notes

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◆ State Basic Benefit Laws: Are They Reaching the Uninsured?

More than 34 million persons under age 65—representing 16 percent of the 218 million persons in this group—currently do not have health insurance. Among this population, nearly 30 million persons are working or are dependents of workers. Forty-six percent of the working uninsured, or 13.5 million people, work for firms with fewer than 25 employees.[1] Health care cost analysts often point out that one reason for the low level of coverage among employees of small firms is the prevalence of state mandated benefit laws, which they contend increase the cost of health care premiums.[2]

State legislatures began in the mid-1960s to enact laws requiring that certain benefits be included in group and individual health insurance plans. These benefits fall into four general categories: provider (e.g., optometrist), treatment (e.g., mental health care), special populations (e.g., children), and coverage continuation mandates. Currently, there are nearly 1,000 state mandated laws.[3]

A study of the implications of these laws concluded that if there were no state mandates (including continuation-of-coverage mandates), 16 percent of the small firms currently not offering health insurance would begin to offer these benefits.[4] To make health insurance more affordable for small firms, some state legislatures have passed bare bones or basic benefits laws that typically exempt small firms from most state mandates.

As of October 1991, 23 states have enacted bare bones health insurance laws. Most of these laws have eligibility requirements that limit firm size, generally to 25 or fewer employees, and restrict coverage to employers that have not offered health benefits for a specified period, usually one year. The laws vary greatly by state. Some states such as Georgia and Oklahoma appoint commissions to develop a model insurance package. Florida, Missouri, and Washington waive all state mandates, while Arkansas, Maryland, New Mexico, Rhode Island, and others specify minimum standards for health insurance policies (table 1).

Whether or not these laws will be effective in expanding access to health insurance for the working uninsured will depend on the state. Most of the laws were enacted in 1991, and preliminary data are available from only a few states:

Oregon—The legislation creating the bare bones plans sets a target of 150,000 individuals to be enrolled by July 1, 1995. The state's Insurance Pool Governing Board reports that five carriers are approved to market the plans in that state. As of Oct. 1, 1991, 3,101 groups were enrolled in the plans, insuring 11,868 employees and their dependents.

[1] Jill D. Foley, *Uninsured in the United States: The Nonelderly Population without Health Insurance*, Special Report SR-10 (Washington, DC: Employee Benefit Research Institute, 1991).
[2] Self-insured plans, which are typically found in larger firms, are exempted from state mandated benefit laws under the Employee Retirement Income Security Act of 1974.
[3] Connecticut has the largest number of mandates: 37; Alabama, Delaware, Idaho, and South Carolina have the least: 9 each.
[4] Jon Gabel and Gail Jensen, "The Price of State Mandated Benefits," *HIAA Research Bulletin* (July 1989): 2–21. The authors drew their conclusions from the 1985 National Federation of Independent Businesses' employee benefits survey in which they were able to control for features of the health insurance plan, employer and employee characteristics, and geographic location. They then merged in information about the state mandates to each observation in the sample.

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Table 1
Bare Bones Laws

State Bare Bones Laws for Small Private Establishments, Eligibility and Benefits, September 1991

State	Group Size	Months Uninsured[a]	Inpatient	Office Visits	Maternity Care	Well Child Care	Effective Date of Legislation
Arizona	Fewer than 40	3 months	15 days/year	2 visits/year	Prenatal & Obstetrical	Through age 6	Sept. 1991
Arkansas	No maximum	12 months	15 days/year	2 visits/year	Prenatal & Obstetrical	Through age 6 (optional)	Feb. 1991
Colorado	Fewer than 26	None					July 1991
Florida[b]	Fewer than 25	None					Oct. 1991
Georgia[c]							d
Illinois	Fewer than 25	12 months				Newborns	Jan. 1991
Iowa	Fewer than 26	12 months	30 days/year	2 visits/year	Prenatal & Obstetrical		July 1991
Kansas	Fewer than 26	24 months					July 1990
Kentucky	Fewer than 51	36 months	14 days/year	50% payment			July 1990
Maryland	2–25	12 months (individuals) 24 months (groups)	10 days/year	10 visits/year	Prenatal & Obstetrical		July 1991
Missouri	Fewer than 51						Jan. 1991
Montana	Fewer than 21				Prenatal & Obstetrical	Through age 2	July 1991
New Jersey	No maximum	12 months	21 days/year				Sept. 1991
Nevada[b]	Fewer than 26	6 months					Jan. 1992
New Mexico	Fewer than 20	6 months	25 days/year (includes home care)	7 visits/year	Prenatal & Obstetrical	Through age 6	July 1991
North Carolina[c]	Fewer than 26						Jan. 1992
North Dakota	Fewer than 25	12 months					July 1991
Oklahoma[c]	No maximum	15 months					Spring 1990
Oregon[c]	Fewer than 26	None					Spring 1989
Rhode Island	Fewer than 26	3 months (individuals) 24 months (groups)	20 days/year	4 visits/year	Prenatal & Obstetrical	First year and immunizations to age 8	Sept. 1990
Virginia	Fewer than 50	12 months	30 days/year	2 visits/year	Prenatal & Obstetrical	Through age 6	July 1990 Sunset date July 1994
Washington	Fewer than 25	None					June 1990
West Virginia	No maximum	None	20 days/year	4 visits/year	Prenatal & Obstetrical		June 1991

Source: Scandlen Publishing, Inc., "Small Group Market Reform Laws Enacted in 16 States," *Health Benefits Letter* (August 8, 1991):1–3; and data compiled by Karen Milgate for Families USA Foundation, July 1991.
[a]Number of months that an employer must not have offered health insurance to any employees to be eligible for bare bones laws.
[b]The Florida and Nevada laws require that the state mandates be offered as an option.
[c]In Georgia, the law authorizes the insurance commissioner to deliver a model health insurance plan; in North Carolina, Oklahoma, and Oregon, the law calls for a committee or board to develop a basic health care plan.
[d]Not available.

Washington—As of June 30, 1991, 250 groups were enrolled in health care plans under the bare bones law; 139 of these groups had no prior coverage. These plans insure a total of 2,206 employees and their dependents, of which 1,135 had no prior insurance. An analysis of policies in that state by the Washington Insurance Commission found that, while some of the bare bones plans offered benefits at 40 percent less than a traditional plan, only 3 percent to 10 percent of the savings could be attributed to the waiver of state mandates. Most of the cost savings came from reductions in core benefits and higher copayments and deductibles.

Virginia—Only three insurers have been approved to market bare bones plans in Virginia. To date, only Blue Cross/Blue Shield has marketed the plans, and the response has been limited. According to Rod Matthews of Blue Cross/Blue Shield Virginia, an initial survey of eligible individuals showed a large positive response, but few enrolled. Blue Cross attributes the slow market response to the particular type of bare bones plan that was offered. The plan emphasized well child care and preventive care, which kept costs high. Current Virginia law requires that bare bones plans include the state mandates for these services, but Blue Cross is now trying to obtain a waiver of the mandates from the state in order to develop a basic plan focusing on catastrophic coverage.

Several recently proposed congressional bills include provisions that would exempt small employers from state mandates. On Oct. 24, Senate Finance Committee Chairman Lloyd Bentsen (D-TX) introduced legislation (S. 1872) aimed specifically at the small group insurance market. This bill would require insurers operating in this market to offer a basic benefits plan that would exclude mental health, substance abuse, and other state mandated benefits. Legislation (H.R. 3626) introduced Oct. 24 by House Ways and Means Committee Chairman Dan Rostenkowski (D-IL) would require insurers to offer a minimum benefit package based on the current Medicare benefit package plus additional preventive benefits. State mandates prohibiting the offering of the benefit package would be preempted. In addition, legislation (S. 1936) introduced by Senate Republicans on Nov. 7, led by Sen. John Chafee (R-RI), contains provisions preempting state mandated benefit laws for managed care plans that meet specified standards.

Action on targeted health care proposals such as small group insurance reform is likely in 1992, and the states could prove to be policy laboratories. A study by the Alpha Center for Health Policy and Planning[5] found that small employers are interested in purchasing insurance that will provide hospital coverage and benefits similar to those offered by large employers. The Alpha Center identifies the fragmentation of risk and the corresponding higher administrative costs as the fundamental barriers to health insurance access for small employers. Practical application of state bare bones laws should give policymakers solid evidence of the effect of state mandates on health care access and coverage.

—Ken McDonnell, EBRI

◆ Retiree Health and Health Care Reform

Although many policymakers currently are calling for comprehensive reform of the U.S. health care system, a number of recent proposals have focused on expanding coverage for specific groups. Some of these proposals would affect current retirees and people near retirement age. Legislation has been introduced that would reduce Medicare eligibility to age 60, eliminate the waiting period required prior to Medicare eligibility for Social Security Disability Insurance (DI) beneficiaries, and allow dependents of Medicare beneficiaries to purchase coverage.

Lower Medicare Eligibility Age—One legislative proposal analyzed by EBRI includes reduction of the Medicare eligibility age to 60 and an employer mandate.[6] The analysis indicates that total Medicare enrollment could increase by as much as 5 million individuals (table 2). The new Medicare enrollees would include two-thirds of the 1.2 million individuals aged 60–64 who are currently uninsured. Generally, Medicare would become the primary source of coverage for all nonworkers not covered by a working family member's group health plan.

The remaining working uninsured would gain coverage through an employment-based plan. Other workers

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[5]Alpha Center for Health Policy and Planning, National Program Office of the Robert Woods Johnson Foundation Health Care for Uninsured Programs, conducted a study of 11 demonstration projects targeting small uninsured employers and individuals. The demonstration projects looked at 4,700 small businesses employing 45,000 workers.

[6]The proposal analyzed by EBRI is similar to some provisions of the Health Insurance Coverage and Cost Containment Act of 1991 (H.R. 3205) introduced by Rep. Dan Rostenkowski (D-IL).

Table 2

Health Insurance Coverage under Current Law and Estimated Coverage After Enactment of an Employer Mandate and Medicare Expansion for Individuals Aged 60–64

Source of Primary Coverage[a]	Before Enactment	After Enactment	Change
	(thousands)		
Aged 60–64	10,683	10,683	0
Employment based	6,587	4,896	–1,690[b]
Other private coverage	1,404	0	–1,404
Medicare	715	5,786	5,072
CHAMPUS/CHAMPVA	413	0	–413
Medicaid	330	0	–330
Uninsured	1,235	0	–1,235
Working Aged 60–64[c]	4,282	4,282	0
Employment based	3,163	4,282	1,119
Other private coverage	522	0	–522
Medicare	36	0	–36
CHAMPUS/CHAMPVA	126	0	–126
Medicaid	28	0	–28
Uninsured	407	0	–407
Retired Aged 60–64[d]	2,445	2,445	0
Employment based	1,508	109	–1,399
Other private coverage	264	0	–264
Medicare	244	2,336	2,091
CHAMPUS/CHAMPVA	116	0	–116
Medicaid	57	0	–57
Uninsured	255	0	–255
Other Aged 60–64[e]	3,956	3,956	0
Employment based	1,915	505	–1,410
Other private coverage	617	0	–617
Medicare	434	3,451	3,016
CHAMPUS/CHAMPVA	171	0	–171
Medicaid	245	0	–245
Uninsured	573	0	–573

Source: EBRI tabulations using the March 1990 Current Population Survey.

[a]Individuals are classified according to their source of primary coverage. Those with more than one source of coverage were included in only one category based on the following hierarchy: employment based insurance, Medicare, CHAMPUS, individually purchased private insurance, and Medicaid.

[b]Employment based health coverage may be lower after enactment than indicated due to several factors. Some workers may be only part-time and may not be eligible for their employer's plan. In addition, workers aged 60 to 64 may choose to retire earlier because of the availability of Medicare.

[c]Includes individuals whose primary activity during the week prior to the survey was working.

[d]Includes individuals whose primary activity during the week prior to the survey was being retired.

[e]Includes individuals whose primary activity during the week prior to the survey was looking for work, keeping house, or going to school. Also includes those who were unable to work, and those whose primary activity was something not mentioned by the survey.

would also switch to employment-based coverage. Individuals currently covered by a group health plan as dependents would keep employment-based coverage as long as either they or their heads of household are employed.[7] Some individuals whose primary source of coverage under existing law is employment based could use Medicare as their primary source of coverage. This group would include retired and other nonworking individuals whose direct employer-sponsored coverage is through a former employer. In addition, some workers might choose to retire because they could now receive health coverage under Medicare.

Medicare Buy-In for Younger Social Security Beneficiaries—Another legislative proposal analyzed by EBRI would permit Social Security recipients aged 62 and over and spouses (aged 62 and over) of Medicare beneficiaries to purchase Medicare coverage.[8] In 1989, 4 million individuals aged 62–64 were in a family in which at least one member received Social Security benefits (table 3). This group included disabled workers (13 percent), early retirees (63 percent), individuals with end-stage renal disease (1 percent), and their dependents (24 percent). Fifty-five percent of individuals in these families were covered by employment-based coverage, and 11 percent were covered by Medicare.

EBRI estimates that 2.6 million individuals receiving early retirement benefits under Social Security would become eligible to purchase Medicare under this proposal. Nearly 1 million dependents of early retirement and disability beneficiaries would also be eligible to purchase Medicare coverage. The proportion of these dependents who would choose to purchase coverage would be directly related to the cost of that coverage. Dependents would only be eligible to purchase coverage if the Social Security beneficiary in their household had purchased coverage.

Additional provisions of the proposal would provide Medicare coverage to disabled workers aged 62–64 without the two-year waiting period required under current law. EBRI estimates that 13 percent of the 4.1 million individuals aged 62–64 in families with a Social Security beneficiary, or 554,000 individuals, were disability recipients who would become eligible for

[7]Head of household is defined as the family member with the greatest personal earnings.

[8]The proposal analyzed by EBRI is similar to some provisions of the Medicare Eligibility Expansion Act of 1991 (H.R. 1444) introduced by Rep. Pete Stark (D-CA).

Table 3
Individuals Aged 62–64 in Families in Which One or More Members Received Social Security in 1989 by Health Insurance Coverage and Major Activity

Primary Source of Coverage[a]	Major Activity Last Week			
	Total	Working[b]	Retired[c]	Other[d]
	(thousands)			
Total	4,155	812	1,475	1,867
Employment Based	2,282	516	905	861
Direct	1,487	415	695	377
Indirect	796	101	211	484
Other Private	636	152	167	318
Medicare	449	e	175	254
CHAMPUS/CHAMPVA	183	e	62	88
Medicaid	86	e	e	70
Uninsured	519	89	153	277

Source: EBRI tabulations using the March 1990 Current Population Survey.
[a]Individuals are classified according to their source of primary coverage. Those with more than one source of coverage were included in only one category based on the following hierarchy: employment-based insurance, Medicare, CHAMPUS, individually purchased private insurance, and Medicaid.
[b]Includes individuals whose primary activity during the week prior to the survey was working.
[c]Includes individuals whose primary activity during the week prior to the survey was being retired.
[d]Includes individuals whose primary activity during the week prior to the survey was looking for work, keeping house, or going to school. Also includes those who were unable to work, and those whose primary activity was something not mentioned by the survey.
[e]Too small to be statistically significant.

Medicare under this legislation. Unlike the early retirement beneficiaries and their dependents discussed above, these individuals would only be required to contribute to Part B of Medicare (similar to current Medicare beneficiaries). These provisions may have a relatively small impact on total Medicare enrollment. EBRI estimates that only about 114,000 disability beneficiaries aged 62–64 would gain Medicare coverage. Only the long-term disabled and individuals with end-stage renal disease are eligible for Medicare before age 65, with the latter group accounting for about 1 percent of all nonelderly Medicare recipients. Nearly 450,000 individuals aged 62–64 in families in which at least one member received Social Security benefits were enrolled in Medicare in 1989. Assuming that 2 percent of these, or 9,000 individuals, were eligible because of end-stage renal disease, EBRI estimates that 440,000 disabled beneficiaries received Medicare in 1989. This suggests that only 114,000, or 21 percent, of all disability beneficiaries in this age group were not covered by Medicare in 1989.

Conclusion

As the proportion of the U.S. population over age 65 increases and health care expenditures continue to rise, financing the elderly's health care is likely to become increasingly difficult. Related issues include the trend toward earlier retirement and employer concern about providing health insurance coverage to retired workers. Many early retirees may be left without health insurance coverage if employers eliminate retiree medical benefits. Individuals who retire because of their inability to continue working will often be left without coverage. Health care reform that extends Medicare coverage to younger retirees and disabled workers may fill this gap. However, the large costs associated with increasing the number of Medicare beneficiaries may discourage this type of reform. The problems of providing health care services to older workers will continue to grow during the next 40 years. It is not yet clear whether the solution will include an expanded role for the federal government or a continued partnership between public and private health care providers.

—Jill Foley, EBRI

◆ Americans Would Trade Some Pension Benefits for Increased Health Insurance—According to Recent EBRI/Gallup Survey

Sixty percent of Americans said they would be willing to accept a reduction in employer contributions to a pension plan for increased health benefits, according to a recent public opinion survey conducted by EBRI and The Gallup Organization, Inc. Those most likely to be willing to accept this exchange were respondents with annual incomes less than $20,000 (66 percent), females (65 percent), and those aged 18–34 (65 percent).

In addition, respondents with employer-provided health coverage (70 percent) said their employer would have to give them a median amount of $4,000 annually to give up their health insurance. Nearly 20 percent said they would require $10,000 or more, and 29 percent said they didn't know how much more money they would need.

Thirteen percent of survey respondents said they or a family member had passed up a job opportunity solely because of health benefits. Of these survey respondents, the most frequently cited reason, from a list of four reasons, was that the prospective employer did not offer health benefits (58 percent).

With regard to pensions, 36 percent of respondents said they would be willing to accept a reduction in employer-provided health benefits for increased employer contributions to a pension plan.

When respondents with an employer-sponsored pension plan (50 percent) were asked how much more money their employer would have to give them annually in order for them to give up their employer-sponsored pension plan, the median amount was $5,000. Twenty-two percent said they would require $10,000 or more, and 31 percent said they didn't know how much more money they would need.

Only 5 percent of survey respondents said they or a family member had ever passed up a job opportunity because of pension benefits. Of these respondents, 39 percent said the reason they did so was because the prospective employer's pension benefits were not as good as the pension benefits they previously had.

When respondents were asked if they could choose only one employee benefit, the majority (64 percent) selected health insurance, followed by pension plan (14 percent), paid vacation/sick leave (8 percent), disability insurance (5 percent), life insurance (4 percent), and child care/parental leave benefits (3 percent).

The survey on benefits trade-offs was conducted in September and is the twenty-eighth in a series of national public opinion surveys EBRI is undertaking on public attitudes toward economic security issues. The surveys, conducted monthly for EBRI by The Gallup Organization, Inc., question 1,000 Americans by telephone. The maximum expected error range at the 95 percent confidence level is ±3.1 percent.

Copies of the survey reports *Public Attitudes on Benefits Trade-Offs, 1991* (G-28) may be ordered from Kim Thorpe, (202) 775-6315, for the following prices: summary—$75; full report—$275; EBRI member prices: summary—$25; full report—$75.

—Carolyn Piucci, EBRI

◆ Washington Update

Congress passed or introduced several pieces of legislation before recessing on Thanksgiving Eve until mid-January. Meanwhile, the regulatory agencies and the courts have also been busy working on employee benefit issues. Highlights of recent activity include:

Tax Extenders—Congress approved Nov. 27 legislation (H.R. 3909) extending for six months (until June 30, 1992) several tax provisions that were scheduled to expire in January. Provisions relating to employee benefits include the exclusion for employer-provided education assistance, the exclusion for employer-provided group legal services, and the 25 percent deduction for the health insurance costs of self-employed individuals. The chairmen of both tax-writing committees intend to hold hearings in 1992 to consider which tax provisions should be made permanent and which should be allowed to expire.

Medicaid—Congress passed Nov. 27 legislation (H.R. 3595) ratifying an agreement reached by the Bush administration and the National Governors' Association on restricting states from using provider-specific taxes and voluntary contributions to obtain federal Medicaid matching payments. The compromise agreement limits the states' ability to obtain Medicaid matching funds for money collected from health care providers as taxes or voluntary donations.

Banking Reform—Congress approved banking reform legislation (S. 543) on Nov. 27. The legislation preserves pass-through federal deposit insurance corporation (FDIC) coverage for pension funds and eliminates FDIC coverage for bank investment contracts (BICs). President Bush is expected to sign the bill.

PBGC—The Bush administration unveiled proposals Nov. 21 to ensure that the Pension Benefit Guaranty Corporation (PBGC) receives priority in bankruptcy proceedings. Sens. Charles Grassley (R-IA) and Bob Graham (D-FL) introduced the proposal Nov. 21 as legislation (S. 2014) in the Senate and Reps. Rod Chandler (R-WA) and Frank Guarani (D-NJ) sponsored the House bill (H.R. 3843). The proposal is designed to overturn a recent court ruling that held that PBGC has no priority claim in bankruptcy court. Under the bill, the priority claim amount would be the greater of 30 percent of a bankrupt corporation's net worth or 10 percent of the pension plan's underfunding, increasing 2 percent a year until it reaches 50 percent. In addition, the proposal would assure PBGC a seat on any creditors' committee.

Separately, PBGC issued Nov. 25 its third annual list of the nation's 50 largest underfunded pension plans.

According to PBGC, the aggregate underfunding increased 50 percent in 1990 to $21.5 billion, up from $14.2 billion in 1989.

Health Care Reform—Health care reform continues to dominate the agenda of congressional leaders. House Democratic leaders have launched a three-month initiative to put forth a health care reform package. They plan to hold town meetings in mid-January in every district belonging to Democratic House members to explain the various options to constituents and hear their concerns and problems with the current system. Senate Democrats will hold a series of five field hearings across the country between Dec. 9–13 on health care reform. This heightened activity has led several observers to speculate that President Bush may unveil his own health care reform proposal in his State-of-the-Union Address in January.

Middle-Income Tax Relief—Proposals aimed at cutting the taxes of middle-income taxpayers and encouraging economic growth are also likely to generate much congressional interest in 1992. Both tax-writing committees will hold hearings in December on the various proposals that have been introduced. The Senate Finance Committee, which held a hearing Nov. 26 on middle-income tax relief, has scheduled additional hearings Dec. 12–13. The House Ways and Means Committee held hearings Dec. 5–6 and has hearings scheduled for Dec. 17–18.

Medicare—The Health Care Financing Administration Nov. 15 issued the new Medicare fee schedule establishing physician payment levels for approximately 7,000 medical services (*Federal Register*, 11/25/91). The physician payment plan, which will take effect Jan. 1, 1992, is based on the relative values of the work, overhead, and malpractice expenses that physicians incur in providing a service.

Pension Regulations—The Internal Revenue Service (IRS) Dec. 2 issued final regulations for determining separate lines of business for purposes of the minimum coverage and minimum participation rules. In addition, IRS issued final minimum participation rules under section 401(a)(26) and an advance copy of Revenue Procedure 91-64, which provides guidance on applying for determination letters under the final separate-line-of-business rules. On Nov. 29, IRS further clarified and broadened the scope of transition methods for complying with final pension nondiscrimination regulations. The amendment clarifies that any employer may operate under Alternative II D for the 1992 plan year regardless of whether the employer operated under Alternative II D in any prior plan year. Notice 91-38, as amended, appeared in the Dec. 9 *Internal Revenue Bulletin*.

Self-Insured Health Plans—A recent decision by the U.S. Court of Appeals for the Fifth Circuit held that employers that self-insure may change or sharply reduce health care coverage for workers who develop expensive illnesses such as AIDS. The court found that self-insured employers are "free to create, modify, and terminate the terms and conditions of employee benefit plans without governmental interference." The decision is highly controversial and could lead to federal proposals relating to preemption of state laws under the Employee Retirement Income Security Act of 1974.

—Nora Super Jones, EBRI

◆ New Publications

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Alexander Consulting Group. **Postemployment Welfare Benefits: The Current Environment.** Free. Alexander Consulting Group, 44 Merrimac St., P.O. Box 926, Newburyport, MA 01950-5626, (508) 465-5374.

American Compensation Association. **1991-1992 Salary Budget Survey Report**. $50. American Compensation Association, 14040 N. Northsight Blvd., Scottsdale, AZ 85260, (602) 951-9191.

Bond, James T. **Beyond the Parental Leave Debate: The Impact of Laws in Four States.** $30. Families and Work Institute, 330 Seventh Avenue, 14th Floor, New York, NY 10001, (212) 465-2044.

Bureau of National Affairs, Inc. (1) **Recognizing Non-Traditional Families**. $35. (2) **Work and Family Today: 100 Key Statistics.** $35. Bureau of National Affairs, Inc., 9435 Key West Ave., Rockville, MD 20850, (800) 372-1033.

Canan, Michael J. (1) **1991 Edition: Qualified Retirement and Other Employee Benefit Plans.** $58. (2) **Interim Supplement to 1991 Edition: Qualified Retirement and Other Employee Benefit Plans.** $18.95. West Publishing Company, 25 W. Kellogg Blvd., P.O. Box 64833, St. Paul, MN 55164-9752, (800) 328-9352.Citizens Fund. **The Seven Warning Signs: Health Insurance at Risk.** $75.Citizens Fund, 1300 Connecticut Ave., NW, Suite 401, Washington, DC 20036, (202) 857-5168.

Employers Council on Flexible Compensation. **Healthcare Flexible Spending Accounts: Results of an ECFC/Mercer Survey of Employers.** Free. William M. Mercer, 1166 Avenue of the Americas, New York, NY 10036-2708, (212) 345-7000.

Graig, Laurene A. **Health of Nations: An International Perspective on U.S. Health Care Reform.** $16.95. Gary Swegle, The Wyatt Company, 601 13th St., NW, Suite 1000, Washington, DC 20005-3808, (202) 508-4645.

Greenwich Associates. **End of the Tunnel?** Institutional Investors 1991. Contact publisher for price. Greenwich Associates, Office Park Eight, Greenwich CT 06831, (203) 629-1200.

U.S. Department of Labor. Bureau of Labor Statistics. **Employee Benefits in Small Private Establishments, 1990.** Order from GPO.

U.S. General Accounting Office. (1) **Aging Issues: Related GAO Reports and Activities in Fiscal Year 1989.** (2) **Health Care: Actions to Terminate Problem Hospitals from Medicare Are Inadequate.** (3) **Private Health Insurance: Problems Caused by a Segmented Market.** (4) **Substance Abuse Treatment: Medicaid Allows Some Services But Generally Limits Coverage.** (5) **Veterans' Benefits; VA Needs to Verify Medical Expenses Claimed by Pension Beneficiaries.** Order from GAO.

William M. Mercer, Inc. (1) **Current Issues in Executive Compensation—1990 Survey.** $50. (2) **1991 Human Resource Management Compensation Survey Results.** $500. William M. Mercer, Inc., 1417 Lake Cook Drive, Deerfield, IL 60014, (800) 333-3070.

William M. Mercer, Inc. **Retiree Health Benefits in the 1990s.** Free. William M. Mercer, Inc., Publications Dept., 1500 Meidinger Tower, Louisville, KY 40202, (212) 345-7584.

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