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Notes

Access to Health Care and Satisfaction: Differences by Insurance Coverage and Insurance Type

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Introduction

The availability of health insurance allows individuals to avoid unnecessary pain and suffering and improves the quality of life. Studies have shown that insured individuals have a higher probability of receiving basic health care services than the uninsured.[1] Individuals without health insurance have been shown to be more likely to delay treatment and not seek preventive health care, postponing it until an emergency occurs, requiring a higher and more expensive level of care.

Currently, access to health care has become an important issue for individuals *with* health insurance coverage. Recent data indicate that 85 percent of workers are enrolled in managed care plans.[2] An increasing number of media stories have focused on anecdotal evidence that managed care organizations are denying care to enrollees, resulting in a negative portrayal of managed care.[3] However, it can be argued that the debate needs to move beyond the anecdotes and start considering nationally representative data.[4] Policymakers on both sides of the aisle have responded to anecdotal evidence by introducing legislation that would increase regulation of the managed care industry. President Clinton's "Consumer Bill of Rights" and the bipartisan "Patient Access to Responsible Care Act" (PARCA) (S. 644/H.R. 1415), co-sponsored by Rep. Norwood (R-GA) and Sen. D'Amato (R-NY), are two examples of the types of legislation that policymakers are considering.

Estimates of the portion of individuals lacking access to health care vary considerably. A recent survey of studies found a range of from 6.2 percent to 45 percent.[5] While it is important to understand how many individuals lack access to health care, it is equally important to understand how access to health care differs not only for the insured and uninsured populations but also within the insured population. This article's purpose is to shed light on the issue of access to health care and satisfaction for the uninsured and insured populations as well as within the insured population.

Data

Data in this article are from the 1996 Panel of the Medical Expenditure Panel Survey (MEPS). MEPS is the third in a series of national surveys conducted by the Agency for Health Care Policy and Research (AHCPR), U.S. Department of Health and Human Services, to provide nationally

Table 1
Percentage of the Population without a Usual Source of Health Care Provider and Main Reason for No Usual Source, by Health Insurance Status, 1996

	Total Population			Individuals with Employment-Based Health Insurance		
	Total	Insured population (private or public)	Uninsured population	Total with employment-based health insurance	HMO[a] or managed care plan with gatekeeper	Managed care plan without a gatekeeper or non-managed-care plan
			(millions)			
Total	231.5	187.6	43.9	145.3	82.9	62.4
			(percentage)			
No Usual Source of Health Care	18.7%	14.3%	37.5%	14.2%	11.5%	17.8%
Main Reason	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Seldom or never gets sick	66.9	69.2	63.2	70.5	68.1	72.6
Cost of medical care	9.3	3.7	18.4	3.1	4.3	1.9
Recently moved into area	5.1	6.2	3.2	6.2	6.1	6.3
Other	4.6	6.0	2.3	6.0	4.8	7.1
Don't use doctors/ treat myself	3.3	2.7	4.1	2.9	3.1	2.7
Usual source of medical care in this area is no longer available	3.1	3.8	2.1	3.5	3.6	3.3
Likes to go to different places for different health needs	2.4	3.2	1.1	3.0	3.0	2.9
Other insurance-related reason	2.1	0.7	4.3	0.5	0.8	0.3
Just changed health plans	1.7	2.5	0.6	2.9	5.2	1.0
Don't know where to go for care	1.0	1.3	0.4	0.9	1.0	0.8
Can't find a provider who speaks person's language	0.2	0.2	0.1	0.2	0.0	0.4
Not determinable	0.3	0.4	0.3	0.3	0.0	0.6

Source: Employee Benefit Research Institute estimates from Rounds 1 and 2 of the 1996 Medical Expenditure Panel Survey.
[a]Health maintenance organization.
Note: Health insurance data are from Round 1, and the usual source of health care provider data are from Round 2. Caution should be used when interpreting these data, as an individual's health insurance status may have changed between Round 1 and Round 2.

representative estimates of health care utilization, expenditures, sources of payment, and insurance coverage for the U.S. civilian noninstitutionalized population. The Round 1 Household Component (HC) for the 1996 panel released in spring 1997 provides detailed data on demographics, health status, health insurance coverage, income, and employment.[6] Additional Round 1 data on managed care enrollment were released in fall 1997. The Round 2 HC, released in fall 1997, contains data on access and barriers to obtaining health care.[7]

This article uses merged data from Round 1 and Round 2, and represents 231.5 million nonelderly individuals who were eligible to be interviewed in Round 2. The data presented on health insurance status were collected in Round 1 and the data presented on access to health care were collected in Round 2. As a result, caution should be used when interpreting these results, as the health insurance status for a small percentage of the population may have changed between Round 1 and Round 2.

Access to Care

Overall, 18.7 percent of the nonelderly population reported that they did not have a usual source of health care (table 1). This does not imply that these individuals did not have access to health care. It simply means that they did not usually go to a particular doctor, clinic, health center, or other place for medical treatment or advice. Of those individuals who did not have a usual source of health care, 66.9 percent reported that they were seldom or never sick. Over 9 percent reported that medical care costs were the reason that they did not have a usual source of health care.

Insured vs. Uninsured—Data on the likelihood of having a usual source of health care and the primary reasons for not having a usual source show interesting differences between the insured and uninsured populations. Among insured individuals, those with private or public coverage, 14.3 percent reported that they didn't have a usual source of health care, compared with 37.5 percent among the uninsured. Not surprisingly, the insured population was more likely than the uninsured population to report that they seldom or never get sick as the main reason for having no usual source of

Table 2

Percentage of the Population with a Usual Source of Health Care Provider and Selected Quality Attributes, by Health Insurance Status, 1996

	Total Population			Individuals with Employment-Based Health Insurance		
	Total	Insured population (private or public)	Uninsured population	Total with employment-based health insurance	HMO[a] or managed care plan with gatekeeper	Managed care plan without a gatekeeper or non-managed care plan
			(millions)			
Total	231.5	187.6	43.9	145.3	82.9	62.4
			(percentage)			
Individuals with a Usual Source of Health Care	80.9%	85.4%	61.4%	85.4%	88.2%	81.8%
Location for Usual Source of Care	100.0	100.0	100.0	100.0	100.0	100.0
Office	88.1	88.9	83.5	90.7	89.4	92.6
Hospital	11.1	10.5	14.7	8.9	10.2	7.1
Emergency room	0.6	0.4	1.8	0.2	0.2	0.2
Not determinable	0.2	0.2	0.0	0.2	0.3	0.1
Provider Generally Listens	100.0	100.0	100.0	100.0	100.0	100.0
Yes	94.5	94.7	93.2	94.9	94.6	95.4
No	3.3	3.1	4.5	2.9	3.3	2.4
Not determinable	2.2	2.2	2.3	2.2	2.1	2.3
Provider Usually Asks about Prior Treatments	100.0	100.0	100.0	100.0	100.0	100.0
Yes	73.8	73.1	78.3	72.6	71.2	74.6
No	20.9	21.7	16.3	22.0	23.9	19.2
Not determinable	5.2	5.2	5.4	5.4	4.9	6.2
Confident in Provider's Ability	100.0	100.0	100.0	100.0	100.0	100.0
Yes	93.9	94.0	93.5	93.9	92.7	95.7
No	4.3	4.3	4.8	4.2	5.1	2.9
Not determinable	1.7	1.7	1.7	1.9	2.2	1.4
Satisfied with Provider's Quality of Care	100.0	100.0	100.0	100.0	100.0	100.0
Very satisfied	77.2	77.5	75.1	78.1	75.1	82.5
Somewhat satisfied	18.5	18.2	20.0	17.6	20.0	14.2
Not too satisfied	2.3	2.2	3.0	2.1	2.3	1.7
Not at all satisfied	0.7	0.7	0.7	0.7	1.1	0.2
Not determinable	1.3	1.4	1.2	1.4	1.4	1.4
Family Did Not Receive Care Because It Needed Money	100.0	100.0	100.0	100.0	100.0	100.0
Yes	6.6	5.1	15.5	3.7	3.6	3.8
No	93.2	94.7	84.3	96.1	96.2	96.1
Not determinable	0.2	0.2	0.2	0.1	0.2	0.1
Satisfaction That Family Can Get Care When Needed	100.0	100.0	100.0	100.0	100.0	100.0
Very satisfied	77.0	80.0	59.4	82.8	81.5	84.6
Somewhat satisfied	17.2	15.9	24.7	14.2	15.1	12.9
Not too satisfied	3.5	2.6	9.1	2.0	2.0	1.9
Not at all satisfied	2.0	1.3	6.2	0.9	1.1	0.5
Not determinable	0.2	0.2	0.6	0.2	0.3	0.1
Family Member Experienced Difficulty Obtaining Needed Care	100.0	100.0	100.0	100.0	100.0	100.0
Yes	11.9	10.2	22.1	8.9	10.2	7.0
No	87.9	89.6	77.6	90.9	89.6	92.8
Not determinable	0.2	0.2	0.2	0.2	0.2	0.2
Main Reason for Difficulty in Receiving Needed Care	100.0	100.0	100.0	100.0	100.0	100.0
Could not afford care	55.1	45.3	82.2	37.9	35.1	43.8
Insurer would not approve care	14.3	16.6	8.1	19.8	16.7	26.3
Other	6.9	8.7	1.9	9.1	9.8	7.5
Could not get time off from work	5.1	6.8	0.4	9.6	11.6	5.3
Did not have time to go get care	3.6	4.6	0.6	6.3	6.3	6.2
No transportation	3.5	3.7	3.0	3.0	2.5	4.0
Insurer required referral	3.0	3.9	0.6	4.7	6.6	0.9
Doctor refused family insurance	2.6	3.5	0.2	3.5	4.7	0.8
Refused services	2.3	2.5	1.6	2.6	3.3	1.2
Pre-existing condition	1.5	2.0	0.3	1.7	1.6	2.0
Medical care too far away	0.8	1.0	0.1	1.1	0.9	1.5
Language barrier	0.8	0.7	1.0	0.0	0.0	0.0
Too expensive	0.5	0.7	0.0	0.9	0.9	0.7
Do not know where to go	0.1	0.1	0.0	0.0	0.0	0.0

Source: Employee Benefit Research Institute estimates from Rounds 1 and 2 of the 1996 Medical Expenditure Panel Survey.
Note: Health insurance data are from Round 1, and the usual source of health care provider data are from Round 2. Caution should be used when interpreting these data, as an individual's health insurance status may have changed between Round 1 and Round 2.
[a]Health maintenance organization.

health care. Over 69 percent of the insured population reported that they did not have a usual source of health care because they were seldom or never sick, compared with 63.2 percent of the uninsured population. In contrast, members of the uninsured population were more likely than those in the insured population to report that they did not have a usual source of health care because of the cost of medical care.

Insurance Type—Differences in the likelihood of having a usual source of health care are also observed among individuals with different types of health insurance coverage. Over 11 percent of individuals enrolled in a health maintenance organization (HMO) or a managed care plan with a gatekeeper reported no usual source of health care, compared with 17.8 percent of individuals enrolled in managed care plans without a gatekeeper and nonmanaged care plans.[8] These two groups reported different main reasons for not having a usual source of health care. For example, individuals in HMOs or managed care plans with a gatekeeper were less likely than other insured individuals to report that they were seldom or never sick. In contrast, individuals in HMOs or in managed care plans with a gatekeeper were more likely to report that they had either just changed health plans or that the cost of medical care was the main reason for not having a usual source of health care.

Satisfaction with Care

Most persons with a usual source of health care receive their care in a doctor's office (88.1 percent) (table 2). Just over 11 percent receive their care in a hospital, and 0.6 percent receive their care in an emergency room. Overall, individuals are generally satisfied with many aspects of their health care and their usual source of health care. Almost all individuals with a usual source of coverage report that their provider generally listens to them during the office visit (94.5 percent); they are confident in their provider's ability (93.9 percent); they are very satisfied or somewhat satisfied with the provider's quality of care (95.7 percent); they were able to get care when they needed it (93.2 percent); and they are very or somewhat confident that their family members could get care when they needed it (94.2 percent). Fewer individuals reported that their family ever experienced difficulty getting care (87.9 percent), and even fewer reported that their usual source of health care asked about prior treatments, including prescription drugs (73.8 percent).

Insured vs. Uninsured—Individuals' satisfaction levels with their usual source of health care does not vary significantly between insured and uninsured individuals, although insured individuals are slightly more satisfied than uninsured individuals. However, confidence in the ability to get health care when needed does vary significantly between the insured and uninsured populations. For example, uninsured individuals were three times as likely as insured individuals to report that someone in their family did not receive health care because the family needed the money for other household resources (15.5 percent versus 5.1 percent). Less than 60 percent of the uninsured population reported that they were very satisfied that they could get health care when needed, compared with 80 percent among the insured population. The uninsured population was more likely than the insured population to report that someone in the family was unable to get needed health care, and 82.2 percent of that population reported the main reason as being that they could not afford to pay for it. This compares with 45.3 percent among the insured population who had difficulty receiving care reporting that they could not afford care. Insured individuals were more likely to report that their insurance company would not approve care, that they could not get time off from work, or that they did not have the time to go for care.

Insurance Type—Satisfaction levels for those with insurance coverage also do not vary significantly by type of health insurance coverage, although individuals enrolled in HMOs and managed care plans with gatekeepers are slightly less satisfied than other insured individuals with various aspects of their usual source of health care. Individuals in HMOs or managed care plans with a

gatekeeper were slightly less likely to report that their usual source of coverage almost always asks about prior treatments, but this may reflect the integrated approach to providing health care in a managed care environment. The degree of satisfaction varied the most by type of health insurance. Seventy-five percent of enrollees in HMOs and managed care plans reported that they were very satisfied, compared with 82.5 percent of individuals with other employment-based health insurance. In contrast, individuals in HMOs and managed care plans with a gatekeeper were more likely to report that they were somewhat satisfied. Overall, enrollees in HMOs and managed care plans with a gatekeeper were almost as likely as individuals with other types of health insurance to report that they were either very satisfied or somewhat satisfied.

Just over 10 percent of individuals in HMOs and managed care plans with gatekeepers reported that a family member had difficulty receiving needed care, compared with 7 percent of individuals with other types of health insurance. The main reasons individuals gave for not receiving needed care were interesting. Individuals enrolled in HMOs and managed care plans with gatekeepers were less likely than those with other types of health insurance to report that the main reason was either the cost of care or that the insurer would not approve the treatment. Alternatively, they were more likely to report that they could not get time off from work, that the insurer required a referral, or that the doctor refused the family's insurance. Individuals in managed care plans without a gatekeeper and in non-managed care plans were more likely than HMO enrollees and enrollees in managed care plans with a gatekeeper to report that they did not get care because the insurer did not approve the treatment (26.3 percent vs. 16.7 percent). However, when you factor in the 6.6 percent of the latter group who did not receive care because the insurer required a referral, the differences between the two groups become even smaller. We do not know from the survey if the individuals who reported the main reason as needing a referral from the insurer ever tried to obtain a referral.

Conclusion

This article presents data from a recent nationally representative survey designed to examine how access to health care and satisfaction with health care services vary not only between insured and uninsured individuals but also within the insured population. We found that, while relatively large differences exist between the insured and uninsured populations, there are smaller differences within the insured population. In addition, we found that the uninsured population is fairly confident that they can get health care when needed. Policymakers are considering legislation that would increasingly regulate health insurers and employment-based health plans. This legislation is in large part driven by an increasing number of anecdotes portrayed in the media. The findings in this article tend to call into question managed care critics' claims that managed care enrollees have less access to health care than other insured individuals.

Access to health care is an important issue for all Americans. In addition, satisfaction with health care providers and health plans is just as important for individuals with health insurance coverage. It is important for policymakers to have nationally representative data on the health care system in order to formulate the most effective policy options, because any attempt to increase consumer protections may do more harm than good if it is based on incomplete information.

Endnotes

[1] *Brenda C. Spillman, "The Impact of Being Uninsured on Utilization of Basic Health Care Services,"* Inquiry *(Winter 1992): 457–466.*

[2] *William M. Mercer, Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans, January 20, 1998.*

[3] *Mollyann Brodie, Lee Ann Brady, and Drew E. Altman, "Media Coverage of Managed Care: Is there a Negative Bias?"* Health Affairs *(January/February 1998): 9–25.*

[4] *Karen Ignagni, "Covering a Breaking Revolution: The Media and Managed Care,"* Health Affairs *(January/February 1998): 26–34.*

[5] *Mark L. Berk and Claudia L. Schur, "Measuring Access to Care: Improving Information for Policymakers,"* Health Affairs *(January/February 1998): 180–186.*

[6] *For an analysis of the Round 1 health insurance data, see Paul Fronstin, "44.5 Million Americans Uninsured and 187.2 Million Insured in 1996: An Analysis of the 1996 Medical Expenditure Panel Survey,"* EBRI Notes*, No. 10 (October 1997): 6–9.*

[7] *The reference period for Round 1 of the MEPS HC was from January 1, 1996, to the date of the first interview, which occurred during the period from March through July. The reference period from Round 2 was from the date of the first interview to the date of the second interview, which took place between August and November. For additional information on MEPS, see J. Cohen, "Design and Methods of the Medical Expenditure Panel Survey Household Component,"* Methodology Report No. 1, *AHCPR Pub. No. 97-0026 (Rockville, MD: Agency for Health Care Policy and Research, 1997).*

[8] *MEPS asks a series of questions to determine if an individual with private health insurance coverage was enrolled in an HMO. However, one of the questions may be picking up individuals with a gatekeeper who are not enrolled in an HMO. Given the limitations of the data, we categorize individuals into two groups: 1) individuals enrolled in an HMO are combined with individuals in gatekeeper managed care plans, and 2) individuals in non-gatekeeper managed care plans are combined with individuals who are insured but not in a managed care setting.*

Keeping Track of Social Security Reform Proposals: An Update

by Kelly A. Olsen and Chris Baylyff, EBRI

Introduction

This article describes several Social Security reform proposals Congress introduced during 1997 and 1998. It updates the summary of reform packages introduced during 1994-1996 that was published in the November 1996 issue of *EBRI Notes*.[1] This article includes a point-by-point table summarizing comprehensive reform packages proposed by Reps. John Edward Porter (R-IL), Mark Sanford (R-SC), Nick Smith (R-MI), and the Committee for Economic Development (CED). The text briefly describes a number of the more incremental legislative proposals advanced in 1997 and 1998.

The Projected Federal Budget Surplus

Among the incremental Social Security reform proposals introduced, several are based on President Clinton's approach to shore up the system as stated in his January 1998 State of the Union address. In his speech, the president called for action to "Save Social Security first . . . by [reserving] 100 percent of the surplus . . . until we have taken all the necessary measures to strengthen the Social Security system for the 21st century." This surplus is projected by the Federal Budget Office to total $679 billion over the next 11 years.

The bills modeled after the president's approach specify various ways to use such a budgetary surplus for "strengthening" Social Security or for reducing Social Security tax rates. For example, Rep. Charlie Rangel (D-NY) has introduced legislation to create a Social Security reserve fund for any federal budget surpluses, and Rep. Charles Schumer (D-NY) has introduced legislation that would allocate 50 percent of any surplus to reductions in Social Security taxes (with the remainder going to discretionary nondefense spending and public debt reduction). Similarly, Rep. David Drier (R-CA) has introduced legislation that would reduce employer and employee Social Security taxes in conjunction with any federal budget surplus. On the Senate side, Sen. Ernest Hollings (D-SC) has introduced a resolution expressing the sense of the Senate that Congress should not finance any tax cuts or make any new investments with other funds until legislation is enacted to make Social Security actuarially sound. In addition, Sen. William Roth (R-DE) outlined in a statement on the senate floor a proposal that would not affect current Social Security recipients but would create new private retirement accounts for each U.S. worker with funding from any

Table 3
A Point-by-Point Comparison of Social Security Reform Plans

	Committee for Economic Development (CED) Proposal	The Social Security Solvency Act of 1997 (Rep. Nick Smith)	The Individual Social Security Retirement Accounts Plan (Rep. John Edward Porter)	Personal Retirement Accounts Plan (Rep. Mark Sanford)
Type of Plan	Defined benefit (DB) and defined contribution (DC)	DB and DC	DB and DC	DB (as a minimum benefit, scaled back to 4 percent of taxable payroll) and DC
Investment Plan				
Private Market Investment?	Yes	Yes	Yes	Yes
Who Invests?	Individuals	Individuals	Individuals	Individuals
Individual Accounts	Yes, called personal retirement accounts (PRAs)	Yes, one or more, called personal retirement savings accounts (PRSAs)	Yes, called individual social security retirement accounts (ISSRAs)	Yes, called PRAs
Individual Participation	Mandatory	Mandatory with option of adding an additional $2,000 contribution annually (one-half of this additional contribution would be tax exempt until distribution).	Optional. New and existing workers can opt to form an ISSRA or stay in the current Social Security system. Additional contributions can be made up to 20 % of gross income.	Mandatory for all new workers, with required minimum of 6% of income also to be invested in the accounts. Workers not retired by the year 2000 have a choice of remaining under the old system or moving to the PRA system. Workers who are retired by 2000 continue to receive benefits under the current system.
Where Is the Individual Account Held?	Privately owned and held	Individual or employer sends money to the Secretary of Treasury, which sends funds to approved asset managers (assuming same approval criteria currently in place for individual retirement acount (IRA)/401(k) managers).	Privately owned and held through approved asset managers (utilizing the same approval criteria currently in place for IRA/401(k) managers)	Privately owned and held by private trustees
Use FICA Revenue for Investment?	No	Yes, carve-out of 2.5% from current Old-Age and Survivors Insurance (OASI) tax goes into PRSAs.	Yes, ISSRA accounts are funded by a 5% contribution from both employer and employee, resulting in 10% of OASI taxable income. The remaining 2.4% of current OASI taxes continues to fund the Social Security trust fund.	No
Increase Payroll Taxes?	Yes, by 1.5 percentage points for both employers and employees. However, the government receives no additional revenue.	No	No, there is a tax cut. The remaining 1.2 percent OASI tax on both employees and employers will be paid into the Social Security trust fund for 10 years after the creation of an ISSRA account. After this period, neither the worker nor the employer will be required to pay this tax, resulting in a net tax cut.	Yes, by a total of 1.4% due to making Disability Insurance (DI) a separate fund.
Property of Beneficiary's Estate on Death?	Yes	Yes	Yes	Yes
Tax Treatment of Individual Accounts	Like a 401(k) plan—contributions and earnings are tax free until distribution.	Contributions and accumulations are tax free until withdrawn, then taxed like regular DB Social Security benefits—one-half of the additional contribution amounts are taxed the same as the Social Security benefit.	Employee contributions to ISSRA accounts will not reduce their taxable income, and employer contributions will be deductible as a business expense. Inside build-up of accounts is tax deferred until	Employee portion taxed as income; all withdrawals for annuities are tax-free.

(continued)

Table 3 (continued)

	Committee for Economic Development (CED) Proposal	The Social Security Solvency Act of 1997 (Rep. Nick Smith)	The Individual Social Security Retirement Accounts Plan (Rep. John Edward Porter)	Personal Retirement Accounts Plan (Rep. Mark Sanford)
			withdrawal, like current IRAs. The portion of retirement benefits derived from individual contributions will be taxed, while the portion of benefits derived from the employer will be tax free.	
Investment Rules	Assets are invested in a limited number of broad-based funds that may invest in private-sector securities, government debt, etc.	Only in regulated investment companies; portfolio assets are limited to investment in indexes of stocks or other types of investments as determined by the Secretary of Treasury (who will establish the criteria). At a minimum, the Secretary would approve the five funds offered by the Thrift Savings Plan. So that investors could diversify among asset managers, multiple fund options would be offered under each type of investment category.	Similar to IRA rules, broad investment options would be available.	Invested by custodians in broad-based portfolios with risk similar to S&P 500.
Form of Distribution Rules	Funds must be withdrawn gradually over life after retirement or annuitized.	Funds can only be distributed after beneficiary turns age 59 1/2. Distribution options would follow current TIAA-CREF options. A lifetime option in the form of an annuity could be elected. Or, beneficiaries could choose a nonlifetime option, which consists of several choices: (1) receiving nothing until a certain age (there are no mandatory distribution requirements), (2) receiving interest only, or (3) receiving principal and interest in regular payments. In addition, other distributions as prescribed by the Secretary of Treasury could be offered. Joint-and-survivor annuities would also be available, and participants would be able to change among nonlifetime options or from a nonlifetime option to a lifetime option any time.	Flexible distribution options, but the ISSRA account would be required to maintain a balance sufficient to provide a minimum benefit.	Minimum benefit annuity must be purchased (providing the equivalent of $9,100 in annual income) or amount maintained in account. Otherwise, no rules.
Preretirement Loans?	No	No	No	No
Accrual of Federal Debt Required?	No	No	No	No
Amounts Expected to Be Allocated to Individual Accounts	More than $100 billion annually, accumulating to $2.5 trillion by 2015 (in 1996 dollars)	Based on estimates from the Social Security Office of the Actuary, approximately $1 trillion would be placed into PRSAs between 1999 and 2008. About $143 billion would be placed into PRSAs during 2025; $400 billion would pour into PRSAs in 2045; and $729 billion would be contributed during the year 2065.	Estimated at $150 billion at inception, rising to $360 billion by 2015	About $240 billion annually (in 1996 dollars)
Expected Increase in Individual Savings?	Large increase is anticipated, but the precise amount is unknown.	Yes	Large increase is anticipated, but the precise amount is unknown.	Large increase is anticipated, but the precise amount is unknown.

(continued)

Table 3 (continued)

	Committee for Economic Development (CED) Proposal	The Social Security Solvency Act of 1997 (Rep. Nick Smith)	The Individual Social Security Retirement Accounts Plan (Rep. John Edward Porter)	Personal Retirement Accounts Plan (Rep. Mark Sanford)
How Much Additional Revenue Is Expected to Flow into Stock Market Annually (in 1996 Dollars)?	Approximately $50 billion, on average	Depends on Secretary of Teasury's decisions on investment options but possibly between 40%–60% of annual contributions (conservative estimate).	Estimated at $75 billion at inception, rising to $180 billion by 2015. (Depends on individual investment decisions, but estimates are based on 50% of assets being invested in equities).	Probably about $200 billion annually
How Much Additional Revenue Is Expected to Flow into Stock Market by 2015 (in 1996 Dollars)?	$1.1 trillion by 2015	Between $50 billion and $75 billion	Between $5 trillion and $6 trillion	About $3.0 trillion
Offsetting Reduction in Social Security because of Private Investment	None	Yes, because benefits are offset on "excess income" from any sources, including private investment and/or wages. If PSRA balance exceeds amount contributed by worker and employers—and income exceeds $50,000 for individuals and $100,000 for couples—then benefits are reduced by 1% for each $300 (individuals) or $600 (couples) exceeding income thresholds.	In recognition of Social Security taxes already paid, Recognition Bonds will be issued by the Treasury to those workers who opt to form ISSRAs. These bonds will be redeemable at retirement to finance monthly benefit payments in amounts proportionate to lifetime Social Security taxes already paid. Workers younger than age 30 opting for ISSRAs will not receive any Recognition Bonds.	None
Miscellaneous Reforms				
Redirect Funds from Hospital Insurance (HI) to Trust Fund?	No	Yes	No	No
Cover New State and Local Government Employees?	Yes	Yes	Optional	Yes
Benefit Reductions for Future Retirees				
Raise Taxes on Benefits?	Yes, federally tax all benefits from DB tier in excess of contributions made by worker. This would be achieved by making 85% of Social Security taxable income, not by individually calculating taxes for each beneficiary.	No	No	No
Increase Normal Retirement Age (NRA) Faster Than Change Mandated by the 1983 Amendments (Age 67 by 2027)?	Yes, raise NRA by two months each year until it reaches age 70 by 2030.	Yes, raise NRA from age 65 by three months per year until it reaches age 69 in 2015; indexed thereafter.	Yes, NRA will increase to age 66 in 2005 and to age 70 by 2028.	Yes, NRA will increase to age 70 in 2028.
Increase Early Retirement Age (ERA)?	No	Yes, gradually from age 62 to age 65 by 2011; indexed thereafter. Exception: The ERA would be two years earlier for widows and widowers.	No	No
Reduce Cost-of-Living Adjustment (COLA) by Reducing Consumer Price Index (CPI)?	Favors improvement of accuracy of CPI measurement beyond already implemented 0.21% correction.	Assumes 0.15 reduction in CPI is made by the Bureau of Labor Statistics (BLS).	No	COLA cut of 0.5% will be made unless BLS revises CPI.

(continued)

Table 3 (continued)

	Committee for Economic Development (CED) Proposal	The Social Security Solvency Act of 1997 (Rep. Nick Smith)	The Individual Social Security Retirement Accounts Plan (Rep. John Edward Porter)	Personal Retirement Accounts Plan (Rep. Mark Sanford)
Change in Benefit Calculations?	Yes, slow the increase of the primary insurance amount (PIA) as linked with real wages for all but lower income workers. In addition, calculate benefits using the best 40 years, rather than best 35 years.	Yes, use the best 39 years instead of 35 years to calculate average indexed monthly earnings (AIME); increasing by one full year as ERA goes up by a full year. Index lower bend-point to wages, and add a fourth bend-point at which 5% of AIME over $3,391 is added to PIA. The highest three bend-points would be indexed to the cost-of-living rather than wages. All bend-points are reduced on a gradual basis, ultimately resulting in a minimum basic benefit payment.	Yes. Benefits will be price indexed instead of wage-indexed.	Yes, change bend-points to reduce benefits.
Reduce Spousal Benefits?	Yes, gradually from 50% of worker's PIA to one-third	Yes, gradually to 33% of PIA for spouses reaching ERA in 2016 or later; increase widow/widowers' benefits to a minimum of 110% of the standard benefit. However, no spousal bequeathal requirements are included, because married workers' contributions to PSRA program are automatically split 50-50 between the husband's and wife's individual PRSAs.	No	Yes, gradually from 50% of worker's PIA to one-third.
Effect on Disability Insurance (DI) and Survivor's Insurance (SI)	Statement data do not address effects on DI program; see above for effects on SI.	No effect; DI and non-aged survivor programs remain DB in nature. (PRSA goes into reserve status once beneficiary is on disability; PRSA balances are not used to pay disability benefits).	A portion of the ISSRA account contribution will be used by the fund managers to purchase private disability and life insurance policies covering at least the same individuals at the same levels as the current Social Security program.	DI program becomes separate program—no effect on benefits; SI covered by a 3x income life insurance component. Personal account fund can be willed to survivors.
Minimum Guaranteed Benefit to All Who Participate?	No change from current law.	Yes, eventually, implicit in the gradual reductions and changes planned in the bend-point formulas (see above).	Yes, equal to the lesser of 40% of average preretirement income or 95% of expected Social Security retirement benefits.	$9,100 annually, indexed by CPI; investment principal up to the amount needed for a $9,100 indexed annuity would be insured against loss by a fund administered by the Securities Exchange Commission or a similar private insurer.
Benefit Reductions for Current Beneficiaries	No change from current law.	Yes, on "excess income" from all sources (see above).	No	No
Implementation Date	Enacted as soon as possible and phased in gradually.	1999	1999	January 1, 2000
Do Plan Advocates Expect Full Projected 75-Year Shortfall to be Eliminated By Plan?	Yes, by 133%.	Yes, as scored by SSA Office of the Actuary.	Yes	No, because a panel will propose government spending cuts, asset sales, and other sources of income to raise additional monies.

Source: Employee Benefit Research Institute.

federal budget surpluses, equal to about 1.4 percent of payroll over the next decade. Finally, Sen. Patrick Moynihan (D-NY) recently endorsed a redesign that would allow individuals to invest 2 percentage points of their payroll tax in individual accounts.

An Individual Accounts System

Incremental reform proposals also include legislation introduced by Rep. Thomas E. Petri (R-WI) that

would establish a retirement account of $1,000 for each newborn American. The start-up funds for the program would be derived from the sale of government assets and would be invested in the same retirement investment funds that are currently available to federal employees through the federal Thrift Savings Plan. Account holders could voluntarily add up to $2,000 per year, tax free, to their retirement accounts.

In addition, Sen. Judd Gregg (R-NH) has introduced legislation that would create employee personal investment plans funded by Social Security payroll deductions. Participants, limited to those under age 55, would receive reduced Social Security tax rates in exchange for contributions to individual Social Security accounts.

Table 3 presents Reps. Mark Sanford's (R-SC) Personal Retirement Accounts Plan, John Edward Porter's (R-IL) Individual Social Security Retirement Accounts Plan, Nick Smith's (R-Michigan) Social Security Solvency Act of 1997, and the Committee for Economic Development's (CED) proposal. Each of these options includes methods that would move the Social Security program away from today's primarily pay-as-you-go system toward a prefunded system using individual accounts. In addition to other provisions, each of these packages would provide retirees with a minimum level of benefits.

Eliminating the Earnings Test

On a different and less expansive note, Senate Majority Leader Trent Lott (R-MS) has introduced legislation that would eliminate the earnings test for retirees. This bill aims to remove the penalties on earned income above certain limits. In 1998, the annual earnings limits are $9,120 for beneficiaries under age 65 and $14,500 for those ages 65–69. Above these thresholds, $1 in Social Security payments is withheld for every $2 of additional earnings for beneficiaries under age 65, and $1 in benefits is withheld for every $3 of additional earnings for beneficiaries ages 65–69. (The earnings test does not apply to those age 70 and older.)

The Social Security Reform Debate Accelerates

A plethora of newspaper articles,[2] as well as the President's State of the Union remarks, ensure that Social Security reform will continue to move toward the forefront of Washington's social policy agenda. As the debate heats up over how to address the system's long-term financial issues, and as additional proposals to alter other aspects of the current program are advanced, the Employee Benefit Research Institute (EBRI) will continue to provide information and analysis to facilitate understanding of these policy issues. For more information on EBRI's Social Security Reform Evaluation Research Program, visit EBRI online at http://www.ebri.org. The site contains program information and information related to the EBRI-SSASIM2 Policy Simulation Model, as well as links to over 70 Internet sites providing material on the Social Security program and perspectives on its impending reform.

Endnotes

[1] *Reform packages profiled included the three 1994–1996 Advisory Council plans, the National Thrift Plan (National Taxpayers' Union Foundation), the 1995 Kerrey-Simpson proposals, and the Social Security Solvency Act (Rep. Nick Smith). To purchase a pdf copy of the September 1996* EBRI Notes *article, "Keeping Track of Social Security Reform Proposals: A Summary," visit the EBRI online publications section at http://www.ebri.org/ebripubs.htm.*

[2] *Alxis Simendinger, "A Good Time to Tackle Social Security,"* National Journal, *10 January 1998, pp. 68–69; "Gingrich Seeks Social Security Reform Panel,"* The Washington Post, *6 January 1998, pp. A1 and A4; "Mr. Clinton and Social Security,"* The Washington Post *(Editorial), 6 January 1998, p. A12; Peter Passell, "Economic Scene: Clinton May Soon Tackle the Devilish Social Security Issue,"* The New York Times, *23 October 1997, p. D2; and The Associated Press, "Clinton Quietly Seeks Dialogue to Plan Social Security Repairs,"* The Washington Times, *26 August 1997, p. A4.*

The authors would like to thank the staff at the CED, the office of Rep. Nick Smith, the office of Rep. John Edward Porter, and the office of Rep. Mark Sanford for their invaluable assistance in creating table 3.

Washington Update

by Bill Pierron, EBRI

Social Security Reform

The Social Security reform debate continues to be dominated by considerations over what to do with the projected budget surplus. Several proposals introduced in March provide a sampling of how Congress may address the issue. Sen. William Roth (R-DE), Rep. John Kasich (R-OH), and Sen. Daniel Patrick Moynihan (D-NY) all introduced individual investment account plans. Sen. Roth outlined a system of individual accounts with limited investment choices modeled on the Federal Thrift Savings Plan. According to Roth, the projected surplus over a decade will equal approximately 1 percent of payroll taxes, which, he claims, would make up for any shortfalls in the Social Security system from 2010 to 2040. Each worker's contribution would equal 1 percent of taxable payroll. Roth expects to introduce legislation in May. Rep. Kasich has introduced a bill (H.R. 3456) that would earmark 80 percent of any future budget surpluses for personal retirement accounts. Unlike Sen. Roth's proposal, Kasich's plan would provide all Americans who earn more than $2,800 the same annual contribution regardless of income. The amount would be determined by dividing the annual surplus by the number of eligible individuals. Like Roth's proposal, individual accounts would be invested in a limited set of investment vehicles, much like the Federal Thrift Savings Plan. Sen. Moynihan takes a different approach, lowering the payroll tax from 12.4 percent (both employer and employee contributions) to 11.4 percent for 1999 and 2000, then to 10.4 percent from 2001 to 2024. The rate would then begin to climb to a high of 13.4 percent in 2044. Beginning in 2001, workers could establish "voluntary investment accounts" that would be funded with the difference between current law payroll taxes and the lowered rate. If workers chose not to establish the accounts, they would be eligible for a 1 percent increase in take-home pay. Sen. Moynihan would also raise the taxable payroll amount, cut the annual cost-of-living adjustment, and raise the normal retirement age beyond the changes already scheduled under current law.

Outlook: A great deal of attention is being paid to individual accounts, but policymakers are only beginning to comprehend the full implications of such an approach, not the least of which is the issue of administrative feasibility. The output of the EBRI-SSASIM2 Policy Simulation Model is already helping to move the debate forward. (Initial results of the model are discussed fully in "How Do Individual Social Security Accounts Stack Up? An Evaluation Using the EBRI-SSASIM2 Policy Simulation Model," *EBRI Issue Brief* no. 195, March 1998.)

Health Care Quality/Liability

The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry did not recommend broadening health plan liability under the Employee Retirement Income Security Act of 1974 (ERISA) in its final report. Although many employers, plan sponsors, and health plans were concerned that the commission might recommend increasing liability for denied benefits, the commission heeded several members who cautioned against such a move. The commissioners have called for a "national discussion" and further study of the issue. Meanwhile, the Department of Labor (DOL) continues to push the position that health plan participants should be provided expanded remedies under ERISA. A DOL official recently indicated that individuals who are wrongly denied a health benefit by their ERISA health plan have to meet a difficult test by alleging a violation of ERISA's fiduciary duties and then proving that the claims review process was based on an arbitrary and capricious standard. DOL is supporting the implementation of an external review process through which plan participants could receive a hearing from a disinterested party in cases where their claim is denied.

In early March, Sens. Jim Jeffords (R-VT) and Joe Lieberman (D-CT) introduced the Health Care Quality, Education, Security and Trust (QUEST) Act of 1998 (S. 1712). The bill would establish a national Health Quality Council, to be appointed by the Comptroller General. The council would serve as a resource for Congress and the White House by providing data on the financial and socioeconomic impact of pending health care legislation. The council would also be responsible for assessing the scientific evidence regarding various types of treatments, and it would be required to issue an annual report on the state of the nation's health. In addition, the bill would expand the duties of the Agency for Health Care Policy and Research (AHCPR), which would be charged with supporting the activities of the Health Quality Council. The bill would also amend ERISA to require plan sponsors to provide more information to enrollees, including comparative information about available health plans, measures of consumer satisfaction, information regarding health providers and facilities, and any financial arrangements that might influence the care provided by the plan. Finally, the bill would amend ERISA to establish a national

Keeping on Track

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

Supreme Court to Review Line-Item Veto—The Supreme Court will hear oral arguments on Apr. 27 in the case *Clinton v. New York City*. On Feb. 12, the U.S. District Court for the District of Columbia ruled that the line-item veto is unconstitutional. The lower court found the line-item veto unconstitutional because it disrupts the balance of powers among the three branches of government. The line-item veto allows the President to veto discretionary spending provisions or "limited tax benefits" that would benefit 100 or fewer individuals. The employee benefits community is interested in the line-item veto because it could impact various pension and welfare-related
provisions.

Sen. Kennedy and Rep. Stark Introduce Medicare Buy-in Bills—Sen. Ted Kennedy (D-MA) and Rep. Pete Stark (D-CA) have introduced bills in the Senate and House that would implement President Clinton's proposal for Medicare buy-ins. The President's budget proposal called for early retirees ages 62–64 to buy into Medicare for a premium of $300 per month, plus an additional monthly premium once they qualify for regular Medicare coverage. In addition, the President's proposal would allow "displaced" workers age 55 and older to obtain Medicare coverage by paying a higher monthly premium, estimated at $400 per month. These individuals would not be assessed an additional monthly premium once they enrolled in Medicare at age 65.

FASAB Drafts Rule on Entitlement Liabilities—The Federal Accounting Standards Advisory Board (FASAB) will soon propose a rule that requires full reporting of liabilities facing the Social Security, Medicare, Railroad Retirement, miners' black lung program, and unemployment insurance benefits. The proposal would affect only these social insurance programs; other federal entitlements would be exempt. In addition to disclosing liabilities, each program would have to report long-range cash flow projections in nominal dollars and long-range projections of the ratio of contributors to beneficiaries. A public hearing on the proposal will be held this summer. For further information, see the FASAB Internet site at http://www.financenet.gov/fasab.htm.

Stabenow Introduces Pension Start-up Credit Bill—Rep. Debbie Stabenow (D-MI) introduced a bill on Feb. 26 (H.R. 3300) that would provide a three-year start-up tax credit for any business that establishes a pension plan. The tax credit would equal 50 percent of the qualified start-up costs, up to a cap of $1,000 in the first year and $500 in the two subsequent years.

Federal Court Bars San Francisco Benefits Ordinance—The U.S. District Court for the District of Northern California has granted a temporary restraining order barring San Francisco from forcing Federal Express to comply with the city's domestic partner statute, holding that FedEx would suffer irreparable harm if it were forced to implement the law. The ordinance requires all companies that do business with the city to offer domestic partner benefits equal to the benefits offered to spouses. FedEx was preparing to lease an airport facility from the city. It joined the Air Transport Association of America and the Airline Industrial Relations Conference in May 1997 in bringing suit against the city, claiming, in part, that the ordinance was preempted by ERISA. At this writing, the court has not yet ruled on the plaintiffs' substantive claims.

"prudent layperson" standard for emergency room care as well as require expedited claims review and an independent appeals process for all health plans. The bill does not attempt to broaden health plans' legal liability, unlike the Patient Access to Responsible Care Act (H.R. 1415/S. 644) (PARCA) sponsored by Rep. Charlie Norwood (R-GA) and Sen. Alphonse D'Amato (R-NY).

Outlook: Sweeping health care quality legislation is unlikely this year, as is any legislation that would increase health plan legal liability. However, modest reforms are likely. And health plan liability remains a compelling issue for many in Congress.

EBRI in Focus

First Annual Health Confidence Survey (HCS)

The first annual Health Confidence Survey (HCS) will be released on April 30. The 1998 HCS is being underwritten by 18 organizations. For more information, visit EBRI online at http://www.ebri.org/hcs/.

1998 Retirement Confidence Survey (RCS)

The Retirement Confidence Survey went into the field in the beginning of March. In addition to the standard RCS questionnaire, the project includes a survey of small businesses this year. We are also oversampling minority groups and will be publishing a minority special report. Results will be released in the spring shortly before the National Summit on Retirement Income Savings at the White House.

It is not too late to become an underwriter of the 1998 RCS project. Given the unique nature of this year's effort, there are three levels of financial commitment. The cost of underwriting the base RCS for 1998 remains $5,000 per organization. An additional contribution of $2,500 will help underwrite the RCS Minority Special Report. For $12,500, your organization can participate in the Small Business Retirement Survey (in addition to the RCS and the Minority Special Report).

If you are interested in funding the 1998 RCS or have any questions regarding the project, please call Paul Yakoboski at (202) 775-6329, or contact him via e-mail at yakoboski@ebri.org.

Educational Briefings

Jack VanDerhei and Kelly Olsen conducted an educational briefing on the initial results of the EBRI SSASIM2 Policy Simulation Model on Mar. 27.

On Mar. 18, Paul Fronstin, Craig Copeland, and Bill Pierron briefed the staff of the National Bipartisan Commission on the Future of Medicare.

EBRI/ASEC Community Education Campaign—"Ballpark Estimate" and "Choose to Save"

For information, see www.asec.org/cts-summ.htm

Planning Is Under Way for the Spring Policy Forum

EBRI-ERF will hold its spring policy forum, entitled "The Future of Medical Benefits," on Wed., May 6.

The agenda is available on the EBRI Web site (www.ebri.org). The policy forum is open to EBRI Members and invited guests. For more information about the forum or attending, please contact Pan Ostuw, (202) 775-6315, ostuw@ebri.org, or Paul Fronstin, (202) 775-6352, fronstin@ebri.org.

EBRI Prepares for 20th Anniversary Celebration

The countdown continues—EBRI's 20th anniversary is less than 136 days away! Have you made plans to join EBRI in celebrating its 20th anniversary on Monday, Sept. 14, 1998, with a black-tie gala to be held in the Waldorf Astoria Grand Ballroom in New York City? Tables are going quickly—at this writing, 12 benefactor tables, 2 benefactor seats, 21 patron tables, and 13 patron seats have already been reserved, so make your reservations soon! Please plan to join us. For more information, contact Patsy D'Amelio at (202) 775-6323, e-mail: damelio@ebri.org or visit EBRI online for more details.

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New Publications & Internet Sites

[*Note: To order publications from the U.S. Government Printing Office (GPO), call (202) 512-1800; to order congressional publications, call (202) 512-2470. To order U.S. General Accounting Office (GAO) publications, call (202) 512-6000; to order from the Congressional Budget Office (CBO), call (202*) 226-2809].

Alexander, Leslie B., and Lenard W. Kaye. **Part-Time Employment for the Low-Income Elderly: Experiences from the Field**. $40. Garland Publishing, Attn: Customer Service, 1000A Sherman Avenue, Hamden, CT 06514, (800) 527-6273.

Brown, David K. **Introduction to Public Policy: An Aging Perspective.** $42.50 + $3. S&H. University Press of America, 4720 Boston Way, Lanham, MD 20706-4800, (800) 462-6420.

Buck Consultants. **Executive Deferred Compensation: A Review of Nonstock-Related, Nonqualified Programs: Survey Report**. $150. Carrie Estevez, Marketing Dept., Buck Consultants, 500 Plaza Drive, Secaucus, NJ 07096-1533, (201) 902-2555.

The Conference Board. **Employee Benefits: Surviving and Thriving With Continual Change**. $100. Customer Service Department, The Conference Board, 845 Third Avenue, New York, NY 10022, (212) 339-0345.

DRI/McGraw Hill. **U.S. Industry and Trade Outlook '98**. $69.95. National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161, (703) 487-4650.

Feldstein, Martin, and James M. Poterba. **Empirical Foundations of Household Taxation**. $45. University of Chicago Distribution Center, 11030 South Langley Avenue, Chicago, IL, (800) 621-2736.

Graetz, Michael J. **The Decline (And Fall?) of the Income Tax**. $27.50. W.W. Norton, Order Dept., Keystone Industrial Park, Scranton, PA 18512, (800) 233-4830.

HR Investment Consultants. **401(k) Provider Directory Averages Book**. $95. 401(k) Provider Directory, 305 W. Chesapeake Avenue, Suite 330, Baltimore, MD 21204, (800) 562-0628.

Krass, Stephen J. **The Pension Answer Book**. $125. Aspen Publishers, 7201 McKinney Circle, Frederick, MD 21704, (800) 638-8437.

Novartis Pharmaceuticals Corporation. **Novartis Pharmacy Benefit Report: 1997 Trends & Forecasts**. Free. Novartis, 59 Route 10, East Hanover, NJ 07936-1080, (800) 456-4994.

Sass, Steven A. **The Promise of Private Pensions: The First Hundred Years**. $39.95. Harvard University Press, 79 Garden Street, Cambridge, MA 02138-1423, (800) 448-2242.

U.S. Chamber of Commerce Research Center. **Employee Benefits: Survey Data from Benefit Year 1996**. $35. U.S. Chamber of Commerce, Publications Fulfillment, 1615 H Street, NW, Washington, DC 20062, (800) 638-6582.

William M. Mercer. **Survey on Employee Savings Plans: 1997**. $75. William M. Mercer, 1166 Avenue of the Americas, Attn: Tara Lewis, New York, NY 10036, (800) 333-3070.

Documents Available on the Internet

EDGAR Database of Corporate Information
http://www.sec.gov/edgarhp.htm

Employer-Sponsored Health Insurance: State and National Estimates
http://www.cdc.gov/nchswww/data/employer.pdf

Employment Laws Assistance for Workers and Small Businesses
http://gatekeeper.dol.gov/elaws/

Financial Accounting Standards Board
(FASB)http://www.rutgers.edu/Accounting/raw/fasb/welcome.htm

Present Law and Background Relating to Tax Incentives for Savings
http://www.house.gov/jct/x-11-98.htm

Privatization of Pensions: The Final Frontier
http://www.marshmac.com/view/archiv97/97winter/spiegel.html

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