notes

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◆ Maternal and Child Health: Are We on the Right Track?

Health care reform has become an important issue in public policy debates. Recently enacted federal laws have improved health insurance access for pregnant women and children. Current legislative proposals include provisions that would further expand access, reduce or control costs, and/or improve the quality of health care services. Some policymakers advocate further expansion of health care access for pregnant women and children because research has shown that women who receive comprehensive prenatal care generally give birth to healthier babies than women who don't receive such care.

The health of pregnant women and children in the United States, as measured by indicators such as the infant mortality rate,[1] has improved in the last several decades. The infant mortality rate declined from 29.2 in 1950 to 10.0 in 1988, and preliminary data for 1989 indicate a decline in the infant mortality rate to 9.7. However, the U.S. rate remains higher than that of other industrialized countries. Although federally mandated Medicaid reforms have increased poor women's access to prenatal care, some states have been unable to implement these mandates because of budget limitations. Moreover, the effects of improved access cannot be evaluated until data covering the years following the mandates' effective dates are available.

Importance of Prenatal Care

Researchers have found that early and frequent prenatal care is associated with more positive birth outcomes. Generally, rates of maternal mortality, infant mortality, and low birth weight are lower when comprehensive prenatal care, hospital-based labor and delivery, and neonatal care services are available and used. However, nearly 24 percent of women giving birth in the United States between 1984 and 1986 did not have their first prenatal visit until their second or third trimester.[2] Delayed or inadequate prenatal care may be the result of a woman's lack of education about the importance of prenatal care, lack of transportation to medical facilities, and/or inability to pay for health services. Studies have shown that prenatal care is cost effective—each dollar spent providing prenatal care to a group of low-income, poorly educated women reduced medical expenditures by $3.38, on average, in 1988.[3]

Low-income women are more likely to lack both public and private health insurance than other women. Nearly 35 percent of women aged 15–44 with incomes below the federal poverty level were uninsured in 1989, compared with only 6 percent of women with incomes more than three times the federal poverty level (table 1).[4] By

[1] The infant mortality rate measures the number of deaths among infants younger than one year old per 1,000 live births.

[2] Three measures of the quality of prenatal care are generally used: (1) frequency—the number of visits made during pregnancy; (2) timing—the trimester or month in which care began; and (3) an index relating the frequency and timing of visits to gestational age. The American College of Obstetricians and Gynecologists recommends that care begin early in the first trimester, with visits every 4 weeks for the first 28 weeks, every 2 to 3 weeks for the next 8 weeks, and each week thereafter until delivery.

[3] See Institute of Medicine, *Prenatal Care: Reaching Mothers, Reaching Infants* (Washington, DC: National Academy Press, 1988).

[4] The federal poverty level was $12,675 for a family of four in 1989 (three times the poverty level was $38,025).

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removing the financial constraints faced by poor women who seek prenatal care, policymakers may be able to increase the percentage of women who receive care. Improved financial access and education about the importance of prenatal care may improve poor women's birth outcomes.

Women with private insurance are more likely to obtain early prenatal care than women who are either uninsured or enrolled in Medicaid. Uninsured women face significant obstacles to obtaining prenatal services. They often rely on free or reduced-cost care from private physicians or public health clinics. Women eligible for Medicaid may be less likely to receive adequate prenatal care as a result of the difficult Medicaid enrollment process. In some states applications have been as long as 45 pages because they are also used to determine eligibility for Aid to Families with Dependent Children (AFDC) and other public programs.[5] The majority of both uninsured and Medicaid-eligible women are poor. Many may have difficulty arranging transportation to health clinics and/or may be unaware of medically recommended standards of care during pregnancy (e.g., frequency and timing of prenatal visits and proper diet).

Even in communities with an adequate supply of maternity care providers, poor and uninsured pregnant women may not have access to care unless the providers are willing to accept their form of payment. Many obstetricians do not accept Medicaid as payment, and many more will not take patients who are uninsured. A 1990 national survey found that Medicaid reimbursement rates for a variety of services were far lower than either the rates paid by Medicare patients or the average fees paid by privately insured patients. Maternity services exhibited the narrowest range of payment levels, reflecting the efforts of policymakers to increase access to obstetrical care. However, in 23 states, Medicaid fees remained less than 50 percent of private payers' average charges for vaginal delivery and were as low as 18 percent of private charges in New Jersey. The ratios of Medicaid fees to those of privately insured patients, on average, were 60 percent for total obstetrical care with vaginal delivery, and 53 percent for vaginal delivery only.

Medicaid Reform in the 1980s

Congress expanded Medicaid eligibility in the Omnibus Reconciliation Act of 1986 (OBRA '86). This expansion

[5]Although states were granted optional authority to simplify the eligibility rules for pregnant women in 1986, some have not adopted these provisions.

[6]See Anne Schwartz, David C. Colby, and Anne L. Reisinger, "Variation in Medicaid Physician Fees," *Health Affairs* (Spring 1991): 131–139.

Table 1
Health Insurance Coverage of Women Aged 15–44, by Family Income as a Percentage of the Federal Poverty Level, 1989

Family Income as a Percentage of the Federal Poverty Level	Total	Private Health Coverage: Total	Private: Employment based	Private: Other private	Public Health Coverage: Total	Public: Medicaid	No Health Insurance Coverage
				(millions)			
Total	57.5	43.6	38.2	5.4	6.4	5.1	9.0
Under poverty	7.9	1.8	1.0	0.8	3.5	3.4	2.8
100%–149% of poverty	4.7	2.4	1.8	0.6	0.8	0.7	1.7
150%–199% of poverty	5.1	3.5	2.9	0.6	0.5	0.4	1.3
200%–299% of poverty	10.5	8.7	7.6	1.1	0.5	0.3	1.5
300% or more of poverty	29.3	27.2	24.9	2.3	1.0	0.3	1.8
			(percentage within poverty categories)				
Total	100.0%	75.8%	66.5%	9.3%	11.1%	8.8%	15.6%
Under poverty	100.0	23.2	12.7	10.5	44.7	42.9	34.9
100%–149% of poverty	100.0	51.3	39.0	12.3	17.6	15.5	34.9
150%–199% of poverty	100.0	68.4	56.8	11.6	10.1	7.1	24.9
200%–299% of poverty	100.0	82.9	72.8	10.1	5.0	2.5	14.5
300% or more of poverty	100.0	92.7	84.9	7.8	3.4	1.0	6.1

Source: Employee Benefit Research Institute tabulations of the March 1990 Current Population Survey.

Table 2
Federal Legislation Affecting Medicaid Eligibility for Pregnant Women and Children, 1986–1990

Legislation	Effective	Medicaid Provisions
OBRA 1986	April 1987	Gave states the option to raise income eligibility thresholds above AFDC levels to as high as the federal poverty level for pregnant women, infants, and children up to five years of age. Also allowed states to ignore assets in determining eligibility for pregnant women. In addition, states could grant continuous eligibility for women throughout their pregnancy (regardless of income fluctuations), and extend presumptive eligibility to pregnant women.
OBRA 1987	July 1988	Allowed states to raise income eligibility thresholds for pregnant women and infants with family incomes up to 185 percent of the federal poverty level, and to raise poverty level coverage to children aged eight and younger.
Medicare Catastrophic Care Ammendments (MCCA) of 1988	July 1990	Required states that had not already done so to provide minimum coverage to pregnant women and infants with family incomes up to 100 percent of the federal poverty level.
OBRA 1989	April 1990	Superseded MCCA's mandate schedule by requiring states to cover pregnant women and children aged six and younger with income at or below 133 percent of the federal poverty level.
OBRA 1990	July 1991	Required states to cover children under age 19 and born after September 30, 1983, whose families had incomes at or below 100 percent of the federal poverty level (the phase-in will be complete by 2002).

Sources: U.S. Department of Health and Human Services, Health Care Financing Administration, "Improving State Medicaid Programs for Pregnant Women and Children," *Health Care Financing Review: 1990 Annual Statistical Supplement* (Washington, DC: U.S. Government Printing Office, 1991); and Employee Benefit Research Institute, *EBRI's Washington Bulletin* (31 October 1990).

together with subsequent Medicaid reforms improved access to health insurance for low-income pregnant women and children by increasing income eligibility levels and severing the link between Medicaid and cash assistance. Prior to the recent Medicaid reforms, individuals were only eligible to receive Medicaid if they were receiving cash assistance from AFDC, Supplemental Security Income, or, in some states, if they were considered medically needy.[7] Both AFDC and Medicaid are administered at the state level, which results in different income eligibility requirements, services provided, and payment systems among states.

OBRA '86 decoupled AFDC eligibility and Medicaid eligibility for low-income pregnant women and children. Beginning in April 1987, states were allowed to increase income eligibility thresholds above AFDC levels to as high as the federal poverty level ($11,611 for a family of four in 1987) for pregnant women, infants, and children up to age five. Medicaid reforms have been enacted every year since 1986. As of July 1991, states are required to extend Medicaid eligibility to pregnant women and children up to age six with family incomes of 133 percent of the federal poverty level or less. States must also extend eligibility to children up to age 18 who were born after September 1983 and who are living in families with incomes at or below the federal poverty level.

OBRA '86 also included provisions that allowed states to accelerate the Medicaid application and qualification process for pregnant women. First, it allowed states to ignore women's personal assets in determining their Medicaid eligibility. Second, it authorized states to extend continuous eligibility to women throughout their pregnancies regardless of fluctuations in income that formerly would have made them ineligible to receive benefits. And finally, it allowed states to establish presumptive eligibility programs extending immediate, short-term Medicaid eligibility to women whose applications are being processed (table 2). As of July 1990, 45 states and the District of Columbia had removed asset restrictions for pregnant women and children, 43 states had extended continuous eligibility, and 28 states had adopted a presumptive eligibility program.

[7]In some states, individuals who have medical expenditures that exceed their means and assets below a state specified level are eligible for Medicaid. Income eligibility thresholds for programs serving the medically needy are generally higher than those for AFDC. Federal law requires those states that offer programs for the medically needy to provide some prenatal and delivery services to pregnant women.

States have adopted or proposed supplemental programs to improve access for poor women, including outreach and information campaigns, increased provider participation, and enhanced prenatal care services. Some states have used the media to create a new image for their Medicaid program, giving it such names as "Baby Love" in North Carolina and "Baby Your Baby" in Utah. Some states have tried to improve provider participation by enhancing reimbursement, simplifying billing procedures, and initiating the use of alternative providers. At least 21 states raised provider fees between 1987 and 1990, although their changes may have only stabilized, rather than improved, provider participation. States with enhanced prenatal care programs often include care coordination services addressing the needs of participants at a single location (33 states as of July 1990). Other services include nutritional counseling (24 states), health education (23 states), and risk assessment programs (30 states).

A U.S. General Accounting Office report released in February 1991 analyzed the effectiveness of Medicaid expansions in 10 states that have had programs in place for at least 2 years. In the eight states that had usable Medicaid enrollment data, participation among pregnant women had increased markedly. Between two-thirds and three-quarters of the target population were enrolled within two years. However, budget shortages have cut short many state expansions. Without additional federal funds or state revenues, further expansion of these programs is unlikely.[8]

Outlook for the Future

The 102nd Congress continues to discuss Medicaid expansion and reform. Legislation has been introduced that would expand Medicaid eligibility to pregnant women and children with incomes up to 185 percent of the federal poverty level. However, the majority of recent congressional health reform proposals have called for systemic reform of the health care delivery system or small group insurance market reform rather than Medicaid-specific action. Many states do not support Medicaid expansion efforts because they are unable to pay for those expansions already enacted. Medicaid expenditures accounted for 12 percent of states' budgets, on average, in 1990, up from 10.8 percent in 1988.

Recent Medicaid expansions may improve the health status of low-income pregnant women and, therefore, reduce the percentage of infants born at low birth weight and the infant mortality rate. However, the effectiveness of improved access cannot be determined until data are available for pregnancy outcomes during several years following the July 1991 effective date of the most recent reforms.

A significant number of factors contribute to women's health, low birth weight, and infant mortality. For example, women with inadequate diets and those dependent on alcohol or other substances are more likely to give birth to low birth weight infants. In addition, interrelated factors such as poverty, lack of education, and teenage pregnancy adversely affect infant mortality. Educating women about the importance of early prenatal care; addressing the social problems of substance abuse, inadequate diets, and pregnancy among young women; and improving physician reimbursement levels to ensure that Medicaid beneficiaries have access to medical providers may improve the health of pregnant women and their infants in the future.

—Jill Foley, EBRI

◆ 1991 Social Security and Medicare Annual Reports Revise Insolvency Projections

The projected date of insolvency for Old-Age and Survivors Insurance (OASI) and Disability Insurance (DI) trust funds (which together form OASDI, or Social Security) has been moved to the year 2041 from the year 2043, according to the 1991 annual report issued by the funds' board of trustees. Although possible shortfalls in the DI trust fund may require a reallocation of funds within the next 10 years from the OASI trust fund, the trustees state that the OASI fund is stable enough that such a transfer would not jeopardize the program. The trustees expect the combined OASDI funds' assets to continue growing well into the 21st century.

The board of trustees for the Medicare Hospital Insurance (HI) fund moved the projected date of insolvency for the HI trust fund to the year 2005 from the year 2003,

[8]U.S. General Accounting Office, *Prenatal Care: Early Success in Enrolling Women Made Eligible by Medicaid Expansions* (Washington, DC: U.S. Government Printing Office, 1991).

Table 3
Projected Year of Trust Fund Exhaustion, by Alternative Sets of Assumptions, in the 1990 and 1991 Reports of the Board of Trustees of the Old-Age and Survivors Insurance, Disability Insurance, and the Hospital Insurance Trust Funds

	OASI		DI		OASDI Combined		HI	
Assumption	1990	1991	1990	1991	1990	1991	1990	1991
Alternative I (optimistic)	a	a	a	a	a	a	2018	2018
Alternative II[b] (intermediate)	2046	2045	2020	2015	2043	2041	2003	2005
Alternative III (pessimistic)	2027	2026	1998	1997	2023	2022	1999	2001

Source: U.S. Department of Health and Human Services, Social Security Administration, *1990 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds* and *1991 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds* (Washington, DC: U.S. Social Security Administration, 1990, 1991). U.S. Department of Health and Human Services, Health Care Financing Administration, *1990 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund* and *1991 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund* (Washington, DC: Health Care Financing Administration, 1990, 1991).
[a]Not projected to be exhausted within the projection period.
[b]The 1990 report used two sets of intermediate assumptions—the II-A and II-B assumptions. The II-B assumptions from the 1990 report are cited here.

according to the 1991 annual report (table 3). The fund is expected to experience shortfalls in the near term.

Revised Methodology for 1991 Reports

The 1991 trust fund reports are based on several revised methodologies from those used in the 1990 reports.[9] The 1990 projections were based on four sets of actuarial (economic and demographic) assumptions: optimistic alternative I, intermediate alternatives II-A and II-B, and pessimistic alternative III. The 1991 reports replaced the intermediate alternatives II-A and II-B assumptions with one set of intermediate alternative II assumptions.[10] In addition, the 1991 reports use a revised test for the short- and long-term financial adequacy of both the individual and combined trust funds. An individual trust fund satisfies the stricter test for short-term financial adequacy if, over a 10-year period, its assets at the end of each year are large enough to cover the estimated expenses for the following year.[11] The revised test to determine the trust funds long-term financial condition (75-year period) is also stricter than that used in previous years. Finally, the methodology used to generate the economic assumptions has been changed.

Social Security OASDI Trust Funds

Social Security (OASDI) is a work-related program in which wage and salary workers in Social Security covered occupations, their employers, and the self-employed make contributions based on wages and earnings (6.2 percent of payroll for employers and employees each) up to the annual maximum taxable wage base ($51,300 in 1990).[12] Employee contributions are automatically withheld from wage and earnings payments, and employers make a matching contribution. Payroll tax contributions, which are automatically deposited in the OASDI trust funds, are used primarily for retirement and disability benefit payments to eligible beneficiaries.[13]

According to the 1991 report, during calendar year 1990 the OASI trust fund accumulated $59.1 billion, and the DI trust fund accumulated $3.2 billion, resulting in

[9]Changes in methodology are based on the recommendations of the Social Security Panel of Technical Experts of the 1991 Advisory Council on Social Security and a board of trustees working group.
[10]Referred to hereafter as the optimistic, intermediate, and pessimistic assumptions.
[11]A trust fund may also qualify if its year-end assets fall short of covering its expenses for each of the first five years as long as the assets are expected to be at or above 100 percent of annual expenses for the sixth through the tenth year of the evaluation period. Failure to meet these short-term criteria indicates that changes in the program must be made in order to ensure that the program maintains short-term adequacy.
[12]The maximum taxable wage base rose to $53,400 in 1991. It is indexed to rise automatically at the beginning of each calendar year with increases in average wages.
[13]For a more detailed description, see Michael Anzick, "Financing Social Security Retirement into the 21st Century," *EBRI Issue Brief* no. 109 (Employee Benefit Research Institute, December 1990).

Table 4

Operations of the Combined OASDI Trust Funds, Based on the Intermediate Alternative II Sets of Assumptions, According to the 1990 and 1991 OASDI Board of Trustees Reports, Calendar Years 1990–2000

Calendar Year	Income 1990[a]	Income 1991	Disbursements 1990[a]	Disbursements 1991	Net Fund Increase 1990[a]	Net Fund Increase 1991	End-of-Year-Balance 1990[a]	End-of-Year-Balance 1991	Difference in End-of-Year-Balance
					(in $ billions)				
1990	$316.3	$315.4[b]	$253.5	$253.1[b]	$62.7	$62.3[b]	$225.7	$225.3[b]	$ 0.4
1991	341.7	330.1	270.8	273.4	70.9	56.7	296.7	281.9	14.8
1992	367.5	354.7	288.5	292.4	79.0	62.3	375.7	344.2	31.5
1993	394.9	379.6	306.8	310.1	88.1	69.5	463.8	413.8	50.0
1994	424.0	407.7	325.6	328.1	98.4	79.6	562.1	493.3	68.8
1995	453.9	435.6	345.1	346.8	108.8	88.7	671.0	582.1	88.9
1996	486.4	466.7	364.9	366.6	121.5	100.1	792.5	682.2	110.3
1997	520.3	498.8	386.1	387.5	134.2	111.2	926.6	793.4	133.2
1998	556.6	533.2	408.7	410.0	147.9	123.2	1,074.5	916.6	157.9
1999	595.0	569.8	433.1	434.2	161.9	135.6	1,236.4	1,052.2	184.2
2000	632.2	609.5	458.8	460.0	173.4	149.5	1,409.9	1,201.7	208.2

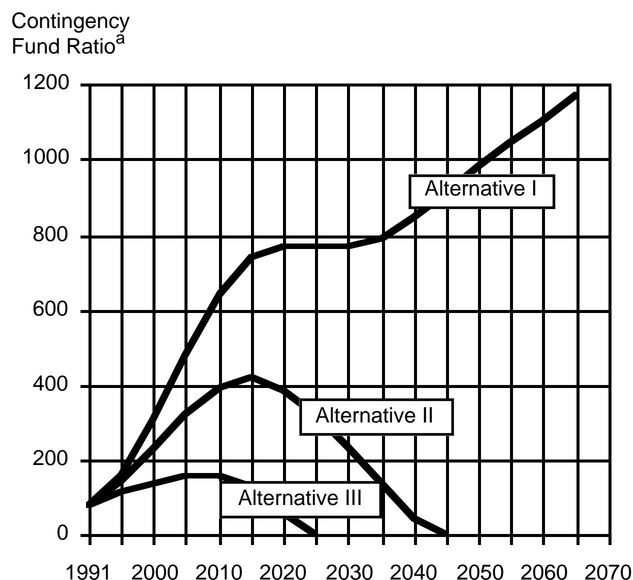
Source: U.S. Department of Health and Human Services, Social Security Administration, *1990 Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds* and *1991 Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds* (Washington, DC: U.S. Social Security Administration, 1990, 1991). EBRI tabulations of these data.
[a]The 1990 report used two sets of intermediate assumptions—the II-A and II-B assumptions. The II-B assumptions from the 1990 report are cited here.
[b]Actual data.

combined assets of $225.3 billion at year-end (table 4). The accumulations for 1989 were $52.2 billion in the OASI trust fund and $1.0 billion in the DI trust fund, with assets of $163.0 billion. These funds have been growing since the enactment of the 1983 Social Security Amendments, which increased OASDI payroll taxes. The board of trustees reduced the OASDI fund's projected short-term (10-year) growth estimate, mainly as a result of the 1990 economic recession (table 4). Projections are for growth to continue into the next century and then decline during the years when the baby boom generation is retiring.

Projected Growth—The contingency fund ratio is the amount of funds in the trust funds in the beginning of a year divided by the projected expenditures for that year. For example, if the contingency fund ratio is 100 percent, there are sufficient funds to cover expenses for an entire year. Under all three assumptions, the combined OASDI trust funds are projected to grow steadily over the short term (the next 10 years). Long-term projections differ under all three assumptions. According to the intermediate assumptions, the OASDI contingency fund ratio will peak at 408 percent (enough to cover expenses for more than four years) in 2015 and fall below 8 percent to 9 percent (the amount required to pay benefits at the beginning of each month) in 2041,

Chart 1

Ratio of Assets to Disbursements in Combined OASDI Trust Funds, by Alternative Assumptions, 1991–2065



Source: U.S. Department of Health and Human Services, Social Security Administration, *1991 Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds* (Washington, DC: U.S. Social Security Administration, 1991).
[a]Represents assets at the beginning of the year as a percentage of disbursements during the year.

leading to the funds' exhaustion. The pessimistic assumptions indicate that the contingency ratio will peak at 160 percent in 2010, and the trust funds will become depleted by 2022. In contrast, the optimistic assumptions indicate that the contingency fund ratio will continue to grow through 2065—the last year in the projection period (chart 1).

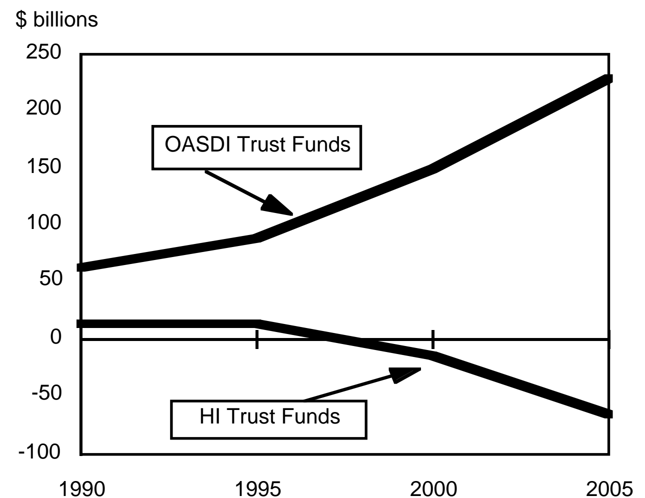
Medicare HI Trust Fund

The Medicare program consists of Hospital Insurance (HI) (Part A) and Supplemental Medical Insurance (SMI) (Part B). Part A pays for acute health care expenditures (primarily hospital care and skilled nursing care). In addition, Part A is an entitlement program for Social Security recipients aged 65 and older, anyone receiving Social Security disability benefits for at least two years, and certain persons with chronic kidney disease. Like the OASDI trust funds, the HI trust fund is funded with a payroll tax on current workers and employers (1.45 percent of payroll on employers and employees each, up to a maximum wage base ($51,300 in 1990)).[14] The self-employed contribute 2.9 percent of earnings.[15]

In calender year 1990, the HI trust fund accumulated $13.4 billion, ending the year with a balance of $98.9 billion. In comparison, in calendar year 1989, the trust fund accumulated $15.9 billion and ended the year with a balance of $85.6 billion.

Projected Shortfalls—In contrast to the projected growth in the OASDI trust funds, the HI trust fund is projected to experience shortfalls in the short term. The intermediate assumptions indicate that the HI trust fund contingency fund ratio will peak at 161 percent in 1995 and steadily decrease thereafter, falling to 8 percent in 2005, resulting in the trust fund's depletion in that year. Under the pessimistic assumptions, the contingency fund ratio is projected to peak at 146 percent in 1993, with depletion of the trust fund in 2001. Based on the optimistic assumptions, the trust fund will remain solvent through the year 2018.

Chart 2
Projected Net Fund Increase of the OASDI Trust Funds and the HI Trust Fund, Based on the Intermediate Alternative II Assumptions, Selected Years, 1990–2005[a]



Source: U.S. Department of Health and Human Services, Social Security Administration, *1991 Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds* (Washington, DC: U.S. Social Security Administration, 1991). U.S. Department of Health and Human Services, Health Care Financing Administration, *1991 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund* (Washington, DC: Health Care Financing Administration, 1991).
[a]HI trust fund projected year of exhaustion.

Conclusion

The OASDI trust funds are projected to continue accumulating sizable reserves into the middle of the 21st century, while the Medicare HI trust fund is projected to become depleted in 14 years. In calendar year 2005, net fund increases in the combined OASDI trust funds are projected to amount to nearly $230 billion, while the HI trust fund is projected to experience a net fund decrease of nearly $66 billion (chart 2). This possibility has motivated some policymakers to suggest that a portion of the OASDI trust funds be shifted to the HI trust fund to avoid short-term insolvency.

—Michael Anzick, EBRI

[14]The maximum taxable wage base rose to $125,000 in 1991 as a result of a provision of the Omnibus Budget Reconciliation Act of 1990. It is indexed to rise at the beginning of each calendar year with increases in average wages.

[15]Participation in Medicare Part B is voluntary. It provides insurance coverage for physician services and outpatient medical care as well as some hospital services not paid by Medicare Part A. The SMI trust fund is funded with enrollee deductibles and monthly premiums and general revenues from the federal budget. For more detailed information about HI and SMI, see Michael Anzick, "The Medicare Program and Its Role in the U.S. Health Care System," *EBRI Issue Brief* no. 115 (Employee Benefit Research Institute, June 1991).

Editor's note: For information on ordering a copy of the *1991 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Trust Funds* and the *1991 Annual Report of the Board of Trusteees of the Federal Hospital Insurance Trust Fund*, see the New Publications listing on page 10.

◆ Americans Expect to Have More Than 20 Years of Retirement, EBRI/Gallup Survey Shows

Americans said they expect to have, on average, 23 years of retirement, according to a recent survey by EBRI and The Gallup Organization, Inc. Nonretired Americans said they plan to retire at a median age of 62, and those already retired said they did so at a median age of 60.

"Twenty-three years is a very long time to support oneself while not working," said Dallas Salisbury, EBRI president. "Inflation, escalating health care costs, and unexpected expenses put a premium on having enough savings throughout retirement to maintain the standard of living you grew accustomed to while working. Personal savings and employment-based economic security programs can make the difference between having adequate income in retirement or not," Salisbury said.

Two out of three (66 percent) of nonretired respondents said they have started to save for their retirement. A similar EBRI/Gallup survey conducted in 1990 showed almost the same result—69 percent of nonretired respondents indicated they were already saving for retirement. Respondents to the 1991 survey most likely to have already started saving include those between the ages of 35–54 (78 percent), those with annual incomes of $75,000 or more (79 percent), and married individuals (76 percent). Respondents most likely not to have started saving include those with incomes less than $20,000 (63 percent), minorities (49 percent), and those who are not married (49 percent). On average, retired and nonretired respondents already saving for retirement said they started to do so at age 31.

Respondents said personal savings are their most common type of individual retirement savings vehicle (41 percent), followed by individual retirement accounts (IRAs) (20 percent) and 401(k) plans (19 percent).

Also among the nonretired respondents, about one-half (47 percent) said they or their spouse participate in an employer-sponsored pension plan.

While one-half of nonretired respondents (53 percent) said they or their spouse is eligible to make a tax-deductible contribution to an IRA, only 18 percent made such a contribution in the last year.

About one-half of nonretired respondents (47 percent) said their or their spouse's employer offers a pretax retirement savings plan. Respondents with high incomes were most likely to say they have such a plan available—53 percent of those with annual incomes of $75,000 or more and 56 percent of those with annual incomes between $20,000–$74,999, compared with 24 percent of those with annual incomes less than $20,000. Of those respondents who contribute to a pretax retirement savings plan, the median contribution is 5 percent of their pay.

Two-thirds (66 percent) of nonretired respondents whose employers did not offer a pretax savings plan said they would contribute to such a plan if one were available to them. The median contribution these respondents said they would make was 7 percent of their pay.

When nonretired, employed respondents were asked what they would do if they left their job today and received a lump-sum distribution from their pension plan equal to three months pay, 45 percent said they would use it for retirement savings. Seventeen percent said they would spend it on current needs, and 36 percent said they would use it for both purposes. EBRI data about individuals' use of preretirement lump-sum distributions show that few lump-sum recipients save their cashouts in an IRA or other tax-qualified plan. Detailed information is available in EBRI Special Report SR-7, *Preserving Portable Pensions: An Analysis of Pension Participation at Current and Prior Jobs, Receipt and Use of Preretirement Lump-Sum Distributions, and Tenure at Current Job.*

The 1991 survey on retirement age and planning was conducted in May and is the twenty-fourth in a series of national public opinion surveys EBRI is undertaking on public attitudes toward economic security issues. The surveys are conducted monthly for EBRI by The Gallup Organization, Inc., which questions 1,000 Americans by telephone. The maximum expected error range at the 95 percent confidence level is ±3.1 percent.

Copies of *Public Attitudes on Retirement Age and Planning, 1991* (#24) and EBRI *Special Report SR-7* can be ordered from Kimberly Thorpe, (202) 775-6315 for the following prices: Gallup Survey #24, summary—$75, full report—$275; EBRI member prices: summary—$25; full report—$75; SR-7—$25 per copy. EBRI member prices: first copy—free, additional copies—$25.

—Carolyn Piucci, EBRI

◆ Washington Update

Shortly before adjourning for its August recess, key policymakers introduced several comprehensive proposals regarding health care reform, insurance solvency, long-term care, and Social Security. In addition, Congress continued to grapple with issues surrounding pension simplification and ERISA preemption.

Health Care Reform—House Ways and Means Chairman Dan Rostenkowski (D-IL) introduced Aug. 2 a bill (H.R. 3205) that would require employers to provide basic health insurance coverage to all employees and dependents or pay an excise tax based on a percentage of wages. The bill is similar to legislation (S. 1227) introduced in June by Senate Democratic leaders, but the House bill would set a mandatory national limit on health expenditures, whereas the Senate bill would make annual health expenditure targets voluntary.

Insurance Solvency—Sen. Howard Metzenbaum (D-OH) introduced Aug. 2 the Insurance Protection Act of 1991 (S. 1644). The bill would establish an independent Insurance Regulatory Commission (IRC), similar to the Securities and Exchange Commission, that would set national minimum solvency standards. States would be accredited based on their adoption and implementation of these minimum standards, which would address areas relating to capital and surplus requirements, consumer disclosure, investment limits, and regulatory resources. The bill would also create a national guaranty fund, which would be funded by preinsolvency assessments against all insurance companies operating in interstate commerce.

Long-Term Care—Legislation (S. 1693) clarifying the tax treatment of private long-term care insurance and benefits was introduced Aug. 2 by Sens. Lloyd Bentsen (D-TX), Bob Packwood (R-OR), David Pryor (D-AR), Robert Dole (R-KS), and John Chafee (R-RI). The bill would provide that certain services (defined as "qualified long-term care services") that are provided to chronically ill individuals would be treated as medical care for purposes of the medical expenses' deduction. In addition, the bill provides that, for tax purposes, long-term health insurance contracts and employer-sponsored plans would be treated as accident and health insurance plans. The bill also contains consumer protection standards.

In addition, Sens. Packwood and Dole introduced separate legislation (S. 1668) that would establish a federal program to provide long-term care services to low-income elderly.

Social Security—Rep. Rostenkowski introduced July 10 legislation (H.R. 2838) to increase the Social Security taxable wage base to a projected $72,600, amounting to a $3,000 increase over a phased-in period. In addition, the bill would increase the Social Security earnings limit by $3,000 for retirees aged 65–69.

Pension Simplification—Treasury's Assistant Secretary for Tax Policy Ken Gideon told a House panel July 25 that the Bush administration supports the enactment of Rep. Rostenkowski's pension simplification legislation (H.R. 2370). At the hearing, the House Ways and Means Subcommittee on Select Revenue Measures examined Rostenkowski's bill and other pension bills, including those introduced by Reps. Rod Chandler (R-WA)(H.R. 2641), Ben Cardin (D-MD)(H.R. 2742), Barbara Kennelly (D-CT)(H.R. 1735), and Sam Gibbons (D-FL)(H.R. 2390). The panel heard testimony from nearly 20 witnesses who expressed both support and opposition for specific provisions of the legislation. Another hearing is scheduled for Sept. 16. In addition, the Senate Finance Subcommittee on Taxation will hold hearings Sept. 10 and 12 on tax simplification proposals, including the Pryor/Bentsen bill (S. 1364).

ERISA Preemption—At a hearing before the House Education and Labor Subcommittee on Labor-Management Relations, Rep. Howard Berman (D-CA) urged the enactment of his legislation (H.R. 1602, H.R. 2782) clarifying that ERISA does not preempt certain state laws. Berman said it was never the intention of Congress for ERISA to "preempt certain critically important state laws and leave a vacuum in their wake." But insurance industry and business representatives disagreed, arguing

that the intention of Congress was to achieve national, uniform regulation of employee benefits.

—Nora Super Jones, EBRI

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