CHILDREN'S HEALTH PROGRAM: NEXT STEPS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

- **By October 1, 1997, define and clarify new law.** Issue guidelines or regulations consistent with the new law to states to guide them as they implement their programs. This will clarify question such as:
    - *What is a "generally available" state employee health plan?*
    - *Does the most popular HMO include those with state or Federal employees?*
    - *What does "well-child care" mean?*
    - *How should states and the Federal government develop and review the actuarial memorandum that states will use in the program?*
- Set up systems to review programs, oversee payment, and collect and disseminate states' annual reports.

STATES

- **By October 1, develop program plan.**

- Target uninsured children. Examples include:
    - *Develop programs in communities with few employers who offer coverage*
    - *Establish program for children who age out of Medicaid*
    - *Use unemployment offices to tag children whose parents are between jobs.*
- Set up good systems for covering for children. They could, for example:
    - *Develop special networks with children's hospitals*
    - *Ask the nation's leading insurers to participate.*
- Develop efficient outreach and enrollment processes. They could, for example:
    - *Coordinate eligibility workers with new program and Medicaid*
    - *Make eligibility the same as that for the School Lunch program*
    - *Use simple application.*
- Coordinate the new program with existing coverage options. They could, for example:
    - *Allow only children without access to employer-based insurance to participate*
    - *Have an automatic enrollment process for children who show up for the new program but are actually eligible for Medicaid.*

FOUNDATIONS

- **Outreach**. There seems to be considerable interest among foundations. They could:
  - *Develop school-based methods to education families about insurance options, such as enlisting the PTA or sending brochures on insurance options home with children*
  - *Sponsor public media campaigns about options available to states.*
- **Work with states to develop plans:**
  - *Packard Foundation may create a clearinghouse for implementation ideas*
  - *Alpha Center and the Robert Wood Johnson Foundation could share their experience in encouraging innovative programs in states like Florida.*
- **Monitor state activities**. Foundations are in a good position to research the new programs. They could:
  - *Sponsor special survey on detailed health insurance coverage in the states*
  - *Track and report on insurance trends in states*

CHILDREN'S GROUPS

- **Encourage states to cover a wide range of children and benefits**
  - *Provide Information and examples of why benefits like vision and hearing are important to children.*
  - *Identify good state employee health plans and encourage states to pick them.*
- **Ensure that adequate quality provisions are put in place**. For example, they could:
  - *Develop a data bank on states' quality programs.*
- **Outreach**
  - *Use volunteer networks to go to places likely to have uninsured children to help them enroll.*

PRESIDENT, FIRST LADY, CABINET SECRETARIES

- **Participate in public events** with Governors, community leaders, and children's groups to promote the new law and to education parents about how best to access coverage in their particular state.
- **Ensure timely, coordinated planning stage** by encouraging coordination among key plays such as the Secretaries of DHHS, Labor, and Education, Governors, state legislature representatives, providers, and children's groups.

THE WHITE HOUSE

WASHINGTON

Want to Dole Gingrich

December 27, 1994

Dear Bob:

While we could not achieve broad-based agreement on a health reform initiative last year, there can be little disagreement that we still face the enormous problems of increasing health care costs and decreasing coverage. We need to confront these problems on a bipartisan basis and address the insecurities that too many Americans have about their health care. I am writing to reiterate my strong desire to work with you in this regard.

I remain firmly committed to providing insurance coverage for every American and containing health care costs for families, businesses, and Federal, State, and local governments. In the upcoming session of Congress, we can and should work together to take the first steps toward achieving these goals. We can pass legislation that includes measures to address the unfairness in the insurance market, make coverage more affordable for working families and children, assure quality and efficiency in the Medicare and Medicaid programs, and reduce the long-term Federal deficit.

We look forward to talking with you in the upcoming weeks about a bipartisan effort to deliver health care reform to the American public. Hillary and I send our best wishes for a safe and happy holiday season.

Sincerely,

Bill Clinton

The Honorable Robert Dole
United States Senate
Washington, D.C. 20510

Did everything through:

1. Enactment of ~~Kennedy~~ Kassebaum - Kennedy law
2. Enactment of children health programs in balanced budget
3. Enactment of structural & quality reforms in balanced budget
4. Enactment of Medicare/Medicaid savings to reduce deficit.

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

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

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

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

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

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

- **Children and Immunization.** As the President announced today, 90 percent or more of America's toddlers in 1996 received the most critical doses of each of the routinely recommended vaccines -- surpassing the goal set by the President in 1993.

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

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

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

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

PRESIDENT BILL CLINTON: STRENGTHENING AMERICA'S HEALTH CARE SYSTEM

Protecting and Strenghtening The Nation's Health Care System

* **Enacted the ~~Kennedy-Kassebaum~~ Kassebaum-Kennedy health insurance reforms that will benefit as many as 25 million Americans.** This law will enable individuals to keep their health insurance coverage when they change jobs. Workers will no longer fear losing their health insurance if they or a family member have a pre-existing conditions. This law also includes several other key provisions that will: ensure that Americans can renew their health care coverage, guarantee access to health care for small businesses; strengthen efforts to combat health care fraud, waste, and abuse.

* **Strengthened Medicare Trust Fund.** The President's 1993 economic package included policy and structural changes that extended the life of the Trust Fund by three years (which were enacted without one Republican vote).

* **Protected the Medicaid guarantee for children, elderly, pregnant women, and people with disabilities**. The President vetoed the Republican's proposal to block grant the Medicaid program, guaranteeing health care coverage or benefits to 37 million beneficiaries. The President also presided over the approval of 12 Medicaid waivers to cover 2.2 million previously uninsured Americans.

* **Established protections for mothers and their newborns.** Today, some health plans refuse to pay for anything more than a 24-hour hospital stay, and some recommend releasing mothers as few as 8 hours after delivery. The President signed into law common sense legislation that requires health plans to allow new mothers to remain in the hospital for at least 48 hours following most normal deliveries and 96 hours after a Caesarean section.

* **Signed into law mental health parity provisions.** The President signed into law legislation to prohibit health plans from establishing separate lifetime and annual limits for mental health coverage.

Improving Health Care for Our Children

* **Increased childhood immunizations to an historic high.** The President's childhood immunization initiative expands community-based educational efforts and makes vaccines more affordable. In 1995, fully 75 percent of two-year olds were immunized -- a historic high.

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

* **Funds Full Participation in Women, Infants, and Children (WIC).** WIC provides nutritional assistance, nutrition education and counseling, health and immunization referrals, and prenatal care to those who would otherwise not get it. WIC participation has grown by 25% over the last four years and will serve 7.5 million by 1998, fulfilling the President's goal of full participation.

* **Enacted laws to prevent and punish handgun violence.** Fought for the Brady Bill, which has already prevented more than 60,000 fugitives, felons, and criminals from buying handguns. The President expanded this bill to prevent individuals who commit acts of domestic violence from buying guns. Banned 19 of the deadliest assault weapons and stopped efforts to repeal the assault weapons ban. Every year at least 39,000 people die and 100,000 are treated in emergency rooms from gun violence.

* **Helped Vietnam veterans whose children were born with spina bifida.** The President signed legislation to provide health care and rehabilitative training for children of Vietnam veterans who are born with spina bifida. The legislation will help thousands of children whose birth defects may be a result of their fathers' or mothers' service to our country.

Important Investments in Health Research

* **Increased investment in biomedical research at the National Institute of Health (NIH) by an impressive 16 percent.** Funding for breast cancer research at NIH has increased by 76 percent and support for AIDS research funding has increased by 25 percent.

* **Increased funding for AIDS research, prevention, housing, and treatment.** In the President's first term, he has presided over a 56 percent increase in spending on programs for people living with AIDS including: the Ryan White Care Act, research, State AIDS drug assistance programs that help patients buy new protease inhibitor drugs, and Housing Opportunities for Persons with AIDS that provides housing assistance for over 65,000 people.

Making Health Care More Efficient

* **Reduced regulations.** The Vice President's reinventing government initiative has resulted in the elimination of 1,600 pages of regulations in the Department of Health and Human Services, a 23 percent reduction.

* **Expedited the FDA review and approval of new drug products.** Under the President's watch, U.S. drug approvals are now as fast or faster than any other industrialized nation. Average drug approval times have dropped since the beginning of the Administration from almost three years to just over one year. In 1997, virtually all breakthrough drugs will be approved within six months without compromising safety standards.

~~THE CHALLENGES AHEAD~~ Included in Balanced Budget

Improving and Strenghtening Our Medicare and Medicaid Program

- **Extending the life of the Medicare Trust Fund for at least a decade.** The President fought to ensure that the Budget Agreement -- which included $115 billion in Medicare savings -- extended the life of the Medicare Trust Fund for at least a decade.

- **Modernizing Medicare and providing more choices.** The President's Medicare plan would increase the choices of plans for beneficiaries by adding a Medicare preferred provider organization option, a Provider Sponsored Organization (PSO) option, and HMOs with a point-of-service option. It also includes "competitive bidding" initiatives that will make Medicare a more prudent and effective purchaser of health care services. The President is working to ensure that these new choices are in the final budget agreement.

- **Adding new preventive benefits for Medicare beneficiaries.** The President's Medicare proposal added preventive benefits by providing for: full coverage of mammography screening, a colorectal screening benefit, diabetes case management, and preventive injections for pneumonia, influenza, and hepatitis B. The final proposal that came out of House did not include copays for mammographies. We are working to ensure that the final agreement includes all of these new benefits.

- **Giving states more flexibility to administer Medicaid.** The President's Medicaid proposal will eliminate the burdensome waiver process for both managed care and home- and community-based care alternatives to institutionalization. It will preserve the guarantee of Medicaid and also make it easier to extend health care coverage.

Improving Health Care for Our Children

#24 Billion

- **Extending health care coverage for millions of uninsured children.** The President has fought to make sure that extending health care coverage to millions of uninsured children is a top priority in any balanced budget deal. The President made sure that the Budget Agreement included $[illegible] billion to provide meaningful health care coverage to uninsured children. The President also supports allocating revenue from tobacco tax to allocate additional Federal support for children's health.

- **Outlining principles to use to evaluate children's health initiatives emerging from the Budget Agreement.** The President is committed to making sure that any investment in children's health care meets three principles: **(1) that coverage is meaningful**: from checkups to surgery -- children should get the care they need to grow up strong and healthy; **(2) that coverage is targeted**: through grant programs and Medicaid, this investment should cover as many uninsured children as possible; and **(3) that this investment supplements not supplants coverage:** this investment should cover children who do not currently have insurance -- rather than replace public or private money that already covers children.

CHALLENGES AHEAD

Making New Strides in Health Care, While Providing Americans With Adequate Protections

- **Protecting Americans from discrimination by health based on their genetic information.** The great strides that scientists are making in their understanding of genetic predispositions for diseases open the door for possible misuse. Specifically, insurance companies may attempt to use this information to raise premiums or deny coverage to Americans. Studies show that a leading reason many women are unwilling to be tested for the genetic predisposition for breast cancer is because they fear that their insurance will be dropped if they test positive. Last year, the President signed the Kennedy-Kassebaum law, which prevents health plans from excluding an individual from group coverage because of genetic information. This year the President is calling for further legislation that extends these protections to consumers in the individual market, prohibits raising premiums in individual and group markets because of genetic information, and prevents health plans from disclosing any genetic information.

- **Challenging the scientific community to find an AIDS vaccine in the next decade.** President Clinton challenged the nation to commit itself to the goal of developing an AIDS vaccine within the next ten years. To help fulfill this commitment, the President is bringing nations together to invest in this commitment (all of the nations at the G-8 agreed to increase their commitment), dedicating a research center for AIDS vaccine research at the National Institutes of Health (NIH), and reaching out to scientists, pharmaceutical companies, and patient advocates to maximize the involvement of both the private and public sectors in the development of an AIDS vaccine. The President has already taken steps to enhance the possibility of developing an AIDS vaccine by increasing funding for NIH vaccine research and development over 33 percent in the last two years.

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NOTE:
PRINTED: 19:33 04-AUG-97

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<gfbyline>By Hillary Rodham Clinton[MC]

<ws>W<gfsmcap>ASHINGTON[MC]
<us98><gfdt>T[MC]he historic balanced budget bill that the President is set to sign today offers hope that as many as five million uninsured boys and girls will receive the health care they need, from check-ups to antibiotics to complicated surgery. As the largest expansion in children's health coverage since Medicaid's creation 30 years ago, the bipartisan legislation could move the United States closer to shedding its status as the only Western industrialized nation that does not provide basic health benefits to all children.

Even as we celebrate this progress, we should recognize that passage of a bill, no matter how historic, does not guarantee success. Whether this legislation fulfills its promise depends on how hard we are willing to work in the months ahead.

Finding uninsured children who are scattered across the country, and then insuring them, will not be easy. As successful as Medicaid has been, an estimated three million eligible children are still not enrolled, because their parents don't know about the program, are unclear about whether they qualify, are reluctant to accept ``government'' help or are confused by complex eligibility rules.

Millions of other uninsured children have working parents who are employed by businesses that don't provide health insurance or who are low-wage workers unable to afford their share of insurance premiums. Still others lose coverage when their par-

ents lose jobs.

For this new bill to fulfill its promise, states first have to agree to participate and build on successful efforts that many have already made. While $24 billion in Federal aid over five years should be a significant incentive, dollars alone may not induce participation across the board. That's why our most urgent task is to educate citizens, especially parents, about what is at stake, and to encourage state officials to join the program and insure adequate benefits for all children.

Meeting this challenge will require a joint effort involving the Federal Government, states, localities, advocacy groups, foundations, health care providers, insurers and businesses - all of whom will have to work to inform families about insurance options for their children.

The Federal Department of Health and Human Services, for example, will offer guidance to state officials by helping to interpret key portions of the law and provide technical assistance to states with little or no experience in children's health programs.

Health care providers and insurers, who will benefit from a population of newly covered patients, can play a pivotal role in designing high-quality health plans and enrolling uninsured children who come to the hospital or emergency room for care.

Finally, states will have to meet the law's requirement that new dollars not be used to replace or supplant existing coverage. Otherwise, the legislation could have the perverse effect of reducing current public and private commitments to children's health.

Luckily, many states have already taken the lead in enrolling children in health plans. Florida works through

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schools to educate parents about signing up. Pennsylvania has adopted outreach efforts that help eligible families find the program best suited to their needs. Minnesota has chosen to use Federal dollars to expand its successful Medicaid program.

Parents will have the most significant role of all. They will have to learn about the programs, demand quality benefit packages, enroll their children if they are eligible, and take advantage of the services provided.

While this law will not fully achieve the universal coverage that I believe is in the nation's best interest, Americans should be proud that our Government has made another down payment on the President's goal of providing health insurance for all citizens. In the last three years we also taken other steps to bring better health care to the nation's young people, from passage of the Kassebaum-Kennedy ~~need-boilerplate-word-here-to-characterize-the-bill-for-readers-who-don't-know-the-shorthand-for-this~~bill to the President's successful efforts to increase immunizations, protect Medicaid, restrict tobacco advertising and sales to minors, extend hospital stays for mothers and their newborns, and expand financing for nutrition and education programs for poor women and their children.

helps ppl keep insurance when they lose or change j-s.

Now we have a chance to build on these achievements in the most profound way yet: By giving millions of children access to the health care they deserve and by offering them genuine hope for a healthy future. It's an opportunity we can't afford to miss.<ws>[OBX]

(END)

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<gfbyline>By Hillary Rodham Clinton[MC] - dexciption

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This version shows what has been cut

restore

Even as we celebrate this progress, we should recognize that passage of a bill, no matter how historic, does not guarantee success. Whether ~~or-not~~ this legislation fulfills its promise depends on how hard we are willing to work in the months ahead.

Finding uninsured children who are scattered across the country, and then insuring them, --~~is~~will not be easy. As successful as Medicaid has been, an estimated three million eligible children are still ~~are-not~~ enrolled, --~~either~~ because their parents don't know about the program, are unclear about whether they qualify, are reluctant to accept ``government'' ~~assistance~~help or are confused by complex~~ieated~~ eligibility rules.

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ents lose jobs.

For this new bill to fulfill its promise, states first have to agree ~~to~~to~~?-participate-and-~~ build on successful efforts that many have already made. While $24 billion in ~~f~~Federal ~~assistance~~aid over five years should be a significant incentive, dollars alone may not induce participation across~~-the-board~~. That's why our most urgent task is to educate citizens, ~~--~~especially parents, ~~--~~about what is at stake, and to encourage state officials to join the program and ~~e~~insure adequate benefits for all children.

Meeting this challenge will require a joint effort involving the ~~f~~Federal ~~g~~Government, states, localities, advocacy groups, foundations, health care providers, insurers and businesses - all of whom will have to work to inform families about insurance options for their children.

The Federal Department of Health and Human Services, for example, will offer guidance to state officials by helping to interpret key portions of the law and provide technical assistance to states with little or no experience in children's health programs.

Health care providers and insurers, who will benefit from a population of newly ~~i~~insured patients, can play a pivotal role in designing high~~-~~quality health plans and enrolling uninsured children who come to the hospital or emergency room for care.

Finally, states will have to meet the law's requirement that new dollars not be used to replace or supplant existing coverage. Otherwise, the legislation could have the perverse effect of reducing current public and private commitments to children's health.

~~That-means-that-states-will-have-to-devise-strategies-for-enrolling-as-many-children-as-possible.~~Luckily, many states have already

in enrolling children in health plans.

taken the lead. Florida works through schools to educate parents about signing up. Pennsylvania has adopted outreach efforts that help eligible families find the program best suited to their needs. Minnesota has chosen to use Federal dollars to expand its successful Medicaid program~~,-model--that-other-states-could-follow~~.

Parents will have the most significant role of all. They will have to learn about the programs, demand quality benefit packages, enroll their children if they are eligible, and take advantage of the services provided.

While this law will not fully achieve the universal coverage that I believe is in the nation's best interest, Americans should be proud that our Government has made another down payment on the President's goal of providing health insurance for all citizens. ~~As-the-President-wrote-in-a--letter-to-then-Senate-Majority-leader--Bob-Dole-andn-House-Speaker-Newt--Gingrich-in-the-wake-of-health-care--reform-in-December-1994:--"While-we--could-not-achieve-broad-based-agreement-on-a-health-reform-initiative,--we-can-pass-legislation-that-includes--measures-to-address-the-unfairness-in--the-insurance-market,-make-coverage--more-affordable-for-working-families--and-children,-assure-quality-and-efficiency-in-the-Medicare-and-Medicaid--programs,-and-reduce-the-long-term--Federal-deficit.--We-can-and-should--work-together-to-take-the-first-steps-to--achieving-these-goals."~~

~~So do-you-want-to-tamper-with-this-transition?~~ In the last three years we have

(also) taken other steps to

~~made step-by-step progress in~~ bringing better health care to the nation's young people, from passage of the Kassebaum-Kennedy ~~need-boilerplate-word-here-to-characterize-the-bill-for-readers-who-don't-know-the-shorthand-for-this~~bill to the President's successful efforts to increase ~~child~~-immunizations, protect Medicaid, re-

strict tobacco advertising and sales to minors, extend hospital stays for mothers and their newborns, and expand financing for nutrition and education programs for poor women and their children. ~~-help-Vietnam-veterans--whose-children-were-born-with-spina--bifida-and-punish-handgun-violence--that-disproportionately-afflicts-our--young.~~

Now we have a chance to build on these achievements in the most profound way yet: By giving millions of children access to the health care they deserve and by offering them genuine hope for a healthy future. -- It's an opportunity we can't afford to miss.<ws>[OBX]

(END)

Chris Jennings

News value = allow extraord. achievement ...
- Dec '94 PONS ltr to Gingrich/Dole after + HSA
- Need to move ahead
  children's health in particular
→ - Work still ahead of us
- start in October of this yr!
- have to work w/ states to get these kids
  local govts
  consumer advocates/ fdn.
- v. diff to target some of these kids
- make sure $ not used for kids who already have $ — but for uninsured
- we are celebrating + we should — but have to make sure the promises are real
- we are committed to:
  wkg w/ states, schools,

Can pass a historic law, but doesn't mean it's gone work

HHS will set up a process — ~~difficult~~ deficit benefit pkgs,
~~ensure~~ that $$
~~Patchwork~~
low wage workers who are just above Medicaid eligibility
90% of uninsured kids come from wkg families

Nick Littlefield / Kennedy's staff
- 3m eligible - still have 10m uninsured, but
- 5m really mean the 5m. uninsured
- ↳ gd article in NYT abt uninsured families

Not a single universal ~~thing~~ program like Medicare
Do most people remain — Aim for universal
4c for children, adults
This is not it — but it's -

Been w/ a Md'ed Cty
Now have 5 or kids who are hope will be
eligible under ~~TEFRA~~. This

Under h.c.c. debate Ball i '93-94, it seemed
to me that if we could + do it for eb
we ought to be

When h.c. w/ died - Re Pres made clear childn
still
Our county shld be moved
IC-IC bill
did we get any
list of everything that cld possible be said to
have been implemented . .

When Re Pres sign bill today it's a big
step

Age issue / Md

6pm 8/4/97

OP-ED PIECE -- THE CHILDREN'S HEALTH BUDGET
By Hillary Rodham Clinton

The historic balanced budget bill that the President signs today offers hope that as many as five million uninsured boys and girls will receive the health care they need — from regular check-ups to antibiotics to complicated surgery. As the largest expansion in children's health coverage since Medicaid's creation thirty years ago, the bipartisan legislation could move the United States closer to shedding its status as the only Western industrialized nation that does not provide basic health benefits to all children.

Even as we celebrate this progress, we should recognize that passage of a bill, no matter how historic, does not guarantee success. Whether or not this legislation fulfills its promise depends on how hard we are willing to work in the months ahead.

Finding uninsured children who are scattered across the country — and then insuring them — is not easy. For example: As successful as Medicaid has been, an estimated three million eligible children still are not enrolled -- either because their parents don't know about the program, are unclear about whether they qualify, are reluctant to accept "government" assistance or are confused by complicated eligibility rules.

Millions of other uninsured children have working parents who are employed by businesses that don't provide health insurance or who are low-wage workers unable to afford their share of insurance premiums. Still others lose coverage when their parents lose jobs.

For this new bill to fulfill its promise, states first have to agree participate and build on successful efforts that many have already made. While $24 billion in federal assistance over five years should be a significant incentive, dollars alone may not induce participation across-the-board. That's why our most urgent task is to educate citizens -- especially parents -- about what is at stake and to encourage state officials to join the program and ensure adequate benefits for all children.

Meeting this challenge will require a joint effort involving the federal government, states, localities, advocacy groups, foundations, health care providers, insurers and businesses -- all of

whom will have to work to inform families about insurance options for their children.

The federal Department of Health and Human Services, for example, will offer guidance to state officials by helping to interpret key portions of the law and provide technical assistance to states with little or no experience in children's health programs.

Health care providers and insurers, who will benefit from a population of newly insured patients, can play a pivotal role in designing high quality health plans and enrolling uninsured children who come to the hospital or emergency room for care.

Finally, states will have to meet the law's requirement that new dollars not be used to replace or supplant existing coverage. Otherwise, the legislation could have the perverse effect of reducing current public and private commitments to children's health.

That means that states will have to devise strategies for enrolling as many children as possible. Luckily, many states have already taken the lead. Florida works through schools to educate parents about signing up. Pennsylvania has adopted outreach efforts that help eligible families find the program best suited to their needs. Minnesota has chosen to use federal dollars to expand its successful Medicaid program, a model that other states could follow.

Parents will have the most significant role of all. They will have to learn about the programs, demand quality benefit packages, enroll their children if they are eligible, and take advantage of the services provided.

While this law will not fully achieve the universal coverage that I believe is in the nation's best interest, Americans should be proud that our government has made another down payment on the President's goal of providing health insurance for all citizens. As the President wrote in a letter to then-Senate Majority Leader Bob Dole and House Speaker Newt Gingrich in the wake of health care reform in December 1994: "While we could not achieve broad-based agreement on a health reform initiative . . . . we can pass legislation that includes measures to address the unfairness in the insurance market, make coverage more affordable for working families and children, assure quality and efficiency in the Medicare and Medicaid programs, and reduce the long-term federal deficit. . . . We can and should work together to take the first steps to achieving these goals."

In the last three years we have made step-by-step progress in bringing better health care

to the nation's young people, from passage of the Kassebaum-Kennedy bill to the President's successful efforts to increase child immunizations, protect Medicaid, restrict tobacco advertising and sales to minors, extend hospital stays for mothers and their newborns, expand ~~funding~~ financing for nutrition and education programs for poor women and their children, help Vietnam veterans whose children were born with spina bifida and punish handgun violence that disproportionately afflicts our young.

Now we have a chance to build on these achievements in the most profound way yet: By giving millions of children access to the health care they deserve and by offering them genuine hope for a healthy future.

It's an opportunity we can't afford to miss.

###

TO: HRC
FROM: Lissa
RE: Op-Ed piece
DATE: Monday, August 4

Here is a draft of the op-ed piece about the budget bill and children's health. The New York Times is interested in seeing it as soon as possible to decide whether they might use it.

Chris and Melanne's suggestions are included in this version.

Please be aware that the piece is long — about 1100 words. I'm not sure what the optimal length is for the Times op-ed page, but I imagine we may have to cut some.

4:30 pm

OP-ED PIECE -- THE CHILDREN'S HEALTH BUDGET
By Hillary Rodham Clinton

The historic balanced budget bill that the President signs today offers hope that as many as five million uninsured boys and girls will receive the health care they need — from regular check-ups to antibiotics to complicated surgery. The largest expansion in children's health coverage since Medicaid's creation thirty years ago, the bipartisan legislation could move the United States closer to shedding its status as the only industrialized nation that does not provide basic health benefits to all children.

But even as we celebrate this progress, we have to admit that passage of a bill, no matter how historic, does not guarantee success. Whether or not this legislation fulfills its promise depends on all of us.

Finding uninsured children who are scattered across the country — and then insuring them — is not easy. For example: As successful as the Medicaid program has been, an estimated three million eligible children still are not enrolled -- either because their parents don't know about the program, are unclear about whether they qualify, are reluctant to accept "government" assistance or are confused by complicated eligibility rules.

Millions of other uninsured children have working parents who are employed by businesses that don't provide health insurance or who are low-wage workers unable to afford their share of the insurance premium. Some children also lose coverage when their parents lose jobs. ~~And state-sponsored children's health plans vary from state to state, not only in whom they cover but in what level of coverage they provide.~~

For this new bill to fulfill its promise, states first have to agree participate. While $24 billion in federal assistance over five years should be a significant incentive, dollars alone may not induce participation across-the-board. That's why our most urgent task is to educate citizens -- especially parents -- about what is at stake and ~~to persuade~~ encourage state officials to take advantage of the program and ensure adequate benefits for all children.

and build on ~~significant~~ successful efforts that may have already made.

Meeting this challenge will require a joint effort involving the federal government, states, localities, health care providers, businesses and insurers, advocacy groups, foundations, grass-roots organizations and individual families -- all of whom will have to work to educate families about insurance options for their children.

The federal Department of Health and Human Services will offer guidance to state officials by helping to interpret key portions of the law and providing technical assistance to states with little or no experience in children's health programs.

Health care providers and insurers, who will benefit from a population of newly insured patients, can play a pivotal role in designing high quality health plans and enrolling uninsured children who come to the hospital or emergency room for care.

Finally, states will have to meet the law's requirement that new dollars not be used to replace or supplant existing coverage. Otherwise, the legislation could have the perverse effect of reducing current public and private commitments to children's health.

That means that states will have to devise strategies for enrolling children who are the hardest to reach. Luckily, a number of states have already taken the lead. Florida works through schools to educate parents about signing up. Pennsylvania has adopted outreach efforts that help eligible families find the program best suited to their needs. Or like Minnesota, some states may choose to use their federal dollars to expand successfully-run Medicaid programs and avoid creating costly and duplicative new systems to administer children's health.

Parents will have the most significant role of all. They will have to learn about the programs, demand quality benefit packages, enroll their children if they are eligible, and take advantage of the services once they are provided.

Americans should be proud that our government has made a down payment on our goal of providing health insurance for all of our citizens, which I have long favored. As the President wrote in a letter to then-Senate Majority Leader Bob Dole and House Speaker Newt Gingrich in the wake of health care reform in December 1994: "While we could not achieve broad-based agreement on a health reform initiative . . . . we can pass legislation that includes measures to address the unfairness in the insurance market, make coverage more affordable for working families and children, assure quality and efficiency in the Medicare and Medicaid programs, and

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The new law offers hope that as many as five million uninsured boys and girls will receive the range of care they need — from regular check-ups to antibiotics to complicated surgery. And it represents an unparalleled investment in children's health that, through expanded preventive care, could reduce costs and improve our nation's health in the future.

But even as we celebrate this extraordinary national achievement, we have to be aware that the mere passage of a bill, no matter how historic, does not guarantee success. Whether or not this legislation fulfills its promise to our children depends on all of us.

Finding uninsured children who are scattered across the country — and then insuring them — is not as easy as it sounds. For example: As successful as the Medicaid program has been, an estimated three million eligible children still are not enrolled -- either because their parents are unclear about their eligibility or are confused by complicated rules governing the program.

Millions of other uninsured children have working parents who are employed by businesses that don't provide health insurance, or are low-wage workers who can't afford to pay their share of the insurance premium. Still others children lose their coverage when their parents lose jobs. In addition, Medicaid and state-sponsored children's health plans vary from state to state, not only in whom they cover but in what level of coverage they provide.

For the new bill to live up to its promise, states have to agree participate. While $24 billion in federal assistance over five years should be a significant incentive, dollars alone may

not be enough to induce participation across-the-board. That's why our most urgent task is to educate citizens -- especially parents -- about what is at stake and to persuade state officials to take advantage of the program and ensure adequate benefits for all children, whether they live in Maine, Hawaii or anywhere in between.

Finally, to make the most of this investment, states will have to meet the law's requirement that new dollars not be used to replace or supplant existing coverage. Otherwise, the legislation will have the perverse effect of encouraging states and employers to reduce their current financial commitment to children's health.

Meeting such a complex set of challenges will require a joint effort involving the federal government, states, localities, health care providers, businesses and insurers, advocacy groups, foundations, grass-roots organizations and individual families.

Already the federal Department of Health and Human Services is setting up a process to guide state officials as they design and implement their programs, either by helping to interpret key portions of the law or providing technical assistance to states with little or no experience in children's health programs.

States, in turn, will have to devise strategies for enrolling children who are the hardest to reach. Some may follow Florida's example and use schools to educate parents about signing up. Others may adopt outreach efforts like those used in Pennsylvania, which help eligible families find the program best suited to their children's medical needs and family income. Or, like Minnesota, states may choose to use their federal dollars to expand successfully-run Medicaid programs and avoid creating costly and duplicative new systems to administer children's health.

Health care providers and insurers, who could benefit from a population of newly insured patients, can play a pivotal role in enrolling uninsured children who come to the hospital or emergency room for care. And they can use their expertise to design high-quality health plans that offer children the services they need most.

There is also a critical role for non-profit organizations like PTAs, churches and community foundations. They can develop local outreach and media campaigns to educate families about the options available for covering their children.

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programs, demand quality benefit packages, enroll their children if they are eligible, and take advantage of the services once they are provided.

While this law is not the universal coverage that I ~~have~~ advocated in the past and continue to favor -- because millions of Americans still won't have health insurance even if the law is implemented successfully -- it does represent a huge and overdue step forward.

Americans should be proud that our government has moved closer to providing health insurance for all of our citizens. As the President wrote in a letter to then-Senate Majority Leader Bob Dole and House Speaker Newt Gingrich in the wake of health care reform in December 1994: "While we could not achieve broad-based agreement on a health reform initiative . . . . we can pass legislation that includes measures to address the unfairness in the insurance market, make coverage more affordable for working families and children, assure quality and efficiency in the Medicare and Medicaid programs, and reduce the long-term federal deficit. . . . We can and should work together to take the first steps to achieving these goals."

In the last three years we have made step-by-step progress in bringing better health care to the nation's young people, from passage of the Kassebaum-Kennedy bill to the President's successful efforts to increase child immunizations, protect Medicaid, restrict tobacco advertising and sales to minors, extend hospital stays for mothers and their newborns, expand funding for nutrition and education programs for poor women and their children, help Vietnam veterans whose children were born with spina bifida and punish handgun violence that disproportionately afflicts our young.

Now we have a chance to build on these achievements in the most profound way yet: By giving millions of children access to the health care they deserve and by offering them genuine hope for a healthy future.

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DRAFT
Monday 8/4/97
9 am

OP-ED PIECE — THE CHILDREN'S HEALTH BUDGET
By Hillary Rodham Clinton

The balanced budget bill that the President will sign today at the White House is historic in many respects, not least in its potential for transforming children's health care across our country.

By offering meaningful health care coverage for an unprecedented number of uninsured American children -- 90 percent of whom are from working families -- the bipartisan legislation will finally move the United States closer to shedding its status as the only industrialized nation that does not provide basic health benefits to all children.

Not only does the new law offer hope that as many as five million uninsured boys and girls will receive the range of care they need — from regular check-ups to needed antibiotics to complicated surgery -- it represents an unprecedented investment in children's health that, through expanded preventive care, could substantially reduce costs and improve our nation's health in the future.

Many people deserve credit for getting us this far: the President, Democratic and Republican congressional leaders, state and local governments, children's advocates and health care providers.

But even as we celebrate this extraordinary national achievement, let us also be aware that the mere passage of a bill, no matter how historic, does not guarantee success. Much remains to be done in the coming months to ensure that the promise of the new law is realized and that millions of children actually get the coverage they are due.

Finding uninsured children who are scattered across the country — and then insuring them — is not as easy as it sounds. For one, not all lack coverage for the same reasons. Some have parents who are employed by small businesses that don't provide health insurance -- or pay little or none of the premium. Still others lose their insurance when their parents lose jobs. And many

When it comes to premiums. children
targeted under this new law,
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which is why ~~the base~~ there will
have to be a variety of approaches
to ...

And because we haven't created
a universal system -- like
Medicare -- we have -

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Monday 8/4/97
12:30 pm

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Millions of other uninsured children have working parents who are employed by businesses that don't provide health insurance or are low-wage workers who can't afford to pay their share of the insurance premium. Still other children lose their coverage when their parents lose jobs. In addition, Medicaid and state-sponsored children's health plans vary from state to state, not only in whom they cover but in what level of coverage they provide.

For the new bill to live up to its promise, states have to agree participate. While $24 billion in federal assistance over five years should be a significant incentive, dollars alone may not be enough to induce participation across-the-board. That's why our most urgent task is to educate citizens -- especially parents -- about what is at stake and to persuade state officials to take advantage of the program and ensure meaningful benefits for all children, whether they live in Maine, Hawaii or anywhere in between.

Finally, to make the most of this investment, states should come up with innovative ways to ensure that the new dollars are not used to replace or supplant existing coverage. Otherwise, the legislation ~~will~~ would have the perverse effect of encouraging states and employers to reduce their current financial commitment to children's health.

Meeting such a complex set of challenges will require a joint effort involving the federal government, states, localities, health care providers, businesses and insurers, advocacy groups, foundations, grass-roots organizations and individual families.

Already the federal Department of Health and Human Services is setting up a process to guide state officials as they design and implement their programs, either by helping to interpret key portions of the law or providing technical assistance to states with little or no experience in children's health programs.

States, in turn, will have to devise strategies for enrolling children who are the hardest to reach. Some may follow Florida's example and use schools to educate parents about signing up. Others may adopt outreach efforts like those used in Pennsylvania, ~~which~~ To help eligible families find the program that best suits their children's medical needs and family income. Or, like Minnesota, states may choose to use their federal dollars to expand successfully-run Medicaid programs and avoid creating costly and duplicative new systems to administer children's health.

Health care providers and insurers, who could benefit from a population of newly insured patients, can play a pivotal role in enrolling uninsured children who come to the hospital or emergency room for care. And they can use their expertise to design high-quality health plans that offer children the services they need most.

There is also a critical role for non-profit organizations like PTAs, churches and community foundations. They can develop local outreach and media campaigns to educate

families about the options available for covering their children.

Parents will have the most significant role of all. They will have to learn about the programs, demand meaningful benefit packages, enroll their children if they are eligible, and take advantage of the services once they are provided.

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Americans should be proud that our government has moved closer to providing health insurance for all of our citizens, In the last three years we have made step-by-step progress in bringing better health care to the nation's young people, from passage of the Kassebaum-Kennedy bill to the President's successful efforts to increase child immunizations, protect Medicaid, restrict tobacco advertising and sales to minors, extend hospital stays for mothers and their newborns, expand funding for nutrition and education programs for poor women and their children, help Vietnam veterans whose children were born with spina bifida and punish handgun violence that disproportionately afflicts our young.

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Health care providers and insurers, who will benefit from a population of newly insured patients, can play a pivotal role in designing high quality health plans and enrolling uninsured children who come to the hospital or emergency room for care.

Finally, states will have to meet the law's requirement that new dollars not be used to replace or supplant existing coverage. Otherwise, the legislation could have the perverse effect of reducing current public and private commitments to children's health.

That means that states will have to devise strategies for enrolling as many children as possible. Luckily, many states have already taken the lead. Florida works through schools to educate parents about signing up. Pennsylvania has adopted outreach efforts that help eligible families find the program best suited to their needs. Minnesota has chosen to use federal dollars to expand its successful Medicaid program, a model that other states could follow.

Parents will have the most significant role of all. They will have to learn about the programs, demand quality benefit packages, enroll their children if they are eligible, and take advantage of the services provided.

Americans should be proud that our government has made a down payment on the President's goal of providing health insurance for all citizens. As the President wrote in a letter to then-Senate Majority Leader Bob Dole and House Speaker Newt Gingrich in the wake of health care reform in December 1994: "While we could not achieve broad-based agreement on a health reform initiative . . . . we can pass legislation that includes measures to address the unfairness in the insurance market, make coverage more affordable for working families and children, assure quality and efficiency in the Medicare and Medicaid programs, and reduce the long-term federal deficit. . . . We can and should work together to take the first steps to achieving these goals."

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The historic balanced budget bill that the President signs today offers hope that as many as five million uninsured boys and girls will receive the health care they need — from regular check-ups to antibiotics to complicated surgery. The largest expansion in children's health coverage since Medicaid's creation thirty years ago, the bipartisan legislation could move the United States closer to shedding its status as the only industrialized nation that does not provide basic health benefits to all children.

But even as we celebrate this progress, we have to admit that passage of a bill, no matter how historic, does not guarantee success. Whether or not this legislation fulfills its promise depends on all of us.

Finding uninsured children who are scattered across the country — and then insuring them — is not easy. For example: As successful as the Medicaid program has been, an estimated three million eligible children still are not enrolled -- either because their parents don't know about the program, are unclear about whether they qualify, are reluctant to accept "government" assistance or are confused by complicated eligibility rules.

Millions of other uninsured children have working parents who are employed by businesses that don't provide health insurance. ~~or who are~~ Others are children of low-wage workers unable to afford their share of the insurance premium. ~~Some~~ And still others are children also lose coverage when their parents lose jobs. ~~And state-sponsored children's health plans vary from state to state, not only in whom they cover but in what level of coverage they provide.~~

For this new bill to fulfill its promise, all states first have to agree participate. While $24 billion in federal assistance over five years should be a significant incentive, dollars alone may not induce participation across-the-board. That's why our most urgent task is to educate citizens -- especially parents -- about what is at stake and to ~~persuade~~ state officials to take advantage of the program and ensure adequate benefits for all children.

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(1) Downpayment on goal of full coverage of all Americans
kill univ. coverage

(2) Largest expansion in public health
since Medicare Medicaid created

(3) Tone for electing
we know ~~it~~ it can work bc
some states are already leading the way.

States have made

TO: MRS CLINTON 456-6255 (fax)

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Even as we celebrate this progress, we should recognize that passage of a bill, no matter how historic, does not guarantee success. Whether or not this legislation fulfills its promise depends on how hard we are willing to work in the months ahead.

Finding uninsured children who are scattered across the country — and then insuring them — is not easy. For example: As successful as Medicaid has been, an estimated three million eligible children still are not enrolled -- either because their parents don't know about the program, are unclear about whether they qualify, are reluctant to accept "government" assistance or are confused by complicated eligibility rules.

Millions of other uninsured children have working parents who are employed by businesses that don't provide health insurance or who are low-wage workers unable to afford their share of insurance premiums. Still others lose coverage when their parents lose jobs.

For this new bill to fulfill its promise, states first have to agree participate and build on successful efforts that many have already made. While $24 billion in federal assistance over five years should be a significant incentive, dollars alone may not induce participation across-the-board. That's why our most urgent task is to educate citizens -- especially parents -- about what is at stake and to encourage state officials to join the program and ensure adequate benefits for all children.

Meeting this challenge will require a joint effort involving the federal government, states, localities, advocacy groups, foundations, health care providers, insurers and businesses -- all of

not be enough to induce participation across-the-board. That's why our most urgent task is to educate citizens -- especially parents -- about what is at stake and to persuade state officials to take advantage of the program and ensure adequate benefits for all children, whether they live in Maine, Hawaii or anywhere in between.

Finally, to make the most of this investment, states will have to meet the law's requirement that new dollars not be used to replace or supplant existing coverage. Otherwise, the legislation will have the perverse effect of ~~encouraging states and employers to~~ reducing their current financial commitment to children's health.

Meeting ~~such a complex set of~~ challenges will require a joint effort involving the federal government, states, localities, health care providers, businesses and insurers, advocacy groups, foundations, grass-roots organizations and individual families.

Already the federal Department of Health and Human Services is setting up a process to guide state officials as they design and implement their programs, either by ~~helping to~~ interpreting key portions of the law or providing technical assistance to states with little or no experience in children's health programs.

States, in turn, will have to devise strategies for enrolling children who are the hardest to reach. Some may follow Florida's example and use schools to educate parents about signing up. Others may adopt outreach efforts like those used in Pennsylvania, which help eligible families find the program best suited to their children's medical needs and family income. Or, like Minnesota, states may choose to use their federal dollars to expand successfully-run Medicaid programs and avoid creating costly and duplicative new systems to administer children's health.

Health care providers and insurers, who could benefit from a population of newly insured patients, can play a pivotal role in enrolling uninsured children who come to the hospital or emergency room for care. ~~And they can use their expertise to~~ design high-quality health plans ~~that offer children the services they need most.~~

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HRC HANDWRITING

three million children are eligible for Medicaid but are not enrolled -- either because they are unclear about their eligibility or are confused by complicated rules governing the program.

In addition, Medicaid and state-sponsored children's health plans vary from state to state, not only in whom they cover but in what level of coverage they provide.

To extend coverage to millions of uninsured children beginning in October, we must do everything we can to encourage all states to participate. While $24 billion in federal assistance is a significant incentive, dollars alone may not be enough to induce participation across-the-board. That's why our most urgent task right now is educate parents about what is at stake and encourage them to lobby their state officials to join the program. Once states devise their plans, we must make sure that the coverage offered is meaningful for all children -- whether they live in Maine, Hawaii or anywhere in between.

Finally, to get the most out of this investment, states will have to assure that the coverage goes solely to children without insurance and not replace or supplant coverage they may already have.

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Already the federal Department of Health and Human Services is setting up a process to guide states as they implement their programs, whether it means providing information about diverse approaches being used around the country or helping to interpret key portions of the law. The federal government also can be helpful to states with little or no experience in offering health plans for children.

States, in turn, will have to devise strategies for finding the children who are hardest to reach. Some may follow Florida's example and use schools to educate parents and enroll children. Or, like Pennsylvania, they may coordinate existing children's health care plans so that families are directed to the program that best suits their children's medical needs and family income.

Health care providers will be pivotal in establishing children's health networks to deliver services and in enrolling uninsured children who come to the hospital or emergency room for care.

It is up to each state to design
...

At the grass roots, foundations will be essential to outreach and education efforts, enlisting PTAs and the local media in promotional campaigns and providing research about the new programs. Children's advocacy groups share information about benefits packages and lobby states to pick the best plans for children. And insurance companies can use their expertise to design high-quality health plans that offer children the services they need most.

Parents, too, will have to do their part. It's up to them to learn about the programs, demand meaningful benefit packages, enroll their children if they are eligible, and take advantage of the services once they are provided.

With a concerted effort at every level, we can make progress in reducing health care costs and improving coverage for children who now live daily without access to adequate care. While this law is not the universal coverage that I have advocated in the past and continue to favor, because millions of Americans still won't have health insurance -- it does represent a huge and overdue step forward.

As the President wrote in a letter to then-Senate Majority Leader Bob Dole and House Speaker Newt Gingrich in the wake of health care reform in December 1994: "While we could not achieve broad-based agreement on a health reform initiative . . . . we can pass legislation that includes measures to address the unfairness in the insurance market, make coverage more affordable for working families and children, assure quality and efficiency in the Medicare and Medicaid programs, and reduce the long-term federal deficit. . . . We can and should work together to take the first steps to achieving these goals."

Americans should be proud that their government has heeded the President's call. In the last three years we have made step-by-step progress in bringing better health care to the nation's young people, from passage of the Kassebaum-Kennedy bill to the President's successful efforts to increase child immunizations, protect Medicaid, restrict tobacco advertising and sales to minors, extend hospital stays for mothers and their newborns, expand funding for nutrition and education programs for poor women and their children, help Vietnam veterans whose children were born with spina bifida and punish handgun violence that disproportionately afflicts our young.

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While this law is not the universal coverage that I have advocated in the past and continue to favor -- because millions of Americans still won't have health insurance even if the law is implemented successfully -- it does represent a huge and overdue step forward.

~~[NOTE: should we kill this paragraph, which now seems out of place? Maybe it should be integrated in the President's remarks at the bill signing]~~ As the President wrote in a letter to then-Senate Majority Leader Bob Dole and House Speaker Newt Gingrich in the wake of health care reform in December 1994: "While we could not achieve broad-based agreement on a health reform initiative . . . . we can pass legislation that includes measures to address the unfairness in the insurance market, make coverage more affordable for working families and children, assure quality and efficiency in the Medicare and Medicaid programs, and reduce the long-term federal deficit. . . . We can and should work together to take the first steps to achieving these goals."

Americans should be proud that our government has moved closer to providing health insurance for all of our citizens. In the last three years we have made step-by-step progress in bringing better health care to the nation's young people, from passage of the Kassebaum-Kennedy bill to the President's successful efforts to increase child immunizations, protect Medicaid, restrict tobacco advertising and sales to minors, extend hospital stays for mothers and their newborns, expand funding for nutrition and education programs for poor women and their children, help Vietnam veterans whose children were born with spina bifida and punish handgun violence that disproportionately afflicts our young.

Now we have a chance to build on these achievements in the most profound way yet: By giving millions of children access to the health care they deserve and by offering them genuine hope for a healthy future.

It's an opportunity we can't afford to ~~waste~~ miss.

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DRAFT #2

OP-ED PIECE — THE CHILDREN'S HEALTH BUDGET
By Hillary Rodham Clinton

The balanced budget bill that the President will sign today at the White House is historic in many respects, not least in its potential for transforming children's health care across our country.

By offering meaningful health care coverage for an unprecedented number of uninsured American children -- 90 percent of whom are from working families -- the bipartisan legislation will finally move the United States closer to shedding its status as the only industrialized nation that does not provide basic health benefits to all children.

Not only does the new law offer hope that as many as five million uninsured boys and girls will receive the ~~preventive and primary~~ care they need — from ~~needed antibiotics~~ to complicated surgery -- it represents an unprecedented investment in children's health that could substantially reduce costs and improve our nation's health in the future.

Many people deserve credit for getting us this far: the President, Democratic and Republican congressional leaders, state and local governments, children's advocates and health care providers.

But even as we celebrate this extraordinary national achievement, let us also be aware that the mere passage of a bill, no matter how historic, does not guarantee success. Much remains to be done in the coming months to ensure that the promise of the new law is realized and that millions of children actually get the coverage they are due.

Finding uninsured children who are scattered across the country — and then insuring them — is not as easy as it sounds. For one, not all lack coverage for the same reasons. Some have parents who are employed by small businesses that don't provide health insurance -- or pay little or none of the premium. Still others lose their insurance when their parents lose jobs. And fully three million children are eligible for Medicaid but are not enrolled — either because they are unsure of their eligibility or are confused by complicated rules governing the program.

In addition, ~~public~~ health plans vary from state to state, not only in whom they cover but

in what level of coverage they provide.

For the new law to succeed, we must reach as many uninsured children as possible and ensure that the benefits they receive are meaningful [sufficient?], whether they live in Maine or Hawaii or any state in between.

States are not required to participate, however, and some may opt out even if it means foregoing millions of dollars in federal aid. That's why our most urgent task right now is to make sure that parents understand what is at stake and lobby their state officials to join the program.

To insure millions of children by the October 1st deadline will require a joint effort involving the federal government, states, localities, health care providers, businesses and insurers, advocacy groups, foundations, grass-roots organizations and individual families.

Already the federal Department of Health and Human Services is setting up a process to guide states as they implement their programs, whether it means providing information about different approaches being used around the country or helping to interpret key portions of the law.

States, in turn, must devise ways to target communities with high concentrations of uninsured children. Some may follow Florida's example and use schools to educate parents and enroll children. Or, like Pennsylvania, they may coordinate existing children's health care plans so that families are directed to the program that best suits their children's medical needs and family income.

Health care providers will be pivotal in establishing children's health networks to deliver services and in enrolling uninsured children who come to the hospital or emergency room for care.

At the grass roots, foundations will be essential to outreach and education efforts, enlisting PTAs and the local media in promotional campaigns and providing research about the new programs. Children's advocacy groups can share information about benefits packages and lobby states to pick the best plans for children. And insurance companies can design high-quality health plans that offer children the services they most need.

And finally, parents must do their part too. It's up to them to learn about the programs, demanding meaningful benefit packages, enroll their children if they are eligible, and take advantage

of the services once they are provided.

With a concerted effort across-the-board we can make progress in reducing health care costs and improving coverage for children who now live daily without access to adequate care. While this law is not the universal coverage that I have advocated in the past and continue to favor — millions of Americans ~~will~~ still ~~remain without any~~ won't have health insurance -- it does represent a huge and overdue step forward.

As the President wrote in a letter to then-Senate Majority Leader Bob Dole and House Speaker Newt Gingrich in the wake of health care reform in December 1994: "While we could not achieve broad-based agreement on a health reform initiative . . . . we can pass legislation that includes measures to address the unfairness in the insurance market, make coverage more affordable for working families and children, assure quality and efficiency in the Medicare and Medicaid programs, and reduce the long-term federal deficit. . . . We can and should work together to take the first steps to achieving these goals."

Americans should be proud that in the last three years we have made step-by-step progress in bringing better health care to the nation's young people, from passage of the Kassebaum-Kennedy bill to the President's successful efforts to increase child immunizations, protect Medicaid, restrict tobacco advertising and sales to minors, extend hospital stays for mothers and their newborns, expand funding for nutrition and education programs for poor women and their children, help Vietnam veterans whose children were born with spina bifida and punish handgun violence that disproportionately afflicts our young.

Now we have a chance to build on these achievements in the most profound way yet: By giving millions of children access to the health care they deserve and by offering them genuine hope for a healthy future.

It's an opportunity we can't afford to waste.

###

/Chris/
5557
fax

DRAFT #1

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TO: CHRIS 703-527-9248
FROM: LISSA 202 337 3171

FIRST LADY HILLARY RODHAM CLINTON
OP-ED PIECE — THE CHILDREN'S HEALTH BUDGET
AUGUST 5, 1997

The balanced budget bill that the President will sign today at the White House is historic in many respects, not least in its potential for transforming children's health care across our country.

By offering meaningful health care coverage for an unprecedented number of uninsured American children -- 90 percent of whom are from working families -- the bipartisan legislation will finally move the United States closer to shedding its status as the only industrialized nation that does not provide basic health benefits to all children. Not only does the new law offer hope that as many as five million uninsured boys and girls will receive the health care they need — from ~~regular check-ups to eye exams [ck] to~~ complicated surgery — ~~but~~ insuring more children could lead to a lower infant mortality rate nationwide and fewer long-term health problems associated with inadequate medical care during the early years of life.

Many people deserve credit for making this possible -- from the President to Democratic and Republican congressional leaders to children's advocates to ~~[need one more group]~~ health practitioners.

Yet as we celebrate this extraordinary national achievement, let us also beware that the mere passage of a bill, no matter how historic, does not guarantee success. Much remains to be done in the coming months to ensure that the promise of the new law is realized and that millions of children actually get the coverage ~~for which they are eligible~~.

Finding uninsured children who are scattered across the country — and then insuring them — is not as easy as it sounds. For one, not all lack coverage for the same reasons. Some have parents who work in small businesses that don't provide health insurance. Many became uninsured when their parents lost ~~or switched jobs. [NOTE: doesn't Kennedy-Kassebaum take care of them?]~~ About three million children are eligible for Medicaid but simply are not enrolled — either because they are unaware of their eligibility or are confused by complicated rules

governing the program. Still others may have parents who can afford private insurance but choose not to purchase it.

In addition, public health plans vary from state to state, not only in whom they cover but in what level of coverage they provide.

For the new law to succeed, we will have to work together to reach as many children as possible, ensure that those children do not currently have public or private insurance, and guarantee that the benefits they receive are meaningful whether they live in Massachusetts or Hawaii or any state in between.

The key will be a coordinated effort that includes the federal government, states, localities, advocacy groups, foundations, grass-roots organizations and, yes, even individual families.

Already the federal Department of Health and Human Services is setting up a process to guide states as they implement their programs. [NOTE: more specific?] States, in turn, must target uninsured children by developing programs in communities where few employers offer coverage. They can follow Florida's example and use schools to educate parents and enroll children. Or they can create networks through the existing Medicaid and school lunch programs or by developing special networks with children's hospitals. [NOTE: should we say anything about Minnesota or New York?]

Foundations also can play a role by enlisting PTAs and the local media in education campaigns and by providing research about viability of the new programs. Children's advocacy groups can share information about benefits packages and lobby states to pick the best plans for children.

And finally, parents must assume responsibility for learning about the programs, enrolling their children if they are eligible, and talking advantage of the benefits provided.

With a concerted effort across-the-board we can make progress in reducing health care costs and improving coverage for children who now live daily without access to adequate care. It's not the universal coverage that I have argued for in the past — xx million adults and another five million children will still remain without any health insurance -- but it is a huge and overdue step forward.

As the President wrote in a letter to then-Senate Majority Leader Bob Dole and House

Speaker Newt Gingrich in the wake of health care reform in December 1994: "While we could not achieve broad-based agreement on a health reform initiative last year. . . . I remain firmly committed to providing insurance coverage for every American and containing health care costs for families, businesses, and federal, state and local governments. . . . We can and should work together to take the first steps to achieving these goals."

Americans should be proud that in the last three years we have made piecemeal — yet significant -- progress in bringing better health care to the nation's young people, from passage of the Kassebaum-Kennedy bill to the President's successful efforts to increase child immunizations, protect Medicaid, restrict tobacco advertising and sales to minors, establish protections for mothers and their newborns, fund nutrition and education programs for poor women and their children, help Vietnam veterans whose children were born with spina bifida and punish handgun violence that disproportionately affect our young.

Now we have a chance to build on these achievements in the most profound way yet: By giving millions of children their first real promise of a healthy future.

###

Under this law he can choose →
fed gov't
Blue X - Blue Shield
any HMO
how do make sure that he states will provide a fd. benefit
fear that some states won't do it
is it law that each state must participate
Refundability →

CHILDREN'S HEALTH PROGRAM: NEXT STEPS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

- **By October 1, 1997, define and clarify new law.** Issue guidelines or regulations consistent with the new law to states to guide them as they implement their programs. This will clarify question such as:
  - *What is a "generally available" state employee health plan?*
  - *Does the most popular HMO include those with state or Federal employees?*
  - *What does "well-child care" mean?*
  - *How should states and the Federal government develop and review the actuarial memorandum that states will use in the program?*
- Set up systems to review programs, oversee payment, and collect and disseminate states' annual reports.

STATES

- **By October 1, develop program plan.**

- Target uninsured children. Examples include:
  - *Develop programs in communities with few employers who offer coverage*
  - *Establish program for children who age out of Medicaid*
  - *Use unemployment offices to tag children whose parents are between jobs.*
- Set up good systems for covering for children. They could, for example:
  - *Develop special networks with children's hospitals*
  - *Ask the nation's leading insurers to participate.*
- Develop efficient outreach and enrollment processes. They could, for example:
  - *Coordinate eligibility workers with new program and Medicaid*
  - *Make eligibility the same as that for the School Lunch program*
  - *Use simple application.*
- Coordinate the new program with existing coverage options. They could, for example:
  - *Allow only children without access to employer-based insurance to participate*
  - *Have an automatic enrollment process for children who show up for the new program but are actually eligible for Medicaid.*

FOUNDATIONS

- **Outreach**. There seems to be considerable interest among foundations. They could:
  - *Develop school-based methods to education families about insurance options, such as enlisting the PTA or sending brochures on insurance options home with children*
  - *Sponsor public media campaigns about options available to states.*
- **Work with states to develop plans:**
  - *Packard Foundation may create a clearinghouse for implementation ideas*
  - *Alpha Center and the Robert Wood Johnson Foundation could share their experience in encouraging innovative programs in states like Florida.*
- **Monitor state activities**. Foundations are in a good position to research the new programs. They could:
  - *Sponsor special survey on detailed health insurance coverage in the states*
  - *Track and report on insurance trends in states*

CHILDREN'S GROUPS

- **Encourage states to cover a wide range of children and benefits**
  - *Provide Information and examples of why benefits like vision and hearing are important to children.*
  - *Identify good state employee health plans and encourage states to pick them.*
- **Ensure that adequate quality provisions are put in place**. For example, they could:
  - *Develop a data bank on states' quality programs.*
- **Outreach**
  - *Use volunteer networks to go to places likely to have uninsured children to help them enroll.*

PRESIDENT, FIRST LADY, CABINET SECRETARIES

- **Participate in public events** with Governors, community leaders, and children's groups to promote the new law and to education parents about how best to access coverage in their particular state.
- **Ensure timely, coordinated planning stage** by encouraging coordination among key plays such as the Secretaries of DHHS, Labor, and Education, Governors, state legislature representatives, providers, and children's groups.

THE WHITE HOUSE

WASHINGTON

Want to Dole

Gingrich

December 27, 1994

Dear Bob:

While we could not achieve broad-based agreement on a health reform initiative last year, there can be little disagreement that we still face the enormous problems of increasing health care costs and decreasing coverage. We need to confront these problems on a bipartisan basis and address the insecurities that too many Americans have about their health care. I am writing to reiterate my strong desire to work with you in this regard.

I remain firmly committed to providing insurance coverage for every American and containing health care costs for families, businesses, and Federal, State, and local governments. In the upcoming session of Congress, we can and should work together to take the first steps toward achieving these goals. We can pass legislation that includes measures to address the unfairness in the insurance market, make coverage more affordable for working families and children, assure quality and efficiency in the Medicare and Medicaid programs, and reduce the long-term Federal deficit.

We look forward to talking with you in the upcoming weeks about a bipartisan effort to deliver health care reform to the American public. Hillary and I send our best wishes for a safe and happy holiday season.

Sincerely,

Bill Clinton

The Honorable Robert Dole
United States Senate
Washington, D.C. 20510

Did everything through:

(1) Enactment of ~~Kassebaum~~ Kassebaum - Kennedy law

(2) Enactment of children health programs in balanced budget

(3) Enactment of structural & quality reforms in balanced budget

(4) Enactment of Medicare / Medicaid savings to reduce deficit.

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

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

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

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

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

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

- **Children and Immunization.** As the President announced today, 90 percent or more of America's toddlers in 1996 received the most critical doses of each of the routinely recommended vaccines -- surpassing the goal set by the President in 1993.

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

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

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

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

PRESIDENT BILL CLINTON: STRENGTHENING AMERICA'S HEALTH CARE SYSTEM

Protecting and Strenghtening The Nation's Health Care System

* **Enacted the ~~Kennedy-Kassebaum~~ Kassebaum-Kennedy health insurance reforms that will benefit as many as 25 million Americans.** This law will enable individuals to keep their health insurance coverage when they change jobs. Workers will no longer fear losing their health insurance if they or a family member have a pre-existing conditions. This law also includes several other key provisions that will: ensure that Americans can renew their health care coverage, guarantee access to health care for small businesses; strengthen efforts to combat health care fraud, waste, and abuse.

* **Strengthened Medicare Trust Fund.** The President's 1993 economic package included policy and structural changes that extended the life of the Trust Fund by three years (which were enacted without one Republican vote).

* **Protected the Medicaid guarantee for children, elderly, pregnant women, and people with disabilities**. The President vetoed the Republican's proposal to block grant the Medicaid program, guaranteeing health care coverage or benefits to 37 million beneficiaries. The President also presided over the approval of 12 Medicaid waivers to cover 2.2 million previously uninsured Americans.

* **Established protections for mothers and their newborns.** Today, some health plans refuse to pay for anything more than a 24-hour hospital stay, and some recommend releasing mothers as few as 8 hours after delivery. The President signed into law common sense legislation that requires health plans to allow new mothers to remain in the hospital for at least 48 hours following most normal deliveries and 96 hours after a Caesarean section.

* **Signed into law mental health parity provisions.** The President signed into law legislation to prohibit health plans from establishing separate lifetime and annual limits for mental health coverage.

Improving Health Care for Our Children

* **Increased childhood immunizations to an historic high.** The President's childhood immunization initiative expands community-based educational efforts and makes vaccines more affordable. In 1995, fully 75 percent of two-year olds were immunized -- a historic high.

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

* **Funds Full Participation in Women, Infants, and Children (WIC).** WIC provides nutritional assistance, nutrition education and counseling, health and immunization referrals, and prenatal care to those who would otherwise not get it. WIC participation has grown by 25% over the last four years and will serve 7.5 million by 1998, fulfilling the President's goal of full participation.

* **Enacted laws to prevent and punish handgun violence.** Fought for the Brady Bill, which has already prevented more than 60,000 fugitives, felons, and criminals from buying handguns. The President expanded this bill to prevent individuals who commit acts of domestic violence from buying guns. Banned 19 of the deadliest assault weapons and stopped efforts to repeal the assault weapons ban. Every year at least 39,000 people die and 100,000 are treated in emergency rooms from gun violence.

* **Helped Vietnam veterans whose children were born with spina bifida.** The President signed legislation to provide health care and rehabilitative training for children of Vietnam veterans who are born with spina bifida. The legislation will help thousands of children whose birth defects may be a result of their fathers' or mothers' service to our country.

Important Investments in Health Research

* **Increased investment in biomedical research at the National Institute of Health (NIH) by an impressive 16 percent.** Funding for breast cancer research at NIH has increased by 76 percent and support for AIDS research funding has increased by 25 percent.

* **Increased funding for AIDS research, prevention, housing, and treatment.** In the President's first term, he has presided over a 56 percent increase in spending on programs for people living with AIDS including: the Ryan White Care Act, research, State AIDS drug assistance programs that help patients buy new protease inhibitor drugs, and Housing Opportunities for Persons with AIDS that provides housing assistance for over 65,000 people.

Making Health Care More Efficient

* **Reduced regulations.** The Vice President's reinventing government initiative has resulted in the elimination of 1,600 pages of regulations in the Department of Health and Human Services, a 23 percent reduction.

* **Expedited the FDA review and approval of new drug products.** Under the President's watch, U.S. drug approvals are now as fast or faster than any other industrialized nation. Average drug approval times have dropped since the beginning of the Administration from almost three years to just over one year. In 1997, virtually all breakthrough drugs will be approved within six months without compromising safety standards.

~~THE CHALLENGES AHEAD~~ Included in Balanced Budget

Improving and Strenghtening Our Medicare and Medicaid Program

- **Extending the life of the Medicare Trust Fund for at least a decade.** The President fought to ensure that the Budget Agreement -- which included $115 billion in Medicare savings -- extended the life of the Medicare Trust Fund for at least a decade.

- **Modernizing Medicare and providing more choices.** The President's Medicare plan would increase the choices of plans for beneficiaries by adding a Medicare preferred provider organization option, a Provider Sponsored Organization (PSO) option, and HMOs with a point-of-service option. It also includes "competitive bidding" initiatives that will make Medicare a more prudent and effective purchaser of health care services. The President is working to ensure that these new choices are in the final budget agreement.

- **Adding new preventive benefits for Medicare beneficiaries.** The President's Medicare proposal added preventive benefits by providing for: full coverage of mammography screening, a colorectal screening benefit, diabetes case management, and preventive injections for pneumonia, influenza, and hepatitis B. The final proposal that came out of House did not include copays for mammographies. We are working to ensure that the final agreement includes all of these new benefits.

- **Giving states more flexibility to administer Medicaid.** The President's Medicaid proposal will eliminate the burdensome waiver process for both managed care and home- and community-based care alternatives to institutionalization. It will preserve the guarantee of Medicaid and also make it easier to extend health care coverage.

Improving Health Care for Our Children

$24 billion

- **Extending health care coverage for millions of uninsured children.** The President has fought to make sure that extending health care coverage to millions of uninsured children is a top priority in any balanced budget deal. The President made sure that the Budget Agreement included $ billion to provide meaningful health care coverage to uninsured children. The President also supports allocating revenue from tobacco tax to allocate additional Federal support for children's health.

- **Outlining principles to use to evaluate children's health initiatives emerging from the Budget Agreement.** The President is committed to making sure that any investment in children's health care meets three principles: **(1) that coverage is meaningful**: from checkups to surgery -- children should get the care they need to grow up strong and healthy; **(2) that coverage is targeted**: through grant programs and Medicaid, this investment should cover as many uninsured children as possible; and **(3) that this investment supplements not supplants coverage:** this investment should cover children who do not currently have insurance -- rather than replace public or private money that already covers children.

CHALLENGES AHEAD

Making New Strides in Health Care, While Providing Americans With Adequate Protections

- **Protecting Americans from discrimination by health based on their genetic information.** The great strides that scientists are making in their understanding of genetic predispositions for diseases open the door for possible misuse. Specifically, insurance companies may attempt to use this information to raise premiums or deny coverage to Americans. Studies show that a leading reason many women are unwilling to be tested for the genetic predisposition for breast cancer is because they fear that their insurance will be dropped if they test positive. Last year, the President signed the Kennedy-Kassebaum law, which prevents health plans from excluding an individual from group coverage because of genetic information. This year the President is calling for further legislation that extends these protections to consumers in the individual market, prohibits raising premiums in individual and group markets because of genetic information, and prevents health plans from disclosing any genetic information.

- **Challenging the scientific community to find an AIDS vaccine in the next decade.** President Clinton challenged the nation to commit itself to the goal of developing an AIDS vaccine within the next ten years. To help fulfill this commitment, the President is bringing nations together to invest in this commitment (all of the nations at the G-8 agreed to increase their commitment), dedicating a research center for AIDS vaccine research at the National Institutes of Health (NIH), and reaching out to scientists, pharmaceutical companies, and patient advocates to maximize the involvement of both the private and public sectors in the development of an AIDS vaccine. The President has already taken steps to enhance the possibility of developing an AIDS vaccine by increasing funding for NIH vaccine research and development over 33 percent in the last two years.

Chris / Benefits pkg —

state picks one of 3 plans:

- fed empl ~~[illegible]~~ plan
- State employees plan
- most pop HMO

HMO /

some state plans don't have vision, hearing, etc. ~~[illegible]~~

Still an optional plan, but a lot of $$ on table so most states will

Work to ensure that your state participates

advocates, parents, insurers, providers

It would be unfortunate to get this can only to see this promise unrealized b/c everyone didn't ~~[illegible]~~ do their part

If they don't spend $$ in 3 yrs → goes to states that are

$24 b incidence

Yet while we celebrate the progress that this legislation represents, we must also

DRAFT

UNINSURED CHILDREN IN AMERICA: THE FACTS AND THE FUTURE

A Report by the

U.S. Department of Health and Human Services
and the U.S. Department of Labor

DRAFT June 19, 1997

HIGHLIGHTS

UNINSURED CHILDREN: A SERIOUS PROBLEM IN THE UNITED STATES

- **About 10 million children under age 18 are uninsured.** Fully 20 million children are uninsured for at least one month over a 28-month period.

- **Lack of insurance has become a middle class problem.** The number of uninsured children above 133 percent of poverty (about $21,000 for a family of four) has risen by over 50 percent since 1987. Today, almost 90 percent of uninsured children have a parent who works.

- **Uninsured children have worse access to health care despite the public safety net.** Sick, uninsured children are 4 times as likely to delay or not receive needed care.

- **The United States ranks poorly when compared to other nations**. It remains the only industrialized nation that does not extend basic health protection to all its children, and ranks 22nd in its infant mortality rate, 26th for its low birth weight babies, and 22nd for its infants' probability of dying before turning 5 years old.

THERE IS NO SINGLE REASON WHY CHILDREN ARE UNINSURED

- **Poverty alone cannot explain the lack of insurance.** About one-third of uninsured children have income between 100 and 200 percent of poverty, and another third have income above 200 percent of poverty. Reasons include:

    - **Lack of access to employer-based insurance**

        - ***Small businesses are less likely to offer health coverage***. Among working families, almost half of all uninsured children's parents work in small businesses. Employment has also shifted to part-time work and firms less likely to offer insurance.

        - ***Change in employment leads to loss of coverage***. Over half of children who became uninsured did so because their parents lost or changed jobs.

    - **Lack of affordability of insurance**

        - **Employer-based as well as individually purchased insurance can be expensive**. Over three-fourths of families who are offered employer-based insurance but decline it cannot afford it.

- **Problems accessing existing programs**

  - **Eligible but not enrolled in Medicaid.** About 3 million children at any point in time are eligible but not enrolled in Medicaid.

  - **Uneven Medicaid eligibility.** Over 2 million uninsured children would become eligible for Medicaid if all children were offered the same coverage as children under 6 (up to 133% of poverty).

  - **Limited size of state programs.** Over 30 states have state-funded or private children's health programs, but most are small.

LESSONS FROM MEDICAID, STATES AND THE 1990 TAX CREDIT

- **Medicaid has made important inroads into children's health coverage.** As a result of the Medicaid expansion, the number of poor, uninsured children has declined by about 10 percent — with much larger reductions in the southern and mountain states.

- **Some states have used innovative programs to target uninsured children**. Experience in private and/or state-funded programs suggests that states can design efficient programs that target hard-to-reach uninsured children.

- **The 1990 child health tax credit did not appear to have improved coverage.** The child health tax credit was difficult to administer and had low participation rates. Similarly, making insurance more available through health insurance reform is important but not necessarily the best tool to increase coverage.

CONCLUSION

- **Carefully designed policies can improve health coverage for American children.** Focusing on the causes of the problem and the lessons from past efforts can lead to policies that succeed in covering children. These include:

  - Making insurance more accessible and affordable through Medicaid and targeted state programs;

  - Assisting small employers through state purchasing cooperatives; and

  - Encouraging outreach through schools and other proven approaches.

- Regardless of the specifics, policies that efficiently extend meaningful coverage to uninsured children should be embraced as essential for today and the next

century.

I. UNINSURED CHILDREN: A SERIOUS PROBLEM

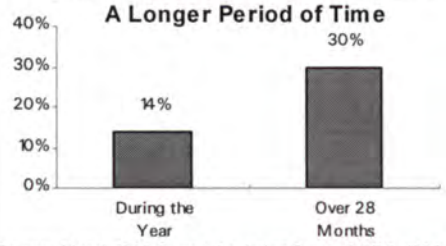
The key to access to the nation's high quality health care system is affordable health insurance. Although there are systems to care for people without coverage, evidence suggests that the uninsured have greater problems getting needed health care.

A. THE NUMBERS OF UNINSURED CHILDREN

One in seven right now. About 10 million children under 18 years old lack health insurance at any point during the year. This represents one in seven children or 14 percent of all children. This proportion has remained about the same for the last 10 years. (For details on uninsured children's characteristics, see Census, 1997.)

Nearly one in three over the course of two years. Yet, looking at more than a snapshot suggests that the problem is much larger. Over a 28-month period, the proportion of children who spent some time without insurance rises to nearly one in three children (Chart 1). In other words, 20 million American children spent at least one month without health insurance over the course of two-years (Census, 1997). Of these children, two-thirds were uninsured for at least six months, while nearly half were uninsured for at least one year (ASPE, 1997).

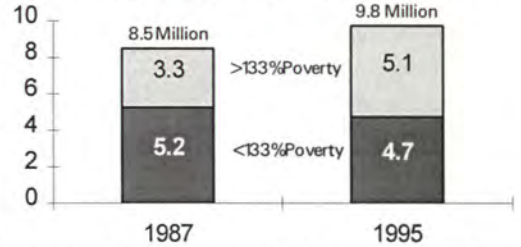
Chart 1. The Proportion of Uninsured Children is Higher over A Longer Period of Time



Source: March 1996 Current Poulation Survey & SIPP, 1992-94

Problem increasing for middle class families. While the proportion of children who are uninsured has remained relatively constant, this masks an underlying trend. The number of poor, uninsured children has been decreasing while the number of middle class uninsured children has been increasing. The number of uninsured children above 133 percent of poverty has risen from 3.3 to 5.1 million — more than a 50 percent increase between 1987 and 1995 (Chart 2). This outpaces the general increase in the number of children in this income range, which was about 15 percent.

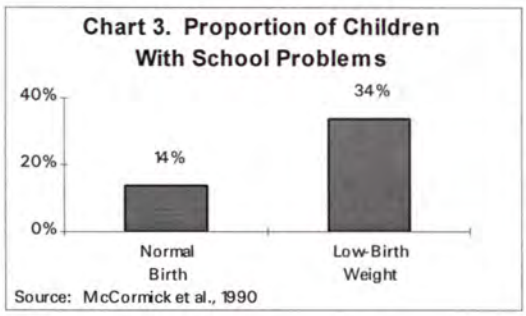
Chart 2. The Number of Uninsured Children Above Poverty Has Increased



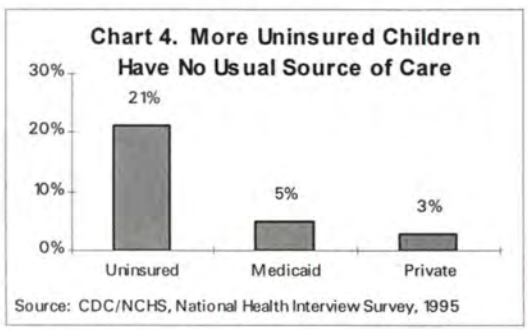
Source: EBRI analysis of the March 1988 & 1996 Current Pop. Survey

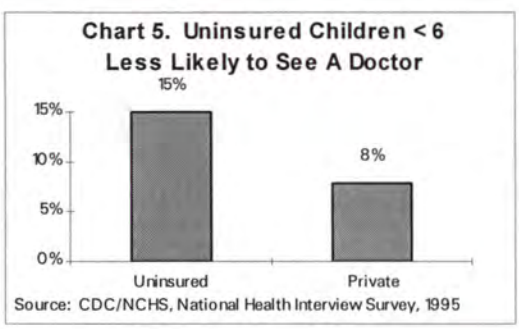
B. WHAT IT MEANS TO BE UNINSURED

Good health is essential to children's development. Children are generally healthy. Only about 3 percent of children have fair or poor health, relative to 4 percent of 18 to 24 year olds, 8 percent of 25 to 44 year olds, and 28 percent of people 65 years and older (NCHSb, 1995). Yet, children tend to have more acute illnesses than adults. Children under 5 years old experienced an average of 3.6 acute illnesses per child in 1994, relative to 2.2 illnesses per child 5 through 17 years and 1.1 per adult 45 years and older (NCHSb, 1995). These illnesses, whether short-term or chronic, can interfere with a child's development. When asked what indicates that a child is ready for kindergarten, teachers overwhelmingly respond that the most essential factor is a child's physical health (NCES, 1996). Children with low birth weight are more likely to repeat a grade or need special education (Chart 3). Mental health is equally important. About 7.5 million children suffer from one or more mental disorders that disrupt their ability to function socially, academically, and emotionally (IOM, 1994).



Uninsured children have more difficulty getting health care. Primary and preventive health care for children allows them to develop to their full capacity (CEA, 1997). Children also require immunizations in the early years of life to prevent lifelong health problems. About 86 percent of children have some type of health coverage. For children without insurance, Federal, state and local governments have developed a set of "safety net" or publicly supported providers, including community health centers, public health departments and children's hospitals. These providers give critical health services to children with and without insurance (see Appendix A for details). However, despite these systems, one in five uninsured children has no usual source of health care (Chart 4).

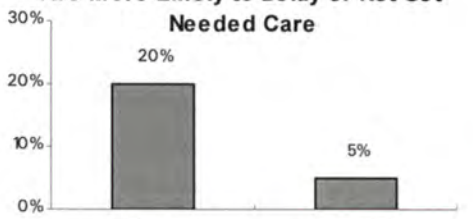




The lack of access appears to lower the use of care as well. Young children usually visit doctors at least once a year for preventive and primary care, since they often experience frequent, minor illnesses at this age. However, 15 percent of uninsured children less than 6 years old did not visit a doctor at all in the past year compared to 8 percent of children with private insurance and Medicaid (Chart 5).

The problems of uninsured children grow worse when they get sick. Uninsured children are four times as likely to delay or not receive needed care as are insured children (Chart 6). Over 40 percent of acute conditions for uninsured kids went unattended as compared to about 30 percent for privately insured children (NCHS, 1994). This is consistent with other studies that have found that health insurance is essential to connecting children with the health system (Donelan, 1996).

Chart 6. Uninsured, Sick Children Are More Likely to Delay or Not Get Needed Care



Source: CDC/NCHS, National Health Interview Survey, 1995

The United States stands alone. The United States leads the world in many important respects, including size of the gross domestic product (GDP) (World Bank, 1997) and real level of family income (Rainwater & Smeeding, 1995). However, the United States is the only industrialized country that does not extend health protection to all its children. It is with Turkey and Mexico at the bottom of a league of nearly 30 developed nations in its coverage of children, and since several developing nations offer greater protections, the U.S. ranks even lower (OECD, 1997). Many countries also do more to lift their children out of poverty as well; a survey of 18 industrialized nations found that the U.S. had the highest child poverty rate even after taxes and transfers (Rainwater & Smeeding, 1996).

Chart 7. Ranking of the U.S. In Child Health Statistics

Highest Total Health Spending as Percent of GDP:	1st
Highest Public Spending on Health as Percent of GDP:	13th
Highest Percent of Infants Immunized for DPT:	30th
Highest Percent of Infants Immunized for Measles:	52th
Lowest Infant Mortality Rate:	22nd
Lowest Percent of Babies who are Low Birthweight:	26th
Highest Life Expectancy at Birth:	12th
Lowest Odds that a Newborn Dies before Reaching 5 yrs:	22nd
Highest Mortality Rate Due to Violence for Children 0-24:	1st
Lowest Child Poverty After Taxes and Transfers:	18th

Sources: World Bank, 1997; OAT, 1992; Rainwater & Smeeding, 1995

The United States also ranks low on child health statistics. The United States does not fare well internationally on major child health indicators. Its immunization rates, while improving, are still worse than many industrialized nations. Twenty-one nations have lower infant mortality rates than the U.S. and 25 have a lower proportion of low birthweight babies (Chart 8). Babies born in the United States have shorter life expectancies than 10 other nations and are more likely to die of violence than in any industrialized nation (OAT, 1993).

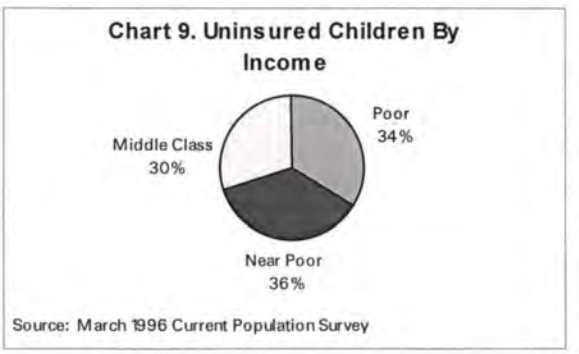
Chart 8. Infant Deaths per 1,000 Live Births in Selected Countries

Source: World Health Organization, 1997

System failure. The number of uninsured children in the United States is particularly alarming because there are systems in place to insure them. The United States has developed a unique, employer-based health insurance system. Preferential tax treatment valued at almost $80 billion per year is intended to encourage health coverage in this way. Additionally, Medicaid, the joint Federal-state health insurance program, offers coverage to most poor children who do not usually have access to employer-sponsored insurance. Yet, as described in greater detail below, about 87 percent of uninsured children have working parents, and nearly 3 million children are eligible for but not enrolled in Medicaid. This leads to the question: **why are there large gaps in the health insurance system for children?**

II. THERE IS NO SINGLE REASON WHY CHILDREN ARE UNINSURED

Probably the largest challenge in covering uninsured children stems from the fact that there is no single cause of the problem. Uninsured children are not a homogenous group, nor is poverty the sole reason why children are uninsured. One third are near poor (100-199% of poverty), suggesting that the family probably earns too much to qualify for Medicaid but too little to afford private insurance. It is this group of children that has the greatest likelihood of being uninsured — nearly one in four lack insurance (CPS, 1996). Another one-third of uninsured children have family income above 200 percent of poverty (Chart 9). Although most children have distinct reasons for being uninsured, there are some patterns that explain why this occurs..



Children often do not have health insurance because of:

- Lack of access to employer-based insurance
- Lack of affordability of insurance
- Problems accessing existing programs.

A. LACK OF ACCESS TO EMPLOYER-BASED INSURANCE

Employers play a central role in providing health insurance to workers and their families. Over 60 percent of nonelderly Americans are covered through employer-based plans (CPS, 1996). In 1994, employers paid for about one-fifth of all health expenditures accounting for 6.7 percent of all compensation (Cowan et al., 1996).

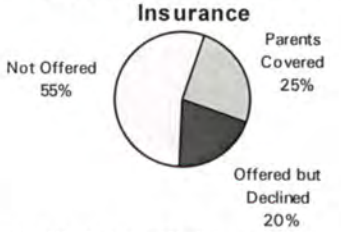
Nearly all uninsured children have a connection to the workforce. Most employers cover their workers' children. About 60 percent of children have employer-based health insurance (CPS, 1996). However, most uninsured children also have parents who work as well. Nearly 90 percent of uninsured children's parents work, and about two-thirds of uninsured children have parents who work full time (Chart 10).

Chart 10. Uninsured Children Come from Working Families

Note: 62%of uninsured children's parents work full-year, full-time
Source: March 1996 Current Population Survey

Many uninsured children's families work in businesses without health coverage. Many workers and their children lack insurance because their employers do not offer it to them. One study found that 80 percent of children with working parents have at least one parent who was offered family health insurance (Mark & Schur, 1996). However, more than half of uninsured children with working parents are not offered health coverage through work (Chart 11). This is especially true for low-income workers. Nearly 70 percent of poor uninsured children and 51 percent of uninsured children with family income between 100 and 200 percent of poverty have parents who are not offered employer-based insurance (NCHS, 1994).

Chart 11. More Than Half of Uninsured Children's Parents Who Work Aren't Offered Health Insurance

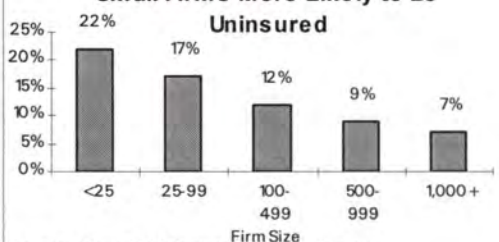


Source: CDC/NCHS, National Health Interview Survey, 1994

These families are most likely to work in small businesses, industries like personal services, and part-time jobs (Mark & Schur, 1996).

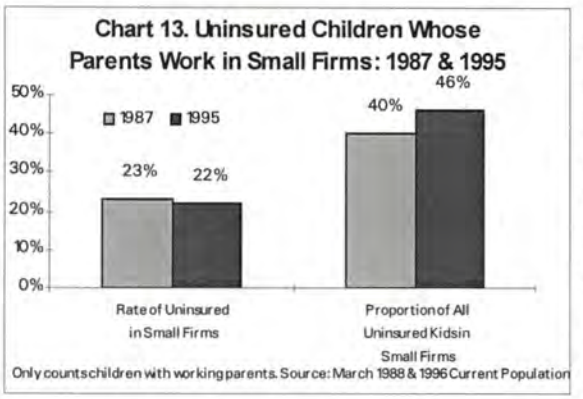
Small businesses are less likely to offer insurance. Children whose parents work in firms with fewer than 25 employees are more than twice as likely to be uninsured as those whose parents work in medium to large firms (Chart 12). This is especially true for low-income children. Over 35 percent of children whose parents work in small businesses and earn between 100 and 200 percent of poverty are uninsured (CPS, 1996). Only about 40 percent of employees in private businesses with fewer than 10 employees were offered coverage in 1993, compared to about 70 percent of employees in private firms with 10 to 24 employees, and nearly 100 percent of employees in firms with 100 or more employees (NEHIS, 1993).

Chart 12. Children with Parents in Small Firms More Likely to Be Uninsured

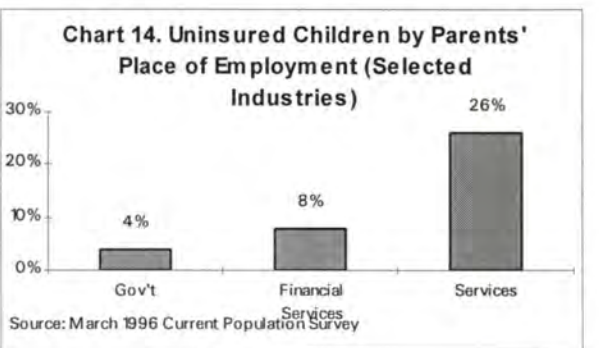


Source: March 1996 Current Population Survey

More children's parents work in small businesses. In 1988, 40 percent of uninsured children in working families had parents employed by small firms. In 1995, this rose to 46 percent (Chart 13). This did not result because small businesses are decreasing their health insurance coverage of children. In fact, in both 1987 and 1995, about 22 percent of children of workers in small firms were uninsured. In the last decade, however, there has been a large increase in the number of workers with children in small businesses. The total number of children whose parents work in firms with fewer than 25 employees increased by over 20 percent between 1987 and 1995 (CPS, 1988; 1996). At the same time, the number of children with parents working in medium and large firms dropped.



Companies in certain types of industries are less likely to offer insurance. Certain industries are less likely to offer coverage than others. Specifically, the rate of uninsured children whose parents work in the service industry (e.g., restaurants, cleaning services) is about twice as high as that for children with parents in most other types of jobs (Chart 14). In part, this reflects the fact that many of these businesses have part-time or part-year jobs. About 22 percent of children whose parents work part-time or part-year lack health insurance compared to 12 percent of full-time workers' children (CPS, 1996). It may also reflect the higher cost of insurance for these types of employers. Traditionally, health insurers have "red lined" or charged higher rates for certain kinds of businesses. While this practice has been limited in many states, it may still account for some of the lack of insurance.

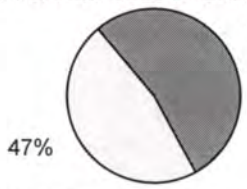


Similar to the trend for workers in small businesses, there has been an increase in the number of children with parents in service jobs — not an increase in the rate of uninsurance in those industries. The number of children with parents working in these types of jobs increased by over 10 percent between 1995 and 1987 (CPS, 1996).

JOB CHANGE AND JOB LOSS

Parents' job changes often mean children lose coverage. Given the strong link between health insurance coverage and employment, it is not surprising that changes in employment disrupt coverage. In fact, over half of uninsured children who had coverage within the past three years lost their coverage because their parents lost or changed jobs (Chart 15). This reason for losing insurance is more prevalent among children whose parents now work in small firms — over 60 percent of these children lost coverage because of job change (NCHS, 1994). It is also the reason why 58 percent of uninsured children in families between 100 and 250 percent of poverty and 54 percent above 250 percent of poverty lost coverage in 1994. Since higher income families are more likely to have job-related insurance, it makes sense that job-related reasons are the primary reason why they lose insurance.

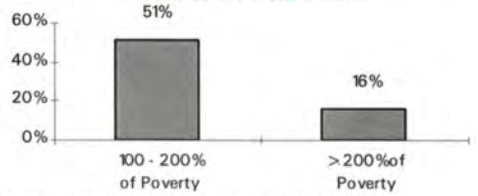
Chart 15. Most Children Who Had Insurance and Lost It Did So Because Their Parents Lost or Changed Jobs



Source: CDC/NCHS, National Health Interview Survey, 1994

Changing jobs leaves children with breaks in coverage. Over 50 percent of all children between 100 and 200 percent of poverty had a lapse in their health insurance coverage over a 28-month period (Chart 16). This compares to 16 percent of children in families with income greater than 200 percent of poverty. This probably reflects the lower rate of job transition for higher income workers.

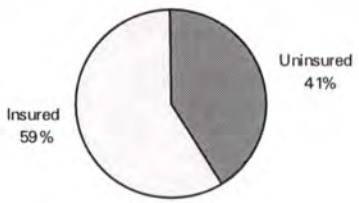
Chart 16. Children of the Working Poor Are More Likely to Have Breaks in Insurance



Source: U.S. Bureau of the Census, SIPP, 1992-1994

For families who spend time unemployed between jobs, the problem is worse. Some of the uninsured families who lose insurance when their parents lose or change jobs do not immediately gain jobs and insurance. About 13 percent of uninsured children have parents who are unemployed or out of the labor force (CPS, 1996). Over 40 percent of children who were covered through their parents' employer before their parents became unemployed became uninsured (Chart 17). Most of these children have parents who worked in manufacturing, transportation, communication, or construction jobs (Klerman, 1997). Most families spend 8 weeks or less looking for a job.

Chart 17. Children of Unemployed Parents Often Become Uninsured



Source: Kerman (1997) analysis of SIPP, 1989-1994

B. LACK OF AFFORDABILITY OF HEALTH INSURANCE

While access to insurance is important, it may not be sufficient. A growing number of families cannot afford to purchase employer-based insurance. Furthermore, insurance in the private, individual market can be prohibitively expensive. This suggests that making insurance accessible is only the first step in covering children: making it affordable is at least as important.

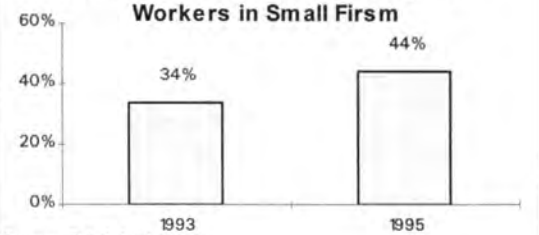
High cost of employer-based insurance. While employers typically pay for some of their employees' family coverage, the family contribution can be expensive. Three-quarters of uninsured children whose parents were offered coverage at work report that they are uninsured because their families cannot afford coverage (Chart 18). A recent survey found that the monthly family premium is about $423 per month, with the family contribution averaging 32 percent or $135 ($1,620 per year) (Jensen et al., 1997). While affordable for middle and upper class families, such premiums may be out of range for low-wage workers. Additionally, small businesses typically ask families to pay more of the premium costs; the family contribution for workers in firms with less than 100 employees was nearly twice as high as that for workers in firms with greater than 100 employees (EBS, 1993-1994).

Chart 18. Most Children with Access to Employer-Based Insurance Remain Uninsured Because of Cost

Source: CDC/NCHS, National Health Interview Survey, 1994

Family contributions are changing. One theory on why workers' children are increasing becoming uninsured is that the families' contribution to employer-based insurance is increasing. There is mixed evidence supporting this theory. One study found that the family contribution has remained about the same as a percent of the premium in the last several years (Jensen et al., 1997). However, several other studies suggest that the family contribution is increasing. One reports that the employees' share of the premium rose from 23.6 to 28.9 percent between 1992 and 1995 (Center..., 1997). Another found that this trend was more pronounced for workers in small firms; the family share increased by nearly one-third, from 34 to 44 percent between 1988 and 1996 (Chart 19).

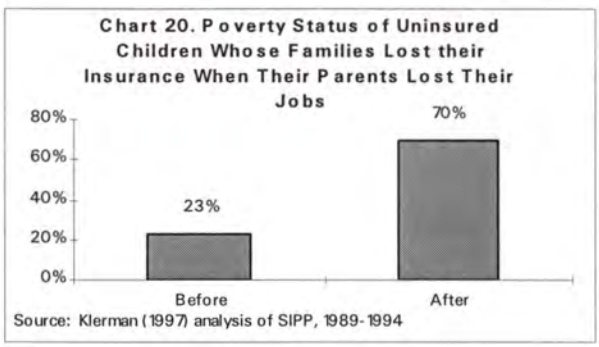
Chart 19. Changes in Family Contribution to Health Coverage for Workers in Small Firsm



Source: Gabel, forthcoming

Individual insurance is an option for families without access to employer-based insurance. Families without access to employer-based insurance may turn to the individual insurance market. About 4 percent of American children are covered by individually purchased insurance policies (U.S. GAO, November 1996). Through insurance agents, associations, or direct marketing, these families can purchase one of a multitude of health benefits packages. The variation in the individual market is huge, since premiums depend on the amount of cost sharing, covered benefits and, in most cases, health status, age, and other sociodemographic characteristics of the individual. This means that a family with a sick child will likely face premiums that are much higher than if obtained through the group market. More importantly, in most states, applicants can be denied coverage based on health status. Insurers in states without guaranteed issue and renewal in the individual market deny nearly 20 percent of applicants (U.S. GAO, November 1996).

Parents cannot afford insurance when unemployed. Affordability is even a greater problem when parents are in periods without work. When looking at uninsured children of unemployed parents, only 20 percent were in poverty when the parents worked while 70 percent were in poverty after the parent lost his or her job (Chart 20). While these periods are usually short-lived, they are problematic because children need preventive and primary care, which may be postponed if there is no insurance, or they may experience a severe illness or injury that could make the family's financial situation even more strained.



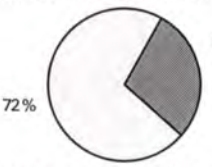
C. PROBLEMS ACCESSING EXISTING PROGRAMS

A third reason why children lack health insurance is that they cannot or do not take advantage of available options. The Federal and state governments have developed programs to help insure children — Medicaid being the largest, single insurer of children. However, many families whose children would be eligible may not enroll in such programs due to lack of information, overly complex programs, or limited funding.

Medicaid and state programs offer coverage to children. Medicaid is the joint Federal-state health insurance program that serves 37 million Americans, including about 20 million children. States are required to cover poor children under the age of 14 (for 1997) and will cover all poor children through 18 by 2002. Additionally, almost all states have used either Medicaid options or state- or privately funded programs to cover older and/or higher income children (see Appendix B).

Many children are eligible but not enrolled in Medicaid. While most poor children are eligible for Medicaid, about three million uninsured children are not enrolled (Chart 21). Researchers estimate that participation rates for Medicaid-eligible children range from about 40 to 70 percent (Summer et al, 1997; Winterbottom et al, 1995). There is no conclusive research on why eligible children without insurance do not enroll in this program which offers free insurance (U.S. GAO, June 1996). Explanations include lack of awareness of the option, the belief that work disqualifies children, and the uncertainty of Medicaid coverage. Families also may be discouraged by complicated eligibility rules.

Chart 21. Nearly 30% of Uninsured Children Are Medicaid Eligible

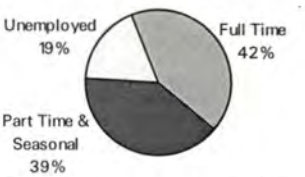


Source: ASPE Analysis of March 1996 Current Pop. Survey

Families lack awareness of Medicaid eligibility. One of the main reasons why children may not be enrolled in Medicaid is that their families do not know that they are eligible. One study that interviewed AFDC recipients — who are or were on Medicaid — found that 23 to 41 percent did not know that their children could remain on Medicaid if they lost AFDC but remained poor (Shuptrine et al., 1994). A study of uninsured people in Minnesota who were eligible for MinnesotaCare (the Medicaid buy-in program for low-income families, described later) found that many were not certain if they were eligible or did not know enough to be able to enroll (Call et al., 1996).

Belief that work disqualifies them. Many workers do not know that their children may qualify for Medicaid so long as their family income is below poverty. In fact, most eligible but unenrolled children do have working parents (Chart 22). However, Medicaid's historical reputation as a "welfare" program may lead families to believe that they are not eligible if they work.

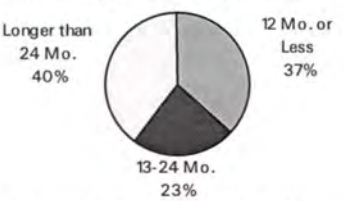
Chart 22. Most Uninsured Children Who Are Eligible For Medicaid Have Parents Who Work



Source: ASPE Analysis of March 1996 Current Population Survey

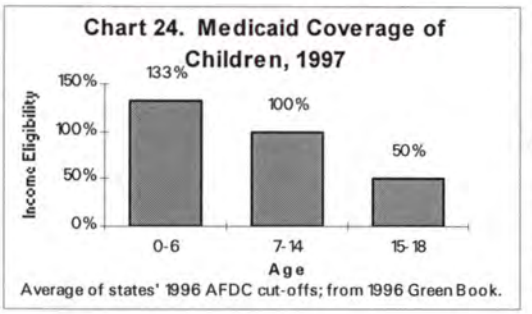
Uncertainty of Medicaid coverage. For a significant number of children, Medicaid coverage does not last long. About 37 percent of children spend less than one year on Medicaid (Chart 23). This may result from the Federal requirement that monthly changes in income or family status that disqualify the child from Medicaid be reported. There appear to be many families whose income regularly rises above and falls below above the poverty line. Over half of children eligible for Medicaid at some point during a 28-month period were not continuously poor (and thus Medicaid eligible) but went in and out of poverty (ASPE, 1997).

Chart 23. Children's Medicaid Coverage Over 28 Months



Source: U.S. Bureau of the Census, SIPP, 1992-1994

Medicaid may not cover all children in a family. Another reason why families may not enroll in Medicaid is its complex eligibility rules. Today, one child in a family may be eligible for Medicaid while another is not. This is because, in poor families, children under 14 years old are eligible while the children 14 years and older are not. And, in families with incomes between 100 and 133 percent of poverty, children below 6 years old are eligible while older children are not (Chart 24).



Average of states' 1996 AFDC cut-offs; from 1996 Green Book.

One consequence of this unevenness in eligibility is that, over time, the number of young, poor uninsured children has decreased while the number of older, poor uninsured children has increased. A study of uninsured children in the South found that between 1989 and 1993, the number of uninsured, poor children ages 0 to 5 declined by over 60 percent for children and nearly 40 percent for children ages 6 to 12. At the same time, the number of uninsured poor children ages 13 to 18 — who were not included in the Medicaid expansion — increased (Shuptrine & Grant, 1996). This inconsistency in eligibility may account for the fact that older poor children are 60 percent more likely to be uninsured than younger poor children (CPS, 1996). If Medicaid eligibility were equalized for children of all ages, about 2 million uninsured children would become eligible for Medicaid.

State programs are limited. State-funded and private programs often experience similar problems in educating families about eligibility. They may also have difficulty attracting families because of limited benefits, limited duration of coverage, and waiting lists. Many programs have "enrollment caps" so that only a certain number of children may be enrolled. Others limit the program's size through restricting where in a state it is offered. According to one study, only about 300,000 children are covered through these programs (Gauthier & Schrodel, 1997).

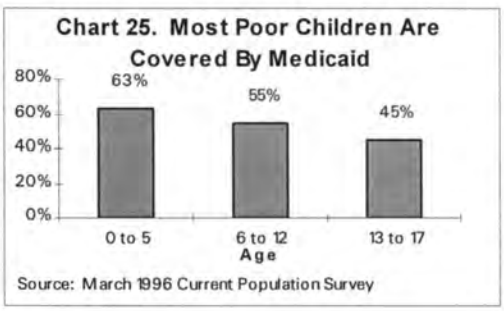
III. LESSONS FROM MEDICAID, STATES AND THE 1990 TAX CREDIT

On the face of it, the problems that come with being uninsured, coupled with many reasons why children are uninsured, seem difficult, if not impossible, to address. However, there is considerable experience in Federal and state health policy that shows how to successfully — and unsuccessfully — expand coverage to children.

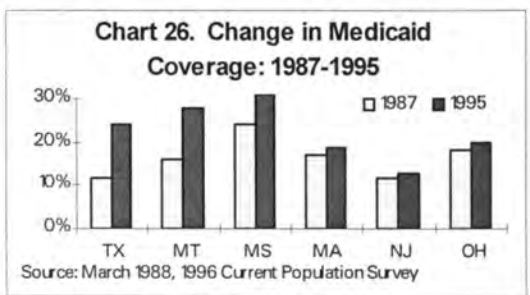
A. MEDICAID

When created in 1965, Medicaid was intended to consolidate spending for the low-income elderly and public assistance recipients into one program. Children were eligible for Medicaid if their family received cash assistance or were income eligible for such assistance. Enrollment of children remained at about 10 million for the first 25 years of the program (HCFA, 1996). Beginning in the mid- to late 1980s, however, changes were made that began de-linking children's eligibility for Medicaid from welfare. A series of bills first offered states the option of covering certain groups of poor children, then required this coverage. This led to OBRA 1990 which made all poor children born after September 30, 1983 eligible for Medicaid.

Millions more children covered. Today, about 20 million children receive Medicaid coverage. In 1995, a large proportion of poor children received Medicaid's basic health protections (Chart 25). It also has been instrumental in keeping the proportion of uninsured children from rising. As seen in Chart 2, the number of uninsured children below 133 percent of poverty has fallen — despite the increase of over 400,000 in the overall number of children in this income range between 1987 and 1995. Had Medicaid not been expanded, millions more children would likely be uninsured today.



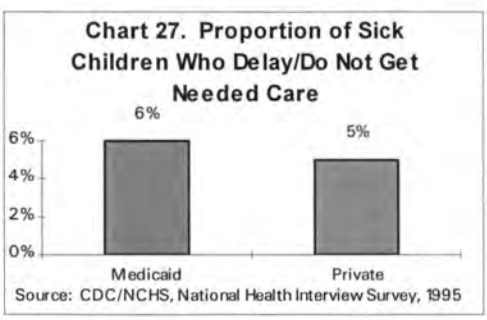
Moves toward a national eligibility "floor" for poor children. Prior to the Medicaid expansion, states varied widely in their Medicaid coverage. States in the South and Mountain regions had much lower Medicaid coverage of children than states in the North East and Upper Midwest (Chart 26). After the expansion, however, the gap in coverage of poor children narrowed by over 20 percent across regions (Shore-Sheppard, 1996). In part, this is because Medicaid was previously linked to welfare, which has very different eligibility levels across states. Moving to a national standard lessened this disparity. Additionally, Southern and Mountain states tend to have more poor children than others. As a result, they had larger expansions since more of their children became eligible.



States' emphasis on outreach. Many states have tried and succeeded in enrolling children eligible for Medicaid through outreach efforts. The Medicaid program has requirements, options, and incentives for states to reach out to eligible but unenrolled children. States have used simplified applications, mail-in applications, no assets test (meaning only income and not assets like cars are counted toward eligibility), annual rather than 6-month redetermination, and outstationed eligibility workers. In New York, for example, there is a single, one-page application for both WIC and Medicaid. In Ohio and Arkansas, coupon books are used as an incentive for families to seek health care: if they receive care, the provider validates the coupon which may be used for discounted baby care and health products (NGA, 1997). Some of the state-funded programs have solicited the help of church groups, parents' groups, and other community-based organizations to educate families about eligibility. One program uses school coaches and shop teachers to promote the program (U.S. GAO, January 1996). These efforts explain why some states have high participation and why Medicaid, in general, has the highest participation rate of all types of public assistance programs (Tin, 1996). However, as described earlier, significant gaps remain.

Has Medicaid "crowded out" private coverage? One question raised about the Medicaid expansion is whether all of the children gaining Medicaid were uninsured before enrolling. Some families, faced with the choice of paying the family share of a premium or enrolling their children in Medicaid, may chose the latter. This substitution of public for private coverage is known as "crowding out". While most researchers acknowledge that the incentive exists, there is some disagreement on the degree to which this occurred (Cutler & Gruber, 1996; Dubay & Kenney, 1995; Shore-Sheppard, 1996; Yazici, 1996). Some argue that, given the relatively low level of private coverage for poor children, this effect cannot be large for this population. However, as income eligibility rises, so does the risk of crowd out.

Medicaid improves access to care. Although Medicaid children do not always have the same access to care that privately insured children do, they are better off than uninsured children on all measures. Only 5 percent of children with Medicaid lack a regular source of care, compared to 20 percent of uninsured children (NCHS, 1995). Whereas 20 percent of uninsured children who are sick delay or do not get needed care, only 6 percent of Medicaid children experience these problems (Chart 27). One study found that children with Medicaid coverage had significantly more preventive care visits than did uninsured children (Gavin & Bencio, 1995). Another found that Medicaid reduced the odds of a child going a year without a doctor's visit by 50 percent (Currie & Gruber, 1996). These access improvements are especially important to children covered by Medicaid since they typically have poorer health than privately insured or uninsured children.



B. STATE EXPERIENCES

In addition to their role in Medicaid, many states have expanded coverage to children through state-funded or private programs. From these experiences, different lessons may be learned. The approach that each state has taken is unique, reflecting its particular problem, availability of funding, and health care system among other factors (see Appendix B). The following is a description of several of the largest programs (in alphabetical order) that have operated for several years and have been evaluated.

Florida

School-based system. The Florida Healthy Kids program uses schools to educate and enroll children in an insurance program. It began as a demonstration in one county and has expanded to 16 counties, with plans to expand further. This program offers comprehensive coverage to uninsured children aged 5 to 19 and, in some counties, their pre-school siblings. Parents pay a sliding-scale premium for the coverage, depending on their child's eligibility for the School Lunch Program. Families with incomes above 185 percent of federal poverty pay the full premium. Services are funded by a mix of state, local public and private funds, and family premiums.

Not displacing private insurance. About 40,000 children are covered through the Florida Healthy Kids program. Almost all of the children were uninsured before enrolling (Chart 28). Of the 7 percent of children who were insured, 94 percent had been on Medicaid. Thus, the program appears to efficiently target uninsured children, not serving as a substitute for existing coverage. This suggestion is strengthened by the short duration of coverage and the reasons why families end enrollment. The average child spends about a year covered by the Healthy Kids program. The main reason why parents disenroll these children is that they gain employer coverage. This implies that the Healthy Kids programs serves as temporary coverage for children and that families prefer private insurance when given the choice.

Chart 28. Previous Insurance Status of Children Enrolled in Florida Healthy Kids

Source: Florida Institute for Child Health Policy

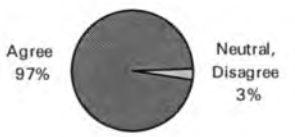
Lower emergency room use. An evaluation of the original demonstration project found that children enrolled in Florida Healthy Kids program were much less likely to use emergency rooms. This use dropped by 70 percent for enrollees in the second year after HMOs were able to educate families about alternatives. It also found that these children's health care utilization more closely resembles that of privately insured than Medicaid covered children (Coulam, 1997). This means that the program is not attracting "bad risks" and is successful at insuring children's without creating excessive demand. The Robert Wood Johnson Foundation is funding other states to create similar programs.

Minnesota

Evolution from a small state program to a large Medicaid expansion. In the late 1980s, Minnesota established the Children's Health Plan that offered subsidized coverage to uninsured children. In 1992, it replaced this program with MinnesotaCare that covers children as well as some uninsured adults. Minnesota uses an 1115 Medicaid waiver to cover children and pregnant women enrolled in MinnesotaCare; the state finances its share of the program through a 2 percent provider tax. MinnesotaCare provides nearly 44,000 children with comprehensive benefits provided through the state's network of Medicaid providers.

Positive attitude toward MinnesotaCare. One of the concerns about publicly subsidized programs is stigma: the negative "welfare" association with such a program that can discourage enrollment. In a study of enrollees of MinnesotaCare, however, researchers found that enrollees felt positive about the program (Lurie et al., 1995). About 85 percent of enrollees responding to the survey felt as though they were treated like anyone else. They also felt good about contributing toward the cost of coverage and agreed that MinnesotaCare is fair price for the benefits (Chart 29).

Chart 29. Almost All Agree that MinnesotaCare is a Fair Price



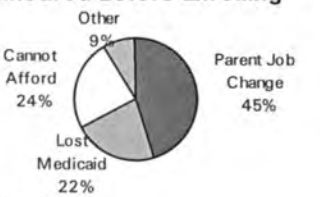
Source: Lurie et al., 1995

New York

Insurer-based children's program. New York's Child Health Plus program began in 1991, and was expanded in June 1996 to cover additional age groups and include inpatient services. Children are eligible for Child Health Plus if they (1) are under the age of 19, (2) reside in New York State in a household having a gross income at or below 222 percent of the federal poverty level, (3) are not eligible for Medicaid, and (4) do not have equivalent health coverage. In September 1996, about 110,000 children were enrolled in Child Health Plus. This is the largest state program; the funding appropriated for 1997 is $109 million. The program is funded by the Statewide Health Care Initiatives Pool as well as from premium contributions from families.

Fills important gaps in insurance coverage for children. An evaluation of the Child Health Plus program found that the program filled an important, unmet need. Most of the children enrolled in the program had become uninsured because their parents lost or changed jobs; others lost Medicaid or could not afford private coverage (Chart 30). Enrolled children also had significant improvements in access and quality of care. For example, parents of children with asthma reported that their children received more primary and specialist visits and their health had improved (Szilagyi et al., 1996).

Chart 30. Reasons Why NY Child Health Plus Enrollees Became Uninsured Before Enrolling

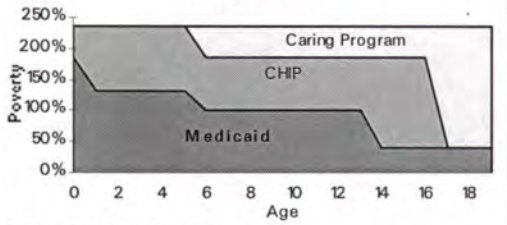


Source: Szigalyi et al., 1996

Pennsylvania

Seamless health coverage for children. One of the earliest state programs for children developed in western Pennsylvania. In 1985, steel mills in that region shut down, leaving many children and their families without insurance. In response, the Western Pennsylvania Caring Foundation was created by local ministers in cooperation with Blue Cross of Western Pennsylvania. It began by providing only preventive and primary care, but today provides comprehensive coverage. Pennsylvania now has a three-tiered, comprehensive, seamless insurance program for children (Chart 31). The first tier is Medicaid, which covers poor children. The second is the Children's Health Insurance Program (CHIP), funded by a dedicated two-cent state cigarette tax and administered by the Caring Foundations. Third, the Caring Program subsidizes children who fall between Medicaid and CHIP eligibility and 235 percent of poverty. The Caring Program is funded by Blue Cross / Blue Shield and private donations. Currently, about 50,000 children are enrolled in these programs and there is a waiting list of 5,000 children.

Chart 31. Eligibility for Pennsylvania's Children's Health Programs



Source: Pennsylvania program data

Importance of coverage to families. The Caring Program, CHIP and Medicaid have made measurable improvements in the lives of children and their parents. A survey found that three out of four parents of uninsured children postponed receiving care for themselves, saving their money for their children. These parents also were likely to restrict their children's activities, such as bicycle riding and playing ball, for fear that they would get hurt. The children themselves had considerable unmet needs. One-fourth of new enrollees needed to see a doctor for untreated illnesses like asthma, bronchitis, and diabetes. Over 40 percent needed dental care, and nearly 20 percent needed glasses (Lave et al., forthcoming). This program served as a model for Blue Cross / Blue Shield who have helped create Caring Programs in 25 states. About 50,000 children are enrolled nationwide (BCBS, 1997).

C. 1990 CHILD HEALTH TAX CREDIT

The tax system offers an alternative to state administration of subsidies for health coverage. Today, most insured Americans benefit from preferential tax treatment of health insurance. Extending deductibility of health insurance or creating a tax credit for children's health coverage could encourage some families to insure their children.

The use of child health tax credits was tried in 1991 to 1992. The Omnibus Budget Reconciliation Act (OBRA) of 1990 included a tax credit for health insurance that covers children. It was a supplement to the earned income tax credit (EITC). An EITC-eligible family could receive a tax credit for its health insurance premium payments if its plan was not an indemnity type and included coverage for children. It was administered as an end-of-the-year credit against taxes or refund if it exceeded the family's tax liability. Unlike the EITC, it could not be received in "advances". About 2.3 million families received the health tax credit in 1991 at a cost of $496 million.

This health insurance credit was repealed in OBRA 1993. Following two years of experience, this health insurance supplement to the EITC was repealed in OBRA 1993. The Treasury Department recommended its repeal because it was difficult for the Internal Revenue Service (IRS) to efficiently and accountably administer the credit. For example, the IRS could not determine whether a health insurance plan met the eligibility criteria for the credit. The only information that the tax payers reported to the IRS was the amount of the premium paid and (in 1991 only) the name of the insurance plan. The IRS could not verify this information since there were no reporting requirements for insurers. A Congressional oversight committee study found that families often bought ineligible policies like cancer and dread disease policies and policies with two-year pre-existing condition restrictions. The IRS could not prevent this.

A second problem was low participation. The GAO (1994) estimated that only 26 percent of the people eligible for the credit received it. Of those who received it, it is not clear how many, if any, of these families had previously been uninsured. However, given the low subsidy (the average credit was $233) it is unlikely that it served as a great incentive for many uninsured families to purchase coverage.

D. COBRA and HIPAA.

Several policies have been enacted to increase access to employer-based insurance for families who are between jobs. In 1985, the Consolidated Omnibus Budget Reconciliation Act (COBRA) required employers with 20 or more employees to allow former employees and their families to buy into their health insurance plan for up to 18 months at their group rate (but without an employer contribution plus an additional 2 percent for administration costs). This is intended to give these families an alternative to the expensive nongroup health insurance market. Further, in 1996, the Health Insurance Portability and Accountability Act (HIPAA) limited preexisting condition exclusions and other practices that bar children from re-entering group insurance when their families change jobs. Both policies are intended to maintain access to employer-based insurance for families with workers between jobs. COBRA appears to have made a difference (Flynn, 1992; Klerman, 1992) but with HIPAA, it is too early to tell.

IV. CONCLUSION

The lack of insurance for millions of American children is clearly a problem. About 10 million American are uninsured during the year, 20 million over the course of 28 months. These children have difficulty accessing the United States' health care system. This lack of access may contribute to the relatively low standing of the U.S. in international comparisons. We rank lower than 29 nations on immunization rates and 21 nations in both infant mortality and the probability that an infant will die before reaching the age of 5 years old.

Yet the cause of the problem is not simple. American children receive health coverage through a fragmented system of employer-based coverage, individually purchased coverage, Medicaid, state programs, the public safety net and philanthropy. Employer-based insurance is the primary source of coverage, so it is not surprising that most coverage loss relates to changes in employment. The dynamic U.S. economy has caused shifts of employment to firms that typically do not offer coverage: small business, service jobs, and part-time work, for example. Yet, even if they have access to employer-based insurance or individual market insurance, families may not be able to afford it. Family premiums have rapidly risen, as has the share of the premium paid for by the family. And, simply navigating this complex system to find affordable options is a challenge to many. Millions of uninsured children have the opportunity to be covered through public or private programs but do not take advantage of it.

There is no easy solution. The complexity of the reasons why children lack insurance, along with the fragmented system that tries to remedy this, make it difficult to design solutions. It may be the case that, in the absence of a requirement that every employer and/or family purchase health coverage, the problem cannot be completely solved. However, past and present experiences provide ideas on how to design, implement and operate initiatives that can make significant improvements in coverage for children.

Lessons from Medicaid and state-funded programs. Through Medicaid, state-funded, and private programs, states have expanded coverage to children. Beginning in 1990, states began to phase in nationwide eligibility for Medicaid for poor children. This has resulted in a more uniform, national "floor" of coverage for children, especially in the South, where eligibility through welfare has historically been low. As a result, millions of the most vulnerable children have seen their access to health care improve. States have also demonstrated that they can efficiently target coverage toward the children who need it. Pennsylvania has been able to coordinate its Medicaid, state-funded, and private efforts to most efficiently create seamless coverage for children. In Florida, the Healthy Kids program appears to be filling an important need while not substituting for existing coverage. We have also learned from the state experiences that funding is a major barrier; most of the programs are quite small.

Lessons from tax credits and insurance reform. The Federal government has tried using tax credits in 1991 and 1992 to encourage low-income families to purchase coverage for their children. However, this attempt was aborted given oversight problems and low participation. Some of the reasons for the failure could have been addressed with policy changes. For instance, some type of state certification of health plans eligible for the credit could have limited the mistaken purchase of substandard plans. However, the experience raises serious questions about whether the tax system is the best system to run coverage programs, and whether it can successfully encourage families to cover their children. Similarly, COBRA and HIPAA serve important roles in assuring coverage options, but extending them as currently structured may not be the best way to improve children's coverage.

Translating lessons into laws. The President and the Congress have agreed that additional funding for children's health insurance coverage is needed. Balancing the budget is critical to our children's future. So, too, is investing in children's health coverage so that they will be able to take full advantage of that future. This priority is reflected in the Balanced Budget Agreement, which dedicates $16 billion between 1998 and 2002 to expand health coverage for children. This amount represents a meaningful commitment toward covering up to 5 million uninsured children. The following policies, drawn from past experiences, may assist in achieving this goal.

Meaningful coverage. Despite their critical contributions, public providers alone cannot ensure that children receive the range of benefits that they need. The statistics suggest that uninsured children, even those with access to safety net providers, do not get all the care required for a healthy childhood. New policies should build on the safety net, but also ensure that children receive meaningful coverage.

Building on Medicaid. States have successfully used Medicaid to cover millions of uninsured children. This success could be extended by giving states options and incentives to expand coverage. For example, states could be encouraged to accelerate the phase-in of coverage for poor children under 19 years old. They could be given higher matching rates for going beyond today's eligibility levels. Administrative flexibility might also increase states' interest in extending Medicaid coverage to children.

State programs to target hard-to-reach children. States have considerable experience in designing and implementing children's health programs. Given flexibility, they could target meaningful coverage to those pockets of uninsured children who may otherwise lack affordable options. For example, children whose parents are in between jobs are at particular risk of losing their coverage. States are in the best position to identify and assist such children. States have also demonstrated that they are interested in expanding coverage to children, with over 15 states proposing expansions this spring. This interest should be harnessed through policies such as grant programs.

Affordable insurance for small businesses. Many small employers want to offer health insurance to their workers and their families but cannot afford it. The power of group purchasing should be extended to small businesses in a way that assures affordability as well as consumer protections. For example, voluntary purchasing cooperatives allow small businesses to collectively negotiate for affordable insurance. These cooperatives have been tried and have succeeded in several states, such as California and Wisconsin. Similar approaches could be encouraged nationwide through grants to states.

Education and outreach for existing options. Finally, families should be educated about existing option. The best programs are meaningless if unused. States have shown how families can be made aware of their options and successfully enrolled in insurance programs. Schools are a natural place to educate children and their parents about affordable coverage. Simplified enrollment processes, telephone hot-lines, and media campaigns also appear to work.

Many of these ideas are in the President's budget and Congressional proposals currently being considered. Regardless of the particular approach, the complexity and magnitude of the problem of 10 million uninsured American children should serve as a challenge, not a barrier, to designing policies that aggressively, carefully, extend coverage to these children.

APPENDIX A. HEALTH CARE SAFETY NET FOR CHILDREN

The nation's health care provider safety net consists of hospitals, ambulatory care facilities, and other providers who offer care to all regardless of their ability to pay. They operate under both public and private auspices. As a group they are diverse, with varied funding sources which include Medicaid and Medicare, Federal grant support, state and local public funding, a limited amount of private third party insurance, patient fees (often sliding scale), and private philanthropy.

Federal support for safety net providers of particular importance to uninsured children includes:

- The Maternal and Child Health Block Grant The Maternal and Child Health Block Grant is funded at $681 million in FY 1997. Of this amount, $565 million is allocated to States on a formula based on FY 1981 levels of funding for related activities and the relative number of low income children in the State. States must match Federal funds at the rate of three State dollars for every four Federal dollars. They must earmark at least 30 percent of their Federal allotment for preventive and primary care for children and at least 30 percent for children with special health care needs. States use these earmarked funds in a variety of ways: they may provide services directly, award funds to counties and other sub-state units for the direct provision of services, or purchase services either directly or through contract with individual providers, professional groups or health care institutions. In addition to primary and preventive care, services provided through these funds can include enabling services, including outreach, case management, transportation and translation and population-based services such as newborn screening and lead paint screening Approximately 17 million women, infants, children, adolescents and children with special health care needs receive services of some type through this program.

- Community Health Centers (CHCs) The Federal appropriation for health centers for FY 1997 totals $802 million. Funds support community health centers, migrant health centers, health centers for the homeless, health centers in and near public housing and the school health centers funded under the umbrella Healthy Schools, Healthy Communities. Federal grants represent about 30 percent of CHC funding: other funding sources include Medicaid; Medicare; other third party payers; patient fees, which are on a sliding scale, and State, local and other sources of funds. On the average, Federal grant funding per CHC user is approximately $100 for a comprehensive package of primary care and preventive health services. In FY 1995, approximately 42 percent of health center patients were uninsured. Approximately 44 percent of the FY 1997 estimated 8.3 million CHC users are children through age 19.

- The Indian Health Service (IHS) funds the delivery of health care to 555 federally recognized Indian tribes and 34 urban health projects located in 35 States. Its FY 1997 appropriation totals $2.054 billion. Care is provided through 49 hospitals, 195 health centers, 8 school health centers, and 289 health stations, satellite clinics, and Alaska village clinics which are administered either by the Tribes or directly by the IHS. Of the 1.3 million active users of the system, about 43.8 percent are children through age 19. The IHS collects payments from those it serves who are insured through Medicaid, Medicare or private insurance, but provides care without charge to those without insurance.

- Federal Disproportionate Share Hospital Payments/Hill Burton Uncompensated Care Obligations Federal funds help to subsidize hospital costs for uncompensated care for uninsured children are provided through payments to States under the Medicaid Disproportionate Share Hospital (DSH) program. It is estimated that Federal payments will total $9.8 billion in FY 1997 for this purpose. Hospitals which received construction funds through the Hill Burton Act are required to provide a reasonable volume of support for persons unable to pay for services for a 20 year period. In FY 1996, approximately 1650 institutions had such obligations. They provided approximately $700 million in care to about 2 million individuals. The number of obligated facilities is decreasing: by 2000, fewer than 700 institutions will have Hill-Burton obligations.

- Childhood Immunization The Vaccines for Children (VFC) program provides for the purchase of vaccines for all children who are uninsured, those eligible for Medicaid, Native American children, and for those children whose insurance does not cover immunization who receiving care through Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). Vaccines are now provided to private providers at 28,000 sites with multiple providers and to approximately 9,000 public clinics in addition to FQHCs and RHCs. Expected expenditures in FY 1997 for VFC are $373 million.

Much of the care delivered to children through the safety net is provided by public health clinics and children's hospitals. Public health clinics operated by the State, county, or local municipality are a significant source of ambulatory care for uninsured children. Freestanding children's hospitals represent only one percent of all hospitals but are a particularly important source of care for uninsured children. Most children's hospitals are affiliated with academic institutions. Roughly half of the care they provide is to poor children and three quarters of their care is to children with chronic or congenital conditions. In FY 1995, they were responsible for 4.6 million primary and specialty outpatient visits, over 1.6 million emergency department visits, and 2.1 million inpatient days, with gross patient revenues of $7.8 billion. On average, 42 percent of the care they provide is to Medicaid children, an additional 5 percent is to uninsured children.

APPENDIX B: STATE HEALTH COVERAGE PROGRAMS FOR CHILDREN

State	Uninsured under 19	Medicaid Expansions	Public or Private State Program	State Funds?	Current Enroll-ment
AK	19,000	None	None		
AL	193,000	None	Alabama Caring Program for Children	No	6,353
AR	129,000	*ARKids First (proposed): 0-18: 200%*	None		
AZ	248,000	Infants: 140%			
CA	1,775,000	Infants: 200% 13-19: 100%	Access to Infants and Mothers (AIM) CaliforniaKids (Caring Program)	Yes No	8,600 (AIM) 8,500 (CalifKids)
CO	125,000	None	Child Health Plan School Connections Caring Program	Yes	6,200 (CHP) New 3,500 (CP)
CT	85,000	0-13: 185%	Healthy Steps	Yes	
DC	25,000		None		
DE	22,000	Infants: 185% 13-19: 100%	None		
FL	652,000	Infants: 185%	Florida Healthy Kids Program	Yes	36,000
GA	319,000	Infants: 185% 13-19: 100%	Caring Program for Children	No	900
HI	24,000	0-19: 300%			
IA	92,000	Infants: 185%	Caring Program for Children	Yes	2,000
ID	49,000	None	Caring Program for Children	No	490
IL	344,000	None	None		
IN	184,000	Infants: 150% *Proposed: 13-18: 100%*	None		
KS	82,000	Infants: 150% 13-17: 100%	Kansas Caring Program for Children	Yes	2,700

State	Uninsured under 19	Medicaid Expansions	Public or Private State Program	State Funds?	Current Enroll-ment
KY	139,000	Infants: 185% 13-19: 100%			
LA	268,000	None	Caring Program for Children	No	375
MA	140,000	Infants: 185%	Children's Medical Security Plan	Yes	33,000
MD	158,000	0-13: 185% (primary and preventive care only)	Kids Count (Caring Program for Children) *Proposed: Thriving by Three*	No *Yes*	1,300
ME	40,000	Infants: 185% 6-19: 125%	None		
MI	235,000	Infants: 185% 6-15: 150%	Caring Program for Children	Yes	4,650
MN	85,000	0-21: 275%			
MO	155,000	Infants: 185% 13-19: 100% *Proposed: 0-18: 300%*	Caring Program for Children	No	5,500
MS	146,000	Infants: 185%	Caring Program for Children (Discontinued)	No	860
MT	29,000	None	Caring Program	Yes	1,400
NC	221,000	Infants: 185% 13-19: 100%	Caring Program	Yes	5,500
ND	16,000	13-18: 100%	Caring Program for Children	No	450
NE	47,000	Infants: 150%	None		
NH	31,000	0-19: 185%	Healthy Kids	Yes	1,600
NJ	243,000	Infants: 185%	Health Access New Jersey	Yes	5,800
NM	137,000	0-19: 185%	None		
NV	76,000	None	None		

State	Uninsured under 19	Medicaid Expansions	Public or Private State Program	State Funds?	Current Enroll-ment
NY	627,000	Infants: 185%	New York's Child Health Plus Program	Yes	110,500
OH	317,000	*Proposed: 0-18: 150%*	Caring Program for Children (Closed to new participants)	No	2,680
OK	216,000	Infants: 150%	Oklahoma Caring Program for Children	No	760
OR	109,000	13-19: 100%	None		
PA	323,000	Infants: 185%	Pennsylvania's Children's Health Insurance Program and Caring Programs for Children	Yes	50,000
RI	28,000	0-7: 250% *Proposed: 0-18: 250%*	RiteCare (1115)		
SC	157,000	Infants: 185% Proposed: 0-19: 133%	None		
SD	23,000	13-19: 100%	Caring Program for Children	Yes	370
TN	182,000	Infants: 185% 13-18: 100%	None		
TX	1,347,000	Infants: 185%	Caring Program for Children	No	
UT	72,000	13-18: 100%	Caring Program for Children	No	1,100
VA	204,000	13-19: 100%	Medical Care for Children Partnership *Proposed: Virginia Children's Medical Security Insurance Plan*	Yes (county)	4,000
VT	13,000	0-18: 225%			
WA	141,000	0-19: 200%			
WI	98,000	0-5: 185%	None		
WV	60,000	Infants: 150% 13-19: 100%	Caring Program	Yes	149
WY	22,000	Minimum	Caring Program	No	400

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Technical note on CPS analysis:
Many parents report that their children had more than one type of health coverage during the year. Children were sorted into these categories by the following rules; any child with private insurance and some other type of coverage was classified as "private & other"; any child with Medicaid and was uninsured is classified as Medicaid, and other children without any coverage were classified as uninsured.

Charts about parents' employment consider the work status of the family adult. The family adult is the household adult with the most complete work history for the year--the work history closest to being full year/full time. Those classified as non-working did not work during the year.

A third option for the states is the creation of private-public initiatives patterned after the Caring Programs for Children, charitable foundations set up by Blue Cross Blue Shield Associations in 24 states. Some states contribute their own funds to the programs, which have a combined enrollment of 60,000 kids.

A fourth option states have is to use the block-grant funds to provide direct health services to children, such as immunizations and well-child care. But the budget agreement forbids states to use more than 10 percent of such funds for non-coverage purposes a clause demanded by those who feared that financially strapped states would use the money for unrelated purposes.

House Overwhelmingly Approves Spending Reduction Bill (Washn) By Sam Fulwood III (c) 1997, Los Angeles Times

WASHINGTON Moving with unusual dispatch and fending off token opposition, the House Wednesday approved legislation that trims projected federal spending by at least $130 billion over five years in an effort to balance the budget by 2002.

Voting 346-85, lawmakers overwhelmingly approved the massive measure, which primarily targets Medicare. The Senate debated the package late into the evening, but put off an actual vote until Thursday.

As in the House, it is expected to pass easily following agreement on its details earlier this week among congressional negotiators and the Clinton administration.

After dispatching the spending side of the budget package, Congress will turn full attention to a companion budget measure providing an estimated $94 billion in tax reductions over the next five years. Top officials on Capitol Hill predicted a House vote late Thursday and Senate consideration Friday, with passage virtually assured.

``I am proud to inform the American people that our democratic process, something that has been maligned in recent years, is working," Rep. Gerald Solomon, R-N.Y., declared as the House opened debate on the spending bill. ``Congress, working with the administration, can achieve fundamental goals."

Rep. John Kasich, R-Ohio, chairman of the House Budget Committee and a key budget negotiator, said: ``What this bill really represents is the dawning of a new era. (It's) an era where we begin to recognized the limits of government. This is a program that puts power in people's pockets by reducing the size of government."

House Majority Whip Tom DeLay, R-Texas, made a point of praising the president. ``You have to give President Clinton some credit, he's rejected the left wing of his party," he said.

While a few liberal House Democrats fretted over the fast-tracking of the budget bills, dissent was limited as lawmakers seemed intent on leaving Washington by Friday evening for a month-long recess with a political trophy to show constitutents back home.

In Thursday's House debate, opposition speeches were more political play-acting than a real threat to the bill. Supporters, meanwhile, rose one after another to defend the legislation and praise negotiators for reaching agreement without the rancor that had marked previous budget battles between the Republican majority in Congress and the Clinton administration.

A majority of members in both major parties supported the spending bill 193 Republicans and 153 Democrats. Voting against it were 52 Democrats, 32 Republicans and the House's single independent, Rep. Bernard Sanders of Vermont.

The most notable Democrat opposing it was House Minority Leader Richard Gephardt, D-Mo., who has denounced the balanced-budget agreement as a short-sighted bid for political dividends that will hurt the American people in the long run. His stance should be a key issue if he follows through with a contemplated bid for the Democratic presidential nomination in 2000 against Vice President Al Gore.

The spending bill accounts for most of its savings through a $115 billion reduction in projected spending for Medicare, the health program that benefits elderly Americans and the disabled. The reduction is achieved largely by reining in reimbursements to hospitals and other health-care providers.

The measure orders another $140 billion cut from unspecified other programs over the next five years, while postponing the decision on precisely what will be trimmed.

At the same time, the legislation calls for a $24 billion expansion of health care coverage of children, allowing individual states to set up the their own programs. The child-health program is expected to cover up to half of the nation's 10 million uninsured children and is to be paid for by a 15-cent increase on the per-pack cigarette tax.

While Clinton and congressional leaders have touted their bipartisian approach to this year's budget neg[illegible] much or more credit should go to the unexpecte[illegible] economy that reduced the deficit at a faster than [illegible] allowed Democrats to have increased spending on s[illegible] programs while allowing Republicans to win approva[illegible] cuts.

Some House Democrats said they could not support[illegible] package, despite the generous outlays for programs su[illegible] insurance program. Indeed, at the onset of the debate, a g[illegible] Democrats tried to stop the scheduled vote, arguing they n[illegible] time to study the provisions.

``What's the rush?" said Rep. Marcy Kaptur, D-Ohio. Addressin[illegible] GOP leaders, she added: ``Are you afraid the American people might actually find out what's in the bill?"

Rep. Henry Waxman, D-Calif, said, ``We are talking about a flawed bill that the administration tried to make better. But a flawed bill is still a bad bill."

Other critics complained that Congress is unlikely to cut veterans, education, nutrition and other politically sensitive programs that they said will require future spending reductions to get a balanced budget in 2002.

``This is an Alice in Wonderland budget process," said Rep. Peter DeFazio, D-Ore.

Tobacco Executives Stand to Reap Big Gains from Truce, Report Says By Myron Levin (c) 1997, Los Angeles Times

Top tobacco executives personally stand to gain more than $200 million in stock option profits if Wall Street remains enthusiastic about the giant tobacco truce as most analysts predict, a report issued Wednesday said.

The biggest winner would be Geoffrey C. Bible, Philip Morris chairman and chief executive whose stock options could grow in value by $72.9 million, according to the report by the Institute for Policy Studies, a liberal think tank based in Washington, D.C.

Two other Philip Morris executives would see the value of their options rise more than $20 million apiece, while Nabisco Chairman Steven F. Goldstone and UST Chairman Vincent A. Gierer Jr. could profit by $8.4 million and $6.7 million, respectively, the report said. Stock options allow executives to buy shares in their companies at below-market prices and profit from the higher current price of the stock.

The report did not take a stand on the $368.5 billion tobacco accord, which if ratified by Congress will restrict future legal claims against the industry in exchange for big settlement payments and an array of public health concessions.

But Sarah Anderson, a fellow at the institute, said the results should ``raise some warning flags."

The executives head ``an industry that has caused a lot of deaths and health problems," she said, and the settlement should be ``about improving public health and not about lining the pockets of these executives."

However, tobacco officials said raising the stock price of their companies is what executives are paid to do.

``Any time a stock moves up, all of the company's shareholders benefit ... and that obviously includes management shareholders," said Jason Wright, spokesman for RJR Nabisco Holdings, owner of R.J. Reynolds Tobacco. ``To try to single out any class of shareholders is just plain silly."

Another industry spokesman, who declined to be identified by name, said the analysis is based on various assumptions that may or may not come true. This is ``speculation about a future that can't be known," he said.

Wall Street has reacted favorably to the tobacco truce, bidding up tobacco stock prices about 15 percent between April 1, when peace talks began, and June 20, when the deal was announced.

Although cigarette price increases required to fund the deal are likely to cut sales and profits, the cigarette makers would benefit from greater predictability and reduced legal vulnerability. Therefore, the companies and most financial analysts are expecting share prices to climb briskly in the next 12 months if Congress approves the deal.

Using proxy statements filed with the Securities and Exchange Commission, the report estimates that rising share prices will create a jackpot of $206 million for 15 executives who between them hold nearly 12.4 million stock options five each from Philip Morris, RJR, and UST, the top manufacturer of smokeless tobacco

Executives from three other cigarette companies were not included: Brown & Williamson because its British parent, BAT Industries, does

[redacted]stly in individual $1,000 checks and money
[redacted]e from members from a Buddhist sect, Cardozo

[redacted]nary," he said of the bundle that Trie unveiled in
[redacted]nce room of his law office.
[redacted]w of the money immediately disqualified about
[redacted]l not satisfy various trust fund guidelines, Cardozo
[redacted]ing $380,000 from 409 donors went into a lock box
[redacted]k.
[redacted]es decided to put Trie's checks in an interest-bearing
[redacted]nile they investigated them. Cardozo said they did not accept
[redacted]oney but merely held onto it during their review.

Meeting with Mrs. Clinton on April 4, Cardozo testified that the first lady was somber, having just returned from a memorial service for Commerce Secretary Ron Brown, who died in a plane crash. To lighten the occasion, Cardozo said he told Clinton that he had good news and bad news. The bad news was that the first couple's legal expenses were $1.5 million. The good news was that someone had just brought in $460,000 in checks to the defense fund.

Cardozo then asked Clinton if she could guess who it was. She could not, and even when Cardozo mentioned Trie by name she needed prompting before she remembered him as the proprietor of a Little Rock restaurant where her husband often ate lunch when he was governor of Arkansas, Cardozo testified.

Cardozo said the first lady urged the trustees ``to be vigilant" about the donations. Deputy White House Chief of Staff Harold Ickes was also at the meeting but reportedly said nothing, even though Trie was organizing a fund-raiser for Clinton.

Later in April, Trie met with Cardozo again. This time he was carrying a large shopping bag.

``Oh, my God, he's got a million dollars this time," Cardozo recalled thinking. Trie told him it was actually $179,000 in checks and money orders. Included in the bag were novelty items from Asia that Trie wanted help in marketing.

Cardozo said he turned down the second batch of contributions. Trie would later return with $150,000 more for the fund, which officials also refused to accept.

On May 9, Cardozo briefed various White House aides about the money from Trie but did not solicit their advice.

By this time, the fund had also launched its own investigation of the donations delivered by Trie. But investigators were instructed not to interview Trie. ``Mr. Trie represented himself as a friend of the president. I didn't want to launch a full-scale background investigation on him," Cardozo said.

On Thursday, the committee will hear the investigators' account of their probe.

Cardozo said his group ultimately decided to reject all the Trie-related contributions because of the unique circumstances under which they were delivered. Fund officials had concerns that the funds had been raised through coercion at meetings of the Ching Hai Buddhist sect and questions about whether some of the money had been advanced by the Buddhist group.

Not wanting to appear as if they were discriminating against Asian Americans or a particular religious group, trustees decided not to publicly disclose the rejection, Cardozo said.

Expansion in Health Care for Kids Seen as Major Victory (Washn) By Edwin Chen(c) 1997, Los Angeles Times

WASHINGTON In the largest expansion of health care for children since Medicaid's creation in 1965, Uncle Sam is about to hand the states $24 billion to cover up to half of America's 10 million uninsured kids. But most states are already a step or two ahead of Washington.

Using a variety of approaches, most notably broadening Medicaid eligibility, nearly every state has extended coverage to children of working, but low-income families in recent years.

That collective effort is a largely unrecognized, if modest success story: Even as the ranks of uninsured adults continue to swell inexorably, the number of uninsured children has remained stable, with about one in seven lacking coverage.

The impending flow of federal largesse to the states over the next five years part of the budget bill the House approved Wednesday and the Senate is expected to pass Thursday means millions of children will enjoy medical insurance, many for the first time in their lives. The children's health-care coverage is to be financed in part by an increase in the federal cigarette tax.

And while a dispute persists over just how many children will actually receive meaningful coverage, the expansion in health care for kids was hailed Tuesday by children's advocates as well as the nation's governors, who will be charged with devising ways to reach the uninsured children.

``This historic investment in children's health is a major victory for America's children and working families," said Marian Wright Edelman, president of Children's Defense Fund.

``This is cause for some serious celebration," added Dr. Irwin Redlener, a New York physician and longtime children's advocate.

And in a statement issued in Las Vegas, site of the 89th annual meeting of the National Governors' Association, Nevada Gov. Bob Miller and Ohio Gov. George V. Voinovich, the group's chairman and vice chairman, praised Congress and President Clinton for ``giving states the ability to build on their successes in designing health insurance programs that meet the unique needs of their states."

The enthusiasm of children's advocates, however, was tempered by the realization that the few-strings-attached block grants to the states will result in a hodgepodge of programs with different eligibility standards and different benefits packages depending on which state a child lives in and perhaps even which region within that state.

Children's advocates also fear the ``substitution effect" the likelihood that at least some employers will stop covering their workers' dependents after new health-care programs for children are created.

But such ``crowding out" is likely to be minimal since most low-paying jobs do not come with health insurance as a fringe benefit in the first place, argued Sen. John D. Rockefeller IV, D-W.Va., another champion of children's health care.

``We want every child in America to grow up healthy and strong, and this investment takes a major step toward that goal," a buoyant President Clinton declared at a White House South Lawn ceremony Tuesday afternoon.

``By investing fully $24 billion, we will be able to provide quality medical care for these children, everything from regular check-ups to major surgery," he added. The president asserted that ``up to 5 million" uninsured children will get coverage.

States face a limited range of options when it comes to extending health care to uninsured children the foremost being the expansion of Medicaid eligibility, although that seems an unlikely route this time around for most states.

In the 32 years since Medicaid was created, 39 states have significantly expanded eligibility for pregnant women and children beyond federal requirements. Between 1989 and 1993, for instance, 5 million children were brought into Medicaid, a joint federal-state health insurance program for certain categories of the indigent.

In all, 34.2 million people, about half of them children, are enrolled in Medicaid.

Most states have extended coverage to uninsured children by expanding Medicaid in part because the program provides comprehensive benefits and relies on existing administrative and reimbursement systems. But this option has proven costly for the states.

That is why governors have increasingly sought greater leeway in setting their own state's benefits package a demand that emerged in bold relief during the recent budget talks.

That desire for greater flexibility is precisely what has prompted many states to extend coverage to children not by expanding Medicaid but by using their own funds to contract with managed care providers to deliver services directly to children who are ineligible for Medicaid, either because of age or family income.

Such arrangements allow states to avoid the array of federal mandates that come with Medicaid thus allowing states to, for example, offer a limited benefits package and even require co-payments and premiums, based on a sliding scale. In addition, such flexibility allows states to test pilot programs that involve as small an area as a county, health care experts said.

Still another benefit of the non-Medicaid approach is that it is easier to enroll children in a program that does not carry the social stigma some attach to Medicaid. (About 3 million uninsured, Medicaid-eligible kids are not enrolled in the program.)

Among the most successful of such approaches are the Florida Healthy Kids program, which uses schools as the administrative base, and the Massachusetts Children's Medical Security Plan, which provides preventive care to children under 19.

Even so, Healthy Kids covers only 18,000 kids, leaving 655,000 Florida children still uninsured, according to the National Conference of State Legislatures. Similarly, the Children's Medical Security Plan covers only 27,000 kids, leaving some 126,000 Massachusetts children uncovered.

Lissa / David FYI

The Balanced Budget Delivers Real Tax Relief for America's Families

How Typical American Families Will Benefit

Example #1 -- Family of Four with income of $40,000

Consider a family of four with an income of $40,000 a year. The father is a carpenter who makes $25,000, and the mother works at a local department store and makes $15,000. They have two children, a son who is 14 and a freshman in high school and a daughter enrolled full-time in her first year at a state university. Her tuition is $5,000 a year.

This family benefits from the tax cut in at least two ways. They will receive a child tax credit of $500 for their son, plus a HOPE Scholarship of $1,500 for their daughter. In total, they will receive a $2,000 tax cut.

Tax Cut

Family of four with two children
aged 14 and 18 and $40,000 income:

Child Tax Credit for 14 year old	**$500**
HOPE Scholarship for 18 year old	**$1,500**

Total tax cut:	***$2,000***

* Tax Year 1999

The Balanced Budget Delivers Real Tax Relief for America's Families

How Typical American Families Will Benefit

Example #2 -- Family of Three making $55,000

Consider a family of three making $55,000 a year. The father has a degree in accounting and works for a local business in the accounting department. The mother works part-time at the local library. They have one daughter aged 7. The father would like to return to school to prepare for his CPA examination. He is going to attend the local liberal arts college. He has signed up for two courses with total tuition of $4,000.

This family will receive a $500 child tax credit for their daughter and an $800 tuition tax credit to help pay for the father's course work.

Tax Cut

Family of three with one child aged 7 and $55,000 income:

Child Tax Credit for 7 year old	$500
Tuition tax credit	$800

Total tax cut:	**$1,300**

* Tax Year 1999

The Balanced Budget Delivers Real Tax Relief for America's Families

How Typical American Families Will Benefit

Example #3 -- Family of Three making $80,000

Consider a family of three making $80,000 combined. They have a daughter who is 17 years old and is trying to decide where to go to college. She is leaning towards a private liberal arts school. Her parents are staring at tuition payments in excess of $10,000 a year for four school years and wondering how they will pay for it.

This tax cut will help. Their daughter will be eligible for a $1,500 HOPE Scholarship in each of her first two years in college. During her junior and senior years, she will be eligible for a tuition tax credit of $1,000. (because four school years fall across five tax years she will be eligible for another $1,000 in the fifth year).

Year	Tuition Tax Credits
1998	$1,500 Hope Scholarship
1999	$1,500 Hope Scholarship
2000	$1,000 Tuition Tax Credit
2001	$1,000 Tuition Tax Credit
2002	$1,000 Tuition Tax Credit

Cumulative Tax Cut to Help Pay for Daughter's Education $6,000

The Balanced Budget Delivers Real Tax Relief for America's Families

How Typical American Families Will Benefit

Example #4 -- Single Mother With One Child

A single mother lives with her six year old daughter in California. She's been working as a bank teller for several years and her pay is now $20,000 a year. Working towards becoming a loan officer, she is taking one course a semester towards a bachelor's degree. Her tuition is $1,000. This family will receive a $500 child tax credit for the daughter and a $200 tuition tax credit.

Tax Cut

Family of two with one child aged 6 and $20,000 income:

Child Tax Credit for 6 year old	$500
Tuition Tax Credit	$200
Total tax cut:	**$700**

* Tax Year 1999