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Progress in Children's Coverage Continued to Stall Out in 2018

Trends in Children's Uninsurance and Medicaid/CHIP Participation

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Decades of federal and state efforts to increase children's enrollment in Medicaid and the Children's Health Insurance Program (CHIP) and reduce uninsurance, including implementation of the coverage provisions of the Affordable Care Act (ACA) in 2014, have been associated with increased health insurance coverage among children. By 2016, children's uninsurance rate reached a historic low, and Medicaid/CHIP participation had reached its highest rate since we started tracking it in 2008. However, this progress began reversing in 2017. In this brief, we update our prior research on uninsurance, Medicaid/CHIP participation, and the number of children eligible for Medicaid/CHIP but uninsured using 2018 data from the American Community Survey (ACS).

We find the following:

- After falling by nearly 40 percent between 2013 and 2016 and reaching a low of 4.3 percent, children's uninsurance rate rose to 4.7 percent in 2017 and remained steady at 4.8 percent in 2018, representing a 12 percent increase in uninsurance since 2016. Also between 2016 and 2018, the number of uninsured children rose by an estimated 370,000.

- Changes in children's Medicaid/CHIP participation rates (the share of Medicaid/CHIP-eligible children without other coverage who enrolled in the programs) and uninsurance rates were similar. After rising from 88.7 percent in 2013 to 93.4 percent in 2016, Medicaid/CHIP participation declined slightly to 92.8 percent in 2017 and remained there in 2018.

- Consistent with prior years, children's uninsurance and Medicaid/CHIP participation rates varied across states. In 2018, children's uninsurance rate was below 5 percent in 36 states and below 8 percent in almost every state, but children in 13 states experienced statistically significant increases in uninsurance between 2016 and 2018. Though children's Medicaid/CHIP participation rate was above 80 percent in every state and above 90 percent in all but 10 states, it declined between 2016 and 2018 in 11 states, many of which also experienced increases in uninsurance.

- Coverage changes in 2018 further widened children's coverage and participation gaps by state ACA Medicaid expansion status. Children in states that did not expand Medicaid eligibility for adults under the ACA (hereafter called nonexpansion states) remained more likely to be uninsured and less likely to participate in Medicaid/CHIP than those living in states that did expand Medicaid eligibility (hereafter called expansion states).

- Between 2013 and 2016, as economic conditions improved following the Great Recession (reducing the number of eligible children) and participation in Medicaid/CHIP grew, the number of Medicaid/CHIP-eligible but uninsured children declined from 3.5 million to 2.0 million. But, we observe no additional coverage gains in 2017 or 2018, and 2.1 million children were eligible for Medicaid/CHIP but not enrolled in 2018.

- As in previous years, more than half of uninsured children (57.4 percent) appeared to be eligible for Medicaid/CHIP but not enrolled in 2018. In 2017–18, 51.2 percent of all Medicaid/CHIP-eligible uninsured children lived in just seven large states (Arizona, California, Florida, Georgia, New York, Pennsylvania, and Texas).

- We find that long-standing disparities in coverage and Medicaid/CHIP participation continued in 2018; uninsurance remained high among adolescents ages 13 to 18, Hispanic and American Indian/Alaska Native children,[i] and particularly noncitizen children and citizen children in families with noncitizens.

Stalled progress in children's coverage is especially concerning as the nation grapples with the COVID-19 pandemic. Uninsured children may face barriers to needed care, which is especially risky during the public health crisis and could add to families' worries and stress (Wagnerman 2017).[1] Many families with children, particularly those with Black and Hispanic parents, are facing increased financial instability and hardship because of the pandemic (Karpman, Gonzalez, and Kenney 2020). And among families losing jobs or income during the crisis, those in which someone lacks coverage report greater unmet health care needs due to cost (Gonzalez et al. 2020). As unemployment rises, incomes fall, and some families lose employer-sponsored coverage, reaching Medicaid/CHIP-eligible children and enrolling them in coverage will help ensure their needs are met.

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[i] The racial and ethnic terms used throughout were chosen for clarity, specificity, and respect. However, we acknowledge these terms may not reflect how people self-identify, and we remain committed to using respectful and inclusive language.

Introduction

In recent decades, policymakers have prioritized reducing children's uninsurance through federal and state policy changes aimed at expanding access to and take-up of publicly subsidized coverage. These efforts began with a series of Medicaid expansions in the 1980s and have included enactment of CHIP in 1997 and its subsequent reauthorizations in 2009 and 2015, simplifications to enrollment and renewal processes and targeted enrollment assistance, and outreach efforts to inform families about the importance of coverage and how to enroll. Implementation of the major coverage provisions of the ACA in 2014 largely focused on expanding coverage options for adults, whose uninsurance rates were much higher than those for children. Increased coverage among parents has spillover effects on their children's coverage (Hudson and Moriya 2017), but many states, particularly those in the South, chose not to expand Medicaid under the ACA (Michener 2020). Some ACA provisions were expected to boost children's coverage rates, such as the creation of marketplaces with available subsidies, funding for navigators to help enroll families in coverage, a federal coverage mandate, and "maintenance-of-effort" provisions prohibiting restrictions on states' Medicaid/CHIP eligibility guidelines (Kenney et al. 2011; Miskell and Alker 2015; Prater and Alker 2013). By January 2018, nearly all states covered children with family incomes at or above 200 percent of the federal poverty level (FPL), and 19 of these states covered those with incomes at or above 300 percent of FPL. The median upper threshold was 255 percent of FPL, and most states extended eligibility for legally present immigrant children without a waiting period (Brooks et al. 2018).

The number of children enrolled in Medicaid/CHIP has risen since 2013 (Brooks, Park, and Roygardner 2019), and children have experienced large declines in uninsurance both before and following ACA implementation (Alker and Chester 2015; Dubay and Kenney 2018; Gates et al. 2016; Hudson and Moriya 2017; Lukanen, Schwehr, and Fried 2019; McMorrow and Kenney 2018; Rosenbaum and Kenney 2014). In addition, the share of eligible children participating in Medicaid/CHIP grew between 2013 and 2016, and the number eligible for the programs but not enrolled fell (Haley, Kenney, Wang, Lynch, et al. 2018; Haley, Kenney, Wang, Pan, et al. 2018). Children also experienced associated gains in health care access and affordability (Karpman, Kenney, and Gonzalez 2018).

However, numerous federal and state-level policy changes were proposed or enacted in 2017 and 2018 that may have deterred families from enrolling or reenrolling their children in Medicaid/CHIP. Federal reauthorization of CHIP funding was delayed in late 2017 and early 2018, and many states warned families that such coverage may not continue, or even implemented enrollment freezes for these programs. Confusion about the availability of coverage may have persisted even after funding was restored,[2] and nationwide discussions about ACA repeal, proposals to restrict adults' access to Medicaid through work requirements and other administrative hurdles, repeal of the federal coverage mandate penalty, and reductions in outreach and enrollment assistance may have added further to this confusion. Some states also began making changes to eligibility and renewal systems that hindered coverage renewal, such as increasing the frequency of periodic eligibility checks or requiring responses to mailed paper forms (Artiga and Pham 2019). In September 2018, the Trump administration proposed expanding the "public charge" rule to consider past or future public benefits use in determining the

status of green card applications and temporary visas. The proposed change appeared to deter public program enrollment among immigrant families, including those not subject to the new rule, even before the rule took effect in February 2020 (Bernstein et al. 2019; Haley et al. 2020).

Children's declining uninsurance reversed in 2017, when the number and rate of uninsured children rose for the first time in more than a decade, despite a strong economy (Alker and Roygardner 2019; Berchick, Barnett, and Upton 2019; Haley et al. 2019). Declines in public coverage largely drove this shift, and children's Medicaid/CHIP participation rate fell in 2017 (Haley et al. 2019). Further, enrollment data indicate the number of children enrolled in Medicaid/CHIP continued falling throughout 2018 (Alker and Roygardner 2019; Brooks, Park, and Roygardner 2019; KFF 2019).

Using 2018 ACS data, this analysis updates for 2018 our prior research tracking national and state-level trends in children's uninsurance and Medicaid/CHIP eligibility and participation (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). For this analysis, we also use an updated methodology for estimating eligibility that results in minimal changes to some previously published estimates, as detailed in the data and methods section. As with our prior estimates of coverage, eligibility, and participation, we acknowledge both coverage and eligibility status are challenging to measure and likely measured with error. The pandemic and associated economic crisis have shown Medicaid/CHIP's critical role in the safety net, and understanding how well such programs reach and enroll eligible children, as well as where greater enrollment efforts are needed, can help ensure all children have access to the care they need to grow and thrive.

Findings

Though uninsurance among children fell between 2013 and 2016, children's coverage gains began reversing in 2017, and 370,000 more children became uninsured between 2016 and 2018.

Following implementation of the ACA's major coverage provisions, children's uninsurance rate fell by nearly 40 percent, from 7.0 percent in 2013 to 4.3 percent in 2016 (figure 1). However, uninsurance began to rise in 2017, reaching 4.7 percent. This was the first increase in children's uninsurance since ACA implementation and since the ACS began collecting data on coverage status in 2008 (Alker and Roygardner 2019).[3] The uninsurance rate remained steady at 4.8 percent in 2018, representing about a 12 percent increase in uninsurance since 2016.

We find similar patterns in the number of uninsured children, which dropped from 5.4 million in 2013 to 3.4 million in 2016 and then rose to 3.7 million by 2018 (table 1). The bulk of this increase occurred between 2016 and 2017. Thus, changes after 2016 eliminated nearly one-fifth of the coverage gains made under the ACA.

FIGURE 1
Children's Uninsurance Rates, 2013–18
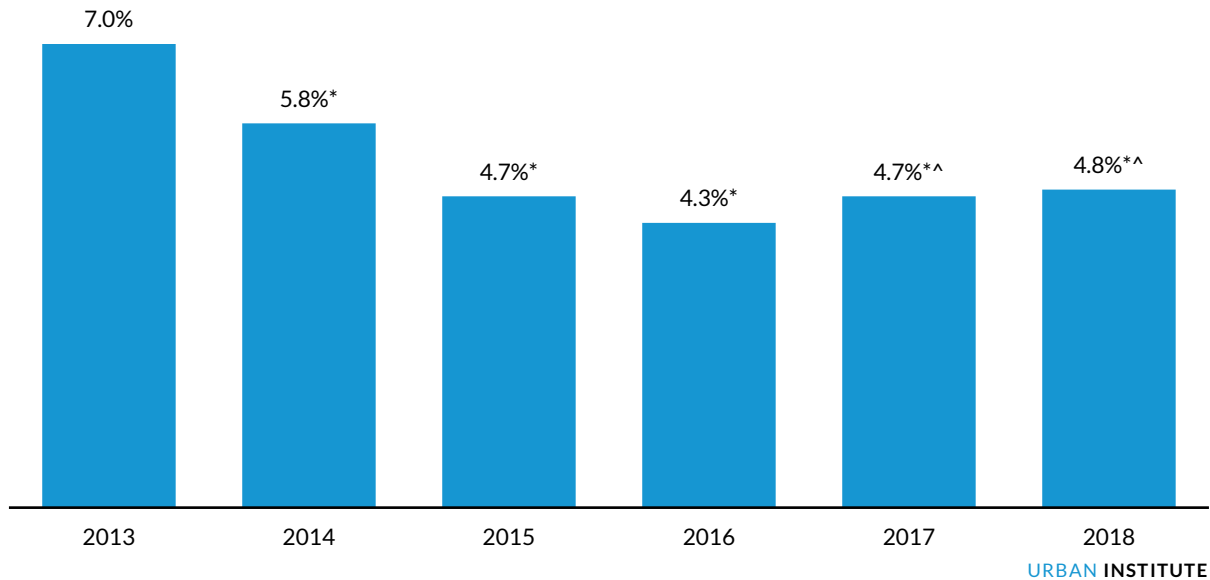
Source: Urban Institute analysis of 2013–18 American Community Survey data from the Integrated Public Use Microdata Series.
Notes: Children are ages 18 and younger. See data and methods section for our definition of uninsurance. Estimates are adjusted for potential misreporting of coverage on the American Community Survey.
* Estimates for 2014–18 are statistically different from the 2013 estimate at the 0.01 level.
^ Estimates for 2017 and 2018 are statistically different from the 2016 estimate at the 0.01 level.

TABLE 1
Children's Uninsurance and Medicaid/CHIP Eligibility, 2013–18

							Change	
	2013	**2014**	**2015**	**2016**	**2017**	**2018**	**2013–18**	**2016–18**
All children								
Uninsurance rate	7.0%	5.8%*	4.7%*	4.3%*	4.7%*	4.8%*	-2.2%^	0.5%^
Thousands uninsured	5,428	4,547	3,667	3,360	3,634	3,730	-1,698	370
Medicaid/CHIP-eligible children only	**45,874**	**43,770**	**42,959**	**42,361**	**41,555**	**40,703**	**-5,171**	**-1,658**
Uninsurance rate	7.7%	6.7%*	5.2%*	4.7%*	5.2%*	5.2%*	-2.5%^	0.5%^
Thousands uninsured	3,548	2,926	2,230	1,996	2,139	2,116	-1,432	120

Source: Urban Institute analysis of 2013–18 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 the data and methods section for our definitions of eligibility and uninsurance. Estimates are adjusted for potential misreporting of coverage on the American Community Survey.
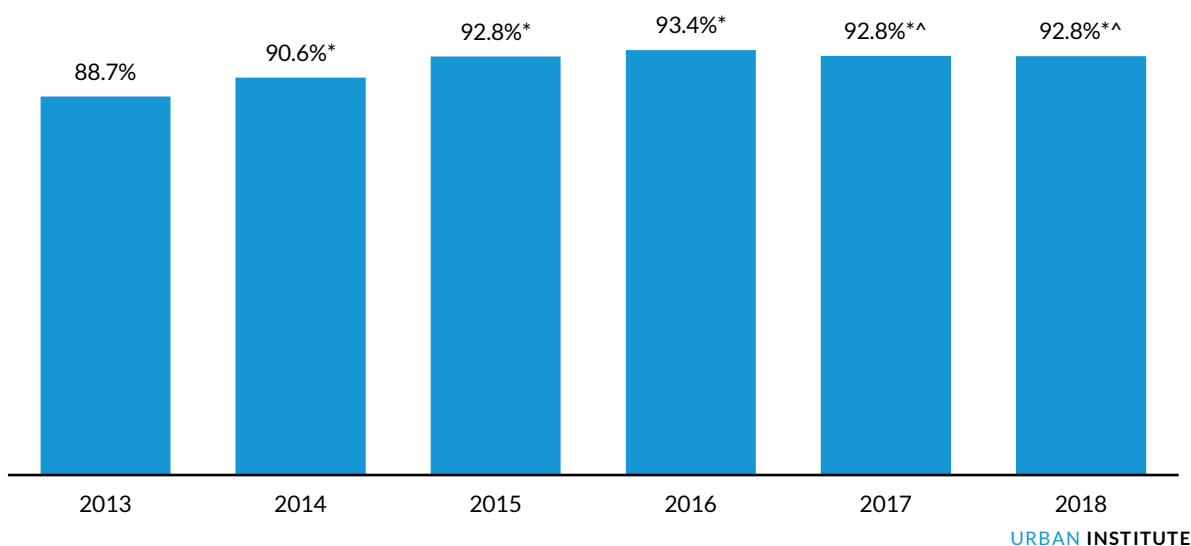* Estimates for 2014–18 are statistically different from the 2013 estimate at the 0.01 level.
^ Change is statistically significant at the 0.01 level.

After rising between 2013 and 2016, children's Medicaid/CHIP participation rate fell in 2017 and remained steady in 2018.

Figure 2 presents changes in Medicaid/CHIP participation rates (the share of Medicaid/CHIP-eligible children without other coverage who enrolled in the programs) over the study period. Children's participation rose between 2013 and 2016, from 88.7 percent to 93.4 percent, while improvements in economic conditions and other shifts reduced the number of children estimated to be eligible for the programs (table 1). Though gains became smaller as ACA implementation continued, they persisted into 2016. But in 2017, the increase in children's Medicaid/CHIP participation reversed; the participation rate fell to 92.8 percent, the first decline in participation among children measured since we began estimating participation in 2008 (Haley, Kenney, Wang, Lynch, et al. 2018; Haley, Kenney, Wang, Pan 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). Further, children's participation rate did not improve in 2018, remaining at 92.8 percent.

FIGURE 2
Children's Medicaid/CHIP Participation Rates, 2013–18

Source: Urban Institute analysis of 2013–18 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 the data and methods section for our definitions of eligibility and participation. Estimates are adjusted for potential misreporting of coverage on the American Community Survey.
* Estimates for 2014–18 are statistically different from the 2013 estimate at the 0.01 level.
^ Estimates for 2017 and 2018 are statistically different from the 2016 estimate at the 0.01 level.

Consistent with prior years, children's uninsurance and Medicaid/CHIP participation rates varied across states. In 2018, uninsurance was below 5 percent in 36 states and below 8 percent in nearly every state, but children in 13 states experienced increases in uninsurance between 2016 and 2018. Though Medicaid/CHIP participation was above 80 percent in every state in 2018, children in 11 states experienced declines in Medicaid/CHIP participation between 2016 and 2018.

In 2018, children's uninsurance rates were below 5 percent in 36 states but varied widely (figure 3), ranging from below 2 percent in Massachusetts (1.1 percent), New Hampshire (1.7 percent), and the District of Columbia (1.7 percent) to above 8 percent in Alaska (8.2 percent) and Texas (10.4 percent). As shown in table 5, children in 13 states experienced statistically significant increases in uninsurance between 2016 and 2018 (Alabama, Florida, Georgia, Illinois, Indiana, Iowa, Minnesota, Nevada, Ohio, Tennessee, Texas, Utah, and West Virginia). Uninsurance fell in just three states (New Hampshire, New York, and North Dakota).

Between 2013 and 2018, uninsurance fell by a statistically significant margin in 32 states and rose slightly in only Nebraska and Wyoming, but some patterns across states persisted over this period. Seven of the 10 states with the lowest uninsurance rates in 2018 (Connecticut, DC, Hawaii, Massachusetts, New Hampshire, New York, Vermont) were also among the 10 states with the lowest rates in 2013, and 8 of the 10 states with the highest uninsurance rates in 2018 (Alaska, Arizona, Florida, Georgia, Nevada, Oklahoma, Texas, and Utah) were also among the 10 states with the highest rates in 2013.

As shown in table 6, children's Medicaid/CHIP participation ranged from below 85 percent in Utah (81.9 percent), Alaska (82.5 percent), and Wyoming (84.6 percent) to more than 95 percent in 16 states and more than 97 percent in DC (97.6 percent) and Massachusetts (97.7 percent) in 2018. Most states experienced overall increases in participation between 2013 and 2018, but participation rates dropped between 2016 and 2018 in 11 states (Alabama, Arizona, Florida, Georgia, Illinois, Ohio, South Carolina, Tennessee, Texas, Utah, and West Virginia), several of which also experienced declines in uninsurance. Children's Medicaid/CHIP participation rose by a statistically significant margin in only New Hampshire, New York, and Virginia.

FIGURE 3
Children's Uninsurance Rates, by State, 2018

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Source: Urban Institute analysis of 2018 American Community Survey data from the Integrated Public Use Microdata Series.
Notes: Children are ages 18 and younger. See the data and methods section for our definition of uninsurance. Estimates are adjusted for potential misreporting of coverage on the American Community Survey.

Coverage changes in 2018 further widened children's coverage and participation gaps by state ACA Medicaid expansion status. Children living in nonexpansion states remained more likely to be uninsured and less likely to participate in Medicaid/CHIP than those living in expansion states.

In 2013, uninsurance was already lower and Medicaid/CHIP participation higher among children in states that would adopt Medicaid expansion for adults by 2016 (figure 4). Though uninsurance fell and Medicaid/CHIP participation rose in both expansion and nonexpansion states between 2013 and 2016, gaps by expansion status grew. In 2016, children in nonexpansion states were nearly twice as likely to be uninsured as those in expansion states (6.0 percent versus 3.2 percent), and they were less likely to participate in Medicaid/CHIP if they were eligible (91.6 percent versus 94.6 percent).

Between 2016 and 2018, these gaps widened further. Though children in both state groups experienced increases in uninsurance and declines in Medicaid/CHIP participation, such changes were larger in nonexpansion states. Over this period, uninsurance rose from 3.2 percent to 3.4 percent in expansion states and from 6.0 percent to 6.8 percent in nonexpansion states. Medicaid/CHIP participation fell slightly in expansion states (from 94.6 percent to 94.3 percent) but fell by more than 1 percentage point in nonexpansion states (from 91.6 percent to 90.5 percent).
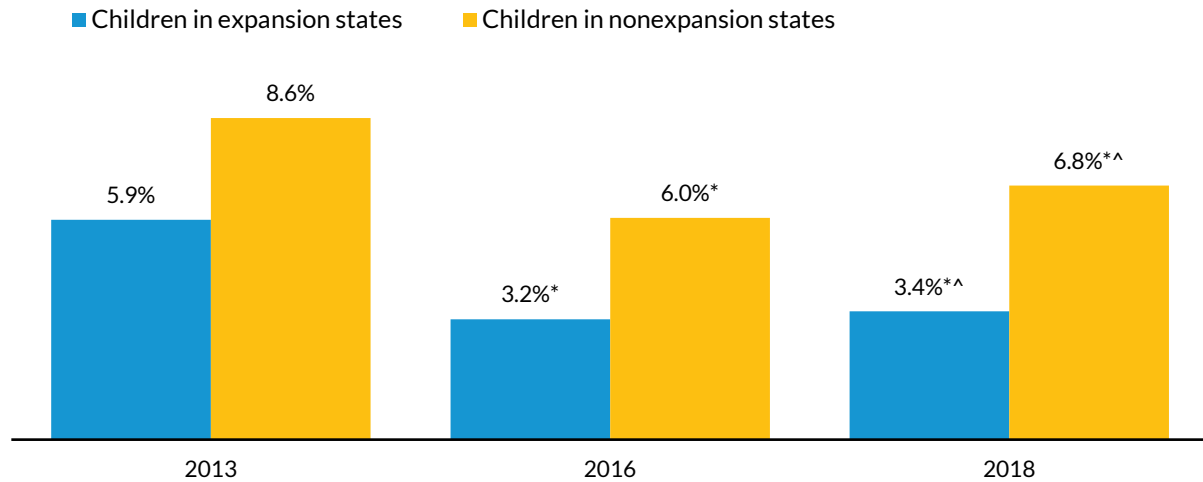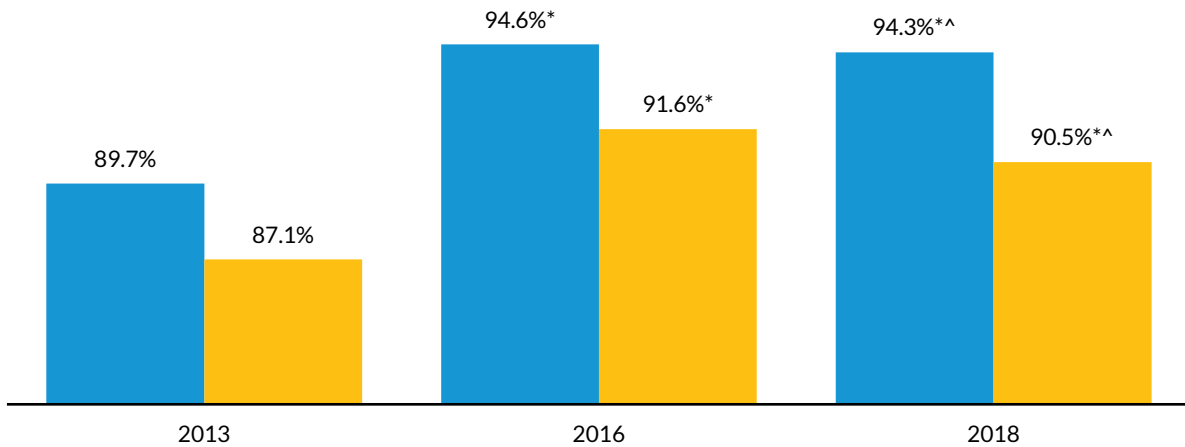
FIGURE 4

Children's Uninsurance and Medicaid/CHIP Participation Rates, by State Medicaid Expansion Status, 2013, 2016, and 2018

Uninsurance rates

■ Children in expansion states   ■ Children in nonexpansion states

Medicaid/CHIP participation rates

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Source: Urban Institute analysis of 2013–18 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 the data and methods section for our definitions of uninsurance, eligibility, and participation. Estimates are adjusted for potential misreporting of coverage on the American Community Survey. State expansion status is as of July 1, 2016.
* Estimates for 2016 and 2018 are statistically different from 2013 estimates at the 0.01 level.
^ Estimates for 2018 are statistically different from 2016 estimates at the 0.01 level.

Between 2013 and 2016, coverage gains reduced the number of children eligible for Medicaid/CHIP but uninsured from 3.5 million to 2.0 million. But, we observe no additional progress in 2017 or 2018, and 2.1 million children were eligible for Medicaid/CHIP but not enrolled in 2018. That same year more than half of all uninsured children appeared to be eligible for Medicaid/CHIP, and in 2017–18, about half of such children lived in just seven states.

As noted, the estimated number of children eligible for Medicaid/CHIP but not enrolled fell by 1.5 million between 2013 and 2016 (figure 5). This decline occurred as economic conditions improved following the Great Recession, reducing the number of eligible children, and as participation rates in the programs increased. These changes further reduced the already declining number of eligible but uninsured children over the past decade; the number of such children fell by more than half, from 4.9 million to 2.0 million, between 2008 and 2016 (Kenney et al. 2016b).

However, these declines stalled after 2016, and the estimated number of children eligible for Medicaid/CHIP but uninsured rose slightly by 143,000, to 2.1 million, in 2017. Further, the number of eligible but uninsured children did not improve in 2018, remaining stalled at 2.1 million.

FIGURE 5

Millions of Children Eligible for Medicaid/CHIP but Uninsured, 2013–18
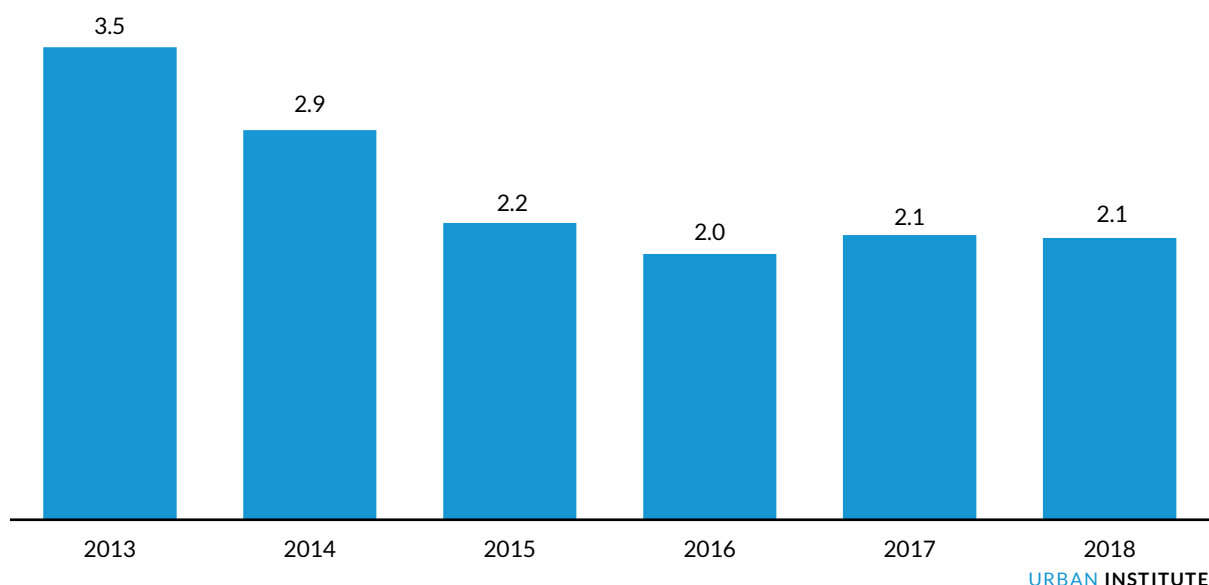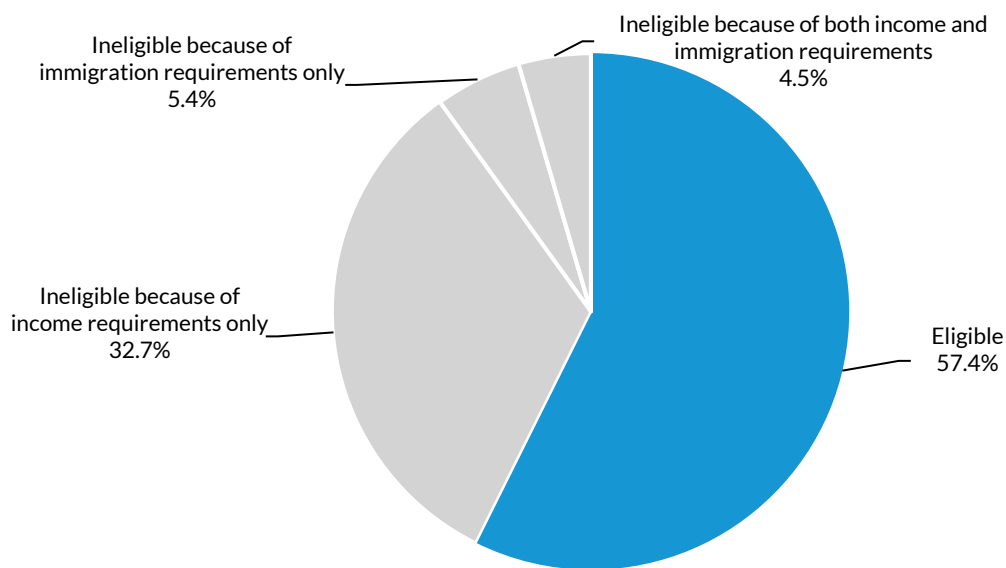

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Source: Urban Institute analysis of 2013–18 American Community Survey data from the Integrated Public Use Microdata Series.
Notes: CHIP = Children's Health Insurance Program. Children are ages 18 and younger. See the data and methods section for our definitions of eligibility and uninsurance. Estimates are adjusted for potential misreporting of coverage on the American Community Survey.

Figure 6 assesses Medicaid/CHIP eligibility and reasons for ineligibility among uninsured children in 2018.[4] Most uninsured children (57.4 percent) met the income and immigration requirements to qualify for Medicaid/CHIP, similar to the share in 2017 (Haley et al. 2019). We estimate that 32.7 percent of

uninsured children were ineligible solely because their family incomes were above their state's Medicaid/CHIP eligibility threshold. Another 5.4 percent met the income requirements but did not qualify because of their immigration status, and 4.5 percent were ineligible because of both income and immigration requirements.

Medicaid/CHIP Eligibility and Reasons for Ineligibility among Uninsured Children, 2018

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Source: Urban Institute analysis of 2018 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 the data and methods section for our definitions of eligibility and uninsurance. Estimates are adjusted for potential misreporting of coverage on the American Community Survey.

Combining 2017 and 2018 data to ensure adequate sample size, we find that most Medicaid/CHIP-eligible but uninsured children (51.2 percent) lived in seven large states (table 2): Texas (385,000), California (184,000), Florida (152,000), Georgia (125,000), Pennsylvania (88,000), New York (79,000), and Arizona (77,000). Thirty states were home to at least 20,000 eligible uninsured children each.

TABLE 2
Medicaid/CHIP-Eligible but Uninsured Children, by State, 2017–18

	Thousands of children	Percent of nation's Medicaid/CHIP-eligible children	Cumulative percent of nation's Medicaid/CHIP-eligible children
Texas	385	18.1	18.1
California	184	8.7	26.8
Florida	152	7.2	33.9
Georgia	125	5.9	39.8
Pennsylvania	88	4.1	43.9
New York	79	3.7	47.6
Arizona	77	3.6	51.2
Indiana	73	3.5	54.7
Illinois	68	3.2	57.9
Ohio	67	3.2	61.1
North Carolina	53	2.5	63.6
Missouri	52	2.4	66.0
New Jersey	44	2.1	68.1
Virginia	40	1.9	69.9
Tennessee	39	1.8	71.8
Oklahoma	36	1.7	73.5
Wisconsin	34	1.6	75.1
South Carolina	33	1.6	76.7
Utah	33	1.6	78.2
Michigan	32	1.5	79.7
Colorado	30	1.4	81.2
Washington	30	1.4	82.5
Maryland	27	1.3	83.8
Minnesota	27	1.3	85.1
Alabama	25	1.2	86.3
Nevada	23	1.1	87.4
Kentucky	23	1.1	88.4
Oregon	23	1.1	89.5
Mississippi	22	1.0	90.5
Kansas	20	1.0	91.5
Louisiana	19	0.9	92.4
Nebraska	17	0.8	93.2
Arkansas	17	0.8	93.9
Iowa	16	0.7	94.7
New Mexico	14	0.6	95.3
Massachusetts	12	0.6	95.9
Connecticut	10	0.5	96.3
Idaho	10	0.5	96.8
Alaska	10	0.5	97.3

Source: Urban Institute analysis of 2017–18 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 the data and methods section for our definitions of eligibility and uninsurance. Estimates are adjusted for potential misreporting of coverage on the American Community Survey. States with fewer than 10,000 eligible uninsured children are not shown.

Though every subgroup of children we examined experienced improvements in coverage and participation between 2013 and 2016, many subgroups' coverage gains began reversing in 2017 and 2018, and disparities across subgroups persisted.

Some of the largest declines in children's uninsurance between 2013 and 2016 occurred among subgroups with higher-than-average uninsurance in 2013, reducing coverage gaps across subgroups. Uninsurance fell from 9.4 percent to 5.6 percent among adolescents ages 13 to 18, narrowing the coverage gap with younger children, who had lower uninsurance than adolescents in both 2013 and 2016 (table 3). Hispanic, Asian/Pacific Islander, and American Indian/Alaska Native[5] children, who had higher uninsurance in 2013 than other racial/ethnic groups, experienced larger declines in uninsurance by 2016. Uninsurance among noncitizen children fell by nearly 10 percentage points, from 32.7 percent to 22.8 percent, and uninsurance among citizen children with noncitizen parents fell from 9.9 percent to 6.1 percent, reducing coverage disparities between citizen children with noncitizen parents and those whose parents are citizens. But despite narrowing differences, these subgroups remained among those with the highest uninsurance rates in 2016.

Every subgroup of children we examined also experienced increases in Medicaid/CHIP participation between 2013 and 2016. As shown in table 4, participation was 95 percent or higher among Black children, children of multiple races or a race other than the five examined, children in families with low incomes, and children in families participating in the Supplemental Nutrition Assistance Program (SNAP) in 2016.

But between 2016 and 2018, increases in uninsurance and declines in Medicaid/CHIP participation were widespread. Uninsurance rose among nearly every subgroup we examined, and some of the largest percentage-point increases occurred among noncitizen children (22.8 percent to 23.7 percent), Black children (3.3 percent to 4.0 percent), and children under age 6 (3.4 percent to 4.0 percent). In some cases, these same subgroups also faced among the largest declines in Medicaid/CHIP participation; such rates fell from 96.0 percent to 95.1 percent among Black children and from 94.9 percent to 94.1 percent among children under age 6.

In 2018, uninsurance was 6 percent or higher among adolescents (6.0 percent), Hispanic (7.5 percent) and American Indian/Alaska Native (8.4 percent) children, children with family incomes between 100 percent and 138 percent of FPL (6.6 percent), citizen children with noncitizen parents (6.6 percent), and noncitizen children (23.7 percent). Medicaid/CHIP participation rates were about 90 percent or lower among adolescents (90.4 percent), American Indian/Alaska Native children (89.2 percent), children with family incomes above 138 percent of FPL (90.3 percent), and children in families not participating in SNAP (88.8 percent).

TABLE 3
Children's Uninsurance Rates, by Socioeconomic and Demographic Characteristics, 2013, 2016, and 2018

	2013 (%)	2016 (%)	2018 (%)	Percentage-point change 2016–18
National	**7.0**	**4.3***	**4.8***	**0.5^**
Age				
Birth to 5~	5.3	3.4*	4.0*	0.6^
6–12	6.2	3.9*	4.4*†	0.5^
13–18	9.4	5.6*	6.0*†	0.4^
Sex				
Male~	7.0	4.3*	4.8*	0.5^
Female	7.0	4.3*	4.8*	0.5^
Race/ethnicity				
White~	5.2	3.3*	3.8*	0.5^
Black	5.9	3.3*	4.0*	0.7^
Hispanic	11.4	7.1*	7.5*†	0.4^
Asian/Pacific Islander	7.2	3.2*	3.6*	0.4^
American Indian/Alaska Native	11.8	8.0*	8.4*†	0.4
Other/multiple races	4.8	3.0*	2.9*†	-0.1
Family income				
At or below 100% of FPL~	8.3	5.1*	5.7*	0.6^
Greater than 100% but less than 138% of FPL	10.8	6.2*	6.6*	0.4^
Greater than 138% of FPL	5.9	3.7*	4.3*†	0.6
Household SNAP participation status				
Does not participate in SNAP~	7.8	4.8*	5.3*	0.5^
Participates in SNAP	4.7	2.7*	2.9*	0.2^
Citizenship				
Citizen	*6.3*	*3.8**	*4.3*†*	*0.5^*
With citizen parents~	5.5	3.3*	3.7*	0.4^
With at least one noncitizen parent	9.9	6.1*	6.6*†	0.5^
Noncitizen	*32.7*	*22.8**	*23.7*†*	*0.9^*

Source: Urban Institute analysis of 2013–18 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. See the data and methods section for our definition of uninsurance. Estimates are adjusted for potential misreporting of coverage on the American Community Survey. Reference groups are indicated by a ~.

* Estimate is statistically different from the 2013 estimate at the 0.01 level.

^ Change is statistically significant at the 0.01 level.

† Group rate in 2018 differs from that for the reference group at the 0.01 level.

TABLE 4

Medicaid/CHIP Participation Rates among Eligible Children, by Socioeconomic and Demographic Characteristics, 2013, 2016, and 2018

	2013 (%)	2016 (%)	2018 (%)	Percentage-point change 2016–18
National	**88.7**	**93.4***	**92.8***	**-0.6^**
Age				
Birth to 5~	91.6	94.9*	94.1*	-0.8^
6–12	89.6	94.0*	93.5*†	-0.5^
13–18	83.6	90.8*	90.4*†	-0.4^
Sex				
Male~	88.6	93.4*	92.9*	-0.5^
Female	88.7	93.5*	92.7*	-0.8^
Race/ethnicity				
White~	87.1	92.6*	91.8*	-0.8^
Black	92.3	96.0*	95.1*†	-0.9^
Hispanic	88.5	92.8*	92.4*†	-0.4
Asian/Pacific Islander	86.1	94.1*	93.1*†	-1.0^
American Indian/Alaska Native	83.6	89.6*	89.2*†	-0.4
Other/multiple races	91.6	95.4*	95.4*†	0.0
Family income				
At or below 100% of FPL~	92.1	95.0*	94.4*	-0.6^
Greater than 100% but less than 138% of FPL	87.1	92.9*	92.6*†	-0.3
Greater than 138% of FPL	82.4	90.7*	90.3*†	-0.4^
Household SNAP participation status				
Does not participate in SNAP~	80.0	89.1*	88.8*	-0.3
Participates in SNAP	95.8	97.6*	97.4*†	-0.2
Citizenship				
Citizen	88.6	93.6*	93.0*	4.4^
With citizen parents~	89.1	94.0*	93.5*	-1.0
With at least one noncitizen parent	87.3	92.6*	91.8*†	0.9

Source: Urban Institute analysis of 2013–18 American Community Survey data from the Integrated Public Use Microdata Series.
Notes: CHIP = Children's Health Insurance Program. FPL = federal poverty level. SNAP = Supplemental Nutrition Assistance Program. Children are ages 18 and younger. See the data and methods section for our definitions of eligibility and participation. Estimates are adjusted for potential misreporting of coverage on the American Community Survey. Participation is not shown for noncitizen children; see the data and methods section for more information. Reference groups are indicated by a ~.
* Estimate is statistically different from the 2013 estimate at the 0.01 level.
^ Change is statistically significant at the 0.01 level.
† Group rate in 2018 differs from that for the reference group at the 0.01 level.

Discussion

By 2016, children's uninsurance rate had fallen to a historic low, and their Medicaid/CHIP participation rate had increased to the highest level since we began tracking it in 2008. But in 2017, these gains halted and even reversed, and by 2018, nearly 400,000 more children were uninsured than in 2016. Though most of the coverage gains under the ACA remained, 3.7 million children were uninsured in 2018, 2.1 million of whom were eligible for Medicaid/CHIP, and children's Medicaid/CHIP participation remained at its 2017 level of 92.8 percent.

Children's coverage patterns have likely shifted since these data were collected in 2018. According to administrative data, the number of children enrolled in Medicaid/CHIP fell by more than 300,000 during the first half of 2019 (KFF 2019). Though some of the decrease may owe to economic improvement, some children appear to have been disenrolled from Medicaid/CHIP under new renewal processes implemented in 2018 and 2019, and many of them likely risk becoming uninsured (Artiga and Pham 2019; KFF 2019). Thus, the participation and coverage gains children experienced between 2013 and 2016 are unlikely to have resumed in 2019. Indeed, recently released 2019 ACS data indicate the number of uninsured children rose by 320,000 (0.4 percentage points) between 2018 and 2019 (Keisler-Starkey and Bunch 2020).

In 2020, the coronavirus outbreak and recession are causing widespread economic decline among families; in March/April, more than 4 in 10 parents reported loss of work or income in their family due to the pandemic (Karpman, Gonzalez, and Kenney 2020), and some families losing jobs are also losing employer-sponsored health insurance coverage (Karpman, Zuckerman, and Peterson 2020). This may mean more children are becoming eligible for Medicaid/CHIP, as family incomes fall and the need for coverage increases. Data from 14 states appear to confirm this, indicating that children's Medicaid/CHIP enrollment rose by an average of 2.6 percent between February and April 2020 (Alker and Roygardner 2020). Additionally, preliminary data from May 2020 indicate overall Medicaid/CHIP enrollment continued rising in May (Rudowitz, Corallo, and Artiga 2020). Retention in the programs is also higher because the Families First Coronavirus Response Act only provides enhanced federal funding to states maintaining eligibility standards and enrollment for people who had Medicaid coverage before the pandemic.[6]

But once the emergency period ends, states can disenroll people who have become ineligible or fail to complete renewal requirements. Uninsurance may also rise if families losing employer coverage do not know how to access Medicaid/CHIP or have trouble enrolling. Currently, families may be facing challenges with obtaining coverage: in March/April 2020, 38 percent of adults applying for or renewing Medicaid during the pandemic reported difficulties doing so (Pollitz et al. 2020). Failing to retain eligible children in Medicaid/CHIP or to reach and enroll newly eligible children could cause large increases in children's uninsurance in 2020 and beyond.

Moreover, these changes likely exacerbate existing disparities. As our analysis showed, uninsurance and Medicaid/CHIP participation varied across subgroups in 2018, and adolescents, Hispanic and American Indian/Alaska Native children, citizen children with noncitizen parents, noncitizen children,

and children in ACA nonexpansion states faced the largest gaps. Policy changes since 2018 could worsen some of these differences: Though Medicaid/CHIP participation is relatively high among Hispanic children, their uninsurance rate is nearly double that of white non-Hispanic children. Fear and confusion related to the administration's public charge rule caused some immigrant families, including Hispanic immigrant families, to avoid public programs in 2019 (Haley et al. 2020), even before the rule's implementation, and program avoidance may have increased since the rule took effect in early 2020. Together, these threats could further reduce Medicaid/CHIP participation and raise uninsurance among children in families with noncitizens, which disproportionately affects Hispanic children (Kenney et al. 2018).

Additionally, the significant racial/ethnic disparities in exposure to the coronavirus, economic hardships, and rates of infection, hospitalization, and death could translate into greater coverage losses or other barriers to obtaining health care among Black, Hispanic, and American Indian/Alaska Native communities (Gonzalez et al. 2020; Karpman, Gonzalez, and Kenney 2020; Rho, Brown, and Fremstad 2020).[7] Thus, economic fallout related to the pandemic could be hurting children overall while widening racial/ethnic and socioeconomic disparities in health and health care.

Threats to children's coverage remain even beyond the pandemic. Because children have experienced gains in coverage and Medicaid/CHIP participation under the ACA, some gains would likely be reversed if the law were overturned in *California v. Texas*, the lawsuit currently challenging the ACA's constitutionality (Blumberg et al. 2019). And states will likely continue grappling with large budget shortfalls after the pandemic, potentially limiting funding for children's health programs and supports that mitigate families' other hardships. Moreover, CHIP reauthorization temporarily increased the federal matching rate for CHIP through fiscal year 2021, and the Families First Coronavirus Response Act enhanced federal Medicaid and CHIP matching rates. But, the CHIP matching rate will revert to its original rate after September 2021, and the Medicaid/CHIP matching rate enhancement will expire at the end of the public health emergency period, increasing states' obligations. In addition, the ACA's maintenance-of-effort provision will no longer require states to maintain Medicaid/CHIP eligibility for children with incomes above 305 percent of FPL starting in fiscal year 2021, meaning 14 states would be authorized to reduce children's eligibility for the programs.[8] Such states may consider reducing Medicaid and CHIP eligibility as their budgets continue facing large shortfalls.

Our findings indicate some potentially effective strategies to boost children's coverage. We find higher Medicaid/CHIP participation in states that have expanded Medicaid for adults, reinforcing other findings that covering parents in Medicaid increases coverage among their children (Hudson and Moriya 2017). In addition to Medicaid expansion in the remaining nonexpansion states, this could be achieved through removal of federal eligibility restrictions related to immigration status and increased efforts to identify and enroll eligible adults. Given noncitizen children's high uninsurance rate, eliminating immigration and documentation status requirements from Medicaid/CHIP eligibility could improve their coverage rates. We also find higher Medicaid/CHIP participation among families also participating in SNAP, suggesting that increasing enrollment in one program could enhance enrollment in the other, which could especially help families facing both uninsurance and food insecurity.

Maintaining children's coverage can help minimize the pandemic's negative impact on children and families as they face increased hardship during the crisis. This is especially true for children of color, for whom the challenges created by the pandemic and recession are likely to be especially detrimental.[9] With more than half of all uninsured children found to be eligible for Medicaid/CHIP in 2018 and income eligibility for children's Medicaid/CHIP coverage set at or above 255 percent of FPL in most states, focusing state and federal policy efforts on Medicaid and CHIP enrollment and retention is critical. Such efforts could be targeted to subgroups of children with currently high uninsurance, such as adolescents, Hispanic and American Indian/Alaska Native children, noncitizen children and children in families with noncitizens, and children living in nonexpansion states. Finally, given how central Medicaid and CHIP are to children's coverage, continuing to assess how well these programs meet their health care needs will also be essential.

Children's Uninsurance and Medicaid/CHIP Participation Rates by State

TABLE 5

Children's Uninsurance Rates, by State and State Medicaid Expansion Status, 2013–18

	2013 (%)	2014 (%)	2015 (%)	2016 (%)	2017 (%)	2018 (%)	Percentage-Point Change		
							2013–18	2016–18	2017–18
US total	**7.0**	**5.8*****	**4.7*****	**4.3*****	**4.7*****	**4.8**	**-2.2*****	**0.5*****	**0.1^^**
Expansion states	**5.9**	**4.7*****	**3.6*****	**3.2*****	**3.4*****	**3.44**	**-2.5*****	**0.2^^**	**0.0**
AK[a]	12.1	11.6	8.5***	10.2***	9.1	8.2	-3.9	-2.0	-0.9
AZ	11.9	9.8***	8.6***	7.3***	7.5***	7.6	-4.3***	0.4	0.2
AR	5.9	4.5***	4.6***	3.6***	4.4	4.1	-1.9	0.5	-0.4
CA	7.3	5.3***	3.3***	2.9***	2.9***	2.8	-4.4***	-0.1	-0.1
CO	8.4	6.0**	4.1***	4.1***	4.0***	4.4	-4.0***	0.3	0.4
CT	4.1	3.9	3.5***	2.4***	3.1	2.6	-1.5	0.2	-0.6
DE	4.9	5.1	2.6*	3.4	2.8	3.4	-1.4	0.0	0.6
DC	2.5	2.3	1.4*	3.1	1.6	1.7	-0.8	-1.4	0.2
HI	3.0	2.2*	1.4**	2.1	2.1	2.4	-0.6	0.3	0.3
IL	4.3	3.8***	2.4***	2.5***	2.8***	2.9	-1.4***	0.4^^	0.1
IN	8.2	7.0***	6.6***	5.2***	5.9***	6.5	-1.7***	1.3^^	0.5
IO	4.5	2.9***	3.2***	2.0***	2.6*	3.0	-1.6*	0.9^	0.4
KY	5.9	4.2***	4.3***	2.9***	3.8***	3.1	-2.8***	0.2	-0.7
LA	5.6	4.8***	3.5***	3.2***	3.0***	3.1	-2.5***	-0.1	0.1
MD	4.5	3.4***	3.9**	3.2***	3.6	2.9	-1.6	-0.3	-0.7
MA	1.5	1.7***	1.1***	0.9***	1.3	1.1	-0.4	0.1	-0.3
MI	4.1	3.4***	3.1***	2.7***	2.6***	2.8	-1.3***	0.1	0.2
MN	5.9	3.2***	3.0***	2.7***	3.1	3.3	-2.6	0.7^	0.2
MT[a]	9.0	8.3***	7.2***	4.2***	5.9	4.7	-4.3	0.5	-1.2
NV	13.4	9.4***	7.6***	6.0***	7.0	7.5	-5.9	1.5^	0.5
NH	3.5	4.7***	3.3***	3.0***	2.5***	1.7	-1.8***	-1.3^^	-0.8
NJ	5.5	4.4***	3.8***	3.1***	3.4***	3.5	-2.0***	0.4	0.1
NM[a]	8.5	7.5***	4.1***	5.2***	4.1***	5.1	-3.4***	-0.1	1.1
NY	3.9	3.2***	2.4***	2.4***	2.5***	2.1	-1.9***	-0.4^	-0.5^^^

	2013 (%)	2014 (%)	2015 (%)	2016 (%)	2017 (%)	2018 (%)	Percentage-Point Change		
							2013–18	2016–18	2017–18
ND[a]	6.9	6.2	8.5*	9.2***	6.6	6.1	-0.8	-3.1^^	-0.5
OH	4.9	4.7***	4.0***	3.2***	4.0*	4.5	-0.4*	1.3^^^	0.5
OR	6.1	4.1***	3.3***	2.9***	3.0***	3.5	-2.6***	0.6	0.5
PA	4.6	5.1	3.9*	4.3	4.2	4.1	-0.6	-0.2	-0.1
RI	5.6	3.1***	2.8***	1.9***	2.1***	2.1	-3.5***	0.1	0.0
VT	3.0	0.8*	1.0*	1.0*	1.4	2.7	-0.4	1.7	1.3
WA	6.1	4.2***	2.7***	2.4***	2.4***	2.5	-3.5***	0.1	0.1
WV	4.6	3.2***	2.5***	1.4***	2.3***	2.7	-1.8***	1.3^^	0.4
Non-expansion States	**8.6**	**7.6***	**6.3***	**6.0***	**6.5***	**6.8**	**-1.8***	**0.9^^**	**0.3^^**
AL	4.6	3.7***	2.6***	2.4***	2.7***	3.3	-1.3***	0.9^	0.5
FL	10.9	9.0***	6.7***	6.1***	6.7***	7.2	-3.6***	1.2^^	0.5^
GA	9.0	7.1***	6.9***	6.1***	6.7***	7.5	-1.5***	1.4^^	0.8^
ID	8.4	7.4*	5.1***	5.3***	5.0***	6.1	-2.4***	0.7	1.0
KS	6.6	6.0	5.2	4.6	5.0***	5.0	-1.7***	0.3	0.0
ME	5.0	6.1	6.0	4.8	3.8	4.6	-0.4	-0.2	0.8
MS	7.1	5.3***	4.3***	4.2***	4.8***	4.8	-2.3***	0.6	0.0
MO	6.8	6.6	5.7	4.7	4.4***	4.7	-2.1***	0.0	0.3
NE	5.5	4.8***	4.8***	5.0	5.5***	6.0	0.5***	1.0	0.5
NC	6.0	5.1***	4.6***	4.3***	4.4***	4.6	-1.4***	0.4	0.3
OK[a]	10.3	8.7***	7.7***	7.2***	6.9***	7.1	-3.2***	0.0	0.2
SC	6.7	5.2***	4.0***	3.9***	5.0**	4.4	-2.2*	0.6	-0.6
SD[a]	6.9	7.2	7.2	4.3**	5.9	5.2	-1.6	1.0	-0.7
TN	5.4	4.9***	3.9***	3.4***	3.9***	4.6	-0.8***	1.2^^	0.7^
TX	12.2	11.0***	9.2***	9.1***	10.1***	10.4	-1.8***	1.3^^	0.3
UT	8.6	8.7	7.2	5.3	6.5**	6.8	-1.8**	1.6^^	0.3
VA	5.5	5.8	4.7	4.9	4.5**	4.5	-1.0**	-0.4	-0.1
WI	4.4	4.4	3.4*	3.2**	3.6	3.6	-0.8	0.4	0.0
WY[a]	6.3	6.9	6.2	7.2	10.0**	7.6	1.3**	0.3	-2.4

Source: Urban Institute analysis of 2013–18 American Community Survey data from the Integrated Public Use Microdata Series.
Notes: Children are ages 18 and younger. See the data and methods section for our definition of uninsurance. Estimates are adjusted for potential misreporting of coverage on the American Community Survey. State expansion status refers to adoption of the Affordable Care Act's Medicaid expansion for adults as of July 1, 2018.
***/** Estimate is statistically different from the 2013 estimate at the 0.01/0.05 level.
^^^/^^/^ Change is statistically significant at the 0.01/0.05/0.10 level.
[a] Estimates are sensitive to the treatment of Indian Health Service (IHS) access. By convention, exclusive reliance on IHS is considered uninsurance; in 2018, the uninsurance rate would change by 1 percentage point or more if IHS were considered coverage.

TABLE 6

Children's Medicaid/CHIP Participation Rates, by State and State Medicaid Expansion Status, 2013–18

	2013 (%)	2014 (%)	2015 (%)	2016 (%)	2017 (%)	2018 (%)	Percentage-Point Change		
							2013–18	2016–18	2017–18
US total	**88.7**	**90.6***	**92.8***	**93.4***	**92.8***	**92.8**	**4.4***	**-0.6^^^**	**0.0**
Expansion states	**89.7**	**91.8***	**94.1***	**94.6***	**94.1***	**94.3**	**4.6***	**-0.3^**	**0.2**
AK[a]	81.8	83.5	87.8	81.9	85.6	82.5	0.7	0.6	-3.1
AZ[a]	81.6	84.6***	89.2***	90.6***	88.5***	88.7	7.1***	-1.8^	0.2
AR	93.1	95.4***	94.2***	95.7***	94.8***	95.7	2.6***	0.1	0.9
CA	88.9	91.0***	94.8***	95.2***	95.3***	95.4	6.5***	0.2	0.2
CO	84.0	89.0***	94.8***	93.7***	93.5***	92.5	8.5***	-1.2	-1.0
CT	93.0	94.8***	94.4***	96.5***	95.7**	96.5	3.5**	0.1	0.8
DE	92.5	90.5	95.6***	95.3***	94.7***	96.1	3.6***	0.8	1.3
DC	97.8	96.5	98.6*	94.3***	98.3	97.6	-0.2	3.3	-0.7
HI	92.7	95.6*	97.5***	96.9***	94.8	94.9	2.2	-1.9	0.2
IL	92.3	92.8***	95.5***	95.3***	94.1***	94.2	1.9***	-1.0^^	0.1
IN	84.3	86.9***	88.0***	89.4***	87.9**	88.2	3.9**	-1.2	0.3
IO	89.7	94.5***	93.1***	96.0***	93.5**	94.4	4.7**	-1.6	0.9
KY	90.3	93.9***	93.6***	95.3***	93.8***	95.7	5.4***	0.4	1.9
LA	92.4	92.7	95.1***	96.4***	96.5***	96.9	4.5***	0.6	0.4
MD	91.5	94.2***	93.7***	94.7***	93.2	95.1	3.6	0.4	1.9
MA	96.8	96.3	97.9***	98.1***	97.2	97.7	0.8	-0.4	0.5
MI	92.8	94.6***	94.8***	95.9***	96.0***	95.9	3.1***	0.0	-0.1
MN	84.9	92.9***	94.1***	94.2***	93.1***	93.6	8.7***	-0.5	0.5
MT[a]	85.8	85.5	86.1	93.0***	89.1	93.1	7.3	0.0	4.0^
NV	74.3	86.7***	88.0***	91.2***	90.4***	90.3	15.9***	-0.9	-0.2
NH	90.3	89.7	92.7***	94.2***	94.6***	96.8	6.5***	2.6^	2.2
NJ	89.8	91.5***	93.4***	94.8***	93.6***	93.7	3.9***	-1.1	0.1
NM[a]	90.3	91.9	95.4***	94.1***	95.5***	94.5	4.2***	0.4	-1.0
NY	93.0	93.9***	95.8***	95.6***	95.5***	96.4	3.4***	0.8^^	0.9^^
ND[a]	84.3	85.4	87.6***	83.3	83.5	85.3	1.0	2.0	1.8
OH	90.3	92.1***	93.0***	94.4***	93.6***	92.1	1.9***	-2.2^^^	-1.4^
OR	89.1	92.3***	93.8***	94.6***	94.3***	93.4	4.3***	-1.1	-0.9
PA	90.5	89.4*	91.7**	91.6**	91.5	91.7	1.3	0.2	0.2
RI	90.3	94.7***	95.9***	97.1***	96.9***	96.5	6.1***	-0.6	-0.5
VT	94.3	99.9***	98.4***	98.4***	98.0	95.5	1.2	-2.8	-2.5
WA	88.1	92.0***	95.3***	95.1***	95.7***	95.3	7.2***	0.2	-0.4
WV	91.7	95.8***	96.7***	97.9***	96.3***	95.8	4.1***	-2.1^	-0.5
Nonexpansion states	**87.1**	**88.8***	**90.8***	**91.6***	**90.9***	**90.5**	**3.4***	**-1.2^^^**	**-0.4^**
AL	91.6	93.7***	95.6***	96.2***	95.8***	94.6	3.0***	-1.6^^	-1.2
FL	85.0	88.4***	91.5***	92.8***	92.1***	91.2	6.2***	-1.6^^^	-0.9
GA	85.5	89.2***	89.4***	90.6***	89.0***	88.2	2.7***	-2.4^^^	-0.8
ID	87.8	90.4**	92.9***	92.5***	94.1***	92.4	4.6***	-0.1	-1.7
KS	87.7	88.4	90.4***	91.5***	91.8***	91.0	3.3***	-0.6	-0.8
ME	94.0	93.7	89.1***	90.7***	95.4	90.3	-3.7	-0.4	-5.1^^
MS	89.2	93.3***	95.0***	94.7***	93.7***	93.8	4.7***	-0.9	0.2
MO	85.5	86.0	88.2***	90.5***	90.8***	90.3	4.9***	-0.2	-0.5
NE	88.4	90.5*	88.9	90.5	88.7	88.6	0.2	-1.9	-0.1
NC	91.9	93.3***	94.1***	94.7***	94.3***	94.6	2.7***	-0.1	0.2
OK[a]	85.6	87.0***	89.0***	91.0***	91.4***	90.7	5.1***	-0.3	-0.7

	2013 (%)	2014 (%)	2015 (%)	2016 (%)	2017 (%)	2018 (%)	Percentage-Point Change		
							2013–18	2016–18	2017–18
SC	89.9	92.5***	94.2***	95.6***	92.1	93.7	3.8	-1.8^^	1.6
SD[a]	86.2	86.3	85.4***	91.9***	89.1	87.7	1.5	-4.2	-1.4
TN[a]	91.1	92.4***	94.0***	95.6***	94.8***	93.4	2.3***	-2.2^^^	-1.4^^
TX	84.7	85.8***	88.5***	88.5***	87.6***	87.4	2.7***	-1.1^^	-0.2
UT	79.0	79.4	82.2***	87.3***	84.9**	81.9	2.9**	-5.4^^	-3.0
VA	89.1	87.8*	90.7***	90.7*	92.0***	92.2	3.2***	1.6^	0.2
WI	90.9	90.4	92.3***	92.6***	90.9	93.0	2.1	0.4	2.1^^
WY[a]	88.4	81.5**	84.7***	90.2***	77.9**	84.6	-3.8	-5.7	6.6

Source: Urban Institute analysis of 2013–18 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 the data and methods section for our definitions of eligibility and participation. Estimates are adjusted for potential misreporting of coverage on the American Community Survey. State expansion status refers to adoption of the Affordable Care Act's Medicaid expansion for adults as of July 1, 2018.
***/** Estimate is statistically different from the 2013 estimate at the 0.01/0.05 level.
^^^/^^/^ Change is statistically significant at the 0.01/0.05/0.10 level.
[a] Estimates are sensitive to the treatment of Indian Health Service (IHS) access. By convention, exclusive reliance on IHS is considered uninsurance; in 2018, the uninsurance rate would change by 1 percentage point or more if IHS were considered coverage.

Data and Methods

For this analysis, we use data from the 2013–18 American Community Surveys, fielded annually by the US Census Bureau, from the Integrated Public Use Microdata Series.[10] We examine coverage status and Medicaid/CHIP eligibility and participation among noninstitutionalized children ages 18 and under. Each year of the ACS includes a public use sample of more than 690,000 children. Because the ACS is fielded continuously throughout the year, estimates reported here reflect averages for each year.

Medicaid/CHIP Eligibility and Participation

To assess Medicaid/CHIP eligibility, we combine the individual and family information survey respondents provide with the Medicaid/CHIP eligibility rules for each child's state of residence in the survey year (DC is considered a state in this analysis).[11] For 2013, we use 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 2018, we use the American Community Survey Health Insurance Policy Simulation Model, which builds on the Medicaid/CHIP Eligibility Simulation Model and applies ACA rules taking effect in 2014 and any changes from 2014 to 2018 (Brooks et al. 2015, 2016, 2017, 2018; Buettgens 2011; Buettgens and Banthin forthcoming; Buettgens et al. 2013), including the shift to determining eligibility based on modified adjusted gross income. Kenney and colleagues (2016a, 2016b) provide further details on this methodology. Where immigration status factors into eligibility determination, both models rely on imputed documentation status for noncitizens (Kenney et al. 2016a, 2016b). We include as eligible people who meet other income and eligibility requirements and are

imputed as documented and meeting residency requirements. We also include those who are barred from Medicaid/CHIP based on immigration status but who qualify for state-funded public coverage (e.g., people living in states that cover undocumented immigrant children using state funds).

Medicaid/CHIP participation rates are calculated as the ratio of eligible people enrolled in Medicaid/CHIP to the sum of (1) eligible people enrolled in Medicaid/CHIP and (2) Medicaid/CHIP-eligible but uninsured people, excluding those with both Medicaid and private coverage (including military coverage) and those with Medicaid/CHIP coverage who lack 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 include several methodological updates, including to the treatment of income for certain married-couple households, the treatment of Social Security income for certain individuals, and edits to some rules where new information was available. We also changed our methodology for imputing documentation status among noncitizens. Under the new methodology, we do not consider nonparent adults who report household SNAP receipt for imputation as undocumented, assuming these individuals must be documented to qualify for SNAP. (The models already exclude the following from being imputed as undocumented: noncitizens covered by Medicaid, Medicare, or Veterans Affairs coverage; members of the military; veterans; and people reporting welfare income.) Though this change only directly affects the imputation of nonparent adults' documentation status, it also affects parents and children: When the model flags a family member as undocumented, it removes the person from the family size and income measures used to determine modified adjusted gross income for other family members, which can therefore change other family members' eligibility. The new methodology also eliminates the chance of nonparent, noncitizen SNAP recipients being imputed as undocumented, which slightly increases other noncitizens' chances of being selected as undocumented.[12]

Because of these methodological changes, the estimates presented here differ slightly from our previously published estimates. Such changes have a larger effect on estimates for adults than those for children, and the changes have no meaningful effect on estimates of children's uninsurance or Medicaid/CHIP eligibility and participation. Our estimates of uninsurance rates and the number of children eligible for Medicaid/CHIP but uninsured both nationally and in most states are similar to such 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 than those produced using our prior methodology. For instance, the new methodology changes Medicaid/CHIP participation estimates in nearly all states by less than 1 percentage point relative to estimates 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).

Analysis

Here we assess uninsurance, Medicaid/CHIP participation, and the estimated number of children eligible for Medicaid/CHIP but uninsured in 2018 and from 2013 to 2018. We present estimates nationally, by state and Medicaid expansion status as of July 1, 2018 (the middle of the 2018 data-collection period, when 32 states, including DC, had expanded Medicaid), and for selected socioeconomic and demographic subgroups. Health insurance coverage is measured as status at the time of the survey, and we apply coverage edits to address potential misclassification of coverage in the ACS (Lynch et al. 2011). Consequently, coverage estimates presented here may differ from other analyses of the same data source that rely on the full sample without incorporating coverage edits; however, the magnitude of differences between subgroups and changes over time are similar. Alker and Roygardner (2019) found unedited uninsurance rates for children of 4.7 percent in 2016, 5.0 percent in 2017, and 5.2 percent in 2018, increasing the number of uninsured children from 3.6 million to 3.9 million to 4.1 million, or by about 400,000 children between 2016 and 2018. Using the Integrated Public Use Microdata Series subset of the ACS sample and incorporating coverage edits, we find uninsurance rates of 4.3 percent in 2016, 4.6 percent in 2017, and 4.7 percent in 2018, increasing the number of uninsured children from 3.4 million to 3.6 million to 3.7 million, or by about 370,000 children over that period.

Estimated uninsurance and Medicaid/CHIP participation rates 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. However, if IHS access were considered coverage, the 2018 uninsurance rate for American Indian/Alaska Native children would drop from 8.4 percent to 3.1 percent. Likewise, Medicaid/CHIP participation for eligible American Indian/Alaska Native children would rise from 89.2 percent to 94.3 percent. By extension, some state estimates of uninsurance and Medicaid/CHIP participation are also sensitive to the treatment of IHS access. In 2018, uninsurance rates would have been 1 to 5 percentage points lower for children in Alaska, Montana, New Mexico, North Dakota, Oklahoma, South Dakota, and Wyoming if IHS access were treated as coverage.

We test changes over time and differences across groups using two-tailed tests and note changes/differences with *p*-values lower than 0.10. In this analysis, we use an approach to calculating the statistical significance of changes over time and differences across groups that adheres to the Census Bureau's methodological recommendations and uses replicate weights for measuring standard errors and conducting tests of changes or differences. [13]

Limitations

We assess changes after 2013, when the ACA's major coverage provisions were implemented. However, other changes occurred between 2013 and 2018, particularly related to the economy, that could also affect trends in coverage nationally and across states. Therefore, the observed changes in Medicaid/CHIP participation and health insurance coverage over this period cannot be wholly attributed to policies instituted under the ACA. Further, as we note in other analyses of health insurance coverage and Medicaid/CHIP eligibility and participation, both coverage and eligibility status

are likely measured with error. In each year, we find "ineligible reporters," or children who appear ineligible for Medicaid/CHIP (mostly because their family's income is above their state's Medicaid/CHIP threshold) but report having such coverage. These inconsistencies may owe to misreporting of income, family size/structure, or coverage status. They may also owe to a disconnection across time frames. For instance, the ACS income measurement reflects the prior 12 months, whereas Medicaid/CHIP eligibility is based on income at the time of application or renewal. Moreover, modeling eligibility before and after implementation of the ACA's coverage provisions requires different approaches that could introduce bias into comparisons of model results, which could, in turn, over- or understate differences between the two periods (Kenney et al. 2016a, 2017).

Notes

[1] Elizabeth Wright Burak, "The Rate of Uninsured Infants and Toddlers Is Growing. Don't Let COVID-19 Pandemic Make Things Worse," *Say Ahhh!* (blog), Georgetown University Health Policy Institute, Center for Children and Families, April 8, 2020, https://ccf.georgetown.edu/2020/04/08/the-rate-of-uninsured-infants-and-toddlers-is-growing-dont-let-covid-19-pandemic-make-things-worse/.

[2] Tricia Brooks, "CHIP Funding Has Been Extended, What's Next for Children's Health Coverage?" *Health Affairs Blog*, January 30, 2018, https://www.healthaffairs.org/do/10.1377/hblog20180130.116879/full/.

[3] Though our estimated uninsurance levels using Integrated Public Use Microdata Series data with coverage edits (as described in the data and methods section) differ slightly from such estimates using the full ACS sample without coverage edits, both samples show similar uninsurance trends over time. We estimate here that children's uninsurance rate increased from 4.3 percent to 4.8 percent between 2016 and 2018, and the number of uninsured children increased from 3.4 million to 3.7 million (370,000 children). These changes are comparable with those found by Alker and Roygardner (2019): an uninsurance-rate increase from 4.7 percent to 5.2 percent and an increase in the number of uninsured children from 3.6 million to 4.1 million (about 400,000 children).

[4] This figure excludes 1.1 percent of all uninsured children (primarily 18-year-olds) who live in noninstitutional group quarters and whose eligibility cannot be assessed. Excluding these cases does not meaningfully alter observed patterns.

[5] As noted in the data and methods section, the uninsurance rate for American Indian/Alaska Native children is sensitive to the treatment of IHS access. Because IHS is not an insurance program and faces funding constraints, we classify people with IHS access only as being uninsured. If IHS access were considered coverage, uninsurance among American Indian/Alaska Native children in 2018 would drop from 8.4 percent to 3.1 percent.

[6] Medicaid and CHIP Payment and Access Commission, letter to US Department of Health and Human Services Secretary Alex Azar, regarding unwinding the COVID-19 public health emergency, August 25, 2020, https://www.macpac.gov/publication/letter-to-the-hhs-secretary-regarding-notice-to-states-on-unwinding-the-covid-19-public-health-emergency/.

[7] "The COVID Racial Data Tracker," COVID Tracking Project, accessed September 16, 2020, https://covidtracking.com/race.

[8] Brooks, "CHIP Funding Has Been Extended, What's Next for Children's Health Coverage?" *Health Affairs Blog*.

[9] Faith Mitchell, "COVID-19's Disproportionate Effects on Children of Color Will Challenge the Next Generation," *Urban Wire* (blog), Urban Institute, August 17, 2020, https://www.urban.org/urban-wire/covid-19s-disproportionate-effects-children-color-will-challenge-next-generation.

[10] Steven Ruggles, Katie Genadek, Ronald Goeken, Josiah Grover, and Matthew Sobek, "Integrated Public Use Microdata Series: Version 7.0 [dataset]," University of Minnesota, accessed September 16, 2020, https://doi.org/10.18128/D010.V7.0.

[11] In 2018, 15 states required children to forgo coverage for a specified waiting period, ranging from one month to 90 days, before enrolling in CHIP (Brooks et al. 2018). Here we estimate eligibility for CHIP as meeting the program's income and immigration requirements; we do not account for prior coverage status or waiting periods.

[12] The 2017 and 2018 models also use revised estimates of the undocumented population that are lower than those in earlier models (Passel and Cohn 2018). Estimates of participation tend to be more sensitive to methodological changes, and comparing participation rates among noncitizens under this methodological change would be misleading; therefore, we do not present changes in participation among noncitizens over time.

[13] Though some recent reports used a slightly different approach (Haley, Kenney, Wang, Pan, et al. 2018), these are more in line with most of our earlier research and more recent research (e.g., Haley et al. 2019).

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Errata

This brief was revised October 6, 2020. On page 2, the share of uninsured children eligible for Medicaid/CHIP but not enrolled in 2018 is 57.4 percent. A previous version said the share was 56.7 percent on page 2 but 57.4 percent on pages 10 and 11.

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