



AMERICAN ACADEMY OF PEDIATRICS

Committee on Child Health Financing

Financing Health Care for the Medically Indigent Child

Children should not be denied access to the health care system because of financial barriers or preexisting medical conditions, and yet evidence suggests that for millions of children this is the case. The American Academy of Pediatrics (AAP) in its 1986 "Medicaid Policy Statement" and its 1983 "Principles of Child Health Financing" espoused the belief that all children have a right to receive comprehensive and quality health care.

Regrettably, no national policy exists which addresses medical indigency among children and their families. Although most state legislatures have considered the indigent care issue, they have focused primarily on hospitals' uncompensated care burdens and not on ambulatory care needs. Moreover, because of budget implications and the lack of federal revenues, these state initiatives appear to be limited measures and are not intended to support comprehensive, long-range health care plans for the medically indigent.

Data show that lack of ambulatory care is a significant problem for medically indigent children. Comparisons of average numbers of visits to physicians for uninsured and insured children point to measurable service gaps.¹ In particular, medically indigent children are not receiving the primary preventive care promulgated by the AAP and its "Recommendations for Preventive Pediatric Health Care."

The AAP believes that equitable financing solutions for the medically indigent child must be developed immediately. The purpose of this statement is to inform AAP Fellows and health policymakers of the growing numbers of underserved children

and to recommend remedial action by the federal, state, and local governments, as well as the private sector.

CHILD POPULATIONS AT RISK

In our society, medical indigence stems from either a family's total lack of health insurance coverage, the uninsured, or the inadequacy of such coverage, the underinsured. Data from the 1980 National Medical Care Utilization and Expenditure Survey and other more current national surveys estimate that between 12 and 16 million of the 35 million people who are uninsured are children.² In other words, even though children represent only 29% of the US population they make up nearly half of the uninsured. Another 7 million children are only insured for part of the year. Gaps in coverage are particularly profound for children between the ages of 0 and 2 years and for adolescents and young adults ages 18 to 24 years.¹ Geographically, children in the West and South and those in rural areas also have a greater tendency to be uninsured or underinsured.

More recent data show that neither parental income nor employment status are adequate predictors of children's insurance coverage. In 1984, 40% or 7.6 million of all uninsured children lived in families with incomes below the poverty level. Yet, 2.8 million (25%) uninsured children lived in families with incomes two times the federal poverty level or greater.² Furthermore, it appears that large numbers of uninsured children have parents working full time who are themselves insured.³ It has been estimated that the number of uninsured children could be reduced by 25% if every child who lived with an insured head of household were insured.⁴ To obtain coverage for their dependents these families must pay for private health insurance at premiums much higher than those charged for more generous and less expensive group insurance

The recommendations in this statement do not indicate an exclusive course of treatment or procedure to be followed. Variations, taking into account individual circumstances, may be appropriate.

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plans. The same is true for families who are self-employed.

In addition, many children become medically indigent because they or their families are uninsurable. These children or their families are denied coverage by insurers because of poor health status, previous medical history, or employment in a hazardous occupation. According to the US Department of Health and Human Services in 1979, 10.3% of all children with chronic disabilities (about 387,000 children) had no health insurance protection.⁵

IMPACT OF THE LACK OF INSURANCE

Access to Needed Care Is Decreased

In their 1982 national access study, the Robert Wood Johnson Foundation⁶ found that lack of insurance was causing many uninsured families not to seek care, even when a family member was ill. Nearly 4 million families who needed health care in the 12 months prior to the survey did not obtain it. In 1 million cases, a family member was refused care because of inability to pay. In 1982, 23% of the uninsured had no regular source of health care.

Children who are poor and have existing health problems are particularly disadvantaged in terms of their access to ambulatory care. A study using data from the 1981 Child Health Supplement to the National Health Interview Survey showed that low-income children with already reduced health status use ambulatory physician services at substantially lower rates than do children from more affluent families or those covered by Medicaid.⁷ The average number of visits per year to a physician for children reported as in fair or poor health were: 10.0 for families with incomes between \$10,000 and \$24,999; 10.5 for incomes greater than \$25,000; 9.3 for families with Medicaid coverage, but only 7.7 for those with incomes less than \$10,000 and without Medicaid coverage.

Evidence of Unmet Health Needs

The AAP believes that children's health care status will improve if the financial barriers to care, especially ambulatory services, are removed. Concomitant with children's decreased access to care are alarming trends in preventable childhood morbidity and mortality. This is reflected in the slowed decline of the infant mortality rate and in the increased incidence of preventable childhood diseases.

The decline in infant mortality has decelerated since 1982. Each year since 1965 to 1982, the mortality rate declined 4.6%. The rate of decline from 1982 to 1983, however, slowed to 2.7%. Twenty

states have reported that in selected regions there was an actual increase in the infant mortality rate.⁸

Preventable childhood diseases are increasing in certain populations. In 1984 the incidence of measles increased for the first time since the introduction of the vaccine in 1963. Many preschool children still do not receive vaccinations for diphtheria-tetanus-pertussis, polio, measles, mumps, and rubella until they enroll in formal day care or public school.⁹ Children of families who are poor and uninsured, and less likely to be in formal day care, are at greater risk of contracting preventable diseases.

In addition, the growing rate of teenage pregnancies is most alarming. One million women between the ages of 15 and 19 years become pregnant each year. A significant number of these teenagers have no health care insurance. According to data from the 1984 Current Population Survey, 21% of adolescents 15 to 17 years of age were uninsured, and 26% of those 18 to 19 years of age also were not insured.¹⁰ Once these teenagers become mothers, their risk of being uninsured is greater, unless they are poor enough to qualify for Medicaid. 1985 census data show that 74.2% of families headed by women 15 to 24 years old have incomes below the federal poverty level.

RECOMMENDATIONS

Solutions to the problem of children's medical indigence are complex. Different solutions are indicated for the poor or unemployed who lack insurance, the working poor who are inadequately insured, and those who lack insurance because of their current disabled or handicapped condition. Nearly always, solutions require a combination of federal, state, and private sector action involving the financing and delivery of health care.

Uninsured Children of the Poor and/or Unemployed

Expand and Improve Medicaid. Medicaid is the largest and most comprehensive health insurance program for children. Nevertheless, because of state variability, fewer than half of the poor are receiving services financed by the program.¹¹ As a first step the federal government should expand and improve the program by requiring that states implement the provisions of the Omnibus Budget Reconciliation Act of 1986 by (1) mandating that states increase their income eligibility standards to 100% of the federal poverty level and allow eligibility at state option to at least 200% of poverty level; (2) extending eligibility to all children up to 21 years of age, including children who are in two-parent families; (3) establishing medically needy programs; (4) im-

proving state outreach efforts for eligible families; (5) implementing the Early and Periodic Screening, Diagnosis, and Treatment program with medical care standards consistent with the AAP's "Recommendations for Preventive Pediatric Health Care"; and (6) requiring realistic payment schedules that will make it economically feasible for providers to participate in the program.

Establish State Indigent Care Funds to Support Subsidized Insurance Programs. States should establish indigent care funds to help finance children's health care. These funds could be generated through taxes on private health insurance, self-insured corporations, and other smaller businesses or by other revenue-generating mechanisms. States could establish their own health insurance system or subsidize vouchers for participants to purchase health insurance from private carriers. The services to be provided by the program should be identical with those recommended in the AAP's "Medicaid Policy Statement." States could choose to underwrite the entire cost of a family's coverage through the program or establish rates on a sliding-scale basis. Wherever possible, states should establish insurance programs that have potential for controlling costs and for demonstrating the program's fiscal accountability to the public.

Encourage Volunteerism. Many pediatricians are now providing free care to indigent children. These efforts should be coordinated within the public sector, primarily public health departments. Better communication regarding shared services as well as a system to link these public and private sector services are needed.

Underinsured Children of the Employed

Health insurance should be made available to children whose parents are employed but nonetheless lack adequate health care insurance for their dependents.

Mandate That Employer Coverage Include Ambulatory Care and Child Health Supervision. Children's ambulatory health care has been systematically excluded from health insurance plans which traditionally emphasize sick and acute care coverage. The AAP urges states and the federal government to mandate coverage of ambulatory care and child health supervision.

Amend the Federal Employee Retirement Income Security Act to Permit States to Regulate the Health Benefit Package of Self-Insured Plans. Coverage of children's ambulatory care and child health supervision should be a requirement of all employers, including those self-insured employers exempt under the Employee Retirement Income Security Act. By current law, when employers self-insure, they

maintain the freedom to determine what type of coverage their employees and their dependents will have, regardless of state mandates.

Provide Corporate Tax Credits for Small-Business Employers to Purchase Coverage for Minimum Wage and/or Part-Time Employees. States should consider providing small businesses with incentives to cover children's health care by allowing employers to fully deduct this coverage as a state corporate tax credit. Many employers cannot afford to provide health care benefits for their employees and/or their dependents. States are encouraged to develop financing mechanisms (eg, multiple employer trusts) that would enable small-business employers to purchase insurance at reasonable rates and/or to participate in developing cost efficient health care delivery systems for children.

Provide State Corporate Tax Credits For Employers to Limit Employee Premium Cost Sharing for Dependent Coverage. States should provide employers with tax credits to limit copayments, deductibles, and premium payments for children's health care. The AAP is concerned about the trend among employers that requires employees to share the expense of health insurance costs. A comparison of comprehensive major medical plans for 1980 and 1984 by the Wyatt Company shows a 37% increase in the proportion of firms requiring contributions for employees' and dependent coverage and a 150% increase in the proportion requiring contributions for dependents' coverage only.¹² If this trend in cost sharing for premiums, deductibles, and copayments increases, fewer families will be able to fully insure their children's health care.

Encourage the Development of a Medicaid Buy-in. Federal law should be reformed to allow states to modify their Medicaid programs to enable underinsured families an opportunity to purchase Medicaid coverage at an income-adjusted monthly premium. This would ensure that families would have access to children's health care services without forcing families to "spend-down" to qualify for Medicaid coverage through a state's Medicaid medically needy program. It also has the advantage of using an existing insurance structure. Funding for this buy-in capability could be supported solely from beneficiary premium contributions or by general federal and state revenues, a surtax on all employer health insurance benefits (group insurance policies or self-insured plans), or a payroll tax on those employers who do not offer health insurance.

Encourage States to Use State Indigent Care Insurance Programs. States should permit underinsured families to participate in state insurance programs that have been established to aid the poor and uninsured.

The Uninsurable Child

It is estimated that from 1 to 2 million families are uninsured because they have preexisting medical disabilities. Many of these families would be able to afford insurance if insurers made such coverage available to them.

Encourage Insurers to Remove Restrictions on Children With Preexisting Conditions. States should require insurers to include children with preexisting conditions in all health insurance plans. To limit insurer risk, states should develop mechanisms, eg, state subsidized reinsurance risk pools, which would be used by the employer's insurer after the child's health insurance expenses have exceeded the group plans's expenditure threshold.

Encourage the Development of a Medicaid Buy-in. Uninsurable children whose families are not poor enough to qualify for the Medicaid program should be allowed to purchase Medicaid coverage at an income-adjusted monthly premium.

Encourage States to Create High-Risk Pools Which Address the Needs of Children. States are encouraged to create insurance pools for high-risk individuals which would enable children with existing medical conditions to obtain health coverage. These pools could be financed through premiums paid by families or by employers in their employee's behalf.

Income-adjusted sliding-scale premiums, copayments, and deductibles should be considered. The pools could be subsidized further by state tax revenues or assessments on health insurance companies. The Employee Retirement Income Security Act should also be amended to require self-insured corporations to contribute in the financing of these pools. States should prevent corporations from excluding their high-risk employees from group plans by limiting employer access to the pool based on company size.

All pools for high-risk individuals should provide a benefit package that would be responsive to the special needs of children with disabling conditions. States should use health care delivery systems that provide comprehensive, continuous, and coordinated care for the child.

REFERENCES

1. Butler JA, Winter WD, Singer JD, et al: Medical care use and expenditure among children and youth in the United States: Analysis of a national probability sample. *Pediatrics* 1985;76:495-507
2. Sulvetta M, Swartz K: The uninsured and uncompensated care. Presented at National Health Policy Forum, George Washington University, Washington, DC, June 1986
3. Monheit A, Hagan M, Berk M, et al: The employed uninsured and the role of public policy. *Inquiry* 1986;22:348-364
4. Rosenbaum S: Children and private health insurance. Presented at the Conference on Children in a Changing Health Care System, Center for Health Policy and Management, Harvard University School of Public Health, Cambridge, MA, October 1986
5. Fox H: A preliminary analysis of options to improve health insurance coverage for chronically ill and disabled children. Prepared for the Habilitation Services Branch of the Division of MCH and Department of HHS, September 1984
6. Robert Wood Johnson Foundation: Updated report on access to health care for the American people. *Special Report*, Princeton, NJ, Robert Wood Johnson Foundation, 1983
7. Newacheck PW, and Halfon N: Access to ambulatory care services for economically disadvantaged children. *Pediatrics* 1986;78:813-819
8. Munding M: Health service funding cuts and the declining health of the poor. *N Engl J Med* 1985;313:44-47
9. Hinman A: Vaccine-preventive disease and child day care. *Rev Infect Dis* 1986;8:573-583
10. Gold R, Kenney A: Paying for maternity care. *Fam Plan Perspect* 1985;17:103-111
11. McManus M, Davidson S: The role of public health insurance for children. Presented at the Conference on Children in a Changing Health Care System, Center for Health Policy and Management, Harvard University School of Public Health, Cambridge, MA, October 1986
12. Fox H, Yoshpe R: Private health insurance coverage of chronically ill children. Prepared for the National Center for Networking Community-Based Services, Georgetown University Child Development Center, March 1986

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