



CHRIS GARDIN FERRARIS -  
Joe Lieberman's daughter  
runs a CHIP outreach program  
in NYC. HRC + the VP  
should know about it.  
Maybe she could be part  
of whatever you do on  
Back-to-School outreach.  
-BR

OFFICE OF PUBLIC POLICY & CLIENT ADVOCACY

Rebecca Lieberman, J.D.  
Director of Policy & Program

Cathleen Clements, Esq.  
Legal Director

August 20, 1999

Bruce Reed  
Assistant to the President &  
Director of Domestic Policy Council  
The White House  
Washington, DC 20502

Dear Mr. Reed:

Thank you for taking the time to speak with me last week about The Children's Aid Society's efforts to make the promise of the State Child Health Insurance Program (SCHIP) a reality for New York City children. The priorities outlined by President Clinton in his address to the National Governors' Association match the strategy we have adopted: using the institution with which all young people must affiliate - the schools - to identify and enroll uninsured children.

Of course, the Administration's commitment to covering America's children has been clear from the start. I was fortunate to attend the Health Care Finance Administration's technical advisory panel on SCHIP outreach to immigrants, which illustrated the depth of this commitment. Over two days, advocates and public health officials from across the country shared experiences and developed strategies about how to reach one of our neediest and most diverse populations - immigrant children.

For the past sixteen months, The Children's Aid Society's Health Care Access Program has been providing bilingual child health insurance outreach, screening, and enrollment assistance in five public schools in Upper Manhattan. The program enables parents, the vast majority of whom are immigrants, to complete the enrollment process in a setting that is familiar, trusted, and central to their daily routines. Between April 1998 and July 1999, our school-based staff screened 970 parents and children, connecting over 750 of them to government-sponsored health insurance.

We have learned a great deal about effective ways to reach and enroll uninsured children, and both local and national advocacy groups have recognized our expertise, seeking information, training, and guidance on program design. We have participated in initiatives that will shape the widespread implementation of SCHIP, including the state's pilot and revision of the unified Medicaid/Child Health Plus application, the development of a simplified recertification process for children, and the city's pilot of procedures for handling Medicaid applications completed by community-based organizations.

The Health Care Access Program has demonstrated the success of the school-based model of facilitated enrollment. Schools offer a highly effective setting for enrollment, particularly for children at the elementary and intermediate school levels, for several reasons:

- **Schools are central to the lives of families with children and young adolescents, providing many opportunities for education and screening.**
- **The convenient location makes follow-up easy.** After the initial screening, parents can quickly stop by with needed documents or sign forms as they pick up their kids from school.
- **Word-of-mouth promotes the program.** Parents whose children attend the same elementary and intermediate schools live in the same community – they are neighbors, they talk with each other at the laundromat, at school functions, at dismissal time. Once a facilitated enrollment program is up and running, the word spreads among parents and they are eager to participate.
- **School functions and mailings provide great opportunities for outreach.** Integrating the program into the life of the school grants access to large numbers of parents. Administrators and PTAs work hard to engage parents, and insurance enrollment programs can benefit from those efforts.

Needless to say, we would welcome the opportunity to be a part of the Administration's effort to highlight child health insurance as young people head back to school. Following, for your information, is a more detailed description of the Health Care Access Program.

Thank you again for taking the time to speak with me last week. I look forward to speaking with you further about our work in the near future. Should you have any questions, I can be reached at 212-358-8930.

Sincerely,



Rebecca Lieberman

Cc: Joe Lieberman



JULY 1999

## **THE HEALTH CARE ACCESS PROGRAM** ***Reaching Uninsured Children at School***

### **INTRODUCTION**

Few organizations have undertaken the challenging work of child health insurance enrollment without the support of public funds. The Children's Aid Society has. In April of 1998, we launched the Health Care Access Program (HCAP), a school-based health insurance enrollment initiative. The agency's mission – to provide children with the support and opportunities needed to become healthy and successful adults – drove the undertaking. The hundreds of uninsured young people passing through our school-based health clinics and programs highlighted the need.

HCAP provides bilingual outreach, screening, and enrollment assistance for New York State's public health insurance programs for children, Medicaid and Child Health Plus. HCAP enables parents to complete the enrollment process in a setting that is familiar, trusted, and central to their daily routines. **Between April 1998 and July 1999, the program's school-based staff screened 970 parents and children, connecting over 750 of them to government-sponsored health insurance.**

The five public elementary and intermediate schools where HCAP operates are Children's Aid Society "community schools," located in Upper Manhattan's Washington Heights neighborhood. Through a close partnership with the New York City Board of Education, the agency offers social services and recreational programs that complement the schools' academic programs. Agency staff work full time in the schools, providing Early Head Start and Head Start programs; medical, dental and mental health services; evening classes for parents, and after-school and Saturday programs.

HCAP's ability to reach families depends largely on the integral role that The Children's Aid Society already plays in the lives of the schools' students and their families. **Institutional trust developed over years of service to the community facilitates HCAP's ability to identify and enroll uninsured children.**

Trust is a critical commodity in the largely immigrant community in which we work. The vast majority of families who apply through HCAP are immigrants from the Dominican Republic. As Latino immigrants, they represent the population with the nation's highest rate of uninsured children, despite their eligibility for public programs. Through our work with this population, we grapple with the reality that underlies these statistics. The application process requires families to present information on informal living arrangements and survival strategies that are often difficult for immigrants to document. In addition, many come to this country with a strong distrust of government programs.

Still others fear that a child's receipt of public insurance will jeopardize undocumented family members or their own ability to sponsor relatives or adjust their immigration status. HCAP's bilingual staff works closely with families to overcome such barriers.

#### **STRATEGIES FOR OUTREACH AND ENROLLMENT**

HCAP works with administrators, teachers, health clinic staff, and parents to identify uninsured children.

- **Social workers, educators, and health care providers** who have ongoing relationships with families conduct **one-on-one outreach**. Confidential eligibility screenings are provided to all interested families. HCAP staff members are available to meet with parents in the evenings and on weekends.
- **Teacher** orientation packets include information on Medicaid and Child Health Plus and how to refer families for enrollment assistance. Program staff reinforce this printed message through presentations at faculty meetings.
- **Parents** receive similar information from HCAP workers who are positioned in front of the school for student arrival and dismissal during the first week of classes. Later in the year, HCAP workers staff **parent-teacher conferences** and report card signing nights. Because the individuals who staff these events are the same people who provide enrollment assistance, parents have the opportunity to schedule an appointment for a comprehensive screening or to get quick advice on their eligibility.
- **Parent-to-parent referral**, or word-of-mouth, provides one of HCAP's most effective outreach mechanisms. Parents whose children attend the same elementary and intermediate schools live in the same community — they are neighbors, they talk with each other at the laundromat, at school functions, at dismissal time. Word of HCAP's work has spread among parents and many are eager to access the program's services.
- Throughout the year, HCAP staff hold **weekly office hours** at the schools during times that are convenient for working parents. Families may drop in for a screening, bring insurance questions, or complete the application process. In addition, staff conduct more formal **information sessions** for groups at the invitation of parent organizations, health educators, and Head Start administrators.

#### **RESULTS**

Between April 1998 and July 1999, HCAP's school-based staff screened 691 children and 279 adults to determine their eligibility for public health insurance. All of the children qualified for either Medicaid or Child Health Plus and 54 percent of the adults qualified for Medicaid.

Eligible families receive intensive application assistance which typically entails three visits with HCAP staff, including the initial screening. At these visits, parents are helped to complete the application, to collect needed documentation, and to select a managed care plan, if appropriate. As needed, families receive basic information on how managed care functions. HCAP staff then finalize and submit the client's application and are available to troubleshoot should problems arise with either the Department of Social Services or a managed care plan.

These methods have yielded the following results:

➤ **SCHOOL-BASED ENROLLMENT AS OF JULY 31, 1999**

Eligible Individuals		Enrolled Individuals	
Adult	151		125
Children	691		625

Of the 625 children enrolled, 372 are now insured through Medicaid and 253 through Child Health Plus. Ninety-two individuals were found to be eligible but are not yet insured, 21 of whom have applications currently in process and 63 of whom have failed to complete the application process. As these figures show, intensive application assistance provided in the schools works.

**LESSONS LEARNED**

In the course of connecting hundreds of individuals to public health insurance, we have learned many lessons, some of which follow.

- **Institutions that are central to young people's lives offer the best setting for enrollment initiatives.** However, leveraging the advantages that are inherent in such settings requires more than simple co-location. Facilitated enrollment should be integrated into a program's fabric, and staff regarded as full members of its client-service team.
- **Facilitated enrollment is a complicated and time-consuming business that demands specialized staff whom parents can trust.** Determining whether a family is eligible and which documents are required can be an extremely complicated task. The application process can be very intrusive, often touching on sensitive information about a family's finances, household composition, and immigration status.
- **School-based health insurance enrollment works.** Ninety-four percent of eligible children and 89 percent of eligible adults screened by HCAP have completed the application process. The majority of parents who have applied for insurance through HCAP are employed. Many receive hourly wages. Providing application assistance in the schools removes some of the barriers parents encounter when trying to access health insurance for their children. **Working parents greatly appreciate the convenience of applying for child health insurance in a place that is already part of their daily routine.**
- **The entire family should be enrolled whenever possible.** In over half of the cases that resulted in a Medicaid application, at least one parent was eligible and applied. While the application form used when applying only for children is one

page and requires less documentation, HCAP is committed to enrolling every family member who is eligible. By providing parents with the means to access the health care system, we hope that they will be more likely to seek health care for their children.

- **The enrollment process is not complete until the family is accessing services.** The application can become derailed at a number of points after it has been submitted to Medicaid or a health plan. Forms may be lost or errors may occur in determining whether a family is eligible. Supervisors must be prepared to troubleshoot and advocate on behalf of applicants. Once families have their insurance, they often need guidance on such matters as their rights under managed care or how to navigate the health care system.

For more information please contact Rebecca Lieberman, Director of Policy and Program, Office of Public Policy and Client Advocacy, (212) 358-8930.

*The Children's Aid Society was founded in 1853 and serves over 120,000 New York City children and their families each year, without regard to race, religion, nationality or socio-economic status. Our mission is to ensure the physical and emotional well-being of children and families and to provide each child with the support and opportunities needed to become a happy, healthy, and successful adult. Our services address every aspect of a child's life from infancy through adolescence and parenthood, including adoption and foster care, medical and dental care, counseling, preventive services, winter and summer camps, recreation, the arts, education and job training.*

**PRESIDENT CLINTON AND VICE PRESIDENT GORE ANNOUNCE NEW INITIATIVES  
TO IMPROVE HEALTH FOR CHILDREN AND OLDER AMERICANS AT FAMILY  
REUNION CONFERENCE HOSTED BY VICE PRESIDENT AND MRS. GORE**

**June 22, 1998**

Today, at the seventh Family Reunion Conference in Tennessee hosted by Vice President and Mrs. Gore, the President and Vice President announced a series of new initiatives to improve health for children, families, and older Americans including improve health for children, families, and older Americans.

**Children:** issued an Executive Memorandum directing an unprecedented eight agencies to use resources to implement over 100 new initiatives to help enroll the millions of uninsured children eligible but not enrolled in health insurance programs; **Families:** announced a new initiative that the Office of Personnel Management will meet with families and revise their health plans to be more family-centered. The President and Vice President also renewed the call on Congress to pass a patients' bill of rights; **Older Americans:** developed a multi-faceted national health initiative for older Americans, which includes: new preventive benefits for Medicare beneficiaries, more usable information for beneficiaries to make informed decisions about health care; and a new nationwide public/private Medicare council with over 80 organizations to encourage prevention and wellness and ensure beneficiaries understand new plan options so they can select the health plan that best meets their needs

**CHILDREN: SIGNED EXECUTIVE MEMORANDUM TO IMPLEMENT OVER 100 NEW FEDERAL COMMITMENTS TO ENROLL ELIGIBLE BUT UNINSURED CHILDREN.** Over 4 million uninsured children are eligible for Medicaid but are not enrolled, and as the new Children's Health Insurance Program is implemented, even more families will have children who are eligible for State/Federal health insurance programs. As part of his historic private/public initiative to reach out to families with uninsured children, last February the President asked eight Federal agencies with programs that serve families and children to find ways to reach these families. Today, the President signed an Executive Memorandum directing these agencies to implement over 100 new commitments to help reach uninsured children. These commitments include:

- **Sending letters to 350,000 Federal workers, including Head Start teachers, school nurses, child support workers, and community health center directors** asking them to ensure that all of the families they work whose children are eligible for Medicaid or CHIP are enrolled in these programs.
- **Working with national organizations and programs that reach millions of families to help enroll children in health insurance programs**, including educating grandparents through the Medicare program, holding a conference with Historically Black Colleges to identify new strategies, and ensuring that sites, including 15,000 public housing projects, 400 IRS walk-in centers, and 113 job centers, and have information for families about how to enroll children in health insurance.

- **Releasing a new guide to help child care workers enroll uninsured children.** Child care centers are one family friendly setting where parents can learn about how insurance programs they may be eligible for. There are already many efforts underway to link child care centers with the health needs for the millions of children in child care. Today, the Department of Health and Human Services is releasing a new child care handbook "Child Care and Medicaid: Partners for Healthy Children" to ensure that child care workers understand how to identify and enroll families with uninsured children.

### **FAMILIES: IMPROVING HEALTH CARE FOR FAMILIES.**

- **Announcing that Office of Personnel Management Will Meet with Families Over the Next Year and Modify Health Plans to be More Family Centered.** FEHBP has 9 million enrollees and 350 participating carriers. It is already a leader in family friendly care; for example, FEHBP uses a broad definition of family that allows foster children and grandchildren to be covered under its plans and has just issued a new customer satisfaction survey. To build on these initiatives, the Office of Personnel Management (OPM) has agreed to hold a series of meetings with families over the next year to identify concrete ways in which their health plans can be more responsive to the needs of families, including reviewing the benefits package, payment structures, and overall family satisfaction. OPM will modify their March 1999 call letter to carriers to reflect the issues that families raise and to become more family-centered.
- **Renewing Call on Congress to Pass a Patients' Bill of Rights.** The President also urged Congress to stop delaying and pass a patients' bill of rights that would ensure that all families have the patient protections they need in a rapidly changing health care system. This patients' bill of rights should contain a range of protections, including guaranteed access to needed health care specialists, access to emergency room services when and where the need arises, an assurance that medical records are confidential, and access to a meaningful internal and external appeals process for consumers to resolve their differences with their health plans and health care providers.

### **OLDER AMERICANS: ANNOUNCED NEW NATIONAL CAMPAIGN TO IMPROVE**

**HEALTH OF OLDER AMERICANS.** One of the greatest concerns for families is the health of older family members. Today, the President and Vice President unveiled new preventive benefits for Medicare, and an unprecedented national outreach campaign to ensure that families have the information they need to make good decisions for family members.

- **Implementing Historic New Preventive Benefits for Medicare Beneficiaries.** The President and Vice President announced that starting July 1st, for the first time, Medicare cover two critical preventive benefits -- bone mass measurement tests to detect osteoporosis and diabetes education. Diabetes and osteoporosis are two of the leading diseases for older Americans, as 16 million Americans suffer from diabetes and The President enacted these new benefits, as well as a series preventive screening benefits to detect cancer implemented earlier this year, as part of the historic Balanced Budget Act of 1997. These benefits underscore how Medicare is trying to encourage better health outcomes for families.

- Unveiling New Nationwide Public Service Announcement on Osteoporosis Featuring the First Lady and Mrs. Gore.** One in two women will have osteoporosis fracture during her lifetime. However, millions of these women are not aware they are at risk until they have a fracture or broken bone. The Vice President unveiled a new public service announcement featuring the First Lady and Mrs. Gore to inform women about the new osteoporosis Medicare benefit and to ensure that all women, particularly older women, get bone mass measurement tests to detect osteoporosis.
- Launching a New Internet Site for Medicare Beneficiaries.** Families need good information to help make the best health care decisions for older family members. Today, the President and Vice President launched a new nationwide Internet site (Medicare.gov) so that families can understand the options and services Medicare provides. This information will be even more critical as the historic changes the President enacted as part of the Balanced Budget Act of 1997 are implemented this fall. These reforms give beneficiaries new plan choices that could improve care for older Americans but also have the potential to cause confusion.
- Creating a Nationwide Public/Private Medicare Education Council, Including over 80 National Organizations to ensure families receive good care.** The President and Vice President announced that over 80 organizations, including the AFL-CIO, American Association of Retired Persons, the Older Women's League, National Rural Health Association, and the American Association of Family Physicians, are joining with the Health Care Financing Administration, the Administration on Aging, and the National Institutes of Health to launch a new National Medicare Education Program that will focus ensuring that families have information they need to make health decisions including: assuring that Medicare beneficiaries: are aware of the new preventive benefits and other prevention and wellness strategies; understand new plan options so they can select the health plan that best meets their needs; know the consumer protections available under Medicare. The President also asked the Council to focus on areas of family caregiving.

THE WHITE HOUSE  
WASHINGTON

February 18, 1998

**MEMORANDUM TO THE FIRST LADY**

**FROM:** Chris Jennings, Jennifer Klein and Jeanne Lambrew  
**RE:** Children's Health Implementation Update  
**CC:** Melanne V., Bruce R., Gene S., Elena K.

This memo summarizes the activities related to the implementation of the Children's Health Insurance Program (CHIP) and our efforts to promote outreach for CHIP and Medicaid. There has been a tremendous amount of energy and activity surrounding the implementation of CHIP in the six short months since the Balanced Budget Act was signed. We expect the next six months to be even more intense, since States need to file their State Plans for CHIP by July 1 to access their 1998 funding allotment.

Tomorrow, you and the President are scheduled to participate with the President in an event announcing some of the first States coming on line in CHIP and highlighting a series of public and private initiatives aimed at enrolling eligible children in Medicaid and/or CHIP. This memo provides you background on what we have done to date in implementing CHIP and summarizes future initiatives to ensure success in enrolling uninsured children in Medicaid and CHIP.

**IMPLEMENTATION ACTIVITIES TO DATE**

The first phase of CHIP implementation consisted primarily of issuing Federal guidance on the new program. To date, there have been over 10 White House-approved, written communications from HHS to States that contain information necessary to implement the program. These and forthcoming communications include reporting forms and a host of technical but extremely important questions and answers. In the next two months, this policy guidance will be collapsed into regulations that will go through the ordinary public process. HHS has also been conducting regional conferences to assist States in the development of their plans.

Right now, we are at the beginning of the second, important phase of implementation: the State plan submissions. To date, we have received 17 State plans and have approved one. You

and the President will announce two more expansions tomorrow (Colorado and South Carolina). Interestingly, 8 States plan to expand coverage for children through Medicaid, 4 through non-Medicaid State programs, and 5 through a combination of the two. We approved the first plan for Alabama on January 30; the State simply expanded Medicaid to cover all poor children (the 14 to 18 year olds not already covered by the mandate). Because by law we have to either approve a State's plan within 90 days or "stop the clock" with a request for additional information, we had little choice in the timing of the Alabama approval.

Beyond the States that have already submitted their State plans, another 18 have some type of task force or work group assigned to identify children's health needs in the State and design the appropriate program. Preliminary reports suggest that another 6 States want to expand through Medicaid, 7 through a non-Medicaid program, and 5 through a combination of the two.

The White House has played a significant role in implementation. We run a weekly children's health implementation meeting, with HHS, OMB and Treasury. These meetings focus mostly on pressing policy issues and HHS's progress in meeting our aggressive implementation schedule. In addition, we run a weekly meeting with HHS staff that focuses on children's health outreach. This meeting serves to generate ideas and promote administrative actions to improve the enrollment of children.

## **ISSUES AND FUTURE ACTIVITIES**

We can fairly say that implementation of the Children's Health Insurance Program, and the parallel focus on children's health outreach, has gone well to date. HHS has mobilized a large group of people to work on the State plan review, and we have had fewer than expected complaints from States and advocates.

That being said, our involvement has been necessary both to facilitate decisions being made and actions being taken by HHS. The Department tends to be divided on major policy issues and slow to resolve those divisions. In addition, we are beginning to get involved in what is sure to be myriad, difficult, State-specific issues. We are often put in this position because the Department does not like to take the hard-line stance with States, and even when they do, States often appeal to the White House. We already have several of these instances (Missouri, Maryland, Wisconsin). This has the effect of making children's health a major part of our daily work.

In addition to this oversight/policy making role, the most critically important activity that we can undertake is to engage in aggressive public-private outreach efforts to enroll eligible, uninsured children. To accomplish this, we need a short and long-term strategy. Tomorrow, you and the President will launch a national outreach campaign. The event will highlight Administration and State plans to enroll children in CHIP and Medicaid, outline the activities of private foundations, provider groups, children's groups, private businesses, and children themselves to help enroll uninsured children, and all members of the community to continue to

build on this important work.

This event, however, is just the first step in a long-term strategy. As you have noted, a sustained effort, both out in States and nationally, is essential to success in enrolling these uninsured children. There are a number of opportunities for you and the President to contribute in this effort, including:

- **Focus on the link between child care and health:** HHS will release in the next month a Medicaid manual for child-workers. In addition, the Association for Child Care Resource and Referral Centers is planning a strategy to assist in outreach. We could highlight these activities in a State that works with such sites already (e.g., Philadelphia, rural Colorado).
- **Engaging schools:** NEA has already announced its intent to educate teachers. We could encourage principals, school coaches, school nurses, and others within schools to get involved as well. This could be done at one of the States coming on line with CHIP that intends to use schools (e.g., Connecticut, Pennsylvania, Florida).
- **AmeriCorps reauthorization:** The legislation to reauthorize AmeriCorps will be announced in the next few weeks. We could add to the legislation explicit encouragement of volunteers to engage in children's health outreach. Some volunteers (e.g., in Utica, NY) already do so.
- **Public Service Announcements:** Once the Bell Atlantic toll free phone number (that will be announced tomorrow) is established, we will work with the private sector on a public service announcement campaign.
- **Announcement of additional foundation or corporate contributions:** We expect that there will be great response to the President's challenge to foundations and the corporate community. We could organize events around such announcements.
- **Late May/early June announcement of Federal outreach plans:** The President will issue a directive tomorrow to Federal agencies to do outreach to the children who they serve in other programs. HHS will release a report in late May/early June describing all agency actions.

THE WHITE HOUSE  
WASHINGTON

February 17, 1998

**CHILDREN'S HEALTH INSURANCE OUTREACH EVENT**

**DATE:** February 18, 1998  
**LOCATION:** Children's Hospital  
**EVENT TIME:** 1:10 pm - 2:00 pm  
**FROM:** Bruce Reed/Chris Jennings

**I. PURPOSE**

To announce the first states to join the Children's Health Insurance Program and new efforts by the federal government and private sector to enroll millions of uninsured children into Medicaid or other state-based children's health programs.

**II. BACKGROUND**

Over 10 million children in America are uninsured, with 3 million of them eligible for but not enrolled in Medicaid. To address this problem, you fought for and signed into law the Children's Health Insurance Program (CHIP) last year, which provides funding for states to expand health care coverage to uninsured children. This event will provide you with an opportunity to highlight steps the Administration is taking to implement this initiative; to detail your 1999 budget proposal to improve children's health outreach; to announce executive actions complementing this legislative proposal; and call attention to significant private sector commitments to children's outreach.

At this event, you will make the following specific announcements:

- **COLORADO AND SOUTH CAROLINA HAVE JOINED ALABAMA AS THE FIRST COVERAGE EXPANSIONS UNDER THE NEW CHIP PROGRAM.** You will announce that Colorado and South Carolina join Alabama as the first states to come into the children's health program. In late January, Alabama received approval to expand its Medicaid program to children ages 14 to 18 up to 100 percent of poverty. South Carolina will expand its Medicaid program to provide coverage to all children up to 150 percent of poverty. And, Colorado builds upon its current non-Medicaid program to cover children up to 185 percent of poverty. You will also announce that many more States are well on their way to expanding coverage to more uninsured children. Currently, 14 states have submitted plans to HHS for approval,

and another 18 States have active working groups or task forces to design plans to address the needs of uninsured children.

- **A NEW PRESIDENTIAL DIRECTIVE TO LAUNCH A GOVERNMENT-WIDE EFFORT TO ENROLL UNINSURED CHILDREN.** At this event you will sign an executive memorandum to seven Federal agencies with jurisdiction over children's programs — the Departments of Agriculture, Interior, Education, HHS, HUD, Labor, and Treasury and the Social Security Administration -- that will direct the establishment of a multi-agency effort to enroll uninsured children. These agencies run programs such as WIC, Food Stamps, Head Start, and public housing that cover many of the same children who are uninsured and eligible for Medicaid or other health insurance. Your memorandum instructs these agencies: (1) to identify all their employees and grantees who might come into contact with these children and ensure that these individuals are aware of the health insurance programs available to children; (2) to develop an intensive children's outreach initiative, such as distributing information, coordinating toll-free numbers, and simplifying and coordinating application forms; and (3) to report back in 90 days on their plan to help enroll uninsured children.
- **NEW BUDGET PROPOSALS THAT PROVIDE MEDICAID ENROLLMENT INCENTIVES TO STATES.** Your FY 1999 budget invests \$900 million over 5 years in children's health outreach policies, including the use of schools and child care centers to enroll children in Medicaid. The budget provides states with the option of automatically enrolling children in Medicaid even before having received all of the complicated eligibility and enrollment forms (a provision known as "presumptive eligibility"). It also expands the use of a Federally-financed administrative fund so that it can underwrite the costs for all uninsured children — not just the limited population allowed under current law.
- **A HISTORIC PRIVATE SECTOR COMMITMENT TO PROVIDE OUTREACH.** To complement the public outreach effort, you will announce unprecedented new contributions from the private sector to help ensure that all children who are eligible for health insurance receive it, including:
  - **A new toll-free number that directs families around the nation to their state enrollment centers.** You will announce that Bell Atlantic will establish and operate a toll-free number to help states enroll uninsured children. The number, which will be put in place during the upcoming months, will be used by the nation's Governors to help millions of families around the nation by directing them automatically to their local state Medicaid enrollment agency.
  - **Over \$23 million in commitments from private foundations across the country.** The Robert Wood Johnson Foundation will spend \$13 million over the next 3 years to fund innovative state-local coalitions to design and conduct outreach initiatives, simplify enrollment processes, and coordinate existing coverage programs. The Kaiser Family Foundation will spend up to \$10 million over the next 5 years on studies to help understand why eligible

children do not enroll in existing programs and how best to provide insurance coverage for these children. America's Promise, with support from the Robert Wood Johnson Foundation and the American Academy of Pediatrics, will mobilize corporations such as Smith Kline Beecham and Sheering Plough and local communities nationwide in children's health outreach efforts.

**New initiatives from corporate and advocacy organizations to reach out to uninsured children.** Pampers has volunteered to include a letter in its child birth education packages, given to 90 percent of first-time mothers, giving families information about available health insurance options. Chain drug stores across the country will provide information about the new Bell Atlantic toll-free number to their customers. The National Education Association is launching an unprecedented effort to educate teachers on how they can inform children and their families about health insurance, through national newsletters, conferences, and special training sessions. The American Hospital Association's Campaign for Coverage will increase its nationwide initiative to engage hospitals in helping uninsured Americans, including children.

### III. PARTICIPANTS

- The First Lady
- Secretary Shalala
- Ned Zechman, President and CEO of Children's Hospital
- Linda Haverson, parent whose son was recently enrolled in Medicaid because of a local outreach effort. Her son was able to have necessary ear surgery because of his coverage.

### IV. PRESS PLAN

Open Press.

### V. SEQUENCE OF EVENTS

- You will be announced onto the stage accompanied by the First Lady, Secretary Shalala, Ned Zechman, and Linda Haverson.
- Ned Zechman, President and CEO of Children's Hospital, will make welcoming remarks.
- Secretary Shalala will make remarks and introduce the First Lady.
- The First Lady will make remarks and introduce Linda Haverson.
- Linda Haverson will make remarks and introduce you.
- You will make remarks.
- You will sign the executive memorandum.
- You will work a ropeline and then depart to the holding room.
- You and the First Lady will briefly meet with private sector representatives who have made commitments to do children's health outreach. (Please see attached list.)

### VI. REMARKS

Remarks provided by June Shih in Speechwriting.

**PRESIDENT CLINTON ANNOUNCES A SERIES OF NEW EFFORTS TO ENROLL  
UNINSURED CHILDREN IN HEALTH INSURANCE PROGRAMS**

**February 18, 1998**

Today, the President announced the first major state coverage expansions under the recently enacted Children's Health Insurance Program (CHIP) and released information showing that many States will soon follow. He also unveiled an unprecedented set of public/private initiatives designed to enroll the millions of uninsured children who are eligible but not enrolled in Medicaid and other state-based children's health programs. These initiatives have been designed in partnership with Governors, health care providers, children's health advocates, foundations, businesses and many others who are committed to providing health care coverage for the nation's uninsured children.

Over 10 million children in America are uninsured. Nearly 90 percent of these children have parents who work, but do not have access to or cannot afford health insurance. Over 3 million of these uninsured children are already eligible for Medicaid. However, many families are not aware that their children are eligible for Medicaid, and others have difficulty filling out the application. Similar problems could undermine the new Children's Health Insurance Program's goal to enroll millions of uninsured children. With these challenges in mind, the President:

- ✓ **ANNOUNCED THAT COLORADO AND SOUTH CAROLINA HAVE JOINED ALABAMA AS THE FIRST COVERAGE EXPANSIONS UNDER THE NEW CHIP PROGRAM.** Today, the President announced that Colorado and South Carolina join Alabama as the first states to come into the children's health program. In late January, Alabama received approval to expand its Medicaid program to children ages 14 to 18 up to 100 percent of poverty. South Carolina will expand its Medicaid program to provide coverage to all children up to 150 percent of poverty. And, Colorado builds upon its current non-Medicaid program to cover children up to 185 percent of poverty. The President also announced that many more States are well on their way to expanding coverage to more uninsured children. Currently, 14 states have submitted plans to HHS for approval, and another 18 States have active working groups or task forces to design plans to address the needs of uninsured children.
  
- ✓ **RELEASED A NEW PRESIDENTIAL DIRECTIVE TO LAUNCH A GOVERNMENT-WIDE EFFORT TO ENROLL UNINSURED CHILDREN.** In an executive memorandum to seven Federal agencies with jurisdiction over children's programs — the Departments of Agriculture, Interior, Education, HHS, HUD, Labor, and Treasury and the Social Security Administration -- the President directed the establishment of a multi-agency effort to enroll uninsured children. These agencies run programs such as WIC, Food Stamps, Head Start, and public housing that cover many of the same children who are uninsured and eligible for Medicaid or other health insurance. The memorandum instructs these agencies: (1) to identify all their employees and grantees who might come into contact with these children and ensure that these individuals are aware of the health insurance programs available to children; (2) to develop an intensive children's outreach initiative, such as distributing information, coordinating toll-free numbers, and simplifying and coordinating application forms; and (3) to report back in 90 days on their plan to help enroll uninsured children.

✓ **HIGHLIGHTED BUDGET PROPOSALS THAT PROVIDE MEDICAID**

**ENROLLMENT INCENTIVES TO STATES.** The President's FY 1999 budget invests \$900 million over 5 years in children's health outreach policies, including the use of schools and child care centers to enroll children in Medicaid. The budget provides states with the option of automatically enrolling children in Medicaid even before having received all of the complicated eligibility and enrollment forms (a provision known as "presumptive eligibility"). It also expands the use of a Federally-financed administrative fund so that it can underwrite the costs for all uninsured children — not just the limited population allowed under current law.

✓ **ANNOUNCED A HISTORIC PRIVATE SECTOR COMMITMENT TO PROVIDE**

**OUTREACH.** To complement the public outreach effort, the President announced unprecedented new contributions from the private sector to help ensure that all children who are eligible for health insurance receive it, including:

- **A new toll-free number that directs families around the nation to their state enrollment centers.** The President announced that Bell Atlantic will establish and operate a toll-free number to help states enroll uninsured children. The number, which will be put in place during the upcoming months, will be used by the nation's Governors to help millions of families around the nation by directing them automatically to their local state Medicaid enrollment agency.
- **Over \$23 million in commitments from private foundations across the country.** The Robert Wood Johnson Foundation will spend \$13 million over the next 3 years to fund innovative state-local coalitions to design and conduct outreach initiatives, simplify enrollment processes, and coordinate existing coverage programs. The Kaiser Family Foundation will spend up to \$10 million over the next 5 years on studies to help understand why eligible children do not enroll in existing programs and how best to provide insurance coverage for these children. America's Promise, with support from the Robert Wood Johnson Foundation and the American Academy of Pediatrics, will mobilize corporations such as SmithKline Beecham and Sheering Plough and local communities nationwide in children's health outreach efforts.
- **New initiatives from corporate and advocacy organizations to reach out to uninsured children.** Pampers has volunteered to include a letter in its child birth education packages, given to 90 percent of first-time mothers, giving families information about available health insurance options. Chain drug stores across the country will provide information about the new Bell Atlantic toll-free number to their customers. The National Education Association is launching an unprecedented effort to educate teachers on how they can inform children and their families about health insurance, through national newsletters, conferences, and special training sessions. The American Hospital Association's Campaign for Coverage will increase its nationwide initiative to engage hospitals in helping uninsured Americans, including children.

✓ **ISSUED A CHALLENGE ACROSS AMERICA TO FIND NEW WAYS TO REACH OUT TO UNINSURED CHILDREN.**

The President challenged every physician, nurse, health care provider, business, school, parent, grandparent, and community across the nation, to find new ways to ensure that uninsured children eligible for health insurance are enrolled in

Medicaid or CHIP. This national commitment should not stop until every eligible child across the country is enrolled in one of the existing health care programs.

## MEMORANDUM

January 15, 1997

TO: Rahm  
FR: Chris  
RE: Fraud and Children's Health  
cc: Bruce and Gene

As per your request, here is an outline of the anti-fraud announcement that I think can be made next week. Also attached is the children's health announcements that we discussed that we can (and in my opinion) should make.

**Anti-Fraud and Abuse Announcement.** We could do this either as an event that Donna and Janet Reno do sometime earlier in the week (remember Melissa wants it as soon as possible) or we can wait for the Saturday radio address with the President. Regardless, any such announcement would release:

- The first Justice/HHS/IG report following the enactment of the Kennedy/Kassebaum law, which empowered and provided full funding for our ongoing anti-fraud and abuse enforcement activities. The report touts we have captured and returned to the Medicare Trust Fund \$1 billion.
- A new regulation that requires medical equipment suppliers to purchase surety bonds to ensure the Trust Fund is protected when fraudulent suppliers go bankrupt and/or are caught cheating Medicare.
- A new requirement directing HHS to conduct on-site inspections for medical equipment suppliers to ensure that they are, and continue to be, legitimate providers of goods and services.
- (We could also release some or the rest of our anti-fraud and abuse initiatives that are currently in the budget to pay for the Medicare buy-in; most fall in the abuse, rather than the fraud categories, but it could be helpful in illustrating our ongoing commitment. If we can come up with any others, we can throw those in as well).

## **CHILDREN'S HEALTH IDEAS:**

**Leak Out Good News About Children's Outreach Initiative to NY TIMES for Monday, which responds directly to the President's concern about the 3 million uninsured children eligible, but not enrolled in Medicaid.** Pear is extremely interested in this population and would doubtless love to do a piece on what we are doing administratively and in the budget for this population. I believe he would play up the story big for the POTUS and the FLOTUS, since these policies are popular state option proposals, which will get validation from Governors and children's groups. Pear will likely validate the policies because there is some money behind them, but the good news is it doesn't sound like big money -- less than \$200 million a year.

**Schedule Event in February With President and First Lady Announcing First States Taking Advantage of New Children's Health Provisions Included in the BBA.** We have two, perhaps as many as four, states that are on the cusp of being approved as the first states coming on line for the new Children's Health Insurance Program (CHIP). Two states have Democratic Governors and two states have Republican Governors. We could do a great event in which Republicans and Democrats would have every reason to sing the praises of this new program and the kids it will cover.

And, by the way, we could set up additional such state-approval events with the First Lady in all sorts of positive settings -- like in child care programs and schools -- where our new outreach proposals will work toward signing up hundreds of thousands of children.

As always, these events need some time to prepare to do well. Please give us as much advance notice as possible. Clearly, it would extremely helpful if we could get closure on these issues sometime tomorrow.

WHITE HOUSE STAFFING MEMORANDUM

DATE: 1/22 ACTION/CONCURRENCE/COMMENT DUE BY: 1/24

SUBJECT: Waivers and the Children's Health Ins. Program (CHIP)

	ACTION	FYI		ACTION	FYI
VICE PRESIDENT	<input checked="" type="checkbox"/>	<input type="checkbox"/>	McCURRY	<input type="checkbox"/>	<input checked="" type="checkbox"/>
BOWLES	<input checked="" type="checkbox"/>	<input type="checkbox"/>	McGINTY	<input type="checkbox"/>	<input type="checkbox"/>
McLARTY	<input type="checkbox"/>	<input type="checkbox"/>	NASH	<input type="checkbox"/>	<input type="checkbox"/>
PODESTA	<input checked="" type="checkbox"/>	<input type="checkbox"/>	RADD	<input type="checkbox"/>	<input type="checkbox"/>
MATHEWS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	REED → <input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RAINES	<input checked="" type="checkbox"/>	<input type="checkbox"/>	RUFF	<input type="checkbox"/>	<input type="checkbox"/>
BLUMENTHAL	<input type="checkbox"/>	<input type="checkbox"/>	SMITH	<input type="checkbox"/>	<input type="checkbox"/>
BERGER	<input type="checkbox"/>	<input type="checkbox"/>	SOSNIK	<input type="checkbox"/>	<input type="checkbox"/>
ECHAVESTE	<input checked="" type="checkbox"/>	<input type="checkbox"/>	SPERLING	<input checked="" type="checkbox"/>	<input type="checkbox"/>
EMANUEL	<input checked="" type="checkbox"/>	<input type="checkbox"/>	STREETT	<input type="checkbox"/>	<input type="checkbox"/>
GIBBONS	<input type="checkbox"/>	<input type="checkbox"/>	TARULLO	<input type="checkbox"/>	<input type="checkbox"/>
HILLEY	<input checked="" type="checkbox"/>	<input type="checkbox"/>	VERVEER	<input type="checkbox"/>	<input type="checkbox"/>
IBARRA	<input checked="" type="checkbox"/>	<input type="checkbox"/>	WALDMAN	<input type="checkbox"/>	<input type="checkbox"/>
KLAIN	<input type="checkbox"/>	<input type="checkbox"/>	YELLEN	<input type="checkbox"/>	<input type="checkbox"/>
LEWIS	<input type="checkbox"/>	<input type="checkbox"/>	BEGALA	<input type="checkbox"/>	<input type="checkbox"/>
LINDSEY	<input type="checkbox"/>	<input type="checkbox"/>	<u>Kagan</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
MARSHALL	<input type="checkbox"/>	<input type="checkbox"/>	<u>Lew</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>

REMARKS: Please advise

RESPONSE:

501 MAY 27 1998

THE WHITE HOUSE  
WASHINGTON

January 21, 1998

MEMORANDUM FOR THE PRESIDENT

FROM: Chris Jennings CJ

SUBJECT: Waivers and the Children's Health Insurance Program

cc: Bruce Reed, Gene Sperling, Jack Lew, Josh Gotbaum, Elena Kagan

This memo seeks your guidance on how much, if any, additional flexibility should be given to states in the Children's Health Insurance Program (CHIP) through the use of §1115 waivers. Although waivers have been instrumental in modernizing and reforming welfare and Medicaid, questions have been raised about the feasibility and advisability of granting waivers for the new children's health care program so soon after its enactment.

Despite acknowledging the great amount of flexibility given to the states in the new CHIP grant program, the Governors asked — soon after the law's enactment — if additional flexibility would be given through waivers. HHS's interim response was that it would be difficult to review and evaluate the merits of waiver proposals until we had some experience with the implementation of the new law. Your advisors agreed that this was the appropriate, initial response, but we also underscored that this was not necessarily our final position.

The National Governors Association (NGA) immediately responded by formally requesting that we affirm states' ability to seek new CHIP grant program §1115 waivers. Since then, two other issues have been raised: (1) Will we approve new Medicaid §1115 waivers in the Medicaid option within CHIP, and (2) Will we allow states with current Medicaid §1115 waivers to expand those programs through CHIP (even though some have provisions below the CHIP minimums).

All of your advisors agree that the HHS Secretary does have the authority to grant waivers for CHIP, whether administered through a new non-Medicaid grant program or through Medicaid. They also generally agree that the CHIP waiver policy need not conform to existing waiver policy. However, they (HHS, OMB, Treasury, NEC/DPC) disagree on whether and under what circumstances HHS should approve waivers in CHIP.

Because HHS is holding state conferences this month on CHIP and the annual NGA conference is in February, it is important that we receive direction from you in short order on this issue. This memo, developed in collaboration with HHS and OMB, outlines these issues, provides policy options for your consideration, and summarizes where your advisors stand on these options.

## BACKGROUND

Your Administration has given states unprecedented flexibility for their health care programs. Since 1993, we have granted 15 comprehensive Medicaid waivers that test approaches not allowed in Medicaid like experimenting with premiums and cost sharing for low-income populations, waiving benefits, and accelerating enrollment in managed care. States have also used waivers to expand coverage to millions of Americans. In addition, with the Administration's strong support, the Balanced Budget Act secured much greater administrative flexibility for the Medicaid program (e.g., eliminated the need for a waiver for a managed care program, repealed the Boren amendment, and reduced cost-based reimbursement requirements for community health centers). In so doing, we eliminated the need for many time-consuming waivers that we heretofore required from states.

The BBA also created CHIP, which has fewer Federal guidelines than any other health insurance program that the Government oversees. Unlike Medicaid, CHIP allows states that opt to expand through a new, non-Medicaid grant program to cap the number of children covered (i.e., no entitlement requirement); to limit programs to parts of the state; to not cover Medicaid's EPSDT (Early, Periodic, Screening, Detection and Treatment) benefit; and to charge beneficiaries long-sought-after (although limited) cost-sharing. Alternatively, states may expand using the enhanced Federal match through the now more flexible Medicaid program. However, states choosing this option must follow Medicaid rules (e.g., no benefits changes or cost sharing).

Although extremely flexible, CHIP includes standards for accountability, benefits, and cost sharing limits; these were secured by you and Congressional Democrats. Accountability provisions include limits on the type of state contribution (e.g., no provider taxes and donations) and provisions to prevent "crowd out" (substitution of the new coverage for existing coverage). For the new non-Medicaid grant program, we developed a benefit standard that simultaneously ensures that it is valuable but provides great flexibility to states in benefits design. Cost-sharing is allowed in the grant program but limited to moderate premium and copayment schedules for those below 150 percent of poverty and to 5 percent of family income for those above 150 percent. As under current law, states electing the Medicaid option must follow Medicaid rules for benefits (including EPSDT) and cost sharing (for children, none is allowed).

Despite the flexibility in CHIP, some states have indicated that they want §1115 waivers. There are three types of waivers that states are seeking. First, several states want to waive provisions for non-Medicaid, CHIP grant programs (e.g., California wants to impose greater cost sharing above the CHIP limits). Second, others want to waive Medicaid provisions within CHIP's Medicaid option since states choosing the Medicaid option must use all Medicaid rules (e.g., Missouri wants to waive the Medicaid requirement to cover non-emergency transportation). Third, most states that already have Medicaid §1115 waivers want to expand those programs to more children to receive CHIP's higher matching rate — even though some include provisions that are significantly below the new CHIP minimums (e.g., Arkansas has higher cost sharing requirements than allowed in CHIP). It is important to note that the provisions that states want most to waive are the benefits and cost sharing minimums we worked to secure before signing off on the budget agreement.

## CONSENSUS RECOMMENDATION: DEFERRING NON-MEDICAID CHIP WAIVERS

Your advisors have achieved consensus on one of the major issues. For CHIP non-Medicaid grant programs, we believe the Administration should consider waiver applications only after a state has had at least a year's worth of experience, followed by an evaluation of its children's health insurance program. As we gain experience with the new CHIP grant program, we will have a better understanding of what types of CHIP demonstrations are appropriate and will develop guidelines at that point.

We believe that deferring approvals for waivers of the already extremely flexible CHIP is advisable because this enables us to see how the program you signed into law last summer will work. Granting waivers now would place great pressure on us to weaken the accountability and benefits standards that we secured in the Balanced Budget negotiations that base Democrats and advocates think are too modest anyway. Having said this, waiver policy for CHIP may well be advisable after we have had time to learn about the program's strengths and weaknesses.

If you agree, we will inform Governors of this policy in a response to their letter. While we believe that Governors will be disappointed with this position, they will likely appreciate that our policy is temporary and that we open up the prospect for waivers soon after they implement their children's health programs.

### Decision

\_\_\_\_\_ Agree on deferring non-Medicaid grant program waivers until plans in place for one year

\_\_\_\_\_ Let's discuss

## ISSUE: POLICY FOR MEDICAID WAIVERS

The other types of waivers, about which there is disagreement amongst your advisors, concern the Medicaid option within CHIP. We all agree that our Medicaid waiver policy should be modified to acknowledge the fact that the Congress did pass legislation that explicitly outlines new guidance on balancing the need for greater flexibility with the need for accountability. However, we differ on how our policy should be modified to reflect this policy change and, more specifically, the extent to which we would hold Medicaid waivers to the CHIP standard.

There are two questions. The first is whether we grant new waivers to states that expand CHIP coverage through Medicaid. States have indicated that they are interested in expanding coverage through the Medicaid option, but since the law allows no flexibility from Medicaid rules, they want waivers, particularly in the area of cost sharing. The second question is whether we allow states that already have Medicaid §1115 waivers to expand those programs, without change, to get the CHIP allotment and higher match. The following are the options proposed by your advisors.

**OPTION 1 (HHS): Defer new Medicaid CHIP waivers (with minor exceptions) and allow expansions of existing Medicaid waivers if consistent with CHIP standards for non-Medicaid grant programs.** HHS recommends that we apply the same policy for new Medicaid and non-Medicaid, grant program waivers. It would hold off on approving any new Medicaid waiver under CHIP until we have at least a year's experience plus an evaluation. (The only exception would be for waivers for small, incidental provisions that have little or no effect on most children — like Missouri's desire to waive the Medicaid requirement for non-emergency transportation.) For states that have waivers already, HHS would allow them access to the new enhanced matching dollars only if they met CHIP's non-Medicaid grant program standards.

Although HHS/OMB have, in years past, approved a number of Medicaid waivers that have less generous benefits than even the new CHIP grant program, HHS believes the new law set a floor that we should not fall below. They fear that once we open the door to waivers, we will have a difficult time maintaining these standards. In addition, they are concerned that waiver negotiations will delay implementation of new programs in a number of states. Rapid implementation is one critical component to covering our target 5 million uninsured children.

If you choose this option, the Democrats and children's health advocates will applaud our decision to respect the rules enacted in the widely praised new health insurance program for children. However, Governors — who are hoping that we will allow some type of Medicaid waivers — will surely react strongly and negatively to this policy.

**OPTION 2 (NEC/DPC): Allow Medicaid CHIP waivers (new or old) if generally consistent with CHIP standards for non-Medicaid grant programs.** This option would allow new waivers through the Medicaid option of CHIP if those waivers were consistent with the standards provided under the new CHIP grant model. In other words, states choosing the Medicaid CHIP option could waive Medicaid rules as long as the benefits, cost-sharing and other accountability provisions are in line with the CHIP grant program standards. Existing (old) Medicaid §1115 waiver programs could also receive the higher matching rate, but they too would have to meet CHIP standards; in a number of cases, this would mean they would have to strengthen some of their benefits/cost-sharing protections to access these additional dollars. Although a few states would have to reduce cost sharing requirements to comply with CHIP, we believe that the higher matching rate available under CHIP would be sufficient to offset these costs.

DPC/NEC believes that this option strikes an appropriate balance by maintaining the integrity of the CHIP program and the Balanced Budget Act and giving the new standards time to be tested. It also removes an important disincentive for states to use the Medicaid option in CHIP. Many states would prefer to use their already-in-place Medicaid programs because it is administratively simple. Moreover, having a seamless Medicaid program serving both poor and children of working parents has obvious advantages. However, allowing any new Medicaid waivers through CHIP will be criticized by our base Congressional Democrats, some Republicans, and advocates. They believe that their support for the flexibility in the non-Medicaid CHIP program was conditional on no new flexibility in Medicaid. The Governors would like this approach better than the HHS option, but they could be counted on to say that it is still not flexible enough.

Within this option, NEC/DPC also recommends that the Secretary have the authority to approve Medicaid CHIP waivers that may be modestly below those standards provided for in the new CHIP grant program. While we strongly believe that the CHIP standards should be the guiding principle for Medicaid waivers, we also recognize that it is unwise and unrealistic to treat the new law's standards as "lines in the sand" that can never be crossed regardless of a waiver's merits. One good example is in the area of cost sharing.

In both previous Medicaid waivers and our internal policy positions, we have allowed limited cost sharing that exceeds the CHIP grant program standards. Such cost sharing can appropriately increase beneficiaries' cost sensitivity in using health services and decrease possible employer insurance dropping problems, since such a policy would more accurately mirror marketplace coverage. While we recommend providing this additional flexibility authority, we also believe that waivers of the CHIP grant standards for children not be granted below 133 percent of poverty -- the level your Administration advisors had previously concluded (during the balanced budget discussions) achieved the balance between appropriate and excessive cost-sharing.

While some might point out that it is inconsistent to allow flexibility below CHIP standards for Medicaid and not the grant option, we believe that the advantages of this approach far outweigh this criticism. First, the CHIP standards were designed for the grant program -- not Medicaid. Second, Medicaid waivers are quite variable and have never been publicly held by Democrats and advocates to the same standards as legislated changes to public programs. And thirdly, as described above, having an additional incentive to administer the children's health program through Medicaid is desirable.

Giving HHS the authority to allow any cost sharing flexibility in Medicaid will likely anger base Congressional Democrats and some moderate Republicans. They will argue (as does HHS) that once we sanction higher cost sharing below 150 percent of poverty, decisions will be perceived as arbitrary, making it difficult to say no to states that demand even greater flexibility. We believe these are valid concerns and should be seriously considered. However, we are also well aware of states (such as Wisconsin) who will be requesting cost-sharing levels just under 150 percent (i.e., 143 percent of poverty) that we would find difficult to oppose on purely policy grounds.

**OPTION 3 (OMB & TREASURY): Allow new CHIP Medicaid waivers if consistent with CHIP standards for non-Medicaid, grant programs, but allow existing Medicaid waivers to expand with no change.** For states requesting *new* Medicaid waivers, OMB/Treasury agree with DPC/NEC option that the CHIP standards should guide approval of such waivers (also allowing for greater cost sharing for families no less than approximately 133 percent of poverty). This policy should be re-evaluated after states gain experience with their programs, at the same time the Administration is re-considering non-Medicaid, grant program waivers.

For states with waiver programs already approved (since the 1994 NGA waiver agreement), OMB and Treasury recommend that we recognize their history and different situation and not hold them to the CHIP standards. We anticipate that these 11 states will want to expand their current waiver programs under CHIP; OMB and Treasury think they should be permitted to do so with no changes. Although this option provides only a few more states with additional flexibility in cost-

sharing or benefits under CHIP than the DPC/NEC option, it helps these states avoid significant coordination problems by sanctioning CHIP programs consistent with approved waiver programs. In addition, lower income children in these states might pay more in premiums than the higher income children newly eligible under CHIP. Waiver states will consider the Administration to have reneged if we don't permit them to carry their waivers to CHIP. This option excludes pre-NGA agreement waivers (e.g., Tennessee) since states have been held to a higher standard since then.

Allowing existing Medicaid waivers into CHIP unchanged will surely be noticed and strongly opposed by base Democrats and children's advocates. They believe that some of the waivers that we have approved to date, such as Tennessee and Arkansas, have gone too far by allowing states to impose "excessive" cost sharing on low-income beneficiaries and waive EPSDT. Ironically, this policy may also be criticized by some Congressional Republicans, who think that many of our CHIP implementation decisions are steering states toward the Medicaid option. It would, however, be the most acceptable option to the NGA and the relevant (existing waiver) states.

## Decisions

### Medicaid Waivers

- \_\_\_\_\_ OPTION 1: Defer new Medicaid waivers in CHIP (with minor exceptions)  
Allow existing waivers to expand through CHIP if consistent with CHIP standards for non-Medicaid, grant programs
- \_\_\_\_\_ OPTION 2: Allow new & existing Medicaid waivers in CHIP if consistent with CHIP standards for non-Medicaid, grant programs
- \_\_\_\_\_ OPTION 3: Allow new Medicaid waivers in CHIP if consistent with CHIP standards for non-Medicaid, grant programs  
Allow existing waivers (post-NGA agreement) to expand through CHIP with no program changes even if they fall significantly below new CHIP grant standards
- \_\_\_\_\_ Let's discuss

### Cost Sharing Flexibility

- \_\_\_\_\_ OPTION 1: Hold all Medicaid waivers to the cost sharing in CHIP for non-Medicaid, grant programs
- \_\_\_\_\_ OPTION 2: Authorize the Secretary to approve, within limits, Medicaid waivers in CHIP with cost sharing below CHIP standards for non-Medicaid, grant programs
- \_\_\_\_\_ Let's discuss

STATES WITH MEDICAID 1115 WAIVERS (Chronological Order)

STATE	Approved	Eligibility Limit	Benefits for New Eligibles	Cost Sharing: New Eligibles
Arizona	10/82	Existing eligibles	Medicaid benefits	None
Oregon	3/93	People < 100% PL	Prioritized benefits	Premiums: \$6 to 28 No copays or deductibles
Hawaii	7/93	People < 300% PL, plus assets test	No long-term care	Premiums: \$142 - 168 Copays: \$5
Maryland	10/93 10/96	Children 133-185% PL Existing eligibles	No inpatient, outpatient, emergency room, some EPSDT; no long-term care Medicaid benefits	Copay: \$5 None
Rhode Island	11/93	Children < 250% PL	Medicaid benefits	Premiums: From 185-250% PL: \$1.50 - \$10.75 No copays or deductibles
Tennessee	11/93	People up to 400% PL, with enrollment cap	Medicaid benefits	Premiums: \$14.25 to 475 Deductibles: \$250 / \$500 Coinsurance: 2 to 10%
Florida	9/94	People < 250% PL	<i>Excludes some EPSDT, transportation, some long- term care and mental health</i>	<i>Premiums: \$90 - 550 / mo Deductibles: Up to \$500 Copays: \$10-200 or 20%</i>
Ohio	1/95	People < 100% PL	Medicaid benefits	None
Massachusetts	4/95	People < 200% PL	Medicaid benefits	Premiums: Variable Deductibles: \$100 / \$250 Copays: \$5 / 10
Minnesota	4/95	Children < 275% PL	Medicaid benefits	Premiums: \$4 to 104 / mo No copays or deductibles
Delaware	5/95	People < 100% PL	Medicaid w/ small changes	None
Vermont	7/95	People < 150% PL	No transportation, long-term care	Premiums: Above 25% PL: \$5 to \$20 every 6 months Copays: \$3 for dental
Kentucky	10/95	<i>Existing eligibles</i>	<i>Medicaid benefits</i>	<i>None</i>
Oklahoma	10/95	Existing eligibles	Medicaid benefits	None
Illinois	7/96	<i>Existing eligibles</i>	<i>Medicaid benefits</i>	<i>None</i>
Alabama	12/96	Existing eligibles	Medicaid benefits	None
New York	7/97	Home relief pop.	Medicaid benefits	None
Arkansas	8/97	Children < 200% PL	No EPSDT, limited long- term care & mental health	Copays: \$10 outpatient; 20% inpatient ; \$5 for drugs

Italics indicated approved but not implemented. States above the line were approved prior to NGA 1994 agreement.

AGENDA

TASK FORCE ON PROTECTING CHILDREN FROM  
ENVIRONMENTAL HEALTH RISKS AND SAFETY RISKS

OCTOBER 9, 1997 1:00-3:00P.M.  
STONEHENGE ROOM  
HUBERT HUMPHREY BUILDING  
6TH FLOOR  
200 INDEPENDENCE AVENUE, S.W.  
WASHINGTON D.C.

*Children's Health*

1:00 p.m. - 1:10 p.m. Introductions and Opening Remarks

Administrator Browner and Secretary Shalala

1:10 p.m. - 1:25 p.m. A Child's Environment: A Day in the Life...

Dr. Mindy Fullilove, Columbia University  
Presentation and video

1:25 p.m. - 1:45 p.m. Environmental Risks to Children: A National Overview

Dr. Richard Jackson, Director  
National Center for Environmental Health, CDC  
Dr. Philip Landrigan, Senior Adviser to the Administrator for Children's  
Health Protection, EPA

1:45 p.m. - 2:15 p.m. What Led to the Executive Order and its Provisions

Dr. Lynn Goldman, Assistant Administrator (1:45 p.m.-1:55 p.m.)  
for Prevention, Pesticides and Toxic Substances, EPA  
-- "Investing in Our Future: A National Research Initiative for America's  
Children for the 21st Century"  
Dr. Kenneth Olden, Director (1:55 p.m.-2:15 p.m.)  
National Institute of Environmental Health Science, NIH  
-- Creation of Work Group on Data Needs and Research  
-- Creation of Work Group on Program Implementation  
-- Agency Responsibilities Under the Executive Order

2:15 p.m. - 2:50 p.m. Department Heads' Remarks on Protection of Children from  
Environmental Health and Safety Risks

-- Agencies invited to comment on their activities

2:50 p.m. - 3:00 p.m. Closing  
Task Force Co-Chairs



UNITED STATES ENVIRONMENTAL PROTECTION AGENCY  
WASHINGTON, D.C. 20460

OCT 2 1997

Honorable Bruce N. Reed  
Assistant to the President on  
Domestic Policy  
The White House  
1600 Pennsylvania Avenue, N.W.  
Washington, DC 20500

Dear Mr. Reed:

On April 21, 1997, President Clinton signed Executive Order 13045, *Protection of Children from Environmental Health Risks and Safety Risks*. The Order responded to concerns about increases in some childhood diseases that may be attributable to environmental exposures and the growing body of scientific knowledge demonstrating that children may suffer disproportionately from environmental health and safety risks. Among other things, the Order establishes the Task Force on Environmental Health Risks and Safety Risks to Children. This Task Force will "recommend to the President Federal strategies for children's environmental health and safety, within the limits of the Administration's budget." The Task Force will work on annual priorities for Administration activities in this area, a research agenda and review of relevant data bases, recommendations for partnerships and outreach, identification of initiatives, and statements about desirability of new legislation. Implementing this order challenges the nation to ensure our children's healthy futures.

The first Task Force meeting will be held on October 9, 1997 from 1:00 to 3:00 P.M. We will send you the agenda and meeting location shortly. Please designate someone from your senior staff to serve as the contact point for the Task Force. Please contact Doug Tsao, EPA, at 202-260-7960 if you have any questions. We are looking forward to seeing all of you at this important meeting.

Handwritten signature of Carol M. Browner in black ink.

Carol M. Browner, Administrator  
Environmental Protection Agency

Handwritten signature of Donna E. Shalala in black ink.

Donna E. Shalala, Secretary  
Department of Health and  
Human Services



UNITED STATES ENVIRONMENTAL PROTECTION AGENCY  
WASHINGTON, D.C. 20460

OCT 3 1997

NOTE TO: Members of the Environmental Health Risks and Safety Risks to Children Task Force

SUBJECT: Information About the Task Force Meeting

The first meeting of the Task Force on Environmental Health Risks and Safety Risks to Children will be held:

Thursday, October 9, 1997

1:00 pm to 3:00 pm

Stonehenge Room

Hubert Humphrey

6th Floor

200 Independence Avenue, S.W.  
Washington, DC

Enclosed is an agenda and other background information. I look forward to seeing you at the meeting.

A handwritten signature in cursive script, reading "E. Ramona Trovato".

E. Ramona Trovato  
Director

Office of Children's Health Protection

## TASK FORCE MEMBERSHIP ROSTER

Carol Browner, Administrator  
USEPA  
401 M Street, S.W.  
Washington, DC 20460

Donna E. Shalala, Secretary  
Department of Health and Human Services  
200 Independence Ave., S.W.  
Washington, DC 20202

Richard W. Riley, Secretary  
Department of Education  
600 Independence Ave., S.W.  
Washington, DC 20202

Alexis M. Herman, Secretary  
Department of Labor  
200 Constitution Ave., N.W.  
Washington, DC 20210

Janet Reno, Attorney General  
Department of Justice  
10th Street & Pennsylvania Avenue, N.W.  
Washington, DC 20530

Frederico F. Pena, Secretary  
Department of Energy  
1000 Independence Avenue, N.W.  
Washington, DC 20585

Andrew M. Cuomo, Secretary  
Department of Housing and Urban Development  
451 Seventh Street, SW  
Washington, DC 20410

Daniel R. Glickman, Secretary  
Department of Agriculture  
14th Street and Independence Ave., SW  
Washington, DC 20250

Rodney E. Slater, Secretary  
Department of Transportation  
400 Seventh Street, SW  
Washington, DC 20590

Franklin D. Raines, Director  
Office of Management and Budget  
Old Executive Office Building  
17th Street and Pennsylvania Avenue, NW  
Washington, DC 20503

Kathleen A. McGinty, Chair  
Council on Environmental Quality  
722 Jackson Place, NW  
Washington, DC 20503

Ann Brown, Chairman  
Consumer Product Safety Commission  
4330 East West Highway  
Bethesda, MD 20814

Gene B. Sperling, Assistant to the President  
Director of the National Economic Council  
The White House  
2nd Floor, West Wing  
1600 Pennsylvania Ave., NW  
Washington, DC 20500

Bruce N. Reed, Assistant to the President  
on Domestic Policy  
The White House  
2nd Floor, West Wing  
1600 Pennsylvania Ave., NW  
Washington, DC 20500

Janet L. Yellen, Chair of Council of Economic Advisers  
Old Executive Office Building  
17th Street and Pennsylvania Ave., NW  
Washington, DC 20500

John H. Gibbons, Assistant to the President  
Office of Science and Technology Policy  
Old Executive Office Building  
17th Street and Pennsylvania Ave., NW  
Washington, DC 20502

THE WHITE HOUSE  
OFFICE OF THE VICE PRESIDENT

FOR IMMEDIATE RELEASE  
MONDAY, April 21, 1997

CONTACT: 202-456-7035

**VICE PRESIDENT ANNOUNCES EXECUTIVE ORDER TO REDUCE  
ENVIRONMENTAL HEALTH AND SAFETY RISKS TO CHILDREN**  
Action Will Require Agencies to Consider Effects of Federal Rules on Children

WASHINGTON D.C. -- Vice President Gore visited the Children's National Medical Center in Washington, D.C. today (4/21) and announced an executive order to reduce environmental health and safety risks to children.

"This executive order says to every federal agency and department: put our children first. We Americans owe our largest responsibility to our smallest citizens" said Vice President Gore. "From now on, agencies will have to take a hard look at the special risks and disproportionate impact that standards and safeguards have on our children."

The executive order, which President Clinton signed today, includes actions that will strengthen policies and improve research to protect children, and ensure that new safeguards consider special risks to children. It would, for the first time, require agencies to analyze and explain the effects of their rules on children.

Studies have demonstrated that children are at a disproportionate risk from environmental health, and safety hazards. These disproportionate risks -- which can lead to illnesses like cancer, leukemia, and asthma -- stem from fundamental differences, in terms of physiology and activity, between children and adults.

The Clinton Administration has taken bold steps to provide explicit protection for children in initiatives such as the Food Quality Protection Act and Safe Drinking Water Act; development of new standards for passive restraints for children in cars; and administrative action to protect children from tobacco, lead and other hazards. This executive order is another example of the Administration's continued commitment to protecting America's children from environmental and safety hazards.

##

## Enhancing Protection of Children's Health

April 21, 1997

Vice President Gore today announced an executive order to reduce environmental health and safety risks to children. For the first time, federal agencies will be required to assign high priority to addressing these risks, to coordinate their research priorities on children's health, and to ensure that their standards take into account special risks to children.

Because children are still developing and because of they take in more food, water, and air relative to their body weight than adults, they are more susceptible than adults to environmental threats. In the past 25 years we have made great progress in protecting public health from environmental hazards, but we still have far to go. Asthma is now the leading cause of hospital admissions for children, 10 million children under the age of four still live within four miles of a toxic dump, and despite a steady decline in childhood lead poisoning, there are still nearly one million children under the age of five who suffer from this condition.

The executive order, which President Clinton signed today, includes the following actions:

- **Strengthen Policies to Protect Children.** The executive order requires all agencies to make the protection of children a high priority in implementing their statutory responsibilities and fulfilling their overall missions.
- **Improve Research and other Initiatives to Protect Children.** The proposed executive order would create an interagency task force to establish a coordinated research agenda, to identify research and other initiatives the Administration will take to advance the protection of children's environmental health and safety, and to enlist public input for these efforts. The Office of Management and Budget is charged with convening an Interagency Forum on Child and Family Statistics, to produce an annual compendium of the most important indicators of the well being of the Nation's children.
- **Ensure that New Safeguards Consider Special Risks to Children.** The executive order would, for the first time, require agencies to analyze and explain the effects of their rules on children. When a major regulation addresses special risks to children, agencies would have to 1) consider disproportionate impacts on children; and 2) explain why their proposed action is preferable to other alternatives. The primary goal of this provision is to link policy decisions to the emerging science regarding children's environmental health and safety. This provision ensures accountability to the public and helps agencies identify their research needs.

Finally, and perhaps most important, this executive order will help us make sure that our policy decisions are linked to the latest science regarding children's health and safety.

If the success stories that we've already had -- the Safe Drinking Water Act and the new tobacco provisions, the NetDays and the Earth Days -- if those success stories teach us anything, it this: we are at our best when we work together. So let's work together to do right by our children. And let's make this -- the strongest nation in the world -- stronger and healthier still.

###

---

# Executive Order on Protection of Children From Environmental Health Risks and Safety Risk

Issued April 21, 1997  
THE WHITE HOUSE  
Office of the Press Secretary  
For Immediate Release

---

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

## *Section 1. Policy.*

1-101. A growing body of scientific knowledge demonstrates that children may suffer disproportionately from environmental health risks and safety risks. These risks arise because: children's neurological, immunological, digestive, and other bodily systems are still developing; children eat more food, drink more fluids, and breathe more air in proportion to their body weight than adults; children's size and weight may diminish their protection from standard safety features; and children's behavior patterns may make them more susceptible to accidents because they are less able to protect themselves. Therefore, to the extent permitted by law and appropriate, and consistent with the agency's mission, each Federal agency:

(a) shall make it a high priority to identify and assess environmental health risks and safety risks that may disproportionately affect children; and

(b) shall ensure that its policies, programs, activities, and standards address disproportionate risks to children that result from environmental health risks or safety risks.

1-102. Each independent regulatory agency is encouraged to participate in the implementation of this order and comply with its provisions.

## *Sec. 2. Definitions.* The following definitions shall apply to this order.

2-201. "Federal agency" means any authority of the United States that is an agency under 44 U.S.C. 3502(1) other than those considered to be independent regulatory agencies under 44 U.S.C. 3502(5). For purposes of this order, "military departments," as defined in 5 U.S.C. 102, are covered under the auspices of the Department of Defense.

2-202 "Covered regulatory action" means any substantive action in a rulemaking, initiated after the date of this order or for which a Notice of Proposed Rulemaking is published 1 year after the date of this order, that is likely to result in a rule that may:

(a) be "economically significant" under Executive Order 12866 (a rulemaking that has an annual effect on the economy of \$100 million or more or would adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities); and

(b) concern an environmental health risk or safety risk that an agency has reason to believe may disproportionately affect children. 2-203. "Environmental health risks and safety risks mean risks to health or to safety that are attributable to products or substances that the child is likely to come in contact with or ingest (such as the air we breath, the food we eat, the water we drink or use for recreation, the soil we live on, and the products we use or are exposed to).

**Sec. 3. Task Force on Environmental Health Risks and Safety Risks to Children.**

3-301. There is hereby established the Task Force on Environmental Health Risks and Safety Risks to Children ("Task Force").

3-302. The Task Force will report to the President in consultation with the Domestic Policy Council, the National Science and Technology Council, the Council on Environmental Quality, and the Office of Management and Budget (OMB).

3-303. Membership. The Task Force shall be composed of the:

- (a) Secretary of Health and Human Services, who shall serve as a Co-Chair of the Council;
- (b) Administrator of the Environmental Protection Agency, who shall serve as a Co-Chair of the Council;
- (c) Secretary of Education;
- (d) Secretary of Labor;
- (e) Attorney General;
- (f) Secretary of Energy;
- (g) Secretary of Housing and Urban Development;
- (h) Secretary of Agriculture;
- (i) Secretary of Transportation;
- (j) Director of the Office of Management and Budget;
- (k) Chair of the Council on Environmental Quality;
- (l) Chair of the Consumer Product Safety Commission;
- (m) Assistant to the President for Economic Policy;
- (n) Assistant to the President for Domestic Policy;
- (o) Assistant to the President and Director of the office of Science and Technology Policy;
- (p) Chair of the Council of Economic Advisers; and
- (q) Such other officials of executive departments and agencies as the President may, from time to time, designate.

Members of the Task Force may delegate their responsibilities under this order to subordinates.

3-304. Functions. The Task Force shall recommend to the President Federal strategies for children's environmental health and safety, within the limits of the Administration's budget, to include the following elements:

- (a) statements of principles, general policy, and targeted annual priorities to guide the Federal approach to achieving the goals of this order;
- (b) a coordinated research agenda for the Federal Government, including steps to implement the review of research databases described in section 4 of this order;
- (c) recommendations for appropriate partnerships among Federal, State, local, and tribal governments and the private, academic, and nonprofit sectors;
- (d) proposals to enhance public outreach and communication to assist families in evaluating risks to children and in making informed consumer choices;
- (e) an identification of high-priority initiatives that the Federal Government has undertaken or will undertake in advancing protection of children's environmental health and safety; and
- (f) a statement regarding the desirability of new legislation to fulfill or promote the purposes of this order.

3-305. The Task Force shall prepare a biennial report on research, data, or other information that would enhance our ability to understand, analyze, and respond to environmental health risks and safety risks to children. For purposes of this report, cabinet agencies and other agencies identified by the Task Force shall identify and specifically describe for the Task Force key data needs related to environmental health risks and safety risks to children that have arisen in the course of the agency's programs and activities. The Task Force shall incorporate agency submissions into its report and ensure that this report is publicly available and widely disseminated. The Office of Science and Technology Policy and the National Science and Technology Council shall ensure that this report is fully considered in establishing research priorities.

3-306. The Task Force shall exist for a period of 4 years from the first meeting. At least 6 months prior to the expiration of that period, the member agencies shall assess the need for continuation of the Task Force or its functions, and make appropriate recommendations to the President.

#### **Sec. 4. Research Coordination and Integration.**

4-401. Within 6 months of the date of this order, the Task Force shall develop or direct to be developed a review of existing and planned data resources and a proposed plan for ensuring that researchers and Federal research agencies have access to information on all research conducted or funded by the Federal Government that is related to adverse health risks in children resulting from exposure to environmental health risks or safety risks. The National Science and Technology Council shall review the plan.

4-402. The plan shall promote the sharing of information on academic and private research. It shall include recommendations to encourage that such data, to the extent permitted by law, is available to the public, the scientific and academic communities, and all Federal agencies.

#### **Sec. 5. Agency Environmental Health Risk or Safety Risk Regulations.**

5-501. For each covered regulatory action submitted to OMB's Office of Information and Regulatory Affairs (OIRA) for review pursuant to Executive Order 12866, the issuing agency shall provide to OIRA the following information developed as part of the agency's

decisionmaking process, unless prohibited by law:

(a) an evaluation of the environmental health or safety effects of the planned regulation on children; and

(b) an explanation of why the planned regulation is preferable to other potentially effective and reasonably feasible alternatives considered by the agency.

5-502. In emergency situations, or when an agency is obligated by law to act more quickly than normal review procedures allow, the agency shall comply with the provisions of this section to the extent practicable. For those covered regulatory actions that are governed by a court-imposed or statutory deadline, the agency shall, to the extent practicable, schedule any rulemaking proceedings so as to permit sufficient time for completing the analysis required by this section.

5-503. The analysis required by this section may be included as part of any other required analysis, and shall be made part of the administrative record for the covered regulatory action or otherwise made available to the public, to the extent permitted by law.

#### **Sec. 6. Interagency Forum on Child and Family Statistics.**

6-601. The Director of the OMB ("Director") shall convene an Interagency Forum on Child and Family Statistics ("Forum"), which will include representatives from the appropriate Federal statistics and research agencies. The Forum shall produce an annual compendium ("Report") of the most important indicators of the well-being of the Nation's children.

6-602. The Forum shall determine the indicators to be included in each Report and identify the sources of data to be used for each indicator. The Forum shall provide an ongoing review of Federal collection and dissemination of data on children and families, and shall make recommendations to improve the coverage and coordination of data collection and to reduce duplication and overlap.

6-603. The Report shall be published by the Forum in collaboration with the National Institute of Child Health and Human Development. The Forum shall present the first annual Report to the President, through the Director, by July 31, 1997. The Report shall be submitted annually thereafter, using the most recently available data.

#### **Sec. 7 General Provisions.**

7-701. This order is intended only for internal management of the executive branch. This order is not intended, and should not be construed to create, any right benefit, or trust responsibility, substantive or procedural, enforceable at law or equity by a party against the United States, its agencies, its officers, or its employees. This order shall not be construed to create any right to judicial review involving the compliance or noncompliance with this order by the United States, its agencies, its officers, or any other person.

7-702. Executive Order 12606 of September 2, 1987 is revoked.

WILLIAM J. CLINTON

THE WHITE HOUSE,

April 21, 1997.

# Environmental Policy and Children's Health

Phillip J. Landrigan  
Joy E. Carlson

*Phillip J. Landrigan, M.D., M.Sc., is a professor of pediatrics and chair of the Department of Community Medicine at Mount Sinai School of Medicine.*

*Joy E. Carlson, M.P.H., is director of the Children's Environmental Health Network, a national project dedicated to preventing the exposure of children to environmental hazards.*

## Abstract

Understanding the differences in the effects of environmental contamination on children and adults is an important part of environmental policymaking; however, unless environmental health policies reflect the differences between adults and children, this knowledge will have little practical effect. The authors of this article consider how the unique vulnerabilities of children challenge environmental policymaking. First, they review the biological differences between children and adults, and then they critique the processes of risk assessment and risk management, the principal tools currently used to form federal environmental policy. While these tools are useful in developing environmental health policy, their implementation frequently fails to consider the unique vulnerabilities of children. In light of the potential to improve environmental policy for children, the authors review both the actual and prospective contributions of educational and advocacy efforts in changing the ways policy addresses children's environmental health, and discuss the interests of industries and the problems of environmental equity. Finally, they present a new approach to environmental health policymaking which places children, rather than individual toxicants and hazards, at the center of the risk assessment and management process.

Children today live in an environment that is vastly different from that of a generation or two ago. While exposures to some environmental hazards have decreased thanks to new regulations and increased vigilance,<sup>1</sup> children are continually in contact with new chemicals in their food, in the air, and in water. They are exposed to thousands of newly developed synthetic chemicals whose toxicity has never been tested and whose potential dangers to children are unknown.<sup>2</sup> These new exposures, along with the triumphs of vaccines and antibiotics, have changed the face of childhood illness in the developed world. Chronic diseases, some thought to be caused by toxic environmental exposures, have come to replace the classic infectious diseases as major causes of illness and death among children in developed countries. These illnesses, along with complex, chronic handicapping conditions of multiple origins, are known today as the "new pediatric morbidity."<sup>3</sup>

This new morbidity includes a broad range of diseases in children. Among these diseases are asthma exacerbated by air pollution and second-

hand cigarette smoke, delayed development caused by lead in paint and contaminated drinking water, and cancers caused by radiation and benzene. Some of these illnesses are acute; others are chronic. Some, such as lead poisoning and asthma, are evident during childhood. But other diseases caused by toxic exposures in childhood may appear only years or decades later after long periods of latency. Examples of the latter category include lung cancer and malignant mesothelioma caused by early childhood exposure to asbestos, or leukemia and lymphoma caused by exposure to benzene in unleaded gasoline.

All of these diseases of toxic environmental origin, no matter whether they are acute or chronic, can in theory be prevented by reducing or eliminating children's exposures to toxic chemicals in the environment. These diseases arise as a consequence of human activity. Therefore, they can be prevented by modifying that activity.

The articles in this journal issue by Bearer and by Goldman discuss in detail how children are different from adults in an environmental context. These articles provide several case studies showing how children are affected by environmental toxins. This article examines the ways in which the unique environmental exposures and vulnerabilities of children present challenges for environmental policy in the areas of regulation, prevention, education, and research. It also considers the policy implications of children's vulnerability for communities, environmental advocates, and industry.

In the broadest sense, all of the conditions around us comprise our environment. These include natural phenomena such as the seasons and the weather, the gravitational field of the earth, the air we breathe, the food we eat, the water we drink, our homes, our workplaces, and other people. If this definition is used, environmental health includes topics as disparate as drownings, sunburn, lung cancer from cigarette smoking, and poisoning from pesticides in food.

This article, however, focuses more specifically on contamination of the environment by manufactured chemicals. It examines policies that address contamination produced by human activities and concentrates on toxic environmental exposures that people cannot easily control individually. This definition is useful in a policy context because all of the diseases and health problems caused by manufactured toxins could potentially be avoided by not using the chemicals in the first place, whereas drownings and sunburn have always happened and require different types of interventions.

## Children's Vulnerability to Toxins in the Environment

Children are uniquely vulnerable to environmental toxins. This heightened susceptibility stems from several sources and is reviewed in detail in the articles by Bearer and by Goldman in this journal issue. To summarize:

- **Children have greater exposures to environmental toxins than adults.** Pound for pound of body weight, children drink more water, eat more food, and breathe more air than adults.<sup>1</sup> For example, children in the first six months of life drink seven times as much water per pound as does the average American adult. Children ages one through five years eat three to four times more food per pound than the average adult American. In addition, children have unique food preferences. For example, the average one-year-old drinks 21 times more apple juice and 11 times more grape juice and eats 2 to 7 times more grapes, bananas, pears, carrots, and broccoli than the average adult.<sup>2</sup> Moreover, the air intake of a resting infant is twice that of an adult. These patterns of increased consumption reflect the rapid metabolism of children as well as their growth and development. The obvious implication for environmental health is that children will have substantially heavier exposures pound for pound than adults to any toxins that are present in water, food, or air. This has been demonstrated very clearly in the case of children's exposures to pesticides in the diet.<sup>3</sup>

Two additional characteristics of children further magnify their exposures to toxins in the environment: (1) their hand-to-mouth behavior, which increases their ingestion of any toxins in dust or soil; and (2) their play close to the ground, which increases their exposure to toxins in dust, soil, and carpets as well as to any toxins that form low-lying layers in the air such as certain pesticide vapors.

- **Children's metabolic pathways, especially in the first months after birth, are immature compared with those of adults.** As a consequence of this biochemical immaturity, children's ability to metabolize, detoxify, and excrete certain toxins is different from that of adults. In some

instances, children are actually better able than adults to deal with environmental toxins. More commonly, however, they are less able than adults to deal with toxic chemicals and thus are more vulnerable to them.<sup>5,6</sup>

- **Children are undergoing rapid growth and development, and their delicate developmental processes are easily disrupted.** Many organ systems in young children—the nervous system in particular—undergo very rapid growth and development in the first months and years of life. During this period, structures are developed and vital connections are established. Indeed, development of the nervous system continues all through childhood, as is evidenced by the fact that children continue to acquire new skills progressively as they grow and develop—crawling, walking, talking, reading, and writing. The nervous system is not well able to repair any structural damage that is caused by environmental toxins. Thus, if cells in the developing brain are destroyed by chemicals such as lead, mercury, or solvents, or if vital connections between nerve cells fail to form, there is high risk that the resulting neurobehavioral dysfunction will be permanent and irreversible.<sup>7</sup> The consequences can be loss of intelligence and alteration of normal behavior.

- **Because children have more future years of life than do most adults, they have more time to develop any chronic diseases that may be triggered by early environmental exposures.** Many diseases that are triggered by toxins in the environment require decades to develop. Examples include mesothelioma caused by exposure to asbestos, leukemia caused by benzene, breast cancer that may be caused by DDT, and possibly some chronic neurologic diseases such as Parkinson's disease that may be caused by exposures to environmental neurotoxins.<sup>8</sup> Many of these diseases are now thought to be the products of multi-stage processes within the body's cells which require many years to evolve from earliest initiation to actual manifestation of illness. Consequently, certain carcinogenic and toxic exposures sustained early in life appear more likely to lead to disease than the same exposures encountered later in life.<sup>9</sup>

## Box 1

**Risk Assessment and Risk Management**

The two principal tools used by policymakers to form environmental health policy are risk assessment and risk management.

- *Risk assessment* is principally a scientific activity. It consists of an attempt to estimate the hazardous properties of a chemical in the environment and to determine the risks to human health that may result from exposure.
- *Risk management* is action oriented. It consists of actions taken to control exposures to toxic chemicals in the environment. Exposure standards, requirements for premarket testing, recalls of toxic products, and outright banning of very hazardous materials are among the actions that are used by governmental agencies to manage risk.

The distinction between risk assessment and risk management was developed by an expert committee convened by the National Academy of Sciences.

Source: National Research Council. *Science and Judgment in Risk Assessment*. Washington, DC: National Academy Press, 1994.

**Public Policy Options**

Despite children's extensive exposures and heightened vulnerability to environmental toxins, there is no coherent research or policy agenda in the United States which ensures that America's children will grow up in a safe environment. Rather, most environmental policies, at both the federal and the state levels, attempt to regulate chemical exposures without reference to children's health. Most current regulatory efforts represent attempts to balance different and competing interests around potential toxins. New chemicals are introduced into the environment because they are useful or because they are by-products of processes that are considered useful. Too often the toxicity of these materials is untested, and the potential hazards they may pose to children are quite unknown.<sup>2</sup> Environmental policy typically attempts to balance the need to protect individuals and the environment against the benefits that may be realized by the use of potential toxins. Most environmental regulation in the United States is not designed specifically to protect the health of either adults or children.

This section examines options for creating a children's environmental health policy in the United States. It focuses first on the processes of risk assessment and risk management, the two principal tools

that policymakers use to form environmental health policy. Within this framework, it studies successes and failures, policy gaps and impediments to formation of policy. Implications of current approaches to risk assessment and risk management for children's environmental health are discussed (see Box 1). It concludes by offering an alternative paradigm for control of toxic hazards in the environment designed specifically to protect children's health.

**Risk Assessment**

Environmental health policy development begins with risk assessment. Risk assessment attempts to evaluate the hazardous properties of a chemical and to determine the risks that result from exposure to it.<sup>3</sup> In some instances, risk assessment is based on clinical and epidemiologic studies in which the effects of a toxic chemical are evaluated directly in humans. More commonly, risk assessment is based on toxicological studies of a chemical in laboratory animals. The results of risk assessment are often controversial. Frequently, to estimate the risk associated with a chemical, assumptions and extrapolations must be made, and different investigators and scientists may make different assumptions.

The four steps in risk assessment are as follows:

1. *Hazard identification*: Identify the hazard by observing the health effects it

produces in humans or animals exposed to it. Health effects may be gross and obvious, such as cancer or death, or they may be subtle, such as delays in development or impairment of immune function.

2. *Dose-response assessment:* Assess the relationship between the amount of exposure and the occurrence of the unwanted health effects. For example, what dose of the contaminant produces how many excess cancers? Are health effects more severe at higher levels of exposure?

3. *Exposure assessment:* Evaluate exposure to the toxin in terms of exposure source, extent of exposure, pathways of

---

***Toxicity testing of chemicals generally fails to consider the special vulnerability of infants and children.***

---

human absorption, internal "dose," and the number and kinds of people likely to be exposed.

4. *Risk characterization:* Using information gathered in the first three steps, characterize the resulting risk. Usually this consists of developing a table depicting estimates of the number of excess unwanted health events expected at different time intervals at each level of exposure.<sup>9,10</sup>

Each of the steps in risk assessment has implications for public policy regarding children's health and the environment.

#### **Hazard Identification**

In pediatric environmental health, the first step, hazard identification, has traditionally begun with clinical observation. Astute pediatricians have observed, for example, that children who ingested chips of lead-based paint developed coma and convulsions, that adolescents at summer camp who were exposed to smog were likely to wheeze, and that babies born to mothers who consumed excessive alcohol during pregnancy showed the facial features and developmental delays characteristic of fetal alcohol syndrome.

The principal problem with this approach is that clinical recognition can, by definition, take place only after disease

has occurred. It requires the fortuitous combination of an alert physician with either a cluster of disease or a new and rare disease pattern. Clinical recognition of links between environmental toxins and disease is very difficult because the diseases caused by chemicals are usually indistinguishable from the illnesses caused by other factors. The asthma caused by air pollution looks the same to a physician as asthma caused by allergy, and the lung cancer caused by asbestos looks the same as that caused by cigarette smoking. Moreover, it is often necessary for many years to elapse between exposure to a toxic chemical and the appearance of disease. In these cases, assessment of past exposures is extraordinarily difficult.

Hazards can be identified much more efficiently and systematically by testing the possible toxicity of new chemical compounds in laboratory animals before the chemicals are ever utilized in commerce or released into the environment. A major advantage of this approach is that it permits identification of chemical hazards before human exposure, disease, and death have occurred.

#### **Dose-Response Assessment**

The second step in risk assessment, assessing the dose-response relationship, is of particular importance for children. Unfortunately, there is a distinct lack of information about the effects of most chemicals on the young. Toxicity testing of chemicals generally fails to consider the special vulnerability of infants and children; therefore, it provides little information about the hazards of toxic chemicals in this age group.<sup>11</sup> For example, the overwhelming majority of pesticides have never been tested in young animals.<sup>4</sup> Testing typically begins at age six to eight weeks, which corresponds roughly to five years of age in humans. Very few studies have been organized in which experimental animals were exposed to pesticides early in life and then followed over a lifetime to assess the late effects of early exposures, the situation that typically occurs in real life when infants are exposed to substantial quantities of pesticides.<sup>4</sup> Consequently, little is known of the delayed effects of early exposures to pesticides and other environmental toxins.

Because of this lack of information concerning the effects of chemicals on the young, the population typically used as the basis of risk assessment calculations is adults. Therefore, the level of exposure to a chemical that is considered by regulatory agencies to represent an acceptable risk usually does not take into account the special vulnerabilities of children.<sup>6</sup> For example, federal standards limiting permissible levels of pesticide exposure in foods (tolerance levels) are geared solely to the protection of adults. These tolerances do not account for the fact that children eat foods that are different from those eaten by adults, eat these foods in quantities different from those eaten by adults, and have different biological susceptibilities.<sup>4</sup> When a child eats a banana that contains the legal limit of a pesticide, he or she takes in more pesticide per pound of body weight than would an adult and therefore experiences an exposure per unit of body weight above the limit established as acceptable. Moreover, children eat more bananas than adults. None of this information is reflected in current approaches to risk assessment.

The fact that risk assessments do not usually consider children's unique risks is a major flaw in the U.S. regulatory system for pesticides in the diet. This flaw could be remedied through changes in the federal regulatory structure.

Of even greater concern is the absolute lack of any information on the health effects of many synthetic chemicals on any segment of the human population, adults or children.<sup>12</sup> An enormous outpouring of new chemicals into the environment has occurred over the past 50 years. More than 70,000 unique chemicals are currently used in industry and consumer products in the United States, and each year hundreds of new chemicals are introduced for commercial use. Reliable information concerning possible health effects is minimal or nonexistent for two-thirds of these substances.<sup>2</sup> Part of the reason for this lack of information is the lack of a strong regulatory mandate. Although the Toxic Substance Control Act (TSCA) of 1976 created a legal mechanism for the testing of each chemical in commerce, in fact there are many inadequacies in the

federal testing requirements established under TSCA. For one thing, many thousands of potentially toxic compounds whose introduction to commerce predated passage of TSCA remain untested, and there are no requirements at present for testing many such compounds (requirements for reregistration of older pesticides are an exception).

Several problems have resulted from the lack of information concerning the health effects of chemicals. For example, in the case of pesticides, the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA) requires that a risk-benefit analysis be performed on each chemical

---

*The fact that risk assessments do not usually consider children's unique risks is a major flaw in the U.S. regulatory system for pesticides in the diet.*

---

being registered. The Environmental Protection Agency (EPA) weighs the risks to health and the environment against the benefits of the chemicals to the producers. However, when information on the health risks is not available, the process is forced to proceed without full information.<sup>13</sup>

The case of pesticides illustrates another problem with the regulatory system. There are approximately 600 active ingredients in pesticides that have been registered for use with the EPA, and most of those were registered at a time when toxicity testing was not as strict as it is today. Manufacturers have been required to reregister these active chemicals, but retesting takes time and the active ingredients will probably not all be reregistered before the year 2000. In the meantime, these pesticides are still available for use and are being used. In addition, the non-active (inert) ingredients in pesticides are considered to be trade secrets. Therefore, they are not required to be registered or tested, despite their widespread distribution. The term "inert" is misleading. It means only that the chemical is not toxic to insects and does not refer to possible effects on human health. Yet many of these "inert" chemicals are, in fact, likely

to be human toxins; they include organic solvents, petroleum products, and diesel fuel. Despite this lack of complete information on pesticides, particularly the inert ingredients, there is far more information available about their toxicity than about the toxicity of most other commercial chemicals. Pesticide regulations require pre-use approval, while regulations of other chemicals are more end of the line, regulating only after first measuring the effects of chemicals on the air or water.<sup>14</sup>

Of course, even if every chemical made in the United States were thoroughly tested and controlled, children would still be exposed to chemicals from imported goods, particularly in food as well as in air that crosses borders. There is no way to eliminate all risk, but reducing risk is a worthwhile, if difficult, proposition. Testing by itself is expensive, and having government agencies shoulder the costs may not be realistic. Building those costs

---

*Risk characterization often ignores children. Then, when regulations or other policy steps are taken to control risk, children's interests are left out of the process.*

---

into product development by having producers perform or pay for testing before new products can be introduced might be a feasible way to finance these activities and, thus, to improve risk assessment.<sup>2</sup> In fact, many chemical manufacturers already engage in intensive premarket testing.<sup>12</sup>

#### **Exposure Assessment**

Exposure assessment, the third step in risk assessment, needs to involve different methods for children than for adults. Children's unique behaviors and their play close to the ground increase their exposure to toxins in dust and soil; those special exposures need particular attention in risk assessment. Indoor air pollution in the places where young children spend the bulk of their time—particularly homes, day care settings, and other indoor environments—should also be carefully considered. In addition, because chil-

dren's diets differ from those of adults, assessment of their dietary exposures requires appropriate sampling methodologies which include the foods that they eat. At the present time, most food sampling for pesticide contaminants in the United States focuses almost exclusively on the diets of adults.<sup>4</sup>

#### **Risk Characterization**

The fourth step, risk characterization, must be based on the information gathered in the first three steps and upon scientific assumptions where information is not directly available. When the risks to children are different from those to adults, the risk characterization should differentiate between children and adults. However, because of data gaps in the previous steps, usually no information about the risks to children is included in the analysis. Thus, risk characterization often ignores children. Then, when regulations or other policy steps are taken to control risk, children's interests are left out of the process.

Another difficulty with risk characterization is that, in the many instances where information from the previous steps is lacking, the overall characterization of the risk must be based on a series of educated guesses. While use of such assumptions is often unavoidable, it is essential for the assessors to make them explicit in their reporting. Policymakers and the public need to know the assumptions that underlie the assessors' decisions. The provision of a range of estimates, based on different assumptions, may be more appropriate than providing a single estimate. No matter how it is done, the characterization of the risk by the risk assessor is the key to risk management strategy. If the process has taken children's unique physiological and behavioral vulnerabilities into account, then the assessor can include assessment of the risks to children in the report to the risk management agency.

Historically, chemicals and toxicants are regulated one at a time; even classes of chemicals known to act in similar ways in the human body are not grouped together in regulations. In a theoretical world, this singular approach may make sense. However, in the world of a child, it bears

little relation to reality. Children are often exposed to a myriad of environmental hazards, often simultaneously, in varying doses at different stages of their development. Currently, risk assessment, although proven to be a very important tool for controlling toxins in the environment, has a major drawback: it considers only one chemical at a time. Future approaches to assessing risk will need to be expanded to incorporate simultaneous, multiple, and cumulative exposures.

### Risk Management

After the level of risk has been assessed and reported, risk management begins. Risk management consists of doing what is necessary to "eliminate an identified risk or to reduce it to a level which is judged, usually by some agency of government with public involvement, as 'acceptable.'"<sup>10</sup> Risk management decisions take into account not only scientific considerations, but also political, economic, and technical factors. Ultimately, the approach taken to manage a particular risk reflects the level of society's concern about the risk.

Agencies of the federal and state governments play an important role in managing risks and, thus, in reducing children's exposure to environmental toxins. One of the most common actions for governments to take is to regulate the production, use, and disposal of toxic chemicals. Legislation such as the Clean Air Act, the Safe Drinking Water Act, and the Toxic Substances Control Act provide the framework for environmental regulations in this country. (See Box 2 for summaries of the several individual acts which regulate different types of toxic chemicals.) A major goal of these laws and of the regulations that flow from them is protection of human health. The federal laws that control toxic substances and manage the risks associated with them are divided into three general categories.<sup>15</sup> (Detailed descriptions of each of the statutes can be found in Box 2.)

### Licensing Laws

The first category, licensing laws, includes statutes that require licensing and registration for new and existing chemicals. Often those laws include an explicit review

process that may involve a requirement for toxicity testing. This category includes statutes such as the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA), which requires the EPA to register pesticides and to determine if they are safe and effective under the intended conditions of their use, and the Toxic Substances Control Act (TSCA), discussed above.

### Standard-Setting Laws

The second category, standard-setting laws, covers statutes that establish standards of exposure for chemicals used in specific situations. Under this legislation, regulatory agencies establish limits on levels of toxic substances which are permitted to be present in air, water, or soil. Limits may be set on the amounts of toxins which are allowed to be emitted by a given source. Typically, these limits are set for one chemical and one environmental source at a time. Little attention is given to the possibility of multiple, simultaneous exposures. These laws also determine

---

*Children are often exposed to a myriad of environmental hazards, often simultaneously, in varying doses at different stages of their development.*

---

appropriate labeling of products containing toxic substances. The Clean Air Act is a well-known example of a standard-setting statute. It requires the EPA to set air quality standards for permissible levels of pollutants in the air and to regulate emissions of hazardous substances. As discussed below, the Clean Air Act is one of the few pieces of environmental legislation that specifically takes vulnerable populations into account.

### Control-Oriented Measures

The third category of federal environmental regulations, control-oriented measures, deals with explicitly identified chemicals, groups of chemicals, or chemical processes. This group of laws includes the two federal statutes that explicitly consider children in their intent and actions: The Lead-Based Paint Poisoning Prevention

## Box 2

## Existing Environmental Regulations

*Licensing laws*

The *Federal Food, Drug, and Cosmetic Act (FFDCA)* controls levels of environmental contaminants as well as substances added to and naturally occurring in food, drugs, and cosmetics. It also provides for the setting and enforcement of tolerances on pesticide residues for food and feed crops, regulates introduction of new drugs and biologics, and requires cosmetics to be labeled.

The *Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA)* provides for the registration of pesticides with the Environmental Protection Agency. It requires that pesticides not cause unreasonable risk of injury to human health or the environment.

The *Toxic Substances Control Act* requires testing of existing chemicals where data are inadequate to assess risk of injury to human health or the environment. It also prohibits the introduction of new chemicals that present an unreasonable risk and restricts or prevents the production, use, or disposal of existing chemicals that present unreasonable risk.

*Standard-setting laws*

The *Clean Air Act* sets standards for air quality, vehicle emissions, fuels, and fuel additives. It also requires the EPA to regulate emissions of hazardous air pollutants and to conduct research on air pollution.

The *Clean Water Act* sets maximum contaminant levels (MCLs) and maximum contaminant level goals (MCLGs) for public drinking water supplies. The MCLGs do not consider feasibility, but MCLs do.

The *Consumer Product Safety Act* promulgates consumer safety standards, balancing risks against the cost, utility, and availability of the product.

The *Federal Hazardous Substances Act* bans hazardous substances that may cause substantial personal injury or illness from use in households.

The *Occupational Safety and Health Act* sets standards for contaminants in the workplace which may cause a "material impairment of health or functional capacity." The act attempts to attain the highest possible degree of occupational health and safety protection.

*Control-oriented laws*

The *Comprehensive Environmental Response, Compensation, and Liability Act* along with the *Superfund Amendments and Reauthorization Act* funds cleanup of hazardous waste sites, designates reportable quantities of toxins for environmental release, reports on community preparedness and release, and mandates the EPA to prepare toxicity profiles on contaminants. These acts focus on the highest risk chemicals, where there is "substantial danger to the public health or welfare."

The *Lead-based Paint Poisoning Prevention Act* mandates the Consumer Product Safety Commission to determine, if possible, a safe level of lead in paint to prevent the poisoning of children by lead-based paint.

The *Poison Prevention Packaging Act* promulgates standards for packaging substances that could produce serious personal injury or serious illness. The Consumer Product Safety Commission is mandated to determine the degree and nature of the hazard to children from the packaging of poisonous products.

The *Resource Conservation and Recovery Act* regulates the handling of hazardous wastes and lists hazardous wastes on the basis of their constituents in order to "protect human health [from] . . . serious irreversible or incapacitating reversible illness [and] . . . substantial present or potential hazard." The act also controls handling to minimize risks.

Act charges the Consumer Product Safety Commission to determine a safe level of lead in paint, if possible, to prevent childhood lead poisoning. The Poison Prevention Packaging Act, enacted in 1970, sets standards for the packaging of substances that could be harmful to children. To prevent personal injury or illness among children, packaging must make it "significantly difficult for children under 5 years of age to open or obtain a toxic or harmful amount of the substance therein within a reasonable time."<sup>16</sup> Of course, the act regulates only packaging, and careless use of substances such as medications or cleaning fluids by parents and caretakers will not protect children from poisoning.

It is unfortunate that the regulations which explicitly include children are not global in scope but, instead, are aimed at controlling specific substances. While the necessity of controlling lead and harmful medications should not be underemphasized, taking children's health explicitly into consideration in the major environmental regulations which consider all pesticides (such as FIFRA) or all water pollutants (such as the Clean Water Act) would have a far more widely beneficial effect on children's health. Happily, there are some instances where children are indirectly considered in global statutes, and progress is slowly being made in taking children into account in some regulations. For example, the Clean Air Act does specifically consider children. Under the Clean Air Act, as discussed in Box 2, the EPA and other federal regulatory agencies are required to set standards for permissible levels of toxins in air which will protect "the most vulnerable members of society." Because the most vulnerable are often children, this language serves, implicitly at least, to protect children.

In addition, standards for lead in air set under the Clean Air Act have addressed concerns about the effects of lead on the health of children beyond lead-based paint. Lead has been known by pediatricians to be a toxic substance since the end of the nineteenth century, but in the United States, it was widely used for many years, most notably in gasoline.<sup>17</sup> It was concern for the protection of children

that led to the establishment under the Clean Air Act of the current federal ambient standard for lead in air of 1.5 mg/m<sup>3</sup>.<sup>18</sup> This standard coupled with the phase-down of lead in gasoline has produced an 80% reduction over the past 15 years in the blood lead levels of American children.<sup>1</sup> This represents one of the great recent successes in pediatric environmental health in the United States.

## Monitoring

After a risk has been characterized through risk assessment and a management structure for it has been established in regulations, the level of the toxin present in the environment must be monitored so that the regulations can be enforced. Although standards are most often set federally, states and localities monitor federal standards on ambient environmental and source discharges.<sup>12</sup> Thus, to monitor compliance with the Clean Air Act, the EPA and state environmental agencies monitor

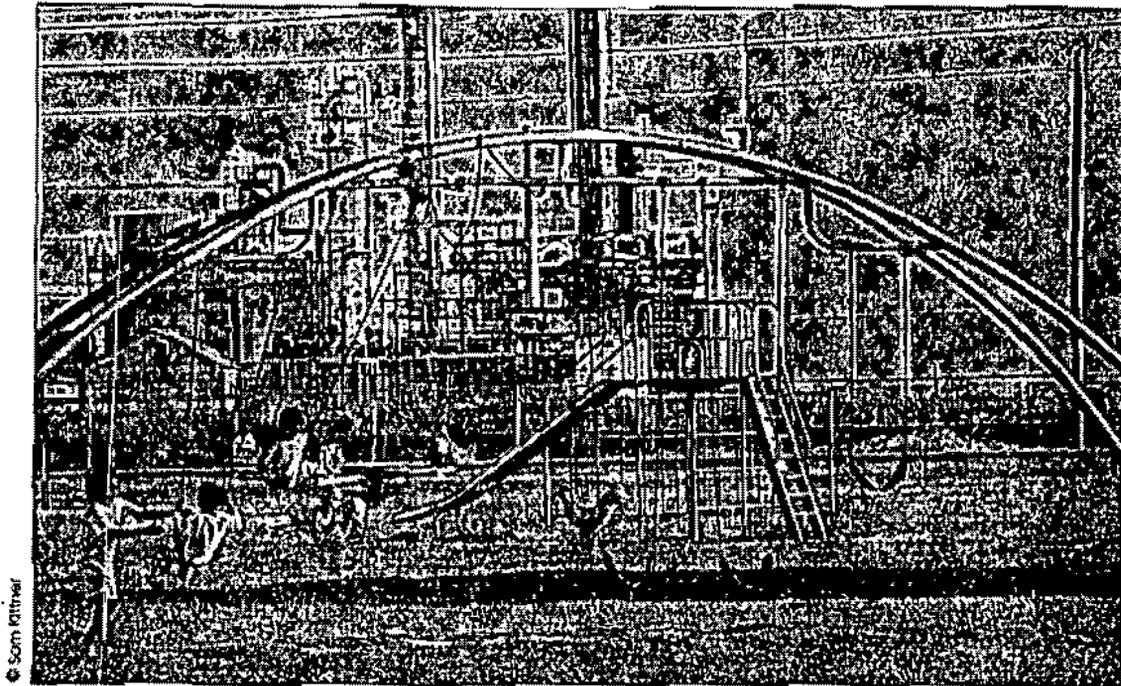
---

*The regulations which explicitly include children are not global in scope but, instead, are aimed at controlling specific substances.*

---

levels of pollutants in air. For acutely toxic air contaminants such as ozone or the components of smog, measurements are made on a daily or even an hourly basis. When permissible levels are exceeded, smog alerts are issued. For chronic air toxins such as lead, quarterly average air lead levels are published. Pesticide levels in foods are monitored regularly by the FDA. If a shipment of food is found to contain excessive levels of a pesticide, the shipment can be seized and destroyed.

The type of monitoring required by environmental regulations varies from substance to substance. The particular type chosen can have large implications for children. Pesticide monitoring is an example. Often pesticide levels are measured only in large batches of food. However, within a batch, the pesticide may be spread unevenly; the levels in some units will be very low while those in other units will be very high. If a child consumes



© Sam Rittner

just one portion of a batch and that portion is heavily contaminated, then the monitoring efforts do not serve to protect that individual child because the reported result represents the average contamination in the whole group of food products, not in an individual portion. For example, in the case of aldicarb on bananas discussed by Lynn Goldman in this journal issue, the level of aldicarb on one banana might be high, but the testing programs for this pesticide previously analyzed groups of bananas, not individual bananas. Foods that are not processed in large batches might need to be tested differently from foods that are processed and blended together.

In assessing children's exposure to environmental toxins, the sampling strategy is very important. Again, pesticides provide an example. Under current sampling procedures, it is very difficult to assess the dietary exposure of children to pesticide residues because food consumption data collected by the U.S. Department of Agriculture examine consumption among children only within very broad age groups.<sup>4</sup> Because there is substantial variation in the diet of children as they age, food consumption data need to be collected within narrower age brackets. In addition, pesticide residue data collected by the U.S. Environmental Protection Agency

typically do not focus on the foods that are most commonly consumed by children.<sup>4</sup>

Surveillance of the effects of contaminants on people is another aspect of managing risks. The collection of data on health problems is one way to obtain information about which children are suffering from which diseases. Several national surveys undertake this task for the entire U.S. population.<sup>1</sup> Unfortunately, most health data collection systems are not specifically designed to collect data on the environmental exposures or toxic diseases of children and, therefore, are not well equipped to support pediatric environmental health policy initiatives.

Perhaps partly because of this drought of data, research into the diseases of children has paid scant attention to environmental causes of illnesses. Although an enormous body of literature has accumulated around a few well-known environmental problems in children, such as lead poisoning, pesticide intoxication, and, more recently, air pollution, there is no concerted research agenda to assess systematically the effects of most environmental toxins upon the health of children. Because of this lack of targeted health research, many pediatric environmental toxins have undoubtedly escaped scrutiny, and diseases have not been recognized as

environmentally related. Environmental sources of illness should receive increased priority and consideration when decisions are made regarding the funding of research on children's health.

## Education

Several kinds of educational efforts might ultimately decrease the exposure of children to environmental contaminants. The first type is education of health care professionals. Medical education has paid scant attention to issues in pediatric environmental health, and this lack of training is reflected in most providers' inability to recognize environmental health problems. In the four years of medical school, the average American medical student receives only six hours of training in environmental medicine.<sup>19</sup> Even pediatric residency programs provide little education on topics in environmental health except perhaps on the most fundamental and popularly acknowledged problems such as lead poisoning. Not surprisingly, therefore, most physicians and other primary medical providers in the United States are not knowledgeable about even the most common problems in environmental health, and it is likely that many illnesses of environmental origin are undiagnosed.<sup>20,21</sup>

Some attempts are being made to improve the state of environmental medical education and its close cousin, occupational medicine. The Institute of Medicine has convened several committees to increase the dissemination of information on the teaching of occupational and environmental medicine to medical students, residents, and physicians.<sup>20</sup> Several federally funded programs have been initiated to increase and expand occupational teaching and experience, such as the Environmental Physician Academic Achievement Award of the National Institute of Environmental Health Sciences. The Agency for Toxic Substances and Disease Registry has also supported the development of training materials and research fellowships in environmental medicine.<sup>19</sup> One example is the course titled Kids and the Environment: Toxic Hazards developed by the Children's Environmental Health Network, which has

been introduced into four pediatric residency programs in California.<sup>22</sup> The principal thrust of these efforts has been to integrate environmental medicine into mainstream internal medicine and pediatrics so that physicians consider environmental diseases in formulating their differential diagnoses.<sup>21</sup>

A second type of education is direct education of parents and children and the public about ways to protect children from environmental contaminants. Public understanding can be advanced through the print and electronic media, in parenting or prenatal classes, or just by word of mouth. Parents who are informed about

---

*Parents who are informed about the risks of a contaminant for their children can be powerful actors on their children's behalf.*

---

the risks of a contaminant for their children can be powerful actors on their children's behalf. When public sentiment is behind a group of involved parents, their influence is increased.

Education of policymakers is very important. Advocacy groups for environmental health have had particular success in communicating their concerns to policymakers. Among these groups are the Natural Resources Defense Council (NRDC), the Children's Environmental Health Network, Physicians for Social Responsibility, and the Colette Chuda Environmental Fund. Because they do not vote and are not able to speak for themselves, very young children are not considered actors in the policy arena. Therefore, adults must take up policy issues that concern the health and welfare of children.

## The Role of Advocacy

Unfortunately, most parents and communities have limited access to comprehensive, usable information regarding the effects of environmental toxins on children's health. Researchers inform each other by disseminating findings in scientific journals but seldom translate "data" into plain language for lay audiences.<sup>23</sup> Non-English-speaking and minority

communities are most excluded from the transfer of information.

An extensive grassroots advocacy movement has developed recently in the United States, centered on issues in pediatric environmental health. The goals of this movement are to educate parents and families about environmental hazards to children, to support research (such as a recent study by the Natural Resources Defense Council on children's exposure to environmental carcinogens),<sup>24</sup> and to effect changes in public policy.<sup>25</sup>

Community groups have become increasingly effective at making impacts at the local level. Local coalitions have joined forces to change many different types of community policies. For example, local coalitions across the country have been key forces in the enactment of local ordinances restricting smoking in restaurants, hospitals, and public places. A coalition of community groups in Oakland, California, called People United for a Better Oakland (PUEBLO) pioneered development of the country's first local lead abatement ordinance. A national group of parents whose

---

*Local coalitions across the country have been key forces in the enactment of local ordinances restricting smoking in restaurants, hospitals, and public places.*

---

children have been lead poisoned (Parents United Against Lead) are working to educate other parents and policymakers about lead hazards. Other parent groups are working to decrease or eliminate the use of pesticides in schools and promote integrated pest management, and to pass local tobacco control ordinances. Concerns about the locations of hazardous waste sites and incinerators have become front-line issues for many communities, particularly communities of color.

In several instances, community groups have identified health problems before the scientific community and helped formulate the steps toward solutions to the problems they believed were caused by environmental exposures. For example, the Akwesasne Mohawk Com-

munity in New York, the Brownsville Community Health Center in Brownsville, Texas, and the People for Community Recovery in Chicago all played significant roles in identifying and moving to change the environmental exposures in their communities.

Advocacy movements have also been effective on the national level. Their impact is often strengthened through alliances with the medical community or governmental regulatory agencies, as happened in the Alar episode (see Box 3). However, there is still a tremendous need for more interaction and communication among the medical, research, and policy-making communities and those parents, children, and community members who have firsthand experience with environmental exposures and potential solutions.

### **Involvement of Industry**

Industries, particularly those that produce or use synthetic chemicals, have a particular interest in environmental health policy. Many face economic problems in the disposal of those chemicals and must make decisions about where and how to store hazardous wastes. The Resource Conservation and Recovery Act makes the producer of a hazard responsible for it from "cradle to grave," regardless of whether the material is in the hands of the producer all the time. The Clean Air Act limits release of airborne toxins. The Toxic Release Inventory makes information available to the public on each company's release of toxins to air, water, and landfills. These types of regulations have a definite effect on industrial practices, and the effects can be both good and bad for the people who are touched by a particular factory or industry. Data from the Toxic Release Inventory have been used by local governments and community groups to force reductions of toxic releases by industries.

An example of the conflicts that can result from a policy of considering children's specific vulnerability arises in the context of occupational regulation of exposure to lead. At the present time under the Occupational Safety and Health Act (OSHA), the U.S. Safety and Health Administration permits adult workers of

## Box 3

**Alar: A Failure of Regulation**

Alar, a synthetic chemical widely used on certain food crops (especially apples) from 1968 until 1989, acts as a growth retardant, delaying crop ripening and thus prolonging shelf life. The compound was not adequately tested for toxicity before it was introduced in the United States. Indeed, limited toxicity data that were circulated around the time of Alar's registration suggested that the compound was carcinogenic. However, those data were ignored. Subsequently, toxicity studies using limited data indicated that Alar produced several different types of tumors, but these studies were also overlooked. Meanwhile, the product remained on the market.

In February 1989, scientists with the Natural Resources Defense Council (NRDC), an environmental advocacy group based in Washington, DC, released a report concluding that children were at risk from pesticides in food and that Alar presented the greatest risk to preschoolers. A vigorous counterattack was launched by the pesticide-manufacturing industry, which claimed that the NRDC findings were inaccurate and alarmist.

Further assessment of Alar was undertaken by the U.S. Environmental Protection Agency (EPA). In this evaluation, the carcinogenicity of Alar was confirmed, thus supporting the NRDC findings. The American Academy of Pediatrics wrote to the EPA to urge that the sale of Alar be suspended, and citizen groups such as Mothers and Others used the national attention to communicate their concerns about Alar to the public. The manufacturer discontinued sales of Alar in late 1989, and all EPA tolerances for Alar expired in 1991. In 1993, the National Academy of Sciences completed a study of the risks of pesticides in food to infants and children. It found that current U.S. federal regulations do not adequately protect children from pesticides in food.

The tragedy of the Alar episode is that it was entirely unnecessary. Proper premarket testing would have prevented 24 years of children's exposure to this potent carcinogen and would have prevented the food scare that occurred in 1989.

either gender to be exposed to lead in the workplace so long as blood lead levels do not exceed 50 micrograms per deciliter ( $\mu\text{g}/\text{dl}$ ). The U.S. Supreme Court has affirmed the right of women, including women of childbearing age, to work in such environments. Recent data from the pediatric literature indicate, however, that lead is toxic to the fetus at blood lead levels as low as 10 to 20  $\mu\text{g}/\text{dl}$ . Lead levels in this range have been linked to development of permanent neurobehavioral impairment in young children, and because the placenta affords no barrier to the passage of lead from mother to child, blood lead levels in newborn babies and their mothers are virtually identical. In addition, clinical reports from the first half of this century described increased incidence of spontaneous abortion in female lead workers and in the wives of male lead workers.<sup>26</sup> Thus, a dilemma exists. Present law permits women to work in an environment where their unborn children can suffer lead poisoning. How do we balance the

desire to work with the protection of health?

One answer is to reduce the biological exposure standard for lead in the workplace to a value below 20  $\mu\text{g}/\text{dl}$  for workers of both genders. Then mothers will be protected, unborn children will be protected, and male workers who, in fact, are at risk of neurological, cardiovascular, and reproductive damage at blood lead levels above 20  $\mu\text{g}/\text{dl}$  will also be protected against the toxic effects of lead.<sup>27</sup> However, this option, while appealing from a health point of view, has economic implications for the industries using lead and the workers exposed to it. The question is whether reducing lead in the workers' environment will prove too expensive to justify continued employment in that industry. Although adults who work in potentially hazardous occupations may do so voluntarily, the same cannot be said of the children who may be damaged by prenatal and take-home exposure to lead and other toxins.

## Box 4

### New York's Policy on Environmental Quality in Schools

A happy exception to the general lack of an overall policy for protecting children is a policy that was developed in New York by the State Board of Regents on Environmental Quality in Schools. The guiding principles of this enlightened policy are that:

- Every child has a right to an environmentally safe and healthy learning environment which is clean and in good repair.
- Every child, parent, and school employee has a "right to know" about environmental health issues and hazards in the school environment.
- School officials and appropriate public agencies should be held accountable for providing an environmentally safe and healthy school facility.
- Schools should serve as role models for environmentally responsible behavior.
- Federal, state, local, and private sector entities should work together to ensure that resources are used effectively and efficiently to address environmental health and safety conditions.

Source: Regents Advisory Committee on Environmental Quality in Schools. *Environmental quality of schools*. Albany, NY: New York State Education Department, 1994.

Thus, although effective environmental policy may frequently require a balancing of interests, it may be particularly appropriate for policymakers to advance the interests of children in such situations as occupational exposure to lead because children cannot represent their own interests.

### Environmental Equity

Another area of concern in pediatric environmental health is the unequal distribution of exposures to toxic hazards among children of different racial, ethnic, or socioeconomic groups. Published reports as well as anecdotal evidence suggest that poor children (and adults) and children of color are heavily, and often disproportionately, exposed to a multitude of toxic environmental hazards.<sup>28</sup> These include lead,<sup>1</sup> industrial and automotive air pollution, and effluvia from toxic waste disposal sites.<sup>29</sup> Although the formal, quantitative analysis supporting the existence of environmental inequity is still in the early stages of development, the idea that some groups in the U.S. population are exposed to more environmental hazards than others has been recognized by many groups and individuals.<sup>30</sup> In February 1994, President Clinton issued an executive order requiring "each federal agency [to] make achieving environmental justice part of its mission by identifying and address-

ing, as appropriate, disproportionately high and adverse human health or environmental effects on minority and low income populations in the United States."<sup>31</sup> In that same year, the New York State Board of Regents on Environmental Quality in Schools affirmed the right of all children to be taught in a safe learning environment and of children, parents, and school employees to know about environmental health hazards in the school environment (see Box 4).

Lead is the classic example of disproportionate exposure of poor children to a highly prevalent and dangerous environmental hazard. Data from the Third National Health and Nutrition Examination Survey (NHANES III) found that 37% of African-American children, 17% of Hispanic children, and 6% of white children living in inner-city neighborhoods had elevated blood lead levels (above 10 µg/dl). By contrast, the proportion of white middle- and upper-class children in suburban and rural areas with blood lead levels above 10 µg/dl was less than 3%.<sup>1</sup> It has been hypothesized that the level of lead in paint and gasoline has resulted in high concentrations of lead in urban soils and, thus, in the high prevalence of elevated blood lead levels in inner-city children.<sup>28</sup>

What are the best policies for alleviating these problems? Recognition of the fact

that there are several causes for differences in exposure of children from different racial, ethnic, and socioeconomic groups to environmental hazards is a first step to reasonable policymaking. In some instances, environmental safeguards appear not to be well enforced in poor neighborhoods. For example, a recent study suggested that EPA standards are less stringently enforced in poorer communities than in wealthier ones so that the poorer communities are not receiving the same regulatory protections.<sup>52</sup> In other instances, hazardous situations may arise in poor neighborhoods because of illegal and reckless disposal of toxic materials. In still other instances, differences in exposure may arise because of a sorting of families from different economic or ethnic groups into more or less-safe environments. For example, poor children in inner-city neighborhoods tend, for economic reasons, to occupy older, frequently inadequately maintained housing units that years ago were painted with lead-based paint. Therefore, they are more likely to be exposed to environmental lead from peeling lead-based paint than are children in families that can afford to move out of such conditions. Thus, the added risk of lead exposure faced by children in the inner city results in part from incomplete remediation of an environmental hazard which at one time affected children of all socioeconomic groups.

Regulations requiring a more equitable distribution of hazardous waste facilities are one approach to the problem of environmental inequity. However, any policy that increases the real and substantial risks borne by some children in the name of equity cannot seriously be considered to be satisfactory. Rather, policies that reduce the exposure for all children are much more desirable. Certain policies can address and reduce existing exposures. For example, policies can promote abatement of contamination resulting from hazardous waste facilities, increase funding for innovative programs that reduce the risks posed by known sources of environmental toxins, and require strict enforcement of environmental protection statutes and regulations in all communities. Other policy options can protect all children from future exposures, by using technolo-

gy and chemical substitution to decrease pollution and risks to nearby residents (known as source reduction) and by eliminating the sources of the hazards completely, thus preventing exposure.

## A New Approach to Protecting Children from Environmental Toxins

The current paradigm for risk assessment and risk management places the toxicant or hazard at the center of the discussion; examines known data on effects, routes of exposure, and mechanisms of action; and from this analysis, develops permissible exposure levels. But what if children, not the toxicant, were placed at the center of the paradigm?<sup>55</sup> A host of different questions would be asked: What is the child

---

*The current fragmented approach to controlling children's toxic exposures mirrors the complex and poorly coordinated federal structure used to establish regulations and protective standards.*

---

exposed to? How is the child exposed and at what stage of development? What are the effects of acute exposures or long-term low-level exposures? What are the delayed effects? What are the effects of multiple and cumulative exposures? What are the transgenerational effects? Using this paradigm, data would need to be collected and analyzed based on children's exposures, not extrapolated from adult data as is done now.

The current fragmented approach to controlling children's toxic exposures mirrors the complex and poorly coordinated federal structure used to establish regulations and protective standards. The Environmental Protection Agency, because its statutory responsibilities are established in numerous policies developed by Congress, has no overarching mission. It is difficult to set priorities within the agency when the various statutes require different and sometimes conflicting standards to be enacted.<sup>55</sup> Furthermore, there are numerous agencies that regulate toxicants, such as the Food and Drug Administration and

the U.S. Department of Agriculture. Rarely are policies coordinated on an intra- or inter-agency level.

Initial approaches to achieving a new child-centered paradigm in environmental health include the following:

1. Develop structures that foster federal interagency coordination and collaboration, such as a federal interagency task force to review and coordinate regulation and policy on pediatric environmental health.

2. Review and evaluate current environmental legislation and regulations to determine if children are included and are adequately protected. Amend any environmental laws undergoing reauthorization to require specifically that environmental standards incorporate consideration of children and other special subgroups.

3. Ensure that henceforth children are specifically included in every new piece of environmental regulation and legislation.

4. Develop new risk assessment models to incorporate the most sensitive populations.

5. Increase research on pediatric environmental health to acquire more data on environmental hazards affecting children and to better understand exposure patterns. Foster more collaboration between the National Institute of Environmental Health Sciences and the National Institute of Child Health and Human Development.

6. Require toxicity testing of chemicals to assess long-term effects of exposure in early childhood, and transgenerational effects.

These six starting points can be accomplished through a variety of means including an executive order, changes in regulation, agency appropriations, and legislation.

## Conclusion

The protection of children against environmental toxins is a major challenge to our society. Hundreds of new chemicals are developed every year and released into the environment,<sup>2</sup> and many of these chemicals are untested for their toxic

effects.<sup>12</sup> Thus, the extent of children's exposure to these chemicals will almost certainly continue to increase. The problem is not going away. The challenge, therefore, is to design policies that specifically protect children against environmental toxins and allow children to grow, develop, and reach maturity without incurring neurologic impairment, immune dysfunction, reproductive damage, or increased risk of cancer.

This challenge of addressing children's unique environmental vulnerabilities is not met in current public policy in the United States. There is no general policy at either the federal or the state level to ensure that our children will grow up in a safe environment. Environmental regulation and regulatory risk assessment typically fail to consider the unique exposures and special vulnerabilities of children. Indeed, most environmental legislation fails to consider children and their special vulnerabilities.

We suggest a new paradigm for developing environmental health policy centered on the needs and exposures of children. The essence of this paradigm is to place the child, not the chemical or hazard, at the center of the analysis. The analysis would then begin with the child, his or her biology, exposure patterns, and developmental stage. This paradigm calls for a new way of thinking, and a retooling of the risk assessment process so that it takes into account not only the increased vulnerability of children but also the effects of multiple and cumulative exposures over the course of a lifetime.

Solutions need to be developed at all levels—federal, state, and local. In the best of all possible worlds, there would be cross-fertilization of ideas and model policies. At the federal level, the above recommendations can be enacted through legislation, an executive order, appropriations, or regulation. At the state level, policies can be reviewed to determine if children are included and protected. Locally, groups of parents, advocates, and other interested citizens can work to develop model strategies and policies to protect their children from environmental exposures.

Danger exists in the current era of government downsizing and regulatory reform that children will become even less well protected against environmental hazards than they are today. We urge policymakers to consider the implications for human health and national productivity that may be associated with increased and unchecked exposure of America's children to lead, air pollution, pesticides, and untested consumer chemicals of unknown toxicity. While short-term concerns about regulation of the business community

certainly need to be heard, the immediate and longer-term effects of environmental degradation on the health of America's children need to be weighed in the balance.

As we move toward the twenty-first century, the issue of environmental exposure and degradation looms large not only in this country but globally. It is imperative that we develop policies which will protect the health of our children now and in the future.

1. Pirkle, J.L., Brody, D.J., Gunter, E.W., et al. The decline in blood lead levels in the United States: The National Health and Nutrition Examination Surveys (NHANES). *Journal of the American Medical Association* (1994) 272:284-91.
2. Schaffer, M. Children and toxic substances: Confronting a major public health challenge. *Environmental Health Perspectives* (June 1994) 102, Suppl.2:155-56.
3. Haggerty, R., Roghmann, J., and Press, I.B. *Child health and the community*. New York: John Wiley and Sons, 1975.
4. National Research Council. *Pesticides in the diets of infants and children*. Washington, DC: National Academy Press, 1993.
5. Ecobichon, D.J., and Stevens, D.S. Perinatal development of human blood esterases. *Clinical Pharmacology and Therapeutics* (1973) 14:41-47.
6. Gray, R., Peto, R., Barnton, P., and Grasso, P. Chronic nitrosamine ingestion in 1040 rodents: The effect of choice of nitrosamines, the species studied, and the age of starting exposure. *Cancer Research* (1991) 51:6470-91.
7. Bellinger, D., Leviton, A., Wateraux, C., et al. Longitudinal analyses of prenatal and postnatal lead exposure and early cognitive development. *New England Journal of Medicine* (1987) 316:1037-43; Needleman, H.L., Schell, A., Bellinger, D., et al. The long-term effects of exposure to low doses of lead in childhood: 11-year follow-up report. *New England Journal of Medicine* (1990) 322:83-88; McLaughlin, J.F., Telzrow, R.W., and Scott, C.M. Neonatal mercury vapor exposure in an infant incubator. *Pediatrics* (1980) 66:6:988-90; Baker, E.L., Smith, T.J., and Landrigan, P.L. The neurotoxicity of industrial solvents: A review of the literature. *American Journal of Industrial Medicine* (1985) 8:207-17.
8. National Research Council. *Environmental neurotoxicology*. Washington, DC: National Academy Press, 1992; Wolff, M.S. Blood levels of organochlorine residues and risk of breast cancer. *Journal of the National Cancer Institute* (1993) 85:648.
9. National Research Council. *Science and judgement in risk assessment*. Washington, DC: National Academy Press, 1994.
10. Millar, J.D. Quantitative risk assessment: A tool to be used responsibly. *Journal of Public Health Policy* (1992) 13,1:5-13.
11. Done, A.K., Cohen, S.N., and Strebler, L. Pediatric clinical pharmacology and the "therapeutic orphan." *Annual Review of Pharmacology and Toxicology* (1977) 17:561-73.
12. U.S. Congress, Office of Technology Assessment. *Identifying and regulating carcinogens*. Background paper. Washington, DC: U.S. Government Printing Office, 1987.
13. Curtis, J., and Profeta, T. *After Silent Spring: The unresolved problems of pesticide use in the United States*. New York: Natural Resources Defense Council, June 1993, p. 34.
14. Mott, Lawrie, Natural Resource Defense Council. Telephone conversation with editor Linda Baker, January 24, 1995.
15. U.S. Congress, Office of Technology Assessment. *Neurotoxicity: Identifying and controlling poisons of the nervous system*. OTA-BA-436. Washington, DC: U.S. Government Printing Office, April 1990, p. 159.

16. Poison Prevention Packaging Act, Public Law 91-601, section 2(4), [as cited in note 15, U.S. Congress], p. 190.
17. Mushak, P. Lead: A critical issue in child health. *Environmental Research* (1992) 59:281-309.
18. More recently there have been efforts to use market-based mechanisms for controlling lead. In California, for example, a tax was added to the manufacture of lead-based products, which was earmarked for abatement programs.
19. Burstein, J.M., and Levy, B. The teaching of occupational health in U.S. medical schools: Little improvement in 9 years. *American Journal of Public Health* (April 1994) 84:4846-49.
20. Institute of Medicine. *Role of the primary care physician in occupational and environmental medicine*. Washington, DC: National Academy Press, 1988.
21. Landrigan, P.J., and Baker, D.B. The recognition and control of occupational disease. *Journal of the American Medical Association* (1991) 266:676-80.
22. Children's Environmental Health Network. *Kids and the environment: toxic hazards*. A course on pediatric environmental health. Berkeley, CA: California Public Health Foundation, 1992.
23. One recent publication that explains pediatric environmental issues to parents in an accessible manner is Needleman, H.L., and Landrigan, P.J. *Raising children toxic free: How to keep your child safe from lead, asbestos, pesticides, and other environmental hazards*. New York: Farrar, Strauss & Giroux, 1994.
24. Mott, L., Vance, F., and Curtis, J. *Handle with care: Children and environmental carcinogens*. New York: Natural Resource Defense Council, 1994.
25. *Preventing child exposure to environmental hazards: Research and policy issues*. Symposium summary. Children's Environmental Health Network, 1994.
26. Oliver, S.T. *Lead poisoning: From the industrial, medical and social points of view*. Lectures delivered at the Royal Institute of Public Health. New York: Hoeber, 1914; Hamilton, A., and Hardy, H.L. *Industrial toxicology*. Acton, MA: Publishing Sciences Group, 1974; as cited in Landrigan, P.J. Toxicity of lead at a low dose. *British Journal of Industrial Medicine* (1989) 46:593-96.
27. Landrigan, P.J., Silbergeld, E., Froines, J.R., and Pfeffer, R.M. Lead in the modern workplace. *American Journal of Public Health* (1990) 80:907-908.
28. Soliman, M.R., Magdi, R.J., Derosa, C.T., et al. Hazardous wastes, hazardous materials and environmental health inequity. *Toxicology and Industrial Health* (1993) 9:5: 901-12.
29. Commission for Racial Justice, United Church of Christ. *Toxic wastes and race in the United States: A national report on the racial and socioeconomic characteristics of communities with hazardous waste sites*. New York: United Church of Christ, 1987.
30. While several reports showed that hazardous waste disposal facilities are more likely to be located in African-American and Hispanic communities than in white communities, other investigations have found less support for the idea. Anderson, D.L., Anderson, A.B., Oakes, J.M., and Fraser, M.R. Environmental equity: The demographics of dumping. *Demography* (May 1994) 31, 2:229-49. However, even though the extent of the inequities is not agreed upon by researchers, that some communities bear greater burdens of environmental exposure should be a concern to policymakers.
31. Executive Order No. 12898, February 1994. Federal actions to address environmental justice in minority populations and low-income populations. *Federal Register* (February 16, 1994) 59; 32:7629.
32. Examples of differences with regard to the way in which EPA standards are enforced in poorer communities include opting for containment instead of permanent treatment or removal of the hazard, greater delay in placement on the Superfund priority list, and more reduced penalty imposition in communities of color than in white communities. Hollenbeck, K.J. Environmental justice. *The Recorder* (Autumn 1994), pp. 8-14.
33. Walker, B., Jr. Impediments to the implementation of environmental policy. *Journal of Public Health Policy* (Summer 1994) 15,2:186-202.

# Case Studies of Environmental Risks to Children

Lynn R. Goldman

## Abstract

Doing a better job of protecting children from environmental hazards requires having more and better information about both children's susceptibility and their exposure to toxic substances. There are many critical gaps in knowledge of this issue. This article presents several examples specifically related to children's exposure to pesticides which illustrate environmental risks for children. The cases examined include the risk posed to children by the use of the insecticide aldicarb on bananas, and reported illnesses in children caused by the use of the insecticide diazinon in the home and by the use of interior house paint containing mercury. The cases presented illustrate how regulatory agencies, parents, health care providers, and others who come into contact with children on a regular basis all have roles to play in filling in the information gaps regarding children's exposure to environmental hazards and the deleterious effects of these exposures.

*Lynn R. Goldman, M.D., M.P.H., is a pediatrician and an epidemiologist, and is the assistant administrator for the Office of Prevention, Pesticides, and Toxic Substances of the U.S. Environmental Protection Agency, Washington, DC.*

As discussed by Bearer in this journal issue, children are more susceptible to the deleterious effects of many environmental exposures than adults. Much current knowledge about the effects of environmental hazards on children comes from experience. We have learned from major environmental disasters, such as the Love Canal experience, which showed what can go wrong when an elementary school is built directly over a hazardous waste disposal site, and from other cases of exposures to chemicals whose effects are not obvious for decades, such as vaginal cancer following exposure *in utero* to diethylstilbestrol (DES).<sup>1</sup> Each discovery of a new deleterious effect adds to the urgency of understanding and responding to the consequences for children of environmental hazards. Environmental legislation of the 1970s and 1980s, which responded to public concern about evidence of a pattern of environmental destruction in America, created a network of laws and regulations to protect the environment. These statutes—including the Clean Air and Water acts, Toxic Substances Control Act, Resource Conservation and Recovery Act, Safe Drinking Water Act, and Comprehensive Environmental Response, Compensation, and Liability Act

(Superfund law), along with state laws and programs—have helped to benefit public health and protect the environment. But more can be done, particularly to safeguard children from environmental risks. Recognizing that children are not simply “little adults” is key to making environmental policy more responsive to children's needs.

Doing a better job of assessing risks for children requires more information about both their susceptibility and their exposure to toxic substances. Too many critical gaps in existing data persist. Although developing the needed information is a complex matter, scientists in government, academia, and elsewhere have succeeded in filling some of the gaps, and research currently under way needs continued support. At the same time, however, incorporating existing information into the assessment of children's risks must become a priority.

Although children typically face environmental risks from a variety of sources, this article presents a series of examples specifically related to pesticides to illustrate environmental risk issues involving children. These cases, drawn from government reporting systems and clinical observation of children, highlight the importance of taking the special status of children into consideration when developing environmental policy.

### **Government Reporting Systems**

One mechanism that can identify the potential effects of environmental chemicals on children is the reporting required of chemical manufacturers by the federal government. One part of that reporting takes place when the manufacturer is seeking government approval for a product. For a pesticide to gain approval for use, manufacturers are required to follow formal testing procedures to show that the product works as intended and does not present an unreasonable risk to humans or the environment. Tolerances, or legal limits, for the amount of a pesticide which is permitted to be present in food are determined from the information gained during this process.<sup>2</sup> This federal reporting system identified circumstances under which aldicarb, a widely used pesticide, posed a special hazard for children.

#### **Aldicarb**

Aldicarb is an insecticide that has been used since the 1970s on fruits, nuts, potatoes, and various other vegetables and recently came under increased scrutiny for potential risk to children.<sup>3,4</sup> Aldicarb is systemic; that is, it is taken up by the roots of a plant and ends up in the plant itself, and

therefore, cannot be removed by simply washing or peeling fruits and vegetables. Aldicarb acts by inhibiting acetylcholinesterase, the enzyme necessary for the proper transmission of nerve impulses. Chemicals that inhibit cholinesterase can be very toxic to humans. Aldicarb belongs to the class of cholinesterase inhibitors called carbamates. They can cause a number of effects, including diarrhea, blurred vision, vomiting, and changes in the function of the central nervous system.

In 1991, the manufacturer of aldicarb notified the Environmental Protection Agency (EPA) of some unexpected aldicarb residues in bananas. Generally, the residues were below the established tolerance when the bananas were blended together.<sup>5</sup> However, when the bananas were analyzed one at a time, some of these bananas were found to have “hot” levels of aldicarb that were up to 10 times more than the legal limit. Therefore, more than the safety threshold for a whole day's exposure could occur in a single serving if certain individuals happened to eat one of the “hot” bananas.

After these data were reported, the U.S. Food and Drug Administration (FDA) checked aldicarb levels in bananas as they were used for different purposes. Processed bananas used for baby food

were found to have very low aldicarb levels, probably because the baby foods are made by blending large numbers of bananas. Therefore, children who ate their bananas in that form were relatively safe from high levels of exposure to aldicarb. However, children who ate pieces of bananas or entire individual bananas were more at risk. The levels of aldicarb in some individual bananas were not only well above the legal limit but potentially high enough to make a child acutely ill. EPA's dietary risk assessment found that, for the "hottest" bananas, the allowable daily limit of aldicarb would be exceeded by an adult's eating more than one-eighth of a banana and by a child's eating more than one bite of a banana. Even for bananas at the legal limit, just one-third of a banana would be an excess for a toddler and one-seventh of a banana would be above the allowable daily intake for an infant.

This increased risk of exposure for children to high levels of pesticide residue on food is compounded by the typical child's diet. In general, children's diets are less varied than those of adults. As a consequence, they eat larger volumes of certain foods per pound of body weight than adults do. A toddler's eating one banana (a fairly common occurrence) is roughly equivalent to an adult's eating five bananas, on a body-weight basis. For this reason, children were at greater risk of high levels of exposure to aldicarb than adults.

Based on this information, the manufacturer voluntarily agreed to stop the sale of aldicarb for use on bananas. The registration of aldicarb for bananas has since been canceled. The company also agreed to reduce the amount of aldicarb recommended for use on citrus fruits, but it is still used on some crops.<sup>6</sup> The pesticide is currently undergoing special review for groundwater concerns.

This case study is particularly disturbing in light of the fact that FDA tests about 40 food samples each day for a limited number of pesticides.<sup>7</sup> Because of this limited sampling and the large number of pesticides used, there are many pesticides for which the EPA never tests, and therefore, their prevalence in the food supply is

unknown.<sup>8</sup> Aldicarb is one pesticide for which a specific risk has been identified, but the potential for many more such risks to go undetected is real.

## Clinician Diagnosis and Reporting

Environmental risks to children are sometimes discovered by clinicians when treating children with unusual health problems. The following section discusses two examples of environmental effects upon children which were diagnosed by physicians alert to the effects of changes in the environment upon their patients.

### Diazinon

The first example involves an infant in Oregon diagnosed with chronic diazinon poisoning.<sup>9</sup> In December 1989, a routine physical examination at age 12 weeks found that the child had excessive muscle tone in her legs—her leg muscles had increased resistance to stretching (hypertonicity). A month later, when symptoms did not improve, the pediatrician consult-

---

*The levels of aldicarb in some individual bananas were not only well above the legal limit but potentially high enough to make a child acutely ill.*

---

ed a specialist, who examined the infant. At this examination, the hypertonicity was also occurring in her arms and hands, and the consultant suspected that the child had a mild case of cerebral palsy. Treatment and physical therapy for cerebral palsy were begun.

Several months later, the child's parents informed the physician that the home had been sprayed with an insecticide a month prior to the first examination. An unlicensed applicator had sprayed the home, including the entire area and furniture of some rooms, with the insecticide diazinon. This type of application was a misuse of the pesticide; the diazinon product should be applied only to cracks, crevices, and small areas. The clinician reported the exposure to the state Pesticide



© Lori Adoraski/Reyk/Forry Stone Kroeger

Analytical and Response Center, which began an investigation. Diazinon residues in the home were evaluated, and urine samples were taken from the child and adults in the home for testing for the metabolites of diazinon. Unexpectedly high levels of residues were found in the home, and the child's urine sample showed levels of metabolites of diazinon (alkylphosphate) comparable to levels found in farmworkers who work with this pesticide. The adults' alkylphosphate levels were too low to be detected by the testing. For the child's sake, the family was advised to leave the home. Six weeks after being removed from the home environment, the child no longer exhibited hypertonicity symptoms, and all cerebral palsy treatment was discontinued.

The infant in this case was more vulnerable to diazinon than the adults for several reasons. Because the pesticide was

sprayed over entire floor surfaces, it is likely that the child was exposed partly by contact with the floor. Children's contact with the floor is typically more extensive than that of adults because of their height and means of getting around. In addition, infants take in more air for their size than adults and breathe more rapidly, so the airborne particles of diazinon which came from the initial application and from disturbances of the floor surfaces (such as by vacuuming) would be more concentrated in the child's body. Moreover, studies have found that young animals are more susceptible to organophosphate chemicals like diazinon than are older animals, and the existence of a parallel phenomenon in humans is quite possible.<sup>10,11</sup>

The unusual feature in this case is that the clinician made the connection between the spraying of the insecticide and the child's problems, even in the absence of effects on the adults in the home and when a different diagnosis had already been proposed and accepted. The clinician also promptly reported the exposure and set in motion laboratory procedures to identify diazinon in the home and to test for metabolites in the child. Even though the child's symptoms were not necessarily the same as those of an adult with similar exposure,<sup>12</sup> the cause of the symptoms was identified and the child was removed from the harmful home environment. Under other circumstances, this child might have gone on to have chronic neurological damage from the exposure, and no one would have known why.

This example also shows that, through the use of home and garden pesticides, parents can inadvertently expose their children to much heavier levels of pesticides than they would normally be exposed to in food, water, or air. Despite good intentions, without knowledge of the potential effects of pesticides on their children, parents themselves may be the largest factor contributing to the exposure of their children. Educating parents about the effects of pesticides on children is one important method of decreasing children's exposure.

### Mercury

The second example concerns chronic mercury toxicity in a child.<sup>13</sup> In this 1989

case, a four-year-old child from Michigan presented in a clinician's office with sweating, itching, headaches, difficulty in walking, gingivitis, hypertension, and red discoloration of the palms and the soles of the feet—all symptoms of mercury poisoning. The physician had knowledge of mercury poisoning cases from the earlier part of this century. At that time, medicines and teething powders containing mercury were commonly prescribed for young children. Children who were exposed to large amounts of mercury developed a condition called acrodynia (which means "painful extremities") weeks or months after exposure. The symptoms of acrodynia include irritability, red discoloration of the hands and feet, pain in joints, heavy sweating, muscle weakness, and difficulty standing or walking. Despite the severity of the effects, it was not until the 1940s that the cause was determined to be mercury poisoning and the use of mercury in medicines for young children was banned. Today it is possible to treat acrodynia, but many physicians are unaware of its existence because it is so rare. This physician, because of his experience, suspected mercury poisoning as the cause of the child's symptoms and began to search for a source of exposure.

The physician reported the symptoms and his suspicion of acrodynia to the Department of Public Health, which found that the mercury exposure came from the painting of the interior of the child's home with latex paint just ten days before the child became ill. At one time, biocides containing mercury were added to about one-fourth of interior latex paints in low concentrations to extend the shelf life of the paint and in higher concentrations to make paints mildew resistant. The paint the family used contained a mercury biocide. After the house was painted, the family slept with the air conditioning system on and the windows closed. The mercury in the paint vaporized, and the child and his family breathed it in. When tested, all members of the family had elevated mercury urine levels; however, only the child was symptomatic. He was hospitalized for four months and received treatments to increase the amount of mercury excreted from the body. After treatment, almost all of the symptoms disappeared, and he could walk again.

There are several reasons the child was more vulnerable to mercury inhalation than the adults in this case. As in the diazinon case, children's higher rate of respiration causes them to take in a greater amount of both air and its contaminants relative to their size than adults (see the article by Bearer in this journal issue). Mercury vapor is also heavier than air, so the area in a room that has the greatest concentration of mercury will be near the floor, where small children play.<sup>14</sup>

Since 1990, the mercury compound involved has been banned for use in house paints, but this case raises the question of whether there have been a number of instances of similar exposure of children in the recent past that went unrecognized. It also raises a more global question. Chemicals such as mercury were used for many years before their effects became

---

*Chemicals such as mercury were used for many years before their effects became known and their use was banned. How many chemicals currently in use are having other, unknown effects on children?*

---

known and their use was banned. How many chemicals currently in use are having other, unknown effects on children? According to the EPA, an estimated three million children each year may have been exposed to mercury through latex paint manufactured before the ban took effect.<sup>15</sup> If three million children were exposed to mercury through paint alone, the number exposed to other harmful chemicals in a variety of forms is likely to be much greater.

## Multiple Exposures

In addition to exposures from single sources, such as the cases presented here, many children may experience multiple chemical exposures, which are even more difficult to identify and evaluate. Pesticides alone could account for several exposures to an individual child. Suppose, for example, that a child's home is treated with a pesticide, and others are used to treat the child's school for pests. Still other

pesticides are in the food the child eats. Over a single day, a child may be exposed to pesticides from many sources, as well as numerous other environmental contaminants.

Illnesses resulting from these multiple exposures are difficult to diagnose and treat for two major reasons. First, several classes of pesticides, such as the organophosphates and carbamates, contain specific chemicals that act in the same way in the body. If a child has an illness caused by a combination of similarly acting chemicals,

knowledge, regulations on maximum exposure levels generally have not taken the effects of multiple exposures into account but, instead, treat each exposure as if it occurred in isolation.<sup>16</sup>

## Conclusion

Much is still unknown about the effects of environmental chemical exposures on people, and on infants and children in particular. Filling the information gaps on effects and exposures is essential, but achieving that goal will take time, focused effort, and support for research dedicated to this end. The cases presented here illustrate that, in addition to regulatory agencies, parents, physicians, and others who come in contact with children on a regular basis all have roles to play. Among clinicians, increased alertness to environmental toxicity when making a diagnosis can be a direct route to identifying environmental causes of disease. Parents can help by identifying, and protecting children from, environmental exposures and by advising physicians involved in treating a child's health problem about possible exposures. Regulators and others who are responsible for environmental safety will have to be particularly sensitive to the increased vulnerability of children, in setting research agendas and regulatory policy and in sharing critical information on risks to children with those who are directly responsible for protecting children.

---

*Given the large number of chemicals many children are exposed to daily, the task of sorting out the effects of multiple exposures is daunting and has not yet been accomplished.*

---

the source of the contamination causing a particular illness may not be clear. In addition, the effects of exposure to multiple toxins are not well understood, particularly when the chemicals have different modes of action. It is simply not known whether these chemicals inhibit each other or if they are additive or synergistic, multiplying one another's potential effects on children. Given the large number of chemicals many children are exposed to daily, the task of sorting out the effects of multiple exposures is daunting and has not yet been accomplished. Because of this lack of

1. Schardein, J.L. Hormones and hormonal antagonists. *Chemically induced birth defects*. New York: Marcel Dekker, 1993, pp. 271-84.
2. According to the Food and Drug Administration, pesticide tolerances for food "reflect a very conservative margin of safety—normally more than 100 to 1,000 times lower than the level that caused 'no effect' in test animals." Farley, D. Setting safe limits on pesticide residues. *FDA Consumer* (October 1988) 6-7.
3. National Academy of Sciences, National Research Council. *Pesticides in the diets of infants and children*. Washington, DC: National Academy Press, 1993, p. 246.
4. Jehl, D. Pesticide may peril children when used on bananas and potatoes, EPA study says. *Los Angeles Times*, March 2, 1989, at sec. 1, p. 11.
5. See note no. 3, National Academy of Sciences, pp. 289-96.
6. Sugarman, C. Small amount of tainted bananas found. *Washington Post*, June 5, 1991, at A14.
7. Farley, D. Setting safe limits on pesticide residues. *FDA Consumer* (October 1988) 11.
8. According to the EPA, there are 860 pesticides currently registered in the United States. U.S. Environmental Protection Agency. *Quantities of pesticides used in the United States*.

- Information sheet. Washington, DC: 1994. If an FDA test detects "more than 100 different pesticides" in a single sample, there are many that are not monitored. Farley, D. Setting safe limits on pesticide residues. *FDA Consumer* (October 1988) 10.
9. Wagner, S.L., and Orwick, D.L. Chronic organophosphate exposure associated with transient hypertonia in an infant. *Pediatrics* (1994) 94,1:94-97.
  10. Gupta, R.C., Rechi, R.H., Lovell, K.L., et al. Brain cholinergic, behavioral, and morphological development in rats exposed in utero to methylparathion. *Toxicology and Applied Pharmacology* (1985) 77:405-13.
  11. Mendoza, C.E., and Shields, J.B. Effects on esterases and comparisons of  $LD_{50}$  and  $LD_{50}$  values of malathion in suckling rats. *Bulletin of Environmental Contamination and Toxicology* (1977) 17:9-15.
  12. Zwiener, R.J., and Ginsburg, C.M. Organophosphate and carbamate poisoning in infants and children. *Pediatrics* (1988) 81:121-26.
  13. Blondell, J.M., and Knot, S.M. Risk analysis for phenylmercuric acetate in indoor latex house paint. In *Pesticides in urban environments: Fate and significance*. K.D. Racke and A.R. Leslie, eds. Washington, DC: American Chemical Society, 1993.
  14. Guzelian, P.S., Henry, C.J., and Olin, S.S. *Similarities and differences between children and adults*. Washington, DC: International Life Sciences Institute Press, 1992, p. 206.
  15. U.S. Environmental Protection Agency. *Environmental fact sheet: Mercury biocides in paint, voluntary cancellation, voluntary deletion, and amended registration*. Washington, DC: July 1990. Cited in *Pesticides in urban environments: Fate and significance*. K.D. Racke and A.R. Leslie, eds. Washington, DC: American Chemical Society, 1993, p. 315.
  16. See note no. 3, National Academy of Sciences, p. 297.

Children's  
Health

**MEMORANDUM**

August 6, 1997

TO: Bruce Reed  
Gene Sperling

FR: Chris Jennings

RE: POTUS memo responding to request for response to op-ed critiques of Children's Health Initiative

---

Yesterday the President sent over a request for information responding to the *Wall Street Journal* and *New York Times* op-ed critiques of the children's health plan. He mentioned his concerns about these articles to me again in today's pre-briefing for the press conference.

Attached is my response. I inadvertently forgot to cc it to you. I apologize for this oversight and wanted to make sure you had it on hand this evening. If you have any questions, call me tomorrow.

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 \$906. 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 of a federally subsidized entitlement. That's what happened when Medicaid was opened in 1967 to pregnant women and their children with incomes 250% of the poverty level. Between 1968 and 1975 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 13.3%. 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 to "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

*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.*

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 "healthcare."

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 ille-

gal. (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 Real Agenda

THE PRESIDENT HAS SEEN

8-5-97

By Douglas J. Besharov

**A**mericans 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 to 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

ers offer. Another provision calls for public coverage to be provided in families earning as much as 175 percent of the poverty level, depending on the state. For a family of four, that's almost \$30,000 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 1990 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 stimulates 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. □

## A new entitlement, poorly designed.

approach implicitly condoned "second class" health insurance. Still, they were prepared to settle for whatever expansion in national health coverage they could get.

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 employ-

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

### 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-natured President we all loved had he felt obliged to sacrifice his legs, 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 best of the half dozen Richard-Contraite terrorists and the know-how to jump most of them full of conspicuous 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

## President Ford the action hero.

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!

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 enrolled in the socialized medicine provided at Walter Reed Hospital.

And a good thing, too, because, grunted that jaw as he will, the terrorist brandishing 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 rumored only in helicopters, this is a President at ease taking the controls of his TG Turbo-Dura-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.

"Fools slapping," 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



UNITED STATES ENVIRONMENTAL PROTECTION AGENCY  
WASHINGTON, D.C. 20460

OFFICE OF THE  
ADMINISTRATOR

NOV 12 1997

Honorable Bruce N. Reed  
Assistant to the President  
on Domestic Policy  
The White House  
2nd Floor, West Wing  
1600 Pennsylvania Avenue, N.W.  
Washington, D.C. 20500

Dear Mr. Reed:

Attached is a summary of the first meeting of the Task Force on Protecting Children from Environmental Health Risks and Safety Risks which was held on October 9, 1997. This summary includes a roster of the Task Force Work Group Co-chairs and draft charges to each Work Group.

If you have any questions, please contact Paula Goode at (202) 260-3356.

Sincerely,

A handwritten signature in cursive script that reads "E. Ramona Trovato".

E. Ramona Trovato, Director  
Office of Children's Health Protection

Attachment

**MEETING SUMMARY**  
**Task Force on Protecting Children from Environmental Health Risks  
and Safety Risks**

- The first meeting of the Task Force on Protecting Children from Environmental Health Risks and Safety Risks was held on October 9, 1997, at the Department of Health and Human Services (DHHS).
- The meeting was opened with introductory remarks by Co-chairs Administrator Carol Browner, Environmental Protection Agency (EPA), and Secretary Donna Shalala, Department of Health and Human Services (DHHS). They both emphasized the need for serious efforts to be made to protect our nation's children from environmental health and safety risks.
- All Task Force members were represented; principals in attendance were John Gibbons, Office of Science and Technology Policy (OSTP); Kathleen McGinty, Council on Environmental Quality (CEQ); and Ann Brown, Consumer Product Safety Commission (CPSC).
- Dr. Mindy Fullilove, Columbia University, spoke about some of the health and safety risks that a child faces in today's environment.
- Dr. Phil Landrigan, EPA, and Dr. Richard Jackson, DHHS, gave a national overview of environmental risks to children. Two main points were:
  - In many cases, children are more vulnerable because:
    - they play close to the ground,
    - their organ systems are still developing,
    - pound-for-pound they eat more food, drink more water, breathe more air.
  - The landscape of childhood illness has changed:
    - traditional childhood illnesses are no longer a threat
    - complex, chronic conditions exist
      - asthma;
      - elevated blood levels;
      - learning disabilities;
      - birth defects; and
      - increased childhood cancers.
- Dr. Lynn Goldman, EPA, talked about the document, *Meeting the Challenge, A Research Agenda for America's Health, Safety, and Food*, which provided the background for the development of the Executive Order. She stressed that research should address the well-being of children and that there should be better coordination of investment in research efforts. Linkages inside and outside the government should be strengthened to achieve a better coordination.

- Dr. Kenneth Olden, DHHS, presented the requirements of the Executive Order and outlined the Task Force Work Groups, including the co-chairs and the proposed charges.
  
- Task Force members agreed that work should be focused in the areas of:
  - developing a research strategy;
  - developing partnerships;
  - educating families about prevention of exposure to environmental and safety risks; and
  - assuring that Federal regulations are protective of children.
  
- Action items include:
  - names of senior staff for Work Groups to Ramona Trovato, EPA, by October 31, 1997;
  - memo from Senior Staff Planning Committee Co-chairs to Administrator Browner and Secretary Shalala with outputs and timelines for the Work Groups by December 1, 1997; and,
  - next Task Force meeting April, 1998.

**Attachments:**

Work Group Co-chairs Roster  
Work Group Charges

DRAFT

**CHARGES TO WORK GROUPS  
OCTOBER 9, 1997**

**Senior Staff Planning Committee – Principal Responsibilities and Milestones**

*Prepare a statement of principles, general policy, and targetted annual priorities to guide the Federal approach to achieving the goals of this order (3-304(a))*

- Principles and general policy submitted to Task Force for approval December 9, 1997.
- Report including targetted annual priorities submitted to Task Force for approval December 9, 1998.

*Draft a statement for Task Force review and approval regarding the desirability of new legislation to fulfill or promote the purposes of the Executive Order (3-304(f)).*

- This statement shall be prepared following the Task Force approval of data needs due on June 9, 1998. Final approval by the Task Force due on September 9, 1998.

**Ongoing Functions:**

- Ensure adherence to deadlines explicitly specified in the Executive Order.
- Coordinate with Work Groups to develop schedules for deliverables, appropriate contractor support, and contacts within Federal Agencies and White House Offices necessary to develop data and information to fulfill Executive Order directives.
- Intervene as necessary to break logjams and advance the progress of the Work Groups.
- Act as liaison between respective Department or Agency Heads and the Task Force for required approvals.
- Provide consistency check among Task Force Departments and Agencies.
- Provide necessary logistical support for Task Force meetings.

**Program Implementation Work Group -- Principal Responsibilities and Milestones**

***Identify for the Task Force high-priority initiatives that the Federal Government has undertaken, or will undertake, in advancing protection of children's environmental health and safety (3-304(e)).***

- Departments/Agencies prepare inventories of ongoing and planned projects that promote the goal of protecting the environmental health and safety of children. (Completion date February 9, 1998)
- The Work Group shall prepare a biennial report to the Task Force that identifies programmatic activities (such as pilot projects, evaluations) that enhance our ability to understand, analyze, and respond to environmental health risks and safety risks to children. (Completion date for submitting a draft report to the Task Force April 9, 1998)

***Recommend for Task Force review and approval appropriate partnerships among federal, State, local, and tribal governments, and the private, academic, and non-profit sectors (3-304(c)).***

- Possible approaches include:
  - Industry contributions to EPA/HHS Centers of Excellence or a non-profit organization receiving federal monies under a cooperative agreement
  - Cooperative Research and Development Agreements (CRADAs) that enable Federal, State and Industry mingling of expertise, laboratory space, equipment, etc.
  - Federal grants (EPA, Indian Health Service, etc.) to promote identification of environmental exposures and opportunities for immediate pollution prevention interventions in tribal communities
  - Federal and State seed grants to implement and evaluate "hands on" interventions such as the "16th Street Clinic" project on leaded paint and contaminated fish in Milwaukee, WI.
- Specific recommendations due June 9, 1998.
- Following approval by Task Force, project plans with milestones due on September 9, 1998.

**DRAFT**

***Recommend for Task Force review and approval proposals to enhance public outreach and communications to assist families in evaluating risks to children, and in making informed consumer choices (3-304(d)).***

- Look to model projects such as the HUD "Healthy Homes Initiative," EPA "Family Right-To-Know Initiative," and others implemented by HHS and CPSC to determine the most effective means to convey information on immediate pollution prevention interventions.
- Identify those leaders in the community -- public health practitioners, educators, PTA leaders -- who are able to most effectively convey pollution prevention information, and target training materials and practical access to information to them.
- Assess the most near term and significant risks to children in their homes, schools and playgrounds, with special emphasis on children at greatest risk because of geographic location or income level, to identify where Task Force priorities should be.
- **Specific proposals due June 9, 1998.**
- **Following approval by the Task Force, project plans with milestones and completion dates due October 9, 1998.**

**Data Needs and Research Work Group – Principal Responsibilities and Milestones**

***IDENTIFY EXISTING DATA AND DATA ACCESS METHODS (4-401), (4-402)***

**October 21, 1997  
(date specified in  
the E.O)**

**Recommendation due to the Task Force that includes the following Executive Order provisions and suggests project design approaches and completion dates to implement the review of research databases:**

- **Develop or direct a smaller subgroup to develop a review of existing and planned data resources (date submitted to the Task Force for review and approval January 9, 1998.)**
  - **The work group may look to the similar and successful Endocrine Disrupter effort to review existing data resources government-wide.**
  
- **Develop or direct a smaller subgroup to develop a proposed plan for ensuring that researchers and Federal research agencies have access to information on all research conducted or funded by the Federal Government that is related to adverse health risks in children resulting from exposure to environmental health risks or safety risks (date submitted to the Task Force for review and approval March 9, 1998.)**
  - **The work group must ensure that the plan promotes the sharing of information on academic and private research; and**
  - **The plan shall include recommendations to encourage that such data, to the extent permitted by law, is available to the public, the scientific and academic communities, and all Federal agencies. (Internet access through existing home pages at EPA and HHS, or other databases commonly accessed by researchers must be designed and available by July 9, 1998.)**

***IDENTIFY NEW DATA NEEDS (3-305)***

June 9, 1998

Obtain Task Force review and approval of the first biennial report on research, data, or other information that would enhance our ability to understand, analyze, and respond to environmental health risks and safety risks to children. For the purposes of this report, the "Data Needs and Research Work Group" shall:

• Ask cabinet agencies and other agencies identified by the Task Force to identify and specifically describe key data needs related to environmental health risks and safety risks to children that have arisen in the course of the agency's programs and activities (date submitted to the Task Force for review and approval March 9, 1998.)

- This task shall be informed by the review of existing and planned data resources
- Completion date for incorporating agency submissions into the draft report April 9, 1998.
- By June 9, 1998 the work group shall recommend a process to the Task Force whereby the final report is conveyed to the Office of Science Policy and Technology Policy and the National Science and Technology Council so that those organizations may ensure that the report is fully considered in establishing research priorities.
- Completion date for ensuring that the report is publicly available and widely disseminated through Internet access to existing EPA and HHS home pages, or databases commonly accessed by researchers is August 9, 1998.

***DEVELOP A COORDINATED RESEARCH AGENDA FOR THE FEDERAL GOVERNMENT ON CHILDREN'S HEALTH AND SAFETY (3-304(b))***

October 9, 1998

Develop and recommend to the Task Force a coordinated research agenda for the Federal Government.

- First draft due to Task Force August 9, 1998

**DRAFT**

A comparison of existing data resources and new data needs will be the primary source of information to develop the research agenda

April 9, 2001

The member agencies shall assess the need for continuation of the Task Force or its functions, and make recommendations to the President.

## **Task Force Work Group Co-Chairs**

### **Senior Staff Planning Committee:**

Ramona Trovato, Director  
Office of Children's Health Protection  
Environmental Protection Agency

Richard Jackson, Director  
National Center for Environmental Health  
Centers for Disease Control and Prevention  
Department of Health and Human Services

### **Program Implementation Work Group**

Barry Johnson, Director  
Agency for Toxic Substances and Disease Registry  
Department of Health and Human Services

Jerry Clifford, Acting Regional Administrator  
Region 6  
Environmental Protection Agency

### **Data Needs and Research Work Group**

Bill Farland, Director  
National Center for Environmental Assessment  
Office of Research and Development  
Environmental Protection Agency

Ken Olden, Director  
National Institute of Environmental Health Science  
Department of Health and Human Services

THE WHITE HOUSE  
WASHINGTON

July 28, 1997

MEMORANDUM TO THE PRESIDENT

FROM: Chris J.

SUBJECT: Children's Health and Medicaid Budget Developments

cc: John Podesta, Bruce Reed, Gene Sperling, John Hilley, Fred DuVal

This responds to your request last night for a quick update of developments in the budget negotiations relating to children's health and Medicaid. Unfortunately, both subjects have individual provisions that -- as of early this morning -- continue to hold up final resolution on the budget: children's health benefits and the Disproportionate Share Hospital (DSH) cut formula. It is worth noting, however, that most other major issues -- like financial accountability in the children's benefit, cost-sharing protections, and the rest of the Medicaid issues -- are either resolved or almost resolved.

**Children's Health Benefits**

Both sides perceive that they have moved a long way on the benefit question. Both are right, but the current conference package is still a long way away from the benefit that overwhelmingly passed the Senate, which required that -- to be eligible for the \$24 billion grant funding -- states offer the FEHBP Blue Cross/Blue Shield PPO benefit with assurances that vision and hearing would be covered and a requirement for mental health parity. It is also a long way from the Medicaid approach we supported earlier this year with our endorsement of the Chafee-Rockefeller bill.

The Republicans' current package requires that a state-eligible plan be the FEHBP plan outlined above, a state-employee plan, or the most popular HMO plan in the state. In addition, it gives states the flexibility to become eligible for grant money if they develop a separate plan that is substantially actuarially equivalent plan to the dollar value of one of these three, and it provides: (1) inpatient/outpatient hospital care; (2) physician services; (3) X-Ray and lab; and (4) well-baby and well child care. Although the first three options would assure that the benefit plans would cover prescription drugs and mental health (and the vast majority already cover vision and hearing services), the fourth plan option would not guarantee this coverage. [NOTE: The health care packages for Florida, Pennsylvania, and New York are waived in; they do not have to design a new benefit plan.]

In our discussions with the Republicans, we have stressed our desire to ensure maximum state flexibility balanced with accountability on the benefits. We have accepted their automatic approval of any State package that meets their three benefit designs (assuming it also includes vision and hearing services.) We have agreed to their provision to waive in certain states. We have rejected, however, their actuarial value option because a benefit could be easily designed to exclude, for example, mental health benefits. This is not just a hypothetical concern: it happens frequently. For instance, for financial and political reasons, only 13 of the over 30 states who have children's health benefit cover such basics as prescription drugs, mental health, dental, and vision and hearing services. (See attached one-pager on why these benefits are so important to kids.)

### **Recent Benefits Negotiations**

Over the last 48 hours, we have suggested ways to add flexibility. For example, we offered that any state could design a different package than one of the conference options as long as it could gain HHS Secretarial approval -- similar to countless welfare and Medicaid waivers. They rejected this option because they (and the Governors) don't want an HHS review process.

We then suggested (but did not offer) the possibility of adding categories of benefits to their basic categories, ensuring that they are meaningful, and setting up an automatic approval if the packages are actuarially equivalent to the other three options. We decided not to take this route because Republicans were (at least then) vehemently rejecting the concept of adding new benefit categories.

Yesterday, we tried addressing their Secretarial review concern and their benefit category concern by offering to automatically approve any benefits package that was actuarially equivalent to the base three packages as long as the value of the individual benefits in the package was not designed to be less than 75 percent of the value of the benefit. We took this approach to ensure that the benefits we are concerned about could not be designed to be basically worthless -- again, mental health comes to mind. We thought the Leadership agreed to this proposal, but the staff (notably from the Commerce Committee) strongly objected and apparently was successful in urging the Speaker to reject it. Although many unfounded arguments were raised, one that is legitimate is that there are benefits in the three basic packages that children may not need.

### **Current Status**

There are very few options left. The first, of course, is for either side to recede to the other. Since that appears unlikely, the only other option may be for us to add our four priority benefits (prescription drugs, vision/hearing, mental and dental) to their actuarial value base package and require only those benefits we are most worried about to have the 75 percent bottom-line actuarial value protection. (Perhaps vision/hearing and mental health should be targeted, since these are the most vulnerable.) This would enable the states to design virtually any benefits package that was actuarially equivalent to one of the three base options as long as it included both sides' benefit categories. This would represent a significant move from us, but could risk attracting serious criticism from some of the children's groups. We have made no final internal decision on whether we would recommend this course of action to you.

## Status of the DSH Formula Fight

All along, we have been urging some moderation in the cuts high-DSH states would be forced to shoulder under the Medicaid agreement. Recently, we have been working with Congressman Spratt to develop alternative DSH allocation formulas. In the absence of reaching some sort of agreement, we will have major problems with our South Carolina, Texas, New Jersey, New Hampshire, Louisiana, and Missouri delegations on final passage.

We believe Mr. Spratt (working with us) has developed a formula that is acceptable to the high-DSH states. It, in effect, simply reduces the high-DSH states' cuts by capping their overall Medicaid reductions to 3.5 percent. In so doing, however, it holds all the other states harmless to the reductions in the House and Senate versions of the budget reconciliation bill. It accomplishes this by simply spending more money (or cutting less) and requires about \$670 million more in DSH spending.

Yesterday, we thought we had an agreement with the Leadership to integrate Congressman Spratt's formula into the final package. However, the same Commerce staffer who objected to our children's health compromise objected to this option. As of this writing, the DSH formula remains a very open issue; it still does appear likely, however, that the Leadership will allocate additional dollars to address our individual state concerns, (as well as some of theirs). Unfortunately, with each passing day we do not reach agreement, the DSH fight will become harder to resolve as more and more states will want special deals. Moreover, the resentment of the low-DSH states will increase to greater levels as time goes by.

## NGA Meeting

Although the Governors are quite satisfied with most of the agreement, they may well raise concerns about the benefits debate. As you know more than anyone, this issue is coming down to the longstanding trust/accountability debate between the Federal and state governments. **As the attached one-pager describes, the budget agreement will go much further than ever in providing great flexibility to states in the administration of Medicaid and the new children's health program.** However the benefits issue is resolved, it will not impose new costs on the states: it comes down to a Federal assurance that the new investment will deliver a set of meaningful benefits to children that some states may not otherwise provide. Because discussions are ongoing, Gene, Fred and I recommend not engaging on this issue to the extent possible.

If you decide to address this issue directly, you certainly could say that we remain open to -- and are looking at -- alternatives that assure some basic benefits of great importance to children. Gene and I will be sending Q&As on these subjects under separate cover. (Remember, the Republicans went on record of endorsing required benefits when they listed four benefits that must be covered in any actuarially-equivalent package; the debate will be around the additional benefits and whether to include some protection that the benefits are real.) However, you should carefully weigh any comments that you may make to be responsive to the Governors with the knowledge that your words will be carefully scrutinized by the children's advocacy community and many Democrats (and some Republicans) on the Hill.

## IMPORTANT BENEFITS FOR CHILDREN

### VISION

- **Why important to children:** Children are 3 times more likely than adults to have acute eye problems. However, children are less likely to recognize that their vision is poor.
- **Problem:** Almost 3 times as many uninsured versus privately insured children did not get needed glasses.

Nearly one in five uninsured children needed but did not have glasses before enrolling in Pennsylvania's state program.

### HEARING

- **Why important to children:** Children are 20 times more likely than adults to have acute ear infections.

After colds and the flu, ear infections and ear conditions are the most common reason why children miss school.

Untreated hearing impairments can delay language development and cause learning problems.

- **Problem:** Low-income children are more than twice as likely to miss school because of an ear infection or ear condition as high income children.

### DENTAL

- **Why important to children:** Tooth decay is the most common childhood disease.
- **Problem:** Dental problems disproportionately affect children from low-income families.

Almost 4.2 million uninsured children were unable to get needed dental care -- almost 3 times the number of privately insured children.

### MENTAL HEALTH

- **Why important to children:** Children are 70 percent more likely to suffer from activity limitations due to mental disorders relative to working age adults.

About 8 to 11 million children have a mental disorder.

- **Problem:** About one in four children who need mental health care did not receive it.

Uninsured children are particularly at risk. Over 270,000 uninsured children needed mental health services but were unable to get them.

## HEALTH CARE WINS FOR THE GOVERNORS IN THE BUDGET

### HEALTH CARE IN GENERAL

- **Increase in Federal funds for states.** States come out winners – a net gain of at least \$10 billion over five years (Medicaid & children's health combined). This does not even include the over \$5 billion in State savings from new flexibility.
- **Liberated from excessive Federal oversight.** State have unprecedented flexibility in running both the children's health initiative and Medicaid.

### MEDICAID

- **No per capita cap,** the NGA's number one concern at its January meeting.
- **Savings to states:** State savings over 5 years include:
  - **Repeal of the Boren amendment.** (Up to \$1 billion).
  - **Medicaid rates for Medicare cost sharing.** (Up to \$4 billion).
  - **Reduced rates for health clinics (FQHC/RHCs).** (Up to \$200 million).
- **Repeals managed care waivers** that required a paperwork-laden, time-consuming review process.
- **Flexibility in cost sharing** for Medicaid beneficiaries.

### CHILDREN'S HEALTH

- **Major investment for states.** \$24 billion over the next five years.
- **Reduced matching rate,** from 43% under Medicaid, on average, to 30%.
- **No requirement to accelerate phase in of poor children 14 to 18 years old.**
- **Flexibility in:**
  - **Eligibility to target children** by area, age, or other circumstances.
  - **Benefits** so that, above a minimum, States determine the mix and amount of services. No early, periodic screening, diagnosis & treatment (EPSDT).
  - **Provider or plan payment rates** which States will negotiate without burdensome Federal oversight.
  - **Use of managed care** so that States may, for example, contract with one plan to deliver care to children.

HC -  
Children's  
Health

THE WHITE HOUSE  
WASHINGTON

July 3, 1997

MEMORANDUM TO THE PRESIDENT

FROM: Chris Jennings (CJ)

SUBJECT: Recent Children's Health Coverage Estimates and Brief Review of Health Investment Alternatives, Including 21st Century Biomedical Research Trust Fund

Following up on our conversation last night, this memo responds to your questions about children's health coverage estimates, policies and health investment issues in general.

**CBO's children coverage estimates.** First, it is important to explain in more detail the CBO analysis and policies discussed in yesterday's *New York Times* article. The low estimate of around one million children covered by the House and Senate bills reflects both flaws in the policies and particularly conservative assumptions used by CBO. CBO assumes that states will use some of the new funds to lower their current state spending — contrary to many analysts' belief that states will leverage, not reduce, existing state investments. They also think that having a higher matching rate for the new program will create an incentive to classify children already covered in Medicaid as higher income children to receive the extra Federal funding. In addition, CBO assumes that a number of children will switch from private insurance coverage to the new program.

**Updated estimates.** Since yesterday's *Times* article, two estimates have been released that increase the figures cited by Robert Pear. Just today, I received a copy of CBO's final analysis of the Senate bill. It reports that 1.7 million uninsured children would be covered by the \$24 billion proposal — 2.0 million uninsured children without the mental health parity provision. This estimate is higher because of the tobacco tax revenue and the effect of new accountability rules. Combined with HHS's estimate that 2 million eligible uninsured children could be enrolled in Medicaid without Federal funds (through outreach, etc.), we could easily claim up to 4 million uninsured children even using some of CBO's new yet still conservative estimates. At least as noteworthy, the Children's Defense Fund released a report today that estimates that 6.1 million uninsured children could be helped by the \$24 billion Senate bill (and over 4 million for \$16 billion). We are analyzing both reports, but they are clearly headed in the right direction.

**Validity of some CBO concerns.** While we believe that CBO estimates are excessively conservative, we do share their legitimate concern about how to best to target the funds. In fact, as I mentioned last night, the article will likely be helpful in that it will provide the needed push to get more effective targeting provisions into conference. As we do this, however, we must balance the need to ensure accountability with the need to avoid onerous provisions that do little more than provide disincentives for states to participate in this voluntary program in the first place. We also must guard against the inclination of helping make CBO the final arbitrator of insurance take-up rates. We empower them at our peril, since few believe they will significantly move off of their current assumptions.

**Potential solutions.** We are working on perfecting and are promoting two general approaches to better assure that the Federal investment goes to the greatest number of children. The first deals with providing better financial incentives to states to do the "right thing." The second focuses on additional accountability rules that give the new Federal dollars if states meet certain conditions.

The financial incentives we are working on would provide greater Federal matching rates for all newly enrolled child, not just children above current mandatory levels. We would give a state a higher matching rate for any additional child enrolled in Medicaid or the grant program above the number of children currently enrolled in Medicaid. This takes away the inefficient incentive in the Senate and House bills for states to get higher matching for a child above poverty. Another approach is to reward states that use proven methods for covering children, such as targeting children whose parents have changed jobs or using school-based enrollment approaches, such as the Florida "Healthy Kids" program.

The accountability rules we are promoting would build on and reform the different maintenance of effort (MOE) provisions that are included in both the Senate and House bills. They are designed to protect the new Federal dollars from being used to substitute for current expenditures by either the States or employers/employees wanting to reduce their health care premium costs. The approaches we think most worth considering are asking states to maintain their current programs' eligibility — to prevent states from moving optional Medicaid kids into the new program — and maintain current spending on existing programs. We also support the Senate bill that does not allow states to cover the employee share of the premium or family coverage. CBO and our staff agree that this would allow funds to be used by families who would have been insured anyway. And, consistent with the Senate bill and Medicaid rules, we strongly oppose the use of provider taxes and donations for the state share of the new program.

There is no question that it will be a great challenge in the coming weeks to balance provisions that promote efficiency with state flexibility. States will assert that policies like those outlined above interfere with their own ability to target funds efficiently. Furthermore, states like Rhode Island and Vermont, which have already expanded children's coverage through Medicaid, will argue that the maintenance of effort is unfair. They contend that they should not be penalized permanently for deciding to have voluntarily chosen to expand coverage.

**Lessons of targeted reforms.** The difficulty — politically and policy-wise — in targeting uninsured children has two important implications. First, additional money alone will not result in all children receiving health insurance. One-third of uninsured children are already eligible for Medicaid — a free program with generous benefits. Another third have incomes above 200 percent of poverty; policies that try to find those children will surely end up enrolling two to three times as many already-insured children. For these reasons, allocating more than \$24 billion for children's coverage may not be very cost-effective. Keeping this in mind, it is prudent that you and the economic team are now recommending dedicating the additional \$7 billion (on top of the \$8 billion currently allocated for children's coverage) to other children's issues -- such as adoption and child care.

Second, these same problems hold true for insuring Americans in general. Stated bluntly, no voluntary health insurance program will ever cover all uninsured Americans, even with an unlimited budget. If there is some financial contribution required, many families will voluntarily opt to not purchase insurance. On the other hand, there will always be people who join these programs who already have insurance. There is no failsafe mechanism that completely prevents "crowd out." Moreover, the larger the initiative, the higher the income eligibility, the greater the risk. Thus, the assertion in yesterday's *USA Today* may be right: without a government policy that requires everyone to be covered, it is virtually impossible to cover all 40 million uninsured.

Consequently, we are approaching possible uses of additional revenue from an increased tobacco tax and/or from the tobacco settlement with caution. As with children, focusing on low-income adults or groups who are unlikely to have access to private insurance may be the most fruitful. For example, job loss and job change are the single largest reason why families lose health insurance. Creating a Medicaid option for these families would increase their access to insurance. Similarly, people between 55 and 65, who have either retired early or whose firms have downsized often find themselves with few affordable insurance options. A Medicare buy-in or premium assistance for COBRA may help these people, as we discussed. We are also exploring other options such as strengthening the public health infrastructure and augmenting our research budget.

### **21st Century Research Trust Fund Update**

To explore biomedical research investment opportunities within the context of the Tobacco Settlement, I met with Dr. Varmus and researchers throughout the Federal government today. As you requested, I pulled Dr. Varmus aside and asked him what he thought of a 21st Century Research Trust Fund concept. He was very interested and wanted to have additional conversations about it. His only immediate concern was that we make sure any new dollars supplement — and not supplant — those the NIH are already getting from the Hill. We will keep you apprised of his recommendations and our ongoing discussions with him.



THE DIRECTOR

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

LATEST  
POSITION

July 2, 1997

The Honorable John R. Kasich  
Chairman  
Committee on the Budget  
U.S. House of Representatives  
Washington, D.C. 20515

Dear Mr. Chairman:

As the Conferees begin to consider this year's budget reconciliation bill, I am writing to transmit the Administration's views on the House and Senate versions of the spending bill on reconciliation, H.R. 2015. The Administration will separately transmit its views on the tax provisions.

We are pleased that the House and Senate adopted many provisions that are consistent with the Bipartisan Budget Agreement, reflecting the continuing bipartisan cooperation that we will need to fully implement the agreement and balance the budget. In several areas, however, the House and Senate bills violate the agreement. In other areas outside the scope of the agreement, we have very strong concerns about the reported provisions. We have raised a number of these issues in letters to you and to the authorizing committee chairmen and ranking members throughout House and Senate consideration of the separate reconciliation spending bills.

On the pages that follow, we have outlined noteworthy provisions of the House and Senate bills with which we agree, others that we believe violate the budget agreement, and still others about which we have concerns.

We expect and will insist that the final budget legislation conform to the budget agreement. In addition, we look forward to working with you to craft a final conference report that is free of objectionable provisions, resolves the other major policy differences between us, and balances the budget by 2002 in a way that we can all be proud of. We hope to meet that goal before the August recess.

standards and would permit the collection and analysis of person-based data. The Senate did not include this provision. We urge the Conferees to adopt the House provision.

Alaska FMAP Change. The Senate bill would increase Alaska's Federal Medical Assistance Percentage (FMAP) above the level of the current law formula. While we have consistently supported efforts to examine alternatives to the current Medicaid matching structure, we believe that changing the FMAP for Alaska alone is unwarranted and does not address the underlying inequities in the current system.

### Children's Health

We are pleased that the children's health initiative is in both the House and Senate bills. In fact, the Senate bill goes beyond the \$16 billion that the budget agreement provides, adding another \$8 billion, which is a portion of the revenue from a 20-cent increase in the tobacco tax.

We support a 20-cent increase in the tobacco tax -- we agree that it complements the budget agreement -- and we endorse the idea of using all of the revenues raised by such an increase for initiatives that focus on the needs of children and health. We urge the Conferees to invest all of these funds wisely in order to ensure meaningful coverage for millions of uninsured children. In addition, we especially support the Senate provisions for benefits and cost sharing.

Notwithstanding these achievements, we have serious concerns about the following House and Senate provisions, which we urge the Conferees to address.

Sunset of Tobacco Tax Revenue for Children's Health. Although we commend the Senate for supporting the use of the tobacco tax for children's health, we urge the Conferees to continue this funding after 2002. A sudden drop in funding in 2003 would cause many of the newly-insured children to lose their coverage.

Meaningful Benefits, Cost Sharing/Direct Services. The budget agreement calls for the children's health investment to go for health insurance coverage. Thus, we support the Senate's definition of benefits and its limits on cost sharing, the latter of which will ensure that low-income children do not shoulder unrealistically high costs that could lead to reduced access to needed health care. We do not support the direct services option of the House bill because we are concerned that a State could spend all of its money on one benefit or to offset the effects of the DSH cuts on certain hospitals, and that children would not be assured appropriate coverage. In our view, this provision does not fulfill the commitment of the budget agreement to provide "up to five million additional children with health insurance by 2002."

**Funding Structure.** We support the straightforward funding structure of the House bill. But its proposal for different matching rates for Medicaid and the grant option could discourage States from choosing Medicaid. We believe Medicaid is a cost-effective approach to covering low-income children, and we support using the same matching rates for both options. In addition, we support the House provision that gives States the flexibility to spend their grant money on Medicaid, a grant program, or a combination of the two. The Senate bill requires States to choose between Medicaid and a grant option.

**Eligibility.** The Senate bill includes a ceiling of 200 percent of poverty. We agree that the funds should first go for insurance coverage for low-income uninsured children, but we believe income ceilings would limit States' flexibility to design programs that best fit their needs.

**Use of Funds.** We want to ensure that the investment in children's health goes to cover children who currently lack insurance, rather than replace existing public or private funds for children's health insurance. Thus, we support a strong maintenance of effort provision and the prohibition on using provider taxes and donations to fund the State share of the program. In addition, we want to ensure that the funds are used in the most cost-effective manner to provide coverage to as many children as possible. Therefore, we do not support provisions that allow States to pay for family coverage or pay the employee's share of employer sponsored insurance.

### **Expansion of the "Hyde Amendment"**

Both the House and Senate bills would expand the Hyde Amendment prohibitions on Medicaid payment for abortion services to include spending on the children's health initiative, and to codify these prohibitions in permanent law. This provision could deny access to abortion services to poor women to the extent that States choose to use the children's health funding to offer family coverage, as the House bill would permit. As we have repeatedly said, we do not support limiting access to medically necessary benefits, including abortion services.

In addition, the Senate bill contains a provision that redefines the term "medically necessary services" in the context of managed care sanctions to exclude abortion services except under certain circumstances. We oppose this attempt to further constrain the availability of abortion services through this provision, and we strongly urge the Conferees not to begin writing into the Medicaid law permanent, restrictive definitions of what are "medically necessary" services -- an issue that is more appropriately decided by health professionals.

THE WHITE HOUSE

WASHINGTON

June 17, 1997

Dear Mr. Chairman:

I urge the Senate Finance Committee to adopt the bipartisan children's health amendment proposed by Senators Chafee, Rockefeller, Jeffords, and Hatch. As you know, I am extremely committed to using the \$16 billion for children's health to provide meaningful coverage for as many uninsured children as possible. The bipartisan amendment offers an opportunity to do just that.

It is critical that we continue to work together in this Congress to find ways to provide health care coverage for millions of uninsured children. As you know, over ten million children lack health care coverage -- and the impact on their families is profound. A recent study showed that nearly 40 percent of uninsured children go without the annual check-ups that all children need. One in four uninsured children do not have a regular doctor. And throughout the country, too many parents are living in fear that they may be forced to make the impossible choice between buying medicine for a sick child or food for an entire family.

Because of the importance of this problem, we need to work together to design the most effective way to invest the \$16 billion. The bipartisan amendment takes a major step toward this goal. This plan rationalizes Medicaid so that children in the same family are eligible for the same coverage. Children under 6 years old and under 133% of poverty -- about \$21,000 for a family of four -- are already eligible for Medicaid. The bipartisan plan provides incentives for states to cover older children up to this same income level. The plan also gives states the option of choosing Medicaid or a more flexible grant approach for uninsured, middle-class children. Resources and flexibility are needed because, unlike low-income children, middle class uninsured children are difficult to target with a single program. In addition, this bipartisan plan offers meaningful coverage that protects vulnerable children from excessive costs.

The bipartisan initiative -- which balances protections for vulnerable children with flexibility to target middle-class children -- stands in sharp contrast to the Commerce Committee's proposal. The plan to simply put out a block grant, with few rules and no benefits requirements, will not result in meaningful coverage for many uninsured children. While your proposal improves

The Honorable William V. Roth, Jr.

Page Two

on the Commerce Committee's plan, the claim that it provides a choice between Medicaid and a grant approach is exaggerated. Given the incentives in the proposal, no rational state would choose Medicaid.

The bipartisan amendment merits strong and favorable support from the full Finance Committee. We should take advantage of this opportunity to significantly reduce the number of uninsured children. I look forward to working with you and others on the Finance Committee and in the Congress to achieve this end.

Sincerely,

A handwritten signature in cursive script that reads "Bill Clinton". The signature is written in dark ink and is positioned below the word "Sincerely,".

The Honorable William V. Roth, Jr.  
Chairman  
Committee on Finance  
United States Senate  
Washington, D.C. 20510



THE SECRETARY OF HEALTH AND HUMAN SERVICES  
WASHINGTON, D.C. 20201

JUN 26 1997

The Honorable Edward M. Kennedy  
United States Senate  
Washington, D.C. 20510

Dear Senator Kennedy:

I understand that later today you will be offering an amendment to increase the tobacco tax by an additional 23 cents over the amount passed by the Senate Finance Committee. Given the bipartisan agreement in the Committee that a tobacco tax is an acceptable complement to the balanced budget agreement, and because the President has long supported using tobacco revenue to fund important programs for children, I am writing to advise you that the Administration supports your amendment.

Each and every day, about 3,000 American children become regular smokers. One-third of these children will die early from tobacco-related illnesses. In the past six years, the smoking rate among eighth graders has risen 50 percent. An increase in the tobacco tax will reduce the use of cigarettes by making them more unaffordable. It will also provide new revenue to invest in our nation's priorities. It is the President's strong belief that all revenue dedicated from the tobacco tax should be invested in improving the lives of our children. Clearly, your amendment is consistent with that vision.

We look forward to working with you and Members of Congress of both parties to produce a balanced budget agreement that reflects the priorities of all Americans. We greatly appreciate your leadership on this important issue.

Sincerely,

Donna E. Shalala

MEMORANDUM

June 23, 1997

TO: Bruce R., John H., Gene, Nancy-Ann, Jen K.

FR: Chris J. and Sarah B.

RE: Children's Health One-Pager and Q&As

Attached is a one-pager on children's health that will be used as background for the President's speech tomorrow on children's health with Kaiser Permanente. (Kaiser is announcing that they are donating \$100 million to cover up to 50,000 uninsured children in California). We have also included our most up-to-date Q&As on children's health, Medicare, and AIDS.

We hope you find this information helpful. Please call with any questions.

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

Today the President joined Kaiser Permanente in announcing that the health plan will give \$100 million to provide health care coverage to up to 50,000 uninsured children in California. Kaiser is responding to the President's challenge at the Summit on Service, and their initiative complements the President's commitment to a national effort to extend health insurance.

**This President will continue to fight hard to make sure that extending health care coverage to millions of uninsured children is a top priority in any balanced budget deal.** The President fought hard to ensure that the balanced budget agreement included \$16 billion to provide meaningful health care coverage to uninsured children. The President also supports the action by the Senate Finance Committee to raise a 20 cent tobacco tax to allocate additional Federal support for children's health.

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

**The Balanced Budget and the Kaiser announcement build on the President's previous successes in strengthening health care coverage for children.**

- **Children and the Kassebaum-Kennedy Law.** By signing this bill into law, the President helped millions of Americans -- and their children -- keep their health care coverage when they change jobs.
- **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.
- **Children and the Environment.** 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 Tobacco.** The President has also taken action to limit children's access to tobacco. Each day about three million children become regular smokers and 1,000 of them will die from a tobacco-related illness. To reduce this trend, the President issued guidelines to eliminate easy access to tobacco products and to prohibit companies from advertising tobacco to kids. According to former FDA Commissioner David Kessler, the possibility of a comprehensive, public health oriented settlement with the tobacco industry could not have come about without the President's leadership in this area.
- **Children and Immunization.** During the Clinton Administration, childhood immunizations have reached a historic high. The President's childhood immunization initiative expands community-based educational efforts and makes vaccines more affordable. In 1995, fully 75 percent of two-year olds were immunized -- an historic high.

## CHILDREN'S HEALTH

**Q: DO YOU BELIEVE THAT A CHILDREN'S HEALTH INITIATIVE CAN EMERGE FROM CONGRESS THAT YOU SUPPORT? DO YOU HAVE A PREFERENCE FOR HOUSE- OR SENATE-PASSED LEGISLATION?**

**A:** Yes. We are working with the Congress to ensure that they produce a children's health initiative that provides meaningful health care coverage to millions of uninsured children. It is imperative that the single largest investment for children's health care since Medicaid was enacted in 1965 is efficiently spent to cover the most number of uninsured children.

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

I am optimistic that the House and certainly the Senate will improve their legislation. It is encouraging that Republicans and Democrats are working to ensure that the children's health package that is produced will ensure that benefits are meaningful and that low-income children are protected from excessive out-of-pocket costs. We will do everything that we can to work with these Members as the bill is debated on the House and Senate floor this week.

**Q: WITH THE TOBACCO SETTLEMENT IN MIND, SENATOR LOTT RECENTLY IMPLIED THAT THE SETTLEMENT MIGHT UNDERMINE SUPPORT FOR THE TOBACCO TAX. DO YOU BELIEVE THAT THE CONGRESS SHOULD RESIST PASSING A TOBACCO TAX BEFORE THE FINAL TOBACCO AGREEMENT IS WORKED OUT?**

**A:** No. The Finance Committee, on a bipartisan basis, passed out an increase in the tobacco tax to provide additional funding for children's health care coverage. The Congress should not alter its decisions based on an assumption that an acceptable tobacco settlement might be reached.

**Q: DO YOU BELIEVE THAT RESOURCES FROM THE TOBACCO SETTLEMENT COULD COVER THE REST OF THE UNINSURED CHILDREN? HOW WOULD YOU RECOMMEND INVESTING THESE NEW DOLLARS?**

**A:** We just heard the details of the tobacco settlement on Friday. Any final decisions about how any money from the potential settlement might be spent are obviously premature. The tobacco settlement could provide significant new funding for children's health and other public health initiatives. While we should be and are looking into possible options, we cannot count on any of these dollars. We should not let the possibility of additional revenue from a tobacco settlement undermine the investment for children that has already been agreed to in the balanced budget agreement.

**Q: DO YOU SUPPORT THE TOBACCO TAX THAT WAS INCLUDED IN THE FINANCE COMMITTEE MARK-UP?**

**A:** Yes. I do hope, however, that we can dedicate more of the savings from the revenue -- beyond the \$8 billion -- to other children's priorities.

**Q: WHY DID YOU OPPOSE THE HATCH-KENNEDY LEGISLATION? AND WHY DID YOU NOT OPPOSE THE ADDITIONAL \$8 BILLION FOR CHILDREN'S HEALTH FROM TOBACCO REVENUE IN THE SENATE FINANCE MARK-UP. HOW DO YOU RECONCILE THIS INCONSISTENCY?**

**A:** I have been supportive of using revenue raised from tobacco for health care since the beginning of his Administration. It was explicitly used as a revenue source for the Health Security Act.

I did not support adding the Hatch-Kennedy amendment in the context of the budget agreement because the Republican Leadership strongly asserted it would have undermined the budget deal and the \$16 billion already allocated for children's health care. I have repeatedly said how difficult it was for me to oppose that legislation, which encompasses goals I clearly support.

In the recent Finance Committee mark-up, the Republican Leadership accepted a down-sized tobacco tax (20 cents) and allocated some of the savings (\$8 billion) for children's health. Their support for this revenue source removes any barrier for me to support it.

Q. DO YOU BELIEVE THAT THE VOTE AGAINST THE CHAFEE-ROCKEFELLER CHILDREN'S AMENDMENT WAS A REJECTION OF THE YOUR HEALTH CARE PRIORITIES?

A. No. While we were disappointed that Chafee-Rockefeller amendment did not pass, the Senators made improvements that responded to a number of the concerns that I had raised about the Chairman's mark and the Commerce Committee bill.

Before the final compromise was reached, the original Finance legislation fell well short of assuring that the \$16 billion for children's health care was being effectively targeted to ensure that the greatest number of children would be given a meaningful benefits package. For example, it would have permitted states to use the \$16 billion for purposes other than expanding health insurance coverage to children, and it would have allowed states to offer health plans that would not have included many important benefits that children need.

I do, however, believe that we need to continue to work to ensure that the final bill includes provisions that guarantee that low-income children are not exposed to excessive cost sharing and to ensure that the benefit that is provided to children is meaningful.

I fought extremely hard to ensure that the \$16 billion for children's health was in the Budget Agreement. I will continue to work to ensure that the final children's health legislation provides children with a meaningful benefits package and covers the most children possible.

## MEDICARE

**Q: DO YOU SUPPORT THE INCOME-RELATED PREMIUM PROPOSAL THAT WAS IN THE SENATE FINANCE COMMITTEE MARK?**

**A:** First, what passed the Senate Finance Committee was not an income-related premium but rather an income-related deductible that would allow high-income beneficiaries to pay deductibles beyond the current limit.

The proposal is also outside of what was decided in the Budget Agreement. We decided on what beneficiary savings were in the agreement and all assumed there would be no other beneficiary cost-sharing burdens.

I agree with the former Congressional Budget Office Director, Robert Reischauer that it would be administratively complex and potentially unworkable in a practical context. Regardless, it needs much consideration before we could support it as an addition to the Medicare program.

For this reason, we do not support this proposal in the context of the budget negotiations. However, we would be happy to have discussions with Senator Kerrey and others about this provision in another context.

**Q: DO YOU SUPPORT EXTEND THE AGE OF MEDICARE AGE OF MEDICARE ELIGIBILITY OLDER AMERICANS FROM 65 TO 67 YEAR OLD?**

**A:** Raising the eligibility age for Medicare from 65 to 67 is not consistent with the spirit of the balanced budget agreement. We do not support this provision in the context of the balanced budget negotiations. It was not thoroughly discussed in the budget agreement, and we believe that it raises a number of issues that have not been thoroughly considered.

**Many early retirees would lose their private health insurance if Medicare was not available to them.** There 4.1 million retirees between the ages of 55 and 64 -- 24 percent of all retirees. Having no alternative available, many would become uninsured while they were waiting for Medicare.

**Health care coverage for early retirees is already dropping.** The proportion of all retirees covered by health insurance from a former employer dropped from 37 percent in 1998 to 27 percent in 1994.

The decline in coverage among active workers, which decreases the likelihood of retiree health benefits, is a significant factor in this decline of coverage. The proportion of workers who with coverage from their employer upon reaching retirement declined from 65 percent to 1988 to 60 percent in 1994.

Only 30 percent of early retirees (age 55-64 years i.e. non-Medicare eligible) have health insurance from a former employer.

The cost of health care is also a significant factor for retirees. One-fourth of all retirees who elected not to carry their insurance into retirement reported they made their decision to drop insurance because it was too expensive.

**Unlike Social Security, if we raised the age limit for Medicare, beneficiaries who retire early would not be eligible for a portion of benefits.**

With Social Security, Americans who retire early are eligible for a portion of their benefits until they reach the age of eligibility. There are no options for partial benefits for Medicare beneficiaries who need access to health care coverage before they reach the age of eligibility.

**Q: DO YOU SUPPORT THE HOME CARE COPAYMENT INCLUDED IN THE BILL FROM THE SENATE FINANCE COMMITTEE?**

**A:** No. It is outside the context of the Budget Agreement and it needs further review before proceeding further in the legislative process.

We must remember that Medicare beneficiaries who use the home health services tend to be in poorer health. Two-thirds are women, and one-third live alone. Forty-three percent have incomes less than \$10,000. We would want to therefore make certain that a copayment would not place excessive burdens on beneficiaries who truly needed the benefit.

While we do not support this proposal in the context of the Budget Agreement, we do believe that proposals like it merit consideration in any serious review of options to address the long-term financing challenges confronting the Medicare program.

**Q: THE HOUSE COMMERCE COMMITTEE, THE WAYS AND MEANS COMMITTEE AND THE SENATE FINANCE COMMITTEE ALL VOTED TO FORM A MEDICARE COMMISSION. DO YOU SUPPORT THIS AS WELL?**

**A:** We have always indicated our support for a bipartisan process to address the long-term needs of the Medicare program. However, our first goal is to pass the Medicare reforms in the Budget Agreement that will extend the life of the trust fund for at least a decade. We still have lots of work to do on this deal to ensure that we get the provisions agreed to in the Budget Agreement.

A Commission similar to the different approaches outlined in Congress may or may not be the best bipartisan process. We will continue our conversations with the Democrat and Republican Leadership to determine the most advisable course of action.

## AIDS

**Q: WHAT IS YOUR POSITION ON THE MAYORS' RESOLUTION IN SUPPORT FOR FEDERAL FUNDING OF NEEDLE EXCHANGE PROGRAMS?**

**A:** Current law prohibits the Administration from authorizing the use Federal funds for needle exchange programs unless there is conclusive evidence that they do not encourage drug use. Although there is strong evidence that indicates that needle exchange programs help reduce the spread of AIDS, we have not concluded our review on whether these programs increase the use of drugs.

We are consulting with HHS and the Office of National Drug Control Policy in this regard. But once again, we are explicitly prohibited from releasing Federal public health dollars until and unless a formal determination is made that the use of these programs does not increase drug use. It is important to point out that local communities remain can and do use non-Federal funds to support such programs.

**Q: HOW DO YOU RESPOND TO AIDS ACTIVISTS CALL FOR MORE FUNDING OF PROTEASE INHIBITORS FOLLOWING UP THE HHS-ISSUED GUIDELINES LAST WEEK ON AIDS TREATMENT?**

**A:** The Department is reviewing the budget implications of the new treatment guidelines for the AIDS Drug Assistance Programs (ADAP). We are working with states to determine whether our current budget does enough to help states treat those in need. If it becomes clear that there is a severe shortage in this area than we will -- as we always have -- make every effort to address these problems.

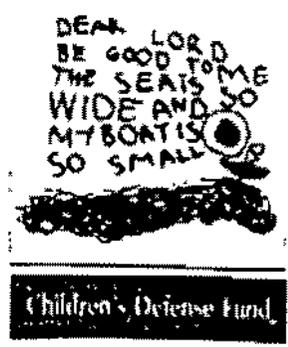
Last year, when we determined we needed more funding for this program to cover the then new protease inhibitor drugs, we sent two budget supplementals to the Hill. My Administration has nearly tripled funding for ADAP since I took office, and my current budget represents an 168 percent increase for Ryan White.

**Q: WHY NOT EXPEND THIS KIND OF ENERGY AND RESOURCES ON A CURE FOR BREAST CANCER OR HEART DISEASE OR DIABETES AS IT SEEMS TO FOR AIDS?**

**A:** This Administration has made a strong improving biomedical research an extremely important priority. We have increased investments in biomedical research at the National Institutes of Health by an impressive 16 percent since the I took office.

These additional investments has been used to increase investments in biomedical research in a number of important areas. For example, funding for breast cancer research has increased by 76 percent since 1993.

*Jean & Sarah  
F4  
Barbara*



**GIVING AMERICA'S CHILDREN A HEALTHY START:**

**HOW THE \$24 BILLION IN THE SENATE RECONCILIATION BILL HELPS UNINSURED CHILDREN IN WORKING FAMILIES**

**Stan Dorn  
Health Division Director**

**Dr. Martha Teitelbaum  
Senior Health Researcher**

**Children's Defense Fund**

**July 3, 1997**

## SUMMARY

The \$24 billion over five years approved by the Senate for children's health insurance represents the most important opportunity to expand child health coverage in many years. A critical question is whether these funds will be well spent to provide good insurance coverage for the largest possible number of uninsured children. Public opinion polls show strong support for raising tobacco taxes to provide health coverage for uninsured children in working families. Strong safeguards, like those in the Senate bill, must be in place to ensure that funds are spent for that purpose.

Some have questioned the need for the additional \$8 billion for children's health insurance that received strong, bipartisan support on the Finance Committee and the Senate floor. It is clear, however, that \$16 billion over five years will take care of only a fraction of uninsured children. More is needed. With the full \$24 billion in the Senate bill, or a greater amount if more tobacco revenues are made available, this country will take a very substantial step towards covering all 10 million of the nation's uninsured children.

## FINDINGS

One key question before Congress is how much money to invest in covering the nation's 10 million uninsured children, 90% of whom have working parents. The Reconciliation bill adopted by the House would allocate \$16 billion in grants to states over five years. By an 18-2 vote in the Senate Finance Committee and an 80-19 vote on the floor, the Senate last week added \$8 billion over that same period, raised by increasing tobacco taxes 20 cents a pack, for a total of \$24 billion over five years. This report looks at what will happen in the year 2002, when the Senate program is fully phased in.

- The \$24 billion in the Senate bill could reach 6.1 million uninsured children, when fully phased in. The \$16 billion originally included in the Senate bill allocated \$3.9 billion in grants for 2002. Even if the rules in the Senate bill apply and states use these funds efficiently and only to provide uninsured children with health coverage, this \$16 billion would cover only 4.0 million otherwise uninsured children. Keeping child health funds approved by the Senate would provide \$2 billion more in grants to states in 2002, so the extra \$8 billion would cover an additional 2.1 million otherwise uninsured children.
- While the \$24 billion in the Senate bill would not cover all uninsured children, it would make a huge down payment on solving the problem of 10 million currently uninsured American children. Congress and the President must ensure that at least \$24 billion remain in the Budget Reconciliation legislation when the bill is signed into law.
- The House bill has no safeguards to assure the \$16 billion will be used for new child health coverage. Therefore it is difficult, if not impossible, to estimate how many children, if any, would be covered by the House bill.

This Special Report assesses how far these different sums could go towards making health coverage available and affordable for every uninsured child. As with any new initiative, it is impossible to foresee its implementation and results with certainty and precision. But we can make estimates based on reasonable assumptions. This Special Report assumes that states do a good job with the basic block grant structure as proposed in the Senate and that the rules work that the Senate put in the bill to keep states from diverting child health dollars away from covering uninsured children. This analysis uses the Senate structure rather than that in the House bill because, under the House bill, it is much easier for states to use federal funds for purposes other than providing health insurance to currently uninsured children.

APPENDIX: TECHNICAL ANALYSIS**1. HOW MANY CHILDREN CAN BE HELPED BY THE BASE \$16 BILLION?**

As part of Budget Reconciliation, both the House and Senate approved two bills: a spending bill and a tax bill. Both the Senate and House spending bills provide \$16 billion in child health block grants to states over five years. The Senate tax bill furnishes an additional \$8 billion for children's health coverage, for a total of \$24 billion. When the \$16 billion in the Senate spending bill is fully implemented in the year 2002, states would receive \$3.9 billion in annual grants. How many children would this cover, if states do an efficient job and do not siphon off funds to other purposes?

The Senate child health bill is complex. Administrative costs, some special program costs, and some particular groups of uninsured children have first claim on the funds:

- **12 months continuing Medicaid eligibility.** Child health coverage appropriations are reduced to compensate for funds spent under the new Medicaid option to provide 12 months continuing eligibility to children who now qualify for Medicaid for only part of the year. CBO projects that this new option would cover 130,000 children. In the year 2002, CBO also projects that federal Medicaid costs per child will average \$900 a year.<sup>1</sup> This analysis accordingly subtracts \$117 million from the funding available for uninsured children.

**Uninsured children eligible for Medicaid.** Under the bill, funding for uninsured children not currently eligible for Medicaid is likewise reduced to the extent outreach activities under the bill increase Medicaid spending by raising enrollment of Medicaid-eligible but uninsured children. Because these children are covered at a lower federal matching rate than the uninsured children for whom remaining appropriations will be spent, a larger estimate of states' success in enrolling Medicaid-eligible uninsured children will increase the total number of uninsured children projected to be covered under a \$16 billion bill. We assume the states will achieve substantial but not implausible success in reaching children eligible for but not enrolled in Medicaid. We assume that the national average percentage of children eligible for Medicaid but not enrolled will move two-thirds of the way towards Vermont, the state with the lowest such percentage.<sup>2</sup> We also assume that, without the Reconciliation bill, the number of eligible but not enrolled children would rise from 3.0 million children in 1995 to 3.2 million children in 2002.<sup>3</sup> Under these assumptions, 1 million eligible but not enrolled children would receive Medicaid

<sup>1</sup> Congressional Budget Office, *January 1997 Baseline: Medicaid* revised February 7, 1997. This document is the source of all our cited CBO projections for future Medicaid costs and enrollment under current law.

<sup>2</sup> *Millions of Uninsured and Underinsured Children are Eligible for Medicaid* (Center on Budget and Policy Priorities 1997). Averaging the high and low ranges reported by the Center, the percentage of eligible but unenrolled children would drop from 35% to 24%, two-thirds of the way towards Vermont's 19%. It will be difficult for many other states to duplicate Vermont's record, given the absence of large urban centers in Vermont, a low immigrant population, and low mobility among Vermont residents. These estimates of unenrolled children may be high, because they are based purely on children's guaranteed income eligibility for Medicaid, as reported by the Census' March Current Population Survey ("CPS"), which many observers believe under-reports Medicaid enrollment; and many of these children in fact may be ineligible for Medicaid because of assets, such as ownership of a car for work, or other factors unrelated to income.

<sup>3</sup> If the 3 million number is projected to rise in proportion to CBO projections of the total number of Medicaid eligibles, it would reach 3.3 million in the year 2002. If it is projected to rise in proportion to Census projections of children's population growth, it would reach 3.1 million. Our 3.2 million estimate averages these two projections.

coverage, at a federal cost of \$900 a child, cutting another \$900 million from the funds available for new coverage of children ineligible for Medicaid under current law.<sup>4</sup>

- **Outreach set-aside.** 1% of the basic allotment fund, which begins at 85% of total appropriations, is set aside to fund increased outreach. We accordingly subtract .85% of the \$3.9 billion, or \$24.5 million, for the outreach set-aside.
- **Funding for the Territories.** The Territories receive .25% of the 85% basic allotment fund. We accordingly subtract .25% of 85% of the total \$3.9 billion allocation, or \$6.1 million, for the Territories.
- **Administrative costs.** We assume that states take advantage of the right the bill grants to take for administrative expenses five percent of the basic allotment fund, less the outreach set aside and funding for the Territories. Assuming that the basic allotment fund continues to comprise 85% of total appropriations, this leaves room for \$121.2 million in administrative costs.
- **5% bonus payments.** The bill provides 5% bonus payments from the basic allotment for each child with family income under 200% of the federal poverty level who was covered in Fiscal Year 1996 as an optional Medicaid beneficiary or under a state child health program. A state receives payments equal to 5% of the cost of covering each such child in future years. Such bonuses do not apply to poor children ages 14-18 after their Medicaid coverage would have been phased in under current law. To derive the number of optional Medicaid eligibles receiving 5% bonus payments, we analyzed data from the March 1996 Current Population Survey ("CPS") and found that 1.8 million children in 1995 were covered by Medicaid and had family incomes below 200% of poverty but above required Medicaid eligibility levels after the above-described phase-in is complete. These levels are: (a) 133% of the federal poverty level for children ages 0 through 5, inclusive; and (b) 100% of poverty for children ages 6 through 18. We estimate that 277,600 children were covered by state programs, based on a recent report by the Alpha Center.<sup>5</sup> To determine 2002 costs per child for optional Medicaid eligibles, we used CBO projections of \$900 in federal costs. Assuming continuation of the current overall federal 57% share of Medicaid costs, that translates into \$1579 in state plus federal costs per child. For non-Medicaid program costs, we assumed they would equal 80% of Medicaid costs (see note 6, below). Based on these assumptions, we concluded that such 5% bonus payments would total \$144.5 million in 2002 for optional Medicaid coverage and \$17.5 million for current state programs.
- **10% bonus payments for caseload growth.** The bill provides 10% bonus payments, above normal federal matching rates, for Medicaid caseload growth among optional eligibles with family incomes below 200% of poverty. We assume that the caseload growth among these children will parallel the growth that CBO projects for Medicaid-covered children as a whole. If so, these 10% bonus payments for caseload growth among optional eligibles will consume an additional \$25.9 million.

After these funds are subtracted, \$2.5 billion remains for grants to cover other uninsured children. In addition to relying on CBO projections of Medicaid costs per child, we make the following assumptions about how many children these funds will reach:

<sup>4</sup> The bill provides that funds are also subtracted based on the number of poor children ages 14-18 who receive coverage earlier than mandated under current law, which phases in their coverage through the year 2002. This factor is not relevant to this analysis, which applies to the year 2002, when their coverage is required under current law.

<sup>5</sup> Gauthier and Schrodel, *Expanding Children's Coverage: Lessons from State Initiatives in Health Care Reform* (Alpha Center May 1997) Table 9, p. 27. Most of the children covered by the programs listed in the Alpha Center's analysis are covered through Medicaid, including through the Hawaii QUEST waiver, MinnesotaCare, RiteCare, TennCare, Vermont's Dr. Dinosaur program, and Washington's Basic Health Plus program.

- **Most states will choose the block grant.** The bill gives states a choice between taking their increased funding in the form of a block grant or expanding their Medicaid programs. Few states will be likely to take the Medicaid option, since the block grant offers them more flexibility and less accountability. Accordingly, we assume that 85% of the uninsured children benefiting from this program (not counting the Medicaid children described above) will live in block grant states and that block grant costs per child will average 80% of Medicaid costs. The latter estimate is consistent with much information emerging from surveys of private insurance and state-level child health programs that offer benefits less comprehensive than those covered by Medicaid and more like those now in the Senate bill.<sup>6</sup> We note, however, that further improving the benefits package in the Senate bill could make an enormous difference for a small number of children with special health needs, increasing average costs per child only slightly, and therefore having only a slim impact on the total number of covered children.
- **Many families will make small premium payments.** Studies report that when low and moderate income families are asked to make more than nominal premium payments, few seek coverage.<sup>7</sup> There simply is very little room for health insurance payments in the budgets of low-wage, working families. Affordability protections in the Senate bill thus limit the amounts that must be paid to cover uninsured children in low-wage, working families with incomes below \$19,950 a year for a family of three (150% of the federal poverty level). Accordingly, we assume that, on average, families will pay 10% of premium costs, with the federal and state governments paying the remainder. This acknowledges that, while some families will pay nothing, others with coverage will pay modest amounts.

Under these assumptions, 4.35 million children would be covered under the \$16 billion bill, including 1 million Medicaid-eligible children not previously enrolled in the program and 130,000 children receiving 12 months of continuous Medicaid coverage. However, some of these children may simply shift over from private insurance. The so-called "crowd-out" problem – the risk that public subsidies may cause cuts in employer-based insurance and pull previously insured children into the public program – is much debated. The General Accounting Office ("GAO") found the academic literature inconclusive, with three of five studies finding no crowd-out effect.<sup>8</sup> Minnesota has had a strong child health program in effect since the 1980s, yet the state now has the third broadest private health coverage of children in the country.<sup>9</sup> The study CBO cites for its analysis of crowd-out concerned pregnant women, not children, and noted that, in fact, much of the effect attributed to crowd-out could result from ongoing declines in dependent coverage offered and funded by employers that are related to general employer cost-cutting and unrelated to state Medicaid expansions.<sup>10</sup>

<sup>6</sup> According to data from the Urban Institute and the Council for Affordable Health Insurance, the typical cost of children's private health insurance averages 83% of Medicaid acute care costs for children. Gauthier and Schrodell, *supra*, p. 23. In part this is because Medicaid children on average have greater health problems than do children with private insurance. State programs offering broad benefits less than the fully comprehensive Medicaid package have costs per child that range up to 89% of Medicaid costs. *Id.* Many state programs, such as those not covering inpatient hospital care or other services, cost much less.

<sup>7</sup> Marquis and Long, "Worker Demand for Health Insurance in the Non-Group Market," *Journal of Health Economics*, vol. 14, no. 1 (May 1995), pp. 47-63, cited by CBO, *Statement of Linda T. Bilheimer on Proposals to Expand Health Coverage for Children before the Subcommittee on Health, Committee on Ways and Means* (April 8, 1997) p. 9.

<sup>8</sup> General Accounting Office, *EMPLOYMENT-BASED HEALTH INSURANCE: Costs Increase and Family Coverage Decreases* (GAO/HEHS-97-35 February 1997) pp. 21-22.

<sup>9</sup> Data from 1994-1996 March CPS, averaging the percentage of children under age 18 with private health insurance in each state over the three-year period from 1993-1995.

<sup>10</sup> Dubay and Kenney, "Did Medicaid Expansions for Pregnant Women Crowd Out Private Coverage," *Health Affairs*, vol. 16, no. 1 (January/February 1997), at p. 186, cited in CBO, *Statement of Linda T. Bilheimer, supra*, p. 11. This

Among the five key crowd-out studies cited by GAO, we base our analysis on neither the three studies finding no crowd out nor on the study finding the largest degree of crowd-out,<sup>11</sup> but rather on an Urban Institute study focused on children that found some modest crowd-out. This Urban Institute study found that, during the period of Medicaid expansion with no measures to prevent crowd-out, 22% of newly covered children in low-wage, working, near-poor families may have shifted from private to public coverage.<sup>12</sup> Both the House and Senate bills require states to take some measures to prevent losses in employer coverage. This analysis assumes that states could cut crowd-out rates to 11%, half of what they may have been without any anti-crowd out measures. This means that 350,000 of the 4.35 million children covered under the bill would have been covered previously by private insurance, leaving 4.0 million uninsured children covered through the \$16 billion in the base bill.

## 2. HOW MANY CHILDREN WILL BE ADDED BY THE PROCEEDS FROM THE TOBACCO TAX?

The additional \$8 billion in tobacco tax funds the Senate reserved for children's health coverage adds \$2 billion to the 2002 allocation. Using the above-described methodology, these funds would cover an additional 2.1 million uninsured children.<sup>13</sup> Altogether, the \$24 billion would cover 6.1 million uninsured children.

---

study, unlike the study by the same authors on which this analysis bases its crowd-out estimates, analyzes pregnant women. There are many reasons why pregnant women might be more likely than children to lose private insurance coverage. For example, some women lose their jobs when they become pregnant.

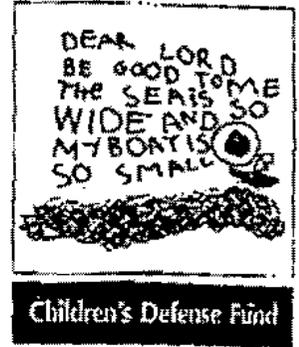
<sup>11</sup> Cutler and Gruber, "Medicaid and Private Insurance: Evidence and Implications," *Health Affairs*, vol. 16, no. 1 (January/February 1997), pp. 185-193, which has received some criticism. See, e.g., Swartz, "Medicaid Crowd Out and the Inverse Truman Bind," *Inquiry* (Spring 1996) pp. 5-8.

<sup>12</sup> Dubay and Kenney, "The Effects of Medicaid Expansions on Insurance Coverage of Children," *The Future of Children*, vol. 6, no. 1 (Spring 1996), pp. 152-161.

<sup>13</sup> With the higher grant amount, the following numbers change: outreach funds reach \$41.5 million; funding for the Territories rises to \$10.4 million; and administrative costs reach \$205.3 million, leaving \$4.4 billion to cover 6.7 million children. 600,000 of these children would have shifted over from private coverage, leaving 6.1 million previously uninsured children obtaining coverage.

## MEMORANDUM

To: Gene Sperling  
 From: Marian Wright Edelman  
 Date: July 2, 1997  
 Re: Assuring a Real Child Health Coverage Victory in Conference



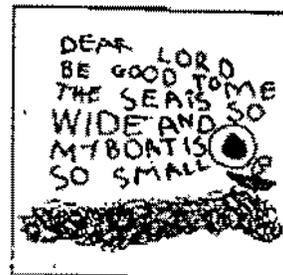
I'm pleased the President has said that the revenues from the 20 cent tobacco tax should go to real child health coverage and children, and that the Administration worked in the Senate to improve the benefits and cost-sharing provisions for children. While there are many important points to work on in the House-Senate Conference to assure that the maximum number of uninsured children is covered, I hope that the Administration will agree and insist on the four steps below as absolutely essential to create a program that takes a giant step toward making real insurance affordable for all 10 million uninsured children:

- 1) Preserve a tobacco tax of at least 20 cents and devote at least \$8 billion of its revenues to child health, in addition to the \$16 billion for child health coverage in the original budget agreement. As you know, paying for children's coverage through a tobacco tax protects children's health twice. Since the variation from the budget agreement requires bipartisan approval, we hope the White House will exert very strong leverage to make sure at least \$8 billion of the proceeds go to child health, and that the rest goes to the other needs of non-affluent children. In addition, the Senate provision that continues the tobacco tax beyond five years but ends the child health funding from that tax must be fixed: the added children's health coverage funding must continue in the out-years along with the funding source.
- 2) Assure that the \$24 billion is spent on health insurance for uninsured children, and there are no loopholes that would allow funds to be siphoned off. These funds should not be available to cover children already insured by optional state Medicaid or other programs, and should not be available for purposes other than providing insurance to new children. The Bipartisan Budget Agreement provides for covering "uninsured" children in the most "cost-effective" manner possible. Avoiding the diversion of funds to purposes other than insurance or to children other than the uninsured would be inconsistent with that agreement. In order to allow states that have already expanded coverage to make the best use of the funds for their own still-uninsured children, the Senate's 200 percent of poverty cap on who is eligible should be lifted, but states should be required to use funds for the lowest-income children first.
- 3) Assure that there is the full range of benefits children need. Coverage for both preventive care and appropriate specialty care is essential. The addition of vision and hearing care in the Senate was an important step. We need to hold onto the Senate package and improve special needs coverage.
- 4) Assure that benefits are affordable, with reasonable premiums and cost-sharing. The Senate bill protects children under 150 percent of poverty.

With these steps, we can achieve a remarkable children's health victory in 1997 and avoid the diversion of taxpayer dollars from urgent and solvable national needs. All of us need to see that government can in fact efficiently and that crucial social problems like lack of child health insurance can be solved.

Please call me at 662-3500 or Jim Weill at 662-3561 if you have any questions.

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



Children's Defense Fund

## MEMORANDUM

**TO:** Gene Sperling  
**FROM:** Marian Wright Edelman  
**DATE:** June 23, 1997  
**RE:** **Bringing Our Children's Health Boat to Safe Harbor: Achieving a Real Child Health Coverage Victory and Legacy**

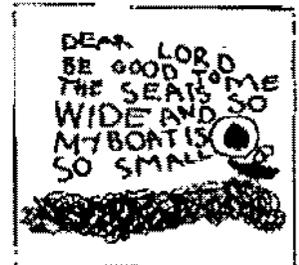
That the child health coverage debate has garnered bipartisan and national attention offers both great hope and danger to children. Any \$16 or \$24 billion investment could make a great leap forward for children's health, but only if the funds are not hijacked into a governors' slush fund so flexible that they can be diverted away from child health insurance for other state needs, or can be used to supplant funds currently being spent to insure 4 1/2 million optional Medicaid children, or erode the benefit package children get or the cost-sharing their families can afford.

At a minimum, I hope the Administration will do whatever is necessary to ensure that new monies go to cover children not currently covered or who are eligible but not receiving the help they need. No child should lose the coverage they currently have. What a tragedy if \$16 - \$24 billion resulted in billions going for purposes other than child health insurance, millions of children getting less benefits and protection, and millions fewer uninsured children getting coverage than the money should reach, yet the public wrongly believing a solvable problem has been solved.

Children -- not governors -- should be the prime beneficiaries of a new child health initiative.

MWE/emb  
hillary.doc

*Bob see how*



Children's Defense Fund

July 2, 1997

The Honorable William Jefferson Clinton  
President of the United States  
The White House  
1600 Pennsylvania Avenue  
Washington, D.C. 20500

Dear President Clinton:

I am writing to express appreciation for your recent positive statements regarding children's health insurance, and to request a meeting with you on behalf of the Coalition for Children's Health Insurance to discuss priorities for ensuring that the child health part of the House-Senate conference on Reconciliation reaches the greatest number of children in the most efficient way. Since the conferees will begin meeting as early as next week, we hope to schedule our appointment with you no later than July 5, 1997.

Representatives from child advocacy, tobacco control, health, religious, seniors', and women's organizations will be present at this meeting, along with the coalition's co-convenors, the American Cancer Society, and the American Nurses Association.

I look forward to discussing with you this opportunity we have to make a giant step toward insuring all of America's uninsured children. I will ask my staff to call your staff to follow up.

7/3/97

*Send to Scheduling*

*Yes*

*no*

Sincerely yours,

Marian Wright Edelman  
President  
Children's Defense Fund

# Campaign for **CHILD Health Now**

## Supporters

Action on Smoking and Health  
 Advocacy Foundation for Women & Children  
 Advocates for Children and Youth, Inc.  
 Advocates for Youth  
 African American Women's Clergy Association  
 Alliance for South Carolina Children  
 Alliance to End Childhood Lead Poisoning  
 Alpha Phi  
 American Academy of Child & Adolescent Psychiatry  
 American Academy of Family Physicians  
 American Academy of Neurology  
 American Association for Health Education  
 American Association for Respiratory Care  
 American Association of Educational Service Agencies  
 American Association of Family & Consumer Sciences  
 American Association of Psychiatric Services for Children  
 American Association of Retired Persons (AARP)  
 American Association of School Administrators  
 American Association of University Women  
 American Cancer Society  
 American College of Chest Physicians  
 American Federation of Teachers, AFL-CIO  
 American Federation of State, County, and Municipal Employees  
 American Heart Association  
 American Lung Association/American Thoracic Society  
 American Medical Association  
 American Medical Women's Association  
 American Muslim Council  
 American Network of Community Options & Resources  
 American Nurses Association  
 American Psychiatric Association  
 American Public Health Association  
 American Society of Addiction Medicine  
 American Society of Clinical Oncology  
 American Speech-Language-Hearing Association  
 Americans for Democratic Action  
 Appalachian Office of Justice & Peace  
 Arkansas Disability Coalition  
 Asian & Pacific Islander American Health Forum  
 Association for Supervision & Curriculum Development  
 Association for the Care of Children's Health  
 Association of Asian Pacific Community Health Organizations  
 Association of Community Organizations for Reform Now  
 Association of Schools of Public Health  
 Association of Women's Health, Obstetric, and Neonatal Nurses  
 Atlanta Women's Fund  
 Avance Family Support and Education Program  
 Bazelon Center for Mental Health Law  
 Ben & Jerry's Homemade, Inc.  
 Boy Scouts of America & Girls Clubs of Greater Washington  
 Board for the City and Zachaeus Free Clinic, Inc.  
 Business and Professional Women/USA  
 Capitol Hill Group Ministry  
 Catholic Community Services  
 Child Development Unit - The Children's Hospital  
 Child Watch of Jacksonville, Florida  
 Child Welfare League of America  
 Children First For Oregon  
 Children Now  
 Children at Risk  
 Children's Action Alliance  
 Children's Alliance  
 Children's Defense Fund  
 Children's Health Fund  
 Children's Health Program  
 Children's Home Society of Virginia  
 Children's Hospital of Pittsburgh  
 Children's Trust Fund  
 Citizens' Committee for Children of New York, Inc.  
 Citizens for Missouri's Children  
 Citizenship Education Fund  
 Coalition on Human Needs  
 Committee for Children  
 Communications Workers of America, AFL-CIO  
 Connecticut Association for Human Services  
 Connolly Consulting  
 Consortium for Citizens With Disabilities - Health Task Force  
 Council of Chief State School Officers  
 Council of the Great City Schools  
 DC Action for Children  
 Dade County Children's Services Council  
 Disability Rights Education & Defense Fund  
 Division for Early Childhood of the Council for Exceptional Children  
 Ebenezer Baptist Church  
 End Hunger Network  
 Episcopal Church  
 Evangelical Lutheran Church in America - Lutheran Office for Governmental Affairs  
 Families USA  
 Family Voices  
 Federation for Children With Special Needs  
 Federation for Citizens with Special Needs  
 Federation of Families for Children's Mental Health  
 Friends Association for Children  
 Garrett County Commission for Women  
 General Federation of Women's Clubs  
 Generations United  
 Georgia Council on Child Abuse  
 Girl Scouts USA  
 Gray Panthers  
 Health Access California  
 Hermanos y Hermanas Mayores

## HATCH-KENNEDY CHILD LEGISLATION, S.525 AND S.526

### Supporters

The HMO Group  
 Human Rights Campaign  
 I CAN! America  
 Indiana Health Centers, Inc.  
 Institute for Child Health Policy  
 Institute for Family-Centered Care  
 InterHealth  
 International Federation of Professional & Technical Engineers  
 Islam Community Relations  
 Jack and Jill of America, Inc.  
 Jesse D. Bland Outreach Ministry  
 Jewish Council for Public Affairs  
 Jewish Women International  
 Julie Community Center, Inc.  
 Justice for All  
 Kids Project  
 Latino Council on Alcohol & Tobacco  
 League of Women Voters of the U.S.A.  
 League of Women Voters (Iowa)  
 League of Women Voters (Virginia)  
 Legal Services of Northern Virginia and the Law Center for  
 Children  
 Lincoln Congregational Temple U.C.C.  
 Maine Children's Alliance  
 Maine Women's Lobby  
 Massachusetts Advocacy Center  
 Massachusetts Campaign for Children  
 Massachusetts Medical Society  
 Maternal and Child Health Committee  
 Memorial Child Guidance Clinic  
 Michigan Head Start/Early Childhood Program  
 Mississippi Forum on Children and Families  
 MultiCultural Family and Youth Foundation  
 Multiple Exceptionalities and Needs Support Group  
 National Alliance to End Homelessness  
 National Association for HomeCare  
 National Association of Child Care Resource & Referral  
 Agencies  
 National Association of Children's Hospitals  
 National Association of Commission for Women  
 National Association of Community Health Centers  
 National Association of County and City Health Officials  
 National Association of Developmental Disabilities Councils  
 National Association of Hispanic Nurses  
 National Association of Minority Political Families, USA, Inc.  
 National Association of Negro Business & Professional  
 Women's Clubs, Inc.  
 National Association of People with AIDS  
 National Association of Public Hospitals & Health Systems  
 National Association of School Nurses  
 National Association of School Psychologists  
 National Association of Social Workers  
 National Black Caucus of State Legislators  
 National Black Child Development Institute

National Black Police Association  
 National Center for the Early Childhood Work Force  
 National Center for Tobacco-Free Kids  
 National Coalition of Hispanic Health and Human Services  
 Organizations, COSSMHO  
 National Committee to Preserve Social Security and Medicare  
 National Community Action Foundation  
 National Community Education Association  
 National Council for Community Behavioral Healthcare  
 National Council of Jewish Women  
 National Council of Negro Women  
 National Council of the Churches of Christ in the USA  
 National Council on Family Relations  
 National Council on the Aging  
 National Down Syndrome Society  
 National Easter Seal Society  
 National Education Association  
 National Family Planning and Reproductive Health Association  
 1199, National Health & Human Service Employees Union,  
 AFL-CIO  
 National Latino/a Lesbian & Gay Organization  
 National Mental Health Association  
 National Office of Jesuit Social Ministries  
 National Parent Network on Disabilities  
 National Parent Teacher Association  
 National Puerto Rican Coalition  
 National Smoking Cessation Campaign for  
 African-American Women  
 National Tuberculosis Association  
 National Urban League, Inc.  
 National Women's Law Center  
 NETWORK: A National Catholic Social Justice Lobby  
 New Mexico Advocates for Children & Families  
 Oncology Nursing Society  
 Parent Network For Children with Disabilities  
 Pennsylvania Partnerships for Children  
 People Inc. of Southwest Virginia  
 Philadelphia Citizens for Children & Youth  
 Prevent Child Abuse, Virginia  
 Ready at Five Partnership  
 Regional Addiction Prevention, Inc.  
 Religious Action Center of Reform Judaism  
 Robert F. Kennedy Memorial  
 Rochester Area Children's Collaborative  
 Rosemount Parent Policy Committee  
 Salt Lake Community Action Program  
 School Social Work Association  
 Seeds Magazine  
 Service Employees International Union, AFL-CIO  
 Social Responsibility Committee, Towson Unitarian Universalist  
 Church  
 Spina Bifida Association of America  
 Stand For Children in Tulsa Committee  
 Sunrise Center, Inc.

## HATCH-KENNEDY CHILD LEGISLATION, S.525 AND S.526 Supporters

Warrent County Youth Collaboration

The Arc

Tucson Association For Child Care, Inc.

Tulsa Area Child Abuse Coalition (OK)

Union of American Hebrew Congregations

United Auto Workers, AFL-CIO

United Cerebral Palsy

United Food and Commerical Workers Union, AFL-CIO

United States Association for Child Care

University of Illinois at Chicago, School of Public Health

Vermont Campaign to End Child Hunger

Vermont Children's Forum

Virginia Interfaith Center for Public Policy

Virginia Poverty Law Center

Voices for Children in Nebraska

Voices for Illinois Children

Washington Ethical Action Office, American Ethical Union

Washington Legal Clinic for the Homeless

Women Work! The National Network for  
Women's Employment

Women's Child Support Assistance

Women's Legal Defense Fund

Women's Missionary Society of the A.M.E. Church

Yellow Springs Community Children's Center

Young Mother's Educational Development

*July 2, 1997*

# A Brief Biography of Marian Wright Edelman



Children's Defense Fund

What's New!

More about CDF

A Voice for Children  
by Marian Wright Edelman

Issues

News and Reports

The Black Community Crusade for Children

Stand For Children

Links

Site map



Marian Wright Edelman, founder and president of the Children's Defense Fund (CDF), has been an advocate for disadvantaged Americans for her entire professional career. Under her leadership, the Washington-based CDF has become a strong national voice for children and families. CDF's mission is to educate the nation about the needs of children and encourage preventive investment in children before they get sick, drop out of

school, suffer too-early pregnancy or family breakdown, or get into trouble. On the eve of a new century and millennium, CDF seeks to ensure that no child is left behind and that every child has a Healthy Start, a Head Start, a Fair Start, a Safe Start, and a Moral Start in life with the support of caring parents and communities.

Mrs. Edelman, a graduate of Spelman College and Yale Law School, began her career in the mid-60s when, as the first black woman admitted to the Mississippi Bar, she directed the NAACP Legal Defense and Educational Fund office in Jackson, Mississippi. In 1968, she moved to Washington, D.C., as counsel for the Poor People's March that Dr. Martin Luther King, Jr., began organizing before his death. She founded the Washington Research Project, a public interest law firm and the parent body of the Children's Defense Fund. For two years she served as the Director of the Center for Law and Education at Harvard University, and in 1973 began CDF.

Mrs. Edelman has received many honorary degrees and awards including the Albert Schweitzer Humanitarian Prize, the Heinz Award, and was a MacArthur Foundation Prize Fellow. She served on the Board of Trustees of Spelman College, which she chaired from 1976 to 1987. She is the author of several books, including *Families in Peril: An Agenda for Social Change*, *The Measure of Our Success: A Letter to My Children and Yours*, and a new 1995 book, *Guide My Feet: Meditations and Prayers on Loving and Working for Children*.

Marian Wright Edelman is married to Peter Edelman, a Professor at Georgetown Law School. They have three sons: Joshua, Jonah, and Ezra.

| [What's New](#) | [More about CDF](#) | [A Voice for Children](#) | [Issues](#) | [News and Reports](#)  
| [The Black Community Crusade for Children](#) | [Stand For Children](#) | [Publications](#) |  
[Links](#) | [Site Map](#) |



All graphics, text, and data © 1997 Children's Defense Fund  
Please report site problems to Webmaster, Children's Defense Fund



WORK | Getting there | Ask biz shrink | 100 best companies



women's wire **profile**

## Children's advocate Marian Wright Edelman



**Profession:** Founder & prez of the Children's Defense Fund, a privately funded children's advocacy group.

**Annual budget:** \$14 million.

**The basic story:** Feisty, fast-talking, tireless crusader for kids. Through the Children's Defense Fund, organized the Stand for Children march on Washington, D.C., which drew 200,000+ people to Washington last June. Recently, she publicly criticized long-time friend President Clinton for signing a bill cutting welfare benefits, saying that it makes a "mockery" of his professed advocacy for kids.

---

**Born:** June 6, 1939, in Bennettsville, S.C., the youngest of five children of a Baptist minister.

**Education:** B.A., Spelman College, 1960; J.D., Yale Law School, 1963.

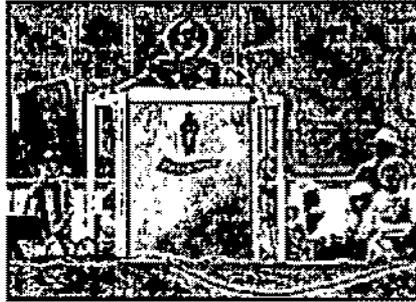
**The way up:** Just out of law school in 1964, she opened and ran the Mississippi office of the NAACP Legal Defense and Education Fund. She brought then-New York Senator Robert F. Kennedy to the homes of poor Mississippians in a successful quest to draw attention to the

"I love going to  
Harvard Law  
School and

seeing kids who started out in Headstart."

in a successful quest to draw attention to the problem of hunger and make federal food stamps free.

**What next:** Helped Martin Luther King Jr. plan the Poor People's March on Washington, which took place after his death, and in the process formed the Washington Research Project, a public interest law firm. It in turn started the Children's Defense Fund in 1973.



**On how things have changed:** "We now take it for granted that children who are mentally, physically and emotionally challenged go to school," Edelman says. "I love going to Harvard Law School and seeing kids who started out in Headstart."

**The march:** While critics called the Stand for Children march a defense of big government, Edelman says, "It wasn't about big government, it was about a just government. We ought to hold the Defense Department to the same standards of effectiveness and need as we do Headstart. We have to stop the slogans."



**On family values:** "We talk about family values, but then we make it very hard for parents to care for their children. And then we say, 'Don't go on welfare! All you middle class women, don't work and neglect your children!'"

**Web site:** The Children's Defense Fund organized the Stand for Children in part on the Net. The march gained the support of 3,700 organizations.

**Household:** Husband Peter Edelman is the assistant secretary for planning and evaluation in the department of Health and Human Services and a former Robert F. Kennedy staffer, whom she met when RFK came to Mississippi. They have three sons, Joshua, 26, Jonah, 24, and Ezra, 21. Her best-selling book, "The Measure of Our Success," was born of a letter she wrote to Joshua on his 21st birthday.

**Balancing work & family:** "Parenting is such a hard job. I know how hard it was for me to hang on with a husband, a good job and healthcare. I don't know what I would have done had I been a single parent."

**On her reputation:** "I know people talk about my not being willing to compromise. On the other hand I don't know what middle ground there is between immunizing a child and not immunizing a child. Between children dying from guns and not. If that's self-righteous or holier than thou, then sorry."

---

--Jonathan Sapers

Posted: 8/7/96

**more  
profiles**

Any comments? Tell us. Who else would you like to see profiled here?

---

Guide | Search | Chat



Copyright © 1996 Wire Networks, Inc. All rights reserved.