STATEMENT FOR THE RECORD

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"The Rising Cost of Health Care: Considering Meaningful Solutions for all Americans"

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Children are not faring well in our country. On almost every indicator of child well-being, the outcomes of importance to child well-being are declining. As examples, child poverty has more than doubled since 2021, the uninsured rate for children is rising, infant and maternal mortality is on the rise, homelessness is increasing, levels of child hunger are growing, and immunization rates are dropping.

We must do better by our children.

Section 1: The Long-Term Imperative for Covering All Children

Investing in our children's and grandchildren's health is not only a moral obligation – it is a strategy for national prosperity and fiscal responsibility. Children make up nearly a quarter of the U.S. population but account for just 10% of personal health care (PHC) expenditures. The average level of PHC spending for senior citizens is over five times that of children.[1]

Despite the relatively low level of spending on children, the return on investment is still immense.[2] In the context of rising healthcare costs, prevention and early intervention should be guiding principles – and nowhere is this more achievable or important than in child health policy, as savings accrue across a lifetime. Investments in public health programs for children, such as childhood immunizations through the Vaccines for Children (VFC) program, have been shown to have an enormous return on investment (ROI).

As Zhou, et al. report, "Among approximately 117 million children born during 1994–2023, routine childhood vaccinations will have prevented approximately 508 million lifetime cases of illness, 32 million hospitalizations, and 1,129,000 deaths, at a net savings of $540 billion in direct costs and $2.7 trillion in societal costs."[3]

Health coverage programs, such as Medicaid and the Children's Health Insurance Program (CHIP), also reap substantial reductions in overall health care costs, according to research.[4] For example, Currie and Chorniy find that Medicaid and CHIP increase access to health care and improve their overall health by "lowering preventable hospitalizations, chronic conditions, and mortality rates in the most vulnerable children…."[5]

They add that Medicaid and CHIP also have important anti-poverty effects by "increasing economic security, children's educational attainments, and their eventual employment and earnings opportunities."[6]

Consider the case of 12-year-old Deamonte Driver of Maryland, whose life ended after an untreated dental abscess spread to his brain. When Deamonte lost Medicaid coverage due to homelessness, delays in restoring it allowed an infection to spread. He underwent surgeries, weeks in intensive care, and ultimately died – leaving behind hospital bills in the hundreds of thousands of dollars. This tragedy became a nationwide story and symbol of the tragic human and economic consequences that occur when health coverage lapses and prevention is missed due to administrative barriers and burdens.[7]

Unfortunately, Deamonte's story remains painfully relevant. Both his death and significant medical expenses could have been averted by timely, affordable preventive health care. Yet, H.R. 1, the so-called "One Big, Beautiful Bill," focused on achieving $911 billion in Medicaid savings[8], in large part by designing new administrative and bureaucratic barriers that will lead to increased access problems for a growing number of uninsured and underinsured children. When coverage is interrupted, churn ensues, health suffers, and costs – both human and financial – multiply rapidly.[9]

We would never padlock the school doors and then claim that fewer kids need education. Yet that's what administrative disenrollment and bureaucratic barriers do – they prevent eligible children from walking through the front door of care, then count them as no longer in need.

Medicaid and CHIP have historically played a transformative role in reducing the uninsured rate for children by over two-thirds, reaching a record low below 5% in 2016.[10] Their design – centered around pediatric needs and

preventive care – offers a roadmap for how to reduce costs system-wide through early and effective intervention. When we cover children early and consistently without bureaucratic barriers, we will improve individual lives and reduce downstream costs from preventable hospitalizations, untreated conditions, and lost human potential.[11]

A. Achieving Full Coverage, Permanency, and Expansion

1. Make CHIP Permanent

The Children's Health Insurance Program is a bipartisan success story – praised for its cost-effectiveness, outcomes, and tailored design. Since its creation in 1997, CHIP has helped reduce the uninsured rate for children by more than two-thirds, reaching historic lows and providing tailored, pediatric-appropriate coverage to millions. CHIP recognizes that children are "not little adults" and have unique health care needs. It is a model of what works: a targeted, efficient, child-focused program.

Unfortunately, its temporary authorization and periodic expirations put the health of millions of children at risk every few years, turning their well-being into a bargaining chip during budget and extension debates.[12] This uncertainty undermines coverage continuity, provider participation, family stability, and state program innovation.

CHIP is the only federal health coverage program that requires an extension just to maintain the status quo. Congress would never do that to senior citizens and people with disabilities covered by Medicare. Millions of children should be afforded greater certainty as well. Consequently, Congress must end this cycle by making CHIP permanent and protecting it from unrelated political fights by ***passing H.R. 1901, the Children's Health Insurance Program Permanency Act, by Rep. Nanette Barragan (CA)*.**

In the absence of CHIP, millions of children would either migrate to the Affordable Care Act (ACA) Marketplaces, private insurance options, or become uninsured. Past comparisons have found that CHIP provides a more tailored pediatric benefit structure and a stronger pediatric network at much lower costs to both children and their families than alternatives.[13] If affordability and cost-effectiveness are the priority and focus, CHIP is a model program for children.

2. Expand CHIP Eligibility and Coverage Options

States should be empowered to ***expand CHIP eligibility up to 300% of the federal poverty level***. This would allow coverage for children in working- and middle-class families who may fall through the cracks of employer-sponsored plans and the ACA Marketplace.

Additionally, a ***CHIP "buy-in" option*** for families, small businesses, and even ACA Marketplace enrollees could be made available for children because CHIP provides pediatric-focused and affordable care for millions of children.[14] CHIP is already a privately delivered benchmark for what effective, child-centered coverage looks like, and it could act to improve continuity of care for children across the country.

B. Eliminating Administrative Barriers ("Sludge") and Promoting Seamless Enrollment

More than two-thirds of uninsured children are eligible but unenrolled in Medicaid or CHIP. The reasons are typically due to procedural barriers. Bureaucratic "sludge" such as confusing paperwork, redundant verifications, and punitive eligibility systems discourage enrollment. These burdens create chaos and churn for children and families – undermining the very purpose of health coverage.

Technology can be used to improve health coverage, simplify enrollment, alert families to renewals, and automatically keep eligible children enrolled and cared for. When used poorly and deployed punitively, it

becomes an "engine of exclusion." Automated systems that disqualify families for minor paperwork errors or missed notices are not cost-effective; they are cost-amplifying. When children lose coverage due to administrative churn – not because of changes in eligibility – they often miss vaccinations, developmental screenings, and chronic condition management. That results in increased emergency visits, delayed diagnoses, and worsening conditions that could have been avoided.

Far too often, the systems that could help families stay supported are now being used to trigger disenrollments, denials, and harm. Solutions include:

- ***Express Lane Eligibility (ELE):*** States should be incentivized to adopt ELE, which uses data from other public programs (like SNAP or the school lunch program) to streamline enrollment of eligible children into Medicaid or CHIP.
- ***Continuous Eligibility:*** Particularly for children from birth through age six, states should guarantee continuous eligibility to eliminate churn during the most critical period of early development. Congress should overturn the recent Centers for Medicare and Medicaid Services (CMS) withdrawal of this state option by the Department of Health and Human Services (HHS)[15] by ***passing S. 2496/H.R. 4641, the Keep Kids Covered Act, by Sen. Michael Bennet (CO) and Rep. Kathy Castor (FL)***.
- ***Presumptive and Default Enrollment of Children:*** Just as seniors are presumed and auto-enrolled in Medicare at age 65, children should be auto-enrolled in Medicaid/CHIP if they are uninsured and eligible for coverage.
- ***Coverage Improvements for Pregnant Women and Babies***: States should be incentivized to adopt the coverage option for pregnant women in CHIP to ensure that more pregnant women receive prenatal care and that children are covered at birth.

Eliminating these access barriers is not only more humane – it is cheaper. Preventive care is far less expensive than delayed or emergency treatment. Every unnecessary disenrollment is a cost multiplier down the line due to delayed care and associated increased emergency and acute care expenses. Furthermore, eliminating unnecessary churn in and out of Medicaid and CHIP reduces red tape, bureaucracy, and administrative costs.

C. Addressing Children's Unique Health Care Needs, Including Children with Special Health Care Needs (CSHCN)

Children with complex health needs are best served by Medicaid's and CHIP's comprehensive pediatric benefit structures. Nearly half of all CSHCN are covered by Medicaid, which provides services that private insurance does not: cancer treatment, habilitative services, private duty nursing, assistive technology, non-emergency transportation, and targeted case management. These are not extras – they are lifelines. Without them, many children would be institutionalized or face life-threatening gaps in care.

Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit is central here. It ensures that eligible children receive preventive screenings, early interventions, and all medically necessary treatments – critical tools to detect developmental delays or disabilities at a stage when intervention can still change a child's trajectory.[16] Removing EPSDT from Medicaid is like removing the seatbelt from a car to "save money." But without it, the costs from crashes (or in this case, untreated childhood illness) are far greater and dangerous.

Investing in these children's health care upfront is the best path. Prevention, habilitation, and continuity of care reduce long-term expenditures and promote family stability. Conversely, disruption of these services leads to emergency care, institutionalization, and greater dependency over time – all at vastly higher long-term cost to the system.

Section 2: Build Upon Rather than Undermine Child Health

A. The Critical Danger of Arbitrary Funding Caps on Medicaid

Medicaid is a comprehensive lifeline for over 40% of America's children. These programs are designed to expand and contract based on need – automatically adjusting during economic downturns, public health epidemics and crises, natural disasters, demographic changes, and for medical innovations.

Medicaid's financing flexibility is one its important strengths. Proposals to impose per capita caps or block grants would seek to replace that responsive design with rigid formulas that disconnect funding from real-world conditions. This would be a catastrophic shift and would disproportionately harm children, particularly CSHCN, foster kids, and babies.

For example, proposals to arbitrarily impose caps on Medicaid would likely be devastating to children with a congenital heart defect who spend weeks in the neonatal intensive care unit (NICU). States would be incentivized to deny or limit their care, as they would for autism or complex neurological disorders due to cost, even in cases when early treatment is proven to reduce future dependence on services.

Arbitrary caps would be unresponsive by design: ensuring not that Medicaid supports children during crisis, but that it rations care to fit a spreadsheet. And as Sen. John Chafee (RI) said in opposition to a Medicaid block grant proposal in 1995, "As states are forced to ration finite resources under a block grant, governors and legislators would be forced to choose among three very compelling groups of beneficiaries. Who are they? Children, the elderly, and the disabled. They are the groups that primarily they would have to choose amongst. Unfortunately, I suspect that children would be the ones that would lose out."[17]

Two decades later, a different proposal to arbitrarily cap the Medicaid program was moving through Congress and proved Sen. Chafee's point. As the bill moved through the process, changes were made to the cap in a manner that Avalere Health found would cut health care to senior citizens by 1.9% and to children by 31.4%.[18]

Children would have been enormous losers, as caps create powerful incentives to ration care, especially for children with high-cost chronic or complex conditions. Again, cutting pediatric care doesn't save money; it simply shifts costs down the line and into emergency rooms and critical care.

Arbitrary caps and block grants don't modernize Medicaid – they would sabotage child health. They would shift costs onto families, hospitals, doctors, and schools. They undermine prevention, threaten long-term outcomes, and violate a basic principle of justice: that children should not be denied care because of where they live, when they were born, or what illness they happen to face.

B. Protecting CHIP: Maintaining and Strengthening a Pediatric Success Story

Despite CHIP having proved to be an enormous bipartisan success story, it faces two persistent threats: (1) efforts to eliminate or absorb it into broader systems not designed for children, and (2) the instability created by its temporary authorization status and expirations in 2007 and 2017. In the context of a national conversation on health care costs, any proposal to undermine or replace CHIP with inferior coverage options is not only fiscally shortsighted – it would be ethically indefensible.

CHIP is more than insurance: it's a pediatric platform built for children. Efforts to fold it into adult-oriented systems like ACA Marketplaces or Medicare-like models would leave children with higher costs, weaker benefits, and reduced pediatric access to care. While each of these systems serves a purpose in our broader health infrastructure, they were not built with children's unique needs in mind.

Due to the fact that children are far less expensive and healthier than other populations, some have proposed to abolish CHIP and move millions of children into these other systems to help stabilize those insurance markets for others. However, for children, they would be subjected to significantly higher premiums and deductibles, reduced benefit protections, and provider networks that often exclude pediatric specialists. These plans

frequently lack coverage for services, such as habilitative therapy, dental and vision care, or early mental health intervention. They are adult products and not child ready.

Moving children from CHIP into these adult-oriented systems is like giving a toddler an adult-sized bicycle and calling it a solution. It may roll, but it doesn't fit – and the **consequences would be costly and leave millions of children worse off**.

Rather than replace CHIP, we should preserve and strengthen it. CHIP ensures that children have affordable and cost-effective access to the right care at the right time. It is a pediatric safety net, but also a cost-control mechanism that reduces expensive emergency room visits, promotes vaccination and screening, and supports early developmental intervention.

CHIP's greatest flaw is not in its design, but in its status. As a temporary program requiring regular reauthorization, CHIP is subject to the political winds and hostage taking with each extension. Families, providers, and states are left in limbo, unsure whether funding will be renewed. During the 2017–2018 lapse in CHIP funding, some states began sending out disenrollment notices, while families scrambled to find replacement coverage – often at higher cost and with poorer pediatric access.

This instability is needlessly damaging. As noted in Section 1, it is past time for Congress to do what it has done for Social Security, Medicare, and Medicaid: ***make CHIP permanent***.

C. Efforts to Undermine or Repeal the ACA Would Harm Children

For many reasons, children are far better off because of the enactment of the ACA.[19] Here are some of the reasons why repealing or undermining the ACA would negatively impact children:

- **Coverage of Over 2 Million Children**: The ACA currently provides coverage to 2.6 million children.
- **Pre-existing Conditions**: The ACA's protections against insurance exclusions due to pre-existing conditions has protected the health coverage of children with cancer, children born with health conditions, children with asthma, special needs children, etc. If repealed, coverage could be denied to these children, as was the case before 2010.
- **Lifetime and Annual Caps**: Children with special health care needs, including children with congenital heart defects, spina bifida, or kids with cancer, were subjected to annual and lifetime caps prior to the enactment of the ACA. One NICU stay could exhaust their entire lifetime allotment. From there, parents would be forced into medical bankruptcy, or children would go without some therapies and interventions that helped them survive and thrive.
- **Dependent Children's Coverage to Age 26**: The ACA allows dependents to retain access to coverage through their parent's policy. Losing that would subject young adults, including some high school students and recent graduates, back into the ranks of the uninsured.
- **Coverage of Core Services**: Among other benefits, the ACA guarantees coverage of core vision and dental care services for children. This would be threatened by changes to the ACA.
- **Access to Preventive Health Services**: Without the ACA, insurers could return to the practice of charging co-payments for preventive health services, including essential well-baby and well-child visits, and vaccinations, creating financial disincentives for parents to get care for their children that keeps them healthy.
- **Coverage of Former Foster Youth to Age 26**: The ACA also allowed children in foster care to remain qualified for Medicaid from age 18 to 26.

Again, we should ***build upon and not undermine children's health coverage*** in this country.

Section 3: Improving Child Health from Prevention to Emergency Care

No discussion of rising health care costs is complete without addressing the need to improve timely public health measures, health promotion, and emergency care services to children. Disinformation drives up costs by fueling preventable disease outbreaks, delaying essential care, eroding trust in science, overwhelming emergency systems, and politicizing basic public health practices while inappropriate emergency care treatment threatens to increase costs and lives.

A. Vaccine Hesitancy and the Public Cost of Preventable Disease

Public health officials, school nurses, and pediatricians – once widely trusted – are increasingly targeted by disinformation campaigns. Harassment has driven many experienced public health leaders from their roles, weakening the very systems that prevent disease outbreaks and protect children. When trust erodes fewer families vaccinate their children, school-based health initiatives face resistance, and outbreak containment becomes politicized rather than coordinated.

Investing in public health science, transparent communication, and evidence-based care is not only a moral imperative: it is a cost-containment strategy**.** Every dollar invested in public health yields an estimated $14 in avoided medical costs,[20] but only when families trust the system enough to engage with it.

Vaccination has been one of the most cost-effective and life-saving public health interventions in human history.[21] Yet vaccine hesitancy – fueled by misinformation and disinformation – has led to troubling declines in childhood immunization rates. In some areas, kindergarten MMR (measles, mumps, rubella) coverage has dropped below the 95% threshold needed for herd immunity.

This decline is not only a public health threat – it is an economic one. At the present time, we are seeing a resurgence of measles and pertussis cases across this country –preventable conditions. These outbreaks can cost millions of dollars in emergency response, school closures, contact tracing, and lost productivity.

Disinformation also raises the cost of governance. When families no longer trust the immunization schedule, the pediatrician's advice, or the school nurse's guidance, the entire system becomes more expensive, more reactive, and less effective.

We must recognize that truth and trust are cost-containment tools. Investing in public education campaigns, supporting evidence-based communication, and defending children's access to care are not partisan acts – they are public health imperatives. We cannot afford a future where the loudest voices on health care are not doctors or parents, but algorithms pushing falsehoods. Nor can we build a sustainable health system if we allow disinformation to take root where prevention and early intervention once stood.

B. Maternal, Infant, and Early Childhood Health

The United States has some of the highest and most racially disparate rates of infant and maternal mortality in the world. The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program is a federal grant program to states, territories, and tribes that supports early childhood home visiting programs with documented, evidence-based success, for families from pregnancy through a child's entry into kindergarten. MIECHV shows positive results in six benchmark areas critical to strengthening families, including in improved maternal and newborn health. The government saves more than $32,000 per child served through home visiting, and over an individual's lifetime, benefits exceed costs by at least 20% and up to more than 200%.[22,23]

Currently, Medicaid pays for some home visiting in some states, depending on the model, state interest, and capacity for obtaining reimbursement. Home home visiting shows benefits in numerous areas, including maternal and child health and social determinants of health. Medicaid should do more

to support home visiting services. This can include helping community organizations outside of the traditional health system understand how to effectively bill Medicaid and how to use Medicaid to cover home visiting alongside other federal funding; incorporating home visiting into EPSDT; or for states that have adopted the 12-month postpartum coverage option, using a complementary benefit category to cover home visiting under extended pregnancy services for pregnant and postpartum mothers.

C. Pediatric Emergency Care: A System Misaligned with Children's Needs

While gun violence is a tragic and urgent pediatric emergency, children also face daily risks that require rapid and specialized emergency care. Yet the vast majority of general emergency departments in the U.S. are not equipped or staffed to treat children properly.[24]

Pediatric emergencies require age-appropriate equipment, medications, and trained staff. A neonate, a toddler, and a teenager each have dramatically different needs when it comes to resuscitation, intubation, and IV access. Most emergency departments lack the right-sized equipment – including child-specific laryngoscopes, suction catheters, or blood pressure cuffs.[25]

Reforming pediatric emergency preparedness is essential not only to reduce mortality and morbidity, but also to control costs: when children are treated correctly the first time, we avoid costly complications, transfers, and readmissions. A national commitment to strengthening pediatric readiness in emergency departments is a cost-effective, life-saving investment in the future.

Section 4: Gun Violence, Trauma, and the Health Cost to Children and Communities

Gun violence has become the leading cause of death for children and adolescents in the United States – a fact that should provoke national mourning, a public health mobilization, and a reordering of policy priorities.[26] Instead, we too often receive moments of silence instead of systems of safety.

This hearing is focused on the rising cost of health care. Gun violence belongs squarely in that conversation. It is a driver of emergency department overload, long-term rehabilitation costs, mental health crises, and educational disruption. But it is also a crisis of inaction in which political paralysis has allowed avoidable trauma to become normalized, especially for children.

Every pediatric trauma surgeon in America now trains for bullet wounds. Children are shot in their homes, at their schools, in parks, in cars, and at birthday parties. Each gun injury comes with immediate costs: emergency surgeries, intensive care stays, long-term physical rehabilitation, bereavement and mental health services for survivors and communities, families who miss work, schools that must close, law enforcement and public health officials responding to the scenes, etc.

These are not theoretical: they are real costs to hospitals, insurers, and families, often ending in debt and long-term disability. Estimates place the societal cost of gun violence in the U.S. at approximately $280 billion annually, encompassing medical care, emergency response, lost productivity, and reduced quality of life.[27] Children carry these burdens in silence. Their nightmares are not calculated in federal budget models, but they show up in school nurses' offices, ERs, and pediatric therapy sessions across the country.

If a virus were killing this many children, we would have declared a national emergency. But because it is bullets and not bacteria, we too often fail to act. ***Improving gun safety and continuing to fund gun violence prevention research could save billions of dollars in the health care system and save the lives of children***.

Section 5: Protecting the Health of Children in Immigrant Families

Any serious effort to control health care costs must ensure that all children, including those in immigrant families, can access timely, affordable care. Denying coverage or creating fear-based barriers does not deter illness – it delays treatment, worsens conditions, and ultimately increases costs to hospitals, taxpayers, and communities.

A. Eliminating the Five-Year Bar and Coverage Restrictions

The state option to allow residing immigrant children and pregnant women to access Medicaid and CHIP should be protected and retained. No child battling cancer, cystic fibrosis, asthma, or congenital heart disease can wait five years to receive care. Furthermore, imposing a five-year waiting period on pregnant woman is nonsensical.

Although there are proposals to require a five-year bar for all legal immigrant children and pregnant women, such a policy would be inhumane and fiscally irresponsible. Early care reduces emergency room use, preventable hospitalizations, and long-term disability in children, and again, a five-year bar for pregnant women is simply ludicrous.

B. The "Chilling Effect": Fear That Keeps Families Away from Care

Policies requiring hospitals to report or collect immigration information create a powerful "chilling effect," discouraging immigrant families — including U.S.-born citizen children — from seeking needed care. When families fear that a hospital visit could lead to immigration consequences, they avoid preventive visits and only present for care when a condition has become severe or life-threatening.

This results in more emergency room visits, higher uncompensated care costs, delayed diagnoses, preventable disabilities, and increased strain on pediatric emergency and specialty systems. Avoiding these costs requires building trust, not erecting bureaucratic barriers.

Rather than cutting access to care for legal immigrant children or children in immigrant households, we would ***urge the Senate to strive to enable all children to obtain health coverage in this country***.

Final Thought: Build with Children at the Center

The Senate Finance Committee has a historic opportunity to redesign a health system that is **pro-child, pro-prevention, and pro-value**. This moment demands not only fiscal prudence, but moral clarity: our children are not line items. They are patients, students, future workers, and emerging voters.

The policy choices outlined here determine whether we choose bureaucracy over compassion, rhetoric over investment, and neglect over progress. We urge the Senate to start by fulfilling our fundamental obligation: ensuring all children have the stable coverage, age-appropriate benefits, and safe environments necessary to thrive. We must commit to improving coverage, not gambling with our children's health.

The Senate should also keep in mind that the share of federal investments in children has dropped from a high of 11.98% in 2021 to just 8.57% in 2025 – a more than 30% decrease in the share in the last four years.[28] The children's share is projected to decline dramatically in the coming years. We would urge the Senate to take children off the chopping block.

Furthermore, as the Senate considers health policy changes, we urge senators to consider one simple question before taking action: Is it good for the children?

ENDNOTES

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