TO: The First Lady

FROM: Neera Tanden

DATE: March 8, 1998

RE: Additional Background on New Report on Children's Health Insurance in America

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HHS' Agency for Health Care Policy and Research will release a new source book, titled *Children's Health 1996*, tomorrow. This report on the status of children's health in America in 1996 provides new, more accurate information than was previously available. The data we have used up to this point for 1996 has been based on Census Data -- specifically, the Current Population Survey -- which was released last year. However, because the data that will be released tomorrow is more precise, it should form the basis of our understanding of this problem for future debates.

Key findings of the report:

- In 1996, 3.3 million children age 12 and under (almost 20% of all eligible children) and more than 1 million children age 13 and over -- 4.3 million overall -- were eligible for Medicaid, but not enrolled. (We have previously stated that only three million children are eligible for Medicaid but not enrolled.)
- Nearly 11 million children were uninsured throughout the first half of 1996. These children represent 15.4% of all children in the United States. (We have previously cited 10 million as the number of children uninsured in America.)
- Of all children uninsured throughout the first half of 1996, about 90% were in households with a working adult.
- 52.8% of children enrolled in Medicaid are living in households with at least one working adult.
- Children aged 13 to 17 years are nearly three times less likely to have a usual source of health care, compared with children five and under.

This data indicates that the Administration's efforts to expand insurance coverage for children are more important than ever. In particular, this data adds urgency to the President's FY 99 budget request of $900 million over five years for an outreach initiative which will enroll more children in Medicaid.

Data Sources:
The estimates presented in this report are drawn from the Medical Expenditure Panel Survey (MEPS). MEPS is a nationally representative survey that collects detailed information on health status, health care use and expenses, and health insurance coverage of individuals and families.

Note:
Some of the above data has been incorporated into your speech before the Association of Maternal and Child Health Programs' Annual Meeting.

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John K. Iglehart
Founding Editor

Project HOPE
Publisher

HEALTH AFFAIRS

7500 Old Georgetown Road
Suite 600
Bethesda, Maryland 20814-6133
Phone: 301.656.7401
Fax: 301.654.2845
E-mail: healthaffairs@projhope.org

For more information, contact:
Linda Loranger, 301-652-1558

HOLD FOR RELEASE WITH A.M. PAPERS
March 9, 1998

NEW STUDY: CHILDREN'S HEALTH PROBLEMS LINKED TO RACE, ETHNICITY, EDUCATION AND EMPLOYMENT

Lack of Health Insurance Not The Only Problem

Hispanic Children Far More Likely Than Others to be Uninsured And in Fair or Poor Health

WASHINGTON, D.C. -- Lack of insurance is not the only critical issue affecting children's health care. A new study published today in the journal *Health Affairs* shows that health problems among children are strongly linked to such socioeconomic factors as race and ethnicity and the education and employment status of their parents. Hispanic children, children whose parents have little education, and those living in families without an employed parent are more likely than other children to have health problems, study researchers found.

The study, conducted by the federal government's Agency for Health Care Policy and Research (AHCPR), sheds new light on issues surrounding children's health insurance coverage, access to care, and health status. Despite various policy initiatives, 11 million children in this country are without any health insurance coverage at all, and nearly three million are reported to be in fair or poor health, the study researchers noted. Children are defined as those under age 18.

The study found that Hispanic children are far more likely than children of other racial and ethnic groups to be uninsured, lack a usual source of care, and to be in fair or poor health. In addition, children whose parents have little formal education are very unlikely to have private insurance, and more than one-quarter of them are uninsured. These children also are more likely to lack a usual source of health care and to be in worse health than children whose parents are more educated. Finally, children with no employed parents are heavily dependent on public insurance coverage and are significantly more likely to be in fair or poor health than children with one or two employed parents.

(More)

"A significant number of children in the United States have serious problems with health insurance coverage, access to care, and overall health status," lead study author Robin M. Weinick noted. She and her colleagues describe the segments of the population to which new initiatives aimed at improving children's health may be targeted.

The study, which relies on data from the Medical Expenditure Panel Survey, could prove to be an important benchmark in helping to determine if the recently established State Children's Health Insurance Program (CHIP) will be able to help the children most in need. The $24 billion program is designed to insure children who would otherwise not have coverage by providing funds for states to expand Medicaid or to establish new programs.

Among the study's specific findings:

- Hispanic children are most likely to be uninsured (27.7 percent, compared with 17.6 percent of blacks and 12.2 percent of whites), while black children are most likely to have public insurance only (40.8 percent, compared with 32.5 percent of Hispanic and 13.1 percent of white children). Hispanic children are also mostly likely to be without a usual source of health care (17.2 percent), and black children (12.6 percent) are more likely than white children (6.0 percent) to lack a usual care provider.

- Children whose parents have more than 12 years of education are most likely to have private insurance (80.7) percent) and least likely to be uninsured (10.1 percent). Children whose parents have fewer than 12 years of education are least likely to have private insurance (21.4 percent), most likely to be uninsured (28.5 percent), and much more likely to lack a usual source of care (16.6 percent).

- Children living with two employed parents are the most likely to have private insurance (83.0 percent) and the least likely to be uninsured (11.4 percent). Children in families without any working parents are least likely to have private insurance (7.7 percent) but the most likely to have public insurance (76.5 percent).

- Hispanic children are most likely to be in fair or poor health (7.8 percent), while white children are most likely to be in excellent health (55.3 percent). Children whose parents have more than 12 years of education are most likely to be in excellent health (59.1 percent), and those whose parents who have fewer than 12 years of education are most likely to be in fair or poor health (8.6 percent). Children in families with no working parents are less likely to be in excellent health (37.9 percent) than those in families with either one (52.1 percent) or two (55.8 percent) working parents.

(More)

The study is based on data from AHCPR's Medical Expenditure Panel Survey (MEPS), the most comprehensive survey of health care in the United States. By analyzing survey data related to children's health, the study researchers sought to document recent evidence concerning children's health care and to provide a baseline for evaluating the results of new health care policies and programs for children.

MEPS is unparalleled in the level of detail and breadth of information it provides about the U.S. health care system. Unlike other surveys used for analyses of health insurance coverage in the United States, MEPS provides the linked information necessary to examine the relationships among health insurance, use and expenditures, access to care, and other health care-related topics. Data for the ongoing survey are collected via five in-person interviews with one or more persons per household, who report on the health care experiences of the entire family over a two-year period.

Health Affairs is a bimonthly multidisciplinary journal devoted to publishing the leading edge in health policy thought and research. Copies of the March/April issue will be provided free to interested members of the press. Copies are available to the public for $25 each from Judie Tucker at *Health Affairs*, 7500 Old Georgetown Road, Suite 600, Bethesda, Maryland 20814.

Health Affairs is published by *Project HOPE*. Established in 1958, *Project HOPE* is an international nonprofit health education foundation providing health policy research and analysis, training for health care professionals, and consultation in health systems planning and development. *HOPE* is now working on five continents – including North America – to enable communities to find lasting solutions to health problems.

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March 5, 1998

HHS Media

ADVISORY

Health correspondents note:

Two items related to availability of health insurance will be issued by HHS agencies next week:

A new report will indicate variations in the availability of employer-sponsored insurance by state, ranging from 86 percent of private sector employees in Hawaii offered health insurance, to 40 percent in Montana. The information (1993 data) is drawn from the National Employer Health Insurance Survey. HHS agencies sponsoring the survey were the National Center for Health Statistics (part of the Centers for Disease Control and Prevention), the Agency for Health Care Policy and Research, and the Health Care Financing Administration. For information call Sandra Smith, Jeff Lancashire or Mary Jones at NCHS, (301) 436-7551.

A new chartbook will be available from the Agency for Health Care Policy and Research, Children's Health 1996. Data for the chartbook are drawn from AHCPR's 1996 Medical Expenditure Panel Survey. Information includes number and characteristics of children without health insurance, as well as other child health information. A companion article is being published in the March/April edition of Health Affairs. For information, call AHCPR, (301) 594-1364 -- Karen Carp (x1378) or Venese DeJernett (x1317).

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P.02

Children's Health 1996

MEPS Chartbook No. 1

Margaret E. Weigers, Ph.D.

Robin M. Weinick, Ph.D.

Joel W. Cohen, Ph.D.

Health Insurance **Access to Care** **Health Status**

MEPS
Medical Expenditure Panel Survey
Agency for Health Care Policy and Research

06-98 03:04P AHCPR

OFFICE OF SCIENCE AND TECHNOLOGY POLICY
Science Division
Executive Office of the President
436 Old Executive Office Building
Washington, DC 20502

202-456-6130
202-456-6027 (FAX)

FAX TRANSMITTAL SHEET

DATE: 2/24/98

TO: Neera Tanden

PHONE NUMBER: 6-6275

FAX NUMBER: 6-2878

FROM: Daniel Goroff

NUMBER OF PAGES (INCLUDING COVER SHEET):

Enjoy!

-D.

EMBARGOED UNTIL 11AM 2/24/98

UNITED STATES DEPARTMENT OF EDUCATION

WASHINGTON, D.C. 20202

TIMSS 12TH GRADE RESULTS SHOW NEED TO BUILD A STRONG FOUNDATION, SET HIGHER STANDARDS, REQUIRE TOUGHER COURSES, AND ENSURE WELL-PREPARED AND EFFECTIVE TEACHERS

TIMSS RESULTS SHOW UNACCEPTABLY POOR U.S. PERFORMANCE. The Third International Mathematics and Science Study (TIMSS) compared the mathematics and science achievement of a half-million students from 41 countries at 4th, 8th and 12th grade. Prior TIMSS reports showed that U.S. students performed relatively well at 4th grade -- above the international average in both mathematics and science, and in science outperformed only by Korea. U.S. students' relative standing declined by 8th grade, to only slightly above the international average in science and below the international average in mathematics. One reason is that while most students in grades 4-8 in other nations are studying the beginning concepts of algebra, geometry and other topics, U.S. students continue to be taught primarily arithmetic.

Today's release of 12th grade results shows that U.S. students' standing relative to other TIMSS countries continues to decline in the high school years. A comparison of U.S. 12th graders' general mathematics and science knowledge to students in 20 other nations shows that our students scored below the international average in both topics and exceeded the performance of only two nations. A separate examination of advanced mathematics and physics comparing our students taking pre-calculus or calculus and our students taking physics with advanced mathematics and physics students in other nations shows that the performance of our advanced students is among the lowest of countries participating in TIMSS. The bottom line is that it appears that U.S. standards of achievement, testing and teaching in mathematics and science are far too low in middle and high schools.

* **BUILD A STRONG FOUNDATION IN THE MIDDLE GRADES: $60 MILLION TO IMPROVE MATHEMATICS ACHIEVEMENT IN THE MIDDLE GRADES.** The President's budget requests approximately $60 million for the U.S. Department of Education (ED) and the National Science Foundation (NSF) to implement an Action Strategy to support local efforts to put in place the rigorous courses and effective teaching that will build a strong foundation in the middle school years. This joint initiative will provide high quality information and technical assistance to communities wishing to select and implement rigorous instructional materials based on challenging standards. It will promote improved mathematics teaching of elementary and middle school teachers by supporting teacher networks and effective teacher training models and materials that help teachers upgrade their content knowledge and learn how to teach for conceptual understanding while still ensuring mastery of the basics of computation. It will maximize existing federal resources via joint Education and NSF capacity-building grants to jumpstart efforts in 200-300 school districts to significantly improve the quality of mathematics instruction in the middle school years. And, it will promote public understanding of the importance of challenging middle school mathematics through a national effort to engage parents and communities.

* **RAISE STANDARDS AND MEASURE STUDENT PERFORMANCE WITH A VOLUNTARY NATIONAL TEST IN MATHEMATICS AT 8TH GRADE.** The TIMSS results demonstrate the need for a rigorous national benchmark that will reflect not only how a student's performance compares across states but also

around the world. The standards of state assessments in 8th grade mathematics vary widely, and many of these 8th grade assessments are not as rigorous as the standards of the National Assessment of Educational Progress (NAEP) according to a recent study by the Southern Regional Education Board. Moreover, recent international comparisons of science and mathematical examinations for college-bound students show that our SAT, ACT, and AP exams are much less rigorous than similar exams from other nations. This is why President Clinton has proposed a voluntary national test in mathematics at the eighth grade. The voluntary national test will be based on the rigorous content and performance standards in NAEP and linked to TIMSS. While TIMSS and NAEP provide a snapshot of the nation's performance, they assess only a sample of students; neither individual student nor school performance can be ascertained. The voluntary national test in mathematics, however, would let parents and teachers know how individual students and schools can improve in relation to rigorous national and international standards and whether students are adequately prepared to take demanding high school mathematics and science.

OFFER A CHALLENGING CURRICULUM AND ENCOURAGE STUDENTS TO TAKE TOUGHER COURSES. TIMSS shows that what we teach and how we teach is what determines our students' achievement. Because decisions about curriculum and teaching are local ones, it rests primarily with local communities and states to ensure that students are getting a rigorous mathematics and science program taught by effective and well-trained teachers. Today, most students -- even most college-bound students – do not take four years of high school mathematics and science. Ninety percent of all high school students stop taking mathematics before getting to calculus. Students should take demanding mathematics and science courses through high school such as physics and calculus -- and these courses must be rigorous.

IMPROVE THE TEACHING OF MATHEMATICS AND SCIENCE. How we teach is as important as what we teach. The TIMSS 8th grade study found that we teach mathematics differently than other nations: U.S. mathematics classes require students to engage in less high-level mathematical thought and solve fewer multistep problems than classes in Germany and Japan. In the nation's high schools, this is compounded by the fact that 28% of high school mathematics teachers and 55% of high school physics teachers neither majored nor minored in these subjects. States, districts, colleges and universities must get serious about teacher preparation, teacher certification, and ongoing professional development to ensure that students are taught by teachers who are prepared to teach challenging mathematics and science.

* **ADDITIONAL ADMINISTRATION INITIATIVES THAT WILL IMPROVE MATHEMATICS AND SCIENCE ACHIEVEMENT.** Many of the President's education proposals in the FY99 budget will raise standards and achievement in mathematics and science. The budget requests $50 million for the Department of Education and $25 million for NSF to support a joint research program to learn how brain research, cognitive science and learning technology can lead to improved achievement in reading and mathematics. The President's $140 million High Hopes for College proposal would promote partnerships between colleges and middle or junior high schools in low-income communities to get and keep students on the track to college, including ensuring that students have access to the rigorous mathematics and science courses that prepare them for college. The President's proposal for Recruiting, Preparing, and Supporting Teachers includes $30 million for improving the preparation of future teachers, with emphasis on teachers of mathematics and reading. Furthermore, the President's $22 billion school modernization proposal will help upgrade mathematics and science classrooms and laboratories in many overcrowded and outdated schools.

THE WHITE HOUSE
OFFICE OF PUBLIC LIAISON

Barbara Woolley
Associate Director

Phone (202) 456-2930
Fax (202) 456-6218

Urgent

Number of Pages (including cover) _____

Date: _____

To: Neera Tanden

Fax Number: 62878

Office Number: _____

.....COMMENTS.....

This is a draft not final

Jeffrey A. Shesol
03/08/98 10:15:48 PM

Record Type: Record

To: Sarah A. Bianchi/OPD/EOP

cc:
Subject:

Draft 03/08/98 5:30PM

PRESIDENT WILLIAM J. CLINTON
SPEECH TO THE AMERICAN MEDICAL ASSOCIATION
LEADERSHIP CONFERENCE
WASHINGTON, DC
March 9, 1998

Acknowledgments: Dr. Percy Wootton (Woo-ton); Dr. Nancy Dickey; Dr. Tom Reardon; Dr. Randy Smoak (Smoke), Dr. Lynn Jensen, all of the AMA.

It is an honor to be here with you today, and to be working with the AMA on so many important fronts. We've had our honest differences on policy. We haven't been on the same side of every health care fight. But one thing we've always agreed on is our profound obligation to the health of American families. And in our step-by-step approach to health care reform, we're walking together. We're expanding the promise of new medical technology and extending health care opportunities to the most vulnerable Americans. We've helped Americans keep their coverage when they change their jobs. And last year, we helped make sure that millions of uninsured children get the medical coverage they deserve and the help they need.

And we've found the right family doctor for America--Dr. David Satcher, our country' s new Surgeon General. We went too long without one. Just last month, your voices were strong and united in support of his nomination. I thank you, and America's families thank you.

This is a great and glorious moment for America. Our economy is the strongest in a generation. Social problems are on the mend. Our leadership is unrivaled around the world. Still, as I said in my State of the Union Address, this is not a time for America to rest. It is a time for us to build--to expand our prosperity, to strengthen our values, and to widen the circle of opportunity.

I am here to talk to you about two of the next, important steps we must take as a nation

as we move forward into the 21st century. This is a moment of great potential, and we must seize it. There are fewer than 70 working days left before Congress adjourns. History is being written by this Congress, and I do not want it to be another story of partisan political bickering in an election year. I want it to be the story of a strong, bipartisan commitment to the health of America's families. First, we have a historic opportunity to protect all Americans with a Patient's Bill of Rights. And second, we can--and must--pass landmark legislation to help end the epidemic of teen smoking.

My mother, as some of you may know, was a nurse. She was an anesthetist at St. Joseph's Hospital--a blond-brick building just off Central Avenue in Hot Springs. So I grew up around doctors. Walking through the wards with my mother, I saw some of the miracles doctors perform every day. And I remember what the profession used to look like--very different than today, I'm sure you'll agree. For one thing, I wasn't familiar with the term " emergency knee surgery" back then.

This is, in fact, a time of great change in American medicine. More than 160 million Americans are now in managed care plans, with profound implications for health services of every kind. Much good has come of these changes. Good plans are promoting preventative medicine. And all of us appreciate it when health care costs don't rise at four or five times the rate of inflation. That means affordable health care for families who need it. And that's most families.

But the new system can make it harder for doctors simply to be doctors. When a doctor spends almost as much time with a bookkeeper as with a patient, something is wrong. When a doctor spends almost as much time filing authorization forms as making rounds, then something is wrong. Insurance company accountants aren't trained to do your job--and you shouldn't have to do theirs.

Traditional care or managed care, every American deserves quality care. And every American deserves medical decisions made by medical doctors, not insurance company accountants. When a patient comes to your office or emergency room, your first question should be: "Where does it hurt?" Not "How will you pay?"

Patients deserve better from their health plans. I was really moved to hear recently about a woman who works in an oncologist's office. Her job is to verify insurance coverage and get authorizations for medical procedures, and she told the story of a 12-year old boy with a cancerous tumor in his leg. The doctor wanted to perform a procedure to save the boy's leg. But the health plan said no--and refused to cover it. For that condition, the approved procedure was amputation. Period. That was the only procedure the plan would pay for.

The boy's parents appealed that decision and were turned down. They appealed again and were turned down again. Only when the father's employer weighed in did the health plan change its mind--but it was too late. After four months of this terrible tug-of-war between patient and plan, the boy's cancer had spread. By now, amputation really was his only choice. A life-or-death choice. One his family shouldn't have had to make.

You are the best trained, best skilled doctors in the world. You've had the best medical educations, and have the best medical technology. We've got to let you do the job that only you can do--to heal.

That's why I have urged Congress to pass a Patient's Bill of Rights--and put medical decisions back in the hands of patients and the best medical doctors in the world.

I have already acted to ensure that our federal employees and their families, our military personnel, our veterans and their families, and every person on Medicare or Medicaid--altogether, one third of Americans--are protected by the Patient's Bill of Rights. And across the nation, state legislatures--Republican and Democratic--are doing what they can. Forty-three have enacted into law one or more of the basic provisions of the Patient's Bill of Rights. But the reality is that state law, and this patchwork of reforms, can't protect most Americans--140 million Americans. That's why Congress must pass a Patient's Bill of Rights with the full force of federal law.

The Patient's Bill of Rights keeps the covenant of care with our parents, our children, and the neediest and most vulnerable Americans. The Hippocratic Oath binds doctors to " follow that method of treatment which, according to my ability and judgment, I consider for the benefit of my patients." That's your responsibility and your patients' right--to know all their medical options, not just the cheapest. Primary care when possible. Specialists when necessary. That's why the Patient's Bill of Rights lifts the gag order on our nation's doctors, and allows patients to follow your best recommendations by appealing any unfair decisions by managed care accountants.

Patients have a right to keep their medical records confidential. And doctors must feel free to write down the whole truth--without it ending up on the Internet, or in the hands of employers and marketing firms, or increasing a patient's insurance rates. Again, we recall the Hippocratic Oath, which says that "all such shall be kept secret." That's why the Patient's Bill of Rights safeguards the sanctity of the patient-doctor relationship.

Patients have a right to emergency services wherever and whenever they need it. And when the EMTs are wheeling a new arrival into your ER, the last thing you--or your patient--should have to worry about is the fine print on a health plan.

With less than 70 days remaining in this legislative session, it is time to guarantee that the best practices of traditional medicine survive in the age of managed care. This administration has acted. The states have acted. The AMA has acted. I ask you to urge Congress to take the next, important step--and take it today.

The other great health issue before this Congress is tobacco. Today--and every day--3,000 children light their first cigarette. 1,000 of them will die prematurely because of it. This is a national epidemic, and a national tragedy. As physicians, you know the importance of preventative care. Often, it is easier to stop a disease before it starts. And that

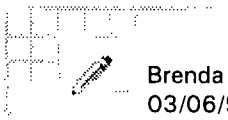
is why, for more than five years, our administration has worked to stop our children from smoking before they start. We launched a nationwide campaign with the FDA to educate children about the dangers of smoking, to reduce their access to tobacco products, and to put a stop to tobacco companies that spend millions on mass marketing to young people.

Last fall, I called on Congress to pass comprehensive bipartisan legislation to reduce teen smoking by raising the price of cigarettes by up to $1.50 a pack over the next decade; imposing strong penalties on tobacco companies that keep advertising to children; and giving the FDA full authority to reduce our children's access to tobacco products. If we do this, we can cut teen smoking by almost half over the next five years. We can stop almost three million children from taking that first puff. We can prevent almost one million premature deaths.

But again, the clock is ticking. It is time for leaders of both parties to put politics aside, protect our children from the deadly threat of tobacco, and protect every patient's right to quality care. It is time for Congress to match the commitment this administration has made, and the AMA has made, to the health of American families as we approach the 21st century.

There is another step we must take, and on this one you and I may disagree. I have made a targeted proposal that gives a vulnerable group of Americans new options for health care coverage. By enabling Americans aged 62 to 65 to buy into Medicare, and giving displaced workers 55 and over a similar buy-in option, my proposal protects them--without burdening the Medicare Trust Fund or busting our balanced budget. The CBO just reported that this policy will cost even less and help even more people. It will provide access to health care for hundreds of thousands of the most vulnerable Americans, and it is clearly the right thing to do. We should not wait to take this next, important step toward quality care in the next century. I challenge you to join me.

This is a time of remarkable promise for American medicine. We have the potential to make it the most powerful force for human health in history. We are finding cures for seemingly incurable conditions. New gene therapies. Revolutionary fertility treatments. The choice we face today is whether to fulfill this promise tomorrow--and carry the best aspects of traditional care forward into the future. I think we will make the right choice as a country. And even though medical technology is ever-changing, the values of the medical profession--the Hippocratic Oath--are everlasting. If we preserve the values you were taught and continue to uphold, then we will truly have a healthier America, and a stronger America, in the 21st century.



Brenda B. Costello
03/06/98 05:32:06 PM

Record Type: Record

To: Neera Tanden/WHO/EOP

cc:
Subject: Briefing for Ass of maternal and child health programs - monday!!!

I'm so sorry. I spaced -my brain is tired.

---------- Forwarded by Brenda B. Costello/WHO/EOP on 03/06/98 05:31 PM ----------

Barbara D. Woolley
03/06/98 02:54:38 PM

Record Type: Record

To: Brenda B. Costello/WHO/EOP

cc:
Subject: Briefing for Ass of maternal and child health programs - monday!!!

REMARKS TO THE ASSOCIATION OF MATERNAL AND CHILD HEALTH PROGRAM'S ANNUAL MEETING

DATE: Monday, March 9, 1998
TIME: 12:00 pm - 12:30 pm
PLACE: Omni-Shoreham Hotel, Washington, DC
FROM: Maria Echaveste
Barbara Woolley

I. PURPOSE:

To speak on this Administration's commitment to child care and to seek their assistance in the implementation of the Children's Health Insurance Program.

II. BACKGROUND

You will speak to 500 attendees of the Association of Maternal and Child Health Programs Annual Meeting and accept their Inaugural AMCHP Award for Leadership in Maternal and Child Health. The theme of this year's meeting is quality in maternal and child health

programs and is entitled "New Environments, New Needs: Setting the Agenda for Quality." It will run from Monday, March 9, 1998 to Wednesday, March 11, 1998.

AMCHP conducts an annual meeting to present cutting-edge information on maternal and child health policy and programs to the maternal and child health community. It is an opportunity for maternal and child health professionals, state officials, and others to exchange best practices, strategies, and lessons learned.

This year, AMCHP's top priority is quality of child care in conjunction with increasing its availability and affordability. Quality needs to include a safe and healthy environment as well as programs equipped to serve children with special needs. AMCHP feels child care should be linked to health care in the community, encompassing access, immunizations, screening, and insurance enrollment.

Since 1944, the Association of Maternal and Child Health Programs has served as a source of ideas and in-depth knowledge on women's and children's health. It is a national non-profit organization principally comprised of 300 directors and staff of state public health agency programs for maternal and child health, and children with special health needs in all 50 states. These programs include WIC, family planning, early intervention, school health, and specific Medicaid programs. They are funded by Title V of the Social Security Act, also known as the Maternal and Child Health Services Block Grant. An additional 100 AMCHP members include academic, advocacy, community-based maternal and child health professionals, and families.

AMCHP has worked with the administration on the Kennedy-Kassebaum legislation, Medicaid issues, and immunization programs and was instrumental in the success of the Children's Health Insurance Program. AMCHP offered strong support for Surgeon General Dr. David Satcher and continues to advocate strong tobacco legislation.

Recently, AMCHP has promoted awareness of uninsured children, assisted states in CHIP implementation and eligibility outreach, worked with the CDC on tobacco control efforts, and helped states understand and address the consequences of welfare reform on infant and child health.

An audience of 500 will be comprised of 150 of AMCHP's membership of directors and staff of state health agency Maternal and Child Health (MCH) programs. The other attendees will be consumers, families with special health care needs, and members of national research, policy, and advocacy organizations concerned with maternal health.

III. PARTICIPANTS:

The First Lady
Deborah Klein Walker, President
Catherine Hess, Executive Director

In Meet and Greet Prior to Remarks

Deborah Klein Walker, EdD, President
Assistant Commissioner, Bureau of Family and Community Health, Boston, MA

Catherine A. Hess, MSW, Executive Director, Washington, DC

Tom Vitaglione, MPH, President-Elect
Chief, Children & Youth Division of MCH, Dept of Environment, Raleigh, NC

Maxine Hayes, MD, MPH, Past President
Assistant Secretary, Dept of Health/ Parent-Child Services, Olympia, WA

Kathryn Peppe, RN, MS, Secretary
Director of Family & Community Health at the Ohio Dept of Public Health, Columbus, OH

Edd Rhoades, MD, MPH, Executive Council Member
Chief Health and Guidance, Oklahoma State Dept of Health, Oklahoma City, OK

Gil Buchanan, MD, Executive Council Member
Medical Director, Children's Medical Services, Arkansas Pediatric Clinic, Little Rock, AR

Patricia Moore-Moss, LCSW, Executive Council Member
Director, Maternal and Child Health, West Virginia State Dept of Health, Charleston, WV

Sally Fogerty, BSN, MED, Executive Council Member
Deputy Director, Bureau of Family & Community Health, Mass. Dept of Health, Boston, MA

W. Sundin Applegate, MD, MPH, Executive Council Member
Medical Director, Family Health Services, Arizona Dept of Health Services, Phoenix, AZ

Cassie Lauver, ACSW, Executive Council Member
Director, Bureau for Children, Youth, and Families, Kansas Dept of Health, Topeka, KS

Donna Barber, RN, MPH, Executive Council Member
Chief, Dept of Health, Family Health Services, Tallahasse, FL

Millie Jones, MPH, Executive Council Member
Section Chief, Maternal and Child Health, WI Dept of Health and Social Services, Madison, WI

Joan Eden, MSPH, RD, Executive Council Member
Director, Health Care Program/ Children with Special Health Care Needs, CO Dept of Public

Health and Environment, Denver, CO

Mavis Matthew, MD, Executive Council Member
Director, Dept of Health MCH & CSHCN, St. Croix, VA

Karen Pearson, BS, MS, Executive Council Member
Section Chief, Maternal, Child, and Family Health, AK Dept of Health, Anchorage, AK

Marie Meglen, MS, CNM, Executive Council Member
Director, MCH Bureau, DHEC, Columbia, SC
Ann Gionet, Family Advocate, Hartford, CT

Conni Wells, Family Voices, Crawfordville, FL

V. PRESS PLAN:

Closed.

VI. SEQUENCE OF EVENTS:

YOU will be greeted upon arrival by Cathy Hess, Executive Director and Deborah Klein Walker, President.
YOU will proceed to the Holding Room accompanied by Cathy Hess and Deborah Klein Walker, where you will meet and greet 20 of AMCHP's executive board.
YOU proceed to the speaker platform with Deborah Klein Walker who will introduce **YOU.**
YOU deliver remarks.
YOU will be presented with a plague (the Inaugural AMCHP Award for Leadership in Maternal and Child Health) by Deborah Klein Walker.
YOU work rope line and depart.

VII. REMARKS:

Remarks provided by speech writer.

VIII. ATTACHMENTS:

1: Bio of Deborah Klein Walker, AMCHP President
2: Bio of Cathy Hess, AMCHP Executive Director
3: Press Release
4: Copy of Award Plaque
5: Annual Meeting Agenda

AHCPR

Agency for Health Care Policy and Research • 2101 East Jefferson Street • Rockville MD 20852

EMBARGOED FOR RELEASE
12:01 a.m., March 9, 1998

Contact: AHCPR Public Affairs
301/594-1364
Karen Carp, x1378 (kcarp@ahcpr.gov)
Venese DeJernett, x1317 (vdejerne@ahcpr.gov)

NEW RESOURCE AVAILABLE FOR CHILDREN'S HEALTH DATA:
Millions of American Children Still Uninsured and Face Barriers to Care

The Agency for Health Care Policy and Research (AHCPR) today released a new sourcebook on data about children's health. The data in *Children's Health 1996* highlights findings from AHCPR's 1996 Medical Expenditure Panel Survey (MEPS).

"This publication allows policymakers, advocacy groups, or anyone with an interest in children's health to understand quickly many important aspects of our children's health data," said AHCPR Administrator John M. Eisenberg, M.D. Dr. Eisenberg said that chartbooks highlighting other aspects of MEPS data are planned.

The chartbook is split into three sections which provide information on children's health status, access to care, and health insurance status. The information is presented in an uncomplicated way, using a question and answer style and many pie charts and bar graphs to communicate current data on children's health.

Significant findings on children's health included in the chartbook are:

- In 1996, nearly 11 million children were uninsured.
- About 90% of all uninsured children lived in households with at least one working adult.
- 52.8% of children insured through Medicaid are living in households with at least one working adult.
- At least 3.3 million American children under age 13, and more than 1 million age 13 and over, are eligible for Medicaid but not enrolled.
- Of families who said they did not receive needed health care, 60% said they did not get care because they could not afford it.
- Children aged 13-17 years are nearly three times less likely to have a usual source of health care, compared with children aged 5 and under.

(more)

•Children in fair or poor health were as likely as children in excellent health to be covered by some form of health insurance. However, 41.8% of children in fair or poor health were covered by a public health insurance program, while only 15.1% of children in excellent health had public insurance.

•Hispanic children are more likely than black or white children to be uninsured (27.7% of Hispanic children, compared with 17.6% of black children, and 12.3% of white children).

•Hispanic children are more likely than black or white children to be in fair or poor health (7.8% of Hispanic children, compared with 4.2% of black children and 2.9% of white children).

Children's Health 1996 (Publication Number 98-0008) is available through the AHCPR Publications Clearinghouse by calling (800)358-9295, or writing to *Children's Health 1996*, P.O. Box 8547, Silver Spring, Md., 20907. It also is available through the redesigned AHCPR Web site at www.ahcpr.gov.

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John K. Iglehart
Founding Editor

Project HOPE
Publisher

HEALTH AFFAIRS

7500 Old Georgetown Road
Suite 600
Bethesda, Maryland 20814-6133
Phone: 301.656.7401
Fax: 301.654 2845
E-mail: healthaffairs@projhope.org

For more information, contact:
Linda Loranger, 301-652-1558

HOLD FOR RELEASE WITH A.M. PAPERS
March 9, 1998

NEW STUDY: CHILDREN'S HEALTH PROBLEMS LINKED TO RACE, ETHNICITY, EDUCATION AND EMPLOYMENT

Lack of Health Insurance Not The Only Problem

Hispanic Children Far More Likely Than Others to be Uninsured And In Fair or Poor Health

WASHINGTON, D.C. -- Lack of insurance is not the only critical issue affecting children's health care. A new study published today in the journal *Health Affairs* shows that health problems among children are strongly linked to such socioeconomic factors as race and ethnicity and the education and employment status of their parents. Hispanic children, children whose parents have little education, and those living in families without an employed parent are more likely than other children to have health problems, study researchers found.

The study, conducted by the federal government's Agency for Health Care Policy and Research (AHCPR), sheds new light on issues surrounding children's health insurance coverage, access to care, and health status. Despite various policy initiatives, 11 million children in this country are without any health insurance coverage at all, and nearly three million are reported to be in fair or poor health, the study researchers noted. Children are defined as those under age 18.

The study found that Hispanic children are far more likely than children of other racial and ethnic groups to be uninsured, lack a usual source of care, and to be in fair or poor health. In addition, children whose parents have little formal education are very unlikely to have private insurance, and more than one-quarter of them are uninsured. These children also are more likely to lack a usual source of health care and to be in worse health than children whose parents are more educated. Finally, children with no employed parents are heavily dependent on public insurance coverage and are significantly more likely to be in fair or poor health than children with one or two employed parents.

(More)

"A significant number of children in the United States have serious problems with health insurance coverage, access to care, and overall health status," lead study author Robin M. Weinick noted. She and her colleagues describe the segments of the population to which new initiatives aimed at improving children's health may be targeted.

The study, which relies on data from the Medical Expenditure Panel Survey, could prove to be an important benchmark in helping to determine if the recently established State Children's Health Insurance Program (CHIP) will be able to help the children most in need. The $24 billion program is designed to insure children who would otherwise not have coverage by providing funds for states to expand Medicaid or to establish new programs.

Among the study's specific findings:

- Hispanic children are most likely to be uninsured (27.7 percent, compared with 17.6 percent of blacks and 12.2 percent of whites), while black children are most likely to have public insurance only (40.8 percent, compared with 32.5 percent of Hispanic and 13.1 percent of white children). Hispanic children are also mostly likely to be without a usual source of health care (17.2 percent), and black children (12.6 percent) are more likely than white children (6.0 percent) to lack a usual care provider.

- Children whose parents have more than 12 years of education are most likely to have private insurance (80.7) percent) and least likely to be uninsured (10.1 percent). Children whose parents have fewer than 12 years of education are least likely to have private insurance (21.4 percent), most likely to be uninsured (28.5 percent), and much more likely to lack a usual source of care (16.6 percent).

- Children living with two employed parents are the most likely to have private insurance (83.0 percent) and the least likely to be uninsured (11.4 percent). Children in families without any working parents are least likely to have private insurance (7.7 percent) but the most likely to have public insurance (76.5 percent).

- Hispanic children are most likely to be in fair or poor health (7.8 percent), while white children are most likely to be in excellent health (55.3 percent). Children whose parents have more than 12 years of education are most likely to be in excellent health (59.1 percent), and those whose parents who have fewer than 12 years of education are most likely to be in fair or poor health (8.6 percent). Children in families with no working parents are less likely to be in excellent health (37.9 percent) than those in families with either one (52.1 percent) or two (55.8 percent) working parents.

(More)

The study is based on data from AHCPR's Medical Expenditure Panel Survey (MEPS), the most comprehensive survey of health care in the United States. By analyzing survey data related to children's health, the study researchers sought to document recent evidence concerning children's health care and to provide a baseline for evaluating the results of new health care policies and programs for children.

MEPS is unparalleled in the level of detail and breadth of information it provides about the U.S. health care system. Unlike other surveys used for analyses of health insurance coverage in the United States, MEPS provides the linked information necessary to examine the relationships among health insurance, use and expenditures, access to care, and other health care-related topics. Data for the ongoing survey are collected via five in-person interviews with one or more persons per household, who report on the health care experiences of the entire family over a two-year period.

Health Affairs is a bimonthly multidisciplinary journal devoted to publishing the leading edge in health policy thought and research. Copies of the March/April issue will be provided free to interested members of the press. Copies are available to the public for $25 each from Judie Tucker at *Health Affairs*, 7500 Old Georgetown Road, Suite 600, Bethesda, Maryland 20814.

Health Affairs is published by *Project HOPE*. Established in 1958, *Project HOPE* is an international nonprofit health education foundation providing health policy research and analysis, training for health care professionals, and consultation in health systems planning and development. *HOPE* is now working on five continents – including North America – to enable communities to find lasting solutions to health problems.

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March 5, 1998

HHS Media

ADVISORY

Health correspondents note:

Two items related to availability of health insurance will be issued by HHS agencies next week:

A new report will indicate variations in the availability of employer-sponsored insurance by state, ranging from 86 percent of private sector employees in Hawaii offered health insurance, to 40 percent in Montana. The information (1993 data) is drawn from the National Employer Health Insurance Survey. HHS agencies sponsoring the survey were the National Center for Health Statistics (part of the Centers for Disease Control and Prevention), the Agency for Health Care Policy and Research, and the Health Care Financing Administration. For information call Sandra Smith, Jeff Lancashire or Mary Jones at NCHS, (301) 436-7551.

A new chartbook will be available from the Agency for Health Care Policy and Research, Children's Health 1996. Data for the chartbook are drawn from AHCPR's 1996 Medical Expenditure Panel Survey. Information includes number and characteristics of children without health insurance, as well as other child health information. A companion article is being published in the March/April edition of Health Affairs. For information, call AHCPR, (301) 594-1364 – Karen Carp (x1378) or Venese DeJernett (x1317).

###

Children's Health 1996

MEPS Chartbook No. 1

Margaret E. Weigers, Ph.D.

Robin M. Weinick, Ph.D.

Joel W. Cohen, Ph.D.

Health Insurance **Access to Care** **Health Status**

MEPS
Medical Expenditure Panel Survey
Agency for Health Care Policy and Research

executive summary

What were we doing well in 1996?

Almost two-thirds of all children were covered by private health insurance (p. 6).

Most children living with working parents had employment-related health insurance (p. 10).

An estimated 3.4 million children who were eligible for Medicaid in 1996 would not have qualified for coverage under the 1987 rules (p. 11).

92% of all children had a usual source of health care (p. 21).

Less than 12% of American families experienced barriers to receiving needed health care (p. 22).

81% of all children were in excellent or very good health (p. 24).

70% of children in excellent health had private insurance, while 15% had public coverage (p. 26).

On the other hand...

Nearly 11 million children were uninsured (p. 7).

Of all children who were uninsured, approximately 90% lived in households with a working adult (p. 7).

Many children remain uninsured despite being eligible for Medicaid. MEPS estimates indicate that over 3 million young children and more than a million older children were eligible but uninsured (p. 12).

20% of uninsured children lacked a usual source of health care (p. 18).

Of families with barriers to receiving needed care, 60% said the main reason they did not get care was because they could not afford it (p. 22).

2.8 million children were in fair or poor health (p. 24).

Only 43% of children in fair or poor health had private insurance, while 42% had public coverage (p. 26).

Agency for Health Care Policy and Research

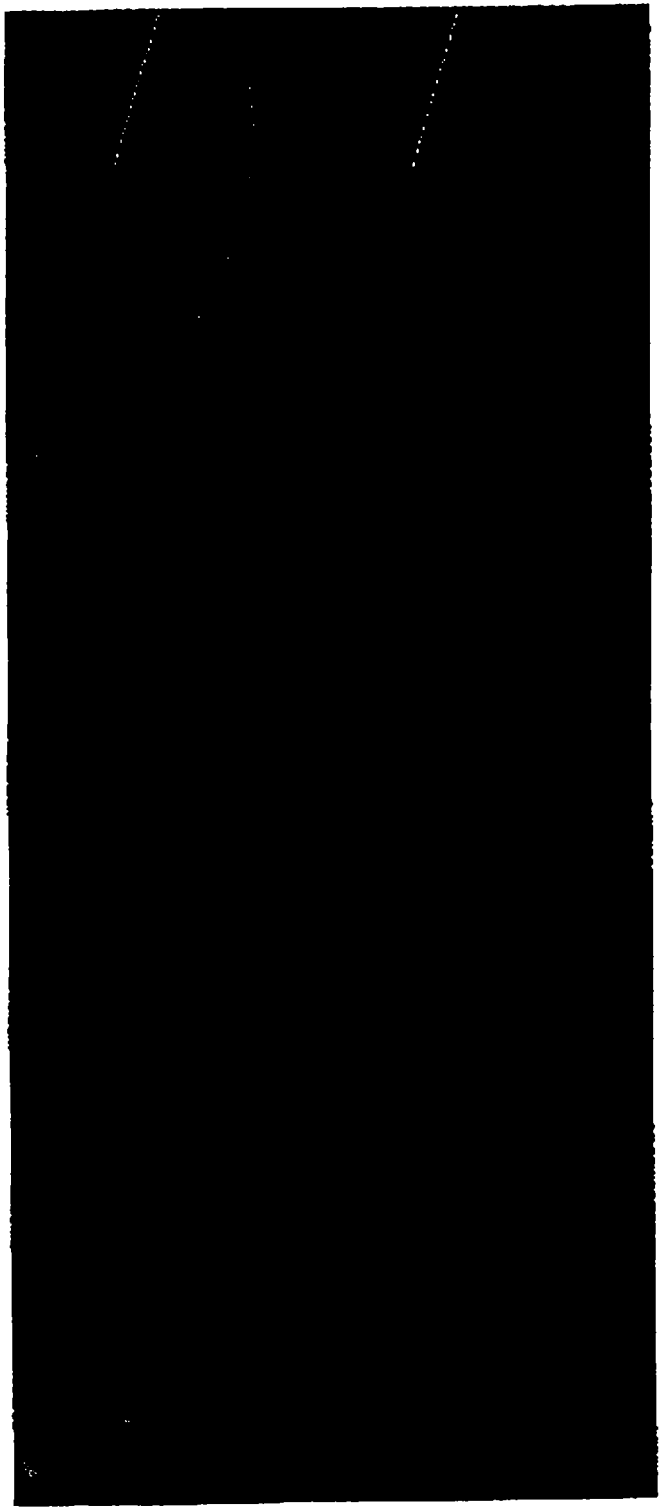
contents

Health Policy for Children

High-quality health care is important to the well-being of America's children. Recent policy changes have attempted to increase children's health insurance coverage and access to care so that children can obtain health care that is appropriate to their developmental needs.

In the last decade, the Medicaid program has been expanded to decrease the proportion of children who are uninsured. However, a substantial number of children still lack health insurance and adequate access to care. Consequently, they risk health problems associated with not being immunized, not receiving appropriate well-child care, and not receiving timely treatment for acute health problems.

In this era of rapid changes in our health care system, it is important to assess periodically where we stand. This report presents the latest available information concerning three key elements related to children's health. The first section of the report presents data on the health insurance status of children in the United States. Since having health insurance is just one factor that may influence children's health and well-being, the second section of the report addresses access to health care, with a focus on usual source of care and barriers to care. Finally, the third section of the report turns to the motivating force behind our Nation's interest in children's health insurance and access to care: the health status of children.

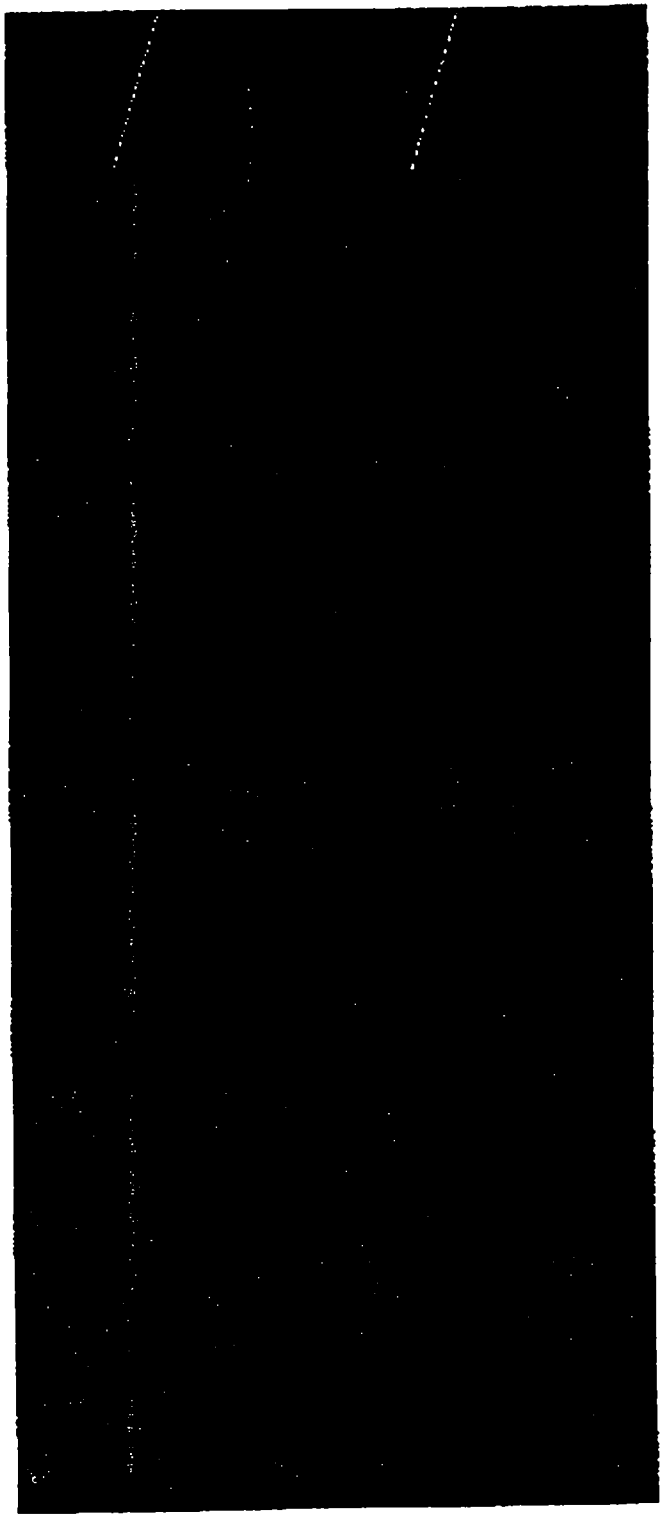


Source of Data for This Report

The estimates presented in this report are drawn from the Medical Expenditure Panel Survey (MEPS). MEPS is the third in a series of medical expenditure surveys conducted by the Agency for Health Care Policy and Research. It is a nationally representative survey that collects detailed information on health status, health care use and expenses, and health insurance coverage of individuals and families in the United States.

These data come from the first and second rounds of interviewing for the Household Component of the 1996 panel of MEPS. (See Note 1.) The estimates presented here are nationally representative of noninstitutionalized children under age 18. In some cases, totals may not add precisely to 100 percent as a consequence of rounding. Where shown, the racial category "white" includes children identified as white as well as a very small number of children identified as American Indians, Aleuts, Eskimos, or other races.

MEPS data are released to the public in a number of formats, including public use data files and the printed *MEPS Research Findings* and *MEPS Highlights* series. The numbers shown in this chartbook are drawn from a variety of the *Research Findings* reports, as well as additional analyses conducted by the MEPS staff. These sources of information are listed in the references at the end of this report.



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section 1

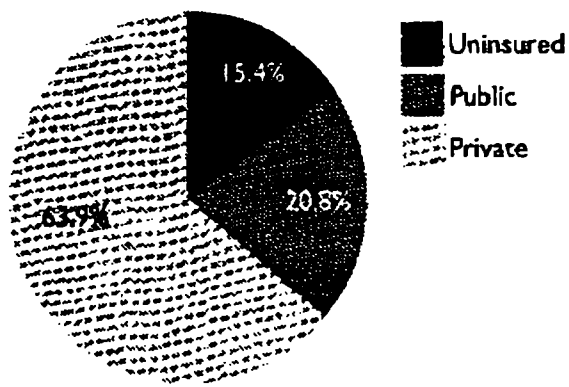
Children's Health Insurance

Health insurance plays a critical role in ensuring that children obtain timely medical care that is appropriate to their developmental needs. In an era of high health care costs, individuals' difficulty affording medical care has made health insurance essential for ensuring that children's health services are both accessible and affordable.

Children's health insurance: Where do we stand?

- 15.4% of the Nation's children were uninsured throughout the first half of 1996.
- One-fifth (20.8%) of children had public coverage.
- Almost two-thirds (63.9%) of the Nation's children were covered by private health insurance.

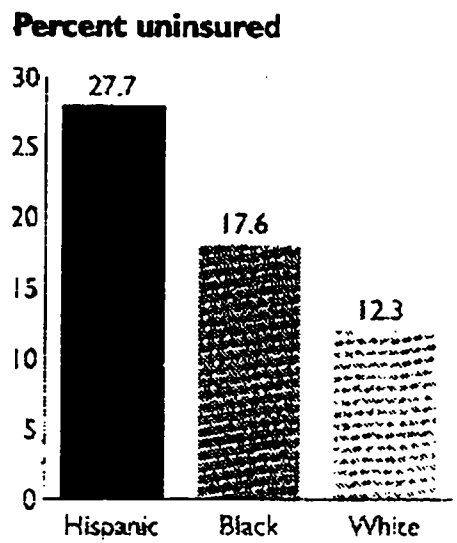
Health insurance status of children under age 18



Who are the uninsured children?

- Nearly 11 million children in America were uninsured throughout the first half of 1996. These children represent 15.4% of all children in the United States.
- Of all children uninsured throughout the first half of 1996, about 90% were in households with a working adult.
- Children in families with a working adult represented over a fifth (22.1%) of the non-elderly uninsured population.

Are minority children at greater risk of not having health insurance?

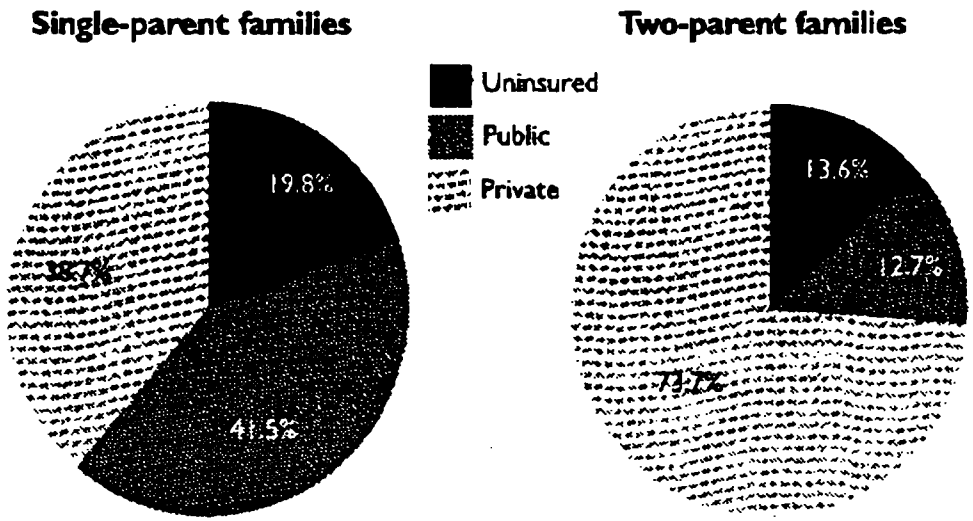


Hispanic children were the most likely to be uninsured: 27.7% of Hispanic children, 17.6% of black children, and 12.3% of white children were uninsured.

- White children were far more likely to have private health insurance (73.9%) than either black (41.7%) or Hispanic children (39.8%).
- Nearly a third (32.5%) of Hispanic children and 40.8% of black children had public health care coverage, compared to only 13.8% of white children.

Are children in single-parent families at greater risk of not having private health insurance?

- Approximately one-quarter of children in the United States live in single-parent families.
- Roughly one in five children (19.8%) in single-parent families were uninsured during the first half of 1996, compared with 13.6% of children in two-parent families.
- Nearly three-quarters (73.7%) of children in two-parent families had private insurance, compared with only 38.7% of children in single-parent households.
- Children in single-parent families were three times more likely to have public insurance than children in two-parent families (41.5% compared to 12.7%).



How do parents' employment and education levels affect children's health insurance?

Employment

Children living with two employed parents were the most likely to have employment-related private health insurance.

- 79.1% of children living with two employed parents had health insurance through an employer.
- 58.8% of children in two-parent households with one working parent had health insurance through an employer.
- 51.1% of children in single-parent households with a working parent had employment-related health insurance.

Education

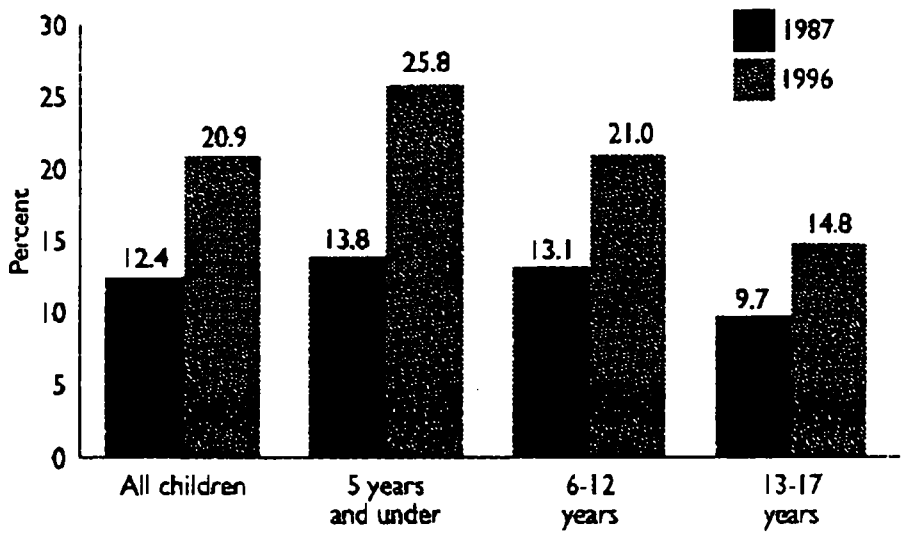
Adults' educational level greatly influenced the probability of children being insured.

- 27.6% of children living in families where adults had less than a high school diploma were uninsured.
- Only 10.6% of children living in families where adults had more than 12 years of education were uninsured.

How did recent Medicaid expansions affect the health insurance status of children?

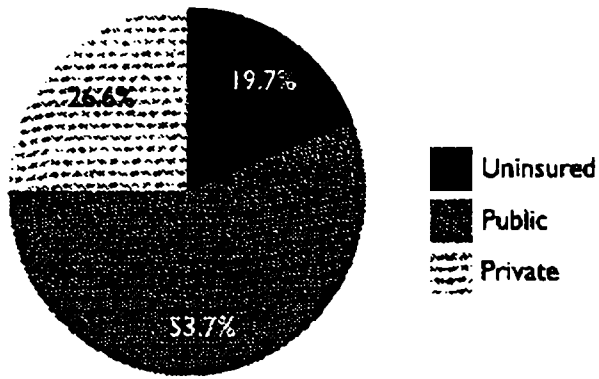
- Medicaid expansions between 1987 and 1996 resulted in more generous eligibility rules for children. During the same period, the proportion of children covered by Medicaid increased from 12.4% to 20.9%.
- Young children were targeted by the expansions, and 1996 estimates show that the largest increase was among that group. Medicaid enrollment among children 5 and under nearly doubled, from 13.8% in 1987 to 25.8% in 1996.
- Approximately 9.4 million children under the age of 18 who were eligible for Medicaid in 1996 would not have qualified for coverage under the 1987 rules.

Medicaid enrollment, 1987 and 1996



Are all the children who are eligible for Medicaid enrolled in the program?

Insurance status of Medicaid-eligible children age 12 and under



The estimates for young children differ from other widely cited estimates for children age 10 and under, primarily because 11- and 12-year-olds who became eligible under the Federal expansion rules in effect in 1996 are included. In addition, children who are eligible under optional State expansions are included, and eligibility is predicted using weekly earned income rather than annual income from all sources.

Medicaid expansions have increased access to health insurance for children. However, many Medicaid-eligible children still are not enrolled.

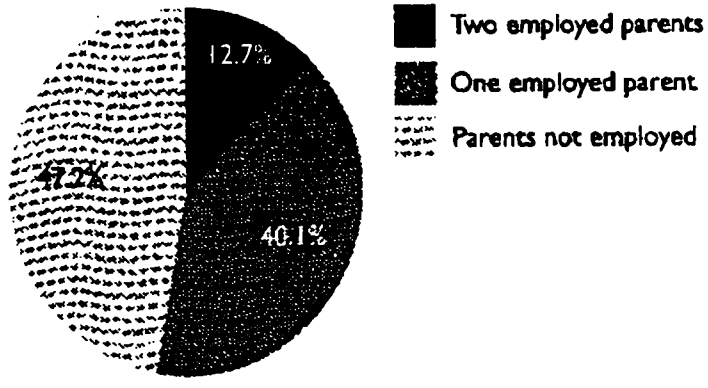
- Of the estimated 16.6 million children age 12 and under who were eligible for Medicaid, approximately 3.3 million (19.7%) were uninsured during the first half of 1996, 4.4 million (26.6%) had private coverage, and 8.9 million (53.7%) had public coverage. (See Note 2.)
- In addition, MEPS estimates indicate that more than 1 million children age 13 and over were uninsured despite being eligible for Medicaid.

Medical Expenditure Panel Survey

What is the employment status of parents of children on Medicaid?

- 40.1% of Medicaid-enrolled children under the age of 18 lived with one employed parent.
- An additional 12.7% of Medicaid-enrolled children under 18 lived with two employed parents.

Medicaid-enrolled children



section 2

Children's Access to Health Care

Having adequate access to health care services can significantly influence health care use and health outcomes. Consequently, measures of access to care are an important tool for evaluating the quality of the Nation's health care system. Limitations in access to care extend beyond such simple issues as a shortage of health care providers or facilities in some areas. Even where health care services are readily available, people may not have a usual source of health care or may experience barriers to receiving services because of financial or insurance restrictions, a lack of availability of providers at night or on weekends, or other difficulties.

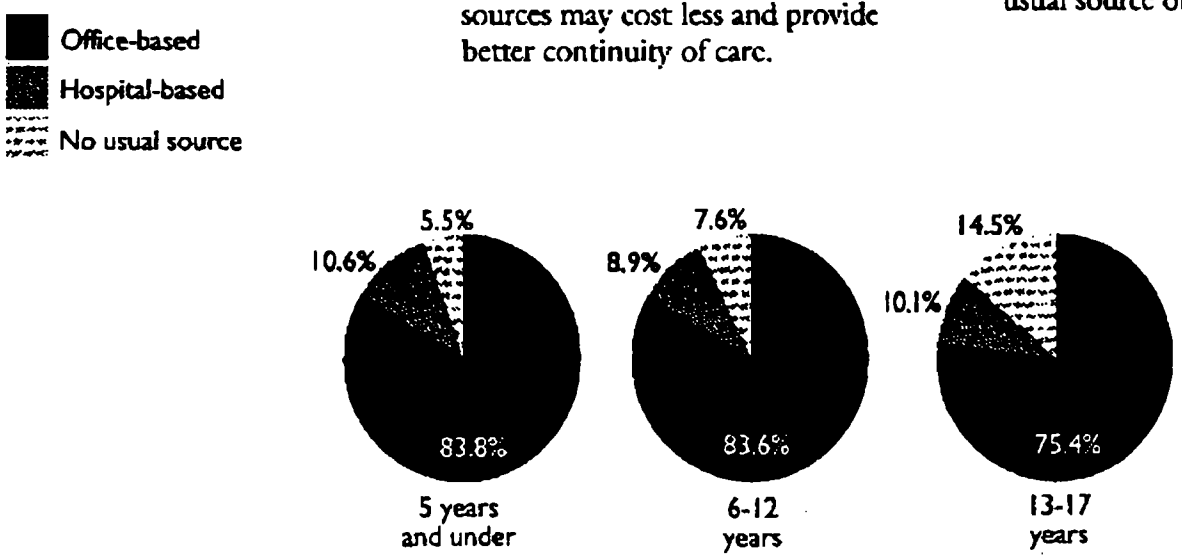
One extensively studied indicator of access is having a usual source of care.

Do children have a place to go when they are sick or need health care?

Persons with a usual source of health care have been shown to be more likely to receive a variety of preventive health services than those without a usual source of care. However, all usual sources of care are not the same. Office-based sources may cost less and provide better continuity of care.

- Children aged 13-17 were less likely than younger children to have a usual source of health care.
- Children aged 13-17 were also less likely to have an office-based usual source of health care.

Usual source of care

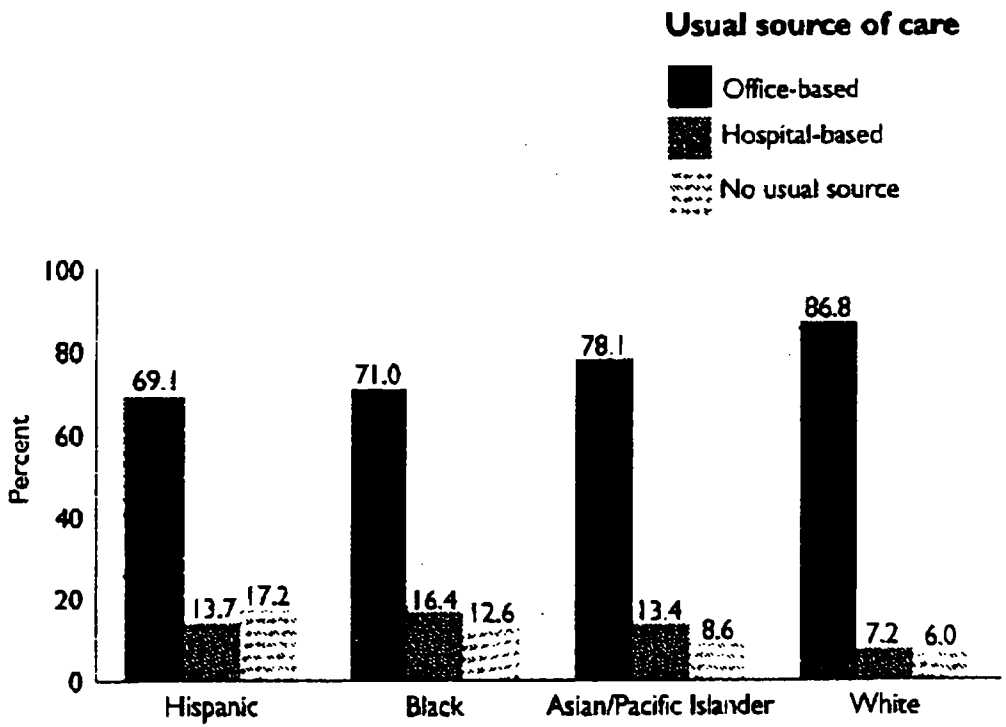


Medical Expenditure Panel Survey

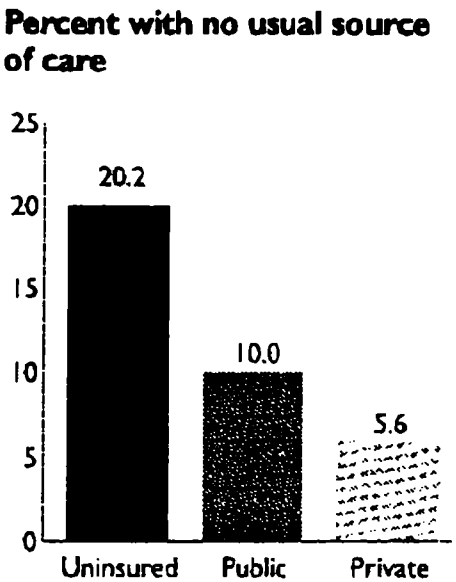
Are minority children at greater risk of not having a usual source of care?

Hispanic and black children were less likely than white children to have a usual source of care and less likely to have an office-based usual source of care.

- Hispanic children were less likely than children in any other racial/ethnic group to have a usual source of health care.
- Black children were less likely than white children to have a usual source of health care.
- Hispanic and black children were less likely than white children to have an office-based usual source of care, and were more likely to have a hospital-based usual source of care.



Does health insurance affect children's chances of having a usual source of care?



Children with private health insurance were more likely to have a usual source of care than those who had public insurance or were uninsured.

- 20.2% of uninsured children lacked a usual source of health care.
- Children who were uninsured were 3.6 times more likely to lack a usual source of care when compared to children with private insurance.
- Children who were uninsured were twice as likely as those with public insurance to lack a usual source of care.

Do children with a usual source of care get the care they need when they need it?

Characteristics of usual sources of health care that can affect access to care include having office hours at times when parents are not working and being easy to contact by phone. Among children under age 18 who had a usual source of care:

- 40.6% had a provider who did not have night and weekend office hours.
- 22.1% of these children's families found their usual source of care providers "somewhat" or "very" difficult to contact by telephone.

How satisfied are families with their usual source of care?

Satisfaction and continuity of care are important aspects of high-quality health care. Families of children with a usual source of care reported that:

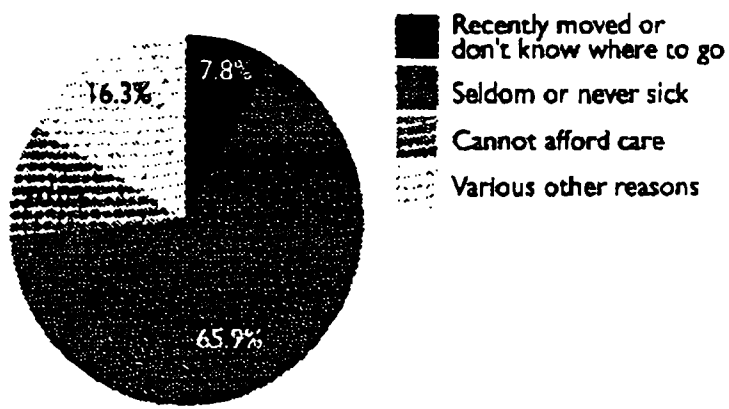
- 97.5% were "somewhat" or "very" satisfied with their usual source of care.
- 96.9% had a usual source of care provider who generally listened and gave them needed information about health and health care.
- 74.9% had a usual source of care provider who generally asked questions about prescription medicines and treatments from other doctors.

Why don't some children have a usual source of care?

While more than 91% of children under age 18 had a usual source of care, 8.8% had no usual source of health care. Of these:

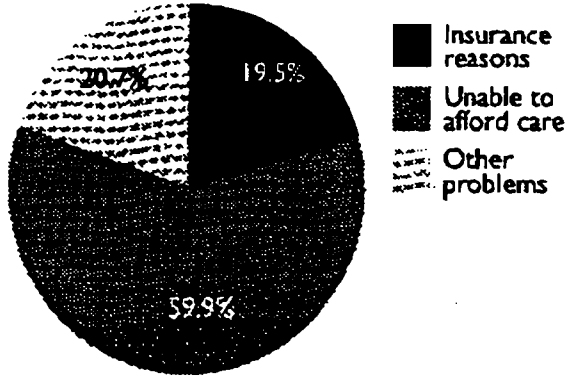
- 65.9% had no usual source of care because they seldom or never got sick.
- 7.8% had no usual source of care because they recently moved to the area or did not know where to receive care.
- 10.0% had no usual source of care because their families could not afford medical care.

Main reasons for not having a usual source of care



Why don't some families get health care when they need it?

Reported barriers to receiving needed care



Approximately 12.8 million families (11.6% of all American families) experienced difficulty or delay in obtaining care, or did not receive needed health care services. (See Note 3.)

- Among these families, inability to afford health care was cited by the majority (59.9%) as the main problem. Another 19.5% cited insurance-related reasons as the main obstacle to receiving care. (See Note 4.)
- Families with a Hispanic head of household, or with one or more uninsured members, were substantially more likely to report experiencing barriers to receiving needed health care.

section 3

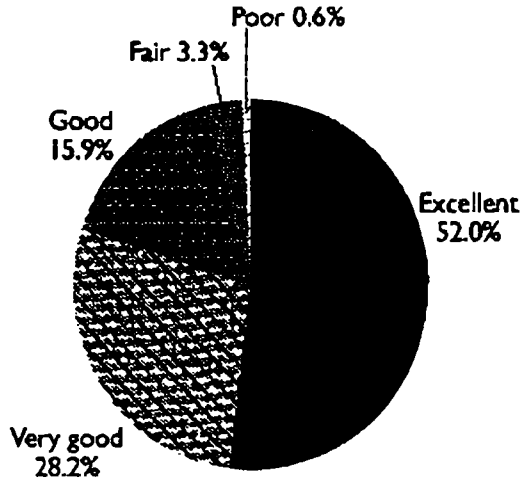
Children's Health Status

One main objective of our health care system is to maintain and improve American children's health. Consequently, children's health outcomes provide one indication of how well the system is functioning.

Answers to simple questions like the one reported here, which asked "Would you rate this child's health as excellent, very good, good, fair or poor?" have been shown to predict both demand for medical care services and medical outcomes.

Children's health status: Where do we stand?

Health status of children



- 80.2% of all children under the age of 18 were in excellent or very good health.
- Less than 1% of children were in poor health.
- Although they represent just under 4% of all American children under the age of 18, **2.8 million children were in fair or poor health.**

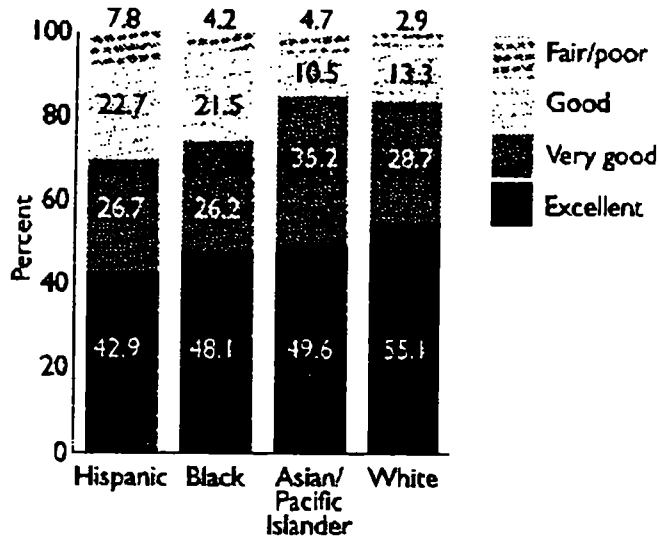
Medical Expenditure Panel Survey

Are minority children at greater risk of poor health?

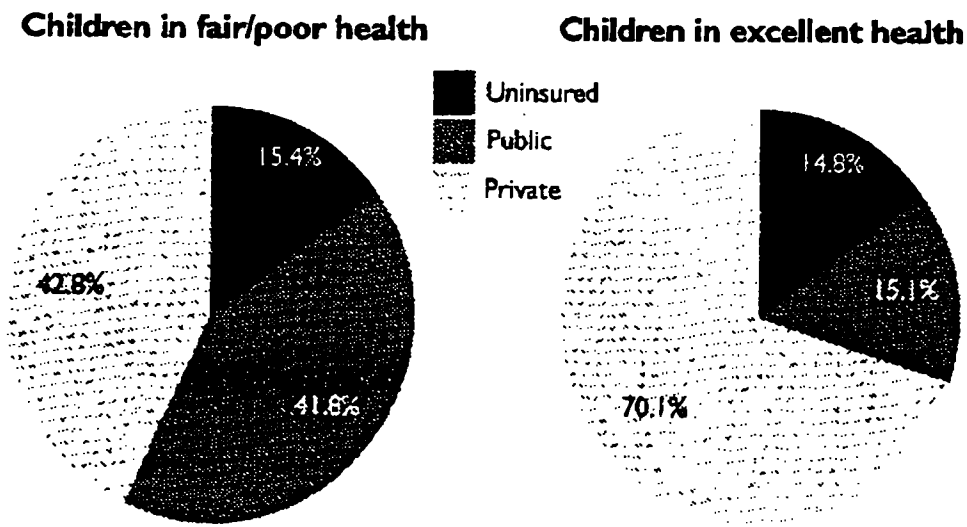
Children's health status varies by racial and ethnic group. This may in part be explained by differences in access to adequate health care.

- Hispanic children were more likely than black or white children to be in fair or poor health (7.8% of Hispanic children, compared with 4.2% of black children and 2.9% of white children).
- Black and Hispanic children were less likely than white children to be in excellent health (48.1% of black children and 42.9% of Hispanic children, compared with 55.1% of white children).

Perceived health status



Where do children in fair or poor health get their health insurance?



Children in fair or poor health were far more likely than children in excellent health to have public insurance. Children in excellent health were more likely to have private insurance. Because of public health care coverage, children with health problems were as likely to be insured as children in excellent health.

- Of children in fair or poor health, only 42.8% had private health insurance and 41.8% had public health insurance. Of children in fair or poor health, 15.4% had no insurance coverage.
- Of children in excellent health, 70.1% had private health insurance coverage, while 15.1% had public health insurance and 14.8% were uninsured.

P.05

conclusions

The data presented in this report suggest that:

- In spite of various policy initiatives, a substantial number of children in America remain uninsured.
- Black and Hispanic children are at increased risk of adverse outcomes, including being uninsured and being in poor health.
- Having a working parent is not enough to ensure children's access to private health insurance.
- The most common reason children do not get needed health care is because their families cannot afford it.
- Public coverage is a critical factor in providing insurance for children with health problems.

Future MEPS Data on Children

This report presents estimates of children's health insurance coverage, access to health care, and health status. Future data from MEPS will address a number of additional aspects of children's health care, including:

- The impact of managed care.
- Use of specific services.
- Use of preventive health services, including immunization status.
- Amounts paid for health care and sources of payment.
- Additional measures of health status, including health conditions and functional limitations.
- Changes in children's health insurance status over time.
- Amounts families pay for private health insurance coverage.

MEPS is a unique data resource for monitoring our Nation's health care system. As an ongoing survey, MEPS will produce data that can be used to examine changes over time.

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Weinick RM, Monheit AC. Family structure and children's health insurance coverage, 1977-1996. Paper presented at the 1997 Annual Meeting of the Association for Health Services Research.

In addition to the sources shown here, statistics in this chartbook are drawn from a variety of analyses by the MEPS staff. Many of these analyses will appear in future publications. Please consult the AHCPR Web site at

http://www.ahcpr.gov/

for an updated publications list or contact the MEPS information coordinator at AHCPR (301/594-1406) for additional information.

HILLARY RODHAM CLINTON

Thank you so much for this award. It is a pleasure to be here, and to join so many committed friends and advocates of America's children and families. I want to acknowledge the strong leadership of the Association of Maternal and Child Health Programs: President Deborah Klein Walker (Massachusetts Assistant Health Commissioner); the AMCHP Executive Council; executive director Catherine Hess and the rest of the staff; and all of you, who have worked so tirelessly to improve and strengthen maternal and child health programs in states and communities across the nation.

This Association has been a pioneer on behalf of America's women and children for over 50 years -- extending health care to servicemen's wives and children during World War II; ensuring community services were available for children with mental disabilities in the 1950's; and placing the spotlight on the need to provide comprehensive prenatal and infant care to low income women in our inner city neighborhoods, beginning in the 1960s.

And you've been our allies in the 1990s, working with the Clinton Administration to place the health and well being of families at the top of the nation's agenda. You've been our ~~allies~~ partners? in our efforts to improve immunization rates, and protect our children from the terrible affects of tobacco. You've helped to pass important legislation like the Kennedy-Kassebaum health insurance reforms. Thank you also for assuring strong national public health leadership -- through support for our new Surgeon General, Dr. David Satcher.

Yet as much progress as we've made on improving maternal and child health over the years, our nation faces another critical cross roads in our journey to give America's families the quality health care they need and deserve. Today, a report released by the Agency for Health Care Policy Research at HHS, confirms that there are eleven million ~~Kids~~ children in America who do not have health insurance. And four million of them are eligible for Medicaid, but are not enrolled. The report confirms our deepest fears, and more accurately reflects the extraordinary challenge before us.

As the world's wealthiest nation, these figures are not just a terrible shame. They are unacceptable. And we cannot let them stand.

The President, along with many of you, has taken the first crucial steps to begin turning this situation around. Last August, he signed into law the largest expansion of health care in 30 years. On that day, our nation made a commitment of $24 billion, aimed at insuring millions of children who didn't have health insurance. We also created a federal state partnership to fulfill this historic promise to America's children and their parents.

The fact that this money has been appropriated is -- as you know so well -- just the beginning of this battle, not the end. Now comes the even greater challenge ~~to~~ see that this health care coverage actually gets to the children who so desperately need it -- either by enrolling them in Medicaid, or the new Children's Health Insurance Program (CHIP).

We can pass all the laws we want, but if parents don't know their children are eligible, ~~or if they can't or won't fill out the forms~~, these laws will never filfill their promise.

We knew that finding them, scattered across the country, and then insuring them, would not be easy. But we also knew the consequences if we failed. So a few weeks ago, we opened a second front. The President announced an all out. $900 million effort to inform every family about health ensurance, so that they can enroll their uninsured children, and take advantage of this historic investment in health care.

First, he directed all federal agencies who run our children's programs -- such as WIC and food stamps, to cooperate in a comprehensive effort to make sure every family gets the information they need to enroll their children. They ~~are~~ can spread the word through agency employees, from pamphlets, a toll free number, or simpler application forms.

Second, states must take responsbility for ensuring that every eligible child within its borders gets insured -- and I know that many of you have been working at the state and community level to help expand insurance coverage -- with states like Colorado and South Carolina and Alabama leading the way.

Third, the private sector can, and must, play a crucial role in this effort. And already, many companies and foundations are stepping up to the plate. Bell Atlantic will ~~provide the leadership to~~ establish a new 800 number that will direct families to state agencies in charge of Medicaid. Safeway will put that number on their shopping bags. And the National Association of Chain Drug Stores and the National Community Pharmacists Association will help us get the word out to parents picking up prescriptions.

Private foundations continue to be strong partners -- with the Robert Wood Johnson Foundation and the Kaiser Family Famountation committing more than $23 million to finding better ways to expand coverage and outreach efforts.

Perhaps the most important allies, however, are the people on the front lines in our communities, who have contact with our children on a regular basis. We need to enlist every parent, every grandparent, doctor, nurse, ~~health care provider~~, teacher, camp counselor, coach, ~~business leader~~, minister, ~~local pharmacist~~, and neighbor to work together, and to find new ways of ~~reaching~~ our children and their parents. They must hear the message: "What you

don't know CAN hurt you." We must get parents informed -- and children enrolled. And we can't do it without all of you.

I recently met one of the families who has already suffered from lack of health care coverage -- but one who would benefit from these new measures. Linda Havemann is a full-time homemaker in Williamsburg, Virginia. Her husband, Tom, has a good job working as a mechanic, but they can't afford health insurance for their sons Raymond, 6, Michael, 3, and Andrew, 18 months. The two youngest have suffered with ear infectiosn since birth -- but they've never had regular doctor's visits because they don't have insurance.

Just recently, a Salvation Army social worker informed them that Michael and Andrew were eligible for Medicaid. When the Havemann's finally took the boys to the doctor, they found that Andrew had already lost 20 percent of his hearing, ~~and that his speech was delayed~~. A few weeks later, after surgery to insert tubes in his ears, Andrew said his first words: Mama, Dada, bubble, and shoe.

That's the good news. The bad news is that 6 year old Raymond is too old to quality for Virginia's Medicaid program. And that's where the Children's Health Insurance Program -- CHIP -- can help the millions of working parents like the Havemann's get the health care coverage they so desperately need. ~~We must remember that~~ the majority of kids not insured -- 90% of them -- live in homes like the Havemman's -- with one working adult.

These efforts to ensure our youngest and most vulnerable kids get the health care they need must be seen as part of the larger fabric of services and programs aimed at ensuring all of our nation's children get a healthy start in life. Children need to be healthy -- physically, emotionally, and intellectually. And one of the ways we can make sure they get those building blocks for the future is by providing safe, quality, affordable child care to America's working families.

That's why the President has proposed the single largest child care investment in the history of our nation. He claims he was responding to my ceaseless requests for action over the past 20 years -- but I know he believes as deeply as I do that this is part of America's unfinished business, and that it's time to give parents child care they can afford, trust, and rely on.

As many of you know, we held the first ever White House Conference on Child Care last year, to jump start efforts to improve child care in America. The urgency to act has been heightened by new scientific information we have gained about the emotional and intellectual developmetn of young children.

Science has confirmed what all mothers and grandparents and care givers have always known instinctively -- that how we interact with a child -- particularly in those early years -- affects how

well he or she learns and develops over a lifetime. And with 45 percent of our children under the age of one in regular day care, the issue of quality has tremendous bearing not only on individual lives, but on the future of this country.

And here, I want to recognize the important work that many of you have contributed over the years to strengthening the links between health care services and child care providers. I'm sure many of you are involved in one such Clinton Administration initiative called the Healthy Child Care America. And it's working. Already, partnerships betwen child care providers andhealth care servies have been established in 46 states.

The Clinton Child Care initiative builds on these efforts, by stepping up enforcement of state health and safety standards, and providing scholarships for child care workers -- so they are better trained to give children the stimulating and loving atmopshere they need to grow and thrive.

Giving our children the best possible start in life -- by building healthy bodies and active minds -- is our greatest challenge -- and when met, our greatest reward. And to succeed, it will demand the resources, energy, creativity, and commitment of every one of us. Whether it's working at the state level to deliver quality maternal and child health programs; promoting literacy efforts in our communities where doctors "presecribe" books for parents to read to their children; or printing an 800 number on shopping bags to alert parents they could be eligible for health insurance; we are making crucial investments in the health and well-being of our children. And thus, in the future of our nation.

This month, we celebrate Women's History Month -- giving us an opportunity to look back on the historic strides that this country has made on behalf of women and children -- but also to guird ourselves for the new and difficult challenges that we face as we enter the 21st century. As this gathering knows so well, and as I've seen so vividly on my travels around the world, whenever we see an investment in women -- whether it's in women's rights, women's businesses, or women's health -- we see progress for families, progress for communities, and progress for the nation.

I was remembering recently one mother's day, when Chelsea, my daughter, was about 4 years old. We were at a church in Little Rock, and during the children's sermon, the minister asked the kids: "If you could give your mommy anything in the world today, what would it be?" Chelsea answered without hesitation: "life insurance." That broke up the congregation. It turned out she thought life insurance meant you could live forever.

As much progress as this group -- and others like you around the country -- we can't make any one of us live forever. But we can recommit ourselves to improving the quality of life of our children and families. Thank you you for your invaluable contributions toward that goal.