qualify, depending on certain thresholds. In reality, there are hospitals on both sides of these arbitrary thresholds that serve a safety-net function. We believe that policymakers should stop trying to define safety-net hospitals per se and start defining safety-net services.

This strategy could involve moving toward a composite "sliding-scale" measure of safety-net status. Such a scale could include, for example, a hospital-level measure of the composition of the patient population (proportion covered by Medicaid, or the Medicare DSH percentage), a geographic measure of socioeconomic disadvantage (area deprivation index, county-level poverty rate), a measure of the proportion of services that are provided to racial- and ethnic-minority populations, a measure of hospital finances (amount of uncompensated care, operating margin), and a measure of hospital investments in the community (amount of community-benefit spending, provision of essential-but-unprofitable services). If safety-net hospital status were measured on a continuum, federal aid or Medicaid DSH funds could be allocated according to a hospital's position on a sliding scale. Similarly, peer comparisons under pay-for-performance and alternative payment models could be performed by grouping hospitals that fall close together on the scale. Such a strategy could gradually steer the United States away from a tiered hospital system in which safety-net functions are concentrated among a few facilities and away from an overreliance on arbitrary thresholds.

An audio interview with Dr. Chatterjee is available at NEJM.org

A continuum-based approach to defining safety-net hospitals isn't without shortcomings. Applying weights to various factors would require stakeholders to agree on what the functions of safety-net hospitals should be, while acknowledging that such functions will vary among communities. But the current approach to characterizing safety-net hospitals limits policymakers' ability to effectively target resources. Supporting these facilities is now more important than ever, and understanding how best to do so will be increasingly vital.

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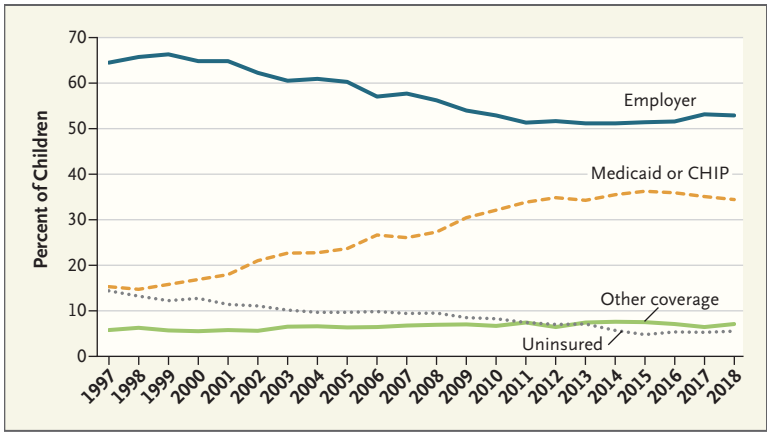
Medicaid and Child Health Equity

James M. Perrin, M.D., Genevieve M. Kenney, Ph.D., and Sara Rosenbaum, J.D.

Medicaid and the Children's Health Insurance Program (CHIP) insure roughly 35% of all U.S. children (see graph). Apart from the elderly, no other age group depends more on public benefits or has more of a stake in the debate over the role of a strong public insurance system in achieving greater health equity. For children, no other insurer has equaled Medicaid's comprehensive coverage and cost-sharing protections. But Medicaid, even as enhanced by CHIP, also has important limitations. Means testing restricts eligibility, and low provider payments create access problems for enrollees. Furthermore, federal Medicaid funding is tied to state spending. Even in normal times, this funding scheme places a substantial burden on states. But these are not normal times, and the Covid-19 pandemic has exposed many deep fissures in the U.S. health system.[1]



Health Insurance Coverage for Children, 1997–2018.

Data are from Urban Institute tabulations of responses on the National Health Interview Survey. Children 18 years of age or younger are included. Coverage is at the time of the survey. Coverage types are organized into the following hierarchy: Medicare, Affordable Care Act (ACA) exchange, employer-sponsored insurance, direct purchase, other private programs, Medicaid or Children's Health Insurance Program (CHIP), and other public programs before being collapsed into four main categories. Other coverage includes Medicare, other public programs, ACA exchange, direct purchase, and other private programs. The analysis uses appropriate survey weights to produce nationally representative insurance estimates.

Making government health programs work better will be a priority for a new president. The fact that so many children depend on Medicaid makes this transition an especially valuable time to look closely at the ways in which reform could improve the program's effects on child health. We believe that the imperative to achieve racial and socioeconomic health equity in the United States demands structural changes to Medicaid to make access universal for children, ensure stable and adequate funding, and address Medicaid's historically low payment rates.

In approaching reform of Medicaid coverage for children, it's instructive to consider the program's original purpose and its evolution. Established as a companion to Medicare, Medicaid was part of a landmark national health reform effort. Medicare was conceived as a universal social insurance program, whereas Medicaid was designed to help the poor and medically indigent. Medicaid for children was thus primarily tied to cash welfare assistance; restrictive rules and low welfare payments excluded millions of poor children. Some states opted to extend coverage to additional needy children, as the law establishing the program permitted, but the real push to extend Medicaid to all poor children began only in the early 1980s and wasn't completed until the turn of the 21st century.

Efforts to expand Medicaid came in response to widespread evidence regarding the combined effects of economic, demographic, cost, and labor trends on children's access to employer-sponsored insurance coverage. Over the past three decades, the proportion of U.S. children who receive insurance benefits through their parents' jobs has steadily declined. Today, the system that we think of as the norm covers slightly more than half of all children. As the rate of employer-sponsored coverage has fallen, federally mandated eligibility expansions for infants and other children have helped Medicaid evolve from a program that covered predominantly children receiving welfare assistance into a foundational source of health insurance for children. Gradually, eligibility was expanded, benefits were enhanced, enrollment and renewal processes were simplified, and cost sharing (in the form of premiums or copayments) was curtailed. CHIP extended Medicaid's reach beginning in 1997, with nearly all states using some of their allotments under the program to expand Medicaid. Today, most children who are eligible for CHIP receive coverage through expanded Medicaid programs.[2]

In addition to markedly reducing uninsurance rates, Medicaid and CHIP provide children with a degree of access to primary care similar to that of commercially insured children and with much greater access than uninsured children. Medicaid also provides vitally important coverage for children with chronic health problems, who may need more care than even a good employer-sponsored plan typically covers. Unlike private insurance, Medicaid is always available, since it doesn't have open-enrollment or fixed special-enrollment periods.[3] It has a broad scope of nationally uniform benefits, chiefly because of the early and periodic screening, diagnosis, and treatment benefit that begins at birth and continues until 21 years of age,[4] as well as strong cost-sharing protections.

But there are also important inequities in the Medicaid program. First, Medicaid's financial-eligibility rules for children remain tied to low income or

disability; children enrolled in the program are therefore overwhelmingly poor or near poor, and the conditional nature of Medicaid coverage leaves millions of children without health insurance. The landscape of poverty in the United States also means that Medicaid disproportionately covers Black, Native American, and Latinx children. As long as Medicaid nearly exclusively targets the poorest children, it's too easy for enrollment in the program to be stigmatized. Such stigmatization disadvantages children who also experience the effects of structural racism and systemic economic inequities and who are at risk for the physical, mental, and developmental health problems to which inequity contributes.

Second, the requirement that states fund a portion of their Medicaid programs creates additional challenges for a program targeted to the poorest children, with the gravest economic and health needs. In contrast, Medicare is fully federally financed. To keep Medicaid spending under control, states have routinely used strategies for limiting enrollment or keeping per capita spending low. The pandemic-induced economic disaster that so many states now face has placed increased budgetary pressure on Medicaid programs.

Third, Medicaid's low physician payment rates, which average about two thirds of rates paid by Medicare for the same services,[5] depress physician participation. Although as a group, pediatricians are more likely than other primary care providers to accept Medicaid, participation levels are still well below those for commercial insurance. Furthermore, participating clinicians often place limits on the number of Medicaid-covered children that they will accept into care.[3] Both the federal government and state governments haven't consistently enforced the federal requirement that Medicaid provide payments that are high enough to ensure that people with Medicaid coverage have as much access to care as people with commercial insurance, and the U.S. Supreme Court, in *Armstrong v. Exceptional Child Center, Inc.*, denied providers the right to directly challenge states' failure to enforce this requirement. Many areas lack community health centers and public hospital clinics, and families without access to these facilities report difficulty finding private physicians who are willing to see additional Medicaid-covered patients. Lack of access to specialists poses additional problems in many communities. Hospitals that are more affluent may limit the number of Medicaid beneficiaries they treat, which concentrates the care of these patients in community "safety-net" institutions.

The Covid-19 pandemic has brought the many historical shortcomings of social programs into sharp relief and now threatens to deepen inequities. Making Medicaid work better for all children offers a strategy for achieving greater health equity among children now and as these children age into adulthood.[3] We believe that Medicaid should be expanded to cover all children from birth through 21 years of age. Among children with employer-sponsored coverage, Medicaid would serve as a secondary payer for those whose special health care needs exceed limits on care imposed by plans. We also believe that the federal government should assume full financial responsibility for Medicaid for children, which would ease the fiscal pressures that cause states to reduce enrollment or impose burdensome renewal requirements. Finally, to lessen stigma and increase provider participation, Medicaid payments should parallel national Medicare standards.

These changes could be phased in over time, as has been the case with previous Medicaid reforms focused on child health. Children are a low-cost population to insure, and investments during childhood shape health and economic trajectories in adulthood. Making Medicaid universal and federally funded would enable states to focus on initiatives that improve health care quality as well as those that enhance integration of health care, education, and social services for all children. Such changes would especially benefit children with heightened health and social needs, such as those with severe mental illness and those in the child welfare system. Even more important, universalizing Medicaid represents a key strategy for achieving greater fairness for Black, Latinx, and Native American children, who have historically experienced grave health inequities.

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FDA Approval of Remdesivir — A Step in the Right Direction

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On January 31, 2020, the U.S. secretary of health and human services declared a public health emergency in response to Covid-19. This disease, caused by the SARS-CoV-2 virus, can have severe manifestations, including pneumonia, respiratory failure, multiorgan failure, and death. Although there is now an extensive global search for therapies, there remains an unmet need for safe and effective treatment options for patients.

On May 1, 2020, on the basis of preliminary results from phase 3 trials, the Food and Drug Administration (FDA) issued an Emergency Use Authorization (EUA) to allow the use of remdesivir for the treatment of suspected or laboratory-confirmed Covid-19 in adult and pediatric patients hospitalized with severe disease.[1] The scope of the EUA was subsequently expanded on August 28, to allow use in a broader hospitalized population. On October 22, the FDA approved remdesivir for use in adults and pediatric patients (12 years of age or older and weighing at least 40 kg) for the treatment of Covid-19 requiring hospitalization.[2]

This approval was based largely on the results of three phase 3 clinical trials in hospitalized patients with disease of varying severity. These were the Adaptive Covid-19 Treatment Trial (ACTT-1) sponsored by the National Institute of Allergy and Infectious Diseases and the supportive trials GS-US-540-5774 and GS-US-540-5773 sponsored by Gilead Sciences. ACTT-1, which had a rigorous design, provided the most compelling evidence of efficacy.

ACTT-1 was a phase 3, multinational, randomized, double-blind, placebo-controlled trial that evaluated the safety and efficacy of remdesivir in hospitalized patients with mild, moderate, or severe Covid-19.[3] A total of 1062 eligible patients were randomly assigned in a 1:1 ratio to receive remdesivir or placebo for up to 10 days. The primary efficacy end point was time to recovery through day 29. In the overall population, the median time to recovery was 10 days in the remdesivir group as compared with 15 days in the placebo group (recovery rate ratio, 1.29; 95% confidence interval [CI], 1.12 to 1.49; P<0.001). The predefined key secondary end point of odds of clinical improvement at day 15, based on an eight-category ordinal scale, also significantly favored remdesivir over placebo (odds ratio, 1.54; 95% CI, 1.25 to 1.91). The 29-day mortality was 11% in the remdesivir group, as compared with 15% in the placebo group (hazard ratio, 0.73; 95% CI, 0.52 to 1.03) — a result that left uncertainty about whether remdesivir provides a survival benefit in addition to accelerating time to recovery.

GS-US-540-5774 was a phase 3, multinational, 1:1:1 randomized, open-label trial that evaluated the safety and efficacy of 5 days of remdesivir, 10 days of remdesivir, and standard of care in 584 hospitalized patients with moderate Covid-19.[4] The primary efficacy end point was clinical status on day 11, assessed on a seven-category ordinal scale. The odds of improvement on the ordinal scale were higher in the 5-day remdesivir group at day 11 than in the group receiving the standard of care (odds ratio, 1.65; 95% CI, 1.09 to 2.48; P=0.02). The odds of improvement in clinical status did not differ significantly between the 10-day remdesivir group and the standard-of-care group (odds ratio, 1.31; 95% CI, 0.88 to 1.95).

GS-US-540-5773 was a phase 3, multinational, 1:1 randomized, open-label trial that evaluated the safety and efficacy of 5 days as compared with 10 days of remdesivir in 397 hospitalized patients with severe Covid-19.[5] The primary efficacy end point was clinical status assessed on a seven-point ordinal scale on day 14. After adjustment for baseline differences between groups, clinical status at day 14 did not differ