Reconfiguring Child Health Services in the Inner City

In this issue of THE JOURNAL, Hoekstra et al[1] demonstrate how 2 public agencies, through innovation and collaboration, were able to dramatically increase immunization rates among thousands of young children in the inner city of Chicago, Ill. The Chicago Department of Public Health contracted with the Chicago Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), which has 47 offices that follow 70% of inner-city families during the first year of an infant's life, to have WIC staff review the parents' immunization record for each child, to educate the parents concerning when immunizations were due, and to make referrals to accessible immunization services, some of which were at the WIC offices. Parents of children found to be delayed in their immunizations or who did not bring in their infant's immunization card were provided only 1 month's supply of WIC food vouchers instead of the usual 3 months' supply that was given if the child's immunizations were up-to-date. In just 15 months, immunization rates for thousands of WIC children, which had been stubbornly low for more than a decade, increased dramatically from 56% to 89%, a stunning accomplishment. Moreover, the intervention did not result in any measurable negative impact on WIC program participation.

See also p 1143.

This initiative has important implications for immunization and child health care delivery to underserved areas. Although immunization rates have been increasing across the country, the rates in US inner cities have lagged behind.[2] In the inner cities of Los Angeles, Calif, Chicago, and New York, NY, only about 50% of 1- and 2-year-olds are up-to-date with immunizations, approximately 30 percentage points lower than rates in these cities' suburbs.[3-5] The geography and demographics of stagnant immunization rates today are remarkably similar to those of the measles epidemic of 1989-1990, during which more than 55 000 cases of measles, 11 000 hospitalizations, and 130 deaths were documented. A disproportionate number of preschool children infected with measles, about 75% of whom were unimmunized, were from inner-city, poor, and minority populations.[6] Studies at the time of the epidemic documented inner-city immunization rates to be as low as 10% to 25%.[7] While overall national rates have risen to new heights, many inner-city areas have made modest gains at best, and immunization rates remain sufficiently low to propagate a future epidemic of measles or pertussis.

From the Department of Clinical Outcomes Management, Shriners Hospitals for Children, and the Departments of Pediatrics, Epidemiology, and Biostatistics and College of Public Health, University of South Florida, School of Medicine, Tampa (Dr Wood); and Center for Healthier Communities, Families and Children, Department of Pediatrics, School of Medicine, and Department of Community Health Sciences, School of Public Health, University of California, Los Angeles (Dr Halfon)

Corresponding author: David Wood, MD, MPH, Director of Clinical Outcomes Management, Shriners Hospitals for Children, 2900 Rocky Point Dr, Tampa, FL 33607 (e-mail: david_wood@bigfoot.com)

In response to the 1989-1990 measles epidemic, the US Congress passed the Children's Immunization Initiative, infusing new funds into vaccine purchase and delivery, especially in high-need areas such as inner cities.[8] As part of this initiative, the Vaccines for Children Program greatly increased financial incentives for physicians to deliver vaccinations to children receiving Medicaid and to uninsured children. In addition, the Centers for Disease Control and Prevention, the American Academy of Pediatrics, and the American Academy of Family Practice issued a unified and simplified immunization schedule. Immunization practice guidelines were published and promulgated in physician education programs across the country.[9] With the new federal dollars, urban health departments vigorously increased immunization efforts in inner-city areas, extended hours for public immunization clinics, and established new clinics at housing projects, WIC sites, and other locations accessible to inner-city residents.

Given these efforts, all of which had been implemented in inner-city Chicago prior to the collaboration between the WIC program and the Chicago Department of Public Health, why did immunization rates lag so far behind more affluent city areas? A wide range of factors can promote or impede access to infant immunizations.[10] Studies commissioned to look more closely at the causes of the measles epidemic demonstrated that a substantial portion of underimmunization in poor, underserved populations was due to multiple deficiencies in the health care system.[11,12] Inner-city child health services are often inadequately distributed and insufficient to meet the demands for essential child health services. Moreover, the high level of acute needs frequently distracts clinicians from providing day-to-day care such as checking immunization records,[13] and opportunities to immunize children are frequently missed.[14] In addition, inner-city families can have problems that impede their use of preventive care, including a lack of understanding of the immunization schedule, difficulties with transportation, and limited social support.[15,16]

The Chicago WIC immunization program succeeded in raising immunization levels by attacking a number of these barriers. System barriers were reduced by screening infant immunizations and providing targeted information and education to the mother during every WIC interview. Immunizations were made more accessible by offering them free in the WIC offices or at nearby offices. Informing parents about specific immunizations the child had not yet received increased parents' perceived need for these services. However, these interventions alone were not sufficient to increase immunization levels as demonstrated by the unchanged immunization levels of children in the study group having all of these interventions but no voucher incentive.

The WIC intitiative added another crucial component—it provided a motivating incentive for families to seek immunizations by reducing the amount of the food voucher from a 3-month supply (if up-to-date) to a 1-month supply (if not up-

(To-date) For families living day to day in poverty, receiving two thirds less infant and maternal food vouchers and having to return to the WIC offices for vouchers monthly rather than every 3 months would be powerful negative incentives. The results indicate that, given a strong enough incentive, families are able to enure that their children are immunized, similar to the effect of school-entry immunization laws.

However, the screening, educational and referral aspects of this initiative may have contributed to its success and prevent drawing the conclusion that negative incentives are the "magic bullet" needed to improve inner-city immunization rates. Screening, education, and referral, although not sufficient in themselves to increase immunization rates, may have provided the parent with tools to act constructively once motivated by the voucher incentive.

There are limitations in generalizing about negative incentive programs from this study. First because this project was tied to the particular Chicago WIC program with a 3-month return policy. It might not work at WIC sites or in communities that have a shorten return policy. In addition, based on only a few studies that have used negative incentives, the effectiveness of negative incentives on immunizations may be uniquely applicable to WIC programs. In a recent evaluation of another immunization WIC collaboration in Milwaukee, WI, a similar positive impact on immunization receipt was demonstrated along with increased rates of screening for lead, tuberculosis and anemia among inner-city children.

Several examples of failed negative incentive programs in other setting suggest that the application of negative incentives beyond WIC to other programs serving poor families should be carefully scrutinized. In the past 5 years, 21 states have initiated negative incentive interventions targeting immunization in the former Aid for Families With Dependent Children (AFDC) programs. In these programs, the welfare payment for families with children who were behind in their immunizations was reduced or withheld until documentation of up-to-date immunization status was provided. These negative incentive programs have been fraught with numerous difficulties and demonstrated minimal to positive effect on immunization levels. For example, in the most "successful" of the state AFDC-sanctioned programs, immunization levels increased by only 6 percentage points (from 57.7% to 63.8%). Replication of the results of Hoekstra et al in other geographic and programmatic settings is necessary before more wide-scale application of the "negative incentive" approach is considered. Moreover, the use of financial sanctions against families that are poor and often struggling to provide their children with basic necessities raises ethical and moral issues and should be undertaken only with great caution and careful monitoring for both positive and untoward outcomes.

The success of the Chicago WIC initiative suggests that interagency collaboration with or without collocation of services should be considered for other services used by inner-city populations. Children of poor, inner-city families are at risk not only for undernutrition and under-immunization but also for many other problems that compromise their health, well-being, and development. These include higher rates of lead exposure, anemia, child abuse and neglect, growth and developmental delay, fatal and nonfatal injury, premature birth, and chronic disabling conditions such as asthma and learning disabilities. Despite the increased need, child health prevention and treatment programs are not readily accessible to most inner-city poor populations. Moreover, the paucity of services that are available are often located at distant sites, require long waits in crowded offices, and have separate applications with unique and complex eligibility criteria. Interagency collaborations that make services more accessible, simply application processes, and reduce other service barriers have been instituted with great success in South Carolina, Wisconsin, and Boston, Massachusetts.

The Chicago Department of Public Health and the Chicago WIC program deserve credit for the innovative steps they have taken to collaborate and increase their effectiveness at immunizing inner-city children. As demonstrated by the Chicago project, collaborations with WIC, which follows 4.4 million low-income children (almost half of the nation's birth cohort), may be the key to reaching inner-city families with needed health services.

to-date). For families living day to day in poverty, receiving two thirds less infant and maternal food vouchers and having to return to the WIC offices for vouchers monthly rather than every 3 months would be powerful negative incentives. The results indicate that, given a strong enough incentive, families are able to ensure that their children are immunized, similar to the effect of school-entry immunization laws.

However, the screening, educational, and referral aspects of this initiative may have contributed to its success and prevent drawing the conclusion that negative incentives are the "magic bullet" needed to improve inner-city immunization rates. Screening, education, and referral, although not sufficient in themselves to increase immunization rates, may have provided the parent with tools to act constructively once motivated by the voucher incentive.

There are limitations in generalizing about negative incentive programs from this study. First, because this project was tied to the particular Chicago WIC program with a 3-month return policy, it might not work at WIC sites or in communities that have a shorter return policy. In addition, based on only a few studies that have used negative incentives, the effectiveness of negative incentives on immunizations may be uniquely applicable to WIC programs. In a recent evaluation of another immunization-WIC collaboration in Milwaukee, Wis, a similar positive impact on immunization receipt was demonstrated, along with increased rates of screening for lead, tuberculosis, and anemia among inner-city children.[17]

Several examples of failed negative incentive programs in other settings suggest that the application of negative incentives beyond WIC to other programs serving poor families should be carefully scrutinized. In the past 5 years, 21 states have initiated negative incentive interventions targeting immunizations in the former Aid for Families With Dependent Children (AFDC) programs. In these programs, the welfare payment for families with children who were behind in their immunizations was reduced or withheld until documentation of up-to-date immunization status was provided. These negative incentive programs have been fraught with numerous difficulties and demonstrated minimal to no positive effect on immunization levels.[18] For example, in the most "successful" of the state AFDC-sanctioned programs, immunization levels increased by only 6 percentage points (from 57.7% to 63.3%).[19] Replication of the results of Hoekstra et al[1] in other geographic and programmatic settings is necessary before more wide-scale application of the "negative incentive" approach is considered. Moreover, the use of financial sanctions against families that are poor and often struggling to provide their children with basic necessities raises ethical and moral issues and should be undertaken only with great caution and careful monitoring for both positive and untoward outcomes.

The success of the Chicago WIC initiative suggests that interagency collaboration with or without collocation of services should be considered for other services used by inner-city populations.[20(p48)] Children of poor, inner-city families are at risk not only for undernutrition and underimmunization but also for many other problems that compromise their health, well-being, and development. These include higher rates of lead exposure, anemia, child abuse and neglect, growth and developmental delay, fatal and nonfatal injury, premature birth, and chronic disabling conditions such as asthma and learning disabilities.[21,22] Despite the increased need, child health prevention and treatment programs are not readily accessible to most inner-city poor populations.[23,24] Moreover, the paucity of services that are available are often located at distant sites, require long waits in crowded offices, and have separate applications with unique and complex eligibility criteria.[20] Interagency collaborations that make services more accessible, simplify application processes, and reduce other service barriers have been instituted with great success in South Carolina, Wisconsin, and Boston, Mass.[25]

The Chicago Department of Public Health and the Chicago WIC program deserve credit for the innovative steps they have taken to collaborate and increase their effectiveness at immunizing inner-city children. As demonstrated by the Chicago project, collaborations with WIC, which follows 4.4 million low-income children (almost half of the nation's birth cohort), may be the key to reaching inner-city families with needed health services.

David Wood, MD, MPH
Neal Halfon, MD, MPH

1. Hoekstra EJ, LeBaron CW, Megaloeconomou Y, et al. Impact of a large-scale immunization initiative in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). *JAMA*. 1998;280:1143-1147.
2. Centers for Disease Control and Prevention. National, state and urban vaccination coverage levels among children aged 19-25 months—United States, July 1996-June 1997. *MMWR Morb Mortal Wkly Rep*. 1998;47:108-116.
3. Wood DL, Halfon N, Sherbourne CD, et al. A randomized trial of case management to raise immunization rates among African American children in inner-city Los Angeles. *JAMA*. 1998;279:29-34.
4. Kenyon TA, Matuck MA, Strogh G. Persistently low immunization coverage among inner-city preschool children despite access to free vaccine. *Pediatrics*. 1998;101:612-616.
5. Fairbrother G, Friedman S, DuMont KA, Lobach KS. Markers for primary care: missed opportunities to immunize and screen for lead and tuberculosis by private physicians serving large numbers of inner-city Medicaid-eligible children. *Pediatrics*. 1996;97:785-790.
6. Wood DL, Brunell PA. Measles control in the United States: problems of the past and challenges in the future. *Clin Microbiol Rev*. 1995;8:260-267.
7. Zell ER, Dietz V, Stevenson J, Conchi S, Bruce RH. Low vaccination levels of US preschool and school-age children. *JAMA*. 1994;271:833-839.
8. *Hearings Before the Senate Committee on Finance*, 10th Cong, 1st Sess (1995) (testimony of David Satcher, MD, director of the Centers for Disease Control and Prevention).
9. Ad Hoc Working Group for the Development of Standards for Pediatric Immunization Practices. Standards for pediatric immunization practices. *JAMA*. 1993;269:1817-1822.
10. Andersen R, Aday LA. Access to medical care in the US: realized and potential. *Med Care*. 1978;16:533-546.
11. Grabowsky M, Orenstein WA. The critical role of provider practices in undervaccination. *Pediatrics*. 1996;97:729-732.
12. Wood D, Donald-Sherbourne C, Halfon N, et al. Factors related to immunization status among inner-city Latino and African-American preschoolers. *Pediatrics*. 1995;96:295-301.
13. Fairbrother G, DuMont KA, Friedman S, Lobach KS. New York City physicians serving high volumes of Medicaid children. *Inquiry*. 1995;32:345-352.
14. Guyer B, Hughart N, Hold E, et al. Immunization coverage and its relationship to preventive health care visits among inner-city children in Baltimore. *Pediatrics*. 1994;94:53-58.
15. Bates AS, Fitzgerald JF, Dittumus RS, Wolinsky FD. Risk factors for underimmunization in poor infants. *JAMA*. 1994;272:1105-1110.
16. Lannon C, Brack V, Stuart J, et al. What mothers say about why poor children fall behind on immunizations. *Arch Pediatr Adolesc Med*. 1995;149:1070-1075.
17. Shefer A, Fritchley J, Stevenson J. Improvement in immunization coverage and other health outcomes following implementation of immunization activities in WIC, Milwaukee, 1995-1997. In: Program and abstracts of the 32nd National Immunization Conference; July 23, 1998; Atlanta, Ga.
18. Minkovitz C, E Holt, Hugart N, Hou W, Guyer B. Penalizing families does not improve the vaccination status of young children: a randomized trial of welfare reform in Maryland. In: Program and abstracts of the Pediatric Academic Society Annual Meeting; May 2, 1998; New Orleans, La. Abstract 24.
19. Kerpelman LC, Ciurea M, Connell DB, McGarry N. *Preschool Immunization Project Evaluation: Annual Report*. Cambridge, Mass: ABT Assoc; 1997.
20. Palfry JS. *Community Child Health: An Action Plan for Today*. Westport, Conn: Praeger; 1995.
21. Wise PH, Meyers A. Poverty and child health. *Pediatr Clin North Am*. 1988;35:1169-1186.
22. Brooks-Gunn J, Duncan GJ. The effects of poverty on children. *Future Child*. 1997;7:55-71.
23. Wood D, Hayward R, Freeman H, Covey C, Shapiro M. Access to medical care for children in the United States. *Pediatrics*. 1990;86:666-673.
24. St Peter RF, Newacheck PW, Halfon N. Access to care for poor children: separate and unequal? *JAMA*. 1992;267:2760-2764.
25. Lasker RD. *Medicine and Public Health: The Power of Collaboration*. New York, NY: New York Academy of Medicine; 1997.

FACSIMILE COVER SHEET

AMERICAN ACADEMY OF PEDIATRICS

Department of Government Liaison

601 Thirteenth Street, NW
Suite 400 North
Washington, DC 20005

202/347-8600 or 800/336-5475
FAX: 202/393-6137

TO: Jennifer Klein

FAX # TO: 202-456-2878

FROM: Keri Briel Frisch, Legislative Assistant

DATE: June 25, 1998

PAGES (including cover): 2

RE: Attached, please find an invitation that was faxed today to the First Lady's scheduler. We wanted to bring it to you attention as well.

Patti -
It didn't sound like we could add much to the schedule for July, but this would be a good thing to do.
Jen

American Academy of Pediatrics

Department of Government Liaison
American Academy of Pediatrics
The Homer Building
601 Thirteenth Street, NW
Suite 400 North
Washington, DC 20005
202/347-8600
800/336-5475
Fax: 202/393-6137
E-mail: kids1st@aap.org
Web Site: http://www.aap.org

June 25, 1998 -- VIA FAX

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

Dear Mrs. Clinton:

On behalf of the American Academy of Pediatrics, I am writing to invite you or your designee to participate in a very special meeting of approximately 300-400 state child care and health leaders on Wednesday, July 28, 1998. The meeting will take place at the Loews L'Enfant Plaza hotel in Washington, DC, between 9:00 and 11:00 am. We would welcome your remarks at any time during this period.

In partnership with the US Department of Health and Human Services' Child Care Bureau and Maternal and Child Health Bureau, the Academy administers the "Healthy Child Care America" campaign. We are also organizing a joint meeting of State Child Care Administrators (state and federal officials who administer the Child Care and Development Fund) and Healthy Child Care America State Grantees (recipients of "Health Systems Development in Child Care/Community Integrated Service Systems" grants developing state health and social services to support children in child care and their families). These two groups will be in Washington at their annual meetings and will meet in joint session on Wednesday morning to promote collaborative efforts.

We think this would be an excellent opportunity for you to share information with state child care and health leaders about the Administration's initiatives to ensure access to both safe and healthy child care and health insurance for all of America's children. The meeting participants will be key players in health insurance outreach efforts and important voices in the debate about child care expansion and improvements.

Please contact Janis Guerney or Keri Frisch at 202-347-8600 regarding your availability. Thank you for your continued efforts on behalf of our nation's children.

Sincerely,

Joe M. Sanders MD

Joe M. Sanders, Jr., MD, FAAP
Executive Director

JMS/JEG/kbf

Jen, et al
Can we touch
about this

July 1, 1998

CHILD HEALTH DAY
AMERICAN HEALTH FOUNDATION
320 East 43rd Street
New York, NY 10017
phone: 212.953.1900
fax: 212.687.2339
www.ahf.org

Ms. Melanne Verveer
Chief of Staff to the First Lady
The White House
Old Executive Office Building - Room 100
Washington, DC 20500

Dear Melanne -

I wanted to take a moment to update you on the American Health Foundation's Child Health Day '98 plans. This year Child Health Day falls on Monday, October 5th and we are honored that Whoopi Goldberg has agreed to serve as the American Health Foundation's new spokesperson.

We are working closely with our partners, Kelloggs, Johnson & Johnson, Schering-Plough, the Allstate Foundation, Sunny Delight and our supporting organizations to plan grassroots activities across the nation in schools and communities aimed at reaching children and families with valuable information they need to make healthful decisions and healthy practices a priority.

We are scheduling a "Town Hall" meeting at the end of October (tentatively 10/22) targeting preventive health behaviors in children. The title is Children's Health Behaviors - Whose Responsibility Is It? Dr. Ernst Wynder, President, AHF, Dr. Steve Hyman, Director of the National Institute of Mental Health, Dr. Pizzo, Director of Oncological Pediatrics, Harvard, Congressman John Porter and Whoopi Goldberg have already made commitments to serve on a panel. It is the American Health Foundation's hope to have a White House presence as well.

This event to be held in Washington, is meant to be a dialogue among young people, members of the entertainment, parental, educational and scientific communities as well as key members of the federal government. We will explore how to impact the health behaviors of our nation's children in a positive way to ensure optimum health in the next millennium. We will discuss where children get their information and the importance of modeling and effective delivery systems specifically in schools, child care, through the media and at home. At the suggestion of Ann Lewis, I will be contacting Ellen McCollough-Lovell with the hopes of working with the Millennium Office on this event.

I know one of the administration's key initiatives is to insure that our nation's children have Healthcare coverage. AHF shares your commitment and feels strongly that the nation's insurance companies must take an active role in providing preventive health information to families. Since our meeting early in February, I have not received any updated information on this effort.

I wrote to you in January requesting that the First Lady serve as Honorary Chairperson for AHF's Child Health Day '98 celebration. We are still hoping for a positive response. We are going to print on a number of items and would like to include the First Lady. Alice Pushkar was a delight to work with last year to have all materials approved.

We would like to work with you again on Child Health Day to create a bigger impact than ever before. I welcome any thoughts you may have and an opportunity to further discuss this letter with you.

Melanne - As always, thank you for your support.

Sincerely,

Maris

Maris Segal-Goodis
Director, Child Health Day
212.551.2523

cc; Dr. Ernst Wynder, President, AHF

FROM: MARIS SEGAL-GOODIS
Director, Child Health Day
PH: 212.551.2523 FAX: 212.687.2339

CHILD HEALTH DAY
AMERICAN HEALTH FOUNDATION
320 East 43rd Street
New York, NY 10017
phone: 212.953.1900
fax: 212.687.2339
www.ahf.org

SAVE THE DATE
CHILD HEALTH DAY '98 - MONDAY, OCTOBER 5TH

Date of Fax: 10/1 **# of Pages with cover:** 2

TO: Jennifer Klein

fax: ph 202 456. 2599 f# 456. 2878

TO:

fax:

MESSAGE:

Hi. last years looking
foward to nearly bth.
Will work on copy!

Thanks, Maris

Child Health Day, 1997

By the President of the United States of America

A Proclamation

For children, childhood seems to last forever; but for adults—particularly for those of us who are parents—it passes in the blink of an eye. The little girl smiling at us from her tricycle and the little boy running to catch the school bus will soon be driving away to their first jobs. One of the greatest gifts we can offer our children while they are still in our care is a healthy start in life.

We are making tremendous progress as a nation in helping more children get that healthy start. This year I signed into law historic legislation to extend health care coverage to millions of uninsured children. This $24 billion initiative over 5 years is the largest investment in children's health since the creation of Medicaid in 1965. On October 1, the Federal Government and the States began a partnership to help provide meaningful health insurance to children whose families earn too much for Medicaid but too little to afford private coverage.

This new initiative will take an enormous step toward improving the health of our Nation's children. In 1995, approximately 10 million of them were not covered by health insurance, and they were either ineligible for or not enrolled in publicly financed medical assistance programs. Last year, another 800,000 uninsured children joined their ranks. These children are less likely to receive the primary care services they need to maintain good health, and they are at risk of receiving lower quality care. Too often they become trapped in a tragic downward spiral—poor health keeps them out of school, keeps them from pursuing their studies with energy and enthusiasm, and often keeps them from acquiring the knowledge and self-esteem they need to reach their full potential. With this new children's health initiative, we can provide millions of children the coverage they need to grow up healthy and strong.

We are making progress in other areas, as well. Thanks to advances in medical research and our increasing knowledge about prevention and the importance of good nutrition, many childhood diseases and illnesses can now be averted. Funding for childhood immunization has doubled since 1993, and immunization rates are at an all-time high. In addition, we recently announced an important Food and Drug Administration regulation requiring manufacturers to do studies on pediatric populations for new prescription drugs—and those currently on the market—to ensure that our prescription drugs have been adequately tested for the unique needs of children. We have dramatically increased participation in the Women, Infants and Children Supplemental Nutrition Program, providing nutrition packages and information and health referrals to more than 7 million infants, children, and pregnant women. With the enactment of the Kassebaum-Kennedy bill last year, we have helped millions of children keep their healthcare coverage when their parents change or lose jobs.

We are also taking strong actions to prevent our children from smoking. Each day 3,000 children become regular smokers and 1,000 of them will die from a tobacco-related illness. Last year, my Administration issued guidelines to eliminate easy access to tobacco products and to prohibit companies from directing advertising towards children.

To acknowledge our profound responsibility to nurture the health and development of America's children, the Congress, by joint resolution approved May 18, 1928, as amended (36 U.S.C. 143), has called for the designation of the first Monday in October as "Child Health Day" and has requested the President to issue a proclamation in observance of this day.

NOW, THEREFORE, I, WILLIAM J. CLINTON, President of the United States of America, do hereby proclaim Monday, October 6, 1997, as Child Health Day. I call upon my fellow Americans to join me on that day, and every day throughout the year, in strengthening our national commitment to the well-being of our children.

IN WITNESS WHEREOF, I have hereunto set my hand this sixth day of October, in the year of our Lord nineteen hundred and ninety-seven, and of the Independence of the United States of America the two hundred and twenty-second.

William J. Clinton

[redacted]

Delia Cohen
6-5462

DRAFT

CHILD HEALTH DAY, 1998

- - - - - - -

BY THE PRESIDENT OF THE UNITED STATES OF AMERICA

A PROCLAMATION

As caring adults and responsible citizens, we must do everything possible to ensure that our Nation's children lead safe and healthy lives. Today, thanks to scientific breakthroughs and increased public awareness of health issues, we have the ability to prevent many of the illnesses and disorders that have afflicted so many children through the years. Although we can be heartened by these important achievements, we must do more if we are to overcome the many health challenges our children still face.

One of the most serious of those challenges is alcohol abuse, and among the most tragic consequences of alcohol abuse is Fetal Alcohol Syndrome. In this country, thousands of infants are born each year suffering from the physical and mental effects of this disorder, caused when a baby, still in the mother's womb, absorbs alcohol from her bloodstream. Its effects are devastating, causing permanent damage. Because we do not know how much alcohol it takes to harm an unborn child, the simplest and best measure that expectant mothers can take for the safety of their babies is to abstain from drinking alcohol at any stage of their pregnancies.

Alcohol abuse continues to threaten our children as they grow. An estimated 6 million Americans under the age of 18 live in homes with a parent who is dependent on alcohol. As children of alcoholics, they face more difficulties in school, more hospital stays, more depression and anxiety, and more child abuse than children who grow up in an environment where alcohol is not abused. They are also more likely to become alcoholics themselves.

As part of my Administration's ongoing efforts to protect our children from the effects of alcohol and other substance abuse, Secretary of Health and Human Services Donna Shalala

DRAFT 2

recently announced a new campaign, "Your Time -- Their Future," to recruit adults to help children and adolescents develop healthy and useful skills and interests. Children who have something constructive to do in their free time are much less likely to abuse alcohol or drugs, and research shows that the guidance and example of caring adults can play an important part in helping young people resist the attraction of alcohol and other harmful or illegal substances. As we work to discourage alcohol abuse in all its forms and reduce the toll it takes on our children, we should also recognize the crucial role health insurance plays in the well-being of our youth. The new Children's Health Insurance Program (CHIP), which I called for in my 1997 State of the Union and signed into law just a year ago, provides $24 billion to help States offer affordable health insurance to children in eligible working families; and in its first year, nearly four out of five States already are participating in CHIP. We are working hard now to identify and enroll in Medicaid the more than 4 million children who are currently eligible to receive health care through that program but are not enrolled. To accomplish this, earlier this year, I directed Federal agencies to assist in signing up these uninsured children and to use their administrative responsibility for school lunch programs, low-income housing programs, the Earned Income Tax Credit, and other low-income tax programs to notify parents whose children may be eligible for Medicaid and other health care benefits.

To acknowledge the importance of our children's health, the Congress, by joint resolution approved May 18, 1928, as amended (36 U.S.C. 143), has called for the designation of the first Monday in October as "Child Health Day" and has requested the President to issue a proclamation in observance of this day.

NOW, THEREFORE, I, WILLIAM J. CLINTON, President of the United States of America, do hereby proclaim Monday, October 5,

DRAFT 3

1998, as Child Health Day. On this day, and every day throughout the year, I call upon all Americans to dedicate themselves to protecting the health and well-being of all our children.

IN WITNESS WHEREOF, I have hereunto set my hand this day of , in the year of our Lord nineteen hundred and ninety-eight, and of the Independence of the United States of America the two hundred and twenty-third.

The White House
Office of Presidential Messages

Telephone 202-456-7487
Fax 202-456-2806

Facsimile Transmittal Sheet

No. of pages (including Cover): # 7 Date: 10/1

Fax Number: 6-2878

To: Jen Klein

Comments: I talked to Jan Aamodt (301) 443-0205 and at SAMSA I talked to Mark Webber, (301) 443-8956

From: Lara X6-5504

U.S. Department of Health & Human Services
Public Health Service

HRSA

Health Resources & Services Administration
Maternal & Child Health Bureau

Office of the Director - Communications

5600 Fishers Lane
Room 18-20
Parklawn Bldg.
Rockville, MD 20857

Tel: 301-443-0205
Fax: 301-443-1797

TO: Lana Duckey

CO: The White House

FAX: 202 456-2806

FROM: Jan Aamodt

DATE: 9-29-98

PAGES TO FOLLOW: 12

COMMENTS:

MCHB

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

SEP 1 5 1998

MEMORANDUM FOR DAN BURKHARDT
DIRECTOR OF CORRESPONDENCE AND
PRESIDENTIAL MESSAGES

FROM: James J. Jukes
Assistant Director for
Legislative Reference

SUBJECT: Child Health Day, 1998

Attached is a draft proclamation which, in accordance with the provisions of a joint resolution of Congress approved on May 18, 1928, as amended (36 U.S.C. 143), would designate October 5, 1998, as "Child Health Day".

The proposed proclamation was submitted by the Department of Health and Human Services, and editorial and format changes made in this Office are marked on the draft.

Attachment

Ctr Identer

Draft: Presidential Proclamation for National Child Health Day, 1998
October 5, 1998

By the President of the United States of Americ
A Proclamation

Indent → **Children are our Nation's most valuable resource; therefore, the health of our children is a top national priority. While the children of the United States receive some of the finest health care in the world, alcohol abuse poses a significant threat to the present and future well-being of millions of our youngest Americans.**

→ **Thousands of infants are born each year in this country suffering from the physical and mental defects of Fetal Alcohol Syndrome, a disorder caused by the absorption of alcohol from the mother's bloodstream into that of the unborn baby. Since nobody knows how much alcohol it takes to harm a baby or at what stage of pregnancy alcohol is dangerous, it is best for all mothers to abstain from drinking during their pregnancies.**

→ **The statistics related to children and alcohol abuse are startling. An estimated 6 million American children under age 18 live in homes with a parent dependent on alcohol. Children of alcoholics face**

more hardships in school, more hospital stays, and show more depression and anxiety than children who do not live in homes beset by alcohol abuse. Child abuse is strongly related to alcohol abuse. Children of alcoholics are four times more likely to grow up to become alcoholics. About 11 million current drinkers were age 12-20 in 1997.

Additionally, driving while under the influence of alcohol is a serious concern. Grassroots organizations such as Mothers Against Drunk Driving and Students Against Drunk Driving have worked tirelessly to reduce teenage drinking and driving. Nevertheless, one-fourth of all traffic deaths among children younger than 15 involved alcohol. Many children die when the driver of the car they are riding in is drunk.

The average age Americans try alcohol is 16. Nearly 20% of all students living on college campuses engage in heavy drinking, defined as having an average of five drinks on five occasions in any given month. These students are more likely to miss class,

experience injuries, have trouble with authorities, and become involved in incidents involving sexual assault. Researchers also correlate drinking with early sexual intercourse and, as a result, unplanned teenage pregnancies and sexually transmitted diseases. Young people who drink are more likely to use illegal drugs than those who never drink. Tragically, alcohol use is also associated with homicides, suicides, and drownings -- three other leading causes of teenage deaths.

The theme for ~~National~~ Child Health Day 1998 is a call for rededicating ourselves to the health and well-being of our children by discouraging alcohol abuse in all aspects of our lives. As parents, teachers, health professionals, and community leaders, we have the responsibility to lead by example and to commit ourselves to protecting our children from the consequences of alcohol abuse.

To underscore our Nation's commitment to the healthy growth and development of its children, the [~~United States~~] Congress, by joint resolution approved May 18, 1928, as amended (36 U.S.C. 143) has

called for the designation of the first Monday in October as "~~National~~ Child Health Day" and has requested the President to issue a proclamation in observance of this day.

Caps

Now, therefore I, William J. Clinton, President of the United States of America, do hereby proclaim Monday, October 5, 1998, as ~~National~~ Child Health Day. On this day, and on every day throughout the year, I call upon my fellow Americans to deepen their commitment to protecting our Nation's most precious resource -- our children.

Caps

In witness whereof, I have hereunto set my hand this ~~fifth~~ day of ~~October~~, in the year of our Lord nineteen hundred and ninety-eight, and of the Independence of the United States of America the two hundred and twenty-third.

Prepared by: Jan Aamodt and Ellen Rogers
August 27, 1998
301-443-0205

October 5, 1998

CHILD HEALTH DAY, 1998

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release
October 5, 1998

CHILD HEALTH DAY, 1998

- - - - - - -

BY THE PRESIDENT OF THE UNITED STATES OF AMERICA

A PROCLAMATION

As caring parents and citizens, we must do all we can to ensure that our children, our Nation's greatest resource, lead safe and healthy lives. Today, thanks to scientific break-throughs and increased public awareness, we have the ability to prevent many of the childhood illnesses and disorders of the past. We have raised immunization rates to an all-time high, ensured that prescription drugs will be adequately tested for children, conducted research to help protect children from environmental health risks, and established protections so that mothers can stay in hospitals with their newborns until they and their doctors decide they are ready to leave. Although we can be heartened by these important achievements, we must do more if we are to overcome the many health challenges our children still face.

Recent studies show that children without health insurance are more likely to be sick as newborns, less likely to be immunized, and less likely to receive treatment for recurring illnesses. One of the great accomplishments of my Adminis-tration has been the creation of the Children's Health Insurance Program (CHIP), which I called for in my 1997 State of the Union and signed into law just a year ago. CHIP provides $24 billion to help States offer affordable health insurance to children in eligible working families -- the single largest investment in children's health since the passage of Medicaid in 1965. CHIP will provide health care coverage, including prescription drugs, and vision, hearing, and mental health services, to as many as 5 million uninsured children; and in its first year, nearly four out of five States already are participating in CHIP. We are also working hard to identify and enroll in Medicaid the more than 4 million children who are currently eligible to receive health care through that program but are not enrolled. The challenge before us now is to realize the promise of CHIP and Medicaid by reaching out to families to inform them of their options for health care coverage.

Due to recent breakthroughs in medical knowledge, we know that the

decisions we make even before our children are born can have a significant impact on their future health. That is why we are committed to fighting, among other afflictions, the tragic consequences of Fetal Alcohol Syndrome. In this country, thousands of infants are born each year suffering from the physical and mental effects of this disorder. Because its effects are devastating, causing permanent damage, the simplest and best measure that expectant mothers can take for the safety of their babies is to abstain from drinking alcohol throughout their pregnancies.

As part of my Administration's ongoing efforts to protect our children from the effects of alcohol and other substance abuse, Secretary of Health and Human Services Donna Shalala

more

(OVER)

2

recently announced a new campaign, "Your Time -- Their Future," to recruit adults to help children and adolescents develop healthy and useful skills and interests. Research shows that the guidance and example of caring adults can play an important part in helping young people resist the attraction of alcohol and other harmful or illegal substances.

To acknowledge the importance of our children's health, the Congress, by joint resolution approved May 18, 1928, as amended (36 U.S.C. 143), has called for the designation of the first Monday in October as "Child Health Day" and has requested the President to issue a proclamation in observance of this day.

NOW, THEREFORE, I, WILLIAM J. CLINTON, President of the United States of America, do hereby proclaim Monday, October 5, 1998, as Child Health Day. I call upon families, schools, communities, and governments to dedicate themselves to protecting the health and well-being of all our children.

IN WITNESS WHEREOF, I have hereunto set my hand this fifth day of October, in the year of our Lord nineteen hundred and ninety-eight, and of the Independence of the United States of America the two hundred and twenty-third.

WILLIAM J. CLINTON

# # #

Go to previous day | Back to this day's list of Press Releases | Go to next day

VERY rough draft!

[First paragraph: Health care is important to your baby's development.]

There are two important health insurance programs to help pay for the health care that your child needs. The Medicaid program pays for health care services for low-income children including well child visits and prescription drugs. Although every State's Medicaid program is different, children in families with income around $15,000 per year or lower may be eligible. In addition, last summer I signed into law a new program for working families. The Children's Health Insurance Program will allow families with income at around $25,000 or lower, in most States, to purchase low-cost health insurance. By 1999, all States should have such programs available.

I encourage you to find out about your health insurance options. [Note: we are looking into either a 1-800 number or attaching a piece of paper that has the appropriate telephone number in each state]

Call Chris re 2/19 -- corporate commitments?

Jen - I also attached the Connecticut Summary

Jeanne

DRAFT

January 25, 1998

MEMORANDUM TO THE FIRST LADY

Call Patti - Natl Assoc of CCR&R mtg - end of February

FROM: Chris Jennings and Jennifer Klein

RE: Possibilities for a Children's Health Outreach Events

cc: Melanne Verveer, Bruce Reed

Per your request, this memo lists some ideas on children's health outreach. We have been working on ideas for quite some time, and think that there are several, worthwhile options. Many could either be combined or taken apart into several events, depending on the timing.

If you would like, you can just mark up this memo, and we will begin working on the events, or, we can meet about this list at your convenience.

1. **Action:** **Highlight budget policies for children's health outreach**
   Site: Connecticut child care event
   Timing: January 29

   Description: Connecticut would be a natural place to highlight our outreach policies, listed in a letter to states released on January 23. First, one of the budget policies allows states to let child care resource and referral centers determine presumptive eligibility. Both because the event is in a child care center and because Connecticut has included in its proposal for CHIP to use the existing presumptive eligibility option, it would be good to discuss the policy. Second, the State is also working on a joint application for both Medicaid and the children's health program -- which we encouraged in the January 23rd letter. Third, since the Governor is a Republican, we can stress the importance bi-partisan support for children's health.

2. **Action:** **Approve first Children's Health Insurance Program plans**
   Site: White House
   Timing: January 30 to February 1

Description: We are very close to approving the first children's health plans. Approval is required for states to access their CHIP allotments. For the first approvals, we would probably invite the relevant governors (Alabama, maybe Colorado and South Carolina) and possibly the NGA who are interested in releasing a report and committing to do outreach. Depending on the timing, this event could also be used to highlight the budget policies. (Note: we do not necessarily have to limit announcements to the first plans; several more states will be ready in February and March).

3. **Action:** **Announce release of report stating that millions of uninsured children are eligible for Medicaid; highlight budget policies**
   Site: White House
   Timing: Early February

   Description: Tulane is about to release a report on the importance of outreach. We could use that to discuss budget policies and a general commitment to children's outreach. We could also complement the budget policies with outside commitments to outreach from groups like NGA, AHA, children's advocates; non-tradition groups like National Education Association, and corporations (e.g., Pampers).

4. **Action:** **Encourage child care workers / referral centers to assist in outreach**
   Site: White House; rural site in Colorado; Philadelphia
   Timing: February or March

   Description: Our budget includes a policy that allows child care resource and referral centers to determine presumptive eligibility (giving children temporary Medicaid coverage). In addition, HCFA is completing a manual for child care workers to assist them in identifying Medicaid eligible children. We already know that a number of child care sites / referral agencies assist in Medicaid enrollment but would like to do more. Examples include a Philadelphia child care resource and referral center whose workers are all trained in educating and assisting families in Medicaid enrollment; a rural Colorado program called "Be for Babies and Beyond" that is a child care resource and referral center, job and housing counseling center, HIPE [?] training site, presumptive eligibility site for pregnant women; and enrollment site for the state Colorado children's health program. They assist families in enrolling children in Medicaid, but would like to do more.

5. **Action:** **Encourage schools to engage in health insurance outreach**
   Site: White House; Massachusetts, Florida
   Timing: February or March

   Description: Our budget proposal also allows schools to determine presumptive eligibility for Medicaid. The NEA is quite interested in outreach and would be willing to train teachers. We also have interesting cases of school nurses assisting in enrollment. One interesting example is a child in Massachusetts whose mother would not let him play football because of lack of insurance. They found out about a state program and insured him. He then organized the "coaches campaign" that educates school athletic coaches to talk to children about insurance options. Also, Florida's Healthy Start program is school based and could be highlighted.

6. **Action:** **Announce commitment by volunteer groups to assist in outreach**
   Site: White House
   Timing: March or April

   Description: America's Promise has made children's health outreach a priority. They may start a nationwide campaign. In addition, AmeriCorps volunteers have assisted in outreach in some states. We could announce a commitment to work with these volunteers to canvas the nation to conduct outreach.

7. **Action:** **Emphasize simplified enrollment**
   Site: White House; community site in a state that uses such a form (e.g., South Carolina, Delaware)
   Timing: February or March

   Description: Simplifying the enrollment process, coordinating across programs, and educating groups on how to use simple forms is essential to outreach. HHS has produced a model application form for both Medicaid and CHIP. We could use a poster of this form as a backdrop at either the White House or at a community site in a state that uses a simple Medicaid application (e.g., South Carolina) or a joint Medicaid/WIC application (e.g., Oklahoma). We also could potentially see if HHS would put all states' Medicaid and CHIP applications on the internet.

8. **Action:** **Speeches**
   Site: Variable
   Timing: Variable

Description: There are several interesting conferences coming up. At the end of February, the Child Care Resource and Referral Centers are having their annual meeting in Washington. In June, HHS is sponsoring a conference entitled "Building Healthy Partnerships: Supporting Community-Based Outreach" (June, Washington DC). In addition, addressing provider group conferences could also be an effective way of enlisting support.

THE WHITE HOUSE
WASHINGTON

In Case you Need health person in Connecticut

Judy Solomon
CT Children's Health Care Council - Hartford
Helped develop / pass "Husky" Plan, Foundation, "Children's Health Info Line" is Run by this group

1110-9

DRAFT: Summary of Connecticut's Children's Health

- **Uninsured children**: In 1996, there were about 190,000 uninsured children in Connecticut, a rate of 12 percent, below the national average of 15 percent.

- **Medicaid coverage of children:** Connecticut's Medicaid program already covers about 180,000 children up to 14 years old up to 185 percent of poverty.

- **Children's Health Insurance Program:** On January 15, 1998, the State submitted a plan for its "Husky" program. This program would cover children up through age 18 through a combination of:

  - **Medicaid** for children in families with income up to 185 percent of poverty

  - A **non-Medicaid program** for children in families with income between 185 and 300 percent of poverty

  The **benefits** for the non-Medicaid program would be based on the State employees' health plan and include vision, hearing, dental health, most mental health

  - In addition, children eligible for the non-Medicaid program with special needs will be eligible for supplemental chronic care and/or behavioral health services

  The **cost sharing** for the non-Medicaid program includes premiums of up to $50 for families above 235 percent of poverty; and copayments of typically $5 for some services, up to annual limits.

  Application: Connecticut is planning to use a mail-in, joint application for both the Medicaid and non-Medicaid programs, similar to the one being developed by HCFA.

  Outreach: Plans include: ad campaigns, a toll-free information number, distribution of materials through the State revenue services, labor department, department of motor vehicles, day care centers, schools, school-based clinics.

  Presumptive eligibility: Connecticut also plans to take the option to allow certain sites to determine presumptive eligibility. [need to confirm]

  IMPORTANT: HHS has not yet reviewed this plan so we cannot make statements about its overall merits. However, we can praise individual elements.

Patti

HARVARD CENTER FOR CHILDREN'S HEALTH

Scheduling
Locker

October 8, 1997

Jan Keller -
What do
you think?
Patti

Hillary Rodham Clinton
Office of the First Lady
1600 Pennsylvania Avenue
Washington, DC 20500

Dear Mrs. Clinton:

We write to invite you to speak at the *Harvard Children's Health Policy Forum*, a program being presented by the Harvard Center for Children's Health. We would be honored to have you address the *Forum*, on your advocacy efforts to promote the health and development of children. Specifically, we hope you will address the *Forum* on the significant work you have done in the area of promoting early intervention programs, child care and health care for children.

Children's health, development and well-being have become a priority issue in America's political colloquy. The public appears supportive of governmental policies and programs which support children, including efforts to ensure all children have access to health care, attempts to prevent children from smoking, and efforts to promote early childhood development. The *Harvard Children's Health Policy Forum* is dedicated to assisting the voting public to understand and evaluate the potential impact and cost of various legislative approaches to enhancing children's health. Because of your leadership on issues that affect children and their families, and your broad knowledge of American health policy, you have much to offer our *Forum* participants.

The *Harvard Children's Health Policy Forum* informs and elevates the public debate on children's health policy by encouraging leading policy advocates to describe their recommendations and to discuss the merits and challenges of their proposals with scholars, health care providers, business and community leaders. The impact of the *Forum* is expanded by encouraging media coverage of the events and including journalists in all aspects of the dialogue. The *Forum* on health policy and children's health was inaugurated in 1992 and has presented a range of speakers including Senators Jay Rockefeller, Edward Kennedy, John Chafee and Nancy Kassebaum, Representative Richard Gephardt, and Food and Drug Commissioner David Kessler. All events have drawn large, diverse audiences and engendered exceptional press participation.

We are currently organizing a schedule for the academic year 1997-1998. We have found that mornings work particularly well (Monday and Friday are best). So, when possible, we begin with an 8:00 am breakfast and a 9:30 am public forum, followed by press interviews. This plan can be readily modified

Harvard School of Public Health
677 Huntington Avenue, Boston Massachusetts 02115
617 432-3222 Fax 617 432-3755
Email: children@hsph.harvard.edu

to accommodate your schedule and needs. We ask you to check your calendar for possible dates and contact Deborah Denhart, the Assistant Director for the Harvard Center for Children's Health, at 617-432-3761 at your earliest convenience.

Your leadership and understanding on issues related to children's health is an important public asset — we would be honored if you would help make the *Harvard Children's Health Policy Forum* a salutary and resonant voice in the public debate.

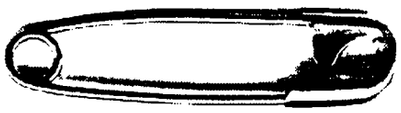
Sincerely,

Marie C. McCormick, M.D., Sc.D.
Director,
Harvard Center for Children's Health

Robert Blendon, Sc.D.
Professor of Health Policy and Political Analysis,
John F. Kennedy School of Government

Our Chance for Healthier Children

By Hillary Rodham Clinton



WASHINGTON

The 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 checkups 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 parents lose jobs.

A big step toward insuring all Americans.

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 assure 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 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.

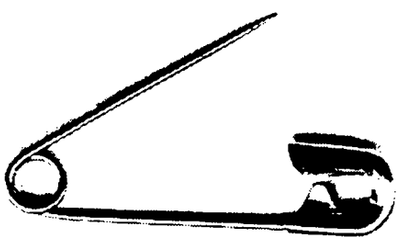
While this law will not fully achieve the universal coverage that I believe is in the nation's best interest, Americans should be proud that our Government has made another down payment on the President's goal of providing health insurance for all citizens.

In the last three years we have also taken other steps to bring better health care to the nation's young people, from passage of the Kassebaum-Kennedy 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.

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. □

Beware The Real Agenda

By Douglas J. Besharov



Chip Kidd

WASHINGTON

Americans have made it clear that they don't want national health insurance. But the five-year, $24 billion provision in the budget bill to finance medical care for two million children is a move in just that direction. And the way this expansion of benefits is designed makes no economic sense.

For every dollar's worth of new coverage, states will wind up spending $1.70. That is because for every 100 uninsured children who enroll in the program, another 70 who now have private insurance are also expected to sign up, according to Congressional Budget Office estimates. Why? Families that now qualify under the plan's expanded income guidelines may stop buying private insurance because government will pay for the children's health care. Or employers will stop offering coverage, knowing that government is now obligated to do so.

The Congressional Budget Office warned about this problem last spring. But in their eagerness to reach a budget deal, Republicans in Congress gave up their initial opposition and voted for the plan anyway.

Throughout the year, as the child health plan worked its way through Congress, Republicans insisted that it be structured in the form of block grants to states. This, they argued, would give states the flexibility to experiment. While some states would have simply expanded Medicaid coverage, most probably would have offered no-frills plans that would have discouraged people with access to private insurance from trying to sign up.

But advocates of national health insurance complained that the block grant approach would let states use the money for other purposes. More important, they claimed, the no-frills approach implicitly condoned "second class" health insurance. Still, they were prepared to settle for whatever expansion in national health coverage they could get.

A new entitlement, poorly designed.

But the political balance shifted in the President's favor, and the Republicans retreated. They agreed to detailed regulations on how states could spend the child health care money. In effect, they agreed to create another entitlement.

For example, each state is required to provide the same benefits for children as Medicaid or large private insurance plans. In many cases, state benefits will be more generous than those private employers offer. Another provision calls for public coverage to be provided to families earning as much as 235 percent of the poverty level, depending on the state. For a family of four, that's almost $38,000 a year.

The inefficiency and high cost of the program may not bother advocates of universal health care; they argue that Americans, especially children, deserve to have coverage. But what they don't acknowledge is that this plan will reduce the market for low-cost insurance used by small businesses and the working poor.

A 1996 study by researchers at the Massachusetts Institute of Technology and Harvard found that previous expansions of Medicaid were responsible for about 17 percent of the decline in the number of children covered by private insurance from 1987 to 1992. That study also reported that as many as half of the children who enrolled in expanded Medicaid plans did so because once they became eligible for those programs, their parents lost coverage at work or decided not to buy insurance.

The more the Government shrinks the insurance market for low-income people, the less economical it becomes for companies to offer them coverage. Companies either abandon the market or raise their prices. Either way, the number of uninsured people increases — and so do calls for more Government involvement.

Maybe that's the real agenda. But it's a long way from here to there, and in the meantime, this plan will do more harm than good. □

Douglas J. Besharov is an American Enterprise Institute resident scholar and a professor at the University of Maryland School of Public Affairs.

Call Jeanne
- HRC possibilities
AAP mtg ?
NCSL ?

Jennifer

CHILDREN'S HEALTH INSURANCE PROGRAM

OUTREACH DISCUSSION/ACTION PLAN

I. Calendar development

Information should be forwarded to Faith McCormick, HHS IGA (401-5879 phone; 690-5672 fax; FMcCormick@DHHS.GOV internet) for all CHIP related meetings, including but not limited to: steering committee meetings; intergovernmental meetings; specific "event" opportunities and invitations; outside organizational meetings; and theme weeks or opportunities for created events.

II. Implementation Plans

The Steering Committee has developed these assignments and deadlines:

A. State Plan Development

1. Sally Richardson letter with details of the law and our plans for implementation: August 27, 1997

2. Template document transmission: September 15, 1997

3. Crowd out "document" and Secretarial letter: due date 10/1

B. Allotment Process

1. Publish Federal Register Notice to inform states of FY 98 allotments: September 11, 1997

2. Develop procedure for redistribution of unused allotments: due date 6/98

C. State Plan Approval Process

1. Need to prepare and disseminate to States instructions regarding submission, approval, and amendment of SPAs: due date 9/15

2. Develop guidelines for Regional office/Central office review of plans: due date 10/1

D. State Payment Process

1. Establish a workgroup to develop and design state instructions for submission of claims under Title XXI: due date 1/98

2. Prepare and publish a Federal Register notice specifying state FMAP rates available under title

XXI: due date 1/98

E. Medicaid Program Coordination

1. Develop state medicaid letter and/or fact sheet: due date 9/15
2. Develop revised State Medicaid plan pre-print for expansion: due date 10/1
3. Develop instruction for claims reporting and data collection: due date 10/1
4. Best practices stories of simplified eligibility/ administrative simplification: due date 10/1

F. Miscellaneous Provisions

1. Develop instructions for annual reports and evaluations with appropriate input from internal and external parties: due date 6/98
2. Develop instructions for determining relation to other laws (HIPAA, ERISA) with appropriate input from internal and external parties: due date 6/98
3. Develop instructions for 12 month option with appropriate input from internal and external parties: due date 6/98
4. Develop other definitions with appropriate input from internal and external parties: due date 6/98

III. Outreach meeting logistics/strategy

A. Intergovernmental

1. State NGA/APWA/NCSL/APWA/ASHTO/NAIC
2. Local NACO/Conf of Mayors/League of Cities/NACCHO etc.
3. Program Administrators MCH/NACMHPD/etc.

B. Beneficiaries, Provider Organizations, Foundations, Advocates

C. Faith Community

D. Unions

E. Business Groups Chamber of Commerce/Washington's Business Group on Health, etc.

F. America's Promise

G. Congressional Caucus specific outreach

IV. Coalition on Healthy Communities/Healthy Cities

Brings together local, state, and national organizations and individuals to assist communities to better address their priority health and quality of life issues. This collaboration among the private, public and non-profit sectors is required to develop long-term solutions to complex and interrelated issues, and build a foundation for creating healthier communities.

A. Strategic planning session last week in Chicago attended by HRSA staff.

B. October 1 meeting @ HHS to discuss strategy to design partnership on how to work on implementation.

V. Agency for Health Care Policy and Research (AHCPR)

The User Liaison Program (ULP) was established in the late 1970's to meet the information and research needs of consumers or "users" of health services research. The ULP translates, synthesizes, and disseminates health services research findings, in easily understood and usable formats to State, local, and Federal policymakers. The primary ULP mechanisms for this information transfer to policymakers are highly interactive workshops and seminars presented in a non-prescriptive manner.

VI. Hotline

A phone, internet, or bulletin board hotline has been discussed. The application should be created to allow the person accessing the site to know that their question had been received, and indicate process for response.

VII. Internet Site

Home pages of HHS, HCFA, HRSA, WH, etc. should have an icon to pull down relevant information and details on CHIP.

VIII. Daily Fax Update

Similar to the Welfare Daily report, a "Kids Health Report" should be developed and distributed on a wide basis.

1997 Children's Health *September* 1997

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	1	2	HHS Steering Committee 3	HCFA Center on Beneficiary Services, Baltimore, MD (Fenton) 4	5	6
7	HHS Steering Committee 8 CSG/Southern Gov's Annual Meeting, 9/7-9, Hot Springs, VA	WH /DPC/HHS Meeting 9	HHS Steering Committee 10	NGA Meeting 11 Advocacy Group Meeting at HHS	NGA Meeting 12	13
APWA-Information Systems Management Annual Conference, 9/14-19, St. Louis, MO 14	-HHS Steering Committee 15 -NCSL/Assembly of Federal Issues Chairs meeting, DC -Nat'l Advisory Committee on Rural Health, DC (Barnette) -AHCPR, User Liaison Program, 9/15-17, Charlottesville, VA -Nat'l Latino Child. (speech)	WH/DPC/HHS Meeting 16 WH/WLL/WAND Meeting	HHS Steering Committee 17 CHIP IGA Planning Meeting Nat'l Coalition on Health Care meeting	18	19	Nat'l Association of Insurance Commisioners Fall Meeting, , 9/20-24, DC 20
21	HHS Steering Committee 22	WH/DPC/HHS Meeting 23	HHS Steering Committee 24 ASTHO 1997 Annual Meeting, 9/23-26, Scottsdale, AZ	CSG/Midwestern Legis.ative Conference, 9/25-27, Lincoln, NE 25	Sec'ty speech-March of Dimes, NYC,NY 26	27
28	HHS Steering Committee 29	WH/DPC/HHS Meeting 30				

1997 Children's Health

October

1997

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	National Domestic Violence Awareness Month		HHS Steering Committee 1 CHIP IGA Meeting	2	3	National Association of Social workers Annual Meeting, 10/4-7, Baltimore, MD 4
5	HHS Steering Committee 6 APWA-Organizational and Professional Development Seminar, 10/6-7, Denver, CO (child care and other issues) CHILDREN'S HEALTH DAY	WH/DPC/HHS Meeting 7	HHS Steering Committee 8	Nat'l Commission on Partnerships for Children's Health meeting (Sec'ty's calendar) 9	10	11
12	HOLIDAY 13	WH/DPC/HHS Meeting 14	HHS Steering Committee 15 CHIP IGA Meeting	16	NCSL Health Seminar, 10/17-19, Naples, FL (HHS invited) 17	18
19	HHS Steering Committee 20	WH/DPC/HHS Meeting 21	HHS Steering Committee 22	23	24	25
APWA-Nat'l Association of State Medicaid Directors, Annual Conference, 10/26-29, Alexandria, VA 26	HHS Steering Committee 27	WH/DPC/HHS Meeting 28	HHS Steering Committee 29 CHIP IGA Meeting	30	Association of American Medical Colleges Annual Meeting, 10/31-11/6, Washington, DC 31	

1997 Children's Health November 1997

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
30	National Adoption Month	National Diabetes Month				American Academy of Pediatrics Annual Meeting, 11/1-5, New Orleans, LA 1
2	HHS Steering Committee 3	WH/DPC/HHS Meeting 4 (Election Day)	HHS Steering Committee 5 NCSL, Assembly on Fed'l Issues, and Assembly on State Issues joint meeting, 11/5-7, DC	6	7	8
CSG/Southern Legislative Conference Fall Issues Conf.., 11/9-12, Oklahoma City, OK 9 American Public Health Assoc. Annual Meeting, 11/9-13, Indianapolic, IN	HHS Steering Committee 10 Health Insurance Association of America Annual Meeting, 11/9-13, Orlando, FL	HOLIDAY 11 Veterans' Day	HHS Steering Committee 12 CHIP IGA Meeting	NACO, Employment-Human Services Conference, 11/13-17, Tulsa, OK 13	14	15
16	HHS Steering Committee 17	WH/DPC/HHS Meeting 18	HHS Steering Committee 19 NCSL Sr. Legislative Drafting Seminar, 11/19-22, Sacramento, CA	20	NCSL Health Seminar, 11/21-23, Newport , RI (HHS invited) 21	22
23	HHS Steering Committee 24	WH/DPC/HHS Meeting 25	HHS Steering Committee 26 CHIP IGA Meeting	HOLIDAY 27 THANKSGIVING	28	29

1997 Children's Health

December

1997

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	HHS Steering Committee 1 *World AIDS Day*	WH/DPC/HHS Meeting 2	HHS Steering Committee 3 --CSG-WEST-50th Pacific Anniv. Meeting, 12/3-5,KohalaCoast, Island of Hawai --American Legislative Exchange Council,Freshman Legislator Orientation, 12/3-6, D C	National League of Cities annual meeting, 12/4-7, Philadelphia, PA 4	CSG 1997 Annual Meeting $ State Leadership Forum, 12/5-9, Honolulu, Hawaii 5	APWA-Nat'l Council of State Human Svc Admin. & Nat'l Council of Local Public Welfare Admin. Winter meeting, 12/6-10, San Francisco, CA 6
7	HHS Steering Committee 8	WH/DPC/HHS Meeting 9	HHS Steering Committee 10 CHIP IGA Meeting	11	12	13
14	HHS Steering Committee 15	WH/DPC/HHS Meeting 16	HHS Steering Committee 17	18	19	20
21	HHS Steering Committee 22	WH/DPC /HHS Meeting 23	HHS Steering Committee 24 CHIP IGA Meeting	HOLIDAY 25 CHRISTMAS	26	27
28	HHS Steering Committee 29	WH/DPC/HHS Meeting 30	HHS Steering Committee 31	HOLIDAY NEW YEAR'S DAY		

cc: Patti
Jen
FYI
Pam

DéLaro, Incorporated

737 N. Michigan Avenue
Suite 1923
Chicago, IL 60611

Telephone 312-751-9696
Fax 312-751-9660

August 4, 1997

Mrs. Hillary Clinton
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear Mrs. Clinton:

Pursuant to our discussion about Marian Wright Edelman and having spent time with her at The Haley Farm last week, I have determined the best way to honor Mrs. Edelman's twenty five years as a child advocate would be to have a fund-raiser, gala. Anytime in April 1998, with the exception of the 9th through the 14th, for the observance of Passover, is a good time for her. The gala would be here in Chicago and I would like to know if your schedule permits you and your family to attend in the month of April. I would appreciate any dates you may have available during that time, and any comments concerning this effort. If possible please have your secretary call Mallory at my office 312-751-9696, or fax the information 312-751-9660 as soon as possible so I may pursue a commitment from the hotel, entertainment etc.

Many blessings.

Sincerely,

Deloris Jordan

/sh

Children's Defense Fund

August 4, 1997

First Lady Hillary Rodham Clinton
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500-2000

Dear Hillary:

As always, thank you for your continuing leadership on behalf of children and their health care. The children's health provisions in the budget reconciliation bill will enable millions of uninsured children to obtain critical health care coverage. Millions will enter school with the immunizations, the physical and mental health care, the eyeglasses and the hearing aids they need to succeed in learning.

We at the Children's Defense Fund look forward to working with you and your staff in encouraging governors and legislators to maximize this historic opportunity for children by putting in place strong, comprehensive child health insurance programs in the states.

You have been a key part of every legislative success for children in recent years. Thank you for continually highlighting children's needs and the solutions as you travel the nation and the world. Thank you for being there for children when they need you.

Sincerely yours,

Marian Wright Edelman

-- 8/4/97 from **Marian Wright Edelman**, thanking for your leadership on behalf of children and their health care. They at CDF look forward to working with you and your staff in encouraging governors and legislators to maximize the opportunity for children by putting in place strong, comprehensive child health insurance programs in states. Thank you for highlighting children's needs and the solutions, and for being there when they need you.

CC To Melanne, Jan, Chris J for info/followup per HRC
✓ File; NRN

25 E Street, NW
Washington, DC 20001
Telephone 202 628 8787
Fax 202 662 3510

August 11, 1997

MEMORANDUM TO THE FIRST LADY

FROM: Chris J.

SUBJECT: Children's Health Update

cc: Melanne, Jen

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

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

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

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

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

I hope you find this information useful.

Jennings
Lambrew
COS

THE WHITE HOUSE

WASHINGTON

August 6, 1997

MEMORANDUM TO THE PRESIDENT

FROM: Chris Jennings and Jeanne Lambrew

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

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

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

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

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

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

The Birth of Clintoncare Jr. . . .

By ROBERT M. GOLDBERG

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

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

Luring Children

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

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

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

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

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

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

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

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

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

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

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

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

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

Clinton's Greatest Legacy

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

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

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

THE WALL STREET JOURNAL
TUESDAY, AUGUST 5, 1997

ACCOUNTABILITY IN THE CHILDREN'S HEALTH INITIATIVE

PROVISIONS PREVENTING SUBSTITUTION FOR PRIVATE COVERAGE

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

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

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

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

PROVISIONS PREVENTING SUBSTITUTION FOR PUBLIC COVERAGE

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

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

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

ACCOUNTABILITY PROVISIONS

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

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

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

FRAUD AND ABUSE PROVISIONS

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

To the Editor:

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

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

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

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

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

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

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

6-3709

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 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 Americans -- and their children -- keep their health care coverage when they 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.

JEANNE

THE WHITE HOUSE

WASHINGTON

MEMORANDUM

TO: **DISTRIBUTION**

FROM: Chris Jennings and Jeanne Lambrew

RE: **CHILDREN'S HEALTH PROGRAM SUMMARY**

DATE: July 31, 1997

Attached is a cleared, 2-page summary of the children's health program, for your information.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

FUNDING

- **About $24 billion between FY 1998- 2002, about $50 billion over 10 years.**
  - Grant spending: $20 billion over five years
  - Other spending: $4 billion over five, including:
    - Coverage for new children enrolled in Medicaid because of the grant program's outreach and required referral of eligible children to Medicaid.
    - Medicaid options for 12-month continuous & presumptive eligibility.
    - Medicaid spending for SSI children who otherwise loose coverage due to welfare reform, two new diabetes grant programs, and revenue effects.
- **State Allotment:** Each state will receive a proportion of the total grant allotment (minus 0.25% spending on the territories). The proportion is determined by each participating state's share of the following:

  1998-2000: Product of (1) proportion of low-income, uninsured children and (2) geographic cost adjuster

  2001: Product of (1) 75% of the proportion of low-income, uninsured children; (2) 25% of the proportion of low-income children and (3) geographic cost adjuster

  2002-2007: Product of (1) 50% of the proportion of low-income, uninsured children; (2) 50% of the proportion of low-income children and (3) geographic cost adjuster.

  States' allotments remain available to each state for three years. After that, any unspent funds are reallocated to states that have used up their allotments.

- **Matching payments:** Federal matching rates are increased to provide incentives for states to participate. As a result, states' contributions are 30% below their Medicaid state matching rate. Provider taxes, donations, other Federal spending, and premiums and cost sharing do not qualify as contributions eligible for Federal matching funds.

ELIGIBILITY

- Children whose income is up to 200% of poverty or 50 percentage points above the state's Medicaid eligibility (whichever is higher). Children who are Medicaid-eligible, privately covered, in prisons, or have parents who are state employees are ineligible.

BENEFITS

- **Services**: States may choose one of three benefits minimums:

  - Plan equivalent to a benchmark plan
  - Plan with the same actuarial value as a benchmark plan
  - Secretary-approved plan.

  Benchmark plans include:

  - FEHBP Blue Cross / Blue Shield PPO option
  - State employee health plan that is generally available
  - HMO with the highest commercial enrollment in the state
  - For NY, FL, and PA, their current state-only programs' benefit plans.

  Actuarial equivalence option: States must (1) cover four basic services (inpatient & outpatient hospital services; physicians' surgical & medical; laboratory & x-ray; and well-baby/well-child care, including immunizations); (2) have an aggregate actuarial value (with adjustments) at least equal to the benchmark plan; and (3) assure that the plan's mental health, vision, hearing, and prescription drug benefits have at least 75% of the actuarial value of prescription drug, mental health, vision and/or hearing services in the benchmark plan.

  Cost sharing: Cost sharing is limited depending on the family income:

  - Below 150% of poverty: premiums no greater than those in Medicaid and cost sharing consistent with Medicaid but appropriately adjusted by the Secretary.
  - Above 150% of poverty, premiums and cost sharing that do not exceed 5% of the family's income.

  Administrative costs, outreach and direct services: Limited to no more than 10% of the states' expenditures in this program.

ACCOUNTABILITY

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

- **Protections against substitution**: State must develop processes to assure that they are not replacing existing coverage. The program is always secondary payer.

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

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

- **Fraud and abuse**: Certain Medicaid and Medicare provisions apply.

Our Chance for Healthier Children

By Hillary Rodham Clinton

WASHINGTON

The 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 checkups 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 parents lose jobs.

A big step toward insuring all Americans.

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 assure 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 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 have also taken other steps to bring better health care to the nation's young people, from passage of the Kassebaum-Kennedy 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.

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. □

The New York Times
TUESDAY, AUGUST 5, 1997

Destroying Land Mines Doesn't Make Sense

To the Editor:

According to a report by the Human Rights Watch arms project, American land mines were picked up in the field or stolen from stockpiles and used against our troops in Korea and Vietnam (news article, July 29). They also killed American soldiers returning through their own minefields. Therefore, the report says, we should destroy them to reduce the risk to our forces. The history is accurate, but the conclusion is nonsense.

Mines used in Korea and Vietnam were laid by hand. They were armed by removing a pin and could be disarmed by replacing the pin. Most of today's United States mines are dropped by aircraft or otherwise remotely delivered; they are sealed and can't be disarmed once laid. Enemy troops foolish enough to try to pick up an active mine for re-use will be killed. Moreover, to let our soldiers move back through the areas we have mined, our mines self-destruct at a preset time after being laid. Thus the mines don't injure or kill civilians after the battle.

Yes, our mines could be stolen, as could any other weapon. Rifles, for example, are easier to steal and to use than remotely delivered mines. Presumably we will next be told that our troops will be safer if we take away their rifles. ENID MCKITRICK

Gaithersburg, Md., Aug. 1, 1997

Reflections on a Lake

To the Editor:

My mind was flooded with childhood memories when I read your Aug. 3 front-page article on "boat-in worship" at Lake Wawasee in Syracuse, Ind. Fifty-two years ago this week I was attending Presbyterian summer camp at Lake Wawasee when the first atomic bomb was dropped and a few days later when Japan surrendered at the end of World War II. I remember how we gathered for services in the Billy Sunday Tabernacle.

At mid-century Lake Wawasee had a strong tradition as a center for leading evangelists — Sunday, Homer Rodeheaver and others — a tradition shared with better-known locales like Chautauqua, N.Y., and Oak Bluffs, Mass.

Indeed, lakes stimulate reflection, whether Lake Wawasee or Walden Pond (where I reflect), especially in the morning and again at dusk. The lakes project a primal beauty that is irresistible. MARTHA H. ZIEGLER

Cambridge, Mass., Aug. 3, 1997

The Times welcomes letters from readers. Letters must include the writer's name, address and telephone number. Those selected may be shortened for space reasons. Fax letters to (212) 556-3622 or send by electronic mail to letters@nytimes.com, or by regular mail to Letters to the Editor, The New York Times, 229 West 43d Street, New York, N.Y. 10036-3959.

What Burroughs Read

To the Editor:

Citing the authors that William S. Burroughs read during his years at Harvard, your Aug. 4 obituary contends that "his favorite writers gave no hint of what was ultimately to come out of his typewriter." Rather, they gave every hint.

James Joyce and Joseph Conrad were linguistic innovators, as Burroughs would become. Both Jean Genet and Franz Kafka dug in the same mines of rebellion, pessimism and dissolution of identity. The moral ambiguity and epistemological doubt found in the writings of Raymond Chandler and Graham Greene also permeate Burroughs's work. Nor was this debt merely implicit. With his "cut-up" technique, Burroughs appropriated phrases from the works of these and other authors, incorporating them into his novels. HUGH SIEGEL

New York, Aug. 4, 1997

Protecting Elephants By Hunting Them

To the Editor:

Matthew Scully ("Kill an Elephant, Save an Elephant," Op-Ed, Aug. 2) not only makes hunters sound like bon vivants with weapons who manage to bag an elephant just in time for cocktails, but also makes us believe that they are solely responsible for the elephant's diminished numbers in southern Africa.

The idea of shooting elephants for the economic development of rural villagers may sound reprehensible to Americans, but Campfire, a program in Zimbabwe under which elephant hunting is allowed as a means of raising local revenue, actually benefits elephant numbers. Drought, competition for land and poaching in Africa reduced the elephant population in Africa from 1.3 million in 1979 to less than 700,000 in 1987. Since the Campfire program was instituted in 1989, Zimbabwe's elephant population increased almost 42 percent, to more than 68,000 in 1995.

Mr. Scully implies that the Campfire program sanctions a Wild West shootout of elephants, but Campfire has strict quota controls on the number of elephants that can be hunted per year. In 1993, only 171 were killed. ALLAN RICHARDS

Fort Lauderdale, Fla., Aug. 2, 1997

Subsidize U.S. Railroads

To the Editor:

The resurgence of the railroad industry (Business Day, Aug. 1) is good news for the economy and the environment. The more freight that is shipped by rail, the fewer pollution-causing trucks on our roads, reducing traffic and wear and tear. To be truly successful, however, we need to reduce unfair government subsidies on trucking.

While railroads must build, maintain and pay taxes on their rights of way, the Government pays for the construction and maintenance of roads. While trucks do pay tolls and other fees, the revenue does not come close to the expenses of roads.

If we believe in free market capitalism, then we should make our roads free from subsidies. Or if our transportation system is a Government responsibility, then we must provide subsidies for rail lines, passenger and freight. MICHAEL ROGOVIN

New York, Aug. 1, 1997

Beware The Real Agenda

By Douglas J. Besharov

WASHINGTON

Americans have made it clear that they don't want national health insurance. But the five-year, $24 billion provision in the budget bill to finance medical care for two million children is a move in just that direction. And the way this expansion of benefits is designed makes no economic sense.

For every dollar's worth of new coverage, states will wind up spending $1.70. That is because for every 100 uninsured children who enroll in the program, another 70 who now have private insurance are also expected to sign up, according to Congressional Budget Office estimates. Why? Families that now qualify under the plan's expanded income guidelines may stop buying private insurance because government will pay for the children's health care. Or employers will stop offering coverage, knowing that government is now obligated to do so.

The Congressional Budget Office warned about this problem last spring. But in their eagerness to reach a budget deal, Republicans in Congress gave up their initial opposition and voted for the plan anyway.

Throughout the year, as the child health plan worked its way through Congress, Republicans insisted that it be structured in the form of block grants to states. This, they argued, would give states the flexibility to experiment. While some states would have simply expanded Medicaid coverage, most probably would have offered no-frills plans that would have discouraged people with access to private insurance from trying to sign up.

But advocates of national health insurance complained that the block grant approach would let states use the money for other purposes. More important, they claimed, the no-frills approach implicitly condoned "second class" health insurance. Still, they were prepared to settle for whatever expansion in national health coverage they could get.

A new entitlement, poorly designed.

But the political balance shifted in the President's favor, and the Republicans retreated. They agreed to detailed regulations on how states could spend the child health care money. In effect, they agreed to create another entitlement.

For example, each state is required to provide the same benefits for children as Medicaid or large private insurance plans. In many cases, state benefits will be more generous than those private employers offer. Another provision calls for public coverage to be provided to families earning as much as 235 percent of the poverty level, depending on the state. For a family of four, that's almost $38,000 a year.

The inefficiency and high cost of the program may not bother advocates of universal health care; they argue that Americans, especially children, deserve to have coverage. But what they don't acknowledge is that this plan will reduce the market for low-cost insurance used by small businesses and the working poor.

A 1996 study by researchers at the Massachusetts Institute of Technology and Harvard found that previous expansions of Medicaid were responsible for about 17 percent of the decline in the number of children covered by private insurance from 1987 to 1992. That study also reported that as many as half of the children who enrolled in expanded Medicaid plans did so because once they became eligible for those programs, their parents lost coverage at work or decided not to buy insurance.

The more the Government shrinks the insurance market for low-income people, the less economical it becomes for companies to offer them coverage. Companies either abandon the market or raise their prices. Either way, the number of uninsured people increases — and so do calls for more Government involvement.

Maybe that's the real agenda. But it's a long way from here to there, and in the meantime, this plan will do more harm than good. □

Douglas J. Besharov is an American Enterprise Institute resident scholar and a professor at the University of Maryland School of Public Affairs.

The New York Times
TUESDAY, AUGUST 5, 1997

Observer

RUSSELL BAKER

Fanatics, Terror, $6.75

All through "Air Force One" I kept thanking the gods who watch over America for not letting this movie be made before Ronald Reagan left the Oval Office.

It was terrifying to think what Mr. Reagan, who was famous for confusing movies with real life, might have done if he'd felt obliged to live up to standards set by President Harrison Ford.

The physical ordeals overcome by President Ford (Harrison, not Gerald) would require a level of physical fitness found only in the rarest Olympic champion.

Ronald Reagan could never have been the sweet, good-humored President we all loved had he felt obliged to sacrifice his long, refreshing naps and sweat his days away under a personal trainer determined to tighten up the Presidential abs.

President Ford, despite all the bad air and sleepless nights that go with a successful political career, still has the muscle to beat the bejeebers out of a half-dozen diehard-Commie terrorists and the know-how to pump most of them full of complicated-automatic-handgun lead.

He also has the cool, witty savoir-faire, despite these exertions, to tell the head terrorist "Get off my airplane," while tossing him through an open hatch.

And not only that!

This is a President who can take a punch that would break Mike Tyson's jaw. Does he fight back with incisors and canines to his opponent's ear?

How can he? His arms — the Presidential arms! — are tied behind the Presidential back. He is completely at the mercy of his captor, who takes the opportunity to deliver a series of brutal bare-knuckle punches to the jaw — the Presidential jaw!

President Ford the action hero.

Any one of these punches would shatter the jaw of the average President and every bone in the hand of the man who delivered it. Harrison Ford, however, is not your average President.

He has had his old, breakable jaw replaced with a granite implant. Such are the medical miracles available free to politicians entitled to the socialized medicine provided at Walter Reed Hospital.

And a good thing, too, because, pummel that jaw as he will, the terrorist brutalizing the President gets only an impatient glare from Harrison Ford. The expression on the President's face makes us, out there in the audience, grateful that we are not fanatical terrorists. It says, "You're going to regret this, buddy."

Please don't ask if the terrorist has bought a granite fist from Terrorist Supplies and Collectibles Inc., and, if not, why his fist doesn't hurt. Didn't I tell you he's a fanatic? Fanatics don't feel pain.

You may be wondering why Air Force One — the President's plane, not the movie — turns out to be as big as Logan Airport once you get inside. Isn't it obvious? President Ford had it built that way.

"Look," he told the people at Boeing, "one of these days Air Force One is going to be hijacked by terrorist fanatics, and I'll need a lot of nooks and crannies to hide in until I can get rid of them. How about redesigning the thing so it's no bigger than an airplane on the outside but roughly the size of Logan Airport inside?"

The President's know-how about really good hiding places inside Air Force One is only one small part of the great mass of evidence proving that America knew what it was doing when it elected Harrison Ford to be its chief executive.

Though previously tutored only in helicopters, this is a President at ease taking the controls of his 747 jumbo. Sure, fanatical-terrorist-type fighter pilots using air-to-air missiles have shattered its tail assembly, but the plane senses there is a master in the cockpit.

"Feels sluggish," President Ford observes, maneuvering Logan Airport with an aplomb that might turn Chuck Yeager green with envy.

Is there nothing this President can't do? Yes, and how heart-warming it is to see him take out a mobile telephone and immediately turn to an instruction manual on how to use it. Of course, this being President Harrison Ford, it doesn't take him two and a half hours to learn how to get results.

This being President Harrison Ford, he does it in 3.5 seconds. Now that's going too far. It defies belief. □

The New York Times
TUESDAY, AUGUST 5, 1997

On My Mind

A. M. ROSENTHAL

Management by Arafat

"Oh Allah, destroy America, for she is ruled by Zionist Jews.... Allah will paint the White House black.... Allah will take revenge on the colonialist settlers who are sons of monkeys and pigs.... forgive us, Muhammad, for the acts of these sons of monkeys and pigs who sought to harm your sanctity."

That prayer was delivered in the mosque on Jerusalem's Temple Mount by Yasir Arafat's handpicked mufti, the chief Islamic cleric of the city. It got a drop of attention in the ocean of Western press coverage about Israel and the Palestinians. The same amount of attention has been the general Western news judgment about other specimens in the unending anti-Jewish propaganda committed by Palestinian officials and clerics and distributed by Palestinian radio and journalism.

> The Palestinian hate campaign.

Mostly, however, the Western press has paid no attention at all to innumerable attacks by Palestinians against the odious religion, nature and criminality of Jews. Western news people apparently have heard so much of this hate-spewing that some of them became professionally disabled and spiritually uncaring.

When they do pay some attention to a particular anti-Jewish nastiness it is usually as if it is some isolated incident. It is not put into its essential context: a deliberate, planned campaign by Yasir Arafat and his Palestinian Authority to dehumanize the Jews with whom they are supposed to want peace.

At that, the press has a better record than the renowned world leaders who were so keen on the Oslo agreement that was supposed to bring the peace — like Presidents Clinton, Yeltsin and Chirac and Chancellor Kohl. They say nothing about the anti-Jewish campaign. Of course not — they would have to point out that this kind of propaganda was considered incitement to violence in the Oslo and Hebron agreements and that Mr. Arafat made international commitments against it — often. Prime Minister Blair?

I am not dealing again only with Mr. Arafat's incitement to terrorism. His anointment of Hamas as a "patriotic" organization, his glorification of terrorists as martyrs, his failure to disarm terrorists and his "jihad, jihad, jihad" chants are all on the record. The litany of his violation of agreements against terrorism and hostile propaganda is so loud that it embarrasses even the State Department, which has been whitewashing him throughout the BushBaker and Clinton Administrations.

I have in mind another enterprise under Arafat management, just as dangerous. Americans who admire him may not like to think about it, but the entire campaign of Jew hatred is carried out with Arafat permission to Arafat officials and through Arafat government machinery.

It is the Arafat Information Minister who congratulates "all the holy martyrs" who died trying to destroy Jewish settlements.

It is the Arafat representative at the U.N. Human Rights Commission who says Jews infected 300 Arab children with the AIDS virus, his Culture Ministry that issues press releases accusing Israel of germ warfare.

Only the spilling of Israeli blood will teach Prime Minister Benjamin Netanyahu a lesson — a clutch of Arafat officials like that one. The enemy has no mercy, hearts of stone, "they are not human beings and one cannot compare them to people; they are like animals" — from the Arafat Palestinian radio.

"The dogs have settled in you, Jerusalem" is one of the pleasanter lines in a poem the Arafat radio broadcast during the intifada and repeated in May. And we have the Arafat Deputy Minister of Health who said that in an "organized conspiracy" by Israeli defense forces, Israel was distributing food with material that causes cancer and impotence.

And so sickeningly on and on — with brief time-outs for teary Arafat visits to the White House. If the U.S. does not persuade Mr. Arafat to plug his sewer of hate, peace will become not a possibility but a miracle.

But no — from the officially directed mouth of Nicholas Burns, the State Department spokesman, only a few months ago came the appraisal that the Palestinians had met their commitments to Oslo, have officials who cooperate with Israel and the U.S., and what's more were "led by a man who has made a fundamental commitment to peace."

"I don't think we have a problem there," said he. □

THE WHITE HOUSE

WASHINGTON

THE PRESIDENT HAS SEEN
3-10-97

February 21, 1997

MEMORANDUM TO THE PRESIDENT

FROM: Bruce Reed and Gene Sperling

SUBJECT: Background Information on Uninsured Children

Following up your meeting with Erskine on Friday, we asked Chris Jennings to provide you with the attached detailed background memo on the status of uninsured children in the nation, a description of possible policy options to address the problem, and an overview of the budgetary and political environment that surrounds this issue. We have also asked him to give you a status report on TennCare and the possible lessons Governor McWherter's legislative success could teach us about the upcoming debate on children's coverage.

Both parties in Congress are considering a number of ways to expand coverage to children: tax incentives, grants to states, Medicaid reform, and vouchers. There is no consensus yet either on the most sensible policy or on the most politically viable approach.

Because we expect this issue to be a top priority in budget negotiations, we have begun a joint DPC-NEC process to review and analyze continually evolving options that are emerging from the Congress. We will use this process to provide you with updated information and to develop sound policy options as the budget debate progresses. We have scheduled a meeting with you on Monday to discuss this issue with you further.

THE WHITE HOUSE

WASHINGTON

February 21, 1997

MEMORANDUM TO THE PRESIDENT

FROM: Chris Jennings CCJ

SUBJECT: Background Information on Uninsured Children

This memo responds to your request for background information about uninsured children. It includes:

(1) A summary of the problem and recent trends that define it;
(2) A description of who the uninsured children are and why;
(3) A brief description of the challenges of covering children;
(4) An overview of the major approaches to covering children; and
(5) An overview of the budgetary and political environment surrounding this issue.

In addition, there are two attachments, one that describes in detail our children's policies and a second on TennCare. Since you have indicated an interest in the status of TennCare, we have attached a three-page summary of the history and status of this innovative program. I asked Nancy-Ann Min to review and edit this document to make certain it provides you with a balanced and up-to-date portrayal of the TennCare experience.

UNINSURED CHILDREN: DESCRIPTION AND TRENDS

Number of Uninsured Children

- **In 1995, 10 million, or 14 percent, of all children lacked health insurance.** This proportion is higher than age groups over 45 years old (13 percent), but less than the 18 to 44 year old age group (about 25 percent). Despite major changes in the private health care coverage (outlined below), the proportion of uninsured children has hovered around 13-14 percent for almost a decade.

Trends

- **Employer coverage has declined.** While the proportion of uninsured kids is unchanged, it hides an underlying trend: coverage of children through employer plans has decreased (from 67 percent in 1987 to 59 percent in 1995). While some have asserted that this decrease stems from employers dropping dependent coverage, two facts challenge this theory. First, the proportion of adults as well as kids with employer coverage has declined, from 70 percent in 1988 to 64 percent in 1995. Second, about 80 percent of uninsured children have uninsured parents. This suggests that the decline in employer coverage is a family problem, not just a children's problem.

  One of the major reasons for the decline in employer-sponsored insurance has to do with the change in the U.S. labor market. Since the 1980s, industries have tended to outsource (subcontract with smaller firms) and hire more part-time workers; these workers are less likely to have health insurance. Additionally there has been a shift away from industries that are more likely to offer insurance, like manufacturing, to industries that often don't offer insurance, like retail. Finally, there has been an increase in workers in firms with less than 25 workers; about 30 percent of workers in firms with fewer than 25 employees lacked health insurance in 1995, relative to about 12 percent for workers in firms with 500 or more employees. In short, it is not that firms are dropping children's coverage so much as employment is shifting to firms less likely to offer insurance.

- **Medicaid coverage has increased, but is slowing.** The reason why the decline in employer coverage has not increased the number of uninsured children is Medicaid. In 1990, Federal law required states to begin phasing in coverage of poor children. As a result, the proportion of children covered by Medicaid increased from 16 percent in 1987 to 23 percent in 1995.

  Recent research suggests, however, that Medicaid did not necessarily help the children who lost their parents' employer coverage. Instead, it expanded coverage to families who did not have full-time workers, lowering the number of uninsured poor children at the same time as the employer trend increased the number of uninsured near poor children.

  While Medicaid has stabilized the proportion of the nation's children without insurance, its expansion is subsiding. In 1994 and 1995, the number of children covered by Medicaid barely increased. This is now reflected in lowered projections of the number of children covered by Medicaid in the future. The Congressional Budget Office (CBO) projects that the number of children covered by Medicaid will grow no faster than general population growth over the next 10 years.

- **Proportion of uninsured children may increase.** If recent trends continue (employer coverage declines and Medicaid expansions slow) and state and Federal government efforts are not stepped up, the number of uninsured children will rise.

WHO ARE UNINSURED CHILDREN

- **Most in working families.** Over 80 percent of uninsured children have a parent who works (two-thirds of these children's parents work full year, full time) (Chart 1).

- **Income varies.** There are large numbers of uninsured children across the income spectrum. In 1995, more than 3 million uninsured children were in families in each of the following income groups: poor, near poor (between 100 and 200 percent of poverty), and middle class (above 200 percent of poverty). Families just above poverty (between 100 and 150 percent of poverty) had the highest rate of uninsured children (24 percent), probably because they are above the Medicaid thresholds but have too little income to afford private coverage (Chart 2).

- **Concentrated in the south and southwest.** There is wide variation in the proportion of uninsured children across states. A disproportionate number of children reside in the south and southwest; in 1995, about 43 percent of all children but 55 percent of all uninsured children resided in these states (Chart 3). In part this reflects those states' Medicaid programs: southern states are less likely to have taken advantage of Medicaid options to expand coverage to children. This concentration also reflects these states' higher prevalence of low-income families, industries that don't provide health insurance, racial and ethnic groups less likely to be covered by insurance, and noncitizens (up to 22 percent of uninsured children — 2.2 million — may be legal immigrants).

WHY ARE CHILDREN UNINSURED

1. **Parents change jobs.** Because most children receive coverage through their parents' jobs, job changes disrupt the continuity of children's coverage. Nearly half of all children who lose health insurance do so because their parents lose or change jobs (Chart 4). About 30 percent of all children, regardless of income, spent at least one month without insurance between 1992 and 1994. In fact, when looking at workers with one or more job interruptions, they are over three times more likely to spend some time without insurance (42 percent relative to 13 percent of workers continuously employed). Thus, middle class children are at risk of losing insurance due to parents' job changes.

2. **Parents earn too much for Medicaid but too little for private coverage.** The highest rate of uninsured children is among families above poverty but below middle class. Low-wage workers are more likely to be employed by firms that do not offer health insurance; only 36 percent of workers earning less than $5 per hour in 1993 were employed by a firm sponsoring health insurance. Since the individual market for health insurance is volatile and costly, families without access to employer coverage may have few options. Even when these families are offered employer-sponsored insurance, they cannot always afford it. When job-related insurance loss is put to the side, the most important reason why children lose insurance is that it is too expensive for the family.

3. **Eligible but not enrolled in Medicaid.** Medicaid has not reached all of the children who qualify for it. An estimated 3 million uninsured children are eligible but not enrolled in Medicaid. Nonparticipation in Medicaid varies considerably across states; one report estimated that the proportion of these children ranged from a low of 7 percent in Vermont to 46 percent of eligibles not enrolled in Nevada. While there are no definitive studies on this problem, some reasons why this occurs include: lack of awareness of eligibility; the welfare stigma associated with Medicaid; cumbersome application processes; and availability of other coverage in the state (employer or state program).

CHALLENGES TO COVERING CHILDREN

Policy options to cover uninsured children usually share the goal of trying to cover the most children for the least amount of money. Children are probably the least expensive population to insure. Their health insurance premiums range from $800 to $1,600, depending on factors like the child's health status, the benefits, and the delivery system. Assuming that an initiative could successfully cover all and only uninsured children at $1,000 per child, the Federal costs would be $10 billion annually — not a small sum. While this amount does not take into account any state, private and family contributions, it also does not consider upward pressures on costs resulting from two challenging issues: (1) substitution of Federal dollars for current employer and state contributions; and (2) administrative complexity of the option. The extent to which an option addresses these issues is central to determining both its cost and coverage potential.

- **Substitution or "crowd out".** Given that uninsured children are not a homogenous group, it is important to design policies that encourage the enrollment of uninsured children but discourage enrollment of already-insured children. Participation in any health insurance program depends both on the families' interest in health insurance and the attractiveness of the policy. While the former cannot be altered, the latter is determined by a policy's visibility, benefits, ease of application, and, most importantly, cost. The higher the premium subsidy, the greater the likelihood of participation.

  The goal of encouraging participation of the uninsured is often at odds with an equally strong desire to ensure that already-insured children do not drop their current coverage. Almost any new initiative risks substitution of Federal coverage for employer coverage, known as "crowd out". Generally, employer crowd out is a problem with policies that extend above 200 percent of poverty, since the number of children with employer coverage increases with income. A different type of crowd out happens when the new initiative replaces state or Medicaid coverage of children. Since most states have used Medicaid options or have funded state-only programs for children, it is nearly impossible to design a policy that does not overlap with at least a few states' programs. Both types of crowd out are problematic because they increase Federal costs without increasing covered children.

- **Administration.** In any subsidy program, there is a conflict between the desire to target efficiently and to limit complexity and bureaucracy. Targeting requires sophisticated rules and protections against substitution of existing coverage and fraud and abuse. This results in a large bureaucratic role in determining eligibility, implementing the program, and enforcing the rules. However, the organization charged with administering the program (probably states and/or the IRS) may not be willing or able to manage this role. Finding the appropriate administrative balance is particularly important in children's initiatives given the heightened complexity of the problem, described above.

Given these issues, it is impossible in a voluntary system to cover more than two-thirds to three-quarters of the 10 million uninsured children without large-scale substitution of Federal dollars for current employer health insurance payments. If one tried, the costs would be prohibitive — much more than the $10 billion per year in the theoretical, perfectly targeted situation. This is because it would unavoidably cover children who now have employer insurance. Moreover, to the extent to which the policy is designed to mitigate employer crowd out with rules, it risks penalizing responsible employers. The best way to prevent employer crowd out is to prevent employers who insure children from eliminating that coverage. Yet, this effectively mandates the employers who have responsibly insured children to maintain that coverage, while letting employers who have not been so responsible off the hook. This helps explain why at some level one cannot get beyond a certain threshold of uninsured people without an individual or employer mandate.

OPTIONS FOR COVERING CHILDREN

Recognizing the complexity of the problem and the challenges in addressing it, proponents have considered four general approaches to increase health insurance coverage for children: tax credits, state grants, Medicaid expansions, and more traditional subsidy programs linked to a new entitlement (usually called vouchers). Clearly, there are other types of approaches, such as employer/individual mandates or a Medicare program for children. While such policies might well be more efficient to administer and more comprehensive in effect, they are not viable by any measure of today's economic and political environment. This section describes the four most considered approaches generally and discusses the major issues surrounding them.

1. **Child health tax credits.** Child tax credit proposals use a built-in system to give subsidies to families that have purchased coverage for their children. Usually this subsidy is granted either in a retrospective, annual refundable tax credit or as "advances", using changes in the withholding on payroll checks like in the earned income tax credit (EITC). While some proposals make the amount of the credit income-related, others have proposed flat credit amounts for all families. All rely on the IRS to administer and to some extent monitor the credit through tax withholdings, filings, refunds and audits.

Proposals for tax credits for children's health coverage are frequently poorly targeted since their goal is to help all families — not just uninsured families — afford coverage. While this approach is equitable, it also is an expensive way to increase coverage since more money will go to families with insurance than without insurance. Additionally, the ability of the IRS to administer a child health tax credit is not proven. In 1991-1992, it oversaw a child health tax credit that was repealed in 1993 for many reasons, including problems that Treasury encountered in monitoring fraud and abuse.

2. **Grants to states.** A second option is to give states grant money to let them design their own programs. Today, most states sponsor non-Medicaid programs, often in partnership with the private sector. In Florida, for example, the Healthy Kids Program combines local, state and family contributions to cover low-income children through schools (we may want to highlight this program at or around your visit to Florida in March). Grant programs allow Federal money to either leverage these types of state programs or create new ones (like the workers between jobs initiative).

States are probably the most efficient vehicle for administering a child health coverage initiative, since they already manage the health care coverage for 18 million children on Medicaid. However, the flip side of this advantage is that they have an incentive to use any new grant money to replace state spending. It is hard to design policy "walls" that prevent this from happening.

3. **Medicaid.** Given the central role that Medicaid already plays in covering children, expanding Medicaid is one of the simplest ways to increase kids' coverage. There are three ways that Medicaid could be changed to increase the number of children covered. First, the current program could be improved. As described earlier, Medicaid intends but does not succeed in covering all eligible children. Legislative and regulatory changes could be made to make Medicaid more accessible and last longer once the child is in the system (e.g., improve outreach, allow states to extend continuous coverage for 12 months). Second, states could be given either more flexibility or a financial incentive to expand optional coverage. For example, states could be allowed to charge premiums to children above the mandatory levels, as is done in several 1115 waiver states. Third, Federal law could be changed to require states to cover more children. However, concerns about unfunded mandates makes any Medicaid mandate extremely difficult to support.

Medicaid options, like others, risk crowding out employer coverage, but the potential is usually low since they mostly focus on populations without access to employer insurance. This low employer crowd out, coupled with low state crowd out (since it builds on rather than replaces Medicaid), make Medicaid options among the most efficient. However, using Medicaid places administrative constraints on the option. It is hard to ask states to use Medicaid to administer a policy that is substantially different than Medicaid in terms of eligibility and benefits.

4. **Vouchers.** A fourth option is a 100 percent Federally funded entitlement program for children's health coverage. This approach allows for national standards for coverage and eligibility but usually relies on states to administer the program.

   This approach, like tax credits, is hard to target. Vouchers create a large financial incentive to substitute Federal for employer and/or state funding. Some options have developed complex eligibility rules to minimize this risk (e.g., restricting eligibility to children uninsured for six or more months). However, the more concerted the effort to keep insured children out of the program, the more difficult it is to implement. And, since the Federal government does not have offices equipped to determine eligibility and deliver subsidies (aside from the IRS), this administration would likely fall to states.

These approaches are not mutually exclusive and can be used in combination. For instance, a state grant program can be coupled with a tax credit to assist families in purchasing coverage. Alternatively, a grant program could be designed to begin where Medicaid coverage ends. Not only are these combinations possible; they may be needed since no single approach can cover the diverse group of uninsured children.

In fact, our children's health initiative uses multiple policies rather than a single, one-size-fits-all approach. We take on the three reasons why children lose coverage through: a grant program for children losing coverage when their parents lose their jobs; a grant program for children with too much income for Medicaid but too little to afford coverage; and a package of Medicaid improvements to target children who fall through the cracks (see attachment for more details). We chose this approach because it covers several rather than one group of uninsured children, it limits crowd out, and it strengthens our partnerships with states. The risk of our policies' crowding out private coverage is not large because (a) the workers between jobs initiative only provides dollars when employer contributions cease (ie., when the worker becomes unemployed) and (b) the state grant and the Medicaid proposals focus on kids that usually do not have private coverage. Administratively, the proposal works with existing state systems rather than requiring Treasury to set up a new program.

The disadvantages of the proposal are, first, that it relies heavily on leveraging state and private dollars, so that covering 5 million children is a best-case scenario. The Medicaid improvements and state grant program require state dollars. State and Federal money in the baseline is used to cover the 1 million poor children phased into Medicaid under current law. While we project that 1 to 2 million children will be enrolled in Medicaid through outreach, we have not explicitly funded it in the budget. Second, we have put the least amount of money toward the group that may have the greatest problem: children in working families without access to employer insurance. Beyond the low level of funding of our proposal ($750 million per year), any state grant program targeting this group is vulnerable to states' substituting this money for existing state funding. Third, on the political front, our proposal does not integrate the approach that is most frequently included in Congressional proposals: tax incentives.

While many Congressional proposals also use a combination of policies, they almost always include some type of tax incentive — clearly the option of choice for Republicans and many Democrats. This reflects Members' attempt to avoid the appearance of a new open-ended Federal program [ironically, the provisions in your proposal are all capped, while tax incentives are open ended, since they entitle a class of people to a particular subsidy]. We did not include such a proposal in our children's health initiative because of concerns about crowd out and because the Department of Treasury believes such approaches are extremely difficult to administer. However, given the potential for both additional money for coverage and Republican support that comes with tax proposals, we will work aggressively on options that could integrate them.

CONCLUSION: CURRENT BUDGETARY AND POLITICAL ENVIRONMENT

As described above, there are countless approaches to expanding coverage for children. And, there will inevitably be additional "unveilings" of proposals in the near future. That a consensus has not developed early in the debate is not surprising. In fact, it is a generally positive development for it gives Members the opportunity to be invested in whatever option can emerge from the Congress. It also gives us the ability to provide helpful technical advice that concurrently keeps us informed of Hill approaches and gives us the opportunity to steer policy options in appropriate directions.

Unfortunately, however, the opposition to our Medicaid per capita cap and DSH policies continues to complicate our ability to get a positive "lift" from our $18 billion investment in coverage expansion. The advocates and Governors — who should be our allies on a children's coverage initiative — are dedicating most of their time and resources to fighting our Medicaid policy. This is despite the fact that we are saving only $9 billion off an over $600 billion, 5-year Medicaid baseline. The disappointing consequence of the Governors' and interest groups' lack of advocacy for our proposal may well be that Republican Members and staff may think that there is little price to pay for deleting coverage investments from the budget.

Having said this, there continues to be strong interest among the Democratic Leadership to include a significant health coverage expansion in any final balanced budget agreement. Succeeding in getting such a high priority item in the final budget might help us keep key Democrats on board in what will be an otherwise difficult vote.

The Blue Dogs are planning on releasing their budget proposal next week. Initial reports suggest that they are going to avoid significant tax cuts and investments at this point. This includes initiatives in the area of children's health coverage. However, Blue Dog staff have suggested that they are taking this position for strategic reasons. They believe it enables their Members to bargain back votes using their excess savings, and have suggested that this could include investments in health care. Notably, the most conservative Members of this coalition (Condit and Hall) have expressed interest in policies to address workers between jobs.

Even more noteworthy has been a quiet movement among a number of Republicans (Gramm, Specter, Jeffords, Chafee, Archer and Bliley) to consider a major health coverage expansion investment for children. This obviously contrasts dramatically with the last Congress, which pushed the coverage issue off of any legislative priority list.

Despite this encouraging news, it remains unclear whether the interest in children's coverage, particularly among Republicans, will be retained after budgetary limitations and policy complexities are imposed on Members. In response, many Republicans may conclude that coverage expansions should be a low priority for them.

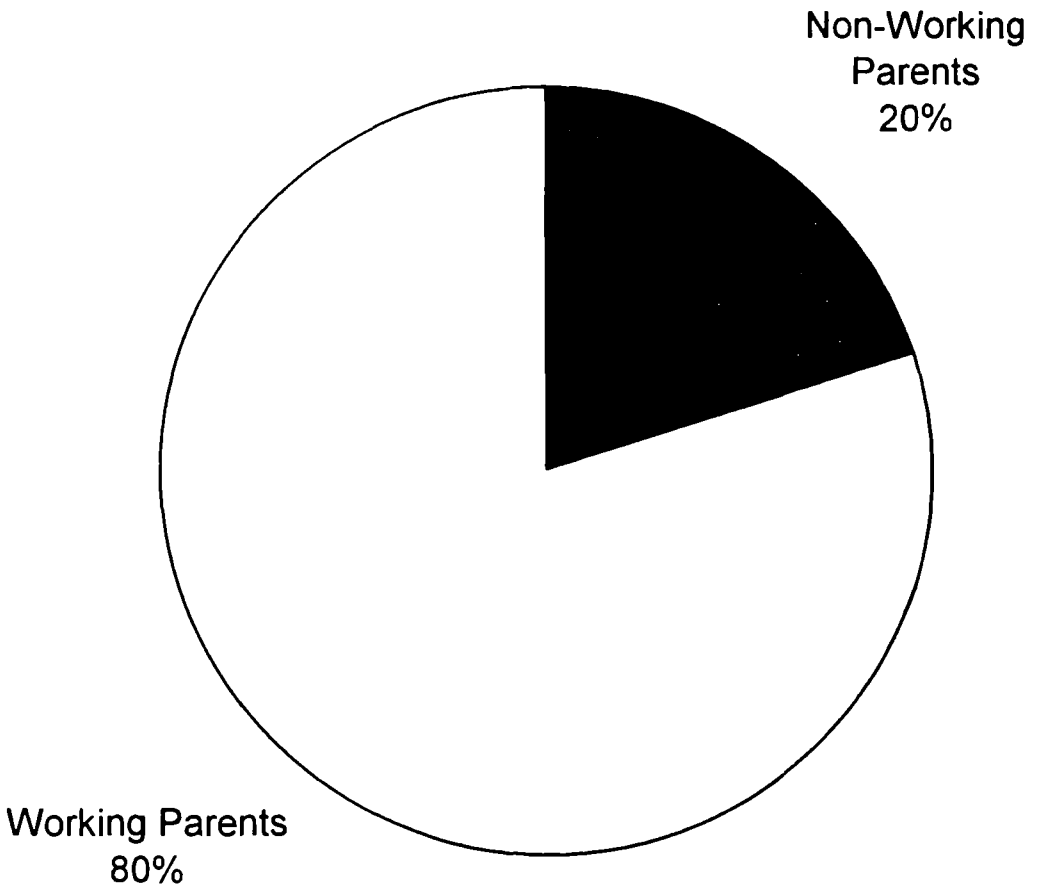
To keep a credible number of Republicans on board will require either major positive or negative incentives (or some combination of both). On the positive side, Republicans will have to believe that they will get at least some of the credit for the policy; they rightly think that Democrats — and particularly you — always get the lion's share of the credit for any health initiative. On the negative side, we will have to create an environment in which they feel they cannot reject a particular children's coverage policy without risking severe political consequences.

To this end, we will need to dedicate time for you and other Administration representatives to highlight the importance of expanding coverage in the context of a balanced budget, stressing the need for a bipartisan commitment in this area. We also will work with influential interest groups to let them know that they need not endorse the particulars of our approach but that they must send strong, unified signals that it is critical to make investments in children's health coverage in this year's budget.

John Hilley agrees that our best Congressional strategy may well be to directly or indirectly continue to encourage Republicans to get out in front of this issue and introduce their own approaches. Even if we find ourselves disagreeing with their policies, we should resist public criticism or comment. The most important goal for now is to get the budget committees to direct the authorizing committees to finance some coverage improvements. If they do, we will have assured funding for an initiative and will still have sufficient time to raise concerns at the authorizing committee level about particular approaches.

As Bruce and Gene mentioned in their memo, we are continuing our DPC-NEC policy review process to monitor legislative evolutions on the Hill and to determine whether we need to re-position our policy or modify our strategy. This process will enable us to evaluate new Hill proposals in great detail, provide you with Administration-wide opinion of them, and to make recommendations to you about legislative, communications and political strategy around children's health proposals.

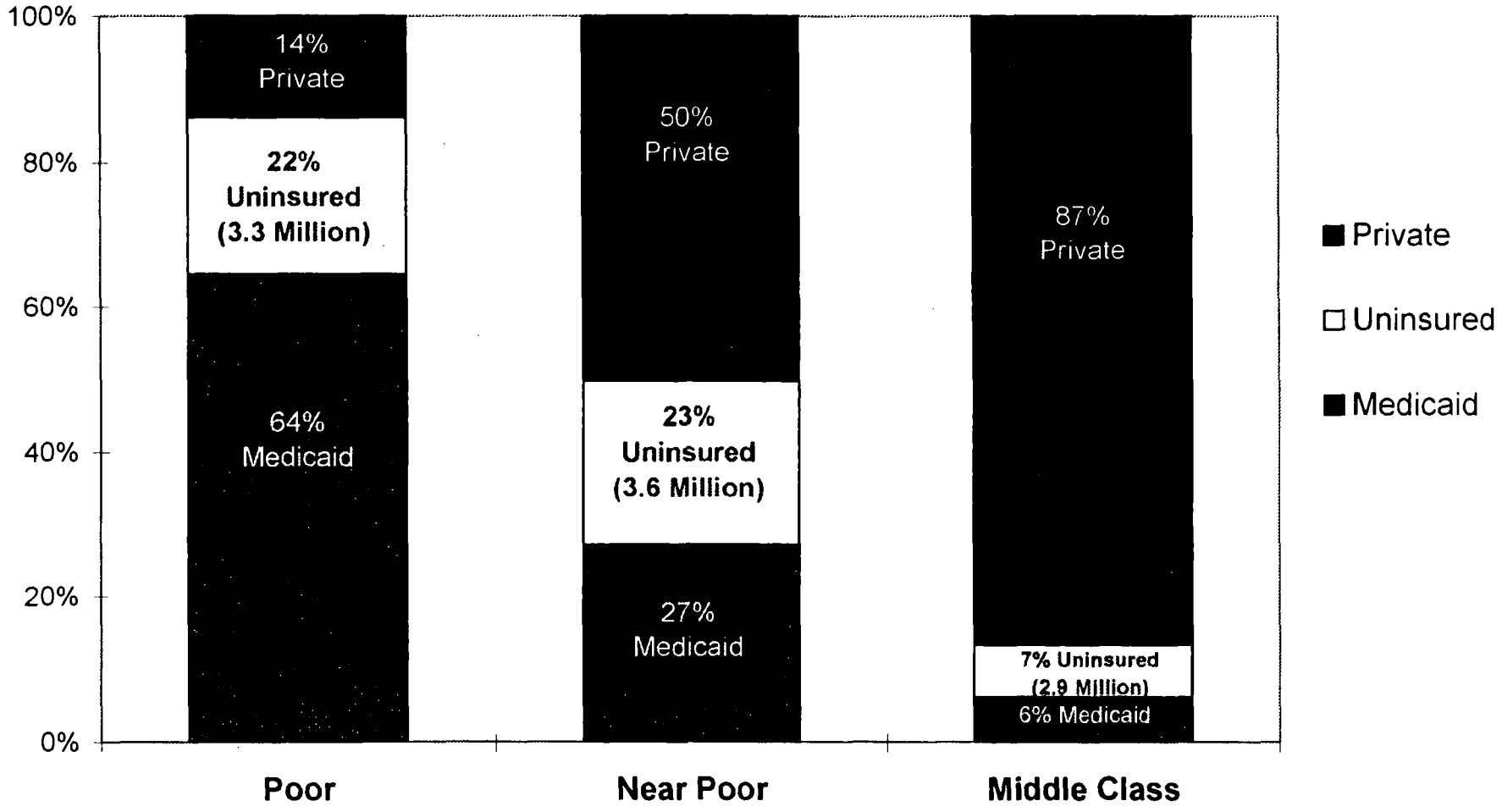
Most Uninsured Children Have a Parent Who Works



Note: 56% of children (two-thirds of working children) have parents who work full year, full time
Source: EBRI, 1996

Chart 1

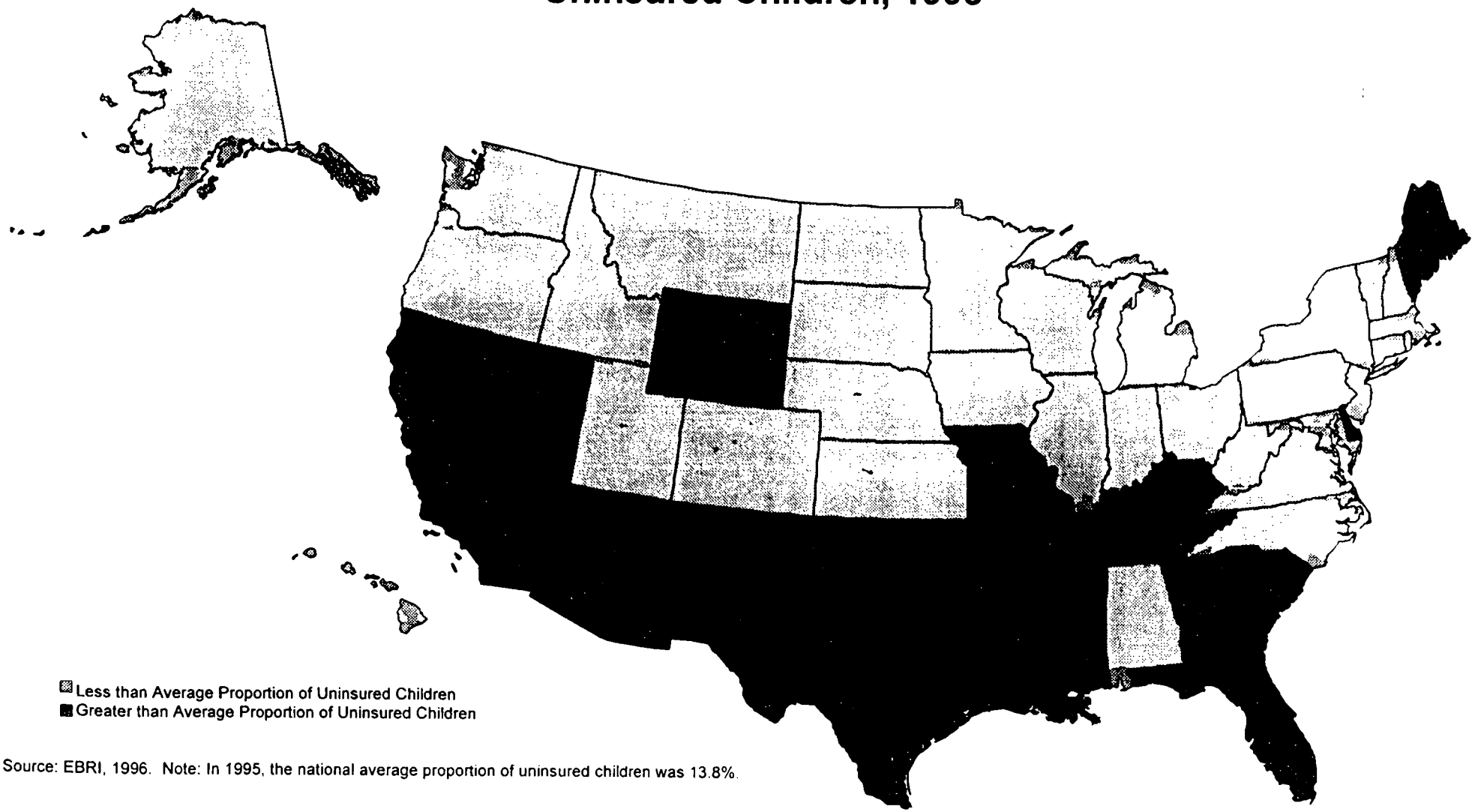
Children's Health Coverage, 1995
Proportion of Children Covered by Different Sources



"Poor" means < 100% of poverty; "Near Poor" means 100-199% of poverty; "Middle Class" means > 200% of poverty. "Private" includes nongroup and other coverage.
Source: EBRI, 1996

Chart 2

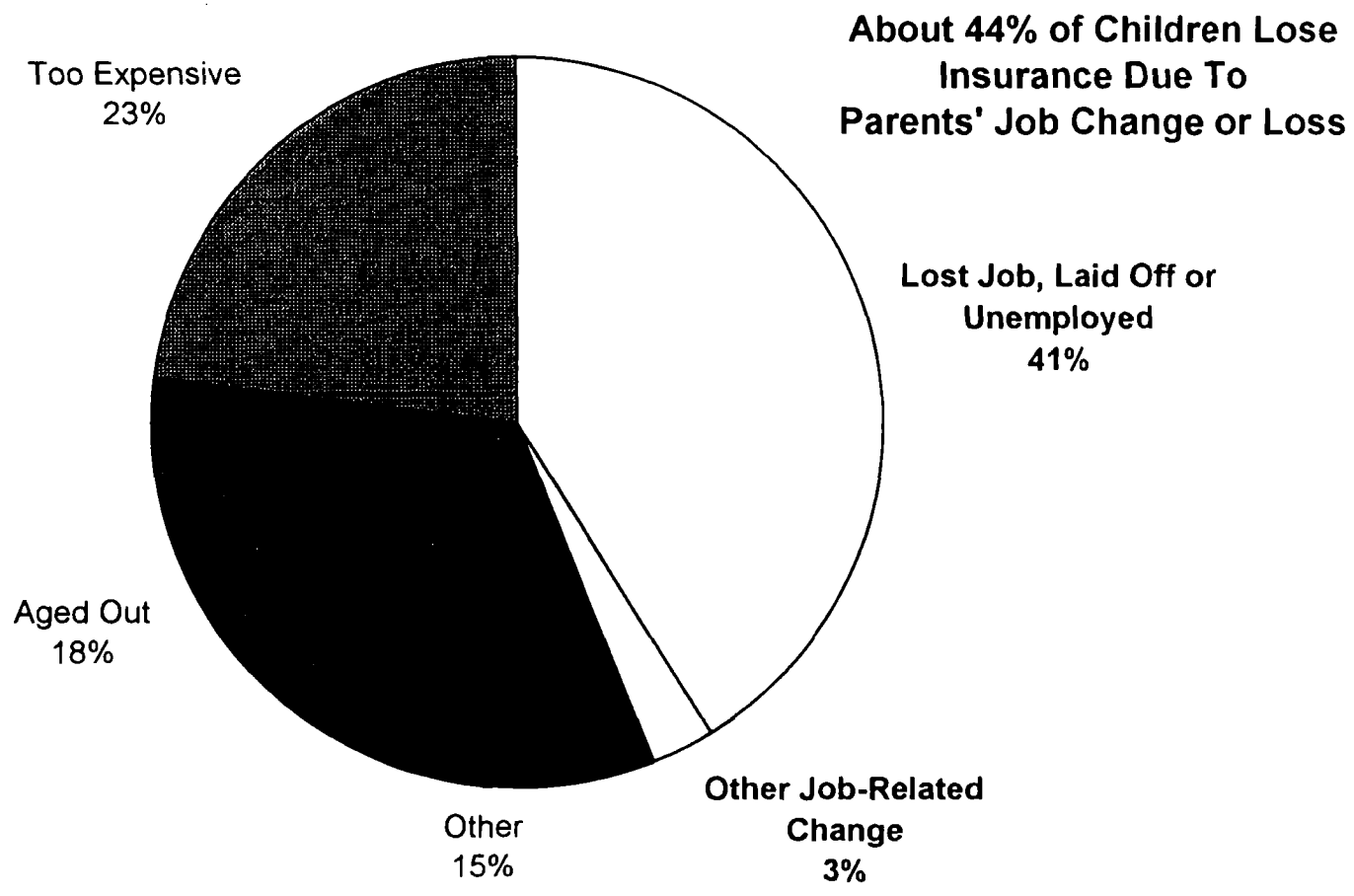
Uninsured Children, 1995



Source: EBRI, 1996. Note: In 1995, the national average proportion of uninsured children was 13.8%.

Chart 3

Reasons Why Children Lost Health Insurance



Note: "Other Job-Related Change" includes shifting to part-time work and employer ending coverage; "Aged Out" means that the child's age change ends eligibility; "Other" includes death or divorce of parent and voluntary termination, etc. Includes children under age 22.

Source: Sheils & Alecxih, 1996.

Chart 4

PRESIDENT' FY 1998 BUDGET
CHILDREN'S HEALTH INITIATIVE

Significant gaps remain in children's health coverage. In 1995, 10 million children in America lacked health insurance. While there are many different reasons why children lack insurance, most uninsured children can be found within three groups, each of which require separate initiatives:

- **Children at risk because their parents change jobs:** Because most children receive coverage through their parents' jobs, job changes disrupt the continuity of children's coverage. Nearly half of all children who lose health insurance do so because their parents lose or change jobs.

- **Children whose parents earn too much for Medicaid but too little for private coverage:** The highest rate of uninsured children is among families who earn too much to qualify for Medicaid but too little to afford coverage. Nearly one in four children in families with income just above poverty have no health insurance.

- **Children eligible but not enrolled in Medicaid:** Medicaid has not reached all the children who qualify for it. About 3 million children are eligible but not enrolled.

Working with States, communities, advocacy groups, providers, and business, the President's initiative will extend coverage to up to 5 million children by 2000.

Continuing Coverage for Children Whose Parents are Between Jobs

- The President's budget will give States grants to temporarily cover workers between jobs, including their children, at a cost of $9.8 billion over the budget window.

- The program would offer temporary assistance (up to 6 months) to these families between jobs who have lost their coverage. This assistance may be used to purchase coverage from the worker's former employer (through COBRA) or other private plans, at States' discretion. States have the option to participate in this grants program, which is structured as a four-year demonstration.

- Families are eligible for full premium assistance if their monthly income is below 100 percent of poverty, and partial premium assistance if their income is below 240 percent of poverty. Only families who do not have access to Medicaid or insurance through a spouse's employer and are receiving unemployment compensation are eligible.

- This program will help an estimated 3.3 million working Americans and their families, including 700,000 children.

- The President's budget also makes it easier for small businesses to establish voluntary purchasing cooperatives, increasing access to insurance for their workers and children.

Building Innovative State Programs for Children in Working Families

- The President's budget provides $750 million a year in grants to States ($3.8 billion between 1998 to 2002). States may use these grants to offer reduced-price insurance for children and leverage State and private investments in children's coverage through a matching system (using the Medicaid matching formula).

- The Federal grants, in combination with State and private money, will target uninsured children whose families earn too much to qualify for Medicaid but too little to afford private coverage. The grant program will also improve Medicaid enrollment since some families interested in the new program will learn that their children are in fact eligible for Medicaid.

- Grants may be used to target the unique problems facing children in each State. The program builds upon the successful efforts of States that have tailored programs to address the particular gaps in coverage for their children. For example, the Florida Healthy Kids program uses schools to enroll and insure children. States have flexibility in designing eligibility rules, benefits and delivery systems. In return for this flexibility, States will provide annual evidence of positive outcomes of the grant money — specifically the number of uninsured children it helps.

Strengthening Medicaid for Poor Children

- The President's budget preserves and strengthens Medicaid's guaranteed coverage for low-income children. In addition to improving coverage for the 18 million children already covered by Medicaid, it continues the commitment to expand coverage to another one million children between the ages of 13 and 17.

- The President's budget gives States the option to extend one year of continuous Medicaid coverage to children. This will cost an estimated $3.7 billion between 1998 and 2002.

    - Currently, many children receive Medicaid protection for only part of the year. This is because Federal law requires a family that has a change in income or some other factor affecting eligibility to report it immediately, possibly making them ineligible for Medicaid.

    - This policy allows States to waive the more frequent redetermination and guarantee coverage for up to one year. This benefits families who will have the security of knowing that their children will be covered by Medicaid for at least a full year. It will also help States by reducing administrative costs and managed care plans by enabling them to better coordinate care.

- The President also proposes to work with the Nation's Governors, communities, advocacy groups, providers and businesses to develop new ways to reach out to the 3 million children eligible but not enrolled in Medicaid.

PRESIDENT'S FY 1998 BUDGET
CHILDREN'S HEALTH INITIATIVE

Significant gaps remain in children's health coverage. In 1995, 10 million children in America lacked health insurance. While there are many different reasons why children lack insurance, most uninsured children can be found within three groups, each of which require separate initiatives:

- **Children at risk because their parents change jobs:** Because most children receive coverage through their parents' jobs, job changes disrupt the continuity of children's coverage. Nearly half of all children who lose health insurance do so because their parents lose or change jobs.

- **Children whose parents earn too much for Medicaid but too little for private coverage:** The highest rate of uninsured children is among families who earn too much to qualify for Medicaid but too little to afford coverage. Nearly one in four children in families with income just above poverty have no health insurance.

- **Children eligible but not enrolled in Medicaid:** Medicaid has not reached all the children who qualify for it. About 3 million children are eligible but not enrolled.

Working with States, communities, advocacy groups, providers, and business, the President's initiative will extend coverage to up to 5 million children by 2000.

Continuing Coverage for Children Whose Parents are Between Jobs

- The President's budget will give States grants to temporarily cover workers between jobs, including their children, at a cost of $9.8 billion over the budget window.

- The program would offer temporary assistance (up to 6 months) to these families between jobs who have lost their coverage. This assistance may be used to purchase coverage from the worker's former employer (through COBRA) or other private plans, at States' discretion. States have the option to participate in this grants program, which is structured as a four-year demonstration.

- Families are eligible for full premium assistance if their monthly income is below 100 percent of poverty, and partial premium assistance if their income is below 240 percent of poverty. Only families who do not have access to Medicaid or insurance through a spouse's employer and are receiving unemployment compensation are eligible.

- This program will help an estimated 3.3 million working Americans and their families, including 700,000 children.

- The President's budget also makes it easier for small businesses to establish voluntary purchasing cooperatives, increasing access to insurance for their workers and children.

Insuring Children

BY STUART AUERBACH

IRWIN, Pa.

Jodie Gavin's serene middle-class lifestyle ended in the wreckage of a car crash that killed her husband, Larry, and his brother 3½ years ago on what she now ruefully describes as a "chance-of-a-lifetime family vacation" to see relatives in Ireland.

The vibrant young wife and mother of two young sons was transformed into a 28-year-old widow who was forced to cope without her husband's paycheck and benefits to pay for all the normal trappings of life: mortgage payments on a neat one-story home, health insurance, money for food, clothing and recreation.

"We came home and the kids were crying. They asked me, 'Will we have to move from our house, Mom?' " Gavin recalled.

Another big worry was health coverage. Her youngest son, Philip, now 6, suffers from congenital heart disease that so far has required three operations. The family had been covered through the husband's job as a maintenance supervisor at the University of Pittsburgh. Although Gavin could have continued her husband's policy, the $650-a-month price tag was beyond her income of $1,476 a month in Social Security benefits.

"It was either food on the table or health insurance or pay the mortgage or health insurance. Social Security meant I was too rich for medical assistance, and I couldn't afford to buy insurance myself," she said.

"Those were really hard times. I didn't know what to do. I was afraid we'd all end up on the street somewhere."

Her most immediate health concern was Philip's heart problem.

A relative told Gavin about the Western Pennsylvania Caring Program for Children, a private community initiative, administered by the local Blue Cross Blue Shield organizations, to provide health insurance to children of parents who can't afford to buy it themselves but whose income is too high to qualify for federal-state Medicaid.

Gavin was able to enroll Philip and Larry, 9, without a waiting period. Once enrolled they had their own Blue Cross Blue Shield card; as far as any doctor or hospital knew, they were members of the health care plan. But the cost of the insurance was borne not by the Gavin family or a private employer, but by the Caring Program, which is funded through charitable donations and state funds.

While the Caring Program only covers children from 1 to 19, Blue Cross Blue Shield offers low cost coverage to parents of children in the Caring Program for $730 a year. "I was devastated by my husband's death. But because of the Caring

A Full Range of Benefits

The 12-year-old program, now expanded to the entire state and financed largely through a two-cent-a-pack tax on cigarettes, provides health insurance for 60,000 Pennsylvania children, 26,000 in the 29 counties of western Pennsylvania. The program provides a full range of health care benefits including visits to doctor's offices, immunizations, diagnostic tests, emergency care, outpatient surgery, dental treatments, vision and hearing care, prescription drugs (with a $5 co-payment), mental health care and hospitalizations.

While the coverage is free for eligible children, Charles P. LaVallee, vice president and executive director of the Caring Program, calculated the cost of the insurance at $850 a year for each enrolled child.

"Covering kids is relatively cheap. Extending coverage to more children should not be a big financial burden," said E. Richard Brown, director of the University of California at Los Angeles Center for Health Policy Research, which studied uninsured children in California.

The Western Pennsylvania Caring Program has been replicated in 26 states by Blue Cross Blue Shield. In some states, including Massachusetts, the program is financed by increases in the cigarette tax.

Pennsylvania's children health insurance program is targeted largely to middle-class working families who don't get health insurance for their children as part of their employee benefits and don't earn enough money to buy insurance on their own. They also earn too much to be eligible for Medicaid. Under the Pennsylvania program, a family of four earning $28,860—185 percent above the $15,600 poverty line—qualifies for free health insurance for their children.

In western Pennsylvania, 92 percent of newly enrolled children have parents who work full or part time. This reflects the national profile of the uninsured. A UCLA study found that nine of 10 uninsured children in California come from a working family and 60 percent of the uninsured children come from families with at least one full-time working parent. The Children's Defense Fund found similar figures in a national sampling, as a growing number of parents are working for employers who no longer offer health insurance for children as a benefit.

A new study released last week by Families USA Foundation, based on federal census data, reported that an estimated 23 million American children were without health insurance coverage for at least one month during a two-year period.

"America's uninsured children live in families where the breadwinners work hard, pay taxes and play by the rules. But they don't get health coverage on the job, for themselves or their children. And they can't afford to pay for it out-of-pocket," said Ron Pollack, executive director of Families USA.

Avoiding Trips to the Doctor

A typical situation is that of Susan Din, executive director of

BY STUART AUERBACH

IRWIN, Pa.

Jodie Gavin's serene middle-class lifestyle ended in the wreckage of a car crash that killed her husband, Larry, and his brother 3½ years ago on what she now ruefully describes as a "chance-of-a-lifetime family vacation" to see relatives in Ireland.

The vibrant young wife and mother of two young sons was transformed into a 28-year-old widow who was forced to cope without her husband's paycheck and benefits to pay for all the normal trappings of life: mortgage payments on a neat one-story home, health insurance, money for food, clothing and recreation.

"We came home and the kids were crying. They asked me, 'Will we have to move from our house, Mom?' " Gavin recalled.

Another big worry was health coverage. Her youngest son, Philip, now 6, suffers from congenital heart disease that so far has required three operations. The family had been covered through the husband's job as a maintenance supervisor at the University of Pittsburgh. Although Gavin could have continued her husband's policy, the $650-a-month price tag was beyond her income of $1,476 a month in Social Security benefits.

"It was either food on the table or health insurance or pay the mortgage or health insurance. Social Security meant I was too rich for medical assistance, and I couldn't afford to buy insurance myself," she said.

"Those were really hard times. I didn't know what to do. I was afraid we'd all end up on the street somewhere."

Her most immediate health concern was Philip's heart problem.

A relative told Gavin about the Western Pennsylvania Caring Program for Children, a private community initiative, administered by the local Blue Cross Blue Shield organizations, to provide health insurance to children of parents who can't afford to buy it themselves but whose income is too high to qualify for federal-state Medicaid.

Gavin was able to enroll Philip and Larry, 9, without a waiting period. Once enrolled they had their own Blue Cross Blue Shield card; as far as any doctor or hospital knew, they were members of the health care plan. But the cost of the insurance was borne not by the Gavin family or a private employer, but by the Caring Program, which is funded through charitable donations and state funds.

While the Caring Program only covers children from 1 to 19, Blue Cross Blue Shield offers low cost coverage to parents of children in the Caring Program for $730 a year. "I was devastated by my husband's death. But because of the Caring Program, I knew that my children could stay in this house and that I could clothe them, that I could feed them and that I could love them," Gavin said.

The Pennsylvania program is gaining attention as a national model for covering the growing ranks of uninsured children, estimated as totaling 10 million across the nation.

A Full Range of Benefits

The 12-year-old program, now expanded to the entire state and financed largely through a two-cent-a-pack tax on cigarettes, provides health insurance for 60,000 Pennsylvania children, 26,000 in the 29 counties of western Pennsylvania. The program provides a full range of health care benefits including visits to doctor's offices, immunizations, diagnostic tests, emergency care, outpatient surgery, dental treatments, vision and hearing care, prescription drugs (with a $5 co-payment), mental health care and hospitalizations.

While the coverage is free for eligible children, Charles P. LaVallee, vice president and executive director of the Caring Program, calculated the cost of the insurance at $850 a year for each enrolled child.

"Covering kids is relatively cheap. Extending coverage to more children should not be a big financial burden," said E. Richard Brown, director of the University of California at Los Angeles Center for Health Policy Research, which studied uninsured children in California.

The Western Pennsylvania Caring Program has been replicated in 26 states by Blue Cross Blue Shield. In some states, including Massachusetts, the program is financed by increases in the cigarette tax.

Pennsylvania's children health insurance program is targeted largely to middle-class working families who don't get health insurance for their children as part of their employee benefits and don't earn enough money to buy insurance on their own. They also earn too much to be eligible for Medicaid. Under the Pennsylvania program, a family of four earning $28,860—185 percent above the $15,600 poverty line—qualifies for free health insurance for their children.

In western Pennsylvania, 92 percent of newly enrolled children have parents who work full or part time. This reflects the national profile of the uninsured. A UCLA study found that nine of 10 uninsured children in California come from a working family and 60 percent of the uninsured children come from families with at least one full-time working parent. The Children's Defense Fund found similar figures in a national sampling, as a growing number of parents are working for employers who no longer offer health insurance for children as a benefit.

A new study released last week by Families USA Foundation, based on federal census data, reported that an estimated 23 million American children were without health insurance coverage for at least one month during a two-year period.

"America's uninsured children live in families where the breadwinners work hard, pay taxes and play by the rules. But they don't get health coverage on the job, for themselves or their children. And they can't afford to pay for it out-of-pocket," said Ron Pollack, executive director of Families USA.

Avoiding Trips to the Doctor

A typical situation is that of Susan Din, executive director of the Ligonier Valley Chamber of Commerce.

See INSURING CHILDREN, Page 12

The Pennsylvania program is gaining attention as a national model for covering the growing ranks of uninsured children.

The Washington Post
TUESDAY, APRIL 1, 1997

1/3

ourselves. There was no way we could have afforded insurance. It was just food on the table and mortgage payments," Din said.

"I just kept saying to the kids, 'Don't get sick.' "

Without insurance, Din also avoided going to the doctor. The family was lucky. There were no injuries or major illnesses. Her husband, Angie, now has a job with an axle manufacturing company in Michigan, where the family will move after the school year is over.

"I can't wait until we get insurance [from her husband's new job]," she said. "I haven't seen a doctor in three years."

She explained that she didn't sign her children up for the Caring Program because her family was not destitute. "We had a nice house and investments we could tap into. We are not like people who don't have anything. There's a lot we could have gone through before we got to the place where a lot of people already are," Din said.

"But I still was afraid to go to the doctor in case he found something wrong. That could wipe us out."

That is a common fear among parents with no health insurance for their children. A survey taken for the Caring Program by the University of Pittsburgh health economists Judith R. Lave and Edmund Ricci found that three out of four parents of uninsured children postpone going to the doctor, preferring to save that cost to pay for medical care for their children.

Because they can't afford it, many parents also put off getting needed treatment for their children.

As a result many of the children who come into the Caring Program have unmet medical needs. The Pittsburgh study found that one in four new enrollees needed to see a doctor for untreated ailments such as asthma, bronchitis, bruised kidneys, depression, diabetes and sprained ankles. The illnesses were caught before they caused permanent damage, and the researchers said treating them meant the children grew up to be healthier adults.

More than four of every 10 children enrolled in the Caring Program needed dental care and almost two in 10 needed glasses.

The lack of health coverage also affected the family's lifestyle. In the study, about 12 percent of the children were forced to restrict activities such as bike riding and ball playing because parents feared their children would get hurt.

"They wouldn't let their children engage in a sport that they feared would lead to an accident and a need for emergency medical care they couldn't afford. I was surprised. It had never occurred to me that lacking health insurance would keep children away from playgrounds and out of sports," Ricci said.

But this was no surprise to social workers in the community. "I can't tell you how many parents say, 'Now he can play baseball again,' " said Kimberly Rodd, an outreach coordinator for St. Michael's of the Valley Episcopal Church in Ligonier. The church both raises money and seeks out children for the program.

"Schools require physicals before a child can participate in organized sports. They can't

gram was born after massive [illegible] steel mills that had been the bedrock of the region's economy. Teams of ministers asking about the needs of thousands of formerly well-paid laid-off steelworkers were told:

" 'Don't worry about us. Do something for our kids,' " recalls LaVallee, who was studying for the ministry at the time.

The ministers settled on offering a basic package of primary care health coverage for children, financed by community donations matched by Blue Cross of Western Pennsylvania and Pennsylvania Blue Shield, now merged into a single organization, Highmark Blue Cross Blue Shield. The Blue Cross Blue Shield organizations took an active interest in the program, donating the administrative services that keep it going.

In the beginning, the benefits were far from comprehensive—doctors' visits, immunizations, diagnostic tests, emergency care and outpatient surgery—but the cost was low, just $13 a month for each child, which amounts to $156 a year.

LaVallee and others raised the money from the community by holding bake sales and making the rounds of Kiwanis Clubs and church groups. They argued that every $156 raised from the community would be matched by the Blues and thus would provide health insurance for two children.

Community fund drives remain a part of the Caring Program, accounting for $500,000 to $900,000 a year. But LaVallee said he quickly realized community support could go only so far. The explosive growth for the program came in 1993, after Democrat Harris Wofford won a U.S. Senate seat from Pennsylvania on a platform favoring national health insurance. He upset former governor and U.S. attorney general Dick Thornburgh, and helped put health insurance on the national agenda for the next three years.

In Pennsylvania, State Rep. Allen Kukovich had a bill to expand and enlarge the western Pennsylvania program, financing it with two cents from a 13-cent-a-pack cigarette tax, which added up to $20 million for the program.

"I had the only serious health care bill around," recalled Kukovich, now a state senator. "It was languishing, but all of a sudden it moved to the front burner. It passed in five weeks and was signed in 1993."

"We had this Caring Program in western Pennsylvania providing primary care only for 6,000 children," recalled LaVallee. "All of a sudden we could provide comprehensive care for 25,000. We got more money in a month from the Commonwealth of Pennsylvania than we got in a year of fund-raising. For us that was a dream come true . . . and enabled us to take the next step."

The program has turned out to be a way station for families, 40 percent of whose children move off the program within a year— largely because their families got jobs. Thus the program becomes a bridge to mainstream coverage.

disturbed children. Neither provided [illegible] insurance for herself or her children.

She saw a Caring Program brochure advertising free health care for children. "I thought this was too good to be true. This is not possible," she said.

"Once I knew we had health care coverage, I could think about steps I have to take, because obviously I was their sole support. If we kept on the way we were going, we would be putting out fires for the rest of our lives. It offered no future."

Ceidro went back to school for her master's degree in theology. "Having health coverage for the children gave me the opportunity to go back to school because I didn't

See INSURING CHILDREN, Page 15

INSURING CHILDREN, *From Page 12*

have to worry about any bad mishaps devastating the family," she said. Unlike Gavin, she didn't worry about health insurance for herself.

In January, after her children had been covered for four years, Ceidro started work as director of pastoral care at Jeannette District Memorial Hospital.

"That's how it works. It got us through that really awful period," she said. "But in January I called up and said, 'I don't need it any more. Make room for three new children.' "

The Gavins have been in the program for more than three years and it has proved its worth. After three operations at Pittsburgh Children's Hospital, covered by the Caring Program, Philip is behaving like any other rambunctious 6-year-old, chasing his older brother Larry, 9, a straight-A student who holds a second-degree red belt in karate.

"Without health insurance in no way could I treat Philip as normal. I have a hard time treating him normally now, but I let him go and I bite my nails. To me he is special, but to an insurance company he's just medical bills," Gavin said.

"When I am sure he is well, then I can figure out what I want to do when I grow up," said Gavin, who believes the best thing she can do now is be "a full-time mom."

"When that happens we won't need insurance from the Caring Program anymore and someone else can get it." ■

The Washington Post
TUESDAY, APRIL 1, 1997

2/3

INSURING CHILDREN, *From Page 10*

"I almost called for help," said the mother of two teenage daughters.

"My husband has been out of work for two years, and I was taking care of a family of four on my chamber salary of about $20,000 a year. We had no insurance for the kids or ourselves. There was no way we could have afforded insurance. It was just food on the table and mortgage payments." Din said.

"I just kept saying to the kids, 'Don't get sick.' "

Without insurance, Din also avoided going to the doctor. The family was lucky. There were no injuries or major illnesses. Her husband, Angie, now has a job with an axle manufacturing company in Michigan, where the family will move after the school year is over.

"I can't wait until we get insurance [from her husband's new job]," she said. "I haven't seen a doctor in three years."

She explained that she didn't sign her children up for the Caring Program because her family was not destitute. "We had a nice house and investments we could tap into. We are not like people who don't have anything. There's a lot we could have gone through before we got to the place where a lot of people already are," Din said.

"But I still was afraid to go to the doctor in case he found something wrong. That could wipe us out."

That is a common fear among parents with no health insurance for their children. A survey taken for the Caring Program by the University of Pittsburgh health economists Judith R. Lave and Edmund Ricci found that three out of four parents of uninsured children postpone going to the doctor, preferring to save that cost to pay for medical care for their children.

Because they can't afford it, many parents also put off getting needed treatment for their children.

As a result many of the children who come into the Caring Program have unmet medical needs. The Pittsburgh study found that one in four new enrollees needed to see a doctor for untreated ailments such as asthma, bronchitis, bruised kidneys, depression, diabetes and sprained ankles. The illnesses were caught before they caused permanent damage, and the researchers said treating them meant the children grew up to be healthier adults.

More than four of every 10 children enrolled in the Caring Program needed dental care and almost two in 10 needed glasses.

The lack of health coverage also affected the family's lifestyle. In the study, about 12 percent of the children were forced to restrict activities such as bike riding and ball playing because parents feared their children would get hurt.

"They wouldn't let their children engage in a sport that they feared would lead to an accident and a need for emergency medical care they couldn't afford. I was surprised. It [was] that lacking health afford physicals if they don't have health insurance," added Amy Salay, a counselor for the Ligonier schools who steers children into the Caring Program.

Founded After Layoffs

The Western Pennsylvania Caring Program was born after massive layoffs hit the steel mills that had been the bedrock of the region's economy. Teams of ministers asking about the needs of thousands of formerly well-paid laid-off steelworkers were told:

" 'Don't worry about us. Do something for our kids,' " recalls LaVallee, who was studying for the ministry at the time.

The ministers settled on offering a basic package of primary care health coverage for children, financed by community donations matched by Blue Cross of Western Pennsylvania and Pennsylvania Blue Shield, now merged into a single organization, Highmark Blue Cross Blue Shield. The Blue Cross Blue Shield organizations took an active interest in the program, donating the administrative services that keep it going.

In the beginning, the benefits were far from comprehensive—doctors' visits, immunizations, diagnostic tests, emergency care and outpatient surgery—but the cost was low, just $13 a month for each child, which amounts to $156 a year.

LaVallee and others raised the money from the community by holding bake sales and making the rounds of Kiwanis Clubs and church groups. They argued that every $156 raised from the community would be matched by the Blues and thus would provide health insurance for two children.

Community fund drives remain a part of the Caring Program, accounting for $500,000 to $900,000 a year. But LaVallee said he quickly realized community support could go only so far. The explosive growth for the program came in 1993, after Democrat Harris Wofford won a U.S. Senate seat from Pennsylvania on a platform favoring national health insurance. He upset former governor and U.S. attorney general Dick Thornburgh, and helped put health insurance on the national agenda for the next three years.

In Pennsylvania, State Rep. Allen Kukovich had a bill to expand and enlarge the western Pennsylvania program, financing it with two cents from a 13-cent-a-pack cigarette tax, which added up to $20 million for the program.

"I had the only serious health care bill around," recalled Kukovich, now a state senator. "It was languishing, but all of a sudden it moved to the front burner. It passed in five weeks and was signed in 1993."

"We had this Caring Program in western Pennsylvania providing primary care only for 6,000 children," recalled LaVallee. "All of a sudden we could provide comprehensive care for 25,000. We got more money in a month from the Commonwealth of Pennsyl- [illegible] in a year of fund-raising.

That is what happened with Maurine Ceidro, 41, who lives with her three children—Sarah, 11, Jason, 13, and Janean, 19—in nearby Greensburg. They were covered by the Caring Program for four years after her husband died in 1992. Although she has a college degree in theology, she was working low-paying, no-benefit jobs: part of a crew cleaning houses and offices after they had been damaged by fire and soot and as a caregiver at a home for disturbed children. Neither provided health insurance for herself or her children.

She saw a Caring Program brochure advertising free health care for children. "I thought this was too good to be true. This is not possible," she said.

"Once I knew we had health care coverage, I could think about steps I have to take, because obviously I was their sole support. If we kept on the way we were going, we would be putting out fires for the rest of our lives. It offered no future."

Ceidro went back to school for her master's degree in theology. "Having health coverage for the children gave me the opportunity to go back to school because I didn't

See INSURING CHILDREN, Page 15

INSURING CHILDREN, *From Page 12*

have to worry about any bad mishaps devastating the family," she said. Unlike Gavin, she didn't worry about health insurance for herself.

In January, after her children had been covered for four years, Ceidro started work as director of pastoral care at Jeannette District Memorial Hospital.

"That's how it works. It got us through that really awful period," she said. "But in January I called up and said, 'I don't need it any more. Make room for three new children.' "

The Gavins have been in the program for more than three years and it has proved its worth. After three operations at Pittsburgh Children's Hospital, covered by the Caring Program, Philip is behaving like any other rambunctious 6-year-old, chasing his older brother Larry, 9, a straight-A student who holds a second-degree red belt in karate.

"Without health insurance in no way could I treat Philip as normal. I have a hard time treating him normally now, but I let him go and I bite my nails. To me he is special, but to an insurance company he's just medical bills," Gavin said.

"When I am sure he is well, then I can figure out what I want to do when I grow up," said Gavin, who believes the best thing she can do now is be "a full-time mom."

"When that happens we won't need insurance from the Caring Program anymore and someone else can get it." ■

The Washington Post

TUESDAY, APRIL 1, 1997