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# NOTES

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## *Findings From the 2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey: Implications for Plan Sponsors,* p. 2

## *Facts from EBRI—The Basics of Social Security: Updated With the 2008 Board of Trustees Report,* p. 6

## *New Publications and Internet Sites,* p. 9

### *Executive Summary:*

### *Findings From the 2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey: Implications for Plan Sponsors*

- ***Survey reaction and analysis—***This article provides reaction to and analysis of results from the "2007 EBRI/Commonwealth Fund Consumerism in Health Survey," published in the March 2008 *EBRI Issue Brief* (online at www.ebri.org).
- ***SWOT analysis—***Analysis focusing on "strengths, weaknesses, opportunities, and threats" (SWOT) is often used to evaluate current or proposed approaches or situations. It is instructive to use this framework to consider whether consumer-driven health plans and high-deductible health plans are effective in managing costs and improving the health of plan participants or not. Findings from this review:
  - ✓ ***Strengths:*** The financial incentives seem to be working, if at least modestly.
  - ✓ ***Weaknesses:*** The level of participant satisfaction is much lower than for traditional health plans.
  - ✓ ***Opportunities:*** The effectiveness of these plans could be enhanced if participants were more committed and assertive in managing their health and their use of health care services.
  - ✓ ***Threats:*** Unless workers become more positive about the consumer-driven health plans meeting their needs, the enrollment may decline.

### *The Basics of Social Security: Updated With the 2008 Board of Trustees Report*

- ***Latest data—***The Social Security Board of Trustees released their 2008 update March 25 on short-range (10 year) and long-range (75-year) projections for the Social Security trust funds. Under intermediate assumptions, the combined OASDI trust fund expenses are expected to exceed income from taxes in 2017. By 2027, OASDI expenses are expected to exceed income from taxes plus interest income, and the trust fund is expected to be exhausted by 2041.

# Findings From the 2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey: Implications for Plan Sponsors

***By Richard Ostuw, EBRI Fellow***

*This article provides reaction to and analysis of the 2007 EBRI/Commonwealth Fund "Consumerism in Health Care Survey," published in the March* 2008 EBRI Issue Brief *and available online at www.ebri.org*

## Introduction

There is great interest in the various forms of health plans that incorporate financial accountability for participants—the so-called "consumer-driven" health plans. Some think these plans are the future of health insurance, while others think they will merely fill a limited niche in the marketplace.

This article identifies strengths, weaknesses, opportunities, and threats related to these plans.

- ***Strengths:*** The financial incentives seem to be working, if at least modestly.
- ***Weaknesses:*** The level of participant satisfaction is much lower than for traditional health plans.
- ***Opportunities:*** The effectiveness of these plans could be enhanced if participants were more committed and assertive in managing their health and their use of health care services.
- ***Threats:*** Unless workers become more positive about the consumer-driven health plans meeting their needs, the enrollment may decline.

## 2007 EBRI/Commonwealth Survey

In recent years, there has been great interest in a new type of health plan. The key feature of these "consumer-driven" plans is greater financial accountability for the plan participants through higher point-of-care cost sharing through the deductible and coinsurance, compared with traditional plans.

The future of these plans depends on the attitudes and behaviors of employers and their workers. While the consumer-driven approach has intrinsic advantages, it also has intrinsic challenges.

The findings of the 2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey are informative in answering questions about how well these plans are working. While it is too early to say definitively that the plans are successful or not, the data can be useful. The purpose of this article is to discuss the implications of the survey results and provide thoughts on the future of these plans.

In the 2007 EBRI/Commonwealth Fund survey, two types of plans are examined and compared with the more traditional health plan. The differentiating feature between the two plans is the presence or absence of an account that accompanies the insurance portion of the plan. The survey examines consumer-directed health plans (CDHPs), which are defined by having either a health reimbursement arrangement (HRA) or a health savings account (HSA). HRAs and HSAs differ in the tax rules about contributions and other elements, but both allow unused amounts to roll over for use in future years.

The 2007 EBRI/Commonwealth Fund survey also examines plans with deductibles that are generally high enough to allow a participant to contribute to an HSA, but in which plan participants have not opened such an account, for various reasons. These plans are known simply as high-deductible health plans (HDHPs). In the survey, traditional plans include such managed-care arrangements as health maintenance organizations (HMOs), preferred provider organizations (PPOs), and other plans that have a greater degree of cost insulation to the participant.

The promise of these new types of plans is to produce lower costs and improved health. The presence of financial incentives (accountability and transparency) has a direct effect on purchasing decisions and an indirect effect of better engaging plan participants in the use of information. The expected result is better management of their health and better use of health care services.

The evaluation of any approach begs the question, "compared with what?" No health plan is perfect. In evaluating a type of plan, one must assess it compared with something else. Too often, today's plans are evaluated compared with the fantasy of perfection. The reality is that the world imposes a variety of

constraints and hurdles. A plan may be mediocre in absolute terms but still be the best in relative terms. This discussion considers plans relative to the practical alternatives.

## The Role of Health Plans

Both employers and workers have diverse needs and desires. All employers want healthy and productive workers, but they have varying views of whether or how their health plans can help achieve that goal. Health plans have an obvious impact on employee health when they facilitate appropriate medical care and healthy behaviors.

Also, the health plan can further enhance worker productivity by influencing which workers seek employment with an employer and which terminate. Most large employers believe that only by offering a meaningful health plan can they attract and retain high-quality workers. Some employers view their role as passive, and offer plans with minimal impact on worker control, while others feel that only by taking a more active role can they achieve what workers and the employer want in terms of cost and quality of care.

Health plans may not create enthusiasm for working hard, but poorly operated plans can damage workers' commitment to the employer. Some employers seem to view health plans as a necessary evil—something they must offer but does not provide any meaningful advantages. A possible analogy is the electric bill: The employer must have electricity and must pay the bill, but thinks of it as a cost of doing business—not as a strategic tool.

Workers also vary in how they view their health plan. Some are concerned with routine costs, while others are focused on overall financial protection against unbudgetable expenses. And what is unbudgetable to one is routine to another. Some workers place great value on their degree of control. Some value assistance by the plan or employer in helping manage chronic or other significant illnesses or conditions.

And of course, health care expenses vary considerably. Roughly 50 percent of health plan participants are relatively healthy and in total incur less than 10 percent of the total health care cost. And about 10 percent have major expenses and incur more than 50 percent of the total cost. Workers with different health conditions and experiences tend to view the same plan features differently.

Health plans are not "zero-sum" arrangements. Many observers seem to feel that there is a zero-sum arrangement between employers and workers, whereby employers gain only if workers lose, and vice versa. Similarly, some feel that it is zero sum within a worker group. There are elements of such trade-offs, but there are also ways that both employers and workers can win or both can lose, and ways that various worker constituencies have common interests. Everyone wins if costs are constrained without sacrificing quality of care, and everyone loses if costs continue to escalate.

## SWOT Analysis

SWOT analysis—focusing on "strengths, weaknesses, opportunities, and threats," is often used to evaluate current or proposed approaches or situations. It is instructive to use this framework to consider whether CDHPs and HDHPs are effective in managing costs and improving the health of plan participants or not.

***Strengths—***Participants in CDHPs and HDHPs report being more cost-conscious about health care than participants in traditional plans. Seventy-four percent of CDHP participants and 60 percent of HDHP participants say that the terms of the health plan make them think about the cost when deciding whether to see a doctor or to fill a prescription, compared with 47 percent of traditional plan participants.

Participants in these new plans are more likely to ask for a generic drug instead of a brand name drug (54 percent for CDHP and 58 percent for HDHP, compared with 46 percent for traditional plan participants).

These data are consistent with other reports that health care costs are lower for enrollees in CDHPs and HDHPs than for those in traditional plans. The difference is commonly estimated at 4 percent to 8 percent. This level of savings is consistent with past changes in health care utilization due to increased employee cost sharing.

***Weaknesses*—**The level of participant satisfaction with these new plans is significantly lower than for traditional plans. About 64 percent of participants in traditional plans are *very* or *extremely* satisfied with their plans, compared with 48 percent for CDHP participants and 35 percent for HDHP participants.

This difference in satisfaction is partly due to the risk of out-of-pocket costs that is intrinsic to these plans. Of traditional plan participants, 47 percent are *very* or *extremely* satisfied with "the cost I pay out of my own pocket for my health care," compared with 24 percent for CDHP and 17 percent for HDHP participants. Of traditional plan participants who had a CDHP or HDHP option, 68 percent said the high out-of-pocket costs were a factor in declining the option. While financial accountability for health care decisions is seen as a key ingredient in achieving more cost-effective purchasing, it is contrary to workers' desire for predictable costs.

When asked how likely they would be to stay in their current plan if they had an opportunity to change, traditional plan participants are much more likely to stay (64 percent, compared with 45 percent and 34 percent for CDHP and HDHP, respectively).

Traditional plan participants are more likely to report that "my health plan is easy to understand" (64 percent, compared with 53 percent for CDHP or 43 percent for HDHP). Lack of understanding of how the plan works by CDHP and HDHP participants will detract from achieving the promised health care behaviors and tend to create anxiety and distrust. This can be a significant issue working against the sustainability of these new plan types. Employers and health insurance companies must recognize and address this challenge.

***Opportunities*—**There are opportunities to improve results under these plans. Because of the financial structure, they offer the possibility of being the most cost-efficient type of health plan.

Although CDHPs and HDHPs provide a financial incentive for participants to be more engaged in their own health care, the initiative by participants in using medical information (such as through Web sites, the health plan, or the physician) is similar among the three plan types.

The promise of lower cost and improved health can only be achieved if workers respond to the financial incentives and are more assertive in making informed decisions about their health and health care services. This will require a more informed and engaged group of participants than currently is the case.

Workers' concerns about the risk of out-of-pocket costs may be due in part to a lack of understanding of the value of the account or the ability to use the account to smooth variations in expense between years.

CDHP and HDHP participants are somewhat more likely to have delayed or avoided health care services because of cost (29 percent for CDHP and 31 percent for HDHP, compared with 16 percent for traditional health plans). The types of care that were affected are similar among the three groups. This is a *strength* if participants were avoiding *unnecessary* care, or a *weakness* if they are avoiding *necessary* care. The use of medical screening (such as mammogram or colon cancer tests) is comparable among the groups.

The ideal is that a health plan will facilitate less of all three problems of the current health care delivery system: *overuse* of health care (such as unnecessary tests), *misuse* (such as inappropriate medicine), and *underuse* (such as care management for chronic conditions). The financial incentives under CDHPs and HDHPs can be significant in gaining workers' attention, but probably are not enough. Enhancing the appropriateness of care will likely require additional efforts in care management and education.

CDHPs and HDHPs tend to emphasize care management and information resources for participants. While these resources have also become common with traditional plans, the financial responsibility of CDHPs and HDHPs could enhance the extent of their use—but only if the management and information resources are easy to use and are perceived as beneficial to participants.

To improve results will take the dual effort of greater engagement by workers and greater support by employers.

***Threats*—**There is somewhat of a chicken and egg problem with consumer-driven health plans. The relatively low enrollment in CDHPs and HDHPs affects the levels of familiarity and confidence. Some degree of skepticism is to be expected and will be hard to overcome unless prospective participants see more of their counterparts satisfied with the change. Enrollment will grow only if workers buy into the idea of the informed and engaged consumer and accept the financial structure.

While it is clear that participants incur lower costs for health care when they are accountable for the cost, the source of the savings is not clear. If the changes are for more appropriate care or reduced prices, workers will gain. If workers feel they have to forego appropriate care, they will work against these plans.

If workers feel that CDHPs and HDHPs are contrary to their needs, participation will stabilize as a limited niche or may decline.

## Other Considerations

Satisfaction with a health plan is about 8 to 10 percentage points higher for workers who have a choice of plans, regardless of which type of plan they are in. This may be caused by two factors. Those who have a choice are more likely to compare the plan with the alternatives available, whereas those without choice may compare the plan to the ideal or to the memory of a prior plan. Also, those who have a choice also have some ownership in the selection of the plan they are enrolled in.

Workers make tradeoffs in selecting a health plan. The most common reason reported for choosing the current plan for CDHP and HDHP participants is lower premium cost (51 percent and 44 percent, respectively) compared with 29 percent of traditional plan participants. Current CDHP and HDHP participants have implicitly said that they are willing to accept greater volatility in out-of-pocket costs in order to get the certainty of lower premium costs. But traditional plan participants have said the opposite. That suggests a degree of resistance among traditional plan participants to being enticed into CDHPs and HDHPs.

## Conclusion

CDHPs and HDHPs are perhaps at a tipping point. The level of enrollment in these plans has grown significantly relative to previous years, but is still modest in absolute terms. That suggests that both workers and employers remain skeptical of them. These attitudes will change only if both the substance and perception are positive. If employers and workers change their mindsets, CDHPs and HDHPs can become a significant part of the U.S. health care financing system. But if there are no changes in employers' and workers' attitudes and behaviors, they will remain as a niche type of plan or decline in the future.

For CDHPs and HDHPs to reach their potential, they must meet both employer and worker needs. It is instructive to consider the rise and fall of managed care plans: They rose in enrollment because they offered the best value, and their cost efficiency was used in part to finance more liberal benefits such as modest copays and no overall deductible. Workers loved the low risk of unplanned expenses and tolerated the network restrictions. But the tipping point came when workers felt that the care management restrictions impaired their access to the health care they felt they needed. Similarly, the cost efficiency of CDHPs and HDHPs could be used to fund larger contributions to employees' accounts or to reduce premium contributions. But that will not be enough for sustained success unless workers accept that the approach supports their needs.

Employers and workers must shift from a passive role to an active role if they want to maximize the results. Many employers face budget and time constraints, which cause a largely passive approach in managing their health care programs. Similarly, many workers lack the desire or capability to be more active in managing their health and health care services. While perfection is not achievable, progress will enable these plans to be more successful for all constituencies.

# ■ *Facts from EBRI—The Basics of Social Security, Updated With the 2008 Board of Trustees Report*

## History and Background

- The U.S. Congress enacted the Social Security Act in 1935, creating the Old-Age and Survivors Insurance (OASI) program, which provided retirement income benefits to workers ages 65 and older in commerce and industry (except railroads). The system became effective in 1937, and is financed by a payroll tax paid by employers and employees. In 1939, the system was expanded to cover dependents and survivors of covered workers. Legislation enacted in 1950 and subsequent years allowed states the option, under certain conditions, to provide Social Security coverage to their employees. The Social Security Act Amendments of 1983 prohibited states from opting out of the Social Security program. In 1990, Social Security coverage became mandatory for state and local employees not covered by a state or local government retirement plan.
- In 1956, the Disability Insurance (DI) program was added to the Social Security program, providing income to disabled workers. In 1958, dependents of disabled workers receiving benefits under the DI program became eligible for benefit payments.
- In 1965, the Medicare program was added, providing health insurance coverage for the elderly; the program was expanded in 1972 to cover beneficiaries of the DI program. EBRI maintains a separate *Fact Sheet* detailing the basics of the Medicare program.
- For budgetary purposes, the date on which the trust funds go into negative cash flow (i.e., the benefit payments exceed the income from payroll taxes and the taxation of benefits) is significant because it marks the point at which the government must provide cash from general revenues to the programs rather than receive surplus cash from them to fund other current spending.

## Key Dates in the Long-Range Financing of the OASDI Trust Fund

- According to the 2008 Trustees' report, the future cost outlook of Social Security looked slightly better from the year before, largely because of methodological changes, but the long-term financial viability of the benefit programs was just as problematic. Specifically, under intermediate assumptions, the combined OASDI trust fund expenses are expected to exceed income from taxes in 2017. By 2027, OASDI expenses are expected to exceed income from taxes plus interest income, and the trust fund is expected to be exhausted by 2041.
- Under low cost assumptions, the combined OASDI trust fund expenses are expected to exceed income from taxes in 2021. The trust fund is expected to remain solvent throughout the 75-year period.
- Under high cost assumptions, the combined OASDI trust fund expenses are expected to exceed income from taxes in 2014. By 2031, the trust fund is expected to be exhausted.
- The unfunded obligation of the OASDI trust funds, for 1935 through the end of the 75-year projection period ending in 2082, is estimated to be $4.3 trillion. The unfunded obligation for 1935 through the infinite horizon is estimated to be $13.6 trillion.
- In 2007, expenditures of the OASDI trust funds were the equivalent to 4.3 percent of gross domestic product (GDP). By 2082, that percentage is estimated to increase to 5.8 percent.

## Tax Revenue

- The Social Security trust funds are derived from payroll taxes assessed on employers and employees. Under current law, the payroll taxes are assessed as follows. OASI payroll taxes for 2008 are based on a combined employer/employee rate of 10.6 percent of earnings up to a maximum annual taxable amount of $102,000. The maximum taxable amount of earnings increases in proportion to increases in the average wage level. In 2007, total income for the OASI trust fund was $675.0 billion: $560.9 billion was in payroll taxes, $17.2 billion was in taxation of benefits, and $97.0 billion was interest income.

- DI payroll taxes for 2008 are based on a combined employer/employee rate of 1.8 percent of earnings, up to a maximum taxable amount of 102,000. The maximum taxable amount of earnings increases in proportion to increases in the average wage level. In 2007, total income for the DI trust fund was $109.9 billion: $95.2 billion was from payroll taxes, $1.4 billion was from taxation of benefits, and $13.2 billion was from interest income.
- In 1992, the DI trust fund went into negative cash flow and was projected to become insolvent in 1995. To alleviate this problem, Congress enacted the Social Security Domestic Employment Reform Act of 1994 (P.L. 103-387), which reallocated a portion of OASI taxes to the DI trust fund, effective retroactively.

## Beneficiaries and Benefit Amounts

- In 2007, 40.9 million beneficiaries received benefit payments from the OASI program. In 2007, 8.7 million individuals, disabled workers, and their dependents received benefit payments from the DI program. Under intermediate assumptions, the number of OASI beneficiaries is projected to increase to 43.2 million in 2010; to 78.4 million in 2040; and to 102.7 million in 2085, and the number of DI beneficiaries is projected to increase to 9.6 million in 2010; to 13.0 million in 2040; and to 17.3 million in 2085.

**Estimated Average Monthly Social Security Benefits:**
**Before and After the January 2008 Cost-of-Living Adjustment (COLA)**

| | Before 2.3% COLA | After 2.3% COLA |
|---|---|---|
| All Retired Workers | $ 1,055 | $ 1,079 |
| Aged Couple, Both Receiving Benefits | 1,722 | 1,761 |
| Widowed Mother and Two Children | 2,192 | 2,243 |
| Aged Widow(er) Alone | 1,017 | 1,041 |
| Disabled Workers, Spouse and One Or More Children | 1,652 | 1,690 |
| All Disabled Workers | 981 | 1,004 |

*Source:* Social Security Administration, "2008 Social Security Changes," *http://www.ssa.gov/cola/colafacts2008.htm*

- In 1945, the number of covered workers per OASDI beneficiary was 41.9. By 1965, that number was 4.0, and in 2007, it was 3.3. Under intermediate assumptions, the number of covered workers per OASDI beneficiary is estimated to be 3.2 in 2010, 2.2 in 2030, 2.1 in 2060, and 2.0 in 2085.
- In 2007, total benefit payments from the OASI trust fund amounted to $489.1 billion. Total benefit payments from the DI trust fund were $95.9 billion.

## Recent EBRI Research on Social Security and Social Security Within Retirement Income (available at www.ebri.org)

- "Americans Much More Worried About Retirement, Health Costs a Big Concern," *EBRI Issue Brief*, no. 316 (April 2008).
- "The Retirement System in Transition: The 2007 Retirement Confidence Survey," *EBRI Issue Brief*, no. 304 (April 2007).
- "Estimating the Value of Changes in OASI Benefits Under Social Security Reforms," *EBRI Notes*, no. 6 (June 2006).
- "Changes in the OASI Benefit Distribution Under Various Social Security Reform Alternatives," *EBRI Notes*, no. 4 (April 2006).
- "Income of the Elderly Population, Age 65 and Over: 2004," *EBRI Notes*, no. 1 (January 2006).
- "Retirement Income Security: A Look at Social Security, Employment-Based Retirement Plans, and Health Savings Accounts," *EBRI Notes*, no. 8 (August 2005).

- "Social Security Reform: The Importance of Disability Insurance and Annuities in Individual Accounts," *EBRI Notes*, no. 7 (July 2005).
- "Comparing Social Security Reform Options," *EBRI Issue Brief*, no. 281 (May 2005).
- "The Inflation Rate and the Actuarial Balance of the OASDI Trust Funds," *EBRI Notes*, no. 6 (June 2004).
- "Americans' Future Retirement Security: Implications of the EBRI-ERF Retirement Security Projection Model," *EBRI Issue Brief* no. 266 (February 2004).
- EBRI also maintains its Social Security Research Program. Contained on that site is EBRI research on administrative issues involved with individual accounts in Social Security as well as links to over 100 Web sites on Social Security.

### Social Security Trustees in 2008

- Treasury Secretary Henry M. Paulson, Jr. acts as the Managing Trustee of the OASDI trust funds. The other trustees include: Elaine Chao, Secretary of Labor; Michael O. Leavitt, Secretary of Health and Human Services; Michael J. Astrue, Commissioner of Social Security; the two public trustee positions are currently vacant.
- For a copy of the 2008 trustees report and a summary of the 2008 Social Security and Medicare reports, click on the following link. www.ssa.gov/OACT/TR/TR08/index.html

For more information, contact Ken McDonnell (202) 775-6367, e-mail mcdonnell@ebri.org

Source: U.S. Social Security Administration, *2008 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and the Disability Insurance Trust Funds* (Baltimore, MD: U.S. Social Security Administration, 2008). Documents online at http://www.ssa.gov/OACT/TR/TR08/

## Peter Bernstein Receives 2008 Lillywhite Award

Peter L. Bernstein, author, educator, and president of an economic consulting firm that bears his name, has been selected for the 2008 EBRI Lillywhite Award in recognition of outstanding lifetime contributions to America's economic security.

The award was presented to Bernstein by EBRI President and CEO Dallas Salisbury at the annual Plan Sponsor Awards Dinner April 3 in New York, with more than 600 attendees.

EBRI established the award in 1992 in honor of the late Ray Lillywhite, a pioneer in the pension field who for decades guided state employee pension plans. The award acknowledges individuals or organizations that have made significant contributions to the investment management and employee benefits fields.

After work in commercial banking and as a portfolio manager, Bernstein in 1973 founded Peter L. Bernstein, Inc., which serves as an economic consultant to institutional investors and corporations around the world. He is president of the firm, author of 10 books on economics and finance and many articles in professional journals, and has lectured widely throughout the United States and abroad on risk management, asset allocation, portfolio strategy, and market history.

A Phi Beta Kappa graduate of Harvard College, he taught at Williams College and for many years was an adjunct professor on the graduate faculty of the New School for Social Research in New York. He was the first editor of *The Journal of Portfolio Management* in 1974, a widely read scholarly journal for investment managers and academics in the field of finance and investments, and is now consulting editor of the *Journal.*

More information about the Lillywhite Award, including a complete list of recipients, is online at http://www.ebri.org/programs/lillywhite/index.cfm?fa=lillywhiteRecipients

# New Publications and Internet Sites

[Note: To order U.S. Government Accountability Office (GAO) publications, call (202) 512-6000.]

### Accounting

The National Center for Employee Ownership. *Accounting for Equity Compensation*. 5th Edition. NCEO members, $35; nonmembers, $50. National Center for Employee Ownership, 1736 Franklin St., 8th Fl., Oakland, CA 94612, (510) 208-1300, fax: (510) 272-9510, e-mail: nceo@nceo.org, www.nceo.org

### Employee Benefits

U.S. Chamber of Commerce. *Employee Benefits Study: 2007*. U.S. Chamber of Commerce members, $75; nonmembers, $125 + S&H. U.S. Chamber of Commerce, Publications Fulfillment, 1615 H St., NW, Washington, DC 20062-2000, (800) 638-6582 or (202) 659-6000, e-mail: ebstudy@uschamber.com, www.uschamber.com/research

### General Reference

Omnigraphics, Inc. *Toll-Free Phone Book USA: A Directory of Toll-Free Telephone Numbers for Businesses and Organizations Nationwide*. 2008 Edition. $193. Omnigraphics Customer Service, P.O. Box 625, Holmes, PA 19043, (800) 234-1340, fax: (800) 875-1340, www.omnigraphics.com

### Health Care

Watson Wyatt Worldwide. *The One Percent Strategy: Lessons Learned from Best Performers: 13th Annual National Business Group on Health/Watson Wyatt Employer Survey on Purchasing Value in Health Care*. $49. Watson Wyatt Worldwide, 901 N. Glebe Rd., Arlington, VA 22203, (800) 388-9868 or (703) 258-8000, fax: (703) 258-8585, www.watsonwyatt.com

### International Employee Benefits

International Group Program. *2007 IGP Country Profiles*. Free. Available on CD only. For further information, contact Elaine Paradiso, John Hancock Financial Services, John Hancock Place, Boston, MA 02117, (617) 572-8637, e-mail: eparadiso@jhancock.com

### Pension Plans/Retirement

Institute of Management and Administration. *Plans in Transition 2008: IOMA's Annual Defined Contribution Plan Report*. $395 + S&H. IOMA, 3 Park Ave., 30th Fl., New York, NY 10016-5902, (800) 401-5937 or (212) 244-0360, fax: (212) 564-0465, e-mail: subserve@ioma.com, www.ioma.com/hr

### Workplace Issues

Marsh Inc. and Mercer LLC. *Survey on Health, Productivity and Absence Management Programs: 2007 Survey Report*. $250. Mercer LLC, 1166 Ave. of the Americas, 28th Fl., New York, NY 10036, (212) 345-2451, www.mercer.com/ushpamsurvey

### Family and Medical Leave Act Sites

American Federation of State, County and Municipal Employees (AFSCME)
www.afscme.org/issues/1764.cfm

Hewitt Associates
www.hewittassociates.com/Intl/NA/en-US/KnowledgeCenter/LegislativeUpdates/LegislativeUpdatesDetail.aspx?cid=4936

National Conference of State Legislatures
www.ncsl.org/programs/employ/fmlachart.htm

National Partnership for Women & Families
www.nationalpartnership.org/site/PageServer?pagename=ourwork_fmla_FamilyandMedicalLeave

U.S. Department of Labor
www.dol.gov/esa/whd/fmla/

## Web Documents

2008 Study of Consumer-Directed Health Plans
www.aappo.org/UserFiles/File/HSASurveyandPressRelease/cdhp_study_2008_final.pdf

2008 Survey of Health Care Consumers: Executive Summary
www.deloitte.com/dtt/cda/doc/content/us_chs_ConsumerSurveyExecutiveSummary_200208.pdf

2008 Wilshire Report on State Retirement Systems: Funding Levels and Asset Allocation
www.wilshire.com/BusinessUnits/Consulting/Investment/2008_State_Retirement_Funding_Report.pdf

Account-Based Health Plans: What Works—and Why
www.towersperrin.com/tp/getwebcachedoc?webc=HRS/USA/2008/200801/ABHP.pdf

AXA Equitable Retirement Scope: New Dynamics – Retirement—A New Life After Work? Results for the United States, with International Comparisons
www.axa-equitable.com/pressroom/2008/2008_SCOPE_DECK_FINAL.pdf

Building Retirement Confidence Amidst Financial Challenges: 9th Annual Transamerica Retirement Survey
www.transamericacenter.org/resources/BuildingConfidencePresentation%20TCRS%201002-0208.pdf

Health Insurance Mandates in the States 2008: A State-by-State Breakdown of Health Insurance Mandates and Their Costs
www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2008.pdf

Liability of Plan Fiduciaries under ERISA: LaRue v. DeWolff, Boberg & Associates
www.assets.opencrs.com/rpts/RS22827_20080304.pdf

Miscellaneous Pension Protection Act Changes [Notice 2008-30]
www.irs.gov/pub/irs-drop/n-08-30.pdf

National Compensation Survey: Employee Benefits in State and Local Governments in the United States, September 2007
www.stats.bls.gov/ncs/ebs/sp/ebsm0007.pdf

Pension Protection Act of 2006: Implementation and Aftermath
www.thompson.com/images/thompson/reports/hr022008_pensionprotectionact.pdf

Promises with a Price: Public Sector Retirement Benefits
www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/State_policy/pension_report.pdf

Saving for Retirement at Work: Employee and Business Reactions to an Automatic IRA Concept
www.prudential.com/media/managed/Retirement-Savings-at-Work-FINAL-1-24-08.pdf

Status of the Social Security and Medicare Programs: A Summary of the 2008 Annual Reports
www.socialsecurity.gov/OACT/TRSUM/trsummary.html

Study of Retiree Health VEBAs
www.segalco.com/publications/surveysandstudies/2008VEBAs.pdf

Survey of Dental Coverage
www.segalco.com/publications/surveysandstudies/2008dental.pdf

Technological Change and the Growth of Health Care Spending
www.cbo.gov/ftpdocs/89xx/doc8947/01-31-TechHealth.pdf

Trends and Experience in 401(k) Plans, 2007 [Survey Highlights]
www.hewittassociates.com/_MetaBasicCMAssetCache_/Assets/Articles/401kHI07.pdf

Wellness Program Analysis [Field Assistance Bulletin No. 2008-02]
www.dol.gov/ebsa/pdf/fab2008-2.pdf

Who Is Ready for Retirement, How Ready, and How Can We Know?
www.aarp.org/research/financial/retirementsaving/2008_01_income.html

# EBRI Notes

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