S. HRG. 99-360

CHILD HEALTH INCENTIVE REFORM PLAN

HEARING

BEFORE THE

SUBCOMMITTEE ON
TAXATION AND DEBT MANAGEMENT

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

ON

S. 376

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THE CHILD HEALTH INCENTIVE REFORM PLAN

MONDAY, SEPTEMBER 16, 1985

U.S. SENATE,
SUBCOMMITTEE ON TAXATION AND DEBT MANAGEMENT,
COMMITTEE ON FINANCE,
Washington, DC.

The committee met, pursuant to notice, at 9:30 a.m. in room SD-215, Dirksen Senate Office Building, the Honorable John H. Chafee (chairman) presiding.

Present: Senator Chafee.

[The press release announcing the hearing and a description of S. 376 by the Joint Committee on Taxation follows:]

[Press Release No. 85-066, Aug. 9, 1985]

FINANCE HEARING ON CHILD HEALTH TAX PROPOSAL SET FOR SEPTEMBER 16

A proposal on child health will be reviewed by the Senate Committee on Finance's Subcommittee on Taxation and Debt Management at a September 16, 1985 hearing, Committee Chairman Bob Packwood (R-Oregon) announced today.

The hearing is scheduled to begin at 9:30 a.m., Monday, September 16, 1985 in Room SD-215 of the Dirksen Senate Office Building in Washington.

Senator John Chafee (R-Rhode Island), Chairman of the Taxation and Debt Management Subcommittee, will preside at the hearing.

The proposal to be examined is S. 376, the Child Health Incentive Reform Plan, sponsored by Senator Chafee, which would amend the Internal Revenue Code of 1954 to deny any employer a deduction for group health plan expenses unless such plan includes coverage for pediatric preventive health care.

"I'm happy we're able to provide this opportunity for this proposal to receive a public hearing before our Committee," Chairman Packwood said. "I'm sure the testimony received will provide us with a solid base of information on which to proceed."

DESCRIPTION OF S. 376

("CHILD HEALTH INCENTIVES REFORM PLAN")

Scheduled for a Hearing

Before the

SUBCOMMITTEE ON SAVINGS, PENSIONS

AND INVESTMENT POLICY

of the

COMMITTEE ON FINANCE

on September 16, 1985

Prepared by the Staff

of the

JOINT COMMITTEE ON TAXATION

September 12, 1985

JCX-19-85

INTRODUCTION

The Subcommittee on Taxation and Debt Management of the Senate Committee on Finance has scheduled a public hearing on September 16, 1985, on S. 376 (introduced by Senator Chafee). This bill, the "Child Health Incentives Reform Plan," would disallow deductions (effective for post-1985 taxable years) for employer contributions to an employee group health plan unless the plan includes coverage for pediatric preventive health care.

This document,[1] prepared by the staff of the Joint Committee on Taxation, summarizes present law and the provisions of the bill.

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[1] This document may be cited as follows: Joint Committee on Taxation, Description of S. 376 ("Child Health Incentives Reform Plan") (JCX-19-85), September 12, 1985.

SUMMARY

Present Law

Under present law, employer contributions to employee health plans and the benefits paid under these plans generally are excluded from the employee's income and wages for Federal income tax and employment tax purposes. The employer generally may deduct the cost of these excludable benefits.

Present law generally does not specify what types of health benefits must be provided under an employer plan in order to obtain these tax benefits. However, no deduction is allowed for employer contributions to a group health plan that discriminates against individuals with end stage renal (kidney) disease.

S. 376

Under the bill, effective for taxable years beginning after 1985, no deduction would be permitted for employer contributions to a group health plan unless the plan includes coverage for pediatric preventive health care.

Pediatric preventive health care would be defined to include (1) the determination of health and development history, (2) comprehensive unclothed physical examinations, (3) developmental and behavioral assessments, (4) appropriate immunizations, laboratory procedures, and vision and hearing testing, and (5) any other medical services that are required by regulations to be issued by the Treasury Department.

DESCRIPTION OF THE BILL

Present Law

Overview

Present tax law includes several incentives designed to encourage employers to provide health benefits to their employees. Employer contributions to a plan providing accident or health coverage, and certain benefits actually paid under such plans, are not subject to income tax, social security tax, or unemployment tax. At the same time, employer contributions to fund such excludable medical benefits are deductible, within limits.

If such benefits are prefunded through a nondiscriminatory welfare benefit fund or qualified pension plan, employers may claim deductions for additions to qualified reserves. Additional contributions are permitted to be made on a deductible basis to provide post-retirement health benefits for former employees. These deductible reserves are also permitted to accumulate in a trust that is exempt from income tax and, in part, from the unrelated business income tax.

Exclusion for employer-provided medical benefits

Gross income, for Federal income tax purposes, includes "all income from whatever source derived" (Code sec. 61(a)). This provision "is broad enough to include in taxable income any economic or financial benefit conferred on the employee as compensation, whatever the form or mode by which it is effected" (Comm'r v. Smith, 324 U.S. 177, 181 (1945)).

However, if an employer-provided fringe benefit program qualifies under a specific statutory provision of Federal income tax law, then the benefits provided under the program are excludable (generally, subject to dollar or other limitations) from the employee's gross income for income tax purposes. The costs of benefits that are excluded from the employee's income nonetheless are deductible by the employer, provided they constitute ordinary and necessary business expenses. The income tax exclusions also generally apply for social security and other employment tax purposes.

Under present law, an employer's contributions to a plan providing accident or health benefits are excludable from the employee's income (sec. 106). Reimbursements to employees under an employer's health plan for costs incurred for medical expenses (within the meaning of sec. 213), and payments unrelated to absence from work, are excluded from the employee's gross income (sec. 105(b)). Similar exclusions apply for employment tax purposes.

Other benefits actually paid under accident and health plans, such as certain disability benefits, generally are includible in the employee's gross income to the extent attributable to employer contributions (sec. 105(a)). In the case of a self-insured medical reimbursement plan (sec. 105(h)), no exclusion is provided for benefits paid to any employee who is among the five highest-paid officers, a 10-percent shareholder, or among the 25-percent highest-paid employees if the program discriminates in favor of this group as to either eligibility to participate or the medical benefits actually provided under the plan.

Employer deductions for funding medical benefits

A deduction is allowed to an employer for compensation paid to employees in the form of contributions to or benefits paid under a health plan, provided such costs constitute ordinary and necessary business expenses (sec. 162).

Effective for taxable years beginning after 1981, no deduction is permitted for expenses paid or incurred by an employer for a group health plan if the plan differentiates in the benefits it provides between individuals having end stage renal (kidney) disease and other individuals (sec. 162(i)(1)). Thus, no deductions are permitted for contributions to a group health plan that differentiates directly or indirectly on the basis of the existence of end stage renal disease or the need for renal dialysis.

Explanation of Provisions

Under the bill, no deduction would be allowed for employer contributions to a group health plan unless the plan provides coverage for pediatric preventive health care with respect to any child of a covered employee who has not attained age 21. As under present law, a group health plan would be defined as any employer plan to provide medical care to employees, former employees, or the families of such employees, directly or through insurance, reimbursement, or otherwise.

The bill would define pediatric preventive health care to include (1) the determination of a child's health and development history, (2) comprehensive unclothed physical examinations, (3) developmental and behavioral assessments, (4) immunizations considered appropriate for the child's age, health, and developmental history, (5) laboratory procedures appropriate for the child's age and population group, and (6) appropriate vision and hearing testing, including referral for treatment as necessary. In the event of any referral, pediatric preventive health care need not include the subsequent services for which the referral is made.

In addition, pediatric preventive health care would include any other medical services as required pursuant to Treasury regulations. The bill requires that the Secretary of the Treasury, in promulgating such regulations, must consult with the Secretary of Health and Human Services and appropriate medical organizations involved in child health care.

The bill would be effective for taxable years beginning after December 31, 1985.

Senator CHAFEE. Today's hearing is by the Subcommittee on Taxation and Debt Management on S. 376, the child health incentive reform plan.

I want to thank the witnesses for joining us today. This hearing is to discuss the merits of S. 376, which I introduced in February of this year.

My legislation would require businesses to include children's preventive care and health supervision services in their employee health benefit packages. Such services would be required for the insurance premiums to be deductible as a business expense.

Employer-provided group health plans which are tax deductible now represent the second largest tax supported health program after Medicare in this country. In 1986, this subsidy will cost the Federal Government $32 billion in lost revenues.

Now in the trade and in the Federal taxation field, this is called a tax expenditure; namely, if the deduction weren't there, the Federal Government would have collected $32 billion more per year.

So we are talking something pretty big. Because of this special tax deductible status, group health plans have become the dominant methods of financing personal health care service in the United States. According to the Bureau of Labor Statistics more than 80 percent of all full-time employees are covered by some form of private health insurance.

Unfortunately, most coverage provided by health insurance plans is aimed at acute illnesses. Few resources are expended to keep individuals out of the hospital. And hospitals are, of course, as we all know, the most expensive part of the spectrum of health care.

Though covering only the most expensive procedures in care, group health plans discourage preventive care and early diagnosis of disease. Let's rephrase that and make sure everybody understands what I am saying.

What the health plans do now, not all of them, but most of them, is cover the most expensive procedures in health care. And they don't get into encouraging prevention—like early diagnosis of diseases--especially for children. It seems to me this is where savings can really occur.

The result of all this is that we have a health care system that takes care of the sick only without any focus on trying to keep the well well. And we all know that the costs of this are escalating way beyond the consumer price index sphere.

Now why is all this so? Well, certainly, there is no incentive now for the plans to cover children. Oh, yes, in some of the bargaining units they succeed in getting children covered. But that's the only incentive And if the employer so chooses to do it.

What we are trying to do here is to put an incentive in. And it's a pretty big incentive. Namely, you can't deduct the cost of it as a deductible expense unless the services for children that I mentioned earlier are included.

Now why do we focus on children? More than any other age group in the population, children require special preventive care and screening to detect and prevent disease and disorder. Preventive care not only improves their overall health, but also it is cost effective. More than one study has shown that immunizations save

money in the long run. I think we all know that. It's the old adage—an ounce of prevention is worth a pound of cure.

For every dollar spent on measles vaccinations, $10 was saved. For every dollar spent on mumps on vaccinations, $7.40 was saved. Other studies have demonstrated that eligible Medicaid children provided with early and periodic screening, diagnosis and treatment had 30 to 50 percent lower hospital and medical costs than other Medicaid children. That's a Medicaid study.

Now opponents to health insurance coverage for preventive services argue that regular health screenings are an expense that families can and do plan and budget for. Well, that's a possibility. But the trouble is young families with children have generally more limited incomes and must rely heavily on their employer-provided health insurance. If the plan does not cover preventive health care, such as immunizations, many families will wait for serious symptoms to appear before they apply for the care.

Now the sad truth is that 24 percent of all preschool children are not immunized. Besides the tragedy of the quality of life for a child left retarded by measles, the cost of life-time institutional care can be staggering. The Children's Defense Fund estimates the cost of between half a million and a million dollars per child for his or her lifetime if the child is institutionalized.

According to a study conducted by the American Academy of Pediatrics, based on data gathered by a major insurance company, the average monthly cost for a family for this additional coverage would be $2.28, or roughly 1 percent of employer's current payments.

The estimated premium for child health supervision does not include credits for reduction in illness and hospitalization. In other words, that estimate of the added cost doesn't have counted against it the savings that would occur from the child not requiring hospitalization that the plan now covers.

I recognize that there are some objections to this, and we want to hear them out and see if we can overcome them. If we have got a problem, let's have a solution.

Obviously, there are going to be objections that if you add this small increase, then the employer might say, well, forget the whole business; I'm having enough troubles now paying for what I am providing and if you add this on, this will be the straw that broke the camel's back, and I will get out of the whole program.

Or else the employer will say, well, I'm just going to restrict the coverage to the employee only; never mind his family. Others are going to say it's wrong for the Federal Government to be mandating any aspect of coverage; we don't want to get into this; this is a bad way to start; we are liable to get into alcoholism coverage, mental health coverage, and once we start down that path, you have the Federal Government putting its nose into all aspects of the private health coverage that presently exist.

Well, I don't think that necessarily follows, but let's hear what the witnesses have to say.

We have two panels. The first panel will consist of Ms. Sara Rosenbaum from the Children's Defense Fund—and if you will come forward as I call your names—Lynn Gustasfson who is from the National Association of School Nurses; Dr. Robert Haggerty,

president, American Academy of Pediatrics; and Dr. David Chadwick who is the medical director emeritus and director, Center for Child Protections, San Diego Childrens Hospital.

Mr. Roger Mentz, Deputy Assistant Secretary for Tax Policy from Treasury, will then testify and finally we will have the last panel.

We welcome you all here. And, Ms. Rosenbaum, why don't you proceed.

STATEMENT OF MS. SARA ROSENBAUM, DIRECTOR, HEALTH DIVISION, CHILDREN'S DEFENSE FUND, WASHINGTON, DC

Ms. ROSENBAUM. Thank you, Mr. Chairman.

The Children's Defense Fund is pleased to have this opportunity to testify today on S. 376. I have submitted lengthier testimony for the record.

Senator CHAFEE. I read that over. And we appreciate you doing that.

Ms. ROSENBAUM. I would like to take my remaining time to summarize my points.

Senator CHAFEE. Everybody will have 5 minutes, so you go right to it.

Ms. ROSENBAUM. There is a general maxim that the health insurance status of most people depends on their employment status. While this maxim is true for adults, we find that it is very untrue for children.

In the United States in 1984, about 86 percent of all children lived with a working parent; among black children, about 67 percent lived with a working parent; among white children, 89 percent lived with a working parent; and among poor children, about two-thirds lived with a working family member.

However, if we look at children's private insurance status, we find a tremendous discrepancy between their family's employment status and their own insured status. In fact, only a little over 60 percent of all children in the United States are insured privately for a full year. Among black children, only about 40 percent are insured privately for a full year. And among poor children, only a startling 16 percent are insured for a full year compared to the two-thirds of poor children who live with an employed parent.

The discrepancy between children's insured status and their family's employment status carries two serious consequences: One, for the nearly 11 million children living in poverty today who are either never insured or else are insured for only a portion of each year, and the other for the Federal and State Governments which, after spending over $30 billion in Federal tax subsidies for employer-purchased health plans, are nonetheless forced to directly subsidize insure the poor through public insurance programs such as Medicaid and other public programs in order to ameliorate this gap in insurance coverage.

We have identified four major barriers to employer-purchased health insurance coverage for children. First, as you mentioned, many employers simply don't offer insurance at all, especially to poor workers and their families. Many children live with only their mothers. Insurance patterns among women reveal that 36 percent

of all women who work as housekeepers are not insured; over 20 percent of women employed in the retail trade industry, the largest employer of women, are not insured at all.

Second, many employers offer insurance to the employee but none to the dependents, even at full employee cost. Again, this is a particular problem among small firms which tend to employ lower paid workers.

Third, many employers offer dependent health care coverage, but at very high premium costs. Only about 60 percent of all employers in 1980 paid the full cost of dependent health coverage. This percentage, in fact, has been coming down, and many lower income employees are forced to pay large amounts in annual insurance premiums in order to insure their families. These amounts are well in excess of what they can afford.

Finally, of course, is the problem that CHIRP has identified, namely, the failure of employer insurance plans to extend coverage for preventive benefits and other outpatient pediatric care that children need. Many of these families, after having paid an exorbitant amount of money for a privately purchased premium, are then forced to pay large amounts out of pocket for care that they cannot afford.

We make several recommendations in our testimony, the first one being the need for a plan to subsidize the purchase of family health insurance coverage for employees whose employers do not offer coverage or offer coverage only at unaffordable rates. This could be done either by subsidizing employees' purchases of their own private coverage or by, for example, expanding the Medicaid program to include a subsidized insurance program for employees and their dependents who can't afford to buy private insurance.

Second, we would recommend that CHIRP be enacted and expanded to include dental benefits, vision and hearing benefits, and diagnostic and treatment services for conditions found during an assessment. These are the requirements of the Medicaid EPSDT Program, and we feel they are equally applicable here.

Finally, we recommend that CHIRP be revised to provide coverage on a first-dollar basis, since as currently drafted, the benefits covered in CHIRP will frequently simply go to meet an employee's insurance deductible rather than going to cover the employee's child's health care needs.

Thank you.

[The prepared written statement of Ms. Rosenbaum follows:]

TESTIMONY
OF THE
CHILDREN'S DEFENSE FUND
BEFORE THE
SUBCOMMITTEE ON TAXATION AND DEBT MANAGEMENT
OF THE
SENATE FINANCE COMMITTEE
REGARDING S. 367, THE CHILD HEALTH INCENTIVE REFORM PLAN

Presented by
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September 16, 1985

Mr. Chairman and Members of the Subcommittee:

The Children's Defense Fund (CDF) is pleased to have this opportunity to testify today on S. 367, the Child Health Incentive Reform Plan. Mr. Chairman, you and the cosponsors of S. 367 are to be commended for examining deficiencies within the nation's employer-purchased health insurance system which have left millions of children uninsured or underinsured. We hope to work closely with your Committee on the broad issue of national tax policy and its relationship to health insurance patterns among America's children.

CDF is a national public charity that provides long range and systematic advocacy on behalf of poor children. We focus on programs and policies that affect large numbers of children. We concentrate our efforts on a number of key issues including health care, child welfare, education, child development and day care, adolescent pregnancy prevention, and youth employment. CDF's work includes extensive research on these issues, as well as federal legislative and administrative advocacy, advocacy at the state and local levels, and technical assistance to public agencies, legislatures and policymakers in nearly all states.

For the past dozen years, CDF has placed particular emphasis on the problem of access to health care among poor children. In a nation such as ours, whose health care system is financed chiefly through public or private insurance, low income children have traditionally faced substantial barriers to basic health care because they are

disproportionately uninsured and their families are unable to purchase necessary services themselves. Moreover, there exists substantial evidence that in recent years poor children have increasingly lost both public and private health insurance coverage. At the same time, cost containment efforts in many parts of the country have reduced the amount of available charity care for low-income and uninsured persons in general and children in particular. Thus, it is extremely timely for the Finance Committee to undertake a review of how private health insurance for children can be strengthened.

Our testimony will be divided into the following three sections:

- a discussion of the demographic characteristics of America's uninsured children, a review of recent trends in both private and public health insurance coverage of children, and an assessment of the impact of children's uninsured or underinsured status on their access to health care services.
- a review of existing barriers to appropriate employer-purchased health insurance coverage for children.
- recommendations for improving employer-based health insurance programs for families with children, including specific recommendations regarding the Child Health Incentive Reform Plan (CHIRP).

I. America's Uninsured Children

In many respects, America can proudly claim the world's most impressive health care system. Pediatric health care of unmatched quality can be found here, and the miracles that our hospitals and physicians have accomplished for children are unequalled.

Unfortunately, however, a substantial portion of America's children may never benefit from these accomplishments and miracles. Depending on the particular study, anywhere from 7.9 percent in 1980[1] to 17.9 percent in 1982[2] of all children under age 18 had no health insurance, public or private. Translated into today's numbers, these figures mean that, of the approximately 61 million children under age 18 living in the United States, anywhere from 4.8 million to 10.8 million are without health insurance.

Furthermore, the problem of uninsuredness among children appears to be growing. Between 1979 and 1982, according to one recent study, while the number of children under age 18 declined slightly, the number of uninsured children actually increased by 700,000.[3] This decline, arising mainly from reductions in coverage under employer-based health insurance plans,[4] unfortunately coincided with significant federal and state reductions in public insurance programs for low-income children, primarily Medicaid. In 1976, approximately two-thirds of all poor children were eligible for Medicaid.[5]

In 1983, however, because of federal budget reductions and states' consequent failure to adjust Medicaid eligibility standards to keep pace[6] with inflation, the program reached under half of all poor children. By 1984, the average state Medicaid program's annual financial eligibility standard for a family of four was roughly $3900 -- approximately 38 percent of the federal poverty level.[7]

Because the public insurance "safety net" for children is so tattered, the issue of how children are treated under private insurance plans is even more pressing than a decade ago. As cutbacks and cost containment efforts among both public and private insurers have increased in the past several years, and as changes occur in the nature of employment and fringe benefits, uninsured children's access to necessary outpatient and inpatient care has become increasingly threatened.

- The health needs of the uninsured are putting a heavy cost burden on hospitals: according to information collected by the National Center for Health Statistics as part of its annual National Hospital Discharge Survey, about a half million women who delivered babies in hospitals in 1983 were uninsured.[8]

- It has been estimated that 40 percent of all hospital care for uninsured patients involves obstetrical cases, and that this care adds up to over $1.5 billion per year in hospital charges.[9]

- The number of uninsured obstetric and pediatric cases is so high that according to a recent satistical profile of the source and distribution of uncompensated care in American hospitals, one out of every two white newborn females will be uninsured. In western hospitals, two out of three white newborn female infants wil be uninsured.[10]

Even more ominous is the fact that certain uninsured newborn infants are among the most expensive charity care cases that a hospital can treat,[11] thereby increasing the pressure on hospitals to stop providing services to these babies. At one hospital, for example, high risk newborn infants represented only one percent of all uninsured patients but nearly 20 percent of the facility's uncompensated care charges.[12] An average hospital bill for a high-risk newborn in Georgia exceeds $11,000, and yet high-risk babies are more likely to be born to women who, because of poverty, lack health insurance and are the least able to afford the cost of care. It is the very poorest and least insured babies who are in the greatest need of care and who ultimately may be the least able to get it.

Given the pressures for cost containment and the large costs associated with caring for medically indigent women and children, there exists a real danger that hospitals will begin to reduce the amount of indigent care they furnish. There are already warning signs of this trend. Between 1981 and 1982, 15 percent of hospitals serving large numbers of poor patients adopted specific limits on the amount of charitable care they would provide.[13] Some hospitals, apparently in response to the high costs involved and the large numbers of children who cannot meet them, have cut back on the newborn intensive care services they will provide to <u>any</u> children. These trends indicate that the cost of caring for uninsured children can indirectly constrict the availability of services for all children.

Moreover, a study recently conducted by the American Academy of Pediatrics[14] reveals a substantial increase in the number of patient referrals by hospitals to other hospitals for economic reasons. Of 115 hospitals responding to the Academy's nationwide survey, fully 26 reported an increased number of referrrals to other institutions. Of the 26, half gave low or exhausted Medicaid payments as the reason, while two identified a total lack of insurance as the reason for the transfer.

Reductions in specialized hospital care for women and children are dangerous for even deeper reasons. Between 1965 and 1979, infant mortality rates declined by more than 40 percent in the United States.[15] These dramatic declines were not the result of more preventive health care and the birth of healthier babies, but instead resulted from the development of very specialized intensive infant care hospital services that now permit us to keep babies alive who would certainly have died 20 years ago.[16]

While the number of babies in need of such care is not declining, these special services are in danger of shrinking, and the number of babies whose families cannot afford to pay for them is growing. We have already begun to witness a slowing in the decline in infant mortality and worse, there are preliminary indications of an actual nationwide mortality increase among older infants.[16a] We cannot afford a lessening of health care services for our most at-risk women and children at this time.

II. Barriers to Employer-Based Insurance Coverage of Children

The private health insurance system in the United States is overwhelmingly employer-based. Eighty-five percent of all private health insurance is purchased through employer group plans.[17] Because private health insurance purchased on an individual basis is extremely expensive, few poor and near-poor or even moderate income families covered by private insurance would be able to maintain private health insurance coverage were their insurance not provided through their employer. Thus, the presence or absence of employer-based health insurance coverage programs will be largely determinative of whether poor and near-poor employees and their families have private health insurance coverage.

It has generally been observed that an individual's insurance coverage depends chiefly on his or her employment situation. However, a comparison of the percentage of children living with an employed parent with the percentage of children covered by private insurance reveals that this maxim does not hold true for dependents of workers. The gap for children between their parents' employment status and their own insurance status is large and growing larger.

In 1984, 86 percent of all children had at least one parent currently employed.[18] Among Black children, 67 percent had a currently employed parent, and among White children, 89.4 percent had a currently employed parent.[19] Even among families with incomes at or below the federal poverty level in 1983, 63.4 percent had at least one employed family member.[20]

In stark contrast, however, data from the 1980 National Medical Care Utilization and Expenditure Survey (NMCUES) indicate that in 1980,

even before recent reductions in employer-based health insurance coverage, only 77.4 percent of all children under age 18 had private insurance and only 64.7 percent had private insurance for a full year.[21] Thus a significant discrepancy exists between the percentage of children living with an employed parent and the percentage of children with private health insurance.

This discrepancy is even more startling among poor and minority children, since lower paid jobs are less likely to carry with them any health insurance or dependent coverage. In 1980, for example, only 59.4 percent of Black children had any private insurance, and only 41.2 percent were insured for a full year.[22] For poor children, the discrepancy is breathtaking. Even though nearly two-thirds of poor children live in employed familes, only 33.9 percent had any private health insurance in 1980, and only 16.4 percent of all poor children under 18 were insured for the full year.[23] Among near-poor children (those with incomes between 100 percent and 150 percent of the federal poverty level) only 61.6 percent had private insurance, and only 44.1 percent had full-year coverage.[24]

These startling numbers have grave implications for both children and federal and state governments. Applying these statistics to 1984 poverty levels, all but 16.4 percent of the 12.9 million children living in poverty that year (some 10.8 million children) were either wholly or partially uninsured for their basic health care needs. Unless they qualified for Medicaid (and in 1980, only half of all poor children qualified for Medicaid for a full year),[24a] they were uninsured. This enormous gap in private health insurance coverage among poor children might be substantially narrowed -- indeed,

the Congressional Budget Office has estimated that 23.8 percent of all uninsured children live with a family head covered by private insurance[24b] -- were their parents' employer-based insurance plans more responsive to their needs.

Federal and state governments are making enormous tax expenditures for employer-based health insurance. The current cost to the Treasury of the employer group health insurance tax deduction is about $35 billion. Because this publicly subsidized system is so ineffective in meeting the needs of children, the federal and state governments are forced to make additional and sizeable direct expenditures for children through public insurance programs, even though some of these children's health care costs could be borne in whole or in part by private insurance were their parents' employer-based plans more comprehensive.

Thus, it is in both children's and government's interests to ensure that the tax expenditures for employer-purchased health plans are more adequate to meet the needs of children. Employer-based health insurance plans that prevent workers from securing health insurance coverage for their children or that offer inadequate levels of family coverage not only place children at risk of being denied needed and cost-effective health care (particularly if they come from poor or near-poor families) but also place added strains on public budgets.

Four Barriers to Employer-Based Health Insurance Coverage

Four basic reasons account for the fact that millons of poor and near-poor children with working parents may nonetheless be uninsured through the work-place.

1. Employers that offer no health insurance: A threshold issue is whether employers offer their employees health insurance at all. In 1980, among families with family heads under age 65 in which at least one family member worked every week, 13.1 percent were without any known coverage.[25]

Moreover, children are increasingly living in single parent headed households. In 1983, 20 percent of all children (51.1 percent of all Black children and 15.0 percent of all White children) lived only with their mothers.[26] Yet eleven percent of women working full-time are not protected by health insurance, and 20 percent of women who work part-time are uninsured.[27] Moreover, women in the workforce tend to be concentrated in industries that pay workers on an hourly, rather than a salaried, basis.[28] Persons paid on an hourly basis are more than twice as likely to lack health insurance coverage.[29] Similarly, women tend to be concentrated in industries with restrictive health insurance practices. For example, the retail trade employs 21 percent of all women in the labor force, and yet 23 percent of women working in this industry are without health insurance.[30] Thirty-six percent of women working in private households are without health insurance.*[31]

2. Employers that offer coverage for their employees only: While most employers who provide some health insurance offer their employees the option of securing coverage for their dependents, a number provide health insurance plans that cover only their employees.

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* Since these statistics identify women without any insurance, either public or private, they may understate the proportion of employers in these industries who offer no private coverage.

Among all employers offering health insurance to their employees in 1980, 4.3 percent offered no dependent coverage at all,[32] not even at the employee's cost. Firms employing 100 persons or fewer were particularly likely to offer no dependent coverage. For example, 9.5 percent of firms employing between one and nineteen employees, and 7.3 percent of firms employing between 50 and 99 persons, offered no 33 dependent coverage in 1980.

3. Employers offering dependent coverage but at an unaffordable cost: Of the more than 95 percent of all establishments that offered health insurance to dependents when it was offered to employees in 1980, only 60 percent paid the full premium costs for their employees' dependent coverage.[34] Eighteen percent contributed nothing toward dependent coverage,[35] and the remainder offered partial payment.

In the 40% of cases where there was no or only partial employer contribution to dependent care coverage, obviously the families hardest hit were those of poor or near-poor workers. A full-time employee making the minimum wage (roughly $550.00 per month) and working for an employer who contributes little or nothing toward dependent coverage, may be in no position to purchase a family coverage plan whose cost might easily total $100 per month. With the full-time minimum wage now equal to only three-fourths of the poverty line for a family of three, such a worker too often must choose between food and medical insurance in such a situation.

An additional problem is the failure of most health insurance plans to distinguish among types or numbers of dependents. In a typical plan the employee payment for dependant coverage is a set amount, whether

employee is a single parent with one child or married and with several children. As a result single parents "subsidize" families with two parents, and small families "subsidize" large families. Since single parents tend to have lower-paid jobs, the effect is exacerbated: dependent coverage for which the employee must pay all or most of the cost is most troublesome for single parents (the rate of return is lower) and low-income workers (who have less discretionary income with which to pay).

Employers' failure to adjust dependent coverage premiums for family type and size and for employee income levels means that many poor and near-poor families are forced to either forego family coverage entirely or else spend significant and often unreasonable portions of their income on health insurance. While there is some tension between the principles of insurance on the one hand and the benefits of adjusting premiums for family income or size or type on the other, we believe that it is an issue which needs scrutiny.

In 1980, the nation's low and moderate income privately insured families with household heads under age 65 who had to pay all of their premiums, incurred an average annual expense of $605 or 6 percent of their annual income. Families with incomes of $35,000 or more who paid who paid all of their premiums had average annual expenditures of $945.00 (2 percent of their annual income).[36] Those families least able to afford it were thus the most likely to pay the greatest share of their family income toward insurance premiums.

Unfortunately, in recent years, the trend has been in favor of further reductions in employer contributions to dependent care coverage, as employers have raised their employees' insurance premium obligations in order to control utilization and cut costs. Between 1982 and 1983, the proportion of employees with family coverage who were required to pay part of their premium cost rose from 47 percent to 50 percent.[37]

4. Employer plans that do not furnish appropriate benefits: Even assuming that the employer pays for the coverage or an employee can afford to purchase dependent coverage, the plan offered by his employer may prove seriously inadequate to meet his or her children's needs. In 1976, according to a report prepared by the Congressional Budget Office, only 9 percent of employer-based plans covered preventive care; only 14 percent, vision care; and only 32 percent, children's dental benefits.[38] While in recent years some employers have added health promotion and wellness programs to their plans, including primary care and well-baby coverage, a serious gap still exists between children's health needs and the scope of coverage in most employer-based benefit plans.[39]

Even an apparently broad scope of coverage may not ensure appropriate access to health care if employees are required to pay sizeable deductibles and coinsurance before coverage begins. In recent years, employers have made increasing use of deductibles and coinsurance to deter utilization of benefits, especially in light of recent studies documenting the deterrent effect of costsharing on health care utilization.[40] High deductibles and coinsurance can have a particularly

chilling effect on children's utilization of preventive and primary care.[41] In an insurance plan under which an across-the-board $100 deductible is applied against each family member before coverage begins, this deductible, plus a possible coinsurance charge, would act as a powerful deterrent to children's utilization of preventive benefits included in their plans.

III. Recommendations

In light of these four barriers, we make the following recommendations for improving employer-based health insurance coverage for children.

1. A program must be established that permits poor and near-poor working families to acquire health insurance. For the millions of poor and near poor workers who are either not offered any group health insurance through the workplace or else are not offered coverage for dependents, a program must be established that permits workers to purchase affordable and adequate coverage for themselves and their families. Two basic options exist for achieving this goal. Congress might expand public insurance programs such as Medicaid to include a program of subsidized insurance coverage on a sliding scale for persons who are not poor enough to automatically qualify for Medicaid coverage but who lack insurance for themselves or their families and are unable to purchase it through their employer.

Alternatively, Congresss might consider amending the federal tax laws to promote affordable private insurance coverage. Minimum criteria might be applied to employer plans. Or, in the absence of employer

insurance, workers might be given tax credits to be applied toward the purchase of family health insurance coverage. Or, as some states are now doing, Congress might consider imposing a federal surtax on employer-purchased health insurance premiums. This tax could then be pooled and dedicated toward subsidizing the purchase of private insurance by uninsured groups of workers and their families.

These approaches are all preliminary suggestions that must be explored in greater detail before decisions can be made. It is evident, however, that large numbers of poor and near-poor employees and their families are inadequately covered and that these families will be able to afford coverage only if they receive some type of tax and/or direct subsidy to purchase either public or private coverage. How to generate the revenues needed to provide the subsidy, and whether to use those revenues to assist families to buy public or private insurance plans are two major questions that must be resolved.

An expansion of the Medicaid program offers several advantages, especially for children. Its benefits are relatively comprehensive and include a wide array of preventive pediatric services. Moreover, Medicaid benefits might be a better investment for the federal government because state Medicaid coverage is often less expensive than private coverage.

On the other hand, a Medicaid purchase option may be seriously flawed because of the current widespread refusal of providers to accept persons with Medicaid coverage as patients.[42] While some of this refusal to participate in Medicaid might abate if the program were increasingly opened to the working poor (and some of the welfare

stigma surrounding the program were thus removed), significant numbers of providers would undoubtedly continue to refuse to participate unless Medicaid reimbursement rates were brought more into line with those currently offered under private insurance plans. For example, according to one recent study, an obstetrician may charge as much as $3,000 for a normal maternity care package; yet on the average, Medicaid programs will pay about $450 for these services.[43]

2. Programs must be developed to assist low-income employees purchase dependent coverage from those employers who offer it. As noted above, a sizeable number of employers offer dependent care coverage for their employees' families, but at a sizeable cost. Reforms are needed either in the form of a tax credit or some other type of subsidy in order to make dependent coverage premiums more affordable for lower income employees. Congress should also look at the propriety of tying the employer tax deduction to the requirement that employer plan premiums be adjusted for family size and income in circumstances where employees pay all or a substantial share of the premiums.

3. The benefit improvements embodied in CHIRP should be enacted and expanded. All employer-purchased health insurance coverage should meet minimum scope and content requirements. This is of course, the aim of CHIRP. The nation invests so many billions of tax dollars in subsidizing employer-purchased health insurance that it is difficult, if not impossible, to justify not setting a modest but important floor on benefit coverage.

In addition to the benefit improvements contained in CHIRP, we recommend that all employer-purchased plans be required to offer the following services:

- o pediatric dental coverage: Over 95 percent of all children need dental care. Indeed, dental problems represent the most common childhood health condition of all. Yet few plans offer such coverage.
- o vision and hearing care, including eyeglasses and hearing aids.
- o followup diagnostic and treatment services for conditions disclosed during a child's periodic CHIRP health assessment.

Each year the federal government spends several hundred million dollars directly through the Medicaid program to ensure that these recommended services are provided to poor children eligible for Medicaid EPSDT benefits. The justification for this expenditure is the broad body of literature confirming the cost effectiveness of continuous preventive health care coverage of children. Children with comprehensive health insurance coverage are more likely to have a regular source of care; and having a regular source of care has been identified with better use of preventive services, more family awareness of good health practices for children, and lower overall health costs per child.[44] If minimum federal standards for pediatric health care can be justified under a direct insurance program such as Medicaid, they are equally as justifiable under private insurance programs subsidized by large federal tax expenditures.

While some would argue that the scope and content of private insurance plans is best left to the employer/employee bargaining process, this argument assumes that in all circumstances the plan is crafted by bargaining. Many plans, of course, are not bargained

for. Where there is bargaining it may be constrained by the choice of benefits offered by a handful of insurance companies. And also, those on both sides of the collective bargaining table may not be fully aware of the human and fiscal importance of insisting on comprehensive coverage of children. Data on children's utilization of health care suggest that many families are simply unaware of the importance of pediatric health care; and thus, employers and employees may not make it a negotiation issue. For example, in 1980, 5.8 percent of children between the ages of zero and two in non-poor families made no visit to a physician, even though accepted medical practice standards call for a minimum of 6 visits in the first year of life and three in the second.[45] Our children cannot afford such ignorance and it is incumbent on government to set minimum standards on how billions of tax dollars will be used.

Finally, coverage for preventive pediatric benefits, including periodic health exams and immunizations, should be exempted from any costsharing requirements. While minimal costsharing might be tolerated for diagnostic treatment care, employees should be encouraged as much as possible to seek preventive services for their children. Therefore, the benefits embodied in CHIRP should be provided to employees on a "first-dollar" coverage basis.

Senator CHAFEE. You missed me on that last point. Would you repeat it?

Ms. ROSENBAUM. The plan, as it is now drafted, mandates coverage of certain benefits, but the coverage is not mandated on what would be called a first-dollar basis. I'll give you an example. I have an insurance plan, and for each of my family members, there is a $100 deductible. Now, currently, my insurance plan does not even credit me toward my deductible if I take my daughter to a doctor for a checkup. If CHIRP were enacted, the effect would be that unless my daughter were very sick during a year and needed to get a lot of sick child care, I would submit the bill for well-child care and I would get credit toward her $100 deductible. I would get no "first-dollar" coverage. Since the last checkup she had cost $60 or $70, and since I would still have to pay that amount "out-of-pocket", were I less well-to-do, I would still not be able to get the care for her, even under CHIRP.

This is a big problem because in the past several years, many employers, in an effort to contain costs, have, in fact, raised deductibles and coinsurance as well as premium requirements for employees and their dependents. It's not uncommon, for example, to find a family coverage plan with a $500 family deductible.

Senator CHAFEE. But that's a cumulative deductible, isn't it?

Ms. ROSENBAUM. Yes. But if nobody else in the family—in my case, it's an individual deductible, but you might look at it as a $300 deductible, since there are three of us in my family—went to the doctor in a year, except my daughter for her well-child exam, the care would be credited toward our family deductible, but, in fact, we would get no compensation for the care.

Senator CHAFEE. But that would be true for you yourself.

Ms. ROSENBAUM. Yes. In my case, it poses no problem because my family has the resources to pay for her checkup regardless of whether it's first dollar or not. A poor family—and as I have mentioned, there are many poor families who need the benefits of CHIRP—would not be in a position to lay out funds on an uncompensated basis for the child's care.

Senator CHAFEE. Didn't you say we should require the first-dollar coverage for children, but not for adults. Is that what you are suggesting?

Ms. ROSENBAUM. Yes. For example, you could decide to require that certain kinds of services under employer-purchased plans not only be included in the plan, but provided on a first-dollar basis. And you could specify what those services would be, similar to the Medicaid Program which specifies that certain services are first dollar, in essence, and others are not.

Senator CHAFEE. All right, fine. Well, thank you very much, Ms. Rosenbaum for your testimony.

Ms. Gustafson.

STATEMENT OF MS. LYNN GUSTAFSON, LEGISLATIVE CHAIR, NATIONAL ASSOCIATION OF SCHOOL NURSES, INC., HEBRON, CT, ON BEHALF OF THE NATIONAL EDUCATION ASSOCIATION

Ms. GUSTAFSON. Thank you, Mr. Chairman.

I am Lynn Gustafson, and I am speaking today on behalf of the school nurses in this country and myself based on my own experiences of 17 years of school health services.

School nurses have always been concerned with preventive health care. In fact, it is our job. My experience, though, tells me that over 60 percent of the children that I serviced are not covered by any preventive health care insurance. Everyone assumes that these children are healthy. However, research has shown that diseases which manifest themselves in the middle years actually begin in childhood. Some of these diseases are Athro sclerosis, hypertension, obesity, anemia, and heart damage from untreated strep infections.

Therefore, we believe that all preventive and health promotions should begin at birth for it is at this age, the period from birth to the age of 5, that a child will experience its most rapid change in physical growth and development. And also his health——

Senator CHAFEE. From when? Birth to 5?

Ms. GUSTAFSON. Birth to 5. And, basically, this is when their health habits begin to develop.

Because of these rapid changes, the Academy of Pediatrics has suggested that there be eight physical exams between the ages of 2 months and 5 years of age. The physical exam will also include immunizations.

In the cost study that I did in my own community, this health care will cost anywhere from $350 to $380 in the 5-year period. However, that is only for the well child. Many of these youngsters do not have well-developed immune systems so they become very vulnerable to many of the infections and diseases that plague early childhood. In particular, middle ear problems.

Moneys for well child coupled with illness payments can really be a great financial burden, especially to the young working family.

As the child enters into the school-age years, ages 6 to 18, the need for physical exams becomes less because of decrease changes in physical growth and development. However, the cost for a physical exam may vary from anywhere from $40 to $65, depending on the need for immunizations and other screening tests.

In looking at health promotion and disease prevention on a national level, the Surgeon General in his report developed five major goals for all Americans. The goal for children is to provide a disease prevention model delivered to a child by a health provider in a system. This means that this health provider may be a physician; he may be a physician's assistant or a nurse practitioner. The setting could be in his office, in a clinic or in a school-based program.

These services should include infant care, immunizations, assessment of growth and development, blood pressure control, family planning, and information on prevention of pregnancy and sexually transmitted diseases.

The Surgeon General continues by saying "the one barrier to achieving this goal is the chronic underfunding for health prevention, especially third-party reimbursements."

We do know that health prevention can be cost effective. Programs such as title 19 of Medicaid, who have the preventive health services, have reduced medical costs within 30 to 50 percent.

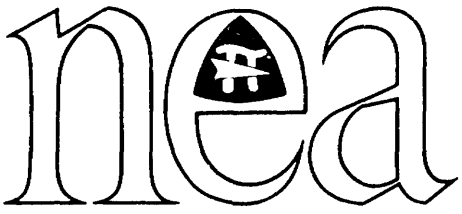
We feel it is time to move from a medical model in which the patient is diagnosed and treated for a disease to a prevention model in which the client with the medical care provider can sit down and review the physical exams, laboratory tests, assessments, screenings, et cetera, so that he can plan a healthier lifestyle and, therefore, decrease the amount of disease in later life.

We feel that this piece of legislation is one step to reaching this goal.

Thank you.

Senator CHAFEE. Well, thank you very much, Ms. Gustafson.

[The prepared written statement of Ms. Gustafson follows:]



LEGISLATIVE INFORMATION

TESTIMONY OF

THE NATIONAL ASSOCIATION OF SCHOOL NURSES

AND

THE NATIONAL EDUCATION ASSOCIATION

ON THE

CHILD HEALTH INCENTIVE REFORM PLAN

S. 376

BEFORE THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

Presented by Lynn Gustafson

September 16, 1985

Chairman Dole, Senator Chafee, Members of the Committee, I am Lynn Gustafson, Legislative Chairperson for the National Association of School Nurses and Supervisor of School Health Services for the Manchester Board of Education, Manchester, Connecticut. I appear today on behalf of the National Association of School Nurses and the National Education Association.

I have come to speak in favor of S. 376, the Child Health Incentive Reform Plan introduced by Senator Chafee.

As a school nurse, I am particularly aware of the importance of preventive health care. In my practice, approximately 60 percent of the school population is not covered by any preventive health insurance. This places an added financial burden on our working parents. Often, parents would wait to obtain medical care for their ill child; thus, incurring more expensive care; a longer recovery time; and a higher absentee rate from school. Until recently, parents would use the emergency rooms for chronic illnesses or injuries because their insurance would pay for this type of care. Recent changes by the insurance carriers now prohibits this.

In reviewing the Surgeon General's report on Health Promotion and Disease Prevention, five major goals were developed in order to improve the health status of all Americans. From these five goals the 1990 Health Objectives for The Nation (227 objectives) were developed.

The objectives for children and adolescents include disease prevention services which are usually delivered to individuals by a health care provider

in various clinical settings. These services included infant care immunizations, assessment of growth and development, high blood pressure control, family planning, pregnancy, and sexually transmitted diseases. All these services are usually paid for under a preventive health care insurance plan. This report also stated that there are several barriers which must be overcome in order for us to achieve the 1990 health objectives. One of these barriers is the chronic underfunding, including the lack of third-party payment, for health promotion and disease prevention. S. 376 would help in tearing down this barrier.

Preventive health care can place a heavy burden on a young family. At birth, many newborns are not covered by any health insurance. If the birth was premature, or if the newborn develops a medical problem the financial burden may be astronomical. From birth to age five, a child will experience rapid changes in his/her physical growth and development. The Academy of Pediatrics suggests that children be examined at two months, four months, six months, nine months, one year, 15 months, 18 months, two years, and at age four-five years. The total cost of well-child care averages from $350-$380 per child (see appendix).

I cannot stress the importance of periodic evaluations strongly enough. Research has confirmed that early identification and treatment of health care problems is not only cost effective, but helps the child function more effectively in his/her environment. Also, at this age, children do not have a well-developed immunity system; thus they are most vulnerable to colds, ear infections, etc. The leading cause of death in this age group is from

accidents. Thus, illness combined with accidents can substantially strain a family's financial burden.

As the child enters the school system, he/she experiences a slowing down in the areas of growth and development; thus periodic exams are less frequent. However, most states have mandated screening programs for vision, hearing and scoliosis within the school setting. If a child has developed a problem in one of these areas, he/she is referred to a medical care provider. These services are not usually included in a health care plan. Several of my families find it very difficult to pay for these services, especially if it affects more than one child in a family. Research indicates that heart, lung, and blood diseases which manifest themselves in the middle years actually begin in childhood. Thus, the health assessment of the school age child (five years to age 18) should include laboratory studies. These studies provide base-line information which is essential to a long-term health care plan. For example, if a child's blood studies indicate an increase in blood cholesterol, the family would be able to alter his/her dietary habits before disease develops.

Routine screening procedures, such as blood pressure screening of all children over three years of age, is essential in controlling hypertension. Recent studies indicate that children, like adults, experience primary hypertension the cause of which is obesity or a history of hypertension in the family.

As the child enters adolescence, other problems begin to develop. Periodic evaluations can lead to early diagnosis of anorexia, bulimia, drug and alcohol addiction, teenage pregnancy, and sexually transmitted diseases. By evaluating the teenager in a health prevention model, many of the above problems can be detected and appropriate interventions can be established prior to the onset of disease or pregnancy.

Although I do not have any cost figures which will predict how much preventive health care will save this nation in health care costs, the Early, Periodic Screening Diagnosis and Treatment Program (EPSDT) funded under Title XIX, has shown a decrease in 30-50 percent in both hospital and medical costs for low-income children. Coverage of preventive health care may be modestly more expensive for employers but will pay for them in reduced family stress and less employer-paid sick leave taken to care for sick children or for repeated visits to a physician for treatment that could well have been avoided if early care had been provided.

The future of health care is in a prevention model, not a medical model. S. 376 will help provide access to this model for our children. It will also help in achieving the 1990 Health Objectives for the nation.

We must take the steps necessary to protect the health of our children and in so doing improve the health of our nation now and for years to come. Thank you for this opportunity to appear before you today. I would be pleased to respond to any questions you may have.

APPENDIX

COST FOR WELL-CHILD CARE

AGES 2 MONTHS TO 5 YEARS

2 months	DPT, polio and check-up	$48.00
4 months	DPT, polio and check-up	48.00
6 months	Polio and check-up	36.00
9 months	Check-up	28.00
1 year	Check-up and DPT	38.00
15 months	M.M.R. and check-up	45.00
2 years	Check-up	25.00
4 or 5 year	Check-up	62.00
		$372.00

STATEMENT OF DR. ROBERT J. HAGGERTY, PRESIDENT, AMERICAN ACADEMY OF PEDIATRICS, NEW YORK, NY

Senator CHAFEE. Dr. Haggerty.

Dr. HAGGERTY. Thank you, Mr. Chairman.

I'm Dr. Haggerty, president of the American Academy of Pediatrics, and I appreciate the opportunity to testify on behalf of the Child Health Incentive Reform Plan.

You've described it very well, and I won't repeat that, but to merely say that these insurance plans currently encourage hospitalization procedures and other acute services that contribute to the escalating costs.

Now the insurance industry says that—one of the arguments is that it does not discriminate against children because the benefits are provided to—the insurers supply equally to adults and children. But here is where we cannot agree. Because children specifically use and need preventive services much more than acute services and particularly hospital services, the receipt of services under the current insurance is not equitable.

We've heard from you and the other witnesses about the payoff of preventive services. Immunizations have a tenfold benefit for every dollar spent. But preventive services for children include much more than immunizations. They include screening for disease, counseling for problems found, anticipatory guidance, prevention of accidents, prevention of problems that will arise in the future, depending on the age and the health habits of the child.

These are all part of preventive services, and part of EPSDT, which, as we have heard, decreases the cost of acute care when it's provided to low-income families.

Now there is no doubt that health insurance premiums have experienced extraordinary inflation, but the cause of this inflation must be traced to the design of the policies themselves, the encouragement of unnecessary acute and largely hospital services.

No fewer than 15 studies have found that preventive health care for children has a clear and positive effect in reducing illnesses.

Now in our judgment, CHIRP does not amount to Federal regulation or mandating of the insurance industry. We believe that this regulation properly belongs to the States. We are supporting tax reform and we are supporting this as an incentive to a more equitable health system.

Now no State mandates coverage of child health supervision services. And this has been an argument—why don't the States do it? But in 1984 and again this year, legislation similar to CHIRP was passed by California legislature but vetoed by Governor Deukmejian. On both occasions the Governor gave as one of his reasons the concern that the bill would create one more State-mandated obligation on an employer that would serve as an impediment to the attraction of new business to our State.

Therefore, individual States are reluctant to institute changes that they perceive would put them at a competitive disadvantage with other States when vying for new business. Therefore, we believe this incentive has to be at the Federal level.

To date, there have been no serious attempts by insurers to test the efficacy or the sales of these changes. With the exception of HMO's, which together now enroll 7 percent of the population——

Senator CHAFEE. What percent is that?

Dr. HAGGERTY. Seven percent. And they are rapidly growing each year. Few plans appropriate benefits for the needs of children.

Blue Shield of Pennsylvania began offering such preventive care 4 years ago and has since halved its modest premium for such coverage. Banker's Life of Des Moines offers this package at no premium increase, as does Union Mutual Insurance Co. Because, as a company spokesman explained, substitution of appropriate preventive care today for acute care tomorrow will lower medical costs, and our policyholder's premiums.

Mr. Chairman, as you have said, the cost of providing such improved coverage is next to nothing. Recently, the Academy of Pediatrics engaged an independent actuary to work with actuaries from a major insurance company to develop a model for estimating premiums. The bottom line is that the total cost for providing all child health supervision services from birth to age 20 costs only as much as 1 day in the hospital or the average monthly premium for families would be $2.28. And this does not take into account the reduction in cost that would occur from picking up disease early and preventing it.

Mr. Chairman, in our opinion, one very good way to reverse the inflationary influence of illness-oriented health insurance is to change the nature of the insurance coverage to encourage prevention and early diagnosis of disease.

CHIRP, we believe, does that.

Thank you.

Senator CHAFEE. Well, thank you very much, doctor. I appreciate the testimony you have given, and particularly your discussion of the experiences of some different insurance companies on this.

[The prepared written statement of Dr. Haggerty follows:]

American Academy of Pediatrics

T E S T I M O N Y

BEFORE THE

UNITED STATES SENATE

COMMITTEE ON FINANCE

SUBCOMMITTEE ON

TAXATION AND DEBT MANAGEMENT

ON

S.376, THE CHILD HEALTH INCENTIVES REFORM PLAN

PRESENTED BY

Robert J. Haggerty, M.D.

President, American Academy of Pediatrics

September 16, 1985

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Mr. Chairman, members of the Subcommittee, I am Dr. Robert J. Haggerty, president of the American Academy of Pediatrics, an organization representing more than 28,000 pediatricians who are dedicated to the promotion of maternal and child health. We appreciate the opportunity to testify today on behalf of the Child Health Incentives Reform Plan (CHIRP), which would amend the Internal Revenue Code to deny any employer a deduction for group health plan expenses unless such plan includes coverage of pediatric preventive care. It is our belief that reform of the tax laws as they apply to employer-provided health insurance is overdue. Current insurance plans encourage hospitalization, procedures and other acute services which contribute directly to escalating health care costs; they discourage preventive care and early diagnosis of disease both of which decrease costs. The special tax status granted to employer-provided health insurance plans thus has helped to create waste, inefficiencies and inflationary pressures on our health care system. It also has permitted serious inequities and discriminatory practices against children.

TAX POLICIES ARE DISCRIMINATORY

Mr. Chairman, among other cherished Constitutional goals, the Founding Fathers established a nation "to promote the general welfare." Surely we all can agree that the good health of America's children is central to that aspiration. Yet taxpayers today are being forced to subsidize group health insurance plans which adversely affect the health of children.

Common sense is at the heart of CHIRP, S.376. Employer-provided group health plans, which are tax deductible, now represent the second largest taxpayer-supported health program, after Medicare, in this country. In 1986, this subsidy

will cost the federal government $32 billion in lost revenues. Because of their special tax-deductible status, group health plans have become the dominant method of financing personal health care services in the U.S. According to the Bureau of Labor Statistics, more than 80 percent of all full-time employees are covered by some form of private health insurance.

But the record of the insurance industry in meeting the personal health care needs of children is not impressive -- indeed it is spotty at best, having pulled the health care system in a direction inimical to children. While overproviding for hospitalization, surgery and procedures, it has underprovided for preventive services, such as well-child care, that children need. The problem for those of us who are directly concerned with delivering health care to children is that insurance carriers have erected financial barriers between the children and the services they need.

The industry admits to certain shortcomings in its treatment of children, namely, that insurance is designed to spread risks; that the types of child supervision services excluded from coverage are not costly; and that, therefore, they are budgetable and should be paid directly by the family. The insurance companies contend, moreover, that they do not discriminate against children because the benefits they provide apply equally to adults and children. But there is a clearly disparate impact -- group health plans generally deny coverage of ambulatory care to adults and children alike, while it is children who more specifically need such services.

COVERAGE EXPANDS - BUT NOT FOR CHILDREN

Health insurance, by design of the industry itself, is unique among the many lines of insurance. For more than three decades, it has developed and expanded as a

form of prepayment. It has covered vision services, toenail-cutting services, dental checkups and prescription drugs. It has developed insurance for stomach aches in Mexico and for specified "dread diseases" in the United States. It has found ways of covering the services of chiropractors, optometrists, and faith healers.

The health insurance companies describe the many coverages as "innovative." They commonly boast, "we will sell anything you want." However, what they do not sell is coverage for child health care needs, even though there is evidence of consumer interest and compelling evidence of the public interest. America's dominant health insurance system has a responsibility to market preventive health care for children. The tax laws should encourage that end.

Young working people with children must rely on their employer-provided health insurance even more than older workers must. Younger families generally have less income. It is often difficult to budget, with after-tax dollars, for any but the most essential costs of living, such as housing, food, clothing and transportation. If the health insurance plan excludes coverage of well-baby and child health supervision services, many families will wait for symptoms of illness to appear before bringing the child in -- and that can be tragic.

MEETING NEEDS IS COST-EFFECTIVE

While most American children have been immunized by the time they enter school, there are still millions of others -- including a substantial percentage of all pre-school children -- who do not receive vaccinations for measles, rubella, mumps, polio and diphtheria-tetanus-pertussis. Immunizations are not generally covered by private health insurance even though a bipartisan study released last month 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. Neither is screening generally covered even though for each dollar spent on screening Texan children for congenital malformations, eye and ear problems, and preventive dental care, $8 was saved in long-term costs and income loss.

It is ironic that Medicaid provides for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) of eligible children, but private health insurance does not. It has been found that children screened through EPSDT in Missouri were on average 33 percent less costly to Medicaid than other children. In Ohio, they were 30 percent less costly; in North Dakota, 40 percent less, and so forth. The House Select Committee has concluded in its report that EPSDT saves $2 for every dollar invested in the program.

CHILDREN ARE DIFFERENT

Children are not just small adults -- they differ in size, metabolism, immunity, joint structure, skin, neurologic maturity, intestinal and digestive ability, brain susceptibility, emotional maturity and more. Children are constantly growing, developing and changing. That is precisely why child health supervision is so vital, and why it is so deplorable that health insurance plans continue to cover adult needs (hospitalization and medicine) and exclude children's needs (preventive services/ambulatory care). It is important to prevent diseases that can be prevented. From diphtheria to measles, there have been repeated unnecessary epidemics. From avoidable meningitis to rheumatic fever recurrences, there have been untold numbers of children damaged or killed. The question arises: Why does private health insurance fail to cover the needs of children, who under the age of 15 require only about one-fourth as much hospitalization as adults do? Is it costly to cover this population? Is the competition so fierce among carriers that price considerations rule out child health supervision?

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 annual rises or more. But surely a major cause of the inflation must be traced to the design of the policies themselves, the encouragement of unnecessary acute, largely hospital services, and the exclusion of office-based 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 half-pound. No fewer than 15 studies have found that preventive health care has a clear, positive effect on reducing illness and improving children's health.

Should taxpayers subsidize health insurance policies which discriminate against children and which cause imbalances and inflationary pressures in health care? In our opinion, the answer is unequivocally NO. We hope the committee will agree -- with us, and with the numerous like-minded organizations which have announced their public support for CHIRP, among them, the American College of Osteopathic Pediatricians; American Parents Committee; American Public Welfare Association; American Veterans Committee; Catholic Health Association; Child Welfare League; Children's Defense Fund; Lutheran Council in the USA; National Association of Children's Hospitals and Related Institutions; National Education Association; National Perinatal Association; People's Medical Society; and the General Board of Church and Society, the United Methodist Church.

ROLE OF THE STATES

Let us make clear that CHIRP does not amount to federal regulation of the insurance industry. We believe insurance regulation properly belongs to the states. We are supporting tax reform. We are calling for an end to favorable tax treatment for health insurance plans which maintain unfavorable provisions for children's

health. What are the states doing about the problem? The answer is that there is little they are doing, can do, or would be inclined to do so long as the system is driven by federal tax policies.

State regulation of health insurance is focused mainly on solvency of the insurer and on any fraudulent practices. The insurance departments approve policy rates to assure they are reasonable in terms of covering the costs of the promised benefits. With hundreds of insurance companies offering differing gradations of benefits, generally for the same hospital, surgical and procedural services, the insurance departments seemingly have enough to do working through this mathematical labyrinth. They do not normally recommend or even suggest policy changes affecting scope of benefits.

No state mandates coverage of child health supervision services. In 1984 and again this year, legislation similar to CHIRP was passed by the California legislature and sent to Governor George Deukmejian for his signature. On both occasions the governor vetoed the bill. One of his reasons, according to the 1984 veto message, was his concern that the bill "would create one more state-mandated obligation on an employer that would serve as an impediment to the attraction of new business to our state." Since states may be reluctant to institute changes that they perceive would put them at a competitive disadvantage with other states when vying for new business, legislation is all the more necessary at the federal level.

To date there has been no serious attempt by insurers to test the efficacy of benefit changes in employer-based health insurance plans. With the exception of the HMOs, which together now enroll about 7 percent of the population, few plans appropriate benefits for the needs of children. Blue Shield of Pennsylvania began

offering children's preventive care four years ago, and has since halved its modest premium for such coverage. Bankers Life of Des Moines offers this package at no premium increase to [redacted] Mutual Insurance Company because, a company spokesman explained, "substitution of appropriate preventive care today for acute-care services tomorrow will lower medical costs and our policy holders' premiums." Yet these carriers remain conspicuously progressive.

HEALTH CARE GUIDELINES AND COSTS

The Academy long has recommended guidelines for the care of children and youth. They provide for specified services at specified times in the child's life, and are broadly incorporated into S.376. Since each child is unique, the guidelines are not rigid, but do offer a basis for premium cost estimates by third-party payers when combined with [illegible]on fees and charges in various communities.

Recently the Academy engaged an outside independent actuary to work with actuaries from a major insurance company to develop a model for estimating premiums. Using a client company with 45,330 employees, of whom 31,490 had a total of 41,167 dependent children, the actuaries applied the Academy's recommended services to calculate utilization figures per child. The Academy then surveyed pediatricians in 60 cities and obtained their charges for covering the recommended services, which we will [illegible] by geography. Pediatricians in 40 cities responded in sufficient detail to include in this report. The bottom line is that the total costs for providing all child health supervision services from birth to age 20 costs about the same as one day in a hospital.

Translated into premium costs, the average monthly premium per family for covering all the services was $7.28. This compares with the $200-plus per month now being expended for illness-covered health insurance. And the premium costs for child

health supervision do not include credits for reductions in illness and hospitalization which would surely result.

CONCLUSION

Mr. Chairman, in our opinion one very good way to reverse the highly inflationary influence of illness-oriented health insurance is to change the nature of the coverage to encourage prevention and early diagnosis of disease. The place to begin is with children, where the research has shown there would be the highest payoff. Considering the dominance of employer-provided health insurance, there is only one way to end the inequitable provisions applying to children, and that is to deny tax deductions to those plans which practice such discrimination.

We further believe that inclusion of equitable benefits for children would create incentives and impetus for an overdue redesign of health insurance plans. Compensating changes are much more acceptable to unions and employers than are cutbacks, and child health care benefits can be an attractive addition to help reduce both employer costs and the amounts deducted for health insurance from taxable income. Reductions would also occur in government health expenditures, which are driven by dysfunctional health insurance incentives.

It has been 30 years since Congress addressed the real issues of tax treatment of employer-based health insurance. Because the laws have lacked even the most basic standards, insurance has driven health care into what is now universally perceived as a cost crisis. It has established financing patterns that are unfair to children and their parents.

We believe the tax laws have to be reformed to create an improved and more equitable system -- CHIRP should certainly be part of that progress.

STATEMENT OF DR. DAVID CHADWICK, MEDICAL DIRECTOR EMERITUS, AND DIRECTOR, CENTER FOR CHILD PROTECTION, SAN DIEGO CHILDRENS HOSPITAL AND HEALTH CENTER, SAN DIEGO, CA

Senator CHAFEE. Dr. Chadwick.

Dr. CHADWICK. Thank you, Mr. Chafee. I convey my compliments and those of the Childrens Hospitals to you for sponsoring this very far-seeing legislation.

I'm also a pediatrician. However, I'm here representing Childrens Hospitals rather than privately practicing pediatricians. The Western Association of Childrens Hospitals consist of nine childrens hospitals, seven of them in California and one in Seattle and one in Denver, the western set.

We don't deliver preventive services for children. That is a very small part of our work. We take care of sick and injured children after things fail to be prevented. So in a certain sense, we look at it from the other angle.

However, we prefer the broad to the narrow view of things, and we see ourselves as part of a health system; not as simply deliverers of curative or remedial services. So we are anxious to eliminate those conditions that we now treat, which we shouldn't be having to do because they are preventable.

And in my brief oral statement, I think I would like to dwell on why this is a public issue rather than a private one and one for the Federal Government rather than the States.

One of the questions that immediately comes up is if preventive services for children are such a good buy, why has it been unbought so long. What are the economics of this? Why aren't people out there scrambling for this wonderful opportunity?

And one of the reasons is—there are several reasons, but one is that the benefits or profits of this may not accrue to the person who is paying. In fact, they quite often don't. They accrue to somebody else. Also, the benefits may not be obvious at the front end. Not many people and very few parents, even people in policy positions, don't get to see the whole picture.

Let me use some examples to explain that. If I failed to take my child to get her immunized for polio, is she going to get polio? Well, no, she is not. In all probability, not in my community at least because 85 percent of the children or 80 percent or 79 or whatever it happens to be are immunized and the virus will not survive in a community where 80 percent of the children are immunized. All immunizations have this characteristic, and are, in fact, public issues for that reason.

The majority protects the minority who fail to receive them, up to a point. And if the level of immunization falls below a certain level, then there is a risk of an epidemic. And I'm old enough to remember polio and iron lungs. I'm old enough to remember even a little diptheria. And you don't have to have seen much of that to know that we don't want anymore.

Dr. Haggerty mentioned that preventive care goes well beyond immunizations, and I would like to mention some of those other things and explain why we need them.

Most people aren't aware that an infant born deaf will look pretty normal for the first year or so of life; will develop in a pretty normal way, although there may be some deviations. Lots of people won't recognize those deviations, and an infant can easily go for 2 or even 3 years before the failure to speak becomes an issue and a child gets referred for evaluation.

The difference between and early and a late referral of a deaf child is the difference between a speaking and a signing person later in life. And those are important communication issues. The child who is not recognized early presents an additional burden to society in the form of special education and other special services.

We still see children of the age of 3 who have dislocated hips that they were born with and weren't treated because they didn't get in to see a pediatrician and weren't recognized early. This particular abnormality is rather infrequent, but it does occur. And when it does, it can be fixed with a little splint which is applied to the baby at 2 months of age or so as opposed to a one-week hospital stay later on.

Dr. Haggerty mentioned nutritional problems. I think it was mentioned that even blood pressure now can be tracked from quite early childhood to later in life. And the proper and preventive and ameliorative provisions put in place early with a great reduction in mortality later in life.

You get the behavioral and the emotional problems dealt with, parent-infant relationships dealt with, avoidance of abuse, proper discipline, prevention of abuse in the next generation, all this and more for $2.28 a month. Such an incredible buy. We have really failed in marketing this in pediatrics, and we hopefully will do better at that in the future.

I think you've heard all the reasons why insurance companies might or might not get into this business. I think it's a Federal responsibility as long as there is a Federal tax deduction for the health premiums. And if we are going to get the most for the tax-exempt dollar, preventive services for children are the way to do it.

Senator CHAFEE. Well, thank you, doctor. You came in right under the wire.

[The prepared written statement of Dr. Chadwick follows:]

Testimony

of the

Western Association of Children's Hospitals

(WACH)

Presented by:

Dr. David L. Chadwick

Director of the Center for Child Protection

and Medical Director, Emeritus

San Diego Children's Hospital and Health Center

RE: CHILD HEALTH INCENTIVES REFORM PLAN

(S.376)

Before the

Senate Finance Committee

Subcommittee on Debt and Tax Management

The Honorable John Chafee, Chairman

My name is David L. Chadwick; I am currently the Director of the Center for Child Protection at San Diego Children's Hospital and Health Center. I am a former chairman of California Chapter 3 of the American Academy of Pediatrics and I served as Medical Director at San Diego Children's for 17 years. Today I appear before you on behalf of the Western Association of Children's Hospitals (WACH).

WACH is a non-profit organization composed of nine member institutions providing the vast majority of tertiary and most of the secondary health care services to children on the west coast and in the western section of the country. WACH was founded to promote recognition of the special needs and circumstances of children's hospitals in the formulation of public health care policy. These institutions include seven hospitals in California: Earl & Loraine Miller Children's Hospital and Medical Center (Long Beach); Children's Hospital and Medical Center of Northern California (Oakland); Valley Children's Hospital (Fresno); Children's Hospital of Orange County (Orange); Children's Hospital (Los Angeles); Children's Hospital (Stanford); and Children's Hospital and Health Center (San Diego). Recently we expanded the geographic scope of our organization to include the Children's Orthopedic Hospital in Seattle, Washington and the Children's Hospital in Denver, Colorado.

WACH applauds Senator Chafee and the Senate Finance Committee for its foresight in addressing the issue of pediatric preventive healthcare coverage under private-sector insurance. In this regard, WACH strongly recommends the adoption of S.376, Senator John Chafee's "Child Health Incentives Reform Plan", or "CHIRP". We would hope that this legislation can be included in the Senate budget reconciliation package.

CHIRP reflects a positive effort to bridge a gap in America's system of health care delivery. The vast majority of employer-provided group health plans contain no special provisions relating to the needs of children. While the health care needs of adults may be closely matched to the kinds of services provided through employee-provided group health benefits, the needs of America's youngsters are not reflected in those insurance policies. Senator Chafee's bill seeks to address this problem by requiring that employer-provided group health benefits include preventive health care services for an employee's children under the age of 21.

1990: The Surgeon General's Objectives and an Emphasis on Prevention.

The focus on health prevention has strong and immediate antecedents in the health policy of this Nation and this Administration. In 1979, the United States Surgeon General released a report on health promotion and disease prevention, entitled Healthy People. In it, the American people were challenged to participate with government, the private industry and healthcare providers to engage in a public health revolution. The focus was health promotion. The following year, in Objectives for the Nation, the Public Health Service (PHS) enumerated 226 specific health care objectives for the country to achieve by 1990 in order to meet the Surgeon General's challenge.

Included in these objectives was the goal that "by 1990, virtually all infants should be able to participate in primary health care that includes well-child care; growth development assessment; immunization; screening, diagnosis and treatment for conditions requiring special services; appropriate counseling regarding nutrition, automobile safety, and prevention of other accidents such as poisonings." Moreover, Objectives for the Nation also set out specific prevention goals for America to achieve by 1990 in limiting the incidence

of seven of the major childhood diseases. Finally, the plan set the objective that, by 1990, no comprehensive health insurance policies exclude immunizations. Since that time, the Reagan Administration has publicly embraced the health prevention mantle and the acceptance of the Surgeon General's 1979 challenge.

Yet, despite heroic appeals and optimistic projections, we, in 1985, remain far from attaining the objectives embodied in the Surgeon General's program. Today, of the more than 60 million children under age 19, one child in every six has no health insurance. Moreover, the insured child is not covered for the kind of necessary well-child ambulatory care that healthy children need because most private insurers do not cover such preventive services. The results of this failure to offer coverage are devastating.

For example, the 1980 Objectives called for a reduction of the reported incidence of measles to less than 500 cases per year. Yet today, 24.4 percent of all preschool children do not receive vaccinations for measles and in 1984 there were 2,534 reported cases. For rubella, the goal by 1990 is less than 1,000 cases. Yet almost one quarter of all preschool children are not vaccinated and, in 1983, 3,816 cases were reported. In 1980 the Public Health Service called on the nation to

reduce the incidence of pertussis to less than 1,000 cases a year. Today, 13 percent of all preschool children have not received the pertussis vaccine and there were 2,187 reported cases of whooping cough in 1984. These figures are not mere abstractions; children continue to suffer from whooping cough-related complications such as pneumonia, convulsions and brain damage.

Pediatric Preventive Medicine: The Need for Additional Incentives.

But the situation is not uniformly grim -- far from it. Over the past twenty-five years this nation has made enormous strides in improving the health of its children. The reduction in the reported cases of rubella by 98.7 percent since 1969 is testimony to this accomplishment. Between 1960 and 1980 the incidence of measles, polio and diptheria was reduced by more than 99 percent. Over the same time period, the incidence of pertussis was reduced by 87 percent and tetanus by 76 percent.

In similar fashion, the screening and testing of infants and children has reaped enormous gains. We have seen that school failure and behavioral problems can be prevented when sensory-deficit children are provided with glasses. We have learned that in order for treatments to be effective, we must

continue to promote the early detection of congenital visual defects, such as amblopia, in order to reduce serious visual difficulties. Only through the identification and treatment of infectious diseases at an early stage can we effectively control the spread of hepatitis, tuberculosis, and venereal disease, while also halting the progressive deterioration of a child's health.

Ten years ago, in Virginia, we learned that screening and counseling helped to significantly reduce the number of physicians visits, prescriptions and number of hospital days and visits. Medicaid EPSDT program statistics indicate that children who previously received benefits under the Medicaid program had almost 30 percent fewer abnormalities requiring treatment. Indeed, health costs for EPSDT children have been variously shown to range anywhere from 30 to 50 percent below the costs for children not receiving the program's screening and treatment. In 1982, the annual savings to Medicaid through the EPSDT program in North Carolina were $30.20 per child, while the comparable figure in Ohio was a whopping $250 per participant.

Similarly, exciting figures document a positive correlation between preventive immunization and lowered health care expenditures. Without an immunization program, the

incidence of measles in 1983 would have been an estimated 3 million cases instead of the 2,872 cases reported. If the measles immunization program had not been available in 1983, complications of measles would have produced an increased burden of $600 million to the nation's bloated health care bill. For all diseases, in the absence of the immunization program, medical costs would have been $1.4 billion in 1983. The cost-benefit ratios for the vaccinations are equally astounding. The mumps, measles and rubella (MMR) vaccine, for instance, produces a savings in later health costs of $14 for every $1 spent.

But it seems that our efforts in the area of preventive pediatric care may have begun to slip. Between 1983 and 1984, the Centers for Disease Control reported a 69 percent increase in the incidence of measles nation-wide. Rather than declining, consistent with the Surgeon General's goals, the number of cases rose from 1,497 in 1983 to 2,534 in 1984. Of these cases, the CDC reported that 34 percent were classed as preventable. Furthermore, in 1982, the number of cases of rubella and pertussis increased over the same figure for the prior year. At this rate, we are jeopardizing our opportunity of meeting the Surgeon General's objectives for 1990. If these objectives are to be achieved, then CHIRP must be seriously considered as one of the necessary vehicles for achieving these goals.

CHIRP would require that all employee health plans provide reimbursement for periodic comprehensive physical examinations, appropriate immunization, laboratory procedures, vision and hearing testing, and developmental and behavioral assessments. Moreover, the Secretary of the Treasury is charged with expanding the list of required services in consultation with the HHS Secretary and appropriate medical organizations. Estimates indicate that the monthly cost of coverage under such a bill for each employee would be approximately $2.28 per family. This figure reflects about one percent of the employer's current payment for employee health benefits.

The legislation would address the current inequity between group health care packages as they benefit adults and as they benefit children. Children are not just little adults. Optimal child health care includes regular visits to a physician for check-ups and immunizations. Preventive health care, however, unlike other medical disciplines such as surgery, is a health care service which all beneficiaries may want to use. Thus, the goals of well-child programs may run counter to some of the principles of insurance. Premiums in the insurance industry are based on the frequency with which beneficiaries use or do not use particular services. Insurers do not want to insure a population for services which all of the recipients are going to use. Insurance would otherwise

become a service for a flat fee, with little risk-related return. And yet, preventive health programs are designed such that all beneficiaries are supposed to visit their physician on a regular basis, receive regular check-ups and regular vaccinations. Hence, it is easy to understand the unpopularity of such programs with the insurance industry despite the limited costs of such programs and the long term gains in terms of overall improved health.

Cost Containment, Pediatric Hospitals and Preventive Care.

The changing environment of the health care industry, with the emphasis on cost containment, has forced pediatric hospitals to more closely examine health care issues from the perspective of the cost of care. Because, to a great extent, Medicare drives the structure of health care reimbursement nationally, the 1981 enactment of the prospective payment system has lent credence to the concept of prospective pricing. Using various techniques for implementation, other governmental entities and private insurers have eagerly adopted such reimbursement systems.

Even more pertinent for pediatric hospitals are the changes in Medicaid policy. While no new overall federal Medicaid reimbursement system has been forced upon the states,

many states have responded to federal cutbacks in Medicaid of over $3.7 billion since 1981 with cost cutting initiatives of their own. In California, we have recently witnessed implementation of a program that requires pediatric Medicaid recipients to receive all these services through HMOs on a prepaid, per capita basis.

WACH hospitals have large Medicaid patient populations. In California, our hospitals carry as high a load of Medicaid patients as 70 percent. Significant indicators show a positive correlation between a patient's severity of illness and a disproportionate share of low-income patients. In a situation where cost control is a preeminent concern, the hospital must support efforts to reduce the severity of the inpatient's illness. Clearly, WACH hospitals have a vested interest in promoting those low-cost procedures, such as well-child care, that help to prevent the onset of more costly conditions.

The Insurance Industry Issues: Objections to S.376.

Insurers argue that the type of coverage required under CHIRP would interfere with employee-bargaining because it would force employees to purchase an unwanted benefit at the expense of other desired options. For the large employer, the variety of health plans offered are oftentimes significant. Industries

in which collective bargaining is common frequently offer multiple benefit options, allowing the employee the opportunity of choosing whether to opt for pediatric preventive care benefits or not. Indeed, General Motors has recently included coverage of preventive health for children as one option in its cafeteria-style health care offering. Such cafeteria plans allow the employee to select among various types of nontaxable benefits up to a certain dollar amount.

The insurance industry has also argued that the infrequency with which such coverage is purchased by employee groups reflects a limited demand. As yet, only a handful of such plans exist. Moreover, when asked about preventive care, individuals in a research project sponsored by Robert Wood Johnson Foundation overwhelmingly indicated (85 percent) their desire for such services. The survey went on to show that these individuals would also be willing to pay for such services.

Finally, the insurance industry has indicated that regulation of the insurance industry has legally and historically been a function of state government. Enactment of legislation mandating pediatric preventive health care has been attempted in several states. In California, for instance, such a bill was vetoed by the Governor in 1984 because the measure,

according to the veto message, would discourage employers from locating in the state. This kind of situation inherently calls for federal intervention. When a state discards its lawful role as regulator in the public interest because of the fear of a resulting imbalance in relation to other states, it is incumbent upon Congress to act.

Preventive Medicine in the Context of the Budget and Tax Reform.

Let me briefly address the CHIRP concept in the context of some of the more global issues the Finance Committee is currently considering. Once again, the Finance Committee will have to bear a heavy share of the burden in obtaining cuts in program spending in order to comply with the Congressional Budget for FY 1986. It has been suggested that one of the methods for achieving some of the $22 billion savings required from programs under the jurisdiction of Senate Finance over the next three fiscal years will involve the enhanced efforts of States to collect payments from third party insurers. Enactment of the CHIRP legislation in the context of deficit reduction efforts may combine with increased third-party liability collection to help reduce both long-term and short-term Medicaid costs significantly.

In this regard WACH supports the report language of the Conference Committee on S. Con. Res. 32, (the 1st Concurrent Budget Resolution for FY 1986) in opposing collection efforts which might adversely affect beneficiaries. We urge consideration of the concept of direct state collection from

insurers. Through such a system, private insurers of Medicaid beneficiaries could pay for preventive care for low-income children. This is certainly an efficient use of resources. In the short-term, this may mean that precious Medicaid dollars spent on the EPSDT program could be diverted to other equally important Medicaid services. In the long run, services made available to non-EPSDT children through private insurance could help reduce Medicaid expenditures as a result of reduced disease incidence stemming from the increased early detection of childhood illness.

This Committee is also scheduled to begin consideration of the tax reform initiative. President Reagan, with the guidance of Republican Senate leaders, wisely decided to maintain the tax exclusion for employer-provided health benefit plans. While the cost to the nation in revenue foregone is variously estimated at $32 to $35 million annually, the alternatives of national health insurance or the provision of health care to vast numbers of chronically-ill, uninsured Americans suggest the cost effectiveness of the current system. The same argument, in terms of the cost effectiveness of private sector coverage, can clearly be made in the case of tax incentives for pediatric health care services. We have already seen how immunization, screening and early testing reduce the costs of health care to children. Moreover, it has been estimated that

the cost of the CHIRP program, given a strict adoption of the kind of services mandated under S.376, would only reduce Treasury receipts by a very insignificant amount.

Despite our strong support for enactment of this statute, WACH believes that S.376 is not a panacea for all the problems in pediatric preventive health. The bill makes no provision for the millions of American children who remain uninsured because their parents are also uninsured. Moreover, the bill cannot guarantee that preventive health measures will always be pursued by the child or the parent. As the HHS Secretary indicated in 1979, preventive health, more than other kinds of health care, requires the participation of community, family, employer, school and self. In line with this, education about the individual's role in assuring good health must be seen as a necessary adjunct to any regulatory schemes. If enacted, the bill introduced by Senator Chafee might well offer the opportunity for an examination of mandatory in-school immunization for all elementary-school aged children.

In summary, the Child Health Incentives Reform on Program is good public policy. Fundamentally it is based on the concept that preventive health care for children is a cost-efficient method of spending tax dollars which are foregone through exemptions from employer income. At a time

when national health care costs, both public and private, are under close scrutiny, it only makes sense to avail ourselves of such an opportunity. The health of this nation's children, and ultimately the health of all Americans, is founded on the proposition that through better preventive care we can all live more happy, productive lives. The Congress, specifically, you gentlemen are now provided with an opportunity act on this proposition. WACH strongly urges your adoption of this measure and inclusion of the language of this bill in the budget reconciliation measure.

Thank you for the opportunity to testify. I will be happy to answer any questions.

Senator CHAFEE. Let me just say that we are going to hear some testimony later on that the Federal Government should stay out of this business, and that we shouldn't even be discussing it. I think the point you made is a good one. That this is a deduction—and it's a very expensive deduction. On the other hand, I think that it has a remarkable effect on health care coverage for American workers.

If industry wasn't providing these, benefits, I think it's very clear that the Government would have to be providing them. Nonetheless, I think we have the right to levy certain requirements if we are going to give deductions which amount to such a large tax expenditure.

So my conscience doesn't bother me when I advocate involvement of the Federal Government in this area.

Now it does seem to me, however, that we've got to be cautious about how far we are going. In some of the testimony that is going to be presented in the following panel, the point is made that S. 376 is too broad. That we just go too far. This is the testimony from the chamber of commerce:

> Senator Chafee's bill would require coverage of, one, treatment, or end-stage renal diseases on the same basis as other health considerations. Pediatric preventive services for children up to 21, including health and development histories, comprehensive physicals, immunizations, laboratory procedures, vision and hearing, testing and treatment and other medical services described by the Department of Health and Human Services.

So the objection is that we are just going whole hog here. I would like to make it clear, however, that the comment about end-stage renal disease is untrue. It is already part of the code.

Now I think that in starting anything new—and I suppose this is what the insurance companies and the employer representatives worry about--you start something on a modest scale and it gets ex-

panded over time. We will let somebody else worry about how much it has expanded. Let's just talk about where we start.

We should try to keep the requirements modest and the cost down so that this is not a very expensive proposition. We do not want to see employers say the heck with the whole business; I won't have any coverage; I can barely afford it now. So we have got to be cautious.

So my question to you, Ms. Rosenbaum, and, Ms. Gustafson, what do you think we ought to start with? How far should we go? In other words, it seems to me that immunizations are so simple. I mean polio immunization seems to me is sine qua non. Diptheria, whatever the immunization is. And in your testimony you say that children don't have these.

Ms. ROSENBAUM. Well, certainly, Senator Chafee, as you know, at the Children's Defense Fund we concentrate our energies on the roughly 13 million children who live below the Federal poverty level. And as I pointed out, there are an awful lot of children living in poverty who by definition are not going to get much health care other than what either a public or private insurance plan furnishes to them.

There are many children——

Senator CHAFEE. Wait a minute. The ones below the poverty level, we assume that Medicaid is going to take care of them.

Ms. ROSENBAUM. That's not true, though. In fact——

Senator CHAFEE. It may not be true, if Medicaid isn't, covering them then chances are that they have got a working parent that is covered by some kind of a health plan which is probably pretty modest.

Ms. ROSENBAUM. Well, what we found when we looked, in fact, was that while two-thirds of children were living in a family—poor children—were living in a family where someone was employed, only 16 percent had full-year private insurance coverage. Now about 33 percent had either full- or part-year insurance coverage. And, of course, we can't even begin to tell you what the quality of that full- or part-year insurance coverage is. Beyond that, however, it was pretty clear that two-thirds of poor children didn't have any private insurance coverage.

Senator CHAFEE. So we are not going to pick them up anyway.

Ms. ROSENBAUM. We are not going to pick them up. We are only going to be helping, at most, the 33 percent of poor children whose current private insurance coverage does not include the CHIRP benefit. And as I said before, the cost is very modest not only because of the actuarial findings that the Academy has submitted, but also of course because those actuarial findings rest on the fact, as I mentioned before, that the coverage is not first-dollar. It's not a substitute, fully funded health care plan. It is simply defining some of the minimum content for the benefit package. The family will still have to incur and pay a deductible and will still have no coverage for so-called "sick child" costs.

The step that CHIRP is taking is, in my opinion, extremely important, but it's also a very modest step. Coming at it as someone who represents poor children, I don't think we ought to lose sight of the fact of how modest CHIRP really is as compared with the unmet need we are experiencing right now.

Senator CHAFEE. Ms. Gustafson—would you talk a little bit about when children get to school. It seems to me that when a child is 6, he or she is in school.

What happens then? Let's answer that question first. Doesn't the school provide these immunizations?

Ms. GUSTAFSON. Some schools do and some don't, depending on what their school health services program component parts are. In our school district, we do provide immunization, but as I said before, the pre-school years is where the immunization really should take place.

Senator CHAFEE. I agree. Now let's go to the pre-school year.

Ms. GUSTAFSON. OK. We will take the school-aged child.

Senator CHAFEE. No, let's take the pre-school. Now let's go back to the pre-schooler.

Ms. GUSTAFSON. OK. In our pre-school programs of which I also work under the Child Find Program, these are youngsters whose parents are working who are covered by private insurance plans, but have no preventive health care as part of that program. Therefore, when we go out and do an evaluation of the youngster, we usually make a referral back to the local pediatrician or specialty groups, or whatever, and that's where the cost to the parent really becomes a problem. There is further testing that has to be done, diagnostic procedures and a treatment modality of which is not covered by any of the insurance plans that I'm aware of except HMO's.

And I figured in our group we only have about 5 percent of our people who are into the HMO system in my community.

My concern—and you asked about how to cap this. In most insurance plans, you do have a capping or ceiling of how much you can get from your insurance plan. Also, there are certain things that are deductible and others that are straightforward being paid for directly from the insurance plan.

So I think by working out the plans is where some of that control can happen.

I would like to address the school-aged child, too, if I may.

Senator CHAFEE. All right. Go ahead.

Ms. GUSTAFSON. When the child goes to school, we begin to have programs such as hearing screening, vision screening, scoleosis and hematic screening and blood pressure. So actually we are trying to take in the five areas of high-risk factors that a child might have to deal with.

My concern is once we find a condition and we refer out, especially if there is one or more children in that family who also need to be referred for one of those screening programs, the parent can't afford it. And what happens is we do a good job in screening, but there is no followup or treatment. And that's where the whole thing breaks down for us.

Also, when a child becomes ill, parents tend to wait a little longer hoping that the child will get better on its own and not seek out medical attention early in the game. So what happens is the youngster is in longer treatment, perhaps has many more secondary problems than what he started with; now the parent has to lose time from work because he has to stay home with a sick child;

it's more costly because of the treatments are going to be longer and more expensive.

So we really see if we can prevent things in the beginning and then we wouldn't have all these other problems.

Senator CHAFEE. All right.

Dr. Chadwick, do you have any illustrations, examples you can give us of what you have seen in your hospital where a child went through a costly curative process that could have been percented, and therefore saved a great deal of money, if more emphasis had been placed prevention?

Dr. CHADWICK. I think I already mentioned congenital dislocation of the hip, the hip joint that is out at birth. And if it's treated right away, it's simple. And if it is delayed for 3 years, becomes a big operation.

She mentioned scoliosis, the bent spine thing that occurs in later childhood, especially in girls. If recognized early, it's a medical issue pretty much without any surgical process being required. Whereas, if it is delayed, the therapy is delayed, it can involve a surgical operation in putting steel in the back and stuff like that. It puts a child in the hospital for 10 days or 2 weeks and a kind of major operation.

I believe I mentioned—that Dr. Haggerty mentioned that counseling and recognition of emotional problems through well-baby care can eliminate—can't eliminate, but it certainly can modify problems in parent-infant relationships that would lead to abuse. And we see abused kids in our hospital that probably wouldn't have to be if they had had better attention along the way.

Senator CHAFEE. Well, I guess what I'm fishing for here, gentlemen and ladies, is that the opposition to this proposal isn't going to be that people are opposed to the idea or think that children shouldn't be taken care of. Nobody is going to come in here and be antichild.

The objections are going to be that we are opening the doors to massive regulatory requirements. What you are proposing, and particularly when you even mention mental illness—you are talking about a very expensive program in the eyes of employers and there is going to be testimony that $2.28 is just not accurate, and so forth. So what I'm trying to get a handle on is various degrees of limitations that we might have. Now, this isn't going to satisfy Ms. Rosenbaum, but we are dealing with realities. I want to get this program through and get started on it. We need choose the areas where we can get the biggest return for the investment.

And I guess that's why I'm trying to get from you—what we might do.

One of the things we've got to be cautious about, Ms. Rosenbaum, is suggestions that this is going to be another way of relieving the cost of Medicaid. Cut the cost of Medicaid, put them on this other program. Well, that's not what we are trying to do here. That's not the objective. So I'm trying to get from you some help.

Dr. HAGGERTY. I think in your wisdom you have not specified the periodicity of these preventive health services. But as I understand it, the bill is limited to that. And our expectation would be that in the regulation writing some existing specification of how many visits for preventive services would be paid for under this bill.

Like the Children's Defense Fund, we are concerned that there are a lot of things left out of this bill. But like you, I think we think this is a start.

Senator CHAFEE. Look, if I were a king, I would put them all in, but the reality is that isn't what is going to happen.

Dr. HAGGERTY. But I think regulations, therefore, can specify—we would think probably the American Academy of Pediatrics list of periodic health visits, which, as Ms. Gustafson said, is only eight from the time 2 months on to entry of school, is a reasonable one. And that really is very limited in cost. And the treatment is not included in this. So, if you talk about mental health services, it is the assessment, diagnosis, and the treatment that would be in the existing mental health services.

So we see this as a very limited and controllable type of expenditure for specifically preventive services.

As I understand it, also the end-state renal disease already covered by Medicare and is not a part of this—I think this was just put in because it is one of the things that currently is excluded from tax deductible insurance. Is that not correct?

Senator CHAFEE. That's correct.

Ms. ROSENBAUM. Senator Chafee.

Senator CHAFEE. Yes.

Ms. ROSENBAUM. I think there are two issues that are quite key. And I don't want to leave you with the impression either that we don't think this is a terribly important first step. We, obviously, have tried to illustrate some of the problems that remain, but I think that CHIRP in and of itself is a very important bill.

No. 1 is the fact that the bill does not cover treatment. At the most, CHIRP will mandate that an employer pay for certain preventive and assessment services. Employers still have tremendous latitude to negotiate the scope of the treatment services they will pay for.

A child may be found to have severe mental illness problems. If the employer's insurance plan does not cover outpatient psychiatric or other sorts of mental health treatment, then the family is going to have to pay for the care out-of-pocket. The same would be true with physical problems.

Second, and I think this is terribly important, most employer insurance plans do put a limit on the amount of coverage that the plans will cover for any sort of care. I'm now handling a case involving a child who unfortunately was born with a host of physical problems. The child's family has in 1½ years used $200,000-plus worth of health insurance. The insurance company stopped paying after the $200,000 mark because the child had hit the company's lifetime ceiling.

Many employer plans are unlike the Medicaid or portions of the Medicare programs, which don't put an upper limit on individual coverage.

Employers are free to indicate that they will go this far and no further. You are simply trying to, I think, "front load" the dollars that the employer is willing to spend. You are not suggesting the employer necessarily spend more dollars. If the premium costs go up slightly, employers and insurance companies have traditionally

had many steps for limiting their liability toward employees with annual or lifetime expenditure "caps."

Unfortunately, at CDF, we see an awful lot of families who are not going to be assisted by CHIRP because they have very sick children who have been left without insurance after they have used up their lifetime reserves.

I think when all is said and done, the very limited coverage offered by many employer plans acts as a natural limitation on the scope of CHIRP.

Senator CHAFEE. Ms. Gustafson.

Ms. GUSTAFSON. I agree, Senator Chafee, with the insurance limits. However, if you had to select, in my opinion, I feel that those preschool years are extremely important for a couple of reasons. Usually within that preschool time, earlier identification of problems is essential. Not only for treatment of the youngster in later years, but also that the parents get an opportunity to know what normal growth and development is all about; that they respond appropriately to their child as he is going through those formative years. I think that's really essential. We are talking about eight physical exams through that period of time. Also, immunizations are included in that packet so you will have your child immunized. You can do a lot of the screening devices during that pediatric check up.

Also, two other areas in the child's life that I think are essential are around 11 or 12 as they are entering adolescence, and then again around the 16-, 17-year-old age group where they are going into later adolescence and into early adult life.

I see those areas as prime for providing preventive health care.

Senator CHAFEE. What do you say about that, Dr. Haggerty?

Dr. HAGGERTY. I agree thoroughly. You were asking for examples before. One recent patient that I saw in the hospital was a young child of 1 year who had fallen off a second-story balcony. Because the child had never walked before, the parents were not anticipating that a child of year would suddenly get up and walk. And fell off and was permanently brain damaged. A huge hospital bill. A huge burden on the family.

This is the kind of thing that we hope by the visit to anticipate for parents who may not know normal development that a child at 1 will walk, will get into medicine, will fall. That kind of thing. And then the preschool period I would also put my emphasis on. But the preadolescent is probably equally important to talk about sexually transmitted diseases, the beginning of sexuality, the problems of school. These are all areas which is what we call the "new pediatrics." They are not the prevention of diphtheria and polio only. They are the prevention of one of the major problems today, accidents and behavior disturbance. And while they are a little less clearly defined, I think they are equally important.

Senator CHAFEE. Anything to add, Dr. Chadwick?

Dr. CHADWICK. I think we have mentioned hearing, we have mentioned a lot of physical disabilities. We mentioned vision. But early vision checks are very important in detecting problems that may come along later. A child can lose the sight of one eye quite easily if that early turning-in eye is not recognized and treated.

And that's quite a common problem. And so the early correction of those things is terribly important as well. I could go on and on.

Senator CHAFEE. All right. Well, thank you all very much for coming. I appreciate it. You did a good job. You were helpful.

All right, Mr. Mentz, Secretary Mentz. Welcome back.

STATEMENT OF HON. ROGER MENTZ, DEPUTY ASSISTANT SECRETARY FOR TAX POLICY, DEPARTMENT OF THE TREASURY, WASHINGTON, DC.

Secretary MENTZE. Good morning, Mr. Chairman. How are you?

Senator CHAFEE. All right. Why don't you proceed? Do you have a statement?

Secretary MENTZ. Yes, I do.

Senator CHAFEE. Let's see.

Secretary MENTZ. Did you not get it yet?

Senator CHAFEE. I do have a copy. Why don't you proceed?

Secretary MENTZ. It's my pleasure to appear before you this morning and testify on S. 376, which would amend the code to disallow to an employer a deduction for expenses relating to a group health plan unless the plan includes preventive health care for the children of employees.

The Treasury opposes this proposal, Mr. Chairman. And what I would like to do is just leave the statement for the record, and just make a few brief remarks about our position.

Certainly, the Treasury and the administration do not oppose preventive health care for children. The fundamental problem that we have is whether the Tax Code is the appropriate vehicle to use for this type of legislation. And, indeed, whether if it is, the task should be undertaken in a piecemeal fashion. It's really this kind of legislation by bits and pieces that could result in the Tax Code being subject to the kinds of problems that we are now trying to deal with in fundamental tax reform.

As you know, the tax advantages of health insurance provided by employers is very significant and very expensive from the Federal Government's standpoint. The benefits are excluded from income to the employees and the costs are deductible by the employers.

The current law does not constrain health care plans except in several respects, modest respects. An employer may not deduct health plan expenses if a plan differentiates in its benefits on the basis of whether an individual has in-stage renal disease, and that's a provision designed to avoid the problem of private insurance getting out of the coverage of in-stage renal disease and lopping it on to Medicare. It was put in in 1981.

Senator CHAFEE. If you want to talk about single shot specifics——

Secretary MENTZ. That is a real single shot.

Senator CHAFEE [continuing]. That goes way beyond specificity than anything I have proposed. If you are upset over what I have suggested, you must have been terribly upset when this one was proposed.

Secretary MENTZ. Well, that's already in the law.

Senator CHAFEE. I mean it was put in the law at some time. It doesn't grow in there.

Secretary MENTZ. Yes. It was put into law in 1981 as part of the omnibus reconciliation bill.

It seems to me it's distinguishable from a provision that provides substantive requirement as to what insurance coverage must be. To my knowledge, your proposal—and there are a couple of others floating around right now—would provide particular requirements for medical coverage. That is, group medical insurance coverage provided by employers.

If you strip away all the language in my testimony, Mr. Chairman, what we are really saying is, query whether the Tax Code is the appropriate place to do this. And even if you decide that it is, query whether the way to do it is in a piecemeal fashion, just taking one aspect of the problem—pediatric care. Some other Member is going to have another of his pet projects and he will want to put that in, and you will have a provision that will grow like Topsy without any rhyme or reason to it.

If this is a meritorious idea, and it seems to me—certainly from the first panel I must agree that there is a lot of persuasion behind this idea—it seems to me it ought to be addressed sort of in the fashion that ERISA looked at qualified retirement plan benefits. You take a kind of a broad look at what needs to be done and how it ought to be done. Should it be done in the Internal Revenue Code or are there other legislative vehicles more appropriate?

It is really that reason, Mr. Chairman, that the Treasury opposes this legislation.

Senator CHAFEE. Well, I see the problems you have raised.

Secretary MENTZ. I do have some technical points that I would just like to mention to you. Maybe that's the easiest way to proceed here.

Senator CHAFEE. Well, why don't you mention them.

Secretary MENTZ. All right.

First of all, the bill talks about children under the age of 21. We assume that that means children of employees covered by the plan. But it's not clear how that rule would apply if the plan does not provide family coverage, but only coverage for the employees—in other words, would the bill mandate this kind of coverage even though no other family coverage is required? I assume it would, but it isn't clear.

Also, age 21——

Senator CHAFEE. Wait a minute. I'm not sure what you are asking. Even though the coverage was only for the individual, would it be required?

Secretary MENTZ. Correct.

Senator CHAFEE. The individual employee?

Secretary MENTZ. Yes.

Or there are issues involving deductibles and copayments. Would it be permitted under this legislation to have a $100 deductible or what about a $10,000 deductible which would basically obviate the coverage?

These are technical points, but I think points that need to be addressed in terms of fashioning whatever legislation ultimately comes out.

Also, the language in the bill that describes the various types of medical services that have to be provided is somewhat general. The

term "appropriate" is used frequently. That term provides very little guidance. And we recognize that in terms of describing specific types of preventive care it's not easy because it is a dynamic field, but unless we have a more specific description, you are going to leave with the Treasury a very difficult project of doing regulation.

Senator CHAFEE. Each of these points are in your testimony?

Secretary MENTZ. Yes, they are, Senator. They are at the end of the testimony.

Senator CHAFEE. Well, I think those are valuable points and if you have covered them I think I would like to move on to the broader situation of whether this is an appropriate way to proceed.

Secretary MENTZ. Fine.

Senator CHAFEE. I must say that the end-stage renal disease provision, as we mentioned before, is far more specific than anything I'm doing here. But I suppose that's just what makes the insurance companies nervous. If we say they did it with in-stage renal disease, then we can do anything else.

Secretary MENTZ. Well, I'm certainly not representing the insurance companies.

Senator CHAFEE. No; I know that.

Secretary MENTZ. But in-stage renal disease, the reason that's in there is to make sure that private insurance provides for the first 12 months and then Medicare takes over. And the idea is that if the private insurance plans excluded in-stage renal disease, Medicare would be stuck for the whole thing. So it is really kind of a technical point.

Senator CHAFEE. Oh, I see.

Well, we appreciate your testimony. And, of course, the suggestion is that there may be a more appropriate way to proceed. Do you have any suggestions of a more appropriate way to proceed?

Secretary MENTZ. Well, I think that if this has the merit that you and obviously the first panel thinks it does it probably ought to be approached on a broader basis as was done in ERISA. It may be, Senator, that at some point we reach—or you collectively reach the conclusion that there is such an enormous tax benefit provided through employer-provided health plans in terms of the tax benefit that there should be limitations and restrictions on what is contained in those plans.

And I think if you do that, the way to do it is not through bits and pieces, but to take a kind of an overall look at it, much the way that the ERISA procedure did when the retirement plan, private retirement plan, system was under consideration. There are probably other areas that have the same type of merit that your proposal does. And it would be unfortunate to deal with it in a piecemeal fashion.

Senator CHAFEE. Well, the trouble with that comparison is that ERISA, as you know, was driven by a whole series of problems that had arisen; namely, the lack of transportability of the pensions, the collapse of several pension funds, and so forth that left employees high and dry. We don't have quite that same driving force here, I don't think.

Secretary MENTZ. Well, we do have one very important consideration that I did want to mention to you and that is that right now

there really are no nondiscrimination rules in certain insurance coverage provided for employees by their employers. This is one area that the administration's tax reform proposals would seek to remedy by providing a uniform non-discrimination rule.

Senator CHAFEE. You mean on accident health plans?

Secretary MENTZ. Yes.

You do have a discrimination rule in the case of self-insured medical plans, but if they are insured plans, there is no such rule in the code.

Senator CHAFEE. You mean under the present law, the boss could have all kinds of provisions and not provide any of them for his employees?

Secretary MENTZ. If it's an insured plan. And, typically, what would happen or what could happen under your proposal is you might have a plan that is well intended, a statute that is well intended, that would be designed to achieve pediatric care for particularly employees of the lower income employees that might not otherwise get it, and through a discriminatory plan, they might not even be covered.

So it seems to me that the nondiscrimination provision is fundamental to having your proposal work effectively.

Senator CHAFEE. Well, that's a good suggestion.

Secretary MENTZ. I seem to be giving you all these suggestions to improve your proposal, which I am opposing. [Laughter.]

Senator CHAFEE. That's what I thought. I think you have been an excellent witness. And we would like to get the Government to join on my proposal.

I thought I had you tilting at least a little bit there.

Do you have any revenue estimates on this?

Secretary MENTZ. We have a revenue estimate of a small loss, but I can't quantify it for you, Senator.

Senator CHAFEE. Yes; it would be a small loss because that is, as they say in the trade, on a static assumption.

Secretary MENTZ. Yes; not taking into account——

Senator CHAFEE. Savings that might occur, which are pretty hard to calculate. But I'm absolutely confident they are there, savings for the U.S. Government too.

Well, I appreciate you coming by, Secretary Mentz, and your views certainly will be taken into consideration.

Secretary MENTZ. It's a pleasure, Mr. Chairman. Thank you.

[The prepared written statement of Secretary Mentz follows:]

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STATEMENT OF
J. ROGER MENTZ
DEPUTY ASSISTANT SECRETARY (TAX POLICY)
DEPARTMENT OF THE TREASURY
BEFORE THE SUBCOMMITTEE ON TAXATION
AND DEBT MANAGEMENT
OF THE SENATE COMMITTEE ON FINANCE

Mr. Chairman and Members of the Subcommittee:

I am pleased to appear before you today to discuss S.376, the "Child Health Incentives Reform Plan." This bill would amend the Internal Revenue Code to disallow an employer a deduction for expenses relating to a group health plan unless such plan includes preventive health care for the children of employees. For the reasons stated below, the Treasury Department does not support this proposal.

Current Law

The Federal tax law provides tax advantages designed to encourage an employer to provide, and employees to accept, a portion of compensation in the form of health insurance. More specifically, under current law, an employer's contributions to a group health plan for its employees and benefits and reimbursements provided under such a plan are excluded from an employee's income and wages for Federal income tax and employment tax purposes. In addition, an employer may deduct the cost of these excludable contributions and benefits.

The tax law generally does not currently constrain employer and employee flexibility in the design of employer health plans. The only constraints include the following: (i) an employer may not deduct health plan expenses if the plan differentiates in its benefits on the basis of whether an individual has end stage renal disease; (ii) a highly compensated employee may not exclude from gross income a benefit provided under a self-insured heal h plan unless the

plan satisfies certain nondiscrimination requirements; and (iii) an employee may not exclude from gross income a benefit or reimbursement provided under a health plan (whether or not self-insured) unless the benefit or reimbursement is for the "medical care" of the employee, his or her spouse, and his or her dependents. "Medical care" is defined for this purpose to include the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.

Thus, under current tax law an employer may choose to maintain or not to maintain a group health plan for its employees. An employer that chooses to maintain a plan, with the exception of satisfying any applicable nondiscrimination rules, may determine which health services and expenses are covered, the appropriate level of deductible and co-payment requirements for each type of expense, the extent to which covered expenses should be restricted to selected health providers, the benefit options that should be made available to employees, and how costs should be allocated between the employer and employees. Of course, employees are able to affect an employer's decisions on these and related questions through the labor market and the collective bargaining process. Also, an employee may be able to design his or her own health benefit package through a cafeteria plan.

S.376: The Child Health Incentives Reform Plan

The Child Health Incentives Reform Plan would require that an employer-maintained group health plan provide employees with coverage for "pediatric preventive health care" as a condition of the employer's deduction for any expenses related to such plan. This rule would apply without regard to whether the employer's health expenses are in the form of payments to an insurance company or health services provider (including a health maintenance organization), contributions to a welfare benefit fund, or direct reimbursements to employees.

Under the bill, "pediatric preventive health care" would include the following types of periodic care provided to children under the age of 21: determinations of health and development history, comprehensive unclothed physical examinations, developmental and behavioral assessments, immunizations appropriate for age, health, and developmental history, laboratory procedures appropriate for age and population groups, and appropriate vision and hearing testing and referral for treatment as necessary. In addition, the bill permits the Treasury Department to require by regulation, after consulting with the Secretary of Health and Human Services and appropriate child care medical organizations, that a plan provide additional types of pediatric preventive care.

Discussion

The Treasury Department does not support the proposed legislation. With the exception of requiring that an employer health plan satisfy appropriate nondiscrimination rules, we do not believe that the Federal government should use the tax system to regulate group health plans provided by employers for employees. (On the nondiscrimination issue, as part of Fundamental Tax Reform, the President has proposed that uniform nondiscrimination rules apply to all tax-favored welfare benefits, including tax-favored health benefits provided under a contract with an insurance company.)

More specifically, we do not believe that substituting the view of the Federal government, no matter how well intentioned, for the choices of employers and employees about the benefits to be provided under employer health plans will result in a more optimal allocation of compensation and health benefits. In addition, we are concerned that imposing the Federal government's view of a proper employer health plan may impair the flexibility that is so important to the maintenance of an effective and cost efficient health care system. Finally, Federal regulation through the tax system of the benefits to be provided in employer health plans would likely be both duplicative of and inconsistent with state regulation of health insurance.

We recognize that pediatric preventive care may be an important form of health coverage, and that many argue that the broad provision of such care would result in significant long-term health benefits. (We of course are not equipped to evaluate many of these issues, and thus on the pure health questions we defer to the Department of Health and Human Services.) However, such a step by Congress in the regulation of health care provided by employers would make it very difficult for Congress to avoid broader imposition of mandatory health benefit provisions in the tax law.

In our view, the Federal government should not mandate that employer health plans provide any particular types of benefits and thus interfere with the decisions of employers and employees about the forms in which compensation should be provided and about the types and levels of benefits that should be provided under health plans. Certain employers and employees will decide that they prefer increased cash compensation over increased health coverage. Also, employers and employees will conclude that, within their cost constraints, one particular type of health coverage is more important than another. For example, an employer and its employees may well prefer to spend the health care dollars on catastrophic coverage rather than on lower deductible and co-payment requirements for other health expenses. Another employer and its employees may prefer to purchase increased preventive care coverage in exchange for reduced catastrophic

coverage or for higher deductibles. Because employers and employees have different compensation, health, and cost needs and constraints, decisions about the appropriate mix and levels of particular forms of compensation, including types of health benefits, are most appropriately made at the employer and employee levels.

We do not believe that the provision of tax advantages with respect to employer health plans justifies the Federal government mandating that such plans provide particular types of health benefits. Through the existing tax incentives, Congress has expressed its policy view that employers should be encouraged to provide a portion of employees' compensation in the form of health benefits. The result has been the successful extension of health coverage to a large portion of this country's employees. It would be in our view a distortion of the original policy of the current tax advantages for the Federal government to substitute its determination of the proper mix among health benefits for the decisions of employers and employees.

In addition, we are concerned that increased Federal regulation of employer health plans of the type proposed in S.376 would interfere with the flexibility that is so crucial to an effective health care system. Medical technology and practice are rapidly changing, and health costs are not easily predictable or controllable. Flexibility thus is crucial to the maintanence of a health plan that delivers the proper mix and levels of health benefits in a cost effective manner. In our view, mandating types of health benefits would limit this flexibility and inhibit both technological and practice innovations and cost containment efforts, many of which may well be consistent with prudent health and economic policy, and thus would likely harm the overall quality of the group health system.

Furthermore, in our view, for the Federal government to embark on the path of conditioning an employer's deduction of compensatory health-related expenses on the provision of particular types of benefits would be an intrusion into an area of responsibility already delegated to the states. Several states currently regulate the insurance contracts under which health benefits may be provided to employees by requiring that such contracts provide certain types of coverage, e.g., coverage for children beginning at birth, rather than shortly after birth, and coverage for services rendered by a particular type of health provider. Congress' desire that the Federal government not interfere with state regulation in this area is expressed in various laws, including the McCarran-Ferguson Act, the Employee Retirement Income Security Act of 1974, and the National Labor Relations Act. Unless the states' authority to regulate health insurance is preempted, Federal regulation would result in a second layer of mandated benefits, which would inevitably be duplicative of and inconsistent with state regulation.

Federal preemption of course should not be undertaken without a full examination of the benefits currently provided to employees, the current extent of state regulation, and the various health, economic, and tax policies that would be affected by Federal preemption and regulation.

The proposed legislation contains several technical uncertainties that require clarification. For instance, the bill requires a plan to provide pediatric preventive health care to any child who has not attained the age of 21. We assume that this requirement would be satisfied if the plan provided pediatric preventive care to only the children of those employees who participate in the plan. How is this rule intended to apply, however, if the plan does not provide family coverage, but rather only coverage for the employees? In addition, is the requirement satisfied if pediatric preventive care is available under the plan, but some employees with children elect not to purchase this benefit?

Another uncertain aspect of the bill is whether a health plan could apply a deductible or co-payment requirement with respect to pediatric preventive care? Would a plan satisfy the proposed rule if only pediatric preventive care expenses in excess of $100 were covered? What about a plan that did not have a separate deductible for pediatric preventive care, but rather contained a $100 or $200 deductible for all health benefits, including pediatric preventive care? Analogous issue arise with respect to co-payment requirements.

Finally, the bill does not in our view adequately describe the various types of medical services that are to be considered pediatric preventive health care. For example, the most frequently used term in the bill is "appropriate," a term that provides little guidance. We recognize that it is difficult to describe the specific types of preventive care that a health plan should provide; the health field is a dynamic one and concrete descriptions risk becoming outdated in a very short time. Indeed, the dynamism of the health field is one of the principal reasons that we do not believe the approach of S.376 is either workable or prudent. Nevertheless, if the approach of S.376 is to be undertaken, additional specificity of description is necessary.

In conclusion, for the various policy reasons set forth above, the Treasury Department does not support the enactment of S.376.

Senator CHAFEE. The final panel consists of Mr. Swain from SBA; Mr. Schrenzel representing the Chamber of Commerce; Mr. Hunt from the Society of Professional Benefit Administrators; and Mr. Lew from the Bankers Life Co. of Iowa.

All right, Mr. Swain, you have submitted your testimony and I looked it over so why don't you proceed in any fashion you want.

STATEMENT OF HON. FRANK S. SWAIN, CHIEF COUNSEL FOR ADVOCACY, SMALL BUSINESS ADMINISTRATION, WASHINGTON, DC

Mr. SWAIN. Thank you very much, Senator. And I appreciate the invitation to our office to offer some comments on S. 376.

You have my written statement for the record and, if it's all right, I would like to summarize some of its points.

First of all, as you know, the Office of Advocacy has been established by the Congress to represent the views and interest of the small business community on policy issues. So, of course, I appear here this morning as I hope somewhat of an expert on small business, but certainly not an expert on the issues that the first panel was largely addressing, which are obviously critical issues relating to preventive pediatric care. Although I should mention I'm a personal expert because at this very time my 21-month-old daughter is at her 21-month-old well-baby visit at the pediatrician this morning.

Senator CHAFEE. Excellent; you are following preventive medicine. [Laughter.]

Mr. SWAIN. I should also say that I am doing that under a health care plan, one of the several health care plans offered by the Federal Government. This one does offer coverage on preventive care. But one of the points that I want to emphasize is that I chose that coverage. I chose that health care plan which specifically offers preventive care coverage. The plan doesn't offer the good dental coverage that some other plans offer, or alcoholism or mental health treatment benefits. I believe that is the best way to handle this situation; have a matter of choice both for the employee and the employer.

At any rate, Senator, what I would like to draw your and the committee's attention to—the chart that is included on the last page of my testimony. The data indicates that for firms with fewer than 25 employees roughly only one-third of those firms cover their workers under health plans as opposed to 85 to 90 percent of the workers being covered by a large firm.

Now it seems to me that this is a national policy problem. And I think I can identify very much with some of the statements made, especially by Ms. Rosenbaum, in the previous panel. There are a lot of people that are out there who aren't covered by anything at all. Roughly, one out of three workers in small firms—to 24 employees—are not covered, compared to only one out of two in large firms.

There may be several ways of enhancing that coverage; that is increasing the proportion of health insurance coverage of workers in small firms. But I don't think that the proposal embodied in your legislation which mandates certain types of health coverage

for those who are covered is going to move in the right direction. Basically, notwithstanding all the excellent reasons from a health care perspective to have preventive care for children, we think that there are tremendous disincentives to employers that have very few people in their work force to buy a plan that is basically going to be more expensive. Health plans would certainly be more complicated if this particular Federal requirement was enacted. You may have, indeed, children that would be covered by preventive care for the first time, but you may well have a great number of workers that would not be covered at all because employers will merely decide they can't afford it, or it's too complicated.

Senator CHAFEE. What you are worried about is that employers will drop the whole business.

Mr. SWAIN. That's right.

And there are some other points in the testimony, Mr. Chairman, that illustrate why it is particularly expensive for smaller employers to buy health coverage in the first place. Certainly the sort of idea that was talked about a couple of years ago with a tax placed on health coverage above a specified amount would have been a very poor idea from the small business perspective. That, I think, would have had the effect of eliminating the potential for an employer to choose some of these optional coverages, whether it's the well-baby coverage, mental health benefits or another type of benefit.

But certainly the Federal Government mandating that the coverage be of a certain degree, I think, is going to be a real disincentive, particularly for small employers. Some firms, barely able to afford health benefits may drop coverage, while others contemplating offering health care may be discouraged from doing so. I suspect that this would happen rather than the general increase in coverage that I am sure your bill contemplates.

I leave you with the prepared statement, Mr. Chairman, and I would be happy to take any questions now or at the conclusion of the panel.

Senator CHAFEE. All right. Thank you, Mr. Swain.

[The prepared written statement of Mr. Swain follows:]

U.S. SMALL BUSINESS ADMINISTRATION
WASHINGTON, D.C. 20416

OFFICE OF CHIEF COUNSEL FOR ADVOCACY

STATEMENT OF

FRANK S. SWAIN

CHIEF COUNSEL FOR ADVOCACY

BEFORE THE

COMMITTEE ON FINANCE

SUBCOMMITTEE ON TAXATION

AND

DEBT MANAGEMENT

SEPTEMBER 16, 1985

MR. CHAIRMAN, I WOULD LIKE TO COMMEND YOU AND YOUR COLLEAGUES ON THE COMMITTEE ON FINANCE SUBCOMMITTEE ON TAXATION AND DEBT MANAGEMENT FOR CONDUCTING THIS HEARING ON S.376, THE CHILD HEALTH INCENTIVES REFORM PLAN. I BELIEVE THAT SMALL BUSINESS HAS AN IMPORTANT INTEREST IN THIS ISSUE AND APPRECIATE THE OPPORTUNITY TO EXPRESS THIS VIEWPOINT BEFORE YOU TODAY. AS CHIEF COUNSEL FOR ADVOCACY OF THE U.S. SMALL BUSINESS ADMINISTRATION I AM CHARGED WITH REPRESENTING OUR NATION'S 14 MILLION SMALL BUSINESSES BEFORE CONGRESS.

HEALTH INSURANCE IS THE MOST COMMON FRINGE BENEFIT PROVIDED BY EMPLOYERS. AS THE MAJOR EMPLOYERS OF PRIVATE-SECTOR WORKERS, SMALL FIRMS ARE GREATLY AFFECTED BY ANY CHANGES IN HEALTH POLICY. IN 1983, 58 PERCENT OF ALL WAGE-AND-SALARY WORKERS WERE EMPLOYED IN FIRMS WITH FEWER THAN 500 EMPLOYEES. THESE BUSINESSES ARE STRUGGLING TO COMPETE WITH LARGE FIRMS TO ATTRACT AND RETAIN QUALIFIED EMPLOYEES. IT IS THEREFORE IMPORTANT TO RECOGNIZE ANY DIFFERENTIAL EFFECTS THE PROPOSED LEGISLATION MAY HAVE ON SMALL FIRMS, IN ADDITION TO EXAMINING THE OVERALL IMPACT THE POLICY WOULD HAVE ON ALL EMPLOYERS WITH GROUP HEALTH INSURANCE. THE MANDATORY EXPANSION OF GROUP HEALTH INSURANCE COVERAGE UNDER S. 376 WILL NOT ONLY SIGNIFICANTLY INCREASE HEALTH PREMIUMS, BUT APPEARS TO DISPROPORTIONATELY AFFECT SMALL FIRMS. I WOULD LIKE TO ADDRESS EACH OF THESE POINTS IN TURN.

BUT FIRST LET ME SAY THAT I CERTAINLY BELIEVE THAT PEDIATRIC HEALTH SERVICES ARE VITAL TO THE HEALTH OF AMERICA'S YOUTH AND THEY WILL CONTINUE TO BENEFIT SOCIETY AS THESE INDIVIDUALS GROW INTO HEALTHY ADULTS. RATHER I AM OPPOSED TO THE NOTION OF CREATING A FEDERAL LAW TO FORCE EMPLOYERS TO INCLUDE ANY SPECIFIC TYPE OF BENEFIT IN THEIR HEALTH PLANS.

MANDATORY BENEFITS LEAD TO SIGNIFICANT EMPLOYER COST INCREASES

HEALTH CARE COSTS HAVE TRIPLED SINCE 1965 AND AT A 9 PERCENT RATE OF INCREASE THEY ARE STILL MORE THAN DOUBLE THE INFLATION RATE. EMPLOYERS SHARE A LARGE PORTION OF NATIONAL HEALTH SPENDING, PAYING ALMOST $100 BILLION IN 1984. LEGISLATIVELY MANDATED BENEFITS WILL INCREASE HEALTH INSURANCE COSTS AND THESE COSTS EVENTUALLY ARE PASSED ON TO THE BUSINESS COMMUNITY IN THE FORM OF INCREASED PREMIUMS. IN TESTIFYING AT A PUBLIC HEARING ON HEALTH CARE COSTS AND SMALL BUSINESS, THE BUSINESS COUNCIL OF NEW YORK STATE CITED SEVERAL EXAMPLES OF THE ECONOMIC IMPACT OF STATE MANDATES. FOR EXAMPLE, AFTER MASSACHUSETTS MANDATED ALL GROUP HEALTH INSURANCE CONTRACTS PROVIDE A $500 MINIMUM PAYMENT FOR MENTAL HEALTH AND ALCOHOLISM

BENEFITS, PAYMENTS ROSE FROM $2 MILLION IN 1975, THE YEAR BEFORE THESE BENEFITS WENT INTO EFFECT, TO $42.4 MILLION IN 1982. FURTHERMORE, THE COUNCIL NOTED THAT REIMBURSED HEALTH CARE DELIVERIES HAS HISTORICALLY LED TO DRAMATIC COST INCREASES.

THE CHILD HEALTH INCENTIVES REFORM PLAN WOULD MOST LIKELY LEAD TO SIMILAR COST INCREASES. THIS IS EVIDENCED BY THE WIDESWEEPING LANGUAGE OF THE BILL THAT COVERS ALL INDIVIDUALS UP TO AGE 21 AND ALLOWS FOR NUMEROUS BENEFITS, INCLUDING "OTHER MEDICAL SERVICES" AS DEFINED BY THE SECRETARY OF TREASURY IN CONSULTATION WITH THE SECRETARY OF HEALTH AND HUMAN SERVICES AND CERTAIN CHILD CARE ORGANIZATIONS. IN AN ERA OF COST CONTAINMENT, BUSINESSES CAN ILL-AFFORD TO FINANCE HIGHER HEALTH PREMIUMS. ALTHOUGH THE INTENT BEHIND THE BILL IS WELL-MEANING, IT CREATES A PERVERSE INCENTIVE - ONE WHICH MAY CAUSE COMPANIES TO CUT BACK INAPPROPRIATELY ON HEALTH COVERAGE.

IT IS ALSO SAFE TO ASSUME THAT S. 376 IS THE "EDGE-TO-THE-WEDGE" IN THAT OTHER HEALTH BENEFIT INTERESTS WILL CLAMOR FOR SIMILAR TREATMENT IF THE BILL BECOMES LAW. ADVOCATES OF ALCOHOLISM AND DRUG ABUSE TREATMENT, MENTAL HEALTH SERVICES, NURSING HOME CARE, AND OTHERS WOULD USE THIS STATUTE

AS A PRECEDENT TO IMPOSE ADDITIONAL OBLIGATIONS UPON THE EMPLOYER. AGAIN, THE RESULT WILL BE LESS COVERAGE AS MORE AND MORE EMPLOYERS BEGIN TO DROP INCREASINGLY EXPENSIVE HEALTH PLANS ALTOGETHER.

SMALL FIRMS CAN LEAST AFFORD TO EXPAND COVERAGE

SMALL FIRMS ARE LESS LIKELY THAN LARGE FIRMS TO PROVIDE BASIC HEALTH CARE AND WOULD HAVE A HARDER TIME AFFORDING MANDATED PEDIATRIC PREVENTIVE BENEFITS. OUR RESEARCH SHOWS THAT THERE IS A SIZABLE GAP BETWEEN SMALL AND LARGE COMPANIES HEALTH CARE COVERAGE. AS FIRM SIZE DECREASES, EMPLOYER-PROVIDED HEALTH INSURANCE DECREASES. IN 1983, 39 PERCENT OF WORKERS IN THE SMALLEST FIRMS (FEWER THAN 25 EMPLOYEES) WERE INCLUDED IN THEIR EMPLOYERS' PLANS, WHILE 85 PERCENT OF WORKERS IN FIRMS WITH OVER 500 EMPLOYEES WERE COVERED BY THEIR EMPLOYER. EVEN IF ANOTHER HOUSEHOLD MEMBER'S HEALTH INSURANCE IS TAKEN INTO ACCOUNT, APPROXIMATELY ONE IN THREE WORKERS IN SMALL FIRMS HAS NO HEALTH INSURANCE COMPARED TO ONE OUT OF TEN IN LARGE FIRMS.

SMALL BUSINESSES PAY HIGHER HEALTH COSTS FOR SEVERAL REASONS. BECAUSE OF THEIR LOWER PROFITABILITY MARGIN, SMALL FIRMS ARE LESS ABLE TO AFFORD COSTLY PREMIUMS. THEIR SIZE ALSO

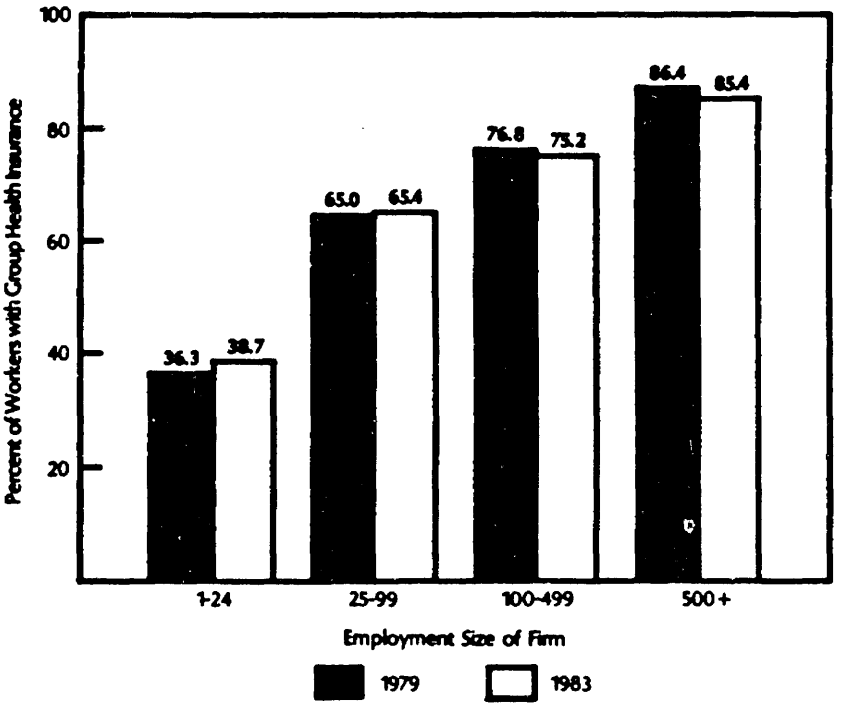
PREVENTS THEM FROM SELF-INSURING AS LARGER FIRMS DO BY SPREADING RISKS AMONG THEIR EMPLOYEES. FINDINGS FROM A RECENT MEDICAL PLAN COST STUDY BY COOPERS & LYBRAND REVEAL THAT 34 PERCENT OF RESPONDENTS WITH LESS THAN 500 EMPLOYEES WERE SELF-FUNDED, COMPARED TO 62 PERCENT IN FIRMS WITH OVER 5,000 EMPLOYEES. CLEARLY, THE FEWER THE EMPLOYEES, THE LESS LIKELY THE FIRM IS SELF-FUNDED. (FIRMS WITH FEWER THAN 500 EMPLOYEES AND WHICH ARE SELF-FUNDED ARE LIKELY TO BE IN THE UPPER RANGE, I.E., EMPLOYING BETWEEN 100 to 400 WORKERS.) IT SHOULD BE NOTED THAT MANY STATES WHICH MANDATE CERTAIN EMPLOYER HEALTH BENEFITS OFTEN EXCLUDE SELF-FUNDED PLANS. SMALL FIRMS ARE MOST LIKELY UNABLE TO TAKE ADVANTAGE OF THIS EXEMPTION AND END UP PAYING MORE TO COMPLY WITH STATE LAWS.

OTHER REASONS WHY SMALL FIRMS FACE HIGHER HEALTH COSTS INCLUDE THEIR LACK OF FLEXIBILITY IN SELECTING, MANAGING, AND DESIGNING PLANS WITH COST-CONTAINMENT FEATURES, LESS ABILITY TO TAKE ADVANTAGE OF ALTERNATIVE DELIVERY SYSTEMS WHICH RELY ON PATIENT VOLUME IN RETURN FOR LOWER COSTS, AND THE DISPROPORTIONATE NUMBER OF ELDERLY WORKERS FOUND IN SMALL FIRMS. ALMOST 80 PERCENT OF ALL OLDER WORKERS ARE FOUND IN SMALL FIRMS; PREMIUMS FOR THESE EMPLOYEES ARE GENERALLY HIGHER THAN THOSE FOR YOUNGER WORKERS. RECENT DECLINES IN MEDICARE FUNDING HAVE ALSO LED TO INCREASED EMPLOYER EXPENSES.

THE NEW YORK TIMES RECENTLY OBSERVED THAT CONCERN IS GROWING IN BOTH THE PUBLIC AND PRIVATE SECTORS THAT SOME BUSINESSES MAY NOT BE ABLE TO MEET THE STAGGERING OBLIGATIONS OF HEALTH CARE COSTS. I HOPE THAT THE COMMITTEE WILL CAREFULLY CONSIDER THE BURDEN EMPLOYER-MANDATED BENEFITS IMPOSES ON COMPANIES, PARTICULARLY SMALL BUSINESSES.

THANK YOU, MR. CHAIRMAN.

Percent of Wage-and-Salary Workers in Employer's Health Plan by Employment Size of Firm, 1979 and 1983



Source: U.S. Department of Commerce, Bureau of the Census, *Current Population Survey*, May 1979 and May 1983, unpublished data.

STATEMENT OF MR. STEVEN SCHRENZEL, DIRECTOR, CORPORATE BENEFITS, THE ROCKEFELLER GROUP, ON BEHALF OF THE CHAMBER OF COMMERCE OF THE UNITED STATES

Senator CHAFEE. Mr. Schrenzel.

Mr. SCHRENZEL. Good morning, Mr. Chairman. Thank you for the opportunity to appear. With me today is Fred Krebs from the chamber staff. We have submitted a written statement.

By way of background, I'm director of employee benefits for a privately owned company in New York City, which employs about 4,000 people nationwide and for whom we provide benefits.

Prior to that, I was manager of benefits planning for a Dallas-based conglomerate that employed over 40,000 employees.

Senator CHAFEE. You cover some Rhode Islanders, too.

Mr. SCHRENZEL. We do, sir.

In my prior employment we provided benefits for over 100,000 individuals in that environment, including employees, retirees and dependents. In that role I was the first chairman of the Dallas Business Group on Health, and I cochaired the Texas Medical Business Forum with the president of the Texas Medical Association. We developed a statewide medical business forum designed to seek out the opportunities most likely to result in an efficient, humane health care delivery system.

With that, I would like to cover several major areas. The chamber does not per se oppose pediatric health care benefits. What we do oppose is the mandating of specific benefits in health care benefit plans by the Federal, State or local governments. We see this as inconsistent with the intent of ERISA.

We also see it as inconsistent with the expressed national policy of holding down the escalation of health care costs, and we see it as inconsistent with the laws governing other employee benefit plans that do not specify minimum benefits.

Perhaps most importantly, we question the need for mandated pediatric preventive benefits. We see ample evidence that HMO's which are projected to cover 17 million persons, mostly employed, by the end of this year provide this. And that many employers are voluntarily providing a broad range of pediatric service benefits.

We question the notion that these benefits would spur better pediatric care. In fact, we see no evidence to support this.

At this point, I would like to introduce several articles into testimony. From the May 1985 issue of Pediatrics magazine, I would like to introduce the "Consequences of Cost Sharing for Children's Health," the "Effect of Cost Sharing on the Use of Medical Services by Children," and a commentary written by one of our former witnesses, Dr. Haggerty.

I believe these articles, if you believe the research, will support the fact that there is not a material difference in spending between people with ample insurance benefit and no insurance benefit or minimal insurance benefit. And, second——

Senator CHAFEE. Slow down. Say that slowly, could you?

Mr. SCHRENZEL. There is a very small difference in total pediatric care spending between people that have insurance, 100 percent insurance, in essence, free care—this is the Rand health insurance study, sir.

Senator CHAFEE. And those who don't?

Mr. SCHRENZEL. And those who don't. It is, in 1983 dollars, approximately an $85-a-year difference.

Now, more importantly, the consequences to the health status of children have not been proven. There is no evidence cited in any of these articles—notwithstanding Dr. Haggerty's rebuttal—there is no significant evidence that there is a disparity in the health status of children. And I'm not an expert in measuring health status, so I have to rely on the articles. But there is no evidence of disparity in their health status.

If I may move forward and take other questions later, sir, we see this not as a financial problem for parents, but we see it as an educational problem. The anecdotes related to us by Ms. Gustafson and Dr. Haggerty indicate patient compliancy and patient ignorance, parent ignorance problems. These are not problems that will readily be served by introducing mandated benefits.

I'm actually quite taken aback by the pediatric group supporting this legislation rather than by taking their concerns to the employer commonity through the channels that many of us in business and medicine are working hard to use as a mechanism to address mutual concerns.

I appreciate the financial plight of the primary care physician. In the most recent Medical Economics Journal indicated that pediatricians are the second lowest paid of the 18 major specialties. Primary care is extremely important, and we recognize that.

Senator CHAFEE. Now wait a minute. What are you saying? You are saying that the American Academy of Pediatrics is testifying here because they see this as a lucrative field for Pediatricians to get into?

Mr. SCHRENZEL. Sir, I don't question the intent of the pediatricians as being a noble intent.

Senator CHAFEE. You certainly are. That's why you brought it up.

Mr. SCHRENZEL. I brought it up to exhibit the fact that we have a tremendous amount of concern over the plight of the primary care physician vis-a-vis the surgeon who spends an awful lot of our corporate health care dollar, the primary care physician who is responsible for managing the health care resources, really the man that introduces you and me as the patient to the health care delivery system.

Senator CHAFEE. You are in heavy weather here, Mr. Schrenzel. What you are suggesting is that they are supporting this legislation because it will put some dollars in their pockets. Is that it?

Mr. SCHRENZEL. Sir, I haven't suggested that. I simply brought out the problem that they face.

Senator CHAFEE. Well, I don't know how you got started down this track. I would stay away from it, stick to your statistics about the care of the children and don't talk about the income to the pediatricians and their being the second lowest paid physician group.

Mr. SCHRENZEL. If I could sum up, sir.

Senator CHAFEE. I don't like that kind of talk. You had better stay right on what you were talking about before.

Mr. SCHRENZEL. May I take 30 seconds to sum up?

Senator CHAFEE. Sure. You go ahead.

Mr. SCHRENZEL. What we are asking you to do is not adopt piecemeal legislation that is contrary to demonstrated need as well as clearly established national policy.

Second, we would ask you to begin considering legislation that would shore up the intent of ERISA to give all concerned a single, consistent body of law that governs benefit plans on a nationwide basis. And we do, as a business, look forward to working in any forum to help develop a consistent national health care policy.

Thank you, sir. I will be glad to answer any questions now.

[The prepared written statement of Mr. Schrenzel and the articles follow:]

STATEMENT
on
MANDATED HEALTH CARE BENEFITS (S. 376, CHAFEE, R-RI)
before the
TAXATION AND DEBT MANAGEMENT SUBCOMMITTEE
of the
SENATE FINANCE COMMITTEE
for the
CHAMBER OF COMMERCE OF THE UNITED STATES
by
Steven N. Schrenzel
September 16, 1985

My name is Steven N. Schrenzel. I am Director of Employee Benefits for The Rockefeller Group. I appear here today on behalf of the U.S. Chamber of Commerce, as a member of the Chamber's Employee Benefits Council. Accompanying me is Frederick J. Krebs, Director of the Chamber's Employee Relations Policy Center. We appreciate the opportunity to express our views on S. 376, which would require that employee group health plans provide benefits for the expenses of pediatric preventive care, and on similar proposals to mandate the design of employee group health care benefit plans.

In brief, the U.S. Chamber supports the present system of voluntary, nondiscriminatory, private-sector employee health care benefit plans which can vary in accordance with the needs of employers and employees. We oppose federal or state government requirements mandating plan design or financing, whether applicable to insured or self-insured plans, because they limit flexibility and raise costs. Furthermore, if Congress decides to embark on the major change in policy that benefit mandates would be, fairness to all affected parties demands that there first be thoroughgoing policy debate similar to the one preceding enactment of federal restrictions on retirement plans.

Success of Private Health Care Benefits

Health benefits are a valuable and enormously successful protection for workers and their families. Voluntary health plans have the flexibility

to meet the needs of workers within the total compensation resources of their employers. The federal government has been vital to the success of this private-sector approach through broad tax incentives for employers to provide group health care benefit plans for their employees without trying to dictate the terms of these plans.

Employers currently spend an estimated 100 billion dollars each year on health care for their employees. As health care costs have risen over the past decade, business, as the purchaser of health care on behalf of most working-age Americans and their dependents, has taken an active role in the redesign of health insurance plans to assure the delivery of quality care in the most efficient manner. Central to these efforts has been the stimulation of competition in providing health care, by offering workers choices of delivery systems.

Health Care Benefit Plan Design

Employee group health care benefit plans vary greatly, covering a variety of health services and requiring different levels and types of employee cost sharing. Within the limits of business's economic circumstances, employers have the flexibility to design plans tailored to the preferences of their work force. At unionized firms, the scope of health care benefits is the subject of collective bargaining.

Historically, various groups have advocated minimum requirements for benefit levels, elements of coverage, or rules for reimbursement for particular categories of health care providers. However, Congress rejected that approach when it enacted the Employer Retirement Income Security Act (ERISA) in 1974. ERISA includes provisions preempting state regulation of "welfare" benefit plans, such as employee group health care benefits.

Nevertheless, many states have passed laws mandating extensions of eligibility to various classes of beneficiaries or requiring health plans to cover treatment for alcoholism, drug abuse, or mental problems or to reimburse for treatment by particular health professionals. The enforceability of these requirements, however, was in doubt because of ERISA.

In June 1985, in Metropolitan Life Insurance Co. v. Massachusetts, the Supreme Court ruled that the states' right to regulate insurance outweighs the ERISA preemption provision. As a result, the states are now free to apply their benefit mandates to all health care benefit plans that are financed through insurance arrangements, affecting about two-thirds of insured workers. However, ERISA still protects self-insured plans from such mandates.

The Metropolitan decision forces difficult choices on insurance companies. They may provide nonuniform plans at a greater administrative expense -- or provide one plan which incorporates all the benefits mandated by differing state laws. Pursuing the latter course will undoubtedly increase the price of health insurance for many businesses. In addition, if states pass contradictory requirements, uniform benefit plans would be possible only if the insurance carrier withdraws from certain states.

Proposed Federal Mandates

In addition to state mandates, several bills are before Congress which would impose federal mandates on employee group health care benefit plan design. Those introduced to date address different aspects of health care benefits. Capsule summaries of these proposals follow:

- S. 376 (Chafee, R-RI) would require coverage of (1) treatments for end stage renal disease (ESRD) on the same basis as other health conditions and (2) pediatric preventive services for children up to age 21, including health and development histories, comprehensive physicals, immunizations,

laboratory procedures, vision and hearing testing and treatment, and other medical services prescribed by the Department of Health and Human Services on the advice of medical groups involved in child health.

- H.R. 3128 (Rostenkowski, D-IL) -- Section 161 of the House Ways and Means Committee's Deficit Reduction Act would require that a worker's separated or divorced spouse or a deceased worker's surviving spouse and their children be permitted to continue in the worker's group health plan for five years at their own expense. This proposal is similar to H.R. 21 (Stark, D-CA), and also is included in several "women's equity" bills, H.R. 2472 (Schroeder, D-CO), and S. 1169 (Durenberger, R-MN). No hearings have been held on this measure.

- H.R. 3210 (Stark, D-CA) would require (1) continuation of coverage, allowing beneficiaries to buy-in at group rates in case of lay-off, death, divorce, or separation; (2) an open enrollment period for workers' spouses who become unemployed; (3) a tax on health plans that do not participate in state-assigned risk pools; and (4) studies and demonstration projects, including standardized health plans for small businesses and the self-employed and other agencies for establishing group health plans.

- S. 1211 (Durenberger, R-MN) would tax employer contributions to health plans which exceed a prescribed amount and require private health plans to cover "reasonable and necessary" physician and hospital services, to provide protection against specific "catastrophic" losses, to include an option of dependent coverage, and to continue coverage for one year (at beneficiary expense) in the event of any termination of employment, death, divorce, or attainment of majority age.

Unlike the state mandates, the federal mandates would apply equally to insured and self-insured plans. All would amend the Internal Revenue Code to disallow the business deduction for the expenses of the employee group health plan unless it contains the required coverage. Several proposals, but not S. 376 or H.R. 3128, also would amend ERISA. Without an ERISA amendment, mandates would not apply to the sizeable work force employed by nonprofit firms and government agencies.

Issues Raised by S. 376

S. 376 raises many questions about how preventive treatments are reimbursed by health insurance. Many individuals already participate in health plans that cover routine examinations and testing, not only for children but also for individuals of all ages. For example, enrollees in HMO's receive these services, which are an attractive feature in marketing HMO plans. HMO's constitute an important and increasingly popular sector of the health insurance market. Current projections of HMO enrollment are 17 million, representing more than eight percent of the total population. Continued growth of HMO's in today's health cost-conscious environment is expected.

Although statistics are not available, many traditional health plans also provide varying degrees of coverage for preventive care for children. The added expense of this type of coverage, of course, is passed on to the purchaser of health care. Ironically, if proponents of the health insurance "tax cap"* succeed, such coverage will be less likely in the future if health plans pare back their coverage to remain under the cap.

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* The tax cap proposal would treat as taxable income to the employee the amount of employer contributions to health insurance exceeding fixed amounts.

Unquestionably, traditional health plans have concentrated on covering acute care needs -- service provided in connection with the diagnosis and treatment of illness or injury.

This coverage is appropriate and compatible with the generally accepted insurance principle of risk shifting, because the costs of acute care are largely unforeseeable for any individual and difficult to bear. On the other hand, preventive care and health maintenance costs are usually small per individual -- although they are substantial in the aggregate -- and predictable. Moreover, studies suggest that the availability of insurance for pediatric services may have little effect on total spending on such services, i.e., spending on children insured for such services is no greater than for those who are not.

Policy Issues Raised by Benefit Mandates

Regulation of health care benefits through federal mandates governing plan design is a major departure from current government policy. It raises many issues which should be addressed before Congress takes action on mandate proposals. Fairness dictates that all affected parties should have adequate notice and opportunity to evaluate the proposals and their implications, such as the public debate preceding the enactment of ERISA. This public policy debate has not occurred.

Questions which need discussion include the following:

- What effect will statutory limits on the flexibility of health plan design have on the continued availability and scope of health insurance for workers and their families?

- Would mandates replace sound economic judgments with political pressure from particular classes of health care providers? To what degree are business decisions with respect to financing health care benefit plans, the result of politically motivated state mandates?

- What effect will mandates have on the ability of health plans to include coverages that meet the preferences of the enrollees?

- If benefit mandates were imposed, is there any sound policy basis for applying such mandates only to taxpaying employers? Plans financed through insurance?

- Will the market satisfy the demand without overt government action? For example, will broader availability of preventive care be achieved through the growth in popularity of Health Maintenance Organizations (HMO's)?

- How will particular mandates affect employers' ability to effect changes in their benefit plans designed to manage their health care costs? Will mandated benefits encourage increased utilization of particular services and increase the total cost of health care?

- What will the effect be of multiple and possibly conflicting state requirements?

- Will more generous benefit packages price health insurance out of reach of small businesses?

- What is the effect of shifting to employers the expense of uncompensated care and/or coverage of individuals who have no current work relationship?

Need to Preempt State Mandates

In opposing federal mandates governing employee group health plans, we urge Congress to preempt state mandates through an amendment to ERISA overturning the Metropolitan decision. This preemption is vital to employers' ability to continue offering affordable health plans for their employees which meet their basic needs.

Conclusion

The Chamber strongly supports the voluntary, private employee group health care benefit system which is successfully providing health protection for most working Americans at a fraction of the price of direct government programs. Government policy has helped promote this system through broad tax incentives for employers to offer health care benefits. The success of private health benefits is in large part the result of the flexibility employers have had in designing health plans. Removal of this flexibility through government mandates affecting the scope of individuals covered, types of services reimbursed, amount and terms of reimbursement, and similar restraints will weaken this system.

Proposals such as S. 376, mandating coverage of pediatric preventive care, and H.R. 3128 requiring the continuation of coverage, and related measures have not been fully evaluated by the affected parties. They will raise the costs of health insurance, just as voluntary action by employers has begun to slow down the rate of growth in health care cost inflation. Employers and employees may be forced to accept lower wages and/or forego benefits they prefer. Businesses that do not already offer health plans will find insurance plans too costly. Inevitably, reductions in the protection afforded by private health plans will place new burdens on already-pressed government programs. Private employee group health care benefit plans are flexible and readily redesigned in response to changes in financial incentives, employer preferences, and information about efficient delivery of health care. Federal programs, however, have been cumbersome, bureaucratic, and difficult to make responsive to the changing health care market. Experience with these federal programs argues strongly against extending the

rigidity of statutory mandates to private health care benefit plans. In addition, concern that decisions will be governed by political pressure rather than sound economics makes direct government intervention in health plan design unacceptable to employers.

Federal action is needed, however, to assure that private health care benefits plans do not fall victim to these same pressures at the state level. We urge Congress to amend ERISA without delay to preempt enforcement of state benefit mandates.

attachment

State-Mandated Health Benefits

	Alcoholism	Allied Practitioners	Drug Abuse	Handicapped Children	Home Health	Maternity	Mental Illness	Newborns	Surgical Centers	Miscellaneous	Nursing Home	Hospice	Continuous Conversion	HMOs	PPOs	Risk Pool/Catastrophic	State Program/Catastrophic	Total
Alabama	•	•						•				•					•	6
Alaska		•															•	4
Arizona	•	•		•	•		•	•		•		•						11
Arkansas		•			•		•	•				•						8
California	•	•			•		•	•				•		•				10
Colorado	•	•					•	•				•						7
Connecticut	•	•		•	•		•	•		•	•		•		•		•	14
Delaware		•						•										2
District of Columbia		•						•										2
Florida	•	•		•	•				•			•			•			12
Georgia		•			•				•			•						8
Hawaii		•			•			•									•	3
Idaho		•			•			•		•		•					•	9
Illinois	•	•			•		•	•				•						8
Indiana		•			•			•										5
Iowa		•						•										5
Kansas	•	•		•				•										8
Kentucky	•	•			•			•										8
Louisiana	•	•		•	•			•										10
Maine	•	•		•				•									•	9
Maryland	•	•		•	•			•										12
Massachusetts	•	•						•										8
Michigan	•	•		•				•										9
Minnesota	•	•		•				•										14
Mississippi	•	•						•										5
Missouri	•	•		•				•										10
Montana	•	•						•										9
Nebraska	•	•						•										8
Nevada	•	•		•				•										13
New Hampshire		•						•										7
New Jersey	•	•						•										9
New Mexico		•						•										7
New York	•	•						•										12
North Carolina	•	•		•				•										8
North Dakota	•	•		•				•										10
Ohio	•	•						•										8
Oklahoma		•						•										7
Oregon	•	•		•				•										8
Pennsylvania		•						•										5
Rhode Island	•	•						•										11
South Carolina		•						•										5
South Dakota	•	•						•										7
Tennessee		•						•										9
Texas		•						•										9
Utah		•						•										9
Vermont		•						•										8
Virginia		•						•										10
Washington		•						•										10
West Virginia		•						•										12
Wisconsin		•						•										13
Wyoming		•						•										5
Total	37	50	19	42	17	38	29	51	12	43	3	4	44	10	11	6	8	na

Consequences of Cost-Sharing for Children's Health

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ABSTRACT. Do children whose families bear a percentage of their health care costs reduce their use of ambulatory care compared with those families who receive free care? If so, does the reduction affect their health? To answer these questions, 1,844 children aged 0 to 13 years were randomly assigned (for a period of 3 or 5 years) to one of 14 insurance plans. The plans differed in the percentage of their medical bills that families paid. One plan provided free care. The others required up to 95% coinsurance subject to a $1,000 maximum. Children whose families paid a percentage of costs reduced use by up to one third. For the typical child in the study, this reduction caused no significant difference in either parental perceptions of their child's health or in physiologic measures of health. Confidence intervals are sufficiently narrow for most measures to rule out the possibility that large true differences went undetected. Nor were statistically significant differences observed for children at risk of disease. Wider confidence intervals for these comparisons, however, mean that clinically meaningful differences, if present, could have been undetected in certain subgroups. *Pediatrics* 1985;75:952-961; *health status, health care financing, insurance plans, cost-sharing.*

Expenditures on health care constitute more than 10% of the gross national product of the United States. Both the public and private sectors have expressed concern over the commitment of additional resources for medical care. In an attempt to induce reductions in the use of nonessential medical services and restrain the increasing cost of medical care, government-sponsored programs as well as employer-sponsored health plans have implemented increases in the proportion of costs borne by users of medical services—in the form of higher cost-sharing (coinsurance and deductibles).[1-4]

Opponents of cost-sharing fear that requiring families to pay out-of-pocket for children's medical services imposes a financial barrier to the use of services that may result in poorer health for children. Although these fears are widely held, little information exists to resolve the issue. Previous studies in special populations suggest that increased use of medical services has been associated with few or no detectable improvements in health, except among the poor.[5-13] No previous studies have examined the effect of cost-sharing on the health of children in a general population. To determine the potential effects of cost-sharing on the demand for medical care, quality of care, and health, the federal government sponsored a randomized, controlled trial, the Rand Health Insurance Experiment.

The Health Insurance Experiment randomly assigned families to various health insurance plans. One group received all of their care free of charge; others paid some fraction of their medical bills up to a stipulated maximum. Field operations began in late 1974 and ended in early 1982. Preliminary results on the use of medical services in the fee-for-service environment showed that demand for services by families insured with the cost-sharing plans was up to one third lower than that of families receiving free care.[14] Reduced demand for children's

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health services was observed only for ambulatory care; cost-sharing did not affect use of the hospital for children.[15]

Previous analyses did not address whether children covered by insurance plans requiring cost-sharing were less healthy as a result.[16] We, therefore, report here on the health outcomes of the trial with respect to children. Specifically, we compare health status outcomes between children who received free medical care and children whose families shared in the cost of their medical expenses.

METHODS

Sample

A total of 1,844 children were enrolled in the experiment. Children were aged 0 to 13 years (at enrollment) and came from 956 families. (Additional children who were enrolled in a health maintenance organization are the subject of a subsequent analysis.) Families participated for either 3 years (70% of sample) or 5 years. They lived in one of six sites: Dayton, OH; Seattle; Fitchburg or Franklin Country, MA; and Charleston or Georgetown County, SC.

Families represent the general population of the area from which they were sampled, except for certain intentional differences.[15,17] Approximately 3% of the families contacted were excluded from the experiment because their annual income exceeded $54,000 (in 1982 dollars). Also excluded were families in which the head of household was eligible for Medicare or who would become so before the end of the study. Additionally, families participating in the Supplemental Security Income (SSI) program, those eligible for the military medical care system, and institutionalized individuals (eg, imprisoned, in mental institutions) were excluded. Children born during the experiment were excluded from these analyses (but not from experimental benefits) because the likelihood of births varied between the plans. They are the subject of a forthcoming analysis.

Study participants aged 14 to 61 years (at enrollment) are the subjects of separate analysis.[18]

Insurance Plans

We assigned families electing to enroll in the trial to one of 14 insurance plans. To make this assignment we used a random sampling method that made the distribution of family characteristics as similar as possible on each plan.[18] Of the families contacted, 15% were not enrolled because they refused either a screening or base-line interview. Another 24% refused an enrollment interview or the offer of enrollment in the experimental plan. Those refusing the offer were no longer eligible to participate.[19]

A wide variety of services were covered in all plans, including acute and preventive ambulatory care, all hospital care, mental health services, visual and auditory services, prescription drugs, supplies, and all dental services except orthodontia with fixed appliances. Families were permitted to seek care from any provider. Services of nonphysician providers such as audiologists, chiropractors, clinical psychologists, optometrists, physical therapists, and speech therapists were also covered.

For these analyses, participants entitled to receive all services free of charge were compared with those in the other 13 plans. The other plans included: (1) "individual deductible" plan, under which families paid 95% of outpatient costs up to an annual out-of-pocket expenditure of $150 for each person or $450 for a family (inpatient care under this plan was free); (2) "intermediate" cost-sharing plans, under which families paid 25% or 50% of all medical expenses until 5%, 10%, or 15% of annual income of $1,000 was spent, whichever was less (in some sites and years, the maximum expenditure was limited to $750); and (3) "catastrophic expense" plans, under which families paid 95% of all medical expenses up to 5%, 10%, or 15% of annual income or $1,000, whichever was less ($750 in some sites in some years).

The maximum expenditure limit of $1,000 for the cost-sharing plans was not adjusted to account for the considerable price inflation experienced during the 1970s. For each family, however, these limits were adjusted yearly to reflect any changes in annual income. The cost-sharing plans are grouped and compared with the free plan because, in analyses reported elsewhere, no significant differences occurred within the cost-sharing plans.[20] Grouping the cost-sharing plans eases exposition of our work without changing our findings or conclusions.

Families assigned to an insurance plan that offered less coverage than their preexperiment insurance plan were reimbursed an amount equal to their maximum possible loss. For example, if a family was assigned to a plan with a $450 maximum out-of-pocket expenditure and had a preexperiment plan with a $100 deductible and a 20% coinsurance above the deductible, it was paid $280 per year ($280 = $450 − $100 − .2($450−$100)). These side payments had insignificant effects on demand for services.[17]

Measurement of Health Status

Using the World Health Organization's definition of health,[21] we developed or adapted various measures to test the effect of cost-sharing on health

status. These measures comprise four distinct dimensions of children's health status: physiologic function, physical health, mental health, and general health perceptions. In this paper, we report data on nine measures in these four dimensions (Tables 1 and 2).

Five conditions (anemia, hay fever, fluid in the middle ear, hearing loss, and visual acuity) provide physiologic information about children in the experiment. The criteria used to evaluate the conditions can be found in Table 1. These conditions were selected because they can be readily detected, are fairly prevalent, and are amenable to medical treatment; in addition, they have important adverse effects if left unattended.

Physical health measures examine limitations in the performance of various specific daily activities. In this paper, we present effects of insurance on one aspect of physical health, namely role limitations; these pertain to limitations in kind or amount of play, school, or other usual activities. Mental health measures were designed to assess both positive and negative states of psychological well-being. In the Health Insurance Experiment, we examine children's mental health status through the use of the Mental Health Rating Index, which provides an aggregate assessment of the child's affective mental health (psychological distress and psychological well-being). Finally, self-ratings of general health, which are among the most commonly used measures of health status, were assessed. For example, ratings of health as "excellent," "good," "fair," or "poor" have been used in the National Health Examination Survey and other health surveys. These general health measures do not assess a specific health status attribute, but they have been shown empirically to be related to a wide range of physical and mental health concepts and illness behaviors. The General Health Rating Index was used in the Health Insurance Experiment to assess perceptions of the child's health—past, present, and future.

TABLE 1. Definitions of Health Status Measures and Percent at Risk of Illness: Physiologic Measures and Parental Worry

	Specific Scoring	% with Condition at Enrollment
Anemia status: a dichotomous (0, 1) indicator of low hemoglobin, adjusted for age and sex	Defined as having anemia if hemoglobin falls below the following limits (in g/dL of blood): Boys and girls 6 mo to 2 yr, 10.0 2-12 yr, 11.0 Boys only 13-18 yr, 12.0 Girls only 13-18 yr, 11.5	9.4
Hay fever status: dichotomous (0, 1) indicator of whether the child is bothered by hay fever or other plant allergies	Based on responses to medical history for children ≥5 yr	8.4
Functional far vision: visual acuity with usual correction (ie, glasses or contact lenses); measured in Snellen lines	Visual impairment indicated if score >2: 2 = 20/20; 3 = 20/25; 4 = 20/30	29.2
Hearing loss: dichotomous (0, 1) indicator of hearing impairment in the better ear	Hearing impaired if average hearing threshold level in better ear (tested at 500, 1,000, 2,000 and 4,000 Hz) is >15 dB	6.6
Fluid in middle ear: dichotomous (0, 1) indicator of fluid in either or both middle ears	Tympanometry results indicate effusion or probable effusion according to the following criteria: air pressure (mm H_2O)/compliance (Madsen units)/slope −400 to −100/5-10/all −100 to 50/5.5-10/all −100 to 50/5.5-4.5/flat or rounded −400 to −100/0-5/flat or rounded 50 to 300/5.5-10/flat or rounded	26.4
Parental worry: 4-point scale measuring worry associated with anemia, hay fever, vision, or hearing loss	Highest level of worry expressed about one of the physiologic conditions examined: 1 = not at all; 4 = a great deal	20.9[a]

[a] Percent whose parent expressed any worry.

TABLE 2. Definitions of Health Status Measures: Health Perceptions Measures

	Typical Item	Meaning of High Score
Role limitations*: dichotomous (0, 1) measure that indicates whether child can play, go to school, or take part in usual activities free of limitations due to poor health	Is this child limited in the amount or kind of other activities (such as playing, helping around the house, hobbies) because of health?	Child is limited in role activities due to poor health
Mental health rating†: standardized (0–10) scale that measures anxiety, depression, and psychological well being during the past month; high score represents a positive level of mental health	During the past month, did this child seem to be anxious or worried?	Child is relaxed and cheerful
General health rating‡: standardized (0–10) scale that assesses perceptions of child's health in the past, present, and future and susceptibility to illness	In general, would you say this child's health is excellent, good, fair, or poor?	Child is in excellent health§

* Constructed from two items for children less than 5 years of age and three items for children aged 5 years and older.
† This battery was not administered to children less than 5 years of age; it was constructed from 12 items for children less than 14 years of age and 38 items for those aged 14 years or older.
‡ Constructed from seven items for children less than 14 years of age and 22 items for children aged 14 years and older.
§ A 0.51 point difference equals the effect of having hayfever, controlling for all other differences.

TABLE 3. Medical Screening Tests and Eligible Population

Disease Condition	Screening Test	Age of Population Screened	Exit Only	Enrollment and Exit
Anemia	Hematocrit, hemoglobin	6 mo to 18 yr	639	906
Hearing loss	Pure-tone threshold audiometry	4–18 yr	775	695
Fluid in middle ear	Tympanometry	4–13 yr, except those with surgery in past 6 mo	627	360
Visual disorder	Near vision, with and without correction; far vision, with and without correction; pinhole acuity correction	5–18 yr	795	796

Information on each dimension of health was collected at the beginning of the study (enrollment) and upon leaving the study 3 or 5 years later (exit) using a medical history questionnaire. The Health Insurance Experiment relied on parental assessments (usually the mother's) for all children less than 14 years of age and on self-reports for adolescents who were 14 to 18 years old at exit. (Recall that our sample is a cohort of those aged 0 to 13 years at enrollment; thus the maximum age at exit was 18 years.) We designed age-appropriate questionnaires to gather information for infants and toddlers (0 to 4 years), children in middle childhood (5 to 13 years), and adolescents and adults (14 years and older).[22-25]

In addition to these questionnaires, a medical screening examination assessed physiologic function for a random sample at enrollment (60%) and all exiting participants. Entrance screening was assigned to a random sample of participants on each plan in order to test for any effect of the examination in stimulating use. Exit screenings were conducted during the fall and winter months except in Massachusetts where they were conducted during the summer. The multiphasic screening was carried out by trained paramedical personnel.[26] Of the two types of health status measures examined (physiologic and health perceptions), the physiologic measures come closer to what many in the medical profession view as "illness." Different groups were eligible for the various medical screening tests administered. The types of screening tests administered for each of the conditions, the population examined, and the number of individuals examined are shown in Table 3.

The reliability and validity of the health status measures have been reported elsewhere.[20,22-30] These measures are applicable to general populations, possess sufficient variability to detect differences in health status in general populations, are reliable, and contain useful information about health status. The selection of medical screening examination tests was also based on considerations of logistics of performance, acceptability to participants, and acceptability to the medical community.

Method of Analysis

We used regression methods to estimate the influence of "explanatory" variables on a variety of

"dependent" or "response" variables that measured health status at exit. The explanatory variables included three policy-relevant variables: type of insurance plan, family income (adjusted for family size and site), and health status at enrollment. We accounted for the influence of other experimental manipulations (eg, taking the screening examination, time in the study, questionnaire form, and respondent) and demographic characteristics (eg, education of the mother, race, sex, site) by including some or all of these variables in the regression equations.[29]

We examined several problems that could have biased our results. First, the plans offered may have been accepted by different kinds of families, and these differences could have biased the results. Second, families may have dropped out of the various plans at different rates as a function of members' health status. Finally, some data were missing: a few exit questionnaires were incomplete or for some participants screening examinations were not required upon enrollment. Only the missing data from incomplete questionnaires posed a threat to our estimates because the experimental design assured that the 60% of participants screened at enrollment were distributed randomly across insurance plans.

We used several strategies to evaluate these potential problems. First, we compared selected characteristics of the families who refused the enrollment offer with those of the families who accepted. If these groups had similar values, there would be little reason to suspect bias. Second, we compared enrollment values for participants in each insurance plan. Third, we included in our regression equations the initial values of the health status variables as well as other variables known to influence health. Thus, we statistically controlled for any effect of nonrandom sample composition with respect to these explanatory variables. We did not attempt, however, to recover physiologic information about children who left the sample prematurely; all results are based only on values for those who completed the experiment normally.

To interpret the effect of the insurance plans, we used regression equations to predict exit health status for children with a given set of enrollment characteristics. Specifically, we calculated health status for two types of children: the typical child participant with average values on all characteristics and those "at risk" of disease because of an existing condition.

The definition of "at risk" varied from condition to condition. For each health status measure, we defined children who scored in the lowest quarter of a health perceptions measure or who were identified as having the physiologic condition at enrollment as being "at risk" of illness for that condition. For example, a child was considered "at risk" of anemia if he or she had been classified as anemic at the enrollment medical screening examination. In the case of functional far vision, "at risk" means children with poorer than 20/20 vision when tested at enrollment. Children not assigned to the enrollment screening examination were missing initial health status data. Because we wanted to include these children in our analyses, we estimated initial health status scores for them from the values for other explanatory variables available at enrollment. Because families were randomly allocated to plans, this procedure should lead to unbiased estimates of the initial scores. These children were then included in our analyses but were given less weight when we determined the estimated plan effects.[30]

Because the effects of differential use of medical care should be most apparent in children who are ill and poor, we also calculated our estimates for "at risk" children who were poor. "Poor" families were identified as those with incomes in the lowest quarter of the enrollment income distribution. Such families had a mean income of $6,200 in 1982 dollars. Families with incomes in the upper half of the distribution were considered "nonpoor" (a mean income of $30,000). For all other explanatory variables in the regression equations, we used mean population values to generate the predicted exit scores.

Because we had no expectation that cost-sharing would affect health status either negatively or positively in a general population, we used two-tailed t tests of significance to evaluate differences between plans. Because children in a family share their mother's tendency to consult a physician, observations from members of the same family contain less unique information than would completely independent observations. Therefore, all statistical tests of significance were corrected for correlation of the error term within each family. They were also corrected for the nonconstant variance of the error term.[31,32]

If a result was likely to occur by chance no more than 5% of the time, the convention of labeling that result "significant" was followed. Results falling short of this criterion should not be ignored, however. Confidence intervals may indicate that despite statistically indiscernible differences at this conventional level, clinically and socially relevant differences are possible.

RESULTS

Investigation of problems that could potentially bias our results suggests that our findings are unlikely to be affected. First, the characteristics of families who refused and those who ultimately participated in the experiment do not differ signifi-

cantly.[19] Second, attrition from the experiment was low (Table 4). Ninety-seven percent of those assigned to the free plan and 92% of those insured by cost-sharing plans completed the study normally. Based on enrollment characteristics, children who withdrew from the study appear similar to those who completed the study. Because attrition from the study was low over the 3- to 5-year period, it is unlikely to affect our results.

Finally, we observed no statistically significant differences at enrollment between those insured by the free plan and those insured by the cost-sharing plans. Enrollment values for all the variables used in these analyses are given in Table 5. We did not attempt to recover physiologic information for children who left the study prematurely. Results are based on children who completed the study.

Effects of Plan on Health Status of Average Child

For the typical child participant, we could not discern significant differences in health status between those who received free care and those insured by the cost-sharing plans (Table 6). Only the difference in the probability of having hay fever approached statistically significant levels ($P = .08$), and this measure suggested a greater prevalence of hay fever among those insured by the free plan (17% *v* 12%). No difference was observed among the cost-sharing plans. Taking all the measures together, the direction of estimated effects favored neither the free plan nor the cost-sharing plans.

For all measures, confidence intervals for the difference between free and cost-sharing plans are fairly narrow. Thus, it is unlikely that we failed to detect substantial differences in health status that are due to differences in insurance coverage.

Effects of Plan on Health Status of Children "At Risk" of Illness

For both poor and nonpoor children at risk of illness because of an existing condition, we observed no statistically significant difference between the free and cost-sharing plans for any of our measures (Table 7). Nevertheless, among the poor families, those insured by the free plan were less likely to have anemia at the conclusion of the experiment than those insured by the cost-sharing plans (8% *v* 22%). Although this difference was not statistically significant ($P = .12$), we believe it may well have clinical importance that should not be ignored.

Confidence intervals among the children at risk are broader than those among all children because of the smaller sample size. Thus, they are more likely to mask some clinically important differences. Therefore, we are less certain of our conclusion that the health effects did not differ between free and cost-sharing plans among children "at risk" of illness.

DISCUSSION

Some government and private sector actions to curb per capita use of medical services rely on cost-sharing in the form of greater coinsurance and deductibles. Those in favor of cost-sharing claim that such provisions prevent the purchase of care that provides little or no benefit. Opponents of cost-sharing argue that the resulting decreased access to medical care adversely affects health. To a great extent, the attractiveness of cost-sharing as a policy instrument depends on its potential to reduce expenditures without producing unacceptable health effects.

Interim results from the Health Insurance Experiment[14,17] indicate that children who were insured by cost-sharing insurance plans reduced expenditures for ambulatory services by up to one third compared with those who received free care. No discernible difference was observed in the use of hospital care. Lower use of ambulatory services does not lead to increased hospital use. Three conclusions can be drawn concerning the influence of this difference in use of ambulatory care on the health of children.

First, for the health status measures included in this paper, receiving free care or having to pay a portion of the medical bill made no difference in

TABLE 4. Distribution of Children According to Category of Participation in Experiment and Plan

Category of Participation	Free Plan		Cost-Sharing Plans	
	No.	%	No.	%
Total enrolled	599	100.0	1,245	100.0
Completed study normally	579	96.7	1,141	91.7
Voluntarily left study early	1	0.2	73	5.9
Terminated from study*	19	3.2	26	2.1
Died†	0	0.0	5	0.4

* Participation ended because family no longer fulfilled criteria for eligibility.
† Three deaths resulted from accidents (fire and asphyxia), one from murder, and one was due to epileptiform seizure with anoxia.

TABLE 5. Values of Demographic, Study, and Health Measures of Children Aged 0 to 13 Years at Enrollment by Type of Experimental Insurance Plan*

	Free Plan	Cost-Sharing Plans	*t* Test Value†
No. of enrollees	599	1245	
Mean age (yr)	7.1	7.2	0.54
Gender (% male)	52	52	−0.23
Race (% nonwhite)	21	25	1.37
Mean family income (adjusted for family size and site ($1982)	17,200	18,700	1.65
Mean education of mother (yr)	11.8	11.9	0.84
Hospitalizations of children in year prior to enrollment (%)	7.5	7.1	−0.30
Mean no. of child visits to physician in year prior to enrollment	3.3	3.1	0.86
Physical screening examination taken (%)	64	60	−1.56
Enrollment for 3 yr (%)	69	70	0.38
Role limitations (% limited)			
Enrollment sample	3.1	3.4	0.30
Analytic sample	2.8	3.1	0.33
Mean mental health rating (0–10 scale)			
Enrollment sample	6.2	6.1	0.97
Analytic sample	6.2	6.2	0.06
Mean general health rating (0–10 scale)			
Enrollment sample	5.9	5.9	0.20
Analytic sample	5.9	6.0	−0.20
Anemia (% with low hemoglobin levels)			
Enrollment sample	8.6	9.8	0.66
Analytic sample	7.9	10.0	1.17
Hay fever (% bothered by plant allergies)			
Enrollment sample	9.8	7.7	−1.02
Analytic sample	12.4	9.9	−0.88
Functional far vision (mean in Snellen lines)			
Enrollment sample	2.8	2.8	−0.49
Analytic sample	2.8	2.7	−0.75
Hearing loss (% with hearing impairments)			
Enrollment sample	8.6	5.6	−1.46
Analytic sample	8.7	4.7	−1.95
Fluid in middle ear (% with suspected effusion)			
Enrollment sample	27.9	25.6	−0.66
Analytic sample	32.5	27.4	−0.99

* For demographic data, entries include everyone with valid enrollment data. For health measures, the mean score for the enrollment sample excludes children not assigned to an initial screening examination or missing data; mean scores for analytic samples exclude the same children in the enrollment sample plus those who did not have exit data, generally because of attrition.
† Test of difference between cost-sharing and free plan.

health status for the typical child. We examined children's health status along four dimensions: physiologic function, physical health, mental health, and general health perceptions. Physiologic function was assessed by results of a multiphasic screening examination. Other health dimensions were assessed by parental responses to a medical history questionnaire. Neither parental perceptions about the child's health nor the presence of physiologic conditions were affected by cost-sharing. Confidence intervals were sufficiently narrow that even the potentially largest likely difference would be quite small in clinical terms.

Second, our data indicate that nearly 30% of children receiving free care in our study had difficulty with their functional vision; about 20% had functional vision (ie, best corrected vision) of 20/40 or worse at exit. (Children insured by the cost-sharing plans experienced similar levels of vision impairment.) Some of these visual difficulties may have been recognized by parents or physicians who decided to wait before attending to them. Some portion, however, may result from inadequate problem recognition by either the parent or physician or from lack of physician follow-up.

Third, no significant differences were observed among children at risk of having or developing illness. In this case, however, confidence intervals were in some comparisons sufficiently wide to include clinically important differences. For instance,

TABLE 6. Predicted Exit Values of Health Status Measures for Child with Average Characteristics, by Measure and Plan

	N*	Free Plan	Cost-Sharing Plans	Free Plan Minus Cost-Sharing Plans*
Health perceptions				
Role limitations (%)	1,480	2.60	2.60	0.0 (−7, 7)
Mental health rating‡	1,048	5.81	5.94	−0.13 (−.37, .11)
General health rating†	1,506	5.47	5.48	−0.01 (−.20, .18)
Physiologic measures				
Anemia (%)	1,538	1.90	2.10	−0.20 (−1.8, 1.4)
Hay fever (%)	1,378	17.00	12.00	5.0 (0, 10)§
Hearing loss (%)	1,463	7.20	6.20	1.0 (−1.7, 3.7)
Fluid in middle ear (%)	987	25.00	25.00	0.0 (−7, 7)
Functional far vision‖	1,591	2.60	2.67	−0.07 (−.21, .07)
Parental worry¶	1,535	1.40	1.35	0.05 (−.02, .12)

* Sample sizes are dissimilar because the number of children included in each health status analysis differs due to age restrictions or missing data.
† Values in parentheses are 95% confidence intervals; approximate confidence intervals for dichotomous indicator variables.
‡ Scale of 0 to 10; a higher value denotes better health.
§ $t = 1.74$, $P = .08$.
‖ In Snellen line values: 2 = 20/20, 3 = 20/25, 4 = 20/30.
¶ Four-point scale: 1, not at all; 2, a little; 3, somewhat; 4, a great deal.

TABLE 7. Predicted Exit Values of Health Status Measures for Children with Preexisting Conditions, by Measure, Plan, and Income

	Poor			Nonpoor		
	Free Plan	Cost-Sharing Plans	Free Plan Minus Cost-Sharing Plans*	Free Plan	Cost-Sharing Plans	Free Plan Minus Cost-Sharing Plans*
Health perceptions						
Role limitations (%)	22.00	30.00	8.0 (−35, 19)	24.00	21.00	3.00 (−19, 25)
Mental health rating†	4.96	5.16	−0.20 (−.61, .21)	5.29	5.39	−0.10 (−.43, .23)
General health rating†	4.77	4.60	0.17 (−.22, .56)	4.76	4.87	−0.11 (−.42, .20)
Physiologic measures						
Anemia (%)	8.00	22.00	−14.00 (−31, 3)‡	12.00	8.00	4.00 (−7, 15)
Hay fever (%)	61.00	44.00	17.00 (−10, 44)	71.00	66.00	5.00 (−16, 26)
Hearing loss (%)	35.00	43.00	−8.00 (−35, 19)	36.00	27.00	9.00 (−15, 33)
Fluid in middle ear (%)	56.00	57.00	−1.00 (−18, 16)	55.00	55.00	0.00 (−15, 15)
Functional far vision§	3.18	3.23	−0.05 (−.32, .22)	3.10	3.17	−0.07 (−.29, .15)

* Values in parentheses are 95% confidence intervals; approximate confidence intervals for dichotomous indicator variables.
† Scale of 0 to 10; higher value indicates better health status.
‡ $t = 1.55$, $P = .12$.
§ In Snellen line values: 2 = 20/20, 3 = 20/25, 4 = 20/30.

among children we classified as the "poor sick," the upper bound of the 95% confidence interval for the differential prevalence of anemia was 31 percentage points. Thus, the actual difference in the occurrence of anemia due to cost-sharing could be considerable. The upper bound on the 95% confidence interval for the general health ratings for this at-risk group approximates the effect of being afflicted with hay fever.

In appraising results among the poor, it is important to remember that the maximum out-of-pocket expenditures in our cost-sharing plans were related to the family's level of income. Under these income-related provisions, the poor used services at about the same rate as the nonpoor. In insurance plans not tied to income, cost-sharing might be expected to affect the use of services of poor children to a greater extent than we observed, and cost-sharing might adversely affect their health.

Many poor children receive care through the Medicaid program. Our insurance plans differ from Medicaid programs in at least two important ways. First, families served by Medicaid often face restrictions in provider choice because many providers do not accept Medicaid assignments. Families insured by our insurance plans obtained care from the

providers of their choice. Second, Medicaid benefit packages vary considerably from state to state. Our plans covered a full range of services with only minor exclusions. Thus, our data do not allow us to comment on the effect of these restrictions on health status.

Future analyses will examine the use of services in more detail, as well as the quality of care provided to children. This work should provide information about why the increased use of services with free care seemingly provided so little benefit. For now, we offer three observations.

First, most children in a general population are healthy on a variety of measures.[22] Only 3% of children experienced restrictions in their usual activities; fewer than 10% suffered from most chronic problems such as anemia or hay fever. Thus, the potential benefit of additional medical care—other than symptomatic relief and relief of anxiety—appears limited.

Second, many physician visits were for acute care, at least some of which may not have a long-lasting effect on health. Preliminary work indicates, for example, that for children insured by the free plan, there were 23 episodes of treatment per 100 children per year for upper respiratory tract infections compared with 12 episodes for those insured by the cost-sharing plans ($P < .05$).

Third, although cost-sharing did exert an appreciable influence on the use of all services, the absolute level of use of mental health services for children (even those insured by the free plan) was low. Fewer than 2% of children less than age 18 years used any mental health service.[33] Therefore, it is not surprising that mental health ratings showed so little change.

Our results must be used with caution to derive policies for seriously chronically ill or disabled children. Although included in our experiment, they constitute only a small fraction of our sample. We are unable to describe accurately the effects of cost-sharing on this special group of children.

Based upon the health measures we have examined thus far, we conclude that providing all medical services free to children is not justified by the health benefits realized. A case for free care, however, can be made on the grounds of equity. In particular, cost-sharing plans require those who need treatment for a chronic problem to shoulder more of the burden of financing their medical care. This may be regarded as unfair to such individuals. Whether this case for free care sufficiently justifies its costs must, of course, be answered by the wider society.

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REFERENCES

1. Brazda JF: The nation's health and the 1983 budget, in *Medicine and Health Perspectives* Washington, DC, McGraw-Hill, Feb 15, 1982
2. Ginsburg PB: *Containing Medical Costs Through Market Forces* Washington, DC, Congressional Budget Office, May 1982
3. Ginsburg PB: Altering the tax treatment of employment-based health plans. *Milbank Mem Fund* 1981;59
4. Phelps CE: Tax policy, health insurance, and health care, in Meyer JA (ed): *Market Incentives in Health Care Reform* Washington, DC, American Enterprise Institute, 1982
5. McDermott W, Deuschle KW, Barnett CR: Health care experiment at Many Farms *Science* 1972;175:23-31
6. Moore GT, Frank K: Comprehensive health services for children: an exploratory study of benefit *Pediatrics* 1973, 51:17-21
7. Gordis L: Effectiveness of comprehensive-care programs in preventing rheumatic fever. *N Engl J Med* 1973;289:331-335
8. Gordis L, Markowitz M: Evaluation of the effectiveness of comprehensive and continuous pediatric care. *Pediatrics* 1971;48:766-776
9. Dutton DB, Silber RS: Children's health outcomes in six different ambulatory care delivery systems *Med Care* 1980;18:693-713
10. Alpert JJ, Robertson LS, Kosa J: Delivery of health care for children: Report of an experiment *Pediatrics* 1976;57:917-930
11. Klein M, Roghmann K, Woodward K: The impact of the Rochester Neighborhood Health Center on hospitalization of children, 1968 to 1970 *Pediatrics* 1973;51:833-839
12. Irwin PH, Conroy-Hughes R: EPSDT impact on health status: Estimates based on secondary analysis of administratively generated data *Med Care* 1982;20:216-234
13. Kessner D, Snow CK, Singer J: *Assessment of Medical Care for Children: Contrasts in Health Status* Washington, DC, Institute of Medicine, National Academy of Sciences, 1974
14. Leibowitz A, Manning, WG, Keeler EB, et al: Effect of cost-sharing on the use of health services by children: Interim results from a randomized controlled trial. *Pediatrics* 1985;75:942-951

15 Newhouse JP. A design for a health insurance experiment. *Inquiry* 1974;11:5-27
16 Brook RH, Ware JE Jr, Rogers WH, et al: *The Effect of Coinsurance on the Health of Adults: Results from the Rand Health Insurance Experiment*, (Rand publication No. R-3055-HHS). Santa Monica, CA, Rand Corp, 1984
17 Newhouse J, Manning W, Morris C, et al: *Some Interim Results from a Controlled Trial of Cost Sharing Health Insurance* (Rand publication No. R-2847-HHS) Santa Monica, CA, Rand Corp, 1982
18 Morris CN. A finite selection model for experimental design of the health insurance study. *J Econometrics* 1979;11:43-61
19 Rogers WH, Camp P: *Refusal and Attrition in the Health Insurance Experiment* (Rand publication No. N-2195-HHS). Santa Monica, CA, Rand Corp, in press, 1985
20. Valdez R. *The Effects of Cost-Sharing on the Health of Children* (Rand publication No. R-3270-HHS). Santa Monica, CA, Rand Corp, in press 1985
21. Constitution of the World Health Organization: *Basic Documents* Geneva, World Health Organization, 1948
22. Eisen M, Donald CA, Ware JE Jr, et al. *Conceptualization and Measurement of Health for Children in the Health Insurance Study*, (Rand publication No. R-2313-HEW). Santa Monica, CA, Rand Corp, 1980
23. Ware JE Jr, Johnston SA, Davies-Avery A, et al: *Conceptualization and Measurement of Health for Adults in the Health Insurance Study: Volume 3, Mental Health*, (Rand publication No. R-1987/3-HEW). Santa Monica, CA, Rand Corp, 1979
24 Ware JE Jr, Manning WG, Duan N, et al: Health status and the use of ambulatory mental health services. *Am Psychol*, in press 1985
25 Davies AR, Ware JE Jr: *Measuring Health Perceptions in the Health Insurance Experiment* (Rand publication No. R-2711-HHS). Santa Monica, CA, Rand Corp, 1981
26 Smith LH, Goldberg GA, Brook RH, et al: *The Health Insurance Study Screening Examination Procedures Manual*, (Rand publication No. R-2101-HEW) Santa Monica, CA, Rand Corp, 1978
27 Rubenstein RS, Lohr KN, Brook RH, et al: *Measurement of Physiologic Health for Children: Vision Impairments*, (Rand publication No. R-2898-4-HHS). Santa Monica, CA, Rand Corp, 1984
28. Lohr KN, Beck S, Kamberg CJ, et al: *Measurement of Physiologic Health for Children: Middle Ear Disease and Hearing Impairment* (Rand publication No. R-2898-2-HHS). Santa Monica, CA, Rand Corp, 1983
29. Foxman B, Lohr KN, Brook RH: *Measurement of Physiologic Health for Children: Anemia* (Rand publication No. R-2898-5-HHS). Santa Monica, CA, Rand Corp, 1983
30. Beck S, Lohr KN, Kamberg CJ, et al: *Measurement of Physiologic Health for Children: Allergic Conditions* (Rand publication No. R-2898-1-HHS). Santa Monica, CA, Rand Corp, 1983
31. Dagenais, MG: Further suggestions concerning the utilization of incomplete observations in regression analysis. *J Am Statist Assoc* 1971;66:93-98
32. Huber PJ: *The Behavior of Maximum Likelihood Estimates Under Nonstandard Conditions: Fifth Berkeley Symposium, 1965*. Berkeley, University of California Press, 1967, pp 221-233
33. Wells KB, Manning WG Jr, Duan N, et al: *Cost Sharing and the Demand for Ambulatory Mental Health Services* (Rand publication No. R-2960-HHS). Santa Monica, CA, Rand Corp, 1982

OXFAM BISCUIT

Officials of the Save the Children Fund last week called on Western governments to take initiatives to relieve the worsening famine in Ethiopia. The fund estimates that 6 million people are at risk in the famine. . . .

A new calorie-enriched famine biscuit is being sent to Ethiopia. The "energy biscuit," as it has been described, was developed recently by Oxfam, Britain's largest overseas aid charity. . . . The main ingredients in the Oxfam biscuit are wheat flour, milk, powder, sugar, and vegetable and butter oils, which cost some 3p per biscuit. Less than 10 percent of the biscuit is protein, but just four biscuits a day will provide a child with 500 calories, which is the vital need in supplementary feeding programmes.

"When children are really badly malnourished they are beyond eating and drinking and this biscuit gives them something to suck on, which eventually gets them interested in food again and on the road to recovery," said Oxfam.

Submitted by Student

From Tirbutt S, Tanner J: Six million Ethiopians face famine. *Manchester Guardian Weekly*, Oct 14, 1984.

Effect of Cost-Sharing on the Use of Medical Services by Children: Interim Results from a Randomized Controlled Trial

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ABSTRACT. Health care expenditures of 1,136 children whose families participated in a randomized trial, The Rand Health Insurance Experiment, are reported. Children whose families were assigned to receive 100% reimbursement for health costs spent one third more per capita than children whose families paid 95% of medical expenses up to a family maximum. Outpatient use decreased as cost-sharing rose for a variety of use measures: the probability of seeing a doctor, annual expenditures, number of visits per year, and numbers of outpatient treatment episodes. Hospital expenditures did not vary significantly among children insured with varying levels of cost-sharing. Episodes of treatment for preventive care were as responsive to cost-sharing as episodes for acute or chronic illness. The results give no reason not to insure preventive care as liberally as care for acute illness. *Pediatrics* 1985;75:942-951; *health care costs, cost-sharing, insurance plans.*

Pediatricians and others concerned about children's health are intensely interested in how health care financing encourages or discourages the use of health care services for children.[1] Early results from the Rand Health Insurance Experiment demonstrate that the use of medical services by people less than age 65 years is sensitive to cost-sharing.[2,3] This paper explores the degree to which the inverse relationship between use and the level of cost-sharing in the fee-for-service system applies to children 13 years old and younger. We examine whether price responsiveness affects both outpatient and inpatient care for children. We also examine how cost-sharing affects different kinds of outpatient use: well-care and care for acute and chronic conditions.

PRIOR STUDIES

In a sample of the population aged 64 years or less, people whose medical expenses were fully covered by insurance spent about 50% more than those who faced cost-sharing.[2] More generous insurance led to more episodes of treatment, particularly for acute conditions.

An immediate question is whether those findings apply equally to children's expenditures. Two characteristics of children's health care suggest that the demand for pediatric health services might be more responsive to price than the demand for adults' care. First, the incidence of chronic disease is lower among children than among adults.[4] Many children's illnesses are acute but self-limiting. The demand for care for these illnesses may depend more on cost-sharing than does the demand for treating diseases that will not resolve by themselves. Second, much of the medical care provided children is preventive care, which parents may regard as more discretionary than treatment for illness.

Conversely, when parents face cost-sharing, they may be less willing to reduce their children's health care than to reduce their own—a preference that may be reinforced by government regulations requiring immunizations and regular checkups for children enrolled in school.

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The literature contains no reports of controlled trials that varied cost-sharing for pediatric care. Noncontrolled studies of pediatric care focus primarily on demographic determinants of health service use rather than on cost-sharing. Families that are more advantaged (high income, high levels of parental education, smaller family size) use more preventive services for their children (reference 5 and D. P. Slesinger, unpublished data). Perhaps because these demographic factors affect curative visits in the opposite way, the effects of demographic factors on total pediatric visits (preventive and curative) show less consistent effects.[6-12]

METHODS

Design of Health Insurance Experiment

Because the details of the experimental design appear elsewhere,[2,3] only the salient points are noted here. Excluding participants enrolled in a prepaid group practice (who are the subject of separate analyses), the Health Insurance Experiment enrolled a representative random sample of more than 5,800 persons aged 62 years or less at enrollment; 1,844 of these were children aged 13 years or younger. The sample was drawn from families in six sites: Dayton, OH; Seattle; Fitchburg and Franklin County, MA; and Charleston and Georgetown County, SC. Of these families, 70% were enrolled for 3 years, 30% for 5 years. Families were assigned to an experimental health insurance plan by an unbiased allocation method that made the distribution of more than 20 characteristics related to health or expenditures as similar as possible across plans.[14] Of families who agreed to an initial interview, 14% refused the enrollment offer (Table 1); others had refused preliminary interviews. These families were not reassigned to another plan. Although there were some differences in the types of families that accepted the enrollment offer,[15] there are no important differences in health or demographic variables between the sample of children enrolled in free and cost-sharing plans.[15a]

The insurance plans varied along two dimensions: the coinsurance rate (fraction of the medical bill paid by the family in any 1 year) and the maximum dollar expenditure (an income-related upper limit on annual out-of-pocket expenditures). For the analyses reported in this paper, the insurance plans are grouped as follows: (1) one plan providing care with no out-of-pocket costs (ie, 0% coinsurance), referred to as the "free-care plan"; (2) six plans with a 25% coinsurance rate for medical care; in this set, the family paid 25% of its medical bills each year up to maximum dollar expenditure of 5%, 10%, or 15% of family income or $1,000 ($750 in some sites in some years), whichever was lower (participants in three of the plans paid a higher rate—50%—of their dental and outpatient mental health expenses); (3) three plans with a 50% coinsurance rate for all medical and dental services and the same income-related limitations as in (2); (4) three plans with a 95% coinsurance rate and the same income-related limitations as in (2); and (5) one plan with a 95% coinsurance rate on outpatient expenditures up to a maximum out-of-pocket expenditure of $150 per person ($450 per family) per year and no coinsurance after that; all inpatient care is free on this plan, which we refer to as the "individual deductible" plan.

All plans had an identical, comprehensive set of covered services that included ambulatory and hospital care, preventive services, all dental services (except nonpreventive orthodontia), all prescription and certain over-the-counter drugs, most supplies and durable medical equipment, psychiatric and psychological services (except outpatient psychotherapy visits exceeding 52 per person per year), and almost all other personal medical services (except cosmetic surgery for preexisting conditions). Services of nonphysician providers such as audiol-

TABLE 1. Proportion of Sample Remaining After Accounting for Refusals at Various Stages*

Enrollment Criteria	Dayton	Seattle†	Massachusetts	South Carolina	Total
Initial sample	1.00	1.00	1.00	1.00	1.00
Did not refuse screening interview	.88	.85	1.00‡	1.00‡	.94
Did not refuse baseline interview	.74	.78	.88	.95	.85
Did not refuse enrollment interview	.73	.70	.76	.84	.76
Did not refuse offer of enrollment	68	59	62	.71	65
No. of families enrolled	390	484	566	568	2,008

* These numbers do not account for families who moved prior to enrollment, could not be located, were chronically not at home, or other losses from the sample not due to refusal.
† Excludes 752 families enrolled in the Group Health Cooperative of Puget Sound.
‡ There was no screening interview in Massachusetts or South Carolina.

ogists, optometrists, and speech therapists were also covered.

Sample for Analysis of Child Health Expenditures

The sample used in this paper includes 3 years of data from Dayton and 2 years each from the Seattle and Massachusetts sites. Analyses of data from the South Carolina sites are not yet complete. Results relating to episodes of treatment are based on data for children in the first 3 years at the Dayton site; data for these analyses for other sites are not yet complete. The expenditure analysis sample includes 1,136 children who participated for at least 1 year and decedents who had participated during the year in which they died, but excludes children whose families withdrew from the experiment in the year they withdrew. More than 90% of the children initially enrolled completed their assigned time on study.[15a] Hence, we have made no adjustments for any bias due to attrition.

We also do not include expenditures for newborns during their first partial enrollment year; they are the subject of a forthcoming analysis. We have limited our analyses to children 13 years of age and younger. Although pediatricians continue to treat many adolescents until a later age, we chose this definition to correspond to the age divisions used in Health Insurance Experiment health questionnaires. Modest sample sizes and comparatively low use of medical care by children in general dictated against separate statistical modeling of use for age subgroups of children. Therefore, we present results on expenditure for the entire sample of children aged 13 years and younger.

After accounting for sample loss, we had 2,662 full years of data on children (Table 2). Children assigned to the free-care plan accounted for about one third of the observations. The remainder of the children faced cost-sharing.

Measures of Child Health Use

We examined several measures of medical use by children, including annual average medical expenditures and counts of the number of outpatient episodes of treatment for acute and chronic illness and well care. Our annual aggregates included all medical care delivered to children, except expenditures on outpatient mental health and dental care (which are examined in separate reports).[16,17] Claims filed by participants provided data on the type and amount of services and expenditures, including those not reimbursed by insurance (eg, the coinsurance and deductible amounts). We summed claims data for each participant to arrive at annual expenditure totals and numbers of visits. Data in this analysis were collected between 1974 and 1978, but we adjusted expenditure data using the "Medical Care" Consumer Price Index published by the Bureau of Labor Statistics[18] to reflect medical care prices in 1983.

We calculated the average number of office visits to doctors of medicine and doctors of osteopathy during the second experimental year in each site. Second-year expenditures should be least affected by any temporary effects arising from the change in insurance experienced by each family at the start of the study. Well care use by free-care plan participants increased slightly in the first 3 months of the study and again at the conclusion of the study.

We categorized care into "episodes of treatment," which consist of one or more medical services related to a given medical problem. Claims data were grouped into episodes using information on diagnosis, interval since previous charge for a related diagnosis, and provider-supplied treatment histories. For example, an initial visit for an ear infection and a recheck visit constituted one episode of treatment, as did a prescription drug purchase without an office visit. We examined three types of outpatient episodes: those for acute problems, for chronic

TABLE 2. Mean Annual Expenditures by Plan for Children and Adults (1983 Prices)*

	Total Medical Expenditure ($)		Ambulatory Expenditure ($)		No. Person-Years for Ambulatory Expenditure	
	Child†	Adult‡	Child†	Adult‡	Children†	Adults‡
Free care	389 ± 167	871 ± 134	192 ± 22	402 ± 32	864	1,970
25% coinsurance	259 ± 81	813 ± 171	153 ± 28	328 ± 39	571	1,221
50% coinsurance	301 ± 125	771 ± 435	192 ± 65	242 ± 39	241	525
95% coinsurance	213 ± 93	570 ± 110	114 ± 22	249 ± 32	513	1,251
Individual deductible	278 ± 85	723 ± 194	162 ± 35	287 ± 37	473	1,136

* Values are means ± 95% confidence interval. All prices have been adjusted using the Medical Care component of the Consumer Price Index.[18]
† Children aged 0 to 13 years.
‡ Aged 14 years and older.

problems, and for well care. Details of the analytic techniques used are given elsewhere.[3,19]

Estimation Methodology

As a result of random assignment, the distribution of factors affecting the demand for medical care use does not vary by insurance plan.[2,14] Therefore, average expenditures on each plan provide unbiased estimates of expenditure differences among the plans. However, large expenditures incurred by a few children with unusual health care needs can affect the mean expenditures on a plan dramatically, even though the Health Insurance Experiment has data on sizable numbers of children in each plan. For example, a single child whose medical expenses amounted to $68,400 in 1 year accounted for 20% of all expenditures on the free-care plan in the data analyzed here. Therefore, we used the estimation method described by Duan et al[19] to provide more stable estimates and to remove the within-plan differences attributable to age, sex, indicators of initial health status, income, and other demographic variables. These adjusted expenditures account for systematic differences in age and sex on children's medical use, allowing us to estimate more precisely the differences related solely to insurance plan. We have corrected the significance statistics to allow for the fact that children in the same family do not provide totally independent observations.[19] The effect of this correction is to provide a conservative estimate of the statistical significance of measured differences. Further details are provided by Duan et al.[19]

The few large users of medical care have less influence on measures of use other than expenditure. In the case of number of visits and numbers of episodes of treatment for acute, chronic, and well care, the sample means estimate the effect of the insurance plan with sufficient precision.

RESULTS

Children and Adults Together

Total expenditures for adults and children together differed markedly as a function of insurance plan.[3] Annual per capita expenditure for medical services, excluding mental health and dental services, on the income-related catastrophic plan was 69% of that on the free-care plan. Expenditures for plans with intermediate levels of cost-sharing fell between these extremes.

Variation in the amounts of services used (eg, numbers of physician office visits or hospitalizations), not differences in prices charged to families, accounted for most of the plan differences. Free-plan participants were 22% more likely to have an office visit during the year, and were 34% more likely to be hospitalized than participants insured by the 95% plan.

Descriptive Results for Children

Expenditures per child averaged only 39% of expenditures per adult (aged 14 to 65 years). The pattern of reduced expenditures with higher levels of cost-sharing was evident, however, for both adults and children (Table 2). Simple means indicated that total expenditure per child (outpatient plus inpatient expenses) averaged about 83% higher with the free-care plan than with the 95% plan; for adults, expenditures with the free-care plan were 53% higher. Expenditures on the intermediate cost-sharing plans fell between these extremes, although average expenditures did not decline monotonically as cost-sharing increased. Mean expenditures on the Health Insurance Experiment plans were similar to an estimate of national health care expenditures for children less than age 19 years derived from Fisher.[20] Adjusted to 1983 prices, expenditures on physician and other professional services, hospital care, and drugs average $311 per year for children less than age 19 years.[20]

Outpatient use accounted for 55% of all children's health expenses on the various plans—much higher than the 42% recorded by adults. The pattern of decreasing use with increasing cost-sharing again was evident for outpatient expenditures, which were about 68% greater with the free-care plan than with the 95% plan.

That pattern is mirrored in measures of use other than expenditures. For both younger and older children, the probability of having at least one office visit per year decreased as cost-sharing increased and as children aged (Table 3). By contrast, the probability of being hospitalized during a year showed no consistent pattern related to cost-sharing for older children. For younger children, the two plans with no cost-sharing for inpatient care—the free-care plan and the individual deductible plan—showed significantly greater hospital use than the cost-sharing plans. The average hospitalization rate for children in the Health Insurance Experiment did not differ meaningfully from the national average (the admission probability is .05 from both data sources).

The average number of outpatient visits per year also declined as cost-sharing increased (Table 4). The office visit rates varied considerably by site, however. With one exception, Dayton rates were

TABLE 3. Children with Outpatient and Inpatient Use, by Plan and Age Group*

	% with Outpatient Use		% with Inpatient Use	
	0–4 yr	5–13 yr	0–4 yr	5–13 yr
Free care	95 (2.4)	85 (1.9)	8.8 (1.9)	4.4 (0.8)
25% coinsurance	90 (3.3)	79 (2.4)	4.2 (1.7)	4.7 (1.1)
50% coinsurance	94 (3.6)	74 (4.8)	6.5 (2.6)	4.9 (1.5)
95% coinsurance	82 (4.5)	68 (4.1)	4.5 (1.8)	4.2 (1.2)
Individual deductible	88 (2.8)	76 (3.3)	10.5 (2.8)	3.9 (1.1)

* Sample includes children aged 0 to 13 years who completed the entire enrollment year. Standard errors are shown in parentheses; they have been corrected for intrafamily and intraperson correlation.

TABLE 4. Annual Office Visit Rates Per Child Less Than 14 Years Old, by Plan and Site*

	Dayton, OH	Seattle	Fitchburg, MA	Franklin County, MA
Free care	4.1 (.43)	3.3 (.33)	3.0 (.54)	3.2 (.53)
25% coinsurance	3.1 (.75)	3.1 (.60)	2.8 (.50)	3.7 (.82)
50% coinsurance	3.7 (.61)	—†	2.0 (.53)	2.1 (.67)
95% coinsurance	3.2 (.69)	2.1 (.43)	1.7 (.42)	2.4 (.58)
Individual deductible	2.0 (.67)	4.0 (.96)	1.9 (.36)	2.4 (.50)

* Sample includes children aged 0 to 13 years who were present the entire second enrollment year. Visits include all visits with physicians and osteopaths occurring in offices, clinics, emergency rooms, etc. Telephone visits and visits to free-standing radiology and pathology providers are excluded. Standard errors, shown in parentheses, have been corrected for intrafamily correlation.
† Plan was not offered in Seattle.

TABLE 5. Proportion of Children's Visits to Pediatricians, by Plan*

	Primary Care† (%)	All Visits (%)
Free care	67.5 (2.5)	49.4 (2.3)
25% coinsurance	61.9 (4.4)	44.1 (3.9)
50% coinsurance	69.1 (6.1)	49.2 (5.4)
95% coinsurance	56.4‡ (4.7)	40.2‡ (4.2)
Individual deductible	73.6 (4.5)	53.5 (4.01)

* Standard errors, shown in parentheses, have been corrected for intraperson correlation.
† Includes visits to pediatricians, internists, and family and general practitioners.
‡ Significantly different from free care ($P_r < .05$).

considerably higher than rates in the other sites, which approximated national averages. The 50% and 95% coinsurance and the individual deductible plans most closely approximate the level of coinsurance coverage available generally for pediatric services, including preventive services. Annual office visit rates per child on these plans ranged from a low of 1.7 visits (Fitchburg) to a high of 4.0 visits (Seattle). Nationally, children less than age 15 years averaged 2.0 visits per year (from a 1977 survey of visits to office-based physicians).[21]

One response to cost-sharing is to reduce outpatient visits; another might be to use a different type of provider. To determine whether cost-sharing was related to type of provider used, we calculated the share of visits to pediatricians among all primary care visits and among visits to all providers. Pediatricians accounted for nearly two thirds of all primary care visits with the free, 25% and 50% coinsurance plans (Table 5). Children with the 95% coinsurance plan were significantly less likely to see a pediatrician for primary care (56.4% of visits *v* 67.5% of visits with the free-care plan). Considering both primary and specialist care, pediatricians accounted for nearly half the outpatient visits on the free-care plan. The pediatrician's share was

TABLE 6. Adjusted Annual Medical Expenditures per Child, by Plan

	Expenditures ($)/Child/yr (1983 Prices)*	Ratio to Free-Plan Expenditures
Free care	345 (39)	1.00
25% coinsurance	309 (38)	.90
50% coinsurance	281 (39)	.81†
95% coinsurance	260 (35)	.75†
Individual deductible	298 (38)	.86†

* Standard error of the estimate is shown in parentheses.
† Significantly different from free plan mean ($P < .05$).

significantly lower on the 95% coinsurance plan (40.2%, $P < .05$).

Adjusted Expenditures for Children's Health Care

Although the pattern of plan differences in expenditures exhibited the expected decrease in use with increased cost-sharing, the relatively large standard errors of simple means yields many insignificant plan differences in Table 2. Therefore, we used statistical methods that generate more precise estimates than simple means.

These methods provide what we consider to be our most reliable estimate of the effect of cost-sharing on children's medical expenditures. Estimated expenditures (expressed in 1983 dollars) show less responsiveness to cost-sharing than do simple means (Table 6). Families who paid 95% of their medical bills averaged 75% of the free-care plan medical expenses for their children. Each plan requiring copayment recorded expenditures per child that were significantly less than for those with the free-care plan ($P < .05$ for plans with more than 25% copayment, $P < .07$ for the 25% copayment plan), thus confirming that cost-sharing reduced total use of medical services. Decreased use of outpatient services as cost-sharing increased largely accounted for the reduction in total medical expenditures because inpatient care for children was not greatly affected by cost-sharing (Table 3). Because hospitalizations for children are infrequent, our estimates of hospital use have wide confidence intervals and we can be less certain than for outpatient care about the presence or absence of a cost-sharing response.

Adjusted expenditures did not differ significantly by family income category (Table 7). The probability of using any medical care during a 1-year period was significantly related to family income (not shown), but the effect of copayment on total medical expenditures did not depend on income level, when other determinants of use are controlled for statistically.

TABLE 7. Annual Medical Expenditure per Child, by Income Tertile*

	Expenditures ($)/Child/yr (1983 Prices)
Low†	341 (41)
Middle	345 (39)
High	357 (41)

* Predicted from estimated multiple regression equation using actual characteristics of families in the various tertiles. The log of income had a positive, significant effect on the probability of any use of medical services ($P < .0001$), but no significant effect on the level of outpatient use, given that it was positive ($P > .30$). Standard error of the estimate is shown in parentheses.
† Low income includes children in families in the lowest third of income distribution in their site. Middle income and high income indicate family income in the middle and highest thirds of the distribution, respectively.

Episodes of Outpatient Treatment for Children

Cost-sharing had its greatest effect in reducing outpatient care. To uncover the mechanisms by which cost-sharing operated, we examined episodes of treatment for both children and adults in the Dayton site.

Did cost-sharing reduce the number of episodes or cost per episode? The number of treatment episodes for children less than 14 years of age declined from 4.4 episodes per year on the free-care plan to a low of 2.6 on the 95% plan (Table 8). Controlling for age, race, family income, and prior health, the number of episodes on each pay plan was significantly lower than with the free-care plan ($P < .01$). Children receiving free care had 67% more episodes of treatment than children with the 95%-care plan, but the average cost per episode did not differ significantly between the two types ($P > .05$). Thus, cost-sharing affected whether parents sought treatment for their children, but did not affect the amount of treatment after a visit was initiated. (Note, however, that the average patient seeking treatment on the free-care plan may be less severely ill because a higher percentage of the episodes of illness are treated.)

TABLE 8. Annual Outpatient Episodes of Treatment, by Plan*

	Mean No. of Outpatient Episodes		Mean Cost/Episode (1983 $)	
	Children <14 yr	Adults ≥14 yr	Children <14 yr	Adults ≥14 yr
Free care	4.4	5.2	48	90
25% coinsurance	3.2	4.1	54	97
50% coinsurance	4.0	3.7	57	90
95% coinsurance	2.6	3.1	47	77
Individual deductible	2.9	3.5	37	84

* Based on 1,015 person-years of data for children aged 0 to 13 years and 2,340 person years of data for adults aged 14 years and older for the first 3 years at the Dayton site. Differences in the mean number of patient episodes between the free-care plan and each of the cost-sharing plans were statistically significant on a one-tailed test ($P < .01$) in a regression equation that also controlled age, race, family income, and measures of health status at enrollment.

TABLE 9. Outpatient Episodes per Year for Children Aged 0 to 13 Years, by Type of Episode: First 3 Years in Dayton*

	No. of Episodes			Mean Cost/Episode		
	Acute	Chronic	Well-Care	Acute	Chronic	Well-Care
Free care	2.79	0.58	1.06	42	91	43
Copayment	2.01	0.37	.81	42	112	46

* Based on 1,015 person-years of data for children aged 0 to 13 years who were enrolled for all 3 years at the Dayton site.

Although children had about the same number of episodes as adults, their outpatient expenditures averaged only half of adults' expenses because their mean cost per episode was lower (Table 8).

Did cost-sharing discourage preventive care more than acute or chronic care? To determine whether families facing cost-sharing would forego treatment for certain types of conditions more readily than for others, we calculated the number of episodes of each of three types (Table 9). With the free-care plan in the Dayton site, 63% of children's episodes were related to acute conditions, 24% to well care, and 13% to chronic conditions. Our data correspond to national averages which show that in 1975, 25.5% of all visits to pediatricians were for well-baby examinations, for general medical examinations, or for required physical examinations.[22]

Grouping together the plans requiring copayment, we determined that children insured by these plans had significantly fewer treatment episodes of each type than children with the free-care plan: They had 72% as many acute episodes, 76% as many well-care episodes, and 63% as many chronic episodes ($P < .05$). Cost-sharing reduced episodes of well care less than it reduced care-seeking for acute or chronic problems. Thus, we have no evidence that well-care episodes were more discretionary, or that they were reduced proportionately more than acute or chronic episodes.

DISCUSSION

Spending for medical services responded to variation in cost-sharing both for children and for adults. Expenditures per child with the free-care plan were one third higher than with the 95% cost-sharing plan—a response only slightly less than that of adults. All the measures we examined showed an increase in outpatient use as cost-sharing declined; those insured by the free-care plan had a higher probability of seeing a doctor, higher annual expenditures, more visits, and more episodes of outpatient treatment.

Children insured by the free-care plan were significantly more likely to receive their primary care from a pediatrician than children with the 95% plan. Although this finding appears to suggest that pediatricians charge more, in fact, Health Insurance Experiment data show only slight price differentials between pediatricians and other providers treating children. Pediatricians' charges for a standard visit (corresponding to an intermediate examination for an established patient) averaged 3.5% more than general practitioners' fees for children in Dayton and 1.4% more in Seattle.[23] These small differentials are confirmed by other recent surveys of physician fees.[24] If participants correctly perceived the lack of a price differential, it is difficult to understand the relationship between plan

and choice of a pediatrician as opposed to another physician.

For the most part, hospital expenditures did not vary significantly among children insured by the various plans. Thus, the lower use of outpatient care by children with the cost-sharing plans does not appear to have increased hospital use among children with those plans. In fact, young children insured by the two plans with free inpatient care were more likely to be hospitalized. The structure of the Health Insurance Experiment plans, however, guaranteed that after a family with the cost-sharing plans exceeded an annual maximum out-of-pocket expenditure, all care was free for the remainder of the year; had the Health Insurance Experiment plans not had MPE, inpatient costs might have differed more among the plans.

Although we found large differences in medical care use as cost-sharing varied, we saw little relationship between use and family income. Because the maximum limit on expenditures was income-related, poor families were more likely than affluent ones to exceed the annual ceiling, after which all care became free. Had this not been the case, lower-income families might have spent less than they did on medical care.

How Much Cost-Sharing for Children's Health Care?

Current Situation. The Health Insurance Experiment plans covered the spectrum of cost-sharing from free care to a sizable family deductible. Where does the current national situation fall in this range? The Health Insurance Experiment free-care plan clearly represented more generous coverage than either Medicaid or virtually all private insurance plans offer. Although Medicaid has very limited out-of-pocket payments, its relatively low fee schedules are not universally accepted by physicians, whereas the Health Insurance Experiment plans, in general, paid billed charges.

Nationally, the amount of cost-sharing seems to be in the range of the experimental 50% to 95% coinsurance plans. National visit rates for children approximate visit rates on those two Health Insurance Experiment plans. These plans also correspond to the national average in terms of the percentage of the medical care bill paid out-of-pocket. Families insured by these two plans paid 66% of children's outpatient costs, when nationally, families paid 75% of the office visit charges for children less than 6 years old, and 71% of charges for children aged 6 to 18 years.[25]

The substantial share of children's outpatient expenses paid by families stands in contrast to the high proportion of children covered by health insurance (87.6%).[26] One reason the out-of-pocket payments remain high despite widespread insurance coverage is that health insurance rarely covers one of the most frequent types of child health care—well care. Although well care represents one fourth of children's treatment episodes, and 15% of expenditures, only 3% of the plans held by Health Insurance Experiment participants before enrollment explicitly stated that they covered preventive services. Seventeen percent of the plans did not cover outpatient care at all, whereas 48% covered some outpatient care, but not preventive care.

Recommendations for Change. In 1983 the Committee on Child Health Financing of the American Academy of Pediatrics[1] called for reforms in health financing that would eliminate "financial barriers" for children's health care as well as broaden the range of services covered to include preventive care.

The results presented here are not sufficient to justify a particular level of cost-sharing. Nonetheless, they do have a number of implications. One rationale for less generous coverage of children's services is that they are more responsive to insurance, so increased coverage would stimulate excessive use. Our results, however, imply that expenditures for children's health care are no more responsive to coverage than those of adults. Moreover, because children's expenditures are only 39% of the adult level, providing free care for children would be less costly in absolute terms than providing free care for adults. However, because of the lower costs and the greater share of outpatient care, children's expenditures are more predictable; therefore, insurance is less necessary to protect families from large financial losses.

Similarly, the current lesser coverage for preventive services is partially rationalized by the belief that only nondiscretionary services—eg, medical care for accidents or severe illness—should be covered by insurance. However, the Health Insurance Experiment results imply that even care for acute illness is somewhat discretionary because it varied with insurance reimbursement. In fact, we have shown that free-care plan participants increased their use of acute care and preventive services at the same rate. Because preventive services appear to be no more discretionary than acute care services, there is no reason to provide poorer coverage for preventive services on that account. As in the case of children's health care generally, however, one can argue that well care is predictable and insurance is, therefore, unnecessary.

Our results do give a rationale for covering inpatient care for children more fully than outpatient care. In contrast to the case for adults,[2,3] older

children's use of inpatient care was not significantly related to insurance plan. This lack of cost-sharing response for inpatient care implies that generous hospitalization insurance would not stimulate hospital use for children, particularly for those more than 4 years old.

Some argue that if inpatient care is covered more generously than outpatient care, medical expenses may rise (and health status deteriorate) because patients will delay seeking care until they have a more serious (hospitalizable) problem,[27] or physicians will hospitalize them for services that could have been provided on an outpatient basis. Neither the results in this paper nor those in a companion paper[134] support these contentions for children. The individual deductible plan fully covered inpatient care, but required some cost-sharing for outpatient care. Overall, children on the individual deductible plan had significantly lower expenses than children with the free-care plan. The reduction in use may be attributable to lower inpatient as well as ambulatory expenses, as was the case for adults. In summary, the Health Insurance Experiment results suggest that with regard to hospitalization, financing packages could completely cover the costs of inpatient care for children with little danger of stimulating excessive use.

By contrast with inpatient care, the responsiveness of expenditures for ambulatory care to cost-sharing implies that outpatient expenditures would be considerably higher if the currently high levels of copayment were eliminated. Assuming that the average family currently faces cost-sharing comparable to that of the Health Insurance Experiment 95% coinsurance plans, moving to free care would increase expenditures for children by about one third.

If preventive services nationally are on average covered somewhat less fully than by the Health Insurance Experiment 95% plan, fully covering preventive services would increase preventive use per se some 30% (Table 3), bu. all outpatient visits would increase by only 5% to 10%, and expenditures would increase by less than 5%. Fully covering preventive services adds little to total expenses because well care represents less than 15% of all expenditures for children's health care (Tables 6 and 9). The 5% increase in cost could clearly be financed by a modest increase in cost-sharing for other services, if desired.

Decisions about financing of children's health care must not be made on the basis of cost considerations alone. Rather, we must ask what are the benefits of variations in coverage for preventive care, and how do they compare with the benefits of more coverage for acute and chronic problems? The Health Insurance Experiment was not designed to test the effectiveness of preventive care because all Health Insurance Experiment plans covered preventive services. However, data on health outcomes for children participating in the Health Insurance Experiment[134] reveal that little health benefit accrued to children insured by the free-care plan who received more care. Together with the findings reported here, those results should aid in the design of financial mechanisms that can provide for necessary medical care but also incorporate incentives to use care wisely.

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Presentation of our findings to the Committee on Child Health Financing of the American Academy of Pediatrics helped to focus the discussion in this paper. The comments of Birt Harvey, MD, on a previous draft are appreciated.

REFERENCES

1. American Academy of Pediatrics: Committee on Child Health Financing: Principles of child health care financing. *Pediatrics* 1983;71:981
2. Newhouse JP, Manning WG, Morris CN, et al: Some interim results from a controlled trial of cost-sharing in health insurance. *N Engl J Med* 1981;305:1501–1507
3. Keeler EB, Rolph JE: *The Demand for Episodes of Medical Treatment* (Rand publication No. R-2829-HHS). Santa Monica, CA, Rand Corp, 1982
4. Eisen M, Donald CA, Ware JE, et al: *Conceptualization and Measurement of Health for Children in the Health Insurance Study* (Rand publication No. R-2313-HEW). Santa Monica, CA, Rand Corp, R-2313-HEW, 1980
5. Edwards L, Grossman M: Adolescent health, family background, and preventive medical care. New York, National Bureau of Economic Research Working Paper 398, October 1979
6. Goldman F, Grossman M: The demand for pediatric care: An hedonic approach. *J Pol Economy* 1978;(pt 1):259–280
7. Wilcox-Gok VL: Sibling data and the family background influence on child health. *Med Care* 1983;21:630–638
8. Wolfe BL: Children's utilization of medical care. *Med Care* 1980;18:1196–1207
9. Dutton D: Children's health care: The myth of equal access, in *Better Health for Our Children: A National Strategy* (Report of the Select Panel for the Promotion of Child Health, vol IV, Background Papers). DHHS, 1981, pp 357–440
10. Inman RP: The family provision of children's health: An economic analysis, in Rosett R (ed): *The Role of Health Insurance in the Health Services Sector*. New York, Columbia University Press (for the National Bureau of Economic Research), 1976, pp 215–254
11. Leibowitz A, Friedman B: Family bequests and the derived

demand for health inputs. *Econ Inquiry* 1979;17:419–434
12. Tessler R, Mechanic D: Factors affecting children's use of physician services in a prepaid group practice. *Med Care* 1978;16:33–46
13. Colle, AD, Grossman M: Determinants of pediatric care utilization. *J Hum Resour* 1978;13:115–158
14. Morris CN: A finite selection model for experimental design of the health insurance study. *J Econometrics* 1979;11:43–61
15. Rogers WH, Camp P: *Refusal and Attrition in the Health Insurance Experiment* (Rand publication No. N-2195-HHS). Santa Monica, CA, Rand Corp, in press 1985
15a. Valdez RB, Brook RH, Rogers WH, et al: Consequences of cost-sharing for children's health. *Pediatrics* 1985; 75:952–961
16. Wells KB, Manning WG Jr, Duan N, et al: *Cost Sharing and the Demand for Ambulatory Mental Health Services* (Rand publication No. R-2960-HHS). Santa Monica, CA, Rand Corp, 1982
17. Manning WG Jr, Bailit HL, Benjamin B, et al: The demand for dental care: Evidence from a randomized trial in health insurance. *J Am Dent Assoc*, in press 1985
18. US Bureau of Labor Statistics: *Monthly Labor Review* (various issues) 1983;106:85, 1978;101:89
19. Duan N, Manning WG Jr, Morris CN, et al: A comparison of alternative models of the demand for medical care. *J Bus and Econ Stat* 1983;1:115–126
20. Fisher CR: Differences by all groups in health care spending. *Health Care Fin Rev*, Spring 1980, pp 65–90
21. National Center for Health Statistics: *The National Ambulatory Medical Care Survey, 1977 Summary, United States*, US Department of Health, Education, and Welfare, DHEW publication No. (PHS) 80-1795, Series 1, No. 44, 1980
22. Ezzati T: *Ambulatory Medical Care Rendered in Pediatricians' Offices During 1975* Advance Data from Vital and Health Statistics of the National Center for Health Statistics, No. 13, Oct 13, 1977
23. Marquis MS: *Cost Sharing and the Patient's Choice of Provider* (Rand publication No. R-3126-HHS). Santa Monica, CA, Rand Corp, 1984
24. Goldfarb DL (ed): *Profile of Medical Practice, 1981*. Chicago, American Medical Assoc, 1981
25. Rossiter LF, Salomon MA: *Charges and Sources of Payment for Visits to Physician Offices*. Data Preview 5, National Health Care Expenditure Survey. DHHS publication No. PHS 81-3291, Hyattsville, MD, National Center for Health Services Research, 1981
26. Kasper JA, Walden DC, Wilensky GR: *Who Are the Uninsured?* Data Preview 1, National Health Care Expenditure Survey. Hyattsville, MD, US DHHS, National Center for Health Services Research, not dated
27. Roemer MI, Hopkins CE, Carr L, et al: Copayments for ambulatory care: Penny-wise and pound-foolish: *Med Care* 1975;13:457–466

CONDEMNED TO EXIST

We should understand that whether abortion is outlawed or not, our work has barely begun: the work of creating a society where the right to life doesn't end at the moment of birth; where an infant isn't helped into a world that doesn't care if it's fed properly, housed decently, educated adequately; where the blind or retarded child isn't condemned to exist rather than empowered to live.

Submitted by Student

From *Religious Belief and Public Morality*. Governor Mario M. Cuomo's speech to the Department of Theology at the University of Notre Dame, Sept 13, 1984.

COMMENTARIES

The Rand Health Insurance Experiment for Children

Results of the Rand Health Insurance Experiment (the largest controlled trial of the impact of different amounts of copayment for child health services ever conducted) published in this issue of *Pediatrics*[1] are a cause for concern among pediatricians. Two questions are posed by these studies. First, is the use of child health services price dependent or, in other words, do children use less health care if there is more out-of-pocket cost? The answer is yes, but mainly for office visits, not hospitalizations, for older children. This finding does not surprise most pediatricians. Most goods and services in our society are sensitive to price. Ambulatory medical care for children is no exception. The average number of visits for both acute illnesses and preventive services in the office were decreased by increasing copayment, while hospital use for children more than 4 years of age was not influenced. Clearly there is little cost-saving to be found by imposing copayment for hospital care for children. On the other hand, there is no reason to treat preventive services differently from acute illness visits in health insurance plans as is now the case, since both are decreased by copayment.

But the answer to the question posed by the second study,[2] "Does health status of children change with change in amount of care received?" is not so clear. The authors report no significant differences, *with the outcome measures used*, in health status among children who used more care compared with children who used less care. Our first response to these unexpected findings is to try to find some methodologic problems to account for them, and there are some major limitations to this (as well as most other) studies of medical care. These limitations should lead to great caution in using this study to change reimbursement policy today.

The small number of subjects (about one third of the average size of one pediatric practice); the exclusion or loss of nearly 40% of the original sample from beginning to end of the study; the inability to analyze for special age groups important to pediatrics (those less than 1 year old or the chronically ill); the lack of information on those families who reached their "threshold" early in a year (eg, poor families in the copayment groups might well reach their threshold in 2 to 3 months, and certainly would after an episode of hospitalization, and have free care thereafter); and the combination of number of admissions with length of stay into one measure (costs) which may have obscured what are likely to be opposite effects of copayment on these measures, are only some of the problems with this study. The threshold effect experienced by the poor in this study is a special problem for policy makers. It would certainly not be wise to impose simple cost-sharing on poor families and expect to replicate this experiment, for in this study the poor reached threshold very soon and had free care thereafter. The complex formula offered in this study is also unlikely to be achieved by any practical coverage. In addition, the reimbursement plan was generous. Few children in the United States today have the equivalent of the "free" plan. Data from 1980 indicate that the average child in the United States made 3.9 visits per year to a physician[3] (compared with 4.1 visits for the free-plan group in Dayton, OH, in the Rand study). Even military dependents and Medicaid recipients have many noneconomic barriers that result in less care than the free-care group or even the 95% copayment group received. In addition, the services covered were extensive: dental, psychiatric, all prescription drugs, and many nonphysician services such as speech therapy. Few medical insurance programs come close to this. Therefore, there may be a ceiling effect to account for the results, ie, beyond a certain point, additional medical care makes little impact.

Most important, the measures used to evaluate care were limited, even though they included physical, physiologic, mental health, and health perceptions as outcomes, and these measures were not those that most pediatricians feel they can influence very much. The authors state that these outcome conditions have adverse effects. Most would argue that vision of 20/40, middle ear effusion, or hay fever do not necessarily have adverse effects if untreated. Vision was labeled abnormal only if it

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was 20/40 corrected; hearing as abnormal if as little as a 15 dB loss was present, and the age groups included were not all at risk for all problems (eg, those patients less than age 2 or 3 years could not be judged to have hay fever). In addition, hay fever was measured by parental judgment, not medical examination, and would likely be increased by more medical care, as was found. More medical care should diagnose more conditions and should result in more parental reporting of conditions.

There were some outcome findings that suggest benefit from more care; however, they did not reach statistical significance. Anemia among poor children was improved with more care, and given the small number of children in this group this could be an important finding if more children were included. For the poor, six of the eight measures used as outcomes were worse among copayment groups. Although findings did not reach significance with the small numbers, these trends may be important.

On the input side of the study (that is the quality of care given) there are no data. The fact that there was greater variation in the amount of care used by children between sites than between payment groups suggests that very different types of care were provided in different places. Unless one knows what care was delivered, it is difficult to come to conclusions about its relation to outcomes. The duration of the study was also short. Most pediatricians feel that they have their greatest impact over longer periods of time than 3 years—the length of study for 70% of these children.

For all of these reasons, I believe that we cannot accept the conclusion of this paper that less care has little or no influence on health. The study did not prove that differences may not exist. It merely failed to prove that they do exist.

PREVIOUS STUDIES

There have been a number of previous studies of the effects of child health care. Shadish[4] reviewed 150 books and articles and found a total of 38 controlled studies of the effectiveness of child health care. At least 15 studies found clear positive effect, 19 studies found mixed effects, and only four found no effect. An especially important conclusion was that when preventive efforts fail, it is largely due to failure to administer the treatment completely or to failure of the patient to follow through. One of the main difficulties in interpreting the Rand study is that we do not know the quality of the services provided nor the level of the families' compliance with recommendations.

Two controlled studies of preventive child health services also have questioned whether the currently recommended American Academy of Pediatrics schedule of visits is necessary for *low*-risk, well children.[5,6] The same conclusions and cautions flow from these studies. The numbers are small in both studies but the conclusion that, for low-risk newborn infants, little or no difference in outcomes is associated with fewer visits, once a basic level of care is achieved, is likely to be correct. It is interesting that in the scheduled low-frequency group (five visits in 2 years in the study of Gilbert et al[6]) there were 1.42 unscheduled additional visits compared with only 0.26 among the ten-visit group. Even among low-risk newborn infants, some appear to need more than the planned minimum number of visits. One conclusion I have reached is that any program should be flexible and vary the number of visits according to need.

It would certainly be a mistake to conlcude from the Rand study that child health care makes no difference to a child's health. As Starfield[7] has documented from a review of literature, medical care has been shown to be efficacious in a wide variety of conditions. Of these conditions, only iron deficiency anemia was used in the Rand study, and interestingly this is the one condition for which findings did approach significance among poor children who received more care.

OUTLOOK

More importantly, this study did not address what many of us consider the "new pediatrics." Most pediatricians today spend most of well-child supervision dealing with children's behavior and parental concerns. Although we have less data on the effectiveness of these services, they are a large part of pediatric practice and should be included in studies of outcome. Future studies should test optimal packages of care including management of behavioral problems and care of children with chronic illness.

As with most of science, no one study is ever definitive. It is only with a number of studies examining the problem from a variety of views that we can begin to reach conclusions.

Some findings from the Rand study which are well recognized bear repeating. Expenditures per child were only 39% of the expenditures per adult. The cost of children's health care is then small in comparison with that for adults. Outpatient use accounted for 55% of all children's health expenditures compared with 42% for adults. Child health services are predominantly provided in the office rather than hospital. As Leibowitz et al[1] note, "... providing free care for children would be less costly in absolute terms than providing free care for

adults." In addition, "Because preventive services appear to be no more discretionary than acute care services, there is no reason to provide poorer coverage for preventive services on that account." As the authors point out, most children are well most of the time and when acutely ill usually recover. Medical care of children provides reassurance during these self-limited acute illnesses (and who can say that is not necessary) and diagnostic and therapeutic skills for the rare but life-threatening problems, which are too uncommon to be discovered in a study of this size.

Most children in the United States do not today have insurance coverage for office visits—preventive or curative. To the degree that this coverage is different from that provided adults, it is discriminatory. If health insurance is to be tax-deductible for the employer or family, it should include preventive as well as acute care services in the office for dependents as well as the wage earner. One facet of health care costs that is often forgotten is the relatively high cost of health care for children compared with family income. During that phase of family life when children are small, family incomes tend to be small. While total costs of child health care are small compared with those for adults, these costs often place an especially large burden on young families. It is no wonder that health services are price-sensitive at that time.

Relman's conclusion[8] following publication of the Rand data on adults bear repeating, "... we dare not let our current preoccupation with cost-containment push us into hasty and ill-considered reductions of health insurance benefits, particularly for those who need insurance the most—the poor, the elderly, and the chronically-ill." I would add "and children."

But as pediatricians, we cannot ignore certain findings. The fact that at exit from this study, 30% of children in all groups have uncorrected vision of 20/40 or worse suggests that we don't do a good job of screening or getting children to obtain and wear glasses. The differences between sites in number of visits suggests that we don't provide a standard service. (It is a pity that more information is not available on the actual content of care provided.) These differences suggest that we need to do a better job of education of pediatricians. We also need to determine the efficacy of the services we provide and eliminate those not proven to be beneficial or design better ones. While we may dispute some of the conclusions because of technical details of the study, the Rand study should challenge us to demonstrate the components of child health care that are beneficial and to educate pediatricians in providing them.

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REFERENCES

1. Leibowitz A, Manning WG Jr, Keeler EB, et al: Effect of cost-sharing on the use of medical services by children: Interim results from a randomized controlled trial. *Pediatrics* 1985; 75:942-951
2. Valdez RB, Brook RH, Rogers WH, et al: Consequences of cost-sharing for children's health. *Pediatrics* 1985;75: 952-961
3. Butler JA, Wintez WD, Singer JD, et al: Medical care use and expenditure among US children and youth: Analysis of a national probability sample. *Pediatrics*, in press 1985
4. Shadish WR: A review and critique of controlled studies on the effectiveness of preventive child health care. *Health Policy Q* 1982;2:24
5. Hoekelman RA: What constitutes adequate well-baby care? *Pediatrics* 1975;55:313-326
6. Gilbert JR, Feldman W, Siegel LS, et al: How many well-baby visits are necessary in the first two years of life? *Can Med Assoc J* 1984;130:857-861
7. Starfield B: *Effectiveness of Medical Care: Validating Clinical Wisdom*. Baltimore, The Johns Hopkins University Press, in press 1985
8. Relman AS: The Rand health insurance study: Is cost sharing dangerous to your health? (editorial). *N Engl J Med* 1983;390:1453

Child Care Workers and Children with Congenital Cytomegalovirus Infection

Children with congenital cytomegalovirus (CMV) infection shed virus intermittently in saliva and urine for months to years; viruria often persists for five or more years.[1] This feature of congenital CMV infection is a problem for institutions such as hospitals and infant developmental centers, as well as for persons who provide care for children with congenital CMV infection. There is concern that these children will transmit CMV to their care givers, who are usually young women in their childbearing years. Unfortunately, this concern can lead to exclusion of handicapped children with congenital CMV infection from special education programs designed to teach children with motor, hearing or other CNS damage. Exclusion of children with congenital CMV from any type of infant care

Reprint requests to (R.F.P.) Suite 752, Children's Hospital Tower, The University of Alabama in Birmingham, Birmingham, AL 35294.
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COVER STORY

DOCTORS' EARNINGS: THE YEAR OF THE BIG SURPRISE

After a year of near-zero growth, practice income is up again, our Continuing Survey reveals. Here's the picture for 18 specialties.

By Arthur Owens SENIOR EDITOR

The key finding in the latest MEDICAL ECONOMICS Continuing Survey is a stunner. Median net professional earnings of office-based M.D.s jumped 7.8 percent last year to a new high of nearly $102,000, reaching six figures for the first time. Making this upswing all the more striking are the circumstances in which it took place.

Going into 1984, the outlook was far from bright. Median net practice income had edged upward only 1.4 percent in 1983, while the cost of living was rising 3.8 percent. The number of nonmilitary M.D.s and D.O.s in patient care had grown by 16,460 in just one year—not to mention increasing competition from hospitals and HMOs. More than ever, government and other third-party payers were resisting reimbursement claims for what they considered non-essential medical services. Then came the freeze on Medicare fees.

One result of all this was that patient visit rates continued their decade-long decline. Total visits per M.D. per week, after dropping 21 percent between early 1974 and early 1984, fell another three visits to a median of 103 by the spring of this year, the survey shows.

In addition, after holding the line on professional expenses in '83, doctors played catch-up last year, laying out a median of 19 percent more. Contributing to this rise was another big jump in malpractice insurance costs, especially for surgeons. Neurosurgeons, for instance, paid a median of 31 percent more for coverage than in 1983, while all surveyed M.D.s combined paid 16 percent more. Thus total expenses as a percentage of gross climbed from 35.8 to 38.0 percent for all surveyed physicians.

Despite all these negative factors, practitioners in most major specialties enjoyed 1984 net-income gains that comfortably exceeded the 4.0 percent rise in the cost of living. The only exceptions among the 18 fields we selected for separate study: GPs and FPs, each with median net gains of less than 1 percent; OBG specialists (+2.7 percent); and pediatricians (+3.3 percent). For most doctors in those four specialties, net gains had also lagged behind inflation in the preceding year.

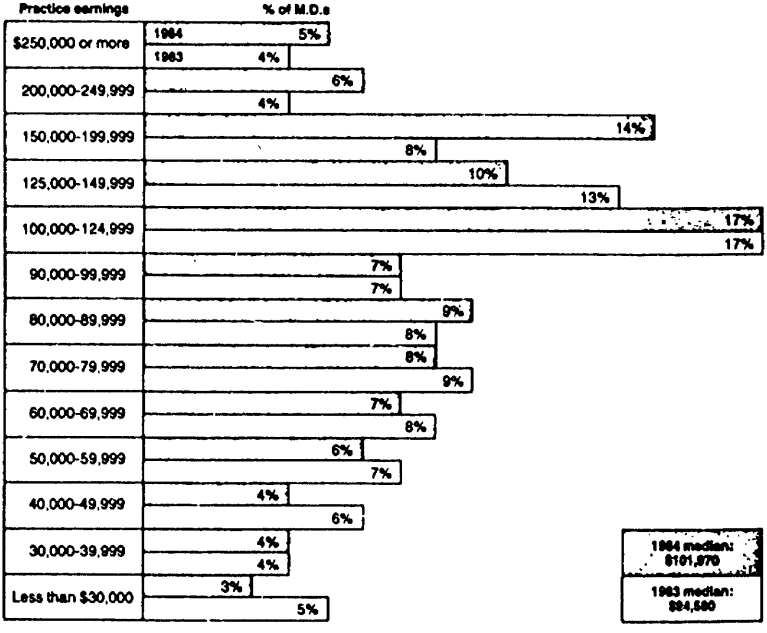
Among primary-care M.D.s, internists alone beat inflation in 1984, with a solid 7.4 percent advance, after losing ground the year before. This suggests that they may have begun to succeed in their long-standing battle to reduce the third-party reimbursement gap between cognitive and procedural services.

Obviously the same can't be said for family practitioners and pediatricians. And overall, the earnings gap between cutters and thinkers is growing. Last year, as in 1983, the surgical specialties were the biggest gainers. General surgeons, for example, raised their practice profits 11.8 percent. Plastic surgeons, who on average suffered actual earnings declines in '83, recovered dramatically last year, gaining a median of 13.6 percent. Ophthalmologists, orthopedists, and neurosurgeons did even better.

Since both office and hospital visits were down and costs were up in virtually all fields of prac-

ONE-FOURTH OF YOUR COLLEAGUES NOW NET AT LEAST $150,000

Last year one in 20 surveyed M.D.s net'ed at least a quarter of a million dollars from practice (after professional expenses but before income taxes). Clearing $150 000 or more were one in four doctors—as compared with only one in 12 back in 1979. Over those five years, the percentage with individual practice earnings of less than $50,000 dropped from 22 to 11 percent.



For unincorporated physicians, net is individual income from practice minus tax-deductible professional expenses, before income taxes. For incorporated physicians, it's total compensation from practice (salary, bonuses, if any, and corporate retirement set-asides) before income taxes

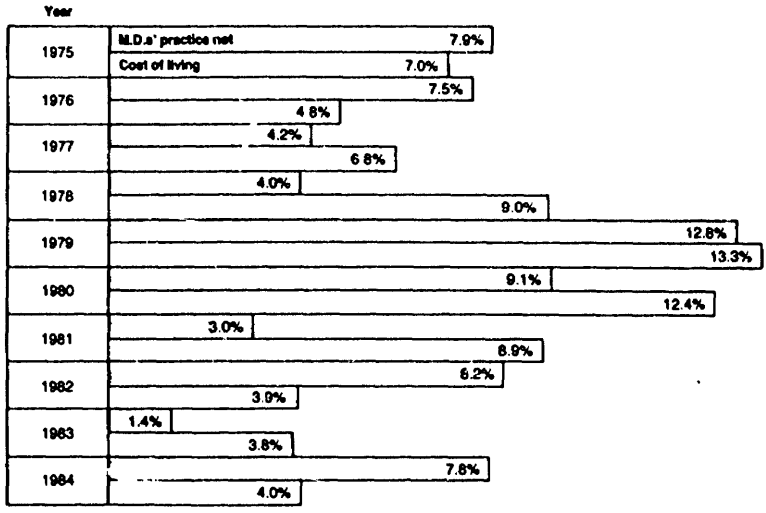
Data in this and the charts and tables that follow apply to office-based M.D.s and, except where otherwise noted, are based on MEDICAL ECONOMICS' Continuing Survey. Where no year is specified, figures are for 1984

tice last year, the widespread increases in medical earnings can only be attributed to higher fees—and/or more services per patient visit. True, the government's Consumer Price Index of physicians' services rose less in 1984 (6.0 percent) than the 7.5 percent increase the year before, when physicians' earnings hardly changed. But that index is based on a small and highly selective list of services that doesn't include many of the higher-priced procedures—especially in the surgical fields, where practice income increased the most last year.

Those are some of the broad-scale findings from our latest Continuing Survey. There are wide differences among regions, types of practice, types of community, and years in practice. For those variations, as well as a report on physicians' current income expectations, see the accompanying charts, tables, and commentaries.

A DECADE OF DOCTORS' INCOME GAINS vs. THE COST OF LIVING

1984 was only the fourth year in a decade that private physicians beat out inflation. In the long run, you and your colleagues have been losing. From the end of 1974 to the end of 1984, the general cost of living leaped 103 percent, while annual median practice earnings rose only 88 percent.



Annual percent changes in physicians' earnings are based on national medians. Percent changes in the cost of living are based on the U.S. Bureau of Labor Statistics' Consumer Price Index (all items) for December of each year.

WILL PRACTICE EARNINGS RISE THIS YEAR? HERE'S WHAT YOUR COLLEAGUES EXPECT

Early this year, seven out of 10 physicians polled by MEDICAL ECONOMICS said they anticipated either lower practice earnings this year or no change from 1984. Only one in four expected to gain at least 5 percent—enough to offset the projected 1985 inflation rate. The highest proportions of doctors expecting some increase were found among plastic surgeons, pediatricians, partners in large unincorporated practices, and Far Westerners. Most pessimistic were thoracic surgeons and Midwesterners.

% of M.D.s who expect 1985 earnings to be:

Higher 28%	Same as in 1984 43%	Lower 29%

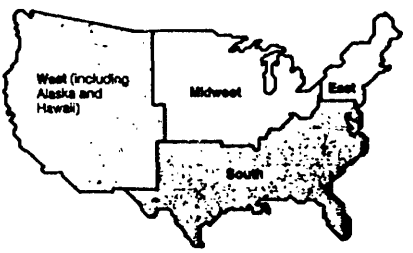
Expected increase	% of M.D.s
25% or more	10%
20-24	9
15-19	7
11-14	3
10	38
5-9	28
1-4	5
Median	10%

Expected decrease	% of M.D.s
25% or more	12%
20-24	16
15-19	15
11-14	4
10	37
5-9	15
1-4	1
Median	11%

BY REGION . . .

% of M.D.s who expect 1985 earnings to be:

	Higher	Lower	Same
East	29%	24%	47%
South	27	28	45
Midwest	24	36	40
West	31	29	40



BY TYPE OF PRACTICE . . .

	% of M.D.s who expect 1985 earnings to be:		
	Higher	Lower	Same
Incorporated:			
Solo	22%	33%	45%
2 or 3 shareholders	23	28	49
4 or more shareholders	28	33	39
Unincorporated:			
Solo	29	28	43
Expense-sharing	33	29	38
2 or 3 partners	32	24	44
4 or more partners	36	27	37

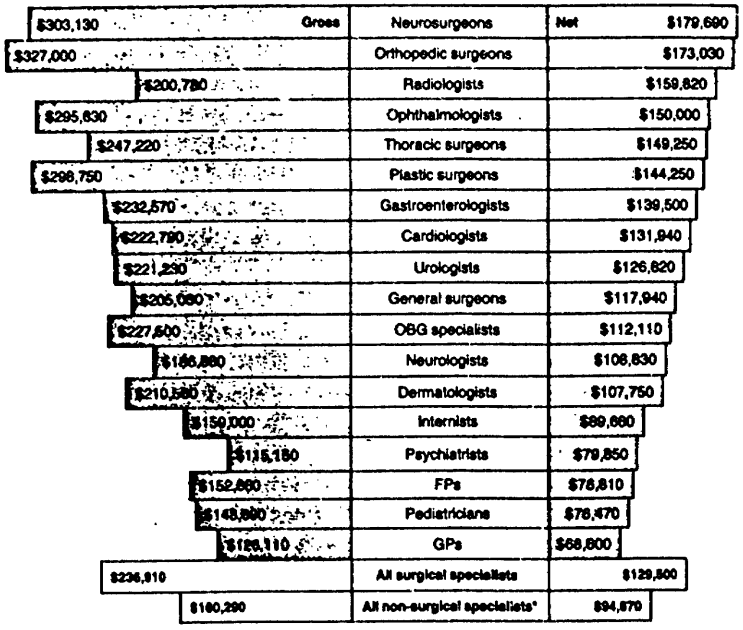
AND BY SPECIALTY

	% of M.D.s who expect 1985 earnings to be:		
	Higher	Lower	Same
Cardiologists	31%	33%	36%
Dermatologists	33	24	43
FPs	34	27	39
Gastroenterologists	27	33	40
GPs	20	34	46
General surgeons	18	38	44
Internists	23	39	38
Neurologists	29	32	39
Neurosurgeons	22	33	45
OBG specialists	28	29	43
Ophthalmologists	32	18	50
Orthopedic surgeons	24	29	47
Pediatricians	37	18	45
Plastic surgeons	38	21	41
Psychiatrists	31	17	52
Radiologists	20	38	42
Thoracic surgeons	18	47	35
Urologists	23	37	40

Continued on page 203

HOW 18 SPECIALTIES RANK IN PRACTICE EARNINGS

In 1984, seven of the top 10 fields in net practice income were surgical specialties, and all of the bottom seven were non-surgical. When ranked by gross income, orthopedists take first place and psychiatrists last among the 18 specialties studied separately. Radiologists, only 12th in gross receipts, rise to third place in net, thanks to their low expenses (16.3 percent of gross).



*Excludes FPs and GPs. Gross represents physicians' individual shares of 1984 receipts from practice before professional expenses and income taxes. Figures are medians

LATEST RANGES OF NET EARNINGS BY SPECIALTY

Netting $300,000 a year or more are one in eight thoracic surgeons, one in nine neurosurgeons, and one in 10 ophthalmologists—but only one in 100 internists, OBG specialists, or

	% of									
Practice earnings	Cardiologists	Dermatologists	FPs	Gastroenterologists	GPs	General surgeons	Internists	Neurologists	Neurosurgeons	OBG specialists
$350,000 or more	1%	1%	—[2]	3%	—[2]	1%	1%	1%	8%	—[2]
300,000-349,999	1	—[2]	—[2]	1	—[2]	2	—[2]	—[2]	3	1%
250,000-299,999	6	2	—[2]	3	—[2]	4	1	1	13	2
200,000-249,999	13	7	—[2]	13	1%	8	4	6	19	10
150,000-199,999	19	14	4%	23	4	19	6	11	19	16
125,000-149,999	14	13	5	15	4	9	9	14	9	12
100,000-124,999	18	19	14	21	13	19	21	26	14	20
90,000-99,999	5	8	9	4	7	6	8	9	2	7
80,000-89,999	7	7	14	6	11	6	8	10	4	8
70,000-79,999	4	7	13	2	8	5	12	7	2	6
60,000-69,999	5	7	14	2	14	6	10	7	2	5
50,000-59,999	4	5	12	3	12	4	9	3	1	4
40,000-49,999	1	4	6	1	9	3	5	2	1	3
30,000-39,999	1	3	5	1	8	3	4	1	1	3
Less than $30,000	1	3	4	2	9	3	2	2	2	3

[1]Excludes FPs and GPs [2]Less than 1 percent

REGIONAL VARIATIONS IN DOCTORS' EARNINGS

Biggest improvements in annual net last year came in the Rocky Mountain states (median up $15,000, or 16.8 percent) and in New England (up $13,640, also 16.8 percent). That moved the Rockies from sixth to fourth rank among the nine census regions, but New England remained in last place. Still on top was the Mid-South, with a regional median of $106,670. The Southwest, with a 6.3 percent increase for the year, jumped from third to second rank, while the Great Lakes states fell from second to sixth position. Median net gains beat last year's 4 percent cost-of-living increase in all but two regions: the Great Lakes (+1.3 percent) and the South Atlantic states (+3.1 percent).

	Gross	Net
WEST	**$184,210**	**$100,000**
Rocky Mountain states	191,500	104,290
Far Western states (including Alaska and Hawaii)	182,190	97,780

	Gross	Net
MIDWEST	**$177,500**	**$103,000**
Great Lakes states	176,110	101,670
Plains states	178,640	105,000

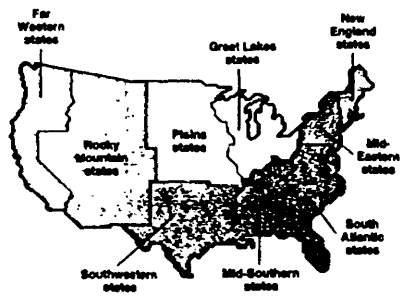
Figures are medians.

neurologists. No surveyed FPs, GPs, pediatricians, or psychiatrists reached that level. From 1979 to 1984, surgical specialists netting at least $150,000 rose from one in nine to two in five. Meanwhile, non-surgeons (except FPs and GPs) at that level increased from one in 17 to one in six.

% of									
Ophthalmologists	Orthopedic surgeons	Pediatricians	Plastic surgeons	Psychiatrists	Radiologists	Thoracic surgeons	Urologists	All surgical specialists	All non-surgical specialists[1]
8%	6%	—[2]	4%	—[2]	1%	11%	1%	3%	—[2]
2	2	—[2]	2	—[2]	1	2	1	1	—[2]
10	10	—[2]	10	—[2]	8	7	5	6	2%
7	20	—[2]	11	2%	13	15	8	10	4
23	21	5%	19	4	32	14	21	20	11
8	10	4	13	9	9	12	15	12	10
18	16	14	18	15	16	12	24	20	18
7	4	11	5	7	3	4	7	6	8
7	4	12	6	13	6	6	6	6	11
4	2	11	3	13	4	5	4	4	10
2	2	10	3	8	2	4	3	4	7
2	1	11	3	8	2	3	2	3	7
1	1	9	—[2]	10	1	1	1	2	5
1	—[2]	7	1	6	—[2]	2	1	2	4
—[2]	1	6	2	5	2	2	1	1	3

	Gross	Net
EAST	$196,280	$ 99,460
New England states	165,000	95,000
Mid-Eastern states	166,760	101,300

	Gross	Net
SOUTH	$196,800	$104,220
South Atlantic states	190,850	102,560
Mid-Southern states	190,830	106,870
Southwestern states	2207,160	105,830



HOW INCOME VARIES BY TYPE OF COMMUNITY . . .

Gross		Net
$181,620	Urban	$104,410
$187,140	Suburban	$103,960
$175,260	Rural	$89,630

BY TYPE OF PRACTICE . . .

Gross		Net
	Incorporated:	
$220,180	Solo	$109,490
$221,680	2 shareholders	$118,000
$208,130	3 shareholders	$130,280
$217,760	4 or more shareholders	$126,430
	Unincorporated:	
$121,630	Solo	$71,170
$155,830	Expense-sharing	$90,560
$154,580	2 or 3 partners	$91,070
$162,000	4 or more partners	$103,570

AND BY YEARS IN PRACTICE

Gross		Net
$111,000	1-2	$71,000
$185,000	3-5	$97,350
$203,700	6-10	$111,710
$215,340	11-20	$119,000
$177,730	21-30	$101,000
$133,480	31 or more	$76,660

Figures are medians.

Continued on page 2

INCORPORATED PHYSICIANS IN EVERY SPECIALTY GROSS AND NET MORE

	Incorporated M.D.s		Unincorporated M.D.s	
	Gross	Net	Gross	Net
Cardiologists	$252,400	$142,270	$168,750	$105,830
Dermatologists	245,000	121,360	155,000	87,690
FPs	181,000	84,290	136,670	69,710
Gastroenterologists	250,430	144,500	170,000	112,140
GPs	182,190	85,120	106,500	59,290
General surgeons	226,250	124,120	149,170	91,000
Internists	187,860	102,500	128,570	72,140
Neurologists	206,070	115,000	148,000	94,580
Neurosurgeons	331,250	196,880	190,000	137,500
OBG specialists	255,000	123,130	151,670	83,130
Ophthalmologists	356,250	173,210	209,380	106,670
Orthopedic surgeons	338,070	178,020	265,000	145,000
Pediatricians	180,000	87,170	126,110	64,580
Plastic surgeons	322,060	150,500	192,500	103,750
Psychiatrists	142,000	85,790	106,390	75,500
Radiologists	207,140	164,580	185,000	115,000
Thoracic surgeons	264,580	160,120	157,500	95,000
Urologists	239,490	134,380	161,430	100,000
All surgical specialists	264,360	143,810	166,250	98,820
All non-surgical specialists*	190,810	109,060	125,000	80,300
All M.D.s	218,510	118,990	131,180	78,750

*Excludes FPs and GPs.

INCORPORATED vs. UNINCORPORATED M.D.s' EARNINGS

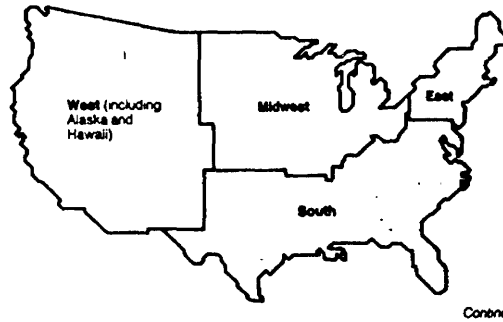
BY TYPE OF COMMUNITY . . .

	Incorporated M.D.s		Unincorporated M.D.s	
	Gross	Net	Gross	Net
Urban	$224,160	$123,530	$125,370	$77,600
Suburban	215,780	117,730	144,620	81,590
Rural	206,250	104,820	135,000	77,140

AND BY REGION

	Incorporated M.D.s		Unincorporated M.D.s	
	Gross	Net	Gross	Net
East	$213,850	$124,290	$128,570	$77,270
South	225,890	123,630	136,250	82,780
Midwest	211,070	114,110	128,890	77,940
West	220,160	111,360	130,000	74,380

Figures are medians



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HOW OUR LATEST SURVEY WAS CONDUCTED

The 1985 MEDICAL ECONOMICS Continuing Survey questionnaires were mailed early in February to 31,138 office-based M.D.s of all ages—a random sampling from the master list maintained by Clark-O'Neill Inc. Non-respondents received a follow-up mailing in early March. By the mid-May cutoff date, 10,117 physicians—32.5 percent—had responded. After we set aside returns with apparent discrepancies and those from physicians who indicated that they hadn't been providing office-based patient care throughout the preceding year, the working sample consisted of 7,285 questionnaires. These were coded by MEDICAL ECONOMICS' research staff, then tabulated by computer under the direction of Harvey Rosenfeld of Digitab Computing Inc. in New York City.

As the accompanying tables show, the survey sample is fairly representative in terms of field of practice, region, and age. It's therefore likely to be representative in other ways as well.

FIELD OF PRACTICE

	% of	
	Statistical universe[1]	Survey sample
Internal medicine	12.1%	10.1%
Family practice	8.7	6.3
General practice	7.8	12.9
Obstetrics/gynecology	6.7	8.2
General surgery	6.6	6.9
Pediatrics	6.3	7.1
Psychiatry	5.3	7.1
Anesthesiology	4.7	3.8
Orthopedic surgery	4.1	4.7
Ophthalmology	3.9	3.7
Cardiology	2.8	2.1
Urology	2.2	2.9
Emergency medicine	2.2	1.5
Radiology	2.1	4.4
Pathology	1.9	1.4
Otolaryngology	1.8	3.0
Dermatology	1.7	2.9
Neurology	1.3	1.1
Gastroenterology	1.2	0.8
Plastic surgery	1.0	1.5
Neurosurgery	0.9	0.8
Thoracic surgery	0.6	1.0
All other specialties	14.1	5.8

REGION

	% of	
	Statistical universe[1]	Survey sample
East	23.5%	21.3%
South	31.3	32.7
Midwest	22.1	23.4
West	23.1	22.6

AGE

	% of	
	Statistical universe[2]	Survey sample
Under 35	11.3%	8.5%
35-44	33.1	32.9
45-54	24.0	27.1
55-64	19.2	23.8
65 and over	12.4	7.7

[1]As of Jan. 1985. [2]As of June 1985. Source of data on the statistical universe: Clark-O'Neill Inc. and the AMA.

■

STATEMENT OF FREDERICK D. HUNT, JR., EXECUTIVE DIRECTOR, SOCIETY OF PROFESSIONAL BENEFIT ADMINISTRATORS, WASHINGTON, DC

Senator CHAFEE. Mr. Hunt.

Mr. HUNT. Senator, we probably have the harshest statement, but I think that's because we feel damned if we do and damned if we don't. From the perspective of our members who have one-third of all U.S. workers, or the day-to-day hands on people who pay the claims and evaluate them, they feel that they are being jerked around in this very room. And by members of this committee, we have been told—I remember Senator Dole specifically telling me that social policy has no place in the Tax Code, when we were defending some of the same things he was defending.

So are we supposed to be cutting costs? What are we supposed to be doing?

Senator CHAFEE. Well, don't look for total consistency. [Laughter.]

Mr. HUNT. But I think like everybody else has said—and I have two little boys and I was going to bring in—they just got check ups too so he stole my idea.

There is no question that this is a good idea. Our members, I should point out since Mr. Mentz made the differentiation, most of our members have self-funded plans. That's about 40 percent of all U.S. workers are covered by self-funded plans. So we already have some pretty tight regulation by the Department of Labor and the Department of Treasury and HHS, et cetera, et cetera, on these types of things.

What we are worried about is that there are already about 12 bills that are either introduced or on the way to being introduced for mandated benefits. And we are just afraid this will begin to be a binge.

And I might add here that we really appreciate you, Senator. You are the only one of the sponsors of these bills who has indicated a willingness to have a public hearing. Everybody else has kind of said, well, we are trying to hustle this through in a hurry. So we appreciate your candor in having this session.

Now we have heard about the $2.28 premium. Mine is not a scientific factor. I based it on revenue losses from the Joint Committee on Taxation. And I come up that this would cost $19 million in revenue losses. And to be very honest with you, that's an unscientific thing. I asked our people and they said—they took, I believe—the Joint Committee on Taxation said it's $190 billion total revenue loss on health plans.

And my members, as I say, are the day-to-day guys, and they figure it could be about 10 percent. And I understand the chamber has come up with a figure also of 3 to 10 percent that it would add to it. By the time you are adding new people, et cetera, et cetera.

The other problem that's related to that, of course, is you are raising the cost to workers. So you are damaging, you know—one of the big issues now is world trade and our position. You are making our employees more expensive. Whether it's for a good purpose inside or not, if somebody buys a Mazda, you know, this is one of the reasons.

Also, as I say, we feel damned if we do and damned if we don't. As far as the cost containment thing, we are being hounded on that. DEFRA will put limits on the reserves. Now this would throw DEFRA out of the line on that.

The other point, as we said, is that employers may say the hell with it. And I would add to that it's not just the employers. I don't want to make the employers the bad guys. There is also a factor of antiselection. And that means when the person says, hey, give me the money, I'm going to buy a stereo; now if that person has a baby next year, that baby just got uncovered because of the antiselection.

The more you add onto the program, the more you have a problem with antiselection.

Most workers would have no protection at all if they dropped out of the plan. And then that creates another cost for Uncle Sam because the person would fall back on Medicare, Medicaid, Social Security, Veterans Administration, whatever, all the various other State and Federal programs.

I think there is a philosophical problem that S. 376 in similar mandates abort free worker and emoloyer choice. Collectively bargaining, as you mentioned in your opening remarks, is probably the most clearest democratic voice of an employer choice, where they want it and they don't have it.

Two-worker families would be forced to have double coverage. You are suddenly saying, I'm sorry, you know, you are going to have it and you are going to have it. That's pretty expensive waste when they could have dental or vision or whatever it might be.

Senator CHAFEE. Slow down a minute.

Mr. HUNT. Yes, sir.

Senator CHAFEE. On the two-worker family problem, that comes up all the time now. The choice system could be worked out. I'm looking for help here. What we are seeking is some constructive criticism.

Mr. HUNT. Well, I think that's fine. But you——

Senator CHAFEE. Now maybe one of the answers is to take care of the two-worker family. But that's not anything beyond the realm of the——

Mr. HUNT. I'm delighted to hear that, Senator.

And one of the points I would make related to that is that in making the choice you tend to create another set of what they call antiselection. In other words, the people who would choose the care are those who expect to have sick children. I mean whether you like it or not, you say, gee, can I take care of my teeth or get a free checkup that may or may not find something.

So what you end up doing is running up the cost of the coverage because those that get it are those that expect to need it. I mean it's a problem that is ongoing.

I agree. I'm glad to hear that you are willing to change it, because, as I say, we walked in not knowing——

Senator CHAFEE. That's what we have got the hearing for.

Mr. HUNT. Yes, sir.

Senator CHAFEE. This thing isn't written in concrete, but it seems to me that some of the objections you raise are discrimina-

tory against childless workers. Well, what about a program that he belongs to that provides family coverage.

Mr. HUNT. Mostly, that's a choice, Senator. Both the employer and the employee work pretty hard to make sure not to have the overlaps. And so I mean I'm delighted to hear your willingness to make it more workable.

And as I say, we really commend you for having the hearing because nobody else is. And so that is good.

The final thing I would say——

Senator CHAFEE. That's a modest commendation. [Laughter.]

Mr. HUNT. We mean it very genuinely, sir. I think the anger that has been raised is partly because so many things are being rushed through. Congressman Stark has rushed the continuing coverage—has rushed that into the budget. No hearings, no nothing. There are a number of others which we are told by the staff are going to be zoom, zoom, zoom.

And as I say, one of the things that is frustrating is most of the sponsors of these programs are the same people who were damning us 1 year ago and even now for spending too much on health care. So we kind of say, which way do you want us to go?

And, finally, the thing I would mention is that there are the technical problems. I'm sort of convinced our self-funded plans for the most part are not covered by State mandates. So I can very—without any problem, say I think if these are national problems, which I think the panel this morning was trying to say and which I guess Mr. Mentz was saying that he's willing to go for that—then do away with the McCarron-Ferguson Act, giving the States the power to regulate it. Otherwise, you are going to end up with—not just on this issue, but we have got to look at the big picture. There are going to be other mandates.

Senator CHAFEE. Well, I'm not sure we want to look at the big picture here all of the time.

Mr. HUNT. We don't want to end up with a double-whammy, an uncoordinated double-whammy.

Senator CHAFEE. I don't want to tangle with the McCarron-Ferguson Act. I've got enough problems.

Mr. HUNT. That was the one that gives the authority to the States to mandate benefits.

And then, DEFRA, National Labor, and a number of other acts would need to be addressed.

Senator CHAFEE. Well, that may be.

All right, fine. Thank you.

[The prepared written statement of Mr. Hunt follows:]

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Testimony to the United States Senate
Committee on Finance, Subcommittee on Taxation & Debt Management
from the Society of Professional Benefit Administrators, (SPBA)
by Frederick D. Hunt, Jr., Executive Director
September 16th, 1985
on S 376, the Child Health Incentive Reform Plan
[illegible] for group health plan expenses
[illegible] pediatric preventive care.

Mr. Chairman, let me first emphasize that there is no question in our mind that the intent of S 376 is good and sincere. However, I think our message is that the road to hell is paved with good intentions. The question today should not be merely the narrow scope of this well-intentioned mandate. Instead, we urge you and the Congress to consider the precedent which would be set, and the side-effects which are counter-productive to most of the other current efforts of Congress. We feel it is a very bad idea for many reasons for Uncle Sam to be the dictator of what benefits are desirable in the private employer/employee relationship.

Yes, preventive pediatric care is a good goal. It also happens to be a coverage which most employers voluntarily currently offer to their employees who choose to have it. Therefore, there is no desperate shortage of this coverage.

The point is that while preventive pediatric care is good...so would be dental coverage, vision insurance, and even good mattresses to assure good sleep. There are hundreds more desirable health protections, and all undeniably good for the nation and the workforce. The question then rises whether Uncle Sam should dictate and mandate this ever-growing list of hundreds of coverages. If you can have preventive pediatric care...why shouldn't every other Member of

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Congress get credit for adding a pet mandate? It is a Pandora's box opened once S 376 becomes the precedent. I should point out that as we speak, there are about a dozen bills in progress in Congress to mandate a variety of new expensive benefits which employers and employees would be forced to accept against their will. While I may sound like I'm being tough on S 376 and you, we do commend you for holding these hearings. The other mandates are being hustled through as quickly and quietly as possible.

We find it ironic and hypocritical that the sponsors of these expensive new Federal mandates happen to all be leaders of the Senate and House tax committees....Yes, the same Congressmen who so strongly criticize the high cost of private health and benefit plans, and urge that workers be taxed on the cost of their benefits. Thus, the effect of S 376 and other mandates is to force workers to take more expensive coverage...and then punish them via taxation for having such a costly plan to pay for those mandates. That seems cruel and counter-productive.

You must decide whether you want to be Santa Claus or Scrooge. Do you want wonderful benefits...which had been the goal of private employers since about 1950. Or, do you want taxes and cost-containment, as you have been demanding for five years. It simply will not work both ways at once, no matter how much we might wish it to be so.

This is a significant revenue reduction measure you are proposing. If S 376 and other mandates force employers to offer expensive mandate benefits, then the employers simply take a larger tax deductio to pay for those new expensive benefits. Can we afford a revenue-loss proposal right now? The consensus of your colleagues and staff seems to be "no".

Employers may just say "to hell with it all". Each year, employee benefit plans must absorb, adjust to, and pay for about 1,000 new laws, regulations, rulings, and court decisions. That is about five significant changes for every

working day of the year! We are very close to having the straw that will break the back of the employers' willingness to continue to provide employee benefits. If employers back out of the private benefits system, and people are left to fend for themselves...Uncle Sam is the big loser. The 162 million people now receiving privately-paid employee benefits will fall back onto Veterans and military medical care, Social Security, Medicare, Medicaid, state/local welfare, and the other publicly-paid safety net benefits. That will be a crisis, since those are already in financial problems without those people on the rolls. No matter how you look at it, S 376 and similar Federally-mandated benefits have a very high revenue and social cost.

S 376 is discriminatory. It applies only to workers with certain life-styles and family formats. Should workers who have no children have to pay for (and possibly be taxed on) this coverage which they know they will never use? What about the documented overwhelming desire of Americans to have a choice in shaping their employee benefits? For instance, the parents whom you hope to help with S 376 would actually be hurt, because it would kill the chance for dual-worker families to tailor their coverage to their needs. You would mandate unnecessary double-coverage for both workers. What about the workers who prefer the choice of high-option or low-option plans? Mandates make every option the expensive version.

Collective-bargaining would be aborted by S 376 and similar Federal mandates. Union/management collectively bargained benefit plans are the clearest example of democracy in action. Workers can demand and negotiate for the benefits which are most desirable and appropriate for that working group. You would now put Uncle Sam in the position of narrowing the choices and democracy of workers. The same kind of worker-desired benefits emerges in the non-unionized arena as well. Is the intent of S 376 and other mandated benefits to stifle the desires of the workers for their own coverage?

S 376 could have a sinister side-effect for some parents. Especially in self-funded plans where an employer pays all of the costs and not just some premium; an employer would be crazy to hire a person with a child with a serious long-term illness. The effect of S 376 would be to severely limit that parent's employability.

For the reasons of discrimination, collective-bargaining, and worker employability, S 376 and similar mandates must make clear that workers may decline the mandated coverages.

S 376 and mandated coverages are especially inappropriate for self-funded plans. The reason is that self-funding is a very different legal mechanism than insurance company plans. The Congress, Supreme Court, Treasury, Department of Labor, and IRS have consistently upheld and expanded that difference. For you to revoke that difference would necessitate revision of dozens of major laws. Self-funded (self-insured) employee benefit plans are payments directly from the employer specifically to cover his own employees...much like salaries paid directly from the employer to the employee are treated differently under law from disability or other payments paid by an insurance company.

Ironically, many of the Federally-mandated benefits being considered right now would leave the 40% of Americans covered by self-funded plans in a damned-if-they-do, and-damned-if-they-don't situation. IRS qualification rules for self-funded plans are extraordinarily tight and complex. In many cases, if the plan obeys IRS self-funding qualification laws, it would need to disobey mandated benefits laws. Or, if they obey your law, they break IRS law. That's a no-win situation...with 40% of America's workers the big losers.

Conversely, is state-mandate of benefits authority revoked under S 376 and similar Federal mandates...or are you designing double jeopardy? Under the McCarran Ferguson Act of 1946, states have an increasingly broad and complex network of mandated benefits. What happens when the dictates of Federal mandates

differ or conflict with the varying mandates passed by 50 states? Which takes precedence, or is it intended that American employers and workers be damned-if-they-do, and damned-if-they-don't. If you proceed with S 376, it is only logical to add an amendment to supercede the authority of states also to mandate benefits. Double- jeopardy would be unwise and harmful to the benefits system.

Therefore, while we applaud your sincerity and desire to provide protection, we urge that S 376 and related mandated benefits from the Federal government be abandoned because:

- The list of "good" things which could be mandated is unrealistically long.
- Federally mandated benefits are tax revenue-losers, and counter-productive to recent Congressional and Administration efforts for cost containment.
- Employers may well say "to hell with it", and simply not offer any coverage.
- It is discriminatory against childless workers, and aborts the rights of choice and collective bargaining of workers and employers in a free enterprise system, while possibly even harming the parent workers.
- Mandated benefits are inappropriate for self-funded plans which are not "insurance", but direct reimbursements from employer to worker.
- State authority to mandate benefits needs to be eliminated if Federal benefits are to be initiated, so that there will not be double-jeopardy.

SPBA is the national association of independent Third Party contract benefit Administration firms (TPAs). It is estimated that one-third (1/3) of all U.S. workers are covered by plans administered by such firms. SPBA TPA member firms operate much like independent IPA or law firms...providing benefit administration services on an independent out-of-house basis to client employee benefit plans (representing every size, format, and type of employer).

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STATEMENT OF JAMES H. VAN LEW, REGIONAL DIRECTOR OF GROUP AND PENSION SALES, BANKERS LIFE CO. OF IOWA, DES MOINES, IA

Senator CHAFEE. Mr. Van Lew.

Mr. VAN LEW. Thank you, Mr. Chairman. I am Jim Van Lew, a regional director of group and pension sales for the Bankers Life Co., a mutual company founded in 1876, a member of the principal financial group.

We have been in the health insurance group since 1941, and have approximately 58,000 policyholders currently. Most of them, in fact the vast majority, have less than 100 employees. These 58,000 policyholders translate to approximately 3 million people covered by the Bankers Life Co. This would include both the workers and their dependents.

I appreciate the opportunity to visit with you this morning about the Bankers Life and want to give you some additional input about a particular policy provision we have which relates to the bill that you have sponsored.

First of all, our group health contract states that in order for a benefit to be payable, it must be the result of either an accident or sickness. But in addition to that, we have some specific coverage statements. And that is in the information I have given you.

And it states specifically that we will cover a routine physical examination. Now this is not related only to children, but relates to all of the insured under our product. This particular provision has evolved through claims practice to include preventive care. And some of those items are like routine immunizations, flu shots, and well-baby care.

I emphasize it is a standard policy provision with the Bankers Life Co. That does not mean, however, that all groups, in fact, must have this if we sell the product to them. And, in fact, some of our larger groups have opted not to take this particular benefit.

Given the fact that the group health insurance area is a very competitive, cost-conscious arena, why did we want to develop a program that would, in fact, probably raise some costs? Well, we feel that in an area where it is so cost competitive, an employer should have the ability to buy whatever he wants. If he wants a plan that is more of a stripped-down plan and that's what he desires and only has the ability to buy, he should be able to buy that. By the same token, if, in fact, the employer has the ability and the desire to buy a more full-type plan with many options in it, we want to be able to offer that particular product to him.

So we elected to have a marketing niche where we would have what we might call a "quality product." And one of the items we decided to include in that was the routine physical examination, which then evolved to where we are today with all of the various preventive items that we have.

We felt by doing this that we would perhaps develop a more loyal customer following that would live through us to the various rate increases that health care has gone through the past years and continues to go through; that we would attract a better risk. Not only from a medical underwriting point of view, but also from a financial point of view.

Again, we wanted to offer a quality product and we feel that's what we are doing. Some other ideas from the Bankers Life Co. that relate to preventive care date back to 1974 when we first came out with a product called prevention and treatment. That now goes by the acronym of PAT-500

This particular program was designed specifically with the idea that we would provide for preventive care. Basically, what we did was to eliminate the deductibles for doctor services, either in or out of the hospital, so that if someone wanted to have a routine physical examination or whatever the situation, they could go see the doctor either in his office, or if it was in the hospital or if they were lucky enough to get somebody to come to their home, they could have that also.

The plan also provides that the deductible for going in the hospital is a 1-day charge on the room and board. Some of the items in this particular plan, the PAT-500, are really pioneer ideas for what has become known as "cost containment" today.

One of the other items that we have recently developed that relates to preventive care has to do with our health information line; whereas, our insurers can use an 800 phone number and can call us, and for among other things, talk to our registered nurses and have a health-care consumer make a more informed decision about their health-care benefit.

In conclusion, I would like to stress again that it is our feeling that the employer should have the opportunity to choose whatever benefits they so desire.

We are glad to be able to offer a full quality product, but that certainly should be the choice of the employer to buy it or not to buy it.

Thank you.

[The prepared written statement of Mr. Van Lew follows:]

MEMORANDUM

September 12, 1985

TO Senator John Chafee

FROM The Bankers Life of Iowa

RE Preventative Care for Children - Group Benefit

Mr. Chairman, and Members of the Subcommittee: I am James H. Van Lew, Regional Director of Group and Pension Sales for the Bankers Life Company of Iowa.

The Bankers Life Company is a mutual insurance company founded in 1879. We have been providing group health benefits since 1941. We currently provide group insurance coverage for approximately 58,000 customers (employer plan sponsors).

The Bankers Life has included as a specific standard provision of our group health contracts for a long period of time routine physical exams. This provision has evolved until it includes a list of preventative health care benefits. These benefits are not limited to children but encompass all people who are covered under our standard group health contracts. Some of these covered charges which might be called preventative health care benefits are: routine physical exams, flu shots, polio vaccines, and other routine immunizations. A complete list of these items which are specifically included in our contracts are attached to this memorandum. These attachments are taken from the following documents.

A. Proposal - which is normally presented to the employer.

B. Contract - which is given to every policyholder.

C. Claim Manual pages - which are used by our claims processors to pay claims.

D. Summary Plan Description - which is given to every covered employee.

We cannot specifically identify the cost of providing these benefits. It has been impossible for us to determine whether the initial cost of providing these benefits is offset later by savings generated from the actual prevention of serious illness and the ensuing greater cost of treatment.

For these reasons, the covered charges providing preventive treatment have been added, as policy enhancements, over the years without a specific, direct increase in the required premium. The actual cost has been trapped in the emerging experience of either a single large policyholder or a block of small accounts. The resulting claims level is then translated into needed premium.

The preventive care benefits are the result of our desire to make quality health care affordable to employees, encourage preventive care to protect employees from more serious illnesses, and to market a competitive product. We are attempting to insure the full risk of health care.

We also provide as a standard policy provision for employer sponsored plans covering two through nine employees full coverage from birth. This means that a new born baby receives the same benefits as any other insured - including normal nursery care. Plans covering 10 employees or more have the option to restrict the benefit and not provide for normal nursery care. This is a small part of a normal

maternity claim and is easily budgetable for most families. Most of our customers (employers sponsoring plans) provide for full coverage from birth.

As implied earlier, we think that preventive medicine contributes significantly to better quality health care. It provides valuable health protection and certainly greater peace of mind to those receiving preventive treatment. These are desirable social goals.

We would like to think preventive treatment reduces the ultimate, total cost of health care for employers and for society. However, there is no conclusive body of empirical evidence to support that supposition. It is possible that the total of the number of smaller charges for the many is greater than the amount saved by the prevention of more expensive treatments for a fewer number of persons. If this is true, we are left with a cost-benefit analysis between greater total expenditure and the increased general level of health among Americans.

Currently employers have adequate access to insured plans and other funding mechanisms which offer preventive care type treatment. And clearly the trend is toward providing broader benefits and greater amounts of preventive care.

Group medical benefits are currently provided for more than 90% of full-time employees. This extensive degree of coverage is a direct result of our voluntary system of employer sponsored benefits; where the employer is free to design a plan which best meets the unique

needs of the employees and whose cost is appropriate to the industry and competitive factors present in a specific set of circumstances.

Mandated benefits discourage regular benefit review and update by employers reluctant to commit benefit dollars which may soon be needed to fund pending mandated benefits. Mandated benefits become a maximum level of benefits instead of the minimum intended. This approach generates a conservatism among benefit managers which is ultimately counter productive and therefore, detrimental to employees and their families.

This system should not be harnessed with mandatory benefits or any other impediments to its success and continued growth.

We do not support mandated benefits of any kind. It is our belief that an employer should be able to select the benefits he wants to provide.

JHVL/df

Covered Medical Charges

The provisions included on this page as well as those included on the page, "Provisions Which Apply to All," apply to Major Medical or Comprehensive Medical Coverage

Covered charges are the actual charges for necessary treatment and care of injury or sickness but only to the extent that such charges do not exceed the prevailing charges.

Covered charges include charges for:

HOSPITAL CONFINEMENT:

Room and board (but not more than the hospital's most frequent semi-private room rate for each day of confinement in a private room) and other hospital services required for purposes of treatment.

Covered charges by a hospital for room and board while confined in a private room are the hospital's most frequent semi-private room rate if the hospital has semi-private rooms.

PHYSICIAN'S SERVICES:

Professional services including surgical operations, diagnosis, medical care, and treatment by a physician who is not in the employee's or dependent's immediate family

INTENSIVE CARE CONFINEMENT

Confinement in a ward, wing or other separate part of the hospital that is used only for patients who require comprehensive observation and care because of shock, trauma, or other life threatening conditions; contains specialized monitoring and life support equipment, and is staffed with specially trained nursing personnel; but not including post operative recovery rooms

NURSING CARE:

Professional services of graduate registered nurses who are not in the employee's or dependent's immediate family

PHYSIOTHERAPY

Professional services of a legally-licensed physiotherapist who is not in the employee's or dependent's immediate family

DRUGS AND MEDICINES:

Drugs and medicines requiring a physician's prescription. (If Prescription Drugs Insurance is provided, only those covered charges not covered by Prescription Drugs Insurance Plan will be payable.)

MEDICAL SUPPLIES:

Surgical dressings, casts, splints, braces, crutches, artificial limbs, artificial eyes; rental of a wheelchair, hospital type bed or an artificial respirator, anesthesia, blood, blood plasma and oxygen (including rental of equipment for its administration)

X-RAY AND LABORATORY:

X-ray and laboratory examinations and x-ray, radium and radioactive isotope therapy.

AMBULANCE SERVICE:

Transportation by ambulance provided by a Hospital or a licensed service to and from a local hospital (or to and from the nearest hospital equipped to furnish needed treatment not available in a local hospital).

DENTAL SERVICES:

Professional services of a dentist or dental surgeon for repair of damage to the jaw and natural teeth as the direct result and within 6 months of an accident (excluding such damage resulting from chewing).

(continued on reverse side)

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THE BANKERS LIFE

BANKERS LIFE COMPANY DES MOINES, IOWA

Additional covered charges are:

Routine physical exams

Preventive medicine (flu shots, polio vaccines and other routine immunizations)

Insulin, syringe and testape

Prescription drugs including sales tax

Registered physical therapists

Speech therapy where an employee or dependent's speech is impaired by an injury or sickness such as a stroke

Elective sterilization vasectomy, tubal ligation

Birth control pills

Medical expenses in the treatment of drug addiction and alcoholism

Dialysis (hospital or home cost for disposable items used in treatments)

Initial glasses or contact lenses following cataract surgery

Audiograms when performed by a qualified technician

The above items are covered charges under our health insurance policies, subject to regular policy provisions including deductibles, coinsurance and limitations.

Article 3 - Covered Charges Carried Forward

To determine deductible satisfaction, treatment or service received by a Member or Dependent during the last three months of a calendar year may be counted as if received in either:

a. the calendar year in which actually received; or
b. the next following calendar year;

whichever would result in the greater benefit payment.

Article 4 - Covered Charges

Covered Charges will be the actual cost charged to the Member or Dependent for:

a. Hospital room and board (but not more than the Private Room Maximum for each day of confinement in a private room); and
b. Hospital services other than room and board; and
c. the services of a Physician, including Physician Visits (but, with respect to Physician Visits for treatment of a mental or nervous disorder, only the first 50 visits for each Member or Dependent in a calendar year); and
d. the services of a graduate registered nurse; and
e. the services of a licensed physiotherapist; and
f. drugs and medicines requiring a Physician's prescription; and
g. surgical dressings, casts, splints, braces, crutches, artificial limbs and artificial eyes; and
h. rental of a wheelchair, hospital type bed or an artificial respirator; and
i. anesthesia, blood, blood plasma and oxygen (including rental of equipment for its administration); and
j. x-ray and laboratory examinations; and
k. x-ray, radium and radioactive isotope therapy; and
l. transportation by ambulance provided by a Hospital or a licensed service to and from a local Hospital (or to and from the nearest Hospital equipped to furnish needed treatment not available in a local Hospital); and
m. Dental Services to repair damage to the jaw and natural teeth, if the damage is the direct result of an accident (but did not result from chewing) and if the Dental Services are completed within six months after the accident; and
n. routine physical examinations;

but only to the extent that the actual cost charged does not exceed Prevailing Charges.

Article 5 - Extended Benefits

The Company will pay Comprehensive Medical benefits for treatment or service received by a Member or Dependent within 12 months after his or her insurance under this policy is terminated, provided that:

a. the Member has been disabled or the Dependent has been in a Period of Limited Activity from the date insurance ceased until the date of treatment or service; and
b. the Member or Dependent would have qualified for benefit payment under this section if insurance had remained in force; and
c. the sickness or injury for which the Member or Dependent receives treatment or service was diagnosed by a Physician on or before the date insurance ceased.

However, no benefits will be paid for treatment or service received on or after the date the Member or Dependent becomes eligible for other group medical expense coverage.

GC 552 PART IV - BENEFITS
SECTION B - COMPREHENSIVE MEDICAL EXPENSE INSURANCE

	covered under Part II of PAT Coverrage.
PATIENT LIFT	NOT covered.
PERITONEAL DIALYSIS	See DIALYSIS.
PERITONITIS TREATMENT WITH PREGNANCY	See PREGNANCY WITH PYELITIS in the Conditions Section.
PHENYL-FREE	Consider a covered expense when administered for the given condition of phenyketonuria (PKU).
PHYSICAL EXAM ROUTINE	Routine physical exam should be considered a covered expense under our Medical plans as part of the preventative care concept. The allowance for a routine physical exam should be based on the prevailing fee concept for the area where the exam is being performed. Under the New Readable policy there is an optional limitation that no benefits will be paid for check-ups, premarital examinations or routine physical examinations. To determine if this limitation applies check plan wording.
profeesional fee	The actual fee for the professional portion of the exam (pre-marital exam, school, camp or athletic physicals is covered under Major Medical, Comprehensive or PAT even if no "injury or sickness" is present, unless the contract specifically excludes such services.
x-ray and lab services or surgery	The charges incurred during a physical which qualify for X-ray and Lab Benefits or Surgical Benefits are payable under the appropriate coverage line.
fitness or specialty exams	These specialty exams are usually seen in connection with changing a person's lifestyle, nutritional habits, and exercise habits. Consider only those services that would be performed during a routine physical exam and apply the prevailing fee concept for the area in which the exam is being performed. This type of exam does not fall within the preventative care concept and therefore is considered a non-covered expense.
PHYSICAL THERAPY, in-patient	The services of a registered physical therapist qualify as a hospital miscellaneous item when provided during a confinement. These charges

	expense.
PRENATAL VITAMINS	If a physician's prescription is required consider a covered expense under the Old Style policy language. Under the New Readable language not covered as it is specifically excluded.
PREVENTATIVE MEDICINE	Preventative medicine such as flu shots, polio vaccination and other routine immunizations are covered under Major Medical, Comprehensive and PAT. Under the New Readable policy there is an optional limitation which states benefits will not be paid for routine immunizations and innoculations given as a preventative measure against disease. Check plan wording to determine if this limitation applies.
PRIVATE AUTO TRAVEL EXPENSES	See AUTOMOBILE TRAVEL.
PROCTOSCOPY WITH HEMORRHOIDECTOMY	Apply separate incision rule if done together.
PROFESSIONAL TAX ON CHARGES	Consider when included on billing.
PROSTATIC MASSAGE	Medical service for which no surgery is payable. Covered only under Major Medical, Comprehensive and PAT.
PROSTHESIS	The charge made by a hospital during a confinement for a prosthesis is payble as Hospital Miscellaneous expense when the prosthesis is of the type which is placed within the body. Examples of covered prosthesis are pacemakers, heart valves, hip cups, etc. Charges for prosthesis such as artificial limbs or eyes are payable only under Supplementary Accident, Major Medical, Comprehensive and PAT.
PSYCHIATRIC CONSULTATION (IN OFFICE)	Payable only under Office Visit Coverage, Major Medical, Comprehensive and PAT when treatment is for a mental or nervous disorder. For example marriage counseling NOT covered.
family consultations	The charge for an occasional consultation with a member of the patient's family can be considered a covered expense under the patient's claim. Though

MEDICAL EXPENSE INSURANCE

COMPREHENSIVE MEDICAL

Payment Conditions

If you or one of your Dependents receives treatment or service for a sickness or injury, We will pay Comprehensive Medical benefits for Covered Charges:

- in excess of the deductible amount; and
- at the payment percentage(s) indicated; and
- to the Maximum Payment Limit;

as described in the SUMMARY OF BENEFITS section.

Covered Charges Carried Forward

To determine deductible satisfaction, treatment or service received by you or by a Dependent during the last three months of a calendar year may be counted as if received in either:

- the calendar year in which actually received; or
- the next following calendar year

whichever would result in greater benefit payment.

Covered Charges

Covered Charges will be the actual charges for:

- Hospital room and board (but not more than the Private Room Maximum for each day of confinement in a private room);
- Hospital services other than room and board;
- the services of a Physician (but, with respect to

Physician Visits for treatment of a mental or nervous disorder, only the first 50 visits for each Member or Dependent in a calendar year);
- the services of a graduate registered nurse;
- the services of licensed physiotherapists;
- drugs and medicines requiring a Physician's prescription;
- surgical dressings, casts, splints, braces, crutches, artificial limbs and artificial eyes;
- rental of a wheelchair, hospital type bed or an artificial respirator;
- anesthesia, blood, blood plasma and oxygen (including rental of equipment for its administration);
- x-ray and laboratory examinations;
- x-ray, radium and radioactive isotope therapy;
- transportation by ambulance provided by a Hospital or a licensed service to and from a local Hospital (or to and from the nearest Hospital equipped to furnish needed treatment not available in a local Hospital);
- Dental Services to repair damage to the jaw and natural teeth, if the damage is the direct result of an accident (but did not result from chewing) and if the Dental Services are completed within 6 months after the accident;
- routine physical examinations;

but only to the extent that actual charges do not exceed Prevailing Charges.

Limitations

Comprehensive Medical benefits will not be paid for:

- any part of a charge for confinement, treatment or service that exceeds Prevailing Charges; or
- confinement, treatment or service that is not for Medically Necessary Care; or
- the services of any person in your immediate family or any person in your Dependent's immediate family; or
- Dental Service and materials (except as described

Senator CHAFEE. You say in your testimony, Mr. Van Lew, on page 3,

> We'd like to think preventive treatment reduces the ultimate, total cost of health care for employers and for society. However, there is no conclusive body of empirical evidence to support that supposition.

In other words, you haven't seen with those long-time customers of yours that those who have used this have done it better, I take it.

Mr. VAN LEW. That's very hard to pinpoint that in fact they have done better. I mentioned earlier that if an employer did not want to buy this particular standard option, that we would in fact reduce our rates. And we will by 1 percent. It gives you an idea of what we think that this particular provision is worth long range.

Senator CHAFEE. Now say that slowly again. If the person takes——

Mr. VAN LEW. If an employer does in fact opts not to take this particular benefit, that is, we would exclude from a covered charge routine physical examinations, and the other items that we have developed along with it, we would say then that we will reduce your rates by 1 percent.

Senator CHAFEE. Well, you seem to be suggesting it's better not to fool around with preventive care.

Mr. VAN LEW. Our feeling is on the front end that it would in fact increase expenses because there would be more benefits covered. A routine physical examination is typically not a covered expense.

Senator CHAFEE. You people are pretty careful in predicting your expenditures. You spend a lot of time on assumptions for the future, and you seem to be testifying here that you are better off not having your employers, customers, take the physical exam option. And, indeed, you give them a lower rate if they don't.

Mr. VAN LEW. That's correct. That's right. There would be less benefits up front because these benefits would not be—we wouldn't be paying for a routine physical examination or the other immunizations.

Senator CHAFEE. What about the future?

Mr. VAN LEW. As I indicated in my written testimony, it's very difficult to indicate what the future will bring. And it's very hard also to do extensive studies in exactly what the results would be long range.

Senator CHAFEE. Do you take your children for a physical checkup?

Mr. VAN LEW. Yes. We have three daughters and we take them.

Senator CHAFEE. Why do you do that? It doesn't seem like a very good investment.

Mr. VAN LEW. Well, at various times they have experienced not only just routine but also—at various times they have complained of stomachaches; they've had illnesses and other situation where we have taken them. And under those circumstances, the benefit is covered the same as anything else. Remember that all of these policies provide for care if, in fact, there is an illness or an injury.

I think maybe we have overlooked that just a little bit in that where there is some thought there is an illness, they go to the

doctor and they indicate that the baby has a stomach ache or one of them talked about a trailing eye or whatever—those things are, in fact, illnesses and they are covered.

Senator CHAFEE. Which wouldn't be true under my legislation.

Mr. VAN LEW. Pardon me?

Senator CHAFEE. Which would not be true under my legislation. We wouldn't provide the care for it. We just provide for the checkups.

Mr. VAN LEW. Yes.

Mr. HUNT. May I ask a question, Mr. Chairman.

Senator CHAFEE. Yes.

Mr. HUNT. One point that intrigued me—I believe it was Dr.—he mentioned about the new pediatrics. And as they talked, it really seemed that more and more of what they were really saying, and I think what Mr. Van Lew and you were just coming to—it's not so much the actual care. That's already covered. If something is wrong, that's covered. Even going to check up to find out and if it turns out there is, it's covered.

But they are talking about things which are really social education, parent education. And I would imagine that whatever they call it, physiology class or something in high schools, perhaps that's where the problem is. Maybe they should need to know. Like the 1-year-old who walked off. I happen to have a 1-year-old. I listened carefully. You know, these are things that I, frankly, learned in baby class. There are millions of books that you can buy at one of the little bookstores.

Maybe what he is talking about in the new pediatrics really can be covered in education. You don't have to go to a doctor to learn that a 1-year-old might suddenly get up and walk.

Senator CHAFEE. Well, I must say it did strike me that a parent would think that a 1-year-old is going to walk sometime.

But we are dealing with a group that in many instances is uneducated. We had some testimony here on an entirely different subject the other day dealing with the illiteracy in adults or near illiteracy. So they are not reading constructive books on what is going to happen to the child as the child progresses. Well, there's the example. Apparently the parents didn't know a child will get up and walk all of a sudden so it walks right off the edge of the porch: I don't know what kind of a porch it was, but enough to put the child in an institution for the rest of her life.

Mr. HUNT. And even with the coverage, even with your bill, that would not have been covered.

Senator CHAFEE. Well, there wouldn't have been coverage but presumably with these checkups that Ms. Gustafson talked about—she had a schedule for those checkups which seemed to make a lot of sense to me.

Mr. HUNT. It was between 1 and 5 years old, eight of them.

Senator CHAFEE. Yes; eight checkups, I think, before the age of 5. And you get the parents in there and you can talk to them about these things.

How many people know that just the presence to smoke around a child isn't good, never mind prenatal smoking. It's just smoking, period.

Mr. HUNT. Senator, I would be inclined to maybe put it into this to shift it to the educational thing rather than creating a lot of new paperwork. Because, frankly, you are going to suddenly have this as a three-way regulation. The Department of Health and Human Services is writing regs. The Department of Labor would have to have a voice in it, and also the Department of Treasury. And that way we are going to get the triple shuffle.

And I think—I've seen some excellent ads like the one teaching people to, you know, buckle up your seatbelt or something like that. Maybe we are really talking about—maybe the new pediatrics is education. Maybe it's not actually going to a doctor's office. Maybe it's education. Maybe it's something like the school nurses.

Senator CHAFEE. Well, I think that's part of it, but when you read about the figures on the absence of just the most basic care, like innoculations, that these children should have and don't receive.

Sure, we may be able catch them in school, but we are not catching them in other areas. I don't think there is going to be a resurgence of polio, but who knows. A lot of these matters are preventive. You heard Dr. Chadwick talk about the child with the hip socket. There is nothing to it if you catch them early enough.

Mr. HUNT. Senator, is there a chance—I'm worried about, as Mrs. Rosenbaum and a number of others have said, about the poor child being left out. Where the person, for whatever reason, the parent is unemployed or whatever. And I think that's where you are going to have to have——

Senator CHAFEE. Well, that's a different category. We are not going to catch those children under this.

Mr. HUNT. Unless, sir, you put it under something—if you said this is going to be a new benefit under Medicare or Medicaid. If we do it for all people——

Senator CHAFEE. Well, under Medicaid, they do it already.

Mr. HUNT. No; but I mean for everybody. Just like we take anyone over 65, why not take anyone under 5?

Senator CHAFEE. Look, we've got enough problems in Medicaid coverage for those who are poor. To suggest that we are going to provide services to people who are not currently eligible is a pipedream.

Mr. SCHRENZEL. Mr. Chairman?

Senator CHAFEE. Yes, sir.

Mr. SCHRENZEL. To that issue, it's an issue of innoculations and vaccinations. They are cheap. They are proven effective. The issue is why don't parents have their child innoculated before they get to school when they are legally required to have their child innoculated. The answer would not appear to be financial. It would appear to be an educational reason which is the point that we have been beating around.

I live in Essex County, NJ, which is Newark. In Essex County, there are any of a number of both government and private agencies that without any question about your income level, if you bring in a child, will provide those innoculations either at no cost or at a very, very low cost.

I hope that's the point we have been trying to drive at. That the public health system is still alive and well out there. Those people

who cannot afford it, have access to a very, very efficient long-standing system.

Senator CHAFEE. Well, I don't know whether the people realize that they could use it. Maybe it is an educational problem.

Mr. SCHRENZEL. I'm sure they don't.

Senator CHAFEE. OK, fine. Thank you all very much for coming. We appreciate it.

[Whereupon, at 11:07 a.m., the hearing was concluded.]

[By direction of the chairman the following communications were made a part of the hearing record:]

AMERICAN COLLEGE OF OSTEOPATHIC PEDIATRICIANS
104 CARNEGIE CENTER • SUITE 300 • [illegible] • NEW JERSEY • 08540 • (609) 987-0077

August 22, 1985

Senator John H. Chafee
U.S. Senate
Washington, DC 20510

Dear Senator Chafee:

The American College of Osteopathic Pediatricians wishes to express its support for S.376, the Child Health Incentive Reform Plan. You are to be commended for your insight in attempting to establish a national policy which would implement the old adage that "an ounce of prevention is worth a pound of cure."

The recently released report of the Select Committee on Children, Youth and Families of the U.S. House of Representatives, concludes that many of the programs providing services to children are not only saving lives but are also saving money. These programs such as the Childhood Immunization Program, the Maternal and Child Health Program, and EPSTD provide to low income families the same services which you have identified in your bill as being required for employer group health insurance plans eligible for income tax deductions.

We commend your efforts to reduce the high cost of sickness in favor of the less expensive investment of prevention.

Sincerely yours,

Neil M Kantor

Neil M. Kantor, D.O.
President

NMK:mc

AMERICAN MEDICAL ASSOCIATION
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JAMES H. SAMMONS, M.D.
Executive Vice President
(645-4300)

September 18, 1985

The Honorable John Chafee
Chairman
Subcommittee on Taxation and Debt Management
Committee on Finance
United States Senate
Washington, DC 20510

RE: S. 376, the Child Health Incentives Reform Plan

Dear Senator Chafee:

The American Medical Association takes this opportunity to present its views on S. 376, the Child Health Incentives Reform Plan. We request that this letter be made a part of the record of the Subcommittee's hearing of September 16, 1985.

BRIEF SUMMARY OF S. 376

S. 376 would require an employer to offer pediatric preventive health care benefits for children of employees by disallowing a business deduction for an employer's group health plan expenses if the plan did not provide coverage for "pediatric preventive health care". The bill defines "pediatric preventive health care" to include, for any child who has not attained the age of 21, periodic determination of health and development history; periodic comprehensive unclothed physical examinations; developmental and behavioral assessments; periodic immunizations appropriate for age, health, and developmental history; laboratory procedures appropriate for age and population groups; appropriate vision and hearing testing and referral for treatment as necessary; and other medical services as required by regulations prescribed by the Secretary of the Treasury after consultation with the Secretary of Health and Human Services and appropriate medical organizations involved in child health care.

AMA COMMENTS

The American Medical Association supports preventive measures, including periodic medical examinations and immunizations, not only in children, but with respect to all age groups. In addition, we recognize that first-dollar preventive coverage for both children and adults can be provided for moderate additional premium cost. However, in our view S. 376 would not be an appropriate means of promoting these goals.

While we believe that under certain circumstances utilization of the tax system for promotion of health benefits meeting certain standards is appropriate (e.g., a "tax cap" on employer-provided health insurance benefits), the program proposed under S. 376, relates solely to pediatric preventive benefits, and fails to reflect all desirable benefits in an employer-sponsored benefit plan. Under this bill, only the named pediatric services would be required to be provided in order for an insurance plan to be tax deductible. Other significant coverages, such as for hospitalization and physician services, would not be named.

The benefits named in the bill fall short of those designated in a report of the American Medical Association's Council on Medical Service as adequate benefits (CMS Report H, December 1983). A copy of this report is attached to this letter. The report describes standards for adequate benefits that should be provided by employer-offered health plans in order for the employer to obtain a business expense tax deduction. Such benefits include:

- diagnostic, therapeutic or preventive medical services,
- emergency and outpatient services for physical and mental illness,
- inpatient hospital care for physical and mental illness,
- inpatient skilled nursing facility care for physical and mental illness,
- home health services, and
- a maximum limit on cost-sharing for covered expenses to a specified maximum of $2,300/person, with this amount updated yearly.

While the AMA supports the beneficial intent of the legislation, we cannot, for the reasons outlined above, support enactment of S. 376.

Sincerely,

James H. Sammons, M.D.

JHS/ss
enclosure

2134p

H. "ADEQUATE BENEFITS" IN EMPLOYER-OFFERED HEALTH INSURANCE
(Reference Committee A, page 312)

HOUSE ACTION: FILED

SYNOPSIS

To implement the Association's "Consumer Choice" principles, approved by the House of Delegates at the 1983 Annual Meeting, the Council on Medical Service has developed and the Board of Trustees has approved standards for "adequate benefits" in employer offered health insurance programs. An employer would be entitled to take premium payments as a tax deductible business expense only if his health insurance programs provided these "adequate benefits." In order to be judged an "adequate benefits" plan and qualify for tax deduction, the plan would have to meet only two basic requirements:

(a) It would have to provide some extent of coverage for all services listed in Addendum A.

(b) It would have to limit the beneficiary's cost-sharing for covered expenses to a specified maximum of $2,300/person, with this amount updated yearly.

The Council believes that this approach has several major benefits: (1) it allows easy comparability of policies against the standards; (2) rather than attempting to come up with a "laundry list" specifying the amount of each service to be covered, it permits the buyer and seller to negotiate the extent of coverage for the required services – while requiring some extent of coverage for all of them and setting a limit on the beneficiary's cost-sharing for covered expenses; and (3) it presents an approach with which the insurance industry is familiar and for which premiums can be determined without significant difficulty.

BACKGROUND

AMA's "Consumer Choice" principle No. 2, as revised by the House of Delegates in June 1983, recommends that health insurance plans offered employees contain adequate benefits, including catastrophic coverage, in order to qualify for tax deduction by the employer as a business expense. The main purpose of such a requirement is to reduce the possibility of underinsurance among employees responding to the economic incentives created by offering a multiple choice of plans (principle No. 3) with equal employer contribution to each plan (principle No. 4), and a tax-free rebate to employees choosing lower priced plans (principle No. 6).

The Council on Medical Service and the Board of Trustees believe that the medical profession has a special contribution to make in developing recommendations as to the general types of health insurance plans which would meet an adequate level of benefits; that is, a level which any group insurance plan must meet or exceed in order for the employer contributing to such a plan to deduct his cost as a business expense. Accordingly, over the past year the Council discussed specific alternative approaches to defining what might constitute "adequate benefits" as called for in the Association's "consumer choice" principle No. 2, and had the benefit of comment on this subject by the Blue Cross and Blue Shield Association and the Health Insurance Association of America.

APPROACHES TO DEFINING "ADEQUATE BENEFITS"

(1) One approach to defining such benefits would be to simply identify the types of service for which coverage should be offered; e. g., hospital inpatient care, emergency and outpatient services, physicians' services, home health care, etc. Under this approach, no attempt would be made to define either the extent of coverage (percent of cost covered, or dollar amount paid toward each service) or the duration of coverage (number of hospital days, home health visits, etc.). A potential drawback to this approach is the greater possibility for underinsurance, since policies could be offered covering a wide range of services but providing only minimal payment toward such services over limited time periods.

(2) A second approach, which would reduce the potential for underinsurance, would be to also recommend a "reasonable" extent and duration of coverage for each type of service. However, a prerequisite to any informed recommendations in this regard would be comprehensive national utilization data – information as to the frequency with which different types of service are used and at what cost – so that the impact on policyholders of a given configuration of benefits could be predicted.

Based on Council discussions with the insurance industry, this type of utilization data does not appear to be available. In fact, there is some question as to whether private payors themselves have data extending

beyond their own plan or company experience with different contracts. This makes it impossible to recommend benefit configurations which are equally appropriate in all areas of the country or for various groups of the population. It is likely that HCFA has or is compiling such data for Medicare beneficiaries; however, this represents only one age group in the population – and a group which already has a reasonable level of coverage for health costs.

In addition, even if such national utilization data were available, benefit standards derived from it would need continuing reevaluation to accommodate demographic and technological change.

(3) A third approach to defining adequate benefits under consumer choice proposals, which avoids problems inherent in the first two, is to identify:

(a) the general types of service for which some coverage should be provided,

(b) the maximum amount of beneficiary cost-sharing* for covered expenses, above which the plan could impose no further cost sharing for such expenses if it is to meet the "adequate benefit" standard – i. e., a maximum "threshold" at which catastrophic coverage would then take effect.

The Council and the Board have concluded that this is a feasible approach, for the following reasons:

- It is consistent with the Association's support for inclusion of catastrophic coverage in adequate benefits.
- It would allow individual companies and plans to use their own actuarial experience to develop packages which would (1) meet these adequate benefit standards, (2) respond to the needs and desires of the prospective purchaser, and (3) contain the types and various combinations of cost-sharing incentives (deductibles, coinsurance and/or copayment) that would encourage the most appropriate and cost-effective use of services, rather than the AMA attempting to recommend the specific amount and type of cost-sharing and duration of benefits for each type of covered service.
- It would allow easy comparability of policies against the standards.
- It presents an approach with which the insurance industry is familiar and for which premiums can be determined without significant difficulty.

STANDARDS FOR "ADEQUATE BENEFITS"

Based on Council recommendations, the Board has approved the following standards for employer-offered insurance plans providing adequate benefits under consumer choice proposals. These standards apply totally within the context and as part of the other consumer choice elements now supported by the AMA; i. e., on the assumption that multiple choice of plans, equal employer contributions to each, nontaxable rebate to employees, and limitation on the amount of tax-free premium contributions are also provided or apply.

(1) The plan would provide some extent of coverage for all of the health services listed in Addendum A.

Discussion: The types of expenses covered are primarily those which are large and/or individually unpredictable although predictable across insured groups, with the exception of two types of service generally acknowledged by the medical community to have

*Beneficiary cost-sharing can take three different forms. One is "coinsurance," defined as payment by the beneficiary of a specified percentage of covered health expenses incurred. Another is a "deductible," defined as beneficiary payment of a specified "front-end" dollar amount at the initiation of service. A third, less frequently used, is a "copayment," defined as beneficiary payment of a specified dollar amount per day or per unit of service.

a high "preventive potential": (a) periodic medical evaluation of infants, children and adults, in accord with frequencies recommended by the AMA Council on Scientific Affairs in its Report D (A-82), and (b) any immunizations which have been demonstrated to be cost-effective for the specific beneficiary group to be covered; i. e., where the cost of procurement and administration will be offset by cost savings from reduced morbidity and mortality across that group.

Such supplemental or elective services as dental treatment or cosmetic surgery, as well as the more routine "budgetable" health expenses, could be included, but would not be required in order to qualify for the tax deduction.

While the list of services in Addendum A is comprehensive, the fact that this proposal calls for significant beneficiary cost-sharing (see Standard 2) makes this an "adequate benefits" rather than overly comprehensive proposal.

(2) Some degree of beneficiary cost-sharing for covered expenses would be required up to a specified per-person limit beyond which no further beneficiary cost sharing for covered expenses would be required. The cost-sharing limit would be the same for all subscribers and should be set at 10 percent of the national median family income rounded to the nearest $100 -- and updated yearly.*

Discussion: Ten percent of median income is a reasonable base figure for such cost sharing, inasmuch as national spending for health care, including health insurance premiums, now approximates 9.8 percent of the GNP.

The amount of the cost-sharing limit should not be individually related to each beneficiary's income status. Although such an approach might reduce economic hardship and the regressive effect of a uniform limit on those in lower income brackets, and assure proportionate cost sharing by the more affluent, the Council and the Board believe, after careful study of this option, that the disadvantages of this approach outweigh the benefits. These disadvantages include:

- The subsidization of premium costs for less affluent policyholders by the more well-to-do, and the resulting difficulty in marketing such plans. Any such subsidization would represent a significant departure from normal insurance concepts in that benefits would be related to economic status rather than just to the premium paid;

- The administrative and underwriting complexity of attempting to calculate group plan premiums on the basis of multiple cost-sharing limits; and

- The difficulty in defining and obtaining complete and accurate beneficiary income data (should fringe benefits, interest, dividends be included?), coupled with the inequities resulting from use of incomplete data.

In addition, because the income range of the group concerned -- employees with employer-financed health insurance -- is not as broad as in the overall population, the Council believes that the cost-sharing inequities at either end of the income range resulting from a uniform cost-sharing limit would be relatively minor. Such inequities would be further mitigated by current provisions of the Internal Revenue Code allowing deduction from taxable income of all uninsured medical expenses in excess of 5 percent of gross income.

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*Based on current data, the per-person cost-sharing limit would be $2,300.

Finally, in order to assure use of the "periodic medical examination" and "immunization" benefits (Items A(7) and A(8) in Addendum A), the plan should not be allowed to impose deductibles or coinsurance on beneficiaries for these services, but should pay for them at the 90th percentile of physicians' customary charges; plan payment for all other required services could be subject to individually negotiated deductibles/coinsurance in the particular group account.

(3) There would be no maximum limit – either lifetime or per episode – on the amount paid by the plan for covered expenses in the catastrophic portion of coverage.

Discussion: Some insurance contracts specify a maximum lifetime or per episode limit on the amount payable by the plan for covered expenses – in such amounts as $250,000, $500,000 or even $1 million. The Council and the Board believe that such limits negate the concept and purpose of catastrophic coverage, and that in any event the incidence of claims in this upper range of health care is small enough to have only a minor or negligible effect on premium levels, while still protecting against financial ruin for the atypical beneficiary.

For example, 1975 data indicate that only 1 in 30 Federal Employee Benefits Plan subscribers incurred yearly medical expenses in excess of $5,800, 1 in 460 incurred expense in excess of $25,800, and 1 in 2,600 incurred expense in excess of $50,800. Although both income and medical care prices have increased substantially since that time, the proportion of individuals who incur medical expenses which are heavy in relation to income remains essentially the same.

(4) In paying for physicians' services, the amount allowed toward meeting the beneficiary's cost-sharing limit would be the difference between the plan payment and the 90th percentile of physicians' customary or median charges in the area (the amount which would cover the customary or median charge for a service at least 90 percent of the time it is performed). Once the cost-sharing limit was reached, the plan would pay the 90th percentile of customary charges in full. The plan would continue to pay for hospital expenses on a service basis, with contractually specified beneficiary cost-sharing being applied toward the cost-sharing limit.

Discussion: If payment for physician services was on an indemnity basis in the basic portion of the plan (a proposal currently being considered by the Council), the entire difference between the indemnity payment and an individual physician's actual charge – no matter how high – could theoretically be applied toward meeting the cost-sharing limit or catastrophic threshold. It would seem more appropriate to allow only the difference between the indemnity payment and the 90th percentile of physicians' customary charges in the area to count toward the catastrophic threshold.

If the plan paid a specified percentage of physicians' customary charges in the basic coverage, then the remaining beneficiary share of those customary charges would be applied toward the cost-sharing limit.

By the same token, once the cost-sharing limit or catastrophic threshold is reached, most insurance plans currently do not pay all additional expenses incurred for covered physicians' services, but rather at a percentile of physicians' customary charges for these services, but without imposing coinsurance on the beneficiary. This approach should continue unchanged under this proposal. (If a plan paid on a flat indemnity basis above the catastrophic threshold, some patients could continue to have major out-of-pocket expenditures for physicians' services. On the other hand, payment for all physician service costs above the catastrophic threshold could be extremely expensive for the

plan. Accordingly, if the catastrophic coverage is to provide meaningful protection on the one hand, while offering some degree of cost predictability to payors on the other, it would seem more appropriate for payors to continue to base their payment for physician services on a percentile of customary charges in the catastrophic portion of their plans.)

Service benefits for hospital expenses would apply regardless of whether plan payment to the hospital was on a retrospective cost or prospective pricing basis. In the latter instance, the institution would be at financial risk, not the beneficiary. Once the beneficiary's cost-sharing limit was reached, the plan would pay for all covered hospital services in full.

COST

The estimated annual premium costs for a plan meeting these adequate benefit-standards (coverage for the services specified in Addendum A and a $2,300/year cost-sharing limit) are displayed in Addendum B. These estimates are approximate, and are derived from discussions and information provided by the health insurance industry. They do not represent firm quotations or commitments by any plan or company to offer programs within the price ranges as shown. They are displayed only because they do illustrate for the House that the level of benefits recommended is neither overly expensive on the one hand, nor dangerously lower than the level of protection now commonly provided in employer-offered plans on the other.

As indicated in the Addendum, premium costs will vary with three factors.

(1) Geographic location: Premium levels will reflect general differences in cost of living and medical care prices from one region to another. Accordingly, premium estimates are given for highest and lowest cost areas as well as for the midpoint of that range.

(2) The manner in which the cost-sharing limit is reached: Premium costs for a plan with a given cost-sharing limit will vary depending on what combination of deductibles and coinsurance is used to reach that cost-sharing limit.

Premium costs will be lowest when the beneficiary pays the entire cost-sharing limit as an up-front deductible before plan coverage begins, and higher when the plan shares part of the cost from the beginning. Accordingly, premium estimates are also given for six different deductible/coinsurance combinations.

The Council believes that the deductible/coinsurance configuration in any given plan should be a matter for individual decision by or negotiation between employer, employees and carrier. However, it is expected that the majority of plans purchased would tend toward the low-deductible extended coinsurance approach, such as Sample Plans 1 and 2 in Addendum B.

(3) How the cost-sharing limits are applied: If deductibles and cost-sharing limits are applied per family rather than per person in family policies, the subscriber will spend a lesser total amount before the plan begins to pay 100 percent of covered expenses, and the premium will be accordingly higher.

Accordingly, Addendum B also gives premium estimates for two of the six sample plans for family policies with a $2,300 cost-sharing limit per family rather than per person (with a yearly deductible of $100 or $1,000 per covered person, maximum of two deductibles per family per year).

Taking into consideration the fact that the 1983 average employer contribution to health insurance premiums (where contribution was made) was an estimated $1,533 for family and $729 for individual coverage, the Council believes that the adequate benefits standards should require a cost-sharing limit per person rather than per family. With this approach, the average or midpoint of premium costs for what is

most likely to be the most popular version of the "adequate benefits" plan – $773 individual and $1,882 family – would not impose a significant new economic burden on employers. Nor, even more importantly, would it allow regression to dangerous levels of underinsurance.

The estimated average premium cost also falls a reasonable distance below the $2,100 family and $840 individual employer premium contribution tax cap currently proposed by the Administration and supported by the AMA.

The Council on Medical Service is pleased to provide this report on activities undertaken to implement the policy established by the House of Delegates in approving "Consumer Choice" principle No. 2 at the 1983 Annual Meeting.

ADDENDUM A – INSURABLE HEALTH EXPENSES

A. Diagnostic, Therapeutic or Preventive Medical Services Provided by or Under Direction of Licensed Physicians in the Office, Hospital or Other Setting

1. Diagnosis and medical or surgical treatment of illness or injury
2. Psychiatric care
3. Diagnostic x-ray and laboratory services
4. Radiation therapy
5. Consultation
6. Pre- and post-natal care of mother and infant, including delivery
7. Periodic medical examinations; 6 visits per dependent per year for the first year of life, biannually for ages 2-21, every 5 years for ages 22-40, every 2 years for ages 41-65
8. Immunizations which are cost-effective for the beneficiary group covered

B. Emergency and Outpatient Services for Physical and Mental Illness

1. Outpatient diagnostic services (x-rays, lab tests, etc.)
2. Use of operating, cystoscopic, cast rooms and supplies
3. Use of emergency room and supplies for emergencies
4. Ambulance services
5. Treatment for alcoholism

C. Inpatient Hospital Care for Physical and Mental Illness

1. Bed, board and nursing services
2. Drugs, oxygen, blood, biologicals, supplies, appliances and equipment used in the facility
3. Operating, delivery, recovery room charges; intensive, coronary, special care, rehabilitation unit charges
4. Diagnostic services (x-rays, laboratory tests, EKGs, etc.)
5. Care for pregnancy and complications
6. Physical, occupational, speech therapy

D. Inpatient Skilled Nursing Facility Care for Physical and Mental Illness

1. Bed, board and skilled nursing
2. Physical, occupational, speech therapy
3. Drugs, biologicals, supplies or equipment used in the facility

E. Home Health Services by a Certified Home Health Agency as Ordered by a Physician

1. Nursing care
2. Physical, occupational, speech therapy
3. Medical supplies and appliances (other than drugs and biologicals)
4. Rental of durable medical equipment
5. Oxygen, blood, biologicals

ADDENDUM B

Plan	Estimated Annual Premium; Per-Person Spending Limit						Estimated Annual Premium; Per-Family Spending Limit		
	Individual Policy			Family Policy			Family Policy		
	Low	Mid	High	Low	Mid	High	Low	Mid	High
Sample 1: $100 deductible, 80/20 coinsurance for remaining $2,220	$524	$773	$1,022	$1,435	$1,882	$2,340	$1,903	$2,917	$3,936
Sample 2: $300 deductible, 80/20 coinsurance for remaining $2,000	$504	$699	$ 958	$1,394	$1,705	$2,238			
Sample 3: $500 deductible, 80/20 coinsurance for remaining $1,800	$462	$640	$ 876	$1,280	$1,564	$2,051			
Sample 4: $1,000 deductible, 80/20 coinsurance for remaining $1,300	$404	$559	$ 764	$1,122	$1,370	$1,793	$1,459	$2,257	$2,988
Sample 5: $1,500 deductible, 80/20 coinsurance for remaining $800	$373	$515	$ 702	$1,036	$1,265	$1,653			
Sample 6: $2,300 deductible, no coinsurance	$344	$503	$ 662	$ 787	$1,018	$1,260			

American
Psychiatric
Association

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September 30, 1985

The Honorable John Chafee
Chairman
Subcommittee on Taxation and Debt Management
Senate Finance Committee
Washington, D.C. 20510

Dear Mr. Chairman:

The American Psychiatric Association, a medical specialty society representing over 31,000 psychiatrists nationwide, is pleased to submit for the hearing record our views and comments on the Child Health Incentive Reform Plan (S. 376) in conjunction with the Taxation and Debt Management Subcommittee's hearings. We are particularly concerned that the legislation recognize and appropriately respond to preventive psychiatric interventions.

The APA has long supported preventive health interventions in the fight against the occurrence of psychiatric disorders and other illnesses in the population as reflected in past testimony and activity in the area. While the pursuit of preventive measures has long been an objective of psychiatry, it is only within recent years that progress in research -- new knowledge about and approaches to the causes, diagnosis, treatment, prevention and control of mental illness -- has led to more successful preventive interventions. Greater accuracy in diagnosis, the matching of appropriate treatment to specific illness, understanding of the causal sequences interacting between the individual and the environment, and the recognition of populations "at risk" have led to the development and expansion of the concept as well as the discipline of preventive psychiatry.

Many approaches to primary prevention of mental illness have been developed simultaneously: biologic, psychoanalytic, behavioral, cognitive, family, cultural, sociologic, political and systems. Primary preventive services range from efforts to reduce major mental illness to reduction in dysfunctional behavior, from organic to experimental. An example of the former would be genetic counseling regarding the risk of transmission of manic depressive disorders, or risk of schizophrenia; an example of the latter would be educational and social supportive services for prospective parents which serve as primary preventive psychiatric measures resulting in the reduced incidence of abusive behavior.

While preventive is a complex issue and while it is difficult to pinpoint behaviors and populations which will respond to preventive strategies, it is possible to identify certain groups at elevated risk for psychiatric disturbance. Areas receptive to psychiatric prevention include: high risk children, children of seriously disturbed parents, children of marital disruption, substance abusing adolescents and pregnant women, children of alcoholic mothers or fathers. Whether it be through the use of family therapy or techniques increasing mutual helpfulness, network therapy and healthy interaction in the case of bereavement, or situational crisis intervention to a population of children entering foster care, the purpose is to undertake measures intended to avert the appearance of disease.

The following amplifies the foregoing and cites programs that have been developed to intervene successfully:

High Risk Infants: The concept of high risk as applied to pregnant women and their infants has led to the formulation of risk categories for the purposes of early identification, prevention and intervention in cases where the outcome of reproduction is likely to be unfavorable. Child psychiatry is particularly concerned with the influence of continued, generational, nutritional depletion during pregnancy that affects women who live in poverty. It is all too likely that such depletion carries over to the infant and adversely affects the development of the infant's central nervous system.

Children of Seriously Disturbed Parents: As a result of social policy, there are more mentally ill parents in the community today than ever before. The changing nature of psychiatric hospitalization has resulted in shorter hospital stays and treatment in the community. When the parent is hospitalized or suffers from a major depressive disorder, he or she is unable to provide the ingredients of care

necessary for the child's optimal development with resultant developmental deviation. Preventive efforts are used to alleviate the impact, especially on the childrens' development. The psychiatrist responsible for the treatment of the mentally ill patient must be aware of the social consequences of the illness for the children in the family.

Adolescence: Primary prevention focuses on the identity and individuation struggles that are characteristic of this developmental period. Prompt recognition and intervention may prevent serious decompensation and its inevitable aftermath. The growing problems of adolescent motherhood offer opportunity for preventive intervention to stem the inherent difficulty of the situation and avert possible harmful effects on the infant. There is evidence that prenatal educational programs and group therapy are effective during pregnancy. These groups have been used to reduce the degree of maternal depression and increase the capacity of both parents to manage the prenatal, delivery and postpartum periods with less stress.

Children of Marital Disruption: The impact of marital dissolution on the social, psychological, and physical adaptation of affected children has attracted considerable attention in recent years. It has been estimated that 16% of children under the age of 18 in the United States have experienced a parental divorce. Work by various researchers on children of divorced couples indicates that considerable emotional distress is experienced by children and adolescents. The overall adjustment of a child in response to divorce is the result of many interacting sets of variables that influence one another in reciprocal fashion. Although precise mapping of these possible interactions is not likely in the near future, the conceptual groundwork for developing preventive programming can be fashioned. As childrens' reactions to separation and divorce appears to be developmentally phase-specific, it is important that those who come into contact with them during the process of separation be attuned to the developmentally related symptoms. Current research is being directed at increasing the knowledge to establish what the protecting variables are in the individual, family and community. It is necessary to develop increased and innovative preventive programming for children if we are to avoid later maladaptive patterns.

Child Abuse: Parents whose own needs for gratification are not met in the course of their lives often experience their child as a severe burden and feel alienated from him. Programs have been organized to discover and help such parents. Because child abuse is a complex problem with multiple causes, prevention strategies must be comprehensive

will operate at the different levels of individual, community and society. An intriging example of preventive efforts is the ability to assess vocalization of infants audiospectrometrically and by highly validatable human reaction to the cries. Both these sets of data can lead to a detection of infants likely to evoke abuse and likely to be already damaged physically, including cerebrally. In 1971 The Grant Foundation of New York sponsored a two-year pilot program, "The Infant Mental Health Program" at the Child Development Project, University of Michigan which was later supported by the National Institute of Mental Health as a demonstration project and outcome study. It is a psychiatric outpatient program for infants 0-3 offering a range of services for infants and parents presenting problems or disturbances in infant-parent relationships. The management of child abuse and neglect has reached a level of sophistication which permits consideration of prevention of this disorder.

The Child Health Incentive Reform Plan could provide the incentive to employers to offer preventive health interventions to serve the children of their workers -- a population often inadequately served by most private sector health plans. Unfortunately, as introduced the legislation fails to recognize the significant role preventive psychiatry can play in the avoidance of the disease process. Moreover, the measure does not provide for referral for treatment for other than those found to be deficient in vision or hearing.

The APA recommends clarification that preventive psychiatric evaluation of child (as appropriate for the age and population group) be included in the definition of "pediatric preventive health care" in the CHIRP legislation. We do not believe that the current provisions for a comprehensive physical examination and developmental and behavioral assessment adequately ensures the provision of an appropriate screening for potential psychiatric difficulties. Similarly, we would urge the inclusion of appropriate referral for treatment as necessary in all cases where either physical or psychiatric examinations yield aberrant results. The detection of an impending problem but absence of a required referral would render the screening essentially ineffective in its stated purpose. With referral on this early interventive basis, the benefits of preventive psychiatry, in the reduction of future health care costs associated with more severe later illness, could become manifest. As with physical illness, prevention of or early detection of psychiatric disorders can and does save dollars -- both in direct health care costs, and in terms of lost productivity, or costs associated with diversion of a child into the juvenile justice or welfare systems.

While we recommend inclusion of preventive psychiatry and appropriate referral as needed as part of CHIRP, we also urge the Subcommittee to be cognizant of the fact that most health insurance plans now arbitrarily and uniquely restrict coverage for the treatment of psychiatric illness. As we continue to work with the Committee, insurers and state and local government to broaden this narrow and inappropriate restriction placed on the treatment of mental disorders, we hope you will help ensure that by providing preventive services for children under employer health plans, there is no corresponding diminution in those benefits now provided for the treatment of any disorders which might be disclosed in the process of the health status evaluation. If such further curtailments are permitted, one would be sacrificing the treatment of one segment of the population for the diagnosis of health or illness in another.

The APA would be pleased to work with you and your staff to help further our mutual concern for appropriate preventive health care for our nation's children.

We hope you will make this statement part of the record of the Subcommittee's hearing on the Child Health Incentive Reform Plan.

Sincerely,

Jay B. Cutler
Special Counsel and Director
Division of Government Relations

JBC:tf:jc

STATEMENT

OF THE

BLUE CROSS AND BLUE SHIELD ASSOCIATION

ON

S. 376

THE CHILD HEALTH INCENTIVES REFORM PLAN

SUBMITTED FOR THE RECORD

TO

SUBCOMMITTEE ON TAXATION AND DEBT MANAGEMENT
COMMITTEE ON FINANCE

UNITED STATES SENATE

SEPTEMBER 16, 1985

The Blue Cross and Blue Shield Association, the national coordinating agency for the nation's Blue Cross and Blue Shield Plans, appreciates this opportunity to submit our views on S. 376 for the record. We support the concept of pediatric preventive health care which this Association and our member Plans have enthusiastically promoted through educational programs, and we congratulate Senator Chafee for his concerns in this area.

We must, however, be very candid and express our strong reservations about the approach embodied in S. 376 to meet this important need.

S. 376 would create a federal mandate that employee health benefit plans must include coverage for specific pediatric preventive health care services. If such services were not offered the employer would not be entitled to deduct any of the costs of providing health benefits for his employees.

The Blue Cross and Blue Shield Association is philosophically opposed to the concept of mandated benefits. We believe that such legislation, however well-intended, would send an inappropriate message to a health care system which is only now maturing into a true marketplace. S. 376 is anti-competitive and certainly counterproductive to the cost containment efforts to employers and third-party payers. Government involvement in the private health care system, particularly governmental mandation of benefits, must be carefully examined and analyzed because the results of such involvement may not be consistent with the outcomes intended.

We believe that the design of employee benefit plans should develop from the contractual arrangement between the employer and employee. A contract is a private agreement and is the product of discussion and negotiation between the parties at interest. With respect to health benefits, the subjects should include the level and type of benefits

which best fit the needs of the employees and the ability of the employer to finance them. When government mandates a particular type of benefit as a part of this private agreement, government inserts itself into the contracting process and thereby limits the options available to both employer and employee. A very likely result of mandates is that some employers may be forced to limit their offerings of other equally important health benefits for employees, for example, catastrophic coverage.

Such government intrusion is a particular problem with respect to the collective bargaining process. In a time of limited economic resources, mandated benefits represent an allocation of certain resources to those mandated benefits at the expense of others — an allocation over which neither management nor labor has any control. It should be the marketplace and those who bargain in it that should determine what benefits are included in employee benefit plans, not the federal government.

Mandated benefits always favor classes of beneficiaries or particular providers. Such proposals frequently reflect special interest and place Congress in the position of judging not only the quantity but the quality of benefits. Once the precedent is established by approving just one mandated benefit, you will be faced with having to decide if pediatric care is preferable to drug abuse treatment. Or, you may have to vote on legislation in which podiatrists are to be favored over osteopaths or psychiatric social workers or acupuncturists. Tremendous pressure is already exerted by providers at the state level to mandate insurance payment for their services.

The Blue Cross and Blue Shield Association and its member Plans have raised these same concerns at the state level and all too often our fears have been realized. In many states employers carry enormous financial burdens because of benefit mandates

by the state. We say to you, as we continue to argue in the states, that this is not the appropriate role for government, no matter how good the intentions are.

The final point we would emphasize is the cost of mandated benefits. The cost of the benefits required by the Child Health Incentives Reform Plan is predictable and, in the aggregate, high. We would point out that we believe insurance should be used to protect against events which are unforseeable and have the potential of being financially catastrophic. Well baby care and preventive health care services are neither. It is not unreasonable to expect that working families (the ones who usually have employer based group health insurance) can budget for such services because they are predictable and are not major financial burdens.

On the other hand, the aggregate cost to an employer for these services may be considerable. When a bill similar to S. 376 was being considered by the Rhode Island legislature, Blue Cross and Blue Shield of Rhode Island estimated it would cost subscribers an additional $4.3 million — or 33% over the annual rate of increase for its 5,600 group accounts. The state's own employee group would have had to absorb almost half a million dollars ($440,000) in added costs just to finance the additional benefits mandated in that bill.

The provisions of the S. 376 appear to us to reflect the well child or health supervision protocol of the American Academy of Pediatrics (AAP). While pricing these benefits must be general and could change quite significantly for any specific group based upon its demographics, using the AAP protocol to clarify the benefits and applying general actuarial principles we would project an annual cost of about $5.47 per month per child under 21 years of age. We believe this mandate could add as much as $3 billion to the nation's insurance premiums.

The added costs of the benefits required under the Child Health Incentives Reform Plan are not insignificant for employers who provide health benefits for their employees. Employees of small employers may be especially disadvantaged by such a benefit mandate. Their employers who may only provide modest health benefits may choose to discontinue their health benefits for employees — or just the dependents — rather than face these higher costs.

We are also concerned about another aspect of the benefits mandated by S. 376. The bill is vague regarding the periodicity and scope of examinations and it promotes regulatory license. This concern is reinforced by the provision that additional medical services may be added "...as required by regulation..." in consultation with "appropriate medical organizations involved in child health care."

Finally, we suggest the need for greater access to the services mandated in S. 376 is not with the fully employed and their families. Rather, those who need these services and whose access is limited are those without employer based coverage. This bill will do nothing to provide access for families who need it most.

To summarize, we reiterate our strong opposition to government's mandating any health benefits, including those prescribed in S. 376. We believe this represents an intrusion into the negotiating-contracting process between private parties and is not warranted. It would discourage the growing competition that is indeed containing health care costs. The specific benefits required by this bill are affordable without insurance for the employed families this bill would extend benefits to. Yet, these same benefits will, in the aggregate, be costly for employers who will have to offer them. And, very importantly, this proposal will not help the very people — the unemployed — whose financial situation may limit their access to such services.

The Child Health Incentives Reform Plan may be a solution for one problem that does not exist and prove to not be a solution to the very real problem of access to such care for those who have no health insurance benefits.

Children's Defense Fund
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October 1, 1985

The Honorable John Chafee
Chairman, Subcommittee on Taxation
and Debt Management
Senate Finance Committee
587 Dirksen Senate Office Building
Washington, DC 20515

Dear Senator Chafee:

Thank you very much for affording CDF the opportunity to testify before your Subcommittee regarding S.376, the Child Health Incentive Reform Plan (CHIRP). During the hearing, the witness testifying on behalf of the United States Chamber of Commerce made two statements that I believe are erroneous. I would like to correct them for the record.

First, I believe the witness asserted that the Rand study on patient costsharing showed that reduced levels of insurance had no effect on children's use of medical care. The Rand costsharing study did indeed report that costsharing had no significant effect on children's use of inpatient medical care and services, since children tend to be hospitalized only when medically necessary. Their use of inpatient care is therefore much less sensitive to price than is the case with elective surgery.

The Rand study also reported, however, that children's use of outpatient services for preventive and acute care needs was significantly sensitive to costsharing requirements. I have enclosed a copy of the study for the record. Given the fact that withholding coverage for certain preventive services, especially for very young children, can have longterm ramifications, I think that the witness's assertion was particularly problemmatic.

The witness also asserted that adequate publicly financed preventive services exist and that there is thus no need for private insurance reforms to improve children's coverage for preventive care. This statement is patently erroneous. Programs supporting public health services, including the Title V MCH Block Grant, Medicaid, and the federal immunization program are all seriously inadequate.

For example, in Fiscal Year 1985, Title V formula funds to states amounted to about $410 million. This amount represents $31.00 annually for every child under 18 living below the federal poverty level, and even this figure assumes that every Title V dollar is spent on preventive pediatric care, which is not true. Sizeable portions of Title V funds are spent on both maternity care and services for handicapped children.

Moreover, while states tend to "overmatch" federal Title V expenditures for maternity and crippled children's services, they spend far less on preventive pediatric services. Finally, federal immunization funds (about $45 million in Fiscal Year 1985) amounted to less than $4.00 for every poor child in 1984. Medicaid covered only about 40% of children living in poverty. These funding realities, in addition to the fact that many counties have no public health departments at all, mean that millions of inadequately insured poor and near-poor children are without public financing for preventive health care needs.

Thank you once again for providing us with this opportunity to testify.

Sincerely,

Sara Rosenbaum
Director, Health Division

SR:sk
Enc.

Effect of Cost-Sharing on the Use of Medical Services by Children: Interim Results from a Randomized Controlled Trial

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ABSTRACT. Health care expenditures of 1,136 children whose families participated in a randomized trial, The Rand Health Insurance Experiment, are reported. Children whose families were assigned to receive 100% reimbursement for health costs spent one third more per capita than children whose families paid 95% of medical expenses up to a family maximum. Outpatient use decreased as cost-sharing rose for a variety of use measures: the probability of seeing a doctor, annual expenditures, number of visits per year, and numbers of outpatient treatment episodes. Hospital expenditures did not vary significantly among children insured with varying levels of cost-sharing. Episodes of treatment for preventive care were as responsive to cost-sharing as episodes for acute or chronic illness. The results give no reason not to insure preventive care as liberally as care for acute illness. *Pediatrics* 1985;75:942-951; *health care costs, cost-sharing, insurance plans.*

Pediatricians and others concerned about children's health are intensely interested in how health care financing encourages or discourages the use of health care services for children.[1] Early results from the Rand Health Insurance Experiment demonstrate that the use of medical services by people less than age 65 years is sensitive to cost-sharing.[2,3] This paper explores the degree to which the inverse relationship between use and the level of cost-sharing in the fee-for-service system applies to children 13 years old and younger. We examine whether price responsiveness affects both outpatient and inpatient care for children. We also examine how cost-sharing affects different kinds of outpatient use: well-care and care for acute and chronic conditions.

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Some of the data from this study were presented at the National Governor's Association Conference on Preventive Health Services for Children and Cost Containment, Phoenix, Oct 28-30, 1984.

The views expressed are those of the authors and do not necessarily represent those of the DHHS or The Rand Corporation.

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PRIOR STUDIES

In a sample of the population aged 64 years or less, people whose medical expenses were fully covered by insurance spent about 50% more than those who faced cost-sharing.[2] More generous insurance led to more episodes of treatment, particularly for acute conditions.

An immediate question is whether those findings apply equally to children's expenditures. Two characteristics of children's health care suggest that the demand for pediatric health services might be more responsive to price than the demand for adults' care. First, the incidence of chronic disease is lower among children than among adults.[4] Many children's illnesses are acute but self-limiting. The demand for care for these illnesses may depend more on cost-sharing than does the demand for treating diseases that will not resolve by themselves. Second, much of the medical care provided children is preventive care, which parents may regard as more discretionary than treatment for illness.

Conversely, when parents face cost-sharing, they may be less willing to reduce their children's health care than to reduce their own—a preference that may be reinforced by government regulations requiring immunizations and regular checkups for children enrolled in school.

The literature contains no reports of controlled trials that varied cost-sharing for pediatric care. Noncontrolled studies of pediatric care focus primarily on demographic determinants of health service use rather than on cost-sharing. Families that are more advantaged (high income, high levels of parental education, smaller family size) use more preventive services for their children (reference 5 and D. P. Slesinger, unpublished data). Perhaps because these demographic factors affect curative visits in the opposite way, the effects of demographic factors on total pediatric visits (preventive and curative) show less consistent effects.[6-13]

METHODS

Design of Health Insurance Experiment

Because the details of the experimental design appear elsewhere,[2,3] only the salient points are noted here. Excluding participants enrolled in a prepaid group practice (who are the subject of separate analyses), the Health Insurance Experiment enrolled a representative random sample of more than 5,800 persons aged 62 years or less at enrollment; 1,844 of these were children aged 13 years or younger. The sample was drawn from families in six sites: Dayton, OH; Seattle; Fitchburg and Franklin County, MA; and Charleston and Georgetown County, SC. Of these families, 70% were enrolled for 3 years, 30% for 5 years. Families were assigned to an experimental health insurance plan by an unbiased allocation method that made the distribution of more than 20 characteristics related to health or expenditures as similar as possible across plans.[14] Of families who agreed to an initial interview, 14% refused the enrollment offer (Table 1); others had refused preliminary interviews. These families were not reassigned to another plan. Although there were some differences in the types of families that accepted the enrollment offer,[15] there are no important differences in health or demographic variables between the sample of children enrolled in free and cost-sharing plans.[16a]

The insurance plans varied along two dimensions: the coinsurance rate (fraction of the medical bill paid by the family in any 1 year) and the maximum dollar expenditure (an income-related upper limit on annual out-of-pocket expenditures). For the analyses reported in this paper, the insurance plans are grouped as follows: (1) one plan providing care with no out-of-pocket costs (ie, 0% coinsurance), referred to as the "free-care plan"; (2) six plans with a 25% coinsurance rate for medical care; in this set, the family paid 25% of its medical bills each year up to maximum dollar expenditure of 5%, 10%, or 15% of family income or $1,000 ($750 in some sites in some years), whichever was lower (participants in three of the plans paid a higher rate—50%—of their dental and outpatient mental health expenses); (3) three plans with a 50% coinsurance rate for all medical and dental services and the same income-related limitations as in (2); (4) three plans with a 95% coinsurance rate and the same income-related limitations as in (2); and (5) one plan with a 95% coinsurance rate on outpatient expenditures up to a maximum out-of-pocket expenditure of $150 per person ($450 per family) per year and no coinsurance after that; all inpatient care is free on this plan, which we refer to as the "individual deductible" plan.

All plans had an identical, comprehensive set of covered services that included ambulatory and hospital care, preventive services, all dental services (except nonpreventive orthodontia), all prescription and certain over-the-counter drugs, most supplies and durable medical equipment, psychiatric and psychological services (except outpatient psychotherapy visits exceeding 52 per person per year), and almost all other personal medical services (except cosmetic surgery for preexisting conditions). Services of nonphysician providers such as audiol-

TABLE 1. Proportion of Sample Remaining After Accounting for Refusals at Various Stages*

Enrollment Criteria	Dayton	Seattle†	Massachusetts	South Carolina	Total
Initial sample	1.00	1.00	1.00	1.00	1.00
Did not refuse screening interview	.88	.85	1.00‡	1.00‡	.94
Did not refuse base-line interview	.74	.78	.88	.95	.85
Did not refuse enrollment interview	.73	.70	.76	.84	.76
Did not refuse offer of enrollment	.68	.59	.62	.71	.65
No. of families enrolled	390	484	566	568	2,008

* These numbers do not account for families who moved prior to enrollment, could not be located, were chronically not at home, or other losses from the sample not due to refusal.
† Excludes 752 families enrolled in the Group Health Cooperative of Puget Sound.
‡ There was no screening interview in Massachusetts or South Carolina.

ogists, optometrists, and speech therapists were also covered.

Sample for Analysis of Child Health Expenditures

The sample used in this paper includes 3 years of data from Dayton and 2 years each from the Seattle and Massachusetts sites. Analyses of data from the South Carolina sites are not yet complete. Results relating to episodes of treatment are based on data for children in the first 3 years at the Dayton site; data for these analyses for other sites are not yet complete. The expenditure analysis sample includes 1,136 children who participated for at least 1 year and decedents who had participated during the year in which they died, but excludes children whose families withdrew from the experiment in the year they withdrew. More than 90% of the children initially enrolled completed their assigned time on study.[15a] Hence, we have made no adjustments for any bias due to attrition.

We also do not include expenditures for newborns during their first partial enrollment year; they are the subject of a forthcoming analysis. We have limited our analyses to children 13 years of age and younger. Although pediatricians continue to treat many adolescents until a later age, we chose this definition to correspond to the age divisions used in Health Insurance Experiment health questionnaires. Modest sample sizes and comparatively low use of medical care by children in general dictated against separate statistical modeling of use for age subgroups of children. Therefore, we present results on expenditure for the entire sample of children aged 13 years and younger.

After accounting for sample loss, we had 2,662 full years of data on children (Table 2). Children assigned to the free-care plan accounted for about one third of the observations. The remainder of the children faced cost-sharing.

Measures of Child Health Use

We examined several measures of medical use by children, including annual average medical expenditures and counts of the number of outpatient episodes of treatment for acute and chronic illness and well care. Our annual aggregates included all medical care delivered to children, except expenditures on outpatient mental health and dental care (which are examined in separate reports).[16,17] Claims filed by participants provided data on the type and amount of services and expenditures, including those not reimbursed by insurance (eg, the coinsurance and deductible amounts). We summed claims data for each participant to arrive at annual expenditure totals and numbers of visits. Data in this analysis were collected between 1974 and 1978, but we adjusted expenditure data using the "Medical Care" Consumer Price Index published by the Bureau of Labor Statistics[18] to reflect medical care prices in 1983.

We calculated the average number of office visits to doctors of medicine and doctors of osteopathy during the second experimental year in each site. Second-year expenditures should be least affected by any temporary effects arising from the change in insurance experienced by each family at the start of the study. Well care use by free-care plan participants increased slightly in the first 3 months of the study and again at the conclusion of the study.

We categorized care into "episodes of treatment," which consist of one or more medical services related to a given medical problem. Claims data were grouped into episodes using information on diagnosis, interval since previous charge for a related diagnosis, and provider-supplied treatment histories. For example, an initial visit for an ear infection and a recheck visit constituted one episode of treatment, as did a prescription drug purchase without an office visit. We examined three types of outpatient episodes: those for acute problems, for chronic

TABLE 2. Mean Annual Expenditures by Plan for Children and Adults (1983 Prices)*

	Total Medical Expenditure ($)		Ambulatory Expenditure ($)		No Person-Years for Ambulatory Expenditure	
	Child†	Adult‡	Child†	Adult‡	Children†	Adults‡
Free care	389 ± 167	871 ± 134	192 ± 22	402 ± 32	864	1,970
25% coinsurance	259 ± 81	813 ± 171	153 ± 28	328 ± 39	571	1,221
50% coinsurance	301 ± 125	771 ± 435	192 ± 65	242 ± 33	241	525
95% coinsurance	213 ± 93	570 ± 110	114 ± 22	249 ± 32	513	1,251
Individual deductible	278 ± 85	723 ± 194	162 ± 35	287 ± 37	473	1,136

* Values are means ± 95% confidence interval. All prices have been adjusted using the Medical Care component of the Consumer Price Index.[18]
† Children aged 0 to 13 years.
‡ Aged 14 years and older.

problems, and for well care. Details of the analytic techniques used are given elsewhere.[3,19]

Estimation Methodology

As a result of random assignment, the distribution of factors affecting the demand for medical care use does not vary by insurance plan.[2,14] Therefore, average expenditures on each plan provide unbiased estimates of expenditure differences among the plans. However, large expenditures incurred by a few children with unusual health care needs can affect the mean expenditures on a plan dramatically, even though the Health Insurance Experiment has data on sizable numbers of children in each plan. For example, a single child whose medical expenses amounted to $68,400 in 1 year accounted for 20% of all expenditures on the free-care plan in the data analyzed here. Therefore, we used the estimation method described by Duan et al[19] to provide more stable estimates and to remove the within-plan differences attributable to age, sex, indicators of initial health status, income, and other demographic variables. These adjusted expenditures account for systematic differences in age and sex on children's medical use, allowing us to estimate more precisely the differences related solely to insurance plan. We have corrected the significance statistics to allow for the fact that children in the same family do not provide totally independent observations.[19] The effect of this correction is to provide a conservative estimate of the statistical significance of measured differences. Further details are provided by Duan et al.[19]

The few large users of medical care have less influence on measures of use other than expenditure. In the case of number of visits and numbers of episodes of treatment for acute, chronic, and well care, the sample means estimate the effect of the insurance plan with sufficient precision.

RESULTS

Children and Adults Together

Total expenditures for adults and children together differed markedly as a function of insurance plan.[2] Annual per capita expenditure for medical services, excluding mental health and dental services, on the income-related catastrophic plan was 69% of that on the free-care plan. Expenditures for plans with intermediate levels of cost-sharing fell between these extremes.

Variation in the amounts of services used (eg, numbers of physician office visits or hospitalizations), not differences in prices charged to families, accounted for most of the plan differences. Free-plan participants were 22% more likely to have an office visit during the year, and were 34% more likely to be hospitalized than participants insured by the 95% plan.

Descriptive Results for Children

Expenditures per child averaged only 39% of expenditures per adult (aged 14 to 65 years). The pattern of reduced expenditures with higher levels of cost-sharing was evident, however, for both adults and children (Table 2). Simple means indicated that total expenditure per child (outpatient plus inpatient expenses) averaged about 83% higher with the free-care plan than with the 95% plan; for adults, expenditures with the free-care plan were 53% higher. Expenditures on the intermediate cost-sharing plans fell between these extremes, although average expenditures did not decline monotonically as cost-sharing increased. Mean expenditures on the Health Insurance Experiment plans were similar to an estimate of national health care expenditures for children less than age 19 years derived from Fisher.[20] Adjusted to 1983 prices, expenditures on physician and other professional services, hospital care, and drugs average $311 per year for children less than age 19 years.[20]

Outpatient use accounted for 55% of all children's health expenses on the various plans—much higher than the 42% recorded by adults. The pattern of decreasing use with increasing cost-sharing again was evident for outpatient expenditures, which were about 68% greater with the free-care plan than with the 95% plan.

That pattern is mirrored in measures of use other than expenditures. For both younger and older children, the probability of having at least one office visit per year decreased as cost-sharing increased and as children aged (Table 3). By contrast, the probability of being hospitalized during a year showed no consistent pattern related to cost-sharing for older children. For younger children, the two plans with no cost-sharing for inpatient care—the free-care plan and the individual deductible plan—showed significantly greater hospital use than the cost-sharing plans. The average hospitalization rate for children in the Health Insurance Experiment did not differ meaningfully from the national average (the admission probability is .05 from both data sources).

The average number of outpatient visits per year also declined as cost-sharing increased (Table 4). The office visit rates varied considerably by site, however. With one exception, Dayton rates were

TABLE 3. Children with Outpatient and Inpatient Use, by Plan and Age Group*

	% with Outpatient Use		% with Inpatient Use	
	0-4 yr	5-13 yr	0-4 yr	5-13 yr
Free care	95 (2.4)	85 (1.9)	8.8 (1.9)	4.4 (0.8)
25% coinsurance	90 (3.3)	79 (2.4)	4.2 (1.7)	4.7 (1.1)
50% coinsurance	94 (3.6)	74 (4.8)	6.5 (2.6)	4.9 (1.5)
95% coinsurance	82 (4.5)	68 (4.1)	4.5 (1.8)	4.2 (1.2)
Individual deductible	88 (2.8)	76 (3.3)	10.5 (2.8)	3.9 (1.1)

* Sample includes children aged 0 to 13 years who completed the entire enrollment year. Standard errors are shown in parentheses, they have been corrected for intrafamily and intraperson correlation.

TABLE 4. Annual Office Visit Rates Per Child Less Than 14 Years Old, by Plan and Site*

	Dayton, OH	Seattle	Fitchburg, MA	Franklin County, MA
Free care	4.1 (.43)	3.3 (.33)	3.0 (.54)	3.2 (.53)
25% coinsurance	3.1 (.75)	3.1 (.60)	2.8 (.50)	3.7 (.82)
50% coinsurance	3.7 (.61)	—†	2.0 (.53)	2.1 (.67)
95% coinsurance	3.2 (.69)	2.1 (.43)	1.7 (.42)	2.4 (.58)
Individual deductible	2.0 (.67)	4.0 (.96)	1.9 (.36)	2.4 (.50)

* Sample includes children aged 0 to 13 years who were present the entire second enrollment year. Visits include all visits with physicians and osteopaths occurring in offices, clinics, emergency rooms, etc. Telephone visits and visits to free-standing radiology and pathology providers are excluded. Standard errors, shown in parentheses, have been corrected for intrafamily correlation.
† Plan was not offered in Seattle.

TABLE 5. Proportion of Children's Visits to Pediatricians, by Plan*

	Primary Care† (%)	All Visits (%)
Free care	67.5 (2.5)	49.4 (2.3)
25% coinsurance	61.9 (4.4)	44.1 (3.9)
50% coinsurance	69.1 (6.1)	49.2 (5.4)
95% coinsurance	56.4‡ (4.7)	40.2‡ (4.2)
Individual deductible	73.6 (4.5)	53.5 (4.01)

* Standard errors, shown in parentheses, have been corrected for intraperson correlation.
† Includes visits to pediatricians, internists, and family and general practitioners.
‡ Significantly different from free care ($P < .05$).

considerably higher than rates in the other sites, which approximated national averages. The 50% and 95% coinsurance and the individual deductible plans most closely approximate the level of coinsurance coverage available generally for pediatric services, including preventive services. Annual office visit rates per child on these plans ranged from a low of 1.7 visits (Fitchburg) to a high of 4.0 visits (Seattle). Nationally, children less than age 15 years averaged 2.0 visits per year (from a 1977 survey of visits to office-based physicians).[21]

One response to cost-sharing is to reduce outpatient visits; another might be to use a different type of provider. To determine whether cost-sharing was related to type of provider used, we calculated the share of visits to pediatricians among all primary care visits and among visits to all providers. Pediatricians accounted for nearly two thirds of all primary care visits with the free, 25% and 50% coinsurance plans (Table 5). Children with the 95% coinsurance plan were significantly less likely to see a pediatrician for primary care (56.4% of visits *v* 67.5% of visits with the free-care plan). Considering both primary and specialist care, pediatricians accounted for nearly half the outpatient visits on the free-care plan. The pediatrician's share was

TABLE 6. Adjusted Annual Medical Expenditures per Child, by Plan

	Expenditures ($)/Child/yr (1983 Prices)*	Ratio to Free Plan Expenditures
Free care	345 (39)	1.00
25% coinsurance	309 (38)	.90
50% coinsurance	281 (39)	.81†
95% coinsurance	260 (35)	.75†
Individual deductible	298 (38)	.86†

* Standard error of the estimate is shown in parentheses
† Significantly different from free plan mean ($P < .05$)

significantly lower on the 95% coinsurance plan (40.2%, $P < .05$).

Adjusted Expenditures for Children's Health Care

Although the pattern of plan differences in expenditures exhibited the expected decrease in use with increased cost-sharing, the relatively large standard errors of simple means yields many insignificant plan differences in Table 2. Therefore, we used statistical methods that generate more precise estimates than simple means.

These methods provide what we consider to be our most reliable estimate of the effect of cost-sharing on children's medical expenditures. Estimated expenditures (expressed in 1983 dollars) show less responsiveness to cost-sharing than do simple means (Table 6). Families who paid 95% of their medical bills averaged 75% of the free-care plan medical expenses for their children. Each plan requiring copayment recorded expenditures per child that were significantly less than for those with the free-care plan ($P < .05$ for plans with more than 25% copayment, $P < .07$ for the 25% copayment plan), thus confirming that cost-sharing reduced total use of medical services. Decreased use of outpatient services as cost-sharing increased largely accounted for the reduction in total medical expenditures because inpatient care for children was not greatly affected by cost-sharing (Table 3). Because hospitalizations for children are infrequent, our estimates of hospital use have wide confidence intervals and we can be less certain than for outpatient care about the presence or absence of a cost-sharing response.

Adjusted expenditures did not differ significantly by family income category (Table 7). The probability of using any medical care during a 1-year period was significantly related to family income (not shown), but the effect of copayment on total medical expenditures did not depend on income level, when other determinants of use are controlled for statistically.

TABLE 7. Annual Medical Expenditure per Child, by Income Tertile*

	Expenditures ($)/Child/yr (1983 Prices)
Low†	341 (41)
Middle	345 (39)
High	357 (41)

* Predicted from estimated multiple regression equation using actual characteristics of families in the various tertiles. The log of income had a positive, significant effect on the probability of any use of medical services ($P < .0001$), but no significant effect on the level of outpatient use, given that it was positive ($P > .30$). Standard error of the estimate is shown in parentheses.
† Low income includes children in families in the lowest third of income distribution in their site. Middle income and high income indicate family income in the middle and highest thirds of the distribution, respectively.

Episodes of Outpatient Treatment for Children

Cost-sharing had its greatest effect in reducing outpatient care. To uncover the mechanisms by which cost-sharing operated, we examined episodes of treatment for both children and adults in the Dayton site.

Did cost-sharing reduce the number of episodes or cost per episode? The number of treatment episodes for children less than 14 years of age declined from 4.4 episodes per year on the free-care plan to a low of 2.6 on the 95% plan (Table 8). Controlling for age, race, family income, and prior health, the number of episodes on each pay plan was significantly lower than with the free-care plan ($P < .01$). Children receiving free care had 67% more episodes of treatment than children with the 95%-care plan, but the average cost per episode did not differ significantly between the two types ($P > .05$). Thus, cost-sharing affected whether parents sought treatment for their children, but did not affect the amount of treatment after a visit was initiated. (Note, however, that the average patient seeking treatment on the free-care plan may be less severely ill because a higher percentage of the episodes of illness are treated.)

TABLE 8. Annual Outpatient Episodes of Treatment, by Plan*

	Mean No of Outpatient Episodes		Mean Cost/Episode (1983 $)	
	Children <14 yr	Adults ≥14 yr	Children <14 yr	Adults ≥14 yr
Free care	4.4	5.2	48	90
25% coinsurance	3.2	4.1	54	97
50% coinsurance	4.0	3.7	57	90
95% coinsurance	2.6	3.1	47	77
Individual deductible	2.9	3.5	37	84

* Based on 1,015 person-years of data for children aged 0 to 13 years and 2,340 person years of data for adults aged 14 years and older for the first 3 years at the Dayton site. Differences in the mean number of patient episodes between the free-care plan and each of the cost-sharing plans were statistically significant on a one-tailed test ($P < .01$) in a regression equation that also controlled age, race, family income, and measures of health status at enrollment.

TABLE 9. Outpatient Episodes per Year for Children Aged 0 to 13 Years, by Type of Episode: First 3 Years in Dayton*

	No of Episodes			Mean Cost/Episode		
	Acute	Chronic	Well-Care	Acute	Chronic	Well-Care
Free care	2.79	0.58	1.06	42	91	43
Copayment	2.01	0.37	.81	42	112	46

* Based on 1,015 person-years of data for children aged 0 to 13 years who were enrolled for all 3 years at the Dayton site.

Although children had about the same number of episodes as adults, their outpatient expenditures averaged only half of adults' expenses because their mean cost per episode was lower (Table 8).

Did cost-sharing discourage preventive care more than acute or chronic care? To determine whether families facing cost-sharing would forego treatment for certain types of conditions more readily than for others, we calculated the number of episodes of each of three types (Table 9). With the free-care plan in the Dayton site, 63% of children's episodes were related to acute conditions, 24% to well care, and 13% to chronic conditions. Our data correspond to national averages which show that in 1975, 25.5% of all visits to pediatricians were for well-baby examinations, for general medical examinations, or for required physical examinations.[22]

Grouping together the plans requiring copayment, we determined that children insured by these plans had significantly fewer treatment episodes of each type than children with the free-care plan: They had 72% as many acute episodes, 76% as many well-care episodes, and 63% as many chronic episodes ($P < .05$). Cost-sharing reduced episodes of well care less than it reduced care-seeking for acute or chronic problems. Thus, we have no evidence that well-care episodes were more discretionary, or that they were reduced proportionately more than acute or chronic episodes.

DISCUSSION

Spending for medical services responded to variation in cost-sharing both for children and for adults. Expenditures per child with the free-care plan were one third higher than with the 95% cost-sharing plan—a response only slightly less than that of adults. All the measures we examined showed an increase in outpatient use as cost-sharing declined; those insured by the free-care plan had a higher probability of seeing a doctor, higher annual expenditures, more visits, and more episodes of outpatient treatment.

Children insured by the free-care plan were significantly more likely to receive their primary care from a pediatrician than children with the 95% plan. Although this finding appears to suggest that pediatricians charge more, in fact, Health Insurance Experiment data show only slight price differentials between pediatricians and other providers treating children. Pediatricians' charges for a standard visit (corresponding to an intermediate examination for an established patient) averaged 3.5% more than general practitioners' fees for children in Dayton and 1.4% more in Seattle.[23] These small differentials are confirmed by other recent surveys of physician fees.[24] If participants correctly perceived the lack of a price differential, it is difficult to understand the relationship between plan

and choice of a pediatrician as opposed to another physician.

For the most part, hospital expenditures did not vary significantly among children insured by the various plans. Thus, the lower use of outpatient care by children with the cost-sharing plans does not appear to have increased hospital use among children with those plans. In fact, young children insured by the two plans with free inpatient care were more likely to be hospitalized. The structure of the Health Insurance Experiment plans, however, guaranteed that after a family with the cost-sharing plans exceeded an annual maximum out-of-pocket expenditure, all care was free for the remainder of the year; had the Health Insurance Experiment plans not had MPE, inpatient costs might have differed more among the plans.

Although we found large differences in medical care use as cost-sharing varied, we saw little relationship between use and family income. Because the maximum limit on expenditures was income-related, poor families were more likely than affluent ones to exceed the annual ceiling, after which all care became free. Had this not been the case, lower-income families might have spent less than they did on medical care.

How Much Cost-Sharing for Children's Health Care?

Current Situation. The Health Insurance Experiment plans covered the spectrum of cost-sharing from free care to a sizable family deductible. Where does the current national situation fall in this range? The Health Insurance Experiment free-care plan clearly represented more generous coverage than either Medicaid or virtually all private insurance plans offer. Although Medicaid has very limited out-of-pocket payments, its relatively low fee schedules are not universally accepted by physicians, whereas the Health Insurance Experiment plans, in general, paid billed charges.

Nationally, the amount of cost-sharing seems to be in the range of the experimental 50% to 95% coinsurance plans. National visit rates for children approximate visit rates on those two Health Insurance Experiment plans. These plans also correspond to the national average in terms of the percentage of the medical care bill paid out-of-pocket. Families insured by these two plans paid 66% of children's outpatient costs, when nationally, families paid 75% of the office visit charges for children less than 6 years old, and 71% of charges for children aged 6 to 18 years.[25]

The substantial share of children's outpatient expenses paid by families stands in contrast to the high proportion of children covered by health insurance (87.6%).[26] One reason the out-of-pocket payments remain high despite widespread insurance coverage is that health insurance rarely covers one of the most frequent types of child health care—well care. Although well care represents one fourth of children's treatment episodes, and 15% of expenditures, only 3% of the plans held by Health Insurance Experiment participants before enrollment explicitly stated that they covered preventive services. Seventeen percent of the plans did not cover outpatient care at all, whereas 48% covered some outpatient care, but not preventive care.

Recommendations for Change. In 1983 the Committee on Child Health Financing of the American Academy of Pediatrics[1] called for reforms in health financing that would eliminate "financial barriers" for children's health care as well as broaden the range of services covered to include preventive care.

The results presented here are not sufficient to justify a particular level of cost-sharing. Nonetheless, they do have a number of implications. One rationale for less generous coverage of children's services is that they are more responsive to insurance, so increased coverage would stimulate excessive use. Our results, however, imply that expenditures for children's health care are no more responsive to coverage than those of adults. Moreover, because children's expenditures are only 39% of the adult level, providing free care for children would be less costly in absolute terms than providing free care for adults. However, because of the lower costs and the greater share of outpatient care, children's expenditures are more predictable; therefore, insurance is less necessary to protect families from large financial losses.

Similarly, the current lesser coverage for preventive services is partially rationalized by the belief that only nondiscretionary services—eg, medical care for accidents or severe illness—should be covered by insurance. However, the Health Insurance Experiment results imply that even care for acute illness is somewhat discretionary because it varied with insurance reimbursement. In fact, we have shown that free-care plan participants increased their use of acute care and preventive services at the same rate. Because preventive services appear to be no more discretionary than acute care services, there is no reason to provide poorer coverage for preventive services on that account. As in the case of children's health care generally, however, one can argue that well care is predictable and insurance is, therefore, unnecessary.

Our results do give a rationale for covering inpatient care for children more fully than outpatient care. In contrast to the case for adults,[2,3] older

children's use of inpatient care was not significantly related to insurance plan. This lack of cost-sharing response for inpatient care implies that generous hospitalization insurance would not stimulate hospital use for children, particularly for those more than 4 years old.

Some argue that if inpatient care is covered more generously than outpatient care, medical expenses may rise (and health status deteriorate) because patients will delay seeking care until they have a more serious (hospitalizable) problem,[27] or physicians will hospitalize them for services that could have been provided on an outpatient basis. Neither the results in this paper nor those in a companion paper[15a] support these contentions for children. The individual deductible plan fully covered inpatient care, but required some cost-sharing for outpatient care. Overall, children on the individual deductible plan had significantly lower expenses than children with the free-care plan. The reduction in use may be attributable to lower inpatient as well as ambulatory expenses, as was the case for adults. In summary, the Health Insurance Experiment results suggest that with regard to hospitalization, financing packages could completely cover the costs of inpatient care for children with little danger of stimulating excessive use.

By contrast with inpatient care, the responsiveness of expenditures for ambulatory care to cost-sharing implies that outpatient expenditures would be considerably higher if the currently high levels of copayment were eliminated. Assuming that the average family currently faces cost-sharing comparable to that of the Health Insurance Experiment 95% coinsurance plans, moving to free care would increase expenditures for children by about one third.

If preventive services nationally are on average covered somewhat less fully than by the Health Insurance Experiment 95% plan, fully covering preventive services would increase preventive use per se some 30% (Table 3), but all outpatient visits would increase by only 5% to 10%, and expenditures would increase by less than 5%. Fully covering preventive services adds little to total expenses because well care represents less than 15% of all expenditures for children's health care (Tables 6 and 9). The 5% increase in cost could clearly be financed by a modest increase in cost-sharing for other services, if desired.

Decisions about financing of children's health care must not be made on the basis of cost considerations alone. Rather, we must ask what are the benefits of variations in coverage for preventive care, and how do they compare with the benefits of more coverage for acute and chronic problems? The Health Insurance Experiment was not designed to test the effectiveness of preventive care because all Health Insurance Experiment plans covered preventive services. However, data on health outcomes for children participating in the Health Insurance Experiment[15a] reveal that little health benefit accrued to children insured by the free-care plan who received more care. Together with the findings reported here, those results should aid in the design of financial mechanisms that can provide for necessary medical care but also incorporate incentives to use care wisely.

ACKNOWLEDGMENTS

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Presentation of our findings to the Committee on Child Health Financing of the American Academy of Pediatrics helped to focus the discussion in this paper. The comments of Birt Harvey MD, on a previous draft are appreciated.

REFERENCES

1. American Academy of Pediatrics: Committee on Child Health Financing: Principles of child health care financing. *Pediatrics* 1983,71 981
2. Newhouse JP, Manning WG, Morris CN, et al: Some interim results from a controlled trial of cost-sharing in health insurance. *N Engl J Med* 1981;305:1501-1507
3. Keeler EB, Rolph JE: *The Demand for Episodes of Medical Treatment* (Rand publication No R-2829-HHS). Santa Monica, CA, Rand Corp, 1982
4. Eisen M, Donald CA, Ware JE, et al: *Conceptualization and Measurement of Health for Children in the Health Insurance Study* (Rand publication No. R-2313-HEW). Santa Monica, CA, Rand Corp, R-2313-HEW, 1980
5. Edwards L, Grossman M: Adolescent health, family background, and preventive medical care New York, National Bureau of Economic Research Working Paper 398, October 1979
6. Goldman F, Grossman M: The demand for pediatric care: An hedonic approach. *J Pol Economy* 1978,(pt I):259-280
7. Wilcox-Gok VL: Sibling data and the family background influence on child health *Med Care* 1983;21:630-638
8. Wolfe BL: Children's utilization of medical care. *Med Care* 1980,18:1196-1207
9. Dutton D: Children's health care: The myth of equal access, in *Better Health for Our Children: A National Strategy* (Report of the Select Panel for the Promotion of Child Health, vol IV, Background Papers). DHHS, 1981, pp 357-440
10. Inman RP: The family provision of children's health: An economic analysis, in Rosett R (ed) *The Role of Health Insurance in the Health Services Sector* New York, Columbia University Press (for the National Bureau of Economic Research), 1976, pp 215-254
11. Leibowitz A, Friedman B: Family bequests and the derived

demand for health inputs *Econ Inquiry* 1979,17 419-434
12 Tessler R, Mechanic D Factors affecting children's use of physician services in a prepaid group practice *Med Care* 1978,16 33-46
13 Colle, AD, Grossman M Determinants of pediatric care utilization *J Hum Resour* 1978,13 115-158
14 Morris CN A finite selection model for experimental design of the health insurance study *J Econometrics* 1979,11 43-61
15 Rogers WH, Camp P *Refusal and Attrition in the Health Insurance Experiment* (Rand publication No N 2195 HHS) Santa Monica, CA, Rand Corp, in press 1985
15a Valdez RB, Brook RH, Rogers WH, et al Consequences of cost sharing for children's health *Pediatrics* 1985, 75 952 961
16 Wells KB, Manning WG Jr, Duan N, et al *Cost Sharing and the Demand for Ambulatory Mental Health Services* (Rand publication No. R-2960 HHS) Santa Monica, CA, Rand Corp, 1982
17 Manning WG Jr, Bailit HL, Benjamin B, et al The demand for dental care Evidence from a randomized trial in health insurance *J Am Dent Assoc*, in press 1985
18 US Bureau of Labor Statistics *Monthly Labor Review* (various issues) 1983,106 85, 1978,101 89
19 Duan N, Manning WG Jr, Morris CN, et al A comparison of alternative models of the demand for medical care *J Bus and Econ Stat* 1983,1 115-126
20 Fisher CR Differences by all groups in health care spending *Health Care Fin Rev*, Spring 1980, pp 65-90
21 National Center for Health Statistics *The National Ambulatory Medical Care Survey, 1977 Summary, United States*, US Department of Health, Education, and Welfare, DHEW publication No (PHS) 80 1795, Series 1, No 44, 1980
22 Ezzati T *Ambulatory Medical Care Rendered in Pediatricians' Offices During 1975* Advance Data from Vital and Health Statistics of the National Center for Health Statistics, No 13, Oct 13, 1977
23 Marquis MS *Cost Sharing and the Patient's Choice of Provider* (Rand publication No. R-3126-HHS) Santa Monica, CA, Rand Corp, 1984
24 Goldfarb DI, (ed) *Profile of Medical Practice, 1981* Chicago, American Medical Assoc, 1981
25 Rossiter LF, Salomon MA *Charges and Sources of Payment for Visits to Physician Offices* Data Preview 5, National Health Care Expenditure Survey, DHHS publication No PHS 81 3291, Hyattsville, MD, National Center for Health Services Research, 1981
26 Kasper JA, Walden DC, Wilensky GR *Who Are the Uninsured?* Data Preview 1, National Health Care Expenditure Survey, Hyattsville, MD, US DHHS, National Center for Health Services Research, not dated
27 Roemer MI, Hopkins CE, Carr L, et al Copayments for ambulatory care Penny wise and pound-foolish *Med Care* 1975,13 457-466

CONDEMNED TO EXIST

We should understand that whether abortion is outlawed or not, our work has barely begun: the work of creating a society where the right to life doesn't end at the moment of birth; where an infant isn't helped into a world that doesn't care if it's fed properly, housed decently, educated adequately; where the blind or retarded child isn't condemned to exist rather than empowered to live.

Submitted by Student

From *Religious Belief and Public Morality* Governor Mario M Cuomo's speech to the Department of Theology at the University of Notre Dame, Sept 13, 1984

STATEMENT

of the

HEALTH INSURANCE ASSOCIATION OF AMERICA
and the
AMERICAN COUNCIL OF LIFE INSURANCE

on

THE CHILD HEALTH INCENTIVE REFORM PLAN S.376

Before the

Subcommittee on Taxation and Debt Management
of the Committee on Finance
United States Senate

September 16, 1985

This statement is on behalf of the Health Insurance Association of America and the American Council of Life Insurance. The HIAA and the ACLI are trade associations representing 335 and 627 member companies, respectively, which together write more than 91% of the nation's commercial health insurance.

Our statement today addresses S.376, the Child Health Incentives Reform Plan, introduced by Senator Chafee. This bill would mandate the inclusion of preventive pediatric services for children up to age 21 in all health insurance policies without regard to the health care needs of the insured or his ability to pay the increased costs this mandate would impose on his insurance coverage.

Our opposition to this measure is not based upon the desirability or medical efficacy of well baby care; S. 376 is well meaning in its concern for the health and welfare of our nation's next generation. However, the mechanism chosen for achieving this objective -- loss of deductibility from income taxes of group health plan expenses for those employers not complying -- attempts to coerce employers into providing a benefit that may not be wanted or needed by most employed individuals.

Our concerns with this proposal can be broadly categorized into two areas. First, there are conceptual problems with this type of regulatory approach. Second, there are specific questions regarding the ambiguities of the proposed bill.

CONCEPTUAL PROBLEMS

The proposed bill directly interferes with the collective bargaining process. Employers and labor/management trust funds have finite resources available with which to purchase employee benefits. Mandated benefits narrow the choices available to the employee bargaining unit and the employer by forcing them to purchase a particular benefit at the expense of a more desired benefit or pay raise.

Coverage for well baby care and preventive child health services already is available from many commercial insurance companies without mandatory legislation. However, most working class families can budget for the cost of well baby care and preventive child health services. Group health insurance provided primarily through employers and unions was never intended to cover the entire spectrum of medical treatment. Rather, it was designed to cover those catastrophic or substantial health expenses which are impossible to anticipate or budget by the average person. Well baby care is an inexpensive and predictable course of treatment which can be managed financially within the budgets of most working people, especially after the first year of a child's life when the need for physician visits and immunizations decrease. Thus, some employee groups may well prefer other benefits that they feel are more essential.

Further, the HIAA and the ACLI do not feel that mandated preventive child health coverage is necessary in order to guarantee that children get needed immunizations, since this issue has been addressed directly through enactment of public health programs in all 50 states. Recent U.S. Center for Disease Control data has shown that each state has passed some form of immunization law as a prerequisite for entry into its public school system. Therefore, additional intervention by the Federal government is not needed.

Mandating a child preventive health benefit would set a precedent. Other special interest groups would be encouraged to attempt to seek mandated coverage for the services they provide, or for the facilities they own or manage, under group health benefit plans. Following are just a sample of services presently mandated on the state level: mastectomies; acupuncture; ambulance services; occupational therapy; treatment for sickle cell anemia, speech or hearing impairments, alcoholism and drug abuse, joint disorders, and leukemia; diabetic education; skilled nursing care; hospice; corrective surgery for birth defects; services for mental retardation, emotional disabilities and epilepsy; maternity care; cancer treatment; second surgical opinions; prescription drugs; and kidney dialysis.

Additionally, we fear that a proliferation of mandated benefit laws similar to S. 376 might cause small, marginally profitable employers to drop what group health coverage they currently provide,

leaving many employees, their spouses, and children with no coverage at all.

AMBIGUITIES IN S. 376

The preventive services set forth in the bill require specification for pricing and claim adjudication purposes. Benefits are described in broad general terms -- for example, "appropriate" laboratory procedures -- and there are no apparent limits on the frequency with which the services could be provided. This lack of specificity would make it impossible for an actuary to determine an appropriate premium.

The proposal also does not provide any guidance for incorporating copayments, deductibles or other standard cost-sharing features. This could lead to wide disparities in the value of the coverage if some plans had low or no cost-sharing provisions while others required substantial cost-sharing.

Another concern is that the proposed bill calls for the Secretary of the U.S. Department of Health and Human Services to define as pediatric health care not only enumerated services but "other medical services as required by regulations prescribed by the Secretary after consultation with...appropriate medical organizations involved in child health care." The open-ended possibility of

adding required benefits by future regulations would further complicate the task of setting a reasonable premium.

Moreover, the proposal would require consultation only with organizations and professional societies that would stand to benefit financially by mandated reimbursement for their services. There is no provision for similar consultation with the insurers, employers or unions who will have to pay for the services.

The HIAA and the ACLI by no means oppose preventive health care. On the contrary, we applaud and support the growing trend toward employer-provided wellness and fitness programs. In 1984, the HIAA set up a nationwide "wellness at the worksite" program including the establishment of wellness councils in cities throughout the U.S. These councils are made up of local employers and insurance companies which seek to promote wellness programs for their employees. Our goal is to encourage healthy living and physical fitness as a means to fighting the rising cost of medical care.

In summary, although the HIAA, the ACLI, and their member companies appreciate Senator Chafee's good intentions in trying to provide preventive protection to young children, we urge that S. 376 and related federally mandated benefits be abandoned in favor of health care cost containment and consumer choice.

STATEMENT OF

METROPOLITAN LIFE INSURANCE COMPANY

ON

S.376

THE CHILD HEALTH INITIATIVES REFORM PLAN

PRESENTED TO

COMMITTEE ON FINANCE

SUBCOMMITTEE ON TAXATION AND DEBT MANAGEMENT

UNITED STATES SENATE

JULY 15, 1985

Metropolitan Life and its affiliated companies provide a broad range of insurance investment products and services throughout the United States. The Company is a leader in providing health insurance protection, underwriting and administering the health benefit programs of more than 18 million Americans. We number among our many group policyholders 68 of the Fortune 100 companies. Because of our day-to-day dealings with a wide range of businesses, we are keenly aware of employers' growing concern that the rising costs of their employee benefit programs threaten their profitability and ability to compete in world markets.

Consequently, we have concentrated on developing effective medical cost containment programs. Our Met-Elect preferred provider arrangements are being expanded nationwide. Met-Review provides our customers with hospital preadmission certification and concurrent hospital utilization review. We created Health Care Help Line, an advisory service provided by health care professionals, to aid employees in making efficient use of medical resources. In these and other activities, the emphasis has been on restraining costs and using the limited funds available for employee benefit programs most effectively. We believe that S.376 moves in the opposite direction.

S.376, "Child Health Initiatives Reform Plan," is a well-meaning, but unsatisfactory proposal. It is well-meaning in that it is based on concern about the health and welfare of

this country's next generation. It is unsatisfactory because the mechanism chosen for achieving its objective, loss of deductibility from income taxes of expenses associated with a group health plan for those employers not complying, attempts to coerce employers into providing a benefit which may not be wanted, or needed, by most employed individuals. Furthermore, it sets a bad precedent for federal involvement in an area of insurance regulation that has heretofore been left to the states.

Concerns with this proposal can be broadly categorized into two areas. First, there are conceptual problems with this type of regulatory approach. Second, there are specific questions regarding the ambiguities of the proposed bill.

Conceptual Problems With S.376

1. Under the McCarran/Ferguson Act, the federal government delegated to the states the responsibility for regulating the business of insurance. Broadly exercising this authority, a number of states have begun to mandate the provision of certain benefits under health insurance policies. Should the federal government now enter the arena of mandated benefits, it will preempt a state prerogative. Further, states have developed extensive regulatory mechanisms to oversee the

business of insurance. Federal legislation to mandate benefits would require establishment of another, duplicative enforcement system.

2. The proposed bill interferes with the collective bargaining process. Employers and labor-management trust funds have finite resources available to purchase employee benefits. To the extent that any health care benefits are mandated by the government, some dollars must be diverted to pay for those benefits. These benefits may not be ones that are desired by the bargaining unit or employer, thus forcing them to purchase an unwanted benefit at the expense of a desired benefit or a pay raise.

3. Coverage for well-baby care and child preventive health services is already available from many commercial insurance companies, without mandatory legislation. The fact that relatively few groups purchase the coverage indicates that it is not regarded as essential for employed groups.

4. Most working class families can budget for the cost of well-baby care and child preventive health services. Individual services are not expensive, and they are predictable. A basic tenet of insurance is that an event should be insured against only if it is unpredictable from

the point of view of the individual and potentially financially catastrophic. Well-baby and child preventive health care are neither.

5. Many of the infants and children in American society who do not obtain immunizations, well-baby care, and child preventive health services are members of families that are near or below the poverty level. As members of these families seldom have full-time employment and, even less frequently, access to comprehensive group coverage when they are employed, the most vulnerable segment of the country's infant and young child population will not be reached by this proposal. More appropriate would be an expansion of maternal and child health programs, Medicaid programs, and other federal, state and local public health programs to reach this disadvantaged group.

6. The mandating of this benefit would set a precedent. Other special interest groups would be encouraged to attempt to have coverage for the services they provide, or facilities they own or manage, covered under group health benefit plans, using the same mechanism as proposed in S.376.

7. A proliferation of mandated benefit laws similar to S.376 might cause small, marginally profitable employers to drop what group health coverage they currently provide.

Specific Concerns With S.376

1. The preventive services set forth in the bill require specification for pricing and claim adjudication purposes. Benefits are described in broad general terms (e.g. "appropriate" laboratory procedures) and there are no apparent limits on the frequency with which the services could be provided. This lack of specificity would make it impossible for an actuary to determine an appropriate premium.

2. The proposal does not provide any guidance for incorporating copayments, deductibles or other standard cost-sharing features. This could lead to wide disparities in the value of the coverage if some plans had low or no cost-sharing provisions while others required substantial cost sharing.

3. The proposed bill calls for the Secretary to define as pediatric health care not only enumerated services but "...other medical services as required by regulations prescribed by the Secretary after consultation with...appropriate medical organizations involved in child health care." The open-ended possibility of adding required benefits by future regulations would further complicate the task of setting a reasonable premium. Moreover, the proposal

requires consultation only with organizations and professional societies which would stand to benefit financially by mandated reimbursement for their services. There is no provision for similar consultation with the insurers, employers or unions who will have to pay for the services.

A Final Problem

It has been stated that this coverage would cost, at most, $2.28 per month per employee. Further, it has been implied that this figure was developed by, or with the assistance of, Metropolitan Life Insurance Company actuaries. These statements are misleading.

A Metropolitan actuary did meet once with a consultant engaged by the American Academy of Pediatrics and provided rough worksheets showing an estimated distribution by age of dependent children of employees of a single large national employer. Using cost data provided by the consultant, aggregate costs of providing a clearly defined list of specified services per age bracket were calculated, and then aggregate costs per month per employee were developed.

It was pointed out in the letter of transmittal that this was "our first attempt at such a cost and hopefully we can go back and forth on this until the package is sufficiently refined."

Three adjustments were suggested in the transmittal letter, which stated, "we can discuss these points and whatever else you wish after your review of this material." There was no further discussion with the consultant regarding either the concepts underlying the calculation or the numbers.

On June 22, 1983, the president of the American Academy of Pediatrics, James E. Strain, M.D., testified before the Senate Finance Committee that an actuary engaged by the Academy worked with "actuaries from the Metropolitan Life Insurance Company to develop a model for estimating premiums." The implication was that Metropolitan participated in developing the estimate that the monthly premium per employee for a well-child care package would be $2.28. This is incorrect. Metropolitan does not know how the figure was derived. In the opinion of our actuaries, the figure is unrealistically low for the set of benefits intended to be priced.

Moreover, it is incorrect to refer to the amount as a premium. Data in the worksheets related only to the cost of providing services, i.e. the claims costs. Premiums would include amounts to cover additional costs such as premium taxes, risk charges and reserve factors, and marketing and administrative costs.

Finally, pure claim costs can be expected to vary, depending upon whether the group is in a high cost or low cost area, and whether there are few or many dependent children involved.

The RockefellerGroup

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September 19, 1985

The Honorable John H. Chafee
Senate Office Building
Washington, D.C. 20510

Dear Senator Chafee:

During the September 16, 1985 hearing regarding Senate Bill 376 introduced by you I attempted to discuss our current third party payment methodology. Unfortunately you curtailed my testimony and drew an erroneous conclusion. I would like to complete my statement for your information.

"Primary care physicians including pediatricians who were the second lowest paid group among 18 specialties surveyed in the most recent issue of Medical Economics, are significantly disadvantaged by our current reimbursement mechanisms. By this I mean that those physicians who are not procedure oriented; including the internist, the family practice physician, the general practitioner, and the pediatrician; bill largely for their time, which is related to their ability to counsel their patients and diagnose their problems. This is done largely without expensive procedures and other services. Surgeons, on the other hand, bill for procedures. These procedures often involve significant additional expenses associated with the hospital. Perhaps a more appropriate way of dealing with the overall problem associated with pediatric care is to develop a mechanism to compensate all primary care physicians for their cognitive services on a basis that creates a more reasonable parity with the more procedure oriented physician. While I am not recommending this, it is an idea that has been aired by The American Society of Internal Medicine in recent white papers and discussed openly in the medical community. I believe that it might be time to take this debate to the public and private sector payor for full consideration. This may be a more efficacious approach than mandating additional benefits which would not in all likelihood achieve the desired result." (This was to be the end of my statement)

In my public role as a business representative in various health care groups, I have repeatedly stated that I do not view physicians' fees, except for occasional abusive excesses, as being a problem. The most effective health care cost management can be achieved by the physician who is compensated for his time, energy and talent in dealing with the patient as a manageable case and is paid for doing so.

Our current reimbursement system does not reward the physician who truly practices cognitive medicine. The amount of uncompensated time for telephone consultations and for longer than normal office visits is not usually recognized. Several years ago Dr. Warren Tingley of Arlington, Texas, a fellow of The American Society of Internal Medicine, made me aware of the issue of cognitive reimbursement, since then I have spent a significant amount of my time and energy asking my private sector colleagues to help me think about ways in which we can deal with this problem. I would suggest that productive efforts at dealing with the intent of S376, as well as other problems related to health care cost management, could be addressed by developing the reimbursement mechanisms that would encourage the physician to act as a manager, as most primary care physicians already do, and get paid for it. I would look forward to working with you and your colleagues in thinking through the options and opportunities available to the medical community which might be presented to both the third party payors of the private sector and the public sector for their consideration. I sincerely regret the unwarranted conclusion that you reached during the hearings on Monday.

Sincerely,

Steven N. Schrenzel
Director, Corporate Benefits

SNS/cb

TESTIMONY OF

RICHARD L. DAVID

CHAIRMAN OF THE BOARD

TOKOS MEDICAL CORPORATION

BEFORE

THE UNITED STATES SENATE FINANCE COMMITTEE

ON

S. 376

SEPTEMBER 27, 1985

Mr. Chairman, thank you for the opportunity to appear before your subcommittee. I am Richard C. David, Chairman of the Board of Tokos Medical Corporation, Santa Ana, California.

We have reviewed the bill introduced by Senator Chafee which would amend the Internal Revenue Code of 1954 to deny an employer a deduction for group health plan expenses unless such plan includes coverage for pediatric preventative health care. This proposal has our full support, however, one aspect of child health care has been overlooked and we urge the committee to consider expanding the bill to include perinatal as well as pediatric health care.

The future well-being of this nation's children is determined even before they are born; determined by the health of the mother and the access she has to perinatal care throughout her pregnancy. Our organization is particularly concerned about preterm birth and the consequences it presents to the infant and to society.

About 7% of the 3.5 million babies born in this country each year weigh less than five and one half pounds. These babies are nearly 40 times more likely to die during their first month of life than babies born full-term - 5 times more likely to die during their first year. In fact, low birthweight babies account for more than two-thirds of the 23,000+ neonatal deaths that occur each year in the U.S. As a result of significant progress in science and technology, neonatal care is helping reduce the

mortality rate associated with preterm birth. Nevertheless, the U.S. has more low birthweight deliveries and greater infant mortality rates than at least 12 other developed countries.

For the survivors of preterm birth, the potential for suffering long term handicaps is extremely high. The smaller a child is at birth, the more prone they are to suffer cerebral palsy, seizures, blindness, chronic lung disease, coronary disease, hearing loss and learning disabilities. While the neonatal death rate is declining, the number of low birthweight babies born each year is increasing with no significant decline in morbidity rates.

The cost of treating these babies in intensive care units alone is $2 billion per year. The average stay in these units (which for a baby under three pounds may be longer than 3 months) can range from $30,000 to $250,000. The cost for a lifetime of care for these children is impossible to calculate but it is safe to say that it represents one of the greatest social and economic burdens we bear.

The Institute of Medicine completed an extensive study on low birthweight babies and the escalating need for prevention. They stated: "Efforts to reduce the nation's incidence of low birthweight must include a commitment to enrolling all pregnant women in prenatal care. Many of the women who now receive inadequate prenatal care are those at greater than average risk of a low birthweight delivery. Moreover, participation in a

system of prenatal care is a prerequisite for many individual interventions that help reduce the risk of low birthweight."

In reaching their conclusions, the Institute of Medicine's committee reviewed data documenting the effectiveness of prenatal care and concluded that an overwhelming weight of evidence indicates that prenatal care reduces low birthweight and that the effect is greatest among high-risk women. This finding "is strong enough to support a broad national commitment to ensuring that all pregnant women, especially those at socioeconomic or medical risk, receive high-quality prenatal care." The committee further reported that "National, state and local data indicate that the proportion of mothers beginning prenatal care in the first trimester increased steadily from 1969 until 1980, but that this trend has leveled off or possibly reversed since 1981...The committee views with deep concern the possibility that the nation's progress in extending prenatal benefits to all women has been disrupted."

This report from the committee went on to outline the principal barriers to early and regular prenatal care. Foremost in their conclusion was financial constraints. They stated: "These may result from absent or inadequate private insurance to cover prenatal care, lack of funds through public sources for prenatal care, lack of support for public agencies that provide maternity services. Support of the Medicaid program, which helps finance care for many high-risk women, should be part of a

comprehensive effort to reduce the nation's incidence of low birthweight. The Health Care Financing Administration, in collaboration with the Division of Maternal and Child Health, should establish a set of generous eligibility standards that maximize the possibility that poor women will qualify for Medicaid coverage and thus be able to obtain prenatal care."

To develop a functioning system of responsibility and accountability, the committee recommended that the Secretary of the Department of Health and Human Services convene a task force that would define a system for making prenatal services available to all pregnant women. The task force would determine (1) how to improve the capacity of state and national data systems to assess unmet need for prenatal services and (2) how to ensure that prenatal care is financed adequately in times of cost containment, when preventative services often lose the competition for dollars.

A considerable investment is currently being made in research dollars to develop resources for preventing preterm birth. Out of this research has come a promising approach for combining advanced monitoring devices with patient education and emotional support services. This combination of better methods for clinical intervention of preterm labor in its early stages and extended perinatal care is leading to greatly improved opportunities for healthy, full-term babies.

The vast majority of preterm births occur because diagnosis of preterm labor could not be made in time for the patient to be a candidate for intervention. Unless therapy is initiated during the early stages of labor, it is either not possible or not recommended that intervention take place. Physicians are now able to utilize an ambulatory uterine activity monitoring device which aids in the early detection of preterm labor. When this monitoring is conducted on a daily basis with women who have been identified as being at high risk of preterm delivery, physicians can detect the increased uterine activity which may indicate the early stages of preterm labor. Daily monitoring is also an opportunity for providing these high-risk mothers with the encouragement and support that can lead to improved emotional and physical well-being.

Participation in prenatal care programs is associated with a reduced incidence of low birthweight as demonstrated in the report by the Institute of Medicine. We believe that a concentrated effort among the public and private sector and the medical community can lead to extremely effective programs. We strongly encourage the Committee on Finance to support legislative measures which will increase access to prenatal and perinatal care, particularly those care programs which seek to prevent catastrophic outcome for our nation's children.

We appreciate the opportunity to endorse the proposal S.376 and express our concern for improved accessibility to prenatal/ perinatal prevention programs.

REFERENCES

"Preventing Low Birthweight" Committee to Study the Prevention of Low Birthweight, Division of Health Promotion and Disease Prevention, Institute of Medicine, National Academy Press, 2101 Constitution Ave., Washington, DC 20418

World Health Organization: Report on the Second Session of the Expert Committee on Health Statistics. Technical Report Series, No. 25. Geneva: World Health Organization.

Van den Berg BJ and Yerushalmy J: The relationship of intrauterine growth of infants of low birthweight to mortality, morbidity and congenital anomalies. J. Pediatr. 69:531-545, 1966.

Wilcox AJ and Russell IT: Birthweight distribution and perinatal mortality. On the frequency distribution of birthweight. Int. J. Epidemiol. 12:314-318, 1983.

Puffer RR and Serrano CV: Patterns of MOrtality in Childhood, Washington, D.C.: Pan American Health Organization, 1983.

Schlesinger ER: Neonatal intesnive care: Planning for services and outcome following care. J. Pediatr. 82:916-920, 1973.

Backet EM, Davies AM, and Petros-Barvazian A: The Risk Approach in Health Care: With Special Reference to Maternal and Child Health, Public Health Papers, No. 76. Geneva: World Health Organization, 1984.

Select Panel for the Promotion of Child Health: Analysis and Recommendations for Selected Federal Programs. Better Health for Our Children: A National Strategy. Vol. II. DHHS No. 79-55071. Public Health Service. Washington, D.C.: U.S. Government Printing Office, 1981.

PROGRAMS FOR TWO PARENT UNEMPLOYED HOUSEHOLDS WITH DEPENDENT CHILDREN UTAH'S EXPERIENCES

TESTIMONY PREPARED FOR:

UNITED STATES CONGRESS
SENATE COMMITTEE ON FINANCE

SEPTEMBER 1985

PRESENTED BY:

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Distinguished Senators of the Finance Committee, staff, and other concerned parties, it is a pleasure for me to address you on such an important topic. As Executive Director of the Utah State Department of Social Services I would like to share with you Utah's experiences in serving unemployed two-parent households with dependent children. These experiences represent three distinct approaches which have had dramatically divergent results in terms of benefits to families in need and in terms of costs to the State of Utah.

The first approach, initiated in 1961, was to establish an Aid to Families with Dependent Children - Unemployed Parent (AFDC-UP) Program with the intention of providing temporary assistance to two-parent households with dependent children who were unable to meet their family's needs due to unemployment. The AFDC-UP Program operated under the general guidelines of the regular AFDC Program providing a monthly grant based on family size. Recipients were required to participate in the Work Incentive Program (WIN).

Utah operated its AFDC-UP Program for two decades (1961-1981). Participation on the program fluctuated with the caseload reaching a high of 2312 families in March of 1981, the monthly average number of families served in its last year of operation was 2000. The grant cost of the AFDC-UP Program in fiscal year 1981 reached $10.5 million, an average cost of $4,500 per family.

In it's 1981 General Session, the Utah Legislature faced severe reductions in available state revenue and was confronted with the necessity for decreasing expenditures. The optional AFDC-UP Program became a prime target for reductions due to its sharply increasing enrollment and corresponding costs of operation. AFDC-UP did not move recipients expeditiously into the job market. While actual placement rates are not available, a Department survey conducted of recipients in 1981 revealed that 35 percent of recipients reported receiving no assistance in job search and that male recipients perceived that they had only a 58 percent chance of obtaining employment and women only 51 percent. Twenty percent of those surveyed reported doing nothing to secure a job.

By the close of its 1981 Session, the Legislature voted to discontinue the AFDC-UP Program effective on July 1, 1981. No alternative program or assistance was authorized for two-parent families.

The second Utah approach to serving unemployed two-parent households with dependent children then was to provide no assistance. This approach was in place from July 1981 to December 1982 and produced some dramatic and undesirable results for our State. Most notable among these results were a near doubling of the separation and divorce rate among previous AFDC-UP families (leading the majority to seek and become eligible for AFDC as a separated or divorced household) and an alarming incidence of reported unmet medical needs.

To illustrate, during the last year of operation it was found that 7.4 percent of AFDC-UP recipient families separated and came back on public assistance as deserted or divorced. In the six month period immediately following termination of the program, this rate rose to 13.6 percent or 195 of the 1439 terminated households. In a sample of 56 of terminated households, it was found that 36 percent were receiving AFDC; of the 64 percent not receiving AFDC, 30 percent reported incomes below $500 per month and 34 percent reported incomes above $500 per month.

When asked how their medical needs were met, 35 percent of terminated recipients reported public assistance or medicaid (usually covering children only) and 36 percent reported that their medical needs went unmet. The result in either case was that the State was to bear the burden either immediately through Medicaid or through the eventual financial impact of unattended medical needs.

Setting the stage for, and exacerbating these consequences was the recession of 1982. Utah was confronted with situations of blatant family hardship which no longer affected only adults but which now placed children on the streets as well. This situation is best examplified by legislative staff researcher Bryant Howe when he states, "Destitute families with children were sleeping in cars, under bridges, and in other temporary shelters. Some people came to Utah hoping to find work in coal mines, but no jobs were available. And many came to Salt Lake City area hoping to find something better.

The Salt Lake County Information and Referral Service reported having to refer families to blood banks for financial assistance." It was clear that the time had come to take action and to develop yet a third approach to serving unemployed, two-parent families.

Working from a conceptualization of Senator Bryce Flamm, then Chair of the Social Services and Health Appropriations Subcommittee, community groups and state Social Services officials entered into a collaborative effort with the State Legislature to design a program addressing the needs of these families within the constraints of limited state funding. The desired outcome was a time-limited, work-oriented program which would assist recipients to promptly enter the regular labor market. The result was the Emergency Work Program or EWP which was initially funded during a special session of the Legislature in December 1982 and began operation in January 1983. In October 1984, we were awarded a demonstration grant for two-years totalling $1.5 million from the Office of Family Assistance with the Department of Health and Human Services. The major goals established for EWP were to meet the basic financial and emergency needs of recipients while assisting them to find "regular" or unsubsidized jobs and to keep unemployed families from separating. These goals reiterate the philosophy of our State which places a high value on family stability and self-sufficiency.

The initial eligibility criteria for EWP parallels that of the national AFDC-UP Program--

- each adult in the household must have been unemployed for at least 30 days;
- the combined assets of households members may not exceed $1,000 excluding the value of the resident's personal and household goods; and
- countable income may not exceed the benefit levels.

That is where the similarity ends, however, and Utah's design for meeting its goals of family stability and placement in the job market takes over.

Performance requirements for EWP serve as the key differentiation. EWP participants must perform a minimum of 40 hours a week in some combination of community work, job search, skill training, adult education or community work experience. Most participants elect to complete community work for 32 hours a week and job search for 8 hours. Spouses must also be involved in job search unless exempted for good cause. Payments are bi-weekly and are made only after performance is verified to the Department. This verification comes to the Department from local JTPA agencies utilized as a manpower agency in administering the program. Payment levels are based on family size and are purposively set at a level which provides incentive to accept even a minimum wage job. Benefits are as follows:

Family Size	Weekly Benefit Level
1	$50
2	70
3-4	100
5+	110

Participants on EWP is limited to 6 months out of any 12 month period. Participants are eligible for Medicaid and Food Stamps and workmen's compensation is paid by the State.

EWP enrollment fluctuates with peaks in the winter months and dramatic reductions in the summer months when jobs are more available. An average of 225 families per month are served in winter and 100 families per month in summer. The average at any point in time is 165 families.

The key question remains, however, of how effective EWP has been in terms of assisting recipients to find employment, and in terms of cost to the State, and in terms of strengthening family stability.

An independent evaluation of the EWP is currently underway so the jury is still out. However, preliminary findings are dramatic and point to the fact that employment benefits can successfully be substituted for public assistance. (For your reference a copy of the preliminary report is attached.)

The following chart depicts findings on several key program characteristics:

PRELIMINARY FINDINGS

CHARACTERISTIC	AFDC-UP 1980-81	NO PROGRAM 1981-82	EWP 1981-85
Benefit Expenditures	$10,500,000	N/A	$450,000
Administrative Expenditures	$ 950,000	N/A	$ 70,000
Job Assistance Expenditures	$ 1,000,000	N/A	$ 80,000
Average Length of Stay on Program	10 months	N/A	9 weeks
Job Placement Rate	Not Available	N/A	70-78 percent
Average Wage Earned Upon Job Replacement	Not Available	N/A	$5.70
Divorce/Separation Rate	7.4 percent	13.6 percent	3.6 percent

The question which these preliminary results raises is, of course, why EWP is as effective as it now appears to be. The answer or answers to this question are vital to future policy decisions in Utah and to the decision you are faced with as it relates to the proposal to make the AFDC-UP Program mandatory in all 50 states.

In Utah we believe that two key components of EWP are at the base of its success. First is the 40 hour per week performance requirement which not only ensures training, education and job search but priorities gainful employment. This requirement which reinforces participant perceptions that they are supporting their family and not simply receiving public assistance. This perception is extended and further reinforced by the second vital component -- payment only after, performance. In essence what these two program requirements accomplish, in conjunction with the six-month time-limit for participation, is to set-up expectations for recipients. It is expected that they perform while on the program and it is expected that they obtain employment within a specified time period. It is our belief that people can accomplish what is expected of them. Without these expectations we are sure EWP would not be successful; with them we are confident it will continue to meet the policy priorities of the State and the self-sufficiency needs of the families it serves.

We do not maintain, that Utah's EWP would be successful in all other states - it works for Utah because it was designed by Utah to meet Utah objectives. Other states which have operated successful work programs have done so because they have tailored them to their specific needs. We believe that state flexibility in establishing employment related requirements is the overall key to operating a successful assistance program. In the May 1985 issue of the Council of State Governments Innovations, Utah's EWP and other successful state work programs were reviewed, the publication concluded that "... the states have carefully developed their own alternatives with innovative ideas aiming at particular targets in their states. Some components of these programs can be transferred to other states, but it might not be realistic to recommend one particular welfare employment program to all the states without regard to their socio-economic diversities."

Utah urges the Finance Committee to provide for state flexibility by allowing or employment oriented alternatives to the AFDC-UP Program. While we understand the desire to assure that all states assist unemployed two-parent families in some way, we cannot emphasize too strongly that this can be most effectively and efficiently accomplished by allowing states the latitude of developing a program which will address their individual problems and needs. Specifically, I would recommend the following language be added to section 407, "Dependent Children of Unemployed Parents," of the Social Security Act"

> State may modify requirements under this Act to enhance the employment and family stability of unemployed families who qualify for assistance.

Thank you for the opportunity to share Utah's experience with you.

PRELIMINARY COMPARISONS BETWEEN UTAH'S EMERGENCY WORK PROGRAM, NO PROGRAM, AND THE DEFUNCT AFDC-UP

August 9, 1985

INDEPENDENT EVALUATION OF THE UTAH COMMUNITY WORK DEMONSTRATION PROJECT
(Emergency Work Program)

by

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II. AN INDEPENDENT EVALUATION

The independent evaluation of the EWP has been contracted and is being conducted by the Social Research Institute (SRI) at the University of Utah. The purpose of SRI's independent evaluation is to establish answers to congressional questions as to whether modified workfare programs such as the EWP are effective in meeting key state objectives. These objectives include:

A. an increase in family stability and unity by providing an alternative method for locating financial assistance other than separation or divorce;

B. an increase in financial solvency on the part of the program participant;

C. an increase in paid employment history of participants;

D. a decrease in barriers to employment; and

E. an increase in economic return or benefit to the community from public assistance funds through payments contingent upon community work and job search.

The scope of the comprehensive evaluation approach is multi- methodical in that the evaluation encompasses a quasi-experimental, pretest/post-test/follow-up design (i.e., a panel survey) and a cost/benefit-cost/effectiveness analysis of the EWP in comparison to Utah's defunct AFDC-UP program and a "No Program" control group. In addition to impact assessment, the Social Research Institute's comprehensive evaluation includes the design and monitoring evaluation phases.

A. The Panel Survey. The panel survey of approximately 390 Emergency Work Program participants has been designed (including both six-month and no limit control sites) to measure household demographics, histories of financial assistance, employment and skills, work barriers, clients' attitudes toward the EWP, self-esteem, and family cohesiveness/adaptability within a time-series framework.

The time series design includes three interview schedules: an Intake Interview Schedule, a Termination Interview Schedule, and a Three Month Follow-up Interview Schedule. There is also a fourth schedule (Approved Non-Participant Interview Schedule). This schedule is designed to measure characteristics and differences between those enrollees approved to participate and subsequently decline, versus those enrollees who were approved and participated in the EWP.

Table 1 indicates the sites chosen to represent the statewide functioning of the EWP. As can be seen, the comprehensive evaluation will also take into account any rural-urban distinctions of the program's impact.

Table 1: Locational Sites of the EWP's Purposive Sample
N = 390*

District	County	Sampled Cities	Number of Participants
1	Cache	Logan**	25
1	Rich	Brigham City**	25
2A	Weber-Morgan	Ogden**	60
2B	Salt Lake	Salt Lake City	30
2K	Salt Lake	Kearns	30
2N	Salt Lake	Salt Lake City	30
2S	Salt Lake	Midvale	30
3	Utah	Provo	25
5	Iron/	Cedar City	
5	Washington	St. George	25
7	Carbon	Price	110

* Taking into account a 10% attrition rate.
** Control (no six month limit) sites.

B. The Hypotheses. In accordance with our comprehensive evaluation design, we anticipate an accurate testing of four major hypotheses. These include:

1. The total cost of the Emergency Work Program is about one-tenth of the cost of the regular AFDC-UP program, given similar initial eligibility requirements.

2. The benefits of the Emergency Work Program are about equal to the benefits of the AFDC-UP program and meet the critical needs of two-parent families. These benefits are: assisting families to stay together, meeting critically-immediate financial needs, and assisting participants in securing employment in the regular labor market.

3. The Emergency Work Program requirements are effective in maintaining and enhancing enrollee participation in the labor market. This requirement is primarily responsible for the reduction in community cost without an equal reduction in benefits.

4. The six-month limit on assistance reinforces participation in the regular labor market and thus reduces program enrollment and cost.

III. UTAH'S EMERGENCY WORK PROGRAM

A. History. During the past two years, Utah has operated the Emergency Work Program as a possible cost effective alternative to the optional AFDC-UP program. The EWP was established by the Utah State Legislature in January 1983. This demonstration project has provided short term financial assistance to two-parent households with dependent children. Key features of the EWP are limiting assistance to six months, requiring work standards which include 32 hours a week of community work and eight hours a week of job search, paying only after the household meets the work standards, and paying an amount designed to ensure a financial incentive for taking a minimum wage job.

B. EWP Preliminary Analysis and Results. It is believed that features such as program costs, length of stay, number of participants, status of terminated participants, the impact of the six-month limit, and participant services have reinforced and motivated EWP participants in working and participating in the regular labor market. Preliminary results suggest the following:

1. EWP project costs are significantly less than the AFDC-UP program.

2. The EWP project has tended to meet the critical or, immediate financial, family support, and employment needs of eligible two-parent households. The benefits to EWP participants appear to approximate those benefits of AFDC-UP recipients.

3. EWP requirements maintain and enhance enrollee participation in the regular labor market.

4. The EWP project tends to demonstrate that a six month limit on assistance may contribute to reducing program enrollment and costs by reinforcing the need for participants to secure regular employment. The effects on participants of a six month limit on assistance are minimized by work, training, and the job search assistance provided to them.

C. Implications. We believe based on preliminary analyses of Utah's EWP that the results will be significant enough to encourage further congressional action on a national basis. If congressional latitude is provided, we project significant cost savings and benefits to those states with or without an AFDC-UP program. In fact, we believe that states currently exercising the AFDC-UP option could, by adopting the EWP standards, achieve an 80 to 90 percent reduction in costs with equivalent benefits. While only a few of the states may initially adopt a similar program which includes all components of Utah's EWP, we expect that many states would adopt one or more of the program components such as the assistance time limit. For states without the AFDC-UP program, the EWP represents a new method for meeting the needs of two-parent families without the costs associated with the present AFDC-UP optional program. Already, Utah has been approached by a number of AFDC-UP and non AFDC-UP states asking about the results of the EWP.

The following are preliminary results based on the first 155 intake interview schedules conducted on EWP two-parent households. Variables to be discussed include basic client characteristics, residency, family stability, prior cash and in-kind assistance histories, work and skill history, activities and barriers finding work, client attitudes of the program, and standardized scale results of self-esteem.

D. Client characteristics. The following data show the mean ages and level of education for the participant and spouse and the mean household size. The participant refers to the household member performing the 40 hours per week program requirement. Normally, but not always, the participant is a male. The family, in agreement with the manpower agency chooses the family member who will be the primary participant.

AGE	Mean	S.D.
Participant	29.0	7.4
Spouse	26.9	7.3
EDUCATION (in years)	**Mean**	**S.D.**
Participant	10.9	2.5
Spouse	11.5	2.7
HOUSEHOLD SIZE		
Number	4.45	1.4

Ethnicity. Typical of Utah, the 155 cases were composed predominantly of caucasians. The following information displays the ethnic breakdown of the EWP participants in comparison with the Utah population (1985):

Ethnicity	No.	Percent	Utah Pop. (1985) Percent
Alaskan/American Indian	7	4.5%	1.2
Asian/Pac. Isl .	5	3.1%	1.8
Black	4	2.6%	0.6
Hispanic	26	16.8%	4.0
White	113	72.9%	92.4
TOTAL:	155	100.0%	100.0

Residency and housing. Of the sample, 66 or 42.6% were lifetime Utah residents while 89 or 57.4% were not. Those that were not lifetime residents of Utah had resided continuously in Utah for an average of 25.5 months. Home arrangements are as follows:

Housing Arrangement	No.	Percent
Own or Buying Home	10	6.4%
Renting	119	76.8%
Living with Friends/Relatives	24	15.5%
Shelter	2	1.3%
TOTAL:	155	100.0%

Marital stability. As for marital stability, 23.9% (N = 37) of the 155 families surveyed had experienced separation or divorce from their current spouse. Seventeen, or 46% of these stated that the separation or divorce was "work related."

Prior assistance history. The following presents the number of EWP participants who had or had not utilized public assistance programs in the past as verified by client histories found in the APA's computer system. Verification of assistance in Utah was made possible by the use of an APA screen.

Assistance Program Participant had or had not Utilized in the Past	Yes	No	Total
AFDC-UP	29 18.7%	126 83.2%	155 100.0%
EWP (prior)	36 23.2%	119 76.8%	155 100.0%
State Stepchild	4 2.6%	151 97.4%	155 100.0%
Medical Assistance	89 57.4%	66 42.6%	155 100.0%
AFDC	28 18.1%	127 81.9%	155 100.0%
General Assistance	57 36.8%	98 63.2%	155 100.0%
Food Stamps	106 68.4%	49 31.6%	155 100.0%

Work and skill history. When the participant was asked what his/her job title for the most recent job was, the most common job responses were as auto mechanic, assembler, truck driver, and laborer. Of those reporting employment, the median months employed in this job was 5.4 months, with a median income of $4.55 an hour.

As for the spouse, the most common jobs held were as cashiers, cleaners, personal services, maids, and food service workers. The median months employed was 11.9 months at an income of $4.00 an hour.

Work finding activities. As a requirement of the EWP, participants are required to search for jobs. Typically, this is for at least eight hours a week. The primary manner in which participants searched for jobs was as follows:

Technique of Searching	No.	Percent
job searching door to door	71	45.8
putting in applications	17	10.9
public job service	15	9.2
newspapers	13	8.7
job search training	9	5.8
asking friends/relatives	5	3.2
other	25	16.1
TOTAL:	155	100.0

Work barriers. The reasons given as barriers to finding employment were varied. The most common reasons included physical problems, no work available, no one was hiring, lacks education or skills, and transportation. On a scale of 1 (small problem) to 5 (large problem), participants with actual or perceived work barriers rated the problem, on the average, at 2.3. The modal response was 1.0 with 81 persons responding.

Client assessment and suggestions. Inquiring about client opinions regarding attainment of the program's major objectives, the 155 intake surveys pointed toward strong positive attitudes. The three major program objectives include: (1) meeting participants' immediate financial needs, (2) assisting family unity, and (3) assisting participants get back into the regular labor market. When asked whether or not the program was doing 1, 2, or 3 above, clients responded as follows:

Objective	Yes	No	Don't Know	Total
Financial assistance	106	47	2	155
	68.4%	30.3%	1.3%	100.0%
Family unity	111	41	3	155
	71.6%	26.5%	1.9%	100.0%
Employment	107	43	5	155
	69.0%	27.7%	3.2%	100.0%

Clearly, EWP participants perceive that the program is going to help in regard to its major program objectives. In fact, on a scale of 1 (low) to 5 (high), participants perceive their employability on the average at 3.3 (S.D. = 1.4). Interviewers closely rated participant's employability on the average of 3.23 (S.D. = 1.2).

Various suggestions were given by program participants on how to improve the Emergency Work Program, namely:

1. Increase grant amount to reflect at least minimum wage, or family needs.
2. Increase job search time to include more than one day.
3. Allow extra community work for extra money.
4. Provide job counseling.
5. Provide mental counseling.
6. Extend participation period (relax or omit the 6-month time limit).
7. Provide bus passes.
8. Provide better community work experiences which teach new skills.
9. Provide more skills training.
10. Better coordination between manpower agency and job service (i.e., provide more referrals).

Index of self-esteem. Employing Hudson's Index of Self-esteem to provide information on client's self image, the scale measured wide variation on how clients saw themselves. Hudson recommends that a score of 30 or more be used as a cutting point as to whether the person needs clinical counseling. Based on the 155 intake surveys, 65 clients scored less than 30, while 85 clients scored above 30. The median score overall was 32.3, which indicates that being unemployed is associated with low self-esteem.

Recommendations, based on the independent evaluator's results, will not be made at this time until further research can be done.

E. Termination Results

The results of this section are based on 76 manpower notifications of client termination. Of these 76 terminations, the following shows the breakdown of survey participants:

	No.	Percent
Completed Interviews	56	73.7%
No Show (for Interview)	3	3.9%
Moved Out of Area	6	7.9%
Could Not Locate	11	14.5%
TOTAL:	76	100.0%

Clients that could not be located or that have moved (a total of 22.4%) may re-enter the panel survey if pertinent information can be obtained through APA follow-up. The following results are based on the 56 completed interviews. Termination results that are discussed include changes in marital status, problems with basic needs, client's reason for termination, work status, salary level, current public assistance, client attitudes of the program objectives, and suggestions by clients of how to improve the program.

Marital status. Since the relationship between marital status and public assistance will be discussed more fully in the forthcoming Interim Report, it shall suffice to report that only 3.6% (2 of 56) of our sample experienced marital separation. Current evidence suggests that the EWP is assisting families to stay together. Further, 35 of 56 (62.5% of the participants) responded positively to whether or not the program assisted family unity. Of the remaining 21 clients, the modal response to the follow-up question "How so?" was that the couple would have stayed together anyhow.

Basic needs. According to the State of Utah's need standards, basic needs include food, clothing, housing/shelter, utilities, transportation, house furnishings, recreation, education, personal care items, and nonprescription drugs. Preliminary results show that near 60% of former EWP clients are having basic needs problems. Needs most commonly cited as a problem were food (28.6%), shelter (19.6%), transportation (17.8%), medical (26.8%), and utilities (8.9%). Those reporting no basic needs problem constituted 37.5% thus far surveyed.

Reason for termination. The most common reason for terminating participation by EWP clients was because they found employment. Indeed, 78% had found work. (Further analysis will be conducted on the salary and employment levels of terminated clients.) Between the time of termination and being interviewed, six had become unemployed. Other reasons for termination were eligibility for other programs, failure to comply with EWP requirements and client's request to terminate.

Work status, salary and assistance. Of the 56 families surveyed to date, 78.6% had at least one adult member working. The average income of the 44 families working was $5.70/per hour (S.D. = 2.64), or a median of $5.00 per hour. Surprisingly, only eight reported earning less than $4.00 per hour. Not surprisingly, families earning near minimum wage tend to receive in-kind assistance, while those families earning significantly more were off all assistance. Further analysis on salary levels, family size, and assistance will be presented in the next report.

Client attitudes and suggestions. Table 3.1 shows positive and negative responses to the inquiries of the program's objectives. In short, the three major program objectives are to meet families' immediate financial needs, assist family unity and to get the families off welfare and into the regular labor market.

Table 3.1

Client Attitudes Toward Program Objectives

Did EWP help you:	Yes	No	Don't Know	Total
Meet immediate financial needs?	44	12	0	56
	78.6	21.4	0.0	100.0
Keep the family together?	35	21	0	56
	62.5	37.5	0.0	100.0
Secure employment?	16	28	12	56
	28.6	50.0	21.4	100.0

Clients responded in a generally positive manner in that they perceived the program helped meet their immediate financial needs as well as kept their families together. On the other hand, 50% responded that the program had little positive influence on helping them secure employment. This finding may be the result of the program's design since participants are expected to find employment on their own.

Suggestions given by clients after program termination to improve the program cluster around two factors. These are personal, and functional/procedural factors. Personal suggestions included better communication and understanding from the manpower agency handling their community work, honesty, and guaranteeing a job. Functional or procedural suggestions were diverse and sometimes quite insightful. Some of the suggestions included:

1. Grants should be based on family needs.
2. Grants should be at a minimum wage rate.
3. Better coordination between EWP and Job Services (more referrals).
4. More than one day to job search.
5. Personal as well as job counseling.
6. Provide extra work for additional money.
7. Remove 6-month limit.
8. Provide public transportation passes.
9. Provide more skill training.

F. Manpower Agency Data

The following information and results were made possible by the assistance of each district's manpower agency. The data collected came from individual case records and payment history reports (operative report 13236B). This data was collected to supplement the survey data. While the survey has more extensive follow-up data, manpower agencies collected other pertinent process measures. These variables include length of stay, payment amount, community work site, official reason for termination, and limited follow-up information such as whether the client is working, job title, and income earnings. With this additional information, cross checking and verification is made possible.

Based on the same 76 terminations reported in the prior section, the average length of program participation was 44.3 days or roughly two months (with a S.D. = 28.8). Average total payments made to the 76 clients was $741.30. From this the average daily wage for eight hours of work or job search was $16.73 or $2.09 per hour.

Participants' program activities in one component or another included:

Component	No.	Percent
Community Work/Job Search		
Public Agency	64	84.2
Nonprofit Organization	4	5.3
Skills Training	3	3.9
Adult Education	0	0.0
Job Search (only)	2	2.6
Never Assigned	3	3.9
TOTAL:	76	100.0

As can be readily seen the major program components used were community work in a public agency and job search. The effect of each component will not be presented here, but will be reported later.

The official reason for termination by the district manpower agency were similar to the survey results. Finding employment tends to be the most significant reason for termination. It is reported that 71.1% (54) were terminated for this reason. Other reasons include:

Reasons for Termination	No.
Eligible for Another Assistance Program	6
Nonperformance	6
Relocated	1
Mandatory Graduation	0
Illegal Behavior	2
Client's Request	6
Found Ineligible	1

Again, similar to survey results in regard to employment, manpower agencies reported 73.7% of the 76 clients to be working at unsubsidized jobs. The average salary was estimated at $5.25/hour (S.D. = 2.32). The most typical type of jobs clients found were custodial, production, laborer, construction, clerical and service.

G. State and District Caseloads

Figure 3.1 shows the number of families on the Emergency Work Program by district and biweekly periods from July 28, 1984 to June 28, 1985 (see Attachment 1). The heaviest program participation occurred between November, 1984 and April, 1985. Indeed, the biweekly period of March 23, 1985 to April 5, 1985 marked an apex for family case loads with 143 families statewide. The lowest case load was experienced during the initially measured biweekly period with 24 families on the program statewide. During the 24 biweekly periods, the average number of families in Utah on the program was 81.62 (S.D. 34.8). The period with the largest increase occurred in March with a 30% increase. On the other hand, an extreme decrease was experienced in May with 106 clients at the beginning of the month and 39 clients at the end of the month--a 62.3% decrease.

As for district aggregates, three areas continue to draw more heavily on program resources than other areas of the state. These three areas include Ogden, Salt Lake City, and Price. The average family case load over the last year for the three areas are as follows:

Area	No.
Price	24.0
Ogden	14.6
Salt Lake City	17.2

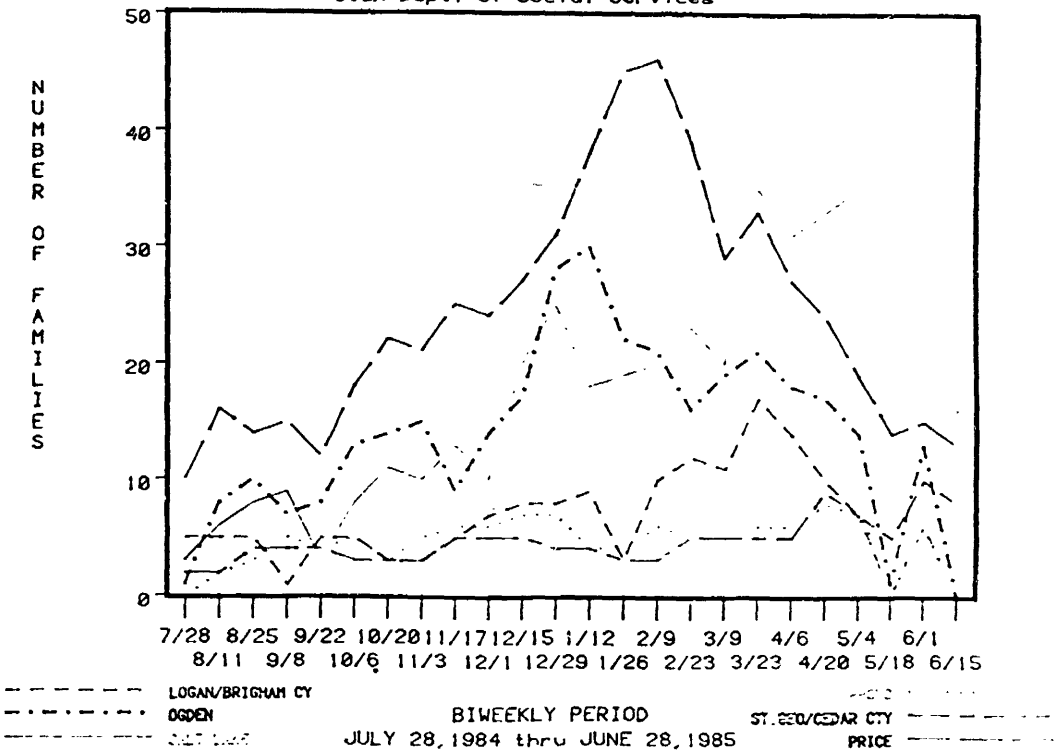
Noted earlier, the program hosts much fewer clients in Logan, Brigham City, Provo, and St. George.

The effect that unemployment rates have on EWP case loads indicate a moderately strong relationship. Unemployment rates were obtained through Employment Security's labor market information, while EWP figures were obtained through Utah's Department of Social Services. The correlation between the number of EWP families (F category) and unemployment rates (nonseasonally adjusted) during the period from August 1984 and June 1985 produced a coefficient r = .685. In other words, unemployment rates explained 46.9% of the variation of EWP family case load. Other significant variables will be included for presentation in the Interim Report.

Figure 3.1

NUMBER OF TWO-PARENT FAMILIES ON EWP
BY DISTRICT AND BIWEEKLY PERIODS

Utah Dept. of Social Services



IV. "NO PROGRAM" GROUP RESULTS OF NO FINANCIAL ASSISTANCE PERIOD

A major question arises as to what happens to people when public assistance is terminated and no financial assistance is available even though they previously qualified for assistance. More specifically, what happens if financial assistance for two-parent households with dependent children is terminated? What consequences are experienced by the households and the state? Do the households become motivated in finding employment, end up with nothing, break up, or apply for cash assistance as separated households? Does the state assume additional expense when no financial assistance program is offered to two-parent households?

To partially answer these questions, data collected from a survey of 56 Utah households representing long-term AFDC-UP participants terminated as a consequence of the optional program cut of July 1981 are presented and analyzed.

The 56 households analyzed were part of a larger sample surveyed by the Utah State Department of Social Services in November, 1980 (eight months prior to program termination). These 56 households who were terminated when the program was ended were then surveyed five months following the program termination of July 1, 1981. Our interest is in determining the effects program termination had on these households.

Client Characteristics. Of the 56 households sampled: the average number of family members was 4.8 (S.D. = 1.8). Other characteristics of the households include:

AGE	Mean	S.D.
Father's	31.7	9.7
Mother's	29.2	7.4
EDUCATION (in years)		
Father's	10.7	2.8
Mother's	11.2	1.8
HOUSEHOLD SIZE		
Number	4.8	1.8

Marital stability and receipt of regular AFDC. Five months after program termination, 13, or 23% of the 56 prior AFDC-UP households, had separated or divorced. Nine, or 16% of the households were receiving regular AFDC assistance as a separated or divorced household.

This finding is consistent with the findings from a comparative study of all households terminated from AFDC-UP as a result of the program elimination. Of 1,434 terminated households, 195, or 13.6% separated and were receiving regular AFDC assistance as a separated or divorced household six months after the program termination.

AFDC, Work and Income. Five months after program termination, 19, or 34% of the families were receiving AFDC. As reported above, 9, or 16% of the 56 households were receiving AFDC as a separated or divorced household. An

additional 10, or 18% were receiving AFDC assistance due to incapacity of one of the parents.

Excluding the AFDC families, 17, or 30.4% of the 56 families had an income of under $500 per month which is interpreted as either not working or employed only part-time. Some of the jobs reported were occasional car repair and metal scavenger.

The remaining 19, or 34% of the households had jobs paying $500 or more a month and were not receiving AFDC. Of the 56 cases, 27, or nearly 50% reported that no one was working. In summary:

Classification	No.	Percent
AFDC	19	34
Separation	(9)	
Incapacity	(10)	
Unemployed or underemployed (income under $500/month)	17	30
Working (income over $500/month)	19	34

Assistance. The type and degree of state cash and in-kind assistance included:

Assistance	Frequency	Percentage
None	15	26.8
Some (includes Medicaid and/or food stamps)	22	39.3
All (includes AFDC, Medicaid and food stamps)	19	33.9
	N = 56	100.0

As expected, there is a strong association between marital status and type of assistance. As may be seen in Table 4.1,, 69.2% of the now nonmarried cases were eligible and received all types of assistance, while 23% of the married cases (those deemed incapacitated) received all assistance.

As for the employability of the sample five months after program termination, 13 of the 56 or 23.2% reported the man to be working. Eight families or 14.3% reported the woman to be working, while another 14.3% reporting both the man and the woman working. Nearly 50% or 27 families reported that no one was working.

Also, as expected the association between the type of assistance and which family member is working is moderately strong. This relationship is demonstrated in Table 4.2. As can be seen, where the man, woman or both are employed, state assistance is rather low. On the other hand, the group where no one was working, nearly 60% were receiving both cash and in-kind assistance and an additional 37% were receiving in-kind benefits only.

The median income for this sample was $450.50 per month, with a wide range of $0 to $2500. In only one case was income unknown. Stated earlier, 19 or the 56 families were receiving financial assistance in the form of

AFDC. (Until further calculations can be made, the cost per family on AFDC to the state is unknown.) After controlling for financial assistance, the strength of the association between which family member is employed and monthly income increases substantially. Of the 56 nonrecipient families, 17, or 30.4% were receiving an income under $500 a month which was interpreted as not working nor employed full-time. The other 19 were not receiving financial assistance and had incomes over $500 a month which indicated full-time employment. Of this latter group, the family member that was reported to be employed included:

Family Member	No.	Percent
Man	9	47.4%
Woman	4	21.1%
Both	6	31.6%
	19	100.0%

Table 4.1

Marital Status and Type of Assistance of Terminated AFDC-UP Households, November 1981, (N = 56)

	MARITAL STATUS			
	Married		Nonmarried	
Type of Assistance	No.	Percent	No.	Percent
No Assistance	13	30.2%	2	15.4%
Some Assistance (Medicaid and/or Food Stamps)	20	46.5%	2	15.4%
All Assistance (AFDC, Medicaid, and Food Stamps)	10	23.3%	9	69.2%
TOTAL:	43	100.0%	13	100.0%

$\chi^2 = 9.5$ with 2 d.f. ($p < .01$

Source: Calculated from Surveys of Utah State Department of Social Services, Office of Assistance Payments.

Table 4.2

Type of Assistance and Family Member Employed of Terminated AFDC-UP Households November 1981, (N = 56)

	FAMILY MEMBER EMPLOYED							
	Man		Woman		Man and Woman		No One Working	
Type of Assistance	No.	Percent	No.	Percent	No.	Percent	No.	Percent
No Assistance	7	53.8%	3	37.5%	4	50.0%	1	3.7%
Some Assistance	6	46.2%	2	25.0%	4	50.0%	10	37.0%
All Assistance	0	0.0%	3	37.5%	0	0.0%	16	59.3%
TOTAL:	13	100.0%	8	100.0%	8	100.0%	27	100.0%

$x^2 = 23.98$ with 6 d.f. ($p < .0005$)

Source: Calculated from Surveys of Utah State Department of Social Services, Office of Assistance Payments.

V. AFDC-UP UTAH CLIENT CHARACTERISTICS AND PROGRAM RESULTS

This section reviews the characteristics and outcomes of program recipients of the defunct Utah Aid to Families with Dependent Children-Unemployment Program (AFDC-UP). The information is taken from a Utah State Department of Social Services' publication reporting the results of a stratified sample of 235 surveyed AFDC-UP clients during a one-week period in November, 1980. When available, data are reported for the entire AFDC-UP population. Variables discussed include basic demographics, employment histories, family stability, case load size, and length of program stay.

The AFDC-UP program was intended to provide assistance to unemployed two-parent households. Its duration in Utah was two decades (1961-1981). The number of households served in March 1981 was 2,312. The AFDC-UP program was terminated June 30, 1981 because of reduced state revenue, sharply increasing enrollments, and basic dissatisfaction with the program's performance.

Client characteristics of the population were reported as follows:

AGE	MEAN	S.D.
Father's	29.5	8.6
Mother's	26.7	7.7
EDUCATION (in years)		
Father's	11.5	2.5
Mother's	11.0	2.0
HOUSEHOLD SIZE		
Number	4.5*	

*November 1980 data for the total AFDC-UP caseload. The survey reported an average household size of 4.36 (S.D.=1.6).

Average monthly grant. The average monthly grant was $453.00. The maximum grant level for a family of four was $415 and for a family of five was $527.

Fathers' job and training experience and barriers to employment. Of those reporting prior work, the most cited job experiences for the men were laborer (10%), truck driver (9%), and carpenter (8%). Of these, their average monthly salary was $783. Work experience and training were reported as 5.76 years and 2.3 years, respectively. "A physical problem" was the most common response to the barriers to work question for 35% of the AFDC-UP fathers. Training and motivation were also frequently mentioned.

Mothers' job and training experience and barriers to employment. Of the 235 surveyed, 150 females reported prior work experience. The most cited forms of job experience for the women were waitressing (16%), sales (15%), and assembly work (11%). These women earned an average monthly salary of $399, with a high incidence of part-time work. Work experience and training were reported as 3.2 years and 1.5 years, respectively. Child care was the most frequent response of barriers to working.

Marital stability and receipt of regular AFDC. The state's department of social services conducted a special computer study of the total AFDC-UP case load to determine how many AFDC-UP families separated and received regular AFDC assistance as a deserted, separated, or divorced household. In a six-month period, 7.4% of the AFDC-UP households separated and received regular AFDC assistance as a deserted, separated, or divorced household.

Length of Stay, Prior Welfare. The Utah Department of Social Services generated a monthly computer report on the average length of stay of households receiving assistance and prior episodes of assistance. The following data represents the average number of days AFDC-UP households in November 1980 had received AFDC-UP or AFDC without a break in assistance of 30 days or more.

AFDC-UP Length of Stay, Recidivism
November 1980

Average length of stay	296 days (10 months)
Average Recidivism (Prior AFDC-UP or AFDC episodes)	1.4 times
Total time on assistance	24 months

Job efforts. When asked what they were doing to find a job, 20% of the AFDC-UP participants surveyed reported they were not searching for a job because of various reasons. Twenty-three percent responded that they were already working and 47.5% reported they were actively seeking employment. In Utah, AFDC-UP recipients who worked over 100 hours a month were not terminated from assistance if they continued to meet other eligibility standards.

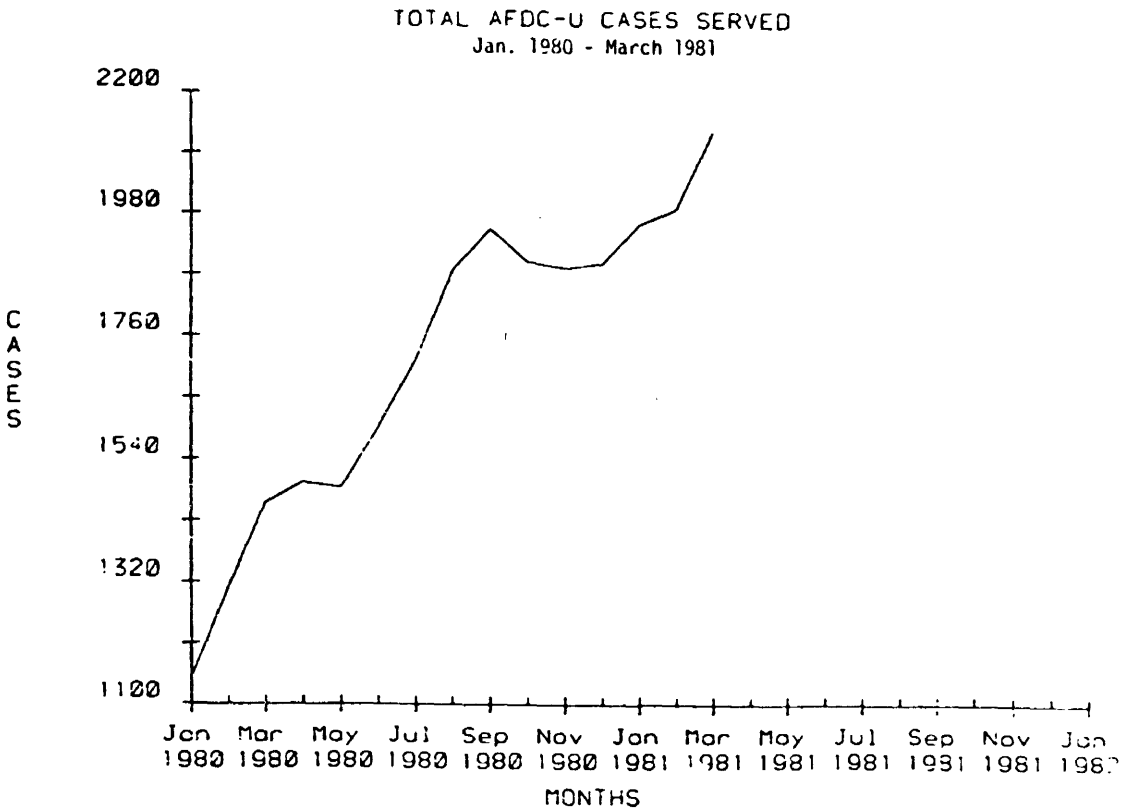
When asked what the government was doing to help them find employment or become employable, 35% reported that nothing at all was being done to help them, while 22% stated that Job Service and WIN were helping them.

About 3% of the participants were involved in a community Work Experience and Training Program (WEAT).

Job Placement Rate and Average Wage. No Utah data are available on the job placement rate for households terminating from AFDC-UP. Data may be available from special AFDC-UP studies conducted in other states. According to Work Incentive (WIN) reports by job service for 1981, the average wage secured was $5.12 an hour. The median wage secured was about $4.75.

Cases served and unemployment rates. Total AFDC-UP cases served between January 1980 and March 1981 is presented in Attachment 2. The average Utah case load size for the year prior to termination of the program on June 30, 1981 was 2,055 families. Unemployment for Utah in 1980-81 averaged 6.8%. Table 2.1 denotes monthly state figures for AFDC-UP cases served and unemployment (seasonably and not seasonably adjusted) rates. As can be seen, average state nonseasonally adjusted yearly unemployment rates continued to increase from 1976 through the program termination at the end of June, 1981. State average case loads basically followed the same pattern. The year 1980 and the first half of 1981 was marked with an enormous increase in AFDC-UP recipients, with an average of 927 in 1979 to 1,755 in 1980--a 46.2% increase. The correlation between these two variables indicates a strong relationship of .86. In other words, a one unit increase in unemployment was associated with a .86-unit increase in AFDC-UP case load. The effects of other variables on the bivariate relationship such as population change will be presented in the Interim Report.

Figure 5.1


TOTAL AFDC-U CASES SERVED
Jan. 1980 - March 1981
2200
1980
1760
1540
1320
1100
CASES
Jan 1980
Mar 1980
May 1980
Jul 1980
Sep 1980
Nov 1980
Jan 1981
Mar 1981
May 1981
Jul 1981
Sep 1981
Nov 1981
MONTHS

VI. COMPARATIVE ANALYSIS

This section will present preliminary comparisons between the AFDC-UP Program, No Financial Assistance Program, and the Emergency Work Program. Comparisons will be made on baseline, process and outcome measures. These include eligibility requirements, unemployment rates, client demographics, marital unity, length of stay, average case load, grant amounts and job placement after program participation. In reiteration, these three programs include the defunct AFDC-UP program, a hypothetical "no program" group, and the Emergency Work Program.

Baseline indicators suggest a strong degree of equivalence in that eligibility requirements, unemployment rates, and client demographics of the AFDC-UP and EWP programs were near identical. Eligibility requirements of the EWP were arranged for direct comparative purposes. As Table 5.1 shows, unemployment rates were three-tenths of a percentage lower during the operation of EWP than during the last year's operation of AFDC-UP. More refined unemployment figures such as seasonally adjusted and nonagricultural employment growth rates will be employed in future reports.

Client demographics are quite similar in that the average years of education for fathers and mothers of all three groups are near equal. Prior monthly income before participating on a program show that households with the father employed earned more before participating on AFDC-UP than for the prior employed households on the EWP. Household income for EWP was based on total, combined incomes of all family members. Barriers to employment were found to be similar. Fathers tend to have physical problems preventing them from working, while women tend to cite child care as their major work barrier. Also, the average number in the households were similar. The range of household size among the three programs were a low of 4.45 (EWP) and a high of 4.8 (no program), and 4.47 for AFDC-UP.

Dissolution rates demonstrated marked differences. Recipients of AFDC, as a result of desertion, separation, and divorce during AFDC-UP program participation, averaged 7.40% over a six-month period. When no program was available, the dissolution rates and receipt of AFDC increased dramatically to 13.4% over a five-month period. With the replacement of two-parent households with dependent children assistance such as the EWP, marital unity was restored. Of the 56 contacted EWP families, only two families separated or divorced, marking a low of 3.6% dissolution. This signifies success to the program objective of maintaining family unity.

Process measures such as length of program participation, average case load, grant amounts, and program requirements reveal marked differences in the comparison between AFDC-UP and EWP. The length of stay on the defunct AFDC-UP program was six times longer than the 44.3-day participation period for EWP families. A much lower case load was served by EWP, which may explain some variance to the lengthy AFDC-UP participation period. One explanation could be made that a more personalized system gets clients off welfare and into jobs. On the other hand, work and job components of the EWP (and lacking from the AFDC-UP program) may explain the average 71.1% placement rate of the EWP; an estimated 51.8% of displaced AFDC-UP participants found employment--a 20% difference. Grant amounts awarded to program participants also varied as is shown in Table 6.1.

Table 6.1

Comparison of Program Characteristics: AFDC-UP, No-Program, and EWP

Program Characteristics	AFDC-UP 1980-81	No Program 1981	EWP 1984-85
Father's average:			
Age in years	29.51	31.70	29.03[a]
Years of education	11.46	10.70	10.97
Barrier to work	physical	unknown	physical
Mother's average:			
Age in years	26.71	29.20	26.87
Years of education	11.01	11.22	11.50
Barrier to work	child care	unknown	child care
Number in household	4.47	4.80	4.45
Separation rate	Unknown	23.2%	3.60%
Separtn. and receipt of AFDC[b]	7.4%	13.4%	N/A[c]
Length of stay w/o 30 day Interuption	10 months	N/A	44.3 days
Average case load	2,055	N/A	82
Unemployment rates[d]	6.8%[e]	6.7%[f]	6.5%[g]
Work requirement.	sometimes (WIN)	N/A	Always
Job search requirement.	sometimes	N/A	Always
Employment placement	unknown	51.8%	71.1%[j]
Average Wage	$5.12	N/A	$5.80
Maximum grant (family of 4)	$415.00	N/A	$433.00
Average monthly grant[h]	$422.00	N/A	$294.00
Grant Cost per Household	$4,220.00[i]	N/A	$741.30
Annual Grant Cost	$10,413,000.00	N/A	$450,000.00

Table 6.1 (Continued)

[a]Defined as program participant for the EWP. [b]1980 only.

[b]Receipt of AFDC as a separated or divorced household 6 months later for AFDC, 5 or 6 months later for the No program group, and 2 or 3 months later for the EWP.

[c]Not Available

[d]Labor market information services, Utah Department of Employment Securities, nonseasonally adjusted state averages.

[e]January 1980 to June 1981.

[f]July 1981 to November 1981.

[g]June 1984 to June 1985 (January '85 forecast.

[h]Monthly grant expenditures divided by the number of cases served monthly.

[i]Average monthly grant times the average length of stay of 10 months.

[j]As reported by the various manpower agencies.

VII. CONCLUSION

In conclusion, further analysis is required to compare the three programs discussed in sections III, IV, and V. Secondary analysis of the AFDC-UP data is necessary to check for consistency of the reviewed results presented in the second section. Unemployment statistics will be associated with the "no program" group. And, the panel survey of the EWP will be updated further for the Interim Report.

Further areas of analysis to be covered in the forthcoming Interim Report (due October 15, 1985) include an analysis of the EWP Demonstration Project, comparisons between AFDC-UP and the EWP Project, further comparisons between these three groups, and why results such as program performance requirements with payment after performance, expectations, and the six-month limit.

ATTACHMENT

Total AFDC-UP Cases Served and Unemployment Rates, July 1977 to June, 1981

Adj. 1977 Rate	AFDC-UP Caseload	Not Seasonally Adj. Unemployment Rate	Seasonally Unemployment
July	683	5.2	5.3
Aug .	697	4.9	5.3
Sept.	714	4.6	5.1
Oct.	688	4.6	5.1
Nov.	723	4.6	4.9
Dec .	896	4.5	4.5
Average	733.5	5.3	
1978			
Jan .	1133	4.9	4.1
Feb .	1220	4.6	3.9
Mar.	1289	4.2	3.8
April	1394	3.6	3.7
May	876	3.3	3.6
June.	779	3.8	3.5
July	809	3.6	3.7
Aug .	841	3.5	3.9
Sept.	797	3.4	4.0
Oct.	823	3.6	4.0
Nov.	801	4.1	4.3
Dec .	832	4.3	4.2
Average	965.4	3.8	
1979			
Jan .	731	4.8	4.1
Feb .	887	4.9	4.2
Mar.	715	4.4	4.0
April	889	4.1	4.2
May	852	3.9	4.1
June	877	4.4	4.1
July	1006	4.1	4.2
Aug .	1042	3.8	4.2
Sept.	1005	3.8	4.4
Oct.	977	3.9	4.4
Nov.	1025	4.4	4.7
Dec .	1123	5.0	4.9
Average	927.4	4.3	

Table 1 (continued)

Total AFDC-UP Cases Served and Unemployment Rates, July 1977 to June, 1981

1980	AFDC-UP Caseload	Not Seasonally Adj. Unemployment Rate	Seasonally Adj. Unemployment Rate
Jan .	1142	5.9	5.2
Feb .	1412	6.0	5.3
Mar.	1541	5.8	5.4
April	1540	5.8	5.8
May	1606	6.1	6.2
June.	1721	6.8	6.6
July	1909	6.6	6.8
Aug .	2050	6.3	6.8
Sept.	2076	6.3	6.9
Oct.	2035	6.3	6.8
Nov.	2005	6.5	6.9
Dec.	2026	7.0	6.9
Average	1755.3	6.3	
1981			
Jan.	1950	7.5	6.8
Feb.	2216	7.5	6.7
Mar.	2312	7.3	6.8
April	2213	6.7	6.6
May	2067	6.6	6.7
June	1796	6.9	6.6
Average	2092.3	6.7	