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Policy Brief

National Security and U.S. Child Health Policy: The Origins and Continuing Role of Medicaid and EPSDT

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Executive Summary

Medicaid has touched the lives of half of all of the low income young adults of prime military service age. The roots of Medicaid's unique child health eligibility and coverage policies can be traced to a seminal, 1964 government study entitled *One Third of a Nation: A Report on Young Men Found Unqualified for Military Service*. This study analyzed the underlying causes of the astounding 50 percent rejection rate among the young men drafted into the military in 1962. It documented pervasive evidence of treatable and correctable physical, mental, and developmental conditions, and its findings influenced the course of Medicaid legislation for children, particularly the comprehensive coverage available to children under the EPSDT program. This 1964 report remains relevant in a modern era of national security concern and serves to underscore Medicaid's ongoing importance to children and adolescents.

Introduction

One in every two young adults between the ages of 18 and 24 and of prime military service age comes from a low-income family.¹ Among this group, there is a one-in-two chance that Medicaid will have touched their lives at some point during childhood.²

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¹ Twice the Federal poverty level (FPL) is \$32,180 for a family of three in 2005. See HHS poverty guidelines at <http://aspe.hhs.gov/poverty/05fedreg.htm>. The percentages of low-income adults aged 18-24 varies by percentage of FPL. According to the March 2004 Annual Social and Economic Supplement of the Current Population Survey, in 2003, 37.3% of adults aged 18-24 (10.4 million) lived at 200% of the FPL; 55.8% (15.5 million) lived at 300% of the FPL; and 69.2% (19.3 million) lived at 400% of the FPL. *Source*: U.S. Bureau of the Census, Current Population Survey. (2004). "POV01. Age and Sex of All People, Family Members and Unrelated Individuals Iterated by Income-to-Poverty Ratio and Race." Available at: http://pubdb3.census.gov/macro/032004/pov/new01_000.htm. See also the Appendix to this policy brief presenting a special analysis of the March 2004 CPS Supplement by age group of children and young adults at 200% and 400% of the FPL prepared by the Kaiser Commission on Medicaid and the Uninsured and the Urban Institute. At 200% FPL, 38% of 18-year-olds and 17% of 19-to-24-year-olds were covered

by Medicaid; at 400% FPL 23% of 18-year-olds and 14% of 19-to-24 year-olds were covered by Medicaid.

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This Policy Brief is part of a project funded by the Robert Wood Johnson Foundation's program to study Changes in Health Care Financing and Organization (HCFO); its purpose is to examine Medicaid's role in financing health care for members of the U.S. military and their families. This analysis explores Medicaid's child health policy roots in national security.

Although Medicaid's importance for children has been extensively documented,³ these national security roots have been forgotten by most. Indeed, the Medicaid child health eligibility expansions enacted during the Reagan and first Bush Administrations,⁴ which virtually doubled program coverage, are the direct descendents of this history, which in great measure can be traced to a seminal Presidential study that documented the poor health status of young military recruits.

The imperative to focus on Medicaid's role in child health policy is considerable because of Medicaid's sheer reach into the child population. Single-year enrollment numbers show that Medicaid now reaches more than 25 percent of all children, 60 percent of poor children (at or below 100% of the Federal poverty level), and 39 percent of near-poor children (between 100% and 200% of the Federal poverty level).⁵ But even these figures understate Medicaid's reach over time into the population of lower-income children and adolescents from whom the U.S. military forces disproportionately are drawn.⁶

Child health policy has been a pivotal theme in Medicaid since its original enactment. Attention originally was focused on eligibility; within two years, however, this focus would be extended to the actual range and depth of Medicaid coverage for children and adolescents. Evidence of the poor health status of young military recruits played a powerful role in this set of policy reforms,

² See Appendix for methodology used to calculate this estimate.

³ See, e.g., Children's Defense Fund, *EPSDT: Does it Spell Health Care for Poor Children?* (Children's Defense Fund, Washington D.C., 1977); Children's Defense Fund, *Doctors and Dollars are Not Enough* (Washington D.C., 1977); Anne Marie Foltz, *An Ounce of Prevention: Child Health Politics Under Medicaid* (MIT Press, Cambridge, MA, 1981); Herz EJ, Chawla AJ, Gavin NI. (1998). Preventive Services for Children Under Medicaid, 1989 and 1992. *Health Care Financing Review* 19(4):25-44; Sardell A, and Johnson K. (1998). The Politics of EPSDT in the 1990s: Policy Entrepreneurs, Political Streams, and Children's Health Benefits. *The Milbank Quarterly* 76(2): 175-205; Rosenbaum S and Sonosky CA. (2001). Medicaid Reforms and SCHIP: Health Care Coverage and the Changing Policy Environment. In C. J. DeVita & R. Mosher-Williams (Eds), WhoSpeaksforAmerica'sChildren? TheRoleofChildAdvocatesinPublicPolicy (pp. 81-104). Washington, DC: Urban Institute Press; Klerman, LV. (1991). "Alive and Well? A Research and Policy Review of Health Programs for Poor Young Children." New York, NY: National Center for Children in Poverty; O'Connell M., Watson, S. (2001). "Medicaid and EPSDT." Neighborhood Legal Services, Buffalo, NY Available at: <http://www.nls.org/conf/epsdt.htm>; Olson K, Perkins J, Pate T. (1998). "Children's Health Under Medicaid: A National Review of Early Periodic Screening, Diagnosis, and Treatment." National Health Law Program. Available at: <http://www.healthlaw.org/pubs/child1998healthxsum.html>.

⁴ Rowland, D., Salganicoff, A., Keenan, P.K. (1999). The key to the door: Medicaid's role in improving health care for women and children. *Ann. Rev. Public Health* 20:403-26.

⁵ Kaiser Commission on Medicaid and the Uninsured. (2004). "Key Facts: Health Coverage for Low-Income Children -- September 2004 Update." Available at: <http://www.kff.org/uninsured/2144-04.cfm>. Accessed April 25, 2005.

⁶ See footnote 1 supra and the Appendix for estimates of poverty rates by age group as well as a discussion of the income estimates derived from the 1998 Department of Defense Population Report (available at: http://www.dod.mil/prhome/poprep98/html/7-index_scores.html). Accessed April 25, 2005.

and at a time when national security and preparedness concerns have once again become prominent features of U. S. policy landscape, this historical context is worth exploring.

This Policy Brief begins with a brief overview of Medicaid and child health, examining both its early eligibility structure as well as the advent of Medicaid's special benefit for children, which is known as "early and periodic screening, diagnosis and treatment (EPSDT)." The Brief then describes the findings from this pivotal 1964 study that so strikingly influenced Medicaid's child health policy: *One Third of a Nation: A Report of Young Men Found Unqualified for Military Service*. The Brief concludes with a discussion of the continued relevance of this history to Medicaid reform.

Background and Overview: Medicaid Child Health Policy

Beginning in 1965, Medicaid was designed to cover low-income children from birth through young adulthood. Consistent with welfare program eligibility rules of the time,⁷ the original Medicaid legislation made coverage of children under age 21 living in families who received Aid to Families with Dependent Children (AFDC). At the same time, the statute also gave states the option to extend coverage to all children under age 21 living in low-income families who did not qualify for cash welfare. This state option to extend coverage to all low-income children was unanimously adopted by the Senate in response to a Floor amendment offered by Senator Abraham Ribicoff of Connecticut.⁸ By the early 1980s, when the modern period of Medicaid child health expansion commenced, approximately half of all states had pursued this option.⁹

Although the original Medicaid legislation provided states with an option to expand eligibility, the original Act did not provide for special standards related to the coverage of children; no minimum preventive and developmental benefit package was specified, nor were there requirements related to outreach to families and support in securing services.

The Medicaid EPSDT amendments were part of a larger package of reforms sent to Congress by President Johnson in 1967, which were aimed at improving the availability and quality of pediatric health care throughout the U.S.¹⁰ In his Letter to Congress transmitting his child health recommendations, the President stated:

Recent studies confirm what we have long suspected. In education, in health, in all of human development, the early years are the critical years. Ignorance, ill health, personality disorder—

⁷ In 1981 the maximum age limit for AFDC benefits was reduced from 21 to 18. (1981 Omnibus Budget Reconciliation Act, Public Law 97-35). In 1996 AFDC was repealed and replaced with the Temporary Aid to Needy Families (TANF) program. The maximum age limit for children under TANF is set at 18 (or 19 if child is a full-time student in a secondary school (or in the equivalent level of vocational or technical training)). (Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law 104-193).

⁸ Anne Marie Foltz, *An Ounce of Prevention: Child Health Politics Under Medicaid*. supra note 3, pp. 18-19.

⁹ Sara Rosenbaum and David Rousseau, "Medicaid at Thirty Five" *St. Louis University Law Journal* 45:1 pp. 1-71 (Winter, 2001). See also, *The Deficit Reduction Act of 1984*, House of Representatives Conference Report no. 98-861, GPO 35-426 0 (Washington, D.C.: US. GPO, 23 June 1984) for a discussion of how many states opted to extend coverage to poor children regardless of their family's work status or family composition.

¹⁰ United States House of Representatives, Committee on Ways and Means, Hearings on the President's Proposals for Revisions in the Social Security System. (GPO, Washington D.C., 1967).

these are disabilities often contracted in childhood: afflictions which linger to cripple the man and damage the next generation. Our nation must rid itself of this bitter inheritance. Our goal must be clear—to give every child the chance to fulfill his promise. Even during these years of unparalleled prosperity: [...] more than four million children will suffer physical handicaps and another two million will fall victim to preventable accidents or disease....

Under the Medicaid program enacted in 1965, the 25 states now in partnership with the Federal Government will help pay hospital costs and doctors' bills for more than 3.5 million poor children this year. By next year, we expect 23 more states to join Medicaid. I am requesting increased funds for ...Medicaid program, including....legislation to expand the timely examination and treatment of ... poor children....¹¹

These sweeping recommendations, which became the EPSDT amendments, were enacted as part of the Social Security Act Amendments of 1967.¹² Termed “altogether different in kind and style”¹³ from anything that preceded them, the Medicaid EPSDT amendment provided for such early and periodic screening and diagnosis of individuals who are eligible [for Medicaid] and under the age of 21, to ascertain their physical and mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby.¹⁴

In sum, within two years of enactment, the President and Congress had come to understand Medicaid’s singular potential to promote child health and development, not merely to finance treatment for diagnosed illnesses. Medicaid’s special relationship to childhood growth and development among low income children was crystallized in the EPSDT amendments.

The continuing evolution of EPSDT has spanned nearly four decades, with important modifications in 1972, and again in 1981 under the Reagan Administration, to add specific outreach and family support requirements to promote health care access.¹⁵ Amendments under the first Bush Administration in 1989 further broadened medical assistance coverage to ensure full coverage for all physical, mental, and developmental conditions. Today EPSDT ensures coverage for all medically necessary diagnostic and treatment services that fall within the federal definition of “medical assistance” for virtually all Medicaid enrolled children. With very limited exceptions for “medically needy children,” EPSDT is a service requirement for children who qualify for Medicaid on either a mandatory or optional basis.¹⁶

Several aspects of the EPSDT benefit make it unique. First, the range and depth of the periodic and interperiodic health examinations provided under the program are striking, with explicit requirements to assess growth and development as an essential part of the screening (i.e., assessment) process.

¹¹ Lyndon B. Johnson. Special Message to the Congress Recommending a 12-Point Program for America’s Children and Youth, February 8, 1967. Transcript available at: <http://www.presidency.ucsb.edu/ws/index.php?pid=28438&st=Medicaid&st1=Johnson>.

¹² Pub. L. 90-248.

¹³ *Welfare Medicine in America*, supra, note 4, p. 248.

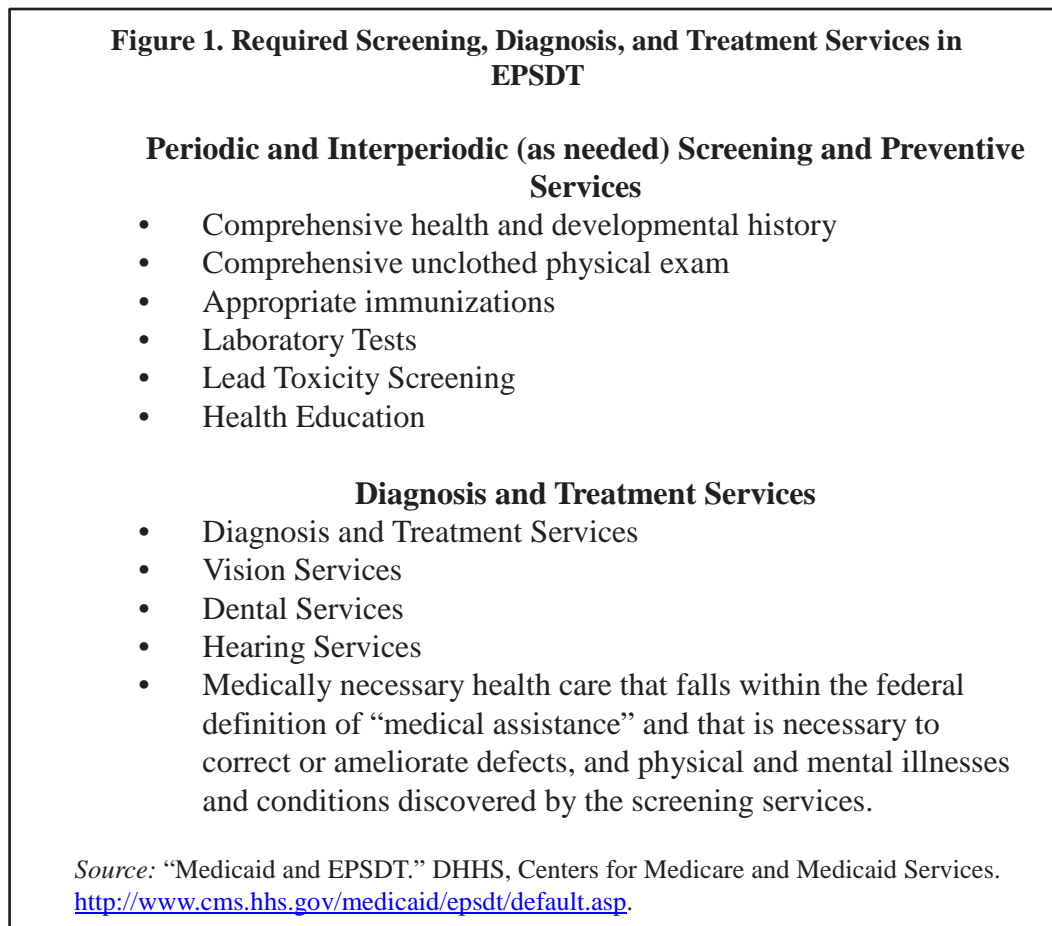
¹⁴ *An Ounce of Prevention*, supra note 3, pp. 22-25.

¹⁵ Social Security Amendments of 1972. October 30, 1972. Pub. L. 92-603.

¹⁶ EPSDT is an optional benefit only in the case of children whose eligibility is based on their “medically needy” status. 42 U.S.C. § 1396a(a)(10)(C). This change was made in 1981.

Second, EPSDT covers an unparalleled range of diagnostic and treatment services for children whose examinations reveal potential physical, mental, or developmental conditions. Unlike conventional commercial insurance, these special coverage standards do not distinguish between acute conditions that can be cured and lifelong and chronic conditions whose effects and severity can be “ameliorated” through health care. Third, from its inception in 1967, EPSDT has been governed by a special medical necessity standard whose scope derives directly from the statutory terms “early” and “ameliorate.”¹⁷ Federal agencies and courts alike have interpreted these term to require health care interventions at the earliest possible time, when needed to ameliorate (i.e., lessen) the effects of conditions, both physical and mental, that potentially could impair childhood growth and development.¹⁸

Figure 1 summarizes all required screening diagnosis and treatment services covered under EPSDT.



¹⁷ §1905(r)(5) of the Social Security Act, 42 USC §1396d(r)(5).

¹⁸ “Medicaid at Thirty-Five.” *op. cit.*

The Historical Context for Medicaid Child Health Policy

*The findings of this Task Force are dramatic evidence that poverty is still with us, still exacting its price in spoiled lives and failed expectations. For entirely too many Americans the promise of American life is not being kept. * * * I wish to see an America in which no young person, whatever the circumstances, shall reach the age of 21 without the health, education, and skills that will give him an opportunity to be an effective citizen and a self-supporting individual. * * ** [Lyndon B. Johnson, January 5, 1964]¹⁹

One historical study in particular sheds light on how federal policy makers might have come to structure within Medicaid such a broad and unprecedented health policy for low income children. Entitled *One Third of a Nation: A Report on Young Men Found Unqualified for Military Service*,²⁰ the study shed overpowering light on the health status of young military draftees. Among its most significant findings: the majority of young men rejected for compulsory military service in the early 1960s failed as a result of physical and mental health conditions, many of which could have been diagnosed and successfully treated in childhood and adolescence. These young adults typically came from impoverished families and had experienced unrelenting deprivation in health care, education, and employment. The report's findings provided compelling evidence for an underlying tenet of President Johnson's conclusion that improving the health and well being of the nation's poor required strategies aimed at ameliorating the effects of social, economic, and health disparities.

The Task Force on Manpower Conservation: Establishment, Charge and Findings

On September 30, 1963, President John F. Kennedy established the Task Force on Manpower Conservation to investigate why, in 1962, an astonishing 49.8 percent of 306,073 Selective Service draftees failed their pre-induction peacetime medical and/or mental aptitude examinations, thus disqualifying them for military service. Beyond its obvious implications for national military preparedness, in the President's view²¹ these figures presented arresting evidence of both the diminished, yet preventable, health status of low-income children and the long-term strength and productivity of the nation.

The President directed that the Secretaries of Defense, Labor, and Health, Education, and Welfare (HEW, predecessor of DHHS) lead a Task Force that would "prepare a program for the guidance, testing, counseling, training and rehabilitation of youths found disqualified because of failure to meet the physical or mental standards of the Armed Forces, and to make such recommendation as their survey of this situation suggests." The Task Force was ordered to submit a final report no later than January 1, 1964.²²

¹⁹ Statement on the report, *One-Third of a Nation*. Cited in: The health status of American youth: A report on young men found unqualified for military service." *Clinical Pediatrics*. 3(11):625-628. November 1964.

²⁰ The President's Task Force on Manpower Conservation. *One-Third of a Nation: A Report of Young Men Found Unqualified for Military Service*. The White House. Washington, DC. January 1, 1964.

²¹ Statement by the President [Kennedy]: Establishing the Task Force on Manpower Conservation. September 30, 1963. Cited in *One-Third of a Nation: A Report of Young Men Found Unqualified for Military Service*. pages A-1 – A-2.

Two months after Kennedy's directive, the Task Force issued its final report, which concluded that the military draft failure rate provided powerful evidence of "the unfinished business of the Nation."²³ The information presented in the report offered a sobering look into the health conditions and socio-economic characteristics of the young men rejected for military service. Reasons for rejection included "medical," "mental," and "administrative or moral." Medical examinations included both physical and psychological criteria designed to identify men whose conditions "may endanger the health of other individuals, cause excessive loss of time from duty, excessive restrictions on location of assignment, or become aggravated through performance of military duty." Mental examinations were conducted through administration of the Armed Forces Qualification Test (AFQT), a written exam designed to test mental aptitude for military service, including questions on vocabulary, reading, writing, arithmetic, and mechanical understanding. Men rejected for administrative or moral reasons included those who had "significant criminal records, anti-social tendencies, such as alcoholism or drug addiction, or for other traits of character which would make them unfit in a military environment."²⁴

In reviewing the records of all categories of examinations for military service between August 1958 and June 1960, the Department of Defense calculated the overall rate of reasons for rejection at 31.7 percent. The Task Force report, using updated information, estimated that the overall rejection rate had since increased to 35–36 percent. This overall rejection rate included both voluntary enlistees and draftees; the 49.8 percent rejection rate noted above was for 1962 draftees only.²⁵

Table 1 shows that among the reasons for rejection, "administrative" reasons accounted for less than four percent of the failure rate among enlistees and draftees and less than three percent of the failure rate among draftees only. Far more important in terms of the high rejection rates were failure rates for medical examinations and mental tests, which (not surprisingly) were particularly elevated among the draftee-only group, since enlistees could be expected to self-select from a healthier socioeconomic pool.

²² *Ibid.*

²³ Letter of Transmittal. President's Task Force on Manpower Conservation. Reprinted in *One-Third of a Nation: A Report on Young Men Found Unqualified for Military Service*. January 1, 1964.

²⁴ *One-Third of a Nation: A Report on Young Men Found Unqualified for Military Service*. *op. cit.* pp. 9-10.

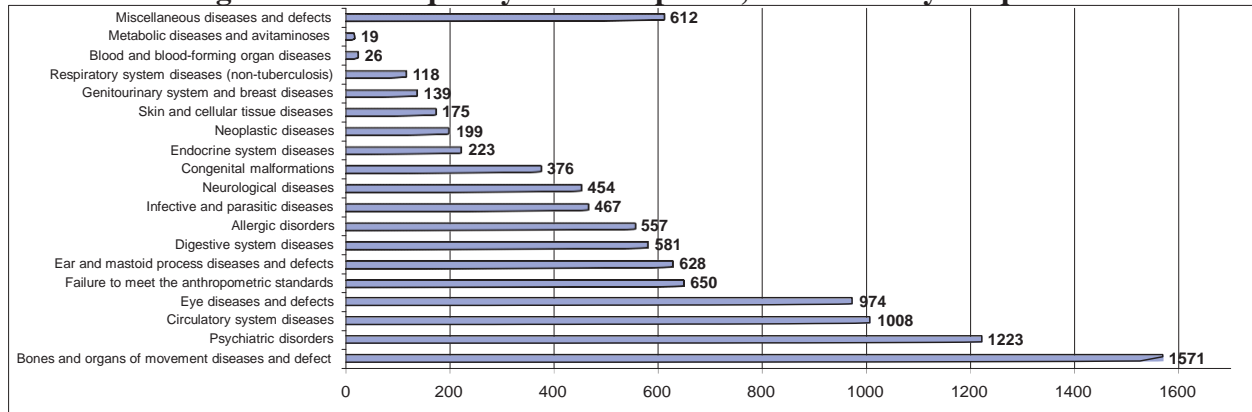
²⁵ The report attributed the differential to large numbers of young men who were examined and accepted for voluntary enlistment or officer training programs at younger ages, before reaching the age of referral for draftee examinations.

Table 1.—Percentages of Military Rejections by Reason, 1958-1962

<i>Reason for Rejection</i>	Enlistees and Draftees, 1958-60	Draftees Only, 1962
	<i>Percent</i>	
Failed medical examination only	14.8	24.5
Failed mental tests only	11.5	22.7
Failed both medical and mental tests	1.5	1.5
Administrative reasons	3.9	2.6
Total rejected	31.7	49.8

Figure 2 presents the reasons for medical rejection noted in the report. Most frequently noted were diseases and disorders of bones and organs of movement, psychiatric disorders, circulatory diseases, eye diseases, and failure to meet anthropometric standards (height and weight).

**Figure 2.—Reasons for Medical Disqualifications:
Medical Diagnoses and Frequency of Defect per 10,000 Medically Disqualified Youth***



* Based on examinations conducted between August 1953 through July 1958. *Source:* Bernard D. Karpinos, "Qualifications of American Volunteers for Military Service." Medical Statistics Division. Office of the Surgeon General, Department of the Army, 1962. Reprinted in *One-Third of a Nation*, p. 26.

Within these diagnostic categories, the report detailed the most frequent specific causes for medical disqualification, as shown in Table 2

Table 2.—Frequently Mentioned Causes for Medical Disqualification

<i>Diagnostic Category</i>	<i>Main Causes of Disqualification</i>
Psychiatric disorders	Character and behavior disorders
Neurological diseases	Epilepsy
Infective and parasitic diseases	Acute poliomyelitis and tuberculosis

Table 2.—Frequently Mentioned Causes for Medical Disqualification

<i>Diagnostic Category</i>	<i>Main Causes of Disqualification</i>
Neoplastic diseases	Pilonidal cyst ²⁶
Allergic disorders	Asthma
Circulatory system diseases	Chronic rheumatic heart disease and
Digestive system diseases	Hernia of the abdominal cavity
Anthropometric standards	Overweight
Defects of bones and organs of movement	Deformities or impairments and amputation of extremities

The Task Force noted that these conditions represented a spectrum of severity and potential for treatment. The report concluded that one out of ten medical rejectees had conditions entirely correctable with medical intervention, ranging from serious infectious diseases like syphilis and tuberculosis to hernias and cleft palates. One out of five rejectees had more chronic conditions requiring longer term treatment such as epilepsy, asthma, and heart disease. Another one out of four rejectees had need of intensive treatment services for conditions such as deafness, loss of limbs, spinal curvature, and serious congenital malformations. Finally, the Task Force noted that one in four medical rejectees had conditions for which medical treatment was not the answer. This included men who were totally blind, or too tall or too short to meet military standards.

In addition to the 24.5 percent of draftees who were rejected for medical reasons, the report noted that another 22.7 percent were rejected for failing the AFQT for mental aptitude for military service. These were men who scored in “mental groups” IV and V (30th percentile or less) in the AFQT scoring system:

Table 3. – Armed Forces Qualification Test Scoring System

<i>Mental Group</i>	<i>Required Correct Answers</i>	<i>Corresponding Percentile Score</i>
I.	89 – 100	93 – 100
II.	74 – 88	65 – 92
III.	53 – 73	31 – 64
IV.	25 – 52	10 - 30
V.	24 or less	9 or below

²⁶ “A pilonidal cyst is a cyst at the bottom of the tailbone (coccyx) that can become infected and filled with pus. Once infected, the technical term is pilonidal abscess. [One] theory is that pilonidal cysts appear after trauma to the sacrococcygeal region (the region relating to both the sacrum [the lower vertebrae] and coccyx). During World War II, more than 80,000 soldiers developed pilonidal cysts that required a hospital stay. People thought the cysts were due to irritation from riding in bumpy Jeeps. For a while, the condition was actually called ‘Jeep disease’.” <http://www.emedicinehealth.com/articles/20243-1.asp>. Accessed Feb. 5, 2005.

To investigate the reasons for this high failure rate of the AFQT among draftees, the Task Force commissioned the Department of Labor and the Selective Service System to interview a national sample of 2,500 recent AFQT rejectees to develop a deeper understanding of the socio-economic conditions that may have affected their lack of educational performance. Much of the Task Force report provides detailed information about these AFQT rejectees' lives, including their incomes, family history, marital status, education, and employment. The common themes that emerged were extreme poverty, limited education, and families living under conditions of significant stress and poverty. Significant disparities by race and national origin were evident in the data as well, with far deeper poverty, higher rates of unemployment, and lower educational attainment among minority rejectees.

The Task Force also found wide variations in rejection rates among the states, particularly for mental rejectees, ranging from as low as 3 percent in some states to as high as 50 percent in others. Southeastern states generally had higher rates of mental rejectees compared to states in the Mountain, Great Plains, and Far West regions, where medical reasons were more common. The Task Force attributed this variation to variations in demographic and socioeconomic status and overall living conditions for the poor.²⁷

Despite the evidence of pervasive harm to children documented in the report, the Task Force concluded that:

*...in every generation, talent appears at every social stratum, in every geographic area. Given equal opportunity, * * * the poor will prove their worth at an early age and go on to live lives of substantial achievement. However, this process can easily be thwarted, and * * * [T]here is little question that the process has not worked for a great many of them young men who fail to meet the mental requirements for military service in the United States today*²⁸

Most of the Task Force's recommendations focused on the development of compensatory programs for young low-income adults rejected from the military draft. However, the Task Force also made recommendations regarding improvements in screening, diagnosis, and treatment of diseases and conditions in early childhood and adolescence, with a strong emphasis on the placement of programs in schools.^{29,30}

The work of the Task Force in combination with subsequent studies on the health status of infants, children, and children with disabilities,³¹ formed the contextual basis for the President's 1967 child health recommendations to Congress.³² Immediately following their submission, the President's

²⁷ *One-Third of a Nation: A Report on Young Men Found Unqualified for Military Service. op. cit.* p. 12.

²⁸ *One-Third of a Nation: A Report on Young Men Found Unqualified for Military Service. op. cit.* p. 15.

²⁹ *Ibid.* p. 29.

³⁰ *Ibid.* p. 35.

³¹ *An Ounce of Prevention; EPSDT: Does it Spell Health Care for Poor Children? Supra*, note 3.

³² Lyndon B. Johnson. Special Message to the Congress Recommending a 12-Point Program for America's Children and Youth, February 8, 1967. *op. cit.*

recommendations were translated into legislative language providing for the amendments to the Social Security Act that incorporated the EPSDT program and its standards into Medicaid.³³

Conclusion

For 40 years, Medicaid has provided essential health coverage to tens of millions of low-income children and youth. Medicaid is a dominant force in the U.S. health care system and its early policy roots are often difficult to discern. This Policy Brief has explored the national security study that lies at the foundations of Medicaid child health policy. The findings of *One Third of a Nation*, as well as the language of the Medicaid statute itself, serve to underscore the fact that Medicaid child health policy hardly has been happenstance. From its virtual enactment, Medicaid aimed to cover all low income children with the broadest possible developmental health benefits. By 1967, the very concept of coverage itself had been transformed, and this transformation has continued throughout Medicaid's history.

The need for a continued Medicaid child health policy that aims at growth and development, not merely treatment of episodic illness, continues to reverberate, not only in a broader health policy context, but as a matter of national security. During a March 12, 1998 hearing before the House Armed Services Committee, Mark E. Gebicke, Director of Military Operations & Capabilities Issues for GAO's National Security & International Affairs Division, stated, "Of the 25,430 enlistees who entered the services in fiscal year 1994 and were discharged in their first 6 months, 29 percent failed to meet minimum performance standards, 27 percent were found medically unqualified for military service and 14 percent had character or behavior disorders."³⁴ The importance of a continuing commitment to broad child health policy endures, even as the health system itself is transformed. National security depends on the growth and development of children; in view of the demographics of those who serve, this dependence is particularly striking in the case of the low-income children who are at greatest risk for poor health outcomes. In this respect, Medicaid's role in reducing health disparities among low-income and minority children remains a paramount national concern.

³³ Social Security Amendments Act of 1967. Pub. L. 90-248.

³⁴ Testimony of Mr. Mark E. Gebicke, Director, Military Operations & Capabilities Issues National Security & International Affairs Division, U.S. General Accounting Office. Available at: <http://www.house.gov/hasc/testimony/105thcongress/3-12-98gebicke.htm>. Accessed April 6, 2005.

APPENDIX

Statistical Methodology for Calculating the Proportion of Military Recruits Who May Have Been Covered by Medicaid at Some Point in Their Lives Prior to Recruitment

The purpose of this analysis was to estimate the proportion of military recruits who may have been covered by Medicaid at some point in their lives prior to recruitment. Ideally, longitudinal data would be used to track health insurance coverage of a cohort of individuals from time of birth to recruitment and identify at least one point in time in which they were covered by Medicaid.³⁵ From such data, a simple calculation can be made by counting the number of recruits covered by Medicaid at any time in their youth and dividing it by the total number of recruits. Although the Department of Defense (DOD) and services collect demographic data on recruits, limited information was publicly available. Unfortunately, none focused on or detailed medical history or health insurance information of recruits.³⁶

Alternatively, data from the 2003 Current Population Survey (CPS) and the 2002 socioeconomic information from the 1998 DOD *Population Representation in the Military* reports were used to estimate the population pool from which individuals are likely to have been recruited. Specifically, the 2002 DOD report shows the average age of recruits is 20 years, and over half of the activity duty force is between 17-24 years.³⁷ This information was used to focus the analysis of the CPS data on persons aged 24 years and younger.³⁸ Table 1 shows the proportion of individuals with incomes less than 200 percent of the Federal poverty level (FPL) covered by Medicaid.

Table 1. Percent Covered by Medicaid, 200% FPL

Age	Percent
Under 1	61%
1-5	59%
6-17	48%
18 only	32%
19-24	17%

Source: KCMU and Urban Institute analysis of the March 2004 Current Population Survey, 2005

These estimates may be considered too high because of the lower income threshold; and the 1998 DOD *Population Representation* report suggests recruits may not come primarily from the low

³⁵ Creswell JW, *Research Design: Qualitative and Quantitative Approaches* (Thousand Oaks, CA: Sage Publications) 1994.

³⁶ The DOD may collect information on insurer prior to recruitment. *Military personnel: first-term recruiting and attribution continue to require focused attention.* Testimony of Rabkin NJ before the Subcommittee on Personnel, Committee on Armed Services, United States Senate, February 24, 2000 (<http://www.gao.gov/cgi-bin/getrpt?GAO/T-NSIAD-00-102>).

³⁷ <http://www.dod.mil/prhome/poprep2002/> (Accessed April 5, 2004).

³⁸ The 2004 Federal poverty guideline for a family of three was \$15,670.

end of the socioeconomic spectrum.³⁹ Therefore, the income limit was expanded to 400 percent of FPL, or \$60,000 per year for a family of three.⁴⁰ Table 2 shows the proportion of the population covered by Medicaid and likely to be targeted by the military for service.

Table 2. Percent Covered by Medicaid, 400% FPL

Age	Percent
Under 1	46%
1-5	42%
6-17	33%
18 only	23%
19-24	14%

Source: KCMU and Urban Institute analysis of the March 2004 Current Population Survey, 2005

Based on the population pool eligible for military service, Medicaid covers approximately one in two persons at some point prior to recruitment. That is, at least 46 percent of recruits may have received Medicaid during infancy, and this estimate may be higher as some individuals become eligible in later years. Given that the data provides only a single point-in-time estimate and does not include the actual cohort of individuals recruited, the one-in-two proportion is given as a conservative estimate for the purpose of this analysis.

³⁹ http://www.dod.mil/prhome/poprep98/html/7-index_scores.html (Accessed April 5, 2004).

⁴⁰ The 1998 DOD report indicated “both active and reserve recruits are primarily from families in the middle and lower middle socioeconomic strata,” which is adjusted by a higher level of education and reading skills compared to their civilian counterparts in addition to employment status, occupation, and home ownership. For purposes of a more conservative estimate, the population pool of potential recruits is adjusted to 400 percent of FPL.