budget crises, past expansions of Medicaid and S–CHIP are in real danger. In fact, with 35 states currently facing budget shortfalls that must be resolved this year, the number of uninsured children will grow. The outlook for the next fiscal year looks even more fiscally challenging for states. Programs like Medicaid and S–CHIP are the most vulnerable for eligibility and service provision reductions due to fiscal crisis.

The number of uninsured children is more than a statistic. It reflects the harsh reality experienced by many families—80% of whom are working families—who are forced to delay or do without needed medical care for their precious children. And, what does the research tell us about children brought up under these circumstances? Compared to those with health insurance, uninsured children have poorer health and higher mortality; they miss more school and have lower educational achievement; and they are less successful as adults in the workforce.

The MediKids Health Insurance Act is a real solution to the growing problem of children without health insurance. Our bill will guarantee health insurance for all children in the United States regardless of family income. Importantly, it would be a fully-federal program so that children's health care would not change from state to state as it does today.

The program is modeled after Medicare, but the benefits are tailored toward children. MediKids is financed like the Medicare Part B program with families paying a premium of 25% of the value of the program and the rest financed through general revenues. Premiums for MediKids would be collected each year when their parents' file their taxes. There is also a generous low-income subsidy for families phasing out at 300% of poverty.

MediKids would not override other forms of health insurance for children. Parents who have other coverage for their children—employer-sponsored insurance, individual policies, S–CHIP, Medicaid, or other policies—could maintain that coverage. But, if something happens and that coverage is no longer available, their children could always rely on MediKids for coverage. If the family moves, MediKids follows the children across state lines. And, no longer would kids get caught with no health insurance coverage if their parents are climbing out of welfare.

Enrollment in MediKids is simple with no complicated paperwork or re-determination hoops to jump through. When children are born or legally immigrate to this country, the parents are automatically given a MediKids insurance card and information on the benefits. For those children who are already born, the bill authorizes presumptive eligibility and enrollment at out-stationed sites such as Disproportionate Share Hospitals and Federally Qualified Health Centers to simplify outreach efforts. Once the program is fully phased in no outreach will be needed because enrollment into the program will be automatic.

Both children's advocates and the health care professionals who care for children support our legislation. Endorsing organizations include: the American Academy of Pediatrics, the Children's Defense Fund, the American Academy of Child and Adolescent Psychiatry, the American Nursing Association, FamiliesUSA, the March of Dimes, the National Association of Children's Hospitals, the National Association of Community Health Centers, the National Association of Public Hospitals and Health Systems, the National Health Law Program, and NETWORK: a Catholic Social Justice Lobby. These providers and children's advocacy groups are united around the concept that children deserve access to continuous health insurance. MediKids meets that goal.

The successful future of our society rests in our ability to provide our children with the basic conditions to thrive and become healthy, educated and productive adults.

Guaranteeing continuous health care coverage is a necessary component for us to realize the potential of our future. This is not only a good investment; it is also a noble goal and obligation that we must fulfill. I look forward to working with my colleagues and with the many supporting organizations for the passage of the MediKids Health Insurance Act of 2003.

Below is a short summary of the bill.

SUMMARY OF THE MEDIKIDS HEALTH INSURANCE ACT OF 2003

The MediKids Health Insurance Act provides health insurance for all children in the United States regardless of family income level by 2009. The program is modeled after Medicare, but the benefits are targeted toward children. Families below 150 percent of poverty pay no premium or copays, while those between 150 percent and 300 percent of poverty pay a graduated premium up to 5 percent of their income and receive a graduated refundable tax credit for cost sharing expenses.

The MediKids enrollment process is simple with no re-determination hoops to jump through because it is not means tested. MediKids follows children across state lines when fan-Lilies move, and covers them until their parents can enroll them in a new insurance program. Moreover, MediKids fills the gaps when families climbing out of poverty become ineligible for means-tested programs. It provides security for children until their parents can obtain reliable health insurance coverage.

ENROLLMENT

Every child born after 2004 is automatically enrolled in MediKids, and those children already born are enrolled over a 5-year phase-in as described below. Children who immigrate to this country are enrolled when they receive their immigration cards. Materials describing the program's benefits, along with a MediKids insurance card, are issued to the parent(s) or legal guardian(s) of each child. Once enrolled, children remain enrolled in MediKids until they reach the age of 23.

Parents may choose to enroll their children in private plans or government programs such as Medicaid or S–CHIP. During periods of equivalent alternative coverage, the MediKids premium is waived. However, if a lapse in other insurance coverage occurs, MediKids automatically covers the children's health insurance needs (and a premium will be owed for those months).

PHASE-IN

Year 1 (2005) = the child has not attained age 6.

Year 2 (2006) = the child has not attained age 11.

Year 3 (2007) = the child has not attained age 16.

Year 4 (2008) = the child has not attained age 21.

Year 5 (2009) = the child has not attained age 23.

BENEFITS

The benefit package is based on Medicare and the Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits for children, and includes prescription drugs. The benefits will be reviewed annually and updated by the Secretary of Health and Human Services to reflect age-appropriate benefits as needed with input from the pediatric community.

PREMIUMS, DEDUCTIBLES, AND COPAYS

Families up to 150 percent of poverty pay no premiums or copays. Families between 150 percent and 300 percent of poverty pay a graduated premium up to 5 percent of their income and receive a graduated refundable tax credit for cost sharing expenses. Parents above 300 percent of poverty are responsible for a small premium equal to one fourth of the average annual cost per child. Premiums are collected at the time of income tax filing. There is no cost sharing for preventive and well childcare for any children; all other cost sharing mimics Medicare.

FINANCING

Congress would need to determine initial funding. In future years, the Secretary of Treasury would develop a package of progressive, gradual tax changes to fund the program, as the numbers of enrollees grows.

STATES

Medicaid and S–CHIP are not altered by MediKids. These programs remain the safety net for children until MediKids is fully implemented and appropriately modified to best serve our nation's children. Once MediKids is fully operational, Congress can revisit the role of these programs in covering children.

To the extent that the states save money from the enrollment of children into MediKids, states are required to maintain those funding levels in other programs and services directed toward the Medicaid population. This can include expanding eligibility or offering additional services. For example, states could expand eligibility for parents and single individuals, increase payment rates to providers, or enhance quality initiatives in nursing homes.

PAYING TRIBUTE TO: GRAND RIVER HOSPITAL DISTRICT

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Tuesday, March 11, 2003

Mr. MCINNIS. Mr. Speaker, it is with great pride that I rise before you today to honor the good people of the Grand River Hospital District of Rifle, Colorado. America's rural health facilities are in crisis and it is our duty to embrace them in these trying times. Fortunately, the success of the Grand River Hospital District offers other rural medical providers hope. It gives me great pleasure to recognize them before this Congress and this nation.

The people of the Grand River Hospital District are devoted servants, dedicated to improving the delivery of quality, cost-effective health care in their community. Their hard work has paid off, and on May 12, they will open the doors to their brand-new 16.5 million dollar Grand River Medical Center. This expansion is an amazing accomplishment at a time when so many rural medical providers are struggling to stay open. Like all success, it has taken smart and dedicated people who have given much of themselves in the pursuit of excellence.

Mr. Speaker, I am proud to stand before this body of Congress and this great nation to recognize the accomplishments of the Grand River Hospital District. They are a guiding light for all struggling medical providers in rural America. Their example offers hope, and I am grateful to them for their dedication and the quality service they provide for the people of my district.