MORE COVERAGE, BETTER CARE:

Improving Children's Access to Health Services

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EXECUTIVE SUMMARY

MORE COVERAGE, BETTER CARE:

Improving Children's Access to Health Services

Children's access to health care has been a longstanding policy issue, with strong bipartisan support for expanding insurance coverage and redesigning the health care delivery system in ways that benefit young people. Despite enormous progress made over the past two decades, however, millions of children remain unable to obtain needed health services. Grantmakers have a unique and historic opportunity to finish the job and guarantee all children access to affordable, appropriate, and high-quality care.

Child Health

The United States has witnessed enormous improvements in children's health over the last century. Despite these successes, however, there are rising numbers of children with serious diseases and disorders (Institute of Medicine 2004). Children's health needs are different than those of adults, because of their vulnerability during periods of rapid development, their exposure to risks that cannot be adequately addressed by traditional medical services, and their dependency on caregivers to arrange for their health care (Halfon et al. 1996). There are both short- and long-term consequences of poor childhood health, from high rates of school failure to diminished economic performance for the nation as a whole (Halfon 2005).

Children's Access to the Health Care System

One of the most important strategies for improving child health is to make health care services available to children. Children need a caring, preventive health care system — one that helps families predict future needs, monitors emerging concerns, and coordinates care (Chung and Schuster 2004). Yet 12 percent of children have had no health care visit to an office or clinic within the past 12 months and 6 percent of children have no usual source of care (National Center for Health Statistics 2005). There are two main approaches to improving access to health care: expanding health insurance coverage and redesigning the health care delivery system (Meyer and Silow-Carroll 2000).

Health Insurance Coverage for Children

Health insurance coverage is one of the strongest predictors of whether children have access to health care. Tremendous progress has been made in the last several decades in improving access to insurance coverage for children (Cunningham and Kirby 2004). Today 88 percent of all children and 80 percent of low-income children in the United States have health insurance, either through the private market or public programs (Kaiser Commission on Medicaid and the Uninsured November 2005).

Private Health Insurance Coverage

Private insurance rates have been dropping since the 1980s, with most of the decline due to the erosion of employer-sponsored coverage (Cunningham and Kirby 2004).

Employer-Sponsored Coverage – The majority (56 percent) of the nation's 78 million children received health insurance coverage through a parent's employer-sponsored policy in 2004, so changes in the availability and affordability of employer-sponsored coverage have a large impact on health coverage for children (Kaiser Commission and the Uninsured November 2005; Rousseau 2005). The proportion of children with employer-sponsored coverage dropped 5 percentage points between 2000 and 2004, as a result of the steep increases in premium costs, a decreasing number of employers offering coverage, and a decreasing number of employees being able to afford coverage even if offered (Kaiser Commission on Medicaid and the Uninsured September 2004; Kaiser Commission on Medicaid and the Uninsured November 2005).

Public Health Insurance Coverage

A quarter of all children and half of low-income children receive some form of public health insurance coverage (Kaiser Commission on Medicaid and the Uninsured November 2005). Most of the progress made in improving children's access to health care over the past two decades has been as a result of the expansion of public programs.

Medicaid – Medicaid is the largest single health insurance program for American children and has long been a critical safety net for low-income children. In 2003, over 25 million children were enrolled in Medicaid at a cost of nearly $45 billion (Kaiser Commission on Medicaid and the Uninsured 2004). Countless studies have recorded the accomplishments of the Medicaid program in terms of children's primary care utilization, mortality and hospitalization rates, school readiness, and health care costs. The key component of Medicaid coverage for children is the mandatory early and periodic screening, diagnostic, and treatment (EPSDT) benefit for individuals under 21. EPSDT is an extremely comprehensive benefit which is important for low-income children and children with special needs; its scope of covered diagnostic and treatment services is unmatched, even by private insurance.

State Children's Health Insurance Program (SCHIP) – SCHIP provides health coverage to low-income children who live in families with income or assets above eligibility levels, yet whose parents cannot afford to purchase private insurance. In 2003, about 4 million children were covered by SCHIP (Kaiser Commission on Medicaid and the Uninsured September 2004). SCHIP coverage has been found to diminish unmet need, boost preventive care, raise the probability of having a usual source of care, lessen parents' stress and financial barriers, and improve children's access to oral health care (Kenney and Chang 2004).

Progress at Risk – Rising Medicaid and SCHIP costs have led state and federal policymakers to explore options for reducing program spending. States have only a few ways to cut Medicaid and SCHIP costs — reducing enrollment, reducing benefits, increasing cost sharing, or reducing provider payments — all of which potentially worsen children's access to health care (Lewit et al. 2003).

Children Without Health Insurance Coverage

Nearly 12 percent of all children and 20 percent of low-income children are uninsured. Lack of insurance is a major barrier to health care. More than 60 percent of the 8.4 million uninsured children in the U.S. appear to be eligible for Medicaid or SCHIP coverage, yet they are not enrolled in either program (Kaiser Commission on Medicaid and the Uninsured 2004).

The Delivery of Health Care for Children

The existence of insurance alone does not eradicate all of the barriers to accessing suitable health care services (Institute of Medicine 1998). Even when insured, children's access to affordable, appropriate, high-quality care cannot be guaranteed without a wide range of health system improvements.

Primary Care

For the parents of uninsured children, and even those who are insured, it may be difficult to find a consistent provider who is conveniently located, with hours that accommodate a family's work and child care schedules; who has the linguistic skills and cultural sensitivity necessary to provide quality care; or who accepts uninsured patients or children with public coverage (Lewit et al. 2003).

Availability of Health Care Providers – Recent research has shown that the number of primary care physicians per capital has been steadily shrinking, and only half of physicians are willing to accept all new Medicaid patients (Proser et al. 2005). This lack of health care providers has serious implications for children and for health care costs.

Linguistically and Culturally Competent Health Care – Parents and children with limited English proficiency are less likely than proficient English speakers to obtain needed health care services. Problems in patient-provider communication also occur between families and health professionals who speak the same language but come from different cultures.

Referral Services

At some point, most children need referral to services not provided as part of a routine pediatric visit. Primary care providers often find it difficult to locate specialists willing to provide care to low-income or uninsured children. Medical home programs are attempting to fill this gap by consolidating primary and specialty care into seamless comprehensive care models (Chung and Schuster 2004; Simpson and Stallard 2004).

The Safety Net

Low-income children tend to rely on an extended but stressed network of safety net providers: those school-based health centers, public hospitals, community health centers, public health departments, individual practitioners, and others who provide health care for uninsured and underinsured adults and children, regardless of their insurance coverage, ability to pay, or immigration status (Institute of Medicine 1998). Despite their importance, there is no sole or sure source of financial support for safety net providers (Regenstein and Huang 2005).

Philanthropic Activities

Foundations and corporate giving programs are supporting a wide range of activities related to children's health care access, with many believing that success in providing access to all children can both improve children's health outcomes and serve as the foundation for broader health reform. Effective grantmaking strategies to improve children's access include facilitating enrollment in existing public programs, enhancing and expanding public coverage, supporting school-based health care, and engaging community members in shared planning and action.

Lessons Learned

- Successful efforts require action at both the grassroots and treetops levels. While winning grassroots support is labor-intensive and takes a long time, success in pushing for change at the policy level often requires quick, bold action, and does not always allow time to consult everyone beforehand.
- It is critical to do the appropriate homework before embarking on a program, for both community leaders and foundations. There is no need to start from scratch in this effort, however, as many existing models for exist.
- Arguments for improving access should be framed in simple, persuasive terms. Effectively promoting greater investment in access to care for children likely requires use of language that frames the issue broadly in terms that make an emotional appeal. Examples include framing the issue as a choice about how society allocates its resources or as a means of addressing the thinning of the social contract between government and its citizens. Campaigns that get too lost in the details and statistics are too often met with deaf ears.
- Meeting participants commented that "nothing succeeds like success." It is important, therefore, to support practical demonstrations, measure their progress, and publicize their successes. Policymakers and opinion leaders want to get behind winning programs.
- Evaluation is also critical to achieving sustainability, since policymakers will not want to fund programs that do not have a proven track record. But it is important to remember that not all projects can or even should succeed. Part of the purpose of evaluation is to identify those that no longer deserve support.
- There are many potential partners for grantmakers, and effective coalitions may consist of strange bedfellows. Much of the work consists of bringing together unnatural allies, such as having the business community join forces with the United Way. Other grantmakers have found unlikely allies in the local farm bureau; while usually a conservative voice, the farm bureau is interested in advocating for greater access to care for farm workers' children.

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FOREWORD

As part of its continuing mission to serve trustees and staff of health foundations and corporate giving programs, Grantmakers In Health (GIH) convened a group of grantmakers and health services researchers on November 4, 2005 for an informative discussion about improving children's access to health services, including the opportunities, challenges, and roles for funders. This Issue Dialogue, entitled **More Coverage, Better Care: Improving Children's Access to Health Services,** *covered how the current health care system succeeds and fails for children, emerging policy developments, and what grantmakers are currently doing to promote children's access to health services. The meeting also explored the lessons learned by grantmakers to help guide future work.*

This Issue Brief synthesizes key points from the day's discussion with a background paper previously prepared for Issue Dialogue participants. It includes quantitative and qualitative information on children's health and their access to services, and also profiles grantmaker efforts to promote access to care for our nation's children.

Special thanks are due to those who participated in the Issue Dialogue, especially the presenters: Neal Halfon, director of the UCLA Center for Healthier Children, Families, and Communities; Kevin Cain, president and chief executive officer (CEO) of the John Rex Endowment; Peter Long, senior program officer at The California Endowment; Kate Keller, program officer at The Health Foundation of Greater Cincinnati; and Sara Rosenbaum, Harold and Jane Hirsh Professor of Health Law and Policy and chair of the Department of Health Policy at The George Washington University.

Lauren LeRoy, president and CEO of GIH, moderated the Issue Dialogue. Osula Evadne Rushing, senior program associate at GIH, planned the program, wrote the background paper, and synthesized key points from the Issue Dialogue into this report. Larry Stepnick of The Severn Group, Inc., Anne Schwartz, vice president of GIH, and Todd Kutyla, communications manager at GIH, also contributed to this report.

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CHILD HEALTH

Although this nation has witnessed enormous improvements in child health over the last century, there are rising numbers of children with serious diseases and disorders. These children have health needs different than those of adults and often face disadvantages that persist throughout their lives.

Certain unique aspects of childhood make children's health needs different than those of adults.

The United States has witnessed enormous improvements in children's health over the last century. Both childhood mortality and infectious disease rates have been drastically reduced, due for the most part to major advances in medicine and public health (Figure 1). Despite these successes, however, there are rising numbers of children with serious chronic diseases, including childhood obesity, diabetes, and asthma. There is also a high prevalence of intentional and unintentional injuries, mental health disorders, and attention deficit disorder among our nation's youth. And it is of great concern to many that several of these diseases and disorders are not equally distributed across the population, with some groups of children suffering more than others (Institute of Medicine 2004).

Certain unique aspects of childhood make children's health needs different than those of adults. Illness, injury, or difficult family and social circumstances can seriously harm a child's physical and emotional development. A number of the complex challenges facing children — including family substance abuse, neighborhood violence, and learning problems — cannot be adequately addressed by traditional medical services and require more comprehensive care. And children are almost totally dependent on adults to identify and react to their health needs, to arrange and consent to care, and to follow treatment guidelines. For these reasons, health promotion, disease prevention, and coordinated care strategies are essential to children's health care (Halfon et al. 1996a).

There are both short- and long-term consequences of poor childhood health. Healthy children are more ready and able to learn, and are more likely to become healthy adults who can contribute to the nation's future growth and prosperity. Children who are not in good health face disadvantages that often persist throughout their lives. Unhealthy children face higher rates of failure in school, often leading to additional societal expenditures for special education, mental health, and juvenile justice. Unhealthy children also often become unhealthy adults, with research showing that many adult health conditions and disparities have their roots in childhood. For this reason, poor childhood health is linked with lower rates of productivity later in life, with the result of increased rates of social dependency among individuals and diminished economic performance for the nation as a whole (Halfon 2005).

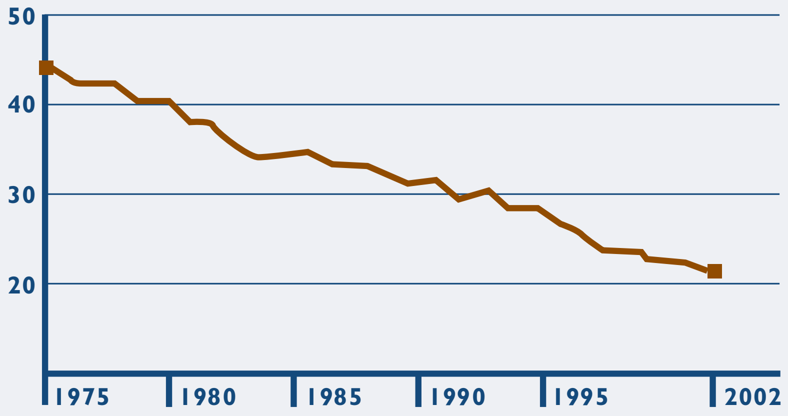
CHILDREN'S ACCESS TO THE HEALTH CARE SYSTEM

One of the most important strategies for improving childhood health is to make health care services more available to children. There are two main approaches to improving access to health care: expanding health insurance coverage and redesigning the health care delivery system.

Unhealthy children often become unhealthy adults, with research showing that many adult health conditions and disparities have their roots in childhood.

Good health is the result of several factors, including the availability and quality of health care, behavior patterns, social circumstances, and environmental exposure (McGinnis et al. 2002). Children need a caring, preventive health care system — one that helps families predict future needs, monitors emerging concerns, and coordinates care (Chung and Schuster 2004). Yet 12 percent of children have had no health care visit to an office or clinic within the past 12 months and 6 percent of children have no usual source of health care (National Center for Health Statistics 2005). These are indicators of access: the degree to which individuals and groups are able to obtain needed services from the health care system

Figure 1. **Child Death Rate (Deaths per 100,000 Children Ages 1 – 14), 1975 – 2002.**



Source: The Annie E. Casey Foundation, *2005 Kids Count Data Book Pocket Guide* (Baltimore, MD: July 2005).

(Institute of Medicine 1993). Family income, race, and ethnicity are clearly related to access to care, with poor children and children of color often faring far worse on access measures than nonpoor or white children (Randolph et al. 2004).

There are two main approaches to improving access to health care: expanding health insurance coverage and redesigning the health care delivery system (Meyer and Silow-Carroll 2000). Insurance coverage reduces the costs associated with health care services that may create barriers to their use. Efficient delivery of care ensures that health services can be easily found and utilized. A number of forces related to insurance and service delivery contribute to the access problem.

Children need a caring, preventive health care system — one that helps families predict future needs, monitors emerging concerns, and coordinates care.

COMPONENTS OF HEALTH CARE ACCESS

Attaining good access to care requires three discrete steps:

- Gaining entry into the health care system.
- Getting access to sites of care where patients can receive needed services.
- Finding providers who meet the needs of individual patients and with whom patients can develop a relationship based on mutual communication and trust.

Health care access is measured in several ways including:

- Structural measures of the presence or absence of specific resources that facilitate health care, such as having health insurance or a usual source of care.
- Assessments by patients of how easily they are able to gain access to health care.
- Utilization measures of the ultimate outcome of good access to care—i.e., the successful receipt of needed services.

Source: Agency for Healthcare Research and Quality, *2005 National Health Care Disparities Report* (Rockville, MD: December 2005).

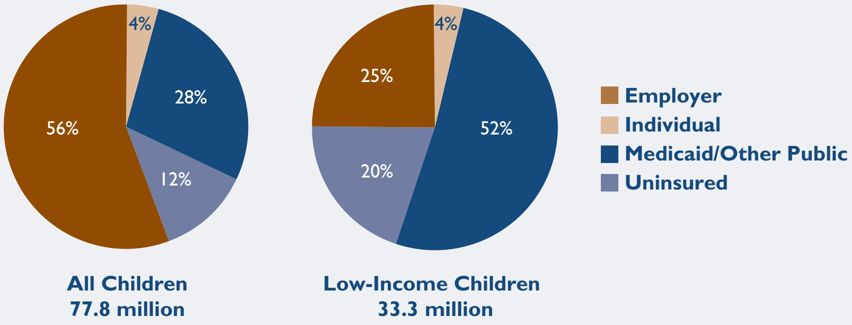
HEALTH INSURANCE COVERAGE FOR CHILDREN

The percentage of children who are insured has grown over the past two decades, but that progress is being threatened. Private insurance, traditionally the major source of coverage for children, is eroding. Public insurance programs, which are largely responsible for the great strides made in providing access to children, are challenged by rising costs and increasing enrollment. And many children who are eligible for existing programs remain uninsured.

Health insurance coverage is one of the strongest predictors of whether children have access to health care. Insurance coverage reduces the out-of-pocket costs of health care, providing children entrée into the health care system and shielding their families from the economic hardships that an unexpected injury or illness can create (Lewit et al. 2003). Those without coverage are less likely to receive preventive care, more likely to use the emergency room and be hospitalized for avoidable health problems, and more likely to face medical debt. Those with coverage have fewer barriers to health care, higher utilization of health services, and better health outcomes. Tremendous progress has been made in the last several decades in improving access to insurance coverage for children, with the percentage of children who are uninsured declining steadily over the last 20 years (Cunningham and Kirby 2004). Today 88 percent of all children and 80 percent of low-income children in the United States have health insurance, either through the private market or public programs (Figure 2).

Health insurance coverage is one of the strongest predictors of whether children have access to health care.

Figure 2. **Health Insurance Coverage of Children, By Income, 2004.**



Source: Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage in America: 2004 Data Update* (Washington, DC: November 2005).

Changes in the availability and affordability of employer-sponsored coverage have a large impact on health coverage for children.

Private Health Insurance Coverage

Private coverage is provided primarily through benefit plans sponsored by employers. Sixty-one percent of nonelderly people were insured through employer-sponsored health insurance in 2004. People without access to employer-sponsored insurance may obtain health insurance on their own through the nongroup market. About 5 percent of nonelderly people purchased individual coverage in 2004 (Claxton 2002; Kaiser Commission on Medicaid and the Uninsured November 2005).

In the mid-1970s, almost 80 percent of children were covered by private health insurance. In the late 1970s and early 1980s, private coverage rates among children began to decline, especially for low-income children. Most of this initial decline was due to increased child poverty, which was caused by a severe economic recession, high unemployment, and stagnating incomes. Private insurance rates have continued to drop since the 1980s, with most of the decline due to the erosion of employer-sponsored coverage caused by increasing health care costs (Cunningham and Kirby 2004).

Employer-Sponsored Coverage

The majority (56 percent) of the nation's 78 million children received health insurance coverage through a parent's employer-sponsored policy in 2004, so changes in the availability and affordability of employer-sponsored coverage have a large impact on health coverage for children (Kaiser Commission on Medicaid and the Uninsured November 2005; Rousseau 2005). The proportion of children with employer-sponsored insurance dropped 5 percentage points between 2000 and 2004, as a result of the steep increases in premium costs, a decreasing number of employers offering coverage, and a decreasing number of employees being able to afford coverage even if offered (Kaiser Commission on Medicaid and the Uninsured 2004; Kaiser Commission on Medicaid and the Uninsured November 2005).

The children of parents who are lower-wage workers are less likely to have employer coverage, because companies with a high percentage of lower-wage workers are less likely to offer health insurance. Even when a company offers health insurance, not all employees are able to get coverage for themselves and their children. Some are not eligible to enroll because of rules about how many hours an employee must work or how much tenure an employee must have to be eligible for coverage; others choose not to enroll because of escalating premium contribution and cost-sharing requirements (Kaiser Family Foundation and Health Research and Educational Trust 2005).

Since 2000, premiums for family coverage have increased by 73 percent, compared with inflation growth of 14 percent and wage growth of 15 percent. Over 90 percent of employees with family coverage made a contribution toward premiums in 2005; employees on average contribute $2,713 of the $10,880 annual cost of family coverage. On average, employees in small companies make a significantly higher contribution ($3,170) toward family coverage than employees in large companies ($2,487). In addition to their premium contributions, most employees also make payments when they use health care services, in the form of deductibles, coinsurance, and copayments (Kaiser Family Foundation and Health Research and Educational Trust 2005).

Individual Coverage

Although there is an individual health insurance market, it is not a significant source of coverage for children. In 2003, only 4 percent of children had health insurance purchased in this nongroup market (Kaiser Commission on Medicaid and the Uninsured November 2005). One important individual market protection for parents, however, is COBRA coverage, which takes its name from the federal Consolidated Omnibus Budget Reconciliation Act of 1985. Through provisions of the act, people losing employer coverage can temporarily remain in their job-based group plan. The ex-employee must pay the full cost of the premium, plus a small administrative fee. Many workers eligible for COBRA coverage, however, find the cost prohibitive. Using average employer-sponsored health plan costs for 2003, a worker with family coverage who had been paying $201 a month would now be required to pay $771 per month for the same coverage (Alliance for Health Reform 2004).

Public Health Insurance Coverage

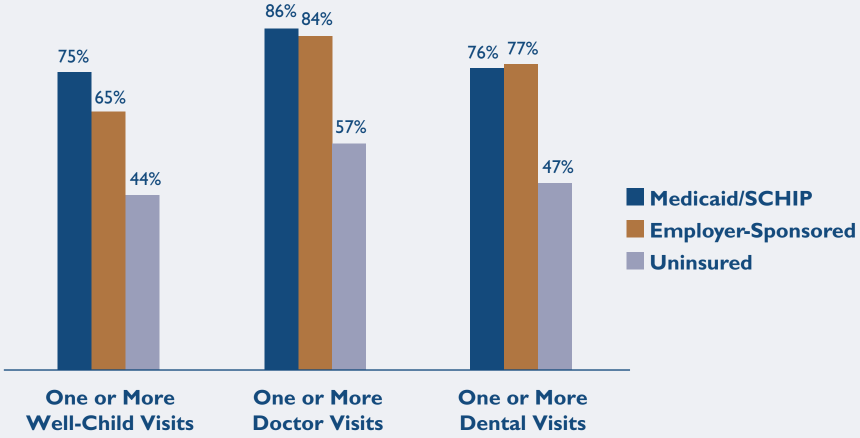
Federal and state partnerships, including Medicaid expansions in the 1980s and the enactment of the State Children's Health Insurance Program (SCHIP) in the late 1990s, have provided public health insurance coverage to millions of children, offsetting the erosion of private health insurance and helping to decrease uninsurance rates. A quarter of all children and half of low-income children receive some form of public health insurance coverage (Figure 2). Most of the progress made in improving children's access to health care over the past two decades has been as a result of the expansion of public programs.

A quarter of all children and half of low-income children receive some form of public health insurance coverage.

Medicaid

Medicaid is the largest single health insurance program for American children and has long been a critical safety net for low-income children. In 2003, over 25 million children were enrolled in Medicaid at a cost of nearly $45 billion. Although children represent nearly half of all Medicaid enrollees, they account for only 19 percent of total program spending (Kaiser Commission on Medicaid and the Uninsured 2004). States receive federal matching dollars to provide Medicaid coverage, and

Figure 3. **Access to Care among Low-Income Children, by Insurance Status, 2002.**



Source: Kaiser Commission on Medicaid and the Uninsured, *Health Coverage for Low-Income Children* (Washington, DC: 2004).

are required to extend Medicaid eligibility to children ages 0 to 5 at or below 133 percent of the federal poverty level, and to children ages 6 to 18 at or below 100 percent of the federal poverty level. Many states have extended coverage to children living in families at higher income levels (Kaiser Commission on Medicaid and the Uninsured 2004). For some types of care, access to health care for children with Medicaid coverage is comparable to that for privately insured children (Figure 3).

Countless studies have recorded the accomplishments of the Medicaid program in terms of children's primary care utilization, mortality and hospitalization rates, school readiness, and health care costs. A recent review of the literature conducted by the Center on Budget and Policy Priorities highlighted a number of these successes. A 2001 Urban Institute study found that 86 percent of children with Medicaid or SCHIP had seen a doctor or other health professional in the past 12 months, while only 58 percent of uninsured children had done so. The study also found that 75 percent of children in Medicaid or SCHIP had a preventive or well-child health visit within the past 12 months, compared to 46 percent of uninsured children. A 1996 study in the *Quarterly Journal of Economics* found that expansions of Medicaid eligibility for low-income children in the late 1980s and early 1990s led to a 5.1 percent reduction in childhood deaths. A 2003 Agency for Healthcare Research and Quality study found that children who live in areas with broader Medicaid eligibility experienced lower average rates of preventable hospitalizations. Children with Medicaid coverage have been found to miss fewer school days due to sickness and have fewer restricted activity days than comparable children

Countless studies have recorded the accomplishments of the Medicaid program in terms of children's primary care utilization, mortality and hospitalization rates, school readiness, and health care costs.

who lack health care coverage. And a 2005 Urban Institute study found that after adjusting for differences in health status and other characteristics, medical expenditures for children enrolled in Medicaid were 10 percent lower than such costs would be under private health insurance (Ku August 2005).

The key component of Medicaid coverage for children is the mandatory early and periodic screening, diagnostic, and treatment (EPSDT) benefit for individuals under 21, which was enacted in 1967, two years after Medicaid was established. EPSDT is an extremely comprehensive benefit, which encompasses a wide range of screening services; physical exams; immunizations; lab tests; health education; and vision, dental, and hearing services (Alliance for Health Reform 2004). EPSDT benefits were expanded in 1989 to address benefit limits for children with mental and developmental disabilities. EPSDT benefits are mandatory for all categorically needy children, who represent 94 percent of all children on Medicaid. The benefits are optional for the other 6 percent who are classified as medically needy and for children covered through separate SCHIP plans.

Several aspects of the EPSDT benefit make it important for low-income children and children with special needs. The scope of the health exams covered by the program is unique, and the range of diagnostic and treatment services provided for children whose examinations reveal potential physical, mental, or developmental conditions is unmatched, even by private insurance. Moreover, EPSDT uses a broad preventive standard to define medical necessity, and the term, early, has been interpreted to require health care interventions at the earliest possible time, when they are needed to lessen the effects of physical and mental conditions that potentially might impair childhood growth and development (Rosenbaum et al. 2005). EPSDT also covers administrative services such as informing families; providing transportation, scheduling, and other assistance; providing linkages to other agencies, such as special education, child welfare, and WIC programs; and reporting (Rosenbaum 2005).

State Children's Health Insurance Program (SCHIP)

Congress expanded children's public coverage in 1997 by creating SCHIP. SCHIP provides health coverage to low-income children who live in families with income or assets above Medicaid eligibility levels, yet whose parents cannot afford to purchase private insurance. When SCHIP was established, the federal government committed $48 billion over 10 years to support the state-administered program (Alliance for Health Reform 2004). Each state receives an annual allotment of this funding, at a match rate higher than that for the Medicaid program. In 2003, about 4 million children were covered by SCHIP. Within SCHIP programs, states may require that families contribute to

Medicaid's EPSDT is an extremely comprehensive benefit which is important for low-income children and children with special needs.

premiums and make copayments (Kaiser Commission on Medicaid and the Uninsured 2004).

SCHIP has resulted in major improvements in children's access and coverage. Under SCHIP, states have worked to improve enrollment and retention processes and have used many different outreach strategies. Declines in the number of uninsured children have been associated with the growth in SCHIP enrollment, and the program has been shown to reach the low-income children it was designed to target. SCHIP coverage has been found to diminish unmet need, boost preventive care, raise the probability of having a usual source of care, lessen parents' stress and financial barriers, and improve children's access to oral health care. Many of the novel enrollment and retention procedures used in SCHIP have also been adopted by Medicaid, increasing enrollment in that program as well (Kenney and Chang 2004).

Progress at Risk

Many of the proven gains achieved by Medicaid and SCHIP may now be at risk. Average annual Medicaid spending increased 10.2 percent from 2000 to 2003, due to overall increases in health care costs, an economic downturn, and increased program enrollment. This growth has contributed to increasing fiscal strain at the state and federal levels, and led policymakers to reconsider the populations served and services covered by the Medicaid program (Perlino 2005).

States have only a few ways to cut Medicaid and SCHIP costs — reducing enrollment, reducing benefits, increasing cost sharing, or reducing provider payments — all of which potentially worsen children's access to health care.

States have only a few ways to cut Medicaid and SCHIP costs — reducing enrollment, reducing benefits, increasing cost sharing, or reducing provider payments — all of which potentially worsen children's access to health care (Lewit et al. 2003). At least half of all states have approved measures to cut costs, by freezing enrollment, increasing

COST SHARING IN MEDICAID

Even at relatively low levels, cost sharing in a serious barrier to health care for low-income families. By definition, cost-sharing in Medicaid and SCHIP shifts a share of the program costs from states and the federal government to program beneficiaries. Research indicates that higher copayments can make it harder for people covered by Medicaid to afford medical services they need, while premiums can make it more difficult for low-income people to enroll and maintain coverage. Research also shows that higher copayments tend to cause low-income people to decrease their use of essential as well as other health care, and can trigger the subsequent use of more expensive forms of care such as emergency room care or hospitalization (Ku 2005; Ku and Wachino 2005; PICO National Network 2005).

IMMIGRANTS' ACCESS TO PUBLIC COVERAGE

A series of policy changes in the past decade — the 1996 Personal Responsibility and Work Opportunity Reconciliation Act, the enactment of sponsor deeming rules, and publicity about the Immigration and Naturalization Service's (INS) efforts to apply public charge enforcement to Medicaid — have dramatically limited immigrants' access to public coverage and caused many immigrants eligible for Medicaid and SCHIP to remain uninsured for fear of jeopardizing their citizenship status. For a more detailed discussion of immigrants' access and coverage, see the GIH Issue Brief, *For the Benefit of All: Ensuring Immigrant Health and Well-Being* (November 2005).

Despite all the progress being made, nearly 12 percent of children and 20 percent of low-income children remain uninsured.

premiums, and making enrollment procedures more complicated (Kaiser Commission on Medicaid and the Uninsured March 2005a). Over the past few years, a growing number of states have also applied for 1115 waivers that have allowed them to make structural changes to the Medicaid program not otherwise allowed under federal law (Kaiser Commission on Medicaid and the Uninsured March 2005b).

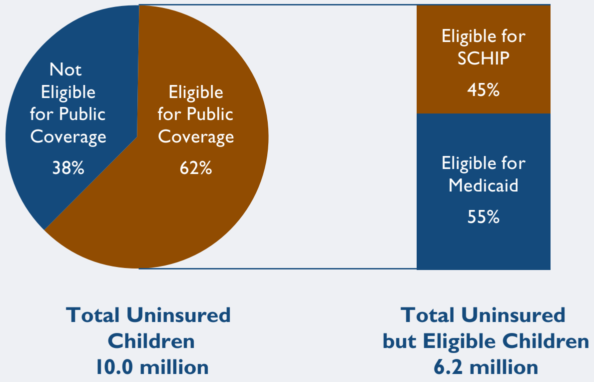
At the same time, federal policymakers have been exploring options for reforming Medicaid in order to reduce the program's costs. A federal Medicaid commission charged with recommending short- and long-term reforms to the program has released a set of proposals which would reduce Medicaid spending growth by $11 billion over the next five years (kaisernetwork.org September 2005). The commission's second report, due December 31, 2006, will include recommendations for stabilizing Medicaid over the long term. The U.S. Congress is also considering legislation that will cut Medicaid costs by giving states greater flexibility to require copayments and premiums from beneficiaries and limit benefits, as well as tighten rules for transfers of assets by individuals to obtain Medicaid coverage for long-term care (kaisernetwork.org December 2005).

Children without Health Insurance Coverage

Even with the coverage offered by employers, available in the individual market, and provided by federal and state governments, nearly 12 percent of all children and 20 percent of low-income children are uninsured. Lack of insurance is a major barrier to health care. Uninsured children are half as likely as privately insured children to have well-child visits, office visits, or hospitalizations (Chung and Schuster 2004). Uninsured children

Sixty percent of uninsured children are actually eligible for Medicaid or SCHIP coverage.

Figure 4. **Uninsured Children by Eligibility Status, 2002.**



Source: Kaiser Commission on Medicaid and the Uninsured, *Health Coverage for Low-Income Children* (Washington, DC: 2004).

are less likely than insured children to receive needed medical care and to have a personal doctor or nurse (State Health Access Data Assistance Center and Urban Institute 2005). Children remain uninsured for a variety of reasons, including the rising costs of private coverage, the inaccessibility of public programs for undocumented immigrants, and the lack of participation in public programs by eligible children.

More than 60 percent of the 8.4 million uninsured children appear to be eligible for Medicaid or SCHIP coverage, yet they are not enrolled in either program (Figure 4). Early evaluations of SCHIP uncovered a variety of reasons for parents not enrolling their potentially eligible children in public health insurance programs, including a lack of awareness about the programs, difficult administrative processes, or not believing that public insurance would be good or necessary for their children (Kenney and Haley 2001).

The retention of health insurance coverage is also a problem for children. There has been a great deal of recent research on so-called churning, a phenomenon in which people gain and lose coverage multiple times in the course of a year. The evidence suggests that having unstable health insurance coverage reduces health care quality and access. Children with gaps in coverage are less likely to receive needed services or medicine than those with continuous private coverage. Though uninsured children are more likely than adults to get and keep coverage, between 1998 and 2000, 29 percent of children with Medicaid coverage experienced a period without insurance (Klein et al. 2005).

State efforts to respond to the administrative obstacles to enrollment and retention have included establishing continuous eligibility; adopting short, joint applications for Medicaid and SCHIP; eliminating face-to-face interviews and resource tests; allowing self-declaration of income and electronic submissions; and using passive renewal systems. States have also undertaken massive outreach campaigns, making use of mass media outlets and community-based partnerships (Kenney and Chang 2004). Unfortunately, many of these strategies are being scaled back as states struggle to respond to the programs' rising costs.

It is important to note that many insured children are underinsured. They often lack coverage for prescription drugs or dental care, or forgo services due to deductibles and copayments that are unaffordable for low-income parents. And not all insurance plans are created equal, with some covering fewer well-child or emergency visits than others (Chung and Schuster 2004). Benefits packages also vary in public coverage. Medicaid eligibility requirements and benefit packages also vary from state to state, and SCHIP benefits are more limited than Medicaid benefits. For example, unlike in EPSDT, some SCHIP services (such as vision, dental, and hearing) are optional rather than required. In addition, the definition of medical necessity is stricter under SCHIP, and some cost-sharing is permitted in the program.

INVESTING IN PUBLIC HEALTH

Some of the largest improvements in child health over the last century have been a result of public health advances. The United States has seen dramatic declines in vaccine-preventable diseases and infant mortality rates, for example. But while several of the current threats to child health — injuries, violence, obesity, and exposure to secondhand smoke and other environmental hazards — would benefit from public health interventions, many communities are struggling to support the public health infrastructure. For a more detailed discussion of promising solutions to the nation's public health challenges, see the GIH Issue Brief, *Building a Healthier Future: Partnering to Improve Public Health* (September 2005).

Most children are children are not well insured "from the neck up" lacking comprehensive coverage for mental health, developmental, dental, or vision care.

THE DELIVERY OF HEALTH CARE FOR CHILDREN

The existence of insurance alone does not eradicate all of the barriers to accessing suitable health care services (Institute of Medicine 1998). Even among those with insurance, an array of barriers prevent timely access to health care, including the availability and location of providers, the cultural and linguistic competence of providers, the existence of referral services, and the strength of the safety net.

Primary Care

Emphasizing the importance of continuity of care in comprehensive health supervision, the American Academy of Pediatrics recommends that children have at least 26 well-child visits by the age of 21 (American Academy of Pediatrics 2000). For the parents of uninsured children, and even those who are insured, it may be difficult to find a consistent provider who is conveniently located, with hours that accommodate a family's work and child care schedules; who has the linguistic skills and cultural sensitivity necessary to provide quality care; or who accepts uninsured patients or children with public coverage (Lewit et al. 2003). Many families who are nonwhite, non-English speaking, less educated, and poor have drastically limited access to well-child care (Chung and Schuster 2004).

In Chicago, the ratio of children to pediatricians in poor neighborhoods is 5,887:1, as compared to a national average of approximately 1,000:1.

Availability of Health Care Providers

Nearly 13 percent of Americans do not have a regular source of care due to the lack of available primary care providers (Proser et al. 2005). In Chicago, for instance, the ratio of children to pediatricians in poor neighborhoods is 5,887:1, as compared to a national average of approximately 1,000:1 (The Center for Health and Health Care in Schools 2005). Private physicians tend not to be sited in low-income areas and many are not available to low-income patients. Recent research has shown that the number of primary care physicians per capita has been steadily shrinking, and only half of physicians are willing to accept all new Medicaid patients (with one-fifth not accepting any) (Proser et al. 2005). This lack of health care providers has serious implications for children and for health care costs; children from families living in areas with fewer primary care physicians, irrespective of health insurance coverage, have been found to have a greater reliance on emergency departments for sick care (Halfon et al. 1996b).

Linguistically and Culturally Competent Health Care

Parents and children with limited English proficiency (LEP) are less likely than proficient English speakers

SCHOOL-BASED HEALTH CARE

Schools are often regarded as an ideal place to provide health care for young people because they are the single place where most children spend the bulk of their time; they tend to be in convenient, accessible locations within communities; and students are often more comfortable seeking health care advice — especially mental health counseling — in the safe, familiar environment that schools present (Brodeurk 2000).

Once considered controversial, with some opponents objecting to school involvement in children's health care and others objecting to the family planning counseling offered at some sites, school-based health centers (SBHCs) are now found in more than 1,500 U.S. schools. SBHCs provide comprehensive physical and mental health services and have come to be viewed as one of the best ways communities address the unmet needs of young people (The Center for Health and Health Care in Schools 2005).

A major challenge facing school-based health centers is the continuing need for long-term financing. SBHCs knit together funding from a variety of sources, often receiving in-kind space from schools; staff and supplies from local hospitals, health systems, and community health centers; and revenue from the federal Maternal and Child Health (MCH) Block Grant program, the federal Healthy Schools/Healthy Communities direct grant program, state general fund support, third-party revenues (especially from Medicaid), local dollars, and foundation grants. Like many community-based programs that rely on categorical funding, school-based health centers (and the children they serve) find themselves uncomfortably vulnerable to shifting policy priorities and fiscal conditions (The Center for Health and Health Care in Schools 2005).

Parents of color more often report that health care providers never or only sometimes understand the ways they prefer to raise their young children and Latino parents report more often than parents in other racial/ethnic groups that providers never or only sometimes completely comprehend what their child needs.

to obtain needed health care services. They have fewer health care visits and receive fewer preventive services — disparities that cannot be fully explained by literacy, health status, insurance coverage, regular source of care, economic indicators, or ethnicity (Brach et al. 2005). Problems in patient-provider communication also occur between families and health professionals who speak the same language but come from different cultures. Parents of color more often report that health care providers never or only sometimes understand the ways they prefer to raise their young children and Latino parents report more often than parents in other racial/ethnic groups that providers never or only sometimes completely comprehend what their child needs (National Initiative for Children's Healthcare Quality 2005).

Referral Services

Children's health care services are delivered by a number of different providers at several different locations. At some point, most children need referral to services not provided as part of a routine pediatric visit, such as dental or vision care. These referrals vary by urgency and approval method. There are a number of challenges inherent in this model. Most children do not have comprehensive coverage for mental health, developmental, dental, or vision care. Primary care providers often find it difficult to locate specialists willing to provide care to low-income or uninsured children. Families are often frustrated by poor communication between providers or lack of coordination between services, which can lead to duplicated tests or treatment errors. And the quality of care provided to a single child with a fragmented group of providers is often jeopardized by confusion about who is responsible for meeting which part of the child's needs (Chung and Schuster 2004; Simpson and Stallard 2004).

Primary care providers often find it difficult to locate specialists willing to provide care to low-income or uninsured children.

Many children, especially those with multiple or special health care needs, would benefit from easier access to specialists and a better coordination of their medical services and providers. Medical home programs are attempting to fill this gap by consolidating primary and specialty care into seamless comprehensive care models (Chung and Schuster 2004). The American Academy of Pediatrics defines a medical home as primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. In the medical home model, pediatricians work jointly with children and families to guarantee that all of the needs of a child are met. The provider helps children and families coordinate specialty care, educational services, out-of-home care, family support, and other public and private community services (American Academy of Pediatrics 2005).

The Safety Net

Low-income children tend to rely on an extended but stressed network of safety net providers: those school-based health centers, public hospitals, community health centers, public health departments, individual practitioners, and others who provide health care for uninsured and underinsured adults and children, regardless of their insurance coverage, ability to pay, or immigration status (Institute of Medicine 1998). Safety net providers are often cited for their essential efforts to ensure access to the underserved, their leadership in developing and delivering culturally and linguistically competent health care, and the prevention-oriented primary care services that they provide (The California Endowment 2004). Community health centers alone provide care to one out of every six ow-income children (Cunningham and Hadley 2004). Research has tended to show that safety-net providers such as community health centers increase access to primary care, although they usually do not offer specialty care.

Communities vary in their concentration and capacity of safety-net providers. In a recent study of 12 cities across the country, those with high rates of insurance coverage and a high capacity of community health centers were found to have the highest levels of access to care (Cunningham and Hadley 2004).

Despite their importance, there is no sole or sure source of financial support for safety net providers. Safety net financing is disjointed and providers must mix funding from several sources to raise the revenue needed to provide a growing number of services (Regenstein and Huang 2005). The combination of unpredictable funding and a rising need for services is placing safety net providers in an increasingly precarious position (The California Endowment 2004).

ACCESS AND QUALITY

While this Issue Brief focuses on improving children's access to health care services, it is important to remember that there are other factors that contribute to children's health, including the quality of health services. Those with access to health care do not necessarily receive appropriate or optimal care. Many parents report not receiving appropriate preventive health care. For example, 43 percent of parents of children on Medicaid report that their child's health provider did not ask about any concerns they may have about their child's learning, development, or behavior. Up to one-third of parents are not asked about concerns regarding speech and language development. Nearly half of parents report having never received a developmental assessment of their child (Halfon 2005).

Research has also shown that many children diagnosed with specific medical conditions do not get the care they need. For example, one in three children with persistent asthma does not get appropriate medication. Low-income children are especially likely not to get needed services. For example low-income children with sickle-cell anemia typically do not receive needed prophylactic antibiotics. Only a third of children with mental health problems receive services for these problems; rates of care for children in foster care are even lower. While in some cases the failure to receive needed care is due to access problems, many times the problems are attributable to poor system design and performance (Halfon 2005).

Despite their importance, there is no sole or sure source of financial support for safety net providers.

PHILANTHROPIC ACTIVITIES

Foundations and corporate giving programs are supporting a wide range of activities related to children's health care access, with many believing that success in providing access to all children can both improve children's health outcomes and serve as the foundation for broader health reform. This section profiles programs in four areas: facilitating enrollment in existing public programs, enhancing and expanding public coverage, supporting school-based health care, and engaging community members in shared planning and action.

Broadening Insurance Coverage

Since most uninsured children are eligible for Medicaid or SCHIP, many foundations have invested heavily in outreach, enrollment, and retention efforts. Other funders have begun to support initiatives that reform Medicaid and SCHIP eligibility and enrollment procedures and develop new insurance products.

Facilitating Enrollment in Existing Public Programs

In 1997, The Robert Wood Johnson Foundation (RWJF) launched *Covering Kids: A National Health Initiative for Low-Income Uninsured Children* to help states and local communities increase the number of eligible children who benefit from public health insurance coverage programs. The RWJF board of trustees originally authorized a $13 million program to run in 15 states for three years. But the following year, in response to the high number of applications for funding and the new opportunities created by SCHIP to enroll even more children in health coverage programs, the board increased the total *Covering Kids* authorization to $43 million and extended the program to all 50 states and the District of Columbia. RWJF also supported the program by authorizing more than $26 million in a separate four-year nationwide communications campaign, beginning in 2000, to increase the visibility and understanding of existing government programs bringing health coverage to eligible children. *Covering Kids* played a key role in increasing the enrollment of children in Medicaid and SCHIP, and made a crucial contribution to the simplification of enrollment procedures and the coordination and cross-linking of both eligibility and enrollment systems for existing public health insurance programs for children.

In May 2001, RWJF's board of trustees announced creation of a follow-up program to *Covering Kids* called *Covering Kids & Families*. The initiative was authorized at up to $65 million and scheduled to run for four years. The program's three goals are to:

Since most uninsured children are eligible for Medicaid or SCHIP, many foundations have invested heavily in outreach, enrollment, and retention efforts.

- reduce the number of uninsured children who are eligible for Medicaid or SCHIP coverage but remain uninsured.
- reduce the number of uninsured adults who are eligible for Medicaid or SCHIP coverage but remain uninsured. (The new focus on enrolling adults in Medicaid and SCHIP is based in part on research findings that demonstrate that offering coverage to parents helps to identify and enroll more eligible children.)
- build knowledge, experience and capacity to achieve an enduring national and regional commitment to sustain the enrollment and retention of children and adults in Medicaid and SCHIP beyond the grant period.

Covering Kids & Families operates in 50 states and the District of Columbia and focuses on the three key strategies utilized during *Covering Kids:* (1) conducting and coordinating outreach programs; (2) simplifying coverage enrollment and renewal processes; and (3) coordinating eligibility and enrollment procedures among existing health care coverage programs.

W.K. Kellogg Foundation's *Community Voices* initiative was created to help ensure the viability of existing safety-net providers and strengthen community support services. This effort, begun in August 1998, provided funding to 13 communities to act as learning laboratories. Some of these communities had funding into 2004. Eight communities and the Morehouse School of Medicine National Center for Primary Care are being funded through 2007. The *Community Voices* learning laboratories have engaged in a number of innovative and successful community-based outreach and enrollment strategies. These communities place particular emphasis on breaking down barriers to enrolling and retaining hard to reach populations in public coverage programs. Some of the most successful strategies have included:

- placing enrollment workers in a variety of neighborhood settings (family support centers, schools, libraries, churches) beyond traditional enrollment offices to expand opportunities for people to learn about and apply for coverage;
- approaching individuals with an understanding of their historical and cultural backgrounds — from using outreach materials in languages and at education levels that are specific to the community involved, to ensuring that community workers speak the languages or are of the same ethnic background as target populations, to addressing the fears and misconceptions many immigrant families have about enrolling in public programs;
- enlisting neighborhood residents, community health workers, or promotores — generally women who have enrolled their own children in Medicaid or SCHIP

Research findings demonstrate that offering coverage to parents helps to identify and enroll more eligible children.

and can speak from their own experiences — to engage community members and participate in the outreach process;

- ensuring a user-friendly atmosphere and process, with enrollment centers that have a children's play area and are accessible by public transportation; outreach and enrollment workers who are friendly and respectful; and an application process that is as quick and efficient as possible;
- working with hospitals and safety net providers to identify potential applicants at the time they access health care services;
- coordinating the efforts of local and state agencies involved in outreach and enrollment activities in order to pool resources, share best practices, and avoid duplication of efforts;
- educating the public about health programs and the enrollment process through community events at which staff and volunteers truly engage with potential applicants;
- using local media and marketing to connect with potential applicants and health care providers; and
- providing financial assistance for the most needy in states that impose application and recertification fees or SCHIP premiums (Silow-Carroll et al. 2002).

Local foundations have also tackled enrollment in their communities. When the John Rex Endowment began its grantmaking in 2001, the staff conducted interviews with providers and agency representatives on the children's health issues of most concern in Wake County, North Carolina. The conversations led endowment staff and trustees to believe that increasing access to care was fundamental to improving children's health and a sound first step for the endowment to take on behalf of low-income children in Wake County. Concerned about the number of children in the county who were eligible for yet unenrolled in public programs, and desiring a first initiative that could have measurable results, the endowment made its first two grants in 2001, one to a local medical society and the second to a federally funded health clinic that is an important safety net provider.[1] These grants of over $2 million, were designed to help these organizations enroll eligible low-income children in Health Check (Medicaid) and North Carolina Health Choice (SCHIP). When the first grants were proposed it was estimated that several thousand of the 160,000 children in Wake County were eligible for public coverage but were not enrolled.

Communities across the country have developed a number of innovative and successful outreach, enrollment, and retention strategies.

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[1] The county health system also joined with the John Rex Endowment at this time to help look for ways to get coverage for children who do not presently quality for Medicaid and SCHIP; the agency did not receive direct funding from the foundation, but participates in the initiative through cooperation with the medical society.

The endowment's enrollment projects provide outreach to uninsured children who are eligible for public health insurance programs, provide assistance with the annual reenrollment process for children, and encourage the parents of those children to use their insurance benefits for well-child visits and health screenings as recommended by pediatricians. An evaluation of these enrollment programs suggest that they are having some success in boosting enrollment: the number of primary Medicaid enrollees grew by 3,100 in 2004 — a 14 percent increase from the year before. The number of SCHIP enrollees grew by 1,478 in 2004 — a 28 percent increase from the year before. Comparisons with other major North Carolina counties suggest that Wake County has been more successful than most in getting insurance coverage for children.

The evaluation effort also provided some valuable insights that helped to refine the project. Early results flagged extremely high disenrollment numbers, which encouraged the project's directors to focus on retention efforts. Later results helped the endowment staff determine which project activities were most effective and sustainable. As the foundation's access work moves forward, the staff and board will be focusing on measuring and improving the utilization of health care services; the capacity of the safety net to serve, respond, and innovate; and improved data collection as to what aspects of the program should be supported in the future (Cain 2005).

Enhancing and Expanding Public Coverage

Communities across the state of California are in the process of developing and implementing health insurance programs that are comprehensive and inclusive for all children, including low-income and undocumented children who do not qualify for existing programs. These programs, which combine reforms to the public coverage enrollment system with the creation of locally developed insurance products and broad outreach efforts, have received extensive support from California's grantmakers. Each foundation has adopted a funding strategy that is consistent with its mission, goals, and style. The funders have been intentional about complementing each other's work and keeping each other informed.

The David and Lucile Packard Foundation provided early support for the *Santa Clara County Children's Health Initiative*, an innovative effort to expand health insurance coverage for children in the county. The children's health initiative (CHI) has two parts. The first is a new insurance product, Healthy Kids, for children in families under 300 percent of the federal poverty level who are not eligible for existing state programs (traditional Medicaid, which is known as Medi-Cal in California, and Healthy Families, the state's SCHIP offering). The second is a comprehensive outreach campaign that finds uninsured children and enrolls them in the appropriate program.

California's grantmakers have provided extensive support to communities in the process of developing and implementing health insurance programs that are comprehensive and inclusive for all children.

Enrollment initiatives can provide additional revenues to counties and states, in the form of increased reimbursements collected from Medicaid and SCHIP for the care of low-income, previously uninsured children.

The CHI has become a model for similar efforts in other counties. The foundation supported premium subsidies, the creation of a technical assistance center, and an evaluation of the Santa Clara CHI. This evaluation is being conducted by Mathematica Policy Research, the Urban Institute, and the University of California, San Francisco. Results from the Santa Clara evaluation found that the CHI has led to a 28 percent increase in enrollment in Medi-Cal and Healthy Families. The Healthy Kids program has improved health by increasing the proportion of children with a usual source of primary care (from 50 percent to 89 percent) and dental care (from 29 percent to 81 percent), and by reducing unmet need for both medical and dental care by 55 percent. The CHI also brought $24.4 million in additional revenues over a two-year period to the county, in the form of increased reimbursements collected from Medicaid and SCHIP for the care of low-income, previously uninsured children. Foundation staff have worked with the evaluators, Santa Clara officials, and advocates to tell the story of the Santa Clara CHI across the state. The foundation has also provided start-up funding for CHIs in other California counties and supported quality improvement collaboratives among counties to improve their outreach, enrollment, and retention systems.

Funding from The California Endowment has helped replicate programs similar to the Santa Clara CHI across the state, with the goal of expanding the locally driven, county-level initiatives into a statewide program. In October 2003, the endowment launched a $45 million, five-year initiative, which provides local coalitions engaged or interested in offering expanded coverage options to uninsured children with funding for a range of activities, including planning, technical assistance, outreach, technology, and premium subsidy support. Pilot programs are either in development or have been implemented in 30 counties throughout the state. Eighteen county programs are operational and enrolling children. Another 12 counties are planning such programs. These 30 counties are home to more than 90 percent of the state's uninsured children. One example of a relatively new effort is the Los Angeles children's health initiative, a coalition of more than 50 organizations that are seeking to simplify the system for low-income families with children. Thanks to public and private funding that has exceeded $100 million and high-level support from the mayor, the Los Angeles children's health initiative has enrolled over 100,000 children into various public and private insurance programs since its launch in 2003.

Because the future sustainability of these programs lies in long-term policy change at the state level, the initiative also focuses on improving the efficiency, effectiveness, and coordination of existing public coverage programs. The endowment is supporting a range of related policy change activities, including research and analysis, polling, issue framing and messaging, community organizing, and public and policymaker education. The endowment's research has helped to define the policy debate by providing trusted data on the number of uninsured children in the state, the estimated cost of covering all children, the percentage of California voters who support covering all children, and the amount of unnecessary administrative spending in the state's Medicaid program (Long 2005).

Through a complementary $4.8 million initiative, the endowment is supporting the implementation of Express Lane Eligibility (ELE), a tool for streamlining enrollment of children in health insurance programs. ELE works by establishing linkages with programs, such as the National School Lunch Program, with similar income eligibility rules to Medi-Cal and Healthy Families, to identify and more quickly enroll uninsured children. Four school districts across the state were selected as pilot sites for ELE implementation: The Los Angeles Unified School District, San Diego Unified School District, the Fresno Unified School District, and the Redwood City School District in San Mateo County.

A formative evaluation commissioned by the endowment shows that:

- Of the express enrolled children that accessed health services, over half used clinical services and a third used pharmacy services within the first two months of express enrollment.
- Families are satisfied with the program, and have been pleased to see the link between school lunch and Medi-Cal.
- Schools and counties are working together in ways that they had not done before, building new relationships may pave the way for other programmatic collaborations in the future.
- The school lunch program appears to benefit from this added attention to health insurance. In three of the four pilots the number of school lunch applications increased when ELE was implemented.

California HealthCare Foundation (CHCF) has been a leader in the development of the technology solutions needed to support these coverage expansion and enrollment reform efforts. Health information technology is one of the foundation's key areas of strategic emphasis. CHCF's support of the children's health initiative has been a good example of a foundation finding its niche in a larger effort. In addition to its providing planning and start-up funds to support local expansion efforts in California's counties, CHCF has focused on building and promoting the effective use and adoption of new tools that streamline enrollment processes and improve access to care. In 1998, CHCF devoted $3 million over three years to address a major barrier to Medicaid and SCHIP enrollment: the required completion of a 28-page application. Working with software developers in Silicon Valley and the California Health and Human Services Agency,

Express Lane Eligibility, a tool for streamlining enrollment of children in health insurance programs, is being piloted in four California school districts with promising results.

One-e-App's state-of-the-art technology streamlines the enrollment process by collecting data from a family once, instead of multiple times (often at different locations) and transmitting it electronically to the appropriate agencies.

CHCF developed *Health-e-App,* a user-friendly Web-based system to automate every aspect of the enrollment process, prompting applicants on the specific information needed and ensuring that essential information is not left out. More importantly, the system was designed so that families receive real time feedback about their preliminary eligibility determination, and the complete application, including an electronic signature, can be submitted online to the state. Total enrollment time decreased from upward of 45 minutes to 20 minutes, with a preliminary eligibility determination delivered in three seconds. After the successful pilot of *Health-e-App* in San Diego County, the foundation licensed the system at no cost to the State of California for statewide implementation; it was also licensed for use in Arizona and Indiana (Schwartz and LeRoy 2004).

More recently, CHCF and The California Endowment have partnered to expand the range of programs available through *Health-e-App* and add new features and functionalities to support retention efforts. The new enhanced system is called *One-e-App*. It provides an efficient one-stop approach to enrollment in a range of public-sector health programs. *One-e-App's* state-of-the-art technology streamlines the enrollment process by collecting data from a family once, instead of multiple times (often at different locations) and transmitting it electronically to the appropriate agencies. *One-e-App's* key features include:

- a consumer-friendly process for screening and enrollment,
- preliminary eligibility determination across multiple programs,
- automated application submission,
- real-time transactions (such as premium payments),
- interfaces with local and state eligibility systems,
- translations into multiple languages,
- case management and client retention tools,
- built-in security and client confidentiality,
- local management of outreach and enrollment activities, and
- support for customization and ongoing maintenance and upgrades.

Counties and their community-based partners use the system to screen and enroll individuals and families in Medi-Cal (California's Medicaid program); Healthy Families (California's SCHIP program); Express Lane Eligibility; County Indigent Care programs; and Healthy Kids (county-sponsored coverage expansion programs). Additional programs under development for inclusion in *One-e-App* include Child Health and Disability Prevention (CHDP) and Food Stamps. *One-e-App* is now operating in Alameda, Fresno, San Mateo, and Santa Clara counties, and is under development in Los Angeles county.

Other foundations are working to educate the public and policymakers about the continuing importance of public coverage for children. Most of the resources of the New Hampshire-based HNH*foundation* are dedicated to the foundation's first goal of breaking down barriers to health insurance coverage for children. HNH*foundation* was the only private foundation in the country to provide the required matching funds to initiate SCHIP. Once the state's SCHIP program was successful, the New Hampshire legislature appropriated the necessary matching funds, and has done so each year since the Foundation's initial investment. The foundation continues to invest $250,000 in the SCHIP program each year, which supports families with incomes between 250 percent and 300 percent of the federal poverty level. The foundation's second goal is to educate the public on the importance of health insurance coverage in order to reduce the number of uninsured children and facilitate systemic change. In 2004, the foundation made a number of policy grants related to these goals, including:

- A $25,000 annual contract to Louis Karno & Co., to design and implement a statewide public awareness campaign to promote the importance of health insurance coverage for New Hampshire children with the goal of maintaining New Hampshire's status as one of the leading states in the nation for providing health care insurance for children.
- A $7,500 grant to the Franklin Pierce Law Center's Institute for Law, Health and Ethics to fund the project "In Defense of Medicaid and Healthy Kids: Bridging New Hampshire's Public Policy Gap." The project informed policy makers and health care advocates about policy decisions proposed during the state budget process that might impact the number of uninsured children.
- A $75,000 grant to the FrameWorks Institute to identify and model new communication strategies that promise to put the issue of health care insurance for children more fully into the arena of public discourse, as well as help the general public better understand the issues involved. The FrameWorks Institute helped stakeholders become more effective in communicating "the problem," and explore and implement positive solutions.

Redesigning the Delivery System

Health insurance is necessary, but not sufficient. In an effort to address the availability and appropriateness of health services for children, a number of grantmakers have focused on school-based health care, which meets young people where they are. Other foundations have emphasized community engagement efforts, which involve parents in dialogue and decisionmaking about what a better system of care for children might look like.

In an effort to address the availability and appropriateness of health services for children, a number of grantmakers have focused on school-based health care, which meets young people where they are.

Supporting School-Based Health Care

RWJF was an early supporter of school-based health care. It has been estimated that 1 in 10 of the health centers in schools across the country have received or are receiving a grant from the foundation. The foundation supported a handful of health centers in schools in the 1970s, but struggled with how the clinics would be maintained without foundation funding. Deciding that school-based health care would need broad community support if it were to be sustainable, the foundation launched the *Community Care Funding Partners Program* in 1981. One of the main lessons learned from that program was that a number of communities were especially concerned about the health of teenagers and were choosing to place school-based health care programs in high schools. This insight led the foundation to launch the *School-Based Adolescent Care Program* in 1986, with a focus on delivering comprehensive physical and mental health services to teenagers.

The foundation returned to its focus on the long-term sustainability of SBHCs in 1992, with the *Making the Grade: State and Local Partnerships to Establish School-Based Health Centers* program. *Making the Grade* helped expand the number of school-based health centers in the nine funded states; brought about more stable state financing, primarily from state general funds; stimulated more favorable state policies, including expanding centers' eligibility to participate in Medicaid and managed care programs; and helped launch the National Assembly on School-Based Health Care (NASBHC). An external evaluation of the program confirmed that school-based health centers need mixed financing strategies involving federal, state, and local sources in both the private and public sectors, and that the political environment and political support for school-based health centers are of fundamental importance to the long-run sustainability of SBHCs. In 2001, the *Making the Grade* national program office at The George Washington University became the *Center for Health and Health Care in Schools* under a RWJF grant program authorized by the board of trustees for up to $6 million. That grant supported both the establishment of the national resource center on school-based health care at the university and a multi-site grant program to fund new models of dental and mental health care provided by school-based health centers.

Begun in 2004, the W.K. Kellogg Foundation's *School-Based Health Care Policy Program* is a five-year program with the goal of making school-based health care financially stable, available, and accessible to children and families, and supported as a consumer-centered model of quality care throughout the United States. The foundation has awarded grants to NASBHC and nine of its state affiliates. Working with numerous local school-based health centers, state affiliates or grantees are

In order to be sustainable, school-based health centers need mixed financing strategies and strong public and political support.

implementing a broad array of strategies to increase the sustainability of school-based health centers, including grassroots advocacy, community organizing, technical assistance, and data collection. Over the five years, the grantees will also build their visibility and capacity to represent and advocate for school-based health care centers in their states. In addition to providing affiliates with direct assistance, NASBHC will coordinate national communications efforts and build widespread support for policies, programs, research, and funding that will advance school-based health care centers throughout the country.

SBHCs are also an important part of The Health Foundation of Greater Cincinnati's school-aged children's health care focus area. The foundation has invested over $10 million in 18 SBHCs in its service area, providing three years of planning and start-up and commissioning two studies that examine the impact of SBHCs. The first study evaluated how SBHCs affect students' health status, use of health care services, and attendance. The second study explored at how the health care costs for students enrolled in the Medicaid program changed before and after the centers opened. Three key findings of the studies were:

- **Health Outcomes** – During the study, 588 students from four schools with SBHCs and four schools without described their health status using the PedsQL, an instrument survey that measures children's health. The foundation then compared these scores to the scores of healthy children and chronically ill children, as defined by Dr. James Varni, developer of the PedsQL. In year 1, all of the children rated their health lower than those of healthy children, and SBHC users rated their health at the same level as chronically ill children, regardless of whether they had a chronic illness. By year 3, however, SBHC users had the highest health status rating of all three groups.
- **Health Care Costs** – Not only did the study reveal healthier students, but SBHCs did so with no significant increase in health care costs. After the SBHCs opened, students in schools with SBHCs cost Medicaid about the same amount of money as the students in schools without SBHCs. The students in schools with SBHCs used different types of services, however. For example, students in schools with SBHCs used more EPSDT, dental, and mental health services than students in schools without SBHCs. Although EPSDT and dental services are relatively cheaper, mental health services can be costly. These higher mental health costs were offset, however, by a reduction in prescription drug use, emergency care, and inpatient services (inpatient and emergency room use dropped among students in rural areas and among students who had asthma, for instance). The net result, therefore, was that while the overall spending remained the

School based health centers have been shown to improve health status, reduce disparities in access, increase the use of preventive services, and decrease the use of emergency care.

same, students in schools with SBHCs received a better mix of services, with more money being spent on prevention, screening, and early treatment, which led to a corresponding decline in the need for expensive emergency and inpatient care.

- **Disparities –** SBHCs were also found to help close the gap between African-American schoolchildren and their peers in terms of access to care. Prior to the SBHCs opening, African American students in schools with SBHCs had much lower total Medicaid costs, suggesting that they were probably not getting the care they needed. By the end of the cost study, African American and white students had similar total Medicaid costs. Interestingly, the study found that, in rural areas, SBHCs created access for children who were both insured and uninsured, suggesting that these communities had inadequate capacity to serve even those with an ability to pay. In urban areas, however, the children who used the SBHCs tended to be those who were uninsured or on public insurance (Keller 2005).

Many argue that the best ideas for improving children's access to health care in a particular community come from parents in that community.

Engaging Community Members in Shared Planning and Action

Many argue that the best ideas for improving children's access to health care in a particular community come from parents in that community. The Sierra Health Foundation recently completed an evaluation of its 10-year, $17 million experiment with community building as an approach to improving children's health. The *Community Partnerships for Healthy Children (CPHC)* initiative invited communities to form collaboratives, learn assessment and planning techniques, implement activities and programs, and evaluate results. The initiative, which focused on children from birth through age 8 and their families, was guided by a set of principles and goals that emphasized prevention and community-based solutions. Thirty-one communities were provided both grants and intensive technical support to achieve the goals of the initiative and to promote the development of local power and voice.

The foundation concluded that community building appears to be well suited for devising and implementing effective strategies to address straightforward health issues. Examples of *CPHC* successes are immunization clinics, dental screenings, fluoride treatments, recreation programs, parent support groups, community cleanups, health fairs, and community gatherings. Community building in *CPHC* was not as successful in addressing more complex health problems, such as drug abuse, child abuse, domestic violence, and school readiness. The foundation determined that, as implemented in *CPHC*, with the level of support available, it may have been unrealistic to expect that a small group of community residents could implement a variety of programs and policy changes that effectively would target the entire population at risk. *CPHC* activities tended to reach small numbers of children through specific programs and services. Reaching a broader group required long term policy change work that would have exceeded the initiative's time frame.

Determined to build better futures for disadvantaged children and their families in the United States, The Annie E. Casey Foundation divides its work into three areas: community building, system reform, and accountability/innovation. The foundation's grantees have used a number of community-designed and -driven strategies to improve children's access to health care. For example, residents in Richmond, Virginia used a neighborhood board to serve as the governing body to obtain approval for federal certification of the Vernon E. Harris Community Health Center. This federally-funded clinic provides comprehensive services to some 6,500 clients each year, many of whom were children previously without health care. The Harris Health Center is part of a larger neighborhood system of care for East District residents, the East End Partnership With Families, in Richmond. Each one of the Partnership agencies and community-based organizations has East End residents on their boards to enhance community input in service delivery. The foundation's grantees have also emphasized the links between a parent's health and their child's health. Using resident outreach as a core service in their Health Families America Program, the Mary's Center for Maternal and Child Care in Washington D.C., has seen significant improvement in maternal health—reductions in maternal depression, stronger social networks, and, when compared with national and District outcomes, higher rates of infant immunizations, birth weights, links to medical homes and fewer additional births to teens. Outreach workers are selected from the community and undergo Healthy Families training to provide home visitation and referrals.

Many foundations have emphasized community engagement efforts, which involve parents in dialogue and decisionmaking about what a better system of care for children might look like.

CONCLUSIONS AND LESSONS LEARNED FOR GRANTMAKERS

Tremendous progress has been made in the last several decades in expanding access to health care for children. But despite efforts to expand insurance coverage, strengthen the safety net, and redesign health care delivery systems in ways that benefit young people, millions of children remain unable to obtain the high-quality health services they need. But a great deal of positive energy remains for tackling the issue of children's access to health services. Grantmakers have a unique and historic opportunity to finish the job with respect to securing access for children. This section summarizes important lessons learned from the work thus far.

Tremendous progress has been made in the last several decades in expanding access to health care for children. Medicaid and SCHIP in particular have been highly successful in expanding insurance coverage to children, even as private coverage has eroded. But despite efforts to expand insurance coverage, strengthen the safety net, and redesign health care delivery systems in ways that benefit young people, millions of children remain unable to obtain the high-quality health services they need. And many more may lose access to care if funding for Medicaid and SCHIP are cut going forward.

Grantmakers have a unique and historic opportunity to finish the job with respect to securing access for children.

Grantmakers have a unique and historic opportunity to finish the job with respect to securing access for children. Even with the obstacles and legislative threats, there is a positive energy surrounding the issue of childhood health and access to care. Thus it is critical that grantmakers continue their good work in this area. To assist in this effort, the GIH Issue Dialogue brought forth a number of lessons that grantmakers can use, as outlined below:

- Successful efforts require action at both the grassroots and treetops levels. While winning grassroots support is labor intensive and takes a long time, success in pushing for change at the policy level often requires quick, bold action, and does not always allow time to consult everyone beforehand.
- It is critical to do the appropriate homework before embarking on a program, for both community leaders and foundations. There is no need to start from scratch in this effort, however, as many existing models for exist.
- Arguments for improving access should be framed in simple, persuasive terms. Effectively promoting greater investment in access to care for children likely requires use of language that frames the issue broadly in terms that make an emotional appeal.

Examples include framing the issue as a choice about how society allocates its resources or as a means of addressing the thinning of the social contract between government and its citizens. Campaigns that get too lost in the details and statistics are too often met with deaf ears.

- Meeting participants commented that "nothing succeeds like success." It is important, therefore, to support practical demonstrations, measure their progress, and publicize their successes. Policymakers and opinion leaders want to get behind winning programs.
- Evaluation is also critical to achieving sustainability, since policymakers will not want to fund programs that do not have a proven track record. But it is important to remember that not all projects can or even should succeed. Part of the purpose of evaluation is to identify those that no longer deserve support.
- There are many potential partners for grantmakers, and effective coalitions may consist of strange bedfellows. Much of the work consists of bringing together unnatural allies, such as having the business community join forces with the United Way. Other grantmakers have found unlikely allies in the local farm bureau; while usually a conservative voice, the farm bureau is interested in advocating for greater access to care for farm workers' children.

WHY KIDS?

Focusing on children's access to health care has been a strategic choice for many health funders. By working to broaden insurance coverage and redesign the delivery system in ways that benefit young people, grantmakers have determined that they can improve access for a group that is inexpensive to care for and viewed as particularly deserving. There is a strong belief that pursuing improvements for children is in line with community priorities, is politically attractive and therefore winnable, can help build the public's interest in the larger goal of providing access to quality care for everyone, and will help identify coverage expansions and system fixes that can later benefit adults. This approach has been controversial, however, with some wondering if winning universal access for children will truly serve as the foundation of broader health reform. Skeptics argue that placing the priority on children reinforces the belief that some people are more worthy of help than others, and that designing programs for families is actually a more efficient way to ensure that children receive care (Holloway 2000; Long 2005).

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ABOUT GIH

With a mission to help grantmakers improve the nation's health, Grantmakers In Health (GIH) seeks to build the knowledge and skills of health funders, strengthen organizational effectiveness, and connect grantmakers with peers and potential partners. We help funders learn about contemporary health issues, the implications of changes in the health sector and health policy, and how grantmakers can make a difference. We generate and disseminate information through meetings, publications, and on-line; provide training and technical assistance; offer strategic advice on programmatic and operational issues; and conduct studies of the field. As the professional home for health grantmakers, GIH looks at health issues through a philanthropic lens and takes on operational issues in ways that are meaningful to those in the health field.

Expertise on Health Issues

GIH's Resource Center on Health Philanthropy maintains descriptive data about foundations and corporate giving programs that fund in health and information on their grants and initiatives. Drawing on their expertise in health and philanthropy, GIH staff advise grantmakers on key health issues and synthesizes lessons learned from their work. The Resource Center database, which contains information on thousands of grants and initiatives, is available on-line on a password-protected basis to GIH Funding Partners (health grantmaking organizations that provide annual financial support to the organization).

Advice on Foundation Operations

GIH focuses on operational issues confronting both new and established foundations through the work of its Support Center for Health Foundations. The Support Center offers an annual two-day meeting, The Art & Science of Health Grantmaking, with introductory and advanced courses on board development, grantmaking, evaluation, communications, and finance and investments. It also provides sessions focusing on operational issues at the GIH annual meeting, individualized technical assistance, and a frequently asked questions (FAQ) feature on the GIH Web site.

Connecting Health Funders

GIH creates opportunities to connect colleagues, experts, and practitioners to one another through its Annual Meeting on Health Philanthropy, the Fall Forum (which focuses on policy issues), and day-long Issue Dialogues, as well as several audioconference series for grantmakers working on issues such as access to care, obesity, public policy, racial and ethnic health disparities, and health care quality.

Fostering Partnerships

Grantmakers recognize both the value of collaboration and the challenges of working effectively with colleagues. Although successful collaborations cannot be forced, GIH works to facilitate those relationships where we see mutual interest. We bring together national funders with those working at the state and local levels, link with other affinity groups within philanthropy, and connect grantmakers to organizations that can help further their goals.

To bridge the worlds of health philanthropy and health policy, we help grantmakers understand the importance of public policy to their work and the roles they can play in informing and shaping policy. We also work to help policymakers become more aware of the contributions made by health philanthropy. When there is synergy, we work to strengthen collaborative relationships between philanthropy and government.

Educating and Informing the Field

GIH publications inform funders through both in-depth reports and quick reads. Issue Briefs delve into a single health topic, providing the most recent data and sketching out roles funders can and do play. The GIH Bulletin, published 22 times each year, keeps funders up to date on new grants, studies, and people. GIH's Web site, www.gih.org, is a one-stop information resource for health grantmakers and those interested in the field. The site includes all of GIH's publications, the Resource Center database (available only to GIH Funding Partners), and the Support Center's FAQs. Key health issue pages provide grantmakers with quick access to new studies, GIH publications, information on audioconferences, and the work of their peers.

DIVERSITY STATEMENT

GIH is committed to promoting diversity and cultural competency in its programming, personnel and employment practices, and governance. It views diversity as a fundamental element of social justice and integral to its mission of helping grantmakers improve the nation's health. Diverse voices and viewpoints deepen our understanding of differences in health outcomes and health care delivery, and strengthen our ability to fashion just solutions. GIH uses the term, diversity, broadly to encompass differences in the attributes of both individuals (such as race, ethnicity, age, gender, sexual orientation, physical ability, religion, and socioeconomic status) and organizations (foundations and giving programs of differing sizes, missions, geographic locations, and approaches to grantmaking).

GRANTMAKERS IN HEALTH

1110 CONNECTICUT AVENUE, NW
SUITE 1200
WASHINGTON, DC 20036
TEL 202 452 8331   FAX 202 452 8340
www.gih.org