



# Medicaid and CHIP Enrollment Decline Suggests the Child Uninsured Rate May Rise Again

by Tricia Brooks, Edwin Park, and Lauren Roygardner

## Executive Summary

There is no debate over the fact that children are losing Medicaid and Children’s Health Insurance Program (CHIP) coverage. Overall, more than 828,000, or 2.2 percent, fewer children were enrolled in Medicaid and CHIP, combined, at the end of 2018 than the previous year.<sup>1,2</sup> A drop in child enrollment is unusual; between 2000 and 2016, enrollment declined in only one year—2007—by 1.1 percent.<sup>3</sup> During this period, the nation achieved historic success in covering children with the rate of uninsured children reaching an all-time low of 4.7 percent in 2016. In 2017, child enrollment in Medicaid and CHIP was basically flat while the uninsured rate for children increased for the first time in a decade to 5 percent despite the strong economy.<sup>4</sup>

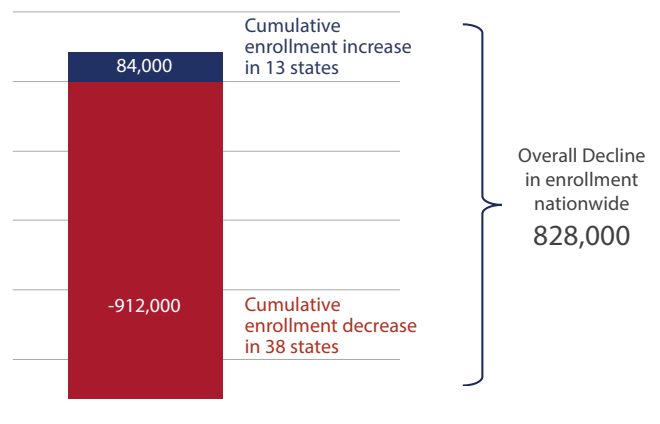
The decline in children’s enrollment in Medicaid and CHIP reinforces serious concerns that this alarming trend could continue—and perhaps even worsen. At a time when the economy is strong, the critical question is whether these children are moving to private coverage or becoming uninsured—a question that will not be answered definitively until the U.S. Census Bureau’s American Community Survey data become available this fall.

### Key Findings

- **Combined enrollment for Medicaid and CHIP declined in 38 states by 912,000 children nationwide in 2018.**

The remaining 13 states had a modest cumulative enrollment gain of 84,000 children, resulting in a net decline of 828,000 children. Enrollment declines are concentrated in seven states (California, Florida, Illinois, Missouri, Ohio, Tennessee, and Texas), which account for nearly 70 percent of the losses. Nine states (Idaho, Illinois, Maine, Mississippi, Missouri, Ohio, Tennessee, Utah, and Wyoming) had decreases of more than double the national average of 2.2 percent.

Figure 1. Nationwide Change in Medicaid and CHIP Child Enrollment in 2018



Source: Georgetown Center for Children and Families analysis of 2017 and 2018 CMS Medicaid and CHIP Enrollment data with May 10, 2019 data update and state enrollment data from Arizona, D.C. and Tennessee.  
Note: Numbers are rounded to nearest 1000.



- **There is scant evidence that the enrollment drop is primarily the result of a strong economy.**

While the economy has been gaining strength in terms of job growth over the past decade, until recently, overall real wage growth in excess of inflation has been modest. Moreover, there is little indication that access to affordable employer-sponsored health insurance (ESI) has improved for parents with dependent children, particularly for low-wage workers. In fact, even with a decade of economic growth, the long-term trend has been a declining share of non-elderly people enrolled in employer-sponsored insurance with incomes between 100 percent and 400 percent federal poverty level (FPL).<sup>5</sup> Although there is some sign of a small increase in the share of employers offering ESI, only 60 percent of workers in these firms are enrolled since some are not eligible and others opt not or cannot afford to enroll (known as take-up rates). Among employers with many lower wage workers, enrollment in ESI was only about one-third. Moreover, only one in five children (20.6 percent) in families with income below 200 percent of the federal poverty level (FPL) are enrolled in ESI, while nearly two-thirds of them (65.3 percent) rely on Medicaid and CHIP to access health care.<sup>6</sup>

- **The economy may have had some impact in 2018, but other factors contributed to the decline in Medicaid and CHIP enrollment.**

At the national level, these include repeal of the individual mandate penalty for not having health insurance under the Affordable Care Act (ACA); reduced funding for outreach and consumer assistance; and the chilling effect of proposed immigration policies. State specific factors may include eligibility system implementation challenges; state choices regarding the use of electronic data to verify eligibility; slow adoption of the ACA's streamlining and simplification measures; and stricter and more frequent reviews of eligibility. A lack of data specifying disenrollment reasons makes it difficult to pinpoint the extent to which state administrative or operational factors are leading to losses of coverage for eligible children.

- **There are many proven strategies that lagging states can implement to advance enrollment and retention of eligible children.**

These include adopting policy options such as 12-month continuous eligibility; boosting outreach and consumer assistance; maximizing the use of technology to increase administrative efficiencies and provide consumer tools that promote self-service; improving the readability of notices; and following up with families when action is required for children to stay enrolled rather than terminating coverage. States that wish to tackle this problem head-on have a variety of options to make sure that eligible kids get covered and stay covered.

- **The federal government should take steps to prevent more children from falling through the cracks.**

Reinvesting in outreach and consumer assistance and rejecting waivers such as work reporting requirements that impose penalties on low-income parents, including loss of coverage, top this list. Additional actions include setting outreach standards, checking state compliance with eligibility worker outstationing rules, ensuring that states are effectively using enhanced federal funding for systems to electronically verify eligibility and streamline enrollment and renewal processes, clarifying how "reasonable compatibility" standards should be applied at renewal or periodic reviews, and adding performance indicators that states must report with more specific denial and disenrollment codes.

Access to health care contributes to improved outcomes in early childhood, a critical time in brain development. There is a large and growing body of evidence pointing to how Medicaid and CHIP support school readiness and academic achievement, reduce school absenteeism, and lead to higher wages and better health in adulthood. If children losing Medicaid and CHIP are becoming uninsured, there are many negative consequences for them and their families, including less access to primary and preventive care, increased exposure to medical debt, and longer term educational and economic impacts.

## Introduction

In 2018, enrollment in Medicaid and CHIP declined by 912,000 children in 38 states while only 13 states experienced gains in enrollment. Despite a strong economy, there is negligible evidence that any significant economic factors have substantially increased access to affordable private or employer-sponsored insurance. It appears that both national and state-specific factors played a role in the decline.

While enrollment growth slows during periods of economic growth, it is uncommon for there to be an actual decline in enrollment. The 2018 decline follows the first year in a decade that the number of uninsured children increased, rising by 276,000 children. The uninsured rate rose from 4.7 percent to 5 percent, both statistically significant increases. If health insurance coverage trends continue, the rate of uninsured children is likely to grow again.

This paper examines the significant decline in children’s combined enrollment in Medicaid and CHIP during 2018 reported in federal/state administrative data; what may be happening to coverage for these children; and why it occurred. Most importantly, we describe what can be done to regain the country’s momentum in providing health coverage to children and ensure that eligible children are not losing access to the health care they need to succeed in school and in life.

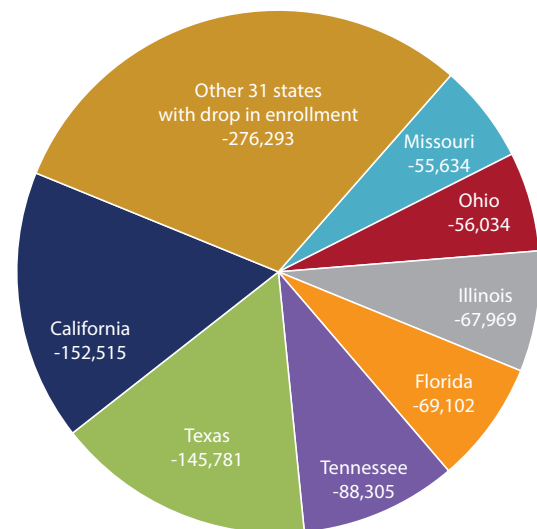
## The Enrollment Decline

The Center for Medicaid and CHIP Services (CMCS), collects various performance measures from states, including enrollment in Medicaid and CHIP with a breakout for children. Enrollment numbers are released monthly, first as preliminary data, followed by an update. Data may be subject to retroactive adjustments.<sup>7</sup> Between December 2017 and December 2018, 38 states experienced combined enrollment declines in Medicaid and CHIP totaling nearly 912,000, ranging from less than 1 percent in Oklahoma to 10.1 percent in Tennessee. Only 13 states experienced an increase in enrollment totaling less than 84,000 children, ranging from 0.2 percent in the District of Columbia (D.C.) to 3.4 percent in Alaska. The combined impact is a decline in enrollment nationwide of 828,000 children. (See Appendix Table 1 for state level data.)

### Decreases in Enrollment Are Concentrated in Seven States

Almost 70 percent of children losing Medicaid or CHIP live in one of seven states (California, Florida, Illinois, Missouri, Ohio, Texas, and Tennessee), each of which experienced an enrollment drop of more than 50,000 children. California tops the list with a decrease of over 150,000 children in Medicaid and CHIP, edging out Texas with 145,000 fewer children.

**Figure 2. States with the Largest Decrease in the Number of Children Enrolled in Medicaid and CHIP between December 2017 and December 2018**



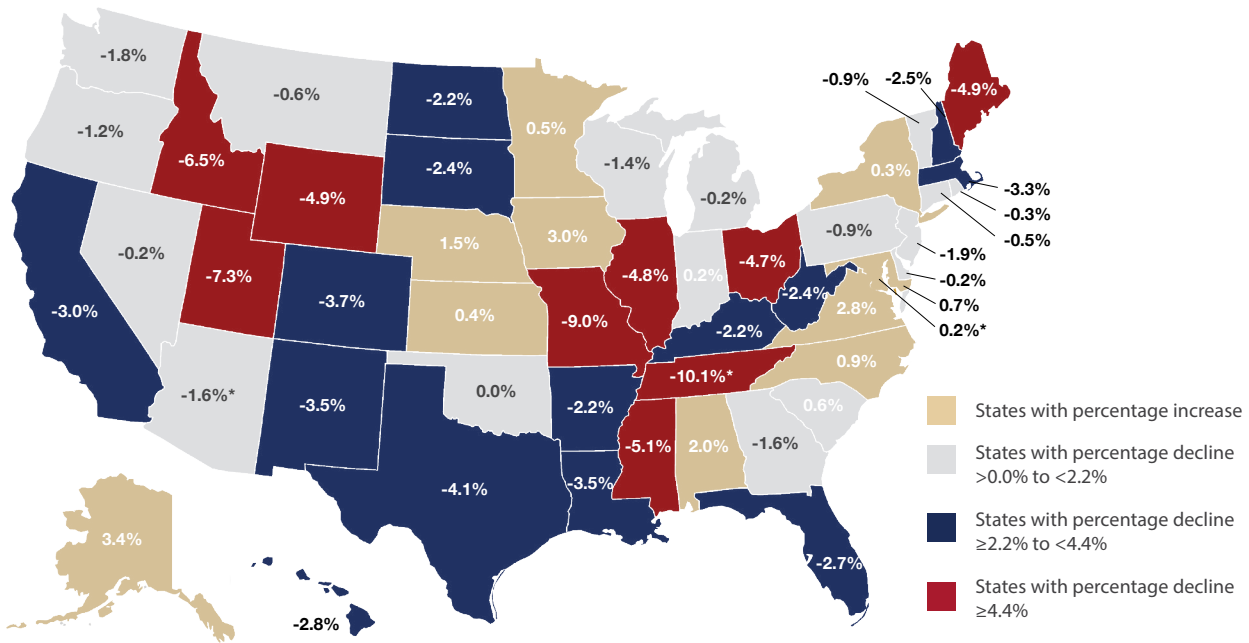
Source: Georgetown Center for Children and Families analysis of 2017 and 2018 CMS Medicaid and CHIP enrollment data with May 10, 2019 data update and state enrollment data from Arizona, D.C. and Tennessee.



### Nine States Experienced a Percentage Decline of More than Double the National Average

The percentage decline in enrollment offers a more comparable view across states given differences in state child population and socio-economic status. Nine states experienced an enrollment decline of more than double the overall national drop of 2.2 percent: Idaho, Illinois, Maine, Mississippi, Missouri, Ohio, Tennessee, Utah, and Wyoming. This list is topped by Tennessee with a 10.1 percent enrollment drop followed by Missouri with a loss of 9 percent. Illinois, Missouri, Ohio, and Tennessee have both enrollment declines of more than 50,000 children and a percentage decline that is more than double the national average.

Figure 3. Percentage Change in Child Enrollment in Medicaid and CHIP, 2018



Source: CMS Medicaid and CHIP Enrollment Data found at <https://data.medicare.gov/Enrollment/State-Medicaid-and-CHIP-Applications-Eligibility-D/n5ce-jxme/data>.

\*The CMS enrollment data does not provide a breakdown of child enrollment for Arizona, the District of Columbia, and Tennessee. Data for those states was collected by Georgetown CCF from state sources. Data for Arizona and Tennessee represented enrollment in January 2018 and 2019. The District of Columbia data is for November 2017 and November 2018.



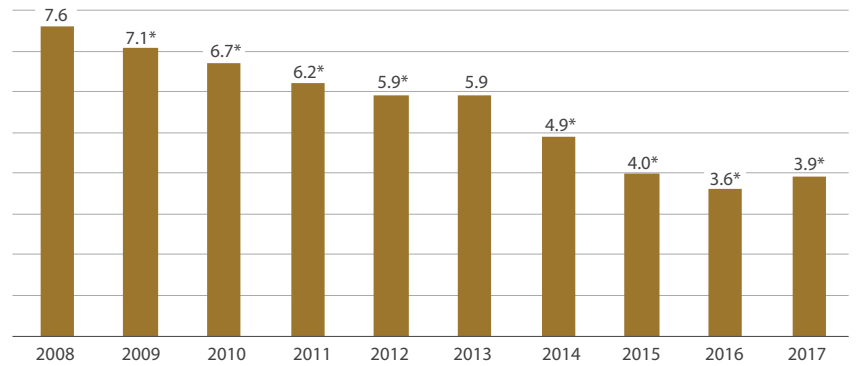
## Children’s Insurance Status

The decline in Medicaid enrollment is concerning because it follows the first increase in the child uninsured rate in more than a decade. In 2017, according to the American Community Survey, the number of uninsured U.S. children increased by 276,000 to 3.9 million children, while the share of uninsured children climbed from 4.7 percent to 5 percent in one year. This reversal in the nation’s progress in covering children was driven by statistically significant increases in the child uninsured rate in nine states, while progress in covering children stalled in other states.<sup>8</sup> (See Appendix Table 3 for state level data.)

**Seven of the nine states with a statistically significant increase in uninsured children in 2017 show an equally large decline in 2018 enrollment.**

The nine states with a statistically significant increase in the uninsured child rate in 2017 are Georgia, Florida, Massachusetts, Ohio, South Carolina, South Dakota, Tennessee, Texas and Utah. Except for South Carolina (which gained enrollment in 2018) and South Dakota. Each of these states has an enrollment decline in 2018 as large or larger than the increase in uninsured children in 2017. These states should be paying close attention since there is clear evidence that their numbers are going in the wrong direction. If the majority of children losing Medicaid or CHIP coverage become uninsured, these states could see statistically significant increases in the uninsured rate again.

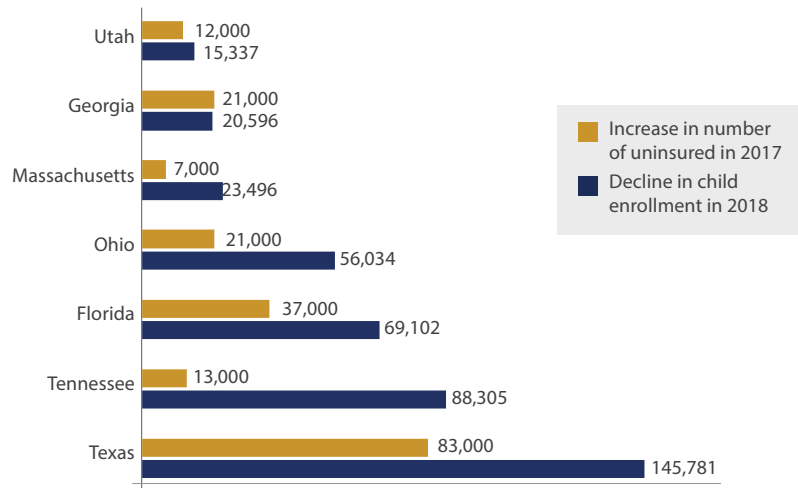
Figure 4. Number of Uninsured Children in the United States, 2008-2017 (in millions)



Source: Table HIC-5 - Health Insurance Coverage Status and Type of Coverage by State—Children Under 19: 2008 to 2017, Health Insurance Historical Tables, U.S. Census Bureau American Community Survey (ACS).

\*Change is significant at the 90% confidence level. Significance is relative to the prior year. 2013 was the only year that did not show a significant one-year increase or decrease in the national rate of uninsured children. The Census began collecting ACS data for the health insurance series in 2008, therefore there is no significance available for 2008.

Figure 5. States with 2018 Enrollment Declines as Large as Statistically Significant Increases in Uninsured Children in 2017



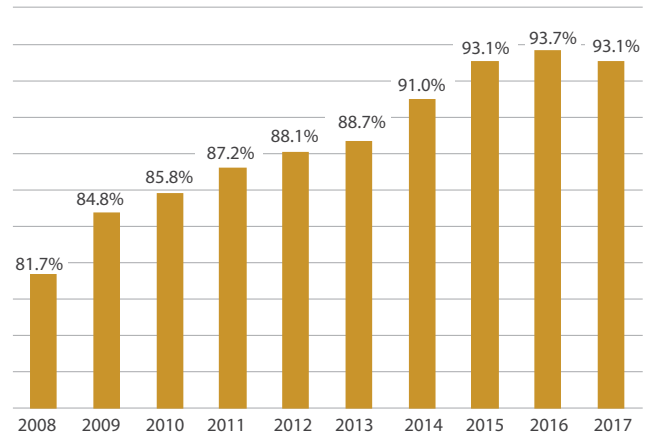
Source: Georgetown Center for Children and Families analysis of 2017 and 2018 CMS Medicaid and CHIP Enrollment data with May 10, 2019 data update and state enrollment data from Arizona, D.C and Tennessee. Table HIC-5, Health Insurance Coverage Status and Type of Coverage by State - Children Under 19: 2008 to 2017, Health Insurance Historical Tables, U.S. Census Bureau American Community Survey (ACS).



## Participation of Eligible Children in Medicaid and CHIP

Another troubling sign that children eligible for Medicaid and CHIP are becoming uninsured is the first statistically significant decline in child participation rates in more than a decade. Participation rates estimate the percentage of children who are eligible and enrolled compared to uninsured, eligible children.<sup>9</sup> Over time, participation had steadily improved from 81.7 percent in 2008, when the rate was first measured by the Urban Institute, to a high of 93.7 percent in 2016. This is a remarkable achievement considering that it was once widely accepted that participation in means-tested benefits could not reach a level comparable to universal programs such as Medicare Part B. However, in 2017, the participation rate declined to 93.1 percent.<sup>10</sup> This helps explain why the uninsured rate went up last year.

Figure 6. Medicaid and CHIP Participation Rates



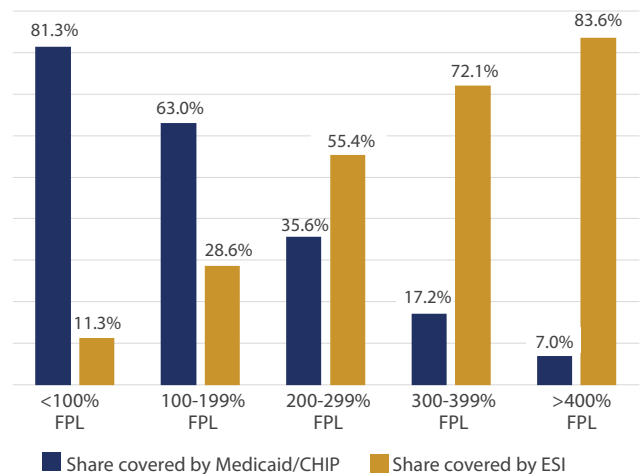
Source: The Urban Institute's analysis of Medicaid/CHIP participation rates from the 2008-2017 American Community Survey data from the Integrated Public Use Microdata Series.

## Relationship of Income to Source of Coverage

Nationwide, Medicaid and CHIP cover 39 percent of children under age 19 while employer-sponsored insurance (ESI) covers the largest share (49 percent) of children.<sup>11</sup> Rates vary by state with the share of children with employer coverage ranging from a low of 33 percent in New Mexico to a high of 64 percent in Utah. Likewise, the share of children covered by Medicaid and CHIP ranges from a low of 25 percent in Wyoming to a high of 56 percent in New Mexico. (See Appendix Table 4 for state level data.)

Examining sources of coverage by income paints a different picture. There is a clear inverse relationship between income and enrollment in Medicaid or CHIP compared to ESI (see Figure 7). More than 86 percent of children in families with income below the poverty level rely on Medicaid for access to health care while only 11 percent are covered through a parent's employer. At the other end of the income spectrum, more than 80 percent of children in families with income above 300 percent are covered by ESI.<sup>12</sup> These data alone suggest that, for families enrolled in Medicaid/CHIP, ESI is not a widely accessible coverage option. And there is no indication that this would have changed in 2018.

Figure 7. Percentage of Children Covered by Medicaid/CHIP and ESI, by Income Level



Source: Georgetown Center for Children and Families analysis of 2017 American Community Survey.





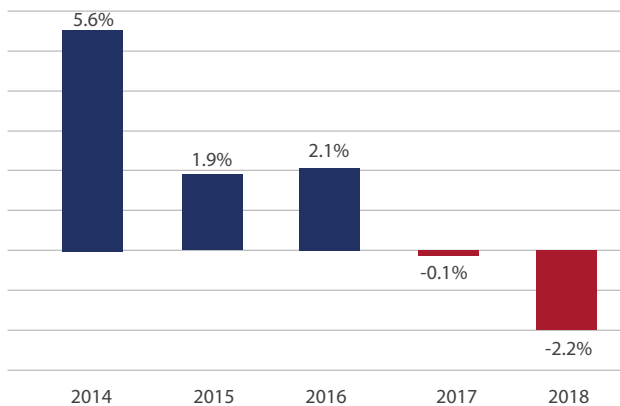
# There is Scant Evidence that the Enrollment Drop is the Result of a Strong Economy

It is true that Medicaid enrollment is sensitive to changes in the economy. Historically, enrollment accelerates during economic downturns and slows, rather than declines, during periods of economic growth.<sup>13</sup> Much of the expected effect related to Medicaid enrollment growth likely occurred in the initial years of the economic recovery after the recession ended in 2009. In fact, Medicaid’s enrollment growth rate steadily fell from a high of 7.6 percent in 2009 to 1.5 percent in 2013 (prior to enrollment growth associated with the implementation of the ACA’s Medicaid expansion in 2014).<sup>14</sup> Over the past five years, enrollment continued to grow before leveling off in 2017 (with a negligible 0.1 percent decline) and then declining by a precipitous 2.2 percent in 2018.

fiscal years 2017 and 2018.<sup>15</sup> Last fall, the CMS actuaries issued their latest report on Medicaid’s financial outlook and expected continued although slower growth in children’s Medicaid enrollment of 1.1 percent between 2017 and 2018 (and an average of 1.2 percent annually through 2026).<sup>16</sup>

In its most recent baseline, however, CBO noted that it has revised its coverage projections for 2018 but not because it had underestimated the impact of a strong economy. CBO now concludes that some of the coverage effects related to repeal of the ACA’s individual mandate penalty occurred earlier than previously expected in 2018 (even though it was not yet in effect) because people thought the penalty already had been lifted or would not be enforced. As a result, 1 million more people were uninsured in 2018 than under prior estimates.<sup>17, 18</sup>

**Figure 8. Child Enrollment in Medicaid and CHIP Year to Year Percentage Change**



Source: Georgetown Center for Children and Families analysis of CMS Enrollment Data, May 10, 2019 Update and 2018 State Enrollment Data from Arizona, D.C. and Tennessee. (See endnote 3 for more details.)

## Government Entities Predicted Steady Enrollment in 2018

Both the Congressional Budget Office (CBO) and the Office of the Actuary consider changes in economic conditions in assumptions used to project Medicaid and CHIP enrollment. Neither organization predicted substantial declines in Medicaid and CHIP children’s enrollment in 2018. For example, in its April 2018 baselines, CBO projected average monthly Medicaid and CHIP child enrollment to remain steady between

## Unemployment Continued Its Steady Decline in 2018

Nationally, the seasonally adjusted unemployment rate of 3.9 percent in December 2018 was modestly lower than the December 2017 rate 4.1 percent.<sup>19</sup> (The unemployment rate has since fallen to 3.6 percent by April 2019.) The average monthly change in non-farm employment in 2018 was higher but not dramatically out of line with the average since March 2010. Of note, parents of minor children, who represent less than a third of the workforce, have had unemployment rates that are consistently around 25 percent lower than workers without minor children.<sup>20, 21</sup> While employment gains continued to be steady in 2018, there was no clear surge in the trend for parents that would explain why nearly 1 million children were disenrolled from Medicaid due to increased income.<sup>22</sup>

## Wage Growth Pulled Ahead of Inflation, But Only Recently

A positive development in 2018 was an uptick in wage growth over the prior 12 months, rising to 3.3 percent by December 2018, which resulted in real wage gains in excess of the average inflation rate of 1.9 percent over the previous 12 months. This compares to wage growth in a range below 3 percent when inflation has generally been in the 2 to 2.5 percent range previously.<sup>23</sup> Wage growth is an important



indicator as it impacts a family's financial ability to purchase private insurance directly or through an employer. Among lower-income workers in the bottom quartile of hourly wages, however, average quarterly wage growth was actually somewhat slower between 2017 and 2018 than between 2016 and 2017.<sup>24</sup>

### Little Evidence that Employer Sponsored Insurance Coverage Has Increased for Low- to Moderate-Income Families

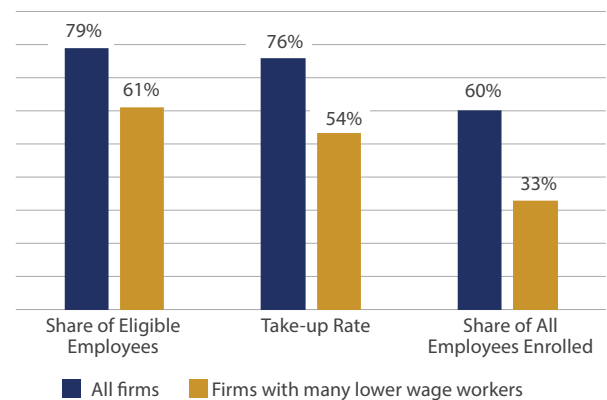
According to the Kaiser Family Foundation's annual survey of employer health benefits, there was a modest uptick in the share of firms that offer health benefits from 53 percent to 57 percent between 2017 and 2018, although the change was not statistically significant. However, certain firms, such as smaller firms and those in certain industries in which low- and moderate-income workers tend to be employed, continue to offer health coverage at lower rates than larger firms. For example, only 47 percent of firms with three to nine workers offered health coverage in 2018, and only 42 percent of retail firms and 53 percent of service industry firms provided health benefits.<sup>25</sup>

Some workers are not eligible even if their employers offer or newly offer health coverage because they are part-time or temporary employees, or are in a waiting period. Overall, only 79 percent of employees are eligible for health benefits, but in firms with many lower wage workers—defined as firms where at least 35 percent of workers earn \$25,000 or less annually—only 61 percent were eligible for health benefits in 2018.<sup>26</sup>

Additionally, many eligible low- or moderate-income families who are offered employer-sponsored insurance do not participate—most likely because it is not affordable. Take-up rates combined with offer rates of employer-based coverage or a lack of eligibility resulted in only 60 percent of workers overall covered through their employer in 2017, a statistic that remained unchanged in 2018. And among firms with many lower wage workers, take-up was only 54 percent and the share of workers with health coverage through their employer was only 33 percent.<sup>27</sup>

In fact, even with a decade of economic growth, the long-term trend has been a declining share of non-elderly people with incomes between 100 percent and 400 percent FPL enrolled in employer-sponsored insurance.<sup>28</sup> There was a modest

Figure 9. Employer Sponsored Insurance in Firms that Offer Health Insurance



Source: Kaiser Family Foundation's "Employer Health Benefits: 2018 Annual Survey," October 2018.

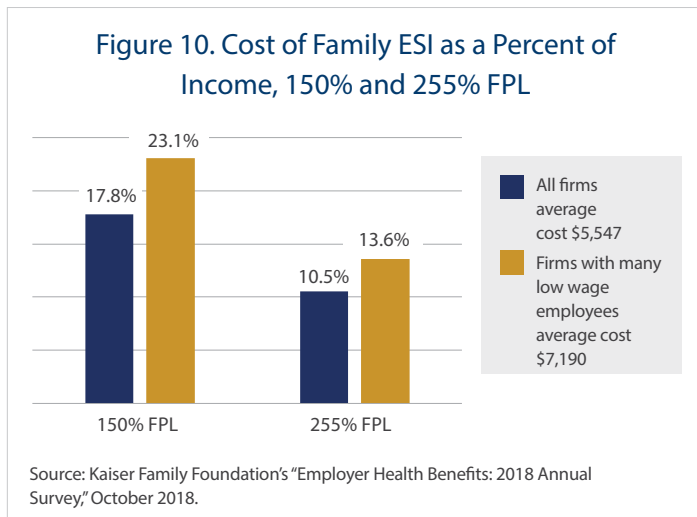
increase in the share of individuals enrolled in ESI with income below 100 percent but this represents less than 15 percent of individuals in that income range.<sup>29</sup> It is unlikely that many children are represented in that number, since the Census data show that only 11 percent of children in poverty are covered by ESI. Unless new Census data, which will be available in the fall of 2019, show significant divergence from these long-term trends, there is no clear evidence that there was a sizable increase in employer-sponsored insurance among children in low- and moderate-income families in 2018. In fact, preliminary data from the National Health Interview Survey show a slight decline in the share of children under age 18 in private health insurance coverage between 2017 and 2018, though it may not be statistically significant.<sup>30</sup>

### Affordability Continues to Be Top Reason Workers Decline to Enroll in ESI

The primary reason for lack of participation in health benefits among eligible, low- to moderate- income workers is affordability. According to the Kaiser Family Foundation's employer survey, on average, employees paid about 28 percent—or \$5,547—of the annual premium cost for family coverage. That consumes 17.8 percent of gross income for a family of three at 150 percent FPL and 10.5 percent for a family at 255 percent FPL (the median income eligibility level for children under Medicaid and CHIP). But among firms with many lower wage workers, the average annual employee



premium was about 39 percent or \$7,190, equaling 23.1 percent of income for a family at 150 percent of the federal poverty line and 13.6 percent of income for a family at 255 percent of the federal poverty line.



Moreover, 40 percent of firms with many lower wage workers required employees to pick up at least half the cost of family coverage in 2018. Firms of relatively smaller size (fewer than 200 workers) and in certain fields such as agriculture, wholesale and the service industry, for which low and moderate-income families disproportionately tend to work, also required employees to bear a share of the cost of family coverage in 2018 that was higher than average.<sup>31</sup>

### No Evidence that More Children are Enrolling in Non-Group Plans

CMS data show the number of children under age 18 in families selecting Marketplace plans nationwide during open enrollment actually declined by more than 64,000 between 2017 and 2018, with a further reduction of 21,000 more children between 2018 and 2019.<sup>32</sup> Data on children's enrollment in individual market plans purchased outside of the Marketplaces is not available but the CBO recently estimated that overall non-elderly individual market enrollment outside of the marketplaces fell by 1.1 million between 2017 and 2018, on top of a 1.4 million reduction between 2016 and 2017.<sup>33</sup> As a result, the individual market inside and outside the Marketplaces did not provide an alternative coverage source for children losing their Medicaid and CHIP coverage in 2018.

### Background on the Country's Commitment to Covering Children

CHIP's enactment in 1997 not only incentivized states to expand coverage with a higher federal match and greater flexibility in program design, it fueled a new determination to enroll eligible, uninsured children by putting out the welcome mat and removing red tape administrative barriers. At that time, 5 million uninsured children were eligible but not enrolled in Medicaid and, despite the previous decade's Medicaid eligibility expansions, it was evident that effective outreach and simplified enrollment and renewal procedures were requisites for making further gains.

CHIP's formative years provided a ripe, pro-child coverage environment for state government and child health policy experts and stakeholders to collaborate on addressing the barriers to enrollment and retention. Thus, its impact was much broader than just creating a new option for moderate-income uninsured children who were persistently losing access to private insurance. CHIP's high profile and bipartisan popularity, at both the federal and state levels, brought about a reappraisal of our approach to children's coverage, spurring states to brand their programs, conduct marketing and outreach, build community partnerships, and test procedural simplifications that improve administrative efficiency and accuracy while boosting enrollment and retention. Importantly, CHIP was required to coordinate with Medicaid, resulting in a decisive welcome mat effect.

The success in covering children through innovations pioneered by states inspired the ACA's vision of streamlined, coordinated enrollment across the continuum of coverage.<sup>34</sup> Coupled with the welcome mat effect of ACA outreach and parent expansions in Medicaid, the results are historic. Between 2008 and 2016, the number of uninsured children dropped by more than half from 7.6 million to 3.6 million, achieving the milestone of coverage for more than 95 percent of U.S. children. This progress is now being eroded.



## Factors Contributing to the Enrollment Decline

Myriad factors are likely contributing to the enrollment decline although these vary across states and are difficult to quantify. At the national level, the repeal of the individual mandate penalty,<sup>35</sup> the negative effects of prolonged efforts to repeal the ACA or cap and cut federal funding for Medicaid, the delays in extending CHIP in 2017, reduced funding for outreach and consumer assistance, and the chilling effect of proposed immigration policy on families with non-citizens had an impact.<sup>36</sup> State specific factors include eligibility system challenges, slow take-up of ACA streamlining measures, stricter and more frequent eligibility reviews, and other procedural barriers. In the aftermath of the 2016 election, the federal climate has been one of inhibiting coverage rather than promoting it.

### Pulling in the Welcome Mat

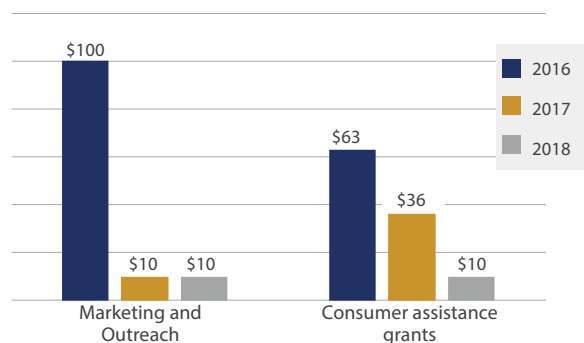
Lessons learned from the nation's success in covering children have proven that positive, inclusive communications, community-based outreach, and consumer assistance are critical to enrollment and retention of eligible children. However, the combination of reduced or delayed funding for outreach and consumer assistance, coupled with the proposed changes to immigration policy, is having a chilling effect on enrollment.

- Cuts to Marketing, Outreach, and Grants for Consumer Assistance – Outreach and consumer assistance are critical elements to ensure that all eligible individuals are enrolled in public coverage programs. In the early years of the ACA's implementation, considerable resources were devoted to marketing, public awareness campaigns, and fostering community-based partnerships. The federal government and states invested in ensuring that consumers had access to individualized assistance through navigators and certified application counselors. But the

Trump Administration has depleted resources for these activities. Funding for the national marketing and outreach campaign was cut by 90 percent from \$100 million to \$10 million in 2017 and remained the same for 2018.<sup>37</sup> Grants for consumer assistance dropped from \$63 million in 2016 to \$36 million in 2017 to \$10 million for 2018.<sup>38</sup>

- Lapse in CHIP Funding Delayed Outreach Grants Targeting Children – Since 2009 there has been consistent funding for a national outreach campaign and outreach grants targeting children. However, the unprecedented lapse in CHIP funding at the end of 2017 disrupted continuity in providing these grants to states, community-based organizations, and tribal entities. The last round of grants expired in June 2018,<sup>39</sup> missing the critical back-to-school outreach season, and the next round is not expected to be granted until June 2019.<sup>40</sup>
- The Chilling Effect of Anti-Immigrant Rhetoric and Policies – About a quarter of children living in the United States have at least one immigrant parent but the vast majority of these children are citizens.<sup>41</sup> Thus, the current anti-immigration climate and onslaught of harmful policy changes targeting immigrant families will likely have far-reaching negative effects impacting children across the country. Children and families may avoid participation in public programs out of fear that family members may be separated and deported.<sup>42</sup> This was perhaps most evident following the release by the U.S. Department of Homeland Security of a proposed rule that would fundamentally alter an immigration proceeding known as public charge.<sup>43,44</sup>

Figure 11. Federal Spending on Marketing, Outreach and Consumer Assistance (in millions of dollars)



Source: S. Gollust, et al, "Health Insurance Television Advertising Content and the Fifth Open Enrollment Period of the Affordable Care Act Marketplaces," Health Affairs, November 2018. K. Pollitz, et al, "Data Note: Further Reductions in Navigator Funding for Federal Marketplace States," Kaiser Family Foundation, September 2018.

Reports of a decline in participation in Medicaid began after draft proposals were leaked to the press and intensified after the proposed rule was released in October 2018. A Medicaid health plan in Texas found



that leaked versions of the public charge proposal contributed to declining enrollment in its state; sharing that “it is thought that nearly 150,000 fewer individuals currently access Medicaid in Texas in part due to the leaked rule.”<sup>45</sup> In a 2018 survey of health care providers in California, 67 percent noted an increase in parents’ concerns about enrolling their children in Medicaid, WIC and SNAP.<sup>46</sup> A recent national survey found that one in six immigrant families with children under age 19 did not participate in noncash government benefit programs like Medicaid and CHIP in 2018 out of fear of risking future green card status.<sup>47</sup> These findings suggest that even proposed policy changes can deter program participation and have a chilling effect beyond those who would be subject to the new rules.

### Systems, Process Changes, Red Tape and Administrative Burden

The ACA institutionalized many of the lessons learned in expanding coverage for children by streamlining and simplifying the application and renewal processes for Medicaid and CHIP. The intent was to replace paper-driven, manual procedures with data-driven, technology-enabled processes. The goal is to limit errors, shrink manual workloads, and reduce administrative costs (like printing and postage) by harnessing technology to automatically verify eligibility using trusted sources of electronic data (such as state wage databases). Despite these advances, in a recent survey conducted by the Kaiser Family Foundation, state Medicaid directors acknowledged that eligibility system changes and verification procedures were contributing to the slowdown in enrollment.<sup>48</sup>

- Eligibility Systems – Developing and deploying a new or upgraded state-of-the-art, interconnected eligibility system is a heavy lift and multi-year effort for states. Technical issues and delays hampered the best of implementation efforts, not the least of which was the rocky rollout of Healthcare.gov, the federal Marketplace’s online eligibility and enrollment system.<sup>49</sup> Some states implemented new systems or major upgrades when the ACA was first implemented in 2014, while others have done so more recently. However, the implementation of new systems does not seem to have gotten easier for states that got a later start.

States like Alaska, Georgia, Illinois, Kansas, Louisiana, Missouri and Tennessee are currently in the throes of various phases of system implementation and refinement. Most of these states report delays in the timely processing of applications,<sup>50</sup> which, in turn, creates more work when individuals increase call center volume trying to determine the status of their application or understand what they need to do to respond to a state’s renewal request. When individuals are unable to secure information about the status of their family’s coverage, they may submit a second application or duplicate verifications, further adding to administrative workloads, or they may abandon the process altogether.

- Slow Take Up of Eligibility Streamlining Rules – States are expected to establish linkages with trusted sources of data to verify eligibility such as confirming citizenship or qualified immigration status through the U.S. Social Security Administration and the Department of Homeland Security. New high-performing systems combined with access to electronic data can result in real-time eligibility determinations (defined as within 24 hours of application) and automated renewals that do not require forms and documents to be submitted by the beneficiary. Although states have had five years to implement the new standards, (following four years to prepare for implementation after the ACA was enacted in 2010), not all states have done so. Eight states have yet to implement real-time determinations and/or automated renewals. Among the states that do, the share of real-time determinations and automated renewals varies significantly.<sup>51</sup> Some states continue to require eligibility worker action to confirm a determination rather than programming the eligibility system to do so, which may contribute to slower enrollment and renewal. Additionally, states are also expected to offer multiple application and renewal paths, including online, by telephone, in-person, or by mailing in paper forms. Eleven states do not allow individuals to apply and/or renew by telephone.<sup>52</sup>
- No Federal Standard in Determining Usefulness of Data Sources – States have long been required to access income information from the State Wage Information Collection Agency, the Internal Revenue Service, the Social Security Administration, state agencies administering unemployment benefits, the SNAP



program, and other federally-funded state administered programs.<sup>53</sup> The ACA further specified that electronic linkages be established with data sources. However, states are given the latitude to decide if such information is “useful to verifying financial eligibility” without any federal criteria to define useful.<sup>54</sup> All of these sources can be useful, some more so than others, but the structure of the regulatory language basically gives states an out.

- Delayed and Complicated Renewals – Some states that have fallen behind with system challenges have requested a temporary suspension of renewals—a mitigation strategy that CMS has allowed. This enables states to dedicate more resources to testing and trouble-shooting new systems, and was a key tactic that helped states handle increased application volume when Medicaid was expanded to adults. Given that multiple studies indicate that often enrollment losses occur at the time of renewal for Medicaid and CHIP, it is no surprise that there can be a surge in disenrollment when renewals are resumed following a temporary suspension. Importantly, the literature consistently shows that most disenrollments at renewal are due to procedural issues, not ineligibility for coverage.<sup>55</sup> Over time, studies have shown that between 30 and 60 percent of uninsured, eligible children were previously enrolled.<sup>56, 57</sup>

When renewals are suspended, there is a greater likelihood that low-income families, who are more transient,<sup>58</sup> have moved and that renewal forms will not catch up with them. Once renewals are restarted, the process and forms are different, leading to confusion. Notices and instructions are notoriously complicated and difficult to understand, and when individuals cannot get through to call centers to get answers, they may abandon the process.

- Insufficient Time to Respond before Automatic Closures – Although applications are valid for 45 days and federal regulations provide 30 days for individuals to respond to requests for information at renewal, there are still reports of states providing only 10 days for individuals to provide needed information.<sup>59, 60</sup> Even when individuals submit the requested information, there

is evidence of lost paperwork or delays in processing documentation. Meanwhile, some states like Texas have programmed their systems to automatically close the child’s Medicaid case without further review or consideration of eligibility for other programs (such as CHIP) that federal regulations require.

- Data on Denial and Disenrollment Reasons – Although CMS established performance indicators in 2013—including denial and disenrollment reasons—that states are expected to submit as a condition of enhanced federal funding for systems deployment and maintenance,<sup>61</sup> few of these indicators are being reported publicly. For the past couple of years, CMS has consistently released data on application volume in addition to enrollment but it has yet to release data on most of the metrics.
- More Specific Reason Codes Are Needed – It is difficult to pinpoint specific reasons children are losing Medicaid due to a lack of actionable reason codes. Current performance indicators delineate only whether “ineligibility was confirmed” or if the determination was for “procedural reasons”—such as missing verification documents. This is a good starting point but for states to reduce inappropriate procedural denials and disenrollments, more actionable reason codes (for example, incorrect address) are needed.<sup>62</sup> Louisiana demonstrated that, by adopting policy options to automate and simplify renewals and conducting outreach and follow-up, procedural denials can be virtually eliminated. More than a decade ago, the state was able to achieve fewer than 1 percent of disenrollments due to procedural reasons.<sup>63</sup>
- Periodic Reviews of Eligibility Between Renewals – Although the ACA set a new standard for renewing eligibility only once every 12 months, states may examine available data sources to determine if there have been changes that could impact eligibility more frequently. Doing so may simply catch increased income due to a few extra work hours or overtime that over the course of a year would not result in lost eligibility for the child. It seems that the political winds have changed and there is pressure to review eligibility more frequently to save money or fight perceived beneficiary fraud, of which there is negligible evidence.



Periodic reviews contribute to churn in Medicaid and CHIP for low-income families who are likely to experience income instability due to more frequent job changes, irregular work hours, part-time employment, or self-employment (see text box below). One of the more stark examples of the move to conduct more frequent and stricter reviews of eligibility is occurring in Texas. The state contracts with a third-party vendor to review children's Medicaid eligibility in months 5, 6, 7, and 8 of enrollment, while more moderate-income children enrolled in CHIP get 12-month continuous eligibility.<sup>64</sup>

### Income Volatility Increases Churn – A Long-Standing Challenge in Medicaid

Medicaid churning—the disenrollment and re-enrollment of beneficiaries—has long been a problem. Churn involves a pattern of short-term enrollment, disenrollment and re-enrollment that drives up administrative costs and results in avoidable medical costs when individuals become uninsured. Over time, numerous studies have shown that many children who are disenrolled for procedural reasons become uninsured even though they remain eligible or regain eligibility in a matter of weeks or months following a temporary increase in income. Families and individuals who experience lapses in coverage often delay accessing care or filling prescriptions until the health condition worsens and then they seek care in more expensive hospital settings.<sup>65</sup>

In addition to interrupting access to health coverage, income volatility can have negative consequences for the health and well-being of families including increasing parent parental stress, food insecurity, and other effects.<sup>66</sup> Numerous studies reach that same conclusion that about one-third of low-income individuals experience income volatility.<sup>67, 68, 69</sup> With the vast majority of children now in managed care and states paying a monthly capitation rate, the incentive to achieve short term budget savings, by facilitating processes that contribute to Medicaid churn, has grown.

- “Reasonable Compatibility” Standard is Inconsistently Applied – One technical issue that could be contributing to disenrollment is how states implement a policy known as “reasonable compatibility.” All states must apply a federal standard explicitly asserting that if the individual's reported income and the income shown through a third-party data source are both below Medicaid income eligibility, the individual must be determined eligible.<sup>70</sup> This reduces administration burden in processing documents to reconcile differences.

States also have the option to set a reasonable compatibility standard when the income reported by the individual and the data source yield different but close eligibility results. About two-thirds of the states have adopted a standard when the individual's reported income is below the eligibility threshold but the data source is above.<sup>71</sup> This helps to account for variability in income and differences in data sources, such as the federal Marketplace using IRS data, which lags behind quarterly wage data that the state agency may use for periodic reviews. However, there is inconsistency in how reasonable compatibility is applied under various scenarios that may be contributing to churn. Thus, it would be helpful for CMS to issue guidance on reasonable compatibility to lessen unintended consequences.

### Families are Tripping Over Red Tape and Administrative Barriers

- Georgia shuts down its online application after normal business hours to curb the volume of work generated by the influx of applications due to limited staff to handle administrative workloads.
- In Missouri, families report facing hours-long waits on the state's phone lines to get help in enrolling or renewing coverage. Additionally, the state provides only 10 days for beneficiaries to respond to requests for information at renewal.<sup>72</sup>
- Tennessee sent renewals packets to families that could be as long as 47 pages to verify their re-enrollment.
- Texas is disenrolling more than 4,000 children monthly when it conducts income reviews for Medicaid at month 5, 6, 7, and 8 of enrollment. Children in families with more moderate-income enrolled in CHIP are not subject to the same reviews.<sup>73</sup>





## Strategies to Improve Enrollment and Retention of Eligible Children

There are many opportunities to improve enrollment and retention of eligible children and families, including adopting policy options, maximizing the role of technology, boosting consumer assistance, and making procedural changes. An assessment of the current status of the state's Medicaid operation, along with identifying strengths and gaps, is necessary in determining which policies or actions will work best in enrolling and keeping children covered.

### Adopt Policy Options that Facilitate Enrollment and Retention

- **12-Month Continuous Eligibility** – One key federal policy option, 12-month continuous eligibility, allows children to stay enrolled until their annual renewal regardless of most changes in family circumstances, which are often modest or temporary. Currently, 24 states provide 12-month continuous eligibility for children in Medicaid, as do 26 separate CHIP programs.<sup>74</sup> Studies have demonstrated that continuous-eligibility policies increase the continuity of children's enrollment in Medicaid.<sup>75</sup> Adoption of the policy has multiple benefits including improving child health outcomes, reducing families' exposure to medical debt, lowering the uninsured rate, and providing a more complete picture of the quality of care children receive in Medicaid and CHIP.<sup>76</sup>
- **Express Lane Eligibility (ELE)** – This federal policy option permits states to use the eligibility findings from other public programs such as SNAP to enroll and renew Medicaid and CHIP for children.<sup>77</sup> For example, almost all children in families receiving food assistance will also be eligible for Medicaid based on income, so SNAP enrollment is an excellent data source for confirming Medicaid income eligibility. It is important to note that an integrated system that determines eligibility for Medicaid and CHIP and non-health programs such as SNAP is not necessary for states to use this policy option. Alabama and Louisiana have successfully used ELE to enroll and retain children in Medicaid for many years without either state having an integrated eligibility system.<sup>78</sup>
- **Presumptive Eligibility** – Often, families are unaware that a child has been disenrolled until they show up for a doctor's appointment or otherwise seek health care. Allowing health care providers to make presumptive eligibility determinations is particularly important for low-

income families whose children are eligible but may have lost coverage for administrative reasons. Presumptive eligibility is a policy option that allows states to train and authorize Medicaid providers and other qualified entities to assess eligibility and expedite temporary enrollment while the regular application is being processed.<sup>79</sup> The ACA gives hospitals the option to determine eligibility presumptively,<sup>80</sup> but authorizing federally-qualified health centers and school-based health centers to enroll children presumptively can minimize gaps in coverage.

### Boost Consumer Assistance and Outreach

- **Targeted Outreach** – Enhanced Federal CHIP matching funds can be used for both Medicaid and CHIP outreach and to support application assisters.<sup>81</sup> States are required to describe their outreach strategies as part of their CHIP state plans but there is no federal standard for what constitutes an adequate level of outreach. Thus, outreach varies dramatically across states. Whether funded through CHIP outreach grants or CHIP administrative costs, it is important for states to conduct outreach in a way that targets potentially eligible children newly in need of coverage or following a disenrollment of eligible children due to procedural reasons.
- **In-Person Consumer Assistance** – Access to user-friendly online accounts that promote self-service will not supplant the need for personalized consumer assistance. Direct, in-person assistance remains critical. A recent MACPAC study found that applicants came to state agency or community assister offices typically because they lacked computer access, had difficulty understanding the application questions, needed help interpreting notices, or needed assistance with documentation.<sup>82</sup> Families often need help with renewals, finding providers, and accessing care, so consumer assistance should not be limited to outreach and assistance with new applications.





- **Outstation Eligibility Workers** – States must provide opportunities for pregnant women, children, and parents to apply for Medicaid at certain locations, including disproportionate share hospitals, federally qualified health centers, and Indian health clinics. States also have the option to establish other outstation sites in locations such as schools or family resource centers that would help to ensure that eligible children are enrolled.
- **Call Center Operations** – All states are required to provide consumer assistance over the phone, as well as report certain call center performance indicators to CMS, although these data have not been reported publicly.<sup>83</sup> Long waits and a lack of knowledgeable staff handling phone inquiries continue to be problematic in some states. Training and oversight of call center staff, along with monitoring key indicators such as wait times and dropped or abandoned calls are critical to providing quality beneficiary assistance. Call center tracking of problems reported by callers can be a valuable resource in identifying common issues faced by consumers related to eligibility, enrollment and renewal, as well as difficulties beneficiaries may face in accessing care.
- **Language Access and Culturally Competent Consumer Assistance** – States are required to provide language access and culturally competent assistance,<sup>84</sup> and must ensure that health care providers do the same. Hiring bi- or multi-lingual eligibility workers, providing cultural competency training, translating forms and outreach materials into multiple languages as appropriate, and using trusted community members to provide community-based assistance help overcome language and cultural barriers that families face in accessing Medicaid and CHIP.
- **Fostering a Strong Network of Community Partners** – Partnerships with community-based organizations and providers who serve low-income families extend the reach of the state. Community-based consumer assistance through trusted entities remains important in providing linguistically and culturally competent help for families with different coverage sources, homeless and near homeless families, immigrant communities, and communities with lower computer literacy or limited internet access. Additionally, community partners serve as an essential feedback loop that helps the state agency understand how its policies and procedures impact families in real time.

## Maximize the Use of Technology

- **Web-Based and Mobile Consumer Tools** – While some individuals may lack internet access, have limited experience using online tools, or need personalized assistance, facilitating self-service pathways for consumers can enhance their experience and reserve limited state resources for those who need a human touch.<sup>85</sup> All states now offer an online application but not all are designed in a way to ensure mobile access. The share of applications received online varies significantly across states from 10 percent to more than 90 percent. A majority of states (42 states) also enable enrollees to access and submit information regarding their coverage through online accounts.<sup>86</sup> Most offer a broad range of online account features and functions such as allowing individuals to submit an address change, renew coverage, receive notices electronically, or submit information and documents needed to confirm eligibility. States should expand and promote the use of web-based tools and mobile access, which are convenient for families and ease administrative burdens on the state.
- **Automated Renewals** – The ACA set a new “annual” standard for renewing eligibility for children, parents, and other non-disabled adults.<sup>87</sup> To streamline the process and reduce administrative burden, states are required to assess ongoing eligibility using trusted electronic data sources before asking the enrollee to complete a form or submit documentation. If the electronic data confirm continuing eligibility, the state simply notifies the beneficiary, requiring the individual to respond only if the data is not accurate or has changed. This process, known as automated or ex-parte renewals (meaning using third party data), facilitates retention of eligible individuals and reduces administrative burden and costs.

While 46 states indicate that their systems are able to conduct ex-parte renewals, the share of renewals processed automatically varies across states. Of the 43 states reporting the share of automated renewals, nearly half (21 states) indicate that 50 percent or more of renewals are determined automatically.<sup>88</sup> Many states have room for improvement.



- **Eligibility System Portals for Community Assistors** – Providing community assistors with protected access to state systems and online tools—as 27 states do—allows them to facilitate applications and renewals, and offer in-person assistance at the community level.<sup>89</sup> It also allows the state to monitor the performance of assistors. Systems can be designed to provide enhanced information to assistors, such as sending reminders in advance of upcoming client renewal dates.

### Improve State Procedures

- **Follow-up When Beneficiary Action Is Required** – Most Medicaid and CHIP programs send a single notice or request for information to beneficiaries that may or may not be successfully delivered. Low-income families are more likely to move more frequently than other households.<sup>90</sup> Email, electronic, or text communications, along with automated phone calls, make it easier and

more cost effective to send reminders that will inevitably result in a higher enrollment and retention rate of eligible individuals.

- **Engage MCOs in Retention** – While federal regulations limit what Medicaid managed care organizations (MCOs) are allowed to do in marketing their plans to new enrollees, MCOs are allowed to assist at renewal. Rhode Island, New York, and Pennsylvania are among states that have effectively engaged MCOs in the renewal process.
- **Improve Notices** – States continue to struggle with ensuring that notices are easy to comprehend and include the legal protections as required by law. States can engage literacy experts, consumer assistors, and beneficiaries in drafting and testing effective written communications that can improve beneficiary compliance with enrollment and renewal requirements.

## Conclusion

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Historically, Medicaid and CHIP enrollment growth slows during favorable economic times, but it is unusual for there to be negative growth—that is, an actual decline in overall enrollment. There is negligible evidence that economic factors have substantially increased access to affordable private or employer-sponsored insurance for low- to moderate-income families between 2017 and 2018. It appears that key contributors to the enrollment decline include repeal of the individual mandate penalty, reduced funding for outreach and consumer assistance, anti-immigrant rhetoric and policy, and administrative procedures have led to losses of coverage for eligible children. While we will not know how many more children have become uninsured until the Census Bureau releases the 2018 American Community Survey later this year, declines in Medicaid enrollment raise considerable concern that the number of uninsured children will rise. Even if a substantial share of the children losing Medicaid and CHIP in 2018 gained other coverage, we could see a larger increase in the number of uninsured children than in 2017.

Medicaid and CHIP not only improve children's health but also support school readiness, reduce school absenteeism, contribute to higher academic achievement and graduation rates, and lead to higher wages and better health in adulthood.<sup>91</sup> Gaps in coverage result in missed opportunities to detect and treat health issues and child developmental concerns early and reduce health care costs when care is delayed due without insurance. Supporting early childhood healthy development through the health care system reduces downstream costs not only in health care but cross-sectors including education, juvenile justice, and the child welfare system.

The Trump Administration has expressed no concern that eligible children may be joining the ranks of the uninsured. Nor has it taken any visible action to make sure that eligible children are not losing Medicaid and CHIP due to red tape and administrative barriers. Instead, the Administration is actively encouraging states to adopt eligibility restrictions for adults including parents, such as work reporting requirements, with punitive penalties, including the loss of coverage. And when parents lose coverage, there is a greater likelihood that their children will also lose coverage.<sup>92</sup> Following more than a decade of continued progress, the nation's success story in covering children is at risk.



Appendix Table 1. Child Enrollment in Medicaid and CHIP

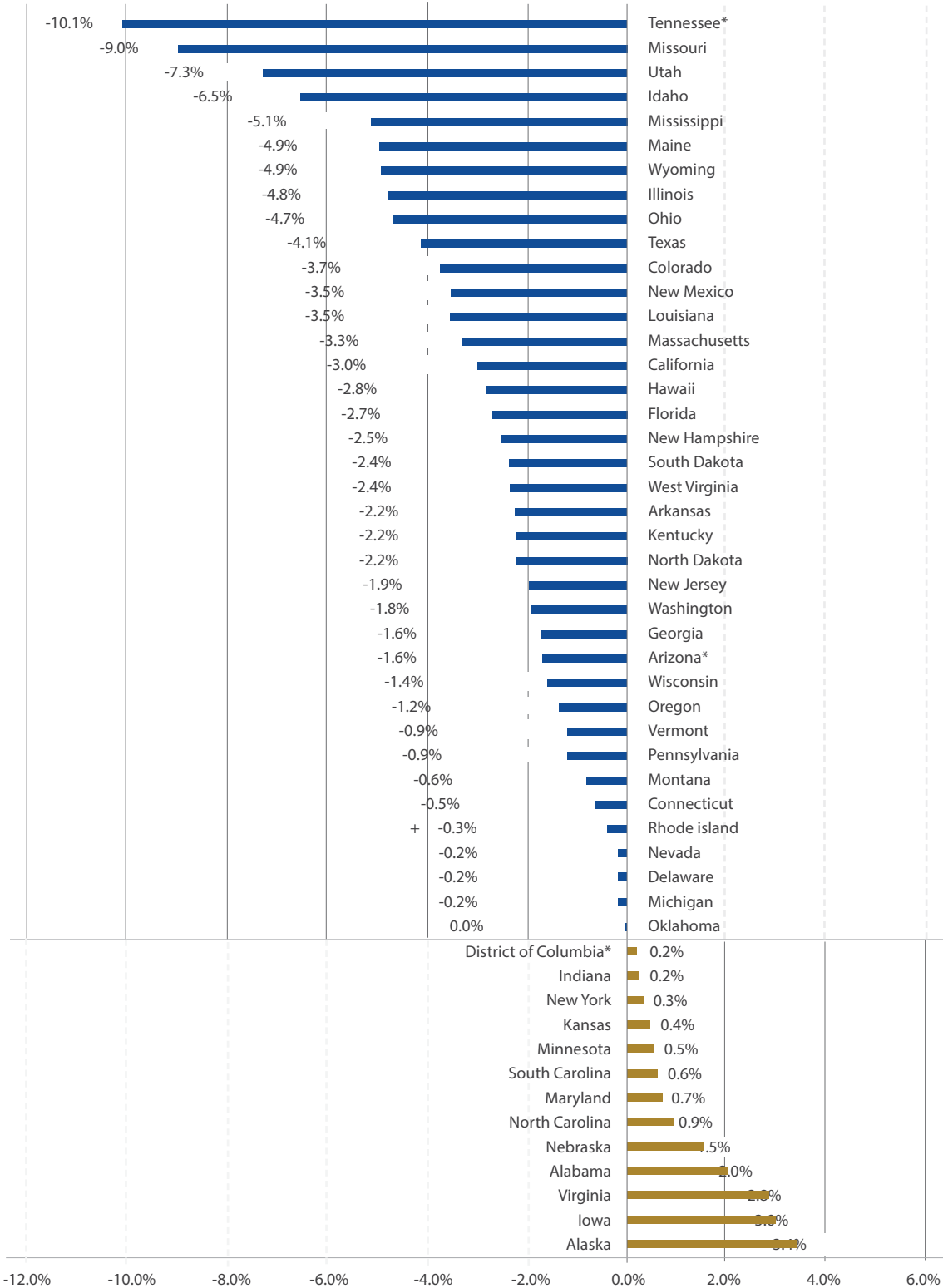
State	December 2017	December 2018	Number Change	Percent Change
California	5,124,031	4,971,516	-152,515	-3.0%
Texas	3,552,079	3,406,298	-145,781	-4.1%
Tennessee*	876,131	787,826	-88,305	-10.1%
Florida	2,556,257	2,487,155	-69,102	-2.7%
Illinois	1,424,819	1,356,850	-67,969	-4.8%
Ohio	1,199,240	1,143,206	-56,034	-4.7%
Missouri	620,110	564,476	-55,634	-9.0%
Louisiana	739,852	713,819	-26,033	-3.5%
Massachusetts	708,729	685,233	-23,496	-3.3%
Colorado	610,867	588,054	-22,813	-3.7%
Mississippi	442,959	420,209	-22,750	-5.1%
Georgia	1,266,151	1,245,555	-20,596	-1.6%
New Jersey	842,208	826,159	-16,049	-1.9%
Washington	844,862	829,464	-15,398	-1.8%
Utah	210,398	195,061	-15,337	-7.3%
Idaho	216,479	202,303	-14,176	-6.5%
Pennsylvania	1,402,983	1,390,084	-12,899	-0.9%
Kentucky	576,740	564,123	-12,617	-2.2%
Arizona*	771,821	759,466	-12,355	-1.6%
New Mexico	342,450	330,359	-12,091	-3.5%
Arkansas	436,335	426,599	-9,736	-2.2%
Wisconsin	487,265	480,642	-6,623	-1.4%
Maine	110,245	104,796	-5,449	-4.9%
West Virginia	220,127	214,948	-5,179	-2.4%
Oregon	419,719	414,548	-5,171	-1.2%
Hawaii	144,476	140,392	-4,084	-2.8%
New Hampshire	93,672	91,337	-2,335	-2.5%
Wyoming	40,929	38,918	-2,011	-4.9%
South Dakota	80,698	78,791	-1,907	-2.4%
Michigan	950,347	948,635	-1,712	-0.2%
Connecticut	331,812	330,253	-1,559	-0.5%
North Dakota	44,054	43,094	-960	-2.2%
Montana	128,671	127,863	-808	-0.6%
Nevada	304,036	303,343	-693	-0.2%
Vermont	63,873	63,270	-603	-0.9%
Rhode Island	123,138	122,710	-428	-0.3%
Delaware	105,969	105,732	-237	-0.2%
Oklahoma	507,980	507,792	-188	0.0%
<b>Total States with Decreases</b>	<b>28,922,512</b>	<b>28,010,879</b>	<b>-911,633</b>	<b>-3.2%</b>
District of Columbia*	90,716	90,881	165	0.2%
Kansas	269,068	270,256	1,188	0.4%
Indiana	798,671	800,565	1,894	0.2%
Nebraska	162,432	164,913	2,481	1.5%
Minnesota	533,361	536,246	2,885	0.5%
Alaska	91,360	94,469	3,109	3.4%
South Carolina	649,599	653,431	3,832	0.6%
Maryland	614,353	618,583	4,230	0.7%
New York	2,495,945	2,504,152	8,207	0.3%
Iowa	324,934	334,623	9,689	3.0%
Alabama	637,705	650,406	12,701	2.0%
North Carolina	1,462,960	1,476,805	13,845	0.9%
Virginia	683,182	702,460	19,278	2.8%
<b>Total States with Increases</b>	<b>8,814,286</b>	<b>8,897,790</b>	<b>83,504</b>	<b>0.9%</b>
<b>Total for All States</b>	<b>37,736,798</b>	<b>36,908,669</b>	<b>-828,129</b>	<b>-2.2%</b>

Source: CMS Medicaid and CHIP Enrollment Data found at <https://data.medicaid.gov/Enrollment/State-Medicaid-and-CHIP-Applications-Eligibility-D/n5ce-jxme/data>.

\* The CMS enrollment data does not provide a breakdown of child enrollment for Arizona, the District of Columbia, and Tennessee. Data for those states was collected by Georgetown CCF from state sources. Data for Arizona and Tennessee represented enrollment in January 2018 and 2019. The District of Columbia data is for November 2017 and November 2018.



## Nationwide Change in Medicaid and CHIP Child Enrollment in 2018, by State



Source: CMS Medicaid and CHIP Enrollment Data found at <https://data.medicaid.gov/Enrollment/State-Medicaid-and-CHIP-Applications-Eligibility-D/n5ce-jxme/data>.

\* The CMS enrollment data does not provide a breakdown of child enrollment for Arizona, the District of Columbia, and Tennessee. Data for those states was collected by Georgetown CCF from state sources. Data for Arizona and Tennessee represented enrollment in January 2018 and 2019. The District of Columbia data is for November 2017 and November 2018.



Appendix Table 3. Change in the Number of Uninsured Children Under 19, 2016 and 2017

State	2016 Percent Uninsured	2017 Percent Uninsured	2016 Number Uninsured	2017 Number Uninsured	2016-2017 Change in Number of Uninsured
United States	4.7	5.0*	3,649,000	3,925,000	276,000 **
Alabama	2.7	3.1	32,000	36,000	4,000
Alaska	10.3	9.6	20,000	19,000	-1,000
Arizona	7.6	7.7	132,000	133,000	1,000
Arkansas	4.0	4.4	30,000	33,000	3,000
California	3.1	3.1	300,000	301,000	1,000
Colorado	4.3	4.3	57,000	57,000	-
Connecticut	2.8	3.1	23,000	24,000	1,000
Delaware	3.1	3.5	7,000	8,000	1,000
District of Columbia	3.1	1.2*	4,000	2,000	-2,000
Florida	6.6	7.3*	288,000	325,000	37,000 **
Georgia	6.7	7.5*	179,000	200,000	21,000 **
Hawaii	2.5	2.2	8,000	7,000	-1,000
Idaho	4.9	4.6	22,000	22,000	-
Illinois	2.6	2.9	82,000	89,000	7,000
Indiana	5.9	6.3	99,000	106,000	7,000
Iowa	2.6	3.1	20,000	24,000	4,000
Kansas	4.5	5.2	34,000	39,000	5,000
Kentucky	3.3	3.8	35,000	41,000	6,000
Louisiana	3.3	3.1	39,000	36,000	-3,000
Maine	4.8	4.9	13,000	13,000	-
Maryland	3.4	3.8	49,000	54,000	5,000
Massachusetts	1.0	1.5*	15,000	22,000	7,000 **
Michigan	3.1	3.0	71,000	69,000	-2,000
Minnesota	3.4	3.4	46,000	47,000	1,000
Mississippi	4.8	4.8	37,000	37,000	-
Missouri	4.8	5.1	71,000	75,000	4,000
Montana	4.9	5.8	12,000	14,000	2,000
Nebraska	5.1	5.1	25,000	26,000	1,000
Nevada	7.0	8.0	50,000	58,000	8,000 **
New Hampshire	2.7	2.3	8,000	6,000	-2,000
New Jersey	3.7	3.7	78,000	78,000	-
New Mexico	5.3	5.1	28,000	26,000	-2,000
New York	2.5	2.7	113,000	118,000	5,000
North Carolina	4.7	4.8	115,000	119,000	4,000
North Dakota	8.0	7.5	15,000	14,000	-1,000
Ohio	3.8	4.5*	104,000	125,000	21,000 **
Oklahoma	7.7	8.1	79,000	82,000	3,000
Oregon	3.4	3.6	31,000	33,000	2,000
Pennsylvania	4.4	4.4	126,000	125,000	-1,000
Rhode Island	2.2	2.1	5,000	5,000	-
South Carolina	4.3	5.1*	50,000	60,000	10,000 **
South Dakota	4.7	6.2*	11,000	14,000	3,000 **
Tennessee	3.7	4.4*	58,000	71,000	13,000 **
Texas	9.8	10.7*	752,000	835,000	83,000 **
Utah	6.0	7.3*	59,000	71,000	12,000 **
Vermont	1.5	1.6	2,000	2,000	-
Virginia	5.0	5.1	99,000	101,000	2,000
Washington	2.7	2.6	46,000	46,000	-
West Virginia	2.3	2.6	9,000	11,000	2,000
Wisconsin	3.7	3.9	50,000	53,000	3,000
Wyoming	8.8	9.5	13,000	14,000	1,000

Source: Table HIC-5, Health Insurance Coverage Status and Type of Coverage by State - Children Under 19: 2008 to 2017, Health Insurance Historical Tables, U.S. Census Bureau American Community Survey (ACS). Data is rounded to the nearest 1,000.

\* States with a significant increase in the uninsured rate from 2016 to 2017.

\*\* States with a significant increase in the number of uninsured children from 2016 to 2017.



Appendix Table 4. Health Insurance Coverage of Children Ages 0-18, by Source, 2017

State	Employer	Non-Group	Medicaid	Other Public	Uninsured
United States	49%	5%	39%	2%	5%
Alabama	44%	5%	46%	3%	3%
Alaska	41%	N/A	36%	11%	10%
Arizona	47%	5%	39%	2%	8%
Arkansas	37%	4%	52%	2%	5%
California	46%	6%	43%	2%	3%
Colorado	50%	6%	36%	3%	4%
Connecticut	58%	4%	34%	1%	3%
Delaware	54%	5%	36%	2%	3%
District of Columbia	41%	5%	50%	3%	N/A
Florida	39%	8%	43%	3%	7%
Georgia	47%	5%	38%	3%	7%
Hawaii	51%	4%	33%	10%	3%
Idaho	47%	9%	37%	2%	5%
Illinois	54%	4%	38%	1%	3%
Indiana	54%	4%	35%	1%	6%
Iowa	58%	6%	33%	1%	3%
Kansas	55%	7%	30%	4%	5%
Kentucky	46%	4%	44%	2%	4%
Louisiana	40%	4%	52%	2%	3%
Maine	56%	5%	31%	3%	4%
Maryland	57%	4%	31%	3%	4%
Massachusetts	58%	4%	35%	1%	1%
Michigan	54%	4%	38%	1%	3%
Minnesota	61%	5%	30%	1%	3%
Mississippi	37%	5%	51%	2%	5%
Missouri	53%	7%	33%	2%	5%
Montana	43%	10%	39%	2%	6%
Nebraska	58%	6%	27%	3%	6%
Nevada	51%	5%	35%	2%	7%
New Hampshire	61%	5%	32%	1%	3%
New Jersey	59%	5%	31%	1%	4%
New Mexico	33%	4%	56%	2%	5%
New York	49%	6%	41%	1%	3%
North Carolina	44%	6%	42%	4%	5%
North Dakota	63%	8%	20%	2%	7%
Ohio	54%	4%	37%	1%	4%
Oklahoma	41%	5%	43%	3%	8%
Oregon	49%	7%	40%	1%	3%
Pennsylvania	54%	5%	36%	1%	5%
Rhode Island	54%	4%	38%	1%	2%
South Carolina	45%	5%	42%	3%	5%
South Dakota	55%	8%	30%	2%	6%
Tennessee	47%	5%	41%	3%	4%
Texas	44%	5%	39%	2%	11%
Utah	64%	9%	20%	1%	7%
Vermont	42%	3%	54%	N/A	N/A
Virginia	55%	6%	27%	8%	5%
Washington	51%	5%	38%	3%	3%
West Virginia	45%	3%	48%	1%	3%
Wisconsin	61%	4%	31%	1%	4%
Wyoming	56%	6%	25%	3%	10%

Source: Kaiser Family Foundation estimates based on the Census Bureau's American Community Survey, 2009-2018.

Notes: The majority of our health coverage topics are based on analysis of the Census Bureau's American Community Survey (ACS) by the Kaiser Family Foundation. ACS includes a 1 percent sample of the US population and allows for precise state-level estimates. Please note that in the past, health coverage data posted to this site had used the Current Population Survey. We have replaced all previously-posted data, including data for previous years, with data based on ACS. The ACS asks respondents about their health insurance coverage at the time of the survey. Respondents may report having more than one type of coverage; however, individuals are sorted into only one category of insurance coverage. A person reporting having Medicaid coverage and another type of coverage would be categorized as having Medicaid coverage in this analysis.

Data may not sum to totals due to rounding.





## Endnotes

<sup>1</sup> Georgetown University Center for Children and Families Analysis of Centers for Medicare and Medicaid Services, “State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data” (Washington: U.S. Department of Health and Human Services, 2019), available at <https://data.medicaid.gov/Enrollment/State-Medicaid-and-CHIP-Applications-Eligibility-D/n5ce-jxme/data>. Note, this estimate does not include Arizona, the District of Columbia, and Tennessee, states that do not report a breakdown of children in their submission of enrollment data; Arizona Health Care Cost Containment System, “AHCCCS Population Demographics” (Phoenix: Arizona Health Care Cost Containment System, January 2019), available at <https://www.azahcccs.gov/Resources/Downloads/PopulationStatistics/2019/Jan/AHCCCS-Demographics.pdf>; District of Columbia Department of Health Care Finance, “Monthly Enrollment Report – March 2019” (Washington: District of Columbia Department of Health Care Finance, March 2019), available at [https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Enrollment%20Report\\_Mar%202019.pdf](https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Enrollment%20Report_Mar%202019.pdf); Tennessee Division of TennCare, “TennCare Enrollment Report for January 2019” (Nashville: Tennessee Division of TennCare, January 2019), available at [https://www.tn.gov/content/dam/tn/tenncare/documents2/fte\\_201901.pdf](https://www.tn.gov/content/dam/tn/tenncare/documents2/fte_201901.pdf), and Tennessee Division of TennCare, “CoverKids Monthly Enrollment Report for January 2019” (Nashville: Tennessee Division of TennCare, January 2019), available at <https://www.tn.gov/content/dam/tn/coverkids/documents/Enrollment0119.pdf>.

<sup>2</sup> CMS enrollment data is subject to retroactive changes. Previous blogs posted by Georgetown CCF have reflected different estimates at different times due to retroactive changes.

<sup>3</sup> Enrollment trends for 2000 – 2013 were based on Medicaid and CHIP Payment and Access Commission (MACPAC) MacStats, “Exhibit 7: Medicaid Beneficiaries (Persons Served) by Eligibility Group” (Washington: Medicaid and CHIP Payment and Access Commission, 2013), which examined data extracted from the Medicaid Statistical Information System, available at <https://www.macpac.gov/publication/medicaid-beneficiaries-persons-served-by-eligibility-group/>. Enrollment data after 2013 has not been reported by MACPAC. To examine the enrollment trends for 2013 – 2017, Georgetown University Center for Children and Families analysis of Centers for Medicare and Medicaid Services, op. cit. These data only reflect states that reported data to CMS at the beginning and end of the period examined. Enrollment changes in 2014 reflects difference between enrollment in January 2014 and December 2014 reported by 36 states, as December 2013 was not reported. The change in 2015, 2016, 2017 and 2018 compares enrollment in December year to year. In 2015, data for 46 states is included. In 2016 and 2017, data is reported for 48 states. 2018 data reflects enrollment from all 51 states, including state level data for Arizona, the District of Columbia, and Tennessee.

<sup>4</sup> J. Alker and O. Pham, “Nation’s Progress on Children’s Health Coverage Reverses Course” (Washington: Georgetown University Center for Children and Families, November 2018), available at <https://ccf.georgetown.edu/2018/11/21/nations-progress-on-childrens-health-coverage-reverses-course/>.

<sup>5</sup> M. Rae et al., “Long-Term Trends in Employer-Based Coverage” (Washington: Kaiser Family Foundation, January 30, 2019), available at <https://www.healthsystemtracker.org/brief/long-term-trends-in-employer-based-coverage/>.

<sup>6</sup> Georgetown CCF analysis of 2017 American Community Survey (ACS) data. Of note, researchers broadly acknowledge that surveys, including the ACS, result in an undercount of Medicaid. Thus, this estimate of 65 percent calculated from the ACS FactFinder Table B27016 is likely higher.

<sup>7</sup> Georgetown Center for Children and Families Analysis of Centers for Medicare and Medicaid Services, op. cit.

<sup>8</sup> J. Alker, op. cit.

<sup>9</sup> Medicaid/CHIP participation rates are calculated 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 do not have a known eligibility pathway.

<sup>10</sup> J. Haley and J. Kenney, “Improvements in Uninsurance and Medicaid/CHIP Participation Among Children and Parents Stalled in 2017” (Washington: Urban Institute, May 2019), available at <https://www.urban.org/research/publication/improvements-uninsurance-and-medicaidchip-participation-among-children-and-parents-stalled-2017>.

<sup>11</sup> Kaiser Family Foundation estimates based on the Census Bureau’s American Community Survey, see Kaiser Family Foundation “Health Insurance Coverage of Children 0-18” (Washington: Kaiser Family Foundation, 2017), available at <https://www.kff.org/other/state-indicator/children-0-18/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>.

<sup>12</sup> Georgetown CCF analysis of 2017 American Community Survey (ACS) data, op. cit.

<sup>13</sup> R. Rudowitz, E. Hinton, and L. Antonisse, “Medicaid Enrollment & Spending Growth: FY 2018 & 2019” (Washington: Kaiser Family Foundation, October 2018), available at <https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2018-2019/>.

<sup>14</sup> Ibid.

<sup>15</sup> Congressional Budget Office, “Medicaid Spending and Enrollment — CBO’s April 2018 Baseline” (Washington: Congressional Budget Office, April 2018), available at <https://www.cbo.gov/system/files?file=2018-06/51301-2018-04-medicaid.pdf> and Congressional Budget Office, “Children’s Health Insurance Program Spending and Enrollment — CBO’s April 2018 Baseline” (Washington: Congressional Budget Office, April 2018), available at <https://www.cbo.gov/system/files?file=2018-06/51296-2018-04-chip.pdf>.

<sup>16</sup> Office of the Actuary, Centers for Medicare and Medicaid Services, “2017 Actuarial Report on the Financial Outlook for Medicaid” (Washington: U.S. Department of Health and Human



Services, September 2018), available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2017.pdf>.

<sup>17</sup> Congressional Budget Office, “Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2019-2029” (Washington: Congressional Budget Office, May 2019), available at <https://www.cbo.gov/publication/55085>.

<sup>18</sup> Congressional Budget Office, “Medicaid — CBO’s May 2019 Baseline” (Washington: Congressional Budget Office, May 2019), available at <https://www.cbo.gov/system/files?file=2019-05/51301-2019-05-medicaid.pdf>.

<sup>19</sup> Georgetown University Center for Children and Families analysis of Bureau of Labor Statistics seasonally adjusted unemployment rate data. Bureau of Labor and Statistics, “Labor Force Statistics from the Current Population Survey” (Washington: U.S. Department of Labor, May 2019), available at <https://data.bls.gov/timeseries/LNS14000000>.

<sup>20</sup> Georgetown University Center for Children and Families analysis of Bureau of Labor Statistics seasonally adjusted non-farm employment data, see Bureau of Labor and Statistics, “Labor Force Statistics from the Current Population Survey” (Washington: U.S. Department of Labor, May 2019), available at <https://data.bls.gov/timeseries/LNS14000000>.

<sup>21</sup> Parent unemployment dropped by 4.6 percentage points from 7.7 percent in 2009 to 3.1 percent in 2018, compared to a 5.8 percentage point drop for workers without minor children from 10.1 percent in 2009 to 4.3 percent in 2018, see Bureau of Labor Statistics, “Women in the Labor Force: A Databook (2010 Edition)” (Washington: U.S. Department of Labor, 2009), available at <https://www.bls.gov/cps/wlftable5-2010.htm> and Bureau of Labor Statistics, “Economic News Release: Table 5” (Washington: U.S. Department of Labor, April 2019), available at <https://www.bls.gov/news.release/fameet05.htm>.

<sup>22</sup> Georgetown University Center for Children and Families analysis of Bureau of Labor Statistics seasonally adjusted non-farm employment data and Center on Budget and Policy Priorities, “Chart Book: The Legacy of the Great Recession” (Washington: Center on Budget and Policy Priorities, updated April 26, 2019), available at <https://www.cbpp.org/research/economy/chart-book-the-legacy-of-the-great-recession>.

<sup>23</sup> Center on Budget and Policy Priorities, op cit.

<sup>24</sup> Georgetown University Center for Children and Families analysis of Bureau of Labor Statistics “Data Retrieval: Labor Force Statistics (CPS)” (Washington: U.S. Department of Labor, September 2015), available at <https://www.bls.gov/webapps/legacy/cpswktab5.htm>.

<sup>25</sup> Kaiser Family Foundation, “Employer Health Benefits: 2018 Annual Survey” (Washington: Kaiser Family Foundation, October 2018), available at <http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018>.

<sup>26</sup> Ibid.

<sup>27</sup> Ibid.

<sup>28</sup> Matthew Rae et al., op. cit.

<sup>29</sup> Ibid.

<sup>30</sup> National Center for Health Statistics, Centers for Disease Control and Prevention, “Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2018” (Washington: U.S. Department of Health and Human Services, May, 2019), available at <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201905.pdf>.

<sup>31</sup> Kaiser Family Foundation, “Employer Health Benefits: 2018 Annual Survey,” op cit.

<sup>32</sup> Georgetown University Center for Children and Families analysis of Centers for Medicare and Medicaid Services Marketplace Open Enrollment Period Public Use Files for 2017, 2018 and 2019, available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/index.html>. Enrollment in 64,257 from 1,068,082 in 2017 to 1,003,825 in 2018, with a reduction of another 21,052 between 2018 and 2019.

<sup>33</sup> Congressional Budget Office, “Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018,” op. cit.

<sup>34</sup> Excerpts of Testimony on CHIP Reauthorization for MACPAC by Tricia Brooks, November 15, 2013, available at <https://ccf.georgetown.edu/2013/11/22/macpac-testimony/>.

<sup>35</sup> See Congressional Budget Office, “Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018,” op. cit. and C. Eibner and S. Nowak, “The Effect of Eliminating the Individual Mandate Penalty and the Role of Behavioral Factors,” (Washington: The RAND Corporation, July 2018), available at <https://www.commonwealthfund.org/publications/fund-reports/2018/jul/eliminating-individual-mandate-penalty-behavioral-factors>.

<sup>36</sup> K. Whitener, “Outreach and Enrollment Grants to Miss Critical Back-to-School Period Due to CHIP Funding Delay” (Washington: Georgetown University Center for Children and Families, May 2018), available at <https://ccf.georgetown.edu/2018/05/14/outreach-and-enrollment-grants-to-miss-critical-back-to-school-period-due-to-chip-funding-delay/>.

<sup>37</sup> S. Gollust et al., “Health Insurance Television Advertising Content and the Fifth Open Enrollment Period for the Affordable Care Act Marketplaces” (Washington: Health Affairs, November 2018), available at <https://www.healthaffairs.org/doi/10.1377/hblog20181107.968519/full/>.

<sup>38</sup> K. Pollitz et al., “Data Note: Further Reductions in Navigator Funding for Federal Marketplace States” (Washington: Kaiser Family Foundation, September 2018), available at <https://www.kff.org/health-reform/issue-brief/data-note-further-reductions-in-navigator-funding-for-federal-marketplace-states/>.

<sup>39</sup> K. Whitener op. cit.

<sup>40</sup> Applications for the latest round of outreach grants were due on January 28, 2019 with an anticipated award date of June 2019. For more information, see <https://www.insurekidsnow.gov/campaign/funding-opportunity/index.html>



<sup>41</sup> J. Zong, J. Batalova, and M. Burrows, “Frequently Requested Statistics on Immigrants and Immigration in the United States” (Washington: Migration Policy Institute, March 2019), available at <https://www.migrationpolicy.org/article/frequently-requested-statistics-immigrants-and-immigration-united-states#Children>.

<sup>42</sup> Center for Law and Social Policy, “Our Children’s Fear: Immigration Policy’s Effects on Young Children” (Washington: Center for Law and Social Policy, March 2018), available at <https://www.clasp.org/publications/report/brief/our-childrens-fear-immigration-policys-effects-young-children>.

<sup>43</sup> K. Whitener, “Hundreds of Thousands Weigh in on Proposed Public Charge Rule” (Washington: Georgetown University Center for Children and Families, December 2018), available at <https://ccf.georgetown.edu/2018/12/12/hundreds-of-thousands-weigh-in-on-proposed-public-charge-rule/>.

<sup>44</sup> Public charge is a term used in U.S. immigration law to refer to a person who is likely to become dependent on the government for financial and material support. An immigrant who is deemed likely to become a public charge may be denied admission to the U.S. or unable to adjust their status to become a lawful permanent resident. If finalized, the rule would make it far more difficult to immigrate to the U.S. or obtain a green card by, among other changes, expanding the list of public benefits considered to include Medicaid. For more information see K. Whitener, “How Proposed Changes to Public Charge would Impact Children in Immigrant Communities” (Washington: Georgetown University Center for Children and Families, November 2018), available at <https://ccf.georgetown.edu/2018/11/09/how-proposed-changes-to-public-charge-would-impact-children-in-immigrant-communities/>.

<sup>45</sup> M.A. Murray, “Comment Submitted by Margaret A. Murray, Association for Community Affiliated Plans,” Regulations.gov (February 5, 2019), available at <https://www.regulations.gov/document?D=USCIS-2010-0012-48337>.

<sup>46</sup> The Children’s Partnership, “California Children in Immigrant Families: The Health Provider Perspective” (Los Angeles: The Children’s Partnership, March 2018), available at <https://www.childrenspartnership.org/wp-content/uploads/2018/03/Provider-Survey-Infographic-.pdf>.

<sup>47</sup> H. Bernstein, D. Gonzalez, M. Karpman and S. Zuckerman, “One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs in 2018,” Urban Institute, Brief (May 22, 2019), available at <https://www.urban.org/research/publication/one-seven-adults-immigrant-families-reported-avoiding-public-benefit-programs-2018>.

<sup>48</sup> R. Rudowitz, op cit.

<sup>49</sup> T. Brooks, “Open Enrollment, Take Two” (Washington: Health Affairs, June 2014), available at <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.0415>.

<sup>50</sup> Centers for Medicare and Medicaid Services, “Medicaid MAGI and CHIP Application Processing Time Report” (Washington: U.S. Department of Health and Human Services, November 2018), available at <https://www.medicaid.gov/state-overviews/downloads/magi-and-chip-application-processing-time/magi-application-time-report.pdf>.

<sup>51</sup> T. Brooks et al., “2019 Medicaid and CHIP Eligibility, Enrollment, Renewal and Cost-Sharing Policies: Findings from a 50-State Survey” (Washington: Kaiser Family Foundation, January 2019), available at [https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2019-findings-from-a-50-state-survey/?utm\\_campaign=KFF-2019-March-Medicaid-CHIP-Eligibility-50-State-Survey&utm\\_source=hs\\_email&utm\\_medium=email&utm\\_content=2&hsenc=p2ANqtz-QHsGYK7if-cUzWeYcUqsjkG9Ulp4PPXr6n1UXg3ExrbyKKnMozFEB7B2vGrcyc6LoUKrci3PCx1CXuAXM8nnRb1J35Kg&hsmi=2](https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2019-findings-from-a-50-state-survey/?utm_campaign=KFF-2019-March-Medicaid-CHIP-Eligibility-50-State-Survey&utm_source=hs_email&utm_medium=email&utm_content=2&hsenc=p2ANqtz-QHsGYK7if-cUzWeYcUqsjkG9Ulp4PPXr6n1UXg3ExrbyKKnMozFEB7B2vGrcyc6LoUKrci3PCx1CXuAXM8nnRb1J35Kg&hsmi=2).

<sup>52</sup> Ibid.

<sup>53</sup> 42 U.S.C. §1137 (2011), see [https://www.ssa.gov/OP\\_Home/ssact/title11/1137.htm](https://www.ssa.gov/OP_Home/ssact/title11/1137.htm).

<sup>54</sup> 42 CFR § 435.948 (2012), see [https://www.ecfr.gov/cgi-bin/text-id.x?SID=38658832c69bd114665214a8cc8ad6c1&mc=true&node=se42.4.435\\_1948&rgn=div8](https://www.ecfr.gov/cgi-bin/text-id.x?SID=38658832c69bd114665214a8cc8ad6c1&mc=true&node=se42.4.435_1948&rgn=div8).

<sup>55</sup> Southern Institute on Children and Families, “Medicaid and CHIP Retention: A Key Strategy to Reducing the Uninsured” (Newnan, GA: Southern Institute on Children and Families, May 2009).

<sup>56</sup> B. Sommers, “Why Millions of Children Eligible for Medicaid and SCHIP Are Uninsured: Poor Retention Versus Poor Take-Up” (Washington: Health Affairs, July 2007), available at <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.26.5.w560>.

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<sup>58</sup> R. Phinney, “Exploring Residential Mobility among Low Income Families” (Chicago: The University of Chicago Press, December 2013), available at [https://www.jstor.org/stable/10.1086/673963?seq=1#page\\_scan\\_tab\\_contents](https://www.jstor.org/stable/10.1086/673963?seq=1#page_scan_tab_contents).

<sup>59</sup> Phil Galewitz, “Shrinking Medicaid Rolls in Missouri and Tennessee Raise Flag on Vetting Process,” Kaiser Health News, February 8, 2019, available at <https://khn.org/news/shrinking-medicaid-rolls-in-missouri-and-tennessee-raise-flag-on-vetting-process/>.

<sup>60</sup> Allie Morris, “Texas kicks thousands of low-income children off Medicaid over missing paperwork,” San Antonio Express-News, March 29, 2019, available at <https://www.expressnews.com/news/politics/texas-legislature/article/Texas-kicks-thousands-of-low-income-children-off-13727929.php>.

<sup>61</sup> T. Brooks, “Tech Tuesday: Phase I Medicaid and CHIP Performance Indicators Released (Part I)” (Washington: Georgetown University Center for Children and Families, September 2013) available at <https://ccf.georgetown.edu/2013/09/17/tech-tuesday-phase-i-medicaid-and-chip-performance-indicators-released-part-i/>.





<sup>62</sup> M. Harrington, C. Trenholm, and A. Snyder, “New Denial and Disenrollment Coding Strategies to Drive State Enrollment Performance” (Washington: National Academy of State Health Policy, October 2012), available at [https://nashp.org/wp-content/uploads/sites/default/files/new.denial.disenrollment.coding.strategies\\_0.pdf](https://nashp.org/wp-content/uploads/sites/default/files/new.denial.disenrollment.coding.strategies_0.pdf).

<sup>63</sup> T. Brooks, “The Louisiana Experience: Successful Steps to Improve Retention in Medicaid and SCHIP” (Washington: Georgetown University Center for Children and Families, February 2009), available at <https://ccf.georgetown.edu/2009/02/26/louisiana-experience-successful-steps-improve-retention-medicaid-schip/>.

<sup>64</sup> T. Brooks et al., op. cit. In Texas, children enrolled in the state’s separate CHIP with income up to 185 percent FPL receive 12 months continuous eligibility (the eligibility upper limit is 206 percent FPL). Those with income between 185 and 206 percent FPL are subject to only one review at six months of enrollment.

<sup>65</sup> K. Swartz et al., “Evaluating State Options for Reducing Medicaid Churning” (Washington: Health Affairs, July 2015), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4664196/>.

<sup>66</sup> V. Anderson et al., “Addressing Income Volatility of Low Income Populations” (Madison: University of Wisconsin-Madison, Spring 2015), available at <https://www.lafollette.wisc.edu/images/publications/workshops/2015-income.pdf>.

<sup>67</sup> J. Smith-Ramani et al. “Income Volatility: Why It Destabilizes Working Families and How Philanthropy Can Make a Difference” (Washington: The Aspen Institute, December 2017), available at <https://www.aspeninstitute.org/publications/income-volatility-destabilizes-families-philanthropy-can-make-difference/>.

<sup>68</sup> A. Hannagan and J. Morduch, “Income Gains and Month-to-Month Income Volatility: Household Evidence from the U.S. Financial Diaries” (New York: Financial Access Initiative, Wagner School of Public Service, New York University and Center for Financial Services Innovation, March 2015), available at <http://www.usfinancialdiaries.org/paper-1/>.

<sup>69</sup> Board of Governors of the Federal Reserve System, “Report on the Economic Well-Being of U.S. Households” (Washington: Board of Governors of the Federal Reserve System, July 2014), available at <https://www.federalreserve.gov/econresdata/2013-report-economic-well-being-us-households-201407.pdf>.

<sup>70</sup> 42 CFR § 435.952(c) (2012), see <https://www.law.cornell.edu/cfr/text/42/435.952>.

<sup>71</sup> T. Brooks et al., “Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-Sharing Policies as of January 2016: Findings from a 50-State Survey” (Washington: Kaiser Family Foundation and Georgetown University Center for Children and Families, January 2016), available at <http://files.kff.org/attachment/report-medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2016-findings-from-a-50-state-survey>.

<sup>72</sup> Galewitz, op. cit.

<sup>73</sup> Texas has 12-month continuous eligibility in CHIP, except for families with incomes above 185 percent FPL, see T. Brooks, et. al, “2019 Medicaid and CHIP Eligibility, Enrollment, Renewal and Cost-Sharing Policies,” op. cit.

<sup>74</sup> Ibid.

<sup>75</sup> L. Ku, E. Steinmetz, and B. Bruen, “Continuous Eligibility Policies Stabilize Medicaid Coverage for Children and Could Be Extended to Adults with Similar Results” (Washington: Health Affairs, September 2013), available at <https://www.healthaffairs.org/doi/10.1377/hlthaff.2013.0362>.

<sup>76</sup> T. Brooks, “Improving the Health of Connecticut’s Children” (Hartford, CT: Connecticut Health Foundation, January 2019), available at <https://www.cthealth.org/wp-content/uploads/2018/12/CHF-Medicaid-CCF-Brief-3-web.pdf?cldee=bXBpbG9uQGHhcRmb3JkYnVzaW5lc3MuY29t&recipientid=contact-fcac9116010fe7118114e0071b6a3101-3dba05a45af94f99b4bef8b85717005b&esid=8a04b752-140a-e911-a96e-000d3a199997>.

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Georgetown University  
Center for Children and Families  
McCourt School of Public Policy  
Box 571444  
3300 Whitehaven Street, NW, Suite 5000  
Washington, DC 20057-1485  
Phone: (202) 687-0880  
Email: [childhealth@georgetown.edu](mailto:childhealth@georgetown.edu)



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