Expanding Health Insurance for Children

BY MARGUERITE Y. HOLLOWAY

Robert Wood Johnson Foundation

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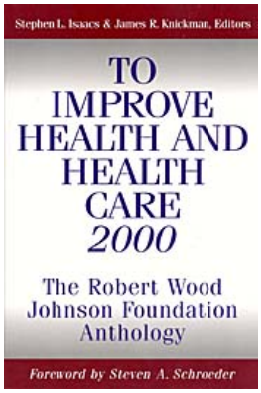

Edited by
Stephen L. Isaacs and
James R. Knickman
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Editor's Introduction

The Foundation has long given high priority to improving the health and well-being of children, although this has never been articulated as one of its specific goals. Over the past quarter century, it has awarded almost 9,000 grants for these purposes. The Foundation has funded regional perinatal networks, large maternal-child health programs, community-based substance abuse programs and initiatives to reduce childhood injuries–to name just a few. Some of the Foundation-funded programs to improve children's access to health care services have been discussed in the *Anthology* series: school-based health clinics (2000 *Anthology*), mental health services for children (1998–1999 *Anthology*) and childhood immunization programs (1998–1999 *Anthology*).

In this chapter, Marguerite Holloway, a contributing editor to *Scientific American* and an adjunct professor at the Columbia University School of Journalism, examines the Foundation's efforts to secure health insurance for children whose parents do not have coverage.

Her chapter offers valuable lessons for philanthropy and for public policy more generally. It demonstrates the problems encountered in developing programs in a complex and highly political environment, the importance of foundations' maintaining the flexibility to meet rapidly changing conditions, and the difficulty of determining whether or not programs have been successful. *Healthy Kids* is a good illustration of the last point. This Florida program, designed to provide health insurance to school children, was originally funded by a small Foundation grant and later by state and federal funds. It earned a coveted Innovations in American Government Award from Harvard University and the Ford Foundation, was widely emulated, and served as the model for a Foundation-supported program that expanded the approach to other states. At the same time, the program enrolled only about 20 percent of the eligible children (a high proportion of whom tended to be sicker than those who didn't enroll, thus making it costly), did not achieve its goal of self-sufficiency, and ultimately abandoned the school-based model on which it had been based. Readers will be able draw their own conclusions about whether the program represents a successful model for expanding insurance coverage or whether it was conceptually flawed from the start. More generally, readers are invited to consider how success should be measured. If a program such as Healthy Kids is able to provide a mechanism to insure some children and improve the lives of their families but fails to provide a workable model that can be adopted more widely, is it a success or a failure?

Karen Fulton has been caught in the Bermuda Triangle of America's health care system. A single mother in Fort Myers, Fla., she is considered too well off to qualify as poor in the eyes of the state, and yet she is too poor to ensure that her child is well off. So Fulton has worked three or more jobs at a time to earn less than $15,000 a year to make her car payments and to keep James, age 10, clothed and fed and cared for. Sometimes a job would provide her and her son with health insurance. But for most of 1997, Fulton found herself without such coverage, unable to afford insurance even for James. And although he is a healthy child, Fulton was worried.

"I applied to Women, Infants and Children, and I didn't qualify," she says of the federal food supplement program. "I felt it was because I came in with clothes that didn't have holes in them. They would rather that someone not work." Fulton's jobs made her and James ineligible for any assistance, whether food stamps or Medicaid.

Last spring, James brought home a reprieve in the form of a one-page document. His school had distributed applications for a children's health insurance program that was being started in Lee County. "You just fill out the form at the beginning of the year," Fulton says. "They do a check on you, verify your income, and you get to choose your doctor from the packet." For $10 a month, Fulton now covers James under the Florida Healthy Kids Corporation. The braces he will need next year will cost Fulton $90 a month instead of the $190 she was going to have to pay. She has been able to quit her weekend job as a saleswoman at a nearby mall, and now juggles only two jobs, cleaning offices and working as a receptionist.

Although Fulton and some 940 other families in Lee County have just signed up for insurance through the Florida Healthy Kids Corporation, the program has been around since 1990. The brainchild of researchers at the Institute for Child Health Policy at the University of Florida, the Florida Healthy Kids Corporation uses schools as a vehicle to reach children without insurance. Families pay for coverage on a sliding scale that is determined by their income, and they are responsible for certain copayments. The rest of the money is provided by the federal and state governments and by each participating county. As of late 1998, about 60,000 children were enrolled, and 34 of 67 counties were involved.

HEALTH INSURANCE COVERAGE OF CHILDREN

The Florida program, which the Robert Wood Johnson Foundation helped establish and has funded since its inception, was designed to help people like Fulton, who are often stuck in the netherworld of the working poor. In a slow but disturbing erosion, employers have increasingly shifted away from providing

coverage to employees and their dependents: in 1990, more than 67 percent of workers obtained insurance for themselves and their families through their employers; in 1995, less than 64 percent did.[1] Between 1988 and 1992, an estimated three million children lost employer-based coverage.[2] At the same time, those companies that still cover their workers are reducing coverage, leaving many dependents without insurance.

The result has led to a seeming paradox: today, 57 percent of uninsured adults work full-time and another 20 percent part-time.[3] In other words, those unable to afford coverage primarily work in low-paying jobs—as waitresses, salespeople, attendants, secretaries, receptionists, construction workers, farmers, clerks, data processors. In terms of their own and their children's health insurance, they are penalized for having jobs.

This trend not only has contributed to the number of American adults without health insurance—estimated at 33 million—but has affected their children as well. In early 1996, nearly 11 million children 18 and younger had no health coverage, and more than 80 percent of them belonged to working families.[4] This is reflected in the poor health of poor children. Children lacking coverage are six times as likely to go without medical care—including treatment for a serious injury—as their privately insured counterparts. Low-income children are less likely to get glasses, dental care or help for mental health problems.[5] They are more likely to have pneumonia, asthma, anemia and diarrhea.[6] And they are five times more likely to rely on emergency rooms as their regular source of care, because their caretakers cannot afford preventive treatment.[7] In emergencies, parents of uninsured children may delay bringing them to an emergency room. By the time they arrive, they are often in worse condition than they would have been with prompt treatment.

THE FOUNDATION AND CHILDREN'S HEALTH INSURANCE: A ROAD MAP

Improving the health of America's children has been a priority of the Robert Wood Johnson Foundation since its inception in 1972. Among the Foundation-funded programs have been those that attempted to expand insurance coverage for children. The first was the Healthy Kids Program, begun in Florida in 1990. Although it improved services for the children it insured, the program did not attract a significant number of children. Nevertheless, as a result of its apparent success, the Foundation established, in the mid-1990s, the Healthy Kids Replication Program, which provided funding to states that wanted to follow Florida's model. In 1997, following the defeat of President Clinton's health reform plan, the Foundation established a new nationwide effort, *Covering Kids,* which focused on a different priority: finding children legally entitled to Medicaid and ensuring that they received coverage.

In the midst of this, a huge federal initiative completely changed the country's financial and philosophical attitude toward the issue of coverage for children. Suddenly, in the fall of 1997, massive amounts of money became available to states through the State Children's Health Insurance Program (CHIP). In this new environment, states needed guidance, and the staff members of Covering Kids suddenly found themselves in great demand–as did those working with a well-established Robert Wood Johnson Foundation program called *State* Initiatives in Health Care Reform. The Healthy Kids Replication Program, however, became largely obsolete. In fact, the federal CHIP money arrived just in time to mend huge structural cracks that had appeared in some Healthy Kids programs.

The successes and shortcomings of the Foundation's efforts to insure children shed light on the complicated relationship between foundations and government initiatives. They also raise an interesting question: Is the emphasis on covering children rather than adults a good long-term strategy? In this regard, the Foundation's focus has mirrored the country's. In both spheres the choices could have important implications for access to health care in the United States–for children and for adults.

FLORIDA HEALTHY KIDS

The Florida Healthy Kids Corporation began as a series of coincidences in the life of public health expert Dr. Steve Freedman, executive director of the Institute for Child Health Policy, a research group founded in 1986 at the University of Florida. His daughter came home with a school form that offered the Freedmans the option of buying accident insurance for her in case she was hurt on school grounds. That same week, Freedman himself received a flier from a professional organization offering him major medical insurance. Freedman, who, with his colleagues, had just been documenting the fact that employer-provided private insurance was covering fewer and fewer Florida children, was primed for the synchronicity. He asked, "If businesses as a group were failing, why not try to find another major grouping mechanism? Why not schools?" Since two-thirds of uninsured Americans live in households that have school-aged children, the idea was fortunate. To many observers, it seemed to be the kind of simple solution that is so obvious no one ever thinks of it.

Freedman wrote up his idea and sent it to the *New England Journal of Medicine*. That 1988 essay[8] led to calls of support and interest from people all over the country. The same year, the Robert Wood Johnson Foundation–which had already been supporting work at the Institute for Child Health Policy–and the Maternal and Child Health Bureau of the federal Department of Health and Human Services gave Freedman and his team money to do a feasibility study. The researchers were to find out whether schools

could work as a way of grouping kids–just as IBM and a union such as the United Auto Workers group their members–in order to set up an inexpensive insurance program.

The results of the feasibility study looked promising, and things moved quickly. Just two years after the original journal article, the Florida legislature unanimously passed a law creating the Florida Healthy Kids Corporation. This corporation would administer the program, meeting with school district leaders and negotiating contracts with health maintenance organizations and insurers. One idea that most attracted the state government was the promise that in the long term the costs for the entire program would be assumed by the counties–which, in Florida, are the same as school districts. Under Healthy Kids, families would buy insurance from the public sector, and the state would, in large part, subsidize the insurance premiums–but only over the short term. As more and more families signed up, the reasoning was that premium prices would fall and that the counties would ultimately be able to pay all the costs of the program that were not being met by the families. The approach appealed to politicians looking to keep their fiscal outlays down. "A lot of states were trying to do things for kids' health, but our model was unique," says Rose Naff, executive director of the corporation. "It deviated from the traditionally accepted ways of providing coverage. It was not Medicaid, and it was not Title V." (Title V refers to federally funded programs to improve maternal and child health.)

Soon after the legislature established the corporation in 1990, the Foundation gave Freedman and his colleagues money to set up the administrative structure of the project and to do a demonstration in one school district: Volusia County, where about 25 percent of 12,000 school-aged kids were thought to be uninsured.[9] "We picked a county that had all the characteristics of Florida," Freedman says. "A mix of urban and rural, of migrant workers and service industry. The full socioeconomic spectrum."

The results of the pilot appeared positive–even dramatic. Three years after Healthy Kids was initiated in Volusia County, researchers in the county's tax department determined that emergency room visits were down 70 percent.[10] Although Freedman notes that reducing expensive emergency room visits was not a specific goal of the Healthy Kids model, it was anticipated. "The original goal was to be sure kids had a 'medical home'–that they used appropriate health care," he says. "Embedded in that idea is less use of the ER." In other words, the children were using a physician, not the emergency room, as the source of their regular medical care.

The apparent success in Volusia County soon led the corporation to expand the program, county by county. It reached Karen Fulton's county at the beginning of 1998. By the end of that year, about sixty thousand children between age five and eighteen were enrolled. (Newborns and toddlers are covered

under another series of federal and state programs.) The target, according to Naff, is 124,000 kids by the middle of 1999. "It has been very positive," she says. "We are not viewed as government in the eyes of the members. They have real doctors. They like the 24-hour access to care."

More important, their health care has improved. According to a 1998 report by the Institute for Child Health Policy–which has done almost all of the studies assessing the corporation's impact on children's health–more than 98 percent of the families enrolled in the plan say that their doctor or clinic, not the emergency room, is their primary source of care.[11] The report indicated that families are satisfied with the Florida Healthy Kids Corporation plan because, as it notes, "those without insurance often do not have a usual source of care." Another study by researchers at the Institute for Child Health Policy found that Florida Healthy Kids participants were receiving the care that they needed and that administrators and health care experts had anticipated they would need.[12]

In other ways, however, Florida Healthy Kids has fallen short. First, it is voluntary, so many eligible kids remain uninsured because their families don't want to sign up. Naff argues that this is not a conceptual flaw in the Healthy Kids model, because expecting 100 percent participation in a voluntary program is unreasonable. Nevertheless, many of Florida's kids have not been covered. Out of the state's estimated 820,000 children who do not have health insurance, 270,000 are eligible for Medicaid and 225,000 (half of the remaining 550,000) could conceivably enroll in Healthy Kids, according to Naff. So at the end of 1998 about 20 percent of the children who could have been covered were enrolled in Healthy Kids. The corporation set a goal of signing up a total of 124,000 children by the middle of 1999–but without more money from the state and federal government, Naff says, Healthy Kids cannot expand further.

Second, the original program plan specified that counties and families would gradually assume a greater share of the costs, letting the state off the hook. But "the problem was that the counties with money were the only ones who could afford it [covering the health insurance premiums]," says Jana Key, who recently left the Healthy Kids Corporation to work at Georgia's PeachCare for Kids. "And the kids in rural counties were still going uninsured."

"The shift to county-based funding didn't seem to have any real hope of panning out without significant taxes," notes Burton Edelstein, director of the Children's Dental Health Project in Washington, D.C., who has worked on children's health policy issues for Sen. Thomas A. Daschle. Florida Healthy Kids "was getting into difficulty with the premiums, and the healthy kids were dropping out," Edelstein says. "There was adverse selection." In other words, parents with ill children would participate, and those with well

children would stop buying the policy–until their children got sick, and then they would enter the system again.

Adverse selection and the financial disparity between the counties is part of the reason the corporation's current financing looks very different from what it was supposed to. The plan that the Florida state legislature endorsed in 1990 promised that counties would eventually pay for everything; the state government would not be responsible. "The state legislature was seeing in ten to fifteen years having no financial liability," Key recalls. Until recently, however, 45 percent of the financing came from the state, 37 percent from families and a mere 18 percent from the counties. Now, because of the recent changes in federal funding for children's insurance, Naff says that support for the roughly $90-million-a-year program comes mostly from the federal government (specifically, $37 million comes from the federal government, with about $20 million coming from the state, $18 million from families, $8 million from counties and $7 million from the tobacco settlement). Without this influx of federal money, Healthy Kids would be limping along.

The school-grouping approach has also fallen by the wayside. Although the school-based model worked initially, Key says some counties were unhappy with it. These school districts argued that schools were there to teach, not to be involved in health care. So the corporation now uses an additional, more traditional, means of outreach–advertising. "We still distribute in schools–they are the best, number-one place to find kids–but we no longer require that kids are in school," Naff says. She sees this shift away from schools as positive: "It has simplified our administration tremendously."

THE HEALTHY KIDS REPLICATION PROGRAM

From the outset, the Florida Healthy Kids Corporation attracted national attention. Over the years, staff members have talked to, advised, or given tours to people from 36 states. The combination of private and public funding was particularly attractive to some legislatures, including those of Colorado, Georgia, Iowa, Kansas, New Hampshire and Texas. Each had its own take on how the model could be altered to suit its particular social or political makeup.

New Hampshire, for example, wanted a way to insure kids that would not cost the state anything. Legislators became interested in Florida Healthy Kids when child advocates in New Hampshire invited Freedman to a seminar. It was just after Volusia County had started to show results, and the plan became interesting to the state government–if it could undergo one major alteration. "It was sold in New Hampshire as a plan that could potentially be self-funded," says Tricia Brooks, executive director of the New Hampshire Healthy Kids Corporation. Legislators "didn't want subsidies," she says. "We are a low-tax,

low-government state." In 1993, the state approved New Hampshire Healthy Kids, but provided only $240,000 in seed money. When Brooks was hired in early 1994, she found herself and her team on their own trying to figure out how to make the program happen without any more government dollars. "The first thing I did was go down to Florida to spend several days learning what was working for them and plagiarizing as much as I could," she says.

Despite what she learned, it has been tough going in New Hampshire. Although Brooks and her colleagues found that Blue Cross/Blue Shield was willing to donate administrative costs and forgo profit in order to cover kids, the financing did not work out. "We had enrolled 1,600 by the end of the second year, so we thought we were doing pretty well," Brooks says. But the dental provider had not anticipated how many kids would visit the dentist, and the company suddenly found that it had lost $100,000. The New Hampshire Healthy Kids Corporation had to pass along some of the added costs to the families, covering less dental care and requiring $250 in deductibles for certain forms of care. Enrollment has evened out at eighteen hundred, leaving another eight thousand or so eligible for the program (an additional fifteen to twenty thousand uninsured children are eligible for Medicaid). Thus, the New Hampshire program enrolled about 20 percent of the children it targeted. Brooks found that $50 a month was the maximum that families could swing, and she was worried that the program was not going to expand without outside financial help.

Despite low enrollments, the Healthy Kids approach was considered successful, and in 1996 the Florida Healthy Kids Corporation received an Innovations in American Government Award from Harvard University and the Ford Foundation. By the mid-1990s, several states were attempting to start programs of the Healthy Kids type, "but none were statewide and none were completely comprehensive," says Jill Meenan, a consultant for the Florida Healthy Kids Corporation. "It was the perfect time to take the model and use it." In response, the Robert Wood Johnson Foundation did just that: it established the $3 million Healthy Kids Replication Program. The National Program Office, formerly directed by Meenan, began operating in 1996.

Meetings for applicants were held at the beginning of 1997, and 13 states initially applied. The Foundation ultimately awarded planning grants to Colorado, Georgia and Iowa and implementation grants to New Hampshire and Texas. Several–including Colorado, Georgia and New Hampshire–were already far along in their planning process, and the grants essentially gave them a final boost. In addition, the national program office provided technical assistance to states interested in covering children and

issued reports, including one on how to establish a pediatric network and another on how to issue a request for proposals for health insurers.

COVERING KIDS

At the same time that the Healthy Kids Replication Program was getting under way, staff members at the Robert Wood Johnson Foundation were considering ways to cover uninsured children who did not need a program like Healthy Kids. These were the millions of children who were eligible for Medicaid but who were not signed up.

In July 1997, the Foundation approved the creation of a new program, Covering Kids, which would fund efforts to find low-income children who had fallen through the cracks. "We have to remember that there are millions of children–about 4.5 million–who are eligible for Medicaid and are not enrolled," says Sarah Shuptrine, president of the Southern Institute on Children and Families in South Carolina and national program director of the Covering Kids program. "The reasons for this failure are complicated." It could be that the parents of these children are just recently off welfare and don't know that their kids are still eligible for Medicaid; it could be that they don't want to rely on government-sponsored insurance because of the stigma; and it could be that the application procedures are so Byzantine and humiliating that they discourage parents from coming in.

Covering Kids also tried to simplify the lives of parents by making the application process easier–but still rigorous, so that it is not susceptible to abuse–and thereby expand enrollment. "You have got to make the process less burdensome and demeaning to parents," Shuptrine says. Further, because the Covering Kids National Program Office will accept only one application per state, it forces collaboration between all the groups advocating for, or covering, children in that state. This eliminates duplication and allows groups to see how difficult they are making the process for parents and their children.

Just one month after Covering Kids was approved, Congress passed the State Children's Health Insurance Program (CHIP). Covering Kids suddenly found itself at the center of a nationwide maelstrom, as state agencies hurriedly tried to figure out how to create insurance programs for children, how to expand Medicaid, how to find children eligible for Medicaid and how to get them enrolled. Within a year, Covering Kids grew from a $13-million project designed to fund 15 states to a $47-million project that by January 1999 was supporting programs throughout the United States.

THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM

For a big, political, bureaucratic initiative, CHIP happened very quickly. President Clinton talked about insuring children in his 1997 State of the Union Address, several members of Congress picked up the charge, and by August the country had a plan. In the early stages of their research, politicians and their staff members examined the states that had innovative approaches, Florida being among them. "When everything was being designed at the federal level, there was a need to show a way to do it," Georgia's PeachCare for Kids' Jana Key explains. "Florida Healthy Kids showed that there was a public response. We showed that families that paid were more likely to access the service." Key notes that many people did not want to sign up for Medicaid because of the stigma of receiving a handout: "For the most part, people really respect their dignity and their ability to provide for their families."

Congress also examined the benefits of expanding Medicaid, and what emerged from the deliberations was a law that granted states great flexibility in their approach. This flexibility acknowledged that a number of states–including Florida, New York, Pennsylvania, Vermont and Washington–already had strong programs in place, and that the rest needed to tailor expansion to their particular constituents. Under CHIP, states can expand Medicaid, expand other programs, design new ones, or create some combination of programs.

CHIP'S IMPACT ON THE FOUNDATION'S PROGRAMS

The passage of CHIP, which makes $48 billion available over the next ten years, affected Covering Kids and other Foundation-funded programs. Although Covering Kids was designed before CHIP appeared, it seemed to be tailor-made. The federal and state money goes primarily toward buying care for children. Covering Kids goes toward finding them. "The challenge is getting kids enrolled: this is the do-or-die question right now," says Stan Dorn, an attorney at the National Health Law Program.

Covering Kids was able to respond to rapidly changing national policy, but the Healthy Kids Replication Program found itself somewhat obsolete after CHIP. "It is just not necessary now," says Jill Meenan, who was the national program director for Healthy Kids. "So after this set of grants finishes, I don't think that it will try to be a national program anymore."

In a political landscape where few options flourished for children, Healthy Kids provided a creative model. "The replication strategy was a very smart move when it was set up before CHIP," Dorn says. "But after CHIP, Florida Healthy Kids didn't represent the high-water mark for children. It was not all that

children could get." Indeed, to a large extent, CHIP bailed out the Florida program. "Luckily, CHIP came around and provided the state with funds before it became a huge problem," Key says.

CHIP also influenced the direction of some activities under the State Initiatives in Health Care Reform program. Since 1991, this program has sought to help states that need policy advice when they seek to expand coverage. Although the State Initiatives program is focused on coverage for all Americans, it has "done several special things targeted just at kids," notes Anne Gauthier, vice president of the nonprofit Alpha Center, the National Program Office for State Initiatives. For instance, a May 1997 report, "Expanding Children's Coverage: Lessons from State Initiatives in Health Care Reform," reviews the approaches taken by nineteen states to cover uninsured children in low-income families not covered by Medicaid. The examination of the various strategies–Medicaid expansion, state subsidies to children and families, state subsidies to employers and their employees, tax incentives and vouchers–provides a road map for states.

When CHIP came along, State Initiatives helped Oregon gather information and do planning and analysis so the state could figure out how to mesh CHIP with its Family Health Insurance Assistance Program without undermining employer-based coverage. State Initiatives has been helpful to other states trying to grapple with CHIP as well. "Since the advent of CHIP, there has been a higher demand for technical assistance, lots of monographs and meetings," Gauthier says. State Initiatives "will help a state decide which kids to cover and how far up the poverty scale. The point is that we help them with the overall design."

CHIP also affected the direction of the analyses undertaken, with Foundation support, by the Institute of Medicine. In the summer of 1996, the Foundation awarded a grant to the National Academy of Sciences to conduct a study on the relationship between children's health insurance and access to health care. In the middle of preparing its report, "America's Children: Health Insurance and Access to Care," which was published in the summer of 1998, the Academy's Institute of Medicine found itself grappling with CHIP. "Things were happening so fast," says Margaret Edmunds, who directed the study and who recently left the Institute of Medicine to join the Children's Defense Fund. The sudden political change led the Institute to do a second report, more narrowly focused on CHIP. This report, "Systems of Accountability: Implementing Children's Health Insurance Programs," was published in the fall of 1998 and outlined the potential pitfalls of CHIP.

CHILDREN AND THE FUTURE OF ACCESS TO HEALTH CARE

Focusing on insuring children has been a strategic choice for the Robert Wood Johnson Foundation, one means to an end: to ensure that all Americans have access to basic health care. Surveys–as well as the failure of President Clinton's health care reform efforts–indicate that Americans are not particularly concerned about the health or well-being of their neighbors. But their neighbor's child seems to be another matter.[13] By working to cover children, the Foundation determined that it could help a group that was relatively inexpensive to insure and that it could avoid the debate about whether the uninsured deserved coverage or not. No one could argue that kids weren't deserving. And by getting people to understand the problems facing the nation's children, the Robert Wood Johnson Foundation hoped to build up the public's interest in the larger picture and the Foundation's ultimate goal: providing access for everyone.

This approach–insuring children as both an end in itself and as a springboard to broader coverage–is controversial. Steve Freedman, of the Institute for Child Health Policy at the University of Florida, agrees with this approach for two reasons. First, he notes, there is some evidence that children actually get better care if they are the focus of a health care plan rather than tagalongs in an adult plan. "When you mix kids and adults in the insurance world, kids come out on the wrong end of the stick," Freedman says. Second, he argues that children are the key to future attitudes toward health insurance. "If we raise a generation of insured children, they will see health insurance in the same way that we see public schools: it will become part of the social fabric," he says. "They will never have been without insurance."

But whether starting with children will prove to be the easiest means to this end remains the subject of strong debate. "I think the jury is out on that," counters Anne Gauthier of the Alpha Center. "There is the argument that if we expand coverage for kids there would not be any momentum to do anything else. And the states that have expanded insurance for kids are thinking that they need to do parents as well." D'Anne Gilmore, former deputy administrator of the Oregon Health Plan, agrees with Gauthier. She explains that she used to be a strong advocate for expanding coverage for children first and foremost–and that she butted heads with the governor on this issue. "He felt that we should not segment people into worthy and unworthy categories," she recalls. "His view was that everyone should have publicly financed coverage." Gilmore now thinks the governor was right–in Oregon, at least. "If you take care of the adults, the kids get taken care of, and that was counter to my logic," she says. "We found that if you could plug a family into things, then the kids were much more likely to get care. If it was only focused on kids, then participation dropped."

However the story unfolds, the Robert Wood Johnson Foundation will continue to look at all possibilities–for children and for uninsured adults. It is not putting all its eggs in one basket, says Pamela S. Dickson, a senior program officer at the Foundation, but, rather, is operating on the principle that, if you cast a thousand seeds, a few will bloom.

Notes

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[12] E. Shenkman and others. "Children's Heath Care Use in the Healthy Kids Program." *Pediatrics,* 1997, 100(6), 947–953.

[13] M. Rothman. *Defining a Grant Making Strategy on the Working Uninsured Issue: Report to the Robert Wood Johnson Foundation.* Princeton, N.J.: The Robert Wood Johnson Foundation, 1998. According to the same report, 52 percent of Americans surveyed think that children should be the focus of any limited efforts on the part of the government to increase coverage. Only 19 percent felt uninsured working people were so deserving.