notes

EMPLOYEE BENEFIT RESEARCH INSTITUTE

JANUARY 1992 VOLUME 13 NUMBER 1

◆ Politics and Employee Benefits: What to Expect in 1992

Congress went out for the year with barely a whimper, leaving much significant legislation still pending at the end of 1991—a year in which rhetoric was more in evidence than action. This year may bring more of the same, but the dynamics of a presidential election year promise to raise issues to a more visible and audible level.

The recent upset victory of Pennsylvania Senator Harris Wofford, who campaigned against the Washington establishment, served as a wake-up call to President Bush and all political incumbents. The anti-incumbency mood is very strong, according to political analysts, and could potentially put many members of Congress in jeopardy of losing their seats. Criticized for being ineffective (not to mention arousing public disgust over bounced checks, free parking tickets, and the Senate confirmation hearings for Supreme Court Justice Clarence Thomas), current members of Congress may feel hard pressed to enact some meaningful legislation before confronting voters on Election Day. Moreover, state redistricting plans have virtually rewritten political maps, leaving many powerful incumbents vulnerable at home. Political analysts predict that 1993 will bring in 80–100 new members of Congress.

Coupled with the desire to save their own seats, congressional Democrats will also strive to gain the advantage in presidential election issues. Policymakers on both sides of the aisle may have more to gain by distancing themselves from each other than by reaching consensus. Politics will almost certainly override substance in 1992, making it critical to understand which way the political tide is moving in order to assess the likelihood for enactment of significant employee benefits legislation.

Health Care Reform

Health care reform issues are likely to dominate policy debate in 1992. During 1991, policymakers offered numerous proposals aimed at reforming the U.S. health care system. Advocates of reform seized upon a variety of approaches, including play-or-pay, single-payer, and incremental small group insurance market reform.

In anticipation that voters will want to see solutions, attaching oneself to a particular proposal has become a political necessity. The Senate Democratic leadership advocates the play-or-pay approach, which requires employers to provide health insurance to their employees or pay a tax into a special fund to finance a public plan. Senate Republicans encourage market reforms, including tax credits, malpractice reform, small group insurance market reform, and incentives for managed care. House Democrats are still working on a plan, and a small group of House Republicans, led by Reps. Nancy Johnson (R-CT) and Rod Chandler (R-WA), have proposed strengthening incentives for managed care plans as well as small group reforms. The difficult challenge for policymakers is to find a proposal that can effectively control costs while simultaneously expanding access. According to public opinion surveys, rising costs and benefit security are the critical issues.

The most politically viable health legislation for 1992 was put forth by the chairmen of the tax-writing committees. Senate Finance Committee Chairman Lloyd Bentsen (D-TX) introduced legislation (S. 1872) to reform the small group health insurance market. The bill would establish minimum standards that would guaran-

In This Issue

tee the availability of insurance for small groups. Specific provisions would restrict variation in premiums and limit preexisting condition exclusions, among other proposed changes.

House Ways and Means Chairman Dan Rostenkowski (D-IL) also introduced a small group reform proposal (H.R. 3626) that contains many provisions identical to those in the Bentsen bill.[1] However, Rostenkowski's bill has three key distinctions. First, it would allow purchasers of all sizes (i.e., insurers, individuals, and employer plans) to pay provider services based on payment rates to be established by the U.S. Department of Health and Human Services. Second, the small group reform standards required by the bill would be established and enforced by the federal government. Third, the bill would require all small group plans to be community rated, with adjustments only for age and sex differences.

Policymakers and insurance industry advocates generally agree that small group reform is needed and desirable, although details of the various proposals would need to be reconciled. Even President Bush, who to date has been largely silent on the health care issue, has indicated a willingness to enact small group reform measures.

Regarding President Bush, his actions relating to health care will be critical to the debate. Congressional Democrats have worked hard to seize the issue as their party's own. Senate Democrats held a series of public hearings across the nation on health care reform in December. House Democrats have planned 200 town meetings to be held Jan. 14 focusing on health care reform. Feeling heat from the GOP, President Bush is expected to unveil his own proposal in his State-of-the-Union address on Jan. 28.

President Bush is likely to advocate an incremental approach to health care reform, calling for small group insurance reform, preemption of state mandated benefits, malpractice reform, expansion of community health centers, expansion of managed care and preventive care, and lower administrative costs through electronic data collection. One of the more controversial proposals that Bush is reportedly considering would either limit employers' tax exclusion for health benefits or cap the employees' tax exemption attributable to group health benefits. The administration plan would use the revenue gained from this provision to pay for credits and vouchers for the purchase of health insurance by low-income individuals and families.

It is still unclear how much detail President Bush will release with his proposal. If he offers little detail, he's likely to be criticized for not being serious. If he provides great detail, he's open to criticism by those who don't like his choices.

The strategy for action on the various reform proposals is still being worked out by Democrats and Republicans. In the interest of achieving some change in the near-term, Congress and the White House may produce a bipartisan small group reform proposal, which could be enacted before the election. On the other hand, Democrats are reportedly considering pushing through a comprehensive reform proposal, such as play-or-pay, and daring the President to veto it. If Bush does, Democrats would attempt to effectively use this action against him during elections. However, the plan could backfire. If the Democrats solidly back a single plan, it could serve as a target for Bush to shoot holes through.

For the most part, Republicans seem to want to move slowly on comprehensive reform proposals. Conventional wisdom holds that Americans want significant reform until they find out they have to pay for it—a view that seems to be supported by public opinion surveys. Proponents of this view point to the repeal of the Medicare Catastrophic Coverage Act of 1988 as a classic example. The law expanded Medicare to cover catastrophic medical expenses and other benefits such as prescription drug costs. To pay for the expansion, it imposed a supplemental premium on beneficiaries based on income tax liability. After intense public outcry from the middle- and upper-income elderly who would have paid the premium, Congress repealed the law in 1989.

Targeted changes such as small group reform generally have broad support. Moreover, such proposals have great appeal because they would have little effect on the federal budget deficit. Thus, it seems that if any health care legislation is enacted in 1992, small group reform measures are the most likely.

ERISA Preemption

Another issue that gained attention in 1991 relates to the preemption of state laws by the Employee Retire-

[1]For a complete description of the Bentsen and Rostenkowski small group reform proposals, see EBRI's *Benefit Outlook*, November 1991, pp. 12–13.

ment Income Security Act of 1974 (ERISA). Legislation (H.R. 1602) proposed by Rep. Howard Berman (D-CA) would restore state laws covering unfair denials of insurance claims. In effect, the bill would overturn a landmark U.S. Supreme Court decision (*Pilot Life v. Dedeaux*) that said benefit plans covered by ERISA are not subject to damages (e.g., punitive) based on state statutory and common law causes of action.

The bill had advanced through subcommittee approval, but it was halted before it reached full committee consideration. House Labor-Management Relations Subcommittee Chairman Pat Williams (D-MT) said he delayed action on the bill because a few insurers had offered alternative proposals. However, some observers have said politics came into play as well. Williams faces a tough election and had recently received bad press on the legislation in his hometown newspaper.

Nonetheless, a few alternatives have been put forth. In general, the alternatives seek to enhance remedies under ERISA rather than restore state laws.[2] Specific ERISA amendments that have been suggested relate to mandatory attorneys' fees and alternative dispute resolution.

As currently written, H.R. 1602 purports to apply solely to insurance companies and not to self-insured health plans. However, most of the alternatives would also apply to self-insured plans. In addition, a recent appellate court decision held that employers that self-insure may change or sharply reduce health care coverage for workers who develop expensive illnesses such as AIDS. This recent development is likely to add weight to arguments calling for the inclusion of self-insured plans in any ERISA reform.

Opponents of H.R. 1602 say that providing for the recovery of punitive damages under ERISA plans would result in increased health care costs as insurers look to recoup their losses through higher premiums. In any case, ERISA preemption legislation seems destined to be considered in the context of overall health care reform rather than as a stand-alone issue.

Middle-Income Tax Relief

Policymakers entering an election year have begun to focus on the needs of the "forgotten" middle-class. Proposals abound on ways to provide tax relief to middle-income taxpayers and to jump start the economy. Policy discussions in 1992 will likely center on a tax bill, which could serve as a vehicle for a number of employee benefit initiatives.

A significant number of the proposals contain provisions to expand individual retirement accounts (IRAs) and to allow penalty-free withdrawals from IRAs and 401(k) plans for first-time home purchases and tuition assistance. Such proposals are likely to be included in the final tax package in 1992.

In addition, Congress will consider a group of 12 tax provisions that are scheduled to expire on June 30, 1992. Over the past few years, these provisions have been packaged together and extended for limited periods of time because of revenue considerations. Those relating to employee benefits include the exclusions for employer-provided education assistance and group legal services and the 25 percent deduction for the health insurance costs of self-employed individuals.

Policymakers seem tired of addressing these provisions year after year. Bentsen and Rostenkowski have promised to hold hearings in 1992 to consider which tax extenders should be made permanent and which should be allowed to expire. Since most of the major health care reform proposals contain provisions extending or expanding the deduction for health insurance costs of self-employed individuals, this provision seems secure. But it is too soon to tell about the remaining provisions. Each of the 12 have advocates in Congress, but not all will be extended. The hearings should give a better indication of their ultimate fate.

Family Leave

Family leave issues are also likely to heat up during an election year. While a family leave bill was passed by both houses of Congress in 1991, the House of Representatives failed to secure the necessary votes to override a presidential veto. The bill has yet to be presented to President Bush. Democrats will likely wait for the politically opportune moment to make sure the outcome plays to their advantage. While President Bush has indicated that he will veto the legislation because of his opposition to mandates of any kind, some observers have questioned whether that commitment will remain as strong with John Sununu gone from the White House.

[2]See EBRI's *Benefit Outlook*, January 1991, p. 9, for further details on alternatives to H.R. 1602.

New Chief-of-Staff Sam Skinner is viewed as being more moderate on social issues and may persuade the President that the potential for alienating some voters may be too great a risk in an election year.

Retirement Security

Issues surrounding retirement security are likely to be lower on the priority list for public debate during this election year, but enactment of pension simplification and expansion legislation may have a good chance if it is folded into an omnibus tax bill.[3] In 1991, opponents of the repeal of five-year forward averaging for lump-sum distributions—a provision included in the three competing pension simplification proposals—were successful in creating enough controversy to cause policymakers to be wary of enacting the legislation in spite of its merits. However, the proposals do have the support of both chairmen of the tax-writing committees and the Bush administration, making them likely to be included in a comprehensive tax bill.

Moreover, the Treasury Department estimates a $3 billion revenue increase over five years if proposed changes to the distribution rules (including repeal of 5- and 10-year forward averaging, favorable capital gains treatment for lump-sum distributions, and the exclusion for net unrealized appreciation of employer stock) are enacted. This money could prove very attractive, either to pay for pension simplification or something else. In addition, now that the Treasury Department and the Labor Department have issued final regulations for most of the pension legislation enacted since 1974, the regulatory agencies can focus more fully on ERISA enforcement issues and pension simplification.

The Bush administration recently unveiled a proposal to strengthen the bankruptcy priority status of the Pension Benefit Guaranty Corporation (PBGC).[4] The legislation faces a number of political hurdles. It must pass through three separate congressional committees in both chambers before it reaches the floor for a vote. Furthermore, its goals conflict with those of other unsecured creditors. In addition, the legislation does not have a strong political constituency supporting its enactment. The business community remains somewhat ambivalent on the issue. While pension plan sponsors (with well-funded plans) could definitely benefit by avoiding a potential premium increase that may occur if PBGC does not improve its deficit, some may fear that they may also be in line as a creditor during bankruptcy proceedings, with PBGC recovering a large portion of available assets.

In addition, many believe that Congress typically does not act on a situation to avoid a crisis; rather it generally waits for the crisis and then reacts. If current conditions persist, PBGC expects to receive less incoming premium income than it pays out in benefits in 1992. However, due to favorable investment returns, the agency does not anticipate a negative cash flow until the end of the decade. With that in mind, policymakers will probably look to issues with more political appeal in 1992.

The same holds true for insurance solvency issues. The collapse of Executive Life Insurance Co. and Mutual Benefit of New Jersey sent policymakers scrambling for solutions in 1991. Countless hearings were held to assess the financial health of the life insurance industry and what a collapse meant to annuitants and policyholders. But now that the dust has settled and it appears that beneficiaries will receive adequate recoveries, the issue no longer seems urgent. Although a few proposals calling for federal minimum solvency standards were proposed in 1991, Congress seems likely to proceed in a cautious manner. Staff members of the House Energy and Commerce Committee have indicated that Chairman John Dingell (D-MI) foresees the enactment of federal insurance standards as a long-term goal to be completed over several years. However, all bets are off if another major insurer collapses in the near term.

Conclusion

Election year dynamics will guide the 102nd Congress and the Bush administration in 1992. In addition to the political maneuvering that will hamper their ability to legislate, lawmakers will also be on the road more in 1992 (and therefore out of Washington) working on their respective campaigns. Thus, the probability that significant legislation will be enacted seems low.

However, faced with a disgruntled electorate, members of Congress may feel pressured to act to prove their worth. A major tax bill is likely and, as previous years have

[3]For an in-depth analysis of the various pension simplification proposals, see "Pension Simplification, Access, and Preservation: Will Pending Proposals Achieve Goals?," *Employee Benefit Notes* (September 1991): 1–7.

[4]For further details on the PBGC bankruptcy legislation, see EBRI's *Benefit Outlook*, January 1991, p. 4.

shown, that means just about anything could happen. At the very least, 1992 should prove to be more interesting than 1991.

—Nora Super Jones, EBRI

◆ Single Parent Families, Poverty, and Health Insurance Coverage

Changes in Family Structure—Policy Implications

While the traditional family of husband and wife living in one household—either with or without children—remains the most common family type, it has declined as a proportion of all families from 50 percent in 1970 to 39 percent 1991. At the same time, the proportion of families with a single parent has grown from 7 percent to 13 percent. Other family types without children comprise the remaining 48 percent of families. The large majority (85 percent) of single parent families are headed by women. Individuals in these families often live in poverty, and many do not receive adequate health insurance protection from either public or private programs.[5]

While only 7 percent of married couple families and 18 percent of individuals without children were living in poverty in 1991, 47 percent of those in female headed single parent families were living in poverty (table 1). An additional 25 percent of single parent families headed by women had income between the poverty line and twice the poverty line. Single parent families with a male head of household were much less likely than their female counterparts to fall under the poverty line.

Many single parents find it difficult to work because they cannot earn enough money to pay for both child care and household expenses. Two-thirds of women heading single parent families were employed in 1991, although less than one-half were employed full-time year round (table 1). Recent survey data show that child care costs amount to 21 percent to 25 percent of income for low-income households that pay for care.[6] Average earnings for women (who make up the large majority of single parent family heads) are lower than they are for men. In addition, occupations traditionally filled by women are less likely to provide health insurance coverage.

[5]The official federal poverty threshold for a family of three in 1990 was $9,587. Poverty levels are adjusted by family size and by location.

[6]U.S. Department of Commerce, Bureau of the Census, *Who's Minding the Kids? Child Care Arrangements: Winter 1986–1987*, Current Population Reports, Series P-70, no. 2 (Washington, DC: U.S. Government Printing Office, 1990).

Table 1
Nonelderly Population with Selected Family Types by Work Status of the Family Head and Poverty Rate, 1991

		Family Type				
		Married—with or without children	Single no children	Single parent families		
	Total			Total	male head of household	female head of household
				(millions)		
Total	218.8	153.2	37.7	28.0	4.1	23.9
Percentage of Selected Family Types	100%	70%	13%	17%	2%	11%
Percentage within Family Groups	100%	100%	100%	100%	100%	100%
Work Status of Family Head						
Full–year, full–time worker	72	80	58	44	68	40
Other worker	18	15	23	28	24	28
Nonworker	10	5	19	28	8	32
Poverty Rate						
Under 50%	6	2	8	22	7	24
50%–74%	4	2	5	13	5	14
75%–99%	4	3	5	9	5	9
100%–199%	18	16	20	25	28	25
200% or more	69	77	63	32	55	28

Source: EBRI tabulations of the March 1991 Current Population Survey.

Table 2
Percentage of State Populations Below Poverty, Percentage Receiving Aid to Families with Dependent Children (AFDC) and Medicaid, Annualized AFDC Eligibility Thresholds,[a] and Percentage without Health Insurance

	Percentage of Nonelderly Residents Who Are Poor	AFDC Maximum Income for Family of Three (July 1991)		Percentage of Nonelderly Receiving AFDC	Percentage of Nonelderly Receiving Medicaid	Percentage of Nonelderly without Health Insurance
		Threshold	Percentage of poverty			
Alabama	19%	$ 1,488	13.4%	7%	11%	20%
Alaska[b]	12	10,692	76.8	7	18	17
Arizona	14	4,008	36.0	4	6	19
Arkansas[c]	19	2,448	22.0	4	9	21
California[c]	15	8,328	74.8	9	13	22
Colorado	14	5,052	45.4	7	8	17
Connecticut	6	6,972	62.6	6	6	8
Delaware	7	4,056	38.4	5	5	16
District of Columbia[c]	21	4,908	44.1	11	15	24
Florida[c]	15	3,528	31.7	6	9	22
Georgia[c]	15	5,088	45.7	7	11	17
Hawaii[b,c]	11	7,992	62.4	5	7	8
Idaho	15	3,780	33.9	4	6	18
Illinois[c]	14	4,404	39.5	9	11	13
Indiana	13	3,456	31.0	6	7	13
Iowa[c]	11	5,112	46.9	5	8	10
Kansas[c]	11	4,752	42.7	4	6	13
Kentucky[c]	17	6,312	56.7	6	10	16
Louisiana[c]	24	2,280	20.5	7	12	22
Maine[c]	14	7,624	70.2	7	11	13
Maryland[c]	10	4,872	43.7	6	7	16
Massachusetts[c]	11	6,948	62.4	7	10	11
Michigan[c]	15	7,032	63.1	10	14	11
Minnesota[c]	12	6,384	57.3	10	12	10
Mississippi	26	4,416	39.7	10	17	23
Missouri	13	3,504	31.5	7	10	15
Montana[c]	17	4,680	42.0	9	13	16
Nebraska[c]	10	4,388	39.2	4	6	10
Nevada	10	3,960	35.5	3	4	19
New Hampshire[c]	6	6,192	55.6	3	4	12
New Jersey[c]	9	5,088	45.7	5	7	12

(continued)

Benefits for Members of Single Parent Families

Government-sponsored programs provide medical assistance to 47 percent of all persons in poor families and 71 percent of those in single parent poor families. The percentage of nonelderly state residents covered by Medicaid varies among states from 4 percent in New Hampshire and Nevada to 18 percent in Alaska (table 2).[7]

Individuals in families above poverty are likely to be covered by private health insurance provided through an employer's group health plan. In 1991, 72 percent of these households were covered by an employment-based plan (table 3). Less than 10 percent of individuals in these households were covered by a publicly sponsored insurance plan, and 14 percent were uninsured. A smaller proportion of individuals in single parent families (53 percent) had group health insurance coverage than did individuals in other families (74 percent). The

[7]AFDC provides cash assistance to individuals in families with dependent children whose assets and income are below a specific level. Although the federal government sets certain minimum standards, income eligibility levels vary by state. AFDC recipients are automatically eligible for Medicaid. Recent legislation has expanded Medicaid eligibility to include pregnant women with income below 133 percent of poverty; poor children under age 9 (and older children in subsequent years); and certain aged, blind, and disabled individuals. States may cover additional optional groups, including the medically needy.

Table 2 (continued)

	Percentage of Nonelderly Residents Who Are Poor	AFDC Maximum Income for Family of Three (July 1991)		Percentage of Nonelderly Receiving AFDC	Percentage of Nonelderly Receiving Medicaid	Percentage of Nonelderly without Health Insurance
		Threshold	Percentage of poverty			
New Mexico	22	3,888	34.9	4	12	25
New York[c]	15	6,924	62.2	10	13	14
North Carolina[c]	13	3,264	29.3	5	8	16
North Dakota[c]	14	4,812	43.2	6	10	8
Ohio	12	4,008	36.0	8	9	12
Oklahoma[c]	15	5,652	50.7	7	8	22
Oregon[c]	10	5,520	49.6	5	7	16
Pennsylvania[c]	11	4,836	43.4	7	10	12
Rhode Island[c]	8	6,648	59.7	5	7	14
South Carolina[c]	16	5,280	47.4	3	7	19
South Dakota	14	4,848	43.5	7	9	14
Tennessee[c]	18	5,112	45.9	11	15	16
Texas[c]	16	2,208	19.8	4	8	24
Utah[c]	9	6,444	57.8	4	7	10
Vermont[c]	11	8,076	72.5	5	8	11
Virginia[c]	11	3,492	31.3	6	8	18
Washington[c]	9	6,372	57.2	5	7	13
West Virginia[c]	19	2,988	26.8	7	10	17
Wisconsin[c]	9	6,216	55.8	5	8	9
Wyoming	11	4,320	38.8	6	7	14
Average State	14	$6,114	45.3%	7	10	16

Sources: National Governors' Association, July 1991; and EBRI tabulations of the March 1991 Current Population Survey.
[a]AFDC/Medically Needy thresholds current through July 1991. Under AFDC, the term "threshold" refers to that income limit that truly drives program eligibility. In most states, this is the payment standard. In Colorado, Georgia, Kentucky, Maine, Michigan, Mississippi, Oklahoma, South Carolina, Tennessee, and Utah, the threshold is the state's need standard. In these 10 states, the threshold that appears on the table is not what the state pays to AFDC recipients. These states' payment standards are actually significantly lower than the eligibility threshold.
[b]Poverty levels for Alaska and Hawaii differ from other states: U.S.—family of three=$10,419 Alaska—family of three = $13,930; Hawaii—family of three = $12,810.
[c]States with Medically Needy programs.

number of nonpoor individuals in single parent families without health insurance was 22 percent compared to 13 percent of individuals in other families.

The most common source of health insurance coverage for all families in poverty in 1991 was the publicly sponsored Medicaid program, which covered 47 percent of the nonelderly poor (table 3). Only 20 percent of the poor were covered by private health insurance, primarily because of the lack of employment-based coverage for this group. However, the proportion of individuals eligible for Medicaid varied largely by family type. Children aged 8 or under were most likely to be covered. Two-thirds of older children in single parent families and women heading single parent families were also eligible for Medicaid. Thirty-one percent of poor individuals who were not members of a single parent family and 30 percent of poor male headed single parent families received Medicaid. The lack of Medicaid coverage for these two groups at least in part accounts for the large proportion who reported no health insurance coverage in 1991. Forty-two percent of the poor who were not members of single parent families and 52 percent of poor male headed single parent families were uninsured in 1991. A smaller proportion of children under age nine in poor single parent families (15 percent) and female heads of poor single parent families (22 percent) were uninsured owing at least in part to the fact that more of these individuals were eligible for Medicaid.

Health Care Reform—Opportunities for Single Parent Families

Policymakers are discussing further expansion and reform of the Medicaid program. Such an expansion could cover a larger percentage of the uninsured poor as well as

remove disincentives to seek employment for poor single parent families. (Because Medicaid receipt is linked to cash assistance, some recipients may choose not to work so that they do not lose Medicaid benefits.)

One illustrative Medicaid expansion would raise the eligibility level to 100 percent of the poverty line and eliminate categorical requirements; establish medically needy programs in all states; and extend coverage to pregnant women and infants with income up to 185 percent of the poverty line. A recent study estimated that under such a proposal, 14.7 million persons would become eligible for Medicaid in an average month, and 18.1 million would be covered sometime during the year (table 4).[8] Not all of those who gained coverage under an illustrative Medicaid expansion were previously uninsured, however. According to the study, 7.3 million were previously uninsured, while the remaining 10.8 million were insured at least some time during the year by Medicare (1.9 million), employment-based coverage (5.7 million), individually purchased private coverage (2.3 million), or other government programs (0.9 million).

The illustrative Medicaid expansion options discussed above would only reduce the number of uninsured by about one-quarter because many of those who would gain Medicaid coverage were previously covered by another plan (table 5). For this reason, most current Medicaid expansion proposals combine the expansion with an employer mandate to avoid having individuals shifted to Medicaid.

Because so many single parent families with income below the poverty line lack health insurance coverage, Medicaid expansion—either a stand-alone expansion or an expansion coupled with an employer mandate—would probably cover a large proportion of this group. In particular, such an expansion would help male headed

[8]Lewin/ICF, *The Health Care Financing System and the Uninsured* (Washington, DC: Lewin/ICF, 1990).

Table 3
Nonelderly Individuals with Selected Sources of Health Insurance Coverage by Family Type, 1991

Health Coverage	Total	Not a Single Parent Family	Single Parent Families				
			Total	Under age 9	Aged 9–17	Female head of household	Male head of household
				(millions)			
Individuals in Families with Income Above Poverty	188.6	172.7	15.9	3.8	4.7	5.8	1.6
				(percentage)			
Private health insurance	81%	82%	66%	58%	70%	69%	66%
Group health coverage	72	74	53	46	52	58	56
Direct	37	38	24	0	0	52	51
Indirect	35	36	29	46	52	6	4
Other private coverage	9	9	13	12	18	10	11
Public health insurance	9	8	16	25	14	15	10
Medicaid	4	3	14	23	12	12	5
No health insurance coverage	14	13	22	23	21	20	27
				(millions)			
Individuals in Families with Income Below Poverty	30.2	18.1	12.1	4.7	3.1	4.0	0.3
				(percentage)			
Private health insurance	20%	25%	11%	9%	14%	12%	17%
Group health coverage	11	14	6	4	7	8	10
Direct	5	6	3	0	0	7	10
Indirect	6	8	3	4	7	1	0
Other private coverage	9	11	6	5	7	5	7
Public health insurance	50	36	73	80	69	69	34
Medicaid	47	31	71	79	68	67	30
No health insurance coverage	33	42	20	15	21	22	52

Source: EBRI tabulations of the March 1991 Current Population Survey.

Table 4
Change in Enrollment Under an Illustrative Medicaid Expansion Proposal for Noninstitutionalized Persons in 1989

	Incremental Increase in Enrollment under Policy[a]		
	Ever eligible in 1986	Ever enrolled in 1989	Average monthly enrollment
		(millions)	
Increase Eligibility Level to Poverty for Categorically Eligible Groups Only	7.6	5.1	4.2
Increase Eligibility Level to Poverty and Eliminate Categorical Criteria	17.5	11.5	9.2
Cover All Pregnant Women and Children up to 185 Percent of Poverty	2.2	1.5	1.3
Total New Enrollees	27.3	18.1	14.7

Source: Lewin/ICF, *The Health Care Financing System and the Uninsured* (Washington, DC: Lewin/ICF, 1990).
Note: The analysis provides estimates for 1989, so that some states were not yet including pregnant women and children up to 100 percent of poverty. Subsequent reforms that required states to cover pregnant women up to 133 percent of poverty and all poor children up to age 8 are also not included.
[a]Eligibility is assumed to be certified for six months (pregnant women through 60 days post partum), the asset eligibility limit is $5,000 (no assets tests for pregnant women), and medically needy programs are implemented in all states.

single parent families who are often not eligible for Medicaid because they do not receive AFDC. Improving health insurance coverage could alleviate some of the concerns of single parent families who are unable to find employment that provides health insurance coverage. However, in light of budget deficits, such expansion has thus far proven unaffordable for states and the federal government.

—Jill Foley, EBRI

◆ Most Americans Think Employers Should Be Required to Provide Family Leave—According to Recent EBRI/Gallup Survey

Three out of four Americans (76 percent) said employers should be required to provide an unpaid leave of absence to employees upon the birth or adoption of a child, with guaranteed reemployment, according to a recent public opinion survey conducted by EBRI and The Gallup Organization, Inc. Individuals most likely to support this view were those aged 18–34 (87 percent), those in professional/managerial positions (83 percent), and those with incomes between $20,000 and $74,999 (78 percent). In a similar survey conducted in 1990, 77 percent of respondents supported such mandated leaves of absence.

Recently, both the House and Senate passed family leave legislation that would require employers with more than 50 employees to provide up to 12 weeks of unpaid leave to care for a newborn child or to handle family medical emergencies. However, President Bush is expected to veto the legislation and it appears the House does not have the necessary votes to override the veto.

Respondents to the 1991 survey who support employers providing guaranteed leaves of absence said the median length of leave should be 12 weeks. Thirty-one percent said the leave should be between 4 weeks and 8 weeks, 21 percent said it should be between 8 weeks and 12 weeks, and 17 percent said the leave should be between 12 weeks and 15 weeks.

Two-thirds of respondents (66 percent) believe employers should be involved to some degree in providing child care assistance. Of those who support employer involvement, 56 percent (or 37 percent of all respondents) said employers should provide assistance with child care even if it meant a reduction elsewhere in the wage or benefit package for all employees. In 1990, 71 percent of all respondents supported employer involvement in child care, and of those, 64 percent (46 percent of all respondents) supported this involvement even if it meant a reduction in other wages and benefits.

Table 5
Impact of Selected Health Insurance Expansion Proposals on the Number of Uninsured Persons, 1989

Characteristic	Uninsured under Current Law	Employer Illustrative I Medicaid Expansion[a]	Mandate with Medicaid Expansion[b]
		(thousands)	
Total	31,554	24,631	2,726
Family Income			
Less than $10,000	8,846	4,535	801
$10,000–$14,999	4,492	3,420	500
$15,000–$19,999	3,996	3,171	294
$20,000–$29,999	5,012	4,511	436
$30,000–$39,999	3,101	2,989	233
$40,000–$49,999	2,537	2,533	140
$50,000 or more	3,570	3,472	332

Source: Lewin/ICF, *The Health Care Financing System and the Uninsured* (Washington, DC: Lewin/ICF, 1990).
[a]Extends Medicaid to all persons with incomes below poverty and pregnant women and infants with income below 185 percent of poverty. Decouples Medicaid eligibility from public assistance eligibility. The assets limit is set at $5,000, medically needy programs are established in all states, and individuals are certified for 6 month periods.
[b]Employers would be required to cover workers and dependents where the worker is employed 17.5 hours per week or more. Medicaid expansion is the illustrative option.

Given the choice between a job that offered free child care and an identical one that did not, respondents said they would require a median amount of $2,400 in order to accept the job without child care. This amount remained unchanged from 1990. However, in 1991, only 3 percent of respondents said they had ever accepted, quit, or changed jobs based on an employer's child care policies, compared with 4 percent in 1990 and 2 percent in a 1989 survey on the same subject.

The number of respondents who said the government should have some role in providing child care assistance for families has remained virtually the same since last year—62 percent in 1991 and 64 percent in 1990. Respondents to the 1991 survey most likely to support this view were those aged 18–34 (79 percent), those with incomes less than $20,000 (70 percent), and females (70 percent).

Among four possible options for government assistance in child care, 84 percent of all respondents said they favor the government setting minimum standards for health and safety. Fifty-eight percent said they favor the government giving direct subsidies to child care facilities, 60 percent said they favor additional tax credits to families with children in which both parents work, and 60 percent said they favor tax credits to all parents of children under age 13, whether or not both parents work.

When respondents were asked how much they would be willing to pay in additional taxes to fund government child care assistance, only one-third indicated an amount and the average amount was $100. Forty percent of respondents said they would not be willing to pay any additional taxes, and 24 percent said they didn't know how much they would be willing to pay. In 1990, the average amount was $86.

Of those respondents who support both government and employer involvement in child care assistance, 51 percent think employers should play the *primary* role, while 34 percent think government should take the lead.

After answering a series of questions on child care and family leave, 21 percent of all respondents said a presidential candidate's position on child care and family leave issues alone would determine whether or not they voted for that candidate. Those most likely to respond this way were individuals with incomes less than $20,000 (37 percent), minorities (32 percent), and those aged 18–34 (31 percent).

The 1991 child care and family leave survey was conducted in October 1991 and is the twenty-ninth in a

series of national public opinion surveys EBRI is undertaking 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 ±3.1 percent.

Copies of the survey reports *Public Attitudes on Child Care and Family Leave, 1991* (G-29), the 1990 survey, G-17, and the 1989 survey, G-5, may be ordered from Kim Thorpe, (202) 775-6315, for the following prices: summary—$75 each; full report—$275 each; EBRI member prices: summary —$25 each; full report—$75 each.

—*Carolyn Piucci, EBRI*

◆ 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) 275-6241.*]

Group Health Association of America. **Patterns in HMO Enrollment: GHAA1991 Edition.** $22.50. Group Health Association of America, Inc., 1129 20th St., NW, Suite 600, Washington, DC 20036, (202) 778-3200.

Hewitt Associates. (1) **Company Reactions to the New Section 16 Rules: 1991**. $75. (2) **Domestic Partners and Employee Benefits: 1991.** $10. (3) **Rabbi and Secular Trusts: 1991.** $35. Cathy Schmidt, Hewitt Associates, 100 Half Day Road, Lincolnshire, Il 60069, (708) 295-5000.

International Foundation of Employee Benefit Plans. **Employee Benefitsin Canada.** $42. International Foundation of Employee Benefit Plans, P.O. Box 69, Brookfield WI 53008, (414) 786-6700.

Jencks, Christopher, and Paul E. Peterson, eds. **The Urban Underclass**. $15.95 paperback, $36.95 clothcover. The Brookings Institution, 1775 Massachusetts Ave., NW, Washington, DC 20036, (202) 797-6258.

Martin E. Segal Company. **Compendium: A Review of Major Developments in Compensation, Employee Benefits, and Human Resources Management.** $75. Martin E. Segal Company, 1 Park Avenue, New York, NY 10016-5895, (212) 251-5304.

McNeil, Bruce J. **The Pension Answer Book: Nonqualified Deferred Compensation.** $79. Panel Publishers, 14 Plaza Road, Greenvale, NY 11548, (800) 457-0222.

Merrill Lynch, Pierce, Fenner & Smith. (1) **The Future Doesn't Add Up: Critical Questions Regarding Retirement Planning in America—and Some Serious Answers.** Free. (2) **America's Retirement Savings Crisis**. Free. William A. Dennison, Merrill Lynch, Marketing Communications (Retirement Survey), P.O. Box 9019, Princeton, NJ 08543-9019. (No requests by phone.)

Mishel, Lawrence. **The Myth of the Coming Labor Shortage: Jobs, Skills, and Incomes of America's Workforce 2000.** $15. Public Interest Publications, P.O. Box 229, Arlington, VA 22210, (800) 537-9359.

National Association of Employers on Health Care Action. **NAEHCA Blue Book: A Digest of HMOs.** $59.50. Blue Book, Inc., P.O. Box 220, Key Biscayne, FL 33149, (305) 361-2810.

National Association of Private Psychiatric Hospitals. **Benefits Watch Survey: A Nationwide Survey of Workers' Attitudes About and Knowledge of Their Employer-sponsored Health Plans.** $3. National Association of Private Psychiatric Hospitals, 1319 F St., NW, Suite 1000, Washington, DC 20004, (202) 393-6700.

Practising Law Institute. **Wrongful Termination Claims: A Preventive Approach.** Second Edition. $90. Practising Law Institute, 810 Seventh Avenue, New York, NY 10019, (212) 265-4742.

Public Employee Retirement Study Commission, Commonwealth of Pennsylvania. **Status Report on Local Government Pension Plans**. Free. Public Employee Retirement Study Commission, Commonwealth of Pennsylvania, 117B Transportation and Safety Building, P.O. Box 1429, Harrisburg, PA 17105-1429, (717) 783-6100.

Sametz, Arnold W. **Institutional Investing: Challenges and Responsibilities of the 21st Century.** $55. Business One Irwin, 1818 Ridge Road, Homewood, IL 60430, (708) 798-6000.

Towers, Perrin, Forster, and Crosby, Inc. **Health Care Cost Survey Results**. Free. TPF&C, 100 Summitt Lake Drive, Valhalla, NY 10595, (914) 745-4000.

U.S. Congress. House Committee on the Budget. (1) **Budgetary Examination of the Health of the Unemployment Insurance System**. (2) **The Federal Budget and the Economic Status of the Elderly.** Order from GPO.

U.S. Congressional Budget Office. **The Economic and Budget Outlook: An Update.** Order from GPO.

U.S. Department of Commerce. Bureau of the Census. (1) **Finances of Employee-Retirement Systems of State and Local Governments**. (2) **Measuring the Effect of Benefits and Taxes on Income and Poverty.** (3) **Money Income of Households, Families, and Persons in the United States.** (4) **Pensions: Worker Coverage and Retirement Benefits, 1987.** (5) **Public Employment.** (6) **Transitions in Income and Poverty Status: 1987–88.** Order from GPO.

U.S. Department of Health and Human Services. Health Care Financing Administration. (1) **Consumer Choice and Cost Containment: SAFECO's United Healthcare Plan.** (2) **Medicare and Medicaid Data Book.** (3) **Medicare/Medicaid Statistical Files Manual.** (4) **Research and Demonstrations in Health Care Financing.** Order from GPO.

U.S. Department of Health and Human Services. National Center for Health Statistics. **Determinants of Total Family Charges for Health Care: United States, 1980.** Order from GPO.

Victor, Richard. **Twenty-Four Hour Coverage**. $25. Workers Compensation Research Institute, 245 First St., Suite 1402, Cambridge, MA 02142 (617) 494-1240.

The Employee Benefit Research Institute (EBRI) is a nonprofit, nonpartisan public policy research organization based in Washington, DC. Established in 1978, EBRI provides educational and research materials to employers, employees, retired workers, public officials, members of the press, academics, and the general public. The Employee Benefit Research Institute Education and Research Fund (EBRI-ERF) is a nonprofit, nonpartisan education and research organization established by EBRI in 1979. EBRI-ERF produces and distributes a wide range of educational publications concerning health, welfare, and retirement policies. Through their books, policy forums, and monthly subscription service, EBRI and EBRI-ERF contribute to the formulation of effective and responsible health, welfare, and retirement policies. EBRI and EBRI-ERF have—and seek—a broad base of support among interested individuals and organizations, as well as among private-sector companies with interests in employee benefits education, research, and public policy.

Employee Benefit Notes and ***EBRI Issue Briefs*** (a monthly periodical devoted to expert evaluations of a single benefit issue) are published by the Employee Benefit Research Institute Education and Research Fund with the assistance of the staff of the Employee Benefit Research Institute. **Annual subscriptions are available for $224**. Editorial inquiries may be directed to EBRI, 2121 K Street, NW, Suite 600, Washington, DC 20037-1896, (202) 659-0670. Orders, payments, inquiries, and all other correspondence relating to subscriptions should be sent to EBRI's distribution agent, The Johns Hopkins University Press, 701 W. 40th Street, Suite 275, Baltimore, MD 21211, USA, (410) 516-6964.

Employee Benefit Notes **and** ***EBRI Issue Briefs*** **are also available to EBRI Periodical Subscribers. EBRI Periodical Subscribers also receive** ***EBRI's Benefit Outlook*** (a monthly review of the latest legislative and regulatory developments in a variety of benefit areas as well as an examination of emerging employee benefit issues and their implications), ***EBRI's Quarterly Pension Investment Report*** (a quarterly report that tracks the growth of private and public pension assets and their investment mix and performance), **and other EBRI special reports, studies, and books.**

For information on subscribing to ***Employee Benefit Notes*** **and** ***EBRI Issue Briefs*** **($224/year), becoming an EBRI Periodicals Subscriber ($1,500/year), or for general membership information call or write to EBRI at 2121 K Street, NW, Suite 600, Washington, DC 20037-1896, (202) 659-0670.**

Nothing herein is to be construed as necessarily reflecting the views of the Employee Benefit Research Institute or the Employee Benefit Research Institute Education and Research Fund or as an attempt to aid or hinder the passage of any bill pending before Congress.

© 1992. Employee Benefit Research Institute. All rights reserved. ISSN: 0887-1388 0887-1388/90 $ .50 + .50 .

EMPLOYEE BENEFIT **notes** is registered in the U.S. Patent and Trademark Office.