expansion in our country's history. Currently, more than 10 million children are totally uninsured, and an additional 5 million are underinsured. More children—presently 1 in 4—grow up in poverty in the United States than in any other industrialized nation. We seem unwilling or unable as a nation to extend to children federal benefits similar to those provided by Medicare.[3]

Medicaid has become the principal means of financing services to children in medically underserved areas. Medicaid is a state–federal partnership, and there are 50 Medicaid programs with varied benefits and reimbursements ranging from the generous to the unattractive. Hoping to control expanding Medicaid costs, the states have turned to managed care; this has brought mixed results, ranging from the early disasters of Tenn Care to other, more cautious, and potentially successful programs. In many of the newer programs, Medicaid is seen as the means to expand both state and federal coverage for children.

Why do the state programs have only limited success? Some states have developed programs for children whose parents earn too much to qualify for Medicaid but cannot afford private health insurance, and a few (Connecticut, Massachusetts, Minnesota, Florida, and New York) are implementing comprehensive programs for children. These are wealthy states that have sufficient resources to develop such programs; most states do not have these resources. In addition, the states are subject to whims of their respective 50 legislatures.

Having failed to achieve true universal coverage, we now seek incremental expansion. The slow pace of change leaves the uninsured and underserved children to suffer. To capture the attention of legislators, we need a national medical care lottery: not to raise more funds but in which our legislative leaders would participate. After the drawing, 15% of legislators would lose their health insurance for the year and experience with their families what the uninsured must live with daily.

Concerns about balanced budgets and hostility toward taxes and big government continue to prevent us from applying the Medicare lesson to all of our nation's citizens. The passage by Congress of Title XXI as part of the 1997 Balanced Budget Act has been a stimulus to the development of state programs providing coverage for uninsured children through Medicaid expansion, a new child health insurance program, or a combination of both. The Rosenbaum et al. survey provides additional evidence that our present course will not work. States alone cannot do the job; federal subsidies are better but also fall short, and community health centers require stable funding.

There should be no financial barrier when medical services are needed. The next step of providing universal coverage, increased access, and a combination of both federal and state subsidies to serve all of our nation's children—and, eventually, all of our citizens—is long overdue. □

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Editorial: Continuity of Insurance Coverage—A Precondition for Continuity of Primary Care

By the end of the decade, most Medicaid recipients will be enrolled in managed care programs. One interpretation of this trend is that state and federal officials regard managed care as financially and administratively expedient. For state governments that were contending with large increases in Medicaid expenditures in the early 1990s, the allure of managed care was understandable. HMOs and other managed care plans offered to accept premium rates below the average costs per beneficiary. Moreover, managed care plans promised to relieve state Medicaid programs of the day-to-day battles over provider payment, claims processing, and utilization management.

Under state Medicaid managed care, programs would be able simply to determine beneficiary eligibility, oversee the process of beneficiaries' enrollment in managed care plans, and issue a monthly check to a managed care plan responsible for organizing and delivering care and accepting financial risk under capitated payment. So irresistible was this strategy that few government officials seemed visibly disturbed by the notion that many managed care plans skim more than 20 cents from every dollar for their administrative costs and profits.

The fiscal logic behind Medicaid managed care may, of course, have been flawed. Most of the growth in Medicaid expenditures in the late 1980s and early 1990s resulted, not from higher costs per enrollee, but from a large jump in enrollment related to more liberal eligibility rules (and more poor people) and from states' mining the generous federal veins of disproportionate share hospital payments.[1] (The rise in Medicaid enrollment buffered much of the steep decline in private insurance coverage during this period.)

As is true for managed care in general, concerns remain that Medicaid managed care plans selectively enroll healthier popula-tions.[2] Thus, managed care has held costs down by focusing primarily on healthier populations eligible for Medicaid because they qualify for Aid to Families with Dependent Children. Managed care has not yet proven that it will also control expenditures for the more costly disabled and elderly Medicaid populations.

Another view regards Medicaid managed care not as simply a method for controlling costs but rather as a strategy for improving access to health care.[3] Access to care, particularly to primary care, has often been poor for Medicaid beneficiaries in the fee-for-service system.[4] Many physicians refuse to participate in Medicaid, citing low fees and disagreeable administrative procedures. Physicians who do participate have not always provided care that was accessible, integrated, and of high quality.[5] Proponents of managed care have suggested that managed care will enhance the quality of primary care by making physicians and

Editor's Note. See related article by Carrasquillo et al. (p 464) in this issue.

health plans more accountable to Medicaid beneficiaries.[6] Managed care would bring patients an identifiable primary care provider to coordinate their care, and plans would be monitored for the quality and accessibility of care they provided.

Better primary care is unquestionably a laudable objective for Medicaid. A substantial body of research has demonstrated that care featuring continuity, comprehensiveness, coordination, and accessibility from primary care physicians and other practitioners promotes better patient outcomes. Patients who experience these elements of primary care are more likely to be satisfied, to adhere to treatment, to avoid hospitalization and inappropriate surgery, and to receive proper preventive interventions.[7–9]

In the United States, these primary care objectives will prove elusive as long as the nation's system of financing health care remains fragmented. The article by Carrasquillo et al. in this issue[7] demonstrates why reorganizing Medicaid into a managed care model cannot compensate for the structural deficiencies inherent in a means-tested, categorical insurance program. These authors examined persons newly enrolled in Medicaid between 1991 and 1993. The proportion still insured by Medicaid after 12 months was only 38% and, after 28 months, only 26%. These findings make it clear that one of the most critical ingredients of primary care—continuity of care with a personal caregiver—will to a large degree be stymied by the lack of continuity of insurance coverage. As the authors point out, many patients who lose Medicaid managed care coverage and fall into the ranks of the uninsured will also lose access to their primary care physicians because those physicians (or physician groups) do not accept uninsured patients. Others disenrolled from Medicaid who find some other form of coverage may, nonetheless, also experience discontinuity of care because the limited panel of physicians approved in their new plan may not include those who previously cared for them.

Such forced discontinuities are not unique to the Medicaid population.[11] In a competitive, employment-based private insurance market, the patient–physician relationship becomes devalued by a system that limits choice and encourages employers to change plans in pursuit of lower premiums. In a recent study of a predominantly privately insured group of patients in Ohio, one quarter had experienced an involuntary interruption of their relationship with a primary care physician because their employer changed health plans.[12] These patients, compared with others who had not experienced a forced interruption, rated the quality of their current primary care as inferior on several scores.

By enacting managed care reforms, some states have extended the minimum period that Medicaid beneficiaries are guaranteed continuous enrollment before having their eligibility reevaluated.[13] These policies may prevent early termination of Medicaid coverage, but they are unlikely to substantially alter the longer-term Medicaid tenure patterns observed by Carrasquillo and others.

The formidable political resistance to a publicly financed system of universal health coverage in the United States may discourage policymakers and health reformers from decisively addressing the fundamental flaws of the US approach to financing health insurance. Yet, as long as a change in earnings, family structure, or employment can mean a loss or change of insurance coverage (and, in turn, of physician or other primary practitioner), efforts to promote effective primary care will be frustrated by the flaws in the underlying insurance structure. No amount of reorganization of delivery systems will alter that reality. Continuity of care is difficult to attain in a nation that cannot assure its residents continuity of insurance coverage. □

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Editorial: NORA—More than a Name

When the National Institute for Occupational Safety and Health (NIOSH) was established in 1970, it was given an unusual mission: to undertake research not only on the causes of occupational disease and injury, but also on prevention of those problems as well as on the effectiveness of the interventions. NIOSH must undertake research that concerns both science and policy, both causality and prevention. Despite its small size, NIOSH was given a mission that intersected with the missions of both the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC).

However, NIOSH has never been provided with a sufficient research budget to achieve its mission. In fact, its research budget is strikingly inadequate to accomplish the tasks inherent in that mission. Consequently, since its inception, NIOSH has directed its energies largely toward establishing the institute and building its intramural research and service program. A

Editor's note. See related article by Rosenstock et al. (p 353) in this issue.