Rethinking Support for Adoptive Parents

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Over the past century, wealthy countries have worked to move away from institutional care of children whose birth families cannot care for them. The aim is to care for children in surrogate families. There is urgent need for surrogate families. In the U.S. there were 899,000 substantiated reports of child abuse and neglect in 2005; at least 12 of 1,000 children in the U.S. were maltreated that year (US Department of Health and Human Services [US DHHS] 2006a). On a given day, over half a million children in the U.S. live with foster families (US DHHS 2008a).

Worldwide the needs of children are even greater. The United Nations (2006) reports that as many as 53,000 children were victims of homicide in 2002; most died at the hands of their parents. Over 225 million children have been sexually abused. Not all children in need of surrogate parents are victims of abuse: Fourteen million children worldwide have lost one or both parents as a result of the AIDS epidemic.

Countries must consider how to protect the rights of their children to experience the benefits of being cared for by a loving family, a right articulated of the United Nations Convention on the Rights of the Child (in the Preamble and Section 20). At the same time, the Hague Convention on Protection of Children and Co-Operation in Respect of Intercountry Adoption of 1993, makes the principle of subsidiarity paramount. The principle of subsidiarity requires that domestic options are to be preferred to international options. For these reasons, the recruitment of surrogate parents has become a major concern in many countries, including transition and developing countries (Rebecca T. Davis 2006).
For children whose birth parents cannot care for them, adoption is preferred to institutional care or a sequence of short-term foster homes. Adoption establishes legal parent-child connections and confers emotional security. As summarized by Mary Eschelbach Hansen (2007a), adoption enhances overall well-being and promotes educational attainment and success in the labor market. In the U.S. case, a child who is adopted from foster care is likely to earn more than counterparts who “age out” of foster care without a permanent family—about $100,000 more over a lifetime. And, like raising children generally (Nancy Folbre 1994, 2001), the work of adoptive parents has positive externalities. Each adoption from foster care in the U.S. nets $350,000 in savings in the child welfare, special education, juvenile justice, and welfare systems (Hansen 2007a, adjusted to 2008 dollars). In all, a dollar spent on the adoption of a child from foster care yields about three dollars in benefits to society. Policies that support adoption are good investments.

Individual U.S. states began to offer financial incentives to encourage adoption of children from foster care in the 1960s and 1970s. In 1978, the federal government began to support the states through a grants program, and in 1980 Congress added reimbursement for adoption subsidies for eligible children to the Social Security Act. In the late 1990s, many states began to use adoption subsidies aggressively to meet adoption targets set by Congress during the Clinton administration (Hansen 2007b). Adoptions from foster care doubled from about 25,000 per fiscal year in the mid-1990s to 50,000 in 2000, by which time most eligible adoptions utilized the subsidy (Hansen 2007c). However, in its current form, the subsidy program does not attract a sufficient number of adoptive parents. As figure 1 shows, the number of adoptions from foster care leveled off after fiscal year 2000. The gap between the number of finalized adoptions
and the number of children waiting in foster care for an adoptive parent has been constant at about 70,000 children for several years.

This paper suggests that the subsidy program has been most effective at attracting adoptive parents whose main financial concern is covering the everyday costs of raising an adopted child. The subsidy program has not attracted greater numbers from the pool of prospective adoptive parents whose main concern is not everyday expenses, but whose concerns include stigmatization from participation in the subsidy program and the significant risks of adoption of a child from foster care.

To understand this risk, consider first the emotional and economic risk inherent in caring for a child born to you. Your child may be healthy or may have a birth defect that requires lifelong medical treatment. Your child may be emotionally healthy or may be challenging or troubled. Your child may take care of you in your old age or she may be disabled in an accident and require lifelong care by you. In many countries, including the United States, the risks of caring for a child are high because of inadequate child care policy and uneven health insurance coverage. Even with insurance, caring for a child with extraordinary needs can bankrupt a family. Mental and emotional health needs are particularly problematic because insurance coverage for these needs is patchy; consequently, providers are few.

Now consider the risks faced by parents who adopt a child from foster care. The current health of the child may be poor. As will be discussed in more detail below, the left-hand tail of the distribution of child “quality” is thicker among children who need adoptive parents than among children cared for by their birth parents. The child waiting to be adopted may have experienced deprivation and terror, but may never have experienced comfort and love. It may take years of therapeutic intervention before the child’s potential for development can be
assessed. There is a small, but positive, probability that the child will be found, only after placement with an adoptive parent, to have a disability such as reactive attachment disorder or fetal alcohol syndrome. These disabilities result from birth parent behaviors that may not be accurately reflected in the child’s case history. A propensity to develop other conditions may not be known because the birth family health history is often incomplete. In short, an adoptive parent is often unable to assess child “quality” prior to an adoption.

Some adoptive parents can accommodate any problem that a child develops, and such flexibility is generally regarded as an important characteristic of a surrogate family (Victor Groze 1996). As part of the evaluation of the parent prior to adoption, social workers ask about perceived limits and flexibility. While many parents are willing to adopt children with disabilities, it is not known how many can accommodate the most difficult problems. What is known is that the current, subsidy-based programs sometimes do not meet the needs of families whose adopted children require care beyond what can be given by the adoptive parents. Some of these children are eventually separated from their adoptive parents. Between 10 and 25 percent of attempted adoptions are not finalized, and perhaps as many of 10 percent of finalized adoptions are legally dissolved before the child grows to adulthood (Child Welfare Information Gateway 2004). The difficulties faced by adoptive parents were recently highlighted in Nebraska, where in 2008 the state legislature originally failed to put an upper limit on the age of children whose parents would be sheltered from prosecution for abandonment under a child safe-haven law. Over the course of a few months, more than a dozen adoptive parents and guardians surrendered their children under the law (Omaha World Herald, November 26, 2008). Said one parent, after ten years of adoptive parenting: “He raised knives at [me and my other adopted children].” She reported that child protective services responded by offering to remove the other
children from her custody (CBS13, November 25, 2008). Similar stories are reported online (for example, ABC News, November 28, 2008). For these parents, the costs and risks of continuing to care for their adopted children are too great given current policies.

Current subsidies for adoptive parents offset part of the everyday costs of caring for an additional child and may include some implicit payment for care-taking. But to sustain and encourage the efforts of adoptive families, and to protect adopted children from further losses, policy should more directly reduce the financial risks of caring. Adoptive families need insurance, even if they do not need income support. Adoption insurance should be comprised of four parts: (1) comprehensive physical, mental and behavioral health insurance to cover the not-so-routine care of children in adoptive families without being limited to Medicaid providers and services, (2) a missed-work policy akin to disability leave to replace income lost by adoptive parents when caring for the child, (3) pre-paid legal insurance to cover defense of the child and parents, (4) long-term care insurance to cover residential mental health treatment should it become necessary.

Adoption insurance would improve outcomes for children by protecting children’s connections to their adoptive parents, by giving adoptive parents a specific incentive to provide care to meet the child’s particular needs, and by encouraging providers to offer more of the specialized care needed by child victims of abuse and neglect.

Further, provision of insurance is likely to increase the number of adoptive parents and thereby close the gap between the number of waiting and adopted children. First, insurance may attract some parents who currently do not participate because of the “doing it for the money” stigma that surrounds the participation in the child welfare system (E.M. Scholte, M. Colton, F. Casas, M. Drakeford, S. Roberts, and M. Williams 1999; Derek Kirton, Jennifer Beecham, and
Kate Ogilvie (2007). Second, insurance would attract parents who currently do not participate because of the fear of lost income from missed work and from fear that the needs of the adopted child will exceed the limits of the parent.

Understanding the histories of the children who need adoptive parents is important to understanding what might better serve them. The next section tells the story of a child in foster care and describes current policy affecting foster parents, who serve as temporary surrogate parents. The second section below follows the story of the child into adoption and describes policy affecting adoptive parents who serve as permanent surrogates, with a focus on the problems that may be mitigated by adoption insurance. The third section discusses how insurance-based policy might improve outcomes for children. The final section provides a rough estimate of the expected payouts under adoption insurance.

SHORT-TERM SAFETY AND CARE FOR THE CHILD

Jenny is six years old, the oldest of several children. Her family never lives anywhere very long; right now they live in a room in a motel. Her father drinks. There is never enough to eat. Jenny has never been to school. Today, while Jenny and her mother were outside a store asking people for food and money, Jenny’s father stole something from the store. The police came. Jenny and her brothers and sisters went with a lady to an office and then to a house. It was a big house.

In a case of apparent neglect, like Jenny’s, or upon report of abuse, the law requires an investigation of the birth parents. If a child is in immediate danger, child welfare workers offer protection in the home of an emergency foster parent. If the charge of abuse or neglect is not substantiated, the child is returned to the custody of the birth parents. Accordingly, for about one
fourth of children, the stay in foster care is less than five months (US DHHS 2008a). If the charge of abuse or neglect is substantiated, and if the court finds the child cannot be returned home safely without further intervention, the child is placed in foster care for a longer period of time.

*Jenny went to a new house. She lived there for four years.*

Foster parents protect and nurture the child and, at the same time, support the efforts of the child welfare system to reunite the child with the birth parents. Reunification requires that the birth parent(s) cooperate with interventions provided by child protective services and other parts of the social service system. Interventions may include, but are not limited to, parenting and anger management training, mental health treatment, and drug or alcohol rehabilitation. Supporting services may include temporary housing and assistance in enrolling in housing programs, enrollment in Medicaid programs, and income support programs. Interventions, especially substance abuse interventions, take time. The median time in care at the end of fiscal year 2006 was 15.5 months (US DHHS 2008a).

*Jenny went to the doctor and got lots of shots. She started school. School was hard.*

*Jenny got in trouble.*

While in foster care, Jenny received medical and dental care under Medicaid, and she received a whole-child evaluation conducted by a Medicaid-funded clinic. She did not receive ongoing mental health care, even when her behavior at school became disruptive. While foster children are more likely than other groups of Medicaid-enrolled children to use mental health services, only a fraction of children with needs receive care (Margo Rosenbach, Kimball Lewis and Brian Quinn 2001). If Jenny’s foster parents received a referral for mental health care, the nearest provider with extensive experience in working with children in surrogate families was
some distance away and not a Medicaid provider. Jenny’s diagnosis remained *child maltreatment syndrome*, a catch-all assigned to her in her evaluation.

It is believed that 30 to 40 percent of children in the child welfare system have physical health problems. Experts disagree on the number of children in foster care who have psychiatric and behavioral disorders. The Child Welfare League of America (2008) reports that about “60 percent of all children in out-of-home care have moderate to severe mental health problems...Adolescents living with foster parents or in group homes have about four times the rate of serious psychiatric disorders than those living with their own families.”

In addition to Medicaid, Jenny’s foster parents received $294 ($380 CPI-adjusted to 2008) per month from the state for her care (National Resource Center for Family Centered Practice and Permanency Planning [NRC] 2006). At the rates then in effect, the state was able to claim reimbursement from the federal government for 51.67 percent of the maintenance payments made to Jenny’s foster parents (US DHHS 2006b). The federal share of the cost of foster care during fiscal years 2001 to 2003 ranged from $4,100 to $33,100 per child in care (US DHHS 2005), depending on the state.

*Over and over, the lady took Jenny to see a judge. The lady said her parents would come, but they didn’t.*

Jenny’s birth parents did not comply with the court-ordered interventions. If the threat of harm to the child from the birth parents is not mitigated through interventions, then the child welfare system petitions the court terminate the parental rights of the birth parents and seeks an adoptive parent or legal guardian for the child. Adoption is the preferred alternative for most children. Child welfare caseworkers may recruit the foster parents, members of the child’s
extended birth family, close friends of the birth family, or previously unrelated adults to adopt. Jenny’s foster parents would not accept permanent responsibility for Jenny.

Jenny went to the lady’s office again. The lady said, “These people want to be your new parents.”

PROMOTING ADOPTION

If Jenny had come into foster care before 1970, she probably would not have been adopted. The 1970s saw the convergence of three trends in child welfare in the U.S. (Andrea Sedlak and Diane Broadhurst 1993). First, the child welfare system began to plan for the adoption of children who could not return to their birth parents. Second, advocates of adoption rallied around the motto “all children are adoptable.” Third, the child welfare systems in a few states came to recognize the importance of the role of foster parents in the lives of children and began to encourage foster parents to consider adoption. Subsidies for adoption emerged in these states because foster parents had a disincentive to adopt if adoption meant the withdrawal of maintenance payments.

Federal reimbursement for adoption subsidy paid by the states was added to Title IV-E of the Social Security Act in 1980. Although the federal government supports adoption subsidies at the same rate as it supports foster care subsidies, the average state commits less to adoption subsidies. About 47 percent of adoptive families in a recent survey reported that they adopted a foster child even though they experienced a loss of financial support (Children’s Rights 2006).

Surrogate parents, both foster and adoptive, “regularly spent more money on the children than the[ir state] stipends provided” (Teresa Toguchi Swartz 2004: 575-6). Assistance to surrogate families is meant to “minimize the financial obstacles” to caring (Child Welfare
Information Gateway 2004b), but the level of subsidy support in the median state is about half the expenditures of the typical family on a child (USDA 2005). In some states the ratio of subsidy to typical expenditures is as low as 0.3; in only one state does the ratio reach 0.9. For the approximately 50,000 adoptions from foster care finalized in fiscal year 2003, the average monthly subsidy was $403 (current dollars), with a standard deviation of $141 (Mary Eschelbach Hansen 2007c). For comparison, in November 2007, survivor’s benefits paid under the Social Security Act to children under 18 averaged $614 per month and Supplemental Security Income payments to children under 18 averaged $696 per month (US Social Security Administration 2007, 2008).

In the 1980s over half of adoptive parents were sometimes unable to provide needed care because of a lack of funds (Sedlack and Broadhurst 1993: 6-59-61). The parents said: “The financial burden is becoming overwhelming”; “[took] a second mortgage on the house”; “[worked] about 20 hours extra per week for four years”. A more recent survey conducted by Children’s Rights reveals little has changed. Fifty-seven percent of adoptive families surveyed reported that adoption assistance was insufficient to meet the child’s needs (Children’s Rights 2006).

Children in surrogate families have great needs. A child is eligible for adoption subsidy under Title IV-E only if the birth family of the child was very poor and if the child has so-called special needs. Jenny was developmentally delayed and prone to violent tantrums (again, symptoms associated at the time with child maltreatment disorder); Jenny was eligible for adoption subsidy by the definition of the special needs in her home state.

It might seem as though the special needs of adopted children should be fewer than the special needs of foster children because only healthier children would be adopted. This is not
clearly the case. Less than 15 percent of the 323,500 adoptions from foster care from 1996 through 2003 involved a child who did *not* have a *special need.* As adoptions rose from 1996 to 2003, the number of adopted children recorded as having no special need dropped precipitously. Children who had a special need because of a medical condition or disability increased from 14 to 24 percent of adoptions. The percentage of adopted children with a physical or sensory disability climbed from 3.3 percent (just over 400 children) in 1996 to almost 5.3 percent (1,600 children) in 2003 (Hansen 2007b).

Incidence of *emotional disturbance* among adopted children increased from about 5.5 percent in fiscal years 1996 and 1997 to 8.3 percent in 1998 and to 12.7 percent in 2003 (Hansen 2007b). For comparison, the National Center for Education Statistics [NCES] (2004) reports that emotionally disturbed students were about one percent of the student population throughout the period. The percentage of adopted children with some other disabling condition, which could include learning disability or psychiatric diagnosis such as attention deficit/hyperactivity disorder, a mood disorder, or post-traumatic stress disorder has increased from an average of nine percent for 1996-1997 to 13.7 percent in 1998 and 18.2 percent in 2003 (Hansen 2007b). Among all pre-school to secondary school-age children, about 6 percent had a learning disability during the period. These statistics underestimate the special needs of children in adoptive families because they are recorded at the time of the adoption. Subsequent diagnoses are not recorded.

The 2000 U.S. census enumerated 2.1 million adopted children, who represented about 8 percent of all sons and daughters of householders in 2000, but did not ask whether the children were adopted from foster care, through a private domestic agency, or internationally. About 1.8 percent (817,000 households) contained only adopted children. Another 1.8 percent
contained both adopted children and birth children. About 5.2 percent of birth children aged five to 17 were reported to have a disability, while 11.8 percent of adopted children were reported to have a disability. Householders reported that just less than one percent of birth children had a sensory, a physical, or a self-care disability, while they reported about 1.5 percent of adopted children had disabilities that fell into one of those categories. Mental disabilities included learning disabilities and difficulties concentrating. About 4 percent of birth children and 10.4 percent of adopted children were reported to have a mental disability. Adopted children were more than twice as likely to have multiple disabilities. The 2005-2006 National Survey of Children with Special Health Care Needs showed that children adopted from foster care are more likely to be cognitively challenged, have emotional problems, have “other” unspecified conditions, and have more conditions on average, as compared to children adopted through private agencies or facilitators or children adopted internationally (US DHHS 2008b).

Jenny went to live with her new family. She had her own bed and toys, but she was scared and angry a lot. She went to new doctors in cities far away.

Jenny had developmental delays and cognitive impairments that required special education. Her evaluations at a Medicaid-funded child development clinic, conducted while she was in foster care, did not indicate a specific cause for her impairments. Her adoptive parents worked with special education staff to develop an Individualized Education Program, arranged for Jenny to receive occupational therapy to address her delays in gross and fine motor skills, and found a play therapist to address her other symptoms. On referral of these professionals, Jenny’s family consulted a nationally-recognized, multi-discipline clinic specializing in diagnoses for adopted children. Jenny was diagnosed with fetal alcohol syndrome, although her case history indicated that her birth mother claimed not to have used alcohol.
Obtaining an accurate diagnosis for Jenny put financial strain on her adoptive parents. The specialized consultation and battery of tests cost several thousand dollars. The clinic did not accept insurance. Medicaid would not pay, and neither would the parents’ private insurance. Jenny’s parents petitioned the department of social services for reimbursement of the evaluation and subsequent treatment expenses paid out-of-pocket. Some bills the department paid, others it did not. In the jurisdiction where Jenny was adopted, it was not possible to obtain guarantees of payment for services in advance.

Jenny was scared and angry at school, too. She hit the teacher and the police came. She hit her mom and the police came. She scratched herself until she bled.

Years of family-based therapies did not resolve Jenny’s problem behaviors; short-term residential treatment did not resolve her problem behaviors. Jenny’s executive functioning was inadequate; she required constant supervision by an adult. She posed a danger to herself, her parents, and her siblings. Jenny’s care providers recommended a permanent residential placement. Funding was denied by the family’s private insurance company, by Medicaid, by the Department of Social Services, and by the state-run “comprehensive services” funding source for at-risk youth. A supervisor at a local public health agency suggested that if her adoptive parents were unable to care for Jenny at home and were unable to pay the full cost of her residential placement, then they should petition the family court to dissolve the adoption.

Dissolution was not in Jenny’s best interest. She needed care. Her adoptive parents knew best what kind of care she needed. New parents would not have been in a position to make good decisions about her care. But her parents had other daughters, and one was college-age. If the parents financed Jenny’s inpatient care out-of-pocket, the other daughter’s college expenses would drive them deeply into debt.
It is tempting to argue that an adoptive parent understands and accepts the financial risks. But, again, consider Jenny’s story. Jenny’s birth mother lied about Jenny’s exposure to alcohol. As a result of the lie, the social workers and the doctors who examined Jenny while she was in foster care did not look for the markers of fetal alcohol syndrome. Her foster and adoptive families were told that Jenny had cognitive impairments but did not have fetal alcohol syndrome.

Jenny’s story is not unique. Less than half of adoptive parents in the 1980s reported that they found out about the extent of their adopted children’s needs from the placing agency (Sedlack and Broadhurst 1993: 6-31). Only physical needs were adequately disclosed; special educational and emotional needs were disclosed only about one-third of the time (Sedlack and Broadhurst 1993: 6-32). Adoptive parents reported: “We were not told all the truth. We got a lot of misinformation” (Sedlack and Broadhurst 1993: 6-33). Adoption insurance would protect adoptive parents against financial losses caused by their inability to gather information about the child and their inability to predict whether the needs of the children could be effectively addressed in the context of their household.

BENEFITS OF ADOPTION INSURANCE

Adoption insurance would improve upon subsidies in two ways. First, insurance would attract additional surrogate parents and reduce the number of waiting children. Second, insurance would improve outcomes for adopted children. It would improve outcomes by encouraging providers to supply the specialized care needed by children in surrogate families, by providing specific incentive for surrogate families to meet the particular special needs of the child, and by protecting the child from separation from the adoptive parents.

Attracting interested surrogate parents
As discussed above, the number of adoptions from foster care doubled during the 1990s. These adoptions were completed by foster parents and by people who had blood ties or other relationships with the children before they entered foster care. Kinship adoptions rose sharply in the late 1990s; see figure 2. The proportion of adoptions by foster parents declined throughout the period.

One of the ways states generated adoptions among kin was by offering higher adoption subsidies and by making more children eligible (Hansen 2007b, 2007c). The percentage of adoptions made with subsidy increased from about two-thirds to more than 85 percent between 1995 and 2003. At the same time, the real value of the adoption subsidy increased 52 percent, from $325 in 1995 to $495 in 2003 (in 2000 dollars). The socioeconomic status of kin carers tends to be low (Jennifer Ehrle Macomber and Rob Geen 2002); subsidies appear to be good incentives for prospective adoptive parents who already have ties to a child but who worry about meeting regular expenses for an additional dependent.

Subsidies do not seem to attract prospective adoptive parents who have no prior relationship with the child to be adopted. The absolute number of adoptions by non-relatives was about the same in fiscal year 2003 as it had been in 2000. Figure 2 shows that the proportion of adoptions finalized by parents with no prior relationship to the adopted child declined from over 20 percent in fiscal year 1996 to about 13 percent in 2003. Yet there is widespread interest in adoption. One in three adults in the United States has considered adoption as a way to start or expand a family; one in five has very seriously considered adoption (Harris Interactive 2002). While some interest in adoption is driven by infertility and impaired fecundity (A. Chandra, J. Abma, P. Maza, and D. Bachrach 1999), many families are preferential adopters; that is, they do not have impaired fecundity, but they choose
to become adoptive parents out of altruism, civic-mindedness, or moral commitment (William Feigelman and Arnold Silverman 1983).

Prospective adoptive parents are not interested in caring only for healthy infants. Of prospective adopters, 15 percent say that they would be likely to consider caring for a child with known problems, and 28 percent say they would be likely to consider caring for a child who waits in foster care. The 1995 National Survey of Family Growth indicated that nearly 10 million women had considered adoption but only one million had taken steps to adopt (A. Chandra, J. Abma, P. Maza, and D. Bachrach 1999). More recent surveys indicate that if one in every 500 people who have interest in adoption from foster care were to actually adopt, all children waiting in foster care could be placed (Harris Interactive 2002).

Why didn’t the increase in subsidies attract additional surrogate parents from the apparently large number of “preferential” adopters? Perhaps, despite recent increases, the level of the subsidy remains too low. Low levels of subsidy signal that society places little value on the care of the children, which in turn may reduce the value that prospective adoptive parents see in the work. In the words of Nancy Folbre (1994: 88): “Failure to remunerate commitments to parental labor may weaken the values, norms, and preferences that supply it.”

Further, surrogate parenting may be particularly unattractive to women as their opportunities for market work, including professional care work, have improved. In response to this concern, some child welfare authorities now formally recognize the fostering of children with special needs as professional care work (Matthew Colton and Margaret Williams 1998; P.H. Delfabbro and J.G. Barber 2004, Deborah Gibbs and Judith Wildfire 2007). If accompanied by adequate payments for direct expenses associated with special needs, professionalization would seem to be a good way to attract surrogate parents who consider themselves “career carers,”
people who expect to provide services for a long time, to many generations of children. But
career caring may not be of interest to the large number of adults whose are interested in
adoptive parenting as an alternative way of forming a family. These families seem more likely
to see parenting as part of a life cycle of caring, not as a career.

Finally, offering higher levels of subsidy doesn’t reduce the stigma of subsidy. While
some adoptive parents try to decline subsidy to avoid stigma, social workers press subsidy upon
parents. Advocates for adoption encourage prospective adoptive families to view the adoption
subsidy as an “essential part of a post-adoption support plan for a child who either has, or is at
risk to develop, some special needs” (Adoption Policy Resource Center 2006). Essentially, then,
the subsidy program is “sold” to adoptive parents as insurance, while it does not function as
insurance.

Adoption insurance would be more responsive to a child’s developing needs than existing
adoptive subsidy bureaucracies in the states. Some states have administrative procedures that
allow adoptive parents to petition for adjustment of the subsidy as needs develop, but many do
not (Richard P. Barth, Judith Wildfire, Chung Kwon Lee, and Deborah Gibbs 2003). Some
states have pre-set “specialized” rates for high-needs children, but many do not (Hansen 2008).
Some states reimburse families directly for approved expenses related to special needs, but
others do not. Some states contract with vendors directly for post-adoption services, but others
do not. When child welfare and public health authorities refused to provide on-going residential
care for Jenny when her needs exceeded the capacity of the family, Jenny’s adoptive parents
final recourse was to retain legal counsel and petition the court to compel the child welfare
authority to provide necessary care. The legal process, of course, required considerable time and
expense. Prospective adoptive parents may well be put off by the risk of adopting a child whose
needs cannot meet at home. Offering adoption insurance may induce some who have considered adoption to follow through.

Expanded out-patient insurance improves access and outcomes

As many as 50 percent of adoptive families do not getting specialized care they need through private insurance or Medicaid (NACAC 2007). Adoption insurance covering adoption-competent mental and behavioral health care could improve this situation. A large literature documents that expanding health insurance coverage improves access to care and outcomes for diverse populations including children (for example, Janet Currie and Jonathan Gruber 1996a, Frank Lichtenberg 2002; Paul W. Newacheck, Margaret McManus, Harriette B. Fox, Yun-Yi Hung, and Neal Halfon 2000). Those with the greatest health needs gain the most from expanded insurance (John Z. Ayanian, Joel S. Weissman, Eric C. Schneider, Jack A. Ginsburg, and Alan M. Zaslavsky 2000). The positive effects are especially strong for those with mental, emotional, and behavioral health needs (D.D. McAlpine and D. Mechanic 2000). Strong evidence that adoption insurance could improve outcomes at a reasonable cost comes from studies of the recent expansion of mental health benefits for federal employees and the passage of state laws requiring parity of coverage between mental and physical health (Katherine M. Harris, Christopher Carpenter, and Yuhua Bao 2006; Susan T. Axrin, Haiden A. Huskamp, Vanessa Azzone, Howard H. Goldman, Richare G. Frank, M. Audrey Burnam, Sharon-Lise T. Normand, M. Susan Ridgely, Alexander S. Young, Colleen L. Barry, Alina B. Busch, and Garrett Moran 2007).

If access to adoption-competent out-patient care can be improved, perhaps the need for residential care will be lessened. Certainly, providing insurance for adoption-competent care will create an incentive for adoptive parents to seek that care that does not exist under the current
subsidy policy, under which subsidy income can be spent on general household expenses. Finally, providing insurance for adoption-competent care eliminate the costly administrative and legal barriers to obtaining care.

*Income insurance*

As discussed above, the movement to professionalize foster care for children with special needs may effectively provide secure income without stigma for foster parents, but professionalization may not be attractive to many prospective adoptive parents. To provide income security to employed adoptive parents, adoption insurance should provide supplemental insurance that pays when substantial time at work is sacrificed to care for the child. The Family and Medical Leave Act, of course, protects the job of a surrogate parent, but does not replace lost income.

*Insurance for residential care and legal expenses*

The final, and possibly the most important, elements of insurance for adoptive families is insurance for residential care of the child and for legal expenses incurred by the adoptive family on behalf of the child. It is important for policy to recognize that adoptive parents cannot in all cases bring the benefits of a permanent family to a child by caring for the child at home. Some children in adoptive families eventually need long-term residential care because of self-harming or anti-social behaviors. Anti-social behaviors may also lead to legal problems; providing adequate defense for the child or the family can threaten a family’s financial health. Policy should help, never hinder, an adoptive parents’ efforts to obtain needed care. Policy should not require parents to petition the court dissolve an adoption in order for the child to receive necessary long-term treatment outside of the family home. Severing this second family bond is unlikely to improve outcomes for the child.
Qualifications

One serious unintended consequence of adoption insurance is that its introduction might reduce the incentive to carefully match the abilities of prospective adoptive families with the needs of waiting children. With insurance, adoption caseworkers might worry less about the possibility of return of the child to foster care. This problem may be solved through appropriately structuring federal financing for adoption insurance. First, states must be required to provide insurance; they must not be allowed to opt out. Then the federal government may cap reimbursement to states for the cost of insurance at a rate equal to the cost of insurance in the median state. States would be required to pay any excess, thus aligning incentives.

Secondly, it is not clear whether there should be co-payments for use of adoption insurance. Small co-payments may prevent over-use of benefits, but significant co-payments could work against the goal of improving outcomes for children adopted from foster care as it did for vulnerable groups in the Rand Health Insurance Experiment (Joseph Newhouse and the Insurance Experiment Group 1993).

Finally, one could object to adoption insurance on grounds of fairness: Mental and behavioral health problems occur in many families, and some birth families are financially ruined by medical, mental health, and legal expenses. More than 12,000 children in the U.S. were relinquished into foster care in 2001 in order to obtain mental health care. It is not known how many of the children came from adoptive families, as opposed to birth families (US GAO 2003). It is known that access to emotional, mental and behavioral health care for all children is limited (Kaiser Family Foundation 2009). It could be argued that adoption insurance should be available to all parents for purchase, as “child care” insurance. Or it could be argued that the elements of adoption insurance should be incorporated into a comprehensive social security
system. The broader issues, while important, are beyond the scope of the present argument. Since past proposals for expansion of insurance coverage to prevent relinquishment have been unsuccessful, I argue that it will pay for policymakers to bring the problems of parents of high-needs children to the fore by highlighting the problems of parents who adopt children from foster care. It will pay because, by offering to try make the benefits of a permanent family available to a child who has none, adoptive parents create benefits for all and reduce costs to the government.

THE COST OF ADOPTION INSURANCE

To obtain a precise estimate of the cost of adoption insurance, an underwriter would perform a thorough systems audit and risk assessment in each state. An estimate of cost in each state would be made on the basis of state-specific information about the cost of care. In the absence of such detailed information, this section instead provides a back-of-the-envelope calculation of expected payouts of adoption insurance per adoption. This rough calculation is shown in table 1. The expected payout per adoption is calculated as sum of the products of the probability of use of each component of adoption insurance and an estimate of the cost through age 18 if that component is used.

A child adopted from foster care is assumed to use expanded coverage for out-patient care in every year after adoption. The annual cost of additional care is assumed to be double the average expenditure on Medicaid per child enrollee. The average annual expenditures of $1,617 in fiscal year 2005 (The Kaiser Family Foundation 2008) was inflation-adjusted using the CPI data on medical cost inflation from the Bureau of Labor Statistics. The average number of years of care is the difference between the average age at adoption (6.6 years; US DHHS 2008) and age 18.
Residential care may be given in a group home care or in a hospital or campus-like institution. The likelihood of an adopted child requiring residential care is assumed to equal the likelihood that a child in foster care is in residential care. This is almost certainly an overestimate; Mary Eschelbach Hansen (2007a) reviews a large literature and concludes outcomes in adoption are superior to outcomes in foster care. And, again, an insurance-related expansion of adoption-competent out-patient mental health care is expected to reduce the incidence of residential care. Information about the total time spent by children in residential care is not available. Information on the length of spells in care is not indicative of total time in care because children who use residential care often have multiple spells in care. It is assumed that a child who needs residential care spends half of the time from adoption to age 18 in care. Since the average age at adoption is 6.6 years, this implies 5.7 years in residential care. It is further assumed that half of the care is provided in the less restrictive setting of a group home; a child in need of care is sometimes “stepped up” from a group home to an institution; institutionalized children are almost always “stepped down” through a group home before returning to the family home. For the purposes of discounting, group home care is assumed to occur at ages 12-14, and institutional care is assumed to occur at ages 13-15.

Although states are to report expenditures on residential care for foster children to the Department of Health and Human Services, these reports do not appear to be made available to the public. It is possible that, while DHHS requests the information, it is not readily available in the states. Partly this is because overall funding for child welfare comes from a variety of sources (Cynthia Andrews Scarcella, Roseana Bess, Erica H. Zielewski, Rob Geen 2006); partly this is because residential care itself is paid for through contributions from the child welfare system, the juvenile justice system, Medicaid, and school systems. A few states have completed
research reports giving recent expenditures. The average cost of care in a group home cited in table 1 comes from a California state research report ($3,900 per child in 2000; California Department of Social Services 2001), while the cost of residential care comes from a Colorado report ($51,000 in 2004, Colorado Association of Family and Children’s Agencies 2004). These costs are in line with other reports of average cost of residential care (Mark E. Courtney 1999). Again, the dollar amounts reported in table 1 are adjusted using the BLS index of medical costs.

It is not known how many adoptive families must cut back on work to care for their child’s needs, nor is it known how many families incur legal expenses on behalf of a child adopted from foster care. Because these costs to the family are most likely to be experienced when the adopted child’s needs are severe, the probability of losing income or incurring legal expenses is assumed to equal to the probability of residential care. Lost income is assumed equal one year’s income for a female-headed household ($22,600 in 2004; Consumer Action 2008). Legal expenses are assumed to equal criminal justice savings per child enrolled in the Perry Preschool Project ($12,800 in 1992 dollars; Lawrence J. Schweinhart, Helen V. Barnes, and David P Weikart 1993).

The undiscounted expected payout is about $46,000 per adoption finalized. Discounting the stream of payouts reduces the current cost by about $1,000. The current gross cost of an adoption to the child welfare system is about $140,000 (Richard P. Barth, Chung Kwon Lee, Judith Wildfire, and Shenyang Guo 2006, includes adoption subsidies, adjusted to 2008 dollars), so insurance is expected to increase the costs of an adoption to about $200,000. Each adoption from foster care saves an average of $300,000 in child welfare costs (Barth et al 2006, adjusted to 2008 dollars, excludes possible relinquishment of adopted children), so on net, with insurance, an adoption from foster care is expected to save $100,000 in child welfare costs. An adoption
from foster care saves other government agencies (through, for example, reduced welfare usage in adulthood) an additional $53,000. The benefits of adoption to the child from improved health and educational outcomes are valued at about $100,000 (Hansen 2007a, adjusted to 2008 dollars). Adding adoption insurance may therefore reduce the benefit-to-cost ratio of adoption from about 3.2 to about 2.4.

CONCLUSION

As has been argued by Jacob Hacker (2006) and Lael Brainard (2007), society benefits from insuring families against the risks of the modern economy. These scholars argue that insuring families against unlucky economic outcomes increases the incentive to invest in general and firm-specific human capital and increases entrepreneurial spirit. Since investments in people have large positive externalities—greater investment in human capital improves the lives all by increasing productivity and growth—there is an important role for government in providing such insurance.

To guarantee investment in the most vulnerable of the children in the U.S., we should introduce adoption insurance to supplement the currently available adoption subsidies. In countries where the child welfare system is relatively undeveloped, policymakers should take pains to implement insurance programs to protect and encourage surrogate parents in their care work. As they move children from institutions to surrogate families, child welfare policymakers around the world should formally recognize the risks involved. By insuring surrogate families against the worst outcomes, they will encourage more families to step forward as surrogates to help children to find their places in society and in the economy. And, as Nancy Folbre (2001, 87) notes: “Reducing the burden of economic pressure on family relationships can improve the
quality of emotional interactions.” Nowhere is the quality of emotional interaction more critical than in the life of a child like Jenny who has suffered traumatic loss, abuse, or neglect.

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Table 1. Estimated Average Payout of Adoption Insurance

| Prob-ability of Use | Expenditure (2008 dollars) | |
|----------------------|-----------------------------|--|---|
|                      | Un-discounted               | Discounted at 3% |
| Expanded Out-Patient Care | 1 20,100 ^d | 19,672 |
| Residential Care |
| Group Home | 0.07 ^a | 15,590 ^e | 15,241 |
| Institution | 0.1 ^a | 172,300 ^f | 166,912 |
| Legal Expenses | 0.17 ^c | 19,400 ^g | 19,015 |
| Lost Income | 0.17 ^b | 25,490 ^h | 12,010 |
| Expected Expenditure per Adoption | 45,990 | 44,900 |

Notes and Sources:


^b Assumed to equal the percent needing residential care (group home plus institution).

^c Percent of foster children in Cook County who are juvenile delinquents. Joseph J. Doyle (2007b).

e 2.85 years of group home care; costs based on average expenditure per foster child in group home, California in 2000. Adjusted for inflation using CPI for medical costs. California Department of Social Services (2001).


g Lifetime criminal justice system savings from the Perry Preschool project. Adjusted for inflation using CPI-U. Lawrence J. Schweinhart, Helen V. Barnes, and David P Weikart (1993).

Figure 1. Number of Adopted and Waiting Children

Figure 2. Trends in Adoptions by Pre-Adoptive Relationship

Source: Author’s calculation from AFCARS Public Use Adoption Files.

The ABC News story documented the story of an adoption from Russia, but many online comments were from parents of children adopted from U.S. foster care. Representative comments read: “Here in America as well you are given no information and you end up with AMERICAN children with RAD [reactive attachment disorder] and you are then fighting for your life for help when there is none;” and “[h]er "file" was given to us to look over. Unknown to us all information about her extensive sexual abuse was removed before we ever saw it. We met her and had her in our home several times over a 6 month period and she seemed very sweet and fit our family very well. After the adoption the fun began. Three years later after continual counseling, molesting our son, accusing my husband of all of the abuse that had happened to her in the past and social services removing him from our home, and her counselor advising us to return her to social services before she totally ruined our lives she was back in foster care. As badly as we felt about the experience, we were told later that her sisters were put in homes without men or boys and she should have been too.”

Foster care maintenance payments in Jenny’s home state are low; the average maintenance payment in rural areas and the urban Midwest in 2004 was about $800 for a 9-year-old; in the urban West payments averaged $939 (NRC 2006).

This “concurrent planning” emerged later outside the U.S. For the U.K. experience, see Derek Kirton, Jennifer Beecham, and Kate Ogilvie (2006).

Author’s calculation from public use version of the Adoption and Foster Care Administration and Reporting System Adoption Files, which include records on all children adopted with state agency involvement. Also see Rita Laws and Timothy O’Hanlon (1999). There is similar
variation in foster care maintenance payments (NRC 2006). Interstate comparisons are complicated because state systems for payment differ widely (Richard P. Barth, Judith Wildfire, Chung Kwon Lee, and Deborah Gibbs 2003; Hansen 2008).

Prior to October 2008, in order for a state to be able to claim federal reimbursement for adoption expenses, most children must have experienced material deprivation in original, birth family. The law defined material deprivation in terms of eligibility for Aid to Families with Dependent Children [AFDC] even after AFDC was dissolved in 1996. The Fostering Connections to Success and Increasing Adoptions Act of 2008 removed this look-back to AFDC from adoption policy, but not from foster care policy.

Author’s calculation from public use version of the Adoption and Foster Care Administration and Reporting System Adoption Files.

The field of post-adoption services is relatively new, but expanding. For a literature review, see Deborah Gibbs, Richard P. Barth and Renate Houts (2005).

See also the postings by adoptive parents at ABC News (2008). For example: “As an adoptive parent of a US older child (13 when we adopted) we have found out that there were many other mental issues that we were not informed of before the adoption. Being told a child has mild ADHD and later finding out he is Bipolar, ADHD, ADD, RAD, PTSD, and a few other disorders…”

On incentive effects in foster care see Claudia Campbell and Susan Whitelaw Downs (1987); Brian Duncan and Laura Argys (2007); and Julian Simon (1974), among others. That incentives attract foster carers is consistent with the ideas of Nancy Folbre and Julie Nelson (2000), who argue that payment for care can initiate caring relationships. It also appears that economic and
altruistic motivations in surrogate parenting work in tandem as noted by Julie Nelson (1999) for
care work in general.

11 Author’s calculation from the AFCARS Public Use Adoption Files.

12 Author’s calculation from the 2002 Adoption Attitudes Survey.

13 The Keeping Families Together Act was introduced in 2003 and re-introduce in 2005. It
aimed to amend the Public Health Service Act and the Social Security Act to assist states in
prevention of relinquishment. The Act was never voted upon.

14 Some nationally representative information may be available soon: DHHS has sponsored the
National Survey of Adoptive Parents, which is a module of the 2007 National Survey of
Children’s Health. Surveys were completed in 2008, but it is not known when data will be
available. For more information see the National Opinion Research Center
(http://www.norc.org/projects/national+survey+of+adoptive+parents.htm) and National Center
for Health Statistics (http://www.cdc.gov/nchs/about/major/slaits/nsap.htm).