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**Environment for Health Reform**

*Introduction*

National health reform is the largest single social policy issue to receive widespread attention in decades. It is likely to be the most extensively covered social issue by the media in history. It has been debated not only in Washington but in schools and work places and around kitchen tables across the country. Public opinion surveys suggest that Americans do believe a crisis exists and that it is necessary to provide health insurance for everyone.<sup>1</sup>

Coverage of the debate has garnered thousands of inches in the print media and hundreds of hours on television and radio. Policy debates, public opinion surveys, and news media coverage about health reform, as with most public policy issues, influence one another. When looking at a public policy issue such as health reform, examining the interrela-

tionships among politics, media coverage, and public opinion surrounding the debate may help to shed some light on the final outcome. This article looks at the political environment for health reform and how it has changed since the 1992 presidential election, tying the ebbs and flows to media coverage and public opinion. Finally, Employee Benefit Research Institute (EBRI) President Dallas Salisbury posits likely outcomes of the health reform debate.

*Evolution of the Health Reform Debate*

Reform of the nation's health care system became a major issue in the 1992 presidential campaign. The candidates' positions on health care apparently were important to voters—26 percent of Americans said a presidential candidate's position on health care alone would determine whether or not they would vote for that candidate, according to a June 1992 EBRI/Gallup survey.<sup>2</sup> Many of the

<sup>1</sup> While public opinion surveys are helpful tools to gauge public support for various types of action, results can be difficult to interpret correctly. Public opinion is extremely volatile. Many Americans form their opinions based on what they read and hear in the media, and responses can change daily based on the public's knowledge at any one time. Results of public opinion surveys, particularly telephone surveys, are also influenced by survey methodology. Slight changes in question wording or question

order can produce dramatically different responses among similar surveys. Survey questions can be worded specifically to elicit certain responses that can, on the surface, show support but may simply be the intended response.

<sup>2</sup> See Employee Benefit Research Institute / The Gallup Organization, Inc., Public Attitudes on Health Insurance, 1992, EBRI Report no. G-37 (Washington, DC: Employee Benefit Research Institute, 1992).

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candidates early on offered campaign promises of health reform. Post-primary candidates, then-President George Bush and Arkansas Governor Bill Clinton, developed their own plans for reforming the nation's health system, and Independent candidate Ross Perot repeatedly cited the need for reform. A poll in late September by The Gallup Organization found that regardless of whom Americans supported for president, 62 percent said Clinton would better handle the health care issue, compared with 26 percent who said Bush would better handle the issue. While the candidates' initial plans may have been somewhat sketchy, it was understood that the next president would be expected by those who elected him to respond to calls for reform.

Public opinion surveys immediately following Clinton's election in December 1992 showed that Americans ranked health care among the top three problems facing the country. During the transition period between the Bush and Clinton administrations, media coverage focused more on the specifics of President-elect Clinton's plans for economic stimulus and job creation, while the coverage of health reform concentrated on his selection of health care advisors and the fact that a consensus had been reached on the need for reform. Predictions in the press were that Clinton would move to the center on health reform—his proposal would not be a pure single-payer system or pure managed competition. Meanwhile, the Kaiser Family Foundation

released a survey on December 15 that found Americans were most likely to support a plan merging managed competition and government regulation. More than 7 out of 10 Americans supported the government setting insurance rates or regulating doctor and hospital charges, while fewer than one-half supported a government limit on all health spending.

If Bill Clinton had a mandate when he took office in January 1993, it was to follow through on his promise to reform the nation's health system. The argument that the system was in a state of crisis was very much alive in both political parties as well as in media coverage and public opinion polls. Congressional Democrats appeared united behind the President, and Republicans agreed with the premise that reform was needed. A January 1993 survey by the *New York Times* showed that 66 percent of Americans believed President Clinton would be able to make significant progress in getting health insurance for all Americans. With momentum in his favor, President Clinton promised to unveil a health reform proposal during his first 100 days in office.

### ***Health Reform in the Early Clinton Days***

The President appointed a task force, chaired by First Lady Hillary Rodham Clinton, to develop a reform plan to send to Congress. Once the task force was in session, a number of articles about reform and the group's activities appeared daily in major newspapers. During the early

days of the task force's work, public opinion polls revealed that Americans believed the health care system needed change, even though most Americans were satisfied with their own health care. A February 1993 EBRI/Gallup poll showed that 91 percent of Americans said the U.S. health care system needed reform.<sup>3</sup> At this time, while Clinton was espousing changes to the U.S. health care system in order to stem rising costs and provide insurance coverage for everyone, a *New York Times* survey reported that 53 percent of Americans thought the President would be able to bring about significant health reform.

Coverage of the debate included detailed explanations of ideas the task force was considering. The media reported extensively on the policy battles and political speculation about the final details to be included in President Clinton's proposal. While public opinion survey results revealed that there may have been a consensus on the need for reform, some public opinion experts, citing other survey results, questioned the extent to which Americans understood the relationship between health care spending and the country's economic condition.

With the daunting task of reforming one-seventh of the nation's economy before them, the 500-plus

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<sup>3</sup> See *Employee Benefit Research Institute / The Gallup Organization, Inc., Public Attitudes on Health Care Reform, 1993, EBRI Report no. G-43 (Washington DC: Employee Benefit Research Institute, 1993).*

member task force was unable to develop a plan within the President's first 100 days as originally anticipated. The deadline continued to slip from late May, to June, and then on to August and then September. The administration increasingly found itself absorbed in other issues—the failed economic stimulus package, the narrowly passed deficit reduction plan, and the economic summit in Japan. This lag caused a loss of momentum for the administration and allowed alternative proposals to begin to take shape and develop support.

The media began to highlight the administration's delay in early April 1993 with regular updates on task force activity. At this point public opinion started to shift. While polls showed that Americans continued to rank health care as the number three problem facing the country, a survey conducted by the Robert Wood Johnson Foundation found that a majority of Americans did not think they would benefit from health reform.<sup>4</sup> In late June 1993, the *Washington Post* reported that public support for the Clinton administration to overhaul the nation's health care system had slipped from 66 percent in April to 45 percent in June. The rating for

Clinton's handling of health reform decreased from 56 percent in favor in April to 34 percent in favor in June. Similarly, a July 1993 EBRI/Gallup survey showed that 55 percent of Americans *did not* believe Congress should adopt whatever reform President Clinton proposed.<sup>5</sup>

During the months of waiting for the President to act, members of Congress began to stake their ground in the health reform debate. A mix of comprehensive and incremental health reform bills began to appear from both political parties. In late spring, media reports tied the delay of the release of the administration's plan to questions about how reform would be financed. One headline in *USA Today* on May 20 read, "Health Reform Plan May Suffer A Relapse: Conflicting Costs Could Put Proposal on Hold." Media coverage of health reform in late summer slowed considerably while the nation waited for the Clinton plan to be unveiled. By the time the administration finally unveiled its plan in September and formally introduced the Health Security Act in November, a half-dozen alternative proposals had been introduced in Congress.<sup>6</sup>

After President Clinton delivered his health reform speech on

Sept. 22, 1993, major newspapers and news shows began to explore aspects of the administration's plan at great length. On the day following the speech, there were more than 40 articles about the Clinton speech and plan in major national papers. Headlines included: "A Consumer's Guide: How Different Groups Would Be Affected," "Getting Down to Basics: The Plan, Item by Item," and "Young and Healthy People Could See Expenses Grow." It seemed the news media, for a time at least, had changed its approach to focus more on what the reform proposal could mean for Americans and less on the Washington political struggles. Media coverage, while occasionally looking at other health reform proposals, still centered almost exclusively on the Clinton plan.

Public support for President Clinton and his proposal climbed after his September speech. Fifty-two percent of Americans said the Clinton plan was better than the present system, according to a *Wall Street Journal* survey, and 56 percent of Americans supported the President's handling of reform, according to a *USA Today* survey. As these surveys revealed support for Clinton and his reform goals, a *New York Times* survey showed 80 percent of Americans believed that taxes would increase if the Clinton plan was adopted. Health care at this time ranked as the number one problem facing the country, followed by unemployment and the economy.

Public opinion surveys showed that support for the Clinton plan did

<sup>4</sup> This survey was conducted in late March 1993. While the results were not published, the Foundation provided the results to the Associated Press in mid-May, which then reported them.

<sup>5</sup> See *Employee Benefit Research Institute/The Gallup Organization, Inc., Public Attitudes on Health Reform, 1993, EBRI Report no. G-49 (Washington, DC: Employee Benefit Research Institute, 1993).*

<sup>6</sup> For an examination of alternative proposals, see William Custer, "Health Reform: Examining the Alternatives," *EBRI Issue Brief no. 147 (Employee Benefit Research Institute, March 1994).*

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not remain solid for long: by October 1993, it began to decline. In October, the *Washington Post* found that 51 percent of Americans approved of the Clinton plan and 39 percent disapproved, compared with 56 percent approving and 24 percent disapproving just the month before. The *Post* also found that more than 8 out of 10 Americans said they knew a little (53 percent) or almost nothing (30 percent) about the Clinton plan.

Changes in public opinion late in 1993 may have been in part a reaction to media reports in late December that connected the latest data on health care cost inflation—the slowest rise in two decades—with a slowdown in personal expenditures on medical care. Concurrently, arguments to allow market forces to drive reform rather than government intervention abounded. However, opponents of this argument maintained that businesses and providers were responding to the pressures of impending reform, and if the President abandoned his plans, the positive trends would reverse themselves.

### ***Impetus Behind Clinton Reform Plan Weakens***

At the beginning of 1994, the percentage of Americans who believed the country's economic conditions were fairly bad or very bad was significantly lower than it had been one year earlier—52 percent in 1994, compared to 67 percent in 1993. In addition, while Americans still

ranked the state of the nation's health system among the top three problems facing the country, crime was rated the number one problem. This refocusing of the public's concerns may have for a time detracted from the health reform issue.

By the start of the second congressional session in January 1994, opponents of the administration's Health Security Act had become increasingly vocal. Republican lawmakers specifically began to address the rhetoric of crisis following President Clinton's State of the Union address—a speech in which the President drew the line in the sand, declaring that any bill he signs must contain universal coverage. In his formal response to the President's speech, Senate Minority Leader Bob Dole (R-KS) stated that “our country has health care problems, but no health care crisis.” His comments were echoed by other Republican lawmakers. William Kristol, a noted Republican strategist, urged fellow Republicans to take aim at the crisis rhetoric and support incremental reform approaches. There were even stirrings in the Democratic party against crisis rhetoric, when Senate Finance Committee Chairman Pat Moynihan (D-NY) indicated that he believed the crisis lies in the current welfare system, rather than in health care. The news media participated in the “crisis or no crisis” debate, with extensive coverage of Sen. Moynihan's remarks appearing in major daily newspapers and on news shows.

Despite political wrangling surrounding the rhetorical debate, public support for the administration's plan and approval of the president's handling of the issue reached the same levels following January's State of the Union address that were reported following Clinton's September speech. A *USA Today* survey on January 30, 1994 found that 57 percent of Americans approved of the Clinton health reform plan, compared with 56 percent following the September speech.

Perhaps out of concern that the wave of anti-crisis rhetoric would harm the Republican party in the eyes of the voters, Sen. Dole later conceded that health reform is a highly important issue in need of bipartisan resolve. Even the normally outspoken critic of the administration, Rep. Newt Gingrich (R-GA), conceded that the “no crisis” approach was a threat to the Republican party. Sen. Moynihan also qualified his remarks by indicating the *financing* of health care is in a state of crisis. However, the spate of criticism dealt the administration's plan its first real political setback, setting the stage for additional road blocks.

The “crisis” debate may have reduced public confidence about whether reform legislation would actually pass in 1994. A *New York Times* survey in late January found that more than one-half of Americans (56 percent) did not think Congress would agree on a health reform plan by the end of the year. Yet, 66 percent of Americans did

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believe significantly more Americans would be covered by health insurance by the end of President Clinton's term in office.

The President's Health Security Act suffered setbacks from the business community early in 1994. The Business Roundtable, a group of about 200 chief executive officers from major U.S. corporations, endorsed as a "starting point" a rival plan sponsored in the House by Rep. Jim Cooper (D-TN) and in the Senate by Sen. John Breaux (D-LA), despite heavy lobbying from the administration. Within a week of the Roundtable's announcement, the National Association of Manufacturers distanced itself from the Clinton plan after months of qualified support. In the same week, the National Governors' Association backed away from key components of the President's plan, including the employer mandate and cost controls. The U.S. Chamber of Commerce, which represents over 200,000 businesses, followed suit by stating at a congressional hearing that the Health Security Act could not be used even as a starting point in the debate. The Chamber later officially rejected employer mandates, despite its earlier support of shared responsibility between employers and employees. More recently, the Jackson Hole Group, the architects of managed competition, backed away from their former support of immediate employer mandates.

Many political pundits felt the administration made a tactical error in trying to win approval from businesses that historically have

never favored government regulation. The administration created an environment in which these groups' announcements became front page material instead of appearing in the newspapers' business sections. The news media closely followed the details of each of these announcements. By early February 1994, media reports stated that Clinton's health plan was back at the same point where it had been at the first of the year.

In another setback to the Clinton plan, Robert Reischauer, director of the Congressional Budget Office (CBO), testified in several congressional hearings that, instead of *reducing* the deficit by \$58.5 billion, the proposal would in fact *add* to the deficit by \$74 billion—a difference of \$133 billion. The analysis indicates that the bill would achieve deficit reduction by 2004—a fact the Clinton administration has repeatedly called attention to when discussing CBO's analysis. The CBO also concluded that the premiums collected by alliances under the proposal should be reflected in the national budget. Opponents of the plan have since used CBO's analysis to call the premiums paid to alliances a huge new tax—a criticism the administration wanted to avoid. The Clinton administration continues to argue that these premiums are not taxes.

At this point, the media spotlighted the CBO analysis and Reischauer's testimony. Sundry articles about CBO's findings appeared, along with numerous predictions about the impact of the

analysis on the fate of the Clinton plan. Concurrently, advertising campaigns sponsored by opponents of the administration's plan were well under way. Not long afterward, public support for the plan took another downturn.

### ***Effects of Advertisements on Public Opinion***

The attacks launched by opponents of the Clinton plan seem to have affected public opinion. A late February survey by the *Washington Post* found that 48 percent of Americans said they disapproved of the Clinton plan based on what they knew, while 44 percent approved. More than 7 out of 10 Americans said they knew little or almost nothing about the Clinton plan. The same survey found that 60 percent of Americans said they had seen or heard one of the advertisements opposing the administration's plan; 39 percent said the ads had made them less likely to support it. Similarly in early March, results from a *Wall Street Journal* survey showed that the advertising undertaken by Clinton plan opponents may have hurt public support for the proposal. Forty-five percent of Americans said they disapproved of the Clinton plan.

This same *Wall Street Journal* poll also showed that major portions of the administration's plan that were described to those surveyed—without associating them with Clinton's proposal—were supported by 76 percent of the respondents. When the public was polled regard-

ing provisions matching those advanced by alternative proposals currently before Congress, none of the results came near the support shown for the administration's provisions. Polls continue to show support of core elements of the Clinton plan—universal coverage, charging more for unlimited choice of physicians, and cost controls.

The administration originally focused its health reform campaign on developing grass roots support for the Health Security Act. However, the Democratic National Committee (DNC), realizing it had lost ground in public opinion to the plan's opponents, changed its strategy in late March to an advertising campaign. It remains to be seen if an advertising campaign can bolster support for the Health Security Act, but public opinion polls continue to show that many people approve of its key elements without associating them with the plan. The DNC's goal is to capitalize on this approval.

A positive event for the administration's plan was the AFL-CIO's decision to budget \$10 million to support passage of the Health Security Act. While Democrats generally can rely on support from the labor community, this support was in question after the administration and labor split ranks over the North American Free Trade Agreement.

### ***Alternative Reform Proposals***

The alternative plan that has garnered the most attention on Capitol Hill and in the media until recently is the Managed Competition Act of 1993.<sup>7</sup> This is the only comprehensive reform bill to receive bipartisan support in Congress.<sup>8</sup> Dubbed "Clinton-lite" by its chief House sponsor, Rep. Jim Cooper (D-TN), the proposal requires small employers to enroll in purchasing cooperatives and requires large employers to offer plans to their employees. Employers under the plan would not be obligated to pay a portion of the employee premium. There are many arguments against the plan. A chief argument is that the bill does not achieve universal coverage—a goal President Clinton says must be included in any health reform bill he signs.

Despite indications from the business community that the Cooper bill is a more acceptable starting point, there does not appear to be broad support for the bill in the House. The business community is ultimately not likely to support a provision in the plan that places an excise tax on coverage beyond the lowest priced plan offered in a given area. There is also a fairly broad coalition in Congress that would not support this concept. Without the goal of universal coverage, it is doubtful the bill as it is currently

drafted will secure enough congressional support to keep it alive.

Several bills in addition to the Clinton and Cooper plans have some measure of support on Capitol Hill. For example, the single payer proponents in Congress number nearly 100. Also, several of the Republican-sponsored alternatives have elements in common that, taken together, clearly have a large contingent in Congress behind them. All of the reform proposals currently before Congress are likely to have some influence on the final outcome of the health reform debate.

### ***Prospects for Health Reform in 1994***

Many in and around Washington are wondering if the Clinton plan is "dead." The answer to that question is a definitive "yes" if it refers to the Clinton bill as introduced. On the other hand, if the question is whether reform itself is dead, the answer is a qualified "no." It is still widely believed that Congress will pass a health reform bill by session's end. The Health Security Act, despite being torn apart, is still the point at which comparisons are made in Congress.

The final bill will not be nearly as complex as the Health Security Act. This voluminous bill is elaborate and far-reaching; there is not enough time before the end of the session for lawmakers to analyze each aspect of the plan or to develop consensus on the many issues involved. Because 1994 is an election year for every House member and one-third of the

<sup>7</sup> *Ibid.* A reform proposal recently passed by the House Ways and Means Health subcommittee has also received a significant amount of attention.

<sup>8</sup> An incremental reform bill introduced on Mar. 3 by Reps. J. Roy Rowland (D-GA) and Michael Bilirakis (R-FL), the Health Reform Consensus Act (H.R. 3955), has bipartisan support.

Provision/Bill	Clinton Bill H.R. 3600/ S. 1757	Cooper Bill H.R. 3222/ S. 1579	Chafee Bill H.R. 3704/ S. 1770	Likely to Be in Final Package?
Universal Coverage	Yes, by 1998	No	Yes, by 2005	Yes, phased in
Employer Mandates	Yes	No	No	Phase-in, called for by size, with triggers
Individual Mandate	Yes	No	Yes	Yes, phased in
Purchasing Cooperatives	Yes	Yes	Yes	Yes, voluntary
Limits on Employee Tax Exclusion	Yes, by 2004	No	Yes	Yes, deferred implementation, tied to standard package and sec. 125
Limits on Employer Tax Deduction	No	Yes	Yes	Yes, deferred implementation, tied to standard package
Uniform/Standard Benefits Package	Yes	Yes	Yes	Yes, but may not be specified
Subsidies	Yes	Yes	Yes	Yes
Price Controls	Yes	No	No	Targets
Health Insurance Reform	Yes	Yes	Yes	Yes
State Flexibility Re: Self-Insured	Yes	No	Yes	More than today

Senate, the fate of lawmakers seeking reelection may indeed reside in passage of some type of reform by year's end. The legislation that ultimately passes may look quite different from the proposal the administration sent to Capitol Hill, but passage of a bill—any bill as long as it purports to achieve universal coverage—will still be seen as a victory for the White House. The President can be expected to keep the pressure on.

The table above lists a number of issues that have been the subject of congressional hearings and general discussion in the health reform debate. For the purpose of comparison, the chart includes the aforementioned Clinton and Cooper bills, as well as the bill introduced by Sen. John Chafee, which has received attention for its goal of

universal coverage.<sup>9</sup> EBRI President Dallas Salisbury posits possible outcomes based upon three primary assumptions: first, that the President maintains his drum beat for reform; second, that House Ways and Means Committee Chairman Dan Rostenkowski (D-IL) remains in that position; and third, that Senate Finance Committee Chairman Pat Moynihan (D-NY) remains committed to passing a bill in 1994.

If a health reform bill passes in 1994, the final package will not likely be anything we see before Congress now but rather a melding of the provisions that currently enjoy support. Lawmakers are still in the early stages of a long and painstaking process. It is therefore difficult to know what will or will not survive the journey, but planning requires assumptions. It is entirely possible

that Congress will simply pass a market reform bill based on those provisions that currently enjoy support and save the more difficult prospect of passing comprehensive reform for the next congressional session. The President will continue to work to assure that this does not happen. A number of members of Congress who are dedicated to health reform will be working with him.

At this time, assuming "comprehensive" reform passes by session's end, it is anticipated that universal coverage, albeit with a very gradual phase in, will be a part of the final package. An employer mandate is not a highly popular facet of health reform; it will likely be greatly scaled back in the congressional process. Such a mandate may be gradually phased in by firm size, or states may have the ability to mandate, with changes to the Employee Retirement Income Security Act of 1974

<sup>9</sup> For an examination of this and other alternative proposals, see William Custer, "Health Reform: Examining the Alternatives," *EBRI Issue Brief no. 147 (Employee Benefit Research Institute, March 1994)*.

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(ERISA). In the absence of an employer mandate, the final package would have to include an eventual individual mandate for universal coverage to be achieved.

Although large, mandatory purchasing pools are enjoying little congressional support, the final package may include voluntary purchasing pools. A provision common to several bills is to limit the tax deductibility of health costs. However, this provision is unpopular among many members of Congress, who believe it would harm modest income individuals with union-negotiated benefits. This can be dealt with through subsidies, however, and the provision would raise revenue. A standard or uniform benefit package, whether as part of the final language or something to be determined after enactment, is also a feature of several proposals that may be retained through the process. There is also strong support for reforming the insurance market to limit preexisting condition clauses, guarantee insurability, provide portability, and assure against cancellation with some form of community rating. State flexibility may include the ability for states to regulate and tax employers that self-insure and that are presently exempt from state regulation under ERISA.

Reviewing the debate surrounding health reform, while perhaps not providing definitive answers, at least provides some perspective on the legislation that may ultimately be enacted. A constant factor in the debate is the impact of public opinion on policymakers' decisions. An

important question revolves around what the American public is ultimately willing to accept in health reform. Recent focus groups conducted by Public Agenda revealed that once participants had been provided with objective information on health reform options, they were willing to accept some change to provide coverage for everyone and contain rising costs.<sup>10</sup> Universal coverage remained a solid priority, yet a major fear was that health reform would result in lower quality medicine and waiting lines.

Interested parties have known from the start that serious discussion of comprehensive reform of the nation's health care system—affecting fully one-seventh of the economy—would be complicated and not without its ebbs and flows. The Tax Reform Act of 1986 is a good example of a bill that was said to be dead on any number of occasions but that was ultimately enacted. And, it *reduced* taxes for nearly everyone. That legislation, which involved only one committee in each house, took 18 months. Much more than issues such as tax reform, the issue of health care is a very personal one for nearly every American. Many Americans may pay more to gain from reform. It is an issue that substantively affects all of our lives. The longer it takes to find a solution, the more questions will undoubtedly arise. Presidential leadership may produce health

reform. Should that leadership waiver, federal reform will waiver as well. In that event, states are likely to be given an open field to run with reform. Either way, the health care delivery system will never be the same.

—Kathy Stokes Murray,  
Carolyn Piucci Pemberton, and  
Dallas Salisbury, *EBRI*

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<sup>10</sup> See John Immerwahr and Jean Johnson, *Second Opinions: Americans' Changing Views on Health Care Reform* (New York, NY: Public Agenda, 1994).

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## Pension and Social Security Income, 1984-1991

As the proportion of the U.S. elderly population continues to grow, and as baby boomers approach retirement age, issues of retirement income security become increasingly important. The growth in the proportion of persons aged 65 and over will continue to outpace the growth in the number of workers in this country as we move into the 21st century. As a result, retirees may need to rely less on potential Social Security income and more on personal savings and retirement income.

According to Census Bureau tabulations of the Survey of Income and Program Participation (SIPP), the number of pension recipients increased from 11.5 million to 13.7 million, or an 18.5 percent increase, between 1984 and 1991 (table 1). Average monthly pension income rose from \$745 in 1984 to \$794 in 1986, and then fell to \$735 by 1991 (all years in 1991 dollars). Pension income, as defined in SIPP, includes annuities from employment-based pension plans but excludes income generated from the proceeds of pension lump-sum distributions.<sup>11</sup> If income generated from preserved lump-sum distribu-

tions or assets attributable to lump sum proceeds were included in these tabulations, more retirees would show pension income, and a greater share of income would show up as pension income. Combined pension and Social Security income followed the same trend as pension income alone, although combined income was somewhat higher in 1991 than in 1984, unlike pension income alone. This suggests that Social Security income offset to some extent the drop in average monthly pension income between 1984 and 1991.

While many current retirees receive monthly pension income and Social Security income, the amount received varies greatly by gender, industry, educational level, age, years since retirement, and marital status.

### Gender

Between 1984 and 1991, the number of male pension recipients increased by 1.5 million (19.9 percent) (table 1), and the number of female recipients increased by 0.6 million (15.7 percent). Additionally, the average monthly pension income for women remained approximately 55 percent of the average monthly pension income for men between 1984 (\$480 and \$878, respectively) and 1991 (\$481 and \$859, respec-

tively). This may be due in part to men's higher overall earnings and more continuous attachment to the work force. Social Security closes a portion of the gap between women's and men's combined pension and Social Security income. In 1984, women's combined income was \$970 monthly, or 71.1 percent of the average for men (\$1,353). Similarly, in 1991, women's combined income averaged \$958 monthly, or 69.3 percent of men's average monthly income of \$1,383.

### Industry

Workers in retail trade, manufacturing, and wholesale trade had the lowest average monthly pension income in 1991, all falling below \$600, compared with the national average of \$735 (table 2). While workers in the manufacturing and wholesale trade industries receive a higher than average monthly Social Security income (\$698 and \$738, respectively), workers in retail trade receive lower than average Social Security income (\$638 monthly).

Federal and local government workers and individuals in the armed forces received average monthly pension incomes in 1991 that were above the overall average of \$735 (\$1,300, \$994, and \$1,316, respectively), while those in state government received lower than average pensions (\$685). In addition, while government workers received just slightly below average Social Security income, those in the armed forces received almost exactly the national average. Those in the

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<sup>11</sup> In 1990, 10.8 million lump-sum total distributions were made from tax qualified plans, totaling \$125.8 billion. Of this amount, 57 percent, or \$71.4 billion, was rolled over into individual retirement accounts (IRAs). For a detailed discussion, see Paul Jakoboski, "Retirement Program Lump-Sum Distributions: Hundreds of Billions in Hidden Pension Income," EBRI Issue Brief no. 146 (Employee Benefit Research Institute, February 1994).

Table 1  
Average Pension and Combined Pension and Social Security Income, 1984, 1986, 1991

	Individuals (thousands)			Average Monthly Pension Income			Average Monthly Pension and Social Security Income		
	1984	1986	1991	1984	1986	1991	1984	1986	1991
Total	11,547	12,378	13,680	\$745	\$794	\$735	\$1,224	\$1,299	\$1,244
Sex									
Male	7,671	8,422	9,195	878	925	859	1,353	1,442	1,383
Female	3,875	3,956	4,485	480	518	481	970	994	958
Age									
55–59	928	968	985	1,220	1,156	1,033	1,268	1,218	1,095
60–61	546	614	714	1,053	1,283	1,124	1,155	1,360	1,190
62–64	1,492	1,599	1,622	932	882	808	1,379	1,336	1,264
65 and over	7,736	8,439	9,792	598	662	641	1,210	1,299	1,262
65–69	3,029	3,162	3,447	700	774	735	1,311	1,381	1,325
70 and over	4,706	5,277	6,344	532	595	591	1,143	1,249	1,228

Source: Employee Benefit Research Institute compilation of Bureau of Census Survey of Income and Program Participation (SIPP) tables.  
Note: All figures are in 1991 dollars.

federal government received the highest combined pension and Social Security income (\$1,609), followed closely by those in the armed forces (\$1,548).

### Education

There is a strong correlation between educational level and level of pension income received (table 2). While persons who did not earn a high school diploma received an average pension income of \$472 in 1991, those who attended four or more years of college averaged \$1,173 of monthly pension income.

### Age

For persons aged 62 and over, average Social Security income increases with age, while average pension income drops. Since younger current retirees had higher earnings during their working years than older current retirees, the younger cohort's monthly pension annuity is likely to be higher. For all retirees, insufficient cost-of-living adjustments to pension income levels can result in lower purchasing power over time.

### Years Since Retirement

Pension income varies with the number of years since retirement. Persons who retired in the five years immediately preceding 1991 received an average of \$836 of monthly pension income, while persons who retired between 10–14 years immediately preceding 1991 received an average of \$638 monthly (table 2). Persons who retired 15 or more years before 1991 received an average monthly amount of \$734 in 1991.

### Marital Status

Among men, those who are married have the highest average monthly pension income and the highest average Social Security income (table 2). Among women, those who have never married have the highest average pension income and the highest Social Security income. Among both men and women, widowers receive the lowest average pension income. While among men, those who are married or who are divorced or separated have the highest total combined pension and Social

Security income (\$1,434 and \$1,210), the opposite is true for women. Women who have never married or who are widowed have the highest combined retirement income (\$1,159 and \$1,020, respectively) among women.

These data from SIPP illustrate the importance of pension income to future retirees. With no adjustments made to the current system, under intermediate assumptions, the Old Age and Survivors Insurance (OASI) Trust Fund is projected to become exhausted in 2044.<sup>12</sup> While the state of current retirees' financial status is positive, future retirees may have to rely less on Social Security than past and present retirees.

—Sarah Boyce, EBRI

<sup>12</sup> See Michael A. Anzick, "Future Solvency of Social Security and Medicare Trust Funds Remains Unclear," EBRI Notes (September 1993): 5–9.

Table 2  
**Retirement Pension Recipients: Average Monthly Pension Income, Total Household Income,  
and Social Security Income, 1991**

	Pension Recipients (thousands)	Average Monthly Pension Income	Average Monthly Total Household Income	Average Monthly Social Security Income	Average Monthly Pension and Social Security Income
Total	13,680	\$735	\$2,988	\$651	\$1,244
<b>Sex</b>					
Male	9,195	859	3,207	705	1,383
Female	4,485	481	2,539	555	958
<b>Industry</b>					
Construction	716	610	2,693	707	1,196
Manufacturing	4,030	524	2,573	698	1,137
durable goods	2,699	553	2,620	705	1,173
nondurable goods	1,331	465	2,478	686	1,062
Transportation, communications, other public utilities	1,600	839	2,891	640	1,328
Wholesale trade	335	577	2,748	738	1,200
Retail trade	640	386	2,186	638	945
Finance, insurance, real estate	489	749	3,132	741	1,416
Professional services	2,782	734	3,067	575	1,203
Public administration	1,741	1,038	3,455	568	1,402
federal government	707	1,300	3,826	528	1,609
state government	454	685	2,838	605	1,148
local government	580	994	3,488	579	1,349
Armed forces	947	1,316	4,354	656	1,548
<b>Education</b>					
Less than high school	3,999	472	2,113	644	1,052
High school graduate	4,784	661	2,783	655	1,156
College					
1-3 years	2,122	829	3,528	668	1,295
4 or more years	2,776	1,173	4,188	644	1,632
<b>Age</b>					
25-61	2,266	1,089	3,863	676	1,150
62-64	1,622	808	3,170	608	1,264
65 and over	9,792	641	2,755	656	1,262
65-69	3,447	735	2,993	640	1,325
70 and over	6,344	591	2,627	664	1,228
<b>Years Since Retirement</b>					
Less than 5	3,488	836	3,302	667	1,254
5 or more	10,193	701	2,881	647	1,241
5-9	3,954	719	2,986	675	1,264
10-14	2,888	638	2,904	662	1,216
15 or more	3,351	734	2,737	600	1,234
<b>Marital Status</b>					
<b>Male</b>					
Male	9,195	859	3,207	705	1,383
married	7,437	911	3,384	714	1,434
divorced or separated	505	811	2,737	667	1,210
widowed	907	560	2,419	686	1,161
never married	345	615	2,157	624	1,133
<b>Female</b>					
Female	4,485	481	2,539	555	958
married	1,907	466	3,146	485	848
divorced or separated	413	485	1,920	565	991
widowed	1,725	456	2,049	602	1,020
never married	440	641	2,407	624	1,159

Source: Employee Benefit Research Institute compilation of Bureau of Census Survey of Income and Program Participation (SIPP) tables.

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## Americans Are Saving for Retirement at Early Ages, According to New EBRI/Gallup Survey

Most Americans are starting to save for retirement at an early age, according to a new public opinion survey by EBRI and The Gallup Organization, Inc. The median age at which Americans say they started saving for retirement is 30 years, and the median amount nonretired Americans say they need to save by the time they retire is \$150,000.

The median age at which Americans say they began to save for their retirement indicates that younger adults are beginning to save earlier in life than older adults. The median age those 18–34 years old began saving was 23 years; for those aged 35–54, the median age was 30 years; and for those aged 55 and over, the median age was 42 years. The median amount respondents said they need to save by their retirement was \$100,000 for those 18–34 years old, \$200,000 for those aged 35–54, and \$100,000 for those aged 55 and over.

“The public apparently has realized that they need to save for retirement, but young Americans may not understand the extent to which they need to save,” EBRI President Dallas Salisbury remarks. “While \$150,000 in savings may sound like a lot of money, it may not give people as much purchasing power in the future as they think

when inflation is factored into the picture. Today, \$150,000 in savings can purchase a monthly annuity for life of \$1,060 at age 62 and \$1,134 at age 65.”

In addition, respondents were asked what they would do with a cashout from their company retirement plan under various circumstances. Two-thirds (66 percent) of nonretired Americans said if they left their job to move directly to a new job and received a cashout from the retirement plan, they would transfer it to another retirement plan such as an individual retirement account (IRA). However, fewer Americans (31 percent) said if they lost their job and received a cashout from their retirement plan they would transfer it to another retirement plan.

“From what Americans say they would do with lump-sum distributions in different scenarios we see the choice being made for current consumption over future security. This may help workers meet today’s needs, but the price may be lower retirement income tomorrow. Many workers may not understand the long-term buildup potential of distributions, even small ones,” Salisbury comments.

The survey also asked a series of questions about Social Security, including if Social Security will be able to pay benefits at retirement; if higher taxes will be needed to pay Social Security benefits from 2000 on; how important Social Security is relative to other government programs; if participation in Social Security should be voluntary;

maximum benefits offered under Social Security; and use of Social Security taxes. In responses to these questions, the survey shows Americans are divided in their confidence about the program’s long-term viability, yet it continues to be an important program to a majority of Americans.

The 1994 survey on retirement income was conducted in January 1994 and is the fifty-fifth in a series of national public opinion surveys EBRI is conducting on public attitudes toward work force and economic security issues. The surveys, conducted monthly for EBRI by The Gallup Organization, Inc., question 1,000 Americans by telephone. The maximum expected error range at the 95 percent level is  $\pm 3.1$  percent.

Copies of the survey report, *Public Attitudes on Retirement Income*, 1994, (G-55), and the 1992 and 1990 surveys may be ordered from Malaika Barnes, (202) 775-6338, for the following prices: summary—\$50 each; full report—\$100 each; EBRI member prices: summary—\$25 each; full report—\$50 each. Annual subscriptions are available for a 25 percent discount. Call Carolyn Piucci Pemberton, (202) 775-6341, for more information on an annual subscription.

—Carolyn Piucci Pemberton, EBRI

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## Washington Update

**Health Reform**—The House Ways and Means Health subcommittee on Mar. 23 narrowly approved the health reform plan crafted by Chairman Pete Stark (D-CA) (*Notes*, 3/94). The proposal would create a “Medicare Part C” arrangement to cover uninsured individuals. Employers would be required to pay 80 percent of the cost of coverage for their employees, whether through a private plan or payment into the federal plan.

The plan, which passed 6–5, will now be passed on to the full Ways and Means Committee, where its future is uncertain. If full committee Chairman Dan Rostenkowski (D-IL) does accept the Stark plan as his starting point, he will likely strip out its financing provisions, as the subcommittee has no jurisdiction over financing.

In passing the plan, the subcommittee replaced the 0.8 percent payroll tax on all employers with a 1 percent payroll tax on companies with 1,000 or more workers who elect to self-insure; placed limits on the tax exclusion of health care benefits provided through cafeteria plans; and increased the tax on cigarettes by \$1.25 a pack. An amendment sponsored by Rep. John Lewis (D-GA) that passed the subcommittee 11-0 would establish an “any willing provider” law to obligate every health benefit plan to contract with a long list of community and other providers. This provision would change managed

care and could significantly reduce quality control while decreasing the potential for cost management.

A number of alternative plans were voted on and rejected, including bills sponsored by Reps. Jim McDermott (D-WA), Jim Cooper (D-TN), Bob Michel (R-IL), and Bill Thomas (R-CA). Subcommittee Republicans forced a vote on the administration’s bill; all Republicans rejected the plan, while Democrats voted “present” to avoid an up-or-down vote.

Meanwhile, moderate Democrats on the full Ways and Means Committee are floating a number of plans in search of middle ground on health reform. Spearheading the effort is Rep. Peter Hoagland (D-NE), whose main concern is to achieve consensus on some “palatable” form of employer mandate that will win bipartisan support in the committee. The full committee is expected to begin markup in April.

House Energy and Commerce Chairman John Dingell (D-MI) is still having difficulty finding consensus on health reform in his committee. To pass a bill out of the full committee, Rep. Dingell needs agreement from 23 of the 44 lawmakers on the panel. The chairman has recently circulated a proposal to committee members that would, among other things, reduce the cost of an employer mandate to small business and give the states the responsibility to achieve cost control. It is anticipated that the committee will begin

markup in mid-April.

The Senate Finance Committee held a two-day retreat on health reform Mar. 20–21. The committee was joined by 10 outside panelists, including EBRI President Dallas Salisbury. Dallas was one of two panelists who discussed the implications of state versus federal regulation of health insurers and self-insured plans.

**Managed Competition II**—The Jackson Hole Group, framers of the philosophy of managed competition, have updated the health reform plan they developed three years ago. Changes in the updated proposal, dubbed “Managed Competition II,” include:

- **Competing HPPCs.** The original plan called for one health plan purchasing cooperative (HPPC) per geographic region; the new proposal calls for competition to better enhance consumer choice. The plan calls for mandatory HPPCs for small groups.
- **Tax Code Changes.** The revised plan maintains the provision that caps tax-free health benefits to instill cost-consciousness. The new plan caps the benefit to the weighted-average cost of accountable health plans (AHPs) in a HPPC area; the previous plan capped the benefit at the lowest-price health plan.
- **Physician Choice.** All plan sponsors would be required to offer at least one AHP with an

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## Keeping on Track

(The following items are listed to keep you up-to-date on issues that were not specifically addressed in *Washington Update*.)

**Educational Assistance**—The exclusion for employer-provided educational assistance is due to expire Dec. 31, 1994. President Clinton's budget proposal does not allow for an extension of this exclusion. The House and Senate passed versions of the budget that did not retain the exclusion.

**Compensation Deduction Limit**—The Internal Revenue Service will hold a hearing May 9 on proposed rules providing guidance on the performance-based exception to the new limit on an employer's deduction for executive compensation above \$1 million. The deduction limit, a provision of the Omnibus Budget Reconciliation Act of 1993, applies to covered employees of publicly held corporations. For further information, contact Mike Slaughter in the Internal Revenue Service Regulations Unit, 202/622-7190.

**Family Benefits**—The Department of Labor received approximately 900 comments on its interim final rules on the Family and Medical Leave Act (*Notes*, 10/93). The final rules are expected to be issued in August, largely mirroring the interim final rules.

**Long-Term Care**—Long-term care provisions contained in the Clinton health care reform bill include a proposal to expand home- and community-based services and a demonstration study intended to pave the way toward greater integration of acute and long-term care. The plan also calls for changes in Medicaid and in the tax treatment of long-term care insurance. There has been no indication of whether these provisions will be maintained through the congressional markup process.

**Pension Reform (PBGC)**—House Ways and Means Chairman Dan Rostenkowski (D-IL) will hold a hearing Apr. 19 on the Retirement Protection Act of 1993, the administration's Pension Benefit Guaranty Corporation (PBGC) reform proposal (H.R. 3396) (*Notes*, 2/94).

**Social Security Retirement Age**—Retiring Rep. J.J. Pickle (D-TX) introduced the Social Security Entitlement Reform Amendments of 1993 (H.R. 3585), which would increase the retirement age to 70 by the year 2029. The bill, which was introduced in the final days of the last session, was referred to the Ways and Means Committee, where no action has been taken. On introducing the bill, Rep. Pickle said he wants to assure that the Social Security system remains viable for the baby boom generation.

**Stock Options**—The Financial Accounting Standards Board wrapped up public hearings Mar. 26 on the controversial proposal to require companies to deduct from their profits the value of stock options granted to employees. Some witnesses were in support of the proposal, but most warned that such a rule would harm the health of U.S. businesses and that the value of options cannot be accurately measured. Under the proposal, compensation costs would be measured at the fair value of the stock option or other stock-based award on the date it is granted.

out-of-plan option to allow enrollees to use non-AHP providers at an increased cost. The original proposal did not set requirements on the type of health care delivery organizations that would compete in a reformed market.

- **Balanced Health Security Budget.** A budget would be established to instill fiscal discipline into the health care system by guaranteeing that federal health expenditures do not grow faster than revenue. Government health expenditures would be disbursed on a pay-as-you-go basis.
- **Universal Access.** As a first step toward universal coverage, the proposal calls for the establishment of a system of universal access, through subsidies that would be financed with progressive taxes. Legislation would include a mandate for the year 2002 if universal coverage has not been achieved by then. Universal coverage is defined as covering 95 percent of the population. Under a phased-in mandate, employers would be responsible for contributing a minimum of 50 percent of the price of the low-cost plan premiums for each employee. All individuals would be required to purchase coverage or pay a free-rider tax.

**Outlook:** The Jackson Hole Group modified the original proposal in

the realization that health reform is stalling over a number of issues. The “Managed Competition II” proposal builds on a modified version of the Cooper/Breaux bill (H.R. 3222/S. 1579). The Jackson Hole Group has widely distributed the updated proposal but has not indicated a strategy for congressional action on the plan.

**Data Bank Requirements**—On Mar. 15, Sen. John McCain (R-AZ) introduced a bill (S. 1933) to repeal the data bank reporting requirement that was enacted with passage of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) (*Notes*, 3/94). Rep. Tillie Fowler (R-FL) introduced the House companion bill (H.R. 4095) on Mar. 21.

**Outlook:** Under budget pay-as-you-go rules, a proposal to repeal the data bank requirement would have to contain a provision to offset the requirement's projected revenue gain of approximately \$1 billion over five years. S. 1933 does not have an offsetting provision. Sen. Joe Lieberman (D-CT), sponsor of an earlier bill (S. 1719)

to suspend the imposition of penalties for reporting failures, may call for a vote to repeal the provision when the health reform debate moves to the Senate floor. The sponsors of these measures may request that the appropriations committees not fund the data bank, which could delay, if not kill, its implementation.

**ERISA Preemption**—The Senate Labor and Human Resources Committee on Mar. 10 held a hearing on a bill (S. 1580) that would limit ERISA preemption of state laws relating to prevailing wages, apprenticeship training programs, and mechanics' liens. The House passed its version of the legislation (H.R. 1036) on Nov. 9 (*Notes*, 12/93).

**Outlook:** Sen. Edward Kennedy (D-MA), chairman of the Senate Labor and Human Resources Committee, vowed at the Mar. 10 hearing to approve the bill quickly. The current focus on health reform in Congress may forestall any action on the legislation in the near term.

—Kathy Stokes Murray, *EBRI*

**Editor's Note:** In the March 1994 *Notes*, *Washington Update* reviewed President Clinton's fiscal year 1995 budget. An error in the administration's budget figures led us to report that the deficit reduction amount related to PBGC reform would be \$958 million over five years. The actual deficit reduction figure is \$190 million.

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## At EBRI

Nora Super Jones will assume a new position at EBRI in April as Manager, Member Relations and Special Projects. In this role, she will work to establish strong communication between EBRI and its members to ensure that EBRI continues to meet members' needs. In addition, she will manage the EBRI Fellows Program and the Lillywhite Award. Nora will also continue to write feature articles and edit Policy Forum books and Special Reports.

After completing a nine month residency, EBRI-ERF Fellow Masaru Hiraiwa has returned to his permanent assignment with the Japanese Department of Health and Welfare in Tokyo, Japan.

### ***Second Opinions: Americans' Changing Views on Healthcare Reform***

Public Agenda, a nonprofit, nonpartisan research and education organization, in cooperation with EBRI, has released a new report, *Second Opinions: Americans' Changing Views on Healthcare Reform*. Based on focus group discussions conducted in 13 cities around the country, this report offers an insightful, authoritative look at the public's current thinking on health care reform. *Second Opinion* is a follow-up to the 1991 Public Agenda/EBRI report, *Faulty Diagnosis*.

Copies of the report are available for \$15.00 each (plus postage and handling of \$1.75) and are available from The Public Agenda Foundation,

6 East 39th Street, 9th Floor, Dept. C, New York, NY 10016, Attn: Michelle Rotman. For more information, call (212) 686-6610.

### ***Health Care Reform Bookshelf***

A new electronic program sponsored by IBM and EBRI allows individuals to view quickly and easily on computer diskette the full text of all the major health reform proposals (Clinton, Cooper, Chafee, Nickles, Michel, and McDermott) introduced in Congress, as well as supporting documents. The Bookshelf allows you to read the text of each proposal, jump to widely separated sections, quickly search alternative proposals to see how they differ from the President's, search for keywords or phrases in the text, print or file selected portions, and insert notes and comments for viewing. The Health Care Reform Bookshelf sells for \$99 (plus \$7.00 shipping and handling for 2nd day UPS). To order, call 1-800-776-8284; be sure to use the **EBR** code when ordering.

## New Publications

[Note: To order publications from the U.S. Government Printing Office (GPO), call (202) 783-3238; to order congressional publications, call (202) 275-3030. To order U.S. General Accounting Office (GAO) publications, call (202) 512-6000].

Alliance for Health Reform.

**Reforming Health Care: A Sourcebook for Journalists.** \$60. Alliance for Health Reform, 1133 20th St., NW, Suite 220, Washington, DC 20036, (202) 466-5626.

American Compensation Association. **Employee Benefits Basics: Developing the Benefits Component of Total Compensation.** \$20 members, \$30 nonmembers. ACA Publication Orders, P.O. Box 29312, Phoenix, AZ, 85038-9312, (602) 951-9191.

American Managed Care and Review Association. **1993-94 Managed Health Care Directory.** \$205 members, \$250 nonmembers. The AMCRA Foundation, 1227 25th Street, NW, Suite 610, Washington, DC 20037, (202) 728-0506.

Annis, Edward R. **Code Blue: Health Care in Crisis.** \$21.95. Regnery Gateway, 1130 17th St., Suite 600, Washington, DC 20036, (202) 457-0978.

Butler, Robert N., and Kenzo Kiiikuni, eds. **Who Is Re-**

- sponsible for My Old Age?** \$28.95. Springer Publishing Company, 536 Broadway, New York, NY 10012, (212) 431-7842.
- Canan, Michael J. **Interim Supplement to 1993 Edition, Qualified Retirement and Other Employee Benefit Plans, Including the Omnibus Budget Reconciliation Act of 1993.** \$18.50. West Publishing Co., 610 Opperman Drive, P.O. Box 64526, St. Paul, MN 55164-0526, (800) 328-9352.
- Congressional Quarterly. **Where the Money Goes: A Comprehensive Guide to the 1994 Spending Choices of Clinton and Congress.** \$9.95. Congressional Quarterly, Customer Service, 300 Raritan Center Parkway, P.O. Box 7816, Edison, NJ 08818-7816, (800) 638-1710.
- Gappa, Judith M., and David W. Leslie. **The Invisible Faculty: Improving the Status of Part-Timers in Higher Education.** \$29.95. Jossey-Bass, Inc., P.O. Box 44305, San Francisco, CA 94144-4305, (415) 433-1767.
- Heath, Angela. **Long Distance Caregiving: A Survival Guide for Far Away Caregivers.** \$9.95. American Source Books, P.O. Box 280353, Lakewood, CO 80228, (303) 980-0580.
- King, Arthur et al., eds. **North American Health Care Policy in the 1990s.** \$40. John Wiley, 605 Third Ave., New York, NY 10158-0012, (212) 850-8800.
- Kruse, Douglas L. **Profit Sharing: Does It Make a Difference? The Productivity and Stability Effects of Employee Profit-Sharing Plans.** \$27 cloth, \$17 paper. W.E. Upjohn Institute for Employment Research, 300 S. Westnedge Ave., Kalamazoo, MI 49007-4686, (616) 343-5541.
- Madrian, Brigitte C. **Employment-Based Health Insurance and Job Mobility: Is There Evidence of Job-Lock?** Working Paper No. 4476. \$5. National Bureau of Economic Research, 1050 Massachusetts Ave., Cambridge, MA 02138. (Written requests only.)
- Mayberry International, Inc. **Free Guide to International Benefits.** Mayberry, Inc., 1160 Spa Road, Suite 2C, Annapolis, MD 21403, (800) 989-5554.
- Milkovich, George T., and Jerry M. Newman. **Compensation.** Fourth edition. \$56.95. Irwin Professional Publishing, 1333 Burr Ridge Parkway, Burr Ridge, IL 60521, (800) 634-3996.
- Martorana, R. George. **Your Pension and Your Spouse: The Joint and Survivor Dilemma.** \$7.95. International Foundation of Employee Benefit Plans, 18700 West Bluemound Road, P.O. Box 69, Brookfield, WI 53008-0069, (414) 786-6710, ext. 240.
- National Health Council. (1) **Health Groups in Washington.** (2) **Congress and Health: An Introduction to the Legislative Process and Its Key Participants.** Each report: \$20 members, \$25 nonmembers. National Health Council, 1730 M Street, NW, Suite 500, Washington, DC 20036-4505, (202) 785-3910.
- Newhouse, Joseph P. **Free for All? Lessons from the RAND Health Insurance Experiment.** \$49.95. Harvard University Press, Sales Dept., 79 Garden St., Cambridge, MA 02138-1499, (800) 448-2242.
- Opatz, Joseph P., ed. **Economic Impact of Worksite Health Promotion.** \$30. Human Kinetics Publishers, 1607 North Market St., P.O. Box 5076, Champaign, IL 61825-5076, (217) 351-5076.
- Rappaport, Anna M., and Sylvester J. Schieber, eds. **Demography and Retirement: The Twenty-First Century.** \$55. Greenwood Publishing Group, 88 Post Road West, Box 5007, Westport, CT 06881, (203) 226-3571.
- Salmon, Jack Warren, ed. **The Corporate Transformation of Health Care: Perspectives and Implications.** \$33.50. Baywood Publishing Company, 26 Austin Ave., Amityville, NY 11701, (800) 638-7819.
- Schaie, K. Warner, and W. Andrew Achenbaum, eds. **Societal Impact on Aging:**

- Historical Perspectives.** \$38.95. Springer Publishing Company, 536 Broadway, New York, NY 10012, (212) 431-4370.
- The Segal Company. (1) **1993 Survey of State Employee Health Benefit Plans.** Free. (2) **Flexible Benefits for the Small Organization: Why Flexible Plans Are Not Just for Large Corporations.** Free. The Segal Company, One Park Ave., New York, NY 10016, (212) 251-5029.
- Schechter, Malvin. **Beyond Medicare: Achieving Long-Term Care Security.** \$34.95. Jossey-Bass Publishers, 350 Sansome St., San Francisco, CA 94104, (415) 433-1767.
- Sheehy, Edward. **Public/Private Partnerships: Building Support for Employer-Sponsored Eldercare.** \$10. National Eldercare Institute on Business and Aging, Washington Business Group on Health, 777 N. Capitol St., NE, Suite 800, Washington, DC 20002, (202) 408-9320.
- Slee, Vergil N., and Deborah A. Slee. **Health Care Reform Terms.** Second edition. \$14.95. Tringa Press, P.O. Box 8181, St. Paul, MN 55108, (612) 222-7476.
- U.S. Congress. House. Committee on Energy and Commerce. **HMO Financial Practices.** Order from GPO.
- U.S. Congress. Joint Economic Committee. **High-Wage Jobs in a Competitive Global Economy.** Order from GPO.
- U.S. Congress. Senate. Committee on Veterans' Affairs. **Present and Future Role of VA Health Care.** Order from GPO.
- U.S. Congress. Senate. Special Committee on Aging. **Preventive Health: An Ounce of Prevention Saves a Pound of Cure.** (2) **Health Care Fraud As It Affects the Aging.** Order from GPO.
- U.S. Congressional Budget Office. **Federal Debt and Interest Costs.** Washington, DC: Congressional Budget Office.
- U.S. Department of Commerce. Bureau of the Census. **State Population Estimates by Age and Sex: 1980 to 1992.** Order from GPO.
- U.S. Department of Commerce. Economics and Statistics Administration. **Statistical Abstract of the United States: 1993.** Order from GPO.
- U.S. Department of Commerce. Department of International Trade. **1994 U.S. Industrial Outlook.** \$37. Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954, fax (202) 512-2250.
- U.S. Department of Health and Human Services. National Center for Health Statistics. (1) **Chartbook on Health Data for Older Americans: United States, 1992.** (2) **Clinical Chemistry Profile Data for Hispanics, 1982-84.** (3) **Common Beliefs About the Rural Elderly: What Do National Data Tell Us?** Order from GPO.
- U.S. Department of Labor. Bureau of Labor Statistics. **Employment, Hours, and Earnings, United States, 1981-1993.** Order from GPO.
- U.S. General Accounting Office. (1) **European Community: Regulatory Issues in Creating a Single Insurance Market.** (2) **Medicaid: Alternatives for Improving the Distribution of Funds to States.** (3) **Medicaid Managed Care: Healthy Moms, Healthy Kids—A New Program for Chicago.** (4) **Social Security: Need to Improve Postentitlement Service to the Public.** (5) **Social Security Disability: SSA Needs to Improve Continuing Disability Review Program.** Order from GAO.
- U.S. Office of Personnel Management. **The Federal Flexible Workplace Pilot Project: Work-at-Home Component.** Order from GPO.
- U.S. Treasury. Internal Revenue Service. **Statistics of Income: Individual Income Tax Returns.** Order from GPO.

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