7.2 million -- of the workers covered under a single-employer defined contribution plan have the option of a full cash out available.

Spend It or Save It? Pension Lump-Sum Distributions and Tax Reform is available for $10 prepaid by writing EBRI-ERF Publications, P.O. Box 753, Waldorf, MD 20601.
Track the flow and investment of pension dollars and federal actions that affect your decisions with . . .

EBRI's New Report On Pensions—

EBRI QUARTERLY PENSION INVESTMENT REPORT

Especially for EBRI sponsors, this new periodical, published by the Employee Benefit Research Institute, contains information on pensions you can't find anywhere else!

Pension funds are now the largest institutional investor in the country. Recognizing the growing national interest in pensions and the U.S. pension system as a whole, EBRI and the Federal Reserve System have launched a joint, ongoing project with the Trust Universe Comparison Service (TUCS) to develop reliable data on assets in the private and public pension system and the performance of pension investments.

The **EBRI Quarterly Pension Investment Report** offers greater detail of pension asset management and performance than asset figures currently available through the government.

EBRI's report provides historical data on net contributions to pension plans and the investment allocation of the contributions by plan type; examines pension plan earnings and rates of return by plan type; and looks at the portfolio allocation of pension funds.

The report supplements the financial data with a review of legislative and regulatory issues affecting private-sector pensions plans. Changes in these issues can affect the rate of accumulation of pension assets, the level of net contributions and the manner in which the funds are managed and invested.

The **EBRI Quarterly Pension Investment Report** is necessary reading for plan managers, investment advisors, plan sponsors, and anyone else interested in the growing pool of pension funds.

To find out how you can receive these reports, contact EBRI, 2121 K Street, NW, Washington, DC 20037, 202/659-0670.
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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