Health Matrix: The Journal of Law-Medicine

Volume 4 | Issue 1

1994

# Agenda for Change in the U.S. Child Health Care System

James E. Strain

# AGENDA FOR CHANGE IN THE U.S. CHILD HEALTH CARE SYSTEM†

*James E. Strain*††

I **WAS ASKED TO COMMENT** on the agenda for change in the child health care system in the U.S. At the present time, the U.S. is one of the few industrialized countries that does not have a national health care policy for its children.[1] In fact, the U.S. and South Africa remain the only two developed countries in the world that do not provide health insurance coverage for all children.[2] Therefore, instead of discussing how U.S. health care policy affects children, I will focus on the lack of national health care policy, how it affects our children and what the American Academy of Pediatrics is doing to address the problem.

First, I think it is important to present a brief historical overview of some of the attempts this country has made at shaping health care policy for children and what the results have been. Traditionally, the U.S. has developed policies and programs that address immediate needs, rather than the long-

---

† The following presentation was given in the Fall of 1992 at a time when major reform of the health care system was being considered by the 103d Congress. Although no significant action was taken, there are indications that the 104th Congress may consider reform measures such as health care of undeserved children, health insurance reform and tort reform. In the meantime, managed care appears to be gaining acceptance in both the private and public sector as a cost control measure. It is the hope of the author that the principles enunciated in the Academy of Pediatrics proposal, Children First, will be considered by any entity that underwrites health insurance for the children of this country.

†† Former Executive Director of the American Academy of Pediatrics. Presently Clinical Professor of Pediatrics at the University of Colorado School of Medicine.

1. *See* Summation & Commentary, *Child Health 1990: The United States Compared To Canada, England, Wales, France, The Netherlands and Norway*, 86 PEDIATRICS 1124, 1124-26 (Supp. 1990) (stressing that health care systems in other Western Nations were developed through government policy, universal participation by physicians and removal of economic barriers to services).

2. *Id.* at 1026 (comparing care provided by countries for acute illness in children).

range comprehensive needs of tomorrow, the next month or the next generation.[3]

It would be impossible to outline all of the patchwork policies and programs that have been developed for children; however, three major formative periods emerge upon examination of the child health care policy in this country. The first period extended from 1912 through 1934. This period was earmarked by an awakening in the U.S. to the health care needs of children. Hence, there was the creation of the Children's Bureau[4] and the enactment of the Sheppard-Towner Act.[5]

The Children's Bureau ("Bureau") was established in 1912, becoming the first federal body dedicated to the welfare of children. Today, the Bureau continues to exist in a modified form with the Maternal and Child Health Bureau assuming many of the Bureau's initial responsibilities.[6]

The Sheppard-Towner Act was a relatively small program for poor mothers. The introduction of the Act eventually led to the formation of the American Academy of Pediatrics as pediatricians who supported the Act broke ties with the American Medical Association.[7]

---

3. *See, e.g.*, CENTERS FOR DISEASE CONTROL, U.S. DEP'T OF HEALTH & HUM SERVS., STRATEGIC PLAN FOR THE ELIMINATION OF CHILDHOOD LEAD POISONING (1991) (outlining a five-year plan which focuses primarily on identifying poisoned children and treatment thereof); Ryan White Comprehensive AIDS Resources Emergency Act of 1990, Pub. L. No. 101-381, 104 Stat. 576 (1990) (codified as amended in scattered sections of 42 U.S.C.) (devised "to provide emergency assistance to localities that are disproportionately affected by the Human Immunodeficiency Virus epidemic and to make financial assistance available to States and other public or private nonprofit entities . . . for the delivery of essential services to individuals and families with HIV disease").

4. Act of April 9, 1912, ch. 73, 37 Stat. 79 (1912) (codified as amended at 42 U.S.C. §§ 191-194, § 192 (1988)) (created to investigate and report on child life in America "especially . . . the questions of infant mortality, the birth rate, orphanage, juvenile courts, desertion, dangerous occupations, accidents and diseases, employment and legislation affecting children).

5. Sheppard-Towner Act, ch. 135, 42 Stat. 224 (1921), *repealed by* Act of Jan. 22, 1927, ch. 53, § 2, 44 Stat. 1024 (1927) (effective June 30, 1929) (providing public funds for maternal and child health care services for those unable to pay).

6. Established in 1987, the Maternal and Child Bureau was allocated the duty of overseeing and focusing on health issues affecting children and pregnant women. For further information, see *infra* note 13 and accompanying text. The Children's Bureau, in conjunction with the Public Health Sercices, continues to monitor and advocate children's welfare issues.

7. The Academy was established by twenty-four pediatricians after the American Medical Association condemned the Sheppard-Towner Act. *See* JAMES G HUGHES, AMERICAN ACADEMY OF PEDIATRICS, THE FIRST 50 YEARS 1-2 (1980) (briefly chronicling the Academy's response to major issues of maternal and child health care, *e.g.* national vaccination programs, child lead poisoning and health insurance).

The second period began in 1935 when Title V made its way onto the national agenda by providing services for disabled children. Medicaid legislation passed in 1965 was designed to meet the needs of the poor. Currently, the program is fraught with problems and inequities, especially for children. Reduced payment for services, restrictions on the number of services covered and excessive paper work are among the factors that limit pediatrician participation in the program.[8] Lack of pediatrician participation in Medicaid has led to a two-class system of child health care.[9] Thus, poor children, our nation's most vulnerable citizens, are often hit the hardest in the Medicaid program. For example, although 52.1% of the Medicaid-eligible population is composed of children, only 21.4% of all Medicaid dollars are actually spent on children.[10] The rest is used to fund long-term care of adults, including the blind, disabled and aged.[11]

The final period of major change occurred during the 1980's, when further amendment to the Social Security Act created the Maternal and Child Health Services ("MCH") Block Grant.[12] This amendment shifted the control of child health programs from the federal government to the state governments. While this period helped remove some of the ambiguity that existed in federal child health policy, it did so at a cost. The federal government was removed from an active role in establishing child health care policy. Subsequently, some states have provided high quality services to children, while many more have experienced severe difficulties.[13]

---

8. Beth K. Yudkowsky et al., *Pediatrician Participation in Medicaid: 1978 to 1989*, 85 PEDIATRICS 567, 571 (1990) (research conducted in 1989 indicated that significant decreases in pediatrician participation was caused by low Medicaid reimbursements, unpredictable payments, payment delays and overall constraints on the Medicaid program).

9. *Id.* at 574 (finding that pediatricians wanted to participate in Medicaid and would do so if fees were adjusted, thereby avoiding the development of a two-tier class system).

10. DEP'T RESEARCH FOR COMM ON CHILD HEALTH FINANCING. AM ACAD PEDIATRICS. MEDICAID STATE REPORT (1991).

11. *Id.*

12. Maternal and Child Health Services Block Grant, Pub. L. No. 977-35, 95 Stat. 818 (1981) (amended by Pub. L. 101-239, 103 Stat. 2273 (1989)) (merging seven health care plans targeting mothers and children to form the Block Grant in order to give the individual states a greater opportunity to access health care services to these groups).

13. ASS'N OF MATERNAL AND CHILD HEALTH PROGRAMS. NAT'L CENTER FOR EDUC IN MATERNAL & CHILD HEALTH. TITLE V IN REVIEW: TWO DECADES OF ANALYSIS OF SELECTED ASPECTS OF THE TITLE V PROGRAM AND CHILD HEALTH PROGRAMS 1-6

It is evident that a fourth period of major change is now occurring, affecting children and the health care they receive. In fact, the current health care reform debate extends far beyond children and promises to affect us all. Americans are demonstratively growing dissatisfied with the inequities and inefficiencies of the current health care delivery system.[14] They are demanding change. Legislators have become acutely aware of the need to take a position on health care reform. The pressures for change are many, but the principal factor is cost.[15] While universal access to care is a concern, the cost of medical care is the driving force behind the debate in Washington.

The federal government is concerned about the cost of Medicare and is seeking ways to shift the cost to consumers.[16] States are being overwhelmed with the cost of Medicaid and are resisting any attempt to expand benefits.[17] Corporations are burdened with increasing costs of premiums for health insurance for employees, employee's dependents and retirees.[18] Employees are also not isolated from the rising costs of medical

---

(1989) (reviewing 20 years of Title V projects and reports and concluding that a combination of a lack of integrated intra- and infra-state communications, a lack of finances and a lack of accountability of state expenditures has resulted in the disparity in services to children nationwide).

14. A survey conducted in the U.S., Canada and the United Kingdom revealed that, of the three, Americans expressed the most discontent with their national health care system. Robert J. Blendon & Humphrey Taylor, *Views on Health Care: Public Opinion in 3 Nations*, 8 HEALTH AFF. 149, 151 (1989). Dissatisfaction was attributed to the rising costs of health care coupled with a growing number of uninsured Americans. *Id.* at 149; *see also* Cindy Jajich-Toth & Burns W. Roper, *Views on Health Care: A Study in Contradictions*, 9 HEALTH AFF 149, 149 (1990) (concluding that while Americans are calling for a reform of a national health care system, this does not necessarily mean that the public wants the system to be directly controlled by the federal government).

15. Jon Gabel et al., *America's View on Health Care: Foolish Inconsistencies?*, 8 HEALTH AFF. 103, 112-14 (1989) (examining Americans' frustration with the desire to expand health care coverage, yet their failure to develop and implement effective cost-containment mechanisms).

16. Donna K. Thiel & Christopher L. White, *What Happens to Medicare and Medicaid Under the Clinton Reform Plan?*, HEALTH SPAN, Nov. 1993, at 15, *available in* Westlaw, 10 No. 10 PH-HTHSP15.

17. Maxwell J. Mehlman & Karen A. Visocan, *Medicare and Medicaid: Are They Just Health Care Systems?*, 29 HOUS L REV 835 (1992).

18. Jon R. Gabel & Thomas Rice, *Is Managed Competition A Field of Dreams?*, 3 J. AM HEALTH POL'Y 19, 21 (1993) (noting that, between 1987 and 1992, there was a 90% increase in the cost premiums for health maintenance organizations and a 105% increase for preferred-provider and point-of-service organizations).

care, as they are being increasingly required to share the cost of care through deductibles and co-insurance.[19]

Health care costs have risen to over fourteen percent of this country's Gross Domestic Product.[20] The nation's medical bill for 1990 was $675 billion and for 1991 approximately $751.8 billion.[21] From 1991 to 1992, that figure increased another 11.5% to an estimated total of $838.5 billion.[22]

Adding to the dissatisfaction with the cost of health care is the fact that there seems to be little correlation between high medical costs and good health. Although the U.S. spends a larger percentage of its Gross Domestic Product on health care than any other nation, it still ranks an embarrassingly low thirty-first in low birth weight births,[23] twentieth in infant mortality rates,[24] and seventeenth in preschool immunization rates.[25] While there are obvious societal problems that contribute to these poor outcomes, there is little doubt that we need to change the way we pay for and deliver child health care. Although there is a consensus that changes need to be made, there is little agreement on what should be done.

Currently, two financing systems are being seriously considered: a managed care system favored by the present Admin-

---

19. SARA ROSENBAUM ET AL., SPECIAL REPORT. CHILDREN AND HEALTH INSURANCE 25-26 (1992) (finding that monthly out-of-pocket costs in 1989 for employees taking part in medium- and large-sized insurance plans reached on average $71.41 a month).

20. BARBARA H. FRANKLIN ET AL., U.S. DEP'T OF COMMERCE, BUSINESS FORCASTS FOR 350 INDUSTRIES U.S. INDUSTRIAL OUTLOOK 1993, at 42-1 (1993).

21. *Id.*

22. *Id.*

23. CHILDREN'S DEFENSE FUND, THE STATE OF AMERICA'S CHILDREN 1992, at 2 (1992) (citing UNICEF, STATE OF THE WORLD'S CHILDREN 1992 (1992)); *see also* U.S. BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES 1992, at 68 (112th ed. 1992) (citing *Vital Statistics Of the United States*) (providing the following statistics: 1) The percentage of White infants born weighing less than 2500 grams in 1987 was 5.7% and in 1988, 5.6%; 2) The percentage of Black infants born weighing less than 2500 grams in 1987 was 12.7% and in 1988, 13.0%).

24. CHILDREN'S DEFENSE FUND, *supra* note 23, at 3 (Table 1.2 represents infant mortality for infants within their first year, per 1,000 live births); *see also* U.S. BUREAU OF CENSUS, *supra* note 23, at 80 (providing the following statistics of infant mortality ("IMR") in Table 109: In 1980 the U.S. IMR was 12.6/1000, in 1988 10.0/1000 and in 1989 9.8/1000).

25. CHILDREN'S DEFENSE FUND, *supra* note 23, at 4 (representing multi-national rankings for the percentage of one-year-old children fully immunized against polio in 1990); *see also* U.S. BUREAU OF CENSUS, *supra* note 23, at 123 (citing U.S. CENTERS FOR DISEASE CONTROL, U.S. IMMUNIZATION SURVEY (1985)) (providing the following statistics for immunization rates for children ages one to four in 1985 in Table 189: for Diphtheria, Whooping Cough and Tetanus 64.9%, for Measles 60.8% and for Polio 55.3%).

istration and a single payer system with federal and state governments being responsible for the funding and the administration of the program. Both systems have their strengths and weaknesses. Most political pundits believe the ongoing debate will be long and arduous. Although everyone voices support for children's services, as a society we have neglected our children, our most treasured resource. Repeatedly, appropriations for children's services have been cut when relatively few dollars would have made a significant difference in the well-being of children.

Thus, as the debate continues it is absolutely essential that those concerned with the health and welfare of children speak out on their behalf. Otherwise, children's issues will be set aside or assigned a low priority.

The nation's pediatricians, through the American Academy of Pediatrics, have lobbied to make access to health care the top priority.[26] As part of this commitment, the Academy developed a health care reform proposal entitled "Children First."[27] This proposal was developed with the assistance of health economists and with the goal of providing health insurance for all pregnant women and children through the age of twenty-one.[28] In the fall of 1991, many key features of Children First's proposal were drafted into legislation and introduced into the U.S. House of Representatives by California Congressman Robert Matsui.[29]

Before describing the merits of the Bill, I would like to address why meeting the health care needs of children is advantageous and sensible. First and foremost, children deserve the best we can offer. As Dr. Antointette Eaton, the past president of the American Academy of Pediatrics said, "although

---

26. AM ACAD. PEDIATRICS, STRATEGIC PLAN GOALS AND OBJECTIVES JULY 1, 1993 - JUNE 30, 1994 (1994) (stating that the Academy's number one specific goal is to reduce any existing barriers to health care for children and pregnant women with the overall objective be that no one in these two groups being either uninsured or underinsured).

27. AM ACAD PEDIATRICS, CHILDREN FIRST A LEGISLATIVE PROPOSAL 9 (1990) (developed in response to the continued decline in insurance coverage of children and the rising cost to society for the neglect of its childrens' health).

28. *Id.* at 4-9 (key components of the proposal include a one-class health care system, emphasis on preventive services, guaranteed financial access to all children and shared fundings).

29. Children and Pregnant Women Health Insurance Act of 1993, H.R. 727, 103rd Cong., 1st Sess. (1993) (originally introduced by Representative Matsui as H.R. 3393, 102d Cong., 1st Sess. (1991)).

children account for just one-third of our nation's population, they represent one-hundred percent of our future."[30] Children are also our most vulnerable population; we should take care of them. Unfortunately, this is not happening, especially among the poor.

It has been said that a nation can be judged by the way it treats its children. If that statement is true, then the U.S. simply does not measure up in terms of health care. In 1991, twenty-one percent of all children lived in families with mean incomes below the federal poverty level.[31] Over 13,000,000 children under the age of eighteen live in poverty, constituting forty percent of the nation's poor.[32]

Furthermore, it has been shown that children who are not given a healthy start in life often encounter other problems later on.[33] For example, the link between good health and readiness to learn is well-documented.[34] In a recent survey of elementary school teachers in rural, suburban and inner-city areas, ninety percent of the teachers reported having at least one child in their classroom whose learning was impaired by poor health. Furthermore, on the average, twelve percent of the students were reported as having significant health problems that affected their learning.[35] This is something we simply cannot afford as a country.

---

30. Antoinette P. Eaton, *Giving Kids a Healthy Start*, JUNIOR LEAGUE REV., Fall 1990, at 10 (promoting community-based preventive care in the form of immunization for all children).

31. U.S. BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES 1993, at 469 (1993).

32. MATERNAL & CHILD HEALTH CARE BUREAU, U.S. DEPT. HEALTH & HUM. SERVS., CHILD HEALTH USA '92, at 10 (1993) (finding further that minority children are two to three times more likely to be impoverished).

33. DAVID A HAMBURG, CARNEGIE CORP. OF N.Y., CHILDREN OF URBAN POVERTY: APPROACHES TO A CRITICAL AMERICAN PROBLEM 4 (1992) (listing risks of impoverished children as early "death, disease, disability, . . . emotional distress, and educational failure").

34. *See, e.g.*, ERNEST L BOYER, READY TO LEARN: A MANDATE FOR THE NATION 155 (1991) (showing results from a national survey of teachers in Table 7 which finds that students who are not ready to learn when entering school were also affected moderately by physical well-being).

35. PORTER/NOVELLI, HEATH CARE AND A CHILD'S ABILITY TO LEARN: A SURVEY OF ELEMENTARY SCHOOL TEACHERS 15 (1992) ("Elementary school teachers almost unanimously agree that a child's overall health and fitness are very important to his/her performance in school."). The Millard/Brown, Inc. Research company conducted the survey which included a total of 500 elementary school teachers and which indicated in its results that poor student health is prevalent and increasing. *Id.* at 1-2.

Dr. Antonia Novello, the U.S. Surgeon General under the Bush Administration, initiated a program called "Healthy Children Ready to Learn."[36] One of the program's educational goals is to have all children ready to learn by the year 2000.[37] This will never occur unless children are provided with appropriate health care. Without it, children will never have the chance to realize their potential.

A second reason for promoting Children First is the emphasis it places on preventive care. Services such as prenatal care, immunizations and growth and development assessment are essential to good health and must be provided. Not only does preventive care contribute to optimal health, it is also cost-effective. Every dollar spent on prenatal care saves more than three dollars in subsequent care of premature infants.[38] The benefit-cost ratio of a measles-mumps-rubella vaccination program is more than 14:1.[39] The benefit-cost ratio of pertussis vaccine given in combination with diphtheria and tetanus is 11:1.[40] For polio immunization, the benefit-cost ratio is 10:1.[41] Clearly, the key to healthier children and lower health care costs is concentrating our efforts on providing preventive health

---

36. Antonia C. Novello et al., *Healthy Children Ready To Learn: An Essential Collaboration Between Health and Education*, 107 PUB HEALTH REP J US PUB HEALTH SERV 3, 3 (1992) (program is designed to promote "optimum use of available and effective preventive measures, such as . . . compliance with immunization recommendations; promoting measures to prevent injuries; ensuring opportunities to identify disease and disabilities early; and providing prompt treatment when needed").

37. Having children beginning school ready to learn is the first of six educational objectives. U.S DEP'T. OF EDUC., AMERICA 2000 AN EDUCATION STRATEGY 19 (1991). Other educational goals include having at least 90% more high school graduates, having every adult in the U.S. literate and having drug and violence-free schools. *Id.* at 55-65.

38. *See* DIVISION OF HEALTH PROMOTION & DISEASE PREVENTION, INST OF MED., PREVENTING LOW BIRTH WEIGHT 232 (1985) (calculating that each additional $1.00 spent on prenatal care for those at risk of having low birth weight infants will save in actual medical expenditures $3.38 for each low birth weight born).

39. *See* Craig C. White et al., *Benefits, Risks and Cost of Immunization or Measles, Mumps And Rubella*, 75 AM J PUBLIC HEALTH 734, 740 (1985) (documenting that the establishment of a vaccination program prevented $1.4 billion in treatment costs from accruing had there been an outbreak of disease).

40. The ratio is a product of a reduction in disease costs divided by program costs. *See* Alan R. Hinman & Jeffrey P. Koplan, *Pertussis and Pertussis Vaccine: Reanalysis of Benefits, Risks, and Costs*, 251 JAMA 3109, 3110 (1984) (evaluation of vaccination program for pertussis showed an overall reduction of costs to be 82%).

41. *See* H. H. Fudenberg, *Fiscal Returns of Biomedical Research*, 61 J INVESTIGATIVE DERMATOLOGY 321, 322 (1973) (the development of the polio vaccination produced savings in the amount of $1 billion a year for six years).

care instead of waiting for children to get sick and then treating them.

A third reason for supporting Children First is that it guarantees insurance for children as a population. Children have quickly become the largest segment of our uninsured population. In 1991, over thirty-six million people in this country had no form of health insurance.[42] Nine-and-a-half million of the uninsured population were children under the age of eighteen.[43] In addition, several million more children are underinsured, which means that they are denied important health care benefits. For example, from 1989 to 1990, less than fifty percent of conventional health insurance plans in this country covered immunizations.[44] This growing population of underinsured children will one day be our leaders and work force — the future of America.

Finally, fully insuring children makes good sense because it is affordable. The estimated cost of Congressman Matsui's bill was twelve billion dollars per year.[45] To put this in perspective, most plans for universal health care are projected to cost well above the proposed twelve billion dollar price tag.

---

42. Employer Benefits Research Institute, *Sources of Health Insurance and Characteristics of the Uninsured*, SPECIAL REP. & EBRI ISSUE BRIEF NO. 133, January 1993, at 7 (comparing characteristics of those Americans who received health insurance and those who did not).

43. *Id.* at 7-8, 14 (finding that children are the family members most likely to be uninsured when the head of the household is self-employed or works for a small company).

44. HEALTH INS ASS'N. OF AM., SOURCE BOOK OF HEALTH INSURANCE DATA 34 (1991) (listing percent of health plans providing coverage for specific services by plan type).

45. LEWIN/ICF. AMERICAN ACADEMY OF PEDIATRICS' PROPOSAL FOR UNIVERSAL ACCESS TO HEALTH CARE FOR CHILDREN AND PREGNANT WOMEN 28 (1991) (detailing the principles of the proposal and the costs of initiating such a program). The estimated change in National spending under the Proposal in 1992 was as follows:

| | In Billions |
|---|---|
| Household Health Spending | $0.8 |
| Employers: | 7.0 |
| Currently Insuring | (0.7) |
| Currently Not Insuring | (7.7) |
| State and Local Governments: (Maintenance of effort assumed) | 0.0 |
| Federal Spending | 3.5 |
| Net Change in National Health Spending: (Includes both increase in health services and additional administrative costs) | 11.3 |

*Id.*

Whatever plan is adopted, the special health care needs of children can be met with very little additional funding.

Congressman Matsui's bill[46] contains several provisions that would bring about important changes in the health insurance program for children. First, the bill guarantees private health insurance for all pregnant women and children through age twenty-one.[47] It also establishes a one-class system of health care, thereby eliminating the inequities that currently exist between our private and public-supported systems.[48] Under our present system, needy children receive disparate treatment and are deprived of necessary services; the health care which is distributed to the poor is unequal to that received by those who can afford to pay for services or who are covered by employer insurance. Under the Children and Pregnant Women Health Insurance Act, the private insurance will be financed either through an employer or through a state-administered fund.[49] Providing insurance in this manner effectively would remove any adverse stigma to those people who are on welfare or use any type of second-class system.

The basic benefit package is divided into three categories or "baskets." Each of the three baskets would cover specific services and apply specific cost-sharing principles.[50] The first category, the Preventive Care Benefit basket, covers mandated benefits such as preventive child health care visits, immunizations and prenatal care.[51] Cost-sharing would not apply to these services since it has been demonstrated that co-payments can reduce utilization of preventive health services.[52]

---

46. *See also* Children and Pregnant Women Health Insurance Act of 1993, S. 1456, 103rd Cong., 1st Sess. (1993) (the Senate companion bill introduced on Sept. 14, 1993 by Senator Christopher Dodd).

47. H.R. 727 at § 2282 (defining "child" as anyone under the age of twenty-two); S. 1456 at § 2700(2).

48. H.R. 727 at § 2201(d)(1) (eligibility for enrollment in the plan is on an employment or non-employment basis); S. 1456 § 2701(a) (eligibility extends to "every child who is legally residing in the United States").

49. H.R. 727 at § 2201(d).

50. H.R. 727 at §§ 2212-2214 (the baskets consist of preventive care services, major medical services and extended services); S. 1456 at §§ 2711-2715.

51. H.R. 727 at § 2212(a); S. 1456 at § 2713(a)(1).

52. H.R. 727 at § 2212(c); S. 1456 at § 2713(c); *see also* ARLEEN LEIBOWITZ ET AL., EFFECT OF COST-SHARING ON THE USE OF MEDICAL SERVICES BY CHILDREN INTERIM RESULTS FROM A RANDOMIZED CONTROLLED TRIAL 12-14 (1985) (demonstrating that, while cost-sharing reduced the number of out-patient services obtained by children under the health plans, it did not increase the hospital use under the plans).

The second category, the Primary/Major Medical Benefit basket, would cover benefits for which a deductible and a twenty percent cost-sharing fee would apply.[53] Hospital care, acute and chronic care and diagnostic services are examples of such designated services.

The third category, the Extended/Major Medical Benefit basket, would require a thirty percent cost-share.[54] Services covered in this basket include rehabilitative services and other special therapies. Any patient requiring "third basket" services would have a care coordination plan developed by or in consultation with the child's primary care physician. There would be a cap on out-of-pocket expenses of one thousand dollars per child per year for all health care services.[55]

Another attractive feature of the bill is that it includes provisions for cost containment, provisions that allow fair compensation for physicians, while simultaneously addressing the need to curtail spiraling health care costs.[56] With its emphasis on guaranteed access to health care, preventive care, cost containment and the elimination of inequities and inefficiencies, the Academy believes that the H.R. 727 is a good piece of legislation. It is the only one out of some fifty bills that focuses specifically on the needs of children.

The American Academy of Pediatrics has no illusions that the Matsui Bill will pass in its present form. However, the bill does provide a framework for children's health care that can be incorporated into other bills calling for universal access to care. In discussions with congressmen and in testimonies before congressional committees, the Academy has advocated for the inclusion of the principles in the Bill in all health care reform proposals. The Academy is open to discussion of various financing mechanisms, but we will not compromise on the comprehensive benefit package and equal financial access for all children.

---

53. H.R. 727 at § 2213(c) (permitting states to exact deductibles on insurance, subject to restrictions); S. 1456 at § 2722(a)(1).

54. H.R. 727 at § 2214(c); S. 1456 at § 2722(a)(2).

55. S. 1456 at § 2723.

56. H.R. 727 at § 2221 (providing for the establishment of a Relative Value Scale for pediatric and obstetrical services and a conversion factor as determined by a National Advisory Committee).

In conclusion, providing health insurance for every child and pregnant woman is only the first step in assuring complete access to health care. Lack of physicians in underserved rural and inner-city areas, cultural differences, transportation problems and lack of public awareness of the importance of preventive services are other barriers that must be addressed. Health insurance reform by itself is not the final answer. I started this presentation by stating that the U.S. lacks a formal, national health care policy for children. Such a policy is needed: a policy that meets the needs of all children, from good nutrition to quality education, from a clean environment to safe neighborhoods. It should be a policy that addresses the most fundamental needs of children: a home and an adequate family income.

These are vast problems requiring comprehensive solutions, problems that require an overall national policy. Health insurance reform should be the cornerstone of this policy. It is time for this country to put children's issues first. Only then can our nation's future be secure.