

notes

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◆ Changes in Medicare: Implications for Employer Health Plan Costs

Recently enacted changes in the Medicare program are likely to have significant effects on employer health plans for both active and retired workers. The Omnibus Budget Reconciliation Act of 1989 (OBRA '89) changes the way that physician reimbursement is determined under Medicare, beginning in 1992, and places limits on physicians' ability to bill Medicare patients for fees in excess of Medicare-approved charges, beginning in 1991. The Omnibus Budget Reconciliation Act of 1990 (OBRA '90) reduces Medicare reimbursements to health care providers by \$34 billion over the next five years. The net effect of these changes will be higher charges to employer plans, higher health care costs for retirees, and, in the longer term, possible reductions in health care access for Medicare eligible retirees.

OBRA '89 mandates that Medicare reimburse physicians according to a resource-based relative value scale (RBRVS). The RBRVS is an index of the resources necessary to provide a specific service. It is based on research performed at the Harvard Medical School, which examined the amount of physician time, the level of training, and the degree of difficulty, as well as other overhead costs (including malpractice insurance), used to produce a given medical service. Each procedure is assigned a value that describes the relative amount of resources necessary for that procedure compared with a baseline procedure. A procedure with a value of 2 requires twice as many resources as the baseline procedure. Reimbursement for a given procedure is determined by multiplying its RBRVS value by a "dollar conversion factor" and making adjustments for geographic differences in cost.

The RBRVS is to be phased in over a four-year period, beginning in 1992. It increases the fees paid to physicians under Medicare for cognitive services (visits and consultations for diagnosis and appropriate treatment) and decreases fees for most surgical and technical procedures. The effect of the RBRVS on physicians' behavior depends on their specialty. Primary care physicians, such as those in family practice and internal medicine, will see their Medicare fees increase, while surgeons and radiologists will see theirs fall. While implementation of the RBRVS may increase the willingness of primary care physicians to treat Medicare patients, it may also provide

these physicians the opportunity to raise their fees to make them compatible with the RBRVS. Surgeons, on the other hand, will see their reimbursement per procedure fall, so they may act to increase utilization of their services by Medicare patients. Failing that, the transition to the RBRVS may make these physicians more amenable to joining managed care networks with a high population of active employees. The net effect on employers' total plan costs is uncertain.

OBRA '89 also sets limits on the amount physicians are able to bill their Medicare patients for the difference between their charges and the Medicare allowable charge. Prior to 1991, physicians have the option of assigning their bill to Medicare, which means that they accept the Medicare allowable fee as payment in full (Medicare pays 80 percent of the allowable fee, the beneficiary 20 percent), or billing the patient for the difference between the physician's fee and the Medicare reimbursement. In the latter case, Medicare reduces its allowable fee by 5 percent and pays 80 percent of that reduced fee; the patient then pays the remainder. Slightly more than 40 percent of physicians who have any Medicare patients are participating, which means that they assign all of their Medicare claims. Nonparticipating physicians may also assign claims on a case-by-case basis.

Estimates of the actual number of claims assigned range from 60 percent to 80 percent, although Medicare beneficiaries with private health insurance are less likely to have their claims assigned. One of the advantages to physicians of assigning claims is lower billing costs, since

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the Medicare reimbursement on assigned claims is paid directly to the physician rather than through the beneficiary. The reduction in the extra return from balance billing may lead more physicians to assign claims, reducing costs to employer plans.

OBRA '89 prohibits physicians from charging more than 125 percent of the Medicare allowable fee to Medicare patients in 1991, 120 percent in 1992, and 115 percent in 1993. The effect of these limitations on employer retiree health costs depends on the rate at which physicians assign claims, the method employers use to integrate their plans with Medicare, and the resulting change in the utilization of health care services by Medicare patients.

Most employer-sponsored retiree health plans provide the same benefits in retirement that the employee received while active. When the retiree becomes eligible for Medicare, the employer-sponsored plan becomes the secondary payer and integrates its benefits with Medicare to avoid double payment of benefits. There are three general integration methods: carve out, exclusion, and coordination of benefits. An employer-sponsored plan that uses a carve out method of integration calculates the amount it would have paid in the absence of Medicare, then subtracts the actual Medicare payment from its payment and pays the remainder. Under the exclusion method, the Medicare payment is subtracted from the total charge first. The employer-sponsored plan's payments are then calculated on the remainder. Finally, under the coordination-of-benefits method, the private plan pays the difference between the Medicare payment and the total charge as long as that difference is less than the total amount the private plan would have paid in the absence of Medicare.

The following table provides an example of these three integration methods, assuming a \$100 Medicare allowable charge, a \$10 private plan deductible, and a 20 percent private plan coinsurance rate, and that the physician assigns the charge. Under the carve out method, the employer-sponsored plan would pay \$72 in the absence of Medicare (80 percent of \$90). Since Medicare pays 80 percent of the allowable charge, its payment is \$80, which is greater than the private plan's payment. The private plan thus pays nothing and the patient pays a \$20 Medicare coinsurance amount. Under the exclusion method, the private plan calculates its benefits on the \$20 Medicare copayment. Subtracting the deductible and taking 80 percent of the remainder, the plan pays \$8 and the patient pays \$12. Under coordination of benefits, the private plan pays the entire Medicare copayment (\$20), since that is less than its payment would have been in the absence of Medicare.

Integration Method	Medicare Pays:	Private Plan Pays:	Patient Pays:
Carve Out	\$80	\$ 0	\$20
Exclusion	80	8	12
Coordination of Benefits	80	20	0

Assuming the OBRA '89 changes in physician reimbursement under Medicare do not lead to a change in utilization rates, plans that use a carve out approach are likely to be the least affected, while plans using a coordination-of-benefits method are likely to see the most savings. A majority of employers integrate their retiree health plans with Medicare using the carve out method, and that majority appears to be growing.

It is unrealistic, however, to assume no change in utilization rates. Research has shown that assignment of Medicare physician claims has led to rapid increases in both the volume and intensity of services and to higher total Medicare costs. This may result from both the lower out-of-pocket payments by beneficiaries, which increases their demand for health care services, and the desire of physicians to increase the volume of their services to make up for lower reimbursement rates.

While employers have developed a number of techniques such as managed care to reduce utilization, the limits on balance billing may make it more difficult to attract physicians into a managed care network that serves a large proportion of retirees with Medicare as the primary payer. Limits on both fees and utilization may make such an arrangement unattractive unless there are sufficient numbers of other types of patients to make the arrangement profitable.

In the longer term, as reimbursement levels are reduced in an attempt to lower Medicare's costs, either utilization will rise or physicians may begin to refuse to accept Medicare patients. Currently, Medicare patients account for only 20 percent of the average physician's patients, although this percentage varies widely by specialty. The ability of physicians to shift out of the Medicare market will depend on their ability to insure an adequate number of other patients. Reductions in Medicare reimbursement may thus make managed care networks that insure mostly active workers more attractive to physicians. It may also lead directly to increased utilization and costs in an unmanaged private patient sector to make up for lost physician income in the Medicare sector.

OBRA '90 reduces Medicare payments to providers by \$34 billion over the next five years. The reductions in

Medicare reimbursement to hospitals will result in increased costs to private plans due to cost shifting. A study of the effects of a large reduction in Medicaid payments to hospitals in Illinois found that for every \$1 reduction in Medicaid payments, private payer costs increased by 50 cents. A similar shifting of costs is likely for Medicare. Hospitals rely on Medicare as a source of income much more than physicians do. Medicare patients account for approximately 40 percent of the average hospital's patients. As a result, private plans' hospital costs are more directly related to Medicare's reimbursement policies than are their physician costs.

OBRA '90 increases the rate at which hospitals with a disproportionate share of Medicaid and uncompensated care patients are reimbursed under Medicare. These hospitals may have less need to shift costs as a result of these higher reimbursement rates, although they are more likely to have had higher private patient charges before the cuts take effect as a result of the burden of the uncompensated care they provide. The degree to which hospitals will shift costs to private patients as a result of the OBRA '90 reductions in Medicare payments depends on these and other market factors. Hospitals that face limited competition and have a sufficient private patient base will shift costs to private patients. Hospitals in a competitive private market may have more difficulty shifting costs.

The net result of the changes in Medicare reimbursement is likely to be higher costs to employer-sponsored health plans for both active and retired employees because of cost shifting and higher utilization rates. Moreover, changes in employer-sponsored retiree health plans in response to both increasing costs and a ruling by the Financial Accounting Standards Board,¹ coupled with reductions in Medicare payments to providers, may lead to a reduction in retirees' access to care. If the elderly experience substantial problems with access or quality of care, their political power is such that these problems will receive prompt action. The resulting legislation would be unlikely to effect a simple transfer of funds into the Medicare system. It more likely would result in a complete overhaul of the Medicare program, if not the entire health care delivery system.

—William S. Custer, EBRI

¹The Financial Accounting Standards Board voted Oct. 17 to tentatively approve a ruling that would require employers to account for future retiree health liabilities (and other postretirement benefits other than pensions) on an accrual basis, obligating them to record unfunded liabilities on their balance sheets. The rules, which would take effect in 1993, are expected to be formally adopted in December.

◆ Americans Willing to Pay for Long-Term Care Coverage, EBRI/Gallup Poll Shows

Nearly three in four Americans (72 percent) think the U.S. government should provide long-term care assistance for the elderly, even if it requires an increase in income taxes, according to the EBRI/Gallup poll, a public opinion survey conducted by the Employee Benefit Research Institute and The Gallup Organization, Inc. Among those who specified an amount they would be willing to pay in additional taxes (52 percent), the median amount was \$100 per year, while the average amount was \$232 per year.

While Congress is not expected to enact a federally financed long-term care program in the near future, because of the potentially massive costs involved, the results of the EBRI survey suggest that the American public may be willing to help finance such a program.

Moreover, the survey results suggest that a market also exists for private long-term care insurance. A majority of respondents (62 percent) said they would purchase such insurance from an insurance company or through an employer if it were available.

Respondents who said they would buy private insurance would be willing to pay an average of \$42 per month in premiums, with 14 percent willing to pay \$61 or more (44 percent were uncertain how much they would be willing to pay); the median amount was \$30 per month. Premiums for long-term care policies vary according to the insured's age and the extent of coverage provided, from \$55 to \$90 per month for 60-year-olds, \$30 to \$40 per month for 50-year-olds, and \$15 to \$25 per month for 40-year-olds (premiums are as of September 1989).²

The survey, which is a follow-up to EBRI's 1989 long-term care survey, also showed that 2 percent of respondents reported having received long-term care during the past five years (compared with 4 percent in 1989). Twenty-four percent of respondents to the 1990 survey said that a family member had received long-term care (23 percent in 1989)—typically a parent or grandparent (77 percent, compared with 71 percent in 1989).

Family members continue to be the most common providers of long-term care; 48 percent of respondents with a family member who had received care said that they or another family member provided the care

²Robert B. Friedland, *Facing the Costs of Long-Term Care* (Washington, DC: Employee Benefit Research Institute, 1990).

(compared with 58 percent in 1989). In 1990, 53 percent said that if they needed long-term care, they would expect a family member to provide it, compared with 46 percent in 1989; in both surveys, this expectation decreased as age increased.

In both surveys, respondents were asked how they would finance their own long-term care. In the 1989 survey (in which the question was asked "open-ended," with no selection of answers provided), 34 percent of respondents said they would use personal savings, 25 percent said they would use private long-term care insurance, and 19 percent were uncertain. In the 1990 survey (in which respondents were provided answers from which to choose), the proportion who said they would use private long-term care insurance rose to 42 percent, with 21 percent indicating they would use personal savings, 18 percent citing reliance on a government program, and 10 percent uncertain.

The EBRI/Gallup survey, conducted in August, is the 15th in a series of national public opinion polls EBRI is undertaking on public attitudes toward economic security issues such as health, retirement, savings, Social Security, and Medicare. The polls are conducted monthly for EBRI by The Gallup Organization, Inc., which surveys 1,000 Americans by telephone. The maximum expected error range at the 95 percent confidence level is ± 3.1 percent.

Copies of the report, *Public Attitudes on Long-Term Care, 1990 (#15)*, may be ordered from Heidi Evans, (202) 775-6319, for the following prices: summary—\$75, full report—\$275; EBRI member prices: summary—\$25, full report—\$75. Copies of *Facing the Costs of Long-Term Care* are available for \$39.95 (hardcover) plus handling from EBRI Publications, (301) 338-6946.

—Stephanie L. Poe, EBRI

◆ Employer Spending on Benefits Exceeds \$500 Billion in 1989

Public and private employer spending for employee benefits exceeded \$500 billion in 1989, according to the most recent data from the U.S. Department of Commerce National Income and Product Accounts (NIPA). This represents a nominal increase of \$31.3 billion, or 6.7 percent, from 1988 (table 1). As a proportion of total employer spending on compensation in 1989 (\$3.1 trillion), however, benefit outlays remained essentially constant at 16.3 percent. The proportion of total compensation that employers spend on benefits has changed little since 1980.

In 1989, employer outlays for benefits as a proportion of total compensation varied substantially by industry, ranging from a low of 12 percent for service industry employers to 20 percent for transportation and public utilities employers and 21 percent for government employers (table 2). This range may reflect industry variations in employee composition. In the transportation and public utilities industries, for example, union employees—who are more likely to have benefits, and for whom benefits constitute a larger part of total compensation costs than for nonunion employees, on average—represent a greater than average proportion of total employees. In the service and retail industries, on the other hand, there is a greater than average proportion of part-time workers—who are less likely to receive certain benefits.³

Retirement benefits continued to represent the largest component of employer benefits spending in 1989, at \$247 billion. Payments for Social Security Old-Age, Survivors, and Disability Insurance (OASDI) payroll taxes (\$127 billion) accounted for more than one-half that amount, with private employer retirement plan contributions (\$48 billion) and public employer retirement plan contributions (\$72 billion) accounting for the balance. Spending on health benefits totaled \$178 billion, the major part of which consisted of contributions to group health insurance plans (\$145 billion), with spending on Medicare Hospital Insurance (HI) payroll taxes amounting to \$32 billion. Employers also spent \$42 billion on workers' compensation insurance, \$23 billion on unemployment insurance, and \$11 billion on employee life insurance.

The NIPA data on wage and salary compensation implicitly include payment for time not worked (including vacations, holidays, sick leave, and personal leave) but do not separate the amount paid for such leave. The U.S. Department of Labor, however, estimates that the value of paid leave averaged 6.9 percent of total private employer costs for employee compensation in March 1990, down slightly from 7.0 percent in March 1989.⁴

Employer spending for group health insurance grew 9.8 percent from 1988 to 1989, the greatest increase for a

³U.S. Department of Labor, Bureau of Labor Statistics, *Employment and Earnings*, various months; U.S. Department of Labor, Bureau of Labor Statistics, *Employment Cost Indexes and Levels: 1975-89* (Washington, DC: U.S. Government Printing Office, 1989); and EBRI tabulations of the May 1988 Current Population Survey.

⁴U.S. Department of Labor, Bureau of Labor Statistics, *Employment Cost Indexes and Levels: 1975-89* (Washington, DC: U.S. Government Printing Office, 1989). The Labor Department data are from a survey that represents private employers only, while the NIPA data represent both public and private employers.

Table 1
Employer Outlays for Employee Compensation, Selected Years, 1960-1989

Component of Compensation	1960	1970	1980	1985	1987	1988	1989
	(billions of dollars)						
Total Compensation	\$296.8	\$618.2	\$1,638.1	\$2,367.4	\$2,686.2	\$2,904.8	\$3,078.7
Wages and salaries	272.8	551.5	1,372.0	1,975.2	2,249.7	2,431.1	2,573.2
All benefits	23.7	66.1	264.3	389.0	432.6	469.4	500.7
Other labor income ^a	0.3	0.6	1.9	3.3	4.0	4.3	4.8
Retirement Income Benefits	14.2	40.3	150.5	205.5	219.2	234.3	247.2
Social Security OASDI	5.6	16.2	55.6	91.5	103.9	118.1	127.2
Private employer pension and profit sharing	4.9	13.1	54.2	54.6	50.9	47.9	47.8
Public employer retirement plans	3.7	11.0	40.7	59.4	64.4	68.3	72.2
Health Benefits	3.4	14.6	71.6	124.3	146.1	162.8	178.1
Social Security HI	0.0	2.3	11.6	22.7	27.7	29.5	31.8
Group health insurance	3.4	12.1	59.6	100.8	117.4	132.1	145.0
Military medical insurance	0.0	0.2	0.4	0.8	1.0	1.2	1.3
Other Employee Benefits	6.1	11.3	42.2	59.1	67.3	72.3	75.4
Unemployment insurance	3.0	3.8	16.4	26.0	24.2	24.3	23.1
Workers' compensation	2.0	4.6	19.2	24.4	33.6	37.8	41.5
Group life insurance	1.1	2.9	6.6	8.7	9.5	10.2	10.8
	(as percentage of total compensation)						
Total Compensation	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Wages and salaries	91.9	89.2	83.8	83.4	83.7	83.7	83.6
All benefits	8.0	10.7	16.1	16.4	16.1	16.2	16.3
Other labor income ^a	0.1	0.1	0.1	0.1	0.1	0.1	0.2
Retirement Income Benefits	4.8	6.5	9.2	8.7	8.2	8.1	8.0
Social Security OASDI	1.9	2.6	3.4	3.9	3.9	4.1	4.1
Private employer pension and profit sharing	1.6	2.1	3.3	2.3	1.9	1.6	1.6
Public employer retirement plans	1.2	1.8	2.5	2.5	2.4	2.4	2.3
Health Benefits	1.1	2.4	4.4	5.3	5.4	5.6	5.8
Social Security HI	0.0	0.4	0.7	1.0	1.0	1.0	1.0
Group health insurance	1.1	2.0	3.6	4.3	4.4	4.5	4.7
Military medical insurance	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other Employee Benefits	2.1	1.8	2.6	2.5	2.5	2.5	2.4
Unemployment insurance	1.0	0.6	1.0	1.1	0.9	0.8	0.8
Workers' compensation	0.7	0.7	1.2	1.0	1.3	1.3	1.3
Group life insurance	0.4	0.5	0.4	0.4	0.4	0.3	0.4

Source: EBRI tabulations based on *Survey of Current Business*, U.S. Department of Commerce, Bureau of Economic Analysis, National Income and Product Accounts, selected years.

^aConsists primarily of directors' fees.

single expenditure, with workers' compensation close behind at 9.7 percent (table 3). Although employers implemented various health care cost savings measures during the 1980s, spending on contributions to private group health plans and HI payroll taxes outgrew spending on every other major component of compensation during the 1980s. Spending on OASDI payroll taxes grew 7.7 percent in 1989, due to increases in the OASDI wage base (the sum of covered employees' earnings that are subject to OASDI taxes).

Private employer contributions to pension and profit-sharing plans and to unemployment insurance were the only two components of total compensation to decline in 1989 (table 3). Contributions to private pension and profit-sharing plans have fallen every year since 1983.

The decline may be attributable to a number of factors, including a rise in the value of pension fund portfolios during the recent market upswings and the reduction in maximum funding limits imposed by the Omnibus Budget Reconciliation Act of 1987. Moreover, the proportion of all workers reporting participation in an employer-sponsored pension or retirement plan has declined slightly since 1979.⁵ The decline in unemployment insurance contributions has accompanied a general decline in the unemployment rate.

Individuals received \$810.6 billion in employment-related benefits in 1989, up 9.1 percent from 1988

⁵Joseph Piacentini, "Pension Coverage and Benefit Entitlement: New Findings from 1988," *EBRI Issue Brief* no. 94 (Employee Benefit Research Institute, September 1989).

Table 2
Employer Outlays on Compensation, by Industry,
Average Outlays on Wages/Salaries and Benefits^a per
Full-Time Equivalent^b Employee, 1989

Industry	Wages/ Salaries	Benefits	
		Dollars	Percentage of Compensation
Average Domestic	\$24,870	\$4,888	16%
Government	26,319	7,147	21
Transportation/ Public Utilities	31,375	7,686	20
Manufacturing	28,504	6,330	18
Construction	26,647	5,601	18
Mining	36,292	7,662	17
Finance, Insurance, Real Estate	30,258	5,166	15
Agriculture, Forestry, Fisheries	12,932	2,113	14
Retail Trade	15,477	2,382	13
Wholesale Trade	30,102	4,572	13
Services	23,251	3,129	12

Source: EBRI tabulations based on *Survey of Current Business*, U.S. Department of Commerce, Bureau of Economic Analysis, National Income and Product Accounts, 1989.

^aIncludes private and public employer spending for Social Security OASDI and HI payroll taxes, retirement plans, group health plans, workers' compensation insurance, unemployment insurance, group life insurance, and other labor income (directors' fees).

^bMeasures full-time and part-time employees in terms of full-time equivalent hours.

(table 4). Retirement income benefit payments totaled \$479 billion in 1989, including \$227 billion in Social Security OASDI payments, \$154 billion in private retirement plan payments, and \$97 billion in payments by public employer retirement plans. Health benefit payments grew 10.8 percent to \$255 billion in 1989. Health benefit payments included \$156 billion in group health insurance plan payments and \$98 billion in Medicare HI and Supplemental Medical Insurance (SMI) payments. Other employee benefit payments totaled \$77 billion in 1989, the largest component of which was workers' compensation payments (\$33.5 billion).

—Karen S. Horkitz, EBRI

◆ Washington Update

Washington remains quiet since the adjournment of Congress on Oct. 27, but is expected to liven up shortly when Congress reconvenes on Jan. 3. The following update provides further details of the final budget agreement reported in the November issue of *Notes*, as well as other legislative and regulatory action that occurred shortly before or after adjournment. The January issue will feature an article previewing what's to come in the 102nd Congress.

Omnibus Budget Reconciliation Act of 1990 (OBRA '90)

State and Local Employees—It was mistakenly reported in the November issue of *Notes* that the final budget agreement extended Medicare coverage to all state and local government employees; this provision was dropped shortly before the bill was passed. However, the new budget law does extend Social Security (OASDI) coverage, including Medicare Hospital Insurance coverage, to those state and local government employees who are not covered by a state or local public employee retirement program. (Note: The Consolidated Omnibus Budget Reconciliation Act of 1985 extended Medicare coverage to all state and local employees hired after March 31, 1986, who are covered by a retirement plan but are not covered by Social Security.)

Group Term Life Insurance—OBRA '90 eliminates the employer's obligation to collect and submit the retiree's portion of any FICA taxes due on group term life insurance. Retirees will be responsible for paying their own portion when filing their income tax returns, effective for coverage provided on or after Jan. 1, 1991.

User Fees—OBRA '90 extends for five years, retroactive to Sept. 30, 1990, the Internal Revenue Service's (IRS) user fee program of charges for rulings, opinion letters, determination letters, and similar taxpayer requests. IRS Nov. 7 reinstated the user fee program described in Revenue Procedure 90-17 issued in March, which raised

Table 3
Nominal Percentage Change in Employer Outlays,
Selected Items, 1988 to 1989

Component of Compensation	Percentage Change, 1988 to 1989
Total Compensation	6.0%
Wages and salaries	5.8
All benefits	6.7
Retirement Income Benefits	5.5
Social Security OASDI	7.7
Private pension and profit sharing	-0.3
Public employer retirement plans	5.7
Health Benefits	9.4
Social Security HI	7.8
Group health insurance	9.8
Other Employee Benefits	4.3
Unemployment insurance	-5.0
Workers' compensation	9.7
Group life insurance	6.2

Source: EBRI tabulations based on *Survey of Current Business*, U.S. Department of Commerce, Bureau of Economic Analysis, National Income and Product Accounts, 1989 and 1990.

user fees for most types of determination letters and private letter rulings (Announcement 90-113).

ERISA Enforcement—A U.S. Department of Labor (DOL) proposal to improve the enforcement of the Employee Retirement Income Security Act of 1974 (ERISA) was introduced as legislation (S. 3267, H.R. 5972) Oct. 27 by Sen. Robert Dole (R-KS) and Rep. Robert Michel (R-IL), respectively.

Health Care Reform—Sen. Dave Durenberger (R-MN) introduced Oct. 26 the Small Employer Health Benefit Reform Act of 1990 (S. 3260). The bill would impose an excise tax on insurance companies that do not meet certain coverage and rating standards with respect to health insurance provided to small employers.

Employer Securities—On Nov. 8 President Bush signed into law H.R. 5872 (P.L. 101-540), which amends the definition of employer securities under ERISA to include interests in publicly traded partnerships.

Retirement Annuities—The Office of Management and Budget (OMB) has reversed its position concerning DOL's practice of collecting information from pension plan sponsors regarding the process they use to select an annuity provider. OMB has now concluded that DOL is not violating the Paperwork Reduction Act and that

DOL should continue to utilize this "valuable investigative tool."

Underfunded Pensions—The Pension Benefit Guaranty Corporation (PBGC) has asked OMB to approve a new form aimed at identifying companies with more than \$25 million in pension plan underfunding. PBGC plans to use this form to compile its annual list of the top 50 companies with the largest aggregate amounts of plan underfunding.

Age Discrimination—President Bush Nov. 5 signed the Technical Correction to the Older Workers Benefit Protection Act (PL 101-521). The new law makes several technical clarifications to the Older Workers Benefit Protection Act (PL 101-433), which reverses the Supreme Court's *Betts* decision by making employee benefit programs subject to the Age Discrimination in Employment Act of 1965.

Retiree Health—Labor Secretary Elizabeth Dole Nov. 7 released the final report of DOL's Advisory Commission on the United Mine Workers of America's Retiree Health Benefits. The commission agreed on 10 broad recommendations for solving the trust funds' deficit, but failed to reach a consensus on who should provide financing for retirees of those companies that have gone out of business or stopped paying for health care benefits (orphan retirees).

—Nora Super Jones, EBRI

Table 4
Payments from Private and Public Employment-Related Benefit Programs, Selected Years, 1960–1989

Benefit Program	1960	1970	1980	1985	1987	1988	1989
	(billions of dollars)						
All Benefits	\$30.6	\$89.8	\$349.1	\$574.6	\$682.2	\$743.0	\$810.6
Retirement Income Benefits	16.8	50.7	198.0	335.2	402.1	441.8	478.7
Social Security OASDI	11.1	31.4	118.6	183.3	201.0	213.9	227.3
Private employer pension and profit sharing	1.7	7.4	31.5	78.9	118.3	137.2	154.3
Public employer retirement plans	4.0	11.9	47.9	73.0	82.8	90.7	97.1
Health Benefits	4.3	22.1	100.8	176.1	211.6	230.0	254.8
Social Security HI and SMI	0.0	7.1	35.6	70.1	81.9	86.7	97.9
Group health insurance	4.3	14.8	64.8	105.2	128.7	142.1	155.6
Military outside health	0.0	0.2	0.4	0.8	1.0	1.2	1.3
Other Employee Benefits	9.4	17.0	50.4	63.4	68.5	71.1	77.0
Unemployment insurance	3.1	4.2	16.1	15.8	14.6	13.6	14.8
Workers' compensation	1.5	3.0	12.5	21.5	27.0	29.9	33.5
Group life insurance	1.1	2.7	5.8	8.4	9.2	9.5	10.1
Miscellaneous disability	0.1	0.5	2.6	2.7	3.0	3.1	3.3
Veterans' benefits	3.7	6.6	13.4	15.0	14.8	15.0	15.3

Source: EBRI tabulations based on *Survey of Current Business*, U.S. Department of Commerce, Bureau of Economic Analysis, National Income and Product Accounts, selected years.

◆ New Publications

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

Buck Consultants. **Flexible Benefits—An Alternate Design.** \$100. Carolee Martin, Manager of Marketing, Buck Consultants, Inc., 500 Plaza Drive, Seacaucus, NJ 07096-1533, (201) 902-2555.

National Conference of State Legislatures. (1) **State Budget and Tax Actions, 1990**, \$35. (2) **Earmarking State Taxes**, \$15. National Conference of State Legislatures, 1560 Broadway, Suite 700, Denver, CO 80202, (303) 830-2200.

Society of Professional Benefit Administrators. **Directory of Third Party Administrators**, 1989 ed. \$105. Society of Professional Benefit Administrators, 2 Wisconsin Circle, Suite 670, Chevy Chase, MD 20815, (301) 718-7722.

U.S. Congress, House Committee on Small Business. **Women-Owned Businesses: Special Problems and Access to Credit.** Order from GPO.

U.S. Congress, Senate Committee on Veterans' Affairs. **Health Care for Veterans in Rural Areas.** Order from GPO.

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