TRANSITIONAL MEDICAL ASSISTANCE IMPROVEMENT ACT

HON. SANDER M. LEVIN

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 2, 2001

Mr. LEVIN. Mr. Speaker, today I am pleased to join with my colleagues MICHAEL CASTLE and HENRY WAXMAN in introducing the Transitional Medical Assistance Improvement Act. I am also pleased to partner with Senators LINCOLN CHAFEE and JOHN BREAUX, who have introduced identical legislation in the other body. This bill is a critical next step toward making welfare reform work for families and for states. Improving access to health insurance for people leaving welfare is also a necessary component of any plan to reduce the number of uninsured people in the U.S.

When we passed the 1996 welfare reform bill, we agreed on a bipartisan basis that people who left welfare for work should not lose health insurance coverage. Unless Congress acts, the program which keeps that promise, the Transitional Medical Assistance program (TMA), will expire at the end of 2002. The TMA Improvement Act would permanently authorize this critical program and fix some of the problems that have kept it from living up to its potential.

We made the commitment to providing health insurance for people who leave welfare for work both because it was the fair thing to do and because health insurance is a critical work support. According to the Welfare-to-Work Partnership, which represents over 20,000 businesses that have hired former recipients, access to health insurance is one of the five most important things that keeps employees on the job. However, it can be difficult for some employers—especially smaller ones—to offer medical benefits to employees and their dependents. For example, while 74 percent of all The Partnership's members offer health benefits to their new workers, only 56 percent of the smallest employers—those with 50 employees or fewer—are able to do so. And health insurance sometimes isn't offered to part-time employees, or doesn't become effective for up to a year. Even when an employer does offer health care benefits, employees may not participate if they can't afford the premiums.

TMA fills the gap for former welfare recipients who aren't offered insurance or can't afford the coverage they're offered. Unfortunately, certain technical problems with the program have made it difficult for states to administer and even more difficult for eligible workers to access. Here are a few of the major problems the TMA Improvement Act would solve.

Our bill would give states the option of offering up to a year of continuous TMA coverage, without burdensome reporting requirements and excessive paperwork. Current law requires beneficiaries to re-apply for coverage every three months and have states redetermine their eligibility for benefits. The redetermination forms are often long, complicated, and difficult to fill out, requiring time and energy that a working parent in a new job may not have. The process also creates a significant burden for primary care providers by forcing them to re-verify insurance coverage each time they see a TMA patient, which makes them reluctant to serve this population.

Our bill would allow states to offer a second year of TMA coverage to workers who were still poor and uninsured. The Urban Institute estimates that 50% of people leaving welfare are uninsured a year after leaving the rolls On average, those workers earn $7 an hour and cannot afford to purchase private insurance. A few states are already trying to offer these workers a second year of Medicaid coverage, but current law makes doing so administratively complex.

Our bill would allow states to provide transitional health coverage to people who find work quickly. Ironically, current law restricts TMA coverage to those who have been receiving assistance for at least 3 months. This means that some of the most motivated people leaving welfare, those that find work the most quickly, are deprived of health coverage. I applaud my home state of Michigan for using state funds to cover this group, but I believe the federal government should be doing its part.

Our bill would make it easier for employers, community groups, schools, and health clinics to help us enroll working parents in health insurance programs. A recent survey of employers of welfare recipients found that 79% would be willing to help a new employee access information on these programs if they knew he or she were eligible. Many were even willing to help the employee enroll. Our bill would ensure that nonwelfare office sites were able to accept applications for TMA, greatly expanding access for working parents who are unable to go to welfare offices during business hours.

Tens of thousands of former welfare recipients have gone to work since 1996, exactly as we asked. I hope that my colleagues will join me in supporting the TMA Improvement Act, which will ensure that Congress keeps its promise of transitional health insurance for these hard-working parents and their children.

REGARDING THE 50TH ANNIVERSARY OF BRANDY VOLUNTEER FIRE DEPARTMENT

HON. ERIC CANTOR

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 2, 2001

Mr. CANTOR. Mr. Speaker, I rise today to honor the 50th anniversary of the Brandy Station Volunteer Fire Department, which has faithfully protected and served its community since 1951.

Throughout its five decades, this organization has served as a true testament to the spirit of volunteerism that makes America such a uniquely compassionate country. After receiving its charter in February, 1951, the department started off by obtaining a single fire truck through the generosity of the neighboring town of Culpeper. Over the course of the next two years, numerous dinners, dances, and bake sales held in order to raise enough money to finance the building of its first fire station in 1953. Although it does receive a small portion of its budget from Culpeper County, the department still operates primarily on the donations of its members and the Brandy Station community. In the year 2000 alone, the volunteers were able to answer seven hundred and twenty-three calls, which included everything from auto accidents and house fires to plane crashes and hazardous chemical spills. Even while answering this extremely high number of calls, they were still able to keep their response time to an incredible low average of 4½ minutes. This is truly an exemplary group of individuals because of their outstanding commitment to the protection of Brandy Station and its citizens.

Mr. Speaker and members of the House, my words here do not do justice to the service of the men and women of the Brandy Station Volunteer Fire Department, but I ask that you join me in honoring their 50th Anniversary and wish them fifty more years of success.

INTRODUCTION OF THE CHILDREN'S LEAD SCREENING ACCOUNTABILITY FOR EARLY INTERVENTION ACT OF 1999 (CHILDREN'S LEAD SAFE ACT)

HON. ROBERT MENENDEZ

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 2, 2001

Mr. MENENDEZ. Mr. Speaker, I am pleased today to re-introduce the Children's Lead Screen Intervention Act. This important legislation will strengthen federal mandates designed to protect our children from lead poisoning—a preventable tragedy that continues to threaten the health of our children.

Childhood lead poisoning has long been considered the number one environmental health threat facing children in the United States, and despite dramatic reductions in blood lead levels over the past 20 years, lead poisoning continues to be a significant health risk for young children. CDC has estimated that about 890,000, or 4.4 percent, of children between the ages of one and five have harmful levels of lead in their blood. Even at low levels, lead can have harmful effects on a child's intelligence and his, or her, ability to learn.

Children can be exposed to lead from a number of sources. We are all cognizant of lead based paint found in older homes and buildings. However, children may also be exposed to non paint sources of lead, as well as lead dust. Poor and minority children, who typically live in older housing, are at highest risk of lead poisoning. Therefore, this health threat is of particular concern to states, like New Jersey, where more than 35 percent of homes were built prior to 1950.

In 1996, New Jersey implemented a law requiring health care providers to test all young children for lead exposure. But during the first year of this requirement, there were actually fewer children screened than the year before, when there was no requirement at all. Between July 1997 and July 1998, 13,596 children were tested for lead poisoning. The year before that more than 17,000 tests were done.

New Jersey has made some progress since then. In the year 2000, New Jersey screened 67,594 children who were one or two years of age. But that is still only one-third of all children in that age group.

At the federal level, the Health Care Financing Administration (HCFA) has mandated that Medicaid children under 2 years of age be screened for elevated blood lead levels. However, recent General Accounting Office (GAO) reports indicate that this is not being done. For