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Designing Children's Health and Health Care

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Debate on reauthorization of the State Children's Health Insurance Program (SCHIP) will dominate health care policy discussions in Congress and state capitals over the next several months, as the program is set to expire on September 30. With that as a backdrop, *Health Affairs* is pleased to announce the release of its March/April 2007 issue, which is devoted to questions surrounding the health of children and how to best provide coverage and care for children in the twenty-first century. This issue of *Health Affairs* was produced with support from the California Endowment, the Nemours Foundation, and the David and Lucile Packard Foundation.

The feature papers fall into three main categories:

- **Societal investments in children** to promote and optimize their development, health, and long-term well-being
- **SCHIP policy debates** ongoing in Washington and state capitals about the insurance program and its relationship to Medicaid and proposals to cover all children
- **The needs of the whole child**, including the challenges of meeting physical, behavioral, and social needs, as exemplified by the childhood obesity epidemic

Kids and the U.S. Health System

Neal Halfon and University of California, Los Angeles (UCLA) colleagues lead off the volume with a description of our current health care system as one built on an outdated model most noted for its fragmented financing and delivery systems and lack of ability to address the prevention and developmental needs of children. They discuss the system's underperformance relative to other developed nations, as evidenced by widespread quality and safety challenges and pervasive disparities, and its inability to respond to the growing socio-behavioral needs of children. To address the lifelong needs of our population, Halfon and colleagues write, we need a dramatic transformation of health care that would require significant realignment of federal and state programs and financing to provide bundled or "nested" services that are vertically and horizontally aligned. **Daniel Eisenberg and Gary Freed of the University of Michigan discuss how society prioritizes and values health interventions**. They point out that our current analytic techniques—even cost-effectiveness analysis—tend to undervalue interventions for children, such as the HPV vaccine, thus making them less likely to be widely adopted in a health system increasingly focused on costs.

Vulnerable Children

In two separate pieces, **Janet Currie (Columbia University) and Wanchuan Lin (UCLA), and Matthew Bramlett and Stephen Blumberg (both of the Centers for Disease Control and Prevention, CDC) call attention to the most vulnerable of children**: those from low-income families and in poor health. Currie notes that even when controlling for income for poor children, we still do not adequately understand or account for the limitations of poor health, particularly poor mental health, dental disease, and vision and hearing disorders. Bramlett and Blumber show for the first time how grandparent-headed families compare to other family structures. The authors conclude that children in families headed by two biological parents or by a single father fare much better on measures of physical and mental health than do children of families headed by single mothers or grand- or stepparents.

SCHIP and Medicaid

A second theme of the issue concerns the history, unique interplay, and future challenges for SCHIP and Medicaid. **Genevieve Kenney and Justin Yee of the Urban Institute outline the successes of SCHIP over the past ten years**. At any given time, more than 6 million children are enrolled in the program, and about 5 percent of all U.S. children rely on SCHIP. Unlike adults, whose rates of insurance coverage and employer-sponsored insurance have declined in the last decade, rates for children went up for most of the period between 1997 and 2005, largely due to SCHIP and Medicaid expansions. The authors counter some previous econometric predictions that suggested that the "crowd-out" phenomenon would be larger than it has been. **The relationship between employer-sponsored coverage for children and crowd-out for the SCHIP population is explored more intensively in a related DataWatch by Anna Sommers, Stephen Zuckerman, Kenney (all of Urban), and Lisa Dubay (of the Johns Hopkins University).** The authors conclude that few SCHIP enrollees could have obtained private coverage.

The challenges facing SCHIP during the reauthorization debate include

- Providing enough funding for the program to continue covering current eligible children
- Providing funding for its innovative and flexible approaches to outreach and retention

- The enrollment of parents and eligible children
- Finding a funding structure that would reward exemplary states
- Creating simplified renewal and retention processes

Studies to address and monitor the quality and costs of care are also needed.

These issues facing SCHIP are mirrored in discussions about Medicaid. **Dubay and colleagues from Georgetown University remind us that Medicaid is the largest public insurance program in the country for children**. Overall, Medicaid covers 80 percent of all children in public coverage. Passage of SCHIP spurred Medicaid to focus on children and to engage in policies and procedures that paralleled SCHIP efforts in reducing barriers to enrollment, engaging in outreach, and easing and simplifying retention. In a DataWatch, **Gerry Fairbrother of the Cincinnati Children's Hospital Medical Center and colleagues reveal that Medicaid varies greatly across states in enrollment retention**. In some states, Medicaid provides a continuous source of coverage; but in other states, sizable numbers of children experience gaps, albeit brief ones, in coverage. Beyond the vast improvements made in streamlining enrollment and retention procedures, **Mireille Jacobson (UC Irvine) and Thomas Buchmueller (University of Michigan) describe outreach innovations in California** that involve paying private insurance brokers and tax preparers to provide application assistance to potential SCHIP enrollees. All the Medicaid and SCHIP papers note the threats posed to these programs by budget shortfalls and administrative barriers, such as caps, waiting periods, and the birth certificate requirement for U.S. citizens for Medicaid enrollment required by the Deficit Reduction Act (DRA).

While Medicaid and SCHIP have had much in common over the last decade, they differ in one crucial measure: Medicaid coverage for children is an individual entitlement, whereas SCHIP is not. Medicaid coverage for children has historically been based on core health and developmental principles, whereas SCHIP programs and features of the DRA take their cues from the model of private insurance, thus potentially providing fewer benefits with greater variation across time and beneficiaries. **Sara Rosenbaum (George Washington University, GWU) and Paul Wise (Stanford) explore this tension in their piece on the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit**. Stephen Berman (University of Colorado) proposes four ways of combining Medicaid, SCHIP, and private insurance to provide universal coverage for children.

In a perspective, **Len Nichols (New America Foundation) reminds us that all children, and particularly poor children, should have a very special place in any discussion of budget priorities**, as providing for them and protecting them are the cornerstones of our faith traditions.

School-Based Care

In the closing section, **Julia Lear (GWU) reminds us that there is a parallel system of health services**, with approximately 200,000 people providing care to children in school settings. **Edward Schor, Melinda Abrams, and Katherine Shea of the Commonwealth Fund make the explicit connection between optimal health coverage and educational achievement**. They tie the use of Medicaid's EPSDT requirement to the promotion of school readiness.

Obesity

The fight against obesity—a major challenge for many Americans—has already met with some success in schools. **William Dietz (CDC) and colleagues provide the evidence for adopting behavioral change strategies in a variety of settings**, and **Charles Homer (Harvard) and Lisa Simpson (Cincinnati Children's Hospital Medical Center) offer a perspective from the National Initiative for Children's Healthcare Quality to act on the evidence we have** and to combat obesity. **How to engage a community in addressing obesity in particular, and influencing behavior in general, is also the theme of Debbie Chang's (Nemours Health and Prevention Services) paper**. It highlights how one foundation with thoughtful preparation and the engagement of community leaders and groups can implement health promotion and prevention activities integrated within a large pediatric health system, influence behavioral change, and tackle childhood obesity in one of Delaware's poorest counties.

In a closing commentary, **Janet Golden, a historian from Rutgers, and Howard Markel, a historian and pediatrician from the University of Michigan, remind us that a century ago the United States embarked on an ambitious program headed by the Children's Bureau to address the problems of children**, particularly infant mortality. Partly from this commitment, the United States was once the world leader in meeting children's medical needs. In contrast, as indicated in the dismal findings of a recent UNICEF report, the United States now ranks second to last among twenty-one industrialized nations in child well-being, which suggests that history may indeed have a lesson to teach us.