

## Health Coverage Matters for Children: The Role of Medicaid in the Healthy Development of America's Children

From well-baby and well-child visits to vaccines, eyeglasses, dental services, and speech and other therapy services, Medicaid plays a significant role in keeping kids healthy, in school, and on track to becoming healthy and productive adults.

The research is clear: After children are enrolled in Medicaid or the Children's Health Insurance Program (CHIP), they are more likely to have a usual source of care, to make regular visits to physicians and dentists, and to use preventive care. Kids covered by Medicaid and CHIP are also less likely to have unmet health care needs. For at-risk children and children with special health care needs, Medicaid covers needed services and support other insurance usually doesn't.

This brief describes the many ways Medicaid provides health coverage uniquely designed for children—coverage that helps them lead healthier lives.

Medicaid is a public insurance program operated as a partnership between the federal government and the states. It provides health insurance coverage for 72 million of our nation's most vulnerable citizens, including very low-income children, people with disabilities, the elderly, and some low-income adults who are uninsured.<sup>1</sup>

Access to health care is crucial to children's health and development. When children have health insurance, they are more likely to get the health care they need.<sup>2</sup>

Access to health care during the earliest years has many benefits—both immediate and long-term—for

children's health and well-being, including lower risk for hospitalization and positive health outcomes well into adulthood.<sup>3</sup>

More than 40 percent of all children in the U.S.—approximately 37 million children—rely on Medicaid for health insurance coverage every year, and an additional 8.9 million children are enrolled in CHIP, a sister program to Medicaid that provides coverage for children just above the Medicaid eligibility threshold.<sup>4</sup>

In 2016, in large part due to the success of Medicaid and CHIP, the coverage rate for children under age 18 soared to 95 percent, with a record number of children having some form of health insurance coverage.<sup>5</sup>

Working together, Medicaid and CHIP are critical sources of coverage for vulnerable children, including many living in or near poverty. These programs cover 69 percent of children with incomes under two times the federal poverty level, or \$41,560 for a family of three in 2018.<sup>6</sup> They have a major role paying for health care for children with special health care needs and children in foster care. Medicaid and CHIP are especially important for young children, who rely on these coverage pathways more than on any other type of insurance coverage.<sup>7</sup>

**For lower-income families, especially those who lack job-based health insurance, Medicaid is often the only affordable health coverage available.**

But it is not only the number of children covered that makes Medicaid so important for children's health and well-being. The types of comprehensive services Medicaid covers, the people it covers, and its low out-of-pocket costs for families all contribute to Medicaid's success in connecting low-income children and children with complex medical needs to cost-effective, high-quality health care that puts them on a healthy trajectory to adulthood.

### **Medicaid Ensures High-Quality, Affordable Coverage for Children in Low-Income Families**

For lower-income families, especially those who lack job-based health insurance, Medicaid is often the only affordable health coverage available. Federal law requires, as a condition for receiving Medicaid funding, that all states offer Medicaid coverage to children in families with incomes below 138 percent of the federal poverty line, or about \$28,680 for a family of three in 2018. Recognizing the importance of Medicaid coverage for children, most states extend income eligibility for children even higher.<sup>8</sup>

Federal law also requires that Medicaid be provided with low out-of-pocket costs. Cost-sharing, premiums and other out-of-pocket costs cannot be more than 5 percent of family income, and copayments are limited

or disallowed for most Medicaid-covered children. As a result, most states do not charge premiums or cost-sharing of any kind for children.<sup>9</sup> Low out-of-pocket cost is one of the most important ways Medicaid differs from other health insurance to serve the interests of children. Out-of-pocket costs are a barrier to children getting the health care they need, particularly for lower-income families.<sup>10</sup> The financial protections built into the Medicaid program make it possible for low-income families to take their children to a doctor when they are sick, to get them vaccinated on schedule, and to make sure they get routine health care and checkups.

### **The Medicaid Children's Health Benefit Guarantees Comprehensive Coverage for the Unique Health and Developmental Needs of Children**

Considered the gold standard for children's care, Medicaid's benefits for children—legally designated the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit—cover a full range of benefits for infants, children, and adolescents. EPSDT is required for all children under age 21 who are enrolled in Medicaid.

This unique benefit covers prevention and screening as well as comprehensive treatment for illnesses and disabilities. Screenings and preventive services must

be provided at regular intervals that meet “reasonable” medical or dental practice standards. When children need treatment, states are required to furnish all “Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions,” including physical, mental, vision, hearing, and dental services.”<sup>11</sup> Because of the EPSDT requirement, Medicaid ensures children receive any and all pediatrician-recommended health care services they need, so that health concerns are averted, or diagnosed and treated as early as possible.

EPSDT is a critical and legally enforceable benefit for millions of children, and its impact is felt in lives saved and medical crises prevented every day. In a broader sense, EPSDT’s commitment to whatever is medically necessary for kids is also an important statement regarding the value that we as a society place on the health of our children.

Although implementation varies across states, EPSDT is, simply put, the definitive standard for children’s health coverage, and it is more comprehensive when compared with other forms of health insurance.

## Medicaid Is a Critical Lifeline for Children with Special Health Care Needs

Over 14 million children in the U.S. have special health care needs—about one in five children under 18 years of age.<sup>12,13</sup> These are children who have one or more ongoing health conditions, including autism spectrum disorders, vision or hearing loss, diabetes, attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD), cancer, or cerebral palsy. Half of these children—nearly 7 million—rely on Medicaid or CHIP for health insurance to cover some or all of their medical care.

Because of the extraordinary potential expense and complexity of childhood illness and disability, there are programs that extend Medicaid coverage to children with disabilities for families with incomes above the broader Medicaid cutoff for child eligibility. Depending on the state, these can include Katie Beckett programs, which were started during the Reagan administration to enable severely disabled children to receive care at home; broader Home- and Community-Based Services waiver programs; or programs that allow higher-income families with children with disabilities to buy in to Medicaid coverage. (For more information on these programs, see the Families USA publication *How Medicaid Protects Children with Special Health Care Needs*.<sup>14</sup>)

Compared to private insurance, Medicaid offers significantly more comprehensive coverage for services and supplies for families with children who have ongoing or lifelong medical needs. Medicaid also offers special flexibilities in income eligibility for children with disabilities or serious illnesses described above. For millions of families, Medicaid can be used to wrap around employer-sponsored insurance. Medicaid ensures that families can care for their children with complex medical needs without facing medical bankruptcy and without quitting their jobs to provide around-the-clock care—risks that families might otherwise face as they care for a sick or disabled child. Medicaid also provides key nursing and home health care services to ensure that children with special health care needs can be cared for at home, preventing seriously ill children from spending their childhood in a medical institution.

## Medicaid Is a Driver of Health Equity

Access to coverage is an important step toward keeping kids healthy and reducing racial and ethnic health disparities. Medicaid and CHIP are essential sources of coverage for children of color and have helped to decrease disparities in health care coverage. Together these programs have cut the number of uninsured children in half, with the greatest improvement in coverage rates for children of color. In 2008, 7 percent of non-Hispanic white children, 10 percent of black children, and 19 percent of Hispanic children lacked health insurance coverage. By 2015, only 4 percent of both non-Hispanic white and black children lacked coverage, and 8 percent of Hispanic children lacked coverage.<sup>i</sup> Currently, children of color are enrolled in Medicaid and CHIP at higher rates than white children, with roughly one in four white and Asian children covered by one of the two programs compared to over half of Hispanic and black children.<sup>ii</sup>

These gains are particularly important because research has shown that due to compounding effects of disadvantage—including implicit bias<sup>iii</sup>—children

of color face greater threats to their health than white children and suffer disproportionately from a number of health conditions, including elevated blood lead concentrations, asthma, and obesity. The most recent data on health disparities show that more work must be done to address health disparities and improve health outcomes, especially for children of color. These disparities are applicable not only to medical conditions but also to dental health. Children of color are more likely to experience dental diseases. Untreated tooth decay is twice as high for Hispanic and black children ages 2 to 8 as it is white children.<sup>iv</sup>

The persistent barriers to quality care for children of color indicate a need for maintaining strong health coverage programs. While continued efforts to improve access to quality services for all children, including children of color, are needed, Medicaid and CHIP have improved access to primary and preventive care, reduced racial and ethnic disparities in children's coverage, and provided a critical safety net for children and families.

<sup>i</sup> Annie E. Casey Foundation, KIDS COUNT data center, “Children Without Health Insurance by Race and Ethnicity,” retrieved from <https://datacenter.kidscount.org/data/tables/7757-children-without-health-insurance-by-race-and-ethnicity#detailed/1/any/false/870,573,869,36,868,867,133,38,35/10,11,9,12,1,185,13/14951,14952>.

<sup>ii</sup> Robin Rudowitz, Samantha Artiga, and Rachel Arguello, *Children's Health Coverage: Medicaid, CHIP and the ACA* (The Kaiser Commission on Medicaid and the Uninsured, March 2014), available online at <https://kaiserfamilyfoundation.files.wordpress.com/2014/03/8570-children-s-health-coverage-medicaid-chip-and-the-aca1.pdf>.

<sup>iii</sup> U.S. Department of Health and Human Services, *2015 National Healthcare Quality and Disparities Report and 5th Anniversary Update on the National Quality Strategy*. (Rockville, MD: Department of Health and Human Services, April 2016), available online at <https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqdr/nhqdr15/2015nhqdr.pdf>.

<sup>iv</sup> Bruce A. Dye, Gina Thornton-Evans, Xianfen Li, and Timothy J. Iafolla, “Dental Caries and Sealant Prevalence in Children and Adolescents in the United States, 2011–2012,” *NCHS Data Brief*, no. 191 (March 2015), available online at <https://www.cdc.gov/nchs/data/databriefs/db191.pdf>.

## Medicaid Covers Pregnant Women and Supports Healthy Births and Healthy Babies

Medicaid and CHIP are important sources of coverage for pregnant women. In 2010, Medicaid covered almost half of the nearly 4 million births in the U.S.<sup>15</sup> Maternity-related services covered by Medicaid include prenatal care, labor and delivery, and 60 days of postpartum care.

All states are required to provide Medicaid coverage for pregnancy-related services to pregnant women with incomes up to 138 percent of the federal poverty level and to cover them up to 60 days postpartum. In addition, many states extend eligibility to pregnant women with incomes considerably higher than this threshold.<sup>16</sup> States must provide basic maternity care free of cost-sharing to eligible pregnant women.

The benefits of Medicaid's prenatal coverage are clear. Prenatal services are shown to improve health outcomes for mothers and children. Several researchers have found significant declines in infant and child mortality associated with expanded prenatal Medicaid eligibility.<sup>17, 18, 19</sup> More recently, a study found strong evidence for higher average birth weight and decreased incidence of very low birth weight in babies born to mothers with prenatal access to Medicaid.<sup>20</sup> Data also suggest that children of mothers who received both Medicaid prenatal and Medicaid post-birth infant care were found to have lower body mass index and lower rates of obesity in adulthood, fewer preventable hospitalizations, and fewer hospitalizations for a range of diseases and immune system disorders than children of mothers who did not have Medicaid for both prenatal and post-birth care.<sup>21</sup> The positive health effects of a mother's

access to prenatal care last throughout a child's life, from infancy to adulthood. And these health benefits have an extraordinarily broad impact on life outcomes. Research has shown that children born to low-income parents covered by Medicaid in the 1980s and 1990s experienced dramatically improved economic outcomes in adulthood relative to children whose parents were uninsured.<sup>22</sup>

## Medicaid Protects the Health of Children in the Child Welfare System

In fiscal year 2011, roughly 1 million children were eligible for Medicaid based on their receipt of child welfare assistance.<sup>23</sup>

As the dominant health insurer for children in foster care, Medicaid provides a range of health care services critical for these children.

Medicaid's comprehensive medical benefit is a pillar of our state child welfare systems. Children in foster care often have significant health care needs, including well-documented high levels of physical, dental and behavioral health issues.<sup>24, 25, 26</sup> Nearly 60 percent of children in the child welfare system experience a chronic medical condition, and nearly 80 percent have a significant mental health need.<sup>27, 28, 29</sup> Many younger children in foster care have developmental problems, with 60 percent of children under 5 exhibiting developmental health issues.<sup>30</sup>

Whether health services for foster care children are delivered by the broader medical system or through a child welfare agency, the predominant source of financing is Medicaid. Medicaid is one of the foundational federal pillars supporting our child welfare system.

## Medicaid Eligibility for Children Involved in Child Welfare Systems

Children involved in child welfare systems are eligible for Medicaid through several potential pathways:

- » All children in foster care receiving Title IV-E are categorically eligible for Medicaid.
- » States may use the so-called Ribicoff option to cover those in foster care but not eligible for IV-E funding if—as is typical—they meet income limits in place as of 1996 for the Aid to Families with Dependent Children (AFDC) program.
- » Other child welfare-involved children and youth are eligible based on family income rather than receipt of child welfare assistance (including those who stay in their homes), using the general income eligibility for children in that state.
- » The optional adoption assistance pathway allows states to provide Medicaid coverage to children who are receiving state-funded adoption assistance if they have significant health needs that could prevent adoption placement if they go untreated. All but one state (New Mexico) has adopted this optional Medicaid pathway.
- » The Patient Protection and Affordable Care Act created a new Medicaid mandatory coverage eligibility category for former foster youth from ages 19 to 26, available for young adults residing in the state in which they aged out.
- » States have the option to cover former foster youth who aged out of foster care in other states. As of now, this option is only available under a Medicaid waiver, although the Centers for Medicare and Medicaid Services has indicated in formal guidance that it supports such waivers and will approve them.

*The Ribicoff option allows states to cover what is called a “reasonable category” of children, such as those who are in foster care but are not eligible for Title IV-E funding, if they meet the income limits established under AFDC (§1902(a)(10)(A)(ii)(I) of the Act and 42 CFR 435.222).*

*The Chafee option refers to a federal option through the Chafee Foster Care Independence Act of 1999 to expand Medicaid coverage to youth formerly in foster care until their 21st birthday.*

November 2016 final rule: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib112116.pdf>.

## Medicaid Helps Children Get Needed Screenings and Health Services in School

Medicaid is also a key source of financing for school-based health services. Medicaid pays for health services in schools when services are provided to Medicaid-enrolled children and adolescents, including through school-based health centers. Medicaid also pays for medical expenses that schools and districts incur for providing services, such as speech or occupational therapy, to students with disabilities included in students' Individualized Education Programs (IEPs) under the **Individuals with Disabilities Education Act** (IDEA). Most of the services provided to children in schools are covered by Medicaid, either under state plan authority or under the Medicaid EPSDT benefit. States may also provide Medicaid payments to schools for Medicaid outreach and enrollment activities.<sup>31</sup>

Given the well-established link between health and learning, providing health and health-related services and supports to children in schools helps ensure that children get connected with health screenings and interventions, and makes it more likely that children will receive the essential services they need.<sup>32</sup>

In recent years, both Congress and the Centers for Medicare and Medicaid Services (CMS) have sought to ensure that schools can leverage Medicaid funding to provide medical services as needed for Medicaid-eligible students. Under a congressional directive by CMS in 2014, availability of Medicaid reimbursement for health services provided in the school setting was clarified.<sup>33</sup> States can obtain federal Medicaid reimbursement for providing any Medicaid-

eligible student with physical and behavioral health care services, including health, vision, and dental screenings; vaccinations; and behavioral health services through EPSDT. Medicaid funding for services in schools is over \$3 billion per year.<sup>34</sup>

Allowing children to access Medicaid-reimbursable health care services in schools—places where children spend a considerable amount of time—can have a meaningful impact on not only on children's healthy development but also on their learning readiness and school performance.

## Medicaid Provides Critical Health Care Access That Families Otherwise Could Not Afford

Because Medicaid offers low-income families coverage with very low premiums and cost-sharing, it allows children to get the medical care they need when they need it and protects families from medical debt. In addition to improving access to health services, Medicaid's role in reducing family medical debt contributes to better long-term health outcomes for children covered through the program.<sup>35</sup>

As noted above, most states offer pathways to qualify for Medicaid coverage for families who have children with complex medical needs, even if family income is above the state's broader Medicaid cutoff for children. States recognize that private health insurance often does not provide comprehensive coverage for the services that special needs children require, and they understand that the expense of chronic and acute care for a child with special needs is often beyond the financial capacity of even middle- to higher-income families.<sup>36</sup>

## Health Coverage for Parents Is Good for Children's Health

When parents have health coverage, their children are more likely to have health coverage, a finding that researchers have known for some time and one that has again been supported through the ACA's Medicaid expansion.<sup>v</sup>

Many of the adults who gained coverage through the ACA's Medicaid expansion are parents.<sup>vi</sup> With that increase in parents' coverage, over 700,000 children also gained health coverage.<sup>vii</sup> If all states expanded Medicaid, it's estimated that an additional 200,000 uninsured children would gain coverage.<sup>viii</sup>

When parents and children have coverage, not only does health coverage improve but children's access to care improves too. In addition, when parents have insurance, children are more likely to see a doctor and have routine well-child visits.<sup>ix</sup> Parents' access to health care can improve their health as well, and that is good for their children. Poor parental health creates a stressful family environment that can negatively impact children's health and performance in school.<sup>x</sup> Finally, health coverage for adults is associated with improved family finances and earnings.<sup>xi</sup> That's good for everyone in a family, including the children.

<sup>v</sup> Leighton Ku and Matt Broaddus, *Coverage of Parents Helps Children, Too* (Washington, DC: Center on Budget and Policy Priorities, October 20, 2006), available online at <https://www.cbpp.org/research/coverage-of-parents-helps-children-too>.

<sup>vi</sup> Prior to the Medicaid expansion, coverage for parents varied greatly by state. For all states that have expanded Medicaid coverage, eligibility is 138 percent of the poverty level. Kaiser Family Foundation, State Health Facts, "Medicaid Income Eligibility Limits for Parents, 2000-2018," accessed June 25, 2018, available online at <https://www.kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-parents/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>.

<sup>vii</sup> Julie Hudson and Asako S. Moriya, "Medicaid Expansion For Adults Had Measurable 'Welcome Mat' Effect on Their Children," *Health Affairs*, vol. 36, no. 9 (September 2017), available online at <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0347>.

<sup>viii</sup> Ibid.

<sup>ix</sup> Maya Venkataramani, Craig Evan Pollack, and Eric T. Roberts, "Spillover Effects of Adult Medicaid Expansions on Children's Use of Preventive Services," *Pediatrics*, vol. 140, no. 6 (December 2017), available online at <http://pediatrics.aappublications.org/content/pediatrics/early/2017/11/09/peds.2017-0953.full.pdf>.

<sup>x</sup> Institute of Medicine Committee on the Consequences of Uninsurance, "Family Well-Being and Health Insurance Coverage," *Health Insurance Is a Family Matter*, (Washington, DC: National Academics Press, 2002), available online at <https://www.ncbi.nlm.nih.gov/books/NBK221008/>.

<sup>xi</sup> Luojia Hu, Robert Kaestner, Bhashkar Mazumder, Sarah Miller, and Ashley Wong, *The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Wellbeing* (National Bureau of Economic Research working paper no. 22170, issued April 2016, revised February 2018), available online at <http://nber.org/papers/w22170>; Nicole Dussault, Maxim Pinkovskiy, and Basit Zafar, "Is Health Insurance Good for Your Financial Health?" Federal Reserve Bank of New York Liberty Street Economics (blog) (June 6, 2016), available online at [http://libertystreeteconomics.newyorkfed.org/2016/06/is-health-insurance-good-for-your-financial-health.html#.V2fhz\\_krLct](http://libertystreeteconomics.newyorkfed.org/2016/06/is-health-insurance-good-for-your-financial-health.html#.V2fhz_krLct).

**The benefits of Medicaid are wide-ranging, long-lasting, and extend beyond childhood. There is a significant body of research that shows these long-term impacts.**

In these cases, Medicaid supplements families' private insurance, covering services private insurance often does not cover at all or covers only on a limited basis, such as home health care; physical, occupational, and speech therapy; and medical equipment and supplies.<sup>37</sup> This supplemental Medicaid coverage provides critical support that ensures a child's medical diagnosis will not lead to financial ruin for the entire family.

When families lose health insurance, as with a job loss, Medicaid can step in to fill the gap and provide critical health coverage. Medicaid is always available for children when family incomes fall below 138 percent of the federal poverty level. This can be particularly important during economic downturns when available jobs are scarce. For example, during the Great Recession, because of Medicaid and CHIP, health care coverage was one area where children didn't suffer. During the high point of the recession, 2007 to 2009, the number of uninsured children actually *fell* by 600,000.<sup>38</sup> In contrast, the number of uninsured adults increased by 6.3 million.<sup>39</sup> (Since 2014, due to the Patient Protection and Affordable Care Act (ACA) Medicaid expansion, Medicaid is also available for poor adults in most states in the event of recession.)

### **Medicaid Coverage Results in Better Lifetime Health and Development**

The benefits of Medicaid are wide-ranging, long-lasting, and extend beyond childhood. There is a significant body of research that shows these long-term impacts. Medicaid coverage in early childhood has been shown to contribute to improved health in later childhood;<sup>40</sup> better overall health in adulthood;<sup>41</sup> improved academic performance;<sup>42</sup> fewer mental health problems; reduced likelihood of eating disorders; reduced likelihood of risky sexual activity; less smoking, marijuana, and alcohol use;<sup>43</sup> reduced likelihood of teen pregnancy;<sup>44</sup> and higher rates of high school and college completion than children's uninsured counterparts.<sup>45</sup> More years of Medicaid eligibility during childhood are also associated with reduced adult mortality rates.<sup>46</sup>

Not surprisingly, given the relationship among educational attainment, health, and earnings, Medicaid coverage in childhood is also linked to higher adult earnings, including higher wages for women.<sup>47,48</sup> Those higher-earning adults also pay more taxes — meaning Medicaid's coverage for children is an investment that partly pays for itself.

Better health, greater educational attainment, and higher earnings—these are all ways Medicaid's investment in children's health care is an investment in our country's future.

## Medicaid Cuts or Restructuring Would Be Harmful for Children

Cuts to Medicaid would have a devastating impact on children. Since children are the largest population of Medicaid enrollees, congressional proposals that would impose arbitrary cuts to Medicaid, including caps on Medicaid spending or restructuring the program as either a block grant or a per-capita cap, would have a severe and devastating impact on their coverage. As described above, children with special needs and pregnant women are highly dependent on Medicaid coverage. Cuts to the program would also be detrimental to child welfare agencies and schools.

### » **Federal funding cuts or changes to Medicaid's structure put states, and children, at risk.**

Medicaid is a state and federal partnership, with the federal government matching state costs at least dollar for dollar, and usually more.<sup>49</sup> Cutting federal funding or changing Medicaid's structure ends that partnership and would pass more costs and fiscal risk to states—costs states would not be able to make up. For nearly all states, reduced federal funding would require program cuts. Children are, by far, the largest enrollment group in Medicaid; it would be impossible for states to make up federal funding cuts without cutting children's health care.

### » **Turning Medicaid into a block grant or capped program would put states in a fiscal bind.** Under a block grant or capped funding program, states would receive no more than a fixed federal allotment, either based on total program or per enrollee costs. States would be responsible for 100 percent of program costs above the predetermined federal cap. Under every block grant and Medicaid capping proposal put forward in 2017 and 2018, states would be severely underfunded.

### » **Capping federal funding would make it harder for states to meet the needs of children.**

Proposals to make Medicaid a block grant would make states responsible for all costs associated with any changes that increase Medicaid costs, from technology advances that increase overall health care costs to increased Medicaid enrollment due to an economic downturn.<sup>50</sup> Caps on federal funding would make it harder for states to respond to unforeseen events that increase health care costs, like a natural disaster or the current opioid epidemic. States would be faced with filling a funding gap with state funds, or they would be forced to cut Medicaid by restricting eligibility, scaling back benefits, or capping enrollment.

The eventual fiscal pressures that would result from capped funding, just like funding cuts or a block grant, would make it harder for states to continue to meet the needs of children who depend on Medicaid. Per-capita caps are particularly troublesome for Medicaid's child population because the cap for children would likely be far lower than for other Medicaid populations. With a low cap for children, states would be less likely to adopt new initiatives to improve access to care or delivery of services for kids. For example, increasing payment rates for pediatric providers or covering scientific breakthroughs for kids via new medical procedures, devices, or drugs would be cost-prohibitive, if such initiatives had to be paid using state funds.

## BLAKE, 8 YEARS OLD

### Michigan



When my son was five years old, I was working as a waitress and my son and I were eligible for Medicaid. My son was experiencing problems that made me worry that he would face severe consequences if I didn't seek help, and so I brought him to the emergency room. The doctor discovered that he had a problem that required a referral to a pediatric urologist. They performed tests to find out that he had a congenital obstruction of his left kidney. As a result of the obstruction, his kidney was retaining fluid and had already lost a third of its function. He needed the surgery to correct it before his kidney would lose all of its function. The surgery was successful! Without Medicaid, we would not have had coverage. We would not have been able to afford the surgery, and it is quite possible that the condition wouldn't have been detected at all. I am thankful for Medicaid and my son will be able to lead a happy, healthy life.

—Chelsey

Blake is a healthy eight year old child who gets his insurance through Medicaid. Thanks to Medicaid:

- » Blake was able to get high-quality health insurance because his family's income qualified him for Medicaid.
- » When Blake was diagnosed with a serious, potentially life-threatening, congenital condition that required surgery he was able to get the care he needed.
- » The insurance was comprehensive—so trips to the hospital, testing and diagnosis, referrals to specialists, and surgery were all covered.
- » Blake's mom did not have to make the heartbreaking choice between seeking care for her son and basic necessities such as food, rent, or paying bills.
- » Blake was able to be treated before his condition caused permanent, irreversible kidney damage.

Medicaid made sure that Blake had the health care he needed to be a healthy, thriving little boy!

» **Federal funding cuts jeopardize coverage and services for the most vulnerable children.**

Children with special health care needs require more medical services—and more costly medical services—than other children.<sup>51</sup> Federal funding cuts to Medicaid would put care for those children at risk. States, faced with less federal support, would likely scale back the costliest care and programs first to save money.

Regardless of the rhetoric from policymakers who want to remake Medicaid, there are no proposals to reduce Medicaid funding or restructure the program that do not put children's health coverage at risk.

## Conclusion

Over 50 years ago, our nation's leaders made a commitment to care for those living in poverty by establishing the Medicaid program. Soon after, they created a unique children's Medicaid benefit to protect the health and well-being of our most vulnerable children. Today, the Medicaid program continues to provide low-cost, high-quality, and comprehensive benefits to ensure that all of our nation's children are able to receive the essential services and supports necessary for a child's healthy development. Medicaid's focus on early childhood interventions and preventive care make it a cost-effective investment that gives all children the chance to maximize their health and potential.

**Instead of reversing our historic progress in improving coverage for children, policymakers should renew their commitment to Medicaid. Policymakers at the state and federal levels must continue to protect Medicaid and proceed with extreme caution if they face new efforts to reform or restructure the program. We owe it to our children and to our nation's future success to keep Medicaid strong.**

## Endnotes

- <sup>1</sup> Kaiser Family Foundation, State Health Facts, “Medicaid Enrollment by Age (Timeframe: FY2013),” available online at <https://www.kff.org/medicaid/state-indicator/medicaid-enrollment-by-age/?dataView=1&currentTimeframe=0&sortModel=%7B%22collid%22:%22Location%22,%22sort%22:%22asc%22%7D>.
- <sup>2</sup> Karina Wagnerman, *Medicaid Provides Needed Access to Care for Children and Families* (Washington, DC: Georgetown University Health Policy Institute Center for Children and Families, March 2017), available online at <https://ccf.georgetown.edu/wp-content/uploads/2017/03/Medicaid-provides-needed-access-to-care.pdf>.
- <sup>3</sup> Rachel Garfield, Melissa Majerol, Anthony Damico, and Julia Foutz, *The Uninsured: A Primer: Key Facts About Health Insurance and the Uninsured in the Era of Health Reform* (Kaiser Family Foundation, November 2016), available online at <http://files.kff.org/attachment/Report-The-Uninsured-A%20Primer-Key-Facts-about-Health-Insurance-and-the-Uninsured-in-America-in-the-Era-of-Health-Reform>.
- <sup>4</sup> Medicaid and CHIP Payment and Access Commission, *MACStats: Medicaid and CHIP Data Book* (December 2017), available online at <https://www.macpac.gov/wp-content/uploads/2015/12/MACStats-Medicaid-CHIP-Data-Book-December-2017.pdf>.
- <sup>5</sup> Kaiser Family Foundation, State Health Facts, “Health Insurance Coverage of Children 0-18 (Timeframe: 2016),” available online at <https://www.kff.org/other/state-indicator/children-0-18/?currentTimeframe=0&sortModel=%7B%22collid%22:%22Location%22,%22sort%22:%22asc%22%7D>.
- <sup>6</sup> Georgetown University Health Policy Institute Center for Children and Families, *Medicaid’s Role for Children* (January 2017), available online at <https://ccf.georgetown.edu/wp-content/uploads/2016/06/Medicaid-and-Children-update-Jan-2017-rev.pdf>.
- <sup>7</sup> Jennifer Haley, Robin Wang, Matthew Buettgens, and Genevieve M. Kenney, *Health Insurance Coverage among Children Ages 3 and Younger and Their Parents* (Urban Institute, December 2017), available online at [https://www.urban.org/sites/default/files/publication/95421/pci\\_report\\_2.pdf](https://www.urban.org/sites/default/files/publication/95421/pci_report_2.pdf).
- <sup>8</sup> Kaiser Family Foundation, State Health Facts, “Medicaid and CHIP Income Eligibility Limits for Children as a Percent of the Federal Poverty Level (Timeframe: as of January 1, 2018),” available online at <https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-children-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22collid%22:%22Location%22,%22sort%22:%22asc%22%7D>.
- <sup>9</sup> Tricia Brooks, Karina Wagnerman, Samantha Artiga and Elizabeth Cornachione, *Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2018: Findings from a 50-State Survey* (Washington, DC: Kaiser Family Foundation, March 2018), available online at <http://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility-Enrollment-Renewal-and-Cost-Sharing-Policies-as-of-January-2018>.
- <sup>10</sup> Anton Nilsson and Alexander Paul, “Patient Cost-Sharing, Socioeconomic Status, and Children’s Health Care Utilization,” *Journal of Health Economics* vol. 59 (May 2018): 109-124, available online at <https://www.sciencedirect.com/science/article/abs/pii/S0167629617306185>.
- <sup>11</sup> Centers for Medicare and Medicaid Services, “Early and Periodic Screening, Diagnostic, and Treatment,” available online at <https://www.medicaid.gov/medicaid/benefits/epsdt/index.html>.
- <sup>12</sup> Health Resources and Services Administration (HRSA) Maternal and Child Health, “Children with Special Health Care Needs,” (February 2018), [available online at https://mchb.hrsa.gov/maternal-child-healthtopics/children-and-youth-special-healthneeds](https://mchb.hrsa.gov/maternal-child-healthtopics/children-and-youth-special-healthneeds).
- <sup>13</sup> MaryBeth Musumeci and Julia Foutz, *Medicaid’s Role for Children with Special Health Care Needs: A Look at Eligibility, Services, and Spending* (San Francisco, CA: Kaiser Family Foundation, February 22, 2018), available online at <https://www.kff.org/medicaid/issue-brief/medicaids-role-forchildren-with-special-health-care-needs-a-look-at-eligibility-services-and-spending/>.
- <sup>14</sup> Cate Bonacini and Dee Mahan, *How Medicaid Protects Children with Special Health Care Needs* (June 2018), available online at [http://familiesusa.org/sites/default/files/product\\_documents/MCD\\_CSHCN\\_issue-brief\\_final.pdf](http://familiesusa.org/sites/default/files/product_documents/MCD_CSHCN_issue-brief_final.pdf).
- <sup>15</sup> Anne Rossier Markus, Ellie Andres, Kristina D. West, Nicole Garro, and Cynthia Pellegrini, “Medicaid Covered Births, 2008 Through 2010, in the Context of the Implementation of Health Reform,” *Women’s Health Issues* vol. 23, no. 5 (September-October, 2013): e273-e280, available online at [https://www.whijournal.com/article/S1049-3867\(13\)00055-8/fulltext?code=whi-site](https://www.whijournal.com/article/S1049-3867(13)00055-8/fulltext?code=whi-site).
- <sup>16</sup> Kathy Gifford, Jenna Walls, Usha Ranji, Alina Salganicoff, and Ivette Gomez, *Medicaid Coverage of Pregnancy and Perinatal Benefits: Results from a State Survey* (Kaiser Family Foundation, April 27, 2017), available online at <https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-pregnancy-and-perinatal-benefits-results-from-a-state-survey/>.
- <sup>17</sup> Janet Currie and Jonathan Gruber, “Saving Babies: The Efficacy and Cost of Recent Changes in the Medicaid Eligibility of Pregnant Women,” *Journal of Political Economy*, vol. 104, no. 6 (December 1996): 1263-1296.

- <sup>18</sup> Janet Currie and Jonathan Gruber, *The Technology of Birth: Health Insurance, Medical Interventions, and Infant Health* (National Bureau of Economic Research working paper no. 5985, issued April 1997), available online at <http://www.nber.org/papers/w5985>.
- <sup>19</sup> Jonathan Gruber, "Health Insurance for Poor Women and Children in the U.S.: Lessons from the Past Decade," *Tax Policy and the Economy* vol. 11 (1997): 169-211, available online at <https://www.journals.uchicago.edu/doi/pdfplus/10.1086/tpe.11.20061848>.
- <sup>20</sup> Chloe N. East, Sarah Miller, Marianne Page, and Laura R. Wherry, *Multi-generational Impacts of Childhood Access to the Safety Net: Early Life Exposure to Medicaid and the Next Generation's Health* (National Bureau of Economic Research working papers no. 23810, issued September 2017), available online at <http://www.nber.org/papers/w23810>.
- <sup>21</sup> Sarah Miller and Laura R. Wherry, "The Long-Term Effects of Early Life Medicaid Coverage," *Journal of Human Resources* (January 2018).
- <sup>22</sup> Rourke L. O'Brien and Cassandra L. Robertson, "Medicaid and Intergenerational Economic Mobility," working paper Harvard School of Public Health, Harvard University, 2017
- <sup>23</sup> Medicaid and CHIP Payment and Access Commission. "The Intersection of Medicaid and Child Welfare," *Report to Congress on Medicaid and CHIP* (June 2015), available online at <https://www.macpac.gov/wp-content/uploads/2015/06/Intersection-of-Medicaid-and-Child-Welfare.pdf>.
- <sup>24</sup> Mark D. Simms and Neal Halfon, "The Health Care Needs of Children in Foster Care: A Research Agenda," *Child Welfare* vol. 73, no. 5 (September-October 1994): 505-524.
- <sup>25</sup> Timothy D. Nelson, Tori R. Smith, R.W. Thompson, M.H. Epstein, A.K. Griffith, K.D. Hurley, T.F. Tonniges, "Prevalence of Physical Health Problems Among Youth Entering Residential Treatment," *Pediatrics* vol. 128, no. 5 (November 2011): e1226-32.
- <sup>26</sup> Council on Foster Care, Adoption, and Kinship Care, Committee on Adolescence, and Council on Early Childhood, "Health Care Issues for Children and Adolescents in Foster Care and Kinship Care," *Pediatrics*, vol. 136, no. 4 (October 2015): e1142-e1166.
- <sup>27</sup> Mark D. Simms, Howard Dubowitz, and Moira A. Szilagy, "Health Care Needs of Children in the Foster Care System," *Pediatrics* vol. 106, supplement 3 (October 2000): 909-918.
- <sup>28</sup> Laurel K. Leslie, Jeanne N. Gordon, Lee Meneken, Kamila Premji, Katherine L. Micheltore, and William Ganger, "The Physical, Developmental, and Mental Health Needs of Young Children in Child Welfare by Initial Placement Type," *Journal of Developmental and Behavioral Pediatrics* vol. 26, no. 3 (June 2005): 177-185.
- <sup>29</sup> Thomas Hillen and Leonie Gafson, "Why Good Placements Matter: Pre-Placement and Placement Risk Factors Associated with Mental Health Disorders in Pre-School Children in Foster Care," *Clinical Child Psychology and Psychiatry* vol. 20, no. 3 (July 2015): 486-499.
- <sup>30</sup> Sandra H. Jee, Moira Szilagy, Claire Ovenshire, Amy Norton, Anne-Marie Conn, Aaron Blumkin, and Peter G. Szilagy, "Improved Detection of Developmental Delays Among Young Children in Foster Care," *Pediatrics* vol. 125, no. 2 (February 2010): 282-289.
- <sup>31</sup> Medicaid and CHIP Payment and Access Commission, *Medicaid in Schools* (April 2018), available online at <https://www.macpac.gov/wp-content/uploads/2018/04/Medicaid-in-Schools.pdf>.
- <sup>32</sup> Jeanita W. Richardson and Linda J. Juszcak, "Schools as Sites for Health-Care Delivery," *Public Health Reports* vol. 123, no. 6 (November-December 2008): 692-694, available online at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2556713/>.
- <sup>33</sup> Available online at <https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf>.
- <sup>34</sup> Medicaid and CHIP Payment and Access Commission, *Medicaid in Schools*, op. cit.
- <sup>35</sup> Michael Boudreaux, Ezra Golberstein, and Donna McAlpine, "The Long-Term Impacts of Medicaid Exposure in Early Childhood: Evidence from the Program's Origin," *Journal of Health Economics* vol. 45 (January 2016): 161-175.
- <sup>36</sup> Cate Bonacini, op. cit.
- <sup>37</sup> Ibid.
- <sup>38</sup> Teresa Wiltz, "Q&A: How The Great Recession Affected Children," *Stateline* (The Pew Charitable Trusts, March 17, 2015), available online at <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/3/17/qa-how-the-great-recession-affected-children>.
- <sup>39</sup> This was prior to when the ACA's coverage options for adults, including the Medicaid expansion, were available in 2014. If a similar economic crisis occurred under current health policies, the availability of Medicaid or subsidized marketplace coverage would reduce insurance losses among adults, particularly in states that have opted to expand Medicaid coverage.
- <sup>40</sup> Janet Currie, Sandra Decker, and Wanchuan Lin, "Has Public Health Insurance for Older Children Reduced Disparities in Access to Care and Health Outcomes?" *Journal of Health Economics* vol. 27, no. 6 (December 2008): 1567-1581.
- <sup>41</sup> Michael Boudreaux, op. cit.

<sup>42</sup> Phillip B. Levine and Diane Whitmore Schanzenbach, *The Impact of Children's Public Health Insurance Expansions on Educational Outcomes* (National Bureau of Economic Research working paper no. 14671, issued January 2009), available online at <http://www.nber.org/papers/w14671>.

<sup>43</sup> Sarah Cohodes, Daniel Grossman, Samuel Kleiner, and Michael F. Lovenheim, *The Effect of Child Health Insurance Access on Schooling: Evidence from Public Insurance Expansions* (National Bureau of Economic Research working paper no. 20178, issued May 2014, revised October 2014), available online at <http://www.nber.org/papers/w20178>.

<sup>44</sup> Jacqueline A. Miller, Deborah R. Graefe, and Gordon F. De Jong, "Health Insurance Coverage Predicts Lower Childbearing among Near-Poor Adolescents," *Journal of Adolescent Health* vol. 53, no. 6 (December 2013): 749-755.

<sup>45</sup> Sarah R. Cohodes, Daniel S. Grossman, Samuel A. Kleiner, and Michael F. Lovenheim, "The Effect of Child Health Insurance Access on Schooling: Evidence from Public Insurance Expansions," *Journal of Human Resources* vol. 51, no. 3 (2016):727-759.

<sup>46</sup> Karina Wagnerman, Alisa Chester, and Joan Alker, *Medicaid Is A Smart Investment in Children* (Washington, DC: Georgetown University Health Policy Institute Center for Children and Families, March 2017), available online at <https://ccf.georgetown.edu/wp-content/uploads/2017/03/MedicaidSmartInvestment.pdf>.

<sup>47</sup> David W. Brown, Amanda E. Kowalski, and Ithai Z. Lurie, *Medicaid as an Investment in Children: What is the Long-Term Impact on Tax Receipts?* (National Bureau of Economic Research working paper no. 20835, issued January 2015, available online at <http://www.nber.org/papers/w20835>).

<sup>48</sup> David W. Brown, Amanda E. Kowalski, and Ithai Z. Lurie, *Long-Term Impacts of Childhood Medicaid Expansions on Outcomes in Adulthood* (National Bureau of Economic Research working paper no. 20835, June 22, 2018).

<sup>49</sup> The average federal matching rate for state Medicaid programs was 63 percent in 2016 and varied by state and program. For example, the federal government pays nearly all the cost of coverage for adults in the Medicaid expansion population. Kaiser Family Foundation, State Health Facts, "Federal and State Share of Medicaid Spending, (Timeframe: FY 2016)," accessed June 20, 2018, available online at <https://www.kff.org/medicaid/state-indicator/federalstate-share-of-spending/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>.

<sup>50</sup> Dee Mahan, *Block Grants: A Bad Idea for Medicaid* (Washington, DC: Families USA, updated January 23, 2017), available online at <http://familiesusa.org/product/block-grants-bad-idea-medicaid>.

<sup>51</sup> Cate Bonacini, op. cit.

This publication was written by:

**Dee Mahan**, Director of Medicaid Initiatives, Families USA

**Shadi Houshyar, Ph.D.**, Director of Early Childhood and Child Welfare Initiatives

The following Families USA staff contributed to this publication (in alphabetical order):

Cate Bonacini, Director of Storytelling Initiatives

Nichole Edralin, Senior Designer

Eliot Fishman, Senior Director of Health Policy

Lisa Shapiro, Chief of Staff and Director of Children's Policy



1225 New York Avenue NW, Suite 800

Washington, DC 20005

202-628-3030

[info@familiesusa.org](mailto:info@familiesusa.org)

[FamiliesUSA.org](http://FamiliesUSA.org)

facebook / FamiliesUSA

twitter / @FamiliesUSA