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CHILD CARE AND CHILD HEALTH INITIATIVE

HEARING

BEFORE THE

COMMITTEE ON FINANCE UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

JUNE 12, 1989

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CHILD CARE AND CHILD HEALTH INITIATIVE

MONDAY, JUNE 12, 1989

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:00 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Lloyd Bentsen (chairman of the committee) presiding.

Also present: Senators Riegle, Packwood, and Dole.

[The press release announcing the hearing follows:]

[Press Release No. H-34, June 6, 1989]

SENATOR BENTSEN ANNOUNCES HEARING ON CHILD CARE/CHILD HEALTH INITIATIVE

WASHINGTON, DC—Senator Lloyd Bentsen (D., Texas), Chairman, announced Tuesday the Finance Committee will hold a hearing on child care/child health legislation.

The hearing is scheduled for 10 a.m. on Monday, June 12, 1989 in room SD-215 of the Dirksen Senate Office Building.

"I believe the plan that I will be proposing constitutes a carefully targeted response to the complex needs of low income Americans for child care and health protection. There are millions of working families who, by reason of income or other eligibility criteria, do not now qualify for the assistance offered by federal and state child care and child health programs," Senator Bentsen said.

"My intent is to provide a way to complement those programs created to encourage the direct provision of child care services for low-income families," Senator Bentsen said.

OPENING STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM TEXAS, CHAIRMAN, SENATE FINANCE COMMITTEE

The CHAIRMAN. This hearing will come to order.

For a long time, I have been concerned about the child health issues in this country—to see what we can do to assure that we have children born with sound minds and sound bodies and that they get off to a good start in life, that we do those things to try to eliminate the crippling diseases, things that are going to give them a very negative start in life.

When I was a kid you got measles and mumps. I can recall when I had measles they drew all the shades in those days. I had to stay home from school. I remember my brother coming in and trying to see if he could catch the measles too so that he could stay home.

But now there are shots for that type of thing. But about 40 percent of the kids under four cannot afford those shots and they go on and have contagious diseases and pass them on to other kids.

I can recall as a kid that they used to think that you had to have your tonsils taken out—all kids. And I had a cold and couldn't seem to get over it and my parents took me in—in a small town—and took me to the doctor to have my tonsils taken out. My father said to the doctor, "What is it going to cost?" People do not usually ask the doctor that, but it was in the middle of the depression. The doctor told him what it was going to cost—$50 or $60—and he was going to do that there in the doctor's office. My father said, "Well, all kids have to have their tonsils out eventually, don't they?" And in those days they thought so. And the doctor said, "Yes."

He said, "Well, what would you charge for five?" And the doctor said, "You mean five sets of tonsils?" He said, "Yes, this afternoon." And the doctor who knew us well said, "But you don't have five kids." He said, "Oh, my brother has some kids."

So he called my uncle and he said, "You know, I have a deal for us this afternoon." He said these kids have to have their tonsils out anyway and said the doctor will do it for whatever the price was. He said it is a real good discount. So we all five had our tonsils out that afternoon.

Well, the systems have changed a bit now. We have done a lot of things to try to help those families that have no income at all. But what we are working on now is families of low income, that really have a very difficult time paying for health insurance. We are looking at a problem where health insurance is growing such in cost—compounding every year. That more and more business, and small businesses in particular, are deciding they cannot afford it or they cut out the dependent care.

So on this committee we have worked together as Chairman, Senator Packwood, and others on this committee, to see if we could not put together a child health package that would assist in that regard. It would help small businesses to continue to provide that kind of health insurance for families with their kids and to see that that kind of health insurance was provided.

We have worked together on child care to assist there. I saw a situation a couple of weeks ago here in Washington, in this area, where a mother went to work and left her child in a car—her baby in a car. She had talked to her estranged husband about giving some money for child care that day for a babysitter and he would not do it. He said he could not. So she did not think she had any alternative and left that child there with the windows, apparently, up farther than they should have been. When she returned, that child was dead.

I cannot tell you that this bill would have taken care of that, but it might have. I cannot tell you that this child health initiative out of this committee will solve all the children's health problems because it will not. But it will be a big plus and it will be a help. And later this month, Senator Chafee and I, and others on this committee, will be introducing further legislation on maternal and child health care, to try to assist in that regard.

I am convinced that our bill is going to make it easier for other young parents to get care for their children—both when they are well and when they are sick.

Senator Packwood.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON

Senator PACKWOOD. Mr. Chairman, I do not think there is anyone who has spent more time on child health in this Congress—the House or Senate—than you in all of the years that I have known you on this committee and before. And I join heartily in co-sponsoring the provision of the dependency care credit that relates to the child health.

In addition, I am hoping that we can adopt the earned income tax credit approach of making this credit not only refundable but putting it into the parents' pay check for the very poor parents who simply cannot afford to go a year until they know whether or not they are going to have any income tax refund.

I just want to thank the Chairman. He has moved these hearings up. He has accommodated my schedule on some days that I could not be here and I think tomorrow, when we have the markup, we are going to send out a first rate dependent care bill with the Chairman's child health provisions in it that will be as good or better than any other bill in this area.

Thank you, Mr. Chairman.

The CHAIRMAN. That is a very generous statement. Thank you very much, Senator.

Our first witness this morning is Mr. Kenneth Gideon, recently before this committee, Assistant Secretary for Tax Policy, Department of the Treasury. We are very pleased to have you and to have back Mr. Rod DeArment.

Mr. Gideon.

STATEMENT OF KENNETH W. GIDEON, ASSISTANT SECRETARY FOR TAX POLICY, DEPARTMENT OF THE TREASURY, ACCOMPANIED BY ROD ERICK DeARMENT, DEPUTY SECRETARY OF LABOR

Mr. GIDEON. Thank you, Mr. Chairman. Having been here so recently as a nominee, it is a delight to be here in this capacity today.

Mr. Chairman and Senator Packwood, I am pleased to have this opportunity to present the Administration's views on your child and health care proposal. Appearing with me today is Deputy Secretary of Labor, Roderick DeArment.

As you know, a little earlier this year Secretary Dole appeared to present the Administration's views on this important topic and I will try to avoid being repetitive of that testimony.

Following my testimony on the child and health care proposal, I am going to comment briefly on S. 1129 which would replace current Section 89 of the Internal Revenue Code and defer the effective date of the new provision until next year.

Child care is one of the key issues facing the nation. However, we believe that we must put choices in the hands of parents and not in the hands of the government. Increasing the range of child care options available to parents, particularly families of modest means, will benefit the nation's children.

The President has established four fundamental principals that we believe should guide the Federal Government's role in the child

care area. First, assistance should go directly to parents. Parents, and not the government, should choose the child care that they think is best for their children. Second, Federal policies should not discriminate against families in which one parent works at home caring for the children. Third, Federal policy should increase, not decrease, the range of choices available to parents. Child care alternatives, including care by religious groups, friends, neighbors and relatives, should be encouraged. Finally, Federal support for child care should be targeted to those most in need—low-income families, particularly those with young children.

The President's child care proposal embraces these principals by making the current child and dependent care tax credit—which I am going to refer to as the DCTC—refundable, by creating a new child tax credit and by expanding the Head Start Program by $250 million over the current funding level.

I am going to concentrate my oral remarks today on the tax provisions of the Chairman's proposal. However, in the interest of giving the committee a fuller picture of the issues, my written statement includes a more technical description of current law and of the tax provisions of the President's proposal.

Current law does not adequately provide for the child care needs of low-income working families with young children. For low-income families which rely on paid child care arrangements, child care expenditures consume a large portion of income. A recent study by the Congressional Research Service examined the child care expenditures of working mothers of preschool children. According to this study, child care expenditures constituted about 6 percent of family income for families that pay for child care. However, for low-income families which paid for child care, child care expenditures consumed about 20 percent of income.

In addition, child care by family members and other relatives, much of which is not paid for in cash, is especially prevalent among low-income families. According to the same Congressional Research Service Study, about 60 percent of low-income families with working mothers depend primarily on family members or other relatives for the care of their preschool children. The study also found that over 50 percent of low-income families with preschool children do not make cash expenditures for child care. Because these parents do not make cash expenditures, they cannot benefit from the DCTC.

Because the current DCTC is not refundable, even when low-income families pay for children, they can not benefit from the credit if they have no income tax liability.

Finally, preschool children require more extensive care than children who are older and in school much of the day. The earned income tax credit, while refundable, does not adjust for differences among working families in the age of the dependent child or the number of dependent children.

Under the President's proposal, low-income families containing at least one worker would be entitled to a new tax credit of up to $1,000 for each dependent child under the age of four. Families could receive a credit equal to 14 percent of earned income, with a maximum credit of $1,000 per child. This credit would initially be phased out between $8,000 and $13,000 of earned income but by

1994 the phaseout ranges would rise to between $15,000 and $20,000. This credit would be refundable.

The existing DCTC, under the President's proposal, would be made refundable. Families could not claim both this credit and the new child credit with respect to the same child, they could choose either. The President's proposal, we believe, would increase the funds available to low-income families and better enable them to choose the child care arrangements that they believe best suit their needs and correspond to their personal values. The President's proposal does not mandate any particular form of child care, trusting parents to make the best decisions concerning the care of their children.

Chairman Bentsen's child and health care proposal would amend the current DCTC in two ways. First, like the President's proposal, it would make the DCTC refundable. Second, it would expand the scope of the DCTC to cover expenditures for health insurance policies that include children. Families could receive both credits. Unlike the President's proposal, Chairman Bentsen's proposal does not include a separate child tax credit.

To be eligible for the proposed refundable health insurance tax credit a family must have a child under age 19. The health insurance policy purchased by the family may cover the child only or may also include the child's parents. The credit would be 50 percent of expenditures for the purchase of health insurance up to a maximum expenditure of $1,000, thereby providing a maximum credit of $500.

I would like to note at the outset that our analysis of the health insurance tax credit is necessarily very preliminary since we have had only a few days to review it. Based on this limited analysis, we have a number of concerns about the design and effectiveness of the credit, and we continue to believe strongly that the President's proposal, as detailed in S. 601 and S. 602, provides a superior approach to assisting low-income families. Moreover, we would like to make clear that we would not support tax credits as an addition to S. 5, the Act for Better Child Care Services, or the ABC bill. The Administration remains strongly opposed to the ABC bill, since it is wholly inconsistent with the President's four principals for child care.

The Chairman's proposed health insurance tax credit singles out health insurance expenditures for special treatment. Because individual health insurance policies tend to be expensive, low-income families which do not already have health insurance through their employer or through some other group arrangement may well be unable to afford to buy coverage, even with this new credit. It is, therefore, unlikely that the credit will help a significant proportion of those low-income families who do not have access to group coverage. Indeed, by providing the credit only to families which have such access, the proposal would not target benefits to the neediest segment of low-income families.

Moreover, health insurance expenditures eligible for the credit are not necessarily related to the cost of providing such benefits to children. The credit could, and often would, subsidize health coverage for adults, simply because they have children. Although this would free up some of the money that eligible families now spend

on health insurance for other expenditures, including child care, the President's proposal would provide this assistance more directly and efficiently, without leaving out low-income families with no access to group health insurance.

The advance payment feature of the Chairman's proposal is intended to permit families to receive the benefits of the DCTC and the new health insurance credit throughout the year. However, the design of these credits is not well suited to advance payment and we are concerned that the implementation and administration of this feature would be very difficult. For example, it would be quite difficult for the Internal Revenue Service to draft "lookup tables" for employers to determine the amount of the advance payments because the amount of the payments will be a function of four variables—earned income, family size, estimated annual dependent care expenses and estimated annual health insurance expenses.

In addition, the existence of three different credits eligible for the advance payment and the resulting larger dollar amounts of advance payments could place a substantial additional administrative burden on employers, particularly small employers, and on the Internal Revenue Service to the extent that the feature is actually utilized.

We are, however, sympathetic to the Chairman's desire to provide these benefits at the earliest possible time and are willing to work with the committee to determine whether an administrable mechanism can be developed.

In looking at this feature, consideration should be given to the time necessary for the IRS to provide taxpayers with guidance and new forms. In particular, it would be very difficult for the IRS if the provision were enacted in the first quarter of fiscal 1990 and effective at the beginning of calendar 1990.

While we have concerns about the design and effectiveness of the health insurance credit, we note that it has some positive similarities to the President's child tax credit in that it is targeted to low-income families and it is available to families in which only one parent works.

Moving now to the revenue offsets in the proposal, we have previously testified in favor of the first two revenue offsets contained in the Chairman's proposal. The extension of the telephone excise tax was proposed as part of the President's budget. The Administration supports early repeal of the special tax provisions for financially troubled financial institutions in connection with the enactment of a thrift rescue package and has no objection to the committee choosing an effective date that corresponds to the House Ways and Means Committee's amendment to H.R. 1278. We also have no objection to the third revenue offset which relates to S corporations' estimated tax payments.

Moving on now to Section 89. We have had even less time to analyze S. 1129 than the child and health care proposal. And as a result, my prepared statement on this will be brief and limited to the major design features of the bill.

As we have testified before this committee and others, the Administration believes that Section 89 in its current form is overly complex and imposes undue compliance burdens on employers. However, the basic objectives of the nondiscrimination rules of Sec-

tion 89 should be able to be accomplished by means of workable tests that can be understood by employers and applied without undue expense in a wide variety of circumstances.

On the 6th of this month, the Chairman and others introduced S. 1129 which repeals Section 89 and replaces it with significantly simpler tests which may be satisfied by plan design. Briefly, the bill provides that an employer must make available to at least 90 percent of its employees a plan providing primarily health coverage and that highly compensated employees cannot exclude the cost of employer-provided health coverage from income to the extent that it exceeds 133 percent of base benefits.

The base benefit is generally the employer-provided premium for the plan that satisfies the 90 percent availability test. In addition, if an employer's health plan and certain other welfare benefit plans do not satisfy the qualification requirements—that is that the plan must be in writing, that it must be enforceable and the like—the bill provides an excise tax equal to 34 percent of the employer-provided premium be imposed on the employer.

We concur with the bill's basic approach to the revision of Section 89. The Administration favors the delay in the effective date until plan years beginning after December 31, 1989. As you are aware, the Secretary of the Treasury has already provided that employers are not required to test their plans for compliance with Section 89 until October 1st and we believe that the additional delay would allow better implementation of the new provision.

Under S. 1129, an employer may require an employee to pay up to 40 percent of the premium for a plan providing primarily core health coverage. This percentage cap approach to availability testing we think facilitates the accommodation of geographic differences and inflation. Now, we are aware of concerns that the percentage cap approach could permit abuse in certain situations. For example, where an employer makes available only very expensive health coverage and thereby effectively excludes low-paid employees from the plan. We have decided, however, on grounds on simplification to support the percentage cap approach. Should, however, significant abuse emerge, some further limitation may be appropriate.

Salary reduction contributions are subject to special rules under the bill. For purposes of determining the base benefit to which the 133 percent test is applied, salary reduction contributions are treated as employer contributions to the extent that those contributions are matched dollar-for-dollar by employer contributions that are made other than through salary reduction. Thus, if the employer pays $600 out of a $1,000 premium for a plan that meets the availability test, and the employee pays the other $400 on a salary reduction basis, all of the salary reduction contribution will be treated as employer provided for purposes of measuring the base benefit under the 133 percent benefits tests.

Under these facts, the result of this treatment of salary reduction contributions is that a highly compensated employee may receive, on a tax favored basis, an employer provided health benefit that is equal to $1,330. Although we support the bill's general approach to salary reduction, we point out to the committee that the

dollar-for-dollar rule permits this very substantial base enhancement that I have just described.

If the salary reduction plan provides that an employee can receive cash instead of employer-provided health coverage when the employee certifies that he or she has other health coverage available—that is, they receive what is called a cashable credit—the bill provides more favorable treatment. Now we are concerned about the special rule that the bill provides for cashable credits as opposed to other salary reduction contributions. We are specifically concerned about the possibility of abuse. As a result, we are not in a position to support the cashable credit approach adopted in the bill. Moreover, we note that the certification requirement in the cashable credit rules raises issues similar to those that cause many to object to the sworn statement rules in existing Section 89.

The Administration commends the sponsors of S. 1129 for considering the special circumstances faced by small businesses and, in general, we support these provisions of the bill.

Finally, the bill provides a sanction for failure to satisfy the qualification rules—that is an excise tax equal to 34 percent of the employer-provided premium, with a grace period of 6 months to correct any failures. The Administration believes that the excise tax should be structured in a way that encourages compliance. We think that a smaller excise tax, perhaps 5 percent, should be imposed initially. Only if the failure is not perspectively corrected within a reasonable period after notice from the Internal Revenue Service do we think that the full 34 percent excise tax should be imposed.

There are specific revenue estimates under our computations that are attached to my written statement, Mr. Chairman. This concludes my prepared remarks. Mr. DeArment and I, depending on the topic, would be happy to respond to your questions.

[The prepared statement of Mr. Gideon appears in the appendix.]

The CHAIRMAN. All right. Thank you very much, Mr. Secretary.

As I understood it, you are going along with this, or approving the thought of raising some of the revenue by the early termination of the tax adjustments for troubled financial institutions and going to the date that was set under the Ways and Means Committee of May the 10th.

Now I have heard some stories, or reports, that some of these institutions are going to be asking for transition relief insofar as being in the process of becoming stock companies during this period of time. What is the Treasury's position on providing transition relief?

Mr. GIDEON. We have consistently opposed transition relief, Mr. Chairman.

The CHAIRMAN. One of the criticisms that you made of the health insurance credit was that it would not result in new insurance because, in effect, it was replacing that part of the cost of policies that are currently in being. I do not agree with that. And what we have seen out of the Joint Tax Committee has been a static study as to that analysis. I do believe that there is a true incentive there that would be of some help. I think the private sector, the insurance companies, once they see that kind of participation in the premium by the Government, will really work at trying to sell

that kind of coverage either on an individual basis or trying to urge special groups to come together for group insurance to try to insist in that regard.

But when you make that point, I also see NFIB, from what I have heard this morning, telling me that they want to support that provision and will be urging that on small business. But when you make your criticism of this one, is that not the same kind of a situation that you would have on the child care credit which the Administration is endorsing—that there would not be from the studies that we have seen thus far an increase in the utilization of that?

Mr. DEARMENT. You mean an increase in the utilization of child care?

The CHAIRMAN. Of the child care credit which the Administration has supported. Could not that identical criticism be made of what the Administration is supporting in child care?

Mr. DEARMENT. Well, the Administration proposes to make the dependent care tax credit—the "DCTC"—refundable and also a new child tax credit. Presumably, the utilization of that would be for every eligible family. The utilization of the dependent care tax credit—the estimating assumptions, which I think that you are referring to, that the Joint Committee is assuming no additional cost—is really not the basis of what the Treasury's criticism was. It really is that the—at least based on the studies that we have been able to look at at this point, and the other available data—most of the uninsured, indeed, according to one study, three-quarters of the uninsured have family incomes below $10,000.

Consequently, the key for those individuals, since at this point the data that I have seen, the lowest cost family coverage in terms of comprehensive group medical coverage is about $2,500 a year. If those poor people do not have an employer picking up part of the cost, they simply cannot afford it. That would be 25 percent of the income of that group. That is, the people that have family incomes up to $10,000.

So consequently, the real incentive to get coverage for those workers has to be an employer incentive. We are concerned that if we just provide $500—unless employers do something to provide group coverage, or unless there is some additional group coverage coming about from something like the demonstration project that you are proposing—simply, $500 is not going to make any difference.

The CHAIRMAN. $500, Rod—let us get back to the employer, too, as you pointed out. With these premiums continuing to move up, compounding up, more and more small businesses are dropping their plans or they are cutting out dependency coverage. I think this will be a major plus in their keeping it, trying to assist in that regard.

Mr. DEARMENT. Well, the problem of the uninsured though is their employers do not offer any coverage now. That is where——

The CHAIRMAN. Yes, but I was speaking of those that are insured that will be dropping that coverage because of the increase in the premiums and this helping them to continue that type of coverage.

Mr. DEARMENT. There is always going to be someone that is going to be helped at the margin.

The CHAIRMAN. Yes.

Mr. DEARMENT. That an additional amount of dollars would not make a difference.

The CHAIRMAN. The problem is, more and more of them are getting at the margin.

Senator Packwood.

Senator PACKWOOD. I have no questions, Mr. Chairman.

The CHAIRMAN. Senator Dole.

OPENING STATEMENT OF HON. BOB DOLE, A U.S. SENATOR FROM KANSAS

Senator DOLE. Well, first, I want to thank the Chairman for having this hearing. I think it would be very helpful if we try to work out some combination of proposals, each of which have some merit. And I would like to include it in the record.

[The prepared statement of Senator Dole appears in the appendix.]

Senator DOLE. I DO HAVE A COUPLE OF QUESTIONS OF EITHER THE TREASURY OR THE LABOR DEPARTMENT.

The $2,500, that is for group coverage, right?

Mr. DEARMENT. That is correct. That is comprehensive group medical. That is the estimate of the low cost area coverage. It would range up to close to $5,000 in a high cost group area.

Senator DOLE. Has Treasury made any estimates, Ken, of the number of children who would benefit from new insurance or increased coverage under this proposal?

Mr. GIDEON. In terms of the number of children that would benefit? We thought we were going to reach well over a million under our proposal but I am not sure that we have an estimate on the Chairman's proposal at this point in time, in terms of the number of children.

Are you aware of any?

Mr. DEARMENT. No, not the—this is the total number of people that would be helped, who would receive benefits or the increment. I mean I have not seen any numbers of the total.

Mr. GIDEON. Nor have I.

Senator DOLE. If you could get some projection, or guess, or whatever and provide it for the record.

Mr. GIDEON. We will certainly get you something, Senator.

[The information appears in the appendix.]

Senator DOLE. What proportion of the revenue cost of this proposal would go to families who currently have employer provided insurance? Do you have any estimates on that?

Mr. DEARMENT. That already have it? Well, as I understand at least the Joint Committee estimate, it is 100 percent.

Mr. GIDEON. And it is our view that it is not clear that you are getting more than you already have. Now you are clearly easing the burden for those who have it.

Mr. DEARMENT. And as the Chairman indicated, you may be preserving some health insurance coverage for people that might be dropping it otherwise. But at least on the convention of revenue estimating, they assume 100 percent.

Senator DOLE. And again in the same—you may not have the numbers, but could you estimate the number of poor families with young children who would benefit from the President's tax credit proposal and would not benefit from either the refundable dependent care tax credit or the new child health credit?

Mr. GIDEON. Well, we would not have those available for you today, but we will certainly look into them for you, Senator.

[The information appears in the appendix.]

Senator DOLE. And then also, if you could at the same time estimate the median family size incomes of this group and provide that information, too, when it is available.

Mr. DEARMENT. Senator Dole, we have seen studies in terms of the number of children that would benefit by the dependent care tax credit versus, or in addition to, the President's proposal.

When Secretary Dole testified earlier, she indicated our belief was that the President's proposal would initially help about 2½ million children; when it is fully phased in it would assist an additional million children. I have seen numbers from the urban institute which suggests in total that about 9.6 million children would claim the refundable dependent care credit; and about 10.6 million would benefit by the Administration's proposal, which includes in part the Administration's credit. That is over about a base of current law that claimed the dependent care credit of about 7.9 million. So that is somewhat consistent with our estimates of 2½ million additional children being helped by the Administration's proposal.

Senator DOLE. Now under the President's plan you could buy insurance with that money, right?

Mr. DEARMENT. Yes.

Senator DOLE. There are no limits on what you can do?

Mr. DEARMENT. That is correct. And it would, as the President proposed it, it would be $1,000 that you could spend on insurance, child care.

Senator DOLE. In your opinion, why do we need the Administration's child tax credit in addition to the current dependent care tax credit? Is there some reason you need them both?

Mr. DEARMENT. Well, their alternative—but our concern is for this poverty population that the dependent care tax credit does not reach the majority of working parents. We found that well over half of the parents, where both parents work, do not have expenses that are documentable for purposes of the dependent care tax credit.

So the dependent care tax credit does not reach a number of these poor families—indeed, over half. The kind of credit that the President proposed does reach those families.

Senator DOLE. I have one additional question.

The CHAIRMAN. Yes, sir; go right ahead, Senator.

Senator DOLE. How would the impact of the child health credit change if the credit were applied only to the incremental cost of family coverage in excess of the cost of insurance covering a single adult?

Mr. DEARMENT. At least the figures that I have seen from the Joint Committee on Taxation indicate that there would be a slight reduction in the cost; consequently, I think the Joint Committee

would be saying it would have relatively little impact on the overall amount of the credit that would go to any one individual. At least the data that I have seen between—about the health insurance costs, I would have thought that the impact would be greater. But that is what the Joint Committee has concluded at least. That just covering that incremental cost of family coverage, which would be the amount that would be covering children, would have some slight reduction in the overall cost of the Chairman's proposal.

Senator DOLE. That is all I have, Mr. Chairman.

The CHAIRMAN. One of the points raised earlier was the question as to how many children would be affected by the proposal that we have made this morning. The Joint Tax Committee tells us that under the proposal that we have brought forth for child health credit that some 14,315,000 would be affected.

Mr. Gideon, we have heard from some that insofar as health benefit plans are concerned there is no discrimination. I listened to that the other night on the floor of the Senate—a couple of them propounding that there was no discrimination in health benefit plans. Yet, the Administration is up here supporting our idea of trying to limit discrimination in health benefit plans.

I would assume from that that you believe there is some discrimination out there. Is that correct?

Mr. GIDEON. Well, we think that there were executive-only plans. I mean, they may not have been widely prevalent but they were certainly out there and there was—with health care becoming a growing area of expenditure, we believe that it was appropriate for the Congress to target this benefit and say that if you are going to provide it, and we are going to provide Federal assistance, it ought to be widely available.

The CHAIRMAN. Do I understand that to mean you think that there was discrimination out there or there would be discrimination out there?

Mr. GIDEON. There were certainly executive-only plans.

The CHAIRMAN. Is that discrimination?

Mr. GIDEON. And I think that if they are for executives only and they are not for the rank and file, that looks like discrimination.

The CHAIRMAN. That is the word I want to hear. [Laughter.]

Thank you. Now you had some concern about salary reduction and cashable credits. When will the Treasury Department be able to give us some specific thoughts in regard to that?

Mr. GIDEON. We are looking carefully at that right now, Mr. Chairman. Our real concern is that by taking it out of your general limitation rule that you basically—what we are trying to determine is whether that provides, if you will, a loophole through the basic arrangement. We have not reached a final conclusion on that but we are studying it carefully at the moment.

The CHAIRMAN. I will have a number of other questions. But we have quite a number of witnesses to hear this morning and I will submit them to you in writing and would ask for an answer.

The CHAIRMAN. Senator Packwood.

Senator PACKWOOD. No other questions, Mr. Chairman.

The CHAIRMAN. Senator Dole.

Senator DOLE. Could I make one point on the Joint Tax Committee's numbers. I was talking with Staff. I am advised there are only

about 13 million children in the pool and this said it would help 14 million. So I think that is something we need to address. Maybe we can get some information.

Mr. DEARMENT. Senator Dole, one of the—this has been one of the challenges that the revenue estimates have had, is figuring out where children are, apparently by income class. There are great differences in the estimates between the Treasury Department and the Joint Committee. And, in part, that difference is based on the number of children.

We have cited how many children we think we are going to help. I believe the Joint Committee thinks we may help more. That is why their revenue estimates are higher.

The CHAIRMAN. Are there other questions.

Senator DOLE. I would just say, we have some information that I am certain is available to you that says all uninsured children, about 12.2 million, under the age of 18. But in any event, that is an area that we need to focus on and maybe we can do that together.

The CHAIRMAN. All right. Thank you very much gentlemen for your testimony.

Our next witness is Hon. Lawrence J. White, Board Member, Federal Home Loan Bank Board. Mr. White, if you would proceed with your testimony.

STATEMENT OF LAWRENCE J. WHITE, BOARD MEMBER, FEDERAL HOME LOAN BANK BOARD

Mr. WHITE. Thank you, Mr. Chairman. I am pleased to be here this morning. Four years ago I was a Commissioner on the New York State Commission on Child Care. I was appointed by New York Governor Mario Cuomo, and I became quite familiar with the problems of child care at that time; and quite honestly, I wish I could be here testifying on the financial problems of child care, rather than the financial problems of the Federal Savings and Loan Insurance Corporation this morning.

But, nevertheless, I thank you for the opportunity to testify on behalf of the Federal Home Loan Bank Board and the Federal Savings and Loan Insurance Corporation regarding the effect of the proposed repeal of the special thrift tax rules on mutual thrift conversations.

As you know, last month the House Ways and Means Committee approved provisions repealing special tax rules relating to supervisory assistance and mergers and acquisitions of financial institutions. The repeal provisions have been attached to H.R. 1278, the Financial Institutions Reform, Recovery and Enforcement Act of 1989, frequently described as FIRREA. We understand that the committee plans to take similar action to repeal these provisions during a markup of the child care and child health care initiative scheduled for tomorrow. That is why I am here testifying today.

The Bank Board supports repeal of these special tax provisions as they apply to assisted transactions because this type of indirect assistance through the Tax Code is no longer necessary now that direct assistance will be provided in FIRREA to help the FSLIC fulfill its statutory mandate of protecting the safety of almost a trillion dollars of Federally insured deposits.

However, the repeal of these provisions will also adversely affect two classes of voluntary supervisory conversions that do not involve direct FSLIC assistance.

Voluntary supervisory conversions are transactions in which an insolvent or near solvent mutual thrift institution and a potential acquirer reach an agreement on the acquisition of the thrift. These transactions involve no FSLIC assistance and provide an infusion of capital by the acquirer into the troubled thrift. In the transaction, the thrift is declared insolvent by the Bank Board and is converted to a stock institution, and the stock is then acquired under the acquisition agreement.

Traditionally, these transactions have been completed under the special tax rules allowing for tax-free reorganizations of troubled financial institutions. The repeal of the rules would create uncertainty about tax treatment and would make it more likely that these insolvent institutions would end up in the pool of assisted transactions that would be more costly to the government.

Under the old rules, there is no assistance, the institutions are recapitalized, and they become future taxpayers. These transactions should be allowed to continue because they bring in fresh capital to the industry—over $5 billion since 1985, $5 billion of fresh capital has been raised through these voluntary supervisory conversions—and they do not raise the "double dipping" concern expressed by members of Congress. Report language expressing this intent would allow the Internal Revenue Service to adapt the regulations to accommodate these transactions.

There are two primary groups of thrifts that are caught in this predicament. The first group, which is relatively small, is composed of thrifts that had voluntary supervisory conversions in process on May 10, 1989, and had filed an application for approval with the Bank Board prior to that date. At this time, the House bill contains no transition rule that would grandfather these conversions. There are approximately 11 thrifts in this situation. A transition rule is needed for these thrifts since their conversions were negotiated in reliance on the provisions in effect at the time without any forewarning that these provisions would be repealed effective May 10, 1989.

The second group of thrifts consists of mutual thrifts that are currently marginally insolvent or that will become marginally insolvent under the regulatory capital requirements of FIRREA. After the legislation passes and regulatory capital requirements are raised, these thrifts must raise substantial new capital. Repeal of the "G" reorganization provisions for these thrifts by this legislation will make it more difficult to raise capital without assistance from the depository insurance fund.

I should point out that there are roughly 150 mutual thrifts in this category. They are in 36 States. So there is widespread coverage, widespread concern here. These are thrifts that could potentially avoid conservatorship or receivership and raise capital if these rules are continued.

These thrifts will be at a disadvantage relative to stock associations or relative to healthy mutual associations in the tax result of their infusions of capital if the rules are repealed. A healthy mutual association can meet the requirements for an "F" reorgani-

zation, thereby retaining their tax attributes. A stock association can do a stock offering that would bypass the reorganization rules and thereby retain its tax attributes. However, a marginally insolvent association may lose its tax attributes altogether in an attempt to raise capital.

One solution to this inequitable tax result would be to retain the special "G" reorganization rules in cases where no government assistance is given. Another solution would be to clarify that such thrifts may set up liquidation accounts based on the franchise value of the association so that the continuity of interest requirements could be met, thereby allowing the conversion to qualify for "F" reorganization treatment.

It may appear that the preservation of these rules, though it would avoid the use of FSLIC funds, would simply substitute other government funds through reduced tax receipts. We believe that this view overlooks the realistic alternative to continuing the rules. These thrifts would likely sink further into insolvency, would stagnate and deteriorate in the FSLIC or FDIC case loan while higher priority cases are resolved, and would eventually require much larger expenditures of government funds than the foregone tax receipts. We believe that continuing the rules truly would be an instance of the Federal Government's using an "ounce of prevention" (reduced tax receipts) now to avoid a "pound of cure" (larger resolution expenditures) later.

To turn this metaphor around, we believe that it would be "pennywise and pound foolish" to cut off the use of these rules for mutual thrifts that are trying to raise fresh capital and convert to stock thrifts.

If it is not possible to secure clear authority for future voluntary supervisory conversions, we ask for coverage under the pre-May 10 rules of those transactions that were already underway on May 10, 1989. Substantial effort and funds were expended by the thrifts and the acquirers prior to their filings of the applications for voluntary supervisory conversions. These agreements were negotiated and applications were filed in reliance on the rules then in place. A list of transactions in process on or before May 10 has been provided to the Finance Committee and the Joint Committee on Taxation staffs.

We would be happy to work with the committee staffs to help draft a narrow transition rule if that is your decision.

Thank you, Mr. Chairman. I have submitted a formal written statement that I hope you will include in the record; and I would be happy to respond to any questions that you might have.

The CHAIRMAN. Mr. White, we will take it in the record in its entirety.

[The prepared statement of Mr. White appears in the appendix.]

The CHAIRMAN. As I understand, what you are asking for is that we keep this special tax treatment for those institutions that are going through a voluntary supervised conversion and the contention is that that does not call for government assistance payments.

Mr. WHITE. That is correct.

The CHAIRMAN. But in effect it does when you are talking about a tax concession.

Mr. WHITE. That is absolutely correct. It would not involve any explicit FSLIC or FDIC funds, but it would mean reduced tax receipts. It is important to remember that these are thrifts that are on the edge anyway. If they are not encouraged to convert to raise fresh capital in this way, they are going to sink into the caseload; they are going to fester; they are not going to get rapid action because they are not going to be a high priority.

The CHAIRMAN. Did you make that point to Treasury?

Mr. WHITE. Yes, sir.

The CHAIRMAN. Well, if they thought it was so meritorious, they would have endorsed it and you heard what they said just a moment ago.

Mr. WHITE. This is a relatively minor part of the repeal of the tax provisions. The major part is repealing them for the FSLIC and FDIC assisted transactions.

The CHAIRMAN. Well, now are you talking——

Mr. WHITE. That is where the big bucks are.

The CHAIRMAN. All right.

Mr. WHITE. This is small stuff.

The CHAIRMAN. Now you are talking about 12 that you speak of specifically that are caught in midstream—in transition so to speak.

Mr. WHITE. Yes, sir.

The CHAIRMAN. Were those binding contractors?

Mr. WHITE. My understanding is that they had already reached an agreement and these were binding contracts.

The CHAIRMAN. Did they have provisions in them that they could take a walk if the legislation changed?

Mr. WHITE. Since I am not familiar with the specifics of those contracts, I cannot tell you. We could try to get that specific information for you and the committee.

The CHAIRMAN. Well, let us take the case of the one that was the most advanced, the farthest along. My understanding is that that deal closed on June 1st, even after being put on notice by the Ways and Means Committee that no exception was going to be made for them. So it did not make or break over the tax provision apparently.

Mr. WHITE. I do not have the specifics at hand, Senator; and I cannot address that specific question.

I do know that there are a lot of these that are really on the edge and that they would otherwise not go through. But for these——

The CHAIRMAN. And here is the one that was the farthest along from everything I have heard and on June 1st, after he had been denied by Ways and Means Committee, it closed—made the deal—contract—solid.

Mr. WHITE. If that is so, then that is so. But I do believe that in many instances the repeal of these rules would mean that the conversions would not go through. These thrifts will sink into the caseload, and a couple of years from now they are going to involve much larger expenditures by the FDIC or the Resolution Trust Corporation to deal with the festering insolvencies in these institutions.

I truly believe that to allow the rules to persist would be a case of an ounce of prevention avoiding a pound of cure later on down the road.

The CHAIRMAN. Well, if all of that comes to pass, it would still be a much more forthright way to approach it—to not go through the tax subsidy, it would seem to me.

Mr. WHITE. As a general proposition, I agree with you entirely, Mr. Chairman. That is why we support the general repeal of these provisions as they apply to assisted transactions. But the voluntary supervisory conversions are transactions where we can head off the problem at the pass by involving smaller—what has come to be called—tax expenditures initially rather than having to wait for these thrifts to fall into receivership, to fall into conservatorship, to fester for a couple of years and then involve larger expenditures of funds.

The CHAIRMAN. All right, Mr. White, I think that is all the questions. Thank you very much.

Mr. WHITE. Thank you, Mr. Chairman.

The CHAIRMAN. Next we will have a panel consisting of Mr. Richard Curtis, Director, Department of Policy Development and Research of the Health Insurance Association of America and Ms. Mary Nell Lehnhard, the Vice President of Blue Cross and Blue Shield Association of Washington, DC.

We are very pleased to have you. Mr. Curtis, would you proceed with your testimony.

STATEMENT OF RICHARD E. CURTIS, DIRECTOR, DEPARTMENT OF POLICY DEVELOPMENT AND RESEARCH, HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, DC

Mr. CURTIS. Yes. As you said, I am Richard Curtis, Director of Policy Development and Research at the Health Insurance Association of America.

Mr. Chairman, we support your proposal to establish a refundable tax credit to assist low-income families in purchasing health coverage for their dependent children. While our policy on the uninsured does not specifically call for such a tax credit, the objects and philosophy are clearly consistent. For example, our policy does place first priority on extending coverage to children in poor and near-poor families. We strongly agree with your special attention to this population.

As you know, the cost of health care—and in this instance of insurance to cover health care outlays—is less affordable to families with more modest incomes. Not surprisingly, the proportion of children who are uninsured in lower income families is greater than the proportion that are uninsured in higher income families.

I might say, Mr. Chairman, as you know the issue of uninsured populations is a complex one. There are very few clear relationships. This is one that is crystal clear. If the look at the proportion of folks who are uninsured by income, as income goes up the proportion goes down. Seven percent (7%) of children who are in families with incomes of 400 percent of poverty or greater are greater; 37 percent of children in families with incomes of 100 to 124 percent of poverty are uninsured. About one-third of near-poor chil-

dren, in fact, have a working insured parent who has opted for individual rather than more expensive family coverage under their employer's benefit plan.

In addition to that, there are a number of children who have an uninsured working parent who had made available to them by the employer, employment base coverage but declined it because of the costs. Available information here is inadequate. But one survey of low wage service workers showed that 48 percent of their uninsured members fell into this category.

Only government can address this problem by identifying and differentially subsidizing lower income populations. The proposal before this committee would significantly assist lower income families in purchasing health care coverage for their children. We believe it exemplifies a constructive public/private partnership to extend health insurance to those in greatest need of coverage.

It is our view, Mr. Chairman, that the proposed tax credit will encourage lower income parents to purchase health insurance coverage for their dependent children and will not cause any significant reduction in employer contributions. We are not concerned about the latter, simply because for most employers the family incomes of individual employees, even those with similar wages, are varied. Many low-income workers, in fact, are members of families with more substantial incomes that would not benefit from the tax credit.

While existing data is not adequate to precisely predict the proposed tax credit impact on low-income employees—and there is some disagreement on that based upon the earlier testimony—we can reasonably anticipate its approximate value. We have supplied to you data from our employer survey and information on the derivation of data in that survey. We find that employers offering conventional health insurance contribute approximately 90 percent of the cost of individual coverage for average employees and about 73 percent on average for family coverage. These figures vary by size of employer and you can find information on the attached tables.

On the basis of these figures, we estimate that the current average employee share is $138 per month for individual coverage and $792 per—I am sorry, that is per year, for individual coverage—and $792 per year for family coverage. Thus, it would reduce the cost. The proposed tax credit would reduce the cost for an uninsured employee of going from no insurance at all to full family coverage from about $66 per month down to $33 per month and would reduce the costs of the employee going from individual coverage to family coverage from about $54.50 per month down to about $2,150 per month.

This should make a very substantial difference in the proportion of low-income employees choosing to extend health care coverage to their children. We strongly commend your proposed tax credit to both your committee and to the Congress.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Curtis appears in the appendix.]

The CHAIRMAN. If you would proceed, Ms. Lehnhard.

STATEMENT OF MARY NELL LEHNHARD, VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION, WASHINGTON, DC

Mr. LEHNHARD. Mr. Chairman, I am Mary Nell Lehnhard, Vice President of the Blue Cross and Blue Shield Association. Our Plans cover some 21 million children.

We appreciate this opportunity to comment on your proposal. We strongly support providing a tax credit to help low-income families purchase health coverage for their children. Many of the families that would benefit from your proposal are not working or they have no employer coverage and now find it difficult to purchase health insurance.

We believe, as you said earlier this morning, that the private market would respond to these new incentives by making coverage available at low cost with a special emphasis on reaching children. Many of our Plans already have developed innovative products especially designed for low-income children. We have described some of these in our testimony, but I would note one in particular.

For example, Blue Shield of California offers coverage for children for as little as $250 a year. Many of the low-income families are not working—are working but it——

The CHAIRMAN. Is that is $250 a year?

Mr. LEHNHARD. A year.

The CHAIRMAN. Per child?

Mr. LEHNHARD. Per child.

Many of the low-income families are working but they find it impossible to pay the premium for dependent coverage, as has been mentioned. According to a survey of our plans last year—and this is significant because it is for small employers rather than large employers—about two-thirds of the small employers covered over 80 percent of the employee's cost. Nearly half of the small employers contributed nothing to the dependent coverage. Under your proposal, the working families would clearly be helped by finding the dependent coverage more affordable.

We also strongly support your proposed demonstration projects to expand coverage to uninsured children and their families. The projects would provide incentives for organizations and communities to become involved in solving access problems at the local level. The Blue Cross and Blue Shield organization has been very active in initiating locally sponsored innovative programs that addresses special needs of low-income children.

The Western Pennsylvania Caring Program for Children, created by Blue Cross of Western Pennsylvania and Blue Shield of Pennsylvania offers primary health insurance coverage to low-income children who are not eligible for Medicaid. Over 12,000 children have received coverage for primary preventive and emergency care at no cost to their families. Benefits include coverage for emergency care, diagnostic tests, out patient surgery, pediatric preventive health maintenance and unlimited medically necessary physician office visits. All children are covered, even if they already have a very serious medical problem when they enroll.

As of May 1989, eight other Blue Cross and Blue Shield Plans had established similar programs and several other plans are scheduled to bring their program on line by the end of this year.

We believe that if demonstration funds are made available, special programs, such as the Caring Program, could be expanded and replicated to cover a greater number of uninsured children.

In conclusion, we believe that your bill would do much to promote a sort of public/private effort at reaching children, particularly those children who need the care the most—those of low-income families. We look forward to working with you.

[The prepared statement of Ms. Lehnhard appears in the appendix.]

The CHAIRMAN. You know, I do not have many questions of you, except to applaud. I am amazed at some of the numbers that you have just given me. It shows that that static analysis made of this piece of legislation does not at all reflect what I think will be the response. As I understood your statement, approximately 50 percent of the small group policies would not have coverage for dependents.

Mr. LEHNHARD. The coverage is available but the small employer is not contributing anything to the dependent coverage.

The CHAIRMAN. I understand that, yes.

Mr. LEHNHARD. That is right.

The CHAIRMAN. Because he talks about the increased costs and the problems of trying to pay for it. This would very materially help in that regard.

Mr. LEHNHARD. Absolutely. Now this is a survey not of small employers, but our Plans perception of the small employer market which they live in day-to-day.

Mr. CURTIS. Mr. Chairman, if I could note, this is not from our member companies. This is a survey of 1667 employers nationally, you will find in Table 2 attached to our testimony, by employers' eyes, the distribution of percent contributions. Based upon that data source—and that includes Blue Cross plans as well as traditional commercial insurance—there is a substantially different understanding of what percent contributions are for small employers.

In fact, of those offering coverage, the percentage that actually covers 100 percent of the cost of family coverage is higher—51 percent—than for other size employers. That is not to say that on average all small employers contribute more. There are vast numbers of small employers who do not offer coverage at all because of the cost of coverage, as you well know.

We could both provide additional information on this, but I thought I would note our data shows something substantially different here.

Mr. LEHNHARD. Some of difference here may come about from the fact that employers have no problem offering the dependent coverage, they just do not pay for it. And if employees do not take it, they say they do not offer it.

The CHAIRMAN. I understand.

In your testimony, too, Mr. Curtis, you hit that point I noticed. "Significant numbers of these uninsured children have a working insured parent who has opted for individual coverage rather than the more expensive family coverage."

Mr. CURTIS. Yes.

The CHAIRMAN. Of course, this directly hits that point and will be of great assistance in that regard.

Mr. CURTIS. Yes.

The CHAIRMAN. I would think a substantial increase would result therefrom insofar as taking family coverage.

Mr. CURTIS. Yes.

The CHAIRMAN. In some instances it might even be a cheaper policy, possibly.

Mr. CURTIS. Yes. I think in some instances it would be.

The CHAIRMAN. With this kind of compensation.

Mr. CURTIS. Right. Yes.

The CHAIRMAN. Thank you. I have no questions. That will be most helpful. Thank you.

I will submit for the record a letter I just received from the NFIB strongly endorsing this proposal for the health insurance credit.

[The letter from NFIB appears in the appendix.]

The CHAIRMAN. Our next panel will consist of Dr. Donald Schiff, the President of the American Academy of Pediatrics, from Denver, Colorado; Mr. Steve Freedman, the Director of the Institute for Child Health Policy, University of Florida; and Mr. Robert Sweeney, the President of the National Association of Children's Hospitals and Related Institutions.

If you will please come forward and take your seats. I have asked all witnesses to limit their oral statements to 5 minutes. We will take your prepared statement for the record. That will give us additional time for questions.

Dr. Schiff, if you would proceed.

STATEMENT OF DR. DONALD W. SCHIFF, PRESIDENT, AMERICAN ACADEMY OF PEDIATRICS, DENVER, CO

Dr. SCHIFF. Thank you. Good morning, Senator Bentsen, Senator Packwood. I am Don Schiff. I am President of the American—oh, Senator Riegle, good morning—I am Don Schiff, President of the American Academy of Pediatrics. I practice pediatrics in Denver, Colorado.

The Academy represents 38,000 pediatricians devoted to improving the health of our nation's infants, children, adolescents and young adults. I want to thank you all for the opportunity to address your new initiative and commend you for your unswerving commitment on behalf of children.

My testimony today will speak to Part B of the children's initiative. The Academy strongly supports this proposal which will allow States to test various approaches to expanding health care coverage for uninsured children. As this committee is well aware, there is no organized effective health care system for children in this country. Despite your best efforts, and ours, the problems are increasing and trends are going in the wrong direction.

The employer-based insurance care system is progressively and quickly eroding. An additional 15 percent of our children lost their health insurance during the past 5 years. Medicaid, our nation's designated source of payment for health care for the poor, now covers only 50 percent of all poor children and state-by-state benefit variations further damage Medicaid's effectiveness.

Additional evidence of the worrisome decline of our children's health is revealed by examining our immunization levels. While most children are immunized when they enter school, fully one-third of the poor are not protected against measles, German measles and mumps by 2 years of age when they are very vulnerable.

Not surprisingly, the incidents of measles, mumps and whooping cough is on the rise. Immunizations remain generally uncovered by traditional health insurance in spite of clear evidence that these programs save $10 for every $1 expended. In an effort to remedy this unconscionable situation, the Academy has developed a proposal which would remove financial barriers to health care for all children through age twenty-one and pregnant women.

Although our plan is not yet complete, we have determined a number of major points which are relevant to this legislation. First, the demonstration projects should assure that all children have access to a comprehensive range of benefits. As you know, a crucial shortcoming of our current health insurance program is the inadequate coverage which commonly excludes preventive health care and services for children with special health needs. These fundamental benefits are either absent or subject to inappropriate caps.

For example, in contrast to adults, hospital in-patient care is less frequently used by children and preventive ambulatory services are clearly more relative to children.

Secondly, the demonstration project should be designed to ensure that there are no discrepancies between services for children who access insurance through privately or publicly funded programs. Indeed, we would be interested in a demonstration project which would provide access to private health insurance through one of two mechanisms—either through employer-based insurance or alternately funded and administered programs, for example, through a State insurance fund.

The objective of such a project would be to eliminate the two-tiered system of health care in this country; and thus, promote equal access to health care for all.

Additional issues which the demonstration issue should consider for inclusion would deal with other barriers to access. These are limited access to services because of geographic barriers, medical liability barriers, and inadequate public education and outreach programs. Additionally, inappropriate reimbursement for services and erroneous, administrative requirements should be addressed.

The Academy has designated access to quality health care for all children through age twenty-one and pregnant women as its main priority for the next several years. We look forward to working closely with you and your committee to meet that goal.

Thank you.

The CHAIRMAN. Well, Dr. Schiff, we certainly agree with you on your priority and want to help in any way we can.

Thank you for the very kind comments you made.

Dr. SCHIFF. Thank you.

[The prepared statement of Dr. Schiff appears in the appendix.]

The CHAIRMAN. Dr. Freedman.

STATEMENT OF STEVE A. FREEDMAN, DIRECTOR, INSTITUTE FOR CHILD HEALTH POLICY, UNIVERSITY OF FLORIDA, GAINESVILLE, FL

Dr. FREEDMAN. Distinguished Chairman and members of the committee, my name is Steve Freedman and I direct the Institute for Child Health Policy of the State University system of Florida; and I also am privileged to direct the National Center for Policy Coordination in Maternal and Child Health, which is funded by the Office of Maternal and Child Health.

Last year we wrote an article for the New England Journal of Medicine describing the concept of school enrollment based family health insurance. Subsequent to that time, both the Robert Wood Johnson Foundation and the Office of Maternal and Child Health have provided some funds for us to begin to look at the feasibility of that concept. I will describe the nature of those projects in just a few minutes.

Like most programs on the current public agenda attempting to deal with the uninsured, school enrollment based family health insurance is not intended to be the universal solution. However, from our understanding of the existing data, we have concluded that nearly two-thirds of the uninsured are members of the immediate family of an individual enrolled in school. The uninsured typically are employed but have a limited economic capacity to afford what has become a prohibitively expensive product—health insurance.

The fact is that most uninsured individuals and families have some resources with which to participate in the cost of health care. However, they can neither afford the full premium for health insurance nor the bill for a single day in most major hospital ICUs.

In traditional employment based insurance, the employer subsidizes premium and acts as the policyholder while the employee is the certificate holder for themselves and for their dependents. In the concept that we have described, the school system becomes the policy holder and subsidizer of premium and the student becomes the certificate holder for themselves and their parents, and their siblings.

The administration of the program would not really be a new role for school districts in that school districts currently administer health insurance for all of their employees—their teachers and supervisors and so forth. The fact is that in order to approach this problem there are going to have to be premium subsidies for these families. But very much like school lunch programs which are also administered by the school district, a sliding scale subsidy does not impose a new administrative burden, just a heavier one, on the school districts.

The other asset that school systems have, that industries are just now beginning to recognize, are programs of health education. Health education is really integral to assuring that people properly utilize the health care system. While it is a new fashion in industry to have such health education programs, in all school systems those programs currently exist and could be used to support this insurance proposal.

Now let me describe where we are with this insurance proposal. One of the first things that we determined by looking at the stat-

utes, in our State and others, is that insurance statutes just simply do not permit this kind of grouping. Recognizing that current laws are based on the traditional employment model, we asked two of our legislators in Florida, Representative Lois Frankel and Senator Jeanne Malchon, to introduce legislation for us to overcome that barrier within Forida's health insurance code.

I am happy to say that, about 10 days ago, legislation unanimously passed both Houses of our legislature and is on the Governor's desk for signature, I think, today.

The Institute organized an advisory panel and asked for the best advice that the insurers and benefits managers and leaders in human services and education could give us. They gave us several very important ideas. One is, that limiting benefits simply does not control costs. That is, the people who really need services are going to go get the services and the costs for those services are going to be there.

So just limiting the benefit structure of a policy does not really make any overall economic sense within the health care system. However, they suggested that managing utilization does make considerable sense. That is, if you have a method of being sure that people get to the right services, at the right time, in the right amount, then you really do have a opportunity to control costs.

There were several other recommendations that were made to us. They are detailed in my written testimony. Additionally, there are several financing principles that surfaced. First, families want to and will participate in a program of health insurance based on their ability to pay. Second, small employers are looking for attractive and economical ways to buy into health insurance programs. Given the size of the group that this program would create, the premium structure and benefit structure might very well be attractive to those small businesses who currently cannot afford insurance.

Because my time has expired, I will close now simply by thanking the committee, both for the invitation to be here and your committee's sensitivity to and advocacy for the health of our Nation's children.

The CHAIRMAN. Thank you very much, Dr. Freedman.

[The prepared statement of Dr. Freedman appears in the appendix.]

The CHAIRMAN. Mr. Sweeney.

STATEMENT OF ROBERT H. SWEENEY, PRESIDENT, NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS AND RELATED INSTITUTIONS, ALEXANDRIA, VA

Mr. SWEENEY. Thank you, Mr. Chairman. I am Robert Sweeney and I am President of the National Association of Children's Hospitals and Related Institutions, known as NACHRI. We have submitted a written statement and I am pleased to have this opportunity to summarize it and to respond to any questions.

Because they are major providers of care to low-income children and children under Medicaid, children's hospitals are especially sensitive to the interactions of changes in publicly funded programs and private health insurance. Therefore, NACHRI strongly

supports child health reforms that seek to reinforce demand for private insurance, while expanding public coverage for families who otherwise are unable to obtain health insurance.

NACHRI strongly supports the efforts to enact major child health financing reform legislation this year. We have endorsed Medicaid reform legislation by Senators Bradley, Reigle, Biden and others; and we have been greatly encouraged by drafts of reforms under consideration by Senator Bentsen.

These Medicaid reform proposals address the four deficiencies in Medicaid's ability to provide access to care to children with no other resources—restrictive eligibility, difficult enrollment processes, limits on essential services and reimbursement inadequate to ensure access to care.

The draft legislation under consideration by Senator Bentsen goes further than the other bills. First, it would establish significant Federal reporting requirements that would enable Congress and the public to assess the annual status of the nation's children, their access to health care, their utilization of services and the cost of making them available.

Second, this draft child health package brings together expansions in public coverage under Medicaid, improved Title V investments in critical services and tax incentives for the purchase of private coverage by near-poor families—and that is that topic which we discuss today.

In our review of the tax credit proposal, we see it as aimed particularly at situations where a parent or guardian is employed, probably provided personal coverage under group health insurance at no cost or reduced cost, and is able to purchase health insurance for dependents generally through payroll deduction. The tax credit would assist in this purchase.

In the situation of an intact family where the spouse is not otherwise employed, generally coverage of the unemployed spouse is included in dependent coverage offered and the proposal allows for that for families with children.

We would recommend that consideration be given, in structuring the tax credit, that qualified expenditures be broadened so that insurance protection be included for the unemployed female spouse of child bearing years, in families with no children if such is not presently contemplated.

Given that, under all Medicaid improvements being considered, low-income women would be eligible for pregnancy benefits, this would serve to reduce expenditures of Federal and State Medicaid funds. Quite possibly, this savings would offset the additional tax credits resulting from this eligibility expansion.

Tax credits for child health insurance should be examined in the context of significant expansions in Medicaid eligibility for pregnant women and children now pending before Congress. Since many low-income persons will be eligible for both programs—the expanded Medicaid program and the tax credits—the committee should consider the need to integrate the proposal for tax credits with those to improve Medicaid to maximize the utilization of private sector insurance coverage.

States should be authorized to use Medicaid funds in such instances to assist eligible low-income families to avail themselves of

private sector insurance, thereby reducing Medicaid's exposure as the prime funding source for their care.

Finally, in our written statement, we have suggested that the Tax Code be amended to require that for tax deduction purposes, employers providing health insurance benefits must offer, but not be required to pay for, such coverage for dependents. And we recommend that the proposed demonstration grants support alternative models of insurance coverage, include hospital care as well as primary care.

The continuum of care for children includes hospital care, and not to include this protection in the demonstration programs could result in the hospitals being co-sponsors of the funding requirements of the projects.

I thank you very much. I will respond to any questions.

[The prepared statement of Mr. Sweeney appears in the appendix.]

The CHAIRMAN. Thank you.

Well, I find it pretty difficult to disagree with this crowd. Let met—Dr. Schiff, I think the point you make about our closing that gap and not having the kind of differentiation in the service from the private sector—or we get from the public sector, insofar as children—is a very worthy objective and that is what we are trying to do. We are closing in from both sides.

Mr. Sweeney, when you talk about what we do here, possibly saving some on the Medicaid side, what we are also thinking about—and Senator Chafee and I have been working on in the package that we hope to bring up next—is to allow this credit to be used to buy into Medicaid, too—to go in both directions. So we are trying to do what I think all three of you are seeking, that is to see that we get some uniformity of health care availability to these kids.

Senator Packwood.

Senator PACKWOOD. Mr. Chairman, I have no questions. Let me say, Dr. Freedman, I find your plan most intriguing.

The CHAIRMAN. Yes. So do I.

Senator PACKWOOD. It is the first time I have heard of it and it does have a lot of logical consistency to it and an easily identifiable beneficiary class gathered in the only one place where they all gather. It is a most intriguing approach and I appreciate your bringing it to us.

Dr. FREEDMAN. Senator, it has been characterized as the Willie Sutton approach to the health insurance.

Senator PACKWOOD. Yes, I noticed your little—in small print, the Willie Sutton quote in your statement.

The CHAIRMAN. That is where the money is, right?

Dr. FREEDMAN. Yes, sir.

The CHAIRMAN. All right. Gentlemen, those are very constructive suggestions. We are appreciative of them.

Dr. FREEDMAN. Thank you very much.

Dr. SCHIFF. Thank you.

Mr. SWEENEY. Thank you.

The CHAIRMAN. Our next panel consists of Mr. Willis Goldbeck, the President of the Washington Business Group on Health; Ms. Sara Rosenbaum, Director of Programs and Policy, Children's De-

fense Fund; Ms. Nancy Duff Campbell, the Managing Attorney for the National Women's Law Center; and Mr. Robert Greenstein, the Director of the Center on Budget and Policy Priorities.

If you would please come forward.

It looks like I combined a couple of panels. Mr. Goldbeck, if you would proceed, please.

STATEMENT OF WILLIS B. GOLDBECK, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH, WASHINGTON, DC

Mr. GOLDBECK. Mr. Chairman, my name is Willis Goldbeck. I am the President of the Washington Business Group on Health which is a national organization representing the health and social policy interests of major employers across the country.

It is a pleasure to support your proposal, both in its child care and health insurance context. Good child care is good health and certainly your proposals are consistent with the trends in family structure and employee benefits in the United States today.

Supporting this kind of a proposal is a prudent business decision. It represents an honest reflection of the future work force in America and the devastation of the current generation of American youth—currently very large consumers of health care without having the ability to ever pay for it through constructive employment. That is a cost, incorrectly called uncompensated care, which is now largely shifted to those employers and employees that, in fact, do have health insurance.

I was delighted to hear your last comment about Medicaid reform because my next comment was to be that, since three-quarters of your target kids live in families whose income is under Federal poverty level, (1) they clearly should be allowed to buy into Medicaid, and (2) this ultimately tells the Congress that we need to have a national eligibility standard for Medicaid at the Federal poverty level. To do less than that is to constantly leave ourselves limited to tinkering around with particular benefits and services, rather than true reforms to gain access to poverty populations.

The advance funding element of your proposal is a good one and its administration is certainly within the capacity of America's employers; and if not them, surely all of those consultants who live off the complexities of new legislation.

If you wish to have health insurance purchased, you must tie availability of the tax credit to health insurance. Otherwise, there will always be some more immediate need that a rational parent will clearly use the money for. Health insurance is an investment decision you are trying to stimulate, not only an immediate purchasing decision.

You raised the question earlier as to whether there is "benefit plan" discrimination today. Of course there is. Executive plans are the easy example. However, what will happen under Section 89 if an employer, heeding the message of your proposal, provides dependent health insurance only for the employees that have children? That would also be ruled discriminatory and, therefore, unallowable. One needs to look at the implications of some of these alleged protections. Discrimination is a matter of perception, not only of an actual event.

The debate over the numbers of kids who may be helped by your proposals strikes me as basically irrelevant to the yes or no decision that you are facing here and in the Congress as a whole. Either we agree that families need child care and that all kids need health insurance or we do not. Whether the population in need is 9 million versus 13 or 14 million is not the issue.

We totally support the demonstration projects. If you are going to do evaluations, you will need to up the ante. There has to be more money in it to get enough participants in the different demonstrations to have research which can tell the Congress later whether or not you learned enough to guide future policies. Clearly, the demonstrations should immediately be able to buy from Medicaid.

The focus on prevention and prenatal care is essential.

I question whether or not the outpatient restriction is good, not just from the standpoint of whether it reimburses hospitals adequately, but from the incentive that it provides to force people into the inappropriate care settings just to get the reimbursement. You want to achieve your cost savings by using quality standards, not the treatment location, as the principal criterion.

We must remove the State insurance barriers that were just mentioned.

Let me close with two points: We can afford this legislation. This committee is also hearing today about $150 billion worth of expenditures needed to bail out savings and loans, whose financial condition results largely from bad management and greed. We certainly ought to be able to decide we can afford as much of an investment for the next generation of Americans who clearly are not guilty of illegal acts, nor responsible for the bad management and greed in the health care system.

There are more than enough sources of revenue to be found in the waste in the current system—in drug noncompliance, in the Rand Study of inappropriateness, in the malpractice system. If you seek other sources of revenue, you can well find them within the medical and health care systems today and not have to look any further.

Finally, what this nation needs is a national investment strategy for child development, not a 1-day focus on health insurance, the next day drugs, the next day education, the next day mental health, all separate, unconnected and confused. There is a role for the Federal Government in these areas that have been traditionally left to State and local authority. The Federal Government could not possibly produce a worse result for America's youth than we have achieved by the current systems.

We support your program and we will be glad to work with it.

The CHAIRMAN. Thank you very much, Mr. Goldbeck.

[The prepared statement of Mr. Goldbeck appears in the appendix.]

The CHAIRMAN. Ms. Sara Rosenbaum.

STATEMENT OF SARA ROSENBAUM, DIRECTOR, PROGRAMS AND POLICY, CHILDREN'S DEFENSE FUND, WASHINGTON, DC

Mr. ROSENBAUM. Thank you. We appreciate the opportunity to testify today in the support of your measure.

The severity and complexity of the problems facing today's children and families require that meeting their needs assumes front burner status on the nation's list of priorities. Multiple strategies that build on one another are essential. And as this committee knows, tax credits have played an important role in overall efforts to promote the health and welfare of families.

With respect to health insurance, the Chairman's proposal to expand the dependent care tax credit to assist low-income families with children offset the cost of health insurance coverage is an important component by an overall effort by this committee to ensure low-income children access to health care. Of the 12½ million living in families who were uninsured in 1986, about 11 million of those children lived in families that worked. And of the 11 million children who lived in families that worked, a substantial proportion lived in families that actually had access to employer provided health insurance but could not afford the cost of the coverage.

We know from the Department of Labor, for example, that between 1980 and 1986 the proportion of employees working at medium and large size firms that had wholly paid dependent coverage dropped from 50 percent to about 35 percent, which is about a one-third drop in the proportion of employees at America's largest companies that wholly paid dependent coverage.

As you heard earlier, in the smaller companies which did not wholly fund dependent coverage historically as well as the medium and large size firms did, more employees historically have been without dependent contributions and that number is probably declining at least as rapidly. I should note that the concomitant decline in employer subsidies for the cost of dependent coverage has been accompanied by a substantial increase in the cost of health insurance—in fact, over 6 years a 500 percent increase in the cost of family premiums—at a time when income, particularly income for young workers, remained stagnant or fell.

So efforts that helped families purchase coverage that is available to them are certainly a part of an overall effort. The committee took similar action through Medicaid as part of the Family Support Act. This is highly consistent using the Tax Code in combination with Medicaid reforms that you will consider in several weeks.

With respect to the dependent care credit, the Children's Defense Fund has long supported making the dependent care credit refundable. We think that the changes in the Tax Reform Act that, of course, protected low-income workers against tax liability had an unintended consequence, which is reducing the utility to them of the dependent care credit. We support the credit. We support the notion of making it refundable.

We see the credit just as we see Medicaid in combination with programs such as community health centers and maternal and child health programs, programs to develop resources. We see the tax credit as a piece of an overall approach that combines a major

resource development effort—that is the act for better child care—with additional income to families to meet the cost of the child care that is not subsidized.

I should note also that to the extent that this committee is considering revisions in Section 89, we want to caution the committee that if, in fact, you are providing subsidies for low wage workers for dependent coverage, that no action be taken that would allow employers to engage in relatively discriminatory behavior with respect to premium subsidization. There is always the inherent problem for employers that do not subsidize premiums at all, that only highly compensated employees would be able to afford their coverage.

To the extent that discrimination in family premium subsidies is permitted, the new credit may, in fact, act over time as a spur for encouraging employers to drop the dependent coverage contributions for their lower wage employees and we do not want to see that happen. We think Section 89 is an important protection and that the need to adjust Section 89 to keep in mind the new credit and the incentives it may or may not produce is important.

Thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Ms. Rosenbaum appears in the appendix.]

The CHAIRMAN. Ms. Nancy Duff Campbell.

STATEMENT OF NANCY DUFF CAMPBELL, MANAGING ATTORNEY, NATIONAL WOMEN'S LAW CENTER, WASHINGTON, DC

Mr. CAMPBELL. Thank you, Mr. Chairman. I, too, am pleased to be here to testify in support of your initiative today.

The National Women's Law Center, as well, has long supported making the dependent care credit refundable. Although the credit is now targeted to provide more of its benefits to low-income taxpayers than to higher income taxpayers, very low-income families are unable to take advantage of the credit's full provisions.

First, they may have no tax liability and therefore can get nothing from the credit. Or, second, they may have only very low tax liability and therefore can only get a portion of the credit they would otherwise be entitled to. In 1985, for example, the most recent year for which data are available, only 8.7 percent of the returns claiming the credit were filed by taxpayers with under $10,000 in adjusted gross income. They received only 5.8 percent of the total tax relief.

Moreover, because the sliding scale for determining the credit percentage is not indexed for inflation, over time its targeting to low-income families also will be eroded as fewer and fewer taxpayers are able to take advantage of the 30 percent credit amount—the maximum. As Sara has said, these problems were exacerbated by the Tax Reform Act of 1986 because no changes were made in the credit to take account of other changes in the brackets and the generally lower tax rates. Now many more low-income families have no tax liability. Not only will they receive no benefit, but virtually no taxpayers are eligible for the maximum 30 percent of their expenses.

The Chairman's proposal addresses these concerns by making the credit refundable. It will provide tax benefits to the lowest income families in the form of refunds. In addition, it makes the sliding scale fully functional because many of the refunds would be calculated using the maximum credit percentage. The largest refunds on a percentage basis would go to the lowest income families.

From the summary of the Chairman's proposal, however, we are not wholly clear about its scope and we have two concerns which we hope will be addressed. First, the credit should be refundable both for adult care expenses and child care expenses. The current credit applies to both kinds of expenses and there is no reason to limit its refundability to child care expenses. Indeed, adult expenses are, on average, even higher than child care expenses, and low-income families with these expenses are as deserving as low-income families with child care expenses.

Second, the current law should be amended to permit low-income families to receive the dependent care credit on an advance basis. Now families have to wait until their tax returns are filed at the end of the year to receive any tax assistance in meeting their dependent care expenses. These families should be able to get the benefit of the credit throughout the year by reducing the taxes withheld from their pay checks or, to the extent they are eligible for a refund, by adding the amount of the credit to which they are entitled to their pay checks.

Advance payment of the earned income credit is now permitted and the Chairman's proposal would permit advance payment of the new health credit. Advance payment of the child and adult dependent care credit should similarly be permitted.

We also support the Chairman's proposal to institute a new health insurance credit. Particularly because it is women and children who are disproportionately among the uninsured. More than half of all uninsured workers are employed in the female dominated trades and services and women are also disproportionately represented in jobs paying under $20,000 a year.

The cost of insurance, as we have heard, is also very expensive. This proposal is a first step in helping low-income families meet this cost, both for policies they finance entirely themselves and for co-payments they make to premiums paid by their employers.

Finally, we support the Chairman's proposal for child health demonstration projects. These projects should result in a modest increase in the number of providers serving uninsured children and their families and thereby improve their health and well being. In addition, the project should provide a basis for evaluating ways of improving access to health services for families who do not have health insurance.

In sum, we urge the committee to approve the initiative in its entirety with the clarifications we have suggested.

Thank you.

[The prepared statement of Ms. Campbell appears in the appendix.]

The CHAIRMAN. Mr. Greenstein, who represents the Center on Budget and Policy Priorities, Washington, DC.

STATEMENT OF ROBERT GREENSTEIN, DIRECTOR, CENTER ON BUDGET AND POLICY PRIORITIES, WASHINGTON, DC

Mr. GREENSTEIN. Thank you, Mr. Chairman. Like the rest of the panel, it is my pleasure to be here this morning to congratulate you on the excellent initiative that you have introduced.

There are a growing number of analysts across the political spectrum who believe that one of the most important things we can do in public policy is to establish a goal that if a family works—particularly if a parent works full-time—that the parent and the children should not have to live in poverty, that they should not be pushed down into poverty by child care and health care expenses and that they should not have to go on welfare to get out of poverty.

This is a goal endorsed by many from the Heritage Foundation, for example, along with a number of traditional supporters of children's issues. Your bill takes important steps in this direction. I think it is an important compliment, among other things, to welfare reform last year. If we do not make work pay, then we are not going to succeed in enabling families to achieve self-sufficiency and to leave public assistance roles.

I know some questions have been raised about the health portion of the bill on the grounds that it may not reach a significant portion of the uninsured, but I think we need to keep in mind that we cannot do all that needs to be done on the health side in one bite, or in one bill.

As I just mentioned, it is important to cover high health care costs that working families who do have coverage now have when those costs can push them back into poverty and end up making them not much better off than those who are not working outside the home. It also can be helpful in inducing more of the working poor to buy coverage.

On the child care side it is well known that the existing credit, as others have said, is somewhat regressive due to the fact that it does not help those who need it most. We now subsidize through the tax system the child care costs of all but those who are the poorest and most need the assistance. If we are to have a dependent care credit, as I think we should, it is essential that it be refundable. As other witnesses have said, I think it is a good compliment to the act for better child care initiative so that on the one hand we can increase the purchasing power while on the other hand we are increasing the quality of care.

Having said that, let me add two notes regarding these proposals. Number one, I would support the comment that the previous witness made of the importance of making all refundable credits available on an advance basis. This is particularly important when we are trying to show people on public assistance the advantage of working rather than being on public assistance. If the credit is available on an advance basis it shows up in the monthly or the weekly check which can be compared to the monthly public assistance payment.

Secondly, and particularly important, I think it would be essential for the committee to ensure that the IRS undertake a promotion campaign. We have removed 5 or 6 million working poor fami-

lies from income tax roles by the 1986 Tax Reform Act and many of them are not filing returns now. If they do not file a return they will not get these refundable credits. We need to let them know the importance of filing a return even if they do not owe income tax. I would not underestimate the importance of that step and I hope something to deal with it can be incorporated into your initiative.

Having said all of that, I think we also need to keep our eye on the longer range goal: again, the importance of lifting working poor families with children out of poverty. In that vein, I would like to note that if and when resources permit—and I know resources are tight given the deficit—that there are several important additional steps that we need to take.

One is the Medicaid initiative that I know you are working on. Secondly, in the area of wages, we need to raise the wages through a combination of mechanisms up to the poverty line for full-time workers. We can do this within our means, I think, if we do a combination of raising the minimum wage and adjusting the earned income credit by family size. Congressman Petri, Congressman Downey, Senator Boschwitz, among others have proposed such an approach.

Finally, but quite important, in the area of the dependent care credit, I think we need to recognize that for families who are poor, covering only 30 percent of the cost leaves a very large amount of the child care costs uncovered. As resources permit, it would be desirable to move to a higher percentage, such as the 40 percent that is in the bill introduced by Senator Packwood and Senator Moynihan.

Thank you, Mr. Chairman. Let me commend you again for the important steps for working families your initiative concludes.

The CHAIRMAN. Thank you very much for your comments. There is no question but that this bill by itself does not resolve it all. But as you have stated, within the limits of the budget constraints—and we have paid for all of this with what we are doing in the way of tax revenues we are addressing—that we are making considerable headway. It is the objection, I know of the vast majority of this committee, and certainly the ranking member of the minority, to continue to address these problems and see what we can get in the way of equity and in the way of health care for all children.

Senator PACKWOOD. I just want to welcome Ms. Campbell back on board the train.

Mr. CAMPBELL. Thank you, Senator.

The CHAIRMAN. It is good to be back together.

Mr. CAMPBELL. Temporary alliances once again.

Senator PACKWOOD. That is correct.

No statement or other comments, Mr. Chairman.

The CHAIRMAN. Thank you very much for your attendance.

And our last witness will be Mr. Charles Shewbridge, III, Assistant Vice President for Taxes, Bell South, testifying on behalf of the United States Telephone Association.

Mr. Shewbridge, we are pleased to have you.

STATEMENT OF CHARLES W. SHEWBRIDGE, III, ASSISTANT VICE PRESIDENT FOR TAXES, BELL SOUTH, TESTIFYING ON BEHALF OF UNITED STATES TELEPHONE ASSOCIATION, ATLANTA, GA

Mr. SHEWBRIDGE. Good morning, Mr. Chairman. I am Charles Shewbridge, Assistant Vice President of Taxes for Bell South Corporation, a worldwide provider of telecommunications and business services.

I speak today on behalf of the United States Telephone Association, whose 1,100 member companies serve 99 percent of the nation's telephone access lines. USTA members range in size from small independent local exchange companies to the large regional holding companies. I am here to express USTA's opposition to the telephone excise tax which the Administration proposes in its 1990 budget be made permanent. The tax last extended for 3 years, beginning in 1988, is imposed at a rate of 3 percent on local and long distance telephone service and on teletypewriter exchange services.

First of all, I would note that the local exchange industry appreciates the difficulty Congress faces in trying to reduce the budget deficit. We understand that everyone is expected to bear their fair share of the burden, but the resulting fair share cannot be achieved through a tax that by its very nature is unfair. Accordingly, on behalf of our customers, we must strenuously object to this proposal.

We take this opportunity to express our hope that Congress will allow the tax to expire as scheduled. Our opposition to the tax and to the Administration's proposal is based on two considerations. First, we agree with the position of the previous Administration which in an August 1987 Treasury Department study recommended that the telephone excise tax be permitted to expire. The Treasury Department had three criteria for imposing an excise tax, all of which the telephone excise tax fails to meet.

Moveover, the Joint Tax Committee in a 1987 report of possible revenue alternatives agreed that there was no rationale for imposing the telephone excise tax. Allowing the expiration of the tax would help to offset increases in the telephone subscriber line charge.

Second, it is a regressive tax, and unlike water, gas and electric service, telephone service is the only household necessity subject to a Federal excise tax burden.

In the past, the Treasury Department has employed three criteria to justify an excise tax. Under the first criterion, external social cost, the tax represents a reimbursement to society for the external costs associated with the product or service tax. For example, tax receipts on cigarettes might be used for cancer research.

While child care is vitally important, there is no external social cost association between telephone service and child care. Under the second criterion, the tax may represent a user fee, which is imposed on a government provided service or product, such as the entrance fee to a national park. Telephone service is obviously not provided by the government.

Under the third criterion, the tax may be characterized as a nondistorted consumption tax, imposed on a product or service that is priced in elastic, that is unresponsive to price changes. The tele-

phone tax and the associated administrative costs of collecting the tax result in higher rates to customers. Unlike consumers of luxury items, consumers of telephone service respond very predictably to price increases by reducing their usage. This phenomenon has been demonstrated frequently in regulatory proceedings throughout the country.

Clearly, none of the three criterion described above fits the telephone excise tax. The telephone excise tax is particularly unfair to consumers in that it is regressive; it falls more heavily on low-income families. A telephone is not a luxury item and should not be taxed as one. It is imposed upon a service that is a necessity of modern life. Among the four basic household utilities—electricity, gas, water and telephone, only telephone service is subject to Federal excise tax.

For almost three decades Congress has recognized that the telephone excise tax is not desirable as a permanent part of the tax structure. Congress has been trying to eliminate this tax since 1959. Nevertheless since 1965 the tax has been extended seven times, each time as a temporary revenue raising measure. It is time to stop this cycle and allow this regressive tax to expire.

The CHAIRMAN. Thank you, Mr. Shewbridge.

Mr. SHEWBRIDGE. Thank you for allowing me to talk to you and to express our views.

The CHAIRMAN. When you talk about the regressive nature of this tax—and I understand that we are talking about an excise tax being on goods or services that a higher percentage of the purchases of low-income are made in those than high income.

Mr. SHEWBRIDGE. Yes, sir.

The CHAIRMAN. That that is a regressive tax.

Mr. SHEWBRIDGE. Yes, sir.

The CHAIRMAN. But in this instance you are talking about telephone service and you have a higher tax on long distance, as I understand it, and I would assume that higher income people would have more telephones and businesses. Have you really made a study as to it truly being regressive?

Mr. SHEWBRIDGE. Well, sir, 90 percent of America's households today have telephones. The local charge—local service charge—for telephones is subject to the tax. So all people, rich and poor, are paying the same amount of tax—3 percent on local service.

The CHAIRMAN. But I would assume also that people of higher income are doing more long distance calls.

Mr. SHEWBRIDGE. That could be possible, as does business.

The CHAIRMAN. And you have a higher tax there as I understand it.

Mr. SHEWBRIDGE. And obviously the cost of long distance is one reason why people do not make long distance calls. And by imposing the tax——

The CHAIRMAN. Except those folks that have higher income make more long distance calls, I would assume. Anyway, I would suggest you take a look at that one.

Mr. SHEWBRIDGE. Yes, sir.

The CHAIRMAN. Now, let us turn this argument over on the other side of it. When you talk about this temporary tax, it has been scheduled to expire since 1959.

Mr. SHEWBRIDGE. Yes, sir.

The CHAIRMAN. It is not very temporary, it sounds to me. And when I hear the Administration and I read the President's lips—"No new taxes"—I do not see any objection to this one. They are talking about it continuing. So it sounds pretty permanent to me.

Mr. SHEWBRIDGE. Well, they are asking for that. It is still a temporary tax on the books right now, set to expire in 1991.

The CHAIRMAN. Since 1959, a temporary tax. Thank you.

Senator PACKWOOD. I have no questions, Mr. Chairman.

The CHAIRMAN. Mr. Shewbridge, you have a tough row to hoe. [Laughter.]

Mr. SHEWBRIDGE. We appreciate that.

[The prepared statement of Mr. Shewbridge appears in the appendix.]

The CHAIRMAN. That will bring the hearings today to an end. Thank you.

[The prepared statement of the Joint Committee on Taxation appears in the appendix.]

[Whereupon, the hearing was adjourned at 12:08 p.m.]

APPENDIX

ALPHABETICAL LISTING AND MATERIAL SUBMITTED

SUBMITTED BY SENATOR BENTSEN

DESCRIPTION OF TAX PROPOSALS RELATING TO TAX CREDIT FOR CHILD CARE AND CERTAIN HEALTH INSURANCE PREMIUMS, SIMPLIFICATION OF SECTION 89 NONDISCRIMINATION RULES APPLICABLE TO CERTAIN EMPLOYEE BENEFIT PLANS (S. 1129), REPEAL OF SPECIAL RULES APPLICABLE TO FINANCIALLY TROUBLED FINANCIAL INSTITUTIONS, AND EXTENSION OF TELEPHONE EXCISE TAX

(PREPARED BY THE STAFF OF THE JOINT COMMITTEE ON TAXATION, JUNE 9, 1989, JCX-13-9)

INTRODUCTION

The Senate Committee on Finance has scheduled a hearing on June 12, 1989, on tax proposals relating to (A) tax credit for child care and certain health insurance premiums; (B) simplification of section 89 nondiscrimination rules applicable to certain employee benefit plans (S. 1129, introduced by Senator Bentsen and others); (C) repeal of special rules applicable to financially troubled financial institutions; and (D) extension of the telephone excise tax.

This document,[1] prepared by the staff of the Joint Committee on Taxation, provides a description of present law and the tax proposals scheduled for the hearing.

DESCRIPTION OF TAX PROPOSALS

A. TAX CREDIT FOR CHILD CARE AND CERTAIN HEALTH INSURANCE PREMIUMS

PRESENT LAW

Child and dependent care credit

Under present law, an individual who maintains a household that includes one or more qualifying individuals is entitled to a nonrefundable tax credit equal to a percentage of the employment-related child or dependent care expenses paid by the individual for the taxable year to enable the individual to work (sec. 21). The maximum amount of the credit is 30 percent of allowable employment-related expenses. This 30 percent is reduced by one percentage point for each $2,000 (or fraction thereof) of the taxpayer's adjusted gross income (AGI) between $10,000 and $28,000. The credit rate is 20 percent for taxpayers with AGI in excess of $28,000.

The maximum amount of expenses that may be taken into account in calculating the credit is limited to $2,400 per year in the case of one qualifying individual and $4,800 in the case of more than one qualifying individual. In addition, the maximum amount of expenses taken into account cannot exceed the individual's earned income or, in the case of married taxpayers, the lesser of the individual's earned income or the earned income of his or her spouse. A special rule applies for determining the income of the taxpayer's spouse if the spouse is a full-time student or mentally or physically incapable of caring for himself or herself.

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[1] This document may be cited as follows: Joint Committee on Taxation, *Description of Tax Proposals Relating to Tax Credit for Child Care and Certain Health Insurance Premiums, Simplification of Section 89 Nondiscrimination Rules Applicable to Certain Employee Benefit Plans (S. 1129), Repeal of Special Rules Applicable to Financially Troubled Financial Institutions, and Extension of Telephone Excise Tax* (JCX-13-89), June 9, 1989.

A "qualifying individual" is (1) a dependent of the taxpayer who is under the age of 13 and with respect to whom the taxpayer is entitled to claim a dependent exemption, (2) a dependent of the taxpayer who is physically or mentally incapable of caring for himself or herself, or (3) the spouse of the taxpayer, if the spouse is physically or mentally incapable of caring for himself or herself.

Tax provisions relating to individual health insurance

Present law generally does not provide tax benefits specifically designed to encourage the purchase of health insurance by individuals; however, present law does provide certain tax benefits for health insurance in particular circumstances.

Under present law, health insurance that is paid by an individual's employer is generally excluded from an employee's gross income. This exclusion also applies for employment tax purposes. In addition, self-employed individuals are entitled to deduct 25 percent of the amount paid for medical insurance for the individual or his or her spouse or dependents; this provision is scheduled to expire for 'taxable years beginning after December 31, 1989. These provisions are subject to the application of nondiscrimination rules and certain other requirements.

Taxpayers who itemize deductions may deduct expenses for medical care (not compensated by insurance or otherwise) of the taxpayer or his or her spouse or dependents to the extent such expenses exceed 7.5 percent of the taxpayer's gross income. Premiums paid for health insurance qualify for the deduction.

Earned income tax credit

Amount of credit

The earned income tax credit (sec. 32) provides a refundable tax credit to taxpayers who maintain a household for a child. The credit is equal to 14 percent of the first $6,500 of earned income for taxable years beginning in 1989. Earned income generally includes wages and salary and self-employment income. The maximum credit allowable in 1989 is $910. For taxable years beginning in 1989, the credit is phased out at a rate of 10 percent of the amount of the taxpayer's AGI (or, if greater, the taxpayers earned income) that exceeds $10,240. The credit phases out completely at $19,340 or the greater of adjusted gross income or earned income. The $6,500 and $10,240 amounts are adjusted annually for inflation, so that the maximum credit amount and the maximum amount of income eligible for the credit also increase with inflation.

Eligibility for credit

The earned income credit is available to taxpayers who maintain a household for a child. The child generally must be under age 19 and must reside in the household for at least half the year. In general, the taxpayer must be entitled to claim the child as a dependent, and thus must provide over half of the support for the child. An exception is made in certain cases where a divorced head of household has custody but riot the right to claim the dependency exemption. Married individuals must file a joint return in order to be eligible for the credit.

Refundability

Unlike most tax credits, the earned income credit is refundable; i.e., if the amount of the credit exceeds the taxpayer's Federal income tax liability, the excess is payable to the taxpayer. If the individual does not claim the credit, the IRS can determine from the return that the individual may be eligible, and performs the credit calculation for the individual. This determination is made after review of the taxpayer's income, filing status, and dependency exemptions.

Under an advance payment system, eligible taxpayers may elect to receive the benefit of the credit in their paychecks, rather than waiting to claim a refund on their return filed the following year. Employers make payments to the employee during the year and receive credit for the payments against the employer's tax liability.

EXPLANATION OF PROPOSAL

The proposal would make the present-law dependent care credit refundable and would allow an additional credit for expenditures for certain health insurance policies.

Refundable dependent care credit

The proposal would make the present-law dependent care credit refundable. That is, taxpayers who do not have sufficient taxable income to offset the credit would be entitled to receive the amount of the credit not offset against tax liability in cash.

Health insurance credit

The proposal would amend the dependent care credit to add a new refundable credit for health insurance expenses. The proposal would provide that an individual who maintains a household containing one or more qualifying individuals is entitled to a credit equal to a percentage of the individual's qualified health insurance expenses. The maximum credit percentage is 50 percent of the qualified health insurance expenses. This 50 percent is reduced by 5 percentage points for each $1,000 (or fraction thereof) by which the taxpayer's adjusted gross income (AGI) exceeds $12,000. Thus, the credit is zero for taxpayers with AGI in excess of $21,000.

Qualified health insurance expenses are amounts paid during the taxable year for health insurance that includes coverage for one or more qualifying individuals. For purposes of this credit, a qualifying individual is a dependent of the taxpayer who is under age 19 and with respect to whom the taxpayer can claim a dependent exemption.

Up to $1,000 of qualified health insurance expenses may be taken into account in calculating the credit. However, the maximum expenses taken into account cannot exceed the earned income of the taxpayer, reduced by employment-related expenses taken into account in determining the child care credit. Expenses, to the extent paid, reimbursed, or subsidized by the Federal Government or a State or local government, are not eligible for the credit.

Eligible taxpayers may claim both the dependent care credit and the health insurance credit.

Child health demonstration projects

The proposal authorizes the appropriation of $25 million for each of the fiscal years 1990 through 1994 to enable the Secretary of Health and Human Services to conduct demonstration projects to evaluate and extend health insurance to children under age 19 who are not covered by other public or private health programs.

The Secretary is authorized to enter into agreements with public and private organizations (for example, schools and hospitals) to provide health insurance coverage to such children. The Federal Government is to share up to 50 percent of the cost of programs under such agreements.

The health care program provided by an organization pursuant to such an agreement cannot restrict enrollment on the basis of a child's medical condition or impose waiting periods or exclusions for preexisting conditions. The program can also cover the parents of the child The Secretary may permit the organization to charge for the health care.

The Secretary is directed to publish by January 1, 1990, criteria governing the eligibility and participation of organizations in the demonstration projects.

Effective dates

The refundability feature of the present-law dependent care credit would be effective with respect to taxable years beginning after December 31, 1989. The health insurance credit would be effective for taxable years beginning after December 31, 1990.

POSSIBLE OPTIONS UNDER THE PROPOSAL

Option 1

For years beginning after December 31, 1991, both the present-law dependent care credit and the health insurance credit could be refundable on an advance basis.

Option 2

The Secretary of the Treasury could be directed to study the feasibility of permitting advance payments of the dependent care credit and the health insurance credit in a manner similar to the advance payment system under the earned income tax credit.

DESCRIPTION OF PRESIDENT'S PROPOSAL

Proposed child tax credit

Under the President's budget proposal, low-income families with at least one working individual would be entitled to claim a new refundable tax credit of up to $1,000 for each dependent child under age four. For each child under the age of four, families could claim a credit equal to 14 percent of earned income, with a maximum credit equal to $1,000 per child. Initially, the credit would be reduced by an amount equal to (1) 20 percent times the number of such children multiplied by (2) the excess of the greater of (a) AGI or (b) earned income over $8,000. The credit

would not be available to families with AGI or earned income greater than $13,000. In subsequent years, both the starting and end-points of the phaseout range would be increased by $1,000 increments. In 1994 and subsequent years, the credit would phaseout between $15,000 and $20,000.

Families would have the option of receiving the tax benefit through an advance payment system similar to the earned income tax credit.

Refundable child and dependent care credit

The existing child and dependent care tax credit would be made refundable. Families could not claim both the new child care credit and the child and dependent care credit with respect to the same child, but could choose the larger of the two credits.

Effective date

The provisions would be effective for taxable years beginning after December 31, 1989.

DESCRIPTION OF S. 412 [2]

The bill would retain the present law child care tax credit with three modifications. First, expenses relating to dependent children under age 13 would be eligible for a higher credit percentage and a different phasedown range than other eligible expenses. The applicable percentage of the expenses that would be eligible for the credit would be 40 percent rather than 30 percent as allowed under present law. The applicable percentage would be reduced by 3 percentage points for each $2,500 of AGI in excess of $12,500.

For taxpayers with AGI in excess of $27,500, the credit rate would be 20 percent. The maximum credit amount for such expenses would be $960 for one dependent child under the age of 13 ($1,920 for two or more qualifying dependents).

Second, under the bill, the credit attributable to expenses described above relating to dependent children under the age of 13 would be made refundable for taxpayers with AGI not in excess of $27,500. A taxpayer could receive the benefit of the credit throughout the year through an advance payment system.

Finally, the bill provides that child care expenses reimbursed or subsidized by the Federal Government through other programs (e.g., Title XX and AFDC recipients), would not be eligible for the child care credit.

The bill also would provide for an increase in the present law Social Services Block Grant Program also, and would require the Administration to report on the Program to the Committee on Finance and the Committee on Ways and Means not later than 3 years after the date of enactment.

The bill would be effective for taxable years beginning after December 31, 1989.

B. Simplification of Section 89 Nondiscrimination Rules Applicable to Certain Employee Benefit Plans (S. 1129) [3]

PRESENT LAW

In general

Under present law, the nondiscrimination rules contained in section 89 apply to certain types of fringe benefit plans, including employer-provided health plans. There are two different ways of testing for nondiscrimination: a 4-part test and a 2-part test. An employer is not required to test under both methods. The employer elects which method to apply.

Four requirements must be met under the 4-part test. First, at least half of the employees eligible to participate in the plan must be rank and file employees. This test is designed to limit the tax-favored treatment of plans primarily covering highly compensated employees (e.g., executive-only plans).

The second requirement is that at least 90 percent of the rank and file employees must have available to them a benefit at least half as valuable as the most valuable benefit available to any highly compensated employee. This test is designed to ensure that a significant percentage of rank and file employees have a minimum benefit available to them. For example, if the highest benefit available to any highly compensated employee is worth $1,000, then to pass this test, 90 percent of the rank and file employees must have available a benefit of at least $500.

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[2] Introduced by Senators Packwood, Moynihan and others on February 9, 1989.

[3] Introduced by Senators Bentsen, Pryor and others on June 6, 1989.

The third requirement is that the value of coverage received by rank and file employees must be at least 75 percent of the average value of coverage received by highly compensated employees. This test is designed to ensure that rank and file employees actually receive a significant portion of the tax benefits spent for health coverage.

Finally, under the 4-part test, the plan may not contain any provision relating to eligibility to participate that discriminates in favor of highly compensated employees (the nondiscriminatory provisions test). This is a subjective test and is intended to be applied in situations that are not measured by the numerical tests, for example, where coverage for a rare disease is theoretically provided to all employees but in fact only the company president can benefit from the coverage. This test also applies to the method by which the employer tests.

Under the 2-part test, the following requirements must be satisfied. First, at least 80 percent of the employer's rank and file employees must be covered by the plan (or group of aggregated plans). This test was designed primarily for small employers.

The second requirement under the 2-part test is that the plan must satisfy the nondiscriminatory provisions test. This is the same test that is described above.

Special rules

Certain employees are disregarded in applying the nondiscrimination tests. In general, the employees that may be excluded are: (1) employees who normally work less than 17½ hours per week (i.e. part-time employees), (2) employees who normally work less than 6 months during a year (i.e., seasonal employees), (3) employees under age 21, (4) employees who have not completed a minimum service requirement, and (5) nonresident aliens.

In general, employees who are covered under a plan of another employer (e.g., a spouse's plan) may be disregarded in applying the nondiscrimination tests. In addition, under special rules, family coverage may be tested separately from other coverage and only by taking into account those employees with families. Under these rules, an employer's plans will not fail the nondiscrimination tests simply because more highly compensated employees have families than do rank and file employees.

Under the rules relating to testing for nondiscrimination, a highly compensated employee is defined as an employee who during the year or the preceding year (1) was a 5 percent owner of the employer, (2) received compensation in excess of $81,720, (3) is an officer of the employer, or (4) received compensation in excess of $54,480 and was in the top paid 20 percent of employees. The dollar limits are indexed annually for inflation. In lieu of calculating the top-paid 20 percent of employees, the employer may elect to treat employees with compensation in excess of $54,480 as highly compensated employees.

In addition to the nondiscrimination rules, section 89 contains minimum requirements for health plans (and certain other types of plans). These rules require that a plan must be in writing, legally enforceable, maintained for the exclusive benefit of employees, intended to be maintained indefinitely, and that employees be given reasonable notification of plan terms.

EXPLANATION OF THE BILL

In general

Under the bill, new section 89 nondiscrimination rules and modified qualification rules are delayed for one year and are effective for plan years beginning after December 31, 1989. Prior to that date, the nondiscrimination rules under section 105(h) as it existed immediately prior to the passage of the Tax Reform Act of 1986 apply to certain self-insured health plans. See the discussion of the effective date below with respect to certain transition rules.

Eligibility test

The bill replaces the current section 89 nondiscrimination rules for health plans with a single test: (the "eligibility" test). In general, an employer's health plan passes section 89 if the plan is not discriminatory on its face and at least one plan or a group of plans providing primarily core health coverage is available to at least 90 percent of the employer's employees at an employee cost to employees of no more than 40 percent of the total cost of the plan in the case of individual coverage, or 40 percent of the total cost of the plan in the case of family coverage (including coverage for the employee).

Under the bill, the eligibility test is satisfied if the plan is not discriminatory on its face and core (or primarily core) health coverage is available to 90 percent of the employees of the employer. This 90-percent test may be met by looking at all plans

maintained by the employer that provide health coverage and that meet certain limits on the amount that may be charged to an employee for coverage. A plan that can be taken into account in applying the 90-percent test is called a qualified core health plan. This test does not require that the employer only offer health plans meeting the employee contribution requirements. Rather, the employer can offer a full array of plans as long as the availability test is met by at least one (or a group of) plans. If the employer fails to meet this new eligibility test, then the value of all health coverage provided to highly compensated employees is includable in the taxable income of the highly compensated employees.

The eligibility test under the bill does not require that a particular level of coverage be provided to employees. Instead, in order for all or a portion of the coverage provided to highly compensated employees to be provided on a tax-favored basis, some health coverage must be available to a broad segment of employees. By using a requirement that limits the percentage of the total cost that may be required of an employee, the bill ensures that the employer subsidizes a portion of core health coverage, while also providing the employer flexibility in those instances where the cost of coverage varies because of geographic locale.

As under present law, the bill generally defines core health coverage as coverage for comprehensive major medical and hospitalization benefits. Core health coverage generally does not include coverage under dental, vision, disability, and accidental death and dismemberment plans. Flexible spending arrangements are not core health plans nor can such plans be a part of a qualified core health plan.

In determining what plans may be considered available for purposes of the eligibility test, the bill limits the percentage of the total cost of a plan that the employer may require an employee to pay. For individual coverage, the mandatory employee contribution cannot exceed 40 percent of the total cost of the plan generally determined under the health care continuation rules. For family coverage, the mandatory employee contribution cannot exceed 40 percent of the total cost determined in the same manner. Under the bill, this 40 percent limitation applies to family coverage that includes coverage for the employee. Thus, to the extent that a plan providing individual coverage requires a lower employer premium than the maximum level of employee premium under the bill, the additional employer subsidy under such plan may be used to help the employer meet the maximum employee premium requirements for a family plan. However, if the employer does not provide individual coverage meeting the employee contribution requirements under the bill, the employer does not meet the eligibility test. This is the case without regard to whether the employer maintains a family plan that meets the maximum employee premium requirements.

As under present law, the bill provides that the employer-provided coverage under a plan may be excluded from the taxable income of a highly compensated employee only if the plan does not contain any provision that (by its terms,, operation, or otherwise) discriminates in favor of highly compensated employees. The purpose of the nondiscriminatory provision requirement is to preclude executive-only plans and other inherently discriminatory practices. As under present law, the requirement applies to the method and circumstances under which an employer determines whether it meets the requirements of section 89. For example, the requirement applies to the designation of a testing date.

The following examples illustrate the eligibility test.

Example 1.—An employer maintains several health plans for its employees. Among these plans is a plan that provides core health coverage that is available to all employees. The plan has a total premium cost of $1,000 for employee-only coverage and requires an employee contribution of $250. This plan is a qualified core health plan and the employer meets this eligibility test without regard to the characteristics or employee contribution requirements of the other plans maintained by the employer.

Example 2.—An employer maintains two plans providing core health coverage. One plan is an indemnity plan and is available to employees at a cost of $200 per year for employee-only coverage (total annual premium cost of $1,200) or at a cost of $700 per year for family coverage (total annual premium cost of $2,000). This plan is available to 40 percent of the employees of the employer. The other plan is an HMO requiring no employee contribution and is available to 70 percent of the employer's employees. When considered together, 90 percent of the employer's employees are eligible for one or both of the plans. Both plans are qualified core health plans and may be considered for the eligibility test: because the cost to employees under both plans is within the mandatory contribution range and both plans primarily provide core health coverage. If 90 percent of the employees can participate in one of the two plans, then the employer meets the eligibility test.

Benefits test

The purpose of the benefits test contained in the bill is to ensure that highly compensated employees do not receive a disproportionately higher level of employer premium than the level of employer premium that is available to a broad group of employees. Under the bill, the maximum tax-favored benefit that a highly compensated employee may receive is generally 133 percent of the employer premium for the employee-only coverage that may be taken into account in applying the eligibility test. However, if a highly compensated employee elects a specific level of family coverage, and if the employer maintains a plan that provides family coverage that meets the requirements under the bill for the eligibility test, then the tax-favored premium is increased to 133 percent of the employer-paid family premium taken. into account in applying the eligibility test. If the employer maintains more than one core health plan providing family coverage (e.g., employee plus one or employee plus two), then for purposes of determining the limitation on benefits, an employee electing a specific level of family core coverage may receive tax-favored coverage based upon the employer subsidy under that plan. If the plan that is elected is not a qualified core health plan or a part of such a plan that meets the eligibility test, then any qualified core health plan with a smaller employer-provided value that passes the eligibility test may be used to determine the limitation on benefits under the benefits test.

A highly compensated employee is not treated as electing a family plan unless the employee has elected a core health plan providing family coverage (without regard to whether the plan elected meets the eligibility test). Thus, for example, an employee that elects only a flexible spending arrangement has not elected family coverage.

For purposes of the benefits test, an employer may aggregate certain plans in determining the employer-provided benefit available to 90 percent of the employees. Because these rules are permissive, an employer is not required to aggregate plans and may designate any smaller level of employer-provided benefit to be multiplied by 133 percent, as long as that benefit satisfies the 90-percent eligibility test. However, an employer is likely to use the highest level of employer-provided benefit that satisfies the eligibility test in calculating the benefit to be multiplied by 133 percent.

Under the aggregation rule, the employer may increase the level of benefit available to employees by aggregating two or more plans if such plans are available to the same group of employees and, when combined, such aggregated plans constitute a qualified core health plan (i.e., are primarily composed of an employer-provided benefit relating to core health coverage and continue to meet the maximum employee contribution limitation on an aggregate basis). As noted above, flexible spending arrangements cannot be part of a qualified core health plan.

For example, if a dental plan with an employer-provided benefit of $499 and a core health plan with an employer-provided benefit of $501 are available to the same employees and the two plans meet the maximum contribution limitation when considered together, then such plans may be treated as one qualified core health plan with an annual employer-provided benefit of $1,000. If 90 percent of the employees are eligible for this plan or for other qualified core health plans with at least the same employer-provided benefit, the benefits test would be met if no highly compensated employee received an employer-provided benefit in excess of $1,330 (133 percent of $1,000). Of course, for purposes of the aggregation rules, overlapping coverage under the plans may not be considered more than once in determining the employer-provided benefit under the combined plans.

For purposes of testing under the benefits test, the bill makes permanent the temporary valuation rule under present law. Thus, as under present law, the employer may use any actuarially reasonable valuation method. In addition, the employer may use the cost of the coverage as that cost is determined under the health care continuation rules. The employer may also make reasonable adjustments to cost, for example, adjustments for differences in cost in different geographic areas.

Any employer-paid premium received by a highly compensated employee in excess of the level of employer-paid premium that meets the benefits requirement is includable in the taxable income of such employee. As under present law, in determining the amount that is actually in excess of the benefits limitation and thus includable in the taxable income of the high paid, only cost as determined under the health care continuation rules may be used, with limited adjustments.

The benefits test is illustrated by the following examples.

Example 1.—An employer maintains only two health plans: an indemnity Plan and an HMO. Both plans are available at no cost to over 90 percent of the employees. An employee may choose either plan. Under this example, there can be no failure of the benefits test because the highly compensated employees can only receive

an employer-paid premium equal in value to the employer-paid premium available to 90 percent of all employees.

Example 2.—An employer maintains two health plans: an indemnity plan providing core health coverage that is available to all employees, and a dental plan available only to 20 percent of employees (including both highly and nonhighly compensated employees). Neither plan requires employee contributions. The employer cost for the indemnity plan is $1,400 as determined under the health care continuation coverage rules. The cost for the dental plan is $500. Under the bill, if a highly compensated employee participates under both plans, then the taxable portion of the premium to such employee is $38 ($1,900 less (1.33 x $1,400)).

Example 3.—An employer maintains several health plans. Three plans are core health plans. Each core plan is available to over 90 percent of all employees. The employer cost of each of the three core plans is $500, $1,000 and $1,500 respectively. The maximum excludable benefit that may be received by any highly compensated employee is $1,995 ($1,500 x 1.33). Thus, any highly compensated employee would have taxable income to the extent that the employee receives over $1,995 in health coverage.

Example 4.—An employer maintains several health plans. Among these plans is a family core indemnity plan with a total premium cost of $2,500, and a required after-tax employee contribution of $1,100. The employer also maintains a family dental plan with a total premium cost of $600 and a required after-tax employee contribution of $100. Assuming these plans are available to all employees and that the employer maintains an employee-only core health plan that meets the requirements of the eligibility test, a highly compensated employee electing family coverage under the described core health plan may exclude $2,527 in health benefits (1.33 x $1,900) because, when combined, these plans constitute a qualified core health plan. The employeecontribution limitation is met because the total employee cost for the plans ($1,200) is less than 40 percent of the total cost for both plans ($3,100).

Example 5.—An employer maintains two core health plans. One plan is an employee-only plan with a total premium cost of $1,250 and a required after-tax employee contribution of $250 per year. The other core plan provides family coverage for the employee, and the employee's spouse and dependents. The employee pays the full cost of the plan. Assuming that the employee-only plan is available to 90 percent of the employees of the employer, a highly compensated employee may exclude $1,330 in coverage ($1,000 x 1.33). whether chat employee enrolls in the family or individual plan.

Special rules for small employers

The bill provides several rules relating to small employers. First, the bill has created a design-based test. An employer can know at the time it offers its plans to its employees that it meets section 89. For example, an employer offering only one plan to 90 percent of its employees may pass the tests without further testing or data collection.

Second, the bill modifies several rules in the excludable employee area. Among these changes is a rule permitting an employer with 20 or fewer employees to disregard employees for purposes of the eligibility test who are determined to be uninsurable by reason of a medical condition by the insurance company that provides core health coverage to the employees of the employer. The insurance company's determination is to be based on its customary standards for insurability applied to groups of that size.

With respect to part-time employees, employers with 20 or fewer employees (including such part-time employees) may exclude part-time employees normally working less than 30 hours per week in 1990, 27.5 hours per week in 1991, and 25 hours per week thereafter.

The bill contains a rule designed to benefit small employers in determining the number of employees to whom coverage must be made available. Under the bill, in determining the number of employees who must be eligible for coverage under the eligibility test, an employer may round down to the nearest number of employees. For example, if an employer has 11 employees, only 9 must have coverage available if the employer is to meet the eligibility test.

The bill clarifies that for testing under section 89, a small employer may use average premium cost even if the employer's premium is calculated on an individually rated basis.

Finally, for employers with 20 or fewer employees, the written plan requirement under the qualification rules may be satisfied by the insurance contract that is currently in effect relating to the coverage provided by the employer.

Part-time employees

Under the bill, employees who normally work less than 25 hours a week are disregarded for purposes of the nondiscrimination tests (compared with 17.5 hours under present law). In addition, the employee premium and the employer-provided coverage may be proportionately adjusted for less than full-time employees. Under this rule, the maximum employee contribution limitation is increased to 60 percent for employees normally working between 25 and 30 hours per week. Further, for purposes of the benefits test, such an employee is treated as contributing only 40 percent of the total cost of the plan despite the higher contribution level. This rule permits a part-time employee to be treated the same as a full-time employee, even though the part-time employee pays more for the same coverage and so receives a lower employer-paid benefit.

Leased employees

Under the bill, the present-law historically performed test is repealed and replaced with a new rule defining who must be considered a leased employee. This change is made because the proposed regulations under the leased employee rules (sec. 414(n)) are overly broad in defining who may be a leased employee. Under the bill, the proposed regulations are no longer valid to the extent they relate to the historically performed test under present law.

Under the bill, an individual will not be considered a leased employee unless the individual is under the control of the recipient organization. The bill clarifies present law in that support staff of professionals continue to be treated as leased employees (to the extent the are not common law employees)

Under the bill, persons who perform incidental services under certain arrangements are not leased employees. This rule does not extend to the operation (including supervision over such operation) of the goods, equipment, or completed facility that is the subject of such arrangement.

Union employees

The bill provides that plans maintained pursuant to collective bargaining agreements are tested separately with respect to employees covered by the agreement. The separate testing rule applies on a bargaining unit by bargaining unit basis. In addition, multiemployer plans are generally exempted from the nondiscrimination rules of section 89. Finally, employees that are covered under the Davis-Bacon Act are excluded employees for purposes of the nondiscrimination rules.

Former employees

As under present law, the nondiscrimination tests are applied separately to former employees of the employer. The bill delays the application of section 89 to former employees for one year, to 1990. Further, employees who separate from service prior to 1990 are not considered for purposes of testing. In addition, the bill provides that in determining whether former employees meet the nondiscrimination requirements, the employer may consider only those employees that meet certain reasonable eligibility requirements relating to age or service. The Secretary is authorized to impose restrictions on instances where age or service requirements are not reasonable and may allow other eligibility criteria to be imposed by the employer.

In applying the nondiscrimination tests to former employees, the mandatory employee contribution limits do not apply. Thus, as long as 90 percent of the employees in a class of former employees being tested are eligible for a core health plan on the same terms, that plan may be a qualified core health plan without regard to whether it meets the limitation on employee contributions.

Excluded employees; individuals participating in certain government-sponsored programs

Under the bill, certain individuals are excluded for purposes of determining whether the employer meets the nondiscrimination tests. In addition to part-time employees, other individuals are excluded from testing. Excluded employees include employees with less than 6 months of service, seasonal employees, non-resident aliens, and students.

A series of new exclusions are added to the statute. These individuals include senior citizens employed pursuant to Title V of the Older Americans Act or under the Environmental Programs Assistance Act of 1984. Students under certain programs qualified under Title VIII of the Higher Education Act of 1965, and certain disabled individuals are also excluded employees. Finally, inmates in state, local, or Federal correctional facilities are excluded employees. The Secretary is authorized to designate certain additional classes of individuals as excluded employees if treatment of such individuals as employees is inappropriate in light of the policy purpose

underlying the Federal or state program authorizing or encouraging such participation and the nondiscrimination rules. This rule excluding certain individuals is not intended to create any inference with regard to the appropriate treatment of such individuals as employees under other provisions of the Code.

Under present law, if the employer provides coverage to an otherwise excluded employee, the employer may test all excluded employees of that class separately from other employees. The bill modifies this rule and allows the employer to disregard excluded employees that receive coverage. A similar rule applies to all classes of excluded employees, except those employees that are excluded because they have not yet met the 6 month service requirement. Present law (including regulations)—continues to apply to these employees.

Definition of highly compensated employee

The bill amends the definition of who constitutes a highly compensated employee for purposes of section 89. Under present law, officers with compensation over $45,000 (indexed) are highly compensated employees. However, an employer will always have at least one highly compensated officer regardless of that officer's compensation. Under the bill, only officers with compensation in excess of the $50,000 limitation (indexed to $54,480 for 1989) that is otherwise applicable for determining who are highly compensated employees must be considered highly compensated employees. This rule will benefit employers who, but for the present-law rule, would have no highly compensated employees. These employers include many municipalities and tax-exempt organizations.

In addition, the bill requires that beginning in 1990, the compensation levels specified in the definition of highly compensated employee will be rounded to the nearest $1,000.

Cafeteria plans

The bill provides special rules for the treatment of salary reduction contributions. For purposes of the eligibility test, the general rule is that salary reduction contributions are employee contributions. Thus, a plan does not meet the eligibility test to the extent that such contributions (and other employee contributions) exceed the 40-percent limitation on employee contributions.

For purposes of both the eligibility and benefits tests, certain salary reduction contributions are treated as an employer-provided benefit. These salary reduction amounts are those that are available to the employee only to the extent that: (1) the employee indicates to the employer that he or she has core health coverage elsewhere, either through another employer or the employer of a spouse or dependent; (2) the employee does not elect any core health plan maintained by the employer; and (3) such amount is available in cash to the employee. These salary reduction amounts are considered employer-provided in determining whether the plan meets the eligibility test. They are also treated as employer-provided in determining the employer-provided portion of the qualified core health plan that is multiplied by 1.33 to determine the benefits limitation under the benefits test (but only to the extent that such amounts relate to the plan in question).

In determining the employer-provided portion of the qualified core health plan that is multiplied by 1.33 to determine the benefits limitation under the benefits test, certain salary reduction amounts other than those amounts described in the preceding paragraph may also be considered (to the extent that such amounts relate to the plan in question). These additional salary reduction contributions are treated as employer-provided to the extent they do not exceed the employer-provided premium relating to such plan, excluding all salary reduction contributions.

For purposes of determining the employer-provided coverage provided to the highly compensated employees, all salary reduction contributions are considered employer-provided.

The treatment of salary reduction contributions under the bill is illustrated by the following example. A plan has a total cost of $1,500 and a required employee contribution of $400, paid through a salary reduction agreement. Under the plan, if an employee has other core health coverage and elects no core health coverage, the employer will pay the employee $300. Thus, there are $700 of salary reduction contributions under the plan. Assuming that this plan is available to 90 percent of the employees, the plan will meet the eligibility test. This is because the required employee contributions ($400) are less than 40 percent of the total cost of the plan ($1,500). The employer-provided portion of the plan for purposes of multiplying by 1.33 under the benefits test is $1,500. This amount is composed of the $800 of employer-provided contributions (excluding salary reduction), $300 of salary reduction that is given preferential treatment under the special rule described above, and the remaining salary reduction under the plan ($400). The $400 is treated as employer-

provided because it does not exceed the $800 in nonsalary reduction under the plan. Thus, the benefits limitation for the highly compensated employees is $1,995 ($1,500 x 1.33).

Group-term life insurance

Under present law, group-term life insurance plans are subject to the section 89 nondiscrimination rules. To further simplify section 89, the bill provides that the nondiscrimination rules in effect prior to the Tax Reform Act of 1986 (with certain modifications) apply to group-term life insurance for years beginning in 1989 (sec. 79(d)).

For years beginning after December 31, 1989, the bill makes certain conforming changes to the pre-Tax Reform Act rules to take into account changes in the law. First, the rules are modified in order to compare highly and nonhighly compensated employees rather than key employees and all other employees. Second, section 79 will include the Tax Reform Act rule that group-term life insurance is discriminatory to the extent it takes into account compensation in excess of $200,000 in determining a multiple of compensation benefit under a plan.

Under the bill, accidental death and dismemberment plans (AD&D) are treated as group-term life insurance plans solely for purposes of nondiscrimination testing. Thus, a death benefit under an AD&D plan that is based on a uniform multiple of compensation (not in excess of the $200,000 limitation) is not discriminatory solely because of the use of such multiple.

Dependent care assistance programs

Under the bill, section 89 does not apply to dependent care assistance programs. For plan years beginning in 1989, the nondiscrimination rules under section 129(d) are applicable to such plans and are modified in two respects. First, if a plan fails to meet the requirements of section 129(d), only highly compensated employees must include benefits under the program in gross income. Second, if a dependent care assistance program fails the 55-percent benefits test contained in section 129(d)(7) then the highly compensated employee must include in gross income only that amount of benefit in excess of that level of benefit that would meet the benefits test.

Election not to test

Under the bill, an employer may elect to forego testing and instead include the employer premium for health coverage as taxable income on the W-2 of highly compensated employees.

Qualification rules

In general

An employer's fringe benefit plans are required to meet certain minimum standards. These standards require that a plan be in writing, employees be notified of plan provisions, the plan be maintained for the exclusive benefit of employees, the plan be legally enforceable, and that the plan is intended to be maintained for an indefinite period of time (the permanence requirement). Under present law, if an employer's plan does not satisfy the qualification requirements, then all employees must include in income the value of benefits (e.g., reimbursements for health care) received under the plan.

The bill replaces the present-law sanction for failure to satisfy the qualification rules with an excise tax on the employer and makes certain modifications to the qualification standards. Under the bill, the qualification rules no longer apply to any plan the benefits under which are excludable under section 132. Thus, the qualification requirements do not apply to no-additional-cost services, qualified employee discounts, or employer-provided eating facilities. As under present law, an employer's failure to meet the qualification requirements does not, in and of itself, create a private right of action on behalf of employees, nor does it create any inference that such a right of action may exist.

As part of the modifications to the sanction for failure to satisfy the qualification rules, the bill removes the rules from section 89 and adds the rules to new Code section 4980C. As is the case generally under the bill, it is intended that legislative history and guidance by the Secretary relating to the qualification rules under present law continue to apply to the rules as modified by the bill, except to the extent inconsistent with the provisions of the bill.

For example, as under present law, a plan generally meets the permanence requirement if the plan provides coverage for a continuous 12-month period. If the plan is in effect for less than 12 months, the employer generally will not violate the permanence requirement upon a showing of a substantial independent business reason for the modification or termination of the plan. Similarly, the notice require-

ment is met if a third party, such as an insurance company, provides notice to the employees of the plan.

The bill modifies the exclusive benefit requirement. This requirement is not violated merely because nonemployees or other individuals without a service nexus to the employer are covered under the plan on an after-tax basis. As under present law, the exclusive benefit rule is not intended to override other provisions with respect to who may be covered under a plan (e.g., rules relating to section 125 and section 501(c)(9).

Sanction for failure to comply

The bill replaces the present-law sanction with an excise tax on the employer. Under the bill, no penalty applies with respect to a failure to satisfy the qualification rules if the employer corrects the failure to comply within 6 months of the date the employer knew or should have known of such failure. If the employer does not correct the failure within this 6-month period, then an excise tax is imposed. The excise tax is equal to 34 percent of the costs paid or incurred by the employer for coverage under the plan that relates to the failure. In the event of a willful failure to comply with the qualification requirements, the tax is imposed from the date of the failure without regard to any subsequent correction. Under the bill, the Secretary is authorized to waive the excise tax in whole or in part if the failure is not due to willful neglect and to the extent the payment of the tax would be excessive relative to the failure involved. In the event the failure relates to a multiemployer plan, the excise tax is imposed on the plan.

Good faith compliance

The Tax Reform Act of 1986 directed the Secretary to issue guidance on certain employee benefit provisions added by the Act, including section 89. Under present law, until the Secretary issues guidance on which taxpayers may rely with respect to such provisions, an employer's compliance with its reasonable interpretation of the provision, based on the statute and its legislative history, if made in good faith, constitutes compliance with the provision. The bill applies this good faith compliance standard to the provisions of the bill. This good faith standard applies, for example, to the rules relating to separate lines of business and the new definition of leased employee under the bill.

The bill also provides that, with respect to lines of business that do not meet the guidance issued by the Secretary, the good faith standard applies to the determination of whether lines of business are separate under section 414(r)(2)(C) until the Secretary begins issuing rulings relating to lines of business.

Except where directly inconsistent with the provisions of the bill, prior legislative history relating to any provision amended by the bill (including the rules of section 89) and guidance issued by the Secretary pursuant to any such provision, continue in effect.

Effective date

The new discrimination rules relating to section 89 are generally effective for plan years beginning in 1990. The employer is permitted an election to use present law with respect to its plans for 1990 and 1991. This election relates to all plans of the employer and may be made on an annual basis. The employer may also elect to use present law to test its dependent care assistance programs under section 89 for 1990 and 1991. Whether or not the employer makes such election, the changes under the bill that relate to part-time employees apply.

C. Repeal of Special Rules Applicable to Financially Troubled Financial Institutions (Code secs. 597, 368(a)(3)(D), and 382(l)(5)(F))

PRESENT LAW AND BACKGROUND

Present law

Special tax rules applicable to financially troubled thrift institutions were adopted in 1981. In the Technical and Miscellaneous Revenue Act of 1988 (the "1988 Act"), these special rules were expanded to cover financially troubled banks. These rules are scheduled to expire for transactions after December 31, 1989.

(1) Assistance payments to financially troubled financial institutions

Payments from the Federal Savings and Loan Insurance Corporation (the "FSLIC") or the Federal Deposit Insurance Corporation (the "FDIC") to a financially troubled financial institution are not included in the income of the recipient institution and such institutions need not reduce their basis in property by the amount

of such financial assistance. However, the 1988 Act provided for a reduction in certain tax attributes of a financially troubled financial institution equal to 50 percent of the amount of the financial assistance (Code sec. 597).

(2) Treatment as a tax-free reorganization

Certain FSLIC- or FDIC-assisted acquisitions involving a financially troubled financial institution may qualify as tax-free reorganizations, without regard to the requirement for a tax-free reorganization that the shareholders of an acquired corporation must generally maintain a meaningful ownership interest in the acquiring corporation (the "continuity of interest" requirement) (Code sec. 368(a)(3)(D)).

(3) Net operating loss carryovers

The general limitations on the ability of an acquiring corporation to utilize the net operating losses, built-in losses, and excess credits of a corporation acquired in a tax-free reorganization are relaxed in the case of a tax-free acquisition of a financially troubled financial institution (Code sec. 382(1)(5)(F)).

House action on H.R. 1278

Repeal of special tax rules

In connection with the consideration of H.R. 1278, (the Financial Institutions Reform, Recovery and Enforcement Act: of 1989), the House Committee on Ways and Means reported out an amendment to repeal the special tax rules applicable to financially troubled financial institutions.[4] The repeal would be effective for transactions occurring on or after May 10, 1989 (the date of Ways and Means Committee action on H.R. 1278).

Under the Ways and Means Committee amendment, the Treasury Department would be granted regulatory authority to issue regulations providing rules for the Federal income tax treatment of transactions involving financially troubled financial institutions. The Treasury Department would be directed to promulgate rules which ensure that taxpayers do not receive duplicative benefits from the combination of tax-free assistance payments together with the deductibility of losses and expenses.

In addition, interim rules contained in the legislative history would specify the Federal income tax treatment of taxable asset acquisitions of financially troubled financial institutions pending issuance of rules by the Treasury Department.

Clarification of 1988 legislation

The Ways and Means Committee amendment would clarify that the reduction in tax attributes equal to 50 percent of the amount of nontaxable financial assistance received with respect to FDIC transactions and certain FSLIC transactions (involving institutions which did not meet a qualifying asset test) is effective on the same date that the special tax rules relating to financially troubled financial institutions were extended to such transactions (i.e., November 10, 1988, the date of enactment of the 1988 Act).

EXPLANATION OF THE PROPOSAL

The special tax rules applicable to financially troubled financial institutions would be repealed prior to their scheduled expiration date.

D. Extension of the Telephone Excise Tax

PRESENT LAW

A 3-percent excise tax is imposed on amounts paid for local telephone service, toll telephone service and teletypewriter exchange service (sec. 4251). The tax is paid by the person who pays for service to the person rendering the service, who in turn remits the tax to the general fund of the Treasury.

Exemptions from the tax are provided for communications services furnished to news services (except local telephone service to news services), international organizations, the American National Red Cross, servicemen in combat zones, nonprofit hospitals and educational organizations, and State and local governments. Other exemptions include amounts paid for installation charges and for certain calls from coin-operated telephones (sec. 4253).

This excise tax is scheduled to terminate, effective with respect to amounts paid pursuant to bills first rendered on or after January 1, 1991.

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[4] See H. Rept. 101-54, Part 2, May 22, 1989.

The 3-percent telephone excise tax was last extended for 3 years (1988-1990) in the Omnibus Budget Reconciliation Act of 1987. The 3-percent tax was previously extended for 2 years (1986-1987) in the Deficit Reduction Act of 1984.

EXPLANATION OF PROPOSAL

The 3-percent telephone excise tax would be made permanent. This proposal is included in the Administration's budget proposal.

NATIONAL FEDERATION OF INDEPENDENT BUSINESS
June 12, 1989.

Hon. LLOYD BENTSEN,
SH-703 Hart Senate Office Bldg.,
Washington, DC.

Dear Senator Bentsen: On behalf of the 580,000 small business owner members of the National Federation of Independent Business, I would like to commend you for your Children's Initiative legislation. As free standing legislation, the bill makes significant strides toward helping low income working families purchase health insurance for their uninsured children.

Many of the uninsured are children in low income families. This bill reaches two major segments of the uninsured population yet retains the private, individual-based character of the U.S. health insurance system. We applaud you for developing a workable solution and for staying away from the unworkable and damaging mandate approach.

NFIB data indicate that the number one problem facing small firms is the cost of health insurance. If this is a significant problem for small businesses, it is clearly an insurmountable problem for individuals, particularly low income families. This legislation helps to put individual health insurance policies within the reach of many more Americans,

NFIB believes that the problem of the uninsured a two-part equation: first, the cost of health insurance; second, the lack of affordable health care for individuals. Employers have come a long way since the 1940's when roughly 40% of the population was covered by health insurance. Today, 84.7% of the population are covered. Your legislation helps address the major gap that remains and provides an incentive for individual to purchase health care protection. More importantly, the bill targets those most in need of assistance—low income families and their children.

Again, NFIB applauds you for recognizing that the issue of the uninsured can be tackled in a step by step approach that uses market incentives rather than mandates. Your legislation an important step toward making sure all Americans have access to health care.

Sincerely,

JOHN J. MOTLEY, III, DIRECTOR,
Federal Governmental Relations.

PREPARED STATEMENT OF NANCY DUFF CAMPBELL

Mr. Chairman, and members of the Committee, the National Women's Law Center is a national women's legal organization that has been working for over sixteen years to protect and advance women's legal rights. We are pleased to have the opportunity to testify in support of the Chairman's Children's Initiative pending before the Committee.

The Chairman's proposal amends the current-law dependent care tax credit in two ways. It makes the credit refundable, and expands its scope to cover expenditures for health insurance policies that include children. Families who have both dependent care expenditures and expenditures for health insurance policies that include children would be eligible for both credits.

In addition, the Chairman's proposal authorizes $25 million a year for five years to fund demonstration projects to extend health coverage to uninsured children under age 19 and their families. The federal government would pay up to 50 percent of the cost of projects, sponsored by public and nonprofit organizations, to provide basic health care.

As you are aware from our testimony before the Committee on April 19, we believe that legislation to make the dependent care credit refundable is not a substitute for the comprehensive child care legislation embodied in the Act for Better

Child Care Services (ABC), but can be an important complement to ABC. Similarly, the proposed health tax credit is complementary to, but not a substitute for, comprehensive legislation to address the problems of families without health insurance.

1. Refundability of the Dependent Care Credit

The National Women's Law Center has long supported legislation to make the dependent care credit refundable.

The dependent care credit allows taxpayers who have employment-related expenses for the care of a child under the age of 13, or for the care of a spouse or other dependent who is physically or mentally incapable of self-care, to set off a percentage of those expenses against their federal income tax liability. The amount of the credit that may be claimed is determined by the amount of the taxpayer's expenses and the taxpayer's adjusted gross income (AGI). With respect to expenses, for all taxpayers eligible expenses may not exceed $2,400 for one dependent or $4,800 for two or more dependents. With respect to AGI, the credit is targeted to provide the greatest benefit to low-income taxpayers. Taxpayers with AGIs of $10,000 or less are eligible for a credit equal to 30 percent of their qualifying expenses, while taxpayers with AGIs over $28,000 are eligible for a credit equal to 20 percent of their qualifying expenses. Between $10,000 and $28,000 AGI, the applicable percentage declines by one percentage point for each $2,000 increase in AGI. Thus, the maximum dependent care credit is 30 percent of $4,800 in expenses, or $1,440, for taxpayers with two or more dependents and AGIs below $10,000, and 20 percent of $4,800, or $960, for taxpayers with two or more dependents and AGIs above $28,000.

The dependent care credit serves three purposes. As a form of assistance to working families, it recognizes that child and adult dependent care are economically-significant and socially-useful expenses, and that government should provide some help to families in meeting those expenses, particularly lower-income families. As a tax measure, the credit promotes "horizontal equity," an important goal of our nation's tax law. That is, the credit recognizes that families with the same income and family size who have employment-related, out-of-pocket dependent care expenses have less ability to pay taxes than families with the same income and family size who do not have such expenses. In order to promote horizontal tax equity between those families, taxpayers with employment-related child care expenses are given a tax credit to partially offset their child care expenses and thereby equalize their ability to pay taxes. Among taxpayers who are eligible for its benefits, the credit also promotes "vertical equity," that is, provides greater benefit to lower-income than to higher-income taxpayers.

The dependent care credit is the largest source of federal assistance to families with employment-related dependent care needs. Internal Revenue Service data demonstrate that for 1985, the most recent year for which data are available, over 8.4 million taxpayers claimed the credit and received over $3.1 billion in tax relief.[1] A large portion of these benefits was received by low- and moderate-income taxpayers. Forty-seven percent of the total benefits, or more than $1.5 billion, went to taxpayers with adjusted gross incomes (AGIs) under $25,000.

Because the credit is not refundable, however, very low-income families are unable to benefit from its provisions, or are limited in the benefit they can receive. Families that have no tax liability derive no benefit from the credit or its special targeting to low-income taxpayers, and families with very low tax liability lose the benefit of a portion of the credit they can claim. In short, these very low-income families—the most in need of government dependent care assistance—receive virtually none of the dependent care tax benefits distributed to their higher-income counterparts. In 1985, for example, only 8.7 percent of the returns claiming the credit were filed by taxpayers with under $10,000 in AGI. They received only 5.8 percent of the total tax relief, or less than $180 million in benefits. Moreover, the sliding scale for determining the credit percentage is not indexed for inflation. As a result, unless the credit is made refundable, over time its targeting to low-income taxpayers will be eroded as fewer and fewer taxpayers with AGIs low enough to take advantage of the maximum 30 percent credit have any tax liability.[2]

These problems are exacerbated by the Tax Reform Act of 1986, which made no changes in the dependent care credit to take account of the Reform Act's bracket changes and generally lower tax rates. Many more low-income taxpayers now have

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[1] For 1989, nearly 10 million taxpayers are expected to claim the dependent care credit, for a total of over $4.3 billion in tax assistance.

[2] This erosion will occur because the dollar amounts of the basic provisions that determine tax liability, including the personal exemption, standard deduction, tax bracket breakpoints, and, for low-income taxpayers, the earned income tax credit, all are indexed and will increase.

no tax liability. Beginning in 1988, the tax thresholds for nearly all taxpayers except single, non-elderly individuals are above $10,000—the income level at which the maximum credit amount of 30 percent of allowable expenses phases out. As a result, virtually no taxpayers are eligible to claim 30 percent of their expenses. Both the availability of the credit and its low-income targeting will continue to erode over time.[3]

The Chairman's proposal addresses these problems by making the credit refundable. It provides tax benefits to the lowest-income families in the form of refunds. In addition, it makes the sliding scale fully functional, because many of the refunds would be calculated using the maximum credit percentage. The largest refunds on a percentage basis would go to the lowest-income families. For example, a married couple with one child, $10,000 in income, and $750 in dependent care expenses is currently eligible for a $225 credit, but has no tax liability for the credit to offset and therefore receives no benefit. Under the proposal, that family would receive a $225 tax refund.

The Chairman's proposal appropriately finances the changes in the credit from broad-based tax limitations. We strongly believe that the dependent care tax assistance currently available to some families should not be curtailed in order to provide new dependent care assistance to other families.

From the summary of the Chairman's proposal, however, its scope is not wholly clear. We have the following concerns, which we hope will be addressed.

First, the credit should be refundable both for families with child care expenses and for families with adult care expenses. The current credit applies to both kinds of expenses, and there is no reason to limit its refundability to child care expenses. Indeed, adult care expenses are, on average, even higher than child care expenses, and low-income families with adult care expenses are equally deserving of tax assistance as families with child care expenses.

Second, current law should be amended to permit low-income families to receive advance payment of the credit in their paychecks. Now, families have to wait until their tax returns are filed at the end of the year to receive any tax assistance in meeting their dependent care expenses. These families should be able to get the benefit of the credit throughout the year by reducing the taxes withheld from their paychecks or, to the extent they are eligible for a refund of the credit, by adding the amount of the credit to which they are entitled to their paychecks. Advance payment of the earned income tax credit is permitted in this fashion, and the Chairman's proposal would permit advance payment of the new health credit component of the dependent care credit. Advance payment of the child and adult dependent care component of the credit should similarly be permitted.

In short, we support the Chairman's proposal to make the dependent care credit refundable for child and adult care expenses, with these clarifications, and urge the Committee to approve it.

2. Health Insurance Credit

The National Women's Law Center supports the Chairman's proposal to extend the scope of the dependent care credit to cover expenses for health insurance policies that include children under age 19. For families with incomes of $12,000 or less, the new health insurance credit is equal to 50 percent of qualified expenditures, up to $500. For families with incomes above $12,000, the credit is reduced by 5 percentage points for every $1,000 in income, phasing out completely at income levels above $21,000. The health insurance credit would be payable in advance and, because it is an extension of the dependent care credit, we assume it would be refundable.

Currently, over 35 million individuals in this country have no health insurance, a growth of 15 percent in the number of uninsured individuals since 1982. The uninsured are concentrated at the low end of the economic scale: two thirds live in families with incomes below 200% of the poverty line, and one third live in families with incomes below the poverty line. Three fourths of the uninsured earn under $10,000 a year, and 93 percent earn less than $20,000 annually.

Women and children are disproportionately represented among the uninsured. More than half of all uninsured workers are employed in the female-dominated trade and services sectors. Women are also disproportionately represented in jobs paying less than $20,000 a year, where virtually all of the uninsured workers are concentrated. A full 80 percent of working women earn under $20,000 annually,

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[3] In contrast, for those taxpayers who continue to benefit from the dependent care credit, the Tax Reform Act's generally lower tax rates have made the credit proportionately more valuable, since many taxpayers have seen their tax liability decrease while their credit amount remains the same.

compared to half of working men. Over one third of uninsured children live in female-headed households, while only nine percent live in male-headed or two-parent households.

In addition, the cost of health insurance is significant. A recent survey of costs in the Washington, D.C. area, for example, found that the cost of insurance for a family with children ranged from $68 a month to $428 a month, depending upon the type of coverage, the amount of the deductible, and, in some instances, the age of the family members. Clearly, these are not amounts that low-income families can even begin to pay without some assistance.

The Chairman's proposal is a modest first step in helping low-income families meet this expense, both for policies that they finance entirely themselves and for co-payments they make to premiums paid by their employers. It is targeted to families at the income levels where most of the uninsured are concentrated. Moreover, because the credit can be advanced, its benefit will be available to families throughout the year, rather than just at the end of the year when they file their tax returns.

We urge the Committee to approve this expansion of the dependent care credit.

3. Child Health Demonstration Projects

The National Women's Law Center supports the Chairman's proposal to authorize $25 million a year for five years to enable the Secretary of Health and Human Services to conduct demonstration projects to extend health coverage to uninsured children under age 19 and their families. Plans assisted under the proposal must include preventive care, doctors' office visits for children, outpatient diagnostic care, outpatient surgery, and, at the option of the organization, emergency care. The plans may not restrict enrollment on the basis of a child's medical condition, and may not impose waiting periods or exclusions for preexisting conditions.

The demonstration projects contemplated by the proposal should result in a modest increase in the number of providers serving uninsured children and their families—and thereby improve the health and well-being of these families. The projects should also provide a basis for evaluating ways of improving access to health services for families who do not have health insurance. We urge the Committee to approve these projects.

In sum, the National Women's Law Center urges the Committee to approve the Chairman's Children's Initiative in its entirety, with the clarifications we have suggested.

PREPARED STATEMENT OF SENATOR JOHN H. CHAFEE

Thank you, Mr. Chairman, for holding this Committee markup on important initiatives for children.

Children are a fragile resource that needs care and attention. In my home state of Rhode Island, we have 65,000 children under age five. Nearly half have mothers who work. And one-fifth of these children lives in poverty. They need assistance if they are to avoid learning and behavioral difficulties later in life. That is why our initiatives, especially those in the Finance Committee, are so important.

Many of us on the Finance Committee have joined as cosponsors of the Act for Better Child Care, or ABC. ABC addresses the three most pressing concerns of parents: the availability, quality, and affordability of child care. However, many members believe that a child care tax credit for parents is preferable to an appropriated program. For the sake of children and their parents, we must sit down and work out a solution that contains the best elements of both approaches.

The proposal of the Chairman addresses the cost of child care in two ways. First, it makes the existing Child and Dependent Care credit refundable. Second, it creates a new health care credit for lower income families.

Generally, I agree that tax credits for low income parents may well help them pay for child care costs. I also feel strongly that tax credits alone do not constitute a child care system. As an element of a national child care program, they are important. But we need to make sure that the child care system we put into place addresses the *availability and quality* of care as well as the cost.

I support efforts to expand access to health insurance to children who are currently uninsured. I have taken a good hard lool at this proposal to provide a tax credit for families who purchase dependent health insurance coverage. It is an interesting approach that has some merit. I agree we should encourage people to buy comprehensive health insurance for their children, particularly if their employers provide such an option.

It is estimated that the Chairman's new Health Care Credit will cost about $1.5 billion. I am delighted at the prospect that, in this time of fiscal restraint, we are considering spending an additional $1.5 billion to give more of our nation's uninsured children access to health care. However, my concern is this: if we spend $1.5 billion on a tax credit, how much room will we have left ourselves for other children's initiatives, such as expansions in Medicaid?

However much money we have to spend on health care for children, we must spend it wisely. I am not convinced that a tax credit is either the most effective or the most cost-efficient mechanism. I have not yet seen the assumptions used in estimating the cost of the proposal, but I believe that very few families in the income range we are discussing will be in a position to make use of the proposed credit.

Employers who pay wages under 200% of poverty frequently do not even offer the *opportunity to buy* dependent coverage. In this case, the family would have to purchase non-group coverage in the private market—at rates that we all know to be extremely expensive. The $500 maximum credit for a family under $12,000 would probably not be sufficient to make this feasible, and the family would not use the credit.

Families who do have access to employer-provided insurance might opt to take family coverage if we implemented this tax credit. However, they would probably have to contribute a significant percentage of the premiums. In fact, it is not uncommon for employees to pay the entire family coverage premium—at a cost ranging from $2,600 to $3,000 per year. Here again, the maximum credit of $500 would probably not be enough to encourage low-income families to purchase the coverage.

A few numbers will illustrate what I mean. In the income category this proposal would affect, there are approximately 8.8 million uninsured children. Of these, there are *only 1.2 million* children that we can assume even have access to employer-provided insurance: that is, they are the children of employer-insured adults. This is the group of uninsured that would theoretically be able to use the credit. But as a practical matter, my guess is that fewer than half would be able to afford to.

Put simply, my concern is this: should we spend $1.5 billion to give a maximum of 1.2 million uninsured children access to health insurance when we could spend the same amount of money or even less and help four or five times that many?

Let me outline what I believe we could accomplish with $1.5 billion through Medicaid other programs. If we: mandated Medicaid coverage for pregnant women, infants, and children under age 6 up to 185% of poverty; provided Medicaid coverage to all children under age 18 who are below the Federal poverty level; improved Medicare and Medicaid reimbursement for Community Health Clinics; increased the state matching rates for outreach services; ensured that all health problems discovered by the EPSDT program be addressed for all Medicaid children; and mandated presumptive eligibility for ambulatory prenatal care we would be serving a minimum of 6 million additional pregnant women, infants and children. Mr. Chairman, the cost of all these items in 1992 would be about $1 billion dollars. This is $500 million less than the tax credit would cost in 1992.

I am looking forward to working with my colleagues in Congress and the President to craft a comprehensive child care measure. I believe that we are starting that process in earnest this morning.

PREPARED STATEMENT OF RICHARD E. CURTIS

I am Richard Curtis, Director of the Department of Policy Development and Research of the Health Insurance Association of America (HIAA) The HIAA is a trade association representing some 350 insurance companies that write 85 percent of the commercial health insurance business in this country.

Mr. Chairman, we support establishing a refundable tax credit to assist lower income families in obtaining health insurance coverage for their dependent children. As you know, HIAA has a comprehensive position on the uninsured that places first priority on extending coverage to poor and near poor children. While our policy does not specifically call for such a tax credit, the objectives and philosophy are clearly consistent.

The cost of health care and insurance to cover health costs is obviously less affordable to families with modest financial resources. Not surprisingly, the proportion of children in lower income families who are uninsured is much greater than the proportion of other children without coverage. Significant numbers of these uninsured children have a working insured parent who has opted for individual rather than (more expensive) family coverage under their employer's health benefit plan. Some children have uninsured working parents who have declined available em-

ployer sponsored coverage altogether. Other uninsured children have parents for whom employer subsidized coverage is not available. Lower income parents in this position often cannot afford health insurance at all.

Only government can address this problem by identifying and differentially subsidizing lower income populations. The proposal before this Committee would significantly assist lower income families in purchasing health care coverage for their children. It exemplifies a constructive public-private partnership to extend health insurance to those in greatest need of coverage.

We strongly agree with the Committee's special attention to the health care needs of children. It is critical that children receive adequate care early in their lives in order to assure a healthy, productive adulthood and avert potentially unnecessary and far more costly care in the future. Adequate financing is essential to meeting these objectives. As you know Mr. Chairman, relative to other populations, government assistance for low income children has not been commensurate with their growing needs. For example, Medicaid spending on children and their parents has not even kept pace with inflation, while spending on other populations has risen dramatically (See Chart 1, 2 and 3). The tax credit proposal, in conjunction with the Chairman's Medicaid proposals, represents a critically important Federal initiative to improve health care coverage for poor and near poor children.

The demographics of uninsured children in fact underscore the need for expanding both public and private health care coverage. Fully 41 percent of children without health care coverage fall below the Federal poverty line. Thanks to the actions of this Committee, recent years have seen badly needed incremental expansion in Medicaid coverage to poor children.

On the private side, the Current Population Survey shows an erosion in the extent of private coverage for children. For example, between 1979 and 1986 the percent of children covered by an employer plan dropped from roughly 64 percent to 61 percent. Low income workers are the most likely to drop or decline coverage for themselves or their family and would benefit greatly from the tax credit. Nearly one-third (29%) of near poor (100%-199% of poverty) uninsured children has a household head covered by an employer based plan [based on tabulations of the CPS by Deborah Chollet of EBRI]. The tax credit would encourage improvements in family coverage for dependents.

A substantial number of children have working parents who decline to purchase coverage even when it is offered by their employer. The Small Business Administration estimates that 13 percent of workers eligible for employer based coverage decline it. One survey of low wage service workers found a much higher 48 percent of employees rejecting available employer based coverage. The inability to afford the cost of coverage is frequently cited as the principal reason lower income workers decline coverage.

Finally, there are children with parents for whom private employer based coverage is not available. Low income parents who are not working, work limited hours, are working full-time but are ineligible for an employer plan, as well as those who work for an employer not offering coverage, would fall into this rubric. Close to 70 percent of near poor children (100-200% of poverty) are in families with a family head having no health coverage at all or, for a small proportion, nonemployment based coverage. Many could avail themselves of the proposed tax credit to obtain coverage for their dependent children.

We also believe that the Federal Government can play an important role in encouraging alternative financing and delivery approaches for providing basic health care to children. For example, we see a critical need for readily accessible community-based clinics that provide well-baby care and basic primary and preventive services to both preschool and K-12 school age children. While we do have reservations about some specific aspects of the proposed Child Health Demonstration projects, we applaud their purpose and the commitment of funding to that purpose.

Private health insurance plans have made major strides to meet the special health coverage needs of children. For example, in 1988, 52% of conventional, 70% of PPO and 97% of HMO employer plans offered well baby care. Over one-half of insureds in conventional and over three-quarters of employees in PPO plans had case management available to meet needs resulting from chronic illness or injury.

It is our view that the proposed tax credit will encourage lower income parents to purchase health insurance coverage for their dependent children without causing reductions in employer contributions. Because the tax credit would benefit only those workers with low total family incomes, a reduction in the employer's contribution would not be offset by the tax credit for most workers. The family incomes of individual employees, even those with similar wages, are varied. Many low wage workers are meters of families with more substantial incomes. For example, tabula-

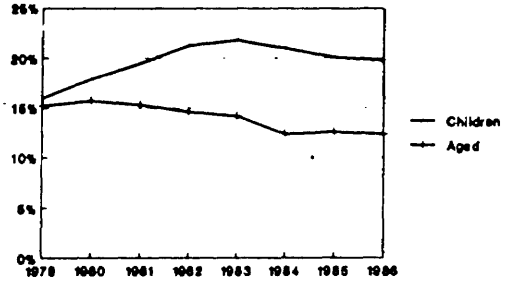
tions of the Current Population Survey show that seven out of ten workers earning only the minimum wage have family incomes in excess of 150 percent of poverty. It therefore seems highly unlikely that employers would reduce their contributions toward family coverage in response to the proposed tax credit. It is virtually certain, though, that the proposal will significantly improve private coverage of low income children.

While existing data is not adequate to precisely predict the proposed tax credit's impact on low income employees, we can reasonably anticipate its approximate value. Our estimates are based on HIAA's 1988 national survey of 1,665 randomly selected employers who offer health insurance benefits to their employees. As shown in Table 1, employers offering conventional health insurance contribute approximately 90% of the cost of individual coverage for the average employee. As shown in Table 2, the average percentage employer contribution for family coverage is 73%. Table 3 shows average annual premium costs (inflated to 1989 dollars): single coverage averages $1,375.92, and family coverage averages $2,934.36. For purposes of this estimate, we assume these figures pertain to lower income workers. While we cannot be certain this is true, it is consistent with 1983--1985 survey data from the State of Washington (Table 4) These data indicate that among persons covered by an employer health plan, both near poor and wealthier populations received approximately the same percentage contribution from their employers. While we understand such data might be available from upcoming National Health Expenditure Survey data, we are not aware of any national data to confirm or deny the assumption at this time.

On the basis of these figures, we estimate that the average employee share is $138 per year for individual coverage, and $792 per year for family coverage. For a family with an income of $12,000 or less, the proposed tax credit would reduce the employee's share for family coverage to $396. Thus, the employee's extra cost for family coverage versus individual coverage would be cut from $654 to $258 per year, or from $54.50 per month down to $21.50 per month. This should make a dramatic difference in the proportion of low income employees choosing to extend health care coverage to their children. We therefore strongly commend the proposed tax credit to your Committee and to the Congress.

CHART 1

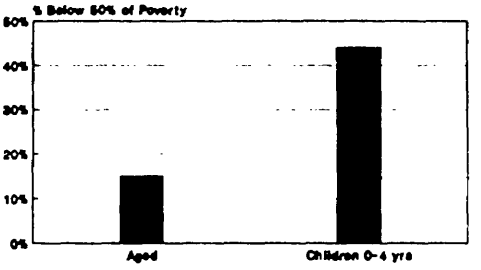
Poverty Rates for Children and the Aged
Using Official Poverty Definition



DATA SOURCE: Bureau of the Census

CHART 2

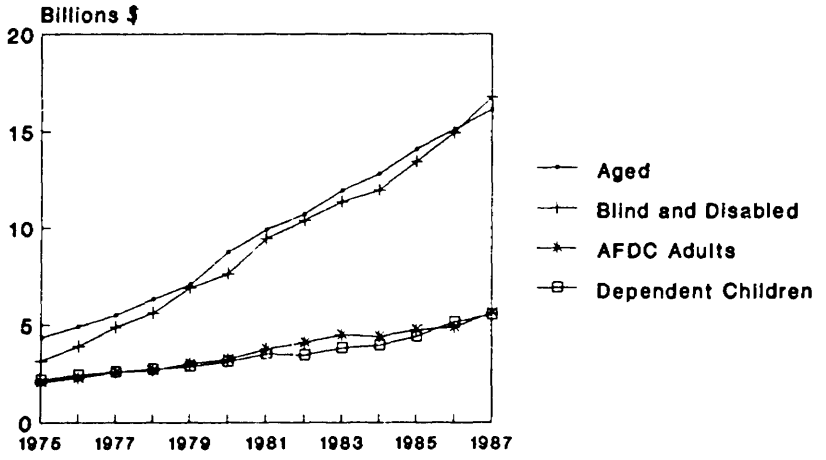
Percentage of Poor Aged and Young Children With Incomes Below 50 Percent of Poverty



Source: 1988 Current Population Survey

CHART 3

Medicaid Payments by Eligibility Status 1975 - 1987



DATA SOURCE: HCFA

TABLE 1

PERCENTAGE EMPLOYER CONTRIBUTIONS FOR CONVENTIONAL
INDIVIDUAL COVERAGE BY FIRM SIZE
(Weighted By Employees)

EMPLOYER CONTRIBUTION	FIRM SIZE				ALL FIRMS
	1-9	10-24	25-99	100+	
AVERAGE					90
0%	0	0	1	0	.5
1-24%	0	0	0	1	.4
25-29%	0	3	2	1	1.8
50-74%	18	15	11	11	11.3
75-99%	11	7	19	34	26.7
100%	71	75	66	53	60
TOTAL	100	100	100	100	100

SOURCE: Initial Tabulations of HIAA Employer Survey, 1988

TABLE 2

PERCENTAGE EMPLOYER CONTRIBUTIONS FOR CONVENTIONAL
FAMILY COVERAGE BY FIRM SIZE
(Weighted By Employees)

EMPLOYER CONTRIBUTION	FIRM SIZE				ALL FIRMS
	1-9	10-24	25-99	100+	
AVERAGE					73
0%	7	0	6	4	4.5
1-24%	2	4	0	3	1.6
25-29%	8	21	12	14	13.5
50-74%	19	26	25	19	22.5
75-99%	11	7	19	34	26.7
100%	51	38	40	25	32.0
TOTAL	100	100	100	100	100

SOURCE: Initial Tabulations of HIAA Employer Survey, 1938

TABLE 3

PROJECTED JUNE 1989
AVERAGE CONVENTIONAL PREMIUMS
BY TYPE OF COVERAGE AND FIRM SIZE
(Weighted by Employee)

TYPE OF COVERAGE	FIRM SIZE				ALL FIRMS
	1-9	10-24	25-99	100+	
Single					
Monthly	111.15	127.53	119.34	108.81	114.66
Annual	1347.84	1530.36	1432.08	1305.72	1375.92
Family					
Monthly	217.62	270.27	245.7	242.19	244.53
Annual	2611.44	2658.24	2948.4	2906.28	2934.36

SOURCE: Initial Tabulations from HIAA Employer Survey, 1988

TABLE 4

WASHINGTON STATE EMPLOYER CONTRIBUTIONS TO GROUP INSURANCE
ON BEHALF OF CONTRACT HOLDERS UNDER AGE 65 1983-1985

	<100% Poverty	100-199% Poverty	≥200% Poverty	Total
Employer paid all of premium	11,500	46,700	485,400	543,600
row %*	2.1%	8.6%	89.3%	47.1%#
column %**	44.6%	39.0%	48.1%	
Employer paid part of premium	11,500	67,800	488,800	568,100
row %*	2.0%	11.8%	86.1%	49.2%#
column %**	44.2%	56.7%	48.4%	
Employer paid none	2,900	5,100	35,200	43,300
row %*	6.4%	11.9%	81.4%	3.7%#
column %**	11.2%	4.3%	3.5%	
Total	25,900	119,600	1,009,400	1,155,000
	2 2%##	10.4%##	87.4%##	100%

* percent of individuals with this employer contribution in this income bracket
** percent of individuals in this income bracket with this employer contribution
# percent of all individuals with this employer contribution
percent of all individuals in this income bracket

Source: Report of the Washington State Health Care Project Commission

PREPARED STATEMENT OF SENATOR BOB DOLE

Mr. Chairman let me begin by thanking you for your willingness to schedule this hearing so quickly. As I indicated to you in my letter last week, I am sympathetic to your desire to improve health insurance coverage for children but felt that there were a number of questions that needed to be asked about a new tax credit.

We know that in 1986 more than one half of the uninsured population lived in families with children and one-quarter lived in single-parent families with children. As a result about 33 percent of the uninsured, or about 12 million people, are children under the age of 18. This is clearly a problem that must be addressed. The question we all have is whether or not a refundable credit is the most cost-effective method and whether it will actually assist those most in need.

As I am sure the representatives of the insurance industry will tell us, a large percentage of the uninsured are in low income families—but they are families who work. Thus some limited assistance might be of help to the family, but is it enough to encourage an employer to provide a benefit he or she currently does not provide.

In the view of this Senator putting money in to the hands of the low income as both the Bush and Bentsen credits do is the direction we should go. There is no question using the private sector to address these problems is a wise decision. However, I want to be sure that we are not, particularly in the case of the child health credit, simply replacing dollars already being spent. And I also want to be sure that all families in need of assistance receive the help that they deserve.

As we all know, there is a limited amount of money available to us to resolve these very real problems.

I look forward to hearing from our witnesses today in the hopes that they can answer some of our questions.

PREPARED STATEMENT OF STEVE A. FREEDMAN

INTRODUCTION

Distinguished Chairman, Members of the Committee, I am Steve Freedman. I direct the Institute for Child Health Policy of the State University System of Florida and I also have the privilege of directing the National Center for Policy Coordination in Maternal and Child Health which is supported by a grant from the Office of Maternal and Child of the U.S. Public Health Service (OMCH).

On March 31, 1988, an article was published in the *New England Journal of Medicine*, that outlined the School Enrollment-based Family Health Insurance concept. Subsequent to the publication of that article, the Robert Wood Johnson Foundation provided a planning grant to the Institute to develop a demonstration of the concept. The Foundation's interest stemmed from their broad national concern for finding alternative mechanisms to finance access to health care for the uninsured. In addition, the Office of Maternal and Child Health of the U.S. Public Health Service has provided funds to the National Center to determine the feasibility of the proposed program of School Enrollment-based Family Health Insurance. OMCH was motivated to provide that support, in part by its commitment under Title V to assuring family centered, community-based comprehensive care. Both of these grants have been in operation some six months. Later in this presentation I will describe the current status of the projects.

CONTEXT OF THE PROPOSAL

The proposal for School Enrollment-based Family Health Insurance evolved out of our understanding of the current financing and access issues related to adequate health care in the United States. Because I am aware that this Committee and its professional staff are fully cognizant of the statistics surrounding the issue of the uninsured, I will not take up your time reiterating those data.

I would like to begin with two fundamental principles. The first is that **all individuals in this country participate in the health care risk pool.** The second is that **there is no such thing as uncompensated care.** Let me explain. Sometime during their lifetime, virtually every individual in this country will seek and secure access to health care. In financing terms that access is called "risk." All those who secure access make up what is termed the "risk pool." However, not all individuals participate in financing the cost of that risk pool. Hence, the financing of that risk is disproportionately distributed to and subsidized by policy-holders and taxpayers through premium increases and tax increases. That brings me to my second point, i.e., there is no such thing as uncompensated care. Compensation is received by pro-

viders for all health care events. However, that compensation is not always paid directly by the individual receiving the care or from a public or private insurance program intended to support the care for that individual. Sometimes the compensation is paid indirectly through increased premium rates for those who are insured and increased taxes for those who must support publicly financed programs. Thus, while there may not be any uncompensated care, there is an overwhelming amount of inappropriately financed care. For example, last year in Florida, $600 million in hospital care was described as uncompensated. However, I can assure you that, in this and subsequent years, this care will be inappropriately financed by increases in per diem rates charged to public and private insurers. Consequently, one of the underlying principles behind the School Enrollment-based Family Health Insurance Program is that we must find ways to encourage all individuals and families to assume some financial responsibility for the cost of their own health care. It is important to get those who are capable, but now pay nothing, to pay something, because the cost of their care is paid for by the rest of us. The $64 billion question is—how?

Like most programs on the current public agenda attempting to deal with the problems of the uninsured, School Enrollment-based Family Health Insurance is not intended to be a universal solution. However, our approach does have broad applicability. From our understanding of the existing data, we have concluded that nearly two-thirds of the uninsured are members of the immediate family of an individual enrolled in school. You already know that the uninsured tend to be young individuals who are employed in circumstances that, as a practical matter, don't offer affordable health insurance. You also know that the largest single uninsured segment of our society is children. Logically, these children are linked to uninsured employees in a majority of cases. As a consequence, the School Enrollment-based Family Insurance idea takes the "Willie Sutton" [Willie Sutton, a bad guy, responded to a question about why he robbed banks with the retort, "That's where the money is!"] approach to grouping the uninsured; because school enrollment is the common bond that links many of the uninsured together within families, that is where we attempt to provide an insurance program.

I want to re-emphasize that the uninsured typically are employed but have a limited economic capacity to afford what has become a prohibitively expensive product, health insurance. The fact is that there is a direct statistical relationship between income and insurance coverage. Another germane fact is that most uninsured individuals and families have some resources with which to participate in the cost pool. However, they can neither afford the full premium for a health insurance policy nor the bill for a single day in most major hospitals.

I cannot help but note the rapidly waning availability of commercial group health insurance, particularly for small businesses. This is due in part to the impact of the Federal ERISA. The exemption of ERISA qualified plans from state mandates and state taxes leaves commercial insurers holding the bag. Not only must they both comply with state public policies, but they are also left with the responsibility for the unpaid costs that are shifted as a result of ERISA plan employees* access to health care services not covered by their plans. As you are well aware, many commercial insurers are moving rapidly away from insuring health risk and toward the administration of self-insurance plans and other financial products such as annuities, real estate, etc. At this time, commercial group health insurance is rapidly becoming available only to large groups. This fact brings me back to school systems as grouping mechanisms that can provide the kinds of large groups that are still attractive to insuring organizations.

CONCEPT OF SCHOOL ENROLLMENT-BASED FAMILY HEALTH INSURANCE

Underlying the concept of School Enrollment-based Family Health Insurance, is the idea of a private/public partnership similar to the private/private partnership in employment-based insurance. In traditional group health insurance, the employer subsidizes premiums and is the policy-holder; the employees are the certificate-holders either for themselves alone or for themselves and their dependents. In School Enrollment-based Family Health Insurance, the school system subsidizes premiums and is the policy-holder; the students are the certificate-holders either for themselves alone or for themselves and their parents, siblings and their own children.

This will not be a new role for school systems. School systems are currently policy-holders for teachers and other employees and administer health insurance plans. While implementation of School Enrollment-based Family Health Insurance would be an expansion of that administrative activity it is not a wholly new responsibility for school systems.

Given what I have already said about the economic characteristics of the uninsured, it is clear that in order to encourage their participation in payment of premi-

ums, some sliding scale subsidy must be made available. Once again, school systems have substantial administrative experience with sliding scale subsidy programs through their administration of the school lunch program.

Indeed, school systems have another existing function that would be of inestimable value in adequately administering a proper family health insurance program. That significant asset is their capacity for health education. Private businesses and industries have only recently begun internal health education programs to assist employees to understand self-help health measures and prudent utilization of health care resources. The school systems, on the other hand, have been in that business for some considerable time and could integrate that function with a comprehensive health insurance program.

As an aside, Florida's Commissioner of Education, Betty Castor, noted that if a family is dependent for health insurance on the active school enrollment of a child, it is likely that this may have a positive impact on the family's efforts to avoid having Johnny dropout of school. Additionally, Florida's Secretary of Health and Rehabilitative Services, Gregory Coler, has been most supportive because he recognizes that, as families rise economically from the public assistance rolls and lose Medicaid coverage, this program provides an opportunity for continuing health care access. Both of these public officials have committed themselves to support a full demonstration of the proposal.

STATUS OF THE PROPOSAL

Having described the context for School Enrollment-based Family Health Insurance and the concept of the program, let me share with you its current status.

In reviewing the legal basis for such a program, we rapidly discovered that existing group health statutes adopt the traditional view of the employer as the principal grouping mechanism. Accordingly, most group health insurance laws are written to permit coverage of the employee as the certificate-holder and, through the employee, coverage of dependents. Clearly, parents, siblings, and the children of a student in school are not dependents of that student. Recognizing that, the Institute worked with State Representative Lois Frankel and State Senator Jeanne Malchon to have legislation introduced to modify Florida's insurance code to permit school systems to be policy-holders, students to be certificate-holders and parents, siblings and children of students to be insured under the student's certificate. I am pleased to share with you that within the last ten days, the Florida Legislature passed and sent to the Governor a law permitting that new grouping mechanism. It should be noted that there was bi-partisan support for the measure and the measure passed unanimously in both Houses of the Florida Legislature.

In planning for the design of this program, the Institute brought together a distinguished panel of advisors representing insurers, benefits managers, insurance regulators and leaders from human services and education to critique the evolving concept. Through those deliberations, several themes came to the fore. First, **limiting benefits does not control costs.** Needed services will be utilized even if no insurance benefits exists and the cost of those services will be shifted inappropriately to existing payment mechanisms. As a consequence, we are planning a comprehensive benefit package similar to the benefits outlined by the American Academy of Pediatrics and those already provided for under the Medicaid EPSDT Program. A second theme was that **managing utilization can control costs.** As a consequence, our planning includes a professional triage and case management function to assure appropriate and timely utilization.

The third theme to evolve was that **enrollment should be both open to all uninsured children and mandatory for that group.** Under that formulation, eligibility is only an issue of eligibility for subsidy. Uninsured children and their families would have access to the program on a subsidized, sliding scale basis. Naturally, as with employment-based insurance, the certificate-holder (student) may elect to be insured alone or may optionally insure uninsured parents, siblings and children. As one of our advisors put it, *"If immunizations are mandatory for school attendance, why shouldn't health insurance be? If everyone is required to participate within their means and subsidized to assure affordability why shouldn't the program be mandatory?"* In many private businesses, participation in the health insurance benefit is mandatory. For example, my wife is an officer with a large banking group that offers a cafeteria plan, including health insurance with a variety of options. However, the corporation requires participation in the minimum health insurance plan irrespective of any other fringe benefit selected or any other health insurance coverage that exists within the family.

The Institute has reviewed a range of options for financing the program and is now exploring the following concepts. First and foremost is the requirement for

family participation in the cost, both directly out-of-pocket and, where appropriate, subsidized by an employer. Small employers with limited resources who offer no health insurance because of the exorbitant cost to small groups, may find participation in this plan economically attractive and feasible. Indeed, small businesses and families in better economic circumstances could be permitted to participate at full cost with no subsidy.

For most participants, public funding would be needed at two levels: premium subsidy and stop-loss protection. The reality is that states already subsidize health care for the uninsured through cost shifting into Medicaid and other health programs supported by state revenues. Some of the funds currently misdirected in that way might be redirected into premium subsidies, an alternative which could serve to lower the burden of financing shifted costs.

An example of creative reprogramming of funds would be to use state Title V Program for Children with Special Health Care Needs as a stop-loss mechanism for children insured under this program. The stop-loss would be invoked for any participating child reaching an annual expenditure threshold, e.g., $25,000. Because it is likely that any child with $25,000 of health expenses has special health care needs, it would be appropriate for the Title V program to participate in this way. The trade-off would be that the first $25,000 for that child's are would come from the School Enrollment-based Family Health Insurance Program and not the state's Title V Program, as it does now. Of great importance is that a stop-loss provision would substantially enhance the attractiveness of the program to private sector insurers.

Because of recent improvements in the Medicaid program we are also exploring methods for articulating that program with School Enrollment-based Family Health Insurance, both in benefit structure and premium subsidy. The state has a compelling interest to assure that people make a successful transition out of public assistance. One significant factor in that transition is the assurance of continuing health care coverage. We would look to the Medicaid program to subsidize premium during that transition since it would be more cost-effective to pay a premium subsidy than to continue to pay the full cost for all care.

We do not expect this program to be budget neutral for the state. Both premium subsidies and stop-loss support would require some level of enhanced state funding. However, policy makers at both the state and Federal levels have long recognized that the assurance of access to adequate health care for all people requires public support; that healthy citizens are more likely to be taxpayers and unhealthy citizens are more likely to be tax consumers.

In the final analysis, the total cost for the care of those insured through School Enrollment-based Family Health Insurance could be substantially reduced. I make this assertion based on data which the Institute collected last year in a state-wide health insurance survey of Florida families with children. One of our findings was that uninsured children had hospital lengths of stay nearly twice that of insured children, a very expensive difference. In fact, when we closely examined the results of that survey, we found that for children who were hospitalized, only 19% of the insured had lengths of stay greater than 5 days, while 43% of the uninsured had lengths of stay greater than 5 days. Thus, it would appear that the provision of health insurance, and the access that comes with it, has the potential to reduce overall expenditures for care.

At the outset I promised not to regale you with statistics, so I will close by expressing my appreciation for the privilege of this opportunity and to personally thank you for your sensitivity to and advocacy for improving the health of our Nation's children.

PREPARED STATEMENT OF KENNETH W. GIDEON

Mr. Chairman and Members of the Committee: I am pleased to have this opportunity to present the Administration's views on Chairman Bentsen's child and health care proposal. Appearing with me today is Deputy Secretary of Labor Roderick DeArment. As you know, on April 19, 1989, Secretary of Labor Elizabeth H. Dole appeared before this Committee to testify concerning the President's child care proposal, which was subsequently introduced in the Senate by Senator Robert Dole as S. 601 and S. 602. I will not repeat that testimony.

Following my testimony on Chairman Bentsen's child and health care proposal, I will comment briefly on S. 1129 which would replace current section 89 of the Internal Revenue Code and defer the effective date of the new provision until next year.

CHILD CARE

Child care is one of the key issues facing the nation. All of us—business, labor, non-profit organizations, and governments at all levels—must play a role in helping families meet this important challenge. However, our policy must have the family as its focus. We must put choices in the hands of parents and not in the hands of government. Increasing the range of child care options available to parents, particularly those who head families of modest means, will benefit the nation's children, their parents, and the country as a whole.

Based on these ideals, the President has established four fundamental principles which should guide the Federal government's role in child care:

First, parents are best able to make decisions about their children, and should have the discretion to do so. Assistance should go directly to parents. Parents (and not the government) should choose the child care they consider best for their children.

Second, Federal policy should not discriminate against two-parent families in which one parent works at home caring for their children.

Third, Federal policy should increase, not decrease, the range of choices available to parents. Thus, the Federal Government should encourage the widest array of child care alternatives, including care by religious groups, friends, neighbors, or relatives. We should not reduce the supply and increase the costs of child care by dictating—or linking Federal support for child care to—State licensing and regulatory decisions.

Fourth, Federal support for child care should be targeted to those most in need, low-income families, particularly those with young children, because they face the greatest difficulty meeting the needs of their children.

The President's child care proposal embraces these principles by making the current child and dependent care tax credit refundable, by creating a new child tax credit, and by expanding the Head Start Program by $250 million over the current funding level. The President has also directed the Department of Labor to undertake a study to determine the extent to which market barriers or failures prevent employers from obtaining the liability insurance necessary to provide child care on or near their employees' worksites.

I will concentrate my remarks today on the tax provisions of Chairman Bentsen's proposal. However, in the interest of giving the Committee a fuller picture of the issues, my written statement includes a more technical description of current law and the tax provisions of the President's proposal.

Current Law

The Internal Revenue Code provides assistance to working families through five provisions: the personal and dependency exemptions, the standard deduction, the earned income tax credit (EITC), the child and dependent care tax credit (DCTC), and the employee exclusion for employer provided child care benefits. Two of these provisions, the EITC and the DCTC, provide enhanced benefits for low-income families.

Personal and dependency exemptions and the standard deduction.—The sum of the personal and dependency exemptions and the standard deduction establishes a threshold below which a family's income is exempt from taxation. Families are allowed a personal exemption for each parent and a dependency exemption for each dependent. The amounts of the personal and dependency exemptions are indexed for inflation. For 1989, each exemption reduces a family's taxable income by $2,000. Families are also allowed to take the higher of their itemized deductions or the standard deduction. The amount of the standard deduction is also indexed for inflation, and, for 1989, is $5,200 for families filing a joint return. For a family of four, the combined effect is to exempt the first $13,200 of income from the income tax in 1989.

Earned income tax credit.—Low-income workers with minor dependents may be eligible for a refundable income tax credit of up to 14 percent of the first $6,500 in earned income. The maximum amount of the EITC is $910. The credit is reduced by an amount equal to 10 percent of the excess of adjusted gross income (AGI) or earned income (whichever is greater) over $10,240. The credit is not available to taxpayers with AGI over $19,340. Both the maximum amount of earnings on which the credit may be taken and the income level at which the phase-out region begins are adjusted for inflation. The dollar figures I have cited are for 1989.

Earned income eligible for the credit includes wages, salaries, tips and other employee compensation, plus the amount of the taxpayer's net earnings from self-em-

ployment. Eligible individuals may receive the benefit of the credit in their paychecks throughout the year by electing advance payments.

Child and dependent care tax credit.—Taxpayers also may be eligible for a nonrefundable income tax credit if they incur expenses for the care of a qualifying individual in order to work. A qualifying individual is: (1) a dependent who is under the age 13 for whom the taxpayer can claim a dependency exemption; (2) the spouse of the taxpayer if the spouse is physically or mentally incapable of caring for himself or herself; or (3) a dependent of the taxpayer who is physically or mentally incapacitated and for whom the taxpayer can claim a dependency exemption (or could claim as a dependent except that he or she has more than $1,500 in income).

To claim the DCTC, taxpayers must be married and filing a joint return or be a head of household. Two-parent households with only one earner do not qualify for the credit unless the non-working spouse is disabled or a full-time student.

The amount of employment-related expenses eligible for the credit is subject to both a dollar limit and an earned income limit. Employment-related expenses are limited to $2,400 for one qualifying individual and $4,800 for two or more qualifying individuals. Further, employment-related expenses cannot exceed the earned income of the taxpayer, if a head of household, or for married couples, the earned income of the spouse with the lower earnings. Employment-related expenses are expenses paid for the qualifying individual's care while the taxpayer works or looks for work. Amounts paid for food or schooling are generally not included.

Taxpayers with AGI of $10,000 or less are allowed a credit equal to 30 percent of eligible employment-related dependent care expenses. For taxpayers with AGI of $10,000 to $28,000, the credit is reduced by one percentage point for every $2,000 of income, or fraction thereof, above $10,000. The credit is limited to 20 percent of employment-related dependent care expenses for taxpayers with AGI above $28,000.

Taxpayers can file for the DCTC on a simplified 1040A return, which further helps low-income filers to take the credit.

Employee exclusion for employer-provided child care benefits.—If the employer has a dependent care assistance program, employees are allowed to exclude from income amounts paid or incurred by the employer for dependent care assistance provided to the employee. The amount excluded from income may not exceed $5,000 per year ($2,500 in the case of a separate return filed by a married individual). An employee generally may not take advantage of both the DCTC and this income exclusion.

Reasons for Change

Current law does not adequately provide for the child care needs of low-income working families with young children. For low-income families which rely on paid child care arrangements, child care expenditures consume a large proportion of income. A recent study by the Congressional Research Service examined the child care expenditures of working mothers of preschool children. According to this study, child care expenditures constituted about 6 percent of family income for families which paid for child care. However, for low-income families which paid for child care, child care expenditures constituted about 20 percent of income.

In addition, child care by family members and other relatives—much of which is not paid for in cash—is especially prevalent among low-income families. According to the aforementioned Congressional Research Service study, about 60 percent of low-income families with working mothers depend primarily on family members or other relatives to care for their preschool children. Of course, care by family members and relatives—particularly by those living outside the home—may not be free. In this regard, the study also found that, not counting care by parents or other relatives living in the home, over 50 percent of low-income families with preschool children do not make cash expenditures for child care. Because these parents do not make cash expenditures for child care, they cannot benefit from the DCTC.

Further, because the current DCTC is not refundable, even when low-income working families pay for child care, they cannot benefit from this credit if they have no income tax liability.

Finally, preschool children require more extensive care than do older children who are in school for much of the day. A study conducted for the Department of Health and Human Services by Dr. Lorelei Brush found that the most significant predictor of child care expenditures was the number of preschool children. The EITC, while refundable, does not adjust for differences among working families in the age of the dependent child or the number of dependent children.

Description of the President's Proposal

The following description is limited to the tax provisions of the President's proposal.

Proposed child tax credit.—Low-income families containing at least one worker would be entitled to a new tax credit of up to $1,000 for each dependent child under age four. For each child under age four, families could receive a credit equal to 14 percent of earned income, with a maximum credit equal to $1,000 per child. Initially, the credit would be reduced by an amount equal to 20 percent of the excess of AGI or earned income (whichever is greater) over $8,000. As a consequence, the credit would be available to families with AGI or earned income of $13,000 or less. In subsequent years, both the starting and end points of the phase-out range would be increased by $1,000 increments. By 1994, the credit would phase out between $15,000 and $20,000. The credit would be adjusted for inflation, starting in 1995.

The credit would be refundable and would be effective for tax years beginning January 1, 1990. Like the EITC, families would have the option of receiving the refund in advance through a payment added to their paychecks.

Refundable child and dependent care tax credit.—The existing DCTC would be made refundable. Families could not claim both the new credit and the DCTC with respect to the same child but could choose either. The refundable DCTC would be effective for tax years beginning January 1, 1990.

Effects of the President's proposal.—The President's proposal would increase the funds available to low-income families, better enabling them to choose the child care arrangements which best suit their needs and correspond to their personal values. The proposal does not mandate any particular form of child care, trusting parents to make the best decisions concerning the care of their children. About 2.5 million working families with children under age 4 would initially be eligible for the new child tax credit. When the proposal is fully implemented, eligibility would be expanded to approximately 1 million additional families. These families would also have the option of claiming the refundable DCTC, although they would not be able to claim both credits with respect to the same child. Parents of children between ages 4 and 12 would benefit from the refundability of the DCTC if they incur child care expenses in order to work, even if they do not owe any income tax. By making the DCTC refundable, an additional 1 million families with children age 4 and over would be able to benefit from it.

Consider, for example, a single working mother of two children, ages 3 and 6. The mother earns $10,000 a year and has no other sources of taxable income. She pays a relative $20 a week to care for her younger child. Her older child is enrolled in an after-school program during the school year and a neighborhood park program during the summer at a total cost of $500 per year. In total, she spends $1,540 a year for child care in order to work. Under current law, at a 30 percent credit rate on dependent care expenses, the potential DCTC would be $462. However, because she has no tax liability as a consequence of the standard deduction and personal exemptions, she cannot claim the credit.

Under the proposal, the mother would be able to claim the proposed child tax credit with respect to her younger child. In 1990, she would be entitled to a credit equal to $600. (A mother in similar circumstances in 1992 would be entitled to the full $1,000 credit.) In addition, because the DCTC would be made refundable, the mother would be able to claim a credit of $150 based on the expenses associated with the day care of her older child. In total, she would be entitled to a refund of $750, which is almost one-half of her total child care expenses for the year.

Description of Chairman Bentsen's Proposal

Chairman Bentsen's child and health care proposal would amend the current DCTC in two ways. First, like the President's proposal, it would make the DCTC refundable. Second, it would expand the scope of the DCTC to cover expenditures for health insurance policies that include children. Families could receive both credits. Unlike the President's proposal, the Bentsen proposal does not include a separate child tax credit.

Refundable child and dependent care tax credit.—The existing DCTC would be made refundable. The refundable DCTC would be effective for tax years beginning January 1, 1990. Families would have the option of receiving the refund in advance through a payment added to their paychecks.

Health insurance tax credit.—To be eligible for the new refundable health insurance tax credit, a family must have a child under age 19. The health insurance policy purchased by the family may cover the child only, or may also include the child's parents.

The credit amount would be based on a percentage of expenditures for the purchase of health insurance up to a maximum expenditure of $1,000. For families with incomes of $12,000 or less, the credit would be equal to 50 percent of qualified expenditures, or up to $500. For each $1,000 (or fraction thereof) in income above

$12,000, the credit would be reduced by 5 percentage points. The credit would be phased out completely for families with incomes above $21,000. This new credit would be effective for tax years beginning January 1, 1991. Families would have the option of receiving the refund in advance through a payment added to their paychecks. Families in which either one or both parents have earnings would be eligible for the credit.

Child health demonstration projects.—$25 million a year for 5 years would be authorized to enable the Department of Health and Human Services to conduct demonstration programs to extend health coverage to uninsured children under age 19 and their families. I defer to the Department of Health and Human Services for comments on this provision.

Revenue offsets.—There are three revenue offsets in the proposal. The first revenue offset is the repeal of the expiring special tax provisions for troubled financial institutions, which are currently scheduled to expire at the end of 1990, effective as of May 10, 1989. May 10, 1989, is the effective date of this same early sunset in the House Ways and Means Committee's amendment to H. R. 1278, the Financial Institutions Reform, Recovery and Enforcement Act of 1989. The second revenue offset would make permanent the 3 percent telephone excise tax, which is scheduled to expire on January 1, 1991. The third revenue offset would require S corporations to pay estimated tax on certain items of income taxable at the S corporation level.

Discussion

I would like to note at the outset that our analysis of the health insurance tax credit is necessarily very preliminary since we have had only a few days to review it. Based on this limited analysis, we have a number of concerns about the design and effectiveness of the credit, and we continue to believe strongly that the President's proposal (S. 601 and S. 602) provides a superior approach to assisting low-income families. Moreover, we would also like to make clear that the Administration will not support such tax credits as an addition to S. 5, the Act for Better Child Care Services (the "ABC bill"). The Administration remains strongly opposed to the ABC bill, since it is wholly inconsistent with the President's four principles for child care.

The Bentsen proposal's new health insurance tax credit singles out health insurance expenditures for special treatment. Because individual health insurance policies tend to be expensive, low-income families which do not already have health insurance through their employer or through some other group arrangement may well be unable to afford to buy coverage, even with this new credit. It is therefore unlikely that the credit would help a significant proportion of those low-income families which do not have access to group coverage. Indeed, by providing the credit only to families which have such access, the proposal would not target benefits to the neediest segment of low-income families.

Moreover, the health insurance expenditures eligible for the credit are not necessarily related to the cost of providing such benefits to children. The credit would apply to both existing and new health insurance policies and would not be limited to the incremental cost of providing health insurance coverage for children. This credit could, and often would, subsidize health coverage for adults simply because they have children. For these reasons, it is not clear that this credit would significantly expand health insurance coverage for children of low-income families as opposed to shifting to the Federal budget the cost of health insurance coverage already being provided. Although this would free up some of the money that the eligible families now spend on health insurance for other expenditures, including child care, the President's proposal would provide this assistance more directly and efficiently—without leaving out low-income families with no access to low cost health insurance.

The advance payment feature of the Bentsen proposal is intended to permit families to receive the benefits of the DCTC and the new health insurance credit throughout the year. However, the design of these credits is not well suited to advance payment, and we are concerned that the implementation and administration of this feature would be very difficult. For example, it would be quite difficult for the IRS to draft "lookup tables" for employers to determine the amount of the advance payments because the amount of the payments would be a function of four variables—earned income, family size, estimated annual dependent care expenses, and estimated annual health insurance expenses.

In addition, the existence of three different credits eligible for advance payment and the resulting larger dollar amounts of the advance payments could place substantial additional administrative burdens on employers—particularly small employers—and on the IRS, to the extent the feature were actually utilized. In this

regard, it should be noted that the advance payment feature of the EITC is not widely used as only about 10,000 taxpayers take advantage of it. We are sympathetic, however, to the Chairman's desire to provide these benefits at the earliest possible time and are willing to explore with the Committee whether an administrable mechanism can be developed.

Further, consideration should be given to the time necessary for the IRS to provide taxpayers with guidance and with new forms. If the advance payment feature is to be effective for 1990, all of this would have to be in place before the end of the year. This would be very difficult for the IRS if the provision were enacted in the first quarter of fiscal 1990.

While we have concerns about the design and effectiveness of the health insurance credit, we note that it has some positive similarities to the President's child tax credit in that it is targeted to low-income families and it is available to families in which only one parent works.

We have previously testified in favor of the first two revenue offsets contained in the Bentsen proposal. The extension of the telephone excise tax was proposed as part of the President's budget. The Administration supports early repeal of the special tax provisions for financially troubled financial institutions in connection with the enactment of a thrift rescue package and has no objection to the Committee choosing an effective date that corresponds to the House Ways and Means Committee's amendment to H. R. 1278. We have no objection to the third revenue offset with respect to S corporations.

SECTION 89

We have had even less time to analyze S. 1129 than Chairman Bentsen's child and health care proposal. As a result, my prepared statement will be brief and limited to the major design features of the bill. As our analysis continues, we will provide the Committee with further comments.

As we have testified before this Committee and others, the Administration believes that section 89 is overly complex and imposes undue compliance burdens on employers. The basic objectives of the nondiscrimination rules of section 89, the elimination of plans providing health benefits only to highly compensated employees and the promotion of coverage of nonhighly compensated employees, should be achieved by means of workable tests that can be understood by employers and applied without undue expense in a wide variety of circumstances.

On June 6, 1989, Chairman Bentsen and others introduced S. 1129 which repeals section 89 and replaces it with significantly simpler tests that may be satisfied by plan design. Briefly, the bill provides that an employer must make available to at least 90 percent of its employees a plan providing primarily core health coverage and that highly compensated employees cannot exclude the cost of employer-provided health coverage from income to the extent it exceeds 133 percent of the base benefit. The base benefit generally is the employer-provided premium for the plan that satisfies the 90 percent availability test. In addition, if an employer's health plan and certain other welfare benefit plans do not satisfy certain so-called qualification requirements (i.e., the plan must be in writing, must be enforceable, etc.), an excise tax equal to 34 percent of the employer-provided premium is imposed on the employer.

The Administration favors the delay in the effective date until plan years beginning after December 31, 1989. As you are aware, the Secretary of the Treasury has already provided that employers are not required to test their plans for compliance with section 89 until October 1, 1989, and we believe that the additional delay would allow better implementation of the new provision.

In addition, the Administration favors the provision of S. 1129 requiring an employer to offer core health coverage to at least 90 percent of its nonexcludable employees. This provision is preferable to the provision in current section 89 requiring an employer to make available certain health coverage to at least 90 percent of its nonhighly compensated employees in that the provision does not require an employer to identify those of its employees who are highly compensated within the meaning of section 414(q) and the regulations thereunder.

Under S. 1129, an employer may require an employee to pay up to 40 percent of the premium for a plan providing primarily core health coverage. This "percentage cap" approach to availability testing facilitates accommodation of geographic differences and inflation. While we are aware of concerns that the percentage cap approach could permit abuse in certain situations, for example, where an employer makes available only very expensive health coverage and thereby effectively excludes low-paid employees, we have decided on grounds of simplification to support

a percentage cap approach. Should significant abuse emerge, some further limitation may be appropriate.

Salary reduction contributions are subject to special rules. First, such contributions are generally considered employer contributions for highly compensated employees. Second, in applying the 40 percent allowable cost test, salary reduction contributions are generally treated as employee contributions. Finally, for purposes of determining the base benefit to which the 133 percent test is applied, salary reduction contributions are treated as employer contributions to the extent such contributions are matched dollar-for-dollar by employer contributions that are not made by reason of a salary reduction arrangement. Thus, if the employer pays $600 of a $1000 premium for a plan meeting the availability test and the employee pays $400 of the premium on a salary reduction basis, all of the salary reduction contribution may be treated as employer-provided for purposes of computing the base benefit under the 133 percent benefits test. Under these facts, the result of this treatment of salary reduction contributions is that a highly compensated employee may receive on a tax-favored basis an employer-provided health benefit that is equal to $1330. Although we support the general treatment of salary reduction outlined above, we point out to the Committee that the dollar-for-dollar rule results in the substantial base benefit enhancement described in the foregoing example.

If a salary reduction plan provides that an employee can receive cash instead of employer-provided health coverage when such employee certifies that he or she has other health coverage (i.e., receives a "cashable credit"), more favorable treatment is provided under the bill. "Cashable credits" are treated as employer contributions rather than employee contributions for purposes of the allowable cost test and are treated as employer-provided benefits for purposes base benefit test without regard to the dollar-for-dollar rule.

We are concerned that the special rule provided for cashable credits as opposed to other salary reduction contributions could be abused. Such a rule could result in a shift in plan design so that many salary reduction contributions could be characterized as cashable credits. As a result, we are not in a position to endorse the cashable credit approach adopted in the bill. Moreover, the certification requirement in the cashable credit rule raises issues similar to those which caused many to object to the sworn statement rules in current section 89.

The Administration commends the sponsors of S. 1129 for considering the special circumstances faced by small businesses. The bill provides that businesses with less than 20 employees that are required to pay individually rated premiums to a third party insurer may consider the cost of each employee's premium to be the average of all of the premiums. In addition, the employees who may be excluded from consideration when testing plans for compliance with section 89 because they work less than 25 hours per week is phased-in over two years.

Finally, the bill provides that the sanction for failure to satisfy the qualification rules is an excise tax equal to 34 percent of the employer-provided premium, with a grace period of six months to correct any failures. The Administration believes that the excise tax should be structured in a way that encourages compliance. A smaller excise tax, perhaps 5 percent, should be imposed initially. Only if the failure is not prospectively corrected within a reasonable period after notification from the IRS should the full 34 percent tax would be imposed.

This concludes my prepared remarks. I would be pleased to respond to your questions.

The following are Treasury's revenue estimates for the Bentsen proposal, the President's proposal, and the revenue offsets under consideration here today. Our estimates for the repeal of the thrift and bank tax provisions assume current law.

REVENUE ESTIMATES

[In billions of dollars]

	Fiscal Year—						Total
	1989	1990	1991	1992	1993	1994	
Refundable child care credit	0.0	−0.1	−0.8	−0.9	−0.9	−1.0	−3.7
Refundable health credit	0.0	*	−0.1	−1.5	−1.4	−1.4	−4.4
Bentsen proposal (total)	0.0	−0.1	−0.9	−2.4	−2.3	−2.4	−8.1
President's proposal (total)	0.0	−0.2	−1.9	−2.2	−2.5	−2.8	−9.6
Telephone excise tax	0.0	0.0	1.6	2.6	2.8	3.0	10.0
Thrift and bank tax repeal	*	0.2	0.2	0.1	0.0	0.0	0.5

REVENUE ESTIMATES—Continued

[In billions of dollars]

	Fiscal Year—						Total
	1989	1990	1991	1992	1993	1994	
S corp. estimated tax	*	0.0	0.0	0.0	0.0	0.0	*
Revenue offsets (total)	0.0	0.2	1.8	2.7	2.8	3.0	10.5

RESPONSES TO QUESTIONS FROM THE SENATE FINANCE COMMITTEE

Question 1: Has Treasury made any estimates, Ken, of the number of children who would benefits from new insurance or increased coverage under this proposal?

Answer: Initially, the number of families who purchase health insurance as a consequence of this proposal will be very small. Over time, as information about the credit spreads, this number would be expected to increase. As many as .5 million families may purchase health insurance in response to the new credit.

Question 2: Could you estimate the number of poor families with young children who would benefit from the President's tax creditproposal and would not benefit from either the refundabledependent care tax credit or the new child health credit?

Answer: In 1990, between 500,000 and 900,000 low-income families might benefit from the proposed new child tax credit who would not otherwise be entitled to a refundable dependent care tax credit or the new child health credit.

PREPARED STATEMENT OF WILLIS B. GOLDBECK

We support the *Children's Initiative.*

Progressive employers understand that the U.S. needs a new, comprehensive child development investment strategy to recover the current .. and prevent a future.. generation of wasted children.

Supporting responsible public and private sector investments in health insurance and child care for our youth is a prudent business decision.

Failing to do so simply guarantees that we'll all be paying for more millions of kids who are born with addictions, grow up with preventable physical and mental illnesses, drop out of school, expand the legions of medically indigent and remain too illiterate to contribute to the American workforce of the 1990's and beyond.

Failing to invest will not result in avoiding to pay. On the contrary, the price will be higher and the value received substantially less.

The proposed Child Health Demonstration Projects are especially important, warrant a larger authorization and should be initiated even if the other parts of the proposed initiative do not become law.

Finally, the refundable tax credit has implications for a national income policy that warrants study beyond the scope of this testimony.

As President of Washington Business Group on Health it is a pleasure to appear before this Committee on an issue that touches the lives and economic well being of every employer and company in our country.

Any review of specific child health initiatives must begin with an understanding of demographics and a philosophical commitment to a societal assumption of responsibility for future generations.

DEMOGRAPHICS

If the future of American business depends on the current generation of our youth we are in big trouble. Child development in the U.S. is currently a failure. When one combines the number of youth without health insurance, the illiteracy rate, teen suicide, teen (and pre-teen) pregnancy, youth (and baby) addiction, etc. with the labor needs of the business community it is not hard to see a problem of unparalleled economic proportions.

To this grim picture must be added the changing nature of the current workforce: predominantly female and minority; increasingly elderly; increasingly dependent upon knowledge rather than physical skills, and increasingly dependent upon small enterprises and service industries with minimal or no social service benefits for children.

The problems of health care costs, shifting of responsibility from the public to the private sector, international competition, and global products compel U.S. employers to rethink the sharing of social service responsibilities among the sectors of our society.

PHILOSOPHY

The U.S. needs an investment strategy for our child development. Unless we all are willing to agree that such a philosophy is politically and economically supportable, your proposal will fail and so will the U.S. as the world economic leader.

Every day, our members see the results of poor maternal and child health, of illiteracy, of the failure of public and private sector programs to work together. We are increasingly aware of the need for a new delineation of financial responsibility. Health insurance, and increasingly child care, for poor youth are societal responsibilities for which an integrated approach is needed.

Progressive employers who desire to be economically viable as we head toward the new century will do their share in meeting the commitment that is embodied in the philosophy that our children's health is central to our future success as a nation.

THE BENTSEN CHILDREN'S INITIATIVES

A. Tax Credit Provisions

1. Child Care

The concept of tax refundability represents a very significant shift in the basic U.S. approach to public assistance, a shift that would be even more important than the service (child care) that you seek to improve in this specific legislative proposal.

If successful, this approach will be proposed for many other social services and we will have taken a giant step towards the use of a national income policy as a basic component of our tax and economic systems. In preparing for this hearing we have had neither the time nor the resources to examine these more comprehensive implications of the refundable tax credit. Further, if this legislation does pass with the refundable tax credit intact, Congress should fund an independent evaluation of its impact not only on child care but also as a harbinger of a true national income policy.

From the more narrow perspective of child care alone, and representing the views of major employers who are now under growing pressure to provide child care benefits, your proposal is worthy of support. Many of those who are in your target population are also in the workforce. They often do not have the income to meet the cost obligations of even employer provided and subsidized child care. Those low income workers who are self-employed, part-time, leased, or are employed in many small businesses have no access to employer supported child care and can not afford most community based systems. Yet these are the people most in need. They are the ones trying hardest to maintain the American work ethic rather than falling prey to the cycle of poverty that we all know is far more expensive to society than the cost of your proposed tax credit.

As an organization of major employers, we believe it is an appropriate role for Congress to use general revenues (real and foregone) to make available to hard working low income residents the child care services that our own members are increasingly offering to their employees.

The concept of refundability is supported as the only practical and equitable way to reach your target population thus producing a reasonable return on the investment of tax dollars.

Your provision to allow prefunding is also supported. Low income workers cannot and will not purchase either child care or health insurance if they have to wait until the end of the year to receive the refund.

2. Health Insurance

We support the provision that makes the credit applicable to the purchase of private sector health insurance.

However, we feel you should also extend this provision to allow those eligible to buy into Medicaid in their respective states. Not only would this make your proposal consistent with those of your colleagues on the other side of the aisle, Senators Chafee and Hatch in particular, but also with the goals of the Bush Administration. The logic of this seems compelling. The population you seek to reach is largely at an annual income level below that of Federal poverty. If Medicaid was doing its intended job, they would already be eligible. Employers should not be required to provide services (child care or even health insurance) for the population of workers for whom public programs exist but are simply underfunded. Your proposals are just

one more piece of evidence to support our basic position that Medicaid eligibility should be made national and set the Federal determination of poverty level.

Of the 37,000,000 uninsured, some two-thirds are either workers or dependents. Quite naturally, Congress has been trying to get more small businesses to offer insurance. Your proposal will help meet this need since the vast majority of such plans involve a high degree of cost sharing. this is especially important since millions of this target group of workers currently refuse their employer's offering of a group health insurance plan due to the cost sharing.

Another important step the Finance Committee can take is to allow the tax deductibility of health insurance purchased by the self-employed and small business owners to be extended (it is about to expire) and increased from 25 to 10% so it is equal to the subsidy given all other employers.

Since you cover teens you will have to address what amounts to coverage for grand children, i.e. those babies born to children. The teen parents will not be eligible or able to purchase your insurance and it is not clear how the baby would be covered when the plan purchased by an adult parent for their child who is also now parent.

Another step the Congress could take to help make your proposal more valuable would be to pre-empt all state health insurance laws and regulations that are barriers to the aggregation of non-homogeneous businesses for the purpose of joint purchase of health insurance.

B. Child Health Demonstration

This is an excellent idea and should be done even if you can not obtain sufficient support to pass the other provisions of your Children's Initiative.

A few comments:

1. The projects should be allowed to purchase from Medicaid as well as the private sector.
2. We are concerned that you will not get enough participants in each demonstration to give you a critical mass for the evaluation to guide future public policy decisions. We would urge you to double the government's contribution thus creating a program which will have a value of one hundred million dollars per year (50% matching).
3. We suggest that it is inappropriate to cover only out-patient services. That forces care into what will often be the wrong setting just to obtain coverage. You want your restriction to be based upon specifications of necessity, appropriateness and outcome, not only location. Savings come from buying the best quality not from using out-patient setting inappropriately.
4. We applaud the emphasis on preventative services and would suggest that you encourage the application of the recently released *Guide to the Use of Clinical Preventative Services* (DHHS) U.S. Preventative Services Task Force.
5. They are several areas of coverage that are not clear in your proposal.
   a. How do you connect this plan with its emphasize on well child care to the critical issue of *prenatal care* and healthy behavior (re: smoking, drinking, drugs, and nutrition) by pregnant woman? Attached to this statement, and submitted for the record, are articles from the WBGH magazine, *Healthy Companies* and *Business and Health* which clearly establish the need for and economic value of prenatal care and childcare.
   b. What about the *technology dependent* child? In effect this is a catastrophic long-term care issue for babies.
   c. A large body of research confirms that *mental and emotional stability, self esteem,* are essential ingredients for a child to have a chance for a healthy life. For a reference, you may wish to refer to the report of the National Mental Health Association's Commission on Prevention, to which I had the honor to be appointed. Unless your authorization for the demonstration explicitly includes mental health, we fear it will too frequently be explicitly excluded and thus your admirable objectives can not be achieved. The recently completed study by the Institute of Medicine noted that "as many as 14,000,000 American children suffer from some mental disorder, a problem that is costing society billions of dollars and depriving the nation of productive citizens." The IOM study also notes that while 80% of kids who are physically handicapped receive treatment, of those who are mentally ill only 20-30% receive care.

CONCLUSION

You are trying to do the right thing.

It is in the direct economic interest of employers, of all sizes to have Congress lead the nation in making a responsible investment in our children. There will be no healthy, literate, creative and hard working young American for our employers to hire unless we invest in their total health and development and do so with the recognition that is a societal obligation from which the total society benefits.

A final note: can we afford your proposal? The answer is an unqualified yes. Not only are there more than enough studies to show the economic value as well as humanitarian justifications for supporting child care of health insurance for children, there is more than enough waste within the current health care system to offset any revenue loss than may be associated with your proposals. A Federal restructuring of the medical malpractice system alone would save more each year than the full five year projected cost of the combined child care and health insurance tax credits.

Just looking at the health care now provided children shows other opportunities for major savings and reinforces the need to establish quality based standards of practice as a companion to any new funds following into the health system.

As reported in the June 5 issue of *Drug Topics*, FDA Commissioner, Frank Young said: "even youngsters with potentially life threatening conditions are misusing the drugs that can save their lives." Supporting this is a report by the National Council on Patient Information and Education (chaired by your former colleague Paul Rogers) which noted that "in a typical two week period, more than 13 million children under age 19 take medicines prescribed or recommended by a physician. Almost half (46%) take them incorrectly . . . up to 4.6% of pediatric hospital admissions are related to (the incorrect use of) medicines and up to 44% of these problems are sever or fatal."

Yes, we can afford your bill far more than we can afford not to act.

Attachments.

The following articles on the topics of employment related child care and health services for children are reprinted from the magazines of the Washington Business Group on Health:

BUSINESS & HEALTH and HEALTHY COMPANIES

The current publisher is American Health Consultants, Inc. Some of the articles were printed when the publisher was Health Learning Systems, Inc.

PERSPECTIVE

HEALTHY PEOPLE, HEALTHY COMPANIES

Striking the Critical Balance

To stay competitive and profitable, we must protect our human assets—our workers—as actively as we protect our financial and capital resources.

BY ROBERT ROSEN

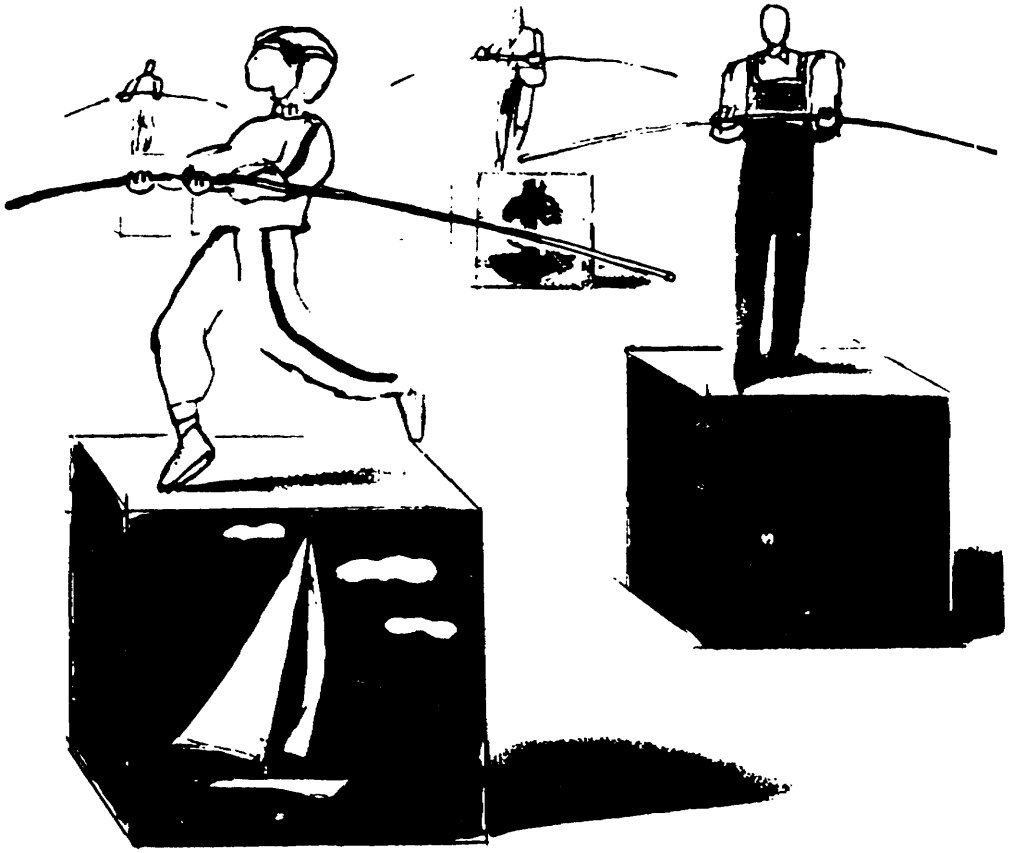
TO SAY THAT AMERICAN BUSINESS is in a state of crisis is to understate the obvious. Tales are legion of America's lost competitive edge, lack of pride among its workers, and their decreased productivity.

Theories on the roots of these problems are legion too. Many blame the U.S. trade imbalance, the federal deficit, or the cheap cost of foreign labor. Others point the finger at management – as being too hard or too soft. Still others blame unmotivated workers, labor unions, government, or the educational system.

There is little agreement on how to solve these complex problems. But one thing is clear – there is an immediate need to get American business back on track. Success depends upon our ability to revitalize our management talent and our workforce. Put simply, we need healthy people and healthy companies. That's where we come in.

HEALTHY COMPANIES is really about workers who are healthy from their bodies and minds to their attitudes and ethics – and healthy jobs that challenge, inspire, and motivate. There are direct and irrefutable links among these three components. Healthy, motivated people, working in healthy, challenging jobs create companies that are healthy, from top management to the bottom line. Says John Sims, vice president of strategic resources at Digital Equipment Corporation, "A healthy, highly motivated workforce is critical for a productive, competitive company."

Robert Rosen, a clinical psychologist, is Founding Editor of HEALTHY COMPANIES. Also contributing to this article were Joel Makower and Annette Kornblum.



For many companies, this concept isn't new. From AT&T to Xerox, large and small corporations are recognizing these links and working them into their corporate cultures. Their efforts are showing up in corporate statements of purpose, benefits packages, office layouts, manufacturing procedures, and wellness programs.

Why the new concern about healthy people and companies? Much of the interest has to do with new definitions of health. At work and in our daily life, health is being defined as more than the mere absence of sickness. It represents lifestyles and company policies that promote positive attitudes and creative, effective solutions to the problems of living and doing business in the late twentieth century. It means retooling future workers, helping managers cope with stress, offering flexible ways for employees to balance work and family responsibilities, and providing wheelchair ramps and equipment so disabled workers can stay on the job.

As William Kizer, chairman and chief executive officer of Central States Health & Life Co of Omaha puts it: "A workforce that can physically and mentally withstand whatever the business climate brings can weather any boom, recession, depression, merger, takeover, or expansion." In a sense, healthy companies provides a positive, proactive solution to the pressures of lean, competitive, cost-conscious companies.

THE PROBLEMS

Despite this knowledge, many employees and their companies are unhealthy. Workers smoke cigarettes,

don't get enough exercise, and ignore nutrition advice. Their companies further erode their health.

Some companies are a site of smoke-filled rooms, job insecurity, territorial squabbles, and employee infighting. Add to this some overcrowding, poorly designed work stations, and limited opportunities for participation and what you get may be an unproductive, unhealthy workforce – unable or unwilling to make commitments and be challenged. Instead of yielding rich dividends, these practices become as debilitating and draining to companies as they are to their workers.

We all see the casualties every day. They show up in our infirmaries, on our health and disability insurance bills, and in our increased personnel costs. We see them in the form of lost work time, increased absenteeism, and decreased productivity. Consider:

- Only two of every ten employees work at full potential, according to the National Commission on Productivity. Nearly half the workforce expends only the minimum effort needed to get by.
- The average Fortune 500 company spends nearly a fourth of its after-tax profits on medical bills. And health insurance premiums are rising about 20 percent a year, without any sign of stabilizing
- Lifestyle-related diseases account for a major chunk of those medical bills – sometimes well beyond 50 percent. At Control Data Corporation, an unhealthy employee costs the company $509 more a year than a healthy one.
- The National Council on Compensation Insurance warns that the growing number of stress-related worker compensation claims will soon strangle an already swelled liability system
- In a 1987 *Harvard Business Re-*

What Companies Are Doing

Companies are initiating all sorts of innovative programs and policies to ensure that their people stay healthy and productive. Don't be mistaken. This is not old-fashioned paternalism. It is simply good business. Some examples:

WORK AND FAMILY

- **Franklin Life Insurance** offers prenatal health education programs at the worksite.
- **Fel-Pro, Inc.** established the Triple R Ranch, a summer camp for children, after noticing increased absences among working parents during the summer.
- **Baxter Travenol Laboratories** prepares educational kits for children and teenagers uprooted because of a parent's relocation.
- **Hewlett Packard** has a flexible time-off policy that makes employees responsible for deciding how to use their leave, whether for vacation, temporary illness, personal business, child care, or to care for a sick relative.

EMPOWERING PEOPLE

- At **Yankelovich, Skelly & White**, one of the nation's foremost analysts of social trends, secretaries formed quality circles that improved office teamwork and reduced stress-related ailments.
- **Ford Motor Co.** operates one of the most extensive employee involvement programs in the country – a program many say is responsible for Ford's recent successes.
- **Federal Express, Citicorp** and **Borg-Warner Corp.** are among more than 100 companies that now use peer review boards to help resolve employee grievances.
- At **W.L. Gore & Associates**, there are no formal job titles and hierarchies. Instead of bosses, employees have "sponsors" who act as friends and mentors.

MANAGING CHANGE

- **Hallmark Cards** provides retraining when needed to broaden workers' inventories of skills to prevent layoffs.
- **Pacific Northwest Bell** uses a computerized job skills bank to help employees and the company locate the "right" workers for the "right" job.
- **Cummins Engine Co.** uses videotapes to educate the company's workers about the changing marketplace – from cost curves and warranties to new competing foreign products.

WORKSITE WELLNESS

- **AT&T Communications'** Total Life Concept is expected to reduce medical costs from potential heart attacks by $22.4 million in 10 years. Employees who have participated report feeling more enthusiastic, positive, confident, and committed to the company.
- **Levi Strauss & Co.** offers education and support on AIDS at a number of different levels – from lectures for managers, to resource and support classes for individuals with AIDS, their families and friends, to a video presentation for home viewing; and regular updates in company newsletters.
- **Safeway Stores Bakery Division** in Clackamas, Ore., built its own fitness facility, performs exercise assessments on all employees, and runs a "Health in Humor" clinic to help employees laugh at themselves and manage stress.
- **United Rubber Workers** initiated an extensive health promotion/health protection program to address the problems of cancer at the worksite.

HEALTHY JOBS

- At **Herman Miller**, a Transitional Work Center helps bring injured or disabled employees back to work quickly, even if they are unable to return to their old jobs.
- **Fisher Price's** production line workers rotate every two hours to avoid boredom. But they are never put on machines without the appropriate skill or experience.
- **IBM** has redesigned factory carts to prevent back strains, supplied workers with rubber hand tools to prevent wrist cramps, and redesigned video display terminals to reduce glare and eye strain.

view survey, almost 90 percent of respondents blamed management for America's competitiveness problem.

THE POSSIBILITIES

Having a healthy, safe workplace is no longer just the concern of blue-collar workers. Some of the most stressful, debilitating jobs involve the cleanest, state-of-the-art technologies used by white-collar and service workers. And the problems can affect any size company – small, medium, or large.

In this and subsequent issues, HEALTHY COMPANIES will describe the problems and solutions. We will visit the worksites and executive suites where some of the healthiest policies are being implemented, and talk with CEOs, managers, and workers to see how they affect – and are being affected by – these new attitudes. Among the kinds of success stories we will look at:

- **Eastman Kodak** operates one of the oldest employee suggestion programs in the country and one of the most profitable. Kodak has adopted thousands of safety suggestions, paid $5.1 million in cash awards to employees, and saved more than $25.4 million.
- **Johnson & Johnson** operates a comprehensive Live for Life wellness program for employees and spouses. Participating employees were hospitalized less often and had lower hospital costs than other employees during a five-year study period – for a projected average annual savings of $1 million.
- **Motorola** invests in training the way other companies do in equipment maintenance. It sets aside 1.5 percent of the payroll to train nearly a third of its employees a year. The company estimates that its return is about 30 to 1.
- **General Motors** had 11,813 referrals to its employee assistance program in 1986 alone. The company reported that lost time was reduced by 40 percent, sickness and accident payments by 60 percent, and both grievance proceedings and job accidents by 50 percent.
- **Transamerica Companies** have 90 percent of their 3,900 Los Angeles-based workforce on flexible schedules. Employee turnover was 45 percent lower nine years after the program began and absenteeism was down 10 percent.
- **E.I. du Pont's** extensive worksite safety and accident prevention programs have made it a leader in the field. With a U.S. workforce of nearly 120,000, Du Pont reports only 40 lost work days this year because of occupational injury. That's 23 times less than the chemical industry average, and 68 times less than the average rate for all industry.

CHANGING WORKPLACE

Tomorrow's companies will survive or die in a fiercely competitive, global marketplace. Deregulation, shifting resources, and political uncertainties mean that no corporation or market can be considered secure for very long.

The result: Companies must be lean, stripped-down, and cost-conscious, ready to undergo sudden facelifts and reorganizations to meet the demands of the day. That means doing more with fewer resources, in less time. "Only the strongest and healthiest survive and thrive in a rapidly changing workplace...we need a more resilient workforce, better able to take the stresses and strains of change," warns James Henderson, executive director of human resources services at Pacific Bell.

Clearly, such environments are highly charged and chronically pressured, as employees worry about their performance and their jobs. For many, the cozy office job is becoming a stressful experience.

Moreover, today's work is more mental than ever before. In factories and offices, workers process and analyze more information, solve more problems, and interact more with customers and co-workers. Creativity, innovation, technical literacy, and teamwork are the valued attributes. Quick minds, focused thinking, and refined interpersonal skills are the keys to success.

To succeed in such a workplace, businesses need more from their employees. Top physical and mental health is vital, to be sure, but so are positive attitudes, values, and personal relationships.

"As time goes by, talking about values will be regarded as absolutely essential...just as essential as marketing or logistics or strategic planning or thinking or decision-making," says Richard Zimmerman, chairman and chief executive officer of Hershey Foods Corp.

Leaders like Zimmerman recognize the key roles they play in influencing the health of their companies.

> "A workforce that can physically and mentally withstand whatever the business climate brings can weather any boom, recession, depression, merger, takeover, or expansion."
>
> —William Kizer
> CEO, Central States Health & Life

Many act to ensure that their policies and practices maximize their workers' potential – that these workers are resources, not costs.

"I really believe that individuals are capable of doing a lot more than they believe they can do...given the right environment, you can get surprising results," says James Burke, chairman of the board and CEO at Johnson & Johnson.

From establishing principles of trust and openness, collaboration and recognition, to espousing philosophies that allow both risks and mistakes, healthy leaders imprint their personal values on those beneath them.

"Many executives touch and influence the lives of thousands of people, both inside and outside the company," says William Walton, co-founder of Holiday Inn hotels. "Their touch can be a blight or a blessing. Their influence can build up a person or tear him down."

CHANGING WORKERS

Workers are changing too, as is the role of work in their lives. Today's workers are better educated than

ever. They know what lifestyle factors and company influences can make them healthier or sicker. Freedom, responsibility, and balance are important too, as workers take more responsibility for managing their careers and personal lives. And they are less loyal to their employers, opting for jobs that enhance quality of life, at work and at play.

At work, their search for purpose takes on profound importance as they seek jobs that are meaningful, challenging, empowering, and rewarding – mentally, spiritually, and financially. They have less patience with boring jobs and blocked careers. They want to be respected for what they contribute, think for themselves, and stay informed about the company's activities.

"Employees today are better educated than they were 30 or 40 years ago," says C.J. Silas, CEO at Phillips Petroleum Co. "They like to participate. They want to know what they're doing and why."

Yet most surveys tell us that companies don't recognize that employee values greatly affect productivity, motivation, and satisfaction. Moreover, many executives try to change employees' work habits without taking into account these beliefs and values. What we end up with is a mistrustful, disgruntled, covertly hostile workforce.

Companies that fail to respond to these changing demands of workers risk frustrating, alienating, and eventually losing the best and the brightest. Those workers who stay behind may cost the company dearly through stress-related illness and productivity problems.

HEALTH CONSCIOUSNESS

Health means more than not being sick. More and more, we are learning that there are multiple, interrelated causes of illness – infections, life-

Voices of Healthy Companies

BY ANNETTE KORNBLUM

Whether they offer quality circles, an employee counseling benefit, child care referrals, flexible work schedules, or leadership training, a growing number of American companies are working hard to create a healthier work environment and heartier employees.

As Jeffrey Harris, director of health and safety at Northern Telecom, puts it, this revolution in employee relations is "not because companies want to be nice or even because it's socially acceptable, but because it works. It's better for society and better for the company."

Employers have many motives. Some see these workplace programs as powerful magnets to attract the best and brightest and as a way to encourage veteran employees to perform up to their potential.

Others believe that by preventing workers from getting sick, they can slow the inflationary spiral of health care benefits, reduce turnover, minimize their culpability in causing disease, fatten profits, and in the process improve their competitive edge in a rough-and-tumble market.

In this attempt to create a healthier work environment, each company uses a slightly different language, a different strategy, and a different set of people and resources.

BANK OF AMERICA

Robert N. Beck, executive vice president of corporate human resources for Bank of America, is convinced most workers will perform well if they're treated well and respected.

Beck is part of a high-level three-person team that experiments with new ways to buoy morale and motivate and reward employees.

Among its people activities is a year-round school for managers, a merit appraisal system, a community-based child care initiative, and a program for managing AIDS (acquired immune deficiency syndrome) in the workplace. There is also a planning, coaching, and evaluation system that encourages managers to help steer the careers of their people, and a hiring and development program to help managers move up the corporate ladder.

In these lean and mean times, Beck also oversees a steady reduction of the corporation's workforce. With at least 3,400 positions scheduled for demolition this year, the bank tries to achieve cutbacks through attrition, redeployment, and outplacement, rather than layoffs.

"It's part of our philosophy to see labor not as a commodity but an asset," says Beck, who looks to flextime, part-time, leaves of absence, and job sharing as other tools for getting through the peaks and valleys.

EXXON

In a massive downsizing, 7,000 Exxon employees were moved out of the organization in a matter of months in 1985. Thousands of others were shuffled into other jobs throughout the company. It was up to Jim Francek, director of the employee health advisory program, to help both the victims and the survivors pick up the pieces and go on. To smooth the way, Francek put together a team of 20 experts specializing in everything from organizational development to employee assistance.

The group held transition seminars to give employees a chance to vent their frustrations and chart their futures. "People in pain are angry, hurting, and grieving. They need help processing their sense of loss and sense of letting go," says Francek, president of Watershed

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"Many executives touch and influence the lives of thousands of people. . . . Their touch can be a blight or a blessing. Their influence can build up a person or tear him down."

—William Walton
Co-founder, Holiday Inn

styles, occupational exposures, family histories, bad bosses, job uncertainties, and unemployment, to name a few.

There are also multiple solutions for health, many in the workplace itself. Indeed, companies can do a number of things to buffer and protect people from becoming ill – from encouraging them to lead healthy lifestyles to managing the human side of change to fostering good relationships among co-workers. All can play a role in creating a committed, resilient and productive workforce.

Consider the issue of control. It is no longer simply a matter of company politics – who has it and who doesn't. Too little control at work has been associated with stress-related ailments and dissatisfied, underutilized workers. Simply put, employees who are able to control their own destinies, create their own opportunities, or make their own decisions are generally the most productive workers. From employee surveys at IBM Corporate Services, Inc., a Westport, Conn., consulting firm.

XEROX

Since 1980, Xerox Corporation has been experimenting with ways to give its employees greater voice in day-to-day decisions. Using the Japanese quality circle as a model, the company has established trouble-shooting teams to tackle such tough issues as streamlining paperwork, eliminating toxic fumes, improving ventilation and lighting, and economizing on the cost of materials.

Along the way, Larry Pace, manager for organizational effectiveness in the company's Business Products and Systems Group, found Type A managers were a serious obstacle to employee participation. Threatened at the prospect of forfeiting power and status, they would often try to thwart the process by dominating discussion groups and opposing proposed changes.

NORTHERN TELECOM

In just three years, the health care tab at this rapidly growing telecommunications corporation soared 75 percent. The company hired a director of health and safety to find out why and to cut those costs. One result was the Health Enhancement Program, which offers employees help on everything from quitting smoking to controlling blood pressure and losing weight.

The program has produced dramatic results:

- The number of headquarters employees who smoke has dropped from 30 percent in 1983 to just 13 percent today.
- The control rate among known hypertensives is over 90 percent.
- The percentage of new cases of high blood pressure has dropped from 14 percent to 6 percent.

In addition, a two-year recheck of 70 headquarters staff found other promising results:

- They averaged two fewer absences a year and one fewer physician visit.
- Their average hospital bill dropped by $297.

The program has also attempted to help managers cope with day-to-day pressures both by offering individual training in relaxation techniques and stress management and by attempting to identify and modify the sources of stress on the job. Why? Because tense work environments can chip away at morale, productivity, and ultimately the bottom line, says Jeffrey Harris.

AETNA LIFE & CASUALTY

This company was one of the first to take a hard look at how new office technologies would affect the people expected to run them. In 1981, it established People/Technology Services to identify the potential problems new technologies can create.

Among the innovations that grew out of that early study was the vision-care program for those who work at video display terminals.

"People have to remember that people do the work," says Aetna Assistant Vice President Emmett J. McTeague, who started the program. "What we did is looked, and we said 'In our enthusiasm for our new technological resources, let's make sure we don't get out of control and forget about our most valuable resource, our people.' "

NEW HORIZONS

The prospect of reaching new horizons in satisfying business goals and at the same time having employees who are healthy and satisfied has spawned a new way of viewing the future. The name of the game is "Let's Make a Deal", as companies begin to offer a cornucopia of rewards and incentives to spur people to be the best they can be.

These run the gamut from training and retraining at General Motors to job security at Hallmark Cards, to parental leave at Merck & Co., and "un-retirement" at Travelers.

The programs and strategies are as varied as the companies implementing them. And they are having an impact on the way these companies do business and on the profits they make.

As Harold Tragash, Xerox's director of human resources development and systems, puts it: "Healthy people, healthy companies can help to meet the goals of the corporation – to satisfy customers, return on investment, be responsible corporate citizens, value employees, and achieve competitive advantage." □

to grievance programs at Coors to quality circles at Ford – participation breeds commitment and health.

Or consider the effects of change. There is now conclusive evidence that poorly managed organizational change can be hazardous to workers' physical and psychological health. This is just as true for blue-collar workers and telephone operators as it is for managers. Whether it involves new robots and computers, corporate acquisitions, downsizing, or a simple factory reorganization – excessive, poorly managed change can make people sick – especially when unpredictability and uncertainty become the norm.

DESTROYING BOXES

We live in a world of boxes. We separate the mind from the body, personal values from corporate productivity, and one's work life from one's family life. Yet in the real world, we live our lives as whole people – all the parts are connected.

But we often ignore these realities – pushing at one end, then paying dearly at the other – turning our employees from valuable assets into costly casualties.

Inside of companies, we have created boxes, hundreds of boxes, to help us manage our most valued resources. Managers from different departments rarely talk to one another, spending much of their time competing in interdepartmental rivalries for limited resources.

Yet unhealthy, unproductive workers don't fit neatly into interdepartmental boxes. They show up all over the corporation:

- Medical departments treat the physical results of their unhealthy lifestyles on a daily basis.
- Employee assistance counselors hear about their personal and emotional turmoil, which often leads to serious health problems.
- Environmental safety staff track the accidents, often related to poor working conditions, insufficient training, or personal problems.
- Organizational development specialists must deal with the poor morale and departmental conflicts.
- In the offices and factories, line managers feel the brunt of unhealthy workers every day – through lateness, errors, burnout, and missed deadlines.
- In the benefits and legal departments, the company pays for all the casualties – excess illness, unnecessary health claims, and grievances.

To tap the potential of workers, we must break down these boxes and start working together. We must also stop treating our employees as if they had no life outside the job. If they are not happy at home, they will bring their problems to work.

Employer-provided child care is one fast-growing response to this need to balance work and family life. The companies that offer it recognize that parents are healthier and work better when they know their children are being taken care of and are accessible to them. There are many other work-family innovations, offering services almost literally from the cradle to the grave.

THE CONSEQUENCES OF UNHEALTHY COMPANIES

- Job dissatisfaction
- Poor morale
- Decreased commitment
- Diminished work quality
- Increased errors
- Work slowdowns
- Group conflict
- Strikes
- Increased transfers
- Accidents
- Disciplinary actions
- Premature retirement
- Indecisiveness
- Tampering and sabotage
- Unnecessary turnover
- Workers' compensation
- Decreased motivation
- Burnout
- Lateness
- Extended lunches
- Decreased work quantity
- Missed deadlines
- Poor decisions
- Tense work relations
- Grievances
- Unnecessary demotion costs
- Excess medical visits
- EEO complaints
- Fatigue
- Mental blocks
- Poor communication
- Unscheduled downtime
- Absenteeism
- Reduced productivity
- Excessive health care cost
- Disability

WIN-WIN

Healthy companies is a win-win approach – one in which workers and employers make sacrifices, take risks, and uphold mutual rights and responsibilities. It all comes down to balance – juggling the career and psychological needs of workers with the company's needs for competitiveness and profitability.

Healthy workers are committed, capable employees who do not drain the company, but personify quality and excellence. They are enthusiastic, self-reliant, and resilient in the face of crisis and change. They are the predictable, peak performers of the future workplace.

They are the company's most valuable resource. If given the right tools and the proper environment, they will shine for the good of themselves and their companies.

Ultimately, healthy companies is a long-term investment in people – a way to prevent problems and manage our human assets. These are not merely "nice-guy" programs. Each has a quantifiable effect on the bottom line, keeping workers at work, performing more productively, and reducing excess illness and turnover costs.

These are not quick-fix solutions either. And some of them are not inexpensive. Many are tough answers to complex people problems. But in company after company, the return on the investment in a healthy workforce has already paid off in big ways.

Healthy companies is an ideal, something to aspire to, much like health itself. Says David Dotlich, vice president of human resources at Honeywell Bull, "Healthy companies is a vision of how companies might be." As such, there is no single blueprint of what a healthy company should look like. Each company must find its own definition of health, tailored to its own history, corporate culture, workforce, and markets.

The bottom line is clear. To stay competitive and profitable, we must protect our human assets – our workers and their families – as actively as we manage our financial and capital resources. Healthy workers in healthy jobs will ensure that our investments pay off.

The above material will be expanded upon in the forthcoming book by Robert Rosen with Joel Makower entitled *Healthy People, Healthy Companies*, to be published by John Wiley & Sons, Inc., 1988

BABIES AND THE BOTTOM LINE

Sick infants can hurt profits and productivity. Here's a look at innovative corporate programs that improve the health of pregnant women.

BY MARCY SWERDLIN

A mother, age 26 and a factory worker, presses her face against the window of the hospital nursery where her child lies in the midst of a maze of tubes and monitors. Doctors say the problem is Fetal Alcohol Syndrome. During her pregnancy, no one told her how much drinking would harm her baby. Then again, no one had a chance to tell her since she never visited a doctor. Now she watches and waits.

Her employer, too, is waiting—for the hospital bill. The cost is certain to be high, as much as $300,000 just for the baby's medical care. That doesn't include the rehospitalizations common with low-birthweight babies, or the lifetime of care that can accompany a permanently disabled child. Then there's the cost of absenteeism and lost productivity.

None of this had to happen, however. With proper prenatal instruction, this factory worker may have quit drinking during her pregnancy. But her employer doesn't offer such a program.

However, if she had worked for Marriott, Oster/Sunbeam, Fruit of the Loom, or a handful of other companies, her child might have had a better start in life. By offering prenatal programs for employees, these companies are taking the health of pregnant women and their children seriously, say child advocates.

"It is in companies' great interest" to help employees with prenatal care because "they're socked with enormous bills if something goes wrong in the pregnancy," says Sara Rosenbaum, director of programs and policies for the Children's Defense Fund.

With more and more women of childbearing age at work, companies have a vital interest in keeping women—and their children—healthy, says Irene McKirgan, director of health promotion programs at the March of Dimes Birth Defects Foundation. Healthier pregnancies mean healthier babies and an earlier return to work for the new mothers.

STAGGERING COSTS

However, the percentage of employers with prenatal programs is low. Indeed, fewer than 25 percent of American companies offer a comprehensive package of benefits to prospective parents, says Rosenbaum. In the last decade, there has been a nearly 10 percent increase in the number of American babies born without having had adequate prenatal care, reports the National Commission to Prevent Infant Mortality.

Employers' inaction comes with a price:

- The initial doctor and hospital bills for babies who are born too early, too small, or with disabilities can range from $16,136 to a staggering $174,278. "One month of intensive care for a baby born with respiratory and digestive problems costs about $61,000," reports the March of Dimes.
- The cost of keeping low-birthweight babies alive for their first year tops $2 billion a year, according to the commission on infant mortality.
- The lifetime costs of caring for one low-birthweight baby can soar to $400,000, reports the commission.

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Prenatal care

• Low-birthweight babies—those born weighing 5.5 pounds or less, account for 7 percent of all births in the United States today.

These are the costs of babies who survive. Many do not. In America, more than 40,000 infants die each year before their first birthday, according to the commision. With a national infant mortality rate of 11 percent, the United States ranks an embarrassing 19th internationally.

Comparing the United States to Japan, the world leader in producing healthy babies with an infant mortality rate of 6 percent, the commission says, "If we could achieve Japan's low rate of infant mortality, the 20,000 children whose lives would be saved each year would contribute in their lifetime up to $10 billion in productive earnings."

American business pays a big chunk of the high cost of unhealthy babies not only through their health insurance plans but also through lost productivity and loss of future workers. But there's much that employers can do to give babies a healthier start to life.

BABIES AND THE BANK

In 1980, the First National Bank of Chicago adopted a self-insurance plan. Three premature births and $200,000 later, the bank realized it had to do something about maternity costs, which represent 15 percent of the bank's self-insurance costs of $15 million a year.

Says Donald Hoy, vice president for employee benefits, "We felt strongly that there wasn't much point in getting heaps of reports [about our medical costs] if we weren't going to do something with them." So the bank looked at those items "taking big dollars and also things that were amenable to change."

After taking stock of the problems, the company decided to offer a financial incentive for pregnant women to attend prenatal classes. The financial incentive was added, says Hoy, "to do something to encourage participation, and cash works wonders to encourage participation."

Under this plan, employees who attend three prenatal classes can have their $200 deductible waived for the first year of their new baby's life.

> Every low-birthweight birth that is averted will save tens, even hundreds, of thousands of dollars.

First National also runs lunchtime seminars covering the ABCs of healthy childbearing, nutrition, and general prenatal care. They are open to both employees and spouses. As part of First National's program, an obstetrician/gynecologist makes weekly visits, performing routine obstetrical care as well as such ob-related services as giving second opinions on caesareans.

Targeting C-sections is one of First National's key goals, Hoy says, since they cost twice as much as vaginal deliveries and in 1984, they accounted for 28 percent of bank employees' deliveries. After the second-opinion program was instituted, the rate dropped to 22 percent, although it's now back up to 25 percent, which Hoy says is in line with national averages.

The bank hasn't calculated the program's cost, but Hoy figures the incentive could run $20,000 if 100 people participate, and payment for the obstetrician runs from $20,000 to $25,000 a year. Plus, he says, there is the cost of time away from work for those participating.

Despite the high upfront costs of providing the incentive plans and prenatal visits by obstetricians, "First National stands to save lots of money," observes Hoy. "If we pay $200 for each baby, and we save only one intensive care situation every five years, we'll have saved money. This is a win/win situation if you can avoid that premature baby."

He adds, "As we looked at alternatives, we thought we'd rather do something like this than tighten up on costs. The ability to avoid premature birth or C-sections improves the quality and quantity of life and reduces costs."

Sometime this year, First National will expand the program to include prenatal care and deliveries, and will offer the services to both rank-and-file employees and bank executives.

HEALTHY EXPECTATIONS

Concerned about the well-being of its employees and the increasing number of premature babies nationwide, Bethesda, Md.-based Marriott Corp. started a prenatal program, called Healthy Expectations, in January of this year.

Mara Puri, senior claims coordinator, got the idea for the program during her own pregnancy: "Knowing as much as I did about the need for prenatal care, I realized that a lot of our employees aren't that privileged, and that we had an obligation to a healthy tomorrow."

Marriott's program requires women to visit their doctor before the end of their fourth month of pregnancy as well as three times in their second trimester and five times in their third trimester. In addition, a Healthy Expectations consultant calls the pregnant women regularly to give them infor-

mation and answer questions. Participants must complete an evaluation form at the end of their pregnancy. For completing the program, employees receive $100.

Marriott, which has 230,000 employees worldwide, expects 2,500 pregnancies in 1989. This program is available only to Marriott employees covered under the company's self-insured Multi-Med plan. Two-thirds of the employees choose Multi-Med; the remaining third are in an HMO. Fifty-three percent of Marriott's employees are female, and many of them are Spanish- or Asian-speaking.

The response to the program has been overwhelming, Puri says, with close to 800 calls coming in from employees in the first 2.5 months of the program. "It's been extremely well-received, from the executive to the worker in the Roy Rogers kitchen."

The average pregnancy costs Marriott $3,800. Although Puri recognizes that Marriott's prenatal program makes good business sense, she refuses to look at it as a cost containment measure. "This was not designed for this purpose," she says.

"A healthy family life and a healthy employee make a happy employee. We look after employees in every way, and this is one way of recognizing that," says Puri. "If we can prevent one premature birth, the plan pays for itself. I've seen claims of $300,000 for one premature birth, although we haven't had one as high as that" at Marriott, she notes.

REACHING IMMIGRANTS

Three years ago, the International Ladies' Garment Workers Union in New York City faced an unusual challenge. How to teach good prenatal habits to recently arrived Chinese immigrants who didn't speak English and who weren't "familiar with Western prenatal care," says George Bailey, director of the ILGWU health center.

The solution: Conduct a prenatal program entirely in Chinese for the workers who make up Local 2325 in New York City. The three-session program, which was developed in conjunction with the March of Dimes, is given after work in Chinatown, where most of the members live and work. The sessions are led by March of Dimes volunteers and cover everything from exercise and nutrition to the doctor-patient relationship, the birthing process, the emotional impact of birth, and the hazards peculiar to the women's work place—the chemicals used in the garment industry. The program is offered twice yearly, with a usual attendance of 35 to 55 people per session.

The program seems to work. A study of 45 participants, completed last fall, showed the following: Ten women who weren't receiving prenatal care began seeing a doctor as a result of the program; five quit smoking; five quit drinking; 10 stopped taking non-prescription drugs; seven stopped ingesting caffeine. Among these 45 women, one miscarriage was reported, but no low-birthweight babies, Bailey reports.

Because of the program's success, the union is expanding the program to all 60,000 of its members in New York City. The first English/Spanish session was held in April 1989.

The union offers a Blue Cross major

Prenatal care

medical plan. The average cost per pregnancy is $4,500, and there are 1,200 to 1,400 pregnancies among the union's New York City members each year. While premature births and resulting complications may be a problem among union members, he says no figures are available. "We weren't doing this for cost containment," Bailey argues. "It's just the right thing to do."

COST SAVINGS

One of the corporate pioneers in prenatal care is Oster/Sunbeam Appliance Co. In 1984, four babies of employees at a Sunbeam plant in Coushatta, La., were born prematurely, chalking up $500,000 in medical expenses for this self-insured company. Strapped by the high cost of caring for premature babies, Sunbeam recognized that getting employees to take better care of themselves when pregnant would be key to reducing costs.

Attendance at Sunbeam's prenatal program is required of all pregnant employees; the program is open to spouses on a voluntary basis. A woman enters the program as soon as it is confirmed that she is pregnant. Classes are offered on a wide range of topics from prenatal care and nutrition to the signs and symptoms of labor and birthing. Blood pressure, weight, and other physiological signs are periodically checked by a medical professional.

The payoffs from the program are high. Average maternity costs in the plants where the program is offered plunged from $16,000 to $3,500 in a one-year period. Says Kevin Breese, director of employee relations, "We're trying to control those elements we can control to reduce the risks of premature births. The educational program has gone a long way to reducing our expenses."

The program costs $20,000 annually, which includes the cost of educators' fees and program participants' time away from work. The program is cur-

CALL IN THE MARCH OF DIMES

With more companies getting interested in prenatal care, whether as a cost containment measure or simply an altruistic one, the question becomes: How do we go about this? For some 200 companies, the answer has been to call in the March of Dimes.

This volunteer organization offers—free of charge—its prenatal education program, Babies + You, which it will customize to an individual employer's needs.

The Babies + You program "takes an educational approach to reducing low birthweight," Irene McKirgan, director of health promotion programs at the March of Dimes Birth Defects Foundation, explains. It's aimed at getting people to understand the issues and to change "the negative lifestyles that can hurt pregnancy," she says.

Among the suggestions made by the March of Dimes are the following:

- An educational campaign can make employees aware of the importance of prenatal care. Articles can be written in the in-house newsletter on such topics as smoking or substance abuse and pregnancy, educational "stuffers" can accompany paychecks; exhibits can be set up in high-traffic areas of the company, or packets can be developed for distribution to pregnant employees.
- Seminars can be offered to interested employees. These seminars, which cover all aspects of a healthy pregnancy, can be presented by volunteer March of Dimes health professionals.
- The March of Dimes can train in-house medical professionals at the company to give the seminars themselves.

McKirgan's advice to a company contemplating a prenatal program is to start simply, with an educational program being "ideal." She encourages companies to involve employees as much as possible in the program design so that they feel it is their program. "The more active you can get employees in owning the program, the more successful the program is." In addition, she says, incentives are "always helpful."

Most important, the "environment and the climate" within the company must be right, argues McKirgan. The management must be supportive and get involved. "You can't just offer a wellness class and leave it at that. The cafeteria should offer nutritious food; there should be a smoking policy," she explains.

According to Denise Maduros, senior nurse at the First National Bank of Chicago, it's important to coordinate any prenatal program with the company's benefits plan. Maduros suggests that whoever puts on the prenatal seminars have ob/gyn experience.

The cost of the program can be minimal, observes George Bailey, director of the health center for the International Ladies' Garment Workers Union in New York City. For the program Bailey runs, the instructors are provided by the March of Dimes at no cost, the cost of refreshments is nominal, and there is no lost work time as the sessions are held after hours.—M S

rently offered in two Sunbeam plants, one in Coushatta, La., and the other in Holly Springs, Miss., where most employees are women. This year, Sunbeam will expand the program into two additional plants acquired when the company merged with Oster.

OTHER EFFORTS

Other companies reaching out to pregnant workers include Fruit of the Loom, AT&T, and Pepsico Inc.

Seventy-five percent of Fruit of the Loom's 22,000 employees are women. Fruit of the Loom, based in Bowling Green, Ky., is self-insured, and paid for 3,300 pregnancies in 1988, at an average cost of $4,000. While no numbers are kept on low-birthweight babies, the company has had cases of premature babies with medical expenses of $100,000 each and disabled babies with expenses as much as $300,000 each, says Hugo Becker, vice president for personnel.

Offered in some plants since 1986, the company's prenatal program will be expanded to all 30 plants within the next year. Since it's conducted on company time, the program costs about $50,000 in lost work time.

At AT&T's Chicago office, the March of Dimes trained a group of nurses and employees from the firm's wellness program, Total Life Concept, to present a prenatal program to employees. TLC is now putting on monthly presentations on such topics as basic prenatal care, nutrition, and the dangers of drugs, alcohol, and smoking in pregnancy.

At Pepsico Inc., prenatal seminars have been run at the corporate fitness center. With 750 employees at Pepsico headquarters in Purchase, N.Y., about half of whom are women, "We're trying to recognize that there are pregnant employees and meet their needs just as we meet the needs of other employees," says Elaine Franklin, manager of corporate information. "We believe fit employees are better employees." Postpartum exercise classes also are offered as are seminars on such topics as combining work and parenting.

Prenatal programs don't have to be complicated or expensive; they can run as little as $400 per pregnancy.

LONG-TERM PAYOFFS

These companies are among just a handful of employers who recognize the link between healthier babies and both higher productivity and lower medical costs.

Prenatal programs don't have to be complicated or expensive; they can run as little as $400 per pregnancy, according to some estimates. Even if employers offer a prenatal program, there's more that can and should be done, says Rosenbaum of the Children's Defense Fund. Efforts to improve the health of pregnant women shouldn't stop at educational programs. To make sure that women are getting the care and instruction they need, companies should provide health insurance for maternity care that involves no cost sharing or deductible, she says.

Companies are discovering that investments in the health of babies pay off. Every low-birthweight birth that is averted will save tens, even hundreds, of thousands of dollars; much of that amount will be saved by employers. And every child born healthy means an earlier return to work for new mothers. Most important, child advocates say, healthier children today mean a healthier work force tomorrow. ☐

SPECIAL REPORT

CHILD CARE

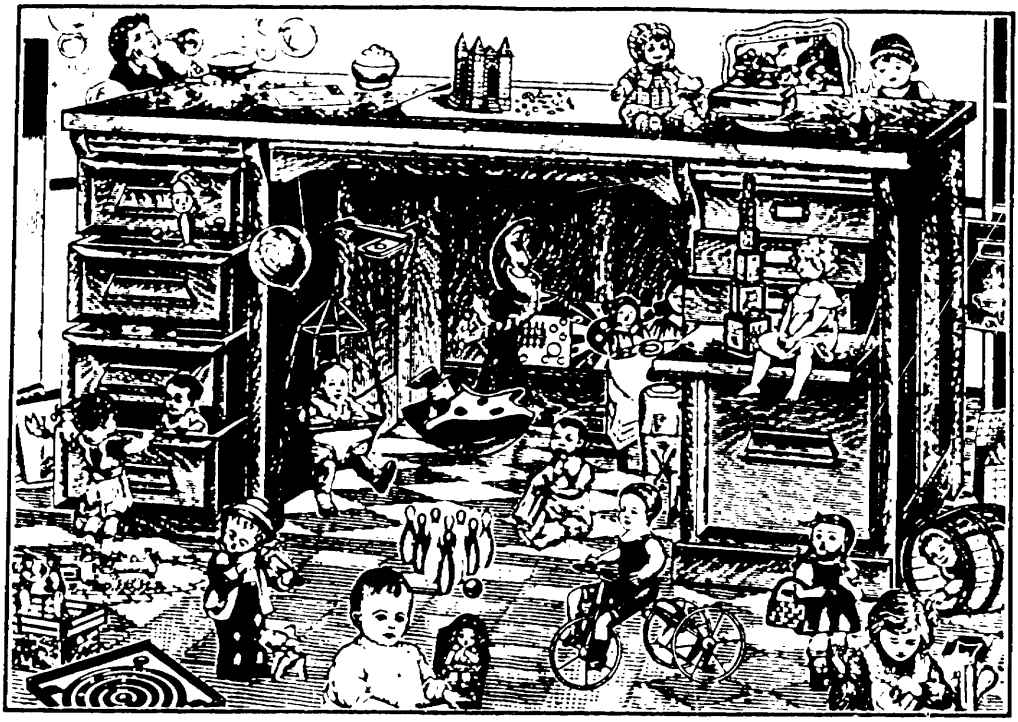
First Aid for Working Parents?

FROM PROCTER & GAMBLE TO WANG, AMERICAN COMPANIES ARE HELPING THEIR EMPLOYEES MANAGE CHILD CARE.

NOW PARENTS CAN WORK MORE AND WORRY LESS.

ARENTS AND CHILDREN. No progressive employer would publically admit to jeopardizing their survival by being insensitive to their well-being. Yet evidence is mounting that there is a strong connection between child care woes and job stress, absenteeism, and diminished productivity.

Moreover, working parents may not be the only ones feeling frazzled. "I'm seeing more and more kids of working parents with symptoms that seem to be stress-related," says pediatrician George Sterne, chairman of the American Academy of Pediatrics' Committee on Early Childhood Adoption and Dependent Care. He suspects that many behavior problems and such physical symptoms as wheezing and stomach disorders may be related to poor quality care.



Although experts continue to debate the pros and cons of putting children into child care at too tender an age, almost all agree that happy parents, regardless of whether they work or stay home, breed happy children, and that stressed-out parents are likely to pass that stress onto their children. Employers could pay the price in not only diminished employee productivity and increased absences, but also in health care claims for both parents and children, some experts fear.

There is ample anecdotal evidence that children are not immune to the stresses and strains of work and family conflicts. Although there is no empirical data as yet, the spillover effect is widely acknowledged, says child care researcher Bradley Googins, a Boston University sociologist. "Over a quarter of working parents interviewed in our studies say that they worry about their kids while they work," he adds. "Parents end up managing the home front from two to five from the office."

Although most American companies are still standing on the sidelines, doing little or nothing to help, a growing number of them are assuming new roles as providers, sponsors or information clearinghouses for child care. About 3,000 of the nation's employers offer some form of child care help, ranging from a Cadillac on-site facility to a Pinto one-time series of seminars on parent education or the art of screening babysitters. That's a 400 percent jump since 1980, but hardly a groundswell of support.

While some companies that do help may view their efforts as the socially responsible thing to do or a good morale booster, most are motivated more by such bottom line concerns as the need to recruit workers in specialized industries, to retain valued employees who might pick up and leave if no child care services were available, and to support employees whose work may suffer, especially during the before and after-school hours or when their children get sick.

Many management-level women in their thirties who put off having children until they established careers are hard to replace in growth industries such as high technology, the service sector and hospitals, where women predominate. "Company-sponsored child care is partially a matter of corporate survival," says Dana Friedman, senior research associate at the Work and Family Information Center of the Conference Board, a New York executive information service.

Some companies have already felt the pinch. Nyloncraft Inc. in Mishawaka, Ind., found that child care problems were behind its high absenteeism and turnover rates in the late 1970s. In 1981, the plastics molding company opened the state's first 24-hour day care facility. Until

COMPETITIVE EDGE

What should managers do when subordinates' child care problems interfere with their work? Barbara Adell, co-author of *The Employer's Guide to Child Care, Developing Programs for Working Parents* (Praeger, 1988), offers this advice:

✓Find out what child care is available. The personnel and benefits departments may be able to help.

✓Be flexible. Give employees as much leeway as possible during emergencies. Let them work unusual hours if necessary to get the job done.

✓Consider a pool of days off from which employees can draw—no questions asked.

✓Contact experts who specialize in helping companies solve child care problems. Check out what your competition does to help.

✓Sponsor a noon-time seminar on parenting and child care.

✓Train supervisors to help employees deal with personal and family problems that interfere with work.

then, the company was writing 900 or more W2s a year in a company that employs just 350 people. That added up to as much as $2,000 in training costs per employee

Six years later, staff turnover is way down. Today, Nyloncraft writes only about 26 more W2s than there are jobs.

WORKING FATHERS TOO

Women are not the only ones struggling to balance their work and family responsibilities. A growing number of men are assuming greater responsibility for their children's care. Some are even turning down promotions and transfers because of family concerns.

One New England bank executive declined a shot at becoming vice president to spend time with his two children. Because his wife was already holding a high-pressure job as a college professor, they agreed that any additional work commitments would shortchange their children.

While mothers continue to shoulder the primary responsibility for tending the children, an increasing number of fathers are reporting that the stress of balancing work and family responsibilities is taking its toll on them as well.

- In a study of 733 Merck & Co. employees, Bank Street College of Education researchers found that bosses insensitive to family responsibilities increased the level of stress and psychosomatic complaints of working fathers.
- Boston University sociologists Dianne Burden and Bradley Googins' study of 1,600 employees in two major corporations in the Northeast found that working fathers are as likely to get depressed or unhappy as working mothers when expected to do a lot around the house.

THE CRITICAL LINK

For many workers today, child care is critical. Yet the high cost of quality care often puts it out of reach of many families. In fact, child care services are the fourth largest expenditure for families with children. Those families only spend more on food, housing, and taxes.

The national price tag for child care comes to a staggering $11 billion a year, a Census Bureau survey found. That figure doesn't include lost work time or the lost productivity of those who give up the search for child care and drop out of the job market altogether.

Even those who can afford quality child care often have trouble finding it. One out of every four of the 1,200 unemployed parents surveyed in California in 1986 blamed inadequate child care arrangements for being unable to return to work or to attend training programs. About one-third of those work-place dropouts were single parents.

In Virginia, a group of corporate executives and state officials this year began working jointly on a child care program to meet the large demand for facilities across the state. "If a child is taken care of while mom is working, it puts her mind at ease so she can be a better, happier, and more productive employee," says Ralph G. Cantrell, head of the Virginia Employment Commission. That state's day care commission, which includes the presidents of several of Virginia's largest corporations, is trying to encourage companies to offer day care services to their employees. Many other states have actively sought public-private partnerships in this area.

About 3,000 of the nation's employers offer some form of child care help—ranging from a Cadillac on-site facility to a Pinto noon-time series of seminars on parent education . . .

COMPANIES THAT HELP

Employers who offer child care assistance are "typically innovative companies that are especially adroit in adapting to changes in the business environments," says Dana Friedman of the Conference Board. Among the companies that offer some kind of child care help:

- **Procter & Gamble.** This company was one of the first in the nation to develop a near-site child care center. It spent $375,000 to renovate two community facilities in Cincinnati in the mid-1980s. The centers devote 75 percent of their slots to P&G dependents. The rest are filled by community children.

To provide greater flexibility, the company also contributed $35,000 for an information and referral service, and helped recruit some 300 family day care homes. The program features a network of providers and free telephone counseling and referrals to parents. Through the company's flexible benefits plan, parents can designate pre-tax dollars to pay for some of their child care expenses. The Procter & Gamble program also allows female employees to take up

to eight weeks paid parental leave and up to six months unpaid leave after a child's birth.

"We recognized early on that something needed to be done to help employees coordinate their work and family lives. No one thing suits everyone's needs," says Linda Ulrey, a P&G spokesperson, whose youngest daughter is enrolled in one of the centers.

■ **Wang.** Since 1979, Wang has offered near-site child care. Company founder An Wang came up with the idea after receiving a note from an employee who was resigning in part because she couldn't find quality child care.

The one-story, semicircular building in Chelmsford, not far from the company headquarters in Lowell, Mass., houses 24 classrooms, a cafeteria, and a gymnasium for 235 youngsters ranging in age from two months to five years. Parents pay $75 a week for preschoolers and $105 for infants and toddlers. There's about one staff member for every eight or nine children, with one for about every three or four infants.

Wang used to run the center itself but this year turned it over to a professional contractor. "We realized that we should rely on people with expertise in the area," reports Paul Henning, a Wang spokesman.

WOMEN: A GROWING FORCE

- Women now make up 44 percent of the workforce.
- Married women with children now assume one of every two new job slots.
- More than 33 million women of childbearing age hold jobs.
- Eight out of every ten of them will probably become pregnant during their work lives.
- In 1970, only 24 percent of new mothers returned to work after giving birth. By 1985, nearly 50 percent did.
- With the trend toward later childbirth, many women are in hard-to-replace professional and managerial positions by the time they have their first child.

SOURCES & RESOURCES

CHILD CARE

BOOKS

EMPLOYER SUPPORTED CHILD CARE: INVESTING IN HUMAN RESOURCES. 1984 By Sandra L. Burud, Sandra L. Aschbacher, and Pamela R. McCroskey (Dover, Mass.: Auburn House)

CHILD CARE AND CORPORATE PRODUCTIVITY: RESOLVING FAMILY-WORK CONFLICTS. 1985 By John P. Fernandez (Lexington, Mass.: Lexington Books)

HOW TO SELECT THE BEST CHILD CARE FOR YOUR EMPLOYEES. 1986. By Penny O'Brien (Binghamton, N.Y.: Almar Press).

REPORTS

BUSINESS AND CHILD CARE HANDBOOK. 1982. By Connie Bell, Natalie Modgy-Collins, and Beverly Propes. A how-to for needs assessment and feasibility studies. Business and Child Care Project, Greater Minneapolis Day Care Association, The Lehmann Center, 1006 West Lake St., Minneapolis, Minn. 55408

INVESTING IN QUALITY CHILD CARE: A REPORT FOR AT&T. 1986. By Ellen Galinsky, Bank Street College, and Dana E. Friedman, The Conference Board. Survey of more than 50 child care experts on what makes quality care and the barriers to achieving it. Contact Mary Callery, AT&T, Room 6117F3, 235 North Maple Ave., Basking Ridge, N.J. 07920

EXPERTS

CATALYST. National research and corporate advisory organization that produces publications about child care, parental leave, and policy planning. 250 Park Ave. S., N.Y., N.Y. 10001

WORK AND FAMILY INFORMATION CENTER. A major clearinghouse for employer-sponsored child care research. The Conference Board, 845 Third Ave., N.Y., N.Y. 10022

PLUSES AND MINUSES

Such on- or near-site facilities have obvious advantages. They cut commuting time and give parents the flexibility to drop in on their children during the day.

Yet some observers aren't so sure most parents really want their children around when they're at work. "Parents prefer child care closer to home than to work because they pick the neighborhoods where they live and they don't like the idea of commuting with their kids," says Carole Rogin, executive director of the National Association of Child Care Management, which represents for-profit, private child care centers.

Start-up costs for company-sponsored centers can be expensive – upwards of $100,000 to $200,000. Liability insurance is also costly and has shot up 1,000 percent in recent years, averaging $75 per child a year on a $1 million policy, according to Barbara Reisman, executive director of the Child Care Action Campaign in New York.

But fear of liability may be a red herring that some employers use because of their basic resistance to paying for child care, says Abby Cohen, managing attorney at the Child Care Law Center in San Francisco. The number of claims filed or cases that have succeeded are too small for child care to be considered a risky business, adds Cohen.

Nevertheless, many unanticipated problems can also crop up to make start-up difficult.

■ *In 1985, Mary Logan, assistant director of the AFL-CIO Department of Occupational Safety, Health, and Social Security, in Washington, D.C., organized a drive for a near-site center to accommodate 52 children of employees. At first, everything seemed to be going well. More than $80,000 in donations had been raised. The project had also been promised more than $60,000 worth of subsidized space and discounted construction costs, as well as pro-bono legal advice and public relations help. Just a few months later the project was terminated.*

"With all that, we had to give the

money back because we couldn t do it," Logan laments. Why not? Technical experts concluded that because first-year deficits would have been high, the project would not have qualified for a loan. Moreover, fees to support the project would have been beyond the reach of many parents.

For a number of reasons, most companies are shying away from getting into the business of running or sponsoring child care centers.

RESOURCE AND REFERRAL

Many companies, including International Business Machines (IBM), Minnesota Mining and Manufacturing (3M), and American Express, are opting instead for the greater flexibility and lower start-up costs of a resource and referral (R&R) service. Between 1984 and 1985, the number of companies taking the R&R route jumped from 300 to 500.

These services hook parents into a network of child care providers in the community. "The key element is parental choice because people are most satisfied with the things they choose to purchase," says Rogin of the Association of Child Care Management.

■ **Steelcase.** This office furniture manufacturer in Grand Rapids, Mich., established its R&R service in 1980, after deciding that an on-site center would be too costly, benefit too few employees, and lack the flexibility parents wanted. In 1982, the service made referrals for 156 families with 249 children; by 1986, the number of referrals had jumped to 372 families with 533 children.

The company works with one full-time and two part-time consultants who personally visit centers and family care homes, then develop a network of licensed or registered child care providers. The providers, in turn, agree to attend a series of workshops on child care, sensible business practices, and child development. The company also requires CPR certification. Local providers get additional support from Steelcase through equipment loans, training workshops, a library, and newsletters.

Like Procter & Gamble and a growing number of other companies, Steelcase allows employees to use their pre-tax flexible benefits to help defray the costs of child care. And the employees say the program is really helping. A 1985 company survey found that 94 percent of the employees who used the service reported it helped them feel more relaxed and productive at work, especially since they get lots of personalized attention from the consultants who help them review their options. Another bonus – child care is provided at the company fitness center to encourage employees to work out there.

■ **IBM.** This corporation's nationwide R&R service is probably the nation's largest. But unlike Steelcase, which runs its own program, IBM has turned the job over to specialists. Under the management of Work/Family Directions, Inc., a Boston-based child care consulting group, the program uses an extensive network of more than 200 local referral organizations around the country to help parents find the most appropriate arrangements for their children.

Although IBM picks up the tab for the referral service, the company makes it clear that parents themselves are responsible for making the final child care selection and for paying for the care. IBM decided to go the R&R route to give parents greater flexibility in finding the type of care they need and to be fair to employees who work in smaller facilities that would not have enough people to warrant a full center.

VOUCHERS

A number of companies are removing themselves even further from making child care choices for their employees by offering working par-

For many workers today, child care is critical. Yet the high cost of quality care often puts it out of reach of many families.

The Productivity Drain

Several recent employee surveys have found that child care problems increase absenteeism and tardiness and distract workers:

Fortune/Gallup Survey

In a *Fortune* magazine survey of 400 working parents, the Bank Street College of Education and the Gallup Organization found that child care responsibilities weighed down productivity:

- **Four of every ten parents took off at least one day of work because of family matters in the three months before the survey.**
- **Six in ten went to work late or left early on up to five days to tend to such matters as caring for a sick child or attending a school play.**

Corporate Survey

A survey of 5,000 employees at five corporations, by AT&T Manager of Personnel Services John P. Fernandes, found:

- **More than half of the women and one-third of the men with young children felt that child care problems distracted them from their work.**
- **Working mothers estimated that between 13 percent and 45 percent of the time they spent on child care matters would otherwise have been devoted to work.**

Honeywell Survey

A survey of 1,200 Honeywell employees with dependent children, conducted by Work & Family Resources of Minneapolis, found:

- **Four of every ten parents said their ability to concentrate was often affected by family concerns.**
- **Two of every three parents with preschoolers were having child care problems. In fact, 15 men wrote that they wanted on-site child care even though there was no such question on the survey.**
- **About half were having second thoughts about climbing the corporate ladder.**

ents vouchers that they can use to pay for services of their own choosing. Among the first to opt for this approach was Polaroid.

■ **Polaroid.** When in the 1970s, a company survey identified the need for help with child care, Polaroid went with a voucher/vendor program, used by an average of 100 employees each year.

Currently, only employees with combined family incomes of less than $30,000 a year are eligible to use the program. Those employees are subsidized for up to 80 percent of their child care expenses, depending on family income and size. They may choose any licensed child care center or home they want. Polaroid will then contract with the provider to pay the amount of subsidy the employee is eligible for. Higher-income employees can get help through the company R&R service.

The system works to everyone's benefit, say voucher advocates, especially in companies with multiple sites.

Voucher plans work through employee payroll deductions. Workers authorize their employers to deduct a set amount of pre-tax dollars from each paycheck. The money is then converted into a voucher redeemable by the child care provider. Because employees pay with pre-tax dollars, they can get a bigger tax break than they would by simply taking the standard federal child care tax credit, experts say.

POOLING RESOURCES

For smaller employers, one way to reduce operating expenses is to pool resources with other area companies. The Broadcasters' Child Development Center in Washington, D.C., is one of the nation's oldest such consortia. It was established in 1980 by seven area television and radio stations which each made a low-interest loan, the balance of which was forgiven in 1985. Some 85 percent of the center's 68 slots are reserved for the children of station employees.

Another popular scheme is for private employers to join with private foundations and public agencies to generate more child care in their communities. In California, the BankAmerica Foundation spearheaded a successful drive by a coalition of corporations and public agencies to expand the supply of family day care homes, especially for infants and toddlers.

Although IBM picks up the tab for the referral service, the company makes it clear that parents themselves are responsible for making the final child care selection and paying for the care.

CHANGING ATTITUDES

Despite the pioneering efforts of a growing number of American companies and former Health and Human Services Secretary Margaret Heckler's prediction that child care would be the "employee benefit of the '90s," most employers aren't ready to shoulder the responsibility for their employees' children.

Child care expert John P. Fernandez, AT&T's manager of personnel services, blames some of corporate America's disinterest on generational differences of managers. In his book, *Child Care and Corporate Productivity: Resolving Family-Work Conflicts* (Lexington Books, 1985), Fernandez reports that older executives tend to be the least sympathetic about child care problems since their spouses are less likely to be in the workforce and more likely to have live-in help.

Margaret W. Newton, assistant director of education and communications at the Employee Benefits Research Institute, in Washington, D.C., has another theory: That corporate efforts to cut labor and benefit costs clash with establishing a new, essentially untried benefit. Moreover, she thinks that when it comes to on-site programs, in particular, employers are fearful that the number of employees who use the service won't justify the cost.

Nevertheless, two-thirds of the 600 working Americans polled this year said they think employers should offer child care benefits and services. The survey was conducted for the American Federation of State, County and Municipal Employees (AFSCME) by the Boston-based firm of Marttila & Kiley. Workers also want an understanding boss and a flexible work environment that allows parents to meet both work and family responsibilities without undue guilt or anxiety.

A 1987 survey conducted for Honeywell by Work & Family Resources, a nonprofit agency in Minneapolis, found that having an understanding boss or spouse was far more important to working parents than whether or not their employer had a formal child care program.

The study found that the mental health of the working family could use some first aid, especially when it comes to guilt, egg-shell relationships with bosses and spouses, and confusion about new roles. Working parents spend an enormous amount of energy tangoing with their anxiety about supervisors who have little appreciation of their pressures, says Work & Family Resources Director Patricia Libbey. She urges companies to begin gearing up their training of supervisory and management personnel to help them become more attuned to work and family issues.

More than half of the 238 clerical workers in 30 states surveyed last year by Adia Personnel said they wanted greater flexibility in their job to help them meet child care responsibilities. On the wish list were staggered hours and flexible shifts along with permanent part-time employment with prorated benefits, job sharing, and paid personal days.

Helping working parents meet their child care needs is in the best interest of employers, Virginia Gov. Gerald L. Baliles told those attending a two-day conference this summer to develop a plan for a public/private day care system. "Studies show that company child care programs improve recruitment, retain valuable employees, increase morale and reduce absenteeism and turnover," said Baliles.

"In short, the provision of child care is more than a family problem, it is an economic problem, a productivity problem."

BUSINESS AND HEALTH

JANUARY 1988 VOLUME 5, NUMBER 3

HEALTH POLICY REPORTS

BENEFITS REPORT

COST MANAGEMENT REPORTS

INTERVIEW

Investing in Future Workers

BY MATHEW H. GREENWALD AND JOHN P. KATOSH

Social and economic trends of an emerging work force offer employers insight into challenges that lie ahead.

HEALTH POLICY REPORT

The year is 1998. Consumer markets have thrust the 1980's boom of technological innovations and business applications into the center of a robust economy thriving in a service oriented market place. A well-educated, thoroughly skilled work force is hard at work, producing a rebound in U.S. economic growth.

This picture represents just one possible scenario of the future, as predicted by The Hudson Institute, a private research organization. But another scene illustrates a different future that awaits America. This one includes a growing underclass that is poorly equipped for a work place that demands increasing skills and a society that has fewer social support mechanisms. Some economic observers of this second scenario perceive the United States as losing in worldwide competition for jobs and markets, in large part because the educational system is falling behind those of other countries. By 1998, say these analysts, a slack economy, a growing gap between the rich and the poor, and a large welfare state will be the reality. Which of these two scenarios comes closest to being accurate depends to a large extent on a generation that is just starting to enter adulthood and on how the business community reacts and works to develop it.

From Boom to Bust

Who is this new generation and why should employers be concerned about it? The first concern is sheer numbers. Will tomorrow's work force be sufficient to meet employers' demands? National data show a decline in births will reduce the number of individuals entering the labor force. According to the U.S. Census Bureau, between 1946 and 1964, almost 76 million children, the baby boom generation, were born in the United States—one-third of the present U.S. population. In 1960, there were 118 births per 1,000 women ages 18 to 44. That rate fell to 88 per 1,000 in 1970 and to 66 per 1,000 in 1975. Overall, between 1965 and 1976 only 38 million babies were born in the United States. That 11-year cohort—the baby bust generation—makes up one-sixth of the current U.S. population.

One implication of a decline in births is a decrease in the number of people entering the labor force two decades later. The Naisbitt Group, a business consulting and forecasting organization, points out that while the U.S. economy is producing 2 million to 3 million jobs a year, only 1.5 million new workers are joining the work force. Some companies already are having difficulty finding young employees. Moreover, *Fortune Magazine* recently noted that by the mid-1990s, the number of college students will have declined by 8 percent, while the size of the economy may well have increased by 25 percent.

Technological advancements—from robots to microchips—can help compensate for fewer humans in America's work plans. Employer investment in the emerging work force can counter some harmful effects of an anticipated labor shortage. Worker shortages will spur greater investment in labor saving devices and an even greater emphasis on increasing productivity. Thus, the decline in new workers will have beneficial effects.

These benefits, however, will not be reassuring to the industries and occupations hit by later shortages. Defense contractors and construction companies are just two types of manufacturers that will be affected adversely by shortages of skilled blue collar workers such as machinists,

Mathew H. Greenwald is president and John P. Katosh is director of survey research with the public opinion and research consulting firm of Mathew Greenwald & Associates, Inc. in Washington, D.C.

bricklayers and electricians. Furthermore, jobs that require technical training such as operating the sophisticated computerized machinery that will play an increasing role in manufacturing, may be difficult to fill. Competition for skilled managers will rise. These pressures will lead to increases in wages in many occupations.

Educational, Family Factors

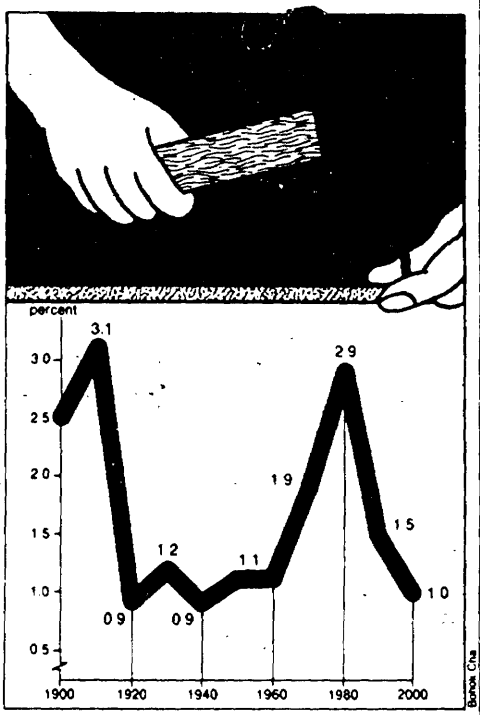
Nurturing a literate, educated pool of workers poses a second challenge for employers. Whether today's students are prepared to enter the work force is a crucial question in shaping a productive society tomorrow. Disturbingly, recent studies show that without change the educational system cannot meet these goals. For example, University of Rochester researcher Eric A. Hanushek found, after a review of 130 studies of conditions affecting academic achievement, that the only factor consistently correlating with student achievement is teacher intelligence. Many bright and educated women and minority teachers have been siphoned off, ironically due to broadened career opportunities outside the academic world.

Another factor contributing to problems within the educational system is teacher dissatisfaction with low salaries. University of Pennsylvania demographer Samuel Preston reported that from 1973 to 1983 teachers' real incomes dropped 12 percent. A 1986 report by the Carnegie Forum Task Force on Teaching as a Profession stated that good teachers "are being driven out by intolerable conditions, and it will be impossible to attract many new people of real ability to teaching unless these conditions are radically altered."

A look at the oldest segment of the next working generation, those aged 18 to 22, reveals one group of baby busters that can have an immediate impact on the work force—pregnant unwed teenagers. Obviously, having a child as an unmarried teenager can be a burden to the young mother, and the child suffers as well. According to the Alan Guttmacher Institute, more than 1 million teenagers become pregnant each year, and four-fifths of them are unmarried. Current trends indicate that as many as two-fifths of pre-adolescent females will be pregnant by age 20. Moreover, the problems associated with this circumstance—greater health problems and deemphasis on education—pose a direct challenge to employers.

Teenage pregnancy is a symptom of a much more serious disease afflicting the emerging working generation—a reduced commitment to familial values. Baby busters have had much less parental supervision, less financial security and much more familial disruption than the generation that preceded them. Causes of this range from the rising rates of poverty among children in the past decade to high divorce rates and the poor record of child financial support from divorced fathers.

Another significant factor about the baby bust generation is their lack of optimism about the future. Too many baby busters see the previous generation struggling with a tight job market for new entrants and the high cost of housing. One of their responses has been to work harder and with a narrower purpose. The idealism of the 1960s never happened for the baby bust generation. According to their calculations, idealism does not seem to have paid off. Interest in business careers—as opposed to social services—is very high among those currently in college.



Ironically, it is likely that the pessimism of the baby busters will be as wrong as the optimism that marked the baby boom generation. The very laws of supply and demand that penalized baby boomers in the labor market will reward the emerging work force by pushing wages up and putting downward pressure on housing prices.

The baby busters, at least a portion of them, will benefit from a number of technical and social advances that are taking place. Electronic, computer and medical breakthroughs appear to be an almost daily occurrence, and not only will move the United States forward economically, but will improve the quality of life. This group also has advantages over previous generations in the areas of health and self-care. For example, there were significant advances in the proportion of the population that received prenatal care in the 1970s. More individuals in this group have been immunized against childhood diseases than in any other generation, in large part because more schools are requiring proof of immunization as a condition for admission. By the time the youngest segment of the baby

Student Views Reveal New Roles for Men and Women

Student perceptions about combining work and family life are factors causing great concern among college recruiters. While many newly hired graduates are prepared in technical skills and knowledge, they are naive about work place culture and the impact it may have on their personal lives, say some prospective employers.

This analysis was explored further in a recent study of college students conducted by Catalyst, a national research and advisory group geared toward helping corporations foster the career and leadership development of women. The study was carried out by the Catalyst Campus Resource, which is funded by the W.K. Kellogg Foundation. Support for the data analysis was provided by RJR Nabisco.

The study participants included 377 students at six universities nationwide who enrolled in a three-month Catalyst-developed college credit class covering topics and activities focusing on career and personal life planning. As expected, many of the students reported being highly career oriented (51 percent) and moderately career oriented (42 percent). Only 7 percent indicated that they were slightly or not at all career oriented. Most of the students—150 men and 208 women—indicated that they have plans to work full time most of their lives.

Rating Success Factors

According to the study analysis, students chose achievement oriented factors as key elements in "getting ahead" in their chosen field. For instance, 89 percent of the study participants ranked superior performance and 80 percent indicated enthusiasm as the most important way of advancing in their profession. Fifty percent cited team work, only 23 percent noted loyalty to employer and 21 percent said getting along well with the boss is a key factor.

While these answers show that college enrollees generally have high career goals, they illustrate the observation that student perceptions are primarily shaped by the experiences of being a student, a role judged not on merit, but on finite results of term papers and tests, which measure academic progress.

Because parenthood plays a role in combining work and family life, the questionnaire surveyed students on future parenthood plans. Overall, 80 percent of the students reported that they plan to have children. About 46 percent of these planning to have children said they would have two children; 31 percent said three children, and 20 percent hoped for more than that. Only 3 percent said they would prefer one child.

Queries regarding the amount of time women should take off from work after the birth of an infant also led to similar responses between both sexes. For instance, 23 percent of the men and 26 percent of women expect the female to take between one and three months of parental leave (see table). Interestingly, this period of time is similar to the amount of time working women cited they would take in a 1986 Catalyst survey.

The student survey, however, also shows that women expect men to take a longer period of time off work after an infant's birth. Approximately 42 percent of the female students, for example, suggested that men take off between two and four weeks, compared with 30 percent of the males who felt that way. Six percent of the females, compared with 2 percent of the males felt men should take one to three months of parental leave.

Asked to select and rank 5 out of 18 items, many of the respondents expect that the most serious problems with having a career will relate to personal and family life. About 63 percent noted tension on the job as one of the most serious conflicts; 42 percent cited that having a career can interfere with having a family; and 38 percent said that a career limits time with children.

Student Expectations on Taking Parental Leave (In percent)

	Time off for Women		Time off for Men	
	What Men Say	What Women Say	What Men Say	What Women Say
None	—	—	19	15
<1 week	—	—	49	37
2-4 weeks	13	9	30	42
1-3 months	23	26	2	6
4-6 months	18	22	—	—
1 year	24	21	—	—
2 years	8	3	—	—
3-5 years	14	19	—	—

Implications for Employers

At the end of the three-month course, students once again were evaluated on their perceptions of work and family life. Plans to work full time did not change. However, students did appear to change their views somewhat on what it takes to get ahead in their careers. By the end of the course, a greater number cited "knowing the ropes" and being a team player as playing an important role in advancing professionally.

Although it cannot be known which of the students' perceptions will become overwhelmingly the realities in the emerging work force, employers can learn from current expectations. For instance, say the survey authors, employers may need to teach new recruits about success elements. On the other hand, student expectations may warrant employer attention to new views on parent-child care roles. For instance, many of the respondents expect a new mother to remain at home for more than a year—in some cases, as long as five years. Moreover, many of the male students—at least 30 percent—reported that they plan to take off at least a week or two.

These findings indicate to employers that unlike their elder colleagues, the male work force of tomorrow will play a larger role in domestic responsibilities and suggest that work place policies reflect recognition of future workers' dual roles in work and family life. ■

Lisa Lopez

bust group entered primary school, at least 95 percent were immunized against polio, mumps, diptheria-pertussis-tetanus, rubella and measles.

Another concern for employers is the extent of substance abuse among today's adolescents. But again, the baby bust generation appears healthier and less likely to use illicit drugs than their older cohorts. Researchers at the Institute for Social Research at the University of Michigan note that since the influx of the new generation into high school, the number of students using illicit drugs has declined. For example, in 1978, 37 percent of high school seniors used marijuana at least once a month prior to the Michigan poll. By 1984, usage in the prior month had declined by one-third. Furthermore, a greater percentage of students today disapprove of drug, alcohol and cigarette use than did so in previous generations. This is good news for employers, who will find tomorrow's healthier workers and their healthier lifestyles reducing their health care costs.

Another positive factor has been created by the small families common in the baby bust population. With reduced birth rates, more families have only one or two children. Fewer siblings means higher per capita incomes in many families and fewer brothers and sisters to share financial resources and parental attention. The children from these smaller families may be the most likely to take greatest advantage of the labor shortages and management needs of the late 1980s and 1990s. The key question is what proportion of the overall population they represent.

A Challenge to Employers

The work force of the future, especially the baby bust generation now entering adulthood, will be extremely diverse. Some are hard working and committed and almost single minded in their determination to succeed. But many others are ill-prepared for adulthood and work roles, especially in the global economy of the 1990s. Some of today's young people have started their families while teenagers, in many cases before they were emotionally or economically ready. Others are delaying starting their families until they are at least 30, or later. Personnel policies in the future will have to be more innovative to encompass the needs and demands of a new group of workers.

Employee benefit plans also will have to be closely linked to the work force of the future. The expected labor shortage will place pressure on employers to maintain benefits to keep employees on staff. Moreover, a growing proportion of individuals with little or no skills will test the capacity of employers to provide training. The increasing number of women in the labor force and the difficulty dual income families have in supervising children will call for new strategies in paternal care and flexible work hours.

Health related benefits are likely to be an especially vexing problem. As the huge baby boom generation ages, this group will put enormous pressure on the nation's health care system. The combination of an older population, increasingly expensive medical technology and the political potential of this older age group to win expansion of federally mandated health care services will undoubtedly put upward pressures on cost. The next generation of workers, while health oriented, is not likely to want to provide expensive benefits to an older population. The early signs are that this group will lean more toward individual responsibility. Thus, employers can expect to be a major part of the debate about company sponsored health care plans to meet a growing, aging work force's health care needs.

Women & Infants Hospital of Rhode Island/David Wetbeck

Sound investment in today's youth means a healthier, more effective work force tomorrow

But these early signs are subject to change. One of the great unknowns about the future work force concerns how they will react if their economic success exceeds their expectations, as now appears likely for many. When the previous generation was frustrated in their economic optimism, they shifted gears from a nonmaterialist or even antimaterialist idealism into a value system stressing hard work, accumulation, and perhaps greed. If the baby busters' smaller numbers lead to a bidding up of the cost of their labor (higher salaries) and reduced demand for consumer goods (lower prices), it may be possible that the baby busters will become more idealistic and less oriented toward self, leading to an emphasis on better health and improved productivity for an even greater number of people in the work force. ■

Improving Maternal Health from the Board Room

BY H. ARTHUR BROWN, JR.

Southern business leaders support company policies targeting preventive maternal and infant health.

HEALTH POLICY REPORT

While a newborn's entry into this world may seem unrelated to the concerns of corporate employers, the two are inextricably bound. The policies of a board room can influence the health of a newborn, which in turn will have an impact on corporate America's future productivity.

There are several simple and compelling reasons for corporate executives to be concerned about maternal and child health. First are the changing demographics of the American work place. According to the U.S. Bureau of Labor Statistics, 30 percent of the work force are women of childbearing age, between ages 16 and 44. Moreover, each year approximately 1 million babies are born to these working women, who represent the single fastest growing part of the work force. This current working group makes up an important population that should be of concern to employers.

The problem of infant mortality also should be addressed. National estimates illustrate the extent of this situation. The National Center for Health Statistics (NCHS) reports that in 1985 there were 10.6 infant deaths per 1,000 live births. Data from the United Nations Statistical Office show that the infant mortality rate in the United States is higher than in 17 other industrialized countries. The decline in U.S. infant mortality rates has been very slow. In fact, death in infants aged one month to one year is actually rising. The rate of low birth weight, a major cause of infant mortality, also is very high at 6.7 percent of all live births in 1985, as reported by NCHS.

Costs a Major Concern

A second important motivation is cost. Infant death and disability add tremendously to the already high price that business pays for health care. A baby born too soon or too small costs as much as $1,000 a day in high tech intensive care. Every year, over 240,000 babies fall into this category and the medical bill for each can be as high as $55,000.

According to studies cited in the Institute of Medicine's 1985 report, "Preventing Low Birthweight," approximately 19 percent of these low birth weight newborns have to be readmitted to the hospital within their first year of life at an additional cost of $10,000. Some never fully recover and require expensive rehabilitative services and a lifetime of institutionalized care—at an average cost of $389,800.

Clearly this is an expensive problem. Who pays for the patients who cannot pay? Hospitals write off some as a loss and make up for it by passing the bill on to paying patients and their insurers. As a result, hospital bills and insurance rates rise. Government steps in with some help and taxes rise. All this expense just to provide late, emergency care—the most expensive kind.

Investments in preventive medicine can pay off in maternal and child health. The public and private sectors have a stake in seeing a healthy, educated and well-trained work force able to take on the challenges of worldwide economic competition.

Southern employers have begun to deal with these issues. Made up of 29 employers from 17 southern states, this group is known as the Southern Regional Corporate Coalition to Improve Maternal and Child Health, and was established in 1986 by the Southern Governors' Associa-

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tion's Project on Infant Mortality. In its recently published report, *Boardrooms and Babies: the Critical Connection*, which examines the problem and offers cost-effective recommendations to business, the message to employers is clear: Healthy children are the key to a prosperous future.

Benefits, Leave Policies as Options

The Southern Corporate Coalition's report calls on employers nationwide to consider four major steps. First, employers should develop a maternal and infant health benefit in their insurance packages with incentives to encourage families to use preventive services such as prenatal care for pregnant women. This benefit should be comprehensive, covering prenatal care, delivery services, post-delivery care, neonatal intensive care if needed, and well child care as part of the basic package. Because private health insurance benefits vary in the range of services provided, reimbursement policies, and exclusionary provisions that limit coverage to certain providers or time periods, business should evaluate their current company sponsored policies.

Efforts at the state and local level show that incorporating preventive and post-delivery services is feasible and can be effective in reducing the incidence of infant mortality and low birth weight. For instance, a 1983 study by the Virginia Perinatal Services Advisory Commission shows that women receiving comprehensive prenatal care gave birth to far fewer low birth weight infants than women who did not receive such services—73.7 low weight infants per 1,000 births, compared with 262.5 low birth weight infants per 1,000, respectively.

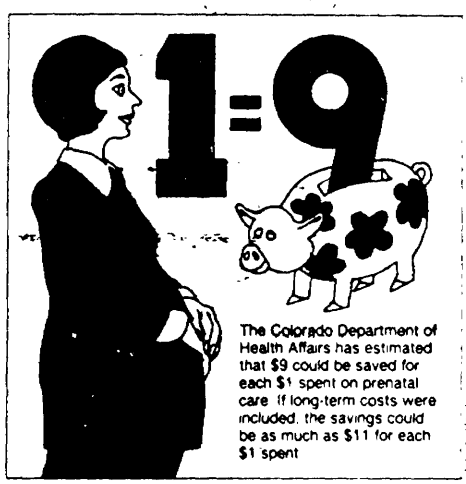
A number of studies also have demonstrated that cost savings associated with prenatal and other maternal services are possible. In Virginia, state estimates show that prenatal services could have saved $49.8 million in state expenditures.

The Southern Corporate Coalition's second recommendation is that employers review their leave policies. Recent studies by the U.S. General Accounting Office have shown that a large proportion of American working women in their childbearing years are not offered maternity leave benefits.

However, some U.S. companies are beginning to recognize the importance of such benefits and are inspiring more to follow. At IBM in Armonk, N.Y., company employees are given 30 minutes flextime to be taken at the beginning or the end of the day. Women are granted paid maternity leave for six to eight weeks and can take unpaid personal leave for up to a year, with their job or an equivalent one guaranteed upon their return. Likewise, female employees at Lotus, a computer software company in Cambridge, Mass., can receive up to eight weeks of paid maternity leave.

Employers also can provide educational programs for employees and their families on preventive health care for mothers and children, notes the coalition report. Burlington Industries, Inc.'s comprehensive employee health education program is an example. Called "Good for You," the Greensboro, N.C., company program teaches workers to be better consumers of medical services. Through a combination of posters, newsletters, videotapes and seminars, employees and managers learn what is going on in the health field. Special emphasis is placed on healthy pregnancies and births.

Informed involvement in the development of health care public policy is a fourth step employers can take to encourage good maternal health. Public-private partnerships formed at local, state and federal levels provide an avenue for employer contribution to policy development. In Norfolk, Va., the computer firm of Systems Management American Corporation (SMA) offers job preparation skills, health training and internships to pregnant teenagers in area schools. SMA also works with the state



The Colorado Department of Health Affairs has estimated that $9 could be saved for each $1 spent on prenatal care. If long-term costs were included, the savings could be as much as $11 for each $1 spent

John L. Hamby

funded Resource Mothers' Program to provide counseling to teenagers on health care, nutrition and substance abuse. Ross Laboratories, a division of Abbott Laboratories based in Cleveland, Ohio, runs a program in Atlanta, Ga., for state legislators that outlines public policy models that can help target and improve the health needs of pregnant women and young children.

But these efforts do not stop here. The southern business leaders continue to investigate new solutions and educate other employers on measures to reduce infant mortality and improve maternal health.

Action on behalf of pregnant women and infants is needed now. Improving the opportunities for their good health makes economic sense, but it demands leadership and innovation at every level from individuals in business and government, especially since these issues have a negative impact on economic development and thus, the ability to meet future work force demands. Everyone pays the high price of infant mortality. Everyone must invest in its prevention. ■

Prevention, Education Spur Sunbeam's Prenatal Program

The battle to provide appropriate health care coverage while containing relentless health care costs is a dilemma common to many employers. As a self-insured employer, Sunbeam Appliance Company found that this battle put a particular strain on its health care plan. Concern about the costs experienced under this coverage arose with the occurrence of premature births among female employees in Sunbeam's Coushatta, La., and Holly Springs, Miss., plants.

In 1984, four Coushatta employees gave birth prematurely. One of the infants required such lengthy hospitalizations in neonatal intensive care units that the $250,000 major medical coverage was exhausted. During that year, Sunbeam paid a total of $1 million in health care costs for the plant's employee population of less than 600. About half the sum—or $500,000—went toward the support of the four premature infants, all of whom since have survived their fight for life.

The situation was not much better in 1985, when an additional three Sunbeam workers had their babies prematurely. All infants survived. But in one case, the expense once again exhausted the company sponsored major medical coverage.

Identifying Health Risks

This pattern of high cost neonatal care prompted benefits managers to investigate the problem. First, information on the employees' health status prior to delivery was collected. Using observation and health records, health service administrators at both plants identified various risk factors in the women's lifestyles. For instance, 60 percent—or 3 out of 5—of the women who had been pregnant smoked and admitted their usual diet was nonnutritional junk food.

Based on their analysis of the data, the managers reasoned that educational and health services could help prevent additional premature births in the future. With the assistance of faculty members at the Northwestern State University of Louisiana, the group devised a company sponsored program that would educate employees during their pregnancies and that would continually monitor their health.

Sunbeam made the program a requirement for all pregnant employees and opened it to their spouses on a voluntary basis. A woman enters the program as soon as it is confirmed that she is pregnant. Any employee who believes she may be pregnant can visit the company's in-house registered nurse for a urine test. If the results turn out to be positive, the employee then is referred to her physician.

A variety of classes are conducted by a Northwestern State University nursing professor on company time for one hour every two weeks. The topics include prenatal care, nutrition, discomforts of pregnancy, problems of pregnancy, development of fetus and related changes in the mother, signs and symptoms of labor and birthing, and recommendations for postpartum home environment. Most important, there is extensive one-on-one discussion to assess each woman's condition. The women's blood pressure, weight, edema and results of urine tests to detect proteins are periodically charted.

In between classes, informal sessions are held for those who are in the later stages of pregnancy or are a high risk because of excess weight, hypertension or past problems in childbirth. These sessions allow time for women to raise questions about any problems they may be experiencing. Moreover, the atmosphere encourages participants to ask instructors questions they would hesitate to discuss with a physician.

As they get to know each other, the women engage in their own form of networking, helping each other stay on the proper regimen. In one case, for example, the women saw someone from their group smoking cigarettes and eating salty potato chips and reminded her of what was discussed in class.

Direct Payoffs

The health service administrators use a combination of teaching strategies and visual aids including slides, videotapes and handouts. For example, one slide presentation shows the effects of alcohol, smoking and drugs on fetal development. Many of the handouts are written in simple language. Emphasis on preventing high risk health behavior such as smoking had significant impact. For instance, 83 percent of 50 smoking women who had entered the class have stopped smoking or cut back. In another case, 3 women were identified as being hypertensive and were found to have a past family history of toxemia. These women were monitored closely and were referred to their physician with instructions for continual observation.

Cost Per Maternity

	1984	1985	1986
Coushatta	$27,242	$16,641	$2,893
Holly Springs	3,500	7,062	2,872

Since Sunbeam's prenatal program began at the Coushatta and Holly Springs plants, no premature births have occurred at either location. As a result, the average cost per maternity at the Coushatta plant, including nursery charges, went from $27,242 in 1984 to $16,641 in 1985 and $2,893 in 1986 (see table). The educational and monitoring program at Coushatta cost $9,800 or approximately $190 per pregnancy.

At Holly Springs, the average maternity cost was $7,062 in 1985. In 1986 the figure was reduced to $2,872. The prenatal program at this location was $6,000, or about $120 per pregnancy. These reductions in costs are only a small part of Sunbeam's program success. The additional benefits can be seen in healthy full-term babies and the enhancement in employee relations. ■

Kevin Breese, Sunbeam Appliance Company

Adolescents at Risk: Safeguarding Today's Youth

BY ELI GINZBERG

Employers share a societal stake in preparing troubled teens to be productive individuals.

HEALTH POLICY REPORT

Quantity and quality have a special meaning for U.S. employers today when applied to one critical group of future workers—adolescents. The number of young entrants into the labor force has begun to decline with the aging of the baby boom cohort and will not rebound until the closing years of this century. Business faces a shortage of young people for entry level jobs, even for jobs that pay twice the minimum wage.

This demographic challenge to American economic competitiveness is compounded by four trends that threaten to undercut the potential quality of adolescents in the work force: drug use, alcohol abuse, teen pregnancies and school dropouts. Each of these trends places the adolescent personally at risk and business collectively at a disadvantage.

With a grant from the Commonwealth Fund, the Conservation of Human Resources at Columbia University carried out a project to determine the potential strategies to reduce if not eliminate adolescent behavioral risks. As noted in the Fund's 1986 Annual Report, "preventing adolescents' destructive behavior . . . could save lives, reduce human suffering, put human unfortunates to productive use and save billions of dollars now directed to repairing damage."

Dangers in Substance Abuse

The stereotype of an adolescent drunk driver can be misleading. The solution may not be as simple as raising the drinking or driving age. This is not to say that teenagers drink more than older age groups, but that they are relatively inexperienced drivers and, as risk takers, impulsive. Since limited skill is a significant added danger in drunk driving, raising the driving age could lead to a rise in the injury and death rates of young adults ages 22 to 24, an age group that not only has a poor record of performance, but tends to drink more.

A review of current literature revealed that no specific intervention tried thus far—from the imposition of severe criminal penalties to media blitzes—has proven effective. Police can erect roadblocks to look for drunk drivers but they cannot shift their anticrime work repeatedly without high risks to the community. Moreover, many drunk drivers who lose their licenses continue to drive illegally.

The evidence suggests, however, that multifaceted adolescent drunk driving programs, although not yet explored, hold promise. These programs should involve the following approaches: raising the legal drinking age; imposing evening curfews; using probationary licenses; applying peer pressure tactics; carrying out widescale education and public information programs; and administering more aggressive deterrence through enforcement. Comprehensive programs are difficult to launch and sustain, but they are needed.

Some employers have programs targeted toward youth. PepsiCo, Inc., for instance, sponsors a school assembly program that uses popular music and movies to focus on teenage alcohol abuse. The company donates its soft drinks for high school proms and graduations and works with student groups, such as Students Against Drunk Driving (SADD). Anheuser-Busch Companies, Inc., not only targets its alcohol awareness efforts among its employees, but sponsors a program called The Buddy System for young adults. Program movies, brochures and posters encourage students not to drink and drive and stress the

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importance of being responsible during spring break and other school vacations.

At Eastman Kodak Co., both teenagers and their parents get involved. Called "DWI . . . Whose Problem Is It?", Eastman's program emphasizes off-the-job aspects of driving while intoxicated. Complete with discussion guides and a film, the program includes a driving contract to be signed by teenagers and their parents as a formal pledge to each other that both parties will seek alternative transportation rather than driving drunk. More than 12,000 employees have participated in the program.

Like drunk driving, drug use among adolescents raises serious concerns about the health and productivity of this generation. National data from the American Medical Association (AMA) reveal that approximately two-thirds of adolescents use an illicit drug before they finish high school. In its white paper on adolescent health, the AMA reports that by the twelfth grade, 4 out of 10 teenagers have used an illicit drug other than marijuana. More than 24 percent indicated that they have tried marijuana. Health care observers and social scientists generally agree that teenagers are less likely than older persons to use hard drugs such as opium and cocaine. However, crack, a low priced cocaine derivative, has made serious inroads among many adolescents. The influx of hard drugs into the United States poses a challenge to public and private sectors in preventing future adolescent drug use.

Effective prevention, however, would need to go beyond barring drug entry into this country and would require total interdiction of the supply of hard drugs. School based programs are increasingly popular, particularly in neighborhoods where drug abuse is prevalent. Often these problems are focused on a single substance such as alcohol or cigarettes. The most successful programs, however, address the drug problem within the broader context of helping young people with their life and career goals.

Teen Pregnancies Rising

Like substance abuse, the increase in pregnancies among unwed teenagers presents a challenge for prevention measures. Among women ages 15 to 19, the number of births rose from 95 per 1,000 in 1972 to 111 per 1,000 in 1981. While overall teenage birth rates have declined substantially from 86 per 1,000 in 1952 to 52 per 1,000 in 1983, births to unmarried teenagers are increasing. According to the U.S. National Center for Health Statistics, in 1960 the percentage of births out of wedlock to women aged 15 to 19 was 14.8 percent. By 1982 that figure had risen to 50.7 percent. The rate for black teenagers in 1960 was 42.1 percent and in 1982, 86.9 percent.

During these two decades the rate for white women had increased even more rapidly—from 7.2 percent to 36.5 percent. In 1983, the total number of live births among both groups was 270,000, or 30 per 1,000, as opposed to 23 per 1,000 a decade earlier. The legalized use

Communities, Employers Reach Out to Pregnant Teens

While some employers may consider link between their companies and pregnant teenagers unlikely, the implications for their future workers makes those ties a particularly meaningful one. Unintended pregnancy is especially taxing on young adolescents and the public welfare. With little financial self-support or adult decision-making experiences, teenage females are poorly prepared for child raising.

Fortunately, for many teens in the western portion of South Carolina County, S.C., motherhood was prevented early on through a program conducted by researchers from the University of South Carolina and the Carolina Institute. Educators, parents, and community leaders, through a project called the School/Community Program for Sexual Risk Reduction Among Teens, encouraged teenagers to postpone sexual activity and to use contraceptives if they did not.

When the project began in 1982, South Carolina County ranked among the top 20 percent of the state's counties with the highest estimated pregnancies among females ages 14 to 17—60 births per 1,000 females.

Using Local Resources

The project first targeted school district teachers. Two-thirds of the district instructors, including administrative staff and other service professionals, completed university graduate level courses relating to sex education and behavior. Trained teachers then introduced sex education to their students by integrating various topics within the regular biology, science, social studies and other required classes.

Meanwhile, parents, clergy and church leaders were recruited to attend mini-courses that addressed similar topics as well as discussions on skills to improve parents' roles as models for youth. Other parts of the community were saturated with the help of the local newspaper and radio station, which promoted the program messages by announcing National Family Sexuality Education Week. The activities broadcast had a broad based health focus. For instance, alcohol and drug abuse, nutrition, weight control and smoking cessation programs were conducted.

Very little change in pregnancy rates was noted in 1983. However, in 1984 and 1985, the number of the estimated pregnancies dropped to 25 per 1,000 females. These figures represent a sizeable decrease in the number of pregnancies, in comparison with other counties that did not carry out any type of intervention. In fact, in one county, the number of pregnancies per 1,000 females increased from 57 in 1982 to 60 in 1985.

Companies Target Parents

Some companies have attempted to play a role in influencing teen health and pregnancy by educating their employees through corporate wellness programs. At C.F. Hathaway, the Waterville, Maine, based manufacturer of men's shirts, the average employee is in his or her late 30s and has adolescent children. Early this year, at least 100 employees, male and female, attended a lunch time seminar on teenage pregnancy on the company's premises. The program, conducted by March of Dimes nutritionists, focused on the health and social risks pregnant teenagers face as well as the need for parents to communicate with their children about sexuality and parenting.

The program also discussed programs that can help adolescents examine their behavior and attitudes. "In some cases, we make referrals to parents whose children are having personal problems," said Helen King, industrial nurse at Hathaway. The programs, which also include prenatal education, are useful especially for Hathaway's female employees, who make up almost 75 percent of the company's 900 workers. Another firm, The Dow Chemical Company, offered a similar program to more than 100 employees at its Torrence, Calif., plant. With the average age of 40 among both men and women, the focus on educating parents was especially pertinent.

Some large employers have become active sponsors of community efforts to educate the public about the benefits of proper prenatal and baby care. The Blue Cross and Blue Shield of the National Capital Area in Washington, D.C., recently contributed $400,000 to a public service project, "Beautiful Babies Right From the Start," sponsored by The March of Dimes Foundation, the National Center for the Prevention of Sudden Infant Death Syndrome, and a local nursing service and television station.

The efforts demonstrated by the companies that have been involved in these programs show that the potential—and resources—exist for employers to make an good investment in future workers. ■

Lisa Lopez

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of abortion largely accounts for the difference in frequency of pregnancies and births; about half of all pregnancies are terminated by abortions and 5 percent to 6 percent by miscarriages.

Employers are at risk from the high teenage pregnancy rate in several ways. Most unmarried teenaged mothers are forced to go onto welfare to support themselves and their children, thereby raising the tax rate. Further, most of the young mothers drop out of school before obtaining their high school diploma, making it difficult for them to get a job, and prolonging their stay on welfare. These young mothers lack many parenting skills, causing their children to get a poor start in life and perhaps repeat the cycle of school dropout, welfare and long-term dependency and prolonged unemployment

Many of the major intervention programs that have been mounted conclude that the design of most did not permit vigorous evaluation; others were of such recent date that evaluation was premature. Without assigning individuals in an experimental or a control group, it usually is

impossible to judge whether the specific program intervention made a difference and how much of a difference it made. Furthermore, considerable time often must pass between the initiation of a program and valid estimates of its results. The Manpower Demonstration Research Corporation, for instance, discovered in its Project Redirection that a large proportion of the experimental group of pregnant teenagers had a second pregnancy within two years.

One of the most impressive results thus far was achieved by a controlled experimental program in the early 1980s using primary prevention techniques in four inner city schools in Baltimore. The measures involved supplementing the state mandated basic sex education curriculum with a voluntary school based counseling and information program as well as medical and educational services provided by a nearby clinic. The drop in the incidence of pregnancy and reported attitudinal changes among the experimental group after several years of exposure to the program suggest that integrated and continuing educational, counseling and contraceptive services by the school and neighborhood health clinics can effectively reduce the number of teenage pregnancies.

The Baltimore school program demonstrated several favorable outcomes: a striking increase in the use of contraceptive pills; a brief postponement of first coital experience from age 15 years 7 months to 16 years 2 months; and a drop in the incidence of conception, the more striking because of the increase in the number of control group members. Such interventions are feasible if community leadership provides strong support for the program (see box). The launching and successful operation of the Baltimore demonstration rested on the cooperation of three interested groups: the Johns Hopkins University faculty; the local school staff; and the health clinic staff.

Given that the incidence of births among unmarried teenagers is closely linked with race, low family income and an economically deteriorating environment, the best prospects of preventing pregnancy and early parenthood would stem from an environment that offers adolescents a realistic expectation of a better future upon graduating from school, supporting one's self through employment and deferring childbearing and marriage.

Targeting Educational Apathy

The Columbia University study found that like unwed pregnant teenagers, a person who drops out of school is young, usually 16 or 17, and in most instances, is not responding to a recent problem but rather to cumulative adverse experiences originating in early childhood and the first years of school. A recent report by the Committee for Economic Development, a nonprofit economic research group, stated that "in 1987, nearly 1 million young people . . . will leave the nation's public schools without graduating. Most of them will be . . . virtually unemployable. Another 700,000 will merely mark time in school and receive their diplomas but will be as deficient in meaningful skills and work habits as most dropouts." Faced with a declining labor force, particularly qualified applicants, business has a good reason to join with other groups to press for major and continuing reforms in the educational system at state and local levels.

Current efforts at the local level to reduce the number of high school dropouts include volunteer tutoring, supervised after-school homework sessions, and summer school. Even more important, however, is to identify weaknesses of the system and to strengthen proven early interventions, such as opportunities for enrollment in pre-school programs (Headstart), greater elasticity in the first three grades to adapt the pace of instruction to the readiness of the children, and remedial classes for those who encounter difficulties in absorbing the basics.

Pepsi-Cola's T.G.I.F. program on alcohol and drugs encourages students to take charge of their lives.

Employers can play a role in furthering this educational effort and at the same time build on strategies to prepare students for the working world. One way is for companies to create part-time, part-year employment opportunities for students in at least tenth grade. This permits adolescents to benefit from early exposure to adults in a work environment and to learn how their school experience is related to work, careers and adult life. Citibank, for example, set up a program encouraging minority students in an inner city high school to remain in school until they earned their diploma. The bank provided after-school jobs and summer jobs for students who maintained a satisfactory grade average. Many of the company's managers invested considerable time and effort in monitoring and counselling the young people and in helping them sharpen their skills.

American business has come a long way in recognizing its role in helping develop the well-being of the community it serves. This role is just beginning. Clearly, employers cannot afford to neglect the serious forms of adolescent malfunctioning. While companies are in no position to solve these problems by themselves, they can be critical partners in strengthening efforts to improve the welfare of the next working generation. ■

Functional Illiteracy in Today's Work Force

BY SUSAN L. KOEN

Employers are finding that gaps in workers' education have productivity, health consequences.

HEALTH POLICY REPORT

The baby boom generation, consisting of those persons born between 1946 and 1964, has been heralded as the most educated group ever to enter the labor force. From the perspective of educational credentials, this is true. More Americans are graduating from high school and pursuing post-secondary education today than at any other time in U.S. history. The 1980 census indicated that the median years of schooling for adults born between 1951 and 1955 was 12.9, while those born before 1951 averaged 11.6 years. The number of persons with advanced college degrees, including legal, medical and doctoral degrees, is greater than ever before; 55 percent of the baby boomers have completed college compared with 30 percent or fewer adults receiving college diplomas in previous generations. Moreover, public education expenditures constitute almost 7 percent of the Gross National Product.

A Crisis in the Making

Yet, in the midst of these major advancements in education, a disturbing story is unfolding. Studies sponsored by the Department of Education and the Ford Foundation have documented that at least 20 percent of adult Americans—approximately 27 million persons—are functionally illiterate. This means their basic reading, language and mathematics skills are so low that these adults cannot perform competently everyday tasks such as reading a medicine bottle, filling out a job application or writing a check. An additional one-third of the adult population, or about 35 million to 40 million Americans, are only marginally competent in everyday activities involving reading, writing or computation skills.

The media have dubbed the situation a "literacy crisis" for today's work force. Some experts are projecting an illiteracy problem that will become increasingly significant when the post-baby boom generation reaches the labor market and employers are forced to rely on previously unemployable segments of the population to fill job vacancies. For example, a 1983 report by the American Society for Training and Development indicates that, by 1995, the declining birth rate will force employers to hire more high school dropouts, minorities and immigrants in order to fill their entry-level positions. These populations traditionally have higher concentrations of the least educated or skilled members of U.S. society.

Other experts say the problems of the future work force will only compound a literacy crisis that already exists. Numerous studies conducted over the past 25 years show there are many members of the baby boom generation who—despite their educational credentials—are lacking in the literacy skills required by the modern work place. More and more employers are reporting that the majority of their employees with high school diplomas have major skill deficiencies in reading, writing, mathematics and basic cognitive processing skills. For instance, over half of the personnel directors from 184 companies who responded to a 1982 survey by the Center for Public Resources, a New York based nonprofit group, identified these literacy deficiencies in their work force. Moreover, the directors indicated that deficiencies exist among all classes of personnel, from clerical and production workers to supervisory and managerial level employees, and that a high school diploma did not guarantee sufficient literacy abilities. Of those companies reporting skill deficiencies in their work force, 75 percent said these problems inhibit

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promotions and lead to employee frustration, low productivity, high turnover and the loss of millions of dollars through errors and accidents.

How can these two phenomena of higher educational credentials within the labor force and more work place literacy problems exist side by side? What implications do work place literacy problems hold for employers? And specifically, how do current literacy levels affect health care cost containment efforts, health promotion programs and future health care decisions within American business and industry? What can business and industry do to reduce or eliminate work place literacy problems?

Functional Illiteracy Widespread

Work place literacy means the ability to use skills and knowledge in the areas of communications, including reading, writing, speaking and listening, mathematics, information processing and problem solving with the functional competence required by a given job. Work place literacy involves more than the rudimentary skills of decoding and computation. Rather, it encompasses the diverse and complex literacy related job requirements typical of the Information Age.

This era—as described by commentators such as futurist John Naisbitt and management consultant Rosabeth Moss Kanter—involves jobs that require the use of new technologies like word processors and microcomputers. In addition, jobs increasingly involve the generation, transfer and processing of written text whether in print form or through electronic mailing procedures. With the Information Age upon them, more Americans—from the shop floor or clerical pool to the board room—will need to use literacy skills in the work place in order to perform successfully their assigned job tasks.

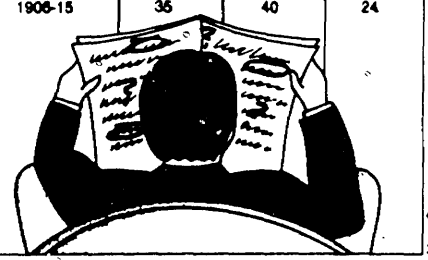
There are two sources that provide a specific indication of the nature and extent of literacy problems among baby boomers. One is the 1975 Adult Performance Level (APL) study conducted by the University of Texas; the other is the 1985 National Assessment of Educational Progress (NAEP) study conducted by Educational Testing Service in Princeton, N.J. While somewhat dated, the 1975 APL study is still recognized as the most definitive research on the functional competency of American adults. Both studies conclude that over half the Americans born between 1946 and 1964 do not possess sufficient literacy skills to be proficient in real world tasks requiring the understanding, processing and using of information contained in printed materials.

The APL study examined the functional competency of adults, ages 18 to 65, in five general knowledge areas considered by researchers to reflect the basic requirements of adult living. These areas are consumer economics, occupational knowledge, community resources, health, and government and law. Five independent, representative samples of U.S. adults participated, bringing the total number surveyed to 7,500. The results were classified into three competency levels with APL-1 being adults who are functionally incompetent, APL-2 being those who are functioning on a minimum level and APL-3 being those who are functionally proficient adults. The baby boomers included in this study were ages 18 to 29, that is, they were born between 1946 and 1957. All other adults included in the study were born prior to the post-war birth explosion and supposedly had fewer educational opportunities than their younger counterparts.

Results from the APL study demonstrate, however, that the 18- to 29-years-olds scored significantly lower than the adults in the 30 to 39 age cluster. In fact, their scores were more like those adults born between 1926 and 1935 who had much less schooling on average (see graph).

Literacy Capabilities to Perform Daily Living Tasks

Age Groups (by year of birth)	Functionally Incompetent	Minimally Competent	Functionally Proficient
1946-57	16%	35%	49%
1936-45	11	29	60
1926-35	19	32	49
1916-25	28	37	35
1906-15	36	40	24



Source: Adult Performance Level Project, University of Texas, 1975

Mary Czarnik

Based on these findings, more than 50 percent of the baby boomers were not proficient in the basic requirements of adult living. The skills they lacked included such ordinary abilities as these: computing the unit price of a grocery item; reading and interpreting a health insurance policy; and matching their education and experience levels with the requirements in a newspaper help wanted ad. In the health area, specifically, the APL study assessed 13 objectives for functional competence and found insufficient skill levels among 52 percent of the study sample (see box).

The findings from the 1975 APL study were corroborated by the 1985 NAEP research with young adults, ages 21 to 25. In this study, the skills of 3,600 young Americans were assessed through task simulations designed to measure proficiency in reading and interpreting prose, identifying and using information located in documents, and applying numerical operations to information contained in printed material. The population included in this study

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Literacy Objectives for Health

The University of Texas, in 1975, conducted one of the most comprehensive studies to date on functional literacy among American adults. The Adult Performance Level (APL) study documented a decline in Americans' capability to digest written material in order to perform daily tasks in areas ranging from consumer purchasing to health care decision making.

The study also established literacy objectives for each study area, including the following for health care:

- To develop a working vocabulary related to health, especially basic medical and psysiological terminology, for accurate reporting of symptoms and following a physician's directions in applying treatments;
- To understand how basic safety measures can prevent accidents and injuries and to recognize potential hazards, especially those related to home and occupational safety;
- To know medical and health services available in the community;
- To understand the physicial and psychological influences of pregnancy as well as the need for proper prenatal care;
- To understand the importance of family planning and its physical, psychological, financial and religious implications, and to be knowledgeable about both effective and ineffective methods of birth control;
- To understand general child rearing practices and procedures for guarding the health and safety of a child, and to apply proper action in accordance with needs and resources;
- To understand the special health needs and concerns of the adolescent and his or her parents, and to become acquainted with some ways to ease the transition from childhood to adulthood;
- To understand what contributes to good mental and physical health and to apply this understanding toward preventive care and health maintenance;
- To understand the interaction of self as a member of small groups (family, work, club, class) and to use this understanding to promote effective interpersonal coping skills;
- To be able to apply first aid in emergencies and to inform the proper authorities of sudden illnesses, various accidents or natural disasters;
- To plan for health or medical insurance and to be aware of available financial assistance for medical or health problems;
- To understand what constitutes a proper diet and to plan meals according to individual needs and resources;
- To understand federal control of various drugs and items for health protection and to comprehend how public reaction influences this control. ■

represents the tail end of the baby boomers, those born between 1960 and 1964. This NAEP study documented that 80 percent of the young adults meet or exceed the literacy performance standards set by the federal War on Poverty program in 1966; namely, reading at the eighth grade level. But in terms of the requirements of the Information Age, the results were disappointing.

Skills Fall Short of Work Place Demands

The major finding from the NAEP study was that the general ability of these younger baby boomers to use printed and written information to function in society was low relative to societal needs. Certain tasks could not be completed with sufficient accuracy by 25 percent to 50 percent of the study sample: writing a letter to state that an error was made in billing; locating eligibility from a table of employee benefits; calculating a checkbook balance; and writing an appropriate message on a phone message form. More than half of these young adults could not complete with proficiency such everyday tasks as these: determining a tip given a percentage of a bill, using a bus schedule to select the appropriate bus for a given departure time; and locating information in a news article. The results were lowest for high school dropouts. But even college graduates demonstrated problems with logical-mathematical processing, information processing that involved complex displays of print, and holding information in their working memory while finding other information.

What are the implications of these findings for the work place? Research has shown that the average time spent per day reading job material—across all job classifications—is almost two hours, or one-quarter of an 8-hour work day. A survey conducted in 1980 of on-the-job reading revealed that the use of printed materials was important or vital to 77 percent of all tasks encountered in American jobs. The majority of this reading was classified as either "reading to do" (63 percent), that is, reading in which the reader uses the printed material to locate and interpret information needed to complete a task assignment; or "reading to assess" (36 percent), in which the reader analyzes the material to determine its usefulness for some later task or other person. Almost 90 percent of the literacy related job tasks call for employees to go beyond the literal level and to interpret and apply the information contained in printed materials.

In short, the primary reading tasks in today's work places are precisely those reading activities in which the NAEP and APL studies found deficiencies among the baby boom generation. The stark reality is that the literacy demands in modern society have outstripped educational attainment. What has been taught in American schools has not transferred well to everyday literacy demands.

There is a primary reason why the skills of this educated generation do not match even some of the basic requirements for adult living. A discrepancy exists between the types of reading activities found in most American schools and the types of on-the-job reading that

predominate in the work place. Students are taught "reading to learn," a process in which a person reads with the intention of remembering the text information. Yet, this type of reading accounts for only 11 percent of the reading required across all job categories, and even less among nonexecutive positions. Instead, employees generally need to read job related material in quick spurts of two minutes to five minutes each, understand what they have read, and then use that information to perform a designated task. For example, a secretary or data entry clerk may need to read a computer manual to find the correct command for a particular word processing or data base program. A forklift operator may have to read an order form to learn what material to pick up from a warehouse. Or an insurance claims specialist may have to refer to a listing of the approved medical procedures for a given diagnosis before processing a claim. In all of these cases, the intent is not to commit the material to memory, but rather to locate specific information for immediate use in task completion. Employees who have been taught "reading to learn" techniques in school often find that these reading methods, at best, are inefficient and often inappropriate for the "reading to do" activities in the work place.

This mismatch stems largely from the difficulties in skill transfer. Reading is a functional competency that depends on the application of a set of skills to a particular task or knowledge area. If the requirements change, and the individual does not adapt by acquiring more or different knowledge and skills, then that person becomes less competent in the new task area.

The deficiencies in information processing and problem solving skills evident among the baby boom generation pose a particular problem for employers. The pressures of worldwide economic competition combined with the changing nature of jobs require employees at all levels of the organization to play an increased role in problem identification and cost containment. Moreover, decisions on organizational procedures and quality control are being pushed closer and closer to the front line.

Many manufacturers, like Ford Motor Company, have installed expensive statistical process control equipment to monitor quality on the production line only to find out that their employees cannot decipher the computer printouts generated by this equipment, and therefore continue to make costly errors or produce inferior products. Similarly, Onan Corporation in Fridley, Minn., which manufactures electrical equipment, discovered that the mathematics and information processing skills of its operators were insufficient for the new automated production process being installed in its plants. This reality is as true for employee welfare programs, including health care and medical insurance, as it is for manufacturing processes.

Obstacles to Health Care Decision Making

Increasingly, employees are being given choices in their medical benefits package. They are being asked to select the benefits plan that will best serve their family's needs at a price affordable to both themselves and their employer. What does it mean if more than half of the work force cannot read and interpret a health insurance policy? What does it mean if 25 percent or more of the employees cannot accurately locate eligibility from a table of employee benefits? Can a company hope to achieve its cost containment goals under such circumstances?

For example, some benefits managers have discovered that, due to literacy problems, employees often incorrectly complete the medical history section of their insurance applications. When such errors result in employees' reporting a higher incidence of previous illness or health conditions, a company's insurance rates can increase.

The implications for health promotion programs are equally troublesome. Many employers spend heavily on wellness and fitness programs in the work place, providing employees with courses on stress reduction, smoking cessation, weight control and other important topics. Yet what assurance do health educators have that employees can read and interpret printed materials provided in these courses? How can employees monitor their blood pressure and cholesterol levels if they cannot accurately read and analyze the data presented in medical charts? What good is the nutritional information provided on food packages if this material is not interpreted correctly? Can businesses help to improve employee health when such information processing deficiencies exist?

Liability Concerns

Two court cases related to employee health and safety illustrate the scope of the problem in real life terms. The first involves a janitor who burned his lungs by mixing the wrong cleaning solutions together. The company had told him to read the directions before using any cleaning chemicals, but had failed to determine whether he could read and interpret the directions on the labels. The lawyer for the plaintiff was attempting to prove liability on the part of the company for failing to ensure that the employee received proper warnings about the use of hazardous materials. The case eventually was settled out of court to avoid publicity and higher damage costs.

The second case concerns a foreman who was rated as a highly successful supervisor. No one knew he had reading problems. A new piece of machinery was installed in the plant and he was instructed to read the operator's manual. Since he could not effectively read and interpret the information in the manual, he failed to set the safety equipment properly and a co-worker's hand was severed. A reading expert, asked to analyze the reading difficulty of the warnings in the instruction manual, testified that the material was written at a level above the reading skill of the foreman. Based on that consultant's testimony, this company also agreed to an out-of-court settlement rather than risk a jury's verdict in a liability case.

Such health and safety problems are most likely to result among blue-collar workers but only because they are more directly exposed to work place hazards. The literacy problems these stories represent also can happen among white-collar employees. Consider, for example, the execu-

tive at a computer company in New Jersey who earns $75,000 a year and could only read at the fourth grade level before enrolling in a community literacy program two years ago. Or calculate the costs in lost productivity for a situation like that reported by Mutual of New York, which estimates that 70 percent of its dictated correspondence has to be redone at least once because of spelling and grammatical errors.

On-the-Job Education

The research on successful adult literacy programs is quite clear. If they want to help reduce work place illiteracy, employers will have to commit to filling in the gaps left by education in literacy skills including communication, mathematics, information processing and problem-solving in the functional context. Thus, programs that use job related materials and provide task simulations closely approximating on-the-job requirements can help employees transfer skills learned during literacy instruction to their job demands.

Two companies that exemplify effective practices in work place literacy development are Polaroid Corporation and Aetna Life and Casualty Company. In the case of Polaroid, this high-tech manufacturer instituted fundamental skills courses for its employees in 1970, when a business expansion effort resulted in the hiring of staff members with insufficient literacy skills to perform their jobs and to take advantage of the corporation's job related math and science courses. Now, Polaroid has a comprehensive on-site program that focuses on reading, writing and problem solving, using job specific learning activities. The courses consist of 30 instructional hours over a 10-week period and are offered in the company's two Boston area plants on a voluntary basis and at times that are convenient for all three shifts of employees. Approximately 10 percent of Polaroid's hourly workers participate in this fundamental skills program. Graduates then proceed to the company's math and science courses or participate in other development opportunities available at the company.

A second example is a new program developed at Aetna's Institute for Corporate Education. The insurance company has been expanding its literacy services for the past 12 years since it first started offering a spelling course for typists. In the early 1980s, it also broadened operations to encompass a new activity. Through its Partnerships program, Aetna is assisting hospitals in complying with Medicare requirements for reimbursement under its diagnosis related group based prospective payment system. This program changed the nature of work for many Aetna employees and brought new responsibilities and vocabulary to its claims processing personnel. Consequently, Aetna implemented the Effective Business Skills program, a curriculum in which functional literacy instruction is infused into a required training program for all personnel assigned to this venture. The program emphasized information processing skills such as the application of newly learned medical terminology to the successful completion of Medicare forms and the speedy processing of hospital payment requests. The materials used in this program are job specific, and all literacy skills are developed in the context of the tasks employees are expected to perform.

The implications of literacy research for health and benefits personnel are critical. They cannot assume that a work place literacy program aimed at the technical or operations areas of the business will help improve employees' skills in reading or interpreting a benefits package or a health promotion pamphlet. Rather, human resource professionals charged with health and safety or compensation and benefits responsibilities must accommodate the literacy skills of their work force in planning and delivering all employee information and services. This means that more literacy expertise will be needed in the design and presentation of health and safety information for employees. It also means that briefings on benefits will need to be expanded to ensure that newly hired employees fully understand their health insurance plans or optional programs. Benefits managers may even need to create a multimedia presentation or prepare fact sheets written at approximately an eighth grade level in order to provide employees with necessary information on their health insurance coverage or other compensation programs. In fact, awareness that the current work place literacy situation touches all employees, including the more well-educated baby boomers, requires new approaches to human resource development and employee services.

"Only by changing the design and delivery of all printed material, while simultaneously introducing targeted and effective work place literacy programs, can American business hope to improve the health, safety and productivity of the largest segment of its work force."

Only by changing the design and delivery of all printed materials, while simultaneously introducing targeted and effective work place literacy programs, can American business and industry hope to improve the health, safety and productivity of the largest segment of its work force. Such changes also will prepare employers for the literacy problems expected well into the Twenty-first Century.

The workers who will fill American jobs between now and the year 2005 already have been born. Demographic projections combined with current research on literacy abilities in the school age and young adult populations make the future quite apparent. It is no longer a question of whether work place literacy instruction will be needed. It is only a question of when. ■

PREPARED STATEMENT OF MARY NELL LEHNHARD

Mr. Chairman, Members of the Committee, I am Mary Nell Lehnhard, Vice President of the Blue Cross and Blue Shield Association. I am appearing at this hearing on behalf of the 75 Blue Cross and Blue Shield Plans across the nation. Our Plans cover some 21 million children, generally through employment-based programs. We commend you for your efforts to bring attention to the problem of assuring access to care for our nation's uninsured children and we appreciate this opportunity to offer our comments on Senator Bentsen's proposal. Our comments are based on descriptive information since the legislation has not yet been introduced.

PROPOSAL BY SENATOR BENTSEN

The proposal introduced by Senator Bentsen, as we understand it, would do several things. First, the proposal would make the dependent care tax credit allowable under current law refundable and would expand the scope of the credit to cover expenditures for health insurance policies that include children. Second, the proposal would authorize $25 million a year for five years for the Secretary of Health and Human Services to conduct demonstration programs to extend health coverage to uninsured children and/or their families.

Refundable Tax Credit.—Under current law a 30 percent non-refundable income tax credit is allowed for qualified individuals with annual adjusted gross incomes (AGI) between $10,000 and $28,000. Qualified individuals include taxpayers with a dependent under age 13 and for whom the taxpayer is entitled to claim as a dependent, a dependent who is physically or mentally incapable of caring for themselves, or a spouse who is physically or mentally incapable of caring for themselves.

The change proposed by Senator Bentsen would provide that the current law credit is refundable. This means that, for the first time, families whose income is so low they have no tax liability would benefit from the provision.

The proposal would also extend this tax credit to families with children under age 19 who purchase a health insurance policy which covers the child. The insurance policy could cover the child only or could also include the child's parents. The credit amount, which decreases as income increases, is based on a percentage of the cost of the qualified expenditure. For families with incomes of $12,000 or less, the credit is equal to 50 percent of expenditures up to a $500 credit. For each $1,000 (or fraction thereof) in income above $12,000, the credit is reduced by 5 percentage points. The credit is phased out completely for families with incomes above $21,000 a year.

While we have not seen specific legislative language, we strongly support the concept of providing a tax credit for low income families who provide health coverage for their children. In 1985, there were approximately 11 million uninsured children in the United States, three quarters were in families that had annual incomes of $20,000 or less. Currently these families would find it difficult to purchase health insurance coverage or even pay any premiums for dependent coverage under employer-provided benefits.

According to a survey of our member Plans conducted last year on the Blue Cross and Blue Shield small group market, Plans estimated that over two-thirds of small employers covered over 80 percent of the cost of employee coverage. However, Plans responded that nearly 50 percent of small group employers did not contribute, all, to dependent coverage. The cost of coverage was the major reason given for the lack of contributions by small employers for this coverage.

Further, we commend the Chairman for using the private sector rather than the Federal welfare system to provide health care coverage to a greater number of low income children and their families. The Medicaid program, as currently structured, frequently forces parents to choose between going to work in a low paying job—with unaffordable health benefits for themselves and/or their dependents—or remaining on Medicaid to assure that their children have access to health care services. Senator Bentsen's proposal provides individuals the financial ability to participate in an employer-sponsored health plan and obtain coverage for their children.

We believe that the tax credit in Senator Bentsen proposal also will allow more low income families to provide needed dependent benefits in cases where no employer-provided coverage is available. We believe that private health insurance markets will respond to these incentives by making available low cost products with the objective of reaching children. The following are just two examples of how many Blue Cross and Blue Shield Plans already have developed innovative products especially designed for low income families who lack access to employer-provided coverage.

(1) Coverage Rated for Children. Blue Shield of California introduced a program last August that reduces significantly the cost of health insurance for children by establishing special rates for children. The rates are based on two age categories—1

to 4 years and 5 to 18 years—and vary depending upon the deductible chosen. For example, traditionally rated coverage for a youth would cost $109 per quarter. Under this program, coverage for a child 1 to 4 would be $80 a quarter while coverage for a child 5 to 18 would be $63 a quarter.

Benefits are the same as under traditional coverage and coverage allows subscribers to choose from more than 36,000 physicians and more than 200 hospitals in California.

(2) **The Unemployed and Marginally Employed.** In a cooperative effort with the Kansas Medical Society, the Kansas Hospital Association and other health care providers, Blue Cross and Blue Shield of Kansas began a pilot program in January 1988 to provide health benefits for the state's unemployed and marginally employed. This program is designed to provide benefits to individuals and families who are low income and are not covered under group insurance plans or by state or Federal health care programs. Applicants must: (a) meet income eligibility limits of $8,000 per year for single persons or $15,000 for families; (b) not be employed full time; and (c) be under age 65.

Monthly premiums are based on subscriber age and begin as low as $17.35 (single) and $38.58 (family). Family coverage includes dependent children up to age 23. Handicapped, unmarried dependent children are covered over age 23 if the child became handicapped while enrolled. Area churches and philanthropic groups are being encouraged to contribute toward the cost of the premiums for needy individuals and families.

Covered benefits under this program include: inpatient and outpatient hospital services, medical and surgical services, emergency care, maternity and newborn care under a family contract, and care for nervous and mental conditions. Deductibles for a 12-month contract period are $1,000 for individual and $2,000 for families; however, health care providers who participate in the program assume responsibility for half of the deductible.

Child Health Demonstration Projects. The Blue Cross and Blue Shield Association also supports the proposed demonstration projects efforts to expand health coverage to uninsured children and their families. We believe that the demonstration projects supported under Senator Bentsen's proposal will provide incentives for organizations and communities to become involved in solving health care access problems. It would also provide experience and data to draw from for future projects.

Under the proposal, state school systems, nonprofit organizations and other qualifying organizations could establish demonstration projects which provide children and their families access to health benefits. The benefits provided would include preventive care, doctors office visits for children as medically necessary, outpatient diagnostic care, and outpatient surgery. Federal grants could fund as much as fifty percent of such projects.

The Blue Cross and Blue Shield organization has been active in initiating locally-sponsored, innovative programs that address the special needs of low income children. One such project is the Western Pennsylvania Caring Program for Children. This program was created in 1985 by Blue Cross of Western Pennsylvania and Pennsylvania Blue Shield in recognition of the number of low income, non Medicaid working poor in the state of Pennsylvania.

The Caring Program offers primary health care coverage free-of-charge to the families—to children who are not eligible for Medicaid but whose parents cannot afford health insurance. Since its inception, more than 12,000 children have received primary preventive and emergency health care service coverage at no cost to their families. Benefits include coverage for: emergency accident care and medical care, diagnostic tests, outpatient surgery, pediatric preventative health maintenance, and unlimited medically necessary physician office visits.

Through contributions of $13 a month, foundations, businesses, unions, individuals, and civic and religious organizations are able to sponsor low income children regardless of their medical condition. Blue Cross of Western Pennsylvania and Pennsylvania Blue Shield match every contribution, dollar for dollar, thus enrolling two children for every one sponsored by a public contribution. In addition, the Western Pennsylvania Plans have further expressed their commitment to these children by subsidizing the administrative costs of the program so that more children can benefit.

As of May 1989, eight other Blue Cross and Blue Shield Plans had established similar programs including Plans in Missouri, Maryland, Alabama, Kansas, New York, Iowa, North Dakota and North Carolina. Several others are scheduled to be operational by the end of 1989.

We believe that with demonstration projects, such as the one described in the Bentsen proposal, special programs such as this one could be expanded and replicated to provide access to a greater number of uninsured children nationwide.

CONCLUSION

We agree with the Committee that improving health coverage for children is a national priority. We believe that reaching all children will require the type of joint public-private effort that is the cornerstone of our health care system.

As we understand the Chairman's proposal, it could do much to promote this type of partnership. We would strongly support establishing a refundable tax credit for low income families with children under age 19 to purchase health insurance protection and demonstration projects to provide increased health coverage to children. Once we have seen specific language on his proposal and have had further time to study the legislation we would be pleased to make additional comments to the committee.

Thank you again for providing us with the opportunity to testify on this issue.

PREPARED STATEMENT OF SARA ROSENBAUM

Mr. Chairman and Members: The Children's Defense Fund appreciates the opportunity to appear today in support of the Chairman's child care and child health proposal. We believe the proposal will provide necessary assistance to low-income families with children and will complement other efforts to aid this especially vulnerable group of Americans.

This Committee is well aware of the increasingly desperate plight of millions of American children. Even when their parents are working long and hard to support them, far too many children have neither the basics of survival—food, shelter, health care, or safe supervision and care while their parents are at work—nor the early development, education and training they need to become productive, self-sufficient adults.

The severity and complexity of the problems facing today's children and families requires that meeting their needs assumes front burner status on the nation's list of priorities. Multiple creative strategies and programs that build upon one another are essential. Recognizing the differences among families in poverty, for example, this Committee has pursued a number of income support strategies that range from efforts to improve the Aid to Families with Dependent Children (AFDC) program for nonworking families to improvements in the Earned Income Tax Credit (EITC) for working families.

Tax credits have played an especially important role in the overall efforts to assist low income children and families. Indeed, the Tax Reform Act of 1986, developed under the stewardship of Senator Packwood, provided more financial assistance to low-income working families than any other single piece of legislation in recent memory. This historic legislation exempted all poor working families with children from the payment of Federal income taxes and provided them further assistance through a substantial expansion in the EITC. As a result, some working families with poverty level wages, including those in which one spouse remains at home to care for the children, gained as much as $1,000 in additional income in 1988.

Low-income working families paying for child care, however, suffered an unintended consequence of tax reform. The Tax Reform Act exempted them from Federal income tax liability. However, the Act did not make the Dependent Care Tax Credit refundable. As a result, these poorest working families no longer were able to use its benefits to offset a portion of their work-related child care expenses.

The proposal before this Committee today therefore builds upon the Tax Reform Act and complements other programmatic efforts to ensure child care and health care for America's low-income children. We urge all members of the Committee and the Congress to support the Chairman's proposal to make the Dependent Care Tax Credit refundable and to expand it to cover the cost of health insurance for low-income families with children.

DEPENDENT CARE TAX CREDIT

Child Care: This Committee has held a number of hearings on the rapidly increasing child care problems faced by millions of American families. As any parent who must work outside the home will attest, it is extremely difficult to find or afford safe and decent child care. These difficulties are seriously compounded for

low-income families, causing far too many poor children to be left alone or in unsafe or inadequate care while their parents are at work.

A comprehensive Federal response is urgently needed to ensure the protection and development of these children. In the years ahead, more and more children will have parents who are forced to work outside the home. Estimates suggest that by 1995, for example, two-thirds of all preschool children and four out of five school age children will have mothers working outside the home. As a nation, we cannot afford to neglect the needs and futures of these children.

As you know from our prior testimony, the Children's Defense Fund believes the Act for Better Child Care Services (S. 5) must be enacted this year in order to comprehensively address the three major facets of our nation's child care crisis: cost, quality and availability. We also believe that the Chairman's proposal to make the Dependent Care Tax Credit refundable is a long overdue and sound one that will complement ABC. Just as publicly funded health efforts combine programs that finance services with programs that develop and underwrite necessary service delivery systems, so will a tax credit and ABC work together to help create a child care system.

Equally important, just as Medicaid alone cannot solve the problems of access, supply and quality of medical care for low-income families, tax credits alone will not solve our child care crisis. ABC takes critically needed steps to improve the quality of child care and expand its supply. Especially important is the fact that it will allow states to fully reimburse many of the poorest working families for child care that can cost $3,000 a year or more. While the lowest-income families are the highest priority for ABC assistance, other families could receive a reimbursement for a portion of their child care expenses under ABC.

The Chairman's proposal will add significantly to the number of low-income families assisted in meeting their child care expenses. By making the credit refundable, it will ensure that the great proportion of low-income working families who no longer have any Federal income tax liability will nevertheless be provided some assistance to offset a portion of their otherwise unsubsidized child care expenses. Under the chairman's proposal:

- A single working mother earning $10,000 a year and paying $1,000 for the care of her child would be able to receive a $300 credit to offset these expenses.
- A family earning $16,000 a year with $2,400 in child care expenses would be able to receive the maximum credit of $648.

This refundable credit thus complements the direct financial assistance provided under ABC which permits the states to determine the actual amount of child care assistance provided to various income families. For example, if the state of Maine used its existing sliding fee scale for subsidized child care services, a family of four earning $10,608 would have to pay a $300 share of its child care expenses in order for the state to pay the remaining share. A refundable Dependent Care Tax Credit would provide this family with an additional $90 to offset its share of child care expenses.

Health Insurance: The Chairman's proposal to expand the Dependent Care Tax Credit to assist low-income families with children offset the cost of health insurance coverage is an important component of an overall effort by this Committee to ensure America's low-income children access to vitally needed health care.

In 1986, nearly 12.5 million American children under 18 living in families lacked either public or private health insurance. Approximately 11 million of these children—87 percent of all uninsured children—lived in families in which the family head worked during the year. Researchers estimate that 25 percent of all uninsured children—more than 4 million—live with at least one adult family member who is insured.

Multiple causes underlie children's serious health insurance problems. While more than a million uninsured children live in families in which no member is attached to the labor force, the vast majority reside in families in which either a parent (or parents) works for firms that offer no insurance coverage at all for their employees (or at least not for their dependents) or else is employed at a firm that offers coverage that excludes certain categories of children (e.g., dependent children other than the natural or legally adopted children of the worker, children with disabling conditions, and so forth)

Particularly serious is the high proportion of children in families whose employers pay only a portion of the cost of coverage for the employees' dependents—or none at all. According to the U.S. Department of Labor, even in 1980 when employer-paid health benefits arguably were at their zenith, only 51 percent of employees in medium and large size firms had wholly paid dependent coverage. By 1986, after

the proportion of uninsured Americans had risen dramatically, that proportion dropped by 16 percentage points to 35 percent. This represents a drop of one-third in six years in the proportion of medium and large firm employees with fully paid coverage.

This situation is exacerbated by the rapid and dramatic increase in the employee cost of health insurance. According to one major study of employer-paid health insurance, the average cost to employees of family coverage rose by 500 percent between 1980 and 1986. Workers' earnings, however, remained essentially flat or in the case of young families declined in real dollar terms.

As employers increasingly look for ways to reduce their health insurance costs, limitations on (or outright cessation of) dependent contributions grow increasingly popular. Several recent articles in business journals expressly target reduction of dependent coverage contributions as a major component of any employer cost containment strategy and focus on a premium increase for dependent coverage as an express means of saving money. Particularly interested in making such reductions are the medium and large-sized firms that historically have paid most or all of the premium costs for their employees' families. As one benefits director at a large firm recently noted:

> One [cost containment] option would increase the contributions employees pay to cover their spouses and dependents. Raising premiums is not a new idea, but the size of the increase will be . . . Now, dependent coverage costs 10-20-30 percent more in out-of-pocket monthly expenses for employees. In the future, employers may charge the full cost of premiums to employees.

Because the issues underlying children's lack of health insurance are so complex, no one solution will remedy this problem. However, we believe that an important piece of the solution might be to provide support to families that have access to employer insurance but whose incomes are too low to permit them to purchase family coverage. A provision permitting the use of Federal Medicaid funds to subsidize the cost of employer-based health insurance for low-income transitional working families was included in the Family Support Act of 1988. We support measures such as this, whether through Medicaid or through the Federal tax code, that would provide a similar type of assistance to all low-income working families. (It should be kept in mind, however, that as in the case of transitional workers, these families will need supplemental Medicaid benefits for uncovered items and services such as long-term care for chronically ill children or EPSDT benefits.)

We believe there is no reason to assume that direct supplementation of employee health insurance expenses will lead to more employer reductions in family premiums. First, the hemorrhage in the employer-based family contribution system is already well underway. The Chairman's proposal, limited to the lowest paid workers who already are the least likely to have such assistance, will not encourage further erosion. In other words, this bill will assist low-income families who, for the most part, have suffered from a longstanding absence of an employer subsidy. The bill would not, in our opinion, add to an already severe problem.

Second, Section 89 of the Tax Reform Act of 1986 offers significant protection from discrimination against lower-paid employees in the design of health benefit plans, including the use of discriminatory employer contribution levels for employee coverage. If, as suspected, many employers respond to Section 89 by reducing premium contributions across the board rather than raising them for low-paid employees, the tax benefit proposed by the Committee for low-paid employees becomes even more important.

In conclusion, we believe this proposal is a sound one that complements efforts to expand Medicaid and provides another strategy to ensure low-income children and families vitally needed health insurance coverage.

PREPARED STATEMENT OF DONALD W. SCHIFF

Good Morning Senator Bentsen and members of the Senate Finance Committee. I am Don Schiff, M.D., president of the American Academy of Pediatrics. The Academy represents over 38,000 pediatricians dedicated to improving the health of this nation's infants, children and adolescents. I want to thank and commend you for your unswerving commitment on behalf of children.

My testimony today will speak primarily to Part B of the Children's Initiative. The Academy strongly supports this proposal which will allow states to design various approaches to extending health care coverage to uninsured children and their

families. As this committee is well aware, there is no organized child health care financing system in this country. Despite your best efforts and ours, the numbers of uninsured are increasing. 16 million children and adolescents through age 21 have no health insurance coverage. Tens of millions of other children have inadequate insurance, particularly for immunizations, other preventive care and services for children with disabilities. The employer based system of care is quickly eroding; 15 percent more children in this country lost insurance in the last 5 years. Medicaid only covers half of all poor children. Moreover, as this country hotly debates health insurance policies, it is clear the needs of children and pregnant women are not being considered. Proposals which continue to finance services utilized more often by adults and that exclude preventive and prenatal care will only continue current problems. We applaud your legislation which will allow states to test a variety of programs to provide health care coverage to children; which will allow them the flexibility to adapt the programs to the needs of the individual state, yet learn principles which may have national application.

The Academy has spent several months developing a proposal that will assure all children through age 21 and pregnant women access to health care through quality health insurance. Although far from complete, we have learned two main points which are relevant to your legislation.

1. The demonstration projects should allow all children access to a comprehensive range of benefits.

As you know, a crucial shortcoming of our current health insurance system for children is the inadequacy of coverage. Primary care, preventive services, and services for children with special health care needs are either completely uncovered or subject to inappropriate limits.

Children are not just small adults—they differ not only in size, but also in metabolism, immunity, neurologic maturity, digestive ability, emotional maturity and more. Children are constantly growing, developing and changing. They have specific health care needs to enable them to become productive adults. Nevertheless, health insurance plans continue to cover adult needs (hospitalization) and exclude children's needs (preventive services/ambulatory care).

While most American children have been immunized by the time they enter school, there are still millions of others including one third of poor preschool children—who do not receive protection against measles, rubella, mumps, polio, diphtheria, tetanus, and pertussis. Immunizations are not generally covered by private health insurance even though a bipartisan study released by the House Select Committee on Children, Youth and Families—as well as previous reports on the same subject—indicates that immunization programs save $10 for every dollar spent. Preventive care is not generally covered, even though for each dollar spent on screening Texas children for congenital malformations, eye and ear problems and preventive dental care, $8 was saved in long-term costs and income loss.

There is no doubt that health insurance premiums have experienced extraordinary inflation. So rapidly have the premiums increased that employers complain of 20-40 percent or more annual rises. But surely a major cause of the inflation must be traced to the design of the policies themselves, the encouragement of unnecessary acute, largely inpatient hospital services, and the exclusion of office based cognitive procedures and preventive care. An ounce of prevention may not be worth a full pound of cure, but for children the data would indicate it is worth at least a great deal. A number of studies have found that preventive health care has a clear, positive effect on reducing illness and improving children's health.

In addition, all children must have access to a full range of benefits, including emergency care, hospital care, outpatient diagnostic care, medical devices, home health care, medical and social services to evaluate and treat suspected child abuse and neglect, transportation, respite care, mental health services, substance abuse treatments and care coordination for children with special health care needs. These plans must be based on the child's needs.

We have found that access to such care is affordable. Our consultants have estimated on a national level it would cost employers $145 per worker per year to upgrade their current benefits package to that recommended by the Academy for children and pregnant women. This does not include the cost savings from preventive and prenatal care. In addition, we believe appropriately implemented care coordination can help families identify and obtain the full range of necessary services, while preventing overutilization and unnecessary duplication of services.

2. The demonstration projects should be designed to ensure there are no discrepancies between the services for children who access insurance through a privately or publicly administered program.

Despite its promise, Medicaid, the current means of financing health care for the poor, falls far short of serving the needs of this population. We have come to believe the problems with the program are inherent; as long as the program is inextricably based on the welfare system, a two-tiered system of care will be perpetuated. Indeed, we would be interested in a demonstration project which will allow all children access to private health insurance through one of two mechanisms—either through employer-based insurance care or a state administered program. The important point is that the benefits package—amount, duration and scope of services—would be specific and identical for the entire child population. Employers who choose to offer a qualified benefits package to dependents might receive a tax credit. Those who do not could pay a tax which would help fund the state administered plan. In addition, current Medicaid dollars and other revenue sources would help finance the state plan.

The objective of such an approach would be to minimize, if not totally eliminate, the link between Medicaid and the welfare system and to ensure all children access to a full range of benefits.

In addition, the demonstration projects need to be carefully evaluated to discern lessons for future national application.

Obviously there are number of other issues which the demonstration projects can address. As we all know, there are a number of barriers to children receiving care, including impaired accessibility of services, liability, and inadequate public information, to name a few. Clearly reimbursement and administrative issues continue to plague the system. We would recommend the demonstration projects experiment with a variety of ways to eliminate all barriers to children receiving care. The Academy has designated ensuring access to quality health care for all children through age 21 and pregnant women as its main priority for the next several years. We look forward to working closely with your and your committee to meet that goal.

PART A—DEPENDENT TAX CREDIT

In addition, I would like to make some comment regarding part A—Proposed Change in the Dependent Care Tax Credit.

There is every indication that the dramatic increase in the workforce of mothers with children under the age of three will continue unabated throughout the next decade. Infants and children of working parents need alternative care in a safe, secure environment with competent, trained caregivers. Out of home care should be available and affordable for working parents at all income levels. Child care in this country is a patchwork of services that varies greatly from state to state, county to county and even neighborhood to neighborhood. There is no infrastructure on which to build a system of affordable, high quality care, with a cadre of well trained providers. Working families need child care policies that accomplish the following:

- Develop an infrastructure for a child care system;
- Ensure quality through the implementation of minimum standards;
- Provide training for caregivers;
- Strengthen licensing and enforcement procedures; and
- Make care affordable.

The Academy of Pediatrics strongly supports the Act for Better Child Care Services because of the improvements it makes to the child care system. This bill will enhance the quality of care available to all families and give them direct help in paying for care.

Families can also benefit from income support through the tax code. Expansions of the dependent care tax credit and the earned income tax credit can put desperately needed dollars into the hands of families to defray child care expenses. However, it still leaves unanswered the serious questions of quality, supply and affordability.

Child care must be a two pronged approach of income supplementation through changes in the tax code and infrastructure support and development.

The Academy urges the committee to recognize this dual purpose as you consider child care legislation.

PREPARED STATEMENT OF CHARLES W. SHEWBRIDGE, III

Good morning, Mr. Chairman. I am Charles Shewbridge, Assistant Vice President of Taxes for Bellsouth Corporation, a worldwide provider of telecommunications and business services. I speak today on behalf of the United States Telephone Association, whose 1,100 member companies serve 99 percent of the nation's telephone

access lines. USTA members range in size from small independent local exchange companies to the large Regional Holding Companies.

I am here to express USTA's opposition to the telephone excise tax, which the Administration proposes in its 1990 budget be made permanent. The tax, last extended for three years beginning in 1988, is imposed at a rate of three percent on local and long-distance telephone service and on teletypewriter exchange service.

First of all, I would note that the local exchange industry appreciates the difficulty Congress faces in trying to reduce the budget deficit. We understand that everyone is expected to bear their fair share of the burden, but the resulting fair share cannot be achieved through a tax that by its very nature is unfair. Accordingly, on behalf of our customers, we must strenuously object to this proposal. We take this opportunity to express our hope that the Congress will allow the tax to expire as scheduled.

Our opposition to the tax and to the Administration's proposal is based on two considerations.

First, we agree with the position of the previous Administration, which in an August 1987 Treasury Department study [1] recommended that the telephone excise tax be permitted to expire. The Treasury Department had three criteria for imposing an excise tax, all of which the telephone excise tax fails to meet. Moreover, the Joint Tax Committee, in a 1987 report of possible revenue alternatives,[2] agreed that there was no rationale for imposing the telephone excise tax, that the tax is regressive and that expiration of the tax would help to offset increases in the telephone subscriber line charge.

Second, it is a regressive tax and, unlike water, gas and electric service, telephone service is the only household necessity subject to a Federal excise tax burden.

THE TAX HAS NO RATIONAL BASIS

In the past, the Treasury Department has employed three criteria to justify an excise tax. Under the first criterion, "external social cost," the tax represents a reimbursement to society for the external costs associated with the product or service taxed. For example, tax receipts on cigarettes might be used for cancer research. While child care is vitally important, there is no external social cost associated with telephone service and child care.

Under the second criterion, the tax may represent a "user fee," which is imposed on a government-provided service or product, such as the entrance fee to a national park. Telephone service obviously is not provided by the government.

Under the third criterion, the tax may be characterized as a "nondistortive consumption tax," imposed on a product or service that is price-inelastic, that is, unresponsive to price changes. The telephone tax and the associated administrative costs off collecting the tax result in higher rates to customers. Unlike consumers of "luxury items," consumers of telephone service respond very predictably to price increases by reducing their usage. This phenomenon has been demonstrated frequently in regulatory proceedings throughout the country.

Clearly, none of the three criterion described above fit the telephone excise tax.

THE TAX IS REGRESSIVE

The telephone excise tax is particularly unfair to consumers in that:

1. It is regressive; it falls more heavily on low-income families. A telephone is not a "luxury" item and should not be taxed as one.
2. It is imposed on a service that is a necessity of modern life.
3. Among the four basic household utilities electricity, gas, water and telephone—only telephone service is subject to Federal excise tax.

For almost three decades Congress has recognized that the telephone excise tax is not desirable as a permanent part of the tax structure. Congress has been trying to eliminate this tax since 1959. Nevertheless, since 1965, the tax has been extended seven times—each time as a "temporary revenue raising measure." It is time to stop this cycle and allow this regressive tax to expire.

Thank you for allowing me the opportunity to express our views.

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[1] Report to the Congress on Communication Services Not Subject to Federal Excise Tax, Office of the Tax Analysis, U.S. Department of Treasury, August 1987

[2] Joint Committee on Taxation, "Description of Possible Positions to Increase Revenues" (JCS-17-87), June 25, 1987.

PREPARED STATEMENT OF ROBERT H. SWEENEY

Mr. Chairman and members of the committee, I am Robert H. Sweeney, President of NACHRI—the National Association of Children's Hospitals and Related Institutions. We appreciate greatly the opportunity to comment on proposed child health initiatives under consideration by the Committee, including the establishment of a Federal tax credit for purchase of health insurance for children under age 19.

NACHRI is the only national, voluntary association of children's hospitals. It represents 100 institutions in the United States and Canada. They have missions of serving children who are very sick, children who have special health care needs, and children whose families often have very low incomes. Virtually all of NACHRI's members are teaching hospitals, involved in conducting research. Most are regional medical centers receiving referrals from larger geographic regions in the United States and from around the world.

In my testimony this morning, I would like to make three points:

- First, at a time of growing national interest in securing much needed improvements in children's access to health care, it is critical that reforms of the health care system build a joint, public-private partnership. We must reinforce access to private insurance coverage while expanding public funding for those who otherwise would be unable to afford needed health care services.
- Second, we have been impressed by the strong commitment of several Members of the Senate and this Committee to develop legislation that would address the need for Medicaid reform for pregnant women, infants, and children. We are particularly encouraged by the package of draft proposals under consideration by Senator Bentsen, which would bring together improvements in Title XIX, Title V, and tax law to respond to the health care needs of poor and near-poor children.
- Third, we believe that the proposed establishment of a child health insurance tax credit should be assessed specifically in the context of the significant Medicaid reforms that Senator Bentsen and other members of the Committee are developing. Such a perspective suggests the need to consider ways to achieve the best fit between Medicaid expansions to cover children of near poor-families and health care tax credits for many of the same families.

PUBLIC-PRIVATE PARTNERSHIP

Health coverage in the United States is a complex system of public and private insurance. Children's hospitals are especially well positioned to appreciate the complexities of that system. On average, a children's hospital devotes more than a quarter of its care to patients under Medicaid, and more than a third of its care to low income patients, including those with Medicaid coverage. Although the availability of Medicaid provides access to health care to these patients, it impacts the hospitals' ability to care for other patients with no resources, public or private, and the charges for care met by private insurers. These unfortunate consequences result from the fact that on average children's hospitals currently receive only 75 cents for each dollar spent to care for a child under Medicaid. The remainder of the cost must be sought from other payers, and results in a restricted ability to expand care to unresourced children.

Because of this experience, children's hospitals recognize that changes in either the public programs or private health coverage available to the American public can have significant implications for the other side of the equation. That is why, during the past year, we consistently have encouraged the development of health care reforms on behalf of children which strengthen public coverage to guarantee access to care, yet do not result in further erosion of private coverage, particularly among children. According to the Congressional Research Service's analyses, declines in employer-paid, dependent coverage are a major factor in the growing numbers of uninsured Americans, including children.

CHILD HEALTH CARE FINANCING REFORM LEGISLATION

During the past few months, several Senators have introduced important legislation to reform Medicaid coverage for pregnant women and children. NACHRI has endorsed Senator Bradley's S. 339, the "Infant Mortality and Children's Health Act of 1989;" Senator Riegle's S. 949, the "Medicaid Children's Health Improvement Act of 1989;" and Senator Biden's S. 440, the "Health Care for Children Act."

These bills, in different and often complementary ways, seek to reduce four major deficiencies in Medicaid's ability to ensure access to health care. They propose to expand *eligibility*, simplify the *enrollment* of eligible individuals, broaden *covered*

services, and improve *reimbursement* for services. We believe attention to all four is essential to effective Medicaid reform.

NACHRI has been privileged to have the opportunity to discuss and review with the health policy staff of the Senate Finance Committee draft proposals for the reform of Title XIX, Medicaid for pregnant women and children; the reauthorization of Title V, the Maternal and Child Health Services Block Grants; and the establishment of a child health insurance tax credit. We understand that consideration is being given to the introduction of these proposals as a package of child health reforms.

As do the bills by Senators Bradley, Riegle, Biden, and others, these draft proposals take significant steps toward reducing each of the four deficiencies which limit access to care under Medicaid. The draft Title V reauthorization speaks to the need for both an increased investment in MCH services and improved accountability for the use of these funds. As providers of care to children with special health care needs, children's hospitals are especially encouraged by the commitment made to such children. A strengthened Title V must go hand in hand with an improved Title XIX—together they represent coverage for children of poor families for services they need and improvement in the availability of these services.

In two ways, the draft proposals go further than do these other bills which we support. First, the draft Title XIX and Title V proposals include significant new reporting requirements that would enable the Congress and the public to assess the annual status of children's health, their financial access to health care, their utilization of services, and the cost of those services. They would direct the administration to define medically-at-risk women and children and to develop model benefits packages for their protection. These kinds of reporting requirements represent a commitment not only to make significant incremental improvements in child health coverage today, but they also lay the foundation for more substantial evaluations of children's health and health care access tomorrow.

The second significant feature of these draft proposals is that they provide for the committee's consideration initiatives to enhance both public and private coverage, and provide the opportunity for their integration. By targeting a child health insurance tax credit to near-poor families—families with incomes from roughly 100 to 200 percent of the Federal poverty level— the committee is demonstrating its commitment to crafting a coordinated public-private initiative to provide health care access for all children. We applaud that commitment, for it is our sense that, in these fiscally constrained times, this is the only way progress on the needs of children will be made.

MEDICAID PERSPECTIVE ON THE TAX CREDIT

Senator Bentsen and the Committee have under consideration a proposal to establish a new Federal tax credit equal to 50 percent of qualified expenditures up to $1,000 for a family's purchase of health insurance, to protect its children, when family income is less than $12,000. On a sliding scale, the credit would decrease as family income rises above $12,000. Families with incomes above $21,000 would be ineligible for the tax credit. It is our understanding this tax credit would be refundable, so that the qualifying family would receive the funds regardless of tax liability.

The key test for such a credit is whether it will persuade families to purchase health insurance coverage for their children, which they otherwise would not do without a financial incentive. NACHRI does not claim the expertise to project such behavior. We believe, however, that it is important to consider the interaction between the tax credit and the Medicaid improvements under consideration. In summary these proposals are as follows:

The Administration has proposed mandating Medicaid eligibility for pregnant women and infants up to 130 percent of the Federal poverty level—about $12,260 for a family of three and $15,720 for a family of four. Several bills pending before Congress would mandate eligibility for pregnant women and infants with family incomes up to 185 percent of the Federal poverty level—about $17,450 for a family of three and $22,380 for a family of four. Senator Bentsen has under consideration a proposal to mandate coverage of children under age 6 with incomes up to 185 percent of poverty.

Obviously, many of these families are the same families who potentially could benefit from the tax credit for child health insurance. A clear distinction is indicated to specify which of these available coverages will be primary, so as to avoid duplicate coverage, one financed by Federal and state funding; the other in part by a tax credit, in part by the families themselves.

Further complicating the interaction of the Medicaid improvements and the tax credit is the scope of coverage of the Medicaid improvements.

These improvements address those health care needs of the woman relating to pregnancy and childbirth only. And they speak to the health care needs of children to age one, or possibly to age 6.

Yet in many states for these covered services, Medicaid provides a scope of services not typically included in private health insurance, and therefore could be the preferred coverage for persons covered in the Medicaid proposals.

It is our recommendation that there be an integration of the proposed tax credit and the Medicaid proposals, as follows:

(1) Private insurance be considered the primary payer.

(2) For women and children also eligible for Medicaid, states be authorized to employ Medicaid, similarly to "Medigap" plans for Medicare, to wrap around the private insurance and meet co-payments, deductibles, and excess amounts owed beyond coverage maximums after application of private insurance benefits.

(3) Medicaid be used to assist families with incomes up to the Medicaid eligibility limit to meet the cost of insurance premiums not met by the tax credit.

We believe that this integration will be cost effective to both Federal and state governments. It will remove the natural incentive to the low income person, in order to avoid the cost of the insurance premium remaining after the tax credit, electing Medicaid coverage instead, with only partial health needs protection.

Rather, by encouraging private insurance, it will result in the movement of many routine health care expenditures to the private insurance side of the ledger which, absent to use of the tax credit, would be met by Medicaid.

This effort could be strengthened further by an appropriate amendment to the tax code requiring that, for tax deduction purposes, employers providing health insurance benefits to employees must *offer (but not be required to pay for)* such coverage for dependents.

We believe that consideration of such integration of tax credits and Medicaid reform is essential if the objective is to build a solid public-private partnership in providing health coverage for all children.

Before closing, I also would like to suggest a modification of the proposed child health demonstration grants. In addition to making funding available for alternative models of basic health care coverage, grants also should be available for qualifying organizations to sponsor conventional family coverage, including inpatient and outpatient hospital services.

CONCLUSION

In conclusion, I would express our great appreciation for the leadership of Senator Bentsen and the members of this Committee during the past year. You have called attention to this nation's need to face up to its responsibility to guarantee access to health care for all our children. We are eager to be of assistance in any way in your efforts to achieve significant improvements in health care access for both poor and near poor children.

PREPARED STATEMENT OF LAWRENCE J. WHITE

Mr. Chairman, Members of the Committee: I am pleased to be here this morning, and I thank you for the opportunity to testify on behalf of the Federal Home Loan Bank Board ("Bank Board") and the Federal Savings and Loan Insurance Corporation ("FSLIC") regarding the effect of the proposed repeal of the special thrift tax rules on mutual thrift conversions.

As you know, last month the House Ways and Means Committee approved provisions repealing special tax rules relating to supervisory assistance and mergers and acquisitions of financial institutions. The repeal provisions have been attached to H.R. 1278, the Financial Institutions Reform, Recovery and Enforcement Act of 1989 (FIRREA). We understand that this Committee plans to take similar action to repeal these provisions during a markup of the child care and child health care initiative scheduled for tomorrow. The Bank Board supports repeal of these special tax provisions as they apply to assisted transactions because this type of indirect assistance through the tax code is no longer necessary now that direct assistance will be provided in FIRREA to help the FSLIC fulfill its statutory mandate of protecting the safety of almost a trillion dollars of federally insured deposits. However, the repeal of these provisions will also adversely affect two classes of voluntary supervisory conversions that do not involve direct FSLIC assistance.

Voluntary supervisory conversions are transactions in which an insolvent or near insolvent mutual thrift institution and a potential acquirer reach an agreement on the acquisition of the thrift. These transactions involve no FSLIC assistance and provide an infusion of capital by the acquirer into the troubled thrift. In the transaction, the thrift is declared insolvent by the Bank Board and is converted to a stock institution, and the stock is then acquired under the acquisition agreement.

Traditionally, these transactions have been completed under the special tax rules allowing for tax-free reorganizations of troubled financial institutions [sec. 368(a)(3)(D)]. The repeal of the rules would create uncertainty about tax treatment and make it more likely that these insolvent institutions would end up in the pool of assisted transactions that would be more costly to the government. Under the old rules, there is no assistance, the institutions are recapitalized, and they become future taxpayers. These transactions should be allowed to continue because they bring in fresh capital to the industry e.g. $5 billion since 1985—and do not raise the "double dipping" concern expressed by members of Congress. Report language expressing this intent would allow the Internal Revenue Service to adapt the regulations to accommodate these transactions.

There are two primary groups of thrifts that are caught in this predicament. The first group, which is relatively small, is composed of thrifts that had voluntary supervisory conversions in process on May 10, 1989, and had filed an application for approval with the Bank Board prior to that date. At this time, the House bill contains no transition rule that would grandfather these conversions. There are approximately eleven thrifts in this situation. A transition rule is needed for these thrifts since their conversions were negotiated in reliance on the provisions in effect at the time without any forewarning that these provisions would be repealed effective May 10, 1989.

The second group of thrifts consists of mutual thrifts that are currently marginally insolvent or that will become marginally insolvent under the regulatory capital requirements of FIRREA. After the legislation passes and regulatory capital requirements are raised, these thrifts must raise substantial new capital. Repeal of the "G" reorganization provisions for these thrifts by the same legislation will make it more difficult to raise capital without assistance from the depository insurance fund.

These thrifts will be at a disadvantage relative to stock associations or healthy mutual associations in the tax result of their infusions of capital. A healthy mutual association can meet the requirements for an "F" reorganization, thereby retaining their tax attributes. A stock association can do a stock offering that would bypass the reorganization rules and thereby retain its tax attributes. (Both the stock association and the healthy mutual will be subject to the limitations under IRC section 382). However, a marginally insolvent mutual association may lose its tax attributes altogether in an attempt to raise capital.

One solution to this inequitable tax result would be to retain the special "G" reorganization rules in cases where no government assistance is given. Another solution would be to clarify that such thrifts may set up liquidation accounts based on the franchise value of the association so that the continuity of interest requirements could be met, thereby allowing the conversion to qualify for "F" reorganization treatment.

It may appear that the preservation of these rules, though it would avoid the use of FSLIC funds, would simply substitute other government funds through reduced tax receipts. We believe that this view overlooks the realistic alternative to continuing the rules: These thrifts would likely sink further into insolvency, would stagnate and deteriorate in the FSLIC or FDIC case load while higher priority cases are resolved, and would eventually require much larger expenditures of government funds than the foregone tax receipts. We believe that continuing the rules truly would be an instance of the Federal government's using an "ounce of prevention" (reduced tax receipts) now to avoid a "pound of cure" (larger resolution expenditures) later.

If it is not possible to secure clear authority for future voluntary supervisory conversions, we ask for coverage under the pre-May 10 rules of those transactions that were already under way on May 10, 1989. Substantial effort and funds were expended by the thrifts and the acquirers prior to their filings of the applications for voluntary supervisory conversions. These agreements were negotiated and applications filed in reliance on the rules then in place. A list of transactions in process on or before May 10 has been provided to the Finance Committee and Joint Committee on Taxation staffs.

Thank you, Mr. Chairman. I would be happy to respond to any questions the Committee may have.

COMMUNICATIONS

CRS ISSUE BRIEF—MEDICAID: FY 90 BUDGET AND CHILD HEALTH INITIATIVES, UPDATED JUNE 14, 1989

[By Mark Merlis, Education and Public Welfare Division]

ISSUE DEFINITION

Medicaid is a Federal-State matching program providing medical assistance to a projected 25 million low income persons in FY89, at a total Federal cost of $34.5 billion. The FY90 budget resolution approved by the Congress provides a $200 million increase in Federal Medicaid funding over current law levels, and permits further expansions if offsetting savings can be found in other programs. There are a variety of proposals to use the additional funds to extend Medicaid eligibility to larger numbers of pregnant women and children and to take other measures to improve access to prenatal and early childhood health care.

BACKGROUND AND ANALYSIS

DESCRIPTION OF MEDICAID

Medicaid, authorized by Title XIX of the Social Security Act, is a Federal-State matching program providing medical assistance to a projected 25 million low income persons in FY89. FY90 program expenditures under current law are expected to reach $67 billion, of which the Federal share will be $38 billion. Although Federal funds account for 56% of total program expenditures, each State designs and administers its own Medicaid program, setting eligibility and coverage standards within broad Federal guidelines. Thus, there is considerable variation among the States in terms of eligibility requirements, range of services offered, limitations placed on those services, and reimbursement policies.

Every State except Arizona participates in the Medicaid program, as do the District of Columbia, American Samoa, Guam, Puerto Rico, the Virgin Islands, and the Northern Mariana Islands. (Arizona currently provides federally funded medical assistance through a demonstration program that has received waivers of certain Medicaid requirements.) At the State level, Medicaid is administered by a designated single State agency. Federal oversight of the Medicaid program is the responsibility of the Health Care Financing Administration (HCFA) within DHHS. HCFA also administers the Federal Medicare program for the aged and disabled.

The Federal share of expenditures for Medicaid services is tied to a formula inversely related to the square of a State's per capita income. For FY89, the Federal matching percentages range from 50% to 79.8%. The matching rate for administrative costs is generally 50% for all States. Higher matching, at levels ranging from 75% to 90%, is available for certain management and control activities. The remaining costs of the program are paid by the State; in some States local governments may also contribute.

Eligibility

Eligibility for Medicaid benefits has traditionally been linked to actual or potential receipt of cash assistance under either of two programs: Aid to Families with Dependent Children (AFDC), and Supplemental Security Income (SSI) for the aged, blind, and disabled. Recently States have been given the option to extend Medicaid to other low-income groups. Coverage of some of these new populations was made mandatory by legislation enacted in 1988.

All States must cover the **categorically needy.** These include all persons receiving AFDC and, in most States, persons receiving SSI. States have the option of limiting Medicaid coverage of SSI beneficiaries by using more restrictive standards for Med-

icaid, if those standards were in effect on Jan. 1, 1972 (before implementation of SSI). Fourteen States continue to use more restrictive standards. States must also cover as categorically needy a number of groups that are not receiving AFDC or SSI. The following are among the more important of these groups:

—Certain persons whose family income and resources are below AFDC standards but who fail to qualify for AFDC for other reasons, such as family structure. These include pregnant women, as well as children born on or after Oct. 1, 1983, to age 7.
—Families losing AFDC benefits as a result of increased employment income or working hours or increased child or spousal support payments. States must continue coverage for these families for various periods, depending on the reason for the loss of AFDC benefits.
—Persons who have been receiving both Social Security and SSI benefits and who become ineligible for SSI because of increases in their Social Security payments.
—Certain disabled people who lose SSI after returning to work but who remain disabled and who could not continue working if their Medicaid benefits were terminated.

In addition to the mandatory groups, there are several optional groups that States may elect to treat as categorically needy for Medicaid purposes. These include families with unemployed parents and "Ribicoff children" in families with income below AFDC standards; these are children whom the State is not required to cover but who are under a maximum age set by the State, which may be 18, 19, 20, or 21. States may also cover persons in institutions who meet a special institutional financial standard set by the State; this standard may not exceed 300% of the SSI payment level. Finally, States may cover disabled children who are not in an institution but who would be eligible if they were in an institution.

Thirty-nine States and other jurisdictions also provide Medicaid to the **medically needy**. These are persons whose income or resources exceed the standards for the cash assistance programs but who meet a separate medically needy financial standard established by the State and also meet the non-financial standards for categorical eligibility (such as age, disability, or being a member of a family with dependent children). The separate medically needy income standard may not exceed 133.3% of the maximum AFDC payment for a household of similar size. Persons may qualify as medically needy after their incurred medical expenses are deducted from their income or resources. This process is known as "spenddown." It is a frequent route to Medicaid eligibility for persons in nursing facilities.

Finally, beginning with the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509), Congress has permitted States to extend Medicaid coverage to certain **target populations**, using eligibility standards which are not directly linked to those used in the cash assistance programs. The Act allowed States the option of covering pregnant women and young children and/or aged and disabled persons meeting State-established income standards as high as 100% of the Federal poverty level.

The Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) converted the options to mandates for several of the target groups. States must phase in coverage of pregnant women, infants under 1 year old, and aged and disabled persons eligible for Medicare with family incomes below 100% of poverty. Lower mandatory income thresholds will be in effect during a transitional period for each group. For pregnant women and infants, States must reach full coverage by July 1, 1990. The transition period for the aged and disabled ends Jan. 1, 1992, or Jan. 1, 1993, in 209(b) States. Coverage for the aged and disabled may be restricted to Medicare premiums and cost-sharing amounts and prescription drugs up to the new Medicare drug deductible. States may still choose to extend coverage to these groups faster than the timetable requires. They may also choose to cover older children with family incomes below 100% of poverty. This option is being phased in on a timetable that ends Oct. 1, 1990, at which time States will be able to cover children through age 7.

Finally, the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) further expanded States' options by allowing coverage, beginning July 1, 1988, of pregnant women and children up to age 1 with incomes less than 185% of the Federal poverty level. The State may impose a premium for this coverage, equal to no more than 10% of the amount by which the family's income exceeds 150% of the poverty level.

Services

All States must cover a minimum set of services under Medicaid and may at their option offer additional services. The minimum service requirements differ for the categorically needy and the medically needy. For the categorically needy, the State must provide inpatient and outpatient hospital services, physician services, laborato-

ry and x-ray, family planning, skilled nursing facility (SNF) services for those over age 21, and home health care for persons entitled to SNF care. The State must also provide early and periodic screening, diagnosis, and treatment (EPSDT), a preventive health program for persons under 21. If the State covers the medically needy it most provide, at a minimum, ambulatory care for children and prenatal and delivery services for pregnant women. States may limit coverage for the mandatory services in a variety of ways. They may impose ceilings on the number of inpatient days or physician visits that will be reimbursed, require prior authorization or second surgical opinions, and deny coverage for services deemed to be experimental.

Among the additional services that States may choose to provide are prescription drugs, dental care (some dental coverage is mandatory for children under EPSDT), eyeglasses, and care in inpatient psychiatric facilities for persons under 21 or over 65. In terms of overall expenditures, the most important optional Medicaid service is care in intermediate care facilities (ICFs). All of the States and the District of Columbia cover ICF services, and every State except Wyoming also covers services in an ICF for the mentally retarded, or ICF-MR.

Whatever services the State chooses to cover, it must offer them uniformly throughout the State and must, with minor exceptions, offer comparable coverage to all persons in the categorically needy groups. Finally, beneficiaries must generally be allowed to obtain services from any qualified provider. All three of these requirements—statewideness, comparability, and freedom of choice—may be waived under circumstances to be described below.

Payment for Services

States are generally free to develop their own reimbursement methodologies and levels for covered services. Specific payment rules or limits are established by law only for three types of service: rural health clinics, hospices, and laboratories. There are general guidelines for certain other services, but only two rules applying to every service type. First, providers must accept Medicaid payment as payment in full and may not seek to collect from beneficiaries. Second, Medicaid pays only after any other insurance or third party payment source available to the beneficiary has been exhausted. In particular, when beneficiaries are eligible for both Medicaid and Medicare, Medicare pays first for the services it covers. Medicaid pays what would ordinarily be the beneficiary's share (deductible or coinsurance) and covers services not available under Medicare.

For institutional services, including hospital inpatient and nursing home care, payment rates must be "reasonable and adequate" to meet the costs of "efficiently and economically operated" facilities. For hospital inpatient care the rates must also be sufficient to assure reasonable access to services and must include adjustments for hospitals serving a high proportion of low-income patients. States use two basic payment methodologies for institutional care: retrospective and prospective. In a retrospective system, payment amounts are determined after services are rendered and are based on the actual costs incurred by the provider in furnishing those services. In a fully prospective system, payment amounts are determined in advance. The provider receives a specified rate for each defined unit of service, such as a day of care or a total hospital stay, regardless of whether the provider's actual costs are more or less than that rate. States are increasingly shifting towards prospective systems for both hospital and nursing facility care.

For services of physicians or other individual practitioners, payment amounts are usually the lesser of the provider's actual charge for the service and a maximum allowable charge established by the State. In setting these maximums, some States use methods comparable to those used by Medicare in establishing reasonable charges for physician services. Other States have developed fixed fee schedules, specifying a flat maximum payment amount for each type of service; the maximum may be unrelated to actual provider charges.

Alternative Delivery Systems

States are permitted to develop alternative ways of providing Medicaid benefits, through a variety of structured systems. Use of some of these alternatives is wholly at the State's option; others require waivers of Federal requirements approved by the Secretary.

First, States may contract with health maintenance organizations (HMOs), or other prepaid health plans for the enrollment of Medicaid beneficiaries. For each beneficiary enrolled in a plan, the State issues a fixed monthly premium payment, out of which the plan provides all covered services.

Second, States may obtain waivers of freedom of choice and other requirements to restrict the providers from whom beneficiaries may obtain services. Some States have used this option, established by Section 2175 of the Omnibus Budget Reconcili-

ation Act of 1981 (P.L. 97-35, OBRA81), to enter into selective contracting arrangements. The State may, for example, choose participating hospitals through a system of competitive negotiation. The more common use of the 2175 waiver authority is to establish primary care case management programs. Beneficiaries are required to select a single primary care provider. Except in an emergency, care from other providers must be authorized by the primary care physician.

Finally, States may obtain waivers, authorized by Section 2176 of OBRA81, to provide home and community-based services to persons who would otherwise require continuing care in hospitals or nursing homes. The waivers allow the State to design a comprehensive package of medical and social services to allow a target population, such as the frail elderly or the mentally retarded, to remain in the community.

FY90 Budget

Each of the last four budget reconciliation acts has provided for expansions of the Medicaid program, chiefly by providing for optional or mandatory coverage of additional groups of women and children. Partly as a result of these expansions, Medicaid expenditures have recently been growing more rapidly than anticipated. In its FY88 budget, the Administration projected that Federal outlays would grow from $25 billion in FY86 to $28.2 billion in N88, for a 2-year growth rate of about 13%. Instead, FY88 outlays rose to $30.4 billion, nearly 22% above the FY86 level. The Administration's original FY89 projections assumed further growth, under current policy, of 6.5%. However, current projections are that FY89 Federal expenditures will reach $34.3 billion, 12.8% above the FY88 level.

Medicaid expenditures under current law are expected to continue to rise faster than medical care inflation, largely as a result of further program expansions that will take effect over the next several years. These include the phased extensions of coverage in the Medicare Catastrophic Coverage Act and the Family Support Act of 1988. State costs for nursing home care are also expected to rise in response to new quality of care mandates included in the Omnibus Budget Reconciliation Act of 1987.

President Reagan's FY90 budget included legislative and regulatory proposals intended to reduce Federal Medicaid outlays from a projected $37.6 billion to $36.0 billion. President Bush's revised proposal, presented to Congress on Feb. 9, 1989, retained only one of the proposed legislative changes, a reduction in Federal funds for State administrative costs. Savings would have been used to finance the Federal share of costs for expanded services to pregnant women and children. The net effect of this proposal was to maintain FY90 Federal spending at current law levels, with costs for Medicaid eligibility and service expansions to be borne by the States.

The Bipartisan Budget Agreement accepted by the President and congressional leadership in April 1989 provided for FY90 Medicaid funding at current law levels. As passed by the House, H. Con. Res. 106, the FY90 budget resolution, provided for a $200 million increase over current law levels. This would be used to fund new initiatives in the area of infant mortality and child health, expanded community services for the frail elderly and the mentally retarded, as well as to make coverage of hospice services mandatory. As amended by the Senate, the budget resolution provided for Medicaid funding at current law levels, with any program expansions to be funded through offsetting savings in Medicaid or other programs. The conference agreement follows the House provision, allowing a $200 million increase for program expansion. It also permits further expansion if the committees of jurisdiction can achieve offsetting savings in other programs.

MATERNAL AND CHILD HEALTH INITIATIVES

The last three Congresses have gradually expanded both mandatory and optional Medicaid coverage for pregnant women and children. At least two major factors have contributed to congressional interest in Medicaid expansion. The first is growing concern over the incidence of infant mortality and other unfavorable outcomes of pregnancy. The United States had an infant mortality rate in 1986 of 10.4 deaths per thousand live births, higher than that of many other major industrial nations. Rates are higher for minorities and residents of inner cities. Beyond the children who die, there are many more low birth-weight infants and others with preventable problems that are costly to treat and that can result in lifelong disabilities. There is evidence that access to prenatal and well baby care is an important factor in these outcomes.

A second source of interest in Medicaid expansion has been the growth in the number of Americans without health insurance coverage. The proportion of the population without insurance has been going up in this decade, from about 14.6% of the

non-elderly in 1979 to 17.5% in 1986. In that year, 37 million persons lacked coverage; of these 12 million were children under age 18. More than half of these children were in families with incomes below the Federal poverty level. In 1987, Medicaid covered only 53% of children in poverty. Many poor children were excluded because Medicaid maximum income standards in most States were well below the poverty level, while others were excluded on categorical grounds, such as restrictions on enrollment of two-parent families with an employed parent. Recent changes in Medicaid eligibility standards, both financial and categorical, are often spoken of as having severed the traditional link between Medicaid and the welfare programs. These changes are only beginning to be implemented, and their impact cannot yet be measured. However, they are expected to reach only a fraction of uninsured children.

The 101st Congress is considering a variety of proposals for further expansion of Medicaid eligibility for pregnant women and children and for initiatives to address other factors in access to care, such as availability of health care providers and coordination of services. The Bush Administration proposal to finance expanded coverage through a reduction in Federal matching for administrative costs has been introduced as H.R. 2216/S. 902. Other congressional proposals include broader expansions, affecting other Federal programs as well as Medicaid.

Further expansion of the Medicaid program could take the form either of new mandates, coverage requirements that all States would have to meet, or of new options, additional populations or services that a State could offer at its discretion. The expansions in recent years have been enacted in a stepwise fashion: a new option established by one year's budget legislation is made mandatory in a later year, at the same time that still more options are offered. Many of the proposals in this Congress follow the same pattern, adding new options while mandating State adoption of options established by the 100th Congress. This approach is facing increasing opposition from State governments. Although many States initially supported the flexibility provided by new coverage options, they object to the conversion of these options into mandates at a time when some of which are currently facing revenue shortfalls.

Eligibility for Pregnant Women and Children

Proposals in the 101st Congress would raise the optional or mandatory maximum income standards for pregnant women and children and would also address other potential barriers to Medicaid coverage for these groups, such as limits on allowable assets, delays in the application and eligibility determination process, and discontinuous eligibility.

Income Standards

Pregnant women and infants. Under current law, States must cover pregnant women and infants under 1 year old with family incomes up to 75% of the Federal poverty level by July 1, 1989, and up to 100% of the Federal poverty level by July 1, 1990. States may, at their option, establish a higher maximum income standard for pregnant women and infants, up to 185% of the Federal poverty level. As of January 1989, 12 States had adopted standards above 100% of the poverty level. H.R. 800/S. 339 would phase in mandatory coverage of pregnant women and infants up to 185% of the poverty level by July 1, 1993. H.R. 1573 would phase in mandatory coverage up to 200% of the poverty level over the same period, and would permit States to raise their standards to 200% of poverty beginning in July 1990. H.R. 2216/S. 902, the Administration proposal, would mandate coverage up to 130% of the poverty level by April 1990; it would remove the requirement that income standards reach 75% of the poverty level by July 1989.

Children over 1 year old. States have the option of providing Medicaid to children aged 1 through 7 who were born after Sept. 30, 1983, and whose family incomes meet a State-established standard no higher than 100% of the Federal poverty level. H.R. 833/S. 339 would mandate coverage of children under age 18 and born alter Sept. 30, 1983, with incomes up to 100% of the poverty level. H.R. 1573 would mandate coverage of 1 through 7 year olds with incomes below 100% of 1 through 5 year olds by Oct. 1, 1992. S. 440 would phase in mandatory coverage up to 100% of poverty through age 18 by FY94. Under each of these proposals, States would have the option of accelerating coverage (covering older children or setting higher income standards before the deadlines for mandatory coverage). S. 949 would leave coverage optional, but would allow States to cover 8 year olds and would raise the maximum permissible income standard for 1 through 8 year olds to 185% of the Federal poverty level. S. 949 would also allow States to cover foster children and children in group homes through age 20 with incomes below 100% of the poverty level.

General expansion. Several other bills include expansions of Medicaid eligibility for all low-income persons, rather than just mothers and children. H.R. 1845, which would mandate that employers provide health benefits to their employees, also expands Medicaid to cover persons not eligible for an employer plan. States would have to cover all persons with incomes below the Federal poverty level by Jan. 1, 1991, all those below 185% of the poverty level by Jan. 1, 1996, and all persons not otherwise insured by Jan. 1, 1999; States could charge an income based premium to enrollees above the poverty level. (The companion bill in the Senate, S. 768, imposes the same timetable but does not refer to the health plan to be offered by the State as "Medicaid." However, it provides for Federal matching payments to each State's program using the current Medicaid formula.) H.R. 950, a general rural health care bill, includes a requirement that State Medicaid programs cover all persons with incomes below 100% of the Federal poverty level by Jan. 1, 1991.

Other Eligibility Standards

In establishing Medicaid eligibility for pregnant women and children, a State must determine income using the same methodology used in the State's AFDC program. States have the option of applying a resource standard (a limit on allowable family assets), but are not required to do so. H.R. 800, H.R. 833, H.R. 1573, and S. 339 would allow States to use an income determination methodology less restrictive than that for AFDC. All of these bills, along with S. 440, would forbid the use of a resource standard for mandatory coverage groups of pregnant women and children. Under H.R. 1573 and S. 440, States could continue to apply a resource standard for optional coverage groups.

H.R. 800/S. 339 and S. 949 would temporarily exempt State determinations of eligibility for pregnant women and children from the Medicaid Quality Control system, under which States may suffer Federal financial penalties for excessive errors in eligibility determination. H.R 800 would also exempt pregnant women from the current requirement that they cooperate with the State in establishing paternity and securing support payments for their children.

Presumptive Eligibility

To insure early access to prenatal care, States have the option of establishing "presumptive eligibility" for low-income pregnant women. Qualified providers (such as Federally funded clinics, providers participating in a State perinatal care program, or Indian Health Service facilities) may make a preliminary determination that a pregnant woman seeking treatment is potentially eligible for Medicaid. The woman may then receive ambulatory prenatal care for up to 45 days, or until the State completes an eligibility review, whichever is earlier. Even if the woman is ultimately found to be ineligible, the provider may be reimbursed for services furnished during the presumptive eligibility period. However, if the woman fails to apply for Medicaid within 14 days, presumptive eligibility ceases. As of January 1989, 20 States provided for a presumptive eligibility period.

H.R. 800/S. 339 and H.R. 1573 would require all States to implement the presumptive eligibility option, effective Jan. 1990, and would eliminate the 45 day limit; eligibility would continue until the State had completed its review of the Medicaid application. H.R. 2216/S. 902 would mandate presumptive eligibility effective Oct. 1989, and would extend eligibility for 60 days even if the woman is determined ineligible before that date. Qualified providers could accept a food stamp card as evidence of presumptive eligibility. (The maximum income level for food stamps, 130 percent of the Federal poverty level, is the same as that established for Medicaid for pregnant women by H.R. 2216/S. 902.) S. 440 and S. 949 would allow States to establish presumptive eligibility for children, through age 17 under S. 440 and through age 20 under S. 949.

Continuation of Coverage

Beginning July 1, 1989, States have the option of continuing coverage for a pregnant woman through the end of the second full month beginning after the end of the pregnancy, even if the woman would otherwise become ineligible during that period. H.R. 800/S. 339 and H.R. 1573 would change this option to a mandate, effective Jan. 1990, and would also require continued coverage of infants through the first year of life; S. 440 would mandate continuation of coverage for pregnant women only. H.R. 833/S. 339, S. 440, and S. 949 would also permit, but not require, extended coverage for older children. Eligibility could be deemed to continue for 1 year from the date of the last previous determination of eligibility.

Other Medicaid Child Health Proposals

Although congressional interest has centered on financial eligibility for medical care, there are concerns that mere extension of Medicaid coverage may not ensure that all mothers and children will receive appropriate services. Low-income people may face other barriers to access. First, not all providers of care will accept Medicaid reimbursement, largely because of low Medicaid payment rates. Second, some low-income mothers may be unaware of the availability of Medicaid benefits or may need help in applying for them. Third, there may sometimes be insufficient coordination between the Medicaid program and other medical and social services available to mothers and children. Medicaid proposals in the 101st Congress seek to address each of these problems. There are also proposals to modify Medicaid to address another child health concern, declining rates of immunization for certain diseases.

Medicaid Provider Participation

Low rates of provider participation, and especially physician participation, have been a historic problem under Medicaid. Surveys of physicians have generally found that low Medicaid reimbursement, relative to the physicians' usual charges, is an important factor in the decision to refuse Medicaid patients.

Federal regulations require that a State's Medicaid payment rates "must be sufficient to enlist enough providers so that services under the [State Medicaid] plan are available to recipients at least to the extent that those services are available to the general population." (42 Code of Federal Regulations 447.204.) H.R. 800, H.R. 833, H.R. 1573, S. 339, S. 440, and S. 949 would all incorporate this rule in the Medicaid statute and would require DHHS to determine the adequacy of States' payment rates for obstetrical and/or pediatric services. (S. 440 would require a review of hospital payment rates as well.) Each bill except H.R. 833 also includes new State data reporting requirements intended to facilitate DHHS rate review. States would have to report on the extent to which providers participated in the program, the relative proportions of Medicaid and non-Medicaid patients receiving prenatal or pediatric care, and the difference between Medicaid payment rates and those offered by other payers. S. 721 focuses on the availability of obstetrical care in rural areas. It would raise the Federal matching rate to 90% for pregnancy related services in rural health manpower shortage areas if the State's Medicaid rates for these services were equal to at least 80% of the rates paid by the health insurance plan offered to State employees.

Several bills would expand current provisions under which States are required to give special treatment to hospitals serving a disproportionate share of low-income patients. Currently, State Medicaid programs must provide increased inpatient payment rates to such hospitals for all inpatient services, make extra payments for infants with very long stays or high costs and must waive any durational limits on covered services for infants. H.R. 800/S. 339 would extend these provisions to all children under age 18, while S. 949 would require higher payment rates to disproportionate share hospitals for outpatient as well as inpatient care.

Some providers may he deterred from accepting Medicaid patients, not just by Medicaid payment rates, but because of problems in dealing with State Medicaid agencies and delays in receiving Medicaid payment, or because of concerns about potential malpractice liability. Several bills, including H.R. 800, H.R. 833, S. 339, and S. 949, would provide grants to States for demonstration projects to test innovative ways of overcoming barriers to provider participation, such as expedited reimbursement, changes in burdensome administrative requirements, or sharing in the cost of malpractice insurance. Federal funding for the projects would be available at enhanced matching rates.

Outreach and Application Assistance

Some mothers may be unaware of the importance of prenatal and well baby care or the availability of Medicaid to pay for that care; others may find the application process difficult. Several proposals would provide for outreach services, to locate potentially eligible mothers or families, educate them about available benefits, and/or assist in filing applications. H.R. 800/S. 339 and H.R. 2216/S. 902 would require outreach activities, while S. 430 would merely permit States to claim Federal matching for such activities. The bills differ in the amount of Federal funding they make available. H.R. 800/S. 339 treats outreach as a service, subject to matching at the individual State's Medicaid percentage (50% to 79%). H.R. 2216/S. 902 treats outreach as an administrative activity, subject to 50% matching. Finally, S. 430 creates a new 75% matching rate for outreach services.

Some proposals would also simplify the process of applying for Medicaid. H.R. 833/S. 339 and H.R. 1573 would require States to process applications at sites other than welfare offices, such as hospitals or clinics. "Outstationing" of eligibility workers could be included as an optional outreach service under S. 430. H.R. 1573 would also require DHHS to develop a uniform application for programs serving children under 6, including Medicaid, the MCH block grant, Head Start, and the supplemental food program for women, infants, and children (WIC).

Coordination with Other Programs

Several proposals seek to improve the coordination between Medicaid and other programs, such as the supplemental food program for women, infants, and children (WIC), which is designed to prevent medical problems due to inadequate nutrition. H.R. 800/S. 339 would require States to make information about WIC available to all eligible Medicaid beneficiaries. S. 949 would fund State demonstration projects to improve the coordination of Medicaid, the, the MCH block grant program, and other services. The Administration has proposed similar demonstrations, to be funded at $40 million over a 2 year period. (This initiative was not included in the Administration Medicaid bill, H.R. 2216/S. 902, but might he undertaken under the Secretary's general authority to conduct Medicaid demonstration projects.)

Childhood Immunizations

Overall immunization rates for children have improved in recent years as a result of requirements that children be immunized for certain diseases before entering elementary school. However, immunization rates in the preschool population have declined for certain diseases, such as polio and diphtheria/tetanus/pertussis. The Administration's Medicaid proposal (H.R. 2216/S. 902) would require States to cover immunizations for children under age 6 who are receiving food stamps, regardless of whether these children were otherwise eligible for Medicaid. It would also require a State to pay for an immunization furnished to a child by any Medicaid provider, even if the child could have obtained the service from some other provider at no charge. (H.R. 1573 would provide supplementary funds for childhood immunization through the Public Health Service Act.)

Related Non-Medicaid Initiatives

In addition to proposals for changes in Medicaid, proposals in the 101st Congress would establish new Federal programs or expand existing ones to provide medical and related social services to pregnant women and young children.

H.R. 1117 would establish a new Public Health Service (PHS) program targeted specifically at teenage mothers and their children. Grants would be made to public and private nonprofit entities to provide medical care to mothers and children under 6, along with outreach, education, and related social services. Authorized funding levels would be $60 million in FY90, $65 million in FY91, and $70 million in FY92.

Several bills would expand the current Maternal and Child Health (MCH) Block Grant program authorized by Title V of the Social Security Act. This program provides grants to States for a variety of health programs, including direct provision of preventive and primary care services to mothers and children, health screenings, immunizations, and rehabilitation services for children with special health care needs (formerly referred to as crippled children). The permanent authorization for the MCH block grant program is $561 million per year; the appropriation for FY89 is $554 million. Of this amount, approximately 84% is allocated to States; the rest is retained by DHHS to support "special projects of regional and national significance" and to conduct research, training, and genetic disease screening programs.

H.R. 1710/S. 708, would increase the permanent MCH authorization to $661 million; any appropriation in excess of $561 million would be used for grants to States for comprehensive infant mortality initiatives, which would include home visits by nurses or social workers and a "one-stop shopping" application process for government medical and social programs. States would also be required to disseminate a new maternal and child health handbook to be developed by DHHS and to operate a toll-free information and referral line. (S. 339 would require DHHS to establish a national MCH information line.) H.R. 1568/S. 1053 would also provide a $661 million authorization, but appropriations in excess of $561 million would be distributed in the same manner as the current MCH funds and would be used for general maternal and infant care programs, with DHHS retaining 15% percent for special projects.

H.R. 1584 would increase the MCH authorization to $612 million. Any appropriation beyond the FY89 funding level of $554 million would be used for grants to States for education and outreach programs designed to promote participation in

the Medicaid, AFDC, food stamps, and WIC programs. Activities would include outstationing of eligibility workers, education about preventive services, and home visits to infants. H.R. 1573 would increase the MCH authorization to $661 million in FY90, $711 million in FY91, and $761 million in FY92 and later years. Funding in excess of $561 million would he allocated to States for perinatal services to low-income women in areas with high rates of infant mortality and inadequate maternity and infant care. This proposal would include direct payment for medical care, as well as the outreach and social service activities included in the other MCH expansion proposals.

H.R. 1573 would also authorize expansion of another existing program, the infant mortality initiative conducted by PHS under the Community and Migrant Health Centers programs. Under this initiative, Federally funded clinics receive supplemental grants to develop coordinated systems of care for pregnant women and infants. Authorized funding for this initiative is $32 million per year; the FY89 appropriation is $20.6 million. The Administration has requested an FY90 appropriation at the full $32 million level. H.R. 1573 would increase the authorization to $80 million for FY90, $90 million for FY91, and $100 million for FY92 and later years.

LEGISLATION

Note: The provisions of the following bills are discussed in detail in the preceding text. The following discussion includes only provisions not discussed above.

H.R. 800 (Rep. Leland et al.)

Medicaid Infant Mortality Amendments of 1989. Expansion of Medicaid for pregnant women and infants under 1 year old. (S. 339 includes similar provisions, along with provisions similar to those of H.R. 833.) Introduced Feb. 2, 1989; referred to Committee on Energy and Commerce.

H.R. 833 (Rep. Waxman et al.)

Medicaid Child Health Amendments of 1989. Expansion of Medicaid for children aged 1 through 17. (S. 339 includes similar provisions, along with provisions similar to those of H.R. 800.) In addition to provisions discussed above, provides for an optional extension of welfare transition coverage, under which Medicaid is continued for families losing benefits after the principal earner re-enters the workplace. Introduced Feb. 2, 1989; referred to Committee on Energy and Commerce.

H.R. 1117 (Reps. Leland and Waxman)

Adolescent Pregnancy and Parenthood Act of 1989. New grants to States under Public Health Service Act. Introduced Feb. 27, 1989; referred to Committee on Energy and Commerce.

H.R. 1568 (Rep. Kennelly et al.)/S. 1053 (Sen. Riegle et al.)

(S. 1053 only entitled Title V Infant Mortality Reduction Act of 1989; otherwise similar to H.R. 1568.) Expansion of MCH block grant. H.R. 1568 introduced Mar. 22, 1989; referred to Committee on Energy and Commerce. S. 1053 introduced May 18, 1989; referred to Committee on Finance.

H.R. 1573 (Rep. George Miller et al.)

Child Investment and Security Act of 1989. In addition to provisions relating to the Medicaid, MCH, and Community and Migrant Health Center programs, the bill includes expansions of the WIC and Head Start programs. Introduced Mar. 22, 1989; referred to Committees on Energy and Commerce and Education and Labor.

H.R. 1584 (Rep. Synar et al.)

Maternal Child Health Improvement Act of 1989. Expansion of MCH block grant. Introduced Mar. 23, 1989; referred to Committee on Energy and Commerce.

H.R. 1710 (Reps. Rowland and Tauke)/S. 708 (Sens. Bradley and Durenberger)

Healthy Birth Act of 1989. Expansion of MCH block grant. H.R. 1710 introduced Apr. 5, 1989; referred to Committee on Energy and Commerce. S. 708 introduced Apr. 5, 1989; referred to Committee on Finance.

H.R. 2216 (Rep. Michel et al.)/S. 902 (Sen. Dole et el.)

Medicaid Pregnant Women, Infants, and Children Amendments of 1989. (Administration proposal.) Funds provisions relating to expanded Medicaid eligibility and childhood immunization programs by reducing Federal matching payments for administrative costs. Matching percentages for the following activities would be reduced to 50% on a timetable ending Sept. 30, 1994: compensation or training of skilled professional medical staff, nursing home pre-admission screening and resi-

dent review, nursing home survey and certification, contracts with utilization and quality control peer review organizations (PROs) or similar entities, and immigration status verification. The current 90% matching rate for family planning services would be retained, but the rate for administrative costs associated with those services would be reduced to 50%. H.R. 2216 introduced May 3, 1989; referred to Committee on Energy and Commerce. S. 902 introduced May 3, 1989; referred to Committee on Finance.

S. 339 (Sen. Bradley et al.)

Infant Mortality and Children's Health Act of 1989. Includes provisions similar to those of H.R. 800 (pregnant women and infants) and H.R. 833 (older children). Does not include the provision of H.R. 800 exempting pregnant women from the requirement that they cooperate in establishing paternity and obtaining support for their child, or the provision of H.R. 833 permitting optional extension of welfare transition coverage. S. 339 contains one provision not included in either H.R. 800 or H.R. 833, the establishment by DHHS of a toll free maternal and child health information line. Introduced Feb. 2, 1989; referred to the Committee on Finance.

S. 430 (Sen. Daschle et al.)

Optional Medicaid coverage of outreach services. Introduced Feb. 22, 1989; referred to Committee on Finance.

S. 440 (Sen. Biden)

Health Care for Children Act of 1989. Medicaid expansions for children aged 1 through 18. Introduced Feb. 23, 1989; referred to Committee on Finance.

S. 721 (Sen. Baucus et al.)

Rural Obstetrical Care Access Act of 1989. Medicaid reimbursement increases. Introduced Apr. 6, 1989. Referred to Committee on Finance.

S. 949 (Sen. Riegle et al.)

Medicaid Children's Health Improvement Act of 1989. Medicaid expansion for children aged 1 through 20. Introduced May 9, 1989; referred to Committee on Finance.

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STATEMENT OF THE NATIONAL MENTAL HEALTH ASSOCIATION

CONCERNING: CHILD HEALTH CARE UNDER MEDICAID AND S. 1201

This statement is submitted by the National Mental Health Association, a nationwide citizen advocacy organization concerned about the care and treatment of persons with mental illnesses, prevention of mental and emotional illness and promotion of mental health, by the Mental Health Law Project a national advocacy organization concerned with expanding legal rights and benefits for people with mental impairments and by the American Psychological Association, a professional and scientific organization representing 90,000 American psychologists.

Nine to twelve percent of America's 63 million children have serious emotional problems. Although much is currently known about how to prevent and effectively treat children's mental health problems, tragically, this knowledge is not widely applied. The needs of these children are multiple and varied and may change over time, but the great majority of them, 70 to 80 percent according to a recent Office of Technology Assessment study, are not receiving appropriate mental health services.

One result of failing to provide mental health care, is that many children who need mental health services are served by other systems, such as child welfare or juvenile justice, but still do not have access to the mental health services they need. Studies consistently show, for example, that a significant percentage of children in juvenile justice facilities have serious emotional problems for which they do not re-

ceive appropriate treatment. A frequent finding is that the problems of these children were long-standing, but the early identification and intervention services that might have helped them were never provided.[1]

Even when children are seen in the mental health system, they are expected to fit into the service system, instead of the service system being designed to adapt to the individual needs of each child. Children tend to be placed in more restrictive settings than they need because of the lack of community services.[2] Since services are not available in the child's immediate community, the family cannot be as actively involved as they should.

Thousands of children are placed by various state agencies (in addition to the state mental health agency) in out-of-state residential facilities and many more are placed instate facilities.

A recent NMHA study, Invisible Children, sought to identify the extent of this problem in each state. According to that data, the typical child placed in out-of-state facilities is a white, adolescent male who presents serious behavior and conduct problems rather than psychosis or other thought disturbances. The study found that most children were referred by the state welfare agency and were sent to a private residential treatment facility at an average annual cost of $40,760. The average length of stay was 15.4 months, although this varied greatly (one child was placed for 10 years!). The demographic characteristics of children placed in state mental hospitals in their home state were similar to the characteristics of those children placed out-of-state.[3]

An in-depth, longitudinal study of the characteristics of children placed in facilities, as contrasted to those who are treated while they continued to live at home, found surprisingly little difference between these two groups of children. Contrary to what one would expect, the diagnosis of those in institutions is no more severe, as a group, than those who stay home and their relative functioning appears to be similar. The criteria which determines whether a child is sent miles from home to be institutionalized, as opposed to being admitted for care on an outpatient basis while living with his/her family, is the availability of comprehensive community services for that child and his/her family.[4]

This and other similar evidence clearly supports the conclusion that not only are children with serious emotional disturbance undeserved, they are also frequently inappropriately and ineffectively served.[5]

Another indication of this problem is the enormous increase in inpatient hospital care for children and adolescents that has recently occurred. Between 1980 and 1984 there was a 400% increase in the use of hospitalization for children.

In addition to an increasing recognition of the need to improve services for this population, there are encouraging developments concerning the means for bringing about this improvement. A better services delivery system that includes innovative and more cost-effective programming can be put in place to ensure the availability of a range of services—continuum of care—in each community. The services required for such a continuum have been identified by Strould and Friedman, and are promoted by the National Institute of Mental Health through its grant initiatives under the Child and Adolescent Service System Program.[6] The continuum includes:

Mental Health Services:

—Early identification and intervention
—Assessment
—Outpatient treatment
—Home-based services
—Day treatment
—Therapeutic foster care
—Independent living services
—Crisis services
—Inpatient hospitalization
—Residential treatment

Other Services:

—Social Services
—Health services
—Education Services
—Vocational Services
—Recreation Services
—Operational Services (Transportation, Legal Services, Advocacy, Self-Help and Support Groups)

In a few isolated places, this continuum actually exists, and the data show it is extremely effective.

The development of such a continuum of care for children with emotional disorders is critically needed in all communities and Federal programs should encourage such a continuum.

PROBLEMS WITH MEDICAID

Lack of eligibility for Medicaid, and uneven and intermittent eligibility for many children is a major problem in accessing appropriate mental health services for low income children. For this reason we strongly endorse the provisions in S. 1201 which will expand Medicaid eligibility. In particular, we commend the sponsors for including a mandate for states to cover children up to age 6 with incomes at or below the poverty line and to mandate the presumptive eligibility requirement for pregnant women. We are also pleased to see the expansion of the state option to cover low income children, up to age 19.

However, even with greater access to Medicaid coverage, children with serious emotional disturbance will still not be well served under Medicaid because it is difficult to finance under Medicaid the necessary continuum of care for these children, particularly intensive inter-agency home services, case management, day treatment, early identification and assessments.

Without the availability of ongoing resources, a continuum of care for children with serious emotional disturbance cannot exist. States and localities can provide significant contributions to such a system of care, but unless major Federal programs such as Medicaid include the services needed by these children, there will always be important gaps in any system of care.

Although Medicaid law permits states to include coverage of these services, but only if the state opts to include the specific service (such as clinic day treatment) in its state plan, states are unable to target outpatient services for children with serious emotional disturbance under Medicaid. States must use services which are broad in nature (i.e. designed for individuals with many diagnoses) to cover services for people with mental illnesses. Even states which develop special emphasis on mental health services, rarely go the next step of describing the specialized services which children may need. For example, often family therapy is critical to treating the child, but only individual and/or group therapy will be covered; or the issue to be addressed is the imminent placement of the child out of home, but home care and family therapy are not available services.

All mental health outpatient services are also optional, with the exception of physician care and outpatient general hospital care. As a result, states have failed to develop the range of services required to ensure that youngsters receive the comprehensive continuum of care which is critical to a successful outcome.

Medicaid also provides a way for states to target expanded Medicaid services to children, through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Under EPSDT states are to screen children for physical or mental problems and ensure that treatment is furnished to correct or ameliorate any "defects or chronic conditions" thus found.

Unfortunately, EPSDT has not been aggressively implemented. In FY 1987 less than 3 million Medicaid eligible children received initial or periodic exams, even though studies show that those who receive screening and services through EPSDT have lower health care costs in later years as a result of early intervention services.[7] In addition, over 70% of the-screens were for children under age 6. Adolescents, a high risk population, received very few EPSDT screens.[8]

A further problem for children who need mental health services is that very few states include adequate assessments of the child's mental and emotional health in the EPSDT screen. According to a recent study of state Medicaid mental health programs for children, only seven states (Alabama, Delaware, Louisiana, Michigan, South Dakota, Utah and Vermont) specify requirements for any screening for psychological and psychiatric problems.[9] Even in these seven states, the screen is still not necessarily adequate. Five states include a mental health component in the checklist of questions that screening providers are expected to ask during the exam, but the questions may not be appropriate for adolescents, one of these seven states (Alabama) has a pilot project designed to elicit information about abuse and neglect and the other state simply directs screening providers to assess the child's emotional health.

As a result of EPSDT deficiencies, most children with serious emotional disturbance are identified and assessed through other systems. For example, Head Start programs, schools, mental health agencies, the juvenile justice system and child wel-

fare agencies often are engaged in such assessments, but these assessments do not necessarily lead to EPSDT services.

Under the law, children in EPSDT who are found to need services to treat identified conditions, should receive them. States have the option to expand services to EPSDT children beyond those in the state plan. However, if the EPSDT screen has not identified the mental illness or emotional disturbance, children in need of care may not enter the EPSDT stream and receive the expanded package of services, even though they may have been diagnosed as needing mental health services by another child care system.

Few states have used the authority to expand services for EPSDT children with a mental illness or emotional disturbance. So, even when they are identified, additional services are generally not provided.

A two part approach should be taken to address these problems and to allow states to specifically target the necessary services for these children. We recommend:

- Establishing a new Medicaid optional service to enable states to target services for children with emotional disorders;
- Strengthening EPSDT by mandating: (1) a mental and emotional evaluation at the screening stage, (2) allowing children to enter the EPSDT stream following diagnosis by a mental health agency and (3) mandating provision of necessary services to children who have been found to them as a result of an EPSDT assessment.

NEW MEDICAID OPTION

A new optional Medicaid service is needed which would allow states to target the community mental health services needed to provide a continuum of care to children. Under this option, states should be required to cover the following package of mental health services for individuals under age 21 (but need not cover these services for adults, unless they opt to do so under the existing Medicaid legislative options). Each of the following services is already a Medicaid option, and the existing Federal regulations and guidelines (modified so they fit terminology used for children) with mental and emotional disturbances) would apply to the service under this new option. The major change made by enacting this option would be permitting the states to waive the comparability rule in order to offer the services only to children.

- Targeted case management for children who are seriously emotionally disturbed.
- Clinic services for children who are seriously emotionally disturbed, provided by a clinic that meets state licensure requirements for the provision of children's mental health services. In addition to basic clinic services offered to adults, children's clinic services shall include intensive services aimed to prevent out-of-home placement and family therapy.
- Mental health rehabilitation services for children who are seriously emotionally disturbed, including any medical or remedial service recommended by a physician or other licensed mental health practitioner for treatment of serious emotional disturbance and restoration of the child to the best possible functional level when provided through an agency which meets state standards. In addition to basic rehabilitation services, children's mental health rehabilitation shall include family therapy and home-based services.

As with other Medicaid services, the state would define the amount, duration and scope of such services.

EPSDT IMPROVEMENTS

S. 1201, introduced June 19 by Senators Bentsen, Chafee, Riegle, Matsunaga and Bradley, includes many changes to Medicaid which would greatly improve the EPSDT program and address these specific problems. We strongly support the bill's proposed amendments to EPSDT and particularly the provisions to improve screening for mental and emotional problems.

S. 1201 would ensure that mental health agencies, schools or other child serving entities could initiate an inter-periodic screen if the child appears to have a physical or emotional problem that needs attention. As mentioned above, this will be very helpful in assuring that children are properly assessed.

Language should be added to Section 1905(r)(1)(A)(ii) to permit an inter-periodic screen to be limited to an assessment of a suspected mental or physical condition alone, provided all other portions of the comprehensive screening services are current. It does not seem necessary to put the child through a full assessment, if one

has recently been done, in order to conduct an assessment in one particular area, such as mental health.

With respect to the language describing all EPSDT assessments, Section 1905(r)(1)(B)(i), we urge inclusion of appropriate phrasing to describe the developmental assessment, so as to read: "a comprehensive health and developmental assessment (including physical, communication, social-emotional and cognitive development)." This language follows more closely than does S. 1201 the wording of the Medicaid manual and reflects terminology used by professionals in the field. language should also be added to specifically require screening for psychological/psychiatric problems (this is recommended in the Medicaid manual for adolescents, however, it is also appropriate for younger children).

We are pleased to see that the current option for states to provide expanded Medicaid service through EPSDT would become a mandate under this bill. We have found that only a very few states have used the option to expand the services available to children in need of mental health care, and believe this amendment will have a significant impact in bringing needed treatment to children with emotional problems.

CONCLUSION

In conclusion, we urge the Committee to act upon both of the proposals described above. The improvements in S. 1201 (with our suggested amendments) would be invaluable to children who enter the EPSDT screening system. However, we are concerned that even with these improvements there will still be children in some states who do not have the benefit of EPSDT. For those children, the separate state optional package could be utilized to provide appropriate mental health care. Further, since children found to need services as a result of an EPSDT screen will then be eligible for all Medicaid defined services, packaging the children's mental health services in this manner would encourage states to make available to these children the range of services shown to be necessary to provide successful interventions: clinical services, in-home services and case management.

On behalf of our membership, and children in need of mental health care services, we applaud the Chairman's initiative in this area, and welcome the Finance Committee's interest in improving child health services under Medicaid. We would be glad to work with you in the development of final legislation in this area.

FOOTNOTES

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