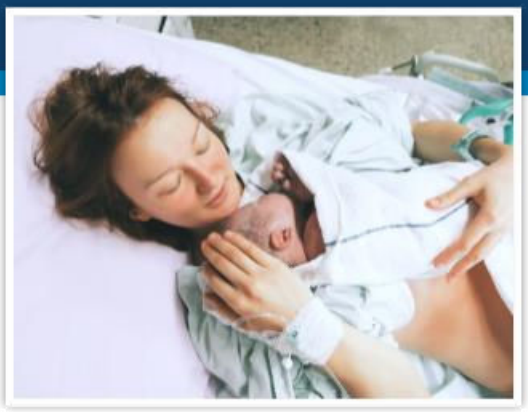
America's Babies Need Affordable Health Care:
The Impact of Medicaid Restructuring on Young Children

ZERO TO THREE
Early connections last a lifetime



For the approximately 4 million babies born each year in the United States, health care can mean the difference between a strong or fragile start. Insured children are much more likely to receive the cost-saving preventive care essential to healthy early childhood development—social and emotional, cognitive, as well as physical. Over the past 50 years, Congress has shaped federal health policy to intentionally focus on opening the door to quality medical care to all children. Consequently, the rate of *uninsured* young children is now at an historic low: 3.2% for children age 5 and under in 2015.[i] These gains are no accident: they are largely due to Medicaid and the Children's Health Insurance Program (CHIP), furthered through the Patient Protection and Affordable Care Act (ACA).

For families, affordable health insurance opens the door to the pediatrician's office for the many routine visits recommended in the early years, as well as inevitable illness care. Medicaid has played that critical role for vulnerable young children, meshing with CHIP to cover 45% of children under age 6 and 74% of young children living in or near poverty. [ii] Children and their families on Medicaid receive coverage comparable to private insurance and far better than the access available to uninsured families.[iii] Medicaid covers almost half the births in the United States, [iv] serving as the key newborn care that gives almost 2 million babies a strong start in life each year.

Medicaid and CHIP cover 45% of children under age 6 and 74% of young children living in or near poverty.

To make America strong and build our future workforce and economy, babies and families must have access to quality and continuous health coverage. Yet, an overall course change for federal health policy in general, and Medicaid in particular, would reverse the historic gains in coverage for children and families and, with it, the federal commitment to healthy children. Proposed changes to Medicaid financing through per capita formulas or block grants would substantially reduce the federal financial contribution over time, shift the cost burden to states, and undermine the assured benefits that place vulnerable young children's coverage on par with their privately covered counterparts. With the loss of an estimated $834 billion in federal funds over 10 years,[v] state budgetary constraints could force difficult choices about where—and on whom—to spend their Medicaid dollars. The resulting changes to an already lean program could reduce eligibility, decrease benefits, or make meeting obligations such as Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) more difficult, and pass more of the cost burden to patients and providers. If young children do not remain insured or receive quality care, ultimately costs to communities could rise with more uninsured children and the increased need for services such as special education down the road.

What Is at Stake: Medicaid's Federal Progress for Healthy Children

More than 37 million children in low-income families are insured by Medicaid, which also covers almost half (45%) of all births in the country.[vi] Through EPSDT *(see "Highlight" below)*, Medicaid requires screening and treatment services attuned to the needs of the very vulnerable children it serves that, when implemented fully, make it superior to what is commonly available through private insurance. Low-income children are more likely to experience adverse circumstances that put them at risk for chronic, unrelenting stress—often called toxic stress—that can undermine their healthy growth and development. These experiences can include unstable housing, poverty and deprivation, maltreatment, and parental stress or mental health issues. Poverty and other stressors literally get under the skin: Early chronic stress becomes embedded, not just in neurological development, but in young children's rapidly developing physical systems as well. More than three out of five children under age 3 have risk factors that could impact their healthy development.[vii]

For babies and toddlers, who are not as likely as older children to be in formal early childhood education settings, a primary care provider is the early childhood professional most likely to see them and catch developmental problems early. Medicaid promotes equity in access to preventive and acute care, particularly for children of color who experience health disparities. It also plays a critical role for especially vulnerable children in the child welfare and early intervention systems, financing the services that can put them on a sound developmental track.

To understand the risks to young children created by proposals to shift the cost burden to states where budgetary constraints may constrict benefits, we need to first look at how Medicaid ensures robust, comprehensive care for them.

Highlight: **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Benefit**

EPSDT is a powerful tool to address the health and developmental needs of low-income children in Medicaid. The emphasis is on early detection through periodic checkups on a range of health areas, followed by further efforts to diagnose and treat any problems identified. EPSDT is a federally required benefit—states must provide this comprehensive approach and all medically necessary services, even if the state Medicaid plan does not include them.[viii] What is involved in EPSDT?

Early: Children's health and development must be assessed to identify problems before they worsen.

Periodic: These assessments, or checkups, must occur at intervals appropriate to the child's age, according to a set schedule.

Screening: Every checkup must include screening for health and development; comprehensive physical examination; immunizations; vision, dental, and hearing services; laboratory tests; and other medically necessary health care services to address illnesses or conditions found.

Diagnostic: If further evaluation is needed when a risk is identified, diagnostic services must be provided.

Treatment: Any physical or mental conditions identified in the screening and diagnostic services must be treated to control, correct, or reduce the problems found, even if the state Medicaid plan does not traditionally cover the services required.[ix]

Medicaid for young children is built on the powerful guarantee of EPSDT and vital preventive care. Medicaid encourages preventive services, as well as early attention to the particular health care needs of low-income children, avoiding more serious and more costly consequences later. Medicaid's constellation of screening and health services puts these very vulnerable children on par with privately insured children in accessing health care services.

EPSDT ensures services attuned to low-income children's health conditions. EPSDT is a robust coverage mechanism that enables children to receive medically necessary services that may not otherwise be covered by Medicaid, especially where low-income children are more prone to particular problems.[x] Examples of how Medicaid can benefit young children include:

- Low-income children are more likely to experience developmental delays than children in the general population. Properly implemented, EPSDT provides a structure for detecting and addressing developmental delays as early as possible through formal screening tools.
- 535,000 of young children between 1 and 5 years old enrolled in Medicaid have lead blood levels high enough to damage their health.[xi] The continued danger of young children's exposure to lead is widely seen as a public health crisis. EPSDT requires screening for lead at 12 and 24 months, increasing the chances that exposure will be flagged early in life and damage prevented.

Medicaid increases use of preventive care. During their first 5 years, children should have 14 well-child visits, half before age 1.[xii] The frequency of visits presents a unique opportunity to deliver preventive services, such as vaccinations, that drastically bend the cost curve.

- **Regular *preventive* care:** Children with Medicaid/CHIP coverage are actually more likely than children with private insurance to have a routine checkup.[xiii] Uninsured young children are much less likely to see a doctor for preventive care (68% compared with 92% of insured children overall).[xiv]
- **Regular *source* of care:** Medicaid/CHIP children are also equally as likely as children with private insurance to have a regular source of care.[xv] Compared to uninsured children, they are significantly more likely to have a regular source of care and to have a physician visit and dental visit in the last 2 years.[xvi]
- **Less "doing without" care:** Children with Medicaid/CHIP coverage, on par with privately insured children, had significantly lower rates than uninsured children of foregoing medical care, prescription drugs, dental care, specialist care, mental health care, and vision care because it was unaffordable.[xvii]

Medicaid provides coverage for particularly vulnerable groups. Some groups of children are more at risk for health and developmental problems and therefore more likely to need assistance with health coverage. Children who live in rural areas or who are racial and ethnic minorities face health disparities, which programs like Medicaid can lessen by creating equity in access to services. Children in the child

welfare system are particularly vulnerable to developmental and social-emotional problems, so access to EPSDT can help their birth, foster, and adoptive families afford the expense of addressing these issues.

- Medicaid/CHIP play a particularly important role for children of color, covering more than half of all Black, Hispanic, and American Indian and Alaska Native children.[xviii] Children of color are more likely to have health conditions such as asthma and obesity, but are less likely to have a usual source of care. [xix]
- Medicaid is a significant source of coverage for children in rural areas. In 2014–2015, 45% of children living in rural areas were covered through Medicaid/CHIP, compared to 38% of urban children.[xx] Coupled with increased coverage of adults in Medicaid expansion states, this public coverage helps support the rural health care infrastructure necessary to give children and families access to care.[xxi,xxii]
    - Rural areas tend to have more uninsured people than urban areas. With lower levels of household income overall,[xxiii] rural residents without insurance are more likely to put off or forego health care because they can't afford it.[xxiv]
    - Increased coverage of children in small towns and rural areas through Medicaid from 2009 to 2015 resulted in a decline in uninsured children from 9% to 6%.[xxv] Residents in rural areas are less likely than those in urban areas to have employer-based health coverage.[xxvi]
- Medicaid funding is also used by states to provide critical Part C Early Intervention services to children birth to 3 years old with developmental delays or disabilities. Federal cuts will require states to reprioritize spending and may result in less access to necessary special education support services that enable babies and young children to arrive at school ready to learn and thrive.
- Under current law, children with special needs who are adopted with federally supported subsidies can receive health coverage through Medicaid, a key element of the nation's success in providing permanent adoptive families for these especially vulnerable children. Federal Medicaid cuts will force states to provide fewer health benefits, lessening the chances that these children have the support they need to thrive. In addition, children in the foster care system also are eligible for Medicaid. Its comprehensive EPSDT benefit can help guard against or provide early detection for the developmental and health problems they are more likely to experience.

Medicaid creates a culture of health in families.

While not part of the core Medicaid program, the ACA's Medicaid expansion has helped make health care more of a family affair, with benefits for both parents and children. When parents are healthy both mentally and physically they are better equipped to be caregivers to their children. Thus, coverage of low-income adults, and parents in particular, should be an important consideration in Medicaid's future course.

- The Medicaid expansion covered 11 million more adults—many of them parents or future parents.[xxvii]
- Parents' access to health insurance helps their children get covered, as they become more familiar with insurance systems and become better advocates for their children.[xxviii, xxix,xxx, xxxi] States that expanded Medicaid for adults saw nearly twice the decline in child uninsured rates as non-expansion states, as parents enrolled more children in Medicaid/CHIP.[xxxii]
- Insured parents have access to much-needed health care, including medical services, substance abuse treatment, and mental health services, that help them provide a safe and nurturing home for their children.[xxxiii] Specifically, mothers covered by Medicaid are more likely than uninsured mothers to have a regular source of care, a doctor visit, and to receive preventative care.[xxxiv]
- Expanded Medicaid coverage for adults has also improved access to behavioral health treatment, including for conditions such as maternal depression.[xxxv] Nearly 30% of adults who receive health insurance coverage through the Medicaid expansion have either a mental disorder or a substance use disorder which, when left untreated, can have a detrimental impact on their young children's social-emotional development.[xxxvi,xxxvii]

Medicaid brings the promise of early and lifelong health. After 50 years, the evidence is clear that receipt of Medicaid prenatally and in childhood yields better health, education, and economic security through adulthood.

- Children's and mothers' access to health insurance during pregnancy and in the first months of life is linked to significant reductions in infant mortality, childhood deaths, and the incidence of low birth weight.[xxxviii] Children whose mothers used Medicaid during pregnancy had fewer hospitalizations for certain health conditions as adults, as well as higher high school graduation rates and less reliance on public assistance, compared with those who were uninsured.[xxxix] Another study found that children whose mothers received Medicaid during pregnancy had greater economic mobility, with a greater likelihood of attending college and higher income levels versus those whose mothers were uninsured.[xl]
- Children enrolled in Medicaid, particularly in early childhood, have been shown to have better health, educational, and employment outcomes into adulthood when compared to those that are uninsured.[xli,xlii,xliii] Research has found that black children particularly benefit from early and extended coverage through Medicaid, with fewer episodes of hospitalization or emergency room visits as adults.[xliv]
- Medicaid receipt during all phases of childhood, including infancy and toddlerhood, contributes to better education outcomes such as high school completion and college attendance and graduation.[xlv]
- Medicaid use leads to economic benefits, as research shows children later pay more taxes, use the Earned Income Tax Credit less, and are more likely to attend college. Women have higher cumulative earnings in their twenties.[xlvi]

The Impact of Medicaid Changes: States Forced to Make Tough Choices That Put Babies and Toddlers at Risk

Proposed structural changes, such as those included in the American Health Care Act, would substantially reduce federal Medicaid funding over time and shift the cost burden for Medicaid to states. As a joint federal-state program, states now receive unlimited federal match for their Medicaid expenditures. Restructuring proposals would limit the federal contribution to a smaller and more predictable amount through either a block grant or per capita funding formula. Both these approaches set limits on federal spending for Medicaid and would leave states to either make up for the lost federal funds or adjust spending. By providing a set amount per enrollee, a per capita cap would account for enrollment increases that a block grant would not, but the cap does not account for the varying needs of beneficiaries, such as healthy children versus chronically ill children. The healthy child and disabled or chronically ill child would have the same amount allotted to them despite the drastic difference in actual cost of coverage.

State health budgets would face additional pressures. Neither restructuring approach—per capita funding or block grants—would account for other reasons health costs increase, such as rises in medical costs, the opioid epidemic, or emergency situations such as that created by Hurricane Katrina or epidemics like the Zika outbreak. If medical advances cause the costs of drugs or devices to rise (such as the EpiPen) or treatment needs to increase, states will not receive additional support from the federal government. Moreover, Medicaid is a counter-cyclical program; when income levels decrease, as in a recession, rates of Medicaid coverage increase. Any of these conditions would add to the shortfall states will already face because of the initial cuts to federal support.

State budgetary constraints could force difficult choices. States, unlike the federal government, must balance their budgets every year. A federal allotment set at a finite amount that grows slowly could result in inadequate funding levels for which no amount of flexibility in program design can compensate. States therefore would face difficult decisions about where—and on whom—to spend their Medicaid dollars and could limit benefits.[xlvii] For example, the Congressional Budget Office estimated that the House American Health Care Act would reduce federal Medicaid funding by $834 billion over 10 years, cutting the federal share by almost a fourth.[xlviii]

Absorbing reduced federal funding could result in constraints on eligibility, benefits, and services, risking harm to children and undermining core protections for all enrollees. If states cannot or will not make up for the federal shortfall in Medicaid spending, savings must come from program changes or the beneficiaries themselves. These choices all carry grave risks that patients, and especially children, will not receive adequate care and many people will be shut off from Medicaid altogether. Potential changes that states could make include:

- restricting criteria for Medicaid eligibility, thereby reducing the number of people covered and their ability to access health care;
- decreasing benefits and access to services, as states may simply refuse to cover certain treatments and leave children and families without services to meet their health needs;
- shifting the cost burden to patients by increasing their share for services or the cost of insurance;
- making enrollment more cumbersome for eligible children;

- cutting already below-market provider payment rates, in turn creating a disincentive for providers to see Medicaid beneficiaries and decreasing access to practitioners for babies and toddlers; and
- denying or constricting historically guaranteed Medicaid benefits, including EPSDT. Funding cuts will undermine states' ability to ensure EPSDT services can be provided and the EPSDT requirement may be eliminated altogether if states have control over program requirements.

A severely constrained Medicaid budget decreases opportunities for innovation, including with young children. States are constantly looking for innovations to make care better while reducing costs. Adequate federal funding allows them to undertake efforts that can change how or to whom care is delivered and reduce the drivers of long-term health costs.

- Significantly reduced federal contributions to Medicaid essentially eliminate states' ability to improve coverage of the low-income population by expanding eligibility, enhancing benefits, and reducing cost sharing. While initially adding to expenditures, these improvements promote usage of health care, thereby improving health and reducing long-term costs.
- With fewer dollars, states will be reluctant to support Medicaid innovation, including initiatives like health homes and pediatric medical homes. Having a medical home reduces health care costs and promotes continuity and access to care that help ensure kids get proper preventive care and reduce sick visits.[xlix]
- Because EPSDT presents a ready-made structure for detecting developmental problems early, states currently build upon this structure and partner with pediatric primary care providers to implement more formal screenings and follow-up.[l] With less federal funding, states may not be able to fund special initiatives to train health providers in using tools or pay other costs associated with referrals and tracking.

Decreased Medicaid coverage means decreased economic security and increased long-term health care costs. Children and pregnant women who qualify for Medicaid have very limited means. The median eligibility limit for infants is 195% of poverty, or $40,023 for a family of three. For toddlers and older children, the median limit is lower, 149% of poverty ($31,038 for a family of three).[li] Costs for shelter, food, energy, clothing, transportation, child care, and other basics of everyday living must come out of these tight family budgets. When no help is available, health care costs are often put off until they reach crisis point, at which points the medical costs become destabilizing.

- Children enrolled in Medicaid protect the whole family from financial hardship by decreasing the probability of debt and bankruptcy for families. In 2010, Medicaid lifted an estimated 2.6 million to 3.4 million individuals out of poverty.[lii] Medicaid effectively shields many children from the effects of poverty, reducing their exposure to adverse childhood experiences that can influence their health in later life.
- Increased understanding of the role that social determinants of health play in health care costs has led some state Medicaid agencies to allow funds to be used to connect families with critical social services to address issues like housing and food insecurity. With mounting fiscal pressure, these important care coordination and case management services may no longer be a priority.

- Increased out-of-pocket cost-sharing, such as co-payments and deductibles, would add financial strain to low-income families, forcing them to go without health care or cut other essentials for meeting basic needs.[liii]
- By cutting Medicaid funding**,** increased pressure will be put on other children's programs in state budgets**.** States will be forced to spend their revenue on health care, and therefore, cut funding for programs such as child care, education, child welfare, family supports, or other services critical to children.
- An uninsured child costs the local community $2,100 more than a child insured by Medicaid.[liv] Unaddressed issues such as developmental delays or disabilities could lead to higher costs in other systems, such as special education.

Conclusion

No federal program is more critical to the healthy development of vulnerable infants and toddlers than Medicaid. Beyond providing critical access to the basic preventive health care in the early years, it provides crucial services to detect and treat developmental problems and other issues that, if not caught early, can undermine success in school. Primary care providers can be sentinels for very young children, identifying and seeking to address the adverse early experiences that drive enormous health costs down the road.

Ending the federal commitment to ensure that all children in low-income families have health coverage so they can access the care necessary to thrive would be a short-sighted, not to mention callous, budget-cutting exercise. A policy choice that looks to improve our future should focus on strengthening health coverage for children and families, in turn reducing family stress and supporting the positive development that lays a foundation for success, for children and our country.

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About Us

ZERO TO THREE works to ensure all babies and toddlers benefit from the family and community connections critical to their well-being and development. Since 1977, the organization has advanced the proven power of nurturing relationships by transforming the science of early childhood into helpful resources, practical tools and responsive policies for millions of parents, professionals and policymakers. For more information, please visit www.zerotothree.org, Facebook.com/ZEROTOTHREE or follow @ZEROTOTHREE on Twitter.

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