FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

Medicaid's Children's Benefit—EPSDT—Supports the Unique Needs and Healthy Development of Children

Medicaid, the joint federal- and state-funded health care program for low-income families, insures more than 40 percent of all children in the United States, including children in very low-income families, children in the child welfare system, and children with disabilities and other complex medical needs. It covers more children than any other single insurance program.[1] The benefits of Medicaid are wide-ranging, long-lasting, and extend beyond childhood. Compared to uninsured children, children covered by Medicaid have greater access to health services[2]; have better health outcomes[3]; do better in school[4]; and earn more as adults.[5]

One of the key reasons Medicaid works so well for children is its comprehensive children's health benefit package, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. States are required to provide the EPSDT benefit for all children under age 21 enrolled in Medicaid. EPSDT covers a full range of medically necessary benefits and services for infants, children, and adolescents. It is designed to identify and treat or ameliorate health conditions early, when treatment can have the greatest impact on a child's health and development.

EPSDT also ensures comprehensive and ongoing treatment for a child's ongoing medical needs and affordability protections to protect families of children with complex needs from financial ruin. The benefits and financial protections of Medicaid's EPSDT benefit are greater than what families receive under other types of health coverage.

EPSDT: Added to Medicaid Early, Built on Over the Decades

EPSDT has been part of the Medicaid program since 1967, added just two years after Medicaid was enacted. The program's genesis was a 1964 study, *One-Third of a Nation: A Report on Young Men Found Unqualified for Military Service*, which found pervasive, treatable developmental and health problems in young men that were serious enough to render over half of them

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unqualified for military service.[6] The findings of that report led to overwhelming bipartisan support for comprehensive investment in better health for children, including the EPSDT benefit, in the Social Security Act (SSA) amendments of 1967.[7,8]

The original EPSDT amendment introduced a special Medicaid benefit for children.[9] Since then, there have been important amendments to strengthen EPSDT, our nation's gold-standard health coverage for children.

In 1972, modifications were made to add requirements for state outreach to ensure children used the benefits.[10] In 1989 under the first Bush administration, the Omnibus Budget Reconciliation Act (OBRA) expanded the EPSDT benefit to require states to cover all medically necessary Medicaid benefits, including those listed as optional benefits for adults, ensuring that children in every state would receive critical benefits such as physical therapy and mental health care.[11] The OBRA amendments ensured that children in every state had access to comprehensive and medically necessary services, setting a national coverage standard for children.

In 1997, Congress passed the Children's Health Insurance Program (CHIP), a sister program to Medicaid that covers children with family incomes above the Medicaid cutoff. All states have the option to include the EPSDT benefit in their CHIP programs, and most do.[12]

What the EPSDT Benefit Covers

What makes EPSDT so important for children is that it covers both preventive and screening services and comprehensive, medically necessary treatment for children with health or developmental issues.

The acronym itself provides some insight into the direct connection between the EPSDT benefit and the healthy development of children:

- ***Early*** assessment and early identification of health and development problems;
- ***Periodic*** preventive services at age-appropriate intervals;
- ***Screenings*** for a wide range of health and developmental issues, including screening for vision, dental, hearing, and mental health issues;
- ***Diagnostic*** testing when a risk is identified; and,
- ***Treatment*** to correct, control, or reduce issues found.

The specific benefits included under EPSDT are outlined in the Medicaid statute and explained below.[13]

Screening and Assessment Schedules.

All state Medicaid programs must provide children with screenings and assessments at age-appropriate intervals to detect health and development problems early. Each state establishes a schedule for physical, mental, developmental, vision, hearing, dental, and other screenings as medically indicated to correct and ameliorate health conditions. To satisfy this requirement, states can develop their own screening schedules in consultation with recognized medical organizations dealing with child health, or states can use the screening reference tables in the American Academy of Pediatrics' Bright Futures Guidelines to set

screening schedules.[14] A separate screening schedule is required for dental services.

Services Covered.

EPSDT covers the following treatments and services:

- Comprehensive health and developmental history;
- Comprehensive physical exam;
- Appropriate immunizations;
- Lab tests appropriate for age and risk factors;
- Health education;
- Vision services, including diagnosis and treatment, including eyeglasses;
- Dental services provided at intervals determined by the state in consultation with a recognized dental organization involved in child dental health, including, at a minimum, pain relief, infection treatment, restoration, and dental health maintenance;
- Hearing services, including diagnosis, treatment, and hearing aids;
- Other necessary health care, diagnostic services, treatment, and other measures classified as "medical assistance" to correct or ameliorate physical and mental illnesses discovered during the screening services, whether or not such services are covered by the state's Medicaid plan.[15]

The last bullet includes terms that require further explanation. First, the service must be necessary, i.e. medically necessary. States determine medical necessity, and many states have developed medical necessity guidelines.[16] However, states' determinations and guidelines must follow Medicaid law, which requires that decisions about medical necessity be made on a case-by-case basis, considering each child's needs. EPSDT's broad coverage requirement (to "correct or ameliorate" physical or mental illnesses) means that states cannot set hard and fast limits on children's coverage.[17] Cost alone cannot be a reason to deny care. This is a critical insurance protection for families of children with chronic medical or developmental conditions requiring services to be delivered regularly over months or years.

Second, states are required to cover services classified as "medical assistance"—that is, all services covered under the Medicaid statute. For adult Medicaid beneficiaries, these services are grouped into mandatory services and services that are optional for states to cover. Optional services include, but are not limited to: prescription drugs; occupational and physical therapy; treatment for speech, hearing, and language disorders; eye glasses, dental care; and private duty nursing.[18] But for children, *all* listed Medicaid services—mandatory and optional—are covered automatically, whether the state includes that service in its Medicaid plan for adults or not.[19] This ensures that children in every state have, as needed, access to the full range of Medicaid services including services such as dental care.

States' determinations and guidelines must follow Medicaid law, which requires that decisions about medical necessity be made on a case-by-case basis, considering each child's needs.

Importantly, these covered benefits are a legal right for children. There has been litigation over states' medical necessity and coverage determinations, and there is a substantial body of legal precedent further underpinning the comprehensiveness of EPSDT.

The breadth of EPSDT's statutory coverage is a testament to the value this country places on children's health.[20]

State Outreach to Families and Reporting.

States are required to inform families with Medicaid-eligible children about the availability of EPSDT services within 60 days of a child's initial Medicaid eligibility determination and on an annual basis thereafter. States are also required to provide or arrange for the provision of screening and any needed treatment services that are identified. States must report EPSDT service use to the public and to the Centers for Medicare and Medicaid Services (CMS) on Form CMS-416, which is designed to track anticipated and actual service use in a state.

In most states, 80 percent or more of the children covered by Medicaid are enrolled in managed care plans.[21] While states are ultimately responsible for ensuring that Medicaid enrolled children have access to EPSDT services, managed care plans may also have a legally enforceable responsibility to ensure that children are notified of and provided EPSDT services. States must fill any gaps in care that the managed care plans do not provide.[22,23]

EPSDT: The Gold Standard Benefit for Children that is More Comprehensive Than Commercial Coverage

More Expansive Services Covered

EPSDT requires that services are provided as medically necessary for a child's condition, with the goal of healthy development and treating or ameliorating illness. Covered benefits start with medical evaluation of the needs of the child and require follow-up treatment for any health conditions identified during regular screenings.

In contrast, commercial plans are designed with standard benefits that are based on the health needs of adults. Commercial plans allow limitations on coverage, regardless of medical necessity.[24] For this reason, the specific pediatric services covered through EPSDT exceed those typically available under private insurance plans.[25]

For example, commercial health insurance coverage often excludes extensive developmental assessment services. While commercial plans provide some coverage for rehabilitation services to address acute medical issues or other short-term health episodes, they typically restrict payment for developmental interventions, like ongoing therapy needed to address health issues for children born with a disability. In general, commercial insurance limits or excludes coverage for services like ongoing speech therapy for infants and young children born with a hearing loss, or physical and occupational therapy for children born with mobility issues.

EPSDT, on the other hand, emphasizes achieving optimal growth and development in children and ensures that children are able to get the services they need to ameliorate physical, mental, and developmental concerns or conditions without arbitrary limits on scope or duration of services. Importantly, a service need not cure a condition to be covered by Medicaid. Services that help a child maintain or improve her health, or that alleviate pain, are covered under EPSDT even if these services will not cure an underlying health condition. This access to ongoing care is particularly critical to address health issues for children with special health care needs.[26]

Direct comparisons with commercial and public employee plans

The difference between the breadth of EPSDT's coverage and coverage offered through other plans is illustrated in Table 1. In a comparison of EPSDT coverage with that of select public employee and small group plans with large enrollment in two geographically and politically different states (California and Florida), EPSDT coverage was consistently more comprehensive.

This also held true when we compared Medicaid's EPSDT benefit with coverage in the Federal Employees Health Benefit Program (FEHBP), long considered among the most comprehensive employee coverage programs available. The plan we used for comparison was FEHBP's Blue Cross Blue Shield Service Benefit Plan Standard Option, the FEHBP plan with the highest enrollment.[27]

In this comparison, we consistently found that EPSDT coverage was more comprehensive. For example, where EPSDT covers hearing services and hearing aids without limitations—medical services that can have a dramatic impact on a child's success in school and later in life—the FEHBP plan covered hearing testing only when associated with an illness or injury, and limited hearing aid coverage to $2,500 for one pair per year, a coverage level that is less than the standard price range of $1,000 to $4,000 for children's hearing aids..[28] Half of the 8 plans in our comparison did not cover hearing aids at all.

Greater Financial Protection for Families

Not only does Medicaid's EPSDT benefit guarantee that children have access to all medically necessary services, but it also includes financial protections, meaning that families will be able to afford to use Medicaid's benefits.

Federal law requires that Medicaid is provided to families with low out-of-pocket costs. Cost-sharing and premiums cannot be more than 5 percent of family income. And cost-sharing is generally prohibited for children under age 18.[29] Without these financial protections that make the benefit affordable, EPSDT would be a benefit on paper only, rather than coverage that children can actually use and benefit from.

Table 1. Medicaid EPSDT Benefit Compared with Select Public and Private Employee Plans, Including FEHBP

BENEFIT	MEDICAID EPSDT	CALIFORNIA		
	All states	City of Los Angeles Employee HMO Plan	City of Los Angeles Employee PPO Plan	State of California Employee HMO Plan
HEARING SERVICES				
Routine Screening	Covered without limit or copay	Covered, no copay	Covered, no copays	Covered, no copays
Hearing Tests	Covered without limit or copay	Covered, $15 copay	Covered, coinsurance 10% plan provider; 30% non-plan provider	Covered, copay $15/visit
Hearing Aids	Covered without limit or copay	Covered up to $2,000/ear every 36 months	Covered, 1 per ear every 2 years; coinsdurance 20%	Covered up to $1,000 every 36 months
Implants	Covered without limit or copay	Not covered	Not covered	Not covered
VISION SERVICES				
Eye exams	Covered without limit or copay	Covered, w/ optometrist, no charge; with physician $15 copay	Covered, w/optometrists, no charge; w/ physician coinsurance 10% plan provider; 30% non-plan provider	Covered, w/ optometrist no charge; w/ physician $15 copay
Glasses/ corrective lenses	Covered, no copay, covers replacement of lost, stolen or broken glasses.	Corrective lenses not covered	1 pair of glasses/lenses related to eye surgery; coinsurance 10% plan provider; 30% nonplan provider	1 pair glasses/contacts following cataract surgery
PHYSICAL, SPEECH AND RELATED THERAPIES				
Coverage, visit limits	Covered, no limits on visits, no copays.	Covered, copays $7-$15, no visit limits	Covered, coinsurance 10% plan provider; 30% non-plan provider. No visit limits	Covered, copays $7-$15, no visit limits
HOME NURSING				
Coverage, visit limits	Covered, no limits; no copays	Coveres 100 visits/year, limit 2 hours per visit. No copay.	Covers 100 visits/year. No copay.	Covered, no copay.
PLAN OUT-OF-POCKET MAXIMUMS	Generally copayments prohibited for children under 18. All costs limited to 5% of family income.	$3,000 for family	$4,000 for family	$3,000 for family
Deductibles	None	None	$1,500 for family/participating providers; $2,500 for family/ non-particiating providers	None

Fully Covered

Covered with Conditions, Limits, or Patient Cost

Not Covered

Continued on the next page

	FLORIDA			FEDERAL
Largest small group market plan in California	**State of Florida Employee HMO Plan (offered in several high populaiton counties)**	**Florida PPO offered state wide**	**Largest small group market plan in Florida**	**FEHBP Blue Cross Blue Shield Plan Basic Option**
Covered, no copay	Covered, no copay	Covered, no copay	Covered, no copay	Covered, no copay
Covered, copays $30 to $35	Not covered to determine need for hearing aid	Not covered unless associated w/ illness or injury other than hearing loss	Not specified in plan documents	Covered when associated with illness or injury, copay $30-$40/visit
Not covered	Not covered	Not covered	Not covered	Covered, 1 pair/year up to $2,500
Not covered	Not covered	Not covered	Not specified in plan documents	Bone anchored hearing aids covered up to $5,000/yr; cochlear implants covered.
Covered, w/ optometrist, no charge; w/ physician $30-$35	Covered 1/year, $20-$40 copay	One annual eye examination, no copay	1 exam/year, coinsurance 50% plan provider; no coverage for non-plan provider.	Covered, copay $30-$40/visit
1 pair of glasses/contacts/ year; 1 pair disposible lenses/6 mos. No copay	1 pair glasses/contacts related to injury or cataract surgery	1 pair glasses/contacts related to injury or cataract surgery	1 pair of glasses/ contacts/year. 50% coinsurance	1 pair glasses/contact lenses covered related to injury or medical condition. Routine corrective lenses not covered.
Covered if provided in skilled nursing facility up to $300/ day, $1,500 per admission, up to 100 days.	Covered if significant improvement expected w/in 60 days. Copay $40/visit. Limit 60 visit/injury.	Covered if part of home health, hospice care or for limited conditions	Covers 35 visits per year for OT/PT and speech therapy combined. Copay $35/visit.	Covered, copay $30-$40/ visit.
Covered up to 2 hours/visit, limit 3 visits/ day, 100 visits/ year.	Covered if service would be covered inpatient and to extent less costly than facility care.	Covered for some conditions if treatment goals met.	Covers 60 visits/year, 20% coinsurance.	Covers 2 hrs/day, 25 visits/year, $30 copay.
$14,000 for family	$3,500 for family not to exeed $1,500 per health plan member.	$500 family for network providers and $1,500 for non-network providers.	$14,000 for family	$11,000 for family
$1,000 for family	None	$5,000 for both network and non-network providers	$10,000 for family	No deductible under Basic Option.Coverage limited to preferred providers.

Sources: For Medicaid EPSDT benefits, EPSDT: A Guide for the States, Department of Health and Human Services, https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf.; data on California and Florida 2018 plans from AXIACI (proprietary resource of LeverageGC). Access made available to Families USA through a grant from Robert Wood Johnson Foundation; FEHBP benefits from FEHBP Blue Cross Blue Shield Basic Option Plan at www.fepblue.org for plan year 2018. The Basic option offers lower deductibles and cost sharing than the Standard option.

Notes: Coverage levels are for children in cases where children's coverage differs from adults'. Several plans (all HMOs) limit coverage to plan providers. When cost sharing differs between in- and out-of-plan providers, that is noted; other cost sharing ranges refer to differences based on provider type. For some services, plan documents did not provide coverage detail and that is noted. When no cost sharing information is provided for a service, the information was not clearly listed in plan documents. More detail on coverage specifics, condiitons and limitations is available upon request.

See Table 1 for a comparison of cost-sharing (copayments and coinsurance) and deductibles between EPSDT and sample government employee and small group plans.

How EPSDT Has Helped Children

EPSDT's critical importance is best shown by looking at its impact.

EPSDT is a Critical Tool to Address Health Inequities.

Medicaid and CHIP are essential sources of coverage for children of color, and EPSDT's comprehensive benefit requirements have been a critical tool to reduce racial and ethnic health inequity. Since 1997, these programs have cut the number of uninsured children in half, with the greatest improvement in coverage rates for children of color.[30] These gains are important because research has shown that, due to the compounding effects of disadvantage, children of color face greater threats to their health than white children, and also suffer disproportionately from a number of health conditions, including elevated blood lead concentrations, asthma, and obesity.[31] While continued efforts to improve access to quality services for children of color are needed, Medicaid and CHIP—and specifically EPSDT—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.

EPSDT Ensures Access to Early Intervention Services.

Coverage for early intervention services may be left out of typical commercial health plans, yet these are critical for healthy child development. Research has shown the benefits of early intervention services include improved academic achievement, improved behavioral and emotional competencies, improved health outcomes, reduced delinquency and crime, and improved labor market success in adulthood.[32]

Importantly, EPSDT is an essential payment source for early intervention services structured to support healthy child development. EPSDT pays for providers to: (1) screen and diagnose developmental problems and risks; (2) provide health education to the family about key developmental milestones and opportunities to maximize a child's early growth; and (3) provide coverage for a broad array of early intervention services, such as physical therapy, speech and language services, assistive technology, and family

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counseling and training. In this way, EPSDT helps reduce the likelihood that a developmental concern could turn into a potentially serious and long-term physical, mental, or developmental condition, by addressing it before it becomes acute and symptomatic.

EPSDT Ensures Key Supports for At-Risk Children and Young Adults.

EPSDT is particularly important to at-risk children and youth, and those with significant medical needs.

Children and Youth in the Child Welfare System.

Children in the child welfare system are categorically eligible to receive health insurance through Medicaid and receive essential care because of the EPSDT benefit. Children in foster care often have significant health care needs, including well-documented high levels of physical, dental, and behavioral health issues.[33] For children in foster care, EPSDT benefit screenings are key to identifying health conditions and concerns, and for referring children for treatment. Studies show that for children in foster care, routine developmental screening identifies problems earlier,[34] allowing for timely intervention.

Children with Special Health Care Needs (CSHCN).

In the U.S., an estimated 14.2 million children have special health care needs.[35] These are children who have one or more ongoing health conditions that require more than routine medical services. In 2016, Medicaid and CHIP covered roughly half of these children,[36] who require more and often specialized health care services due to their complex health conditions.

For CSHCN, EPSDT is especially important. Medicaid offers comprehensive coverage of services and supplies these children frequently need—services often excluded, or greatly limited, by private insurance plans. Under EPSDT requirements, states cannot set limits on medically necessary pediatric benefits. For example, unlike commercial coverage, states cannot limit the number of speech or physical therapy sessions they will cover, as long as they are medically necessary. These services are essential for CSHCN who might require months or years of these services in order to gain or maintain function. (For more on the benefits of Medicaid for CSHCN, see Families USA's brief, How Medicaid Protects Children with Special Health Care Needs.)

School-based Services for Children with Disabilities.

Under the Individuals with Disabilities Education Act (IDEA), public schools must provide special education and related services necessary for children with disabilities. For children enrolled in Medicaid, these related services (e.g., physical and speech therapies) can be financed by Medicaid, if otherwise covered by Medicaid and if the school-based providers meet the same requirements (e.g., state licensure) as other Medicaid providers. See Families USA's brief, Health Coverage Matters for Children: The Role of Medicaid in the Healthy Development of America's Children, for more information on Medicaid and school-based health services.

Given the unquestionable benefits that EPSDT provides for children, ensuring that all eligible children receive the EPSDT benefit should be a priority.

The EPSDT Benefit Helps Children Succeed.

Medicaid's EPSDT benefit helps children do better overall. Studies have shown that children who receive the EPSDT recommended well child care visits during their first two years of life are better prepared to start school.[37] Better school readiness relates to better school performance. Additionally, compared to uninsured children, children covered by Medicaid do better in school,[38] have better health outcomes,[39] and do better financially as adults.[40]

Areas for Improvement

EPSDT's benefits are clear. However, not all children who are eligible for the services receive them.

Of the 40 million children eligible for EPSDT services in 2014, just under 60 percent of the children who should have received at least one screening received one.[41]

As noted above, states are responsible for ensuring that families are notified about their children's eligibility for EPSDT services; that children receive appropriate screenings and receive any medically necessary treatments; and that data on EPSDT use is reported to CMS. However, for some time, stronger efforts have been needed to ensure children's use of the services and to improve state reporting.

In 2001, a Government Accountability Office (GAO) report noted that many children were not receiving needed screenings and better data was needed from states.[42] A 2010 report from the Office of the Inspector General (OIG) found that most children in Medicaid in nine states were not receiving all of the recommended screenings. The OIG recommended that CMS and states collaborate more closely to ensure that eligible children receive EPSDT services.[43]

Given the unquestionable benefits that EPSDT provides for children, ensuring that all eligible children receive the EPSDT benefit should be a priority. This includes making sure that states coordinate with managed care plans, which cover most children in Medicaid, to make sure that children enrolled in those plans receive the screenings and treatments they need.

Proposals to Restructure Medicaid Would Affect Children and Undermine the EPSDT Benefit

In spite of the benefits that Medicaid and its EPSDT benefit have provided to children across the country, the two programs are at risk from both legislative and administrative threats.

SAM

New York, NY

> The support and services Sam has received throughout his life because of Medicaid are a big deal.
>
> —Amber, Sam's mom

Sam, is a teenage boy who attends public school and enjoys taking part in poetry workshops at the local public library, chess club, and even a scooter meet up in the park. This is all possible because of the support and care he has received through Medicaid.

Sam started having developmental delays when he was an infant, and was eventually diagnosed with Autism Spectrum Disorder and Coordination Disorder, a motor skill development disorder. Among other delays, he had significant trouble speaking, only repeating sounds and phrases, until he was four. Because of early intervention and treatment covered through Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit—which ensures children with Medicaid get comprehensive screening services and any medically necessary follow-up treatment—Sam received home-based habilitation services, including speech, language, and occupational therapy beginning at 18 months, and he has continued to receive services throughout his life.

Following his diagnosis, Sam was able to receive Pre-School Special Education Services that were critical in his development. As Sam has grown up, Medicaid now helps Sam attend school, supporting his successful integration into a public school general education classroom. For Medicaid-enrolled students with disabilities, schools provide children with a series of medically necessary services as part of their special education plans. Medicaid reimburses schools for these services for eligible children, like Sam. All of this is provided to children as part of Medicaid's EPSDT benefit.

"The support and services Sam has received throughout his life because of Medicaid are a big deal," Amber says, "Had Sam not received early identification and treatment services I have no doubt that he would still be spinning and hand flapping, and he would probably have limited communication skills. He would have most likely been placed in a 'special school,' rather than in a regular classroom where is he is developing important social and life skills and learning aside his peers."

Today, with the help of a trained direct support worker, Sam is able to work on valuable skills towards an independent adulthood. The services he receives through Medicaid allow him to work daily with a "life skills coach" to improve his communication and conversational skills. Sam is also working with his coach on a range of pre-vocational skills, helping get Sam on track for college. His mom says, "Medicaid has provided promise and hope that despite Sam's significant developmental and medical challenges, he will one day be able to live independently, fully integrated into his community and society."

His mom worries about cuts to Medicaid funding and the possibility that program cuts could put the support services Sam relies on at risk. She notes that cuts to the programs could mean "his chance for independence would be jeopardized."

Sam's progress and continuing health improvements are only possible because of Medicaid's early screening and diagnosis benefit—EPSDT—which ensured that Sam was been able to get the care he needed early in his life and continuing support for as long as he will need it.

Legislative Threats

Federal efforts to cut Medicaid or change the program's structure would put children's Medicaid coverage at risk.

While efforts to restructure Medicaid in 2017 ultimately failed, President Trump and congressional leaders continue to propose regulations and legislation that threaten the federal-state Medicaid partnership, Medicaid financing, and its benefits structure.

President Trump has proposed enormous cuts to Medicaid in his last two annual budget requests to Congress, and Republican leaders in Congress also continue to signal that they intend to pursue legislation to cut entitlement spending, including cuts to Medicaid. Because children represent the largest single group covered in Medicaid—children comprise over 40 percent of all Medicaid enrollees—program cuts would almost certainly affect them.[44] Cuts in federal Medicaid funding would pass program costs on to states. Most states would not be able to absorb large increases in their Medicaid spending and would be forced to cut the program.

Administrative Threats

Administrative actions pose a threat to Medicaid that is potentially even greater than that posed by legislators.

Federal law allows the Secretary of Health and Human Services (HHS) to waive many federal Medicaid requirements at a state's request, provided that doing so would promote Medicaid's statutory objectives of "furnishing medical assistance."[45] The administration is using 1115 waivers (which take their name from the section of the Social Security Act in which they appear), to essentially sidestep Congress and remake the Medicaid program through administrative action.[46,47] These waivers could put Medicaid's EPSDT benefit at risk.

Some states have asked the Secretary of HHS for permission to waive the EPSDT benefit for children over age [18.48] States are required to provide the EPSDT benefit to children up to age 21. Although none of these waivers have been granted yet, they raise concerns.

There are important health reasons to extend the benefit to older children. For example, neuroscience has shown that onset of serious mental illness is a significant risk during early adult years.[49] But beyond the health implications, waiving the benefit for some states would signal that this administration does not see EPSDT as a uniform national benefit that ensures the same services to children no matter where in the country they live. It would be a precedent that could lead to broader erosion of Medicaid's benefit for children, starting down a path of stepping back from our country's commitment to children's health.

EPSDT is Not a High-cost Proposition.

EPSDT provides comprehensive benefits for all children and youth enrolled in Medicaid under age 21, but it is not actually a high-cost service. In fact, children have the lowest per-enrollee costs of any group covered by Medicaid.50 Eliminating the EPSDT benefit for 19- and 20-year-olds would not yield significant savings—but it would make it difficult for these young adults to receive the care they need, taking away access to important services and supports at precisely the time they are transitioning toward becoming healthy and productive adults.

Comparing Medicaid's EPSDT Benefit With Other Coverage

Medicaid's child health benefit, EPSDT, is often called the gold standard of children's health coverage. To see how that coverage compares with other children's coverage, we used the AXIACI Centralized Information Library, a proprietary resource developed by LEVERAGE and publicly available information on Federal Employee Health Benefit Program (FEHBP) participating plans to compare Medicaid's EPSDT benefit with children's coverage across a total of eight health plans. The sample includes offerings from a mix of employers, different plan types, and each plan has large enrollment. All plans are for 2018. Findings are in Table 1.

We looked at coverage in seven health plans from two very different states, four in California and three in Florida, plus one of the most popular plans among the FEHBP offerings. For both California and Florida, we selected plans that cover government (state or municipal) employees (government employee plans tend to offer very generous coverage) plus each state's largest (by enrollment) small group plan. We selected a mix of HMO and PPO plans to examine coverage across different types of insurance. Our Methodology has more information on the database used and plan selection.

For each plan, we compared EPSDT coverage with coverage for services that can have a significant impact on a child's development and school performance, or services that can be essential to allowing children with special health care needs to continue living in the community. The services we looked at were: hearing; vision; physical, occupational, speech and other therapies; and, home nursing.

Dental is another services where the differences in coverage between Medicaid's EPSDT benefit and commercial plans can be stark. ESPDT guarantees children affordable, comprehensive dental coverage with no benefit caps. There is no guarantee that families' commercial insurance plans will cover dental care, and if covered, dollar coverage caps and visit limits are common. Commercial plan benefits are typically less generous, less affordable, and not designed to meet children's needs. However, because employers often offer dental coverage through separate policies from medical coverage, we did not include dental in this analysis.

While depth and breadth of coverage varied between the two states and by type of plan and employer, we found that across the board, Medicaid's EPSDT coverage was more comprehensive, designed to meet children's needs, and also offered families greater financial protection from high health care costs. That protection is critical for lower income families and for families with children who have ongoing high-cost medical needs.

Our head-to-head comparison of plan benefits confirms that Medicaid's EPSDT benefit is, indeed, the gold standard in children's coverage.

Conclusion

More than 50 years ago, Congress created Medicaid's children's benefit, EPSDT, to ensure that all children would have a chance at a healthy start in life and access to screening and treatment services throughout their childhood to allow them to reach their fullest potential. Since then, both parties have built on the foundation established over a half century ago, to ensure a strong national Medicaid benefit for children and young adults.

The goals that prompted our nation's leaders to create a benefit that meets a child's unique health and developmental needs are as important today as when EPSDT was first set in law. Efforts to restrict EPSDT for children or young adults, either through legislation or waivers, put both our children's health and our nation's future at risk.

Our nation's leaders on both sides of the aisle played a role in securing this critical benefit for our nation's most vulnerable children, and we are relying on them to keep this benefit and Medicaid strong for all who rely on Medicaid. Instead of proposals to cut or limit Medicaid, we urge our leaders to protect the EPSDT benefit and continue to improve coverage and benefits for children. EPSDT continues to be the gold standard for a children's health benefit, and should serve as the model for a children's benefit package in any future coverage reform efforts. Efforts to restrict access to medically necessary care are not only short-sighted, but will also result in poorer health outcomes for children and have serious and long-term economic consequences for our nation.

Instead of proposals to cut or limit Medicaid, we urge our leaders to protect the EPSDT benefit and continue to improve coverage and benefits for children. EPSDT continues to be the gold standard for a children's health benefit, and should serve as the model for a children's benefit package in any future coverage reform efforts.

Methodology

For our comparison of Medicaid's EPSDT benefit and other coverage shown in Table 1, we compared EPSDT benefits with benefits in eight plans: seven plans from two different states and one plan from the Federal Employee Health Benefit Program (FEHBP). For the seven state plans, our analysis was based on plan information in the AXIACI Centralized Information Library (see "About the Database," below). Information on the FEHBP plan chosen was from publicly available plan documents. In all plans, where adult and children's benefits differed, we profiled children's benefits.

Our selection process (states, plan selection, benefits for comparison) is outlined below. The analysis was designed to give a snapshot of how Medicaid's EPSDT benefit compares with coverage through employer plans that cover a large number of individuals. We chose plans from different geographic areas, and included a mix of HMO and PPO plans.

State Selection

We chose plans from California and Florida, two very populous states representing different geographic areas of the country, and whose leadership has taken very different positions on health coverage for residents. To cite only two examples, California has expanded Medicaid coverage whereas Florida has not; and California has a state-based marketplace, while Florida does not.

Plan Selection and Source of Plan Information

Our plan selection was designed to capture plans with large enrollment, including both state/city employee plans and small group plans and a mix of HMOs and PPOs, plus one of the largest federal employee plans.

For plans in California and Florida, we chose state/city employee plans because those plans tend to have generous coverage when compared to other employer-offered plans and would also allow us to compare very generous offerings with Medicaid's EPSDT benefit. We also compared benefits under the largest (by enrollment) small group plan in each state to provide insights into plans that are typically available to non-government employees.

- *State/municipal plans selected.* In California, we selected two plans offered to employees of the City of Los Angeles (the most populous city in California) and one plan offered to California state employees. In Florida, we selected one PPO plan offered to employees across the state, and one HMO plan offered to state employees in select counties, including many of Florida's most populous counties. Given the large number of employees working for the City of Los Angeles, the state of California, and the State of Florida, all of the plans tend to have significant enrollment numbers.[51] All plan data is from the AXIACI Centralized Information Library.

- *Small group plans selected.* To provide a snapshot of benefits offered through smaller employers or other groups, we examined coverage in small group plans. For both states, we looked at coverage in the state's largest (by enrollment) small group plan. All plan data is from the AXIACI Centralized Information Library.

- *FEHBP plan.* We included benefits of one of the largest (by enrollment) plans offered to federal employees. Benefits were obtained from the plan's publicly available benefits documents.[52] The FEHBP provides coverage for over 8 million people (federal employees, retirees, and their families). Two-thirds of enrollees are enrolled in one of the program's Blue Cross Blue Shield plans.[53] We profiled one of those plans.

» *Medicaid EPSDT.* Information on Medicaid's EPSDT coverage was gathered from the Department of Health and Human Services.[54] All state Medicaid programs provide the EPSDT benefit.

Benefits Selected for Comparison

The benefits we selected for comparison were those covering conditions that, if not adequately treated, can have a significant impact on a child's development and ability to perform in school (benefits for hearing, vision, and physical, speech, and related therapies) and home nursing benefits that can be critical for children with special health care needs to be able to remain living in the community.

We evaluated coverage, general coverage limitations, and cost sharing. In some plan documents, details on specific benefits were not always described explicitly, and we noted whenever this was the case. When no cost sharing or coinsurance is noted in the table, it reflects that for that service, the information was not explicit in the plan documents available to us.

About the Database

Data on California and Florida plans is from the AXIACI Centralized Information Library, a proprietary resource developed by LEVERAGE, that contains both structured and unstructured data and information from health insurance plans offered by insurance carriers and self-insured employers. AXIACI contains an array of plan designs and plan documents loaded across different market segments and subsegments, representing approximately 50% of covered lives in the United States. The resource includes information on in 175,000+ plan variations, and is updated regularly. The data available in AXIACI include plan design, benefit variations, exclusions, limitations and restrictions, medical policies, and guidelines for medical and behavioral services and drugs/devices. The information is extracted from government and commercial sources, including CMS, DOL, SERFF, and Payers/Carriers. Access to AXIACI is provided through a grant from the Robert Wood Johnson Foundation.

For our analysis of coverage offered by the City of Los Angeles to its over 60,000 employees, we selected one of its Kaiser Permanente plans. Kaiser Permanente, a staff model HMO, is one of the largest insurers in California. The second plan was an Anthem Blue Cross PPO plan. Anthem is among the largest insurers in California.[55] Selecting one HMO and one PPO allowed us to compare benefits across different delivery models.

One plan for California state employees. California has over 200,000 active, full-time employees. We selected the Kaiser Permanente plan offered to state employees for comparison.

Two plans for employees of the state of Florida. The two Florida plans selected are the Blue Cross Blue Shield plan offered statewide and the HMO plan offered in Florida's most populous counties.[56] Florida has approximately 22,000 employees.

New Mexico. Presbyterian Health Plan

Benefits selected for comparison

The benefits we selected for comparison are those where coverage tends to vary significantly from plan to plan and includes benefits covering treatment of conditions that can have a significant impact on a child's ability to perform well in school, such as vision and hearing benefits, or physical and speech therapy. We also included home visit coverage, a service that can be critical for children with special health care needs.

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