sors, and mercury that fossil-fuel combustion generates. By one account, nearly half a million people in the United States died between 1999 and 2020 as a result of exposure to particulate emissions from burning coal.[4] In addition, the processes of extracting coal and natural gas have adverse health consequences. Living near natural gas fracking areas, for example, has been linked to an increase in the risks of leukemia in young children, low birth weight and preterm births, childhood asthma, and premature deaths in older adults.[5] The OBBBA also includes myriad other harmful provisions, such as rescinding block grants for antipollution programs in underserved communities and (incredibly) repealing funding to reduce diesel emissions and air pollution near schools.

The IRA set the United States on a path toward a cleaner-energy future. The OBBBA sharply reverses course. Some observers claim that since market forces are driving a shift to clean energy because of its relatively low production costs, the law s energy provisions will not meaningfully slow the reduction in GHG emissions. The OBBBA s aim, however, is to disrupt these forces by eliminating the cost advantages of clean-energy production and displacing it with highly subsidized fossil-fuel production. The many resulting health harms are likely to disproportionately affect already-disadvantaged communities, including those located near sources of conventional air pollutants such as electric power plants or in low-lying areas at greater risk for flooding owing to climate change. As those consequences manifest, Americans are likely to regard the OBBBA as sickening, not beautiful.

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Medicaid Cuts and U.S. Children s Health Fixing a Broken System

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U.S. children are not all right, and neither is the health care system that serves them. Medicaid cuts, a centerpiece of the 2025 One Big Beautiful Bill Act (OBBBA), will exacerbate these problems. A strategy for improving children s health care is urgently needed.

Children in the United States have faced rising rates of chronic conditions, psychological stress and psychiatric illness, and fatal injuries in recent years, and they are nearly twice as likely as children in other high-income countries to die. These trends have occurred alongside growing pediatric workforce shortages; reductions in preventive care, which have been exacerbated by misinformation and threats to vaccine access; and increases in unmet health care needs.

Medicaid, which covers 4 in 10 U.S. children, is a critical driver of children s health and shapes the pediatric health care landscape in the United States. Although the OBBBA s Medicaid provisions target adults, there are several mechanisms by which the legislation could harm children.

First, reduced insurance coverage and increased out-of-pocket health care costs for parents and caregivers will jeopardize coverage and access to care for children. When parents gained coverage under the Affordable Care Act (ACA) Medicaid expansion, Medicaid enrollment and health care access increased among their Medicaid-eligible, but previously unenrolled,

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children. The OBBBA will most likely have the opposite effect. Some parents and caregivers, including childcare workers, covered by Medicaid expansion will lose coverage because of work and eligibility-redetermination requirements, in many cases owing to procedural red tape. Coverage losses will increase mental distress and financial strain among parents and caregivers, which could increase the risk of child maltreatment.

New limits on some pediatric provider payments are also expected to reduce children s access to care. The OBBBA limits states ability to direct Medicaid managed care plans to increase provider payments, as some have done in the past. Low payment rates have already made pediatrics one of the lowest-paid specialties and limited Medicaid participation among pediatric clinicians, which has contributed to poor health care access and outcomes for children. One study found that increases in Medicaid payments for pediatric clinicians were associated with reductions in chronic school absenteeism attributable to injury or illness.[1]

In addition, policies pertaining to state taxes on providers will undermine coverage for children with extensive medical needs. The OBBBA prohibits states from implementing new provider taxes and caps existing taxes. States use these taxes to fund their share of Medicaid spending. Given tighter budgets, states will probably constrain optional eligibility and benefits, potentially including eligibility for children with disabilities in Katie Beckett or Family Opportunity Act programs. Optional benefits include disability-support services, such as home modifications to help children with disabilities live at home, and school-based health care services.

Reductions in retroactive Medicaid coverage will most likely increase the amount of uncompensated care provided by children s hospitals, which could curb access to care. The OBBBA allows Medicaid to cover services provided to children and adults who are eligible for but unenrolled in traditional Medicaid up to 60 days before Medicaid enrollment, as compared with the previous limit of 90 days. Increases in uncompensated care associated with this change could be particularly problematic for children s hospitals. Lower margins could lead hospitals to employ fewer specialists, a shift that would affect all children.

Finally, the OBBBA revokes Medicaid eligibility for many lawfully present immigrants, including eliminating coverage for some immigrant children in the 13 states that don t cover them under the Immigrant Children s Health Improvement Act option. Moves by the Centers for Medicare and Medicaid Services (CMS) to share Medicaid data with Immigration and Customs Enforcement, which will deter Medicaid enrollment and prevent families from seeking care for their children, could compound these effects.

Medicaid cuts will worsen the state of U.S. children s health. Both near-term innovations that respond to the OBBBA and a longer-term strategy for enhancing children s health will be required. When the policy window for strengthening Medicaid ultimately opens, health policy experts should be ready with actionable, evidence-driven reforms.

Several overarching goals could guide these responses. First, policymakers should strive to maximize children s insurance coverage. Insurance coverage reduces rates of forgone care and promotes uptake of preventive services among children, which leads to improved health and economic success in adulthood. Second, it will be critical to enhance the pediatric workforce. Third, integration of behavioral health services into pediatric care should be emphasized to improve access to such services. Finally, stronger connections should be established between the children s health care system and social services to prevent and mitigate adverse childhood experiences, poverty, and food insecurity, which drive poor health throughout the life course.

In the near term, states need budget-neutral or cost-saving strategies for supporting children s health. Coverage initiatives should prioritize maintaining enrollment among children whose parents become ineligible for Medicaid or are at risk for disenrollment because of paperwork issues. States gained experience in this area during post-pandemic Medicaid unwinding, when some developed promising strategies for maintaining enrollment, including partnering with Medicaid managed care organizations to prevent procedural disenrollment and using administrative data to make automatic eligibility determinations. Approaches such as transdiagnostic brief behavioral therapy, which involves targeting common mechanisms underlying various psychiatric conditions and is more cost-effective than standard referral to specialty treatment,[2] can support behavioral health integration in the OBBBA era.

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A budget-neutral approach to boosting payments for pediatric clinicians would be to reduce payment rates for services that have become more efficient with the introduction of new technology and reinvest those funds in pediatric services. CMS has proposed similar efficiency adjustments in the Medicare physician fee schedule. State excise taxes on recreational cannabis and settlement funds from state lawsuits against opioid manufacturers may offer alternative funding streams for pediatric behavioral health and social services. For example, New York is using opioid-settlement funds to support substance use disorder recovery services for young people and recreational cannabis excise taxes to fund services to address adverse childhood experiences.

States will be forced to innovate in response to the OBBBA. A concerted effort to learn from those innovations and from existing programs, such as the Integrated Care for Kids APM, is imperative.

For the longer term, children s health coverage and care will require a reimagining that includes increased government funding, rather than cuts. Children s Medicaid coverage is a sound economic investment that is associated with reduced preventable mortality and disability and increased employment in adulthood. Universal childhood coverage, combined with sustainable pediatric health care payment and delivery models, could promote better health throughout the life course and help control spending growth. Strategies for achieving universal coverage should be developed and assessed. One example is a recent proposal to combine Medicaid, the Children s Health Insurance Program, and the ACA exchanges into a national marketplace that automatically enrolls all uninsured Americans, including children, with out-of-pocket costs based on income.[3] To bolster the workforce, higher payment rates in pediatrics and enhanced pipeline and loan-repayment programs for early-career clinicians will be essential.

Alternative payment models (APMs) that tie health care financing to value have the potential to reduce clinician burnout stemming from volume-based, fee-for-service models and to support integration of behavioral health and social services by holding historically fragmented sectors jointly responsible for children s health. Pediatric APMs have gained limited traction, however, since there are fewer opportunities to generate short-term cost savings in children s care than in adult care. Pediatric APMs require different features than adult APMs, such as whole-family services (e.g., parenting programs) and financial incentives that are tied to metrics predicting future health outcomes and cost savings (e.g., developmental assessments and mental health screening and treatment metrics).[4]

Shorter-term cost savings associated with improved pediatric health care can accrue in nonhealth sectors for example, by means of reductions in the need for special education or child-welfare services which highlights the importance of cross-sectoral measures and partnerships.[4] Six states are implementing CMS s Integrated Care for Kids APM, which incorporates some of these principles. For example, North Carolina s program ties financial incentives to emergency department utilization and kindergarten-readiness services.

States will be forced to innovate in response to the OBBBA. A concerted effort to learn from those innovations and from existing APMs is imperative. New efforts should be modeled on past successes, such as the passage of federal mental health parity legislation in 2008, which was enabled by research partnerships with payers and the convening of researchers, actuaries, and government policy experts to address specific, actionable policy issues.[5] Leaders in various sectors could collaborate to develop a cohesive strategy for supporting health care early in life, when interventions can have the longest-lasting and most meaningful effects.

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If You Break It, They Won t Come

In Season 3, episode 4, of the Not Otherwise Specified podcast, host Lisa Rosenbaum and her guests explore the fraught relationship between medical training and primary care and why even trainees who once aspired to be PCPs are changing course midstream.

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