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001. list	Attendees - December 11 Press Conference (partial, DOB, SSN) (12 pages)	12/10/1997	b(6)
002. report	Re: presenting parent (1 page)	00/00/0000	b(6)

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Children's Health

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RESTRICTION CODES

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P1 National Security Classified Information [(a)(1) of the PRA]
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P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
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file - Children

President Continues to Fight to Expand Health Care Coverage for Our Nation's Children

Today, the President announced that he is committed to assuring that the balanced budget agreement's children's health plan have meaningful benefits and that it include the Senate-passed 20 cent tobacco tax which increases the investment for children's health care from $16 billion to $24 billion. This would represent the largest investment in children's health since Medicaid passed over thirty years ago. In making this announcement, the President outlined the principles he will use in evaluating children's health coverage emerging from the Budget Agreement:

- **That coverage is meaningful:** from checkups to surgery -- children should get a full range of benefits to ensure that children receive the care they need to grow up strong and healthy. It cannot be a meaningful benefit if it does not include prescription drugs, vision, hearing, and mental health coverage. It must also ensure that families are not forced to shoulder excessive costs for their children.

- **That it supplements not supplants coverage** these funds must be used wisely. This investment should cover children who do not currently have insurance; it should not replace public or private money that already covers children.

- **That it includes revenue from the Senate-passed tobacco tax:** in an overwhelming bipartisan basis, the Senate passed a 20 cent tobacco tax and allocated revenue from this tax for children's health. Including these additional revenues in the children's health initiative will not only further reduce the number of uninsured children, but it will serve as a financial barrier to help prevent our children from starting smoking in the first place.

Today's announcement builds on the President's previous successes in strengthening health care coverage for children.

- **Children and Immunization.** As the President announced today, 90 percent or more of America's toddlers in 1996 received the most critical doses of each of the routinely recommended vaccines -- surpassing the goal set by the President in 1991.

- **Children and Tobacco.** The President issued guidelines to eliminate easy access to tobacco products and to prohibit companies from advertising tobacco to kids. Each day about three thousand children become regular smokers and 1,000 of them will die from a tobacco-related illness. According to former FDA Commissioner David Kessler, the possibility of a comprehensive, public health oriented settlement with the tobacco industry could not have come about without the President's leadership in this area.

- **Children and the Kassebaum-Kennedy Law.** By signing this bill into law last year, the President helped millions of American children keep their health care coverage when their parents lose or change jobs.

- **Children and the Environment.** Earlier this year, the President signed an Executive Order to reduce environmental health and safety risks to children by requiring agencies to strengthen policies and improve research to protect children and ensure that new regulations consider special risks to children.

- **Children and Medicaid.** Throughout his Administration, the President has fought to preserve and strengthen the Medicaid program; its coverage of about 20 million children, makes it the largest single insurer of children. The Administration has partnered with states through Medicaid waivers to expand coverage to hundreds of thousands of children.

EFFECTIVENESS OF CHILDREN'S HEALTH INITIATIVES

Q. **TODAY'S *NEW YORK TIMES* REPORTED THAT NEITHER THE HOUSE NOR THE SENATE'S CHILDREN HEALTH INSURANCE PLANS WILL ACHIEVE MUCH COVERAGE. HOW DO YOU RESPOND?**

A. **We believe that CBO estimates are excessively low.** CBO assumes that states will prefer to use the money to offset existing spending -- not to expand coverage. We believe this lack of trust in the states is unwarranted and not backed up by recent experience. Specifically:

- **Most states have expanded Medicaid for children well above the minimum levels required under current law.** Over 30 states have taken up a Medicaid option to cover more children.

- **More expansions proposed.** This year alone, over 15 states will expand Medicaid or state programs for children.

- **Strong response to private initiatives.** Private foundations (such as Robert Wood Johnson) report that they are flooded with responses from states interested in expanding children's coverage. This interest exists even though states would have more "strings" and have to put up real money to receive the private funding.

- **Non-political career policy experts at the Department of Health and Human Services believe that a carefully structured initiative will increase the number of children with health insurance well beyond CBO estimates.**

CBO analysis does underscore the importance of ensuring tight targeting of funds and state accountability. Although flawed, the analysis does reinforce the President's belief that the investment should be used wisely to ensure that as many uninsured children as possible receive meaningful health coverage. This is why we support:

- **New coverage not existing coverage.** The President supports strong provisions (called maintenance of effort requirements) to prevent the new funds from replacing existing funds for children's health coverage. States should use the new investment to leverage not reduce their current spending.

- **Deletion of provisions that provide for services rather than insurance coverage.** The House bill would allow states to spend all of their

money on one service or to offset the reductions to disproportionate share hospitals (DSH). This will not translate into meaningful coverage for children that protects their families from excessive cost sharing.

file - children's health

August 11, 1997

MEMORANDUM TO THE FIRST LADY

FROM: Chris J.

SUBJECT: Children's Health Update

cc: Melanne, Jen

Following up on our conversation last evening, I am attaching a number of enclosures:

(1) The first is a copy of the memo I sent into the President in response to his questions about two critical Op Ed pieces about the children's health law. One was written by Robert Goldberg in the *Wall Street Journal* and the other, of course, was written by Douglas Besharov in the *New York Times.* (In case you don't have it, I am also enclosing the Journal Op Ed.)

(2) A copy of a one-pager outlining the accountability provisions in the children's health care law; this helps respond to the substitution issues that some of the right-wing critics are raising. We are now circulating this document to interested parties.

(3) The response that Jonathan Gruber, Deputy Assistant Secretary of Treasury, sent into the *New York Times* late Friday evening rebutting Besharov's misuse of Gruber's research. Jonathan is known to be quite conservative in his views and his writings, so we think his response will carry some weight. We hope that it gets published early this week.

(4) A copy of my DPC weekly report paragraph insert that provides the President with a brief update of the status of the implementation of the children's health initiative. This is going to be a real test for HHS. Although they know it is one of our highest priorities, I must confess that I am a bit nervous as to whether they have all the personnel and resources they need to do this right.

I hope you find this information useful.

Jennings-
Lambrew
COS

THE WHITE HOUSE
WASHINGTON

August 6, 1997

MEMORANDUM TO THE PRESIDENT

FROM: Chris Jennings and Jeanne Lambrew

SUBJECT: Response to Private Coverage Substitution in the Children's Health Initiative

Yesterday, two op-ed pieces (attached) critiqued the children's health initiative. Both claimed that it is inefficient because it will replace private coverage, and one stated that children who have only been uninsured for one month will be eligible. These articles are factually incorrect in numerous instances and totally ignore the provisions in the law aimed to prevent substitution.

First, it is misleading to assert based on one, controversial study that the new state programs will fill up with privately insured children. Other studies document much lower coverage of privately insured children by Medicaid, and even one of its authors thinks that the new program will be much more efficient. More importantly, states running these programs will have both the flexibility and incentive to target funds to uninsured children since they have a reduced but still significant matching contribution. In fact, state-designed programs like Minnesota and Florida have proven that over 93 percent of their enrolled children were not previously privately insured.

Second, there is no requirement that states provide coverage for children uninsured for only one month. While not explicitly prohibited, it is highly unlikely since states have often restricted eligibility to children uninsured for at least six months. States are prohibited from using Federal funds to pay for children who would otherwise have private coverage. States also are required to prove that they are not substituting for private coverage. This means, for example, that they verify that the child's parent does not have access to employer-based insurance or target children like those of workers between jobs who often lack access to affordable private insurance.

Third, the authors suggest that the benefits offered to children through the state initiatives will be so much better than private coverage that families will prefer it. This is an exaggeration. Although the benefits offered to children by states will be meaningful, they will not be more generous than those received by most privately covered children. In fact, the benchmark plans for the new coverage were purposefully chosen because they already cover many children in the state. States also will be allowed to charge premiums and cost sharing, within limits, so that the financial difference between state and private coverage will be small (if not zero).

We are working on a fact sheet about the law's accountability provisions since there is a general misunderstanding about them. In addition, there will be a letter to the editor of the *New York Times* by Jonathan Gruber, now a deputy assistant Secretary at Treasury, who co-authored the crowd-out study cited in the op-ed. He will object to its misuse and support the new law.

The Birth of Clintoncare Jr. . . .

By ROBERT M. GOLDBERG

Clintoncare is alive and well, living in the budget agreement's $24 billion child health care program. The key to its resurrection has been the silence supporters maintained regarding the details of what will be the biggest new social program since Medicare. With a few honorable exceptions, Republicans, for fear of being tagged as cruel, didn't want to know what was in the plan. If they had looked, they would have found a program cleverly designed to consolidate government control over health care by moving as many middle-class children into federally funded and regulated health programs as quickly as possible.

The new law provides the states $24 billion to set up health insurance programs for five million children. But according to a survey conducted by the Department of Health and Human Service, only 1.3 million children under 18 lack insurance because of its cost. The average cost of a health insurance plan for a child is $900. So over a five-year period, the program should cost only $6 billion.

Luring Children

Why then is the program so expensive? Because, in order to hit the five million figure, a vast amount of money must be spent luring as many children as possible from private health insurance into the new entitlement.

In fact, the Congressional Budget Office estimates that half of all new enrollees will be from families who drop private coverage in favor a federally subsidized entitlement. That's what happened when Medicaid was opened in 1987 to pregnant women and their children with incomes 250% of the poverty level. Between 1988 and 1995 the percentage of children covered by private insurance fell to 64% from 72%. At the same time, the percentage of children covered by Medicaid climbed to 23.1% from 15.5%. Studies have shown that at least three-fourths of the shift was the result of parents dropping private coverage for themselves and their children.

This new program will have the same effect. It prohibits an employer from conditioning or varying contributions to health insurance premiums because of an individual's eligibility for assistance under the new program. But it says nothing about dropping coverage for dependents altogether, or about simply not offering family coverage to new employees.

The key to making an entitlement permanent is to cover the middle class. Thus the new "kid care" plan will be available to every child in families with income of up to $50,000 a year. Children must be uninsured to participate in the program, but the law is written in such a way that even children who lack coverage for a month or so because of a parent's job change can sign up.

Getting the cooperation of powerful health care interests is critical to the program's success. Thus, 15% of the state grant can go to newly created direct services to kids from hospitals and for "administrative costs." In other words, the money will go to well-connected health care consultants and the more powerful health care interests they work with, in order to win their support for any move to managed care that will result from this new program.

What happened in New York state as part of plan to move more Medicaid children into managed care illustrates the value of this giveaway. To get the political support of the nonprofit hospitals and the state's health worker unions, the "savings" from the reform—nearly $1.25 billion over five years—are going to pay for worker retraining and for the cost of hospitals that set up their own managed-care plans. But this new plan has fewer doctors tending to more children than ever before. The phalanx of nonprofit (and often privately funded) community clinics that provide most of the primary care for children in New York City were completely cut out of the new plan. Expect more of the same in other states as the special interests fight for feeding space at this new trough of corporate "healthfare."

Children must be uninsured to participate in the program, but the law is written in such a way that even children who lack coverage for a month or so because of a parent's job change can sign up.

In pushing for the entitlement, advocates pointed to innovative state health insurance programs for children as examples of what the new money would support. "The basic principles of this proposal are neither novel nor untested," said Sen. Edward Kennedy (D., Mass.). "Fourteen states already have similar programs for children. In Massachusetts, an existing program was expanded last year, so that families up to 400% of the poverty level are now eligible for financial assistance to buy

insurance. In 17 additional states, Blue Cross/Blue Shield offers children's-only coverage, with subsidies for low-income families. These state initiatives provide a solid base on which to build an effective federal-state-private partnership to get the job done for all children."

But in fact these innovative programs, including Massachusetts's, merely served as Potemkin villages that will be torn down to make way for a federal health care complex. Under the new law such low-cost and innovative approaches to care will be illegal. (For political reasons, existing children's health plans in Florida, New York and Pennsylvania were exempted from federal mandates.) Instead, states have to enroll children in either Medicaid, the health plan offered to state employees or the largest health maintenance organization in the state. States can design their own plan, but they have to provide a rich benefits package to get federal money.

States will probably take the relatively easy approach of extending Medicaid or Medicaid managed-care. Hence, the result of the new entitlement will be a relocation of millions of children into expanded Medicaid programs at the expense of parental choice and grass-roots efforts to provide primary care for children.

This might make sense if it would improve children's health. But a close look at clinical studies suggests that health claims for Clintoncare Jr. have been vastly overstated. Advocates argue that the program will reduce reliance on emergency rooms as a regular source of care. But studies show that children on Medicaid or Medicaid managed-care are more likely than anyone else to use emergency rooms for routine care.

Supporters also claim that the new entitlement would lead to healthier babies. But when Medicaid eligibility was extended to pregnant working-class women it produced no improvement in low birth weight or other perinatal problems. Similarly, there is evidence that children in Medicaid-style programs receive care that is decidedly inferior: They are more likely to have asthma and to die from it than any other group. One study found that despite having Medicaid coverage, poor children also were more likely to be hospitalized and less likely to receive effective preventive asthma therapy than children with private insurance were. A National Institutes of Health study shows that children who receive care through Medicaid or public clinics were less likely to get appropriate mental health treatment than those with a private physician.

Clinton's Greatest Legacy

Hence, moving more children into Clintoncare Jr. will have a decidedly limited benefit on their health. But then the real objective of the new entitlement was never healthier children. It was to move as many children into government-run health plans as possible. For once the cash reaches the states, and the bureaucratic apparatus for enrolling children and enforcing federal health mandates is set up, it will be easy to extend the program to their families as well, and to organize the political muscle to make it happen.

During a recent phone-in conference about the new program, Sen. Kennedy crowed that "this is a major step forward" toward national health insurance. So perhaps President Clinton's greatest legacy, after all, will be the enactment of national health care. How ironic that the Republican party, by not raising the same fuss it did in 1994, has made it possible.

Mr. Goldberg is a senior research fellow at the Center for Neuroscience, Medical Progress and Society, George Washington University.

THE WALL STREET JOURNAL
TUESDAY, AUGUST 5, 1997

ACCOUNTABILITY IN THE CHILDREN'S HEALTH INITIATIVE

PROVISIONS PREVENTING SUBSTITUTION FOR PRIVATE COVERAGE

- **Targeted eligibility**. States have great flexibility to design eligibility criteria to best target uninsured children. They may, for example, restrict eligibility to children who have been uninsured for at least 6 months. Or they may focus on children whose parents have lost or changed jobs.

- **Comparable benefits**. States may design their benefits package to be comparable to that of state employees or typical workers' children. They may also charge premiums and cost sharing. This makes the new program no more attractive than private coverage, a protection against substitution of private coverage.

- **No payments for children with private coverage.** States are prohibited from paying for coverage for children who would otherwise receive private coverage.

- **Procedures to prevent substitution**. States must develop procedures to ensure that their plans do not substitute for group health coverage. They may, for example, ask for verification that the child's family does not have access to employer-based insurance.

PROVISIONS PREVENTING SUBSTITUTION FOR PUBLIC COVERAGE

- **Maintenance of effort.** States cannot change their Medicaid eligibility (including standards & methodologies) from its level as of June 1, 1997 and must enroll eligible children in Medicaid. States also must continue their 1996 state spending on non-Federal health insurance programs.

- **Referral to Medicaid.** Children found eligible for Medicaid must be enrolled in Medicaid, not enrolled in the new program.

- **Procedures to prevent substitution**. States must develop procedures to coordinate coverage across programs.

ACCOUNTABILITY PROVISIONS

- **Reporting requirements**. States must report annually on their success at covering uninsured children and coordination with other types of coverage.

- **State contribution.** Provider taxes, donations, other Federal spending, and premiums and cost sharing do not qualify as contributions eligible for Federal matching funds.

- **Auditing and sanctions.** The Secretary has authority to withhold funds & audit programs as necessary to ensure that the funds are used for the intended purpose.

FRAUD AND ABUSE PROVISIONS

- **Disclosure of ownership, previous convictions, and miscellaneous other fraud and abuse provisions** from Medicaid and Medicare.

To the Editor:

On the day that the President signed into law the largest expansion of health insurance for children in 30 years, I was disappointed to see my own research being used to attack that policy by Douglas Besharov ("Beware the Real Agenda", Op-Ed, August 5). As Besharov notes, David Cutler of Harvard University and I have documented that there is a substitution problem with the existing Medicaid program: as the government provides public insurance to uninsured children, it also covers some children who would otherwise have private insurance. This substitution problem exists because the traditional Medicaid program is more generous than most private insurance plans, and it is completely free, making it attractive for some privately insured to drop their less-generous and costly private coverage and move onto the public program.

What Besharov does not recognize, however, is that the $24 billion children's health initiative is explicitly designed to deal with this problem. It allows states unprecedented flexibility in designing the benefits package, while maintaining high quality comprehensive coverage. The benefits package offered by states need be no more generous than the typical private insurance policy in the state, and states are allowed to charge both copayments and premiums to enrollees. Dropping private insurance to join the state program will be much less attractive in this environment. Moreover, states that expand their children's coverage are required to ensure that the program is not substituting for private insurance.

The experience of state programs in Florida and Minnesota strongly support this argument These states offer benefits packages in line with private insurance policies, charge nominal copayments to low income enrollees, and have safeguards against the substitution of public for private insurance. In both cases, researchers have documented much lower substitution than Cutler and I found for Medicaid.

The potential for substitution should not overshadow the enormous public health benefits of these expansions. Due to the Medicaid expansions of the 1980s and early 1990s, there are 4000 fewer infant deaths in the U.S. each year. These crucial benefits of public insurance will now be extended to millions more American children.

Our work on children's health is not done. There are important implementation issues to be addressed, including how to most efficiently target the new funds. We must also educate parents about their options, including the Medicaid program: three million children are already eligible for Medicaid, but are not enrolled, and are mostly uninsured. But as we begin the work we should appreciate the tremendous gains for public health afforded by this historic expansion of insurance for our nation's children.

JONATHAN GRUBER
Deputy Assistant Secretary, U.S. Treasury Department
Professor of Economics, MIT

Implementation of Children's Health Initiative. We have started a process with HHS, OMB, the First Lady's office, and others designed to assure an effective implementation of the new children's health initiative. By next week, we will have completed a timetable that outlines important due dates for any necessary guidelines and regulations to help the states interpret and design children's health plans. It will also list meetings/forums with state representatives (Governors, Medicaid Directors, etc.), children's advocates, health care providers and others who are extremely interested in the new children's health options. We will be evaluating whether participation by you, the First Lady, Donna and other principals may be desirable to highlight the new Federal dollars and opportunities to cover uninsured children. We are also producing responses to frequently asked questions about the new law, so interested parties have a good sense of the statute and the process for implementing it. Lastly, we are now reaching out to foundations to determine their interest in using private dollars for outreach efforts designed to cover the 3 million children currently eligible but not enrolled in Medicaid. There seems to be a good deal of interest and we will keep you informed of developments.

for children hospitals

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National Association of
Children's Hospitals

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Children's Hospitals

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An affiliate of the National Association of Children's Hospitals and Related Institutions

It's Time To Take The Next Step.

Full GME Funding for Children's Hospitals!

The future of pediatric health care rests in our hands. Last year Congress heard the cry for equitable graduate medical education (GME) support for children's hospitals. We appropriated $40 million to get started in FY2000 and then unanimously authorized $285 million for FY2001. This year we should appropriate full, equitable GME support for our independent children's hospitals in FY2001. It's for all of our kids.

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release December 6, 1999

STATEMENT BY THE PRESIDENT

Today I am pleased to sign S. 580, the "Healthcare Research and Quality Act of 1999," which authorizes appropriations for the Agency for Health Care Policy and Research (and renames it the "Agency for Healthcare Research and Quality") and authorizes a new grant program to support children's hospitals with graduate medical education programs.

This legislation combines two important health care priorities of my Administration: first, ensuring that our nation's children, especially those who suffer from complex or unusual diseases, continue to receive the highest quality care that our health care system can provide; and second, developing the scientific evidence that we need to improve the quality and safety of our health care system.

The Act takes an important first step to ensure the delivery of high quality health care for America's children by investing Federal funds in graduate medical education at freestanding children's hospitals. This long overdue initiative was included in my Administration's FY 2000 budget and was strongly advocated by the First Lady. Her leadership in this area is longstanding, and it is with great pride that I sign this groundbreaking legislation.

In an increasingly competitive health care market dominated by managed care, teaching hospitals struggle to cover the significant costs associated with training and research as private reimbursements decline. Millions of American children each year are treated by physicians affiliated with or training in one of the 60 independent children's hospitals across the country. While other teaching hospitals receive support for these costs through Medicare, children's hospitals receive virtually no Federal funds, even though they train nearly 30 percent of the Nation's pediatricians and nearly 50 percent of all pediatric specialists. This inequity exacerbates an already difficult financial situation for children's hospitals, which often serve the poorest, sickest, and most vulnerable children. In many cases, they provide the regional safety net for children, regardless of medical or economic need, and they are the major centers of research on children's health problems.

This Act creates a new grant program to provide much-needed support for training of these critical health providers. I am pleased that the Consolidated Appropriations Act that I recently approved included my full $40 million request to get this program started.

The Act also authorizes appropriations through 2005 for the Agency for Healthcare Research and Quality (AHRQ) and represents the culmination of a genuine bipartisan effort to make better information available to health care decisionmakers to use to improve health care. AHRQ will help close the numerous data gaps throughout the health care delivery system. It will also serve as a bridge between the best science in the world with the best health care in the world.

The AHRQ will build on the foundation of strong scientific approaches to health services research established by the Agency for Health Care Policy and Research. This legislation was passed on an overwhelmingly bipartisan basis by the Congress, which is a tribute to the many members of both chambers, from both sides of the aisle. I particularly want to single out Senators Frist and Kennedy and Congressmen Bliley, Dingell, Bilirakis, and Brown, who have championed quality information for quality health care, for their commitment to this important reauthorization.

The AHRQ is now designated the lead Federal agency in health care quality to help meet the needs of decisionmakers and work in partnership with the private sector. AHRQ will develop a national report on quality, stimulate evidence-based medicine, sponsor primary care research, help eliminate medical errors, and apply the power of information systems and technology in a manner that assures adequate patient privacy protections. AHRQ will also be a principal source of research that will guide health plans, purchasers, health care systems, clinicians, and policymakers as they seek to improve access to health care and make it affordable for all Americans.

I am delighted to sign S. 580, which will support research needed to improve health care and help train new pediatricians and pediatric sub-specialists who will be able to put this knowledge to work for America's children.

WILLIAM J. CLINTON

THE WHITE HOUSE
December 6, 1999

House Republican Cosigners of Rep. Johnson's Letter (3/31/00)

ALABAMA
The Honorable Robert Aderholt (R-AL)
The Honorable Spencer Bachus (R-AL)
The Honorable Terry Everett (R-AL)
The Honorable Bob Riley (R-AL)

CALIFORNIA
The Honorable Brian Bilbray (R-CA)
The Honorable David Dreier (R-CA)
The Honorable Elton Gallegly (R-CA)
The Honorable Steve Horn (R-CA)
The Honorable Duncan Hunter (R-CA)
The Honorable Steven Kuykendall (R-CA)
The Honorable Jerry Lewis (R-CA)
The Honorable Howard "Buck" McKeon (R-CA)
The Honorable Gary Miller (R-CA)
The Honorable George Radanovich (R-CA)
The Honorable Jim Rogan (R-CA)

COLORADO
The Honorable Scott McInnis (R-CO)
The Honorable Bob Schaffer (R-CO)
The Honorable Thomas Tancredo (R-CO)

CONNECTICUT
The Honorable Nancy Johnson (R-CT)
The Honorable Christopher Shays (R-CT)

FLORIDA
The Honorable Michael Bilirakis (R-FL)
The Honorable Lincoln Diaz-Balart (R-FL)
The Honorable Mark Foley (R-FL)
The Honorable Ileana Ros-Lehtinen (R-FL)
The Honorable Clay Shaw (R-FL)

GEORGIA
The Honorable Johnny Isakson (R-GA)

ILLINOIS
The Honorable Thomas Ewing (R-IL)
The Honorable Henry Hyde (R-IL)
The Honorable Ray LaHood (R-IL)
The Honorable Donald Manzullo (R-IL)
The Honorable Jerry Weller (R-IL)

MICHIGAN
The Honorable Dave Camp (R-MI)
The Honorable Vernon Ehlers (R-MI)

MINNESOTA
The Honorable Jim Ramstad (R-MN)

MISSOURI
The Honorable Kenny Hulshof (R-MO)
The Honorable Jim Talent (R-MO)

NEW YORK
The Honorable Sue Kelly (R-NY)

OHIO
The Honorable John Boehner (R-OH)
The Honorable Steve LaTourette (R-OH)
The Honorable Bob Ney (R-OH)
The Honorable Michael Oxley (R-OH)
The Honorable Rob Portman (R-OH)
The Honorable Deborah Pryce (R-OH)
The Honorable Ralph Regula (R-OH)
* In addition to the above, all 19 House members from this state have signed a state delegation

PENNSYLVANIA
The Honorable Jim Greenwood (R-PA)
The Honorable Phil English (R-PA)

TEXAS
The Honorable Pete Sessions (R-TX)
The Honorable Lamar Smith (R-TX)
* Three Republicans from Texas also signed a state delegation letter in support of GME.

UTAH
The Honorable Chris Cannon (R-UT)
The Honorable Merrill Cook (R-UT)

VIRGINIA
The Honorable Herbert Bateman (R-VA)

WASHINGTON
The Honorable Jennifer Dunn (R-WA)
The Honorable Jack Metcalf (R-WA)

WISCONSIN
The Honorable Mark Green (R-WI)

Congress of the United States

Washington, DC 20515

House Republican Supporters

March 31, 2000

The Honorable John Edward Porter
Chairman
Labor, Health and Human Services, and Education Subcommittee
House Appropriations Committee
U.S. House of Representatives
Washington, D.C. 20515

Dear John:

Thanks to your efforts, Congress provided initial funding last year for graduate medical education (GME) in our nation's independent children's hospitals. For the first time, the federal government recognized the contributions provided by these essential institutions in training the pediatric physician workforce.

For fiscal year 2001, we urge you to continue this commitment to GME funding for children's hospitals at a level as close as possible to the program's full authorization of $285 million. This would be a significant step forward in critically needed support for our children's hospitals. The $40 million provided in the FY2000 budget provides the down payment to start the program for the 2000 academic year.

Last year Congress passed legislation authorizing GME for independent children's hospitals at $285 million for each of fiscal years 2000 and 2001, recognizing that these pediatric academic medical centers are basically left out of our current GME financing system. Because current GME funding is based on the number of Medicare patients a hospital treats, independent children's hospitals are severely disadvantaged. The authorization of $285 million is equal to the amount these independent children's hospitals would receive under Medicare. This funding is meant to provide interim support for these children's hospitals until Congress acts to provide broader-based GME financing to include these institutions.

These funds are necessary to ensure not only the future strength of these institutions, but also the future of the pediatric workforce, including pediatric researchers. Equitable GME funding will allow independent children's hospitals to sustain their core missions of caring for all children, training tomorrow's workforce and advancing pediatric treatments through research. We know that you understand the essential contributions of these children's hospitals. They serve as the health care safety net for low-income children in their respective communities and are often the sole regional providers of many critical pediatric services, serving as centers of excellence for very sick children across the nation.

The independent children's hospitals play an influential role in children's health, far beyond the children they directly serve. Although only one percent of all hospitals, they train almost 30 percent of the pediatric workforce, almost half of pediatric specialists, and two-thirds of our children's critical care physicians. They are the major pipeline for future pediatric

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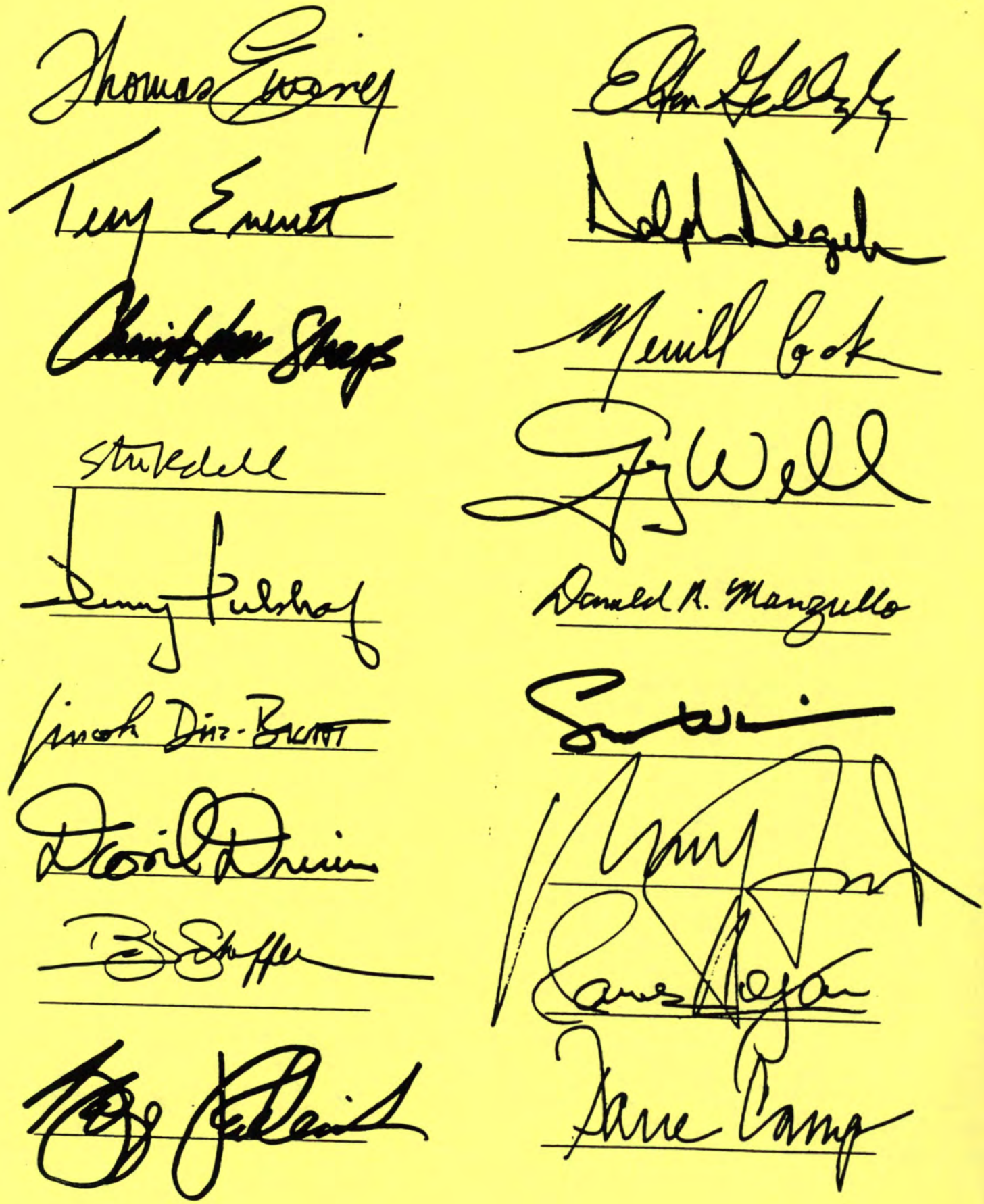
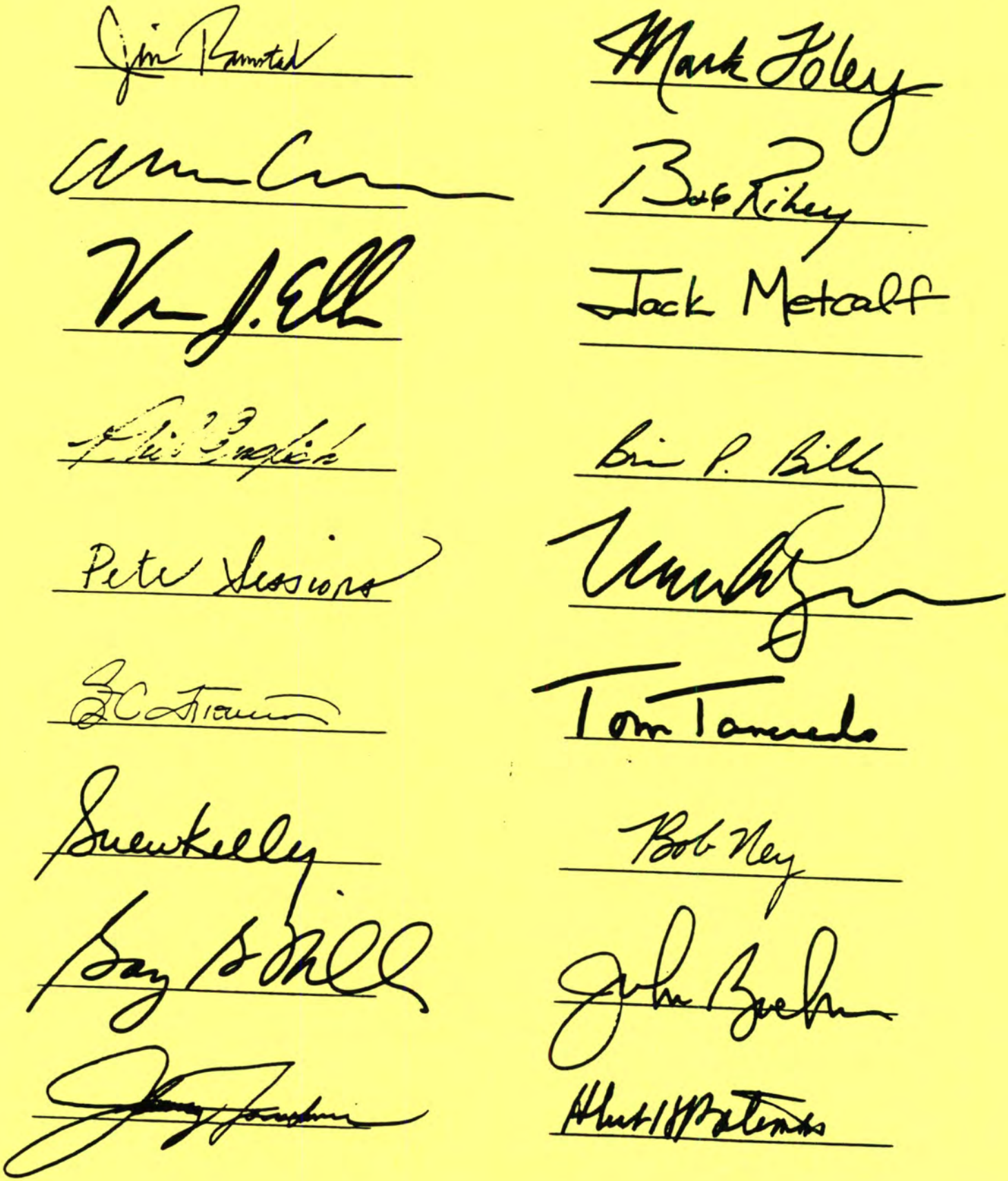
researchers. and these institutions and their affiliated pediatric departments conduct at least 20 percent of all NIH-sponsored pediatric research.

Federal support for GME for children's hospitals is a sound investment in children's health. and provides stability for the future of children's hospitals. The pediatric and hospital communities join us in the support of this important program. Your continuing leadership on behalf of these institutions is much appreciated.

Sincerely,





Jim Talent

Henry Hyde

Robert B Aderholt

Jerry Lewis

Republican Members who Signed 3/31/00 Letter to Chairman Porter Re: GME Funding for Children's Hospitals

Page 2
Michael Bilirakis
Jim Greenwood
Jennifer Dunn
Rob Portman
Buck McKeon
Michael Oxley
Clay Shaw

Page 3
Thomas Ewing
Terry Everett
Christopher Shays
Steve Kuykendall
Kenny Hulshof
Lincoln Diaz-Balart
David Dreier
Bob Schaffer
George Radanovich

Page 4
Jim Ramstad
Chris Cannon
Vernon Ehlers
Phil English
Pete Sessions
Steve LaTourette
Sue Kelly
Gary Miller
Johnny Isakson

Page 5
Jim Talent
Robert Aderholt

Page 2
Nancy L. Johnson
Spencer Bachus
Deborah Pryce
Steve Horn
Ileana Ros-Lehtinen
Lamar Smith
Duncan Hunter

Page 3
Elton Gallegly
Ralph Regula
Merrill Cook
Jerry Weller
Donald Manzullo
Scott McInnis
Ray LaHood
James Rogan
Dave Camp

Page 4
Mark Foley
Bob Riley
Jack Metcalf
Brian Bilbray
Mark Green
Tom Tancredo
Bob Ney
John Boehner
Herbert Bateman

Page 5
Henry Hyde
Jerry Lewis

House Democratic Cosigners of Rep. Sherrod Brown's Letter (3/31/00)

ALABAMA
The Honorable Robert "Bud" Cramer (D-AL)

ARKANSAS
The Honorable Marion Berry (D-AR)

CALIFORNIA
The Honorable Xavier Becerra (D-CA)
The Honorable Howard Berman (D-CA)
The Honorable Lois Capps (D-CA)
The Honorable Julian Dixon (D-CA)
The Honorable Calvin Dooley (D-CA)
The Honorable Anna Eshoo (D-CA)
The Honorable Bob Filner (D-CA)
The Honorable Tom Lantos (D-CA)
The Honorable Barbara Lee (D-CA)
The Honorable Zoe Lofgren (D-CA)
The Honorable Matthew Martinez (D-CA)
The Honorable Ellen Tauscher (D-CA)
The Honorable George Miller (D-CA)
The Honorable J. Millender-McDonald (D-CA)
The Honorable Grace Napolitano (D-CA)
The Honorable Lucille Roybal-Allard (D-CA)
The Honorable Loretta Sanchez (D-CA)
The Honorable Brad Sherman (D-CA)
The Honorable Fortney "Pete" Stark (D-CA)
The Honorable Mike Thompson (D-CA)
The Honorable Henry Waxman(D-CA)

COLORADO
The Honorable Diana DeGette (D-CO)
The Honorable Mark Udall (D-CO)

CONNECTICUT
The Honorable Sam Gejdenson (D-CT)
The Honorable John Larson (D-CT)
The Honorable James Maloney (D-CT)

FLORIDA
The Honorable Jim Davis (D-FL)
The Honorable Peter Deutsch (D-FL)
The Honorable Alcee Hastings (D-FL)
The Honorable Robert Wexler (D-FL)
The Honorable Karen Thurman (D-FL)

GEORGIA
The Honorable John Lewis (D-GA)

ILLINOIS
The Honorable Rod Blagojevich (D-IL)
The Honorable Jerry Costello (D-IL)
The Honorable Danny Davis (D-IL)
The Honorable Lane Evans (D-IL)
The Honorable Luis Gutierrez (D-IL)
The Honorable William Lipinski (D-IL)
The Honorable David Phelps (D-IL)
The Honorable Bobby Rush (D-IL)
The Honorable Janice Schakowsky (D-IL)

KANSAS
The Honorable Dennis Moore (D-KS)

MAINE
The Honorable Tom Allen (D-ME)

MASSACHUSSETTS
The Honorable Richard Neal (D-MA)
The Honorable John Tierney (D-MA)
* In addition to the above, all 10 House members from this state have signed a state delegation letter in support of GME.

MICHIGAN
The Honorable John Conyers (D-MI)
The Honorable John Dingell (D-MI)
The Honorable Dale Kildee (D-MI)
The Honorable Debbie Stabenow (D-MI)

MINNESOTA
The Honorable James Oberstar (D-MN)
The Honorable Bruce Vento (D-MN)

MISSISSIPPI
The Honorable Bennie Thompson (D-MS)

MISSOURI
The Honorable Pat Danner (D-MO)
The Honorable Karen McCarthy (D-MO)
The Honorable Ike Skelton (D-MO)

NEVADA
The Honorable Shelley Berkley (D-NV)

NEW YORK
The Honorable Carolyn Maloney (D-NY)

OHIO
The Honorable Sherrod Brown (D-OH)
The Honorable Tony Hall (D-OH)
The Honorable Marcy Kaptur (D-OH)
The Honorable Dennis Kucinich (D-OH)
The Honorable Tom Sawyer (D-OH)
The Honorable Ted Strickland (D-OH)
The Honorable Stephanie Tubbs-Jones (D-OH)
* In addition to the above, all 19 House

members from Ohio have signed a state delegation letter in support of GME.

PENNSYLVANIA
The Honorable William Coyne (D-PA)
The Honorable Ron Klink (D-PA)
The Honorable John Murtha (D-PA)

RHODE ISLAND
The Honorable Patrick Kennedy (D-RI)

TEXAS
The Honorable Ken Bentsen (D-TX)
The Honorable Eddie Bernice Johnson (D-TX)
The Honorable Charles Gonzalez (D-TX)
The Honorable Gene Green (D-TX)
The Honorable Solomon Ortiz (D-TX)
The Honorable Ciro Rodriguez (D-TX)
*12 Democrats from Texas signed a state delegation letter in support of GME.

VIRGINIA
The Honorable James Moran (D-VA)
The Honorable Robert Scott (D-VA)
The Honorable Norman Sisisky (D-VA)

WASHINGTON
The Honorable Norm Dicks (D-WA)
The Honorable Jay Inslee (D-WA)
The Honorable Jim McDermott (D-WA)
The Honorable Adam Smith (D-WA)

WISCONSIN
The Honorable Tammy Baldwin (D-WI)
The Honorable Tom Barrett (D-WI)
The Honorable Ron Kind (D-WI)
The Honorable Gerald Kleczka (D-WI)

Congress of the United States

Washington, DC 20515

House Democratic Supporters

March 22, 2000

The Honorable David Obey
Ranking Member
Labor, Health and Human Services, and Education Subcommittee
House Appropriations Committee
U. S. House of Representatives
Washington, D.C. 20515

Dear Congressman Obey:

With your support, Congress provided initial funding of $40 million in fiscal year 2000 to support graduate medical education (GME) in our nation's independent children's hospitals. In so doing, the federal government recognized the essential role these institutions play and the value inherent in addressing their GME funding needs.

Now is the time to build on our initial progress and fund the program's full authorization of $285 million. If the challenge of balancing priorities necessitates incremental progress, we respectfully request FY 2001 funding of at least $125 million. This level of investment would mark solid progress toward equitable GME funding.

When Congress passed legislation authorizing GME for independent children's hospitals, it recognized that pediatric academic medical centers were virtually left out of the financing system for GME. The purpose of the legislation was to remedy this situation and to provide children's hospitals equitable federal GME funding, comparable to what other teaching hospitals receive, until broader GME financing is achieved.

We know you appreciate and understand the essential contributions of these institutions. Children's hospitals are the health care safety net for low-income children in their communities. They are often the sole regional provider of many critical pediatric services. They serve as centers of excellence for very sick children across the nation.

Although they comprise only one percent of all hospitals, independent children's hospitals train almost 30 percent of the pediatric workforce, almost half of pediatric specialists, and two-thirds of our children's critical care physicians. They are the major source of future pediatric researchers. Indeed, they and their affiliated pediatric departments conduct at least 20 percent of all NIH-sponsored pediatric research.

PRINTED ON RECYCLED PAPER

An investment in children's hospitals GME is a sound investment in children's health, as well as children's hospitals. Your continuing leadership on behalf of these institutions is much appreciated.

Sincerely,

Sherrod Brown

James M. Inhofe

Henry A. Waxman

Rod R. Blagojevich

Carolyn B. Maloney

Lucille Roybal-Allard

William J. Coyne

Bob Filner

Tony P. Hall

Bobby Scott

Bruce F. Vento

Sam Gejdenson

Jerry Kleczka

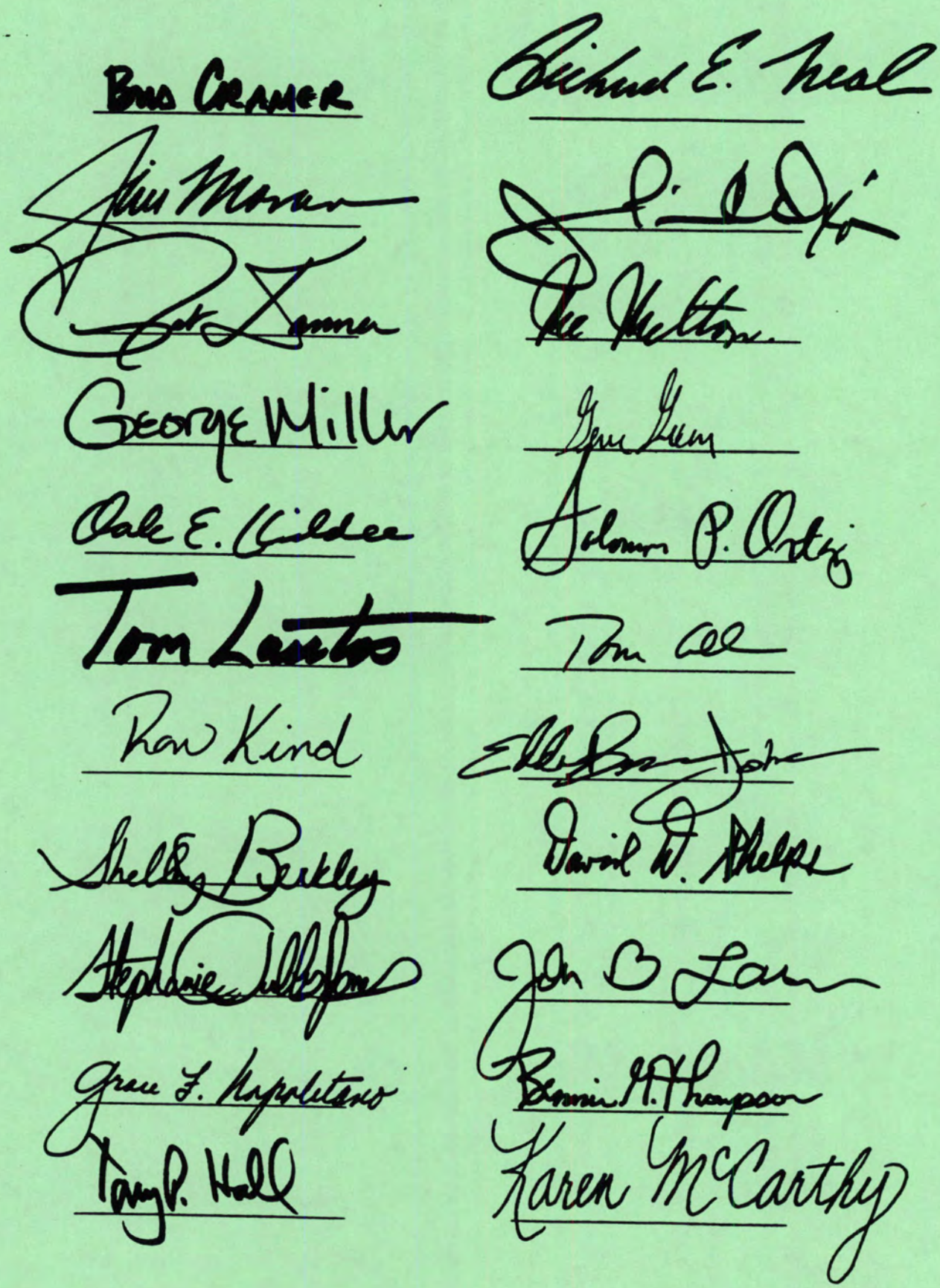
James Oberstar

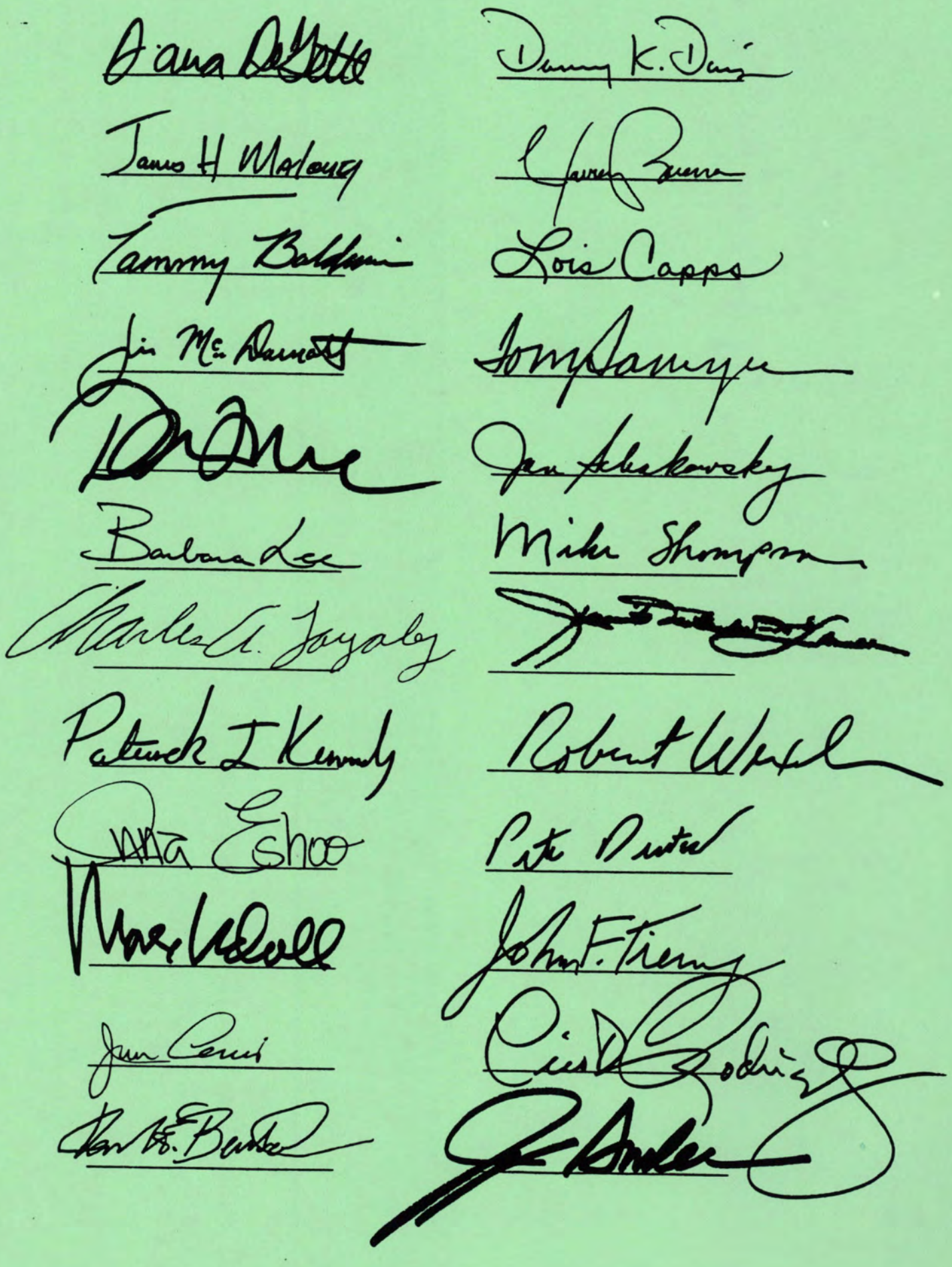
Marcy Kaptur

Norman Sisisky

Lane Evans

Howard L. Berman


Bud Cramer
Richard E. Neal
George Miller
Tom Lantos
Ron Kind
Shelley Berkley
David D. Phelps
Grace F. Napolitano
Bennie G. Thompson
Karen McCarthy



Pete Stark

Norm Dicks

Bobby L. Rush

Alcee L. Hastings

Matthew H. Martinez

Loretta Sanchez

Brad Sherman

Cal Dooley

Ellen O. Tauscher

Tom Barrett

Marion Berry

John Lewis

Ted Strickland

Adam Smith

Dennis J. Kucinich

Debbie Stabenow

William O. Lipinski

Jim Langevin

Lane Evans

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SENATORS SUPPORTING REQUEST FOR INCREASED APPROPRIATIONS FOR CHILDREN'S HOSPITALS GME, Co-Signers of March 10, 2000, Letter to Labor-HHS Leadership

ALABAMA
The Honorable Jeff Sessions (R-AL)

ALASKA
The Honorable Frank Murkowski (R-AK)

ARKANSAS
The Honorable Blanche Lincoln (D-AR)
The Honorable Tim Hutchinson (R-AR)

CALIFORNIA
The Honorable Barbara Boxer (D-CA)
The Honorable Dianne Feinstein (D-CA)

COLORADO
The Honorable Wayne Allard (R-CO)

CONNECTICUT
The Honorable Christopher Dodd (D-CT)
The Honorable Joseph Lieberman (D-CT)

DELAWARE
The Honorable Joseph Biden (D-DE)

FLORIDA
The Honorable Bob Graham (D-FL)
The Honorable Connie Mack (R-FL)

GEORGIA
The Honorable Max Cleland (D-GA)

HAWAII
The Honorable Daniel Inouye (D-HI)

ILLINOIS
The Honorable Richard Durbin (D-IL)
The Honorable Peter Fitzgerald (R-IL)

IOWA
The Honorable Tom Harkin (D-IA)

KANSAS
The Honorable Pat Roberts (R-KS)

LOUISIANA
The Honorable John Breaux (D-LA)

MARYLAND
The Honorable Paul Sarbanes (D-MD)

MASSACHUSSETTES
The Honorable Edward Kennedy (D-MA)
The Honorable John Kerry (D-MA)

MICHIGAN
The Honorable Spencer Abraham (R-MI)
The Honorable Carl Levin (D-MI)

MINNESOTA
The Honorable Rod Grams (R-MN)
The Honorable Paul David Wellstone (D-MN)

MISSOURI
The Honorable John Ashcroft (R-MO)
The Honorable Christopher "Kit" Bond (R-MO)

NEBRASKA
The Honorable Robert Kerrey (D-NE)

NEW YORK
The Honorable Daniel P. Moynihan (D-NY)
The Honorable Charles Schumer (D-NY)

OHIO
The Honorable Mike DeWine (R-OH)

OREGON
The Honorable Gordon Smith (R-OR)

PENNSYLVANIA
The Honorable Rick Santorum (R-PA)

RHODE ISLAND
The Honorable Lincoln Chafee (R-RI)

SOUTH DAKOTA
The Honorable Thomas Daschle (D-SD)

UTAH
The Honorable Orrin Hatch (R-UT)

VIRGINIA
The Honorable Charles Robb (D-VA)
The Honorable John Warner (R-VA)

WASHINGTON
The Honorable Slade Gorton (R-WA)
The Honorable Patty Murray (D-WA)

WISCONSIN
The Honorable Herbert Kohl (D-WI)

WYOMING
The Honorable Michael Enzi (R-WY)
The Honorable Craig Thomas (R-WY)

Senate Supporters

United States Senate

WASHINGTON, DC 20510

March 10, 2000

The Honorable Arlen Specter
Chairman
Subcommittee on Labor, HHS, & Education
Senate Appropriations Committee
186 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Tom Harkin
Ranking Member
Subcommittee on Labor, HHS, & Education
Senate Appropriations Committee
123 Hart Senate Office Building
Washington, DC 20510

Dear Senators Specter and Harkin,

With your leadership last year, Congress provided initial funding for graduate medical education (GME) in our nation's independent children's hospitals. For the first time, the federal government recognized the essential contributions these hospitals provide in training the physicians who care for our children. This year, we hope that we can take an important step towards full funding for this important program.

With strong bipartisan support, Congress authorized up to $285 million for this program for each of fiscal years 2000 and 2001. We understand the difficulties you will face in setting priorities during this year's appropriations cycle and understand that full funding may not be possible this year. However, we respectfully request funding for the children's hospitals GME program of $125 million. This would be a significant step forward in providing the critical support we began last year for children and children's hospitals' efforts to train the doctors who treat them.

The ever-changing world of health care simply does not compensate children's hospitals for their teaching and academic missions. Hospitals that do not receive medical education support from outside sources will simply not be able to maintain their teaching programs. Yet children's hospitals are essentially left out of the current GME financing system, which relies substantially on Medicare. Fully funded, this program would provide children's hospitals with GME funding equitable to that provided to other teaching hospitals, allowing them to sustain their core missions – medical care, teaching and research – which benefit all children.

We know that you appreciate the essential contributions of our children's hospitals. They serve as the health care safety net for low-income children in their respective communities and are often the sole regional providers of many critical pediatric services. These institutions also serve as centers of excellence for very sick children across the nation. Their teaching mission is also essential – comprising less than one percent of all hospitals, children's hospitals train five percent of all physicians, nearly 30 percent of all pediatricians, and almost 50 percent of all pediatric specialists.

Federal funding for GME in children's hospitals is a sound investment in children's health and provides stability for the future of the pediatric workforce. The pediatric and hospital communities join us in the support of this important program. Your continuing leadership on behalf of these institutions is much appreciated.

Sincerely,

Herb Kohl

John Ashcroft

Charles Schumer

Frank H. Murkowski

Connie Mack

Wayne Allard

Tom Daschle

John Breaux

Orrin G. Hatch

Mitch McConnell

Mike DeWine

Paul Sarbanes

Paul Wellstone

Craig Thomas

Jon Kyl

Lincoln Chafee

Edward M. Kennedy

Carl Levin

Dick Durbin

John Warner

Chris Dodd

Max Cleland

Dianne Feinstein

Barbara Boxer

American Academy of Pediatrics
141 Northwest Point Blvd., Elk Grove Village, IL 60007

National Association of Children's Hospitals
401 Wythe St., Alexandria, VA 22314

July 2000

Dear Senator:

On behalf of the American Academy of Pediatrics (AAP) and the National Association of Children's Hospitals (N.A.C.H.), we urge Congress to make a critically important investment in the future of pediatric medicine and the nation's pediatric workforce.

Please pass a FY 2001 appropriation for graduate medical education (GME) funding for independent children's hospitals as close as possible to the full authorization of $285 million, which the House and Senate both approved by unanimous consent just last November.

The AAP is an organization of 55,000 primary care pediatricians, pediatric medical specialists, and pediatric surgical specialists dedicated to the health, safety, and well being of infants, children, adolescents, and young adults. N.A.C.H. represents more than 100 independent children's hospitals, children's hospitals organized within larger medical systems, and children's specialty and rehabilitation hospitals across the country.

The AAP and N.A.C.H. are very invested in the education of the future pediatricians. We recognize that independent children's hospitals play an essential role. They represent less than 1% of all hospitals but educate nearly 30% of all pediatricians and nearly half of all pediatric specialists. Yet, they qualify for virtually no GME support from Medicare, the nation's one, remaining significant source of financial support for physician training, only because they care for children, not the elderly. Funding of $285 million represents equitable GME support – the amount of federal GME funding children's hospitals would receive if they qualified for the same level of GME support other teaching hospitals now receive through Medicare.

Both of our organizations and their respective members advocate comprehensive GME financing reform for all hospitals, but its achievement may well be years away. In the interim, the inability of independent children's teaching hospitals to continue their substantial contribution to training the next generation of pediatricians will be increasingly disadvantaged, without equitable federal GME support.

Please include equitable GME funding -- the full authorization – for children's hospitals in the FY 2001 Labor-HHS Appropriations Bill. For more information, call Karen M. Hendricks, AAP, at 202/347-8600, or Peters Willson, N.A.C.H., 703/684-1355. Thank you for your consideration.

Sincerely,

Joe M. Sanders, Jr., M.D.
Executive Director
American Academy of Pediatrics

Lawrence A. McAndrews
President and CEO
National Association of Children's Hospitals

ASSOCIATION OF MEDICAL SCHOOL PEDIATRIC DEPARTMENT CHAIRS, INC.

Elizabeth R. McAnarney, MD
President

Professor and Chair
Department of Pediatrics
Pediatrician-in-Chief
Children's Hospital at Strong
601 Elmwood Avenue, Box 777
Rochester, New York 14642-8777
Phone: (716) 275-4673
Fax: (716) 273-1079
E-Mail: carole_berger@urmc.rochester.edu

Jean Bartholomew
Coordinator

American Board of Pediatrics
111 Silver Cedar Court
Chapel Hill, North Carolina 27514
Phone: (919) 942-1993
Fax: (919) 929-9255
E-Mail: jbartholomew@abpeds.org

March 12, 2000

The Honorable Arlen Specter
United States Senate
Washington, D.C. 20510

The Honorable David Obey
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Tom Harkin
United States Senate
Washington, D.C. 20510

The Honorable John Edward Porter
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairmen/Ranking Members:

As the chairs of pediatric departments in medical schools across this country, we are writing to urge your support in making equitable graduate medical education (GME) funding for children's hospitals a priority in the FY2001 Labor-HHS Appropriations bill.

With your leadership, and strong bipartisan support, Congress appropriated $40 million for FY2000 children's hospitals GME in 1999. Shortly after the appropriations bill passed, Congress then enacted an authorization of $285 million annually for the program with strong bipartisan support. The level of funding in the authorization would provide independent children's hospitals with federal funding comparable to the Medicare GME support provided to other teaching hospitals.

Congress has taken a critically needed first step in recognizing the contributions of these institutions in training our children's doctors. We respectfully ask that you build on this important beginning and provide a funding level as close as possible to the full authorization so that independent children's hospitals' GME contributions may be treated equitably with other institutions.

This funding is essential not only to these pediatric academic medical centers but also to pediatrics overall. Because they care only for children, not the elderly, children's hospitals' are unable to qualify for significant support from the one reliable source of GME funding – Medicare. In an increasingly price-driven market place, that puts at risk their ability to sustain their core missions of caring for all children, teaching and research. It is a risk we cannot afford for the future of our pediatric workforce and advancements in children's care.

Although they represent less than one percent of all hospitals, these children's teaching hospitals train almost 30 percent of all pediatricians, almost half of pediatric specialists and two-thirds of pediatric critical care physicians. They are the major pipeline for future pediatric researchers, and they and their affiliated pediatric departments are among our nation's leading centers of pediatric research.

Equitable GME funding for children's hospitals is a sound investment in the future of pediatric medicine and children's health. Please provide a FY 2001 Labor-HHS-Appropriation for children's hospitals GME that moves as close as possible to the full authorization of $285 million.

Sincerely,

Robert C. Boerth, M.D., Ph.D.
Professor and Chair, Department of Pediatrics
University of South Alabama
Mobile, Alabama

Sergio Stagno, M.D.
Professor and Chair, Department of Pediatrics
The Children's Hospital at Alabama
Birmingham, Alabama

Debra Fiser, M.D.
Professor and Chair, Department of Pediatrics
University of Arkansas for Medical Sciences
Little Rock, Arkansas

Mark Batshaw, M.D.
Professor and Chair, Department of Pediatrics
Children's National Medical Center
Washington, District of Columbia

Renee R. Jenkins, M.D.
Professor and Chair
Department of Pediatrics and Child Health
Howard University College of Medicine
Washington, District of Columbia

David B. Nelson, M.D., M.Sc.
Interim Chair, Department of Pediatrics
Georgetown University
Washington, District of Columbia

Douglas J. Barrett, M.D.
Professor and Chair, Department of Pediatrics
University of Florida
Gainesville, Florida

R. Rodney Howell, M.D.
Professor and Chair, Department of Pediatrics
University of Miami School of Medicine
Miami, Florida

Bernard Pollara, M.D., Ph.D.
Professor and Chair, Department of Pediatrics
University of So. Florida
Tampa, Florida

Frank P. Bowyer, M.D.
Professor and Chair, Department of Pediatrics
Mercer University School of Medicine
Macon, Georgia

J. Devn Cornish, M.D.
Professor and Chair, Department of Pediatrics
Emory University School of Medicine
Atlanta, Georgia

Frances J. Dunston, M.D., M.P.H.
Chair, Department of Pediatrics
Morehouse School of Medicine
Atlanta, Georgia

William P. Kanto, Jr., M.D.
Professor and Chair, Department of Pediatrics
Medical College of Georgia
Augusta, Georgia

Larry N. Cook, M.D.
Bill F. Andrews Professor and Chair
Department of Pediatrics
University of Louisville School of Medicine
Louisville, Kentucky

Vipul N. Mankad, M.D.
Professor and Chair, Department of Pediatrics
University of Kentucky Medical School
Lexington, Kentucky

Ricardo U. Sorensen, M.D.
Professor and Acting Chair
Department of Pediatrics
LSU Medical Center
New Orleans, Louisianna

John E. Lewy, M.D.
Professor and Chair, Department of Pediatrics
Tulane University School of Medicine
New Orleans, Louisianna

Ildy M. Katona, M.D., CAPT, MC, USN
Chair, Department of Pediatrics
Professor of Pediatrics and Medicine
Uniformed Services Univ. of Health Sciences
F. Edward Hebert School of Medicine
Bethesda, Maryland

George J. Dover, M.D.
Chair, Department of Pediatrics
Johns Hopkins University School of Medicine
Baltimore, Maryland

Terrence L. Stull, M.D.
Hobbs-Recknagel Professor and Chair
Department of Pediatrics
University of Oklahoma Health Sciences Center
Oklahoma City, Oklahoma

Jay A. Perman, M.D.
Professor and Chair, Department of Pediatrics
University of Maryland School of Medicine
Baltimore, Maryland

Jon S. Abramson, M.D.
Weston M. Kelsey Professor and Chair
Department of Pediatrics
Wake Forest University School of Medicine
Winston-Salem, North Carolina

Roberta G. Williams, M.D.
Professor and Chair, Department of Pediatrics
University of North Carolina/Chapel Hill
UNC School of Medicine
Chapel Hill, North Carolina

Robert W. Block, M.D.
Professor and Chair, Department of Pediatrics
University of Oklahoma College of Med.
Tulsa, Oklahoma

John W. Sparks, M.D.
Professor and Chair, Department of Pediatrics
University of Texas, Houston Medical School
Houston, Texas

Charles P. Darby, M.D.
Professor and Chair, Department of Pediatrics
Medical University of South Carolina
Charleston, South Carolina

Owen B. Evans, M.D.
Professor and Chair, Department of Pediatrics
University of Mississippi Medical Center
Jackson, Mississippi

Michael M. Frank, M.D.
Professor and Chair, Department of Pediatrics
Duke University School of Medicine
Durham, North Carolina

Susanne Tropez-Sims, M.D., M.P.H.
Professor and Chair, Department of Pediatrics
Meharry Medical College
Nashville, Tennessee

Charles M. Ginsburg, M.D.
Professor and Chair
Marilyn R. Corrigan Distinguished Chair in Pediatrics
Department of Pediatrics
Southwestern Medical Center at Dallas
Dallas, Texas

C. Warren Derrick, Jr., M.D.
William Weston Professor and Chair
Department of Pediatrics
University of South Carolina School of Medicine
Columbia, South Carolina

Russell W. Chesney, M.D.
Le Bonheur Professor and Chair
Department of Pediatrics
University of Tennessee, Memphis
College of Medicine
Memphis, Tennessee

David Kalwinsky, M.D.
Interim Chair
Department of Pediatrics
East Tennessee State University
James H. Quillen College of Medicine
Johnson City, Tennessee

Ralph D. Feigin, M.D.
President & J.S. Abercrombie Professor of Pediatrics
Chair, Department of Pediatrics
Baylor College of Medicine
Houston, Texas

Celia I. Kaye, M.D., Ph.D.
Professor and Chair, Department of Pediatrics
Health Science Center at San Antonio
San Antonio, Texas

Walter J. Meyer, M.D.
Interim Chair, Department of Pediatrics
University of Texas Medical Branch, Galveston
Children's Hospital
Galveston, Texas

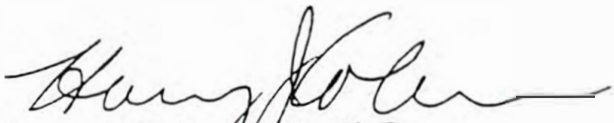
Robert L. Chevalier, M.D.
Benjamin Armistead Shepherd Professor and Chair
Department of Pediatrics
Univ. of Virginia Children's Medical Center,
School of Medicine
Charlottesville, Virginia

Arno L. Zaritsky, M.D.
Professor and Chair, Department of Pediatrics
Eastern Virginia Medical School
Norfolk, Virginia

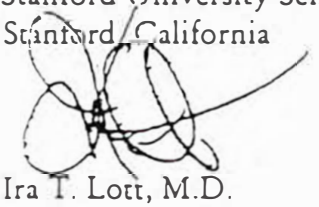
Don P. Wilson, M.D.
Professor and Chair, Department of Pediatrics
Texas A&M University College of Medicine
Scott and White Children's Health Center
Temple, Texas

Lindsey Grossman, M.D.
Interim Chair, Department of Pediatrics
Medical College of Virginia
Virginia Commonwealth University
Richmond, Virginia

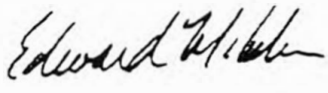
F. Bruder Stapleton, M.D.
Ford/Morgan Professor and Chair
Department of Pediatrics
Children's Hospital and Medical Center
Seattle, Washington



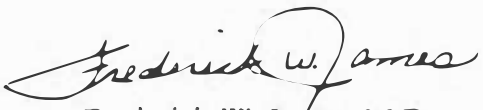
Harvey J. Cohen, M.D., Ph.D.
Professor and Chair
Department of Pediatrics
Stanford University School of Medicine
Stanford, California



Ira T. Lott, M.D.
Professor and Chair
Department of Pediatrics
University of California, Irvine
Orange, California



Edward McCabe, M.D., Ph.D.
Professor and Executive Chair
Department of Pediatrics
UCLA School of Medicine
Physician-in-Chief
Mattel Children's Hospital at UCLA
Los Angeles, California



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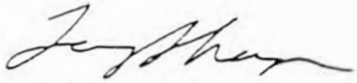

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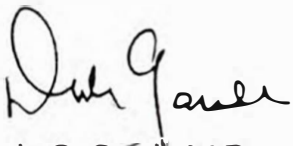

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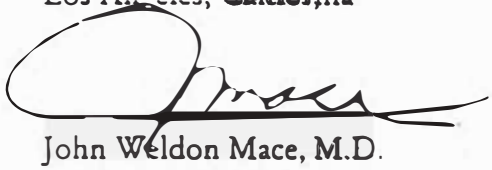

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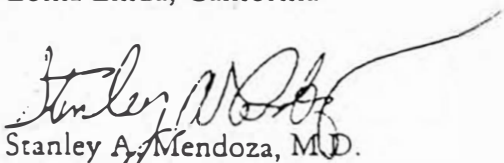

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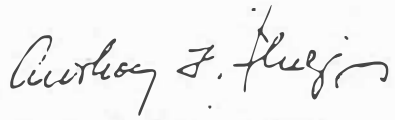

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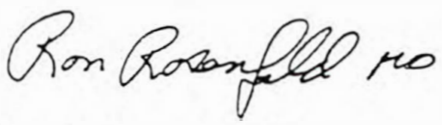

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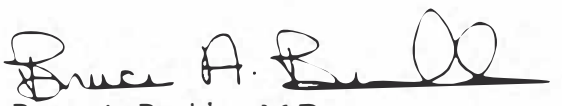

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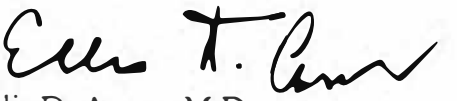

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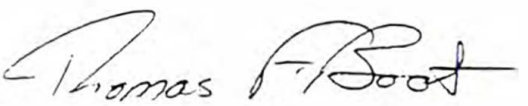

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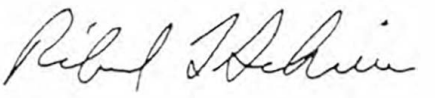

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National Association of
Children's Hospitals

N · A · C · H

Testimony

on behalf of the
National Association of Children's Hospitals
Alexandria, VA

to the
Labor, Health and Human Services, Education,
and Related Agencies Subcommittee
Committee on Appropriations
U.S. House of Representatives
Washington, DC

on
10:00 a.m., Tuesday, March 7, 2000

Russell W. Chesney, M.D.
Vice President for Academic Affairs
LeBonheur Children's Medical Center
Chairman, Department of Pediatrics
University of Tennessee
Memphis, TN

Mr. Chairman, my name is Russell Chesney, M.D.

Thank you for the opportunity to testify on behalf of the National Association of Children's Hospitals (N.A.C.H.) in Alexandria, VA, in support of equitable federal investment in the future of the graduate medical education (GME) programs of the nation's independent children's teaching hospitals. This investment is authorized under P.L. 106-129 and administered by the Bureau of Health Professions (BHPr) in the Health Resources and Services Administration (HRSA).

Background

I am Vice President for Academic Affairs of Le Bonheur Children's Medical Center in Memphis, TN. I am also Le Bonheur Professor and Chair of the Department of Pediatrics and Professor of Biochemistry at The University of Tennessee in Memphis.

My entire career has been devoted not only to clinical care of children but also to academic pediatric medicine, including training and research. I have served the larger pediatric academic community in a number of capacities. Currently, I am President-elect of the Association of Medical School Pediatric Department Chairs (AMPSDC), which represents the pediatric leadership of the nation's medical schools. I also am Secretary-Treasurer of the American Board of Pediatrics (ABP), which is responsible for the board certification of most of the nation's pediatric workforce.

In addition, I recently completed three years of service as Vice Chairman of the Future of Pediatric Education Task Force II (FOPE II), a project of the entire pediatric community. It was sponsored by the American Academy of Pediatrics, AMPSDC, ABP, and others with financial support of the David and Lucile Packard Foundation and the federal Maternal and Child Health Bureau to address the future supply and education of pediatricians and the provision of care to children into the next millennium.

N.A.C.H. is a non-profit trade association, representing more than 100 children's hospitals across the country. They include independent acute care children's hospitals, such as Children's Memorial Hospital in Chicago; acute care children's hospitals organized within larger medical centers, such as Le Bonheur Children's Medical Center in Memphis; and children's specialty and rehabilitation hospitals, such as Hospital for Sick Children in Washington, DC.

N.A.C.H. seeks to serve its member hospitals' ability to fulfill their four-fold missions of clinical care, education, research, and advocacy devoted to the health and wellbeing of the children of their communities. Children's hospitals are regional and national centers of excellence for children with serious and complex conditions. They are centers of biomedical and health services research for children and the major pipeline for future pediatric researchers. They train a significant number of our children's doctors. These institutions are advocates for the public health of children, and they are often the health care safety net for children of low-income families.

N.A.C.H. Recommendation for FY 2001

N.A.C.H. deeply appreciates the Subcommittee's recognition of the need for new federal GME support for independent children's hospitals by including $40 million for this program in last year's appropriation bill.

Congress has authorized GME funding for children's hospitals at $285 million for FY 2001 – an amount that would provide these institutions with federal funding equitable to the level of GME support provided to other teaching hospitals under Medicare. **On behalf of N.A.C.H., I urge you to build on the initial funding provided in FY 2000 and move toward full funding for this program by appropriating a minimum of $125 million for independent children's hospitals in FY 2001.** This would represent a significant step toward achievement of the full authorization level.

This investment is important to the future of our independent children's hospitals. It also is essential to the future of the nation's entire pediatric workforce, including our pediatric research enterprise.

Importance of GME Support for Children's Hospitals to the Future of Pediatric Medicine

Independent children's teaching hospitals provide a disproportionately large source of training for the nation's workforce of pediatricians and pediatric subspecialists. They represent less than 1% of all hospitals in the country, comprising approximately 48 acute care children's hospitals and 11 specialty or rehabilitation facilities – children's hospitals that operate under their own Medicare provider number for purposes of patient care billing.

But they train nearly 30% of the nation's pediatricians, nearly half of the nation's pediatric subspecialists, and the majority of selected subspecialists, such as pediatric emergency care physicians. In addition, they are the pipeline of training for many of the nation's pediatric research scientists.

As a consequence, they are essential to the training of the pediatric workforce overall. They are essential to the training of the pediatric subspecialty workforce. And they are essential to the training of our pediatric research scientist workforce. The future of pediatric clinical care and pediatric science depends considerably upon them.

That is why among its 34 recommendations, the Future of Pediatric Education II Task Force specifically recommended:

> *"Pediatric residents and fellows at freestanding children's hospitals should receive the same level of federal support as those trained elsewhere."*

The recommendations of the FOPE II Task Force culminated three years of work by pediatric leaders in consultation with the entire pediatric community and the many professional organizations within it.

The academic community, including N.A.C.H., strongly endorses the goal of achieving broad-based financing of GME with the support of all payers. But the achievement of that goal is not on the political horizon. Until it can be achieved, it is critical that equitable federal support for independent children's teaching hospitals, which would amount to about $285 million annually, be invested.

Absence of GME Support for Independent Children's Hospitals

In today's increasingly price competitive health care market place, all teaching hospitals, including independent children's hospitals, face mounting challenges to their ability to cover the added costs that result from their teaching missions.

However, independent children's teaching hospitals face an additional financial challenge, which other teaching hospitals do not face. Because they care for children, not the elderly, independent children's teaching hospitals qualify for virtually no GME support from the one remaining, significant source of funding for physician training – the federal Medicare program.

On average per resident full time equivalent (FTE), in FY 1997 independent children's hospitals received Medicare GME support that amounted to less than 0.5% of the Medicare GME support that other teaching hospitals received. Were independent children's teaching hospitals to receive federal GME support comparable in amount to the Medicare GME support that other teaching hospitals receive, it would total approximately $285 million for 59 institutions, according to estimates of The Lewin Group, an independent health policy analysis firm.

The combination of price competition and inability to qualify for significant Medicare GME support places children's hospitals at a serious competitive disadvantage. According to data from the National Association of Children's Hospitals and Related Institutions (NACHRI), while the financial performance of children's hospitals has been positive on average, it is due largely to two factors. The first is state Medicaid disproportionate share payments, and the seconds is investment of endowment income in the financial markets. However, federal Medicaid disproportionate share funding is scheduled to decline by 17% between 1997 and 2002, with the largest reductions coming in FY 2001 and 2002. And financial market performance is by no means guaranteed, as market changes in recent weeks demonstrate.

Indeed, in hospitals' fiscal year 1998,

- more than 69% of the independent acute care children's teaching hospitals experienced patient care operating losses,
- more than 20% experienced financial losses on total operations, and
- more than 15% had total losses; that is, total expenses exceeded total revenues.

In every region of the country – north, south, east, and west -- there are independent children's teaching hospitals today, which already are experiencing very serious financial challenges to their ability to sustain their missions. In addition to the challenges of covering the costs of their academic programs, they also include challenges in covering the higher costs of sicker patients in a price competitive marketplace, meeting the costs of uncovered services such as child protection services and poison control centers, and assuming the costs of devoting a large portion of their patient care to children of low-income families.

On average, independent acute care children's hospitals devote nearly half of their patient care to children who are assisted by Medicaid or are uninsured. They devote more than 75% of their care for children with one or more chronic or congenital conditions. For children with rare and complex conditions, independent children's hospitals often provide the majority of care in their region or even nationwide.

Left unresolved, children's hospitals' financial challenges will seriously affect not only their academic programs of education and research but also their clinical care missions as safety net providers and centers of excellence. In fact, their roles as safety net providers and centers of excellence are made possible in part by their having strong academic programs.

Congress' Recognition of the Need for GME Support for Independent Children's Teaching Hospitals

In 1999, the 106th Congress took two important steps to recognize the need for equitable GME support for independent children's teaching hospitals.

First – with an authorization bill pending -- Congress appropriated initial funding of $40 million to begin to address the need for GME support for these institutions. Second, in the final hours of its first session, the 106th Congress enacted legislation authorizing $285 million for FY 2001.

This legislation had broad, bipartisan support in Congress. The pediatric community – including the American Academy of Pediatrics, American Pediatric Society,

Association of Medical School Pediatric Chairs, and Society for Pediatric Research, as well as N.A.C.H. – agrees on the need to address this issue.

Conclusion

Mr. Chairman, we know that the Subcommittee faces many challenges of its own as it seeks to craft its annual funding bill that balances fairly competing priorities for limited resources.

Support for a strong investment in graduate medical education at independent children's teaching hospitals is consistent with the repeated concern the Subcommittee has expressed for the health and well-being of our nation's children --- through education, health, and social welfare programs.

It also is consistent with the Subcommittee's repeated emphasis on the importance of enhanced investment in the National Institutes of Health (NIH) overall, and in NIH support for pediatric research in particular, for which we are very grateful. **Without strong GME programs, children's hospitals cannot maintain their pediatric research programs or compete effectively for new research support.**

Again, I urge you to include a minimum funding level of $125 million in FY 2001 for independent children's hospitals' GME. Thank you for this opportunity to appear before your subcommittee.

WITNESS BIOGRAPHY

Russell W. Chesney, Jr., is Le Bonheur Professor and Chair of the Department of Pediatrics and Professor of Biochemistry at The University of Tennessee in Memphis, TN. He also is Vice President of Academic Affairs at Le Bonheur Children's Medical Center and Adjunct Faculty Member at St. Jude Children's Research Hospital, both in Memphis. And he serves as Co-director of the Crippled Children's Foundation Research Center at Le Bonheur Children's Medical Center.

Honors and Societies Dr. Chesney has served in numerous professional societies and been honored for his contributions to the field of pediatric medicine. Currently, he is President-Elect of the Association of Medical School Pediatric Department Chairs, Secretary-Treasurer of the American Board of Pediatrics, and Editor-in-Chief of the journal *Pediatric Nephrology*. He is the recipient of the Nutrition Award of the American Academy of Pediatrics in 1996 and The Founders Award of the Southern Society for Pediatric Research in 1993.

Education, Research, and Publications Dr. Chesney received his A.B. in Biology from Harvard College, Cambridge, MA, in 1963 and his M.D. from the University of Rochester, Rochester, NY, in 1968. He received his internship and residency training in pediatrics at Johns Hopkins Hospital in Baltimore, MD. He has participated in numerous research projects and is the author of more than 400 articles and chapters in professional publications.

Faculty Appointments The following summarizes Dr. Chesney's faculty appointments:

1970 – 1972	Clinical Associate in Renal Biochemistry, National Institute of Child Health and Human Development, Lab of Molecular Aging, National Institutes of Health, Bethesda, MD
1973 – 1974	Pediatric Nephrology Fellowship, Montreal Children's Hospital, McGill University, Quebec, Canada
1974 – 1975	Biochemical Genetics Fellowship in Renal Transport Physiology, DeBelle Labs, Montreal Children's Hospital, McGill University, Quebec, Canada
1975 – 1979	Assistant Professor of Pediatrics, University of Wisconsin, Madison, WI
1979 – 1981	Associate Professor of Pediatrics, University of Wisconsin, Madison, WI
1980 – 1985	Professor of Pediatrics, University of Wisconsin, Madison, WI
1985 – 1987	Professor and Vice-Chair, Department of Pediatrics, University of California, Davis, CA
1988 – Pres.	Le Bonheur Professor and Chair, Department of Pediatrics and Professor of Biochemistry, the University of Tennessee, Memphis, TN
1994 – Pres.	Co-Director, Crippled Children's Foundation Research Center, Le Bonheur Children's Medical Center, Memphis, TN
1997 – Pres.	Adjunct Member, St. Jude Children's Research Hospital, Memphis, TN

FINANCIAL DISCLOSURE
OF RECEIPT OF FEDERAL GRANTS
FOR FY 1998, 1999, 2000

1. The National Association of Children's Hospitals (N.A.C.H.) in Alexandria, VA, has not received any federal grants, contracts, subcontracts, or other federal funding in the current or previous two fiscal years.

2. Russell W. Chesney, M.D., Chair of the Department of Pediatrics, The University of Tennessee, Memphis, TN, is a principal in two federally funded grant projects:

   - **National Institute of Child Health and Human Development, National Institutes of Health, U.S. Department of Health and Human Services**

     "Network of Pediatric Pharmacology Research Investigators"
     Principal Investigator: Russell W. Chesney
     Agency NIH – U01 HD31326-05
     Funding Period: 1994 – 2000
     Total Direct -- $154,175
     Year Direct -- $1,872,126

   - **Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services**

     "The Future of Pediatric Education II: Organizing Pediatric Education to Meet the Needs of Infants, Children, Adolescents, and Young Adults in the 21st Century"
     Principal Investigator: American Academy of Pediatrics
     Agency: Maternal and Child Health Bureau, Project #MCJ379381
     Funding Period: 1998 – 2000
     Total Direct -- $80,000
     Year Direct -- $250,000

file chips (children weekend)

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release February 23, 1999

PRESS BRIEFING BY
CHRIS JENNINGS, DEPUTY ASSISTANT TO THE PRESIDENT
FOR HEALTH CARE POLICY

The Briefing Room

1:12 P.M. EST

MS. WEISS: Ladies and gentlemen, today Chris Jennings will brief you on what the President will be announcing in the next hour. The President will launch a national outreach campaign called "Insure Kids Now," which is aimed to enroll eligible, but uninsured children in Medicaid by promoting awareness and increasing enrollment in the Children's Health Insurance program, also known as CHIPS.

Chris Jennings is the Deputy Assistant to the President for Health care Policy.

MR. JENNINGS: Today we're very excited; on the heals of the NGA meeting over this weekend, we have been working with them very, very closely, as well as a whole bunch of corporate entities, in developing a major new outreach campaign for eligible children who are eligible for either -- millions of eligible children, over 5 million children in this country are eligible and not enrolled in either the Medicaid program or the new CHIP program the President signed into law in 1997.

It builds on a whole host of other initiatives that the President and the First Lady and the Vice President have been involved in the last year. I'm going to just briefly talk about that, and then I'm going to talk about what we're doing today.

After the enactment of the historic $24 billion CHIP program, the President and the First Lady and the Vice President held a series of events, working with the governors and over 11 agencies in the federal government, to develop ways to use our resources to target these children and make them aware of this information about the new children's programs, as well as to help enroll them more effectively.

One of the big challenges in targeting and enrolling children is not just making sure they're aware of the program, but also simplifying applications procedures, actually going to where those children are, whether it be in the school, whether it be in public housing, whether it be in churches and other places, and what we've done last year was to work with all our federal agencies -- not just HHS, which has done a remarkably good job this year for us, but also agencies you wouldn't necessarily think automatically -- Agriculture, Labor, HUD, Justice -- all of the 11 agencies have been participating very, very actively.

And what we've done is laid the groundwork for being able to enroll the children very, very effectively. But really, what we need to do now is to not just make sure we have the on-the-ground support and the infrastructure and the enrollment forms, but we have to make sure kids are actually aware of the programs and have a place to go to get information about these programs.

So what we've been doing with NGA, working very closely and working with Bell Atlantic, is developing an 800 toll-free number. And the toll-free number is now up and running, as of today. I just called it about two minutes ago and they answered, and they have information. The number is: 1-877-KID-SNOW. And that number translates into 1-877-543-7669.

Now, what we're doing today is announcing the availability of that toll-free number, and what's most interesting about this, this is the first time we've ever done this nationally. Anyone who calls that number, wherever they are in the country will be automatically forwarded to an operator and an information worker within the state they're calling. So if I call from the State of Washington or Utah or whatever, I'll go the national number, but I'll be routed back to the state, where someone will know information about this program, which is really very, very important.

But now that we have this national campaign, and national toll-free number up and running today, we can actually utilize our resources, working with the networks, working with a whole bunch of corporate entities, to advertise this number.

And I want to give you a couple of examples about this, because we're really thrilled about this. First, NBC is going to be -- they have made a commitment to air a public service announcement beginning February 24th, using NBC stars from well-known shows. ABC has made a similar commitment as well -- we're quite pleased about that, Sam -- as well as a whole host of other people, including Turner Broadcasting, Univision, the National Association of Broadcasters, Univision and others.

Getting the information out is critically important for -- and particularly about how to access it, through the toll-free number -- is something very, very important. But also, we need to do this, not just in terms of national networks, but we have to do targeted -- both networks and targeted radio. And we have gotten commitments for radio ads in 45 states -- Bonneville Communications and others are going to be doing a whole host of radio announcements as well -- as has a whole host of print media establishments, too.

But, not just getting the information there, because -- well, everyone watches TV, everyone hears the radio, but we also know where parents go. They go to grocery stores, they go to K-K-Mart, they go to McDonald's. And what we're really thrilled about today is to announce that a whole host of these corporate entities are making commitments to educate even their own shoppers and their consumers with access to information about the program, and even about the toll-free number.

K-Mart, McDonald's, General Motors -- General Motors is going to affix a label to all their child safety seats that they sell, so when you're putting in your children you're going to see your toll-free number, how you can access -- Safeway, Rouse Grocery Store, others are going to be putting this in all their paperbags and everything. So people are going to know this number, if we can find any way at all to do it.

But we've also found that, obviously, the other places where people and their parents try to seek health care is with their providers, whether it be their doctors, their nurses, their dentist -- the American Dentist Hygienist Association is going to put the toll-free number on all their toothbrushes that they send out. We're going to have AMA, the Nurses Association, the American College Emergency Physicians are all going to be providing information directly to their patients who come in.

And we're also thrilled about a whole host of

community-based organizations -- United Way, Volunteers of America, Points of Light, America's Promise, others are really making a significant commitment in this area to get the word out as well.

The real point of all this activity -- and I could go on and on and on -- we have a real major commitment from the religious organizations as well. From Amy we can give you a host of -- a nine-page list of commitments from around the country, and I think the most important thing is that we get out the message -- is that children who are uninsured now have access to a free or low-cost option, that there is no excuse that we don't all work together to get this information out, and we must do a better job of target enrolling it. We're very happy that we have the governors on board. We think they've done some creative things and we're going to be committing today to do some more over the next several months and weeks and months to come, and I'd be happy to answer any questions specifically about this initiative.

Q CHIPS was created two years ago. Why has it taken so long to deal with the enrollment problem? Because, presumably, is millions of kids is still out there.

MR. JENNINGS: Actually, it's true. CHIP was enacted into law -- it was the end of 1997. What we're actually quite thrilled about is less than a year after enacting it, we have over 45 states who are now up and running, and they're projecting, I think it's about 2.5 million kids that they will eventually get to. But again, the programs are just up and running.

The most important thing is, you start the programs; now that they're up and running, now that we're doing these easier administrative application and enrollment forms, we're getting the information out about how to access them, really, I've got to tell you, when you're trying to enroll children into these programs, it's a lot of hard work. You've got to go to where they are, you have to go to places that you otherwise might have not immediately thought. You can't just say I have a program, you have to go out and find them and find their parents.

This program that we're doing today actually we think will go a long way to ensure CHIP is successful, but so is the promise of the Medicaid program as well.

Q I don't know what you're talking about. What is CHIP?

MR. JENNINGS: CHIP is the Children's Health Insurance Program. CHIP --

Q State by state?

MR. JENNINGS: Yes, in 1997 in the balanced budget program, the President advocated for and the Congress passed an historic $24-billion Children's Health Insurance Program, short for CHIP. And it is a state-administered program. We provide for flexibility, but --

Q Where does the money come from?

MR. JENNINGS: The money comes specifically from the Balanced Budget Agreement. We had savings from the balanced budget that we achieved that we redirected towards providing

subsidies to states so they could provide for children to make health care affordable, and in many cases free.

Q So this is for poorer families? In other words, there is an eligibility requirement?

MR. JENNINGS: There is an eligibility requirement. Actually, there is a lot of flexibility. Many states are -- all the way up to over 200 percent of poverty, some go up to 200 percent of poverty. All these kids, almost probably 95 percent-plus are children of working families -- families who are workers, but who cannot afford or do not have access to health care. And this program was designed to target that population.

As you know, we have the Medicaid program that we've had some success in covering children. We have not done as good a job as we should in terms of enrolling all of the eligible kids even for the Medicaid program. The advantage of this activity that we're announcing today is, it will benefit both the Medicaid program and the CHIP program together.

Q Chris, what are some of the leading reasons after all this publicity that kids are not enrolled? Is it just ignorance in the existence of these programs?

MR. JENNINGS: Historically, lower income programs, you don't have as significant enrollment as you want to have, but what we've learned over the years past is you can significantly improve your enrollment if you can go to the places where the children are, where the populations are, and you can do it in a way that is a non-threatening way. That is in other words, you don't have a 100-page application form you have to fill out, you have a five-page form. You automatically are eligible.

They almost immediately enroll you if you come in and you come close to fulfilling eligibility. In many states, they have what they call "presumptive eligibility," so they can say, okay, you look like you're enrolled, so I'm going to enroll you automatically. And what we've found in many, many states who are using these type of programs, and others, they are having much greater success. But, you have to do the hard work of educating and informing, and publicize this over and over and over again. And you have to use the foundations, the churches, the providers, the schools. You can't just do this about a big public campaign. You have to use the private entities.

And what we're most pleased about is, we're really being joined today by a lot of the corporate community, to educate people about this program, where children go every day.

Q Can you point to any pattern of health problems among children who are not enrolled in this? Is there any --

MR. JENNINGS: Absolutely. I mean, what we have learned, of course, is if you don't have access to health care, you frequently don't have access to the preventive-type coverage that you really need to avoid the illnesses and diseases over a period of time. And we have some really good data on that, we'd be happy to supply to you.

But the lack of uninsured means, also, lack of even performance in schools, a lack of ability to go day in and day out to increase your education capability, increase your economic standing, which again, of course, is a huge correlation between economic standing and health care as well.

Q How old, and how many children are we talking about in this particular --

MR. JENNINGS: Well, in a CHIP program, we believe that there's about -- well, first of all there's probably, or almost 4 million children who are eligible but still not enrolled in the Medicaid program. In CHIP, we think it's, you know, it's over 2 million probably. We're talking about a number of -- certainly in aggregate, over 5 million kids who are eligible and not enrolled in either Medicaid or CHIP. And those are the numbers that we're using right now.

And if we can just -- if we can be very effective at targeting and enrolling these kids, we can, with programs currently available, get millions of kids coverage that they really desperately need.

Q And that is compared to how many that are in? Enrolled?

MR. JENNINGS: And that's -- well, in the Medicaid program for children I think we have about 20 million children today. In CHIP, we have just started the program; we're probably around a million or so, and hoping to increase that number over a period of time.

Q This is on a different subject. Tomorrow the Medicare Commission is meeting, and there's been some concern about what kind of guidance the President or the White House has been giving their four appointees, and also some concern that they're kind of moving on bloc and haven't been given the latitude to split up in their different ways over -- plan. What can you tell us about what kind of guidance the President has given his appointees in the Medicare Commission and where is that commission going?

MR. JENNINGS: First, our hope, of course, is that the Medicare Commission integrates the President's proposal that he announced in the State of the Union, dedicating 15 percent of the surplus to the Medicare program. Every one of our commission members and appointees believes strongly, as does every independent analyst out there, that you can't significantly extend the life of the trust fund without an infusion of dollars. And it almost doesn't make sense to proceed and say that you're going to have really significant reforms without those infusion of dollars.

Having said that, I'll tell you -- I don't know if you've been watching our commission members -- I don't think people would say that Bruce Vladeck and Stuart and Laura Tyson are always in the same exact place. They're not acting or behaving like they are in a bloc vote here at all.

The President did lay out some principles, one of which was dedicating the surplus. The other was a defined benefit; the other was a viable prescription drug benefit; and for low-income protections for beneficiaries. Those are just very basic principles that I think he and his members believe in, but I think most Democrats do believe in. And I think we've been encouraged that some Republicans are.

I guess I would just say that, in general, we're not going to comment on individual iterations of the commission until they complete their work. They have not completed the work, they don't have the details done. We have worked with Senator Breaux for months; we're trying to provide technical assistance and we

will continue to do so. And as you know, we respect him greatly and we hope that we can get something very, very positive out of this commission.

Q Senator Breaux was actually trying to get some time with the President this week to talk about the commission. Has he gotten any and is there any time on the schedule for that?

MR. JENNINGS: I'll tell you what, I don't know if he's talked to the President yet. I don't believe he has, but Senator Breaux has never had a difficulty in contacting the President and they have a very close working relationship and I assume they'll be talking soon -- not just this week, but into the future as we talk about the developments around the Medicare Commission.

Q But if the appeal is for -- if Senator Breaux makes an appeal to the President, have one of your members vote for this so that we can get the 11 votes, the super majority that we need, what's the answer?

MR. JENNINGS: Our members -- first of all, our members, our commission members feel very strongly about some core principles. They feel very, very strongly about defined benefit, they feel very strongly about the issue of a viable prescription drug benefit that's available for all Medicare beneficiaries, and they also all agree very strongly that you should dedicate the surplus to the Medicare program.

Those are things that they, independently, they've been saying this for two months. Now, if the commission moves to address all of those things, I think that they'll see much more openness by our members of working on this issue. But we're just not there just yet. We're hopeful that we will get there. But we're not going to say to one commission member against their desires to vote for something that they don't believe in, but we also think that Senator Breaux really values the input that our people have given to this commission, and our hope is, over a period of time that that will strengthen the work of the commission.

So I'm not going to get into this political "I'll give you this and that." I really believe that this whole policy, this whole issue of the Medicare program is too important to say it's all about political positioning. It really is about having a strong product emerging from the Medicare Commission that we can all be happy with on a bipartisan basis and that does significantly move to extending the trust fund, but also strengthening and improving the program as we know it today.

Q Senator Lott said today that he does not believe -- he believes that if you can't get the 11 votes, you will not get Medicare reform in this Congress. Do you agree with that, or no?

MR. JENNINGS: I think you definitely want to have a strong vote out of the commission and have a bipartisan one. I think that there was not a uniform agreement out of the Social Security recommendation of the commission, and our hope has been and continues to be, as we've seen in recent weeks, that there is growing momentum to have an agreement on Social Security. So despite the fact that the Social Security Commission had a uniform agreement, some of the base ideas that were formed and given to us provide a solid foundation for us to move forward.

The Medicare Commission, we think, with the majority or without a majority, at least has the potential to do so.

Obviously, our preference would be if everyone voted for -- if it was all 17 members, it would mean that you would have a very, very -- have a much greater chance. But I wouldn't say that having 11 or 10 or whatever is necessarily dispositive to whether or not it has a significant influence on whether or not we have strong Medicare reform emerging from this Congress.

Q Will the President embrace this thing and will he put as much attention into Medicare as he has into Social Security so far? What kind of priority is this?

MR. JENNINGS: Sure. One thing that people didn't recognize about the President, even during the whole year of Social Security, it was the President who continually said over and over again, he said Social Security and Medicare. It was never Social Security independent of Medicare. He feels they're really joined at the hip, and he feels quite strongly that with his foundation of dedicating the surplus to the Medicare program and some of the reforms he would like to see of the program, modernizing the program, making it more competitive, making it more oriented towards being able to use the same purchasing tools for the fee-for-service program that private sector now has, we can significantly strengthen and improve the Medicare program, and he hopes that as part of an overall agreement on Social Security, we can get an overall agreement on Medicare.

THE PRESS: Thank you.

END 1:32 P.M. EST

December 10, 1997

NYC CHILDHOOD ASTHMA INITIATIVE ANNOUNCEMENT

DATE:	**Thursday, December 11**
TIME:	**11:05 am - 12:00 pm**
LOCATION:	**South Bronx Children's Health Center Bronx, NY**
FROM:	**Brenda Costello**

I. PURPOSE

To tour the South Bronx Children's Health Center and mobile unit and to participate in the announcement of plans to create the New York City Childhood Asthma Initiative.

II. BACKGROUND

NYC Asthma Initiative

Thursday's event will announce plans to create the *New York City Childhood Asthma Initiative*, addressing the incidence of childhood asthma in New York City (one of the highest in the country). The initiative is aimed at increasing national public attention recognizing Asthma as a serious growing health problem, particular amongst young and high risk children, children that are medically under served, and in poor communities.

This city-wide Asthma Initiative would demonstrate a public/private partnership between The Children's Health Fund, Councilman Ken Fisher, and the New York City Department of Health. While the Initiative is proceeding and there has been an agreement with the city for $1.2 million earmarked in the Mayor's budget for this initiative, the actual contract has not yet been signed. You will help announce plans to create the partnership rather than announcing the actual partnership.

The Initiative is comprised of the following components:

- Primary Care and asthma services, as well as provider education and awareness
- Community-based programs/School-based programs - asthma awareness and education, community outreach
- Collaborative Component - Citywide Asthma Awareness Campaign developed by the New York City Council, NYC Department of Health, and CHF.

Children's Health Fund/National Children's Health Project Network

As you know, Dr. Irwin Redlener established the CHF, which supports pediatric programs designed to meet the complex health care needs of medically under served, homeless and indigent children. Since its inception in 1987, CHF has provided grants

and technical assistance to establish Children's Health Projects (CHP) in a variety of urban and rural communities, and has recently introduced *Kids First, Kids Now!*- a public awareness initiative introduced by CHF and cartoonist Garry Trudeau to promote appropriate health care available to every child in America.

The CHP's provide primary medical care to homeless and indigent children via fixed-site medical settings and through a fleet of mobile medical unit, that are based in, or affiliated with, academic medical centers. The CHF pediatric programs currently consist of 12 Children's Health Projects (CHP's), including two projects in New York City. CHF's New York Programs are: The South Bronx Children's Health Center (SBCHC), and The New York Children's Health Project. These initiatives provide comprehensive pediatric care to some of New York City's neediest children.

South Bronx Children's Health Center (SBCHC)

SBCHC opened in 1993 and is one of CHF's 12 clinics across the country. (According to Dr. Redlener, you saw a mobile unit in April 1997 in Philadelphia at the Service Summit and also in Florida.) Providing pediatric and prenatal care as well as mental health services and entitlement assistance, the center serves permanently housed and recently relocated families in the South Bronx area. The program has a neighborhood based focus, and pays explicit attention to promoting access to health services. The clinic is a program of the Montefiore Medical Center-Albert Einstein College of Medicine in the Bronx, which recently committed to building a children's hospital in the Bronx. SBCHC is funded through a combination of a Federal grant (330 Public Housing grant), a New York City Department of Health grant, and the Children's Health Fund.

Located in the Longwood Avenue/Hunts Point section of the South Bronx, SBCHC serves one of the lowest income areas of the country, where approximately 65 percent of residents are Hispanic and 35 percent African American. Clients are covered by Medicaid (65 percent, although many kids are eligible but not enrolled), third party (15 percent), and 20 percent are uninsured.

The new facility, scheduled to open in March 1998, will treat children with asthma in the Hunts Point area of the South Bronx, providing education to parents and kids, and evaluations. Funding for the Asthma Initiative and a new satellite facility in Hunts Point will be provided by the Children's Health Fund, NY state and city Health Departments, and a recently announced $750,000 grant from Shering-Plough to enhance current resources.

Clinton Administration Asthma Accomplishments

Funding for asthma research at the NIH has increased by 36 percent during the Clinton Administration, from $63 million in 1993 to $86 in 1997. Several organizations within the NIH are involved in the following asthma projects:

NHLBI (National Heart Lung and Blood Institute), NIAID (National Institute of Allergy and Infectious Diseases), NAEPP(National Asthma Education and Prevention Program)

- Childhood Asthma Management Program -- examines and compares the long-term effects of asthma on lung growth and development.
- National Cooperative Inner City Asthma Study -- supports seven centers to design, implement, and evaluate a comprehensive intervention program to reduce recurrent asthma episodes among inner-city children.
- NAEPP has convened two expert panels to prepare guidelines for the diagnosis and management of asthma. The first in 1989 and the most recent in May 1997.

AHCPR(Agency for Health Care Policy and Research)

- Pediatric Asthma Patient Outcome Research Team (PORT II) -- will test the cost-effectiveness of the NHLBI (described above) and evaluate new educational and organizational approaches to deliver pediatric asthma care in managed settings

Clean Air

EPA Administrator Browner signed the new standards for smog and soot on July 16, 1997. These standards will prevent approx. 350,000 cases of aggravated asthma. These standards are expected to prevent 15,000 premature deaths and 1 million cases of decreased lung function. In September 1996, Browner issued the National Agenda to protect Children's Health from Environmental threats. This agenda called on the EPA to address the special vulnerabilities of children - like susceptibility to air pollution and asthma. In May, 1997, Browner created the Office of Children's Health Protection to ensure implementation of the Agency's National Agenda. President Clinton signed the Executive Order on the Protection of Children from Environmental Health and Safety Risks (EO #13045) on April 21, 1997, which stated that each federal agency must address environmental health threats to children in its regulations and programs. The executive order also created the Task Force on Environmental Health and Safety Risks which is chaired by Browner and Shalala.

Format

The audience will be comprised of approximately 60 local elected officials and staff. Dr. Suzanne Hurd, Director of the Division of Lung Diseases at the National Heart, Lung, and Blood Institute (NIH) will also attend.

Tour

Upon arrival at the Center, you will tour the waiting and exam rooms, and the mobile units. The mobile units are part of the South Bronx Children's Health Center, located in the parking lot of the Center and occasionally traveling to area neighborhoods. These mobile units are being utilized until the new facility is complete (expected completion: March 98). One of the two units (the second one you will tour) is used specifically for asthma-related treatment.

Announcement
The announcement will take place in the outside the Health Center in heated tents. Other speakers in the program include Dr. Redlener, Richard Zahn, Kim Diaz and her daughter Elyse Torres, patients at the clinic,

III. PARTICIPANTS

Tour
-The First Lady
-Dr. Irwin Redlener, President, the Children's Health Center; Vice President for the Children's Medical Center, Montefiore Medical Center
-Dr. Alan Shapiro, Medical Director, South Bronx Children's Health Center

Announcement
-The First Lady

-Richard Zahn, President, Shering Laboratories
-Kim Diaz, parent
-Elyse Torres, daughter
-Kenneth Fisher, Councilman, Borough of Brooklyn
-Fernando Ferrar, Bronx Borough President
-Dr. Irwin Redlener
-Peter Vallone, New York City Council President
-Rep. Elliot Engel

IV. SEQUENCE OF EVENTS

- Fernando Ferrer, Bronx Borough President, gives welcoming remarks and introduces Dr. Irwin Redlener.
- Dr. Irwin Redlener, President, Children's Health Fund, gives brief remarks and introduces Mr. Fisher.
- Kenneth Fisher, City Councilman, gives brief remarks and introduces Mr. Vallone.
- Mr. Vallone, City Council Speaker, gives brief remarks and introduces Rep. Engel.
- Rep. Eliot Engel gives brief remarks and introduces Mr. Zahn.
- Richard Zahn of Schering Laboratories gives brief remarks and introduces Kim Diaz and daughter Elyse Torres.
- Mrs. Torres gives brief remarks and her daughter introduces The First Lady.
- The First Lady proceeds to the podium and gives brief remarks.
- Upon the conclusion of her remarks, The First Lady works a short ropeline and departs.

V. PRESS

Tour: Micro Pool Press/WH Photo.
Announcement: Open press /WH Photo.

VI. REMARKS

Talking points provided by Jen Klein.

IRWIN REDLENER, M.D., F.A.A.P.

Dr. Redlener is President and co-founder of The Children's Health Fund, a philanthropic initiative created to develop and support health care programs for medically underserved children. At Montefiore Medical Center he is Vice President for the Children's Medical Center, Director of the Child Health Network and Director of Community Pediatrics. He is also Professor of Pediatrics at the Albert Einstein College of Medicine and Lecturer in Pediatrics at Harvard Medical School.

The nationally acclaimed New York Children's Health Project, the country's largest health care program for homeless children, was developed in 1987 by Dr. Redlener. It is the model for a number of innovative health care projects in The Children's Health Fund's program network for disadvantaged child populations in urban and rural communities across the country.

In his role as pediatrician-child advocate, Dr. Redlener has published, spoken and testified widely on the subjects of health care for homeless and indigent children, child abuse and neglect and national health policy.

Dr. Redlener currently serves as co-chairman of the Healthy Start Advisory Group for America's Promise: The Alliance for Youth. He recently completed a two year term as Chairman of the National Advisory Council on the National Health Service Corps. In 1993 Dr. Redlener was Vice Chairman of the Health Professional Review Group for the White House Task Force on National Health Care Reform.

Dr. Redlener has served as a physician special consultant to the White House, as well as Expert Consultant to Assistant Secretary for Health, Department of Health and Human Services. Dr. Redlener currently leads *Kids First, Kids Now!*, a national initiative proposing comprehensive health reform for children.

From 1986-1987 he was Director of Grants and Medical Director of USA for Africa and Hands Across America. Dr. Redlener practiced general pediatrics and directed a special care nursery for seven years. Previous experience also includes development and direction of a pediatric intensive care unit as a member of the faculty of the University of Miami School of Medicine. He founded and directed a regional program in Florida for the management and prevention of child abuse and neglect.

In his various professional capacities Dr. Redlener has traveled in Europe, the Soviet Union and Central America. He has assisted relief efforts in Honduras, Guatemala, and Ethiopia. From 1971-73 he directed a rural, VISTA-run health center in East Arkansas.

Dr. Redlener received his M.D. from the University of Miami School of Medicine and pediatric training at Babies Hospital of the Columbia-Presbyterian Medical Center in New York City, the University of Colorado Medical Center and the University of Miami-Jackson Memorial Hospital in Miami.

Dr. Redlener and his wife Karen, Director of the New York Children's Health Project, have four children.

Schering

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RICHARD W. ZAHN

President – Schering Laboratories
Schering-Plough Corporation
Kenilworth, New Jersey

Richard W. Zahn is president of Schering Laboratories, the U.S. pharmaceutical arm of Schering-Plough Corporation, a research-based manufacturer and marketer of pharmaceutical and health care products worldwide.

He is responsible for the Company's domestic pharmaceutical marketing, sales, manufacturing, human resources and financial services.

Mr. Zahn joined Schering-Plough in 1992 from Johnson & Johnson, where he was vice president, marketing and sales, for Ortho Biotech from 1987 through 1992. Prior to that he held various positions with Ortho Pharmaceutical, beginning in 1973 as a sales representative. He subsequently advanced to product manager, product director, group product director and, in 1983, to director, product marketing/new product development.

Currently, he is a trustee of the Leukemia Society of Northern New Jersey and president-elect. He was honored by the Leukemia Society of America with a 1997 Special Recognition Award.

Mr. Zahn received a B.S. degree in business/accounting from Kansas State Teachers College, Emporia, Kansas.

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3/97

Withdrawal/Redaction Marker
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. list	Attendees - December 11 Press Conference (partial, DOB, SSN) (12 pages)	12/10/1997	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer
OA/Box Number: 20027

FOLDER TITLE:
Children's Health

2013-0534-S
ry1776

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

1

Attendees - December 11 Press Conference Final - 12/10/97 - 6:52 pm

Source Key:
BOD - The Children's Health Fund Board of Directors/Advisory Board
BOLD - Bronx
CHF - The Children's Health Fund
DKA - Dan Klores Associates, Inc.
MOM - Mothers on the Move
MMC - Montefiore Medical Center
SBCHC - South Bronx Children's Health Center
SP - Schering-Plough
WIC - Women, Infants, and Children

Name	Status	Source	DOB	SS#
Druyan, Ann	No	BOD		
Dyer, Esther	No	BOD		
Ebersol, Dick	No	BOD		
Evans, David Dr.	No	Diane	(b)(6)	
Ewing, Patrick	No	BOD		
Fisher, Zachary	No	BOD		
Fixler, Herbert	No	BOD		
Foster, Geraldine	No	SP	Ask Com strat	
Francis, Fred	No	BOD		
Friedman, Robert W	No	BOD		
Galpin, Steve	No	SP	(b)(6)	
Geiger, Jack MD	No	BOD		
Goldberg, Bob	No	Writer	(b)(6)	
Gooding, Claude	No	Banana Kelly	awaiting - invite sent Tues pm	
Hanna, Mark	No	BOD		
Herman,Dave	No	BOD		
Jackson McCabe, Jewell	No	BOD		
Keesal, Samuel	No	BOD		
Kinney, Richard	No	SP	(b)(6)	
Klores, Dan	No	DKA		
Lamstein, Joel H.	No	BOD		

[001]

2

Attendees - December 11 Press Conference Final - 12/10/97 - 6:52 pm

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SBCHC - South Bronx Children's Health Center
SP - Schering-Plough
WIC - Women, Infants, and Children

Name	Status	Source	DOB	SS#
LaRosa, Joseph	No	SP	(b)(6)	
Manfredi, Karen	No	SP		(b)(6)
Mattingly, Don	No	BOD		
Maurer, Jeffrey S	No	BOD		
McIntosh, Bill	No	BOD		
Mellins, Robert Dr.	No	Diane	(b)(6)	
Metselaar, Paul	No	BOD		
Migliara, Lee	No	SP		(b)(6)
Osborne, Robert C.	No	BOD		
O'Donnell, Bill	No	SP	(b)(6)	
Pauley, Jane	No	BOD		
Ricchetti, Steve	No	BOD		
Rockefeller IV, John D	No	BOD		
Rosen, Marvin S	No	BOD		
Rosenthal, Steve	No	MMC	(b)(6)	
Sadiq, Medina	No	Better Bronx	awaiting - invite sent Tues pm	
Tannnenhauser, Robert F	No	BOD		
Trainor, Robert	No	SP	(b)(6)	
Trudeau, Gary	No	BOD		
Werthammer, Joseph W. MD	No	BOD		
Wolfgang, Ronald	No	BOD		

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Attendees - December 11 Press Conference Final - 12/10/97 - 6:52 pm

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Name	Status	Source	DOB	SS#
Eisner, Andrea	?	Community Board 2	awaiting - invite sent Tues pm	
Ferrer, Frederic	?	Political		
Goodman, Andrew MD	?	?		
Hunter-Grant, Cheryl	?	Bronx Perinatal	awaiting - invite sent Tues pm	
Maylahn, Christopher	?	?		
Montenegro, Lorraine	?	Bronx Parents	awaiting - invite sent Tues pm	
Nagan, Deborah MD	?	Diane		
Pennachio, Madeline MD	?	Diane		
Roberts, John	?	Community Board 2	awaiting - invite sent Tues pm	
Rosenstreich, David	?	Diane	invite sent Wed am	
Serrano, Jose	?	Politician		
Taveras, Santiago	?	Banana Kelly	awaiting - invite sent Tues pm	
Thomas (sister)	?	Community Board 2	awaiting - invite sent Tues pm	
Vallone, Peter	?	Politician		

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Name	Status	Source	DOB	SS#
Vera, Anthony	?	Unitas	awaiting - invite sent Tues pm	
Wattford, Mary	?	La Peninsula	awaiting - invite sent Tues pm	
Wilson, Stephanie	?	Inwood	awaiting - invite sent Tues pm	

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Name	Status	Source	DOB	SS#
Adler, Nadia	Yes	MMC	(b)(6)	
Ashkenase, Donald	Yes	MMC		
Bannerjee, Kinkini	Yes	SBCHC		
Benson, Diane	Yes	SP		
Betancourt, Love	Yes	SBCHC		
Bonilla, Millie	Yes	MOM		
Bracey, Leslie	Yes	CHF		
Brennan, Elaine	Yes	MMC		
Burke, Gregory (Vice President, Planning)	Yes	MMC		
Butler, Ashley	Yes	CHF	(b)(6)	
Byrne, John	Yes	food delivery		
Calzada, Nancy	Yes	CHF		
Camarda, Leonard	Yes	SP		
Caso, Joseph	Yes	?		
Cassidy, Sean	Yes	DKA		
Charlop, Megan	Yes	MMC		
Clymer, Nat Photographer	Yes	SP		
Conaty, Robert	Yes	MMC		
Connell, James	Yes	MMC		
Cooperman, Jacqueline	Yes	P.S. 48, Bronx		
Cruz, Kenny	Yes	MMC (van driver)		

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Name	Status	Source	DOB	SS#
Dawson, Arnold	Yes	SBCHC - driver	(b)(6)	
de la Rosa, Manuel E.	Yes	41st precinct		
Delano, Richard	Yes	Scholastic, Inc.		
Diaz, Kim	Yes	Asthma Mother		
Diaz, Theresa MD	Yes	NY Academy of Medicine		
Dugan, George	Yes	MMC		
Egan, Michael D.	Yes	B.O.L.D.		
Elan, Paviel	Yes	Better Bronx		
Feinberg, Marian	Yes	South Bronx Clean Air Coalition		
Ferrer, Fernando	Yes	VIP	Cleared by White House	
Figuroa, Carmen	Yes	Family	Cleared by White House	
Findley, Sally Dr.	Yes	Center for Pop. & Family Health	(b)(6)	
Fisher, Ken	Yes	VIP	Cleared by White House	
Fisher, Loren	Yes	SP	(b)(6)	

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Name	Status	Source	DOB	SS#
Ford, Jean Dr.G.	Yes	Harlem Hospital		
Foreman, Spencer MD (President, Montefiore Medical Center)	Yes	MMC		
Freudenberg, Nicholas	Yes	Hunter College	(b)(6)	
Garcia, Yolanda	Yes	Nos Quedemos		
Gardner, Dennis	Yes	MMC		
Gemian, Gary (Director, Rx Marketing, Allergies)	Yes	SP		
Gillespie, Sara	Yes	CHF	(b)(6)	
Gonzalez, Jeromi	Yes	Family	Cleared by White House	
Gonzalez, Luis	Yes	SBCHC	(b)(6)	
Gonzalez, Toi	Yes	Family	Cleared by White House	
Greene, June	Yes	SBCHC		
Gross, Barbara	Yes	MOM		
Guarnotta, Brian MD	Yes	SBCHC		
Hageman, Andrew F.	Yes	SP	(b)(6)	
Hall, Joe	Yes	Banana Kelly		
Hason, Elissa	Yes	SBCHC		

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Name	Status	Source	DOB	SS#
Hindi-Alexander, Michelle	Yes	Division of Lung Diseases, NHLIB	(b)(6)	
Hogan, Scott	Yes	Tent		
Holoren, Michael	Yes	Tent		
Hurd, Suzanne Dr. (Director, Division of Lung Diseases)	Yes	NHLIB		
Irizarry, Iris	Yes	AIDs FORUM		
Janes, Barbara	Yes	MMC		
Johnson, Dennis	Yes	CHF		
Jones, Charlie	Yes	Trabajamos		
Jones, Lucretia	Yes	MOM		
Kass, Daniel	Yes	Diane		
Kattan, Meyer	Yes	Mt. Sinai School of Medicine		
Kehoe, William	Yes	SP	(b)(6)	
Kelly, Geraldine	Yes	SBCHC		
Kind, Susan	Yes	MMC		
LaBonne, Maurice	Yes	MMC		
Landau, Theresa	Yes	WIC		
Langner, Jay B.	Yes	MMC		
Lantos, Phyllis	Yes	MMC		

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Name	Status	Source	DOB	SS#
Lehner,Alex	Yes	SP	(b)(6)	
Lengi, Steve	Yes	Tent		
Levinsohn, Jeff	Yes	DKA		
Lipson, Paul	Yes	The Point		
Lucks, Lora H.	Yes	P.S. 48, Bronx		
Magder, Richard	Yes	CHF		
Maggio, Joe	Yes	SP		
Marlin, Joanne	Yes	SP		
Marquez, Sonia	Yes	SBCHC		
Martin, William	Yes	MMC		
Matte, Tom MD	Yes	NY Academy of Medicine		
Mays-Hardy, Dawn	Yes	Hunter College	(b)(6)	
McLaughlin, Carolyn	Yes	Citizen's Advice Bureau		
Mclean, Diane	Yes	CHF		
McMahon, Thomas	Yes	NY City Council		
McNamara, Kevin	Yes	Tent		
Meara, Karen	Yes	NY City Council		
Mejia, Maria	Yes	SBCHC		

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Name	Status	Source	DOB	SS#
Meyer, Ilan	Yes	Harlem Lung Center	(b)(6)	
Mittelman, Roy	Yes	Melissa - photographer		
Nachman, Sami	Yes	Harlem Lung Center		
Norville, Nneka	Yes	DKA		
Ortiz, Luis	Yes	SBCHC		
Pechefsky, David	Yes	NY City Council		
Pepe, Donna	Yes	SP		
Perez, Iris	Yes	SBCHC		
Perez, Martha	Yes	SBCHC		
Perlman, Joel	Yes	MMC		
Polkes, Todd	Yes	DKA		
Przybilla, Elizabeth	Yes	SBCHC		
Puglisi, Maria	Yes	CHF		
Purslow, Robert	Yes	Tent		
Raincy, Lisa MD	Yes	SBCHC		
Redlener, Irwin MD	Yes	CHF		
Redlener, Karen	Yes	CHF		
Redlener, Sasha	Yes	per Irwin		
Richardson, Lynne Dr.	Yes	medical		

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Name	Status	Source	DOB	SS#
Rivera, Yolanda	Yes	Banana Kelly	(b)(6)	
Rodriquez, Benardo	Yes	Seneca		
Rosario, Carmen	Yes	SBCHC		
Safyer, Steven MD	Yes	MMC		
Schang, Gabrielle	Yes	CHF		
Schillace, Kim	Yes	SP		
Schroeder, Scott MD	Yes	MMC		
Schulte, Ray	Yes	BOD		
Scim, Lynn	Yes	CHF		
Shapiro, Alan MD	Yes	SBCHC		
Sherman, Peter MD	Yes	CHF		
Silard, Kathy	Yes	MMC		
Silverman, Ann	Yes	MMC		
Simon, Andi	Yes	MMC		
Snider, Debbie	Yes	SBCHC		
Sotolongo, Wilfredo	Yes	41st Precinct		
Starkey, Joseph P.	Yes	SP		
Straun, Claudette	Yes	WIC		
Stumpo, Dennis	Yes	MMC		
Sugarman, Raphael	Yes	DKA (Daily News Reporter)		
Swiss, Drew	Yes	MMC		

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Name	Status	Source	DOB	SS#
Thomas, JoAnn	Yes	SBCHC		
Torres, Ana	Yes	SBCHC		
Torres, Elyse	Yes	Child		
Torres, Maria	Yes	The Point		
Torres, Teresa A.	Yes	P.S. 48, Bronx		
Urrutia, Felix	Yes	Police Athletic League		
Vasquez, Carmen	Yes	SBCHC		
Vincenti, Anna	Yes	Nos Quedemos		
Walker, Ann Marie	Yes	CHF	(b)(6)	
Walter, Deborah Lynn	Yes	SP		
Watkins, Mark	Yes	SP		
Weinblatt, Charlotte	Yes	MMC		
Weiss, Linn	Yes	SP		
Westphal, Dart Alfred	Yes	MMC		
Wolf, Jack	Yes	MMC		
Wyatt, Hugh	Yes	Medical Herald		
Zahn, Eunice	Yes	SP		
Zahn, Julie	Yes	SP		
Zahn, Rich	Yes	SP		

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Name	Status	Source	DOB	SS#
Zeppenfeldt-Cestero, George	Yes	MMC	(b)(6)	
Ziriakus, Melissa	Yes	CHF		
Anderson, Ron MD	No	BOD		
Andrzejewski, Steve	No	SP	(b)(6)	
Anthony, Mark	No	BOD		
Berger, Ron	No	BOD		
Bradley, Bill Honorable	No	BOD		
Braun, Neil	No	BOD		
Cohen, Michael MD	No	BOD		
Crain, Ellen MD	No	Diane		
Dodd, Christopher J. Hon.	No	BOD		
Driscoll, Marty	No	SP	(b)(6)	

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LEGISLATIVE STAFF ATTENDEES

NAME	STAFF OF	DOB	SS #
Henry, Tracey	Councilman Fisher	(b)(6)	
Talmadge, John	Councilman Fisher		
Kozicharow, Mia	Councilman Fisher		
McGrath, Karen	Councilman Fisher		
Fisher, Kirsten	Councilman Fisher		
Tuozzolo, Steve	Councilman Fisher		
Talmadge, Melissa	Councilman Fisher		
Anderson, Steve	Councilman Fisher (press)		
Falk, Brian	Councilman Fisher (press)		
Chinn, Sam	Councilman Fisher (press)		
Ware, Robert	Councilman Fisher (press)		
Ithier, Jose L.	B. P. Ferrer		
Smikle, Basil A., Jr.	B. P. Ferrer		
Segarra, Arnaldo	B. P. Ferrer		
Yeger, Kalman	B. P. Ferrer		
Kalfus, Robert	B. P. Ferrer		
Roswell, Clint	B. P. Ferrer		
Farrell, Judy	B. P. Ferrer		

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. report	Re: presenting parent (1 page)	00/00/0000	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer
OA/Box Number: 20027

FOLDER TITLE:
Children's Health

2013-0534-S
ry1776

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
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RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

ASTHMA IN CHILDREN

KEY FACTS

What is asthma?

- Asthma is a chronic inflammatory disorder of the airways. In susceptible individuals, this inflammation causes recurrent episodes of wheezing, breathlessness, chest tightness and coughing, particularly at night or in the early morning. These episodes, or "asthma attacks", are usually associated with airflow obstruction that is often reversible, either spontaneously or with treatment.

- Asthma can vary in severity and is categorized as either: mild intermittent, mild persistent, moderate persistent or severe persistent.

- Asthma often begins in childhood and can start as early as the first year of life: 70% of all people with asthma developed asthma before age seven.

- Asthma is frequently found in association with what is referred to as "atopy", the susceptibility to produce antibodies toward common allergens such as animals, cockroaches, house-dust mites, indoor molds and outdoor allergens.

- Other factors that can precipitate or **trigger** asthma attacks include: tobacco smoke, indoor/outdoor pollution, viral respiratory infections, trauma and other stressors, exercise, drugs, emotions, cold air, aspirin and sulfite sensitivity.

Who has asthma?

- As of 1994, approximately 4.8 million children under the age of 18 have asthma, according to the National Institute for Allergy and Infectious Diseases, for a prevalence rate of 4.3%. Nationally, asthma rates are highest in New York, Chicago, Fresno, California and Maricopa County, Arizona. Asthma prevalence and mortality rates are continuing to rise nationwide.

- In 1994, in high risk areas of New York City the asthma prevalence rate for children reached between 8.6% and 14%. In 1996, it reached 25% for the population of homeless children cared for by The Children's Health Fund.

- As of 1993, New York City children were hospitalized for asthma at more than four times the national rate and the hospitalization rate is continuing to rise. Within New York City, African Americans and Latinos have three to five-and-and a- half times the hospitalization rates of whites. Among New York City children 14 and younger, those living in a zip code in the lowest 20th percentile of median income had four times the hospitalization rate of those living in the highest 20th percentile of median income. Areas in New York City with highest asthma hospitalization rates include the South Bronx, Upper Manhattan , Central and North Brooklyn.

- The number of children hospitalized for asthma nationwide has increased fivefold over the past 20 years. In 1993, asthma accounted for nearly 200,000 hospitalizations among people less than 25 years old.
- Hospitalization rates for children less than five years old have increased by 57% since 1980.
- Compared with white children, African American children are four to six times more likely to die from asthma and three times more likely to be hospitalized for asthma.
- Poor children with asthma reported 40% fewer physician visits, yet were 40% more likely to be hospitalized than children with more economic resources.

What are the consequences of asthma for children?

- Nationwide, asthma is associated with the loss of 28 million activity days annually and 2.2 million pediatrician visits. It is the leading cause of school absenteeism. It has been estimated that among children 5-17 years old, asthma accounted for approximately 10 million missed school days, at a cost of $726.1 million in caretaker's time lost from work.
- Asthma can be fatal. Over 3,800 children and young adults under 25 died from asthma nationwide during the period of 1980-1993. In 1993 alone, 342 children and young adults under 25 died from asthma.

What are the costs of asthma?

- In 1993, the total direct and indirect annual costs of asthma were estimated to be over $6.2 billion in 1990 dollars, not including the economic impact of this disease on affected patients and families.
- Non-monetary costs for children with asthma include decreased quality of life, mental distress for patients and families, social labeling associated with a chronic disease and complications from medication use.

1ST STORY of Level 1 printed in FULL format.

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The San Francisco Chronicle

APRIL 17, 1997, THURSDAY, FINAL EDITION

SECTION: NEWS; Pg. A8

LENGTH: 359 words

HEADLINE: Boxer Bill Would Make EPA Rules Fit Kids
Research on effects of pollutants on children called fo

BYLINE: Louis Freedberg, Chronicle Washington Bureau

DATELINE: Washington

BODY:

Senator Barbara Boxer yesterday introduced legislation that would require environmental standards to take into account the unique vulnerabilities of children.

''Children are not little adults, they are more vulnerable than adults,'' said Boxer. ''Every day, whether in school, day care or home, children are exposed to unnecessary and preventable health risks.''

Boxer's Children's Environmental Protection Act would require that Environmental Protection Agency standards be set at levels that protect children. It would also require the EPA to publish a list of products that are afe for children and to conduct research on the health effects of pesticides i other pollutants on children.

Boxer was joined by Nancy and Jim Chuda of Malibu, whose daughter Colette died of cancer at age 5. The Chudas, who established the Children's Health Environmental Coalition after Colette's death in 1991, said they believed that her cancer was caused by unspecified pollutants. ''Today, we are convinced her cancer could have been prevented,'' said Nancy Chuda.

Representative James Moran, D-Va., who introduced a companion bill in the House, said a malignant tumor was found in his now 5-year-old daughter when she was 3. He said that in the neighborhood where he lived, six other children had brain tumors.

''Were they caused by spraying for gypsy moth, or by pesticides in the shed out back, or by weed-killers, or by paint thinner?'' he said. ''We do not know.

''The kids can't speak out for themselves, so we must do it for them. This needs to be a national priority.''

Boxer said that at least 11 federal laws -- including the Pollution Prevention Act, the Clean Water Act, the Solid Waste Disposal Act and the Ocean Dumping Act -- do not address the health needs of children.

''Not taking care of our children is costing our nation a fortune,'' said Boxer, noting that a bone-marrow transplant for a child with cancer can cost as much as $ 100,000. ''In the overall scheme of things, it would cost us a pittance to keep a child out of the hospital by preventing them from getting ck in the first place.''

14TH STORY of Level 1 printed in FULL format.

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Milwaukee Journal Sentinel

December 1, 1997 Monday Final

SECTION: News Pg. 1

LENGTH: 838 words

HEADLINE: Teachers unprepared on asthma, group says
Lung association points to risks as more children suffer from disorder

BYLINE: MIKE JOHNSON

SOURCE: Journal Sentinel staff

DATELINE: Waukesha

BODY:

Few physical education teachers in the state are fully prepared to deal with a student's asthma attack even though the number of children with asthma is on the rise, according to a survey by the American Lung Association of Wisconsin.

In response, the Brookfield-based association said it is developing an asthma education program for teachers and students.

Terry Schuh, the association's program director, said that while the survey wasn't scientific, it showed more must be done to help teachers be ready for an asthma attack, which can be fatal.

The association sent surveys to 560 physical education teachers across the state exercise often can trigger an asthma episode and 216 responded.

The results:

Only 9% of the teachers responding said they were fully prepared to deal with an asthma attack. Schuh said teachers are fully prepared when they are able to recognize the signs of an asthma attack coughing, wheezing, shortness of breath and a tightness in the chest and know what kind of medication to give and whom to call.

51% said they do not have individualized plans on file for dealing with students' asthma emergencies.

Nine of 10 teachers responding said they would like more information on how to respond to an asthma episode.

99% of those who responded said asthma interferes with the physical activity of children in their classes at least occasionally.

43% said it interferes weekly or daily.

The push for an asthma education program comes at a time when childhood asthma cases have increased sharply. More than 14.6 million people nationwide have asthma; about 4.8 million of them are children. Between 1982 and 1994,

childhood asthma cases increased 72%.

Between 1979 and 1994, the annual number of deaths attributed to asthma increased 111%, from 2,598 to 5,487.

Doctors are uncertain about what causes asthma and have not been able to determine why it is increasing.

About 95,000 children in Wisconsin have asthma, according to the association. And 80% to 90% of all people with asthma are susceptible to exercise-induced asthma attacks.

In the Waukesha School District, 1,023 students reported they have asthma this year, up 12.9% over the 906 who reported having the disorder last year.

In Waukesha last month, tragedy was averted when a Summit View Elementary School physical education teacher and an aide revived a girl who collapsed from an asthma attack and had no pulse.

The pupil, fifth-grader Jessica Ranieri, had difficulty breathing while running during a physical education class on Nov. 11. Her teacher took her to the health room, where Jessica collapsed. The teacher and the health-room aide performed cardiopulmonary resuscitation for about a minute, and Jessica started breathing on her own.

Schuh said the incident illustrates how knowing what to do when asthma strikes can save a life.

While exercise can trigger an asthma attack, physical workouts are necessary to improve lung function and fitness in children with asthma, Schuh said. Children with asthma who exercise regularly can do more work without developing exercise-induced asthma, he said.

One way to prevent an asthma attack during exercise is to have students inhale asthma medication 15 to 20 minutes before the workout begins, Schuh said.

Only 43% of teachers responding to the survey said their students with asthma follow this practice.

Some school districts don't allow students to carry their inhalers with them, although the Waukesha district and Milwaukee Public Schools do, Schuh said.

The Waukesha district also requires parents of asthmatic children to fill out a care plan, which is shared with physical education teachers, said Twyla Lato, one of the district's school nurses. The district last year also conducted teacher workshops on asthma.

MPS runs a program called "Awesome Asthma School Days" at its Health Education Center, 1533 N. River Center Drive in Schlitz Park, to help pupils deal with their asthma. Each week, 50 to 100 pupils from several elementary schools attend the daylong program.

Cheryl Gotts, MPS curriculum specialist for health and physical education, estimated that 10% of the district's nearly 100,000 students have asthma.

The Milwaukee Journal Sentinel December 2, 1997

In the Germantown School District, physical education teachers help students with asthma recognize their symptoms.

"Kids can handle the exercise if they know their own limits," said Sue Cattle, the curriculum coordinator for physical education in the district.

"Our kids have their inhalers with them," she said. "If they don't, they don't do the exercise that day."

"Getting more education out to districts is important," said Schuh. "Kids should be allowed to have their inhalers with them. If a kid is on the soccer field and has an attack and the inhaler is 200 yards away in an office, who knows what could happen?" ---------- For a list of asthma resources available from the American Lung Association of Wisconsin, phone 782-7833 or (800) 586-4872.

LOAD-DATE: December 2, 1997

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The Washington Post

January 03, 1997, Friday, Final Edition

SECTION: A SECTION; Pg. A03

LENGTH: 954 words

HEADLINE: Soaring Asthma Rate May Be Linked to Defeat of Childhood Diseases, Study Says

BYLINE: Rick Weiss, Washington Post Staff Writer

BODY:

Asthma rates are skyrocketing in the United States and other Western nations not because of increased air pollution or other environmental toxins, as many scientists have theorized, but because people are getting fewer serious respiratory diseases in childhood, a provocative new study suggests.

The study, in today's issue of the journal Science, suggests that diseases such as tuberculosis and whooping cough may permanently alter a child's immune system in a way that confers lifetime protection against asthma. If true, then the public health victories of the past few decades that have largely eliminated those diseases in developed nations may be making people more susceptible to asthma or other allergies.

On a positive note, researchers said, the findings suggest that asthma might be prevented in children or treated in adults by giving a vaccine that mimics a serious lung infection.

"Immunization with harmless bacteria, related to tuberculosis, might be helpful in preventing and treating allergy," said lead researcher Julian M. Hopkin of Churchill Hospital in Oxford, England.

Experts called the findings controversial, and even the study's authors conceded that their conclusion is based both on science and speculation. But several experts said the hypothesis made sense and deserved serious attention, given the scope of the global asthma epidemic and the lack of understanding about why it is occurring.

More than 14 million Americans suffer from asthma -- an allergic overreaction to airborne particulates such as pollen or dust in which a flood of antibodies causes lung inflammation, airway restriction and a life-threatening shortness of breath. That's about twice as many Americans as suffered from the disease in 1982.

Asthma incidence and death rates have increased similarly in Europe, Japan and other developed countries, leading some researchers to blame air pollution or other aspects of modern living. But recent findings of low asthma rates in several cities with extremely dirty air have partially exonerated environmental toxins.

The new research focused on 867 schoolchildren in Japan who, like most Japanese, received so-called BCG vaccines at birth and at 6 and 12 years of age. That vaccine is made from a kind of bacteria closely related to the one that causes tuberculosis, and is popular in some countries to help prevent that disease. It is not commonly used in the United States, in part because it inexplicably fails to stimulate the immune system in many recipients.

Hopkin and his co-workers in Wakayama, Japan, tested fully vaccinated 12- and 13-year-olds to see whether they had developed the intended immune response against tuberculosis. They also checked for a history of asthma or related allergies, and performed immune system tests.

Children who mounted the strongest immune responses against BCG had about one-third the incidence of asthma compared to children with weak or no immune response. The researchers conclude that exposure to tuberculosis or related microbes may help protect against asthma, and they offer an explanation of how.

The immune system uses two main arsenals to protect the body. One system centers on antibodies, which when over-produced in the lungs cause asthma. The other system, called cell-mediated immunity, centers on white blood cells called macrophages, and is the main response to respiratory infections and BCG vaccinations.

Generally speaking, when one arm of the system is operating, the other backs off. The researchers propose that in the absence of severe childhood lung infections, youngsters never develop the strong cell-mediated response that might permanently temper the antibody arm. (Unlike the BCG vaccine, vaccines against whooping cough and other childhood diseases in this country stimulate antibodies but not cell-mediated immunity.) Without that early cell-mediated response, they propose, the antibody-generating arm of the immune system is left unbridled and poised to overreact to innocuous particles such as dust or pollen.

Indeed, immune system studies conducted by the researchers showed the antibody arm to be dominant in the children with asthma, while cell-mediated immunity appeared dominant in those with good BCG responses. But while the two arms classically oppose each other on a day-to-day basis, no one knows whether early childhood infections can lead to a permanent shift in the balance of power.

"I bet the interpretation is wrong," said Thomas Platts-Mills, head of the University of Virginia's asthma and allergic disease center in Charlottesville. Rather than BCG protecting against asthma, he said, some children probably have an underlying genetic factor that both causes a strong BCG response and also protects against asthma.

He and others blame the asthma epidemic on the increasing amount of time spent indoors, where dust mites and other triggers of asthma reside. They note that asthma is booming in U.S. inner cities such as the Bronx, despite the prevalence of respiratory diseases there.

Still others, however, said they were intrigued. "It's interesting and certainly needs to be followed up," said Norman Edelman, dean of medicine at the

State University of New York at Stony Brook and medical affairs consultant for the American Lung Association. "The mistake is if we think that this is the reason for the increase in asthma and in the deaths. It's probably a contributing factor."

Daniel Rotrosen of the National Institute of Allergy and Infectious Diseases said the work could spur development of better vaccines that invoke cell-mediated as well as humoral immune responses. "It's an attainable goal in five to 20 years," he said.

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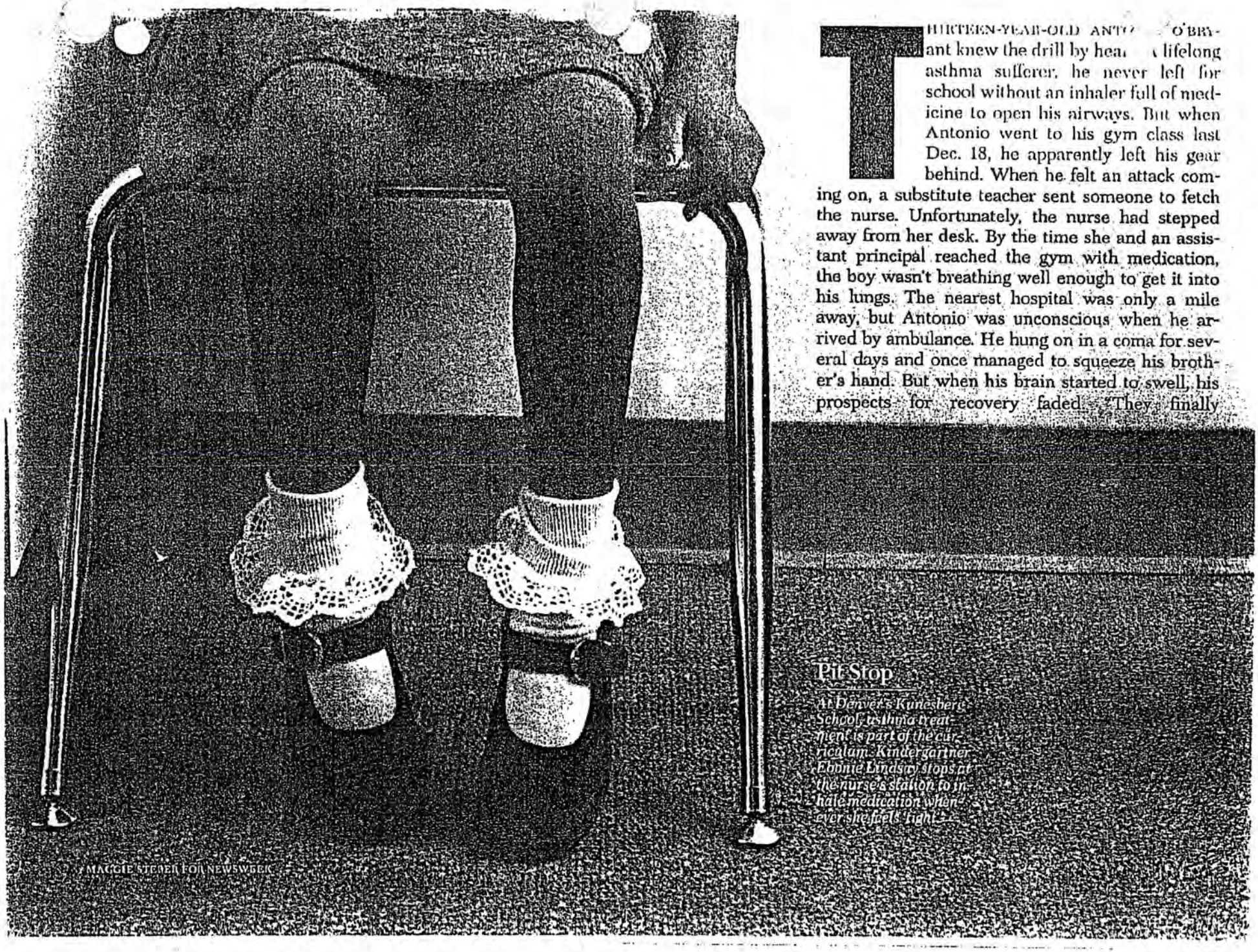


MAGGIE STEBER FOR NEWSWEEK

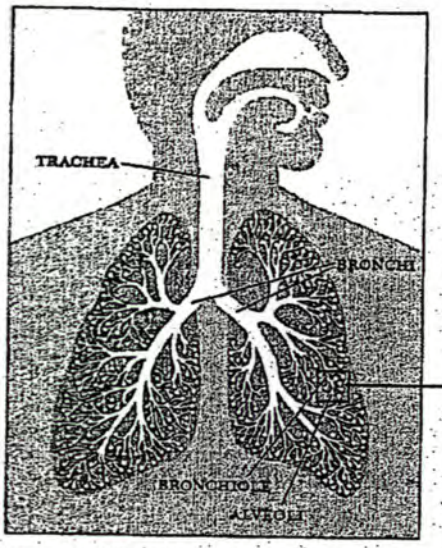
THIRTEEN-YEAR-OLD ANTO[illegible] O'BRY-ant knew the drill by hea[illegible] a lifelong asthma sufferer, he never left for school without an inhaler full of medicine to open his airways. But when Antonio went to his gym class last Dec. 18, he apparently left his gear behind. When he felt an attack coming on, a substitute teacher sent someone to fetch the nurse. Unfortunately, the nurse had stepped away from her desk. By the time she and an assistant principal reached the gym with medication, the boy wasn't breathing well enough to get it into his lungs. The nearest hospital was only a mile away, but Antonio was unconscious when he arrived by ambulance. He hung on in a coma for several days and once managed to squeeze his brother's hand. But when his brain started to swell, his prospects for recovery faded. They finally

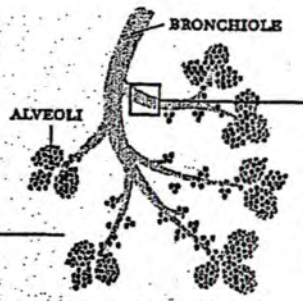
Pit Stop

At Denver's Kunsberg School, asthma treatment is part of the curriculum. Kindergartner Bonnie Lindsey stops at the nurse's station to inhale medication whenever she feels tight.

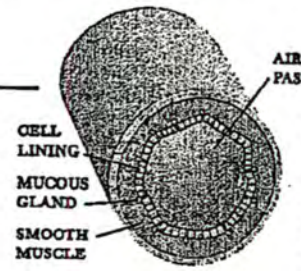
Anatomy of an Asthma Attack

When the respiratory system is working properly, the air we breathe passes in and out of the lungs through a network of airways (left). But for people with asthma, even a minor irritant will set off an immune response that can shut down the airways.

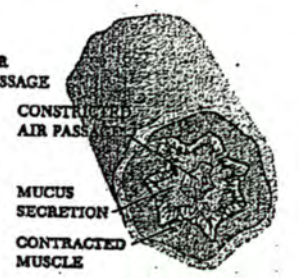




Bronchiole network: Air is distributed throughout the lungs via small airways known as bronchioles.



Healthy bronchiole: When they're clear and relaxed, the small airways accommodate a constant flow of air.



Asthmatic bronchiole: During an attack, mucus and tight muscles narrow the airways and interfere with breathing.

SOURCE: NORMAN EDELMAN, M.D., "FAMILY GUIDE TO ASTHMA AND ALLERGIES"; DIAGRAM BY CHRISTOPH BLUMRICH—NEWSWEEK

place for two minutes," says Nancy Sander, president of the Allergy and Asthma Network/Mothers of Asthmatics in Fairfax, Va. "Then hold your nose and try breathing through a straw in your mouth. That's what an asthma attack feels like."

Almost anything can act as an irritant. Toddlers who live with at least one smoker are nearly three times as likely to wheeze as kids in smoke-free homes, but nonsmokers' children also suffer. Dust mites, those tiny creatures that thrive in bedding, upholstery and carpets, spike their droppings with a highly allergenic protein. So do cockroaches. Molds and pollens cause a lot of asthma in humid environments. But people who flee the Everglades for Arizona don't end up suffering less asthma. They just find something else to react to, like the dander from their pets. Liz Aplin, a 47-year-old art teacher in Chattanooga, Tenn., is so sensitive to the dust from her pastels that she wears a mask to class. "Show me the dust from 100 houses in a community," says Dr. Thomas Platts-Mills of the University of Virginia's Asthma and Allergic Diseases Center, "and I'll tell you what people are allergic to."

WITH THE RIGHT MEDICINES, even a severe asthmatic can make the condition manageable (page 62). But the greater challenge is to prevent it. Clearly, something is making us ever more sensitive to allergens. The question is, what? Genes clearly play a role in the disease. Children with one asthmatic parent contract asthma at three to six times the rate of other kids, says Dr. Fernando Martinez of the University of Arizona's Respiratory Sciences Center. Those with two asthmatic parents have 10 times the risk. And identical twins are more likely than fraternal twins to share allergies. But the gene pool hasn't changed dramatically in the past few decades. And as Wedner observes, "there is no gene that says, 'If you have this, you will wheeze.' Something in the environment must have changed."

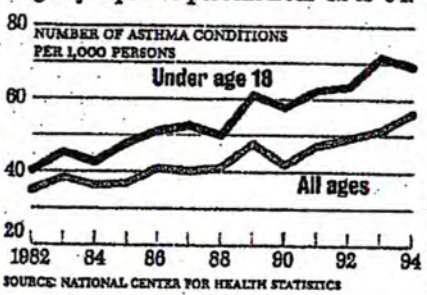
Asthma isn't usually a problem in preindustrial societies, regardless of their natural surroundings. But when development sets in, asthma quickly follows. Dr. Hal Nelson of Denver's National Jewish Medical Center cites a 1991 study of children in Zimbabwe. Only one in 1,000 of those living in rural villages suffered from obstructed airways. Yet asthma plagued one in 17 (5.8 percent) of those in a prosperous section of the capital, Harare. Researchers have documented the same pattern among Aboriginal people in Kenya, South Africa, Papua New Guinea, New Zealand and Australia. Even within Western societies, increasing urbanization seems to make people more and more vulnerable. The United States has an overall asthma rate of about 5 percent, says Dr. Irwin Redlener of New York's Montefiore Medical Center. But the rate is 8.4 percent in New York City, and it can reach 25 percent among kids in the poorest urban neighborhoods.

If asthma is a disease of civilization, the question becomes: what aspects of modern life are to blame? Air pollution might seem an obvious suspect. As Dr. Norman Edelman notes in the American Lung Association's new "Family Guide to Asthma and Allergies" *(238 pages. Little, Brown. $19.95)*, ozone, diesel fumes and exhaust particles can all irritate the airways. Hospital admissions for asthma often rise 20 to 30 percent during periods of severe air pollution. But outdoor air pollution can't be driving the asthma pandemic, because it has improved in recent decades. Londoners suffered horribly from bronchitis during the 1950s, when the city was blanketed by noxious industrial fog. But asthma arrived after the worst of the pollution was gone. And Martinez has found that east German children enjoy lower asthma rates than west Germans, despite pollution levels that are often 10 times as high.

If outdoor air isn't to blame, could indoor air be playing a role? There's no question that modern urban life entails large doses of the stuff. Most Americans now spend at least 90 percent of their time indoors, according to the Environmental Protection Agency—and when we're not locked in buildings, we're usually sealed in vehicles. During the 1960s, American kids spent an

A Growing Menace

Asthma rates have increased in every age group, but kids have seen one of the largest jumps—73 percent from '82 to '94.



SOURCE: NATIONAL CENTER FOR HEALTH STATISTICS

Molly Buford <mbuford@doc.gov>
05/30/2000 04:30:58 PM

Please respond to mbuford@doc.gov

Record Type: Record

To: Eric W. Woodard/WHO/EOP

cc:
Subject: Hello Eric!

Welcome back from Berlin or where ever you were. I hope you had a good trip. I am writing to ask you a huge favor (as usual). A woman who used to work here in my office (at commerce) Dad loves, loves, loves the First Lady and she would like to give him a signed photo of her for his birthday. She knows that it takes a long time to get them. Can you fill out one of those photo request forms and send it to the photo office for me? she just needs one of the standard photos autopenned like they do. I would really appreciate it if you could do it for me.

His name is Arnold Evans and she would like the inscription to read Happy Birthday (if that is one of the choices, if not just best wishes). The mailing address is Dawn Evans Cromer

3330 Denver St., SE

Washington, DC 20020-1430

Thank you so much. You remain to be the best person on earth and I appreciate you. I hope you are well & maybe I'll run into you soon. Let me know if you have any problems or you can't do it. Thanks again.

Molly