EDITORIAL

# Medicaid and Child Health—Threats and Opportunities

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**Over the past 150 years,** US government leaders have slowly but surely expanded access to health insurance and medical care for children. The Medicaid program represents federal and state governments' largest commitment to financing health care for children from low-income families and children with chronic medical conditions. In 2025, we took a big step, potentially backward. The recent One Big Beautiful Bill Act (OBBBA) will challenge states to maintain coverage for vulnerable children and families and stretch health systems to their limits.[1] The legislation may also create the conditions for greater experimentation and ultimately a more comprehensive system of care for children's health in the US.

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As Berry et al[2] show in this issue of *JAMA Pediatrics*, the stakes could not be higher; Medicaid now funds nearly half of all hospitalizations for children in the US. Medicaid cuts pose a particular challenge to health care access for children and families in the rural US, where 62% of hospital charges are financed by Medicaid, and for children with complex chronic conditions, over half of whom rely on primary or secondary Medicaid coverage.

Examining the history and landscape of children's health insurance coverage in the US highlights the potential threats and opportunities for child health. Through the late 19th century, low-income families relied on charity care from hospitals, dispensaries, and individual clinicians when their children were ill. At the turn of the 20th century, municipal and local governments became more involved in pediatric health promotion, and the bipartisan 1921 Sheppard-Towner Maternity and Infancy Protection Act established America's first federally funded health care for children through state grants. Government programs focused narrowly on health education to address maternal and infant mortality, however, to avoid competing with private clinicians. US leaders used the same reasoning as their European counterparts—the health of children and mothers is essential to the health of the nation—but did not establish broad health care schemes for every child, regardless of income.[3]

By the 1950s, private health insurance, typically through a large employer, became the primary mechanism for financing health care in the US. Millions of children and families without health insurance relied on charity. In the 1960s, President Lyndon Johnson established Medicaid as part of his Great Society initiative focused on addressing economic inequality. Subsequent decades brought additional coverage expansions. In 1997, with strong bipartisan support, Congress established the Children's Health Insurance Program (CHIP) to provide coverage to children from low-income families who do not qualify for Medicaid but cannot afford private health insurance.[4] In 2010, the Affordable Care Act (ACA) incentivized states to expand Medicaid to cover low-income adults.[5] These ACA expansions benefited children directly and indirectly. The health of parents is essential to their children's well-being, and there were concurrent increases in children's coverage, termed *welcome mat effects*.[6] With the ACA and state Medicaid expansions, the US moved closer than ever to having children universally insured.

Over the past few decades, Medicaid and CHIP have also become an increasingly important source of insurance coverage for children in working families. As employer-sponsored private insurance costs rise, many working families are opting into Medicaid and CHIP to allow their children to maintain affordable coverage and access high-quality health care,[7] including the comprehensive and evidence-based preventive care services provided through Medicaid's Early Periodic Screening, Diagnosis, and Treatment program.

Medicaid has also become the backbone of health insurance coverage for children with special health care needs.[8] Private insurance often fails to cover the comprehensive services these children need to thrive, including therapies and home and community-based services. Families must, therefore, rely on secondary Medicaid coverage, which plays a critical role not only in supporting children's health, but also in allowing these children to remain in their communities and their parents to remain in the workforce.

In their research letter, Berry et al[2] illustrate how Medicaid's footprint on children's health insurance coverage has expanded. Using data from the 2022 Kid's Inpatient Database, they found that Medicaid was the primary payer for 48% of all pediatric discharges, including 44% of newborn infants and 55% of children. Medicaid covered the majority of discharges among children with multiple chronic conditions, who account for nearly 80% of all pediatric hospital days in the US.[9] In rural areas, 1 in 4 hospitals had more than 75% of their pediatric hospitalizations covered by Medicaid.

The OBBBA proposes to cut Medicaid and CHIP spending by more than a trillion dollars, according to estimates from the nonpartisan Congressional Budget Office, in part by implementing policies that will eliminate coverage for 10.5 million beneficiaries.[10] The bill's proponents have framed their goal as eliminating waste, fraud, and abuse by ensuring that no one who is able to work is taking advantage of Medicaid benefits. Federal Medicaid spending reductions of this magnitude, however, will impact not just Medicaid beneficiaries, but all children and families seeking care at hospitals and clinical practices that rely on Medicaid funding. Medicaid is the single largest line item in most state budgets, comprising 30% of

states' total spending on average.[11] As federal Medicaid funding decreases, states will be forced to rebalance their budgets significantly and may need to cut essential benefits, such as home and community-based services for children with special health care needs. States may also need to lower Medicaid reimbursement rates, which could result in insurmountable funding cuts for clinical services such as rural hospitals already operating on thin margins, leading to hospital closures and worsening capacity strain at pediatric hospitals throughout these regions.[12]

Robust research has shown that Medicaid exposure during early childhood leads to better overall health in adulthood.[13] Children who receive Medicaid also achieve better educational outcomes, including higher rates of college attendance.[14] In addition, children exposed to Medicaid during early childhood have higher rates of employment and pay more in taxes as adults.[14] In the short term, pediatricians, researchers, and child health advocates can work with state health policy leaders to ensure that children and families can continue to benefit from Medicaid services as the OBBBA is implemented. We can also support families by helping them understand coverage changes and navigate work-reporting requirements and insurance transitions, including by connecting them with relevant resources like medical-legal partnerships.

Medicaid's structure as a federally funded, state-administered system provides opportunities for states to be creative, and times of broad federal policy changes can facilitate innovation. Several states are already implementing and evaluating multiyear continuous coverage policies for children ages 0 to 6 years, to preserve children's access to coverage and care in early childhood. The implementation of OBBBA will create an environment for states to review and revise their current policies, and it is possible that innovative approaches that focus on health promotion and disease prevention will emerge. For example, most models of child health financing have not yet shifted to value-based care arrangements designed to support primary prevention of illness and promote broad health goals. State Medicaid programs could learn from existing models for value-based child-centered service delivery and payment, like the Centers for Medicare and Medicaid Innovation's Integrated Care for Kids Model, which focuses on cross-sector integration of services and supports for children with complex medical and social needs.[15] States could also adapt adult payment models that empower clinical teams to deliver high-quality, coordinated care that addresses both medical needs and social drivers of health and prioritizes prevention of chronic conditions.

In the long run, child health advocates can take this opportunity to recognize the limits of Medicaid and child health care financing more broadly. The US remains the only high-income country that does not provide universal health insurance coverage to children. As noted previously, each generation since the 1960s has added legislation that addressed the pressing policy issues of their time; the result is a child health care system that is complex, fragmented, and unmanageable from a national policy perspective. None of the specific policy decisions of the last century were inevitable, however, and the future can be radically different.

The American Academy of Pediatrics' 2023 Policy Statement on Medicaid and CHIP provides 1 roadmap for transforming child health insurance. It recommends evidence-based reforms including expanding Medicaid and CHIP eligibility to all children under age 26 without other coverage, instituting automatic enrollment for qualifying children at birth, and providing continuous eligibility through age 6 years.[16] These reforms will require upfront investment but are likely to yield substantial returns in the long term.

As the forthcoming Medicaid cuts unfold, we as pediatricians, researchers, and policy leaders are charged with continuing to serve children to the best of our ability despite reduced resources, advocating for reforms that preserve children's coverage, and measuring and documenting the impacts of these cuts on child health and well-being. We can also imagine the opportunities. Other industrialized nations have achieved universal health insurance coverage for children, and the US can, too. Our current system is the direct result of choices our government and citizens have made in the past, and we have the ability to make better choices, and generate better outcomes, for future generations of US children.


## ARTICLE INFORMATION

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