Why the Private Sector Should Care About the Medicare DRG System

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[Editor's Note: Growing concern over the cost of the Medicare program led the Congress in 1983 to enact the prospective payment system (PPS) for Medicare hospital spending based on diagnosis-related groups, or DRGs. The Department of Health and Human Services recently proposed to increase Medicare payments to hospitals by 0.5 percent, rather than the 2 percent recommended by the Prospective Payment Assessment Commission (ProPAC). Budget reconciliation legislation approved by the House Ways and Means Committee calls for a 1.3 percent increase; the Senate Finance Committee has approved a 1.5 percent increase. HHS has also proposed or implemented other rules that could reduce Medicare costs. The following article, by Dr. Stuart H. Altman, presents his views of the issue, as stated at EBRI's June 3 Policy Forum on "The Changing Health Care Market." Altman is dean and professor of national health policy at the Florence Heller Graduate School at Brandeis University, where he is chairman of the Health Policy Center. He is also president of the National Foundation for Health Services Research and chairman of the Prospective Payment Assessment Commission.]

What Medicare does, and what the federal government does, very much affects the private sector, and they're not going to wait for you. Congress is going to pass laws which might look like they only affect the Medicare program, and since you're knee-deep into worrying about people buying Xerox machines, or what bank you should invest in, you say, "Gee, that's not that important to the private sector or my employees."

I'm here to tell you that the medical care system is a partnership. Whether you like it or not, if one partner goes out and decides to knock down his part of the house, it's going to get drafty on your side. So, I would like to put a plea in for you to become concerned about some of the Medicare issues that have come before us at ProPAC, which we are not convinced are being handled well by the administration. With the new direction at HCFA started by Dr. William Roper, [HCFA administrator], maybe I'll feel differently in the future.

Some of you may remember the concerns expressed by representatives of the insurance industry in the early 1980s about the shifting of costs from Medicare to the private sector. Medicare paid 77.1 percent of the charges paid by private patients in 1980.

This relative Medicare payment rate fell and continued to fall and reached 71.8 percent by 1982. Many of you learned the hard way as you found your premiums going up, not by the 10 or 15 percent that you expected, but by 30 to 40 percent. One of the reasons that happened is the hospital just didn't voluntarily accept the Medicare reduction. They looked around for another deep pocket. And, guess who it was?

While you may know these past statistics, what is interesting is what has happened in the last few years. I don't know if this information is correct, but it comes from the Office of the Actuary, and economists have learned to respect actuaries, even if we don't understand them. Wilbur Mills once said, "Get all the economists out of here. I want to see an actuary."

Medicare Paying Larger Share of Patient Charges

These HCFA figures indicate that since 1982, the 71.8 percent rate rose to 75.7 percent in 1983, and to 82.9 in 1984, indicating that Medicare is now picking up a larger and larger relative percentage of private patients' charges. This should be wonderful news ... because that means you're not as likely to be cost-shifted against.

But this number could turn down, and that's what I want to talk about. Congressman Gradison indicated in his six points a number of reasons why this is likely to happen as the government becomes a tougher, more prudent buyer. [See "Gradiosn on Congressional Health Issues," July 1986 Employee Benefit Notes.] I also want to focus on the issue of how we should pay for new medical technology.
Is the DRG System Responsive to New Technologies?

When Congress passed the PPS/DRG [Prospective Payment System/Diagnosis-Related Group] system in the early 1980s, I don’t think it wanted to freeze the medical care delivery system with the technology and procedures that were in place in 1981. It recognized that it was putting in place a totally new package that had many positive incentives in terms of making Medicare providers more concerned with costs and trying to find the most efficient type of hospital care. But Congress also realized that it was putting in place a payment system that might not be responsive to new kinds of medical technologies.

There was no problem with technologies and procedures that saved the hospital money. That the DRG system does in spades, and no one needs to be concerned about that.

But there are other kinds of technologies. We can dismiss those technologies that are both cost increasing and bad for health care, and good riddance to them. We know they exist, and I think the DRG system provides the right incentives to eliminate such technologies.

But what about two other kinds of technologies: (1) Those technologies that increase costs to the hospital, but reduce costs for the total medical care system. Most of you in this room are not concerned about hospital costs alone. You either pay total medical care expenses or you insure total medical care expenses, and, therefore, you have to be concerned about a system that only worries about part of the total. (2) The other type of technologies are those that are cost increasing, not only to the hospital but for the entire medical system, but increase the quality of care or improve a patient’s lifestyle. I know most of you are not so hard-hearted for yourself or your employees that you only think about the bottom line. The discussion at this policy forum clearly indicates the importance that many of you place on increasing the quality of our medical care system.

Where does that all take us? I want to focus on three issues that have come before ProPAC in the last two years. I’m not saying that we at ProPAC have come up with the right solution. As a matter of fact, I’m going to suggest that in one case we may have come up with the wrong solution.

The first example I’d like to use, and they are just examples, is the cardiac pacemaker. I’ve never seen a pacemaker, and I hope I never need one, but for those of you who know less than I do, there are several different types of pacemakers. Some are rather simple little gizmos: they’re not programmable, and they’re one chamber. Then there are dual chamber units, and there are dual chamber pacemakers that are programmable. I gather you can press a button if you’re going to run upstairs, or you can turn your VCR on, and it probably makes coffee as well.

**DRGs Fail to Adjust for Price Differences**

As you might expect, the more sophisticated units are much more expensive than the simple garden variety. Unfortunately, the DRG system doesn’t adjust for any of these financial differences. While there are different DRGs for pacemakers, they are based on whether the pacemaker is put in during a myocardial infarction, or whether it’s a replacement, but it makes no adjustment for differences in the cost of the technology.

Now, to make the numbers simple, let’s say the cheap one costs $2,500 and the expensive one costs $5,000. You could almost double that difference, because when you finish with the extras, e.g., when the surgeon puts in the cheap one, it’s less expensive than when he puts in the more expensive one, and everything else goes along in the same direction.

Well, just think about the pressure on the hospital. The hospital gets one payment, and, say, the payment is the average of the two, or $3,750. That means every time the more expensive pacemaker goes into a body in that hospital, the hospital loses $1,250. Likewise, when the less expensive model is used, the hospital gains $1,250.

When you hear a lot of hoorays, it’s when a doctor implants the less expensive unit, so the hospital is happy. Well, that sounds great, except there are times when the patient really needs the more complicated device. It’s not clear to me that I want to see that much of a financial incentive to always implant the less costly unit. Suppose the difference was $2,000 and $10,000 or $2,000 and $20,000. Since the DRG system is nondevice specific, these cost differences do not translate into differences in payments to the hospital. It was designed that way and there is, in fact, a religion built up supporting the notion that the DRG payment amount should not be related to the cost of the medical devices used. I fear that while I’m speaking some nontechnology god is going to come out and zap me.

Since the DRG system is nontechnology specific, it makes no adjustment for these kinds of differences. We at ProPAC had to grapple with this issue. Of course, the pacemaker industry educated us on this problem. Why should we be different than any other part of the government? Good information flows from people with self-
interests, so we looked at what they presented and said, "You know, you're right. This is not right. This is not the way the DRG system should work." We had a variety of choices, but it all comes down to the question of whether to split the DRG system based on whether it's a single chamber or dual chamber device, or create an alternative based on a mixed payment system.

The commission decided to split DRGs based on whether the device used was a single chamber or a dual chamber model. We had three basic alternatives. We could leave it alone, which I suspect is what HCFA is going to do. They are much more religiously inclined. But, as is true in many religions, the rules are violated many times by the faithful. So, too, in the DRG system. For example, if a patient needs surgery, then a new DRG is assigned. Surgery, after all, is a medical procedure. So why not accept some procedure or device DRGs on the medical side?

The commission recommended that we split the pacemaker DRGs because it believes that the current system is not good for high-quality care; it does not establish the right set of incentives. I support the commission. I think we need to make such a change. The reason I'm bringing this issue to your attention is that once the decisions are made by Medicare, the private sector is not going to be able to stay completely free from the implications. The hospitals will stock a more limited number of the higher-cost pacemakers, or they will make sure that all the high-cost pacemakers go to your patients because you're better payers, while the Medicare patients get the garden variety device; or you're going to find yourself paying for the more expensive units through your Medicare wraparound plans.

Current System Does Not Allow Supplementation

One other item: As many of you know, we currently have a system that does not allow supplementation, which means that if my doctor and the hospital decide I should get the single chamber pacemaker, but I want my pacemaker to turn my VCR on, or I want to be able to run up and down the hill or do some other things that require the more complicated device, I can't pay the extra amount to get the more expensive unit.

Most of the pacemakers being implanted today, even with this negative incentive, are the more expensive devices, but who knows what will happen when things really get tough? Understand this: The DRG system has been an easy system to work out the arithmetic, you will come up with a coinsurance of about 12.5 percent.

The important message of this example is that the DRG system is not a simple technique that can be left alone. Regardless of the rhetoric that got the legislation passed, this is a very technically complicated piece of legislation.

In spite of the rhetoric, which indicated that we now have an "Adam Smith" hospital payment system that can be left alone, if Adam Smith doesn't work for HCFA, it isn't going to get changed, and if it doesn't get changed, it's going to get worse.

The old cost-based system was like Silly Putty. If somebody in a white coat decided what piece of medical machinery should be bought by the hospital, it would get bought and the costs would
filter their way down through the cost report and out on the bottom would come a statement, and the Medicare system would have to pay.

While we didn't like this system for many reasons, nobody had to make a big decision about how it operated. Now we do have to make big decisions on how to pay, and the biggest one I see in the immediate future deals with something called MRI [magnetic resonance imaging]. I don't have any stock in an MRI company, nor do I care about MRIs per se, but I do care about the types of incentives that the current system will send to the next generation of MRIs.

I don't believe personally that we want a technologically nonexistent medical care system. MRI is a very expensive technology. We all know that. It costs a couple of million dollars to buy. It might cost a half-million to a million dollars to operate.

Currently, the capital side is passed through, but many of us believe that at some point capital ought to be added in, in some way, to the DRG payment. HCFA has announced that MRIs are a wonderful new machine and should be added to the medical armament. So, they have now said it's a covered service, and have said nothing else.

How is the hospital going to get paid for the MRI? Well, one way to do it is what we call recalibration, the old trickle-down approach. Let me explain how the trickle-down system is supposed to work.

The MRI affects maybe 100 DRGs, which means that the cost of operating all the MRI machines will be spread among all the patients that are hospitalized for those 100 DRGs, regardless of whether they had a scan or not. That is, the reimbursement for each patient that does have a scan may increase by a nickel.

You're in the business world. Just think of what kind of incentive that sends to hospital administrators. How would you like to be the salesman for the next generation of MRIs that tries to explain to the hospital why it's in the hospital's best interest to buy this new machine? Again, it's not MRIs that are important. They are already in production and have proven to be a valuable addition to diagnostic radiology. It's whether you want the health system to have a balanced set of incentives.

ProPAC grappled with this issue and finally said, "Yes, we need to make a major exception to the way other DRGs are priced. We need an add-on payment for each MRI scan provided, at least for the next couple of years. The add-on should be a fair but limited amount. It should not be a giveaway. It should be based on the cost of operating a machine in the most efficient manner. The hospital should not make money by simply doing scans on every patient. If a scan is done on a patient, regardless of whether the hospital owns the MRI, the hospital should get paid an extra amount of money. If the hospital owns the MRI, it should get a smaller amount because it's getting its capital passed through. But if the hospital doesn't own the MRI, and has to go out and purchase it either from another hospital or an outpatient unit, then it should get a payment that includes something for capital. But the amount will be tough and, in some cases, will be inadequate to pay for those MRIs in institutions that are not using their machines efficiently.

This may not be the best method of paying for the new technology, but at least it says to the medical technology world, "If this technology is valuable, and most medical people think it is, it should not be overused, but it should be available." You, too, need to be concerned with this issue, because either you're going to wind up paying disproportionately for it, if Medicare doesn't, or it's just not going to be available. You need to voice your collective or individual impressions on what needs to be done.

One other issue I'd like to mention is that the DRG system suffers from a serious problem, one that, unfortunately, happens in the federal government all too often.

The federal government likes to fight with the hospitals. There are few of them, they're standing targets, and nobody likes hospitals. The federal government does not like to fight with the doctors. They're not fixed targets, and congressmen and administrators know doctors and like them, for a variety of reasons.

**Inpatient Versus Outpatient Charges**

So, just like we did in Medicare during the 1970s, when we were very tough on inpatient care and did little to control outpatient spending, so, too, today we are very tough on the inpatient side of the DRG system. Just think of what the health care world is going to look like if we keep tough controls only on inpatient care, including capital as well as operating expenses. Not only will the hospital not get the operating money for the MRI, it won't get the capital payment, either. It's going to get a fixed amount of money per DRG, regardless how much is spent for the patient, but we will continue to pay outpatient care on a cost basis or some other rate.

How complicated do you think it's going to be for a hospital to put every piece of equipment on the outpatient side of the...
Table 1
Number of Defined Benefit and Defined Contribution Plans in Operation, 1974-1975

<table>
<thead>
<tr>
<th>Year</th>
<th>Defined Benefit Plans</th>
<th>Defined Contribution Plans</th>
<th>All Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of plans (thousands)</td>
<td>Percent change</td>
<td>Percent of all plans</td>
</tr>
<tr>
<td>1974</td>
<td>128</td>
<td>--</td>
<td>32%</td>
</tr>
<tr>
<td>1975</td>
<td>132</td>
<td>2.6%</td>
<td>31%</td>
</tr>
<tr>
<td>1976</td>
<td>130</td>
<td>-1.1%</td>
<td>30%</td>
</tr>
<tr>
<td>1977</td>
<td>132</td>
<td>1.2%</td>
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<td>5.7%</td>
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<td>13.1%</td>
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<td>8.2%</td>
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<td>6.8%</td>
<td>30%</td>
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<td>238</td>
<td>1.6%</td>
<td>30%</td>
</tr>
<tr>
<td>1985</td>
<td>243</td>
<td>2.1%</td>
<td>30%</td>
</tr>
</tbody>
</table>

Source: EBRI estimates based on Labor Department data and IRS determination letter statistics.

ledger? Then the government will pass a law that says outpatient care cannot be in the same building, so you'll probably see some knife come down and chop the hospital so that there will be a two-inch margin between the inpatient side and the outpatient side, or they might require a minimum distance of 500 yards so we'll have to have tunnels or whatever.

It's a bad system. I think everybody who knows about it agrees. We have several choices. Many people, including Dr. Roper, are supporting the need to go to capitation, full payment, vouchers. Others are talking about including an ambulatory DRG.

While capitation is very attractive, and vouchers are very attractive, I would like to add a cautionary note that says it's one thing to look at capitation when it's 5 or 10 percent of the health care system and all of the needed redundancies are being picked up by the fee-for-service system. But what happens when the percentages flip completely the other way around and you have 80 percent capitation and 10 or 20 percent fee-for-service? Can we be sure that all the incentives that were good and virtuous for the prepaid capitation will continue, and can we be sure that the set of incentives that exists today will continue? I'm not so sure. As a matter of fact, I am almost sure that they won't be. It may be that the worst thing we could do for capitation would be to overburden it.

I believe we do best legislatively when we offer choice. We do worse when we mandate complete A or B. I'd like to see capitation grow. I would fear very much if, in the process, we forgot about the fee-for-service DRG system altogether. Sometimes I have the feeling that some people are doing that, or that we penalized fee-for-service so much that we have reversed history and put the same burden on fee-for-service that used to be on capitation. I think we're best off in dealing with many systems, in dealing on the margin.

Again, let me end by saying what I did when I started. This is not only for the Medicare program. You cannot run your one-half or two-thirds of the health care system without that other third in sync. So please, make your voices heard.

1985-86 Estimates Show More Pension Plans
By June 30, 1986, the number of defined benefit and defined contribution plans in operation had reached 834,000, according to new EBRI estimates. This represents an increase of 17,000 plans, or 2.1 percent, over year-end 1985.

During the first two quarters of 1986, the number of defined benefit plans in operation increased by 5,000, or 2.1 percent, to reach 249,000. This suggests more rapid growth than was
Between January 1, 1985 and June 30, 1986, the IRS processed applications for 75,642 new plans which included 10.2 million participants, according to IRS reports of determination letter activity. In addition, the IRS processed termination applications for 36,777 qualified plans which included 11.0 million participants. (Participants may be double counted if they participate in more than one plan for which an application was processed.)

During those 18 months, 10,202 more new applications than termination applications for defined benefit plans were processed by the IRS. The 27,035 new plans included 5.2 million participants, while the 16,833 terminating plans included 5.0 million participants. Notably, 85 percent of participants in new defined benefit plans qualified during the 18-month period were in plans qualified during the first two quarters of 1986.

For defined contribution plans, there were 28,713 more new applications than termination applications processed by the IRS during those 18 months.

The number of defined contribution plans in operation increased by 12,000, or 2.1 percent in the first half of 1986, to reach 586,000 by year end. This follows an increase of 3.0 percent during all of 1985 (chart 1 and table 1).

These new EBRI estimates are based on U.S. Labor Department tabulations of ERISA reporting forms (IRS forms 5500 and 5500c), which provide accurate counts of plans for years 1977 to 1982, and on Internal Revenue Service (IRS) determination-letter statistics. Earlier EBRI publication of similar estimates incorporated Labor Department tabulations only through 1980 (see Employee Benefit Notes, March/April 1985, and July/August 1985); hence estimates from 1981 forward are slightly revised in this publication. Formerly, estimates of the number of plans in operation could be made on a quarterly basis using IRS determination letter statistics. Due to a recent cutback in the frequency of IRS reporting, these estimates can now be made only semi-annually.

observed in 1985, when the number of plans in operation increased by only 2.1 percent during the entire year. If this trend holds, it will mark the second consecutive year in which growth in the number of defined benefit plans has accelerated.
IRS during the 18-month period ending June 30, 1986. But in contrast to defined benefit plans, the 48,607 new defined contribution plans included only 5.0 million participants, while the 19,894 terminating plans included 6.0 million participants.

Within the overall defined contribution picture, the trends varied by plan type. The number of participants in new stock-bonus plans and ESOPs far exceeded the number of participants in terminating plans. The number of participants in new profit sharing plans (including 401(k) plans) only slightly exceeded the number in terminating plans. In both money purchase and target benefit plans, the number of participants was larger in terminating plans than in new plans. However, the number of new plans outstripped the number of terminating plans for each type of defined contribution plan (charts 2 and 3).

HHS Reports on Retirement Age Increase

[Editor's Note: The Department of Health and Human Services transmitted to Congress on August 4 a congressionally mandated report on Increasing the Social Security Retirement Age: Effect on Older Workers in Physically Demanding Occupations or Ill Health. When Congress passed the Social Security Amendments of 1983 with a phased-in increase in the age at which full benefits are payable from 65 to 67, it asked for an analysis of the implications of the change for those in physically demanding jobs or ill health. The following is the "summary of major findings" taken verbatim from the new report. The full report, along with technical appendices and three background papers commissioned as part of the study, can be requested from the Publications Office, Office of Research, Statistics, and International Policy, Room 921 Universal North Building, Social Security Administration, U.S. Department of Health and Human Services, 1875 Connecticut Avenue, NW, Washington, DC 20009.]

Summary Of Major Findings
This study began by estimating the percentage of workers approaching retirement now who had had physically demanding jobs and/or who were in ill health. For purposes of this study, physically demanding jobs were identified by using a criterion dependent largely on requirements to lift or carry heavy objects. Ill health was determined by whether the new retirees said they were partially limited or totally unable to work at the time of the survey. Estimates of the number of persons retiring now who were in physically demanding jobs and/or ill health provide a baseline against which future projections of this group's size can be measured. The data base used for these estimates was the New Beneficiary Survey conducted in 1982 by the Social Security Administration. The study also estimated the potential effect on these recent retirees of the increase in the retirement age. Some 29.9 percent of new retirees were in physically demanding jobs and/or ill health. A narrow definition of the group about which Congress was concerned when it wrote the mandate for this study includes those who said they were totally unable to work and those with partial limits who had jobs with heavy strength requirements. Some 18.5 percent of new retirees met those narrow criterion. A broad definition adds to that group those who had partial work limitations and jobs with medium strength requirements, and those with no work limitations and jobs with heavy strength requirements. Some 29.9 percent of new retirees were in the latter group.

New retirees in physically demanding jobs and/or ill health

—had median unit income that was
about 25 percent lower than the median unit income of other new retirees;

—were proportionately more likely to be in the lowest fifth of the income distribution, where reliance on Social Security benefits is greatest; and

—on average, relied on Social Security benefits for slightly more than half their income, and would experience about a 7 percent decrease in total income at retirement if their Social Security benefits were reduced by about 13 percent under the new law.

The study then estimates the percent of workers in physically demanding jobs approaching retirement age in the future and describes factors that could affect the health status of older workers in the future. It also assesses potential economic implication of the change in the retirement age for older workers.

The study finds the following.

Projected changes in the occupational mix of the labor force are likely to reduce the percentage of older workers in physically demanding jobs in the future who will be in jobs with heavy strength requirements from the current 11.4 percent. It is estimated that the percentage will be in the range of 8 to 10 percent by 2000 and 7 to 9 percent by 2020. The projected rate of decline in physically demanding jobs is smaller than the historical rate of decline because much of the potential decrease in such jobs has already occurred (primarily in the agriculture sector) and because a certain irreducible minimum number of such jobs are unlikely to be automated out of existence.

The evidence is ambiguous as to recent trends in the health status of older workers. Improvements in life expectancy that have occurred over the past several decades have not necessarily improvements in the active work lives of older persons. This appears to be in part because medical science has succeeded in prolonging life after the onset of potentially fatal diseases. Thus, victims of those diseases are living longer after the onset of disease and so the prevalence of the diseases may actually have increased. At the same time, the prevalence of disabling, but not life-shortening, diseases seems to have increased.

It is unclear whether improvements in lifestyle and behavior, the environments in which people live and work, and the quality and quantity of medical care will lead to improvement in the ability of older workers to work in the future. Some of the fragmentary evidence available suggests reason for optimism about the effects of the recent trend toward healthier lifestyles, but it is still difficult to predict the future effect of such changes on work ability. Similarly, it is impossible to predict whether medical breakthroughs will occur that will reduce the prevalence of work-related impairments. However, a significant breakthrough could dramatically reduce the percentage of older persons who are unable to work.

It appears unlikely that incomes will grow more rapidly for those in physically demanding jobs or poor health than for other retirees in the future. Consequently, the current 25 percent difference between the median unit income of new retirees in physically demanding jobs or poor health and the median income of other new retirees is unlikely to narrow in the future.

Future retirees in physically demanding jobs and/or ill health are the least likely to have saved more to offset a potential benefit reduction; available research indicates that they are unlikely to extend their work lives substantially in response to the increase in the retirement age.

This report does not include recommendations for legislative changes. It will be many years before the new retirement age provision phases in and in the intervening period we will gain experience with the determinants of work ability among older persons. Also as time passes, more will become known about the proportion of older workers likely to be in physically demanding jobs or ill health in the future.

In sum, fewer older workers than today—7.9 percent by 2020 versus 11.4 percent in 1984—are expected to be in jobs with heavy strength requirements. It is unclear whether fewer than the 16.3 percent who now say they are unable to work will be unable to work in the future. Thus, it appears that there will be some decline—but not a dramatic decline—relative to today in the proportion of retirement age workers who could find it difficult to extend their work lives a year or two in response to the increase in the age at which full Social Security retired-worker benefits are payable. If workers do not delay retirement and if there are not offsetting increases in other income sources, it appears that the average reduction in total income at retirement for workers in physically demanding jobs and/or ill health will be on the order of 6 to 7 percent when the new retirement age is fully phased in in 2027.

**National Health Care Expenditures Show Smallest Increase in Two Decades**

Total health care spending in the United States in 1985 was $425 billion, an increase of 8.9 percent over 1984, according to William L. Roper, administrator of the Health Care Financing Administration (HCFA).

Roper said that the overall 1985 health
On July 17, 1986, LTV Corporation filed for reorganization under chapter 11 of the Bankruptcy Code in the United States Bankruptcy Court for the Southern District of New York, and at the same time notified its retired employees that it had terminated the life and health benefits provided to them under collective bargaining agreements.

"The company explained that it was prohibited from paying these insurance premiums because such payments represented pre-petition obligations. The corporation stated that, when it filed under chapter 11, it was legally required to treat retirement health and life insurance benefits like all other obligations, and suspend payment.

"Section 1113 of the Bankruptcy Code was added in 1984 to provide a procedure for the acceptance or rejection of collective bargaining agreements in bankruptcy. Section 1113(f) provides that no provision of the Bankruptcy Code shall be construed to permit a debtor to unilaterally terminate or alter any provisions of a collective bargaining agreement prior to compliance with the provisions of section 1113."

"There is disagreement over the applicability of section 1113 of the Bankruptcy Code to retired employees' benefits. The bankruptcy court in the Unimet Case found that section 1113 was intended to protect the interests of active employees only and excluded retirees from the collective bargaining process. The Second Circuit, however, in the Century Brass case held that the retirees' benefits under labor agreements are subject to section 1113, and that the debtor corporation must comply with the provisions of that section before terminating or modifying those benefits. The implication of the latter is that changes in retirees' benefits under a collective bargaining agreement must be made in compliance with the procedures..."
of section 1113 of the Bankruptcy Code, and that a corporation would be acting unlawfully if it unilaterally terminated or altered those benefits without seeking prior court approval under section 1113."

The Senate in August approved S. 2690, which requires LTV to continue to pay all medical and life insurance benefits to retired employees sending a bankruptcy court decision; the measure now moves to the House for action.

Senate Approves Immunosuppressive Drug Therapy Act

Before adjourning August 15, the Senate unanimously approved legislation to help pay for the costs of drugs that help prevent the body from rejecting a transplanted organ.

S. 2536, sponsored by Sen. Orrin Hatch (R-UT), authorizes an annual $15 million grant to states for three years to pay for immunosuppressive drugs for those who lack health insurance or are underinsured. It also amends Medicaid laws by giving states increased flexibility to add coverage for immunosuppressive drugs. The bill now moves to the House for consideration.

Regulations

New Arbitration Procedure for Multiemployer Pension Plan Withdrawal

The Pension Benefit Guaranty Corporation (PBGC) has approved an alternative procedure for the arbitration of withdrawal liability suits between multiemployer pension plan sponsors and contributing employers, effective September 1.

The amendments eliminate certain procedural differences between rules administered by the American Arbitration Association and the PBGC (see the June 20, 1986 Federal Register, vol. 51, no. 119, pp. 22585–22586).

Litigation

Administration Asks Court to Uphold Disability Rule

The Reagan administration has asked the U.S. Supreme Court to uphold its use of the "severity rule" in deciding disability claims under the Social Security Act. The Social Security Administration, in making a sequential disability determination, uses the "severity" test early in the decision process to screen out claims that it believes do not meet the strict definition of disability under the law. SSA considers a medical impairment "severe" if it limits one's ability to perform basic work activities. Appeals court decisions in several circuits have said SSA's use of the rule violates the Social Security Act because it deprives claimants of the individualized determination of disability required under the law, which includes an evaluation of the individual's impairment in relation to vocational factors -- the person's age, education and work experience. SSA only considers the vocational factors if the impairment is considered "severe." The administration is asking the Court to uphold the rule for the sake of "administrative flexibility and efficiency." In recent years, application of the severity test has resulted in the denial of more than one-third of the roughly two million disability claims filed annually.

At EBRI

Presentations

During the month of September, EBRI President Dallas Salisbury made a number of presentations. These include a discussion on short- and long-term impacts of tax reform and the delivery of alternative health care systems for multi-state operated corporations before the Vision Service Plan Fall Employee Benefits Seminar September 10; keynote address before the Department of Labor Enforcement Seminar September 15; participation in a panel discussion on "Washington v. U.S. Pension Plans — An Update" before the Manufacturers Hanover Investment Corporation Master Trust Seminar September 23; briefing on tax reform benefits and trends before the Pacific Telesis Human Resources Group Benefit Planners and Administrators Meeting September 26; and a presentation on "Employee Benefits Legislation" before the Financial Executives Institute International Conference September 29.

Frank McArdle, EBRI education and communications director, participated in a September 23 panel discussion on employee benefit legislative issues for Washington: Now (An Inside Look at the Shaping of Public Policy) sponsored by the Corporate Executive Development program of the National Chamber Foundation, U.S. Chamber of Commerce.


Announcements and Publications

Government Publications

Eliminating Mandatory Retirement, House Select Committee on Aging, Subcommittee on Health and Long-Term Care

In response to legislation now moving through Congress to abolish mandatory retirement, this executive summary describes the impact of mandatory retirement on the nation and the individual worker, and provides information on how many workers are affected by mandatory retirement provisions annually. For a free copy of the executive summary, contact Rep. Claude Pepper's office, Subcommittee on Health and Long-Term Care, House Annex 2, Room 377, Washington, DC 20515. (202) 226-3381.

Families with High Out-of-Pocket Health Services Expenditures Relative to Their Income, U.S. Department of Health and Human Services

Sponsored by the National Center for Health Services Research and Health Care Technology Assessment, this report was part of a project on high-cost illness. Among the findings are that nearly 20 percent of American families spend more than five percent of their incomes on out-of-pocket expenses for health care. Such expenditures account for more than 40 percent of total expenditures for all families. Compared with all families, the report notes, families with a high ratio of out-of-pocket expenses to income were more likely to be headed by someone under age 18, or over age 65, not employed, and with lower income. For a free copy, contact Publications and Information Branch, NCHSC, 146 Park Building, Rockville, MD 20857. (301) 443-4100.

Projections of Health Care Spending to 1990, Health Care Financing Administration

National health care expenditures will rise at an average annual rate of 8.7 percent from 1984 to 1990, compared with 12.6 percent from 1978 to 1984, according to new projections published in the Spring 1986 issue of Health Care Financing Review.

In developing the projections, the authors assumed moderation of overall economic price growth, reduction in the use of hospital care, and greater use of less costly types of health care. Also taken into consideration was "an increased awareness and cost consciousness on the part of the consumer."

Overall health care expenditures are projected to grow to $640 billion, or 11.3 percent of the gross national product (GNP), by 1990. Demographic factors, such as the aging of the population, will have an increasing impact on health care spending, the authors predict.

Requests for reprints of the article by Ross H. Arnett III, Sally T. Sonnefeld, and Carol S. Cowell, of HCFA, and David R. McKusick, of Actuarial Research Corporation, may be directed to M. Carol Pearson, Division of National Cost Estimates, Health Care Financing Administration, L-1 1705 Equitable Building, 6325 Security Blvd., Baltimore, MD 21207.

Nongovernment Publications

Employment and Aging. The Brookdale Foundation and The Community Council of Greater New York

This report anticipates a change in the general composition of the work force because of the dramatic demographic data on the aging population. It addresses the possibility that a greater number of older people will be seeking employment, and says that there are indications that business is moving in the right direction to keep older people in the work force. For a free copy, contact Judith Podell, Community Council of Greater New York, 275 Seventh Avenue, New York, NY 10001. (212) 741-8844.

Surveys

U.S. Hospitals: The Next Five Years, Touche Ross

Almost half of the hospitals included in this survey may be forced to close within the next five years, the smallest hospitals being four times as likely to be vulnerable to failure. Cutbacks in federal funds, competition with health maintenance organizations and increasing operating costs are among the reasons cited as cause for concern. For a free copy, contact Touche Ross, 1900 M Street, NW, Washington, DC 20036. (202) 955-4000.

Survey on Five-Year Vesting, International Foundation of Employee Benefit Plans

More than half of the respondents to the National Opinion Panel (NOP) do not support five-year cliff vesting in an employer-sponsored pension plan, proposed in the Senate version of H.R. 3838. Respondents to the survey, conducted by the International Foundation of Employee Benefit Plans, indicated that the five-year vesting schedule could have a negative impact on new pension plan formation. Free copies of the survey are available by writing the Public Relations Department, International Foundation of Employee Benefit Plans, P.O. Box 69, Brookfield, WI 53008-0069.
The Employee Benefit Research Institute (EBRI) is a nonprofit, nonpartisan public policy research organization based in Washington, DC. Established in 1978, EBRI provides educational and research materials to employers, employees, retired workers, public officials, members of the press, academics, and the general public. Through its books, policy forums, and monthly subscription service, EBRI contributes to the formulation of effective and responsible health, welfare and retirement policies. The Institute has—and seeks—a broad base of support among interested individuals and organizations, as well as among private-sector companies with interests in employee benefits education, research, and public policy.

Employee Benefit Notes and EBRI Issue Brief (a monthly periodical devoted to expert evaluations of a single benefit issue) are written, edited, and published by the staff of the Employee Benefit Research Institute and its Education and Research Fund (ERF). For information on periodical subscriptions and other EBRI publications, contact EBRI-ERF subscription service, 2121 K Street, NW, Suite 860, Washington, DC 20037-2121. (202) 659-0670.

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