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Notes

### Consumer-Driven Health Benefits: A Continuing Evolution?

*By Jim Jaffe, EBRI*

A return to double-digit annual growth in health benefit costs is fueling interest in new structures for employment-based health benefits. These plans are still works in progress and there's not yet agreement on what they should be called. Some are called "consumer driven" because of the hope that individual consumer choices will help contain health care costs. Others are described as "defined contribution" because they could create a situation in which sponsors can require workers to take responsibility for using this fixed amount for health coverage provided by the employer.

The basic goal is to control costs by delegating more direct responsibility to consumers (and beneficiaries) of health insurance. Advocates say this could reduce consumer resentment caused by restrictions common to managed care plans. Critics say the plans will only shift health care costs away from the employer and onto the worker.

Today's employment-based health benefits system covers the vast majority of insured Americans under age 65. Not only do most Americans depend on jobs for health insurance coverage, they also rely on

employers to choose and/or design health plans, negotiate premiums, and intervene on their behalf when there is a coverage dispute.

Historically, employers have played a crucial role in determining how the American health insurance system operates. Employers learned years ago that using a limited number of carefully selected health-care providers, and imposing protocols for providing health care services, can cap costs—although using that knowledge has proven difficult. This insight fueled the growth of managed care plans, especially health maintenance organizations (HMOs) and later less-restrictive plans. The decline of "traditional" indemnity health insurance is a direct result of this employer response to rising health coverage costs.

Health costs are soaring again, so employers are again looking for ways to provide health benefits that are affordable, palatable, and medically adequate for beneficiaries and sustainable for both employers and their workers. Whatever the potential ancillary benefits of these plans, cutting costs is clearly the top priority.

"If it wasn't for costs increasing 15 percent to 30 percent a year, we probably wouldn't have moved as quickly as we have to discussing new ways to provide health benefits," said Paul Fronstin, director of EBRI's health research program.

Policymakers, leading thinkers on benefits, employers, and labor representa-

tives examined some of the deeper implications of greater cost sharing and consumer-driven models during the May 2, 2002, policy forum on “Consumer-Driven Health Benefits: A Continuing Evolution?” sponsored by the Employee Benefit Research Institute Education and Research Fund (EBRI-ERF). Attended by about 100 invited experts, the policy forum examined research on consumer-driven health benefits, how health insurance coverage is changing in the United States in an effort to perfect managed care, and the implications for consumers, business, and government.

### ***New Models for Providing Employment-Based Health Benefits***

The theory is that giving consumers greater power over diagnostic and treatment options will have two positive results—it will provide them with broader choices and their aggregate decisions will cap costs more effectively than top-down conventional managed care plans. But some analysts warn that consumers lack the discipline and sophistication to master an increasingly complex system. They see the initiative as an opportunity for employers to transfer a growing portion of rising costs to employees. Whether employees are willing to take on greater responsibility, have the ability to be more successful shoppers than health plans, and can create a more efficient system are all open questions. These questions are particularly relevant for the rela-

tively few but very sick plan participants who account for the majority of the costs. This problem is particularly acute in low-income families, who will most feel the impact of increased cost sharing.

So far there is no definition of “consumer-driven health care” and few specifics on what the new plans involve. While the concept has various names and definitions, all aim to contain health costs—or, at least, employers’ costs—while increasing consumer choice. Jim Murphy, chairman of the American Academy of Actuaries Defined Contribution Health Plan Work Group, said it could take the form of traditional cost-sharing methods (such as higher deductibles, co-insurance, out-of-pocket limits) or it could include the newer form of spending or savings accounts.

Murphy envisioned a menu ranging from structures in which the employer designates plans, determines a single contribution level, and allows employers to pick the coverage they prefer and pay any difference to structures involving a savings account option where the employer merely decides the per-worker contribution and leaves all other decisions to employees.

The basic concept that drives the new plans is a shift of responsibility for health care decisions from employers to individuals. Common components include:

- Greater employee responsibility for the first several thousand dollars in expenses.
- An employer-funded account that workers use for a wide

variety of medical expenses, including premiums and/or out-of-pocket expenses, that sometimes can be rolled over from one year to the next if unused.

- Catastrophic coverage covering costs above a level higher than those now common.

Many questions about portability and taxes remain. Changes in tax laws could make participation more or less attractive (the Internal Revenue Service announced June 27 that balances in individual health care accounts could be carried over untaxed from one year to the next, a step seen by proponents as a major boost). But, regardless of the financial structure, the one common feature is the transfer of responsibility from the employer to the workers, a change that proponents say offers potential rewards to both groups.

Consumer-driven plans could provide all consumers with adequate coverage, smoothing out today’s pattern that gives healthy young workers more coverage than they need while their older, sicker colleagues have inadequate protection. Today, the younger group subsidizes the older. The new plans might reduce such intergenerational cross-subsidies. An individual health account would allow workers to accumulate assets that could be spent later when more costly care is required.

Amit Gupta, a physician who founded Caregain, a New Jersey firm among the first to offer such

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plans, predicted that “employees will respond to an opportunity to save for future health care expenses, and this will lead to real cost savings for the employers today, which is where Caregain is turning the theory into practice.”

Under Caregain’s plan, some money initially reserved to pay employee health bills that remains unspent at the end of the year is rolled over into health IRAs. Because this computation reflects spending for the entire group, the employee rebate depends on both individual and group behavior.

In other words, the worker doesn’t receive savings for his or her long-term account unless the employer enjoys immediate savings.

These short-term employer savings are common to all such plans, whatever their specific dimensions, noted Bill Reindl, senior vice president of Definity Health, a Minneapolis-area plan that also offers such plans. “Everybody holds us up to the standard of helping to control long-term costs of health care,” Reindl said.

Definity Health covers basic preventive care and leaves other decisions to employees, who become aware of the economic consequences and regularly check their health account balances on a Web site. “Pricing transparency is critical to the success of this plan, and our members are actively looking at what things cost and what the alternatives are, and they’re using that information to make economic decisions,” he says. One result, he noted, is that their members have a

higher-than-average usage of generic drugs.

Partly because of this sensitivity, Definity Health estimates that 60 percent to 70 percent of participants will have money in their accounts at year-end that can be rolled over. Working with fewer than three dozen employers (including CVS, Staples, and Budget Rent-A-Car), Definity Health is finding that employees selecting consumer-driven plans are slightly older and sicker than the market, making age-specific disease management plans for those with chronic problems essential.

But the needed tools sometimes aren’t available. For instance, he said, a child with Type 1 diabetes has far different needs than a 54-year-old male who’s had Type 2 diabetes for 30 years. But “because we haven’t been able to leverage the data that’s been available, we are still using ‘one-size-fits-all’ disease management programs,” he complained.

This need to focus on sicker, more expensive patients is seen as a key component of containing costs generally. A worst case feared by many would have the plans siphon off healthy participants, creating an adverse selection problem in more conventional plans.

Dr. Michael Parkinson, executive vice president and chief health and medical officer at Lumenos, another consumer-directed plan based in Alexandria, VA, counsels self-insured employers who want to create such plans. Parkinson argued that new plans should not be

portrayed solely as opportunities for employers to reduce their responsibility, but rather as a way to refocus it and concentrate on those who use the most resources and need the most help.

“Consumers can’t be asked to ferret out the third of care that experts believe is now inappropriate, and will need a lot of counsel if they’re going to make decisions that are both correct and cost-effective,” Parkinson said. “Critics worry that consumers may forego care they truly need just to save money. One way to avoid this is to make money decisions before medical problems appear—by selecting specialists, for instance.”

Perhaps the most complex plan discussed was Vivius, another Minneapolis-area plan. Executive Vice President Lee Newcomer said the plan allows consumers to create their own individual provider network and premium, with the result that “the payroll deduction that they will make goes up or down depending on who they choose to be in their network.”

Unlike the other plans, Vivius doesn’t use spending accounts. Instead, it allows employees to start with a level employer contribution and, by making 18 decisions, build an individualized provider network and copay level.

Whether any of these products will last remains to be seen. At first blush, some employers are enthusiastically embracing the plans while few have explicitly rejected them. Most are still watching from the sidelines.

The pharmaceutical firm Pharmacia is an early adopter, partly out of frustration with the existing system. “We all know that health care—and retiree medical as the long appendage to that—is a train wreck ready to happen,” said Pattie Duca, senior director of global benefits for Pharmacia. “So why not consumer health care? There really does need to be some fundamental change.”

The company faced two issues, one unique (a merger required it to deliver cost savings while creating a new, unified plan) and one not (the sickest employees regularly selected the most extensive plan offered, routinely costing the employer more than anticipated). The result was a menu of four plans, each with the same benefit package and each requiring employees to pay \$1,200, or 20 percent of the entire premium. But there were differences in provider selection, copays, and the option of having a health care savings account and rolling over unspent money into subsequent years. Only 5 percent of eligible employees selected the new consumer-directed plan, which was not unexpected. But the firm was surprised that this group did not skew toward the young and healthy.

Michael Thompson, a principal in the PricewaterhouseCoopers global human resource solutions group, suggested that such modest take-up rates were unsurprising and that participation in the new programs will continue to be too small to impose the changes needed in the

entire system. But he did believe that their components would be the pillars of a new, broader policy that resulted in both happier consumers and more affordable coverage.

“I think there’s a belief that people will be more satisfied with their health care and we will save money if they are involved in a shared decision-making process. So again, the objectives are increased transparency, shared responsibility, and supplying participants with the tools to act as better informed consumers,” he said.

But he stressed that plan specifics would determine whether these goals were achieved—and that the precise parameters to maximize the odds weren’t yet clear. Change is a certainty, but progress isn’t a given, Thompson said.

This emphasis on execution was seconded by Arnie Milstein of Mercer Human Resource Consulting, also medical director of the Pacific Business Group on Health, who pointed out that the consolidation of insurers was another goad for finding a new approach from the employer side.

Milstein, who began his quest for a new approach three years ago, recalled nearly two years of frustration in trying to come up with the elements of a better system. He concluded that consumer choices in three areas could curtail costs:

- Choice of provider (the key issue here is total treatment cost per incident, rather than the price per visit).
- Treatment options (generic versus brand-name drugs are

one example).

- Care management for the sick (with a focus on the 5 percent of participants who run up 55 percent of health costs).

The importance of those seriously ill was echoed by researcher Jon Gabel, vice president of health systems studies at the Health Research and Education Trust, the research affiliate of the American Hospital Association. Gabel said that managed care taught employers lessons about what worked—that disease management made sense, but forcing the healthy to first approach gatekeepers merely caused resentment. He summarized his research in this area, and concluded that, despite the obvious self-interest of consultants in promoting new plans, something truly important is occurring in health plan design.

Nonetheless, Gabel added, most employers are reluctant to embrace something that appears to be cutting back on health benefits. So he expects the new options (at least initially) to augment rather than replace existing plans. Gabel agreed with the Wall Street view that consumer-driven choices offered by major insurance companies would soon overwhelm those from the newer firms in the field.

### ***The Role of Managed Care in a Consumer-Driven World***

One such wary employer is Delta Airlines. Miles Snowden, Delta’s director of health services, said that most of Delta’s 200,000 employees

are in a single plan and there was a fear that offering greater choice would dilute the airline's bargaining power. That raised questions about whether such a plan would be cheaper.

Rollover provisions raised some significant questions, since Delta expected workers to spend down their accounts before they quit. "We as a company have not been willing to accept the premise that if you are going to develop a consumer-driven health plan and you're going to provide them with a personal health or medical spending account or care account, that upon termination of their relationship with the company that account just disappears," Snowden said. "If an employee knows that they're going to lose the balance in their health spending personal care account, our sense was that we would lose much of what we had previously gained by altering that consumer's behavior."

Delta was also troubled by "first-dollar" coverage that would lead to higher payments to the 40 percent of participants who had low bills. It was difficult to see how giving them greater benefits would drive down the airline's total health benefit bill.

Despite frustration about rising costs, some employers feel they've learned some valuable lessons from managed care and want to utilize these lessons as new plans are developed. Ken Jacobson, senior vice president of the Segal Company, a New York actuarial and consulting firm, argued that sponsors know more about how to contract for

health care than before because of managed care. Nevertheless, he said, health costs cannot be controlled unless consumers become sensitive to them.

"The consumers have been forever insulated from cost," Jacobson said. "If we don't introduce consumerism at some point along the way, we'll continue to spiral out of control. Anybody can walk in and put \$10 on the counter and buy \$1,000 or \$100,000 worth of health care under the system today...the HMO model is an all-you-can-eat frenzy."

Jacobson presented a glowing summary of how a health benefits system could work if consumers knew the real costs and made appropriate purchasing decisions. But he warned that both consumers and employers are cautious, and predicted there would be a transition period before necessary economic and medical information is fully shared with consumers—as happened with managed care.

Kaiser Permanente, which provides care for more than 9 million Americans, thinks the consumer-driven health care movement raises some provocative issues. Christine Paige, a vice president of marketing for Kaiser, predicted the movement would remain competitive in the next few years, but expressed concern about subsequent developments, particularly very low-cost, minimum-benefit plans that could be attractive to healthy young people and create serious adverse selection problems for big carriers like Kaiser.

Nonetheless, she added, Kaiser shared the perception that consumers must be more cost-conscious. "There is no getting away from the fact that some kind of meaningful cost sharing is in the future of all of us," she said.

While there seems to be little doubt that both employers and workers will be asked to pay more for health insurance, there is lots of debate about who pays how much more.

The pressures for this change were documented by Jason Lee, senior research manager at the Academy of Health Services Research and Health Policy, a Washington, DC, health policy center. He noted that a Harris poll of corporate human resource directors found that within the next two years, almost 80 percent of employers intend to increase the share of employee cost-sharing of the premium, and 70 percent plan to increase employee cost sharing. He noted that a study by Watson Wyatt found that 71 percent of surveyed large employers are considering decreasing benefits or increasing cost sharing in the next 12 months.

Lee discussed two models, each of which could reduce premium costs by more than 20 percent—one simply eliminates certain types of benefits, while the other increases participant copays. When those decisions will be made—and by whom—remain open questions.

### ***Consumer Knowledge***

Ray Werntz, president of the Con-

sumer Health Education Council (CHEC), summarized the extent of consumer decision-making contemplated by the consumer-driven models by comparing the structural differences between these models and conventional managed care-type (HMO) plans. Besides having to make more of their own decisions regarding health care providers for the services they need, individuals may also have to make some medical necessity decisions formerly made by third parties, he predicted, which highlights the need for giving patients information that is accessible and relevant to their concerns. CHEC, which aims to inform and educate both consumers and sponsors of health insurance, is currently conducting research to better identify what individuals expect of the U.S. health care system.

One group that is likely to face special challenges is the “near-elderly”—workers who retire prior to age 65 and find themselves ineligible for Medicare at a time when employers are reducing their health insurance commitment to retirees generally. Getting people, many of whom lack adequate retirement savings, to put away money for health care that will be required during the last years of their life could prove to be a particularly challenging task, noted Daniel Holmes, an executive vice president of Fidelity Investments.

Holmes said that even those in Medicare are often ignorant of the health-related expenses that lie ahead in retirement. For instance, he said, Fidelity estimates that a couple

currently age 65 faces present-value costs of about \$160,000 just to cover Medicare Part B, the co-pays and deductibles under Medicare, prescription drugs which are not covered by Medicare, and some miscellaneous expenses.

Despite the acknowledged flaws in the current system, reformers should be wary of changes that would undermine its strengths, argued John Abraham, senior associate director of the research department of the American Federation of Teachers. Existing conventional employer plans are very good at pooling risk to allow the healthy to subsidize the care of the ill who otherwise might find necessary medical attention unaffordable, and have relatively low administrative costs, he noted.

Abraham embraced the idea of concentrating on the 20 percent of the covered population that generates 80 percent of health care costs. And he called for a bipartisan effort to force government to address the issue. “Regardless of your position on reform, lend your voice to the various reform coalitions and press your representatives to address the health care problem,” Abraham said.

A similar wariness about abandoning the strengths of the existing system came from Gail Shearer, director of health policy analysis for Consumers Union, publisher of *Consumer Reports* magazine. “This type of new health care could actually undermine the employer-based system and throw more people into the individual market,” Shearer said, criticizing

“the myth of consumer choice.”

Shearer voiced a special concern about medical savings accounts (MSAs), which she characterized as an extreme consumer-choice option that pushes people into the individual market. “There’s growing evidence that affordable coverage simply isn’t available to some patients with serious chronic problems. Insurance companies that annually adjust premiums based on claims, mirroring the pattern of auto insurance, push out the group that needs the most care,” said Shearer. Whatever the appeals of the individual market, it has yet to come up with a way of coping with the adverse selection problem, she said.

Despite disagreements about what a more “efficient” health insurance system would look like, there’s a universal belief that patients who come to the system with better information could help bring about better outcomes. But how to collect and communicate that information is not an easy task. Lee Newcomer of Vivius points out that patients tend to depend on friends, neighbors, and some medical professionals who seem to have expertise. He noted that managed care health plans are not trusted by patients as a reliable source of medical information, which is why they tend to refer patients to third-party sources, including medical Web sites on the Internet.

### ***The Role of Public Policy***

Given the significant role of federal tax policy in shaping the nation’s

current health benefits system, policy forum discussants inevitably focused on whether government policies could be used to push individuals into participating in a reformed system and making appropriate health insurance choices. Charles Kerby III of Mercer Human Resource Consulting, a multinational human resources consulting firm, reviewed the issue of what employees could do with money in medical savings accounts (MSAs) and rollover restrictions on flexible spending accounts (FSAs). He said that the recent IRS announcement on individual health care accounts may make the options more attractive to individuals. He suggested another possibility might be to impose structural requirements on employer health plans to push them toward using techniques that had been proven effective in dealing with price and quality issues.

But any such incentives should not be viewed as a quick fix, as there is no consensus within the health care industry on how to proceed, and lawmakers in Congress currently are struggling with more immediate problems, he said.

Nevertheless, according to EBRI's Fronstin, health policy professionals see the movement toward consumer-driven health care to be inevitable because of ever-growing cost pressures—even though there is still no clear definition of what it is or precisely how it will work.

"We do think it's going to

happen. There's going to be winners and losers. The plans are going to be very flexible in their funding and in their structure, and providers will need to be engaged in the plans and the decision-making. Employees will need to be engaged and they will need to be educated, and they will need to be provided with tools to navigate the system," Fronstin said. He also predicted that rather than replacing managed care, consumer-driven care will build on it and alter the way managed care currently operates.

"I think we're at the point we were with managed care in the late 1980s, when it was just about to take off, except that we're moving faster than we did back in the '80s with managed care," Fronstin said. "On the one hand, that's exciting. On the other hand, my fear is that 10 years from now we're all be back a little bit grayer talking about why consumer-driven health care didn't work, and what the next latest and greatest thing is that we think may solve the health care problem."

## Washington Update

### *Congressional Count-Down*

Congress reconvened Sept. 3 for its end-of-session push, with a lame-duck (post-election) session all but certain. The official target date for adjournment is Oct. 4 and that is expected to be missed by at least a week or possibly more—but with the November elections right around the corner, members of Congress are eager to return home to campaign.

The first priority is the need to have a budget in place by the start of the fiscal year Oct. 1, and there's still much work to be done. This makes a "continuing resolution" inevitable—a stopgap funding bill that continues some spending at current levels until legislators can complete a year-long budget.

The White House and House Republicans may offer legislation providing new tax relief, probably including accelerated effective dates for higher contribution limits for 401(k)s and IRAs and raising the age for required minimum distributions. Democrats counter that these proposals would do little to help the economy and be unlikely to help savers who are either limited by work place contribution caps or who can't afford higher contributions. At this writing, it is expected these issues will be on the Senate floor in late September as part of 401(k) diversification, "pension protection," and executive compensation legislation.

*Outlook:* 401(k) and retirement issues are a big target on the radar screens of both political parties. Combined with the prevailing corporate criticism in the wake of the Enron and WorldCom failures, and with control of both the House and Senate up for grabs in the November elections, new regulations on 401(k) plans are quite likely to be enacted this fall. At this point it seems the major question is exactly what will pass and how extensive the new regulations will be—but never underestimate the potential for gridlock on Capitol Hill.

#### **401(k) Bill Pending**

At this writing, Senate Democratic leaders were working to meld competing 401(k) bills reported by the Health, Education, Labor, and Pensions Committee (HELP) and the Finance Committee, so a single proposal can be brought to the Senate floor. Assuming the Senate approves the new bill, a House-Senate conference committee will then be required to iron out differences between the two measures (the House passed its version of the bill earlier this year).

House sponsors are particularly interested in allowing employers to provide workers with investment counsel. But the Senate focus seems to be on redress for employees whose pension assets decline because of corporate misbehavior.

## **Keeping On Track**

**Medical Privacy Rules Set**—Final medical privacy rules were published in the *Federal Record* of Aug. 14. An earlier proposal was amended to drop a requirement that providers not release personal information unless they had written permission from the patient. Privacy advocates were troubled by the change. The new rules guarantee patients access to their medical records and bar pharmacies from selling information that can be used by drug marketers.

**TSP Again Delays Daily Valuation**—The board of the federal Thrift Savings Plan (TSP) recently announced that a new computer system that would give federal employees more control over their 401(k)-style Thrift Savings Plan accounts won't be ready until November. This marks the fifth time in two years that the computer modernization schedule has slipped.

The board had previously announced that the new system would be up and running in September. TSP officials said the new system is fully developed, but testing has fallen behind because it took longer than expected to convert TSP participants' records to the new system. Contractors are testing the records to make sure they were completely and accurately converted, TSP officials said.

Perhaps ironically, the difficulty of account conversions in Enron's 401(k) plan during a so-called "blackout" period was one of the key issues Congress seized on in the legislation it enacted this year to limit trading blackouts during private-sector 401(k) plan conversions. There has been no such blackout period for federal workers, but investment options in the TSP are limited.

**Public Pension Plans Suffering**—More than half of all public pension plans are underfunded, up from 31 percent two years ago and the problem is getting worse, according to a recent study by Wilshire Associates Inc., of Santa Monica, CA. Its study of 93 pension systems, which provide pensions to teachers, firefighters, and other state and municipal employees, indicates that the percentage of underfunded public plans will rise to 75 percent, primarily due to investment losses in the stock market.

**Universal Health Care System on Oregon Ballot**—Oregon voters will vote in November on a ballot measure (Initiative 27) that, if passed, would create a statewide universal health care system. If approved, the ballot initiative would make Oregon the first state to adopt a single-payer system. A new state agency would be created to implement and operate the system, starting in 2005. The benefits would be paid for by new income taxes on Oregon residents and new payroll taxes on employers. Certain employers and employees in multi-employer plans would be excluded from participation and the new taxes.

*Outlook:* Pollsters for both political parties see this as a vote-getting issue, so the pressure is on to enact something before the Nov. 4 elections. The House approach largely is based on greater disclosure and investment advice, while the Senate is leaning toward greater restrictions on the use of company stock in 401(k) plans and greater litigation powers for plan participants. If a bill is not enacted prior to the November elections, there may be less incentive for lawmakers to return to the issue during a lame-duck session.

### ***COBRA Subsidy Created***

Workers who lose their jobs as a result of competition from imports will be eligible for a new COBRA subsidy that will pay 65 percent of health insurance costs. The new program is part of legislation renewing presidential trade negotiating authority that the president signed into law Aug. 6.

### ***Health Bills on Critical List***

It appears increasingly likely that Congress will quit for the year without enacting new protections for patients or a Medicare drug benefit.

Senate negotiators Edward Kennedy (D-MA), John Edwards (D-NC) and John McCain (R-AZ) declared talks at an impasse in July, after they were unable to schedule a meeting with the Bush administration in an effort to

resolve differences about patients' rights. The issue, which was a top priority at the start of this Congress, was subsequently eclipsed by other issues. Instead of providing a Medicare drug benefit, the Senate settled for a bill that would make generic drugs more quickly available. That will go to conference with a House bill that would have the private sector provide a modest Medicare drug benefit, but chances are slim a compromise will be reached before adjournment.

*Outlook:* Observers say there's scant likelihood that the Medicare program will be expanded this year. And unless one party wins control of both houses of Congress, patients' rights legislation is unlikely to be enacted any time soon.

## **EBRI in Focus**

### ***On-the-Road Education***

EBRI continued its series of presentations on EBRI research findings in August, including these events:

- On Aug. 2, EBRI staff participated in a luncheon briefing on Capitol Hill for congressional staff and news reporters on the connection between health care costs and the uninsured, organized by the Alliance for Health Reform. EBRI focused on what employers are doing, or anticipate doing, to deal with health benefit cost increases.
- On Aug. 8, EBRI staff was interviewed on videotape on CNBC in New York on the issue of underfunded pension plans. The interview aired on Aug. 12.
- Also while in New York on Aug. 8, EBRI met with several editors and business/economics reporters at the *New York Times*, to provide background and perspective on retirement-related issues related to both defined benefit plans and 401(k) plans.
- Aug. 8–10, EBRI attended the Society for Human Resource Management's Fourth Annual Thought Leaders Retreat in Denver.
- On Aug. 14, EBRI staff participated in a client forum luncheon sponsored by Fidelity in

Covington, KY, and spoke on the challenge for the individual in funding retiree health care.

- On Aug. 21, EBRI staff spoke at the West Coast Health Care Executive Summit briefing on “consumer-driven health care.” The following day, EBRI met with the editorial page deputy-editor and reporters of the *Los Angeles Times* on pension and other employee benefits issues.
- Aug. 29, EBRI attended the Emmy Award dinner in New York (the EBRI-ERF Choose to Save® program was nominated for a national Emmy).

### **EBRI, CHEC Co-Sponsor Health Conference**

On Oct. 29, an EBRI-organized and -moderated panel on “employers and health care coverage” will be held at ECRI’s (formerly the Emergency Care Research Institute) 10th Annual Conference on Healthcare Policy, Law, and Methodology in Philadelphia. The event is co-sponsored by EBRI and its affiliate, the Consumer Health Education Council (CHEC); the Leonard Davis Institute Center for Health Policy; and the Milbank Memorial Fund.

This three-day policy and law conference and methodology workshop will examine how coverage decisions are made for

health benefit plans in the public and private sectors. The EBRI panel will address decisions made by employers, unions, HMOs, and health plans about covering particular services or procedures. This is an important conference because it addresses a key issue faced by all plan sponsors and their associated organizations as they seek to provide beneficiaries access to clinical best practices in an affordable manner.

### **EBRI Media Calls**

EBRI routinely handles a heavy load of media inquiries. During August, health-related calls came from reporters with the *New York Times*, the *Wall Street Journal*, *Fortune* magazine, *Business Week*, Dow Jones News Service, the *Raleigh News and Observer*, *CBS MarketWatch*, the *Boston Globe*, *Employee Benefit News*, the *Sacramento Bee*, and *Health Marketplace Survey*. Retirement-related calls came from: the *New York Times*, *Newsweek*, *Consumer Reports*, *Fortune*, *Money*, the *Kiplinger Report*, the *Chicago Tribune*, *Plan Sponsor*, *Pensions & Investments*, *CBS MarketWatch*, Bloomberg TV, *Crain’s Chicago Business*, the *San Diego Union-Tribune*, the *Sacramento Bee*, the (St. Paul) *Pioneer-Press*, *Hearst News Service*, *Maryland Public TV*.

## **New Publications & Internet Resources**

[Note: To order publications from the U.S. Government Printing Office (GPO), call (202) 512-1800; to order congressional publications published by GPO, call (202) 512-1808. To order U.S. General Accounting Office (GAO) publications, call (202) 512-6000; to order from the Congressional Budget Office (CBO), call (202) 226-2809.]

### **Employee Benefits**

Hewitt Associates. (1) Salaried Employee Benefits Provided by Major U.S. Employers: 2001–2002. \$325. (2) Work/Life Benefits Provided by Major U.S. Employers: 2001–2002. \$125. Hewitt Associates LLC, Attn: Publications Desk, 100 Half Day Rd., Lincolnshire, IL 60069, (847) 295-5000, was.hewitt.com/hewitt.

William M. Mercer and Marsh, Inc. Survey of Employers’ Time-Off and Disability Programs. \$200. William M. Mercer, Corporate Publications, 462 S. Fourth Ave., Suite 1500, Louisville, KY 40202, (800) 333-3070.

### **ESOPs**

Frisch, Robert A. ESOP Workbook: The Ultimate Instrument in Succession Planning. Second edition. \$35. John Wiley & Sons, 1 Wiley Dr., Somerset, NJ 08875, (800) 225-5945.

### **Health Care**

AARP. (1) Beyond 50: A Report to the Nation on Trends in Health

- Security. (2) Reforming the Health Care System: State Profiles 2001. Free. AARP, 601 E St., NW, Washington, DC 20049, (202) 434-2277.
- California HealthCare Foundation and William M. Mercer. Why Don't More Small Businesses Offer Health Insurance?: Summary Report on the 2000 California Healthcare Foundation/Mercer Survey. Free. California Healthcare Foundation, 476 Ninth St., Oakland, CA 94607, (510) 238-1040, fax: (510) 238-1388, [www.chcf.org](http://www.chcf.org).
- Committee for Economic Development. Research and Policy Committee. A New Vision for Health Care: A Leadership Role for Business. \$15. Committee for Economic Development, 2000 L St., NW, Suite 700, Washington, DC 20036, Attn: Publications, (202) 296-5860.
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