Health Care Reform: Recommendations and Analysis

The following are the Center for the Future of Children staff recommendations for policy to make health care reform work effectively to improve the health of children. An Analysis discussing these recommendations follows.

Recommendations

1. Because health insurance coverage can play a crucial role in facilitating access to effective health care services, meaningful health care reform should include a system of financing to pay for treatment of acute and chronic illness and for preventive care for children and pregnant women. Coverage should be assured regardless of income level, employment status, or geographic location.

2. Because health care reform may include changes in benefits, financing, administration, and the delivery system, evaluation of any reform package must address each of these elements lest any tendency to focus on specific elements cause significant harm in another area.

3. Because the main reasons children are uninsured are low levels of family income and inability to finance insurance, any effort to provide universal coverage or coverage for all children should provide substantial subsidies to low-income families. Employer mandates without additional targeted subsidies may substantially penalize low-wage workers and their children.

4. Because achieving meaningful overall health care reform will require reaching a consensus for action among a number of different competing groups, assuring that the processes established for making key decisions are rational and equitable will be crucial for protecting children’s interests.

5. Because catastrophic outcomes are rare among children but deficient health care may have deleterious long-range consequences for...
children, new procedures for monitoring children’s health care are needed. These procedures must be sensitive to the causal relationships between health care and important long-run health outcomes. Monitoring should be integrated and affordable and should provide information that can be used to improve care, not merely identify problems for sanctions.

6. Because new, more adequate, and more equitable financing mechanisms are not sufficient to assure full availability and accessibility of important services to all children, it may be necessary to protect and strengthen those direct service providers who address the needs of underserved populations. To better assure their financial stability, increase their accountability, and provide a more efficient delivery system, these providers should ultimately be incorporated into a unified health care system which serves all population groups.

7. Because complex, chronic, and high-cost illness and handicapping conditions occur in a very small proportion of children, it will be necessary to develop and maintain special payment and referral procedures to assure that very sick children get the care they need.

Analysis

In 1992, the Center for the Future of Children sponsored a series of policy forums on health insurance for children for U.S. congressional staff and other key federal health care policymakers. It was a time of dramatically increased attention to the problems of the U.S. health care system and increased interest in health care reform. Many different reform measures had been introduced into Congress. Some were targeted specifically to children and pregnant women, others were more general in scope, but none seemed to catch fire and develop the following necessary to afford it serious consideration. It was clearly a time when the beginning of serious deliberation regarding legislative action on health care reform created new demands for thoughtful analysis of how reform could be made most effective. Recognizing that health care reform is a highly complex issue constrained by many competing interests, the forums were designed to provide policymakers with objective information and analysis on how to make the variety of initiatives under consideration work effectively to improve children’s health.

Much has happened since these forums took place. In particular, the election of a new president who has placed fundamental reform of the health care system among his highest priorities has created the expectation that reform may be imminent. Yet, there is reason to believe that
reaching a broad consensus on health care reform may still be a slow, wrenching process. Daniel Yankelovich, one of America’s leading public opinion samplers, has pointed out that mounting criticism of the current U.S. health care system does not mean that Americans are really ready for a major change. According to Yankelovich, the process of public decision making proceeds in a series of well-defined stages beginning with a dawning of awareness about an issue and gradually evolving toward a fully integrated, thoughtful public judgment. According to this timeline, Americans are still in the early stages of development on health care reform, and enactment of major reforms may, despite the current heightened level of interest, be a long way off. Support for Yankelovich’s reading of where the public stands on health care reform can be found in a recent analysis which demonstrated a significant gap between expert and public views on the nature of the problem with health care, its causes, and how it should be solved. Addressing this gap may prove particularly difficult given the likely attempts to game the reform process by the large assortment of vested interests who will be trying to protect their turf in the nation’s largest industry.

There is good reason to believe that the U.S. public is currently working through the health care reform issue. It seems likely that this process of exploring choices, dealing with wishful thinking, and weighing the pros and cons of alternatives would be facilitated by the same kinds of objective information provided to the congressional staff last year. Accordingly, this issue of The Future of Children focuses on making health care reform work for children. It brings together updated papers based on the forum sessions and a number of additional articles on selected issues of importance to the current debate over health care reform. A general overview article by Marilyn Moon of the Urban Institute, co-director of the forums, provides a context for the remaining articles which address specific components of health care reform.

This Analysis explores some of the issues involved in effectively including children in the larger process of health care reform which may prove inevitable. First, we examine the forces driving reform of the health care system and the rationale for giving children special attention in the reform process. Then, we consider the need to balance all aspects of reform, financing and benefits, process and results, health care and other children’s programs, if children are to be well served by systemic reform. Finally, we turn our attention to those components of a reform proposal that are especially important for children.

**Problem: High Costs and Limited Access**

It has become the conventional wisdom that high costs and limited access are the problems which are precipitating the movement to reform the U.S. health care system. At present, U.S. health care costs are the highest in the world on a per capita basis, and they are increasing at what many feel are unsustainable rates. Health care, which consumed 9.1% of gross national product in 1980, is projected to account for more than 16% of gross domestic product (GDP) by the year 2000 unless action is...
taken to reduce its rate of growth. There is no inherently correct ratio of health care expenditures to GDP since every country must spend 100% of its GDP on something. But an increasing share of GDP consumed by health care creates problems for individuals, families, and government agencies because it means that health care is competing with other worthwhile activities for scarce resources. Limited resources and competing wants are economic facts of life, but they give rise to particular concern regarding health care in the United States because there are strong presumptions that many health care services do not provide benefits which justify their costs and that the U.S. health care system uses substantially more resources than necessary to produce health services.

The issue of limited access to health care has a number of dimensions, but it is epitomized by the fact that a large number of Americans (more than 36 million in 1991) lack basic health insurance. An equally troubling statistic is that many more families fear that they may be without insurance coverage when they need it most because of a job change, unemployment, or because of changes in employer benefit plans and actions by insurance companies to limit or eliminate coverage for those who are sickest.

The problems of rising costs and limited access are inexorably entwined. From a personal perspective, escalating costs make both health care and health insurance less affordable, but health insurance more desirable. The high cost of health care also makes extending coverage to the uninsured, by itself a conceptually easy goal to achieve, costly and especially problematic because extending health insurance to the currently uninsured without successfully managing health care costs will almost surely lead to an exacerbation of the health care cost spiral.

**RECOMMENDATION:** Because health insurance coverage can play a crucial role in facilitating access to effective health care services, health care reform should include a system of financing to pay for treatment of acute and chronic illness and for preventive care for children and pregnant women.

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**Children’s Stake in Health Care Reform**

Although families of children without significant disabilities or illness often possess the financial resources to see that their children receive needed health care, improving access to care through expanded health insurance coverage for children and/or universal health insurance coverage has been the main focus of the reform debate as it concerns children. For those for whom extending health insurance coverage to the entire population is a moral imperative, including all children in a universal plan requires no further justification. In addition, rationales are offered for focusing particularly on children. First, children are viewed as innocent because they do not themselves make the individual choices that may impede their access to care or cause them to suffer other important deprivations. Second, there is a strong sense of equality of opportunity and fairness which, holding children innocent of the circumstances into which they are born, provides a bedrock of support for children’s programs. Another reason for supporting special programs for children is that many of their problems may be more “fixable” than adult problems. The latter argument supports preventive interventions for children on the grounds that these interventions are investments which will yield positive returns in the future. Such positive returns include reduced overall spending on health and social problems and higher national productivity that would accrue from a healthier, more skilled work force.

These rationales, in and of themselves, are not sufficient to guide the health care reform process. First, they are not specific enough to prescribe concrete pieces of a reform package. For example, they say little about what benefits should be covered, how programs should be financed, and how to control costs, pay providers, or assure access to services to those who face nonfinancial barriers. Second, these same rationales could be used to justify any number of programs for children and for adults. With rising poverty rates, family instability, homelessness, crime, and a host of personal and social problems, the needs of many—children and adults—are great, and it can be argued that there is an imperative to address them. In this environment, it is essential that those who argue for expanded access to health care for
children be prepared to engage in a much broader debate about why children should receive priority and how to pay for expanded access.

It is also important to acknowledge that the request for more health care programs for children is not isolated. It will be evaluated in the contexts of both the broader health care reform debate and budgeting decisions for children’s programs generally. The issue is both what role children’s health care should play in general health care reform and what place health care reform should occupy in a general children’s agenda. In fact, the political process is such that the additional dollars required for expanded access to health care may actually be taken from other programs for children.12 It is also possible that negative consequences could ensue from focusing only on the health agenda. For example, in the health care reform debate, it may be tempting to label many interventions such as education, nutrition, substance abuse prevention, home visiting, and other programs as health services in order to obtain their financing in the current reform process. But this strategy may be problematic in a reform process which focuses on cost controls. If great care is not taken, it may also result in cutbacks in funding for other children’s services and subject a broad array of children’s services to the restrictive cost controls that may be part of comprehensive health care reform.

For these reasons, it is essential that those developing the specifics about expanded benefits and expanded insurance/financing for children’s health care be mindful of the broader agendas and array of possibilities. They must be prepared to discuss the rationale and relative value of expanding health care for children vis-à-vis expanding health care for other population groups and other programs for children and families.

Children Only, Children First

As the article by Susan Bales in this journal issue and the coverage of the administration’s health care reform task force in the press attest, there seems to be a consensus that the health needs of children and pregnant women should receive high priority in any reform process.13 We have previously recommended the implementation of a financing system to pay for all effective health care services for pregnant women and children, regardless of their income, employment status, or location.14 Whether there will be sufficient support for a children-only health care program to accomplish these ends if general reform bogs down cannot be determined, but there appears to be support for covering children as a first step in the phase-in of a system of universal coverage. Children first is an attractive strategy because of strong public sentiment for children and because children’s health care is relatively inexpensive. Extending health insurance coverage to the 9 million currently uninsured children would be a “bargain” as compared with covering the entire uninsured population of 36 million.

However, phasing in health care reform may give rise to a number of problems which have yet to be seriously considered. First, if the primary reason for phasing in universal coverage is to save money, it is not clear that a phase-in is a good strategy. If overall reform is, in fact, successful at controlling the growth in health care costs, then delaying reform by phasing it in will allow health care to become more expensive and the costs associated with ultimate universal coverage greater. In addition, some of the uninsured will be denied coverage during the phase-in period.15

Even though cost savings may not provide a strong justification for phasing in health care reform over several years, the benefits and safeguards of learning by doing may still justify a gradual approach. A radical change in the current health care system is likely to be controversial and disruptive, and many of the models proposed for the reformed system are largely untried.16 Moreover, many experts agree that neither the administrative know-how nor the information technology currently exists to make a full-scale reform work well. Comprehensive cost containment and quality assurance systems under a general reform may take as long as a decade for development and full implementation.17

Although building reform on a series of scheduled incremental changes may make sense, a children-and-pregnant-women-first approach which does not anticipate broader reforms may not. In the long run, reforms directed toward children will have to fit within the overall reform package. As Marilyn Moon observes in the Overview, it does not make much sense to build one elaborate admin-
istrative structure for a children’s health care system and another one for their parents and other adults, particularly when excessive administrative costs are perceived to be an especially egregious source of waste in the present U.S. health care system.2

If overall reform really gets delayed, expansion of Medicaid or Medicaid-type programs, either nationally or on a state-by-state basis, to cover more children may look increasingly attractive. As documented by Hill, Bartlett, and Brostrom in this journal issue, the children-only approach has been used in a number of states. One obstacle to this approach is the concern, expressed at several levels of government, about the cost and rate of increase in cost of the Medicaid program.18 The cost issue with regard to Medicaid is something of a red herring since there will be a need to pay for any expansion of health insurance, and there is mounting evidence that part of the increase in the cost of Medicaid has occurred because it is filling in more gaps in coverage as the private insurance system shrinks.18 A more creditable objection may be that the Medicaid program does not have a good reputation for adequately serving many of its current enrollees and is under reform in many states.19

Whether expanding Medicaid eligibility is an effective children-first strategy is, however, unclear. The recently reported experience from Minnesota suggests that the gradual expansion of Medicaid–look-alike children-only programs to include more services and adults may not result in a smooth transition to a system of universal coverage.20 As the Minnesota program has become more expensive, emphasis appears to be shifting from expanding access to controlling costs, and a number of key players are challenging pieces of the financing package designed to underwrite expanded coverage.21

In general, it appears likely that a children-only reform strategy would result in a system very different from one designed to cover all Americans. A children-first strategy requires that the design of the child component be consistent with the ultimate global reform plan. This latter approach builds on the children-first strategy as part of a shakedown process for a more inclusive reform. It is also responsive to an important subsidiary goal of reform—simplification of the administrative structure of the U.S. health care system and reduction in burdensome and wasteful administrative procedures which present, in some instances, important barriers to the timely receipt of necessary health care.5

Expanding Insurance Coverage

To date, much of the discussion regarding the impact of health reform on children has accepted as a premise that insurance coverage would be extended to all children and has focused on defining an appropriate benefit package and developing an effective delivery system,22 two important considerations which are addressed below. In contrast, much of the discussion of general health reform has focused on specific policies to achieve universal coverage and control costs,23 topics which have received less attention from many child advocates. If general health care reform is to work in the best interests of children, it may be useful to focus also on issues of financing, coverage, and cost control from a children’s perspective and on benefit and delivery system issues from a systemic perspective.

RECOMMENDATION: Because health care reform may include changes in benefits, financing, administration and the delivery system, evaluation of any reform package must address each of these elements carefully.

Insurance Reform

Recommendations to improve access to health insurance in the private sector have focused on reform of the private health insurance market to correct gaps in coverage that are perceived to result from market failures. They include proposed modifications in the employment-based insurance system and/or an expanded role for government financing and provision of coverage. As these important issues are analyzed thoroughly in this issue by Kevin Haugh and Gary Claxton and by Marilyn Moon, respectively, here we only highlight their relevance for children.
Gaps in the private health insurance system which jeopardize adequate and continuous coverage for children and their families result from an attempt by those providing coverage to reduce their exposure to high-risk participants. Insurance industry practices such as exclusions and limitations related to health problems, medical underwriting, waiting periods for people changing jobs, and disputes over coordination of benefits create both benefits and burdens for individuals with health insurance. On the benefit side, these practices help keep premiums down for those fortunate enough to qualify for coverage. On the burden side, they significantly undermine the risk-spreading aspect of insurance, making any given health insurance plan less effective as protection against substantial financial risk.

While most Americans currently have health insurance and are satisfied with their health care, these insurance practices make them uneasy because they undermine the security associated with being insured. Laws to address the most egregious of these practices have been enacted in several states, and proposals to deal with the problems these practices create are found in most reform proposals. In fact, there is reason to believe that action to correct these problems would find strong support either as a first step in a protracted reform process or as a stand-alone measure if comprehensive reform gets bogged down. These changes will probably require increased payments into health care insurance pools by young, low-risk, healthy individuals to finance care for sicker enrollees who might otherwise be excluded from coverage, but they will likely reduce anxiety and promote fairness among the large population of insured families. Undoubtedly reforms in this area will benefit some children; however, because inadequate financial resources (typically low earnings) are the key reason many children are uninsured or inadequately insured, reforming the current health insurance system will impact only a small number of the 9 million children without insurance.

**Covering the Uninsured**

Because most insured Americans under 65 years old are insured under employment-based programs, many proposals to cover the currently uninsured are built on an expansion of the employment-based insurance model. This approach appears attractive for uninsured children also. Almost two-thirds of all uninsured children have parents who work but are not covered by an employment-based insurance plan, and an additional 18% of uninsured children have parents with employment-based coverage for themselves. Marquis and Long estimate that a broad mandate requiring that all employees working 25 hours or more per week and their dependents be provided with health insurance by their employers would have reduced the number of uninsured children by about 80% in 1991. Most of the remaining children without insurance would be very poor children whose parents do not work. Most proposals to expand employment-based coverage for children supplement that coverage with an expanded public program to cover children whose parents do not work.

One of the great myths of employer-based health insurance is that it is paid for by the employer when, in fact, most of the money comes eventually from the employees themselves. This is a crucial consideration when it is appreciated that it is primarily low-wage workers who are uninsured and that unsubsidized employer mandates will ultimately shift most of the cost of coverage onto these workers, their families, and children. To avoid shifting the burden onto low-wage workers, it will be necessary to subsidize employment-based insurance for low-wage workers. The precise form of the subsidies and of the policies followed to finance these subsidies will determine how expansion of health insurance will affect the overall financial well-being of children.

**RECOMMENDATION:** Because the main reason children are uninsured is low levels of family income, any plan to provide universal coverage or coverage for all children should provide substantial subsidies to low-income families.

The 1990 OBRA legislation will extend Medicaid coverage to most children living below poverty by the year 2002. These children are primarily those that would be missed by an employer mandate. This phase-in will, by itself, reduce the number of uninsured children by almost one-third over the next nine years.
Because recently enacted and scheduled expansions of the Medicaid program provide coverage to many additional children, more than 80% of the currently uninsured who would be covered for the first time by a new universal health insurance program would be adults. As a result, most of the subsidies associated with expanding health insurance will flow to adults. Some of the subsidies may flow from families with children to those without. Exactly how the burden of health care reform gets distributed, however, will depend, as discussed in the paper by Marilyn Moon, on the mechanisms used to pay for reform. Therefore, to evaluate the net impact of reform on families with children, it will be necessary to compare both the benefits and burdens enjoyed by these families under the current system and under alternative reform proposals. This perspective seems to be missing from much of the debate over reform. Because the cost of extending health insurance to all adults will greatly exceed the cost of covering all children, children may not gain as much as adults under a general reform. However, the distribution of serious illness and high-cost, specialized care is much more skewed among children than among adults: 5% of children account for almost 60% of health care expenditures on children. These and other differences between children and adults are addressed in the papers by Budetti and Feinson, Freund and Lewit, and Moon, Ginsburg, and Young. They reflect differences in benefit packages (coverage for “uninsurable” preventive care), reimbursement issues (adjusting hospital rates to reflect differences in the cost of care for children), and access to specialized services.

Although the many differences noted between the health care needs of children and adults are undoubtedly valid, the distinction can be overdrawn. There is also considerable variability in health care needs within the adult population; women and men consume different health services. Moreover, the needs of thirtysomethings and octogenarians may frequently be quite different, while the dependency care needs of sick elderly patients and young children may be quite similar. The real need is for health care reform to include a mechanism and a set of guidelines for making the critical decisions necessary to fashion a health care system responsive to the needs of a very heterogeneous population.

The Benefit Package

Identification of a core benefit package is fundamental to a health insurance reform that aims at universal coverage. As discussed in the Budetti and Feinson article in this journal issue, for children an ideal benefit package would go beyond traditional acute medical services to include preventive and chronic care services, and health-care-access-related benefits. The
challenge in health care reform, however, requires more than listing benefits that should be covered. Benefits lists in and of themselves do not address the interrelationships between covered services and reimbursement rates and between the need for cost control and the desire for improved health outcomes. In addition, they do not provide guidance about choosing among benefits when resources are limited. The real challenge is to develop a set of principles and a process for determining benefits initially and for modifying coverage over time.

The thousands of different health insurance plans available in the United States today demonstrate that experience designing benefit packages abounds. Less clear are the techniques for deciding on an appropriate benefit package for a universal insurance system. The many different existing models range from indemnity fee-for-service plans with significant cost sharing and little coverage for preventive care to comprehensive health maintenance organization (HMO) packages which cover many services but control utilization through the practice patterns of providers. That each type of plan has enrollees suggests that distribution of preferences is quite broad.

Confounding the situation is the fact that merely including a benefit in a package does not result in the same degree of access to the service in different health plans. Consider inpatient hospital care, perhaps the one benefit offered in almost all health plans. Among adults, rates of hospital utilization in most HMOs are lower than in comparable indemnity plans. (See the article by Freund and Lewit in this journal issue.) Although the nominal benefit may be the same, restrictions on access in the HMOs make actual utilization of services quite different. The example of Medicaid is equally to the point and perhaps more germane for a discussion of children’s health care. Few health insurance plans offer a benefit package that is richer and more tailored to the special needs of children than many comprehensive Medicaid programs. Yet, children’s access to these services is very frequently limited by low reimbursement rates, burdensome administrative practices, and a shortage of providers in close proximity to populations of children in need. It is arguable that, in the current environment, Medicaid beneficiaries would be better served by a program that offered a less generous menu of benefits which were also much more available. In any event, it is clear that listing a service as a covered benefit does not equate with access to that service.

In this issue, Budetti and Feinson suggest that a benefit package for children include a very comprehensive list of services which knowledgeable experts agree are important for the health of children. In their article, they discuss why they believe the criteria of medical necessity, insurability and cost-effectiveness are not workable as the basis for determining benefits. But even after such a consensus process produces a benefits list, difficult decisions will have to be made. Other experts will likely put together equally comprehensive and perhaps even more expensive benefit packages for other population groups. Actually providing all these benefits to all population groups could lead to great escalation in health care costs. Therefore, reform will need to include a mechanism for deciding among claims for coverage and for balancing the costs and the benefits of different health services.

For example, it may be helpful to appoint a committee or board of citizens and professionals to make specific decisions on benefits. The committee would take some time to develop a benefit package based on public values, scientific data on effectiveness, and the costs and benefits of services. Separate subgroups could be used to develop benefit packages for different population groups starting perhaps with a list reflecting expert consensus as suggested by Budetti and Feinson. The overall board could merge and modify the recommendations to make an overall package which balanced the needs of different population subgroups. This process would be distinguished from the typical expert consensus process in that it would require that explicit decisions be made about trade-offs among different benefits for different groups. Experts have traditionally been driven primarily by technological concerns, and lists developed by expert panels have focused on including any service which may be beneficial without attempting to balance the value of the benefit against the cost of the service or to consider the distribution of costs and benefits in the population.

An additional advantage of relying on a board of experts and citizens to design a
benefit package is that it provides a mechanism for modifying that package as new technologies are developed and information about the results of established clinical practices accumulates. For example, board approval might be required to add a new technology to the benefit package, and the board might develop clinical guidelines to underscore the medical effectiveness of procedures in the benefit package.

**RECOMMENDATION:** Because achieving meaningful overall health care reform will require reaching a consensus for action among a number of different groups, assuring that the processes for making key decisions are rational and equitable will be crucial for children.

**Paying for Services**

Identification of the population served and development of a benefit package are the necessary foundations to health reform, but it is the system of paying the providers of health services that will make the system work. Payment systems not only furnish providers with the resources necessary to produce health services but also provide important incentives to signal which types of services should be produced and where and for whom they should be provided (see the article by Moon, Ginsburg, and Young in this journal issue). From the perspective of children, it will be necessary to make sure that service providers are adequately reimbursed not only so that they will be able to provide quality services appropriate to children’s needs but also so that they will want to. Payment systems can also be used to redeploy resources—for example, by offering relatively higher rates of reimbursement in underserved areas to attract providers—and for obvious reasons, payment systems are an integral part of cost control systems.

Any modifications of the payment system that may accompany health care reform are likely to be among the most contentious issues in the reform process because provider payments are the source of income to one-seventh of the national economy. Moreover, excessive earnings of providers are viewed by the public as being a primary cause of health care cost inflation, and there is reason to believe that considerable excess capacity exists in the health care system. Efforts to reduce costs by reducing excess capacity will be threatening to established providers and are likely to be countered by strong political pressure to maintain the status quo. But failure to address what the public perceives as excessive health care prices may also create political problems.

**Controlling Costs**

Although it does not have the same moral underpinning as expanding insurance coverage and access to services, the desire to control health care costs is clearly an important motivating force behind the push for health care reform. Controlling health care costs is likely to prove extremely difficult. Despite more than 20 years of effort to control costs, real health spending per person grew more rapidly between 1980 and 1990 than between 1970 and 1980. Even more ominous is that real health spending per person grew most rapidly during the 1960s, the decade that witnessed the substantial expansion of health insurance coverage which accompanied the enactment of the Medicare and Medicaid programs.

In general, a case can be made that cost control considerations should be less of a concern for children’s health care than for other groups. On a per capita basis, expenditures on children’s personal health care are only about 60% as large as expenditures on adults’ health care, and children account for only approximately 14% of personal health care expenditures. Moreover, since the relative proportion of children in the population is likely to decline as the population over 65 years old increases, children’s health care should account for a smaller share of total health care expenditures over time. In short, those who want to save big money on health care should look to where the money is being spent, and children do not account for a big piece of expenditures.

Knowledge that expenditures on health care for children are relatively modest, however, should not engender a false sense of complacency regarding the need to address cost issues in providing for their health care. Costs will be an important consideration for some significant subgroups of children, such as those under two years of age, for whom per capita expenditures are increasing at a more rapid rate than per capita expenditures on
those over 65, and chronically ill, technology-dependent children, for whom costs are very high on an individual basis. Moreover, to the extent that the same forces are fueling the escalation of health care costs for children as for adults, similar issues of waste and inefficiency, inappropriate utilization of resources, and competing unmet alternative uses for resources are as real for children’s health care as for adult health care.

There has been very little analysis of policies to control the costs of children’s health care under reform. Many observers have expressed concern that rising costs have made even routine health care so expensive that it presents a substantial burden for many families of even moderate means and a real disincentive for others. A frequently suggested solution to these problems is to increase the subsidies for these services; but while increasing subsidies may enhance access, it also fuels the cost spiral.

Two frequently prescribed routes to lowering health care costs for children are improving access to primary and preventive care and increasing use of nonphysician personnel to deliver such care. An approach that has received much attention is to expand access to prenatal care to reduce the number of very premature births, which are very costly. Although these interventions offer the potential of cost savings in certain situations, whether they will yield significant savings has yet to be determined.

Recently, attention has turned increasingly to “managed competition” and “managed care” as more systemic routes to control health care costs without sacrificing quality. Managed competition provides a flexible framework for organizing an entire health care system. It can accommodate many different financing mechanisms, special cases, and local modifications so assessing the impact of managed competition per se on children is, at this time, quite problematic.

Although managed competition is conceptually quite different from managed care, it does rely on competition among several managed care plans and fee-for-service alternatives, all offering a standard benefit package, to control costs and assure quality. Accordingly, it would appear that many of the conclusions and caveats expressed by Deborah Freund and Eugene Lewit in this journal issue regarding managed care for children would apply as well in a managed competition environment. The key finding of the Freund-Lewit review is that available research does not support most claims of reduced costs and/or improved quality and access for children and women in managed care. But there is also little evidence of deleterious health effects associated with managed care. While these findings do not support the benefits alleged to accrue to managed competition, they may not be adequate to judge the results of managed competition.

Alternatives to the managed competition model to cost control are more regulatory approaches which rely on the government’s establishing global budgets, setting prices, and controlling utilization. How these budgets are established, allocated among different groups and services, and enforced are the key unresolved issues which will determine how children will fare under such a cost control system. For example, the many programs for children with special health care needs which have been developed locally or by states frequently with federal funding (important examples of this type of program are Medicaid and Title V, the Maternal and Child Health Services Block Grant) vary considerably in their benefit structure, eligibility criteria, and the extent to which they provide adequately for those with special needs. Moreover, the experience of most with the Medicaid system for children’s health services suggests that excessive reliance on price controls and other explicit regulations to control costs may reduce access, increase waste, and stifle innovation while institutionalizing inefficiencies. Because of problems with Medicaid programs, many states are seeking to restructure their Medicaid systems using the managed care model. (See the article by Freund and Lewit in this journal issue.) Whether this restructuring will actually improve performance and lower costs remains an open question.

All in all, the significant level of activity on the health care cost front with apparently little to show for it in the way of systemic cost savings underscores the difficulties of addressing the cost issue.

**Quality Assurance and Monitoring**

Because health care reform will likely include strong incentives to reduce costs and utilization, incorporating mechanisms to assess the quality of care and assure that at least minimum standards of
care are provided should be a top priority. This activity is particularly important for children, who are unable to make these assessments themselves and who may experience long-term morbidity as a result of inadequate levels of care. Quality assurance for children presents challenges along three dimensions: (1) research needs to be done to provide sensitive outcome measures to accurately assess and adequately direct the health care system; (2) an efficient data collection and monitoring system needs to be developed; and (3) mechanisms need to be established to use the information from the monitoring system to correct deficiencies and improve performance.

A key feature of a reform plan that provides consumers with a choice of health plans or a choice of providers is that it relies on consumers’ choices to police the health care system. But the definition of quality is complex. Consumers may be able to assess alternative plans and providers according to such criteria as access to regular, after-hours, and emergency care and perhaps referrals for specialty care, but it may be difficult for nonprofessionals to assess the adequacy and quality of clinical care. The extremely skewed distribution of illness among children may also make the assessment of quality difficult for parents. Parents who are able to judge the quality of routine child supervision, preventive care, and care for acute illnesses may have difficulty assessing the quality of care for more infrequent major acute or chronic illnesses and disabilities. Moreover, even information based on a large population of children may not be adequate to assess quality for those conditions that are encountered infrequently.

Even if reform takes a more regulatory path and de-emphasizes direct consumer choice of health plans and/or providers, it will still be necessary to develop a mechanism for assuring consumer input into the management of the health care system and the reform process. In this situation, and because consumer choice, by itself, is unlikely to be sufficient to assure quality in competitive models, most reform plans will need a formal system of quality assurance. These systems are likely to follow the three traditional components of health care quality: (1) structural measures, which focus on the adequacy of available facilities and staff to produce needed health services; (2) process measures, which assess the appropriateness of the content of clinical interactions; and (3) outcomes assessment, which focuses on measuring patient health and functioning rather than the inputs into medical care.

Initially, quality assurance schemes are likely to rely on structural measures because these are easy to formulate and monitor. For example, to be eligible to participate under a managed competition system, health plans would be required to have sufficient staff and other resources to provide adequate levels of care for children. Because certification of adequate staffing does not assure adequate access or appropriate care for all plan members, other criteria will need to be developed to assure quality.

Because improvement of health and functioning is the underlying purpose of health care, basing quality assessment on outcomes would be optimal. At the present, however, especially for children, outcomes that are most easily quantified (such as mortality and hospitalization) occur with very low frequency and so are difficult to use to measure quality. Differences in physical, mental, and social functioning are more prevalent among children than mortality and may serve as markers for outcome assessment. To promote quality, it will be useful to develop and agree on procedures for monitoring these outcomes and for establishing any links between specific health care interventions and changes in important measures of functioning. Without these links, it will be difficult to justify using these measures to indicate quality of care and, what is more important, it will be impossible to use the outcome measures to modify the process of care to improve results.

In practice, carefully designed process measures may prove to be more sensitive and reliable indices of the quality of children’s health care than outcome measures. But using process measures requires the development of consensus standards of practice, an activity that may prove difficult and costly. In addition, it requires investment in systems to collect data on the individual components of care. Many feel, however, that a national data system for measuring patient outcomes and relating outcomes to process and structure would be an important by-product of the data gathering and monitoring that could be integrated into a systemic reform.
The trick will be to develop efficient monitoring systems so that the cost of monitoring does not overwhelm the value of any benefit monitoring yields.44

RECOMMENDATION: Because catastrophic outcomes are rare among children but deficient health care may have deleterious long-range consequences for children, new systems for monitoring children's health care should be developed and deployed.

Health care reform will create the need to revisit and expand the role of quality assurance in the health care system. It will be necessary to establish a public or quasi-public structure to oversee the quality assurance effort; leaving quality assurance to the providers seems too likely to present conflict-of-interest problems. It will be necessary to invest in the development of an efficient, integrated quality assurance system as part of the overall management system of the health care industry. If quality assurance is to work well, attention must be paid to the special health care needs of specific groups, including children. In a competitive, cost-conscious environment, monitoring for quality should be performed by independent agencies, and the results of quality audits should be made public to foster accountability. In addition, it will be valuable to maintain and strengthen the monitoring and surveillance of health care that goes on at the public health level in order to spot trends, monitor the overall progress of reform, and identify health problems that are best addressed at the public health level.45

Protecting Vulnerable Populations

Over the years, a number of programs have been developed to serve the special needs of large groups of women and children, especially poor and medically underserved children and children with significant disabilities and chronic illness.46 In addition, attention has increasingly focused on the problems posed by undocumented aliens.47 To the extent, however, that health care reform focuses on controlling costs and assuring access to the millions of Americans who are concerned about the insecurity of their existing employment-based health insurance, the needs of these vulnerable groups of children may be overlooked. Simply providing these children with a typical health insurance plan may not be sufficient to assure them appropriate health care.46

But effective mechanisms for reaching these needful children may be difficult to fashion within an overall reform. Key issues are likely to revolve around the value of maintaining and strengthening special programs for vulnerable children versus attempting to fold these children into the standard reform package and the extent to which their special problems can be best addressed through the health care system.

Safety Net Providers

Over the years, the problem of provider maldistribution—not enough well-trained, licensed providers to care for women and children who have low incomes, are medically high risk, or live in rural areas or inner cities—has appeared exceedingly complicated and intractable.48 One approach has been to establish special clinics in underserved areas.

While these so-called safety net providers—community health centers, migrant health centers, public hospitals, health departments, and other similar facilities—have, as discussed by Sara Rosenbaum in this issue, made an important contribution to the health care of especially vulnerable populations, they appear to have been chronically underfunded. Consequently, many existing clinics lack the capacity to serve their target populations adequately, and additional centers are needed. These facilities could be expanded in the absence of health care reform, but it also may not be unreasonable to attempt to integrate these special providers into the mainstream of a reformed health care system in the manner suggested by Rosenbaum. In particular, it may be possible, as suggested in the paper on provider payment by Marilyn Moon, Paul Ginsburg, and Donald Young, to modify reimbursement rates to (1) underwrite the true costs of care for high-risk populations and (2) create incentives for providers to serve these populations.

To date, these populations, many of whom are eligible for Medicaid, have remained underserved in part because they
are more difficult to serve and because reimbursement associated with their service has typically been substantially below rates received for serving less challenging groups. 48 The adjustment of relative reimbursement rates could not only support existing health centers, but also lead to the creation of additional centers and attract additional providers to underserved areas in organizational models other than health centers.

There has been considerable concern voiced that safety net providers are threatened by health care reform. First, a strong emphasis on cost control may undermine those providers, who will not be able to pass on the costs of the specialized services and uncompensated care they provide to extremely cost-conscious payers. 49 Second, there is the realization that excess capacity exists in the health care system generally and a fear that attempts to reduce this excess capacity may focus disproportionately on providers who serve vulnerable populations. 50 And finally, there is a concern that movement to universal coverage and the need to find funding to finance that coverage will undermine support for special targeted programs. 51

Ultimately, the needs of special populations and the survival of the safety net providers will depend on the precise details of a reform package. If strict cost controls precede universal coverage, then health clinics and other safety net providers who provide large amounts of uncompensated care may be seriously compromised. Children and others who depend on them for care may also suffer if they cannot find alternative sources of care. Alternative scenarios wherein reform enhances the viability of networks of safety net and mainstream providers to better serve underserved children are also possible, however. Perhaps most encouraging is the fact that children’s advocates and health systems experts together acknowledge the need to exercise care where vulnerable populations are concerned. To quote Alain Enthoven, the architect of the managed competition model, “Managed competition is aimed at the 90% to 95% of Americans whose medical needs can be met by programs that look like prevailing employment-based coverage.” Enthoven acknowledges that special publicly supported programs will be needed for special populations. 37

RECOMMENDATION: Because new financing mechanisms are not sufficient to assure availability of important services to all children, it may be necessary to protect and strengthen those direct service providers who address the needs of underserved populations. These providers should ultimately be incorporated into a unified health care system which serves all population groups.

Undocumented Aliens

Although the needs of many other special populations will have to be addressed in designing health care reform, undocumented aliens present a particularly difficult problem. Despite the fact that there are many children and pregnant women among the large population of undocumented immigrants in this country, there appears to be little public sentiment for including them in any health reform package. 51 Moreover, because these immigrants are in the country illegally, enrolling them in a public or employment-based health care plan could present significant procedural difficulties, even if the idea was more popular. Accordingly, if sick immigrants are not to be denied acute health care in the cost-conscious, competitive environment that may evolve under reform, it may be good policy to provide some direct public funding to safety net and other providers to underwrite the cost of this care. The most likely source of these funds would be the federal government as this would spread the cost of this care nationally. Relying on states or local governments to underwrite this care would place a substantial burden on several states on both coasts and the border with Mexico. 47

Very Sick Children

Serious concerns also arise about how well very sick children and those needing expensive, specialized care over an extended period of time may fare under reform. Because many of these high-cost children suffer from chronic conditions which persist over a number of years, costs and special health care needs are more concentrated among children than among adults. Care of these children may be not only costly, but also may be most
effectively delivered by a small number of specialty providers.

These children may be adversely affected by cost controls implemented under health care reform if safeguards are not built into reform itself. As Freund and Lewit discuss in their article on managed care, capitated health plans face strong incentives to underserve these expensive cases because they are paid per enrollee, not per service rendered. Similarly, health insurance plans also have strong incentives to avoid high-risk groups and may do so indirectly by failing to contract with high-cost specialty providers which high-risk patients may find attractive. Finally, even in a fee-for-service setting, payment to providers of specialty care may be problematic as it may be difficult to apply cost controls equitably to different providers. As Moon, Ginsburg, and Young relate, while accommodating special providers of health care for children in a global payment system may be conceptually possible, it will undoubtedly require special adjustment of existing payment systems developed for Medicare and other general purposes. Moreover, attempts to create special adjustments in payment systems for children’s health care will likely open the Pandora’s box of requests for special consideration from other providers. While such requests may well be justified in select cases, attention to these requests may place the goal of cost control in jeopardy.

RECOMMENDATION: Because high-cost illnesses and handicapping conditions occur in a very small proportion of children, it will be necessary to implement special payment and referral procedures to assure that very sick children get the care they need.

Several different strategies may be useful alone or in combination to address the special needs of high-cost children. Under a managed competition type model, health care plans could receive adjustments in their premiums to reflect the costs of treating high-cost enrollees including children. These higher payments would, however, need to be accompanied by extensive monitoring of the treatment of such patients to see that the additional money buys additional, appropriate care. Alternatively, health plans could be mandated, as part of a structural quality requirement, to contract with appropriate specialty providers and to arrange for capitation payments to the specialty providers to reflect the expected utilization of services. This would remove all referral disincentives from health plans and create an assured funding stream for specialty providers at negotiated rates. Capitated plans could be designed with point-of-service or stop-loss features which would allow the transfer of high-cost cases out of the plan when appropriate, or catastrophic cases could be monitored by independent case managers who would coordinate and assure access to necessary services. Of course, the viability of all of these options depends upon the existence of appropriate specialty providers. In rural or other underserved areas, it may be necessary to build relationships between primary care health plans and specialty providers to assure adequate access to specialty care.

Conclusion

It is beyond the scope of this analysis to discuss all aspects of health care reform as it concerns children. State and federal roles, global budgeting, and integrating health care with other programs are but a few of the important issues that have not been examined. But health care—even health care for children—is a mammoth enterprise which touches many lives. Thus, it should not be surprising that reforming it should prove so daunting. As this journal issue goes to press, close to 100 reform proposals have been introduced into Congress or floated by think tanks and special interest groups, and none appears to have won the support of the majority of Americans. The evidence suggests that it may be more useful to view health care reform as a process rather than as an event. It seems likely that progress will be gradual and that there will be many opportunities to amend and rethink policies.

Children have a big stake in health care reform, but their stake may be no greater than the stake of other population groups. Concerns about children are diverse, and the current debate on health care reform may be too focused on reform of the health insurance system per se. Attention should also be paid to reform of the health care delivery system so that it will better serve the health care needs of all children.
and the entire population. More attention to the many needs of children during the reform process may help that process focus more clearly on the different health care needs of the entire population.

Attention to the health care needs of children, however, should not divert attention from the fact that many of the special health care needs of children are the result of failures in families themselves and in the educational, social service, child protection, and environmental safety systems. Overreliance on the health care system to salvage and shore up social systems which are malfunctioning is likely to be ineffective and expensive and particularly frustrating in a cost-conscious environment. It seems most appropriate, therefore, to be vigilant in protecting children’s interests during the health care reform process, but to be cautious in not overselling the potential of health care reform to solve many of the problems children face. Rather, exposure of these problems during the debate over health care reform should be seized as an opportunity to widen the agenda and seek effective policies wherever they may be found.

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Marilyn Moon, Deanna Gomby, and Patricia Shiono provided thoughtful comments on this Analysis. In addition, Marilyn Moon’s participation in this project from its planning stages through the publication of this journal issue is gratefully acknowledged.

3. The analysis by Susan Bales in this journal issue also points out that a high level of public concern about the welfare of children may not find expression in support and a willingness to pay for expanded health insurance coverage for children.
4. Judith Feder’s participation as co-director of the forums is acknowledged with sincere appreciation. She, however, bears no responsibility for the content of this issue in its final form.
12. This is not solely a hypothetical concern. There is evidence that over time the expanding cost of Medicaid has lead to a substantial reduction in funds available for other important programs for needy children and families. Vladeck, B.C. Comments. In Proceedings of the fourth conference of the National Academy of Social Insurance: Security for America’s children. P.N. Van de Water and L.B. Schorr, eds. Dubuque, IA: National Academy of Social Insurance, 1992.
13. In a March 1993 survey by the Kaiser Family Foundation and Louis Harris and Associates, 54% of respondents said that, if coverage of the uninsured is phased in gradually, children and pregnant women should come first. However, in the same poll, 70% of respondents favored a gradual five-to-eight-year phase-in of extending coverage to the uninsured


15. For example, because Medicaid is being phased in gradually for budgetary reasons, most children currently between six and 19 years of age and living below poverty will never be eligible for Medicaid coverage under current federal legislation.


20. Medicaid expansion may segue relatively easily into a universal single-payer system like Canada’s. It may not work well, however, as a first step to an employment-based universal system.

21. The plan was opposed by the Minnesota Medical Association, which objected to some specific features including mandatory Medicare assignment and a 2% tax on doctors’ revenues. Slomski, A.J. Will Minnesota’s sweeping changes spread nationally? Medical Economics (December 7, 1992) 69,23:31-37. The plan also faces legal challenges from out-of-state hospitals over a tax on revenue they receive from Minnesotans and from self-insured benefit funds that do not want to pay for expanding coverage to the uninsured on ERISA grounds. In addition, cost containment efforts are handicapped by inadequate data. Minnesota round two begins. State Health Notes (April 5, 1993) 14,153:1,8.


25. Although it would cover many currently uninsured children, a children-only health insurance system based on an employer mandate appears ill-advised because: (1) it may be awkward to require employers to provide for dependents of employees and not the employees themselves; (2) it preserves the link between children’s insurance status and parent’s employment status which makes children’s status somewhat unstable and subject to fluctuation with external economic and other forces; (3) it is not likely to shift the cost of insurance from the family to the employer, because most of the burden of employment-based insurance is borne by the employee; and (4) it might lead to increased unemployment for low-wage workers with children as employers will find them more expensive to employ than workers without children.


27. Overall, families with children currently pay for a smaller proportion of their health care out of pocket and have a greater proportion of care financed through Medicaid and uncompensated care than childless adult families. In 1989, more than 90% of the direct costs of health care for families with children and no working adults (the poorest families with children) were financed by Medicaid and uncompensated hospital care. Only 8% of health care costs for these families were paid out of pocket. In contrast, married-couple families with no children and no workers paid for 36% of their health care directly out of pocket and received only 44% of their care through Medicaid and uncompensated care.
28. Children may also be affected indirectly if reaction to the broad-based taxes that are used to finance reform makes it difficult to raise revenue for other children’s programs or if the new taxes fall disproportionately on families with children.


33. One very hotly debated new benefit which may be included in a health care reform package is long-term care for the elderly. A comprehensive package of coverage for this service could add $65 billion to the cost of health in the short run and many billions more each year as the population of eligible elderly continued to grow over time. Pear, R., and Rosenbaum, D.E. As health plans come together, big price tag comes into focus. *New York Times.* April 19, 1993, at A1.

34. The Health Standards Board, as proposed by the Jackson Hole Group, appears to be a reasonable prototype. Ellwood, P.M., Enthoven, A.C., and Etheredge, L. The Jackson Hole initiatives for a twenty-first century American health care system. *Health Economics* (October 1992) 1,3:149-68.


36. However, many critiques of these programs, especially Medicare, have concluded that a conscious effort was made not to limit costs as one way of “buying” support from physicians. Marmor, T.R., and Marmor, J.S. *The politics of Medicare.* Chicago: Aldine Publishing Co., 1973. This attitude certainly does not hold in the current debate.

37. According to Alain Enthoven, its leading architect, managed competition is consonant with American preferences for limited government, voluntary action, decentralized decision making, individual choice, multiple competing approaches, pluralism, and personal and local responsibility; Enthoven, A.C. The history and principles of managed competition. *Health Affairs* (1993) Supplement:24-48.

38. In the current market for health insurance, plans vary widely, information on total cost and quality is hard to come by, and consumers may have only limited incentives to purchase cost-effective health insurance plans because of heavy subsidies and high information costs. It is conceivable that managed competition, with its emphasis on providing consumers with the information they need to make price- and quality-conscious purchases, could change the environment for managed care plans and stimulate them to take advantage of any inherent efficiencies they possess. It may be only in such a competitive system that the true potential of managed care to control costs and assure quality can be evaluated.


41. In addition, the personal health care system may have limited ability to prevent mortality among children because mortality among children above one year of age is principally due to injuries and violence. Starfield, B. Child and adolescent health status measures. *The Future of Children* (1992) 2,2:25-39.

42. Low and very low birth weight are outcome measures which occur frequently enough and are of sufficient consequence to warrant their use as measures of quality in health care plans for pregnant women and children. Unfortunately, comprehensive linkages between medical practice and the incidence of low birth weight are not well established.


44. Ironically, information on the individual components of care is most easily obtained in a fee-for-service reimbursement system in which each activity can generate a claim form. For reasons of cost savings, health reform is likely to rely more on capitated and other
types of global payment systems. Under these systems, it may be necessary to develop and maintain separate process monitoring systems to measure and assure quality practices and acceptable outcomes.

45. For example, the prevention of injuries and violence are public health activities which would remain important under any reform initiative. Most reform initiatives concentrate on modifying the delivery of personal health services. The issue of where and how public health activities will fit into a reformed health system has been the subject of concerned commentary by much of the maternal and child health community, but it has yet to be resolved. See note no. 22.


48. See note no. 32, Perloff, and note no. 46, Klerman.

