FINANCING CHILDREN'S HEALTH CARE NEEDS IN THE NEXT CENTURY

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Ongoing changes in the US economy and health insurance challenge the nation's quest to meet children's health care needs in the years ahead. Financing health care for all children has been a particularly elusive goal. Despite national and state efforts over the past decade to expand health insurance for children, based on the most recent national surveys 11 million children—nearly 1 in 6—are uninsured.*

Thanks to recent congressional action, we have an exciting new opportunity to procure needed health care for children. In response to widespread calls for action, the federal government enacted the State Children's Health Insurance Program (CHIP) in 1997. CHIP will provide \$24 billion in new federal matching funds, of which \$20.3 billion is for new expansions of insurance starting in 1998 for children and \$3.7 billion is for Medicaid expansions.† This provides an opportunity to invest in children's health in ways that yield improved health

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*All estimates of the number of uninsured children come from the *Current Population Survey* of the US Bureau of Census. In March of each year, the *Current Population Survey* includes a special supplement of questions about health insurance coverage during the previous year. As a result, the March 1997 survey reports on 1996 data. P. Fronstin, *Characteristics of the Uninsured, 1997 Based on Analysis of the March 1997 Current Population Survey*, Washington, DC: Employee Benefit Research Institute; December 1997.

†Pub L 105-33, 105th Congress, First session. Enacted as part of the Balanced Budget Act of 1997. CHIP provides a total of \$24 billion over the fiscal year 1998–2003 period. Funds above the CHIP allocation are targeted to cover the expected costs of child-related Medicaid reforms.

and quality of life for children as they mature into adults. By assessing what changes are likely to be necessary in the future and examining the opportunities we are missing to enhance child health now, we can determine better how to move forward in the 21st century.

A key to effective program design will be our success in developing approaches that fit the realities of a changing economy and society and that respond to the health care needs of children and their families. A clear understanding of the trends underlying the persistent erosion of children's insurance and the consequences for children of being uninsured will help focus attention on the challenges before us. An assessment of the opportunities we are missing to enhance child health is vital to the goal of using resources effectively in the future.

To examine the issues of financing children's health care needs in the 21st century, this paper first reviews the major trends affecting children's access to health care that are likely to continue into the foreseeable future and discusses the consequences of financial barriers to health care for children. We summarize the implications of recent trends in children's health insurance, poverty, and managed-care restructuring for financing and caring for children's health. To highlight the importance of health insurance for children, we present data from the *Kaiser/Commonwealth 1997 National Survey of Health Insurance*, as well as recent studies on financial barriers for children.

We then turn to the potential of CHIP and Medicaid expansions for children and discuss missed opportunities to care for children's broad health needs. These include meeting children's development needs in the early years and providing outreach and support appropriate to the complex concerns and health risks of adolescents as they mature to young adults. Leaving parents out of expansions is also a major missed opportunity for improving children's health given the strong link between children's health and family health. To illustrate the concern, we profile the insurance gaps and care experiences of parents in low-income families.

Our future ability to finance the health care needs of children also must be coupled with a vision of the organization of child health services or the delivery of care. Structural changes in the American health system provide the possibility of more comprehensive approaches to children's health. The integration of financing and delivery of care sparked by managed care, in theory, could facilitate flexible use of resources and team approaches to complex problems. The challenge will be how to reap the promise of managed care while avoiding new risks to access.

Creative thinking about financing children's health care in the 21st century

is in the nation's interest. The programs we devise today could provide the building blocks for children's health care tomorrow. The nation's children are the future: investments in their health are down payments on improved quality of life and a healthier and more productive society.

FINANCING CHILDREN'S HEALTH CARE: TRENDS

During the past decades, three trends stand out as influencing the nation's ability to finance and assure children access to needed care: an ongoing erosion of employer-based health insurance for children; persistently high rates of poverty among children, with little relief in times of economic growth; and the rapid spread of managed care as the dominant mode of financing and delivering care. These trends are likely to be with us into the next century, challenging efforts to improve children's health.

EROSION OF PRIVATE AND EXPANSION OF PUBLIC INSURANCE FOR CHILDREN

Health insurance is essential for children's access to a broad range of health and medical care in the US health care system. Although federal, state, and local governments pay for some preventive care and public health services directly, adequate health insurance is critical for ready entry to most health care services.

For a variety of historic reasons, employer-based health insurance has been the foundation for children's health insurance for most of the post-World War II era. For the past decade and beyond, however, this foundation has been eroding steadily. Today, employer-based plans cover only 59% of the nation's 71 million children under 18, down from 67% in 1987. Despite tight labor markets and efforts of parents to work, employer-based coverage now covers 6 million fewer children than it would have a decade earlier if coverage rates had been maintained.*

As a result of structural changes throughout the economy, the steady erosion of employer-based coverage is likely to continue. Indeed, the decline is a direct consequence of a changing mix of industries and jobs, as well as a reflection of a shift in employer fringe benefit policies. Jobs have been moving out of industries that have traditionally provided more comprehensive health benefits (manufacturing and large employer sites) to industries such as service and retail trades, which historically have been less likely to provide and pay for health benefits, particularly family health benefits. Restructuring of jobs into temporary, part-time, contracted, or self-employed arrangements also has moved work into settings less likely to support group health benefits.¹

*Authors' calculation based on March 1997 Current Population Survey data.

Changing employer health benefit policies likely have accelerated the downturn in coverage. Employers have been moving more of the costs of health benefits onto the budgets of workers and their families. On average, the share of premiums paid by employees for family health plans has increased from 34% to 44% in the past 10 years, based on recent employer surveys, and family deductibles have doubled, increasing by an average of \$300 over the same time period.² As a result, employer health plans have become less affordable: an increasing share of low-wage workers are foregoing employers' offers of health benefits as out-of-pocket costs relative to low incomes become unaffordable.³ In general, employer benefit policies have been moving away from a group philosophy toward individualized benefits, with less support of family coverage.⁴

As private coverage erodes, health insurance for children has become a growing public responsibility. Confronted with declining rates of private insurance coverage for children throughout the 1980s, Congress expanded Medicaid in 1989 and again in 1990. Medicaid or public health insurance expanded to cover more than one in five (22%) of all children by 1996, up from 16% in 1987. Although the expansions have prevented a major increase in the percentage of uninsured children, it has not kept pace with the decline in employer-based coverage. As a result, the percentage of children uninsured increased over the decade, rising from 13% to 15% from 1987 to 1996, respectively (Fig. 1).

Distribution of children by insurance source

FIG. 1 Sources of health insurance for children under age 18, 1987 and 1996. From P. Fronstin, *Characteristics of the Uninsured, 1997, Based on Analysis of the March 1997 Current Population Survey*, Washington, DC: Employee Benefit Research Institute; December 1997.

PROFILE OF UNINSURED CHILDREN

The decline has left nearly 11 million children under age 18—nearly one in six—uninsured.* The majority live in poor or near-poor working families. Comparing family income to federal poverty standards, one-third (34%) live in families with incomes below poverty (about \$13,500 for a family of three in 1997), and another third (36%) live in families with incomes between poverty and twice the poverty level (\$27,000 for a family of three.)

Reflecting the fact that most parents work, all but 13% of uninsured children live in families with an adult who has worked at some point during the year. Nearly two-thirds (63%) of uninsured children live in families headed by a parent who works full time the year around. The lower the family income is, the greater the risk that children and their parents will be uninsured despite year-round work efforts. While low-wage workers working for small employers are particularly vulnerable, those working for larger employers are also at high risk of being uninsured† (Table I).

IMPORTANCE OF MEDICAID FOR LOW-INCOME CHILDREN

Scarcity of employer-based coverage for low-wage working families has made Medicaid and other state-based public programs a particularly important source of coverage for poor and near-poor children. Medicaid expansions required all states to cover pregnant women and children up to age 6 in families with incomes up to 133% of poverty and to phase in coverage of all poor children by the year 2002. By 1998, all poor children aged 6 through 14 were eligible for Medicaid, and children aged 15 through 18 will be phased in a year at a time over the following four years.‡ Several states have opted to go beyond federal mini-

*The count of uninsured children varies depending on survey source and whether children age 18 are included or excluded. Based on the *March 1997 Current Population Survey*, 10.6 million children under age 18 and 11.3 million children under age 19 were uninsured in 1996.

†For example, a recent chart book prepared by the Kaiser Family Foundation, which compared the percentage uninsured working for small and larger employers by wage groups, found that, in firms employing more than 1,000 workers, 25% of workers with wages less than \$10,000 were uninsured, a percentage similar to that for those working for employers with 25–99 employees (29.8%). Those working for employers with less than 25 employees and earning under \$10,000 were at the highest risk (33.6%). Across firms of all sizes, a consistent pattern exists: low-wage workers are at highest risk of being uninsured. C. Hoffman, *Uninsured in America, A Chart Book*, Washington, DC: Kaiser Commission of Medicaid and the Uninsured; June 1998:80.

‡As of 1997, 41 states expanded Medicaid coverage to children in one or more age or income levels (The Kaiser Commission on the Future of Medicaid, *Medicaid Facts*, November 1997). Medicaid expansions require states to cover any child living in poverty born after September 30, 1983. States have the option of accelerating this phase in to cover older children to age 18 in families with incomes below 100% of poverty.

TABLE I Characteristics of Uninsured Children Under Age 18, 1996*

	Distribution of All Children	Distribution of Uninsured Children	Percentage Children Uninsured
All children under 18	71.2 million	10.6 million	14.8%
Percentage	100	100	14.8
Poverty level			
< 100%	21.1%	34.2%	24.0%
100–199%	22.6%	35.6%	23.7%
200% or more	56.3%	30.3%	7.9%
Work status			
Full time, full year	73.7%	63.4%	12.7%
Full time, part year	7.2%	11.0%	23.0%
Part time	8.7%	12.5%	21.2%
Not working	10.4%	13.0%	12.7%

*Data from *March 1997 Current Population Survey*. From P. Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1997 Current Population Survey*, EBRI Issue Brief Number 192. December 1997.

mums for children, expanding the availability of subsidized insurance beyond poverty.*

As a result of these expansions, Medicaid currently insures two-thirds of all poor children and one-quarter of children with incomes between poverty and twice poverty. Yet, the scarcity of employer-based health coverage in these income ranges has meant that one in four poor and near-poor children remain uninsured. As illustrated in Table II, employer-based plans cover barely 1 in 10 poor children and less than half of near-poor children. Even if employers offer coverage, dependent coverage is often unaffordable (Table II).

POVERTY: PERSISTENTLY HIGH RATES FOR CHILDREN

Any discussion of financing child health needs in the next century must begin with an understanding of the living circumstances of today's children and likely future trends. Despite an extended period of economic growth and the long upswing of the business cycle, rates of poverty among children have remained stubbornly high. Today, one in five children live in poverty, roughly the same rate as in the early 1980s. After falling during the War on Poverty era and 1970s

*Medicaid "medically needy" provisions make families or children eligible for coverage if, as a result of medical expenses, family net incomes meet income standards. As family members take jobs, Medicaid provisions also enable families to keep coverage for a specified time period and to "disregard" some wage earnings when calculating incomes for program purposes.

TABLE II Children's Insurance Coverage and Family Income Relative to Poverty, 1996, in Percent*

	All Children	Less than Poverty	100-199% of Poverty	200% or More of Poverty
Uninsured	14.8	24.0	23.7	7.9
Medicaid	21.7	62.0	25.0	5.7
Employer	58.8	12.0	46.9	81.3
Other	4.7	2.0	4.4	5.1

*Data from *March 1997 Current Population Survey*. From P. Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1997 Current Population Survey*, EBRI Issue Brief Number 192. December 1997.

economic expansion, rates of poverty among children rose steeply in the 1980s and have remained high for well more than a decade (Fig. 2).

The increase in income inequality that has accompanied recent economic growth has left lower-wage and moderate-wage families behind. At the bottom of the wage hierarchy, wages have declined or stagnated.⁵ Low-wage and moderate-wage families have partly responded by working longer hours, with mothers of even very young children returning to work soon after birth. However, these efforts to work longer hours appear, at best, to have helped low-wage families hold the line.

Poverty, by definition, leaves families unable to cover basic living expenses, much less health insurance costs. Those living within 200% of poverty standards also are struggling to make ends meet, with perhaps enough for basics, but little

FIG. 2 Children in poverty 1965-1996, rates rise and remain high. From US Census Bureau, *Poverty in the United States: 1996*.

extra. By 1996, two of five children were either poor or living in families with incomes less than twice the poverty level. Rates of poor and near-poor children are even more disturbing for minority children: over two-thirds of black children and nearly three in four Hispanic children are growing up in families with incomes less than 200% of poverty (Fig. 3).

Again, forecasts show little sign of trends reversing. Shrinking job opportunities for those with less than a high school education and intensified international competition have been depressing wages for lower-wage workers around the industrialized world. Given this future, policies concerned with child health will need to take into account persistently high rates of poverty among children and develop programs accordingly. Knowing the strong link between poverty and poor health,⁶ programs must be developed that target resources to those in need, with a flexible understanding of the broad range of child health concerns among families with few economic resources.

The implication for children's health insurance is straightforward. In an era when buying a decent family health plan even at group rates costs \$5,000 on average, health insurance is likely to be beyond the reach of a family of three living on \$27,000 wages before taxes.² In other words, for 40% of the nation's children, either public subsidies or employer payments for all or a substantial share of health plan premiums will be necessary to bring the cost of health plans within reach.

FIG. 3 Poverty and children, poor and near-poor children in 1996. From US Census Bureau, *Poverty in the United States: 1996*.

MANAGED CARE: RAPID GROWTH BRINGS RISKS AS WELL AS PROMISES

Coming on top of coverage erosion and high rates of poverty, the dramatic, rapid restructuring of insurance to couple financing with networks of care has brought new complexities for children's health care. By 1997, based on a Commonwealth Fund *National Survey of Health Insurance*,* three of four children with insurance were enrolled in some form of managed-care plan. The spread of managed care for low-income children covered by Medicaid has been particularly rapid, leaping from barely 10% of Medicaid enrollees in 1991 to nearly half (47.8%) enrolled by June 1997.⁷ By mid-June, 12 states had enrolled 75% or more of all Medicaid beneficiaries in managed care.

Restructuring brings with it opportunities to develop creative arrangements for providing appropriate health care for children, with variations depending on their needs and family circumstances. Managed care's promise of integrated services and an emphasis on primary and preventive care could be particularly beneficial for children. Notably, links among teams delivering more-specialized care for seriously ill children, as well as improved teamwork between primary care physicians, health educators, nurses, and child development and public health workers, offer the potential for more effective responses to children with complex health needs or exposure to multiple health risks.

Yet, managed care brings new risks as well as promises. The current dynamic of competitive, managed-care markets raises new concerns about children's access to care and care experiences in three major areas:

1. Continuity of care
2. Financial incentives to avoid risk
3. Access and quality

CONTINUITY

Basing health insurance on work, poverty, or welfare status has been the practice in the US for most of our recent history. Yet, this practice leaves families vulnerable to frequent changes in health insurance plans. A change in jobs, work arrangements, income, marital status, and other life circumstances can well mean a

*The Kaiser/Commonwealth 1997 *National Survey of Health Insurance* interviewed 4,000 adults nationwide about their health insurance and care experiences. For the 1,350 adults with children, the survey included a series of questions on children's coverage and care experiences as well. In this article, references to the survey throughout the text, tables, and charts are based on the authors' analysis of responses of parents with children. For a summary report of major findings for adults, see C. Schoen, C. Hoffman, D. Rowland, et al., *Working Families at Risk: Coverage, Access, Cost, and Worries*, New York: The Commonwealth Fund; 1998.

change in health insurance options and availability. Employers' search for plans that promise better premiums or care rates can destabilize coverage further.

Reflecting the turbulence in today's insurance markets, fluidity in employment, and reforms in welfare policies, changing health plans is a frequent experience. Based on the *Kaiser/Commonwealth 1997 National Survey*, one-third of the insured have been in their current health plan for less than 2 years. Turnover rates are even higher for Medicaid enrollees, with 42% covered for less than 2 years.* In the past, such frequent changes—with no break in insurance coverage—might have left families with little disruption in care. In an era of managed care, however, a change in health plans well may require a change of physicians, undermining continuity of care.

To the extent that parents are unable to maintain contact with their child's regular source of care or, for those with chronic conditions, source of specialty care, managed care threatens to exacerbate an already unstable base of health insurance. Rather than improving the likelihood that children will have a regular source of care, managed-care networks built on a base of frequent, involuntary plan changes may disrupt continuity-of-care relationships.

FINANCIAL INCENTIVES

In today's highly competitive market, managed-care health plans compete on the basis of average costs, unadjusted for the health risks of the patients they serve. In this environment, plans have a strong financial incentive to avoid risk. Although the philosophy of managed care may emphasize the values of prevention, teamwork, and integrated care for children with chronic or complex health needs, plans that gain a reputation for doing so risk losing out to competitors that serve a healthier mix of families. Similarly, given a rapid turnover of enrollment, plans have few financial incentives to invest in new delivery systems or the preventive and behavioral health needs of children: these systems have relatively high short-term costs, and plans may never reap the longer-term benefits if families leave for other coverage.

In fact, payments without adjustment for the health care risks of children or families provide the perverse incentive to avoid risk. Rather than rewarding plans that seek out children that might benefit most from managed care's promise of a more-integrated delivery system and an emphasis on health, current incentives encourage plans to be quiet about successes while extolling services for

*Medicaid families are particularly vulnerable because eligibility is tied to current income and work status. A wage increase or increase in hours could trigger a loss of coverage.

healthier families.⁸ Yet, few public or private purchasers are adjusting payments to plans based on the mix of patients they serve or rewarding plans for high-quality performance.^{9,10} As a result, competitive dynamics well may undermine efforts to improve or maintain access or quality of care.

ACCESS AND QUALITY

Financial incentives, instability of coverage, and more restricted care networks also raise concerns about new forms of access barriers. Location itself can become a barrier as families enroll in plans with relatively restrictive care networks. Parents may well travel to work locations distant from local communities, or families may be in need of physicians who are not included in plan networks. To the extent that primary care clinics, physicians, or specialized services are not located near homes, or plan networks disrupt pre-existing relationships, managed care may erect new, unintended barriers. Access also may be a concern to the extent that families in these care networks are unable to gain referrals to specialists that fit their children's health care needs.

The pace of managed-care restructuring has far outdistanced the art and science of setting standards for and monitoring the quality of care. Tracking care experiences and outcomes is particularly difficult for the minority of children who account for the majority of medical care costs. Yet, pioneers of more-organized, integrated systems of care have long promised that the greatest gains in quality would be for the children and adults at highest risk: those with complex care needs. Today, given the financial incentives to "do less," high turnover in plan membership, and the complexity of offering networks that meet multiple family needs, the absence of adequate quality standards, monitoring, and tools for families to advocate for themselves raises general concerns about quality. We must devise methods of holding plans more accountable in the future if financing is to build from a base of managed care and to enhance children's health.

THE IMPORTANCE OF HEALTH INSURANCE FOR CHILDREN: CONSEQUENCES OF GAPS IN COVERAGE

Studies repeatedly confirm the belief that health insurance is critical for access to care and children's health. Uninsured children are far more likely to face access problems, such as a lack of a regular source of care and preventive care services and reliance on emergency rooms and episodic care. Clinical studies find that a lack of insurance leads to delays in parents seeking care for children, which can have long-term health consequences, as well as result in unnecessary pain and suffering (not to mention medical care costs) that could have been prevented with early treatment.¹¹⁻¹³ Studies also have found that uninsured chil-

dren are less likely to get care for injuries or to see physicians for appropriate care when chronically ill.^{14,15}

The *Kaiser/Commonwealth 1997 National Survey of Health Insurance* highlights the importance of health insurance for children. The survey finds that, compared to insured children, uninsured children are two to three times more likely to have had no visit to a physician or preventive care in the past year, to lack a regular source of care, and to rely on emergency rooms for care (Fig. 4).

The survey also finds that uninsured children are likely to have more negative experiences when they do get care. Based on parents' ratings of care, uninsured children are 20% less likely to be "very satisfied" with care when they received it; nearly 1 in 10 is dissatisfied with care received. When families can no longer postpone care for their uninsured children, they often are left struggling to pay their child's medical bills. The survey finds that, despite the fact that 1 in 4 uninsured children have not seen a doctor in the past year, medical bills are a problem for one-third of all uninsured children (Table III).

Table IV illustrates the heightened vulnerability for children in the bottom half of the national income distribution. Reflecting the high proportion of uninsured children in families with incomes below \$35,000 (the median household income), children in low-wage and moderate-wage families are more likely to go without care, to be less satisfied with care they receive, and to have families with medical bill problems. One in four or more children in families with incomes below \$20,000 or between \$20,000 and \$35,000 are affected by access or cost concerns.

*Under age 18

FIG. 4 Children's health insurance and access to care. From *Kaiser/Commonwealth 1997 National Survey of Health Insurance*, New York: The Commonwealth Fund; 1997.

TABLE III Children's Access and Care Experiences by Child's Insurance Status*

	Percentage of Children with Problem		
	Total	Uninsured	Insured
No doctor visit in the past 12 months	23	39	20
No routine physical or checkup in the past 12 months	14	22	13
No regular doctor	10	25	8
Child's usual source of care is the emergency room or hospital outpatient department	5	11	5
Family has problems paying child's medical bills	17	33	15
	Percentage Satisfaction Ratings		
	Total	Uninsured	Insured
Satisfaction with quality of care child receives			
Very satisfied	70	57	72
Somewhat	25	24	30
Not very or not at all satisfied	3	9	2

*Data from Kaiser/Commonwealth 1997 National Survey of Health Insurance.

Studies indicate that health insurance can make a critical difference for children in such low-income and moderate-income families. A recent study of expanded coverage in Pennsylvania, for example, found a 70% drop in the proportion of children reporting any unmet health need or delayed care (from 57% to 16%) 6 months after enrolling in the new program. During the same time period, the percentage of previously uninsured children visiting an emergency room dropped by 22%.¹⁶ An earlier study found that Medicaid expansions at the beginning of the 1990s contributed significantly to reductions in child mortality, improvements in infant and child health, and increased use of preventive services.^{17,18}

CHILD HEALTH INSURANCE PROGRAM AND MEDICAID EXPANSIONS

The new CHIP, combined with recent expansions of Medicaid, offers a major opportunity to move forward in closing the gaps in children's health insurance coverage. CHIP provides funds for states to expand coverage for income levels up to 200% of poverty for children up to 19 years of age, providing they are not eligible for Medicaid and have no affordable employer coverage available.* Based

*States that have previously expanded on their own to levels above 150% of poverty have the option of using new federal funds to expand up to 50 percentage points beyond current program levels and go beyond 200% of the poverty level.

TABLE IV Children and Parents: Insurance, Access, and Bill Problems by Income*

	Income			
	Less than \$20,000	\$20,000 to \$35,000	\$35,001 to \$60,000	More than \$60,000
Children				
Percentage uninsured	26	16	7	3
Child care experiences				
No regular doctor	18	10	7	5
No doctor visit in past 12 months	25	26	21	17
Satisfaction with quality of care child receives				
Very satisfied	60	65	76	82
Somewhat satisfied	31	30	22	16
Not very or not at all satisfied	7	3	1	1
Cost experiences				
Trouble paying child's medical bills	21	26	14	7
Parents				
Percent uninsured	36	18	5	1
Parent care experiences				
No regular doctor	34	26	19	12
No visit in past 12 months	21	25	17	14
Difficult to get care	33	14	9	5
Did not get needed care or did not fill a prescription due to cost in past year	34	20	15	10
Problems paying medical bills	31	27	15	9
Problems paying medical bills or access problem	45	34	23	15
Satisfaction with care for self and family				
Very satisfied	44	36	52	50
Somewhat satisfied	40	48	38	39
Somewhat or very dissatisfied	16	16	11	11

*Data from Kaiser/Commonwealth 1997 National Survey of Health Insurance.

on the family incomes of currently uninsured children, CHIP and Medicaid together have the potential to cover 9 million of the 11 million uninsured children—if states can find and identify those who are eligible¹⁹ (Table V).

A recent analysis of children's eligibility experiences commissioned by the Commonwealth Fund finds, however, that innovative outreach programs will be critical to the success of the program. By comparing family income to existing standards for Medicaid eligibility in different states, the study estimates that as many as 5 million of the 11 million currently uninsured children are likely already eligible for Medicaid.¹⁹ While new resources provided by CHIP and additional funds available for Medicaid should be more than adequate to cover eligible

TABLE V Children's Health Insurance Expansions

	Medicaid Expansions	CHIP
Eligibility standard	<ul style="list-style-type: none"> • 133% of poverty level for children aged 1–5 • 100% of poverty level for children aged 6–14 • Phase in children aged 15–18 by 2002 to 100% of poverty level 	Uninsured children to age 19 who are <ul style="list-style-type: none"> • up to 200% of poverty level • not eligible for Medicaid • have no access to employer coverage
Cost sharing	No cost sharing	Up to 5% income for families at 150–200% of poverty level
Eligible children (of 11.3 million uninsured under age 19)	5.1 million poor children currently eligible	4 million newly eligible

uninsured children, the Medicaid experience warns that reaching families will be a challenge.

The complexity of recent expansions alone is likely to make it difficult for families to understand what programs might be available and how to enroll. Current program enrollment and eligibility rules vary by children's age and family employment status across states. As illustrated by Table V, a family could find itself with one child eligible for Medicaid under one set of rules and another child eligible for CHIP under other standards, with different health plans participating in the two programs. Fluctuations in income or work status could change eligibility over the course of a year with the need to reapply to a different program at year end. States are finding that administrative efforts to make the complexity invisible and to keep paperwork requirements to a minimum, as well as new strategies to find and talk to those eligible to participate, will be necessary to make the incremental expansions work.

MISSED OPPORTUNITIES TO MEET CHILDREN'S AND ADOLESCENT'S NEEDS

Extending coverage to parents, as well as children, may well be a critical next step in meeting children's health care needs. Parents are notably absent in the planned CHIP and recent Medicaid expansions, despite the fact that analyses of the uninsured repeatedly find that being uninsured tends to be a family affair. Based on analysis of the most recent *Current Population Survey* data, fully 80% of the parents of the 11.3 million uninsured children under age 19 are themselves uninsured.¹⁹ Providing coverage to entire families, rather than to children one age group at a time, might well enhance the value and attractiveness of expansions for families and ease the enrollment process.

Children's health is also at risk if we leave parents uninsured. As illustrated in Table IV, parents in low-wage families are at even higher risk of being uninsured than their children. As a result of gaps in coverage and inadequate coverage, parents in low-wage and modest-wage families report widespread problems getting care they need, struggling to pay family medical care bills, and negative care experiences when they do get care. Nearly half (45%) of low-wage parents had either an access or cost problem during the past year, as did one-third of parents with incomes between \$20,000 and \$35,000. Similar to their children, gaps in coverage resulted in parents going without or delaying needed care and lacking a regular source of care.

Leaving parents at risk for health problems that could be prevented, treated, or eased undermines family health, as well as economic security. In addition to the risk of passing infectious disease from adults to children, we know that parents' illnesses can affect directly their ability to provide children with the nurturing and supportive environment critical to healthy child development. A recent Commonwealth Fund survey of parents with children under age 3, for example, found that parents with depressive symptoms were twice as likely to become frequently frustrated with their child's behavior (44% of those with depressive symptoms compared to 21% with no symptoms), 50% more likely to yell or spank their child (51% vs. 34% yell, respectively; 17% vs. 11% spank, respectively), and less than half as likely to read to their child daily (27% vs. 43%, respectively) or to have regular routines (31% vs. 58%, respectively).²⁰ Findings from a recent study of the long-term impact of adverse childhood family experiences on adult health are startling. Adults who grew up with four or more negative childhood risk factors, including depressed, alcoholic, or abusive parents, were twice as likely to have a stroke, heart attack, or cancer.²¹

**FINANCING ESSENTIAL SERVICES: DEVELOPMENTAL CARE,
OUTREACH, AND COUNSELING**

Studies of the importance of parent-child interaction in the developing child's early years speak strongly for a more comprehensive approach to child health. We are missing opportunities to reach out to parents, who are generally eager to learn more about how to raise healthy children and to improve parenting skills. The striking contrast between parents' interest in learning more and their reports on information provided by their children's pediatricians underscores the importance of taking time to talk with parents and to address children's developmental issues. Half of parents in the recent Commonwealth Fund survey of parents with children under 3 wanted more information about helping their child to learn, and two in five parents wanted more information about learning

how to discipline young children. Yet, barely one in four had talked to their pediatricians about these issues.²²

Evaluation of efforts to reach out to families at risk with home visits provides strong evidence for the positive effect of early support, education, and interaction with families. The evaluation found that, compared to a control group, 2-year-old children whose mothers had participated in a prenatal and infant home visitation program were less likely to have been victims of accidents or poisoning, less likely to have experienced physical punishment, and had fewer visits to emergency rooms. Reduced rates of injuries persisted at 4-year assessments. A 15-year follow-up found continued evidence of reduced rates of child abuse and neglect and improved rates of maternal well-being.²³⁻²⁵

We also are missing opportunities to improve the health of older children. A recent Commonwealth Fund survey of 6,700 adolescent girls and boys in grades 5 through 12 offers vivid indicators of the need to provide more effective care and counseling for adolescents.* When asked about issues they believe a physician should discuss with them, adolescents give strong endorsement to discussions of sensitive topics such as drinking, drugs, eating disorders, and sexually transmitted disease, as well as other behaviors or risk factors known to affect adolescent health. Yet, adolescents report that they rarely discuss these issues with physicians. Based on adolescents' reports, physicians appear to stay on safer ground, discussing topics such as weight and exercise (Fig. 5).

As is true for adults, costs and lack of insurance were frequently a barrier to care for adolescents in the survey. Adolescents, however, experienced barriers that are unique to their age: unwillingness to tell their parents led among reasons that adolescents did not get care they felt they needed. Among all adolescents not receiving needed care, one-third said a major reason was that they did not want to tell their parents about the problem.

The adolescent health survey also found strong evidence that adolescents at risk because of depressive symptoms or experiences of abuse are particularly at risk for barriers to health care—often because their own reluctance or embarrassment caused them not to seek help. Half of adolescents with depressive symptoms said they had a time they did not get needed care or were too embarrassed to

*The 1997 *Adolescent Health Survey* was completed by 6,748 adolescents in roughly 300 schools around the country, with those surveyed drawn randomly from grades 5 through 12. For reports on major findings for adolescent girls and boys, see C. Schoen, K. Davis, C. S. Collins, L. Greenberg, C. DesRoches, and M. Abrams, *The Commonwealth Fund Survey of the Health of Adolescent Girls*, New York: November 1997; and C. Schoen, K. Davis, C. DesRoches, et al., *The Health of Adolescent Boys: Commonwealth Fund Survey Findings*, New York: Commonwealth Fund; June 1998.

FIG. 5 Gap between what adolescents believe their physicians should discuss and the topics discussed. From *The Commonwealth Fund 1997 Survey of the Health of Adolescent Girls*, New York: The Commonwealth Fund; 1997.

discuss a problem with a physician. Similarly, half of adolescents who reported either physical or sexual abuse said that they did not get care or discuss problems of concern, more than twice the rate of those who had not experienced abuse (Fig. 6).

Our failure to reach out to adolescents with depressive symptoms or experiences of abuse may well result in long-term health problems. Confirming clinical studies, the survey found a strong negative link between adolescents with mental health or abuse problems and drinking, smoking, and eating disorders and thoughts about suicide—the major risk factors during this critical age. Adolescents with depressive symptoms or suffering abuse were two to three times more likely to put their health at further risk through their own behaviors.

We are missing opportunities to reach out and make adolescents feel welcome. Providing adequate counseling and giving physicians, other health professionals, and counselors time to talk and probe for warning signs are essential to effective adolescent health care. Sports physicals are not enough. The expansions of CHIP to low-income adolescents to age 19 offer the opportunity to make a difference.

CHALLENGES AND OPPORTUNITIES AHEAD

A wealth of studies and the voices of children and their parents tell us that we can do a better job. Developing financing strategies that at once insure children

FIG. 6 Adolescents with mental health problems or abuse often go without needed care. From *The Commonwealth Fund Survey of the Health of Adolescent Girls*, New York: The Commonwealth Fund; 1997.

and seize opportunities to improve care will be key ingredients in an effort to move beyond insurance and improve children's health and the quality of their lives.

A central challenge to financing health care for children in the next century remains the goal of providing adequate, stable health insurance coverage for all children. New resources provided by CHIP should enable us to move forward. Recognizing that affordability lies at the heart of the program, the national commitment to provide publicly subsidized coverage is a vital first step. The widespread erosion of employer-based coverage for children of low-wage workers and the fact that two in five children live in families with incomes less than twice the poverty level leads to the conclusion that subsidized coverage will be a foundation for a more stable future for children's health insurance. Given the present level of family incomes, we, in fact, should expect that public coverage of as many as half of all children will be necessary to finance care adequately.

The strong link between parents' health and children's health presents the challenge of extending coverage to entire families. States now are experimenting with creative ways of using children's health resources to expand family coverage. Given the high costs of health plans relative to family income, however, new federal matching funds are likely to be necessary to provide states with the resources to insure adults.

With incremental, rather than universal, expansions to children, the task of letting families know what is available and helping them enroll now lies before us. Even with more universal coverage, outreach would be essential for caring for adolescents and children at high risk. Preventing problems early in a child's life has shown long-term rewards. The challenge is how to focus resources on those at risk and to define health care flexibly enough to address all health concerns.

Covering services pertinent for child health is also a central concern. Again, financing is at issue. Managed care and traditional insurance plans both tend to be unwilling to pay for child developmental services, counseling and outreach, and broadly defined health risks. Strategic financing options are needed to expand the vision of child health as appropriate to fit family circumstances.

Finally, the continued spread of managed care challenges us to turn the promise of managed care into success stories. To offset or moderate incentives to provide too little care or to avoid the sick, we need to develop plan payment mechanisms that adjust for health care risk and reward plans with high-quality performance. Devising payment incentives that reward appropriate care and emphasize long-term health improvement will help safeguard access as well as quality. Public and private initiatives are under way that seek to at least neutralize incentives to avoid risk and, more optimally, reward organizations with high success rates for more-complex care or vulnerable populations.^{10,26} For children at risk because of poverty as well as health problems, payment mechanisms also may need to adjust for social risks to reward more-innovative delivery systems.

Managed care confronts us with issues well beyond financing. In an era when changing health plans can disrupt care even with no gap in coverage, we will need to build more-secure bases for health insurance to promote continuity of care. To avoid creating new access barriers for those with insurance, it will be necessary to develop new standards for access and quality and early warning indicators. Monitoring the progress of managed care, developing standards, and financial incentives are all ingredients in holding plans accountable for care in the future.

CHIP and Medicaid provide us with an opportunity for creative thinking on the eve of the next century. With renewed commitment to invest in our children, we now must invest these resources well. The challenges before us are relatively clear; the collective task is to learn from today to improve tomorrow.

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