Cutting Children's Health Care Costs

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Despite our nation's relatively poor performance on many major health indicators (eg, life expectancy, infant mortality, obesity rates), the United States has the most expensive health care system in the world.[1] As a nation, we spend 17.9% of our gross domestic product on health care, or ~$10 348 per person per year.[2] The largest share of this spending comes from the federal government. Because increased focus has been turned to curbing health care costs, a possible approach to reducing federal health care spending would be to tighten eligibility requirements for public insurance, including Medicaid and the Children's Health Insurance Program (CHIP). Indeed, President Trump's proposed 2018 budget included a plan to reduce eligibility for CHIP, which was projected to result in a net saving of $5.8 billion over 10 years.[3] Although Congress recently reauthorized the CHIP at stable funding levels, the administration's 2019 budget proposal continues to propose >$1 trillion in Medicaid cuts over a decade, with the reallocation of some funds coming in the form of block grants to states.[4]

In this issue of *Pediatrics*, Bettenhausen et al[5] report the results of a retrospective cohort study of hospitalizations from 14 states to evaluate what impact various reductions in public insurance eligibility thresholds would have on children. States' current thresholds for public insurance eligibility vary considerably because of underlying state-level variation in the cost of living, the proportion of states' residents living in poverty, and the prioritization of public health insurance in the political landscape of that state. In modeling possible federally driven reductions in changes to eligibility, the authors found that reductions in eligibility to 300%, 200%, or 100% of the federal poverty level would have increasingly profound effects across states on the number of current hospitalizations that would become ineligible for public insurance. The midpoint case they considered, a reduction of public insurance eligibility to 200% of the federal poverty level, would make 57% of hospitalizations that are currently covered by public insurance ineligible. This would represent $3.1 billion in hospitalization costs that would need to be absorbed by patients, families, hospitals, and the private insurance market. In many cases, private insurance would be financially out of reach for these families, and the costs of even a single hospitalization could be financially devastating. Children's hospitals and all other hospitals caring for pediatric patients would likewise suffer major financial consequences because up to one-sixth of all hospitalized children would suddenly be lacking a source of payment (half of the 1 in 3 currently covered by public insurance).

As policy makers seek to achieve the desirable goal of lowering health care costs, it is essential that this goal not be pursued in a manner that is blind to the effects of particular cost-reduction strategies on equity, quality of care, or the real effects these choices have on individual patients and their families. Any policy that widens disparities in care will exacerbate the problems in health outcomes the United States already experiences relative to comparator developed nations. A major driver of our problem with health outcomes is the high rate of poverty in the United

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States and the manner in which we as a nation address this problem.[1] Poverty worsens health outcomes both by exposing its victims to high-risk living conditions and by creating barriers to primary care and other health services that many cannot overcome. Although decreasing eligibility for public insurance would lower governmental expenditures in the short-term, it would do so at the expense of the health and well-being of some of our most vulnerable children and their families. Decreased access to primary care and acute-care services would particularly affect the health of children with complex chronic illnesses. The burden of bearing unreimbursed health care costs would also drive some families with borderline financial means deeper into poverty. Worsening financial circumstances would in turn increase exposure to adverse living conditions and make access to needed primary care and hospital services even more inaccessible—a destructive downward spiral of decreasing financial stability and health.

Lowering short-term costs at the expense of our most vulnerable patients is not the answer. How then do we address the unsustainably high costs of health care? As with so much of pediatrics, the answer may lie in prevention. It is not only individual diseases that must be prevented, however, but the common root cause of so many of these illnesses: poverty. Many of the nations that demonstrate the best health care outcomes, and do so at the lowest cost, invest far more in social infrastructure than does the United States.[1,6] By providing higher levels of housing support, job assistance, child care, retirement benefits, and other programs, these nations appear to mitigate the conditions that drive poverty and the health care disparities that result from it and avert the high costs of downstream health care that we experience in the United States. Although the United States differs from these comparator nations in many important respects, and although no single approach can address all of our cost or quality problems, a stronger focus on promoting health and reducing disparities is a crucial, underused approach to our current health care cost crisis. Effectively addressing the conditions that drive disparities in care has the potential not only to reduce health care expenditures, but to yield better health, productivity, and well-being for our most vulnerable children now and throughout their lives.

ABBREVIATION

CHIP: Children's Health Insurance Program

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