



# Children's Uninsurance Fell between 2019 and 2021, but Progress Could Stall When Pandemic Protections Expire

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## Key Findings

The pandemic and associated job losses threatened to reduce employer-sponsored health insurance coverage and increase uninsurance among American families. Though such risks were higher for adults because of the long-standing generosity of public coverage policies for children, the severity and novelty of the pandemic also had the potential to exacerbate children's coverage losses that had occurred between 2016 and 2019 and to jeopardize decades of progress in reducing their uninsurance rate (Brooks et al. 2021; Haley et al. 2021). Here we explore changes in coverage status and type among children from birth to age 17 from 2019 to 2021. To do so, we use data from the National Health Interview Survey (NHIS) and the Current Population Survey (CPS) Annual Social and Economic Supplement and administrative data on children's enrollment in Medicaid and the Children's Health Insurance Program (CHIP) and Marketplace coverage through early 2022. We examine (1) changes between early 2019 and early 2021 to reflect the first year of the pandemic and the first round of pandemic recovery legislation passed in March 2020 and (2) changes from early 2021 through late 2021 and early 2022 to reflect continuing trends and initial responses to the second major federal recovery effort in March 2021. We find the following:

- Children's uninsurance rates were relatively stable between early 2019 and early 2021, according to both the NHIS and the CPS.
- Recent NHIS data suggest a decline in uninsurance among children between early and late 2021; no data are yet available for this period from the CPS.
- Overall, the NHIS indicates a decline in the annual uninsurance rate among children from 5.1 percent in 2019 to 4.1 percent in 2021, which translates to about 700,000 fewer uninsured children.

- Both survey and administrative data sources suggest public coverage increased among children between early 2019 and early 2021.
  - » The NHIS indicates a significant 4.9 percentage-point increase in public coverage and a roughly corresponding decline in private coverage over the period.
  - » Changes in coverage on the CPS are much smaller in magnitude and not statistically significant but suggest offsetting public coverage gains and private coverage losses between March 2019 and March 2021.
  - » Administrative data show that approximately 4 million more children were enrolled in Medicaid/CHIP in March 2021 than in March 2019.
- Administrative data indicate further gains in Medicaid/CHIP and Marketplace enrollment among children between early 2021 and early 2022.

Policies such as the continuous coverage provision in the Families First Coronavirus Response Act (FFCRA), which has prohibited states from disenrolling people from Medicaid during the COVID-19 public health emergency since March 2020, appear to have limited the pandemic's effects on children's coverage rates. Enhanced Marketplace subsidies under the American Rescue Plan Act (ARPA), passed in March 2021, and other economic recovery efforts seem to have further protected children's insurance coverage. Together, these provisions may have even contributed to a decline in uninsurance by the end of 2021. The decline in children's uninsurance observed on the NHIS is remarkable given the economic downturn, and if it is confirmed by other federal surveys, policymakers will have a better understanding of which policies can successfully mitigate coverage losses during recessions. But without federal and state actions to maintain the enhanced Marketplace subsidies and limit coverage losses when the continuous coverage requirement expires, children's uninsurance could once again increase in 2022 and beyond (Alker and Brooks 2022; Buettgens and Green 2022).

## Background

Building on decades of coverage gains, the uninsurance rate among children had reached a historic low by 2016. This significant progress is partially attributable to the Affordable Care Act (ACA) Medicaid expansion and federally subsidized Marketplaces (Haley, Kenney, Wang, Pan, et al. 2018; Karpman, Kenney, and Gonzalez 2018; Kenney et al. 2016a, 2016b, 2017; Lukanen, Schwehr, and Fried 2019; McMorrow and Kenney 2018). Starting in 2017, likely owing to federal and state policy changes, some of these gains were reversed, and hundreds of thousands more children had become uninsured by 2019. However, children still remained much more likely than parents and other adults to have coverage (Haley et al. 2021).

In part, lower uninsurance among children owes to much more generous Medicaid/CHIP eligibility rules than those for adults. In 2019, the median state extended Medicaid/CHIP eligibility to children with family incomes up to 255 percent of the federal poverty level (FPL), and 19 states extended eligibility to those with family incomes at or above 300 percent of FPL. That same year the median eligibility threshold for adults was just 138 percent of FPL in states that had adopted the ACA Medicaid

expansion, whereas eligibility was often below half the FPL for parents in the states that had not expanded Medicaid.<sup>1</sup> Further, nondisabled, nonpregnant adults without dependent children in nonexpansion states had few pathways for eligibility at any income level. Immigration-related rules also remained less restrictive for children than for most adults (Brooks, Roygardner, and Artiga 2019). In addition, among those who qualify for Medicaid/CHIP, participation is much higher for children than for parents; an estimated 93.7 percent of children who were eligible for Medicaid/CHIP and had no other coverage were enrolled in 2019 (Haley et al. 2021).

When the pandemic began, many people worried that steep increases in unemployment would result in losses of employer-sponsored insurance and therefore increase uninsurance rates among workers and their families, consistent with trends during prior recessions (Banthin and Holahan 2020; Banthin et al. 2020; Garrett and Gangopadhyaya 2020; Holahan and Chen 2011). However, Congress implemented several policies intended to reduce coverage losses during the pandemic. In March 2020, the FFCRA implemented the continuous coverage requirement, which prohibited state Medicaid programs from disenrolling people during the public health emergency (unless they move out of state or request to disenroll) in exchange for enhanced federal funding. This requirement applied to both traditional Medicaid and Medicaid-expansion CHIP programs but not separate CHIP programs.<sup>2</sup> By temporarily eliminating regular reassessments of eligibility, this policy was expected to reduce “churn,” or transitions in and out of coverage, which can occur when family circumstances change or when enrollees cannot complete reenrollment requirements despite still being eligible for coverage (Corallo et al. 2021; Osorio and Alker 2021). The ARPA, enacted in March 2021, included additional efforts to enhance the affordability of coverage, such as increases in the size of Marketplace premium subsidies.

Data-collection difficulties related to the pandemic, such as disruptions in procedures for federal surveys, have complicated efforts to measure changes in coverage since 2019 (Ruhter et al. 2021). Some evidence from the US Census Bureau’s Household Pulse Survey showed an increase in uninsurance among adults early in the pandemic (Bundorf, Gupta, and Kim 2021; Gangopadhyaya, Karpman, and Aarons 2020). However, recent evidence from the NHIS, the CPS, and the Urban Institute’s Health Reform Monitoring Survey suggests the uninsurance rate among nonelderly adults remained relatively flat between early 2019 and early 2021, with gains in public coverage offsetting losses of private coverage (McMorrow et al. 2022). However, because some of the most timely data sources for tracking insurance during the pandemic exclude children, including the Household Pulse Survey and the Health Reform Monitoring Survey, available information on children’s coverage during the pandemic has been limited.

In this study, we assess changes in health insurance coverage status and type among children between 2019 and early 2022. First we use two federal surveys, the NHIS and the CPS, to track changes in coverage between early 2019 and early 2021. This period captures the first year of the pandemic and the first round of recovery legislation, including the FFCRA. We then present administrative data on enrollment in Medicaid and Marketplace coverage from early 2019 through early 2022. This period captures the second year of the pandemic and the second round of recovery legislation in March 2021, including the ARPA. Finally, we use the most recent data from the NHIS on children’s uninsurance

through the end of 2021 to capture changes in uninsurance in the second year of the pandemic. We conclude with a discussion of our findings' implications for policy, especially as pandemic protections in the FFCRA and the ARPA expire.

## Data and Methods

This analysis examines health insurance coverage for children from birth to age 17. We rely on data from two nationally representative surveys: the NHIS and the CPS. We chose these surveys because each provides point-in-time coverage estimates for early 2019 and early 2021. This allows us to explore coverage trends over the first year of the pandemic from multiple sources without relying on 2020 survey estimates, which likely suffered the most significant data-collection challenges and nonresponse bias related to the pandemic (Dahlhamer et al. 2021; Stewart 2021).

The NHIS is the principal source of information on the nation's health, providing nationally representative estimates for the noninstitutionalized civilian population. We use publicly reported estimates from the 2019 and 2021 NHIS Early Release Program, which produces nationally representative estimates for each calendar-year quarter (Cohen and Cha 2020, 2021; Terlizzi and Cohen 2022). The estimates include the shares of children with any public, any private, and no health insurance coverage at the time of the survey. Public coverage includes Medicaid, CHIP, Medicare, military health plans, and other government- or state-sponsored coverage. Private coverage includes employer-sponsored insurance and insurance purchased directly, through local or community programs, or through the federal or state-based Marketplaces. People can report multiple coverage types, and those identified as uninsured report no comprehensive public or private coverage. Following a redesign in 2019, the survey has approximately 2,300 responses each quarter for a randomly selected child, where present, from each family surveyed. According to NHIS population estimates, there were approximately 73.0 million children ages 17 and younger in 2019.<sup>3</sup>

The CPS is a nationally representative survey of the noninstitutionalized civilian population conducted by the Census Bureau and the Bureau of Labor Statistics that serves as the primary source of monthly US labor force statistics. In addition to the demographic and labor force data the survey collects monthly, the CPS Annual Social and Economic Supplement (ASEC), fielded between February and April, collects detailed data on health insurance coverage, income, work experience, noncash benefits, and migration. Most of the ASEC data are collected in March. The ASEC samples more than 90,000 households annually, providing information on about 47,000 children in 2019 and about 42,000 in 2021.

The ASEC, redesigned in 2014, asks about health insurance coverage at the time of the survey and during the prior calendar year. Though published Census Bureau reports emphasize estimates for the prior year, our analysis focuses on coverage at the time of the survey for consistency with the NHIS. ASEC respondents can report more than one coverage type for themselves and the other members of their households. In this brief, we focus on the shares of children reporting any private coverage (defined as employment-based coverage or nongroup coverage purchased either directly or through the

Marketplaces and excluding coverage through the military), any public coverage (defined as Medicaid, CHIP, and other means-tested programs; Medicare; and TRICARE, CHAMPVA, or Veterans Affairs health care), and no coverage at the time of the survey. Though the Census Bureau classifies TRICARE as private coverage, we classify it as public coverage in this analysis for consistency with the published estimates from the NHIS.

Because we do not have access to 2021 NHIS microdata, we use the 95 percent confidence intervals provided in the NHIS Early Release reports to assess the statistical significance of changes on the NHIS. We classify estimates for 2021 as statistically different from those for 2019 at the 5 percent level if the 95 percent confidence interval for the 2021 estimate does not contain the 2019 estimate.<sup>4</sup> For the CPS, we use the March supplement weight and replicate weights to account for the complex survey design and to calculate standard errors. We then use two-tailed tests to assess whether changes in coverage between 2019 and 2021 were statistically significant.

We also rely on administrative estimates of Medicaid/CHIP and Marketplace coverage to provide additional context for interpreting patterns in the population-based surveys. The Centers for Medicare & Medicaid Services (CMS) provides monthly Medicaid/CHIP enrollment counts for all states and the District of Columbia, which are based on information submitted by each state's Medicaid/CHIP agency. The monthly child Medicaid/CHIP enrollment estimates in this brief represent the number of children enrolled in Medicaid and/or CHIP programs and who receive comprehensive benefits at a point in time.<sup>5</sup> States' definitions of "child" vary; all states' counts include children up to age 19 but some may include 19- and 20-year-olds. In addition, these data do not include all states and the states included vary slightly over time; data before May 1, 2019, exclude Arizona and Tennessee, and data reported on or after May 1, 2019, exclude Arizona. CMS also provides information on the number of people enrolled in Marketplace coverage. For the purposes of this brief, we use an analysis by Osorio that focuses on plan selections for children from birth to age 17 during the annual open enrollment period.<sup>6</sup> Plan selections differ from monthly effectuated enrollment, which reflects people who have an active Marketplace policy and have paid any required premiums, but effectuated enrollment estimates are not available for children.

## Limitations

This analysis has several limitations; some predate the public health emergency and others were directly caused by it. First, comparing coverage estimates across surveys always presents challenges. The surveys vary in the timing of their data collection; their classifications of specific coverage types into public and private categories; and their designs, including question order and mode of data collection, which yield uninsurance estimates that differ in magnitude (SHADAC 2022). We also note long-standing underestimates of Medicaid/CHIP enrollment in survey data relative to administrative data, known as the "Medicaid undercount."<sup>7</sup>

In addition, Marketplace enrollment estimates for children are imprecise. As noted above, we report plan selections for children, but some people who select a plan during the open enrollment

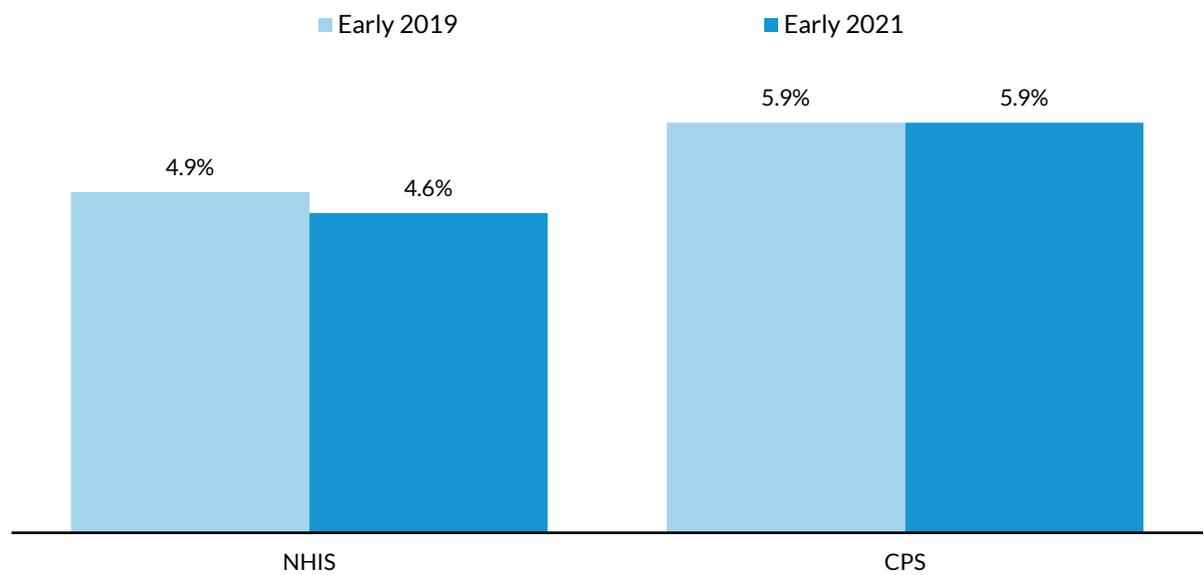
period do not make their required premium payments and their coverage does not become effective. Thus, estimates of Marketplace enrollment among children may be lower than discussed here.

We do not report 2020 survey data to avoid the worst effects of the pandemic on data collection, but some nonresponse bias may linger into 2021 on all surveys. Our analysis is further limited because data from 2021 are not yet available from other major surveys of US health insurance coverage, including the American Community Survey (Daily et al. 2021), the Medical Expenditure Panel Survey, and the National Survey of Children’s Health. Lastly, despite our best efforts to produce comparable estimates, all survey data are self-reported and subject to measurement error.

## Results

Neither the NHIS nor the CPS showed statistically significant changes in children’s uninsurance between early 2019 and early 2021 (figure 1). Uninsurance rates on the CPS were 5.9 percent for both early 2019 and early 2021, whereas uninsurance rates on the NHIS were 4.9 percent in early 2019 and 4.6 percent in early 2021. Similarly, uninsurance among adults varied little over the same period (McMorrow, et al. 2022).<sup>8</sup>

**FIGURE 1**  
**Uninsurance Rate among Children from Birth to Age 17, by Survey, Early 2019 and Early 2021**



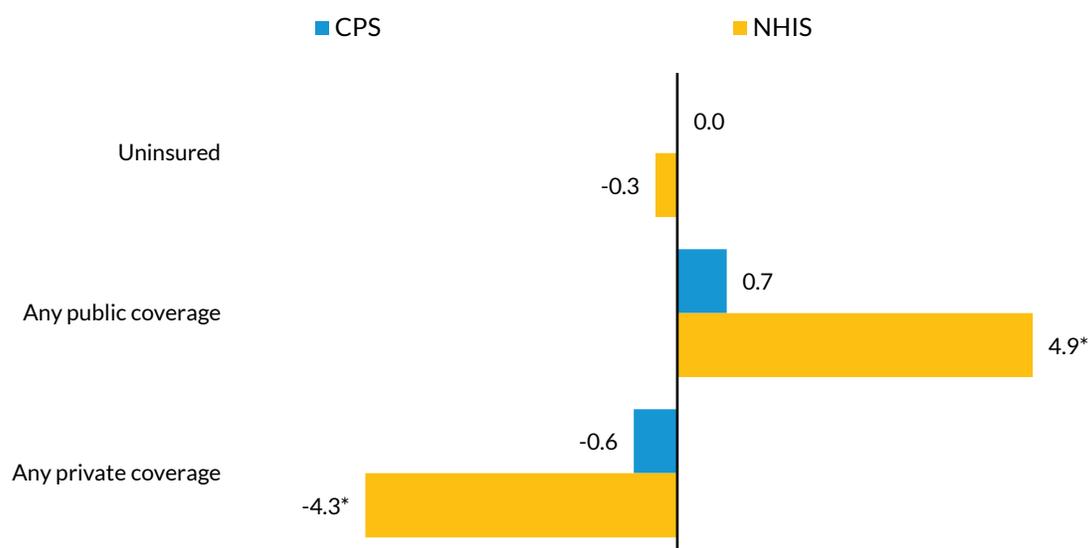
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**Source:** Authors’ analysis of National Health Interview Survey and Current Population Survey Annual Social and Economic Supplement data.

**Notes:** NHIS = National Health Interview Survey. CPS = Current Population Survey. Coverage status is at the time of the survey in the first quarter (NHIS) or February to April (CPS) of the survey year.

Though uninsurance remained relatively stable among children between early 2019 and early 2021, both surveys show an increase in public coverage and a similar and corresponding decrease in private coverage over the period (figure 2). The NHIS reports a 4.9 percentage-point increase in public coverage and a 4.3 percentage-point decrease in private coverage between early 2019 and early 2021, both of which are statistically significant. On the CPS, the differences are much smaller and not statistically significant: an estimated 0.7 percentage-point increase in public coverage and a 0.6 percentage-point decrease in private coverage.<sup>9</sup>

**FIGURE 2**  
**Percentage-Point Change in Coverage Type between Early 2019 and Early 2021 among Children from Birth to Age 17, by Survey**



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**Source:** Authors’ analysis of National Health Interview Survey and Current Population Survey Annual Social and Economic Supplement data.

**Notes:** CPS = Current Population Survey. NHIS = National Health Interview Survey. Coverage status is at the time of the survey in the first quarter (NHIS) or February to April (CPS) of the survey year. “Any public coverage” includes enrollment in Medicaid, the Children’s Health Insurance Program, and other public or means-tested programs; Medicare; and TRICARE, CHAMPVA, or Veterans Affairs health care. “Any private coverage” refers to enrollment in employment-based coverage or nongroup coverage purchased either directly or through the Marketplaces. Respondents can report multiple coverage types.

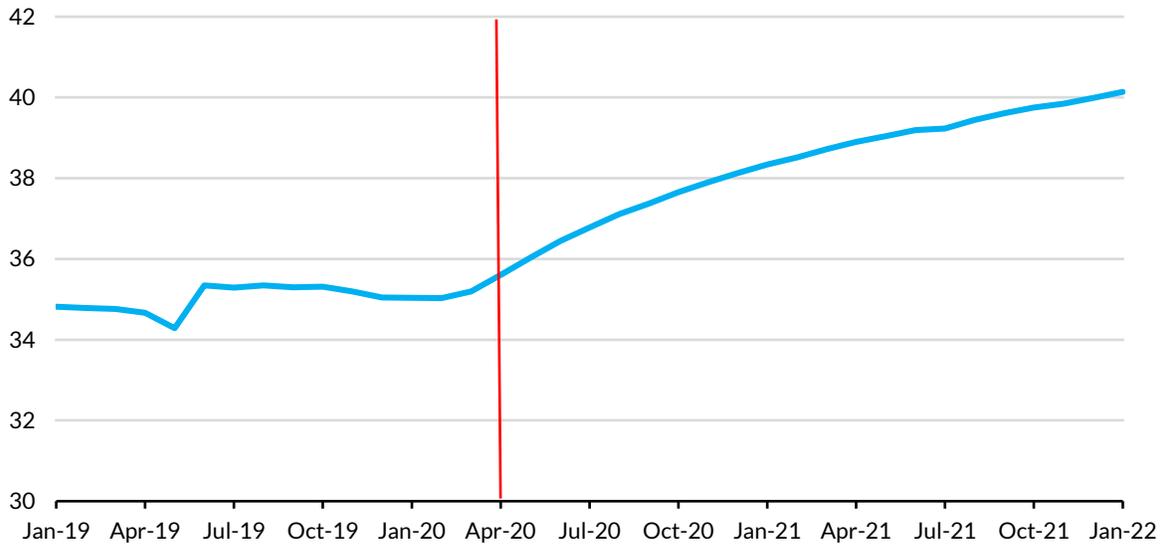
\* Estimate is statistically different from zero ( $p < 0.05$ ).

CMS recorded an increase of nearly 4 million children enrolled in Medicaid/CHIP from March 2019 to March 2021, and much of the increase occurred after the Medicaid continuous coverage requirement was enacted in the FFCRA in March 2020 (figure 3).<sup>10</sup> These enrollment numbers are relatively consistent with the implied increase of 3.6 million children with any public coverage between early 2019 and 2021 derived using the estimated 4.9 percentage-point increase in public coverage among 73 million children from birth to age 17 from the NHIS.

FIGURE 3

**Monthly Medicaid/CHIP Enrollment among Children from Birth to Age 17, January 2019 to January 2022**

Millions of children



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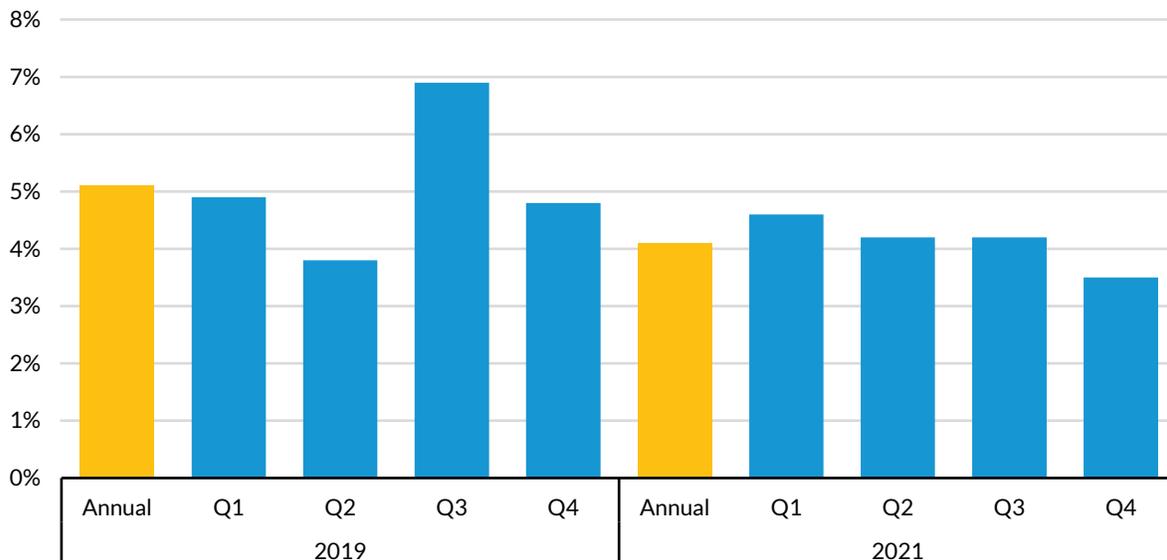
**Source:** Centers for Medicare & Medicaid Services (CMS) state Medicaid and Children’s Health Insurance Program applications, eligibility determinations, and enrollment data for 2019 to 2022.

**Notes:** CHIP = Children’s Health Insurance Program. The red line indicates the implementation of the FFCRA continuous coverage requirement. Enrollment totals reflect preliminary enrollment reports submitted by states to CMS. Data before May 1, 2019, exclude Arizona and Tennessee; data reported on or after May 1, 2019, exclude only Arizona. The definition of children’s Medicaid/CHIP, including age ranges for defining children, varies by state.

Since early 2021, child Medicaid/CHIP enrollment has continuously increased; total child enrollment increased by 1 million between March 2021 and January 2022 and topped 40 million in January 2022. Some evidence also shows an increase in Marketplace enrollment among children during the 2022 open enrollment period. An analysis of CMS data found that 2022 plan selections for children from birth to age 17 increased by about 300,000 compared with 2021.<sup>6</sup> This increase followed the introduction of the ARPA enhanced Marketplace subsidy schedule in March 2021. Plan selections are only reported for the annual open enrollment period, but additional data on monthly effectuated enrollment totals indicate Marketplace enrollment began to increase in 2021, during the special enrollment period that ran from February through August (McMorrow et al. 2022). Though effectuated enrollment data are not available for children, plan selection data indicate children have represented a similar share of plan selections over time.<sup>11</sup> If the same pattern holds for effectuated enrollment, this would suggest children’s Marketplace enrollment also started increasing following the introduction of the enhanced subsidies and the 2021 special enrollment period.

FIGURE 4

Annual and Quarterly Uninsurance Rates among Children from Birth to Age 17, 2019 and 2021



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**Source:** National Health Interview Survey Early Release estimates for 2019 and 2021.

**Notes:** Figure shows coverage status at the time of the survey. Annual, Q3, and Q4 estimates for 2019 and 2021 are statistically different at  $p < 0.05$ . The difference between Q1 and Q4 2021 estimates is also statistically different at  $p < 0.05$ .

The most recent NHIS data suggest these gains in Medicaid and Marketplace enrollment during 2021 may have helped reduce the uninsurance rate among children from 4.6 percent in the first quarter to 3.5 percent in the fourth quarter of the year (figure 4). Though the quarterly uninsurance rates in 2019 show more variability than those in 2021, the trends suggest stability in uninsurance between the first half of 2019 and the first half of 2021 and a decline in uninsurance between the second half of 2019 and the second half of 2021. Moreover, the annual uninsurance rate among children declined from 5.1 percent in 2019 to 4.1 percent in 2021, which translates to about 700,000 fewer uninsured children in 2021. Still, an estimated 3 million children remained uninsured that year, according to the NHIS.<sup>12</sup>

## Discussion

This analysis suggests children's uninsurance remained stable during the first year of the pandemic, with private coverage losses offset by increases in public coverage. Administrative data suggest an increase in Medicaid/CHIP enrollment of approximately 4 million children between March 2019 and March 2021, and estimates from the NHIS suggest public coverage gains of a similar magnitude. Between early 2021 and early 2022, children's Medicaid enrollment continued to grow and their enrollment in the Marketplaces also appeared to increase. These enrollment gains likely contributed to the decline in uninsurance among children between the first and last quarters of 2021 observed on the NHIS. Ultimately, these patterns resulted in a decrease in children's annual uninsurance rate from 5.1 percent in 2019 to 4.1 percent in 2021, or about 700,000 fewer uninsured children.

As previously noted, the decline in children’s uninsurance observed on the NHIS is remarkable given the economic downturn, and if it is confirmed by other federal surveys, policymakers will have a better understanding of which policies can successfully mitigate coverage losses during economic downturns. Several federal policy responses to the pandemic likely contributed to these coverage patterns, which have not been observed during previous downturns. First, in March 2020, Congress took the unprecedented step of implementing a continuous coverage requirement that required states to maintain Medicaid enrollment for all beneficiaries in exchange for an increased federal matching rate. The observed increases in Medicaid/CHIP enrollment among children and adults since March 2020 clearly indicate that millions of Americans benefitted from this policy. In March 2021, Congress passed the ARPA, which expanded access to federal subsidies to purchase insurance in the Marketplace and enhanced existing subsidies for Americans with lower incomes. The Biden administration also announced a special enrollment period from February through August 2021, during which people could purchase Marketplace coverage with these enhanced subsidies before the next scheduled open enrollment period began in November 2021. CMS found that more than 2.8 million people enrolled in Marketplace coverage during this period.<sup>13</sup> Along with other supports provided through recovery legislation, these two policies likely helped stabilize coverage for adults and children alike and helped avoid the dramatic increases in uninsurance feared at the start of the pandemic. For children, the continuous coverage requirement was especially important given that the share of children covered by Medicaid/CHIP is much larger than the share with Marketplace coverage.

This stability is now at risk, however. The continuous coverage requirement will expire at the end of the public health emergency, which if not renewed again, will occur as early as fall of 2022. After that, states will resume eligibility verifications, and because more than three-quarters of Medicaid/CHIP-enrolled children are covered by Medicaid (MACPAC 2020), most child enrollees will be affected, potentially threatening the coverage of millions of children (Alker and Brooks 2022).<sup>14</sup> Nearly two-thirds of children who could lose Medicaid are likely eligible for CHIP or Marketplace subsidies (Buettgens and Green 2021), but connecting these children to other coverage sources and ensuring smooth hand-offs to the Marketplaces will be critical. This may be especially important in states with less generous Medicaid/CHIP eligibility policies, where children will be more likely to qualify for Marketplace coverage (Alker and Brooks 2022).

States can also work to minimize unnecessary coverage losses among children who still qualify for Medicaid and CHIP by

- maximizing automatic renewals;
- maintaining sufficient workforce and consumer assistance capabilities;
- using up-to-date contact information, using multiple modes to reach families for needed information, and following up with families as needed;
- and working with managed-care organizations, providers, navigators, and community-based organizations to assist families as they renew coverage (Alker and Brooks 2022).

Though the expiration of the continuous coverage requirement is expected to affect far more people, and especially more children, failure to continue the enhanced Marketplace subsidies beyond 2022 also poses coverage risks. A new analysis suggests more than 3 million people could become uninsured in 2023 if the enhanced subsidies expire, and even more families will see their Marketplace premiums increase (Buettgens, Banthin, and Green 2022). An earlier analysis found that if the enhanced Marketplace subsidies expire, approximately 303,000 children and 686,000 parents could lose coverage, and an estimated 4.5 million families with children would see premium increases of 28 percent per person (McMorrow et al. 2022). Without federal action, states could take steps to help minimize coverage losses and affordability problems if the subsidies expire,<sup>15</sup> such as supplementing the federal subsidies for all enrollees or targeting specific groups hardest hit by the expiration of the federal policy. In addition, states could support more outreach and enrollment assistance to ensure people eligible for affordable premiums do not remain uninsured.

Pandemic policies' success in stabilizing and even strengthening children's insurance coverage is impressive, but without additional efforts, children's uninsurance could once again increase later in 2022 or in 2023. Beyond the actions described above to extend the enhanced Marketplace subsidies and limit coverage losses when the continuous coverage requirement expires, many additional opportunities to maintain or expand children's coverage exist, including

- increasing enrollment and retention among Medicaid/CHIP-eligible children (Alker, Kenney, and Rosenbaum 2020; Michener 2021; Sullivan et al. 2021),
- adopting continuous Medicaid/CHIP eligibility policies for children to avoid coverage gaps (First Focus on Children 2021),<sup>16</sup>
- expanding Medicaid to parents in nonexpansion states to further support family coverage (Hudson and Moriya 2017), and
- fixing the "family glitch" to improve coverage affordability for families (Buettgens and Banthin 2021).<sup>17</sup>

Together, these and other policies would help ensure children and families do not lose access to health insurance coverage as the economic recovery continues.

## Notes

- <sup>1</sup> Moreover, income eligibility levels for parents are often defined as specific dollar amounts that effectively fall as the FPL rises (Brooks et al. 2021).
- <sup>2</sup> Medicaid enrollment and Medicaid-expansion CHIP enrollment among children vastly outnumber separate CHIP enrollment (MACPAC 2020).
- <sup>3</sup> This is consistent with "POP1 Child Population: Number of Children (in Millions) Ages 0–17 in the United States by Age, 1950–2020 and Projected 2021–2050," ChildStats.gov, accessed June 7, 2022, <https://www.childstats.gov/americaschildren/tables/pop1.asp>.

- 4 For all significant differences in this analysis, it is also true that the 95 percent confidence interval for the 2019 estimate does not contain the 2021 estimate.
- 5 "State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data: Preliminary Monthly Enrollment Reports, January 2019-January 2022," Data.Medicaid.gov, accessed June 7, 2022, [https://data.medicaid.gov/dataset/6165f45b-ca93-5bb5-9d06-db29c692a360/data?conditions%5b0%5d%5bproperty%5d=report\\_date&conditions%5b0%5d%5bvalue%5d=2018-12-01&conditions%5b0%5d%5boperator%5d=%3E&conditions%5b1%5d%5bproperty%5d=preliminary\\_updated&conditions%5b1%5d%5bvalue%5d=P&conditions%5b1%5d%5boperator%5d=%3D](https://data.medicaid.gov/dataset/6165f45b-ca93-5bb5-9d06-db29c692a360/data?conditions%5b0%5d%5bproperty%5d=report_date&conditions%5b0%5d%5bvalue%5d=2018-12-01&conditions%5b0%5d%5boperator%5d=%3E&conditions%5b1%5d%5bproperty%5d=preliminary_updated&conditions%5b1%5d%5bvalue%5d=P&conditions%5b1%5d%5boperator%5d=%3D).
- 6 Aubrianna Osorio, "More Children Enrolled in ACA Marketplace Coverage in 2022, but Marketplaces Still Remain Modest Source of Health Coverage for Children," *Say Ahhh!* (blog), Georgetown University Health Policy Institute, Center for Children and Families, April 21, 2022, <https://ccf.georgetown.edu/2022/04/21/more-children-enrolled-in-aca-marketplace-coverage-in-2022/>.
- 7 Lacey Hartman, "Understanding the Undercount of Medicaid Enrollees in the 2020 Current Population Survey Health Insurance Coverage Data," State Health Access Data Assistance Center, April 6, 2022, <https://www.shadac.org/news/understanding-undercount-medicaid-enrollees-2020-current-population-survey-health-insurance>.
- 8 Estimated uninsurance rates vary across surveys for many reasons (SHADAC 2022). In 2021, children's uninsurance rate appeared somewhat higher on the CPS than on the NHIS, whereas adults' uninsurance rate was higher on the NHIS than on the CPS and the Health Reform Monitoring Survey (McMorrow et al. 2022). All three surveys consistently find little change in uninsurance for adults from 2019 to 2021.
- 9 An analysis using the March 2019 and March 2021 CPS measures of coverage over the prior year also found no statistically significant changes in children's full-year uninsurance rate between 2018 and 2020 (Keisler-Starkey and Bunch 2021). Using that measure, Keisler-Starkey and Bunch found a statistically significant decline in any private coverage and a statistically significant increase in any public coverage for people of all ages. But the magnitude of the changes in public coverage for the point-in-time measure for children and the prior-year measure for all ages do not align with the increase in public coverage as estimated in administrative data and the NHIS.
- 10 The FFCRA requirement included both Medicaid and Medicaid-expansion CHIP but excluded separate CHIP coverage. However, administrative counts included here combine these three coverage pathways.
- 11 Centers for Medicare & Medicaid Services, "Health Insurance Marketplaces 2022 Open Enrollment Report," January 15, 2022, <https://www.cms.gov/files/document/health-insurance-exchanges-2022-open-enrollment-report-final.pdf>.
- 12 CPS estimates indicate approximately 4.3 million children were uninsured in 2021.
- 13 Centers for Medicare & Medicaid Services, "Biden-Harris Administration Announces Record-Breaking 12.2 Million People Are Enrolled in Coverage through the Health Care Marketplaces," news release, September 15, 2021, <https://www.cms.gov/newsroom/press-releases/biden-harris-administration-announces-record-breaking-122-million-people-are-enrolled-coverage>.
- 14 Joan Alker, "Secretary Becerra Will Extend the PHE Again, What Does This Mean for Medicaid's Continuous Coverage Protections?" *Say Ahhh!* (blog), Georgetown University Health Policy Institute, Center for Children and Families, May 18, 2022, <https://ccf.georgetown.edu/2022/05/18/secretary-becerra-will-extend-the-phe-again-what-does-this-mean-for-medicaids-continuous-coverage-protections/>.
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<sup>16</sup> Joan Alker and Aubrianna Osorio, “Why Is Medicaid/CHIP Continuous Eligibility So Important for Kids?” *Say Ahhh!* (blog), Georgetown University Health Policy Institute, Center for Children and Families, October 8, 2021, <https://ccf.georgetown.edu/2021/10/08/why-is-medicaid-chip-continuous-eligibility-so-important-for-kids/>.

<sup>17</sup> *Affordability of Employer Coverage for Family Members of Employees*, 87 Fed. Reg. 20354 (Apr. 7, 2022).

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