

This in no way changes the primary purpose of the Congressional Research Service, which is to serve Congress; but it gives an additional window to the citizens to understand the workings of their Government and see some of the resources we have available.

There is an entire library of resources we could be making available to citizens, information we have at our fingertips and often mail out to our constituents on a regular basis; and yet these resources cannot now be made available to American citizens in the same timely and complete manner on the Web.

This legislation that I am introducing today moves such sharing of information by Members to the public into the next century. I am pleased that many of my colleagues are taking advantage of the Internet with their committees and often Web pages to provide citizens with hearing transcripts and testimonies and copies of the CONGRESSIONAL RECORD.

As we move into the 21st century, I believe reports prepared by the Congressional Research Service should be included, as well.

We live in an democracy, a government of the people, by the people, and for the people; and we must give a clear view of what is going on in the Government to the people. That is why we are introducing the CLEAR Act today.

I look forward to working with the Congressional Research Service, the gentleman from California (Chairman THOMAS), and the Committee on House Administration and other interested Members of Congress to make what we do a lot clearer to our voters and continue to reform our Congress as we move into the new millennium.

REVISIONS TO ALLOCATION FOR HOUSE COMMITTEE ON APPROPRIATIONS

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Ohio (Mr. KASICH) is recognized for 5 minutes.

Mr. KASICH. Mr. Speaker, pursuant to Sec. 314 of the Congressional Budget Act, I hereby submit for printing in the Congressional Record revisions to the allocation for the House Committee on Appropriations pursuant to House Report 106-623 totaling \$1,271,000,000 in additional new budget authority and \$723,000,000 in additional outlays. This will change the allocation to the House Committee on Appropriations to \$601,681,000,000 in budget authority and \$625,915,000,000 in outlays for fiscal year 2001. Budgetary aggregates will increase to \$1,529,886,000,000 in budget authority and \$1,495,136,000,000 in outlays for fiscal year 2001.

As reported to the House, H.R. 4577, the bill making fiscal year 2001 appropriations for the Department of Labor, Health and Human Services, Education and Related Agencies, includes \$801,000,000 in budget authority and

\$315,000,000 in outlays for emergencies; \$450,000,000 in budget authority and \$396,000,000 in outlays for continuing disability reviews; and, \$20,000,000 in budget authority and \$12,000,000 in outlays for adoption incentive payments.

These adjustments shall apply while the legislation is under consideration and shall take effect upon final enactment of the legislation. Questions may be directed to Dan Kowalski or Jim Bates at 67270.

HEALTH CARE FOR CHILDREN IN TEXAS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 1999, the gentlewoman from Texas (Ms. EDDIE BERNICE JOHNSON) is recognized for 60 minutes as the designee of the minority leader.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, for the 60 minutes, we plan to address the House on health care for children in Texas. I will be joined by several Members.

My colleagues can see, Mr. Speaker, that this ad has a child that has on boxing gloves. Our children should not have to fight to get health care coverage that they truly deserve.

A child born in the year 2000 is far more likely to grow up healthy and to reach adulthood than a child that was born in 1900. Over the past 100 years, our Nation's scientific, technological, and financial resources have built the most advanced health care system in the world. But the doors of health care still remain shut to some.

Millions of children have inadequate medical care. Ensuring that every child in our Nation receives the best possible health care, we must have a top priority in this Nation. To a large extent, health status is still determined by race, language, culture, geography, and economics.

In general, children in low-income communities get sick more often from preventable acute and infectious illnesses, such as measles, conjunctivitis, and ear infections. Low-income children and teens are also more likely to suffer from chronic medical conditions, such as diabetes and asthma. These are the leading causes of school absences.

In fact, the sharpest increases in asthma rates are among the urban youth. Very prevalent. Despite the tremendous advances in medical technology and public health, millions of children have less of a chance to grow up healthy and strong because of unequal access to health care.

Texas is a perfect example. Children without health insurance or a regular source of health care are more likely to seek care from emergency rooms and clinics, which have long waits to see a provider, limited follow-up, and little to no health education about preventive strategies or ways to manage a chronic illness.

Compared with insured children, uninsured children are up to eight times

less likely to have a regular source of care, four times more likely to delay seeking care, nearly three times less likely to have seen a provider in the last past year, and five times more likely to use emergency room as a regular place of care.

There is no question that insurance is key to maintaining health. When Medicaid was initiated in 1965, infant mortality rates began to decrease, and that continues today.

The health insurance status of children through age 18 in Texas compared to that of the rest of the country. On this next chart, imagine 100 children from Texas standing in front of us, 54 of these children are insured through private employer-based policies; 24 percent are uninsured; 22 percent are covered through Medicaid. This equals to about 1.4 million of the 6 million children in Texas without health insurance.

On our next chart, just imagine 100 children from all over the country standing in front of us. Sixty-four percent of these children are insured through private employer-based programs; 21 are covered through Medicare; 15 are uninsured.

Why is it that Texas's percentage of uninsured children is higher than the Nation's average? The reason is due to a Texas Government that chooses not to take advantage of the government funding that will allow many children to be insured.

I just read a news clipping here talking about the millions of dollars that is turned back or unused in the Federal Government simply because we have not enrolled these children. It is unfortunate that we have a Government so benign in Texas that will not enroll the children.

□ 1915

As a matter of fact, Texas can expand its Medicaid coverage to the age of 18 and cover those whose income is up to 300 percent of the Federal poverty level. Presently, Texas only covers children up to age 18 and whose income is 100 percent of the Federal poverty level with title XXI funds. There is something grossly inadequate about how we take care of our children and their health care in Texas. Over half of all States have expanded the coverage to 200 percent and beyond.

The next chart shows income eligibility levels for children 1 and older in Medicaid and separate State programs. This chart shows that most States have expanded health care coverage to children in title XXI funds. This coverage is provided through Medicaid expansions and/or separate insurance programs. Why, then, Texas? Ten States offer Medicaid to those with incomes up to 150 percent of the Federal poverty level. Texas falls within that category. Texas falls at the bottom. Our children fall at the bottom.

There are several colleagues that I have here, Mr. Speaker, who will also make comments on whether or not our children are being treated fairly if they have to simply fight for the health care they deserve.

I yield to the gentleman from Texas. Mr. HINOJOSA. Mr. Speaker, I thank the gentlewoman from Texas (Ms. EDDIE BERNICE JOHNSON) for the work that she is doing, and I agree with her opening remarks that our children should not have to fight to get the health care coverage that they deserve.

Mr. Speaker, I am happy to announce that for the first time, a Children's Health Insurance Program, or CHIP, is available in South Texas. CHIP is low-cost health insurance provided under a State-subsidized insurance program. Any Texas uninsured children, newborns through age 18, are eligible. All costs are flexible and based on family income. For example, a family of four qualifies if the household income is \$34,000 or less. If they make more than that, they can qualify for greatly reduced insurance through another program, Texas Healthy Kids.

The CHIP operates like a health maintenance organization, or HMO. It is run by the TexCare Partnership which partners with all 254 Texas counties to sponsor services through one of three different plans. One is CHIP, two is Medicaid, and three is the Texas Healthy Kids. CHIP provides services such as hospital care, surgery, x-rays, therapies, prescription drugs, mental health and substance abuse treatment, emergency services, eye tests and glasses, dental care and regular health care checkups and vaccinations.

For Texas, CHIP is funded from the proceeds of our tobacco settlement with the tobacco companies a couple of years ago. It is critically important in our State because Texas has the highest rate of uninsured in the country. Unfortunately, Texas has the Nation's second highest number of uninsured children. The worst problem we have is that not enough parents are using this great program.

South Texas, in particular, has carried the burden of uninsured children for many years. About 1.4 million of Texas' 5.8 million children lack health insurance, but 470,000 of them are now eligible for coverage under CHIP. Almost one-fourth, or 109,000, of the newly-eligible kids live on the Texas-Mexico border. When children do not have the health insurance, they have to rely on costly medical treatment at the last minute. This threatens the child's future well-being. But now we have a true opportunity to change that. CHIP will give a lot of children the opportunity to lead healthy lives without the fear of getting sick.

Let me share a quote from a lady from my district who recently went through the enrollment process. She said: "My husband and I are hard-

working middle-income people who were disqualified from Medicaid because I became employed. We have two incomes, and we can't afford insurance. Now we are told by the TexCare Partnership we will have insurance for our children with low premiums and low copayments that we can afford. My children have health care when they need it."

CHIP was first implemented in 1998 to address a national crisis, almost 12 million children that were without insurance. In Texas, we are now able to offer insurance to approximately half a million children that otherwise would have none. While we can make this offer, it is up to each parent or guardian to enroll or at least inquire about getting their children in this program.

Believe it or not, the hardest part of the CHIP program is getting parents to enroll their children. Most parents need to take advantage of this genuinely great program. I want to stress that even if a parent has never qualified for health insurance for their children before, now they can. CHIP solves the cost problem for many Texas families. In CHIP, many families will only pay an annual fee of \$15 to cover all their children in this plan. Some higher-income families will pay monthly premiums of \$15 or maybe \$18 which covers all children in the family. Most families will also have copayments for doctor/dental visits, prescription drugs, and emergency care. And families must reenroll their children once a year.

Mr. Speaker, children can only get this insurance if their parents apply. I hope all parents listening will take the initiative and make certain their children are enrolled. The application process is simple and straightforward. Any Texan can call my office in McAllen or in Beeville to get the number for the CHIP hotline. If parents want local assistance or information in my congressional district, they can call my office for that number or visit any public library in Hidalgo County or in Bee County to pick up a bilingual brochure and application.

Ms. EDDIE BERNICE JOHNSON of Texas. Could the gentleman tell me why we are just beginning to talk about this information since this has been available for a while?

Mr. HINOJOSA. It has been a fight to get the Texas leadership in the legislature to move the decision-makers to get this enrollment process going. I know that in my office we have been fighting on this for at least 18 months. I can assure the gentlewoman that I am delighted to see it finally get started, because it will stop the suffering of many of the working families that I represent in the 15th District.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I yield to the gentleman from Texas (Mr. LAMPSON).

Mr. LAMPSON. I thank the gentlewoman from Texas for yielding. Mr.

Speaker, I rise to address this issue of children's health insurance. I want to commend the gentlewoman from Texas (Ms. EDDIE BERNICE JOHNSON) for the work that she is doing in this regard, the gentleman from Texas (Mr. HINOJOSA), and the other Members that we are going to be hearing from. As a government worker, I am guaranteed that my children will have access to quality health care. This knowledge brings me some peace of mind. As it stands, many parents in my home State of Texas do not have this same peace of mind. In fact, many children who are eligible for State or Federal programs are needlessly foregoing quality health care or receiving care in expensive emergency situations only.

As a Member of Congress and as a father, I believe that every family deserves to share the peace of mind that I have today. That is why I am working to reform the current children's health care insurance system. Medicaid and the new State Children's Health Insurance Program, S-CHIP, are the two key publicly funded health insurance programs that offer coverage for low-income adolescents in Texas today. Medicaid provides health insurance coverage for more than 40 million individuals, mostly women, children and adolescents, at an annual cost of about \$154 billion in combined Federal and State funds.

In addition to these funds, S-CHIP made available approximately \$48 billion in Federal funds over 10 years to help States expand health insurance coverage to low-income children and youth. S-CHIP works to subsidize families with income levels not covered by the Medicaid program. Funded with Federal block grant dollars and State matching dollars, S-CHIP is a health insurance program for children in families who make too much money to be eligible for Medicaid but who cannot afford other private insurance options.

Mr. Speaker, Texas gained a major victory during the 1999 legislative session when it passed S-CHIP. This State program will help affordable health insurance for families earning up to 200 percent of the Federal poverty level. The Federal Government currently allows coverage to children as high as 300 percent. Together, these programs provide many uninsured children in Texas with quality health care.

While the combination of S-CHIP and Medicaid offers powerful opportunities to reduce the percentage of uninsured children in the United States, we can do more. Despite the recently passed S-CHIP program, my home State still has the second highest rate of uninsured children in the country. At the present time, there is a pressing and undisputable need for eligibility reforms and aggressive outreach to low-income families in Texas. Statistics show that Texas is ineffective in retaining low-income kids on Medicaid.

Part of this failure can be attributed to the red tape that unnecessarily burdens the neediest families in Texas. The bureaucratic hurdles that must be overcome to receive Medicaid eligibility in Texas include a face-to-face interview, an assets test, no continuous eligibility, and no presumptive eligibility.

Fortunately, Texas has been given the opportunity to adopt less restrictive methods for counting income and assets for family Medicaid. Without these changes, enrollment will continue to be difficult and complex for applicant families that are referred to Medicaid, many of whom will have a child eligible for CHIP and another one eligible for Medicaid.

Texas can make the system more navigable by implementing a few simple changes. These changes include eliminating the assets test for children's Medicaid, ending the requirement for face-to-face application, adopting uniform statewide documentation and verification options for Medicaid and Texas CHIP, and, finally, adopting 12-month continuous eligibility for children's Medicaid.

At a time of unprecedented prosperity, it is untenable for children to not have access to basic health care. Even more absurd is the fact that many of these sick children are eligible for State and Federal health insurance programs. The time to act is now. We cannot sit idly by and watch our children suffer needlessly. The solution is in our hands.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, this has been available now for at least 2 years. We have already talked about the fact that when people have a language problem or they live a long ways from where they might be able to get health care relief, it is usually the lowest income level means usually the least well educated.

Has Texas taken on any leadership or responsibility to try to be sure that we can spread the word to the persons who are eligible?

Mr. LAMPSON. We certainly should be. We need to spread that word, because what it is doing it is encouraging people to go into the most expensive areas to seek the care that they need. That may be a hospital emergency room. A hospital in my hometown and other hospitals within my district are grossly strapped right now because of the closing of so many, just as an example, rural health care facilities that have lost their ability to continue to offer services across this country.

As this group of people, the children about which we are speaking right now, also find their way into these same facilities, we are driving the cost of health care up to the point where it is causing others not to have access. Where we can do something about it and help fix this problem and make it

easier for those to gain the access that they so richly deserve and that we want them to have so that their health does not have an adverse effect on the rest of us in society, then certainly we ought to be taking the opportunity to do it.

□ 1930

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, according to the New York Times, on Sunday, May 21 of this year, Texas had not spent any of the dollars allocated to take care of these children that are poor.

Mr. LAMPSON. Mr. Speaker, if the gentlewoman will yield, that is obviously very, very, very wrong. We have the opportunity to help children, we have the opportunity to help people, and if we cannot reach out and let them know, and make certain that they know about the programs that can provide a better quality of life, then we make serious mistakes. That is why I commend the gentlewoman for the work that she is doing in trying to accomplish just that task.

We can make a difference in people's lives if the word can reach them, if we can do the things that help make their task a little bit easier in getting the quality of care that they need and deserve. I thank the gentlewoman for doing that, and I thank her for sharing the time this evening.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I yield to the gentlewoman from Texas (Ms. JACKSON-LEE).

Ms. JACKSON-LEE of Texas. Mr. Speaker, I thank the gentlewoman for this emphasis on a very important issue. To even begin to think of the great need of children with respect to health care and not respond to their need seems to be a travesty and a tragedy.

I could not help but listen to the dialogue that the gentlewoman had with our colleague, the gentleman from Texas (Mr. LAMPSON). It seems certainly that there has been a problem with the leadership from the executive of the State of Texas and particularly the Texas Department of Health. Although there may be other issues that they have excelled on, this is one that has seen a great vacuum in leadership.

I remember following the work of the State legislature, and many of the legislators from the urban centers had to work very hard to ensure that the funding for the CHIPS program included children beyond the age of 12. The initial effort by the Texas Department of Health and the governor's office was to only provide these CHIP monies for children up to 12, and many of them with the encouragement of many of us in Congress and the questioning of many of us in Congress, asked the question: Do you mean a child does not get sick after age 13?

It seems to me an outrage. I want to applaud those legislators who took the

leadership and demanded that they address the question of the needs of good health care, like Sylvester Turner and Rodney Ellis and Garnett Coleman and I am sure that I am leaving out many others around the State, who were actively involved in pressing the point that we needed to have this kind of funding for children beyond the age of children.

Mr. Speaker, it has already been said that Texas is at the bottom of retaining low-income kids on Medicaid since welfare reform in 1996. It also has been noted that Texas has the highest rate of uninsured in the country, and Texas has the second highest rate of uninsured children in the Nation. But what also needs to be noted is that right now in the State of Texas, some 500,000 children qualify for CHIP, and that means, that symbol that the gentlewoman has, the picture of that baby that says, do our children have to really fight, or should our children have to really fight to get good health care. With 500,000 children already qualifying for CHIP, it seems that we are behind the times in moving forward to ensure that this program works. It is well known that Texas has been slow compared to other States in implementing CHIP.

This is not to say that we do not have some very committed health professionals in our own local communities who have been begging for the CHIP program to be implemented. Children enrolled in Texas CHIP can get a comprehensive benefits package which include eye exams and glasses, prescription drugs and limited dental checkups and therapy, all of the items that provide for a healthy child.

Just last week in my district, Senator PAUL WELLSTONE and myself held hearings on mental health. I know we do not have mental health parity, but to hear the parents of children come forward and cry out for needed services in mental health for diagnostic services, for counseling services, knowing full well that we need to keep working toward parity, that is also health care that parents need.

So we can see that the CHIPS program is long overdue in our community. To avoid a logistical nightmare for both the State and parents, Texas should act as quickly as possible to implement changes in children's Medicare eligibility. To reinforce what has been said, we need to eliminate the access test for children's Medicaid. Texas now makes parents of Medicaid-eligible children document not just income, but also the value of savings, IRAs, automobiles, and valuables. There is a lot better way to do it, and we can utilize the Federal law that is used by the Federal Government in 40 States, plus the District of Columbia.

It is important to drop the requirement for face-to-face applications, recertification interviews, because we realize that parents are very busy. We

should allow mail-in applications. This is not required by Federal law. Thirty-eight States, plus the District of Columbia, allow mail-ins. So it is important that as we deal with the elimination of assets which are not required by the Federal Government, nor required by 40 States, we can then make more easier, if you will, the ability for these parents to apply and become eligible for CHIP.

The main point that I think we are trying to impress upon our State and the focus of this Special Order that I think is so very important is our children are voiceless. Their parents are fighting for them, but they are the ones who every time a ballot is cast, a child cannot vote, yet they are in need of the good health care that this CHIPS program would allow.

Mr. Speaker, I would hope that the State of Texas would see the value of responding to the needs of our children and quickly eliminate the complicated process that keeps this CHIPS program from being implemented. I think it is important that we get leadership from the State, and I think it is most important that the Texas Department of Health establish a focus that says in a certain period of time, we will ensure that the CHIPS program is working throughout the entire State, and that that needs to be done now.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, reclaiming my time, statistics tell us that more and more children are being absent from school because of asthma, and yet, it has been determined that we have one of the worst environments in the Nation, so bad that Oklahoma is complaining that we are polluting parts of Oklahoma. If we have this available and not making any effort to cover the children while we are also providing an environment that is conducive to making them even more unhealthy, what does this tell us? Is there any compassion in Texas?

Ms. JACKSON-LEE of Texas. Mr. Speaker, if the gentlewoman will yield, it seems like we are lacking a great deal of compassion, and the gentlewoman has hit the nail on the head. Healthy children make healthy adults. Children are apt to get all manner of childhood diseases and ailments. Asthma is one of the most devastating childhood diseases that lead into adult asthma. We do have a problem in our respective communities with air quality. We are fighting that problem well now. In fact, as the gentlewoman well knows, she was one of the supporters, and I continue to support, the Mickey Leland Toxic Center that is located in the Texas Medical Center that deals with air quality standards and does the research on respiratory diseases. We find that many children have them.

I believe that there is no compassion in this State if we cannot get the CHIPS program implemented to pro-

vide for the children of this State when the program has been passed by this Congress under the Balanced Budget Act since 1997. This is now the year 2000. Why does not the State of Texas, 43rd, if you will, in the care of mental health and some very low number, I know, in the care of health period having the highest number of uninsured cannot provide the CHIPS program for their children. I think that we need to show a great deal more compassion on behalf of Texas children and the Nation's children and ensure that these children do have insurance to make them healthy children and then healthy adults.

Mr. Speaker, I am happy to rise in support of our nation's increased investment in childcare in the form of insurance coverage. A serious oversight has occurred when studies and statistics show a large portion of children that are not covered by medical insurance.

Nationally, over 11 million of our nation's children—one in seven of those children living in the United States are uninsured. Two-thirds of these children live in families with income below 200 percent of the poverty level (\$33,400 for a family of four in 1999).

Many escape through the cracks simply because they do not fit the description policy makers have in regards to poverty. Low-income uninsured children typically live in two-parent, working households and have little contact with the welfare system.

In the same instance, families who are below standard income have the misfortune of being undereducated regarding the health benefits they and their children have access to through their entitled aide. Forty-one percent of parents of these eligible uninsured children postponed seeking medical care for their offspring because they could not afford it.

A much-needed solution for adolescents who need insurance comes in the form of Medicaid and the new State Children's Health Insurance Program (CHIP). These two key organizations are publicly funded health insurance programs that offer coverage for low-income adolescents.

These programs enacted by Congress more than thirty years apart, both augment and complement each other. While each has distinctly different characteristics, together they offer a powerful opportunity to reduce the percentage of uninsured adolescents in the United States and to increase adolescents' access to health care.

I must ask that as my colleagues deliberate this week on the real and necessary benefits of the defense appropriations to our nation's security, that they also consider the benefit to domestic security, which is created by their support of health care for all of our nation's youth.

Medicaid provides health insurance coverage for more than 40 million individuals—most are women, children, and adolescents—at an annual cost of about \$154 billion in combined federal and state funds.

Eligibility for Medicaid is determined by each state according to its specific guidelines. However, the federal government specifies the mandatory eligibility categories and the optional eligibility categories.

Medicaid is significantly affected by several of the mandatory and optional eligibility categories.

The State Children's Health Insurance Program made available approximately \$48 billion in federal funds over ten years to help states expand health insurance coverage to low-income children and youth.

Federal law permits states to use CHIP funds to expand coverage in three ways: through Medicaid expansions; state-designed, non-Medicaid programs; or a combination of these two approaches.

SCHIP, is funded with federal block grant dollars and state matching dollars, as a health insurance program for children in families who make too much money for Medicaid, but who cannot afford other private insurance options.

SCHIP has extended coverage to an additional 2 million children who do not qualify for Medicaid. Yet millions of children are believed to be eligible for these programs, but remain uninsured.

Uninsured youth will benefit from Medicaid and CHIP only if the states in which they live chose to extend eligibility and if states then work to enroll them. This requires more than working with funding for these programs. It entails communicating to the community that needs the service that something is available.

SCHIP benefits depend heavily on program design and state discretion. States currently cover children whose family incomes range generally from below the Federal poverty level (FPL) to as high as 300 percent of poverty.

Even when adolescents are enrolled in insurance programs that provide comprehensive benefits, a number of other factors influenced whether adolescents actually receive the services they need. These include affordability, confidentiality, and availability of providers with expertise and experience in caring for adolescents.

In Texas the rate of uninsured is higher than any other state in the country. In particular Texas has the second highest rate of uninsured children in the nation. In an attempt to combat this high rating the state of Texas has combined the options available to states in order to expand health insurance coverage. This combination includes expansion of Medicaid and state-designed, non-Medicaid programs.

Texas covers children whose family incomes range from below the FPL to 200 percent of poverty. The Federal government allows coverage to children as high as 300 percent.

TEXAS—STATISTICS

Texas has the highest rate of uninsured in the country.

Texas has the second highest rate of uninsured children in the nation.

There are 1.4 million uninsured children in Texas—600,000 are eligible for, but not in Medicaid; nearly 500,000 qualify for CHIP.

Texas attempt to combats the number of uninsured children by combining the options available to states in order to expand health insurance coverage. Texas' combination includes the expansion of Medicaid and state-designed, non-Medicaid programs.

At present time, there is a need for eligibility reforms and aggressive outreach for low-income health programs in Texas.

Texas is at the bottom of retaining low-income kids on Medicaid since welfare reform in 1996.

193,400 Texas children fell off the Medicaid rolls during the past three years, a 14.2 percent decline.

Medicaid data collected finds an increase in the number of people enrolled in Medicaid in June 1999 compared to June 1998, but the magnitude of this success rate is dampened due to the decline of Medicaid in nine states—one of them was Texas.

The status quo in Texas is that children (up to age 19) in families with incomes at or under 100 percent of the federal poverty income level (FPL, \$14,140 for a family of 3) can qualify for Medicaid.

Drop the requirement for face-to-face application/re-certification interviews for children's Medicaid. (Allow mail-in applications.) This is not required by federal law, and 38 states plus the District of Columbia allow mail-in application for children. Three states also allow community-based enrollment outside the welfare office.

Adopt and publicize for children's Medicaid the same simple, flexible documentation and verification options used for Texas CHIP. To make a joint mail-in application feasible, children's Medicaid and CHIP must accept the same documents for income and other required verifications. Children's Medicaid documentation should be identical statewide, to make a true joint CHIP-Medicaid mail-in application possible. Federal law allows states to reduce income documentation for children's Medicaid in any way, or even to eliminate it in favor of using third-party verification. Seven states require no income documentation for children's Medicaid.

To avoid a logistical nightmare for both the state and parents, Texas should as quickly as possible implement changes in children's Medicaid eligibility. Without these critical changes, enrollment will be difficult and complex for the many applicant families that are referred to Medicaid—many of whom will have one child eligible for CHIP, and another eligible for Medicaid. States already implementing CHIP report that large proportions of applicants end up in Medicaid. The changes needed are as follows:

Eliminate the assets test for children's Medicaid. Texas now makes parents of Medicaid-eligible children document not just income, but also the value of savings, IRAs, automobiles, and valuables, etc. The test is not required by federal law, and 40 states plus the District of Columbia have already dropped in for children.

Recent federal law changes allow states to cover parents in families with children up to any income limit the state chooses.

Texas has been given the choice to adopt less restrictive methods for counting income and assets for family Medicaid; for example, states can increase earned income disregards, and alter or eliminate asset tests.

Texas has been slow compared to other states in implementing CHIP.

Children enrolled in Texas CHIP will get a comprehensive benefits package—includes eye exams and glasses, prescription drugs, and limited dental check-ups, and therapy.

CHIP does not serve as an alternative to Medicaid for those families, who based on their income, are eligible for Medicaid.

Adopt 12-month continuous eligibility for children's Medicaid. Children enrolled in Texas CHIP stay enrolled for 12 months, regardless of any changes in income during that period. In Texas Medicaid, parents must report any income change within 10 days, and Medicaid is cut off the next month if the new family income is too high for Medicaid. Twelve-month eligibility for Children's Medicaid is a state option Congress created when it passed CHIP. This was done in an effort to allow for identical policies in Medicaid and CHIP, and promote continuity of health care. Fifteen states have adopted continuous eligibility for Children's Medicaid, and Ohio will begin the policy July 2000.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I thank the gentlewoman very much.

I yield to the gentleman from Texas (Mr. BENTSEN).

Mr. BENTSEN. Mr. Speaker, I thank the gentlewoman for yielding.

Let me first start out by commending the gentlewoman for having this Special Order to talk about the CHIPs program and the need for greater access to health care for children in this country. As the gentlewoman knows, back in 1997, we were part of an effort to start the CHIPs program, this was a Federal effort. I was pleased to be a member of the House Committee on the Budget when the 1997 Balanced Budget Act, the reconciliation bill, was crafted and ultimately passed and signed by the President. I think there is a certain amount of credit that is due the President as well for his steadfast support for this program.

It is correct that unfortunately, our State, and as a proud Texan I have to say it is unfortunate that our State was a little late in getting a CHIPs program up and running. The legislature, which meets biennially, did not get a chance to take this up or did not choose to take this up until 1999.

I think it is a little ironic when some of us were saying that the legislature should move on this, that the governor perhaps should call a special session to address this very popular bipartisan program, that with fear that Texas might ultimately lose some funds, we now see that the other body has decided to borrow from some of the funds that Congress set aside back in 1997 from the tobacco tax for this. We do know that Congresses have a way sometimes of borrowing and failing to repay those funds. So I am a little nervous that Texas might lose out as a result of that.

Mr. Speaker, I watched with great interest when our legislature had the debate over whether to cover at 150 percent or 200 percent of the poverty level. I think the legislature, under the leadership of Speaker Pete Laney, did the right thing in going to 200 percent, and that will begin to address what is really a health care crisis in Texas and a health care crisis across the country with uninsured children.

When we were doing the 1997 act, we estimated that there were 10 million children across the country without insurance; about 3 million of those are Medicaid-eligible children and the rest are children of working families who make too much money to be in the Medicaid program but do not get health insurance through the workforce or choose not to take it but cannot afford to buy it on their own.

Now, with respect to that, as my colleague from Houston just talked about, in terms of the Medicaid program, there is no question that we could do a much better job of enrolling children in Medicaid. I have offered, and I think the gentlewoman is a cosponsor, a bill, H.R. 1298, that would give schools the ability to grant presumptive eligibility for children who might be eligible, who are eligible for Medicaid, in the same way that the 1997 act gave that to Federal health care workers.

Our colleague, the gentlewoman from Colorado (Ms. DEGETTE) has a bill that would extend that same ability to grant presumptive eligibility to what are called SCHIP workers, State Children's Health Insurance workers as well, so that we would have the ability of not only enrolling children in the CHIPs program, but also enrolling those children who are Medicaid eligible in the Medicaid program.

One of the unfortunate facts of our home State of Texas is that we lead the Nation in the number of Medicaid-eligible children who are not enrolled in the program, about 800,000 kids in Texas who should be in the Medicaid program.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, reclaiming my time, there has been a whole legislative session that has come and gone since these dollars have been available, and as of May 21 of this year, we had not used any of the dollars allocated for Texas. Can the gentleman think of any reason why we have denied these children the right to health care when there is nothing standing in the way between them and health care enrollment?

Mr. BENTSEN. Mr. Speaker, if the gentlewoman would yield, we hear from some that we should not be passing new laws, we ought to be enforcing the laws that we have, but sometimes we find from some of the people who say that they are not enforcing the laws that are on their books, and this is one that ought to be enforced.

That gets to the point that I was making on Medicaid, why this is important. I represent the largest medical center in the world, has the largest children's hospital, Texas Children's Hospital, in my district. They have an emergency room that was built I think for something along the lines of 20,000 emergency room visits a year. They get about 60,000. Why do they get so many? They get so many because they have a

lot of children who do not have health insurance who are getting ambulatory care, who are getting primary care in the emergency room.

What is wrong about that? Well, one, it overwhelms the system, but the other problem is the cost structure. As the gentlewoman well knows from her professional career before Congress, the cost structure is much higher in the emergency room. A lot of these kids who could have gotten more preventive care if they had been receiving regular primary care, and from the Federal standpoint, and this is something that those of us in the Congress, as stewards of the Federal taxpayer and the budget, should be concerned about is the way that is funded are two ways.

One, it is funded by the hospitals picking up the cost any way they can, and the other is the Federal Government picks up 100 percent of the tab through the disproportionate share program.

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This becomes a big problem, because the States share the Medicaid program with the Federal government, as the gentlewoman knows, and at least they could be picking up 40 percent of the tab for these 800,000 kids in Texas who ought to be in the program, rather than having the Federal government pick up the entire tab.

As the gentlewoman knows, we reduced the Medicaid DSH program in the 1997 Act. We were able to hold the line in Texas because of the good work she did and others in the delegation. But it only makes sense that we ought to enroll these kids in the Medicaid program, we ought to get full enrollment in the CHIP program. In the long run, it will be cheaper than having to continue to fund huge dollars through the DSH program.

Beyond the bottom line aspect, it is the right thing to do, because we want to have healthy kids in Texas, we want to have healthy kids across this country. It is the compassionate conservative thing to do, but it is not enough to care. It is to care enough to do it.

The gentlewoman is on the right track with her special order. We have much more work to do in this area. We need the leadership to get this done, to get these kids enrolled, to make the changes in the Medicaid law so that we can get more kids in there, and we will have a healthier and a stronger society by it. I commend the gentlewoman for having this special order.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, the gentleman from Texas (Mr. GREEN) could not be here, but he left a statement. I notice in the statement, in his congressional district, which is also in the Houston area, at least 70 percent of the children in the Aldine School District rely on the school nurse for primary health care services, or as their initial health

care provider. That does not have to be, and it should not have to be.

We have too many children who are not getting any kind of attention in Texas. We cannot allow this to continue. It is ironic that we talk about how great we are, this big, wonderful State, with the greatest prosperity in the history of the State. We have all of these children starting out, without the availability of health care, a full life perhaps with chronic illnesses because they do not have access to the care that they deserve, and they can have it. They would have it if we had a Texas government that had enough compassion to enroll them in the program.

Nobody wishes to be poor, no one wishes to be uneducated, no one wishes to be a long ways from various health care outlets. But when that happens, the entire State ought to have access to that care. They need to be informed and they need to be enrolled. This is simply not the time to turn our heads and pretend this is not going on. It is not the time to simply say to poor kids, get back, be quiet, you might make us look bad.

We have got to give attention to these poor kids who are kids of working parents, low-income parents, who do not have access to health care that taxpayers are willing to pay for. The money is available. Texas has access to the money and refuses to use it. Is that compassion, I ask the Members? Is this America? This is not what we stand here and fight for, and what we fund each day.

We tried to be very sure that when welfare reform came, that our poor kids would not fall through the cracks. We did our part at this level. It is time for the State of Texas to look up and acknowledge that though we have much wealth, we have the largest number of poor kids being neglected. In a State where you can hardly breathe the air, we have kids who are getting their lungs injured every day simply because they do not have access to care that has been paid for. We simply refuse to use it.

Mr. Speaker, I call upon all of my colleagues to join me in making a plea to the State of Texas, my home State. I was born in the State and I know the State. I served there in the House and in the Senate. This callousness must not continue, and certainly we must not allow it to spread in this Nation.

Mr. Speaker, I include for the RECORD the statement of the gentleman from Texas (Mr. GREEN).

The statement referred to is as follows:

Mr. GREEN of Texas. Mr. Speaker, it is hard to believe that, here in the world's richest country, one in seven American children does not have health insurance.

Yet, in the midst of our Nation's longest and strongest economic expansion, the health of over 11 million of our children is being jeopardized.

In the Houston region, over a quarter million children are uninsured.

In my Congressional district, at least 70% of children in the Aldine Independent School District rely on the school nurse for primary healthcare services or as their initial healthcare provider.

Our children deserve better.

Congress created Medicaid, and later the new Children's Health Insurance Program (CHIP), to offer coverage for low-income children.

These two programs are an investment in good health—an investment that pays dividends in the long term because prevention saves taxpayers money.

They have reduced the percentage of uninsured children and parents in the United States. And, they have increased access to quality health care services.

Medicaid provides health insurance coverage for more than 40 million individuals—mostly women, children, and adolescents—at an annual cost of about \$154 billion in combined federal and state funds.

Eligibility for Medicaid is determined by each state according to its specific guidelines.

States have wide discrepancy in determining what optional benefits will be given, who will be eligible for those benefits and the procedure used to grant the benefits.

While Medicaid has benefited the poorest of the poor, it has not been able to address a second group of uninsured—the working poor.

In 1997, Congress passed the Children's Health Insurance Program or CHIP, which made available approximately \$48 billion in federal funds over ten years to help states expand health insurance coverage to low-income children and youth.

Federal law permits states to use CHIP funds to expand coverage in three ways: through Medicaid expansions; state-designed, non-Medicaid programs; or a combination of these two approaches.

CHIP, funded with federal block grant dollars and state matching dollars, is a health insurance program for children in families who make too much money for Medicaid, but who cannot afford other private insurance options.

CHIP has extended coverage to an additional 2 million children who do not qualify for Medicaid. Yet millions of children are believed to be eligible for these programs, but remain uninsured.

Uninsured children will benefit from Medicaid and CHIP only if the states in which they live chose to extend eligibility and if states then work to enroll them.

States currently cover children whose family incomes range generally from below the Federal poverty level (FPL) to as high as 300% of poverty.

While some states moved very quickly to insure low-income children, Texas did not. In the first year in which funds were available, the State of Texas expanded Medicaid coverage for children at or below 100 percent of the federal poverty line.

This resulted in 58,286 children ages 15–18 having insurance. More than 102,000 remained uninsured, even though they were eligible for coverage under the old federal Medicaid rules. This was a very slow start.

However, thanks to the efforts of the Texas Legislature during the 76th Legislative Session, our state is making progress.

Because of the efforts of Senator John Whitmore and Representative Kevin Bailey, Texas created a separate children's health insurance program for children at or below 200 percent of the federal poverty line.

This will provide health insurance for 500,124 Texas children through age 18. In my region, this means 90,802 children will have health insurance.

While this is a good development, we still have a long way to go.

Other states are further along in providing health coverage for children. In the first year of the program, Texas expanded coverage for 58,286 children. By comparison, Alabama enrolled 38,980 children; California enrolled 222,351 children; Florida enrolled 154,594 children; Georgia enrolled 47,581 children; Massachusetts enrolled 67,852 children; Missouri enrolled 49,529 children; New Jersey enrolled 75,652 children; New York 521,301 children; North Carolina enrolled 57,300 children; Ohio enrolled 83,688 children; and South Carolina enrolled 45,737 children.

Of the states that chose to create a separate children's health program, many are extending coverage to more children than is Texas, including California at 250 percent; Connecticut at 300 percent; New Jersey at 350 percent; Vermont at 300 percent; and Washington at 250 percent.

Texas can do more. And we should do more. We have the highest rate of uninsured persons in the country.

And, Texas has the second highest rate of uninsured children in the nation. Over 41% of parents of eligible uninsured children postponed seeking medical care for their child because they could not afford it.

There are 1.4 million uninsured children in Texas—600,000 are eligible for, but not in Medicaid; nearly 500,000 qualify for CHIP.

Texas covers children whose family incomes range from below the federal poverty level to 200% of the federal poverty level. Yet the Federal government allows coverage to children as high as 300%.

Texas, like the rest of the nation, could do more to conduct an aggressive outreach to ensure that eligible children receive the services they need.

New outreach is clearly needed—now, more than ever. Like many states, after federal welfare reform was enacted in 1996, we saw a huge drop in the number of persons applying for and participating in Medicaid. 193,400 Texas children fell off the Medicaid rolls during the past three years, a 14.2% decline.

Because these two programs are no longer linked, many lower-income persons do not realize that they are eligible for health insurance.

Unfortunately, Texas is the worst state in the Nation in terms of retaining low-income kids on Medicaid.

And, a recent New York Times article shows that Texas has used none of the federal funds it is entitled to for outreach. We can do better.

Why are so many persons not receiving the Medicaid and CHIP services they're entitled to?

Red tape burdens the neediest families in Texas.

Medicaid program eligibility requirements in Texas include:

A Face-to-face interview

An Asset test

No continuous eligibility—families must periodically re-enroll

No presumptive eligibility—even if families have proven that they are eligible for another program with the same income guidelines, they must go seven states (Texas included) expanded coverage to only 100 percent of the as quickly as possible implement changes in Children's Medicaid eligibility.

Texas can take steps now to reduce its state government bureaucracy. For example, the state could:

Eliminate the assets test for children's Medicaid. Texas now makes parents of Medicaid-eligible children document not just income, but also the value of savings, IRAs, automobiles, and valuables.

The test is not required by federal law, and 40 states plus the District of Columbia have already dropped it for children.

Texas could also drop the requirement for face-to-face application/recertification interviews for children's Medicaid and allow mail-in applications.

Thirty-eight states plus the District of Columbia allow mail-in application for children. Three states also allow community-based enrollment outside the welfare office.

Texas could adopt for children's Medicaid the same simple, flexible documentation and verification options used for Texas CHIP. To make a joint mail-in application feasible, children's Medicaid and CHIP must accept the same documents for income and other required verifications.

Federal law allows states to reduce income documentation for children's Medicaid in any way, or even to eliminate it in favor of using third-party verification. Seven states require no income documentation for children's Medicaid.

The state could adopt 12-month continuous eligibility for children's Medicaid. Children enrolled in Texas CHIP stay enrolled for 12 months, regardless of any changes in income during that period.

In Texas Medicaid, parents must report any income change within 10 days, and Medicaid is cut off the next month if the new family income is too high for Medicaid.

Texas could also adopt twelve-month eligibility for Children's Medicaid—this continuous eligibility is a state option Congress created when it passed CHIP. Fifteen states have adopted continuous eligibility for Children's Medicaid, and Ohio will begin the policy in July 2000.

Hopefully, my colleagues in the state legislature will consider some of these ideas as they continue their push to expand health care to the uninsured.

Thanks to their efforts, Texas has done many good things in the past year to reduce the number of uninsured children. We can certainly do more. I am hopeful that successful state partnerships like Medicaid and CHIP will be used by the state to their full potential.

EDUCATION IN AMERICA AND PUBLIC SCHOOL REFORM

The SPEAKER pro tempore (Mr. SHERWOOD). Under the Speaker's announced policy of January 6, 1999, the gentleman from Colorado (Mr. SCHAFF-

FER) is recognized for 60 minutes as the designee of the majority leader.

Mr. SCHAFFER. Mr. Speaker, I intend to be joined here in a few minutes by the gentleman from Michigan (Mr. HOEKSTRA) and possibly some other Members of the House as well.

Mr. Speaker, we had the occasion today of holding a field hearing in St. Paul, Minnesota, and I want to talk a little bit about the content of that hearing, and also some other issues that are critical with respect to education in America in and public school reform in general.

Mr. Speaker, the hearing was held, as I mentioned, in St. Paul this morning. It was conducted by the gentleman from Michigan (Mr. HOEKSTRA). The subcommittee that conducted the hearing was the Subcommittee on Oversight and Investigations of the Committee on Education and the Workforce, the committee that deals with most of the investigations not only that we have conducted with respect to waste, fraud, and abuse in the Department of Education, but also focusing on research and investigation into different innovative activities in public schools; finding out what works, for example, and what does not work; finding out and learning more and witnessing firsthand some of the innovative ideas that are taking place throughout the fifty States under the leadership of Governors and State legislators and other more local leaders.

Today we met with the Superintendent of Schools and some State legislators and some others who are leading the way in education reform and providing some great examples in the State of Minnesota. That just adds, Mr. Speaker, to the collection of data and information that we have been assembling from throughout the country. The subcommittee has been now to 21 different States analyzing the various education reform efforts that are taking place in those States.

One of the topics that was discussed at great length this morning at the hearing was charter schools. Charter schools really got their start in the State of Minnesota. The idea had been discussed and had been bantered around in the halls of State legislatures throughout the country from time to time prior to that. I think it was in 1991 that Minnesota became the first State to pass charter school legislation.

Charter schools are public schools. They are still funded by the government, run by the government. In fact, they are owned by the government, but they are managed and operated often in different ways, largely defined by a specific contract or a charter, as it is called; hence the name "charter schools."

That contract is one that is usually proposed by a group of parents, sometimes a group of teachers, sometimes