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- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
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**THE KAISER COMMISSION ON
Medicaid and the Uninsured**

**CHIP PROGRAM ENROLLMENT:
DECEMBER 1998 TO DECEMBER 1999**

Prepared by:

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July 2000

The Kaiser Commission on Medicaid and the Uninsured serves as a policy institute and forum for analyzing health care coverage and access for low-income populations and assessing options for reform. The Commission, begun in 1991, strives to bring increased public awareness and expanded analytic effort to the policy debate over health coverage and access, with a special focus on Medicaid and the Uninsured. The Commission is a major initiative of the Henry J. Kaiser Family Foundation and is based in the Foundation's Washington, D.C. office. The Foundation is an independent national health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries.

Introduction

In the Balanced Budget Act of 1997 Congress authorized the creation of the State Child Health Insurance Program (CHIP) under Title XXI of the Social Security Act. Since then, states have moved quickly to design and implement their programs. States have placed priority on finding and enrolling eligible children, reflecting the great public policy interest in providing health coverage to uninsured children.

The first CHIP State Plan was approved by the Health Care Financing Administration (HCFA) for the state of Alabama in January 1998. By December 1998, HCFA had approved CHIP plans in 39 states and the District of Columbia, and in all states and territories by the end of 1999.¹ In three states (Hawaii, Washington and Wyoming) CHIP programs were not yet operational as of December 1999.²

This study focuses on the changes in enrollment in State CHIP programs over the period from December 1998 to December 1999.³ It is part of a larger study of enrollment trends in Medicaid and CHIP for the Kaiser Commission on Medicaid and the Uninsured.⁴

Under Title XXI of the Social Security Act, a state can opt to implement its CHIP program as a Medicaid expansion program, or as a separate, stand-alone program, or as a combination of both program types. This study presents data on each of these program types.

Study Methodology and Data Issues

This study is based on a survey of all 50 states and the District of Columbia. It reflects data from all State Child Health Insurance Programs. The data are those as reported by the states for the specific months of December 1998, June 1999 and December 1999. The goal was to gather point-in-time data for the number of children enrolled in these specific months.

¹ Although CHIP programs were also operational in the Territories, data for these programs were not obtained for this report.

² Minnesota's CHIP program had zero enrollment in December 1999. However, the MinnesotaCare Medicaid expansion program covers children up to 275% of the federal poverty level. Because Minnesota Care was implemented prior to Title XXI, it does not qualify for CHIP funding. MinnesotaCare covered 57,889 children in March 2000.

³ This study updates an earlier study: *Enrollment Increases in State CHIP Programs: December 1998 to June 1999*, Kaiser Commission on Medicaid and the Uninsured, July 30, 1999. (Publication #2153).

⁴ See: *Medicaid Enrollment in 21 States, June 1997 to June 1999*, Kaiser Commission on Medicaid and the Uninsured. April 2000. (Publication #2190).

THE KAISER COMMISSION ON Medicaid and the Uninsured

Point-in-time monthly data are useful in examining trends over specific periods of time, particularly during the early months of implementation of a new program. In contrast, data reported by HCFA present a different measure of enrollment. HCFA data are based on the number of children enrolled at any point in time, for any number of months, during the federal fiscal year.

For example, in January 2000 the U.S. Department of Health and Human Services reported "...that two million children who would otherwise be without health insurance coverage were enrolled in the State Child Health Insurance Program (CHIP) in fiscal year 1999."⁵ The report shows that 1,979,450 children were enrolled during all or a part of the federal fiscal year, the period from October 1, 1998 to September 30, 1999. This total included 1,284,387 in separate CHIP programs and 695,063 in Medicaid expansion programs.⁶

The HCFA report thus reflects the total number of children who were enrolled in a State CHIP program at any time during the twelve month period. A child enrolled for one month is counted the same as a child enrolled for the year. In contrast, the data in this report show the number enrolled at specific points in time: the months of December 1998, June 1999 and December 1999. By definition, the number of children enrolled in any specific month is less than or at most equal to the number enrolled during all or any part of the year. Thus, the CHIP enrollment numbers reported here are lower than those presented in the HCFA annual report.

The data in this report were provided by each state after a lag of one to five months following the month of December 1999. In some cases, states updated data they had provided for December 1998 and for June 1999 that were in our previous report.⁷ That report was published just one month after the period for which data were reported. A greater period of time to gather data was taken for this report to provide additional time for states to make adjustments in their counts of enrollment.

Study Results

Over the one-year period from December 1998 to December 1999, the number of children enrolled in State Child Health Insurance Programs more than doubled. Based on data reported by the states, the number of children enrolled in CHIP programs increased from 833,303 in December 1998 to 1,766,174 in December 1999. As shown in Table 1, this increase in enrollment of 932,871 represents an annual increase of 112%.

⁵ Press release from HCFA Press Office dated January 11, 2000, "State Children's Health Insurance Program Now Reaching Two Million." See <http://www.hcfa.gov/init/20000111.htm>.

⁶ HCFA, State Children's Health Insurance Program, Annual Report for FY1999, January 11, 2000.

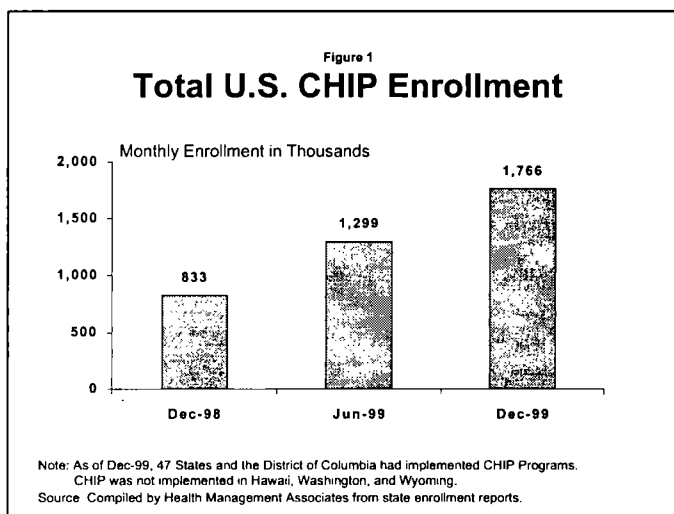
⁷ *Enrollment Increases in State CHIP Programs: December 1998 to June 1999*, Kaiser Commission on Medicaid and the Uninsured, July 30, 1999. (Publication #2153).

Table 1

CHIP Enrollment by Program Type, December 1998 to December 1999

	Enrollment		Growth	Percent Change
	Dec-98	Dec-99	12/98 to 12/99	12/98 to 12/99
Total (47 States and DC)	833,303	1,766,174	932,871	112%
Medicaid Expansions Only <i>21 States and DC</i>	228,465	455,848	227,383	100%
Separate Programs Only <i>14 States</i>	391,772	752,913	361,141	92%
Combined Programs <i>12 States</i>	213,066	557,413	344,347	162%
Medicaid Expansion	105,317	171,597	66,280	63%
Separate Program	107,749	385,816	278,067	258%
All Medicaid Expansions <i>33 States and DC</i>	333,782	627,445	293,663	88%
All Separate Programs <i>26 States</i>	499,521	1,138,729	639,208	128%

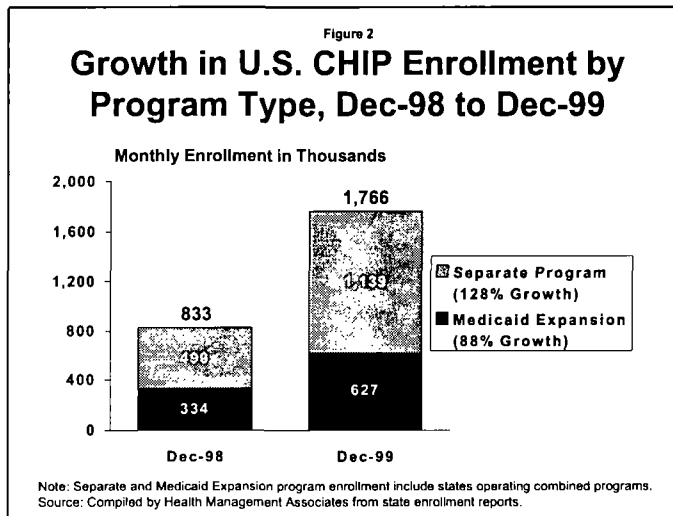
The increase in the number enrolled was roughly the same in the first six months of the year as in the last six months. As shown in Figure 1, in the first six months of 1999, the number enrolled increased by 465,239, from 833,303 to 1,298,542 (56%). In the last six months of 1999, the number enrolled increased by 467,632 to 1,766,174 (36%).



These aggregate increases mask considerable variation at the state level (see Appendix Table 1). While enrollment doubled in 20 states during the study period, growth began to moderate in several states, particularly in those that had implemented their programs relatively early on. However, one state (Texas) reported an 18% decrease over the study period.

CHIP Enrollment by Program Type 1999

From December 1998 to December 1999, substantial rates of increase occurred across all program types as many states began to implement CHIP during this period. Enrollment increases in separate programs were greater than in Medicaid expansion programs, both in the number of children enrolled and in the percentage increase.

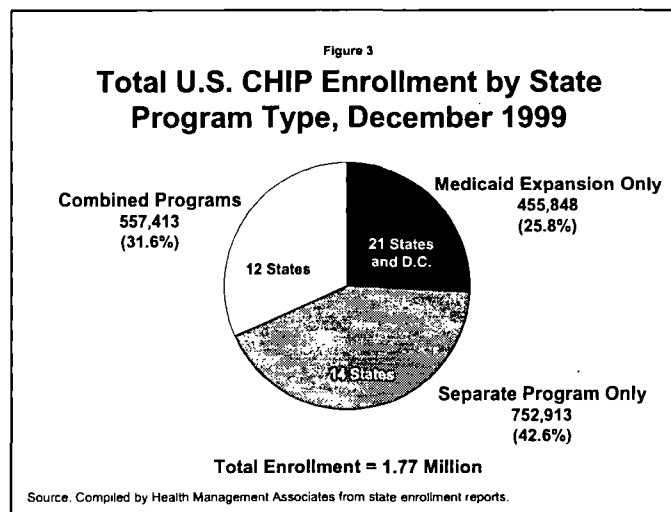


Total Medicaid expansion program enrollment increased by 88% while total separate program enrollment increased by 128% over the year ending December 1999 (Figure 2). Just over two-thirds of the growth in total CHIP enrollment was in separate programs over this period.

The greatest rates of growth occurred in the 12 states with both types of programs

operating at the same time. In these states, the overall CHIP enrollment increased by 162% over the study period, with separate program enrollment rising by 258% (Table 1).

Figure 3 displays total CHIP enrollment by state program type as of December 1999. The majority of children were enrolled in states with separate CHIP programs (42.6%), while 31.6% were enrolled in states operating combined programs, and the remaining 25.8% were in Medicaid expansion states.



Conclusion

Significant rates of increase in enrollment in State Child Health Insurance Programs occurred in the year ending in December 1999. The pace of enrollment increase continued throughout the year and in almost every state. These increases reflect the priority that states continue to place on finding and enrolling eligible children.

Appendix Tables

Table 1: Total CHIP Enrollment, December 1998 to December 1999

Table 2: CHIP Enrollment in Medicaid Expansion Only States, 12/98 to 12/99

Table 3: CHIP Enrollment in Separate Program Only States, 12/98 to 12/99

Table 4: CHIP Enrollment in Combined Program States, 12/98 to 12/99

Table 5: CHIP and Medicaid for Children Eligibility Levels, July 2000

**THE KAISER COMMISSION ON
Medicaid and the Uninsured**

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Medicaid and the Uninsured**

Table 1

Total CHIP Enrollment, December 1998 to December 1999

	Program Type*	Enrollment			Percent Change		
		Dec-98	Jun-99	Dec-99	12/98-6/99	6/99-12/99	12/98-12/99
United States		833,303	1,298,542	1,766,174	56%	36%	112%
Alabama	C	22,102	31,258	33,337	41%	7%	51%
Alaska	M	0	3,093	7,346	NA	138%	NA
Arizona	S	3,710	14,985	27,765	304%	85%	648%
Arkansas	M	341	712	1,021	109%	43%	199%
California	C	55,189	133,991	202,514	143%	51%	267%
Colorado	S	11,704	17,783	23,375	52%	31%	100%
Connecticut	C	5,524	8,569	9,088	55%	6%	65%
Delaware	S	0	1,732	2,494	NA	44%	NA
District of Columbia	M	569	1,924	2,187	238%	14%	284%
Florida	C	56,265	101,080	124,763	80%	23%	122%
Georgia	S	0	31,085	56,116	NA	81%	NA
Hawaii	M	0	0	0	NA	NA	NA
Idaho	M	2,937	3,541	4,728	21%	34%	61%
Illinois	M	26,877	38,586	47,020	44%	22%	75%
Indiana	M	24,982	28,909	31,668	16%	10%	27%
Iowa	M	7,004	9,252	9,979	32%	8%	42%
Kansas	S	0	11,024	15,206	NA	38%	NA
Kentucky	C	1,145	8,179	31,783	614%	289%	2676%
Louisiana	M	3,741	17,628	26,581	371%	51%	611%
Maine	C	4,490	6,514	8,147	45%	25%	81%
Maryland	M	9,192	14,494	16,160	58%	11%	76%
Massachusetts	C	28,146	31,565	52,508	12%	66%	87%
Michigan	C	10,949	17,738	20,467	62%	15%	87%
Minnesota	M	8	8	4	0%	-50%	-50%
Mississippi	C	5,968	7,717	11,380	29%	47%	91%
Missouri	M	24,910	42,251	54,306	70%	29%	118%
Montana	S	0	943	2,458	NA	161%	NA
Nebraska	M	3,764	5,192	6,252	38%	20%	66%
Nevada	S	2,782	6,545	7,634	135%	17%	174%
New Hampshire	C	11	1,568	2,169	NA	38%	NA
New Jersey	C	22,926	35,574	52,322	55%	47%	128%
New Mexico	M	0	868	2,383	NA	175%	NA
New York	S	270,683	352,273	425,522	30%	21%	57%
North Carolina	S	17,887	43,774	55,723	145%	27%	212%
North Dakota	M	79	92	1,026	16%	1015%	1199%
Ohio	M	35,300	38,420	64,609	9%	68%	83%
Oklahoma	M	15,523	25,452	32,503	64%	28%	109%
Oregon	S	10,366	12,608	14,118	22%	12%	36%
Pennsylvania	S	68,376	78,998	87,592	16%	11%	28%
Rhode Island	M	2,981	4,666	6,978	57%	50%	134%
South Carolina	M	34,026	42,198	43,773	24%	4%	29%
South Dakota	M	1,405	2,038	2,789	45%	37%	99%
Tennessee	M	0	0	16,935	NA	NA	NA
Texas	M	34,826	34,527	28,490	-1%	-17%	-18%
Utah	S	4,438	9,937	13,709	124%	38%	209%
Vermont	S	406	1,095	1,632	170%	49%	302%
Virginia	S	1,420	12,138	19,569	755%	61%	1278%
Washington	S	0	0	0	NA	NA	NA
West Virginia	C	351	2,618	8,935	646%	241%	2446%
Wisconsin	M	0	3,400	49,110	NA	1344%	NA
Wyoming	S	0	0	0	NA	NA	NA

* M = Medicaid Expansion (23) / S = Separate Program (16) / C = Combined Program (12)

Note: As of 12/31/99 CHIP was implemented in 47 States and the District of Columbia. CHIP was not implemented in Hawaii, Washington, and Wyoming. Increases above 10,000% reported as NA.

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Table 2

CHIP Enrollment in Medicaid Expansion Only States, 12/98 to 12/99

	Enrollment			Percent Change		
	Dec-98	Jun-99	Dec-99	12/98-6/99	6/99-12/99	12/98-12/99
Total (22 States)	228,465	317,251	455,848	39%	44%	100%
Alaska	0	3,093	7,346	NA	138%	NA
Arkansas	341	712	1,021	109%	43%	199%
District of Columbia	569	1,924	2,187	238%	14%	284%
Idaho	2,937	3,541	4,728	21%	34%	61%
Illinois	26,877	38,586	47,020	44%	22%	75%
Indiana	24,982	28,909	31,668	16%	10%	27%
Iowa	7,004	9,252	9,979	32%	8%	42%
Louisiana	3,741	17,628	26,581	371%	51%	611%
Maryland	9,192	14,494	16,160	58%	11%	76%
Minnesota	8	8	4	0%	-50%	-50%
Missouri	24,910	42,251	54,306	70%	29%	118%
Nebraska	3,764	5,192	6,252	38%	20%	66%
New Mexico	0	868	2,383	NA	175%	NA
North Dakota	79	92	1,026	16%	1015%	1199%
Ohio	35,300	38,420	64,609	9%	68%	83%
Oklahoma	15,523	25,452	32,503	64%	28%	109%
Rhode Island	2,981	4,666	6,978	57%	50%	134%
South Carolina	34,026	42,198	43,773	24%	4%	29%
South Dakota	1,405	2,038	2,789	45%	37%	99%
Tennessee	0	0	16,935	NA	NA	NA
Texas	34,826	34,527	28,490	-1%	-17%	-18%
Wisconsin	0	3,400	49,110	NA	1344%	NA

Table 3

CHIP Enrollment in Separate Program Only States, 12/98 to 12/99

	Enrollment			Percent Change		
	Dec-98	Jun-99	Dec-99	12/98-6/99	6/99-12/99	12/98-12/99
Total (14 States)	391,772	594,920	752,913	52%	27%	92%
Arizona	3,710	14,985	27,765	304%	85%	648%
Colorado	11,704	17,783	23,375	52%	31%	100%
Delaware	0	1,732	2,494	NA	44%	NA
Georgia	0	31,085	56,116	NA	81%	NA
Kansas	0	11,024	15,206	NA	38%	NA
Montana	0	943	2,458	NA	161%	NA
Nevada	2,782	6,545	7,634	135%	17%	174%
New York	270,683	352,273	425,522	30%	21%	57%
North Carolina	17,887	43,774	55,723	145%	27%	212%
Oregon	10,366	12,608	14,118	22%	12%	36%
Pennsylvania	68,376	78,998	87,592	16%	11%	28%
Utah	4,438	9,937	13,709	124%	38%	209%
Vermont	406	1,095	1,632	170%	49%	302%
Virginia	1,420	12,138	19,569	755%	61%	1278%

**THE KAISER COMMISSION ON
Medicaid and the Uninsured**

Table 4

CHIP Enrollment in Combined Program States, 12/98 to 12/99

	Enrollment			Percent Change		
	Dec-98	Jun-99	Dec-99	12/98-6/99	6/99-12/99	12/98-12/99
Combined Total (12 States)	213,066	386,371	557,413	81%	44%	162%
Medicaid Expansion Total	105,317	148,790	171,597	41%	15%	63%
Alabama	9,696	10,510	9,461	8%	-10%	-2%
California	11,563	16,815	20,548	45%	22%	78%
Connecticut	3,668	5,089	4,647	39%	-9%	27%
Florida	24,662	24,733	21,078	0%	-15%	-15%
Kentucky	1,145	8,179	28,474	614%	248%	2387%
Maine	3,198	4,707	5,442	47%	16%	70%
Massachusetts	17,186	27,326	36,460	59%	33%	112%
Michigan	4,943	7,059	8,218	43%	16%	66%
Mississippi	5,968	7,717	10,872	29%	41%	82%
New Hampshire	11	273	113	2382%	-59%	927%
New Jersey	22,926	35,574	25,198	55%	-29%	10%
West Virginia	351	808	1,086	130%	34%	209%
Separate Program Total	107,749	237,581	385,816	120%	62%	258%
Alabama	12,406	20,748	23,876	67%	15%	92%
California	43,626	117,176	181,966	169%	55%	317%
Connecticut	1,856	3,480	4,441	88%	28%	139%
Florida	31,603	76,347	103,685	142%	36%	228%
Kentucky	0	0	3,309	NA	NA	NA
Maine	1,292	1,807	2,705	40%	50%	109%
Massachusetts	10,960	4,239	16,048	-61%	279%	46%
Michigan	6,006	10,679	12,249	78%	15%	104%
Mississippi	0	0	508	NA	NA	NA
New Hampshire	0	1,295	2,056	NA	59%	NA
New Jersey	0	0	27,124	NA	NA	NA
West Virginia	0	1,810	7,849	NA	334%	NA

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Medicaid and the Uninsured**

Table 5

CHIP and Medicaid for Children Eligibility Levels, July 2000

State	Medicaid Infants (0-1)	Medicaid Children (1-5)	Medicaid Children (6-16)	Medicaid Children (17-19)	Separate State Program	Date Implemented*
Alabama	133	133	100	100	200	Feb-98/Sep-98
Alaska	200	200	200	200	---	Mar-99
Arizona	140	133	100	29	200	Nov-98
Arkansas	200	200	200	200	---	Oct-98
California	200	133	100	100	250	Mar-98/Jul-98
Colorado	133	133	100	36	185	Apr-98
Connecticut	185	185	185	185	300	Jul-97/Jun-98
Delaware	185	133	100	100	200	Feb-99
D.C.	200	200	200	200	---	Oct-98
Florida	200	133	100	100	200	Apr-98/Apr-98
Georgia	185	133	100	100	235	Nov-98
Hawaii	200	200	200	200	---	Jan-00
Idaho	150	150	150	150	---	Oct-97
Illinois	200	133	133	133	185	Jan-98
Indiana	150	150	150	150	200	Oct-97 phase-in
Iowa	200	133	133	133	200	Jul-98
Kansas	150	133	100	100	200	Jan-99
Kentucky	185	150	150	150	200	Jul-98/Jul-99
Louisiana	150	150	150	150	---	Nov-98
Maine	200	150	150	150	200	Jul-98/Aug-98
Maryland	200	200	200	200	---	Jul-98
Massachusetts	200	150	150	150	400	Oct-97/Aug-98
Michigan	185	150	150	150	200	May-98/Sep-98
Minnesota	280	275	275	275	---	Oct-98
Mississippi	185	133	100	100	200	Jul-98/Jan-99
Missouri	300	300	300	300	---	Jul-98
Montana	133	133	100	40	150	Jan-99
Nebraska	185	185	185	185	---	May-98
Nevada	133	133	100	70	200	Oct-98
New Hampshire	300	185	185	185	300	May-98/Jan-99
New Jersey	185	133	133	133	350	Feb-98/Mar-98
New Mexico	235	235	235	235	---	Aug-98
New York	185	133	100	100	250	Apr-98
North Carolina	185	133	100	100	200	Oct-98
North Dakota	133	133	100	100	140	Oct-98
Ohio	200	200	200	200	---	Sep-98
Oklahoma	185	185	185	185	---	Dec-97 phase-in
Oregon	133	133	100	100	170	Jul-98
Pennsylvania	185	133	100	36	235	May-98
Rhode Island	250	250	250	250	---	May-98
South Carolina	185	150	150	150	---	Oct-97
South Dakota	140	140	140	140	---	Jul-98
Tennessee	400	400	400	400	---	Oct-97 phase-in
Texas	185	133	100	100	200	Jul-98
Utah	133	133	100	100	200	Aug-98
Vermont	300	300	300	300	---	Oct-98
Virginia	133	133	100	100	185	Oct-98
Washington	200	200	200	200	250	Jan-00
West Virginia	150	150	100	100	150	Jul-98/Mar-99
Wisconsin	185	185	185	185	---	Jul-98 phase-in
Wyoming	133	133	100	50	133	Nov-99

* Combined programs are reported as Medicaid Expansion Date / Separate Program Date. Those programs where eligibility was expanded over time are reported as "phase-in."

Note: Refer to "Medicaid for Children and CHIP Income Eligibility and Enrollment Procedures: Findings from a 50-State Survey," April 2000, prepared by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured for more details on eligibility requirements.

Source: The Center on Budget and Policy Priorities (unpublished), July 2000 and National Governors' Association and National Conference of State Legislatures, State Children's Health Insurance Program: Annual Report, 1999.

National Bipartisan Commission on the Future of Medicare

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**THE NATIONAL BIPARTISAN COMMISSION ON
THE
FUTURE OF MEDICARE**

**TRANSCRIPT OF
COMMISSION MEETING**

Washington, DC

Wednesday, February 24, 1999

MEMBERS OF COMMISSION

SENATOR JOHN BREAUX, *Statutory Chairman*

REPRESENTATIVE BILL THOMAS, *Administrative Chairman*

**STUART H. ALTMAN, Ph.D.
SENATOR J. ROBERT KERREY
REPRESENTATIVE MICHAEL BILIRAKIS
REPRESENTATIVE JIM McDERMOTT
COLLEEN CONWAY-WELCH, Ph.D.
SENATOR JOHN D. ROCKEFELLER, IV
REPRESENTATIVE JOHN D. DINGELL
DEBORAH STEELMAN
SENATOR WILLIAM H. FRIST
LAURA D'ANDREA TYSON, Ph.D.
ILLENE GORDON
BRUCE VLADECK, Ph.D.
SENATOR PHIL GRAMM
ANTHONY L. WATSON
SAMUEL H. HOWARD**

BOBBY JINDAL, *Executive Director*

**THE NATIONAL BIPARTISAN
COMMISSION ON THE
FUTURE OF MEDICARE**

Transcript of

Wednesday, February 24, 1999

Commission Meeting

Mr. ALTMAN. I have made them very clear. I think we need to be able to cover drugs for everybody. I think they ought to be affordable in a balanced way. I don't think what is in the chairman's outline is a drug benefit. That is my point of view. I do think we need to define a set of benefits, because I am afraid of shifting around.

I need to know how we are going to fund this. I am concerned about the regional reallocation of dollars and what it could do to high-spending, high-quality areas in different parts of the country. These are areas that are very important to me and I think to the health care system.

Yet, I like the premium support. I think it moves us in the right direction. I think it brings around these kinds of competitive forces that I would like to see. But these four areas just overwhelm me. I have a feeling I am not alone. So, my concern is I am missing something; why we are forcing this into today or tomorrow. Is there something about the calendar I am missing? We are talking about the Medicare Program for 50 years.

Mr. THOMAS. I thank the gentleman for the specific points.

Senator BREAU. Dr. Vladeck?

Mr. VLADECK. This is really a question. The staff analysis, about which I still have some very serious concerns, does make estimates of the impact on beneficiaries, on their premiums on this proposal. That is not apparent. It was done more quickly and I understand some of the limitations of the actuaries scoring. But I have a very specific two-part question in this regard if I can.

As I understand the proposal that the actuaries scored, the premiums paid by beneficiaries, putting aside all the other savers in this proposal; just on the premium support, the premiums paid by beneficiaries who chose to remain in the fee-for-service plan would go up to a level substantially higher than current law under this premium support proposal.

Mr. DINGELL. Under one proposal it would go up 18 percent. Then under the other it would go up 30 percent.

Mr. VLADECK. With all due deference to your expertise, I wonder if we could address the issue to the actuary.

Senator BREAU. Jay Rockefeller qualifies.

Senator ROCKEFELLER. Rick Foster is sitting right over here.

Mr. VLADECK. I'll be glad to have Bobby.

Senator BREAU. Bobby will go first and will give a comment to Dr. Vladeck's question.

Mr. JINDAL. Let me start with the Commission analysis.

Mr. VLADECK. I don't want to talk about the Commission analysis because we will get into a fight. I have asked you about the actuarial analysis. I am trying to move this along and be quiet about it.

Mr. DINGELL. Let's have the actuary come up and give us the actuarial view.

Senator BREAUX. Bob, give the explanation. Then I can ask Rick to come up if he wants to come.

Mr. JINDAL. Right.

Now, we have provided the details provided to us by--I did talk to Rick who indicated under their assumption it is true that even though the weighted-average premium would decline and, therefore, the average premium paid would decline. The fee-for-service premium and other plans that are higher than the national average would also go up.

I think you referred to two numbers; the Representative referred to two numbers, 18 and 30 percent. In my conversation I understood that they would go up by between 18 and 30 percent depending on the standard or the limited variation. Then they would come back down because you would have savings in fee-for-service plans because of some of these things like the BBA extenders and the modernization.

Mr. VLADECK. But that is to say that if you had those other things and no premium support, the premiums paid by beneficiaries staying in fee-for-service would go down relative to current law; is that not correct?

Mr. JINDAL. I am sorry? One more time?

Mr. VLADECK. I think what you just said is that the impact on beneficiaries staying in fee-for-service options of premium support would in the aggregate proposal be substantially ameliorated by the savings from the other aspects of that proposal.

Mr. JINDAL. Two points; first of all this was something that we started off discussing at the very beginning. As about the savings, for instance, the BBA extenders and the fee-for-service modernizations. Certainly it is something for the Commission to discuss as to whether those policies would be outside the context of premium support or those will only be considered inside the context of premium support.

Mr. VLADECK. I am not asking a policy question. I am just asking a factual question, Bobby; that if you did everything in Senator Breau's proposal other than premium support, premiums for beneficiaries in fee-for-service plans would go down relative to current law. Whereas they would go up if you included premium support as analyzed by the actuary. That is just a factual question.

Mr. JINDAL. Accepting all of those caveats, I would say yes. Now, if you will allow me to talk about our analysis and why we disagree, I would give you a different answer.

Mr. VLADECK. I didn't ask you that. If someone else wants to, that's fine.

But I do have a separate question.

Mr. JINDAL. I'm sorry; I forgot. I said two things; there was a second point I had in terms of the actuarial analysis. When I talked to the actuary, he reflected that 18 to 30 percent off of today's premiums, not what they would necessarily otherwise be.

Two big caveats on that. Even under current law; even if you assume the part B premium only was 25 percent of part B's cost, it would not stay at 12 percent of the program's cost. Whereas, in our premium support proposal we've assumed that it stays at 88/12, it would grow up to 14 percent over time.

So, if you look at that increase, that would increase the 12 percent up to approximately 14 percent; maybe a little bit higher, maybe a little bit lower. So, if you actually look at

current law in Medicare spending versus what the premium support would do, even if you are forced to stay within that role and even if you take away those other offsets, all you are really talking about is a matter of timing. In some sense, the current law premiums are going to go up anyway as part B costs increase faster than part A.

The second caveat is that assumes that there is a way to fund part A after the trust fund goes insolvent, and that when it is funded, that is not going to result in benefit cuts or increases in costs to the beneficiaries.

So, those are huge caveats. If you accept all those, then yes, this would accelerate it, but those costs would have gone up over time.

Mr. VLADECK. I just heard the administrative chairman say there was a continuing commitment to fund it in a restructured manner. But two other points I want to make very, very quickly.

Senator BREAUX. Let me ask Rick Foster.

Rick, do you have anything different from what Bobby had? Is that accurate? Are there any differences? Do you have any different comment?

Mr. VLADECK. When Rick stands up, he really stands up.

* [Mr. FOSTER. What Bobby said is basically correct under the proposals that we estimated. The fee-for-service premiums; in other words, the premiums paid by people on fee-for-service plans would be significantly higher than under present law.

Now, the 18 and 30 percent that Representative Dingell mentioned, that is before you reflect the impact of other provisions that would reduce fee-for-service costs.

Mr. DINGELL. What are those other provisions?

Mr. FOSTER. The extensions in the Balanced Budget Act, the Medigap reforms.

Mr. DINGELL. So, what you are talking about here then is essentially reduction of benefits or increases in costs? One or the other, because the things that we are talking about in the Balanced Budget Act are, in fact, reduction of benefit levels to those covered retirees.

Mr. FOSTER. Their reductions in payments to providers.

Mr. DINGELL. Same difference. Cut benefits to provider----

Mr. THOMAS. Could you speak into a mike so that we could at least pick up half the conversation?

Mr. DINGELL. It is very simple. If you reduce those premiums, you are going to cut the benefits that you are going to be affording that class of persons. That is exactly what you are doing.

Mr. FOSTER. I characterize it differently. Back to what Dr. Vladeck asked, on the one hand the premium support formula is clearly designed to charge higher premiums for more expensive plans and lower premiums for the less expensive plans. Fee-for-service plans in this category will come out as a somewhat more expensive plans than average. They would carry a higher premium as a result.

The 18 to 30 percent can be reduced by about 7 or 8 or 9 percentage points to reflect

the fee-for-service that would otherwise be part of the package. I can't give you the exact figure today. We could do that. Under the one plan it would be 18 minus about 8 or 10. Under the other it would be 30 minus about 8 or 9, which would be 20 or even more.

Senator BREAU. I have got a whole lot of people----

Mr. VLADECK. I started out by saying I had two parts to this question. I just want to finish them.

Is it also correct that that higher premium paid by those in fee-for-service plans would be experienced under this model--and this is maybe even a design question--even by those who lived in communities such as rural communities in which there were no low-cost plans?

Mr. JINDAL. I think the design question is that the board could require private plans to offer in communities that might not otherwise have plans.

Mr. VLADECK. How would they do that?

Mr. JINDAL. The same way, in FEHBP. You can say, If you are going to serve a particular large city in this state, you have to also serve the surrounding rural parishes or counties. You are not allowed to come in and "cherry-pick" certain territories. In the FEHBP model you do have 10 choices in every county in the country.

Mr. VLADECK. That's constantly alleged and we can talk further about that at some other time, but just not to take all the time.

The answer to your first question, as I look at the actuaries scoring of the total savings associated with Senator Breau's proposal, depending on which of the two variations you use, I calculate that approximately two-thirds of the savings represent increases to beneficiaries. I would be curious if you or Rick wanted to comment on the extent.

Mr. JINDAL. I certainly would. First of all I would be curious if you characterize every reduction, for example, in payment to providers.

Mr. VLADECK. I would exclude those. I would count those in reductions in payments to providers as the other 30 percent.

Mr. JINDAL. I will certainly look at your math, but I do want to make the point that if you look at the Commission staff analysis, if you do believe there is a reduction in the growth rate, the vast, vast majority of these savings come from premium support.

Now, clearly if you start with a different assumption that premium support will not slow down the growth rate, you are going to get most of your savings from those proposals which result in short-term savings. If you look, for example, at the Commission staff analysis, and look at the long-run, the 20 to 30 analysis: Over 90 percent of the savings at that point in time are due to the fact that you have got these competitive forces that reduce the growth rate. If you will look at the handout, we do have people that say that, yes, they believe that would happen.

Mr. VLADECK. The people in the handout who attributed most of those savings, as the Shields Report does, to the increased costs for beneficiaries and higher costs----

Senator BREAU. I appreciate the questions. Let me get to Tony.

I'm sorry; Phil is next.

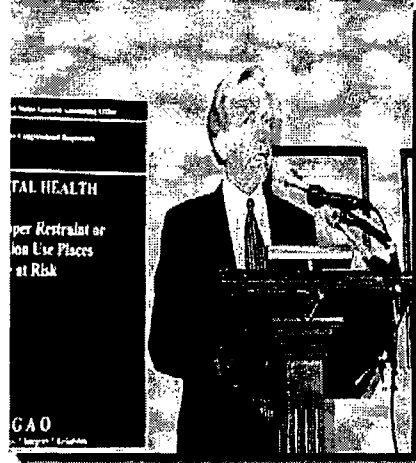


Senator Joe Lieberman
Representing the People of Connecticut



HEALTH CARE ISSUE BRIEF

Providing access to affordable, quality health care for people of all ages and economic backgrounds is an urgent priority for Senator Joe Lieberman. Far too many Americans, particularly seniors, lack coverage for critical commodities like preventive care, prescription drugs, and vision and dental care. Even the fully insured often do not receive services that they need to avoid illness; for example, a 1996 industry survey reported that 35 percent of children in HMOs had not been properly immunized. Medical miracles may be common on TV, but they are rare in real life. More people died from cancer in 1994 than 1979, diabetes is up, pneumonia is killing more often, and incidences of chronic pulmonary disease have increased. The human tragedy of unnecessary deaths and suffering is a constant call to action.



These are some of the reasons why Lieberman is committed to reforming the delivery of health care and rewarding providers who do the best job of keeping their patients alive and healthy. Just as the manufacturing industry went through a quality revolution in the 1970s, health care needs its own quality revolution. The cutting-edge information systems and productivity gains that have driven our economic boom now must be infused into American health care.

Lieberman has led the fight to address problems arising from this country's swift movement to managed care. He co-sponsored the Federal Health Care Quality, Consumer Information and Protection Act, which uses the federal government's purchasing power to drive competition on quality through the health care market place.

Promoting Responsible Managed Care Act

Driven by his belief that our public health is too important to be mired in politics-as-usual, Lieberman has tried to forge common ground as Congress has taken up managed care reform. Amid the partisan logjam in Congress over a Patients' Bill of Rights, Lieberman has sought to integrate the best ideas from both parties – introducing the bipartisan Promoting Responsible Managed Care Act in July 2000. The bill included a grievance process, health plan liability for economic damages, enhanced civil enforcement, information requirements for beneficiaries, and important benefit protections such as access to emergency care and breast surgery. Unfortunately, Congress has yet to pass any comprehensive HMO reform.

Reducing Medical Error

The disturbing findings of a December 1999 report on medical errors revealed a glaring hole in the American health care system and underscored the absence of patient safety controls. A study by National Academy of Sciences found that as many as 98,000 Americans die each year due to preventable medical mistakes, more than from breast cancer, AIDS, or car accidents. The Academy estimated that the cost of these mistakes in terms of health services and lost income and productivity to be between \$17 billion and \$29 billion annually.

Alarmed by these chilling numbers, Lieberman introduced the S.A.F.E. Act (Stop All Frequent Errors in Medicare and Medicaid Act.) The legislation requires all health care facilities that accept Medicare and Medicaid to establish safety procedures and report instances of serious error. The S.A.F.E. Act would require these hospitals to 1) establish medical safety programs that produce measurable reductions in errors, 2) report all deaths and serious injuries caused by medical error, 3) identify their exact causes, and 4) take steps to prevent further accidents. The bill also requires public disclosure of any facility that fails to comply with the reporting requirements or to address safety problems.

Deadly Restraints & The Mentally Ill

In 1998, the *Hartford Courant* ran a series of articles that detailed 142 deaths connected to the use of physical restraints and seclusion in mental health facilities. In response to the deeply disturbing series of reports, Lieberman joined with Senator Chris Dodd to propose a national remedy. Lieberman testified at two Congressional hearings, requested studies by Government Accounting Office and Congressional Research Service, chaired a panel at the White House Conference on Mental Health, and cosponsored numerous bills and amendments. As a result, patients in over 6,200 hospitals are now protected by new regulations on the use of restraints.

Health Care for the Armed Services

Senator Lieberman is a senior member of the Senate Armed Services Committee, which puts him in a unique position to push for health care quality reforms for the nation's military families. Lieberman has launched a coordinated effort to improve health services offered by the Department of Defense, whose programs care for millions of Americans.

The centerpiece of these reforms is known as informatics – an ambitious effort to use information technology to overhaul the nation's antiquated health information structure. Most industries spend about 10 percent of their budgets on information systems, yet the health care industry spends just two percent. As a result, doctors must rely on their memories for the bulk of clinical decisions and must keep abreast of rapidly evolving medical science by reading written journals. Moreover, patients' medical records today are kept almost entirely on paper, making life-or-death diagnoses difficult when those records are not immediately available. Informatics would use computer technology to integrate medical records and the latest scientific advances into one central network, enabling doctors to immediately access patient histories and the most recent, effective treatment options.

Lieberman has urged the Department of Defense to invest hundreds of millions of dollars in informatics – and then share the technology with the health care industry to benefit all Americans.

Breast Cancer

Lieberman has been an ardent supporter of the medical fight against breast cancer. He pushed the U.S. Postal Service to issue a breast cancer stamp to fund breast cancer research. His managed care legislation included several provisions to force HMOs to allow longer hospital stays for women who undergo reconstructive breast surgery. Lieberman also pushed for \$175 million (in FY99) to continue the innovative work of the Department of Defense Breast Cancer Research Program. He has also led Senate efforts to establish national standards for breast cancer screening for women ages 40 to 49, and to create a National Mammography and National Breast Cancer Survivors Day.

Lyme Disease

For years, Lieberman and Dodd have teamed up to wage a war against Lyme disease, which was initially discovered in Lyme, Connecticut. The pair shepherded through the FDA the

first Lyme Disease vaccines and helped pass new requirements for research and education on Lyme disease and other tick-borne illnesses.

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July 27, 2000

Lieberman Calls For Legislation To Address Medicare HMO Problems

WASHINGTON – Responding to concerns about the growing exodus of HMOs from Medicare, Senator Joe Lieberman today called for an immediate legislative solution to safeguard the health coverage of millions of seniors in Connecticut and around the country.

The problem stems from legislation Congress passed in 1997 to balance the budget. The Medicare provisions in that bill were expected to save \$100 billion over five years, but recent calculations put the actual cuts in Medicare payments at more than \$200 billion. As a result, community hospitals, teaching hospitals, rural hospitals, home health agencies, nursing facilities, and Medicare HMOs have been forced to cut back or drop services.

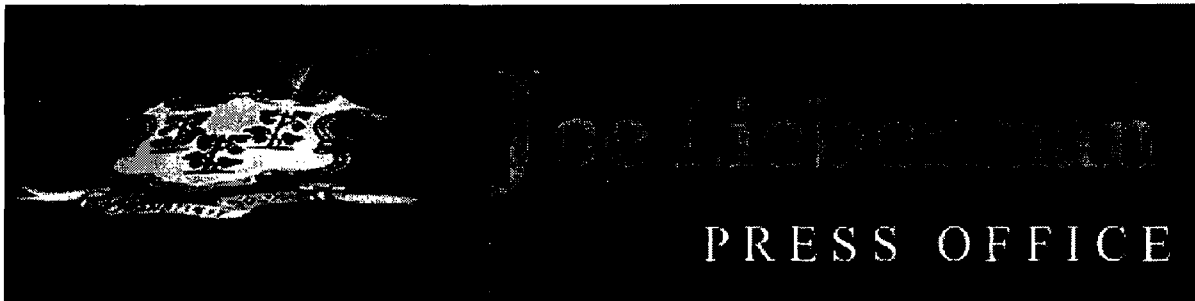
To prevent Medicare beneficiaries from losing coverage and access to care, Lieberman joined with 68 other senators in sending a letter to leaders of the Senate Finance Committee calling for action this year.

"When Medicare fails to pay its share, it threatens health care for all patients," the senators wrote in a letter to Senate Finance Chairman William Roth (R-DE) and Ranking Democrat Daniel Patrick Moynihan (D-NY). "Reduced Medicare payments are contributing to decisions by many providers and insurers that threaten Medicare beneficiaries' access to care, including staff layoffs, reductions in services, or even outright facility closures or decisions to withdraw from the Medicare program. As you well know, entire communities suffer when such actions take place."

Last month in Connecticut, four leading insurance providers – Aetna, Anthem Blue Cross, CIGNA, and Foundation Health – announced plans to withdraw from the state's Medicare HMO market, while Physicians Health Services said it will pull coverage in Middlesex and Litchfield counties. The withdrawals will force more than half of the state's seniors in Medicare HMOs, an estimated 52,000 people, to find other health insurance next year.

Connecticut's dire outlook mirrors the national picture, where Medicare shortfalls threaten the health coverage of more than 711,000 seniors next year. The crisis is a result of greater-than-expected savings wrought by the Balanced Budget Act, the senators wrote.

"The Balanced Budget Act had many benefits for the economy and the country," the senators wrote. "But the savings extracted from Medicare providers have gone much further than any of us expected when we voted for the legislation. A further installment of relief is clearly needed this year, and Congress can clearly afford to provide it."



April 6, 2000

Section-By-Section "Stop All Frequent Errors (SAFE) in Medicare and Medicaid Act of 2000" April 6, 2000

Section I. Title and Table of Contents

Section II. Purposes - This section describes the intent of the legislation which is to create a non-punitive medical error reduction program under the Medicare and Medicaid programs through identification of medical errors, extension of confidentiality with limited disclosure, and implementation of systems and processes to reduce the number of adverse events that occur.

Section III. Improvement of Patient Safety under the Medicare Program - This section establishes the guidelines for the medical error reduction program in the Medicare and Medicaid programs as a condition of participation.

Facilities that choose to participate in the Medicare and Medicaid programs including hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, hospice, renal dialysis facilities, and ambulatory surgery centers would have to meet the requirements of this Act.

Hospitals would be required to participate one year after the date of enactment of this Act. The other institutions would be phased-in on a timetable to be determined by the Secretary of Health and Human Services.

Providers would have to implement a patient safety program to reduce medical errors. The program will target both sentinel events and additional events associated with injury as targeted by the Secretary, or local providers. The program shall utilize active investigation to discover health care errors and achieve measurable improvement in the rates of health care errors.

In addition, providers would be required to report sentinel events and additional designated errors to the following: (1) their state health department; (2) a national accrediting organization when applicable, i.e. the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO); and (3) the Medicare peer review organizations. The facility would be responsible for performing a root-cause analysis and implementing a corrective action plan that reduces the risk of such event happening in the future. Providers can designate which agency or entity described above to approve their compliance with the reporting and

correction program. Aggregated reports without identifiers would be submitted to the Secretary by the agency or entity.

Confidentiality and privacy protections based on current peer review protections would be extended to ensure that institutions would be encouraged to report and to implement effective patient safety programs. Information would also be protected for the purposes of conducting peer review activities and root cause analysis.

A definition of poor performance in complying with the reporting and correction program will be specified by the Secretary, JCAHO, the Agency for Healthcare Research and Quality (AHRQ), the peer review organizations, providers and consumer organizations. When a facility has a pattern of poor performance, this information is reported to the Secretary and the Secretary shall then release this information to the public. This would occur if the pattern of poor performance continues for more than two years, and a provider fails to report sentinel events and implement corrective actions to address safety problems.

Section IV. Improvement of Patient Safety Under the Medicaid Program - This section extends the Medicare provisions above to congregate care providers in the Medicaid program. Congregate care provider is defined as facilities in the Medicaid program that provide hospital services, nursing facility services, services of intermediate care facilities for the mentally retarded, hospice care, residential treatment centers for children, services in an institution for mental diseases, and inpatient psychiatric hospital services for individuals under age of 21.

Section V. Establishment of the Center for Patient Safety - This section establishes a Center for Patient Safety (Center) within HHS. The mission of the Center is to improve patient safety and reduce the incidence of medical errors. The Center would establish national goals for patient safety and mechanisms to track such goals. In addition, the Center would prepare and submit an annual report to the President and Congress with recommendations concerning patient safety. Among some of its duties, the Center would develop a national health care patient safety research agenda, disseminate information and evaluate mechanisms to improve patient safety, and conduct pilot projects to conduct new or innovative patient safety reporting systems.

Section VI. Grants to Establish Patient Safety Programs - This section authorizes the Center to award grants to providers and health professionals affiliated with such providers for the establishment and operation of patient safety programs.

Section VII. Authorization of Appropriations - This section authorizes the following amounts:

- (1) For fiscal year 2001, \$30,000,000.
- (2) For fiscal year 2002, \$35,000,000.
- (3) For fiscal year 2003, \$40,000,000.
- (4) For each fiscal year thereafter, such sums as may be necessary.



February 22, 2000

Lieberman Praises White House Plan on Medical Errors as Solid First Step

WASHINGTON - Senator Joe Lieberman issued the following statement in response to the release of President Clinton's proposal to combat medical errors:

I am delighted that the Administration is heeding the Institute of Medicine's call for immediate action to reduce the number of preventable deaths caused by medical errors. The plan of action released today by the President underscores the enormous value and gravity of the IOM's report and the wisdom of its recommendations, many of which were incorporated wholesale into the President's proposal.

The President's statement today made absolutely clear that medical error is a serious problem in our healthcare system and it demands a serious response. The Administration has stepped up to the plate with funding, management changes in the health programs they run, and calls for a new way of fighting medical error in private health facilities.

I am particularly pleased that the Administration accepted responsibility for combating medical error in federal programs like Medicare, Tricare, and FEHB. Seniors should be able to go to a hospital with the confidence that they aren't going to die from a medication mistake. And soldiers and their families and other federal employees should be informed whether their health plans are serious about safety.

I am also pleased that the President reaffirmed the IOM's call for mandatory reporting of serious errors and reached out to health providers to extend confidentiality protections in current law to address their liability concerns.

The President has asked Congress to appropriate a modest amount of money, and we need to move quickly to fund that request, as well as to extend the confidentiality protections for medical safety and reporting programs.

But I hope we will not stop there. I am working with a bipartisan coalition in the Senate on legislation that will apply several of the key reforms the President talked about

apply several of the key reforms the President talked about today to the four major federal health care programs, which cover 90 million people, and we look forward to working with the Administration to building broad support for this complementary effort.

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February 15, 2000

Clinton Requests \$1 Million To Combat West Nile Virus

President heeds Lieberman's call for federal funding, proposes national monitoring system for infectious diseases

WASHINGTON - President Clinton has asked Congress to allocate \$1 million to research last fall's outbreak of the West Nile virus in New York and southwestern Connecticut and help prevent a recurrence.

In December, Senator Joe Lieberman convened a field hearing of the Senate Environment and Public Works Committee, where experts testified that though the West Nile virus had not previously been documented in the Western Hemisphere, it likely will return in the fall. Following that hearing, Lieberman wrote a letter to Clinton outlining the need for federal assistance.

In response, Clinton requested \$1 million in his FY20001 budget proposal to support biological research and surveillance of the virus across 19 states throughout the East, where officials fear that infected migratory birds may have spread the virus.

"It is crucial that this outbreak is seen as a national concern - not merely an isolated regional problem," Lieberman said. "I am glad that the President has heeded the advice of experts who desperately require funding to monitor bird populations. This funding, if approved by Congress, will allow public health agencies to anticipate exactly when and where the disease might return and take preventive action that could save lives."

The West Nile outbreak also prompted Clinton to request a \$35 million budget increase for the Centers for Disease Control and Prevention (CDCP) to study infectious diseases and create a "national architecture" for infectious disease surveillance that links public health clinics, hospitals and health care providers.

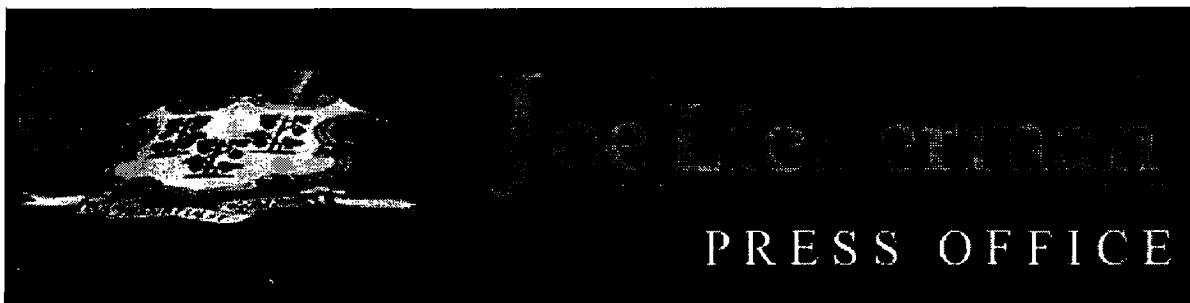
In January, the CDCP announced the availability of \$2.94 million in supplemental funding for states exposed to the West Nile virus. Lieberman wrote a letter to the CDCP in support of Connecticut's application for \$275,000 of that funding. Lieberman previously contacted CDCP Director Jeffery Koplan in December to request that the center take a leadership role in coordinating West Nile research and response efforts among federal agencies.

response efforts among federal agencies.

“All of these efforts represent our considered judgment that the most effective way to eliminate this virus is to vigorously study and monitor it now, at the earliest stages of detection,” Lieberman said. “Knowing your enemy is the key to winning any fight.”

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December 7, 1999

Lieberman Praises White House Action on Medical Errors

=====

Urges Hospital Association To Take Stronger Steps

WASHINGTON - Senator Joe Lieberman issued the following statement today in reaction to the directive President Clinton issued earlier in the day on medical errors.

I want to express my support and appreciation for the President's swift and decisive response to the disturbing findings of the Institute of Medicine, which revealed that every 10 minutes a patient dies somewhere in the U.S. as a result of medical error.

The federal government can help play a highly constructive and influential role in diminishing this risk as a purchaser, researcher, and patient advocate. That potential will soon be realized thanks to the President's call to implement the latest error reduction techniques in Medicare, the Federal Employee Health Benefits Program, and other government health services.

I applaud the President for not stopping there, and ordering the government's top health care experts to report back to him in 60 days with a series of recommendations on what else we can do to reduce the number of preventable deaths. As a senior member of the Senate committees with jurisdiction over the health care purchased for federal employees and members of the Armed Services, I am eager to see what they come up with and how we can work with the Administration to quickly implement the appropriate measures.

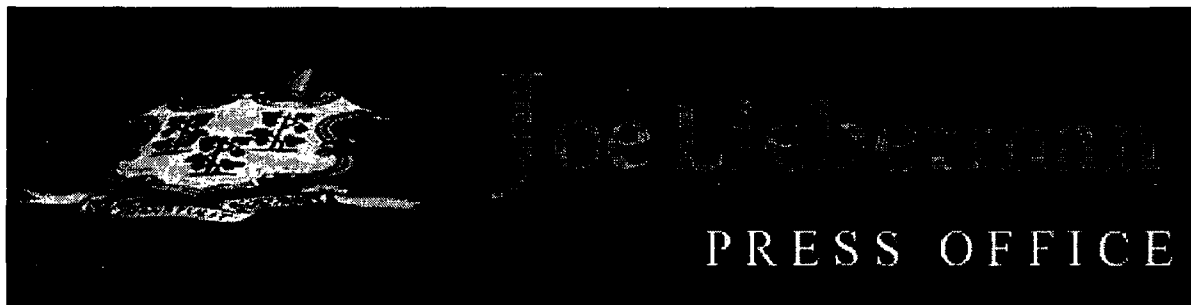
I also support the American Hospital Association's announcement of a partnership with the Institute for Safe Medication Practices. Hopefully, that broadened relationship will help reduce medication errors.

But I hope the hospitals will go beyond that. The public has the right to know when a medical error results in death. Husbands, wives, parents, and children deserve reports on facilities with error-prone systems that could result in death. I would urge the American Hospital Association and the

I would urge the American Hospital Association and the Administration to move quickly to implement the Institute of Medicine's mandatory reporting requirement. The policy of concealing medical error is a deadly failure according to the IOM. Now is the time to adopt a life-saving policy of disclosure.

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July 15, 1999

Lieberman Expresses Disappointment with Outcome of Patients' Bill of Rights Debate

=====

Centrist coalition denied opportunity to offer bipartisan alternative

WASHINGTON - Senator Joe Lieberman issued the following statement upon the conclusion of the Senate debate on patients' rights legislation Thursday night:

We have a serious problem with managed care in this country, as the angry complaints of many consumers have made abundantly clear. Unfortunately, we did not find a way to work across party lines this week to reach agreement on a suitable remedy.

As a result, we leave this debate having missed a valuable opportunity to improve the quality of health care for millions of American families.

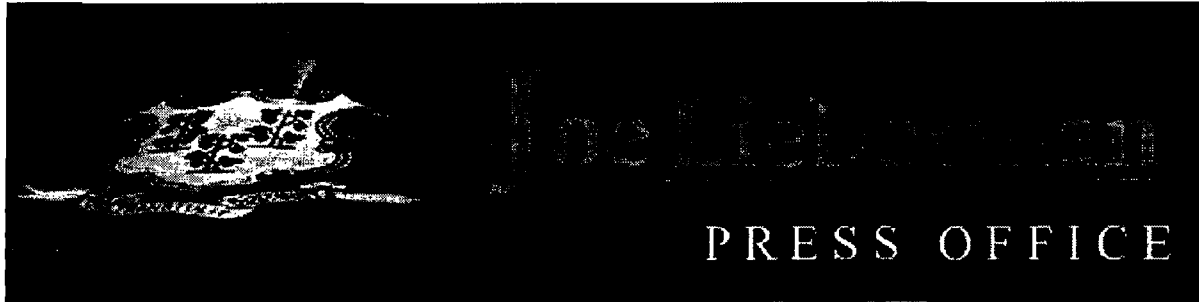
It did not have to be this way. There was a balanced, bipartisan alternative that would have provided strong patient protections and could have attracted a strong bipartisan majority, a plan that I was privileged to help craft and cosponsor.

But much to my disappointment, we were not allowed to put this plan before the Senate today, and instead, the Senate approved a bill that the President will most likely veto, leaving us right back where we started.

This is not where it is going to end, though. We will be back with our bipartisan patient protection bill sometime later this year, and the Senate will have another chance to do right by the rights of the nation's consumers.

[Click here for Senator Lieberman's floor statement on the Patients' Bill of Rights](#)

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February 4, 1999

A Modest Health Care Proposal

Special Attention: Health Care

WASHINGTON - Predicting the 106th Congress will reform managed health care, Senator Joseph Lieberman Thursday joined a bipartisan group of Senators to reintroduce legislation protecting the rights of 161 million Americans enrolled in managed care plans.

The Promoting Responsible Managed Care Act of 1999 - co-sponsored by Senators Lieberman, John Chafee, R-R.I., Bob Graham, D-Fla., Arlen Specter, R-Pa., Max Baucus, D-Mont., and Chuck Robb, D-Va. - "provides all Americans with the tools to pick a good health plan and the leverage to hold their plans accountable," Lieberman said.

"The prospects for passing managed care reform this year look very good. We will build on the bills introduced in the 105th Congress; we're all anxious to return to the business the people sent us here to do; and we are making aggressive efforts to reach across party lines to find a compromise."

Key elements of the Promoting Responsible Managed Care Act:

- ☐ Health plans must provide "report cards" on their performance in delivering services, as Medicare and Medicaid are now required to do.
- ☐ Plans must guarantee access to timely and independent external appeals.
- ☐ The Secretaries of Health and Human Services and Labor could impose civil penalties up to \$250,000 and injunctive relief against health plans in violation of the law.
- ☐ Patients would have the right to sue plans for economic recovery such as medical expenses and lost wages.

"Managed care has helped control the cost of medical services but that achievement is worth nothing if it comes at the expense of quality of care and patients' rights," Lieberman said. "People want to know they can go to the emergency room if they think it's necessary. They want to see a specialist if their condition warrants it. And they want to know they aren't going to be locked out of medical care by an unresponsive bureaucracy."

bureaucracy.

“We're proposing to give patients the strongest tools at our disposal -
information, appeals rights, agency enforcement and access to the courts
- without the baggage that could doom reform efforts.”

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THE CLINTON-GORE ADMINISTRATION'S HEALTH INSURANCE INITIATIVE BACKGROUND INFORMATION

January 19, 2000

THE UNINSURED IN AMERICA

- **Most of 44 million uninsured work or are in working families.** Three-fourths of the uninsured work or are in working families. Although the uninsured rate remains highest among the poor (33 percent), it has been growing faster for the middle class. All income groups experienced increases in the uninsured rate since 1993, but the increase was 50 percent higher for the middle class than that of the poor.¹
- **Access to health insurance can be a major barrier.** Employer-based insurance is the predominant form of health insurance. In 1996, about 82 percent of workers had access to it. However, 45 percent of low-wage workers and about one-third of workers in small business do not have access to group insurance.² The private-sector alternative, individual insurance, is frequently inaccessible, particularly for older and less healthy people. In addition, Medicaid, the State Children's Health Insurance Program, and Medicare have state and Federal rules which limit who can enroll.
- **For others, affordability of health insurance remains the biggest barrier.** Health insurance premiums for employer-based coverage in 1999 averaged \$2,300 for an individual and \$5,700 for a family – with the workers' share being \$420 and \$1,740 respectively.³ People purchasing coverage in the individual insurance market not only lack employer contributions but usually face higher premiums due to higher administrative costs and, if ill or older, medical underwriting and age rating.

CONSEQUENCES OF LACKING HEALTH INSURANCE. Compared to people with insurance, those without insurance are likely to:

- **Forego needed health care.** The percent of uninsured adults who did not receive needed medical care is more than three times that of privately insured adults (30 versus 7 percent).⁴ The proportion of uninsured adults who postponed care is even higher (55 versus 14 percent).⁵ Over one in four uninsured children need health care (e.g., prescription medicine, surgery) but do not get it.⁶
- **Suffer adverse health effects and need expensive health care.** The uninsured are 50 to 70 percent more likely to need hospitalization for avoidable hospital conditions like pneumonia or uncontrolled diabetes than the privately insured.⁷ Children without health insurance are nearly twice as likely to forego health care for conditions like asthma or recurring ear infections.⁸
- **Rely on emergency rooms or have no regular source of care.** One-fourth of the uninsured adults rely on the emergency room or have no regular source of care, compared to 6 percent of the privately insured.⁹ The proportion of uninsured children lacking a usual source of care is 3 times that of privately insured (20 v. 6 percent).¹⁰

OVERVIEW OF THE INITIATIVE. The Clinton-Gore Administration's budget invests over \$110 billion over 10 years in a multi-faceted health coverage initiative. It would expand coverage to at least 5 million uninsured Americans¹¹ and expand access to millions more through its four-pronged approach of:

I. PROVIDING A NEW, AFFORDABLE HEALTH INSURANCE OPTION FOR FAMILIES (\$76 billion over 10 years, about 4 million uninsured covered). The s budget proposal would build on S-CHIP to pay higher Federal matching payments to states for covering parents as well as their children. In the new "FamilyCare" program, parents would be enrolled in the same health plan as their children, and states could help families afford job-based insurance.

II. ACCELERATING ENROLLMENT OF UNINSURED CHILDREN ELIGIBLE FOR MEDICAID AND S-CHIP (\$5.5 billion over 10 years, an additional 400,000 uninsured children covered). States would be given new outreach tools:

- Allowing School Lunch Programs to Share Information with Medicaid for Outreach (\$345 million over 10 years)
- Expanding Sites Authorized to Enroll Children in S-CHIP and Medicaid, Including Schools, Child Care Referral Centers, and Other Sites (\$1.2 billion over 10 years)
- Requiring States to Make their Medicaid and S-CHIP Enrollment Equally Simple (e.g., No Assets Tests, Mail-In Applications) (\$4.0 billion over 10 years)

III. EXPANDING HEALTH INSURANCE OPTIONS FOR AMERICANS FACING UNIQUE BARRIERS TO COVERAGE (\$28.7 billion over 10 years, about 600,000 million uninsured people covered). Some Americans like older people, workers in job transitions, and workers in small businesses, have limited health insurance options. This initiative broadens Medicare and Medicaid options and makes private insurance more accessible through tax incentives by:

- Establishing a Medicare Buy-In Option and Making It More Affordable Through a 25 Percent Tax Credit (\$5.4 billion for both buy-in and credit over 10 years)
- Making COBRA Continuation Coverage More Affordable (\$10.3 billion over 10 years)
- Improving Access to Affordable Insurance for Workers in Small Businesses through Health Insurance Purchasing Coalitions (\$313 million over 10 years)
- Expanding State Options to Insure Children Through Age 20 (\$1.9 billion over 10 years)
- Extending Transitional Medicaid (\$4.3 billion over 10 years)
- Restoring State Options to Insure Legal Immigrants (\$6.5 billion over 10 years)

IV. STRENGTHENING PROGRAMS THAT PROVIDE HEALTH CARE DIRECTLY TO THE UNINSURED. (At least \$1 billion over 10 years). The budget expands a new program that coordinates and expands systems that increase access to health care for the uninsured and invests in community health centers.

PROVIDING A NEW, AFFORDABLE HEALTH INSURANCE OPTION FOR FAMILIES

Over 80 percent of parents of uninsured children with incomes below 200 percent of poverty (about \$33,000 for a family of four) are themselves uninsured. Recognizing that family coverage not only helps a large proportion of the nation's uninsured adults but increases the enrollment of children, the Vice President, National Governors' Association, consumer advocates and insurers have called for expanding S-CHIP to cover parents. The Administration's proposal does this by building on S-CHIP to provide higher Federal matching payments for states to insure parents through the same health plan as their children. "FamilyCare" costs \$76 billion over 10 years and will insure an estimated 4 million uninsured people when fully implemented.

BACKGROUND

- **Most uninsured children are in families with uninsured parents.** Over 80 percent of parents of uninsured children with income below 200 percent of poverty (about \$33,000 for a family of four) are themselves uninsured.¹²
- **Nearly two-thirds of uninsured parents – 6.5 million -- have children who are in Medicaid and S-CHIP eligibility range** (income below 200 percent of poverty). This represents about one in seven of the uninsured in the U.S.¹³
- **Medicaid eligibility limits are much lower for parents than their children.** While all states cover poor children and many states cover children up to 200 percent of poverty, only 13 states cover parents at or above the poverty level.¹⁴ The median upper eligibility limit for parents in Medicaid is about 60 percent of poverty. In 32 states, uninsured parents who work full time at minimum wages jobs are not eligible for Medicaid because their incomes are too high.¹⁵ S-CHIP does not include an explicit authority to cover parents.
- **Many low-income families decline employer-based insurance, primarily due to cost.** About 20 percent of all uninsured people have access to employer-sponsored insurance. Families with lower incomes are especially likely to turn down such coverage and remain uninsured. Three-fourths of these uninsured people cite cost as the major barrier. The amount that low-wage families pay for the employee share of premiums is, on average, over 50 percent higher for a family with a worker earning less than \$7 per hour than those with a worker earning over \$15 per hour.¹⁶

UPPER ELIGIBILITY IN MEDICAID / SCHIP (14)		
	CHILDREN	PARENTS
	(Percent of Poverty)	
ALABAMA	200	22
ALASKA	200	83
ARIZONA	200	51
ARKANSAS	200	22
CALIFORNIA	250	100
COLORADO	185	45
CONNECTICUT	300	185
DELAWARE	200	108
DC	200	200
FLORIDA	200	34
GEORGIA	200	45
HAWAII	185	100
IDAHO	150	36
ILLINOIS	133	52
INDIANA	150	33
IOWA	185	93
KANSAS	200	43
KENTUCKY	200	54
LOUISIANA	150	23
MAINE	185	108
MARYLAND	200	46
MASSACHUSETTS	200	133
MICHIGAN	200	48
MINNESOTA	280	275
MISSISSIPPI	133	40
MISSOURI	300	100
MONTANA	150	73
NEBRASKA	185	43
NEVADA	200	90
NEW HAMPSHIRE	300	60
NEW JERSEY	350	47
NEW MEXICO	235	62
NEW YORK	192	59
NORTH CAROLINA	200	56
NORTH DAKOTA	100	74
OHIO	150	85
OKLAHOMA	185	37
OREGON	170	100
PENNSYLVANIA	200	71
RHODE ISLAND	300	193
SOUTH CAROLINA	150	58
SOUTH DAKOTA	140	70
TENNESSEE	200	67
TEXAS	200	32
UTAH	200	58
VERMONT	300	158
VIRGINIA	185	33
WASHINGTON	250	96
WEST VIRGINIA	150	30
WISCONSIN	185	185
WYOMING	133	69

- **Covering parents would increase enrollment of uninsured children.** Families are more likely to learn about Medicaid and S-CHIP and to enroll their children in the programs if the whole family is eligible. As such, the NGA and policy experts believe that this option would reduce the number of uninsured children as well as parents.¹⁷ Wisconsin, Minnesota and Vermont are among the states using Medicaid state plan options or 1115 demonstrations to achieve this effect.
- **Cost-effective way to expand coverage.** A recent study compared the effectiveness of covering uninsured adults through a refundable tax credit for group or individual insurance and expanding S-CHIP. It found that S-CHIP would much more efficiently expand coverage to the uninsured than a tax credit. The study found that the tax credit would subsidize 5 already-insured people for every single newly insured person at a total cost 6 times higher than that of the S-CHIP proposal.¹⁸
- **Widespread support.** The concept of extending S-CHIP to parents is one of the few ideas for expanding coverage that is supported by a broad range of groups. The National Governors' Association supported expanding S-CHIP to cover parents in its 1999 policy resolutions, arguing that "CHIP is a promising vehicle to promote the goal shared by the Governors, Congress, and the Administration – decreasing the number of Americans without health insurance."¹⁹ At a January 13, 2000 conference to discuss ideas on expanding coverage, Families USA, the Health Insurance Association of America, the American Hospital Association, the Catholic Health Association and the Service Employees International Union all recommend using S-CHIP or a similar model to cover the parents of Medicaid and S-CHIP children.²⁰

PROPOSAL. The Clinton-Gore Administration would expand S-CHIP to provide higher Federal matching payments for expanding affordable health insurance to parents of children eligible for or enrolled in Medicaid and S-CHIP. This new "FamilyCare" program:

- **Provides higher Federal matching payments for expanding coverage to parents.** States that raise their eligibility for parents above their Medicaid level as of 1/1/00 would be eligible for the enhanced S-CHIP matching rate for this expansion group. The S-CHIP matching rate is up to 15 percentage points higher than the regular Medicaid matching rate. States' plans for covering parents would only be approved if they first expand eligibility for children up to 200 percent of poverty (30 states have already done so²¹) and do not have waiting lists for S-CHIP. This preserves the bipartisan commitment made in 1997 to focus funding on children first.
- **Increases S-CHIP allotments.** To ensure adequate funding for parents and their children, the current S-CHIP allotments would be increased by \$50 billion for 2002 through 2010 and made permanent. The higher Federal matching payments for the expansion group of parents would generally come from increased S-CHIP state allotments, called FamilyCare allotments. Allotments are fixed dollar amounts allocated to each state based on a formula similar to S-CHIP for the higher Federal matching payments. As in S-CHIP, should the allotment limits be reached, states expanding through Medicaid may continue to cover parents at the regular Medicaid matching rate or roll back eligibility while states expanding through non-Medicaid programs may use state-only funds to continue coverage or limit enrollment.

- **Enrolls parents in the same program as their children.** Parents would be insured in the same program as their children to promote continuity of care and administrative simplicity. States would use the same systems and follow most of the same rules as they do in Medicaid and S-CHIP, and coverage for parents would be overseen by the same state agency that runs their children's program. Parents of children eligible for Medicaid would be enrolled in Medicaid, while parents of children eligible for non-Medicaid S-CHIP programs would be enrolled in those programs.
- **Covers lower income parents first.** As in S-CHIP, states would cover lower-income parents before covering higher-income parents. States could not cover parents at income eligibility levels above those of children, but could set eligibility limits for parents lower than that of children. For the first five years, states could set parents' eligibility limit anywhere between their current minimum levels for parents and their maximum levels for children. Given states' enthusiastic response to S-CHIP and the NGA support for this option, we expect strong state responses and significant expansions to parents under FamilyCare. If, after 5 years, some states have not expanded coverage of parents to at least 100 percent of poverty (about \$16,700 for a family of four), a fail-safe mechanism would be triggered to require these states to go to this level of coverage. Thus, by 2006, all poor parents would be eligible for coverage like their children are today.
- **Creates more equitable funding structure.** From 2001 to 2005, all enhanced matching payments for states' expansion group of parents would come from the FamilyCare allotment, as would all payments for S-CHIP children. For example, a state that covered parents to 50 percent of poverty prior to 1/1/00 and then expanded coverage above that would receive enhanced matching payments drawn from their allotments for coverage of the newly eligible parents (as well as S-CHIP kids). Beginning in 2006, two changes would be made. First, the enhanced Federal matching payments for parents below poverty would no longer be deducted from the allotment. States would still receive the enhanced matching payments for poor parents covered under expansions implemented after 1/1/00, but these payments would come from uncapped Medicaid funding and would no longer be subtracted from allotments. Second, all states could receive enhanced matching payments for covering any parent above the poverty line and any child above the Medicaid mandatory coverage levels²² – irrespective of when the state expanded coverage. This ensures that states that have already expanded coverage would be rewarded.
- **Facilitates employer-based coverage.** FamilyCare would also expand the option to pool allotment funding with employer contributions towards the purchase of private insurance, which can be a cost-effective way to expand coverage. States could enable families otherwise eligible for FamilyCare to purchase their employers' health plan as long as it meets FamilyCare standards. Under this option, employers would have to contribute at least half of the family premium cost to discourage them from reducing or dropping coverage because of this program. In addition, the S-CHIP crowd-out policies would apply. One study found that over one in five families whose children were enrolled in the Florida Healthy Kids program previously had access to employer-based coverage but their parents could not afford the premium so they remained uninsured.²³ This option, supported by states²⁴, would help keep such families in private coverage.

ACCELERATING ENROLLMENT OF UNINSURED CHILDREN ELIGIBLE FOR MEDICAID AND S-CHIP

The State Children's Health Insurance Program (S-CHIP) helps children in families with incomes too high for Medicaid eligibility but too low to afford private insurance. Enrollment in S-CHIP doubled to 2 million children in 1999. However, despite this encouraging trend, millions of children remain eligible but unenrolled in both S-CHIP and Medicaid. The budget would give states needed tools to increase coverage. About an additional 400,000 uninsured children would be covered because of these policies. The initiative costs about \$5.5 billion over 10 years.

BACKGROUND

- **The number of children enrolled in the State Children's Health Insurance Program (S-CHIP) has doubled in less than a year.** Nearly 2 million children were covered by S-CHIP between October 1, 1998 and September 30, 1999, a doubling in enrollment from December 1998.²⁵
- **The number of states covering children up to 200 percent of poverty has increased by more than seven fold.** Prior to S-CHIP's creation, only 4 states covered children with family incomes up to at least 200 percent of the Federal poverty level (about \$33,000 for a family of 4). Today, 30 states have plans approved to cover children with incomes up to at least this level.²⁶
- **However, over 4 million eligible children remain uninsured.**²⁷ One study found that two-thirds of eligible uninsured children are in two-parent families, 75 percent of parents of these children work, and only 5 percent receive welfare.²⁸
- **Barriers include lack of knowledge of eligibility and complex application processes.** A survey of parents whose uninsured children are likely to be eligible for Medicaid found that 58 percent did not try to enroll their children because they did not think that their children were eligible and over half (52 percent) said that they believed that the application process would take too long or believed that the forms are too complicated (50 percent).²⁹
- **Uninsured children are often in programs like the school lunch program that can help enroll them.** A number of programs, like the school lunch program, subsidized child care, and Head Start, target the same children who are also eligible for Medicaid and S-CHIP. A recent study by the Urban Institute found that approximately 60 percent – almost 4 million – of the uninsured children nationwide are currently enrolled in school lunch programs.³⁰ However, Federal law prohibits school lunch programs from sharing enrollment information with Medicaid and does not allow states to use school lunch eligibility as a proxy for Medicaid eligibility.

PROPOSALS

- **Allowing School Lunch Program to Share Information with Medicaid (\$345 million over 10 years).** This proposal, similar to bipartisan legislation proposed by Senator Lugar and Congresswomen Carson, would allow school lunch programs to share application information with Medicaid staff for the sole purpose of outreach and enrollment (this is already allowed for S-CHIP).
- **Expanding Sites Authorized to Enroll Children in S-CHIP and Medicaid (\$1.2 billion over 10 years).** The Administration's proposal expands the Medicaid "presumptive eligibility" option for children by authorizing additional sites for enrollment including schools, child care centers, homeless shelters, agencies that determine eligibility for Medicaid, TANF, and S-CHIP, and other entities approved by the Secretary. Presumptive eligibility means that qualified entities, at the states' discretion, may immediately enroll potentially eligible children in Medicaid and S-CHIP on a temporary basis while their applications are formally processed. With the help of Congresswomen DeGette, the law that created the children's health program in 1997 included presumptive eligibility as an option in S-CHIP and Medicaid. However, it limited the types of entities that could presumptively enroll children in Medicaid to Medicaid providers and entities determining eligibility for WIC, Head Start and Child Care & Development Block Grant services. To date, 9 states have opted to use presumptive eligibility for children in Medicaid³¹ and 12 states for S-CHIP.³² Expanding the sites authorized for this option can help states provide critical health care services to children pending official enrollment and increases the likelihood that families complete the application process. More than half (53 percent) of parents of uninsured but eligible children think that immediate enrollment with completion of forms later is one of the best ways to encourage enrollment.³³
- **Requiring States to Make their Medicaid and S-CHIP Enrollment Equally Simple (\$4 billion over 10 years).** Studies confirm that complicated, long application processes for Medicaid and S-CHIP discourage enrollment. While many states have recognized this and have simplified the process in S-CHIP, not all states have carried over all of their S-CHIP simplification strategies to Medicaid. To ensure that children do not fall through the cracks in states that have different rules and procedures for Medicaid and S-CHIP, this proposal would require that states conform certain Medicaid eligibility rules and procedures for children to the simplified rules and procedures used in S-CHIP. If a state, in S-CHIP: (1) does not require an assets test; (2) uses simplified eligibility requirements and a mail-in application; and (3) determines eligibility for S-CHIP no more than once a year, it would need to apply these same rules and procedures for children in Medicaid. Both conforming Medicaid and S-CHIP and these specific simplifications are recommended by the National Governors' Association as best practices.³⁴ Over 40 states have already made Medicaid as simple as S-CHIP.³⁵

ESTABLISHING A MEDICARE BUY-IN OPTION AND MAKING IT MORE AFFORDABLE THROUGH A TAX CREDIT

People ages 55 to 65 are at greater risk of developing health problems. Recognizing that this age group is also the fastest growing group of uninsured, the President has called on Congress to pass legislation that allows certain people ages 55 to 65 to buy into Medicare. The proposal also would require employers who drop previously-promised retiree coverage to allow early retirees with limited alternatives to have access to COBRA continuation coverage until they reach age 65 and qualify for Medicare. This year, to make the policy more affordable, the Clinton-Gore Administration proposes a tax credit, equal to 25 percent of the premium, for participants in the Medicare buy-in. Coupled with the tax credit for COBRA (described later), this policy will address both access to and the affordability of health insurance for this vulnerable group. The Medicare buy-in plus the tax credit for this buy-in cost about \$5.4 billion over 10 years.

BACKGROUND

- **Fastest growing number of uninsured.** Between 1997 and 1998, the proportion of people ages 55 to 65 who are uninsured increased from 14.3 to 15.0 percent – about five times the rate increase for the general population. All of this increase occurred among people with incomes above poverty, with a dramatic increase for those with income between 300 and 400 percent of poverty (between \$33,000 and \$44,000 for a couple) – from 10.2 to 14.6 percent.³⁶
- **Less access to employer-based coverage.** The major reason for the increase in the uninsured in this age group is their lower access to employer-based insurance. In 1998, 66 percent of people ages 55 to 64 had employer-based insurance compared to 75 percent of people ages 45 to 55.³⁷ Some lose their employer-based health insurance when their spouse becomes eligible for Medicare. Many lose coverage because they lose their jobs due to company downsizing or plant closings. Still others lose insurance when their employer drops retiree health coverage unexpectedly.
- **Greater reliance on individual insurance.** Because of a weaker connection to the workplace, a disproportionate percent of people ages 55 to 65 rely on individual insurance. However, the nature of individual insurance makes it easier to avoid people likely to have health problems. In addition to being subject to age rating, a health condition can trigger higher rates, exclusion of certain benefits coverage, or denial of coverage.³⁸ People ages 60 to 64 are nearly three times more likely to report fair to poor health as those ages 35 to 44. Their probability of experiencing health problems such as heart disease, emphysema, heart attack, stroke and cancer is double that of people ages 45 to 54.³⁹
- **Problems will get worse with demographic changes.** As the Baby Boom generation enters its 50s, the proportion of people ages 55 to 65 is expected to increase from 21 to 30 million by 2005 and to 35 million by 2010 — to 12 percent of the U.S. population, over a 50 percent increase.⁴⁰ Even if the uninsured rate remained the same, the proportion of uninsured in this age group would climb. One study projects that the uninsured rate for people ages 55 to 65 will rise even faster given the decline in access to private insurance for this group.⁴¹

PROPOSALS

- **Providing a New 25 Percent Tax Credit for New Options for People Ages 55 to 65.** This year, for the first time, the President will propose a 25 percent tax credit for people eligible for the buy-in. It helps make the original option – which already is more affordable than alternatives in the individual insurance market – even more attractive to people with limited income. In addition, people participating in the extended COBRA coverage would be eligible for the new COBRA tax credit (described later). This tax credit has the advantage of encouraging greater participation in these options for people ages 55 to 65 which could, in turn, reduce the premium costs for these programs over time since new participants are likely to be healthier. It would not, however, be large enough to encourage firms to drop their early retiree coverage or individuals to retire earlier.

This policy builds on the three-pronged initiative advocated by the President, the Vice President and the Democratic Congressional leadership (Daschle, Gephardt, Moynihan, Rangel, Dingell, Rockefeller, Stark, Brown), described below.

1. **Enabling Americans Ages 62 to 65 to Buy Into Medicare.** People ages 62 to 65 who do not have access to employer-based insurance would have a one-time option to buy into Medicare. The premium they would pay would be divided into two parts. First, participants would pay a base premium of about \$300 per month — the average cost of insuring Americans this age range. Second, participants would pay an additional monthly payment, estimated at \$10 to \$20, for each year that they buy into the Medicare program. This premium, to be paid once participants enter Medicare at age 65, covers the extra costs of sicker participants. This two part “payment plan” enables these older Americans to buy into Medicare at a more affordable premium, while ensuring that the financing for the buy-in option is sustainable in the long run.
2. **Allowing Displaced Workers Ages 55 to 65 to Buy Into Medicare.** Workers who have involuntarily lost their jobs and their health care coverage would be eligible for a similar Medicare buy-in option. Such workers have a harder time finding new jobs: only 52 percent are reemployed compared to over 70 percent of younger workers. Nearly half of these unemployed, displaced workers who had health insurance remain uninsured. Individuals choosing this option would pay the entire premium at the time they receive the benefit without any Medicare “loan,” in order to ensure that Medicare does not pay excessive up-front costs and participants do not have to make large payments after they turn 65.
3. **Giving Americans Ages 55 and Older Whose Employers Reneged on Providing Retiree Health Benefits Access to COBRA until Eligible for Medicare.** In recent years, the number of companies offering retiree benefits has declined. Some companies have ended coverage only for future retirees, but others have dropped coverage for individuals who have already retired. This policy provides much-needed access to affordable health care for these retirees and their dependents whose health care coverage is eliminated after they have retired. It allows these retirees to buy into their former employers’ health plan through age 65 by extending the availability of COBRA coverage to these families. Retirees would pay a premium of 125 percent of the average cost of the employer’s group health insurance.

MAKING COBRA CONTINUATION COVERAGE MORE AFFORDABLE

To improve continuity of health coverage as workers change jobs, the Clinton-Gore budget includes a 25 percent tax credit for COBRA premiums. COBRA allows workers in firms with greater than 20 employees to pay a full premium (102 percent of the average cost of group health insurance) to buy into their employers' health plan for up to 18 months after leaving their job. However, fewer than 25 percent of people eligible for this coverage participate, in part due to cost. This tax credit address the issue of cost to help reduce the number of Americans who experience a gap in coverage due to job change. It costs \$10.3 billion over 10 years.

BACKGROUND

- **Changing jobs risks losing health insurance.** Since most insurance is job based, changing jobs puts workers and their families at risk of becoming uninsured. One study found that 58 percent of the two million Americans who lose their health insurance each month cite a change in employment as the primary reason for losing coverage.⁴² About 44 percent of workers with one or more job changes experienced a gap in health insurance coverage. This is even more pronounced for men, over half of whom were uninsured for a month or more when they had a job interruption.⁴³
- **COBRA continuation coverage provides an important option.** Passed in 1985, the Consolidated Omnibus Budget Reconciliation Act (COBRA) included a provision aimed at minimizing the disruption in health insurance due to job change. It allows workers in firms with greater than 20 employees to pay a full premium (102 percent of the average cost of group health insurance) to buy into their employers' health plan for up to 18 months after leaving their job. On the whole, evidence supports claims that COBRA decreases the probability that a person between jobs is uninsured, reduces "job lock", and covers workers during pre-existing condition waiting periods.⁴⁴
- **Participation in COBRA is low, primarily due to cost.** Studies suggest that only 20 to 25 percent of COBRA eligibles purchase this coverage. Although some of these people had access to insurance through other family members, the primary reason cited for declining COBRA is its high cost.⁴⁵

PROPOSAL

- **New Tax Credit To Make COBRA More Affordable.** The budget includes a 25 percent tax credit for COBRA premiums to reduce the number of Americans who experience a gap in coverage due to job change. It not only helps workers and families access insurance but may help employers, since the current tendency for only people with health problems to participate would be reduced.

IMPROVING ACCESS TO AFFORDABLE INSURANCE FOR WORKERS IN SMALL BUSINESSES

Recognizing the problems that small businesses face in offering their workers insurance, the President proposes a set of policies to harness the purchasing power of large employers and provide assistance for premium payments. It would give small firms that have not previously offered health insurance a tax credit equal to 20 percent of their contribution – twice the credit proposed last year -- towards health insurance obtained through purchasing coalitions. In addition, tax incentives would be given to foundations to help pay for start-up costs of these coalitions, and technical assistance would be provided. Altogether, this initiative costs \$313 million over 10 years.

BACKGROUND

- **Nearly half of uninsured workers are in firms with fewer than 25 employees.** The likelihood of being uninsured is greater for workers in small firms – nearly three times higher than that of workers in large firms.⁴⁶
- **Small firms are less likely to offer health insurance.** The proportion of small businesses offering health insurance declined between 1996 and 1998 – from 53 to 49 percent for firms with 3 to 9 workers and from 78 to 71 percent for firms with 10 to 24 workers.⁴⁷ Businesses blame the high cost of premiums for this problem. Small businesses typically pay higher premiums for the same benefits and administrative costs may consume as much as 40 percent of premium dollars. Trends suggest that the situation will worsen.
- **Purchasing coalitions a growing option for small businesses.** Although still relatively unknown, nearly one in 10 businesses with 3 to 9 employees participated in cooperatives in 1998, and interest and participation are growing.⁴⁸

PROPOSAL

- **Provide a 20 Percent Tax Credit for Employer Contributions.** A tax credit equal to 20 percent of employer contributions toward health premiums would be given to eligible small businesses. Small businesses with between 3 and 50 employees that have not offered coverage in the past could receive this credit if they purchase coverage for their workers through a qualified coalition. This credit is time-limited.
- **Financial Assistance in Creating Coalitions.** Start-up costs are a barrier to developing purchasing coalitions. Yet the current tax provisions for foundations makes private foundations reluctant or, in some cases, prohibited from offering grants for these costs. Under this proposal, any grant or loan made by a private foundation to a qualified small business health purchasing coalition would be treated as a grant (or loan) made for charitable purposes. This provision is time-limited.
- **Technical Assistance in Creating Coalitions.** Since the Federal Employees Health Benefits Program is a model for coalitions, its managers would provide technical assistance to coalitions, sharing its administrative experience.

EXTENDING MEDICAID TO VULNERABLE POPULATIONS

Medicaid has proven to be a critical source of health insurance for millions of Americans. However, some vulnerable groups of people – children aging out of Medicaid and S-CHIP, people leaving welfare for work, and legal immigrants – cannot or will not be allowed into Medicaid due to current restrictions. The President's budget includes several important provisions to remove these barriers.

EXPANDING STATE OPTIONS TO INSURE CHILDREN THROUGH AGE 20 (\$1.9 billion over 10 years)

- About 1.2 million people ages 19 and 20 have low incomes (below 200 percent of poverty) and are uninsured.⁴⁹ Mostly, this results because they age out of Medicaid or S-CHIP or no longer qualify as dependents in their parents' private plans.
- The budget would give states the option to cover people ages 19 and 20 through Medicaid and S-CHIP.

EXTENDING TRANSITIONAL MEDICAID (\$4.3 billion over 10 years)

- Many people leaving welfare for work take first jobs that do not offer affordable health insurance.⁵⁰ As such, transitional Medicaid provides a critical bridge to work. Created in 1988, transitional Medicaid extends coverage for up to a year for those losing it due to increased earnings. The 1996 welfare reform bill extended this provision through 2001. A recent survey found that nearly half of former welfare recipients had Medicaid coverage, most likely due to this benefit.⁵¹
- The budget makes this provision permanent and simplifies the state and family requirements to promote enrollment.

RESTORING STATE OPTIONS TO COVER LEGAL IMMIGRANTS (\$6.5 billion over 10 years)

- Over the strong objections of the Administration, the 1996 welfare law prohibited states from providing health insurance for certain legal immigrants who entered the U.S. after the enactment of welfare reform. The uninsured rate for people of Hispanic origin was 35 percent – over twice the national average of 16 percent.⁵²
- The President's budget would give states the option to insure children and pregnant women in Medicaid and S-CHIP regardless of their date of entry. It would eliminate the 5-year ban, deeming, and affidavit of support provisions. The proposal would also require states to provide Medicaid coverage to disabled immigrants who would be made eligible for SSI by the FY 2001 budget's SSI restoration proposal.

STRENGTHENING PROGRAMS THAT PROVIDE HEALTH CARE DIRECTLY TO THE UNINSURED

BACKGROUND

- **Greater demand.** In the absence of a universal health insurance system, public hospitals, clinics, and thousands of health care providers give health care of the millions of uninsured. About 6 percent of all hospitals and 26 percent of safety net hospitals annual costs are estimated to be uncompensated, and 2,500 community health center sites serve an estimated 4 million uninsured.⁵³
- **Fewer resources.** Despite a rising need, reductions in government spending and aggressive cost cutting by private insurers has left less money in the health care system to address these needs.

PROPOSALS

- **Increasing Funding for Increasing Access to Health Care for the Uninsured (At least \$1 billion over 10 years, +\$100 million for FY 2001).** Last year, the President and Secretary Shalala proposed an historic new grant program to support community providers of services to the uninsured. The Congress funded an initial \$25 million investment for this program. This year, the Administration proposes funding this initiative at \$125 million, a \$100 million increase over 2000. This represents a down payment on the its proposal to invest \$1 billion over 5 year. The Administration will also aggressively pursue an authorization to ensure that the program is established as a core element of the health care safety net.
 - **Providing new services to the uninsured.** These grants will allow providers to deliver the full range of primary care services to the uninsured, rather than treating only the most emergent problems. Currently, many uninsured individuals do not have access to primary care, mental health, and substance abuse services.
 - **Preserving access to critical tertiary care services.** These funds will help support large public hospitals, that often are the only source for trauma care, burn units, neonatal intensive care units, and other specialized services that are critical to all of the residents in a service area. If these institutions succumb to the burden of uncompensated care costs, both the insured and uninsured residents of the service area will be forced to seek these essential health care services elsewhere.
 - **Holding providers accountable for health outcomes.** These grants will help local providers develop the financial, information, and telecommunication systems that are necessary to appropriately monitor and manage patient needs. This will improve the efficiency and effectiveness of service delivery within the safety net, permitting more clients to be served with existing resources.
- **Investing in Community Health Centers (+\$50 million for FY 2001).** The budget proposes an increase of \$50 million to support and enhance the network of community health centers that serve millions of low-income and uninsured Americans – for total funding of over \$1.069 billion in FY 2001.

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View Related Topics

April 11, 2000, Tuesday, Late Edition - Final
Correction Appended

SECTION: Section A; Page 1; Column 3; National Desk

LENGTH: 1917 words

HEADLINE: **Bush** and Texas Have Not Set High Priority on Health Care

BYLINE: By ADAM CLYMER

BODY:

Texas has had one of the nation's worst public health records for decades. More than a quarter of its residents have no **health insurance**. Its Mexican border is a hotbed of contagion. The state ranks near the top in the nation in rates of AIDS, diabetes, tuberculosis and teenage pregnancy, and near the bottom in immunizations, mammograms and access to physicians.

But since George W. **Bush** became governor in 1995, he has not made health a priority, his aides acknowledge. He has never made a speech on the subject, his press office says. His administration opposed a patient's bill of rights in 1995 before grudgingly accepting one in 1997, and fought unsuccessfully to limit access to the new federal Children's **Health Insurance** Program in 1999.

Health care is near the top of the election agenda, with Vice President Al Gore already proposing a vast expansion of insurance coverage for children. Mr. **Bush** will begin discussing insurance and other health issues starting on Tuesday with a speech in Cleveland.

Democrats, not waiting for Mr. **Bush's** proposals, are already attacking him for the Texas record. But politics aside, two things are clear: Texas' health problems run far deeper than the identity of any Austin officeholder, and Mr. **Bush** has not tried to tackle them, despite a large state budget surplus.

The Democrats point out that Texas' lack of **health insurance** is among the most severe in the country. Among Texans ages 19 to 65, the percentage without coverage rose slightly under Mr. **Bush** and is higher than in any state but Arizona. The numbers are even worse among poor children, and hundreds of thousands of them are not enrolled in Medicaid, even though they qualify.

Governor **Bush** declined to be interviewed for this article, but the views expressed by the state's commissioner of health, Dr. William R. Archer III, cast a light on the **Bush** administration's approach to the issue.

(Dr. Archer, the son of Representative Bill Archer, Republican of Texas and the chairman of the House Ways and Means Committee, said the governor asked him to apply for the commissioner's job; he was formally chosen by the Board of Health in 1997, and took office after Mr. **Bush** approved the appointment.)

Almost alone among health experts in Texas, Dr. Archer minimizes the importance of the low rate of **health insurance**, a protection that two-fifths of the state's poor children lack. In an interview, he said he thought that while "eventually we have to insure everybody," he believed the uninsured were still getting care.

"I think insurance is important," he said. "But I don't think it's the most important thing."

Dr. Archer said he doubted that coverage made much real difference to health.

When told of that view, one of the state's leaders in public health, Dr. Ron Anderson of Parkland Hospital in Dallas, said, "Then he hasn't read the literature. Shame on him!"

Dr. Archer also accused Texas doctors of opposing preventive health care out of misplaced concern for their own billings.

"If I can prevent certain diseases upstream, and then there is no need to treat that disease, then there is nothing to charge against," he said.

And he has stirred disputes with his efforts to take his department away from the traditional services it has provided to examine the cultural causes of unhealthy behavior and lifestyles.

For example, he said Texas' high teenage pregnancy rate came about because the state's Hispanic population lacked the belief "that getting pregnant is a bad thing."

"If I were to go to a Hispanic community and say, 'Well, we need to get you into family planning,' they say, 'No, I want to be pregnant,' it doesn't work very well," he said.

According to the Alan Guttmacher Institute, Hispanic teenagers in Texas had a higher pregnancy rate than non-Hispanic whites or blacks, but the white rate was among the nation's highest, too.

The health problems of Texas go back far beyond Governor **Bush** and Dr. Archer. Texas ranks 25th in per capita income, just ahead of Oregon, but taxes lightly and provides a modest level of public services. Only six states collect a smaller percentage of their residents' personal income in state and local taxes than Texas does.

"The flip side of having no income tax is having a very low level of services," said Anne Dunkelberg, a senior analyst at the Center for Public Policy Priorities, a nonpartisan research institution in Austin.

Dr. Archer explained why the state tolerated having 598,000 children eligible for Medicaid, the federal-state health plan for the poor, but not enrolled in the program: "The problem is that the Legislature knows that if we are successful, and we got all those kids registered, they would not balance their budgets any more. It's not one person saying, 'Don't do this.' It's not one agency saying, 'Don't do this.' It's sort of 'Why would we all rock the boat at this point?'"

Except for Dr. Archer, most prominent health experts in Texas see the low insurance rates as the state's biggest health problem. Clair Jordan, executive director of the Texas Nurses Association, said, "Uninsured children end up in the most costly place, the emergency room."

State Representative Elliott Naishtat, a Democrat who is chairman of the House Human Services Committee, said, "The biggest health problem in Texas is the exorbitant number of people, primarily children, who have no **health insurance**."

Without insurance, said Jose Camacho, head of the Texas Association of Community Health Centers, children get only sporadic treatment for ear infections, asthma and diabetes.

Health insurance coverage in Texas has been stagnant for years. According to the Kaiser Commission on Medicaid and the Uninsured, among Texans 19 to 65 years old, 27.5 percent were uninsured in 1998, compared with 19.7 percent for the nation. In 1994, before Mr. **Bush** took office, the Texas percentage was 27.8 and the national figure 18.6 percent.

Among poor children the coverage was much worse. In 1998, 39.1 percent of Texans under 18 living at no more than twice the poverty level lacked insurance, compared with 25.7 percent nationally. In 1994, 36.7 percent of poor children in Texas and 22.8 percent of poor children nationally were uninsured.

There are many reasons for the low rates of insurance, including migratory labor, a large rural

population and many low-wage workers in nonunion jobs.

But the single biggest reason is probably the state's Medicaid program, which has some of the nation's most severe limits and complicated eligibility rules and thus makes Texas "one of the most difficult states for someone to figure out how to get enrolled," said Diane Rowland, executive vice president of the Henry J. Kaiser Family Foundation, a research organization.

State Representative Garnet F. Coleman, a Democrat who is vice chairman of the House Public Health Committee, contended that the state had created an "atmosphere of fear" around applying for Medicaid.

Bertha Rochel, a homemaker interviewed at an El Paso clinic, said some of her neighbors did not seek Medicaid because "they are afraid and maybe some of their children are illegal." Some others would find their citizenship applications barred if they sought government benefits now. Mr. Camacho pointed to the Texas rule that missing an appointment meant a Medicaid applicant had to start over.

Of the 1.4 million to 1.5 million children without **health insurance**, the number may drop sharply in the next year when Texas finally starts enrolling children in the children's **health insurance** program, known as CHIP, which was enacted by Congress in 1997. Mr. **Bush** let the question wait until the 1999 legislative session, and fought to limit its coverage to children with family incomes up to 150 percent of the poverty line, although the federal law allowed covering children up to 200 percent of the poverty level.

The **Bush** approach would have excluded 200,000 of the 500,000 who became eligible when the legislature insisted on the higher level. Mr. **Bush** said at a Sacramento news conference on Thursday, "I signed the 200 percent bill" and would not say why he pushed for 150 percent.

The reason given at the time for the **Bush** position, legislators said, was a fear that a big new program would be costly by itself and turn up a "spillover" of many thousands who were already eligible for Medicaid, which has an income ceiling of 100 percent of poverty. The federal government reimburses Texas 61.5 cents out of every dollar spent for Medicaid, and will pay 75 cents on the dollar for CHIP.

Many states, like Texas, have been slow to take advantage of the CHIP program; President Clinton took the nation's governors to task over the issue in August.

But Texas now has a large effort planned for CHIP. Don Gilbert, the state commissioner of Health and Human Services, said he expected to enroll 420,000 children in CHIP and perhaps another 120,000 in Medicaid over the next year.

The worst health in Texas, with disease rates at Third World levels, is on the Mexican border. Almost a fourth of the state's population lives in 43 border counties along the 1,264 miles of the Rio Grande from El Paso to Brownsville, and as far from the river as San Antonio, about 125 miles.

Except for San Antonio, it is a poor area. El Paso, Laredo, McAllen and Brownsville are four of the five poorest cities in the country. About a third of the population lives below the poverty level. All but two of the counties have a shortage of doctors.

A 1998 report by the state comptroller's office observed: "Health conditions in the Texas-Mexico border are among the worst in the U.S., so distressful that reports on health conditions suggest a remote country in need of medical missionaries, not a part of Texas." For example, it said, "Cases of hepatitis A, a gastrointestinal virus borne by contaminated food and water, are four times as common in the Rio Grande Valley as in the rest of Texas." Tuberculosis, diabetes and dengue fever are other high-incidence diseases.

At the border some improvement has been made in recent years, but very slowly, said Dr. Laurance N. Nickey, a retired city-county health director who now serves on the binational border health commission. Dr. Nickey said 72,000 people (about a tenth of El Paso's population) live in unincorporated colonias, or settlements, where "some of the water is safe to drink," and less than half

have safe sewerage.

As primitive as some conditions are on the United States side of the border, they are worse on the south. Ciudad Juarez, a city of 1.6 million people across from El Paso, is just building its first two sewage treatment plants. Until now, a 17-mile open trench has been used for sewage disposal, and it pollutes the groundwater on both sides of the border.

Dr. Archer said Governor **Bush** had persuaded Mexican authorities to put money into tuberculosis control, a move they had resisted because the border states in Mexico are not nearly its poorest.

El Paso alone sees about 65 million legal border crossings a year. "With this kind of a rate of crossings," Dr. Nickey said, "you don't keep measles on one side of the border and chicken pox on the other."

"We share the same air. We share the same water. We share the same pollution. We share the same hazardous waste." And because the border counties are a gateway to the rest of Texas and the rest of the country, he said, "It's not just a border issue. it involves the whole United States."

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CORRECTION-DATE: April 12, 2000, Wednesday

CORRECTION:

A front-page article yesterday about health care in Texas misstated the extent of Gov. George W. **Bush's** public discussions on the subject. According to his presidential campaign office, Governor **Bush** has given at least two speeches on the subject -- on Sept. 15, 1995, to the Texas Medical Association and on June 2, 1998, to the Texas Health Care Association. His gubernatorial press office had said, and the article reported, that he had never made a speech on the subject.

GRAPHIC: Photo: Health coverage has been low in Texas, with 39.1 percent of low-income children uninsured. Last week at a clinic in El Paso, 10-year-old Ismael Acosta had a checkup with Maria Moreno, a nurse. (Bruce Berman for The New York Times)(pg. A26)

Chart: "CHECKUP: State of Health in Texas"

A look at several health indicators. The first line, in bold, shows the most recent data available; the second line shows the incidence when George W. **Bush** became governor in 1995.

Adults ages 19 to 65 with no **health insurance**

1998

UNITED STATES: 27.5%

Texas: 19.7

1994

UNITED STATES: 27.8

Texas: 18.6

Low-income (less than 200% of poverty) children with no **health insurance**

1998

UNITED STATES: 39.1

Texas: 25.7

1994

UNITED STATES: 36.7

Texas: 22.8

Adults who reported not seeing doctor because of cost in last year

1998

UNITED STATES: 12.7%

Texas: 10.1%

1994

UNITED STATES: 14.4

Texas: 12.5

Women over 50 who had mammogram in past two years

1997

UNITED STATES: 67.8

Texas: 73.7*

1994

UNITED STATES: 63.7

Texas: 67.5*

Adults saying they were in fair or poor health

1998

UNITED STATES: 18.6

Texas: 13.1

1994

UNITED STATES: 15.6

Texas: 13.7

Per capita income

1998

UNITED STATES: \$24,957

Texas: \$26,412

1994

UNITED STATES: 19,857**

Texas: 23,988**

State and local taxes per capita

1996

UNITED STATES: \$2,128

Texas: \$2,597

1992

UNITED STATES: 1,860

Texas: 2,183

People in poverty

1998

UNITED STATES: 15.2%

Texas: 12.8%

1994

UNITED STATES: 19.1

Texas: 14.5

Medicaid spending per enrollee

1996

UNITED STATES: \$2,677
Texas: \$3,397

1994
UNITED STATES: 1,751
Texas: 2,956

Teenage pregnancies per 1,000 women
1996
UNITED STATES: 113
Texas: 97

1992
UNITED STATES: 123
Texas: 112

Infant mortality per 1,000 live births
1997
UNITED STATES: 6.3
Texas: 6.6

1994
UNITED STATES: 7.2
Texas: 7.9

Tuberculosis cases per 100,000
1999
UNITED STATES: 8.2
Texas: 6

1994
UNITED STATES: 13.8
Texas: 9.4

Cancer death rate per 100,000
1997
UNITED STATES: 122.8
Texas: 125.6

1994
UNITED STATES: 129.0
Texas: 131.5

Diabetes death rate per 100,000
1997
UNITED STATES: 17.4
Texas: 13.6

1994
UNITED STATES: 17.1
Texas: 13.0

Physicians per 100,000 population
1998
UNITED STATES: 226
Texas: 288

1992

UNITED STATES: 179

Texas: 224

*Median.

**Adjusted for inflation in 1998 dollars.

(Sources: Centers for Disease Control and Prevention; National Center for Health Statistics; Statistical Abstract of the United States; Kaiser Commission on Medicaid and the Uninsured; CQ's State Fact Finder; Alan Guttmacher Institute; American Association of Retired Persons)(pg. A26)

LANGUAGE: ENGLISH**LOAD-DATE:** April 11, 2000

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Teenage Births in the United States: National and State Trends, 1990-96

by Stephanie J. Ventura, M.A.; Sally C. Curtin, M.A.; and T. J. Mathews, M.S.
Division of Vital Statistics

Overview

Every year in America almost 500,000 teenagers give birth. Most are unmarried and many are not ready for the emotional, psychological, and financial responsibilities and challenges of parenthood. Teenage childbearing has important health and social consequences for these young women, their babies, and their families. Recently, the teenage birth rate has declined in all States. Rates for black teenagers have dropped more than for any other population group. Contributing to this decline are indications that teenagers today are less likely to be sexually active, and sexually active teenagers are more likely to use contraception. This publication presents the latest statistics as well as trends on the important topic of teenage childbearing in the United States. Data are from the National Center for Health Statistics' (NCHS) National Vital Statistics System.

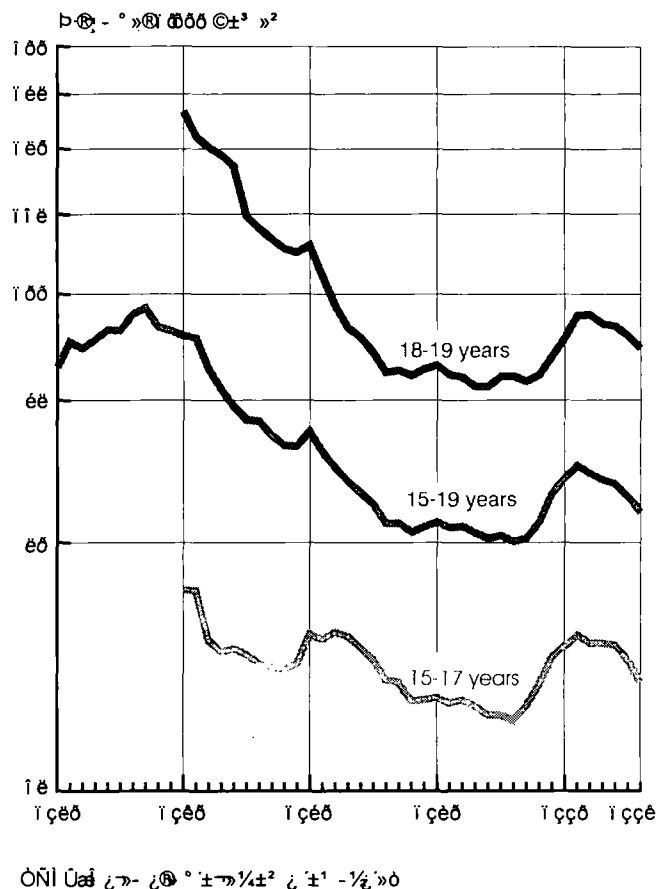
Patterns of teen childbearing can be examined in terms of numbers and rates of births. The numbers indicate how many teenagers gave birth in a given year. The teenage birth rate is defined as the number of births to a group of 1,000 teenagers. Rates among different population groups can be compared because they are all computed on the basis of 1,000 women. The number of births to teenagers is affected by both the birth rate (the proportion of teens giving birth) and the number of teen-aged women in the population. Therefore, trends in the birth rate and the number of births are not necessarily the same. To measure *pregnancies*, data on live births must be combined with information on induced abortion and fetal loss. Because abortion and fetal loss statistics are not as current as live birth statistics, this report focuses on trends in births, with a brief discussion of pregnancy trends.

Teenage Birth Rate Declines in 90's; Reverses Trend of the Late 80's

The U.S. birth rate for teenagers in 1996 was 54.7 live births per 1,000 women aged 15-19 years, down 4 percent

from 1995 (56.8). The teenage birth rate has declined steadily since 1991 when the rate was 62.1, an overall decline of 12 percent. These recent declines reverse the 24-percent rise in the teenage birth rate from 1986 to 1991 (figure 1 and table 1).

Figure 1. Birth rates for teenagers by age:
United States, 1950-96



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Teenage Birth Rate in 90's Higher Than in Early 80's

Despite the recent declines however, the rate for 1996 is still higher than it was during the early to mid-1980's (50–53 per 1,000) when the rate was at its lowest point. The teenage birth rate was substantially higher in the 1950's and early 1960's than it is now. The highest recorded teenage birth rate was 96.3 in 1957.

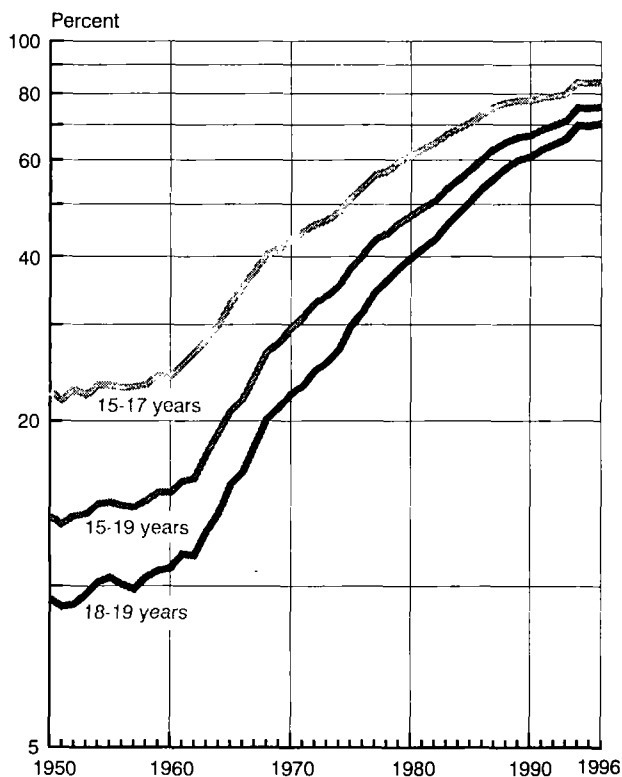
Most Teenage Mothers Are Unmarried

The issues in teenage childbearing are different now than in past decades. Most teenagers giving birth prior to 1980 were married, whereas most teenagers giving birth recently are unmarried (figure 2). The percent unmarried among teenage mothers 15–17 years more than tripled between 1950 and 1996, rising from 23 percent to 84 percent; among older teenage mothers, the percent unmarried in 1996 (71 percent) was nearly 8 times the percent in 1950 (9 percent).

The increases in the proportion of teenage mothers who are unmarried reflect the convergence of two important demographic trends:

- Sharply increasing birth rate among unmarried teenagers especially during the 1980's

Figure 2. Percent of births to unmarried teenagers by age: United States, 1950-96



NOTE: Percents are plotted on a log scale.

- Decline in marriage among teenagers since the mid-1970's

It is important to note, however, that while most teenage births are nonmarital, the majority of births to unmarried women are not to teenagers.

Teenage Birth Rates and Pregnancy Rates Fall

The teenage birth rate describes the number of births in a given year to a group of 1,000 teenagers. Thus, on average in 1996 (preliminary data), 55 out of 1,000 women aged 15–19 had a baby. Total teenage pregnancies include live births combined with estimates of induced abortions and fetal losses. Abortion and fetal loss data are not as current as the data on live births. According to the most recent estimates, the teenage pregnancy rate for 1994 was 108 pregnancies per 1,000 women aged 15–19 years, nearly twice the birth rate in that year (58.9). The pregnancy rate declined 8 percent from 1991 to 1994 and has continued to fall since 1994. This is based on the continued decline in the teenage birth rate and preliminary data that indicate a drop in abortions among teenagers since 1994.

Births and Birth Rates Decline for Younger and Older Teenagers

While teenage childbearing patterns differ considerably by age, rates for all age groups have declined in the 1990's, with greater declines for younger than for older teenagers.

Teenagers Under 15 Years

The birth rate in 1996 for teenagers under 15 years of age was 1.2 births per 1,000 young women 10–14 years of age. This rate has fallen since 1991, when the rate was 1.4 (table 2). The number of young women under 15 years of age who had a baby in 1996 was 11,242. This number has fallen in recent years; in 1991–95, there were 12,000 to 13,000 births each year to young women aged 10–14 years. The decline in the number of births to very young teenagers has occurred despite the increase in the number of teenagers in this age group.

Rates and Numbers Fall for Teenagers 15–17 and 18–19 Years

The birth rate for teenagers 15–17 years was 34.0 per 1,000 in 1996, 12 percent lower than in 1991 (38.7). Half of the recent decline occurred between 1995 and 1996. The rate for older teenagers 18–19 years dropped 8 percent from 94.4 per 1,000 in 1991 to 86.5 in 1996; the decline between 1995 and 1996 was 3 percent. Despite the recent declines, however, the birth rates for younger and older teenagers are still higher than they were in the early to mid-1980's (figure 1).

Overall, the number of births to teenagers 15–19 years declined by 5 percent between 1991 (519,577) and 1996

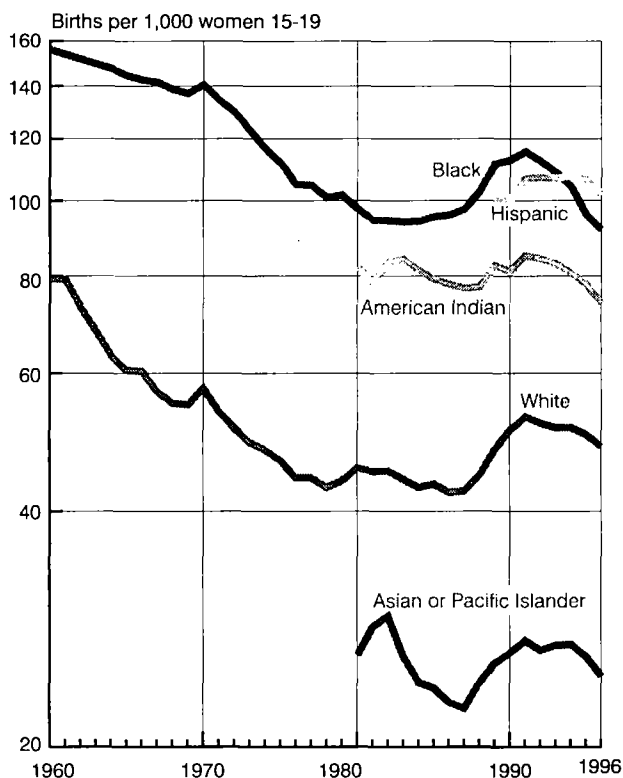
(494,272). This decline resulted from the 12-percent drop in the teenage birth rate, which more than compensated for the 8-percent increase in the number of women aged 15–19 years. The decline in the number of births to teenagers in the 1990's followed a period of increase during the late 1980's, when the number increased 13 percent from 1986 to 1990. As is true for the teenage birth rate, the number of births to teenagers was substantially higher several decades ago. The number peaked in 1970, when there were 644,708 births to women aged 15–19 years, nearly one-third more than the number reported in 1996 (table 1).

Rates for Black Teenagers at Record Lows

Teenage birth rates for ages 15–19 years dropped 5–12 percent between 1991 and 1996 for white, American Indian, Asian or Pacific Islander, and Hispanic women (figure 3 and table 2). The largest declines since 1991 by race were for black women. The overall rate for black teenagers 15–19 years fell 21 percent between 1991 and 1996, to the lowest rate ever recorded, 91.7 per 1,000. The rate for Hispanic teenagers changed little between 1991 and 1995, before declining 5 percent between 1995 and 1996.

Black teenagers experienced the most substantial reductions in rates for teenagers in both age groups 15–17 and 18–19

Figure 3. Birth rate for teenagers 15-19 years by race and Hispanic origin: United States, 1960-96



NOTE: Rates are plotted on a log scale.

years. The rate for young black teenagers, 15–17 years, declined 23 percent between 1991 and 1996, while the rate for older black teenagers, 18–19 years, fell 16 percent. Despite the sharp decline in the rates for black teenagers, their birth rates and the rates for Hispanic teenagers remain higher than for other groups. Hispanic teenagers now have the highest teenage birth rates.

Serious Health Consequences for Teenage Childbearing

Teenage mothers are much less likely than older women to receive timely prenatal care and more likely to have no care at all (figure 4). Teenage mothers are also more likely to smoke and less likely to gain adequate weight during pregnancy. As a consequence of these and other factors, babies born to teenagers are at greatly elevated risk of low birthweight (less than 2,500 grams or 5 lb 8 oz), of serious and long-term disability, and of dying during the first year of life.

Teenage Birth Rates Vary Greatly by State

State-level birth rates for teenagers vary substantially (figure 5 and tables 3 and 4). In 1995, the most recent year for which State-specific rates can be calculated, rates varied from 28.6 (Vermont) to 105.5 (District of Columbia). Some of the

Figure 4. Selected characteristics for teenage mothers and mothers aged 20 years and over: United States, 1995

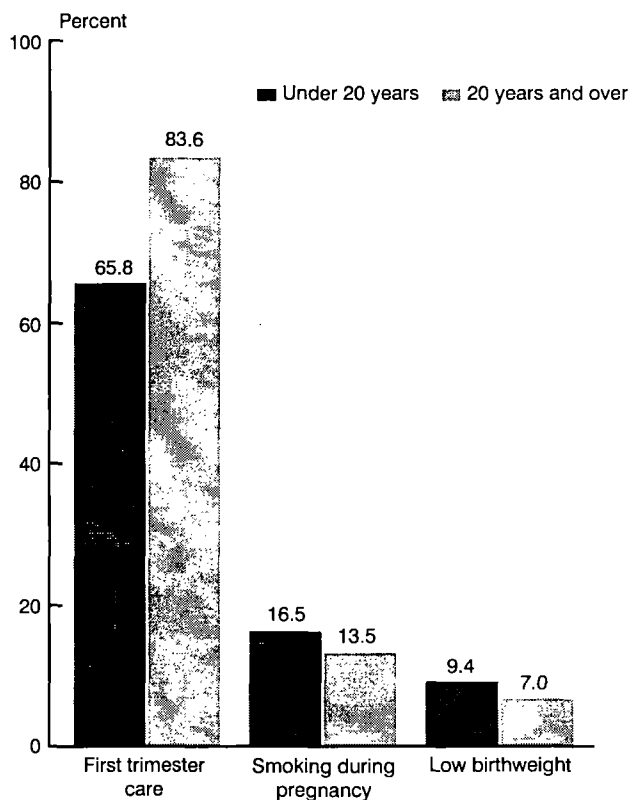


Figure 5. Teenage birth rates by State, 1995

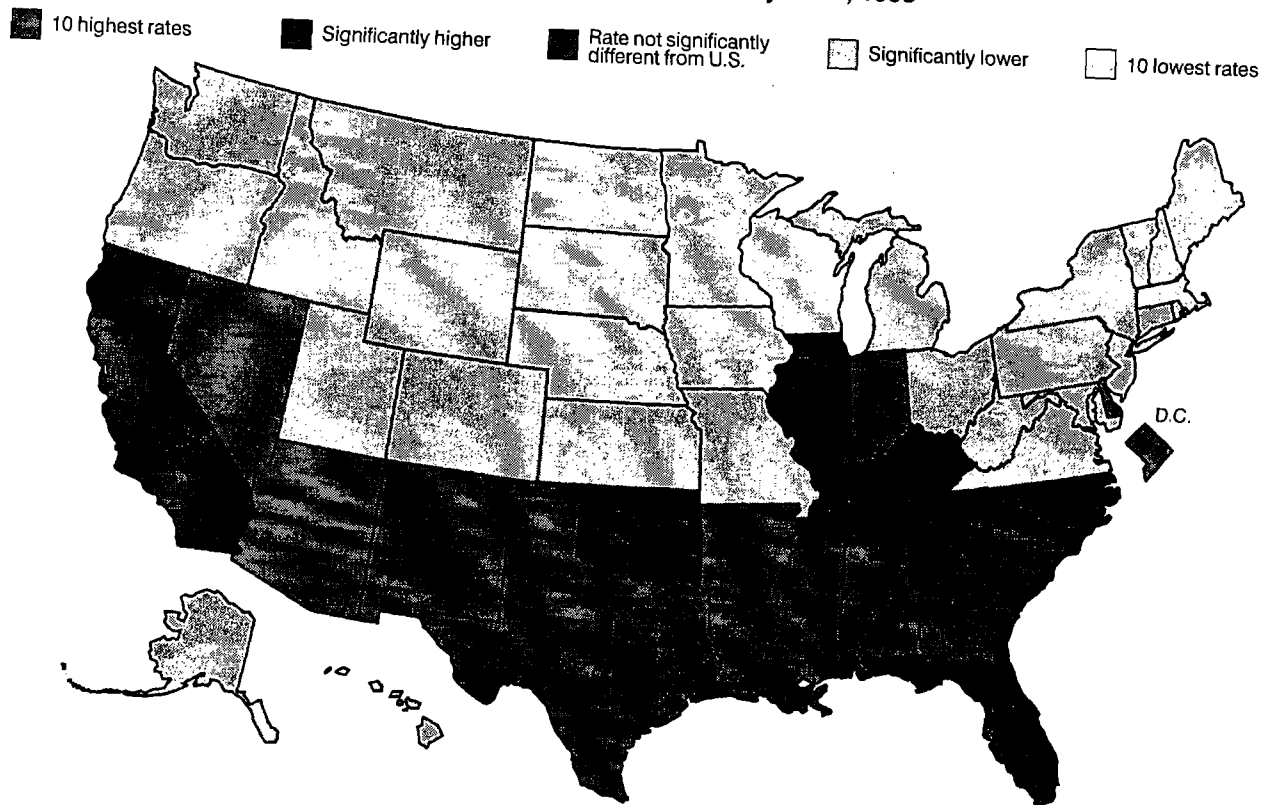
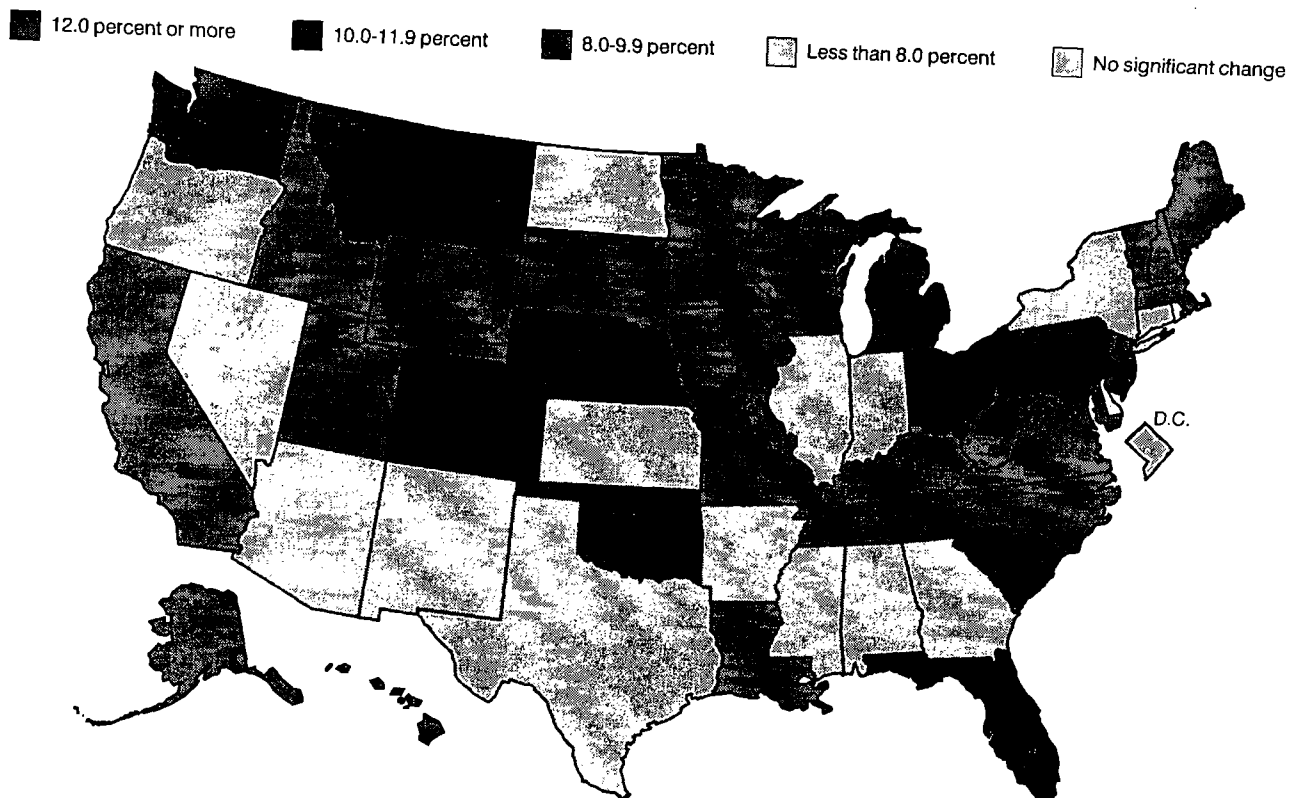


Figure 6. Percent declines in teenage birth rates by State, 1991-95



differences in overall rates by State reflect differences in the composition of the teenage populations by race and Hispanic origin. Given that birth rates for Hispanic and black teenagers are more than double the rates for non-Hispanic white teenagers (table 4), States with relatively high proportions of Hispanic and/or black teenagers in their populations would be expected to have higher overall teenage birth rates. In comparing teenage birth rates across States, it is important to keep these compositional differences in mind.

Rates Decline for All States

Birth rates for teenagers 15–19 years declined between 1991 and 1995 in all States and the District of Columbia, echoing the national trends during this time. (Declines in 5 States were not statistically significant.) (See figure 6 and table 3.) The reductions in State-specific teenage birth rates reflect and in many cases exceed those reported for the country as a whole. While the U.S. rate fell 8 percent between 1991 and 1995, rates fell by 8.0 percent or more in 33 States. Rates dropped by 12.0 percent or more in 12 States; declines in 5 States exceeded 16.0 percent. While the decline in the teenage birth rate varied among States, States with both high and low teenage birth rates were successful in achieving reductions.

Declines in Sexual Activity and Increases in Condom Use Are Key Factors

The declines—for the country and for the States—in birth rates for teenagers since 1991 likely reflect a combination of demographic and behavioral factors. According to the 1995 National Survey of Family Growth (NSFG), conducted by NCHS, the proportion of teenagers who are sexually experienced has stabilized, reversing the steady increases over the past two decades. Moreover, teenagers are now more likely to use contraceptives at first intercourse, especially condoms. In addition, some teenagers, particularly black teenagers, are using injectable and implant contraceptives. Similar changes in sexual experience for teenage males have been reported in the National Survey of Adolescent Males. Initial results from the National Longitudinal Study on Adolescent Health (Add Health), a congressionally mandated survey of students in grades 7 through 12, suggest that a feeling of personal connection to home, family, and school is essential for protecting young people from a vast array of risky behaviors, including sexual activity.

For more information on teenage birth rates and other aspects of teenage pregnancy and childbearing, the following references may be consulted:

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Table 1. Births and birth rates for teenagers 15–19 years of age, by age and race of mother: United States, selected years, 1950–75 and 1980–96

[Birth rates per 1,000 women in specified group]

Year	All races ¹			White			Black		
	Total	15–17 years	18–19 years	Total	15–17 years	18–19 years	Total	15–17 years	18–19 years
Number of births									
1996 ²	494,272	186,762	307,509	346,509	124,031	222,477	131,059	56,218	74,841
1995	499,873	192,508	307,365	349,635	127,165	222,470	133,694	59,112	74,582
1994	505,488	195,169	310,319	348,081	126,388	221,693	140,968	62,563	78,405
1993	501,093	190,535	310,558	341,817	121,309	220,508	143,153	63,156	79,997
1992	505,415	187,549	317,866	342,739	118,786	223,953	146,800	63,002	83,798
1991	519,577	188,226	331,351	352,359	118,809	233,550	150,956	63,571	87,385
1990	521,826	183,327	338,499	354,482	114,934	239,548	151,613	62,881	88,732
1989	506,503	181,044	325,459	340,472	111,736	228,736	150,699	63,832	86,867
1988	478,353	176,624	301,729	323,830	109,739	214,091	140,608	61,856	78,752
1987	462,312	172,591	289,721	315,464	108,592	206,872	134,050	59,361	74,689
1986	461,905	168,572	293,333	317,970	107,177	210,793	131,594	57,003	74,591
1985	467,485	167,789	299,696	324,590	107,993	216,597	130,857	55,656	75,201
1984	469,582	166,744	302,938	326,301	106,782	219,519	131,497	55,932	75,565
1983	489,286	172,673	316,613	343,199	111,163	232,036	133,953	57,332	76,621
1982	513,758	181,162	332,596	363,742	117,644	246,098	137,456	59,362	78,094
1981	527,392	187,397	339,995	375,432	122,561	252,871	140,344	60,944	79,400
1980	552,161	198,222	353,939	393,564	129,341	264,223	147,378	65,069	82,309
1975	582,238	227,270	354,968	410,129	148,344	261,785	161,044	74,946	86,098
1970	644,708	223,590	421,118	463,608	143,646	319,962	171,826	76,882	94,944
1965	590,894	188,604	402,290	443,754	124,294	319,460	141,026	62,488	78,538
1960	586,966	182,408	404,558	458,130	129,544	328,586	118,044	---	---
1955	484,097	149,722	334,375	372,678	103,503	269,175	108,375	---	---
1950	419,535	126,941	292,594	318,822	85,107	233,715	98,100	---	---
Birth rate									
1996 ²	54.7	34.0	86.5	48.4	28.6	78.8	91.7	64.9	133.0
1995	56.8	36.0	89.1	50.1	30.0	81.2	96.1	69.7	137.1
1994	58.9	37.6	91.5	51.1	30.7	82.1	104.5	76.3	148.3
1993	59.6	37.8	92.1	51.1	30.3	82.1	108.6	79.8	151.9
1992	60.7	37.8	94.5	51.8	30.1	83.8	112.4	81.3	157.9
1991	62.1	38.7	94.4	52.8	30.7	83.5	115.5	84.1	158.6
1990	59.9	37.5	88.6	50.8	29.5	78.0	112.8	82.3	152.9
1989	57.3	36.4	84.2	47.9	28.1	72.9	111.5	81.9	151.9
1988	53.0	33.6	79.9	44.4	26.0	69.6	102.7	75.7	142.7
1987	50.6	31.7	78.5	42.5	24.6	68.9	97.6	72.1	135.8
1986	50.2	30.5	79.6	42.3	23.8	70.1	95.8	69.3	135.1
1985	51.0	31.0	79.6	43.3	24.4	70.4	95.4	69.3	132.4
1984	50.6	31.0	77.4	42.9	24.3	68.4	94.1	69.2	128.1
1983	51.4	31.8	77.4	43.9	25.0	68.8	93.9	69.6	127.1
1982	52.4	32.3	79.4	45.0	25.5	70.8	94.3	69.7	128.9
1981	52.2	32.0	80.0	44.9	25.4	71.5	94.5	69.3	131.0
1980	53.0	32.5	82.1	45.4	25.5	73.2	97.8	72.5	135.1
1975	55.6	36.1	85.0	46.4	28.0	74.0	111.8	85.6	152.4
1970	68.3	38.8	114.7	57.4	29.2	101.5	140.7	101.4	204.9
1965	70.5	36.6	124.5	60.6	27.8	111.9	144.6	99.3	227.6
1960	89.1	43.9	166.7	79.4	35.5	154.6	156.1	---	---
1955	90.3	---	---	79.1	---	---	---	---	---
1950	81.6	---	---	70.0	---	---	---	---	---

--- Data not available.

¹Includes races other than white and black.²Data for 1996 are preliminary; figures are based on weighted data rounded to the nearest individual, so categories may not add to totals.

NOTE: Figures for 1950–75 are by race of child; see references.

Table 2. Birth rates for women under 20 years of age, by age, race, and Hispanic origin, United States, 1990–96, and percent change in rates, 1991–96

[Rates per 1,000 women in specified group]

Age and race and Hispanic origin of mother	1996 ¹	1995	1994	1993	1992	1991	1990	Percent change, 1991–96
10–14 years								
Total	1.2	1.3	1.4	1.4	1.4	1.4	1.4	–14.3
White, total	0.8	0.8	0.8	0.8	0.8	0.8	0.7	0.0
Non-Hispanic White	---	0.4	0.5	0.5	0.5	0.5	0.5	---
Black	3.7	4.2	4.6	4.6	4.7	4.8	4.9	–22.9
American Indian ²	1.8	1.8	1.9	1.4	1.6	1.6	1.6	12.5
Asian or Pacific Islander	0.6	0.7	0.7	0.6	0.7	0.8	0.7	–25.0
Hispanic ³	2.6	2.7	2.7	2.7	2.6	2.4	2.4	8.3
15–19 years								
Total	54.7	56.8	58.9	59.6	60.7	62.1	59.9	–11.9
White, total	48.1	50.1	51.1	51.1	51.8	52.8	50.1	–8.9
Non-Hispanic White	---	39.3	40.4	40.7	41.7	43.4	42.5	---
Black	91.7	96.1	104.5	108.6	112.4	115.5	112.8	–20.6
American Indian ²	75.1	78.0	80.8	83.1	84.4	85.0	81.1	–11.6
Asian or Pacific Islander	25.4	26.1	27.1	27.0	26.6	27.4	26.4	–7.3
Hispanic ³	101.6	106.7	107.7	106.8	107.1	106.7	100.3	–4.8
15–17 years								
Total	34.0	36.0	37.6	37.8	37.8	38.7	37.5	–12.1
White, total	28.4	30.0	30.7	30.3	30.1	30.7	29.5	–7.5
Non-Hispanic White	---	22.0	22.8	22.7	22.7	23.6	23.2	---
Black	64.9	69.7	76.3	79.8	81.3	84.1	82.3	–22.8
American Indian ²	47.0	47.8	51.3	53.7	53.8	52.7	48.5	–10.8
Asian or Pacific Islander	15.6	15.4	16.1	16.0	15.2	16.1	16.0	–3.1
Hispanic ³	68.9	72.9	74.0	71.7	71.4	70.6	65.9	–2.4
18–19 years								
Total	86.5	89.1	91.5	92.1	94.5	94.4	88.6	–8.4
White, total	78.4	81.2	82.1	82.1	83.8	83.5	78.0	–6.1
Non-Hispanic White	---	66.1	67.4	67.7	69.8	70.5	66.6	---
Black	133.0	137.1	148.3	151.9	157.9	158.6	152.9	–16.1
American Indian ²	124.3	130.7	130.3	130.7	132.6	134.3	129.3	–7.4
Asian or Pacific Islander	41.5	43.4	44.1	43.3	43.1	43.1	40.2	–3.7
Hispanic ³	150.7	157.9	158.0	159.1	159.7	158.5	147.7	–4.9

0.0 Quantity more than zero but less than 0.05.

--- Data not available.

¹Data for 1996 are preliminary.²Includes births to Aleuts and Eskimos.³Persons of Hispanic origin may be of any race.

Table 3. Birth rates for teenagers 15–19 years of age, by age group and State, and percent change for 15–19 year-olds, United States, 1991 and 1995

[Rate per 1,000 women in specified group]

State	1991			1995			Percent change, 1991–95
	15–19 years	15–17 years	18–19 years	15–19 years	15–17 years	18–19 years	15–19 years
United States ¹	62.1	38.7	94.4	56.8	36.0	89.1	–8.5
Alabama	73.9	47.7	109.5	70.3	47.2	104.4	–4.8
Alaska	65.4	35.3	111.7	50.3	29.8	80.6	–23.1
Arizona	80.7	51.4	122.6	75.3	48.9	114.7	–6.6
Arkansas	79.8	49.4	122.8	73.5	47.9	112.1	–7.9
California	74.7	46.9	113.6	68.2	43.4	106.8	–8.6
Colorado	58.2	35.3	91.4	51.3	32.8	80.1	–11.8
Connecticut	40.4	26.3	59.4	39.4	26.8	59.5	–2.6**
Delaware	61.1	40.3	87.1	57.1	39.6	82.8	–6.5**
District of Columbia	114.4	102.8	125.5	105.5	77.2	144.1	–7.8
Florida	68.8	44.0	102.9	61.6	40.0	95.7	–10.4
Georgia	76.3	50.6	110.9	71.0	48.3	106.3	–7.0
Hawaii	58.7	34.7	91.5	48.1	27.7	76.4	–18.1
Idaho	53.9	29.3	90.8	49.0	26.9	81.9	–9.1
Illinois	64.8	40.6	99.1	60.0	38.5	94.4	–7.4
Indiana	60.5	35.2	95.2	57.5	34.7	92.2	–4.9
Iowa	42.6	22.8	71.5	38.6	22.2	64.7	–9.3
Kansas	55.4	29.4	94.1	52.3	30.1	87.3	–5.6
Kentucky	68.9	42.6	105.5	62.6	39.0	98.1	–9.2
Louisiana	76.1	51.1	111.4	69.9	45.3	106.6	–8.2
Maine	43.5	23.8	70.1	33.7	19.3	56.7	–22.4
Maryland	54.3	35.2	79.8	47.6	31.9	72.5	–12.3
Massachusetts	37.8	25.2	52.9	34.3	21.7	53.2	–9.3
Michigan	59.0	35.5	91.1	49.2	30.0	79.6	–16.6
Minnesota	37.3	20.7	61.4	32.4	19.4	53.5	–13.2
Mississippi	85.6	60.1	120.4	80.5	57.8	114.8	–5.9
Missouri	64.5	38.7	100.7	55.5	32.6	92.0	–13.9
Montana	46.7	23.6	83.0	41.9	22.9	71.7	–10.4
Nebraska	42.4	23.6	69.2	37.6	22.1	61.1	–11.3
Nevada	75.3	43.9	119.1	73.4	44.0	120.4	–2.5**
New Hampshire	33.3	17.1	53.8	30.6	14.7	57.1	–8.0
New Jersey	41.6	26.3	62.9	38.0	24.4	59.5	–8.7
New Mexico	79.8	50.0	124.4	74.4	49.0	114.4	–6.7
New York	46.0	29.1	69.0	43.9	27.5	68.6	–4.6
North Carolina	70.5	46.2	101.7	64.0	41.6	97.9	–9.3
North Dakota	35.6	18.1	62.4	33.5	17.9	58.4	–5.8**
Ohio	60.5	36.2	93.8	53.4	32.6	85.6	–11.7
Oklahoma	72.1	41.7	115.6	64.0	38.8	103.3	–11.2
Oregon	54.9	31.3	90.7	50.5	30.0	83.1	–7.9
Pennsylvania	46.9	29.2	70.5	41.7	26.3	65.6	–11.1
Rhode Island	45.4	30.1	63.6	42.9	26.4	68.3	–5.6**
South Carolina	72.9	48.0	105.4	65.2	43.5	97.1	–10.6
South Dakota	47.5	26.3	79.2	40.5	21.5	69.9	–14.8
Tennessee	75.2	47.8	112.1	68.0	42.0	108.3	–9.5
Texas	78.9	50.4	119.3	75.8	50.7	114.1	–3.9
Utah	48.2	27.0	79.8	42.3	25.2	67.3	–12.2
Vermont	39.2	21.3	62.0	28.6	10.8	56.9	–27.1
Virginia	53.5	31.8	81.2	48.5	30.5	74.8	–9.3
Washington	53.7	31.0	86.5	47.5	28.0	77.7	–11.5
West Virginia	57.8	32.4	93.2	52.6	30.4	85.9	–9.0
Wisconsin	43.7	24.8	71.2	37.8	22.7	61.8	–13.4
Wyoming	54.2	26.4	98.6	47.3	24.7	84.3	–12.8
Puerto Rico	72.4	50.8	105.9	74.3	54.3	104.1	2.6**
Virgin Islands	77.9	48.6	124.0	63.0	38.3	100.1	–19.1
Guam	95.7	55.0	156.1	108.4	78.3	167.2	13.3

** Not significant at $p < 0.05$.¹Excludes data for Puerto Rico, Virgin Islands, and Guam.

NOTES: Birth rates by State shown in this table are based on population estimates provided by the U.S. Bureau of the Census and, therefore, the rates shown here may differ from rates computed on the basis of other population estimates. Rates by State for 1995 have been revised; therefore rates shown in this table may differ slightly from rates for 1995 previously published.

Table 4. Birth rates for teenagers 15–19 years of age, by age and race/Hispanic origin: United States and each State, 1995

[Rates per 1,000 women in specified group]

State	15–19 years					15–17 years					18–19 years				
	All ¹	White				All ¹	White				All ¹	White			
		Total	Non-Hispanic	Black	Hispanic ²		Total	Non-Hispanic	Black	Hispanic ²		Total	Non-Hispanic	Black	Hispanic ²
United States ³	56.8	50.1	39.3	96.0	105.5	36.0	30.1	22.0	69.8	72.6	89.1	80.9	66.1	136.8	154.2
Alabama	70.3	55.9	55.5	99.4	89.4	47.2	34.0	33.9	73.6	*	104.4	88.0	87.1	137.8	*
Alaska	50.3	36.5	34.7	*	*	29.8	19.1	18.0	*	*	80.6	61.6	58.9	*	*
Arizona	75.3	75.6	47.4	77.5	132.1	48.9	49.2	26.6	51.4	95.7	114.7	114.5	78.2	115.0	185.5
Arkansas	73.5	62.2	61.3	112.2	98.8	47.9	37.2	36.8	84.3	*	112.1	99.8	98.1	154.8	*
California	68.2	73.2	36.3	85.2	111.6	43.4	46.5	20.1	56.4	75.3	106.8	114.5	62.4	130.6	165.4
Colorado	51.3	50.1	34.4	77.1	114.9	32.8	31.8	19.7	54.3	83.2	80.1	78.4	57.4	112.0	161.9
Connecticut	39.4	33.3	20.6	83.8	117.3	26.8	22.0	11.2	60.8	93.8	59.5	51.2	35.5	122.9	154.9
Delaware	57.1	43.2	38.1	102.9	*	39.6	26.9	22.8	79.5	*	82.8	66.8	60.4	138.0	*
District of Columbia	105.5	25.8	9.4	154.8	89.6	77.2	33.0	*	90.2	*	144.1	22.5	*	326.4	*
Florida	61.6	51.0	45.8	100.6	69.1	40.0	30.8	26.7	73.2	46.2	95.7	82.8	76.4	144.5	103.1
Georgia	71.0	55.7	52.6	101.4	123.4	48.3	35.1	33.2	73.9	79.2	106.3	87.2	82.5	145.5	188.8
Hawaii	48.1	24.1	22.4	48.7	90.0	27.7	9.8	8.4	*	60.3	76.4	43.9	41.9	*	132.2
Idaho	49.0	48.9	43.7	*	107.4	26.9	26.9	23.6	*	64.9	81.9	81.4	73.4	*	170.0
Illinois	60.0	45.8	33.0	126.2	114.6	38.5	26.2	17.6	93.9	73.7	94.4	77.0	57.8	178.2	176.8
Indiana	57.5	52.2	51.0	106.1	85.8	34.7	30.0	29.3	76.2	51.6	92.2	85.9	84.2	152.2	134.1
Iowa	38.6	36.5	34.8	116.4	111.9	22.2	20.1	18.7	95.4	87.8	64.7	62.5	60.6	*	*
Kansas	52.3	47.4	43.6	115.5	100.9	30.1	26.1	22.8	82.5	73.1	87.3	81.0	76.3	169.5	143.8
Kentucky	62.6	59.1	58.9	102.2	*	39.0	35.8	35.6	73.8	*	98.1	94.2	93.9	146.3	*
Louisiana	69.9	48.4	48.8	103.6	35.1	45.3	26.5	26.7	74.7	22.0	106.6	81.0	81.9	147.0	53.4
Maine	33.7	33.2	33.0	*	*	19.3	19.1	19.0	*	*	56.7	55.6	55.1	*	*
Maryland	47.6	33.0	31.1	81.4	58.6	31.9	18.7	17.3	61.4	39.8	72.5	55.6	53.1	112.9	86.7
Massachusetts	34.3	30.5	22.8	77.8	112.9	21.7	18.5	12.0	58.4	89.0	53.2	48.8	39.2	105.4	147.3
Michigan	49.2	38.6	36.4	100.7	91.6	30.0	21.3	19.8	73.2	58.5	79.6	66.3	62.9	142.9	141.4
Minnesota	32.4	26.5	24.8	121.0	111.5	19.4	14.7	13.5	98.4	71.4	53.5	45.8	43.1	158.4	173.9
Mississippi	80.5	56.3	56.4	108.1	*	57.8	34.8	35.0	83.4	*	114.8	88.2	88.4	145.8	*
Missouri	55.5	47.3	46.8	108.7	70.1	32.6	25.5	25.0	77.9	47.1	92.0	81.9	81.4	157.4	105.3
Montana	41.9	35.4	34.1	*	*	22.9	18.2	17.5	*	*	71.7	62.1	60.1	*	*
Nebraska	37.6	33.7	30.1	100.4	102.5	22.1	18.9	16.4	70.6	67.8	61.1	56.1	50.8	146.0	154.3
Nevada	73.4	72.2	55.2	101.7	134.5	44.0	41.8	30.5	77.6	85.0	120.4	120.9	95.3	140.4	208.9
New Hampshire	30.6	30.6	30.2	*	*	14.7	14.6	14.2	*	*	57.1	57.1	56.7	*	*
New Jersey	38.0	28.6	16.5	85.7	83.9	24.4	16.9	8.4	61.7	57.2	59.5	46.9	29.3	124.2	124.1
New Mexico	74.4	73.6	43.0	68.3	98.5	49.0	48.5	23.0	49.6	70.0	114.4	112.7	74.8	*	142.0
New York	43.9	39.1	24.7	66.4	84.6	27.5	23.2	13.2	46.7	55.8	68.6	63.2	42.2	95.8	127.5
North Carolina	64.0	51.7	48.6	92.6	155.2	41.6	30.1	28.4	68.3	87.9	97.9	84.2	79.0	129.6	257.1
North Dakota	33.5	28.1	27.3	*	*	17.9	13.9	13.2	*	*	58.4	50.6	49.7	*	*
Ohio	53.4	45.5	44.5	107.2	87.2	32.6	25.5	24.8	79.2	56.5	85.6	76.1	74.7	152.0	132.7
Oklahoma	64.0	57.4	55.1	99.2	93.2	38.8	33.7	32.0	69.2	60.9	103.3	93.6	90.4	146.6	143.5

See footnotes at end of table.

Table 4. Birth rates for teenagers 15–19 years of age, by age and race/Hispanic origin: United States and each State, 1995—Con.

[Rates per 1,000 women in specified group]

State	15–19 years					15–17 years					18–19 years				
	All ¹	White				All ¹	White				All ¹	White			
		Total	Non-Hispanic	Black	Hispanic ²		Total	Non-Hispanic	Black	Hispanic ²		Total	Non-Hispanic	Black	Hispanic ²
Oregon	50.5	50.0	43.5	88.4	130.6	30.0	29.2	24.7	69.8	86.2	83.1	83.0	73.3	*	200.9
Pennsylvania	41.7	32.9	29.1	109.3	130.7	26.3	18.8	15.7	83.7	101.4	65.6	54.8	50.0	148.7	174.9
Rhode Island	42.9	37.4	29.4	92.6	115.2	26.4	21.6	16.2	61.4	75.9	68.3	62.1	50.1	*	173.3
South Carolina	65.2	51.9	51.3	86.2	78.1	43.5	31.4	30.8	62.7	*	97.1	82.1	81.5	120.7	*
South Dakota	40.5	30.8	30.3	*	*	21.5	14.8	14.3	*	*	69.9	55.2	54.7	*	*
Tennessee	68.0	57.3	56.8	109.5	90.5	42.0	32.2	31.8	79.4	59.7	108.3	96.0	95.3	157.8	*
Texas	75.8	75.2	47.0	91.4	112.2	50.7	49.8	26.9	64.6	80.7	114.1	113.6	78.1	133.4	158.2
Utah	42.3	41.4	37.3	*	109.0	25.2	24.5	21.1	*	81.3	67.3	66.1	60.9	*	148.8
Vermont	28.6	28.8	29.1	*	*	10.8	10.9	10.9	*	*	56.9	58.0	59.4	*	*
Virginia	48.5	38.9	37.1	83.1	70.5	30.5	21.5	20.2	60.8	45.3	74.8	64.0	61.5	116.4	106.2
Washington	47.5	45.8	39.1	76.2	119.7	28.0	26.6	21.8	52.3	79.0	77.7	75.6	65.8	114.0	181.5
West Virginia	52.6	51.7	51.8	82.3	*	30.4	29.5	29.6	54.5	*	85.9	84.8	85.0	*	*
Wisconsin	37.8	28.6	25.9	132.7	108.6	22.7	15.0	13.0	101.2	73.2	61.8	50.1	46.1	183.3	162.6
Wyoming	47.3	45.4	41.2	*	95.9	24.7	23.7	20.7	*	*	84.3	80.9	74.8	*	*
Puerto Rico	74.3	---	---	---	---	54.3	---	---	---	---	104.1	---	---	---	---
Virgin Islands	63.0	---	---	---	---	38.3	---	---	---	---	100.1	---	---	---	---
Guam	108.4	---	---	---	---	70.3	---	---	---	---	167.2	---	---	---	---

* Figure does not meet standards of reliability or precision (based on fewer than 20 births or fewer than 1,000 women in specified group).

--- Data not available.

¹Includes races other than white and black.²Persons of Hispanic origin may be of any race.³Excludes data for Puerto Rico, Virgin Islands, and Guam.

NOTES: Birth rates by State shown in this table are based on population estimates provided by the U.S. Bureau of the Census and, therefore, the rates shown here may differ from rates computed on the basis of other population estimates. Rates for all races by State for 1995 have been revised; therefore rates shown in this table may differ slightly from rates for 1995 previously published.

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Table 13. Gonorrhea — Reported cases and rates by state/area, ranked according to rates: United States and outlying areas, 1998

<i>Rank</i>	<i>State/Area</i>	<i>Cases</i>	<i>Rate per 100,000 Population</i>
1	Mississippi	10,689	391.5
2	South Carolina	11,575	307.8
3	Alabama	12,737	294.9
4	Louisiana	12,499	287.2
5	Georgia	20,666	276.1
6	North Carolina	19,230	259.0
7	Maryland	11,254	220.9
8	Tennessee	11,840	220.6
9	Delaware	1,556	212.7
10	Illinois	21,735	182.7
11	Missouri	9,463	175.2
12	Texas	32,833	168.9
13	Michigan	16,359	167.4
14	Ohio	18,275	163.4
15	Oklahoma	5,243	158.1
16	Arkansas	3,953	156.7
17	Virginia	9,265	137.6
	U.S. TOTAL¹	355,642	132.9
18	Florida	19,080	130.2
19	Wisconsin	6,351	122.9
20	Indiana	6,307	107.6
21	New York	19,062	105.1
22	Kansas	2,622	101.0
	YEAR 2000 OBJECTIVE		100.0
23	Kentucky	3,813	97.6
24	New Jersey	7,858	97.6
25	Pennsylvania	11,719	97.5
26	Connecticut	3,177	97.2
27	Arizona	4,213	92.5
28	Nevada	1,445	86.2
29	Nebraska	1,204	72.7
30	California	19,518	60.5
31	Minnesota	2,708	57.8
32	Iowa	1,616	56.7
33	New Mexico	957	55.3
34	Alaska	331	54.3
35	Colorado	2,033	52.2
36	West Virginia	920	50.7
37	Guam	72	46.1
38	Rhode Island	430	43.5
39	Hawaii	506	42.6
40	Massachusetts	2,258	36.9
41	Virgin Islands	39	35.6
42	Washington	1,948	34.7
43	South Dakota	221	29.9
44	Oregon	880	27.1
45	Idaho	182	15.0
46	North Dakota	80	12.5
47	Utah	236	11.5
48	Puerto Rico	400	10.5
49	New Hampshire	91	7.8
50	Wyoming	36	7.5
51	Vermont	38	6.5
52	Montana	55	6.3
53	Maine	67	5.4

¹Includes cases reported by Washington, D.C., but excludes outlying areas (Guam, Puerto Rico and Virgin Islands).

Table 38. Congenital syphilis — Reported cases and rates in infants <1 year of age by state/area, ranked according to rates: United States and outlying areas, 1998

<i>Rank</i>	<i>State/Area*</i>	<i>Cases</i>	<i>Rate per 100,000 Live Births</i>
1	Arkansas	30	82.5
2	New Jersey	86	75.2
3	Maryland	44	61.5
4	Puerto Rico	27	42.8
	YEAR 2000 OBJECTIVE		40.0
5	Illinois	71	38.8
6	Florida	71	37.5
7	South Carolina	19	37.2
8	Mississippi	15	36.6
9	Arizona	25	33.2
10	Oklahoma	15	32.5
11	Texas	102	30.9
12	North Carolina	24	23.0
13	California	119	22.1
14	New York	56	21.2
	U.S. TOTAL¹	801	20.6
15	Missouri	15	20.3
16	Alabama	9	14.9
17	Pennsylvania	21	14.2
18	Georgia	14	12.3
19	Louisiana	8	12.3
20	Tennessee	9	12.2
21	Michigan	16	12.0
22	Kentucky	5	9.5
23	Wisconsin	6	8.9
24	Virginia	4	4.3
25	Ohio	4	2.6
26	Massachusetts	2	2.5
27	Utah	1	2.4
28	Colorado	1	1.8
29	Washington	1	1.3
30	Alaska	0	0.0
31	Connecticut	0	0.0
32	Delaware	0	0.0
33	Hawaii	0	0.0
34	Idaho	0	0.0
35	Indiana	0	0.0
36	Iowa	0	0.0
37	Kansas	0	0.0
38	Maine	0	0.0
39	Minnesota	0	0.0
40	Montana	0	0.0
41	Nebraska	0	0.0
42	Nevada	0	0.0
43	New Hampshire	0	0.0
44	New Mexico	0	0.0
45	North Dakota	0	0.0
46	Oregon	0	0.0
47	Rhode Island	0	0.0
48	South Dakota	0	0.0
49	Vermont	0	0.0
50	West Virginia	0	0.0
51	Wyoming	0	0.0
52	Guam	0	0.0
53	Virgin Islands	0	0.0

*Mother's state of residence used to assign case.

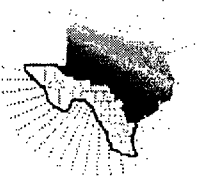
¹Includes cases reported by Washington, D.C. but excludes outlying areas (Guam, Puerto Rico and Virgin Islands).

Table 4. Chlamydia — Reported cases and rates by state/area, ranked according to rates: United States and outlying areas, 1998

<i>Rank</i>	<i>State/Area</i>	<i>Cases</i>	<i>Rate per 100,000 Population</i>
1	South Carolina	18,510	492.3
2	Mississippi	10,614	388.7
3	New York ¹	26,218	357.1
4	Delaware	2,608	356.5
5	Louisiana	15,188	349.0
6	Georgia	25,250	337.3
7	Alaska	1,907	313.0
8	Texas	60,436	310.9
9	North Carolina	22,197	298.9
10	Oklahoma	9,393	283.2
11	Wisconsin	13,878	268.5
12	Guam	410	262.5
13	Maryland	13,097	257.1
14	Tennessee	13,717	255.5
15	Arizona	11,489	252.2
16	Ohio	27,786	248.4
17	California	76,490	237.0
	U.S. TOTAL²	607,602	236.6
18	Missouri	12,670	234.5
19	Colorado	9,113	234.1
20	Rhode Island	2,307	233.6
21	Alabama	10,065	233.0
22	Michigan	22,156	226.7
23	Illinois	26,363	221.6
24	Hawaii	2,604	219.5
25	New Mexico	3,793	219.3
26	Kansas	5,587	215.3
27	Connecticut	6,977	213.4
28	South Dakota	1,572	213.0
29	Pennsylvania	24,629	204.9
30	Virginia	13,561	201.4
31	Nevada	3,320	198.0
32	Washington	10,998	196.0
33	Indiana	10,801	184.2
34	Iowa	5,174	181.4
35	Oregon	5,855	180.5
36	Nebraska	2,911	175.7
37	Florida	24,949	170.3
38	Idaho	2,035	168.1
39	Kentucky	6,441	164.8
40	Arkansas	4,123	163.4
41	North Dakota	1,036	161.7
42	Montana	1,412	160.7
43	West Virginia	2,791	153.7
44	Wyoming	725	151.1
45	Minnesota	6,970	148.8
46	New Jersey	11,686	145.1
47	Massachusetts	8,363	136.7
48	Utah	2,209	107.3
49	Maine	1,073	86.4
50	New Hampshire	960	81.9
51	Vermont	413	70.1
52	Puerto Rico	1,685	44.0
53	Virgin Islands	10	9.1

¹New York's cases and rate are based on New York City. No cases were reported outside of New York City.

²Includes cases reported by Washington, D.C., but excludes outlying areas (Guam, Puerto Rico and Virgin Islands).

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Carole Keeton Rylander
Texas Comptroller of Public Accounts
Window on State Government

Bordering the Future

HEALTH Chronic Conditions

Health conditions on the Texas-Mexico border are among the worst in the U.S., so distressful at times that reports on health conditions suggest a remote country in need of medical missionaries, not a part of Texas. Cases of hepatitis A, a gastrointestinal virus borne by contaminated food and water, are four times as common in the Rio Grande Valley as in the rest of Texas.¹ The diabetes-related death rate in the Border region is nearly 25 percent greater than the state rate.²

Nor is it a secret that the region's health care delivery system is unable to serve all residents who need care. All but two of the 43 Border counties--including every county on the Rio Grande--are federally designated "medically underserved areas."³

Why is the Border's health care system so fragmented? With so many people, and so much sickness, why aren't there enough providers to treat everyone?

One answer, of course, is money, or lack of it. Too often in addressing the Border's health needs, Texas has made a common mistake of modern medicine--treating the symptom, rather than the underlying condition. The Border's underlying condition is poverty, which has hindered development of the region's health sector.

In the Border region and beyond, the health sector consists of three systems: the public health system, which tries to prevent disease; the health care delivery system, which treats people when they get sick; and the health care finance system, which pays for prevention and medical care.

Ideally, local health care finance systems draw upon a balanced mix of private, public, and non-profit support. In the ideal scenario, most residents have health insurance paid by their employer, their own wages, or a combination of both. And public insurance programs cover other groups--low-income populations, the elderly, and government employees. Publicly funded facilities serve local populations, and charities help fill gaps by funding facilities and specific services.

In contrast, the Border region's health care finance system is out of balance, missing a stable base of private insurance to complement public and charity programs. Only 40 percent of Texans living in Border cities had private insurance by one 1994 estimate, compared to almost 60 percent of non-Border city residents. The study found that the Border economy, with its predominance of small employers and low-wage jobs, appeared to be a breeding ground for an epidemic of "uninsurance."⁴

Lack of insurance has been compounded by a lack of infrastructure--especially potable



The Border's health care system struggles to make care available to everyone in need.

water--necessary for disease prevention. Lack of infrastructure is also the result of poverty, that of communities and of individuals.

Even if poverty were not an issue, the Border region would face significant and unusual health challenges. The flow of people back and forth between Mexico and the U.S. creates opportunities for diseases to spread across a border invisible to germs. Such routine comings and goings naturally spotlight the different focuses of the U.S. and Mexican health care systems. The former system emphasizes private insurance and public health infrastructure, while the latter revolves around a publicly owned delivery system. Differences between the systems can be addressed and overcome on a case-by-case basis. But the long-term efforts of health care providers in both countries to coordinate two public health care systems and two health care delivery systems can hardly meet health needs without sufficient financial glue to hold them together.

Just as the root of poor health along the border is financial, so too are many outcomes. A health care system that functions less than optimally has a draining effect on an area's economy. Individuals with poor health, especially chronic, untreated conditions, lose the capacity to work, and families are unable to remain self-sufficient. This, in turn, costs state and local taxpayers, who pay the tab for indigent health care. A fragmented health care delivery system can be an impediment to economic development.

Finally, health care amounts to a significant economic sector in its own right--one typically providing a large number of living-wage jobs. Improving the Border's health care delivery system would contribute to economic development by generating jobs that offer workers and their families the insurance coverage they need.

Money Alone No Solution

It would be simple to recommend a rapid infusion of health care dollars to remedy the widespread gaps in the Border region--simple, perhaps, but misguided.

To be sure, the Border's health care system needs money. But it doesn't need "quick fix" public spending that further fragments the delivery system by setting up more special programs covering specific illnesses or serving individuals who meet special guidelines. Instead, the region may need a health care finance system based more on private payments and less on public contributions. To win support from all, and to benefit many, the system must be based on the shared responsibility of families, businesses, and public programs. In short, Border residents should "own" their health care system, rather than lie at its mercy.

A Different Kind of Melting Pot

From a public health perspective, the Border is a unique epidemiological melting pot of diseases such as tuberculosis, leprosy, dengue fever, typhoid, and hepatitis A, and conditions such as diabetes and hypertension.⁵ Diseases pass freely via shared water resources, contaminated foods, and sometimes uncontrolled pharmaceuticals and consumer products, generally because of human and animal migration (see *A Tale of La Crema de Belleza*).

Sidebar:

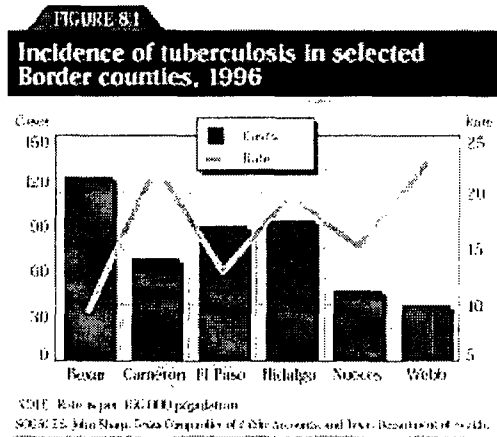
A Tale of La Crema de Belleza ➔

Beyond its economic implications, poor health along the border ripples through both nations

that share the boundary. The massive, daily movement of people and goods through the region--often to places far beyond--comprises an entirely too efficient disease transportation system.

In general, public health officials rank specific diseases and conditions based on prevalence, the potential for widespread outbreaks, and severity. As of early 1998, Texas state officials listed tuberculosis, hepatitis A, and shigellosis, a gastrointestinal ailment, as communicable disease priorities in the Border region (see **Table 8.1** and **Figure 8.1**).⁶

Health officials refer separately to the threat of "emerging" diseases, defined as those with low incidence along the border and elsewhere in modern times, yet once again ripe for outbreaks because of inadequate sanitation. In the 1990s, Texas Border communities experienced outbreaks of dengue fever and rabies. Communities on the Mexican side of the border confronted cholera, a deadly gastrointestinal illness extremely rare in the U.S.⁷



Unlike contagious diseases, chronic diseases are less the results of infrastructure deficiencies and more the products of lifestyle and genetics. In the Border region, public health officials have focused on health problems prevalent in the predominant Hispanic population, such as diabetes, cervical cancer, and breast cancer.⁸ Birth defects have also drawn attention, including a cluster of Cameron County infants born in 1991 with anencephaly, a fatal neural tube defect.

While many health conditions are worse in the region than elsewhere, residents are better off than the state average in at least two ways. Border mortality rates for exposure to HIV, the virus that causes AIDS, were 9.4 per 100,000 population in 1995, compared to 14.8 statewide. And the generally healthy habits of Hispanic women and a cultural commitment to family and children were reflected in better birth outcomes than the state average.⁹

As Goes Mexico...

Public health strategies that work well in other parts of Texas often fail to address the Border's unique needs. For instance, to function optimally in Texas Border communities, government disease prevention programs must collaborate with Mexico in attacking shared problems and root causes.

Concerns are not limited to the Texas side of the border. Mexico, for instance, fears the spread of afflictions such as HIV/AIDS to its population, which has reported infection rates much lower than the U.S. Mexico also must contend with increasing rates of diseases from U.S. conditions such as drug abuse, diabetes, heart disease, and hypertension.

The two nations take different tacks to track diseases and other health indicators. Unfortunately, the differences sometimes impede collaborative efforts to prevent and control outbreaks. In the U.S., for instance, health officials record both new cases of tuberculosis (TB) and TB-related deaths. In Mexico, TB-related deaths are recorded, but not all areas of the country report new cases. Since TB is a highly treatable disease, focusing only on deaths may minimize TB's true prevalence.

Such reporting differences are due largely to a lack of resources for tracking diseases and conditions, commonly called surveillance. Scarce funds are spent on direct treatment and

basic health education. In many cases, a local health department on the Mexican border may have only one computer, if any, to share among many users. In other cases, staff might have to rely on a single shared manual or electric typewriter.

Inadequate Health Care Access

Just as the public health system along the border struggles to promote health, the health care delivery system labors to provide care to those who need it. By common measures, many Border residents have inadequate access to health care. Without access, they miss school and work while spending hours waiting for scarce services, or they do without care until their conditions are severe, when they may travel to other cities for care, often at considerable cost to Texas taxpayers.

Sidebar:



Visiting la Farmacia

Quantifying an individual's or community's access to health care is an imperfect science. Common indicators of deficiency in the health care delivery system are HPSA and Medically Underserved Area (MUA) designations, which the federal government gives to areas that meet certain criteria. Another indicator is the amount of indigent care provided by local hospitals. A high level of indigent care indicates that many local residents cannot afford to pay for services. Most lack health insurance.

The U.S. Department of Health and Human Services assigns a Health Professional Shortage Area (HPSA) designation to U.S. counties based on their ability to provide health services to local residents. Counties with less than one physician for every 3,500 residents are designated a federal HPSA if physicians are not accessible within a reasonable distance. The designations may apply to primary medical care, dental services, or mental health services.¹⁰

While less than half of the state's 254 counties had HPSA designations in 1998, 27 of 43 counties (63 percent) in the Border region had HPSA designations for primary medical care. For dental services, 44 percent of the region's counties had a HPSA designation, compared to 20 percent of non-Border counties. Some 95 percent of the Border counties were designated HPSAs for mental health care, compared to 72 percent for the rest of the state. Only Nueces and Bexar counties lacked this designation.

Counties with a HPSA designation become eligible to have health care providers placed with them from the National Health Service Corps. This program pays to train health care professionals if participants agree to serve a "tour of duty" in an area lacking adequate health care services. Primary care physicians practicing in HPSAs also may qualify for federal repayment of their medical school loans.

Counties may also be designated as MUAs, based on a shortage of personal health services for local residents. The federal government determines a county's qualification for such a designation by comparing its percentage of aged residents, poverty rate, infant mortality rate, and ratio of primary care physicians per 1,000 residents to national averages. If the resulting Index of Medical Underservice score falls below the national average, the county is considered underserved.

Of the 43 Texas Border counties, 31 were designated as MUAs in 1998. Ten other counties, including urban Bexar, El Paso, Webb, Hidalgo, Nueces, and Cameron counties, received partial MUA designations. In total, 95 percent of Border counties were judged MUAs in whole or in part, compared to 85 percent statewide. Importantly, even the region's most urban counties, with greater medical resources, still were considered at least partly

underserved.

Local Health Centers

By law, hospitals cannot turn away patients in need of emergency care, regardless of their ability to pay. But what resources are available for preventive care, primary care, and the treatment of chronic conditions such as diabetes, cancer, or heart disease? In the Border region and statewide, community and migrant health centers, public health clinics, and public hospitals shoulder much of the burden. In 1997, 22 community health centers in the Border region served 203,027 medical and dental clients in more than 700,000 visits. A single community health center in the Rio Grande Valley served more than 22,000 patients; its five pediatricians treated an average of 138 children a day.

Community and migrant health centers have a variety of medical personnel on staff such as family practice physicians, obstetricians, gynecologists, pediatricians, internists, dentists, nurse practitioners, physician's assistants, certified nurse midwives, and other specialists. For treatment of conditions ranging from allergies to HIV/AIDS, clinics maintain referral agreements with nearby subspecialists, who are paid up to 50 percent of their regular rates.

If a specialist refuses to accept less than full reimbursement, patients may be left without care. They also could be referred to public hospitals with specialists available to provide indigent care, which would be welcome if the referrals led to accessible care, but that is not the case. Indigent patients in the Rio Grande Valley faced with conditions such as kidney disease or cancer may be referred to the closest medical facility for indigent care--the University of Texas Medical Branch in Galveston nearly 400 miles away. For older residents, 40-hour-per week workers, or people without reliable transportation, such a referral is daunting at least, probably impractical, and even potentially life-threatening.

In West Texas along the border, the city of Presidio offers no full-time physician, no hospital, nor even a pharmacy. The nearest emergency care facility on the U.S. side of the river is 90 miles away in Alpine--a \$200 trip by ambulance. Presidio's clinic staff, without a pharmacy, wait two to three days to receive medicine delivered from Alpine. The Texas Department of Health's nearest regional office is in El Paso, more than five hours away.

There is an immediate border solution. Presidio residents simply cross the river to obtain health care services and medicine in Ojinaga; some also may depend upon folk medicine to treat routine ills (see *Folk Medicine*).

Sidebar: **Folk Medicine**



Women in Presidio are not as likely to receive prenatal care and are more likely to deliver their babies at home. This isolation also makes disease tracking and record-keeping nearly impossible. Incomplete tracking can lead to misleading conclusions, limiting the effectiveness of public health care. For example, Presidio reported low rates of hepatitis A from 1992 through 1997. But the low rates did not necessarily mean a lower rate of infection; state health officials suspect many infected individuals sought care in Ojinaga and weren't noted in Texas.

Community health advisors have long helped public health advocates serve communities. In the Border region, such workers--known as *promotoras de salud*, health promoters, or simply *promotoras*--provide a bilingual liaison between health care providers and the public.¹¹ As members of the community, *promotoras* are uniquely positioned to work within communities, bridging cultural gaps and gaining the trust of residents. Some *promotoras* are paid while others volunteer.

Within a health center, *promotoras* may assist in daily clinical activities such as case conferences, patient education, referrals to other health and social services, and volunteer coordination. In the community, *promotoras* may conduct needs assessments, distribute surveys to identify barriers to health care delivery, and make home visits for patient education or with a health professions student for patient follow-up. In addition, *promotoras* help families talk to their health care providers.

By 1998, at least 30 *promotora* projects operated in the Texas Border region. The level of training received by *promotoras* varied based on each program and the responsibilities of the individual involved. In a project funded by the Kellogg Foundation, for instance, El Paso *promotoras* received 60 hours of training in the agencies they served. A cadre of volunteers, known as Volunteer Community Health Advocates, receives 55 hours of training through El Paso Community College.

Texas has no uniform training curriculum or certification program for *promotoras*. Anyone can call themselves a *promotora* without training. Furthermore, *promotoras* may receive different degrees of training, ranging from lay workers who provide basic health education materials to community health workers who provide clinical services such as blood pressure monitoring. Having a uniform training and certification program would enable clinics, hospitals, and patients to know exactly what type of training *promotoras* have received.

Experts agree that a key element to the success of any *promotora* project is the close ties *promotoras* have to their communities. Any training or certification program should preserve this vital linkage. Furthermore, training or certification should remain an option for *promotoras*, not a requirement. Just as some *promotoras* maintain that they do not want to be paid for their work, not every *promotora* wishes to attain additional training or certification. Basic theory behind community health workers validates the need for *promotoras* representing a broad spectrum of abilities and skills.¹² Certification, however, should be available for those that want it, and for health care providers who wish to hire *promotoras* with known medical and other job skills.

A pilot project under the Health Education Training Centers Alliance of Texas (HETCAT) has been developing a uniform curriculum for training and educating *promotoras* along the Texas-Mexico border, along with a plan to establish a certification process to enable employment.

Given the shortage of health care providers, cultural considerations, and transportation issues, expanding the use of paid and volunteer *promotoras* in the Border region could be one way of maximizing resources while having the greatest impact on the community. To achieve uniformity, the state could invest in developing a training curriculum and certification program.

To date, *promotoras* have worked in public health services and community/rural clinics. If the program were to be standardized through training and certification, *promotora* services could be an integral part of public health coverage for Border residents.

For rural areas, difficult-to-reach populations, and MUAs, a delicate balance must frequently be struck between bringing services to residents and bringing residents to services. *Promotoras* seem to merit support as a popular, low-cost way of making sure residents get the health services they need. They also seem to be a model for making sure medical personnel hear precisely what patients desire.

Health Care Finance: A System Out of Balance

In general, residents of the Border region are much less likely to have health insurance than

are other Texans. In a 1994 analysis, 28 percent of residents in a sample of the Border population were uninsured, compared to 20 percent of other urban Texans. The analysis indicated that the prevalence of insurance along the border was on the decline.

The Border's high uninsured rate is due to the low incidence of private coverage. Because private coverage rates are so low, the federal, state, and local tax burdens of public programs are much higher in Border cities and counties than in other parts of Texas.

The Border's low rate of private insurance stems largely from the region's employment profile. A greater portion of Border residents work for small employers than do non-Border residents. Small employers--those with 75 employees or fewer--are less likely than larger employers to pay for employee insurance.¹³ More than 50 percent of Border workers worked in small firms in the early 1990s, compared to 43 percent of workers in other Texas cities. Border workers also are more likely to work in low-wage jobs than non-Border workers, and low-wage jobs typically do not include insurance coverage.¹⁴

The Texas Insurance Purchasing Alliance (TIPA), established by state lawmakers in 1995, has served as an avenue for small businesses to offer employees affordable health insurance. TIPA has expanded the pool of Texans with private, employer-sponsored insurance. More than 50 percent of the employers who joined TIPA were previously uninsured, compared to only 17 percent of all the small businesses who purchased coverage in 1997.¹⁵

Despite this success, however, TIPA has not eliminated wide variations in insurance. According to preliminary TIPA estimates, more than 200,000 Texas small businesses did not offer employee insurance as of 1998. This figure reflected more than 60 percent of all small businesses in Texas.¹⁶

To obtain employee coverage through TIPA or any other program, small employers must guarantee that 75 percent of their workers will enroll in the insurance plan they are offered, to avoid the actuarial problem of self-selection. But many small businesses cannot convince enough employees to participate--unless the employer is willing to pay for most or all of the cost of coverage.

According to TIPA staff, small business coverage has been even more uncommon in the Border region. At least part of the difficulty stems from problems insurers have had in contracting with providers to care for their enrollees because the managed care system is newer in the region.

While the Border's private insurance rate has been substantially lower than the rest of Texas, public health insurance coverage consistently reaches more residents. In 1994, more than 32 percent of sampled Border city residents were covered under Medicare, Medicaid, or CHAMPUS, the military's health program, compared to 21 percent of non-Border Texans.

Medicare and CHAMPUS are federal programs, but Medicaid is funded by a mix of state and federal dollars.

The Medicaid coverage rate in Border cities is nearly twice that of non-Border cities--11.4 percent compared to 6.3 percent. If the Border's Medicaid profile were consistent with the rest of Texas, the state's Medicaid program would cost state and federal taxpayers \$1 billion a year less. In 1996, the Border region accounted for 22 percent of Texas' population, but more than 30 percent of Texas' Medicaid clients.¹⁷

The pervasive lack of private insurance along the border results in public and non-profit funding stepping in to fill the gap. Border hospitals provided more than \$600 million in uncompensated care in 1997, amounting to about 8 percent of gross patient revenues for the providing hospitals.

Public hospitals are less common in the Border region than in the rest of Texas. The region has four county hospitals, two city-county hospitals, and 13 hospital districts. Two state-owned hospitals--South Texas Hospital in Harlingen and the Texas Center for Infectious Disease in San Antonio--are almost entirely devoted to indigent care.

Health care experts say that most Border counties make substantial efforts to fund health care, given their limited local tax bases.¹⁸ By state law, counties are responsible for funding indigent care for residents not served by a hospital district. The Texas Indigent Health Care and Treatment Act of 1989 provides state matching funds for counties that spend more than 10 percent of their gross revenue tax levies on qualified indigent care. In 1997, Border counties accounted for six of 16 counties qualifying for state matching funds. Four Border counties were among the state's five leaders in the share of gross tax levies devoted to indigent care. Border counties spent \$8.8 million of the \$14.6 million spent by the 16 qualifying counties. Hidalgo County alone spent \$6.5 million.¹⁹

Imbalance in the Border's health care finance system has kept the health care delivery system from developing the capacity to serve residents adequately. Health care experts have said that continuing gaps in the finance system could put the area's entire health care safety net in jeopardy as managed care requirements cause for-profit providers to shift more and more indigent patients to public facilities.

Even more than the traditional "fee for service" system, managed care derives its profit by assuming that most people are insured. Dr. David Smith, head of the Texas Tech University Health Science Center in Lubbock and former head of TDH, told the Comptroller's review team that insuring segments of the Border region's uninsured population would bring much relief to the region's health care delivery system.²⁰

Children's Health Insurance Program

The federal Children's Health Insurance Program (CHIP) could be an important tool for increasing the level of private insurance along the border. CHIP, created by Congress in 1997, subsidizes insurance for children with family incomes below 200 percent of the federal poverty level. Unlike many programs, CHIP is intended only to purchase insurance, as opposed to providing direct services. More flexible than traditional Medicaid, CHIP emphasizes family and employer contributions and is designed to promote shared responsibility and private contributions.

In Texas and other states, debate continues over the appropriate strategy to expand children's insurance. For example, CHIP could be used to fund additional insurance through a new, state-sponsored plan, through Medicaid, through private employer-sponsored plans, or a combination of any of the approaches. Lacking data on the success rates and costs of various options, most states have been slow to implement CHIP-funded programs.

CHIP was designed in part to encourage innovative ideas such as premium "credits," which parents could use to purchase children's insurance in the market. Federal officials stressed that states were free to test a variety of approaches with CHIP funds to see what strategies worked best for their populations.²¹ Pilot programs would help a state insure children immediately, without locking states into long-term commitments to programs that may not serve particular state needs.

Mexican Health Care: A Constitutional Right

The Mexican Constitution deems health care a fundamental right.²² The federal government owns and operates most of the country's health care infrastructure, including hospitals and primary care facilities.

Mexico's health care system can be described as "quasi-socialized," since it is funded with employer-paid premiums as well as taxes. Mexican employers are required to cover their employees under the *Instituto Mexicano del Seguro Social*, which covers private-sector employees, retirees, and their families. Federal employees are covered under the *Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado*, and state and local governments operate their own employee insurance systems.

All of Mexico's compulsory insurance programs cover care through the government's network of providers and facilities. Employers may also purchase private insurance, covering care by private providers, but this is in addition to the compulsory government program.

The Mexican government also operates the health care system for the uninsured, called the "open population." The open system includes both primary care and hospitals, including Mexico's major health institutions.²³

Approximately 30 percent of Mexicans, generally middle- and upper-class individuals, opt for private health care, often in addition to their guaranteed public benefits. Some 70 percent of private providers offer basic care only--most of Mexico's advanced medical facilities are government-owned.²⁴

Private health insurance is a new but growing industry in Mexico. The industry more than doubled the number of policies sold between 1987 and 1989, from 242,000 to 533,000.²⁵ As the number of policyholders grows, the market should become more sophisticated, profitable, and desirable to foreign investors.

Binational Cooperation

Joint public health efforts teaming Texas experts with their Mexican counterparts can make a lasting difference, saving dollars, time, and lives. Unfortunately, most "technical assistance" of this sort relies on shoestring budgets, surplus equipment, and, all too often, the generosity of staff to provide lodging and meals to foreign visitors.

All the same, U.S. personnel gain a greater understanding of cooperative mechanisms for disease surveillance and treatment by experiencing first-hand the Mexican health care system and its strategies of health care delivery. Mexican personnel receive laboratory and computer training as well as exposure to U.S.-style managed care.

As Mexico boosts its ability to diagnose and treat diseases, the U.S. health care system could see fewer patients with intractable health problems, especially in the Border region. Furthermore, improvements in detection and disease surveillance in Mexico help U.S. health officials by yielding early warnings of disease outbreaks.

For more than four decades, Mexican and U.S. health officials have collaborated to various degrees. In 1942, the U.S. government asked the Pan American Health Organization (PAHO) to help coordinate venereal disease controls on the U.S.-Mexico border. This effort started the PAHO field office in El Paso, serving the 10 U.S. and Mexican border states by conducting workshops, seminars, and an ongoing epidemiological surveillance program along the border. Another group, the U.S.-Mexico Border Health Association, created in 1943 as an arm of PAHO, encourages communication among border health care providers, in part through an annual international meeting.

Another collaborative effort, the Border XXI program, is a "binational interagency program aimed at protecting the environment and environmental health while fostering sustainable development in the U.S.-Mexico border area."²⁶ Objectives include decentralization of

border decision-making, public involvement, and increased U.S.-Mexico cooperation. In 1992, environmental officials for both countries released the Integrated Environmental Plan for the Mexican-U.S. Border Area. In 1996, the second stage of the plan, Border XXI, included environmental health and natural resource issues.

The U.S.-Mexico Binational Commission (BNC), a forum established by the two countries in 1977, allows for regular exchanges between cabinet-level officials and their staffs on a range of issues critical to U.S.-Mexico relations. The health secretaries of both countries participated in the BNC for the first time in 1996. Begun by U.S. President Jimmy Carter and Mexican President Jose Lopez Portillo, it was formalized by Presidents Ronald Reagan and Lopez Portillo in 1981. Its original focus was on trade and international relations, but it has since expanded to include 14 working groups such as environmental cooperation, agriculture, business development, fisheries and tourism, health, labor, and trade and investment. The health working group has four subgroups: smoking cessation, women's health, migrant health, and HIV/AIDS.

Sometimes, an emergency underscores the importance of smoothly teaming U.S. and Mexican resources. In fall 1996, the Texas coast fell victim to a "red tide," a large bloom of the *Gymnodinium breve*, which gets its name from the red tinge it casts on water.²⁷ This naturally occurring algae can kill fish, poison shellfish, and cause respiratory, eye, nose, and throat irritation for humans. Human consumption of shellfish contaminated by red tide can lead to neurotoxic shellfish poisoning. Although infected waters can be visible, layers of clear water can cover the red tide. The Texas seafood and oyster industries suffer substantial losses when waters are closed due to red tide contamination.

When Texas health officials contacted their counterparts in the Mexican Gulf Coast state of Tamaulipas to warn them about the red tide, Mexican officials said that they could not confirm its presence because they lacked equipment to perform the diagnostic tests. TDH staff needed to know the extent of the bloom to gauge how long it might last, so they headed to Mexico the next day. They worked alongside local and state health professionals from Tamaulipas and showed them how to administer the test. When they departed, the Texas staff left behind extra test kits so that their Tamaulipas colleagues could conduct the test when needed, improving the ability to monitor red tide along the Gulf Coast.

In 1996, the Migrant Health Subgroup formed a Binational Health Professional Exchange between U.S. and Mexican health care professionals.²⁸ Participants hope to extend funding past 1999 and increase the number of sites participating in the exchange. In fall 1997, six Mexican delegates, three from Jalisco and three from Coahuila, joined staff at migrant health clinics in Colorado and Washington State for a two-week exchange. The U.S. delegation went to work with health care providers in Jalisco, Puebla, Michoacan, Guanajuato, and Coahuila. Members of the U.S. delegation said they gained a greater understanding of the health care that Mexican migrant farm workers receive at home, and a better understanding of the cultures from which they come. They were also impressed by the efficiency of the Mexican public health system, especially by how much it does with little money. From a clinical perspective, learning first-hand the types of medicines used to treat various diseases in Mexico allowed the U.S. providers to enhance the continuity of care for farm workers returning to the U.S.

Since 1995, TDH has led a successful binational attempt to control TB in the Border region and to create new mechanisms for binational disease control and prevention called Ten Against TB (TATB), a partnership of state and federal government as well as private-sector participants. Some Border counties' rates are more than four times as high as the 1997 statewide TB case rate of 10.3 per 100,000 residents.²⁹ Central to the success of the initiative is the creation of lasting relationships among the states to foster the trust necessary to share information and to learn from differing treatment regimens and programs.

This must come from a true desire among public health professionals, policy-makers, and

the private sector to address a problem of common concern and to attain real solutions. As part of its initiatives to unify surveillance and diagnostic capabilities in both countries, one of TATB's priorities is to lend computer and laboratory equipment to local and state health departments in Mexican border cities and states to increase their ability to diagnose, treat, and record TB cases.

A 1997 TATB survey found that many Mexican local health departments lacked such basic equipment as computers, microscopes, and safety hoods.³⁰

TATB's related attempts to provide surplus U.S. equipment to Mexican health departments were slowed by side issues such as determining maintenance responsibility and insuring equipment, as well as questions on how to transport items across the border safely. In addition, the stewardship of state and federal funds for the equipment came into play.

Due to a general lack of equipment, Mexico has historically relied upon a "smear test" to diagnose TB. This test, while diagnosing the presence of TB, does not diagnose any strains that are resistant to antibiotics. Each diagnosed Mexican patient, in turn, receives a protocol of four antibiotics, an approach that can be more harmful than no treatment at all because strains of TB can develop antibiotic resistance merely from exposure to the drug.

The cluster of infants born with brain defects in Cameron County in the early 1990s spawned a number of surveillance and monitoring activities. The projects, housed within TDH's Texas Birth Defects Research Division, include cooperative endeavors with Mexican sister cities to collect and share data and information. The key to this process is to ensure that data collection and surveillance systems in both countries are compatible in how they record information.

Some policy-makers contend that state and federal funds used in Mexico can have a greater impact on health in the U.S. than certain funds spent domestically. Others disagree, saying that U.S. funding should be spent solely on U.S. soil.

While the basic premise of spending state funds in Texas is sound, reaching the root of many public health problems requires the direct involvement of Mexico. Furthermore, in some cases, allocating certain funds to help Mexico address the root causes could be more cost-effective than using the funds to treat the symptoms of the problem as they are manifested in Texas. For a mosquito-borne disease such as dengue fever, spending funds to eliminate the source of mosquito breeding grounds in Mexican states could keep the disease from spreading north.

Exchanges benefit health outcomes in both countries. Increased efforts to remove barriers and to expand and institutionalize programs contribute greatly toward improved health in the Border region.

Trends in Binational Health Care

Some U.S. companies along the U.S.-Mexico border have begun to cover health care services received in Mexico. While looking for lower cost health care, the companies also want to control costs and ensure quality care.

For nearly two decades, the Western Growers Association, an agricultural trade group, has provided benefits in Mexico and even operated its own managed care network in Mexico. More than 14 percent of the 70,000 people covered by the association seek care in Mexico. Of those, 80 percent are U.S. residents, and the rest are dependents residing in Mexico. The plan offers a financial incentive for members to receive care in Mexico: patients must pay 20 percent of their cost of care for services provided in the U.S., while care provided in Mexico requires a \$2.50 copay per visit.

Individual companies also provide health coverage. In one survey, some 30 of 39 companies in Brownsville, El Paso, McAllen, and San Diego, Calif., reported covering employee health care services received in Mexico. Three plans allowed only for emergency care, and others had restrictions on the type of care received or the facility used.³¹

A survey of medical care providers in 16 Texas counties on the Mexico border looked into the use of U.S. primary care physicians, specialists, and dentists by Mexican nationals residing in the Texas Border region.³² Of the providers responding, 85 percent reported seeing Mexican nationals as patients. Of those who did not see Mexican patients, most were public providers who were prohibited from using state or federal funds to treat Mexican nationals. Among physicians who treated Mexican nationals, 72 percent said they were fully or partly paid in cash. Of Mexican nationals seeking health care in the 16-county region, more than 78 percent lived in cities on the Mexican side of the border.

Mexican residents who purchase private insurance can obtain benefit packages that cover services provided in the U.S. In some cases, the package may cover care only at specific U.S. facilities.³³

In 1997, the Mexican government began offering Mexican nationals and those of Mexican descent residing in the U.S. the opportunity to buy health insurance through the Mexican social security system.³⁴ A family qualifies for hospital and maternity care, doctor visits, lab work, and medicines for \$300 a year. But services must be delivered in Mexico. U.S. workers with uninsured family members in Mexico benefit most, but others targeted by the effort include legal Mexican immigrants in the U.S. who find it difficult to obtain health coverage. The program also has been opened to people of Mexican origin who are not Mexican nationals.

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Tuberculosis Cases and Case Rates per 100,000 Population: States, 1999 and 1998

State	Cases		Case Rates		Rank According to Rate		Population Estimates July 1, 1999
	1999	1998	1999	1998	1999	1998	
United States	17,528	18,361	6.4	6.8	--	--	272,690,000
Alabama	314	381	7.2	8.8	11	6	4,369,000
Alaska	61	55	9.9	9.0	4	5	619,000
Arizona	262	254	5.5	5.4	19	21	4,778,000
Arkansas	181	171	7.1	6.7	12	16	2,551,000
California	3,599	3,852	10.9	11.8	2	2	33,145,000
Colorado	88	79	2.2	2.0	39	42	4,056,000
Connecticut	121	128	3.7	3.9	31	30	3,282,000
Delaware	34	36	4.5	4.8	24	23	754,000
District of Columbia(a)	70	107	13.5	20.5	--	--	519,000
Florida	1,281	1,302	8.5	8.7	6	7	15,111,000
Georgia	665	631	8.5	8.3	5	9	7,788,000
Hawaii	184	181	15.5	15.2	1	1	1,185,000
Idaho	16	14	1.3	1.1	46	47	1,252,000
Illinois	825	850	6.8	7.1	15	15	12,128,000
Indiana	150	188	2.5	3.2	37	34	5,943,000
Iowa	58	55	2.0	1.9	41	43	2,869,000
Kansas	69	56	2.6	2.1	36	39	2,654,000
Kentucky	209	179	5.3	4.5	21	27	3,961,000
Louisiana	357	380	8.2	8.7	8	8	4,372,000
Maine	23	13	1.8	1.0	43	48	1,253,000
Maryland	294	324	5.7	6.3	18	19	5,172,000
Massachusetts	270	282	4.4	4.6	26	26	6,175,000
Michigan	351	385	3.6	3.9	33	28	9,864,000
Minnesota	201	161	4.2	3.4	27	32	4,776,000
Mississippi	215	225	7.8	8.2	10	10	2,769,000
Missouri	208	184	3.8	3.4	28	33	5,468,000
Montana	14	20	1.6	2.3	44	38	883,000
Nebraska	18	31	1.1	1.9	48	44	1,666,000
Nevada	93	128	5.1	7.3	22	14	1,809,000
New Hampshire	19	14	1.6	1.2	45	46	1,201,000
New Jersey	571	640	7.0	7.9	13	12	8,143,000
New Mexico	64	68	3.7	3.9	32	29	1,740,000
New York	1,837	2,000	10.1	11.0	3	3	18,197,000
North Carolina	488	498	6.4	6.6	16	17	7,651,000
North Dakota	7	10	1.1	1.6	47	45	634,000
Ohio	317	230	2.8	2.1	35	41	11,257,000
Oklahoma	208	198	6.2	5.9	17	20	3,358,000
Oregon	123	156	3.7	4.8	30	24	3,316,000
Pennsylvania	454	448	3.8	3.7	29	31	11,994,000
Rhode Island	53	63	5.3	6.4	20	18	991,000
South Carolina	315	286	8.1	7.5	9	13	3,886,000
South Dakota	21	23	2.9	3.1	34	35	733,000
Tennessee	382	439	7.0	8.1	14	11	5,484,000
Texas	1,649	1,820	8.2	9.2	7	4	20,044,000
Utah	40	52	1.9	2.5	42	36	2,130,000
Vermont	3	5	0.5	0.8	50	49	594,000
Virginia	334	339	4.9	5.0	23	22	6,873,000
Washington	258	265	4.5	4.7	25	25	5,756,000
West Virginia	41	42	2.3	2.3	38	37	1,807,000
Wisconsin	110	109	2.1	2.1	40	40	5,250,000
Wyoming	3	4	0.6	0.8	49	50	480,000
Puerto Rico(a,b)	200	201	5.1	5.2	--	--	3,889,507

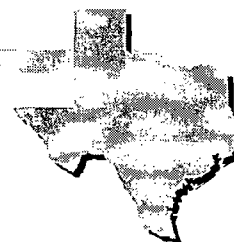
(a)Not ranked with states.

(b)Not included in U.S. totals.

Source: Division of Tuberculosis Elimination, Centers for Disease Control and Prevention. Provisional data for 1999. Final data for 1998.

Population Estimates: U.S. Census Bureau. ST-99-3 State Population Estimates: Annual Time Series, July 1, 1990 to July 1, 1999. Available from <http://www.census.gov/population/estimates/state/st-99-3.txt>. Internet release date: December 29, 1999.

Date: 3/27/00.



CANCER BURDEN

In 2000, the American Cancer Society estimates¹

- 1,220,100 new cancer cases will be diagnosed in the United States, including 76,100 in Texas.
- 552,200 cancer deaths will occur in the United States, including 34,400 in Texas.

The average annual age-adjusted mortality rate for cancer deaths² per 100,000 persons

Texas: 168.1 **National:** 170.1

Texas ranks 30th highest overall in cancer mortality rates among the 50 states and Washington, D.C.

LUNG CANCER

In 2000, the American Cancer Society estimates¹

- 10,700 new cases of lung cancer will be diagnosed among men and women in Texas.
- 10,300 men and women will die of lung cancer in Texas.

The average annual age-adjusted mortality rates for lung cancer deaths^{2,3} per 100,000 persons, by race, 1992–1996

	Texas	National
Overall	50.7	49.5
White	49.7	49.2
Black	65.8	60.0
Hispanic	22.5	19.5
Asian/Pacific Islander	17.2	23.9
American Indian/Alaska Native	9.0	29.5

BREAST CANCER

In 2000, the American Cancer Society estimates¹

- 11,500 new cases of breast cancer will be diagnosed among women in Texas.
- 2,600 women will die of breast cancer in Texas.

The average annual age-adjusted mortality rates for breast cancer deaths^{2,3} per 100,000 persons, by race, 1992–1996

	Texas	National
Overall	23.4	25.4
White	22.8	25.1
Black	31.6	31.3
Hispanic	17.0	14.9
Asian/Pacific Islander	6.8	11.3
American Indian/Alaska Native	-	12.8

COLORECTAL CANCER

In 2000, the American Cancer Society estimates¹

- 8,300 new cases of colorectal cancer will be diagnosed among men and women in Texas.
- 3,600 men and women will die of colorectal cancer in Texas.

The average annual age-adjusted mortality rates for colorectal cancer deaths^{2,3} per 100,000 persons, by race, 1992–1996

	Texas	National
Overall	16.2	17.5
White	15.5	17.1
Black	25.3	22.9
Hispanic	10.5	10.8
Asian/Pacific Islander	6.3	11.1
American Indian/Alaska Native	-	9.9

PROSTATE CANCER

In 2000, the American Cancer Society estimates¹

- 11,300 new cases of prostate cancer will be diagnosed among men in Texas.
- 2,000 men will die of prostate cancer in Texas.

The average annual age-adjusted mortality rates for prostate cancer deaths^{2,3} per 100,000 men, by race, 1992–1996

	Texas	National
Overall	25.7	25.6
White	23.3	23.4
Black	53.1	54.8
Hispanic	16.7	16.6
Asian/Pacific Islander	5.7	10.8
American Indian/Alaska Native	-	14.7

¹ Source: American Cancer Society Facts and Figures, 2000. Estimates exclude about 1.3 million cases of basal and squamous cell skin cancers and in situ cancers, except urinary bladder, that will be diagnosed in 2000. Lung cancer rates include bronchus cancer. State death totals between 51-99 were rounded to 100.

² Source: CDC National Center for Health Statistics, vital statistics data, underlying cause of death, 1992–1996.

³ Some data were excluded because there were 75,000 or fewer persons in the denominator or 20 or fewer deaths in the numerator.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES • Public Health Service

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July 7, 2000 / Vol. 49 / No. 26

MMWRTM

MORBIDITY AND MORTALITY WEEKLY REPORT

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National, State, and Urban Area Vaccination Coverage Levels Among Children Aged 19-35 Months — United States, 1999

Childhood vaccinations have a major impact on the reduction and elimination of many causes of morbidity and mortality among children (1). Monitoring vaccination coverage levels is necessary to characterize undervaccinated populations and to evaluate the effectiveness of efforts to increase coverage. The National Immunization Survey (NIS) provides ongoing national estimates of vaccination coverage among children aged 19-35 months based on data for the most recent 12 months for each of the 50 states and 28 geographic areas (2). This report presents the findings of the 1999 NIS*, which indicate that vaccination coverage among U.S. children aged 19-35 months were at or near record high levels.

To collect vaccination information for all age-eligible children, NIS uses a quarterly random-digit-dialing sample of telephone numbers for each survey area. During 1999, 33,548 household interviews were completed, representing 34,442 children. The response rate for eligible households for the 78 survey areas was 66.3%. Following the interviews and with parental/guardian consent, data accuracy was verified from vaccination providers. Children with provider data were weighted to represent all children surveyed and to account for nonresponding households, changes in natality patterns, and lower vaccination coverage among children in households without telephones (2).

In 1999, national vaccination coverage for three doses of any diphtheria and tetanus toxoids and pertussis vaccine (DTP) was 95.9%; for three doses of poliovirus vaccine, 89.6%; for three doses of *Haemophilus influenzae* type b vaccine (Hib), 93.5%; for one dose of measles-mumps-rubella vaccine (MMR), 91.5%; for three doses of hepatitis B vaccine (HepB), 88.1%; and for one dose of varicella vaccine (VAR), 59.4%.

From 1998 to 1999, national coverage with the combined vaccination series 4:3:1 (four doses of DTP, three doses of poliovirus vaccine, and one dose of measles-containing vaccine) and with 4:3:1:3 (4:3:1 series and three doses of Hib) did not change significantly (Table 1). Coverage with VAR increased from 43% in 1998 to 59% in 1999 (Table 1).

In 1999, state-specific coverage for the 4:3:1 series ranged from 70% to 91%, and the 4:3:1:3 series ranged from 69% to 91% (Table 2). For selected urban areas, coverage ranged from 67% to 87% for the 4:3:1 series and from 63% to 87% for the 4:3:1:3 series (Table 2).

*For this reporting period (January-December 1999), NIS included children born during February 1996-May 1998.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

*Vaccination Coverage Levels — Continued***TABLE 1. Vaccination coverage levels among children aged 19–35 months, by selected vaccines — National Immunization Survey, United States, 1995–1999**

Vaccine/Dose	1995*	1996†	1997‡	1998§	1999**
	% (95% CI) ^{¶¶}	% (95% CI)	% (95% CI)	% (95% CI)	% (95% CI)
DTP^{¶¶}					
3 Doses	94.7 (±0.6)	95.0 (±0.4)	95.5 (±0.4)	95.6 (±0.5)	95.9 (±0.4)
4 Doses	78.5 (±1.0)	81.1 (±0.7)	81.5 (±0.7)	83.9 (±0.8)	83.3 (±0.8)
Poliovirus					
3 Doses	87.9 (±0.8)	91.1 (±0.5)	90.8 (±0.5)	90.8 (±0.7)	89.6 (±0.8)
Hib^{¶¶}					
3 Doses	91.7 (±0.6)	91.7 (±0.6)	92.7 (±0.5)	93.4 (±0.6)	93.5 (±0.5)
MMR^{***}					
1 Dose	87.8 (±0.7)	90.7 (±0.5)	90.5 (±0.7)	92.0 (±0.6)	91.5 (±0.6)
Hepatitis B					
3 Doses	68.0 (±1.0)	81.8 (±0.7)	83.7 (±0.6)	87.0 (±0.7)	88.1 (±0.7)
Varicella					
1 Dose	NA ^{¶¶¶}	NA	25.9 (±0.7)	43.2 (±1.0)	59.4 (±1.0)
Combined series					
4 DTP/3 Polio/1 MCV ^{¶¶¶}	76.2 (±1.0)	78.4 (±0.8)	77.9 (±0.7)	80.6 (±0.9)	79.9 (±0.8)
4 DTP/3 Polio/1 MCV/3 Hib ^{¶¶¶}	74.2 (±1.0)	76.5 (±0.8)	76.2 (±0.8)	79.2 (±0.9)	78.4 (±0.9)

* Children in this survey period were born during February 1992–May 1994.

† Children in this survey period were born during February 1993–May 1995.

‡ Children in this survey period were born during February 1994–May 1996.

§ Children in this survey period were born during February 1995–May 1997.

** Children in this survey period were born during February 1996–May 1998.

¶ Confidence interval.

¶¶ Includes diphtheria and tetanus toxoids and pertussis vaccine (DTP), diphtheria and tetanus toxoids (DT), and diphtheria and tetanus toxoids and acellular pertussis vaccine.

¶¶ *Haemophilus influenzae* type b vaccine (Hib).

*** Previous reports of vaccination coverage were for measles-containing vaccine (MCV); the above reflects coverage with measles-mumps-rubella vaccine (MMR).

¶¶ Data not available in this reporting period. Data collection for varicella vaccine began July 1996.

¶¶ Four doses of DTP/DT, three doses of poliovirus vaccine, and one dose of MCV.

¶¶ Four doses of DTP/DT, three doses of poliovirus vaccine, one dose of MCV, and three doses of Hib.

Reported by: National Center for Health Statistics; Assessment Br, Data Management Div, National Immunization Program, CDC.

Editorial Note: National coverage for routinely recommended childhood vaccines has increased substantially since 1993, when the Childhood Immunization Initiative (CII) was implemented by the federal government (3). The findings in this report indicate that national coverage for the recommended vaccines remain at or near record high levels. However, this coverage level cannot ensure protection for children born during or after 1999 even though levels observed in 1999 demonstrate the feasibility of attaining high coverage. Achieving and sustaining the national health objectives for 2010 vaccination coverage and disease-elimination (4) will require developing a functional vaccine-delivery system. This effort will require collaboration between national, state, local, private, and public partners.

A comprehensive vaccine-delivery system that would achieve and maintain high vaccination coverage levels (5) and low morbidity in children born during or after 1999 should consist of three components. These components are 1) state- and community-based computerized vaccination registries that include all children from birth, that can identify children needing vaccination, and can recall them for missed vaccinations (6); 2) ongoing quality-assurance and information-feedback activities (7); and 3) education programs for parents and health-care providers.

Vaccination Coverage Levels — Continued

TABLE 2. Estimated vaccination coverage with the 4:3:1* and 4:3:1:3† series among children aged 19–35 months, by state and selected urban areas — National Immunization Survey, United States, 1999‡

State/Urban area	4:3:1		4:3:1:3	
	%	(95% CI) [§]	%	(95% CI)
Alabama	79.7	(±4.5)	78.4	(±4.6)
Jefferson Co.	86.6	(±4.4)	85.2	(±4.6)
Rest of state	78.5	(±5.2)	77.2	(±5.3)
Alaska	82.2	(±4.7)	80.1	(±4.8)
Arizona	73.9	(±4.5)	72.4	(±4.6)
Maricopa Co.	71.7	(±6.4)	71.0	(±6.4)
Rest of state	77.5	(±5.7)	74.8	(±5.9)
Arkansas	78.5	(±5.8)	77.1	(±5.8)
California	78.3	(±3.5)	75.3	(±3.6)
Los Angeles Co.	78.1	(±5.6)	76.0	(±5.7)
San Diego Co.	78.6	(±5.4)	74.5	(±5.6)
Santa Clara Co.	84.3	(±4.3)	81.8	(±4.6)
Rest of state	78.1	(±5.4)	74.4	(±5.6)
Colorado	77.2	(±5.2)	75.8	(±5.3)
Connecticut	87.1	(±4.4)	85.9	(±4.6)
Delaware	80.0	(±5.0)	78.2	(±5.1)
District of Columbia	78.5	(±5.4)	77.5	(±5.4)
Florida	82.0	(±4.1)	80.3	(±4.2)
Dade Co.	86.7	(±4.5)	84.0	(±5.0)
Duval Co.	79.1	(±4.9)	77.7	(±5.1)
Rest of state	81.3	(±5.2)	79.8	(±5.3)
Georgia	83.1	(±4.3)	81.9	(±4.4)
Fulton/DeKalb cos.	86.4	(±4.5)	83.4	(±4.8)
Rest of state	82.3	(±5.2)	81.5	(±5.3)
Hawaii	82.8	(±4.7)	81.6	(±4.8)
Idaho	70.0	(±5.5)	69.4	(±5.5)
Illinois	78.8	(±4.1)	77.4	(±4.2)
Chicago	73.2	(±6.1)	71.4	(±6.2)
Rest of state	81.0	(±5.3)	79.8	(±5.4)
Indiana	75.4	(±5.0)	74.3	(±5.0)
Marion Co.	79.7	(±5.8)	79.1	(±5.8)
Rest of state	74.5	(±5.8)	73.3	(±5.9)
Iowa	84.5	(±4.4)	83.4	(±4.5)
Kansas	79.7	(±4.9)	78.9	(±4.9)
Kentucky	88.6	(±4.4)	87.6	(±4.5)
Louisiana	76.9	(±4.7)	76.8	(±4.7)
Orleans Parish	72.6	(±5.8)	71.5	(±5.9)
Rest of state	77.5	(±5.3)	77.5	(±5.3)
Maine	84.1	(±4.8)	82.9	(±5.0)
Maryland	80.6	(±4.2)	79.4	(±4.3)
Baltimore	73.2	(±6.6)	71.9	(±6.8)
Rest of state	81.8	(±4.8)	80.7	(±4.9)
Massachusetts	87.3	(±3.9)	85.2	(±4.4)
Boston	86.1	(±5.1)	83.6	(±5.8)
Rest of state	87.4	(±4.3)	85.3	(±4.8)
Michigan	75.9	(±4.8)	74.4	(±4.9)
Detroit	66.9	(±6.5)	66.4	(±6.5)
Rest of state	77.2	(±5.4)	75.6	(±5.5)

* Four doses of any diphtheria and tetanus toxoids and pertussis vaccine, three doses of poliovirus vaccine, and one dose of measles-containing vaccine (MCV).

† Four doses of any diphtheria and tetanus toxoids and pertussis vaccine, three doses of poliovirus vaccine, one dose of MCV, and three doses of *Haemophilus influenzae* type b vaccine.

‡ Children in this survey period were born during February 1996–May 1998.

§ Confidence interval.

*Vaccination Coverage Levels — Continued***TABLE 2. Estimated vaccination coverage with the 4:3:1* and 4:3:1:3† series among children aged 19–35 months, by state and selected urban areas — National Immunization Survey, United States, 1999† — Continued**

State/Urban area	4:3:1		4:3:1:3	
	%	(95% CI) [‡]	%	(95% CI)
Minnesota	87.0	(±4.8)	85.2	(±5.1)
Mississippi	81.7	(±5.4)	81.7	(±5.4)
Missouri	75.5	(±5.2)	76.0	(±5.2)
Montana	84.8	(±4.4)	82.5	(±4.6)
Nebraska	83.7	(±4.5)	81.8	(±4.8)
Nevada	② 73.4	(±5.3)	73.1	(±5.4)
New Hampshire	84.5	(±4.7)	84.5	(±4.7)
New Jersey	80.9	(±5.0)	80.8	(±5.0)
Newark	68.7	(±8.0)	66.5	(±8.0)
Rest of state	81.5	(±5.3)	81.5	(±5.3)
New Mexico	75.6	(±5.9)	73.0	(±6.1)
New York	83.4	(±3.3)	81.0	(±3.5)
New York City	81.5	(±5.1)	78.3	(±5.3)
Rest of state	85.0	(±4.2)	83.3	(±4.5)
North Carolina	81.8	(±5.0)	81.8	(±5.0)
North Dakota	83.0	(±4.5)	80.4	(±4.8)
Ohio	79.1	(±4.0)	78.1	(±4.0)
Cuyahoga Co.	74.6	(±5.6)	73.5	(±5.7)
Franklin Co.	79.1	(±5.1)	77.9	(±5.1)
Rest of state	79.9	(±5.0)	78.9	(±5.1)
Oklahoma	④ 74.0	(±5.7)	72.9	(±5.7)
Oregon	73.2	(±5.9)	② 72.3	(±6.0)
Pennsylvania	86.6	(±3.7)	86.0	(±3.7)
Philadelphia	82.7	(±4.7)	81.3	(±4.9)
Rest of state	87.3	(±4.2)	86.8	(±4.3)
Rhode Island	90.4	(±3.9)	87.4	(±4.6)
South Carolina	81.1	(±4.7)	80.6	(±4.8)
South Dakota	83.4	(±4.5)	81.7	(±4.7)
Tennessee	79.5	(±3.8)	77.7	(±3.9)
Davidson Co.	75.4	(±5.5)	73.3	(±5.6)
Shelby Co.	76.5	(±5.5)	75.0	(±5.6)
Rest of state	81.0	(±5.3)	79.2	(±5.4)
Texas	④ 74.7	(±3.6)	④ 72.4	(±3.7)
Bexar Co.	70.2	(±6.2)	69.9	(±6.2)
Houston	66.5	(±6.8)	63.3	(±7.0)
Dallas Co.	78.0	(±6.5)	71.6	(±6.9)
El Paso Co.	75.0	(±5.2)	72.7	(±5.5)
Rest of state	76.5	(±5.3)	74.5	(±5.4)
Utah	81.7	(±5.1)	80.2	(±5.3)
Vermont	90.7	(±3.5)	90.5	(±3.5)
Virginia	81.6	(±5.2)	80.3	(±5.3)
Washington	78.5	(±3.9)	74.9	(±4.0)
King Co.	78.5	(±5.3)	77.4	(±5.4)
Rest of state	75.8	(±5.0)	74.0	(±5.2)
West Virginia	82.1	(±4.7)	81.0	(±4.8)
Wisconsin	85.4	(±3.3)	84.5	(±3.4)
Milwaukee Co.	75.3	(±6.2)	74.1	(±6.3)
Rest of state	88.2	(±3.8)	87.6	(±3.9)
Wyoming	83.5	(±4.9)	82.8	(±4.8)
Overall	79.9	(±0.8)	78.4	(±0.9)

* Four doses of any diphtheria and tetanus toxoids and pertussis vaccine, three doses of poliovirus vaccine, and one dose of measles-containing vaccine (MCV).

† Four doses of any diphtheria and tetanus toxoids and pertussis vaccine, three doses of poliovirus vaccine, one dose of MCV, and three doses of *Haemophilus influenzae* type b vaccine.

‡ Children in this survey period were born during February 1996–May 1998.

§ Confidence interval.

Vaccination Coverage Levels — Continued

High coverage levels are necessary to maintain and reduce illness, disability, and death associated with vaccine-preventable diseases. Assessment of vaccination coverage levels is an important component of the U.S. immunization program. To maintain the integrity and reliability of the national immunization system, a core surveillance effort that includes immunization coverage levels is essential (8). NIS is the primary source of vaccination coverage data among U.S. preschool-aged children (5). NIS should continue to characterize at-risk children and evaluate the effectiveness of programs designed to increase coverage.

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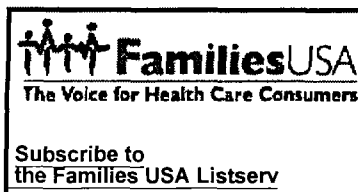
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Prevalence of Intimate Partner Violence and Injuries — Washington, 1998

Approximately 20% of emergency department visits for trauma and 25% of homicides of women involve intimate partner violence (IPV) (1,2). To assess IPV prevalence in Washington, the Washington State Department of Health added questions from the Conflict Tactics Scale (3) and the Revised Conflict Tactics Scale (4) to its 1998 Behavioral Risk Factor Surveillance System (BRFSS) survey. This report describes an analysis of responses to the questions, which indicated that women were more likely than men to experience IPV in their lifetime, and more than three times more likely than men to experience injuries from IPV.

BRFSS is an ongoing, state-based, random-digit-dialed telephone survey of the U.S. civilian, noninstitutionalized population aged ≥18 years that collects information about modifiable risk factors for chronic diseases and leading causes of death. In 1998, 3604 persons responded to the Washington BRFSS. Because the questions were considered sensitive, permission was asked before beginning the IPV section, and 3381 (93.5%) gave permission. Only English-speaking persons were respondents. The survey response rate was 61.4%.

Respondents were asked whether they had experienced IPV during their lifetime (i.e., kicked, bit, or hit with fist; hit or tried to hit with something; beat up; threatened with gun or knife; or used gun or knife) and whether they had sustained physical injury (sprain, bruise, or small cut; physical pain the next day; passed out from being hit on head; went



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Deep in the Heart of Texas: Uninsured Children in the Lone Star



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INTRODUCTION

Congress passed the State Children's Health Insurance Program (CHIP) in 1997 order to reduce the number of children without health insurance. Nationally, there 11 million children uninsured throughout 1997, and over ten percent of those children lived in Texas. Texas is one of the last states—and by far the largest state—yet to decide whether it will take full advantage of CHIP to expand opportunities for health insurance coverage in 1999.

Doing without insurance coverage is not a problem limited to children in low-income families or families headed by people who do not work. Nine out of ten uninsured children in Texas live in working families. More than half of all uninsured children in Texas are from families with moderate incomes. Most uninsured Texas children live in two-parent families in which the family head has a high school education or more and works full-time throughout the year.

This report provides a statistical portrait of the families of children without health insurance in Texas based on the most recent available data from the Census Bureau's Current Population Survey. It also tells the story of three Texas families—why their children lack coverage and what it has meant to the children's health and well-being and their parents' peace of mind.

The numbers and characteristics of uninsured children matter. National research, summarized in this report, shows beyond doubt that uninsured children do not get the health care they need. Texas has the opportunity to insure three-fourths of its uninsured children by expanding eligibility for children's health insurance to families earning less than 100 percent of the federal poverty level, about \$27,000 per year for a family of three. Figure 1

KEY FINDINGS

Data compiled by the Census Bureau based on the average of the three most recent Current Population Surveys for 1995, 1996, and 1997 show:

- Approximately 11 million children are without insurance, and 1.4 million of them live in Texas. After California (1.7 million), Texas has the largest number of uninsured children of any state in the country.

- Nationally, 15 percent of all children are uninsured. In Texas, 24 percent of all children are uninsured—the second highest rate of uninsured children in the country after Arizona (25 percent).

Data about Texas compiled by the Employee Benefit Research Institute for this report based on the average of the three most recent Current Population Surveys for 1996 and 1997, show:

- Most of the uninsured children in Texas have parents who work. Of children without insurance, almost nine out of ten (88 percent) live in a family where the head of household works during all or part of the year.

- Of Texas children who are uninsured, six out of ten (63 percent) live in a family whose head of household is employed full-time throughout the year.

- Only half (51 percent) of all Texas children are covered by employment-based insurance. A recent study by the Texas Department of Human Services found that 47 percent of families who left welfare for work were not offered health insurance by employers.¹

- A large proportion of uninsured children in Texas are from moderate-income families. Nearly two-thirds of all uninsured children in Texas (64 percent) live in families with incomes above the federal poverty level. Fifteen percent—220,000 uninsured children—have family incomes between 150 and 200 percent of poverty (\$20,475 to \$27,300 for a family of three in 1998).

- Half of Texas children without health insurance (52 percent) live in families in which the head of household graduated from high school or went on to obtain further education.

- Almost two-thirds of uninsured children in Texas live in two-parent families (64 percent). However, those children who do not live in two-parent households are more likely to be uninsured than children in two-parent households (30 percent uninsured versus 22 percent uninsured).

- Only one uninsured child in six (16 percent) lives in a family whose head of household is covered by employment-based insurance.

- Hispanic children in Texas comprise a majority (56 percent) of the children without health insurance. White non-Hispanic children make up 28 percent; black children 12 percent; and other children, less than 2 percent of the children without health insurance.

- Nine out of ten uninsured Texas children are U.S. citizens. Almost three-fourth of uninsured children living with citizen parents. However, an estimated 240,000 uninsured children live with non-citizen parents, and these children are twice as likely to be uninsured as children with citizen parents.

Estimates prepared by Texas State agencies find variation in the rate of insurance coverage among Texas counties. Hidalgo and El Paso Counties have a higher rate of uninsured children than the state average of 24 percent. Dallas and Tarrant Counties have a lower rate of uninsured children than the state average.

Research from many sources shows that uninsured children nationwide do not get the health care they need. Uninsured children have fewer physician visits per year, are less likely to receive adequate preventive services and immunizations, and are less likely to be seen by physicians when they are ill. While poverty and minority status also present significant barriers to care, the biggest barrier is the lack of insurance coverage.

BACKGROUND

Congress passed the State Children's Health Insurance Program (CHIP) in 1997 to address the alarming number of children without health insurance. CHIP gave states the opportunity to offer insurance to children whose parents could not get affordable coverage from their employers but earned too much to qualify for Medicaid coverage.

Most Americans get health insurance through their employers. However, as the health care coverage rose over the last decade, employment-based coverage fell, and the rate of decline was faster for children. In 1997, only 60 percent of children nationwide were covered by employment-based coverage—down from 67 percent in 1987.² In Texas, only 51 percent of all children were covered by employment-based health insurance in 1995-1997. (See Figure 2.)

Several factors account for the low rate of insurance coverage in Texas. National decline in employer-based coverage was greatest among moderate-income families—those earning between 100 and 200 percent of the federal poverty level.³ Low- and moderate-income workers are less able to afford premium costs, and they are less likely to be offered employment-based insurance.⁴ In 1996, only 43 percent of workers earning less than \$7 per hour were offered health insurance by their employers.⁵ In Texas, average per capita income is lower than the national average even though rates of employment in Texas are higher.⁶

Workers in manufacturing industries have much higher rates of insurance coverage than other private sector workers.⁷ Nationally, 22 percent of all workers are in the manufacturing sector.⁸ However, in Texas, manufacturing accounts for only 13 percent of employment.⁹ Firm size is another important factor affecting insurance status. Nationally, almost 48 percent of all uninsured workers are either self-employed or working in private sector firms with fewer than 25 employees.¹⁰ Workers in private sector firms with fewer than ten employees are uninsured at almost twice the rate of other workers. In Texas, 19 percent of the Texas workforce—one in five—work in firms with fewer than 20 employees.¹¹

Expanded Medicaid coverage for younger children protected some children from becoming uninsured as employment-based coverage fell. However, many children in families that earn too much to be eligible for Medicaid. Many other working families remain unaware that Medicaid coverage for children is available for families that receive cash welfare assistance.

In Texas, there were 105,000 fewer children receiving Medicaid coverage in January 1998 than in June 1997, with most of the decline occurring in families that were receiving cash welfare.¹² However, early evidence shows that most of these children were replacing Medicaid with employment-based health insurance. A recent study by the Texas Department of Human Services found that 60 percent of families leaving welfare to take a job were not offered health insurance by their employers. Almost 40 percent of families leaving welfare for any reason had unmet health care needs for themselves, their children and reported the need to obtain insurance in order to keep working a job.¹³

An increase in the number of the uninsured in Texas means an increasing burden local taxpayers who support county programs for the medically indigent. On the hand, for every dollar in Texas Medicaid costs, federal funds pay 62 cents; the state share is only 38 cents. In CHIP, the federal matching rate in Texas is even higher: 75 percent federal funding and only 26 percent state funding for every dollar spent on expanding children's health insurance.

HOW MUCH WILL IT COST NOT TO INSURE CHILDREN?

As a pediatrician at a teaching hospital in San Antonio, Dr. Cynthia Beamer knows the costs of not insuring children. Families often delay medical treatment because they don't have health insurance. One of the health problems carrying a high price for delay is appendicitis. The University Health System where Dr. Beamer sees patients, had nine admissions with a diagnosis of perforated appendix in the space of a week in November 1998. Most of them were teenagers without insurance coverage.

Treated early, a child needing an appendectomy will generally be home from the hospital within 48 hours. After the appendix has ruptured, the child can expect a 7-10 day minimum hospital stay; if complications develop, the stay may be as long as a month. Delay also exacts a heavy price on the patient among the health risks associated with a perforated appendix for girls is sterility. Dr. Beamer described one of her patients, a 15-year-old boy, who had been treating his perforated appendix at home with Pepto Bismol and A Seltzer for four days before seeking admission because the family had no health insurance.

Interview with Cynthia Beamer, M.D., Assistant Professor of Pediatrics, Department of Critical Care, University of Texas Health Sciences Center, San Antonio, Texas. January 1999.

The Children's Health Insurance Program

The State Children's Health Insurance Program offers states federal matching funds to expand health insurance for children in families with incomes at or under 200 percent of the federal poverty level (or higher in certain states).¹⁴ (See Table 1.) In 1999 matching rate will permit the state to receive \$2.81 in federal funds for every dollar in state spending. Over \$564 million in federal matching funds were received by Texas in federal fiscal year 1998 alone.

Prior to CHIP, the Medicaid program in every state covered (at a minimum) (1) children under age six living in families with incomes at or under 133 percent of the federal poverty level; and (2) older children born after September 30, 1983, with incomes up to 100 percent of poverty. (Federal law requires that all older children with family income at or under 100 percent of poverty would have to be covered by 2002.)

Over 40 states had already expanded children's Medicaid coverage beyond minimum levels before CHIP was enacted. Over half the states, including Texas, covered infants (and pregnant women) with family income at or under 185 percent of poverty. With the enactment of CHIP, almost every state has taken advantage of the opportunity to expand insurance coverage for children beyond prior Medicaid eligibility levels. (See Table 2.)

As of January 1999, 29 states and the District of Columbia have made a commitment to cover children up to 200 percent of the federal poverty level or higher by using Medicaid programs or expanding coverage through CHIP. Only 12 states have

expand eligibility beyond 150 percent of poverty, and all but a few of those including Texas, have indicated that further expansions are planned. Pending II CHIP expansion, Texas now ranks with North Dakota and Wyoming as the lowest threshold of coverage for children. However, for every uninsured North Dakota or Wyoming, there are over 70 uninsured children in Texas.

In its Phase I CHIP plan, Texas did expand Medicaid eligibility up to 100 percent of poverty for older adolescents effective July 1, 1998. Texas Medicaid now covers infants to 185 percent of poverty, children age 1 to 5 to 133 percent of poverty, and children age 6 to 18 to 100 percent of poverty. (See Figure 3.)

The first meeting of the Texas legislature after the enactment of CHIP was in January 1999. Senate and House interim committees of the Texas legislature met in the summer and fall in 1998 to study the problem of uninsured children. Their committees recommended that the 1999 Texas legislature raise eligibility for health insurance to 200 percent of the federal poverty level. The legislature had the opportunity to act on the committees' recommendations during the 1999 session, which began January 12, 1999.

FINDINGS: THE NUMBER OF UNINSURED CHILDREN IN TEXAS **Texas has both large numbers of children without insurance and a high proportion of children without insurance.**

- Texas averaged 1.4 million uninsured children in 1995-1997. This is the greatest number of uninsured children after California, which had 1.7 million. California alone accounts for almost 30 percent of the nation's uninsured children. States with the next largest number of uninsured children, Florida (651,000) and New York (708,000) have fewer than half the uninsured children that Texas does (See Figure 3.)

- Texas has the second highest percentage of children without insurance in the country after Arizona. Nationally, 15 percent of all children lack health insurance. In Texas, the proportion is 24 percent. Other states with high rates of uninsured children are also in the Southwest (Arizona, 25 percent; Nevada, 20 percent; New Mexico, 21 percent; Oklahoma, 20 percent) and South (Arkansas, 22 percent; Louisiana, 19 percent; Mississippi, 19 percent).

FINDINGS: THE CHARACTERISTICS OF UNINSURED CHILDREN IN TEXAS

■ Most uninsured children in Texas live in working families

The uninsured child population in Texas is comprised primarily of children whose parents work. Almost nine out of ten children (88 percent) live in households in which the family head works full- or part-time. Six out of ten children (63 percent) live in households in which the family head who works full-time for the full year. (See Figure 4.)

Among families headed by full-year, full-time workers, a majority have employment-based insurance for their children (64 percent), but 22 percent do not. There are 920,000 uninsured children in families in which the head of household is not working full-year, full-time. In families in which the head of household is not working full-year, full-time, almost a third (32 percent) of children are uninsured.

Brittany's parents can't afford private health insurance, but too much for Medicaid.

Brittany Martinez, like most seven-year-old children, is healthy but her Linda and Mike, can't stop worrying about what they would do if she needs hospital care. Brittany has no insurance coverage.

Her parents both work. Their employers offer health insurance at no cost to their employees, but charge \$250-300 per month to cover dependents. With a combined income of less than \$20,000 per year, Linda and Mike can't pay the extra costs for family coverage. Just paying for housing, food, and transportation to work, and other household expenses takes almost all of their income.

Medicaid financial eligibility requirements are too low to help Brittany. Medicaid income threshold for a seven-year-old child in a family of three is only \$13,650 per year.

Interview with Linda Martinez, San Antonio, Texas. January 12, 1999

■ **Most uninsured children's parents in Texas are also uninsured.**

Most uninsured children in Texas (81 percent) live with a family head who is uninsured. Only one uninsured child in six (16 percent) live with a family head who has employment-based insurance.

■ **A large proportion of children without health insurance in Texas are from moderate-income families.**

In Texas, nearly two-thirds of all uninsured children (64 percent) live in families with incomes above the federal poverty level. Four in ten children without health insurance (40 percent) live in families with annual incomes of 150 percent of poverty or higher (\$20,475 per year for a family of three in 1998). Fifteen percent—220,000 uninsured children—have family incomes between 150 and 200 percent of poverty (\$27,300 for a family of three in 1998). More than one-fourth (27 percent) of children without health insurance coverage live in families with annual incomes of 200 percent of poverty or higher (\$27,300 per year for a family of three in 1998) (Figure 5.)

Rates of health insurance coverage are lowest among families in Texas that earn between 100 and 175 percent of the federal poverty level. (See Figure 6.) These are the families who earn too much for Medicaid, but not enough to afford private

Medicaid no longer pays for Barry's heart medicine since he left welfare for a job that doesn't offer health benefits.

Barry Authenreith is five years old and has a heart condition called supraventricular tachycardia. He needs medication that costs about \$70 month. Barry doesn't have health insurance anymore.

After Barry's mother passed away, his father Gary worked part-time, and received cash welfare. Both he and Barry qualified for Medicaid. Gary went back to school to get a better paying job. He studied computer drafting a full-time job earning about \$1600 per month (about 175 percent of the poverty level).

With the added income, the Authenreiths lost their Medicaid benefits. (Child-only Medicaid benefits have an income cut-off of about \$1200 per month for a five-year-old child in a family of two). However, Gary's new employer doesn't offer any health insurance benefits, and with Barry's condition, the cost of an individual health insurance policy was out of the

The medication usually keeps Barry's heart rate within normal levels, but in December he had to be hospitalized. Barry's father hasn't gotten the hospital bill yet, and doesn't know where the money will come from to pay it.

Interview with Gary Authenreith, Manor, Texas. January 10, 1999.

■ The majority of Texas uninsured children live in two-parent households.

Two-thirds (64 percent) of uninsured children live in households with two parents in Texas, compared to 36 percent living in households with only one parent or no parent. However, those children not living in two-parent households are more likely to be uninsured than children in two-parent households (30 percent uninsured compared to 22 percent uninsured).

■ Many Texas children whose parents have high school degrees or higher are uninsured.

Half of Texas children without health insurance (52 percent) are in families where the head of household graduated from high school or went on to receive further education. One out of four (26 percent) uninsured children live in a family whose head of household has no high school education, and approximately one out of five lives in a family whose head of household has some high school, but did not finish high school education.

■ The majority of uninsured children in Texas are Hispanic

Hispanic children comprise 40 percent of all Texas children and make up the largest group of children without health insurance (56 percent). White non-Hispanic children constitute 44 percent of all Texas children and 28 percent of all uninsured children. Black children make up 14 percent of uninsured Texas children, and remain the smallest group, accounting for two percent of uninsured children. (See Figure 7.)

Hispanic children not only make up a significant percentage of the population of uninsured children in Texas, they are uninsured at higher rates than non-Hispanic children. One in three Hispanic children (34 percent) are uninsured compared to one in four non-Hispanic children (25 percent).

four black children (25 percent) and one in six (16 percent) white non-Hispanic children. (See Figure 8.)

■ Most uninsured children and their parents in Texas are citizens

Nine in ten uninsured Texas children (90 percent) are citizens. Almost three-quarters of uninsured children are citizens living in families in which the family head is a citizen, but 17 percent are citizens living with a family head who is not a citizen. (See Figure 9.) Citizen children living with a non-citizen family head are at greater risk of being without insurance—40 percent of such children are uninsured, compared to 20 percent of citizen children with citizen parents.

Medicaid and CHIP are available to all otherwise eligible "qualified aliens" who entered the country prior to August 22, 1996, as well as certain immigrants entering later, and all citizens. However, the complexity of the rules defining "qualified aliens" and fear and confusion about whether public benefits may have adverse consequences for non-citizen family members may account for the low rate of insurance coverage among citizen children in immigrant families.

Lack of insurance is an even bigger problem among the estimated 240,000 children in Texas, 63 percent of whom are uninsured. The Current Population Survey does not provide enough information to know how many of these children are "qualified aliens" eligible to benefit from Medicaid or CHIP.

■ County estimates of the number of uninsured children in Texas

The Office of Public Insurance Counsel and the Texas Health and Human Services Commission both developed estimates of the distribution of the 1.4 million uninsured children among the 254 counties in Texas. Both estimates generally agree on which counties have the highest incidence of uninsured children. Among the six largest counties in Texas, Hidalgo and El Paso have the highest rate of uninsured children, while Dallas and Tarrant have the lowest. However, the estimates differ on the variation among the counties.¹⁵ (See Table 4.)

LACK OF INSURANCE COVERAGE LIMITS CHILDREN'S ACCESS TO HEALTH CARE SERVICES

Lack of insurance coverage limits children's access to health care services. Children have unique developmental needs that require ongoing "well-child visits," dental screening, and preventive services—such as immunizations—to ensure that they develop into healthy adults. Unfortunately, uninsured children often do not get the care they need, and recent research indicates that the disparity in access to health care for uninsured children has gotten worse over the last decade.¹⁶

Jason may have lost his hearing because of untreated ear infections when his family was uninsured.

Jason Alvarado is a 17-year-old boy who has no hearing in his right ear severe hearing loss in his left ear. Now his family can afford insurance but the doctors say nothing can be done to restore the hearing loss. During Jason's formative years, he had recurrent ear infections that sometimes went untreated because he had no health insurance. Both his parents worked full-time. Jason's mother worked for a nursing home that didn't offer its employees insurance. Mr. Alvarado's employer, a hospital, covered him but charged over \$200 per month for family coverage. With a combined income of about \$25,000 per year, they couldn't afford family coverage made too much for Medicaid.

Mrs. Alvarado remembers that Jason often complained of earaches when he was growing up, but he didn't say anything about the hearing loss until he was a teenager. By that time, Mr. Alvarado had a better paying job and the family could afford to pay \$255 per month for family coverage, but it was too late for Jason's hearing. She will never know for certain, but Mrs. Alvarado feels strongly that if they could have taken Jason to a pediatrician on a regular basis, his hearing problem could have been detected and treated. Sara Alvarado is now employed by a Community Action program and works with the Ten Steps to Health program to counsel mothers of young children to get preventive care, such as hearing tests, for their children.

Interview with Sara Alvarado, Tahoka, Texas. January 20, 1999.

Research has shown that uninsured children receive fewer health care services than insured children do. Uninsured children have fewer physician visits per year, are less likely to receive adequate preventive services and immunizations, and are less likely to be seen by physicians when they are ill.¹⁷

- Uninsured children are much less likely to receive the medical care they need than insured children. Recent studies have found that uninsured children were six times more likely than children with private insurance to go without medical care.¹⁸

- Uninsured children often do not see doctors for conditions that require treatment that could cause long-term problems. For example, uninsured children are less likely than children with health insurance to receive care from a doctor for conditions such as acute or recurrent earaches and asthma.¹⁹

- Uninsured children are much less likely to have a usual source of care than insured children. One recent study found that uninsured children were six times more likely to lack a usual source of care (24 percent for uninsured children compared to four percent for insured children).²⁰

- Uninsured children are more likely to delay or go without needed medical care because of financial barriers. Parents of uninsured children were almost five times more likely to delay getting care for their children because of costs than parents of children with publicly funded insurance.²¹

- Compared to children with health insurance, uninsured children who experience injuries—even serious injuries—are less likely to receive medical attention. Children without insurance coverage are only 73 percent as likely to have their injuries treated by a medical provider.²²

- When they are hospitalized for similar problems, uninsured children fare worse in hospitals than insured children fare, and they are more likely to die. One study found that the in-hospital death rate was 1.46 times higher among uninsured white children and 1.88 times higher among uninsured black children when compared to privately insured children.²³

- Hispanic children are the most likely to be uninsured. They are also the least likely to have a usual source of health care, and are almost three times as likely to report fair or poor health as white children (eight percent for Hispanic children compared to three percent for white children).²⁴

Research by Paul Newacheck and his colleagues reported that lack of insurance coverage was the most significant barrier to gaining access to primary care for children.²⁵ This study, based on the 1993 National Health Interview Survey, found that while poverty and minority status posed significant barriers to gaining access to primary care, **the most important barrier** was lack of insurance coverage.

While numerous studies have shown the disparity in access to health care between insured and uninsured children, the recent implementation of child-only health insurance programs has allowed some researchers to focus on the impact of newly acquired health insurance on children and families. One such study examined the impact of health insurance for children who were uninsured and recently became insured. The study found that becoming insured had a strong, positive effect on children and families.²⁶ Among the results of that study:

- ■ The proportion of newly insured children reporting any unmet medical delay in receiving care declined from 57 percent to 16 percent after having insurance for 12 months.²⁷
 - After 12 months of insurance, 99 percent of the children had a regular source of health care, and fewer of them visited the emergency room (a decline from 25 percent to 17 percent).
 - Having insurance for their children greatly reduced parents' stress and alleviated family burdens. It also improved the quality of life for children by eliminating restrictions on normal childhood activities that require proof of insurance, such as after-school sports and summer camp.²⁸

CONCLUSION

This report shows that 1.4 million children in Texas go without health insurance. The potential losses connected to children's lack of insurance are great. If a child develops a chronic health problem while uninsured, it can affect that child's health and well-being for decades to come.²⁹ Failure to provide continuous health insurance coverage for children in Texas compromises their access to health care. Well-child care, preventive services, and diagnostic screenings are crucial health care services to ensure a child's healthy development.

In the years ahead, the number of children without health insurance coverage is likely to grow. Health care premium costs are predicted to increase, and this will likely further decline employment-based coverage among low- and moderate-wage workers and their children. Further, Medicaid is protecting fewer children as parents leave the welfare system for low-wage employment that does not offer private insurance coverage.

The decisions facing the State of Texas in 1999 could not be more timely for the health and well-being of the children profiled in this report. With a decision to provide health insurance to children living in families with incomes up to 200 percent of the federal poverty level, Texas could cover three-fourths of its uninsured children.

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number of uninsured children by county.

A limitation of both estimates is that neither accounts for the growth in the Hispanic population in Texas since the 1989/1993 census data. The Hispanic population has a lower rate of insurance coverage than the total population; thus both estimates probably underestimate the extent to which children are uninsured in counties with a large Hispanic population.

The Office of Public Insurance Counsel finds that poorer counties will have more uninsured children, and richer counties fewer uninsured children than the estimates of the Texas Health and Human Services Commission. The differences between the two estimates can largely be explained by the different methods used by the two agencies.

The Office of Public Insurance Counsel related insurance status to just one income level—200 percent of poverty—while THHSC used several different income levels. The Office of Insurance Counsel results may have overestimated the rate of uninsurance in poor counties where more of those under 200 percent of poverty have incomes low enough to qualify for Medicaid and underestimated the rate of uninsurance in richer counties where more of those under 200 percent of poverty have incomes too high to qualify for Medicaid.

The Texas Health and Human Services Commission, on the other hand, adjusted its data in a way that reduced the variation between rich and poor counties. THHSC adjusted its results to reflect the statewide estimates of uninsured children at various income levels that were developed for the three legislative committees making recommendations to the 1999 legislature. The Committees' estimates show a lower number and rate of uninsured children among children under 200 percent of poverty and a higher number and rate of uninsured children among children over 200 percent of poverty than the unadjusted THHSC data.

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uninc-state:March 99

**Tabulation of the March 99 CPS: All Persons & Uninsured by
Poverty by State**

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All Persons						
	Under 100%	100%-150%	150%-200%	200%-250%	>=250%	Total
TOTAL	35,159,149	23,840,387	25,062,906	24,994,885	162,685,507	271,742,834
AK	65,992	40,747	57,684	58,689	423,730	646,842
AL	619,209	328,717	351,576	391,010	2,510,414	4,200,926
AR	381,240	332,989	315,302	294,488	1,238,568	2,562,587
AZ	830,561	485,147	595,159	452,272	2,542,194	4,905,333
CA	5,200,659	3,474,180	3,210,601	2,909,339	18,580,372	33,375,151
CO	368,014	215,702	287,848	287,348	2,811,895	3,970,807
CT	318,236	202,201	239,974	274,679	2,248,242	3,283,332
DC	115,147	51,110	37,031	30,983	277,440	511,711
DE	82,237	59,916	72,751	77,520	490,588	783,012
FL	1,971,457	1,320,379	1,505,526	1,518,119	8,362,431	14,677,912
GA	1,066,315	746,730	609,814	778,033	4,465,539	7,666,431
HI	131,418	92,891	128,961	73,731	773,863	1,200,864
IA	260,376	252,913	295,850	353,146	1,674,870	2,837,155
ID	166,139	140,022	139,005	130,440	698,625	1,274,231
IL	1,274,227	1,064,718	959,153	1,002,529	7,994,235	12,294,862
IN	556,607	476,168	475,774	719,725	3,611,465	5,839,739
KS	251,721	240,332	249,916	209,117	1,665,232	2,616,318
KY	525,830	368,670	386,414	363,732	2,220,033	3,864,679
LA	825,677	451,118	477,010	448,320	2,108,160	4,310,285
MA	544,799	482,089	551,621	469,198	4,069,099	6,116,806
MD	390,530	300,285	322,619	255,202	3,777,535	5,046,171
ME	134,290	101,182	85,559	138,528	806,939	1,266,498
MI	1,126,375	842,825	714,994	837,364	6,519,121	10,040,679
MN	516,824	199,111	277,346	364,086	3,475,912	4,833,279
MO	536,660	447,764	363,963	558,188	3,498,869	5,405,444
MS	489,784	381,740	313,770	338,323	1,237,805	2,761,422
MT	154,853	96,931	112,321	117,260	443,218	924,583
NC	1,054,229	711,585	717,413	701,732	4,241,950	7,426,909
ND	99,427	76,652	67,455	62,252	340,294	646,080
NE	213,784	143,736	190,020	203,039	965,838	1,716,417
NH	127,784	79,568	78,329	105,160	833,358	1,224,199
NJ	713,273	553,777	719,409	672,776	5,433,060	8,092,295
NM	377,484	201,089	216,991	177,540	856,060	1,829,164
NV	212,287	135,657	184,504	201,409	1,128,419	1,862,276
NY	3,118,707	1,487,500	1,655,858	1,599,590	10,558,352	18,420,007
OH	1,276,603	792,077	957,006	993,286	7,205,551	11,224,523
OK	476,138	288,647	328,467	350,828	1,824,759	3,268,839
OR	506,948	291,656	350,265	298,902	1,907,968	3,355,739
PA	1,359,892	850,661	1,106,164	1,045,874	7,549,519	11,912,110
RI	114,593	83,853	65,139	76,864	627,607	968,056
SC	527,466	295,834	451,345	363,139	2,213,383	3,851,167
SD	77,989	64,426	72,390	77,271	419,251	711,327
TN	752,057	581,407	630,035	584,714	3,024,257	5,572,470
TX	3,049,251	2,278,211	2,170,234	1,837,872	10,609,168	19,944,736

All Persons						
	Under 100%	100%-150%	150%-200%	200%-250%	>=250%	Total
UT	189,988	144,259	236,205	225,238	1,309,975	2,105,665
VA	598,051	548,976	530,869	650,063	4,359,935	6,687,894
VT	59,898	44,619	42,346	64,043	382,255	593,161
WA	529,996	340,244	462,743	561,417	3,852,982	5,747,382
WI	450,791	389,389	439,557	442,525	3,406,711	5,128,973
WV	313,716	210,817	204,073	192,048	829,418	1,750,072
WY	53,620	49,170	48,547	55,934	279,043	486,314

Uninsured Persons

	Under 100%	00%-150%	50%-200%	00%-250%	>=250%	Total
TOTAL	11,495,237	6,837,649	5,742,554	4,780,059	15,425,313	44,280,812
AK	25,106	12,540	11,953	10,809	51,292	111,700
AL	207,996	82,594	88,147	76,856	258,068	713,661
AR	143,961	103,434	60,538	43,534	126,919	478,386
AZ	399,302	187,044	212,093	84,289	304,047	1,186,775
CA	1,999,587	1,188,839	1,003,256	943,702	2,237,835	7,373,219
CO	174,111	28,182	63,974	43,008	290,108	599,383
CT	124,338	42,180	42,326	37,962	165,274	412,080
DC	27,195	17,346	10,364	6,137	26,156	87,198
DE	28,203	16,042	17,910	11,702	41,403	115,260
FL	662,811	364,659	279,533	278,578	978,643	2,564,224
GA	353,293	252,424	122,999	185,686	426,863	1,341,265
HI	25,298	26,319	13,319	10,083	45,576	120,595
IA	33,853	55,837	47,216	34,357	93,861	265,124
ID	64,030	41,885	31,351	14,569	73,374	225,209
IL	349,743	319,159	278,690	206,727	687,931	1,842,250
IN	194,531	171,043	80,365	81,524	311,668	839,131
KS	46,551	51,670	24,652	27,808	119,142	269,823
KY	171,070	89,362	66,289	31,407	187,000	545,128
LA	244,633	90,632	98,045	86,420	297,657	817,387
MA	104,883	61,051	86,141	77,082	297,839	626,996
MD	195,237	103,447	113,289	55,395	369,808	837,176
ME	24,337	39,621	24,224	16,230	56,231	160,643
MI	255,796	241,032	167,256	104,725	559,606	1,328,415
MN	145,829	37,619	58,222	26,306	180,465	448,441
MO	94,519	91,751	56,998	52,561	274,024	569,853
MS	196,143	140,946	66,245	43,948	106,347	553,629
MT	55,460	27,173	27,204	28,264	42,751	180,852
NC	302,848	208,723	124,883	106,603	367,678	1,110,735
ND	28,068	21,817	12,698	5,899	23,459	91,941
NE	36,677	21,972	30,956	18,902	46,604	155,111
NH	37,746	12,610	12,946	20,369	54,248	137,919
NJ	242,017	132,097	145,734	165,517	643,594	1,328,959
NM	132,453	57,271	57,428	41,882	97,392	386,426
NV	93,971	46,553	44,176	40,976	168,520	394,196
NY	868,614	440,521	376,210	301,144	1,191,006	3,177,495
OH	259,398	190,950	111,723	106,393	500,724	1,169,188
OK	187,923	71,337	72,637	60,499	206,658	599,054
OR	160,655	51,306	78,323	50,890	139,350	480,524
PA	321,194	141,674	162,678	138,354	483,943	1,247,843
RI	25,351	15,527	5,455	3,725	46,364	96,422
SC	226,241	78,701	72,478	41,755	175,171	594,346
SD	22,361	18,945	13,697	13,387	33,340	101,730
TN	144,579	73,379	161,131	97,928	246,658	723,675
TX	1,343,873	939,398	822,447	584,061	1,190,022	4,879,801

Uninsured Persons

	Under 100%	00%-150%	50%-200%	00%-250%	>=250%	Total
UT	53,212	40,541	37,325	42,198	120,212	293,488
VA	235,570	175,995	78,186	87,631	368,713	946,095
VT	10,215	5,012	2,828	11,076	29,324	58,455
WA	162,134	47,765	46,397	124,741	324,503	705,540
WI	141,990	92,842	56,301	61,614	251,337	604,084
WV	92,200	57,782	53,014	24,435	74,176	301,607
WY	18,131	11,100	10,304	10,411	32,429	82,375

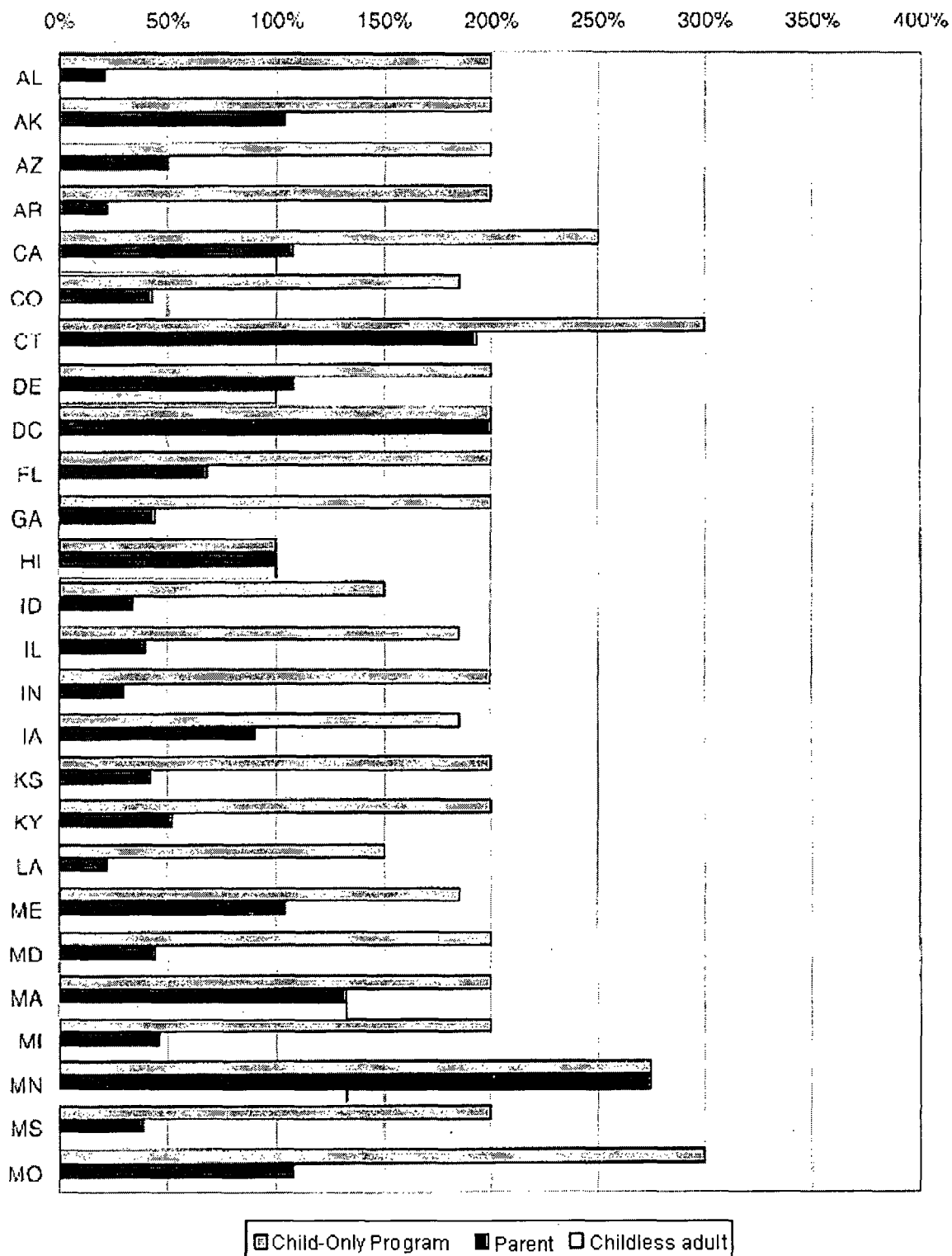
Percentage of Uninsured Persons

	Under 100%	0%-150%	0%-200%	0%-250%	>=250%	Total
TOTAL	32.7%	28.7%	22.9%	19.1%	9.5%	16.3%
AK	38.0%	30.8%	20.7%	18.4%	12.1%	17.3%
AL	33.6%	25.1%	25.1%	19.7%	10.3%	17.0%
AR	37.8%	31.1%	19.2%	14.8%	10.2%	18.7%
AZ	48.1%	38.6%	35.6%	18.6%	12.0%	24.2%
CA	38.4%	34.2%	31.2%	32.4%	12.0%	22.1%
CO	47.3%	13.1%	22.2%	15.0%	10.3%	15.1%
CT	39.1%	20.9%	17.6%	13.8%	7.4%	12.6%
DC	23.6%	33.9%	28.0%	19.8%	9.4%	17.0%
DE	34.3%	26.8%	24.6%	15.1%	8.4%	14.7%
FL	33.6%	27.6%	18.6%	18.4%	11.7%	17.5%
GA	33.1%	33.8%	20.2%	23.9%	9.6%	17.5%
HI	19.3%	28.3%	10.3%	13.7%	5.9%	10.0%
IA	13.0%	22.1%	16.0%	9.7%	5.6%	9.3%
ID	38.5%	29.9%	22.6%	11.2%	10.5%	17.7%
IL	27.4%	30.0%	29.1%	20.6%	8.6%	15.0%
IN	34.9%	35.9%	16.9%	11.3%	8.6%	14.4%
KS	18.5%	21.5%	9.9%	13.3%	7.2%	10.3%
KY	32.5%	24.2%	17.2%	8.6%	8.4%	14.1%
LA	29.6%	20.1%	20.6%	19.3%	14.1%	19.0%
MA	19.3%	12.7%	15.6%	16.4%	7.3%	10.3%
MD	50.0%	34.4%	35.1%	21.7%	9.8%	16.6%
ME	18.1%	39.2%	28.3%	11.7%	7.0%	12.7%
MI	22.7%	28.6%	23.4%	12.5%	8.6%	13.2%
MN	28.2%	18.9%	21.0%	7.2%	5.2%	9.3%
MO	17.6%	20.5%	15.7%	9.4%	7.8%	10.5%
MS	40.0%	36.9%	21.1%	13.0%	8.6%	20.0%
MT	35.8%	28.0%	24.2%	24.1%	9.6%	19.6%
NC	28.7%	29.3%	17.4%	15.2%	8.7%	15.0%
ND	28.2%	28.5%	18.8%	9.5%	6.9%	14.2%
NE	17.2%	15.3%	16.3%	9.3%	4.8%	9.0%
NH	29.5%	15.8%	16.5%	19.4%	6.5%	11.3%
NJ	33.9%	23.9%	20.3%	24.6%	11.8%	16.4%
NM	35.1%	28.5%	26.5%	23.6%	11.4%	21.1%
NV	44.3%	34.3%	23.9%	20.3%	14.9%	21.2%
NY	27.9%	29.6%	22.7%	18.8%	11.3%	17.3%
OH	20.3%	24.1%	11.7%	10.7%	6.9%	10.4%
OK	39.5%	24.7%	22.1%	17.2%	11.3%	18.3%
OR	31.7%	17.6%	22.4%	17.0%	7.3%	14.3%
PA	23.6%	16.7%	14.7%	13.2%	6.4%	10.5%
RI	22.1%	18.5%	8.4%	4.8%	7.4%	10.0%
SC	42.9%	26.6%	16.1%	11.5%	7.9%	15.4%
SD	28.7%	29.4%	18.9%	17.3%	8.0%	14.3%
TN	19.2%	12.6%	25.6%	16.7%	8.2%	13.0%
TX	44.1%	41.2%	37.9%	31.8%	11.2%	24.5%

Percentage of Uninsured Persons

	Under 100%	0%-150%	0%-200%	0%-250%	>=250%	Total
UT	28.0%	28.1%	15.8%	18.7%	9.2%	13.9%
VA	39.4%	32.1%	14.7%	13.5%	8.5%	14.1%
VT	17.1%	11.2%	6.7%	17.3%	7.7%	9.9%
WA	30.6%	14.0%	10.0%	22.2%	8.4%	12.3%
WI	31.5%	23.8%	12.8%	13.9%	7.4%	11.8%
WV	29.4%	27.4%	26.0%	12.7%	8.9%	17.2%
WY	33.8%	22.6%	21.2%	18.6%	11.6%	16.9%

Eligibility of Children, Parents & Childless Adults for Public Health Programs, by Percent of Poverty, 2000 (Part 1, AL-MO)



Eligibility of Families, Children, & Childless Adults for Public Health Programs, by Percent of Poverty, 1999 (Part II: MT - WY)

