ASPE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION | OFFICE OF HEALTH POLICY

ISSUE BRIEF
March 2, 2023

HP-2023-07

Children's Health Coverage Trends: Gains in 2020-2022 Reverse Previous Coverage Losses

Recent national survey data suggests that 1.4 million children have gained health coverage since the end of 2020

Ann B. Conmy, Christie Peters, Nancy De Lew, Benjamin D. Sommers

KEY POINTS

- Recent national survey data show that the uninsured rate among children (ages 0-17) fell from 6.4 percent in late 2020 to 4.5 percent in the third quarter of 2022. These gains have nearly erased the loss in children's coverage that occurred between 2016 and 2020.
- By income, coverage gains were greatest among children living in households with incomes between 100 and 200 percent of the Federal Poverty Level (FPL).
- Federal policies such as the Medicaid continuous enrollment provision in the Families First Coronavirus Response Act (FFCRA), expanded Marketplace premium tax credits under the American Rescue Plan (ARP), an extended Marketplace special enrollment period (SEP) in 2021, and robust enrollment outreach have potentially contributed to families and children gaining and retaining health coverage since 2020.
- While there has been growing health care coverage for children, there has also been a general decline in utilization of services, especially pediatric preventive services, during the pandemic. There are growing income and race-related disparities in use of preventive care services among children, suggesting the pandemic may have had a greater impact on children in lower income households and Black, Latino, and Asian children.
- Older children (age 12-17) received the lowest rates of preventive care. Preventive care in this age group typically includes depression and suicide risk screenings, so this decline is particularly concerning given rising burdens of mental illness and suicide attempts among adolescents.
- A new provision in the Consolidated Appropriations Act, 2023 (CAA), requires 12-month continuous eligibility for all children enrolled in Medicaid and CHIP, which may improve access to preventive and other types of care. The Inflation Reduction Act (IRA) extended enhanced premium subsidies for Marketplace coverage, resulting in record-high enrollment in 2023. The elimination of the "family glitch" for Marketplace subsidies will improve affordability of coverage for many families with children.
- Under the CAA, the Medicaid continuous enrollment provision will come to an end on March 31, 2023. Many children who lose Medicaid coverage as eligibility redeterminations resume may be eligible for CHIP, zero-premium or low-premium plans through the Marketplace, or employer sponsored coverage.

INTRODUCTION

In 2021 there were 74.2 million children under the age of 18, accounting for 22.1 percent of the total U.S. population.[1] As of November 2022, over half of all children (41.5 million) were covered by Medicaid (34.7 million) or CHIP (7.0 million).[2*] Health insurance coverage generally is associated with improved access to care for children, just as it is for adults.[3] Uninsured children and adults are substantially less likely to have a usual source of health care or a recent health care visit than their insured counterparts.[4] Children who lack health insurance are disproportionately Black, Latino, and American Indian/Alaska Native (AI/AN). Children living in low-income households are also at higher risk for being uninsured.[5] There are large disparities in children's health status and outcomes dependent on household income, race, ethnicity, disability status, geography, and various social determinants of health.[6] Studies have found health inequities are consequences of multiple socio-economic factors that are largely the result of structural racism, income inequality, and poverty.[7, 8]

These considerations regarding health insurance coverage and equity are even more troubling as the population of children in the U.S. is becoming increasingly diverse. Children of people of color are expected to represent more than half the population of children (53.1 percent) by 2030. In 2021, White non-Latino children comprised the largest percentage of children (48.0 percent), followed by Black non-Latino children (12.6 percent), Latino children of all races (25.7 percent), Asian American and Native Hawaiian and Pacific Islander children (5.2 percent), multiracial children (i.e., children of two or more races) (7.9 percent), and AI/AN children (0.6 percent).[9] In 2021, the child poverty rate was 16.9 percent, 4.2 percentage points higher than the national poverty rate (12.8 percent). The child poverty rate varied greatly by state, ranging from 8.1 percent (Utah) to 27.7 percent (Mississippi).[10]

Health coverage rates for children are higher than those for working age adults (19-64) and the uninsured rate for children declined significantly between 2007 to 2016, after reauthorization of the CHIP and implementation of the Affordable Care Act (ACA).[11] However, starting in 2016, the uninsured rate for children increased from 4.5 percent in 2015 to 5.1 percent in 2016, and it remained relatively steady at that level until 2021.[12] At the start of the COVID-19 pandemic in 2020, 5.1 percent of children were estimated to be uninsured.[13]

Early evidence shows children's access to care and utilization declined during the COVID-19 pandemic, with parents and guardians delaying preventive check-ups and recommended childhood vaccinations beginning in 2020.[14, 15] A survey of parents in 2021 found that 41 percent of parents reported their children had missed a routine medical visit due to the COVID-19 pandemic, and approximately 25 percent of parents reported not catching-up after missing a routine medical visit for their child during the first year of the pandemic.[16] Additional studies found children in households with less than $25,000 in income, families reporting financial hardships, and Latino households were most likely to miss or delay preventive services between spring 2021 and spring 2022.[17] These studies document that COVID-19 exacerbated existing health disparities.[18] Children without health insurance, children with specialized health needs, children of color, and children in low-income families were disproportionately impacted by COVID-19 and decreased access to care during the public health emergency (PHE).[19, 20]

Legislative and administrative actions since 2020 have helped individuals and families maintain and gain access to affordable coverage through Medicaid and Marketplace during the COVID-19 pandemic. Strengthening Medicaid and CHIP and lowering the uninsured rate are key priorities of the Biden-Harris Administration.[21] This Issue Brief examines children's health coverage trends from 2010 through the third quarter of 2022 and reviews recent research findings on children's access to and utilization of health care services during this period, including the COVID-19 pandemic. The report concludes with a discussion of recently enacted policies related to health coverage, including expanded Marketplace subsidies and 12-month continuous eligibility in

[*] As of November 2022, 34,705,366 children were enrolled in Medicaid and 7,083,374 were enrolled in CHIP, for a total child Medicaid and CHIP Enrollment of 41,788,740. This number excludes Arizona as the state did not report a breakout for adult and child enrollment between February 2020 and November 2022.

Medicaid/CHIP for children, elimination of the "Family Glitch" that affected Marketplace subsidy eligibility, and the potential coverage implications of the end of the continuous coverage provisions on March 31, 2023.

METHODS

Our primary data source was the National Health Interview Survey (NHIS). Administered by the National Center for Health Statistics (NCHS) and housed within the Centers for Disease Control and Prevention (CDC), the NHIS releases quarterly health insurance estimates.[†] Analyses are weighted to represent the noninstitutionalized population and to adjust for the complex survey design.

This Issue Brief also uses data from the National Survey of Children's Health (NSCH), an annual national survey on children's health and well-being conducted by the Health Resources and Services Administration.[22] We assessed trends in several measures of access to care and preventive services utilization: one or more preventive care visit(s) in the last 12 months; received both preventive medical and dental care in the last 12 months; had a developmental screening (age 9-35 months) in the last 12 months; and had forgone needed health care in the last 12 months; and the contributing factors for foregoing care.

CHILDREN'S HEALTH COVERAGE

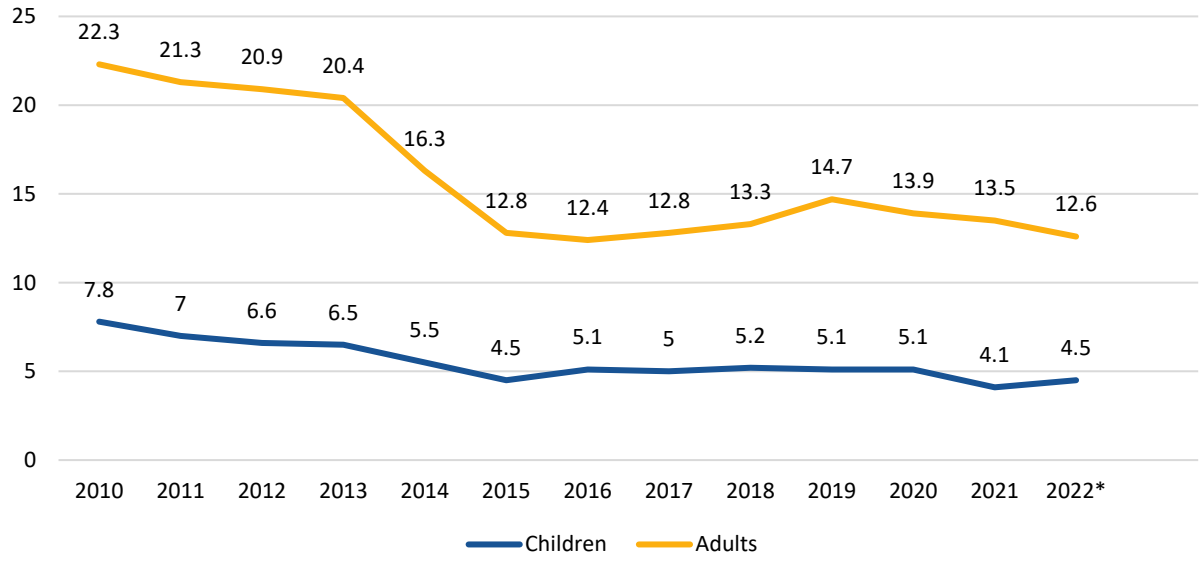
Long-Term Trends in Children's Health Coverage

Since the implementation of the ACA's coverage provisions, the uninsured rate among both adults and children decreased substantially. Both before and after the ACA, children had overall higher rates of health coverage compared to adults, largely due to the availability of the CHIP and more generous eligibility for Medicaid that provide more stable health insurance options for children than adults.

Since the enactment of the ACA, the uninsured rate decreased among children by 3.7 percentage points, from 7.8 percent in 2010 to 4.1 percent in 2021 (Figure 1).[23] Beginning in 2016, the previous 10-year downward trend in the uninsured rate among children reversed, climbed and plateaued around 5 percent until 2021. Since 2021, the children's uninsured rate once again began to decrease.

[†] NHIS data from 2020 should be interpreted with caution compared to previous years, due to survey redesign and the COVID-19 pandemic, which led to challenges conducting in-person interviews, nonresponse bias, and lower response rates. Additional information on 2020 health insurance survey data collection can be found in a previous ASPE available at: https://aspe.hhs.gov/reports/tracking-health-insurancecoverage

Figure 1. Annual Uninsured Rate Among Adults (18-64) and Children (0-17), 2010-2022*

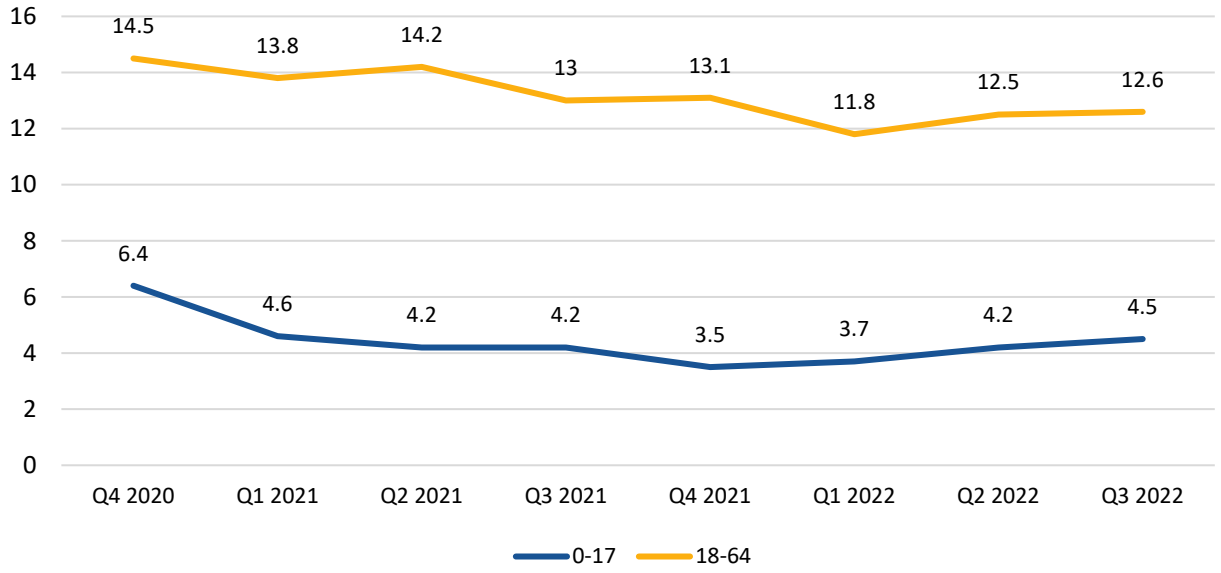


Source: National Health Interview Survey, 2010-Q3 2022. [24] [25] [26] [27] [28] [29] [30] [31] [32] [33] [34] [35]
Notes: *2022 is the uninsured rate from Q3 2022. The 2022 annual uninsured rate using NHIS is not available at the time of this publication. People were defined as uninsured if they did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan, additionally, people were also defined as uninsured if they had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

Recent Children's Health Insurance Trends

The most recent quarterly NHIS data show that children's uninsured rate decreased from 6.4 percent (4.7 million children) in the last quarter of 2020 to 4.5 percent (3.3 million children) in the third quarter of 2022 (Figure 2).[36, 37, 38] The largest decrease in children's uninsured rate occurred between the end of 2020 to the last quarter of 2021, 6.4 percent to 3.5 percent. Over 1.4 million children gained coverage between the end of 2020 and the third quarter of 2022.[39] Alternatively, annual uninsured rates among children decreased 1 percentage point from 5.1 percent (3.7 million) in 2020 to 4.1 percent (3.0 million) in 2022 to date.[40, 41]

Figure 2. Quarterly Uninsured Rate Among Adults (18-64) and Children (0-17), Q4 2020-Q3 2022

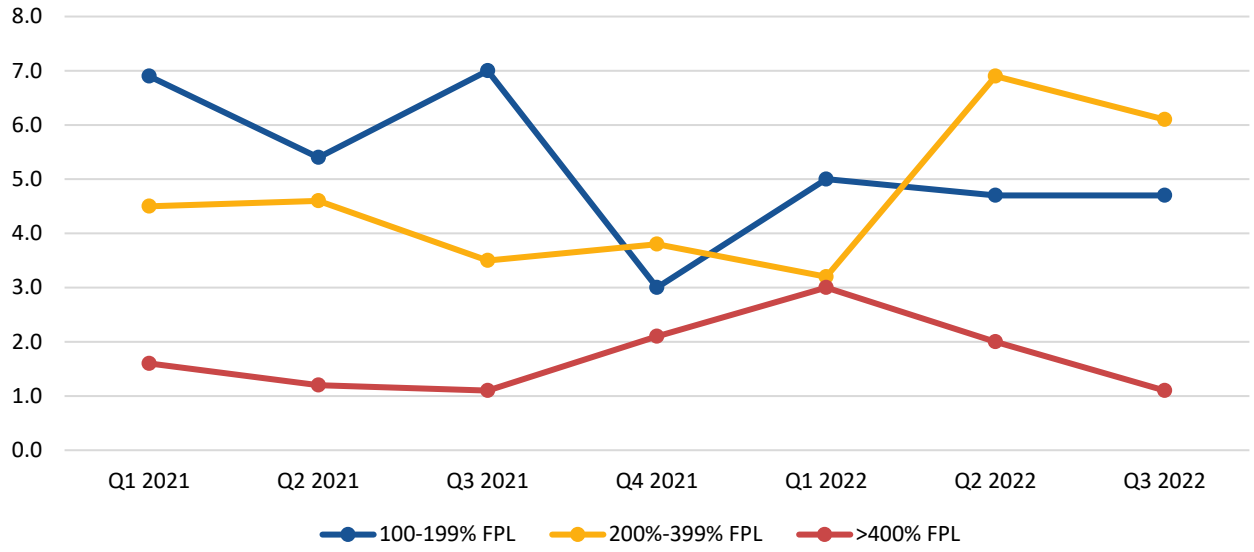


Source: Health Insurance Coverage: Early Release of Quarterly Estimates from the National Health Interview Survey, Q4 2020-September 2022.[42, 43]

Notes: People were defined as uninsured if they did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan, additionally, people were also defined as uninsured if they had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care. The change in children's uninsured rate from Q3 2021 and Q3 2022 is not statistically significant.

Figure 3 shows the quarterly uninsured rate among children by income, by percentage of the Federal Poverty Level (FPL). The uninsured rate for children in households with income at or below the federal poverty level (100 percent of FPL) declined from 6.8 percent to 6.1 percent during the first three quarters of 2021 but estimates for the last quarter of 2021 and the first half of 2022 have not been reported because the data do not meet NCHS' standards of reliability (i.e., due to sample size) and therefore are not included in Figure 3.[44] Most recent quarterly NHIS results report the uninsured rate for children living in households with income at or below 100 percent FPL was 8.7 percent in the third quarter of 2022. Overall, children living in households with an annual income between 100 and 400 percent FPL had higher uninsured rates than children living in households with incomes above 400 percent FPL. The uninsured rate for children living in households with annual incomes between 100 and 400 percent FPL has fluctuated over this time period. Children in households with annual incomes between 200 and 400 percent FPL experienced a 2.9 percentage point increase from the first to the third quarter of 2022. Overall, Figure 3 generally shows gains in coverage among children living in households with incomes between 100 and 200 percent FPL. These coverage patterns could be associated with policies aimed at maintaining and increasing access to affordable coverage during 2021 through early 2022.

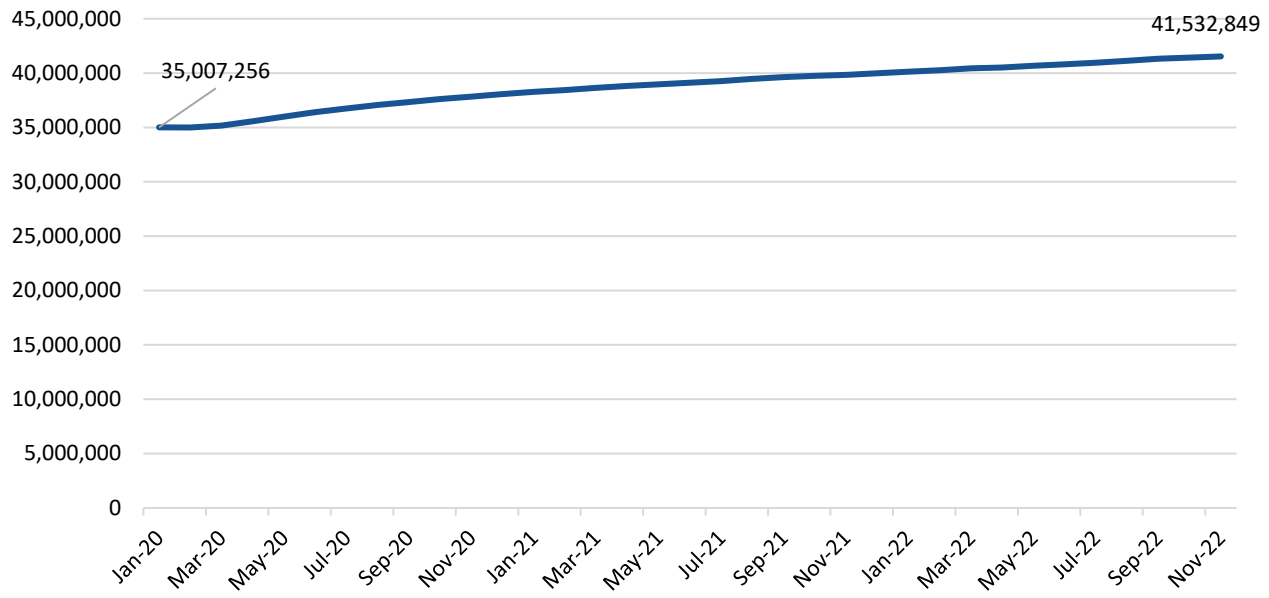
Figure 3. Percentage of Children (0-17) Without Health Insurance by Household Income (FPL), Q1 2021-Q3 2022



Source: Health Insurance Coverage: Early Release of Quarterly Estimates from the National Health Interview Survey,
Notes: Quarterly estimates of uninsured rate among children living in households with income <100% FPL were not reported by NCHS for Q42021 and the early quarters of 2022 because they do not meet NCHS standards of reliability. People were defined as uninsured if they did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan, additionally, children were also defined as uninsured if they had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

Federal Medicaid policy changes implemented during the COVID-19 pandemic contributed to these coverage trends among children in lower income households. Figure 4 uses administrative data, released by the Centers for Medicare & Medicaid Services (CMS), and shows the growth in monthly child Medicaid and CHIP enrollment from January 2020 through November 2022. Approximately 6.6 million children gained Medicaid or CHIP coverage from January 2020 to November 2022, representing a 18.6 percent increase.[45] Appendix Table 1 shows Medicaid and CHIP enrollment, Children's Medicaid Enrollment, and CHIP Enrollment by state as of November 2022. State Medicaid and CHIP enrollment is largely reflective the size of each state's population. States with the largest Children's Medicaid enrollment were California, Texas, Florida, and New York and smallest children's Medicaid enrollment were Wyoming, North Dakota, and Vermont. The steady increase in children's Medicaid and CHIP enrollment since March 2020 is concurrent with the FFCRA's continuous enrollment provision in Medicaid, which prohibited states from disenrolling Medicaid beneficiaries (unless the beneficiary moves out of state or chose to disenroll) in exchange for a temporary 6.2 percentage point increase in the Federal Medical Assistance Percentage (FMAP).

Figure 4. Monthly Child Medicaid/CHIP Enrollment, January 2020 – November 2022



Source: CMS, Medicaid & CHIP Monthly Applications, Eligibility Determinations, and Enrollment Reports: January 2020 - November 2022 (preliminary), as of February 28, 2023.
Notes: This table summarizes adult and child enrollment in Medicaid and CHIP since January 2020. This table is provided as a supplement to Figure 2, and includes preliminary enrollment data from 49 states and the District of Columbia. Arizona is excluded from because the state did not report the breakouts for adult and child enrollment between February 2020 and November 2022. States use the definition of "child" as included in the state's Medicaid or CHIP state plan in reporting performance indicator data to the Centers for Medicare & Medicaid Services (CMS), which varies from state to state. Monthly enrollment data may be updated in subsequent CMS Eligibility and Enrollment Reports.

Children's health coverage varies by their race and ethnicity. Table 1 shows the annual uninsured rate among children by race and ethnicity from 2019 through 2021. Children of Latino ethnicity have the highest rate of being uninsured among children at 7.8 percent in 2021 and have experienced a modest increase in the uninsured rate since 2019, a 0.6 percentage point increase. Previous ASPE analysis found Latino individuals for whom English is not their primary language are disproportionately uninsured compared to English-speaking Latino individuals.[46] All other races experienced a decrease in the uninsured rate among children since 2019. Asian non-Latino children have the lowest uninsured rate at 1.3 percent, down more than 50% since 2019 (3.2 percent).

Table 1. Percentage of Children Without Health Insurance by Race and Ethnicity, 2019-2021

	2019	2020	2021
Total	5.1%	5.1%	4.1%
Latino	7.2%	7.8%	7.8%
White, Non-Latino	4.5%	3.8%	2.7%
Black, Non-Latino	3.5%	5.1%	3.0%
Asian, Non-Latino	3.2%	3.4%	1.3%
Other races and multiple races, Non-Latino	5.9%	6.1%	5.0%

Source: Health Insurance Coverage: National Health Interview Survey 2019- 2021
Notes: People of Hispanic or Latino origin may be of any race or combination of races. Hispanic or Latino origin includes people of Mexican, Puerto Rican, Cuban, Central and South American, or Spanish origin. Race is based on respondents' descriptions of their own racial background. More than one race may be reported. People were defined as uninsured if they did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. People also were defined as uninsured if they had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

A recent ASPE analysis comparing U.S. Census Bureau's 2019 and 2021 American Community Survey (ACS) data aligns with the NHIS data on children's health insurance coverage. The ASPE analysis finds a modest decrease in the uninsured rate among children (age 0-18) between 2019 and 2021 (from 5.7 percent to 5.4 percent).[47] Further, an estimated 3 million children did not have health insurance in 2021, representing 14.5 percent of the nonelderly population without health insurance.[48]

CHILDREN'S ACCESS TO PREVENTIVE HEALTH CARE

Table 2 shows selected measures of access to care from the NSCH in 2019-2020 compared to 2020-2021 for total children and by age (0-5, 6-11, 12-17), with the exception of the developmental screening measure which applies only to children 9 months to 35 months old. Overall, rates of children receiving preventive services decreased from 2019 to 2021. Of the selected measures shown below, rates of children receiving both preventive dental and medical care in the last 12 months decreased the most, by 4.8 percentage points.[49] Rates of children receiving development screenings was the lowest, with percentages nearly less than half the other two measures. Further, the percentage of younger children who reported having a developmental screening are less than half for both 2019-2020 (36.9 percent) and 2020-2021 (34.8 percent).

Overall, older children (12-17) were less likely to receive preventive care compared to younger children (0-11) (Table 2). Older children (age 12-17) experienced a larger decrease in receiving preventive care from 2019 to 2021 (6.0 percentage points). Notably, preventive care visits in this age group (age 12-17) typically include depression and suicide risk screenings, raising concerns about the possibility of missed behavioral health screenings. However, children of all ages received less preventive care in 2020 and 2021 (76.7 percent) compared to 2019 and 2020 (80.7 percent).

Table 2. Selected Measures of Children's Access to Care by Age, 2019-2020

	One or more preventive care visit in the last 12 months	Received both preventive medical and dental care in the last 12 months	Had a developmental screening (9-35 months) in the last 12 months
2019-2020			
Total	80.7%	65.7%	36.9%
0-5 years old	87.8%	57.6%	—
6-11 years old	79.1%	71.6%	—
12-17 years old	75.6%	67.6%	—
2020-2021			
Total	76.7%	60.9%	34.8%
0-5 years old	85.9%	54.2%	—
6-11 years old	75.2%	67.0%	—
12-17 years old	69.6%	61.3%	—

Source: Child and Adolescent Health Measurement Initiative. 2019-2020 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).
Notes: Percentages are weight to represent the child population of the U.S. Preventive care includes a visit with a doctor, nurse, or other health care professional to receive a preventive check-up. Health care includes medical care as well as other kinds of care like dental care, vision care, and mental health services. The developmental screening measure age breakdown is not available since the question is only for children 9 to 35 months olds.

Tables 3 and 4 present the selected measures of children's access to care by race and ethnicity, and household income. Children of all races and ethnicity received fewer preventive services in 2020-2021 compared to 2019-2020. In both Tables 3 and 4 there are growing disparities across race groups and household income related to the larger impact of the COVID-19 pandemic. For all three selected measures of access to care, Asian children

received the fewest preventive services, followed by Latino children and Black children (Table 3). White children reported receiving preventive services at higher rates than children of other races and ethnicity.

Table 3. Selected Measures of Children's Access to Care by Race and Ethnicity, 2019-2021

	One or more preventive care visit in the last 12 months	Received both preventive medical and dental care in the last 12 months	Had a developmental screening (9-35 months) in the last 12 months
2019-2020			
Total	80.7%	65.7%	36.9%
Latino	75.8%	60.8%	35.8%
White, Non-Latino	83.8%	69.5%	38.4%
Black, Non-Latino	79.4%	62.9%	30.7%
Asian, Non-Latino	74.3%	57.3%	30.0%
2020-2021			
Total	76.7%	60.9%	34.8%
Latino	69.5%	54.4%	29.5%
White, Non-Latino	81.5%	66.5%	38.3%
Black, Non-Latino	74.6%	56.5%	31.3%
Asian, Non-Latino	67.1%	48.8%	25.1%

Source: Child and Adolescent Health Measurement Initiative. 2019-2020 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).
Notes: Percentages are weight to represent the child population of the U.S. Preventive care includes a visit with a doctor, nurse, or other health care professional to receive a preventive check-up. Health care includes medical care as well as other kinds of care like dental care, vision care, and mental health services.

Table 4 shows the selected measures of children's access to care by household income. Children across all income levels experienced a decrease in receiving preventive service visits from 2019 to 2021. Overall, children living in households with incomes below poverty (0-99 percent FPL) reported the lowest rate of preventive services from 2019-2021. These results suggest widening disparities — comparing children living in households with annual incomes of 400 percent FPL to those 0-99 percent FPL, there was a 15.5 percentage point difference and 19.7 percentage point difference in children receiving "one or more preventive care visits in the last 12 months" between 2019-2020 and 2020-2021, respectively. There were similar trends among the other selected measures. Children living in lower income households (0-99 percent FPL and 100-199 percent FPL) experienced the largest decrease in receiving at least one preventive care visit, with a 6.8 percentage-point decrease and 4.8 percentage-point decrease, respectively.

Table 4. Selected Measures of Children's Access to Care by Household Income, 2019-2021

	One or more preventive care visit in the last 12 months	Received both preventive medical and dental care in the last 12 months	Had a developmental screening (9-35 months) in the last 12 months
2019-2020			
Total	80.7%	65.7%	36.9%
0-99% FPL	72.6%	54.5%	29.7%
100-199% FPL	77.6%	60.5%	36.1%
200-399% FPL	80.2%	66.3%	35.5%
400% FPL or greater	88.1%	75.5%	42.8%
2020-2021			
Total	76.7%	60.9%	34.8%
0-99% FPL	65.8%	47.5%	23.1%
100-199% FPL	72.8%	55.2%	34.1%
200-399% FPL	76.8%	61.3%	35.6%
400% FPL or greater	85.5%	72.2%	40.7%

Source: Child and Adolescent Health Measurement Initiative. 2019-2020 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).
Notes: Percentages are weight to represent the child population of the U.S. Preventive care includes a visit with a doctor, nurse, or other health care professional to receive a preventive check-up.

Table 5 shows the percentage of children with forgone needed health care, and among those who did forgo care, the contributing reasons why the care was forgone by household income.[‡] Compared to non-elderly adults, children have overall much lower rates of forgone care.[50] However, among those children who did forego care, the most common reason cited in 2019-202 was due to cost (54 percent), followed by problems getting an appointment (46.1 percent); respondents were allowed to choose more than one reason for missing care. Conversely, that ranking switched in 2020-2021, when more parents reported problems getting an appointment (55.6 percent) followed by cost (46.0 percent). Similar to the widening disparities in the selected measures of care, there are growing disparities in reported reasons for forgone care among children between low income and higher households with children. When comparing 2019-2020 and 2020-2021 reasons for forgone care, children of all incomes experienced decreased forgone care due to cost and eligibility. Conversely, children of all incomes had higher rates of forgone care due to pandemic and safety related reasons: troubles getting an appointment and the office or clinic was not open. Parents reporting forgone care due to eligibility decreased 6.4 percentage points from 2019 to 2021, corresponding with federal policies such as the Medicaid continuous enrollment provision in the FFCRA, expanded Marketplace premium tax credits under the ARP, and extended Marketplace SEP, that helped children maintain coverage.

[‡] These measures of forgone care and reasons for why the care was forgone by race and ethnicity are not presented due to a large amount of estimates where the 95 percent confidence interval exceeds 20 percentage points and the Data Resource Center for Child & Adolescent Health advises caution when interpreting results, as they may not be reliable.

Table 5. Percentage of Children with Forgone Needed Health Care and Reasons Why, Total and by Household Income, 2019-2021

Year	Forgone needed health care	Among those who had foregone needed care, reasons for not obtaining care: "the child was not eligible for the services"	"the services this child needed were not available in the area"	"problems getting an appointment"	"problems with getting transportation or child care"	"clinic or doctor's office was not open when the child needs care"	"issues related to cost"
2019-2020							
Total	3.5% (n=2,255)	34.0%	25.5%	46.1%	12.2%	24.9%	54.0%
0-99% FPL	4.8%	33.6%	26.1%	45.7%§	23.7%	24.0%	43.3%
100-199% FPL	4.8%	45.2%§	27.1%	43.3%	11.8%§	23.5%	56.1%§
200-399% FPL	3.9%	32.4%	21.2%	45.2%	4.8%	25.5%	67.5%
400% FPL or greater	1.7%	16.2%	31.0%§	54.6%§	9.9%§	26.6%	38.0%§
2020-2021							
Total	3.8% (n=3,229)	27.6%	27.6%	55.6%	11.5%	30.5%	46.0%
0-99% FPL	5.3%	29.2%	31.0%	55.2%	23.3%	33.8%	41.1%
100-199% FPL	5.2%	37.6%	30.7%	52.6%	10.8%§	27.7%	47.3%
200-399% FPL	3.7%	26.4%	22.6%	56.5%	4.6%	31.2%	58.4%
400% FPL or greater	2.1%	10.8%	26.3%	59.4%	7.7%	29.3%	30.5%

Source: Child and Adolescent Health Measurement Initiative. 2019-2020 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).

Notes: The percentages may not add up to 100% as survey participants were able to select more than one contributing reasons for forgone care. Percentages are weighted to represent the child population of the U.S. Preventive care includes a visit with a doctor, nurse, or other health care professional to receive a preventive check-up. Health care includes medical care as well as other kinds of care like dental care, vision care, and mental health services. Survey did not offer definitions for services children were not eligible for.

§ The National Survey of Children's Health and Child and Adolescent Health Measurement Initiative advise interpreting these results with caution since the estimate has a 95 percent confidence interval width exceeding 20 percentage points or 1.2 times and the estimate may not be reliable.

DISCUSSION

Recent health coverage gains among children reduced their uninsured rate from 6.4 percent in late 2020 to 4.5 percent in the third quarter of 2022, resulting in 1.4 million children gaining coverage.[51] This occurred after a 4-year period from 2016 to 2020 where the uninsured rate among children had increased from its previous levels. After the implementation of the ACA's Marketplace plans and Medicaid expansion, the uninsured rate among children decreased from 7.8 percent in 2010 to 4.5 percent in 2015. Research shows that Medicaid expansion for parents resulted in increased coverage for their children as well.[52, 53, 54, 55]

Beginning in 2017, administrative and state-based policy changes were implemented that made enrolling and maintaining Medicaid coverage more difficult. Policy changes included reduced funding for Marketplace outreach and enrollment, administrative changes to Medicaid eligibility and enrollment, and immigration-related policies. Specifically, the changes in immigration-related policy were associated with declines in Medicaid and CHIP enrollment and adverse consequences for maternal and child health, particularly among Latino children who have the highest rates of being uninsured.[56, 57, 58, 59, 60]

Despite the renewed progress increasing health coverage for children by 2022, substantial disparities in health coverage remain by income, race, and ethnicity. Children living in households with incomes between 100 and less than 400 percent of the FPL and Latino children have disproportionately high uninsured rates.[61] Although many Latino individuals are eligible for coverage, these immigrant groups face a range of potential barriers to enrollment, including confusion about eligibility policies, difficulty navigating the enrollment process, and language and literacy challenges. Culturally-tailored outreach and marketing for the ACA Marketplaces are important in closing the gaps in coverage among Latino children and families, particularly among Latinos who reside in predominantly Spanish-speaking households and who are eligible for Marketplace subsidies.[62] Additionally, there are growing income-related disparities in preventive care utilization, suggesting a greater pandemic impact for children in low-income households than for children in higher income households.

There are various factors and policy changes that may explain the decrease in the children's uninsured rate beginning in 2020. The FFCRA implemented a 6.2 percentage point-increase in state's FMAP in exchange for maintaining Medicaid continuous enrollment from January 2020 through the end of the quarter in which the PHE ends. With the passage of the CAA, the continuous enrollment requirement is no longer tied to the end of the PHE and will end March 31, 2023. As shown above, this policy has resulted in significant growth in Medicaid and CHIP enrollment among children. In addition to continuous Medicaid and CHIP enrollment throughout the COVID-19 PHE, administration efforts to promote affordable coverage include increased funding for Marketplace outreach, an extended 2021 Marketplace Special Enrollment Period (SEP) and increased and expanded eligibility of Marketplace subsidies under the American Rescue plan of 2021 (ARP) and the Inflation Reduction Act of 2022 (IRA). Under the increased and expanded premium subsidies, ASPE estimated that in 2021 61.7 percent of non-elderly adults without health insurance had access to zero-premium plans and 73.3 percent had access to low-premium plans (less than $50 per month).[63]

Starting in plan year 2023, the Administration closed the "family glitch," which will increase availability of premium tax credits to help cover the cost of Marketplace plans, particularly among children and families. Previously, consumers were ineligible for premium tax credits to help cover the cost of Marketplace coverage if they had access to affordable employer coverage, determined affordable if the cost of employer coverage for an individual (i.e., employee-only coverage) did not exceed a percentage of household income, determined annually. Under the final rule published by the Internal Revenue Service, eligibility for premium tax credits is based on the cost of a family plan.[64]

Moreover, Administration policy changes are aiming to not only make coverage more affordable, but to reduce disruptions or churning in coverage for children in Medicaid and CHIP. HHS recently approved Medicaid demonstrations in Massachusetts and Oregon expanding children's Medicaid coverage. In Oregon children enrolled in Medicaid have continuous eligibility until they reach the age of 6.[65] In Massachusetts, children enrolled in Medicaid or CHIP have 12 months of continuous eligibility after release from a correctional facility, and children enrolled in Medicaid with chronic homelessness have 24 months of continuous eligibility. However, the end of the Medicaid continuous coverage provision under FFCRA starting in April 2023 means millions of children will be at risk for coverage loss due to the resumption of eligibility redeterminations.[66]

Meanwhile, in terms of access to care, early evidence of children's utilization trends during the COVID-19 pandemic shows disruptions in preventive care, namely routine vaccination rates and recommended well child and physical visits. Among older children (age 12-17), who received the lowest rates of preventive care, these visits typically include depression and suicide risk screenings. The possibility of disruptions in these behavioral health screenings is particularly concerning given rising burdens of mental illness and suicide attempts among adolescents.[67]

In addition to mental health, vaccinations are another key area of concern. Administered by the CDC, the Vaccines for Children program, program (VFC) is a federal vaccine distribution program for children enrolled in Medicaid, without comprehensive health insurance, underinsured, or are AI/AN.[68] While health care staff and provider shortages remain an on-going problem to circumvent physician shortages, increased pharmacy enrollment in the VFC could help address the decrease rates of routine vaccinations among children during the COVID-19 pandemic and existing disparities in vaccination rates.[69, 70]

Telehealth was an important tool to help maintain health care access during the pandemic for people of all ages; however, delivery of preventive pediatric services via telehealth is limited as vaccinations and certain screenings cannot be completed virtually.[71, 72] Additionally, adults are more likely to use telehealth than children.[73] Similar to adults, telehealth use for pediatric care helped mitigate the decrease in utilization but did not completely offset the decrease in utilization.[74] Some potential factors explaining the decrease in utilization among children attributed to the COVID-19 pandemic include, physician office closures, limited available appointments, concerns about COVID-19 exposure at physician offices, COVID-19 vaccine hesitancy among parents, virtual school, and children becoming eligible for the vaccine after adults.[75, 76]

A growing body of research evidence shows that providing stable coverage to children improves health care access, quality of care, and both health and economic outcomes in the short and long term.[77, 78, 79] Permanent, mandatory, 12-month continuous eligibility in Medicaid and CHIP for children up to age 19 is included in the Consolidated Appropriations Act, 2023 and coverage begins in 2024. This provision may mitigate some of the coverage losses as the Medicaid continuous coverage provision comes to an end.

CONCLUSION

Insurance coverage among children has increased substantially since the implementation of the ACA and policies implemented since 2020, including those in response to the COVID-19 pandemic. These gains in health insurance coverage since 2020 may help address the pandemic-related disruption in access for children's health care utilization services, specifically among preventive care services. In addition, provisions in the IRA will continue increased and expanded availability of premium subsidies established in ARP to help families access affordable coverage through Health Insurance Marketplaces. HHS recently approved Medicaid

demonstrations in Massachusetts and Oregon expanding continuous eligibility for children enrolled in Medicaid with certain circumstances and until children reach the age of 6 in Oregon.[80] In addition, the Consolidated Appropriations Act, 2023 will for the first time require all states to implement 12-month continuous eligibility for children enrolled in Medicaid and CHIP. These policies will be particularly important as the pandemic-era continuous coverage provision in Medicaid comes to an end and people of all ages begin to experience coverage transitions. The coverage gains of the past two years – combined with policies designed to improve continuity of Medicaid and CHIP coverage going forward – are important steps toward the goal of improving the health and well-being of children.

APPENDIX

Table 1. Total and Children's Medicaid and CHIP Enrollment, November 2022

State	Total Medicaid Enrollment	Total Children's Medicaid Enrollment	Total CHIP Enrollment**
Total	85,012,436	34,709,860	7,083,374
Alabama	967,142	579,793	197,836
Alaska	251,627	93,350	11,902
Arizona	2,140,101	—	143,032
Arkansas	997,449	403,792	36,619
California	12,717,571	3,975,900	1,291,945
Colorado	1,585,335	544,278	101,849
Connecticut	987,984	352,931	14,583
Delaware	291,405	115,956	6,816
District of Columbia	274,554	84,195	16,673
Florida	4,752,201	2,913,306	99,598
Georgia	2,156,969	1,398,564	317,284
Hawaii	431,843	140,677	23,690
Idaho	410,466	172,559	38,737
Illinois	3,419,471	1,221,434	339,758
Indiana	1,863,768	745,192	130,107
Iowa	774,518	313,544	70,891
Kansas	433,773	268,627	68,021
Kentucky	1,479,337	511,311	130,742
Louisiana	1,705,488	618,440	182,014
Maine	359,479	130,450	5,249
Maryland	1,516,806	561,186	164,614
Massachusetts	1,762,636	548,301	204,581
Michigan	2,894,002	989,621	133,923
Minnesota	1,368,169	635,231	2,627
Mississippi	691,640	398,653	75,777
Missouri	1,399,020	700,574	32,597
Montana	295,445	103,043	28,641
Nebraska	344,997	160,535	42,147
Nevada	807,777	305,930	53,211
New Hampshire	223,899	83,145	23,881
New Jersey	1,930,588	690,716	263,972
New Mexico	832,045	331,029	50,684
New York	6,805,150	2,045,404	557,979
North Carolina	2,026,358	1,085,285	296,077
North Dakota	125,749	54,831	3,673
Ohio	3,095,655	1,099,331	242,212
Oklahoma	1,150,917	510,977	133,447
Oregon	1,184,752	305,108	184,045
Pennsylvania	3,405,253	1,318,570	254,079
Rhode Island	324,814	92,472	35,891
South Dakota	1,179,802	638,556	111,121
South Carolina	125,005	81,242	18,900
Tennessee	1,627,831	821,114	143,155

** Total CHIP enrollment includes children and a small number of adults. Nationally approximately 140,000 adults are enrolled in CHIP each month.

Texas	5,374,020	3,919,895	369,745
Utah	443,996	204,281	34,474
Vermont	187,213	61,020	4,621
Virginia	1,797,221	739,096	187,524
Washington	2,079,075	829,884	77,581
West Virginia	607,347	209,991	33,473
Wisconsin	1,327,894	553,398	86,135
Wyoming	76,879	47,142	5,241

Source: CMS, Medicaid & CHIP Monthly Applications, Eligibility Determinations, and Enrollment Reports: November 2022 (preliminary); Arizona is excluded because the state did not report a breakout for adult and child enrollment for November 2022 enrollment.

REFERENCES

1. U.S. Census Bureau, American Community Survey. (2021). S0101 AGE AND SEX. 2021: ACS 5-Year Estimates Subject Tables. Accessed at: https://data.census.gov/cedsci/table?q=population%20by%20age&tid=ACSST5Y2020.S0101
2. Centers for Medicare and Medicaid Services (CMS). (February 2023). November 2022 Medicaid and CHIP Enrollment Trends Snapshot. Accessed at: https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/november-2022-medicaid-chip-enrollment-trend-snapshot.pdf
3. Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Health, Office of the Secretary, U.S. Department of Health and Human Services. (2022). Healthy People 2030: Health Care Access and Quality. Accessed at: https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality
4. Centers for Disease Control and Prevention, National Center for Health Statistics. (February 2017). NCHS Fact Sheet: Health Insurance and Access to Care. Accessed at: https://www.cdc.gov/nchs/data/factsheets/factsheet_hiac.pdf
5. Keisler-Starkey, K, Bunch, L.N. (September 2022). Health Insurance Coverage in the United States: 2021. Accessed at: https://www.census.gov/content/dam/Census/library/publications/2022/demo/p60-278.pdf
6. Pearce A, Dundas R, Whitehead M, et al. Pathways to inequalities in child health, Archives of Disease in Childhood 2019;104:998-1003.Accessed at: https://adc.bmj.com/content/104/10/998
7. Alker, J., Osorio, A. (September 15, 2021). The Poorest Children Are The Ones That Lost Health Insurance During the Pandemic. Georgetown University Health Policy Institute, Center for Children and Families. Accessed at: https://ccf.georgetown.edu/2021/09/15/the-poorest-children-are-the-ones-that-lost-health-insurance-during-the-pandemic/
8. Bailey, Z.D., Feldman, J.M., Bassett, M.T. (February 25, 2021). How Structural Racism Works - Racist Policies as a Root Cause of U.S. Racial Health Inequities. N Engl J Med. 2021 Feb 25;384(8):768-773. Accessed at: https://www.nejm.org/doi/full/10.1056/NEJMms2025396
9. Kaiser Family Foundation. (2021). Population Distribution of Children by Race/Ethnicity, KFF estimates based on the 2008-2021 American Community Survey, 1-Year Estimates. Accessed at: https://www.kff.org/other/state-indicator/children-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D#notes
10. Benson, C. (October 4, 2022). Poverty Rate of Children Higher than National Rate, Lower for Older Populations. U.S. Census Bureau. Accessed at: https://www.census.gov/library/stories/2022/10/poverty-rate-varies-by-age-groups.html#:~:text=The%20child%20poverty%20rate%20(for,lower%20than%20the%20national%20rate
11. Centers for Disease Control and Prevention, National Center for Health Statistics. The National Health Interview Survey, Health Insurance Coverage. Accessed at: https://www.cdc.gov/nchs/nhis/healthinsurancecoverage.htm
12. Centers for Disease Control and Prevention, National Center for Health Statistics. The National Health Interview Survey, Health Insurance Coverage. Accessed at: https://www.cdc.gov/nchs/nhis/healthinsurancecoverage.htm
13. Cohen, R.A. & Cha, A.E. (August 2021). Health Insurance Coverage: Early Release of Quarterly Estimates From the National Health Interview Survey, January 2020–March 2021. Centers for Disease Control and Prevention, National Center for Health Statistics. Accessed at: https://www.cdc.gov/nchs/data/nhis/earlyrelease/Quarterly-Estimates-2021-Q11-508.pdf
14. Health Care Cost Institute. (Sept. 7, 2022). COVID-19 Disrupted On-Time Vaccination Rates In ESI and Medicaid in 2020. Accessed at: https://healthcostinstitute.org/hcci-research/covid-19-disrupted-on-time-vaccination-rates-in-esi-and-medicaid-in-2020
15. Williams, E. & Drake, P. (Aug. 5, 2022). Headed Back to School: A Look at the Ongoing Effects of COVID-19 on Children's Health and Well-Being. Kaiser Family Foundation. Accessed at: https://www.kff.org/coronavirus-covid-19/issue-brief/headed-back-to-school-a-look-at-the-ongoing-effects-of-covid-19-on-childrens-health-and-well-being/#:~:text=The%20pandemic%20may%20have%20worsened,mental%20health%20later%20in%20life

16. Teasdale, C.A., Borrell, L.N., Shen, Y., et al. (May 2022). Missed routine pediatric care and vaccinations in US children during the first year of the COVID-19 pandemic. Preventive Medicine, Vol. 158. Accessed at:https://www.sciencedirect.com/science/article/pii/S0091743522000731
17. Williams, E. & Drake, P. (Aug. 5, 2022). Headed Back to School: A Look at the Ongoing Effects of COVID-19 on Children's Health and Well-Being. Kaiser Family Foundation. Accessed at: https://www.kff.org/coronavirus-covid-19/issue-brief/headed-back-to-school-a-look-at-the-ongoing-effects-of-covid-19-on-childrens-health-and-well-being/#:~:text=The%20pandemic%20may%20have%20worsened,mental%20health%20later%20in%20life
18. Simmons A, Chappel A, Kolbe AR, Bush L, and Sommers BD. (March 16, 2021). Health Disparities by Race and Ethnicity During the COVID-19 Pandemic: Current Evidence and Policy Approaches. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Accessed at: https://aspe.hhs.gov/reports/health-disparities-race-ethnicity-during-covid-19-pandemic-current-evidence-policy-approaches
19. Williams, E. & Drake, P. (Aug. 5, 2022). Headed Back to School: A Look at the Ongoing Effects of COVID-19 on Children's Health and Well-Being. Kaiser Family Foundation. Accessed at: https://www.kff.org/coronavirus-covid-19/issue-brief/headed-back-to-school-a-look-at-the-ongoing-effects-of-covid-19-on-childrens-health-and-well-being/#:~:text=The%20pandemic%20may%20have%20worsened,mental%20health%20later%20in%20life
20. Williams, E. & Drake, P. (Aug. 5, 2022). Headed Back to School: A Look at the Ongoing Effects of COVID-19 on Children's Health and Well-Being. Kaiser Family Foundation. Accessed at: https://www.kff.org/coronavirus-covid-19/issue-brief/headed-back-to-school-a-look-at-the-ongoing-effects-of-covid-19-on-childrens-health-and-well-being/#:~:text=The%20pandemic%20may%20have%20worsened,mental%20health%20later%20in%20life
21. The White House. (Jan. 28, 2021). Executive Order 13765: Executive Order on Strengthening Medicaid and the Affordable Care Act. Accessed at: https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/executive-order-on-strengthening-medicaid-and-the-affordable-care-act/
22. Data Resource Center for Child & Adolescent Health. (n.d.). The 2020-2021 National Survey of Children's Health (NSCH) Combined Dataset Fast Facts. Accessed at: https://www.childhealthdata.org/docs/default-source/nsch-docs/2020-2021-nsch-fast-facts_cahmi_10-1-22.pdf?sfvrsn=78645c17_10
23. Centers for Disease Control and Prevention, National Center for Health Statistics. The National Health Interview Survey, Health Insurance Coverage. Accessed at: https://www.cdc.gov/nchs/nhis/healthinsurancecoverage.htm
24. Cohen, R.A., Ward, B.W., and Schiller, J.S. (June 2011). Health insurance coverage: Early release of estimates from the National Health Interview Survey, 2010. Centers for Disease Control and Prevention, National Center for Health Statistics. Accessed at: https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201106.pdf
25. Cohen, R.A., Martinez, M.E. (June 2012). Health insurance coverage: Early release of estimates from the National Health Interview Survey, 2011. Centers for Disease Control and Prevention, National Center for Health Statistics. Accessed at: https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201206.pdf
26. Cohen, R.A., Martinez, M.E. (June 2013). Health insurance coverage: Early release of estimates from the National Health Interview Survey, 2012. Centers for Disease Control and Prevention, National Center for Health Statistics. Accessed at: https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201905.pdf
27. Cohen, R.A. & Martinez, M.E. (June 2015). Health insurance coverage: Early release of estimates from the National Health Interview Survey, 2014. Centers for Disease Control and Prevention, National Center for Health Statistics. Accessed at: https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201506.pdf
28. Cohen, R.A., Martinez, M.E, & Zammitti, E.P. (May 2016). Health insurance coverage: Early release of estimates from the National Health Interview Survey, 2015. Centers for Disease Control and Prevention, National Center for Health Statistics. Accessed at: https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201605.pdf
29. Cohen, R.A., Zammitti, E.P., & Martinez, M.E. (May 2017). Health insurance coverage: Early release of estimates from the National Health Interview Survey, 2016. Centers for Disease Control and Prevention, National Center for Health Statistics. Accessed at: https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201705.pdf .
30. Cohen, R.A., Zammitti, E.P., & Martinez, M.E. (May 2018). Health insurance coverage: Early release of estimates from the National Health Interview Survey, 2017. Centers for Disease Control and Prevention, National Center for Health Statistics. Accessed at: https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201708.pdf
31. Cohen, R.A., Terlizzi, E.P., & Martinez, M.E. (May 2019). Health insurance coverage: Early release of estimates from the National Health Interview Survey, 2018. Centers for Disease Control and Prevention, National Center for Health Statistics. Accessed at: https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201808.pdf

32. Cohen, R.A., Cha, A.E., Martinez, M.E., Terlizzi, E.P. (September 2020). Health insurance coverage: Early release of estimates from the National Health Interview Survey, 2019. Centers for Disease Control and Prevention, National Center for Health Statistics. Accessed at: https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur202009-508.pdf
33. Cohen, R.A., Terlizzi, E.P., Cha, A.E., & Martinez, M.E. (August 2021). Health insurance coverage: Early release of estimates from the National Health Interview Survey, 2020. Centers for Disease Control and Prevention, National Center for Health Statistics. Accessed at: https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur202108-508.pdf
34. Cohen, R.A., Cha, A.E., Terlizzi, E.P., & Martinez, M.E. (May 2022). Health insurance coverage: Early release of estimates from the National Health Interview Survey, 2021. Centers for Disease Control and Prevention, National Center for Health Statistics. Accessed at: https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur202205.pdf
35. Cohen, R.A. & Cha, A.E. (January 2023). Health insurance coverage: Early release of quarterly estimates from the National Health Interview Survey, July 2021–September 2022. Centers for Disease Control and Prevention, National Center for Health Statistics. Accessed at: https://www.cdc.gov/nchs/data/nhis/earlyrelease/quarterly_estimates_2022_q13.pdf .
36. Cha, A.E. & Cohen, R.A. (Aug 2021). Health Insurance Coverage: Early Release of Quarterly Estimates From the National Health Interview Survey, January 2020–March 2021. Centers for Disease Control and Prevention, National Center for Health Statistics. Accessed at: https://www.cdc.gov/nchs/data/nhis/earlyrelease/Quarterly-Estimates-2021-Q11-508.pdf
37. Lee A, Ruhter J, Peters C, De Lew N, Sommers BD. (August 2022). National Uninsured Rate Reaches All-Time Low in Early 2022. (Issue Brief No. HP-2022-23). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Accessed at: https://aspe.hhs.gov/sites/default/files/documents/15c1f9899b3f203887deba90e3005f5a/Uninsured-Q1-2022-Data-Point-HP-2022-23-08.pdf
38. Cohen, R.A. & Cha, A.E. (Jan 2023). Health Insurance Coverage: Early Release of Quarterly Estimates From the National Health Interview Survey, July 2021–September 2022, Centers for Disease Control and Prevention, National Center for Health Statistics. Accessed at: https://www.cdc.gov/nchs/data/nhis/earlyrelease/quarterly_estimates_2022_q13.pdf
39. Cohen, R.A.& Cha, A.E. (January 2023). Health insurance coverage: Early release of quarterly estimates from the National Health Interview Survey, July 2021–September 2022. Centers for Disease Control and Prevention, National Center for Health Statistics. Accessed at: https://www.cdc.gov/nchs/data/nhis/earlyrelease/quarterly_estimates_2022_q13.pdf
40. Cohen, R.A., Cha, A.E., Terlizzi, E.P., Martinez, M.E. (May 2022). Health insurance coverage: Early release of estimates from the National Health Interview Survey, 2021. National Center for Health Statistics. Accessed at: https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur202205.pdf
41. Cohen, R.A., Terlizzi, E.P., Cha, A.E., Martinez, M.E. (August 2021). Health insurance coverage: Early release of estimates from the National Health Interview Survey, 2020. National Center for Health Statistics. Accessed at: https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur202108-508.pdf
42. Terlizzi, E.P. & Cohen, R.A. (April 2022). Health insurance coverage: Early release of quarterly estimates from the National Health Interview Survey, October 2020–December 2021. Centers for Disease Control and Prevention, National Center for Health Statistics. Accessed at: https://www.cdc.gov/nchs/data/nhis/earlyrelease/quarterly_estimates_2021_q14.pdf
43. Cohen, R.A.& Cha, A.E. (January 2023). Health insurance coverage: Early release of quarterly estimates from the National Health Interview Survey, July 2021–September 2022. Centers for Disease Control and Prevention, National Center for Health Statistics. Accessed at: https://www.cdc.gov/nchs/data/nhis/earlyrelease/quarterly_estimates_2022_q13.pdf
44. Cohen, R.A.& Cha, A.E. (January 2023). Health insurance coverage: Early release of quarterly estimates from the National Health Interview Survey, July 2021–September 2022. Centers for Disease Control and Prevention, National Center for Health Statistics. Accessed at: https://www.cdc.gov/nchs/data/nhis/earlyrelease/Quarterly_Estimates_2022_Q13.pdf
45. Centers for Medicare and Medicaid Services. (Feb 2023). October 2022 Medicaid & CHIP Enrollment Data Highlights, Accessed at: https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html
46. Issue Brief No. HP-2021-2. (October 2021). “Health Insurance Coverage and Access to Care Among Latinos: Recent Trends and Key Challenges” Washington, DC: Office of the Assistant Secretary for Planning and

Evaluation, U.S. Department of Health and Human Services. Accessed at: https://aspe.hhs.gov/reports/health-insurance-coverage-access-care-among-latinos
47. Lee A, Ruhter J, Bosworth A, Peters C, De Lew N, Sommers BD. (January 2023). Changes in Health Insurance Coverage from 2019 to 2021: Geographic and Demographic Patterns in the Uninsured Rate (Issue Brief No. HP-2023-01). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Accessed at: https://aspe.hhs.gov/sites/default/files/documents/c70c558101dae57f0946dc880499f71b/aspe-uninsured-2021-acs-ib.pdf
48. State and Local Estimates of the Uninsured Population in the U.S. Using the Census Bureau's 2021 American Community Survey. (Nov 18, 2022). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Accessed at: https://aspe.hhs.gov/reports/state-county-local-estimates-uninsured-population
49. Data Resource Center for Child & Adolescent Health. (n.d.). The 2020-2021 National Survey of Children's Health (NSCH) Combined Dataset Fast Facts. Accessed at: https://www.childhealthdata.org/docs/default-source/nsch-docs/2020-2021-nsch-fast-facts_cahmi_10-1-22.pdf?sfvrsn=78645c17_10
50. National Center for Health Statistics. Percentage of adults aged 18 and over who did not get needed medical care due to cost in the past 12 months, United States, 2019, Jan-Jun—2022, Jan-Jun. National Health Interview Survey. Accessed at: https://wwwn.cdc.gov/NHISDataQueryTool/SHS_adult/index.html
51. Centers for Disease Control and Prevention, National Center for Health Statistics. (Jan 2023). Health Insurance Coverage: Early Release of Quarterly Estimates From the National Health Interview Survey, July 202–September 2022. Accessed at: https://www.cdc.gov/nchs/data/nhis/earlyrelease/Quarterly_Estimates_2022_Q13.pdf
52. Flores, G., Lin, H., Walker, C. et al. The health and healthcare impact of providing insurance coverage to uninsured children: A prospective observational study. BMC Public Health 17, 553 (2017). Accessed at: https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-017-4363-z
53. Schubel, J. (June 14, 2021). Expanding Medicaid for Parents Improves Coverage and Health for Both Parents and Children. Center on Budget and Policy Priorities, Accessed at: https://www.cbpp.org/research/health/expanding-medicaid-for-parents-improves-coverage-and-health-for-both-parents-and
54. Hudson JL, Moriya AS. Medicaid Expansion For Adults Had Measurable 'Welcome Mat' Effects On Their Children. Health Aff (Millwood). 2017 Sep 1;36(9):1643-1651. Accessed at: https://pubmed.ncbi.nlm.nih.gov/28874493/
55. Sommers, B.D. Insuring children or insuring families: do parental and sibling coverage lead to improved retention of children in Medicaid and CHIP? J Health Econ. 2006 Nov;25(6):1154-69. Accessed at: https://pubmed.ncbi.nlm.nih.gov/16753234/
56. Health Insurance Coverage and Access to Care for Immigrants: Key Challenges and Policy Options (Issue Brief No. HP-2021-26). Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. December 2021. Accessed at: https://aspe.hhs.gov/reports/insurance-coverage-access-care-immigrants
57. Broaddus, M. (July 17, 2019). Research Note: Medicaid Enrollment Decline Among Adults and Children Too Large to Be Explained by Falling Unemployment. Center on Budget and Policy Priorities, Accessed at: https://www.cbpp.org/research/health/medicaid-enrollment-decline-among-adults-and-children-too-large-to-be-explained-by
58. Chu RC, Lee A, Peters C, and Sommers BD. (January 2022). Health Coverage Changes From 2020-2021. (Data Point No. HP-2022-05). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. https://aspe.hhs.gov/reports/health-coverage-changes-2020-2021
59. Alberto, C.K. & Sommers, B.D. "The Harmful Impacts of Anti-Immigrant Policies on Maternal and Child Health", American Journal of Public Health 112, no. 12 (December 1, 2022): pp. 1732-1734. Accessed at: https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2022.307122?role=tab
60. Churchwell, K., Elkind, M. S., et al. (2020). Call to action: structural racism as a fundamental driver of health disparities: a presidential advisory from the American Heart Association. American Heart Association, Circulation, 142(24), e454-e468. Accessed at: https://www.ahajournals.org/doi/10.1161/CIR.0000000000000936
61. Centers for Disease Control and Prevention, National Center for Health Statistics. (Jan 2023). Health Insurance Coverage: Early Release of Quarterly Estimates From the National Health Interview Survey, October 2020–December 2021. Accessed at: https://www.cdc.gov/nchs/data/nhis/earlyrelease/quarterly_estimates_2021_q14.pdf

62. Issue Brief No. HP-2021-2. (October 2021). "Health Insurance Coverage and Access to Care Among Latinos: Recent Trends and Key Challenges" Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Accessed at: https://aspe.hhs.gov/reports/health-insurance-coverage-access-care-among-latinos
63. Branham DK, Conmy AB, DeLeire T, Musen J, Xiao X, Chu RC, Peters C, and Sommers BD. (April 1, 2021). Access to Marketplace Plans with Low Premiums on the Federal Platform, Part II: Availability Among Uninsured Non-Elderly Adults Under the American Rescue Plan (Issue Brief No. HP-2021-08). Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Accessed at: https://aspe.hhs.gov/sites/default/files/private/pdf/265321/ASPE%2520ACA%2520Low%2520Premium%2520Plans%2520Issue%2520Brief%2520II.pdf
64. Internal Revenue Service (IRS), Treasury. (October 13, 2022). Affordability of Employer Coverage for Family Members of Employees., 87 FR 61979. https://www.federalregister.gov/documents/2022/10/13/2022-22184/affordability-of-employer-coverage-for-family-members-of-employees
65. Department of Health and Human Services. (September 28, 2022). HHS Approves Groundbreaking Medicaid Initiatives in Massachusetts and Oregon. Accessed at: https://www.hhs.gov/about/news/2022/09/28/hhs-approves-groundbreaking-medicaid-initiatives-in-massachusetts-and-oregon.html
66. Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches (Issue Brief HP-2022-20). (August 19, 2022). Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Accessed at: https://aspe.hhs.gov/sites/default/files/documents/60f0ac74ee06eb578d30b0f39ac94323/aspe-end-mcaid-continuous-coverage.pdf
67. Centers for Disease Control and Prevention. (February 2023). Youth Risk Behavior Survey Data Summary & Trends Report. Accessed at: https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS_Data-Summary-Trends_Report2023_508.pdf
68. Centers for Disease Control and Prevention. (October 24, 2022). Vaccines for Children Program. Accessed at: https://www.cdc.gov/vaccines/programs/vfc/index.html
69. Markit, I. (2021). The complexities of physician supply and demand: projections from 2019 to 2034. Washington, DC: AAMC. Accessed at: https://www.aamc.org/media/54681/download
70. Roth, E., Greene, K, & Fiscus, M. (July 25, 2022). Increasing Access to Routine Child Immunizations: State Approaches for Increasing Pharmacy Enrollment in the VFC Program. National Academy for State Health Policy. Accessed at: https://nashp.org/increasing-access-to-routine-child-immunizations-state-approaches-for-increasing-pharmacy-enrollment-in-the-vfc-program/
71. American Academy of Pediatrics. (April 15, 2020). Guidance on Providing Pediatric Ambulatory Services via Telehealth During COVID-19. Accessed at: https://www.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections2/guidance-on-providing-pediatric-ambulatory-services-via-telehealth-during-covid-19/
72. Swain, D.S. (May 2, 2022). Telehealth Services Start With Your Pediatrician. Healthychildren.org. Accessed at: https://www.healthychildren.org/English/family-life/health-management/Pages/Telehealth-Services-for-Children.aspx
73. Karimi, M., Lee, E.C., Couture, S.J., Gonzales, A.B., Grigorescu, V., Smith, S.R., De Lew, N., and Sommers, B.D. National Trends in Telehealth Use in 2021: Disparities in Utilization and Audio vs. Video Services. (Research Report No. HP-2022-04). Office of the Assistant Secretary for Planning and Evaluation, U. S. Department of Health and Human Services. February 2022. Accessed at: https://aspe.hhs.gov/sites/default/files/documents/4e1853c0b4885112b2994680a58af9ed/telehealth-hps-ib.pdf
74. Cox, C., Amin, K., & Kamal, R. (March 22, 2021). How have health spending and utilization changed during the coronavirus pandemic?. Petterson Kaiser Family Foundation Health System Tracker. Accessed at: https://www.healthsystemtracker.org/chart-collection/how-have-healthcare-utilization-and-spending-changed-so-far-during-the-coronavirus-pandemic/#item-covidhealthspendingutilizationcollection_5
75. Nguyen, K.H., Nguyen, K., Lekshmi, D., Corlin, L., Niska, R.W. Delays in Children's Preventive Health Services During the COVID-19 Pandemic. Fam Med. 2022;54(5):350-361. Accessed at: https://journals.stfm.org/familymedicine/2022/may/nguyen-2021-0392/
76. Kaiser Family Foundation. (July 26, 2022). 43% of Parents with Children Under 5 Newly Eligible for a COVID-19 Vaccine Say They Will "Definitely Not" Get Them Vaccinated. Accessed at: https://www.kff.org/coronavirus-

covid-19/press-release/43-of-parents-with-children-under-5-newly-eligible-for-a-covid-19-vaccine-say-they-will-definitely-not-get-them-vaccinated/
77. Flores, G., Lin, H., Walker, C. et al. The health and healthcare impact of providing insurance coverage to uninsured children: A prospective observational study. BMC Public Health 17, 553 (2017). Accessed at: https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-017-4363-z
78. Wherry, L.R., Kenney, G.M., Sommers, B.D. The Role of Public Health Insurance in Reducing Child Poverty. Acad Pediatr. 2016 Apr;16(3 Suppl):S98-S104. Accessed at: https://pubmed.ncbi.nlm.nih.gov/27044710/
79. Miller, S. & Wherry, L.R. (Jan 30, 2018). The Long-Term Effects of Early Life Medicaid Coverage. Journal of Human Resources 0816_8173R1. Accessed at: http://jhr.uwpress.org/content/early/2018/01/25/jhr.54.3.0816.8173R1.abstract
80. Department of Health and Human Services. (September 28, 2022). HHS Approves Groundbreaking Medicaid Initiatives in Massachusetts and Oregon. Accessed at: https://www.hhs.gov/about/news/2022/09/28/hhs-approves-groundbreaking-medicaid-initiatives-in-massachusetts-and-oregon.html

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Assistant Secretary for Planning and Evaluation

200 Independence Avenue SW, Mailstop 447D
Washington, D.C. 20201

For more ASPE briefs and other publications, visit:
aspe.hhs.gov/reports

ABOUT THE AUTHORS
Ann B. Conmy is an Analyst in the Office of Health Policy in the Office of the Assistant Secretary for Planning and Evaluation.
Christie Peters is the Director of the Division of Health Care Access and Coverage for the Office of Health Policy Office of the Assistant Secretary for Planning and Evaluation.
Nancy De Lew is the Acting Deputy Assistant Secretary for for the Office of Health Policy Office of the Assistant Secretary for Planning and Evaluation.
Benjamin D. Sommers is a Senior Counselor in the Office of the Assistant Secretary for Planning and Evaluation.

SUGGESTED CITATION
Conmy AB, Peters C, De Lew N, Sommers BD. Children's Health Coverage Trends: Gains in 2020-2022 Reverse Previous Coverage Losses. (Issue Brief No. HP-2023-07). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. March 2023

DISCLOSURE
This communication was printed, published, or produced and disseminated at U.S. taxpayer expense.

Subscribe to ASPE mailing list to receive email updates on new publications:
https://list.nih.gov/cgi-bin/wa.exe?SUBED1=ASPE-HEALTH-POLICY&A=1

For general questions or general information about ASPE: aspe.hhs.gov/about