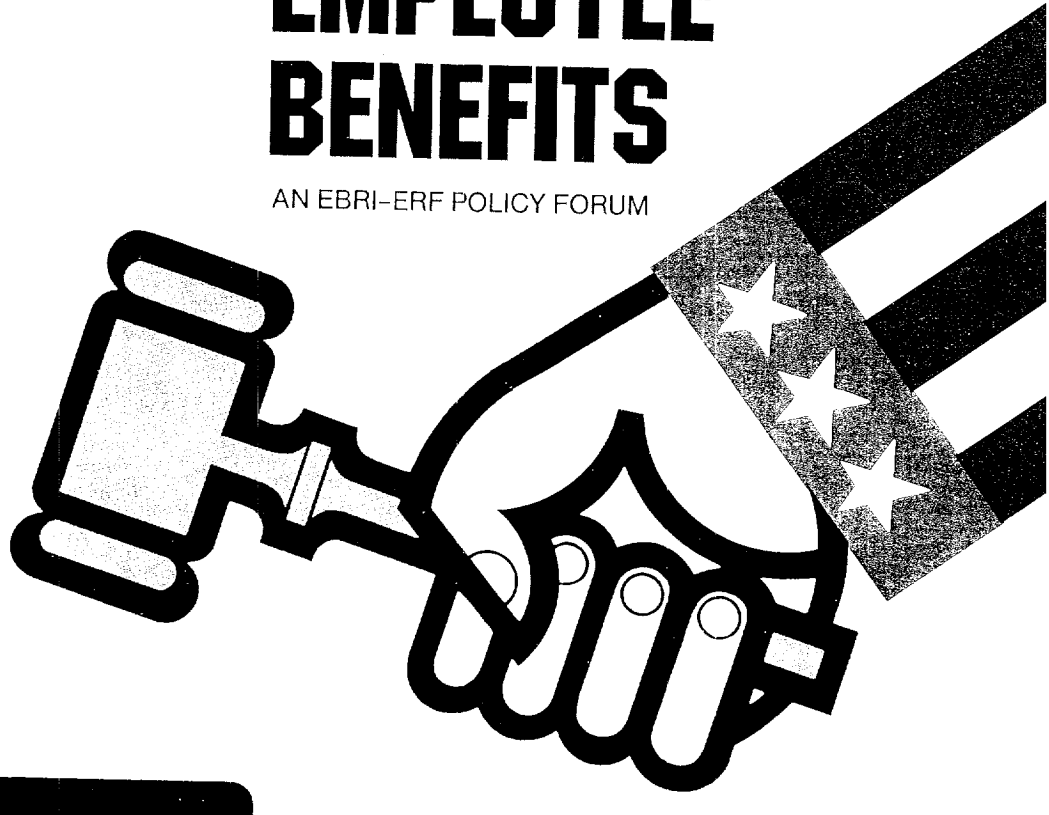
GOVERNMENT MANDATING OF EMPLOYEE BENEFITS

AN EBRI-ERF POLICY FORUM



EBRI EMPLOYEE BENEFIT RESEARCH INSTITUTE

GOVERNMENT MANDATING OF EMPLOYEE BENEFITS

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Employee Benefit Research Institute

The *Employee Benefit Research Institute* (EBRI) is a Washington-based, nonprofit, nonpartisan, public policy research institution. EBRI's overall goal is to promote the development of soundly conceived private and public employee benefit plans. The Employee Benefit Research Institute Education and Research Fund (EBRI-ERF) is a nonprofit, nonpartisan education and research organization that was established by EBRI in 1979.

Through research, policy forums, workshops, and educational publications, EBRI and EBRI-ERF contribute to the expansion of knowledge in the field and to the formulation of effective and responsible health, welfare, and retirement policies. This work is intended to complem d by aca-
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Table of Contents

PART SIX
CAN A CONSENSUS EMERGE ON MANDATED BENEFITS?

List of Tables

List of Charts

Foreword

The role of government in addressing the social needs of the nation has undergone a dramatic and controversial change in the 1980s. Soaring federal budget deficits have forced both Democrats and Republicans in Congress to view with caution any proposals for new programs that would require increased federal spending. In this climate, a program that attempts to resolve a societal problem must be revenue-neutral—that is, finance itself in some manner and not require additional federal revenues.

But another answer has suggested itself to lawmakers when they try to grapple with national public policy issues, such as extending health care coverage to the millions of Americans without it or extending pension and other benefits to employees, primarily in small, nonunionized firms, who lack them. That answer is to transfer the responsibility to private-sector employers.

This intensified congressional direction comes at a time, however, when American industry is going through a restructuring triggered by severe foreign and domestic competition. Employers seeking to cut costs are closely examining every phase of their operations, including their benefit plans. Health care costs have escalated rapidly in the last decade, with the result that more and more employers require employees to contribute to their health care coverage.

If the federal government requires businesses to absorb the increased cost of mandated-benefit programs, employers fear their competitive position could erode further. The result, many employers maintain, could be loss of jobs, or a reduction in wages or other benefit programs—the opposite effect that mandates are intended to accomplish.

But with the American public demanding more in benefits, and with federal spending constrained by large budget deficits, the pressures are irresistible for lawmakers to seek solutions in mandates on the work place rather than in government. This could mean more government intervention in the work place in the form of mandatory minimum health and pension coverage and parental leave and child care programs.

On April 27, 1987 EBRI's Education and Research Fund sponsored a policy forum, "Government Mandating of Health, Pension, and Other Employee Benefits." The forum brought together corporate executives, state and federal government officials, and representatives from

labor, academia, elderly, and research organizations to discuss the issue of mandated benefits.

The policy forum examined the forces with which employers are contending in today's competitive environment; reviewed recent state and federal responses to the pressures to provide expanded health, pension, and other benefit programs; and discussed the impact of mandated-benefit programs on employers, workers, and the economy.

This book integrates the papers and proceedings of the policy forum into a single work, organized into six parts. We have supplemented the actual policy forum material with additional chapters written by EBRI staff and invited outside experts.

On behalf of EBRI and its Education and Research Fund, I wish to thank the policy forum speakers and participants for their substantial contributions to this book. We believe it will assist policymakers, benefits experts, and the public in better understanding what the mandated-benefit debate is all about: the background and the issues, the arguments for mandates as a means to meet many of society's needs, and the arguments against mandates as added burdens for employers with potentially high costs to the economy. Special thanks are due to Frank McArdle and Cindy O'Connor who helped to plan and organize the policy forum and compile, edit, and produce this book. Thanks are also extended to Lisa Schenkel; Stephanie Poe, and Barbara Coleman for editorial assistance and to Christine Dolan for creating the index.

The views expressed in this book are solely those of the speakers and the forum participants. They should not be attributed to the officers, trustees, members, or associates of EBRI, its staff, or its Education and Research Fund.

DALLAS L. SALISBURY
President
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Introduction: The Pressure for New Legislated Mandates

PAPER BY FRANK B. MCARDLE

The current political environment is shaping to a major degree the environment in which businesses function. The trend in recent years has been to expand the social responsibilities thrust upon employers, for their own employees, for families and dependents of employees, and for society as a whole.

These directives to business, or "mandates" as they are now called, are coming from every different angle, from federal government and state government, from the courts and the legislature. The issues range from Medicare protection of older workers to laws concerning immigration and occupational health. What all these varied mandates have in common is the goal of using the regulation of the work place as a way of accomplishing social change.

Forces at Work

Historically, there has been a pull in this direction. The United States has had a history of "creeping mandates" up until the 1930s, when the federal role was clearly viewed as the answer to major social policy issues. By the late 1970s, however, high inflation and rampant problems in the financing of many federal programs indicated that the use of the federal government to fund social policy reforms was not a fully adequate solution. President Reagan arrived with an offer of allowing an increased role for the private sector, and although the Congress did not always give him his way, skepticism about the role of the federal government led to increasing and bipartisan discussion of the need for private and public partnerships. Now, we are in an era where the boundaries between public and private programs are no longer clearly defined; they are blurred. Our analysis of tax policy and of social policy leads us to understand better the private aspects of financing public programs through taxation as well as the public or social functions fulfilled by private enterprise. We have moved into an era of philosophy where "mandating" seems much more appropriate to policymakers than either direct federal action or a more *laissez-faire* policy.

Politically, we are also seeing more mandating because Congress wants to provide more services for constituents. The American public often demands expanded benefits even if it is reluctant to pay for them. The federal government is limited as to what it can do because of the large federal budget deficit and mounting projected costs for programs that offer services to the aging population. Mandates are one method of accomplishing social objectives without imposing direct federal costs; while mandates have been termed "hidden taxes" because of their economic effects, hidden taxes are often more politically acceptable than "open taxes," where we have seen, on the contrary, a reluctance to raise rates.

Mandating proposals in Congress have drawn support among members of both political parties. In addition, the 1987 change in the Senate majority means that several key Democrats with strong ties to organized labor are in positions of leadership. Therefore, certain issues important to organized labor, such as increasing the minimum wage and mandating health insurance benefits, are more likely to get a sympathetic hearing in the Senate, which in turn could influence outcomes in the Democratic-controlled House more so than in 1981–1986, when Republicans controlled the Senate. Finally, federal lawmakers are not alone in seeking mandates. State lawmakers have already taken major steps in this direction.

State Action

Trends in state mandated health benefits are discussed at length in chapter IX and form the basis for our discussion here. In the area of health benefits alone, during the past 20 years, there have been a total of 645 mandating laws enacted in the 50 states. Such mandating increased during the mid-1960s, then escalated in the mid-1970s. In 1975 alone, 75 state laws were enacted. Preliminary indications are that such activity may have peaked at the state level, but it may be too premature to draw definite conclusions. 1987 has seen as many or more state mandating bills introduced as in other years. In Texas, for instance, 33 separate pieces of legislation that mandate some form of expanded coverage on employer-based health insurance are being considered.

In general, state-enacted mandates have been an expansion of the variety of benefits that must be provided by an employer, (such as alcoholism treatment or in vitro fertilization); an expansion in the number and types of providers eligible to perform and be reimbursed for services, such as social workers and chiropractors; and an exten-

sion of the length of time coverage will be in effect and the type of dependents covered—typically handicapped children until they reach the age of majority or adopted children and newborns.

A major Supreme Court decision in 1985, *Metropolitan Life vs. Commonwealth of Massachusetts*, upheld the rights of states to mandate certain employer-provided health benefits through their insurance regulation capacity. The Employee Retirement Income Security Act (ERISA) preempts state regulation of employee benefit welfare plans. Therefore the many employers who self-fund rather than use insurers have been able to escape the state health mandates. If growing numbers of employers self-fund, state mandates become less effective. This has led to a drive to include self-funded plans in the new regulatory efforts at the state level.

In addition, legislation has passed in four states (Washington, Oregon, Arizona, and Pennsylvania) that requires that any consideration of mandated benefits include evaluation criteria—a form of social and financial impact statement. That requirement has slowed mandating activity in those states, and employers in other states may seek similar action.

Meanwhile, some of the advocates of mandates are turning to the federal level, to encourage Congress to approve legislation that will affect all 50 states.

Federal Action

The issue of preemption, or the relationship of federal rules and state rules, is critically important for employers who provide benefits. For example, the Consolidated Omnibus Budget Reconciliation Act (COBRA) mandated in 1986 that employers offer continued coverage for former workers and family members at the beneficiary's expense. But since COBRA did not preempt state law, employers have to comply with the new federal rules and, where they exist, more restrictive state rules on top of the federal rules.

It is important to keep in mind that, often, legislation is proposed that will lay dormant for years, but then is quickly passed into law. For example, for years, a congressional resolution that Social Security benefits will never be taxed was unanimously approved. Then in 1983, Congress voted to tax one-half of Social Security benefits of beneficiaries whose total income exceeds $25,000; and in 1985, then-House Speaker Tip O'Neill proposed taxing as much as 85 percent of Social Security benefits. And in 1987 there was a proposal before the House

Ways and Means Committee—which was not adopted—to tax the actuarial value of Medicare.

Quick reversals of legislative fortunes seem particularly characteristic in this area. For example, legislation abolishing mandatory retirement was introduced and reintroduced for many years but received little serious consideration. In 1986, however, efforts attributable to Rep. Claude Pepper (D-FL), combined with a major election contest, resulted in quick congressional action to abolish mandatory retirement for nonexecutives. The same year (1986) witnessed other long-standing issues—such as a requirement that employers make pension contributions for workers beyond age 65—become law, along with a host of detailed new pension, health, and other benefit rules, hitched onto the fast-moving train—the tax reform legislation.

Mandated Health Benefits

Not surprisingly, health is now one of the top four issue areas for mandating activity at the federal level. Among the major health issues considered are:

- catastrophic health insurance coverage for active workers and retirees;
- minimum health benefits for all workers;
- risk pools for the uninsured, to which employers would contribute;
- specific coverages; and
- growing identification of occupational risks to health.

Several pieces of legislation addressing such issues have been introduced in Congress. Among those receiving consideration is S. 1265, sponsored by Sen. Edward Kennedy (D-MA), which would require employers to provide minimum health coverage to workers and their families. Advocates of the bill say it will help address the current issue of the growing number of Americans—37 million in 1987—who have no health insurance, and the related issue of uncompensated care. Opponents of the bill fear the competitiveness of American firms in world markets would suffer because of additional labor costs; they also predict the bill will increase unemployment as employers cut costs in other areas to compensate for the added insurance costs. Two other bills introduced in the 100th Congress, S. 1370, sponsored by Sen. Dale Bumpers (D-AR) and S. 1386, sponsored by Kennedy, are intended to ease access to health insurance for self-employed individuals by expanding the favorable tax treatment of such purchases.

While Congress has not yet approved legislation that would require employers to provide catastrophic health insurance coverage for all employees covered in group plans, it has been debated in the House Ways and Means Subcommittee on Health and will likely be the focus of a recurring debate.

Risk pools for the uninsured are another type of mandating proposal. The House Ways and Means Subcommittee on Health has approved, as part of the fiscal 1988 budget reconciliation package, language to clarify that states may voluntarily establish and finance risk pools from which the uninsured could buy health care coverage. The language sets guidelines for states to follow in setting up the risk pools and according to congressional staff, is aimed at alleviating states' concerns that their establishment of risk pools could be found to violate terms of ERISA. In other words, Congress may not be ready yet to mandate such risk pools, but they may enact legislation granting states the clear authority to do so.

There is also increased congressional awareness of occupational risks to health and discussion of employers' responsibility to inform workers of hazardous substances and processes in the work place. One such bill, H.R. 162, sponsored by Rep. Joseph Gaydos (D-PA), entitled the "High Risk Occupational Disease Notification and Prevention Act of 1987," was approved by the House. A similar bill—S. 79, sponsored by Sen. Howard Metzenbaum (D-OH)—is moving through the Senate.

Other health-related issues of concern to employers because of possible mandating action include:

- Medicare's financial problems—There is a concern that many of the solutions proposed by Congress will continue to shift Medicare costs over to employer plans.
- Retiree health funding—Proposals are being discussed that might extend employer responsibilities for retiree health, through, for example, an expansion of COBRA to provide for continuation of coverage for retirees and their families throughout retirement. Legislation to provide a tax-favored vehicle for employers to fund retiree health benefits has been introduced. Sponsored by Reps. Rod Chandler (R-WA), and Ronnie Flippo (D-AL), H.R. 2860 would establish tax-exempt voluntary retiree health plans (VRHPs) to encourage employers to prefund retiree health and long-term care benefits. But along with these incentives, Congress is reviewing the law in terms of maintaining employer obligations to retirees and terminated employees in the event of bankruptcy. The House and Senate are in the process of resolving differences in legislation (H.R. 2969, S.548) that each has approved to give retiree groups a legal standing in bankruptcy proceeding. The legislation would make it illegal for firms in Chapter 11 bankruptcy filings to teminate retiree life and health

benefits without first securing the agreement of the retirees or, failing that, the bankruptcy court.

Plant Closings and Terminations

Another area in which Congress may approve mandates, in an effort to address the lack of work place security, concerns plant closings and terminations. This activity has intensified with industrial restructuring and "downsizing" of the 1980s. Here again, states have taken the lead in enacting legislation affecting plant closings. More than 12 states have enacted either "plant closing" laws or assistance for "dislocated workers." Some require businesses to notify workers in advance of a closing. Others require the state or businesses to provide such benefits as health insurance, severance pay, or reemployment assistance to displaced workers. Still others set up a program of assistance to help workers purchase plants threatened with closure.

Many would argue that the American work place has become far less secure than it was in the past. Increasing international competition is often cited as one reason. Interestingly, some American firms are reacting by using temporary or so-called "buffer" employees similar to the method used by the Japanese. In the United States, a recent congressional estimate put the number of people working part-time because they cannot have full-time work as having more than doubled since 1970, to some 5.5 million workers.

Because of widespread downsizing, overall employment by very large firms has apparently declined rather than increased in recent years. In particular, extensive layoffs, terminations, plant shutdowns, and all these signs of change and insecurity in the work place have created political pressures to address the issues of advance notification rights, and continued benefit coverage during layoff, among others.

At the end of 1986, a task force of business, labor, and government officials issued a report to Labor Secretary Brock, entitled "Economic Adjustment and Worker Dislocation in a Competitive Society." The task force found that in the five years from 1981 to 1986, 10.8 million persons permanently lost their jobs. Nearly half of these, some 5.1 million workers, had three years or more of job tenure and constituted "displaced" workers. Although some dislocated workers found new jobs, more than one-half of these jobs paid less than their previous jobs.

The task force found that displacement is becoming a fact of life in the American economy, and that displaced workers suffer personally and financially. The task force said that the United States needs a comprehensive federal/private partnership policy to rehabilitate and retrain the displaced workers. The report noted that while many employers already demonstrate responsibility in this area, many others do not: and it called for the private sector to take prime responsibility for dislocated workers. Among the task force's recommendations were the creation of a federal entity to oversee a national program of assistance, with new federal funding. The report pointed out that the use of advance notice of plant closings and layoffs helps public and private services aid displaced workers.

Since 1974, legislation requiring that companies give advance notice of plant closings has been introduced in Congress in every single year. Proponents of plant closing legislation point to: (1) the possibility of another recession, (2) the foreign trade imbalance and resulting economic dislocation, and (3) the downsizing of major American industries as the reasons such a measure is needed immediately.

This drive for a national employment policy for displaced workers is an essential component in the overall competitiveness "rush" in Washington and has resulted in controversial legislation. For example, the bill sponsored by Sen. Metzenbaum of Ohio, entitled the Economic Dislocation and Worker Assistance Act of 1987, S. 538, is designed to help train and relocate workers dislocated by import competition. A modified version has been incorporated into the trade bill approved in the Senate (S. 1420), and would require companies with 100 or more employees to give their workers at least 60 days notice of: (1) plant closings that affect at least 50 people; and (2) mass layoffs that affect at least 50 people and at least one-third of the work force. Metzenbaum's original version required up to 180 days notice and included language requiring disclosure of the firm's financial information; those provisions were deleted from the trade bill amendment. The House version of the trade bill (H.R. 3) does not include the plant closing provision. Proponents argue that the provision is basic human fairness. Opponents of the legislation argue that it will destroy venture capital and discourage plant openings. They also claim it will inhibit the adaptations necessary for American firms to remain competitive.

Regardless of the outcome of this provision, Congress is likely to consider additional measures on worker dislocation and plant closings in the future.

Family Leave

Many countries, including all of the major industrial nations except the United States, provide standard employee leave benefits for maternity and child care. In the United States, some employers and some states provide various levels of dependent care benefits, but there is no national standard. At issue is the question of whether such benefits in the United States should be mandated by federal law or left to the states, to individual employers, and to the collective bargaining system, as is current practice.

Legislation introduced in the 99th and reintroduced in the 100th Congress would require that employers provide up to 18 weeks of unpaid parental leave of either parent, with job reinstatement guarantees. The legislation also includes a provision that addresses the issue of continuation of health insurance coverage and unpaid medical leave with job reinstatement to employees with serious medical illnesses. It would also establish a commission to study methods of providing salary replacement for employees who take such leave. In some versions of the bill, the same unpaid leave could also be used by workers taking care of elderly dependent parents, argued as being necessary as more and more Americans find themselves during their mature working years with increased responsibility for their children and for their parents. As of November 1987, a conference version of the mandatory family leave policy has been approved by the House Education and Labor Committee and is expected to pass the full House by year end.

Pensions

Proposals to require companies to increase contributions to underfunded pension plans and to place restrictions on the surplus pension assets that companies can recover from their defined benefit plans are foremost among pension issues pending before Congress. Those are closely followed by other legislation designed to increase pension portability and mandate rollovers and acceptance of lump-sum transfers of pension benefits from employer plans.

Legislation first proposed by the Reagan Administration and later approved by Congress would substantially increase the Pension Benefit Guaranty Corporation's (PPGC's) basic per participant insurance premium for defined benefit plans. A variable premium surcharge would also be added under some versions of the bill in proportion to the amount the plan was underfunded. The premium increase would

be used to reduce the PBGC's $4 billion deficit. The large deficit is primarily the result of the termination of underfunded pension plans in the steel industry. The pension funding legislation, as proposed by the administration, has since been modified, but some type of pension funding and PBGC premium increase will likely be enacted in the 100th Congress.

Legislation prohibiting asset reversions to employers upon the termination of a pension plan was introduced into Congress (H.R. 1942) by Rep. Edward Roybal (D-CA). While most legislation does not go so far as to prohibit reversions, Congress is discussing proposals that would, among other things, double the current 10 percent excise tax on asset reversions or require plans to share a portion of the surplus assets with plan participants.

Legislation imposing restrictions on mergers and acquisitions is another related issue before Congress in 1987. Increased activity during 1985 and 1986 caused several congressional committees to begin inquiries into the economic effects of mergers and acquisitions. One of the proposals would prohibit the use of surplus pension plan assets to finance a takeover.

Other pension "reform" legislation includes a number of portability proposals. Such legislation is designed to increase the ability of employees to have their pension assets transferred when leaving jobs. The bills are not identical, but many of the provisions are similar and would require employers to offer lump-sum transfers of benefits to an individual retirement account (IRA) or another type of individual portable pension account, to another employer plan, or a simplified employee pension plan (SEP). In addition, employers who currently do not provide pension plans could be required to establish a SEP for an employee if requested, and employers who offer defined contribution retirement plans would be required under certain legislative proposals to accept transfers from other plans.

The Economic Equity Act (H.R. 2577 and S.1309), which has been introduced in previous sessions of Congress, is designed in part to address concerns of women in the work place in areas such as pensions, Social Security, insurance, and dependent care. Sponsored by Reps. Pat Schroeder (D-CO) and Olympia Snowe (R-ME), and Sens. Alan Cranston (D-CA) and Dave Durenberger (R-MN), the legislation is divided into two parts—work and family. It would prohibit the integration of pension plans after December 21, 1999. It also clarifies that integration rules in the Tax Reform Act of 1986 would apply to all accrued benefits as of December 31, 1988, and not just to benefits accrued after that date. Five-year vesting for multiemployer pension

plans would be required. While the legislation as a whole has not passed Congress, provisions of prior versions of the bill have been approved and are now law.

Minimum Wage

Numerous bills are pending before Congress to increase the minimum wage. Most of the legislation is designed to increase the minimum wage by 50 percent—from the current $3.35 to $4.65—over the next three years and to index future increases after 1990 to 50 percent of the average private nonsupervisory, nonagricultural hourly wage. The legislation (S. 837 and H.R. 1834) sponsored by Sen. Kennedy and Rep. Augustus Hawkins (D-CA), is being actively debated in both houses of Congress.

Other types of mandating legislation are also being considered that would address employee drug testing, prohibit polygraph testing, and address acquired immune deficiency syndrome (AIDS) discrimination. Of these measures, the "Employee Polygraph Protection Act," (H.R. 1212) was approved by the House on November 4, 1987. The legislation, sponsored by Rep. Pat Williams (D-MT), would generally prohibit private employers from subjecting current and new employees to polygraph tests.

Conclusion

Congressional activity is often driven by themes. During the 99th Congress, a major theme was tax reform. In 1987, it is competitiveness in international trade. Legislation addressing a variety of issues from worker dislocation protection to pension portability is being packaged as being procompetitive, protrade, and proindustrial policy.

The wide range of legislation imposing some type of mandate on business—though not altogether new—indicates an intense interest in the mandated benefits issues.

In the past, employers have sometimes been silent on benefit mandating. One reason is that congressional bill sponsors often attach benefit mandates to tax bills, and employers may then be more concerned with the key tax provisions, not the mandates. In addition, some employers prefer to keep a low public profile. The issue of mandated benefits is now beginning to gain so much attention that employers are becoming more involved in the debate.

Most of the current inspiration for specific work place "entitlements" consists of extending to the noncovered population valuable,

extensive, and socially desirable benefits policies that many companies voluntarily provide on their own or through collective bargaining. The issue is whether a given mandate is appropriate and necessary national policy and what the costs and the benefits will be.

The papers and discussion that follow explore this issue in greater detail.

PART ONE
IMPLICATIONS FOR LABOR COSTS AND BUSINESS COMPETITIVENESS

Debate in Washington over the issue of mandating benefit programs comes at a time when American businesses are facing stiff challenges at home and abroad. The U.S. trade deficit totaled $148.5 billion in 1985 and almost $170 billion in 1986. Global competition in manufacturing has been increasing for almost two decades. Some economists believe that more than 2 million jobs may have been lost since 1980 due to declining exports.

At home, major industries such as steel are suffering plant shutdowns and massive cutbacks in employment. Deregulation has caused increased competition in telecommunication and airline industries. Companies are restructuring to trim costs and increase productivity so they can remain competitive in domestic and international markets.

In this environment, a key issue is productivity. Although U.S. production costs, especially labor costs, are among the highest in the world, U.S. businesses previously had been able to compete successfully against countries with much lower production costs because of superior productivity performance. However, foreign countries have been increasing productivity at a faster pace than the United States in recent years. Japan, West Germany, and other European countries are experiencing higher rates of growth in productivity.

Since labor is a significant component of production costs, measures that would increase the already-high cost of labor cause concern in the business community. Although federally mandated benefits would raise employer costs, the extent of those increases have not been quantified. Nine out of ten full-time workers in medium and large U.S. companies are already covered by health and life insurance programs and pension plans, as well as paid holidays and vacations. In 1985, 66 percent of the U.S. population was covered for health care by an employer plan. The trend until recently has been for employers to expand and improve these benefit packages, generally at little cost to the employees.

But the federal government has also imposed requirements on employers, such as the minimum wage and the payment of Social Security taxes, to achieve specific social goals. Congress has financed

other social welfare programs through tax revenues that benefit the U.S. worker as well as other Americans. With lawmakers under increasing pressure to curb federal deficits, however, they have begun looking more closely at policy solutions that can be financed by employers. One possibility that has been discussed, for example, would require employers to provide a minimum health insurance benefit analogous to the minimum wage law.

But lawmakers must wrestle with the dilemma that mandated benefit programs intended to ensure wider access to benefits and expanded coverage could raise employer costs and thus could have a serious impact on job opportunities and the ability of American business to compete in the world marketplace.

To view mandated benefits in the context of business productivity and competitiveness requires trying to assess what effects such mandates could have on labor costs and thus on the U.S. competitive trade position. Part one of *Government Mandating of Employee Benefits* examines these questions. In chapter I, Olivia S. Mitchell and Angela M. Mikalauskas review research that has been done on the labor market impact of federal policies in six areas. These are: (1) minimum wage; (2) work place safety and health; (3) overtime compensation; (4) antidiscrimination legislation; (5) increases in Social Security payroll tax; and (6) employer-provided pensions.

Each of the policies reviewed in these areas has served to increase the cost of labor, Mitchell and Mikalauskas say. Federal regulations have had an impact on employment and wage levels, primarily for small firms, because they have the least flexibility with regard to wage levels, according to the authors. To the extent that these costs could not be offset by less expensive labor or capital, they contend, employment and output have decreased.

The authors also conclude that the federal policies reviewed have achieved uneven results in terms of their intended social goals. For example, they say, antidiscrimination policies appear to have contributed to an improvement in the earnings of women and minorities relative to white males. But overtime pay policies that were intended in part to stimulate employment have resulted in only small employment gains according to the studies they have reviewed.

Mitchell and Mikalauskas predict that the burden of any future mandated benefits will fall on small firms with a consequent loss in jobs for females and teen-agers.

In chapter II, Kenneth McLennan examines the relationship between the competitiveness of U.S. industries and the issue of mandatory benefits. McLennan offers the argument that the major long-

run source of the U.S. competitiveness problem has been increased costs of production compared to the costs of foreign competitors. As long as U.S. productivity levels kept rising, increasing production costs could be offset, but that is no longer the case, McLennan continues.

Instead of financing social goals through higher production costs with adverse effect on competitiveness, McLennan says, U.S. industry should be increasing its rate of investment. McLennan provides data on comparative investment spending and compensation costs of the United States and other major trading countries and industrialized nations.

McLennan says that the cost of health benefits even without further mandated benefits contributes to the competitiveness problem of American business. If policymakers believe medical indigency should be reduced, he says, government resources already devoted to health care should be shifted to that goal. He suggests that some health care resources now consumed by middle- and upper-income Americans could be transferred to those who lack health care services.

I. The Impact of Government Regulation on the Labor Market: A Survey of Research Findings

PAPER BY OLIVIA S. MITCHELL AND ANGELA M. MIKALAUSKAS*

Introduction

How regulation affects labor markets is a topic of considerable current interest. This paper summarizes what economists do and do not know about the labor market impact of regulations.

There is little research that speaks directly to the likely impact of current proposals to mandate health care, pension benefits, parental leave, or other social welfare policies. However, there has been a great deal of work on the question of how previous policies have affected the labor market. This paper summarizes what is known about the labor market impact of six specific regulations: 1) minimum wage legislation; 2) work place safety and health; 3) regulation of overtime compensation; 4) antidiscrimination legislation; 5) the Social Security payroll tax; and 6) employer-provided pensions.

Labor market regulation often increases the cost of one or more elements of employee compensation including wages, employee benefits, and perhaps working conditions. When regulation alters labor costs, some firms may be able to reallocate compensation to offset these new costs. Frequently, however, labor costs must rise as a result of a policy change, and hence production costs rise as well. Firms respond by raising product prices and/or reducing output. In general, then, labor market regulation may reduce total employment, and possibly firm profitability as well. The impact will be more pronounced on small employers who have less flexibility to rearrange compensation packages. As a result, small employers face greater competitive pressures because of their inability to deflect rising labor costs.

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*Support for this research was provided by the Employee Benefit Research Institute. In particular, this paper updates and extends an earlier survey article by Mitchell (1982b), titled "The Labor Market Impact of Federal Regulations: OSHA, ERISA, EEO and Minimum Wage." The full references cited by the authors and other references are listed in Appendix A.

If a policy increases the cost of hiring one particular category of labor relative to other categories of labor and capital, employers will move away from the more expensive category to other categories (Hamermesh and Grant, 1979). Several researchers have attempted to measure the percentage change in the employment of one category of labor when the wage rate of other groups of labor (or the price of capital) changes. While the magnitudes of the estimates vary, several general conclusions can be drawn. In particular, production workers and capital are substitutes, as are production and nonproduction workers. In addition, skilled labor is less substitutable with capital; part-time workers are easily substituted for full-time workers; young workers are easily substituted for capital (Hamermesh and Grant, 1979). Within specific age and sex categories of labor, it appears that older males are substitutes for male teen-agers; older females are substitutes for younger males; women aged 20–34 are substitutes for teen-agers of both sexes (Levine and Mitchell, 1986). Of course, the extent to which any individual firm would be able to substitute among various categories of labor and capital would depend on its particular production process, union and labor contract constraints, and the pool of labor available for employment.

This chapter provides a brief overview of the major regulatory developments in the six regulatory areas listed above followed by a description of the policy's labor market implications. Then statistical evidence is presented on each policy's labor market impact.

Minimum Wage Legislation

Policy Overview

The Fair Labor Standards Act (FLSA) of 1938 established a minimum wage rate. Congress has changed the nominal value of this minimum several times over the years.* On average it has been approximately half of the average hourly earnings in manufacturing, though its relative value declines during inflationary periods (Ehrenberg and Smith, 1985). Initially, the minimum covered approximately 40 percent of nonsupervisory wage and salary workers; coverage now stands at approximately 80 percent of all nonsupervisory workers. The FLSA is administered and enforced through a special division of the Department of Labor.

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*Editor's note: The 100th Congress is considering legislation to increase the minimum wage from the current level of $3.35 per hour to $4.65 per hour by 1990, and indexing the minimum wage after 1991 to 50% of the average industrial wage rate.

Implications for the Labor Market

When workers are employed in a competitive labor market, the equilibrium level of employment is determined by the supply and demand of labor (Ehrenberg & Smith, 1985). When a nominal minimum wage is imposed that exceeds the equilibrium wage, employment is reduced. To offset the resulting unemployment, the government tends to adopt expansionary fiscal and monetary policies, fueling inflation. Over time, nominal earnings increase, the relative value of the minimum wage decreases, and employment again rises to its initial prelegislation level. This suggests, therefore, that a legislated increase in the minimum wage triggers repeated cycles of unemployment and inflation.

In the case of incomplete FLSA coverage (Ehrenberg and Smith, 1985) a minimum wage higher than the equilibrium wage decreases employment in the covered sector. Workers displaced by the minimum wage legislation tend to seek employment in the uncovered sector.This influx of workers to the uncovered sector depresses wages and increases employment in the uncovered sector. Workers in the uncovered sector may withdraw from the labor force or choose to remain unemployed and wait for jobs in the covered sector in response to the depressed wage rates they face. This suggests that total employment and unemployment may rise or fall given a legislated increase in the minimum wage, though more workers may be paid less than the minimum. Specific outcomes depend on the extensiveness of coverage, and the level of the minimum wage relative to the equilibrium wage for unskilled workers. In addition, the ability of firms to substitute skilled labor or capital for unskilled labor determines the extent of disemployment effects induced by a rise in the minimum wage.

Statistical Evidence

Many studies have estimated the effect of minimum wage legislation on various labor groups. Most of the research has focused on youth and teen-agers, because they appear to be the most susceptible to the disemployment effects of the minimum wage (Brown, Gilroy and Kohen, 1982; 1983).

Time series studies focusing on teens indicated that a 10 percent increase in the minimum wage results in a 1 to 3 percent reduction in total teen-age employment. Using 1985 employment figures (Mellor, 1986) for males and females aged 16 to 19, this would represent a decrease of approximately 19,000 to 57,000 teen-age jobs. The re-

search also suggests that many teen-agers simply withdraw from the labor market once they become disemployed. Teen unemployment levels remain virtually the same as a result of the substantial labor force withdrawal triggered by a rising minimum wage. In addition, there is evidence to suggest that many employed teen-agers reduce their hours of work in response to minimum wage increases. Full-time employment declines as the fraction of employed teens who work part-time increases. Studies examining the effects of minimum wages on teen-agers by sex and race are less conclusive.

Cross-sectional studies of the effect of the minimum wage on the employment levels of teen-agers are less numerous, but produce a wider range of estimates. Although these studies vary methodologically, the estimates are not inconsistent with the time series results.

Time series studies on the effect of the minimum wage on young adults, age 20 to 24, indicate that a 10 percent increase in the minimum wage yields a less than one percent reduction in employment. This would amount to a loss of approximately 99,000 jobs among young males and females, age 20 to 24 (when 1985 employment figures are used; Mellor, 1986). In contrast to the results for teen-agers, there appears to be no labor force withdrawal among young adults who are disemployed as a result of an increase in the minimum wage. Consequently, the unemployment effects are greater for this group relative to teen-agers (Brown, Gilroy and Kohen, 1982; 1983).

The impact of minimum wage increases on adults is difficult to measure with precision because this demographic group does not contain a large percentage of workers who would have earned less than the minimum wage in the absence of federal legislation. It comes as no surprise that empirical research has produced mixed and conflicting results (Mitchell, 1982b).

The minimum wage also affects firms' choices among various factors in the production process. Hamermesh (1981) indicates that increases in the minimum wage constrain the ability of firms to substitute adult labor for the labor of young adults and teen-agers. This suggests that a youth subminimum wage rate would offset the level of disemployment among teens and young adults, while having little impact on adult employment.

Conclusion

Federally legislated wage floors have apparently decreased teenage employment and to a lesser extent, the employment of young adults. Minimum wage increases induce teens to withdraw from the labor market rather than remain disemployed, which offsets much

of the job loss; this leaves unemployment statistics virtually unchanged. Young adults tend not to withdraw from the labor force in response to an increase in the minimum. Consequently, the minimum wage has larger unemployment effects for this group relative to teens. The impact of the minimum wage is inconclusive with respect to adult employment and differential effects by sex and race.

How minimum wages affect firm performance has not yet been adequately addressed in the literature. Increases in the minimum wage increase firms' total labor costs. They respond by decreasing the employment of young workers and teen-agers. The size of the reduction has been shown to be relatively small, however. Two reasons may account for this empirical observation. First employers may alter the total compensation package, thus minimizing the costs they bear as a result of the legislated increase in the minimum wage. By reducing nonwage compensation that is not covered by the legislation, the employment effects are probably smaller than what they otherwise would have been. Second, enforcement of the minimum wage is less than perfect and noncompliance carries limited penalties. The availability of workers willing to offer their labor services for less than the minimum, combined with low enforcement and sanctions, minimizes the disemployment effects that would otherwise have been present (Ehrenberg and Smith, 1985). Empirical research on the extent of noncompliance with the law and the ability of firms to cushion the impact of increases in the minimum is needed before the full impact of the legislation on firm profitability can be addressed. There is also some indication that increases in the effective minimum wage erodes firm's ability to substitute adult labor for teen-agers and younger workers.

Occupational Safety and Health Regulation

Policy Overview

With the exception of federal standards aimed at a few specific industries, responsibility for safety in the work place lay within the jurisdiction of individual states until 1970. As a result, regulatory standards and enforcement were highly variable and erratic, and worker safety often depended on voluntary adherence to self-imposed industry standards. Concern with rising work-related injury rates led to the passage of the Occupational Safety and Health Act (OSHA) in 1970.

OSHA legislation provides employers with work place health and

safety standards, and makes them responsible for protecting workers from hazardous conditions. The Department of Labor is responsible for the development and enforcement of national standards, although manpower limitations minimize the frequency with which a firm is inspected. The primary method of enforcement is on-site inspections of firms in targeted industries. Noncompliance is sanctioned through fines, although the size of the fine is often not large (Mitchell, 1982b). As a result, firms may deliberately violate OSHA regulations because the penalty associated with noncompliance is smaller than instituting the necessary health and/or safety changes. Violations of the standards may also be a form of protest by firms when the standards set by the regulatory agency are deemed too stringent or cost-prohibitive (Gray, 1984).

Implications for the Labor Market

Workers who are fully informed and able to judge the inherent dangers in their work place will demand a wage premium reflecting the degree of on-the-job risk. A worker choosing not to accept the risk would be able to locate a different job, with lower wages but acceptable levels of risk. Employers can reduce the amount of on-the-job risk by implementing safety standards. Wages must be lowered to offset the costs associated with reducing the risk of injury. Consequently, low risk is associated with low wages and high risk is associated with high wages.

When the government mandates minimum standards of safety for all workers, labor costs increase. Some firms may adopt policies that reduce the total compensation package. To the extent that this does not fully offset the increase in safety costs, firms may also substitute capital for labor in their production process. If these measures fail, firms may seek to raise output prices. The subsequent reduction in demand is predicted to induce a decrease in profitability and employment and generate inefficiencies. Government-imposed standards may still be desirable if workers are unable to ascertain the level of risk associated with a job. Some studies indicate that workers are in fact poorly informed about work place hazards, while others show that workers receive wage premiums for high-risk jobs (Mitchell, 1982).

Statistical Evidence

Several researchers have attempted to address the impact of safety regulations on a firm's choice of factor inputs and on productivity.

Unfortunately, quantitative research in this area is hampered by the lack of appropriate data on worker exposure to risk, both before and after the passage of OSHA.

Gray (1984) examines the impact of government safety standards on productivity growth in the economy. Using 1958–1980 figures on 450 manufacturing industries, he shows that there was a slowdown in average productivity growth during the 1970s. It is estimated that safety regulations significantly contributed to this slowdown in productivity growth. There is also some indication, however, that the large impact of regulation on productivity in the 1970s represented a one-time cost of adjustment to new regulatory pressures. After this initial adjustment, the author speculated that continued regulation at the same level may not affect future productivity growth.

Elder (1985) examines the impact of work place safety regulations on a firm's choice of capital and labor in production. His results indicate that the cost of safety regulations strongly influences levels of capital and labor. As costs increase, firms reduce output, decreasing their levels of capital and labor utilization. In addition, there is evidence that firms also substitute capital for labor in the production process, thus further decreasing the level of employment. The magnitudes of these effects have not yet been established.

Conclusion

Available empirical evidence suggests that the cost of government implemented safety standards is high. Productivity levels in the economy are reduced, although this may be the result of initial adjustments to the new regulatory environment. Firms respond to increased costs of safety by decreasing their output and substituting capital for labor. This creates a downward pressure on both profitability and labor utilization.

Research on the benefits of safety regulations are inconclusive due to data limitations. In general, it appears that OSHA regulations have little impact on worker safety. These results must be tempered, however, by the recognition that infrequent inspection and small penalties severely limit the effectiveness of the legislation. In addition, the perceived benefit of the regulation depends on the workers' level of knowledge about work place hazards. Lack of appropriate data has generated inconclusive empirical evidence on this issue.

Overtime Compensation

Policy Overview

The Fair Labor Standards Act requires that all employees covered by the legislation receive at least 50 percent of their regular hourly pay as a premium for overtime hours of work (in excess of 40 hours per week). Initially, the legislation applied to less than 20 percent of employees, but today approximately 60 percent of all employees are covered. The major categories of workers who are exempt from overtime premiums include executive, administrative, and professional personnel, outside salespersons, state and local government employees, and agricultural workers (Ehrenberg and Schumann, 1982; Ehrenberg and Smith, 1985).

The goals of the legislation were twofold. First, the legislation was concerned with protecting workers from excessive fatigue associated with long workweeks. A second motivation was the stimulation of employment. Although many overtime hours are worked because of conditions such as seasonal demand and absenteeism, a significant portion is regularly scheduled. The overtime pay premium can be viewed as a deterrent to scheduling overtime work and an inducement to substitute new employees for overtime work, in an effort to cover needed manhours of labor.

Administration and enforcement of the law is under the auspices of the Employment Standards Administration (ESA). The investigative resources of the ESA are limited. It rarely initiates investigations of noncompliance; most investigations arise from reports of alleged violations from employees. Penalties for noncompliance are generally limited to back payment of monies owed to workers.

Implications for the Labor Market

Given a level of capital stock and other production inputs, a firm's output is related to its level of employment as well as the average number of hours worked per employee. Fixed costs of employment, such as hiring and training costs, employee benefits, and employer contributions to insurance plans (i.e. unemployment insurance, Social Security) substantially increase the cost of employing a worker. These costs are employee-related, not a function of the number of hours worked. Sometimes the cost of hiring an additional worker is greater than the cost of extending the hours of the existing work force and paying an overtime premium.

To minimize production costs, a firm wants to find the optimal combination of workers and average hours. When the fixed costs of

hiring additional workers rise, it becomes cheaper to extend the hours worked of existing employees rather than hire new workers. This results in a decline in employment levels and an increase in the hours worked per employee. Government increases in the overtime premium offset the cost effectiveness of extending the workweek of the existing work force. Consequently, increases in the overtime premium should stimulate employment levels.

The conclusion grows ambiguous, however, when other factors are considered. Increases in the overtime premium raise the average cost of hiring labor. This induces firms to substitute capital for labor in the production process. In addition, if higher labor costs are passed on to consumers in the form of higher prices, the demand for the firm's output may decrease. Both of these effects would reduce the total demand for hours of labor by the firm, and offset employment gains induced by an increase in the premium. Curtailing of overtime hours of work may also prompt currently employed workers to seek additional part-time jobs. This would reduce the employment gains of an increase in the overtime premium. Additionally, if the skill levels of the unemployed are dissimilar to the skill levels of those who are currently employed, a rise in the premium will undermine the goals of the proposed legislative amendment. Lastly, firms may not fully comply with the overtime pay provisions of the FLSA, weakening the law's impact (Ehrenberg and Smith, 1985).

Statistical Evidence

Early research on the overtime premium indicated that employment grew 0.5 to 1.5 percent in manufacturing, and 0.8 to 2.1 percent in nonmanufacturing, as a result of the law. Using 1985 employment figures (Mellor, 1986), this would represent an approximate increase of 91,000 to 274,000 jobs in the manufacturing sector; and 284,000 to 745,000 jobs in the nonmanufacturing sector. However, the assumptions underlying these estimates are questioned by Ehrenberg and Schuman (1982), who conclude that job creation estimates should be reduced by at least 10 to 20 percent, and possibly more.

Conclusion

The evidence suggests that employment gains associated with increases in the overtime premium are small. Although there have been no studies on how the premium affects firm profitability and productivity, simulation evidence suggests that firms do pass on some of the increased labor costs to consumers (Ehrenberg and Schuman,

1982). In addition, firms may realign their capital/labor ratios in an effort to minimize their use of labor hours.

Antidiscrimination Policy

Policy Overview

Discriminatory labor market practices against women and minorities were first addressed by the federal government in the 1960s. Two major pieces of legislation and an executive order have outlawed discriminatory behavior by employers. The Equal Pay Act of 1963 requires "equal pay for equal work." This legislation prohibits wage discrimination on the basis of sex, when men and women are engaged in work similar in skill level and job conditions. The legislation does not directly address equal opportunity in hiring and promotion. Title VII of the Civil Rights Act, enacted in 1964, goes beyond the Equal Pay Act by outlawing discriminatory practices based on an individual's race, religion, gender, or ethnic origin. The legislation also addresses a broader range of employment issues, including hiring, discharge, promotion, and training. Title VII is enforced by the Equal Employment Opportunity Commission (EEOC), which has a mandate to investigate and mediate complaints of discrimination, as well as to initiate court proceedings on behalf of employees or the government (Beller, 1978; Mitchell, 1982b).

The federal government's unique leverage as a purchaser of goods and services is also used to influence employment practices in firms holding federal contracts. Executive Order 11246, issued in 1965, stipulates that in addition to compliance with antidiscrimination law, federal contractors must commit to a schedule of affirmative action. Specifically, firms must formulate affirmative action goals and timetables with respect to the hiring, training, and promotion of women and minorities, in an effort to correct past unequal career opportunities. Enforcement is consolidated into the Office of Federal Contract Compliance Programs (OFCCP); the office is authorized to cancel contracts or limit a firm's eligibility for future contracts in cases of noncompliance. These measures are rarely taken, however (Ehrenberg and Smith, 1985).

Implications for the Labor Market

As noted above, federal antidiscrimination policy regulates labor market outcomes (wages, hiring, training, and promotion), rather than altering labor market interactions, per se. This approach relies

on the belief that legislating outcomes will prompt corrective action on the part of the parties perpetuating market discrimination (Mitchell, 1982b).

The wage provisions associated with antidiscrimination laws generate both anticipated and unanticipated outcomes. Equal pay laws are expected to raise wages of women and minorities, in accordance with intentions. However, pay increases for these groups relative to other factors of production (including white males) make women and minorities appear more costly to employers. Consequently, firms with discriminatory attitudes are seen as hiring fewer women and minorities, because they are viewed as relatively more expensive than white males (Beller, 1978; Ehrenberg and Smith, 1985). Consequently the equal pay provisions are predicted to reduce employment among the groups suffering discrimination.

In contrast, the employment provisions of Title VII and compliance with affirmative action are expected to facilitate the removal of labor market barriers confronting women and minorities. If the probability of apprehension and the costs of violation are sufficiently high, a firm will respond to the policy by increasing its demand for female and minority workers. Hence, in addition to increasing employment levels of these groups, this regulation is predicted to diminish wage disparities relative to white male workers. As more qualified women and minorities are hired and trained, discriminatory attitudes held by employers, co-workers, and customers should be revised (Mitchell, 1982b).

The wage provisions of antidiscrimination legislation can actually reduce the relative employment and earnings of women and minorities, while employment provisions and affirmative action should increase their relative employment and earnings levels. Consequently, the net effect of antidiscrimination legislation is ambiguous.

Statistical Evidence

(1) Affirmative Action—Analyses of the early years of affirmative action indicate that the contract compliance program was relatively ineffective for blacks. Black employment gains among federal contractors were modest and appear to have been concentrated in low-skilled positions. In addition, these employment gains were apparently not related to specific enforcement efforts such as contract compliance reviews (Mitchell, 1982b). While early studies unanimously concluded that affirmative action was ineffective in achieving occupational upgrading, Leonard (1984) argues that this was no longer true in the late 1970s. Specifically, the later years of affirmative action

appear to have been more effective in increasing the employment of black males in skilled occupations. These advances may reflect the larger employment pool of skilled black males, as well as more aggressive enforcement of compliance by the OFCCP.

Leonard (1984) also found that between 1974 and 1980, the proportional employment of white females and black males and females was larger in compliant firms relative to noncompliant firms. (Nonblack minority employment did not differ significantly based on compliance behavior.) In addition, firms subjected to compliance review appeared more likely to employ a larger proportion of black males and females, and were more likely to upgrade the occupations of all minority groups (results are less positive for white females). As affirmative action has increased the demand for minority workers across occupational groups, it has generated a rise in the wage earnings of minorities. Consequently, affirmative action has also contributed to a decline in earnings inequality.

(2) Equal Employment Opportunity (EEO)—Empirical research on the effectiveness of EEO legislation has been hampered by the difficulty of quantifying relevant policy variables. Beller (1978) measures EEO enforcement based on the probability that a firm would be apprehended and the costs associated with violating the law. In 1972, an amendment to Title VII strengthened the EEOC's enforcement capabilities by granting the agency the right to initiate court proceedings against private-sector firms. This suggests that EEO policy should have had a stronger impact on relative earnings and employment after 1972, than before.

EEO policy appears to have narrowed the male/female earnings differential (Beller, 1978). Furthermore, post-amendment enforcement narrowed the gap more than prior to the amendment. The effectiveness of EEO enforcement is more ambiguous with respect to minorities. Some studies find that black employment decreased while the black/white differential remained virtually unchanged (Mitchell, 1982b). Other research claims that enforcement of EEO legislation has increased black earnings relative to whites (Beller, 1977). The evidence, therefore, is inconclusive for minorities, though EEO enforcement does appear to have had a positive impact on the relative earnings of females.

Conclusion

Antidiscrimination policy appears to have contributed to a decline in earnings inequality for both women and minorities, relative to white males, although the impact is more pronounced for women

(Levine and Mitchell, 1986). Affirmative action also increased the proportional employment of blacks in compliant firms and generated occupational upgrading among minority groups.

The policy impact on firm performance and the level of overall employment has not yet been demonstrated. Wage provisions of antidiscrimination laws will most likely increase total labor costs for discriminatory firms. Such firms will seek to replace the now higher-paid women and minorities with relatively less expensive labor or capital. Substitution to less expensive categories of labor and capital may be hampered, however, by the production process or the costs of employing white males and capital equipment. Furthermore, affirmative action and EEO legislation limit the degree to which covered firms can curtail employment of women and minorities. In lieu of substitution, such firms may attempt to increase their output price, and/or decrease production. Profitability and total employment at discriminatory firms would be predicted to decline, though the magnitude of the decline will depend on the demand for such firms' output. Empirical estimates of these theoretical impacts are not available in the existing literature.

Social Security Payroll Tax Increases

Policy Overview

Social Security benefits were first paid to retirees in 1940. The basic structure of the program has remained unchanged since the system's inception. The public income security system is administered by the Social Security Administration and is composed of the Old Age, Survivors, and Disability Insurance (OASDI) program and the Supplemental Security Income (SSI) program. The former accounts for 95 percent of the combined benefit payments of the two programs (Thompson, 1983). Revenue used to pay benefits is derived primarily from a flat-rate payroll tax on annual earnings, up to a specified limit. In general, any individual 62 years of age or older who has worked for at least 7 1/2 years is eligible to receive benefits (Ehrenberg and Smith, 1985). Within limits, the size of the pension depends on the retiree's average monthly earnings while working and his/her age of retirement.

Concern with the solvency of the Social Security program has arisen in the past decade as a result of falling birth rates and increasing life expectancy. This has spurred Congress to legislate increases in the payroll tax and raise the retirement age prospectively, in an effort to

align revenue and expense projections. The focus here is on the effect of increases in the employer's portion of the payroll tax.

Implications for the Labor Market

Both workers and consumers bear the burden of the employer's portion of the Social Security tax. An increase in the Social Security tax raises a firm's labor costs, which reduces the benefit of hiring an additional unit of labor. Firms respond by substituting capital for labor in the production process. To the extent that firms are unable to sufficiently reduce their utilization of labor, the additional labor costs are passed on to consumers in the form of higher prices, reducing demand. Both effects decrease total employment levels. The resulting excess supply of labor exerts downward pressure on wages. Depending on the relative responsiveness of the demand and supply of labor to changes in wage levels, the tax burden would be divided between those who lose their jobs and those whose wages are depressed.

Statistical Evidence

Studies of who bears the burden of the employer's share of the Social Security tax are few in number. Early research concluded that an increase in the employer's share of the payroll tax reduced the wage rate by roughly one for one, suggesting that no jobs would be lost (Brittain, 1972). More recent evidence suggests that half of the rise in labor costs generated by an increase in the tax is offset by depressed wage levels (Hamermesh and Rees, 1984). To offset the remaining increase in labor costs, firms reduce their work force. The extent to which the burden depresses wages versus employment is still subject to debate.

Conclusion

Research has been hampered by the complexity of the Social Security program and the need to quantify relevant variables for empirical analyses. No empirical study has yet been conducted linking firm profitability to payroll tax increases. Economists have also disagreed on the precise conceptual framework with which to examine the question of who bears the burden of the payroll tax (Thompson, 1983). Nevertheless, evidence to date suggests that increases in the employer's contribution to Social Security taxes reduces wages and decreases employment, as well as increasing product prices.

Pension Income Security

Policy Overview

Pensions have become an increasingly important source of retirement income since the mid-1940s. It is projected that two-thirds of the current full-time work force will be entitled to a private pension upon retirement (Andrews, 1985; Ippolito, 1983).

Several factors account for this growth, among them organized labor's push for pensions. Another factor was the War Labor Board's pay policies during World War II. Wage increases were restricted, but employees' benefits were allowed to rise more freely. The Revenue Act of 1942 further enhanced the attractiveness of company-sponsored pensions by allowing pension contributions and investment earnings on these contributions to be tax-deferred.

After World War II, the federal government implemented several other regulations affecting the tax status of benefits, the ability of pension plans to integrate benefits with Social Security, and their responsibilities regarding disclosure of pension information. The most wide ranging was the 1974 Employee Retirement Income Security Act (ERISA). This law restricted multiple aspects of defined benefit pension plans and many features of defined contribution plans as well (Coleman, 1985). The legislation also liberalized vesting rules and established standards that would ensure an employee would receive promised pension benefits. In addition, the law imposed minimum standards for participation and vesting, liability for fund mismanagement, and reporting and disclosure requirements. Finally, the law established insurance provisions for cases of pension fund illiquidity through the Pension Benefit Guaranty Corporation (PBGC).

Three different entities monitor the administration and enforcement of ERISA policy. Issues regarding pension fund asset holdings, reporting, and disclosure are under the jurisdiction of the Office of Pension and Welfare Benefits Administration of the Labor Department. Compliance with the policy's standards for participation, vesting, and fund management are monitored by the Internal Revenue Service. Lastly, the Pension Benefit Guaranty Corporation, a nonprofit independent corporation, oversees the financial status of pension funds (Mitchell, 1982b).

Subsequent to ERISA's passage, the pace of regulation has been rapid. New regulation has been imposed on company-sponsored pensions in almost every year from the mid-1970s to the present (Rosenbloom and Hallman, 1986; Wyatt Company, 1986). Regulatory activity

has emphasized continued eligibility for pension accrual at older ages (rules outlawing mandatory retirement, and provisions requiring employers to continue pension benefit accrual after workers attain the age of 65), limits on integration (curtailing firms' ability to reduce pension payments by a portion of retired workers' Social Security benefits), and nondiscrimination rules (including ceilings on the amounts that can be contributed each year into a tax-qualified corporate pension plan on behalf of highly paid employees).

Implication for the Labor Market

Understanding how pension regulation affects labor markets is facilitated by focusing on: (1) rules regarding contribution levels, benefit accruals, and benefit amounts; and (2) rules regarding the probability of benefit receipt.

Rules regarding contribution levels, benefit accruals, and benefit amounts have progressively limited the conditions under which a pension may maintain its tax-qualified status (Mitchell, forthcoming). From the employer's perspective, such reforms make more workers eligible for pensions, thus raising pension costs. Where possible, the firm will offset these higher pension costs by adjusting other components of the total compensation package such as wages (Mitchell, 1982a; Ippolito, 1983; Ehrenberg and Smith, 1985). Alternatively, firms that cannot offset these costs may terminate their pension plans (Wendling et al., 1986), and/or substitute capital for labor.

Regulation raises the probability of benefit receipt by increasing the likelihood of vesting, increasing benefit accrual rates, making pension trustees liable for imprudent pension investments, increasing funding requirements, limiting circumstances under which a firm can avoid paying promised benefits, and setting up the Pension Benefit Guaranty Corporation. In essence, these rules provide a legal context for pension participants' claim on retiree benefits, and define the terms under which promises must be backed either by corporate assets, if any, or tax revenue, if assets are insufficient (Ippolito, 1986; Logue, 1979; Mitchell, forthcoming; Tepper, 1981). Such measures increase the expense of offering a pension plan and could, in some cases, lead to plan termination. In addition, some have speculated that the existence of the PBGC itself may induce more serious funding problems in the pension system as a whole, than already experienced. Several analysts have also pointed to the delicate financial position of the PBGC, wondering whether benefits security can be guaranteed in the long run (U.S. General Accounting Office, 1987).

Statistical Evidence

Empirical research on pension regulation has taken several tacks. Most frequently, researchers have sought to determine when and how more generous pensions tend to be offset by reduced wages (or wage growth rates). A recent review (Mitchell and Pozzebon, 1986) concludes that, on the whole, workers with pensions have higher rather than lower wages as compared to workers without pensions. This tends to call into question the notion that wages and pensions are traded off in the compensation package. However, that study also finds that among workers with pensions, wages are lower where retirement provisions are more generous and benefit security greater. For example, Smith (1981) finds a dollar-for-dollar tradeoff between pension underfunding and wage levels, suggesting that rules enhancing benefit security will directly lower wages. In overview, available studies disagree on the extent to which mandating more benefits will directly reduce wages.

A second strand of pension research uses existing evidence on the substitutability between various types of workers and capital to infer the impact of pension regulations. For instance, some researchers argue that pensions are part of an optimal risk-sharing arrangement between workers and firms, and predict that government interference with a privately efficient contract between workers and their firms will have negative consequences for employment, compensation, and profitability (Lazear, 1979). However, evidence along these lines is mixed. For instance, Allen and Clark (1987) suggest that pensions have little measurable impact on firm profitability. The effect of reducing permissable pension vesting rules has also been studied (Andrews, 1985) and appears to be relatively small, on average. Other studies have focused on the elimination of mandatory retirement rules, which find a relatively small effect since most workers retire well before age 70 (Burkhauser and Quinn, 1983). It should be recalled, however, that this particular law does have a significant impact on subsectors of the economy; older employees at universities have tended to defer retirement in response to this new ruling. Also, pension plans appear to have increased their incentives for early retirement, just as the mandatory retirement rules were abolished (Mitchell and Luzadis, 1986; Lazear, 1983).

A third strand of pension research examines the overall impact of ERISA and the far-reaching pension regulations subsequent to that law. Some claim that pension termination patterns rose over time as a result of growing regulatory constraints (Cummins et al, 1979; Wen-

dling et al., 1986), although others disagree (Ippolito, 1986). More research remains to be done on this broad regulatory question.

A fourth strand of pension research uses simulation analysis to investigate the impact of pension regulation. For instance, ICF Inc. has inserted a pension module into its complex multi-equation model of the U.S. economy. This was used to evaluate the likely effects of a mandatory universal pension proposal discussed in 1981 by the President's Commission on Pension Policy (ICF Inc., 1981). The proposed policy would have required all employers to contribute a minimum of 3 percent of pay into a tax-deferred account, for all workers over 25 years of age. A five-year vesting rule was assumed and small firms were to be granted a tax credit to offset starting costs (President's Commission on Pension Policy, 1981).

The ICF study found that some employers without pensions would have responded to cost increases brought about by the mandatory pension scheme by reducing wages and employment. Specifically, pension costs were predicted to rise from 5 percent to 28 percent, which in turn would lower overall employment by 58,000 to 160,000 jobs. The job loss was predicted to be concentrated primarily in small firms and in the service and trade sectors. The range of job loss estimates depended on how much workers' wages were assumed to absorb pension cost increases; that is, job loss estimates were larger, the less wages were assumed to fall. (Workers in larger firms already covered by more generous benefits were assumed not to be directly affected.) Hence, the simulation analysis implies that mandating pension benefit improvements has an important effect on the labor market, and the impact is quite uneven.

Conclusion

Labor market theory suggests that workers trade off wages for more secure and generous pension promises. Consequently, mandating better and more certain benefits are predicted to have a negative effect on wages and employment.

Some available evidence supports this contention. Statistical studies on the wage-pension tradeoff show little effect on coverage, but much more response of wages to benefit security. Also, other pension regulations such as the banning of mandatory retirement seem to have an impact on the way pension plans are structured. The simulation analyses also confirm the findings, implying that mandating pension benefit improvements both lowers wages and produces job loss concentrated among small firms. In general, pension regulation

has had an important effect on the labor market, although the impact has been uneven.

Overall Conclusion

In overview, it appears that each of the regulatory policies reviewed above serves to increase the cost of labor to the firm. These costs can sometimes be minimized by rearranging elements of the compensation package, leaving total compensation unchanged. However, rigidity in one or more elements of employee compensation (wages, benefits, and/or working conditions) limits employer ability to offset policy-induced labor cost increases. In response, firms will substitute less expensive factors of production within technological limitations. Cost increases may also be passed on to consumers in the form of higher prices. To the extent that labor costs cannot be offset, employment and output levels will decrease.

Empirical studies reviewed here generally confirm the predictions regarding the impact of legislation on employment levels and the degree of substitution between types of labor and capital. The primary lesson of these studies is that any mandatory social welfare policy (e.g., health care, parental leave, pension benefits) increases labor costs. The impact will be the greatest for small firms because they have the least flexibility to rearrange compensation packages. Furthermore, large firms may already provide their employees with benefits such as pensions and health insurance. In contrast, small firms less frequently provide such extensive employee benefits. The greatest burden of mandated social welfare policies would fall, therefore, on small firms. Often, small firms employ the least skilled workers, such as females and teen-agers, who are concentrated in the service sector. As a result, negative impacts in the form of lost jobs will be shouldered by the least skilled categories of labor.

II. U.S. International Competitiveness and Government Mandating of Employee Benefits*

PAPER BY KENNETH MCLENNAN

Introduction

Since 1965 public and private expenditures for health care services and for programs to provide greater income security for retirees have expanded enormously. Improvements in health care services for the elderly have resulted in a doubling of public expenditures for Medicare and Medicaid every four years. In the private sector, employer-based health insurance costs grew rapidly and by 1984 averaged $1,549 per employee, or 7.4 percent of payroll (U.S. Chamber of Commerce, 1986).

Income security for retirement was greatly improved through the transfer of income from workers to the elderly, as employer and employee payroll taxes were raised substantially to provide much higher Social Security benefits for the growing proportion of retirees in the population. During most of the sixties and seventies, the proportion of the work force participating in an employer-based pension plan continued to increase, and by 1985 employer contributions to employee pension plans averaged about 5 percent of payroll.

The trend in social policy toward improvements in income security for retirement and protection against the adverse economic and medical consequences of illness produced important benefits for many Americans. This has been especially true for the elderly. Indeed, by the early 1980s, on an after-tax basis and when noncash payments from government programs were taken into account, the elderly had a slightly higher per capita income than the rest of the population ("Pious Hopes and Criticisms," Machinery and Allied Products Institute, 1985).

Despite the greater participation in health insurance and retirement income programs, some groups of workers and their dependents still lack access to employer sponsored health and pension plans.

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*Editor's note: A version of this paper was prepared as a Machinery & Allied Products Institute memorandum as part of its series on U.S. international competitiveness.

About 17 percent of the nonelderly, nonfarm population have no health insurance protection. A majority of these individuals are relatively young workers who are heads of households and work for smaller businesses in relatively low-wage industries. For many of them, medical care is provided as indigent care, financed through charity and by the major health care bill payers—government and business.

Congressional Proposals for Mandated Benefits

In the 100th Congress one focus of attention will be the "gaps" in health care protection. Among the major areas of concern are:

- the significant and growing number of individuals with inadequate or no health care protection through their employer or through Medicaid;
- the need for catastrophic health care protection, particularly for the elderly; and
- the "unfairness" of eliminating health care protection plans for retirees as part of a bankruptcy procedure.

To meet these "gaps," a series of measures has already been introduced, such as:

- the Medicare catastrophic illness legislation that would place limits on elderly and disabled Medicare beneficiaries' out-of-pocket expenses for acute care;
- a proposal, S. 177, that would require states either to enact their own programs to provide coverage for the uninsured or to adopt a federal model of the state health care pool concept; and
- measures, H.R. 931 and S. 548, that would amend the U.S. bankruptcy law to protect health and life insurance benefits. The most far-reaching measure introduced to date is H.R. 200 which would establish a national health insurance program. In order to provide protection to all U.S. citizens and residents, the bill, when fully effective in 1992, is expected to raise *$780 billion*[1] in new revenues to cover the national health care costs anticipated for that year. Among the revenue-raising provisions are a new payroll tax and a surcharge on corporate and individual income taxes.

Although only indirectly related to the legislation above, Congress has already begun consideration of parental leave legislation, H.R. 925/S. 249. The Senate measure, entitled the "Parental and Medical

[1]By way of comparison, the current total health care expenditures of the United States in 1985 were roughly $400 billion.

Leave Act," would permit an employee to take up to 18 weeks of unpaid leave over a 24-month period for birth, adoption, or serious illness of a child. Employees taking leave under the bills would have the right to return to the same or equivalent position, with health benefits continuing during their absence.

In a period of large federal budget deficits, it is both economically and politically difficult to introduce major new government expenditure programs. It is no doubt for this reason that the proponents of expanded entitlement programs are now attempting to advance their social policy goals by mandating these benefits as part of the conditions of employment. In the past, it may have been possible for employers to pass on some of the cost of mandated benefits to the consumer in the form of higher prices. In most industries this is no longer possible.

The vast majority of U.S. businesses are now facing severe price competition in both domestic and international markets. The additional cost of mandated employee benefits will put strong upward pressure on employee compensation costs. Since compensation costs are a major component of the total costs of production—roughly two-thirds of gross domestic product of nonfinancial corporations—additional mandated benefits will make it more difficult for U.S. businesses to compete in international markets.

The fact that other nations have extensive social programs financed through payroll taxes and mandated employment costs does not mean that the United States can adopt similar programs without any deterioration in the competitive position of U.S. business. For many years, the hourly compensation costs for production workers in U.S. manufacturing have been higher, and in some cases substantially higher, than similar costs in other countries. Consequently, the only way the United States can both improve social benefits and its competitive position is through more rapid productivity growth.

Despite an upswing in economic activity and an improvement in manufacturing productivity growth rates in the United States since 1982, our rates of productivity growth still lag behind those of other countries. For the foreseeable future, any attempt to improve health care coverage and provide parental leave entitlements through mandated employee benefits can only result in lower wages and/or unemployment for some workers.

It would be much better to provide for those who lack sufficient health care protection out of more efficient use of the huge expenditures the government now devotes to health care programs, than to finance a reduction in medical indigency by mandating additional

expenditures to employers. As a nation, we are no longer in a position to transfer additional resources from industry to meet desirable social goals, without considering first whether these resources are likely to yield greater economic and social benefits if invested in activities that improve the competitive position of the U.S. economy.

Sources of the U.S. Competitiveness Problem

After 1980 many U.S. industries lost their competitive edge during the severe cyclical downswing in economic activity and the unprecedented increase in the value of the dollar. But this source of the competitiveness problem is quite different from the long-run underlying causes that eroded the U.S. competitive position throughout the 1970s.

Cyclical Sources of U.S. Loss of Competitiveness

Part of the competitiveness problem is attributable to adverse cyclical trends. During the 1981–83 recession, to eliminate double-digit rates of inflation, the government adopted a mix of loose fiscal policy and tight monetary policy. The result was relatively high interest rates that attracted a substantial flow of foreign capital to the United States. This raised the value of the U.S. dollar very substantially. As a result, U.S. imports were stimulated and it became more difficult for U.S. exporters to sell their products in overseas markets.

Under the new regime of global markets, the recession in the United States and in other industrialized countries had serious adverse effects on the economies of developing nations. It made it more difficult for those countries to export products and earn currency to purchase U.S. exports. In addition, the rapid rise in the value of the U.S. dollar raised the real cost of interest on the loans held by many third-world countries. This precipitated the third-world debt crisis. After 1980, the demand for imports by developing countries moderated, making it more difficult for the United States to export to third-world markets. While the debt crisis was partially attributable to U.S. policy, its underlying cause is to be found in the domestic policies of many of the third-world countries. Many third-world countries, even those that had relied heavily on loans from industrialized countries to finance the restructuring of their economies toward manufacturing, have been successful in overcoming the debt crisis. The difference in response to the debt crisis between Asian and Latin American countries suggests that the external environment was only one factor in the problem facing developing countries in the 1980s (Maddison, 1985).

Underlying Problem: Relative Unit Costs of Production

The most important long-run source of the U.S. competitiveness problem has been the adverse trend in the unit cost of production of U.S. products compared to foreign competitors' unit costs. This trend began long before 1980.

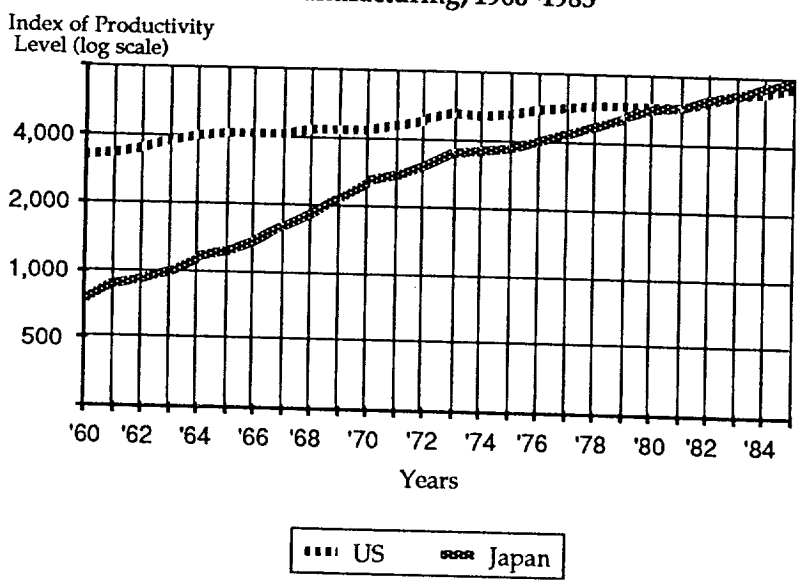
Ideally, the measurement of unit costs should include the cost of capital, intermediate inputs (such as energy), and labor, but data limitations require that unit labor costs of production be used as a proxy. If foreign competitors can lower their unit production costs by a margin sufficiently large enough to offset the marketing and servicing costs and the cost of transportation to U.S. markets, their products can pose a competitive threat to products manufactured in the United States.

Unit costs depend on the level of productivity as well as the cost of production inputs. In the past, unit costs in the United States were lower than similar costs in other countries primarily because of higher productivity levels in the United States. Even though U.S. production input costs, especially labor costs, were the highest in the world, our superior productivity performance was sufficient to offset the threat of foreign competition from countries with lower wage structures.

Over the past two decades, this traditional advantage enjoyed by U.S. manufacturing has been eroded gradually. The major culprit in the U.S. competitiveness problem has been our poor *comparative* productivity performance. As shown in chart II.1, in 1960 the average level of labor productivity in Japanese manufacturing was less than one-third of the level in the United States. This means that U.S. factories, on average, produced at least three units of product per person that year for every one produced in Japanese factories. By 1980, however, the cumulative effect of 20 years of extraordinarily high manufacturing productivity growth rates in Japan—two to three times more than average U.S. annual rates—caused productivity *levels* in the two countries to converge. Some U.S. manufacturing industries are still more productive than their Japanese competitors, but in others our productivity levels have been surpassed. The combination of high productivity and lower input costs gave Japanese manufacturers substantially lower unit costs of production and a substantial competitive advantage in global markets.

The United States probably continues to have a higher average level of manufacturing productivity than its European rivals, although a similar convergence trend has occurred over the past 25 years. In some manufacturing industries, a number of Pacific Basin

CHART II.1
U.S. and Japanese Productivity Levels in Manufacturing, 1960–1985



Source: Based on William J. Baumol and Kenneth McLennan (eds.) Productivity Growth and U.S. Competitiveness, (New York: Oxford University Press, 1985), Chapter 1.
Note: The benchmark year for the comparative levels is 1977. The relative productivity levels for 1977 are based on the Japan Productivity Center's industry comparison of most manufacturing industries in each country for the 1970s. To determine the estimates for the period 1960–1981, the U.S. government's growth rate statistics were applied to the Japan Productivity Center's 1977 productivity level estimates.

countries, such as South Korea, Taiwan, and Hong Kong, are also now rapidly approaching U.S. levels of productivity.

During the 1960s and 1970s, relative compensation costs also affected the competitive position of U.S. industries. Over the 1960–1973 period, the higher rates of productivity growth of our major trading partners permitted them to increase the compensation of their workers at a rapid rate. This trend in other countries, along with very moderate annual wage increases in the United States during the 1960s and early 1970s, substantially narrowed wage levels among industrial countries. Indeed, as shown in table II.1, by 1978

manufacturing compensation in West Germany was higher than in the United States; for Japan the level had risen from 48 percent of the U.S. level in 1975 to 67 percent in 1978.

There was also a slight convergence of labor compensation rates for the United States and some newly industrializing countries. It is reasonable to expect that as these nations continue to industrialize, there will be some convergence of compensation levels with those in the major industrialized countries. Nevertheless, their labor cost advantage relative to the United States is likely to remain extremely large well into the future.

Several Newly Industrialized Countries (NICs) achieved outstanding growth rates during the 1970s. These include several European countries (Spain, Portugal, Greece, and Yugoslavia); three Latin American countries (Argentina, Brazil, and Mexico); and certain Asian countries (Hong Kong, Korea, Taiwan, and Singapore). For example, the average annual percentage change in real Gross National Product (GNP) in both Taiwan and South Korea since 1975 was more than twice as great as in most industrialized economies. Low compensation costs, along with high levels of productivity in manufacturing, gave some developing countries a strong competitive advantage through relatively low unit costs of production in a wide range of manufacturing industries. As these countries acquired new technology involving routine production processes, they became formidable international competitors.

The poor comparative productivity performance of the U.S. economy during most of the 1970s was clearly detrimental to the competitive position of many U.S. industries. In addition, since 1973 the average increase in wages in the United States has been larger than the increases in many of our major competitor countries, especially Japan and West Germany. The combination of poor productivity growth and escalating wage trends since 1973 increased relative unit costs of production in the United States, threatening the competitiveness of many U.S. industries.

Prior to 1978, the trend in exchange rates partially offset the detrimental effect of low U.S. productivity growth and rising compensation costs. After 1978, however, exchange rate fluctuations had the opposite effect, making it more difficult for some U.S. industries to compete internationally.

As shown in table II.1, since 1978 the differential in the *levels* of hourly compensation in manufacturing between the United States and its major trading partners has increased. Expressed in U.S. dollars, the Japanese compensation level declined from 67 percent to 51

TABLE II.1

Comparative Hourly Compensation Costs for Production Workers in All Manufacturing Industries and in Steel and Auto Industries for Selected Countries (Index U.S. = 100)

	1975			1978			1983		
	Manufacturing	Iron & Steel	Motor Vehicles & Equipment	Manufacturing	Iron & Steel	Motor Vehicles & Equipment	Manufacturing	Iron & Steel	Motor Vehicles & Equipment
United States	100	100	100	100	100	100	100	100	100
Major Trading Countries									
Canada	96	73	80	93	74	79	93	71	72
Japan	48	51	38	67	69	54	51	49	42
Fed. Republic of Germany	97	70	81	116	79	94	84	52	70
France	72	57	55	79	59	58	62	43	45
United Kingdom	51	38	42	52	39	39	53	36	39
Italy	73	58	55	73	54	50	62	42	42
Sweden	113	87[b]	79	116	85[b]	77	73	50[b]	48
Other Industrialized Nations									
Austria	64	48	—	75	53	—	56	38	—
Belgium	103	79	80	125	98	97	75	55	57
Netherlands	103	80	71	120	87	79	78	56	50
Ireland	47	—	—	47	—	38	45	—	33
Denmark	99	—	—	106	—	—	74[a]	—	—
Spain	41	—	—	47	—	—	43[a]	—	—

Newly Industrialized Countries									
Brazil	18	14	17	20	16	19	14	10	12
Korea	6	6[b]	5	10	11[b]	11	10	9	9
Taiwan	8	7[b]	7	10	9[b]	8	13	10[b]	9
Mexico	30	—	31	25	—	24	12	—	14[c]

Source: Compiled from unpublished data prepared by the U.S. Department of Labor, Bureau of Labor Statistics, Office of Productivity and Technology, January 1984.

[a]Excludes foundries
[b]Includes foundries
[c]Figures for 1982

percent of the U.S. level. In 1978, the level of hourly compensation for West Germany was higher than the U.S. level; but by 1983, compensation in West Germany had dropped to 84 percent of hourly compensation in U.S. manufacturing. Except for Taiwan, the gap between manufacturing compensation costs in the United States and the NICs widened, making it more difficult for the United States to compete with manufacturing in developing nations. The recent substantial decline in the value of the U.S. dollar will again narrow the compensation differential, but not for most NICs since their currencies have generally not appreciated against the U.S. dollar.

For the individual business and for industry generally, productivity growth determines the amount of additional resources available to increase wages, to pay a financial return sufficient to encourage additional investment in industry, and to introduce new social programs. It is, of course, possible to pay for government-mandated employer-provided benefits, such as catastrophic health insurance or parental leave, by reducing wages or cutting back on other employee benefits, but it is unrealistic to expect that this will occur.

Future productivity growth is also a major determinant of U.S. unit costs of production relative to our competitors' costs of production. Many types of business decisions, as well as government policies, will affect our productivity performance. In general, however, an increase in the current consumption of resources to provide social benefits is precisely the wrong approach for improving the competitive position of U.S. industry in a period of rising global competition.

Global Competition

The continuing record U.S. trade deficit has made the international competitiveness of U.S. industry a central issue on this nation's policy agenda. The deficit is a dramatic symptom of loss of U.S. competitiveness, but the source of the problem can be traced to the early 1970s as producers in other industrialized countries gradually began to compete for a share of U.S. markets.

The long-run trend in the pattern of import penetration illustrates the chronic nature of the U.S. competitiveness problem. As trade has expanded over the past two decades, some import penetration of U.S. markets was to be expected. What was not expected was the high degree of penetration even in markets for relatively high technology products. Since 1972, imports as a proportion of new supply (domestic production plus imports) increased consistently and by 1981

had doubled for a number of major product markets.[2] Import penetration increased significantly in a wide variety of apparel products and by the end of the decade import penetration was between 15 percent and 30 percent, depending on the product. A similar upward trend occurred in phonograph and TV equipment with imports accounting for 50 percent of the U.S. market by the end of the seventies.

Since the early 1970s, import penetration has doubled for such industries as motor vehicles and steel products; in each case the penetration rose to about 25 percent. Aircraft engines also experienced a significant increase with imports accounting for about 12 percent of the U.S. market. Perhaps the most dramatic import penetration occurred in the rubber and plastic footwear industry, which increased from 33 percent to over 70 percent during the decade.

The rapid transfer of technology has permitted foreign competitors to produce manufactures requiring moderate skills. In the 1970s import penetration increased in semiconductors (25 percent), electrometallurgical products (40 percent), watches (48 percent), and metalcutting tools (over 20 percent) with the penetration rate for some of the more sophisticated computer-assisted machine tools reaching 50 percent or more. Import penetration also rose rapidly in industrial chemicals and resistors for electronic applications. Since 1981, import penetration has continued, and it is now clear that the United States has lost its predominant position in a wide range of fairly sophisticated manufacturing products.

Another unexpected feature of the changing pattern of imports is that the competitive threat is no longer confined to competitors from a small number of highly industrialized countries. Over the past two decades, the NICs have increased their share of world exports of manufacturers almost threefold and by the end of the 1970s accounted for about 8 percent of all trade in manufacturers.

By 1981, Taiwan was the fourth largest supplier of imports to the United States and accounted for more imports than any European country except West Germany. South Korea, Mexico, and Hong Kong each supplied more imports than either France or Italy. While the Asian NICs were major suppliers of textile mill and apparel products, many were also leading suppliers of other manufactures. For example, Taiwan and South Korea had become major suppliers of fabricated

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[2]Import penetration data for 1970–1981 are based on unpublished data on "U.S. Imports and Related Output" from the Office of Productivity and Technology, Bureau of Labor Statistics, U.S. Department of Labor, November 1983.

metal products (third and fourth, respectively) and electrical machinery (second and fourth, respectively).

During the 1970s, the real volume of trade in the Pacific Basin (including Japan) grew at an annual rate of more than 10 percent, compared to 6.7 percent for Europe. For some of the smaller NICs, the rate was well above this average growth rate. For Korea, the real growth rate in exports was 20 percent. Singapore was not far behind at 16.5 percent, followed closely by Taiwan (13.9 percent). Japan, and especially Australia and New Zealand, had much slower growth in exports. While Europe is still the most important region for U.S. trade, by 1980 a significant shift in U.S. trade to the Pacific Basin had occurred and, by 1985, the United States had growing trade deficits with many countries in this region.

Global competition in manufacturing has been increasing for almost two decades. The United States, as well as other countries, has generally benefited from this expansion in trade even though our *share* of world exports has declined. Income and employment in U.S. trade-related industries expanded rapidly, at least until the recession of 1981–83. Increased import penetration of U.S. markets is not necessarily detrimental to the competitive position of the U.S. economy, provided the penetration occurs in industries with relatively low value-added jobs. For example, rapid import penetration of some apparel production requiring a high proportion of relatively low-skilled labor is not a threat to U.S. competitiveness overall, provided industrial restructuring results in capital and labor resources moving to higher value-added types of production. But global competition is now fairly pervasive throughout many sectors of U.S. industry. Unless U.S. productivity growth matches the rates of growth of our trading partners, compensation levels of U.S. workers will decline relatively, and workers in some industries are likely to experience an absolute decline in compensation.

Impact of Government-Mandated Employee Benefits

In an era of global markets, there are compelling reasons why mandated employee benefits should be opposed as a solution to the problems of gaps in coverage. The cost of health benefits is already an important component of the competitiveness problem facing many businesses. During the 1960s and 1970s, business improved the benefits included in employment-based health and pension benefit plans. Initially, this did not have a major impact on U.S. competitiveness since the basic features of these plans were introduced at a time when

U.S. industry still had a significant competitive advantage over foreign competitors. Moreover, the full cost of providing these benefits was frequently deferred into the future. Over time, as employment growth in manufacturing began to slow and the average age of the work force rose, the cost of these benefits became a significant cost in the overall costs of production.

By the late 1970s, the rapid escalation of health care costs became an especially serious problem for manufacturing industries. Many companies had plans that provided an extensive range of services to employees and retirees, with the employer paying all or most of the cost. The problem of "moral hazard"—the tendency of individuals to increase their use of services simply because they give up little in return for consumption—became pervasive. Most employer health plans had no incentives to make the consumer of health services—and those who provided them—cost-conscious in the use of services. In businesses with fairly comprehensive employee health plans, it was not unusual for employer costs to rise at rates of 15–20 percent per year.

In the private sector, employers responded dramatically by modifying the financing and management of their health plans to reduce cost escalation. This has changed our health care system substantially, forcing providers to compete on the basis of price as well as quality. Most employer plans have introduced cost sharing, with employees usually paying part of the insurance premium as well as part of the cost when health services are consumed. More and more employers are attempting to control costs by encouraging competition among providers and by emphasizing prevention through employee wellness programs and the reduction of exposure to hazards at the work place.

Since the cost of health care in the private sector was rising at a rate well above the rate of inflation, employment-related health care costs were clearly a problem even before competitiveness became part of the public policy debate. The growth of import penetration simply made it even more essential for employers to reduce compensation costs, and in many industries reducing health care costs became a major part of a strategy to make labor costs more competitive. While employers have made some progress in constraining these costs, this problem has not been solved. Overall health care costs are still rising much more rapidly than the rate of inflation, suggesting that the proportion of the nation's resources devoted to health care will continue to increase.

The effect of mandated benefits on U.S. competitiveness depends

on labor costs in other countries and on the type and level of benefits the U.S. government intends to mandate. Table II.2 provides an approximate estimate of the variation in hourly compensation costs for production workers in a broad range of countries. The differential in *total* hourly compensation between the United States and its competitors is, of course, the critical element in the role of labor costs in determining competitiveness. But as shown in table II.2, the additional compensation costs, including employer-paid costs for health care and retirement income benefits, are proportionately higher in

TABLE II.2
Hourly Compensation Costs for Production Workers in Manufacturing, 1985 (Provisional Estimates)

Country	Ratio of Additional Compensation to Hourly Earnings	Hourly Compensation*	
		$ U.S.	Index US=100
United States	34.5	12.82	100
Major Trading Countries:			
Canada	28.4	10.89	85
Japan	16.8	6.35	50
Fed. Republic of Germany	73.2	9.60	75
France	85.5	7.71	60
United Kingdom	32.1	6.14	48
Italy	90.1	7.65	60
Sweden	68.5	9.66	75
Other Industrialized Nations:			
Austria	88.0	7.24	56
Belgium	82.2	8.95	70
Netherlands	72.1	8.62	67
Ireland	32.7	5.47	45
Denmark	22.8	8.16	64
Spain	40.0	4.79	37
Newly Industrialized Countries:			
Brazil	35.4	1.22	10
Korea	21.0	1.44	11
Taiwan	5.0	1.48	12
Mexico	44.9	2.07	16

Source: Based on "Hourly Compensation Costs for Production Workers, All Manufacturing," 1975–85, U.S. Department of Labor, Bureau of Labor Statistics, Office of Productivity and Technology, November 1986.

*Editor's note: The hourly compensation figures include the value of employee benefits in addition to basic wages.

many European countries than in the United States. In many countries, a high proportion of these additional costs are mandated by government.

One lesson to be drawn from the European experience with high mandated benefits is that it increases the fixed costs of hiring. In a period of industrial restructuring, this reduces compensation flexibility and makes employers cautious about hiring additional workers even during an economic upswing. Increases in these types of labor costs during the 1970s may have contributed to the extremely low rate of employment growth and to the high proportion of long-term unemployed workers included within rising unemployment rates in many European countries.

The competitive position of U.S. business, compared to our European rivals, is unlikely to be affected adversely by the cost of a minimum benefit package for all workers, provided those workers are willing to give up some current and future wage gains in return for such benefits. Since the incidence of benefit coverage would be, however, greatest among workers in low-paid industries working for relatively small businesses, it is unlikely that such a tradeoff will be made. The employer response to the increase in fixed labor costs is more likely to be a reduction in employment or a slower rate of employment growth.

Much of the competitiveness threat is now coming from Japan and the Asian NICs. The compensation data in table II.2 for these countries shows that government mandating of even a minimum level of employee benefits for U.S. employees will almost certainly reduce the competitiveness of U.S. products versus imports from these countries. The substantial labor costs advantage that these countries have over U.S. production means that any increase in fixed labor costs in the United States is likely to result in the loss of American jobs.

Even if government action can be justified to solve the problems of medical indigency and other needs, a mandatory approach is likely to produce an enormously complex system of regulation that goes far beyond prescribing minimum benefit packages. Experience with federal health care policies and with state-mandated health insurance plans strongly suggests that any benefits package mandated by government is likely to specify in detail the services to be covered. Interest group pressure from providers is likely to lead to demands for a mandated package that include additional services not usually covered by health plans. In the long run, this can lead easily to proposals for adding such benefits as long-term care for the frail and elderly, extended care for mental illness, rehabilitation services for substance

abuse, etc., in all employer health plans. Government mandating of benefits will put increasing pressure on the cost of all health care services and a greater share of the nation's resources will inevitably be devoted to health care at a time when the nation can ill afford it.

In 1950, the United States devoted 4.4 percent of its GNP to health care. Health insurance premiums, paid mostly by employers, were less than 6 percent of corporate profits. By 1986, 10.7 percent of our GNP—the highest of any country—was spent on health care and premiums were about 40 percent of corporate profits. Over the past 30 years, spending a greater proportion of resources on health care was clearly justified, but it is also evident that the health care reimbursement system encouraged unnecessary health care expenditures. If the past trends in economic growth in health care spending were to continue, in another 30 years we would be spending about 18 percent of GNP on health care (Fuchs, 1985). Such a trend is unlikely, of course, but if society decides to allocate more of its resources to health care, it must be prepared to give up the greater long-run benefits that the additional resources are likely to produce if they were invested in improvement in the technological sophistication of U.S. plant and equipment—investments more likely to raise the real income of American workers. *Without strong economic growth, the transfer of additional resources to health care becomes a zero-sum game.*

The government—and business—have a responsibility to address such problems as financing indigent care. If U.S. business is to remain competitive and generate sufficient economic growth to meet the nation's social goals, however, it is essential to improve the efficiency of health care expenditures and transfer some existing health care resources now consumed unnecessarily by middle- and upper-income Americans to those who now lack access to health services.

Government and business also have a responsibility to increase the opportunity for all employees to participate in employer-based pension plans. This is especially important since part of our competitiveness problem is related to our low rate of investment in new plant and equipment. The assets held by employer-based pensions have grown tenfold since 1950 with about one-half of this increase representing a net addition to savings (Ippolito, 1986). The growth of pension funds also reduces the pressure to raise payroll taxes and rely exclusively on Social Security for retirement income. The problem with relying heavily on Social Security for retirement income is that the system is unfunded, with current workers financing current retirees. As the proportion of the elderly increases rapidly, the present

Social Security system is likely to reduce the savings pool available for investment in future growth.

While government and business can play an important role in improving social well-being, individuals also have a responsibility to contribute to their own health care insurance and income maintenance for retirement. Experience with individual retirement accounts (IRAs) and voluntary 401(k)-type pension plans has demonstrated that, given the appropriate tax incentives, employees—and employers—can be encouraged to use part of their resources to save now, and thereby generate income for the future.

Both the health care and retirement income systems should be flexible enough to permit different approaches to meeting desirable social goals. While employers can assist in meeting health care and retirement income goals, their major contribution to social well-being comes from increasing productivity and maintaining their competitive position in domestic and international markets.

Restoring Competitiveness: The Key to Economic and Social Progress

There are two major ways to reduce relative unit costs of production and restore the competitive position of U.S. industries. In the short run, a decline in the value of the U.S. dollar compared to the currencies of our major trading partners will eventually raise the relative price of imports and reduce the price of U.S. exports, making U.S. products price competitive in world markets. In the long run, however, the only economically desirable way to restore U.S. competitiveness is to match or surpass our competitors' productivity performance and moderate the growth in U.S. labor costs.

There are differences of opinion on how much reliance should be placed on policies designed to reduce the value of the U.S. dollar compared to concentrating on stimulating productivity growth. Some economists argue that the value of the U.S. dollar is still too high and that a further devaluation is necessary to restore U.S. competitiveness and reduce substantially the U.S. trade deficit.

There is no question that the rapid rise in the value of the U.S. dollar in the early 1980s made U.S. products less competitive, but much of the U.S. problem of rapid import penetration from Japan and other Asian countries occurred in the 1970s when the dollar depreciated substantially. Japan's remarkable economic performance in world markets continued during the period 1979–1983 when

the yen appreciated about 21 percent on a trade-weighted basis. This appreciation was similar to the U.S. dollar appreciation between 1982 and 1985. Clearly, Japan's long-run outstanding productivity performance was the underlying source of its competitive superiority in trade in manufacturing products.

Devaluation: Its Potential Benefits and Costs

The substantial devaluation of the U.S. dollar since 1985 will eventually make U.S. products more competitive, but only after the relative prices of imports *increase* significantly and there is a relative *decline* in the price of U.S. products in export markets. The lag in relative price changes, however, is likely to continue throughout most of 1987 and it will probably be well into 1988 before there is any significant reduction in the U.S. trade deficit.

There are two other necessary conditions for devaluation to make any contribution to the long-run competitive position of U.S. industry. First, U.S. business must continue to take advantage of this two-year period to hold down costs and prices. Second, the Congress and the administration must make the painful decision to substantially reduce the huge federal budget deficit.

Since 1984, the U.S. manufacturing sector has made significant progress in improving efficiency. Industrial restructuring has included widespread closing of less efficient plants, concentration of production in low-cost locations both in the United States and abroad, reductions in underutilized production and managerial personnel, modification of inefficient work rules, and lower annual increases in wages (Paulus and Gay, 1987). These efficiency improvement measures will give U.S. industry a one-time improvement in costs. This should raise profit levels and increase business cash flow. Unless U.S. business leaders use an improved cash-flow position to increase research and development (R&D) expenditures, increase investment in new plant and equipment, and move resources to higher value-added activities, the beneficial effect of industrial restructuring on U.S. competitiveness is likely to be only temporary.

Further federal budget deficit reductions are essential if the U.S. economy is to gain any long-term benefit from devaluation. In 1986, the federal budget deficit was about 4.9 percent of GNP. Net U.S. private savings in 1986 were about 5.7 percent of GNP which was augmented by state and local government savings of about 1.4 percent of GNP. This left only 2.2 percent of GNP available for private-sector investment. Indeed, in the United States, the pool of savings for investment would have been much lower without a large net foreign

capital inflow equivalent to 3.4 percent of our GNP (Congressional Budget Office, 1987).

As a nation, we are consuming substantially more than we save. In the long run, this federal debt and our debt to foreigners has to be serviced. Such large future debt servicing obligations will inevitably make it extremely difficult for future generations to increase the national savings rate and maintain a high rate of private sector capital investment.

Failure to reduce the size of the federal budget deficit may lead to additional adverse consequences. If foreigners begin to lose confidence in the willingness or ability of the U.S. Congress and the administration to reduce budget deficits and service future debt obligations, it may lead to a dramatic slowdown in foreign investment and a significant decline in the value of the U.S. dollar.

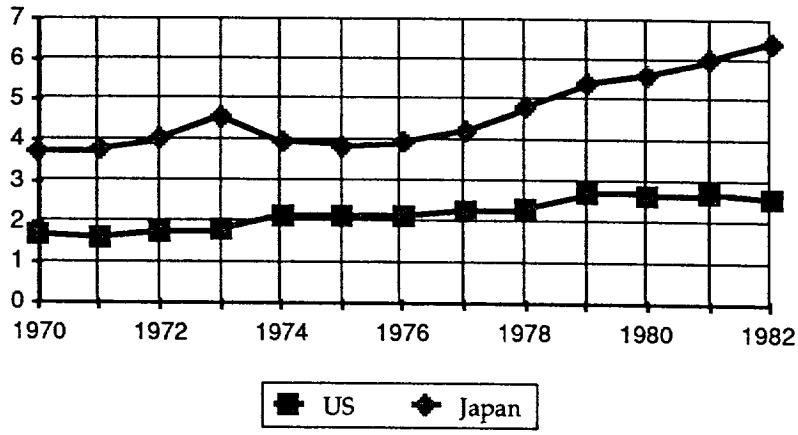
While devaluation of the U.S. dollar from its record high in 1985 will eventually provide some relief from the consequences of loss of U.S. competitiveness, further devaluation is a highly undesirable technique for restoring the competitive position of U.S. products in world markets. Devaluation amounts to a markdown sale in the price of our export products, which must be offset by a much greater volume of exports so that revenues from foreign sales increase. Devaluation also forces us to pay more for our imports and puts upward pressure on consumer prices. Such an approach to our competitiveness problem will simply reduce U.S. relative income levels and risk eventual loss of our position of economic leadership. For some groups of workers, it will mean an absolute decline in living standards.

Productivity Improvement: A Winning Strategy

Strategies that relocate productive facilities to lower cost regions, reduce U.S. relative wage levels, or lower the value of the U.S. dollar will improve U.S. competitiveness, but each approach imposes costs on many groups in society. In the long run, only more rapid productivity improvement will maximize benefits for the vast majority of workers and enable the nation to meet desirable social goals.

A wide range of actions in both the private and public sectors is necessary to match or surpass the productivity performance of our economic rivals. Public policies designed to reform the tort liability system, encourage the commercialization of basic research, and protect the intellectual property rights of successful innovations are worthwhile reforms that will improve the competitive position of some businesses. But, by themselves, none of these activities is likely

CHART II.2
Fixed Investment per Employee in Manufacturing, in Thousands of 1975 Dollars



Source: Organization for Economic Cooperation and Development

to do much to raise the overall level of U.S. manufacturing productivity.

The single most important reason for Japan's extraordinary productivity performance was that its *rate of investment in new manufacturing plant and equipment was two or three times the rate in the United States*. More rapid capital investment in Japan accounts for well over half the difference between United States and Japanese manufacturing productivity growth rates during the period 1965–1978 (Norsworthy and Mamlquist, 1985).

A high rate of capital investment may not be a sufficient condition for maintaining higher productivity levels than our competitors, but it is a necessary condition. The pervasive implication of failure to increase our rate of investment in new plant and equipment is illustrated by the comparative capital investment rates in table II.3. Since 1965, several European countries, as well as Japan, Korea, and Singapore, have all had higher rates of investment than the United States; for Japan and Korea the rates are nearly twice those in the United States. If these differential investment rates continue for any length of time, foreign workers will eventually have newer and more efficient capital than U.S. workers, giving them a competitive advantage over some U.S. industries.

TABLE II.3

International Comparison of Gross Fixed Capital Investment as a Percentage of Gross National Product

	1950	1955	1960	1965	1970	1975	1980	1985*
United States	16.8	15.8	14.6	13.4	14.3	14.1	16.3	16.6
Germany	19.1	23.5	24.2	26.2	25.5	20.3	22.6	19.5
France	16.2	17.8	19.9	23.1	23.3	23.2	21.8	18.8
United Kingdom	12.8	14.9	16.3	18.2	18.7	16.2	18.1	17.0
Japan	19.8	25.5	30.2	29.9	35.6	32.5	31.6	27.6
Korea	10.4	10.2	11.0	13.8	22.9	25.5	31.9	30.9
Singapore	—	—	9.5	21.1	32.2	35.2	41.0	48.2

Source: International Financial Statistics Year Book, 1986.

*Or latest available year.

To improve the competitive position of U.S. manufacturing production, it is essential to increase our rate of capital investment. The U.S. budget deficit must be reduced in a way that encourages saving and reduces the consumption bias in public expenditures. Middle- and upper income beneficiaries of government entitlement programs, including the elderly, must bear their share of the burden of reducing public expenditures. If we must raise taxes to reduce the budget deficit, the burden should fall far less heavily on saving than on consumption. Tax increases that discourage individual saving and reduce business' ability to invest in new plant and equipment will further weaken the competitive position of U.S. manufacturing.

Proposals that attempt to finance social policy goals by raising production costs will also be harmful to U.S. competitiveness and act as a tax on the employment of new labor market entrants. It is inconsistent to support the need for policies to improve U.S. competitiveness and, at the same time, advocate programs that increase the cost of producing goods and services in the United States. Unless all groups in society are prepared to make some sacrifice to improve U.S. productivity performance, future generations may suffer a relative decline in income and as a nation we will have fewer resources to meet desirable social goals.

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Policy Forum Discussion

Comparative Investment and Labor Costs

MR. SALISBURY: In table II.3, interpret the significance of Japanese investment as a percent of GNP starting to decrease while there is a tremendous growth pattern in Korea.

MR. MCLENNAN: From 1975 Japan's rate dropped from about 32 percent of the GNP to about 28 percent, and it is a decline, but 28 percent is still an enormous rate of investment in new plant and equipment. Now the interesting thing about Korea is that in 1955 they started off as a country that invested less than we did proportionately and they have risen to the point where they are now outstripping Japan. This change is quite typical as economies begin to industrialize, but it would be interesting to see if there is anything comparable to what has happened in countries like Korea and Taiwan. That is an enormous increase over a relatively short period of time.

MR. UGORETZ: Is there an implication that, as the economy becomes more mature, there is some natural progression or natural decline in the rate of savings?

MR. MCLENNAN: You may find that the proportion of your resources that you invest may decline. As I recall, our savings rate, which has been traditionally very low, has not varied a great deal, even during times when we were not as highly developed an economy. So I would not like to draw that implication. As countries like Korea and Taiwan and Japan begin to industrialize, they transfer part of the benefits of economic growth to the workers in the form of more rapid increases in wage rates.

Eventually there may be some slowing down in their investment rate as their rate of consumption increases.

MR. HUNT: On table II.1 Sweden caught my eye, but it is true as well of other countries. Have they done something to lower their costs, or is it simply that it looks lower on this chart because ours has gone so much higher?

MR. MCLENNAN: Sweden is a country that has always had the discipline of working in global markets, because trade has been very important to their economy. It may also reflect the fact that as a smaller economy they are able to adjust the value of their currency more than the United States. Sweden can devalue their currency to increase competitiveness. This is not an option open to a large economy like the United States.

MS. DAILEY: I am interested in your saying that Sweden can manipulate its currency because it is a small country. The reason other countries' labor costs look lower than U.S. labor costs is due to the value of the dollar, and not necessarily due to actual lower labor costs; table II.1 would change dramatically based on the value of the dollar.

Do you think it really is the size of the U.S. economy that means that the United States cannot do things that, say, Switzerland or Sweden manages to do?

MR. MCLENNAN: Since the U.S. dollar is used as the currency of exchange internationally, it would be very disruptive of trade and investment relations if, for example, we were to reduce the dollar to 120 to the yen; whereas, a country like Sweden can do that, and it does not have very much impact on international markets.

MS. PHILLIPS: I am watching the ongoing debate over catastrophic health coverage. As you said, some people feel that although these benefits are very desirable, they ought not be mandated to be provided by employers because of the competitiveness implications. Are you suggesting that, if the federal government rather than employers were to shoulder that burden, it would be more desirable from a competitiveness point of view, or would it be the same in terms of the overall impact on the economy?

MR. MCLENNAN: Well, I think that it would—the excess of our consumption over what we produce is largely due to excessive government expenditures. The reason our consumption is greater than our production is that politicians always like to give us good news. In fact, the bad news is that they have been giving us too much good news. We have to be prepared to cut some federal government expenditures. The budget problem is the single most important source of our trade problems. We either have to cut government expenditures, or raise taxes. If we ever raise taxes, we must do so in a way that does not discourage investment in plant and equipment and investment in research and development.

We must be prepared to revise our major social programs by, for example, reallocating existing resources spent on health care and retirement income. In other words, we have to take part of the 10.8 percent of GNP that we now spend on health care and redistribute it from those who are now receiving substantial subsidies from government policies to those who actually need health care coverage.

MR. MOSER: It occurred to me that the banking system in Japan is significantly different than it is in the United States. For example, it is my understanding that manufacturing involved in nondomestic production in Japan—for export, in other words—obtains a much lower interest rate from the central banking system than does any industry that is engaged in domestic productions.

That obviously gives exporters in Japan a significant advantage over those they might be competing with in the world market. My question is: If that is true, is not the solution, or at least a significant part of the solution, tied to the banking arrangements in the United States, if we are ever going to be competitive, regardless of the benefit costs, labor costs, and everything else?

MR. MCLENNAN: It is an interesting question. My knowledge of this area is not extensive, but as I understand it, the problem is not that

Japanese banks give special preference to manufacturers, but that their cost of capital, the cost of borrowing, is generally lower than it is in the United States. The Japanese have been guilty of some manipulation in international markets, in that they have made it quite difficult for U.S. companies to borrow in the Japanese market to raise the capital there.

It would be dangerous to trust U.S. bankers to decide who should get the lower rates for investment.

MR. MOSER: It is my understanding that a Japanese bank for a Japanese manufacturer of export goods may give an interest rate of 3 percent, 2 percent, 1 percent, or even no interest, compared to an interest rate for a borrower who is engaged in domestic production of 12, 13, 14 or 15 percent.

MR. MCLENNAN: The solution, though, is not to copy them here. The solution is to let us be able to borrow in their markets just as they can borrow in our markets. That is the kind of restriction we ought to get the Japanese to give up, because obviously if we were allowed to borrow in their markets easily, then these rates would not stay at 1 and 2 percent.

One of the advantages that Japan has is that its mortgage market is very poorly developed. This is a disadvantage socially because they need a much bigger down payment—like a third to a half of the price of buying a house. But this is one reason why more funds are available for Japanese industrial investment.

Mandated Benefits and U.S. Trade Position

MR. PAUL: I think we have to be careful in making these comparisons not to confuse industries that already have health insurance or pensions and thus are affected very little by any mandating of benefits from industries that have no benefits and would be very seriously affected.

I do not know the exact numbers, but I estimate there are 30 million workers uncovered by either health insurance or pensions in this country, but they are not generally in heavily industrialized components of the economy, and largely they are not in international markets as yet. Maybe they should be; McDonald's is, but McDonald's is not hiring Americans to serve its activities overseas, presumably.

So, if you argue that we cannot afford to mandate benefits because that is going to make us less competitive internationally, I think you have to demonstrate that in fact there will be secondary effects on

the economy that will result. To argue that mandating benefits means wage rates cannot be raised in industries in which there is very little international business is a little bit weak. That idea ought to be examined a little more analytically than simply putting up numbers showing international rates of wages. If McDonald's is compelled to put in benefits for its workers or a retail establishment is compelled to put in benefits for its workers because the government mandates such benefits, I question what effect that is going to have on our international competitiveness, except by way of secondary effects.

MR. MCLENNAN: I do not know what health benefits McDonald's provides its employees. But take a company in the textile or apparel industry, for example, that pays relatively low wages. Then the government mandates that all firms, large or small ones, provide a specific benefit package. This will affect the position of these industries in the global market.

I agree with the point you make, however. It would be useful if we had more detailed analysis of the competitive position of U.S. firms by industry, but it is very dangerous to assume that, simply because you do not export, you are not in global markets. The import penetration that has occurred over the last fifteen years has been pervasive throughout manufacturing.

MR. WELSH: Ken, you made the point that further social and health mandates on U.S. employers would hurt U.S. competitiveness in international markets. But looking at the larger picture, is it not true that poor manufacturers are already competing with such social and health burdens on them? In terms of equity, if some form of national health insurance through mandates were enacted in the United States, would this effect level the playing field, so that international competition would be more logically based on economic as opposed to social considerations?

MR. MCLENNAN: This argument is often used. Indeed, it has crept into the latest trade bill coming out of the House Ways and Means Committee;* if countries do not have the same "social policies" as we have, they have an unfair trade advantage, and we ought to force them to level the playing field.

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*Editor's note: The House of Representatives April 30 passed a comprehensive trade bill (H.R. 3), "The Trade and International Policy Reform Act of 1987." The legislation would impose a broad range of economic penalties against countries that engage in unfair trade practices that lead to huge trade surpluses.

I do not think the United States is justified in telling other countries what kind of social programs they ought to have. Other countries would resent that, and I am not sure that we ought to export some of our weaknesses as well as our successes. It does not matter whether half of compensation is in social benefits or half of it is in wage rates. It is the total cost of compensation that matters.

I do not care what we have or what they have. In terms of competitiveness it is the total cost of compensation that is important. The way we all become winners is by raising productivity. If we can raise productivity, compensation becomes less important in the competitiveness equation.

MR. FOREMAN: Back to that productivity question, I am not sure what constitutes the fixed investment in the "fixed investment for an employee in manufacturing" graph (chart II.1), but I assume that does not include investment in research and development or investments in education, training, and retraining. If that is the case, it strikes me that the picture is even bleaker than what the graph shows.

MR. MCLENNAN: No, it includes simply investment in new plants, fixed plants, and equipment like machinery and so forth. It does not include investment in education or in health. I should say that you raise an interesting point.

It is true that investment in health is more than simply a consumption good, as economists would say. It also is an investment in the sense that if you make some investment your workers can become more productive. This feature of health care expenditures supports the case for providing some protection for those who are uncovered, but it does not justify further enriching of benefits for those who already are consuming a substantial amount of health care and for some of those who are receiving government assistance through the Medicare system.

MR. SCANDLEN: In the United States health coverage is largely employment based, while in the other countries listed on your first graph, it is based on taxation. In either case, employees get health coverage. Are you suggesting that carving health benefits out and perhaps providing them in some other fashion such as national health insurance could make the United States more competitive with these other countries?

MR. MCLENNAN: Your question, is whether it would not be simpler if we all just had national health insurance. I really had not thought that was still a major issue. I thought the issue was how we deal with

the gaps in the present system. One of the advantages we have is that our health system is diverse. It has weaknesses, but it also has substantial strengths. Most of the studies I have seen suggest that we should be very cautious before we adopt anything like a national health insurance system.

Trade-offs between Wages and Benefits

MS. ALTMAN: I guess mandated benefits could result either in an increase in the compensation package or simply a change in the mix. If it results simply in a change in the mix, and if there are minimum funding requirements, shouldn't that help our competitiveness because it will increase the capital?

MR. MCLENNAN: If you want to give up wage increases or take pay cuts in order to get health care protection or improved retirement income benefits or maternity and paternity leave, that is fine. All I am saying is, I do not think that choice could be made by employees, and I do not think it will happen. I do not think anyone who is a proponent of mandated benefits is prepared to say that you have to give up something in wages to get mandated benefits.

MR. SALISBURY: But you do not think that in long-term economics, that adjustment would not likely be made?

MR. MCLENNAN: I think it is also likely to be made in terms of employment. That is the way the adjustment can be made. If we look at collective bargaining experience, we find that during the recent period of restructuring of U.S. industry, two-tier wage payment systems developed. Collective bargaining has protected the "ins" and no one ever talks about the "outs." By protecting the benefits of most senior workers you protect those who have jobs, and you really do not care too much about the next generation of workers. That is the way we would do it if we adopted mandatory benefits.

MR. GARBER: I always use the term compensation to include benefits and employment-based taxes and so on. There was something you just said that made it sound as though that is not the way this term is used in these charts. I wanted to clarify that.

MR. MCLENNAN: It is included, the question that was being asked was whether the employer's contribution to Medicare, for example, is included. I do not think so.

MR. GARBER: What about the large government-provided benefits in the European countries? Is that included in their compensation numbers, or not?

MR. MCLENNAN: The employee's contribution will be included. I do not know whether or not the employer's contribution is included. As you know, they are mandated employer payments. Benefits are substantially greater in most of European countries than they are in the United States.

MR. LENDEMAN: I am trying to interpret the numbers in table II.2. In one column you have a ratio of additional compensation to hourly earnings. Then in the other columns on the right, you have a ratio of hourly compensation in other countries to U.S. hourly compensation. In the Swedish case, for example, their $9.66 per hour compensation level is 75 percent of our $12.82. How does the 68.5 percent compare to the 34.5 percent in the United States.

MR. MCLENNAN: The comparison between the Swedish 68.5 percent additional cost with the U.S. 34.5 percent additional cost would be roughly as follows. For the United States, the 34.5 percent in fringes is approximately worth $3 (about one-third of an average wage of $9). For Sweden, the 68.5 percent of fringes over the average basic Swedish wage is equivalent to about $4 (68 percent of about $6). The $12.82 hourly compensation figure shown for the United States includes the value of employee benefits, as do the hourly compensation figures for all other countries on the table.

PART TWO

FEDERALLY MANDATED HEALTH BENEFITS

In 1985, 17 percent of the nonagricultural, nonmilitary population under age 65—nearly 35 million people—reported no health insurance from any private or public source. In 1985, 81 percent of the uninsured were either workers or their nonworking spouses and dependents. The number of workers without coverage grew by more than 22 percent between 1982 and 1985.

The increase in the number of uninsured workers can be attributed largely to a rapid growth of employment in small firms where employer-provided health care coverage is least likely. More than one-half of all uninsured workers in 1985 were employed in two industries: retail trade and services.

Workers in very small firms are about half as likely as workers in larger firms to have an employer health plan; about one-half of all workers are either self-employed or employed in firms with fewer than 25 employees.

Workers without employer-provided health insurance tend to earn low wages. In 1985, fully three-fourths of all uninsured workers earned less than $10,000. Their incomes may not be low enough, however, for them to qualify for health care assistance under Medicaid.

Federal lawmakers have begun examining public policy options that would help improve access to health care for all uninsured—workers and nonworkers. Private employers that provide health insurance benefits for workers have also become more concerned about the issue since the health care costs of the uninsured wind up being shifted to the insured, which means largely to employer plans. This has a major impact on labor costs and ultimately on business competitiveness in world markets.

Legislation introduced in the 100th Congress targets employer plans and Medicaid. Sen. Edward M. Kennedy (D-MA) has introduced a bill (S. 1265) that would require employers to provide at least a minimum health benefit package for most workers and their dependents. Sen. John H. Chafee (R-RI) has introduced a bill (S. 1139) to expand Medicaid eligibility and permit people living near poverty to purchase Medicaid coverage.

To set the debate over federally mandated health benefits in perspective, part two begins with a two-part EBRI analysis by Deborah

Chollet, senior research associate, that details the characteristics of the under-65 uninsured population (chapter III) and examines public policy options in terms of their potential effectiveness in reducing the uninsured population (chapter IV). The EBRI analysis suggests that extending employer coverage to workers and their dependents not now covered by an employer plan could greatly reduce the number of people without health insurance coverage, but the cost would be significant. Part-time workers and nonworkers would still remain unprotected, however, unless Medicaid eligibility rules are eased to allow additional low-income families to qualify.

Next, we turn to an analysis by Princeton University professor Uwe E. Reinhardt of federally mandated health benefits versus a national health insurance program. Professor Reinhardt says that mandated employer-paid health insurance is an example of 'hidden taxes' to which politicians are likely to turn when they are unwilling "to confront the electorate directly with hard questions on social ethics."

In chapter V, Reinhardt contends that no other industrialized nation in the world has an equally high proportion of persons without basic health insurance coverage. Placing the responsibility on business to provide coverage for all workers, he says, would constitute a tax on employment and entrepreneurship, and would place an especially heavy burden on small and medium-sized businesses.

An alternative to mandated employer-paid health benefits, he says, would be a national health program that would cover all Americans, not just workers, and would be financed by a tax on individual incomes rather than a tax on employment. Such a program, Reinhardt says, could be based on ability to pay and designed to cover only the small proportion of the population that could not afford private insurance.

Chapter VI provides a discussion by Rep. Rod Chandler (R-WA) of possible congressional action in the area of mandated benefits. Rep. Chandler is a member of the House Ways and Means Committee, which has jurisdiction over Medicare and other health and pension issues.

Rep. Chandler suggests that Members of Congress find it politically difficult to oppose new programs that evoke public support, such as the plan to protect elderly Medicare beneficiaries against the costs of catastrophic illness. The congressman adds that lawmakers are also fearful of hundred-billion dollar budget deficits. The result, he says, is legislation like the catastrophic care proposal that puts the cost burden largely on the beneficiaries, not the federal government.

Rep. Chandler contends that many lawmakers would like business to pay the bill for other mandated health programs. The Washington State Republican also discusses a bill he has introduced (H.R. 2860) to provide incentives for employers to create voluntary retiree health plans for the purpose of prefunding retiree health and long-term care coverage.

In chapter VII, Deborah Steelman, a former associate director of the Office of Management and Budget, describes the budget dilemma facing Congress. She compares Congress to a balloon; "Squeeze on it in one place—reduce spending—and it pushes out the other side—mandated benefits," Steelman says.

The former budget official sees a political stalemate over setting national priorities. The American public continues to demand federal programs, she adds, but is unwilling to have taxes raised to pay for such programs and also resists cuts in defense and domestic spending.

Steelman says that mandated benefits are the direct result of congressional and administration reluctance to set priorities. The use of the mandated-benefit route will continue, she predicts, unless the public "agrees to spend more or want less."

To conclude part two, David Repko of JCPenney explains that company's viewpoint on mandated benefits. Repko describes the range of benefits provided by JCPenney, a company with about 2,500 locations and over 180,000 employees.

Federal mandates could have the opposite effect than the lawmakers intended, Repko maintains. As an example, he discusses the possibilities facing employers like JCPenney in regard to the welfare plan nondiscrimination test required by the 1986 Tax Reform Act. To meet the test, he concludes, an employer might have to pull out the highly compensated employees from the plan.

Employers will be faced with higher payroll costs because of mandated benefits, Repko adds, and may be forced to eliminate certain benefit plans, reduce wages, or reduce the number of employees. Proponents of mandated benefits should demonstrate, he says, that the mandate will not create more problems than it solves.

III. A Profile of the Nonelderly Population Without Health Insurance

PAPER BY DEBORAH CHOLLET

Introduction

The lack of health insurance coverage among many Americans is drawing increasing attention as a public policy issue. Although most nonelderly people are covered by employer-based health insurance, many are not. In 1985, 17 percent of the population under age 65—nearly 37 million people—reported no health insurance coverage from either a private plan or a public insurance program. Among the nonmilitary population under age 65 and not engaged in agriculture, nearly 35 million people reported no health insurance coverage of any type.[1]

The significant minority of nonelderly Americans without health insurance may confront serious difficulties in obtaining necessary health care except on an emergency basis. People without health insurance use much less health care than those with insurance, even when health status or medical conditions are similar (Monheit et al., 1985). Noncoverage has been linked with higher mortality rates in general, and higher rates of infant mortality in particular (Grossman and Goldman, 1981).

Furthermore, the health care that people without insurance may use but for which they are unable to pay imposes costs on providers and on insured consumers. The estimated provider burden of uncompensated health care in the United States is 5 percent of gross revenues—about 13 billion in 1986 (Chollet, 1987). The cost of uncompensated care shifted to insured patients in the form of higher charges for care has not been measured, but is presumed to be commensurate with the cost for providers. Because nearly 80 percent of the nonelderly population with health insurance coverage are covered

[1]Tabulations of the March 1986 Current Population Survey (CPS) reflect responses to questioning about sources of health insurance coverage during 1985. Due to the relatively extensive recall required by the question, responses probably reflect: (1) noncoverage at the time of questioning (March 1986) for some respondents; and (2) a significant period of noncoverage during 1985 for others. Historically, the CPS-reported noncoverage is slightly higher than noncoverage reported in panel surveys that require shorter recall periods, but is lower than surveys that measure noncoverage only at the time of questioning.

by an employer plan, employers that provide health insurance benefits for their workers presumably pay most of these shifted costs.

The Emerging Uninsured Population

The number of people reporting no health insurance coverage of any type—35 million people in 1985, excluding the agricultural and military populations—has grown steadily since the 1982 economic recession. Between 1982 and 1985, the nonelderly, nonagricultural, civilian population without health insurance increased by 4.5 million people, nearly 15 percent. Most (nearly three-fourths) of this increase occurred among workers; the number of workers without health insurance has grown by more than 22 percent since 1982 (table III.1). The number of children without coverage, however, has also grown. In 1985, nearly 20 percent of all children under age 18 had no health insurance coverage from any source—an increase of nearly 16 percent since 1982.

The erosion of employer-based coverage among workers and dependents is an important source of the growing number of nonelderly people without health insurance. In 1982, more than 67 percent of the population had coverage from an employer plan; this percentage declined to nearly 65 percent in 1984 (EBRI, 1986) and edged upward to 66 percent in 1985.

The decline in employer-based coverage has been most apparent among nonworkers—primarily children (table III.2). Although the rate of employer coverage among workers has declined (from 78 percent in 1982 to 76 percent in 1985), employer plans have actually covered a growing number of workers—nearly 88 million in 1985, compared to 84 million in 1982. Among nonworkers, however, both the rate and the number of people covered by employer plans have declined. In 1982, employer plans covered more than 47 million nonworkers, including 36 million children. In 1985, employer plans covered 44 million nonworkers and fewer than 35 million children. The rate of employer coverage among nonworkers declined from 55 percent in 1982 to 52 percent in 1985.

The number and proportion of the nonelderly population with other private (nonemployer) insurance coverage has also declined since 1982; again, the decline is most apparent among children. In 1982, nearly 13 percent of the nonelderly population and nearly 9 percent of children reported nonemployer private coverage; in 1985, less than 12 percent of the nonelderly population and 7 percent of children reported coverage from such a plan.

TABLE III.1

Civilian Nonagricultural Population[a] without Health Insurance and Percent within Own Work Status Group, 1982 and 1985

Work Status	1982		1985		Percent Increase 1982–1985
	(millions)	(percent)	(millions)	(percent)	
Total uninsured	30.3	15.6%	34.8	17.4%	14.9%
Workers	13.9	12.8	17.0	14.7	22.5
family head[b]	8.2	12.5	10.2	14.4	24.0
other	5.6	13.4	6.8	15.3	21.1
Nonworkers	16.4	19.1	17.8	21.0	8.3
children[c]	9.6	17.0	11.1	19.7	15.6
other	6.8	23.1	6.7	23.9	−1.8

Source: Employee Benefit Research Institute (EBRI) tabulations of the March 1983 and the March 1986 Current Population Surveys.

[a]Data exclude people under age 65 employed in the military or in agriculture and members of their families.

[b]The family-head worker is the family or subfamily member with the greatest earnings; all other family members with earnings are designated as secondary workers. Family-head workers include unrelated individuals that are workers.

[c]People under age 18 that reported no earnings and were not the family head.

TABLE III.2
Civilian Nonagricultural Population[a] with Private Health Insurance, by Own Work Status and Source of Coverage, 1982 and 1985

Work Status	1982 Total private coverage	1982 Employer coverage	1982 Other private coverage	1985 Total private coverage	1985 Employer coverage	1985 Other private coverage
			millions			
Total	146.9	130.8	24.0	147.6	131.8	23.0
Workers	91.2	83.7	13.0	95.2	87.6	12.9
family head[b]	55.8	51.1	8.2	58.4	53.6	8.1
other	35.4	32.6	4.8	36.8	34.0	4.8
Nonworkers	55.7	47.1	11.0	52.5	44.3	10.1
children[c]	39.5	36.1	4.9	37.7	34.9	4.1
other	16.2	11.0	6.1	14.8	9.4	6.0
			percent within work status group			
Total	75.8%	67.5%	12.4%	73.9%	66.0%	11.5%
Workers	84.5	77.6	12.1	82.6	75.9	11.2
family head[b]	84.6	77.5	12.4	82.4	75.6	11.4
other	84.4	77.7	11.6	82.8	76.4	10.8
Nonworkers	64.9	54.9	12.8	62.1	52.4	11.9
children[c]	70.1	64.3	8.7	66.8	61.9	7.3
other	54.8	37.0	20.5	52.5	33.4	21.3

Source: EBRI tabulations of the March 1983 and the March 1986 Current Population Surveys.
Note: Detail may not add to totals because of rounding and/or coverage from more than one source.
[a]Data exclude people under age 65 employed in the military or in agriculture and members of their families.
[b]The family-head worker is the family or subfamily member with the greatest earnings; all other family members with earnings are designated as secondary workers. Family-head workers include unrelated individuals that are workers.
[c]People under age 18 that reported no earnings and were not the family head.

The declining coverage from employer plans reported among nonworkers (and particularly among children) is related to eroding employer coverage among workers. While the number of civilian nonagricultural workers increased nearly 7 percent between 1982 and 1985, the number of workers with health insurance coverage from an employer plan rose less than 5 percent. One reason for the slower growth in covered workers compared to total employment may be the slow redistribution of employment towards jobs that historically have not offered benefits—jobs in small firms and low-coverage industries.

Between 1979 and 1983 (the most recent year for which data are available), total employment shifted slightly toward wage and salary jobs in firms with fewer than 1,000 workers. In 1983, nearly 53 percent of the work force was self-employed or employed in firms with fewer than 100 workers; more than one-half of these (27 percent of all workers) were employed in firms of fewer than 25 workers (table III.3). The potential acceleration of this trend toward greater employment in small firms over the economic recovery years following 1982 may explain some of the decline in employer coverage as a percent of total employment during those years. In 1983, the rate of employer-based health insurance coverage among workers in smaller establishments was less than one-half the rate reported among workers in very large establishments (table III.4).

The redistribution of workers toward industries that have historically lower rates of employer coverage may also explain the erosion of employer-based health insurance coverage among workers. Industries with historically lower rates of health insurance coverage have shown relatively rapid gains in employment since 1980. Between 1980 and 1985, employment in industries with below-average rates of employer health coverage (retail trade, services, and construction) grew more than four times as fast as employment in industries with above-average rates of coverage (17 percent, compared to 4 percent; table III.5). In 1985, low-coverage industries accounted for 35 percent of total employment, compared to 30 percent in 1982.

Who Are the Uninsured?

Nearly one-half of all nonelderly people without health insurance in 1985 (49 percent, or 17 million people) were workers (chart III.1). Another one-third (32 percent, or 11 million people) were children age 18 or younger. Only 19 percent of the uninsured were nonworking

TABLE III.3

Distribution of Private-Sector Nonagricultural Civilian Workers by Firm Size, 1979 and 1983

Firm Size (number of employees)	Number of Employees (millions)	Percent of Total[a]	Cumulative Percent[a]
	Year: 1979		
Total	77.9	100.0%	—
Self-employed	8.6	13.1	13.1
Under 25	17.4	26.6	39.7
25–99	8.5	13.0	52.8
100–499	7.2	11.0	63.7
500–999	2.7	4.2	67.9
1,000 or more	20.9	32.1	100.0
Firm size unknown	12.7	—	—
	Year: 1983		
Total	81.6	100.0%	—
Self-employed	9.1	13.0	13.0%
Under 25	19.2	27.3	40.3
25–99	8.7	12.3	52.6
100–499	8.3	11.8	64.4
500–999	3.2	4.6	69.0
1,000 or more	21.8	31.0	100.0
Firm size unknown	11.2	—	—

Source: EBRI tabulations of the May 1979 and May 1983 Current Population Surveys.

[a]Percentage figures exclude workers for whom firm size is unknown.

TABLE III.4

Public- and Private-Sector Civilian Nonagricultural Workers by Participation in an Employer-Based Health Insurance Plan and by Firm Size, 1983

Firm Size	Total (millions)	Participants			Nonparticipants[a]		
		Number of workers (millions)	Percent of workers within firm size	Percent of all participants	Number of workers (millions)	Percent of workers within firm size	Percent of all non-participants
Total[b]	83.9	51.0	60.8%	100.0%	33.0	39.3%	100.0%
Self-employed	9.1	0.1	1.3	0.2	9.0	98.9	27.3
under 25	20.1	7.5	37.3	14.7	12.6	62.7	38.2
25–99	10.0	6.6	66.0	12.9	3.4	34.0	10.3
100–499	10.7	8.1	75.7	15.9	2.7	25.2	8.2
500–999	4.4	3.5	79.5	6.9	0.9	20.5	2.7
1,000 or more	29.5	25.2	85.4	49.4	4.3	14.6	13.0

Source: EBRI tabulations of the May 1983 Current Population Survey.

[a]Includes those that reported they did not know whether they were included in their employer's health insurance plan.
[b]Total excludes 13.7 million workers that reported they did not know their firm's size.

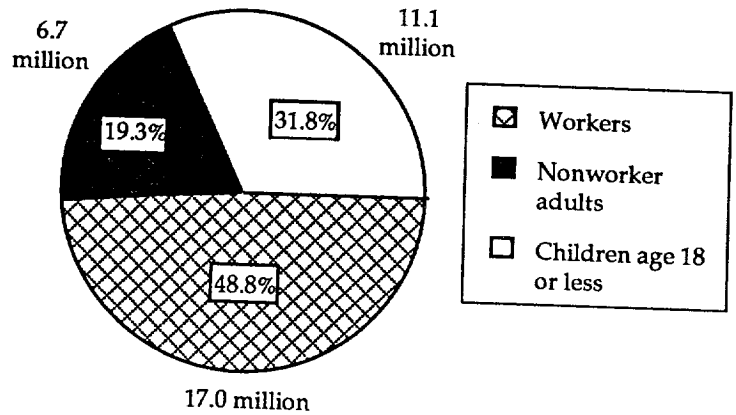
Total Nonagricultural Civilian Employment, Rates of Employment Growth, and Employer-Based Health Insurance Coverage by Industry, 1985

Industry	1985 Employment: Number of workers[a] (thousands)	1985 Employment: Percent of all workers	Rate of Employment Change, 1980–1985	Percent of Workers with Employer Health Plan, 1985[b]
All workers	103,163	100.0%	8.3%	75.8%
		high-coverage industries		
Mining	939	0.9%	−4.1%	88.8%
Manufacturing	20,879	20.2	−4.8	88.2
Transportation, communication, & public utilities	7,548	7.3	15.7	87.5
Finance, insurance, & real estate	7,005	6.8	16.9	86.1
Wholesale trade	4,341	4.2	10.7	84.1
Professional & related services	21,563	20.9	8.6	81.7
Public administration	4,995	4.8	−6.5	87.6
Total, high-coverage	67,270	65.2%	4.2%	85.6%
		low-coverage industries		
Construction	6,987	6.8%	12.4%	66.2%
Retail trade	17,955	17.4	10.4	63.7
Business & repair services	5,321	5.2	60.6	66.0
Personal services	4,352	4.2	13.4	50.3
Entertainment & recreation	1,278	1.2	22.1	59.4
Total, low-coverage	35,893	34.8%	17.0%	62.9%

Source: EBRI tabulations of the March 1986 Current Population Survey; and U.S. Department of Commerce, Bureau of the Census, *Statistical Abstract of the United States*, 1987, p. 388.

[a]Excludes agriculture, forestry, fisheries, and miscellaneous services.
[b]Includes wage and salary workers; excludes the self-employed.

CHART III.1
Nonelderly Population without Health Insurance Coverage by Own Work Status, 1985



Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

adults—that is, people over age 18 that neither worked nor looked for work during 1985.

More than two-thirds (69 percent) of the uninsured were either full-time, full-year workers (that is, they worked or sought work 35 weeks or more during the year and worked 35 hours or more in a typical week) or lived in families headed by a full-time, full-year worker. About 17 percent of the uninsured lived with a full-year worker that reported some unemployment in 1985; but more than one-half (52 percent) of the uninsured population lived in families of full-time workers that were steadily employed throughout the year. Relatively few uninsured (17 percent) lived in families headed by a part-year or part-time worker or in families headed by a nonworker (14 percent). This distribution of the uninsured by the work status of the family head is presented in table III.6.

A significant minority of the uninsured in 1985—more than 9 percent—lived with a spouse or parent that had coverage from an employer plan. Among children without health insurance, 20 percent lived with a parent that reported coverage from an employer plan. Available data do not indicate whether: (1) the insured worker's plan

TABLE III.6

Nonelderly Population by Selected Sources of Health Insurance Coverage and Employment Status of Family Head, 1985

Family Head	Work Status of Total	Insured Population: Private & Public				No Health Insurance Coverage
		Total	Employer-provided			
			total	direct	indirect	
	millions					
Total	199.8	165.0	131.8	68.3	63.5	34.8
Full-year, full-time workers[a]	143.5	125.3	115.7	59.4	56.3	18.2
Full-year, part-time workers[a]	8.7	5.9	3.1	1.7	1.3	2.8
Sometime-unemployed workers[b]	19.6	13.6	9.9	5.3	4.6	6.0
Part-year workers[c]	10.3	7.1	3.1	1.8	1.3	3.2
Nonworkers	17.7	13.1	[d]	[d]	[d]	4.7
	percent within source-of-coverage groups					
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Full-year, full-time workers[a]	71.8	75.9	87.8	87.0	88.7	52.3

Full-year, part-time workers[a]	4.4	3.6	2.4	2.5	2.0	8.0
Sometime-unemployed workers[b]	9.8	8.2	7.5	7.8	7.2	17.2
Part-year workers[c]	5.2	4.3	2.4	2.6	2.0	9.2
Nonworkers	8.9	7.9	[d]	[d]	[d]	13.5
			percent within worker categories			
Total	100.0%	82.6%	66.0%	34.2%	31.8%	17.4%
Full-year, full-time workers[a]	100.0	87.3	80.6	41.4	39.2	12.7
Full-year, part-time workers[a]	100.0	67.8	35.6	19.5	14.9	32.2
Sometime-unemployed workers[b]	100.0	69.4	50.5	27.0	23.5	30.6
Part-year workers[c]	100.0	68.9	30.1	17.5	12.6	31.1
Nonworkers	100.0	74.0	[d]	[d]	[d]	26.6

Source: EBRI tabulations of the March 1986 Current Population Survey.

[a]Includes only steadily employed, full-year workers.
[b]Includes only workers that worked or sought work 35 weeks or more during the year (full-year workers).
[c]Includes both steadily employed and sometime-unemployed workers that worked or sought work fewer than 35 weeks.
[d]Number too small to be statistically reliable.

offered no coverage for dependents; or (2) dependents' coverage was available but the worker did not elect to take it.

Data on health plan provisions in medium-sized and large establishments in the United States indicate that employee contributions for dependents' coverage are increasingly common (U.S. Department of Labor, 1987). Some employers have eliminated most or all contributions to dependents' coverage to achieve comparable benefits for married and single employees in a marketplace increasingly concerned with pay equity.

Nevertheless, the personal earnings of at least some employer-covered workers with an uninsured spouse or child suggest that the likely amount of an employee contribution to dependents' coverage, were it offered, might have been affordable. For approximately one-fourth of uninsured children living with an employer-covered parent (or, rarely, a spouse), the parent earned more than $20,000 in 1985, worked full-time, and reported an employer contribution to his or her own coverage. Approximately 4 percent lived with an employer-covered parent that earned $40,000 or more in 1985.

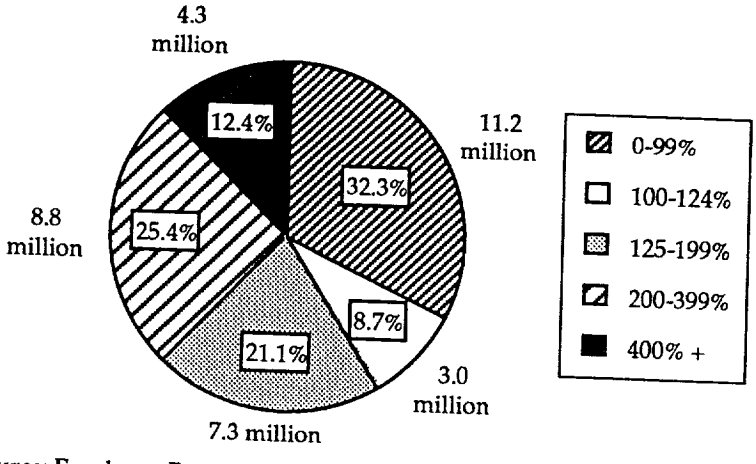
These uninsured living with employer-insured workers, however, are not typical of the uninsured as a group. In 1985, 62 percent of the uninsured lived in families with income below 200 percent of the federal poverty standard; nearly one-third (32 percent) lived in families with below-poverty income (chart III.2).[2]

The typical family structure of people without insurance coverage differs markedly from that of people with either private insurance coverage or public program coverage, reflecting differences in access to employer coverage and Medicaid benefits. In particular, the uninsured are much more likely than the privately insured population to live in single-adult or single-parent families, and are more likely than the publicly insured population to live in families without children or in two-parent families with children.

While less than one-third (32 percent) of the total population lived in single-adult or single-parent families in 1985, one-half of all uninsured people lived in single-adult or single-parent families. One-fourth (25 percent) of the uninsured lived in single-parent families—that is, in families with children but with no spouse present (table III.7). While nearly one-half of the total population lived in two-parent

[2]The federal poverty standard is adjusted for family size. The 1985 federal poverty standard for a nonelderly family of two was $7,230 in 1985; the poverty standard for a family of four was $10,990.

CHART III.2
Nonelderly Population without Health Insurance Coverage by Family Income As a Percent of Poverty, 1985



Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

families with children in 1985, only 35 percent of the uninsured lived in families of this type.

The majority of uninsured children in 1985 (55 percent) lived in two-parent families where typically one or both parents were full-year workers (table III.8). However, nearly one-half (45 percent) of uninsured children under age 18 in 1985 lived in single-parent families; most of these children (37 percent of all uninsured children) lived in families headed by single women.

Uninsured children living in poverty were substantially more likely to live in single-parent families (57 percent, compared to 45 percent among all uninsured children), and more likely to live in families headed by single women. In 1985, fully one-half of all uninsured children in poverty lived in families headed by single women. Nearly one-half of these children (31 percent of uninsured poor children) lived with single women that were workers (chart III.3).

People with family income below the federal poverty standard may not qualify for Medicaid benefits if: (1) they are not categorically eligible (that is, they are not in families with dependent children, disabled, or otherwise eligible for benefits from a federal or state cash

TABLE III.7

Nonelderly Population and Population without Health Insurance, by Family Type and Family Head's Employment Status, 1985

Family Type and Employment Status	Total (millions)	No Health Insurance (millions)	No Health Insurance (percent of uninsured population)	No Health Insurance (percent within category)
Total	199.8	34.8	100.0%	17.4%
Spouse present,				
no child present	40.2	5.1	14.7	12.7
full-year worker[a]	35.1	4.0	11.5	11.4
part-year worker[b]	1.6	0.3	0.9	18.8
nonworker	3.5	0.8	2.3	22.9
Spouse present,				
child present	95.6	12.1	34.8	12.7
full-year worker[a]	91.0	10.8	31.0	11.9
part-year worker[b]	2.3	0.7	2.0	30.4
nonworker	2.3	0.6	1.7	26.1
No spouse present,				
no child present	34.3	8.7	25.0	25.4
full-year worker[a]	27.7	6.2	17.8	22.4
part-year worker[b]	2.4	0.9	2.6	37.5
nonworker	4.2	1.6	4.6	38.1
No spouse present,				
child present	29.6	8.8	25.3	29.7
full-year worker[a]	18.0	5.9	17.0	32.8
part-year worker[b]	4.0	1.2	3.4	30.0
nonworker	7.6	1.7	4.9	22.4

Source: EBRI tabulations of the March 1985 Current Population Survey.
[a]Includes steadily employed and sometime-unemployed workers that worked or sought work 35 weeks or more during the year.
[b]Includes all workers that worked or sought work fewer than 35 weeks during the year.

TABLE III.8

Children under Age 18 without Health Insurance, by Family Type and Poverty Status, and Sex and Work Status of the Family Head, 1985

	Total	Family Income As a Percent of Poverty			
		0–99%	100–124%	125–199%	200%+
		millions			
All uninsured children	10.8	4.2	1.1	2.4	3.1
Family type and work status:					
Spouse present, family head is:	5.9	1.8	0.6	1.4	2.0
full-year worker[a]	5.2	1.4	0.6	1.3	1.9
part-year worker[b]	0.3	0.1	c	0.1	c
nonworker	0.3	0.2	c	c	c
Spouse absent, family head is:	4.9	2.4	0.4	1.0	1.1
male	1.0	0.3	0.1	0.2	0.3
full-year worker[a]	0.7	0.2	c	0.2	0.3
part-year worker[b]	0.1	0.1	c	c	c
nonworker	0.1	c	c	c	c
female	4.0	2.1	0.3	0.8	0.8
full-year worker[a]	2.5	0.9	0.3	0.6	0.7
part-year worker[b]	0.5	0.4	c	c	c
nonworker	1.0	0.9	c	c	c

(continued next page)

TABLE III.8 (continued)

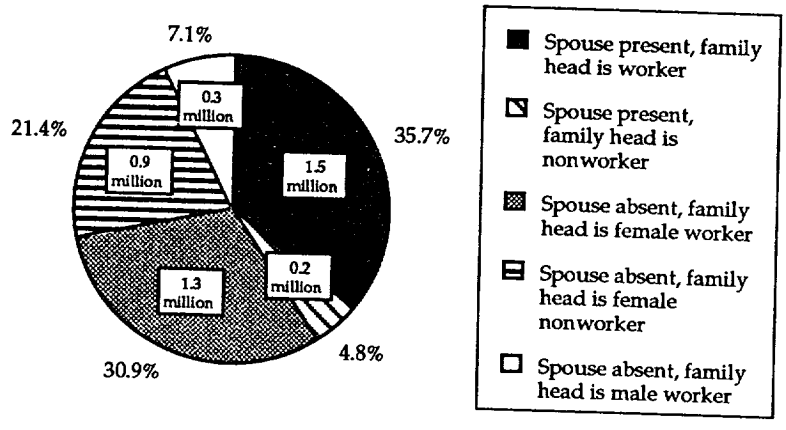
	Total	Family Income As a Percent of Poverty			
		0–99%	100–124%	125–199%	200%+
		(millions)			
		percent within family status groups			
All uninsured children	100.0%	100.0%	100.0%	100.0%	100.0%
Family type and work status:					
Spouse present, family head is:	54.6	42.9	54.5	58.3	664.5
full-year worker[a]	48.1	33.3	54.5	54.2	61.3
part-year worker[b]	2.8	2.4	[c]	4.2	[c]
nonworker	2.8	4.8	[c]	[c]	[c]
Spouse absent, family head is:	45.4	57.1	36.4	41.7	35.5
male	9.3	7.1	9.1	8.3	9.7
full-year worker[a]	6.5	4.8	[c]	8.3	9.7
part-year worker[b]	0.9	2.4	[c]	[c]	[c]
nonworker	0.9	[c]	[c]	[c]	[c]
female	37.0	50.0	27.3	33.3	25.8
full-year worker[a]	23.1	21.4	27.3	25.0	22.6
part-year worker[b]	4.6	9.5	[c]	[c]	[c]
nonworker	9.3	21.4	[c]	[c]	[c]

		percent within poverty status groups			
All uninsured children	100.0%	38.9%	10.2%	22.2%	28.7%
Family type and work status:					
Spouse present, family head is:	100.0	30.5	10.2	23.7	33.9
full-year worker[a]	100.0	26.9	11.5	25.0	36.5
part-year worker[b]	100.0	33.3	[c]	33.3	[c]
nonworker	100.0	66.7	[c]	[c]	[c]
Spouse absent, family head is:	100.0	49.0	8.2	20.4	22.4
male	100.0	30.0	10.0	20.0	30.0
full-year worker[a]	100.0	28.6	[c]	28.6	42.9
part-year worker[b]	100.0	100.0	[c]	[c]	[c]
nonworker	100.0	[c]	[c]	[c]	[c]
female	100.0	52.5	7.5	20.0	20.0
full-year worker[a]	100.0	36.0	12.0	24.0	28.0
part-year worker[b]	100.0	80.0	[c]	[c]	[c]
nonworker	100.0	90.0	[c]	[c]	[c]

Source: EBRI tabulations of the March 1986 Current Population Survey.

[a]Includes steadily employed and sometime-unemployed workers that worked or sought work 35 weeks or more during the year.
[b]Includes all workers that worked or sought work fewer than 35 weeks during the year.
[c]Number too small to be statistically reliable.

CHART III.3
Children under Age 18 without Health Insurance Living in Poverty by Family Type, 1985



Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.
Note: The number of uninsured poor children living with a single male nonworker is too small to be statistically reliable.

assistance program); and/or (2) their income is not sufficiently low to qualify for Medicaid. In 1986, the median level of qualifying income for the Aid to Families with Dependent Children (AFDC) program, which confers most Medicaid eligibility was 48 percent of the federal poverty standard; only 43 percent of the nonelderly population living in poverty qualified for Medicaid (Chollet, 1987).

Rates of noncoverage vary substantially among states. States characterized by high unemployment or low rates of employer health insurance coverage among workers (e.g., Arkansas, New Mexico, Oklahoma, and Florida) and/or low rates of Medicaid coverage (e.g., Louisiana) have populations with particularly high proportions of uninsured people. In 1985, more than one-fourth of Oklahoma's population (25.3 percent) reported no health insurance of any type, including Medicaid. In 14 states and the District of Columbia, 20 percent or more of the nonelderly population was uninsured (table III.9).

Noncoverage among Workers

Employer plans are the predominant source of health insurance in the United States. In 1985, more than three-fourths of all nonagri-

TABLE III.9

Total Nonelderly Population and Percent with Health Insurance Coverage from Selected Source by Region and State, 1985

Region/State	Total (thousands)	Total Private (percent)	Total Employer Provided (percent)	Total Public (percent)	Medicaid (percent)	No Health Insurance	
						(thousands)	(percent)
Total	199,765	73.9%	66.0%	12.0%	8.0%	34,759	17.4%
New England	10,733	80.9	74.0	9.9	6.7	1,302	12.1
Maine	929	78.6	71.1	14.3	9.2	109	11.7
New Hampshire	863	84.4	78.3	[a]	[a]	109	12.6
Vermont	454	78.6	71.1	[a]	[a]	[a]	[a]
Massachusetts	5,022	78.8	72.4	10.9	8.2	657	13.1
Rhode Island	790	80.2	73.0	[a]	[a]	101	12.8
Connecticut	2,675	85.0	77.5	8.2	4.9	258	9.7
Middle Atlantic	31,412	75.2	67.8	13.0	10.5	4,521	14.4
New York	15,226	70.3	64.2	15.9	13.7	2,471	16.2
New Jersey	6,517	80.5	72.3	9.3	6.6	806	12.4
Pennsylvania	9,669	79.3	70.4	10.9	8.2	1,245	12.9
East North Central	36,678	76.2	69.0	13.3	10.5	4,894	13.7
Ohio	9,191	76.8	69.7	11.3	8.3	1,332	14.5
Indiana	4,537	79.0	71.1	6.6	3.6	769	16.9
Illinois	10,137	73.9	67.5	14.4	11.6	1,469	14.5
Michigan	7,886	74.9	67.0	18.2	15.2	940	11.9
Wisconsin	3,928	80.3	72.2	13.2	11.2	383	9.8
West North Central	13,928	78.4	68.1	10.6	7.2	1,957	14.1
Minnesota	3,410	81.9	71.3	10.5	7.4	383	11.2
Iowa	2,135	77.9	68.1	12.4	10.7	272	12.7

TABLE III.9 (continued)

Region/State	Total (thousands)	Total Private (percent)	Total Employer Provided (percent)	Total Public (percent)	Medicaid (percent)	No Health Insurance	
						(thousands)	(percent)
Missouri	4,234	74.3	65.5	11.4	7.4	697	16.5
North Dakota	500	82.4	67.7	[a]	[a]	[a]	[a]
South Dakota	504	76.5	64.3	[a]	[a]	89	17.7
Nebraska	1,224	80.0	68.3	7.8	[a]	185	15.1
Kansas	1,920	80.4	69.2	9.3	5.4	273	14.2
South Atlantic	32,627	73.1	64.8	12.0	6.4	6,123	18.8
Delaware	519	74.9	69.2	[a]	[a]	93	17.9
Maryland	3,641	77.9	69.8	10.0	6.0	546	15.0
District of Columbia	517	62.7	53.9	18.2	[a]	117	22.7
Virginia	4,549	76.4	70.7	10.0	5.2	754	16.6
West Virginia	1,571	68.4	58.3	17.9	13.0	292	18.6
North Carolina	5,066	77.1	69.2	10.9	4.3	824	16.3
South Carolina	2,713	76.6	68.8	12.9	7.9	392	14.4
Georgia	4,968	71.5	65.2	14.2	8.5	904	18.2
Florida	9,083	68.3	57.6	11.6	5.2	2,200	24.2
East South Central	12,511	70.4	61.5	11.8	7.4	2,641	21.1
Kentucky	3,001	72.3	62.0	10.7	6.7	638	21.2
Tennessee	3,944	69.1	60.9	13.2	8.3	834	21.1
Alabama	3,432	72.5	64.3	9.5	6.5	686	20.0
Mississippi	2,134	66.6	57.6	14.6	8.1	483	22.6

West South Central	22,487	69.9	62.5	9.8	5.2	5,255	23.4
Arkansas	1,928	64.4	56.6	16.9	9.3	469	24.3
Louisiana	3,741	72.4	62.7	8.1	4.0	822	22.0
Oklahoma	2,762	68.2	59.0	10.3	4.4	698	25.3
Texas	14,056	70.3	63.9	9.2	5.1	3,266	23.2
Mountain	10,889	74.7	65.3	9.6	3.8	2,114	19.4
Montana	668	74.2	62.1	11.5	[a]	123	18.4
Idaho	800	74.2	64.2	[a]	[a]	169	21.2
Wyoming	419	77.6	69.0	[a]	[a]	[a]	[a]
Colorado	2,795	77.2	68.1	7.1	3.4	513	18.4
New Mexico	1,228	64.8	57.8	16.2	6.9	286	23.3
Arizona	2,658	73.7	62.0	9.6	[a]	570	21.4
Utah	1,481	80.8	74.2	7.5	[a]	206	13.9
Nevada	839	73.0	63.3	10.6	[a]	179	21.3
Pacific	29,499	70.3	62.6	13.3	9.1	5,951	20.2
Washington	3,565	75.0	65.2	13.6	8.0	589	16.5
Oregon	2,268	77.9	67.1	8.7	4.5	388	17.1
California	22,422	68.3	61.5	13.7	9.9	4,803	21.4
Alaska	439	76.6	62.4	[a]	[a]	77	17.4
Hawaii	805	80.6	70.7	13.8	[a]	95	11.8

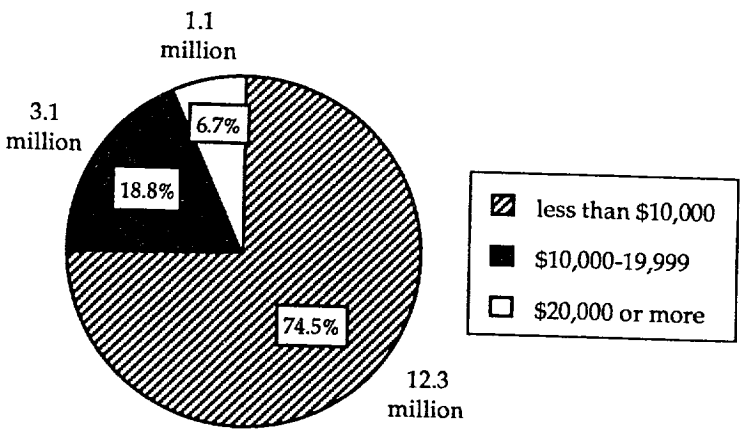
Source: EBRI tabulations of the March 1986 Current Population Survey.
Note: Detail may not add to totals because of rounding or coverage from more than one source.

[a]Number too small to be statistically reliable.

cultural, civilian workers in the United States age 18–64 (76 percent) reported coverage from an employer plan; these plans provided coverage to two-thirds of the nonelderly population. Eighty percent of covered workers (61 percent of all workers) had coverage from their own employer plan; the rest were covered as dependents of another worker. However, in 1985, 15 percent of all civilian, nonagricultural workers reported no coverage from an employer plan, from another private plan, or from any public program; more than three-fourths of the uninsured population are associated with these workers.

Workers without employer-based insurance coverage are characterized by relatively low earnings. In 1985, fully three-fourths of all uninsured workers earned less than $10,000 (chart III.4). Nearly all (93 percent) earned less than $20,000. The relatively low earnings reported by uninsured workers were not necessarily related to part-time or part-year work. Among full-year workers without health insurance coverage, 69 percent earned less than $10,000 in 1985; nearly 92 percent earned less than $20,000. About one-third of all full-year workers earning less than $10,000 were uninsured (table III.10).

CHART III.4
Workers Age 18–64 without Health Insurance Coverage by Personal Earnings, 1985



Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

Workers earning less than the federal minimum wage are more likely to be uninsured than higher-wage workers. While 16 percent of all workers earned, on average, less than the federal minimum wage in 1985, these workers accounted for more than 35 percent of all uninsured workers (table III.11). Approximately 40 percent of all workers in the United States are in jobs or occupations not subject to the minimum wage provisions of the Fair Labor Standards Act.[3]

More than one-half of all uninsured workers in 1985 were employed in two industries: retail trade and services (24 and 28 percent, respectively; chart III.5). Another 16 percent of all uninsured workers were self-employed. Among workers employed in retail trade or in any service industry other than professional and related services, the rate of noncoverage varied between 23 percent (retail trade) and 32 percent (personal services). Nearly one-fourth (24 percent) of all self-employed workers were uninsured in 1985; although fewer workers nationwide are employed in construction, they reported a comparable rate of noncoverage (table III.12).

Most uninsured workers are employed in small firms. In 1983, two-thirds of workers reporting no coverage from their own employer were either self-employed (27 percent) or employed in firms with fewer than 25 employees (40 percent). Although these data do not reflect the coverage that small-firm employees may receive as dependents of other workers' plans, the total coverage rate among small-firm employees is probably lower, nevertheless, than that among large-firm employees. In 1985, 15 percent of all workers (and 20 percent of covered workers) had employer-based health insurance only as a dependent.

Table III.13 provides summary demographic information on uninsured workers. In 1985, men that were employed at any time during the year were slightly more likely than women workers to be uninsured (15 percent among men, compared to 14 percent among women). The greater propensity of women to have health insurance—despite lower average earnings, which alone would suggest a lower probability of coverage—is consistent with the findings of earlier research (Chollet, 1984). Young workers, particularly, are likely to be uninsured. Workers age 21 to 24 show the highest rate of noncoverage; workers in this age group are less likely than older workers to have

[3]Supervisory and professional workers, as well as workers in small establishments in particular industries, are exempted from minimum-wage provisions of the Fair Labor Standards Act. Service and retail trade workers in small establishments (defined in terms of annual gross revenues) represent more than 80 percent of all nonagricultural, nonsupervisory workers exempted from the federal minimum wage (Welsh, 1982).

TABLE III.10

Full-Year Workers Age 18–64 by Sources of Health Insurance and Personal Earnings, 1985[a]

Personal Earnings	Total	Employer Coverage			No Coverage
		Total	Direct	Indirect	
	millions				
Total	98.5	77.1	65.5	11.6	13.3
Under $10,000	31.3	16.6	9.3	7.3	9.2
$10,000–19,999	30.3	25.8	23.0	2.9	3.0
$20,000–29,999	19.4	18.1	17.2	0.9	0.7
$30,000–39,999	9.8	9.3	9.0	0.3	0.3
$40,000–49,999	3.8	3.6	3.5	0.1	[b]
$50,000 or more	3.9	3.6	3.5	0.1	0.1
	percent within coverage groups				
Total	100.0%	100.0%	100.0%	100.0%	100.0%
Under $10,000	31.8	21.5	14.1	63.0	69.0
$10,000–19,999	30.8	33.5	35.1	24.6	22.5

$20,000–29,999	19.7	23.5	26.3	7.9	5.4
$30,000–39,999	9.9	12.1	13.8	2.7	1.9
$40,000–49,999	3.8	4.7	5.3	0.9	[b]
$50,000 or more	4.0	4.7	5.3	0.9	0.7
		percent within earnings groups			
Total	100.0%	78.3%	66.5%	11.8%	13.5%
Under $10,000	100.0	52.9	29.5	23.4	29.3
$10,000–19,999	100.0	85.3	75.9	9.4	9.9
$20,000–29,999	100.0	93.4	88.7	4.7	3.7
$30,000–39,999	100.0	95.2	92.0	3.2	2.6
$40,000–49,999	100.0	95.9	93.2	2.7	[b]
$50,000 or more	100.0	92.6	89.8	2.7	2.5

Source: EBRI tabulations of the March 1986 Current Population Survey.

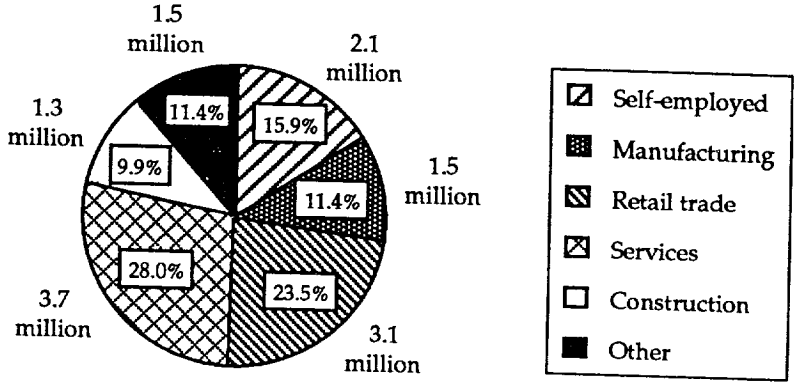
[a]Includes full time and part-time full-year workers; 14 percent were unemployed one week or more during 1985.
[b]Number too small to be statistically reliable.

Workers Age 18–64 by Selected Sources of Health Insurance Coverage and Hourly Earnings As a Percent of the Federal Minimum Wage, 1985

Hourly Earnings as a Percent of Minimum Wage	Total	Total insured	Insured Population: Private & Public						No Health Insurance Coverage
			Private				Public		
			total private	employer-provided			total public	medicaid	
				total	direct	indirect			
	millions								
Total	112.4	95.9	92.6	85.1	68.4	16.7	6.6	2.6	16.5
0–99%	18.3	12.5	11.1	8.3	3.2	5.0	2.0	1.1	5.8
100–124%	8.8	6.3	5.8	5.0	2.7	2.3	0.9	0.5	2.5
125–199%	24.5	20.0	19.3	17.6	13.2	4.4	1.5	0.6	4.5
200–399%	40.6	37.6	37.1	35.7	31.7	3.9	1.6	0.4	3.0
400% or more	20.2	19.4	19.3	18.6	17.5	1.1	0.7	0.1	0.8
	percent within source-of-coverage groups								
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
0–99%	16.3	13.0	12.0	9.8	4.7	29.9	30.3	42.3	35.2
100–124%	7.8	6.6	6.3	5.9	3.9	13.8	13.6	19.2	15.2
125–199%	21.8	20.9	20.8	20.7	19.3	26.3	22.7	23.1	27.3
200–399%	36.1	39.2	40.1	42.0	46.3	23.4	24.2	15.4	18.2
400% or more	18.0	20.2	20.8	21.9	25.6	6.6	10.6	3.8	4.8
	percent within minimum-wage groups								
Total	100.0%	85.3%	82.4%	75.8%	60.9%	14.9%	5.9%	2.4%	14.7%
0–99%	100.0	68.3	60.7	45.3	17.5	27.6	10.7	5.7	31.7
100–124%	100.0	71.6	65.6	56.4	30.7	25.7	9.8	5.3	28.3
125–199%	100.0	81.6	78.8	71.2	54.1	17.9	6.3	2.6	18.3
200–399%	100.0	92.6	91.5	87.8	78.1	9.7	3.9	0.9	7.4
400% or more	100.0	96.0	95.5	92.1	86.9	5.3	3.5	0.6	3.8

Source: EBRI tabulations of the March 1986 Current Population Survey.
Note: Detail may not add to totals because of rounding or coverage from more than one source.

CHART III.5
Full-Year Workers Age 18–64 without Health Insurance Coverage by Industry of Primary Employment, 1985



Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

direct employer coverage, and are less likely than younger workers to have indirect coverage (from a parent or spouse's plan). In 1985, more than one-half of uninsured workers (52 percent) were under age 30; 35 percent were younger than age 25.

Conclusion

Most health insurance in the United States is provided through employer plans. In 1985, 66 percent of the nonelderly population (and 80 percent of the nonelderly insured population) were covered by an employer plan. Employer plans provided coverage for nearly 132 million people. However, employer coverage among workers and their dependents has begun to erode as employment has shifted toward small firms and industries with historically low rates of employer coverage. The nonelderly population without health insurance of any type—from an employer plan, from another private plan, or from a public program like Medicaid—grew nearly 15 percent between 1982 and 1985; the number of uninsured workers grew by more than 22 percent.

TABLE III.12
Workers Age 18–64 by Selected Sources of Coverage and Industry of Primary Employment, 1985

	Total (millions)	Employer-Based Coverage (percent)			No Coverage	
		Total	Direct	Indirect	(millions)	(percent)
Total	112.4	75.6%	60.8%	14.8%	16.6	14.8%
Self-employed						
Mining						
Construction	9.7	51.5	28.9	21.6	2.3	23.7
Manufacturing	1.1	81.8	81.8	a	0.1	9.1
Transportation, communication, & other public utilities	6.3	66.7	55.6	11.1	1.5	23.8
	21.9	88.1	81.7	6.4	1.9	8.7
Wholesale trade	7.6	86.8	80.3	6.6	0.6	7.9
Retail trade	4.1	82.9	73.2	9.8	0.4	9.8
Finance, insurance, & real estate	17.6	63.6	39.8	23.9	4.1	23.3
Business & repair services	6.6	86.4	72.7	13.6	0.5	7.6
Personal services	5.3	66.0	49.1	17.0	1.2	22.6
Entertainment & recreation services	3.7	48.6	27.0	21.6	1.2	32.4
Professional & related services	1.3	53.8	30.8	23.1	0.3	23.1
Public administration	21.9	81.7	63.9	17.8	2.2	10.0
	5.4	88.9	79.6	9.3	0.3	5.6

Source: EBRI tabulations of the March 1986 Current Population Survey.
[a]Number too small to be statistically reliable.

TABLE III.13

Workers Age 18–64 by Selected Sources of Health Insurance Coverage, by Sex and Age, 1985

	Total (millions)	Total Private (percent)	Employer-Based		Total Public (percent)	Uninsured	
			Direct (percent)	Indirect (percent)		(millions)	(percent)
Total	112.4	82.4%	60.9%	14.9%	5.9%	16.5	14.7%
Men	60.2	82.4	68.2	8.1	5.0	9.3	15.4
Women	52.2	82.3	52.5	22.7	6.9	7.3	13.9
Age							
18–20	7.9	70.6	20.1	42.7	9.7	1.9	23.6
21–24	13.3	66.6	48.2	11.8	6.3	3.9	29.3
25–29	17.5	80.6	65.7	10.1	4.4	2.9	16.6
30–44	43.3	86.3	66.4	14.9	5.0	4.8	11.1
45–54	17.6	87.6	67.0	13.6	6.2	1.8	10.3
55+	12.7	87.8	65.9	9.0	7.8	1.2	9.8

Source: EBRI tabulations of the March 1986 Current Population Survey.
Note: Detail may not add to totals because of rounding.

The employment growth associated with recovery from the 1981–82 economic recession has not brought commensurate growth in employer coverage. Since 1980, employment has grown more than four times as fast in industries characterized by low rates of employer coverage as in high-coverage industries. Continued faster employment growth in small firms may also account for declining rates of employer coverage among workers. Workers in very small firms are about half as likely as workers in larger firms to have an employer health plan; about one-half of all workers are either self-employed or employed in firms with fewer than 25 employees.

Most of the uninsured population live in families of workers. For most of these people, the absence of health insurance is not a result of fragmented employment or unemployment of the family head. In 1985, 52 percent of the uninsured population lived with a full-time, full-year worker that was steadily employed throughout the year. About 14 percent of the uninsured population lived with workers that were unemployed at any time during the year.

The uninsured population is characterized by low earnings (in worker families) and/or relatively low family income. Three-fourths of uninsured workers in 1985 earned less than $10,000; more than one-third earned less than the federal minimum wage. Among the uninsured population, one-third lived in families with below-poverty income; two-thirds reported family income below 200 percent of poverty.

People with family income below the federal poverty standard may not qualify for Medicaid benefits. In 1984, the median level of qualifying income for Medicaid assistance was 48 percent of the federal poverty standard; only 42 percent of the nonelderly population living in poverty qualified.

Congressional interests in the uninsured population focuses on problems of access to health care among people without insurance. Interest is also mounting among private employers that provide health insurance benefits for workers, as concern about the uninsured's health care costs being shifted to employer plans has grown and firms have become increasingly concerned about their competitiveness in world markets.

However, formulating effective public policy to expand health insurance coverage among the nonelderly population is made difficult by the diversity of the uninsured population. Whereas many of the uninsured population could have access to insurance coverage through the work place if all employers sponsored a health insurance plan, a significant minority—nonworkers and self-employed workers and their dependents—would not.

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IV. Public Policy Options To Expand Health Insurance Coverage Among The Nonelderly Population

PAPER BY DEBORAH CHOLLET

Introduction

The growing number of Americans under age 65 without health insurance has captured the attention of Congress and state legislators. The issues associated with this population are twofold. First, people without insurance or other apparent means of payment for health care services commonly have difficulty gaining access to needed care. Second, financing uncompensated health care (care for which recipients are unable to pay) has become an increasingly difficult problem for health care providers. Uncompensated care provided by hospitals and physicians in 1986 may have totaled $13 billion—approximately 5 percent of providers' aggregate gross revenues, but unevenly distributed among providers (Chollet, 1987). Presumably, much of this cost is shifted to privately insured consumers, most of whom are covered by employer plans.

Public policy options to expand health insurance coverage among the nonelderly population are of three general types: (1) options that would encourage individuals to buy coverage; (2) options related to expanding employer-based coverage; and (3) options related to expanding Medicaid eligibility.

This chapter examines various public policy options in each category in terms of their potential effectiveness in reducing the number of nonelderly people without health insurance coverage. The numbers of uninsured people in 1985 that might have been covered by an employer plan or Medicaid under various options are estimated. These estimates are based on the nonmilitary, nonagricultural, under-65 population reporting no health insurance coverage from any source in 1985: nearly 35 million people. Also evaluated is the possible impact that public policy options to expand coverage through employer plans may have on the availability of jobs for low-wage workers.

Encouraging the Individual Purchase of Health Insurance

Relatively few nonelderly Americans purchase individual health insurance. In 1985, fewer than 12 percent of nonelderly Americans reported health insurance coverage from an individual, nonemployer insurance plan, compared to 66 percent that reported coverage from an employer plan (EBRI, May 1987). Among nonworker adults (the group most likely to have individual coverage) fewer than 21 percent reported coverage from an individual plan, compared to more than 33 percent covered as dependents under an employer plan.

The relatively low rate of individual insurance purchase in the United States is a result of at least two factors. First, individual insurance is expensive relative both to the average price of a group plan with comparable benefits and to average family income. Informal industry estimates suggest that insurance premiums for individual coverage may average more than 130 percent of large-group premiums for the same benefits. The higher cost of individual coverage relates to the health care risk posed by individuals without access to an employer group and to the cost of administering individuals plans.

Second, people that would buy individual coverage may be more likely to be uninsurable than the population with access to an employer plan. That is, they may be more likely to have a health condition that would predictably generate large claims against the plan. Such people, who represent a poor insurance risk, may be unable to buy individual insurance coverage at any price. Although 14 states have formed insurer-underwritten financing pools for uninsurable residents, most have no arrangement other than the state Medicaid program. In such states, uninsurable people that are categorically or financially ineligible for Medicaid benefits may have no insurance option outside of an employer group.

The low income that characterizes most of the uninsured population suggests that relatively few might purchase insurance coverage if they had to pay the full cost. In 1985, one-third of the nonelderly uninsured population lived in families with income below the federal poverty standard;[1] two-thirds reported family income less than 200 percent of poverty. Past research suggests that employer plans—the principal sources of insurance coverage in the United States—have achieved widespread coverage among workers precisely because they

[1]Poverty income for a nonelderly family of four was $10,990 in 1985.

provide a subsidy to participants: they do not rely on individual decisions to purchase coverage at market prices (Chollet, 1984). The relatively high family income reported by some uninsured people suggests that individual preferences for health insurance may also be an important obstacle to achieving universal insurance coverage through a system of individual, voluntary purchase.

States that have examined the possibility of establishing a state-level insurance plan to provide coverage to uninsured residents have recognized that a substantial subsidy (reducing the price to participants) may be critical to achieving widespread participation. The problem of financing a subsidy for participants in a voluntary health insurance plan may be exacerbated by individual preferences. Insurance coverage that would be attractive to most consumers without access to an employer plan and provide adequate protection may be more expensive than the standard individual or group insurance plans that are now marketed—raising the subsidy needed to induce widespread participation.

In particular, deductible and copayment provisions that are standard in individual or employer health insurance plans may be too stringent to adequately protect the low-income families that make up more than one-half of the uninsured population. An insurance plan with lower cost-sharing by participants (commensurate with their lower incomes) could be structured for the same cost by reducing benefits—in particular, reducing the scope of services covered by the plan. However, plans that provide only narrow or catastrophic coverage may be unattractive to consumers at virtually any price if they are seeking to finance basic health care services. In addition, such scaled-down insurance plans may be prohibited by law in many states that require insurance plans to cover a variety of specific services or the services of specific provider types.[2]

To date, only the state of Washington has authorized a subsidized, voluntary individual health insurance plan for its uninsured population. In March 1987, the Washington legislature authorized the establishment of a managed-care "basic health" plan for uninsured individuals with family income below 200 percent of poverty; coverage under this plan is to commence in July 1988. The plan is to be financed from general revenue appropriations and federal matching funds associated with any Medicaid participation that may occur, as

[2]Most states require that specific benefits and/or the services of specific categories of health care providers be covered by insurance plans sold in the state. Commonly mandated health insurance benefits include coverage for mental health care and treatment for substance abuse.

well as from enrollee premiums. Premiums and coinsurance provisions are to be scaled to family income and adjusted for family size. Prior to July 1, 1989, the plan must accept individuals with preexisting health conditions (that is, people that are uninsurable); after that date, the plan administrator may exclude new applicants that are uninsurable, based on the plan's cost experience for enrollees with preexisting health conditions.

In addition to authorizing a basic health care plan for its low-income uninsured population, Washington state also authorized a health care financing pool for its uninsurable population in April 1987. This plan is to be underwritten by commercial insurers doing business in the state; enrollee premiums are limited to 150 percent of the average small-group premium charged by the state's five largest commercial insurers. Net aggregate losses to the plan that may result from claims that exceed the premium limit are to be financed by the participating insurers. Washington is the fourteenth state to establish this type of health care financing pool for residents that are unable to qualify for individual insurance from a commercial carrier. However, allowable premiums for coverage in these plans—typically much more than the price of individual coverage—may discourage high levels of participation among the uninsurable population, many of whom may have low or moderate family income.

Expanding Employer Coverage

Employer-based strategies to expand health insurance coverage among the nonelderly population are, on their face, appealing to public policymakers. They represent public policy options that may involve little or no direct public expenditure, compared to the expenditures that might be associated with a service-providing public program. Furthermore, most uninsured people are workers or dependents of workers. In 1985, 81 percent of the uninsured were either workers or the nonworking spouses or children of workers. Public policymakers view employer plans, therefore, as an opportunity to bring most of the uninsured into an established system of private health insurance coverage.

However, the potential employer cost of expanding coverage to now-uninsured workers is considerable, both absolutely and relative to most uninsured workers' wages. One survey of employer health plans (Johnson & Higgins, 1987) indicates that employers' health benefit costs averaged $1,857 per employee in 1986. Extending benefits to uninsured workers at the average level of employer plan ben-

efits in 1986, therefore, might raise employers' aggregate plan costs by more than $26 billion.

Furthermore, most uninsured workers are in low-wage jobs. In 1985, 75 percent earned less than $10,000; more than one-third (35 percent) earned less than the federal minimum wage. The cost of health insurance for these workers, if paid by their employer, could represent a substantial increase in labor costs—potentially 15 to 20 percent or more for workers earning less than $10,000 a year.

A mandatory increase of this magnitude in real compensation could affect the availability and nature of low-wage jobs, employment among low-skilled workers, and product prices. (The potential labor market effects of an increase in minimum compensation are discussed in a later section, "Mandatory Minimum Compensation and Unemployment.") Thus, public policymakers that look to employer plans to expand health insurance coverage among workers and their dependents must also address competing objectives: full employment, economic growth, and competitiveness in world markets. However, the average cost of health insurance coverage, if paid by workers themselves, is likely to be prohibitive. That is, simple access to insurance coverage from an employer plan without an employer contribution is unlikely to produce a significant expansion in coverage.

Public policy toward employee benefits is generally formulated as either an incentive or a mandate. Since employer contributions to health insurance coverage are already tax-exempt both to the employer and the employee, remaining options for broadening tax incentives relate primarily to the individual income-tax deduction for insurance purchased by individuals and the deductibility of insurance purchased by self-employed workers.[3]

New regulation of employer plans related to tax qualification authorized by the Tax Reform Act of 1986 might achieve some expansion of the coverage provided by existing plans, if the act's nondiscrimination rules induce employers to extend coverage to more part-time workers. The act requires insured and self-insured employer plans to meet various nondiscrimination tests based on their employees that work more than 17.5 hours per week. However, if the result is reduced availability of part-time work and greater unemployment among part-time workers, no net change in the actual number of covered workers might occur.

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[3]Under current law, individuals may deduct expenditures for health insurance if they, together with other health-related expenses, exceed 7 percent of adjusted gross income. The 1986 Tax Reform Act allows qualified self-employed workers to deduct 25 percent of expenditures for health insurance adjusted gross income.

An alternative federal policy to expand employer-based health insurance might be to mandate coverage. For example, legislation introduced in the 100th Congress by senators Edward M. Kennedy (D-MA) and Lowell P. Weicker (R-CT), S. 1265, would require all employers to provide a health insurance benefit for workers employed 17.5 hours per week or more and for their dependents. The bill specifies minimum required benefits, but would allow employers to offer substitute plans that are at least "actuarially equivalent" (that is, the plan benefits net of employee-paid premiums, deductibles, and copayments are at least equal to those required in the bill).

Employers would be required to contribute at least 80 percent of the minimum-plan premium for individual and family coverage. For workers earning less than $4.19 per hour in 1988 (125 percent of the 1987 federal minimum wage), however, employers would be required to pay the full minimum-plan premium. In 1985, 8.3 million uninsured workers (50.4 percent of all uninsured workers) reported average annual earnings less than 125 percent of the federal minimum wage (EBRI, May 1987).[4]

Public policy to expand employer-based coverage could target various groups of uninsured workers and their families, specifically:

- dependents of any employee covered by an employer plan;
- all or some subset of employees only (for example, full-time employees); or
- qualified employees (again, for example, those working full time) and their dependents.

Each of these options would target different numbers of the uninsured. Assuming that there would be some level of employer contribution, each would imply different levels of employer cost.

Table IV.1 provides estimates of the maximum potential effectiveness of alternative public policies targeted to each of the above populations. The estimates assume that self-employed workers and their dependents do not gain coverage from any policy option; they do, however, include employees of self-employed workers as well as their

[4]The committee mark-up on the Kennedy-Weicker bill is likely to include a special provision for employers that have been in business for less than two years and have fewer than 10 employees. These employers would be permitted to offer a less comprehensive, catastrophic health insurance plan. As of this writing, the minimum coverage allowed for these plans has not been specified. Wage and salary workers in firms with fewer than 10 employees were an estimated 20 percent of all uninsured wage and salary workers in 1983.

dependents. (This assumption reflects the difficulty of developing effective public policy that would require self-employed workers with no employees to insure themselves for health care expenses.) Furthermore, the estimates assume that no changes in employment would occur as employer health coverage expands.

Qualified wage and salary employees are alternatively defined as: (1) all employees; (2) employees that work 18 hours or more per week (both the 1986 Tax Reform Act and the Kennedy-Weicker bill define qualified employees as those that work 17.5 hours or more per week); and (3) employees that work 35 hours or more per week (full-time workers). Changes in the work-hours rule used to define qualified employees produce differences in the target populations by redefining workers (as qualified employees only) and nonworkers (as nonqualified employees as well as nonworkers). Increasing the number of work hours that define a qualified employee: (1) decreases the count of workers; (2) potentially increases the count of workers' dependents, both adults and children; and (3) increases the count of nonworkers and their dependents.

If employer coverage had been extended to dependents of all covered wage and salary workers in 1985, the total number of uninsured people might have declined by nearly 9 percent; the number of uninsured children might have declined by more than 2 million. Differences in the work-hours definition of qualified employees would have produced little difference in the number of dependent adults or children in the target population.

Public policy aimed at providing coverage for all workers (with no provision for dependents) might achieve substantially larger increases in coverage by targeting a much larger group of the uninsured. The work-hours rule used to define qualified employees is critical to the number of workers that might be affected, however. If qualified employees were defined as full-time wage and salary workers (35 hours per week), nearly 28 percent of the total uninsured population in 1985 might have gained coverage. If qualified employees were defined as those that worked 18 hours or more per week, 37 percent of the uninsured in 1985 might have gained coverage.

Public policy aimed at providing coverage for both employees and their dependents obviously would target the largest population and largest proportion of the uninsured. The number of uninsured that might obtain coverage from public policy targeted to workers and their dependents relies critically on how qualified employees are defined. If qualified employees are defined as full-time workers (35 hours or more per week), public policy targeting wage and salary workers

TABLE IV.1

Reduction in the Uninsured Population through Expanded Employer Coverage Using Alternative Definitions of Qualified Employees, 1985

Employer-Related Policy Option/ Definition of Qualified Employees (hours worked per week)	Total Uninsured[a]	Populations Affected[b]				Net Uninsured
		Total	Wage & salary workers	Dependents of wage & salary workers		
				adults	children	
	millions					
Cover all dependents:						
more than 0 hours	34.8	3.0	0.4	0.3	2.3	31.7
18 hours or more	34.8	3.1	0.4	0.3	2.4	31.6
35 hours or more	34.8	3.0	0.3	0.4	2.3	31.7
Cover all employees:						
more than 0 hours	34.8	14.3	14.3	0.0	0.0	20.4
18 hours or more	34.8	13.0	13.0	0.0	0.0	21.8
35 hours or more	34.8	9.6	9.6	0.0	0.0	25.2
Cover all employees and dependents:						
more than 0 hours	34.8	24.4	14.3	1.5	8.5	10.4
18 hours or more	34.8	22.9	13.0	1.6	8.3	11.9
35 hours or more	34.8	18.6	9.6	1.7	7.4	16.1

			percent			
Cover all dependents:						
more than 0 hours	100.0%	8.7%	1.1%	0.9%	6.8%	91.3%
18 hours or more	100.0	9.0	1.0	1.0	7.0	91.0
35 hours or more	100.0	8.7	0.7	1.2	6.7	91.3
Cover all employees:						
more than 0 hours	100.0	41.3	41.3	0.0	0.0	58.7
18 hours or more	100.0	37.3	37.3	0.0	0.0	62.7
35 hours or more	100.0	27.6	27.6	0.0	0.0	72.4
Cover all employees and dependents:						
more than 0 hours	100.0	70.2	41.3	4.4	24.5	29.8
18 hours or more	100.0	65.9	37.3	4.5	24.0	34.1
35 hours or more	100.0	53.6	27.6	4.8	21.1	46.4

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.
Note: Detail may not add to totals because of rounding.

[a]Includes self-employed workers and nonworkers and their respective dependents.
[b]Estimates assume self-employed workers and their dependents are unaffected by coverage options; employees of the self-employed are included, however, as are those employees' dependents.

and their dependents might have achieved coverage for over one-half (54 percent) of the uninsured in 1985. If qualified employees were defined as those working at least 18 hours per week, two-thirds of the uninsured (66 percent) might have gained coverage.

The anticipated cost of health insurance to small employers may be the most significant obstacle to federally mandating health insurance coverage for workers. In 1983 (the most recent year for which data are available), two-thirds of uninsured workers were either self-employed or worked in firms with fewer than 25 employees. Unlike larger groups, small employers may be unable to obtain any discount on a community-rated health insurance plan to reflect their potentially more favorable claims experience, since their employee group is too small to be rated separately.

Public policy options for reducing the cost of health insurance to small employers include: (1) extending to insured employer plans the federal protection from state regulation and taxation that larger, self-insured plans enjoy; and (2) facilitating small-group insurance pools to gain the economies of scale associated with a larger group.

Most states regulate the benefits provided by insured employer plans under their authority to regulate and tax the business of insurance. The state-mandated benefits that establish threshold benefits for individual plans, therefore, also establish threshold benefits for insured employer plans. Typically, state mandates require: (1) that particular services or providers be covered by insured plans; and/or (2) that insured plans offer workers that separate from service continued coverage under the group plan or conversion coverage (that is, the option to convert coverage to a self-paid individual plan regardless of health status).[5]

Opponents of state-mandated benefits—including employers as well as organized labor—claim that they impose substantial benefits and administrative costs on their plans and/or that they interfere in benefit negotiations. Furthermore, they claim that some state-mandated benefits more apparently serve the interests of health service providers than the best interests of workers.

In fact, substantial cost may be associated with some state-mandated benefits. In Maryland, for example, state-mandated insurance benefits were estimated to raise the combined average cost of group and individual Blue Cross/Blue Shield coverage by more than 11

[5]The Consolidated Omnibus Budget Reconciliation Act requires employers with health insurance plans to allow employees, under most circumstances, to buy continued coverage from the group upon separation from service. State laws mandating continuation of coverage may or may not parallel COBRA's provisions.

percent in 1984; outpatient mental health benefits alone were estimated to raise total plan costs by more than 4 percent, and the cost of major medical coverage by more than 27 percent (Dyckman and Anderson, 1985). State taxes on insurance premiums can also raise small-plan costs by several percentage points.

These costs imposed on insured plans have encouraged many employers to self-insure their health benefits. Self-insured plans may avoid state-mandated benefits and taxation under the protection of the Employee Retirement Income Security Act, which exempts employee benefit plans from state regulation. In 1985, 42 percent of workers in establishments of approximately 250 workers or more that participated in an employer health plan had all or part of their benefit provided on a self-insured basis (EBRI, November 1986).

Congress may be reluctant to exempt insured plans from state regulation, however, for at least two reasons. First, lacking a better measure, the cost of state-mandated benefits is seen as an indicator of the value of these benefits to insured workers and individuals, even if relatively few plan participants account for most of the cost of these benefits. The perception that at least some people benefit from these statutes makes eliminating them politically difficult. Second, although a decision to override state-mandated benefits might be justified in terms of cost-effectiveness, information to support this argument is generally not available.

In fact, federal legislation preempting the states' authority to mandate specific benefits for insured employer plans has not been forthcoming. Although the Kennedy-Weicker bill would provide federal relief from state-mandated benefits, it does so in the context of a federally mandated minimum health insurance plan. The bill would preempt all state mandates that conflict with or add to the specified minimum package of employer-covered health care services.

Pooling small employer groups is commonly suggested as a way to reduce the per-employee cost of health insurance benefits for small-firm employees. The Kennedy-Weicker bill, for example, would establish six to eight regional pools, primarily for employers with fewer than 25 employees. Whether small-group pools can actually achieve significantly lower costs is uncertain, however. Since they would probably retain some important costs that are lower for single-employer groups of comparable size, they may be unable to achieve the relatively low average cost of a large employer group.

For example, average employee turnover in small firms is higher than in large firms, and the expected lifetime of the firm itself is shorter. Greater movement in and out of the plan increases admin-

istrative cost and potentially the difficulty of underwriting even a large group of small firms. Also, the administrative cost associated with billing and recordkeeping for a group of small employers might not be significantly less than for small employers individually.

Second, similarity among employees in a single large-employer group may make underwriting much easier than for participants in a group of many small employers with no particular similarity. Some researchers have suggested that multiemployer groups may be most feasible if they are industry-specific (Bovbjerg, 1986) and geographically compact, minimizing the difficulty of managing plan costs across areas with different medical practices and provider reimbursement systems.

The Kennedy-Weicker bill would attempt to reduce the cost of health insurance coverage for participants in regional small-group pools by: (1) limiting the ability of participating employers to move in and out of the pool; (2) establishing at least one managed-care insurance option available to participants in the pool, which would compete with other available insurance options; and (3) requiring periodic competition among insurers to provide coverage through the regional pool. The potential effectiveness of these provisions in reducing the cost of health insurance to small employers is unknown.

Because any inherent cost advantage of small-group pooling is unmeasured, the public policy discussion of small-employer pools has also pursued ways to explicitly reduce participant cost by defining a minimum package of benefits that would be less comprehensive—and therefore less costly—than conventional employer or individual plans.

Despite its potentially low cost, defining a minimum-benefits plan that would adequately serve now-uninsured workers and their families is difficult. Such a plan might provide, for example, catastrophic coverage with a high deductible and a high limit on out-of-pocket costs for covered services. However, the low family income of most uninsured workers suggests that the prospect of even nominal out-of-pocket expenditures for health care could seriously discourage them from seeking needed care. As a result, many argue that any acceptable plan should cover expenses for some specific services (prenatal and well-baby care, for example), with a low deductible reflecting the limited income of now-uninsured workers. The insertion of such provisions, however, establishes a significant threshold cost for the plan.[6]

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[6]The Kennedy-Weicker bill (S. 1265) and its companion bill in the House (H.R. 2508, introduced by Rep. Henry A. Waxman, D-CA) would require that employer plans

Despite these difficulties, public policy that would facilitate the pooling of small-employer groups may be more effective in expanding insurance coverage among workers and their families than forming an insurance pool from which individuals would buy coverage. Although much of the administrative cost associated with an insurance pool for individuals would also occur in a pool for small-employer groups, defining a low-cost insurance product that would be attractive to workers with an employer contribution might be easier, since workers might perceive their own costs of participating in the plan to be minimal. While such a product might not provide adequate financing for basic care, it might ensure access for episodes of high-cost care (for example, neonatal care) and reduce cost shifting from the uninsured population for catastrophic illnesses.

Nevertheless, even if a low-cost catastrophic plan for employer groups were available, employers might not choose to provide such coverage for workers, since doing so might invite pressure from workers to subsequently increase the generosity of the plan. Legislative proposals that would require employers to provide coverage, however defined, are a response to precisely this concern—that employers may decline to offer even low-cost catastrophic coverage if they are not confident of being able to eventually offer a more generous plan. However, employer opposition to federally mandated health insurance benefits could lead Congress to reconsider proposals to facilitate insurance pools for individuals rather than for employers.

Expanding Medicaid Eligibility

Medicaid is a state-based public insurance program for the poor in specific eligibility categories. Medicaid is intended to serve children, the disabled, and the elderly. Most nonelderly people that receive Medicaid coverage qualify through a federal or state income assistance program, usually Aid to Families with Dependent Children (AFDC) and, less commonly, Supplemental Security Income (SSI); these pro-

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cover a variety of specific benefits, including: inpatient and outpatient hospital care and physician services; diagnostic and screening tests; and prenatal and well-baby care. The bill explicitly does not require employers to provide coverage for either inpatient or outpatient mental health care, routine physical examinations and preventive care, or experimental services and procedures. By one estimate, the average cost of such a plan (including claims incurred and administrative expense) would be $1,186 in 1988: $642 for individual coverage and $1,631 for family coverage (Trapnell, 1987). Others have informally estimated the average cost to be higher (Wilensky, 1987).

grams automatically confer Medicaid eligibility. Like Medicaid, AFDC is a federal-state program, with levels of qualifying income determined by the states. In 1986, the average (and median) level of qualifying income for AFDC benefits was 48 percent of the federal poverty standard. In 1986, only 43 percent of the nonelderly poor qualified for Medicaid benefits (Chollet, 1987).

Options for expanding Medicaid eligibility among the poor and the near-poor populations might include:

- extending Medicaid coverage to all children under age 18 living in families with income below the federal poverty standard;
- extending Medicaid coverage to parents of dependent children in families with income below the federal poverty standard;
- extending Medicaid coverage to all adults in below-poverty families without dependent children, possibly on a buy-in basis; and
- allowing all persons within 200 percent of the federal poverty standard to buy Medicaid coverage.

In 1985, these populations—below-poverty children, adults in below-poverty families with children, below-poverty adults without children, and the nonpoor population with income less than 200 percent of poverty—were 62 percent of the nonelderly uninsured population.

Although federal law allows all states to extend Medicaid coverage to financially eligible children under age 18, about 20 states currently do so. The 1984 Deficit Reduction Act (DEFRA) requires all states to extend coverage to financially eligible children under age 5 by 1988. The first option listed above would extend coverage to children under 18 immediately and raise states' qualifying income levels to the federal poverty standard.

Current federal law requires states to provide Medicaid coverage to adults in families that qualify for AFDC benefits (typically single mothers) and to all financially eligible pregnant women. States may also extend Medicaid to parents in intact families that may not qualify for AFDC benefits, if they financially qualify and if the primary family worker (typically the father) is unemployed. In 1985, 25 percent of all Medicaid recipients (5.5 million people) were adults in families with dependent children and were covered under these current-law provisions. The second option listed above would make such coverage mandatory, requiring states to cover all parents in intact families if they financially qualify for benefits, thus including the working poor.

In addition, qualifying income would be raised to the federal poverty standard.

Current law does not enable people that do not categorically qualify for Medicaid benefits to buy coverage from state Medicaid programs. The possibility of accommodating a "buy-in" Medicaid population, however, is frequently mentioned as one option for insuring the poor that do not categorically qualify for Medicaid, as well as the near poor (potentially, people with income between 100 percent and 200 percent of the federal poverty standard).

A bill introduced by Sen. John H. Chafee (R-RI), S. 1139, pursues several of these Medicaid options. The Chafee bill would allow states to provide Medicaid coverage to all people with family income less than the federal poverty standard, discarding the concept of categorical eligibility. In addition, the Chafee bill would allow all people with income between 100 percent and 200 percent of the federal poverty standard to buy Medicaid coverage. The bill would set individual premiums for Medicaid coverage at Medicaid's average per-capita cost adjusted to exclude program costs for skilled and intermediate nursing care, and family premiums at 150 percent of adjusted average per-capita cost; the maximum premium payment for these families would be 3 percent of adjusted gross family income.

The Chafee bill would also allow people that are uninsurable or that have exhausted their private insurance benefits, as well as small employers (those with 25 or fewer employees), to buy Medicaid coverage. Again, premiums would be set 100 percent and 150 percent of Medicaid's total per-capita cost for individual and family coverage, respectively, excluding Medicaid's expenditures for skilled and intermediate nursing home care.

Table IV.2 provides estimates of the 1985 uninsured population that might have benefited if Medicaid eligibility were extended to the four groups identified above. Extending Medicaid coverage to all poor children would have covered an additional 4.3 million children, 38 percent of all uninsured children in 1985. Extending Medicaid coverage to adults in below-poverty families with dependent children would have increased coverage by 2.4 million people. If Medicaid had covered these two populations in 1985 (an additional beneficiary population of 6.7 million people), the total Medicaid population would have increased by approximately one-third over its actual 1985 level. Differences among states in the potential growth of their respective Medicaid populations might have been substantial, owing to demographic differences and to differences among states' levels of qualifying income relative to the federal poverty standard.

TABLE IV.2

Reduction of the Uninsured Population through Expanded Medicaid Coverage Under Alternative Medicaid Options, by Work Status of Potential Beneficiaries, 1985

Medicaid-Related Policy Option	Total	Full-Time Workers	Part-Time Workers and Nonworkers	
			Adults	Children[a]
		millions		
Total uninsured	34.8	11.5	12.0	11.3
Medicaid options:				
cover all children in poverty	4.3	[b]	[b]	4.3
cover adults in families with children in poverty	2.4	0.9	1.5	[b]
cover other adults in poverty	4.5	1.4	3.2	[b]
cover all people living in 100–200% of poverty	10.4	3.5	3.2	3.6
Total, all Medicaid options	21.6	5.8	7.9	7.9
Net uninsured	13.2	5.7	4.0	3.4
		percent within population group		
Total uninsured	100.0%	100.0%	100.0%	100.0%
Medicaid options:				
cover all children in poverty	12.3	[b]	[b]	38.0
cover adults in families with children in poverty	7.0	7.7	12.9	[b]

cover other adults in poverty	13.0	11.7	26.5	[b]
cover all people living in 100–200% of poverty	29.8	30.6	26.9	32.2
Total, all Medicaid options	62.2	50.1	66.3	70.2
Net uninsured	37.8	49.9	33.7	29.8
		percent of all uninsured		
Total uninsured	100.0%	33.1%	34.5%	32.4%
Medicaid options:				
cover all children in poverty	12.3	[b]	[b]	12.3
cover adults in families with children in poverty	7.0	2.6	4.4	[b]
cover other adults in poverty	13.0	3.9	9.1	[b]
cover all people living in 100–200% of poverty	29.8	10.1	9.3	10.4
Total, all Medicaid options	62.2	16.6	22.9	22.7
Net uninsured	37.8	16.5	11.6	9.7

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.
[a]Includes part-time workers and nonworkers under age 18.
[b]Unaffected by policy option.

The other categories of individuals that might be made Medicaid-eligible, at least on a buy-in basis—poor adults not living with children and the near-poor population—represent a larger percentage of the uninsured population and potentially a much greater expansion of the Medicaid program. These populations together totaled nearly 15 million people in 1985, or 42 percent of the uninsured. Including the near poor as well as the entire poor population without insurance coverage would have more than doubled the population participating in Medicaid in 1985.

In combination, these Medicaid options might have assisted 21.6 million uninsured in 1985—62 percent of the total uninsured population. About 37 percent of those newly covered by Medicaid would have been children; another 37 percent would have been adults that either did not work or worked less than full-time (called part-time workers and nonworker adults in table IV.2). About 26 percent would have been full-time workers—workers employed 35 hours or more per week.

The idea of allowing individuals to buy into Medicaid raises the question of affordability. In fact, the average cost of Medicaid coverage for this population might be comparable to the cost of comprehensive private insurance coverage. In fiscal year 1985, Medicaid spending for AFDC population (presumably the population most like the one that might buy into Medicaid) averaged $600 per beneficiary. For AFDC children, Medicaid spending averaged $453; for adults in families with dependent children, Medicaid spending averaged $860 (table IV.3). The potential Medicaid premium for a family of two adults and two children, therefore, might have totaled $2,626, or $219 per month.

For families with near-poverty income, this cost might be prohibitive. In 1985, poverty income for a family of four was $10,990; 150 percent of poverty income for a family of four was $16,485. A $2,626 annual Medicaid premium, therefore, would have totaled almost 16 percent of gross family income for people living at 150 percent of the federal poverty standard. For a two-adult family of four with income at 200 percent of the federal poverty standard ($21,980—potentially the highest income level that might qualify for a Medicaid buy-in), a $2,626 annual Medicaid premium would have totaled nearly 12 percent of gross family income. Historic Medicaid costs, moreover, reflect Medicaid reimbursements to providers that are substantially below charges. This level of discount might not be feasible in the long term if the Medicaid population—and providers' Medicaid caseloads—were expanded.

TABLE IV.3

Number of Medicaid Recipients and Expenditures by Basis of Eligibility, Fiscal Year 1985

Basis of Eligibility	Number of Recipients (thousands)	Percent of All Recipients	Total Expenditures (millions)	Percent of Total Expenditures	Average Expenditures per Recipient
All eligibility categories	21,808.3	100.0%	$37,507.6	100.0%	$1,720
age 65 or older	3,061.4	14.0	14,096.3	37.6	4,605
blind	80.3	0.4	249.4	0.7	3,106
permanently and totally disabled	2,936.4	13.5	13,202.8	35.2	4,496
dependent children under age 21	9,752.4	44.7	4,414.3	11.8	453
adults in families with dependent children	5,517.5	25.3	4,746.4	12.7	860
other SSI[a] recipients	1,213.7	5.6	798.4	2.1	658

Source: Unpublished data from U.S. Department of Health and Human Services, Health Care Financing Administration.
Note: Detail may not add to totals because of rounding. Also, eligibility figures may not add to totals because a recipient may be eligible under more than one category.
[a]Supplemental Security Income.

The potential cost of Medicaid buy-in relative to income suggests that the population to be served—poor and near-poor uninsured—would require a substantial subsidy to afford coverage. If Medicaid were to finance 70 percent of the premium for the above two-adult family of four, the family's net premium payment for coverage would equal $66 per month—approximately 5 percent of gross family income at 150 percent of poverty.

Combining Private and Public Strategies

The growing number of the uninsured and the cost associated with providing health insurance coverage for them suggests that Congress may consider combining private and public strategies to maximize coverage and distribute the cost burden as widely as possible. Table IV.4 presents the potential effectiveness of combining employer-related and Medicaid-related strategies, based on the 1985 uninsured population. For the purpose of estimating workers and dependents that would be affected by each of the employer-related options, qualified employees are defined as those that work 35 hours or more per week.

The tabulations presented in part A of table IV.4 assume that employers extended coverage to all dependents of currently covered wage and salary workers, providing new coverage to 3 million dependent adults and children in 1985. If employer coverage were primary to Medicaid (that is, people with employer coverage did not participate in Medicaid), sequentially expanding Medicaid to include all poor uninsured without access to an employer plan might have assisted an additional 10.9 million uninsured—raising Medicaid's 1985 beneficiary population by 50 percent. Including the near-poor population in Medicaid would have reduced total noncoverage by two-thirds. The net uninsured population—people that would not have been assisted either by the expansion of employer coverage to dependents or by any of the Medicaid-related options—would have exceeded 11 million people. These people would have been the 1985 uninsured population with family income at or above 200 percent of poverty. Of the newly insured, 13 percent would have obtained their coverage from employer plans.

Part B of table IV.4 assumes that employers extended coverage to all workers but extended no additional coverage to dependents beyond that already provided in 1985. This employer-related option would have provided new employer coverage to almost 10 million

TABLE IV.4

Potential New Coverage from Employer Plans and Medicaid: Alternative Employer and Medicaid Options by Work Status of Potential Beneficiaries, 1985

Employer/Medicaid Coverage Options	Total Uninsured/ Net Uninsured[a]	Newly Insured Population								Net Uninsured
		Wage & salary workers	Dependents of wage & salary workers		Self-employed workers & their dependents			Nonworkers & their dependents		
			adults	children	workers	adults	children	adults	children	
Part A:					millions					
Employer option:[b]										
cover dependents	34.8	0.3	0.4	2.3	0.0	0.0	0.0	0.0	0.0	31.7
Medicaid options:[c]										
cover children in poverty	31.7	0.0	0.0	1.7	0.0	0.0	0.2	0.0	2.0	27.7
cover poor adults with children	31.7	0.8	0.2	0.0	0.1	0.1	0.0	1.2	0.0	29.3
cover other poor adults	31.7	1.1	0.2	0.0	0.2	0.2	0.0	2.9	0.0	27.3
cover people 100–200% of poverty	31.7	3.0	0.5	1.9	0.5	0.3	0.3	2.3	0.6	22.4
Total, all options	31.7	4.9	0.9	3.6	0.8	0.5	0.5	6.4	2.7	11.5
					percent of all uninsured					
Employer option:[b]										
cover dependents	100.0%	0.7%	1.2%	6.7%	0.0%	0.0%	0.0%	0.0%	0.0%	91.3%
Medicaid options:[c]										
cover children in poverty	91.3	0.0	0.0	4.9	0.0	0.0	0.7	0.0	5.9	79.8
cover poor adults with children	91.3	2.2	0.7	0.0	0.3	0.3	0.0	3.5	0.0	84.3
cover other poor adults	91.3	3.2	0.5	0.0	0.5	0.4	0.0	8.2	0.0	78.4
cover people 100–200% of poverty	91.3	8.6	1.3	5.5	1.3	0.8	0.8	6.7	1.8	64.5
Total, all options	91.3	14.0	2.5	10.4	2.2	1.6	1.4	18.4	7.7	33.1

(continued next page)

TABLE IV.4 (continued)

Employer/Medicaid Coverage Options	Total Uninsured/ Net Uninsured[a]	Newly Insured Population								Net Uninsured
		Wage & salary workers	Dependents of wage & salary workers		Self-employed workers & their dependents			Nonworkers & their dependents		
			adults	children	workers	adults	children	adults	children	
Part B:					millions					
Employer option:[b]										
cover all employees	34.8	9.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	25.2
Medicaid options:[c]										
cover children in poverty	25.2	0.0	0.0	2.0	0.0	0.0	0.2	0.0	2.0	21.1
cover poor adults with children	25.2	0.0	0.3	0.0	0.1	0.1	0.0	1.2	0.0	23.7
cover other poor adults	25.2	0.0	0.2	0.0	0.2	0.2	0.0	2.9	0.0	22.1
cover people 100–200% of poverty	25.2	0.0	0.6	2.7	0.5	0.3	0.3	2.3	0.6	18.9
Total, all options	25.2	0.0	1.0	4.7	0.8	0.5	0.5	6.4	2.7	8.5
					percent of all uninsured					
Employer option:[b]										
cover all employees	100.0%	27.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	72.4%
Medicaid options:[c]										
cover children in poverty	72.4	0.0	0.0	5.7	0.0	0.0	0.7	0.0	5.9	60.8
cover poor adults with children	72.4	0.0	0.7	0.0	0.3	0.3	0.0	3.5	0.0	68.2
cover other poor adults	72.4	0.0	0.6	0.0	0.5	0.4	0.0	8.2	0.0	63.6
cover people 100–200% of poverty	72.4	0.0	1.7	7.9	1.3	0.8	0.8	6.7	1.8	54.2
Total, all options	72.4	0.0	3.0	13.6	2.2	1.6	1.4	18.4	7.7	24.5

Part C:

Employer option:[b]					millions					
cover all employees and dependents	34.8	9.6	1.7	7.4	0.0	0.0	0.0	0.0	0.0	16.1
Medicaid options:[c]										
cover children in poverty	16.1	0.0	0.0	0.0	0.0	0.0	0.2	0.0	2.0	14.1
cover poor adults with children	16.1	0.0	0.0	0.0	0.1	0.1	0.0	1.2	0.0	14.9
cover other poor adults	16.1	0.0	0.0	0.0	0.2	0.2	0.0	2.9	0.0	13.3
cover people 100–200% of poverty	16.1	0.0	0.0	0.0	0.5	0.3	0.3	2.3	0.6	13.2
Total, all options	16.1	0.0	0.0	0.0	0.8	0.5	0.5	6.4	2.7	5.3
Employer option:[b]					percent of all uninsured					
cover all employees and dependents	100.0%	27.6%	4.8%	21.1%	0.0%	0.0%	0.0%	0.0%	0.0%	46.4%
Medicaid options:[c]										
cover children in poverty	46.4	0.0	0.0	0.0	0.0	0.0	0.7	0.0	5.9	40.6
cover poor adults with children	46.4	0.0	0.0	0.0	0.3	0.3	0.0	3.5	0.0	43.0
cover other poor adults	46.4	0.0	0.0	0.0	0.5	0.4	0.0	8.2	0.0	38.2
cover people 100–200% of poverty	46.4	0.0	0.0	0.0	1.3	0.8	0.8	6.7	1.8	37.9
Total, all options	46.4	0.0	0.0	0.0	2.2	1.6	1.4	18.4	7.7	15.2

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.
[a]Includes the self-employed and their dependents.
[b]Employer options define qualified workers as working 35 hours or more per week and exclude the self-employed and their dependents; employees of the self-employed are included, however, as are those employees' dependents.
[c]Calculation of newly insured population under Medicaid assumes that employer coverage is primary.

workers. Sequentially expanding Medicaid coverage might have assisted an additional 17 million uninsured, leaving a net uninsured population of nearly 9 million people. In this case, 37 percent of the newly insured population would have obtained their coverage from employer plans.

Finally, part C of table IV.4 assumes that employers extended coverage both to workers and to their dependents—the largest population that might gain coverage from employer plans. In this case, employers would have provided new coverage to nearly 19 million workers and dependents in 1985. Sequentially expanding Medicaid coverage might have assisted an additional 11 million uninsured, leaving a net uninsured population of more than 5 million—15 percent of the uninsured population in 1985. Of the newly insured population, 63 percent would have obtained their coverage from employer plans.

Changing the definition of qualified employee to include employees that worked fewer than 35 hours per week raises the number of newly insured that might have received coverage from an employer plan and reduces the number of people that might have qualified for Medicaid (table IV.5) However, these tabulations do not reflect the population that might have lost employment because of the increased employer cost associated with providing health insurance benefits; at least some of these people might have become eligible for Medicaid.

Mandatory Minimum Compensation and Unemployment

In an effort to expand private-sector coverage, Congress is likely to seriously consider mandating that employers provide health insurance benefits to workers and/or their dependents. The implications of such a mandate for employment are an important consideration, since most workers without coverage earn low wages and may be particularly vulnerable to being laid off. Furthermore, uninsured workers are concentrated in relatively few industries: retail trade, services, and low-wage manufacturing. Employment gains in these industries have been strong since the 1981–1982 recession.

The relationship between compensation and employment is a complicated one. The simplest economic models of wages and employment suggest that increases in mandatory compensation over the level of compensation determined by the market (for example, a higher minimum wage or the imposition of a mandatory benefit) will reduce

employment in jobs subject to that change. However, little or no change in employment might occur if employers are able to: (1) make workers more productive; (2) raise product prices; or (3) reduce other types of compensation, such as wages or other benefits. Because a mandatory increase in compensation can produce a variety of market changes, its effect on unemployment is largely an empirical question.[7]

Most studies of the effects of mandatory compensation have focused on the impact of raising the federal minimum wage. In particular, the effect of minimum-wage increases on employment among teen-agers has been extensively researched, since teen-agers tend to work in lower-wage jobs that may be most affected by legislation mandating minimum compensation. Among teen-agers, a 10 percent increase in the minimum wage reduces employment by 1 to 3 percent; a consensus of research also indicates that unemployment among teen-agers in response to a higher minimum wage is reduced because some of them stop looking for jobs. The unemployment effect might be greater among adults with similar wages but a stronger attachment to the labor force.

Workers in retail trade, services, and low-wage manufacturing may be particularly vulnerable to reduced employment because of mandatory health insurance coverage. In 1985, 24 percent of all uninsured workers were employed in retail trade; another 39 percent were employed in services or manufacturing. While there is no consensus on the size of the effect, most studies indicate that the imposition of the minimum wage reduced employment in these industries.[8]

Imposing a mandatory minimum health insurance benefit is presumably equivalent to raising the minimum wage in its effect on employment in low-wage jobs. Employment among workers earning more than the minimum wage may also be reduced by mandated minimum health insurance coverage, although employment among these workers may be less vulnerable than employment among minimum-wage workers.

Based on research findings for teen-agers (where a 10 percent increase in the minimum wage reduced employment by from 1 to 3

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[7]Empirical estimates of unemployment resulting from a higher minimum wage are complicated by the movement of workers in and out of the labor force. For example, long-term unemployed workers that stop looking for jobs (called "discouraged workers") are not counted in unemployment statistics, but new entrants attracted by higher wages but unsuccessful in finding employment are counted. Because unemployment is a relatively complex concept, most empirical studies measure the impact of the minimum wage on employment levels rather than on unemployment.

[8]For a comprehensive review of this literature, see Brown et al., 1982.

TABLE IV.5

Potential New Coverage from Employer Plans and Medicaid: Alternative Definitions of Workers, and Alternative Employer and Medicaid Options, 1985

Employer Coverage Options: Worker Hours per Week	Total Newly Insured	Employer Coverage	Medicaid Policy Options[a]				
			Total	Cover children in poverty	Cover poor adults with children	Cover other poor adults	Cover people at 100–199% of poverty
			millions				
Cover dependents:							
more than 0 hours	23.2	3.0	20.2	3.9	2.4	4.5	9.3
18 hours or more	23.3	3.1	20.1	3.9	2.4	4.5	9.3
35 hours or more	23.3	3.0	20.2	4.0	2.4	4.5	9.3
Cover all employees:							
more than 0 hours	28.2	14.3	13.8	4.2	1.2	2.4	6.0
18 hours or more	27.6	13.0	14.6	4.2	1.3	2.7	6.4
35 hours or more	26.2	9.6	16.6	4.3	1.7	3.4	7.3
Cover all employees and dependents:							
more than 0 hours	31.3	24.4	6.9	1.4	0.9	2.2	2.4
18 hours or more	30.8	22.9	7.9	1.6	1.0	2.5	2.8
35 hours or more	29.5	18.6	10.9	2.3	1.4	3.2	4.0

		percent of newly insured					
Cover dependents:							
more than 0 hours	100.0%	13.1%	86.9%	16.7%	10.4%	19.6%	40.2%
18 hours or more	100.0	13.5	86.5	16.8	10.4	19.4	40.0
35 hours or more	100.0	13.0	87.0	17.2	10.4	19.2	40.1
Cover all employees:							
more than 0 hours	100.0	50.9	49.1	14.9	4.3	8.5	21.3
18 hour or more	100.0	47.0	53.0	15.3	4.8	9.7	23.1
35 hours or more	100.0	36.6	63.4	16.3	6.4	12.9	27.9
Cover all employees and dependents:							
more than 0 hours	100.0	77.9	22.1	4.5	3.0	6.9	7.7
18 hours or more	100.0	74.4	25.6	5.2	3.4	8.0	9.1
35 hours or more	100.0	63.2	36.8	7.7	4.8	10.9	13.4

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.
Note: Detail may not add to totals because of rounding.
[a]Calculation of newly insured population under Medicaid assumes that employer coverage is primary.

percent), a 20 percent effective increase in minimum compensation due to mandatory health insurance coverage might reduce employment among workers at or near the minimum wage by 2 to 6 percent. This impact might be reduced by scaling back the level and scope of coverage required as a minimum health insurance benefit, minimizing plan cost. Nevertheless, this is probably a conservative estimate of the employment losses likely to result from mandating health insurance as an employee benefit.

Conclusion

The growing number of nonelderly people without health insurance coverage has become an important public policy issue. Impaired access to health care among this population and the problem of financing health care for which uninsured people cannot pay are increasingly drawing the attention of state legislators and the Congress. Legislation introduced in the 100th Congress would address the issue of noncoverage by expanding coverage through existing sources—employer plans and Medicaid.

Most private health insurance is provided through employer plans. Extending employer coverage to workers and their dependents not now covered by an employer plan could greatly reduce the number of people without health insurance coverage. If employers had provided coverage to all employees that worked 18 hours or more per week in 1985, 66 percent of the uninsured population might have gained coverage.

The cost of providing coverage for now-uninsured workers and their dependents, however, is significant—both absolutely and relative to their wage income. The estimated average cost of the mandatory insurance plan proposed by Senators Kennedy and Weicker (S. 1265) is nearly $1,200 per year. Even this cost is achieved by allowing employer plans to exclude coverage for some potentially costly services (mental health care, routine physical examinations, and other preventive care), and by preempting benefits that are now mandated by most states. Nevertheless, this benefit would represent at least a 12 percent increase in compensation for most workers that are now uninsured. Although devising a less-expensive minimum health insurance plan may be politically difficult, the public policy discussion of mandatory employer health benefits may focus on this task.

Despite the important gains in insurance coverage among workers and their families that might be made from an expansion of employer

coverage, employer plans cannot provide coverage for all of the nonelderly population that is now uninsured. An important minority of the uninsured live in families of part-time workers and nonworkers, who would not have access to an employer plan under most proposals to expand employer coverage. Whereas two-thirds of the uninsured nonelderly population might have gained coverage from an employer plan in 1985 if all workers employed 18 hours or more, and their dependents, had been covered by an employer plan, one-third of the uninsured population still would have been uninsured.

Furthermore, the lower average incomes of these uninsured families suggest that their health care needs may be greater, on average, than those of worker families that might have gained access to an employer plan; research has repeatedly found a correlation between poor health and low income. Providing health insurance coverage to these people—families of low-income, part-time workers and nonworkers—is a critical part of resolving the access and financing problems of the uninsured.

Proposals to expand Medicaid coverage, including authorizing some people to buy Medicaid coverage, address this population. S. 1139, introduced by Sen. Chafee, would discard the idea of categorical eligibility for Medicaid, allowing states to cover all residents with family income below the federal poverty standard. In addition, people with family income between 100 percent and 200 percent of the federal poverty standard and people that are uninsurable or have exhausted their health insurance benefits would be authorized to buy Medicaid coverage, as would small employer groups. Had Medicaid been provided to the entire uninsured population with family income less than 200 percent of poverty in 1985, 62 percent of the uninsured would have gained coverage.

This discussion has presented estimates of coverage that might have been gained from employer plans and Medicaid under various public policy options. The estimates are generous in that they assume expansions of employer coverage (either by incentive or mandate) do not reduce employment among low-wage workers, and that everyone who has the option to buy coverage (in particular, from Medicaid) does so. Whether these assumptions are realistic depends on how the debate over expanding health insurance coverage answers critical questions related to cost: (1) how employer coverage can be made sufficiently low-cost to minimize job dislocation among now-uninsured workers; and (2) how federal and state governments might finance an expansion of Medicaid coverage among the poor and near-poor populations.

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V. Should All Employers Be Required by Law to Provide Basic Health Insurance Coverage for their Employees and Dependents?*

PAPER BY UWE E. REINHARDT

The Number of Uninsured Americans

It is beyond dispute that a large number of American families currently lack adequate health insurance coverage. Precisely what is "adequate" in this context remains, of course, a highly subjective matter. One suspects that measurements of the phenomenon tend to be strongly colored by the analyst's own ideological predilections.

In principle beyond dispute ought to be the notion that the complete absence of health insurance coverage is *ipso facto* inadequate coverage, although even here it can be argued that at least some families now completely uninsured might simply have preferred to self-insure. Leaving aside that fine point, however, it can be asked: how many Americans are currently "inadequately" insured in the sense that they have no health insurance coverage at all?

Surprisingly—or perhaps not[1]—the answers to that question range over a large number as well. In their paper "The Employed Uninsured and the Role of Public Policy," Monheit et at. suggest that there were about 17.2 million uninsured Americans in 1977 and about 16.9 million in 1980 (Monheit, Hagan, Berk and Farley, 1985). These authors base their estimate on two large nationwide surveys on medical expenditures by American households.

In announcing in 1986 its "Health Care for the Uninsured Program," on the other hand, the Robert Wood Johnson Foundation suggests that "between 1979 and 1984, the number of people without health insurance in the United States increased by 22.3 percent—from 28.7 million to 35.1 million Americans." This estimate appears

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[1]After all, among social scientists perceived, "objective" truth tends to be colored by the beholder's ideological predilections.

to be based on data from the U.S. Bureau of the Census *1984 Current Population Survey*.

Whichever estimate one believes, however, it is clear that the absolute number of uninsured Americans is large. It can also be asserted that no other industrialized nation in the world now has an equally high proportion of persons without basic health insurance coverage. Finally, one would suppose that lack of insurance coverage must on occasion—perhaps on many occasions—visit both fiscal and physical hardship on uninsured, poor families whose members fall ill.

Precisely how many families and individuals are so afflicted in a given year is, once again, a question with many answers. Remarkably, the question is not subject to sustained, careful research. In a survey conducted in 1982, the Robert Wood Johnson Foundation found that roughly one million Americans were denied needed care in that year for want of ability to pay for that care. As a proportion of the entire U.S. population, this number is small. As a proportion of poor Americans, it is much larger. As a proportion of poor Americans who were seriously sick in that year the number is larger still.

Individuals who conduct health-services research or who fashion the nation's health policy usually rank in the top 10 percent of the nation's income distribution. For such individuals, it may be instructive to ponder occasionally the anecdotes on denied care published with distressing regularity in the nation's major newspapers. For example, in an article entitled "Hospitals in Cost Squeeze 'Dump' More Patients Who Can't Pay Bills" the *Wall Street Journal*—a daily given more to Yankee jingoism than to Yankee bashing—reported *inter alia*:

> A 32-year old accident victim lies unconscious in a Florida hospital that has no neurosurgeon available. But two larger hospitals with neurosurgeons refuse to accept him upon learning there is no guarantee his bill will be paid.
>
> A pediatrician in a Rock Hill, South Carolina hospital wants to transfer a comatose three-year old girl to a better-equipped urban medical center. But her family has no health insurance, and two nearby hospitals refuse to take her. A hospital 100 miles away finally accepts her.

Similar stories have been reported from other parts of the country. The point of citing the preceding two here is merely to add some coloring to the statistical abstractions within which policy analysts and policy makers ply their trade. It is left as an exercise for the reader to close his or her eyes and to imagine that the 32-year old

was one's brother or husband, and the little girl one's child. Contemplated in this fashion, the denial of health care to some one million Americans evokes a different imagery than "a mere 0.4167 percent of the United States population." The coloring is further enhanced if it be recalled, as it should be, that ours is a nation constantly lamenting its *surplus* of doctors and hospital beds!

It may be added parenthetically that vignettes of this sort are simply inconceivable in neighboring Canada or, say, in France, Germany, or Sweden. Indeed, this author would be hard put to think of any developed country on the globe in which a comatose three-year old would be denied available resources simply because she is poor. Obviously, most other nations march to a different moral drummer—or at least, a different political drummer—than we seem to do.

Health Insurance and Employment Status

All estimates of uninsured Americans indicate that low-income households are more likely to lack insurance coverage than middle- or high-income households.

This phenomenon may be thought to reflect largely the fact that, in the United States (and only in the United States), employees who lose their job thereby tend to lose also their insurance and their family's coverage. Remarkably, however, the majority of the uninsured belong to households with *employed* members. Monheit et al. estimate, for example, that about 55 percent of the uninsured are employed part or all of the time. A similar estimate is suggested by the Robert Wood Johnson Foundation.

It might seem, then, that a good part of the problem could be eliminated simply by mandating all American employers to provide all of their employees (and the latters' dependents) with basic, adequate health insurance coverage. That approach seems particularly inviting, because there is already a tradition in this country to provide health insurance through employer-financed group insurance. It may appear, then, that mandating employer-paid coverage is merely a marginal extension of an already widespread practice in this country. Before jumping to that conclusion, however, it behooves the analyst and the policymaker to inquire why some firms offer their employees health insurance coverage—hitherto on a strictly voluntary basis—while others do not, and what additional regulations might be required to implement mandatory employer-paid health insurance nationwide.

Fringe benefits form part of what accountants call payroll expense and economists think of as total employee compensation. Standard economic theory, and common sense, suggest that in the determination of employee-compensation, fringe benefits function as a substitute for cash payments to employees. Under current tax laws, cash income is subject to normal income-taxation while most fringe benefits—certainly employer-provided health insurance—are not taxable income at all. Consequently, many employers and employees find it expedient to structure large parts of employee compensation in the form of tax-exempt fringe benefits.

The provision of employer-provided health insurance, however, entails non-trivial administrative overhead, that is, costs that do not vary proportionately with the number of employees. Both employers and the insurance industry experience such fixed costs. From the perspective of the insurance industry, the marketing of group-insurance to small firms has therefore always been uneconomic unless premiums were high enough to cover these fixed costs, including the difficulty of collecting premiums from small enterprises during periods of economic adversity. Such premiums, however, would be an extraordinary burden to small business firms that would be saddled, in addition, with their own relatively high fixed cost of administering a health-insurance package for full- and part-time workers whose turnover is frequently rather high.

These circumstances may explain why many American employers—particularly small business firms—have so far chosen not to offer their employees basic health insurance coverage, in spite of the obvious tax advantages of doing so.

If employer-paid health insurance were mandated by law, the first question to arise would touch on the proper pricing of the mandated transaction. Should a group policy sold to a firm be experience rated over that firm, or over a larger aggregate? If the former, how would one prevent discrimination on the part of employers who see in heads of large households a fiscal threat, or who might seek to prejudge who among the firm's employees would be likely to contract an expensive illness—e.g., AIDS. If the price of the policy is to be based on a larger aggregate—e.g., on community rating—what regulatory mechanism would have to be developed to preclude risk skimming on the part of insurers?

There is the added question about the extent to which an employer will be held responsible for health insurance coverage after the termination of an employment contract. If any attempt were made to mandate coverage beyond periods of employment, then the law would

have helped to convert an erstwhile variable cost (payroll expense) into a quasi fixed cost, thus raising the firm's so-called "operating leverage," also known as its "business risk."

Finally, questions arise over part-time employees and, particularly, over employees paid the minimum wage. For employees paid above the minimum wage, a firm can, in principle, shift part or all of the cost of insurance backwards by paying commensurately lower cash wages. Firms effectively subject to minimum wage constraints, on the other hand, could presumably not shift insurance premiums backward. They would either have to absorb them or shift them forward in the form of higher prices, were that possible in the first place.

In short, mandated employer-paid health insurance would in effect constitute a tax with highly unpredictable and probably highly undesirable incidence. That the fiscal flows triggered by the mandate would not flow directly through public budgets does not detract from the measure's status of a *bona fide* tax. After all, when the government orders Jones to purchase something for Smith, a tax has been effectively imposed upon Jones whether or not that payment is routed through the government's budget.

Mandated employer-paid health insurance is a tax that would constitute an undue burden particularly on small and medium-sized businesses and, within that class, on small entrepreneurial firms which have always been the main source of new jobs in this country and which tend to face enormous financial risks even in the absence of the proposed new burden. *Indeed, one need not be a hysterical mouthpiece for American business to label mandated employer-paid health insurance as a tax on employment and entrepreneurship.*

Role of the Public Sector

It is a much-mouthed maxim in American political discourse that every American in need of medical care should have access to it regardless of ability to pay. Just what constitutes "need" in this context, however, is usually left unsaid. It is an issue that has never been openly discussed in our debate on health policy, an omission that has led to much confusion in the nation's health policy.

Some politicians reserve the term "need" only to life-threatening situations and therefore would guarantee access only to *life-saving* medical interventions. Other politicians would be more generous and include in "needed medical care" also interventions that are not life-saving, but merely reduce or eliminate acute pain. Still others would include in "needed care" interventions that merely reduce acute anx-

iety over health status. Finally, at the extreme, some politicians would even include *preventive services* administered to potentially healthy persons—for example, glaucoma tests to prevent blindness, mammographies to detect breast cancer, or Pap-smears to detect cancer of the cervix.

Suppose one settled on a particular definition of "need," and suppose further that the much-mouthed maxim mentioned above had wide support at the grassroots and were truly believed by the politicians who recite it. Then what policy measures might flow from it?

Clearly, one further issue must be settled before concrete policy proposals could be fashioned from the maxim. That issue centers on the following question:

> What level of government is responsible for guaranteeing access to whatever health services the political process has defined as "needed care"?

The question may be rephrased more pointedly thus:

> Should a resident of, say, New Jersey be at all concerned over what is and what is not being done for the health of an *American* infant in, say, Texas (and vice versa)?

Obviously a New Jerseyan would very much care what is done for the health of an *American* child from Texas if that child were some hijacker's captive on a tarmac somewhere in, say, the Mideast. Experience has taught that one need not question our sense of nationhood in such instances. The question, however, is whether that New Jerseyan should also care about the *American* infant's health if that infant is merely a hostage to poverty, illness, and possibly parental ignorance *in Texas* (and vice versa). Remarkably, this nation has never been able to reach a consensus on this question, a problem that sets us very much apart from other countries that consider themselves "nations."

A National Health Program for the Uninsured

Suppose that, after some debate, it were decided that, yes, a New Jerseyan should care about the health status of an *American* infant in Texas (and vice versa), and likewise for an *American* adult. It would then follow that any program to implement this noble sentiment would have to be a federal one. To say that it should be a state and local matter would be tantamount to saying that it is *not* a New Jerseyan's business to worry about what Texans do or do not do for

fellow *Americans* in Texas (and vice versa), that our concept of nationhood is good enough to legitimize the burning of firecrackers on July 4, but not strong enough to make "Americans" in one state effectively care about the aches and pains of "Americans" in another.

Chart V.1 indicates (a) that the United States tax burden as a percentage of Gross Domestic Product (GDP) is low by international standards and (b) that this burden did not grow very much at all during the period 1970–82, contrary to public belief. The complete table (V.1) follows.

If Americans decided, in the end, to practice nationhood in matters of health care, and if a consensus could be reached on what constitutes "need" in health care—only life-saving interventions, or life-saving *and* pain-reducing interventions, and so on—than a sensible *national* health policy might work as follows:

1. As a matter of principle, every American resident is *ipso facto* covered by a federal health insurance program that pays for a defined set of "needed" health services.

2. Although the insurance program is a federal one, it could be administered by the states (as is the case in Canada and West Germany). Individual states could enhance the benefit package at their own cost.

3. No health care provider in the United States would ever be asked to render "needed" health services to patients without some reasonable compensation for that service. This compensation should be negotiated *ex ante*. It need not be equal to the compensation *desired* by providers, but should be high enough that no provider would ever lose income by serving patients. Although the underlying fee schedule would be a national one (as is now foreseen for the Medicare program, and as is the case in many other nations), there could be some adjustments for interregional cost variations.

4. This national health program would be financed on the basis of ability to pay. One approach might be to include in Internal Revenue Service Form 1040 a line labelled "Health Insurance Tax." The taxpayer would enter in that line, say, 11 percent of his or her Adjusted Gross Income unless (s)he clipped to the 1040 evidence of a private health insurance policy whose benefits are at least as extensive as those under the national policy. If the taxpayer had a qualifying private policy, (s)he would enter only X percent of Adjusted Gross Income in the health-insurance line, where X would be large enough to make the federal health insurance program break even.

Clearly this is a *national* health insurance program whose financing is based largely on the principle of *ability to pay* and not on *actuarial principles*. (A moment's thought makes it clear that anyone yearning for "actuarially fair" health insurance premiums is really signalling

TABLE V.1

Tax Revenues in Relation to Gross Domestic Product in Selected Countries[a] Selected Years 1960–1982[b]

Country	Taxes as a Percent of Gross Domestic Products										Per Capita Taxes 1982[c]
	1960	1970	1975	1976	1977	1978	1979	1980	1981	1982	
Australia	23.5	25.32	29.02	29.56	29.58	28.40	29.26	30.30	31.06	30.97	$3,392
Austria	30.5	35.72	38.69	38.56	39.19	41.53	41.22	41.33	42.57	41.08	3,629
Belgium	26.5	35.75	41.82	42.36	43.93	45.11	45.63	44.72	45.20	46.65	3,990
Canada	24.2	32.00	32.93	32.51	31.80	31.49	31.42	32.71	34.67	34.85	4,304
Denmark	25.4	40.38	41.35	41.55	41.89	43.42	44.49	45.48	45.03	43.97	4,244
Finland	27.7	32.24	36.21	39.97	39.50	36.43	34.97	35.27	36.84	36.60	3,728
France	n.a.	35.58	37.44	39.36	39.42	39.50	41.13	42.54	42.71	43.72	4,379
Germany	31.3	32.93	35.96	34.37	38.02	37.74	37.49	37.77	37.38	37.27	3,985
Greece	n.a.	24.30	24.64	27.27	27.59	27.93	27.74	28.64	29.22	31.92	1,250
Ireland	22.0	31.21	32.08	35.51	34.51	33.18	33.03	35.94	37.83	39.57	2,003
Italy	34.0	27.91	28.98	30.27	30.89	31.26	30.49	33.21	37.75	38.27	2,447
Japan	18.2	19.72	21.01	21.90	22.47	24.24	24.81	25.91	26.76	27.21	2,465
Luxembourg	n.a.	30.25	38.50	38.30	41.34	42.54	39.51	40.37	39.68	37.69	4,378
Netherlands	30.1	37.93	43.55	43.20	43.97	44.58	44.96	45.74	45.04	45.47	4,372
New Zealand	27.3	26.88	29.57	29.45	32.26	30.84	30.71	31.03	32.31	33.63	2,557
Norway	31.2	39.19	44.82	46.16	47.20	46.53	45.68	47.05	48.63	47.77	6,530
Portugal	16.3	23.12	24.79	26.91	27.39	26.45	26.10	29.27	31.51	30.82	721
Spain	n.a.	17.22	19.60	19.61	21.54	22.88	23.44	24.11	25.01	25.33	1,210
Sweden	27.2	40.23	43.88	48.19	50.46	50.87	49.54	49.36	51.21	50.26	5,984
Switzerland	21.3	23.81	29.61	31.30	31.63	31.58	31.08	30.78	30.56	30.93	4,618
Turkey	n.a.	17.66	20.73	21.06	21.65	21.26	20.80	19.00	20.43	20.11	228
United Kingdom	28.5	37.30	35.74	35.30	35.04	33.48	33.27	35.95	37.08	39.60	3,375
United States	26.6	29.79	29.63	28.92	30.05	29.93	29.91	30.35	30.77	30.46	3,978

Source: Organization for Economic Cooperation and Development.

[a]Tax revenues collected by all levels of government, recorded on a cash basis.

[b]Primarily calendar years; however, data from some countries recorded on a fiscal year basis.

[c]In U.S. dollars.

a preference not to pay for someone else through his or her contribution to the financing of health care.) The program would be based on the assumption that the United States is not just a place where sundry people live but, indeed, a *bona fide nation*, and one that takes pride in professing allegiance to the Judeo-Christian ethic.

Such a program would mimic only partially the national health insurance programs of other nations, which typically cover over 90 percent of these countries' population. The program proposed here could be calibrated to cover only a much smaller proportion of the U.S. population, leaving the bulk to be covered by private insurance. Would such a program add to the deficit? Not if the taxpayers' health insurance contribution were set so as to make the program break even. Would the program increase government spending? It most assuredly would, perhaps by as much as $50 billion. Could the already "overtaxed" United States population absorb such a blow? Most assuredly it could for, if truth ever were to be told, this nation is *undertaxed* by any standard one might use.

It is, indeed, a popular theme in this nation's contemporary political debate that Americans are sorely overtaxed. On closer examination, however, it is obvious that politicians espousing that theme either are woefully ignorant of basic facts or knowingly engage in a deceptive exploitation of ignorance among the electorate.

Chart V.1 presents part of the data one should consider before judging the United States overtaxed. The diagram shows that, in comparison with other nations in the industrialized world, the United States channels a relatively small proportion of its gross domestic product (GDP) through the public sector. Most other nations appear to have discovered that the conduct of a highly industrialized nation in a civilized manner requires a larger proportion of social overhead than the United States appears willing to commit.[2] Among the advanced economies included in the Organization of Economic Development (OECD), government revenues represented a smaller proportion of 1982 GDP only in Japan (27.21 percent). That nation, however, is rather unique in its homogeneity and reliance on an extended family for the delivery of social services. The price of that reliance, of course, is a considerable suppression of womens' rights.

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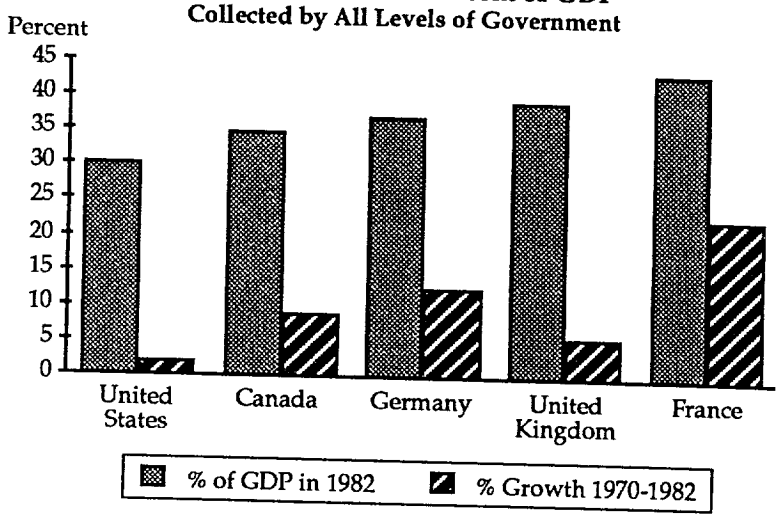
[2]A nation's gross domestic product includes the output of all goods and services produced by capital and labor within that nation's borders. It differs from gross national product in that the latter also includes income from resources owned by the nation but located outside its borders. Most international comparisons are based on gross domestic product.

CHART V.1
Tax Revenues as a Percent of GDP
Collected by All Levels of Government



Source: Tax Foundation, Inc., *Facts and Figures on Government Finance*, 23rd edition, 1986, p. a36.

But even Americans have, in recent years, signalled unmistakably that they wish a larger government sector than is represented by the proportion of *government revenues in GDP*, and this is the second bit of data one should consider in this context. The signal in question is our large government deficit. If one lists all of the items the American people apparently wish to see delivered by the government, that total comes to about 35 percent of GDP. The president's own laundry list (as expressed by the *expenditures* he has proposed in his annual budgets) comes to about this total. It follows that, even by this nation's own standards, Americans are now sorely *undertaxed*. Sooner or later this nation will become sufficiently mature to acknowledge this fact through explicit political action: the raising of taxes sufficiently high to cover the desired public laundry list.

In short, then, the populist theme that government expenditures in this country simply cannot be raised any further rests on such patently brittle grounds that, before too long, it can no longer serve as an effective constraint on social policies designed to preserve this nation's membership in the club of civilized nations. (One must surely wonder whether a nation that would deny a comatose three-year old

girl available health care just because she is poor is still *in* the club of civilized nations.) When that day comes, perhaps as early as the 1990s, the time will be ripe for a program such as that described above.

When that day comes it may also be propitious to reexamine the desirability of excluding fringe benefits from taxable income. Abolition of that tax preference, which benefits high-income persons much more than low-income persons, might yield an additional $20 to $30 billion in additional tax revenues that could be diverted to finance health care strictly for low-income households.

One can understand why the nation's insurance industry and its higher-income groups like this feature. To the insurance industry, this tax-preference simply means a subsidization of its products. Of course that industry must like such a subsidy. To high-income groups, the tax-preference represents a way to procure health insurance at half-price. Of course they will like it as well. Why union leaders like it is more difficult to explain, because for low-income employees the tax-preference represents a far less lucrative tax shelter than it does for, say, a corporation's executives who are in a much higher tax bracket.

In what way does a national health program of this sort differ from mandated employer-paid health insurance? Not in its being "national" for, presumably, the proposal under consideration would entail federal legislation as well. That proposal had best be called a "national health-care tax on entrepreneurship." The national health program described above would differ from the "national health care tax on entrepreneurship" in two major respects.

First, it would embrace *all* Americans, and not only employed Americans, thus eliminating from the national landscape the rather disgraceful feature that an unemployed person, already down on his or her luck in other ways, also is burdened with the anxiety of uncertain availability of health care.

Second, its financing would rest on the principal of ability to pay. It would be financed by a tax on *individual incomes* rather than by a tax on employment. With few exceptions, all taxes entail side effects that detract from economic efficiency. The argument here is that a tax on individual incomes is less distortive than a tax on employment.

Conclusion

In the preceding section it was explicitly assumed that the American people truly wish to be their poor and sick brethren's and sisters'

keepers. The stresses now developing at the nether fringe of our health care system raise the question whether such an assumption is realistic. What if deep down the American people were actually as mean-spirited as seems suggested by the current practice of denying sick people resources of which the nation has too many?

Should the political process then not respect these sentiments at the grassroots? After all, we are a democracy and as such should respect the popular will.

An argument of this sort has a certain charm, but it abstracts inappropriately from the wider context of U.S. policy. Clearly it seems counterproductive to expend enormous resources on efforts to sell our economic and political order to the rest of the world all the while supplying Soviet propagandists with homegrown newspaper articles that chronicle the agonies of our economic order. Soviet propagandists merely need to photocopy such newspaper items into their tracts against our nation. That possibility should give even a misanthrope second thoughts.

If the American people really were unwilling to be their sick and poor brethren's and sisters' keepers, and if the nations' political leaders were otherwise inclined (if only for purposes of foreign policy), a case could be made for tricking the plebs into being kind through taxes the plebs would not recognize as such. This author sees current attempts to implement such hidden taxes as implicitly based on just this premise.

What are these hidden taxes? In the past decade, they were known as "cost shifting." That practice involved charging the cost of indigent care to paying patients—either the patients themselves or third parties paying on their behalf. It was the mechanism by which this nation was kept in the club of civilized nations during the 1970s. The introduction of "prudent purchasing" in price-competitive markets naturally squeezes such hidden cross subsidies out of the system like water out of a sponge. This form of hidden taxation, then, has had its day.

Unwilling to confront the electorate directly with hard questions on social ethics and with requests for added taxes, the nation's politicians have now discovered other forms of hidden taxes. Such taxes include statewide revenue pools to which each health care provider is obligated, by law, to make specified contributions. They may involve mandatory surcharges on private health insurance premiums, or still other coerced transfers of this sort. Finally, a veritable *pièce de resistance* in this menu of hidden taxes is, of course, mandated employer-paid health insurance.

Collectively, we may refer to all of these forms of hidden taxes as "health care financing enhancements" (HCFEs). From the perspective of the politician these HCFEs have the great virtue of remaining outside of the public budgets over which the politician presides and for which (s)he can be held accountable. One should think that such hidden taxes, that spare politicians both embarrassment and accountability, would revolt a people dedicated to democratic principles.

By calling these taxes the "only realistic, politically feasible measures to help the poor at this time," politicians making that statement tell us much about their own respect for these democratic principles and, indeed, about their own views of their electorate's intelligence and social ethics. These politicians are proceeding on the premise that, unless coerced through legislative trickery, the American people would be too miserly to care for their poor and sick fellow Americans. If these politicians are right, they know something this author would never even have dreamt in his philosophy.

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VI. Congressional Perspective on Mandating Health Benefits

REMARKS OF REP. ROD CHANDLER

Support for the argument about the unsustainability of U.S. dependence on foreign capital was given by John Berry, in the *Washington Post* business section yesterday [April 26, 1987]. The first sentence of his article says confidence in the U.S. dollar has dropped so much abroad since the start of the year that foreigners are now shunning investments in the United States. That decision has already resulted in higher interest rates for American consumers and businesses.

I just got back from the Shimoda Conference in Japan. The Japanese now are beginning to struggle with the same kinds of problems that we have. To say that the situation between Japan and the United States is critical, tense, and sensitive would be a vast understatement. The imposition of tariffs on $300 million worth of imported goods from Japan is on the one hand a mere slap on the wrist and yet you wonder why it did not happen sometime before. Still, the Japanese have reacted almost like a child whose doting, loving, spoiling father has never once in the last 20 years raised his voice and all of a sudden has beaten it mercilessly to the floor.

So it was ironic then to discover that in Japan, where they need and have suggested that they want to expand domestic demand for greater consumption and especially of imported items, they were considering imposition of a sales tax. Here in the United States, if there is anything that we need to do, it is stop spending, encourage saving, and stop importing both foreign goods and capital. But in the very same week, we were considering increasing spending through a supplemental budget.

Proposals for Catastrophic Health Insurance

In the Ways and Means Committee, we are about to take up consideration of a catastrophic health insurance bill. It would cover most of the costs of acute health care—primarily hospital care, but not long-term custodial care. A very important element in both the Bowen

proposal and the Stark-Gradison proposal is that in both cases the benefits are being paid for by the recipients of those benefits.*

There is a proposal to which I am bitterly opposed that would have current workers pay for the benefit through a diversion of part of the FICA (Federal Insurance Contributions Act) tax to pay for the benefit.

Now the question is: Will there be consideration this year of further Consolidated Omnibus Budget Reconciliation Act (COBRA)-like mandated benefits and what form will that take?* The answer is, yes, there will be consideration. In fact, there has been at least a beginning of that attempt, and we will see it on the catastrophic health insurance bill with amendments to be offered by Rep. Bill Gradison (R-OH).

Other Congressional Initiatives

The first proposal will be a mandated minimum benefit level including catastrophic coverage for current workers to be required of employers who provide health insurance. It would not affect anybody who does not provide health insurance. Now the effect of that in terms of cost would depend, obviously, on how low you set the limits, and would also have a great deal to do with the current benefit level of the employer plan.

Another proposal calls for some form of encouragement for states to establish risk pools. There was similar language in last year's reconciliation bill.* A dozen or so states already have a risk pool scheme, and what I understand is going to be suggested will be legislation to

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*Editor's note: The Bowen proposal is the plan recommended to President Reagan by Health and Human Services Secretary Otis Bowen in November 1986, a modified version of which was proposed to Congress in February 1987. The administration bill calls for a flat premium increase of $6.10 in 1988 for Medicare Part B to pay for the catastrophic benefit.

Rep. Fortney (Pete) Stark (D-CA), chairman of the House Ways and Means Subcommittee on Health, and Rep. Willis Gradison (R-OH), ranking Republican on the subcommittee, have sponsored H.R. 2470, which originally proposed paying for the catastrophic benefit partially through a flat premium increase and partially by taxing the actuarial value of Part B benefits. As approved by the Ways and Means Committee, however, H.R. 2470 provides for a flat premium increase and an income-related premium.

*Editor's note: The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers with 20 or more employees to offer health care continuation coverage for up to 18 months for employees who quit or have been laid off and for up to 36 months to widows, divorced spouses, and dependents of covered workers.

*Editor's note: The Sixth Omnibus Budget Reconciliation Act of 1986 included a state risk pool provision in the House version, but the provision was dropped during conference between the House and the Senate.

cover persons who could otherwise afford coverage but who have been disqualified for reason of a previous condition.

Prefunding Retiree and Long-Term Benefits

I am working on a voluntary health retirement plan for health and long-term care. What I have in mind is to replace the old VEBA (Voluntary Employees' Beneficiary Association)* and section 401(h),* especially 401(h) because nobody uses it anyway, and among its major provisions would be to allow transfers of excess assets of overfunded pension plans into retiree health plans.

The legislation would allow employers to prefund retiree and long-term benefits. If, in conjunction with my bill, we also pass a catastrophic health insurance bill, most employers then would be encouraged, and wisely so, to cover long-term care benefits rather than the already covered acute care. There might be a mix of services that would include prescription drugs and so forth. There would be a limited deduction for contributions, and the earnings that accrue from those contributions would be tax-exempt. We would utilize a defined contribution approach rather than a defined benefit approach, which is not going to be popular with employees but much more popular with employers. Given the certainty of demographics in the future, this seems to be the wise way to go and is the responsible way to keep employers out of the kind of trouble that many of them are in now.*

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*Editor's note: Under IRC sections 419(A), 401–420, and 512(a)(3)(e), an employer can set up a tax-exempt VEBA for the purpose of funding employee benefits for education, vacation, or current and retired employee health care, among other things. However contributions to a VEBA may still be subject to tax. Employers are discouraged from prefunding retiree health benefits because of a limit on the amount an employer may deduct as reserves and because of a tax on the earnings on the reserves. These restrictions on VEBAs were enacted as part of the Deficit Reduction Act of 1984.

*Editor's note: Under IRC section 410(h), a qualified pension plan may provide health insurance benefits to retirees, if maintained in a separate account. The contributions may not exceed 25 percent of the aggregate of all plan contributions, however, and are subject to the overall limits on contributions to qualified pension plans.

*Editor's note: On July 1, Rep. Chandler and Rep. Ronnie Flippo (D-AL) introduced H.R. 2860, "The Retiree Health Protection Act of 1987." H.R. 2860 provides incentives for employers to create Voluntary Retiree Health Plans (VRHPs) to prefund retiree health and long-term care benefits. Contributions to the VRHPs would be tax-deductible, and the interest accumulated in each account would not be subject to federal taxation.

Policy Forum Discussion

Mandating Employer-Provided Health Insurance

MR. SALISBURY: Rod, you touched on proposals like those being discussed by Sen. Edward Kennedy (D-MA)* and other staff working groups, that would require employers who do not provide health insurance to begin providing such coverage. Do you see the likelihood of this type of legislation moving in this Congress as relatively low?

MR. CHANDLER: I think that would characterize it. I am not sure how it is being viewed on the Senate side. I do not sense that the Kennedy proposal is being taken seriously in the House Ways and Means Committee. I hear suggestions from some of my colleagues that we should go back to the tax reform ideas, for example, and tax benefits beyond the level of a certain cap, as was proposed in the original Treasury Department tax reform recommendations. I categorize those two ideas as unlikely, but you never know.

MR. FOREMAN: I do not understand the rationale of those who would add a burden to employers already providing benefits and ignore employers who are providing nothing at all. Employers who are providing benefits are more in global competition. The companies that are providing benefits tend to be in the manufacturing sector as opposed to the service trades. And to the extent, even in the manufacturing sector, that someone is not providing benefits as opposed to someone who is, you are adding to the competitive disadvantage of the benefit-providing employers. I do not understand the rationale.

I thought you were proposing mandating minimum standards and other things for those who already provide benefits.

MR. CHANDLER: No. Rep. Bill Gradison is the author of both the proposals that I mentioned, the mandated minimum benefit and also the risk pool idea. I find it very, very difficult to imagine the circumstances under which I would support that idea. I am not even sure at this point that I am going to support the catastrophic health insurance bill, although I did from the subcommittee. There are, however, some pretty valid reasons why that catastrophic health insurance bill could make sense.

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*Editor's note: Sen. Edward M. Kennedy (D-MA) introduced S. 1265, The Minimum Essential Health Care Act, on May 21, 1987.

Politics of Catastrophic Health Care

MR. ROMIG: I am curious about the politics of catastrophic health care. I am confused about how they are working out. The success that the Democrats had on Social Security in 1982, 1984, and with some degree of success in 1986, suggested that they should follow the lead of Rep. Claude Pepper (D-FL)* who wants a much expanded Medicare program. On the other hand, Republicans who have learned their lessons after three successions of watching the other party do well in the congressional elections, would probably have gone along with a small sweetening of the pot.

It seems that it is not working that way at all. Democrats, the majority party, are now pushing for a very modest step, trying to entice the president and the Republican party to have their fingerprints on the same proposal. The Republicans appear very willing to go along. This basically runs afoul of the very basic philosophy the current administration has pursued, that is, try to move government functions to the private sector. Ironically, in this catastrophic proposal, they are taking a fairly significant step to remove from the private sector an area in which we have done a fairly good job. Why?

MR. CHANDLER: The private sector has done an excellent job. There have been, as you know, some abuses of the Medigap system. I think that has been largely corrected by legislation.

I have had trouble understanding the logic of ignoring prescription drugs, long-term care, and so forth, and passing legislation that would cover a benefit need that is largely already covered by private health insurance. So I am as puzzled as you are about the urgency over this legislation. I think probably a couple of things have happened that have set political thinking in the United States almost in concrete. One was the 1982 election when I do not know how many Republican members of the House were defeated on the issue of Social Security, but a large number of them; and President Reagan in the State of the Union address not long after that said his famous: "I almost never say never, but this time I will say we will never touch Social Security."

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*Editor's note: Rep. Claude Pepper (D-FL) has introduced a catastrophic health coverage bill (H.R. 65) that would expand Medicare to pay for long-term care as well as expand other services and benefits. The other major catastrophic proposals do not provide a long-term care benefit.

The same thing happened with Walter Mondale and the tax increase issue. Democrats have taken almost the same hard-line position that, as soon as Ronald Reagan begs on hands and knees, then and only then will he get a tax increase.

So I suspect that there is a great deal of fear about opposing a catastrophic health insurance bill, because the public believes it is a more serious problem than it really is.

Right now surveys show that 80 percent of Americans covered by Medicare think they are covered for long-term care without the catastrophic insurance coverage for acute care. So this is just a way of demonstrating my being puzzled, as you are.

Problems for Small Business

MR. HUNT: One of the big frustrations that you often run into, especially with smaller and medium-size employers who seem to be the target of people who say they do not offer coverage because they do not have full-time benefits advisors on staff, is that they feel as if they are on a roller coaster. From about 1935 until about 1979, womb-to-tomb security was encouraged. You know, money is no object; offer it!

Then, in 1979, Uncle Sam found he was in financial trouble. And I can remember the dramatic reversal in the Senate Finance Committee, testifying pre-1979 and hearing: "You ought to offer more, you ought to offer more, why are people not offering more?" After 1979—it was about 1981 or so—suddenly it was "You are terrible people, you are giving away entirely too much money to these employees; they ought to live a little bit harder."

That continued until 1984 with DEFRA (Deficit Reduction Act). A lot of people got the message from DEFRA: "Uncle Sam really does not want you to have benefits because of the tax revenue loss." The next cycle, starting in late 1984, was: "We want you to give citizens more. In fact, we want employers to pay for what we are promising." So, a lot of people are just very leery about getting involved, because no one knows where the roller coaster will go next.

MR. CHANDLER: I think where it will go next is toward the small employer, the nonunion employer, the start-up employer. I was one of those in the state of Washington. I have often described my business as not being small but minute, and when you are a minute business owner, you do not have the time or the capital to invest in employee benefits, certainly not any qualified plans.

So what do you do? You try to salve your conscience some way or

another and do without. And that is what is happening to a tremendous degree as this economy shifts from the large union manufacturing business to the small service, independent start-up business. That is going to be a growing problem and, as members of Congress see the problem they will try to address it.

We are going to be faced this year with paternal and maternal leave and many other employer mandates that include health warnings for hazardous chemicals of some kind or another. If this kind of legislation is not improved substantially, it will do more harm to the workers than good but, nevertheless, members of Congress want to go home able to say they have done something for workers.

With all of the deficit problems that we have, however, members do not have any Treasury funds to spend, and so they will spend the funds of business. That is a trend that is going to continue, and you will see more and more attempts to mandate this kind of benefit without ever taking money and putting it through the Treasury.

MR. MIKKELSEN: Congressman Chandler, would you elaborate for a moment on the nature of the long-term financing provisions of this bill you are sponsoring?

MR. CHANDLER: Essentially, we would create a new funding mechanism for employers who wish to provide retiree health and long-term care benefits by allowing them to contribute a certain amount of money per year per employee. Those funds would be tax deductible and the earnings on them would be allowed to accrue tax free. Annual contributions for persons under age 50 could not exceed the lesser of $1,500 or 25 percent of the employee's income. (For persons age 50 to 55, the limit would be $1,750; age 55 to 60, $2,000; and age 60 to 65, $2,250.) Employers would be able to choose 5-year, 100 percent vesting, or 3-to-7-year vesting schedules, as in pension law. When employees retire, they would be entitled to health insurance coverage that could be purchased with the accumulated funds. An employee leaving the job before retirement could transfer all assets into a new employer's program or continue to have the accumulated funds maintained by the former employer until retirement.

Unfunded Liability for Retiree Health Benefits

MR. CHANDLER: Despite the fact that you have a great number of people covered both by employer-provided health insurance plans for retirees and by plans that they purchase themselves, you have many companies in the United States that have promised health benefits

that I think you can say with some assurance are vastly beyond their ability to pay.

It seems to me that one argument in favor of a catastrophic health insurance plan is that you would then largely cover with the catastrophic health insurance program under Medicare the benefits that have otherwise been promised by those employers, perhaps freeing up that liability, some or all of which could be shifted to long-term care. Instead of the employer then paying for this benefit and suffering this liability, the cost would be shifted from the employer to the retired employee, either again through the premium or through the tax on actuarial value.

MR. GARBER: I had hoped that was the case, and I looked at the Bowen proposal as something that would take off what for us is a very large, unfunded liability. So we got our actuaries to work. They reported back that the catastrophic proposal would take care of 10 to 15 percent of the unfunded liability. The rest of it, which includes prescription drugs, eye care, and other things, are not covered by the catastrophic proposals.* It has not done much to reduce the amount of that liability, because all it did was pick up some things that were not already being covered by Medicare. So that may turn out to be an illusion for other employers as well. It certainly was one for us.

It seems to me that we have a couple of institutional problems here, institutional in terms of an agent. One is that the cost of medical care and health care is essentially out of control in this country, and it continues to rise as a percentage of GNP to some level as yet unknown. In the long term, if we mandate benefits people will be required to divert more and more money into the health system, because mandating means eventually it comes out of people's pockets. It may come through the employer, but it is going to come back to the citizens of this country in one way or another.

There seems to be no ability, desire, or institutional way in which Congress can address that particular problem. Second, we were talking about a sort of propensity of elected officials to mandate costs on other people, which they are reluctant to assess directly through taxes, and the negative effects that will have on our competitive position. Is there an institutional way within the government, where one could begin to address these problems? I despair, really, at this point of seeing a way in which that can be addressed in a responsible fashion.

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*Editor's note: Prescription drugs were added as benefits to be covered under the catastrophic health insurance proposed in H.R. 2470.

MR. CHANDLER: What I think we are going to have to do in this country is something akin to what we did with the 1983 Social Security bill, but on a much broader scale. That is, build a solution to this problem at the White House level with every level of leadership in Congress. In order to come to a solution, we have to make some fundamental changes, the kinds of changes that can cause the same kind of political fallout that members suffered in 1982 and again in 1984 when the Democrats raised the tax issue. Those were responsible decisions and were not intended to destroy people's livelihood or the American way of life or anything like that.

What you need is some political cover. That leadership can come only from the White House itself, from the leadership of the House and Senate, and it has not yet been there on the greater issues of the entire economy, spending and taxes.

MR. OLSEN: What is your impression of the level of support in Congress for providing viable methods for prefunding health benefits?

MR. CHANDLER: Actually there probably is very little knowledge of the need or the subject in general. The Ways and Means Committee will be aware of it, and members of the Education and Labor Committee will, and that will be pretty much the extent of any particular knowledge.

This is the kind of thing that I hope we will amend onto the budget reconciliation bill. Then it will just go through as part of the package, and most will not even be aware that we have done it. There is no reason why they should not be aware of it because it is a positive thing; but if I had to go on the floor of the House and amend the catastrophic health insurance bill, the idea would probably fail simply from doubt. Most people vote no when they are in doubt.

Financing Mandated Benefits

MS. DAILEY: My comment is related to financing mandated benefits, too. Most of the proposals seem to be financed by a cost per employee or a percent of pay; these methods affect labor-intensive businesses a lot more than capital-intensive businesses. This seems to be why small businesses object to mandated benefits so much. Fast food restaurants or something of the sort are more apt to have a large number of employees, so that any cost that is a percent of pay is going to affect them more than a tax that is a percent of profits.

MR. CHANDLER: That is exactly right. And in defense of what Ken McLennan was saying, even though you as an employer may not be

competing with the Japanese, in Brazil, or Ecuador, or Spain, or someplace, you very likely are competing with them or some other foreign competitor here in our own market. So if we do something that makes it even less competitive with them, you have lost your ability to compete.

That is really the trade problem. It is not so much that we do not have access to those other markets. That is an element and a very important one, and Americans have every right and should continue to aggressively demand fairness when we deal with competitors abroad. But you could close or open every market in the world to American products, and until you started to compete here in our own market, you would still have a huge trade imbalance.

So I think that anything we do to compound that problem is going to be very counterproductive.

MR. GEISEL: I just wanted to clarify something. You would introduce your VEBA-type proposal as part of the reconciliation bill. Did you say you have gotten any support from the Administration on this? Regardless of the answer, what gives you optimism that this would happen?

MR. CHANDLER: Well, this is in its infancy. We will go over a policy options sheet today and will make the decisions necessary to get it to drafting. Then we will circulate it and begin the process of building support for it.

MR. GEISEL: What is your rationale for the proposal?

MR. CHANDLER: It is to help employers who have made the commitments and are finding themselves in an underfunded position, to allow the transfer of overfunded pensions so that you do not end up with this problem of those being folded into somebody's benefit, say, the defined benefit plan being enhanced and mandated by Congress if that occurs. That is the main rationale. And to allow the prefunding of these retiree health benefits.

National Retirement Income Policy

MR. MOSER: Businesses without a stated benefit policy tend to wind up with benefit programs that are inconsistent with one another and programs that are working at odds with each other. As I look at all the varying legislative proposals, some 12 or 13 in the health care field, and try to assess what the impact of any or all of those would

be on us, I find myself in the position of saying: "Well, if I support something in one bill here, that same provision in another bill might wind up causing me problems over there. In other words I wind up shooting myself in the foot."

I wonder—though I despair of ever having it happen—if Congress could develop a national policy toward benefits or pensions; and if not a policy, is it possible that committees, which are proposing and dealing with these bills might not develop a set of principles by which they would judge all the proposals coming before them? If they developed that set of principles, would that not potentially lead to some consistency, to some rationale that would prevent the chaos that I think exists right now?

MR. CHANDLER: The obvious answer is yes, that would be tremendous. I have felt since I have been in Congress that we need a national retirement income policy, and I think that you would include health insurance coverage within that. It has been largely elusive. We have a policy, but it is one that has pretty much evolved over the years to what it is today.

There is no standard to guide our decisions today, and I wish there were. That would be helpful. You would hope that a standard would be developed, but the likelihood of that happening, I think, is pretty remote.

One of the problems that I have encountered is committee jurisdiction. You have what I believe to be the strangest of jurisdictions—the Committee on Ways and Means has most of the responsibility for Medicare, but Energy and Commerce shares part of that jurisdiction. Education and Labor has a piece of the action as well. At the federal level, the Post Office and Civil Service Committee becomes a player, and so forth.

MR. ACHENBAUM: Congressman, let me follow up on that last response, because I am struck by how often you referred to the 1983 Social Security Commission. What would make mandating a high priority this year? Will it be because it is a crisis situation that requires all the principles to come to the table? Or, is there just no better alternative.

MR. CHANDLER: It is more the latter than the former, and again it is back to the politics of this question. I can tell you that my staff advisors were very, very concerned about the possibility that I would vote against the catastrophic health insurance bill, not because I cannot go out and explain that vote, but because when you are in

this political environment, you never have the opportunity to explain it.

In our last Senate race at home, Slade Gordon* was defeated in part of the Social Security issue. All it took was one vote, which I also have taken, on a budget resolution that did not include cost-of-living adjustments for Social Security recipients. I think probably without that issue, he would be a U.S. Senator today. Never mind the fact that it was a totally responsible vote. It would have been irresponsible to do anything else.

It is a little hard not to be resentful over this, but that it is the American way. That is the way we decide who is going to be in Congress and in the U.S. Senate. I am not wise enough to suggest how to change it, let alone able to come up with a plan. But I can tell you that it is more a factor in how we get from here to there than any logic on what a policy ought to be.

Fiscal Impact Statements for Mandated Benefits

MR. UGORETZ: One of the suggestions that Sen. Dan Quayle (R-IN)* had was that before a congressional committee, his committee in particular, reported a mandated benefit, the Congressional Budget Office (CBO) or the GAO (General Accounting Office) would be required to develop a report on the actual cost and who in fact is ultimately going to pay that cost, and how. Senator Quayle did win something of a victory in his own committee when the committee agreed to look at the issue, although not quite the way he had suggested. I think it will be very helpful.

MR. CHANDLER: I think so, too. In the state of Washington—and this is not uncommon in legislatures around the country—before you pass legislation, you have a fiscal impact statement. And that served us very well. That was sometimes sobering information to carriers of great ideas, and in states most of which have to balance the budget either by restraining themselves or by passing taxes to fund their programs. That is the kind of thing that is very sobering.

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*Editor's note: Sen. Slade Gordon (R-WA) was defeated in his bid for re-election in 1986 by Brock Adams, who represented the 7th District (Seattle) in the House of Representatives from 1965 to 1977.

*Editor's note: Sen. Dan Quayle (R-IN) has introduced legislation (S.Res. 218) in 1987 that requires any committee reporting legislation that mandates benefits to include in its report an analysis of its impact on domestic employment and American competitiveness.

The Future of the Social Security System

MR. CHANDLER: Let me share with you another concern that I have. We were told five years ago that the Social Security system faced imminent bankruptcy. But at the end of January 1987, the balance in the trust fund reached $49.9 billion and by 1991 the balance will have reached $247 billion. Where is that money, and where will it be in the year 2010, 2015, and 2030 when it is needed?

Let me answer my own question. I would suggest that the money will not be there, because it will have been spent on current operations of the government of the United States, and we may as well not even have collected the money as to have created a trust fund balance for which there are no funds.

We have not saved anything. We have simply diverted these monies from one account to another and spent them. And to suggest, as Robert J. Myers does, that this is good news, I think is to mislead people.* That is the kind of thing that we ought to be telling the American people about. I have a hell of a time looking across the dinner table at my kids at night and telling them that is what they are going to be up against. Either they do not get the benefits we promised, or we are going to have to tax the devil out of ourselves to pay for it because we will have spent the trust fund money that was supposedly set aside to cover them.

MR. LINDEMAN: I think the reality is that the trust fund balances are always kept in Treasury notes. Unless we start buying corporate debt, they are in fact claims on the future resources of the U.S. government. That is the legal, fiscal reality.

The fundamental point underlying your comment is whether those so-called trust fund surpluses are used in a way over the next 20 years such that the productive capacity of the United States is increased as opposed to not changing from what it would otherwise be, if indeed those monies are merely used to finance other portions of the government.

It is not that there are any fewer claims in the trust fund at the end of the period when it flips around. It is just that you may not have built up capital infrastructure or whatever that would make the redemption of those claims more viable. But I think that gets into larger fiscal and economic questions to which nobody has any very

*Editor's note: Robert J. Myers was chief actuary for the Social Security Administration from 1947–1970; Deputy Commissioner from 1981–1982; and executive director of the National Commission on Social Security Reform from 1982 to 1983.

good answers. But the legal reality is that the trust fund balances are always claims on the future resources of the government.

MR. MIKKELSEN: Congressman Chandler, how would you assess the appetite of the other members of Ways and Means for that aspect of the administration's initiative that would permit pension surpluses to be redirected to the financing of postretirement health care benefits?*

MR. CHANDLER: There has not been a general enough discussion about that to say. We had a retreat in Williamsburg (Va.) toward the end of March with an extensive discussion of the issues in the committee's jurisdiction. Unfortunately, this did not happen to be one that was brought up. So I have not had a chance to make a sounding of my colleagues' opinions.

MS. DOMONE: I had a comment to make on the catastrophic issue. Some people have been talking to me about it. These bills increase the number of days that Medicare pays for in the hospital; but under the DRG (diagnosis-related groups) system, hospitals are paid really to get their patients out as fast as possible. One way they do that, as soon as the immediate danger is over, is to ship them to nursing homes. Since the catastrophic proposals would not pay for nursing home care, these bills really do not do anything. Have you addressed that at all?

MR. CHANDLER: It has certainly been raised. The only impact I can see is that the cost of the proposed coverage is being shifted from private insurance and retiree health plans to the beneficiaries. I have heard that there would be somewhere in the range of 2,000 people assisted per year by the program, who are not now in some other way covered.

MR. SALISBURY: The subject of national retirement income policy has come up. Pat Dilley, could you give us a brief comment on the status of the study that the Ways and Means Committee has been working on?

MS. DILLEY: The Ways and Means Committee asked the Congressional Research Service to do a major study for the committee as

*Editor's note: The administration has proposed that defined benefit pension plans be allowed to recover excess assets from ongoing plans provided certain conditions are met. Under the proposal, employers would be allowed to transfer such assets to pay health benefits of retirees, without current tax consequences.

part of our retirement income security policy study last year, on the whole issue of retirement of the baby boom generation. [The study has been completed], and I think the committee plans to have a series of hearings on the generational issues involved in the retirement of the baby boom. The study covers the whole range of income issues, funding of the retirement for the baby boom and what advanced funding really means in both the public and private context.

MR. YOUNG: We have talked about allocating pension assets for mandated benefits if the employer is so inclined. On the other hand, we have Bob Paul and other actuaries telling us that we should be concerned about overfunding, because the Pension Benefit Guaranty Corporation (PBGC) might raise the ante. My question is: Is there some coordination between the PBGC looking at pension assets to meet its needs and the health and welfare industry looking at pension assets?

MR. CHANDLER: I do not propose that there be a requirement of any kind for the transfer of what would be considered actuarially surplus assets from pensions to a retiree health plan, but simply that employers would have the option to do so, and without a tax activity taking place in that transfer.

Now the PBGC issue is a completely different one. Congressman Pickle's (D-TX) committee* is working on that. The issues include who pays the liability when a pension plan terminates, over what period of time, and so forth, and on the other side of it, what the minimum funding standards are. Another question is whether we should change the insurable event, from Chapter 11 bankruptcy to Chapter 7.

Since the Ways and Means Committee has jurisdiction over both issues, there will be a coordination of those decisions.

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*Editor's note: Rep. J. J. Pickle (D-TX) is chairman of the oversight subcommittee of the House Ways and Means Committee.

VII. The Role of the Federal Government in Mandating Employee Benefits

REMARKS OF DEBORAH STEELMAN

The budget policy process is like a balloon, squeeze on it in one place—reduce spending—and it pushes out the other side—mandated benefits. Policymakers at both ends of Pennsylvania Avenue see paralysis for the federal budget process, not only for the remainder of this year, but for some years to come. A Congress that can no longer afford to create new programs will turn to a regulatory agenda or to mandating new programs on other payers—such as states or employers.

Are the American People Exploiting the Government?

In a recent article published in *Public Interest*, titled "The 'New Science of Politics' and the Old Art of Government" Sen. Daniel Patrick Moynihan (D-NY) asks the basic question of what happens in a system of government designed to preclude exploitation of the people by the government when instead the people exploit the government. Can this system continue to support proper governance; are deep changes required?

Senator Moynihan wrote:

> Can we agree, then, that the great object of the constitutional arrangements we thereupon put in place was that the government should leave the citizen alone? Thus the thundering prohibitions of the Bill of Rights: "Congress shall make no law"; "No soldier shall"; "no Warrant shall. . . ." Fair enough. That was the problem then. *The problem now is that citizens won't leave government alone.* They now plunder the State as the State was once thought to plunder them. . . . The checks and balances of an early age seem less effective. Are we approaching this newer question with anything like the clarity and method with which the Founders approached the earlier one? I would answer no.

Is this crying wolf? After all, we have been through much as a nation. We have faced tougher times in our history and survived them: the Civil War, the Depression. You may ask, why now doubt a system that always carried us through before?

We have a much different situation today than we have faced during many of these tougher times. The demand for services and programs that has been growing at the national level since the beginning of our nation is a cancer. The fact that we have survived serious conflict before does not mean we are equipped to deal with today's dilemma.

This tension that has been building up for years has reached its zenith in today's budget debate. While demands for national service programs have been on the rise for over a century, never before has the unwillingness to pay for these services been so bold. For this first time the antitax movement has equal if not greater strength than the big spending constituencies. As a whole, the population of the country today demands tremendous benefits, yet insists, as a whole, on not paying for them. And today's politicians respond accordingly.

How is a population that expects something for nothing to be governed?

Reducing the Budget Deficit

There are four basic components to the budget: interest on the debt, defense and international spending, domestic spending, and revenues. Interest is controlled by the going interest rate and the economy. The government can take no unilateral action to reduce the interest debt other than reduce the amount it is borrowing.

Revenues? This administration believes spending must be reduced, not taxes increased. I think the next administration will also have great difficulty raising taxes of the magnitude required to significantly reduce the deficit. While there is much debate regarding tax increases of many varieties inside Washington, sufficient revenues through tax increases will be a long time in coming. The size of the deficit and the size of the tax increase it would take to provide serious relief is too great. The voting public simply will not tolerate it.

Cuts in defense spending? The growth in the defense budget has been flattened, both in terms of the president's request and the appropriation passed by Congress. The Defense Department's annual budget is now in the neighborhood of $295 billion; reductions of the size necessary to significantly reduce the deficit cannot be found in defense spending alone.

Cuts in domestic spending of that size? Highly doubtful. The largest package of domestic cuts this administration ever proposed was about one-fourth of today's deficit. And in that package very few of the administration's proposals were accepted by Congress.

Obviously, some combination of the three tactics will have to occur. The most important exercise in this endeavor is how to get the public to sign on to one combination or another, how to get on with the chore of setting national priorities. This is the point at which one begins to realize the seriousness of the people's exploitation of the government. The key component of this exploitation is the growth of programs designed to benefit the middle class. Even more important has been the growth in the belief that these programs are a *right*.

The kind of benefits that have seen the greatest growth are typified by Medicare, Social Security, student loans, and payments to farmers. A very small proportion of these benefits go to the truly needy, those who cannot do for themselves. But a vast proportion of these benefits have come to be expected by many who may not truly be needy. Those who provide many of the services—banks, health care providers, managers—have vested interest in these programs. And the middle class votes.

We will continue to see vast program expansions in these areas. We will continue to see cost-of-living adjustments for all Social Security recipients, regardless of need, even though their contributions average about 7 percent of their benefits; we will continue to subsidize interest to banks for low-interest loans at high-tuition schools; we will continue to see major farm payments to huge landowners and wealthy farmers.

While the 1988 elections may be too far off to predict, the tension now in the system will not disappear simply with a new election. While some partisans insist the pressure will cease when this president leaves office, there are a couple of reasons why the election process will exacerbate the tension. First, elections tend to elicit promises, especially of the something-for-nothing variety. Members of the House and, more and more, their Senate colleagues, run for office every day. Second, this president has had a remarkable ability to remain at the center of a wildly divergent country. Few leaders have appealed to so many. The next president's agenda will not be so widely supported.

Thus, we are facing a long-term stalemate over the inability to set national priorities. We cannot succeed on the deficit as long as decision makers continue to try to divide and conquer it, until we stop believing that either lower defense spending, *or* lower domestic spending, *or* a tax increase will solve it. We must begin to discuss the issue in larger terms, and recognize that we have a system now that may not be able to grapple with the demands being placed upon it.

Operating Under Gramm-Rudman-Hollings

A question was raised about whether or not the criteria that the state of Washington has set out for itself would work in a federal context. Will a legislative body, particularly at the federal level, abide by a system based on good analysis and hard data?

Examine our experience with Gramm-Rudman-Hollings. This law was designed to provide Congress with the best estimate of the deficit that the Office of Management and Budget (OMB) and the Congressional Budget Office (CBO) could develop, and to "force" Congress to make the necessary cuts or raise sufficient revenue to meet an ever-declining target. If Congress did not, an automatic across-the-board cut would occur. One may then ask how it is possible to have a deficit today of $170 billion when Congress passed and the president signed a reconciliation bill last year that allegedly met the fiscal 1987 Gramm-Rudman-Hollings target of $144 billion? There was great fanfare in the fall of 1986 when the reconciliation bill was passed, when Congress and the president proved it could reduce the deficit. Yet today the deficit is easily $20 billion more than the target. How did this happen?

It happened because a political system cannot be forced to operate in apolitical ways, even based on the best analysis, the best data. Each of the 536 players in this system—every member of Congress and the president—is a politician. If the data and analysis tells these policymakers something they believe the public does not want to hear, they will find a way to change the data into something they do want to hear. Thus, the 1987 reconciliation bill "met" the target, even though it is doubtful if any member of Congress actually believed that.

Each of the political institutions in our government—Republicans, Democrats, Congress, the executive branch—will figure out a political way to get around that data.

Thus, Gramm-Rudman-Hollings has forced the debate, not on how to set national priorities, but instead on how to play with numbers. Today's debates are highly artificial. Each player uses its own numbers, and depending on who is talking or what time in the process it is, the debate fails to include—let along focus on—the real implications.

This is true not only of the "macro" debate of how to reduce the deficit, but has the same impact on all policy debates. A recent example is the debate over welfare reform. This debate is the classic example of numbers driving a policy debate that belongs on a much

more sociological and traditional public policy footing. OMB and CBO have priced the congressional proposals and the President's proposal very differently. OMB prices the administration's proposal low and the congressional proposals high; CBO does the reverse.

This kind of manipulation of the numbers is not particularly helpful or insightful in assessing policy implications. Of course, what we should be talking about is whether or not mothers with babies and young children should be exempt from work and training programs, whether or not transitional benefits help or hinder entry into the work force, and what is the best way to ensure health care for poor children. Does the numbers exercise facilitate these debates? The answer, of course, is no. Thus, a mandatory apolitical process has resulted in some of the best gamesmanship that can be imagined, not a debate on national priorities or on an orderly reduction of the deficit. Merely a process change is not the answer.

Gramm-Rudman-Hollings was an attempt to force Congress—and the American people—to set priorities—to choose between competing demands. Instead, it has resulted in shifting the focus from a real policy debate to simple numbers manipulation and gamesmanship.

Lack of Political Consensus

Congress has been without a political will, a consensus on the appropriate direction for the country for a number of years. The two parties themselves no longer function as political parties. There is no agenda around which a party centers itself, no consensus as to what is more important in terms of setting national priorities. Should our national priority be to reduce the deficit? Is that more important than catastrophic illness insurance? Is it less important than a strong defense? Is it more important than aid to Israel? You can tick off the list.

This country has not produced in recent years the political will to accomplish a specific task. Instead we have elected a Congress and an administration to do all these things at once, to fight over every issue as though it is a top priority. Mandated benefits and other regulatory approaches are the direct result of decision makers in Washington admitting that they cannot achieve all these things on their own tab, but insist on having them anyway—on somebody else's tab.

Consequently, the pressure to use the regulatory or mandated route will only decrease when the public agrees to spend more or want less.

There is no snap-of-the-finger solution that will solve the riddle. It is not a question of simply electing a new president, or a Republican-controlled or Democrat-controlled Congress. The issue is that an awful lot of people in this country have come to expect a great deal from people other than themselves.

Policy Forum Discussion

OMB Agency Review

MR. SALISBURY: Could you explain the percentage of domestic spending that your budget examiners deal with, and which agency budgets fall within your area?

MS. STEELMAN: My jurisdiction covers about $450 billion in spending, administered by the Departments of Health and Human Services (HHS), Labor and Education, the Veterans Administration, and about 20 independent agencies. On its own, HHS has a fiscal year (FY) budget of about $380 billion, of which Social Security accounts for about $220 billion and Medicare/Medicaid accounts for about $90 billion.

We assess the agency budgets that are submitted to OMB every fall. Agency ceilings are set in the previous year's budget. The agency ceilings for the fiscal year 1989 budget were set in the fiscal year 1988 budget. They were set to meet the Gramm-Rudman-Hollings targets for FY 1989. The target this year is $108 billion, and the target next year is $72 billion.

Unless something radically different happens this year in Congress and we get a deficit reduction of a heretofore unknown magnitude, it is going to take somewhere in the neighborhood of $60–$70 billion in deficit reduction measures to meet the Gramm-Rudman-Hollings targets next year. Some of that will be revenues, but a great huge chunk of it will be in domestic spending. The other alternative is to move the Gramm-Rudman-Hollings target, something that may prove more attractive.

On the question of OMB responsibilities, we review the agency budgets and are in charge of getting the budgets submitted in to Congress January. We also review agency testimony and regulations to ensure that they are in line with administration policy. We apportion funds to the agencies to ensure compliance with the Anti-

Deficiency Act.* It operates like the budget and planning offices in any state or large corporation—just the nuts and bolts of government.

MR. SALISBURY: Do you ever make an evaluation of whether the agencies are performing well? For instance, Medicare has been very, very sloppy about health care cost containment, and the same thing in the Department of Labor. Does OMB ever go into that kind of thing, or are you not necessarily concerned with how they perform?

MS. STEELMAN: Clearly, evaluation is a big part of the job. We are always the second guessers and the nitpickers and the ones who are looking over people's shoulders. We irritate the agencies half to death, and they say: "OMB, you just do not understand; it is a difficult world out here." We say: "You just do not understand; this program has to be managed much more carefully."

Cash flow policy is a perfect example. The Medicare payment cycle policy is an example of a policy that is very well known to have come from OMB. We consider it a common sense business practice policy, and we expect the Health Care Financing Administration (HCFA) to manage its cash flow to the benefit of the taxpayer. However, the providers view it differently. If they do not borrow the money from the government, which is interest free, they have to borrow it from banks, which is not interest free. HCFA gets caught in the middle.

HCFA is a front-line agency. It is a very difficult agency to manage. The pressures on that agency over the last 10 years have been tremendous, both in terms of the tensions that are occurring in the health care sector nationwide, but also in terms of the federal policies this administration has put forward. So it is really easy to sit back in my agency and say: "Get with it," but when you are in that agency, you say: "We are swamped."

The answer is, yes, we evaluate programs and management. But reality is sometimes very difficult.

Health Coverage for the Uninsured

QUESTION FROM THE AUDIENCE: It could be suggested that Sen. Edward Kennedy's (D-MA) proposal for mandated benefits is not a subsidy for the middle class, but what he is talking about is a way to address the problem of the 35 million uninsured. He probably

*Editor's note: The Anti-Deficiency Act states that [I]t shall not be lawful for any department of the government to expend in any one fiscal year any sum in excess of appropriations made by Congress for that fiscal year . . . ."

would argue that since government is not ready or perhaps able to finance that care, it has to be done through the private sector. If that is not a good idea, what would you consider an alternative?

MS. STEELMAN: The question is whether mandated benefits are not designed to reach the 35 million uninsured in this country, rather than being middle-class benefits. And if the government cannot afford to reach the uninsured, why shouldn't employers? Or vice versa. How should it be provided?

Most proposals, particularly the one that Rep. Rod Chandler was talking about, do nothing more than mandate employers who provide existing coverage to increase or decrease or do something else with that coverage. The assumption that the federal government should be solely responsible for the uninsured population in this country is an assumption that I am not willing to make.

For access problems, Medicaid buys-in are a better option for the low-income group. For those who earn more than the low-income population and who work for small businesses or some other sector, risk pools should be turned to first. In terms of mandating federal coverage, it is doubtful that the federal government knows or has the capability to design programs that will meet the variety of abilities and needs, either of those employers or of the uninsured population.

QUESTION FROM THE AUDIENCE: How does the alternative that you just articulated square with the administration's own proposal, as part of its catastrophic health care plan essentially, to encourage the states to require that catastrophic coverage be provided by those employers who offer health plans?

MS. STEELMAN: That is one of the weaknesses in this proposal. Another question has been asked about whether people are getting conflicting signals from employers who are trying to drive down costs and increase cost sharing and from Congress, which is saying: "Do not worry about it; the federal government will take care of it." It is a complex issue; many cost/quality/access issues are unresolved in this country. That is just one of the reasons I believe it is inappropriate to legislate one national solution.

What is "Minimal" Coverage?

MS. STEELMAN: In terms of incentives and in terms of minimal coverage, the most interesting question is: What is minimal coverage? Is minimal coverage catastrophic coverage, so that if you face a financially devastating cost, you will be covered? And should cata-

strophic coverage not be a very different thing for low-income people than it is for wealthy people? Does out-of-pocket spending of $2,000 represent a true catastrophe for many people?* It is a significant problem for Social Security recipients, many of whom are single women whose income support amounts to less than $10,000 a year.

Why are we not looking at the issue in this way? Why are we not looking at it in terms of who needs catastrophic coverage and redesigning the whole benefit package toward the back end and away from the tendency toward first-dollar coverage? We seem to be sending the wrong signals in terms of cost containment and proper purchasing of health care, especially preventive care. Once the threshold is met, we seem to be exacerbating the high utilization problems associated with low to no deductibles and copayments.

This is another example of an area in which there is no political consensus as to what is important. Is it not a lot more fun to give something to everybody in terms of first-dollar coverage versus giving something to the 3 percent of the population that really ends up having a catastrophic experience? That is a prime example of the political problem I mentioned above.

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*Editor's note: The administration's catastrophic health insurance proposal provides for a $2,000 cap on out-of-pocket expenses for Medicare beneficiaries.

VIII. Employer Reaction to Mandating Benefits

REMARKS OF DAVID V. REPKO

The essence of what I am going to present as our perspective is that currently there does exist, between employer-provided benefit programs and the social welfare programs that are available, a reasonably effective partnership providing a wide range of coverage. I would concede, though, that there are gaps, and the key issues that confront us are who should pay for those gaps, and how they should be paid for.

JCPenney Benefit Package

JCPenney is a large employer with about 180,000 associates. In a certain respect, we are a small employer, because we have approximately 2,500 locations. We have a full range of benefit plan coverage, offering two medical plan options, as well as 220 health maintenance organizations (HMOs). We believe in associate (or employee) cost sharing. So there is a contribution for individuals who elect health care coverage. The company pays 75 percent of the cost. Our associates pay 25 percent.

We have a dental plan, disability plans (both short-term and long-term), and life insurance coverage, both contributory and noncontributory. A wide range of retirement programs are also available. They include a defined benefit pension plan, a defined contribution savings and profit sharing plan, and medical and dental plan coverage for retired associates. We also offer a wide range of miscellaneous benefits such as discount privileges, vacations, etc. One key point that I would like to make, is that JCPenney offers the same benefits for all associates from the chairman to the person at the lowest hourly wage.

Just to give you an idea of the numbers, out of 180,000 associates that we employ at any one given time of the year—and of course, our work force peaks at holiday season—140,000 are eligible for our welfare benefits.

Eligibility at JCPenney is 20 hours a week. In actuality, it is a little lower. In order to achieve initial eligibility, one needs to work 260 hours in a 13-week period. To maintain eligibility one needs only to work 200 hours in each of the following 13-week periods.

Some of the variety of state-mandated benefits that exist have been referred to earlier. They are as follows: coverage for specific services, such as drug and alcohol abuse; coverage for certain types of dependents, such as divorced spouses and newborns; coverage for specialty providers, such as psychologists, psychiatric social workers, and nurse/midwives; and now a more recent type of state mandate, coverage for specific diseases, such as Alzheimer's. Coverage for AIDS (acquired immune deficiency syndrome) is even being discussed now.

How do major nationwide employers cope with this? By and large, most major employers are self-funded or self-insured, and rely on Employee Retirement Income Security Act (ERISA) preemption. Obviously, if one of our objectives in benefit plan design is uniformity and we were to be faced with this wide range of state benefit plan mandates, we would be left with an approach leading to a benefit program that satisfied the lowest common denominator.

Impact of Federal Mandates

What are some of the federal mandates? I do not know that it is taking too much of a liberty to use the word "mandate" to refer to some of the recent legislation that we have seen; but in a sense, we do face some mandates with respect to pension plans. For instance, there are various minimum standards applicable to vesting and other kinds of restrictions, such as those affecting integration.

In the medical plan area, we have seen other examples of what could be referred to as mandates. An example is the shifting by Medicare of the cost of health care to employers for those employees and dependents of covered employees who are over age 65 and also for the disabled dependents of covered employees.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is another type of mandate that we are now facing. In fact, at JCPenney COBRA became effective on January 1, 1987. Here are some numbers on what the impact has been thus far. Since the law is relatively new, we do not have good numbers on the claims cost because of the claims lag.

In any case, thus far we have had approximately 100 people enroll in COBRA coverage each month. Just to give you an idea of what that represents, it is believed to be about 5 to 10 percent of those people who have had a qualifying event.* However, we do not have

*Editor's note: A "qualifying event" under COBRA is an event, such as termination of employment or divorce from a covered employee, that causes the individual or family to be eligible for continuation coverage.

a lot of statistics on how many qualifying events there are—for instance, how many divorces or how many children attain majority status.

A more recent type of mandate that employers have not yet had to deal with but soon will is the mandate, using that term loosely, that we face with the Tax Reform Act (TRA). TRA includes a welfare plan nondiscrimination test to which employers will be subject.* [If a plan fails to satisfy the nondiscrimination test, then the discriminatory portion of the health benefit is taxable to the highly compensated employees.] One objective of this legislation, of course, is to broaden the base of coverage, which is to be done through this testing.

There is little chance, however, that the objective of broadening the coverage will be met because there are alternatives to complying with the nondiscrimination test. One easy way, of course, is to attribute the imputed income to the highly compensated group. Another way is simply to take the highly compensated group out of the tax-advantaged health care coverage or welfare plan coverage.

Therefore, it is ironic that coverage may, in fact, diminish; and this may greatly exacerbate the demand for a federal mandate. So the objective of broadening coverage may, in fact, lead to an outcry for more mandates. One other irony is that the mandates referred to earlier—COBRA, Medicare becoming the secondary payer, and tax reform—are directed at employers who are already providing coverage; and, of course, the legislation makes it more difficult to administer the plans and more costly for those employers that do provide coverage.

The JCPenney medical plans require participant contributions. Chart VIII.1 illustrates how many people elect to participate in company-offered medical coverage, broken out by the option that they elect. About 30 percent of employees who elect to participate in company-provided coverage choose an HMO for that coverage (19.3 percent of *all* eligible employees).

We offer two medical plan options—but for reasons under study now—36 percent of those eligible elect not to participate in company-provided health care coverage.

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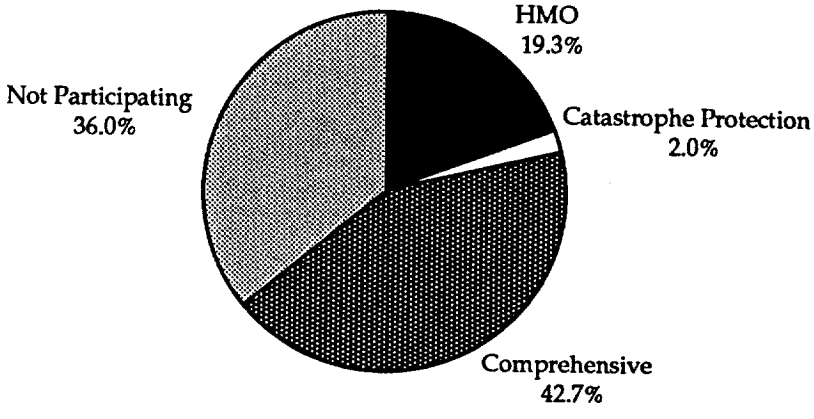
*Editor's note: The Tax Reform Act of 1986 (TRA) establishes comprehensive nondiscrimination rules for certain statutory employee benefit plans. For an explanation of the new rules, see Employee Benefit Research Institute, "Tax Reform and Employee Benefits," *EBRI Issue Brief* 59 (October 1986).

CHART VIII.1
Participation of Eligible Associates in Company-Offered Medical Plans

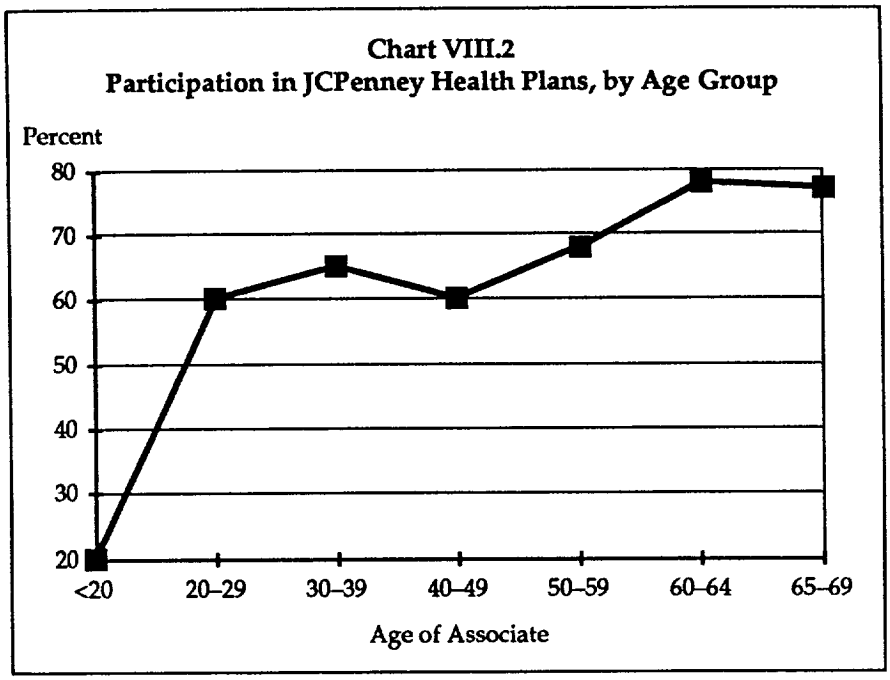


Participation by Age and Hours

Let's look at those numbers a little bit differently and look at the participation by age group (chart VIII.2). As one would imagine, there is a correlation between the age of the individual and the decision to elect health care coverage. It is difficult to guess what causes the dip at ages 40 to 49, but one possible explanation is that many of these associates have coverage provided through their spouses.

Chart VIII.3 shows participation by hours scheduled. It shows that, as one becomes a "full-time" employee, he or she is more likely to elect health care coverage. In fact, if JCPenney were to offer coverage only to people who work 35 to 40 hours a week, we would exclude about 45 percent of those currently eligible. So we are talking huge numbers and huge dollars, but the quandry that we will now face with the welfare discrimination test is that as you get to the lower end of hours scheduled, people are less likely to participate. That is going to be a real obstacle when we face the welfare plan discrimination test.

Chart VIII.4 shows participation by hours scheduled, broken down by marital status. At the 20-hour range, single people are expected to be more likely to participate, although only a small percentage of



that group participates. Many of the married individuals may well be participating in coverage provided through another employer.

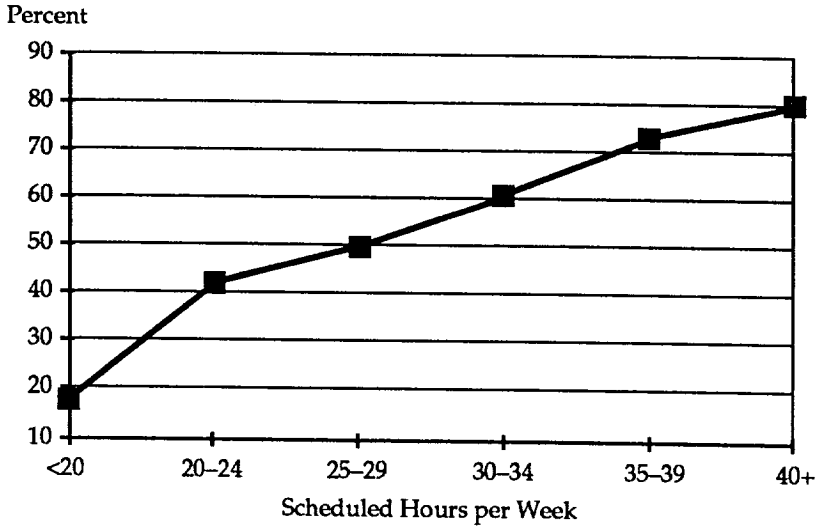
As the hours scheduled increase, singles who are usually relying upon themselves for coverage are more likely to elect to participate in plan coverage.

The company cost of health care coverage per hour for an employee who works 20 hours a week is extremely significant. Obviously, it is double that of a 40-hour-a-week person. But in terms of people who work at or near the minimum wage in particular, it would not be unusual for the value of medical coverage for a person who is covering his or her family to be in the range of $1.25 to $2.00 or even more per hour for that individual.

Mandated Benefits and Competitive Position

Mandates could be viewed as being minimum wage increases, whether they are health care or pension mandates. Employers with benefit plans can attract and retain employees when they provide more generous benefit plan coverage.

CHART VIII.3
Participation in JCPenney Health Plans, by Hours Scheduled

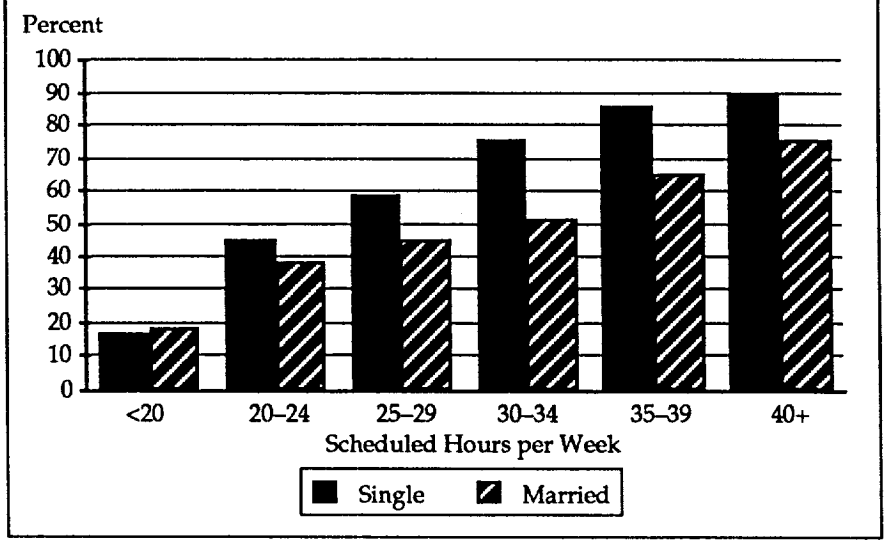


We are able to attract someone at $4.50 an hour from the retailer who is across the street because we offer a full gamut of benefit plan coverage. To the extent that all employers have the same benefit coverage, the ability to compete for employees is reduced to the wage that the person is paid, and even General Motors would be faced with that. I do not know what their average hourly wage is, but whatever it is, it might very well have had to be greater if it were not for the fact that General Motors provides its employees, for the most part, with almost a cradle-to-grave kind of benefit plan protection.

What are the options that employers would be faced with, if they had to deal with mandated benefits? Obviously, payroll costs would go up. There are limited choices. You can reduce or eliminate other plans. You can reduce wages, but to the extent that wages are at or near the minimum wage, that is not much of an option.

You lose the ability to provide wage incentives. To the extent that you increase the base or the total cost of wages, indirect though they may be in benefits, you have a reduced amount of resources you can allocate through the hourly wage as incentives for people to be more productive.

CHART VIII.4
Participation in JCPenney Health Plans, by Hours Scheduled and Marital Status



Additionally, as mandates increase prices, both domestic and foreign competition are obviously affected. Another alternative is to reduce the number of employees, particularly the number of people who are part-time employees.

There is a "mandate" applicable to employers who have pension plans—employees must be considered eligible to participate in the plan if they work at least 1,000 hours a year. With this pension "mandate" or minimum eligibility standard, pension benefits are income-related. They are largely a function of the average hourly wage times the number of hours a person works.

Therefore, there is a relationship between pension benefits and hours worked. For those people who work few hours or get paid relatively low wages, the pension benefit is directly related to those factors. But with medical benefits, there is no similar relationship. And the welfare plan nondiscrimination test requires employers to include employees who work 17.5 hours a week.

Health care costs are already a major cost. Retiree health care costs have only very recently received significant attention. With respect to health care costs, we are dealing with a system that is rapidly changing. Alternative delivery systems such as PPOs (preferred pro-

vider organizations)* are going through a dramatic evolutionary process. Were we to pick and choose a type of mandate, this might in fact lock in existing programs to the detriment of what might evolve to a better and more efficient system, which I think is what we all seek.

The partnership between employer-provided programs and social welfare programs leaves some gaps. How we cover those gaps and who should pay are the big questions. Mandated benefits through employers are essentially a tax on employment.

For mandated benefits to become a legislative reality, proponents need to demonstrate both that (1) the mandate addresses a genuine problem, and (2) the initiative builds on existing programs in important ways. Another requirement should be that any proposed initiative must not create more problems that it solves. The burden of proof ought to be shifted—as it has been in certain respects with the state legislation that we have talked about—to those proponents of new systems that try to fill the gaps.

Policy Forum Discussion

Opting Against Coverage

MR. HUNT: On chart VIII.1 where you showed 36 percent of employees not participating in your health plans, I would assume that group would be part of the millions that everybody talks about who are not covered, and yet it is not a sin that you are not covering them. These are people who have decided not to participate in your plans.

Is this not good evidence that the statistic about millions without health insurance coverage is misleading? I assume that you are not unlike other major employers in that regard. Do these figures not destroy the argument that most of the American workers who are not covered by health insurance work for small firms because, theoretically, 36 percent of JCPenney's employment would be representative of thousands of small employers?

MR. REPKO: What needs to be taken into account, when you look at the 36 percent, is that there is reason to believe a large percentage of those people have other coverage available to them and, therefore, elect not to participate. Of course, the welfare discrimination tests are going to force us to determine who are the "haves" and who are

*Editor's note: Preferred provider organizations are agreements between health care providers and third-party payers to provide fee-for-service health care at a discount.

the "have nots" in that kind of equation. But taking as a given, that you are not going to exclude all 36 percent, what do you do about the remaining population of people who are at the younger ages and believe they are immortal and elect, therefore, not to purchase health care coverage?

MR. SALISBURY: There is a subset issue that I would throw out, though. What you find when you look underneath the statistics on employee health care coverage is that a significant percentage of those without coverage turn out to be the children of adults who are employed and have coverage. We are talking about many, many millions of very young children and a lot of cases where spouses are not covered in addition to children not being covered, even though the primary worker is covered. Many of the 36 percent at JCPenney have coverage from someone else's plan. But the people who choose not to buy coverage do not have well-baby care as a result even if well-baby care is a standard feature of the employer's plan. The details on who make up that 36 million are rather telling, in terms of some of the subissues.

MR. REPKO: One other observation. One of the things that we have done in our plan design was to allow a catastrophic protection option. The percentage of participation is very, very small. The plan has a $1,750 deductible. It pays nothing up to that point, and then once you get to that point with out-of-pocket expenses, it pays for everything. It is offered at a relatively low cost, and the message is: "Look, you ought not to be self-insured the full way." It gets back to the basic concept of insurance, protection when protection is needed most. And it really is something that is trying to get to those people who say: "Gee, I never meet the deductible." We are saying, you ought to have some kind of protection.

MR. HUNT: That is the 2 percent on chart VIII.1. Would you think that is an accurate indicator if that kind of coverage were offered by the federal government—that only 2 percent would be interested?

MR. REPKO: No. I would not make that kind of projection. I do not know what that is. I can not give you any easy answers on why such a small percentage of the employees participate in that option, except to say that those people who think they are immortal do not ever think they are going to get to the $1,750 amount, and figure that since they get $10 extra a month in their pocket, they are going to save by not electing that option.

MR. MIKKELSEN: How heavily contributory is your plan?

MR. REPKO: The ratio is 75:25. Twenty-five percent of the contributions are paid for by our associates. So for single coverage, it is about $20 a month for medical and dental coverage.

MR. MIKKELSEN: Is that on a pretax or post-tax basis?

MR. REPKO: We offer the option on a before or after-tax basis, under section 125 of the IRC (Internal Revenue Code).

Passing the Welfare Plan Nondiscrimination Test

MR. MIKKELSEN: As it stands now, is JCPenney going to be able to pass the proposed welfare plan nondiscrimination test?

MR. REPKO: No. It is a question of how badly we will fail. It really is not a question of being able to pass. The way it is currently written, as we understand it, we will fail miserably.

MR. SALISBURY: What do you view as your option as an employer to deal with the fact that you will have failed the test?

MR. REPKO: The imputed income appears to be the most readily available option. The other option I alluded to is certainly worth considering, which is just taking the highly compensated group out of the plan. One of the worst things that we could do as a result of tax reform is to take the highly compensated group out of the same plan that everybody else is in.

It is very desirable to have our chairman and senior officers in the same plan that everyone else in the company is in, and to the extent you have a piece of legislation driving out this kind of coverage and putting them in a separate kind of coverage—granted, it would not be tax advantaged—you have lost a great deal, in my opinion.

MR. SALISBURY: So what you are really saying is that the two most likely optional approaches—one being imputed income, the other being to simply pull the highly compensated group out of the plan—neither one of them has anything to do with expanding the number of people who are not now participating in the plan.

MR. REPKO: That is correct.

MR. SALISBURY: And your second comment means that you fear what potentially could happen to the balance of the plan if you pull out the highly compensated group?

MR. REPKO: That is correct. Not so much for the JCPenney company, but I would say for other companies as well that would lose this same fraternity of membership plan design.

MR. MIKKELSEN: Many plan sponsors with whom I have discussed the impact of the nondiscrimination tests are concluding, as am I, that maybe the course of least resistance is to simply impute taxable income to the highly paid individual and then increase their salary to compensate for it. If we assume that most of corporate America does just that, how long will it be before Congress and the regulators cry foul and argue that this is not in keeping with the intent of the legislation?

MR. HUNT: The IRS (Internal Revenue Service) is tentatively planning to have what I think they are calling an "easy out" option so that it will be easy for you to simply pay the tax if you fail or know you will fail the nondiscrimination tests. They recognize that it is just an unworkable kind of test for an awful lot of people. So the regulation writers right now are working on that option. They can salve their conscience because they will be collecting the money, which is really all the IRS cares about.

That does not answer the question that you are asking Congress. But the regulators—at least the IRS—are expected to come out with an easy-out option. What you are saying could still happen.

MR. SALISBURY: A working group on the Hill of 20 or 30 staffers has been meeting for months with a large number of private-sector people. That group supposedly has been moving in the direction of proposals for mandating minimum standards on employers who have health programs. The proposal they may eventually draft would, as well as the Kennedy proposal, require employers who currently do not offer health insurance to provide some level of health insurance, even if it is on a copay basis. The lawmakers might view themselves in a win/win situation if in the next five years they were to enact this proposal. If you pull out the highly paid or impute income to them, the government gets the additional tax revenue. But Congress has also insured that the nonhighly compensated employees end up getting a benefit that Congress views as an adequate benefit on a mandated basis.

If the private sector response to the health and welfare nondiscrimination rules is to pull out the highly paid from the active worker plan and simply impute income to them, would Congress view that as foul and try to find a way to force those people back into the plan?

MS. PHILLIPS: You mean, would the imputation be considered a tax increase?

MR. SALISBURY: No. Would it be viewed as not expanding coverage of the plan and contrary to the implied intent of the welfare plan nondiscrimination standards? One has to assume that Congress put such standards in because it wanted more people covered, not less. If the way around those rules is simply to take the penalty of pulling out the highly paid and imputing taxable income, would Congress try to counteract that move, or would Congress just be happy the government has the additional tax revenue and not worry about the coverage issue?

MS. PHILLIPS: From the budget point of view, they probably could take the money and run. They could say that it is something they have to get back to soon, but maybe not this particular year.

Collecting Taxes or Broadening Coverage?

MR. GARBER: You have to remember the discussion that went on over the tax reform bill. There were assumptions of a significant amount of revenue in the process, and so they assumed they were going to catch some people. The only way they are going to catch them is if there are plans that do not qualify. These are the tax-writing committees. They were concerned that nontaxable health benefits be nondiscriminatory. If they were discriminatory, then somebody could be paying some tax. They really were not getting to the issue of how to cover the 37 million people with much more narrowly based tax considerations. So if they collect some taxes, that is what would be expected.

MR. HUNT: The people who were writing the regulations were just as glad to have that easy-out option as anybody else. They were not at the Treasury policymaking level. Suddenly they realized that there was no way the nondiscrimination test was going to work. They asked themselves: "How are we going to apply this in all the different kinds of circumstances that we are discovering exist. For instance, like testing the corporate family: What is the protocol? Does the subsidiary tell the parent that it wants to be done separately, or do you do them together. These are all different sorts of permutations that can happen. The regulation writers were thrown for a loop.

They were just as happy to get a reprieve, for lack of a better word, and they could salve their conscience with the extra revenue. That does not mean this was an official policy, that they were delighted

to be getting the extra money and that would keep them happy forever.

MR. FEINSTEIN: What was driving the nondiscrimination provisions was the problem of a tax subsidy in a discriminatory context. It really was not directed at solving the coverage problem, although there were some that thought that perhaps it would help somewhat in that area. What is driving Congress to look at the coverage problem goes way beyond that provision.

MR. REPKO: If you follow the approach that you are going to take the highly compensated group out and maybe take the extra step of increasing income, of course, there is going to be a cost associated with having done that. One of the alternatives that would find the revenues to pay for that is to reduce the level of coverage; because once you have taken out the highly compensated group, you can discriminate to your heart's content.

So we can raise the bar from 20 hours to 25 hours to fund the cost for providing the increased income cost to the highly compensated group. I am not saying this is going to be done, but it can be done. You can paint a scenario that the cost is neutral to the employer, but certainly you have not achieved a broadening of the coverage. In fact, you will reduce the base of coverage. It is a perverse kind of result that is quite possible.

MS. ALTMAN: What we are talking about in this discussion is the exact tension in having a voluntary system. It pushes us toward mandated benefits. The idea of tax incentives is to ensure that everyone is covered, and yet as the government imposes more and more onerous requirements, fewer and fewer participate. Then you switch from an incentive system to a mandated system. So it is a tension.

MR. TOMLINSON: Dave Repko is absolutely accurate. If you take upper management out of the plans, they do not have any interest in the plans anymore other than as an expense to the corporation. If upper management participates in the plan they have an interest in it based on their own self-interest. When you start cutting them out, you are going to have all kinds of other changes happen. Also with this issue, there are always different ways to play the game and to beat the system.

MS. LEWIN: I was intrigued that JCPenney extends health care coverage to part-time employees. What is the nature and extent of that

benefit package? How little do they have to work in order to be eligible for health care coverage?

MR. REPKO: In order to qualify for coverage, one has to work 3 months and have 260 hours in that period. Having achieved that initial eligibility, in order to maintain eligibility you need to have 200 hours in a 13-week period. So it is really below the 17.5-hour limit of the welfare plan nondiscrimination rules.

It is a comprehensive option. The deductible is $250. The copayment is 85:15 up to a stop-loss of $2,500 per individual or $5,000 per family. A point worth emphasizing is that it is the same coverage for a person who works a 20 hour week as for the chairman of the board. No different coverage. We also offer options, a catastrophic protection option, and 220 HMOs, which in most respects cost a little bit more. But for those people who elect to have virtually no out-of-pocket expenses, HMOs are tantamount to our high-option plan.

So those are the range of health care coverages, and the dental coverage as well, which is a $60 deductible on 80:20.

MR. HUNT: What approximate percentage of your work force work 20 to 25 hours a week, and what is the theory behind providing coverage for that segment of your work force?

MR. REPKO: Out of the 140,000 associates who are eligible for coverage, 55 percent work 35 to 40 hours. Thirty-five hours is tantamount to a full-time work week. Therefore, 45 percent work between 20 and 34 hours.

Making the election to provide that kind of coverage gives us maximum flexibility in scheduling individuals to work schedules that are less than 35 hours a week. The demands of our business go up and down from season to season. The big peak is obviously the holiday season. We also peak at back-to-school, even Easter and a few other times during the course of the year. So we have maximum flexibility in scheduling individuals who do not have at issue loss of health care coverage. Therefore, it gives us a competitive advantage in attracting and retaining individuals as opposed to them going to the competitor and working for that company.

They get their full benefit coverage, and they are not as concerned when their hours in one particular period go from 34 to 28, because they do not have at issue health care and benefit plan coverage or the loss of those coverages.

PART THREE
STATE MANDATED BENEFITS

State governments are already familiar with the issue of mandated benefits, particularly for health insurance coverage. Every state in recent years has enacted legislation requiring either that specific diseases or treatments be covered or that specific health care providers be allowed to receive reimbursement.

State mandates have not extended, however, to businesses that self-fund their health insurance plans because of federal preemption under the Employee Retirement Income Security Act. As the number of mandates increase, it appears that more employers self-fund. The trend toward self-insuring is particularly evident in medium to large companies. Seventy percent of employers with a work force from 10,000 to 19,999 employees maintain self-insured health plans; as do 85 percent of employers with more than 40,000 employees.

At the state level, about 645 mandated health care provisions are in effect today, a majority of which have been enacted since 1980. However, proposals for mandates are now facing tougher scrutiny in state legislatures. The year 1986 saw the fewest number of state-enacted mandates (26) since 1972.

Part Three provides a review of state activity pertaining to mandated benefits. Greg Scandlen explains in chapter IX why mandated benefits suddenly have become a major concern in the business community. In an article that appeared in the June 1987 EBRI *Employee Benefit Notes,* Scandlen points to two major developments that have led to the current focus on the issue: the June 1985 Supreme Court decision in *Metropolitan Life Insurance Company v. the Commonwealth of Massachusetts,* which had the effect of leaving insured health plans still subject to state mandates; and the enactment of the 1985 Consolidated Omnibus Budget Reconciliation Act, which required continuation of health care coverage for terminated workers and dependents whether they are covered by self-funded or insured plans.

Scandlen describes four categories of mandated coverage laws: benefits, provider, continuation/conversion, and dependents. Since the expansion of all four categories must increase costs, Scandlen argues, the question that must be answered is whether the social need justifies the potential cost. Since state legislatures are increasingly asking that

question, Scandlen predicts that future proposals for mandates at the state level are less likely to be enacted.

In chapter X, Linda L. Lanam describes the types of mandates that states have recently adopted, noting as an example that 45 states now require newborn care to be included in both group and individual health insurance policies.

Pressures for mandates are difficult for state legislators to resist, Lanam says, partially because interest groups try to portray the proposed benefits as having little cost or even as helping to reduce costs. Lanam contends, however, that increasing the number of benefits available for reimbursement cannot help reduce total health care costs unless the new benefits are a substitute for other benefits.

State cost-containment efforts are leading, Lanam adds, to efforts to evaluate new mandated-benefit proposals more cautiously.

Next, we turn in chapter XI to an examination of a 1984 law enacted in the state of Washington that requires a review process before passage of mandated third-party benefits. A senior staff member of a Washington State legislative committee, John B. Welsh, Jr., explains the state law, which requires an assessment of the social and financial impacts of the proposed coverage on the basis of 12 guidelines or questions. A mandated coverage proposal must also be analyzed by a State Health Coordinating Council. Such a review, Welsh suggests, puts the burden of proof on those proposing the mandated coverage.

The legislature and a governor's task force recommended the legislation, Welsh explains, because they saw that interest groups would continue to petition for additional mandates, and those mandates could increase rather than help control health care costs. Although the requirement for the State Health Coordinating Council review was added to the law in 1987 and is not yet in effect, Welsh says that since 1983 groups proposing mandated benefits have had difficulty justifying the recommendations to the legislature.

IX. The Changing Environment of Mandated Benefits*

PAPER BY GREG SCANDLEN

Over the past year there has been a meteoric rise in concern by employer and business organizations over the topic of mandated employer-paid health benefits.

- The Employee Benefit Research Institute (EBRI) in late 1985 began planning for a day-long policy forum on mandated benefits held in April 1987.
- The White House Conference on Small Business has named elimination of mandated benefits as the second most important priority out of 60 recommendations sent to the president in November 1986.
- The National Association of Manufacturers, in conjunction with the Washington Business Group on Health, made mandated benefits a primary topic at their third annual Health Agenda Conference in January 1987.
- The National Chamber Foundation commissioned a major study for 1987 of mandated benefits and mental health and substance abuse benefits.
- The National Federation of Independent Business has become increasingly concerned about mandates, devoting most of one newsletter edition to it and lobbying vigorously against certain mandated proposals.

Two events have sparked this sudden increase of interest over an issue that has existed for over 20 years.

Supreme Court Decision

First was the U.S. Supreme Court Decision *Metropolitan Life Insurance Company v. the Commonwealth of Massachusetts*, June 3, 1985. This decision dashed the hopes of many in the business community that the Employee Retirement Income Security Act meant what it said when it preempted state laws relating to employee benefits plans—that the content of such a plan could not be regulated by the states. Unfortunately for those in the business community, the Court placed more emphasis on the "saving clause" which allowed the states to continue to regulate insurance, while prohibiting them from regu-

* Editor's note: The following article appeared in the June 1987 *Employee Benefit Notes*.

lating employee benefits plans. The upshot of this decision is that insured health benefits would remain subject to state mandates, while self-funded health benefits would not.

Enactment of COBRA

The second event was enactment of the Consolidated Omnibus Budget Reconciliation Act (COBRA) in 1985, with its federal continuation-of-coverage mandate. Unlike previous state mandates on the same topic, the federal mandate made no exception for self-funded health benefits, but included all health programs. Buried in a congressional omnibus budget bill [now P.L. 99-272], this provision did not cause a great stir until after it became law and employers were faced with first trying to understand it, and then with trying to comply with it. Employers demanded to know how this was allowed to happen. And their Washington representatives have answered: "Never again."

It is ironic that this heightened awareness is coming at a time when the popularity of mandating health insurance benefits appears to be tapering off at the state level. In fact, in 1986, there were fewer mandate laws enacted by the states (26) than any year since 1972, when only six were enacted. Several states have passed legislation to require that mandating proposals be subject to an objective evaluation. It remains to be seen how effective these evaluations, based on the social and financial impact of the new benefits, will be. But the fact that they have become law indicates a new skepticism on the part of state legislatures.

Categories of Mandated Benefit Laws

Mandated coverage laws fall into four categories roughly equivalent to "who, what, when, and where." These may be explained as follows:

Benefits (what)—These mandates expand the kind of services covered under a health insurance contract. Examples would be alcoholism treatment or in vitro fertilization.

Provider (where)—These expand the numbers and types of providers eligible to perform and be reimbursed for the covered services. Examples are requirements that birthing centers be covered as are hospital maternity units, or that social workers be reimbursed for covered services that are within the scope of their license.

Continuation/Conversion (when)—These expand the length of time the coverage will be in effect. Like COBRA, these may require that a

worker may continue participating in the group contract for a certain period after termination.

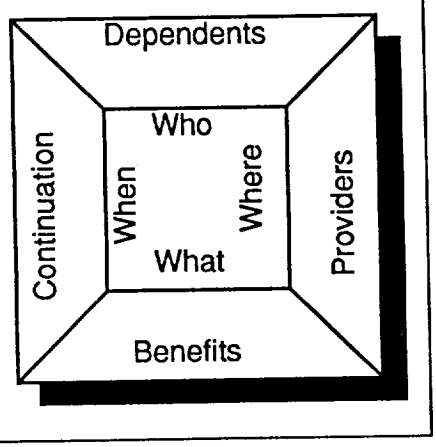
Dependents (who)—Not always applicable to actual dependents, these mandates expand the numbers of people to be covered under a contract. Typically, these may be applied to handicapped children upon reaching the age of majority or to adopted children and newborns.

Like a square balloon (chart IX.1), these four kinds of mandates result in an exponential enlargement of the exposure to risk for a health insurance contract.

The actual increase in claims cost is the subject of vitriolic debate. Insurance companies and employer groups maintain the costs of mandates are high and getting higher. Providers and advocates for certain disease victims argue that the costs are not high, and that in any event, the money spent on one service is offset by eventual savings in the cost of traditional services.

Whatever the actual cost in terms of claims submitted, there can be little doubt that if one expands the services covered, *and* the number of people providing the services, *and* the number of people receiving the services, *and* the length of time in which they are eligible to receive them, the exposure to cost increases *must* be large.

CHART IX.1
The Square Balloon of Mandated Coverage Laws



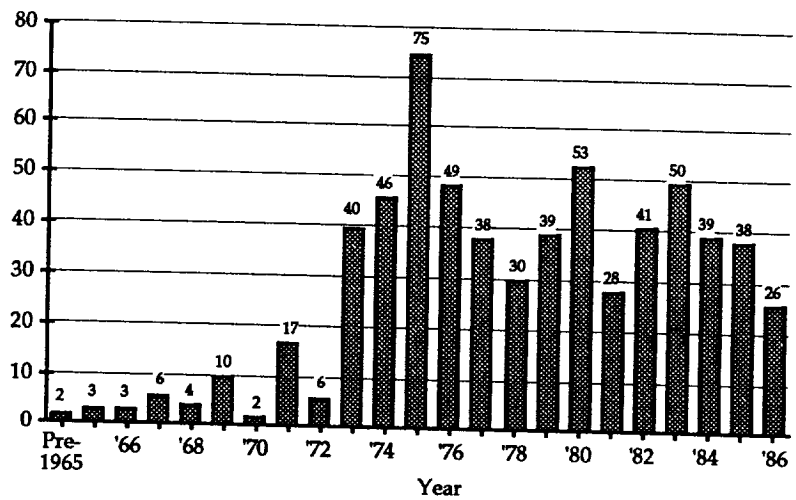
Social Need Versus Potential Cost

The argument then becomes a question of whether the social need justifies the potential cost—precisely the question that increasing numbers of state legislatures are asking. Indeed, the most recent trends with respect to mandates in the states, have been a slowing down of further enactments, and interest in developing objective criteria to measure the social and financial impact of new mandates.

Chart IX.2 illustrates the number of mandates enacted by all the states for each year since 1965. Prior to 1965, only two such laws existed. 1975 was the peak year, with 75 mandated coverage laws being enacted in that year alone. In 1986, only 26 new laws were enacted—fewer than any year since 1972.

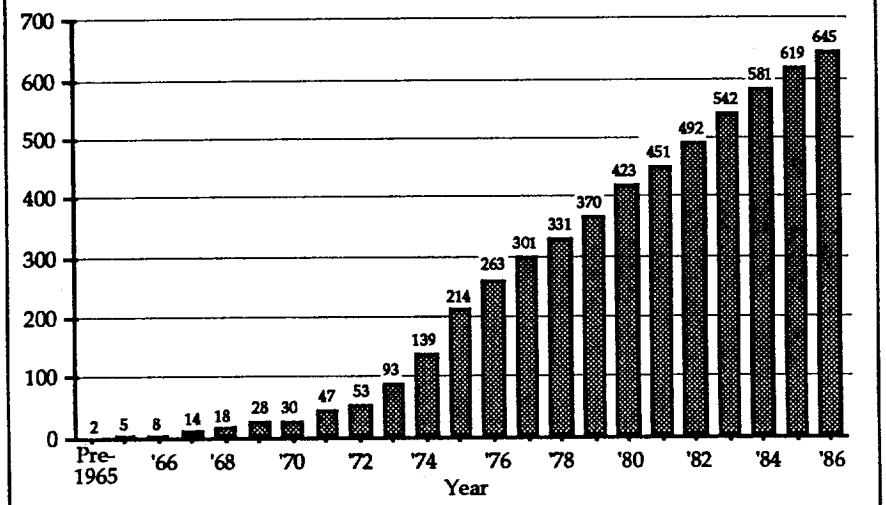
The chart is remarkably similar to the traditional product life cycle as taught in basic marketing courses. There is an introduction period (1965–1970) in which the product is just becoming known; a market acceptance period (1971–1975) characterized by a large growth in "sales;" a maturity period (1976–1983) in which sales level off; and a period of decline (1984–1986) in which the market has become saturated and new customers are hard to find. This type of cycle

CHART IX.2
Number of Health Mandates Enacted by 50 States Each Year Since 1965



Source: Blue Cross and Blue Shield Association

CHART IX.3
Cumulative Number of Health Mandates Enacted by 50 States Each Year Since 1965



Source: Blue Cross and Blue Shield Association

applies to everything from Hula Hoops and Wacky Wall Walkers to video cassette recorders and compact discs. Unfortunately, unlike Wacky Wall Walkers, when the "customers" become bored with these products (state mandates) they cannot toss them in the back of the closet. They are laws and continue as laws until they are repealed. Thus we get a situation like that demonstrated in chart IX.3, which shows the aggregate number of mandating laws throughout the country. The total has climbed from two prior to 1965 to 645 at the end of 1986.

It remains to be seen whether the decline in mandates will continue. It is possible there could be a resurgence as there has been in other years. In fact, during 1987 there have been as many or more mandate bills introduced as other years. The 70th session of the Texas legislature, for instance, is considering 36 separate pieces of legislation mandating some form of expanded coverage on employer-based health insurance.

There are numerous reasons, however, for believing these bills will not be successful.

The Future of State Mandated Benefit Proposals

- States appear to be less enamored of mandates than they used to be. One indicator is the decreasing numbers of laws enacted for three years in a row. More significant, however, may be the "mandate evaluation" laws enacted in six states and being considered by several others. These laws were inspired by criteria developed by the NAIC [National Association of Insurance Commissioners] in 1983 and recommended for adoption by state legislators and insurance commissioners. To date, Hawaii, Florida, Washington, Oregon, Arizona, and Pennsylvania have enacted some form of the criteria, which amount to a social and financial impact statement.

- The growth in self-funding and the concomitant escape from state regulation has made mandating benefits ever less effective in securing services for the general population. A recent Johnson & Higgins Health Group survey of more than 1,300 employers reported 46 percent were self-funding their health benefits (Johnson & Higgins. *Corporate Health Care Benefits Survey.* Princeton, New Jersey: Johnson & Higgins HealthGroup, 1986). The larger the group, the more likely they were to self fund. Seventy percent of the employers with 10,000–19,999 employees self-funded, as did 85 percent of those with more than 40,000 employees. [Nationally, 42 percent of health plan participants in medium and large establishments had all or part of their plans self-funded by their employers. See November 1986 *EBRI Issue Brief*]. Given the usual variation between states, there may be some states in which 70–75 percent of the population escapes mandated coverages. Thus, even the most desirable of mandates may have very little effect.

- Recognizing the diminished effect of state-level mandates and increasing resistance from state legislators, provider groups have begun turning to Congress to achieve their purposes. Congressional action has the very attractive advantage of one-stop shopping for lobbying new mandates. Not only will one law affect all 50 states, but one law will also cover all employer health plans, not just insured ones. Congress has a traditional reluctance to tamper with insurance issues, but like state legislators, members of Congress may be drawn to the possibility of achieving some social good without spending any taxpayer money. Mandates make that easy. If substance abuse is a national problem, congress can require that all employers provide benefits for the treatment of substance abuse. A noble purpose is served, without spending a penny of direct federal revenues.

Proponents of mandates like this approach so much that some have begun to believe they are wasting time attempting to enact mandates at the state level. This may be particularly true of certain patient advocacy organizations with limited budgets and national constituencies.

- The fourth reason state mandates are less likely to become law is the sudden interest by employers. The COBRA continuation law shocked employer organizations into heeding the threat posed by mandates, both to those still insured (at the state level) and to all employers providing health benefits (at the federal level). Suddenly, like minimum wage increases and unemployment compensation hikes, mandates have become a red flag for all employers. Business coalitions have been developing a marketplace model for health care throughout the country, and "let the market decide" is a slogan easily applied to mandates as well as to hospital rate-setting or cumbersome health planning regulations.

The primary arena for discussion of mandates has clearly shifted from the state to the federal level. It remains to be seen whether Congress will heed the lessons learned at the state level—that mandates never end. Once one is enacted, other provider groups are encouraged to seek more. Possibly the product life cycle will be replicated by Congress, until they, too, become saturated and decide to evaluate these proposals objectively. Meanwhile, however, employer and business groups are on the alert and will strive to dissuade Congress from continuing very far along this path.

X. Mandated Benefits—Who Is Protected?

PAPER BY LINDA L. LANAM

More than 600 state-mandated health benefits statutes exist today in various combinations across the 50 states, over 350 of them enacted since 1980. Every state has at least one mandated benefit and hundreds of new proposals are introduced in state legislatures each session. And yet, more than 30 years after the first one was enacted in Massachusetts, mandated benefits remain something of a mystery.

Proponents of mandates (whether of coverage to be provided or providers to be reimbursed) argue that they:

1. assure the general availability of at least a minimum level of health benefits to the insured population; and
2. encourage the inclusion of lower-cost health care providers within the health care delivery system.

Opponents of mandates contend that such statutes:

1. increase the overall cost of the health care system; and
2. encourage the growth of self-funded (and unregulated) health benefit programs.

Despite decades of debating, neither side has been particularly successful in substantiating their claims with any generally accepted data. As a result, much of this paper must be based on what are, hopefully, logical deductions rather than on desirable but unavailable statistical studies or other documentation of what purposes mandated benefits actually serve or what costs they really involve.

Political and Philosophical Problem for State Legislators

One thing that is relatively easily understood is why mandated benefits are so difficult to defeat in the legislative arena. Mandated benefits pose both a political and a philosophical problem for many state legislators. The purported goals of the supporters of each and every mandate appear to be in the public interest. The advocates, usually locally based, are increasingly well-organized and prepared for dealing with the technical aspects of the legislative process. The opponents are generally insurers, employers, and doctors—in other

words, "the establishment." They often lack a true state base or adequate local staff and time for consistent lobbying.

The proponents generally represent a single-issue group who may be prepared to promise or withhold votes on election day based on that issue. The opponents generally have a number of concerns that may be considered by the legislature in any one session and cannot deliver a significant voting block based on any one of them.

However, perhaps the biggest single force behind enactment of many of the state mandated benefits laws in existence today (and the federal ones tomorrow) is the perception that there is little or no cost connected to them. In the beginning, in fact, that was almost true. In the 1950s and 1960s as the economy grew, so did employee wage and benefit packages. No one individual increment was sufficient in and of itself to be a cause for alarm and so legislators (and labor negotiators) were lulled into a state of almost blissful ignorance. Mandated benefits were seen by many as a means to assure that employees without union-negotiated contracts and persons purchasing individual health insurance policies could obtain similar coverage.

Coverage and Provider Reimbursement

The growth of mandates in those early years occurred in both the areas of coverage—newborn baby care for example—and provider reimbursement—chiropractors and psychologists in particular. Today 45 states require that newborn care be included in both group and individual health insurance policies, 34 require payment to psychologists, and 26 require that chiropractors be reimbursed for covered services. In addition, the current availability of benefits and providers now ranges from *in vitro* fertilization in Maryland to acupuncturists in California.

Perhaps original momentum at the state level came from social policy considerations and a desire for something close to a risk-free society. However, in the decades of the 1970s and 1980s two things occurred that had an indelible impact on the development status of mandated benefits and the people they were intended to protect: (1) the Employee Retirement Income Security Act (ERISA) became law, and (2) the seemingly unending upward spiral of health care costs began to be recognized.

ERISA, enacted in 1974 as the culmination of an effort began under President John F. Kennedy to provide some form of comprehensive protection for participants in employee benefits plans, is generally thought of as a pension law. However, it also contains provisions

specifically dealing with "welfare benefit plans." Among those provisions is section 514, which provides in part that "the provisions of this title . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . except . . . nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance . . ." The result of this rather convoluted preemption combined with an exemption from preemption was to create the framework for distinctly different regulatory approaches to insured and self-funded employee benefit plans.

Transfer or Spread the Risks?

As a general rule, employers can either transfer the risks involved in making benefit payments or retain the risks and spread them over a large group of employees. If the decision is to transfer the risks, the two principal techniques are the purchase of group insurance or the use of a prepaid service program. Under a group insurance contract, the economies of a large volume of insureds serve to decrease administrative costs and agent commissions so that the premium charged to the employer-policyholder is less than that for equivalent individual insurance. The most common prepaid service plan is the health maintenance organization (HMO). However, other alternative delivery systems are developing which, like HMOs, can offer significant advantages over the conventional fee for service programs from the standpoint of utilization control and quality of service.

Employers may choose not to transfer the risk of loss associated with employee benefit payments but to either retain the risk or self-insure it. The relatively narrow distinction between these two approaches relates to whether or not an actual claims reserve is established to fund the future payment of benefits. Most such employer-established plans are self-insured, often with some form of reinsurance or stop-loss coverage as additional protection.

The 1985 Supreme Court decision in *Metropolitan Life Insurance Co. and Travelers Insurance Co. vs. Massachusetts* served to reinforce the fact that states have the power and prerogative to regulate the contents of the group insurance policies through which many employee health benefit plans are provided. Self-funded benefit plans, even those that are the subject of stop-loss or reinsurance coverage, are subject only to regulation under ERISA and cannot be made subject to such state regulation as mandated benefits or participation in state risk pools or guaranty associations. This discrepancy in reg-

ulation alone creates some incentive for employers to fund their own benefit plans. An additional incentive to self-funding is that of the buzz phrase of the early 1980s: "health care cost containment."

Cost containment, in fact, has had a wide-ranging impact on both the health care delivery and reimbursement systems, in both the public and private sectors, and at both the state and federal level. The efforts to gain some control over rising health care costs, which have been attempted in recent years, necessitate a relatively high degree of flexibility in benefit design, reimbursement patterns, and delivery systems to achieve real long-term success. Mandated benefits, in effect, freeze into place a set of benefits that will require legislation to alter and that may not be appropriate to today's, let alone tomorrow's conditions. The legislative process can be stimulated by a variety of factors and can achieve a variety of results, but the ability to respond quickly and appropriately is not generally characteristic of the process and certainly cannot be depended upon.

Impact on Cost Containment Efforts

One effect of the public pressure brought to bear regarding cost containment has been to cause a growing number of state legislatures to evaluate new mandate proposals more cautiously. The states of Washington, Arizona, and Oregon, for example, have adopted requirements for social and financial impact studies on all proposed mandated coverages. The Virginia legislature even passed a resolution placing itself in general opposition to all mandates. These actions may have somewhat slowed their success, but advocates of mandates have also adapted to the new cost-conscious environment. Arguments presented on behalf of such provider groups as nurses, psychiatric social workers, and such benefits as substance abuse treatment are couched in terms of savings, if not in health care costs then in terms of lower absenteeism or greater productivity. Supporters claim that costs are minimal on a per person basis or that the services or providers will actually reduce overall costs.

As an aside, I would point out that the cost of any benefit relates to two factors: price and frequency of utilization. Only when benefits are substituted is there likely to be any real savings. Adding benefits without qualification only increases the universe eligible for reimbursement and does little or nothing to reduce total health care costs. This the is the dilemma that faces state legislators—limit access or increase costs.

Most recently, "catastrophic coverage" has become the primary focus of the discussion about health care. Yet it was the earliest mandates, maternity and newborn coverage, continuation and conversion privileges, which were those that came closest to meeting the "new" goal of assuring the availability of health benefits intended to protect beneficiaries from losses due to gaps in or complete lack of coverage. Current state efforts to deal with the uninsurable population are concentrated in the area of adopting risk pools for those who cannot otherwise obtain private insurance and are not eligible for Medicaid, rather than enacting or evaluating proposed mandated benefits in light of their impact on the availability of private insurance coverage for the uninsured population. However, pool coverage may provide a new area for experimentation with mandates since it requires the availability of a set benefit package. Here any increase in costs could have an even more devastating impact than in standard insurance products because of the vulnerable population involved.

Both sides of the debate on mandated benefits can be said to be motivated by concern for the public interest. But it must be recognized that the concept of public interest is anything but a static one. In fact, there may be more than one public and their interests may, at times, be in direct conflict.

XI. Legislative Review of Third-Party Mandated Benefits and Offerings in the State of Washington

PAPER BY JOHN B. WELSH, JR.

Introduction

In 1984, the legislature of the state of Washington passed a "sunrise" law for reviewing legislative proposals for mandating third-party benefits prior to their enactment. The new law was occasioned by the introduction of a growing number of bills that would require insurance carriers, including health care service contractors such as Blue Cross and Blue Shield, and health maintenance organizations (HMOs), to include in all accident and sickness policies sold in the state some form of specific benefit or coverage. The trend toward mandating benefits in the 1970s, continuing unabated to date in virtually every state of the nation, has resulted in growing concerns about the cost ramifications of these mandates as well as the social utility of the benefits themselves.

The philosopher Santayana said it is more important to have some of the questions than all of the answers. On the subject of mandated benefits, or coverages as they are termed here, we do not pretend to have either all of the questions or all of the answers.

But we do have one answer at least, and a number of questions for the perennial bills are being introduced yearly that seek to mandate health coverage, or offer health coverage, by virtue of law.

The recent law[1] requires every person or organization seeking sponsorship of a legislative proposal that would require a mandated benefit to submit a report to the legislative committees of reference, assessing both social and financial impacts of the coverage according to 12 enumerated criteria. The mandated coverage proposal is then referred by the legislative committee to the State Health Coordinating Council for an independent review, analysis, and recommendation. The State Health Coordinating Council is an advisory body composed of a majority of consumers whose mission is to develop a biennial

[1]RCW 48.42.060–080

state health plan for assessing needs and guiding budgetary expenditures in the health area.

The history of the legislation goes back to 1983 when the governor appointed a health cost containment task force that initiated the idea in its report to the governor and legislature, recommending that the legislature conduct a systematic review of any proposed mandated health coverage under specified guidelines to determine whether the benefit is in the public interest. The state presently has about 14 such mandates.

Effect of Insurance

By way of introduction, I would like to touch briefly on the effect health care insurance has on health care costs in general, of which mandated benefits are but a part.

Most families in the United States today have insurance, either through commercial insurers, HMOs, or health care service contractors (Blue Cross and Blue Shield). In the state of Washington, 80 percent of the population are covered by HMOs and "the Blues."

One often-cited reason for the increase in health care costs is the widespread reliance on insurance as a way of financing and prepaying health expenditures. About half of consumer health expenditures are paid through public and private insurance. There is general agreement that reliance on health insurance encourages the use of health services, and health insurance shields both patients and providers from the awareness of costs.

There are strong indications that the fee-for-service form of reimbursement, which is the most prominent system for reimbursing health providers, creates incentives for health practitioners to increase both the price and volume of services. It reimburses the provider for each service rendered: the more services that are provided, the higher the reimbursement. In addition, as insured patients are not paying the cost, they are not likely to question the number of services or the cost. On the contrary, they may prefer, even demand the maximum in available services. Consequently, the fee-for-service system has not encouraged efficiency or provided appropriate incentives to restrain increases in the costs of health care.

The health provider's role consists of a number of elements: technical, professional, and entrepreneurial. These elements vary between physicians and other practitioners depending on their practice setting, style, and associated economic incentives. Due to the significant control physicians and other health providers have over the medical

care process, and the lack of incentives inherent in the fee-for-service system for controlling the utilization of services, the entrepreneurial element has been a major factor in health cost inflation.

Physicians generate about 70 percent of all health care expenditures. The fees of physicians and other health providers make up 22 percent of the health care dollar and hospitals almost 50 percent.

Mandating coverage of health benefits provided by health insurers has exacerbated the problem, because these increased benefits will be reimbursed largely through fee-for-service, and control over their utilization is minimal. Copayments and deductibles may abate some of the problem, however, as the insured patient is at risk for some of the costs of care.

Rationale for Mandated Coverages

Constitutionally, the legislature may indeed interfere with contractual relationships with insurance carriers by mandating benefits consistent with its authority to regulate insurance. There never has been a successful legal challenge to these mandates, as courts will rely on legislative findings of what constitutes the best interests of public health, welfare, and safety. Beyond the question of whether lawmakers can interfere in the health insurance marketplace, there remains the open question of whether they should.

In consideration of the legislation, both the legislature and governor's task force were motivated to act principally for two reasons:

1) interest groups will continue to petition the legislature for additional mandates; and

2) these mandates may be cost inflating, rather than cost containing and provide little benefit to the public.

The factors that underlie the efforts to mandate are numerous and varied, but let me mention six principal reasons why we see mandated-coverage proposals:

1) Incomplete health insurance coverage—access to health insurance for a given condition may be difficult to find for a person with a special need.

2) Expanding definitions of health care and new services and treatments because of the new technology.

3) Anti-physician sentiment—physicians are the core of the health care delivery system, but the medical establishment is seen by many as too monopolistic and overpaid; and physicians are getting competition from other nonmainstream health providers.

4) Expansion of the number and types of health practitioners—there are today 142 separate health-related professions with 240 occupational job classifications.

5) Changing values and expectations of society—health care is increasingly considered a right these days without which those of "life, liberty, and the pursuit of happiness" could not exist.

6) Perceived discrimination against certain practitioners by the "established" professions, e.g., naturopaths, chiropractors, acupuncturists, midwives, and other nonmainstream professions.

There are generally three distinct types of mandated coverage proposals, depending on who is proposing them:

1) Those that are provider generated—this is by far the most numerous. Health provider groups want to get coverage to increase their clientele, to assure a steady flow of fees.

2) Those that provide coverage for a very limited number of people, e.g., reconstructive breast surgery resulting from mastectomies, newborn infants with congenital anomalies, etc.

3) Those that attempt to use insurance to address social problems as a means of increasing access of people to health care services, such as alcoholism and mental health benefits.

Problems

Despite the motives for mandating health coverages, there are a number of problems associated with these coverages. An Oregon study concluded that mandated coverages account for about 3 percent of total health care expenditures.[2] That is not insignificant, though, when we consider that health expenditures are fast approaching 12 percent of the gross national product, and are outstripping inflation threefold. In effect, however, cost impacts of different mandates do vary considerably. The largest fiscal impacts are those related to large-scale services: obstetrical care, newborn infant care, mental health, and alcoholism.

Coverage by insurance tends to increase utilization of particular services, as we have seen, and therefore the total cost of health care. In fact, the third-party reimbursement system is the biggest culprit of the health cost spiral: the patient is insulated from the true costs;

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[2]Oregon State Health Planning and Development Agency, *Mandated Health Insurance Benefits in Oregon.* March 1983.

and the provider is given an economic incentive to provide maximum services regardless of costs/benefit considerations in the fee-for-service reimbursement system.

In consideration of all these problems, the decision to legislatively impose a health insurance mandate therefore represents a complex policy judgment. A systematic review of all the ramifications of these proposals will assist the policymakers in determining whether the mandate is truly in the public interest.

Legislative Guidelines

There are a total of 12 guidelines or questions mentioned in the law, divided according to social and financial impacts, as follows.

The Social Impact

(a) To what extent is the treatment or service generally utilized by a significant portion of the population? (b) To what extent is the insurance coverage already generally available? (c) If coverage is not generally available, to what extent does the lack of coverage result in persons avoiding necessary health care treatments? (d) If the coverage is not generally available, to what extent does the lack of coverage result in unreasonable financial hardship? (e) What is the level of public demand for the treatment or services? (f) What is the level of public demand for insurance coverage of treatment or services? (g) What is the level of interest of collective bargaining agents in negotiating privately for inclusion of this coverage in group contracts?

The Financial Impact

(a) To what extent will the coverage increase or decrease the cost of treatment or service? (b) To what extent will the coverage increase the appropriate use of the treatment or service? (c) To what extent will the mandated treatment or service be a substitute for more expensive treatment or service? (d) To what extent will the coverage increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders? (e) What will be the impact of this coverage on the total cost of health care?

These guidelines represent a framework for analysis. The process should involve consumers, insurers, health planning groups, and labor and business groups interested not only in employee benefits but

containing costs. Analysis should be as objective as possible in a legislative forum, where "politics is the art of the possible," as was noted by Bismark a century ago. And the process should be deliberative and take time during the interim to study. A summary report should be fashioned that responds to all the questions in the statute.

Conclusion

In sum, the legislature of the state of Washington has now required a set of guidelines to assist the members in assessing whether proposed mandated coverages are truly in the public interest. Under certain circumstances, mandated coverages may be very appropriate. This legislation then is not so much of an answer after all, but a process for getting at the answer.

In the final analysis, the main benefit of the legislation is to place the burden of proof squarely on the groups proposing the mandated coverage. Testimony on this subject can get emotional at times, but for those wishing to judge these proposals on their merits, this sort of analysis may be very useful.

Listed below are the actual citations referenced in this chapter by John Welsh.

RCW 48.42.060 MANDATED HEALTH COVERAGE—LEGISLATIVE FINDING. The legislature takes notice of the increasing number of proposals for the mandating of certain health coverages or offering of health coverages by insurance carriers, health care service contractors, and health maintenance organizations as a component of individual or group policies. Improved access to these health care services to segments of the population which desire them can provide beneficial social and health consequences which may be in the public interest.

However, the cost ramifications of expanding health coverages is resulting in a growing concern. The way that such coverages are structured and the steps taken to create incentives to provide cost-effective services or to take advantage of cost off-setting features of services can significantly influence the cost impact of mandating particular coverages.

The merits of a particular coverage mandate must be balanced against a variety of consequences which may go far beyond the immediate impact upon the cost of insurance coverage. The legislature hereby finds and declares that a systematic review of proposed mandated or mandatorily offered health coverage, which explores all the

ramifications of such proposed legislation, will assist the legislature in determining whether mandating a particular coverage or offering is in the public interest. This chapter provides for a set of guidelines which should be addressed in the consideration of all such mandated coverage proposals coming before the legislature. [1984 c 56 | 1.]

48.42.070 MANDATED HEALTH COVERAGE—REPORT TO LEGISLATIVE COMMITTEES. Every person or organization which seeks sponsorship of a legislative proposal which would mandate a health coverage or offering of a health coverage by an insurance carrier, health care service contractor, or health maintenance organization as a component of individual or group policies, shall submit a report to the legislative committees having jurisdiction, assessing both the social and financial impacts of such coverage, including the efficacy of the treatment or service proposed, according to the guidelines enumerated in RCW 48.42.080. [1984 c 56 | 2.] *Copies of the report shall be sent to the state health coordinating council for review and comment. The state health coordinating council, in addition to the duties specified in RCW 70.38.065, shall make recommendations based on the report to the extent requested by the legislative committees.* [C 150 L 87]

48.42.080 MANDATED HEALTH COVERAGE—GUIDELINES FOR ASSESSING IMPACT. Guidelines for assessing the impact of proposed mandated or mandatorily offered health coverage to the extent that information is available, shall include, but not be limited to, the following:

(1) The social impact: (a) To what extent is the treatment or service generally utilized by a significant portion of the population? (b) To what extent is the insurance coverage already generally available? (c) If coverage is not generally available, to what extent does the lack of coverage result in persons avoiding necessary health care treatments? (d) If the coverage is not generally available, to what extent does the lack of coverage result in unreasonable financial hardship? (e) What is the level of public demand for the treatment or service? (f) What is the level of public demand for insurance coverage of treatment or service? (g) What is the level of interest of collective bargaining agents in negotiating privately for inclusion of this coverage in group contracts?

(2) The financial impact: (a) To what extent will the coverage increase or decrease the cost of treatment or service? (b) To what extent will the coverage increase the appropriate use of the treatment or service? (c) To what extent will the mandated treatment or service

be a substitute for more expensive treatment or service? (d) To what extent will the coverage increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders? (e) What will be the impact of this coverage on the total cost of health care? [1984 c 56 | 3.]

XII. Part Three Policy Forum Discussion

Congressional Tools for Fiscal Analysis

MR. SALISBURY: Could I ask whether any of the people present from the government would like to comment on the feasibility of Congress adopting a fiscal impact statement approach or a preadoption study approach as has been established in the state of Washington? One could argue that the Congressional Budget Office (CBO) in some ways performs a function similar to that.

MR. LINDEMAN: We at CBO have been getting these kinds of proposals already, particularly in the international competitiveness area, and I really should defer to Paul Cullinan since I would hope that it would end up on his side of the building rather than my side of the building. But one of the problems we have is the lack of very good models as to where these costs fall and how they affect larger issues like trade balances. Congress sometimes thinks that the models and the information are better than they in fact are. I think it was alluded to earlier about how little information you sometimes have even to begin one of these analyses.

In the trade area, we concluded that we could give some kind of qualitative assessment, although we were not, I suspect, terribly enthusiastic about even that. But hard, quantitative assessments are hard to come by.

MR. CULLINAN: I will follow up on Dave Lindeman's comments on the difficulty of doing the actual estimates. While I was putting together a list of the costs of the various bills that are going to be wrapped up in the omnibus trade legislation in the House, I was struck with the number of estimates that we had that really were not estimates. They were letters saying the costs were uncertain because of X, Y, and Z.

Now trade estimates are perhaps a little more complicated than some of the mandating benefits ones, but I do not think that fundamentally it is that different. The data really are not very good, and the good data tend to be good because people have spent a lot of time and investment in them, and that usually means they are out of date. So it is really very difficult for us. If we are going to start to get into this area, I guess I would suggest that we start to budget for a few more people in the Congressional Budget Office, but I am not sure

that would get us very far, even if we tap the resources of the Congressional budget committees a little better.

MS. PHILLIPS: Let me turn this idea around and come at it the other way. There already is a procedure under which CBO produces cost estimates. There are some excellent people at CBO working on cost estimates for programs such as Medicare and Medicaid or Aid to Families with Dependent Children (AFDC) or Social Security, to name some that I am particularly familiar with. They produce very careful estimates. If the long write-up of how they got their final number does not satisfy you, they are happy to sit down and tell you what assumptions they used. So I would say that most of the *financial* impact issues mentioned in John Welsh's paper are already dealt with by the federal Congressional Budget Office estimates of fiscal impact of proposed legislation.

They have to define what is going to be the take-up of this new benefit, what is going to be the cost, what are some of the tradeoffs, what are the offsets, what benefits will people not use. Now admittedly, it gets a little hairy, because often the data just does not exist to help you make even more than an educated guess. But much does already exist, so that we are not operating in a complete vacuum.

Where I have real problems is with assessing the *social* impact of proposed policies as mentioned by John Welsh. When you get into behaviorial impact analysis and then try to project it out into what it will do to the economy at large, you may run into major difficulties.

There have been pushes for more analysis over the years—for family impact statements, environmental impact statements, fiscal impact statements, and as David Lindeman mentioned, the new push for a trade competitiveness impact statement. There comes a point when the system clogs up with all of these analyses.

MR. CULLINAN: At present, the CBO is required to give an assessment of federal budget costs and assessment of the impact this legislation might have on state and local government. It is not required to make any assessment of the financial cost being imposed on the private sector.

MR. LINDEMAN: If you get into order of magnitude difficulties, I think we could say as an example what the take-up rate of a new matching proposal for AFDC would be. You are dealing with state behavior. You have some historical trends. You have some information you can be tapping, although that can get "iffy" as well. But when you are talking about mandating a particular thing in a health

insurance package on a nationwide scale, it becomes a very different kind of analysis.

As Paul Culinan said, we already have to get into the business of measuring the impact on the states. A colleague of mine was complaining the other day that he was having some problem determining what the effect would be of raising the age for drinking from 18 to 21—whether it was going to be more costly to enforce the law at the state level, or whether it was going to decrease the number of accidents and lessen the burden on public hospitals. It is that kind of analysis you get into. It gets awfully speculative. While I do not want to discourage Martha Phillips and others giving more resources to CBO, some caution should be exercised.

MS. LANAM: It is true, from both the insurance perspective and the employer perspective, that what the state reviews have helped to do to some extent in the states that have developed them, is to get employers and insurers to try to develop some of this data and come up with the kinds of studies they never had to do before. The one positive thing about the growth of these laws is that it forces us to study what the impact is.

However, it is somewhat easier, for example, for a Blue Cross and Blue Shield Plan, with identified participating providers, to gauge an increase in the total number of participating providers after a new mandate than it may be for a company like mine to gauge an increase in claims when we just pay a claim that comes in with an identifiable person on it. We do not have a defined universe. However, we can do administrative cost studies and that kind of thing.

The move to create a need for this data—for somebody saying, "we have to have it, therefore, you have to come up with it"—is a positive point, to some extent, regardless of whether we are right or wrong about costs.

MR. UGORETZ: If Congress or a state—as the state of Washington has admirably indicated—is going to require somebody else to pick up the tab for some specific benefit or even a range of benefits, then it is not too much to ask those who are supposed to pay for the benefit that there be some very careful and detailed analysis of the costs of those benefits. The burden is on those who are asking for the benefit, to show what those costs are going to be. If they cannot, then I do not think that the benefits should be requested until they can come up with the data. What we have seen in the states with almost 700 mandated-benefit provisions, is that, by and large, the decision to require those specific benefits has been made, not with careful and

detailed analysis, but on some warm and fuzzy belief that it would be very nice if everybody in the state had access to a particular benefit.

The question is: In light of the kinds of expenses that we are seeing in the health area, can we afford all of it? I think that probably we cannot, that at some point individuals are going to have to pick up a greater share of the health burden; and it may be that they have to pick up more in the area of noncore benefits.

Coordination of Mandates between Federal and State Governments

MR. KILLEEN: Does this not raise the issue of whether the whole focus of the debate has gone from the state level to the federal level? What I heard described is a very fine state law in the state of Washington, at least with the issues as they have been confronted by the state legislatures. But with the Employee Retirement Income Security Act (ERISA) preemption of self-insured plans and the increasing move to self-insurance, debate is beginning in Congress now about a federally mandated program. And I suspect if that happens, part of that will replace any existing state mandate. Has the debate not now moved to the Congress and away from the state legislatures?

MS. LANAM: What it has done is open a debate in Washington. The difficulty is that it has not replaced the debate at the state level, and perhaps one of the best examples of this is the Consolidated Omnibus Reconciliation Act (COBRA).

There was specific discussion during enactment of the continuation requirements that there be no specific preemption of state laws. Now in effect what happens is that if a state had a continuation requirement of less than the COBRA requirement, it is superceded; but if a state wanted to take the position, for example that six months of continuation occurs after the three-year COBRA requirement, it could do that. There is no preemption of additional state requirements on top of COBRA.

The discussions so far of the minimum benefits at the federal level have tended, along that same line, to be minimums that would, in effect, preempt state requirements that were equal to or less than. There has not yet been a specific discussion about replacing state legislation and state requirements above that minimum level.

Given the rather strong state's rights approach that a lot of insurance regulators take, most insurance companies think we are going to get the worst of both worlds.

MS. DILLEY: I wanted to make a comment on the earlier discussion about impact statements. Many of the complaints people have had about the budget process and many of the complaints many people had about the tax bill last year are that the budget and the tax bill tended to get wrapped up in numbers and in questions about whether there was enough money for this or that right down to the dollar level. Getting as much data as possible is fine, but the policy discussion should precede that, and we should not fool ourselves that collecting enough data is going to answer the questions as to what we ought to be doing. As a former budget analyst, I can attest that numbers mean what people want them to mean, and they are as good as today's newspaper and do not last much longer than that.

It is good to get as much data as possible. But the policy decisions are going to precede that and we should not expect the data to answer the questions.

What Do the Data Mean?

MR. KLEIN: It was suggested that it might be difficult for the federal government to go through this data analysis. Has the Council in the state of Washington had much difficulty doing the necessary data review work or going through the policy questions that are put before it to evaluate what should be mandated?

MR. WELSH: The requirement that the State Health Coordinating Council do this review was just added to the law this year. It was signed by the governor last week. It is not even in effect yet. But to address your question anyway, between 1983 and now the persons who are proposing these mandated benefits have had difficulty in justifying their requests for consideration of legislation.

The basic question is how much information does a member of the legislature or a member of the Congress need to make the policy decision. Some will make that decision right now without the data, on an emotional, heartfelt level perhaps, and automatically be in favor of a benefit. Others will be automatically opposed to the benefit.

The primary advantage of the statute is at least to lay out a framework of the right questions, if we do not have all the right data, at least a framework for addressing it—for those members who are in the middle and who have not initially committed to either being for or against the proposal. Yes, there is a paucity of data around, but at least the burden of proof is now squarely on people that are proposing the mandate, and it is up to them to come up with the ar-

guments for the mandate so it can at least be considered in a rational as opposed to an emotional or political setting.

MR. SCANDLEN: I think it is also true that most of these laws require a social impact statement as well as a financial impact statement. So it is not just a matter of counting money.

The biggest effect is whether there is really a sentinel effect to these laws. It is sort of putting the legislature on record as having a certain sentiment that is skeptical of mandated benefits. The state of Nebraska passed a law that required any mandates that passed to be applicable only if they also applied to self-funded groups, which is, of course, impossible without congressional action.

It remains to be seen if the statute passed by one legislature in Nebraska will be effective in succeeding legislatures. It may very well not be. These laws are indicative, however, of a trend that is perhaps best shown by the number of mandates that have actually been enacted. The year 1986 saw the fewest number of enacted health benefit mandatory laws since 1972. There were only 26 passed in 1986, which is a significant dropoff from the previous 14 years. It remains to be seen if that decline will continue. The state of Texas right now is considering 36 different mandating laws. They are currently just proposals.

The issue of self-funding is a real key one, and somebody made the point that it looks like more attention is being paid to Congress getting some of these benefits put into employee health benefit packages. I think that is in part because even the most desirable mandate on the state level can only apply to, in most states, about half of the group health market. If you switch your attention to Congress, then you can affect all states, all covered employees, with one law.

PART FOUR
WILL MANDATED PENSION BENEFITS FOLLOW?

In 1981, the President's Commission on Pension Policy recommended a "Minimum Universal Pension System" or MUPS, which would have required employers to contribute a minimum of 3 percent of payroll for all eligible workers for pension coverage. MUPS never became law, but incremental changes in private pension law have been enacted through tax measures almost every year since MUPS was proposed. Many of these changes have constituted mandated pension benefit requirements, such as five-year vesting and a lowered eligibility age.

Interest in expanded pension coverage continues, however, since millions of American workers still lack such coverage, particularly those who work for small firms. But Congress has become more preoccupied recently with the issue of health insurance coverage. Family and work place issues have also begun gaining attention with lawmakers.

In chapter XIII Frank S. Swain and Lynne L. Garbose look at the issue of mandated pensions from the perspective of the small business firm. They explain the relationship between size of firm and the likelihood of an employer sponsoring a pension plan, and the reasons why plan sponsorship is low among small businesses. The costs are too high and the benefits too low, the authors conclude, for many small businesses to consider establishing plans. They predict that a mandated pension system, in conjunction with Social Security, would have a significant negative impact on small business, resulting in the loss of jobs or reduction in wages.

In chapter XIV, Joseph Anderson describes the effects that a mandatory pension system such as MUPS might have on firms, workers, and the economy.

Anderson reports on the study conducted by ICF, Incorporated of the MUPS proposal in 1979–1980 and the estimation methodology that was used. The cost of the proposal in 1982 would have been about $12 billion, he says, and the loss of about 160,000 jobs in the short run and about 60,000 jobs in the long run. Over half of the jobs lost would have been in small firms, he says.

Anderson outlines initial effects on labor costs and on pension contributions, and the secondary effects these factors could have in turn on individual firms and workers and the economy. The four key areas affected, according to Anderson, are profits, wages, pension fund asset levels, and tax payments. The issues for the economy include such factors as wages and profits, investment, inflation, and interest rates.

In chapter XVI, Lorna M. Dailey describes the mandatory corporate pension plan law enacted in Switzerland in 1982 that became effective on January 1, 1985. She explains that at the time the law was being debated, about 80 percent of Swiss employees were already covered by some kind of employer-sponsored retirement plan. The original impetus for the mandatory pension plan reflected more of a concern to head off proposals to expand the social security system in Switzerland, she maintains, than to provide a minimum pension for the remaining workers without pension coverage. Some proponents of mandatory pension coverage initially feared that existing employer and union-sponsored pension funds might be nationalized to provide the resources for an expanded social security system.

Dailey provides a detailed review of the provisions of the Swiss law. The law is significant, she says, not only because it guarantees minimum pension coverage for almost all Swiss workers, but also because it provides immediate and full vesting of the mandatory pension and establishes portability of a pension when an employee changes jobs.

XIII. Mandated Pensions: The Next Hurdle for Small Businesses?

PAPER BY FRANK S. SWAIN AND
LYNNE L. GARBOSE

Discussions of mandated benefits have largely focused on nonpension employee benefits, notably health coverage and family leave. Policymakers are concerned about the large number of medically uninsured, the high cost of health care, and the increasing number of women in the work force. Discussion of pension issues does not now involve the intense emotionalism and popular interest of the current health care debate probably because the Social Security system requires employers partially to pay for current retirees' pensions, and because today's elderly appear to be better off than ever before.

There is evidence that the quality of life has improved for people over age 65. Poverty among retirees has been reduced from almost 30 percent in 1967 to 12.6 percent in 1985 (U.S. Small Business Administration, July 1986).

However, as issues ebb and flow in Washington, sooner or later there will doubtless be renewed proposals for increasing pension coverage of U.S. workers through government requirements that employers offer pensions to employees. The pressures needed to bring the mandated pension issue to the fore exist: many workers lack pension coverage; Social Security, alone, is inadequate to finance retirement; Social Security may be in trouble in the long run as the work force ages and life expectancies increase; and popular sentiment often supports requiring employers to assume greater responsibility for employee welfare. In addition, current interest in improving the equitable distribution and portability of pension benefits ultimately could evolve to mandated pension proposals.

The small business community will be at the center of any debate over mandating pensions. The goal of mandated pensions would be to improve pension coverage of the U.S. work force. Any mandate will fall the hardest where coverage does not currently exist: in small businesses, generally defined as those with under 500 employees.

Small business employers have staunchly opposed attempts to mandate health and family leave benefits. The same opposition can be expected in the pension area, perhaps even more so because small businesses feel that they are already paying for mandated pension

benefits in the form of Social Security payroll taxes. Small business delegates to the 1986 White House Conference on Small Business recommended as their second priority that there be no federal- or state-mandated employee benefits. To ensure the retirement income security of American workers, the delegates asked policymakers to promote the voluntary private pension system.

A Catch-22 for Small Business

Concern about the 29.7 million workers not covered by private pensions will spark the drive for mandated pensions. Approximately 84 percent (about 25 million) of uncovered workers are employed in firms with under 500 employees: and 72 percent of the uncovered work force, is employed by firms with fewer than 100 employees.[1]

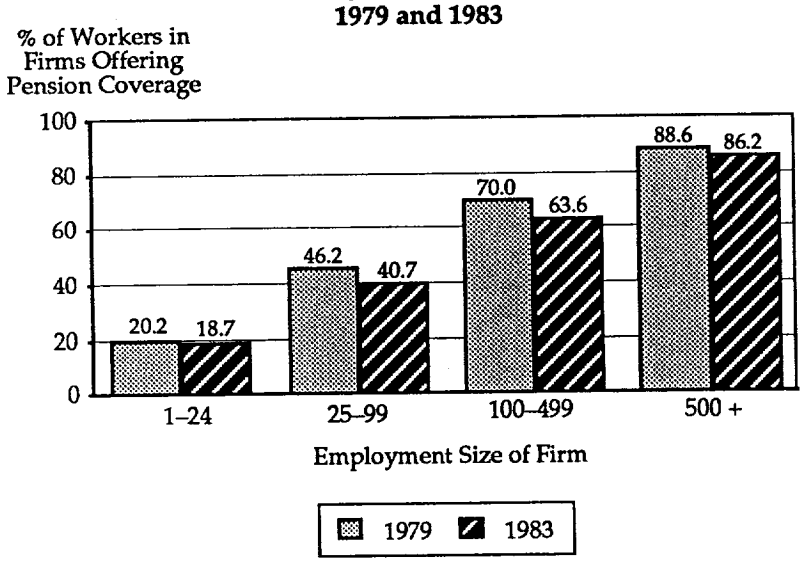
The relatively low level of worker coverage in small business primarily stems from the lack of retirement plans in small firms, rather than from the failure of existing small business pension plans actually to cover workers and deliver benefits. To no one's surprise, the likelihood of an employer sponsoring a plan increases with firm size. Fewer than one of five workers in firms with less than 25 employees is employed in a business that offers a retirement plan, as compared to five of six workers employed in businesses with over 500 employees. See chart XIII.1.

There are a number of reasons why plan sponsorship is low among small businesses. First and foremost, many small businesses cannot afford pension plans. A small employer's profits may be insignificant, unstable, or nonexistent, and business owners may prefer reinvesting earnings in the business. When funds do become available to spend on employee benefits, research indicates that small firms are more likely to purchase health insurance for their workers than initiate pension plans (James Bell, March 1984). Other reasons for the relatively low incidence of pensions in small firms are the disproportionately high cost and complexity of plan administration, the limits on benefits that business owners can obtain from plans, and the constantly changing legal and regulatory environment for pension plans.

Since 1982, there have been four new laws that have required major revisions to retirement plans: the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (P.L. 97-248), the Deficit Reduction Act

[1]These estimates are based on an analysis of unpublished data from the 1983 Current Population Survey. The figures include nonagricultural private-sector wage and salary workers and do not take into account the potential pension coverage of other household members.

CHART XIII.1
Percent of Wage and Salary Workers in Firms Offering Pension Plan Coverage, by Employment Size of Firm, 1979 and 1983



(DEFRA) (P.L. 98-369), the Retirement Equity Act (REA) (P.L. 98-397), and most recently the Tax Reform Act of 1986 (TRA) (P.L. 99-514). These laws sought to improve the pension benefits and security of younger workers, women, shorter-term employees, lower-paid workers, and workers' spouses. The apparent, but unintended, effect of the laws, however, is to impede new plan formation and encourage the termination of existing retirement plans.

Employee Benefit Research Institute analyses of Labor Department data and IRS determination letter statistics indicate that net plan growth has slowed since 1981 (Employee Benefit Research Institute, September 1986). Anecdotal information provided to the Small Business Administration by service providers of small retirement plans suggests that terminations have increased and are linked to the rash of new laws. There are no IRS or Labor Department data analyzed providing information on plan formations and terminations by size of firm.

Not only have the legal changes required costly plan amendments, they have increased complexity and on-going plan administration costs and curtailed the benefits available to business owners. Fre-

quent legal changes, which require costly plan amendments, funnel dollars that could be used to provide benefits into plan administration. The massive changes to pension plans required by TRA, in conjunction with TRA's lower individual tax rates, are expected severely to restrict small plan growth and increase terminations.

In short, the costs are too high and the benefits too low for many small business employers to be interested in sponsoring pension plans. While pensions have always been a sort of "luxury" item for small businesses, plans are becoming even more unfavorable and impractical for small employers. Assuming changes in pension law continue on this course, imposing new costs and limitations on plans almost on an annual basis, terminations by small employers can be expected to increase. Unfortunately, because of these recent changes in the law, the gap between large and small firms in the provision of pensions is more likely to grow.

As pension coverage of the small business work force declines, pressure may mount for mandated benefits. The failure of government regulation and policy to expand the voluntary pension system, ironically, will prove to be a significant factor in creating an environment in which mandated pensions may be considered a solution. These will be proposals that employers, who have already found voluntary pensions to be unaffordable or inefficient, be legally required to assume the costs of a mandated pension program.

What Would a Mandated Pension Look Like?

The small employer typically views the Social Security system as a form of pension mandate. While Social Security is a mandated pension program in the sense that the payments by employers are legally required to finance retirement benefits, the type of mandated pension benefit likely to be the subject of future debate will look and function differently from Social Security. Social Security relies on current employer and employee tax revenue to finance a specific level of benefits paid to current retirees. In contrast, a mandated pension proposal, intended to complement Social Security, would provide an unspecified level of benefits—an account balance—that is paid in the future to today's employees, the workers for whom the contributions are made.

The 1981 report of the President's Commission on Pension Policy describes the prototype mandated pension: the Minimum Universal Pension System (MUPS). MUPS would require employers with and without pension plans to contribute a minimum of 3 percent of pay-

roll for all eligible workers. The contributions would be immediately vested, could not be integrated with Social Security, and could be managed by the employer in a trust or with a financial institution, or by the Social Security Administration. Employees could make voluntary contributions to their accounts on a tax-favored basis, and consolidate all pension monies from various sources in the MUPS account. In addition, as part of the MUPS proposal, the President's Commission recommended that a tax credit be available for small businesses to help offset the additional payroll costs required by MUPS.

Most likely, a future proposal to mandate pensions would resemble MUPS. This view is supported by the direction that government regulation of voluntary pension plans has taken since 1981. Consistently, policymakers have focused on quicker vesting, greater portability, restrictions on integration, and required minimum contributions (in top-heavy plans). In addition, there has been an overall trend toward reducing the disparity—and creating a greater uniformity—in the benefits available to business owners, officers, highly paid employees, and rank-and-file workers. In general, while private pensions have remained voluntary, the legal requirements for providing benefits have become more and more prescribed.

The simplified employee pension (SEP), currently a voluntary plan option in which employers contribute to workers' individual retirement accounts (IRAs) subject to higher limits, embodies many of the MUPS characteristics. Although contributions are discretionary, employers must contribute a uniform percentage of pay for all participants when contributions are made; the contributions are immediately vested and cannot be integrated with Social Security in the case of a model plan.

In certain circumstances, employees are permitted to make pretax contributions to these accounts. The Tax Reform Act of 1986 permits elective deferrals of up to $7,000, if there are fewer than 25 participants in the SEP and at least half of the participants elect to make contributions. To some extent, workers can consolidate retirement savings from various sources in the SEP. The plans are subject to the same restrictions as IRAs for accepting transfers of assets from other retirement plans. Also, similar to the MUPS proposal, there is minimal administrative cost and complexity associated with the SEP.

Impact on Small Business

A mandated pension system, in conjunction with Social Security, would have a significant impact on small business and the economy.

Additional payroll costs, which make it more expensive for labor-intensive small businesses to employ workers, ultimately will reduce the contribution of small business to the economy of jobs, products, services, and innovations. Small businesses now employ about half of the private sector work force and contribute 44 percent of the gross national product.

In a 1981 report submitted to the President's Commission on Pension Policy and the U.S. Department of Labor, ICF Inc. estimated the impact of the MUPS proposal on businesses of different sizes (ICF Inc., April 1981). MUPS was estimated to cost employers with under 100 employees $9.6 billion, as compared to $3.3 billion for businesses with 100-500 employees and $3.0 billion for businesses with 500 or more employees.[2] Even after taking into account a three-year phase-in period and tax credits for small employers to ameliorate the added costs, small businesses still experienced a disproportionate increase in costs.

Small businesses, which typically have low profit margins, may be at a disadvantage in shouldering the increased costs. They will have less flexibility to raise wages, create new jobs, or provide other voluntary employee benefits. Small businesses can be expected to shift costs to consumers by raising prices, where possible, or to workers by reducing wages or by cutting back on voluntary employee benefits. In addition, a mandated pension program will result in a loss of jobs, particularly among lower-and minimum-wage employees whose compensation cannot be further reduced to absorb the added payroll costs.

The ICF study concluded that while aggregate job loss from a pension mandate would not be significant (160,000 jobs), approximately 75 percent of the employment decline would occur in businesses with under 100 employees and more than half of the job loss would be in the services and trade sectors which are dominated by small businesses. Approximately 75 percent of the decline would be among workers earning under $7 an hour. The study noted that if pension cost assumptions were increased, the overall impact on employment would be greater but the distribution by firm size, industry, and wage level would remain about the same. Because ICF's cost assumptions

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[2]These figures are in 1982 dollars and include the cost of adding new participants and the cost of bringing existing plans up to minimum standards. The figures assume a 3 percent contribution, immediate vesting, and participation at age 25 with one year of service. They do not reflect the MUPS tax credit or three-year phase-in of the proposal.

were, in fact, very conservative (using a 3 percent contribution with participation at age 25 and 5-year vesting) the actual employment effects of any future proposals to mandate pensions will likely be greater. In light of legal changes since 1981, it is reasonable to assume that a future mandate would have at least a 3 percent minimum contribution, participation at age 21, and immediate vesting.

In addition, the cost impact of a mandated pension program on small business should not be viewed as an isolated cost, but as one component of the whole package of increasing labor costs. Wages are expected to continue rising faster than productivity as growth of the work force slows and demand for labor increases.[3] Social Security payroll tax increases are scheduled for 1988 and 1990, and mandated health and family leave benefits loom on the horizon. Add to these payroll costs, employers' required contributions for workers' compensation, and unemployment insurance. The incremental effect of a pension mandate, on top of all these costs, may indeed prove to be the last straw. Future analyses of mandated pension programs, therefore, must focus on the whole package of payroll costs as they relate to business revenue.

Some might argue that if pensions were mandated, thereby reducing the gap between large and small firms in providing pensions, small business would be put on more equal footing with large business in competing for qualified employees. However, the converse may be true. Required pension contributions would impair the flexibility of small businesses to structure a package of compensation that includes wages and other employee benefits that may be of more interest to certain workers. For instance, small business employers will lose their current ability to pay higher wages instead of employee benefits, which tends to appeal to younger workers, or to provide employee benefits tailored to meet the needs of a particular work force.

If pensions were mandated, small businesses would likely offer disproportionately low wages and minimum "bare-bones" legally required retirement benefits, while large businesses might offer higher wages and more generous pension benefits through voluntary plans. Small business' current disadvantages in attracting labor—lower wages

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[3]For example, output per hour is projected to increase no more than about 2 percent annually between 1987 and 2000, compared with increases of about 5.5 percent annually for compensation per hour during this period (Data Resources, Inc., Winter 1986).

and fewer employee benefits—may be further exacerbated if payroll costs are increased.

On the surface, a mandated pension program would appear to expand worker coverage and increase retirement savings. The ICF analysis of MUPS, however, indicates that mandated pensions may have little effect on overall savings. While pension assets would increase, the increase would be offset by reductions in savings by businesses, which will have lower profits, and by individuals, who will have lower wages. In addition, the number of workers newly covered by mandated programs must be offset by the increase in unemployment attributable to the new pension costs. Also, many workers can be expected to shift from full-time to part-time work or establish themselves as independent contractors. Both of these employer/employee relationships would lead to a decrease in coverage.

Whether pensions remain voluntary or are mandated, policymakers must recognize that there will always be a "fringe" or uncovered population. Under a voluntary system, uncovered workers are most likely to be small business employees; however, a mandated system may result in a new universe of uncovered individuals—those who cannot find employment or were laid off because of increased labor costs.

The very appearance of mandated benefit proposals suggests a failure in the voluntary system. Rather than punish small business for the failure of that system, the system should be repaired. By simplifying plan regulation and by providing tax incentives, policymakers can increase plan sponsorship by small employers who would be assuming costs they can afford. Fostering an environment for the voluntary adoption of retirement plans by small employers seems the most direct and logical way to increase retirement security for millions more workers.

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XIV. Effects of Mandatory Pensions on Firms, Workers, and the Economy

REMARKS OF JOSEPH ANDERSON

ICF, Inc. did an analysis six years ago for the President's Commission on Pension Policy on the Commission's proposal for a mandatory minimum universal pension system. ICF estimates are presented on the effects of that proposal on firms, workers, and the economy. These estimates are presented to illustrate the effects of one proposal for mandatory pensions. Most of these estimates refer to the year 1982. The work was done in 1979 and 1980.

Four points are covered: what is meant by mandatory pensions; the general types of effects that mandatory pensions should be expected to have on firms and on the economy; the estimation methodology that ICF used to estimate these effects to illustrate the types of information required; and some of the illustrative results.

The definition of a mandatory pension that we are using is a requirement that all employers provide a pension for workers who meet established participation and vesting standards. The required pension must meet or exceed an established level, defined either in terms of the benefit formula or the required employer contribution. We considered both a defined benefit mandatory pension, which has an established benefit formula, and a defined contribution proposal with an established minimum contribution rate. The costs and the benefits, and the effects of the proposal, are determined by the participation standards, the vesting standards, and the benefit formula or the contribution rate.

Effects on Labor Costs and Pension Contributions

What are the general types of effects that we would expect? The initial effects are labor costs and pension contributions. These will have feedback or secondary effects that will affect both individual firms and workers, or microunits, and the economy. These in turn will have economywide effects, or macroeconomic effects.

For firms, the major areas affected would be profits, workers' compensation, pension fund asset levels, and tax payments. For the economy, the areas affected would be economywide wages and profits, incomes, consumption and savings, investment, inflation, interest rates,

imports and exports, and gross national product (GNP), depending on the size of the mandatory pension.

Workers, firms, and pension assets would be directly affected. From the firm's perspective, the first major area affected will be labor costs. Initially they will rise by the full amount of the required contribution. At first, profits would be reduced by that amount, less the change in taxes. Firms will respond to these changes in four major ways, if possible, to reduce wages (or wage growth) or to maintain profits.

First, to the degree that workers perceive that the increased pension accrual that they are now receiving is a substitute for other forms of compensation, it will be possible for firms to reduce wages or other benefits.

Second, firms may attempt to increase prices to offset the increase in labor costs. To the degree that all firms in a specific market are affected equally by the mandatory pension, it will be possible for firms to increase prices.

A third potential effect would be a reduction in employment and output. If the firm cannot pass all of the increased pension costs on to workers, either because workers do not perceive the increased pension accrual to be substitutable for other compensation, or because of bargaining power that workers have, then the firm would be required to increase prices, which would reduce demand for its output and in turn reduce employment.

The fourth effect would be a reduction in employment as firms substitute other inputs—capital for example—for workers because the cost of workers has increased.

The second major area affected will be pension funds. Pension fund contributions will increase, and pension fund assets will increase.

Then, finally, administrative expenses to firms will increase as firms require the services of additional actuaries, accountants, and managerial personnel.

Secondary impacts will result from the changes in labor costs and profits. First, tax collections will be reduced, as wage income is transferred to a nontaxable form of compensation. Personal income and payroll taxes will fall. Ultimately, workers will pay taxes on the benefits provided by the increased pensions. However, to the degree that retired persons are in lower tax brackets than persons in the labor force, overall personal taxes will be reduced in the long run. To the degree that firms' profits are reduced, profit taxes will be reduced. And to the degree that payrolls are reduced, payroll taxes will be reduced. Changes in wages, profits, and taxes will change net incomes

of individuals, and that in turn will prompt them to change their consumption and savings patterns.

Mandatory pensions will also have an effect on the flow of funds. Increased pension contributions will flow into the various categories of financial assets held by pension funds, such as life insurance reserves, currency and demand deposits, time and savings deposits, government securities, and corporate and foreign bonds. To the degree that personal savings are reduced, the types of financial assets into which personal savings flow will be reduced, and to the degree that these differ from the types of assets held by pension funds, there could be a structural shift in the composition of assets.

Impact on the Economy

From these effects on individual firms and households, economywide effects will result. Labor costs on the whole in the economy should be expected to increase. Average labor costs for nonaffected firms, obviously, will be increased less than those of firms affected directly.

One estimate of one particular mandatory pension proposal that we made showed that the proposal would generate pension contributions and, consequently, direct cost increases of about $12 billion. When these direct costs have worked their way through the economy, aggregate labor costs could be expected to increase by about $19 billion. This estimate refers to 1982 and a mandatory universal pension that required a minimum 3 percent contribution.

In the aggregate, wages and profits will be changed. The ultimate changes will depend on the amount of the incremental costs that can be shifted to wages and the economywide response to the increased cost. Aggregate incomes will change. The immediate effect of a mandatory pension would be to reduce discretionary income. This in turn may tend to reduce consumption and the aggregate demand for output, changing employment, increasing unemployment, and affecting aggregate income. This in turn may further affect consumption and savings. The general interactions between incomes, consumption, and savings will eventually generate changes in variables far beyond those initially affected.

The overall effect on the economy should be sensitive to what economists refer to as the marginal propensities to consume: the amount of additional income spent on consumption by each of the affected groups—the workers affected directly, owners of firms, and recipients

of dividends. The higher the consumption propensities of groups are directly affected, the greater will be the overall economywide effects.

Investment will be affected. The effects on investments will go in both directions. The increased contribution to pension funds is a direct increase in savings and may tend to reduce real interest rates. However, to the degree that a mandatory pension contribution reduces incomes and contributes to inflation, and in turn reduces overall output in the economy, that will tend to reduce the demand for investment. Which of these two offsetting effects predominates depends on the specific configuration of the economy and the specifics of the proposal.

Similarly, net exports will be affected in two offsetting ways. To the degree that economic activity is dampened, demand for imports will be reduced. To the degree that costs of production in the United States are increased, the prices of our exports will increase, and the demand for our exports abroad will be reduced.

All of these together will have effects on the gross national product, which is made up of goods produced for consumption, investment, government purchases, and net exports.

If employers are able to pass on additional labor costs by raising prices, there would be, in turn, multiple price effects through the economy. Other industries that use the output of industries whose costs and prices have increased will be forced to raise their prices. The increase in prices overall, the average price level, will tend to increase nominal wages as workers facing higher prices demand higher wages. The increase in prices will also increase nominal interest rates, which are roughly equal to real interest rates plus the average change in prices. Real wages are likely to fall as the nominal increase in wages falls behind the increase in average prices.

Finally, the increase in pension fund assets could increase the demand for bonds, pushing up the price of bonds, and in turn tending to reduce the nominal interest rate. If it tends to increase the demand for corporate equity, it may reduce the cost of capital to corporations.

Methodology for Estimating Effects of a Mandatory Pension

The first task is to estimate the costs of a proposal and the distribution of those costs over various types of firms. To do that, in 1979 and 1980, we used the Bureau of Labor Statistics' data base on expenditures for employee compensation. To estimate the effects on specific types of firms and workers, we put together a data base and

modeling system, that we refer to as the Pension and Retirement Income Simulation Model, or PRISM. PRISM at that time operated on a data base provided by the March and May 1979 Current Population Surveys (CPS). The May 1979 CPS included a special pension supplement. These data bases provided considerable information on individual workers and household characteristics, and a supplement that provided a lot of information on their pensions. The 1979 CPS files were matched with a Social Security Administration earnings and contribution records file to provide information on workers' Social Security earnings records. We then could "age" this matched data base to estimate the effects on costs and benefits to workers in future years.

To look at the allocation of the direct cost on firms, we developed and used what we call the ICF Employee Benefits Cost Allocation Model. Given assumptions about marginal and payroll tax rates, and consumption and savings propensities, this model provided an estimate of the ultimate allocation of an initial level of cost to firms over various savings and spending categories of workers, governmental entities, and firm owners. To look at the effects on employment, we developed an employment impact model showing how firms in various industries would respond to changes in their labor costs based on specific studies of the employment propensities of those industries.

Finally, to estimate the effects on the macroeconomy, we used these estimates of various microeffects to modify corresponding variables in two large-scale macroeconomic forecasting models, and then simulated the behavior of the economy under the various mandatory pension proposals that had been put forth. In particular, we used the quarterly model of the U.S. economy developed by Data Resources, Inc. (DRI). We put into the DRI model the various effects on firm costs, wages, the changes in costs and employment by industry, the changes in pension fund assets, and other variables. We then ran the model to stimulate the behavior of the economy under each of various specific mandatory minimum pension proposals, and compared those simulations to the current DRI base case simulation or forecast of the time, to estimate the changes in overall employment, inflation, and GNP that would result.

Table XIV.1 shows the costs to private employers of a mandatory 3 percent defined contribution pension in 1982, measured in billions of 1982 dollars. The column on the right shows the proportional increase in costs for different size firms. We estimated costs for three different sets of participation and vesting standards that the Pension Commission was analyzing in their preliminary review of various

TABLE XIV.1

Estimated Costs to Private Employers of a 3 Percent Defined Contribution Mandatory Pension in 1982[1] (in billions of 1982 dollars)

Participation Requirement (Age/Tenure/Hours) and Size of Establishment	Current Policy	Added Costs For			Percent Increase
		New participants	Existing participants	Total	
25/1/1000 Participation and 5-Year Vesting					
Less than 100 employees	$21.1	$5.2	$0.7	$5.9	28%
100–500 employees	13.4	1.1	0.4	1.5	11
500 or more employees	22.3	0.7	0.3	1.0	5
Total	$56.8	$6.9	$1.4	$8.4	15%
30/1/1000 Participation and 3-Year Vesting					
Less than 100 employees	$21.1	$4.8	$0.7	$5.5	23%
100–500 employees	13.4	0.9	0.4	1.3	10
500 or more employees	22.3	0.5	0.3	0.8	4
Total	$56.8	$6.2	$1.4	$7.6	13%
40/1/1000 Participation and 3-Year Vesting					
Less than 100 employees	$21.1	$3.3	$0.7	$4.0	19%
100–500 employees	13.4	0.6	0.4	1.0	7
500 or more employees	22.3	0.3	0.3	0.6	3
Total	$56.8	$4.2	$1.4	$5.6	10%

Source: ICF estimates are based on May 1979 CPS and 1977 BLS Survey of Expenditures for Employee Compensation (EEC) data.
[1]The estimates apply to private wage and salary workers only. The costs exclude potential increases in administrative costs and the effects of MUPS tax credits and the three-year phase-in.

mandatory minimum pension proposals. All of the results refer to a mandatory minimum 3 percent defined contribution pension system. We also looked at minimum defined benefit pensions that had costs that were quite comparable. The various proposals that were considered at that time had similar costs, all in the same general ballpark.

The proposals that received the most attention from the Pension Commission were those that involved a participation standard of age 25, one year of service, and 1,000 hours worked, and initially, five-year vesting. Ultimately, the Pension Commission proposed a 25-1-1000 participation standard and full and immediate vesting. We also looked at the macroeconomic effects of an age 20, one year of service, and 500 hours worked proposal. Therefore, the various estimates presented to illustrate potential effects are not strictly comparable, because they refer to proposals that differ from one another. The overall general results are comparable.

Table XIV.1 also shows the difference in the costs of a mandatory minimum pension to firms of different sizes. The largest cost increases are experienced by the smallest firms. Firms of less than 100 employees, for this specific minimum pension proposal, would have an increase in their pension costs of about 28 percent; whereas for the larger firms the increase was only about 5 percent. As the participation standard is relaxed, the increases in costs are smaller.

Table XIV.2 shows the offsetting changes in costs and effects that would result from this mandatory pension proposal. It illustrates the types of offsetting changes that would result from any kind of mandated benefit.

To estimate the effects on firms' costs and employment, we needed assumptions about how much of the increased pension costs could ultimately be shifted to workers. We made two assumptions: 1) that 40 percent of the costs could be shifted to gross wages, and 2) that 79–80 percent of the costs could be shifted to gross wages.

Because some employee benefits are tied to wages and because payroll taxes are a proportion of wages, a shift of 40 percent of pension costs to gross wages actually enables the employer to shift about 50 percent of the cost. A shift of 80 percent to gross wages enables the employer to shift 100 percent of the cost. So these assumptions imply that the employer shifts about 50 percent and about 100 percent, respectively, of the cost.

If 40 percent is shifted, we estimated that ultimately household disposable income would absorb about 40 percent of the increased cost, about 9 percent would be reflected in a reduction in employee benefits, and about 37 percent of the total increase in cost would

TABLE XIV.2

Potential Distribution of Costs of a 3 Percent Defined Contribution Mandatory Pension, 1982

	40 Percent Shifted to Gross Wages		80 Percent Shifted to Gross Wages	
	Amount ($ billions)	Percent of total	Amount ($ billions)	Percent of total
Additional Pension Costs Borne Through Lower:				
Household disposable income	$4.2	40%	$6.6	63%
Employee benefits	0.8	9	1.7	16
Employer retained earnings	1.5	14	—	—
Taxes paid by:				
—households	1.2	11	1.7	16
—businesses	2.7	26	0.6	5
Total Costs	$10.5	100%	$10.5	100%

Source: ICF Employee Benefits Cost Allocation Model, 1979–1980.

Note: Columns may not add to totals due to rounding.

show up as a reduction in tax collections. Therefore, federal, state, and local governments would end up picking up a considerable part of the increased cost associated with the mandatory pension.

For the case where we assumed that 80 percent of the costs could be shifted, about 63 percent ended up being absorbed as a reduction in household disposable income, and about 21 percent was absorbed in reduced tax collection.

Table XIV.3 shows the same cost estimates as table XIV.2, broken out to show the changes in savings, consumption, and fringe benefits. Proponents of a mandatory pension system argued that it would increase savings, because it is essentially, in the short run, a type of forced savings program. We estimated, however, that because of the reduction in household disposable income, part of the increased pension costs would show up as a reduction in consumption and part as a reduction in savings. For this particular proposal the estimated cost was about $10.5 billion (1982 dollars). For the case where half of the costs of the mandatory pension are initially paid by the employer,

TABLE XIV.3

Potential Change in Savings and Consumption Under a 3 Percent Defined Contribution Mandatory Pension, 1982

	40 Percent Shifted to Gross Wages		80 Percent Shifted to Gross Wages	
	Amount ($ billions)	Percent of total	Amount ($ billions)	Percent of total
Additional Pension Costs Borne Through:				
Reduced Savings:	$1.9	18%	$0.3	3%
By business	1.5	14	0.0	0
By households				
—workers	0.2	2	0.3	3
—dividend recipients	0.2	2	0.0	0
Reduced Consumption	3.9	37	6.3	60
Reduced Fringe Benefits	0.8	9	1.7	16
Reduced Tax Collections	3.9	37	2.3	22
Total Costs	$10.5	100%	$10.5	100%

Source: ICF Employee Benefits Cost Allocation Model, 1979–1980.

Note: Columns may not add to totals due to rounding.

about 18 percent of those costs ultimately would be borne through a reduction in savings—about 14 percent as a reduction in business savings, and about 4 percent as a reduction in household savings. Part of the latter would come from a reduction in savings by workers and part from a reduction in savings of dividend recipients whose dividends would have been reduced because of a reduction in corporate profits.

About 37 percent of the costs are utimately borne by a reduction in tax collections. A reduction in tax collections will require the federal and state and local governments to increase other taxes or to reduce expenditures or to borrow. This will have additional effects on savings. If it all shows up in increased borrowing, that is a direct reduction in net national savings. In this case, the combination of the reduction in direct business and personal savings plus the reduction in government savings means that essentially 55 percent of the cost of the mandatory pension is borne by savings.

In this case, therefore, up to half of the additional "forced" savings generated by the mandatory pension contribution, are ultimately offset by reductions in other sources of private and government savings.

In the case where we assume that 80 percent of the costs are shifted to gross wages, that is, where firms are able to shift 100 percent of the costs to wages, fringes, or taxes, the reduction in consumption is much larger. The reduction in savings is smaller, because there is no reduction in business savings, and the reduction in taxes is smaller, because there is no reduction in business taxes.

Macroeconomic Effects

Using these estimates of the direct or micro effects of a mandatory pension proposal on employment and savings and tax revenues, we estimated the effects on the macroeconomy. These estimates should be considered illustrative. They demonstrate the general and widespread effects of any kind of mandatory benefit program like this. These particular estimates correspond to the macroeconomic effects of a mandatory universal pension that would provide for a minimum 3 percent defined contribution each year and a participation standard of age 20, one year of service, and 500 hours worked, with five-year vesting. We estimated that the cost of this particular proposal in 1982 would be about $12 billion.

Estimates of the various direct effects were used and we simulated the aggregate effects on the economy with the Data Resources macroeconomic model for the period 1980 through 1990. We assumed that the program went into effect in 1982, and that in the initial year firms were unable to shift any of the costs. We also assumed that they were not able to reduce wages by any amount in 1982, but they were able to reduce wages by 40 percent in 1983 through the end of the period.

The estimates of the macroeconomic effects are shown in table XIV.4. In the first year, the effects on inflation are noticeable, but not as large as when the full effects began to feed through in the second year. In the first year, the effects on employment account for a very small increase in the unemployment rate—about .05 of one percentage point. In the short run we estimated that the changes in employment would result in about 160,000 jobs lost.

After the second year and in later years, when a large part of the costs can be shifted to wages, the costs to employers increase less, and the reduction in employment is smaller. We estimated that the

TABLE XIV.4

Potential Effects of a 3 Percent Defined Contribution Mandatory Pension Proposal on Selected Economic Indicators

	1982	1983	1984	1985	1988	1990
Annual Percent Change in:						
Inflation	+0.2%	+0.3%	−0.2%	0.0%	0.0%	0.0%
Unemployment	+0.05	+0.16	+0.18	+0.03	+0.07	+0.12
Wages	−0.1	−0.3	−0.5	−0.3	−0.5	−0.6
Pension assets	+1.3	+2.6	+3.9	+6.0	+7.8	+9.3
Real GNP	−0.2	−0.5	−0.4	−0.3	−0.5	−0.7
Real after tax profits	−0.8	−2.6	−2.0	−0.6	−1.4	−1.3

Source: ICF Employee Benefits Cost Allocation Model, 1979–1980 (using the quarterly model of the U.S. economy developed by Data Resources, Inc.)

TABLE XIV.5

Potential Impact on Employment of a 3 Percent Defined Contribution Mandatory Pension

	Short Run (No Cost Shifting to Workers)			Long Run (40 percent of Costs Shifted)		
	Employment decline			Employment decline		
	percent	number of jobs (thousands)	Percent of total	percent	number of jobs (thousands)	Percent of total
Establishment Size (number of employees)						
Less than 25	.26%	87	54%	.10%	32	55%
25–99	.17	34	21	.06	12	21
100–499	.16	27	17	.06	9	16
500 or more	.08	13	8	.03	5	8
Hourly Wage Rate (in 1979 dollars)						
Less than $4	.23	61	38			
$4–7	.18	58	36			
$7 or more	.15	42	26			

	Short Run (No Cost Shifting to Workers)			Long Run (40 percent of Costs Shifted)		
	Employment decline			Employment decline		
	percent	number of jobs (thousands)	Percent of total	percent	number of jobs (thousands)	Percent of total
Industry						
Mining	.08	1	—	.02	—	—
Construction	.24	11	7	.06	3	5
Manufacturing	.16	33	21	.05	11	18
Transportation	.16	8	5	.06	3	5
Trade	.25	45	28	.10	17	29
Finance	.16	8	5	.06	3	5
Service	.27	42	26	.11	17	29
Local government	.06	7	4	.02	3	5
Federal government	.04	1	1	.01	—	1
Other	.30	5	3	.11	2	3
Total	.19%	161	100%	.07%	58	100%

Source: "Estimating the Employment Effects of a Minimum Universal Pension System," ICF Incorporated, April 1981.

long run effects on unemployment of this particular proposal would be a loss of about 60,000 jobs.

Table XIV.4 shows the growth in pension assets as the percentage change in the stock of pension assets compared to the base case where there was no mandatory minimum pension. Under the mandatory pension system, pension contributions are increased about $10–$12 billion each year.

Finally, table XIV.5 shows the effects on employment, classified by size of the establishment, wage rate, and industry. It shows the estimated effects of a mandatory minimum 3 percent defined contribution pension with a participation standard of 25-1-1000, and five-year vesting, that would cost about $11 billion.

As noted earlier, the firms where employment is hit the hardest are the smallest firms with less than 25 employees. Their employment is reduced the most, both in percentage terms—about a third of a percent change in their employment—and absolutely—about 87,000 jobs. Over half of all jobs lost would be lost by small firms. The next hardest hit group is the group of establishments with 25–99 workers, which would account for another 21 percent of job losses. So about 75 percent of all the jobs lost would be in establishments with fewer than 100 workers.

Most of the workers who would lose their jobs would be relatively low-paid workers. This is no surprise. These workers do not have pension and other benefits at the current time, and their costs would be increased the most. In fact, about 74 percent of all the jobs lost would be among workers who in 1982 would have been earning less than $7.00 an hour.

The three industries that are hardest hit in terms of the numbers of jobs lost and the percent of the total are manufacturing, trade, and services. In terms of percent change in employment, the three hardest hit are construction, trade, and services. About 54 percent of all the jobs lost under this particular proposal, we estimated, would occur in trade and service industries.

While these estimates are only illustrative of the potential effects, they indicate that the smaller firms and firms with lower paid workers, which are found largely in the trade and service sectors, are those that would be hit hardest by a mandatory pension plan.

XV. Part Four Policy Forum Discussion

MR. MORGAN: I represent small companies here, particularly new emerging companies, average age about five years average employment of 100. There is an added factor that has to be included when you look at small companies, and that is how long they have been in existence.

Most of the jobs created in the last five years, at least in our part of the world, Massachusetts, come from the new and emerging companies. For those companies that I work with—the last thing in their mind is pensions, because survival is an issue, and they are not thinking about pensions. They are worried about whether they can survive next year.

So when you talk about small businesses, the length of their life span is an added factor that you have to consider. A small company that has been in business for 50 years is different from one that has been in business for 3 years and struggling to survive. It is not in the macro statistics, but it sure is in the micro planning.

Mandatory Pensions Versus Expansion of Social Security

MS. ALTMAN: I can understand people arguing that it is important for all workers to have adequate retirement income. Nevertheless, I can understand that a voluntary system will never work. But if we are going to have a mandatory system, there are at least two ways it could be structured. We could have the mandatory pension, but we could also simply expand Social Security. That would be administratively simpler. There would not be problems with integration, obviously, of two competing systems.

If we are concerned about the private pension system as it now exists, presumably there could be some kind of contracting-out system. It is not clear to me why proponents of a mandatory system believe a private mandatory system is practicable.

MR. GARBER: Clearly the difference in the funding favors mandatory private-system pensions. A private system is prefunded, whereas Social Security is essentially pay-as-you-go, although sometimes you do not get the same rate you do at other times. So if we have a problem with capital formation in the country, as we do, and a problem with

the rate of savings, then to add to Social Security exacerbates that problem rather than assists it.

MR. JOSEPH ANDERSON: That was certainly the motivation behind recommendation of the President's Commission on Pension Policy for a mandatory pension rather than an expansion of Social Security.

MR. LEONARD: One of the easiest ways to fund it would be to allow small employers to opt out, contract out of Social Security, at least up to an acceptable level—3 percent, for example. That is less than one-half of an employer's cost for Social Security. By opting out you could produce a factor of more than twice the amount of benefit provided under the Minimum Universal Pension System (MUPS).

MR. LINDEMAN: The President's Commission probably made its proposal because it was considering advanced funding and capital formation. You can increase the size of the Social Security program. You can bank those extra taxes if you do not use them to increase the current level of government services, and roll down the amount of the national debt, presumably releasing both foreign and domestic capital for investment in the U.S. private sector.

Similarly, if you mandated MUPS, government can simply borrow the money that it forced people to save. Some would argue we have two competing philosophies—tax and spend, borrow and spend.

It is not clear that one strategy necessarily gets you the desired result in capital formation, as opposed to the other. That depends a great deal on government fiscal policy, and that is the ultimate question you always have to return to.

MS. DAILEY: There is another point about the possibility of increasing Social Security instead of mandating private benefits. Other countries that have followed the route of high Social Security benefits have discovered that they have promised more than they can afford, and now they are left with the problem of a huge government expense that they cannot finance. So they are pulling back and trying to push that expense onto some other sector, which is either the corporate sector or individuals. Those countries that have tried high Social Security benefits have not been too satisfied either.*

*Editor's note: For addition information on international trends in Social Security reform and retirement plans see Employee Benefit Research Institute, "International Trends in Corporate and Individual Retirement Plans," *EBRI Issue Brief* 69 (August 1987); and "International Trends in Social Security Reform," *EBRI Issue Brief* 68 (July 1987).

Pension Protection for the Low-Income Worker

MR. KILLEEN: What is the constituency for a mandated pension program, a MUPS program? The analysis is very sophisticated and interesting, but unlike, say, the mandated health care coverage issue, which is a hot issue over which the business community is currently divided, there does not seem to be a constituency out there for MUPS. There does not seem to be one in the labor movement. Is this an issue that we realistically expect to be facing?

MR. PAUL: When you look at the demographics of the problem, it is really a low-wage problem. It is the low-wage worker who is not adequately protected by Social Security. It is the low-wage worker who, therefore, needs more retirement income, if you want to set that as a priority. That is the social policy question. The reason pension protection is not as high a priority as health insurance is that you collect a pension only once in your lifetime, when you retire; but you have health insurance claims periodically throughout your life. Accordingly, the attitude you have about health insurance is far more immediate than the attitude you have about pensions.

In response to the comment about the labor movement position on mandated pensions, the labor movement has negotiated pensions. Union members are not, generally speaking, a group of people who are not covered by private pensions.

It is clear from a study of the problem that the retirement income replacement ratio is about 15 percent short of where it ought to be for someone who earns under $20,000 a year, using $20,000 a year as a proxy for the average wage in the country. As it happens, if one puts aside 3 percent of pay for a career, it will provide a 15 percent replacement ratio. That is how that number was calculated by the President's Commission.

So if you wanted to be sure that a retiree who earned the average wage throughout his or her lifetime would have adequate retirement income—even if the employer did not provide a private pension—you could change Social Security around in such a way that it provided 15 percent more replacement ratio up to $20,000 and about the same thereafter. You could accomplish that by changing the payroll tax from 7.15 percent of wages up to $43,600 to whatever additional percentage it would take to finance that.

It is clearly not going to be 3 percent of pay, because you would be collecting it from everybody instead of just from the people who lack the amount of benefits that you are trying to achieve. Call it one

percent of pay, half from the employee and half from the employer, to be illustrative. So as a society we could impose an extra payroll tax of one percent of pay on the Social Security system, half from the employee and half from the employer. That would raise the replacement ratio for the lower-paid worker who makes $20,000 a year. Then, even if a private employer does not provide any kind of pension, that worker will retire with enough retirement income so we do not have to worry about poverty anymore.

When will that happen? That will happen when there are enough retired workers who do not have adequate retirement income to start demanding it, which is probably about 20 years from now. It is not a problem for today, and many people who are saying health insurance is a more urgent problem are right. It may be that Social Security is a better solution than mandating private pensions.

Is Social Security a Better Solution?

MR. PAUL: It has been said that Social Security is going to run a surplus until the year 2010. We have not demonstrated the political will to allow the belief that we will maintain that surplus until it is needed early in the next century. Nor can we be sure what the demographics are going to look like over the next 75 years. We are making a very huge bet on the demographics.

Also, we are a country that does not save enough, and if we continue to maintain "pay-as-you-go" Social Security financing, that may not be the best answer.

The debate is whether we need to do this at all. Do we care that there are people who earn less than $20,000 a year throughout their careers who may retire without an adequate retirement income after a lifetime of work or episodic work? Half the workers today are women, and they do not ordinarily work steadily throughout their lives. They go in and out of the work force as they marry and have children or do anything else they might want to do with their careers.

The Social Security system is not adequately geared to women. So it you perpetuate the inadequacies in the Social Security system by enlarging it somewhat more, you may still find women who reach retirement with under $20,000-a-year average working lifetime earnings who are not going to get this benefit even if you do it with Social Security.

That is the argument for mandating private pensions. The private sector might do it better and add to the country's savings in the bargain.

MR. REPKO: The problem is one whose time has not yet arrived. When people in the baby boom generation start reaching retirement age and realize that they have no defined benefit pension plan, which is particularly advantageous in terms of retirement replacement objectives, that is when this issue will have its day in court, so to speak. But that is why the constituency is not there right now.

Projected Retirement Incomes

MR. LINDEMAN: Social Security is better oriented toward taking care of women and other episodic workers in the labor force than most private pension systems are, particularly defined benefit plans.

Some background studies that went into the Pension Commission's report have been cited as saying that replacement rates are too low. These are normative standards of replacement rates that may not actually mirror what people are doing in terms of their retirement decisions and behavior. Maybe people are retiring at lower replacement rates than our hypothetical norms, but they are making their decisions rationally according to their best interest.

You can accurately forecast how long one spouse of a couple will live; and there may be insufficient prudence in society with respect to the problem of the surviving widow. That may argue either changes to Social Security policy or pension policy. But if you look at projected retirement incomes, using the same model, these projections indicate fairly substantial retirement incomes, even for the baby boom. In addition, we may not be taking into account how much people are saving for their retirement in nonpension forms and in nonqualified plans; and that is currently an extremely important component in people's retirement income and projected to be important also in the future.

So the case may not have been made on adequacy grounds for mandating pensions, at least vis-a-vis some absolute standard like poverty. The replacement-rate issue is a dubious concept. We do not know enough about people's actual retirement decisions to postulate what the optimum replacement rate is.

MR. REPKO: The President's Commission was, I believe, looking at the issue of poverty, the issue of how much retirement income was needed by a worker whose career average annual earnings were $20,000. This replacement ratio number was not derived in some normative sense. It was derived by looking at what a person actually has to spend in retirement to have an adequate living standard.

Social Security could do a better job for women than it is doing,

but at the moment it is not doing an adequate job. Second, the difficulty with defined benefit pension plans as a better instrument is that for a woman who goes in and out of the work force having, for example, 3 percent of pay invested in a decent investment medium would be worth more than the present value of a defined benefit at young ages and other ages. You have to think about what it is really worth in terms of take-home money rather than in terms of what it would be worth at age 65, because not every woman is going to stay in the work force for her entire career. If she works only at the beginning of her career, the value of her pension in retirement is much less important than if she works an entire career. A defined benefit plan is a less perfect instrument if she only works in the early part of her career, which is why MUPS is a defined contribution proposal.

MR. OLSEN: In relation to the effect of mandated pension benefits on small towns and rural communities, do you see a greater negative effect than in other segments of the society?

MR. SWAIN: About 20 percent of the population and about 26 percent of the business establishments are located in what the Department of Agriculture defines as nonmetropolitan areas, which is beyond suburbia. So there is a greater than proportional penetration, if you will, of small business in rural areas.

We have not done any analysis on a geographic basis to indicate whether there is any geographic factor in who makes enough money to fund a pension plan. There may well be such a factor, to the extent that pension income may have some other replacements in an urban area where a retired person can go out and get a part-time job at McDonald's. That may be less available in rural areas. There may well be a greater extent of lack of coverage in rural areas; but, likewise, businesses in rural areas probably have a thinner cash flow.

Small business employers would embrace the Social Security system if they felt it was a genuine pension system rather than a pay-as-you-go welfare system. That is basically what it is. Any suggestion to have an additional retirement plan in the Social Security system would force to the surface the issue of what it is and why it is that we have Social Security in this country.

Mandated Pension Coverage

MR. SALISBURY: There is an advantage in getting all parties to focus on all aspects of economic security programs together and to be forced

actually to focus on the fact that there are tradeoffs and that there are alternatives, expenses, and choice patterns one can make.

Second, there is a time horizon issue. With a significant proportion of the population at the lower-income levels not having pension coverage and the aging of the population, there is a certain inevitability of the issue of a mandated pension at least coming up again. It came up at a different point in time vis-a-vis federal budget deficits and vis-a-vis the nation's political mood at the end of the Carter Administration. That discussion is still active, and at least in terms of the inquiries that we at EBRI get both from the media and from people in government, there continues to be a range of people very interested in this issue, even though they would be less prepared to say today than they might have five years ago that now is the time to make this particular push.*

When this administration has finished the process of meeting all of the Gramm-Rudman-Hollings targets and getting that particular issue under control, you may see that a fairly sizeable number of people are more than ready to move to this particular discussion, if they have taken care of the deficit and taken care of what they view as the health coverage problem. But we at EBRI do try institutionally to have material and information on the written record in advance of people getting to that point, if that is at all possible.

The analysis done by ICF that Joe Anderson has presented also has tremendous relevance to the concept of mandated health benefits. If you equate the mandated health benefit cost of 3 percent of pay hypothetically, then other than the dates at which the analysis was done, everything in it theoretically would have the same applicability today. The fact is, for whatever reason, no one has yet done that type of analysis attached to the concept of mandated health benefits. Congressional staff groups looking at it have not, and to my knowledge, no private-sector group has.

MR. SWAIN: On the question of whether the mandatory pension issue is a credible issue, the April 13, 1987 *BNA Pension Reporter* notes the introduction of H.R. 1992, the Portable Pension Plan Act of 1987, the Matsui-Feighan* bill, which would require employers who have

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*Editor's note: This issue was addressed in the Committee on Ways and Means 1987 report, *Retirement Income for an Aging Population*, which states, "If Congress wishes to increase overall retirement savings or the role the private sector plays in delivering retirement income, it could reexamine the proposal of President Carter's Commission on Pension Policy to establish a minimum universal pension system."

*Editor's note: Rep. Robert T. Matsui (D-CA) and Edward F. Feighan (D-OH).

not maintained a qualified pension plan within the last five years to open a simplified employee pension (SEP) account under the requesting employee's name. Obviously, that is not saying the SEP has to be funded by the employer, but we all know that legislation tends to be on a slippery slope. So there is at least one proposal that would require an employer who does not have a qualified pension plan to open a SEP account for an employee upon request, and presumably at least undertake some record keeping and reporting costs.

Analyzing the Benefits of a Minimum Mandatory Pension Program

MR. JOSEPH ANDERSON: My presentation may have been somewhat unbalanced. I was asked to discuss the effects of a mandatory minimum pension on the economy and on employer costs, and that is what I talked about. Because of the effort to provide a discussion that could be generalized to mandated health benefits and to other mandated benefits, I think that was approximate. However, I did not discuss the benefits of a mandatory pension program at all. I should go back to our report on this particular proposal, the President's Commission MUPS proposal of 1980, and discuss some of the effects on pension benefits very briefly to give some illustrative numbers.

We looked at four different groups of individuals who would be age 25 to 29 if the mandatory pension program was established in 1980, and estimated the effects on their pension benefits when they retired at age 65 with and without a MUPS. Married couples who would receive both Social Security and employer pensions, we estimated, would have a retirement income from those two sources of about $15,700 (1980 dollars) without a MUPS. With the 3 percent defined contribution MUPS, that amount would be increased 7 percent to $16,800.

For married couples without any private pension at all, their entire retirement income without a MUPS is Social Security, which would be about $8,500. That would be increased by the 3 percent defined contribution MUPS to about $10,600, or about a 25 percent increase for this relatively low-income group.

For unmarried individuals with both Social Security and private pensions, the increase in retirement income would be from $11,200 to $12,800, a 14 percent increase. For unmarried individuals without any employer pension at all, the increase would be from a Social

Security benefit of about $5,200 to a total retirement income of $7,200, an almost 40 percent increase.

So the benefits of a mandatory minimum pension, in terms of providing income for lower-income people, would be substantial. The effects of a 3 percent defined contribution MUPS in reducing the numbers of elderly below the poverty line would also be substantial. While there would be costs and effects on the economy, a mandatory minimum pension would also provide significant benefits targeted upon the low-income elderly.

MR. SCANDLEN: The White House Conference on Small Business made the elimination of mandated health benefits its number two priority. Does Small Business Administration (SBA) have any additional material on that topic?

MR. SWAIN: ICF just completed for SBA a very excellent and comprehensive study of the incidence of health policy coverage among small business workers titled *Health Care Coverage and Costs in Small and Large Businesses.** It is a study based on a survey of small business employers who have coverage and who do not, by type of business, when they have coverage, what kind of coverage they have, and all sorts of things along those lines. That is the basic empirical work that we have done so far, but obviously, on the major issue of mandated benefits, we cannot determine the cost impact until someone puts a credible cost figure on it.

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*Editor's note: The "Executive Summary" of the 1987 study by ICF, Incorporated, *Health Care Coverage and Costs in Small and Large Businesses*, can be found in Appendix C of this book.

XVI. Mandatory Corporate Pension Plans in Switzerland

PAPER BY LORNA M. DAILEY

All companies in Switzerland have been required to provide a retirement, death, and disability pension plan with a minimum level of benefits to almost all employees, since January 1, 1985. These requirements derive from the federal law on the Occupational Old Age, Survivors' and Disability Benefit Plan. This law is usually referred to as the second pillar law or BVG/LPP legislation.

The first pillar is social security; the second pillar is employer-sponsored benefit plans, and the third pillar is individual savings for retirement. BVG represents the name of the law in German (Bundesgesetz über die berufliche Alters-, Hinterlassenen- und Invalidenvorsorge); LPP represents the name of the same law in French (Loi federale sur la prevoyance professionelle vieillesse, survivants et invalidite).

Background

Mandatory retirement benefit provisions were under discussion in Switzerland in the early 1970s, but it took nearly 15 years before such legislation became effective. During these years, there was considerable public discussion of pension issues; a new article was added to the constitution formally instituting the three pillar system; several draft pieces of pension legislation were introduced, and a referendum[1] was held on the issue of mandatory pension provisions. The BVG/LPP law was finally passed on June 25, 1982; it became effective beginning January 1, 1985.

It has been estimated that about 80 percent of employees in Switzerland were already covered by some type of employer-sponsored retirement plan by the late 1970s, although no good survey data exist.

[1]The Federal Council comprises seven members representing various political parties and interests. The Federal Council can introduce legislation of its own accord, but such legislation is subject to challenge by a popular vote on the issue by all citizens. This popular vote, known as a referendum, must be held if any group is able is obtain 50,000 authorized signatures requesting the referendum within 90 days of the passage of the legislation. If the original legislation is overturned by the referendum, there is usually a considerable period of discussion before new legislation is introduced.

Many large companies and some unions already had retirement plans with benefit levels well in excess of the minimum requirements of the law as it was finally passed. The lengthy discussions and the prospect of mandatory requirements encouraged other firms to introduce plans, so that by January 1, 1985, it was estimated that only about 10 percent of employees remained to be covered for the first time for retirement benefits under the mandatory legislation. These uncovered employees were mainly employed in very small or newly established firms or in industries with many part-time employees or a high turnover rate, such as restaurants.

The original impetus for the pension discussions was *not* necessarily concern for employees without benefit coverage. There were no surveys of actual numbers and types of employees without pension coverage. One of the early events that instigated interest in pension reform was a political initiative, by the Communist party, to expand the social security system to a level that would be sufficient for a retiree's full income. Even though the Communist party did not have significant power at the time, the other political parties, employers, trade unions, banks, and insurance companies all feared that if this initiative gained popularity, it would undermine the private pension system. There was concern that the existing employer and union-sponsored pension funds, some of which were quite substantial, might be nationalized to provide the resources for an expanded social security system.

Whether this fear of nationalization of corporate pension funds was realistic or not, it created the environment for serious discussion of retirement pensions and how they should be funded in Switzerland. Many Swiss now feel that a pay-as-you-go social security system and a funded employer-sponsored pension system create the best economic mix for the country.

A significant pension issue, which developed during the years of discussion prior to the BVG/LPP legislation, was the lack of stringent vesting regulations in existing retirement plans. No vesting was required prior to 5 years of plan membership, and full vesting was not required until after 30 years of plan membership. Between 5 and 30 years, most companies used some form of vesting scaled by years of service.

A second pension concern was the lack of portability of any vested retirement benefits when an employee changed jobs.

Therefore, passage of the BVG/LPP legislation accomplished a number of significant goals:

- It accomplished another step in the preservation of funded, employer-sponsored pension plans as a significant part of the overall retirement income system in Switzerland (versus a pay-as-you-go social security system with a high level of benefits and no private pension plans).
- It placed the mandatory, funded portion of the pension in the Second Pillar, employer-sponsored category (versus creating a second-tier, earnings-related part of the social security system such as exists in Canada).
- It provided almost 100 percent coverage for the minimum pension for employed persons, excluding only those not meeting the minimum qualifications (described below).
- It provided immediate and full vesting of the mandatory retirement pension, but not for any excess portion provided voluntarily by the employer.
- It established the principle of portability of pensions when an employee changes jobs.[2]

Provisions of the BVG/LPP Legislation

The retirement pension in the BVG/LPP legislation is based on the concept of a defined contribution pension plan with minimum levels of contributions, or "retirement credits," varying by age and sex, accruing at a minimum rate of interest set by the government. However, this does not prevent companies from continuing an existing defined benefit plan, with minor modifications, or from introducing a new defined benefit plan. Such companies need only to conduct a theoretical accounting exercise each year to demonstrate that employees receive the minimum benefits that would have accrued to them under the mandatory defined contribution formula. The term "retirement credits" is often used instead of "contributions," because of the large number of defined benefit plans in existence; technically, defined benefit plans have "retirement credits" which accrue and not "contributions."

The main provisions of the BVG/LPP legislation are described below.

[2]Although the BVG/LPP legislation provides the framework for the portability of benefits, some administrative problems have developed that were not anticipated. Further legislation will probably be introduced to enhance the portability of benefits.

Coverage of Companies

All companies in Switzerland must provide a pension/risk benefit plan for employees at least equal to the minimum provisions of the law beginning January 1, 1985.

There are no exemptions for firms with a small number of employees. In fact, the trade association for small business employers does not favor labor legislation that exempts small companies. It believes that such provisions would make small firms less desirable places of employment, and therefore, less competitive with large firms.

Self-employed persons with no other employees may choose to cover themselves under the BVG/LPP legislation or may make individual arrangements for themselves under the third pillar; they are not required to do either. An owner of a business may be excluded from the BVG/LPP provisions, if he or she wishes, but must include any family members who earn the required salaries.

Eligibility of Employees

All employees who are age 25 or over[3] and who earn more than $11,700[4] per year from one employer must be covered for at least the minimum retirement benefits, from the date of employment.

Temporary, part-time, or seasonal employees must be included if they earn over one-twelfth of the annual minimum for the months they work. Foreign workers on nine-month work permits must be included. (Work permits for a maximum of nine months per year are issued to workers of neighboring countries (Italy, Turkey, etc.) who are usually employed in the hotel and restaurant industries. Such employees cannot become permanent residents of Switzerland, but many of these workers return to Switzerland regularly each year.)

As an example of 1987 wage levels in Switzerland, a secretary in a government agency earns about $27,000 per year.[5] Therefore, a secretary who worked three days per week would probably earn sufficient income to be included; a waiter who worked one or two days

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[3]Employees must be included in the plan from the January 1 following their 24th birthdays.

[4]All dollar amounts are approximate and are calculated at the exchange rate of Swiss francs (SF) 1.48 = $1.00 (June 10, 1987) and rounded to the nearest $100.

[5]Actual wage rate quoted for a government secretary with about three years experience in Bern in early 1987, converted at an exchange rate of $1.00 = SF 1.48 (June 10, 1987.) This salary appears high by U.S. standards partly due to the decrease in the value of the U.S. dollar. The same salary converted at the end-85 exchange rate of $1.00 = SF 2.46 would be $16,300 with an eligibility level of about $7,000 for inclusion in the mandatory benefit plan.

a week would probably not. For 1985, the latest year for which average wage rates are available on a national basis, an "average production worker" in Switzerland earned about $26,700 (OECD, 1986), if the salary is converted at 1987 exchange rates.

All employees who are age 17[6] or over and who earn more than $11,700 per year from one employer must be covered for the minimum risk benefits only, from the date of employment.

Risk benefits include disability, widows' and orphans' benefits, and benefits for children of disabled parents.

Contributions

The minimum mandatory contributions for retirement benefits are paid on wages between $11,700 and $35,000 per year. The employer must pay at least half of the minimum mandatory contribution rate.

The lower limit for contributions is equal to the maximum annual old age benefit from social security for a single person; the upper limit is three times the lower limit. These limits are adjusted whenever the social security benefits are raised, usually once a year.

An employee does not necessarily pay the other half of the contribution rate. The split between the employer/employee can be negotiated by the union or employee group (e.g., as a 70/30 employer/employee split), or an employer can pay more than 50 percent of the contribution as an extra benefit to employees.

The rate of the minimum mandatory contribution varies by the age and sex of each employee:

Age of Employee		Contribution
Males	Females	% of Covered Wages
25–34	25–31	7%
35–44	32–41	10%
45–54	42–51	15%
55+	52+	18%

The contribution rates were scaled by age to allow employees nearing retirement to accrue a higher benefit. It was assumed that older employees would have a greater interest in making contributions for their retirement than younger employees, and it also helps those employees with only a few years to work under the mandatory system to accrue a reasonable benefit. The rates for the highest two age

[6]Employees who turn age 17 must be included from the January 1 after their 17th birthdays.

brackets were reduced to 11 percent and 13 percent, respectively, for 1985–1986 only, as an introductory measure.

Contribution rates scaled to age present the possibility of discrimination in the employment of older workers. There is no age discrimination legislation in Switzerland, nor most other European countries. However, in Switzerland, older employees are unlikely to be dismissed just to avoid the higher contribution rate because of a long-standing atmosphere of good employee/employer relations and stability of employment.

There is some possibility that older employees in smaller firms might be encouraged to accept early retirement, or to work on contract without employee status, so that the employer can avoid the mandatory pension contributions. Employers might offer new, older workers a lower salary to offset the higher contribution rate. This situation may be somewhat alleviated in the future by new regulations which combine the highest two age brackets with an average contribution rate.

Any company whose average contribution rate for all covered employees is over 14 percent for the prior year, because of a high proportion of older employees, may apply for reimbursement from the Security Fund (described below), so that its actual rate of contribution does not exceed 14 percent of covered earnings. The average contribution rate nationally is expected to be about 12 percent (after 1987 when the full rates are in effect). If the actual average rate differs substantially, the Federal Council can change the 14 percent maximum contribution.

In addition to the retirement contribution, employers must

- pay the full cost of the risk benefits,
- contribute 0.2 percent or more of covered payroll to the Security Fund (a national fund), and
- contribute an additional 1 percent of covered payroll (to their own foundation) for "special measures."

The cost of risk benefits averages 2 to 4 percent of covered earnings and is determined by the insurance company.

The Security Fund is a national fund specified in the BVG/LPP legislation, but administered jointly by the central trade unions and the central employers' federation.[7] It reimburses companies with un-

[7]It is common in Switzerland for the unions and employer associations to cooperate or for companies in an industry sector to agree to handle a function jointly to prevent the function from being managed directly by the government.

favorable age structures to reduce their total contribution to a maximum of 14 percent of payroll and guarantees benefits in case of insolvency of a foundation (the financing vehicle for the benefit plan). The contribution to the Security Fund was not required to be paid in 1985 and 1986, as the maximum rate for retirement contributions was 13 percent and the accrued benefits in the case of insolvency were minimal. A rate of 0.2 percent of covered payroll has been set for 1987 for the employers' contribution to the Security Fund.

The special measures contribution is made to a company's own foundation (or to the general foundation in which it participates) and is intended to provide for future indexing of retirement benefits and to provide supplements for persons over age 25 at the time the BVG/LPP law was passed. The special measures contribution need only be made within the company's financial ability and accrues solely for the benefit of a company's own employees.

Retirement Pension

The formula for the annual amount of the pension "annuity" is 7.2 percent of the retirement credits accumulated in the employee's name over his or her years of service, based on the scheduled age-related contributions, and credited with a minimum of 4 percent interest per year.

The 7.2 percent rate used to convert the total retirement credits into an annual pension amount was recommended by the Federal Council and has not been changed since the law was passed. This annual pension amount is paid for life, usually in 12 monthly installments.

If the foundation rules specifically allow for it, the retirement pension may be made as one lump-sum payment consisting of the total accumulated retirement credits, plus 4 percent interest per year.

If both methods of payment are allowed under the foundation rules, the employee must choose either the pension "annuity" or the lump-sum payment three years prior to retirement. The value of either method is intended to be equal, although in practice it would not be for all employees. When the total retirement credits are a nominal amount (i.e., less than about $1,200), the pension is awarded as a lump-sum payment.

Even if the foundation rules do not specifically mention it, an employee can request a partial lump-sum payment for the purpose of buying a home or paying off a mortgage, providing his or her retirement benefit is not reduced by more than half.

Such a request must be made three years prior to retirement and the lump sum is paid at retirement age.

Interest Rate

The minimum interest rate of 4 percent per year is set by the Federal Council.

The rate of 4 percent per year has been in effect since January 1, 1985. There are no provisions for automatically changing the rate. In practice, this is not a problem as interest rates are kept low and fairly stable in Switzerland. The annual government bond yield has fluctuated between 4.3 percent and 5.6 percent for several years. Insurance companies normally expect to earn a 4.5 to 5.0 percent annual return on their pension assets. If the foundation earns more than 4.0 percent, the board of the foundation decides how to use the excess earnings. Generally, the excess earnings are simply distributed proportionately among all participants, but the board could decide to increase benefits to retirees or decrease contributions equally for the employer and employees. In the unlikely event the foundation earned less than 4 percent, the employer is still responsible for crediting a minimum of 4 percent interest to each employee's account.

Interest is credited to each employee's account at the end of a calendar year based on the account balance at the end of the *preceding* year, not the year just ended.

Past Service

The mandatory retirement credits accrue from January 1, 1985, or the date of employment, providing the minimum age restricitons are met.

There are no provisions for crediting prior service.

Retirement Age

Retirement credits accrued under the BVG/LPP law are preserved until retirement, with certain exceptions.

Normal retirement age in Switzerland is age 65 for male employees and age 62 for female employees. The rules for the foundation of a particular company can specify other retirement ages and BVG/LPP benefits would be available at that time.

Withdrawal Provisions

Withdrawal of the funds accumulated is permitted prior to retirement age if a person is leaving Switzerland permanently or, for female employees only, upon marriage and the cessation of employment.

Even for persons leaving the country, funds are not actually paid out for 12 months. Foreign workers who return each year to Switzerland cannot withdraw their funds.

Minimum Pensions for Entry Generation

An employee who reaches retirement age before January 1, 1994, and has had low earnings is entitled to a supplement to his or her retirement credits. This results in a minimum retirement benefit calculated as if covered earnings were about $9,000 per year.

The limit on covered earnings to calculate the minimum benefits is established by the Federal Office of Social Insurance. These minimum benefits for persons within nine years of retirement when the BVG/LPP law became effective are paid for from a company's special measures contribution.

Disability Pension

The annual benefit upon total disability is 7.2 percent of the total of the accumulated retirement credits, plus 4 percent interest, at the time of disability, and future retirement credits for the years up to retirement age, without interest.

Scaled benefits are payable upon temporary, permanent, partial (50 percent or more disabled) or total disability under the same conditions as for the social security disability pension.

Disability and survivors' benefits are only payable under the BVG/LPP law for conditions due to illness. Benefits for death or disability due to an accident are covered under a separate federal law on accident insurance which became effective on January 1, 1984.

Survivors' Pensions

A widow who is under age 45 with a dependent child, or over age 45 and married at least five years, is entitled to a widow's pension of 60 percent of the employee's actual retirement or disbility pension, or 60 percent of a pension calculated as if the employee had become disabled, if the death of the employee occurred prior to retirement.

A widow who does not qualify for a pension under the above conditions receives a lump sum of three times the annual widow's pension. There are no widower's benefits under the BVG/LPP law, nor under social security in Switzerland. However, company benefit plans sometimes make provision for widower's benefits.

A divorced wife is eligible for a widow's pension if the marriage lasted at least 10 years and the divorce decree awarded her an annuity or a lump-sum payment. Pensions for divorced wives are coordinated

with those from social security, so that her total benefit is not in excess of the amount specified in the divorce decree.

Upon death of an employee, the children's pensions are 20 percent, per child, of the parent's actual retirement or disability pension, or the disability pension that would have been paid. A child is entitled to a pension until age 18, or age 25 if still a student or if disabled.

Vesting

All retirement credits are fully vested immediately. As a practical matter, this means that very short-term employees accrue benefits if they meet the salary requirements.

Employee Participation

Employee representatives must make up half of the board of a foundation established to provide pensions under the BVG/LPP legislation.

Prior to this legislation, membership of the board of a Foundation was in proportion to the contribution split between the employer and employees. If two-thirds of the contribution was paid by the employer and one-third by the employees (a common arrangement), then the board was composed of two-thirds employer's representatives and one-third employees' representatives. The BVG/LPP law requires that employee representatives compose 50 percent of the membership of the board, even if the contribution split is other than 50/50. The law does not specify any particular method of choosing the employee representatives, but usually they would be elected by the employees. The number of board members required is not specified in the law.

Some companies with substantial existing pension assets, accumulated prior to the BVG/LPP legislation, were reluctant to have employee representatives composing half of their foundation board. These companies established a second foundation with a second board only for the mandatory benefits, and continued their voluntary pension plan under the original board dominated by employer representatives. In general, it seemed to be U.S. companies that were the most concerned with this issue. Swiss companies are accustomed to cooperative relationships with their unions and employees and seemed less concerned over the issue.

U.S. companies are also likely to have a more aggressive investment policy for their pension assets and to want more of their assets to be

invested outside of Switzerland for higher returns. The average investment return on a Swiss pension fund is between 4.5 and 5.5 percent. Some companies feared that Swiss employee representatives might oppose overseas investments.

In addition, companies that maintain two pension funds can more easily communicate to employees which part of their benefits is mandatory and which is provided voluntarily by the company.

Education and Training

Most of the larger unions and employers' associations have been active in providing education and training for their members on the provisions of the BVG/LPP law and the responsibilities of board members. These efforts, plus the marketing activities of banks and insurance companies, and the two and a half year period between the passage of the BVG/LPP law and its effective date meant that the government did not have to organize educational sessions.

Legal Structure

In Switzerland, an employer or financial institution sponsoring a pension plan must first establish a legal structure known as foundation.[8] A foundation is a legal entity separate from the plan sponsor with a deed of constitution, regulations, and board of directors. Only a corporation, an insurance company, a bank, or a trustee company can legally establish a foundation.

Financing Choices

A company in Switzerland has several choices for arranging the financing of the mandatory pensions. The main choices are for a company to

- establish and manage its own foundation (similiar to a U.S. trusteed plan),
- establish its own foundation and insure the pensions (similar to a U.S. insured plan),

[8]Two other legal entities, a co-operative and a public law institution, are authorized as legal structures for pension plans in the BVG/LPP law, but these would be used by co-operatives or government entities, respectively.

- participate in a general foundation organized and managed by an insurance company, bank or trustee company,
- participate in a general foundation organized by a trade or industry association or region and managed by a bank or insurance company, or
- participate in the suppletory foundation (a national "catch-all" foundation).

Foundation Managed by the Employer

A foundation can be established by a company to provide only the mandatory pensions specified under the BVG/LPP law, only voluntary pensions, or a combination of both types of pensions. The board of directors of the foundation is composed of equal numbers of employee and employer representatives. All contributions are made to the foundation which then insures the risk benefits by paying premiums to an insurance company. The assets of the foundation accruing from the retirement contributions can be managed in-house or allocated, by a decision of the board, to one or more banks or independent portfolio managers to manage. Insurance companies in Switzerland have not managed separate accounts for their pension clients in the past, but some have recently sought permission to do so.

This is the only financing method that gives the plan sponsor control of the actual investments of the foundation. An individual employee never has control over the manner in which his or her retirement credits are invested.

Pensions Insured with an Insurance Company

A plan sponsor can establish its own foundation and the board of directors of the foundation can choose to insure both the risk and the retirement benefits with an insurance company. The contributions are used to pay the premiums to the insurance company. The foundation itself has only minimal assets. This is similar to an insured pension plan in the United States, except that it is the foundation that pays the premiums to the insurance company, not the plan sponsor. The insurance company would ordinarily manage the assets with its general assets. The plan sponsor has no control over the investments.

This method ordinarily would be used only if the plan sponsor has a particular reason to want its own foundation and board. If a company is going to insure all the benefits anyway, it is administratively easier to participate in the general foundation of an insurance company. However, a company might have had its own foundation for historical reasons and not want to disband it, or a company might

feel there are employee relations advantages in allowing its own employees to participate on the board.

General Foundation of an Insurance Company

A plan sponsor can participate in a general foundation operated by an insurance company. In this case, the plan sponsor does not have its own foundation or board at all. The general foundation has a board of which half of the members are employee representatives, but not necessarily from every company that participates in the general foundation. The general foundation pays premiums to the insurance company that operates it to insure both the risk and the retirement benefits. Therefore, the general foundation itself has only minimal assets.

General Foundation of a Bank

The plan sponsor can participate in a general foundation operated by a bank. This is similar to the method above except that the board must still insure the risk portion of the benefits with an insurance company. The retirement contributions are accrued in the general foundation and the assets are managed by the bank. Therefore, in this case, the general foundation has substantial assets. All investment decisions are made by the bank. Often a bank and an insurance company will cooperate in sponsoring a general foundation to market their joint services to clients more effectively.

General Foundation Operated by a Trustee Company

The plan sponsor can participate in a general foundation operated by a trustee company. The board must insure the risk benefits with an insurance company. The retirement contributions are accrued in the general foundation and allocated by the board to a stockbroker or independent portfolio manager to invest. This arrangement is necessary if a stockbroker or independent portfolio manager wants to manage the assets of a general foundation, because a trustee company is legally permitted to establish a foundation and a stockbroker or portfolio manager is not. In practice, there are very few trustee companies operating general foundations.

General Foundation Operated by an Association or Regional Organization

Organizations such as employers' federations, trade and industry associations, professional associations, unions, and regional entities can organize a foundation for their members. The board includes

employer and employee representatives from member organizations. Some organizations tried to make it mandatory for their members to join their foundation to be able to negotiate better terms from the insurance company or bank by being able to guarantee a specified number of participants. However, no organization can really enforce such a requirement if a member chooses to make other arrangements.

In this case, because the assets are sizable, the sponsoring organization usually chooses a lead insurance company or bank to operate the foundation. The lead company then allocates a portion of the insurance premiums or assets to other insurance companies and/or banks.

Suppletory Foundation

This is a national "catch-all" foundation for companies or self-employed persons who have no other appropriate foundation to join. The Insurance Authority can also require firms to contribute to the suppletory foundation if they are negligent about making other arrangements. The suppletory foundation is administered jointly by the central employers' federation and the central trade unions, in the same manner as the Security Fund.

Choices for Small Business Employers

A company with under 100 employees and no previous benefit plan would probably choose to provide the mandatory benefits by joining the general foundation sponsored by its trade or industry association, or the general foundation sponsored by the bank or insurance company with which it had an existing relationship. During the start-up period for implementation of the BVG/LPP law, all organizations sponsoring foundations conducted very active marketing campaigns to solicit participants. It is unlikely that any firm would have had difficulty finding an appropriate foundation to join.

Virtually all businesses in Switzerland belong to some kind of employers' association covering their trade or industry. The various employers' associations are grouped into many federations which then have a central employers' federation to provide a coordinating role. This existing structure makes it fairly easy to inform and enlist the participation of small businesses in Switzerland. It would be considerably more difficult to introduce a similar requirement for all small businesses in the United States without this structure.

For example, the trade association for restaurants organized a foundation to provide the BVG/LPP benefits, and virtually all restaurants

and small guesthouses joined this foundation. The major hotel chains already had their own benefit plans before the BVG/LPP was passed, but most restaurants did not. Therefore, the new foundation for the Restaurant Association covered a significant share of the previously uncovered employees. Since the contributions were expected to be substantial, the Restaurant Association chose a major insurance company, Swiss Life, to be the lead insurer for the foundation, and Swiss Life then arranged prorata participation for other insurance companies.

This arrangement makes it extremely simple for any individual restaurant owner to provide his or her employees with the minimum mandatory BVG/LPP benefits. Every restaurant owner is already a member of the Restaurant Association. The Restaurant Association makes all the initial decisions and provides individual owners with information. Swiss Life manages the administration of the foundation. The restaurant owner simply needs to sign up. All the participating insurance companies have agents to maintain direct contact with the restaurant owners and collect the required data on employees. It is the insurance agent's responsibility to see that clients actually submit the necessary information on their employees and pay their contributions.

Transfers Upon Change of Employment

Upon changing employment, the BVG/LPP law permits an employee to transfer the value of his or her mandatory "retirement credits," plus 4 percent interest, to the foundation of a new employer. Theoretically, an employee who has 10 jobs before retirement should keep transferring retirement credits to the foundation of each new employer, so that by retirement age, all the benefits are due from the foundation of the last employer.

The BVG/LPP legislation requires the transfer of the mandatory retirement credits, but simply allows transfers of excess benefits if the new employer's foundation wishes to accept them. Since the mandatory portion is being transferred, naturally, there have been more attempts to transfer excess benefits since 1985. For plans providing the minimum mandatory benefits only, the transfer value is a simple calculation, and neither the new nor the former employer is likely to have any problems with the transfer of retirement credits or assets.

A standardized method for calculating the transfer value for excess benefits was not established before the BVG/LPP legislation was enacted. In the last two years, companies have discovered that there

are technical problems in calculating an acceptable transfer value in some cases. The transfer value is often not communicated well to employees, causing misunderstandings when the transfer is made. New legislation on the transfer issue is likely to be introduced to alleviate this problem.

As a practical matter, the benefit transfer problems arise mainly upon job changes between corporations maintaining their own foundations and having different, complicated defined benefit formulas and vesting schedules for their excess retirement benefits. The general foundations sponsored by employers' federations and industry associations eliminate many of the problems associated with job changes, as there is a high probability that an employee will move to a new company that participates in the same general foundation as the previous employer.

One significant gap in the implementation of the BVG/LPP legislation seems to be the lack of standardized forms and procedures for actually effecting a transfer of retirement credits, even when the value is easy to establish. When an employee changes jobs, the old employer is supposed to notify the insurance company or bank managing the foundation; the insurance company or bank notifies the employee by letter of his or her retirement credits and inquires as to where to transfer the credits. The employee notifies the insurance company or bank of the name of the new employer and the new employer's foundation, and the retirement credits are duly transferred to the new employer's foundation by the former employer's insurance company or bank.

Unfortunately, this sequence of events does not occur smoothly in all cases. It is really the employee's responsibility to see that retirement credits are transferred properly to the new employer's foundation. There is no particular penalty for either the new or former employer if they are inefficient with their part in the transfer. A myriad of events can occur which cause difficulties:

- An employee quits his or her job without leaving a forwarding address.
- Foreign workers on work permits are likely to be less aware of their accrued retirement credits than Swiss employees.
- A person is unemployed for a while before finding a new job and loses track of the information, even if it was supplied.
- The former employer is slow in notifying its insurance company or bank about making the calculation.
- The new employer does not ask its new employee if he or she has incoming retirement credits.

- The employee does not have sufficient knowledge or interest in the procedures to follow up.

In the two years that the BVG/LPP legislation has been in effect, sponsors of foundations have discovered that they are accumulating small amounts of retirement credits for people who they can no longer locate. Most insurance companies continue to award the 4 percent interest to these accounts, but it is unclear whether they are legally required to do this. It is actually the responsibility of the employer's foundation to accrue the interest to an account. The law assumed that everyone would transfer retirement credits directly from one employer's foundation to another and did not make any provisions for retirement credits that are no longer part of an employer's benefit plan.

If an employee does not have a new employer, or the new employer does not want to accept his or her excess retirement credits, the employee can convert the retirement credits (BVG/LPP and excess retirement credits) into a personal retirement insurance policy. Beginning January 1, 1987, new individual retirement savings plans (similar to individual retirement accounts in the United States) were introduced, but there are no regulations as yet allowing the transfer of BVG/LPP retirement credits to these accounts.

Investment of Assets

Only a plan sponsor that chooses to establish and operate its own foundation has any choice over the manner in which the assets are invested. An individual employee never has any choice over the investment of the assets for his or her account.

The BVG/LPP regulations include the following general restrictions on the investment of retirement assets:

Investment Vehicle	Maximum % of Assets
Mortgages and mortgage bonds	75%
Stocks of Swiss companies	30%
Bonds of foreign issuers	30%
Stocks of foreign companies	10%
Foreign currency debts	20%
Real estate in Switzerland	50%
Foreign real estate	prohibited

In addition, there are overall maximums, including:

Real estate and stocks	70%
Swiss and foreign stocks	30%
Foreign bonds and foreign currencies	30%
Foreign currencies and foreign stocks	30%
Any one Swiss company	10%
Any one foreign company	5%
Any one issuer of bonds or debt, except the Swiss Government, a Canton, or a bank	15%
Loans to the plan sponsor	20%
Stock of the plan sponsor	10%

Any loans to the plan sponsor must accrue interest at market rates. This list of investment restrictions should be taken as a general guide only, as there are detailed specifications for each class of investments.

Historically, Swiss pension funds, banks, and insurance companies have been very conservative in their investments. For 1984 (latest available figures), the average asset mix was as follows:[9]

Bonds	31.1%
Stocks	4.0%
Loans to and other obligations of the plan sponsor	22.6%
Other loans	1.9%
Mutual funds	6.2%
Mortgages	9.2%
Real estate	18.7%
Cash and short-term investments	4.8%
Other assets	1.5%
Total assets	100.0%

Taxation

Employer and employee contributions to BVG/LPP benefits are tax deductible. Interest accrued on the account is not taxable income to the employee until retirement. Pensions are fully taxable at the regular income tax rates when received. However, for a 15-year transitional period beginning January 1, 1985, pensions will be taxed on only 80 percent of their value.

[9]L'office federal de la statistique, published in *La Vie Economique*, May 1986.

Persons Not Covered by Mandatory Pension Plans

The BVG/LPP law intended to encompass almost all employee groups. Those still uncovered for retirement pensions, unless they make individual arrangements, include:

- housewives,
- unemployed persons,
- owners of small businesses who choose to exclude themselves,
- relatives working on family farms (not other family businesses), and
- employees earning under $975 per month (one-twelfth of the annual minimum of $11,700.

Employees who receive room and board as part of their wages are supposed to have a monetary value placed on the room and board, and the contributions are supposed to be assessed on the total value. As a practical matter, this category is difficult to monitor unless the employee complains; it consists mainly of hired hands living and working on small farms. Large dairy farms are members of an industry association and so would include their employees in the association's foundation. Relatives working in a family business must be included if they earn the required salary.

Penalties on Employers

The law does not include any specific penalties for employers that do not fulfill the requirements of the BVG/LPP law. It is the responsibility of the insurance authority in each canton (similar to a state) to follow up on nonparticipating employers. To date, they have used persuasion to enlist participation. If an employer does not register its employees with an appropriate foundation, the Cantonal Insurance Authority will issue a letter outlining the employer's responsibilities. If the employer still takes no action, the canton can require the employer to join the suppletory foundation. If an employer is late in registering its employees, the employer is still responsible for contributions from January 1, 1985. The Cantonal Insurance Authorities have access to the records of businesses making social security contributions and to the records of registered foundations, so they can check up on individual employers, but this is not an easy administrative task.

Nonparticipation has not really been a significant problem in the implementation of the law. Most Swiss are well aware of the law and dutifully fulfill their obligations. Some sponsors of general foundations have noticed that there are employers who duly registered their employees with a foundation as required, but who have made no further contributions for them. This creates additional administrative work for the insurance company or bank to collect the contributions.

So far, there have not been significant claims for retirement benefits from employees who should have been covered, but were not.

Effect of the BVG/LPP Law on Small Businesses

Based on interviews during April 1987 with a number of Swiss people involved with the BVG/LPP law (government officials, insurance companies, trade associations, employers, benefit consultants), the implementation of the BVG/LPP law seems to have gone relatively smoothly. The existing trade association structure was a significant asset in enlisting the participation of small business employers.

Although some small companies objected to the cost of the contributions, they were simply overruled. The general feeling in Switzerland seems to be that if a small business is so marginal that it cannot make its retirement contributions, it probably would have gone out of business anyway from other causes. There are no statistics on the number of businesses that did close for this reason. There were no arrangements made for government subsidies to businesses that could not afford the contributions.

Some restaurants used the increased contributions as a reason to increase prices, but this seems to have had little negative effect. There has been no noticeable drop in the number of foreign tourists visiting Switzerland because of it.

Effect of Mandatory Pensions on International Competitiveness

No Swiss person interviewed believed that the BVG/LPP law had any effect on the international competitiveness of any company or of Switzerland in general. Switzerland has always been competitive internationally even while maintaining high wage rates and good living standards for the entire population. The Swiss believe that their international competitiveness derives from:

- their economic policy of keeping interest rates low so that capital is easily available to business;

- their economic policy of keeping the inflation rate low; and
- their concentration on export markets in which they can excel (e.g., precision instruments).

When these issues are under control, the extra costs deriving from retirement contributions are simply not significant to the international competiveness of Switzerland. The types of businesses that were newly covered for retirement pensions under the BVG/LPP law are not significant players in the export market anyway. The major exporting companies already had pension plans with benefits in excess of the minimum requirements before the BVG/LPP was passed.

Implications for the United States

Legislation such as that introduced in Switzerland would not transfer easily to the United States. The low percentage of employees to be newly covered and the trade association structure made the implementation relatively easy in Switzerland. The United States has a considerably higher percentage of employees who do not have retirement benefit coverage, and less existing coordination of its small businesses. The United States does not have the same economic policies or export market as Switzerland, so the effect on international competitiveness is not comparable.

The real implication of the Swiss experience that is of importance to the United States is the reason why mandatory retirement benefits were introduced in the first place. It was a political compromise to avoid the less desirable alternative of an expanded social security system the demise of the private pension system.

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PART FIVE
MANDATED FAMILY BENEFITS

In 1955, 60 percent of American households consisted of a working father, a mother who was at home, and two or more children in the family. That type of family pattern was true of only 4 percent of American households in 1986.

In 1940, only 29 percent of all women were working or looking for work; by 1986, that figure had risen to 53.3 percent. By 1995, as many as 80 percent of all 25- to 44-year-old women are expected to be in the labor force. The number of working mothers totaled 18.6 million in 1985, triple the number 25 years earlier.

These changes in the American family and the demographics of the work force have major implications for employers who want to attract and retain employees and who soon may be competing for workers in a tight labor market. Workers may put more value in the future on employee benefit programs that include flexible working schedules, expanded maternity and paternity leave, and day care facilities at work. Finding appropriate child care has become a major problem for working mothers, and both husbands and wives are struggling to handle the pressures of work and family responsibilities.

Almost alone among the nations of the world, the United States has no paid maternity or paternity leave policies. Canadian workers are guaranteed up to 41 weeks of leave with 60 percent pay; Italian workers up to five months with 80 percent of pay. Congress has been debating family leave legislation since 1985; bills being considered in the 100th Congress would require employers to provide workers with up to 18 weeks of unpaid leave for the birth or adoption of a child or for the care of an ill parent.

The legislation has spawned considerable debate over its potential impact on employers, particularly small business employers. Some employers contend that such mandates would result in higher labor costs even though the leave would be unpaid because they would have to hire temporary workers and continue health insurance for the workers on leave.

In Chapter XVII, Sara Rix talks about the changing American family and the implications of those changes for public and private policy on work place issues. The rapid increase in labor force participation

by women will continue, Rix predicts, despite the conflicts that often arise between work and family responsibilities.

Rix contends that pressure is mounting on Congress to improve the status of women and families through mandated benefit programs. Incremental improvements for women have already been made, she says, through provisions in the Retirement Equity Act that have had the effect of broadening pension coverage of women and through the Tax Reform Act provision that lowers vesting in private pension plans from ten to five years. She sees less chance, however, that Congress will require employers to provide child care for their employees.

In chapter XVIII, Gwen G. Morgan reviews a number of family and child care bills that have been introduced in the 100th Congress. She directs her attention to the Family and Medical Leave Act in particular (H.R. 925), which was first introduced in 1985 by Rep. Patricia Schroeder (D-CO). Research on work and family issues, Morgan says, points to the needs of the millions of working mothers in the work force today whose incomes are essential to the family in the present economy. She also describes new research findings on infant development and child care, which argue for a mother's involvement with a young child.

Morgan summarizes the arguments against parental leave legislation from the employer's point of view, such as the cost burden on business, the effect on small business, and the employer's loss of flexibility. But, she concludes, not only would children benefit from such legislation, but so would business through a more loyal and productive work force.

XVII. Mandated Benefits and the Work/ Family Dilemma or What's a Good Congress To Do?

PAPER BY SARA RIX

Once upon a time, and that was not so very long ago, little girls grew up, got married, stayed married, had children—maybe 3.7 of them—and remained at home caring for those children while their husbands went out and earned a living wage. If reality was not always postcard pretty—if there were hasty marriages, divorces, desertions, and family poverty to mar the picture—the slip-ups were not sufficiently numerous or visible to threaten the stereotypical ideal of the nuclear family with a single wage earner. A range of policies, institutions, customs, norms, and expectations evolved to support this ideal: public schools that do not admit children before kindergarten; mid-afternoon school closings; government offices that are typically open only on weekdays; doctors and dentists who take their weekends off.

All of this worked, of course, when the primary caregiver was a full-time homemaker who could see to it that the children remained out of mischief, the banking got done, and the baby was taken to the pediatrician. Maternity leave was a nonissue at a time when employed mothers of infants (or even older children) were frowned upon unless they were widowed or their husbands could not support them; child care needs were at worst not much more complicated than finding a baby sitter on Saturday night.

The Changing American Family

Times have changed, however, and the "American Family" poster would no longer feature mom in an apron, dad with a briefcase, and several apple-cheeked dumplings cavorting on the front lawn. Rather, it would likely portray both parents dashing to the car with briefcases or lunch pails and perhaps a toddler in tow, for today's typical American family (some 40 percent of all families and half of all married-couple families) is the dual-worker family. The family that boasts a single male earner with a stay-at-home wife and one or more children—a mere 15 percent—is actually outnumbered by the female-headed family, which, at 16 percent of all families, is the second most

common family type. Moreover, the number of female-headed families has been growing at a rate faster than that of married-couple families. Given continuing high divorce rates and growing acceptance of out-of-wedlock motherhood, this family type may assume even greater prominence in the future.

Few trends of the past several decades have been quite as pronounced as that of women's march into the paid labor force. In 1940, only 29 percent of all women were working or looking for work; by 1986 that figure had risen to 53.3 percent.[1] Especially dramatic has been the increased labor force participation on the part of mothers with young children. No longer do these mothers stay out of the work force until their youngest child reaches school age. Even mothers of infants are going to work—mostly back to work: nearly half of all married mothers are entering or reentering the work force soon after giving birth, a proportion that is up from less than a third only 10 years ago. By the time their youngest child is four, 60 percent of all mothers are in the labor force. And although women are more likely than men to work part time, full-time work is by far the most common status among women working for pay, again even when they are mothers of very young children. For example, two-thirds of employed mothers with children under the age of three were full-time workers in 1985. Not surprisingly, full-time work is especially characteristic of employed female single parents: nearly 80 percent of such mothers with children younger than three were full-time workers in 1985. All told, 25 million children are living in families in which the mother goes off to work for all or some of the day (Hayghe, 1986).

Public and private policies have been slow to reflect the growing diversity of family types and as yet do not meet the need of working mothers particularly well. The country acts, as Secretary of Labor William Brock has noted, as if workers had no families (Bureau of National Affairs, 1986). Almost alone among the nations of the world, the United States has no paid maternity or paternity leave policies. (Many countries, but again not the United States, have very comprehensive family policies; some, such as Germany, Sweden, Norway, and Russia even pay cash benefits to parents who care for ill children.)

It is not always easy, but most families manage to muddle on without support, of course. A recent analysis of the work/family balancing act asserts that "confronted with inadequate child care and outdated

[1]Figure for 1940 refers to females 14 and older; in 1986, labor force participation rates were computed for persons 16 and above.

personnel policies, . . . women are pioneering new frontiers in many areas with important policy implications" (O'Connell and Bloom, 1987, p. 1). One of the biggest obstacles to work/family adjustment seems to be the supply of adequate, affordable, dependable child care. For the most part, parents—admittedly often by choice—turn to family members and other informal sources for child care. A rather substantial amount of shift work enables many parents to share the burden of care (Cherlin, 1987). Day care centers and nurseries are used by a minority of parents (U.S. Bureau of the Census, 1983), but if they were more widespread, parents would undoubtedly take advantage of them. Eighty percent of the respondents to a Roper-conducted 1985 Virginia Slims women's opinion poll voiced approval for the establishment of more formal day care centers, a proportion that was well above the comparable figure for 1970.

Labor Force Participation Rate of Women

Lingering ambivalence about the proper role of married women with children may explain why some of our family policies are so deficient, but this ambivalence is unlikely to have any appreciable affect on women's employment patterns. By all accounts, the labor force participation rate of women will continue to rise, albeit at a slower rate than it did in the recent past. Women should account for some 60 percent of the growth in the labor force between 1984 and 1995; by 1995, as many as 80 percent of all 25- to 44-year-old women are expected to be labor force participants. (That was the case for 72 percent in 1986.) And, as more women are entering the labor force, they are deciding to stay there: length of work life among women has been rising sharply (Smith, 1985).

Several factors should encourage greater female labor force attachment: later marriages, delayed childbearing, greater work experience prior to childbearing, smaller family size, higher educational attainment, growing acceptance of the fact that women intend to work, and, as discussed subsequently, need.

Birth rates may be well below the baby boom highs and showing no sign of returning to those levels; however, working *mothers* will be very much part of the future employment scene. Of the women who are in the labor force today, three-fourths are in their childbearing years, and most of them apparently expect to have children if they have not done so already. In 1985, for instance, women between the ages of 18 and 34 reported that they planned on having an average of two children (U.S. Bureau of the Census, 1986). There is no reason

to expect that these young women will withdraw from the labor force to rear their two children.

It is not just youngsters who are placing demands on working women. Improvements in life expectancy mean an increase in the elderly and infirm who depend largely on wives and daughters for assistance. As of 1982, over 2.2 million caregivers—the vast majority of whom were women—were providing help to some 1.6 million impaired non-institutionalized aged (Stone, 1987). According to Stone, women apparently can now expect to spend more years caring for an aged parent than they spend in the care of their children.

Caregivers are not as likely as the total population to be working, in part because many are themselves of retirement age; nonetheless, about one-third do work for pay. For them, work and family responsibilities frequently come into conflict, and 11 percent had actually left a job in order to manage caregiving responsibilities. Twenty percent resolved the work/family dilemma by working fewer hours, almost 30 percent by rearranging schedules, and 19 percent by taking time off without pay.

Juggling work and family responsibilities is not made any easier by the relative paucity of alternative work schedules, which are available to only one in eight employees. Eighty percent of all full-time wage and salary workers start work between 7 and 9 a.m. Even though women are the caregivers, men are more likely to have flexibility in scheduling (Mellor, 1986).

If women were working merely for personal fulfillment, concern for their dual burden might be misguided. But the fact of the matter is that while some may work for personal satisfaction, most women work for the same reason men work: they need the money. One minor indicator of this need may be the sharp increase in the number of women with two jobs (Stinson, 1986). There are not many, but these women are not holding two jobs for the fun of it: the need for more income now (as opposed to, for example, the desire to set aside for the future) predominates among the motivations of those taking on additional work, especially in the case of widowed, divorced, or separated women. Children are not mentioned, but they are probably a factor propelling most of these women into second jobs.

Of the 8.7 million women who were caring for children in the absence of a father in 1983, 21 percent were never married and their chances of being awarded and/or getting child support would appear to be slim. Still, having been married is no guarantee that a father will provide: of all "custodial" mothers in 1983, two-thirds were re-

ceiving no child support payments.[2] For these women, then, it is work or welfare, and it seems to be work in more cases than not.

Single parents are not the only mothers who need to work. Intact families are apparently finding it increasingly difficult to maintain a middle-class lifestyle with a single earner. In the case of the middle-aging baby boomers, it has been suggested that because married couples are reaching the point where earnings no longer increase rapidly, wives must increase their time in the labor force to maintain living standards. Some economists suspect that the size of the baby boom generation itself has depressed lifetime earnings, further necessitating wives' contributions to family income (Fullerton, 1985).

More worrisome, perhaps, is what may be a growing difficulty in reaching the middle class, let alone of staying there. Income inequality appears to be rising (Bradbury, 1986), the result, perhaps, of what may be a decline in high-paying jobs and a corresponding increase in low-wage ones (Bluestone and Harrison, 1986). Not everyone agrees that the situation is so bleak (Samuelson, 1987), but a significant amount of evidence points to a deteriorating economic status on the part of families with children; working wives seem to be keeping family incomes from deteriorating even further. Sheldon Danziger and Peter Gottschalk have found that families with children at each of five income levels lost real income between 1967 and 1984. Were it not for the earnings of working mothers in these families, the drop would have been greater. Among low-income families in their study, poverty rates in 1984 would have been 35 percent higher, all other things being equal, if wives had not been employed (Danziger and Gottschalk, 1985).

In sum, Mom is working because she is the only wage earner or because her husband no longer earns a living wage.

Pressures on Congress for Mandated Benefits

These facts form the backdrop for congressional action over the rest of the decade. The question that this paper addresses is whether Congress will require employers to provide additional benefits in the wake of efforts to mandate health benefits. The paper focuses on

[2]These figures are not meant to point the finger at anyone, but merely to highlight the lack of child support and the consequent need to work. Half of the fathers who were supposed to make child support payments in 1983 did pay what they owed. The problem is that many mothers are not entitled to child support (U.S. Bureau of the Census, 1985).

proposals that involve families. While one is naturally cautious about implying any special insight into the collective consciousness of Congress—if indeed there is such—the motivation to improve the status of women and families through mandated benefits may be all but overwhelming.

Pressure is sure to mount for policies and programs that will make it easier for women (and men) to combine their dual roles as providers and nurturers. (One should not lose sight of the fact that men are also parents, and that some men are assuming a more active role in the rearing of children. But the indisputable fact is that the work/family conflict is experienced most acutely by women, so policies and programs to minimize this conflict would naturally have the most direct impact on women.)

If women's work benefits families, the argument goes, it benefits everyone, and there ought to be greater sharing of the costs of promoting family well-being. If everyone agreed with this perspective, Congress would have a far easier time of it, but not everyone does. As Alice Ilchman, president of Sarah Lawrence, has observed: "Balancing work and family responsibilities is difficult because everyone thinks it's someone else's problem .... Management thinks it's a worker's problem, men think it's women's, and older parents think it's the problem of younger parents" (Bureau of National Affairs, 1986, p. 20). Congress might prefer to think it is a problem of the private sector.

Since the current political and economic climate does not augur well for government initiatives that add to the strain on the federal coffers, mandated fringe benefits, which do not appear to cost the U.S. Treasury anything, have obvious appeal. Family policy expert Sheila Kamerman contends that "at a time when direct public expenditures for social programs are being reduced, there is growing pressure on the private sector—including employers—to do more, whatever 'more' may mean" (Kamerman, 1983).

Even the most cursory review of congressional action over the past six years suggests that mandated benefits are nothing new: Congress has used mandated benefits to improve the status of women a number of times recently and may well do so again in the future. Many of the laws mandating benefits were introduced in Congress as part of what is known as the Economic Equity Act (EEA), a legislative package first put together during the 97th Congress to promote economic equity for women.

Although some of the "big ticket" items in the EEA (e.g., earnings

sharing under Social Security and fringe benefits coverage for part-time workers) have yet to be passed, Congress has continued to endorse incremental improvements in mandated benefits coverage, some of which serve to compensate women for their dual roles as wives and workers and the penalties that might arise therefrom. For example, sponsors of the Retirement Equity Act (REA) (P.L. 98–397) promoted changes that would remove some of the penalties experienced by women who enter the labor force at young ages and then leave to have children.

Among the REA changes that amended the Employee Retirement Income Security Act (ERISA) and those sections of the Internal Revenue Code regulating pensions were provisions that: (1) lowered the minimum vesting age and age for enrollment in private pension plans; (2) barred pension plans from treating a one-year paternity or maternity benefit as a break in service; and (3) allowed a worker to leave and return to a job without losing pension credits as long as the absence did not exceed a specified period of time. Other changes recognized the homemaker's economic contribution to the family by requiring that both spouses agree in writing to a waiver of survivor benefits under private plans. The right of a homemaker to a spouse's vested pension in the event of death was also protected.

Workers with intermittent or interrupted work lives stand to improve their private pension coverage as a result of the Tax Reform Act (TRA) of 1986, which, among other things, lowered vesting from 10 to 5 years. TRA's restriction on private pension integration with Social Security is, of course, sex neutral, but to the extent that it actually helps low-income workers, it will help women most.

One final mandated benefit, among others, that should be reviewed here is of considerable importance to that group of women—typically middle-aged and un- or under-employed—whose access to employer-provided health insurance is lacking. The Consolidated Omnibus Budget Reconciliation Act requires that employers continue to provide health care coverage to widows, divorced or separated spouses, and certain other dependents in the event that the covered worker dies or is terminated (for non-"cause" reasons). Beneficiaries are required to pay for this coverage, which is limited in duration; nonetheless, it is an important form of protection for many individuals formerly dependent on a spouse's insurance.

Recent improvements in mandated benefits, generally modest in scope, have typically built upon existing benefits. This building-block approach, however, is not enough for groups that find the going slow

and whose members are lobbying hard for more innovative and radical benefits, particularly in the area of dependent care. What is likely to happen?

Meeting Child Care Needs

Despite growing acknowledgment of the inadequate child care facilities for the children of working parents, there are no signs that Congress will, at least in the foreseeable future, require private-sector employers to meet the child care needs of their employees. Consensus as to what might be doable or even appropriate is totally lacking. Nor is it likely that the 1986 reauthorization of the Higher Education Act of 1965, which included $10 million in 1987 to provide college day care centers for low-income, first-time students, is a precursor of more extensive *federal* involvement in dependent care. This is despite the fact that child care and/or supervision for preschoolers, afterschoolers, and perhaps even teen-agers (over whom no one seems to be watching) is probably something that can best be provided by a commitment on the part of the federal government, most particularly in the form of funds to establish public day care centers.

Recent research, for example, suggests that considerably more mothers of preschool children—particularly unmarried mothers, black mothers, mothers from low-income families, and those who never finished high school—would work if reasonably priced child care were available. While the labor force increase might not turn out to be as substantial as that predicted (e.g., 24 percent points in the case of never married women [O'Connell and Bloom, p. 8]), public policymakers would do well to keep in mind the role that day care could play in improving the economic status of poor and low-income women. But since providing day care centers for perhaps 25 million children would be akin to developing the country's public school system, it would—to say the least—entail vast sums of money. Thus, although everyone would benefit if infants and children were appropriately cared for, such a costly initiative is out of the question.

Family and Medical Leave Act

While it would seem that employers are, at least for the moment, off the hook as far as paying for child care is concerned, they should not be so sanguine when it comes to care of the newborn or of sick children and incapacitated employees. Persons following the man-

dated benefits scene would do well to keep tabs on the Family and Medical Leave Act, known familiarly as the parental leave bill.

Introduced in the 100th Congress as H.R. 925 and S. 249, the Family and Medical Leave Act would provide 18 weeks of unpaid, job-guaranteed leave to parents of a newborn, newly-adopted, or seriously-ill child and up to 26 weeks of unpaid job-guaranteed medical leave for workers with serious temporary health conditions.* Employers would be required to continue health insurance coverage for workers on leave, who could expect to return to their same or a comparable job with no loss of seniority. Such protection would extend to workers in firms with 15 or more employees. The House version also provides leave for the care of seriously ill parents; neither the House nor the Senate would cover care of a spouse. With an eye toward future expansion of coverage, Title III of the bill would require a study of the feasibility of implementing paid benefits to workers on parental leave.

An earlier incarnation of the Family and Medical Leave Act would have extended coverage to *all* employers, but to broaden its appeal, drafters of the bill ultimately agreed on a 5- and then 15-employee compromise. (A similar bill introduced by Rep. Marge Roukema [R-NJ] would exempt establishments with fewer than 50 employees.) However, despite the fact that only unpaid leave would be required, opposition to the bill runs strong. The U.S. Chamber of Commerce, which objects to all mandated benefits, contends that the bill would be very burdensome because employers would bear the expense of hiring temporary workers and continuing health coverage. Voicing the sentiments of small employers, 96 percent of the delegates to the 1986 White House Conference on Small Business voted against government-mandated employee benefits, specifically objecting to employer-paid health benefits, parental leave, and disability leave. Rather, conference participants supported efforts in the private sector to identify new and voluntary approaches that would enable working parents to fulfill their job and family responsibilities. The conference also recommended Social Security changes, including the possible phaseout of the present system.

Business has traditionally objected to government's efforts to impose worker health, safety, and economic security requirements in the private sector, and the arguments against "encroachment" have

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*Editor's note: A bipartisan compromise agreement approved by the House Education and Labor Committee would provide fewer weeks of leave than originally proposed and would apply to firms with 50 or more employees.

hardly changed over the years. One need only recall the opposition of Massachusetts employers to a proposed law "that would lead to chaos in the productive process," cause employers to move out of state, and even lead to socialism. That 1880 evil? Child labor laws (Steinberg and Haignere, 1984).

To be fair, many employers have been generous in the benefits area: agreed-upon benefits are a greater proportion of the fringe benefit package than are those that are legally mandated (Munnell, 1984). Moreover, to attract the best employees, businesses find it in their own interest to offer the benefits employees want, when they can afford to do so. Nonetheless, the typical benefit package of today is still better suited to yesterday's male-dominated workforce. While it is true many firms provide such benefits as maternity and disability leave, most workers still lack those benefits that make it easier to be a working parent: liberal paid parental benefits, paid child care, or generous leave for sick children (O'Connell and Bloom, p. 1).

Not everyone regards family and medical leave as a "benefit." Some view it as merely a minimum labor standard (Radigan, Blankenhorn, 1987) arguing that it is not "mandated" since workers can *choose* to take the benefit. Parental leave might, in the words of one commentator, be more appropriately called an option, which only those who could afford to do so would exercise (Blankenhorn). Although most of the costs would be borne by the worker who lost wages, the Chamber prefers to focus instead on what the establishment would pay,[3] all but ignoring any gains that might be accrued. Proponents, on the other hand, tend to emphasize such hard-to-quantify pluses as productivity and improved employee morale. As is often the case, each side stresses the extremes of good or bad, but the fact of the matter is that neither opponents nor proponents can do much more than guess at what the costs and savings might be.

Congress will clearly pay attention to the concerns of business, particularly those suggesting that mandated benefits will raise labor costs and thus cut down on the ability of business to compete internationally. But business, it must be remembered, is not Congress' only constituency. (And not everyone is convinced that fringe benefits are what will destroy American competitiveness.[4]) There are parents who vote and who are clamoring for relief. National women's rights

[3]The General Accounting Office has since refuted the Chamber's estimates, maintaining that they are based on unreasonable assumptions about how many parents would take advantage of leave provisions and for how long and thus exaggerate the cost.

[4]See, for example, Richard S. Belous, *An International Comparison of Fringe Benefits: Theory, Evidence, and Policy Implications*, December 31, 1984, for the perspective that

groups, which have shown themselves to be effective lobbyists and increasingly savvy and experienced in the art of politics and compromise, have united behind a common agenda, among the priorities of which is the Family and Medical Leave Act.[5]

Moreover, unions, which have traditionally taken the lead in the push to expand benefits coverage, are increasingly sensitive to the particular needs of the women workers. Currently, women are 41 percent of union membership, up from 25 percent a decade ago (Nelson, 1987), and the drive to organize them goes on. Unions can be expected to be in the forefront of the fight for benefits that women want—pensions for part-time workers, day care, and family/dependent care.

In a surprise move that represented a breaking of ranks with business overall, the National Association of Women Business Owners (NAWBO) has expressed its support for the general principles of mandated parental leave and actually suggests extending such leave to establishments with fewer than 15 workers. (NAWBO's leave policy would, however, be considerably less generous: six weeks would be the limit.)

A parental leave requirement would be more radical than many of the other mandated benefits approved by Congress during the early part of the decade, so ready acceptance of the appropriate legislation is by no means guaranteed, but Rep. Roukema may be right when she contends that "members [of Congress] are beyond the stage of questioning whether family and medical leave is a discretionary benefit that employers have the option of providing."[6] And parental leave is not just a women's issue; it is, in the words of Rep. Barbara Boxer (D-CA), a human rights and family issue.[7] As such, it cuts across the political spectrum, appealing to both conservatives and liberals, which, of course, improves its chances of moving swiftly through the legislative system.

In the grand scheme of worker/family well-being, the provisions of the Family and Medical Leave Act itself are hardly earth-shattering. Why then, all the fuss and words over one simple bill that would not even replace a portion of wages for the relatively few weeks of leave it would provide?

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exchange rates are far more significant than fringe benefits in escalating labor costs vis-a-vis other countries.

[5]See, for example, *WEAL Washington Report*, February/March 1987.

[6]Quoted in *Update*, a publication of the Congressional Caucus for Women's Issues, February 1987.

[7]Quoted in *Congressional Quarterly*, January 26, 1985, p. 146.

It is not merely the provisions of the Family and Medical Leave Act that its proponents consider so important. Of equal, if not greater, importance is the fact that its passage would represent acknowledgment on the part of national policymakers that times and the family have truly changed and that the relatively simple days of the 1950s and earlier are probably gone for good. The Act would reflect, and address some of the needs caused by, those changes. It may not be perfect, but it is—and should be regarded as—a first step in the right direction. And if Congress, as it seems to, really does prefer incremental changes over innovations, the first step is the one that counts.

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XVIII. Parental Leave and Other Child Care Issues

PAPER BY GWEN G. MORGAN

The Family and Medical Leave Act, H.R. 925, was introduced in the 100th Congress by Rep. Bill Clay, (D-MO), Pat Schroeder (D-CO) and 72 co-sponsors; its companion bill in the Senate is S. 249, introduced by Sen. Christopher Dodd (D-CT) and Arlen Specter (R-PA).

First introduced in 1985 by Rep. Schroeder, the present bill, as amended in response to hearings, provides for:

- up to 18 weeks protected unpaid leave for the birth or adoption of a child or placement of a foster child (leaves to be available for both mothers and fathers);
- up to 18 weeks protected unpaid leave for the illness of an older parent of the employee (House version);
- six months protected unpaid leave for the personal illness of a sick or disabled employee;
- continuation of health benefits during the leave;
- protection of benefits the employee has at time of leave;
- guarantee to the returning employee of the same job or a similar one;
- limits on the total amount of leave for combined family and medical leave to 36 weeks over a 12-month period;
- provisions for the option of reduced hour schedule for the returning parent;
- exemption of companies with fewer than 15 employees;
- requirement of a three-month or 500-hour work period before new employees would be eligible for the parental or medical leave (House version);
- requirement that the employees seeking a leave provide reasonable notice when the leave is forseeable and schedule the leave to accommodate the needs of the employer when medically feasible (House version);
- establishment of a commission to study the feasibility of paid parental and medical leave policy, to report to the Congress with recommendations within two years.

Another bill, the Family and Medical Leave Job Security Act, introduced by Rep. Marge Roukema (R-NJ) would exempt companies

with 50 or fewer employees and would provide a family leave of eight weeks and a medical leave of 13 weeks.

Introduction

Over 100 other countries have policies that guarantee working mothers the right to some time off for childbirth. Most of these countries have a fairly long paid leave, and some countries extend this leave on an unpaid basis. A few countries include fathers as well as mothers in the leave policy.

The United States has no national leave policy for working parents at the time of childbirth, and does not pattern its benefit and worker policies on those of other countries. However, the issue is receiving attention in both state and federal legislation. Media coverage has been high, and there is strong public interest in the measure.

The Family and Medical Leave Act has been reintroduced for a third year. The bill has been endorsed and enthusiastically supported by 78 national organizations representing child care advocates, child development and family support experts, labor, health experts and the medical community, the aging, and women's groups.

Massive and heated opposition has come from business-related groups, led by the U.S. Chamber of Commerce and the National Association of Manufacturers. They argue that small business employers cannot afford to accommodate such leaves, and that the federal government should not invade the private decisions about employee benefits made by employers.

Clearly this bill is very controversial with a high potential for misunderstanding between business and the advocacy groups. This kind of polarization with strong feelings cannot result in good national policy, regardless of whether the bill is passed or defeated. More involvement of business leadership is needed with its talent for problem solving in broader solutions to this and other child care issues.

The Concept of Parental Leave

Basic leave for childbirth has been included in disability leave, from the belief that a woman is not physically able to work for a brief period just before and just after the birth of a child. Disability leaves are paid leaves, through an insurance approach.

Parental leaves begin where disability leaves for childbirth stop. The parental leave is usually unpaid, allows mothers and fathers to stay at home to care for their newborn children, and enables the

employee to return to the same or an equivalent position without loss of benefits.

The federal 1978 Pregnancy Discrimination Act established that pregnancy should be treated as any other disability. Companies with disability plans must extend them to cover pregnancy and childbirth leaves. This policy provides a benefit without mandated coverage. The focus is on equity for women workers with men workers. It aims to protect working women from discrimination, since only one gender bears children, but both men and women have temporary disabling conditions. Treating childbirth as a disability puts it into a class of action where women are treated equitably. This approach does not address broader issues of reconciling children and family needs with work place needs, since it only reaches employees covered by disability insurance.

This policy is not a mandatory benefit, but it is an example of governmental intervention to define the scope of a benefit. This policy deals with the temporary incapacitating aspects of childbirth, but not the parenting aspects.

California, Hawaii, New Jersey, New York, and Rhode Island have employer-financed state temporary disability insurance laws. Bills are appearing in state legislatures that will add to the number of states that have enacted paid disability leaves. These bills are an example of mandatory benefits.

Recently the Supreme Court by a vote of six to three upheld a California law requiring employers to grant up to four months of unpaid leave and job reinstatement for pregnancy and childbirth, but not other disabilities. The California Federal Savings and Loan Association had argued that the California law discriminated against men by treating pregnancy differently. The Supreme Court ruled that California, and the other states that have such legislation, are free to mandate a higher level of leave policy than that mandated federally.

The decision addressed the issue of whether treating women differently from men is discriminatory. California's statute, it said, "allows women, as well as men to have families without losing their jobs." In order to be treated equally, the decision ruled that women need to be treated differently since only one gender bears children.

The new federal bill offers leave to fathers as well as mothers, and adds the concept that leave should be granted for the purpose of parenting, not just because of physical inability to work. At present 60 percent of working women do not have any job-protected leave at the time of childbirth. Most of them work for smaller companies. The federal bill exempts companies with fewer than 15 employees, but

would extend protection to many employees in companies with more than 15 employees.

The aim of the legislation is to achieve coverage of most employees in the nation, but without a mandated paid benefit. The legislation creates, from the perspective of its advocates, not so much a mandatory benefit as an entitlement, a minimum labor standard. No parent is mandated to stay home, and no employer is mandated to pay for a leave. What the legislation says is that if a parent asks for such leave, in full or in part, the request cannot be denied. Since the entitlement has to do with retention of a job, the labor standard as a policy can only be structured in relation to the work place. It is not an example of using the work place to pay for social benefits outside the work place.

Newly proposed state bills may be more generous to parents than the federal bill. For example, in New Jersey, Senate Bill No. 2392 would allow mothers and fathers to take a 26-week leave to care for newly born, adopted, or seriously ill children. Parents could take paid, unpaid, or a combination of paid and unpaid leave, as long as the total does not exceed 26 weeks in any two-year period. The leave may also take the form of a reduced work schedule for either parent. Job security would be mandated.

In Massachusetts, a proposed Parenting Leave bill (H. 5200) is being considered to replace the existing maternity leave statute. This bill entitles an employee to leave related to the birth or adoption of a child

- for 18 weeks on a full-time or flexible hours basis;
- with restoration to the previous job or a similar one, with the same pay, seniority, and benefits as before;
- with health insurance coverage maintained by the employer during the leave;
- but not to affect any bargaining agreement or company policy providing greater benefits.

Much of the leave in the bill is paid, although not at full pay. The Massachusetts bill establishes a Wage Replacement Fund, funded by contributions of .025 percent of all employees' incomes. Employees on leave will receive 60 percent of income, but not to exceed 66 percent of the statewide average weekly wage, for up to 12 weeks.

Behind the Advocates' Position

The reasoning of the advocates of the federal bill is based on new knowledge coming from three directions: research in work and family issues; research in parenting and infant development; and research in child care.

Work and Family

Today's work force is half female. Nearly two-thirds of the expected growth in the labor force between now and 1995 will be women. There is nothing new about working women; many women have worked in the past. What is new today is the reliance on women for the nation's productivity, and the facts reflected in the following data.

1) Eighty percent of working women are of child-bearing age, and 90 percent of them have or will have children during their careers. The number of women who have their first baby after age 30 is 300 percent greater today than ten years ago. Formerly women had children early in their lives, before they had much work experience; now many working women have babies in the middle of serious careers. Employers can expect that a high number of women currently childless and in the work force will have babies.

2) There is an enormous increase in the number of working mothers. Of all women with children, 62.8 percent work outside the home, as compared with 8.6 percent in 1940. The most dramatic increase in the rate of labor force participation has been in women with children under the age of one. Forty-nine percent of mothers with children under age one are working. This represents a social change that has already taken place. While women a generation ago tended to work only before having children and after their children were of kindergarten age and older, today's working woman expects to return to her job while her child is an infant.

3) In today's economy, families usually need two incomes to reach the median family income. Most jobs do not pay enough to support a family of four at a modest level. Forty percent of married working women have husbands who earn less than $15,000 a year. In addition, real income for families has declined in the past ten years, and this trend does not appear to be temporary. New jobs created in the past several years average lower wages than in previous years.

4) About 40 percent of the work force is now made up of families in which both spouses are working, with another 6 percent being single parents. The typical family of 20 years ago might have been a

two-parent family with one wage earner and one nonworking parent, with two children; but such families are not the norm today or expected to be in the future. Only 10 percent of the population today lives in families that fit this pattern. Interestingly, a much higher percentage of such families are represented among the top policymakers in business and government. Those who make policy for the new families have little firsthand experience of the change that has taken place.

5) There is a strong relationship between dissatisfaction with child care arrangements and unproductive time at work. Fifty-seven percent of 400 men and women surveyed recently by *Fortune*, who had children under the age of 12, worried that their children did not get enough attention. More men than women reported that they had turned down job promotions or transfers in order to have more family time.

6) Those who deal with teen-agers in today's world—police, schools, and social agencies—are concerned that families may not be as available to their children as in the past, and that the parent/child bond may be so weakened that teen-agers are more subject to influences in the culture than to influence of their parents. Whether problems can be attributable to the fact that parents work or not, there are certainly serious problems of undereducation, violence, suicide, and premature pregnancy among today's youth, that lead to a concern to strengthen parent/child bonds.

7) The family responsibility to arrange for their own aging parents has been studied recently, with the finding that the burden for such responsibility falls heavily on women. A study at Traveler's found 38 percent of employees over age 30 spending ten hours a week or more assisting an aging relative, with some involved in caregiving up to 35 hours a week; 65 percent of the responsible caregivers were women.

Infant Development

Research-supported knowledge of the new baby's rapid learning, process of attachment, and vulnerability to emotional harm is relatively recent. Formerly many members of the public assumed that babies were not yet at the age of learning, and that they were little affected by what went on around them if the physical care offered was adequate. Today there is agreement among professionals that deal with infants and parents on the following broad concepts.

The time near when the baby is born is a critical period for parent-infant bonding for both mothers and fathers. During the months that follow, parents and babies form a strong attachment. The baby is

biologically programmed to participate in what can be described as a reciprocal feedback system. Researchers and clinicians have identified four stages during the first six months.

Parents have of course been engaged in this process for centuries and across cultures. What is new is (1) the widespread understanding of the importance of this critical period to a deeply attached and committed relationship between parent and child; (2) the understanding that bonding with their babies is important to fathers and not just to mothers; and (3) the understanding of the infant's active learning process.

Federal or state legislation cannot make parents and children bond together, and parenting leave will not create responsible parents. However, the development of healthy attachment will not take place easily in good and responsible parents if the right time is not available.

Separation from the infant is very painful for the new mother early in this process. The employer with a rigid policy, such as limiting the leave to whatever vacation and sick leave time the employee has accrued, or demanding that the employee return in two weeks, is likely to lose a valuable employee, since many parents will decide to relinquish a job they like and need rather than return to it too soon. It may be that the growth in entrepreneurship among women came about because the work place lacked flexibility for parents.

Pediatrician/researcher T. Berry Brazelton recommends that parents should have the option to be at home for at least four months, putting them near the beginning for the fourth stage mentioned above. In an ideal world, he would prefer that parents be able to take six months. The four months minimum recommendation, however, gives babies a good start in life and makes the separation a little less painful for the parent. The parent will be able to be more productive on returning to the job. Employees will go through this process once or twice. Few working families have more than two children.

Although young parents today are seeking a stronger attachment between fathers and babies, there is no expectation that both parents, simultaneously or serially, will opt to take the full leave, with the 36 weeks of unpaid nonworking parent per newborn. On the contrary, it is very unlikely that most fathers would want to take more than a week of unpaid leave, unless it were to free up the mother to return to work. All surveys indicate, too, that parents would be likely to be back on the job sooner if they had the option of a transitional part-time return. The legislation is written in such a way as to give maximum flexibility to parents in arranging for this period.

Child Care

Parents who are able to make child care arrangements and return to work will still engage in the same processes with their babies as parents who are at home. However, if there is not a parent available full time, there is no one person who sees and responds to the baby's emerging patterns of communication through the 24-hour day. Some researchers, including Dr. Brazelton, worry that the parents' depth of attachment does not develop as fully under those circumstances, and the discontinuity of caregivers may lower the quality of the response the baby gets. For this reason, there is agreement that whenever possible parents should have the option to be at home with their babies.

When parents return to work, they use a variety of child care arrangements over the years when their children are in the infant through preschool years. According to Census data, 39 percent solve their child care needs with the help of members of their own family, by staggering work hours between couples, or by relying on close relatives or older siblings. The remaining parents do not have a solution with the family. Twenty-two percent of families use family day care, which is the care of a few children in the home of the caregiver. Twenty-three percent use centers, either full-day centers or part-day nursery schools. Another 5.9 percent use in-home care, by caregivers who care for children in the children's homes. Any of the arrangements can be very good or harmfully bad.

Most researchers have found that children's attachment to their parents is strong even when the parent also uses a stable and quality child care arrangement. Children's learning has been found to proceed about the same, whether in parent plus child care or parent care alone.

There have been some minor variations in findings about babies in child care. One research writer (Jay Belsky, 1986) has recently concluded that there is some evidence that children might be harmed if they enter child care during their first year.

Other experts (Phillips et al.) believe that any minor variations in how infants in child care behave in research situations are explained not by age of entry into child care, but by four other factors:

1) the quality, stability, and continuity of the child care arrangement;
2) how the parent feels about working;
3) the degree of flexibility and understanding of work/family issues of the supervisor and the work place; and
4) whether there is unusually high family stress.

With these facts and concepts as background, there is a strong consensus among many very varied groups who support the federal legislation that it is important to entitle parents in the United States to the option to spend necessary time with their babies at the beginning. There is already concern among some that parents may be too disengaged to rear their children to become strong and competent adults. Since the next generation is the human resource pool, the bill aims to preserve the type of parenting that research indicates is important.

At this stage, it would be very valuable always to have a business perspective involved in the further development of work and child care policy as it may develop. This bill is only one aspect of the national child care issues.

Issues for Discussion: Arguments Against the Bill

Too Great a Cost Burden for Business Alone

The Chamber of Commerce estimates the annual cost of hiring temporary replacements and maintaining health benefits for those on leave at $16.2* billion. Estimates of increased payroll expenses make up 60 percent of the total and are based on the assumption that workers will be replaced by temporary workers who are more costly than the permanent ones.

Most companies will find less costly solutions, either by reassigning tasks to other employees temporarily, by employing a temporary worker at lower cost than the permanent worker, or by postponing some less urgent work. These are customary solutions when an employee has a heart attack, extended jury duty, National Guard or military reserve leaves, or other reason for temporary absence. Often they are arranged with far less planning time than is available in the case of childbirth. For some types of work, however, these solutions are much more difficult, or impossible, than for other types of work.

The Chamber estimates the cost of reduced productivity at $5.5 billion assuming that every new father and mother, given the option, would take the full 18-week leave. In real life, fathers will be ten times less likely to use it than mothers, and not everyone will take the full 18 weeks. As long as the leave is unpaid, many parents will not find it feasible to take the leave for the full duration permitted. The Chamber's figure is an over-estimation for the current bill. However, the

*Editor's note: In March 1987 the Chamber revised its estimate from $16 billion downward to $2.6 billion. The GAO estimate is expected to be even lower.

bill does open the door for further study potentially leading to a paid leave. The General Accounting Office is doing a study of the cost impact of the Family Leave bill, which will probably correct some of the over-estimation described above.

Effect on Small Business

The major objection to the bill has been its potential devastating effect on small business and on small specialized work units in larger businesses. Amendments have been added exempting small business, limiting the total leave in a year, requiring reasonable notice and the like that partially address this set of objections.

At present 60 percent of working women do not have any job-protected leave at the time of childbirth. Most of them work for smaller companies. The federal bill exempts companies with fewer than 15 employees, but would extend protection to many employees in companies with more than 15 employees.

The exemption excludes 22 percent of the private work force from coverage. Proponents are reluctant to add further to the exemption because to do so would exclude large numbers from the entitlement. The national distribution of workers by firm size is as follows:

Employees Per Firm	Percent of Companies Within Firm Size	Number of Workers
1–24	30.3%	17,921,000
25–99	14.0%	8,309,000
100–499	13.6%	8,030,000
500+	42.1%	24,945,000

There is another aspect of small business that has not been considered: the age of the business. Most small businesses fail in their first year. The major concern of any new business is survival. Personnel policies and benefits are refined later when the business stabilizes. It may be that the requirement for new small firms should be different from that for older, more stable ones.

Reduces Employer Flexibility

Most major corporations have parental leave policies that are more progressive than that proposed, but they may fear the impact of pressures toward longer leaves, part-time transitions back to work, and job guarantees for the returning worker.

Parental leave as a mandated benefit reduces the employer's options with regard to other benefits for employees. Some have sug-

gested that the leave should be a benefit that parents could choose by giving up some other benefit such as a high retirement benefit.

This set of objections views the leave policy only as a mandatory benefit, reaching a special interest group, rather than a labor standard affecting all workers over a lifetime of employment. There may be some value in pursuing this approach further, however.

Other Perceived Problems

There is fear that the employee may take the full leave and then fail to return to work. It is important that nothing in the legislation would inhibit an employer in trying to protect against this danger by reserving some payment until the employee returns. However, since this is primarily an unpaid leave, there is no way fully to protect the employer.

Another set of issues revolves around the replacement plan. Will this legislation further institutionalize the two-tier work force that relies on a temporary work pool that has no job security? The two-tier issue is an existing one, which is not created by the parental leave policy.

The Broader Questions

There is general recognition that the shift of the work force to its present reliance on parent/workers creates a need for new social policies and community services. However, the issues are costly, and various sectors tend to pass the issue back and forth because no sector is willing to assume the entire responsibility.

The major question to address in thinking about this bill is whether employers are asked to assume too great a burden in accomplishing a social benefit that should be supported by government. American employers today face competitive forces that are unprecedented, stemming from rapid technological change, mergers, deregulation, and internationalization. Adding a social cost to the work place could inhibit their competitive edge in global competition, unless there are offsetting benefits in productivity.

Government is generally responsible for meeting new social needs; however, government at all levels is preoccupied with resistance to taxation and at the federal level with the alarming growth in a national deficit. Adding new costs to government could increase the growth in the national debt which also concerns business.

Failing to pay the social cost may increase problems for business in the social environment in which it does business and from which

its future workers will be drawn. The potential social cost to government, or society, is as alarming as the national indebtedness.

Important questions to ask about this bill and other child care measures, are: Who benefits? Who bears the major burden? Who pays what share?

Who Benefits?

Children clearly benefit first. Parents, especially mothers, benefit in not having to interrupt their careers and start over at another job with each child, as well as in their family life. Society in general benefits, since the best and most cost-effective way to assure human development is to rely on families. And at bottom without commitment to families and the transmission of human values, a society loses its purpose.

There are business benefits, too. Success in worldwide competition requires a loyal and productive work force and a stable social structure. Within the United States, companies benefit if policy is made at the federal level. A state-by-state approach raises serious questions of disparities in competitive edge, and creates difficulties for multi-sited national businesses.

Who Bears the Major Burden?

The burden of costs for parental leave is borne by parents. The bill does not entitle anyone to an extended leave with pay. Parents who take the leave will have to find ways to pay for it. More affluent parents therefore benefit more than those with fewer resources, a drawback of the legislation. In practice, however, data indicate that the moderate- and lower-income workers are more likely to take the unpaid leave than the higher-paid professional and managerial employees.

The work place bears a large burden because of the cost of replacing, or doing without, the person on leave. The legislation places most of the burden, after parents, on the work place simply because this particular entitlement has to do with work.

Government, representing society which benefits, bears little burden in this bill as currently designed. It may or may not be desirable that government should pick up more costs of this measure. If so, further study and discussion may reveal new ways of distributing the burden among parents, employers, and society at large.

The issue in productivity is whether American companies want to assume that new parents, particularly mothers, must quit their jobs and start their careers again the same year in a new position to be

able to fulfill family responsibilities. That assumption may or may not have been appropriate when working parents interrupted careers until their babies were age five and went to kindergarten. But in the current work force with parents returning to work soon after their babies are born, this kind of turnover is costly, the cost varying with the cost of recruiting and training new permanent employees. Parental leave would both reduce this particular cause of turnover and would improve employee loyalty and morale. Is it possible that these positive effects on productivity are as important to companies as the negative effects figured in the Chamber's cost analysis? In fact, most companies that have generous parental leave as part of their benefits cite recruitment and retention as the main reason for the program.

The broader question is whether this work force is here to stay. The feminist concerns that became strong with the 1970s, followed rather than preceded the massive increase in working parents. A return to a society where a basic standard of living is maintained by most families with only one paycheck is not feasible, even if it were desirable, without a drastic restructuring upward of wages. Nor is it imaginable that the United States could maintain productivity without the labor of working parents.

Our work force does include women, and those women will have children. Our standard of living does require more than one paycheck for most families. Competition in the global economy requires that this work force, not some other work force, be productive and loyal in this economy. If we are to have a decent society, and a productive present and future work force, we need policies that make sure that work and family life are compatible. Business cannot assume that total responsibility, but business leadership and a broad perspective is needed in sharing the new policies.

Other Child Care Policies

One thing that the parental leave legislation does not do is to eliminate the need for child care. Nor could we eliminate the need for parental leave by more and better child care. Both are needed to support parents at work. Parents returning to work after a parental leave, whether they take a short or long leave, will need child care.

The major issues in child care are basically economic ones. We know how to create a high quality cost effective child care system that would benefit children and support families. What we do not know is how to structure the sharing of who will pay for it.

There are three unresolved issues that are so interrelated that to make one better is to make the others worse. These are the "trilemma" issues of quality, wages, and affordability. All three issues need to be addressed at once in public policy. The unresolved trilemma issues have an adverse effect on the supply. There is very little infant care, for example, in states where regulation mandates a staff-child ratio of 1:4. Yet that ratio is not an unreasonable one for adequate quality. The availability of supply is an issue, but addressing supply alone without attention to the trilemma issues will not be an effective strategy.

Most legislation and proposed legislation in child care does not include any mandates to business or place major burdens on the business sector. There is strong interest in public/private partnerships on the part of state and federal legislators, but a lack of direction on how to involve business without using intrusive powers, or without offering so much financial incentive that the value of the employer participation is forgone.

An exception is the interest in local incentives and mandates to developers though zoning powers to offer density bonus incentives, linkage ordinances, and other measures to require new day care development. These measures may take the form of mandates for which developers bear the major burden.

Developer Ordinances

The most recent approaches at the local level, to child care supply and affordability have included density bonuses, required set-asides, and linkage fees that offer incentives or requirements that developers add to the supply of child care. In the most well-known of these measures, the San Francisco linkage ordinance, developers are required to include space for child care, or pay into a child care fund that would support child care development elsewhere. The developer bears the major burden, passing it on to business tenants in the case of office parks. Planners can relieve some of the burden by offering offsetting benefits, such as permission to include more overall space in the development.

At least one state, Massachusetts, is considering state legislation requiring that all developers set aside space for child care or pay into a fund for the purchase of child care.

Employer Child Care "Incentives"

At the federal level, there is strong congressional interest in encouraging employers to offer on-site child care, but no agreement on

what would constitute an incentive or whether further incentives are needed at all. This approach also fails to take into account other options that employers might choose rather than on-site centers.

H.R. 541, the On-Site Day Care Privatization Act, introduced by Rep. Mario Biaggi (D-NY) would amend the Internal Revenue Code to provide tax credits for employers who provide on-site dependent care assistance for the dependents of their employees. H.R. 1001, introduced by Rep. George Miller (D-CA) includes a Community Child Care Fund set up as a partnership with business. The drafters of the Alliance for Better Child Care (ABC) Comprehensive Child Care bill (see below) are discussing including provisions for employer participation.

At the state level, states may provide technical assistance to businesses interested in taking private action on various child care options. Massachusetts has created a day care office in the Secretariat of Economic Affairs, at a very high level, which provides consultation and assistance to employers. New Jersey has also offered assistance to employers. A number of states have published informational material for employers.

At least six states have tax provisions that were intended as incentives to stimulate employer support for child care:

- *Arizona*: Employer child care facilities are deductible over 60 months instead of depreciated, and a 24-month amortization is allowed.

- *California*: Certified public day care or preschool in employment centers may be depreciated and amortized in 60 months. Child care contributions, payments, or reimbursements to parents are deductible.

- *Connecticut*: Neighborhood Assistance Credit offers a state tax credit for investment in day care. Thirty percent of an investment in day care for employees may be credited, and 40 percent if the day care facilities are not for profit.

- *New Mexico*: A credit is allowed to an employer paying for child care services for dependents of employees during work hours, including employer-operated child care facilities, up to 30 percent of the cost for a maximum of $30,000.

- *Ohio*: Urban jobs and enterprise zones programs pay $300 maximum per child or dependent for day care for new employees.

- *Pennsylvania*: Employment incentive payment credits are offered as an added credit if the employer provides day care services for children of

employees: $600 in the first year, $500 in the second, and $400 in the third.

These tax measures have not been widely used by employers.

The ABC Comprehensive Child Care Bill

A major federal bill is to be supported by a broad coalition of advocacy groups under the sponsorships of a new organization called Alliance for Better Child Care (ABC), with leadership from the Children's Defense Fund.

The bill authorizes $2.5 billion in new federal funds in 1988, increasing to $4 billion by 1991, for federal support to states to offer child care on a sliding fee scale for parents who cannot afford the full cost. Both contracts and individual certificates could be used. Local resource and referral organizations would be funded, and mandated to compile ongoing supply/demand data, administer child care certificates, create new child care supply, and offer consumer education and referral.

The bill will include provisions for a federal role in the development of state licensing standards, funds for improved state licensing, priority for continued child care for former welfare recipients and for teen parents, provisions for training of staff, improved wages, and links to Head Start, existing day care, and school-based preschool programs.

Welfare Reform

Efforts to reduce the welfare roles have in the past failed because too little attention was given to the necessity of a stable child care arrangement that can support work. This year, there is serious interest in creating a national welfare policy that would work, and most of the bills introduced include child care provisions.

While the child care provisions of this proposed legislation are better than in the past, they do not go far enough toward providing stable child care. With the proposed per child cap on child care expenditures, the care that could be purchased would have to be part-time, or an informal arrangement between friends and neighbors that past experience indicates would support training but not full-time employment.

The Outlook on Legislation

Parental leave legislation appears to have strong support, despite massive opposition from business-related groups. There is time and

openness, however, to amend this bill to make it more acceptable. If it loses momentum at the federal level, its advocates will probably succeed in passing a number of state bills, some of them mandating paid leave. Welfare reform legislation, although new, has very strong support. It seems likely that some version will pass next year. Child care measures will have rougher going because of the problem of financing. A bill (H.R. 1572) sponsored by Rep. Nancy Johnson (R-CT) attracted positive attention because of its revenue neutral funding mechanism, but has little support from advocates because it undermines state licensing of family day care. The new legislation written by Alliance for Better Child Care will have strong support from advocate groups, but appears costly. S. 1 and H.R. 1001 include useful provisions, but are not the focus for the advocates' support that the ABC bill will be.

The same questions need to be asked about any child care policy. Who benefits? Who bears the majority burden? Who should pay what share? The parental leave policy under discussion is a social entitlement, but one that cannot be accomplished except through the work place. Leadership is needed from the business community in resolving both the parental leave issues and the other child care issues that affect work and family life. The present and future work force, which heavily involves parents, is the only work force we have.

CHILD CARE LEGISLATION—100th CONGRESS
1987

Bill Number and Name	Chief Sponsors	Summary
	Parental Leave Bills	
H.R.925 S. 249. Family & Medical Leave Act	Rep. Bill Clay (D-MO) and Rep. Pat Schroeder (D-CO); Sen. Christopher Dodd (D-CT) and Sen. Arlen Specter (R-PA)	18 weeks protected unpaid leave for mothers and fathers for birth, adoption, placement of foster child, or serious illness of child; option of reduced hours upon return to work; study of feasibility of paid leave in future; 6 months leave for employee serious illness or disability; exempts companies with fewer than 15 employees; limits on total leave, eligibility, and notice.

H.R. 284 Family & Medical Leave Job Security Act	Rep. Marge Roukema (R-NJ)	Family leave of 8 weeks; medical leave of 13 weeks; exempts companies with fewer than 50 employees.

Comprehensive and Omnibus Child Care Bills

Alliance for Better Child Care	Rep. George Miller (D-CA) will introduce	Expanded child care; improved state licensing; federal role in writing state licensing standards; state-wide resource and referral; training; advisory groups at federal, state, and local level; state plan required; funding can be grant, contract, or parent certificate; start-up funds.
S.4, H.R. 686 Child Care Assistance Act of 1987	Sen. Alan Cranston (D-CA) Rep. Edward R. Roybal (D-CA)	$200 million to states to expand and improve quality of child care for working parents; funds to help states upgrade licensing and improve monitoring; facilitates sharing of information among states about innovative child care programs.
H.R. 1001 Child Care Opportunities for Families Act	Rep. George Miller (D-CA) and 70 colleagues	Increases Title XX to expand and improve early childhood services; creates school based early childhood pilots; funds to states to upgrade standards and monitoring for child care; a community child care fund to expand child care in partnership with business; training in child development and child abuse prevention for licensors and child care staff; training for family day care providers.

Bills to Expand Child Care

H.R. 1572 Child Care Act of 1987	Rep. Nancy Johnson (R-CT)	Child care vouchers for families with incomes less than 200 percent of poverty; $300 million a year through 1991 with 25 percent state match; caps child care tax credit at $70,000, and phases it down for families earning above $60,000; requires state "registration" for family day care providers not currently licensed; requires a 3-year

		grace period before the licensing law is applied to an unlicensed home.
H.R. 1365 Amendments	Rep. Barbara Kennelly (D-CT)	Increases Title XX to $3.3 billion in FY 1988 and beyond; requires more detailed state reports.
H.R. 334 National Medicare Lottery Act	Rep. Cardiss Collins (D-IL)	Establishes a national lottery and savings bond program to help finance Medicare, education, and child care.
S. 183 Public Housing Child Care Act	Sen. Don Riegle (D-MI)	$15 million to states to establish child care in public housing projects run by community nonprofit organizations.
H.R. 95 Child and Family Development Act	Rep. Cardiss Collins (D-IL)	Funds for training and improved state licensing. Expands existing programs, like Head Start.
Child Care Employer Incentive Bills		
H.R. 541 On-Site Privatization Act	Rep. Mario Biaggi (D-NY)	15 percent tax credit to businesses for start-up and operating costs of employer operated on-site day care, and a 10 percent tax credit for expenses of worker salaries at the day care facility.
H.R. 1254 Internal Revenue Code of 1986, Amendment	Rep. John R. Kasich (R-OH)	A tax credit for employers for on-site day care for employees dependents.
Resource and Referral Support and School Age Planning		
S. 222 State Dependent Care and Amendments of 1987	Sen. Don Riegle (D-MI)	Increases funds for dependent care block grant; authorized full funding of $20 million; eliminates current prohibition of funding operating costs of school age programs and resource and referral.
Child Protection		
S. 226 National Child Protection Act	Sen. Alphonse D'Amato (R-NY)	Addresses abuse issue through a national licensing program; establishes a clearinghouse for criminal records of center employees and a national hotline to report child abuse in day care.

Welfare Reform Bills

H.R. 1720 Family Welfare Reform Act of 1987	Rep. Harold Ford (D-TN) Sen. Daniel Moynihan (D-NY) will introduce similar bill in Senate	Replaces Aid to Families with Dependent Children with a family support program that includes employment, education, and training targeted to hard-core unemployed; child care; health care; child support enforcement; 60 percent federal reimbursement match; health and safety requirements for child care; federal reimbursement limited to $175/month/child or $200/month/infant; provides standard $100 deduction plus 25 percent disregard of remaining earnings for those who find jobs; child care financial assistance continues only six months after job starts; welfare benefits required to be at least half state median family income and extended to two-parent families; states to receive more federal aid if they increase benefits for welfare mothers with very young children and working recipients who earn very little; $5.5 billion over five years; $832 million for child care; the major House welfare reform bill.
H.R. 1255 The Family Investment Act of 1987	Rep. Barbara Kennelly (D-CT) and Robert Matsui (D-CA)	Sets up welfare-to-jobs program in every state that agrees to provide job training and increase quality child care.
H.R. 598 Welfare Reform Plan	Rep. Virginia Smith (R-NB)	Requires states to develop their own workfare plans that include child care; federal reimbursement of 50 percent of costs.
S. 514 Jobs for Employable Individuals	Sen. Edward Kennedy (D-MA)	Directs federal, state, and private job training toward long-term welfare recipients in order to get the neediest off welfare; no child care provisions.
H.R. 30 Fair Work Opportunity Act of 1987	Rep. Augustus Hawkins (D-CA)	Job training and education to help welfare recipients to get off welfare; a child care plan will be added to the bill.

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XIX. Part Five Policy Forum Discussion

Parental Leave and Day Care

MR. LEONARD: Mandated benefits seem to strike fear in the heart of employers when there should be a little more segmentation of that fear. From the standpoint of parental leave and day care and that type of thing, it is corporate hari kari not to recognize that if more than 50 percent of your potential work force are affected by something like that, it makes common sense to try to deal with it. The issue is employment cost. Even if you gave unpaid leave and picked up the full cost of health care, it is only going to cost you about $800 year. If you went out to employ a new worker, the agency fee, if you paid one, might be a hell of a lot more; plus the fact that you are gaining good will with that $800 and you have an experienced worker. You have less training.

When someone gets pregnant, it does not happen overnight. With a reasonable planning period of five or six months, you could provide for a substitute for a four-to-six month leave. It is not really a problem hiring a temporary worker. In fact, the solution for the fear of not being able to maintain business is in the area of temporary workers, which is on the upswing. Everybody is touting that as a way to cut down benefits.

I was asked by an employer recently to predict seven or eight things that were going to happen by the year 2001. I said I was absolutely certain that this fuss over parental leave was going to be long gone. In fact, people are going to be paying for it willingly, as well as for what might be called "X" care, which would be care for anybody who is a qualified dependent. Employers will be paying for whatever benefits it takes to get an employee because the demographics suggest that to get an employee 12 to 13 years from now will be quite hard.

So why not spend a little money now with common sense and invest in purchasing some good will and get on to something else?

MS. LANAM: One of the things that mandates tend to do to a discussion is to bring out the generalist in all of us. We talk about business as if it is monolith and parents as if they were a monolith. From my company's perspective, we have probably the ideal situation. We provide on-site day care, with a limited copay for children of male and female employees. It was done for a particular reason. In the mass market of direct response insurance companies, there are

a large number of primarily female employees who we spend a lot of money training to provide a particular service. Turnover is very high because it is not exciting work, and the day care service was designed to retain those people.

Moreover, it is a generally useful benefit. For those of us who have supported employee benefits at different times, it is wonderful. But it is not universally popular. The people running a company tend to be people with children not eligible for day care. As the company grows and we need space, the question increasingly will be asked: "How important is it?"

The danger with a mandate is that the mandate offers an answer, and it allows people to turn and say: "Let's do that." Let's give unpaid leave, and let them stay home; and we will develop a temporary force. You may lose a better benefit, because the mandate is an option to those people who are looking for alternatives for it. The mandate limits flexibility. It provides a statement of what government says is what you should do, and that may discourage flexibility.

Mandates are simpler. They are more deliverable. In many ways, they are more politically attractive, because someone can say: "I got this benefit added;" whereas the negotiation that has gone on within companies and between state governments and local employers has developed, to some extent, a patchwork solution. But perhaps a patchwork solution may be more workable and flexible to the needs of individual businesses than a mandate would be.

MS. KARDOS: We in the telephone industry have had parental leaves for 10 years, and the issue for employers is not really medical insurance. In fact, the obligation under our disability and medical plan comes out to about one-quarter of one percent of our total medical cost. This would be what we would experience if we extended medical insurance for four months, which is what this bill calls for. If anybody can come that close in their budgeting process, one-quarter of one percent in their medical plan, they are doing pretty well.

The Guaranteed Reemployment Issue

MS. KARDOS: For most of the businesses where opposition is massive, it is the guaranteed reemployment issue. It is simply a mental block on people's part to being flexible, to being innovative. You do have at least six or seven months to make plans, to work with the employee.

We have done all kinds of things in our company, such as flexible work hours, working part-time, working at home with a word processor. We find that we do not hire temporary labor unless it is a strictly clerical job, and that is easy to do, and at no additional cost—at the very least, it is a wash. There might even be a saving. We have found that we just tighten our belts and spread the work. You can say that maybe we are not as productive as we should be, but we just find that that is the way we usually handle it. Southern New England Telephone is a big company, but a big company is made up of a lot of little companies. My office has about 30 people in it that are skilled in one thing, employee benefits; and we have had all kinds of leaves where normally we do not replace people. They just come back after about three months.

One of the other main arguments that keeps being made is that this is a Yuppie kind of benefit, that only those who are more highly paid take these benefits. That is exactly the opposite of our experience. We find that the lower-paid workers in our company take more of the leaves and longer leaves, and they plan for how long they are going to be out.

We also have a child care center, and, through our last negotiated bargaining, we put in a Section 125 plan* for all workers, which will include dependent care accounts. This was in response to a request on the part of the union to subsidize child care. They wanted something like $35 a week. We were able to demonstrate that for an employee who was paying for infant care, in excess of $100 a week, if we gave them this tax-free benefit, they would be getting about the same thing, and they could use it on a much broader base than just in the child care center.

There are many innovative things that employers can do.

MR. CULLINAN: Robert Leonard demonstrated the opposite of what he was arguing, and that was that businesses were going to have to compete for workers, and they were going to have to do a lot of things to retain workers. That implied that businesses would start generating these policies on their own anyway.

Whether mandating benefits is what we have to do now or not, there clearly is an issue with regard to employer size and employer specialization. In a company or a portion of a company that has 30 to 50 people doing very similar tasks, it probably is not difficult for

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*Editor's note: Section 125 of the Internal Revenue Code provides the cafeteria plan rules of the code.

them to absorb the loss of an individual for a portion of the time, and it may be that, in fact, temporary help can work relatively well. In smaller employers with more diverse functions within the firm, that may not be the case.

Role of Business in Work and Family Issues

MS. GAGLIARDI: Many businesses are still struggling with what their role should be when it comes to work and family issues, because historically it has always been very separate. This is a very new thing because organizations move very slowly in deciding how they are going to tackle historic issues. That is one of the things that they struggle with. We talk about this in my organization very frequently. Also right behind this issue is the concern not only about children but also about the older folks who are very frequently in the care of many of our workers, and how we will begin to deal with that issue.

My organization has implemented one section 125 dependent care program throughout all of its subsidiaries, and one of the innovative ways in which it is dealing with the whole child care issue is through our foundation. It actually sponsors and funds development of local day care centers in various cities across the country, because it really does feel that there is a need in terms of those resources. That is the way American Express has to go about it, although we ourselves do not sponsor on-site care.

MR. SWAIN: The point about concern over the issue of guaranteed reemployment is absolutely true. The small business vehemence heard through the course of the White House Conference on this issue did not relate at all to giving someone time off, or to whether that time off ought to be three weeks or three months, but was almost exclusively focused on the guaranteed reemployment process. First, small business employees were concerned that it might not be viable from a management perspective to find an identical or similar job for a returning employee, and second, that the failure to find an identical or similar job might lead to, for instance, a federal cause of action like an equal employment opportunity type procedure. The aggreived employee could bring some certain complaint and, thereby, trigger an exhaustive administrative mechanism. Someone at some distant place, a state or a federal capital, would make a decision that one job really was equivalent to another job, and there should have been a reinstatement to that sort of position.

So that is a very basic, almost emotional concern of the small business community. It is a very important point that all depends on where you stand. Even within my own office, people of childbearing age or people that have children have a much greater understanding and personal sympathy with this issue than people beyond that age. There is great antipathy depending on one's age group.

Leave for Care of Elderly Relatives

MR. SWAIN: On the issue of leave for care of an aging relative, if one believes that it is important socially to take care of children, a gerontological specialist could make equally convincing arguments that it is important to take care of our aging population. The average woman in this country today supposedly spends something like four months more taking care of an elderly relative than a child at school, something like 17½ years taking care of a child, but 18-plus years taking care of an elderly relative. So, although the sponsors of the parental leave legislation have trimmed it down to some degree to child care for purposes of moving along a little bit more quickly, clearly care of elderly relatives is an issue that the employer community will be faced with very quickly.

MR. FEINSTEIN: In fact, the House bill has elderly care in it. It has not been trimmed out. The House bill includes birth or adoption of a child, care of a seriously ill child, and care of a seriously ill parent. What we always anticipated would be one of the most controversial aspects of this legislation is virtually never mentioned in discussions such as these; that is, the bill also includes a right to leave for a serious illness of the employee.

The concept behind the bill is that it sets a minimal standard for leave in all situations that are construed as appropriate. It is perceived by the advocates as a minimum leave bill like a minimum wage bill. It attempts to address those serious situations in family life where a national leave policy is appropriate.

Are Mandated Benefits a New Notion?

MR. FEINSTEIN: The way the concept of mandated benefits has been used in this discussion has been to define it as any requirement whatsoever placed on an employer. A mandated benefit is anything that attempts to regulate the employment process. We have heard that

mandated benefits include the Employee Retirement Income Security Act (ERISA) provisions, the requirements regarding pension funds, and so on. The term "mandated benefits" is used as if it covers any form of regulation of the employment process. This point undermines or undercuts one of the things we have heard most in this discussion, not only today but in general, about mandated benefits; and that is that somehow mandated benefits is a brand new notion, that Congress is moving into new fields, new policy arenas where it has never dared to tread before.

Especially when we use this broad definition, that just simply is not the case. The quote we heard about child labor laws goes back to the 1890s. We have the federal minimum wage law, which passed in the 1930s. We have Social Security, which is certainly a minimum benefit. This has really been very much what public policy has been about in regard to the employment process for at least 100 years now.

What we are seeing is not some brand new issue that requires a new term—that is, mandated benefits. Whether you call it minimum benefits or you call it regulation or what have you, it has been a part of our policy right along. All of the arguments that people have been raising against such benefits, if that is what you want to call them, are the same arguments that have been raised against the minimum wage, against the child labor laws, against Social Security, against Occupational Safety and Health Administration (OSHA), against ERISA, against Title 7 of the Civil Rights Act, and so on.

If you go back to the debates on all of these issues, you will see many of the same objections: Mandated benefits detract from other benefits and limit flexibility. They are inappropriate and an inefficient delivery system, and so forth. It is important to remember this. We make a mistake when we try to lump these things all together and respond to them as though they were all the same thing. In each instance, there really are different considerations.

Let's take health policy. Not many people argue that this society should not deal with the issue of health care. There is an assumption that everybody deserves some level of health care. We are not saying that every employee, and for that matter, every unemployed person and everybody else is not entitled to it. What we are really talking about is how to provide health care efficiently. That is a very important debate, but it is different from some of the other considerations that are also dealt with in the general category of mandated benefits. It is a different kind of issue, for example, than whether there should be laws providing that any employer with a health care plan should have this benefit or that benefit. The arguments for and

against that are, in a basic way, quite different from the arguments as to whether or not all employers should have health benefits.

Now if we turn to the Family and Medical Leave Act, which is the current subject, there again we are talking about a specific problem and a specific set of responses. The issue is very much like some of the other situations in which Congress felt it was appropriate to establish a minimum level of benefits.

We do not question anymore certain kinds of benefits like the minimum wage. We do not say, in regard to health and safety laws, that because of difficulties, small business employers should not have to maintain the same level of a safe and healthy work place as do large businesses.

We are getting to the point in the family policy area where we have the same kind of concern. That is to say, the issue deserves a serious response. The statistics and the numbers indicate that there has been a virtual demographic revolution in the work place. The time has come to consider if maintaining families is an important enough social value, to warrant a minimum leave standard. Many members of Congress are beginning to move in that direction.

PART SIX
CAN A CONSENSUS EMERGE ON MANDATED BENEFITS?

The papers and discussion that comprise this book have examined mandated-benefit programs and analyzed their impact on employers, the economy, and American society in general. We have seen that mandated-benefit programs offer the potential for increasing access to pension and health care coverage and other benefits for millions of Americans who lack such coverage today. Yet policy forum participants also point to the inherent contradiction in the enactment of mandated-benefit programs: an increase in labor costs and deterioration in business competitiveness that could result. These factors could lead to a loss of jobs or lowered wages for the very workers who most need the coverage and for whom it is intended.

In the concluding chapter to *Government Mandating of Employee Benefits*, Professor W. Andrew Achenbaum considers whether the American public and policymakers have reached a consensus about a need to address the problems of Americans who lack health care or pension coverage and if public policy solutions are to be found, what forms they should take.

In chapter XX, Achenbaum begins by looking back through history to answer the question of whether mandates are a new concept. He suggests that the origins of mandating can be traced to 1787 and that the foundations for federal mandates were laid during the Depression with programs such as Social Security. In Achenbaum's words, mandating is "the latest phase in a 200-year historical evolution of federal policymaking."

Despite this background, he says, policymakers today cannot agree on what they mean by "mandating," and have different interests in mind when they use the term. Achenbaum contends that there is no political consensus among major political and pressure groups in American society on how to achieve certain political goals that would meet the needs of millions of Americans.

Professor Achenbaum describes what he sees as confusion and discord within the political parties, conflicts within corporate America and within labor unions, and a divided citizenry. As an example, he cites the dilemma for Republicans that mandating on the one hand

could help relieve the president's "budget woes," but on the other hand might require more, not less, government intervention. The Democrats, he continues, are faced with the contradiction of saying they are turning away from making social policy in the tax code and yet trying to influence retirement and health care policies through tax breaks.

Achenbaum concludes that policymakers will be unable to enact further mandates unless Americans are persuaded that such policies are in their best interests.

Given the divisions he has described, Achenbaum says that there is no certainty the 100th Congress will endorse mandating. As the debate continues, he says, the issue should be separated from politics and all participants in the debate will need to try to understand each other's position and the constituency that each represents. Achenbaum argues that the challenge for policymakers is to determine the importance of the issue of mandating in the context of national policy toward social welfare needs.

XX. Mandating: What Can We Learn from History?

PAPER BY W. ANDREW ACHENBAUM

"Mandating" became a buzzword in Washington this political season. The term refers to the power (presumably) vested in the federal government to dictate rules and responsibilities onto employers in both the private and public sectors concerning their employees' rights to health care and pension benefits as well as their access to an array of other paid and in-kind services. During a visit to the Capitol in March, I was told by the staff of a prominent liberal Democrat congressman from California that mandating is "new—it is the train leaving the station." A seasoned legislative aide of a moderate Republican senator from the East agreed: "Everybody (with the exception of lobbyists representing small business) is for it." And an astute observer of the local scene who works in a prominent think tank confidently predicted that "mandating will transform the political agenda." Even discounting for hyperbole, such assertions suggest that the time has come to think carefully about the scope and limits of federal mandating.

I must confess that I am surprised by all of the fuss over "mandating." I thought that the debate over catastrophic health care insurance was the chief domestic policy issue that engages national reporters and editorial writers. Both bemused and appalled by Washingtonians' sense of time—only here is the clock heard to strike just at the 11th hour; only here is the calendar marked up in 2-year intervals and eras said to begin and end when new occupants enter 1600 Pennsylvania Avenue—I listened with more than a little skepticism as my informants tried to convince me that mandating was certain to usher in a brave new world. I found all of their propositions debatable. Nothing is certain in American policymaking save death (literal and figurative, depending on whether one is talking about actors or their bills) and taxes (actual or imputed). It was conceivable that "mandating" is all the natives claimed it was—and possibly more. But the hypothesis that there is no solid mandate to mandate (even in designing a catastrophic insurance plan) could not be dismissed.

Three propositions about mandating merit analysis:

1. "Mandating" may be a new term, but surely the concept is not. Should Congress seek to legislate entitlements it will not itself underwrite, supporters of mandating will be able to invoke ample precedents to legitimate this initiative. Depending on how broadly this implicit federal power is defined, one can trace the origins of mandating back to 1787.

2. There are smart people who advocate "mandating" in federal and state governments, business, labor, and in offices all along K Street, in Washington, DC. Even more striking than the chorus of support, however, is the volume of disharmony within each of these groups.

3. If mandating becomes the motor that drives the legislative agenda of the 100th Congress, it will be fueled by a distinctive set of political constraints and historical opportunities. But it is not clear how Congress, corporate executives, and America's working people (and their families) will be affected by and seek to effect its implementation. That said, it is reasonable to predict that mandating will require fundamental changes in the current policymaking process.

Let us consider each proposition in turn.

Is "Mandating" New?

The obvious answer is "yes." According to *The American Heritage Dictionary of the English Language*, when "mandate" is used as a transitive verb, it means "to assign (a colony or territory) to a specified nation under a mandate." Congress typically "mandates" something to happen in international relations. Until recently, the term did not refer to domestic-policy initiatives.

The 1983 Social Security Amendments and the 1986 Consolidated Omnibus Budget Reconciliation Act, however, elaborated a principle set forth in the Minimum Universal Pension System (MUPS) recommended in 1981 by the President's Commission on Pension Policy. Under MUPS, roughly 21 percent of the work force would have gained access to the kinds of employee benefits that most employers are providing under the terms of Employee Retirement Income Security Act (ERISA) of 1974. Analyses of the potential effects of MUPS remain pertinent: several competing catastrophic insurance proposals use a similar 3 percent fee for financing (Anderson, 1987). Policy analysts are now using the gerund "mandating" to describe third-party financing of benefits to which government declares the workers of America are entitled.

"Mandating" employee-related benefits and services approaches the issue of governmental intervention in a manner consonant with

the political realities of the day. The magnitude of the federal deficit has spelled the end of any willy-nilly expansion of automatic entitlements. Paying the interest on a national debt, which has increased three-fold since 1981, has become the third largest single item in the annual budget. Unless steps are taken to reduce this debt and/or cut back current and future outlays, conservatives and liberals alike understand that we are rapidly mortgaging our future. More and more members of Congress question the need for automatic cost-of-living adjustments that are presently written into a panoply of Social Security Old-Age, Survivors, Disability and Hospital Insurance (OASDHI) provisions and welfare programs.

To avoid a contraction in federal activities, both the executive and legislative branches need to do something. If they do not want to reduce their policymaking options, whatever they do must be decisive. "Mandating" may well become the vehicle for constructive policy initiatives.

The president must prove that he can govern in the wake of setbacks at home and abroad. Reagan uses nearly every media opportunity to reiterate his pledge to "get on with business," to fulfill promises made during the 1984 campaign in his remaining months of incumbency. Under the banner of "mandating," members of the executive branch could advance the logic of their "New Federalism" by insisting that individuals, the private sector, and state and local governments assume responsibilities that the federal government no longer can afford to underwrite.

Similarly, key figures in the Democratic-controlled Congress need provocative headlines if they are to capture the White House in 1988. Criticizing the administration at every turn will be perceived as politics-as-normal; it cannot serve as a blueprint for victory. Presidential hopefuls and committee chairs on both sides of Capitol Hill hence must assume a proactive posture that seems efficacious. A sensible way for them to proceed is to demonstrate their ability to adjust their longstanding liberal agenda to the policy parameters delineated by neo-conservatives. "Mandating" can appeal to the interests of their traditional constituencies. If clever, Democrats can claim to have increased people's access to benefits that afford them greater protection in a topsy-turvy world without raising workers' taxes or imposing a new source of revenue.

Basic facts of political life, in short, have created a situation that might very well catalyze bicameral, bipartisan support for mandating in the 100th Congress. Yet the sheer power of ideas alone has rarely resulted in the articulation and creation of innovative departures

from incremental policymaking at the federal level (Polsby, 1984). Being innovative seldom motivates politicians. Increasing the probability of getting re-elected is incentive enough. To accomplish that end, politicians and public officials like to appear responsive to issues and, after assessing their options, to endorse solutions that serve a variety of career-related purposes in a manner that ideally dovetails with the national interest.

For "mandating" to become a legislative reality, its proponents must demonstrate that this tack BOTH addresses a genuine problem AND that it builds on existing programs in important ways. In my opinion, mandating meets this set of criteria. That various members of both the executive and legislative branches have implicitly or explicitly recommended that the federal government require the elderly, hospitals, physicians, Blue Cross/Blue Shield, and state governments to assume some of the burden of providing catastrophic health insurance attests to growing consensus that mandating can be at once operationally sound and fiscally prudent. If such a strategy seems sensible in the health-care arena, the same logic doubtless could be applied in expanding pension benefits, increasing income-maintenance entitlements, and extending social services.

Indeed, *de facto* mandating already has taken place at the state level. More than 600 state-mandated health-benefit statues are in effect; 350 of these have been enacted since Reagan took office (Lanam, 1987). According to a survey prepared by Blue Cross and Blue Shield of America (1987), the scope of and access to specified services varies from place to place. The services range from sterilization in California (enacted in 1970), to reimbursing all "healing arts" practitioners in South Dakota (1980), to coverage in Arizona of maternity benefits for the natural mother of an adopted child on the adopting parents policy (1986).

Note that these examples highlight three important trends. First, mandated health-care coverage is not limited to the elderly. The principle has been utilized in attending to the needs of people who find themselves in widely different circumstances at successive stages of life. Second, mandating does not deal exclusively with procedural matters. It involves substantive rights. Third, state legislatures have often required commercial institutions to provide coverage for services deemed in the public interest that are not necessarily to be financed at the taxpayers' direct expense. Early experience suggests that the fiscal impact of different mandates vary: large-scale services such as obstretical care and alcoholism treatment cost more than other benefits (Welsh, 1987).

Can a comparable set of partnerships between the state and federal governments and between the public and private sectors be mandated by the 100th Congress? From this historian's perspective, the answer is self-evident. A quick glance backwards in time suggests that mandating has long been a cornerstone of our federalist policy, though heretofore few have described it as such.

The intellectual and political foundations for federal mandating were laid by Franklin Delano Roosevelt in the depths of the Great Depression. Reviewing his accomplishments in 1934, the president challenged Congress to enact "the essential fulfillment of measures already taken toward relief, recovery, and reconstruction." FDR wanted social insurance for all Americans:

> This is not an untried experiment. Lessons of experience are available from States, from industries and from many Nations of the civilized world. The various types of social insurance are interrelated; and I think it is difficult to attempt to solve them piecemeal. Hence, I am looking for a sound means which I can recommend to provide at once security against the great disturbing factors in life—especially those which relate to unemployment and old age. I believe there should be a maximum of cooperation between States and the Federal Government. I believe that the funds necessary to provide this insurance should be raised by contribution rather than by an increase in general taxation. Above all, I am convinced that social insurance should be national in scope, although several States should meet at least a large portion of the cost of management, leaving to the Federal Government the responsibility of investing, maintaining and safeguarding the funds constituting the necessary insurance reserves (Roosevelt, 1934).

Common sense—not an elaborate new theory about the nature of federalism—inspired FDR's vision.

Pressed to alleviate problems beyond human control that had caused mass insecurity, hunger, and familial disruption, New Dealers pieced together a strategy that built on corporate welfarism, state-funded old-age assistance measures, unemployment programs, and Mother's pensions. Yet, as the president insisted, for any social insurance scheme to pass, Americans had to be persuaded that government intervention would not reduce private savings, undermine the value of commercial insurance plans, or vitiate the nation's longstanding commitment to individual self-reliance. Experts took cues from the writings of Lester Frank Ward, Richard Ely, Louis Brandeis, and John R. Commons to make nascent welfare-state policies palatable. Politicians were told that social insurance embodied ideals translated into regulatory policies during the Progressive era, which were themselves the pragmatic response to contemporary ills.

The Committee on Economic Security devised an omnibus bill that became the basis for the landmark Social Security Act of 1935 (Public Law 271). Congress then adopted the language of private insurance while simultaneously increasing Washington's role in matters traditionally left to individuals, private enterprise, charitable organizations as well as to state and local agencies. Under Title I, $49,700,000 initially was appropriated "for the purpose of enabling each state to furnish financial assistance, as far as practicable under the conditions in such states, to aged needy individuals." Plans for old-age insurance (Titles II and VIII) called for an Old Age Reserve Account funded by a 1 percent tax on an employee's wage (up to $3,000) and the same amount from the employer. Under Titles III and IX, Congress established an unemployment compensation scheme that forged a new partnership between the public and private sectors; Washington gave the states considerable latitude in determining benefits, which were largely paid for by taxes on employers. Additional funds were earmarked for the states to provide "aid to dependent children" (Title IV), "grants to states for maternal and child welfare" (Title V), augmented public health services (Title VI), and the blind (Title X). Federal responsibilities for overseeing these activities were delegated to the Social Security Board (Title VII), though "the right to alter, amend, or repeal any provision of this Act [was] hereby reserved to the Congress" (Title XI).

As Social Security survived constitutional tests and became accepted in official policymaking circles and among the public at large, its purview was adapted to meet changing needs (U.S. Senate, Special Committee on Aging, 1985; Achenbaum, 1986). The 1939 amendments doubled old-age insurance coverage (by extending protection to a qualified employee's survivors) without raising FICA taxes. Disability insurance was added in the 1950s. Medicare and Medicaid, which became the basis for Washington's hospital insurance system, were enacted in the heyday of the Great Society. The passage of the 1972 Social Security amendments—which among other things established a nationwide "floor" of payments and services for those who would never earn enough to be self-sufficient (particularly widows, the disabled, the blind, and the very old)—addressed the remaining risks that had preoccupied social-insurance advocates four decades earlier. The 1977 and 1983 amendments sought to shore up the system's long-term financial integrity by shifting some of the overall costs to employees as well as public and private employers.

Meanwhile, other legislation has been passed that should give the 100th Congress precedents for present-day "mandating." The need

for strong governmental wage-and-hour regulation was recognized in the United States around the turn of the century. To bolster state-level proposals that became laws during the progressive period, Washington enacted successive measures that sought to give low-income workers increasing protection against the hazards of the marketplace (Levitan, Carlson, Shapiro, 1986). The Smith-Hughes Act of 1917, for instance, gave grants to states to support vocational education in agriculture, home economics, and selected trades. Later amendments focused on the employment needs of women, minorities, and high-school students. The Carl D. Perkins Vocational Education Act (1984) emphasized programs for underserved populations, especially those disadvantaged groups neglected by states and private employers. A year later, the federal government was deeply enmeshed in activities at both the state and local levels and across public/private boundaries even though it was contributing only 10 percent of all public outlays for this purpose.

Comparable patterns are to be found in other areas affecting employer/employee relations. Unemployment insurance during the first three decades of the twentieth century was a matter left to states, labor unions, and corporate managers (Nelson, 1969; Garrity, 1978). Washington became a partner in existing arrangements thanks to New Deal measures such as Social Security, the Wagner-Peyser Act (1933), the National Labor Relations Act (1935), and the National Apprenticeship Act (1937). The Fair Labor Standards Act (1938) inaugurated a minimum socially acceptable floor under wages and a standard 40-hour work week. The Taft-Hartley Act (1947) transformed the federal government into an impartial referee between labor and management; 12 years later, the Landrum-Griffin Act superimposed civil law onto union law. Gender, racial, and older-worker discrimination were respectively the focus of the Equal Pay Act (1963), Title VII of the 1964 Civil Rights Act, and the 1967 Age Discrimination in Employment Act. Washington exercised its regulatory powers in enacting OSHA (Occupational Safety and Health Act) (1971), ERISA (1974), and CETA (Comprehensive Employment and Training Act) (1973) [which was superceded by JTPA (Job Training Partnership Act) in 1982]. Subsequent amendments have served mainly to fill in gaps in existing legislation (Patterson, 1981; Achenbaum, 1983; Trattner, 1986).

What is the bottom line? I would argue that "mandating" is merely the latest phase in a 200-year historical evolution of federal policy-making.

The process of reconciling the needs of the commonweal and the

aspirations of ordinary citizens actually began with the founding fathers. Based on their experiences as colonists, their understanding of the meaning of the Revolution, and their appreciation of the foibles of humankind, those who met in Philadelphia in 1787 reserved to the national government the power to enact legislation "to promote the general welfare." While this is not the place to expostulate the true meaning of "original intent" (Powell, 1985; Wood, 1971), it should be noted that the Constitution at once created a powerful federal apparatus and an effective brake on the bureaucratic pretensions.

The Federalists wanted enormous powers implicitly vested in the new state, because they keenly recognized the deficiencies of the Articles of Confederation. Yet their vision of a "good society" would never have been adopted without the Bill of Rights, which took the threat of tyrannous officialdom off the people's backs while putting "government squarely (in a double meaning) *on* people's backs" (Freund, 1987). The result of intense debate and negotiation two centuries ago was a form of government still accommodating individual liberty while protecting property interests.

Thus, while the present push for federal mandating is relatively new, it began in earnest in the midst of the economic crisis of the 1930s. The latest transmogrifications can only be fathomed in the context of the tumultuous international and domestic developments that have unsettled the political economy over the past two decades. And yet, if we are to understand the underlying logic of "mandating" in its fullest sense, we must turn to the classic documents of the American experience: The Federalist papers, de Tocqueville's *Democracy in America*, and the 1934 report of the Committee on Economic Security. Therein lie the core of principles that rightly should serve as guidelines in charting future developments.

If Mandating Is Inevitable, Where's the Beef?

In suggesting that "mandating" may symbolize our bicentennial celebration of the adoption of the U.S. Constitution, I do not mean to suggest that the forces of history inexorably lead to this outcome. Historians, after all, play the "what if" game too! What if there is a war? Another nuclear accident? What if the international monetary system collapses? What if urban unrest flares up or racial riots recur? What if the Acquired Immune Deficiency Syndrome (AIDS) crisis or a breakthrough in arms negotiations or SDI (Strategic Defense Ini-

tiative) suddenly dominate this year's policy agenda? Any of these events is possible; each would put mandating on the backburner.

Even if key policy actors were all talking about mandating, moreover, it does not necessarily follow that everybody is saying the same thing. Indeed, just the opposite is true. Government leaders, corporate and union officials, and various segments of the populace have different interests uppermost in mind. These interests are neither mutually compatible nor easily satisfied (Simon, 1983). The potential for discord among representatives *within* these three groups actually looms larger than the prospects for reaching a consensus *across* party lines, *betwixt* the public and private spheres, and *between* elite actors in the policy arena and those they govern or whose affairs they manage.

The Conundrum at the Federal Level: The Republicans' Quandary

President Reagan might support mandating to relieve his budget woes and to scale back federal bureaucracies. During his administration, however, the total number of government workers has risen dramatically. Since it is hard to imagine how mandating would reduce the cadre of federal and state-level employees—someone will have to coordinate activities and evaluate results—pursuing this tack will require more, not less, governmental intervention. And to the degree that governmental regulations are a neo-conservative bugaboo, the president will have to justify to his partisan critics the irony of establishing another layer of intra-agency paperpushers and multiple levels of responsibility through a newly mandated chain of command as the price of his effort to diminish Washington's influence in people's daily affairs.

The Conundrum at the Federal Level: The Democrats' Inconsistency

Liberal Democrats such as Senator Edward Kennedy (D-MA) obviously have no difficulty using Washington's power of the purse to ensure the American people greater access to more comprehensive health care and to other basic social services. Yet Rep. Dan Rostenkowski (D-IL), who chairs the powerful House Ways and Means Committee, claims that "we are turning away from the idea of making social policy in the tax code" (quoted in McArdle, 1986). The Democrats cannot have it both ways: to choose *not* to influence retirement and health-care policies through tax breaks and incentives is perforce a policy decision.

Reprise: Washington Sings an Atonal Tune

Adding to the confusion within party ranks are the inconsistencies in bipartisan, bicameral politics. After all, how many people remember that the father of ERISA was a New York Republican senator? And Claude Pepper, a senior member of the House, is called "Senator," because he served on the other side of the Capitol in the 1930s and 1940s. Leaving biography aside, policymaking on the Potomac invariably wreaks havoc with social scientists' artificially simple models of behavior. That the executive branch's Office of Management and Budget and the Congressional Budget Office do not evaluate various policy options using the same economic assumptions means that the experts rarely agree on cost estimates. Because so many standing committees can claim jurisdictional responsibility over pensions, health care, and old-age entitlements, turf battles are inevitable. Furthermore, lawmakers usually prefer to tinker with existing operational procedures rather than spark discord over philosophical issues. Debate over mandating thus can be expected to shy away from ideological disputes and focus on technical adjustments. Nonetheless, for a majority coalition to emerge will require all the party discipline and joint committee politicking that the present congressional leadership can muster.

Even if we assume that the 100th Congress produces a mandating measure that Reagan can sign into law, it is highly unlikely that the effect of this initiative will be felt evenly or implemented uniformly across the land. The history of American social welfare initiatives and employment-benefit provisions attests to the fact that each state responds to federal grants-in-aid and policy guidelines in accordance with its own distinctive set of political, economic, and philosophical priorities that reflect widely divergent demographic imperatives and fiscal realities (Steiner, 1971). The current scene conforms to past trends. States with solid economic resources and/or steep tax rates known for their "progressive" heritage tend to be at the vanguard of efforts to provide residents with liberal benefits. State legislatures laboring under conditions of severe fiscal austerity and ones that traditionally have been "conservative" in such matters generally offer less comprehensive and generous entitlements (Estes et al., 1983; Palmer and Sawhill, 1984).

There is no reason to suppose that "mandating" health care or social services will ensure that every American citizen gains equal access to a new set of provisions. Citizens in New York might "win" because Governor Cuomo likes to use public policy to strengthen

family security; Texans might "lose" because the Sunbelt's future is cloudy. Mandating would mesh with the "Michigan Strategy" enunciated by Gov. James J. Blanchard (1987)—assuming that Detroit continues to rebound from its recent downturn. Not only will there continue to be considerable variations across state lines, but marked discontinuities from county to county will remain. Most states give local officials considerable latitude in determining how to spend general revenues.

"All politics are local politics," observes former House Speaker Thomas P. (Tip) O'Neill, who ought to know. This epigram effectively conveys the blessing and bane of our federalist system. As a democratic nation, we want the people to decide for themselves what matters most to them. As a pluralist society, this often means that the people's elected officials do not do what the experts and planners who exchange ideas in Washington predict will happen. For this reason, how and when health care coverage is broadened should provide important clues to the unfolding drama (Stein, 1987).

Conflicts with Corporate America—Differing Bottom Lines

Kenneth McLennan (1987) makes an impressive case against governmental mandating of employee benefits. American corporations are already handicapped in the international marketplace, he claims. Capital investments are essential if we are to regain our competitive advantages. To his elegant brief must be added the fears of executives who run America's small businesses. These men and women oppose mandating because of its lack of profitability; they feel that they can ill afford to provide for their workers' retirement or to offer a sufficient array of cafeteria benefits, given the high failure rate among new firms (which tend to be small) and the volatility of their labor pool (Swain, 1987). Such concerns must be taken seriously, for it is the smaller companies, not the larger ones, that are generating most new job opportunities: firms that hired fewer than 20 people provided about two-thirds of the new positions created between 1969 and 1976 (Birch, 1979).

And yet, corporate executives at leading American firms are adopting a human-resource strategy that facilitates rather than discourages mandating. These firms believe that contented workers are their most valuable asset, particularly given the profound demographic shifts and technological innovations transforming the marketplace. In addition, personnel managers and academicians have produced an impressive battery of empirical studies, which indicate that employing people over the age of 40 increases rather than decreases productivity

(Jacobson, 1980; Root, 1984; Pifer and Bronte, 1986). Chronological age per se tends to be a poor predictor of job performance. Turnover, (re)training costs, and personal absences usually are much lower among older workers than among younger ones. And as the baby boom generation matures, employers can expect prevailing stereotypes of (old) age to be overturned by a well-educated, feisty cohort of men and women who will demand, and expect, to be treated well.

More than has been evident in discussions thus far, it is imperative to recognize that corporate America views the bottom line on mandating in diametrically opposed ways. Some—but certainly not all—who worry about the next quarterly report and invoke statistics gathered in the late 1970s and early 1980s (data, incidentally, which reflect modern America's sorriest economic performance since the 1930s) tend to be bearish. Some—but again not all—are bullish in predicting that an aging work force can enhance their long-term opportunities.

Union Rifts: Who Speaks for America's Workers?

The likelihood of divisions among union representatives complements dissension that currently exists in boardrooms. Traditionally, organized labor's stance on employee-benefit issues reflected its twofold belief that (1) it can most successfully appeal to younger workers by reducing their competition from older workers for a shrinking number of jobs in the industrial sector and that (2) it can best serve its older constituency by pressing for better health care and early retirement provisions and disability benefits. This suggests that most union officials should favor mandating.

But times are changing. Declining union representation in the labor force corresponds to unions' diminishing influence in the policy arena. Some unions might support mandating to attract women and white-collar employees to their ranks. Women, after all, now constitute 41 percent of union membership—up from 25 percent a decade ago. Thus unions representing teachers and public employees, which have large female constituencies, might be expected to be in the vanguard in demanding pensions for part-time workers, day care for children, and respite care for aging parents (Rix, 1987). But lobbyists speaking for these groups' interests yelled loudest when the 1983 Social Security amendments were enacted. Postal workers joined other unions within the AFL-CIO in voicing their fear that any changes in the status quo might affect existing pension rights or bankrupt already vulnerable funding vehicles (Seidman, 1979; Stearns, 1981; Achenbaum, 1986). My best guesstimate is, therefore, that unions will assume a united

front on neither side of any major (or even ancillary) issue surrounding the mandating debate.

A Divided Citizenry: The Gap between the Haves and Have-Nots

Because patterns of employment and forms of compensation have changed during the twentieth century, the relative importance of various components in retirement programs and employee-benefit packages have shifted over time. Social Security is the major source of money for older Americans nowadays, but no one can live well on that single source of funds alone. And because the "safety net" provided by government to men and women who have not retired depends on their being able to meet a complicated set of OASDHI requirements or satisfy welfare means tests, it has become increasingly important for working people to make their own provisions to cover unexpected health care expenses and to seek to insure themselves against a variety of occupational risks.

Although most workers contribute to Social Security, probably only 50 to 67 percent are also vested in another retirement program. [It should be noted that my figures are intentionally conservative. EBRI has produced a series of careful analyses during the past decade, which indicate that the figure is closer to 70 percent (Schieber, 1982; Andrews, 1985).] There are serious gaps, moreover, in health insurance coverage: 17 percent of all Americans are uninsured; another 13 percent are thought to be underinsured for acute illnesses. More than 85 percent of the population is underinsured for catastrophic-acute or long-term illnesses. Significantly, reports the National Center for Health Services Research, a majority of employees who are covered in group plans at work are underinsured (U.S. House of Representatives, Select Committee on Aging, 1986).

Pension coverage and benefit entitlements, not surprisingly, vary markedly. Those who work more than 1,000 hours per year are more likely to participate in an employer-provided program than those who are part-time or seasonal workers or who are currently under the age of 25. Yet even among full-time workers, significant variance persists. The gender gap may well be closing in terms of initial employment opportunities, but there remain disturbing signs that women whose career patterns and choices do not conform to that of their "ideal" male counterparts still are penalized in terms of advancement and pay; that fact alone explains why women as a group still gain more (and more generous) employee-related benefits on the basis of their status as spouses than they do based on their employment status.

A similar story can be told about Blacks, Hispanics, and those who earn salaries and wages below the national median.

Variations in coverage depend on more than demographic features of the labor force. They also reflect differences in the occupational structure and the dynamics of employer-employee relationships. Nearly 40 percent of all jobs exist in trade and services, but workers in this sector make up roughly 60 percent of all noncovered employees (Schieber and George, 1981). Federal workers (including military personnel) and state bureaucrats appear to be eligible for better benefit packages than people who work for private employers, but there are obvious exceptions to such a generalization. It usually takes public employees longer to gain vested rights; county officials rarely enjoy decent benefits; the options available to a New York City sanitation worker would never play in Peoria, much less in Wilmerding, PA. Manufacturing workers are more likely to be covered by employee-benefit plans than those in other private-sector industries—in part because at least some of their colleagues are union members and the firms for which they work are large.

What's the beef? The very groups of employers that can least afford to support mandating tend to be the source of jobs for the very groups of workers that need the protection that mandating would provide.

There is no doubt that this country has endured some very rough times economically. Some of us *are* better off than we were a decade ago. But many of us are not (Edelman, 1987). The average American family's income was lower in real terms in 1985 than it was in 1979. The average male worker's wage had fallen (again in real terms) nearly 10 percent during the same period. Most of the new opportunities available in relatively high-growth service industries turn out to be low-paying clerical positions or jobs for fast-food cooks. Many employers who extol the virtues of hiring part-time workers and establishing flexi-time opportunities also know that such arrangements tend to reduce overall costs for employee benefits.

How can we get out of this catch-22 situation? We certainly cannot ask owners of small businesses to participate in a mandatory mandating scheme without giving them simultaneously some tax incentives or rewards for promoting broader employment opportunities. Nor can we expect opponents of mandating in the public sector to go along with the idea unless we appeal to some higher principle. Altruism is a noble gesture but rarely a persuasive bargaining chip. People must be convinced that it is in their best self interest to endorse mandating as a policy that enables them to do well as they do good.

Where Do We Go from Here?

Let my recap my argument. Mandating has merits but it is by no means certain that the 100th Congress will translate the idea into law. And even if a critical mass of advocates can be mobilized at all levels of government, in business, in unions, and among diverse interest groups and a heterogeneous population of workers and their dependents, it is risky to predict how quickly or effectively any mandating policy could be implemented on an incremental basis. The final shape, precise timing, and ultimate impact of mandating, in short, are unclear.

This means that there will be an intense round of negotiations in Washington. If Congress is persuaded that too many Americans are un(der)insured, it will try to pass a mandating law. It is up to us, the people, to make sure that any measure is enacted pursuant to a free and open democratic process. And if we cut a really good deal, mandating will do something unpleasant to all of us without singling out a powerless minority interest for victimization or invoking a powerful shibboleth for scapegoating (Ely, 1980; Fisher and Ury, 1981).

As we proceed, we should keep three things in mind:

- *Mandating Must Transcend Politics.* Innovative, bipartisan policymaking presupposes frank discussions that are as nonpartisan as possible. If a reasonable law is to be enacted, everyone will (rightfully) want to take credit for making such a felicitous outcome possible. At this stage in discussions, however, it is essential to bear in mind that to decide *not* to mandate "x" is both a reasonable stance and possible outcome. If this latter choice reflects the public will and should prove congruent with the congressional temperament, then members will deem it appropriate to congratulate themselves on the collective wisdom of exercising restraint.

- *To Thine Own Self Be True.* If there is so much potential for disagreement within the three levels of the federal polity, between the public and private sectors, and among various interest groups, then there is no "right" position for anyone to take. What you say will depend primarily on where you sit and to whom you are speaking. Choose your words accordingly.

- *Understand Your Opposition.* American policymaking does not require you to love your neighbor, but it never hurts to understand the interests motivating others around a bargaining table. Assuming that some mandating bill becomes a legislative priority, most of the finetuning will occur at the margins. Thus it is essential to anticipate the needs of those with whom one is negotiating and to appreciate the fact that they want to serve their constituency as much as anyone else.

Before we get into the thicket, it is essential that we get down to basics. Is mandating health care and pension benefits essential now? On the one hand, David Stockman was correct when he observed that few incumbent members of Congress are willing to waste capital on a problem which may not occur until they have left the Capitol. On the other hand, if we do not attend to the needs of an aging work force, and accommodate the diverse needs of men and women in the baby boom cohort, it may be too late by 2010 to take remedial action.

The challenge before us, in other words, is to decide whether mandating is of merely academic interest. Or, does the concept get to the heart of "the problem of the commons?" Americans have been haggling over the boundaries between individual rights and public concerns at least since the Pilgrims tried to settle property disputes in their town meetings. The debate over "mandating," in my opinion, is best viewed as the latest skirmish in the ongoing dialog concerning what America is all about.

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Appendix A

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Appendix B Forum Participants

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Appendix C

The following is the Executive Summary from the final report, "Health Care Coverage and Costs in Small and Large Business," prepared for the Small Business Administration by ICF Incorporated.

Health insurance premiums have been rising dramatically in recent years. A variety of congressional concerns, including the budget deficit and the uninsured and underinsured segment of the population, have led to sometimes conflicting goals in recent legislative initiatives. Several legislative changes have been made to encourage the expansion of private health insurance. Simultaneously, the public and private sectors have been trying to contain the rate of increase in health care costs. Such attempts have included the advent of Medicare's prospective payment system in the public sector and a wide range of cost shifting and utilization controls in the private sector.

The purpose of this study is to analyze the difference in health plan availability and characteristics across firm size and industry including differences in eligibility reqirements, comprehensiveness of benefit packages, cost containment measures, the cost of plans, and cost sharing mechanisms. The findings of this study help to describe the variation in health plan coverage across firm size and industry.

Chapter one describes the goals of the study and provides details of the survey instrument and sample stratification, which consists of five firm size categories and seven industry groupings.

Chapter two reviews the availability and relative cost of voluntary fringe benefits. This study finds that:

- After paid vacations, health insurance is the most common fringe benefit offered by firms. Fifty-six percent of all 3.7 million U.S. firms offer health insurance, 37 percent offer sick leave, and 30 percent offer life insurance.
- The probability of a fringe benefit being offered increases dramatically with firm size. However, only in those firms with 500 or more workers does a majority of firms offer health, life insurance, and pension benefits.
- The costs associated with fringe benefits relative to total payroll increase with firm size. For all firms, voluntary fringe benefits as a percentage of payroll range from an average of 7 percent for firms with under 10 workers to an average of 15 percent for firms with over 500 workers.

Chapter three discusses the availability and eligibility requirements of employer-sponsored health plans. This study finds that:

- Smaller firms are less likely to offer health benefits for a variety of reasons:
  - — Smaller groups face higher per capita premium costs because risk per capita is higher in small groups.
  - – Smaller firms often do not benefit to the same extent as large firms from tax advantages associated with offering health insurance.
  - – The fixed costs associated with choosing and administering a health plan are higher for small firms.
  - – Higher employee turnover rates and greater use of part-time and seasonal employees also increases administrative fees for small firms relative to large firms.
- Only 46 percent of the 2.8 million U.S. firms with under 10 workers offer health insurance, compared to practically 100 percent of the 15,000 U.S. firms with 500 or more workers. Seventy-eight percent of firms with 10 to 24 workers, 92 percent of firms with 25 to 99 workers and 98 percent of firms with 100 to 499 workers offer health plans to some or all of their workers.
- This study also finds that the percentage of firms offering health plans to some or all of their workers varies by industry. For example, over 70 percent of the firms in the manufacturing, finance, and wholesale trade industries offer plans. On the other hand, less than one-third of retail trade firms offer health insurance plans.
- This study also examined the number of workers whose employers offer health plans. It finds that 91 percent of workers have employers who offer a health plan to some or all of their workers.
- The study also finds that 41 percent of all workers whose employers do not sponsor plans are in the retail industry and that 65 percent of all workers in firms without health plans are employed by firms with under 10 employees. The services industry accounts for 19 percent of workers in firms not offering health insurance.
- The form of ownership is related to the probability of offering health insurance; corporations are more likely to sponsor plans than firms with other forms of ownership.
- The most common reason cited for a firm's not offering health insurance is insufficient profits; 67 percent of those not offering a plan cite this reason. Sixty-two percent cite the high cost of insurance, while high employee turnover, lack of access to group coverage, and employee lack of interest are cited in 19, 16, and 13 percent of the cases, respectively.
- For those firms that sponsor health plans, 73 percent of the firms exclude certain employee groups through eligibility requirements. Larger firms are more likely to have restrictive requirements, with part-time and temporary workers the most likely groups to be excluded.

- The percentage of workers covered by employers' health plans increases dramatically by firm size, reflecting both the increased likelihood of a plan being available in a larger firm, and the increased likelihood of a worker choosing coverage. This study finds that 14 percent of eligible workers in small firms turn down coverage in their firms' plans, compared to 7 percent in the largest category. This is partially explained by the large number of part-time workers and women employed in small firms who choose coverage through a family member's plan.

Chapter four analyzes the comprehensiveness and costs of health benefit plans. It finds that:

- Of those firms sponsoring health plans, 64 percent offer at least one indemnity or service benefit plan. This number falls to 47 percent in the "500 or over" size group, with 41 percent of these large firms offering self-insured plans. The likelihood of a firm sponsoring a self-insured plan increases dramatically with firm size, while larger firms are also much more likely to offer health maintenance organizations (HMOs).
- Virtually all firms' health plans cover hospital room and board, surgical care, x-ray and lab, physician hospital care, and some level of outpatient care. Larger firms are more likely to cover office visits, home health care, maternity care, mental health, and other benefits. However, firms with 1 to 9 workers had more comprehensive packages than the 10 to 24 size category.
- Over 75 percent of health plans have annual out-of-pocket limits of $2,000 or less. Five percent have no limit. The overall average out-of-pocket limit, for those plans that have limits, is $1,687. This limit is slightly over $2,000 for firms with 1 to 9 workers and varies between $1,000 and $1,300 in the other size categories.
- Ninety-six percent of self-insured plans in firms with 100 to 499 workers have reinsurance against catastrophic claims, while 80 percent of firms with over 500 workers have reinsurance. Reinsurance protects, or insures, these firms against a higher-than-expected level of claims.
- Average premiums for nonself-insured plans are lower for large firms. Average single contract premiums fall from $88 per month for the smallest firms to $76 for the largest. Family contracts range from $208 for the smallest firms to $187 for the largest.
- The share of premiums paid by workers increases with firm size. Seventy percent of firms with fewer than 100 workers pay 100 percent of their employees' single premium contracts, compared to 61 percent of firms with 100 or more workers. On average, the smallest firms pay 89 percent of single premiums and 87 percent of family premiums, while firms with over 500 workers pay 87 percent of single premiums and only 67 percent of family premiums.

Chapter five discusses measures that firms have taken to control health care costs:

- The most common cost containment measures taken by firms with health plans are increasing the deductible (43 percent of all firms), changing carriers (32 percent), requiring a second opinion before surgery (31 percent), and introducing outpatient surgery (25 percent). At least 84 percent of the firms taking these measures feel they had been effective.
- Large firms have been more aggressive in taking cost containment measures than smaller firms. Larger firms have been much more likely to require a second surgical opinion, introduce outpatient surgery, increase copayments, add HMOs or preferred provider organizations (PPOs), and implement a health promotion program.
- Of the most popular cost containment measures taken, small firms feel that increasing the deductible was effective for 81 percent of firms with under 24 employees, and 96 to 99 percent of firms in the remaining size categories. Adding outpatient surgery is also more effective for larger firms. Changing carriers and adding a second surgical opinion requirement are considered highly effective for all firm sizes.
- Most firms are unable to identify the most effective measure taken, partly because many firms have implemented a number of changes simultaneously and are unable to attribute cost savings to particular measures. Nineteen percent of all firms think increasing the deductible was the most effective measure, and 11 percent chose changing carriers. No other measure is considered as the most effective by more than two percent of the firms.
- Only 25 percent of the firms with health plans are considering cost containment measures, and 57 percent are not considering taking any measure. One possible explanation for the larger share of firms not considerinng cost containment measures is that a significant number of firms had recently implemented changes. Also, those firms that contribute to union health plans note that they have no control over specific features of their plan.

Index

Selected EBRI and EBRI-ERF Publications

Fundamentals of Employee Benefit Programs for Education Employees, 1987 (ISBN 0-86643-059-8)
Measuring and Funding Corporate Liabilities for Retiree Health Benefits, 1987 (ISBN 0-86643-054-7)
Fundamentals of Employee Benefit Programs, 3d ed., 1987, paperback (ISBN 0-86643-051-2), hardbound (ISBN 0-86643-052-0)
America in Transition: Benefits for the Future, 1987, paperback (ISBN 0-86643-049-0), hardbound (ISBN 0-86643-057-1)
The Changing Health Care Market, 1987, paperback (ISBN 0-86643-053-9), hardbound (ISBN 0-86643-055-5)
Spend It or Save It? Pension Lump-Sum Distributions and Tax Reform, 1986 (ISBN 0-86643-046-6)
Medicare Reform: The Private-Sector Impact, 1985, paperback (ISBN 0-86643-045-8), hardbound (ISBN 0-86643-044-X)
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A Bibliography of Research: Health Care Programs, 1981 (ISBN 0-86643-021-0)
Should Pension Assets Be Managed for Social/Political Purposes?, 1980 (ISBN 0-86643-001-6)

GOVERNMENT MANDATING OF EMPLOYEE BENEFITS

Is government mandating of employee benefits a solution for many of society's needs, or are the potentially high costs too high a burden for some employers and employees? As the American public demands more employee benefits and the federal government looks for ways to reduce federal spending, mandating of benefits has become one of the hottest controversies in public policy.

In this book, the Employee Benefit Research Institute Education and Research Fund brings together views of corporate executives, state and federal government officials, and representatives from labor, academia, elderly, and research organizations on the issue of mandated benefits and the forces with which employers are contending in today's competitive environment. It reviews recent federal and state responses to the pressures to provide expanded health, pension, and other benefit programs; and it discusses the impact of mandated-benefit programs on employers, workers, and the economy.

With all of the deficit problems that we have, members do not have any Treasury funds to spend, and so they will spend the funds of business. That is a trend that is going to continue. . ."
Rep. Rod Chandler—(R-WA)

"This tension that has been building up for years has reached its zenith in today's budget debate. While demands for national service programs have been on the rise for over a century, never before has the unwillingness to pay for these services been so bold."
Deborah Steelman—Former Associate Director, Human Resources, Veterans & Labor, Office of Management and Budget

"Pressure is sure to mount for policies and programs that will make it easier for women (and men) to combine their duel roles as providers and nurturers."
Sara Rix—Director of Research, Women's Research and Education Institute

"A mandated pension system, in conjunction with Social Security, would have a significant impact on small businesses and the economy. Additional payroll costs,. . .ultimately will reduce the contribution of small business to the economy of jobs. . .Small businesses now employ about half of the private sector work force,"
Frank Swain—Chief Counsel for Advocacy, Small Business Administration

". . .additional mandated benefits will make it more difficult for U.S. businesses to compete in international markets."
Kenneth McLennan—President and Chief Executive Officer, Machinery and Allied Products Institute

"What are the options that employers would be faced with if they had to deal with mandated benefits? Obviously, payroll costs would go up. . . . You can reduce or eliminate other plans."
Dave Repko—JCPenney

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