Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

# Millions of Children May Lose Medicaid: What Can Be Done to Help Prevent Them from Becoming Uninsured?

*by Joan Alker and Tricia Brooks*

## Key Findings

- ***About half of children in the United States (40 million) are now insured through Medicaid or the Children's Health Insurance Program (CHIP)—the vast majority in Medicaid.*** These children have had stability in their Medicaid coverage during the COVID-19 public health emergency due to a continuous coverage requirement, but this protection is likely to expire sometime in 2022—perhaps as soon as April. States will have to recheck eligibility for everyone enrolled in Medicaid including children. During this unprecedented event, ***we estimate that at least 6.7 million children are likely to lose their Medicaid coverage and are at considerable risk for becoming uninsured for some period of time***. For reference, in 2019 (the last year for which data is available), 4.4 million children were uninsured according to the Census Bureau.
- ***When this mass eligibility redetermination happens, the outcomes will vary enormously for children depending on where they live and how well their states handle the transition.*** State Medicaid and CHIP policy choices matter, as will states' administrative capacity and desire to get this right. ***Children in all states are at risk of losing their health insurance but those living in Delaware, Florida, Georgia, Missouri, Nevada, and Texas are especially at risk***.
- Children could lose coverage in one of two ways: become eligible for other coverage (more than half for CHIP) and get lost in transition; or they could remain eligible for Medicaid but lose their coverage due to procedural reasons. ***It is critical that state and federal policymakers act to minimize coverage losses, make data available to the public, and intervene quickly if children begin to lose coverage and end up uninsured.***

## Introduction

As of June 2021, over 40 million children were enrolled in Medicaid or CHIP for their health insurance—the vast majority in Medicaid.[1] From the month prior to the pandemic in February 2020, through June 2021, children's enrollment increased by 11 percent.[2] Now, *about half of the nation's children are covered by Medicaid or CHIP*.[3] The growth in Medicaid enrollment is the result of income and job losses during the pandemic and an impactful federal provision enacted in 2020 that requires states to keep children and adults continuously covered by Medicaid during the COVID-related public health emergency. (See Appendix A for state enrollment data.)

It is very likely that the continuous coverage requirement will be lifted in 2022, perhaps as early as April.[4] At that time, states will need to restart renewals for everyone in their Medicaid program if they have not been able to verify their eligibility using data already available to the state. Prior survey data shows that in many states, less than half of renewals are completed through automated or administrative processes.[5] This means that most states will have large numbers of people whose ongoing eligibility will need to be verified, and whose enrollment can be terminated starting as early as May 1st.

There are many reasons to be concerned about how this process will unfold. This brief explores how many children will be impacted, what policies can minimize disruption to children's coverage, and identifies states where children are at greater risk of losing their coverage.

Parents and millions of other adults will also have their Medicaid eligibility redetermined when the continuous coverage requirement lifts. Many adults whose income has gone up will become eligible for subsidized coverage through the federal and state marketplaces. Children will suffer if their parents and caregivers lose coverage during this transition. It is clear from past state experience that many parents will not successfully make the transition. In 2015, Connecticut began to rollback eligibility for parents on Medicaid who would become eligible for subsidized Marketplace coverage—only 27 percent of parents successfully enrolled in a qualified health plan that year.[6]

Unlike their parents, children whose families' income has increased modestly are more likely to be eligible for the Children's Health Insurance Program (CHIP). State and federal systems are likely to be overwhelmed by this mass event—especially as many states are understaffed. While attention has been paid to the transition paths for adults, there has been little discussion about children's transitions and the risks they face.

# Background

During the COVID-19 pandemic, Congress has enacted a number of relief bills to address the public health and economic crisis the nation has faced. One of the first such bills, the Families First Coronavirus Response Act (FFCRA), included enhanced federal funding for the Medicaid program. To qualify for the extra 6.2 percentage points in the federal Medicaid match rate, states are required to meet specific maintenance of effort provisions. Prior recessions saw Congress enact similar provisions when economic challenges arose. But in recognition of the importance of Medicaid in addressing the twin public health and economic crises the country was facing, a new protection was also included to ensure that large numbers of children, parents and other adults did not lose their health insurance during this crisis. This provision is referred to in different ways—most commonly as the Medicaid continuous coverage requirement or Medicaid disenrollment freeze.

The continuous coverage requirement ensures that states cannot involuntarily disenroll anyone from Medicaid who was enrolled on or after March 18, 2020 through the duration of the public health emergency regardless of changes in income or age, or nonpayment of premiums (only four states charge premiums to children in Medicaid). Most importantly, states also cannot disenroll someone for "procedural" reasons—i.e., when a family is required to submit income data and is unable to respond to the state's request in a timely fashion. Even "returned mail" can and does lead to a child losing their health insurance coverage in "normal" times.[7] Prior to the pandemic, children from low-wage working families, particularly those in families of color, often experienced periods of uninsurance in part due to administrative churn.[8] Any gap in coverage is problematic for children and families as they are exposed to large medical bills in the event of a child becoming sick or breaking a bone. Uninsured children are also less likely to receive needed primary and preventive care for conditions such as asthma that can worsen and land a child in the emergency room.

There is clear evidence that *the Medicaid continuous coverage requirement has been an extremely important policy tool to avoid increases in the number of uninsured people during the pandemic*. The number of uninsured generally rises during economic downturns as people lose their jobs and health insurance, but with the pandemic, some predicted there would be historic large-scale increases in the number of uninsured people.[9] Early national data suggest that the uninsured rate may not have increased much during the pandemic despite the many disruptions.[10]

Given the considerable housing instability for low-income families, and changes in employment patterns and child care due to the pandemic, there has likely been a great deal of movement and changes for these families over the past two years.[11] Many of these families are likely to have outdated addresses and information in the Medicaid eligibility systems.

## How many children may lose coverage?

We estimate that 37.3 million children are currently protected by the Medicaid continuous coverage requirement. This includes children in Medicaid, as well as children whose coverage is provided through Medicaid but is financed by CHIP (known as M-CHIP programs). Prior to the pandemic, the Medicaid and CHIP Payment and Access Commission (MACPAC) estimated that 18 percent of non-disabled children covered by Medicaid were disenrolled in 2018.[12] Disenrollment due to administrative barriers or fluctuations in family income are the top reasons children lose Medicaid. Forty-four percent of these children were re-enrolled within a year suggesting that many of these children remained eligible and were likely uninsured in the interim.[13] Children who go through an annual regular renewal process may also lose coverage for procedural reasons and become uninsured.

There are many reasons that the Medicaid disenrollment rate for children in the upcoming and unprecedented mass eligibility redetermination event will be considerably higher due to more income volatility during the pandemic and the sheer volume of work states face in resuming routine operations amidst workforce challenges and the fiscal incentives to remove children quickly when the enhanced match expires. However, applying this prior MACPAC rate to the estimated number of children protected by the Medicaid disenrollment freeze, we project that 6.7 million children will likely lose Medicaid coverage when the continuous coverage requirement is lifted. These children are at significant risk of experiencing a gap in coverage. Because of the many factors unique to what lies ahead, this estimate should be considered the lower bound of what is likely to happen. For comparison purposes, in 2019 there were 4.4 million uninsured children according to the Census Bureau's American Community Survey.[14]

*Separate CHIP programs need to prepare to more than double their current enrollments.*

### Utah CHIP Experience Raises Red Flags

An instructive lesson about what lies ahead can be imparted from Utah's CHIP program. In 2020, several states received approval from the Center for Medicare and Medicaid Services (CMS) to impose a disenrollment freeze on its separate CHIP program, in addition to Medicaid. In late 2020, these states, including Utah, were asked by CMS to lift the freeze. In Utah, the state was unable to locate many of the families, and 41 percent of children enrolled in CHIP dropped off.[15] It is not known how many of these children found other insurance or became uninsured.

## The Role of CHIP

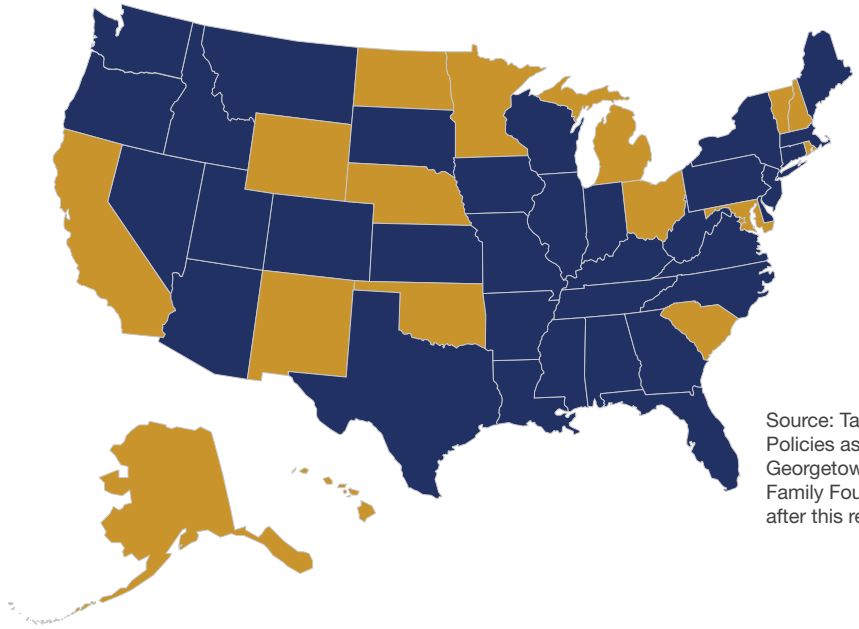
States administer their CHIP programs differently—states may choose to extend Medicaid coverage under CHIP or establish a "separate" state program. All children enrolled in Medicaid (regardless of whether they are funded through Medicaid or CHIP) have been protected by the disenrollment freeze. However, this is not the case for children enrolled in separate CHIP programs, who constitute just over 40 percent of the 6.9 million children enrolled in CHIP.[16] As discussed below, two-thirds of states (34) have a separate CHIP program.

All children in Medicaid are at risk of losing coverage for procedural reasons. For those in M-CHIP states, the transition may be smoother if they are successfully redetermined as eligible since these children will retain their Medicaid coverage. However, children in states with separate CHIP programs will be at greater risk when the continuous coverage requirement lifts.

When a family's income rises slightly, a child's eligibility often changes from Medicaid to CHIP. Researchers at the Urban Institute project that approximately 3.4 million currently enrolled in Medicaid and M-CHIP will become eligible for separate CHIP programs when the freeze lifts.[17] If this is roughly accurate, *separate CHIP programs (with an estimated enrollment of 2.9 million as of June 2021) will have to process enrollment for more than double their current numbers—increasing separate CHIP enrollment to its highest number of children ever*—at a time when many states are understaffed and overwhelmed. How states can prepare for this massive change is discussed below.

# Issues to Consider as Children Transition to Other Sources of Coverage

If the household income of a child enrolled in Medicaid has increased, the child will likely become eligible for CHIP while a minority may be eligible for subsidized federal or state marketplace coverage. Some children may have a parent who has an offer of employer coverage, although affordability may be a barrier. While all children could face difficulties in transitioning to other coverage, transition issues will likely be more challenging in the 34 states with separate CHIP programs compared to the 16 states and D.C., where all CHIP-funded children are enrolled in Medicaid.



## Figure 1.
## Type of CHIP Program by State

- Medicaid expansion only (M-CHIP) (16 states and D.C.)
- Separate CHIP program (S-CHIP) (34 states)

Source: Table 1, "Medicaid and CHIP Eligibility and Enrollment Policies as of January 2021: Findings from a 50-State Survey," Georgetown University Center for Children and Families and Kaiser Family Foundation, March 2021. Wyoming became an M-CHIP state after this report was published.

## Medicaid to Separate CHIP Program

In half of the states with separate CHIP programs, a family of three could have an income gain of up to $23,000 and still be eligible for CHIP. The difference in Medicaid and CHIP upper income limits varies considerably across the 34 states. But, even in South Dakota, the state with the smallest difference in income eligibility between Medicaid and CHIP, the household income of a child enrolled in Medicaid would need to increase by more than $5,000 to be over income for CHIP. Thus, a majority of children who lose Medicaid because their families income has increased are likely to be eligible for CHIP.

**Children with other private health insurance, even those with complex health care needs, are not eligible for CHIP.** A key difference between Medicaid and CHIP coverage is an eligibility requirement in CHIP that a child must be uninsured. Children eligible for Medicaid are allowed to have other coverage, such as employer-sponsored insurance, with Medicaid acting as a secondary payor for additional "wraparound" services that the child's primary insurance does not cover.

**Enrollment is an added step in CHIP.** In most states with separate programs, CHIP eligibility is integrated in the Medicaid eligibility system, so a change in Medicaid eligibility should automatically trigger CHIP eligibility. However, additional steps may be needed before a child can be enrolled. For example, in Florida, eligibility information has to be transferred from Medicaid to the Florida Healthy Kids Corporation, a separate agency which administers CHIP. Additionally, families must choose a managed care plan (or be auto-assigned) before coverage starts in almost all separate CHIP programs. As a consequence, children living in states with a separate state CHIP program face more complexity in navigating the path to a newly financed coverage source.

**Premiums can be a barrier.** The most significant barrier to CHIP enrollment is upfront payment of premiums or an annual enrollment fee, which are prohibited in Medicaid for children with family income below 150 percent federal poverty line (FPL) (about $34,500 for a family of three). States are not required to charge premiums for CHIP but many do. Of the 34 states with separate CHIP programs, 22 states charge monthly or quarterly premiums and 4 states require annual enrollment fees. In eight separate CHIP programs, premiums and enrollment fees are family-based, while 14 states set a maximum amount that families pay—often two or three times the per-child premium.[18] Of note, 10 states with separate CHIP programs (AZ, CA, GA, IA, KS, LA, ME, NC, NJ, PA) have waived CHIP premiums in response to the COVID public health emergency.[19] Iowa received approval to suspend CHIP premiums for up to 90 days after the end of the PHE.[20] States could limit the number of children losing coverage by lifting premiums and annual enrollment fees during this transition period—or permanently—especially for children whose families have income below twice the poverty level.

**Once enrolled, premiums must be paid within grace periods to avoid loss of coverage and potential lockout.** Premiums are a barrier to enrollment in and of themselves, but some states also lock kids out of coverage if premiums are not paid within the state's grace period, which can be as short as 30 days. Two-thirds of states with premiums (14 of 22 states) have lockout periods, most of which are 90 days.[21] A child who is disenrolled for nonpayment is not allowed to re-enroll in CHIP until the end of the lockout period, forcing a gap in coverage.

## Medicaid to Marketplace

In the 16 M-CHIP states and D.C., children whose household income is above the combined Medicaid/CHIP threshold may be eligible for subsidized coverage in the state or federal marketplace. This is also the case for children in separate CHIP programs whose household income exceeds the upper CHIP limit.

**The family glitch is still a problem.** Some families will be barred from receiving financial assistance to purchase a marketplace plan as a result of the family glitch. This is a well-known technical problem in how marketplace subsidies work.[22] Dependents, including a worker's spouse and children, are not eligible for financial assistance if the worker has access to individual coverage through an employer that costs less than 9.61 percent of income and the employer that offers family coverage—regardless of the cost of family coverage, which is generally much higher. [23]

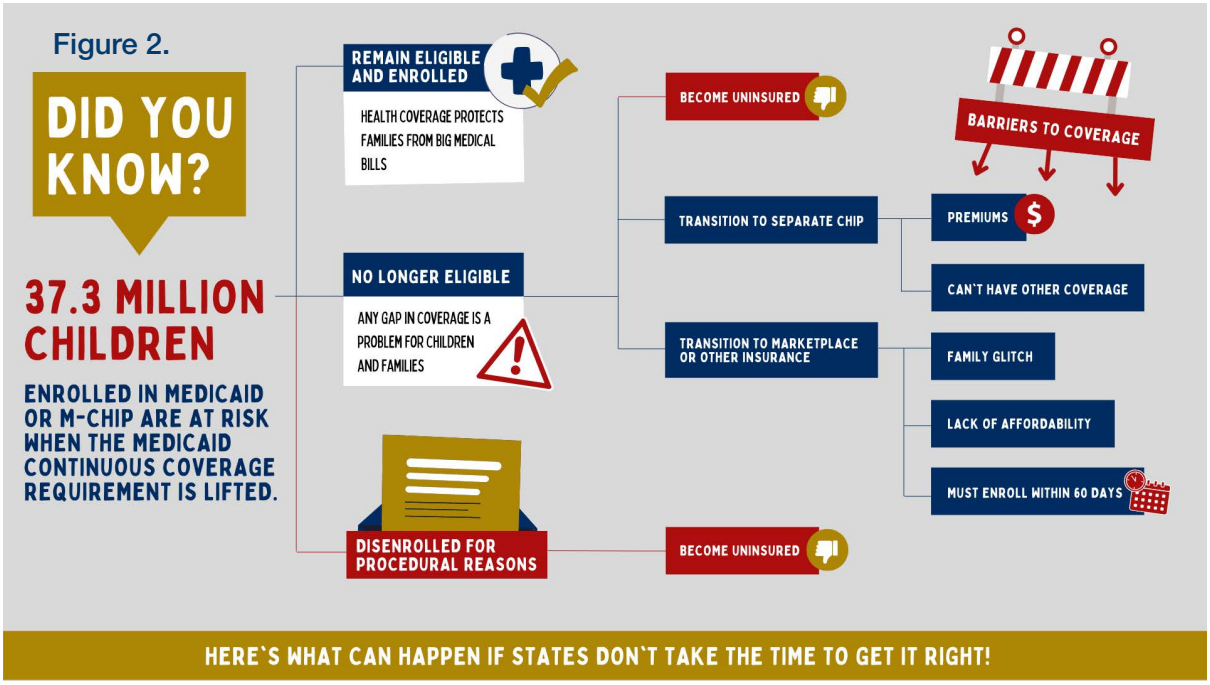
**Coverage may not be affordable.** The median upper income eligibility level for children in Medicaid/CHIP nationwide is 255 percent of the federal poverty line, above the income at which families qualify for reduced cost sharing in the marketplace.[24] At that income level, the family would be expected to pay at least 4 percent and up to 8.5 percent of total income in premiums in 2022, which may be unaffordable. However, those percentages reflect a temporary change, as the American Rescue Plan Act increased the marketplace subsidies; expected family contributions could revert to between 8 and 9.5 percent of income for families earning more than 250 percent FPL if the temporary subsidy improvements are not extended beyond 2022.[25]

**Time allowed to enroll in a marketplace plan may be limited to 60 days following loss of other coverage.** Families with parents who are already enrolled in marketplace plans may find it relatively straightforward to add their child. Families without any members currently enrolled in marketplace plans may find the application and plan selection process challenging. And consumer assistance resources may be stretched thin as millions of adults transition from Medicaid to the marketplace. In either situation, families will need to act quickly. Outside the annual open enrollment period, individuals must enroll within 60 days after the loss of other coverage unless their income is less than 150 percent FPL, which will not apply to children losing Medicaid or CHIP.

## Medicaid to Other Insurance Sources

The Urban Institute estimates that as many as one-third of children expected to lose Medicaid may have a parent with an offer of employer coverage. However, even if an employer offers coverage to dependents of employees, they may pass on a larger share of the added cost to the family, making it unaffordable. High cost-sharing and limits on benefits could make it harder for families to access all of the services they need. Similar to the marketplace, short enrollment windows outside of open enrollment can be another transition barrier.

Figure 2.




# What about the majority of kids who will remain eligible for Medicaid? What can be done to protect their coverage?

Recent estimates suggest that almost half of children who lose Medicaid or CHIP re-enroll within twelve months.[26] While fluctuating income can result in temporary ineligibility, a significant share of gaps in enrollment are for procedural reasons where children remain eligible but lose coverage. Some families never receive the one and only notice the state sends or are confused about what, if anything, they need to do to retain coverage. These challenges are undoubtedly worse in families for whom English is not the parent's primary language and who are less able to access culturally and linguistically competent consumer assistance—worsening existing health disparities.[27] The gaps in coverage created by churn and administrative barriers inhibit preventive care; disrupt management of chronic conditions; expose families to large medical bills; impact the financial stability of providers serving large numbers of Medicaid enrollees; increase administrative costs for states and health plans; and undermine efforts to measure the quality of care.

Taking steps to minimize procedural disenrollments, outlined in Figure 3, should be a TOP priority for state and federal policymakers. Discussion on ways states can be better prepared for this mass event follows.

**Figure 3.**
**Strategies to Reduce Procedural Disenrollments**

- Improve automatic renewal rates
- Boost eligibility and call center workforce capacity
- Increase funding for community-based outreach and application assistance
- Send follow-up notices and reminders when action is required
- Maximize use of communication modes (mail, phone, automated messages, online accounts, text, email)
- Expand the ways enrollees can submit needed information either verbally or electronically to replace the inefficiency of processing paper documentation
- Work with Medicaid managed care organizations (MCOs) and health care providers to update contact information and remind members that their renewal is due
- Ensure that call centers have adequate, trained staff to avoid call wait times that impede families from getting assistance

**Higher rates of success in data-driven renewals mean less catch-up work.** Although states have been required to keep most people continuously enrolled during the PHE, they were expected to continue to process renewals using data sources available to the state, such as quarterly wage data. States that have been more successful in conducting these data-driven renewals (also known as ex parte or administrative renewals) will have a smaller volume of work to be completed when the continuous enrollment requirement is lifted. While states have been encouraged to use the past year to improve their ex parte renewal rates, the impending resumption of all renewals will likely prevent states from implementing additional enhancements to its automated renewal processes or data sources at this time. Thus, children living in states with low rates of ex parte renewals are at greater risk of losing coverage for procedural reasons.

**Workforce capacity dictates how quickly states can complete outstanding work.** Like many employers, state eligibility agencies have experienced challenges in retaining and recruiting eligibility workers. Staff hired in the past two years are not experienced in processing renewals, and even workers with more tenure need refresher training. States can supplement workforce capacity by approving overtime, bringing retirees back, hiring temporary staff, and using contractors to handle certain administrative tasks. But these steps require adequate budgets and authority for agencies to take action.

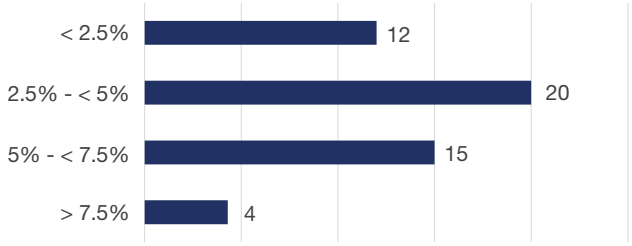
**The timeline should be aligned with workforce capacity and the volume of work.** CMS guidance gives states up to a full year to catch up on pending actions and return to routine operations. However, enhanced federal Medicaid matching funding will end or phase out earlier, putting pressure on current state budgets and prodding some states to move quickly. States should balance the timeline for resuming routine operations with workforce capacity and the volume of work. Otherwise, state eligibility and consumer assistance resources will be overwhelmed, errors will occur, and it will be difficult for families to get the assistance they need to stay enrolled or transition to other sources of coverage.

**Improving Outreach and Communications.** There is still time to boost communications. It is extremely important that families and key stakeholders, including the Medical Care Advisory Committee (MCAC), managed care plans, providers, consumer groups, advocates, tribal entities, and other stakeholders, know what is on the horizon and are engaged in efforts to prepare for what is coming. Moreover, messaging to parents needs to be mindful of the likelihood that many children will be eligible for a different coverage source than their parents.

**Updating contact information.** CMS has provided guidance to states on handling returned mail and working with managed care plans to update contact information. States can also check addresses against the US Postal Service National Change of Address Database. Some states have begun to launch outreach efforts to encourage enrollees to make sure their contact information is up-to-date. Other tactics include working with other benefit programs, like SNAP, and community-based organizations that serve low-income families to get the word out. States should also introduce new low-tech ways for enrollees to report changes, such as a secure online change form or a dedicated line at the state's call center to collect address and other changes.

**Allocating more CHIP outreach funds.** States are required to conduct outreach to families of children likely to be eligible for child health assistance through CHIP or other public or private health coverage programs and assist them in enrolling their children.[28] Outreach costs qualify for the higher CHIP federal match rate in all states (regardless of program type) but total administrative expenses, including outreach, may not exceed 10 percent of total CHIP expenditures. In 2019, only two states reported total administrative expenditures close to 10 percent cap.[29] In fact, almost two-thirds of the states (32) reported total CHIP administrative expenditures of under 5 percent, meaning there is adequate funding available to boost outreach and consumer assistance to families who are uninsured or experiencing coverage transitions if states choose to increase their efforts. In addition, the federal government just released a notice of funding availability for $49 million for outreach, enrollment and retention efforts directed at children, families, and pregnant people.[30]

**Figure 4. Count of States by Share of CHIP Administrative Costs**




Source: 2019 Annual CHIP Financial management Reports

# States where children are more at risk

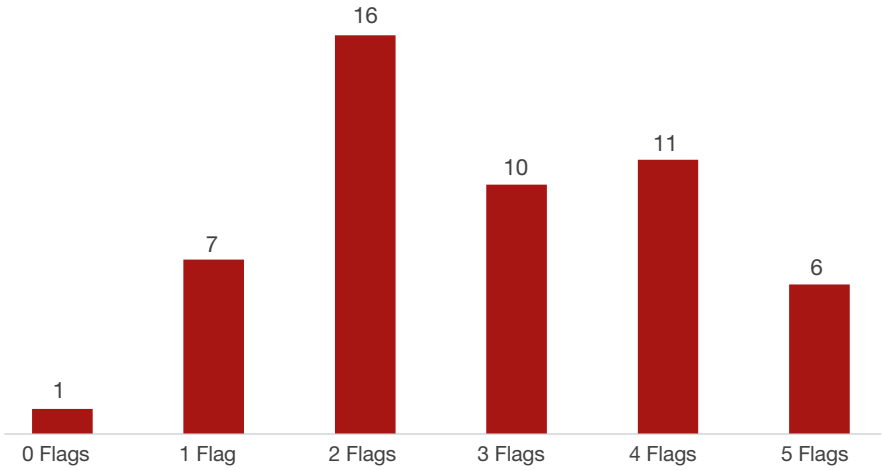
Children in states with certain characteristics of their Medicaid/CHIP programs are at greater risk of losing their coverage (see Table 1). These include states with separate CHIP programs, states that charge premiums for CHIP coverage (especially families with incomes below twice the poverty level), states that do not provide 12 months of continuous coverage for children in Medicaid, and states that process less than half of their renewals using existing data sources. Most states have risk points; *states where children are at the greatest risk with all five factors are Florida, Georgia, Missouri, and Texas*.

Other impactful practices include ensuring that notices are easy-to-understand and sending reminders via multiple modes of communications (mail, phone, text, and email) when action is required to avoid a loss of coverage. Less is known about these procedures on a state-level basis, so we have not included these factors in identifying states where children may face a higher at risk of coverage loss.

However, it's important to note that in states with proven enrollment and retention policies but poor administrative procedures, children will face a higher risk of becoming inappropriately disenrolled. Likewise, in states without these key policies but rise to the daunting administrative challenge when the continuous enrollment requirement is lifted, children would face a lower risk.

For example, Ohio has good enrollment and retention policies but has contracted with a third-party vendor to conduct data searches to identify potential ineligibles that would be prioritized for renewals, and not just those with an increase in income. These kind of data searches can quickly go awry, as evidenced by the recent Missouri experience. Missouri's contract with Lexis-Nexis has flagged people with the same name who live in a different state resulting in the state sending termination notices to Missourians who have not moved and remain at their original address. On the other hand, Massachusetts has not adopted many of the enrollment and retention policies that promote coverage. Yet, the state has consistently had one of the lowest child uninsured rates in the country.

**Figure 5. Count of States by Number of Red Flags**




Source: Table 1; see Methodology for additional details.

## Table 1. Potential Barriers for Children Transitioning from Medicaid to CHIP

| State | State has separate CHIP program | State does not have 12-month continuous eligibility in Medicaid | No ex parte renewals or share under 50% | State charges premiums or annual enrollment fee | Premiums or enrollment fees below 200% FPL | Red Flag Warning |
|---|---|---|---|---|---|---|
| Alabama | ✓ | | ✓ | ✓ | ✓ | 🚩🚩🚩🚩 |
| Alaska | | | ✓ | | | 🚩 |
| Arizona | ✓ | ✓ | | ✓ | ✓ | 🚩🚩🚩🚩 |
| Arkansas | ✓ | ✓ | | | | 🚩🚩 |
| California | | | | ✓ | ✓ | 🚩🚩 |
| Colorado | ✓ | | | ✓ | ✓ | 🚩🚩🚩 |
| Connecticut | ✓ | ✓ | | ✓ | | 🚩🚩🚩 |
| Delaware | ✓ | ✓ | ✓ | ✓ | ✓ | 🚩🚩🚩🚩🚩 |
| District of Columbia | | ✓ | ✓ | | | 🚩🚩 |
| Florida | ✓ | ✓ | ✓ | ✓ | ✓ | 🚩🚩🚩🚩🚩 |
| Georgia | ✓ | ✓ | ✓ | ✓ | ✓ | 🚩🚩🚩🚩🚩 |
| Hawaii | | ✓ | | | | 🚩 |
| Idaho | ✓ | | | ✓ | ✓ | 🚩🚩🚩 |
| Illinois | ✓ | | ✓ | | | 🚩🚩 |
| Indiana | ✓ | ✓ | | ✓ | ✓ | 🚩🚩🚩🚩 |
| Iowa | ✓ | | | ✓ | ✓ | 🚩🚩🚩 |
| Kansas | ✓ | | ✓ | ✓ | ✓ | 🚩🚩🚩🚩 |
| Kentucky | ✓ | ✓ | ✓ | | | 🚩🚩🚩 |
| Louisiana | ✓ | | | ✓ | | 🚩🚩 |
| Maine | ✓ | | ✓ | ✓ | ✓ | 🚩🚩🚩🚩 |
| Maryland | | ✓ | | ✓ | | 🚩🚩 |
| Massachusetts | ✓ | ✓ | | ✓ | ✓ | 🚩🚩🚩🚩 |
| Michigan | | | ✓ | ✓ | ✓ | 🚩🚩🚩 |
| Minnesota | | ✓ | ✓ | | | 🚩🚩 |
| Mississippi | ✓ | | ✓ | | | 🚩🚩 |
| Missouri | ✓ | ✓ | ✓ | ✓ | ✓ | 🚩🚩🚩🚩🚩 |
| Montana | ✓ | | ✓ | | | 🚩🚩 |
| Nebraska | | ✓ | ✓ | | | 🚩🚩 |
| Nevada | ✓ | ✓ | ✓ | ✓ | ✓ | 🚩🚩🚩🚩🚩 |
| New Hampshire | | ✓ | ✓ | | | 🚩🚩 |
| New Jersey | ✓ | | ✓ | | | 🚩🚩 |
| New Mexico | | | ✓ | | | 🚩 |
| New York | ✓ | | ✓ | ✓ | ✓ | 🚩🚩🚩🚩 |
| North Carolina | ✓ | | | ✓ | ✓ | 🚩🚩🚩 |
| North Dakota | | | ✓ | | | 🚩 |
| Ohio | | | | | | |
| Oklahoma | | ✓ | ✓ | | | 🚩🚩 |
| Oregon | ✓ | | | | | 🚩 |
| Pennsylvania | ✓ | ✓ | ✓ | ✓ | | 🚩🚩🚩🚩 |
| Rhode Island | | ✓ | ✓ | | | 🚩🚩 |
| South Carolina | | | ✓ | | | 🚩 |
| South Dakota | ✓ | ✓ | ✓ | | | 🚩🚩🚩 |
| Tennessee | ✓ | ✓ | ✓ | | | 🚩🚩🚩 |
| Texas | ✓ | ✓ | ✓ | ✓ | ✓ | 🚩🚩🚩🚩🚩 |
| Utah | ✓ | ✓ | | ✓ | ✓ | 🚩🚩🚩🚩 |
| Vermont | | ✓ | ✓ | ✓ | ✓ | 🚩🚩🚩🚩 |
| Virginia | ✓ | ✓ | | | | 🚩🚩 |
| Washington | ✓ | | | ✓ | | 🚩🚩 |
| West Virginia | ✓ | | ✓ | ✓ | | 🚩🚩🚩 |
| Wisconsin | ✓ | ✓ | ✓ | ✓ | | 🚩🚩🚩🚩 |
| Wyoming | | | ✓ | | | 🚩 |

Note: In states with proven enrollment and retention policies in place but poor administrative procedures, children will face a higher risk of becoming inappropriately disenrolled than indicated by the chart. Likewise, in states that do not have key policies in place but rise to the daunting administrative challenge when the enrollment requirement is lifted, children would face a lower risk.

Source: Based on a national survey conducted by the Kaiser Family Foundation with Georgetown University Center for Children and Families, 2020 and 2021. See methodology section for more details.

# Conclusion

Half of the nation's children are receiving their health insurance through Medicaid or CHIP today—the vast majority through Medicaid. Since March 2020, state Medicaid programs have been prohibited from involuntarily disenrolling anyone from Medicaid; this prohibition is likely to lift in the near future. States are understaffed and face huge challenges in processing renewals as well as managing transitions to other public coverage sources for such a large number of people. It is possible, even probable, that significant numbers of children and families will lose coverage—in many cases while they are still eligible. These coverage losses will be exacerbated in states that make less effort to avoid them and have policies that create more barriers to enrollment and retention.

The window of opportunity to make procedural or eligibility systems changes is quickly narrowing as states anticipate the lifting of the continuous enrollment requirement as early as April 2022. System changes can take weeks or months to program and test, and states may be restricted from hiring eligibility or call center staff, or taking other steps to expand capacity, until there is a date certain for the lifting of the PHE and/or work begins.

Because the risk of significant coverage loss is so high, it is critical that transparency is built into the process. As of this writing, It is unclear that the public will have access to the information and data needed to assess how the lifting of the disenrollment freeze is impacting low-income children and families. States should voluntarily, or be required by the federal government to, post their plans for resuming routine operations, as well as key performance data needed for monitoring and oversight. In particular, call center statistics can serve as an early warning signal when the system is becoming overloaded. As call volume goes up, so do call wait times and abandonment rates resulting in people not getting the help they need to stay enrolled. States should also increase CHIP funding for outreach and enrollment efforts. Additionally, if a large share of disenrollments occur due to procedural reasons, states should pause and refine the state's plan or boost workforce capacity to make sure that eligible children are not losing coverage inappropriately. Without careful attention, the number of uninsured children in the nation could rise very rapidly.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The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high-quality, affordable health coverage for America's children and families. CCF is based at the McCourt School of Public Policy's Health Policy Institute.

# Methodology

Medicaid child enrollment through June 2021 was 33.3 million children and is largely based on data reported CMS. We use updated, rather than preliminary, enrollment data with the following adjustments. Arizona does not report a breakout of child enrollment to CMS, so we substitute state administrative data. Indiana is currently adjusting its reporting methodology, resulting in enrollment fluctuations, so we substitute preliminary data for this state in June 2021. CMS reported an additional 6.9 million children in CHIP. CHIP enrollment data includes children in CHIP-funded Medicaid expansions (M-CHIP), as well as children enrolled in separate CHIP programs. According to MACPAC 2020 data reflecting the total number of children ever-enrolled during the year (vs. point-in-time enrollment), 58 percent of CHIP children received coverage through Medicaid. We use this statistic as a proxy to estimate the total number of children enrolled in Medicaid and M-CHIP programs, whose coverage has been protected during the continuous enrollment requirement. As of June 2021, an estimated 37.3 million children received coverage through Medicaid and M-CHIP.

Next we use the recent churn analysis based on T-MSIS data examined by MACPAC. In 2018, 18 percent of non-disabled children Medicaid were disenrolled. Almost of half (44 percent) of children who were disenrolled (8 percent of total enrollment) re-enrolled within 12 months. Although, there are significant reasons to anticipate that churn will be higher as states process the unprecedented volume of delayed renewals and pending actions when the continuous enrollment requirement is lifted, we use these data as a very conservative estimate of the share of children whose coverage will likely be disrupted. Eighteen percent of current child enrollment in Medicaid and M-CHIP would mean that at least 6.7 million children could be disenrolled. Based on the MACPAC churn data, 2.9 million may re-enroll, leaving 3.8 million children who may transition to other coverage sources or potentially become uninsured for some period of time (data may not sum due to rounding).

Table 1 is based on 2020 and 2021 data from the Kaiser Family Foundation and CCF's Annual 50-State Surveys on Medicaid and CHIP Eligibility, Enrollment, and Cost-Sharing Policies. Since the last survey update, Wyoming transitioned its separate CHIP program to M-CHIP. South Carolina did not respond to the survey in 2020, but prior surveys and state plan amendments confirm that the state has 12-month continuous eligibility. These changes will be reflected in the forthcoming 2022 survey. Additionally, a number of states suspended ex parte renewals at the start of the pandemic. States that were not processing ex parte renewals in 2021 receive a flag, as well as states that continued to conduct ex parte renewals in 2021 but were either unable to report the share of ex parte renewals or reported a share of less than 50 percent in 2020. State reporting on ex parte renewals may reflect additional changes when the 2022 survey results are published. This table also reflects that both Illinois and New Jersey have recently passed legislation to permanently eliminate premiums in CHIP.

## Appendix A: Child Enrollment in Medicaid and CHIP

| State | February 2020 | June 2021 | Number Change | Percent Change |
|---|---|---|---|---|
| Alabama | 660,859 | 722,551 | 61,692 | 9.3% |
| Alaska | 97,379 | 102,501 | 5,122 | 5.3% |
| Arizona * | 752,139 | 851,574 | 99,435 | 13.2% |
| Arkansas | 370,840 | 403,861 | 33,021 | 8.9% |
| California | 4,806,615 | 5,065,962 | 259,347 | 5.4% |
| Colorado | 567,677 | 636,554 | 68,877 | 12.1% |
| Connecticut | 331,656 | 357,691 | 26,035 | 7.9% |
| Delaware | 104,741 | 118,833 | 14,092 | 13.5% |
| District of Columbia | 90,421 | 96,566 | 6,145 | 6.8% |
| Florida | 2,410,942 | 2,765,737 | 354,795 | 14.7% |
| Georgia | 1,268,470 | 1,528,843 | 260,373 | 20.5% |
| Hawaii | 138,826 | 157,141 | 18,315 | 13.2% |
| Idaho | 175,309 | 199,776 | 24,467 | 14.0% |
| Illinois | 1,347,284 | 1,464,366 | 117,082 | 8.7% |
| Indiana ** | 817,962 | 910,732 | 92,770 | 11.3% |
| Iowa | 337,748 | 368,696 | 30,948 | 9.2% |
| Kansas | 263,184 | 310,284 | 47,100 | 17.9% |
| Kentucky | 547,576 | 618,054 | 70,478 | 12.9% |
| Louisiana | 720,218 | 787,182 | 66,964 | 9.3% |
| Maine | 108,717 | 125,413 | 16,696 | 15.4% |
| Maryland | 622,062 | 678,961 | 56,899 | 9.1% |
| Massachusetts | 656,626 | 715,662 | 59,036 | 9.0% |
| Michigan | 944,233 | 1,047,876 | 103,643 | 11.0% |
| Minnesota | 530,743 | 594,870 | 64,127 | 12.1% |
| Mississippi | 417,689 | 477,806 | 60,117 | 14.4% |
| Missouri | 536,875 | 676,635 | 139,760 | 26.0% |
| Montana | 114,894 | 125,924 | 11,030 | 9.6% |
| Nebraska | 165,414 | 187,064 | 21,650 | 13.1% |
| Nevada | 295,392 | 345,840 | 50,448 | 17.1% |
| New Hampshire | 89,507 | 100,990 | 11,483 | 12.8% |
| New Jersey | 811,342 | 902,347 | 91,005 | 11.2% |
| New Mexico | 332,629 | 364,546 | 31,917 | 9.6% |
| New York | 2,389,703 | 2,533,260 | 143,557 | 6.0% |
| North Carolina | 1,189,125 | 1,313,672 | 124,547 | 10.5% |
| North Dakota | 42,563 | 53,060 | 10,497 | 24.7% |
| Ohio | 1,152,914 | 1,287,087 | 134,173 | 11.6% |
| Oklahoma | 502,359 | 600,490 | 98,131 | 19.5% |
| Oregon | 416,860 | 459,928 | 43,068 | 10.3% |
| Pennsylvania | 1,383,641 | 1,509,001 | 125,360 | 9.1% |
| Rhode Island | 116,420 | 123,942 | 7,522 | 6.5% |
| South Carolina | 648,589 | 708,511 | 59,922 | 9.2% |
| South Dakota | 77,955 | 90,524 | 12,569 | 16.1% |
| Tennessee | 819,732 | 902,374 | 82,642 | 10.1% |
| Texas | 3,301,272 | 3,901,121 | 599,849 | 18.2% |
| Utah | 184,630 | 221,915 | 37,285 | 20.2% |
| Vermont | 60,890 | 64,693 | 3,803 | 6.2% |
| Virginia | 756,692 | 852,438 | 95,746 | 12.7% |
| Washington | 826,585 | 873,362 | 46,777 | 5.7% |
| West Virginia | 213,391 | 230,570 | 17,179 | 8.1% |
| Wisconsin | 506,220 | 588,489 | 82,269 | 16.3% |
| Wyoming | 37,242 | 45,597 | 8,355 | 22.4% |
| **Total** | **36,062,752** | **40,170,872** | **4,108,120** | **11.4%** |

Source: Georgetown University McCourt School of Public Policy Center for Children and Families analysis of February 2020-June 2021 Centers for Medicare and Medicaid Services State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data.

* The dataset does not include child enrollment for Arizona and consequently the authors have added Arizona state administrative enrollment data to the estimate. See the methodology section for more details.

** Indiana updated its reporting methodology in June 2021, but did not retroactively update enrollment for prior months. Consequently, preliminary data (in line with the older reporting methodology) are used for June 2021 only in this table. See methodology section for more details.

## Endnotes

[1] Georgetown University Center for Children and Families analysis of February 2020-June 2021 Centers for Medicare and Medicaid Services State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data, available at https://data.medicaid.gov/dataset/6165f45b-ca93-5bb5-9d06-db29c692a360. The dataset does not include child enrollment for Arizona and consequently the authors have added Arizona state administrative enrollment data to the estimate. See the methodology section for more details.

[2] Ibid.

[3] Georgetown University Center for Children and Families analysis of June 2021 Centers for Medicare and Medicaid Services State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data and Census Bureau Current Population Survey, 2021 Annual Social and Economic Supplement (CPS ASEC), Table H-01. According to the CPS ASEC, there are an estimated 76.1 million children (ages 0-18) in the U.S.

[4] For more details on how and when the public health emergency may lift, see Brooks, T. "Secretary Becerra Extends the PHE: What Does this Mean for Medicaid and the Continuous Enrollment Provision?" Say Ahh! Health Policy Blog (Georgetown University Center for Children and Families, January 14, 2022), available at https://ccf.georgetown.edu/2022/01/14/secretary-becerra-extends-the-phe-what-does-this-mean-for-medicaid-and-the-continuous-enrollment-provision/.

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[12] Medicaid and CHIP Payment and Access Commission, "An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP" (Washington D.C.: Medicaid and CHIP Payment and Access Commission, October 2021), available at https://www.macpac.gov/wp-content/uploads/2021/10/An-Updated-Look-at-Rates-of-Churn-and-Continuous-Coverage-in-Medicaid-and-CHIP.pdf.

[13] The MACPAC analysis reflected an eight percent churn rate. Analysis conducted by the Kaiser Family Foundation estimated the churn rate to be 11.2 percent for children. Corallo, B., Garfield, R., and Tolbert, J., et al., "Medicaid Enrollment Churn and Implications for Continuous Coverage Policies" (Washington D.C.: Henry J. Kaiser Family Foundation, December 2021), available at https://www.kff.org/report-section/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies-issue-brief/.

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[28] 42 U.S.C. §1397bb (2018); and, 42 C.F.R. §457.90 (2001).

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