Op-Ed

Will Republicans Abandon Child Health?

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2017 MARKS THE 50TH ANNIVERSARY OF MEDICAID'S SPECIAL early and periodic screening diagnosis and treatment (EPSDT) benefit, which establishes a coverage standard for the nation's poorest children that has no parallel in other forms of health insurance. A core element of Medicaid for 5 decades and reflecting the documented, lifetime health risks associated with childhood poverty, EPSDT entitles children to all medically necessary care covered by Medicaid—without cost sharing—under a medical necessity standard grounded in principles of child health and development. Although EPSDT implementation has been uneven, its legal guarantee is unwavering, and EPSDT remains the bar to which state Medicaid programs aspire.

This year also marks the 20th anniversary of the Children's Health Insurance Program (CHIP). Enacted in 1997 as a companion to Medicaid, CHIP provides affordable insurance to over 8 million near-poor and lower-income children. Many states use CHIP funds to expand Medicaid; others apply their CHIP allotments to high-quality private health insurance plans for children in families with incomes that exceed Medicaid eligibility levels.

Together, Medicaid and CHIP insure 36 million children, 51% of all people enrolled in Medicaid and CHIP.¹ In a nation that considers employer-sponsored coverage the central form of health insurance for working-age Americans and their families, it is striking that 1 in 2 children depends on public health insurance.

Two principal factors help explain the extraordinary role of Medicaid and CHIP in the lives of American children. The first factor is poverty. One-fifth of all children and nearly a quarter of children under age 3 live in poverty; 45% live in families with incomes below 200% of the federal poverty level.² Poverty puts private health insurance out of financial reach.

A second and related factor is the limited access to employer-sponsored health insurance coverage that confronts low-wage workers. Employer

insurance, a key aspect of overall employer compensation, works well for affluent Americans with good-paying jobs, but not for workers with low earnings. Studies document the magnitude of the gap. Ten years ago—even before the largest recession since the Great Depression—90% of higher income workers had workplace coverage, while only about 40% of workers earning below-poverty incomes had workplace coverage, and only about 60% of workers with incomes between 100% and 200% of poverty had employer-sponsored insurance.³

Firms employing a predominantly low-income workforce are significantly less likely to offer health insurance. Even when they do, the cost is unattainable for low-income workers. In 2015 the price of a family plan exceeded \$17,500 and, on average, families faced out-of-pocket premium payments of \$5,000.⁵⁴ For lower-income families, employer benefits for their children are wildly out of reach, and public insurance becomes a basic necessity.

Over the years, Medicaid and CHIP have proven themselves to be among the nation's most effective investments. Compared to children with employer-sponsored coverage, children enrolled in Medicaid or CHIP enjoy virtually equal access to care. They are equally likely to have a usual source of care, to receive preventive care, and to have access to specialty care. Studies have documented the positive impact of both programs on preventable hospitalization, school performance, educational achievement, and premature adult mortality.

One would think that given the evidence of need and impact, Congress's ongoing commitment to Medicaid and CHIP would be unwavering. Think again.

The American Health Care Act (AHCA), passed by the House of Representatives on May 4, 2017, would not simply undermine the Affordable Care Act's adult Medicaid expansion by repealing the enhanced funding that states need to support this expanded coverage. The bill would go exponentially further by fundamentally restructuring the federal financial contribution to state programs. This restructured formula would impose an arbitrary upper limit—divorced from the actual cost of health care—on federal payments. As the years go by, states would lose hundreds of billions of dollars in federal Medicaid funding. A study of the impact of the federal cap on Medicaid funding for children estimates that over 10 years, the cap will eliminate \$43 billion in federal children's health financing.⁵ Reductions of this magnitude will, in turn, create a Hobbesian choice for states: either replace the lost federal funding

with their own state funds in order to maintain their programs or slash benefits below the minimum EPSDT guarantee, along with already low provider payments. Ten-year state reductions would range from \$68 million in Wyoming to \$4.7 billion in California. Because Medicaid already places such enormous demands on state and local budgets, any notion that states will make up the deficit left by the loss of federal funding is essentially wishful thinking.

It gets worse. The House bill also gives states the option to convert coverage for children into a block grant that would grow at the rate of general inflation rather than the medical inflation rate of the general capped payment system, and without adjustment over time for population size. Under the block grant option, electing states would be expected to control costs by completely eliminating not only the EPSDT coverage obligation but also children's basic underlying entitlement to *any* Medicaid coverage. With federal funding cuts of this magnitude—estimated by the same study at \$78 billion over 10 years—disadvantaged families everywhere would face long waiting lists for their children.

To top matters off, federal CHIP funding, separate from the federal Medicaid financing structure, faces an uncertain future. The CHIP legislative authorization does not expire, but the money runs out at the end of September 2017. As of the end of May, with 4 months to go until the first states start to experience a loss of funding, there is zero movement on Capitol Hill to ensure coverage stability for children by extending the life of CHIP.

According to the Medicaid and CHIP Payment and Access Commission (MACPAC), which advises Congress on Medicaid and CHIP, if CHIP funding is not extended, over one million children will lose coverage altogether. This number will be far higher, of course, if the House bill becomes law and triggers major state rollbacks in Medicaid eligibility, thereby affecting children in the Medicaid expansion CHIP states. Some families whose incomes exceed Medicaid eligibility levels might find coverage through the workplace or by buying health insurance policies sold in the individual market. But these families—already pressed economically—would face far steeper costs and their children likely would have significantly poorer coverage.

Today Medicaid and CHIP are foundational to US pediatric health policy—not just for low-income children but for all children. Like their parents, American children may have many separate pathways to health insurance but they all depend on the same health care system. What

Congress does to health programs for low-income children ultimately will affect the overall stability of the health care system for all children. This is a fundamental truth our nation must remember as it wallows in the fog of politics and ideology.

References

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