DRAFT

September 26, 1995

CHILDREN'S CIRCLE OF CARE LEADERSHIP CONFERENCE

DATE:	**Wednesday, September 27**
TIME:	**10:25 am**
LOCATION:	**Natcher Conference Center, NIH**
FROM:	**Brenda Costello**

I. PURPOSE

To recognize and address major benefactors to Children's Hospitals at a Conference, and to underscore the importance of support for Children's Hospitals.

II. BACKGROUND

Children's Circle of Care

Established in the development circle as a gift club last year, the Children's Circle of Care (CCC) is composed of leading individual benefactors from nineteen of the largest children's hospitals in North America. All have demonstrated both their committment to children and tremendous financial support to the children's hospital in their community. You are the Honorary Chairperson of the Children's Circle of Care effort. Brought together by the heads of fundraising organizations at various children's hospitals, their mission is to advance the work of quality pediatric patient care, research, education and advocacy through philanthropic support. The group was formed to help educate the public about the significant contribution of children's hospitals and to encourage future annual support from individual donors. (See background on children's hospitals.)

CCC grew out of a fundraising venture started by the Oki Foundation in 1993. In an effort to attract new donors to Children's Hospital in Seattle, Scott and Laurie Oki made a $1 million donation to the hospital, agreeing to match gifts of $10,000. The result was a pledge from the Oki Foundation to establish the Children's Circle of Care.

Circle of Care founding hospitals
Arkansas Children's Hospital - Little Rock, AR
British Columbia Children's Hospital Foundation - Vancouver, BC
Children's Hospital Medical Center - Cincinnati, OH
Children's Hospital Foundation - Seattle, WA
Children's Medical Foundation of Texas - Dallas, TX
Children's Hospital Foundation - Denver, CO
Children's Hospital Los Angeles - Los Angeles, CA

Children's Hospital of Philadelphia - Philadelphia, PA
Children's Memorial Hospital - Chicago, IL
Children's National Medical Center - Washington, DC
Children's Hospital Foundation - Milwaukee, WI
Children's Hospital and Health Center - San Diego, CA
Children's Hospital of Pittsburgh - Pittsburgh, PA
Children's Hospital Foundation - Oakland, CA
Columbus Children's Foundation - Columbus, OH
Lucile Salter Packard Children's Hospital at Stanford - Palo Alto, CA
St. Louis Children's Hospital - St. Louis, MO
Texas Children's Hospital - Houston, TX
The Children's Hospital - Boston, MA
The Hospital for SIck Children Foundation - Toronto, Ontario

Note: As you may recall, aside from your work with the Arkansas Children's Hospital Foundation, you have visited Children's Hospital of Boston "Patient Entertainment Center" in September 1994 with Sen. Kennedy, Children's Hospital of Philadelphia, Children's Memorial Hospital in Chicago, and Children's National Medical Center in Washington, D.C.

Circle of Care Leadership Conference

The Circle of Care Leadership Conference, in its first year, is an opportunity to honor major donors to children's hospitals as well as providing an educational forum. All members are committed to the purpose of children's hospitals, and the Conference serves as an affirmation of their commitment. They hope to have annual conference, and will distribute an annual report.

The conference was underwritten the Oki Foundation, founded by Scott Oki and his wife Laurie, and by Price Costco (Price Club), who make significant contriutions to several children's hospitals. The Oki's provided the seed money for this conference, as well as the original idea.

Approximately 600-650 people are expected to attend, including Boards of Trustees, business leaders, foundations, football players --- a cross-section of the community. The group is comprised of citizens from across the U.S. and Canada who make donations of $10,000 and above to their local children's hospitals. Invited guests include: Ben Bradlee and Sally Quinn, Mrs. John Heinz III, Mr. and Mrs. Jerry Jones of Dallas, Mr. and Mrs. Walter Annenberg of Pennsylvania and Rupert Murdoch. The same guests will attend the black-tie dinner on the South Lawn.

Program

The Leadership Conference will take place at NIH and begins with a reception, followed by the welcome, speaking program, and then lunch. You will arrive for the start of the speaking program. Later in the evening, you will attend/host the

Children's Circle of Care Gala Dinner on the South Lawn at the White House.

The discussion at the Conference will center on leadership rather than a technical medical discussion since a majority in the audience are not physicians. Dr. Harold Varmus delivers the welcome, followed by Scott Oki who delivers brief remarks on the importance of philanthropic support. Dr. Nathan of Children's Hospital in Boston will discuss current work in pediatric research. NBC correspondent Dr. Bob Bazell will emcee the program.

III. PARTICIPANTS

Meet & Greet??

Speaking Program
HRC
Dr. Harold Varmus, Director, National Institute of Health
Bob Bazell, NBC Medical/Science Correspondent
Scott Oki, Seattle Children's Hospital, President, Oki Development
Dr. David Nathan, Physician-in-Chief, Children's Hospital of Boston

IV. SEQUENCE OF EVENTS

- Dr. Harold Varmus delivers welcome
- Bob Bazell, Emcee,
- Scott Oki delivers brief remarks
- Dr. Nathan, Children's Hospital in Boston, delivers remarks
- Bob Bazell introduces HRC
- HRC delivers remarks
- HRC departs

V. PRESS

Open press.

VI. REMARKS

Prepared by Jennifer Klein.

Facts About Children's Hospitals

There are currently 50 free-standing acute care children's hospitals in the United States. In addition, there are more than 100 children's specialty hospitals and children's hospital and pediatric programs within larger hospitals and medical centers.

Children's hospitals represent only one percent of all hospitals, but they are the nation's safety net for the poorest children, the sickest children, and children with the most specialized health needs.

By virtue of their locations in major metropolitan areas, children's hospitals are essential providers of care to children of low income families. They serve the primary as well as specialty care needs of inner city children. On average, children's hospitals devote almost 50 percent of their care to children of low income families.

Why do we need children's hospitals?

Childhood Development
Children pass through many developmental stages before reaching maturity. Consequently, depending on age and stage of development, children will respond differently to both illness and treatment. Children's psychosocial needs also vary by age.

Communication/Understanding
Because young children have only a limited ability to communicate, their symptoms must be examined more closely to diagnose or monitor illness. They also require more reassurance in treatment and more assistance with activities of daily living.

Size
Children are smaller than adults, and they range in size from very premature infants to adult-sized adolescents. Smaller children are vulnerable to sudden shifts of conditions. Medication must be more finely calibrated, and procedures can be more difficult.

Parental Dependence
Because children's health and recovery depend on parental involvement, parents require education and support, both during the hospital stay and in anticipation of discharge.

MEMORANDUM

To: Lissa
Fr: Deb
Re: Circle of Care Conference
Dt: Sept. 21, 1995

The Event

The Children's Circle of Care Leadership Conference (to be held at the NIH) is the first annual conference to honor the gift club of donors to children's hospitals who have given $10,000 or more to any one of the top nineteen children's hospitals in the U.S. and Canada. Hospitals are listed at the bottom of the memo.

The audience will number approx. 600 people and will consist of philanthropists from a variety of backgrounds. The audience has in common their commitment to children and their exemplary volunteer and financial support which they give through their local children's hospitals.

The conference is in the morning, beginning at 10:30. HRC will speak between 11:30 and noon. The conference will be followed by an evening dinner at the White House for which it appears she is not to give a speech. Her main address will be in the morning and the evening will consist of some sort of greeting and perhaps introduction of other speakers.

Other Speakers

1. **Scott Oki**-is founder of the Oki Foundation which he established as a trustee to Children's Hospital in Seattle. His initial pledge of $1,000,000 was matched by local donors and eventually planted the seed for the nationwide Circle of Care that includes big philanthropists from around the country who give to their respective children's hospitals. Oki also founded the international division of Microsoft and is responsible, in large part, for the company's overall success. He retired from his work there and now directs many corporate and non-profit boards and philanthropic endeavors. He will speak about the importance of big donor philanthropy.

2. **David Nathan**-Physician-in-Chief at Children's Hospital in Boston, he will address the policy/medical side of the issue as well as the **Children's Circle of Care mission statement:**

> **It is the mission of the Children's Circle of Care to advance the work of pediatric patient care, research, and teaching by encouraging and recognizing annual**

major gift giving to participating children's hospitals in North America. In so doing, the program also seeks to educate the public about child health issues and the unique mission and service of children's hospitals.

3. **Dr. Harold Varmus**-director of the NIH; he will provide the welcome and some short remarks.

HRC's speech should relate to the health and well-being of children, the importance of children's hospitals, and should perhaps discuss her own involvement with Arkansas Children's (only in the morning conference so as not to single them out too much). Mrs. Clinton is the **Honorary Chairman of the Circle of Care.**

Hostpitals involved in Children's Circle of Care:
Arkansas Children's; British Columbia's Children's; Children's Hospital in Boston; Children's Hosptil in Columbus, Ohio; Children's Hospital and Health Center in San Diego; Children's Hospital and Medical Center in Seattle; Children's Hospital Los Angeles; Children's Hospital Medical Center in Cincinnati; Children's Hospital Medical Center of Northern California; Children's Hospital of Pittsburgh; Children's Hospital of Wisconsin; Children's Medical Center of Dallas; Children's Memorial Medical Center in Chicago; Children's National Medical Center in D.C.; Lucile Salter Packard Children's Hospital at Stanford; St. Louis Children's Hospital; The Children's Hospital in Denver; The Children's Hospital of Philadelphia; and the Hospital for Sick Children in Toronto.

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release September 21, 1994

REMARKS BY THE FIRST LADY
AT THE CHILDREN'S HOSPITAL IN MASSACHUSETTS

MRS. CLINTON: Thank you very much, Senator, and thank you David Wyner (phonetic), for your invitation and for your deep concern on behalf of this hospital and all Children's Hospitals. I want to thank Helen Spalding (phonetic) and the board members, Dr. Lovejoy and the medical staff, the nursing staff, and the entire staff that make this hospital such an extraordinarily place.

I have been very privileged in my life because I've been associated with Children's Hospitals, one in particular in my state of Arkansas where I served on the board, where I helped raise money and where I also had my daughter, luckily, for a very short stay. So I experienced it as a parent, and there is something that undeniably is special about Children's Hospitals, but this particular hospital, as Senator Kennedy never tires of telling me, is the most special place of all when it comes to the universe of Children's Hospitals because you are the biggest.

You have had the most extensive experience in many forms of treatment, and you have a research capacity that is unmatched by any others. As I was walking through the hallway and having a chance to talk to Mr. Wyner, I realized that much of what this hospital stands for and much of which it can be proud is directly related to the partnership between the public and private sector.

As a former board member of Children's Hospital in Arkansas, I know what it takes to raise private funds through private philanthropy, but I also know how essential it is and absolutely the basis of our continued existence as Children's Hospitals to have government support that understands there is a difference between treating children and treating adults.

There is a need for the kind of entertainment center and the child-like work and the family support, and those differences are just a few of what it takes to make sure that

MORE

not only the child but the entire family is supported.

I remember very well when one of my brothers was in a Children's Hospital in Chicago in the days before parents were permitted to do anything other than show up for that one hour of visiting time 8 o'clock at night. So children would wait all day long scared, lonely, confused, and then their mother or their father, because siblings were not permitted, would come in and then be told to leave.

I know what that did to my parents and my brother and the rest of us while he stayed in the hospital. Contrast that with my own experience when my daughter had to go in overnight. I was there in the room. My husband was in and out. Finally, the nurse came in, took one look at me and said, "One thing about Children's Hospital is we take care of parents as well. You need some sleep."

It was that kind of family center care that has made the difference, but there have also been a number of other changes in the last several years that have made a difference for this hospital, for Children's Hospital and for academic health centers.

Senator Kennedy talked about research. What he didn't say is we would not have the NIH budget and the research capacity that this country now enjoys that permits the sort of breakthroughs that enable you on the medical and nursing staff to give the quality of care to our children were it not for Senator Ted Kennedy and the tireless work he has done over the years to promote medical research, and he did it not just because of his own personal experience; he did it because he wanted every single child to have the same aspects of quality care that his children had, and that's the kind of leadership that he has shown when it comes to the health care of our children. (Applause)

I also think as I walk around this hospital of those specialists who are here, pediatric cardiologists, nephrologists, oncologists, and in large measure the training that you have received is because the federal government supported that specialist training. Training of positions is not done in the marketplace without any government support. It is done because the federal government decided 20 years ago or more that we needed certain specialists, and we had to pay for their training because no institution alone could absorb the cost.

Again, as I look at the medical staff, the nursing specialties, I think of the role that Senator Kennedy has played in his Senate career and his chairing of the important committee through which health legislation passes in the United States Senate and so many other ways.

Now, I say that not as a paid political advertisement, because I'd be glad to say it anywhere, anytime, but as a reminder about what it takes to build great institutions. It takes common purpose, a sense of mission, and resources from both the public and the private sector in order to make the difference, and over and over again I have seen this senator be the only one who would break a logjam, the only one who could talk to both democrats and republicans, who would bring them together. Over and over out of his committee bipartisan solutions emerged because he always talked about what we were trying to do for others and particularly for children.

We are at a kind of funny point in our history right now as a country because we are struggling with how we want to target our resources, what kinds of policies we want to follow, how we feel about our government, what we want to do for all of the needs that exist.

To me, a lot of that is, frankly, just rhetoric. I hear the arguments on the talk shows. I see all of the back and forth in the political game. What matters to me is have we done something today, this week, this month that makes the lives of children better?

That's how I try to measure every single -- (Applause) and every day those of you who work here and those of you who support the work here, you can answer the question, "Yes, I have. I have. I've done something not only to help cure a child or fix a problem but to help with a parent's anxiety or to solve a financial issue that they confront in order to get the care that they need. I've done something to help at least one child."

I wish that is the way we would measure all of our political leaders in America today because, when it is all said and done, what will really count in a lifetime, whether it be of an individual or of a nation, is what have we done to set the groundwork and to make it possible for every child to live up to his or her God-given potential. If we can answer the question positively about that, then I think we have fulfilled our responsibilities as adults and as leaders.

Based on my work and my long-time observation of Senator Kennedy, he can say that, but we need to work together in partnership to make sure that all of us can say that, because I love coming to Children's Hospitals.

I cannot bear looking into the eyes of parents who don't know whether they will be able to afford to keep coming or whether they will have lifetime limits on their insurance policy coverage cut just when they need it most or who look at me, as a couple did in Cleveland at the Children's Hospital there with two chronically ill children and say, "We can't get insurance. We make too much money to qualify for Medicaid. We've gone from place to place to try to get financial help. The hospital carries us as a charity case, which is not what we think is right, but finally I knew I would never get help in our current system, because after hearing about our children's illnesses and have insurance companies say, 'You just don't understand. We don't insure burning houses.'"

I could not imagine how I would have felt had anyone said that to me about my daughter. I don't want to live in a society where we can say it about anyone's child. (Applause) All of you every day, from those who are in the operating rooms to those who clean the floors and make this place shine, every day you are doing what you can to make it possible that parents with sick children know that they will be taken care of, and I hope that you will speak out to your friends and neighbors about what you see here, what you know are the needs and demand the kind of leadership from the public and private sector in our country that puts our children first. That is the way to maintain a great America for the 21st Century. Thank you all very much.

(End of tape.)

* * * * *

Sabrina

Children's
Hospital Foundation

CHILDREN'S HOSPITAL FOUNDATION/GUILD ASSOCIATION

DATE: 8/7/95 **TIME:** 1:15 pm

TO: JULIE HOOPER THE WHITE HOUSE

FAX PHONE# 202/456-5340

VOICE PHONE#

FROM: DOUGLAS PICHA

FAX PHONE# 206/527-3851

VOICE PHONE# 206/526-2152

NUMBER OF PAGES SENT INCLUDING THIS SHEET: 4

CHILDREN'S CIRCLE OF CARE
LEADING BENEFACTORS TO CHILDREN'S HOSPITALS

LEADERSHIP CONFERENCE
and
WHITE HOUSE DINNER/GALA

Wednesday, September 27, 1995
Washington, D.C.

Leadership Conference -
Natcher Conference Center, National Institutes of Health — 10:00 a.m.-1:00 p.m *(confirmed)*

- Reception — 10:00-10:30 a.m.
- Welcome - Emcee & Dr. Harold E. Varmus, Director, NIH — *(pending)*
- Program
  1. Scott Oki, Seattle Children's Hospital — *(confirmed)*
     The Importance of Philanthropy
  2. Dr. David Nathan, Boston Children's Hospital, Physician-in-Chief — *(confirmed)*
     Promising Work being Conducted in Pediatric Research

FEATURED SPEAKER: Cèlie Roberts to introduce
3. Hillary Rodham Clinton, First Lady — *(pending)*

Lunch — 12:15-1:00 p.m.

White House Dinner/Gala
South Lawn - 700 guests attending

- Reception — 7:30-8:30 p.m.
- Dinner/Entertainment/Dancing — 8:30 -

WOODMARK FORUM
CHILDREN'S CIRCLE OF CARE PARTICIPANTS

HOSPITAL	# INDIVIDUALS INVITED
1. Arkansas Children's Hospital Foundation - Little Rock, Arkansas	39
2. British Columbia Children's Hospital Foundation - Vancouver, BC	50
3. Children's Hospital Medical Center - Cincinnati, Ohio	27
4. Children's Hospital Foundation - Seattle, Washington	70
5. Children's Medical Foundation of Texas - Dallas, Texas	26
6. Children's Hospital Foundation - Denver, Colorado	11
7. Children's Hospital Los Angeles - Los Angeles, California	46
8. Children's Hospital of Philadelphia - Philadelphia, Pennsylvania	37
9. Children's Memorial Hospital - Chicago, Illinois	50
10. Children's National Medical Center - Washington, D.C.	56
11. Children's Hospital Foundation - Milwaukee, Wisconsin	52
12. Children's Hospital and Health Center - San Diego, California	32
13. Children's Hospital of Pittsburgh - Pittsburgh, Pennsylvania	32
14. Children's Hospital Foundation - Oakland, California	22
15. Columbus Children's Foundation - Columbus, Ohio	28
16. Lucile Salter Packard Children's Hospital at Stanford - Palo Alto, California	38
17. St. Louis Children's Hospital - St. Louis, Missouri	12
18. The Children's Hospital - Boston, Massachusetts	58
19. The Hospital for Sick Children Foundation - Toronto, Ontario	47
Sponsors	12
TOTAL	**745**

CHILDREN'S CIRCLE OF CARE

MISSION STATEMENT

IT IS THE MISSION OF THE CHILDREN'S CIRCLE OF CARE TO ADVANCE THE WORK OF PEDIATRIC PATIENT CARE, RESEARCH, AND TEACHING BY ENCOURAGING AND RECOGNIZING ANNUAL MAJOR GIFT GIVING TO PARTICIPATING CHILDREN'S HOSPITALS IN NORTH AMERICA. IN SO DOING, THE PROGRAM ALSO SEEKS TO EDUCATE THE PUBLIC ABOUT CHILD HEALTH ISSUES AND THE UNIQUE MISSION AND SERVICE OF CHILDREN'S HOSPITALS.

Children's
Hospital Foundation

CHILDREN'S HOSPITAL FOUNDATION/GUILD ASSOCIATION

DATE: 8/7/95 TIME: 1:15 pm

TO: JULIE HOOPER _ THE WHITE HOUSE

FAX PHONE# 202/456-5340

VOICE PHONE#

FROM: DOUGLAS PIGHA

FAX PHONE# 206/527-3851

VOICE PHONE# 206/526-2152

NUMBER OF PAGES SENT INCLUDING THIS SHEET: 3

4800 Sand Point Way N.E. P.O. Box 05371 Seattle, Washington 98105 (206) 526-2153

Children's Hospital Foundation

Patti TO Call

19 Hospitals Involved

August 7, 1995

VIA FAX: 202/456-5340

Julie Hooper
The White House
Old Executive Building
1600 Pennsylvania Avenue, Room 185 1/2
Washington, DC 20500

NIH Bethesda 301-496-4000

Dear Julie:

It was nice talking to you on Wednesday.

It remains our hope to have Mrs. Clinton address our attendees at the first Children's Circle of Care Leadership Conference on September 27 at the National Institutes of Health. This letter will serve as a follow-up to Larry Woodard's July 7 invitation to Mrs. Clinton and provides you with additional information which you requested.

The Children's Circle of Care is composed of leading individual benefactors from nineteen of the largest children's hospitals in North America. Mrs. Clinton is the Honorary Chairman of our Children's Circle of Care effort to further enhance the mission of our respective hospitals.

On September 27, 600-700 of these individuals will attend a Leadership Conference in the morning and early afternoon. That evening the President and Mrs. Clinton are hosting a black tie dinner at the White House to honor the Children's Circle of Care.

The Leadership Conference will take place at the Natcher Conference Center on the NIH campus in Bethesda, Maryland. It will start at 10:00 a.m. and conclude with lunch at approximately 1:00 p.m. Those attending this conference are the same individuals who will be guests for the dinner that evening. The list of the individuals who have been invited and are expected to attend include: Ben Bradlee and Sally Quinn, Washington, DC; Craig McCaw, Seattle; Mrs. John Heinz III, Pittsburgh; Mr. and Mrs. Jerry Jones, Dallas; Mr. and Mrs. Walter Annenberg, Wynnewood, Pennsylvania, and Mr. and Mrs. David Packard, Palo Alto, California.

We envision people will arrive at the Leadership Conference at 10:00 a.m. The program will begin at 10:30 a.m. We have asked Dr. Harold Varmus, Director of the NIH, to provide the welcome and some short remarks. The two confirmed speakers at this time include Mr. Scott Oki, a retired Microsoft executive and Seattle Children's Hospital Foundation Trustee, and Dr. David Nathan, Physician-in-Chief at Boston Children's Hospital.

Mr. Oki will speak on the purpose of the Children's Circle of Care and the important role philanthropy plays in our institutions. Dr. Nathan will give an address on the promising work being conducted in pediatric research and other aspects of our collective missions of providing quality pediatric patient care; education and advocacy on behalf of children.

We hope Mrs. Clinton would be able to be our featured speaker for the morning addressing the audience between 11:30 to 12:00 noon. We suggested an earlier speaking time in our July 7 correspondence. It is our feeling this is the most appropriate time slot for Mrs. Clinton as our featured speaker. After her remarks the group will have lunch at the conference center and depart back to their hotels via the bus transportation we will provide.

As Larry Woodard suggested in his earlier correspondence, the content of Mrs. Clinton's speech should relate to the health and well-being of children. The audience has two things in common: their commitment to children, and their exemplary volunteer and financial support which they give through their local children's hospital. Thus, it is because of their individual examples of commitment that we felt it was appropriate to call this educational program our Leadership Conference.

I have included additional information on three separate sheets. Hopefully this will give you an even greater understanding of the scope of our activities.

Thank you for your work in our efforts. It is our hope to know as soon as possible if Mrs. Clinton is available. I will call you later this week to follow-up.

Most sincerely yours,

Douglas T. Picha
Executive Director

DTP/sd

Oki Introduction
Children's Circle of Care Leadership Conference
September 27, 1995
Draft: September 11

Our next speaker... is a man named Scott Oki.

Scott is –among other things– a trustee of Children's Hospital in Seattle.

The "other things".....include being founder and president of Oki Development Inc., whose holdings range from numerous start ups and young high tech companies to ownership of the Seattle Sounder's professional soccer team and more. PLUS, founding the Oki Foundation with his wife Laurie.
(pause)

If there's one thing that's distinguished Scott Oki.... it's been his association.....with successful new ventures.

(pause)

He played a pivotal role in the success of a young computer software company in the early 80's. It's name? Microsoft.

The 120th employee to join Microsoft..Scott founded the international division.

Four years later, it had subsidiaries in 17 countries and profits that accounted for more than 50 per cent... of Microsoft's total profits.

When Scott retired from Microsoft as Senior Vice President of Sales Marketing and Services ...the company's total revenues exceeded 2 billion dollars.

Today, he's a director on 11 corporate and 18 non-profit boards– 10 of which..he founded. And, to his credit, he's combined his

entrepreneurial strengths... with a weakness for good causes....especially ones involving children.

(pause)

When he and his wife Laurie began having children and couldn't find baby blankets they liked, they started a company to manufacture them. Today, all profits from their blankets– now sold through Nordstroms– go to children's charities. So do the profits of the Seattle Sounders.

So, what does Scott Oki ...have to do with the Children's Circle of Care?

In 1993, the Oki Foundation agreed to stake a $1 million gift to Children's Hospital in Seattle...on a new venture. That venture was intended to attract new donors to the hospital ...and plant the seed for a gift giving culture...based on repeat gifts of $10,000 or more.

Scott and Laurie Oki's agreement to match gifts of $10,000 with one time gifts of their own...inspired many of those who participated in the program to pledge $10,000 or more... for more than one year. AND add Children's to their bequests.

Ultimately, the Oki's $1 million gift grew Children's list of major givers from 20 to more than 80 people. And, generated $11.4 million.

Enthused by those results, the Oki Foundation made the first pledge needed to help get the concept of a Children's Circle of Care–that would embrace ALL the institutions represented here, today-- off the ground. And to bring us to this moment.

Ladies and Gentlemen, please welcome.....Scott Oki.

Oki Presentation
Circle of Care Leadership Conference
September 27, 1995

Good Morning,

The first thing I need to tell you ...is how humbled I feel to be standing here before you, today.

(pause)

My name is hardly a household word.

I'm an unknown in national philanthropic circles.

My background is very ordinary.

(pause)

If there was anything EXtraordinary...about the Japanese American neighborhood I grew up in..it was a powerful sense of community and connectedness.

It gave me an understanding of how good it feels to a child.. to be part of a family... or any other circle of people who love and care for one another.

(pause)

Very simply...that's why we're here today: to discuss what the Children's Circle of Care is all about.

(pause/look around)

WE ARE.....a very diverse group.

We come from different parts of the country—even different parts of the world.

We represent different business and personal interests.

Some of us come from families or organizations who are renown for their tradition of giving.

Others of us--like myself-- are relative newcomers to the world of charitable giving.

But we have one very important thing in common.

(pause/look up)

We all have a children's hospital, back home or here in Washington, that's close to our hearts.

(pause)

A hospital to which we've demonstrated a commitment.

(pause)

Why?

The reasons for that are as diverse as we are.

Why do we and the people in the communities we come from provide millions of dollars of support to those same institutions?

(pause)

Perhaps we learned, as children, that giving is a part of being human.

Maybe we know--or can imagine--how it feels ...to sit holding the hand of a seriously ill child that is precious to us.

(pause)

For whatever reason..the generosity of people like you has CREATED, the premier Children's hospitals represented HERE-- North America's 19 largest.
Without that generosity, they wouldn't exist.

And these hospitals are still, today, very dependent ...upon charitable giving.

(pause)

To give you some basis for comparison...the average non-profit hospital in any year, raises about $600,000 through charitable contributions.

(pause)

The average CHILDREN'S hospital raises 5 MILLION dollars every year....through philanthropic contributions.

That not only says how much we cherish our children's hospitals.

It also speaks to the intelligent stewardship and management of charitable dollars by the institutions themselves.

And that's important.

(pause)

I think, when we GIVE, most of us like to think that our gift will grow into something bigger.
That we're making a wise investment.

(pause)

That sense that we WERE making a sound investment--along with our passion for Children's causes--is what drew my wife Laurie and me to Children's Hospital in Seattle. AND to the Children's Circle of Care.

We've seen in our own community how exciting an endeavor like this can be. And, we're convinced that through the Children's Circle of Care....we can help lay the financial foundation ...for the future of our Children's Hospitals.

(pause)

You see..to even HAVE a future, they're going to have to continue generating charitable dollars...at levels greater than the ones they're enjoying right now.

(pause)

One of the best ways of getting the dollars they'll need to continue fulfilling their missions.. is increasing the number of large gifts they receive from individual givers, like you and me.

(pause)

Last year over 221,000 individual charitable gifts were made to the 19 children's hospitals represented here, today. (Now that's not corporate gifts or gifts generated through events.)

Only 527 of those 221,000 gifts were for $10,000 or more... And YET ...those gifts of $10,000 or more accounted for $33 million, or over HALF,.... of the total number of dollars raised from individuals.

That gives you some idea of just how important we are... to our Children's Hospitals. And, of why we are, in a very real way, leaders ...in their world.

(pause)

The Children's Circle of Care.. is to be made up of people, like you, who care deeply and who make a gift of $10,000 or more, in one year, to one of our 19 Children's Hospitals.

(pause)

THROUGH the Children's Circle of Care.... we hope to grow the ranks of those who make contributions of that size.

You see, the small individual gift, the galas and telethons and the grass roots efforts that are and will continue to be so much a part of the lives of these institutions....won't be enough to sustain our Children's Hospitals.

(pause)

Colleges and universities learned a long time ago how important it is to have major gifts and bequests.. as a solid foundation upon which to build their futures.

Even United Way has realized that their future success will depend-- largely-- on their ability to attract gifts larger than those they're able to generate through the work place.

(pause)

What is our vision for the Children's Circle of Care? How do we believe it will help Children in the future?

Consider what's been accomplished already through philanthropy.

Each of our institutions was born ...as a result of generous people... seeing a need to help ill or injured children
...and doing something about it.

And, they have grown up ...on philanthropy.

It was the generosity of William Cooper Proctor that built a new Cincinnati Children's Hospital, back in 1926, and endowed the Children's Hospital Research Foundation. This endowment--today, one of America's largest-- has helped establish Cincinnati Children's... as a world renowned pediatric research facility.

In Arkansas, thanks to Mrs. Bernice Jones of Springdale, children in the northwest part of the state will now have available some of the specialized pediatric services available before only at the main hospital in Little Rock.

Mrs. Jones, who is here, today, recently made the largest gift ever given to Arkansas Children's, and created a Children's Institute. This outreach program consists of seven clinics and child care programs.

• In California, the Lucile Salter Packard Children's Hospital at Stanford, is largely a testament to the compassion and energy of the late Lucile Packard.

She and her husband, David, and the Packard family contributed their leadership and a lead gift that accounted for more than HALF the cost..of the new hospital building. Mr. Packard and his daughter Susan Packard Orr are here, today, too.

• Philanthropy is also an essential in the life of British Columbia's Children's Hospital.

In a health care system where costs and charges are capped by government funding, equipment like the latest isolettes for tiny premature babies... or the only pediatric MRI in the province... are available only because of the contributions of generous givers.

Those are just four examples.

Every one of our institutions has success stories, like these, that show there's no limit...to where we can go...with the Children's Circle of Care.

In fact, I've been told that it is the collective goal of our participating children's hospitals to DOUBLE.....the number of $10,000 donors at each hospital within the next four years.

By doing so, we will have advanced the mission of our medical centers. A mission which includes quality patient care, research, teaching and education.

(pause)

Those are some very formal words..directed to what is really a matter of the heart.

7

(pause)

I think it's interesting how we humans have demonstrated a propensity for drawing circles around the things we love.

Medieval Kingdoms fashioned moats around their castle walls ...*(Here possible other circle images)* as a means of walling out future danger...And preserving the things that mattered to them.

(pause)

Those devoted to the study of ancient symbols say the circle stands for <u>many</u> things.

(pause)

Life, the earth, eternity. And--interestingly <u>enough</u>--the unborn child.

(pause)

Well I believe, in years to come, future generations who treasure their children... will bless the **DAY** we came together in this place.....

To draw a <u>circle</u> of love and life and care .....around the children's hospitals...which **LONG AGO**.....stole a piece ...of each of our hearts.

Thank You.

Arkansas Children's Hospital Foundation 800 Marshall Street, Little Rock, AR 72202

SM

FAX

Date: July 7, 1995

Number of pages including cover sheet: 3

ups

To:	
	Ann Stock
	Social Secretary
	The White House
Phone:	(202)456-2399
Fax phone:	(202)456-6235
CC:	

From:	
	Larry Woodard
	President
	Arkansas Children's Hospital
	Foundation
Phone:	(501)320-1470
Fax phone:	(501)320-3644

REMARKS: ☐ Urgent ☒ For your review ☐ Reply ASAP ☐ Please comment

Ann,

Thanks for your help. Let me know if I can help further.

7/7/95 – Patti, we're doing a dinner for them but they're asking HRC to keynote the conference. Fr Tues. scheduling meeting

Arkansas Children's Hospital Foundation, Inc.
800 Marshall Street, Little Rock, Arkansas, 72202-3591
(501)320-1470 or 1-800-880-7491 (Arkansas) or TDD (501) 320-1184

File Sept

July 7, 1995

First Lady Hillary Clinton
Office of the First Lady
The White House
1600 Pennsylvania Avenue
Washington, DC 20500

file 9/27

Dear Hillary:

This letter is to serve as a formal invitation for you to deliver the keynote address at our September 27 day-long function honoring major donors to 20 of the U.S. and Canada's largest and finest children's hospitals. These individuals are to be honored that evening at a black tie gala on the lawn of the White House. As a side note I want to express our heartfelt appreciation to Ann Stock and her staff for the magnificent assistance they have provided us in preparing for this day of celebration.

From 10:00 a.m. until approximately 2:00 p.m. on that date, we will be presenting a leadership forum to these donors. We anticipate approximately 500-700 in attendance. We would be deeply honored to have you deliver the opening address at approximately 10:15 a.m. Also to appear on the program is Dr. David G. Nathan, Physician in Chief, Boston Children's Hospital, and Strahan Professor of Pediatrics at Harvard Medical School. Dr. Nathan is also a national Medal of Science winner. He will be addressing some of the more promising areas of pediatric research.

We would like to leave your topic as broad as possible, thus providing you with significant latitude in your remarks. The only parameter is that it deal with issues of significance affecting the health and well-being of children everywhere. Knowing full-well of your very strong, personal commitment to the children of the world, we felt certain that this is a subject area you could address with great enthusiasm.

Carolyn Peachy 636-8740

We hope to have the exact location of this function finalized within the next week or two, and I will notify Ann just as soon as a decision is made. At this time we are working with the National Institutes of Health, with the hope we will be able to host this portion of the day at that location. It seemed to be most appropriate for the occasion and the audience.

I know I speak for the others who are involved with me in the planning of this day of recognition when I say that we are terribly excited about the possibility of your presentation to this group of truly special donors. Thank you for considering our request, and we're all looking forward to being with you and the President on the 27th.

Sincerely,

Larry Woodard, President
Arkansas Children's Hospital Foundation, Inc.

Faxed to Ann Stock July 7, 1995. Original sent by U.S. Mail.

You of all people know what these Medicaid cuts will mean for children's hospitals. Children's hospitals represent only one percent of all hospitals, but you provide vital health care services to so many children -- including the poorest, sickest and most vulnerable. You devote nearly half of your care to children of low income families and more than three-quarters of your care to children with chronic or congenital conditions.

You care for the premature baby who needs intensive care for the first months of his life and extensive rehabilitation therapy for years to come. For the small child who is severely injured when she is hit by a car and sent to a pediatric intensive care unit at a nearby children's hospital. And for the eight year old boy who contracts viral encephalitis, loses his health insurance, and is covered by Medicaid because of his high medical costs and severe disabilities.

The proposed cuts in Medicaid will be particularly devastating for children's hospitals. Medicaid patients on average account for 46 percent of the inpatient days in your hospitals. In addition, Medicaid and uninsured patients together account for more than 47 percent of all gross revenues. Virtually all children's hospitals are designated by their states as serving a disproportionate number of children insured by Medicaid.

As you well know, it costs more to care for sick children than adults. And children's hospitals are not able to shift these higher costs to adult patients like other hospitals can. Already Medicaid pays children's hospitals on average less than 80 cents for every dollar spent to care for a child. The impact of a $182 billion in Medicaid is clear; your hospitals simply will be unable to provide all of the crucial health services that you do today.

We need to protect the safety net provided by our children's hospitals. So that children continue to have access to desperately needed specialized care. That children's hospitals continue to train pediatricians and other care-givers for children. And that you are able to continue to do research on the prevention and treatment of childhood disease.

MEMORANDUM

To: Lissa
Fr: Sabrina
Re: Children's Hospitals
Da: September 22, 1995

I spoke with Ann Langly, a consultant for NACHRI (National Association of Children's Hospitals and Related Institutions) about the state of Children's Hospitals.

Almost all of them are urban research and teaching institutions. Almost 50% of their patient load depends on Medicaid or have no insurance at all. About two thirds of the children they care for have serious illnesses or chronic conditions.

What happens with Medicaid affects the standard of care for all children - not just poor children, because the children's hospitals will not turn anyone away.

Right now, children's hospitals are facing substantial cuts -- it is as if they won't get paid for two years out of the next seven.

HRC role at Arkansas Children's Hospital

An article in Arkansas Time Magazine reports that in the 1970's the new governor (Clinton) and his wife took an interest in the future of the Children's Hospital. HRC became an enthusiastic backer, and when hospital officials presented the need for a neonatal intensive care unit to the legislature, the "politicians listened." In 1979, with funding from the state, Children's Hospital opened a twelve-bed intensive-care unit for newborns.

At about the same time, the Hospital board seized the chance to become a regional medical center. The problem was finding lenders. The success of that would depend almost entirely on the hospital's getting a decent bond rating. So HRC and members of the board flew to Wall Street, to the offices to Moody and Standard and Poor's. Their trip has taken on a mythic status within the Arkansas Children's community. HRC was eight months pregnant. Leland McGinnis, CEO of the hospital, says of the experience: "...when the first lady of Arkansas is there, big with child, and she stands up and speaks, with no notes, about how this is the only children's hospital in the state and about how everybody supports it...Well, we received a bond rating that was probably higher than we merited."

Arkansas Children's Hospital Foundation, Inc.

800 Marshall Street, Little Rock, Arkansas, 72202-3591
(501)320-1470 or 1-800-880-7491 (Arkansas) or TDD (501) 320-1184

September 19, 1995

Mr. Douglas Picha
Children's Hosptal Foundation
P.O. Box 5371
Seattle, WA 98105

Dear Doug:

Following is the information you requested about Hillary's activities with Arkansas Children's Hospital.

Back in the 70's, the hospital was preparing to issue bonds for a building project, and a group from the hospital (administration and Board), including Hillary who was 8 months pregnant at the time, flew to New York to make a presentation before the rating agency. Hillary was First Lady of Arkansas at the time and had been a strong advocate for the hospital in this role. Hillary was there to represent the hospital as a volunteer, supporter, and as First Lady of the state. It is my understanding that her presentation was instrumental in the hospital receiving a very favorable bond rating.

Since the beginning of the telethon, Hillary has served as chairman of this event for Children's Hospital. She was one of the on-air hosts for the 10 years she was still in Arkansas and did an extremely effective job in telling the hospital's story and encouraging others to support our work.

During her first year as chairperson, she personally signed 1,500 letters that were sent to prospective donors seeking their support of the telethon. More than half of those letters had a personal, hand written note from Hillary to the individual.

Hillary served on the hospital's Board of Trustees from 1988-1993. During this time, she was a very active member of the Board and served

on the Board's Legal Committee for 3 years and also served on the Development and Community Affairs Committee for one year.

On many occasions, Hillary participated in the solicitation of major gifts for the hospital and she and her husband have long been a personal donors.

Since Chelsea's birth, Arkansas Children's Hospital provided all needed health care for the daughter of the First Family.

Hope this information is helpful.

Sincerely,

Larry Woodard, President
Arkansas Children's Hospital Foundation, Inc.

Reprinted with permission from March 1990 ARKANSAS TIMES MAGAZINE, P.O. Box 34010, Little Rock, AR 72203, 501-375-2985.

Miracle

On Wolfe Street

In 1972, Arkansas Children's Hospital was a small charity operation, mostly for poor, crippled kids. It was also broke; the board of trustees considered closing. ☐ Today, Arkansas Children's Hospital, on Wolfe Street near the state Capitol in Little Rock, spends $2 million a week. It is the sixth-largest pediatric medical center in the United States. The staff boasts that, with the exception of liver transplants, any pediatric procedure offered anywhere in the world can be performed as well or better at Arkansas Children's Hospital. ☐ Dr. Randall O'Donnell, the current chief executive officer, describes the hospital's level of sophistication this way: "You either can do a heart transplant in the middle of the night, or you can't. We can." ☐ It is as though the institution got up from its own deathbed and started running. The rise has been so rapid that O'Donnell speaks of it almost in inspirational tones. What was attempted at Children's Hospital was a long shot, almost as long as if Arkansas, right now, were to declare a ten-year goal of becoming a leader in education. Reactions were about as predictable. As recently as the late Nineteen Seventies, O'Donnell says, "there were people who, when they heard what we were trying to do, said, 'You people must be heady with wine.' " ☐ The doubters had history and a lot of probability on their side. The builders of the hospital had zeal, savvy, and a little bit of luck on theirs. ☐ They needed it all. For years after its founding by the Arkansas Home Finding Society in 1924, the

By Mara Leveritt

Not so long ago, Arkansas Children's Hospital was unloved and nearly bankrupt. Today, it's the sixth-largest pediatric medical center in the country.

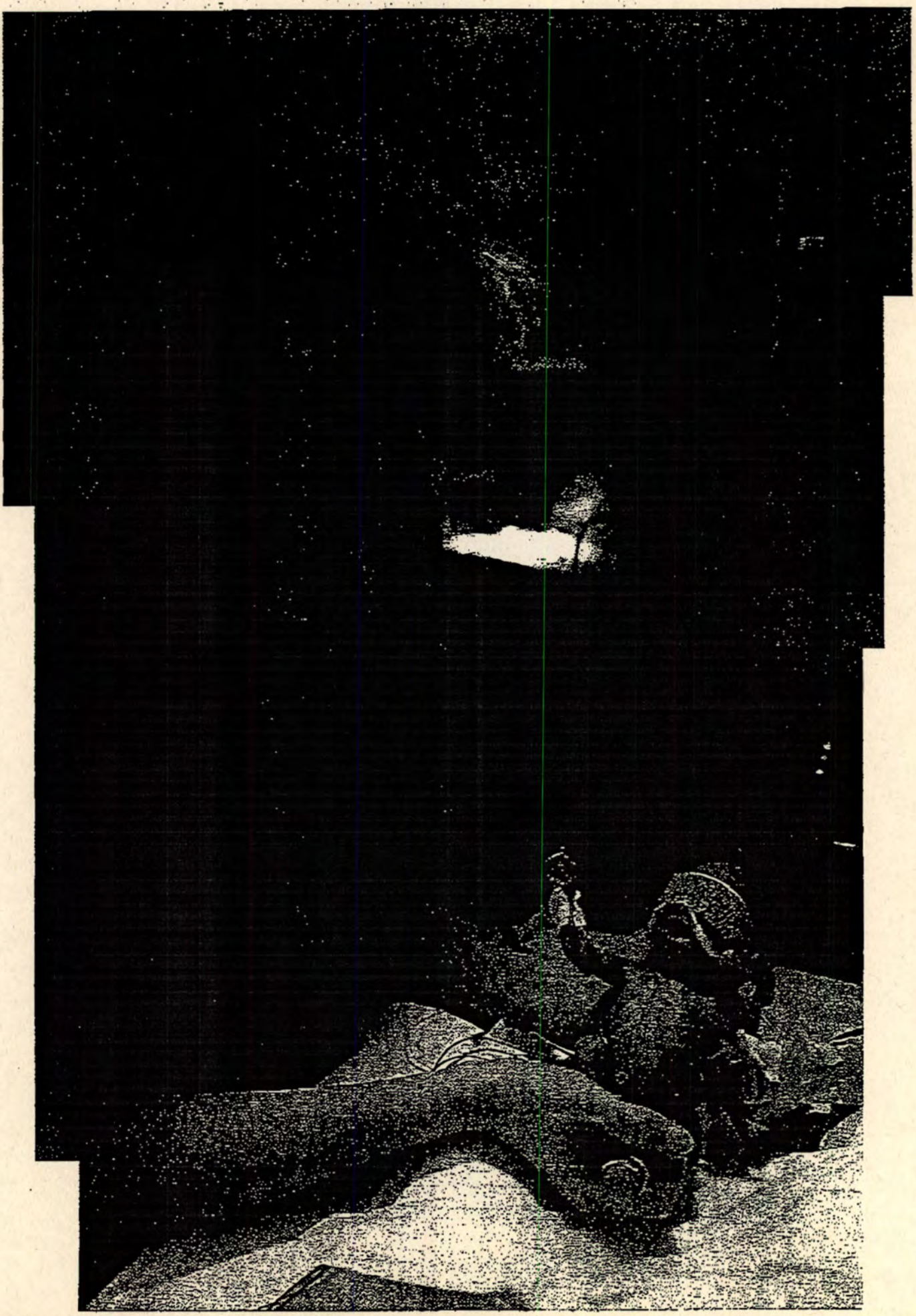
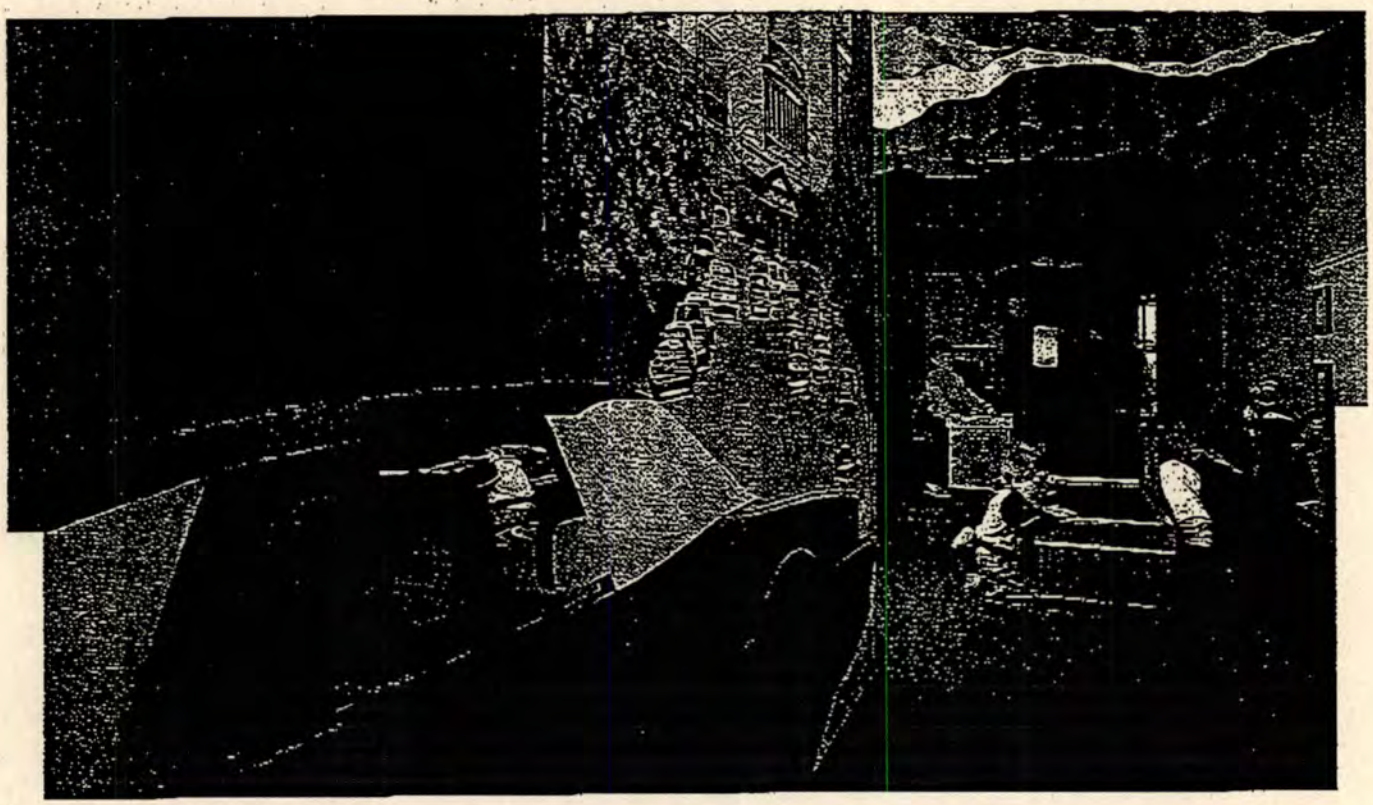


PHOTO: MARK MORGAN



Two staff artists design rooms, hallways, and projects (above) to soothe hospitalized children. In an examining room (right), shiny equipment and a pediatrician's calm offer comfort of another sort.

Profit wasn't a dirty word at Children's, but it was one seldom heard. Even in the darkest hours, the hospital treated all children, regardless of ability to pay.

hospital was little more than an orphanage infirmary. When the orphanage closed, the hospital added a burn center and an orthopedic wing. A small but loyal band of supporters kept the lights on, but by the Seventies, the hospital was itself a crippled orphan. With fewer than a hundred beds, a medical staff on the verge of revolt, and a clientele unable to pay for even the cheapest services, its condition was dire.

Enter Leland McGinness, a retired Air Force officer of forty-two, with experience in Korea, Vietnam, and military hospital administration. In 1973, one year after accepting a job at Arkansas Children's Hospital, McGinness became its chief executive officer—"the lowest-paid hospital administrator in the world"—when his predecessor died suddenly of a heart attack.

"When I came in and looked at his desk, I could understand his, shall we say, hasty demise," McGinness says. "It was piled high with obligations and responsibilities, with not much help in sight. I sat down, and that's when Mildred Ward came in. She ran the purchasing department and the switchboard; she ran everything. She told me, 'Mr. McGinness, no one should have to come in and take on this responsibility. Payroll is due tomorrow, and we can't meet it.' "

McGinness could handle that, with help from the board of trustees. But there was worse. As McGinness now rather delicately puts it: "Back then, Children's Hospital was not a place where excellent care was given at all times." In fact, no parents who could afford to do otherwise—not even members of the hospital's own board—sent their children there.

When they could afford it, families with sick children traveled to hospitals in Boston, St. Louis, or Houston, often at great expense. Seriously ill children whose families couldn't afford to travel were treated locally or at the pediatric wing of the University of Arkansas for Medical Sciences. There, they either responded to the level of care available, McGinness says, or they died.

McGinness found the situation intolerable. "Because of the things I'd achieved in the military," he says, "I had a certain self-esteem, a certain pride. I wanted to be associated with the best, and it was damn clear that this hospital was not one of the best."

That it operated at all was largely due to a long-standing arrangement with the University of Arkansas for Medical Sciences. Because of its mandate to deliver what used to be called "indigent" care, as well as its responsibility for training young doctors in pediatrics, UAMS had for years been supplying Children's Hospital with medical staff and equipment. Medical students took part of their pediatric training at Arkansas Children's Hospital and part at the medical center's own forty-bed children's wing.

But students and faculty were frustrated by the lack of facilities at both sites. In the early Seventies, Dr. Robert Merrill, then chairman of the UAMS pediatrics department, established a twenty-four-hour walk-in clinic at Children's. It was the front line in delivery of health care for very sick children. But while hospitals elsewhere were making remarkable advances, especially in saving the lives of high-risk newborn infants, or neonates, neither Arkansas Children's Hospital nor UAMS had the needed equipment. While the death rate of babies in other states was dropping, Arkansas's was not.

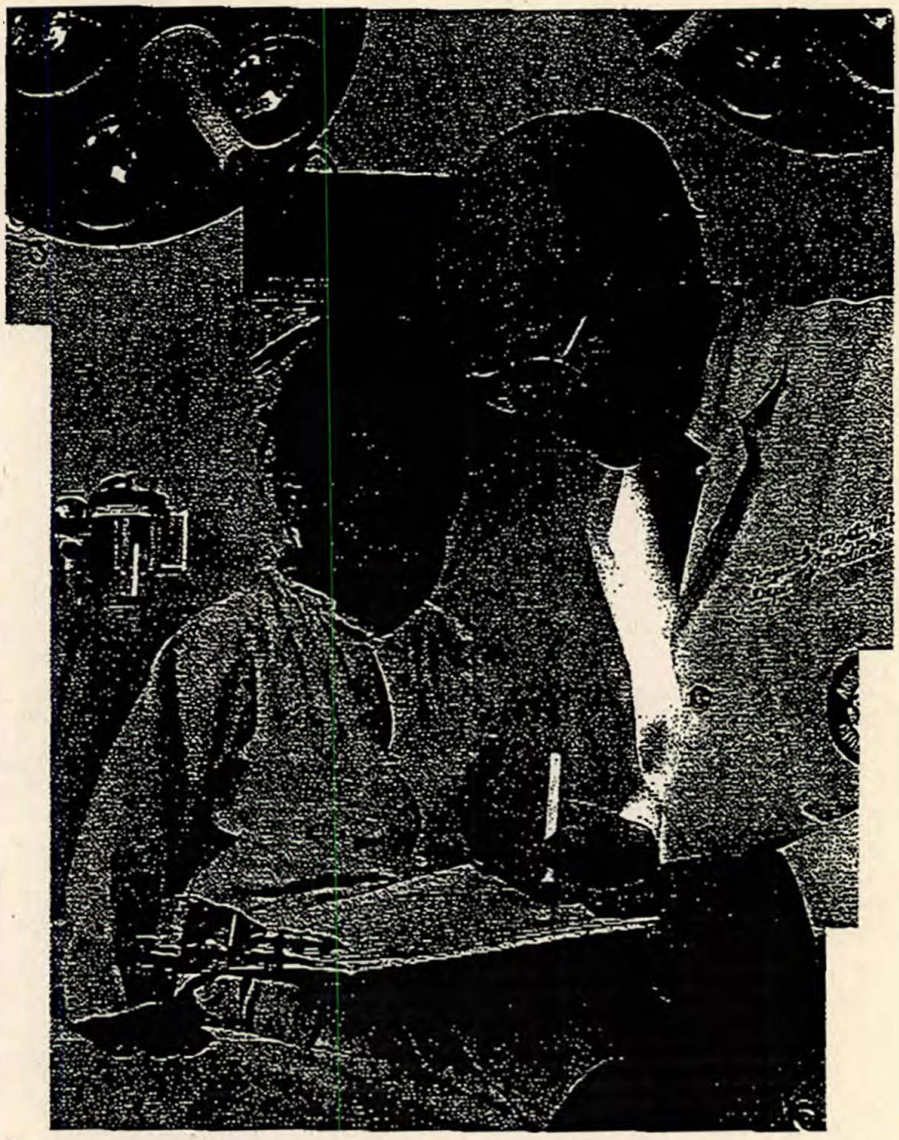
Finally, Merrill resigned. McGinness says, "He was so frustrated at the univer-

PHOTOS: MARK MORGAN

sity's failure to provide for what he considered to be the legitimate health-care demands of neonates that he said, 'I will no longer admit them to this facility.' "

Moreover, student doctors complained that they were not being trained in current pediatric techniques. They told McGinness they felt exploited—overworked and undertrained.

For McGinness it was a baptism of fire. But he considered the doctors' grievances legitimate, and he saw in them an opportunity.



He was able to share that vision with Dr. Robert Fiser. Fiser, a native of Arkansas and a graduate of the University of California at Los Angeles, was hired by the UAMS to replace Merrill. At thirty-two, he was the youngest chairman of a pediatrics department in the country. Fiser is now fairly well known around the hospital for the agility of his imagination, and back then it took him no time at all to embrace McGinness's dream—that the near-destitute Arkansas Children's Hospital could become a pediatric medical center of excellence.

Together, McGinness and Fiser pushed the school's chancellor for increased support for Children's Hospital. "But he thought our ideas were too grandiose," McGinness recalls. "He patted our heads like good little boys and sent us on our way."

Meanwhile, Fiser remembers, conditions remained "frustrating" at the hospital. "We couldn't even tell people what needed to be done for their children, because there was no place to do it anyway. We just didn't have the facilities."

Nonetheless, another critical person agreed to sign on to the dream. Dr. Betty Lowe of Texarkana accepted the post as medical director at Children's Hospital. She did, she says, largely because of McGinness and his strong belief that the staff "ought to try to have a real hospital or quit."

With Fiser heading the teaching department and Lowe overseeing medical operations, McGinness developed the strategy that drives the hospital to this day. "I said to myself, 'Any program that has anything to do with children, I will embrace it.' If somebody was unhappy at the medical center because their program was not being funded or they weren't getting the support they needed, I'd say, 'Come on over. We love you.' And I'd make them feel appreciated."

His tactic was simple. "With the support of our board, I told them, 'You tell us what you need, and we'll get it.' It might not be in six days or even in six months, but they'd know we were working on it and eventually they'd get what they asked for."

It was the beginning of an ardent courtship. Lowe says, "That was when the medical school was suddenly taking in a lot more students. In essence, Tom Bruce [then dean of the college of medicine] needed more clinical beds and McGinness needed doctors. Tom Bruce said, 'If you'll provide more beds, I'll enhance the faculty.' "

Armed with little more than that promise and a sales pitch stressing the advantages of getting in on the ground floor of a fast-rising young medical center, McGinness and Fiser recruited nationwide, seeking an array of pediatric specialists. McGinness remembers, "We told them, 'If you have any pioneering spirit left, then this is the last frontier.' "

Project by project, the strategy worked. In the next few years, the hospital brought in pediatric surgeons, orthopedists, ophthalmologists, pulmonary specialists, nephrologists, radiologists, pathologists, and a host of other talented young physicians. McGinness calls them his "all-Americans."

"It was a throw of the dice," says McGinness. "I was betting on the come. We didn't have much by way of buildings, and we didn't even have private rooms for our patients, but we did have these people chomping at the bit to build a hospital that would be recognized by their peers at Boston and St. Louis and Houston."

It was a start. But as the medical expertise increased, the hospital's physical limitations became increasingly intolerable. McGinness remembers a child from Searcy who was referred to the new kidney specialist at Children's, only to have his parents change their minds when they saw the hospital. They wanted a private room for their son, and Children's could offer only a twenty-bed ward.

"So they took him back to Searcy," McGinness recalls. "It was a great failure. It was something that needed to be pointed out to us. Here we had the only pediatric kidney specialist in Arkansas, but because

MIRACLE

our facility didn't meet the parents' expectations, the child was deprived of this expertise."

But increasingly there were also successes. As word of the specialists' coming to Children's Hospital spread, pediatricians in Pulaski County and around the state began referring patients there. And as rapidly as the hospital's reputation grew, so did its level of fund-raising. The board of trustees became so active it earned a reputation that persists today of being perhaps the most powerful and prestigious nonprofit board in the state.

"We were sending out thousands and thousands and thousands of letters to the people of the state, asking them to contribute money," McGinness recalls, "and they did. Meanwhile, the university was quite content to be unloading programs on us because they were losing their shirt on pediatrics. It wasn't profitable for them—not like, say, surgery is. Of course, the board became a little nervous. They said, 'We're not going to go bankrupt, are we, if we take on all these losers?' I said, 'I don't think so.' "

BY THE LATE Seventies, the bigger question was how to house all the professional newcomers and the surge in patients they generated. Lowe remembers recruiting doctors "knowing full well we didn't have an office to put them in.

"They'd arrive and someone would say, 'Oh, you can put your things over there in the corner of my office.' Three weeks later, when they complained, we'd say, 'Oh, that's nothing.' And then we'd tell them about whoever held the record and how long he'd had to wait for an office."

The board considered moving, possibly to the UAMS campus. But in the end it opted to hang onto its autonomy. "The board of trustees were cautious, anxious, apprehensive about giving up what they had," says McGinness, "even though it wasn't all that much."

Adjoining property on Wolfe Street was purchased, and with the help of Senator John L. McClellan, who tacked a special appropriation for two children's hospitals—one in Little Rock, the other in Washington, D. C.—onto another piece of legislation, a new south wing was added to the hospital in 1978. The hospital's capacity reached one hundred nineteen beds.

The addition had a strong emotional effect. "It was sort of our impetus," Lowe

says. "It made us think, by golly, maybe we could do it."

But the lack of neonatal equipment continued to grate. Scientists had developed technology that could warm a newborn, feed it, and even breathe for it in the first critical weeks of life, but the machinery still was not available in Arkansas.

"The pediatricians were pretty damn upset," Lowe says, "because this was the era of level-three pediatric care, and we weren't able to provide it." She and Fiser kept pressing.

Finally, McGinness says, "I told them, 'Okay, we'll try to build one.' Of course, the board wanted to know, 'How much is this going to cost?' I told them, 'It's the most expensive modality in medicine.' The board thought it over and finally they said, 'Okay, but this time we've got to make sure it makes at least a *little* profit.' "

PROFIT WASN'T A DIRTY word at Children's Hospital, but it was one seldom heard. Then, as now, Children's was a private, nonprofit entity. Even in its darkest hours, when operating expenses threatened to close the place, the administration stuck to its policy of treating all children, regardless of the families' ability to pay. McGinness's plan was to offer the poor such a high level of care that parents who could actually afford to pay would take advantage of it as well.

Now that gamble was beginning to pay off. A young governor, Bill Clinton, had taken office, and the hospital quickly attracted the attention of his wife, Hillary, who was already well known for her interest in children's-health issues. She became an enthusiastic backer—as had by now hundreds of others around the state—and when officials from Children's presented the need for a neonatal intensive-care unit to the legislature, the politicians listened. In 1979, with funding provided by the state, Children's Hospital opened a twelve-bed intensive-care unit for newborns.

The unit was a sign of the new wave of regionalization that was changing the face of medicine. Technology that sophisticated wasn't needed in every hospital, nor could every hospital afford it. The key was to have at least one centrally located facility and a quick way of getting children to it.

With what was becoming characteristic verve, the board seized the chance to build Children's Hospital into a regional medical center. It drew up plans for a $14 million structure that would double the size of the hospital and increase its patient capacity to one hundred sixty beds.

The problem, considering the hospital's financial history, was finding lenders. The board would have to raise a large part of the money itself—more than $3 million in less than three years—and that would require fund-raising on a scale never tried before in Arkansas. It was willing, but success would hinge on the hospital's securing a decent bond rating. It had never before had a bond rating. Now it needed one high enough to let it borrow most of the money at a reasonable rate of interest.

This begins what most of those involved remember as the pivotal episode upon which all future development at Children's depended. The story of how McGinness, Lowe, Ward, Hillary Clinton, board member James Foster, and board chairman Guy Amsler Jr. flew to New York, to Wall Street, to the offices of Moody's and Standard and Poor's, has almost taken on the aura of myth.

With what was becoming characteristic verve, the board seized the chance to build Children's into a regional medical center. It drew up plans for a $14 million structure that would double the size of the hospital and increase its capacity to 160 beds.

"Here we get on a plane," McGinness says. "Hillary is visibly pregnant. It's icy. We land in New Jersey and drive into the innards of Wall Street, and we make our presentations.

". . . I mean, when it's a bad day, and when the first lady of Arkansas is there, big with child, and she stands up and speaks, with no notes, about how this is the only children's hospital in the state and about how everybody supports it . . . Well, we received a bond rating that was probably higher than we merited."

Lowe also remembers "toodling up to New York."

"Hillary was what—God forbid—eight and a half months pregnant? Jim Foster, one of our board members, was there. He worked for Stephens, I think, the ones who were going to float our bonds. So one of the men we were talking to kind of challenged him on that. He said, 'Isn't it a conflict of interest, Mr. Foster, for you to work for Stephens and also be here representing Children's Hospital?'

"And Jim Foster said, 'Well, that may be. But I'll tell you what. I owe my life to that orphanage. They took me in when I was six weeks old, and they kept me until I was six months old. I was adopted from Children's Home and Hospital, I consider them part of my family, and I'm proud to serve on their board of trustees.' I'll tell you, that was the end of *that* discussion.

"Finally the guy we were talking to said, 'You know, you people don't really have a very sound financial base. But we have not heard such an enthusiastic presentation from such a broad spectrum of the community in a long time.' And we got—what was it?—an A rating."

Part—some say a large part—of the reason the hospital got such a good rating was that the UAMS just a few months earlier had agreed to transfer its entire pediatrics department—patients, faculty, staff, the works—over to Children's Hospital. It was one of the first decisions made by Dr. Harry Ward after he took over as UAMS chancellor.

Ward recalls, "If they were going to stay there, I couldn't see that our pediatric unit here was going to increase in size, whereas for them to increase in size was absolutely critical. To me it made medical sense, and, obviously, to the financial people it made financial sense. We moved the entire pediatric department over there. I mean, the University of Arkansas for Medical Sciences for pediatrics *is located* in Children's Hospital."

The marriage of Children's Hospital and the UAMS pediatrics department gave new life to both. Since the board of trustees could undertake independent and aggressive fund-raising, it freed the pediatrics department from the limits of state funding. At the same time, the link-up with the publicly funded medical center assured Children's Hospital of the caliber of staff it needed to attract the private support. It also created a delicate and fairly unusual balance, in this state at least, between a private, nonprofit institution and a publicly funded agency of the state.

Hillary Clinton calls the hospital that emerged a "funny hybrid," a strong institution formed by the combination of two relatively weak ones. And, despite muted objections from some competing hospitals who protest that the state affiliation gives Children's an unfair advantage, Clinton sees the efficiencies of such public-private affiliations, wherever possible, as enormously helpful to both.

The arrangement hasn't always been easy. Ward alludes to bruised egos, and McGinness, who's now retired, to "shouting matches." But both say they're proud of the result. "We're here and we're suc-

cessful," says McGinness. "We're married, and we're not going to get divorced. We can't afford to get divorced. It would be too injurious to health care for the children of this state. It's unthinkable."

The marriage—and the bond rating that resulted—set off a flurry of building at Children's that continues today. Ten years ago this month, on March 30, 1980, two children turned a spade of earth, marking the beginning of construction on the hospital's new east wing. Then, while the building was still going up, a change occurred that no one could have foreseen.

As Ward puts it: "A loophole was set up in the early Eighties that allowed the state to make an exception in the Medicaid rules for children needing health care." It was a tremendous stroke of federal luck, and the hospital, with help from the Clintons, lost no time in taking advantage.

THE IMPORTANCE of Medicaid to Children's Hospital cannot be overstated. Half the patients admitted are covered by it. The new arrangement allowed Children's to recover 100 per cent of its costs on children covered by Medicaid. So long as the state comes up with one-fourth of that money, the federal government picks up the tab on the other three-fourths.

It's a good deal for Arkansas, letting the state help kids and families, while also attracting to the state some strong scientific talent. But Medicaid is also the "number-one worry" of Randall O'Donnell, the current CEO. There already have been times when state budget cutbacks have reduced its allowance for Medicaid, at times by several million dollars. "I worry about it all the time," O'Donnell says. "I worry that they could pull the rug right out from under us." Hastily, he adds, "Actually, I've got a high level of confidence, but I can't really afford to ever turn my back on it because it is so significant."

This year, Arkansas Children's Hospital expects operating expenses of about $96 million and net patient revenues of $88 million. It makes up the balance through the aggressive fund-raising work of thousands of volunteers statewide and through the annual Children's Miracle Network Telethon, a national event for children's hospitals, from which Arkansas gets all the money raised in the state.

Financial officials now say that their chief aim is to buffer the hospital from the vagaries of Medicaid funding. They never expect to be independent of it, but they long for some added security. They say the future could depend on it.

It will also depend on how well Children's Hospital can attract: (1) ordinary patients, those who are not seriously ill; (2) privately insured patients; (3) patients from outside Arkansas; and (4) money for research. If the hospital continues to grow as expected, O'Donnell says, it could double in size in the decade ahead.

"Just look at what we've already accomplished," he says. "We've added fourteen hundred jobs in the last ten years. We're one of the largest employers in the state. And five to ten years from now the research center has the potential of being similar in size to the hospital. We're already twelve times the size we were eight to ten years ago, so just doubling doesn't sound so implausible."

Dr. Bob Fiser, the chairman of the university's pediatrics department, is even more optimistic. "Right now," he says, "Vanderbilt University does more research than any pediatric department in the U.S. I told my board that in ten years—no, we'll up that—in *five* years, we're going to do better than Vanderbilt."

The marriage of Children's Hospital and the UAMS pediatrics department gave new life to both. Hillary Clinton calls the hospital that emerged a "funny hybrid," a strong institution formed by the combination of two relatively weak ones.

Fiser's ideas are so big that people new to the hospital often hardly know how to take them. He already has on display in his office an architectural model of another new building he wants to see erected on the Children's Hospital campus. The sign over its front door reads, "The Max Howell Child Health and Family Life Institute"—the facility would be named for the state senator from Jacksonville who is one of the hospital's most powerful backers. Bringing together research and social services for children in much the way McGinness gathered up medical services, the new facility would be a "center for excellence" in the overlapping areas of medicine, education, nutrition, and developmental care. And, like the medical model, it would also serve smaller, similar satellite centers located all over Arkansas. "Everywhere there's a Wal-Mart," Fiser says, "there should be one of these family-life centers—because you cannot separate the child's welfare from the welfare of the family."

Hillary Clinton, a close friend of Fiser's, supports the notion of a system of family-life institutes. "It will be a center for a lot of disparate services we have right now," she says. "It will house what a lot of us think is the future of family health care—as much of a one-stop-delivery center as we can possibly do. I see it as the next stage, the frontier for the Nineties for bringing together all sorts of human resources."

Fiser also hopes to lead Children's Hospital to the forefront of research in the broad area of child development. "What I want to do is do both," he says, "deal with the social-clinical concerns as well as basic research."

Building on research that is already under way, he says, "we're going to become the best place in the U.S. to study the developing nervous system. We're going to have a research institute better than Sloan-Kettering [in New York]. I honestly think we can do this. I told our faculty, 'You don't have to win it, but in ten years somebody's got to be nominated for a Nobel prize.' "

Dr. Betty Lowe, who has worked with Fiser for a long time now, doesn't discount a bit of it. "Bob comes on," she says, "and he says, 'In five years, we're going to wipe 'em out. We're going to get all the research dollars out there.' And then others of us come along, and we say, 'Well, we might not get them all, but we'll get a few.' And frankly, we'll get a heck of a lot more of them than a lot of people think we will."

Lowe, Fiser, and O'Donnell all point proudly to the fact that young physicians specializing in pediatrics now compete to come to Arkansas for their residency. "Right now," says Lowe, "we're the one institution in the South that fills our quota of resident trainees every year, and we fill it with the top twenty or thirty candidates—the ones that *we* want to pick."

Ultimately, that fact may predict more about the future of Arkansas Children's Hospital than any other. With pediatricians scattered around the state and country who "grew up" at Children's, the likelihood of its attracting both patients and national research grants increases.

"There always will be new therapies, new approaches, new programs," says Lowe, "and we'll have a respectable share of them. I don't know exactly where we're going, but I can tell you this: If you had told me in 1975 that in ten years we'd be doing renal [kidney] transplants and bone-marrow transplants at this hospital, I'd have told you you were crazy."

WHY IS THE MEDICAID SAFETY NET SO IMPORTANT FOR CHILDREN?

- **Medicaid pays for health care for one in four children, one in three infants.** In some states, it covers one in three children, one in two infants. On average, it also pays for nearly half of the inpatient care provided by children's hospitals.

- **If it wasn't for Medicaid, 40% of children would be uninsured.** Even with Medicaid, 16% of children are uninsured.

- **Medicaid coverage for children was "delinked" from welfare in the 1980s — it supports employment.** Nearly 60% of children assisted by Medicaid live in low income but working families.

- **Medicaid is a national safety net for economically and medically vulnerable children.** It covers 80% of poor children; 25% of children with family incomes between 100% and 200% of poverty. 15% of Medicaid-covered children are disabled or need health care so expensive their families are threatened with poverty.

- **Medicaid coverage for children is low cost.** Medicaid for an elderly adult is 8 times more expensive than for a child. Children are half of Medicaid recipients but less than 20 percent of Medicaid spending.

NACHRI

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Some Cuts Hurt More Than Others...

...like the cuts in Medicaid funding to children's hospitals.

Just ask a child with a serious illness. A children's hospital provides a lifeline during long months of grueling treatments. And, support services help the family through many very difficult days.

Cuts in Medicaid funding will be devastating to children throughout Illinois, not just Medicaid patients. If the proposed budget becomes law, children's hospitals will lose more than $25 million.

Such deep cuts will force children's hospitals to cut back on services used by all patients -- like trauma and neonatal intensive care, child abuse protective services, parenting education, social work and rehabilitation therapy.

The proposed cuts to Medicaid will hurt all Illinois children.

That is the cruelest cut of all.

Cuts In Medicaid Funding Hurt Children Throughout The State

Children's hospitals are mainstays in their communities, providing vital health care services to all children. The proposed budget cuts in Medicaid funding will be particularly devastating because it costs more to care for sick children than adults. Children's hospitals are not able to shift these increased costs to adult patients like other hospitals can. Inadequate Medicaid funding will force these hospitals to scale back the many crucial services they provide to the entire community.

The consequences are about much more than dollars and cents... they're about children and families.

Consider the following examples:

Amy was severely injured when struck by a car near her suburban home. Her community hospital was not equipped to treat her injuries, so she was immediately transported to a children's hospital with a specialized pediatric intensive care unit.

Without adequate funding for children's hospitals, kids like Amy won't receive the specialized care they need.

Derrick, a diabetic child, was brought to a children's hospital once again for an insulin reaction. The hospital social worker discovered the family didn't have a refrigerator to keep Derrick's insulin cold. She spent hours helping the family locate a refrigerator, warding off another hospital stay and saving the state thousands of dollars.

Without adequate funding for children's hospitals, chronically ill kids like Derrick won't receive the specialized care they need.

Baby Jeremy, born prematurely, was confined to a children's hospital for the majority of his first year of life. He received extensive rehabilitation therapy to ensure that he continued to grow and learn at a normal rate and wasn't disadvantaged when he went home.

Without adequate funding for children's hospitals, babies like Jeremy won't receive the specialized care they need.

If children's hospitals are not adequately funded, you're hurting not only the hundreds of thousands of children in the State of Illinois who are Medicaid recipients, you're also affecting non-Medicaid families who rely heavily on children's hospitals for health care and support services unavailable to them anywhere else.

SOME OF OUR LITTLEST CITIZENS NEED YOU THE MOST.

Children's Memorial Medical Center
La Rabida Children's Hospital and Research Center
Wyler Children's Hospital
Cardinal Glennon Children's Hospital
St. Louis Children's Hospital

FAX TRANSMITTAL

TO:	Marilyn Yaeger	
ORGANIZATION:	The White House	
Telephone Number: 456-6683	Fax Number: 456-6218	# of Pages (including cover sheet) 19
FROM:	Gregg Haifley	
	CHILDREN'S DEFENSE FUND HEALTH DIVISION	
Telephone Number: (202) 662-3541 FAX Number: (202) 662-3560	Secretary: Allison Watts (202) 662-3551	Date: 7/17/95 Time: AM PM

Comments: Attached is my testimony before the Senate Finance Committee on maternal and child health and the Medicaid program.

Please call (202) 662-3553 or 662-3541 if you did not receive all of this fax transmission.

TESTIMONY OF GREGG HAIFLEY
THE MATERNAL AND CHILD HEALTH COALITION

SENATE COMMITTEE ON FINANCE
HEARING ON MEDICAID

THURSDAY, JULY 13, 1995

My name is Gregg Haifley and I am the Senior Health Associate at the Children's Defense Fund. The Maternal and Child Health Coalition, of which CDF is a member, thanks you for inviting us to testify today on the national Medicaid health safety net for children and pregnant women, which now pays for the health care of one in four children and one and three infants in America. I am testifying on behalf of the many state and national groups that have agreed to the principles on the Medicaid program attached to our testimony.

The Maternal and Child Health Coalition itself is composed of fifty national organizations for whom maternal and child health is a significant priority. Members include provider groups such as the American Academy of Pediatrics and the National Association of Children's Hospitals; advocacy organizations representing children with disabilities and their families, such as Family Voices and The Arc; state and local government organizations such as the National Association of Counties, the Association of Maternal and Child Health Programs, and the National Association of County and City Health Officials; and advocates of maternal and child health such as the March of Dimes Birth Defects Foundation, Child Welfare League of America, Catholic Charities USA, U.S. Catholic Conference, the Women's Legal Defense Fund, and the American Public Health Association.

The maternal and child health community has a very simple message to convey today. As you consider reform of the Medicaid program, we believe it is essential to preserve certain critical features for children and pregnant women -- minimum national standards for children's and pregnant women's eligibility, benefits, and access to appropriate care. Attached as Appendix A is a set of recommendations endorsed by one-hundred and fifty organizations on the importance of preserving Medicaid's basic eligibility and benefits provisions for low-income

children and pregnant women as well as a statement by thirteen national organizations of pediatric health care providers. It is essential to maintain the guaranteed federal floor for eligibility, coverage of prenatal and preventive care, and medically necessary services, and access to appropriate care for children and pregnant women. This is sound policy for maternal and child health, but it is also sound policy for future national health, productivity and economic growth.

Previous Congresses have taken a bipartisan approach to shaping Medicaid policy with an important priority on the health of children and pregnant women. That approach continued this year with the maternal and child health Medicaid provision adopted unanimously by the Senate Budget Committee for inclusion in the budget resolution. This provision had bipartisan co-sponsorship, including the co-sponsorship of Senator Grassley. It emphasizes that the health care needs of low-income pregnant women and children should be a top priority in any restructuring of Medicaid. We applaud Senator Grassley, as well as the other co-sponsors, for taking the lead in ensuring that maternal and child health remain a critical focus during Medicaid reform. Our recommendations to preserve guaranteed coverage and access to medically necessary pediatric and obstetrical services would preserve those best Medicaid features that have developed out of this bipartisan approach.

ELIGIBILITY: Let me first discuss eligibility. Medicaid has covered welfare recipients since its beginnings in 1965. But, because of eligibility expansions in the 1980s and early 1990s, developed in part because of high infant mortality rates and other negative child health indicators, Medicaid has increasingly become an essential source of health care coverage for children and pregnant women in low-wage working families. Today, among the children of all

ages covered by Medicaid, more than half live in working families. Of the 1.4 million infants (babies up to age one) covered by Medicaid in 1993, 70 percent were from working families and did not receive AFDC cash assistance. While this program is essential for families receiving welfare, it also provides health care for a broad band of poor and near-poor working American families.

In covering more children and pregnant women, Medicaid played a crucial role in offsetting, in part, the long-term trend of declining employment-based coverage for dependents. Without these Medicaid expansions, there would certainly have been millions more uninsured children. Between 1977 and 1987, the percentage of children with employer-based insurance declined from 72.8 percent to 62.9 percent. (This pace of private disinsurance continued at roughly the same pace in the late 1980s and early 1990s.) Between 1977 and 1987, the proportion of children who lacked insurance for all or part of the year increased from 17.5 percent to 23 percent.

The 1989 Congressional enactment of Medicaid eligibility expansions for children and pregnant women (requiring coverage of pregnant women and children under age six with family income up to 133 percent of poverty and certain older children--those born after September 30, 1983--up to 100 percent of poverty, and allowing coverage to higher income levels if states choose) has led to Medicaid coverage for 3 million additional children and pregnant women in low-wage working families.

Medicaid helps

Medicaid now covers nearly one-third of the births in this country and covers more than 17 million children overall -- one in four children. Even while private insurance coverage was dropping, the proportion of pregnant women who were uninsured fell from 11 percent to 7

percent between 1988 and 1994 because of expanded Medicaid coverage. Given the long-term trend of steadily eroding private health insurance, it is imperative to preserve the national Medicaid safety net for pregnant women and children, including the ongoing phase-in of older children from working poor families. Doing otherwise could add significantly to the numbers of uninsured children and pregnant women.

The need to preserve the safety net of continued guaranteed eligibility for children and pregnant women deserves heightened attention in light of The Kaiser Commission on the Future of Medicaid's recent report "The Impact of the House and Senate Budget Committees' Proposals on Medicaid Expenditures." That study projects that the Congressional budget resolution targets for Medicaid spending would require eliminating coverage for as many as 5.8 million adults and children in families. This Kaiser Commission projection assumes that controls on spending through managed care, reductions in covered services, and cuts in provider payments would be implemented prior to cutting beneficiaries from the program.

MEDICALLY NECESSARY CARE: Second, it is essential to maintain Medicaid's existing coverage of the benefits pregnant women and children need, including prenatal care, preventive care, and medically necessary care -- the scope of coverage which is of particular importance to children with chronic conditions or disabilities, but is important to all children. The Early and Periodic Screening, Diagnosis and Treatment services -- the benefits component of the Medicaid program for children -- must be preserved. "EPSDT" ensures that screenings, prevention, and the full range of medically necessary services are available. This national commitment to children makes complete medical sense and is eminently affordable. There is no concept of state flexibility that would make rational the coverage of speech therapy or

essential prescription drugs or hearing aids for school children in South Dakota, New Jersey or Louisiana, but not in North Dakota, New York or Florida.

Covering this full range of necessary services is remarkably inexpensive. Children represent more than half of all Medicaid beneficiaries. However, even with many of America's most disabled children in the program, on average children's care is much less expensive than that for adults. Payments for maternity and infant care through the first year of life represent less than 7 percent of total Medicaid expenditures. Children account for only one-quarter of all Medicaid payments for services. Payments on behalf of children and pregnant women accounted for only 11 percent of the growth in Medicaid spending between 1988 and 1991. In 1993, the average Medicaid expenditure for a covered child under age 21 was $1,065. The Medicaid expenditure per elderly adult that year was $7,590. Attached as Appendix B are fact sheets with coverage, expenditure, uncompensated hospital delivery costs, and infant mortality statistics.

This does not mean that there should not be greater state flexibility in operating the program, nor that considerable federal savings in the cost of the program could not be achieved over the next several years. State flexibility for the delivery of care through managed care, if carefully structured and monitored, could move toward these goals. This committee should act to ensure, however, that children and pregnant women realize improved access to and quality of care, not a deterioration. We believe that Senator Chafee's S. 839, for example, makes important strides to strike a balance between protecting children's and pregnant women's health under the Medicaid program while granting states considerable flexibility and protecting providers from burdensome regulation.

We want to emphasize that "outcome measures" can not substitute for basic eligibility and services criteria or for standards for managed care. First, there are very few measures for pediatric health care in the managed care context. They consist of rates of childhood immunization at age two, hospitalization for asthma and rate of low birthweight births. While these measures are fine for certain narrow purposes, they tell very little about the range of childhood disorders. Moreover, the immunization measure commonly used is for children enrolled in a plan from birth to age two -- few Medicaid children go from birth to age two in one plan with continuous eligibility. Outcomes measures for early prenatal care typically look at the initiation of prenatal care within the first trimester for women enrolled in plans for the twelve month period prior to delivery. Pregnant women covered by the Medicaid program, particularly those women who become eligible based in part on their pregnancy, will not meet the twelve month enrollment criteria for being included in the outcomes sample.

BLOCK GRANTS: Some governors have testified before this committee seeking total state flexibility, through a Medicaid block grant, to determine eligibility and benefits, while projecting that they would continue to cover children and pregnant women at current eligibility levels. Maternal and child health advocates appreciate their commitments. However, we have two concerns. First, the major strategy for achieving Medicaid savings is managed care. However, managed care has been largely untried for the services required by the elderly and disabled, who account for 70 percent of Medicaid spending. States will be forced to seek additional ways to save, including changes in eligibility and coverage, which disproportionately affect children. Second, we know historically that many states have moved to cover children and pregnant women only when minimal national standards were put in place. For example,

when the federal minimum eligibility level for young children and pregnant women went to its current level, roughly two-thirds of the states had to act to meet that level, despite having had the option to do so prior to the enactment of that federal floor. Recent comments by the Director of the Missouri Department of Social Services serve to underscore our point. He predicted that low-income children and pregnant women would bear the brunt of cuts, including cuts of prenatal and preventive care, since it would be politically impossible in his state to cut eligibility or services for the disabled and elderly. Children and pregnant women would be the targets for cuts because "...compared to the political clout of the elderly and disabled, that's where we'd have to go...."

CO-PAYMENTS: Finally, we want to emphasize the need to waive co-payments on children's services or keep such co-payments nominal. In a 1993 report titled "Benefit Design: Patient Cost-Sharing," the Office of Technology Assessment (OTA) reviewed cost-sharing studies and noted that, when there is no cost-sharing, there is increased use of pediatric preventive services. OTA said this finding justifies having no cost-sharing when prevention is a policy goal. We urge the Committee to specifically exclude preventive services from any cost-sharing requirements. OTA also noted that research demonstrated the disparate impact that cost-sharing had on utilization of necessary services for children in low-income families and that special protection relating to cost-sharing for children in families with income less than 200 percent of poverty may be necessary to ensure access to care.

CONCLUSION: The maternal and child health community looks forward to further discussions with the Committee as you develop proposals to reform the Medicaid program. As you seek to secure savings from the program and allow greater state flexibility, it will be critical

that you also continue to provide the ensured coverage, benefits and access essential for low-income children and pregnant women.

APPENDIX A

Maternal and Child Health Advocates Recommend:

PRESERVE MEDICAID AS A NATIONWIDE SYSTEM OF ENSURED HEALTH COVERAGE FOR LOW-INCOME CHILDREN AND PREGNANT WOMEN, INCLUDING THOSE IN WORKING FAMILIES

Among all Americans, the rate of coverage by private health insurance is declining fastest for children. It is therefore critical that Congress **preserve Medicaid as a nationwide system of ensured health coverage for-low income children and pregnant women, including those in working families.** If current trends in declining dependent coverage continue, fewer than half of all children would have employment-based insurance by the year 2000.

With bipartisan effort in the 1980s, Congress created a nationwide system of ensured health coverage for children and pregnant women. It delinked Medicaid from states' welfare programs in order to reach poor children of working families, and it established minimum standards for eligibility, benefits, and access to care. Such standards have reduced the past inequities of variation in state eligibility and benefit rules, as well as the practice of excluding children and pregnant women of low-income, working families.

Because of these changes, **Medicaid now covers one in four children and one in three births. Nearly 60 percent of Medicaid-covered children live in low-income, working families. Medicaid has improved access to needed care; yet, coverage of children is the least expensive part of Medicaid. Children are half of all Medicaid enrollees but account for only about one-fifth of Medicaid spending.**

We urge Congress to preserve the federal-state partnership that ensures eligible children and mothers have access to necessary care. This includes preserving standards enacted in the 1980s for eligibility, scope of benefits, and access to appropriate care, which make Medicaid a reliable system of ensured health coverage for children and pregnant women.

ELIGIBILITY Federal Medicaid law sets minimum eligibility standards for all children of low- income families. The law requires state Medicaid programs to cover children under age six and pregnant women with family incomes below 133% of poverty -- $16,745 for a family of three. States also must phase-in Medicaid to older children whose incomes are below 100% of poverty -- $12,590 for a family of three. These standards do not preclude states from having the flexibility to set higher eligibility standards. (Federal law also provides for coverage of vulnerable children, such as children who are disabled or depend on foster care or adoption assistance.)

SCOPE OF BENEFITS Federal law requires each state's Medicaid program to guarantee that eligible children receive coverage for all medically necessary health services. This guarantee of medically necessary care is contained in Medicaid's "Early and Periodic Screening, Diagnosis, and Treatment" (EPSDT) program. The law guarantees maternity care for eligible pregnant women.

ACCESS TO APPROPRIATE CARE Recognizing that access to appropriate care is critical for children and pregnant women, federal law requires states to guarantee Medicaid-covered children and pregnant women access to pediatric and obstetrical services comparable to the access of privately insured individuals.

ABC FOR HEALTH INC. (MADISON, WI)

ADVOCATES FOR CHILDREN AND YOUTH (BALTIMORE, MD)
AGENDA FOR CHILDREN (NEW ORLEANS, LA)
AIDS POLICY CENTER FOR CHILDREN, YOUTH & FAMILIES
AITKIN COUNTY PUBLIC HEALTH (AITKIN, MN)
AITKIN COUNTY PUBLIC HEALTH, MATERNAL CHILD HEALTH (AITKIN, MN)
AIAO, A COUNCIL OF THE ARTHRITIS FOUNDATION
THE ALAN GUTTMACHER INSTITUTE
ALLIANCE FOR CHILD SURVIVAL (ROCKVILLE, MD)
AMERICAN ACADEMY OF PEDIATRIC DENTISTRY
AMERICAN ASSOCIATION OF UNIVERSITY AFFILIATED PROGRAMS
AMERICAN OCCUPATIONAL THERAPY ASSOCIATION
AMERICAN PUBLIC HEALTH ASSOCIATION
THE AMERICAN REHABILITATION ASSOCIATION
AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION
THE ARC
ARKANSAS ADVOCATES FOR CHILDREN & FAMILIES (LITTLE ROCK, AR)
ASSOCIATION FOR THE CARE OF CHILDREN'S HEALTH
ASSOCIATION OF MATERNAL & CHILD HEALTH PROGRAMS
BAZELON CENTER FOR MENTAL HEALTH LAW
BEECH BROOK (PEPPER PIKE, OH)
BELLEFAIRE JEWISH CHILDREN'S BUREAU (SHAKER HEIGHTS, OH)
BELTRAMI COUNTY CHILD & TEEN CHECKUP PROGRAM (BEMIDJI, MN)
BOARD ON HOME ECONOMICS, NATIONAL ASSOCIATION OF STATE UNIVERSITIES AND LAND GRANT COLLEGES
BRIDGEPORT CHILD ADVOCACY COALITION (BRIDGEPORT, CT)
CALIFORNIA CHILDREN'S HOSPITAL ASSOCIATION (SAN DIEGO, CA)
CARVER COUNTY COMMUNITY HEALTH SERVICES (WACONIA, MN)
CATHOLIC CHARITIES USA
CENTER FOR MULTICULTURAL HUMAN SERVICES (FALLS CHURCH, VA)
CHILD CARE CONNECTION (NORTH LAUDERDALE, FL)
CHILD CARE, INC. (NEW YORK, NY)
CHILD GUIDANCE CENTER OF SOUTHERN CT. (STAMFORD, CT)
CHILD WELFARE LEAGUE OF AMERICA
CHILDREN WITH SPECIAL NEEDS GRADUATE NURSING PROGRAM, SCHOOL OF NURSING, UNIVERSITY OF MINNESOTA (MINNEAPOLIS, MN)
THE CHILDREN'S ALLIANCE (SEATTLE, WA)
CHILDREN'S ALLIANCE OF NH (CONCORD, NH)
CHILDREN'S DEFENSE FUND
CHILDREN'S DEFENSE FUND - GREATER CLEVELAND PROJECT (CLEVELAND, OH)
CHILDREN'S HOSPITAL OF ALABAMA (BIRMINGHAM, AL)
CHILDREN'S LEAGUE OF MASSACHUSETTS (BOSTON, MA)
CINCINNATI CHILDREN'S HOSPITAL MEDICAL CENTER (CINCINNATI, OH)
CITIZENS' COMMITTEE FOR CHILDREN (NEW YORK, NY)
CITIZENS FOR MISSOURI'S CHILDREN (ST. LOUIS, MO)
COALITION FOR HISPANIC FAMILY SERVICES (BROOKLYN, NY)
COALITION FOR MISSISSIPPI'S CHILDREN (JACKSON, MS)
COLEMAN ADVOCATES FOR CHILDREN & YOUTH (SAN FRANCISCO, CA)
COLORADO CHILDREN'S CAMPAIGN (DENVER, CO)
COMMUNITY FOOD RESOURCE CENTER (NEW YORK, NY)
COMMUNITY PREVENTION PARTNERSHIP OF BERKS COUNTY (READING, PA)
CONNECTICUT ASSOCIATION FOR HUMAN SERVICES (HARTFORD, CT)
CONNECTICUT CHAPTER, AMERICAN ACADEMY OF PEDIATRICS (MIDDLEFIELD, CT)
CONNECTICUT FEDERATION OF FAMILIES FOR CHILDREN'S MENTAL HEALTH (WETHERSFIELD, CT)
THE COUNCIL OF WOMEN'S AND INFANTS' SPECIALTY HOSPITALS
COUNTRYSIDE PUBLIC HEALTH SERVICE (BENSON, MN)
CROSSROADS PROGRAMS, INC. (MOUNT HOLLY, NJ)
DELUTH COMMUNITY HEALTH CENTER (DELUTH, MN)
DELUTH HEAD START (DELUTH, MN)
DEPARTMENT OF SOCIAL SERVICES (LEXINGTON-FAYETTE URBAN COUNTY GOVERNMENT, KY)

DOUGLAS COUNTY PUBLIC HEALTH (ALEXANDRIA, MN)
DOUGLAS COUNTY PUBLIC HEALTH NURSING SERVICE (ALEXANDRIA, MN)
EGLESTON CHILDREN'S HEALTH CARE SYSTEM (ATLANTA, GA)
FAMILY SUPPORT NETWORK (ST. LOUIS, MO)
FAMILY VOICES
FOOD RESEARCH ACTION CENTER
FREMONT COMMUNITY HEALTH SERVICES (MINNEAPOLIS, MN)
FRIENDS OF THE CHILDREN'S HOSPITAL AT YALE - NEW HAVEN (NEW HAVEN, CT)
FRIENDS OF THE FAMILY, INC. (BALTIMORE, MD)
GEORGIANS FOR CHILDREN (ATLANTA, GA)
GOOD KNIGHT CAMPAIGN FOR PROTECTION OF CHILDREN (BOWIE, MD)
HEALTHWORKS FOR CONNECTICUT (CHESHIRE, CT)
HEALTHY START/NYC - MHRA (NEW YORK, NY)
HELPING HAND DENTAL CLINIC (ST. PAUL, MN)
HENNEPIN COUNTY MEDICAL CENTER (MINNEAPOLIS, MN)
HOUSTON INDEPENDENT SCHOOL DISTRICT, MEDICAID - SCHOOL HEALTH AND RELATED SERVICES (SHARS) FINANCE (HOUSTON, TX)
INDEPENDENT SCHOOL DISTRICT #199 SCHOOL NURSE (GROVE HEIGHTS, MN)
INDIAN HEALTH BOARD CLINIC (MINNEAPOLIS, MN)
ISANTI COUNTY PUBLIC HEALTH SERVICES (CAMBRIDGE, MN)
JEWISH COMMUNITY RELATIONS COUNCIL - HARTFORD, CT (WETHERSFIELD, CT)
JUVENILE JUSTICE TRAINERS ASSOCIATION (BROOKTONDALE, NY)
JUVENILE RIGHTS DIVISION, LEGAL AID SOCIETY OF NEW YORK (NEW YORK, NY)
KANSAS CHILDREN'S SERVICE LEAGUE (WICHITA, KS)
KENTUCKY YOUTH ADVOCATES, INC. (LOUISVILLE, KY)
LA CASA (LOS ALAMOS, NM)
LEECH LAKE RESERVATION PUBLIC HEALTH NURSING (CASS LAKE, MN)
LEGAL AID SOCIETY OF HARTFORD (HARTFORD, CT)
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MD COMMITTEE FOR CHILDREN, INC. (BALTIMORE, MD)
MEEKER COUNTY PUBLIC HEALTH (LITCHFIELD, MN)
MICHIGAN COUNCIL FOR MATERNAL AND CHILD HEALTH (LANSING, MI)
MICHIGAN FEDERATION OF PRIVATE CHILD & FAMILY AGENCIES (LANSING, MI)
MICHIGAN LEAGUE FOR HUMAN SERVICES (LANSING, MI)
MISSISSIPPI CHAPTER, NATIONAL ASSOCIATION OF SOCIAL WORKERS (JACKSON, MS)
MS. HUMAN SERVICES AGENDA (JACKSON, MS)
MS. HUMAN SERVICES COALITION (JACKSON, MS)
MOTHERS PROTECTING CHILDREN, INC. (ANSONIA, CT)
MULTI-COUNTY NURSING SERVICE (DETROIT LAKES, MN)
NATIONAL ASSOCIATION OF CHILD ADVOCATES
NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS AND RELATED INSTITUTIONS
NATIONAL ASSOCIATION OF COUNTIES
NATIONAL ASSOCIATION OF HOMES & SERVICES FOR CHILDREN
NATIONAL ASSOCIATION OF SCHOOL NURSES
NATIONAL ASSOCIATION OF SOCIAL WORKERS
NATIONAL BLACK CHILD DEVELOPMENT INSTITUTE
NATIONAL CHILDREN'S CENTER
NATIONAL EASTER SEAL SOCIETY
NATIONAL EDUCATION ASSOCIATION
NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION
NATIONAL MENTAL HEALTH ASSOCIATION
NATIONAL NETWORK FOR YOUTH
NATIONAL PARENTING ASSOCIATION (NEW YORK, NY)
NATIONAL PERINATAL ASSOCIATION (TAMPA, FL)
NATIONAL SAFEKIDS CAMPAIGN
NATIONAL WOMEN'S LAW CENTER
NOBLES-ROCK PUBLIC HEALTH SERVICE (WORTHINGTON, MN)
NOBLES-ROCK WIC PROJECT (WORTHINGTON, MN)
NORTH CAROLINA CHILD ADVOCACY INSTITUTE (RALEIGH, NC)
OHIO HUNGER TASK FORCE (COLUMBUS, OH)

OKLAHOMA INSTITUTE FOR CHILD ADVOCACY (OKLAHOMA CITY, OK)
PANHANDLE ASSESSMENT CENTER (AMARILLO, TX)
PENNSYLVANIA CHILDREN'S HEALTH COALITION
PENNSYLVANIA PARTNERSHIPS FOR CHILDREN (HARRISBURG, PA)
PLANNED PARENTHOOD FEDERATION OF AMERICA
PLANNED PARENTHOOD OF CONNECTICUT, INC. (NEW HAVEN, CT)
PLANNED PARENTHOOD OF MINNESOTA (ST. PAUL, MN)
POLK COUNTY NURSING SERVICE (CROOKSTON, MN)
RHEEDLEN CENTERS FOR CHILDREN AND FAMILIES (NEW YORK, NY)
ROCHESTER AREA CHILDREN'S COLLABORATIVE (ROCHESTER, NY)
ST. LOUIS CHILDREN'S HOSPITAL (ST. LOUIS, MO)
SPINA BIFIDA ASSOCIATION OF AMERICA
STATE COMMUNITIES AND ASSOCIATION (ALBANY, NY)
STATEWIDE YOUTH ADVOCACY, INC. (ALBANY, NY)
STEELE COUNTY PUBLIC HEALTH NURSING SERVICE (OWATONNA, MN)
SUDDEN INFANT DEATH SYNDROME ALLIANCE
SUPPORT CENTER FOR CHILD ADVOCATES (PHILADELPHIA, PA)
THE SYCAMORES (ALTADENA, CA)
TEEN AGE MEDICAL SERVICE (MINNEAPOLIS, MN)
TENNESSEE COMMISSION ON CHILDREN AND YOUTH (NASHVILLE, TN)
UNITARIAN UNIVERSALIST SERVICE COMMITTEE (CAMBRIDGE, MA)
UNIVERSITY OF MINNESOTA ADOLESCENT HEALTH PROGRAM (MINNEAPOLIS, MN)
UNIVERSITY SETTLEMENT SOCIETY OF NEW YORK (NEW YORK, NY)
UNIVERSITY-VARIETY HOSPITAL FOR CHILDREN, UNIVERSITY OF MINNESOTA (MINNEAPOLIS, MN)
UPPER VALLEY YOUTH SERVICES (LEBANON, NH)
UTAH CHILDREN (SALT LAKE CITY, UT)
VOICES FOR CHILDREN IN NEBRASKA (OMAHA, NE)
VOICES FOR ILLINOIS CHILDREN (CHICAGO, IL)
WADENA COUNTY HEALTH DEPARTMENT (WADENA, MN)
WASECA COUNTY PUBLIC HEALTH NURSING SERVICES (WASECA, MN)
WIC - BELTRAMI COUNTY (BEMIDJI, MN)
WIC PROGRAM (DETROIT LAKES, MN)
WOMEN'S HEALTH CENTER (DELUTH, MN)
WOMEN'S LEGAL DEFENSE FUND
WRIGHT COUNTY HUMAN SERVICES [MINNESOTA] (BUFFALO, MN)
YOUTH LAW CENTER (SAN FRANCISCO, CA)
ZERO TO THREE

Ambulatory Pediatric Association
American Academy of Pediatrics
American Board of Pediatrics
American Pediatric Society
American Pediatric Surgical Association
Association for the Care of Children's Health
Association of Medical School Pediatric Department Chairmen
Association of Pediatric Program Directors
National Association of Children's Hospitals and Related Institutions
National Association of Pediatric Nurse Associates and Practitioners
Society for Adolescent Medicine
Society for Pediatric Research
Society of Pediatric Nurses

As Congress debates proposals to restructure Medicaid, it is essential to consider the enormous importance of the program to the health of our nation's children and adolescents.

According to the annual American Academy of Pediatrics' analysis of HCFA's 2082 data set, in federal fiscal year 1993, Medicaid financed medical care for nearly one-fourth of all US children under the age of 21, more than one-third of children under age 6, and half of all infants. Medicaid eligibility expansions have helped offset the accelerating erosion of employer-based health insurance coverage of children which has occurred since the early 1980's. Absent Medicaid, nearly 40% of all US children would be uninsured.

According to the Census Bureau's 1994 Current Population Survey data set, nearly 18 million children were Medicaid eligible in 1993. In a very real sense, Medicaid is a children's program since 54% of all beneficiaries are under age 21. However, because children's health care costs are so modest in comparison to adults, the elderly, and eligible nursing home beneficiaries, children's costs represent just 23% of total Medicaid spending.

As health care providers who specialize in children's care we know from first hand experience the critical difference Medicaid has made in the health and access to care of children who otherwise would have been uninsured. We also are cognizant of Medicaid's weaknesses. For over 15 years we have conducted research to improve the efficacy of the program and have advocated on behalf of progressive reforms. We remain committed to the goal of Medicaid's improvement.

This year Congress is expected to act on proposals to restructure Medicaid in order to control federal spending and increase state flexibility in the use of federal funds. We believe these goals can be accomplished without sacrificing the quality of the Medicaid program for children and adolescents if the following core principles are honored: (1) low-income children and adolescents must maintain guaranteed Medicaid coverage; (2) the medically necessary care assured by Medicaid through its EPSDT component must not be compromised; and (3) children and adolescents must retain access to appropriately trained and certified providers of pediatric care.

MEDICAID PROTECTS MATERNAL AND CHILD HEALTH

BETWEEN 1984 AND 1990, THE CONGRESS, THE REAGAN AND BUSH ADMINISTRATIONS, AND STATES ENACTED A SERIES OF MEDICAID REFORMS TO COVER MORE CHILDREN AND PREGNANT WOMEN.

MILLIONS OF CHILDREN AND PREGNANT WOMEN, INCLUDING THOSE IN WORKING FAMILIES NOW DEPEND ON MEDICAID FOR HEALTH COVERAGE. Federal law requires states to cover pregnant women and children under age six with family incomes up to 133% of poverty and to cover certain older children (those born after September 30, 1983) up to 100% of poverty ($12,590 per year for a family of three). Recent Medicaid expansions for these groups provided coverage for 3 million low-income children. Additional children are covered because they are disabled and receive Supplemental Security Income (SSI).

- In the United States, 21.1% of children under 18 were covered by Medicaid during 1990-92.

- Among children covered by Medicaid, more than half live in working families.

By 1994, at their option, 34 states had gone beyond federal mandates to cover more pregnant women and infants in low-income, working families. Most (22) states set eligibility at 185% of poverty (about $23,000 per year for a family of three), and several go beyond that level.

- Nationally, Medicaid finances care for one out of three babies -- 1.4 million in 1993.

CHILDREN AND PREGNANT WOMEN ARE NOT THE MAJOR CONTRIBUTORS TO INCREASED MEDICAID COSTS. The cost of Medicaid for children and pregnant women is relatively low and represents only a small fraction of Medicaid payments. While children and pregnant women accounted for half of the new Medicaid enrollees between 1988 and 1991, payments made on behalf of these groups were only 11% of the growth in Medicaid spending.

- Children are half of Medicaid recipients, but use less than one-quarter of the dollars spent in Medicaid for the entire United States. This low figure includes payments for care of children who are very sick or have disabilities.

- In 1993, Medicaid expenditures for all covered children under age 21 were $1,065 per child, compared to $7,590 per elderly adult.

- Medicaid payments for maternity and infant care through the first year of life are estimated at less than 7% of total U.S. Medicaid expenditures.

APPENDIX B

AS EMPLOYER-BASED COVERAGE FOR WOMEN AND CHILDREN DECLINED, MEDICAID FILLED THE GAP TO KEEP THE NUMBER OF UNINSURED FROM EXPLODING. During the 1980s, as the cost of private insurance rose for employers and families, many dropped dependent coverage for women and children. For children and pregnant women, Medicaid expansions offset much of the loss of private coverage for a few years. However, by 1992, growth in the number of uninsured children outpaced Medicaid.

- In the United States, 17.4 million children under age 21 received Medicaid covered services in 1993, but an estimated 12 million children under age 21 were uninsured.
- The proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994. Yet many women remain without coverage.
- There were 9,586,099 uninsured women of childbearing age in 1993.

MEDICAID EXPANSIONS SIGNIFICANTLY REDUCED UNCOMPENSATED HOSPITAL COSTS FOR DELIVERIES. In the mid-1980s, maternity and infant care was the single largest source of hospital uncompensated care costs.

- As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).

INFANT MORTALITY RATES DECLINED AS MEDICAID WAS EXPANDED FOR PREGNANT WOMEN. During the period of the Medicaid expansions for pregnant women, the U.S. infant mortality rate reached its lowest level in history.

- Overall, the U.S. infant mortality rate decreased 21% between 1984 and 1992 -- from 10.8 to 8.5 per 1000 live births.
- The infant mortality rate decreased in every state in the U.S., ranging from a 3.5% to 42% decrease, from 1984 to 1992.

Primary Data Sources: U.S. Bureau of Census Current Population Survey, Health Care Financing Administration 2082 Data, National Center for Health Statistics Hospital Discharge Survey, and National Center for Health Statistics Final Mortality Data; and publications by the Kaiser Commission on the Future of Medicaid, Urban Institute, Alan Gutunacher Institute, Employee Benefit Research Institute, Children's Defense Fund, and RAND.

Prepared by the *Maternal and Child Health Coalition*, May 1995

Children's Circle of Care

Founding Hospitals

Arkansas Children's Hospital
Little Rock, Arkansas

British Columbia's Children's Hospital
Vancouver, British Columbia

Children's Hospital
Boston, Massachusetts

Children's Hospital
Columbus, Ohio

Children's Hospital and Health Center
San Diego, California

Children's Hospital and Medical Center
Seattle, Washington

Children's Hospital Los Angeles
Los Angeles, California

Children's Hospital Medical Center
Cincinnati, Ohio

Children's Hospital Medical Center of Northern California
Oakland, California

Children's Hospital of Pittsburgh
Pittsburgh, Pennsylvania

Children's Hospital of Wisconsin
Milwaukee, Wisconsin

Children's Medical Center of Dallas
Dallas, Texas

Children's Memorial Medical Center
Chicago, Illinois

Children's National Medical Center
Washington, D.C.

Lucile Salter Packard Children's Hospital at Stanford
Palo Alto, California

St. Louis Children's Hospital
St. Louis, Missouri

The Children's Hospital
Denver, Colorado

The Children's Hospital of Philadelphia
Philadelphia, Pennsylvania

The Hospital for Sick Children
Toronto, Ontario