



# Uninsurance Rose among Children and Parents in 2019

## National and State Patterns

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*July 2021*

**Both children and parents experienced steep declines in uninsurance following implementation of the major coverage provisions of the Affordable Care Act (ACA) in 2014. Between 2013 and 2016, uninsurance fell by nearly 40 percent for both groups. But these coverage gains stalled starting in 2017 and 2018. In this brief, we use the most recently available data from the American Community Survey (ACS) to assess trends in coverage for children and parents through 2019. Our main findings are as follows:**

- Altogether, the number of uninsured children and parents rose by just over 1.0 million between 2016 and 2019. Nearly 700,000 more children and more than 300,000 additional parents were uninsured in 2019 than in 2016.
- An estimated 4.0 million children (5.2 percent) were uninsured in 2019.
- Children's uninsurance rose between 2016 and 2019 both in states that had implemented the ACA's Medicaid expansion and those that had not (hereafter called Medicaid expansion and nonexpansion states). However, the increase was larger in nonexpansion states on average. In 2019, as in prior years, uninsurance remained higher in nonexpansion states: 7.6 percent of children in nonexpansion states were uninsured, compared with 3.8 percent of children in expansion states.

- Children’s uninsurance also continued to vary widely across states. Texas remained the state with the highest rate of uninsured children (11.9 percent) and was among the states with the largest increases in uninsurance between 2016 and 2019.
- Underlying the rise in uninsurance among children was a decline in take-up of Medicaid/Children’s Health Insurance Program (CHIP) coverage. An estimated 91.9 percent of Medicaid/CHIP-eligible children without other coverage participated in the programs in 2019, compared with 93.4 percent in 2016. Participation fell in both expansion and nonexpansion states, but the drop was larger in nonexpansion states.
- An estimated 2.3 million children, constituting 57.7 percent of all uninsured children, were eligible for Medicaid/CHIP but uninsured in 2019.
- Uninsurance among parents rose from 11.2 percent in 2018 to 11.7 percent in 2019.
- Parents’ uninsurance rose in both expansion and nonexpansion states in 2019, and parents were twice as likely to be uninsured if they lived in a nonexpansion state (17.2 percent) than if they lived in an expansion state (8.6 percent).
- In Medicaid expansion states in 2019, the Medicaid participation rate among parents not enrolled in other coverage averaged 84.0 percent, nearly 10 percentage points lower than the Medicaid/CHIP participation rate among children in those states (93.7 percent).
- We estimate that more than 1.0 million parents were likely eligible for Medicaid but uninsured in 2019, and 70.5 percent of these parents had at least one child who was enrolled in Medicaid/CHIP.

Though the COVID-19 pandemic and associated economic upheaval have changed these patterns, the magnitude and direction of the resulting impacts on health insurance coverage for children and their parents are unclear. On the one hand, the Families First Coronavirus Response Act prohibits states from disenrolling people from Medicaid until after the public health emergency ends, which is more than likely increasing both children’s and parents’ Medicaid enrollment relative to the rates reported here.<sup>1</sup> The Centers for Medicare & Medicaid Services indicate, for instance, that child Medicaid and CHIP enrollment grew by nearly 2.9 million between December 2019 and November 2020 (CMS 2021). On the other hand, many families with children, particularly those with Black and Hispanic parents,\* have faced increases in financial instability and hardship; these hardships include job losses due to the economic crisis (Karpman, Gonzalez, and Kenney 2020), which can translate into losses of employer-sponsored coverage and increases in eligibility for subsidized coverage. These findings and the COVID-19 pandemic underscore the urgent need to reverse the coverage losses among children and parents that occurred between 2016 and 2019 and put families back on a path toward affordable health care.

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\* We capitalize “Black” to denote the unique Black experience as one characteristic of a diverse group of people, ethnicities, and cultures. We have not capitalized white, a term and label for a range of historically grouped ethnicities used to delineate a contrast with people of color.

# Introduction

Implementation of the ACA, including the expansion of Medicaid, the establishment of federal- and state-based Marketplaces with available subsidies, and investments in outreach and enrollment systems, largely intended to increase health insurance coverage for parents and other adults. But these efforts also had spillover effects for children, as parents seeking coverage also enrolled their children. Uninsurance fell among both children and parents following ACA implementation in 2014 (Alker and Chester 2015; Haley, Kenney, Wang, Lynch, et al. 2018; Haley, Kenney, Wang, Pan, et al. 2018; Henry J. Kaiser Family Foundation 2017; Karpman, Kenney, and Gonzalez 2018; Kenney et al. 2016a, 2016b, 2017; Lukanen, Schwehr, and Fried 2019; McMorrow and Kenney 2018). By 2016, uninsurance had fallen by nearly 40 percent for both groups nationally and had fallen across many states and for specific subgroups of children and parents (Haley, Kenney, Wang, Pan, et al. 2018).

But from 2017 to 2019, numerous federal and state policy changes were proposed or enacted, including nationwide discussions about ACA repeal, proposals to restrict Medicaid for adults through work requirements and other policies, repeal of the federal coverage mandate penalty, and reductions in outreach and enrollment assistance. These changes likely sowed confusion among families about available coverage options and discouraged enrollment. In September 2018, the Trump administration also proposed expanding the “public charge” rule to consider past or future public benefits use in applications for green cards and temporary visas. The proposed change deterred public program enrollment among immigrant families, including those not subject to the new rule, even before the rule was implemented in February 2020 (Bernstein et al. 2019; Haley, Kenney, Bernstein, et al. 2020). Over this same period, decreases in uninsurance began to stall out for parents and reverse for children in 2017 (Haley et al. 2019), and children’s uninsurance continued to increase in 2018 (Haley, Kenney, Wang, et al. 2020).

Since the late 1980s, Medicaid/CHIP eligibility for children has been expanding; by 2019, the median state covered children with family incomes up to 255 percent of the federal poverty level (FPL), and 19 states were extending eligibility to those with family incomes at or above 300 percent of FPL (Brooks, Roygardner, and Artiga 2019). In contrast, Medicaid eligibility levels were much lower for parents; in the 34 states (including Washington, DC) that had implemented the ACA’s Medicaid expansion by 2019, the median income eligibility cutoff for parents was 138 percent of FPL. On the other hand, the median Medicaid threshold for nondisabled, nonpregnant parents was below half of the FPL in the 17 nonexpansion states. Partly because of these differences in eligibility, parents have remained more than twice as likely as children to be uninsured over recent years, despite their coverage gains (Haley et al. 2019). The consequences of parents being uninsured could adversely affect the health and well-being of the entire family, including children.

Using ACS data through 2019, this brief updates our prior research tracking national and state-level trends in uninsurance and Medicaid/CHIP eligibility and participation (Haley et al. 2019; Haley, Kenney, Wang, et al. 2020; Haley, Kenney, Wang, Lynch, et al. 2018; Haley, Kenney, Wang, Pan, et al. 2018; Kenney, Anderson, and Lynch 2013; Kenney et al. 2011, 2015, 2016a, 2016b, 2017; Kenney,

Lynch, Haley, et al. 2012; Kenney, Lynch, Huntress, et al. 2012). We have also updated our methodology for estimating eligibility. The revised methodology resulted in revisions to some estimates released for prior years and a potential alternative measure of estimated eligibility to assess the sensitivity of our core results of the number of Medicaid/CHIP-eligible but uninsured parents and children, as detailed in appendix B. As with our prior estimates, we emphasize that both coverage and eligibility status are challenging to measure and considerably uncertain, particularly when assessing eligibility and participation for parents in Medicaid nonexpansion states.

## Findings

In this section, we describe changes in uninsurance for children and parents and assess differences by whether states adopted the ACA's Medicaid expansion, by state, and by socioeconomic and demographic subgroups. We also assess Medicaid/CHIP participation and estimate the number of children and parents who appear eligible for the programs but remain uninsured.

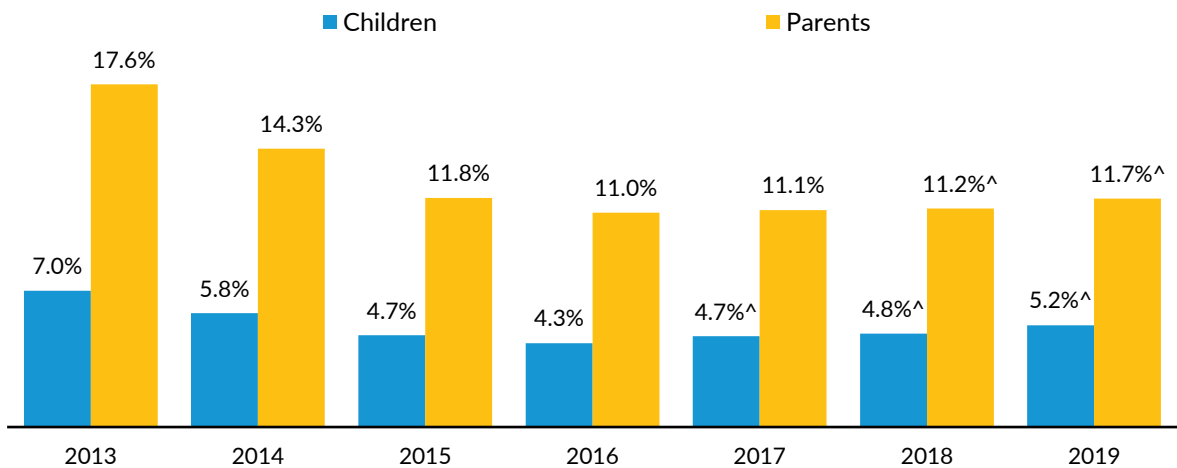
### **Trends in Uninsurance among Children and Parents, 2013–19**

*Uninsurance fell following implementation of the coverage provisions of the ACA, but these gains stalled after 2016, and uninsurance among parents and children rose between 2016 and 2019.*

During the first three years of implementation of the major coverage provisions of the ACA, uninsurance fell from 7.0 to 4.3 percent among children and from 17.6 to 11.0 percent among parents (figure 1). But these declines stalled after 2016: In 2017, children's coverage gains began to reverse, marking the first increase in uninsurance for children since the ACS began collecting coverage status in 2008 (Alker and Pham 2018). And parents' coverage gains stalled. In 2018, both children's and parents' uninsurance rates rose slightly again. Children's uninsurance rate increased once again in 2019, from 4.8 percent in 2018 to 5.2 percent, and parents' uninsurance rate rose from 11.2 to 11.7 percent.

An estimated 4.0 million children were uninsured in 2019, an increase of 313,000 since 2018 and an increase of 685,000 since 2016 (figure 2). An estimated 7.2 million parents were uninsured, an increase of 245,000 since 2018 and an increase of 363,000 since 2016. Overall, we find just over 1.0 million more uninsured children and parents in 2019 than in 2016.

**FIGURE 1**  
**Children's and Parents' Uninsurance Rates, 2013–19**

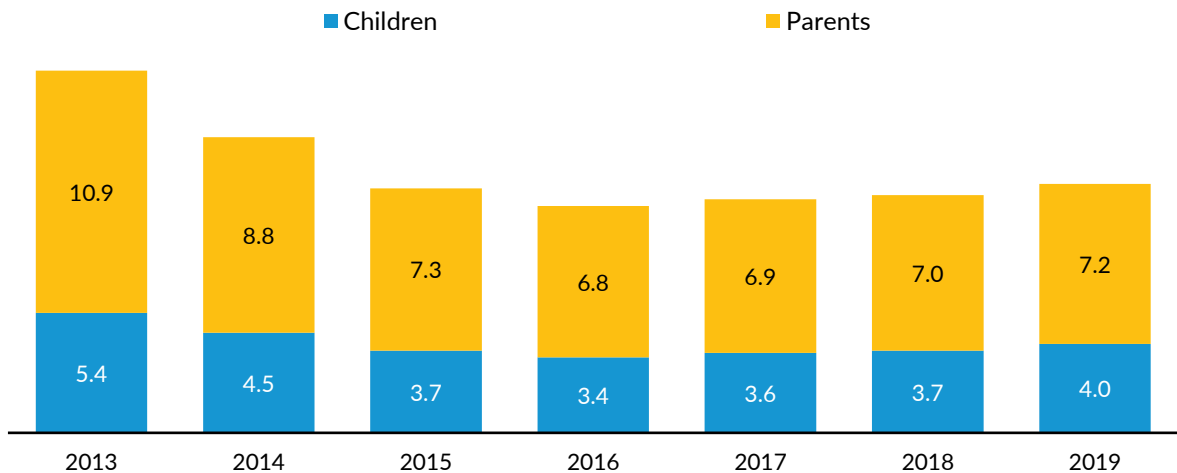


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**Source:** Urban Institute analysis of 2013–19 American Community Survey data from the Integrated Public Use Microdata Series.  
**Notes:** Children are ages 18 and younger. Parents are ages 19 to 64. See appendix B for our definition of uninsurance. Estimates reflect an adjustment for potential misreporting of coverage on the American Community Survey. The 2014–19 estimates are statistically different from the 2013 estimates at the 0.01 level.

^ The 2017–19 estimates are statistically different from the 2016 estimates at the 0.05 level.

**FIGURE 2**  
**Millions of Uninsured Children and Parents, 2013–19**



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**Source:** Urban Institute analysis of 2013–19 American Community Survey data from the Integrated Public Use Microdata Series.  
**Notes:** Children are ages 18 and younger. Parents are ages 19 to 64. See appendix B for our definition of uninsurance. Estimates reflect an adjustment for potential misreporting of coverage on the American Community Survey.

## Variation in Uninsurance According to State ACA Medicaid Expansion Status

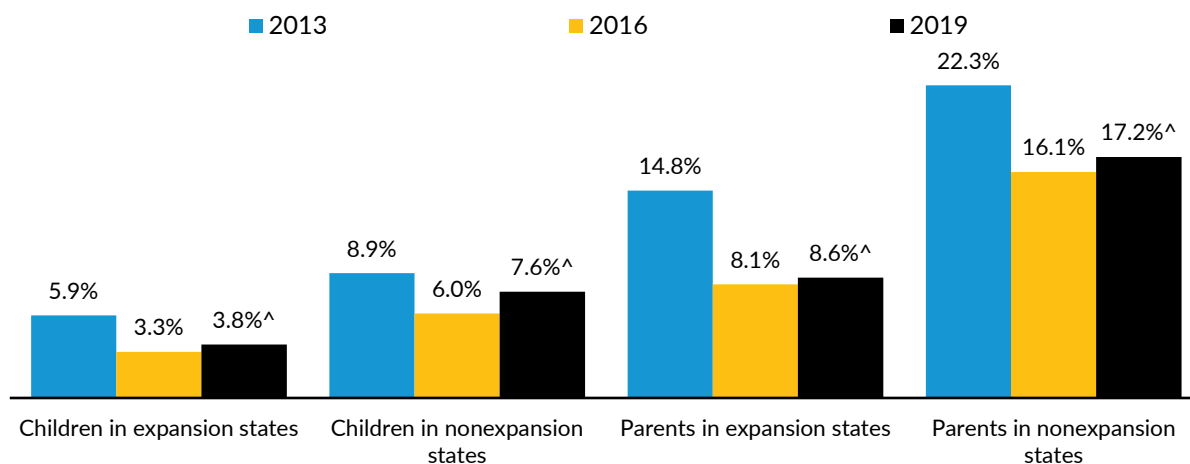
Changes in uninsurance through 2019 further widened coverage gaps between ACA Medicaid expansion and nonexpansion states. Children and parents living in nonexpansion states were about twice as likely to be uninsured as those living in expansion states.

In 2013, children’s and parents’ uninsurance was already lower in states that did adopt the ACA’s Medicaid expansion by 2019 than in states that did not (figure 3). Uninsurance fell among both groups in expansion and nonexpansion states between 2014 and 2016, but drops were larger in expansion states, widening the coverage gap between these groups of states.

Between 2016 and 2019, uninsurance rates for children and parents rose by a statistically significant margin in both expansion and nonexpansion states. However, increases for both parents and children were larger in nonexpansion states on average. In 2019, 3.8 percent of children and 8.6 percent of parents in states that had implemented the ACA’s Medicaid expansion by mid-2019 were uninsured, compared with 7.6 percent of children and 17.2 percent of parents in nonexpansion states.

FIGURE 3

Children’s and Parents’ Uninsurance Rates, by State ACA Medicaid Expansion Status, 2013, 2016, and 2019



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**Source:** Urban Institute analysis of 2013–19 American Community Survey data from the Integrated Public Use Microdata Series.

**Notes:** ACA = Affordable Care Act. Children are ages 18 and younger. Parents are ages 19 to 64. Expansion status refers to implementation of the Affordable Care Act’s Medicaid expansion by mid-2019. See appendix B for our definition of uninsurance. Estimates reflect an adjustment for potential misreporting of coverage on the American Community Survey.

The 2016 and 2019 estimates are statistically different from the 2013 estimates at the 0.01 level.

^ The 2019 estimates are statistically different from 2016 estimates at the 0.01 level.

## Variation in Uninsurance across States

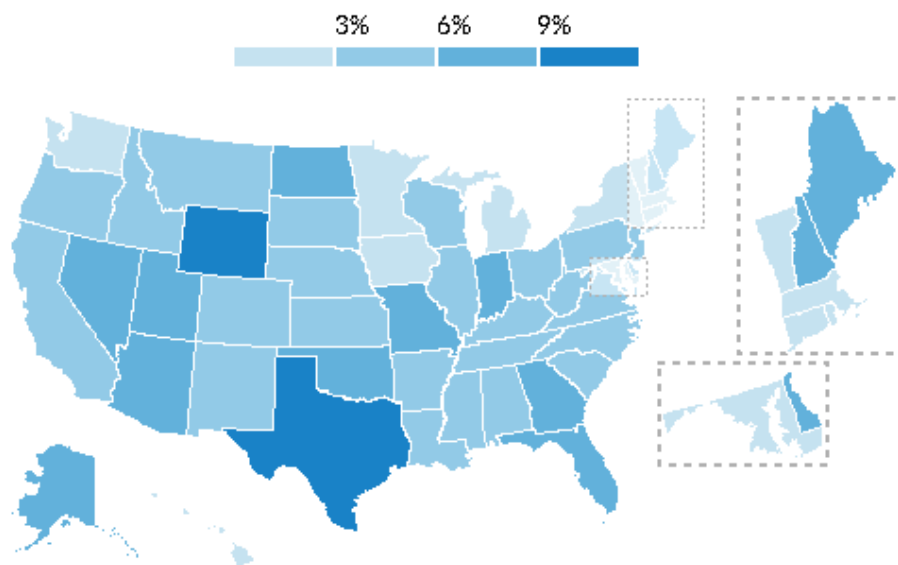
*In 2019, uninsurance rates varied across states but were higher among parents than among children in nearly all states; 24 and 19 states experienced significant increases in uninsurance for children and parents, respectively, between 2016 and 2019.*

Children's uninsurance rates were below 3.0 percent in 11 states and below 6.0 percent in 37 states in 2019; such rates were above 9.0 percent in just 2 states (figure 4). Statistically significant increases in uninsurance occurred between 2016 and 2019 in 24 states (appendix table A.1).<sup>2</sup> Texas remained the state with the largest number (933,000) and rate (11.9 percent) of uninsured children in 2019 and was among the states with the largest increases in uninsurance between 2016 and 2019.<sup>3</sup>

In 2019, uninsurance was significantly higher among parents than among children in most states,<sup>4</sup> and parents' uninsurance rates were below 6.0 percent in just 7 states (figure 5). Two states, Oklahoma and Texas, had parental uninsurance rates above 20.0 percent that year. Parents' uninsurance rose by a statistically significant margin between 2016 and 2019 in 19 states and fell in only 5 states (appendix table A.1).<sup>5</sup>

FIGURE 4

Children's Uninsurance Rates, by State, 2019



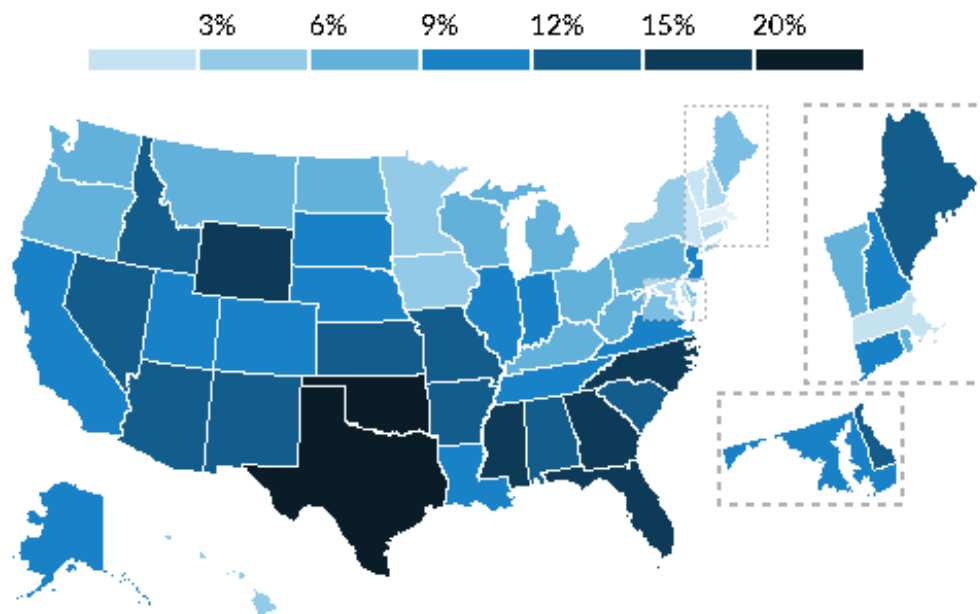
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**Source:** Urban Institute analysis of 2019 American Community Survey data from the Integrated Public Use Microdata Series.

**Notes:** Children are ages 18 and younger. See appendix B for our definition of uninsurance. Estimates reflect an adjustment for potential misreporting of coverage on the American Community Survey.

FIGURE 5

Parents' Uninsurance Rates, by State, 2019



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**Source:** Urban Institute analysis of 2019 American Community Survey data from the Integrated Public Use Microdata Series.

**Notes:** Parents are ages 19 to 64. See appendix B for our definition of uninsurance. Estimates reflect an adjustment for potential misreporting of coverage on the American Community Survey.

## Variation in Uninsurance across Demographic and Socioeconomic Subgroups

*Though coverage rates improved from 2013 to 2016 for every subgroup we examined, many of these gains had begun to reverse by 2019, and disparities across subgroups have persisted or grown since 2016.*

Increases in uninsurance between 2016 and 2019 were widespread (table 1). Uninsurance rose for nearly every subgroup of children. The largest increases were for Hispanic children (1.6 percentage points) and children in families with incomes below the FPL (1.2 percentage points) or between 100 and 133 percent of FPL (1.4 percentage points). These are also subgroups with among the highest rates of uninsurance in 2016, indicating that the changes between 2016 and 2019 widened coverage gaps by ethnicity and income.

The largest increases in parents' uninsurance we observed between 2016 and 2019 occurred among young parents ages 19 to 24, American Indians/Alaska Natives,<sup>6</sup> and those with incomes between 100 and 138 percent of FPL; in each of these subgroups, nearly one in five parents, or more, were uninsured in 2019. For both children and parents, large disparities in coverage across subgroups remained in 2019.



TABLE 1

**Children's and Parents' Uninsurance Rates, by Socioeconomic and Demographic Characteristics, 2013, 2016, and 2019**

Percent

	Children				Parents			
	2013	2016	2019	Change 2016-19	2013	2016	2019	Change 2016-19
<b>Age</b>								
Birth to 5	5.3	3.4	4.3	0.9***				
6 to 12	6.2	3.9	5.0	1.1***				
13 to 18	9.4	5.6	6.4	0.8***				
19 to 24					28.7	18.1	19.9	1.8***
25 to 34					22.4	14.1	14.9	0.8***
35 to 44					16.7	11.0	11.6	0.6***
45 to 64					13.0	7.6	8.7	1.1***
<b>Sex</b>								
Male	7.0	4.3	5.2	0.9***	17.1	10.9	11.9	1.0***
Female	7.0	4.3	5.3	1.0***	18.0	11.1	11.6	0.5***
<b>Race/ethnicity</b>								
American Indian/ Alaska Native <sup>a</sup>	11.8	8.0	8.9	0.8	24.8	17.0	18.7	1.8**
Asian/Pacific Islander	7.2	3.2	4.0	0.8***	14.0	6.0	5.9	-0.1
Black	5.9	3.3	4.1	0.8***	17.9	10.3	11.0	0.7***
Hispanic	11.4	7.1	8.7	1.6***	38.4	26.8	27.2	0.4
Other/multiple races	4.8	3.0	3.2	0.1	15.4	8.1	8.2	0.1
White	5.2	3.3	4.0	0.7***	11.1	6.2	6.9	0.7***
<b>Family income</b>								
At or below FPL	8.3	5.1	6.3	1.2***	29.4	23.8	24.3	0.5*
Greater than 100% but less than 138% of FPL	10.8	6.2	7.6	1.4***	38.1	23.0	25.4	2.4***
At or above 138% of FPL	5.9	3.7	4.6	0.9***	10.2	6.9	8.3	1.4***
<b>Household SNAP status</b>								
Does not receive SNAP	7.8	4.8	5.7	0.9***	14.6	9.1	10.6	1.5***
Receives SNAP	4.7	2.7	3.1	0.4***	30.5	20.1	18.9	-1.2***

Source: Urban Institute analysis of 2013-19 American Community Survey data from the Integrated Public Use Microdata Series.

Notes: FPL = federal poverty level. SNAP = Supplemental Nutrition Assistance Program. Children are ages 18 and younger.

Parents are ages 19 to 64. Blank rows indicate the column heading does not apply. See appendix B for our definition of

uninsurance. Estimates reflect an adjustment for potential misreporting of coverage on the American Community Survey.

<sup>a</sup> Uninsurance rates would be 5.7 and 8.5 percentage points lower among American Indian/Alaska Native children and parents,

respectively, in 2019 if Indian Health Service access were considered health insurance coverage.

The 2016 and 2019 estimates are statistically different from 2013 estimates at the 0.01 level.

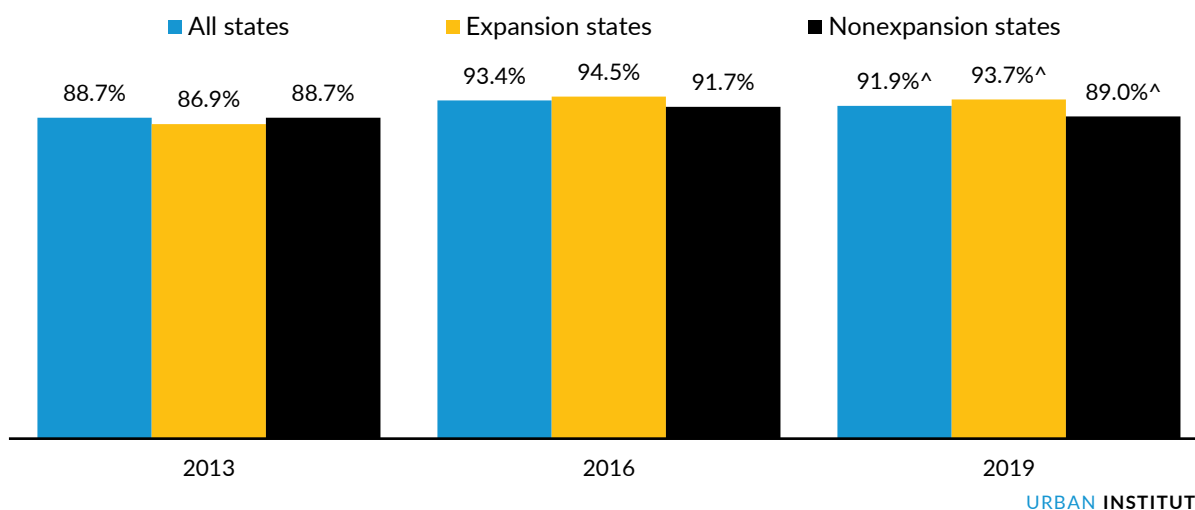
\*\*\*/\*\*/\* The 2019 estimates are statistically different from 2016 estimates at the 0.01/0.05/0.10 level.

## Children’s Medicaid/CHIP Participation and Eligible but Uninsured Children

Medicaid/CHIP participation among eligible children without other coverage fell between 2016 and 2019, contributing to the increases in children’s uninsurance.

Consistent with the shifts in uninsurance we observed, children’s Medicaid/CHIP participation rate rose between 2013 and 2016, from 88.7 to 93.4 percent nationally (figure 6). Here we define Medicaid/CHIP participation rates as the shares of Medicaid/CHIP-eligible children without other coverage enrolled in the programs. Over this period, Medicaid/CHIP eligibility thresholds were relatively stable for children, and improvements in economic conditions somewhat reduced the number of eligible children. Still, Medicaid/CHIP enrollment rose (data not shown).

**FIGURE 6**  
**Children’s Medicaid/CHIP Participation Rates, 2013, 2016, and 2019**



**Source:** Urban Institute analysis of 2013–19 American Community Survey data from the Integrated Public Use Microdata Series.

**Notes:** CHIP = Children’s Health Insurance Program. Children are ages 18 and younger. Expansion status refers to implementation of the Affordable Care Act’s Medicaid expansion by mid-2019. See appendix B for our definitions of uninsurance, eligibility, and participation. Participation rates exclude children with private coverage. Estimates reflect an adjustment for potential misreporting of coverage on the American Community Survey. The 2016 and 2019 estimates are statistically different from the 2013 estimates at the 0.01 level.

<sup>^</sup> The 2019 estimates are statistically different from 2016 estimates at the 0.01 level.

However, children’s Medicaid/CHIP participation declined between 2016 and 2019, falling by 1.5 percentage points to 91.9 percent nationally. These patterns are consistent with declines in children’s Medicaid/CHIP enrollment reflected in administrative data.<sup>7</sup> Further, we find a larger drop in children’s participation in nonexpansion states than in expansion states over this period; the participation rate fell from 91.7 to 89.0 percent in nonexpansion states but dropped from 94.5 to 93.7 percent in expansion states, corresponding with the larger increases in uninsurance in nonexpansion states.

The 0.9 percentage-point drop in participation between 2018 and 2019 was the largest annual drop in Medicaid/CHIP participation we have observed among children since the ACS began collecting coverage data in 2008 (data not shown). Overall, children in 19 states experienced statistically significant declines in Medicaid/CHIP participation between 2016 and 2019 (appendix table A.2).

As described in appendix B, we also considered a more expansive alternative measure of eligibility that adds 50 percentage points to each state’s upper income threshold. The participation rate for children in 2019 is similar, at 91.4 percent, under this alternative eligibility model (appendix table B.1).

*The estimated number of Medicaid/CHIP-eligible uninsured children rose between 2016 and 2019; in 2019, as in prior years, more than half of all uninsured children were eligible for Medicaid/CHIP.*

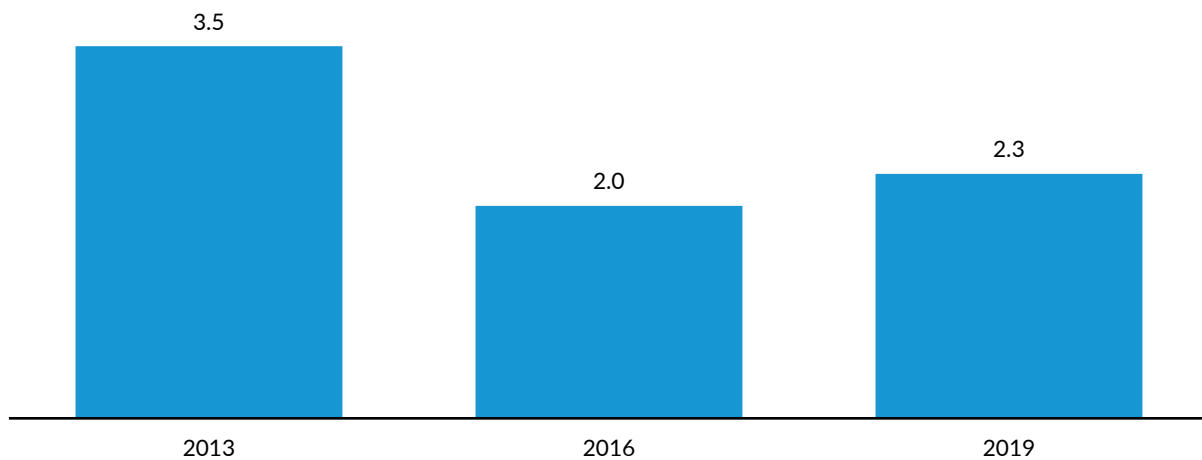
The number of children estimated to be eligible for Medicaid/CHIP but uninsured fell from 3.5 million to 2.0 million between 2013 and 2016, under increased Medicaid/CHIP participation and economic gains that reduced the number of children estimated to qualify. The 2.0 million eligible uninsured children in 2016 is less than half the number of such children in 2008 (4.9 million; Kenney et al. 2016a). But by 2019, the number of eligible uninsured children had risen to 2.3 million.<sup>8</sup>

As shown in table 2, more than a third of Medicaid/CHIP-eligible uninsured children in 2019 lived in just three large states: Texas (460,000), California (205,000), and Florida (166,000). With significant numbers of such children in Georgia (117,000), Illinois (82,000), Indiana (81,000), and Arizona (80,000), too, we find that half of Medicaid/CHIP-eligible uninsured children lived in just seven states.

#### FIGURE 7

#### Estimated Number of Medicaid/CHIP-Eligible Uninsured Children, 2013, 2016, and 2019

Millions



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**Source:** Urban Institute analysis of 2013–19 American Community Survey data from the Integrated Public Use Microdata Series.

**Notes:** CHIP = Children’s Health Insurance Program. Children are ages 18 and younger. See appendix B for our definitions of uninsurance and eligibility. Estimates reflect an adjustment for potential misreporting of coverage on the American Community Survey.

TABLE 2

## Medicaid/CHIP-Eligible Uninsured Children, by State, 2019

	Thousands of children	Percent of nation's Medicaid/CHIP-eligible uninsured children	Cumulative percent of nation's Medicaid/CHIP-eligible uninsured children
Texas	460	19.9	19.9
California	205	8.9	28.8
Florida	166	7.2	36.0
Georgia	117	5.1	41.1
Illinois	82	3.5	44.6
Indiana	81	3.5	48.1
Arizona	80	3.5	51.6
Pennsylvania	78	3.4	54.9
Ohio	73	3.2	58.1
Missouri	71	3.1	61.2
New York	69	3.0	64.2
North Carolina	64	2.8	67.0
New Jersey	48	2.1	69.0
Tennessee	45	2.0	71.0
Oklahoma	42	1.8	72.8
Utah	40	1.7	74.6
Colorado	36	1.5	76.1
Michigan	35	1.5	77.6
Virginia	35	1.5	79.1
South Carolina	34	1.5	80.6
Wisconsin	33	1.4	82.0
Washington	32	1.4	83.4
Alabama	28	1.2	84.6
Minnesota	25	1.1	85.7
Arkansas	24	1.1	86.8
Kentucky	24	1.0	87.8

**Source:** Urban Institute analysis of 2019 American Community Survey data from the Integrated Public Use Microdata Series.

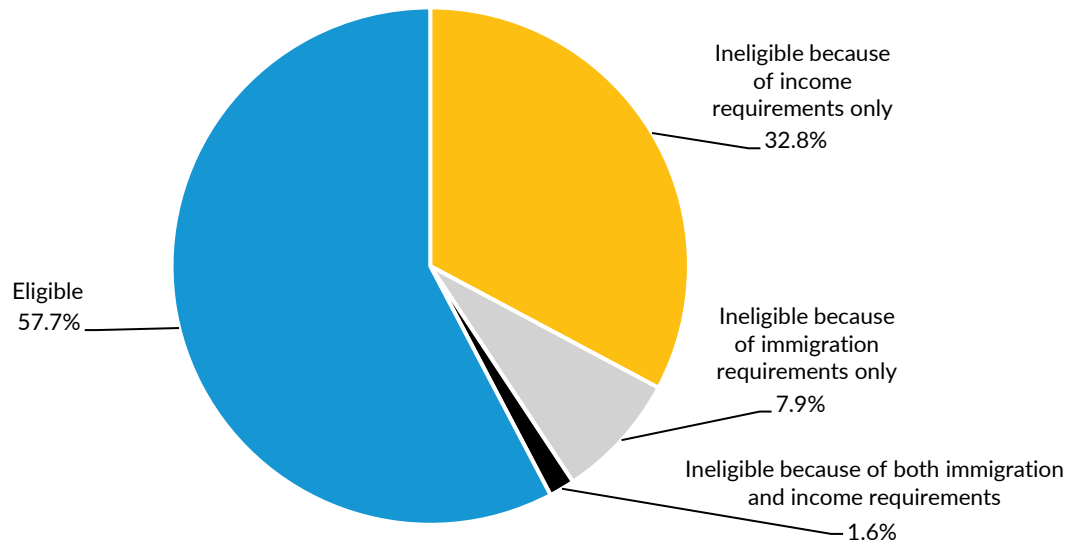
**Notes:** CHIP = Children's Health Insurance Program. Children are ages 18 and younger. See appendix B for our definitions of eligibility and uninsurance. Estimates reflect an adjustment for potential misreporting of coverage on the American Community Survey. States with a sample size of eligible uninsured children smaller than 200 are not shown.

The estimated 2.3 million eligible uninsured children in 2019 represented 57.7 percent of all uninsured children (figure 8), indicating that enrolling uninsured children who qualify for the programs could cut the number of uninsured children by more than half. Similar to prior years, we estimate that among the 42.3 percent of uninsured children who appeared ineligible for Medicaid/CHIP, most (32.8 percent of uninsured children) were ineligible because their family incomes were above their state's eligibility thresholds. Another 7.9 percent had family incomes below state thresholds but were ineligible because of their immigration status, and 1.6 percent met neither the income nor immigration requirements to qualify.

As detailed in appendix B, we use an alternative methodological approach to reassess the number of eligible but uninsured children that includes uninsured children whose family incomes are within 50 percentage points of their state's upper Medicaid/CHIP eligibility threshold. Through this, we identify an additional 300,000 uninsured children who could be potentially eligible for Medicaid/CHIP

(appendix table B.1). Using that alternative approach, we find that a somewhat larger share of uninsured children could be eligible for Medicaid/CHIP (65.4 percent).

**FIGURE 8**  
**Medicaid/CHIP Eligibility and Reasons for Ineligibility among Uninsured Children, 2019**



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**Source:** Urban Institute analysis of 2019 American Community Survey data from the Integrated Public Use Microdata Series.  
**Notes:** Children are ages 18 and younger. See appendix B for our definitions of uninsurance and eligibility. Estimates reflect an adjustment for potential misreporting of coverage on the American Community Survey.

## Parents' Medicaid Participation and Eligible but Uninsured Parents

*Medicaid-eligible parents in expansion states who did not have other coverage were less likely than Medicaid/CHIP-eligible children without other coverage in those states to participate in the programs.*

Table 3 presents Medicaid/CHIP participation rates for both children and parents without other coverage in the 34 states that had implemented the ACA's Medicaid expansion by 2019. Overall, participation was lower among parents (84.0 percent) than children (93.7 percent) in these states, and we find Medicaid/CHIP participation was lower among parents than among children in nearly every expansion state.<sup>9</sup>

**TABLE 3**

**Medicaid/CHIP Participation Rates among Children and Parents in Medicaid Expansion States, 2019**  
Percent

	Children's participation rate	Parents' participation rate
Alaska	89.9	75.9
Arizona	87.4	77.0
Arkansas	92.9	74.0
California	94.6	87.7
Colorado	91.3	81.1
Connecticut	96.5	88.7
Delaware	95.6	83.3
District of Columbia	95.6	88.8
Hawaii	95.4	88.3
Illinois	92.5	83.0
Indiana	86.1	72.3
Iowa	96.2	89.9
Kentucky	94.3	83.5
Louisiana	95.4	78.8
Maine	91.2	81.5
Maryland	96.0	84.8
Massachusetts	97.7	94.4
Michigan	95.2	85.6
Minnesota	93.7	81.4
Montana	89.8	81.6
Nevada	89.9	70.6
New Hampshire	91.1	81.1
New Jersey	92.9	80.0
New Mexico	94.1	85.9
New York	96.3	88.4
North Dakota	82.1	84.8
Ohio	92.0	83.3
Oregon	93.0	85.7
Pennsylvania	92.6	82.1
Rhode Island	95.3	90.8
Vermont	97.3	86.2
Virginia	93.0	75.8
Washington	95.1	82.9
West Virginia	94.7	86.7
<b>All expansion states</b>	<b>93.7</b>	<b>84.0</b>

Source: Urban Institute analysis of 2019 American Community Survey data from the Integrated Public Use Microdata Series.

**Notes:** ACA = Affordable Care Act. Children are ages 18 and younger. Parents are ages 19 to 64. Expansion status refers to implementation of the Affordable Care Act’s Medicaid expansion by mid-2019. See appendix B for our definitions of eligibility and participation. Participation rates exclude those with private coverage. Participation for adults excludes those with Supplemental Security Income–based eligibility. Estimates reflect an adjustment for potential misreporting of coverage on the American Community Survey. Rates for parents are significantly lower than those for children in every state shown at the 0.01 level, except in North Dakota, where the rate for parents is significantly higher at the 0.01 level.

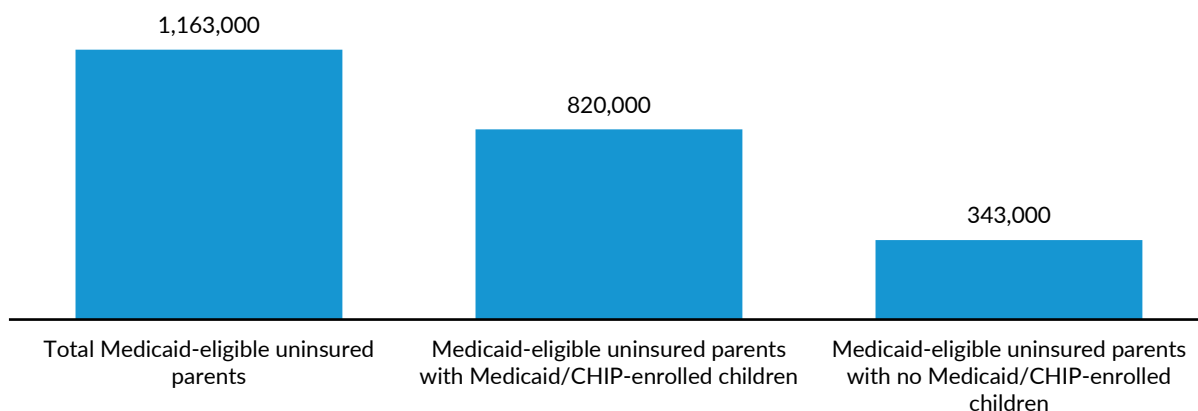
*We estimate over 1.0 million parents were likely eligible for Medicaid but uninsured in 2019 nationwide, and most had a Medicaid/CHIP-enrolled child.*

An estimated one in six uninsured parents (1.2 million) were likely eligible for Medicaid but uninsured in 2019 (figure 9). Of these, 820,000, or 70.5 percent, had at least one Medicaid/CHIP-enrolled child.

As indicated above, because Medicaid eligibility status is challenging to measure, particularly for parents in nonexpansion states, we constructed an alternative estimate of eligible uninsured parents. As noted, this alternative model adds 50 percentage points to each state’s upper income eligibility threshold. Thus, using two measures of parents’ Medicaid eligibility, we estimate 1.2 to 2.0 million parents were eligible but uninsured nationwide in 2019 (appendix table B.1).<sup>10</sup>

Regardless of the methodology used, we find that the majority of parents eligible for Medicaid but uninsured resided in expansion states. Though, as noted in appendix B, evidence shows we are likely understating the number of eligible uninsured parents more in nonexpansion states than in expansion states. In addition, using either methodology, we find a much smaller share of uninsured parents than uninsured children who appeared eligible but not enrolled, consistent with the less expansive income thresholds (especially in nonexpansion states) and more restrictive immigration rules for parents.

**FIGURE 9**  
**Medicaid-Eligible but Uninsured Parents Nationwide, Overall and by Whether Parents Have a Medicaid/CHIP-Enrolled Child, 2019**



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**Source:** Urban Institute analysis of 2019 American Community Survey data from the Integrated Public Use Microdata Series.

**Notes:** CHIP = Children’s Health Insurance Program. Parents are ages 19 to 64. See appendix B for our definitions of uninsurance and eligibility and a discussion of greater evidence of measurement error in estimating parents’ eligibility than in estimating children’s eligibility. Estimates reflect an adjustment for potential misreporting of coverage on the American Community Survey.

## Discussion

Uninsurance among children and parents rose between 2016 and 2019, reversing some of the coverage gains they had experienced between 2013 and 2016. Together, just over 1.0 million more children and parents were uninsured in 2019 than in 2016. These changes increased coverage gaps between Medicaid expansion and nonexpansion states and across the subgroups examined. Given the importance of health insurance to ensuring affordable access to health care, these findings suggest the number of families facing challenges obtaining needed health care was rising even before the COVID-19 pandemic began.

Our finding that millions of children and parents were likely eligible for Medicaid/CHIP but uninsured in 2019 highlights the importance of enrolling and retaining families in coverage for which they qualify, which will likely require more resources for advertising, targeted outreach, and enrollment assistance to connect families with available publicly subsidized coverage. It will also require systematic efforts to dismantle the administrative hurdles and hassles people face when applying for Medicaid (Michener 2021). Also important will be addressing other barriers to enrollment, such as experiences of unfair treatment or judgment when applying for public assistance, which are reported at significantly higher rates among Black and Hispanic adults, particularly among those with incomes below 200 percent of FPL (Gonzalez et al. 2021; Pratt and Hahn 2021).

The declines in children’s Medicaid/CHIP participation between 2016 and 2019 are likely related, in part, to policy choices over that period, such as reduced investments in outreach and enrollment assistance and more frequent and burdensome Medicaid/CHIP renewal procedures (Brooks, Park, and Roygardner 2019). However, substantial opportunities exist to increase children’s and parents’ Medicaid enrollment and reduce uninsurance among those who are eligible but uninsured. One promising method for doing so is targeting parents of Medicaid/CHIP-enrolled children, as we find the majority of eligible but uninsured parents already have a Medicaid/CHIP-enrolled child.

We also find that disparities in coverage by race and ethnicity persisted in 2019. Hispanic and American Indian/Alaska Native children remained more than twice as likely as white children to be uninsured. And Black parents were more than 1.5 times as likely, American Indian/Alaska Native parents were more than 2.5 times more likely, and Hispanic parents were nearly 4.0 times more likely to be uninsured than with white parents in 2019. Since then, the large racial and ethnic disparities in coronavirus exposure; COVID-19 infection, hospitalization, and death rates; and economic hardships during the pandemic could be translating into greater coverage losses or unmet health care needs among communities of color (Gonzalez et al. 2020; Karpman, Gonzalez, and Kenney 2020; Rho, Brown, and Fremstad 2020).<sup>11</sup> Also, the Trump administration’s expansion of the public charge rule caused some immigrant families to avoid public programs even before the rule’s implementation;



though the Biden administration has since rescinded the rule, program avoidance may be continuing. This could reduce Medicaid/CHIP participation and raise uninsurance among certain subgroups, such as Hispanic communities, which include a large share of noncitizen families (Haley, Kenney, Bernstein, et al. 2020; Haley, Kenney, Bernstein, et al. 2021). Our analysis of ACS data indicates that increases in uninsurance and drops in Medicaid/CHIP participation were larger for citizen children with noncitizen parents than for other citizen children; this suggests that fears about the public charge rule and other anti-immigrant policies have contributed to the overall declines in children's coverage observed here (Haley, Kenney, Wang, et al. forthcoming). Investments will be needed to rebuild trust with immigrant families and effectively communicate that Medicaid and CHIP coverage for parents or their children will not threaten immigration status.

To reduce the harms of rising uninsurance on children's and parents' health and financial well-being in the short and long runs (Goodman-Bacon 2021; Institute of Medicine 2009), it will be important to maintain focus on increasing coverage for both groups. Recent executive actions and implementation of the American Rescue Plan Act have expanded opportunities for families to obtain subsidized coverage, including the extended special enrollment period for Marketplace coverage with expanded subsidies and increases in funding for health insurance navigators to connect people with coverage.<sup>12</sup> And for states to receive enhanced federal funding, they must maintain Medicaid eligibility standards and enrollment for people who had such coverage as of March 2020 or have gained it since then for the duration of the public health emergency (MACPAC 2020). These changes could help spark greater take-up of Medicaid/CHIP among eligible children and parents.

However, the public health emergency period will likely expire at the beginning of 2022, at which point state Medicaid programs can disenroll those who fail to complete renewal requirements or have become ineligible (MACPAC 2020). To prepare for the end of the emergency period, many states are processing renewals using *ex parte* procedures, requesting documentation from enrollees if more information is needed to verify eligibility, proactively updating mailing addresses, and offering online accounts to ensure they can reach enrollees for needed renewal information (Brooks et al. 2021). But states can take additional steps to minimize coverage losses, like providing robust support to enrollees likely to face challenges renewing for procedural reasons and phasing in renewals to allow adequate time for follow-up for enrollees who do not respond to initial inquiries. Given the importance of coverage for children and parents in both the short and long terms (Wagnerman, Chester, and Alker 2017), especially as the pandemic and economic downturn continue, it is more important than ever that families recover from the coverage losses that occurred between 2016 and 2019 and have the financial stability and access to care that health insurance coverage provides.

## Appendix A. 50-State Tables

TABLE A.1

Number of Uninsured Children and Children's Uninsurance Rate, by State, 2013, 2016, and 2019

	2013		2016		2019		Change 2016-19	
	Number (1,000s)	%	Number (1,000s)	%	Number (1,000s)	%	Number (1,000s)	%
<b>US total</b>	<b>5,428</b>	<b>7.0</b>	<b>3,357</b>	<b>4.3</b>	<b>4,042</b>	<b>5.2</b>	<b>685</b>	<b>0.9***</b>
<b>Expansion states</b>	<b>2,913</b>	<b>5.9</b>	<b>1,619</b>	<b>3.3</b>	<b>1,844</b>	<b>3.8</b>	<b>224</b>	<b>0.5***</b>
Alaska <sup>a</sup>	24	12.1	20	10.2	13	7.0	-7	-3.2*
Arizona <sup>a</sup>	203	11.9	126	7.3	146	8.4	21	1.1*
Arkansas	45	5.9	27	3.6	38	5.2	12	1.6***
California	704	7.3	277	2.9	315	3.4	38	0.5***
Colorado	111	8.4	54	4.1	66	5.0	11	0.9
Connecticut	35	4.1	19	2.3	23	3.0	5	0.7*
Delaware	11	4.9	7	3.4	7	3.5	0	0.1
DC	3	2.5	4	3.1	3	2.2	-1	-0.9
Hawaii	10	3.0	7	2.1	8	2.7	2	0.6
Illinois	138	4.3	76	2.5	110	3.7	34	1.2***
Indiana	138	8.2	87	5.2	114	6.9	27	1.7***
Iowa	35	4.5	15	2.0	16	2.1	1	0.1
Kentucky	63	5.9	31	2.9	40	3.8	9	0.9**
Louisiana	66	5.6	38	3.2	49	4.2	11	1.0**
Maine	14	5.0	13	4.8	15	5.7	2	0.9
Maryland	64	4.5	45	3.2	41	2.9	-4	-0.3
Massachusetts	22	1.5	14	0.9	20	1.4	6	0.5**
Michigan	99	4.1	62	2.7	64	2.8	2	0.1
Minnesota	80	5.9	36	2.6	40	2.9	4	0.3
Montana <sup>a</sup>	21	9.0	10	4.2	15	6.0	4	1.8*
Nevada	93	13.4	43	6.0	53	7.4	11	1.4*
New Hampshire	10	3.5	9	3.0	11	4.1	3	1.1
New Jersey	118	5.5	64	3.1	82	4.0	18	0.9***
New Mexico <sup>a</sup>	46	8.5	27	5.2	26	5.1	-1	-0.1
New York	177	3.9	106	2.4	91	2.1	-15	-0.3
North Dakota	12	6.9	17	9.2	15	8.1	-2	-1.1
Ohio	138	4.9	89	3.2	120	4.4	32	1.2***
Oregon	55	6.1	26	2.9	36	3.9	9	1.0**
Pennsylvania	134	4.6	121	4.3	109	3.9	-12	-0.4
Rhode Island	13	5.6	4	1.9	4	1.9	0	0.0
Vermont	4	3.0	1	1.0	2	1.2	0	0.2
Virginia	109	5.5	97	4.9	88	4.5	-9	-0.4
Washington	102	6.1	41	2.4	49	2.8	8	0.4
West Virginia	19	4.6	6	1.4	14	3.6	8	2.2***
<b>Nonexpansion states</b>	<b>2,514</b>	<b>8.9</b>	<b>1,738</b>	<b>6.0</b>	<b>2,198</b>	<b>7.6</b>	<b>461</b>	<b>1.6***</b>
Alabama	54	4.6	27	2.4	38	3.3	10	0.9**
Florida	465	10.9	266	6.1	321	7.2	55	1.1***
Georgia	238	9.0	163	6.1	183	6.8	19	0.7
Idaho	38	8.4	24	5.3	23	4.8	-2	-0.5
Kansas	50	6.6	35	4.6	40	5.4	5	0.8
Mississippi	55	7.1	33	4.2	42	5.6	9	1.4**
Missouri	100	6.8	69	4.7	90	6.2	21	1.5***

	2013		2016		2019		Change 2016–19	
	Number (1,000s)	%	Number (1,000s)	%	Number (1,000s)	%	Number (1,000s)	%
Nebraska	27	5.5	25	5.0	25	5.0	0	0.0
North Carolina	146	6.0	104	4.3	131	5.4	27	1.1***
Oklahoma <sup>a</sup>	103	10.3	73	7.2	77	7.7	4	0.5
South Carolina	76	6.7	45	3.9	65	5.5	20	1.6***
South Dakota <sup>a</sup>	15	6.9	10	4.3	14	6.0	4	1.7
Tennessee	86	5.4	54	3.4	80	5.0	26	1.6***
Texas	908	12.2	702	9.1	933	11.9	231	2.8***
Utah	81	8.6	51	5.3	76	7.8	25	2.5***
Wisconsin	61	4.4	44	3.2	46	3.4	2	0.2
Wyoming <sup>a</sup>	9	6.3	11	7.2	14	9.6	3	2.4

**Source:** Urban Institute analysis of 2013–19 American Community Survey data from the Integrated Public Use Microdata Series.

**Notes:** Children are ages 18 and younger. Expansion status refers to implementation of the Affordable Care Act’s Medicaid expansion by mid-2019. See appendix B for our definition of uninsurance. Estimates reflect an adjustment for potential misreporting of coverage on the American Community Survey.

<sup>a</sup> These states’ 2019 uninsurance rates would be 1 to 5 percentage points lower if Indian Health Service access were treated as coverage; see appendix B.

\*\*\*/\*\*/\* The rate change between 2016 and 2019 is statistically significant at the 0.01/0.05/0.10 level.

**TABLE A.2**

**Number of Uninsured Parents and Parents’ Uninsurance Rate, by State, 2013, 2016, and 2019**

	2013		2016		2019		Change 2016–19	
	Number (1,000s)	%	Number (1,000s)	%	Number (1,000s)	%	Number (1,000s)	%
<b>US total</b>	<b>10,621</b>	<b>17.5</b>	<b>6,838</b>	<b>11.0</b>	<b>7,201</b>	<b>11.7</b>	<b>363</b>	<b>0.7***</b>
<b>Expansion states</b>	<b>5,812</b>	<b>14.8</b>	<b>3,227</b>	<b>8.1</b>	<b>3,344</b>	<b>8.6</b>	<b>116</b>	<b>0.5***</b>
Alaska <sup>a</sup>	27	19.1	22	15.6	13	10.5	-8	-5.1**
Arizona	245	20.1	160	12.4	190	14.5	30	2.1***
Arkansas	135	23.6	70	12.1	72	12.5	2	0.4
California	1,483	19.9	745	9.5	744	9.8	-1	0.3
Colorado	171	16.0	104	9.3	114	10.2	10	0.9
Connecticut	58	8.2	35	5.3	46	7.1	11	1.8***
Delaware	20	12.1	10	6.1	16	9.9	6	3.8**
DC	4	4.2	3	3.0	4	4.7	1	1.7
Hawaii	16	6.9	9	3.6	8	3.7	-1	0.1
Illinois	328	13.0	219	8.7	219	9.2	0	0.5
Indiana	227	17.4	139	10.6	138	10.8	-1	0.2
Iowa	68	10.7	33	5.1	33	5.2	0	0.1
Kentucky	162	18.9	48	5.6	72	8.6	25	3.0***
Louisiana	182	21.1	115	13.6	94	11.5	-20	-2.1***
Maine	23	10.3	16	7.1	21	9.3	5	2.2*
Maryland	123	10.5	79	6.7	89	7.7	10	1.0*
Massachusetts	44	3.4	23	1.8	37	3.0	14	1.2***
Michigan	224	12.0	105	5.7	112	6.2	8	0.5
Minnesota	88	8.1	56	5.0	62	5.4	5	0.4
Montana <sup>a</sup>	45	24.1	16	8.3	17	9.0	1	0.7
Nevada	128	24.3	77	14.5	83	14.8	6	0.3
New Hampshire	31	11.6	18	7.2	19	7.9	1	0.7
New Jersey	265	14.6	172	9.4	181	10.3	10	0.9*

	2013		2016		2019		Change 2016-19	
	Number (1,000s)	%	Number (1,000s)	%	Number (1,000s)	%	Number (1,000s)	%
New Mexico <sup>a</sup>	102	26.7	46	12.5	44	12.3	-2	-0.2
New York	411	11.4	255	7.1	210	6.0	-46	-1.1***
North Dakota	15	10.5	13	9.1	13	8.0	-1	-1.1
Ohio	227	10.3	119	5.5	160	7.4	40	1.9***
Oregon	130	17.3	55	7.3	68	9.0	13	1.7**
Pennsylvania	271	11.7	151	6.5	159	7.0	8	0.5
Rhode Island	21	11.3	9	5.1	11	5.9	1	0.8
Vermont	7	5.9	4	3.5	4	3.9	0	0.4
Virginia	225	14.0	177	10.7	147	9.2	-30	-1.5***
Washington	252	18.1	111	7.7	124	8.4	12	0.7
West Virginia	55	17.0	15	4.9	21	6.8	6	1.9**
<b>Nonexpansion states</b>	<b>4,809</b>	<b>22.3</b>	<b>3,611</b>	<b>16.1</b>	<b>3,857</b>	<b>17.2</b>	<b>247</b>	<b>1.1***</b>
Alabama	176	19.1	107	12.1	113	12.9	5	0.8
Florida	791	24.5	536	15.5	589	17.2	54	1.7***
Georgia	459	23.2	348	16.9	332	16.4	-16	-0.5
Idaho	74	21.3	48	14.4	50	13.4	2	-1.0
Kansas	105	17.3	67	11.3	72	12.3	5	1.0
Mississippi	108	19.6	81	14.6	95	17.6	14	3.0***
Missouri	184	15.9	137	11.7	151	13.0	14	1.3*
Nebraska	56	14.5	48	12.0	38	9.3	-10	-2.7**
North Carolina	384	20.7	275	14.0	306	15.5	31	1.5***
Oklahoma <sup>a</sup>	185	24.4	140	17.9	154	20.3	14	2.4***
South Carolina	165	19.1	105	12.0	111	12.4	6	0.4
South Dakota <sup>a</sup>	24	14.3	16	9.3	20	11.7	4	2.4
Tennessee	202	16.3	122	9.9	138	10.9	16	1.0*
Texas	1,681	30.2	1,428	24.0	1,519	25.2	91	1.2***
Utah	110	15.9	74	10.4	77	10.3	2	-0.1
Wisconsin	84	7.5	67	6.0	75	6.9	8	0.9
Wyoming <sup>a</sup>	19	16.5	11	9.8	17	15.2	6	5.4***

Source: Urban Institute analysis of 2013-19 American Community Survey data from the Integrated Public Use Microdata Series.

Notes: Parents are ages 19 to 64. Expansion status refers to implementation of the Affordable Care Act's Medicaid expansion by mid-2019. See appendix B for our definition of uninsurance. Estimates reflect an adjustment for potential misreporting of coverage on the American Community Survey.

<sup>a</sup> These states' 2019 uninsurance rates would be 1 to 5 percentage points lower if Indian Health Service access were treated as coverage; see appendix B.

\*\*\*/\*\*/\* The rate change between 2016 and 2019 is statistically significant at the 0.01/0.05/0.10 level.

TABLE A.3

## Children's Medicaid/CHIP Participation Rate, by State, 2013, 2016, and 2019

Percent

	2013	2016	2019	Change 2016–19
<b>US total</b>	<b>88.7</b>	<b>93.4</b>	<b>91.9</b>	<b>-1.5***</b>
<b>Expansion states</b>	<b>89.7</b>	<b>94.5</b>	<b>93.7</b>	<b>-0.8***</b>
Alaska <sup>a</sup>	81.8	81.9	89.9	8.0**
Arizona <sup>a</sup>	81.6	90.6	87.4	-3.2***
Arkansas	93.1	95.7	92.9	-2.8**
California	88.9	95.2	94.6	-0.6**
Colorado	84.0	93.7	91.3	-2.4*
Connecticut	93.0	96.5	96.5	0.0
Delaware	92.5	95.3	95.6	0.3
District of Columbia	97.8	94.3	95.6	1.3
Hawaii	92.7	96.9	95.4	-1.5
Illinois	92.3	95.3	92.5	-2.8***
Indiana	84.3	89.4	86.1	-3.3**
Iowa	89.7	96.0	96.2	0.2
Kentucky	90.3	95.3	94.3	-1.0
Louisiana	92.4	96.4	95.4	-1.0
Maine	94.0	90.7	91.2	0.5
Maryland	91.5	94.7	96.0	1.3
Massachusetts	96.8	98.1	97.7	-0.4
Michigan	92.8	95.9	95.2	-0.7
Minnesota	84.9	94.2	93.7	-0.5
Montana <sup>a</sup>	85.8	93.0	89.8	-3.2
Nevada	74.3	91.2	89.9	-1.3
New Hampshire	90.3	94.2	91.1	-3.1
New Jersey	89.8	94.8	92.9	-1.9**
New Mexico <sup>a</sup>	90.3	94.1	94.1	0.0
New York	93.0	95.6	96.3	0.7
North Dakota <sup>a</sup>	84.3	83.3	82.1	-1.2
Ohio	90.3	94.4	92.0	-2.4***
Oregon	89.1	94.6	93.0	-1.6
Pennsylvania	90.5	91.6	92.6	1.0
Rhode Island	90.3	97.1	95.3	-1.8
Vermont	94.3	98.3	97.3	-1.0
Virginia	89.1	90.7	93.0	2.3**
Washington	88.1	95.1	95.1	0.0
West Virginia	91.7	97.9	94.7	-3.2***
<b>Nonexpansion states</b>	<b>86.9</b>	<b>91.7</b>	<b>89.0</b>	<b>-2.7***</b>
Alabama	91.6	96.2	94.6	-1.6**
Florida	85.0	92.8	90.6	-2.2***
Georgia	85.5	90.6	89.1	-1.5*
Idaho	87.8	92.5	91.9	-0.6
Kansas	87.7	91.5	89.8	-1.7
Mississippi	89.2	94.7	93.1	-1.6
Missouri	85.5	90.5	87.1	-3.4***
Nebraska	88.4	90.5	89.6	-0.9
North Carolina	91.9	94.7	93.1	-1.6***
Oklahoma <sup>a</sup>	85.6	90.9	89.3	-1.6
South Carolina	89.9	95.5	92.5	-3.0***
South Dakota <sup>a</sup>	86.2	91.9	89.0	-2.9
Tennessee	91.1	95.6	92.7	-2.9***
Texas	84.7	88.5	84.5	-4.0***
Utah	79.0	87.3	79.4	-7.9***

	2013	2016	2019	Change 2016–19
Wisconsin	90.9	92.6	91.7	-0.9
Wyoming <sup>a</sup>	88.4	90.2	79.0	-11.2**

**Source:** Urban Institute analysis of 2013–19 American Community Survey data from the Integrated Public Use Microdata Series.

**Notes:** Children are ages 18 and younger. Expansion status refers to implementation of the Affordable Care Act’s Medicaid expansion by mid-2019. See appendix B for our definitions of uninsurance and participation. Participation rates exclude children with private coverage. Estimates reflect an adjustment for potential misreporting of coverage on the American Community Survey.

<sup>a</sup> These states’ 2019 participation rates would be 1 to 5 percentage points higher if Indian Health Service access were treated as coverage; see appendix B.

\*\*\*/\*\*/\* The rate change between 2016 and 2019 is statistically significant at the 0.01/0.05/0.10 level.

## Appendix B. Data and Methods

### Data Source

This report uses data from the 2013–19 ACS, an annual survey fielded by the US Census Bureau, from the Integrated Public Use Microdata Series.<sup>13</sup> We examined coverage status, Medicaid/CHIP eligibility, and Medicaid/CHIP participation among noninstitutionalized civilian children ages 18 and under and parents ages 19 to 64. Parents are those living with their child or children ages 18 and under. In unmarried-couple households, we include only the parent identified as the child’s parent; we did not necessarily know whether the partner was also a parent. Each year of the ACS includes a public-use sample of more than 680,000 children and 567,000 parents. The ACS is fielded continuously over the course of the year, so the estimates reported here reflect averages for each year.

### Medicaid/CHIP Eligibility and Participation

To assess Medicaid/CHIP eligibility, we combined the individual and family information survey respondents provided with the Medicaid/CHIP eligibility rules for each person’s state of residence in the survey year (Washington, DC is considered a state in this analysis).<sup>14</sup> For 2013, we used the Urban Institute Health Policy Center’s Medicaid/CHIP Eligibility Simulation Model (Kenney, Lynch, Haley, et al. 2012; Lynch, Haley, and Kenney 2014). For 2014 to 2019, we used the Health Insurance Policy Simulation Model–ACS version, which builds on the Medicaid/CHIP Eligibility Simulation Model and applies ACA rules that took effect in 2014 and any changes from 2014 to 2019 (Brooks et al. 2015, 2016, 2017, 2018; Brooks, Roygardner, and Artiga 2019; Buettgens 2011; Buettgens et al. 2013), including the shift to eligibility determination procedures based on modified adjusted gross income. Further detail on this methodology is available in Kenney and colleagues (2016a, 2016b). Both models rely on imputation of documentation status and account for a noncitizen’s length of US residency and documentation status when they factor into eligibility determination (Kenney et al. 2016a, 2016b). We included as eligible those who met other eligibility requirements, were imputed as documented, and met residency requirements; we also include those who qualified for state-funded public coverage but were barred from federally funded coverage because of immigration status (e.g., children in states that cover undocumented immigrant children in Medicaid/CHIP using state funds). We also included as

eligible those living in the two states (Minnesota and New York) that have adopted Basic Health Program coverage for adults with incomes between 138 and 200 percent of FPL.

We calculated Medicaid/CHIP participation rates as the ratio of Medicaid/CHIP-eligible enrolled people to the sum of Medicaid/CHIP-eligible enrolled people plus Medicaid/CHIP-eligible uninsured people, excluding those with both Medicaid and private coverage (including military coverage) and those with Medicaid/CHIP coverage who did not have a known eligibility pathway. Participation rates excluding people with private coverage are often used to indicate how successfully programs reach their primary target populations.

For this analysis, our eligibility simulation models included several methodological updates, including the treatment of income for certain married-couple households, the treatment of Social Security income for certain individuals, the inclusion of Basic Health Program coverage with Medicaid for adults, and edits to some rules for which new information was available. We also refined our parameters for imputing documentation status among noncitizens. Under the new methodology, nonparent adults who report household Supplemental Nutrition Assistance Program receipt are assumed to be documented, because people must be documented to qualify for that program. The new methodology also eliminates the chance of nonparent, noncitizen Supplemental Nutrition Assistance Program recipients being imputed as undocumented, which slightly increases other noncitizens' chances of being selected as undocumented. (The models already exclude the following from being imputed as undocumented: noncitizens with Medicaid [in states where they are eligible], Medicare, or Veterans Affairs coverage; members of the military; veterans; and people reporting welfare income.) This change only directly affects the imputation of nonparent adults' documentation statuses. However, it also affects parents and children, because when the model flags a family member as undocumented, it affects the chances of other family members being imputed as undocumented and affects a family's taxable income, which can therefore change other family members' eligibility.

Because of these methodological changes, the estimates presented here for the years before 2019 may differ slightly from our previously published estimates. Such changes have a larger effect on estimates for adults than those for children; in fact, they have no meaningful effect on estimates of children's uninsurance or Medicaid/CHIP eligibility and participation. Our estimates of children's and parents' uninsurance rates and the number of uninsured children eligible for Medicaid/CHIP both nationally and in most states are similar to the estimates produced using our prior methodology. These methodological changes slightly reduce our estimates of participation and increase our estimates of the number of uninsured children eligible for Medicaid/CHIP, but trends over time and nearly all state-level estimates of participation are similar to those produced using our prior methodology. For instance, the new methodology changed Medicaid/CHIP participation estimates in nearly all states by less than 1 percentage point relative to the estimates we generated using earlier methodology. (Participation changed by more than 1 percentage point in only a few small states, in which participation estimates can be more volatile from year to year.) For parents in expansion states, the effects of the changes on participation were likewise relatively small, changing estimates of participation by fewer than 2 percentage points in nearly all expansion states. Estimated participation

rates for parents in nonexpansion states were more affected by the change in methodology. However, we do not report these rates in the body of this paper because of concerns about the magnitude of the measurement error. Because of these methodological changes, differences between estimates presented here and in our prior publications should not be considered as representing changes over time.

## **Alternative Estimates of the Number of Children and Parents Eligible for Medicaid/CHIP**

Like in our prior estimates of health insurance coverage and Medicaid/CHIP eligibility and participation, both coverage and eligibility status are likely measured with error here. In each data year, we found people who report having Medicaid/CHIP coverage but have no identifiable eligibility pathway, called “ineligible reporters” (who most commonly have family incomes above their state’s Medicaid/CHIP threshold). This inconsistency may owe to misreporting of income, family size or structure, or coverage status; disconnects in time frames (e.g., the measurement of income in the ACS reflects the prior 12 months, whereas Medicaid/CHIP eligibility is based on income at the time of application or renewal); a lack of detailed eligibility-related data (e.g., medical expenses that may make an individual eligible for Medicaid on the basis of being medically needy); or respondents reporting partial or more limited coverage (e.g., family planning benefits) as comprehensive Medicaid. Modeling eligibility before and after implementation of the ACA’s coverage provisions required different approaches that could introduce bias into comparisons of model results between the two periods. This bias could, in turn, over- or understate differences between those periods (Kenney et al. 2016b, 2017).

Moreover, we consistently found it more challenging to measure eligibility for parents than for children. Though we processed the data for children and parents similarly, the eligibility rules for children are both more generous and more straightforward to model than those for adults. In addition, a much lower percentage of children than parents are noncitizens, and rules related to immigration and citizenship status are more generous for children’s Medicaid/CHIP. Though some eligibility pathways for children (e.g., related to disability for children with functional limitations or for children whose families receive Supplemental Security Income) are not measured well, assessing eligibility for most children based on ACS data is relatively straightforward; doing so normally requires comparing a family’s income and size, as well as the child’s age and immigration status, with a state’s Medicaid/CHIP income thresholds and immigration rules.

Though Medicaid/CHIP eligibility is overall less generous for parents than for children, parents have more potential pathways to eligibility. However, those pathways are often more complicated to model because the ACS does not collect the necessary data. As we did for children, we modeled Supplemental Security Income–based eligibility for parents using the limited survey information on functional limitations to estimate disability status. In addition to parental, ACA expansion, and disability-related eligibility, parents and other adults often qualify for the programs through medically needy, pregnancy-related, transitional, caretaker relative, and other pathways with different income thresholds. However, the personal and family characteristics needed to model eligibility through these



pathways, such as pregnancy, high medical expenses relative to income, or prior receipt of cash assistance, are not measured in the ACS. Moreover, these eligibility pathways often have higher income thresholds than parental and ACA expansion pathways. Thus, our ability to estimate eligibility for higher-income adult Medicaid enrollees was more limited than for those with lower incomes. For instance, the median upper threshold for pregnancy-related Medicaid/CHIP is above 200 percent of FPL, and some states' eligibility thresholds exceed 300 percent of FPL. However, because the ACS does not measure pregnancy at the time of the survey, we could not model which women may qualify for pregnancy-related coverage in our model. Also, some parents may have reported access to partial Medicaid coverage, such as family planning benefits, which we did not include in our model of eligibility for comprehensive coverage.

Consequently, our models identify a higher share of ineligible reporters among parents than among children. As shown in appendix table B.1, the share of parents who reported Medicaid but who have no identifiable eligibility pathway (44.1 percent) was much higher than the share among children (12.6 percent). And the share of parents who were ineligible reporters was much higher in nonexpansion states (69.7 percent) than expansion states (36.6 percent). This difference means our measurement of eligibility in nonexpansion states has greater error than that for expansion states. This may be because a higher share of enrollees qualify through other pathways, such as pregnancy-related or medically needy factors, than through pathways we can measure in our model. In addition, more adults may have partial benefits in nonexpansion states, given the very low parental eligibility thresholds in those states. This possible error risks introducing bias into comparisons of Medicaid participation by state Medicaid expansion status. Therefore, we only present estimates of Medicaid participation for parents residing in expansion states in this paper.

Among parents who were ineligible reporters, we find that most were citizens, about 53 percent were women of childbearing age (suggesting that some may qualify for pregnancy-related eligibility, which is missing from our models), and 56 percent had estimated incomes for the prior year below 200 percent of FPL. The latter suggests that some parents may qualify for temporary transitional Medicaid based on past receipt of cash assistance, which has an income eligibility cap of 185 percent of FPL. But, as indicated above, we cannot measure receipt of cash assistance in this data source. Not surprisingly, given the differential patterns to be expected in income misclassification, the income distribution of parents who are ineligible reporters differed by expansion status. Thirty-one percent of such parents in expansion states had incomes between 150 and 200 percent of FPL, and another 55 percent had incomes above 200 percent of FPL, well above the eligibility threshold of 138 percent of FPL in most expansion states. In contrast, parent ineligible reporters' incomes were lower, on average, in nonexpansion states (corresponding with their lower Medicaid thresholds): 36 percent had incomes below the FPL, 42 percent had incomes between 100 and 200 percent of FPL, and 23 percent had incomes above 200 percent of FPL.

Given the uncertainties in estimating parents' Medicaid eligibility and participation, especially in nonexpansion states, we created an alternative indicator of eligibility that attempts to account for understating eligibility to assess the size of the eligible but uninsured population. To do so, the model

adds 50 percentage points to each state's upper income threshold, though it does not change rules related to immigration or parental status. We created a similar alternative model for children as a comparison. Having standard and alternative models allowed us to assess the robustness of our standard estimates of eligible uninsured parents and children and to consider the extent to which the alternative approach reduces the number of ineligible reporters. We present our standard estimates of eligible uninsured children and parents as lower bounds. Though the alternative estimates may represent upper bounds, based on the information available at this time, we cannot estimate an upper bound with sufficient precision, particularly for parents in nonexpansion states.<sup>15</sup>

Extending income eligibility thresholds in our model by 50 percentage points to account for potential measurement error increased our estimates of eligible uninsured children from 2.3 to 2.6 million and of such parents from 1.2 to 2.0 million. It also increased our estimates of the share of all uninsured children and parents who appear eligible for Medicaid/CHIP; such shares increased from 57.1 to 65.4 percent for children and from 16.1 to 27.2 percent for parents. As expected, this change also reduced the share of ineligible reporters by 6.0 percentage points among children and 21.8 percentage points among parents. The exploratory alternative approach reduced the share of ineligible reporters among parents in nonexpansion states even more than it did among parents in expansion states. However, parents in nonexpansion states remained more likely than their counterparts in expansion states to lack an identifiable eligibility pathway in our model. Therefore, our exploratory approach seems to reduce some measurement error, but it does not eliminate the fact that measurement errors are larger among parents than among children and larger among parents in nonexpansion states than among parents in expansion states.

TABLE B.1

**Medicaid/CHIP Eligibility and Participation Estimates for Parents and Children under Standard and Alternative Methodological Approaches, by State Medicaid Expansion Status, 2019**

	Parents			Children		
	Base model	Base model + 50 pctg. pts.	Diff.	Base model	Base model + 50 pctg. pts.	Diff.
<b>US</b>						
Total Medicaid/CHIP reporters (thousands)	8,844	9,244	400	31,521	32,116	595
Ineligible reporters						
Number (thousands)	3,896	2,056	-1,840	3,980	2,123	-1,857
As a share of all Medicaid/CHIP reporters	44.1%	22.2%	-21.8%	12.6%	6.6%	-6.0%
Participation rate	80.9%	78.0%	-2.9%	91.9%	91.4%	-0.5%
Eligible but uninsured						
Number (thousands)	1,163	1,952	789	2,308	2,630	321
Share of uninsured people eligible	16.1%	27.2%	11.0%	57.1%	65.4%	8.3%
<b>Expansion states</b>						
Total Medicaid/CHIP reporters (thousands)	6,847	7,149	302	19,743	20,088	346
Ineligible reporters						
Number (thousands)	2,503	1,286	-1,217	2,348	1,233	-1,115
As a share of all Medicaid/CHIP reporters	36.6%	18.0%	-18.6%	11.9%	6.1%	-5.8%
Participation rate	84.0%	82.2%	-1.8%	93.7%	93.3%	-0.4%
Eligible but uninsured						
Number (thousands)	816	1,228	412	1,119	1,252	133
Share of uninsured people eligible	24.4%	36.7%	12.3%	60.7%	68.3%	7.6%
<b>Nonexpansion states</b>						
Total Medicaid/CHIP reporters (thousands)	1,998	2,096	98	11,778	12,028	249
Ineligible reporters						
Number (thousands)	1,393	770	-623	1,632	890	-741
As a share of all Medicaid/CHIP reporters	69.7%	36.7%	-33.0%	13.9%	7.4%	-6.5%
Participation rate	64.9%	63.3%	-1.6%	89.0%	88.3%	-0.7%
Eligible but uninsured						
Number (thousands)	346	724	377	1,189	1,377	188
Share of uninsured people eligible	9.0%	18.8%	9.8%	54.1%	62.9%	8.8%

**Source:** Urban Institute analysis of 2019 American Community Survey data from the Integrated Public Use Microdata Series.

**Notes:** CHIP = Children's Health Insurance Program. Diff. = difference. "Base model + 50 pctg. pts." adds 50 percentage points to 2019 upper income thresholds for child, parental, or Affordable Care Act expansion eligibility as an exploratory alternative. Children are ages 18 and younger. Parents are ages 19 to 64. Ineligible reporters are those with Medicaid/CHIP who lack an identifiable eligibility pathway. Expansion status refers to implementation of the Affordable Care Act's Medicaid expansion by mid-2019. The base model estimates eligibility under rules for 2019. Estimates reflect an adjustment for potential misreporting of coverage on the American Community Survey.

## Analysis

We assessed 2019 uninsurance rates and changes in uninsurance over time nationally, by state, and by selected socioeconomic and demographic subgroups. We also assessed changes by ACA Medicaid expansion status as of July 1, 2019 (the middle of the data-collection period, when 34 states, including Washington, DC, had participated in the expansion). We measured health insurance coverage as status at the time of the survey. To address potential misclassification of coverage in the ACS, we applied a set of coverage edits (Lynch et al. 2011). Consequently, the coverage estimates presented here may differ from those in other analyses of the same data source that rely on the full sample and do not incorporate coverage edits. However, the magnitude of differences between subgroups and changes over time are similar. For instance, Alker and Corcoran (2020) found unedited uninsurance rates for children of 7.5 percent in 2013, 4.7 percent in 2016, and 5.7 percent in 2019, changing the number of uninsured children from 5.9 million to 3.6 million to 4.4 million. These changes represent an increase of about 726,000 uninsured children nationwide between 2016 and 2019. Using the Integrated Public Use Microdata Series subset of the ACS sample and incorporating coverage edits, we find similar children's uninsurance rates of 7.0 percent in 2013, 4.3 percent in 2016, and 5.2 percent in 2019, changing the number of uninsured children from 5.4 million to 3.4 million to 4.0 million. These changes represent an increase of 685,000 uninsured children between 2016 and 2019.

Estimates of uninsurance and participation for American Indians/Alaska Natives are sensitive to the treatment of Indian Health Service (IHS) access; by convention, exclusive reliance on IHS is considered uninsurance. The 2019 uninsurance rate for American Indian/Alaska Native children would drop from 8.9 to 3.2 percent and the rate for parents would drop from 18.7 to 10.2 percent if IHS access were considered coverage. Likewise, Medicaid/CHIP participation for American Indian/Alaska Native children would rise from 88.7 to 95.7 percent if IHS access were considered coverage. Some state estimates of uninsurance and participation are also sensitive to the treatment of IHS access. Uninsurance rates for 2019 would be 1 to 5 percentage points lower for children in Alaska, Arizona, Montana, New Mexico, North Dakota, Oklahoma, and South Dakota if IHS access were treated as coverage.

We tested changes over time and differences across groups using two-tailed tests and note changes and differences with p-values below 0.10.

## Limitations

We assessed changes after 2013, when the ACA's major coverage provisions were implemented. However, other changes occurred during this time that could also affect trends in coverage nationally and across states. Therefore, the observed changes in participation and coverage following ACA implementation cannot be wholly attributed to the policies instituted under the ACA, because other factors, such as the improving economy, may also have contributed to these changes. And as indicated above, coverage status, eligibility, and participation are likely estimated with error here.

Future research could consider using data from the Transformed Medicaid Statistical Information System to address some of the limitations in the ACS for estimating Medicaid/CHIP eligibility, including imputing medically needy, pregnancy-related, and other types of Medicaid eligibility to some of the parents who report Medicaid but for whom we could not identify an eligibility pathway. These additional analyses could potentially reduce measurement error, particularly among parents in nonexpansion states.

## Notes

- <sup>1</sup> Medicaid and CHIP Payment and Access Commission commissioners, letter to Alex M. Azar II (secretary, US Department of Health and Human Services), regarding notice to states on unwinding the COVID-19 public health emergency, August 25, 2020, <https://www.macpac.gov/wp-content/uploads/2020/08/Letter-to-the-HHS-Secretary-Regarding-Notice-to-States-on-Unwinding-the-COVID-19-Public-Health-Emergency.pdf>. See also Joan Alker and Allie Corcoran, “Child Medicaid Enrollment Grew by 10% during the Pandemic in 2020,” *Say Ahhh!* (blog), Georgetown University Center for Children and Families, February 12, 2021, <https://ccf.georgetown.edu/2021/02/12/child-medicaid-enrollment-grew-by-10-during-pandemic-2020/>.
- <sup>2</sup> Increases in children’s uninsurance rate between 2018 and 2019 were statistically significant in nine states (Arkansas, California, Illinois, Louisiana, Missouri, New Hampshire, North Carolina, South Carolina, and Texas; data not shown).
- <sup>3</sup> Uninsurance rose between 2018 and 2019 in 10 states for parents and in 9 states for children.
- <sup>4</sup> Uninsurance was higher among parents than among children in every state, with the exception of North Dakota, where such rates were not significantly different (data not shown).
- <sup>5</sup> Increases in parents’ uninsurance between 2018 and 2019 were significant in 10 states (Arkansas, California, Kentucky, Louisiana, Mississippi, Missouri, New Hampshire, North Carolina, Oklahoma, and Pennsylvania), and uninsurance fell in only 2 states (Georgia and Idaho; data not shown).
- <sup>6</sup> As described in appendix B, estimates of uninsurance and participation for American Indians/Alaska Natives are sensitive to the treatment of Indian Health Service access; by convention, exclusive reliance on the IHS is considered uninsurance. The 2019 uninsurance rate for American Indian/Alaska Native children would drop from 8.9 to 3.2 percent if IHS access were considered coverage.
- <sup>7</sup> Tricia Brooks, “Child Enrollment in Medicaid and CHIP Remains Down in 2019,” *Say Ahhh!* (blog), Georgetown University Center for Children and Families, February 18, 2020, <https://ccf.georgetown.edu/2020/02/18/child-enrollment-in-medicaid-and-chip-remains-down-in-2019/>.
- <sup>8</sup> Comparisons over time mentioned here refer to the base eligibility simulation model and alternative scenarios, as discussed in appendix B.
- <sup>9</sup> As detailed in appendix B, we could not reliably estimate Medicaid participation for parents in nonexpansion states and do not present state-level rates; however, under the two methodological approaches we discuss in appendix B, we estimate participation rates of 64.9 and 63.3 percent for parents in nonexpansion states, which are lower than for parents in expansion states and lower than for children in nonexpansion states.
- <sup>10</sup> Under the alternative scenario, the share of eligible uninsured parents with a Medicaid/CHIP-enrolled child would be similar, at 73.4 percent.
- <sup>11</sup> “The COVID Racial Data Tacker,” the COVID Tracking Project at *The Atlantic*, accessed June 3, 2021, <https://covidtracking.com/race>.
- <sup>12</sup> US Department of Health and Human Services, “HHS Announces the Largest Ever Funding Allocation for Navigators and Releases Final Numbers for 2021 Marketplace Open Enrollment,” press release, April 21, 2021, <https://www.hhs.gov/about/news/2021/04/21/hhs-announces-the-largest-ever-funding-allocation-for-navigators.html>; and Katie Keith, “Final Coverage Provisions in the American Rescue Plan and What Comes

Next,” *Health Affairs Blog*, March 11, 2021,  
<https://www.healthaffairs.org/doi/10.1377/hblog20210311.725837/full/>.

- <sup>13</sup> Steven Ruggles, Katie Genadek, Ronald Goeken, Josiah Grover, and Matthew Sobek, “Integrated Public Use Microdata Series: Version 7.0 [dataset],” University of Minnesota, accessed April 24, 2019,  
<https://doi.org/10.18128/D010.V7.0>.
- <sup>14</sup> In 2019, 15 states required children to be without coverage for a specified waiting period ranging from 1 month to 90 days before being able to enroll in CHIP (Brooks, Roygardner, and Artiga 2019). Estimated eligibility for CHIP refers to meeting the program’s income and immigration status rules and does not account for prior coverage status.
- <sup>15</sup> Only a very small share of parents and children whom we identified as having Medicaid/CHIP coverage also reported having employer or military coverage, suggesting most Medicaid/CHIP enrollees are not reporting on Medicaid wraparound services only.

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# Acknowledgments

This brief was funded by the David and Lucile Packard Foundation. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute's funding principles is available at [urban.org/fundingprinciples](https://urban.org/fundingprinciples).

The authors also thank Tricia Brooks and Stephen Zuckerman for helpful comments and Rachel Kenney and Elaine Eldridge for careful editorial assistance.



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