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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

What Should Be the Nature and Scope of Pediatricians’ Duties to Keep Their Patients Insured?

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Abstract

Access to health care is a key structural determinant of health, with lack of health insurance as a main barrier. In the United States, nearly half of children rely on Medicaid or the Children’s Health Insurance Program for health insurance. Children’s eligibility for coverage under these programs is income dependent and can vary over time, so changes in insurance status signal a need to screen for unmet structural needs. Clinicians, who are obligated to respond to what screening reveals, should be prepared to help deploy practice-based, health system, and community resources to help meet the needs of children and families.

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Case

DD lives in a rural state, works 2 jobs, and is a grandparent and legal guardian of 3 children under the age of 12. DD’s English language proficiency is limited, so DD brings a letter she received in the mail for review by Dr P, the children’s pediatrician. The letter states that, unless several forms are completed, DD’s grandchildren will be ineligible for the state’s Medicaid insurance coverage. Dr P walks DD and her grandchild to the front desk and says, “Our staff will help you with this paperwork,” and then moves on to their next patient.

A member of Dr P’s office staff looks briefly at the letter and informs DD, “You need to find these forms on the internet, print them, fill them out, and then send them to the address on the bottom of the letter.” Office staff members are overwhelmed with helping patients complete enrollment paperwork and structural determinants of health (SDoH) screening documentation.

Three months later, when DD brings one of the grandchildren to Dr P, Dr P’s office staff inform DD that the child is no longer enrolled in Medicaid. DD’s grandchild is part of the 72% of individuals disenrolled from Medicaid for procedural reasons.[1]

Commentary

Events experienced by Dr P, Dr P's staff, DD, and her grandchildren are, unfortunately, likely all too familiar to clinicians working in US primary care settings, particularly those serving under-resourced communities. Defined by the National Academies of Science, Engineering, and Medicine (NASEM) as the "timely use of personal health services to achieve the best possible health outcomes,"[2] access to health care is a key SDoH.

Lack of health insurance or inadequate health insurance coverage is among the most common barriers to health care access.[3] Among all children, those who identify as American Indian or Alaska Native or as Hispanic,[4] and those in the South and West,[5] are most likely to lack health insurance. In the absence of health insurance coverage, many choose to delay or forego care, further contributing to health inequity. Uninsured children are less likely than insured children to have a regular source of care and more likely to have unmet dental and preventive care needs, including immunizations.[6,7] Moreover, children with chronic conditions without health insurance are less likely to receive appropriate treatment, increasing their risk for morbidity and mortality across the lifespan.[8,9] In general, pediatric patients are more likely to fragment their care across primary and emergency department care,[10] thereby increasing opportunities for errors and for gaps in services that could be prevented—and duplication of services that could be provided—through a medical home.

Accessing Health Insurance

Today, for nearly 40% of US children, health insurance coverage is synonymous with Medicaid enrollment.[11] Medicaid, jointly financed by states and the federal government, was first expanded to include children in 1984.[12] In 1997, the State Children's Health Insurance Program (now the Children's Health Insurance Program, or CHIP) was established to provide a public option for children left out of employer-based insurance systems who resided in low- and moderate-income households with incomes exceeding Medicaid's upper income limits.[13] Under the Affordable Care Act of 2010, income limits nationwide for Medicaid eligibility for citizen children under 18 years of age were increased to 138% of the federal poverty level,[14] with some states choosing to expand even higher. In addition, Medicaid serves as a key source of supplemental insurance for children with special health care needs for whom employer-based coverage is insufficient to cover their care.[15] Eligibility varies by state: in some states, lawfully residing immigrant children and pregnant women are immediately eligible, while others first require 5 years of residence.[15] However, children's eligibility for these programs, which is tied to household income, can vary substantially over time. Frequent changes in insurance status, referred to as "churn,"[3] can incur substantial administrative burden (time costs, psychological impact, stigma)[16] for families and result in disruptions in care as substantial as those experienced by children who lack insurance altogether.

Despite limitations on eligibility, Medicaid and CHIP coverage helped reduce the percentage of children without health insurance from 12.3% in 1980 to an all-time low of 4.8% in 2015.[15] Among families in one state's CHIP program, unmet needs for dental care, mental health care, and eye care decreased and visits for routine care increased within a year of enrollment without concomitant increases in emergency department care or hospitalizations.[17] Since 2015, however, the percentage of children without insurance has steadily increased to 5.3%,[18] largely due to losses in Medicaid coverage. Reasons for Medicaid losses include policy reversals to streamline enrollment and renewal, temporary expansion of the public charge rule to include Medicaid use,[19] and, most recently, Medicaid unwinding efforts (ie, the end of continuous coverage) following the COVID-19 pandemic,[20] with the result that an estimated 4.7 million fewer children were enrolled in Medicaid and CHIP by January 2025 than at peak enrollment in April 2023 at the start of unwinding.[20]

Responding to Structural Determinants

As "babies don't go to the doctor by themselves,"[21] pediatricians are charged with not only delivering care to the child in their exam room but assessing and diagnosing the child's family context. In the case of DD, her limited English language proficiency, combined with a request for assistance with the Medicaid enrollment forms, should signal to Dr P that this family likely faces other health-related social needs (including, but not limited to, food needs, housing, and legal aid) and would benefit from connection to services that address her household's health-related social risks.

The 2019 NASEM consensus report, *Integrating Social Care Into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health*,[22] provides a useful framework whereby individuals and organizations can tailor their approach to coordinating such care. The framework identifies 5 strategy areas that can be implemented individually or in combination to increase the likelihood that patients can access and make optimal use of health care services in a timely fashion.

Awareness. As a minimum standard, every clinical team should engage in "activities that identify the social risks and assets of defined patients and populations," such as by screening all patients at a regular cadence or leveraging population-level data to inform practice.[22] A growing body of research indicates that universal approaches to such awareness activities mitigate practitioner bias and patient experience of stigma.[23,24,25] Thoughtful planning of SDoH screening and documentation workflows is essential to ensure that such screening is implemented not merely as a "box-checking" activity[26] but in alignment with patient preferences, as well as staff skills and capacities. A practice-level needs assessment can be useful in determining the social needs most likely to impact the population served and thus inform which screening questions should be universally asked and how those questions should be framed.

Notably, many commonly used SDoH screening tools for children do not include specific questions about insurance status,[27] perhaps because most are designed for implementation in the context of a health care visit that presupposes health insurance coverage. It is therefore important for pediatric practices to have a good understanding of the populations they serve and tailor their SDoH screening activities accordingly—for example, by adding a question to their screening protocol to elicit parent concerns regarding insurance. Practices may also leverage extant tools embedded within the electronic medical record to alert team members to patients who are without, or who are at risk of losing, health insurance. Practice workflows and documentation procedures should prioritize upstream opportunities to identify unmet needs and intervene early.[25]

Adjustment. The NASEM report defines adjustment as "activities where social risk information is used to inform clinical care decision making."[22] In DD's case, such adjustment might include providing language- and literacy- concordant information resources (eg, handouts, flyers, videos),[28] integrating interpreter services into the appointment,[29] and extending appointment times,[30] with a scheduling flag applied to all of her grandchildren's charts to signal these needs. When balanced against lost revenue due to Medicaid disenrollment and no-shows, interpreter services have been demonstrated to be nearly cost neutral,[31] while manifesting the ethical commitment to ensure clear communication with families[32] and quality care.[29]

Assistance. The NASEM report defines assistance as "strategies to link patients with social needs to government and community resources."[22] Assistance can take many forms, depending on the resources available to the clinical team and accessible in the broader community. Within a given practice, options for assistance range from provision by the clinician of a language-concordant resource list to active navigation of resources by volunteers[33] or employed community health workers.[34] Where space, funds, or other considerations limit face-to-face intervention, referral to community-based social care resources may be necessary. In DD's case, rather than verbally directing her to search the internet for the correct application, office staff could instead provide a flyer in her preferred language that provides instructions, contact information, and hours for local organizations that focus on Medicaid enrollment. In many communities, local libraries and neighborhood family service centers are staffed to support those who need help applying for public health insurance. 2-1-1 is another widely available service providing free and confidential referral services.[35] For Dr P, an effective strategy could be for Dr P's front desk team to verify DD's current address, telephone number, and other relevant contact information at every visit. Caregivers like DD often miss communications from Medicaid and other social services because of frequent changes in residential address and telephone number.

For practices that function within larger hospital or health systems, it is also important to identify any internal (in-system) financial assistance resources. For example, financial counselors might be available to assist patients with insurance enrollment or, at a minimum, to help patients get on a payment plan until their insurance can be reinstated.

Alignment. Alignment is defined as "[a]ctivities undertaken by health care systems to understand existing social care assets in the community, organize them to facilitate synergy, and invest in and deploy them to positively affect health outcomes."[22] While less often implemented than the other strategies, alignment strategies can help mitigate the "wrong pocket problem" by supporting health systems' and funders' investment in those individuals and organizations best positioned to provide SDoH resources to patients and their families.[36] Alignment activities typically occur at the organizational level, examples of which might include investment in infrastructure to facilitate electronic referrals and closed-loop communication between health care and community organizations or direct funding of community-based personnel. In Dr P's case, alignment might take the form of working with the state's Medicaid program, managed care providers, or local health system to support the presence of an in-practice-facilitated enroller so that caregivers like DD can meet with an expert in a comfortable and familiar location.

Advocacy. Advocacy concerns "activities in which health care organizations work with partner social care organizations to promote policies that facilitate the creation and redeployment of assets."[22] Advocacy can take many forms—from local efforts to inform and educate the public on the impact of a current or proposed policy to formal legislative advocacy. In the case of seismic events, such as Medicaid unwinding, pediatricians and practices can serve as key communicators to impacted families by posting signage in waiting areas, by having staff wear buttons, or by disseminating informational flyers to families to maximize awareness of what may be coming and what steps they may need to take to preserve coverage. For example, in advance of the

Medicaid unwinding, the authors' team sent out a series of letters to all patients in the practice, informing them of the upcoming change and alerting them to the forthcoming communication from state Medicaid, the timeline for response, and resources available to them in the practice and community if they had questions or concerns.

Pediatricians and health care systems also have opportunities to advocate for more far-reaching solutions to barriers to enrollment in state Medicaid programs, such as improving automated renewal procedures, simplifying renewal forms, extending time to respond to renewal notices, increasing income eligibility levels for children, and extending continuous coverage periods for young children. Indeed, between 2020 and 2024, 25 US states reported having made efforts to expand children's Medicaid and CHIP eligibility and reduce churn by increasing income eligibility or eliminating the 5-year enrollment wait for lawfully residing immigrant children and by otherwise reducing administrative barriers to enrollment.[37]

Conclusion

Health insurance is foundational to children's access to health care, and thus even in the face of competing demands, helping families to acquire and sustain health insurance coverage for their children must be a high priority to clinicians, practices, and health systems. Given that access to care is a key SDoH, lapses in health insurance should trigger assessment of and response to related structural needs. Although practices can devise their own response strategies, they should also leverage health system, community-based, and policy approaches to ensure that all children are afforded the opportunity for optimal health.

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