

RESEARCH REPORT

Assessing Health Care Access among Medicaid/CHIP-Enrolled Children

A National Chartbook, 2016–19

Jennifer Haley

Stacey McMorrow

Julia Long

Genevieve M. Kenney

Emily M. Johnston

Carla Willis

Kristen Brown

April 2023



ABOUT THE URBAN INSTITUTE

The Urban Institute is a nonprofit research organization that provides data and evidence to help advance upward mobility and equity. We are a trusted source for changemakers who seek to strengthen decisionmaking, create inclusive economic growth, and improve the well-being of families and communities. For more than 50 years, Urban has delivered facts that inspire solutions—and this remains our charge today.

Contents

Acknowledgments	iv
Assessing Health Care Access among Medicaid/CHIP-Enrolled Children	1
Background	5
Results	8
Children’s Unmet Needs and Reported Challenges Accessing Care	8
Variation in Experiencing Access Problems across Subgroups	15
Co-Occurring Access Challenges	27
Material and Financial Hardships and Other Public Program Enrollment	36
Discussion	43
Appendix. Data and Methods	49
Notes	64
References	67
About the Authors	71
Statement of Independence	73

Acknowledgments

This report was funded by the J. B. and M. K. Pritzker Family Foundation. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute's funding principles is available at urban.org/fundingprinciples.

The authors thank Heather Hahn and Kelly Whitener for helpful comments and Liza Hagerman and Lauren Lastowka for excellent editorial assistance.

Assessing Health Care Access among Medicaid/CHIP-Enrolled Children

Following decades of expansions in children’s eligibility for Medicaid and the Children’s Health Insurance Program (CHIP) and efforts to enroll eligible children, by 2018, uninsured rates among children had declined substantially and more than a third of children younger than age 19 were served by public programs at some point during the year (Berchick, Barnett, and Upton 2019). Relative to being uninsured, children’s Medicaid/CHIP coverage has long been found to be associated with better access to care, greater utilization of health services, and improved health outcomes, with benefits that extend to later in life in health, educational attainment, and financial stability (Boudreaux et al. 2016; Brown, Kowalski, and Lurie 2015; Cohodes et al. 2014. Goodman-Bacon 2021; Howell and Kenney 2012; Lipton et al. 2016; MACPAC 2021; Miller and Wherry 2018; Thompson 2017; Wagnerman, Chester, and Alker 2017; Wherry et al. 2018).¹ However, being enrolled in Medicaid/CHIP coverage alone does not ensure that children receive high quality, timely, affordable, evidence-based care for all of their health needs in ways that are accessible and culturally effective for them and their families.

Medicaid/CHIP coverage is comprehensive and includes no or generally low cost-sharing, but barriers such as lack of participating providers because of insufficient provider payments, inadequate access to specialty and mental health care services, and language and transportation issues may keep enrolled children from obtaining the care they need (Bishop et al. 2014; Children’s Health Fund 2016; MACPAC 2011; Petersen and Miller 2016; Zero to Three and CLASP 2022). As a consequence, racial, ethnic, socioeconomic, and other disparities in access to and receipt of high-quality care may exist among enrolled children (Keet et al. 2017; MACPAC 2016).

In this chartbook, we assess health care services receipt, unmet needs for care, and challenges families report with obtaining care for children covered by Medicaid/CHIP. We present both national and regional patterns, identify the subgroups of children who are at highest risk of not receiving needed care, and explore other material hardships and public benefits use.

We use data from the 2016–19 National Survey of Children’s Health (NSCH) and 2016–18 National Health Interview Survey (NHIS) (see table A.1 in the appendix).² We rely on these two national surveys to capture a variety of health care access and material hardship measures among Medicaid/CHIP-enrolled children because they capture different dimensions that are relevant to our study questions. We find several patterns that are consistent across both surveys, adding credence to the findings. Overall, we find that most Medicaid/CHIP-enrolled children are obtaining key preventive health services and that relatively few are reported to have unmet needs. But some are not receiving basic preventive care or are reported to experience access barriers, with particular subgroups at higher risk of facing these access issues. Key takeaways from our analysis of Medicaid/CHIP-enrolled children in the 2016–19 period are as follows:

- Medicaid/CHIP programs across the country appear to be providing access to health care for most children’s basic needs, with more than three-quarters receiving preventive medical and dental care in a 12-month period, and very few covered by the programs were reported to have unmet needs for health services.
- Overall, about 4 in 10 Medicaid/CHIP-enrolled children faced at least one observed barrier to accessing care. Some children were reported to have more than one of these issues.
 - » An estimated 40.1 percent of children ages 2 to 17 experienced one of four access challenges identified in the NSCH, and 38.7 percent of children ages 2 to 17 experienced one of six access challenges identified in the NHIS.
 - » Among children experiencing an access barrier in the NSCH, most reported experiencing only one (77.7 percent), while 19.6 percent reported experiencing two of the four barriers and 2.7 percent reported experiencing three or more.
 - » Medicaid/CHIP-enrolled children had significantly higher rates of access barriers than privately insured children on all four measures identified in the NSCH and all six measures identified in the NHIS. After adjusting for observed differences in characteristics such as self-reported health status and race and ethnicity, differences in rates of access barriers between Medicaid/CHIP-enrolled children and privately insured children in both surveys were smaller, and in the NSCH, fewer differences were statistically significant.
 - » Medicaid/CHIP-enrolled children had significantly lower rates of access barriers compared with uninsured children all four measures identified in the NSCH and all six measures identified in the NHIS. The magnitude and statistical significance of all but one of these differences remained after adjusting for observed differences in the characteristics of these two groups.

- According to both surveys, relatively few Medicaid/CHIP-enrolled children were reported to have unmet needs for health care in the prior 12 months.
 - » According to the 2016–19 NSCH, 4.0 percent of Medicaid/CHIP-enrolled children ages 17 and under had at least one unmet need for care.
 - » According to the 2016–18 NHIS, 8.2 percent of Medicaid/CHIP-enrolled children ages 2 to 17 had some sort of unmet need for care because of cost (most commonly dental care).
- Some Medicaid/CHIP-enrolled children had parents who reported noncost delays in obtaining needed care for their children (with 12.0 percent of children ages 2 to 17 in the NHIS experiencing office-based delays and 3.4 percent experiencing transportation-related delays) and always or usually experiencing frustration when trying to obtain care (3.7 percent of children in the NSCH).
- Though most Medicaid/CHIP-enrolled children were reported to receive regular preventive medical and dental care within a 12-month period, 22.2 percent of children ages 17 and under had not received a preventive medical visit and 19.1 percent of children ages 2 to 17 had not received a preventive dental visit in the past 12 months, according to the NSCH. And according to the NHIS, 15.0 percent of children had not had a well-child visit and 15.8 percent had not had a dental visit in the past 12 months.
- Several subgroups of Medicaid/CHIP-enrolled children were at higher risk of experiencing access problems, according to one or both of the data sources we analyzed.
 - » Groups reported to have higher unmet needs included adolescents, Black children, children in fair or poor health, children living with a single parent, noncitizens, children with a foreign-born parent, and children who experienced a period without coverage in the past year. Children who are Hispanic,³ Asian American/Pacific Islander, and American Indian/Alaskan Native, as well as noncitizens and children with non-English-speaking or foreign-born parents were at higher risk of having received no preventive medical and/or dental visits.
- Medicaid/CHIP-enrolled children experiencing access barriers were also more likely than those not experiencing barriers to report other access challenges. For example, according to the NSCH, more than half of children with health-related expenses whose parents also reported they had an unmet need experienced problems paying for medical care, and more than 40 percent of children without a preventive medical visit and of those without a preventive dental visit did not have at least one personal doctor or nurse.

- Though most families of Medicaid/CHIP-enrolled children also participated in at least one other public program such as free or reduced-price meals in school or daycare, the Supplemental Nutrition Assistance Program (SNAP), and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), many also reported other material or financial hardships, including finding it hard to cover basic needs and food insecurity.
 - » For example, more than a third of Medicaid/CHIP-enrolled children were in families where it was very or somewhat hard to cover basic needs, according to the NSCH, and more than 1 in 5 Medicaid/CHIP-enrolled children ages 2 to 17 were in families experiencing low or very low food security, according to the NHIS.
 - » Rates of hardships were generally higher among Medicaid/CHIP-enrolled children also facing access challenges. For instance, among children with unmet needs on the NSCH, almost two-thirds had parents who reported it was somewhat or very hard to cover the basics. In the NHIS, nearly half of children with unmet needs because of cost were in families experiencing low or very low food security.

This analysis indicates that the majority of Medicaid/CHIP-enrolled children were receiving preventive care visits and that few Medicaid/CHIP-enrolled children were reported to have unmet needs. However, it also suggests that such needs co-occur with a variety of other access challenges and that other barriers delay receipt of care or frustrate parents when they try to obtain needed care for their children. Further, although according to both surveys more than three-quarters of Medicaid/CHIP-enrolled children received preventive care in the past year, this rate falls below recommendations by the American Academy of Pediatrics and Bright Futures that all children have an annual preventive medical visit.⁴ And the rate in the NSCH and for some subgroups in both surveys falls below the Centers for Medicare & Medicaid Services' (CMS's) goal of 80 percent of such children obtaining well-child screenings (GAO 2019). In addition, while some children have parents who report their health needs are met, even when they are not accessing ongoing preventive care, missed preventive visits could mean that underlying health problems are undiagnosed and that children's health care needs are not being detected and addressed in a timely way. Thus, some children reported to not have unmet needs may have additional needs of which their parents are unaware. Importantly, the data sources we use provide a general assessment of access among Medicaid/CHIP-enrolled children overall and do not allow for an assessment of how well Medicaid and CHIP programs are specifically meeting the health needs of children with chronic or acute needs, serious mental health needs, or who are medically fragile. Other research would be needed to explore concerns about access to specialty or other care for these children (Kuo et al. 2022).

Access gaps can have important adverse implications for children’s future health, educational success, and development. Changes to Medicaid/CHIP policies, including increases in targeted outreach, will likely be needed to improve service delivery systems and support families in accessing care for their children, especially for the subgroups facing larger challenges.

Background

Expansions in children’s eligibility for Medicaid and CHIP in recent decades have increased the share of children who have health insurance (Paradise 2014). Medicaid and CHIP eligibility is much more expansive for children than for parents or other adults. The median state covered children with family incomes up to 255 percent of the federal poverty level (FPL), or \$54,000 per year for a family of three in 2019, while the median state’s eligibility threshold for adults was 138 percent of FPL. State income eligibility thresholds for children ranged from a low of no more than 200 percent of FPL in two states to 300 percent of FPL or higher in 19 states. In that same year, 34 states allowed Medicaid/CHIP coverage for lawfully residing immigrant children without a five-year waiting period, and six states and the District of Columbia covered all children regardless of immigration status, but eligibility restrictions for most noncitizen adults were much stricter (Brooks, Roygardner, and Artiga 2019). Efforts to expand eligibility and enroll eligible children have been fairly successful; more than 9 in 10 eligible children without other coverage were enrolled in Medicaid/CHIP in 2019 (Haley et al. 2021), and overall, more than a third of all children, the majority of children living in or near poverty, and nearly half of children with disabilities or special other health care needs were covered by Medicaid/CHIP in the prepandemic period (Brooks and Whitener 2017; Rudowitz, Garfield, and Hinton 2019).

States’ coverage programs for children are operated through both Medicaid and CHIP (CHIP programs can be an expansion of Medicaid, a separate program, or a combination of the two) and most receive services through managed care organizations (Rudowitz, Garfield, and Hinton 2019). Medicaid’s Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit guarantees access to the full range of physical, dental, vision, hearing, and mental health services that children need, including evaluations to monitor development and diagnose and treat problems.⁵ Many CHIP programs have also adopted EPSDT standards, meaning most CHIP-eligible children also qualify for the full range of comprehensive benefits (Brooks and Whitener 2017). Moreover, costs for enrollees are generally very low; premiums are prohibited for those with incomes below 150 percent of FPL, and cost-sharing is minimal and prohibited for certain services (including preventive services) and for children in families with incomes below 133 percent of FPL (Brooks, Roygardner, and Artiga 2019).

Research on access to care among Medicaid/CHIP-enrolled children suggests that Medicaid/CHIP coverage, compared with uninsurance, is associated with better access to care and greater utilization of health services, as well as improved health, educational, and economic well-being later in life (Boudreaux et al. 2016; Brown, Kowalski, and Lurie 2015; Howell and Kenney 2012; MACPAC 2021; Miller and Wherry 2018; Thompson 2017; Wagnerman, Chester, and Alker 2017; Wherry et al. 2018).⁶

But some services remain more difficult to access, and financial and nonfinancial barriers prevent some families from obtaining needed care for children (Bishop et al. 2014; Children’s Health Fund 2016; Petersen and Miller 2016; Zero to Three and CLASP 2022). Such barriers can be related to provider availability and participation, perceptions of provider quality, affordability, and language and transportation barriers when navigating service delivery systems (MACPAC 2011). For instance, research has highlighted low provider payment rates that reduce participation of providers, including specialists and mental health providers, in Medicaid (Decker 2012; Zuckerman and Goin 2012; Zuckerman, Skopec, and McCormack 2014; Zuckerman, Williams, and Stockley 2009). Regulations issued in 2016 require that states using managed care organizations to deliver services for Medicaid and CHIP enrollees develop and monitor strategies to maintain access such as through pediatric provider network standards and time and distance requirements to providers (CMS 2017). In addition, CMS provides oversight on states’ implementation of EPSDT benefits, finding that very few states meet CMS’s goal of 80 percent of child enrollees receiving recommended well-child screenings. State reporting indicates that in 2017 slightly more than half of children who should have received well-child screenings did so, with older beneficiaries at higher risk of not obtaining such care, and that fewer than half received preventive dental care (GAO 2019). In addition to challenges related to balancing work, child care, and other logistical issues that may inhibit families’ capacity to obtain health care for their children, parents may face knowledge barriers and other challenges accessing ongoing preventive medical and dental care despite evidence of the need for such care to identify and treat problems before they develop or worsen (Zero to Three and CLASP 2022; CMS 2013). Families also face other challenges such as navigating a lack of coordinated care across different providers and systems.⁷

Moreover, enrolling in Medicaid/CHIP does not guarantee a child is continuously covered. States can choose to adopt 12-month continuous eligibility for children,⁸ such that families do not have to undergo periodic renewal screenings and children remain covered even if a family’s income changes during the year. However, not all states have adopted this option, and even during renewals that occur annually, children can become disenrolled because of families’ challenges completing renewal processes. In 2018, more than 1 in 10 Medicaid/CHIP-enrolled children had been disenrolled and subsequently reenrolled within a 12-month period, a phenomenon known as coverage churn, leading to

periods without coverage and likely reducing access to care among those who are not continuously enrolled (Corallo et al. 2021). Further, specific subgroups of children may face additional access challenges related to parents' language abilities; availability of providers that are located nearby, convenient to reach, and that provide culturally competent care; and other family circumstances that may affect how easily they can obtain care for their children.

In this chartbook, we use data from the 2016–19 period to assess access barriers for children enrolled in Medicaid/CHIP nationally and by subgroup and region. This period was a time of volatility in Medicaid/CHIP coverage, as some states instituted more frequent eligibility checks and more burdensome paperwork requirements; immigration-related concerns led some immigrant families to forego public benefits; federal application and enrollment assistance was reduced; and, in 2017, reauthorization of CHIP funding was delayed (Brooks, Park, and Roygardner 2019). We use this time frame to have a sufficient sample size across multiple data years and to exclude pandemic-era data years during which access patterns were likely atypical. Medicaid/CHIP coverage patterns have shifted since then as a result of the pandemic and related policy changes. The Families First Coronavirus Response Act (FFCRA) included a continuous enrollment requirement that prohibited states from disenrolling beneficiaries during the federal public health emergency; children's Medicaid/CHIP enrollment grew by more than 6 million between February 2020 and August 2022.⁹ At the same time, new access challenges likely arose during the pandemic related to office closures, virus exposure concerns, and other disruptions to daily life (McMorrow et al. 2020).¹⁰ As the nation recovers from the most disruptive period of the pandemic, prepandemic data can reveal barriers to accessing care that families were experiencing before these disruptions and offer insights about changes that state Medicaid/CHIP programs could make in policy and practice to better serve enrolled children.

The chartbook consists of a series of tables and figures drawn from NSCH and NHIS data. We rely on these two national surveys to capture a variety of health care access and material hardship measures among Medicaid/CHIP-enrolled children because they capture different dimensions that are relevant to our research questions. As discussed in the appendix, each data source has different strengths and weaknesses, and there are notable differences in the universes, question structure, timing, and identification of Medicaid/CHIP-enrolled children in these two data sources, so differences in estimates across the two data sources are to be expected. Nonetheless, we find several patterns that are consistent across both surveys, adding credence to the findings. We conclude with a description of some key patterns that emerge from the analysis and policy implications. The appendix includes descriptions of the two data sources and study methodology, as well as detailed tables. This report is part of a larger project focused on Illinois, identifying and assessing strategies for increasing family

economic stability and opportunity in the state (Giannarelli et al. 2023; Giannarelli, Minton, and Wheaton 2023; Hahn, Pratt, and Knowles 2023), and an accompanying report focuses on some of the access issues discussed here specifically for Medicaid/CHIP-enrolled children in Illinois (Haley et al. 2023).

Results

Below we present estimates from our descriptive analysis of service use, unmet needs for care, and challenges families report with obtaining care for children covered by Medicaid/CHIP—including identifying the characteristics of children who appear to be at highest risk of not receiving needed care and assessing other access issues, material hardships, and benefits use families report. Estimates from the 2016–19 NSCH focus on all enrolled children ages 17 and under nationally, except when considering access to dental care, or any barrier, where we focus only on children ages 2 to 17. Because several NHIS measures focused only on children ages 2 to 17, all NHIS analyses focus on enrolled children nationally who are in this age range.

Children’s Unmet Needs and Reported Challenges Accessing Care

According to both the NSCH and NHIS, relatively few Medicaid/CHIP-enrolled children were reported to have unmet needs for health care in the prior 12 months, but about 4 in 10 Medicaid/CHIP-enrolled children in each survey faced at least one challenge accessing care.

TABLE 1

Unmet Health Service Needs, Utilization of Selected Services, and Frustration Obtaining Health Care in the Prior 12 Months, Children Ages 17 and Under, by Insurance Coverage Status, 2016–19

	All Children		Medicaid/CHIP-Enrolled Children		Privately Insured Children		Uninsured Children	
	Rate	Count (1,000s)	Rate	Count (1,000s)	Rate	Count (1,000s)	Rate	Count (1,000s)
Unmet needs for care								
<i>Reported any unmet need for services, past 12m</i>	3.0%	2,117	4.0%	986	1.7%*	688	10.1%*	443
<i>Type of unmet needs</i>								
Unmet need, medical care	1.0%	702	1.3%	318	0.4%*	163	5.1%*	221
Unmet need, dental care	1.6%	1,110	2.0%	503	0.7%*	293	7.2%*	314
Unmet need, vision care	0.6%	431	0.8%	201	0.2%*	80	3.4%*	150
Unmet need, hearing care	0.2%	140	0.3%	79	0.1%*	28	0.8%	33
Unmet need, mental health care	0.9%	629	1.2%	301	0.6%*	252	1.7%	76
Unmet need, other	0.3%	235	0.5%	122	0.2%*	83	0.7%	30
<i>Reasons for unmet needs</i>								
Unmet need, not eligible for services	0.9%	664	1.3%	327	0.4%*	145	4.4%*	192
Unmet need, no services available in your area	0.7%	504	1.3%	311	0.3%*	113	1.8%	80
Unmet need, problems getting an appointment	1.2%	814	2.0%	485	0.5%*	223	2.4%	106
Unmet need, problems getting transportation or child care	0.4%	296	0.8%	193	0.1%*	58	1.0%	44
Unmet need, clinic or office not open when care was needed	0.4%	263	0.6%	151	0.1%*	57	1.3%	56
Unmet need, cost reasons	1.8%	1,248	1.9%	471	1.1%*	438	7.8%*	339
Use of preventive medical care, past 12m								
Two or more preventive medical visits, past 12m	31.6%	22,153	37.0%	9,175	29.3%*	12,004	22.3%*	973
One preventive medical visit, past 12m	48.6%	34,102	40.8%	10,122	55.5%*	22,773	27.7%*	1,207
One or more medical visits, no preventive medical visits, past 12m	3.2%	2,268	3.2%	786	3.1%	1,256	5.2%*	227
No medical visits at all, past 12m	16.6%	11,671	19.0%	4,712	12.2%*	5,007	44.8%*	1,952
No preventive medical visits, past 12m	19.9%	13,939	22.2%	5,498	15.3%*	6,262	50.0%*	2,179
Use of preventive dental care, past 12m								
Two or more preventive dental visits, past 12m (among children ages 2 to 17)	48.6%	30,535	41.2%	9,070	55.2%*	20,351	28.2%*	1,114
One preventive dental visit, past 12m (among children ages 2 to 17)	34.6%	21,719	39.8%	8,766	31.7%*	11,672	32.4%*	1,281

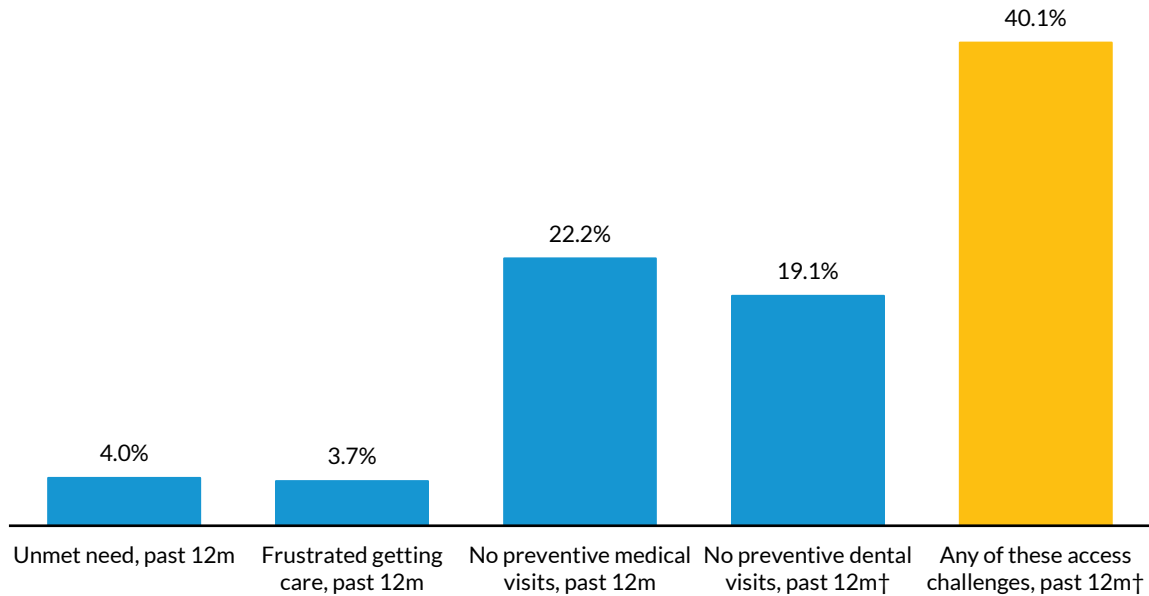
	All Children		Medicaid/CHIP-Enrolled Children		Privately Insured Children		Uninsured Children	
	Rate	Count (1,000s)	Rate	Count (1,000s)	Rate	Count (1,000s)	Rate	Count (1,000s)
One or more dental visits, no preventive dental visits, past 12m (among children ages 2 to 17)	2.5%	1,585	3.2%	707	1.9%*	705	4.4%*	173
No dental visits at all, past 12m (among children ages 2 to 17)	14.3%	9,000	15.9%	3,497	11.2%*	4,118	35.0%*	1,386
<i>No preventive dental visits, past 12m (among children ages 2 to 17)</i>	16.8%	10,585	19.1%	4,204	13.1%*	4,823	39.4%*	1,559
Parental frustration when trying to get care for child, past 12m								
<i>Parent always or usually felt frustrated when trying to get care for child, past 12m</i>	2.6%	1,831	3.7%	923	1.4%*	579	7.6%*	329
Parent <i>always</i> felt frustrated when trying to get care for child, past 12m	1.0%	694	1.3%	328	0.5%*	195	4.0%*	172
Parent <i>usually</i> felt frustrated when trying to get care for child, past 12m	1.6%	1,137	2.4%	595	0.9%*	384	3.6%*	157
Parent <i>sometimes</i> felt frustrated when trying to get care for child, past 12m	14.5%	10,182	18.5%	4,614	11.4%*	4,694	20.2%	874
Parent <i>never</i> felt frustrated when trying to get care for child, past 12m	82.9%	58,314	77.7%	19,342	87.2%*	35,840	72.3%*	3,132
<i>Any of the above bolded and italicized access challenges, past 12m (among children ages 2 to 17)</i>	34.6%	21,450	40.1%	8,677	27.8%*	10,129	68.9%*	2,644

Source: Authors' analysis of the National Survey of Children's Health, 2016–19.

Notes: 12m = 12 months. CHIP = Children's Health Insurance Program. Coverage is measured at time of survey. * indicates significantly different from rate for children enrolled in Medicaid/CHIP, at the $p < 0.05$ level. "Any of the above bolded and italicized access challenges, past 12m" include reported any unmet need for services, had no preventive medical visits at all, had no preventive dental visits at all, and parent always or usually felt frustrated when trying to get care for child. More than one type of or reason for unmet need can be reported. "All Children" includes all children except those missing information on insurance coverage.

FIGURE 1

Unmet Health Service Needs, Frustration Obtaining Health Care, and Utilization of Selected Services in the Prior 12 Months, Medicaid/CHIP-Enrolled Children Ages 17 and Under, 2016–19



URBAN INSTITUTE

Source: Authors' analysis of the National Survey of Children's Health, 2016–19

Notes: 12m = 12 months. CHIP = Children's Health Insurance Program. Coverage is measured at time of survey. "Unmet need" refers to those who reported any unmet need for services, past 12m. "Frustrated getting care" refers to those whose parent reported always or usually feeling frustrated when trying to get care for their child, past 12m. †Indicates measure is among children ages 2 to 17.

- According to the NSCH, in 2016–19, relatively few Medicaid/CHIP-enrolled children were reported to have unmet needs for care for any reason in the prior 12 months. An estimated 4.0 percent of Medicaid/CHIP-enrolled children were reported to have any unmet need for medical, dental, vision, hearing, mental health, and/or other services (table 1; figure 1). The highest reported unmet need was dental care (2.0 percent).
- The most common reasons parents reported their child did not receive needed care were problems getting appointments (2.0 percent) and cost (1.9 percent).
- Though most Medicaid/CHIP-enrolled children had received preventive medical and preventive dental visits, 22.2 percent had received no preventive medical visits and 19.1 percent of those ages 2 to 17 had received no preventive dental visits in the past year—rates that were significantly higher than for privately insured US children.

- Some parents also reported frustrations when trying to get care for their Medicaid/CHIP-enrolled children; 3.7 percent of children had parents who reported always or usually feeling frustrated, and another 18.5 percent were sometimes frustrated. These are significantly higher rates than for privately insured US children on average (1.4 percent and 11.4 percent, respectively).
- Overall, 40.1 percent of Medicaid/CHIP-enrolled children ages 2 to 17 reported at least one of these four access challenges (an unmet need for services, parents who always or usually felt frustrated when trying to get care for the child, no preventive medical care, or no preventive dental care), higher than for privately insured children (27.8 percent) and lower than for uninsured children (68.9 percent).
- As noted, privately insured children overall had fewer access barriers than Medicaid/CHIP-enrolled children. However, when adjusting for differences in the characteristics of privately insured children and Medicaid/CHIP-enrolled children, differences in medical and dental preventive care use and experiencing any of the four barriers were no longer significant (appendix table A.4). Differences in unmet need and frustration getting care were still significant, but smaller. See the appendix for more details.
- Rates of all four of the access barriers we examined were at least twice as high for uninsured children than for those with Medicaid/CHIP coverage, with 10.1 percent of uninsured children reported to have unmet needs for care, half not receiving any preventive medical visits, nearly 4 in 10 not receiving any dental visits, and 7.6 percent having parents who reported always or usually feeling frustrated when trying to obtain care for the child. The magnitude and significance of these differences relative to Medicaid/CHIP-enrolled children remained similar after adjusting for differences in characteristics (appendix table A.4).

TABLE 2

Rates of Access Challenges in the Prior 12 Months among Children Ages 2 to 17, by Insurance Coverage Status, 2016–18

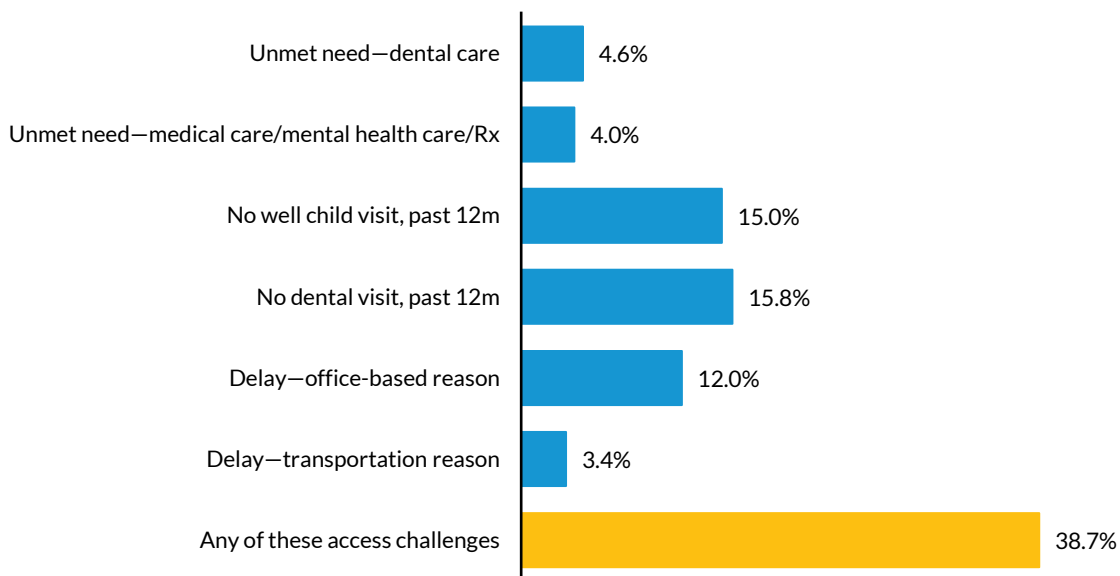
	All Children (Ages 2–17)		Medicaid/CHIP- Enrolled Children (Ages 2–17)		Privately Enrolled Children (Ages 2– 17)		Uninsured Children (Ages 2–17)	
	Rate	Count (1,000s)	Rate	Count (1,000s)	Rate	Count (1,000s)	Rate	Count (1,000s)
Any unmet need because of cost, past 12m	7.2%	4,726	8.2%	1,966	4.8%*	1,758	26.6%*	915
Unmet need—medical care	1.4%	892	1.0%	234	0.8%	290	10.2%*	353
Unmet need—Rx drugs	1.8%	1,184	2.4%	580	0.9%*	348	6.9%*	239
Unmet need—mental health	1.0%	624	1.1%	255	0.7%*	272	2.7%*	92
Unmet need—vision	1.7%	1,118	1.9%	450	1.1%*	402	6.8%*	646
Unmet need—dental	4.4%	2,893	4.6%	1,102	3.0%*	1,100	18.8%*	235
Unmet need—medical care/mental health care/Rx	3.5%	2,303	4.0%	950	2.1%*	788	15.4%*	530
Usual source of care	95.2%	62,607	95.4%	22,797	97.3%*	35,901	72.7%*	2,515
Any noncost delay getting care, past 12m	9.6%	6,287	14.0%	3,329	6.7%*	2,482	10.4%*	360
Delay—office-based reason	8.7%	5,686	12.0%	2,863	6.6%*	2,418	9.3%*	322
Delay—getting through on phone	1.8%	1,202	2.8%	670	1.1%*	390	3.6%	126
Delay—wait for appointment	4.7%	3,086	6.6%	1,564	3.6%*	1,328	4.4%*	152
Delay—office hours	2.7%	1,738	3.3%	782	2.3%*	855	2.4%	83
Delay—wait in office	3.5%	2,321	5.6%	1,340	2.2%*	804	4.1%	143
Delay—transportation reason	1.6%	1,032	3.4%	803	0.3%*	128	2.0%*	69
No well child visit, past 12m	15.3%	9,916	15.0%	3,553	12.9%*	4,723	43.6%*	1,485
No dental visit, past 12m	14.8%	9,639	15.8%	3,740	11.9%*	4,385	39.8%*	1,352
Problem finding a provider	1.8%	793	2.5%	394	1.2%*	293	4.0%	93
Could not find a provider	0.4%	188	0.5%	72	0.2%	60	2.2%*	50
Any of the above bolded access challenges, past 12m	34.6%	22,406	38.7%	9,143	29.2%*	10,665	65.2%*	2,207

Source: Authors' analysis of the National Health Interview Survey, 2016–18.

Notes: 12m = 12 months. CHIP = Children's Health Insurance Program. Coverage is measured at time of survey. All unmet needs are because of cost in the past 12 months. All noncost delays are in past 12 months. Office-based delays include trouble getting through on phone, long wait for appointment, long wait in the office, and inconvenient office hours. Problem finding a provider was not asked in 2018. * indicates share among privately insured children or uninsured children is statistically different from share among Medicaid/CHIP-enrolled children at the $p < 0.05$ level.

FIGURE 2

Rates of Access Challenges in the Prior 12 Months among Medicaid/CHIP-Enrolled Children Ages 2 to 17, 2016–18



URBAN INSTITUTE

Source: Authors' analysis of the National Health Interview Survey, 2016–18.

Notes: 12m = 12 months. CHIP = Children's Health Insurance Program. Coverage is measured at time of survey. All unmet needs are because of cost in the past 12 months. All noncost delays are in past 12 months. Office-based delays include trouble getting through on phone, long wait for appointment, long wait in the office, and inconvenient office hours. Problem finding a provider was not asked in 2018.

- According to the 2016–18 NHIS, 8.2 percent of Medicaid/CHIP-enrolled children ages 2 to 17 had some sort of unmet need for care because of cost in the past 12 months (table 2). The most common type was dental care (4.6 percent), followed by prescription drugs (2.4 percent), vision care (1.9 percent), mental health care (1.1 percent), and medical care (1.0 percent). A combined 4.0 percent had an unmet need for medical care, mental health care, or prescription drugs (figure 2).
- Many more children were reported to have noncost delays getting care, including 12.0 percent who had any office-based delays, including waiting for appointments (6.6 percent), wait time in the office (5.6 percent), accessing care during open office hours (3.3 percent), and/or getting through on the phone (2.8 percent), and 3.4 percent who had a transportation-related delay.
- Similar shares of Medicaid/CHIP-enrolled children had not received a preventive medical visit in the past 12 months (15.0 percent) and had not seen a dentist for any reason in the past year (15.8 percent).

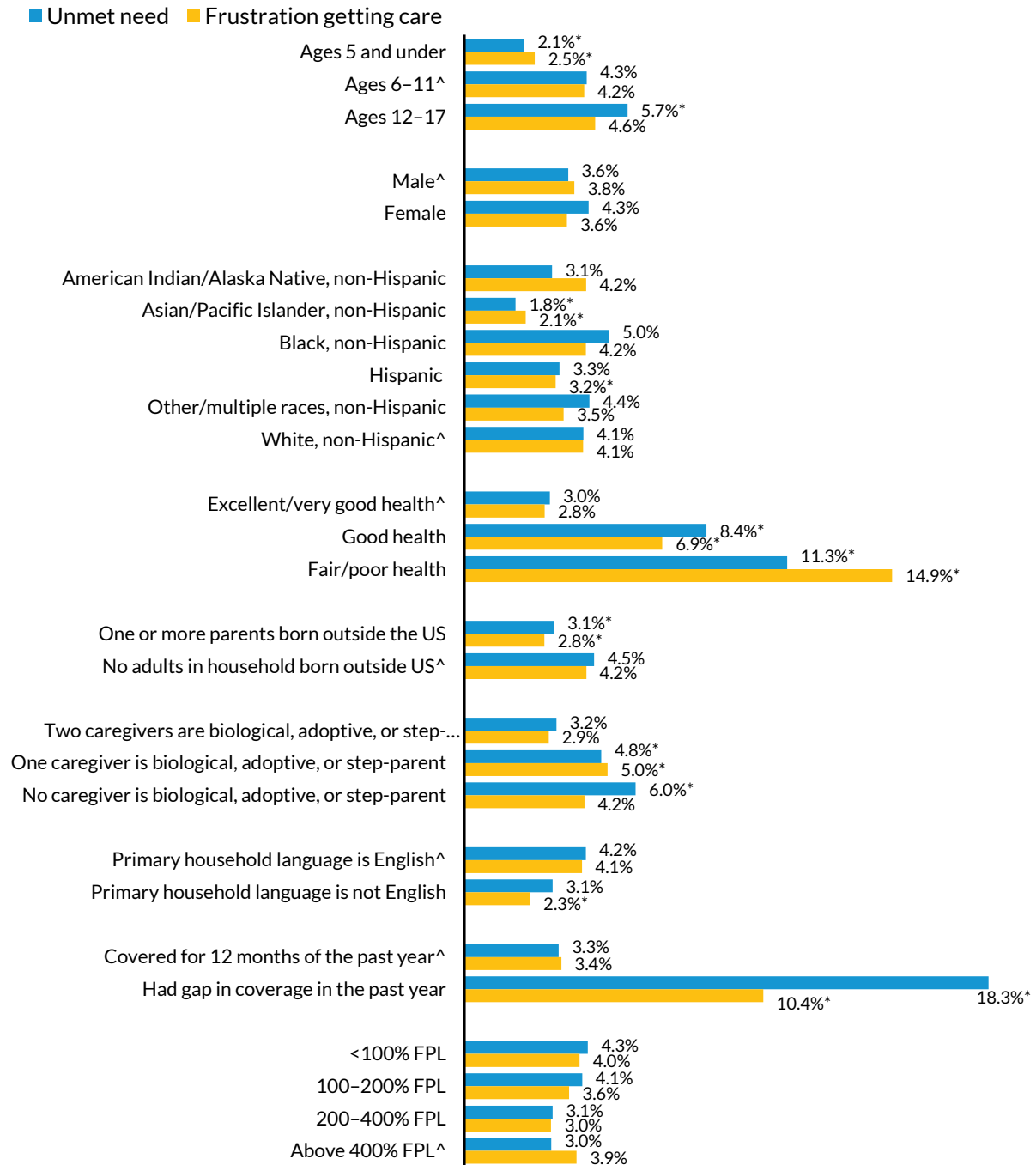
- Overall, nearly 4 in 10 (38.7 percent) Medicaid/CHIP-enrolled children ages 2 to 17 had at least one of these six access challenges (unmet need for medical care, mental health care, or prescription drugs because of cost; unmet need for dental care because of cost; noncost delays related to office-based reasons; noncost delays related to transportation reasons; no preventive medical visit; and/or no dental visit; figure 2).
- Children ages 2 to 17 enrolled in Medicaid/CHIP were more likely than privately insured children ages 2 to 17 to experience at least one access challenge (38.7 percent versus 29.2 percent) and to report each individual challenge alone. After accounting for demographic differences between Medicaid/CHIP and privately enrolled children, differences shrank slightly but remained significant (appendix table A.5).
- Medicaid/CHIP-enrolled children were much less likely to experience at least one of these challenges than uninsured children (38.7 percent versus 65.2 percent), and rates of several individual challenges were also significantly lower than for uninsured children—differences that remained after accounting for socioeconomic and demographic differences between Medicaid/CHIP-enrolled and uninsured children.

Variation in Experiencing Access Problems across Subgroups

Several subgroups of children were at higher risk of experiencing access problems, according to one or both of the data sources we analyzed.

FIGURE 3

Rates of Unmet Health Service Needs and Frustration Getting Care in the Prior 12 Months by Selected Characteristics of Medicaid/CHIP-Enrolled Children Ages 17 and Under, 2016–19



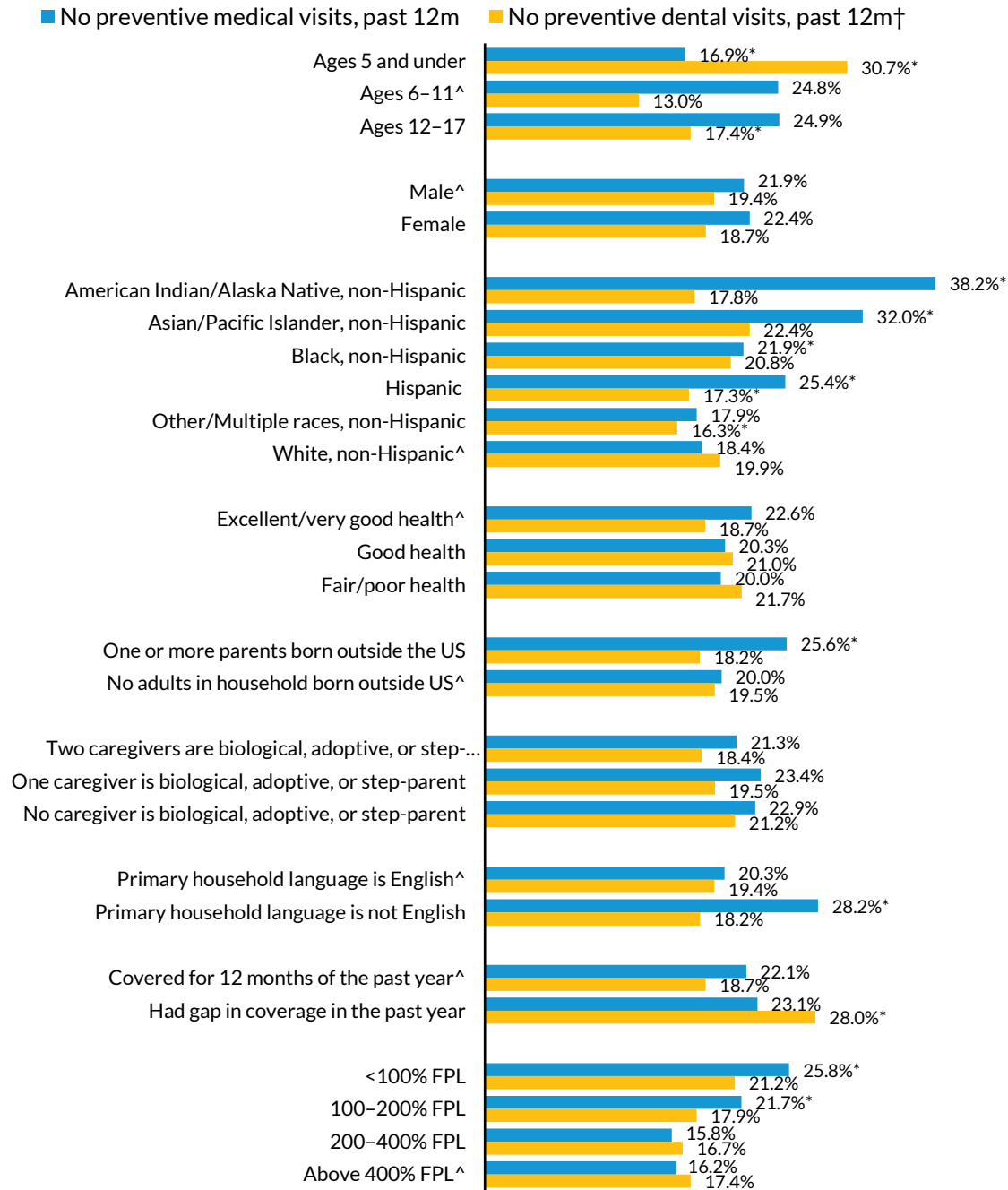
URBAN INSTITUTE

Source: Authors' analysis of the National Survey of Children's Health, 2016–19.

Note: CHIP = Children's Health Insurance Program. Coverage is measured at time of survey. FPL = federal poverty level. "Unmet need" refers to those who reported any unmet need for services in the past 12 months. "Frustrated getting care" refers to those

whose parent reported always or usually feeling frustrated when trying to get care for their child in the past 12 months.* indicates estimate is significantly different from reference group (^) at the $p < 0.05$ level.

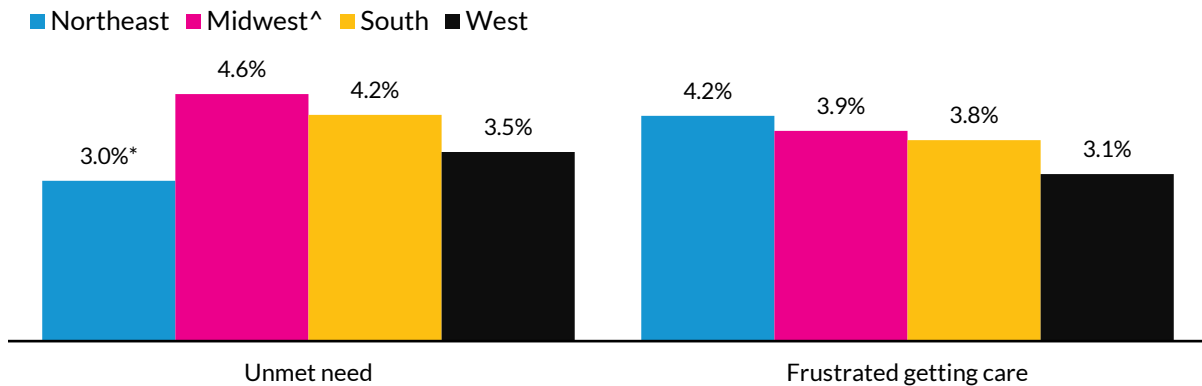
FIGURE 4
Rates of No Utilization of Preventive Medical and Dental Services in the Prior 12 Months by Selected Characteristics of Medicaid/CHIP-Enrolled Children from Ages 17 and Under, 2016–19



Source: Authors' analysis of the National Survey of Children's Health, 2016–19.

Notes: 12m = 12 months. CHIP = Children's Health Insurance Program. Coverage is measured at time of survey. FPL = federal poverty level. †Indicates measure is among children ages 2 to 17. * Indicates estimate is significantly different from reference group (^) at the $p < 0.05$ level.

FIGURE 5
Regional Differences in Rates of Unmet Health Service Needs and Frustration Obtaining Health Care in the Prior 12 Months, Medicaid/CHIP-Enrolled Children Ages 17 and Under, 2016–19

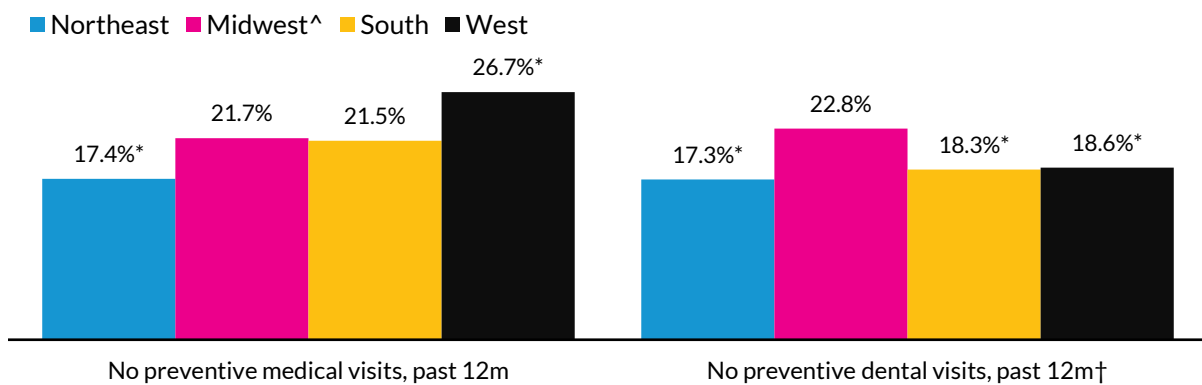


URBAN INSTITUTE

Source: Authors' analysis of the National Survey of Children's Health, 2016–19.

Note: CHIP = Children's Health Insurance Program. Coverage is measured at time of survey. "Unmet need" refers to those who reported any unmet need for services in the past 12 months. "Frustrated getting care" refers to those whose parent reported always or usually feeling frustrated when trying to get care for their child in the past 12 months. * indicates estimate is significantly different from reference group (^) at the $p < 0.05$ level.

FIGURE 6
Regional Differences in No Utilization of Preventive Medical or Dental Services in the Prior 12 Months, Medicaid/CHIP-Enrolled Children Ages 17 and Under, 2016–19



URBAN INSTITUTE

Source: Authors' analysis of the National Survey of Children's Health, 2016–19.

Notes: 12m = 12 months. CHIP = Children's Health Insurance Program. Coverage is measured at time of survey. †Indicates measure is among children ages 2 to 17. * Indicates estimate is significantly different from reference group (^) at the $p < 0.05$ level.

TABLE 3

Rates of Unmet Health Service Needs, No Utilization of Preventive Medical or Dental Services, or Frustration Obtaining Health Care in the Prior 12 Months by Selected Characteristics of Medicaid/CHIP-Enrolled Children Ages 2 to 17, 2016–19

	Faced none of the four barriers, past 12m	Faced any of the four barriers, past 12m	Faced 1 barrier, past 12m	Faced 2 barriers, past 12m	Faced 3 barriers or more, past 12m
All Medicaid/CHIP-enrolled children	59.9%	40.1%	31.1%	7.9%	1.1%
Age					
Ages 5 and under	55.6%*	44.4%*	36.6%*	7.0%	0.8%
Ages 6–11^	63.0%	37.0%	29.1%	6.8%	1.1%
Ages 12–17	59.7%*	40.3%*	29.3%	9.7%*	1.3%
Sex					
Male^	60.2%	39.8%	30.5%	8.2%	1.0%
Female	59.6%	40.4%	31.7%	7.5%	1.1%
Race/ethnicity					
American Indian/Alaska Native, non-Hispanic	50.0%*	50.0%*	40.5%*	8.9%	0.5%
Asian/Pacific Islander, non-Hispanic	52.0%*	48.0%*	35.3%	12.3%*	0.3%*
Black, non-Hispanic	56.9%*	43.1%*	34.0%*	7.9%	1.1%
Hispanic	60.4%	39.6%	30.6%	7.9%	1.1%
Other/multiple races, non-Hispanic	65.9%*	34.1%*	26.1%*	7.3%	0.7%
White, non-Hispanic^	61.4%	38.6%	30.0%	7.4%	1.2%
Health status					
Excellent/very good health^	60.7%	39.3%	31.1%	7.4%	0.7%
Good health	57.3%	42.7%	30.7%	9.6%	2.4%*
Fair/poor health	51.3%*	48.7%*	32.9%	12.4%*	3.5%*
Family nativity					
One or more parents born outside the US	59.7%	40.3%	31.1%	8.1%	1.0%
No adults in household born outside US^	60.4%	39.6%	30.8%	7.7%	1.1%
Family structure					
Two caregivers are biological, adoptive, or step-parents^	62.1%	37.9%	29.9%	7.1%	0.9%
One caregiver is biological, adoptive, or step-parent	57.7%*	42.3%*	32.3%	8.5%	1.5%
No caregiver is biological, adoptive, or step-parent	55.7%*	44.3%*	33.9%	9.8%*	0.6%
Region					
Northeast	64.6%*	35.4%*	28.7%*	6.0%*	0.7%

	Faced none of the four barriers, past 12m	Faced any of the four barriers, past 12m	Faced 1 barrier, past 12m	Faced 2 barriers, past 12m	Faced 3 barriers or more, past 12m
Midwest [^]	57.0%	43.0%	33.4%	8.5%	1.1%
South	60.8%*	39.2%*	30.3%*	7.9%	1.0%
West	57.9%	42.1%	32.2%	8.5%	1.4%
Language					
Primary household language is English [^]	60.3%	39.7%	31.2%	7.4%	1.1%
Primary household language is not English	59.0%	41.0%	30.5%	9.5%	1.0%
Past-year insurance coverage					
Covered for 12 months of the past year [^]	60.5%	39.5%	31.2%	7.5%	0.8%
Had gap in coverage in the past year	48.5%*	51.5%*	30.1%	15.1%*	6.4%*
Family income					
<100% FPL	56.3%*	43.7%*	32.5%	9.8%*	1.4%
100–200% FPL	60.4%	39.6%	31.6%	7.0%	1.0%
200–400% FPL	66.7%	33.3%	27.2%	5.7%	0.4%
Above 400% FPL [^]	64.8%	35.2%	29.3%	5.3%	0.6%

Source: Authors' analysis of the National Survey of Children's Health, 2016–19.

Notes: 12m = 12 months. CHIP = Children's Health Insurance Program. FPL = federal poverty level. Coverage is measured at time of survey. The four access barriers include reported any unmet need for services, had no preventive medical visits at all, had no preventive dental visits at all, and parent always or usually felt frustrated when trying to get care for child. * Indicates estimate is significantly different from reference group (^) at the $p < 0.05$ level. For all subgroups, the sample is limited to those with nonmissing responses to all barriers.

- For some socioeconomic, demographic, and geographic characteristics, we found notable variation in access challenges across subgroups of children in the NSCH (figure 3; table A.3). While we found few differences by sex or family income, for instance, we observed other subgroups at higher risk of having unmet needs and/or frustrations obtaining care:
 - » Medicaid/CHIP-enrolled children who had a gap in coverage in the past year were nearly six times more likely to have an unmet need than Medicaid/CHIP-enrolled children covered by insurance for all 12 months (18.3 percent versus 3.3 percent). They were also more likely to have parents who reported frustrations obtaining care for them.
 - » Medicaid/CHIP-enrolled children in fair or poor health were nearly four times more likely than children in excellent or very good health to have an unmet need in the past year (11.3 percent versus 3.0 percent) and more than five times more likely to have parents who reported frustrations obtaining care for them (14.9 percent versus 2.8 percent).
 - » Unmet needs were also higher for other subgroups such as adolescents ages 12 to 17, children with no foreign-born adults in the household, and children living with a single parent or no parents.

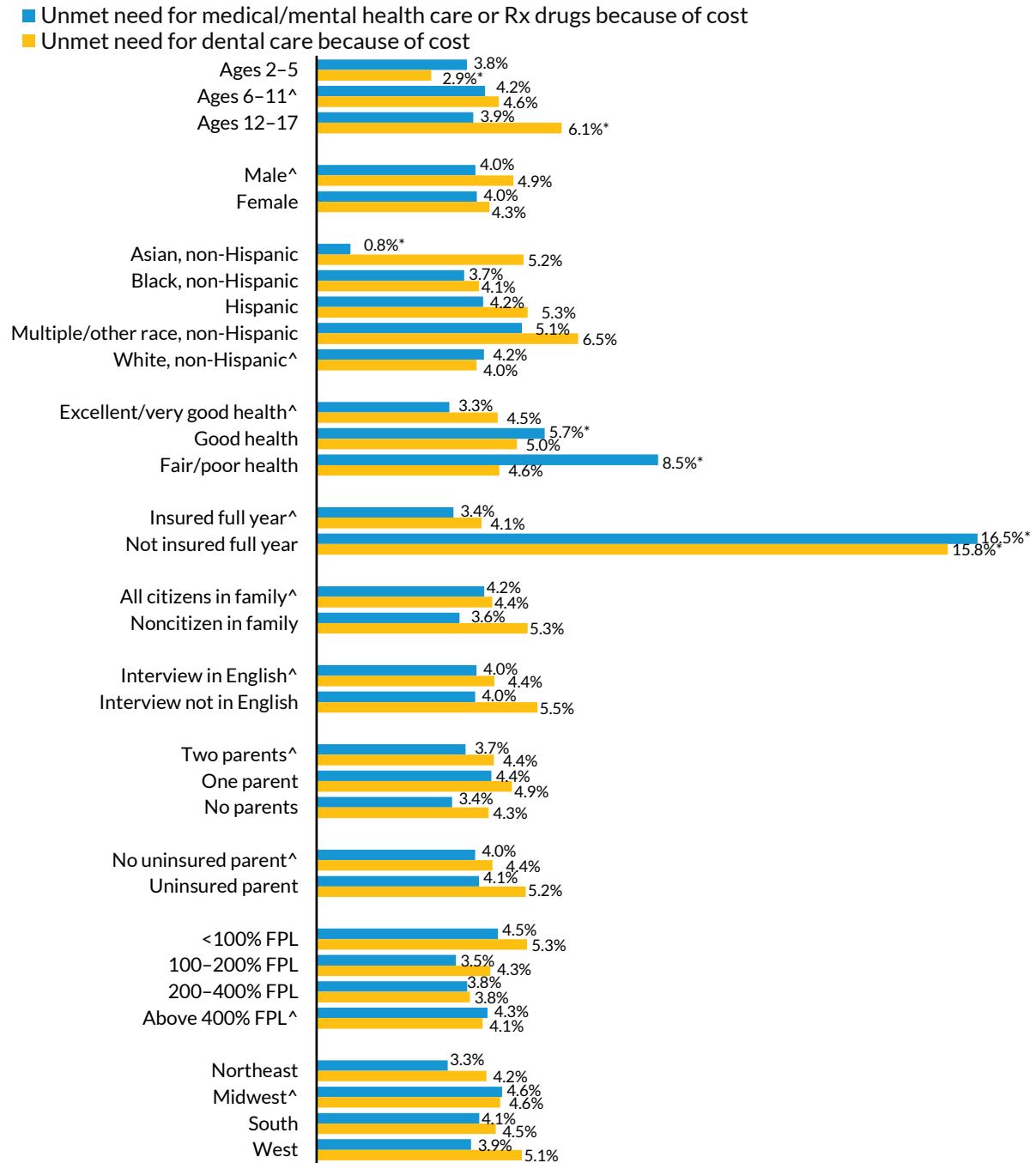
- While we found no significant differences in rates of lacking preventive visits by some characteristics, such as health status, sex, or family structure, we found higher rates of not obtaining preventive care in the past 12 months among some subgroups, as shown in figure 4.
 - » Children who were Black, Hispanic, Asian American/Pacific Islander, or American Indian/Alaskan Native were at higher risk of having no preventive medical visits than non-Hispanic white children. Likewise, children in households whose primary language was not English or with one or more foreign-born parents were more likely to have not received preventive medical care.
 - » Lack of preventive dental visits was higher among children ages 2 to 5 (30.7 percent) and adolescents ages 12 to 17 (17.4 percent) than among children ages 6 to 11 (13.0 percent). About 1 in 4 children ages 6 to 11 or 12 to 17 had no preventive medical visits, compared with 16.9 percent of children younger than age 6.
 - » Though rates of not receiving preventive dental visits did not vary significantly by income, children in families with lower incomes had higher rates of not receiving preventive medical visits than the highest income group of Medicaid/CHIP-enrolled children. On the other hand, rates of preventive medical care use did not vary according to whether a child had coverage all of the prior year, but children who experienced a gap in coverage were

more likely to have had no preventive dental care than those covered for the entire year (28.0 percent versus 18.7 percent).

- When examining variation in access challenges by region (figures 5–6), we found few statistically significant differences in unmet needs and frustrations obtaining care, but children in the Midwest (4.6 percent) were more likely than children in Northeastern states (3.0 percent) to have an unmet need. Regional differences in preventive care use were larger; for example, rates of no preventive medical visits were highest in the West while rates of no preventive dental visits were highest in the Midwest.
- Overall, 31.1 percent of Medicaid/CHIP-enrolled children in the NSCH experienced one barrier to care in the past 12 months, 7.9 percent experienced two barriers to care, and 1.1 percent experienced three or more barriers to care (table 3). Co-occurrence of barriers was more common for some subgroups than others:
 - » Experiencing two of the four barriers was more likely for some subgroups including children ages 12 to 17; children in families where no caregiver is biological, adoptive, or a step-parent; and children in families with incomes below 100 percent of FPL.
 - » Experiencing three or more of the four barriers was more likely for children who had a coverage gap in the past year and children in fair or poor health or good health.

FIGURE 7

Rates of Unmet Needs due to Cost in the Prior 12 Months among Medicaid/CHIP-Enrolled Children Ages 2 to 17, by Selected Characteristics, 2016–18



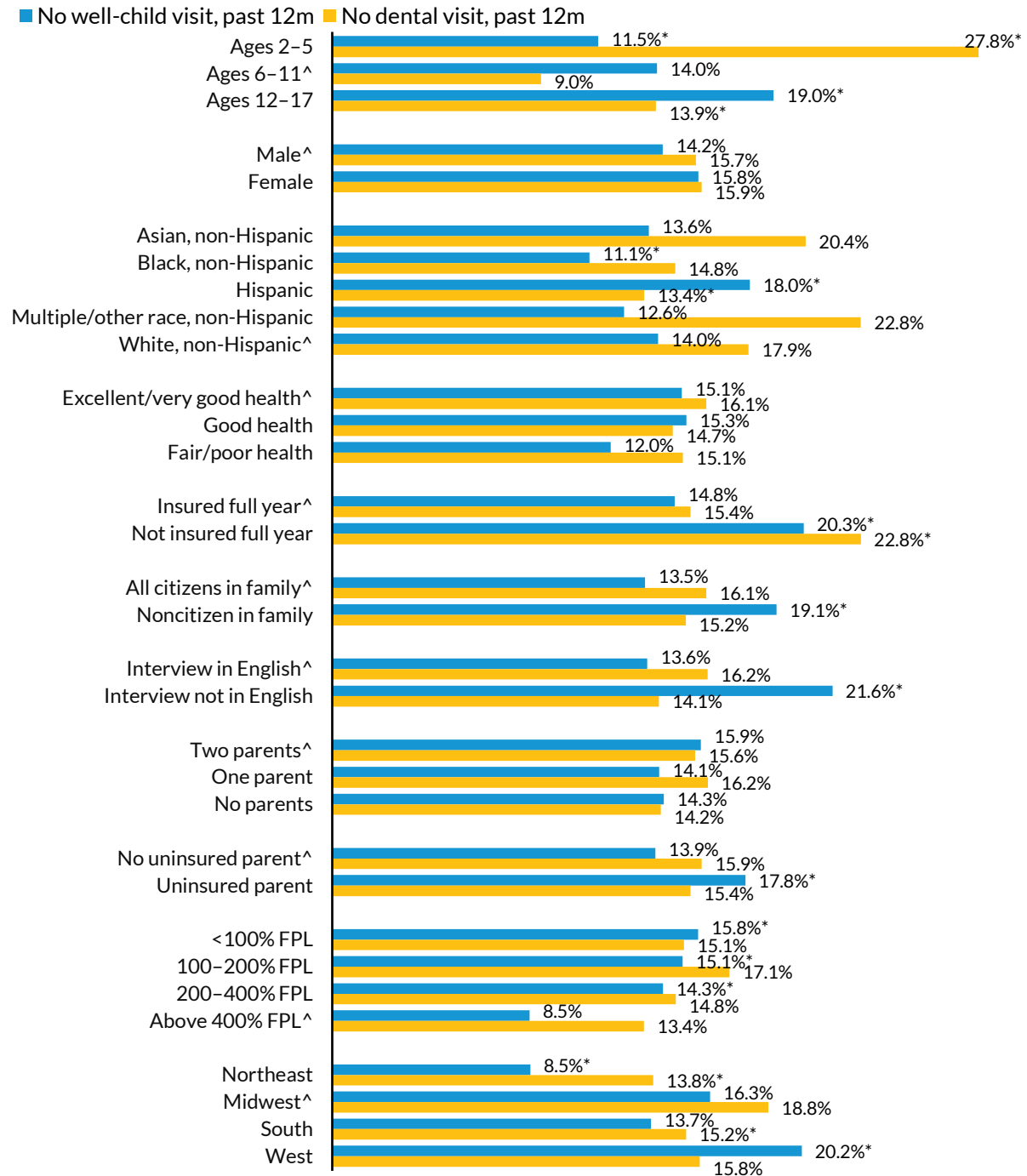
URBAN INSTITUTE

Source: Authors’ analysis of the National Health Interview Survey, 2016–18.

Note: CHIP = Children’s Health Insurance Program. Coverage is measured at time of survey. FPL = federal poverty level. * indicates estimate is significantly different from reference group (^) at the $p < 0.05$ level.

FIGURE 8

Rates of Lacking a Well-Child Visit and a Dental Visit in the Prior 12 Months among Medicaid/CHIP-Enrolled Children Ages 2 to 17, by Selected Characteristics, 2016–18



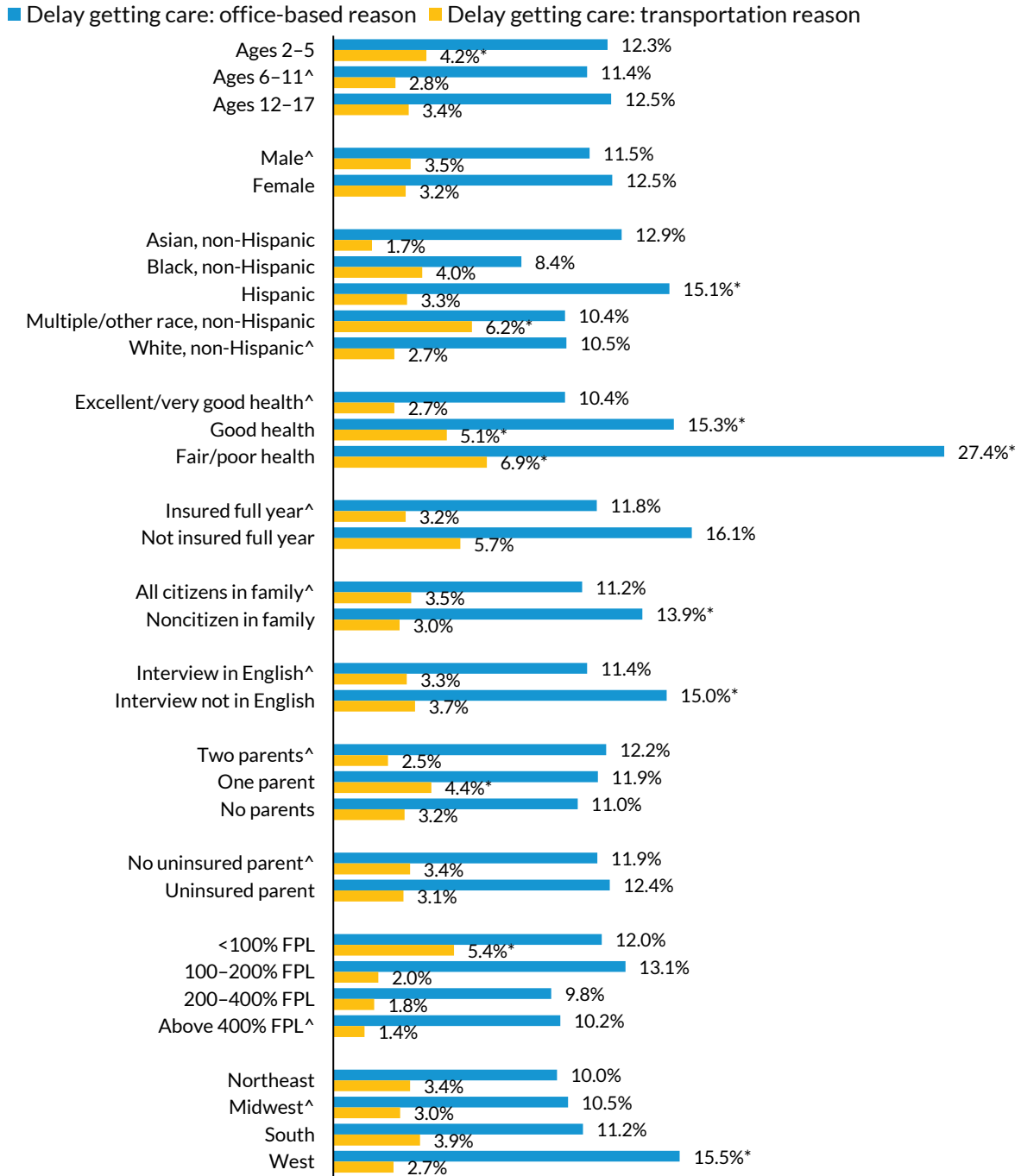
URBAN INSTITUTE

Source: Authors' analysis of the National Health Interview Survey, 2016–18.

Notes: 12m = 12 months. CHIP = Children's Health Insurance Program. Coverage is measured at time of survey. FPL = federal poverty level. * indicates estimate is significantly different from reference group (^) at the $p < 0.05$ level.

FIGURE 9

Rates of Delays Getting Care in the Prior 12 Months among Medicaid/CHIP-Enrolled Children Ages 2 to 17, by Selected Characteristics, 2016–18



URBAN INSTITUTE

Source: Authors' analysis of the National Health Interview Survey, 2016–18.

Note: CHIP = Children's Health Insurance Program. Coverage is measured at time of survey. FPL = federal poverty level.

* indicates estimate is significantly different from reference group (^) at the $p < 0.05$ level.

- Among children ages 2 to 17 with Medicaid/CHIP in the NHIS, there was little significant variation in rates of unmet needs for medical care, mental health care, or prescription drugs because of cost or rates of unmet need for dental care because of cost by sex, family citizenship status, survey language, family structure, parental uninsurance, income, or region, but we found several patterns by past year coverage status, health status, and age (figure 7):
 - » Those with a period of uninsurance in the past year were much more likely (16.5 percent) than those insured all year (3.3 percent) to report unmet needs for medical care, mental health care, or prescription drugs because of cost, and this pattern was similar for unmet needs for dental care (15.8 percent versus 4.1 percent).
 - » Rates of unmet needs for medical care, mental health care, or prescription drugs because of cost were much higher for those in fair or poor health (8.5 percent) than those in excellent or very good health (3.3 percent), while there was less variation by health status for unmet dental needs. Adolescents were more likely to report unmet dental needs than their younger counterparts, while there was no such gradient for unmet medical care, mental health care, or prescription drug needs.

- Patterns for lacking a dental visit were generally less variable by subgroup, but we found some variation in lacking well-child visits (figure 8).
 - » Having a gap in coverage in the past year was associated with higher rates of having no well-child visit and no dental visit, but the gaps were not nearly as stark as for unmet needs.
 - » Several groups were more likely to have had no well-child visit, including Hispanic children, those with a noncitizen in their family, those in families who responded to the survey in a language other than English, those with an uninsured parent, and those with incomes below 400 percent of the FPL.
 - » Children ages 2 to 5 were much more likely to lack a dental visit than older children.
 - » We found some variation in receipt of dental care by region but larger differences in receipt of well-child care, for instance with children in the Northeast (8.5 percent) much less likely and children in the West much more likely (20.2 percent) than those in the Midwest (16.3 percent) to have had no preventive medical care.

- Many of the same groups that were more likely to have no well-child visit also reported higher rates of noncost delays in care for office-based or transportation reasons (figure 9).
 - » Several groups reported higher rates of office-based delays in care, including Hispanic children, those with a noncitizen in their family, and those with a non-English language

interview. In addition, children in fair or poor health were much more likely to report office-based delays getting care (27.4 percent) compared with those in excellent/very good (10.4 percent) or good (15.3 percent) health.

- » Rates of transportation-related delays in care were highest among children in fair or poor health (6.9 percent), those with multiple races or in additional racial groups (6.2 percent), those in single parent families (4.4 percent), and those living in poverty (5.4 percent).

Co-Occurring Access Challenges

Some of the access challenges we observed co-occurred, and parents reported additional challenges with access to and utilization of care.

TABLE 4

Health Care Experiences of Medicaid/CHIP-Enrolled Children Ages 17 and Under Overall and with Specified Access Challenges in the Prior 12 Months, 2016–19

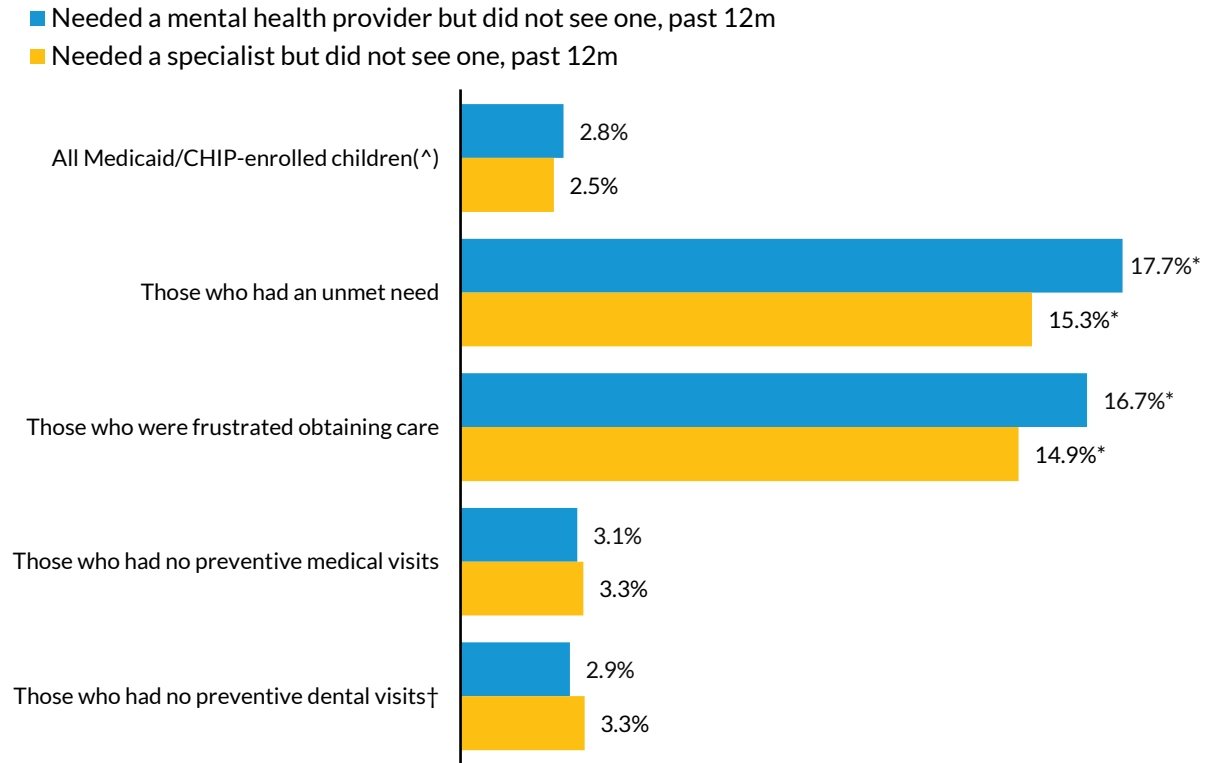
	Medicaid/CHIP-Enrolled Children with Specified Access Challenge				
	Medicaid/CHIP-enrolled children	Reported any unmet need for services, past 12m	Parent frustrated obtaining care for child, past 12m	No preventive medical visits, past 12m	No preventive dental visits past 12m†
Access barriers					
Reported any unmet need for services, past 12 months	4.0%		40.4%*	3.6%	6.8%*
Parent always or usually felt frustrated when trying to get care for child, past 12 months	3.7%	37.9%*		3.4%	5.1%*
No preventive medical visits, past 12 months	22.2%	20.0%	20.4%		31.3%*
No dental preventive visit (among children ages 2–17 only), past 12 months	19.1%	30.6%*	24.1%*	26.2%*	
Other health care utilization and access measures					
Two or more emergency department visits, past 12 months	8.5%	15.7%*	20.3%*	4.9%*	8.9%
Did not see an oral health provider (children ages 2–17 only), past 12 months	16.1%	26.2%*	20.8%*	21.5%*	83.2%*
Did not see a provider for any kind of medical care, past 12 months	18.9%	15.5%	15.6%	85.7%*	26.1%*
Needed a mental health provider but did not see one, past 12 months	2.8%	17.7%*	16.7%*	3.1%	2.9%
Needed a specialist but did not see one, last 12 months	2.5%	15.3%*	14.9%*	3.3%	3.3%
Does not have a usual source of care	7.9%	9.2%	6.3%	15.3%*	13.9%*
Does not have at least one personal doctor or nurse	32.3%	28.6%	33.4%	46.6%*	41.6%*
Among those reporting health-related expenses, share reporting problems paying for medical care	23.4%	60.8%*	54.1%*	21.4%	22.8%

Source: Authors' analysis of the National Survey of Children's Health, 2016–19.

Notes: CHIP = Children's Health Insurance Program. Coverage is measured at time of survey. "Frustrated obtaining care" refers to those whose parent reported always or usually feeling frustrated when trying to get care for their child in the past 12 months. † Indicates measure is among children ages 2 to 17. * indicates estimate is significantly different from counterfactual (Medicaid/CHIP-enrolled children without the barrier) at the $p < 0.05$ level.

FIGURE 10

Unmet Needs for Specialist and Mental Health Care among Medicaid/CHIP-Enrolled Children Ages 17 and Under with Unmet Health Service Needs, No Utilization of Selected Health Services, or Frustrations Obtaining Health Care in the Prior 12 Months, 2016–19



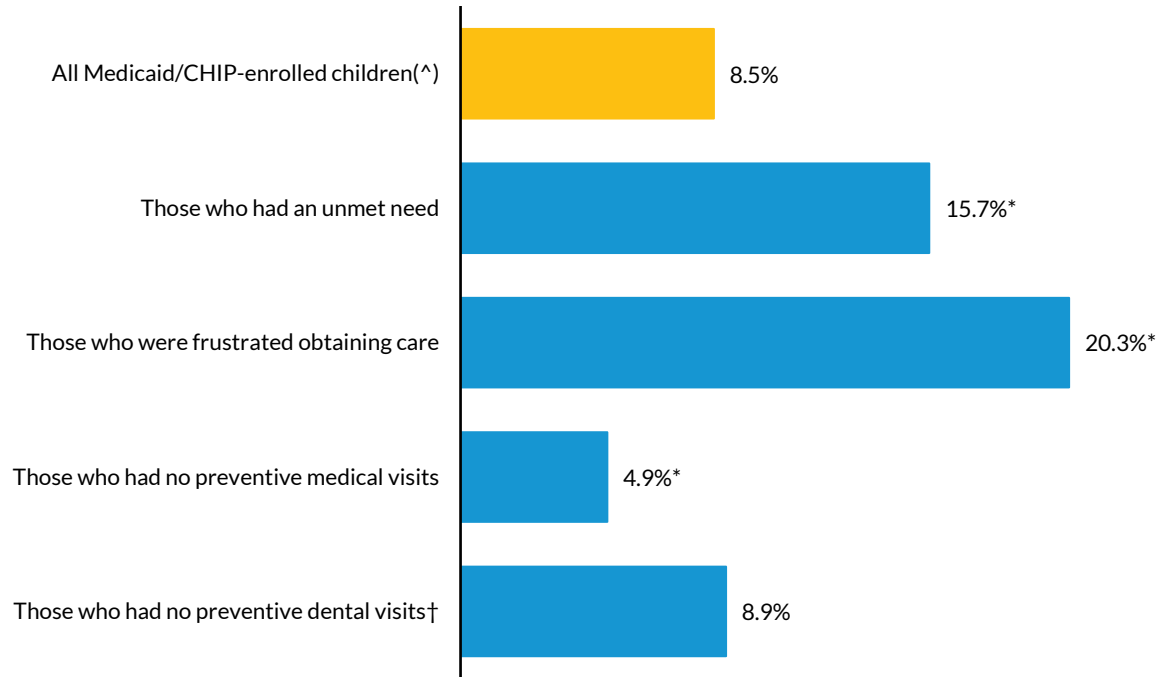
URBAN INSTITUTE

Source: Authors' analysis of the National Survey of Children's Health, 2016–19.

Notes: 12m = 12 months. CHIP = Children's Health Insurance Program. Coverage is measured at time of survey. †Indicates measure is among children ages 2 to 17. * indicates estimate is significantly different from counterfactual (Medicaid/CHIP-enrolled children without the barrier) at the $p < 0.05$ level. "Unmet need" refers to those who reported any unmet need for services in the past 12 months. "Frustrated obtaining care" refers to those whose parent reported always or usually feeling frustrated when trying to get care for their child in the past 12 months.

FIGURE 11

Repeat Emergency Department Visits during the Past 12 Months, among Medicaid/CHIP-Enrolled Children Ages 17 and Under with Unmet Health Service Needs, No Utilization of Selected Health Services, or Frustrations Obtaining Health Care, 2016–19



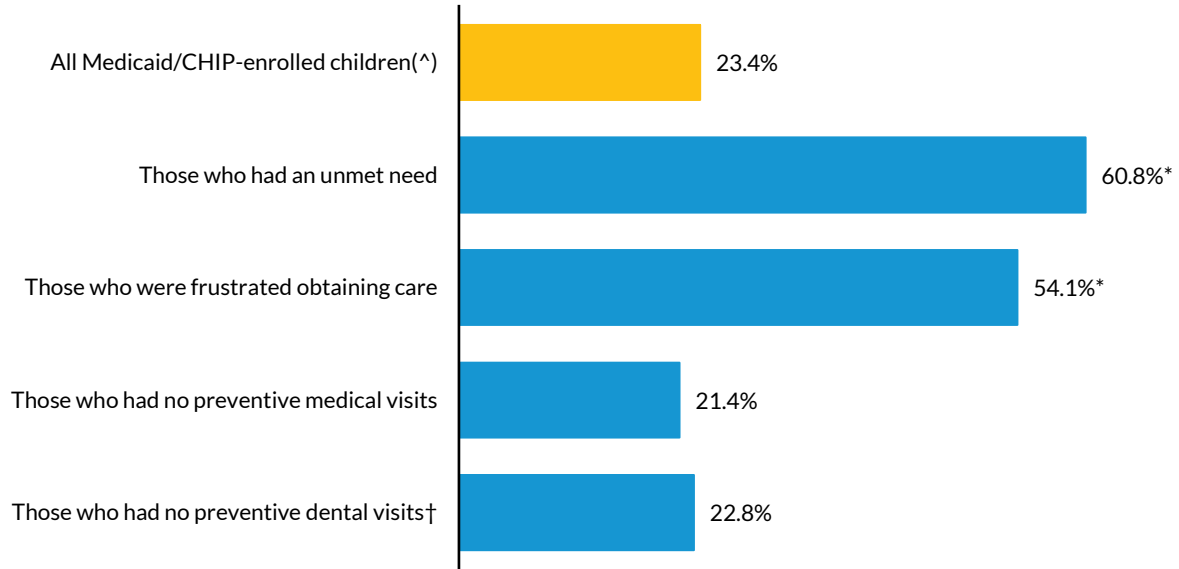
URBAN INSTITUTE

Source: Authors' analysis of the National Survey of Children's Health, 2016–19.

Notes: CHIP = Children's Health Insurance Program. Coverage is measured at time of survey. †Indicates measure is among children ages 2 to 17. * indicates estimate is significantly different from counterfactual (Medicaid/CHIP-enrolled children without the barrier) at the $p < 0.05$ level. "Unmet need" refers to those who reported any unmet need for services in the past 12 months. "Frustrated obtaining care" refers to those whose parent reported always or usually feeling frustrated when trying to get care for their child in the past 12 months.

FIGURE 12

Problems Paying for Child’s Medical Care among Medicaid/CHIP-Enrolled Children Ages 17 and Under Reporting Medical Expenses with Unmet Health Service Needs, No Utilization of Selected Health Services, or Frustrations Obtaining Health Care in the Prior 12 Months, 2016–19



URBAN INSTITUTE

Source: Authors’ analysis of the National Survey of Children’s Health, 2016–19.

Notes: CHIP = Children’s Health Insurance Program. Coverage is measured at time of survey. †Indicates measure is among children ages 2 to 17. * indicates estimate is significantly different from counterfactual (Medicaid/CHIP-enrolled children without the barrier) at the $p < 0.05$ level. “Unmet need” refers to those who reported any unmet need for services in the past 12 months. “Frustrated obtaining care” refers to those whose parent reported always or usually feeling frustrated when trying to get care for their child in the past 12 months.

- The upper panel of table 4 assesses how the four access challenges we identified in the NSCH co-occur, showing that many of the children with one challenge were also reported to have others. For instance, 40.4 percent of children whose parents reported frustrations obtaining care also had unmet needs for services. And children with either no preventive medical visits or no preventive dental visits were also more likely than other children to not have received the other type of preventive care.

- As shown in the lower panel of table 4, some parents also reported other challenges with health care access and utilization.
 - » Overall, slightly less than 3 percent of Medicaid/CHIP-enrolled children needed care from a mental health care provider or specialist but did not see one in the past year; 7.9 percent had no usual source of care; 32.3 percent had no personal doctor or nurse; and of those with health-related expenses, 23.4 percent were in families who had problems paying for their medical care.

 - » Some of these problems were higher among the children who also had unmet needs for services or whose parents were always or usually frustrated when trying to get care for their children. Among children with unmet needs or whose parents experienced such frustrations, more than 1 in 5 (26.2 percent and 20.8 percent, respectively) did not see a dental care provider for any type of care, and more than half (60.8 percent and 54.1 percent, respectively) with health expenses had families who had problems paying for their medical care. As highlighted in figure 10, about 1 in 6 of these children needed a mental health provider but did not see one, and 15.3 percent and 14.9 percent needed a specialist but did not see one, much higher than those not experiencing these barriers. Likewise, such children were more likely than those not experiencing these barriers to report having two or more emergency department visits (figure 11). In addition, more than half of children with unmet needs or parental frustrations obtaining care who had medical expenses for the child's care reported problems paying for care (figure 12).

TABLE 5

Health Care Experiences of Medicaid/CHIP-Enrolled Children Ages 2 to 17 Overall and with Selected Access Challenges in the Prior 12 Months, 2016–18

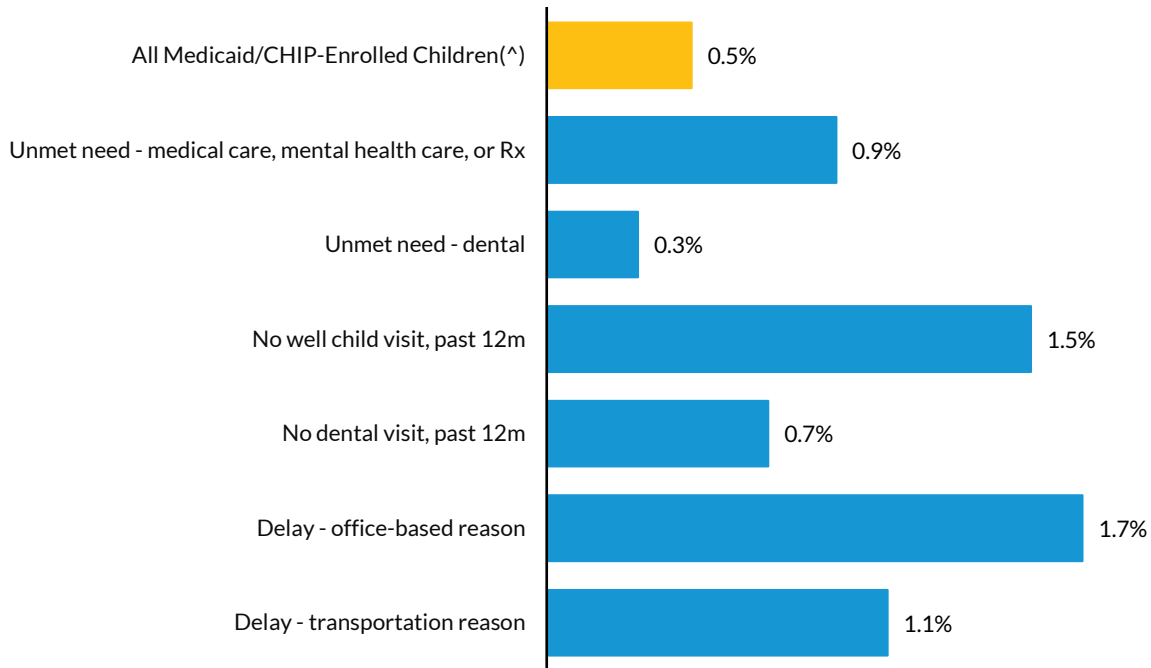
	All Medicaid/CHIP-enrolled children	Unmet need for medical care/ mental health care/Rx because of cost, past 12m	Unmet need for dental care because of cost, past 12m	No well-child visit, past 12m	No dental visit, past 12m	Delay getting care: office-based reason, past 12m	Delay getting care: transportation reason, past 12m
Selected access barriers							
Unmet need because of cost—medical care/mental health care/Rx	4.0%		25.5%*	4.5%	4.2%	11.3%*	19.7%*
Unmet need because of cost—dental	4.6%	29.6%*		6.3%*	6.1%*	9.8%*	14.0%*
No well-child visit	15.0%	17.0%	20.6%*		23.4%*	16.9%	17.9%
No dental visit	15.8%	16.7%	20.9%	24.7%*		16.2%	21.3%
Any office-based delay	12.0%	34.0%*	25.3%*	13.6%	12.3%		42.2%*
Delay—transportation	3.4%	16.6%*	10.2%*	4.0%	4.5%	11.7%*	
More detailed and other access measures							
Any unmet need	8.2%			10.1%*	9.6%	19.2%*	27.7%*
Unmet need—medical care	1.0%	24.7%*	6.4%*	1.2%	1.2%	2.1%*	2.6%
Unmet need—Rx drugs	2.4%	61.0%*	17.6%*	2.4%	2.3%	6.8%*	14.1%*
Unmet need—mental health	1.1%	26.8%*	8.3%*	1.4%	1.5%	4.5%*	6.3%*
Unmet need—dental	4.6%	29.6%*		6.3%*	6.1%*	9.8%*	14.0%*
Unmet need—vision	1.9%	11.4%*	19.8%*	2.9%	1.9%	4.4%*	7.4%*
Any noncost delay	14.0%	40.9%*	29.7%*	16.2%	15.0%		
Delay—phone	2.8%	15.1%*	6.9%*	3.5%	2.8%	23.4%*	14.0%*
Delay—wait for appointment	6.6%	21.2%*	14.7%*	7.2%	8.1%	54.6%*	27.6%*
Delay—office hours	3.3%	8.1%*	7.6%*	4.5%	3.2%	27.3%*	18.0%*
Delay—wait in office	5.6%	16.7%*	12.1%*	6.2%	6.3%	46.8%*	19.7%*
Delay—transportation	3.4%	16.6%*	10.2%*	4.0%	4.5%	11.7%*	
Problem finding a provider	2.5%	11.3%*	6.5%*	3.3%	3.9%	10.6%*	5.4%
Could not find a provider	0.5%	0.9%	0.3%	1.5%	0.7%	1.7%	1.1%
Minimum sample size	8346	334	395	1268	1358	924	272

Source: Authors' analysis of the National Health Interview Survey, 2016–18.

Notes: CHIP = Children's Health Insurance Program. Coverage is measured at time of survey. All unmet needs are because of cost in the past 12 months. All noncost delays are in past 12 months. Office-based delays include trouble getting through on phone, long wait for appointment, long wait in the office, and inconvenient office hours. Problem finding a provider was not asked in 2018 so sample sizes are lower than stated minimum. * indicates share is statistically different from all Medicaid/CHIP-enrolled children at the $p < 0.05$ level.

FIGURE 13

Difficulty Finding a Provider among Medicaid/CHIP-Enrolled Children Ages 2 to 17 Overall and by Reported Access Challenges in the Prior 12 Months, 2016–18



URBAN INSTITUTE

Source: Authors' analysis of the National Health Interview Survey, 2016–18.

Note: 12m = 12 months. CHIP = Children's Health Insurance Program. Coverage is measured at time of survey. * indicates estimate is significantly different from reference group (^) at the $p < 0.05$ level.

- As with the NSCH, we found that some problems accessing care tended to co-occur, according to the NHIS analysis of children ages 2 to 17 (table 5). In general, unmet needs because of cost for medical care, mental health care, or prescription drugs and dental care co-occurred with both office-based and transportation barriers to care. On the contrary, lacking preventive and dental visits generally co-occurred with each other and with unmet needs for dental care, but not with other unmet needs or noncost barriers to care.
- Likewise, while very few children ages 2 to 17 in the NHIS were unable to find a provider at all (0.5 percent) and 2.5 percent of Medicaid/CHIP-enrolled children overall experienced problems finding a provider, 11.3 percent of those with medical care, mental health care, or prescription drug unmet needs because of cost and 10.6 percent of those experiencing office-based delays in care reported problems finding providers, suggesting these problems may be interrelated (figure 13).

Material and Financial Hardships and Other Public Program Enrollment

Though most families of Medicaid/CHIP-enrolled children also participated in at least one other public program, many also reported other material or financial hardships. Such problems were generally higher for children whose parents also reported to experience access challenges including unmet needs, parental frustrations obtaining care for their child, and noncost delays.

TABLE 6

Public Program Enrollment, Family Material Hardships, and Neighborhood Characteristics among Medicaid/CHIP-Enrolled Children Ages 17 and Under Overall and with Reported Access Challenges in the Prior 12 Months, 2016–19

	Medicaid/CHIP-Enrolled Children with Specified Access Challenge				
	Medicaid/CHIP-enrolled children	Reported any unmet need for services, past 12m	Parent always/usually felt frustrated when trying to get care for child, past 12m	No preventive medical visits, past 12m	No preventive dental visits (among ages 2–17 only), past 12m
Public program enrollment					
Enrolled in SNAP	46.8%	49.9%	51.2%	48.5%	50.1%*
Enrolled in TANF	9.4%	10.2%	12.6%	9.6%	12.9%*
Enrolled in WIC	29.7%	23.6%*	22.3%*	27.3%*	28.0%*
Enrolled in Free or Reduced Cost Meals at school/daycare	65.9%	72.4%*	74.2%*	70.0%*	64.6%*
Food insecurity					
Family often could not afford to eat	2.1%	7.1%*	7.2%*	1.8%	3.1%*
Family sometimes could not afford to eat	10.2%	21.9%*	20.6%*	10.3%	13.0%*
Family could afford to eat but not always nutritious food	38.9%	44.0%	46.1%*	34.8%*	42.4%*
Family could always afford to eat nutritious food	48.8%	27.0%*	26.1%*	53.1%*	41.6%*
Financial strain					
Very hard to cover the basics (food, housing, etc.)	9.0%	26.7%*	29.0%*	7.9%	11.2%*
Somewhat hard to cover the basics	25.2%	37.8%*	35.9%*	21.7%*	27.4%
Rarely hard to cover the basics	36.8%	23.7%*	22.6%*	37.7%	35.4%
Never hard to cover the basics	29.0%	11.8%*	12.5%*	32.7%*	25.9%
Neighborhood amenities					
Sidewalks or walking paths in neighborhood	73.0%	72.6%	70.8%	74.2%	73.2%
A park or playground in neighborhood	72.7%	71.0%	70.7%	71.8%	70.7%
A recreation/community center in neighborhood	45.7%	44.2%	43.5%	43.5%	42.7%*
A library or bookmobile in neighborhood	66.6%	62.3%	60.7%*	62.8%*	63.6%*
Neighborhood negative elements					
Litter or garbage on the street or sidewalk	28.0%	38.2%*	36.3%*	28.5%	26.6%
Poorly kept or rundown housing	18.9%	30.7%*	31.4%*	15.7%*	20.3%
Vandalism, such as broken windows or graffiti	11.6%	21.5%*	19.5%*	10.1%*	11.5%

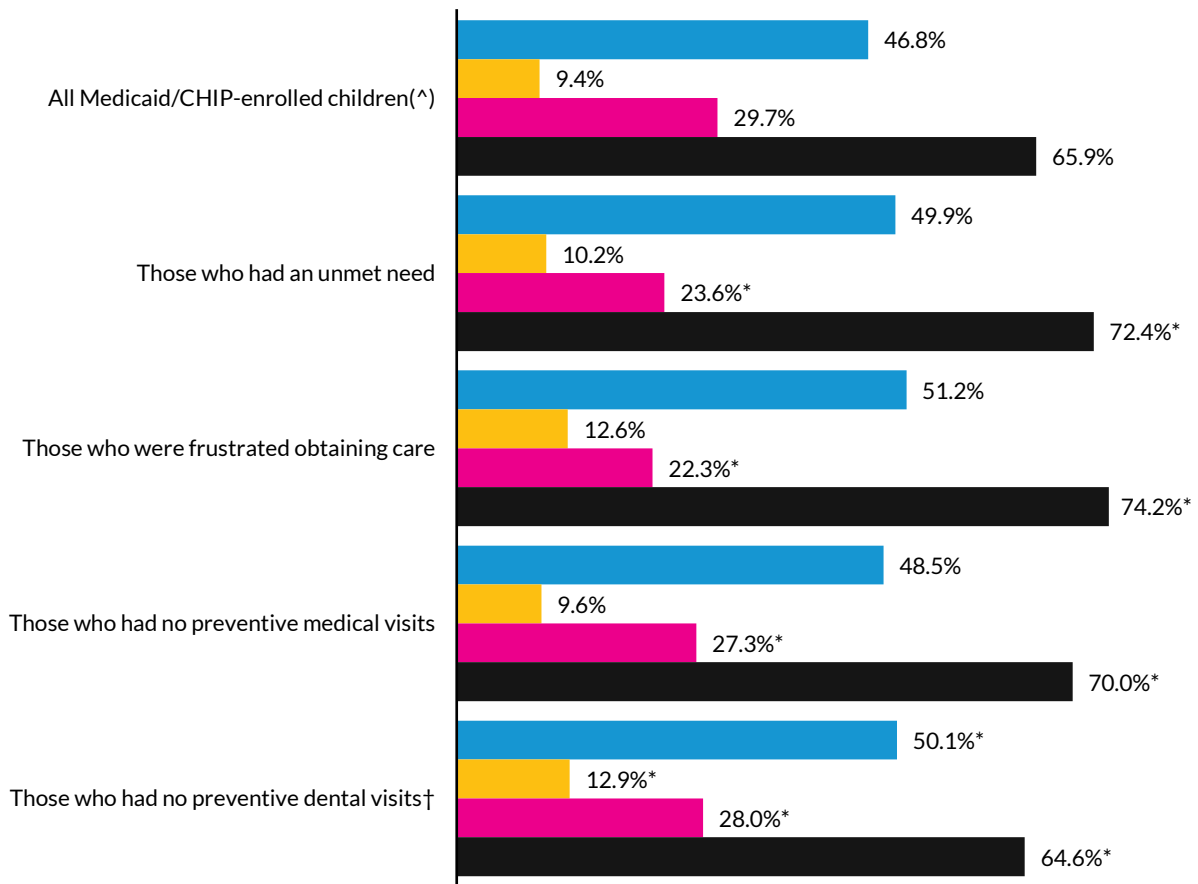
Source: Authors' analysis of the National Survey of Children's Health, 2016–19.

Note: SNAP=Supplemental Nutrition Assistance Program. TANF = Temporary Assistance for Needy Families. WIC = Special Supplemental Nutrition Program for Women, Infants, and Children. CHIP = Children's Health Insurance Program. Coverage is measured at time of survey. * indicates estimate is significantly different from counterfactual (Medicaid/CHIP-enrolled children without the barrier) at the $p < 0.05$ level.

FIGURE 14

Public Program Enrollment of Medicaid/CHIP-Enrolled Children Ages 17 and Under, Overall and with Reported Access Challenges in the Prior 12 Months, 2016–19

- Enrolled in SNAP
- Enrolled in TANF
- Enrolled in WIC
- Enrolled in free or reduced cost meals at school/daycare



URBAN INSTITUTE

Source: Authors’ analysis of the National Survey of Children’s Health, 2016–19.

Notes: SNAP=Supplemental Nutrition Assistance Program. TANF = Temporary Assistance for Needy Families. WIC = Special Supplemental Nutrition Program for Women, Infants, and Children. CHIP = Children’s Health Insurance Program. Coverage is measured at time of survey. “Unmet need” refers to those who reported any unmet need for services in the past 12 months. “Frustrated obtaining care” refers to those whose parent reported always or usually feeling frustrated when trying to get care for their child in the past 12 months. †Indicates measure is among children ages 2 to 17. * Indicates estimate is significantly different from reference group (^) at the $p < 0.05$ level.

- Given that most Medicaid/CHIP-enrolled children are eligible based on family income, it is not surprising that such children often qualify for other public benefits. Among those with Medicaid/CHIP coverage in the NSCH, nearly two-thirds were enrolled in free or reduced-price

meals in school or daycare; nearly half (46.8 percent) were enrolled in SNAP; 29.7 percent were enrolled in WIC; and 9.4 percent were enrolled in TANF (table 6). Enrollment in these programs was often higher among children facing access challenges than among Medicaid/CHIP-enrolled children overall (figure 14).

- Despite some families receiving public benefits, more than half of Medicaid/CHIP-enrolled children overall reported problems with the family accessing sufficient healthy food (2.1 percent often could not afford to eat; 10.2 percent sometimes could not afford to eat; and 38.9 percent could afford to eat but not always nutritious food). In addition, 34.3 percent had parents who reported it was somewhat or very hard to cover the basics.
- Such problems were higher for children also reporting unmet health care needs or with a parent who was always or usually frustrated when trying to get care for the child. Among children with unmet needs, 7.1 percent were in families who often could not afford to eat, 21.9 percent were in families who sometimes could not afford to eat, and 44 percent were in families who could afford to eat but not always nutritious food. In addition, 64.4 percent had parents who reported it was somewhat or very hard to cover the basics. Patterns were similar for those with a parent who was always or usually frustrated when trying to get care for the child, with 7.2 percent in families who often could not afford to eat, 20.6 percent in families who sometimes could not afford to eat, and 46.1 percent in families who could afford to eat but not always nutritious food, and 64.9 percent who had parents who reported it was somewhat or very hard to cover the basics.
- According to the NSCH, Medicaid/CHIP-enrolled children with an unmet need or whose parents felt frustrated when obtaining care for them were also more likely than those without these access problems to live in neighborhoods with negative elements such as litter or garbage on the street or sidewalk, poorly kept or rundown housing, or vandalism such as broken windows or graffiti.

TABLE 7

Public Program Enrollment and Family Material Hardships and Concerns among Medicaid/CHIP-Enrolled Children Ages 2 to 17 Overall and with Reported Access Challenges in the Prior 12 Months, 2016–18

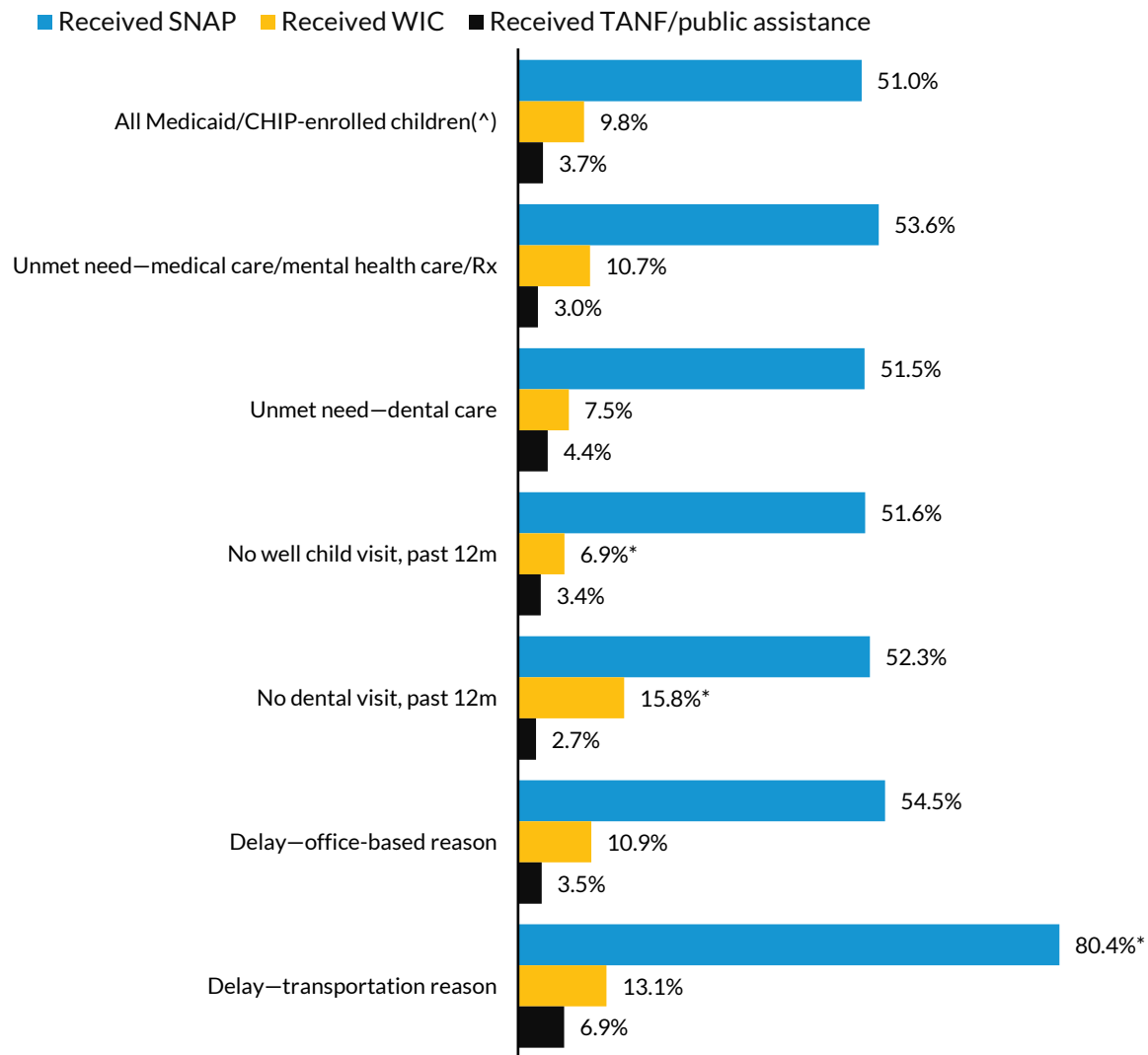
	All Medicaid/CHIP-enrolled children	Unmet need for medical care/mental health care/Rx because of cost, past 12m	Unmet need for dental care because of cost, past 12m	No well-child visit, past 12m	No dental visit, past 12m	Delay getting care: office-based reason, past 12m	Delay getting care: transportation reason, past 12m
Public program enrollment							
Received SNAP	51.0%	53.6%	51.5%	51.6%	52.3%	54.5%	80.4%*
Received WIC	9.8%	10.7%	7.5%	6.9%*	15.8%*	10.9%	13.1%
Received TANF/public assistance	3.7%	3.0%	4.4%	3.4%	2.7%	3.5%	6.9%
Food security							
High food security	62.3%	36.0%*	45.2%*	61.1%	59.8%	47.2%*	23.3%*
Marginal food security	16.6%	16.2%	13.7%	15.5%	15.8%	18.2%	16.4%
Low food security	12.3%	21.2%*	19.7%*	14.2%	13.6%	19.0%*	28.0%*
Very low food security	8.8%	26.5%*	21.3%*	9.2%	10.9%	15.6%*	32.3%*
Family problems paying medical bills	22.3%	56.3%*	40.2%*	22.5%	25.9%*	34.3%*	38.9%*
Parents' worries about paying expenses							
Very worried about costs of illness/accident	33.2%	51.0%*	50.0%*	35.9%	34.7%	44.0%*	54.8%*
Very worried about routine health care costs	21.7%	38.1%*	34.9%*	26.9%*	24.2%	31.4%*	39.8%*
Very worried about monthly bills	22.0%	41.0%*	38.6%*	24.2%	25.9%*	34.2%*	49.7%*
Very worried about paying rent	19.4%	36.4%*	31.8%*	21.8%	23.5%*	28.2%*	44.1%*

Source: Authors' analysis of the National Health Interview Survey, 2016–18.

Notes: SNAP=Supplemental Nutrition Assistance Program. TANF = Temporary Assistance for Needy Families. WIC = Special Supplemental Nutrition Program for Women, Infants, and Children. CHIP = Children's Health Insurance Program. Coverage is measured at time of survey. All unmet needs are because of cost in the past 12 months. All noncost delays are in the past 12 months. Office-based delays include trouble getting through on the phone, long wait for appointment, long wait in the office, and inconvenient office hours. Problem finding a provider was not asked in 2018, so sample sizes are lower than stated minimum. * indicates share is statistically different from all Medicaid/CHIP-enrolled children at the $p < 0.05$ level.

FIGURE 15

Public Program Enrollment of Medicaid/CHIP-Enrolled Children Ages 2 to 17, Overall and with Reported Access Challenges in the Prior 12 Months, 2016–18



URBAN INSTITUTE

Source: Authors' analysis of the National Health Interview Survey, 2016–18.

Note: SNAP=Supplemental Nutrition Assistance Program. TANF = Temporary Assistance for Needy Families. WIC = Special Supplemental Nutrition Program for Women, Infants, and Children. CHIP = Children's Health Insurance Program. Coverage is measured at time of survey. * indicates estimate is significantly different from reference group (^) at the $p < 0.05$ level.

- Overall, 51.0 percent of Medicaid/CHIP-enrolled children ages 2 to 17 in the NHIS were in families who received SNAP, 9.8 percent were in families who received WIC, and 3.7 percent were in families who received TANF (table 7; figure 15). The group who reported transportation challenges delaying their access to care had higher rates of participation in most

of these programs, with 80.4 percent enrolled in SNAP, 13.1 percent enrolled WIC, and 6.9 percent enrolled in TANF.

- More than 1 in 5 Medicaid/CHIP-enrolled children (21.1 percent) experienced low or very low food security in the family. The rate was very high among children reported to have some access challenges: 60.3 percent of those with delayed care because of transportation and 47.8 percent of with unmet needs for medical care, mental health care, or prescription drugs because of cost reported low or very low food security in the family.
- Overall, 22.3 percent of Medicaid/CHIP-enrolled children lived in families with problems paying medical bills, and many had parents who reported worries about costs of illnesses or accidents (33.2 percent), monthly bills (22.0 percent), routine health care costs (21.7 percent), and paying rent (19.4 percent). Rates of these concerns among those lacking a preventive or dental visit were generally similar to Medicaid/CHIP-enrolled children overall. Rates were higher among the groups of Medicaid/CHIP-enrolled children with unmet needs because of cost (medical or dental) and those with noncost barriers to care (office and transportation-based) than among Medicaid/CHIP-enrolled children overall.

Discussion

The findings presented here suggest that in the 2016–19 period Medicaid/CHIP programs for children across the country appeared to be providing access to basic care to most enrollees because only a small fraction of children covered by the programs were reported to have had an unmet need for health services. In addition, the majority of Medicaid/CHIP-enrolled children had received preventive medical and dental care within the previous 12-month period.

We find that approximately 4 in 10 Medicaid/CHIP-enrolled children faced at least one observed barrier to accessing care, and some faced more than one barrier, including having an unmet need for care, noncost delays in obtaining care, parental frustrations when obtaining care, and/or not receiving preventive medical or dental care. The prevalence of reported access issues was somewhat higher for children enrolled in Medicaid/CHIP than for privately insured children, though these differences became smaller and some were no longer significant after taking into account observed differences in the health and socioeconomic status of children with different types of coverage. Access challenges were most prevalent for uninsured children, and many of these differences held up even when controlling for other differences between Medicaid/CHIP-enrolled children and uninsured children. Therefore, policy solutions to improve children’s access to care will need to extend beyond

Medicaid/CHIP programs to ensure that all children—regardless of coverage status—can obtain the care they need. These analyses also highlight several service areas where Medicaid/CHIP access appears to be problematic and subgroups of enrolled children who are experiencing more problems getting the health care they need.

The Biden administration has focused attention on the importance of coverage continuity and access to needed health care among Medicaid/CHIP enrollees, as well as improvements needed to expand access to timely, high-quality, and equitable health care in the programs.¹¹ Expanding access to coverage and care is one of six pillars in CMS's strategic plan,¹² and the administration is preparing regulations aiming to improve enrollment and retention in Medicaid and CHIP and reduce barriers to access among enrollees, including progress monitoring.¹³ And a recently proposed CMS rule would provide patients with improved access to their own claims and encounters data, improve data interoperability across organizations, and streamline prior authorization processes, including in both fee-for-service and managed-care Medicaid/CHIP delivery systems. It also seeks information on adoption of standards for measuring social risk.¹⁴ These findings suggest the need for additional federal and state-level policy solutions that would target the access barriers identified in this analysis:

- **Unmet needs for health services.** Though relatively few Medicaid/CHIP-enrolled children were reported to have unmet needs for health services overall, among those with unmet needs, about 1 in 6 needed to see a mental health provider but did not see one, and more than 1 in 7 needed a specialist but did not see one. Problems accessing mental health care are particularly concerning given that the US Surgeon General, along with the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and Children's Hospital Association declared a children's mental health crisis in late 2021 (Office of the US Surgeon General 2021).¹⁵

Several federal and state initiatives, such as the Bipartisan Safer Communities Act of 2022, are attempting to address young people's mental health challenges and increase access to behavioral health services, including through school-based care (Hinton et al. 2022).¹⁶ The CMS Administrator recently declared mental health parity and other interventions to improve behavioral health care as priorities for the Biden administration's Medicaid and CHIP policies.¹⁷ Additional policy changes are likely needed in Medicaid and CHIP to help address mental and related health challenges facing children and adolescents, such as proactive screening to identify problems accompanied by referrals to evidence-based, culturally effective treatment, as well as attention to the adequacy of provider payments and provider networks.¹⁸ State Medicaid and CHIP agencies have a number of tools for monitoring managed care plans'

network adequacy and service availability that could address problems with finding providers that may be contributing to these challenges (CMS 2017).

- **Lack of receipt of ongoing preventive care.** The American Academy of Pediatrics recommends regular preventive medical care throughout childhood and adolescence occurring annually or more frequently, while the American Academy of Pediatric Dentistry has set recommendations for age-appropriate dental care.¹⁹ Our finding that some children are not receiving any preventive medical care and/or dental care during a 12-month period suggests that such needs are not reliably getting met for all Medicaid/CHIP-enrolled children. Moreover, this may mean that some may be underdiagnosed, and therefore health conditions that have not been identified are undertreated or unmet needs have not been identified. Children not obtaining preventive care are also likely not receiving recommended immunizations.

In 2022, the Center for Medicaid and CHIP Services issued a bulletin reminding states of EPSDT requirements and of other state authorities to meet children’s health care needs, including behavioral health needs, as well as the role of preventive care in identifying problems.²⁰ State-level variation in the association between rates of managed care use among pediatric Medicaid enrollees and their use of EPSDT benefits suggests that state policy levers such as reimbursement rates, quality oversight, and overall implementation of Medicaid managed care could affect children’s receipt of preventive services (Kusma, Cartland, and Davis 2021). States have a variety of tools available for promoting preventive care, such as utilizing community health workers, while managed care organizations can provide transportation services and send electronic appointment reminders to support families in obtaining such care (Polacheck and Gears 2020; Vulimiri et al. 2019). Strategies for improving receipt of dental care may vary across states given variation in Medicaid/CHIP dental care delivery systems (Fontana, Hallum, and Lewis 2020). Ensuring that children and adolescents receive preventive care is especially important given the care that was missed during the COVID-19 pandemic (McMorrow et al. 2020).²¹ In 2022 and 2023, some states are focusing on encouraging preventive care, including catching children up on missed childhood vaccines (Hinton et al. 2022).

- **Noncost delays and frustrations.** The findings on frustrations parents report when seeking care for their children and noncost delays they experience obtaining care suggest that some children are not receiving treatment in a consistently timely or convenient way. In addition to overall workforce shortages and inadequacy of provider networks that limit the availability of providers, some frustrations and delays may be related to the uneven distribution of pediatric

providers across geographic areas, highlighting the importance of states enforcing time and distance standards for pediatric care, particularly for specialist, behavioral health, and related services beyond primary care (CMS 2017). Despite the requirement that Medicaid provide nonemergency medical transportation as part of EPSDT benefits and inform families that such transportation is available, lack of knowledge of this benefit or logistical barriers such as not being able to bring other children to appointments may be contributing to the transportation-related delays some families reported (CMS 2017; MACPAC 2021; Silow-Carroll et al. 2021). Reducing access barriers related to transportation or office-based reasons may require Medicaid/CHIP programs and managed care plans to more aggressively and proactively publicize transportation benefits and provide oversight and enforcement on their adequacy, expand provider networks in rural areas where there are transportation-related shortages and require some types of health care providers to expand evening and weekend hours and meet appointment wait time standards (CMS 2017; MACPAC 2021, Silow-Carroll et al. 2021).

- **Larger barriers for certain subgroups.** Targeted efforts are likely needed to reduce barriers for subgroups who are facing greater access challenges in Medicaid and CHIP, including children in immigrant or non-English-speaking families, children of color, and children with chronic conditions. For instance, greater access barriers experienced by children in households not primarily speaking English suggest that outreach and education in multiple languages is needed not only to reduce enrollment challenges, but also to help families after they enroll in coverage so they are better able to navigate the health care system for their children. A growing number of states are also covering more adults in Medicaid, such as through adoption of the Affordable Care Act's Medicaid expansion, which could increase their involvement with service delivery systems within Medicaid and help improve access to care for their children.²²
- **Coverage gaps.** Medicaid/CHIP-enrolled children who experienced a period without coverage in the past year were among the groups we identified with the highest likelihood of reporting access challenges and the most likely to report multiple access challenges. This suggests not only that the rate of access problems we observe here could be lower if only analyzing children with continuous Medicaid/CHIP throughout the prior 12 months, but also that better ensuring coverage continuity would be important for expanding access.

Nationwide, though the patterns described here reflect a time of shifting coverage patterns, coverage and access likely changed even more during the pandemic as FFCRA protections increased coverage stability and new barriers to accessing care arose. Though the Medicaid continuous coverage requirement effectively eliminated many coverage gaps since March

2020, this requirement is ending in April 2023, with millions of children at risk of losing Medicaid (Alker and Brooks 2022; Buettgens and Green 2022). The return to Medicaid renewals highlights the need for reducing coverage gaps among children that can occur during renewal periods, even when children remain eligible for coverage. For instance, states have a variety of tools to maximize rates of *ex parte* renewals, or use electronic data sources to verify continued eligibility, to help reduce procedural denials that can occur when families are unable to complete renewal processes despite remaining eligible (Boozang and Serafi 2022; Brooks and Gardner 2021). Other recent federal and state actions can also help increase children's coverage stability. Beginning in January 2024, the Consolidated Appropriations Act will permanently require that states provide children with a full year of continuous eligibility in Medicaid and CHIP, formerly a state option that fewer than half of states took up for all Medicaid/CHIP-enrolled children (Park et al. 2023). States are also seeking waivers that stand to dramatically reduce coverage gaps. Oregon recently received approval for a Section 1115 demonstration waiver providing continuous coverage of enrolled children from birth to age 6, as well as continuous eligibility for two years for older children, and other states are considering similar proposals.²³

- **Other material and financial hardships.** We found that while the families of many Medicaid/CHIP-enrolled children participate in other public benefits programs, they also experience high rates of material and financial hardships, which can undermine the health and well-being of children and their parents. Investments in social drivers of health have historically been more limited for children than for adults (Mann and Ferguson 2020). Recently, CMS has provided guidance²⁴ on addressing social needs in Medicaid, and a growing number of states are enacting²⁵ programs to help address such needs. For instance, North Carolina's section 1115 demonstration program provides housing, transportation, and nutrition benefits for children with particular health and social risk factors, while New York uses CHIP Health Service Initiatives funding for food assistance and health education programs.²⁶ Recent research identified a number of strategies that state governments, community organizations, and other state and local entities can take to improve families' access to and retention of public benefits (Hahn, Pratt, and Knowles 2023). Broader income support programs and increases in the size and availability of benefits would likely also be needed to improve families' financial stability (Ballentine, Goodkind, and Shook 2022; Carlson, Llobrera, and Keith-Jennings 2021; Finkelstein et al. 2022). The large effect of overall well-being in childhood on health later in life highlights the urgency of broadening efforts to ensure that the housing, nutritional, safety, and other basic needs of both children and their families are adequately met.

Importantly, the data sources we used in this analysis provide a general assessment of access among Medicaid/CHIP-enrolled children overall and do not allow for an assessment of how well Medicaid and CHIP programs are specifically meeting the health needs of children with chronic or acute needs, serious mental health needs, or who are medically fragile. Documenting access experiences and challenges for these children is critical (Kuo et al. 2022). Future research could also include comparisons of enrollees' access to and quality of care across states or groups of states to help illuminate how state policies may be contributing to barriers and how state policy changes can alleviate challenges families face obtaining health services. In addition to survey data and other state-level reporting to CMS, since 2010, states have had the option to report on a Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set). Though most states report on at least some measures, state variation in reporting makes standardized comparisons difficult. As required by the Bipartisan Budget Act of 2018, CMS in 2022 proposed a rule making Child Core Set reporting mandatory beginning in 2024 for the purpose of better understanding quality nationally and monitoring performance at the state level; the rule would also phase in reporting of measures by characteristics such as race and ethnicity, age, disability, and rural versus urban status.²⁷ Research comparing state performance on these measures across states could help identify strategies for improving access.

With many Medicaid/CHIP-enrolled children living in families with low incomes and facing other systematic disadvantages, these programs have the potential to reduce or even eliminate barriers they may face accessing needed health care. However, evidence presented here suggests that these programs have not been able to sufficiently overcome these hurdles. Moreover, with indications that service use among Medicaid/CHIP-enrolled children fell during the pandemic,²⁸ monitoring the extent and nature of access barriers and unmet health care needs as children and families continue to face the fallout from the pandemic will be critical. Ensuring the quality and accessibility of physical, dental, and mental health care for Medicaid/CHIP-enrolled children is important for ensuring their immediate needs are being met as well as allowing them to grow and develop into healthy adults (Centering on the Developing Child 2010).

Appendix. Data and Methods

In this chartbook, we use data from the 2016–19 National Survey of Children’s Health (NSCH) and 2016–19 National Health Interview Survey (NHIS).²⁹ These data sources and our methodology are discussed below.

2016–19 National Survey of Children’s Health

First, we used 2016–19 data from the National Survey of Children’s Health (NSCH), an annual household survey conducted by the US Census Bureau that collects information on the physical and emotional health of children ages 17 and under. Estimates from the NSCH are meant to be nationally and state representative of children younger than 18 who are not institutionalized and are living in a housing unit.³⁰ We obtained publicly available datasets for each year of the survey between 2016 and 2019.³¹ All estimates are pooled across four years, from 2016 to 2019, to increase sample sizes and allow for more accurate estimates.³² Missing observations are not included in our estimates. We refer to responses reported by a “parent” but note that some responses were provided by nonparent caregivers.

Our primary analytic sample is children with Medicaid/CHIP coverage at the time of the survey, defined as children whose parent reported that the child was covered by “Medicaid, Medical Assistance, or any kind of government assistance plan for those with low incomes or a disability.” We also examine subgroups of children with Medicaid/CHIP coverage, specifically: children with any unmet need for services in the past year; children whose parent reported being always or usually frustrated when obtaining care for their child in the past year; children without a preventive medical visit in the past year; and children without a preventive dental visit in the past year. We abbreviate these categories as “those who had an unmet need,” “those who were frustrated obtaining care,” “those who had no preventive medical visits,” and “those who had no preventive dental visits,” respectively. More information about the precise survey instrument language used to construct each of these subgroups is available in appendix table A.1. Based on US Preventive Services Task Force recommendations, we further restricted the “no preventive dental visit” group to children ages 2 to 17 to reflect later initiation of dental care, compared with medical care, and to align with the National Health Interview Survey.

Our total sample is approximately 29,000 Medicaid/CHIP-enrolled children. We test the significance of differences between children with Medicaid/CHIP coverage and privately insured children, between Medicaid/CHIP enrolled-children and uninsured children, and between Medicaid/CHIP-covered children with and without these barriers to care using two-tailed *t*-tests. Because demographic and socioeconomic characteristics vary between Medicaid, private insurance, and uninsured groups (MACPAC 2021), we estimate adjusted differences between these groups using multivariable analysis controlling for individual and family socioeconomic characteristics with three models: model 1, including age, sex, and self-reported health status; model 2, which adds race/ethnicity, survey language, parental family nativity, and family structure; and model 3, which adds family income. These results are presented in appendix table A.4.

2016–19 National Health Interview Survey

Second, we used 2016–18 National Health Interview Survey (NHIS) data obtained from the Integrated Public Use Microdata Series at the University of Minnesota.³³ The NHIS is the primary source of information on the nation’s health and provides nationally representative estimates of the civilian noninstitutionalized population for a variety of demographic, socioeconomic, and health care access measures. We construct five mutually exclusive insurance coverage categories: Medicaid/CHIP, employer coverage, private nongroup including Marketplace, other public or private coverage, and uninsured. Insurance coverage is measured at the time of the survey, and we focus on children with Medicaid/CHIP coverage.

The NHIS consists of a person file, which includes information on all residents of a household, as well as sample child and sample adult files, which include more detailed information on one selected child or adult per household. Most of the access measures of interest in this analysis appear on the sample child file, so we limit our main analysis sample to sample children. All responses for sample children come from a knowledgeable adult in the household, which we sometimes refer to as a “parent” but may be another adult. We also use information from the full household file to construct measures of family circumstances including family income, food security, having a noncitizen in the family, having an uninsured parent, and survey response language. In addition, we use details from the sample adult file on worries about various financial commitments and assign the responses of the sample adult to the sample child in the household.

We include six primary measures of challenges accessing health care for sample children. These include (1) unmet need for medical care, mental health care, or prescription drugs because of cost in the

past 12 months, (2) unmet need for dental care because of cost in the past 12 months, (3) no well-child checkup in the past 12 months, (4) no dental visit in the past 12 months, (5) any office-based delay getting needed care in the past 12 months, and (6) any transportation-related delay getting care in the past 12 months. Office-based delays getting care include trouble getting through on the phone, long wait for appointments, long wait in the office, and inconvenient office hours. Together, we refer to office-based delays and transportation-related delays as “noncost delays.” Additional details on question wording for each of these measures can be found in appendix table A.1.

Because questions related to mental health and dental care are only asked of children ages 2 to 17 and we have chosen to combine several access measures, we limit our analytic sample for all measures to children ages 2 to 17. This results in a sample size of approximately 8,400 sample children ages 2 to 17 with Medicaid/CHIP at the time of the survey from 2016–19. We use appropriate survey weights in all analyses and we use two-sided *t*-tests to test for statistical differences between (1) Medicaid/CHIP-enrolled children and privately insured children and between Medicaid/CHIP-enrolled children and uninsured children; (2) subgroups of Medicaid/CHIP-enrolled children by age, sex, race/ethnicity, health status, full-year coverage status, family citizenship status, parental structure, survey language, parental insurance status, family income, and region; and (3) Medicaid/CHIP-enrolled children facing access challenges and all Medicaid/CHIP-enrolled children. To account for demographic and socioeconomic differences between Medicaid/CHIP-enrolled children, privately insured children, and uninsured children, we estimate adjusted differences between these groups using multivariable analysis controlling for individual and family socioeconomic characteristics, using the same adjusted models as in the NSCH. These results are presented in appendix table A.5.

Limitations

Our analysis has several limitations. First, the measures of health insurance coverage in both surveys refer to coverage at the time of the survey, whereas the access measures refer to experiences over the prior 12 months, and the data do not indicate whether the access challenges identified occurred when the child had the coverage identified at the time of the survey. For instance, if a child who was covered part of the year with Medicaid/CHIP and part of the year with private coverage experienced an unmet need at some point during that 12-month period, we cannot determine whether it occurred during the time they had Medicaid/CHIP or private coverage, or an access barrier could have occurred during a time a child was uninsured. Access challenges may be smaller if limiting the analysis to only those with continuous Medicaid/CHIP coverage over the course of a year.

Second, the definition of Medicaid in the NSCH survey instrument is broad and not limited to Medicaid—and it also does not specifically mention CHIP. Further, it does not make specific reference to state-specific Medicaid or CHIP program names like in the NHIS, which could result in parents misreporting their child’s insurance coverage.³⁴ The NSCH also does not have an overall measure of experiencing barriers to care, and the low rates of reported unmet need suggest that not all barriers to care are captured by this measure.

Third, estimates of Medicaid/CHIP-enrolled children differ between the NSCH and NHIS and are lower than in administrative data and other data sources. As shown in appendix table A.2, we observe a slightly smaller share and number of children of all ages reporting Medicaid/CHIP coverage in the NSCH between 2016 and 2019 than we do in the NHIS between 2016 and 2018 (34.1 percent on the NSCH compared with 37.1 percent on the NSCH), both of which are lower than comparable estimates drawn from the American Community Survey (data not shown). In addition, all survey estimates are likely an undercount of children with Medicaid/CHIP coverage, as national surveys tend to underestimate children compared with administrative data from the CMS.³⁵ This could suggest that one or both samples are not representative of all enrolled children. However, the distribution of enrolled children according to age, sex, race/ethnicity, region, and income are fairly similar across the two data sources, suggesting that both data sources represent similar distributions of children. Moreover, despite the differences across the surveys in survey design and measures of access, we find several patterns that are fairly consistent across surveys, lending them further credibility.

Importantly, the data sources we use provide a general assessment of access among Medicaid/CHIP-enrolled children overall and do not allow for an assessment of how well Medicaid and CHIP programs are specifically meeting the health needs of children with chronic or acute needs, serious mental health needs, needs for long-term care, or who are medically fragile. Other research would be needed to comprehensively explore concerns about access to specialty or other care for these children. We were also unable to identify differences for urban versus rural children, or by other substate geographic indicators, where differences in provider supply and proximity may introduce differences in access.

Finally, as with all survey data, responses are self-reported and subject to error and bias. In addition, the measures we use assess parents’ understanding of their children’s health needs; for instance, some children reported to not have unmet needs who are not getting regular preventive care may have additional needs of which their parents are unaware.

Appendix Tables

TABLE A.1

Survey Instrument Language for Selected Measures of Unmet Needs, Health Care Utilization, Delays, and Frustration Getting Care, by Data Source, 2016–19 National Survey of Children’s Health (NSCH) and 2016–18 National Health Interview Survey (NHIS)

Measure	Years	Survey instrument language	Response options	Universe
NSCH (2016–19)				
Any unmet need for services	2016–19	During the past 12 months, was there any time when this child needed health care but it was not received? By health care, we mean medical care as well as other kinds of care like dental care, vision care, and mental health services.	Yes/no	All children ages 17 and under
Always or usually felt frustrated when getting care for their child	2016–19	During the past 12 months, how often were you frustrated in your efforts to get services for this child?	Always, Usually, Sometimes, Never	All children ages 17 and under
No preventive health care visits†	2016–19	During the past 12 months, how many times did this child visit a doctor, nurse, or other health care professional to receive a preventive checkup? A preventive checkup is when this child was not sick or injured, such as an annual or sports physical, or well-child visit.	0 visits, 1 visit, 2 or more visits	All children ages 17 and under who reported they had seen a doctor for any kind of medical care
No preventive dental health care visits†‡	2016–19	During the past 12 months, did this child see a dentist or other oral health care provider for preventive dental care, such as checkups, dental cleanings, dental sealants, or fluoride treatments?	No preventive visit in the past 12 months; Yes 1 visit, Yes 2 or more visits	All children ages 17 and under who reported they had seen a dentist or oral health care provider for any kind of dental or oral health care
NHIS (2016–18)				
Unmet need for medical care, prescription drugs, or mental health care because of cost	2016–18	Constructed: Yes if child reported any of the selected unmet needs; No if child reported none of the selected unmet needs	Yes/no	Sample children ages 2–17
Unmet need for medical care because of cost		DURING THE PAST 12 MONTHS, was there any time when [person] needed medical care but did not get it because [person] couldn't afford it?	Yes/no	All children ages 17 and under
Unmet need for mental health care because of cost		DURING THE PAST 12 MONTHS, was there any time when [SC name] NEEDED any of the following but	Yes/no	Sample children ages 2–17

Measure	Years	Survey instrument language	Response options	Universe
		didn't get it because you couldn't afford it?...Mental health care or counseling?		
Unmet need for prescription drugs because of cost		DURING THE PAST 12 MONTHS, was there any time when [SC name] NEEDED any of the following, but didn't get it because you couldn't afford it?...Prescription medicines?	Yes/no	Sample children ages 2-17
Unmet need for dental care because of cost	2016-18	DURING THE PAST 12 MONTHS, was there any time when [SC name] NEEDED any of the following, but didn't get it because you couldn't afford it?...Dental care (including checkups)?	Yes/no	Sample children ages 2-17
No well-child visit past 12 months	2016-18	During the past 12 months did [SC name] receive a well-child checkup—that is, a general checkup when [he/she] was not sick or injured?	Yes/no	Sample children ages 17 and under
No dental visit past 12 months	2016-18	About how long has it been since [SC name] last saw a dentist? Include all types of dentists, such as orthodontists, oral surgeons, and all other dental specialists, as well as dental hygienists.	Never; 6 months or fewer; more than 6 months, but not more than 1 year; more than 2 years, but not more than 5 years; more than 5 years ago	Sample children ages 1-17
Any office-based delay in getting care	2016-18	Constructed: Yes if child reported any of the selected delays; No if child reported none of the selected delays	Yes/no	Sample children ages 17 and under
Delay because of trouble getting through on phone	2016-18	Have you delayed getting care for [SC name] for any of the following reasons in the PAST 12 MONTHS?...You couldn't get through on the telephone	Yes/no	Sample children ages 17 and under
Delay because of wait time for appointment	2016-18	Have you delayed getting care for [SC name] for any of the following reasons in the PAST 12 MONTHS?...You couldn't get an appointment for [SC name] soon enough	Yes/no	Sample children ages 17 and under
Delay because of wait time in office	2016-18	Have you delayed getting care for [SC name] for any of the following reasons in the PAST 12 MONTHS?...Once you get there, [SC name] has to wait too long to see the doctor	Yes/no	Sample children ages 17 and under
Delay because of inconvenient hours	2016-18	Have you delayed getting care for [SC name] for any of the following reasons in the PAST 12 MONTHS?...The clinic/doctor's office wasn't open when you could get there	Yes/no	Sample children ages 17 and under

Measure	Years	Survey instrument language	Response options	Universe
Transportation delay in getting care	2016-18	Have you delayed getting care for [SC name] for any of the following reasons in the PAST 12 MONTHS?...You didn't have transportation	Yes/no	Sample children ages 17 and under

Source: National Survey of Children's Health (NSCH) 2016–19 and National Health Interview Survey (NHIS) 2016–18.

Notes: † indicates measure is reported among all children. Those who were not included in the sample because of a survey skip pattern are classified as not having the service.

‡ indicates measure is asked among all children ages 17 and under, but the only reported data were for children ages 2–17. SC = sampled child.

TABLE A.2

Selected Characteristics of Medicaid/CHIP-Enrolled Children Ages 17 and Under, by Data Source, 2016–19 and 2016–18

	NSCH (2016–19)			NHIS (2016–18)		
	Share	SE	N	Share	SE	N
Share of children ages 17 and under in Medicaid/CHIP	35.4%	0.003	127,846	37.1%	0.006	28,077
Count of children ages 17 and under in Medicaid/CHIP	25,043,000			26,019,000		
Among Medicaid/CHIP-enrolled children						
Age						
Ages 5 and under	33.9%	0.006	29,739	35.8%	0.007	9,663
Ages 6–11	35.1%	0.006	29,739	34.4%	0.007	9,663
Ages 12–17	31.0%	0.006	29,739	29.7%	0.006	9,663
Sex						
Male	51.6%	0.006	29,739	50.9%	0.006	9,663
Female	48.4%	0.006	29,739	49.1%	0.006	9,663
Race/ethnicity						
American Indian/Alaska Native, non-Hispanic	0.6%	0.001	29,739	1.2%	0.004	9,663
Asian/Pacific Islander, non-Hispanic	3.6%	0.002	29,739	2.9%	0.002	9,663
Black, non-Hispanic	21.1%	0.005	29,739	20.2%	0.009	9,663
Hispanic	35.3%	0.007	29,739	37.7%	0.013	9,663
Other/multiple races, non-Hispanic	5.6%	0.002	29,739	4.5%	0.003	9,663
White, non-Hispanic	33.9%	0.005	29,739	33.5%	0.011	9,663
Region						
Northeast	14.7%	0.004	29,739	15.8%	0.010	9,663
Midwest	19.0%	0.004	29,739	17.8%	0.009	9,663
South	42.1%	0.006	29,739	41.6%	0.014	9,663
West	24.3%	0.006	29,739	24.8%	0.014	9,663

	NSCH (2016-19)			NHIS (2016-18)		
	Share	SE	N	Share	SE	N
Family income						
<100% FPL	42.2%	0.007	29,739	41.0%	0.008	9,663
100-200% FPL	36.3%	0.006	29,739	38.5%	0.007	9,663
200-400% FPL	16.8%	0.005	29,739	17.0%	0.005	9,663
Above 400% FPL	4.7%	0.002	29,739	3.5%	0.002	9,663

Source: National Survey of Children's Health and National Health Interview Survey.

Note: CHIP = Children's Health Insurance Program. Coverage is measured at time of survey. FPL = federal poverty level.

TABLE A.3

Rates of Unmet Health Service Needs, No Utilization of Dental or Preventive Services, or Frustration Obtaining Health Care in the Prior 12 Months by Selected Characteristics of US Medicaid Children Ages 17 and Under, 2016-19

	Medicaid/CHIP-Enrolled Children with Specified Access Challenge								
	Reported any unmet need for services, past 12m	Parent always/usually felt frustrated when trying to get care for child, past 12m	No preventive health care visits, past 12m	No dental preventive visit (ages 2-17 only), past 12m	Faced any of the four barriers (ages 2-17 only), past 12m	Faced none of the four barriers (ages 2-17 only), past 12m	Faced one barrier (ages 2-17 only), past 12m	Faced two barriers (ages 2-17 only), past 12m	Faced three barriers or more (ages 2-17 only), past 12m
All Medicaid/CHIP-enrolled children	4.0%	3.7%	22.2%	19.1%	40.1%	59.9%	31.1%	7.9%	1.1%
Age									
Ages 5 and under	2.1%*	2.5%*	16.9%*	30.7%*	44.4%*	55.6%*	36.6%*	7.0%	0.8%
Ages 6-11^	4.3%	4.2%	24.8%	13.0%	37.0%	63.0%	29.1%	6.8%	1.1%
Ages 12-17	5.7%*	4.6%	24.9%	17.4%*	40.3%*	59.7%*	29.3%	9.7%*	1.3%
Sex									
Male^	3.6%	3.8%	21.9%	19.4%	39.8%	60.2%	30.5%	8.2%	1.0%
Female	4.3%	3.6%	22.4%	18.7%	40.4%	59.6%	31.7%	7.5%	1.1%
Race/ethnicity									
American Indian/Alaska Native, non-Hispanic	3.1%	4.2%	38.2%*	17.8%	50.0%*	50.0%*	40.5%*	8.9%	0.5%

Medicaid/CHIP-Enrolled Children with Specified Access Challenge

	Reported any unmet need for services, past 12m	Parent always/usually felt frustrated when trying to get care for child, past 12m	No preventive health care visits, past 12m	No dental preventive visit (ages 2-17 only), past 12m	Faced any of the four barriers (ages 2-17 only), past 12m	Faced none of the four barriers (ages 2-17 only), past 12m	Faced one barrier (ages 2-17 only), past 12m	Faced two barriers (ages 2-17 only), past 12m	Faced three barriers or more (ages 2-17 only), past 12m
Asian/Pacific Islander, non-Hispanic	1.8%*	2.1%*	32.0%*	22.4%	48.0%*	52.0%*	35.3%	12.3%*	0.3%*
Black, non-Hispanic	5.0%	4.2%	21.9%*	20.8%	43.1%*	56.9%*	34.0%*	7.9%	1.1%
Hispanic	3.3%	3.2%*	25.4%*	17.3%*	39.6%	60.4%	30.6%	7.9%	1.1%
Other/multiple races, non-Hispanic	4.4%	3.5%	17.9%	16.3%*	34.1%*	65.9%*	26.1%*	7.3%	0.7%
White, non-Hispanic^	4.1%	4.1%	18.4%	19.9%	38.6%	61.4%	30.0%	7.4%	1.2%
Health status									
Excellent/very good health^	3.0%	2.8%	22.6%	18.7%	39.3%	60.7%	31.1%	7.4%	0.7%
Good health	8.4%*	6.9%*	20.3%	21.0%	42.7%	57.3%	30.7%	9.6%	2.4%*
Fair/poor health	11.3%*	14.9%*	20.0%	21.7%	48.7%*	51.3%*	32.9%	12.4%*	3.5%*
Family nativity									
One or more parents born outside the US	3.1%*	2.8%*	25.6%*	18.2%	40.3%	59.7%	31.1%	8.1%	1.0%
No adults in household born outside the US^	4.5%	4.2%	20.0%	19.5%	39.6%	60.4%	30.8%	7.7%	1.1%
Family structure									
Two caregivers are biological, adoptive, or step-parents^	3.2%	2.9%	21.3%	18.4%	37.9%	62.1%	29.9%	7.1%	0.9%
One caregiver is biological, adoptive, or step-parent	4.8%*	5.0%*	23.4%	19.5%	42.3%*	57.7%*	32.3%	8.5%	1.5%
No caregiver is biological, adoptive, or step-parent	6.0%*	4.2%	22.9%	21.2%	44.3%*	55.7%*	33.9%	9.8%*	0.6%
Region									
Northeast	3.0%*	4.2%	17.4%*	17.3%*	35.4%*	64.6%*	28.7%*	6.0%*	0.7%

Medicaid/CHIP-Enrolled Children with Specified Access Challenge

	Reported any unmet need for services, past 12m	Parent always/usually felt frustrated when trying to get care for child, past 12m	No preventive health care visits, past 12m	No dental preventive visit (ages 2-17 only), past 12m	Faced any of the four barriers (ages 2-17 only), past 12m	Faced none of the four barriers (ages 2-17 only), past 12m	Faced one barrier (ages 2-17 only), past 12m	Faced two barriers (ages 2-17 only), past 12m	Faced three barriers or more (ages 2-17 only), past 12m
Midwest [^]	4.6%	3.9%	21.7%	22.8%	43.0%	57.0%	33.4%	8.5%	1.1%
South	4.2%	3.8%	21.5%	18.3%*	39.2%*	60.8%*	30.3%*	7.9%	1.0%
West	3.5%	3.1%	26.7%*	18.6%*	42.1%	57.9%	32.2%	8.5%	1.4%
Language									
Primary household language is English [^]	4.2%	4.1%	20.3%	19.4%	39.7%	60.3%	31.2%	7.4%	1.1%
Primary household language is not English	3.1%	2.3%*	28.2%*	18.2%	41.0%	59.0%	30.5%	9.5%	1.0%
Past-year insurance coverage									
Covered for 12 months of the past year [^]	3.3%	3.4%	22.1%	18.7%	39.5%	60.5%	31.2%	7.5%	0.8%
Had gap in coverage in the past year	18.3%*	10.4%*	23.1%	28.0%*	51.5%*	48.5%*	30.1%	15.1%*	6.4%*
Family income									
<100% FPL	4.3%	4.0%	25.8%*	21.2%	43.7%*	56.3%*	32.5%	9.8%*	1.4%
100-200% FPL	4.1%	3.6%	21.7%*	17.9%	39.6%	60.4%	31.6%	7.0%	1.0%
200-400% FPL	3.1%	3.0%	15.8%	16.7%	33.3%	66.7%	27.2%	5.7%	0.4%
Above 400% FPL [^]	3.0%	3.9%	16.2%	17.4%	35.2%	64.8%	29.3%	5.3%	0.6%

Source: National Survey of Children's Health, 2016-19.

Note: 12m = 12 months. * Indicates significant difference at the 0.05 level from reference group (^). FPL = federal poverty level.

TABLE A.4

Adjusted Differences Reported Access Challenges, Children Ages 17 and Under with Medicaid/CHIP Coverage Compared with Children with Private Insurance Coverage and Uninsured Children, 2016–19

	Difference between Medicaid/CHIP-Enrolled Children and Privately Insured Children				Difference between Medicaid/CHIP-Enrolled Children and Uninsured Children			
	Unadjusted	Adjusted model 1	Adjusted model 2	Adjusted model 3	Unadjusted	Adjusted model 1	Adjusted model 2	Adjusted model 3
		Difference (pp)	Difference (pp)	Difference (pp)		Difference (pp)	Difference (pp)	Difference (pp)
Unmet needs for care								
Reported any unmet need for services, past 12m	2.3%*	1.7%*	1.5%*	0.9%*	-6.1%*	-6.0%*	-6.3%*	-6.6%*
<i>Type of unmet needs</i>								
Unmet need, medical care	0.9%*	0.7%*	0.6%*	0.4%*	-3.8%*	-3.7%*	-4.0%*	-4.0%*
Unmet need, dental care	1.3%*	1.2%*	0.9%*	0.4%	-5.2%*	-5.0%*	-5.3%*	-5.6%*
Unmet need, vision care	0.6%*	0.5%*	0.4%*	0.2%	-2.6%*	-2.5%*	-2.8%*	-2.9%*
Unmet need, hearing care	0.3%*	0.2%*	0.1%	0.0%	-0.4%	-0.4%	-0.3%	-0.4%
Unmet need, mental health care	0.6%*	0.3%*	0.3%*	0.2%	-0.5%	-0.5%	-0.6%	-0.6%
Unmet need, other	0.3%*	0.2%*	0.2%*	0.2%*	-0.2%	-0.2%	-0.2%	-0.2%
<i>Reasons for unmet needs</i>								
Unmet need, not eligible for services	1.0%*	0.8%*	0.6%*	0.4%*	-3.1%*	-3.0%*	-3.4%*	-3.5%*
Unmet need, no services available in area	1.0%*	0.8%*	0.9%*	0.8%*	-0.6%	-0.6%	-0.6%	-0.7%
Unmet need, problems getting an appointment	1.4%*	1.0%*	0.9%*	0.8%*	-0.5%	-0.4%	-0.5%	-0.7%
Unmet need, problems getting transportation or child care	0.6%*	0.5%*	0.5%*	0.4%*	-0.2%	-0.3%	-0.4%	-0.4%
Unmet need, clinic or office not open when care was needed	0.5%*	0.4%*	0.3%*	0.2%*	-0.7%	-0.7%	-0.7%	-0.8%
Unmet need, cost reasons	0.8%*	0.6%*	0.4%*	0.0%	-5.9%*	-5.8%*	-6.1%*	-6.4%*
Use of preventive medical care, past 12m								
Two or more preventive medical visits, past 12m	7.8%*	5.1%*	3.8%*	5.5%*	14.7%*	12.8%*	12.7%*	13.0%*

	Difference between Medicaid/CHIP-Enrolled Children and Privately Insured Children				Difference between Medicaid/CHIP-Enrolled Children and Uninsured Children			
	Unadjusted	Adjusted model 1	Adjusted model 2	Adjusted model 3	Unadjusted	Adjusted model 1	Adjusted model 2	Adjusted model 3
		Difference (pp)	Difference (pp)	Difference (pp)		Difference (pp)	Difference (pp)	Difference (pp)
One preventive medical visit, past 12m	-14.7%*	-12.7%*	-8.2%*	-4.8%*	13.1%*	14.3%*	14.0%*	14.7%*
One or more medical visits, no preventive medical visits, past 12m	0.1%	0.0%	0.1%	-0.2%	-2.0%*	-1.9%*	-2.1%*	-2.1%*
No medical visits at all, past 12m	6.8%*	7.5%*	4.3%*	-0.4%	-25.8%*	-25.1%*	-24.5%*	-25.6%*
No preventive medical visits at all, past 12m	6.9%*	7.5%*	4.4%*	-0.7%	-27.8%*	-27.0%*	-26.6%*	-27.8%*
<u>Use of preventive dental care, past 12m</u>								
Two or more preventive dental visits, past 12m (among ages 2–17)	-14.1%*	-13.4%*	-9.8%*	-4.7%*	13.0%*	14.0%*	15.7%*	16.9%*
One preventive dental visit, past 12m (among ages 2–17)	8.1%*	8.1%*	5.8%*	4.0%*	7.4%*	7.3%*	5.9%*	5.6%*
One or more dental visits, no preventive dental visits, past 12m (among ages 2–17)	1.3%*	1.2%*	0.9%*	0.5%	-1.2%*	-1.1%*	-1.5%*	-1.6%*
No dental visits at all, past 12m (among ages 2–17)	4.7%*	4.2%*	3.1%*	0.1%	-19.2%*	-20.2%*	-20.1%*	-20.9%*
No preventive dental visits at all, past 12m (among ages 2–17)	6.0%*	5.4%*	4.0%*	0.6%	-20.4%*	-21.3%*	-21.6%*	-22.5%*
<u>Parental frustration when trying to get care for child, past 12m</u>								
Parent always or usually felt frustrated when try to get care for child, past 12m	2.3%*	1.6%*	1.5%*	1.3%*	-3.9%*	-3.9%*	-4.4%*	-4.5%*
Parent always felt frustrated when trying to get care for child, past 12m	0.8%*	0.6%*	0.4%*	0.3%	-2.6%*	-2.6%*	-3.0%*	-3.2%*
Parent usually felt frustrated when trying to get care for child, past 12m	1.5%*	1.0%*	1.1%*	1.0%*	-1.2%*	-1.2%*	-1.3%*	-1.3%*

	Difference between Medicaid/CHIP-Enrolled Children and Privately Insured Children				Difference between Medicaid/CHIP-Enrolled Children and Uninsured Children			
	Unadjusted	Adjusted model 1	Adjusted model 2	Adjusted model 3	Unadjusted	Adjusted model 1	Adjusted model 2	Adjusted model 3
		Difference (pp)	Difference (pp)	Difference (pp)		Difference (pp)	Difference (pp)	Difference (pp)
Parent sometimes felt frustrated when trying to get care for child, past 12m	7.1%*	5.3%*	5.4%*	5.5%*	-1.6%	-1.7%	-2.5%	-2.4%
Parent never felt frustrated when trying to get care for child, past 12m	-9.4%*	-6.9%*	-6.9%*	-6.8%*	5.5%*	5.6%*	6.9%*	6.9%*
Any of the above bolded access challenges, past 12m (among ages 2–17)	12.3%*	11.5%*	8.0%*	1.5%	-28.8%*	-29.1%*	-29.3%*	-30.7%*

Source: National Survey of Children’s Health, 2016–19.

Notes: 12m = 12 months. CHIP = Children’s Health Insurance Program. pp = percentage point. Coverage is measured at time of survey. * indicates significantly different from rate for children not enrolled in Medicaid/CHIP, at the $p < 0.05$ level. Model 1 controls for age, sex, and self-reported health status; model 2 adds race/ethnicity, survey language, parental family nativity, and family structure; model 3 adds family income.

TABLE A.5

Adjusted Differences in Reported Access Challenges, Children Ages 2 to 17 with Medicaid/CHIP Coverage Compared with Children with Private Insurance Coverage and Uninsured Children, 2016–18

	Difference between Medicaid/CHIP-Enrolled Children and Privately Insured Children				Difference between Medicaid/CHIP-Enrolled Children and Uninsured Children			
	Unadjusted	Adjusted model 1	Adjusted model 2	Adjusted model 3	Unadjusted	Adjusted model 1	Adjusted model 2	Adjusted model 3
		Difference (pp)	Difference (pp)	Difference (pp)		Difference (pp)	Difference (pp)	Difference (pp)
Any unmet need because of cost, past 12m	3.5%*	3.0%*	2.6%*	2.6%*	-18.4%*	-18.0%*	-18.2%*	-18.2%*
Unmet need—medical care	0.2%	0.0%	0.0%	0.0%	-9.2%*	-9.2%*	-9.6%*	-9.6%*
Unmet need—Rx drugs	1.5%*	1.2%*	1.0%*	1.0%*	-4.5%*	-4.6%*	-5.0%*	-5.0%*
Unmet need—mental health care	0.3%*	0.2%	0.4%*	0.4%*	-1.6%*	-1.6%*	-1.6%*	-1.6%*
Unmet need—vision	0.8%*	1.6%*	1.2%*	1.2%*	-4.9%*	-13.8%*	-13.8%*	-13.8%*
Unmet need—dental	1.6%*	0.7%*	0.6%*	0.6%*	-14.2%*	-4.7%*	-4.7%*	-4.7%*
Unmet need—medical care/mental health care/Rx	1.8%*	1.3%*	1.3%*	1.3%*	-11.4%*	-11.5%*	-12.1%*	-12.1%*
Usual source of care	-2.0%*	-2.0%*	-1.6%*	-1.6%*	22.6%*	22.3%*	21.4%*	21.4%*
Any noncost delay getting care, past 12m	7.2%*	6.0%*	5.3%*	5.3%*	3.5%*	3.1%*	3.1%*	3.1%*
Delay—office-based reason	5.4%*	4.3%*	3.6%*	3.6%*	2.7%*	2.3%	2.5%*	2.5%*
Delay—getting through on phone	1.7%*	1.4%*	1.4%*	1.4%*	-0.8%	-1.0%	-1.0%	-1.0%
Delay—wait for appointment	3.0%*	2.2%*	2.3%*	2.3%*	2.2%*	1.9%*	2.0%*	2.0%*
Delay—office hours	1.0%*	0.6%	0.5%	0.5%	0.9%	0.8%	0.8%	0.8%
Delay—wait in office	3.4%*	2.9%*	2.1%*	2.1%*	1.5%	1.3%	1.7%*	1.7%*
Delay—transportation reason	3.0%*	2.7%*	2.6%*	2.6%*	1.4%*	1.2%	1.1%	1.1%
No well child visit, past 12m	2.1%*	2.5%*	1.4%*	1.4%*	-28.6%*	-27.7%*	-26.2%*	-26.2%*
No dental visit, past 12m	3.8%*	3.0%*	3.7%*	3.7%*	-24.0%*	-24.9%*	-23.4%*	-23.4%*
Problem finding a provider	1.3%*	0.8%*	1.1%*	1.1%*	-1.6%	-1.9%*	-1.6%	-1.6%
Could not find a provider	0.2%	0.2%	0.1%	0.1%	-1.7%*	-1.8%*	-1.5%*	-1.5%*

	Difference between Medicaid/CHIP-Enrolled Children and Privately Insured Children				Difference between Medicaid/CHIP-Enrolled Children and Uninsured Children			
	Unadjusted	Adjusted model 1	Adjusted model 2	Adjusted model 3	Unadjusted	Adjusted model 1	Adjusted model 2	Adjusted model 3
		Difference (pp)	Difference (pp)	Difference (pp)		Difference (pp)	Difference (pp)	Difference (pp)
Any of the above bolded access challenges	9.6%*	8.0%*	7.2%*	7.2%*	-26.4%*	-26.9%*	-25.1%*	-25.1%*

Source: Authors' analysis of the National Health Interview Survey, 2016–18.

Notes: 12m = 12 months. CHIP = Children's Health Insurance Program. pp = percentage point. Coverage is measured at time of survey. All unmet needs are because of cost in the past 12 months. All noncost delays are in past 12 months. Office-based delays include trouble getting through on phone, long wait for appointment, long wait in the office, and inconvenient office hours. Problem finding a provider was not asked in 2018. * indicates share among Medicaid/CHIP-enrolled children is statistically different from all children at the $p < 0.05$ level. Model 1 controls for age, sex, and self-reported health status; model 2 adds race/ethnicity, survey language, parental family nativity, and family structure; model 3 adds family income.

Notes

- ¹ Matt Broaddus, “Medicaid at 50: Covering Children Has Long-Term Educational Benefits,” Center on Budget and Policy Priorities, July 7, 2015, <https://www.cbpp.org/blog/medicaid-at-50-covering-children-has-long-term-educational-benefits>.
- ² “The National Survey of Children’s Health,” Data Resource Center for Child & Adolescent Health, accessed March 15, 2023, <https://www.childhealthdata.org/learn-about-the-nsch/NSCH>; “National Health Interview Survey,” Centers for Disease Control and Prevention, National Center for Health Statistics, last updated February 9, 2023, <https://www.cdc.gov/nchs/nhis/index.htm>.
- ³ We use the term “Hispanic” in this analysis because this is the primary terminology used in the surveys that provided the household-level data for the analysis.
- ⁴ “Recommendations for Preventive Pediatric Health Care,” American Academy of Pediatrics, accessed March 15, 2023, https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.127805389.1386825880.1677605016-1777318367.1677605015.
- ⁵ “EPSDT: A Primer on Medicaid’s Pediatric Benefit,” Georgetown University Health Policy Institute Center for Children and Families, March 2017, <http://ccf.georgetown.edu/wp-content/uploads/2016/03/EPSDT-fact-sheet.pdf>; Medicaid and CHIP Payment and Access Commission (MACPAC), “EPSDT in Medicaid,” <https://www.macpac.gov/subtopic/epsdt-in-medicaid/>.
- ⁶ Matt Broaddus, “Medicaid at 50: Covering Children Has Long-Term Educational Benefits.”
- ⁷ US Government Accountability Office, “Medicaid and CHIP: Reports for Monitoring Children’s Health Care Services Need Improvement,” letter to Chairman of the US Senate Committee on Finance Orrin Hatch and Chairman of the US House of Representatives Committee on Energy and Commerce Henry A. Waxman, April 5, 2021, <https://www.gao.gov/assets/gao-11-293r.pdf>.
- ⁸ “Continuous Eligibility for Medicaid and CHIP Coverage,” Medicaid.gov, last updated September 9, 2021, <https://www.medicaid.gov/medicaid/enrollment-strategies/continuous-eligibility-medicaid-and-chip-coverage/index.html>. Per the Consolidated Appropriations Act, 12-month continuous eligibility for children will become mandatory in 2024.
- ⁹ “August 2022 Medicaid and CHIP Enrollment Trends Snapshot,” Centers for Medicaid and Medicare Services (CMS), last updated November 28, 2022, <https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/august-2022-medicaid-chip-enrollment-trend-snapshot.pdf>.
- ¹⁰ Dulce Gonzalez, Michael Karpman, and Jennifer Haley, “Worries about the Coronavirus Caused Nearly 1 in 10 Parents to Delay or Forgo Needed Health Care for Their Children in Spring 2021,” Urban Institute, August 18, 2021, <https://www.urban.org/research/publication/worries-about-coronavirus-caused-nearly-1-10-parents-delay-or-forgo-needed-health-care-their-children-spring-2021>.
- ¹¹ Chiquita Brooks-LaSure and Daniel Tsai, “A Strategic Vision for Medicaid and the Children’s Health Insurance Program (CHIP),” *Health Affairs*, November 16, 2021, <https://www.healthaffairs.org/doi/10.1377/forefront.20211115.537685/full/>.
- ¹² “CMS Strategic Plan,” CMS, last updated February 3, 2023, <https://www.cms.gov/cms-strategic-plan>.
- ¹³ “Biden-Harris Administration Announces Request for Information on Access to Care and Coverage for People Enrolled in Medicaid and CHIP” (press release), CMS, February 17, 2022, <https://www.cms.gov/newsroom/press-releases/biden-harris-administration-announces-request-information-access-care-and-coverage-people-enrolled>

- ¹⁴ “Advancing Interoperability and Improving Prior Authorization Processes Proposed Rules CMS-0057-P: Fact Sheet,” CMS, December 6, 2022, <https://www.cms.gov/newsroom/fact-sheets/advancing-interoperability-and-improving-prior-authorization-processes-proposed-rule-cms-0057-p-fact>.
- ¹⁵ American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and Children’s Hospital Association, “Declaration of a National Emergency in Child and Adolescent Mental Health,” October 19, 2021, <https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/>.
- ¹⁶ “FACT SHEET: Improving Access and Care for Youth Mental Health and Substance Use Conditions,” the White House Briefing Room, October 19, 2021, <https://www.whitehouse.gov/briefing-room/statements-releases/2021/10/19/fact-sheet-improving-access-and-care-for-youth-mental-health-and-substance-use-conditions>.
- ¹⁷ LaSure and Tsai, “A Strategic Vision for Medicaid and the Children’s Health Insurance Program (CHIP).”
- ¹⁸ Daniel Tsai, Deputy Administrator and Director Center for Medicaid and CHIP Services, “Leveraging Medicaid, CHIP, and Other Federal Programs in the Delivery of Behavioral Health Services for Children and Youth,” CMCS Informational Bulletin, August 18, 2022, <https://www.medicaid.gov/federal-policy-guidance/downloads/bhccib08182022.pdf>; Laura Conrad, “Medicaid’s Essential Role in Improving the Mental Health of America’s Most Vulnerable Youth,” The Commonwealth Fund, September 20, 2022, <https://www.commonwealthfund.org/blog/2022/medicaids-essential-role-improving-mental-health-americas-most-vulnerable-youth>.
- ¹⁹ “Recommendations for Preventive Pediatric Health Care,” American Academy of Pediatrics; “State Dental Periodicity Schedules,” American Academy of Pediatric Dentistry, accessed March 16, 2023, <https://www.aapd.org/research/policy-center/state-dental-periodicity-schedules/>.
- ²⁰ Tsai, “Leveraging Medicaid, CHIP, and Other Federal Programs in the Delivery of Behavioral Health Services for Children and Youth.”
- ²¹ “Service Use among Medicaid & CHIP Beneficiaries Age 18 and Under during COVID-19: Preliminary Medicaid & CHIP Data Snapshot: Services through May 31, 2020,” CMS, accessed March 16, 2023, <https://www.medicaid.gov/resources-for-states/downloads/medicaid-chip-beneficiaries-18-under-COVID-19-snapshot-data.pdf>; Gonzalez, Karpman, and Haley, “Worries about the Coronavirus Caused Nearly 1 in 10 Parents to Delay or Forgo Needed Health Care for Their Children in Spring 2021.”
- ²² “Status of State Medicaid Expansion Decisions: Interactive Map,” Kaiser Family Foundation, February 16, 2023, <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>.
- ²³ “2022-2027 Medicaid 1115 Demonstration Waiver,” Oregon Health Authority, accessed March 16, 2023, https://www.oregon.gov/oha/hsd/medicaid-policy/pages/waiver-renewal.aspx?utm_medium=email&utm_source=govdelivery; Madeline Guth, “Section 1115 Waiver Watch: Approvals to Address Health-Related Social Needs,” Kaiser Family Foundation, November 15, 2022, <https://www.kff.org/medicaid/issue-brief/section-1115-waiver-watch-approvals-to-address-health-related-social-needs/>.
- ²⁴ CMS, “RE: Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH),” letter to state health officials, accessed March 16, 2023, <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf>.
- ²⁵ Mindy Lipson and Cindy Mann, “CMS Approves Groundbreaking Section 1115 Demonstrations,” The Commonwealth Fund, December 7, 2022, <https://www.commonwealthfund.org/blog/2022/cms-approves-groundbreaking-section-1115-demonstrations#2>.

- ²⁶ CMS, “RE: Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH),” letter to state health officials.
- ²⁷ “CMS Releases Proposed Rule to Improve Medicaid & CHIP Quality Reporting Across States” (press release), CMS, August 18, 2022, <https://www.cms.gov/newsroom/press-releases/cms-releases-proposed-rule-improve-medicaid-chip-quality-reporting-across-states>; “Medicaid Program and CHIP; Mandatory Medicaid and Children’s Health Insurance Program (CHIP) Core Set Reporting,” 42 CFR 433, 437, 457 (Aug. 22, 2022), <https://public-inspection.federalregister.gov/2022-17810.pdf>.
- ²⁸ “Service Use among Medicaid & CHIP Beneficiaries Age 18 and Under during COVID-19,” CMS.
- ²⁹ “The National Survey of Children’s Health,” Data Resource Center for Child & Adolescent Health; “National Health Interview Survey,” Centers for Disease Control and Prevention, National Center for Health Statistics.
- ³⁰ “2019 National Survey of Children’s Health: Data Users Frequently Asked Questions,” US Census Bureau, August 25, 2020, <https://www2.census.gov/programs-surveys/nsch/technical-documentation/methodology/2019-NSCH-FAQs.pdf>.
- ³¹ “NSCH Datasets,” US Census Bureau, October 8, 2021, <https://www.census.gov/programs-surveys/nsch/data/datasets.html>.
- ³² “NSCH Guide to Multi-Year Estimates,” US Census Bureau, September 30, 2022, <https://www2.census.gov/programs-surveys/nsch/technical-documentation/methodology/NSCH-Guide-to-Multi-Year-Estimates.pdf>.
- ³³ IPUMS Health Surveys, accessed March 16, 2023, <https://nhis.ipums.org/>.
- ³⁴ “2018 National Health Interview Survey Description,” Centers for Disease Control and Prevention, June 2019, pages 35–40, https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHIS/2018/srvydesc.pdf.
- ³⁵ 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>.

References

- Alker, Joan, and Tricia Brooks. 2022. *Millions of Children May Lose Medicaid: What Can Be Done to Help Prevent Them from Becoming Uninsured?* Washington, DC: Georgetown University Health Policy Center, Center for Children and Families.
- Ballentine, Kess, Sara Goodkind, and Jeffrey Shook. 2022. "How Low-Paid Parents Navigate the Complex Financial Landscape of Benefits Cliffs and Disincentive Deserts." 2022. *Health Affairs* 41(12). <https://doi.org/10.1377/hlthaff.2022.00742>.
- Berchick, Edward R., Jessica C. Barnett, and Rachel D. Upton. 2019. "Health Insurance Coverage in the United States: 2018." Washington, DC: US Census Bureau.
- Bishop Tara F., Matthew J. Press, Salomeh Keyhani, and Harold Alan Pincus. 2014. "Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care." *JAMA Psychiatry* 71 (2): 176–81. <https://doi.org/10.1001/jamapsychiatry.2013.2862>.
- Boozang, Patricia, and Kinda Serafi. 2022. "Improving Ex Parte Renewal Rates: State Diagnostic Assessment Tool." Princeton, NJ: State Health and Value Strategies.
- Boudreaux, Michel H., Ezra Golberstein, and Donna D. McAlpine. 2016. "The Long-Term Impacts of Medicaid Exposure in Early Childhood: Evidence from the Program's Origin." *Journal of Health Economics* 45:161–75. <https://doi.org/10.1016/j.jhealeco.2015.11.001>.
- Brooks, Tricia, and Alexa Gardner. 2021. "Unwinding the COVID Continuous Eligibility Requirement at the End of the Public Health Emergency: Tips for Advocates." Washington, DC: Georgetown University Health Policy Institute, Center for Children and Families.
- Brooks, Tricia, Edwin Park, and Lauren Roygardner. 2019. *Medicaid and CHIP Enrollment Decline Suggests the Child Uninsured Rate May Rise Again*. Washington: Georgetown University Health Policy Institute Center for Children and Families.
- Brooks, Tricia, Lauren Roygardner, and Samantha Artiga. 2019. *Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2019: Findings from a 50-State Survey*. San Francisco: Kaiser Family Foundation.
- Brooks, Tricia, and Kelly Whitener. 2017. "At Risk: Medicaid's Child-Focused Benefit Structure Known as EPSDT." Washington, DC: Georgetown University Health Policy Institute Center for Children and Families.
- Brown, David W., Amanda E. Kowalski, and Ithai Z. Lurie. 2015. "Medicaid as an Investment in Children: What is the Long Term Impact on Tax Receipts?" Working paper 20835. Cambridge, MA: National Bureau of Economic Research.
- Buettgens, Matthew, and Andrew Green. 2021. *The Impact of the COVID-19 Public Health Emergency Expiration on All Types of Health Coverage*. Washington, DC: Urban Institute. Center on the Developing Child. 2010. *The Foundations of Lifelong Health Are Built in Early Childhood*. Cambridge, MA: Harvard University.
- Carlson, Steven, Joseph Llobrera, and Brynne Keith-Jennings. 2021. "More Adequate SNAP Benefits Would Help Millions of Participants Better Afford Food." 2021. Washington, DC: Center on Budget and Policy Priorities.
- Children's Health Fund. 2016. *UNFINISHED BUSINESS: More than 20 Million Children in U.S. Still Lack Sufficient Access to Essential Health Care*. Washington, DC: Children's Health Fund.
- CMS (Centers for Medicare and Medicaid Services). 2013. *Keep Kids Smiling: Promoting Oral Health through the Medicaid Benefit for Children & Adolescents*. Baltimore, MD: CMS.
- — —. 2017. *Promoting Access in Medicaid and CHIP Managed Care: A Toolkit for Ensuring Provider Network Adequacy and Service Availability*. Baltimore, MD: CMS.

- Cohodes Sarah, Daniel Grossman, Samuel Kleiner, and Michael F. Lovenheim. 2014. “The Effect of Child Health Insurance Access on Schooling: Evidence from Public Insurance Expansions.” Working paper 20178. Cambridge, MA: National Bureau of Economic Research.
- Corallo, Bradley, Rachel Garfield, Jennifer Tolbert, and Robin Rudowitz. 2021. “Medicaid Enrollment Churn and Implications for Continuous Coverage Policies.” San Francisco: Kaiser Family Foundation.
- Decker, Sandra. 2012. “In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help.” *Health Affairs* 31 (8): 1,673–79.
- Finkelstein, Daniel M. Jessica F. Harding, Diane Paulsell, Brittany English, Gina R. Hijjawi, and Jennifer Ng’andu. 2022. “Economic Well-Being and Health: The Role of Income Support Programs in Promoting Health and Advancing Health Equity.” *Health Affairs* 41(12). <https://doi.org/10.1377/hlthaff.2022.00846>
- Fontana, Joanne, Annie Hallum, and Catherine Lewis. 2020. “Medicaid Dental Program Delivery Systems.” Seattle: Milliman.
- GAO (Government Accountability Office). 2019. “Medicaid: Additional CMS Data and Oversight Needed to Help Ensure Children Receive Recommended Screenings.” Report GAO-19-481.
- Giannarelli, Linda, Sarah Minton, and Laura Wheaton. 2023. “The Value of Unclaimed Safety Net Benefits in Illinois.” Washington, DC: Urban Institute.
- Giannarelli, Linda, Kelly Dwyer, Sarah Minton, and Sarah Knowles. 2023. *What Portion of Illinois Residents Eligible for Safety Net Benefits Receive Those Benefits?* Washington, DC: Urban Institute.
- Goodman-Bacon, Andrew. 2021. “The Long-Run Effects of Childhood Insurance Coverage: Medicaid Implementation, Adult Health, and Labor Market Outcomes.” *American Economic Review* 111 (8): 2,550–93.
- Hahn, Heather, Eleanor Platt, and Sarah Knowles. 2023. *Strategies for Improving Public Benefits Access and Retention.* Washington, DC: Urban Institute.
- Haley, Jennifer M., Genevieve M. Kenney, Clare Wang Pan, Robin Wang, Victoria Lynch, and Matthew Buettgens. 2021. *Uninsurance Rose among Children and Parents in 2019: National and State Patterns.* Washington, DC: Urban Institute.
- Haley, Jennifer M., Carla Willis, Genevieve M. Kenney, Emily Johnston, Julia Long, and Kristen Brown. 2023. *Assessing Health Care Access Among Medicaid/CHIP-Enrolled Children in Illinois: Changes in Policy and Practice to Improve Access.* Washington, DC: Urban Institute.
- Hinton, Elizabeth, Madeline Guth, Jada Raphael, Sweta Heldar, and Robin Rudowitz. 2022. *How the Pandemic Continues to Shape Medicaid Priorities: Results from an Annual Medicaid Budget Survey for State Fiscal Years 2022 and 2023.* San Francisco: Kaiser Family Foundation.
- Howell, Embry M., and Genevieve M. Kenney. 2012. “The Impact of the Medicaid/CHIP Expansions on Children: A Synthesis of the Evidence.” *Medical Care Research and Review* 69 (4): 372–96. <https://doi.org/10.1177/1077558712437245>.
- Keet, Corinne A., Elizabeth C. Matsui, Meredith C. McCormack, and Robert D. Peng. 2017. “Urban Residence, Neighborhood Poverty, Race/Ethnicity, and Asthma Morbidity among Children on Medicaid.” *Journal of Allergy and Clinical Immunology* 140 (3): 822–27. <https://doi.org/10.1016/j.jaci.2017.01.036>.
- Kuo, Dennis Z., Rylin C. Rodgers, Nathaniel S. Beers, Sarah E. McLellan, Teresa K. Nguyen. 2022. “Access to Services for Children and Youth With Special Health Care Needs and Their Families: Concepts and Considerations for an Integrated Systems Redesign.” *Pediatrics* 149 (supplement 7): e2021056150H. <https://doi.org/10.1542/peds.2021-056150H>.
- Kusma, Jennifer D., Jenifer Cartland, and Matthew M. Davis. 2021. “State-Level Managed Care Penetration in Medicaid and Rates of Preventive Care Visits for Children.” *Academic Pediatrics* 21 (8): P1,338–44.

- Lipton, Brandy J., Laura R. Wherry, Sarah Miller, Genevieve M. Kenney, and Sandra Decker. 2016. "Previous Medicaid Expansion May Have Had Lasting Positive Effects on Oral Health of Non-Hispanic Black Children." *Health Affairs (Millwood)* 35 (12): 2,249–58. <https://doi.org/10.1377/hlthaff.2016.0865>.
- MACPAC (Medicaid and CHIP Payment and Access Commission). 2016. "Access in Brief: Children's Difficulties in Obtaining Medical Care." Washington, DC: MACPAC.
- . 2011. "Chapter 4: Examining Access to Care for Medicaid and CHIP." In *Report to the Congress on Medicaid and CHIP*. Washington, DC: MACPAC.
- . 2021. "Chapter 5: Mandated Report on Non-Emergency Medical Transportation." In *Report to the Congress on Medicaid and CHIP*. Washington, DC: MACPAC.
- Mann, Cindy, and Mandy Ferguson. 2020. "Caring for the Whole Child: A New Way to Finance Initiatives to Improve Children's Health." New York: Manatt Health.
- McMorrow, Stacey, Dulce Gonzalez, Clara Alvarez Caraveo, and Genevieve M. Kenney. 2020. "Urgnet Action Needed to Address Children's Unmet Health Care Needs During the Pandemic." Washington, DC: Urban Institute.
- Miller, Sarah, and Laura R. Wherry. 2018. "The Long-Term Effects of Early Life Medicaid Coverage," *Journal of Human Resources* 54 (3): 785–824. <https://doi.org/10.3368/jhr.54.3.0816.8173R1>.
- Office of the US Surgeon General. 2021. "Protecting Youth Mental Health: The U.S. Surgeon General's Advisory." Washington, DC: US Department of Health and Human Services.
- Paradise, Julia. 2014. "The Impact of the Children's Health Insurance Program (CHIP): What Does the Research Tell Us?" San Francisco: Kaiser Family Foundation.
- Park, Edwin, Anne Dwyer, Tricia Brooks, Maggie Clark, and Joan Alker. 2023. *Consolidated Appropriations Act, 2023: Medicaid and CHIP Provisions Explained*. Washington, DC: Georgetown University Health Policy Institute Center for Children and Families.
- Petersen, Dana, and Rachel Miller. 2016. "Health Care Coverage and Access for Children in Low-Income Families: Stakeholder Perspectives from California." Washington, DC: Mathematica.
- Polacheck, Stefanie, and Hannah Gears. 2020. "COVID-19 and the Decline of Well-Child Care: Implications for Children, Families, and States." Trenton, NJ: Center for Health Care Strategies.
- Rudowitz, Robin, Rachel Garfield and Elizabeth Hinton 2019. "10 Things to Know about Medicaid: Setting the Facts Straight." San Francisco: Kaiser Family Foundation.
- Silow-Carroll, Sharon, Kathy Gifford, Carrie Rosenzweig, Kathy Ryland, and Anh Pham. 2021. *Medicaid's Non-Emergency Medical Transportation Benefit: Stakeholder Perspectives on Trends, Challenges, and Innovations*. Washington, DC: Health Management Associates.
- Thompson, Owen. 2017. "The Long-Term Health Impacts of Medicaid and CHIP." *Journal of Health Economics* 51:26–40. <https://doi.org/10.1016/j.jhealeco.2016.12.003>.
- Vulimiri, Madhulika, William K. Bleser, Robert S. Saunders, Farrah Madanay, Connor Moseley, F. Hunter McGuire...and Charlene A. Wong. 2019. "Engaging Beneficiaries In Medicaid Programs That Incentivize Health-Promoting Behaviors." *Health Affairs* 38 (3): 431–39. <https://doi.org/10.1377/hlthaff.2018.05427>.
- Wagnerman, Karina, Alisa Chester, and Joan Alker. 2017. "Medicaid Is a Smart Investment in Children." Washington, DC: Georgetown University Health Policy Institute, Center for Children and Families.
- Wherry, Laura R., Sarah Miller, Robert Kaestner, and Bruce D. Meyer. 2018. "Childhood Medicaid Coverage and Later-Life Health Care Utilization." *The Review of Economics and Statistics* 100 (2): 287–302. https://doi.org/10.1162/REST_a_00677.

- Zero to Three and Center for Law and Social Policy (CLASP). 2022. "Building Strong Foundations: Advancing Comprehensive Policies for Infants, Toddlers, and Families." Washington, DC: Zero to Three and CLASP.
- Zuckerman, Stephen, and Dana Goin. 2012. *How Much Will Medicaid Physician Fees for Primary Care Rise in 2013? Evidence from a 2012 Survey of Medicaid Physician Fees*. Washington, DC: Kaiser Family Foundation.
- Zuckerman, Stephen, Laura Skopec, and Kristen McCormack. 2014. "Reversing the Medicaid Fee Bump: How Much Could Medicaid Physician Fees for Primary Care Fall in 2015?" Washington, DC: Urban Institute.
- Zuckerman, Stephen, Aimee F. Williams, and Karen E. Stockley. 2009. "Trends in Medicaid Physician Fees, 2003–2008." *Health Affairs* 28 (3): 510–19. <https://doi.org/10.1377/hlthaff.28.3.w510>.

About the Authors

Jennifer M. Haley is a principal research associate in the Health Policy Center at the Urban Institute, where she studies maternal, child, and parental health and health care; Medicaid and the Children's Health Insurance Program; challenges to accessing the safety net among immigrant families; barriers to enrollment in publicly subsidized health insurance coverage; opportunities for improved collection and use of data on race and ethnicity; health equity; and other issues related to coverage and care for children and families. She holds an MA in sociology from Temple University.

Stacey McMorrow was a principal research associate in the Health Policy Center until her untimely death from cancer in January 2023. Her research ranged across many different areas, including gaps in coverage and access during the postpartum period, impacts of the Affordable Care Act, health care disparities, closures of labor and delivery units, the drivers of health care spending, health care prices, reproductive health access, and behavioral economics. McMorrow received her PhD in health economics from the University of Pennsylvania.

Julia Long is a research analyst in the Health Policy Center, where her research focuses on access to health care for low-income children and families. She uses quantitative data analysis to track health reforms and their impacts on the health of children and their families, leveraging national survey data. In addition, she takes part in qualitative data collection relating to perinatal health and Medicaid.

Genevieve M. Kenney is a vice president and senior fellow in the Health Policy Center. She is a nationally renowned expert on Medicaid, the Children's Health Insurance Program (CHIP), and health insurance coverage; health care access and quality; and health outcomes for low-income adults, children, and families. She has played a lead role in several Medicaid and CHIP evaluations, including multiple congressionally mandated CHIP evaluations, and has conducted state-level evaluations of the implementation of managed care and other service delivery reform initiatives and policy changes in Medicaid and CHIP. Currently, she is leading a project focused on health equity that involves working with a community advisory board. Her prior work has used mixed methods to examine Medicaid expansions for pregnant women, parents, and children; Medicaid family planning waivers; and a range of policy choices related to Medicaid and CHIP. She received a master's degree in statistics and a doctoral degree in economics from the University of Michigan.

Emily M. Johnston is a senior research associate in the Health Policy Center. She studies health insurance coverage, access to care, Medicaid policy, reproductive health, and maternal and infant health, with a focus on the effects of state and federal policies on the health and well-being of women and families. She received her PhD in health services research and health policy from Emory University.

Carla Willis is a principal research associate in the Health Policy Center. Her work focuses on Medicaid policy, payment incentives, and delivery system reform. She previously served as the director of performance, quality, and outcomes for the Georgia Medicaid program and holds a PhD in political science from the Ohio State University.

Kristen Brown is a senior research associate in the Health Policy Center. Her research takes a multilevel, transdisciplinary approach to examining racial and socioeconomic health inequities. A trained epidemiologist, her current work focuses on the health impact of the COVID-19 pandemic including the examination of mechanisms through which exposure to adverse social determinants has shaped access to health care resources, insurance coverage stability in children, and strategies for mitigating the long-term effects of the pandemic in communities of color. Before joining Urban, Brown worked at the National Institutes of Health and Emory University. She holds a PhD in epidemiologic science from the University of Michigan.

STATEMENT OF INDEPENDENCE

The Urban Institute strives to meet the highest standards of integrity and quality in its research and analyses and in the evidence-based policy recommendations offered by its researchers and experts. We believe that operating consistent with the values of independence, rigor, and transparency is essential to maintaining those standards. As an organization, the Urban Institute does not take positions on issues, but it does empower and support its experts in sharing their own evidence-based views and policy recommendations that have been shaped by scholarship. Funders do not determine our research findings or the insights and recommendations of our experts. Urban scholars and experts are expected to be objective and follow the evidence wherever it may lead.



500 L'Enfant Plaza SW
Washington, DC 20024

www.urban.org