A revolution in health care has taken place during the past decade in the United States. The revolution was ignited by skyrocketing health care costs and fueled by the widespread public sentiment that the high cost of health care was the most important problem in the health care industry. The health insurance industry and providers responded to the public’s outcry by creating lower-cost health care insurance alternatives—managed health care plans. Managed health care is a vast array of financing and health care delivery systems that are designed to limit costs and ration health care. Employers and individuals seized the opportunity to lower their health care costs and began to buy these managed health care plans. Today, managed care plans are pervasive; 85% of all employed families and a growing number of those covered by Medicaid are in managed health care plans. By choosing managed health care, U.S. employers and consumers have changed the nation’s health care system.

The managed health care revolution produced major changes throughout the health care system. The lower health insurance rates that employers and consumers demanded were made possible in part by lower reimbursement rates to health care providers, hospitals, and suppliers. To lessen the impact of these lower reimbursement rates, health care providers and hospitals were quickly reorganized into networks to capitalize on economies of scale. Lower insurance rates also resulted in reductions in the salaries of health care providers and more stringent use of preauthorization procedures to reduce unnecessary care. Plans obtained additional cost savings by negotiating large-volume discounts from health care providers, hospitals, and suppliers; by reducing hospital utilization; and by offering financial incentives for providers to economize. The increase in marketplace competition among plans also has served to bring costs down.
In the early 1990s, it appeared that managed health care was very successful in reducing health care insurance rates. Health insurance costs were kept low, and employers and families continued to buy managed care health plans. The popularity of managed care plans, coupled with the successful use of cost-saving techniques, resulted in huge profits for insurers. Some of these profits were funneled out of the health care system and used for increased administrative management costs and increased salaries and bonuses for health plan executives. To reap the financial benefits of the new managed health care system, many traditionally nonprofit insurers and hospitals quickly transformed themselves into for-profit corporations.

**Managed Health Care Means Losing Freedom of Choice**

To employers and consumers, managed care appears to be a health care bargain; in most markets, it is the lowest-cost health insurance package, with low copayments for health care services. However, the financial savings associated with managed care have required certain sacrifices. Most notably, in exchange for lower costs, managed care enrollees typically have to accept some restrictions on the population of health care providers from whom they can receive covered services. In managed care, individuals usually are not able to choose just any health care provider or hospital. They must use only the providers and hospitals associated with the plan. Likewise, health care providers who work for or contract with plans are not always able to prescribe any treatment, diagnostic test, or drug that they think is appropriate. Instead, providers must follow the plans’ treatment and hospitalization rules.

Families and providers have, in essence, joined a closed health care system and agreed to abide by all of the system’s rules. In some cases, physicians have forged even tighter bonds with the health plans by becoming their financial partners and agreeing to share in the financial risks and benefits of the companies. The managed health care revolution changed the previous open, high-cost, unmanaged system into a closed, lower-cost, highly competitive, managed health care system.

For healthy individuals, adjusting to the rules of a managed health care plan may require few or no major changes in the way they obtain care as compared to traditional unmanaged plans. For families with children, managed care plans often provide easier access to well-baby care. In almost all cases, joining a managed care plan replaces the confusing insurance claims-processing procedures with a simple cash copayment taken at the point of service. Only when individuals become ill do they learn the full impact of managed health care. This experience is particularly relevant for children who suffer from rare, severe, or chronic conditions. As illustrated by Gleason’s commentary in this journal issue, these children and their families often test the limits of the managed care system’s ability to provide appropriate, coordinated, and effective care.

**Needs of Children Being Overlooked by Managed Health Care Industry**

Because healthy young employees and their families are model enrollees for cost-conscious managed care organizations, they
have been the focus of industry growth. Paradoxically, although child enrollees represent a disproportionately large share of the managed care market (see the article by Hughes and Luft in this journal issue), their needs have generally been overlooked in the development of new managed care models. Children also have been overlooked in evaluations that examine the effect of managed care on health service delivery and health outcomes.

Despite the lack of conclusive evidence, emotionally charged stories abound in the popular press of managed care gone awry for children. These cases typically have involved disputes about denied coverage for services; a lack of in-plan providers qualified to deliver specialty pediatric care; unwillingness among managed care providers to perform expensive and sophisticated tests; and a lack of coverage for mental health care or expensive experimental therapies. Although both positive and negative effects of managed care undoubtedly exist, the prevailing perception today seems to be that managed care has threatened core values of the U.S. health care system. Ignorance about the effect of managed health care feeds concerns about the nation’s ability to effectively use its sophisticated knowledge and technology to care for all Americans.

What is being sacrificed in exchange for these financial savings in health care? How has managed health care changed the delivery of health care services to children? What impact has managed care had on children’s health? Has managed care threatened the high-quality health care so valued in the United States? Or has the managed care movement brought with it an opportunity to enhance the quality of and access to health care, while at the same time improving the efficiency of care delivered in a framework of cost containment?

The purpose of this Analysis and Recommendations is to go beyond the anecdotes and analyze the existing data on the effect of managed health care on children. Managed care is not inherently good or bad. The ultimate goal of any changes in the health care system should be to create a comprehensive health care system in which high-quality services are delivered in a convenient way for patients, and without financial waste. Because the managed care revolution is a work in progress, it will be necessary to wait to see if this goal will ultimately be attained. Success will depend on how incentives are structured and reinforced in the rapidly evolving health care market.

**Defining Managed Health Care**

The one feature that most managed health care plans have in common is that they provide strong incentives for subscribers to obtain care only from physicians and hospitals that contract with the plan and follow all plan rules. Managed care plans are different from traditional fee-for-service or indemnity insurance plans. Under indemnity insurance, the insurers guarantee payment to any licensed health care provider for all covered services. In their article, Hughes and Luft define the alphabet-soup mix of managed care plans, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point-of-service (POS) plans. These managed care plans differ in how they pay physicians and other providers and in how they organize their networks of providers. The plans also vary as to whether they own their hospitals and clinics, directly employ or contract out for the services of health care providers, and provide coverage for out-of-plan services.

HMOs are the most tightly closed of all managed care systems. HMOs typically provide no coverage for out-of-plan services and require health care providers to share the financial risk for the amount of services provided. PPOs are more open than HMOs. While coverage for in-plan providers is the highest in PPOs, they often provide partial coverage for out-of-plan services. PPOs negotiate volume discount rates for physician and hospital services and do not require providers to share in the financial risk of the companies. POS plans are typically the most open plans, allowing families to obtain services from almost any provider, although they reimburse only part of the cost for out-of-plan providers. POS plans often require providers to share the financial risk for the amount of services provided.

Managed care plans also adopt a variety of other techniques aimed at controlling costs and service utilization, and at improv-
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Although the techniques used may differ among types of plans (such as HMOs, PPOs, and POS plans), the techniques also may differ within health plans of a given type (such as different PPOs). This variability makes it difficult to evaluate the effect of any specific type of managed care plan. For example, some plans rely on primary care providers as gatekeepers to coordinate access to specialists and diagnostic tests for enrollees, while others give enrollees more flexibility to access specialty care directly. Other plans allow individuals with chronic diseases such as diabetes or asthma to obtain all of their care from specialists. The relative importance of strategies to control service utilization, such as preapproval for procedures, also varies by plan. Similarly, some health plans have invested resources to improve health care quality by adopting practice standards for their physicians to follow, while others primarily have focused on cost containment. The number and types of health care providers included within a managed care network also vary widely from plan to plan.

In recent years, fee-for-service indemnity plans also have grown more similar to managed care plans. Traditionally, fee-for-service indemnity plans gave individuals an unrestricted choice of licensed health care professionals. Care providers were free to determine which services were appropriate based on their professional judgment and were reimbursed for all the care they delivered. Today, nearly all fee-for-service plans have adopted some form of the utilization-management strategies formerly associated with managed care, such as preauthorization for hospitalization or referral to specialists.

The blurring of boundaries between traditional fee-for-service, indemnity, and managed care plans limits the usefulness of most of the previous research that compared managed care and fee-for-service plans. Past research on managed care has been restricted to comparisons of HMOs and fee-for-service plans or has used the term “managed care” loosely in reference to any cost-containment and/or utilization-control mechanisms (see the articles by Szilagyi and by Bergman and Homer in this journal issue). Few studies have focused on specific managed care strategies and their effects on health care costs, service use, and health outcomes. Consequently, there is little concrete evidence about the effect of managed care on health service delivery and health outcomes for children. Additional research is needed to identify which aspects of managed care work and which do not work for children.

The Lack of Child-Focused Managed Care Systems

From their inception, managed care organizations were designed to provide health services for working adults, and the needs of children received little attention. As managed care has evolved over the years this lack of attention has continued, even though the proportion of children enrolled has grown substantially. Children often are perceived as tagalongs in the private managed care industry, because their enrollment is entirely dependent on their parents’ employment-based coverage. In Medicaid managed care, the situation is different, because children represent the large majority of enrollees, and their eligibility is independent of their parents’. Recently, managed care plans that traditionally served only employed populations have begun serving families covered by Medicaid. Plans that contract with state Medicaid agencies usually have limited knowledge about the nature of benefits necessary for low-income children, and they have not been required to develop provider networks that include appropriate pediatric specialists (see the article by Fox and McManus in this journal issue).

Child Health Care Expenditures Are Low

Health care expenditures for children are low compared with those for adults; children account for only 14% of all health care expenditures. Not only do children account for a small portion of overall national expenditures in health care, they also have lower rates of health care expenditures. In 1995, for example, annual health care expenditures for children under age 18 averaged $1,007 per individual. This is less than one-half the per-person cost for adults ages 18 to 64 ($2,235) and only about one-seventh the cost for those ages 65 and older ($7,039). The low cost of providing health care services for children is even more pronounced when one considers that more than 90% of child health care expenditures are
consumed by the approximately 15% of children who have disabilities or are chronically ill. Because children account for only a small percentage of all health care dollars, it has been difficult to convince managed care organizations to tailor programs to meet the unique needs of children.

**Children Have Unique Health Care Needs**

The unique nature of children’s health care needs and illnesses is complex because children are growing and developing. Physiological, cognitive, and emotional change occurs more rapidly between infancy and adolescence than at any other time during one’s life. This early and rapid growth causes children to be extremely vulnerable to factors in their physical and social environments, which affect their immediate and long-term health and development. Consequently, preventive health care is particularly important for children. Most infectious diseases are preventable if infants receive a complete set of immunizations at the appropriate time. To keep their infants safe and healthy, parents need to learn about their babies’ physical and emotional needs as well as their developmental abilities. Anticipatory guidance provides parents with this critical information about their babies’ changing needs. Children also must receive prompt acute medical care for common conditions such as ear infections. If ignored, serious ear infections can result in long-term problems, including hearing loss or, in extreme cases, learning disabilities.

The 10 million children in the United States with chronic or disabling conditions require an even broader array of health and social services to help them develop to their fullest potential. Health care services for these children can be very costly because they often require sophisticated care for a long period of time. The proportion of children with special health care needs enrolled in managed care plans has increased dramatically as state Medicaid agencies have started to contract with managed care organizations to serve this vulnerable population. As managed care organizations increasingly enroll both healthy children and those with special needs, it is imperative that plans understand how children’s health needs differ from those of adults and how they are influenced by developmental processes. However, because any one plan is likely to insure only a small number of children with special needs, targeted efforts to improve care for these children are likely to be minimal at best. Because poverty is strongly linked with poor health status among children, this issue is particularly important for children enrolled in state Medicaid programs. Managed health care plans should carefully consider the unique needs of children when crafting benefit packages.

**The Promise and Reality of Managed Care**

The transition to managed health care brings many opportunities to improve the financing and delivery of health care services. When health care providers are organized into networks, care can be provided in a more coordinated and efficient way, particularly for children with chronic or complex illnesses who require care from a variety of health care specialists. As discussed later, capitated payment systems (in which health plans or physicians are paid a predetermined amount per patient per month) and financial bonuses to providers could be used to stimulate improvements in preventive care and the overall quality of health care. A new orientation toward consumer satisfaction and accountability also could improve the managed health care system. However, the drive of many health care corporations to produce financial profits introduces new fears about the potential to place profits before quality health care.

**Potential Benefits of Managed Care**

Coordination of care among physicians and other providers could be easier in managed care systems made up of defined networks of providers. In their article, Bergman and Homer discuss how restricted provider networks, if configured appropriately, could include an array of specialists large enough to meet enrollees’ needs, but small enough to be cost effective and to implement and monitor quality-improvement activities. Structured networks make it easier for plans to monitor the quantity and quality of services provided. In addition, these networks lend themselves to easier implementation of collaborative quality-improvement efforts. When structured correctly, capitated pay-
Capitated payment systems have the potential to promote the use of preventive services.

Capitated payment systems reward plans or providers if they keep families healthy; keeping individuals from becoming sick is more profitable than waiting for them to become sick or chronically ill. Ideally, the cost savings from improved efficiencies achieved through coordinated networks of care and collaborative improvement efforts could lead to better access, higher-quality services, and reduced health care expenditures for the health care system overall. As discussed in the article by Hughes and Luft, and in the article by Szilagyi, managed care plans have an obligation to be accountable to their enrollees, and ideally they should have data systems in place to track utilization patterns and health care outcomes.

Managed care has other potential advantages, particularly for children who have chronic or disabling conditions. As noted in the article by Stroul and colleagues, for children with mental health problems in particular, managed care brings an opportunity to improve the efficiency and cost-effectiveness of care by substituting less-costly community-based care that is linked to medical providers for high-cost hospital services when appropriate. Community-based and school-linked care are also important for children with chronic or other special health care needs. Often, a multidisciplinary or multisector approach is the best way to address the interwoven socioeconomic, environmental, and developmental influences on children’s health. The fee-for-service medical system did not include incentives to provide coordinated and comprehensive services for children, particularly for children from low-income families.

**The Reality of Managed Care**

Managed care was embraced in the 1990s, largely on the basis of its theoretical advantages. Many changes in health care expenditures, access to care, utilization of care, and quality of health services have since occurred. However, it is unclear whether the theoretical advantages have been borne out in practice. Although most empirical data have not focused on children, those studies that have done so suggest that the promises of managed care often have not been demonstrated in practice.

**Impact on Cost**

There is widespread agreement that managed care has achieved the goal of controlling health care costs. Whether managed care will continue to be successful at curbing rising health care expenditures, however, remains open to speculation. In 1996, U.S. health care spending rose just 4.4%, reaching the lowest point in nearly four decades. This slowed rate of growth in health care spending was a result of multiple changes in the health care market, including the rapid spread of managed care, fierce competition among managed care organizations attempting to increase their market share, and low inflation (overall and medical-specific). Nonetheless, health care analysts caution against being overly optimistic about future savings.

Managed care has achieved its stronghold in the health care industry by attracting employers and enrollees with low health insurance premiums. This has meant insurers have often set premium levels low, reduced the profit margins of managed care organizations, and lowered reimbursements to physicians and hospitals. As a result of these cost-cutting strategies, several of the nation’s largest managed care organizations, including Kaiser Permanente, Oxford Health Plans, and Aetna U.S. Healthcare, reported substantial losses or lower-than-expected profits in 1997. To compensate for these losses, premium levels for 1999 are likely to rise sharply. Analysts anticipate the largest rate hike for health insurance since 1994. Higher premiums combined with an aging population, rising prescription drug costs, and costly advances in medical technology are expected to accelerate the growth of health care expenditures in future years. Estimates by the Congressional Budget Office predict that health care costs will rise at an annual rate of 6.5% during the next decade, outpacing overall economic growth.

Still, this anticipated rate of growth is much lower than the double-digit increases observed during the late 1980s and early 1990s.

Although the initial onetime savings attributable to managed care have already been achieved by negotiating lower payments to doctors and hospitals and by reducing hospital lengths of stay, premiums for managed care enrollees continue to be lower than those in traditional indemnity
plans. During 1994–95, for example, premiums for employer-sponsored health insurance grew by 2.3% overall. When analyzed by type of health plan, however, increases were smallest for HMOs (0.9%) and largest for fee-for-service plans (3.4%). PPOs and POS plans showed intermediate increases, at 2.6% and 2.2%, respectively. Other data have shown that, at an aggregate level, premiums are lower in communities with a higher penetration of HMO plans and more intense competition among health plans. Restricted provider networks and a strong reliance on primary care physicians have been major forces allowing HMOs to keep health care premiums below those of other plans. However, the tradeoff between low cost and limited provider choice has been unacceptable to many consumers, as evidenced by the recent trend toward looser and more expensive forms of managed care, such as PPOs and POS plans. This trend is likely to raise premium levels and individual copayments and deductibles in the future.

Impact on Health Care Delivery

Despite the success of managed care at slowing the rate of health care spending growth in recent years, increased cost efficiencies in the health care system are beneficial to children only if they do not compromise other dimensions of health care, including access, utilization, and quality. As noted in the articles by Szilagyi and by Bergman and Homer, the majority of studies conducted have been inconclusive about the effect of managed care on the availability, use, and quality of child health services. In addition, most studies were conducted at least a decade ago, when market forces and managed care arrangements were significantly different from what they are today. Nonetheless, this information sheds light on how specific managed care incentives may affect children, either positively or negatively.

Impact on Access and Utilization

Based on a comprehensive review of the literature on children’s access to care, Szilagyi reports that there is some evidence of improved access to primary preventive health care services under managed care, especially for privately insured children. In contrast, for poor children covered by Medicaid, capitated managed care arrangements result in decreased use of primary care services. This decrease in primary health care services is disturbing, given that the children covered by Medicaid have a much higher need for health services because of their diminished health status in general. Although the reasons for the lower visit level for children enrolled in capitated Medicaid plans are unknown, it is plausible that high rates of disenrollment and reenrollment, in which children go on and off Medicaid, may be to blame. Because benefits associated with preventive health and primary care services may not be observed for several years, managed care organizations also may be discouraged from making large investments in this area for children who are likely to be enrolled for only a short period of time. Another explanation for lower visit levels may be that Medicaid recipients had difficulty making the transition from fee-for-service to managed care, which often requires seeing a new health care provider at a different site. Finally, for poor and nonpoor children alike, access to specialty services for those with chronic or disabling conditions tended to be worse after the implementation of managed care.

Results from studies on the actual use of health services by children have been ambiguous. The results have varied depending on the type of health service and whether the investigation focused on privately insured children or Medicaid recipients. For children with private insurance, the amount of services used is largely dependent on physician financial incentives and the level of out-of-pocket costs for families, regardless of health plan type. Specifically, use of health care services tends to be higher when physicians are reimbursed using a fee-for-service arrangement (compared to a capitated arrangement), when children have more comprehensive benefit coverage, and when families have lower out-of-pocket costs for services such as ambulatory care. Children enrolled in Medicaid managed care plans also use fewer emergency room and pediatric specialty services than children enrolled in traditional fee-for-service Medicaid plans. So, it can be concluded that managed care hampers both access to and use of care for children covered by Medicaid.

Impact on Quality

Closely related to access and utilization is the quality of health care available to children.
As discussed in the article by Bergman and Homer, managed care organizations have used three types of strategies that have the ability to compromise the quality of health care that children receive: (1) reducing the scope of the benefit package; (2) restricting provider networks; and (3) creating financial incentives for physicians to economize. For example, if managed care organizations reduce the scope of covered benefits for children such as mental health services, support services, or durable medical equipment (required by children with chronic or disabling conditions), this could adversely affect health outcomes. However, there is little conclusive evidence that widespread reductions in benefits have actually occurred. Problems associated with restricted provider networks and physician financial incentives have been more evident, especially for children with special health care needs, who have less access to qualified pediatric specialists when enrolled in managed care. Moreover, capitated reimbursements that do not adequately adjust for the added expense of caring for these children discourage plans from enrolling them or reward physicians for providing less care.

On balance, the reality of managed care for children during the past decade is that managed care has meant managed costs for health care services. The overall growth in health expenditures has been reduced, and this may benefit children and adults alike. However, there is little empirical evidence that managed care organizations have taken a proactive role in meeting the comprehensive health care needs of children. As discussed below, recent trends in managed care also show little promise for promoting children’s access to high-quality health services.

More Flexible Managed Care Arrangements
In the employed population, there has been a recent trend toward greater participation in more flexible managed care arrangements, including PPOs and POS plans, which allow consumers a broader selection of health care providers than traditional closed-network HMOs. Between 1993 and 1995, enrollment rose from 20% to 25% in PPOs, and from 9% to 20% in POS plans offered through employer-sponsored packages.21 While overall enrollment in HMOs also increased during this time, membership in the most restrictive group of staff-model HMOs (for example, Kaiser Permanente, in which physicians and other health care providers are employed directly by the plan) actually dropped from 42% of total HMO membership in 1988 to 31% in 1994.24 This occurred at a time when HMOs began to diversify by offering POS and PPO alternatives to meet consumer demands and remain competitive in the health care market. Open-access plans, which allow patients to see specialists without approval from a primary care physician or “gatekeeper,” also have recently gained popularity.25 This trend toward more loosely affiliated and more flexible health plans, which allow consumers a broader choice of providers, albeit at a somewhat higher cost, may signify dissatisfaction among much of the U.S. public with the tight rein HMOs traditionally have on choice of providers and access to specialists.

Growth of Physician-Owned Provider Groups
Health care provider groups are making demands that are having a profound effect on the managed care market. Increasingly, physicians and hospitals are banding together to become more savvy negotiators with managed care organizations, or are creating managed care–like entities to compete directly in the health care market.26 The two major types of provider organizations gaining prominence in the managed care industry are (1) physician hospital organizations (PHOs), which are typically nonprofit organizations built on a tradition of community service and made up of physicians who
contract directly with hospitals to provide inpatient and outpatient care; and (2) physician practice management (PPM) organizations, which tend to be for-profit entities built on a tradition of physician entrepreneurship and made up of physician-managers who are responsible for developing contracting arrangements between medical practices and various hospitals. Overall, the growth of both PHOs and PPM organizations has resulted in a greater number of managed care organizations entering nonexclusive contracts with these physician-run organizations, giving managed care organizations less bargaining power to drive down physician payments.

**Growth of For-Profit Health Care Industry**

The growing strength of large for-profit health care systems during the 1990s is another important trend in the managed care industry having a major impact on health care delivery. In 1981, for-profit HMOs represented 18% of all HMO plans; by 1995, the dominance of for-profits had increased to 71% of the HMO market, with nearly 60% of all HMO members enrolled in for-profit plans. The prominence of for-profit organizations is even greater among more loosely integrated managed care arrangements. For example, approximately 80% of all PPOs are for-profit entities.

The primary concern about for-profit health care organizations is that because of their efforts to serve both shareholders and patients, the potential benefits of managed care may be lost as efforts to maximize profits become more acute. Traditionally, nonprofit health care institutions have been committed to providing community benefits such as care for the uninsured, programs for special needs populations, communitywide health assessments and screening, and medical research and education. Nonprofits also have worked to establish trust in the communities where they operate. Although there is little empirical evidence to support substantial differences in the quality of care provided by for-profit versus nonprofit managed care organizations, it is nonetheless true that the incentives created by an investor-owned health care organization make an emphasis on promoting health care quality and meeting community needs in the long term less likely.

**Impact of Managed Care Trends on Children**

How these recent trends in the managed care industry will affect children remains open to speculation. On the positive side, the trend toward more flexible health plans should increase provider choice and access to specialists, which would be of particular benefit to children with special health care needs. The tradeoff, however, is likely to be increased health care costs both to employers and consumers. Higher costs may make these more flexible plans unavailable to families that already are stressed by the high costs of caring for chronically ill children, and may decrease employment-based health insurance coverage for families. In addition, these more costly alternatives are not likely to be available to low-income children enrolled in Medicaid.

The growth of PHOs also is likely to raise health care costs. Profits realized by managed care organizations come from the difference between health insurance premiums collected and money paid out to providers for the health care delivered. As physician groups continue to make it more difficult to negotiate lower rates, profit-motivated managed care organizations may increase premiums to compensate. Finally, the pressures to maximize shareholder profits faced by investor-owned managed care organizations are likely to take precedence over concerns about health care access and quality, especially for children, who receive little attention in the health care debate. As stated previously, there is a risk that for-profit managed care organizations will be less responsive than nonprofits when addressing the broader and more long-term needs of children within a community. Persuasive arguments on both sides of this debate have been presented. As the trend toward for-profit managed care organizations continues, it will be important to ensure that community-based health promotion services for children continue to be supported.

**RECOMMENDATION**

- Identify the aspects of managed care that work and do not work for children. A new era of health services research should focus
on how specific features of managed care influence the cost and delivery of child health services and child health outcomes. Individual elements of managed care that should be carefully evaluated include provider payment methods and incentives, the configuration of provider networks, the use of physician practice standards, techniques to control service utilization, and the use of monitoring and feedback systems for providers to improve outcomes of care. Funding should be made available to evaluate the effects of recent trends in the managed care industry on child health service delivery and health outcomes. These trends include increased enrollment in more flexible health plans, the growing prominence of physician groups in the managed care market, and the trend toward investor-owned managed care organizations.

Creating a Managed Health Care System That Works for Children

There is uncertainty about how current managed care arrangements affect children; nonetheless, children’s enrollment in managed care continues to accelerate. As articulated in the commentary by Finkelstein, there is now an opportunity to move away from the defensive position of protecting children from managed care and toward a vision of promoting children’s health within the managed care system. This process requires identifying system attributes that promote child health and well-being; assuring that these features are included in managed care contracts; structuring financial incentives that reward providers for delivering high-quality health services; and encouraging managed care organizations to take a leading role in promoting high-quality care.

What are the elements of a managed health care system that are crucial for children, given their unique health care and developmental needs? As discussed by Finkelstein, at the individual level, children need a “medical home” that is available to provide a consistent source of health care. At the aggregate level, this should be complemented by the commitment of managed care systems to look beyond their enrolled populations and support health promotion activities within the communities where children live. Health plans also have created powerful financial incentives that could be used to improve access to preventive health care and the quality of health care overall.

Individual Level

A Medical Home

The concept of a medical home endorsed by the American Academy of Pediatrics (AAP) suggests that children should have access to medical care that is “accessible, continuous, comprehensive, family-centered, coordinated, and compassionate.” At its core, the medical home concept emphasizes that health care providers offer preventive care and parental education about child development and how to protect their children from harm, and that these services are provided by a consistent source of care (such as an individual pediatrician or clinic) over a continuous period of time.

The structure of most managed care systems ensures that most children have links to regular health care providers. Children and their parents select or are assigned to receive care from primary care providers, who are expected to provide for all of a child’s primary care needs, and who often act as gatekeepers for all other medical services. The concept of a medical home, however, goes beyond receiving care at the same site or clinic. It recognizes the importance of being able to see the same provider over time. This allows families and children to build confident, trusting relationships with their health care providers. Once children are linked with health care providers, they must also have access to appropriate health care services.

A Defined Benefit Package

Because of the strong link between health status and children’s physiological, cognitive, and emotional development, children often require a much broader range of health services than adults, particularly those that involve counseling, psychosocial, and environmental interventions. The recognition that children may need health care interventions now to prevent adverse outcomes during later childhood or even
adulthood is reflected in the early and periodic screening, diagnosis, and treatment (EPSDT) program standards adopted by Medicaid.\textsuperscript{10}

Federal law requires that children enrolled in Medicaid also have access to a broad range of preventive health and treatment services defined under EPSDT. These benefits include comprehensive physical, developmental, and mental health screenings; immunizations; laboratory tests; health education and anticipatory guidance; and all medically necessary treatment services allowed under federal Medicaid guidelines. Medically necessary services encompass a range of therapies aimed at improving children’s ability to function and preventing developmental delays. Speech, physical, and occupational therapy are examples of these services. EPSDT requirements also ensure that children have access to so-called “enabling services” (for example, translation, outreach, and transportation) that make obtaining health care easier for many families.\textsuperscript{31}

Health care services available to low-income children through Medicaid’s EPSDT program typically are much broader than services available to privately insured children, and EPSDT could serve as a model for managed care organizations designing benefit packages to meet the needs of pediatric enrollees. The adoption of benefit packages that follow EPSDT guidelines should be monitored carefully to determine their impact on child health outcomes and cost.

**RECOMMENDATION**

- Ensure that health insurance benefit packages meet children’s needs. Covered benefits will need to change as children progress through key physical and emotional stages of development. Benefit packages for children should include adequate coverage for preventive health care, anticipatory guidance, psychosocial counseling, and access to prompt care for acute illnesses. Children also need a medical home—one that provides comprehensive, continuous, and coordinated care; an emphasis on preventive health care and anticipatory guidance; and a comprehensive benefit package that includes health services consistent with EPSDT guidelines.

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**Access to Pediatric Specialists and Support Services**

Creating health system attributes that promote optimal health for all children requires meeting the unique needs of children with chronic and disabling conditions. Children with chronic and disabling conditions often require access to a wide range of pediatric specialists and ancillary support services to manage their complex conditions.

As discussed in the article by Fox and McManus and in the commentary by Gleason, the lack of qualified pediatric specialists within health plan networks often has been a problem for children with special health care needs enrolled in managed care. Addressing this issue is particularly important as more managed care organizations assume responsibility for providing comprehensive health services to this vulnerable group of children. It is imperative that managed care plans structure their provider networks to include an array of pediatric specialists to meet the needs of the enrolled population. As an alternative, some managed care organizations may elect to subcontract with regional pediatric referral centers that already have the capacity and expertise to meet the needs of children with chronic and disabling conditions and their families.

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**RECOMMENDATION**

- Ensure that managed care plans provide access to appropriate pediatric specialists for children with chronic or disabling conditions. Managed care organizations should include appropriate pediatric specialists to care for children in their provider networks who have chronic or disabling conditions. Alternatively, plans should contract with out-of-plan pediatric centers of excellence that have pediatric specialists and multidisciplinary teams of health care
providers who are experienced in caring for seriously ill children. Plans should conduct research to define the optimum size and scope of these networks to meet the needs of children.

Coordinating Care with Other Child-Serving Organizations

Another major challenge for managed care organizations enrolling chronically ill or disabled children lies in the coordination of services between the managed care organizations and other systems—such as special education, social services, and federal or state maternal-child health programs—that typically serve children with special health care needs and their families. Without financial incentives that encourage the coordination of services between managed care and other systems, the economic costs of caring for these children may be shifted to other institutions that have traditionally met many of the health-related and nonhealth needs of children with chronic or disabling conditions. As an example, one recent study of children with special needs in a Minneapolis HMO found evidence of cost shifting, in that physical and occupational therapy services covered by the HMO were instead provided and paid for by the educational system.32 Creating a system of care that works for children, particularly those with special health care needs, requires that managed care organizations either develop the internal capacity to meet more health-related and nonhealth needs of children, or improve their mechanisms to coordinate health care services with related services provided by other institutions.

RECOMMENDATION

- Improve coordination between managed care organizations and other service providers. Managed care organizations should improve efforts to coordinate pediatric health care services with the health and nonhealth-related services provided by other systems, such as education and social services, that also assume responsibility for promoting child health and well-being. Safeguards are needed to ensure that cost shifting from managed care to these systems does not occur.

Family Level

Encouraging the Active Participation of Parents

For managed care to work for children, it first must work for the families responsible for these youngsters. At a minimum, managed care organizations must educate parents about how managed care arrangements work, involve them in their children’s care, and offer supportive services as parents deal with their children’s illness and navigate their way through complex managed care systems. Guidelines developed by the AAP suggest that upon enrollment in a managed care plan, parents should be educated about how to obtain health care services, and incentives should be structured that reward parents who comply with the rules of a given managed care organization.33 As discussed in the articles by Fox and McManus and by Stroul and colleagues, numerous opportunities exist to strengthen families’ involvement in health plan processes, such as developing plan policies and evaluating quality-performance measures.

In his analysis of state regulation of the managed care industry, Anderson finds that most states have laws requiring health plans to provide families with clear statements of what is covered under their plans, any changes in coverage, how to use the grievance/complaint system, and the plans’ financial condition. Unfortunately, approximately 40% of insured families are not covered by these state laws.34 State laws regulating managed care usually do not apply to families working for employers that self-insure health care for their workers. The vast majority of large employers (80%) and many midsized employers (35%) choose to self-insure because they receive special exemptions from state premium taxes and from providing state-mandated benefits through the Employee Retirement Income Security Act (ERISA).35 Federal regulations that would protect all families may be needed to ensure consumer safeguards.
Taking a Closer Look at the Specific Needs of Families

Typically, families have not been active participants in managed care, and their needs have not been adequately addressed. In a commentary based on her personal experiences as a parent of a child with special health care needs enrolled in a large HMO, Gleason discusses this issue in depth and offers suggestions about how parents could better be supported within the context of managed health care. According to Gleason, opportunities for managed care organizations to meet the needs of families include providing parents with adequate information to make educated decisions when selecting a health plan or provider; using parents as advocates to promote the use of high-quality, cost-efficient services and discourage unnecessary treatments; having available consulting nurses to provide home visits and patient education, and to help families obtain necessary services in complex managed care settings; and devising an anticipatory process that would address parental concerns with managed care up front, thus avoiding later complaints. As more children are enrolled in managed care, managed care organizations must take a closer look at the specific needs of families and develop strategies to actively meet these needs.

RECOMMENDATION

- Require health plans to include mechanisms that encourage active parental involvement. Health care insurance purchasers should require that health plans have mechanisms in place that encourage the active participation of parents in the delivery of health services to their children. At the plan level, this should include systems that educate parents about the rules of the health plans and how to obtain care for their children, that provide opportunities for parental involvement in health plan policies and evaluation strategies, and that address parents’ concerns with a health plan before problems occur. At the family level, plans should support parents during a child’s illness and link families with appropriate services; provide families with the appropriate skills to care for their sick children; provide home nursing care when appropriate; and include families in all major health care decisions.

Community Level

Focus on Community-Based Health Promotion

As managed care systems assume more responsibility for the health care of children, especially low-income children and those with special health care needs, it is important that they broaden their mission. Plans have an opportunity to include health promotion interventions and other activities that address community needs beyond those of their enrolled populations. Fostering social responsibility among managed care organizations is essential, because children’s health status is dependent not only on traditional medical care, but also on socioeconomic and environmental factors within communities where they live.

Collaborative approaches to health promotion for all children in a given community may, over time, benefit the managed care system as a whole. Children who leave one managed care plan will likely enroll in another managed care plan. Given the fluidity of health plan disenrollment and enrollment in the competitive market, investments aimed at promoting the health of children outside of an individual managed care organization’s enrolled population may pay off in the long term for all plans serving a given community. Financial rewards aside, however, it also has been argued that managed care organizations have a special obligation to invest in the health needs of communities in which they operate, simply because they possess the knowledge, skills, and resources to do so.

Although a devotion to broader community needs may seem an unrealistic goal for managed care organizations vigorously competing for enrollees and for-profit managed care organizations, there is evidence that some health plans already are seizing this opportunity. In Minnesota, for example, several managed care organizations collaborated with public health agencies and two school districts to successfully improve
hepatitis B immunization rates among adolescents. While the local public health agencies assumed responsibility for coordinating and implementing the project within the participating school districts, the managed care organizations provided financial support. Other health plans in Minnesota have collaborated on a campaign to reduce gun violence in schools. In Colorado, Kaiser Permanente participated in a collaborative effort with school-based health centers, which resulted in greater use of mental health and substance-abuse services, fewer urgent care visits, and a greater likelihood of a comprehensive health supervision visit among health plan enrollees with access to school-based health centers. From the perspective of the HMO, these findings suggest that working with schools may be cost effective and benefit the adolescents served. In addition to these community-focused interventions, some large managed care systems have created data systems that can be used to track health care outcomes at the community level. Evaluations of these community-focused efforts should be closely monitored to determine their effectiveness.

**Caring for the Uninsured**

Historically, safety net institutions (for example, public health agencies, community health centers, public hospitals, and so forth) have been a major source of care for the uninsured, and Medicaid funds largely have subsidized this care. As more states begin to contract with commercial health plans to provide health care for families covered by Medicaid, traditional safety net providers are losing their share of the Medicaid market. As a result, safety net institutions are beginning to lose the financial capacity to care for the uninsured population. Although no data are available specifically for children, studies indicate that high rates of managed care enrollment and minimal public funding have resulted in significant declines in the ability of safety net hospitals to care for the uninsured. Hospitals have traditionally filled some of the gaps in caring for the uninsured by charging higher fees for insured patients and by using community fundraising to help offset the cost of caring for the uninsured. It is estimated that safety net hospitals could have provided up to 36% more uncompensated care in some areas if they had not lost their Medicaid patients to commercial managed care plans.

The new State Children’s Health Insurance Program (CHIP) may ease some of the financial burden on the safety net providers by providing health insurance for approximately 3.4 million of the 10 million uninsured children, many of whom will be enrolled in managed care plans (see Lewit, “Revisiting the Issues,” in this journal issue). These newly insured children may boost the enrollment for safety net providers if there are sufficient incentives for enrollment. Unfortunately, it is not clear whether safety net providers will be able to continue to subsidize the cost for the remaining 6.6 million uninsured children. Other researchers also predict a painful future for safety net providers and disadvantaged groups that rely on their services as a result of lower reimbursement levels for Medicaid managed care plans and fewer financial protections for traditional community-based providers.

Medicaid managed care plans that decide to contract with safety net institutions may benefit from community-based providers’ experience with meeting the health needs of low-income children. Plans that take this route could begin by restricting contracts with safety net providers to include only a limited set of services, then expand the contracts depending on the providers’ expertise. As an example, the HMO associated with Blue Cross of California made arrangements with a Planned Parenthood clinic to provide family-planning and obstetric services for low-income plan enrollees. Later, the clinic developed the capacity to function as a primary care provider as well, and its contract with the HMO was expanded to include these services. More collaborative arrangements such as this—between community-based providers and managed care organizations with Medicaid contracts—should be encouraged to meet the health care needs of low-income children.

**RECOMMENDATION**

- Include managed care organizations in efforts to ensure that the health care needs of uninsured poor children are met. Managed care organizations should support...
the viability of local safety net institutions by including them in provider networks, whenever possible. Rigorous evaluations addressing how the expansion of Medicaid managed care and CHIP affect the viability of safety net providers and access to care for uninsured children should be undertaken.

Health Plan Level

Financial Incentives to Improve Health Care Quality

An important way to help ensure that managed care organizations provide high-quality care for children at a reasonable cost is to give them positive financial incentives to do so. The current managed health care system has several types of financial incentives that may work against the best interests of children. Most of these incentives are aimed at changing the behavior of doctors by shifting some of the financial risk from the insurance company to physicians. In 1995, more than half of all physicians had contracts with managed care organizations that placed them at financial risk for the care they provided.46 Like Columbia/HCA in Florida, a growing number of for-profit managed care organizations also encourage their contracting physicians to purchase shares in the company, providing additional incentives for physicians to economize and encouraging them to use company hospitals and laboratories.47 Financial incentives are powerful tools that can be used to reduce the utilization of all health care services.48 Unfortunately, there is little data to explain how these changes in physician behavior affect the health of children. The impact of these financial incentives on child health should be rigorously tested.

Fair Capitation Rates

Capitated payment systems are a common financial incentive used by managed care organizations. Rather than paying for services rendered, the organizations provide payment at a fixed monthly rate for each covered patient. If physicians underuse the allotment of money, they keep the remainder. Alternatively, if they overuse the allotment, they must make up the difference with their own money or forgo any bonus. Capitated payment systems clearly reduce the use of health care services;49 however, there is no data on the impact of fewer visits on the health of children.

Setting the capitation rate at a fair level has been a challenge, particularly for children with special health care needs. If the rate is set too low or is not fairly adjusted for the health status of children in the plan, then plans and providers have an incentive to discriminate against insuring children who have serious or chronic illnesses that are costly to treat. Researchers are currently developing statistical techniques to determine payment rates that are sensitive to differences in the types of children covered by a plan. Factors such as age, gender, race, health status, physiological indicators, and prior use of health care services are being used in an attempt to set fair rates. Unfortunately, even the most sophisticated statistical adjustments have not produced satisfactory results. Tests of a variety of adjustment techniques show that adjusted capitation rates for children with selected chronic illnesses would still pay for only 40% to 60% of their actual costs.50 The best predictor of one’s future health care use is one’s current use.51 Critics of methods that use the rate of prior utilization of services to calculate adjusted capitation rates argue that these methods reward plans whose costs are high because of inefficient practices.

Capitated payment systems work fairly only when there is little variation in the cost of care. These systems do not tend to work well for the population of children with special needs. Until there is a better understanding of how to define capitation rates fairly, health plan purchasers will continue to require plans to participate in a form of reinsurance in which plans contribute to a risk pool to pay for the care of individuals with very high costs. Plans are reimbursed out of the pool when the cost of caring for an individual reaches a preset threshold or if the patient has a specified condition (such as a transplant or low birth weight).50 Reinsurance using cost thresholds or carve-outs for specific diseases raises premium costs and does not remove all incentives to discriminate against children with severe or chronic illnesses. Plans must still reach the threshold of cost before being able to use the reinsurance funds, or they must pay for
the care of children with special needs who do not have one of the specified carved-out conditions.

**RECOMMENDATION**

- Develop fair reimbursement rates, particularly for children with special health care needs. Children with chronic or disabling conditions have greater health care needs than most children. The system for allocating health care resources within managed care must account for this by using appropriately risk-adjusted capitation rates, special reinsurance pools, or other methods. Plans and employers should fund research aimed at improving the performance of risk-adjustment techniques.

**Appropriate Use of Bonuses and Penalties**

In addition to capitation, managed care organizations have instituted another form of financial incentive for physicians in the form of bonuses and penalties. Some plans set aside a defined amount of money in a special-purpose account to cover the cost of referrals to out-of-plan specialists, high-cost diagnostic tests, or drugs. If the funds set aside in these accounts are not completely used at the end of the year, physicians share the remaining money. If the amount set aside is exceeded, then physicians do not receive cash bonuses. It is estimated that 79% of network independent practice associations (IPAs), 34% of group/staff-model HMOs, and 100% of PPOs that already use capitated arrangements also employ bonus systems. Like capitation, these bonuses reduce utilization and are positively related to the ability of the HMOs to break even or profit financially.

A growing number of managed care organizations also use financial incentives to change the way physicians care for individuals with certain conditions. For example, physicians who contract with U.S. Healthcare receive rewards or penalties depending on whether they follow plan-determined “best practices.” Cash bonuses often are given to physicians who prescribe fewer cesarean section deliveries or receive high scores on patient-satisfaction surveys. These financial incentive programs have the potential to improve the quality of care only if the “best practices” prescribed by the plans promote care that is based on sound scientific evidence, is proven to be effective, and is not used solely to save money. Distinguishing between best practices that are designed to provide scientifically based care and those that are designed only to save money will be difficult. To do this, a system will be needed that will monitor the effects of these financial incentives on the short- and long-term health of children. Ideally, physician compensation should reward physicians for high-quality care, patient satisfaction, productivity, and promoting prevention.

**Commitment to Health Care Quality**

There is no doubt that the driving force behind the recent managed care revolution has been cost containment. Concerns about improving the quality of health care services have taken a backseat, and evidence for quality-improvement efforts initiated by managed care organizations has been minimal. As Bergman and Homer discuss in their article, active strategies to improve care for children are few, although two promising strategies may provide needed incentives for health plans to improve care for children. The first is for health care consumers to require health plans to report on an array of objective measures of child health outcomes and to begin buying health insurance based on quality as well as cost. Large health plan buying cooperatives such as the Pacific Business Group on Health, California Public Employees’ Retirement System (CALPERS), and state Medicaid programs could require health plans to report their child health outcomes and to show measurable improvements in these outcomes over time. The second strategy is for members of the Performance Measure Coordinating Council (that is, the National Committee for Quality Assurance, which accredits health plans; the Joint Commission on Accreditation of Health Care Organizations, which accredits hospitals, nursing homes, and home health care agencies; and the American Medical Accreditation Program, which sets standards for physicians) to begin requiring plans to report their child health outcomes. In either of these strategies, it is important not to leave...
out those children with special health care needs who are likely to be excluded from these monitoring systems.

Managed care is falling short of the ideal—to deliver quality health services in a cost-containment framework—but managed care organizations themselves are not entirely to blame. Health care purchasers, including employers and state governments, have not made it realistic for managed care organizations to place quality-improvement efforts at the top of their agendas. According to industry experts, although many employers are encouraging providers to offer high-quality health services, cost is still their biggest concern. Families have little power to drive the quality agenda through competitive mechanisms because the vast majority of employers give individuals little or no choice in selecting a health plan. In the public sector, states are also looking for ways to reduce the amount they spend on Medicaid. As presented in the article by Fox and McManus, few mechanisms to encourage quality performance are built into state contracting arrangements with health plans.

In his article, Anderson reports that, in 1996, state legislatures introduced more than 400 bills aimed at regulating the managed care industry. Many of these laws focused on improving the quality of health care. Unfortunately, too many of them were created in reaction to perceived unique problems in health care and have resulted in a patchwork of often-intrusive laws. Anderson argues that state legislatures do not have the time or the expertise to regulate the health care industry. Instead of regulating the industry by “body part” or creating laws that micromanage the delivery of health care (such as requiring health plans to cover at least 48-hour hospital stays after the birth of a baby), many states, including California, are now calling for the creation of new independent regulatory bodies. These newly formed independent agencies could systematically and thoughtfully develop a fair way to regulate the managed health care industry, taking into account the needs of families, buyers of health insurance, health plans, and providers. As these new independent regulatory agencies are developed, it will be critical to include strong incentives for health plans to follow mandates to improve the quality of health care they provide.

A recent focus on health care quality at the national level suggests that a concerted effort for improvement may be coming. President Bill Clinton convened a 34-member Advisory Commission on Consumer Protection and Quality in the Health Care Industry. This commission was charged with making recommendations to improve quality and protect consumers in the health care industry. In March 1998, the commission recommended a health advisory panel be created that would gather information on best practices in medicine, establish national goals for quality improvement in health care, and monitor progress in achieving them. Central to this task is developing standardized ways to measure health care quality, promote the use of care that is based on the available scientific evidence of effectiveness, eliminate unnecessary or ineffective care, and eliminate health care errors.

**RECOMMENDATION**

- Reward health plans for improving the health of children. Health care purchasers, such as employer groups and state Medicaid agencies, should begin to buy insurance from accredited health plans that (1) demonstrate a commitment to providing effective care that is based on the available scientific evidence; (2) invest in developing information systems necessary to monitor the outcomes of care; and (3) demonstrate continuous improvements in the health of the children they serve. Health care purchasers should also invest in research and development to create valid child health performance measures and effective solutions to improve care. Health plans should find new ways to compensate their physicians based on their ability to provide high-quality care, patient satisfaction, and productivity, and on their efforts to promote prevention.

**Conclusion**

Overall, the managed care industry has been highly successful in responding to demands to cut the rising costs of health care in the United States. Health care costs are lower,
hospital stays are shorter, and waste and inefficiencies in the health care system are being eliminated. The effect of managed health care on health service delivery and health outcomes is less certain, however, particularly for children. Realistically, the national crisis in health care cannot be solved by managed care alone. The root cause of the crisis comes from the convoluted system that now exists to buy, sell, and insure health care services. Favorable tax incentives underwrite the purchase of health insurance by employers. Consumers do not directly pay for most of the health care services they receive, and despite the demands to pay less for health care insurance, when individuals become ill they demand the most sophisticated care regardless of cost. One trillion of the nation’s health care dollars travel through a confusing spiral that cycles through consumers, employers, governments, insurers, providers, and health care management groups. In the midst of this spiral, it is very difficult to see exactly what motivates each of these groups, and to whom or whether they are being held accountable.

As a result of this confusion, the current health care system seems to make everyone unhappy. Consumers are unhappy with insurers because they are not receiving all the care they demand, and consumers have lost trust in health care providers because of fears that doctors are less interested in improving their patients’ health and more interested in assuring their own financial health. Physicians are angry with managed care organizations because they must answer questions about their care decisions through utilization review, are at risk for losing their jobs if they do not meet a plan’s financial expectations, and continue to see reductions in their pay. Moreover, as the health care industry bows to the realities of the marketplace, the ability to provide free care to the uninsured, which in large number are children, is in serious jeopardy. Calls to simplify the health care system by taking employers out of the loop and having consumers buy their health care directly from insurers are growing in popularity but will probably not be a cure for the ailing health care system. In pursuit of high-quality care at a reasonable cost, health care leaders should look to other American industries that have made tremendous advances in quality, such as the car, computer, and retailing industries. While caring for children is obviously not the same as manufacturing a car or a computer, there are valuable lessons that the health care industry could learn from other industries. Saturn, Hewlett-Packard, and Wal-Mart are only a few industry leaders that have improved the quality of their products and kept costs low. They have accomplished this by developing long-term relationships with suppliers that provide the highest-quality parts and by putting the needs of the consumers first.

Children are more likely than adults to receive their health care through managed care plans, yet their complex health care needs continue to be ignored by the managed care industry. After reviewing the existing information about managed care and children, many have come to the same sobering conclusion: There remains a critical shortage of information about the effect of managed care on this population. Managed care organizations essentially are an experiment that the nation has entrusted with its children’s health and well-being.

Future systemwide health care reforms, whether market driven or planned, should take into consideration the unique needs of children and their families. A reformed system should provide innovative methods for delivering health care services that change with the needs of children and their families. It should provide children with a stable medical home, which makes care continuously accessible, comprehensive, family centered, coordinated, and compassionate. The families of children also deserve a clearly defined benefit package that emphasizes preventive health care and developmental services. Financial incentives should be structured to reward providers who demonstrate improvements in the health of the children they serve, and health plans should be fairly compensated so that they can afford to care for children who become chronically ill or debilitated. The pioneering
innovations implemented by the managed health care industry have features that make it possible to create a health care system that works for children and their families. However, systemwide health care reforms will be needed to move ahead in the twenty-first century. A strong, concerted public-private-family alliance must be created and sustained to provide the best health care possible for children.

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