



# Medicaid and CHIP for Children

## Trends in Coverage, Affordability, and Provider Access

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### Key Findings

This brief uses data from the National Health Interview Survey (NHIS) to assess changes in Medicaid and Children's Health Insurance Program (CHIP) coverage for children between 2008 and 2015. Key findings are as follows:

- The share of children with Medicaid/CHIP coverage at the time of the survey<sup>1</sup> increased by 8.9 percentage points between 2008 and 2015, from 27.3 percent to 36.2 percent, while the share of uninsured children declined by 49.5 percent. In 2015, 64.1 percent of children in fair or poor health had Medicaid/CHIP coverage at the time of the survey. An estimated 6.8 million more children had Medicaid/CHIP coverage in 2015 than in 2008.
- Financial barriers declined over this period for children covered by Medicaid/CHIP.
  - » Between 2008 and 2015, the share of children covered by Medicaid or CHIP who did not receive needed medical care because their families could not afford it decreased 2.3 percentage points to 7.6 percent, and the share of children who delayed care because of cost decreased 1.0 percentage points to 1.1 percent.
  - » Between 2011 and 2015,<sup>2</sup> the share of children in families that reported having problems paying medical bills decreased 7.4 percentage points to 21.6 percent, and the share of children in families that reported being unable to pay medical bills decreased 5.5 percentage points to 13.8 percent.

- Receipt of care increased or remained constant among children covered by Medicaid/CHIP.
  - » Between 2008 and 2015, the share of children who had routine checkups increased 3.8 percentage points to 85.0 percent, and the share of children who had seen a dentist in the past year increased 8.8 percentage points to 81.2 percent.
  - » Nearly all children covered by Medicaid/CHIP had a usual source of care (95.4 percent in 2015), and just over one in ten Medicaid/CHIP-covered children saw a specialist (11.0 percent in 2015), but these shares did not change significantly over time.
- Access to providers improved among children covered by Medicaid/CHIP.
  - » Between 2008 and 2015, the share of children who delayed care for reasons other than cost decreased 2.7 percentage points to 11.5 percent. This decrease was driven by declines in care delays related to long waits at the doctor’s office, inconvenient doctor’s office hours, and difficulty reaching the doctor’s office by phone.
  - » Only 1.5 percent of children had trouble finding a doctor in 2015. Between 2011 and 2015,<sup>3</sup> the share of children who were told a doctor was not accepting new patients decreased 1.0 percentage points to 2.0 percent, and the share told that a doctor did not accept their insurance type decreased 1.8 percentage points to 2.8 percent.

As children’s Medicaid/CHIP enrollment increased by almost a third (32.6 percent) and adult Medicaid enrollment also expanded significantly (85.7 percent), the children’s uninsured rate fell by 49.5 percent, and financial access, provider access, and receipt of routine care improved among children covered by Medicaid/CHIP. Congress is now considering cuts to federal funding for Medicaid and CHIP that could jeopardize these gains in coverage and access for children. If the cuts are approved, fewer children may be covered by Medicaid/CHIP, and those who are covered may see their care deteriorate.

## Introduction

The fate of the Affordable Care Act (ACA) and the Children’s Health Insurance Program will have large impacts on health insurance coverage and health care access for children. Congress is currently considering a replacement to the ACA that would include large cutbacks in federal financing for Medicaid.<sup>4</sup> CHIP and Medicaid funding cuts were also proposed in the president’s budget for fiscal year 2018 (OMB 2017). These cuts raise the risk of coverage losses and greater barriers to needed health care for families. To show what is at stake for children, this analysis examines coverage, financial barriers, receipt of care, and provider access in Medicaid and CHIP for children, as well as changes in these measures since 2008.

Over the last several decades, uninsurance among children has declined tremendously (Harrington et al. 2014; Rosenbaum and Kenney 2014). By 2015, the children’s uninsured rate had fallen below 5 percent (Aiker and Chester 2016; Gates et al. 2016). Underlying the drop in children’s uninsurance is an increase in public coverage, which began with a series of Medicaid eligibility expansions in the 1980s and the enactment of the Children’s Health Insurance Program in 1997. Two recent pieces of federal

legislation also affected children's coverage: First, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) extended federal funding for CHIP and included enrollment and outreach efforts to identify and enroll uninsured children who were eligible for either Medicaid or CHIP coverage. Second, the Affordable Care Act of 2010 gave states the option to expand Medicaid to low-income adults with family incomes at or below 138 percent of the federal poverty level (FPL), provided new federal subsidies for private coverage, and included an individual mandate for health insurance coverage. Although chiefly designed to expand coverage among nonelderly adults, the ACA coverage provisions were also expected to increase coverage for children, particularly through Medicaid and CHIP (Kenney et al. 2011).

Since the implementation of CHIPRA and the ACA, children have come to rely increasingly on Medicaid and CHIP for coverage (Alker and Chester 2016; Kenney, Haley, et al. 2016; Skopec, Holahan, and Solleveld 2016). In 2015, 39 percent of children were covered by Medicaid or CHIP at the time of the survey, and between 2013 and 2015, the number of uninsured children who were eligible for Medicaid/CHIP coverage but not enrolled declined by 40 percent (Chester and Burak 2016; Kenney, Haley, et al. 2017). The research shows that expansions in eligibility and coverage through Medicaid and CHIP have led to increased receipt of health care among children and lower family financial burdens related to children's health care (Banthin and Selden 2003; Davidoff, Kenney, and Dubay 2005; Howell and Kenney 2012). Although the reductions in uninsurance among children have been accompanied by improvements in their access to care (Gates et al. 2016; Karpman, Gates, and Kenney 2016; Karpman, Gates, et al. 2016; Karpman, Kenney, et al. 2016; Kenney et al. 2012; Larson et al. 2016; Rosenbaum and Kenney 2014), no published study has examined whether and how access to care has changed for kids enrolled in Medicaid and CHIP since the passage of CHIPRA and the ACA.

Access to care among children covered by Medicaid and CHIP is particularly important. Earlier research has shown that children with high health care needs and children in poor families with minority backgrounds disproportionately rely on Medicaid and CHIP for their coverage (Cornachione, Rudowitz, and Artiga 2016; Coyer and Kenney 2013; Musumeci 2017). Not only has enrollment in public coverage increased among children, but enrollment in Medicaid has also risen among adults, particularly after the expansion of Medicaid under the ACA.<sup>5</sup> Fewer physicians participate in Medicaid than in private coverage, so the increased demand for care among children covered by Medicaid and CHIP could outpace supply (Decker 2012; Sommers, Swartz, and Epstein 2011). At the same time, federally qualified health centers (FQHCs) have received substantial funding increases, and federal payments for Medicaid primary care increased in 2014 and 2015; together with other changes in the service delivery system, these funds may have expanded access to care (Polsky et al. 2017; Polsky et al. 2015). Moreover, Medicaid and CHIP programs have increasingly focused on measuring access and quality and on expanding preventive care receipt among children, particularly for oral health care (CMS 2017).

In this brief, we examine how children with Medicaid and CHIP are faring, using data from the National Health Interview Survey for 2008 through 2015. We chose this period because it spans the implementation of CHIPRA and the ACA coverage provisions. We examine children's health insurance coverage and assess financial barriers, receipt of care, and provider access among children enrolled in

Medicaid and CHIP. We also estimate differences in these measures over time among children enrolled in Medicaid and CHIP, adjusting for changes in their sociodemographic and health characteristics.

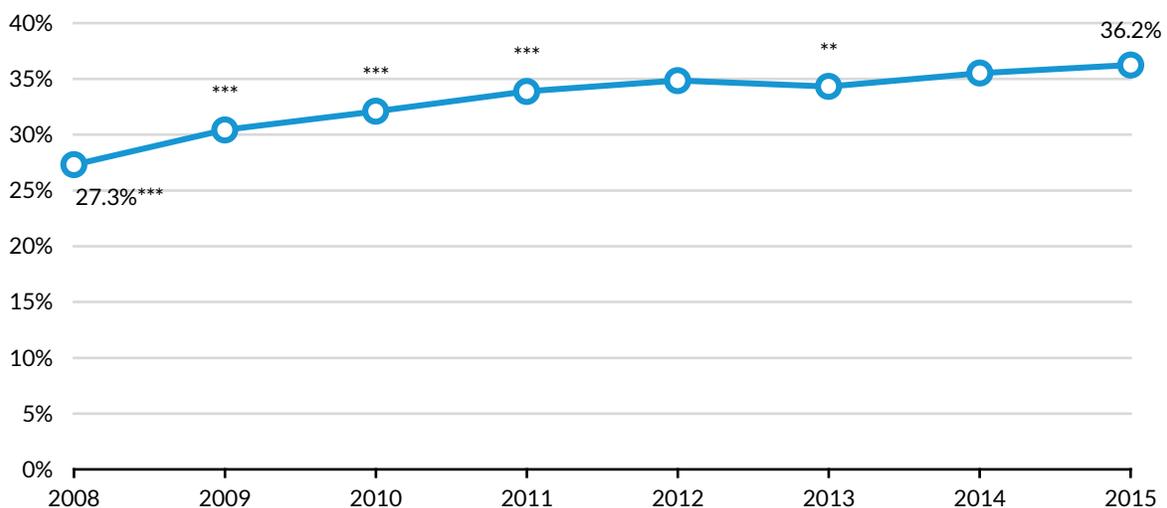
## Results

### Medicaid/CHIP Coverage and Uninsurance among Children

Medicaid/CHIP coverage of children ages 18 and younger increased 8.9 percentage points, from 27.3 percent in 2008 to 36.2 percent in 2015 (figure 1), a 32.6 percent increase. Over the same period, the estimated number of children covered by Medicaid/CHIP at the time of the survey increased by 6.8 million, and the number of nonelderly adults covered by Medicaid or CHIP increased by 9.8 million (data not shown). The largest single-year increase in the Medicaid/CHIP coverage rate for children occurred between 2008 and 2009, during a period of economic contraction in which CHIPRA was passed and implemented; Medicaid/CHIP coverage increased from 27.3 percent to 30.4 percent. Medicaid/CHIP coverage for children also increased after the implementation of the major coverage provisions of the ACA, from 34.3 percent in 2013 to 36.2 percent in 2015.

As children's Medicaid/CHIP coverage increased between 2008 and 2015, children's uninsurance fell by 49.5 percent, from 9.5 percent to 4.8 percent (figure 2). After implementation of the major coverage provisions of the ACA began in late 2013 and early 2014, the uninsurance rate declined from 7.1 percent in 2013 to 5.7 percent in 2014 and to 4.8 percent in 2015.

**FIGURE 1**  
**Medicaid/CHIP Coverage among Children, 2008–15**



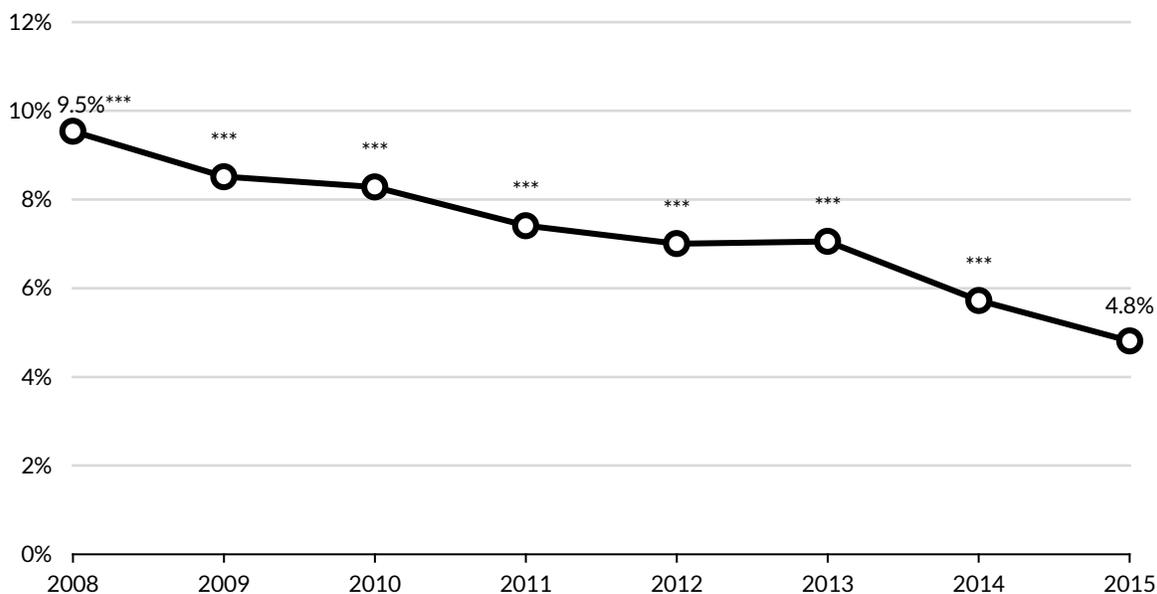
**Source:** Urban Institute tabulations of 2008–15 National Health Interview Survey data.

**Notes:** Children are ages 18 and younger. Insurance coverage is measured at time of survey. See Data and Methods section for definition of Medicaid/CHIP coverage. Estimates are weighted to account for NHIS sample design.

\*/\*\*/\*\*\* Estimate differs significantly from 2015 estimate at  $p < 0.10/0.05/0.01$ , using two-tailed  $t$ -tests.

FIGURE 2

### Uninsurance among Children, 2008–15



Source: Urban Institute tabulations of 2008–15 National Health Interview Survey data.

Notes: Children are ages 18 and younger. Uninsurance is measured at time of survey. See Data and Methods section for uninsurance definition. Estimates are weighted to account for NHIS sample design.

\*/\*\*/\*\* Estimate differs significantly from 2015 estimate at  $p < 0.10/0.05/0.01$ , using two-tailed  $t$ -tests.

### Characteristics of Children Covered by Medicaid/CHIP

Table 1 shows the characteristics of children covered by Medicaid/CHIP in 2008 and 2015. In both years, as in the intervening years (data not shown), children covered by Medicaid/CHIP varied widely in age and race/ethnicity. In both years, most had parents with a high school degree or less, were in excellent or very good health, and had family incomes at or below 138 percent of FPL. Over 97 percent were citizens, and almost 70 percent had at least one full- or part-time worker in the family. Between 2008 and 2015, an increasing share of the children covered by Medicaid/CHIP lived in the South (42.0 percent in 2015 versus 38.7 percent in 2008), were ages 6 to 18 (65.3 percent in 2015 versus 59.7 percent in 2008), reported excellent or very good health (75.5 percent in 2015 versus 71.6 percent in 2008), and had higher family incomes and greater family educational attainment.<sup>6</sup>

TABLE 1

## Characteristics of Children Covered by Medicaid/CHIP, 2008–15

	2008 (%)	2015 (%)		
<b>Insured for the full year</b>	91.9	95.3	***	
<b>Sex</b>				
Female <sup>a</sup>	48.4	48.4		
Male	51.6	51.6		+++
<b>Age</b>				
0–5 <sup>a</sup>	40.2	34.7	***	
6–12	35.4	39.1	***	+++
13–18	24.3	26.2	**	+++
<b>Race/ethnicity</b>				
White, non-Hispanic <sup>a</sup>	33.1	33.8		
Black, non-Hispanic	25.2	21.0	***	+++
Hispanic	34.2	37.1	*	++
Other race, non-Hispanic	7.5	8.2		+++
<b>Citizenship status</b>				
Citizen <sup>a</sup>	97.7	97.9		
Noncitizen	2.3	2.1		+++
<b>Self-reported health status</b>				
Excellent or very good health <sup>a</sup>	71.6	75.5	***	
Good health	24.6	21.2	***	+++
Fair or poor health	3.8	3.3		+++
<b>Limitations</b>				
Has an activity limitation <sup>a</sup>	11.1	10.7		
Has no activity limitation	88.7	89.2		+++
<b>Region</b>				
Northeast <sup>a</sup>	15.6	13.9		
South	38.7	42.0	*	+++
Midwest	20.3	19.5		+++
West	25.3	24.6		+++
<b>HIU highest education</b>				
Less than high school <sup>a</sup>	28.9	24.4	***	
High school	35.6	30.3	***	+++
Some college	28.4	33.2	***	+++
College	6.6	11.9	***	+++
<b>HIU work status</b>				
Two full-time workers <sup>a</sup>	8.9	10.3		
One full-time worker	49.3	49.5		+++
Only part-time workers	11.5	12.6		+++
No workers	30.0	27.5	*	+++
No adults	0.4	0.2		+++
<b>HIU citizenship status</b>				
Any noncitizen in HIU <sup>a</sup>	23.2	24.0		
No noncitizens in HIU	76.7	76.0		+++
<b>HIU income</b>				
At or below 138% of FPL <sup>a</sup>	65.8	67.7		
Greater than 138% but less than 400% of FPL	32.0	29.6		+++
At or above 400% of FPL	2.2	2.7		+++

**Source:** Urban Institute tabulations of 2008–15 National Health Interview Survey data.

**Notes:** FPL = federal poverty level; HIU = health insurance unit. Children are ages 18 and younger. All measures are at time of survey. See Data and Methods section for measure definitions. Estimates are weighted to account for NHIS sample design.

\*/\*\*/\*\*\* Estimate for 2015 differs significantly from estimate for 2008 at  $p < 0.10/0.05/0.01$ , using two-tailed  $t$ -tests.

+/\*\*/+++ Estimate for 2015 differs significantly from estimate for the reference category (marked with <sup>a</sup>) at  $p < 0.10/0.05/0.01$ , using two-tailed  $t$ -tests.

## Medicaid/CHIP Coverage Rates among Children

Table 2 shows the share of children of different demographic and socioeconomic backgrounds who were covered by Medicaid/CHIP in 2008 and 2015. In both years, Medicaid/CHIP coverage rates were higher among children who were younger, nonwhite, or in fair or poor health; had family incomes at or below 138% of FPL; had activity limitations; lived in the South; lived in families without full-time workers; and had a noncitizen in the family.<sup>7</sup>

Between 2008 and 2015, Medicaid/CHIP coverage increased for all subgroups of children except those who are not Hispanic, black, or white (i.e., other race) and those in households without an adult present (less than 0.5 percent of children in both years). Despite smaller percent increases in Medicaid/CHIP coverage among certain groups of children—such as those who were younger, non-Hispanic black, in low-income households, or in fair or poor health—children in these groups were still substantially more likely to be covered by Medicaid/CHIP than other children.

In 2015, Medicaid/CHIP coverage was higher among children who were in fair or poor health (64.1 percent), were non-Hispanic black or Hispanic (55.8 percent and 54.9 percent, respectively), were in families with no workers (74.9 percent), had parents with less than high school education (72.7 percent), or had household incomes at or below 138% of FPL (74.9 percent). Children with activity limitations had a higher Medicaid/CHIP coverage rate than those without (45.5 percent versus 35.4 percent), and children in the South and the West had higher Medicaid/CHIP coverage rates (40.0 percent and 37.7 percent, respectively) than children in other regions.

**TABLE 2**  
**Medicaid/CHIP Coverage among Children, 2008–15**

	2008 (%)	2015 (%)		
<b>Insured for the full year</b>	29.1	37.5	***	
<b>Sex</b>				
Female <sup>a</sup>	27.0	35.8	***	
Male	27.6	36.7	***	
<b>Age</b>				
0–5 <sup>a</sup>	34.3	41.0	***	
6–12	27.0	38.0	***	++
13–18	20.7	29.7	***	+++
<b>Race/ethnicity</b>				
White, non-Hispanic <sup>a</sup>	16.1	23.4	***	
Black, non-Hispanic	46.8	55.8	***	+++
Hispanic	43.9	54.9	***	+++
Other race, non-Hispanic	26.6	30.8		+++
<b>Citizenship status</b>				
Citizen <sup>a</sup>	27.5	36.4	***	
Noncitizen	22.3	31.7	***	+
<b>Self-reported health status</b>				
Excellent or very good health <sup>a</sup>	23.7	32.5	***	
Good health	42.7	54.8	***	+++
Fair or poor health	55.5	64.1	*	+++

	2008 (%)	2015 (%)		
<b>Limitations</b>				
Has an activity limitation <sup>a</sup>	40.8	45.5	*	
Has no activity limitation	26.2	35.4	***	+++
<b>Region</b>				
Northeast <sup>a</sup>	25.7	32.3	***	
South	29.6	40.0	***	+++
Midwest	23.6	31.2	***	
West	28.6	37.7	***	+++
<b>HIU highest education</b>				
Less than high school <sup>a</sup>	58.5	72.7	***	
High school	42.6	58.3	***	+++
Some college	26.1	40.3	***	+++
College	5.4	11.1	***	+++
<b>HIU work status</b>				
Two full-time workers <sup>a</sup>	8.9	13.3	***	
One full-time worker	25.0	34.7	***	+++
Only part-time workers	53.9	68.0	***	+++
No workers	64.8	74.9	***	+++
No adults	20.7	19.8		++
<b>HIU citizenship status</b>				
Any noncitizen in HIU <sup>a</sup>	43.3	55.0	***	
No noncitizens in HIU	24.6	32.7	***	+++
<b>HIU income</b>				
At or below 138% of FPL <sup>a</sup>	63.9	74.9	***	
Greater than 138% but less than 400% of FPL	20.9	27.9	***	+++
At or above 400% of FPL	2.0	3.4	***	+++

Source: Urban Institute tabulations of 2008–15 National Health Interview Survey data.

Notes: FPL = federal poverty level; HIU = health insurance unit. Children are ages 18 and younger. All measures are at time of survey. See Data and Methods section for measure definitions. Estimates are weighted to account for NHIS sample design.

\*/\*\*/\*\* Estimate for 2015 differs significantly from estimate for 2008 at  $p < 0.10/0.05/0.01$ , using two-tailed  $t$ -tests.

+/\*\*/+++ Estimate for 2015 differs significantly from estimate for the reference category (marked with <sup>a</sup>) at  $p < 0.10/0.05/0.01$ , using two-tailed  $t$ -tests.

## Financial Barriers to Care among Children Covered by Medicaid/CHIP

Between 2008 and 2015, the share of children covered by Medicaid/CHIP who did not receive needed medical care because their families could not afford it decreased 2.3 percentage points to 7.6 percent, and the share who delayed care because of cost decreased 1.0 percentage points to 1.1 percent (table 3, figure 3). We find no significant changes between 2013 and 2015 after implementation of the major ACA coverage provisions.

Both reductions in financial barriers remain significant when we control for several demographic and socioeconomic characteristics (table 3). When we adjust for these characteristics, children covered by Medicaid/CHIP in 2015 were 2.5 percentage points less likely to have had unmet need because of cost than children covered in 2008. Children covered in 2015 were also 1.2 percentage points less likely to report having delayed care because of cost than children covered in 2008.

Between 2011 and 2015, the share of children in families that had difficulty paying medical bills declined by 7.4 percentage points to 21.6 percent, a reduction of 25.5 percent (table 3, figure 3).

Similarly, the share in families that were unable to pay medical bills decreased 5.5 percentage points to 13.8 percent, a decline of 28.5 percent. We observe particularly large declines in these shares between 2014 and 2015 (15.6 percent and 13.8 percent, respectively), which may be because of coverage gains among parents through the Medicaid expansion or newly created Marketplaces. Again, these observed improvements remain significant and comparable in magnitude when estimated as regression-adjusted differences (table 3).<sup>8</sup>

TABLE 3

Changes in Access among Medicaid/CHIP-Covered Children, 2008–15 and 2011–15

	2008/2011 (%)	2015 (%)	Unadjusted percentage point change	Adjusted percentage point change
<b>Financial barriers</b>				
Had unmet need because of cost	9.9	7.6	-2.3***	-2.5***
Delayed care because of cost	2.1	1.1	-1.0***	-1.2***
<i>Had problems paying family medical bills<sup>a</sup></i>	29.0	21.6	-7.4***	-7.4***
<i>Unable to pay family medical bills<sup>a</sup></i>	19.3	13.8	-5.5***	-5.2***
<b>Receipt of care</b>				
Had a usual source of care	96.3	95.4	-0.9	-1.0*
Had a routine checkup	81.2	85.0	3.8***	3.6***
Saw a dentist	72.4	81.2	8.8***	6.6***
Saw a specialist	10.3	11.0	0.7	1.0
<b>Provider access</b>				
<i>Had trouble finding a doctor<sup>a</sup></i>	2.1	1.5	-0.6	-0.7*
<i>Was told a doctor was not accepting new patients<sup>a</sup></i>	3.0	2.0	-1.0**	-1.1**
<i>Was told a doctor did not accept insurance type<sup>a</sup></i>	4.6	2.8	-1.8***	-2.0***
Delayed care because couldn't get through by phone	2.6	1.6	-1.0**	-1.0**
Delayed care because couldn't get appointment soon	5.4	5.3	-0.1	-0.3
Delayed care because office hours not convenient	3.3	2.3	-1.0*	-1.0*
Delayed care because didn't have transportation	4.9	3.7	-1.2	-0.6
Delayed care because of wait at doctor's office	6.8	5.1	-1.7**	-2.0**
Delayed care for any noncost reason	14.2	11.5	-2.7**	-2.5**

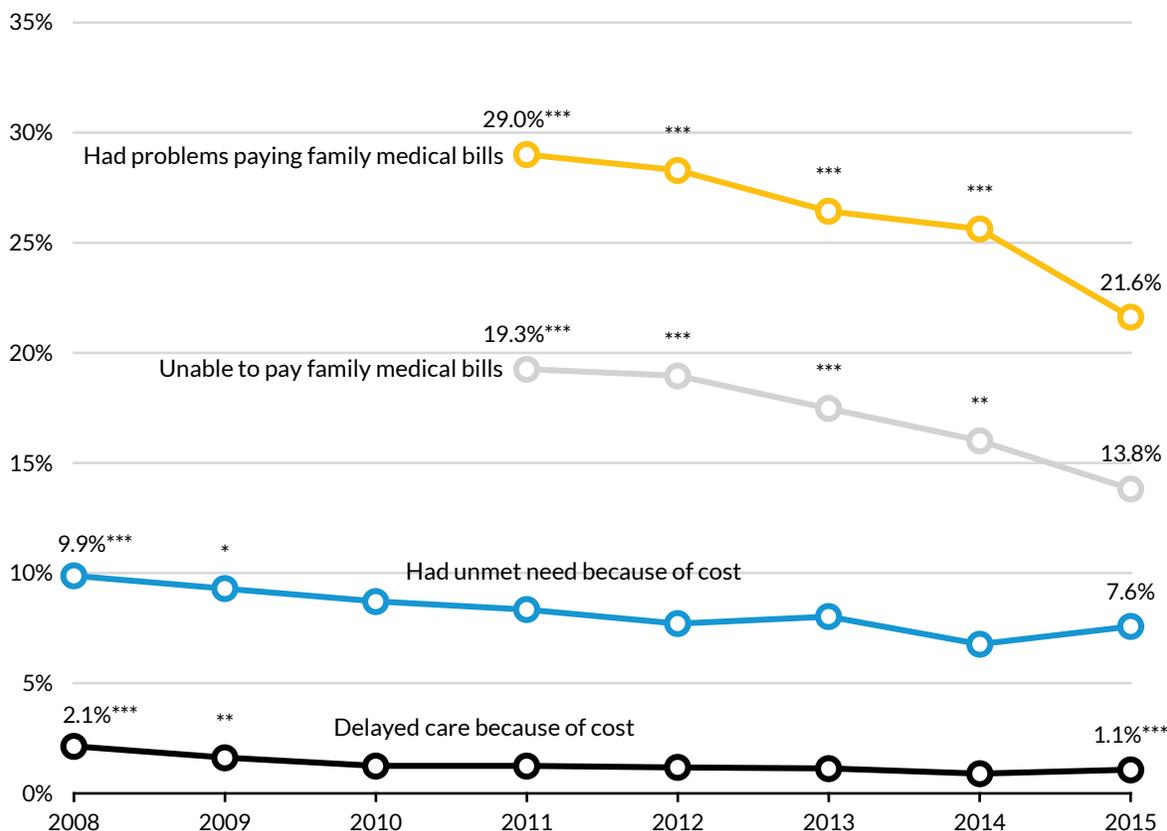
Source: Urban Institute tabulations of 2008–15 National Health Interview Survey data.

Notes: Children are ages 18 and younger. Medicaid/CHIP coverage is measured at time of survey. Sample is limited to children who were insured for the full year. See Data and Methods section for measure definitions. Estimates are weighted to account for NHIS sample design. Percentage point changes are between 2008 and 2015 except where noted by <sup>a</sup> and *italics*; changes noted by <sup>a</sup> and *italics* are between 2011 and 2015. Questions denoted by <sup>a</sup> and *italics* were first asked in 2011. “Delayed care for any noncost reason” indicates delayed care for any of the following five reasons, which are not mutually exclusive: couldn't get through by phone, couldn't get appointment soon, office hours not convenient, didn't have transportation, and wait at doctor's office. Adjusted percentage point change is regression-adjusted for age, sex, race/ethnicity, citizenship status, self-reported health status, activity limitations, region, HIU educational attainment, HIU work status, HIU citizenship status, and HIU income.

\*/\*\*/\*\*\* Estimate for 2015 differs significantly from estimate for 2008 at  $p < 0.10/0.05/0.01$ , using two-tailed  $t$ -tests.

FIGURE 3

**Financial Barriers to Care among Medicaid/CHIP-Covered Children and Their Families, 2008–15 and 2011–15**



**Source:** Urban Institute tabulations of 2008–15 National Health Interview Survey data.

**Notes:** Children are ages 18 and younger. Insurance is measured at time of survey. Sample is limited to children with Medicaid/CHIP coverage at time of survey who were insured for the full year. Measures reflect the past 12 months. Questions about paying medical bills were first asked in 2011. See Data and Methods section for measure definitions. Estimates are weighted to account for NHIS sample design.

\*/\*\*/\*\*\* Estimate differs significantly from 2015 estimate at  $p < 0.10/0.05/0.01$ , using two-tailed  $t$ -tests.

**Receipt of Care among Children Covered by Medicaid/CHIP**

Reported health care receipt increased or remained constant among children covered by Medicaid/CHIP between 2008 and 2015. The share of children ages 17 and younger who had a routine checkup in the past year increased 3.8 percentage points to 85.0 percent (table 3, figure 4). The share of children ages 1 to 18 who had seen a dentist in the past year also improved, increasing 8.8 percentage points to 81.2 percent.

We find no significant changes in the share of children who had a usual source of care or saw a specialist in the past 12 months, but nearly all children covered by Medicaid/CHIP had a usual source of

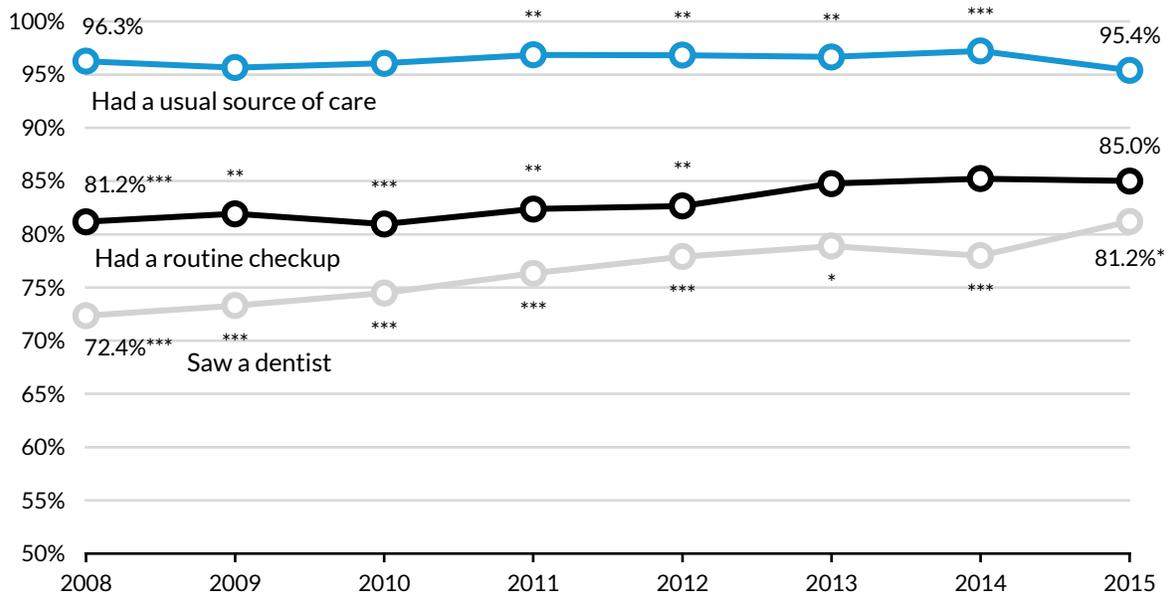
care (95.4 percent in 2015). Just over one in ten Medicaid/CHIP-covered children had seen a specialist in the past 12 months (11.0 percent in 2015).

We find no significant changes in the share of children who had a routine checkup between 2013 and 2015, but the share of children who had a dental visit continued to increase. We find small but significant reductions in the share of children who had a usual source of care (1.3 percentage point decline) and in the share of children who saw a specialist in the past 12 months (2.1 percentage point decline) between 2013 and 2015. Although the share of Medicaid/CHIP-covered children who had a specialist visit declined between 2013 and 2015, we do not observe an increase in the share reported to have an unmet need for specialty care; only 1.2 percent had unmet need for specialty care in 2015 (data not shown). Moreover, fewer children were reported to experience a provider access problem between 2013 and 2015.

Increases in routine checkups and dental visits from 2008 to 2015 remain significant and similar in magnitude when differences are regression-adjusted to control for the demographic and socioeconomic characteristics of children and their families (table 3).<sup>9</sup>

FIGURE 4

Receipt of Care among Medicaid/CHIP-Covered Children, 2008–15



Source: Urban Institute tabulations of 2008–15 National Health Interview Survey data.

Notes: Children are ages 18 and younger. Insurance is measured at time of survey. Sample is limited to children with Medicaid/CHIP coverage at time of survey who were insured for the full year. Measures reflect the past 12 months. “Routine checkup” is only asked for children ages 17 and younger, and “saw a dentist” is only asked for children ages 1 and older. See Data and Methods section for measure definitions. Estimates are weighted to account for NHIS sample design.

\*/\*\*/\*\* Estimate differs significantly from 2015 estimate at  $p < 0.10/0.05/0.01$ , using two-tailed  $t$ -tests.

## Provider Access among Children Covered by Medicaid/CHIP

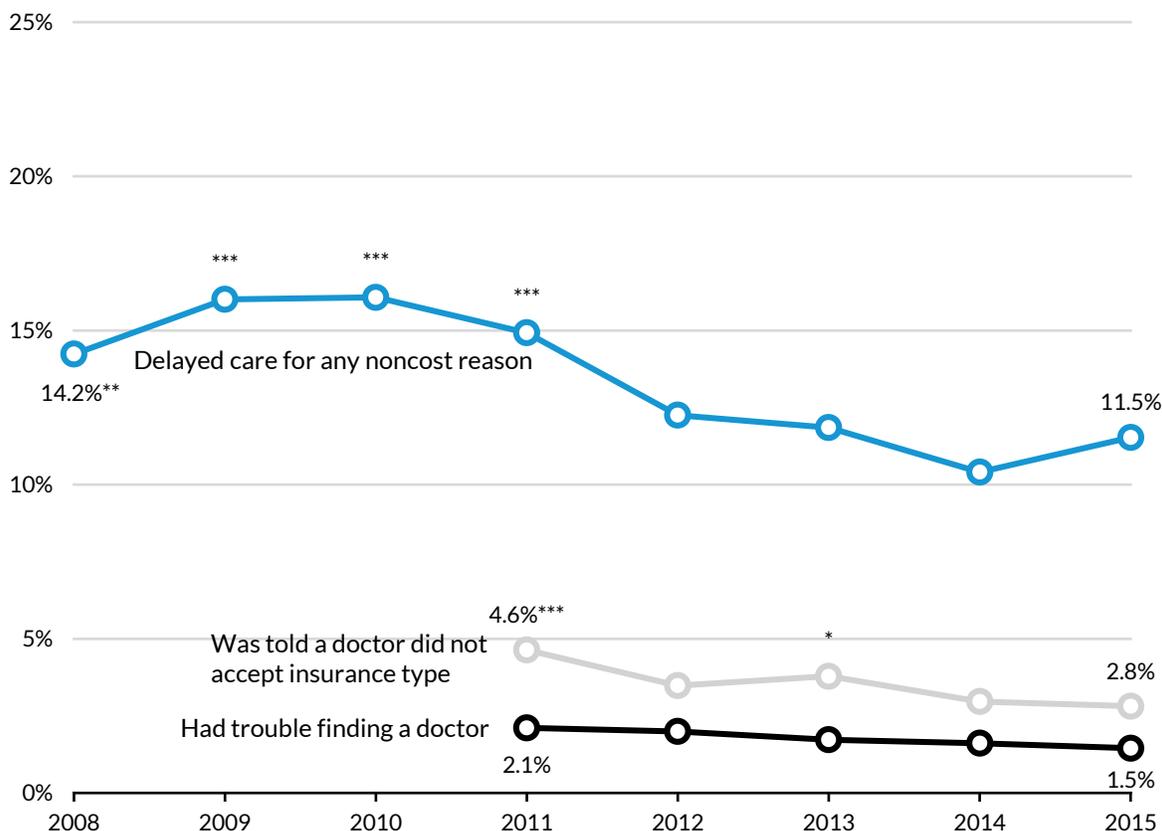
Provider access improved among children covered by Medicaid/CHIP between 2008 and 2015. The share of children who had delayed care for a noncost reason (couldn't get through by phone, couldn't get appointment soon, office hours not convenient, didn't have transportation, or wait at doctor's office) decreased 19 percent to 11.5 percent in 2015 (table 3, figure 5).<sup>10</sup> This decrease was driven by significant declines (1.0 to 2.0 percentage points) in the following factors: delayed care because of long waits at the doctor's office, delayed care because of inconvenient doctor's office hours, and delayed care because of difficulty reaching the doctor's office by phone. We find no significant changes in the share of children with delayed care because they could not get an appointment soon or because they did not have transportation. The decreases in delayed care for noncost reasons remain significant and similar in magnitude when controlling for observed changes in the characteristics of children with Medicaid/CHIP coverage (table 3).<sup>11</sup>

Among children with Medicaid/CHIP coverage, the share who reported having trouble finding a general doctor or provider who would see them was small in 2015 (1.5 percent) and did not change significantly between 2011 and 2015 (table 3, figure 5). The share of children told that a doctor was not accepting new patients decreased 1.0 percentage points to 2.0 percent between 2011 and 2015. The share of children told that a doctor did not accept their insurance type decreased 1.8 percentage points to 2.8 percent. We find a 1.0 percentage point decline in the share of Medicaid/CHIP-covered children who were told that a doctor did not accept their insurance type between 2013 and 2015, after implementation of the major ACA coverage provisions.

When differences between 2015 and 2011 are regression-adjusted to control for the demographic and socioeconomic characteristics of children and their families, reductions in the share of children told that a doctor did not accept their insurance type or was not seeing new patients remained significant, and the decline in trouble finding a doctor was small but significant (table 3).<sup>12</sup>

FIGURE 5

Provider Access Problems among Medicaid/CHIP-Covered Children, 2008–15 and 2011–15



Source: Urban Institute tabulations of 2008–15 National Health Interview Survey data.

Notes: Children are ages 18 and younger. Insurance is measured at time of survey. Access and use measures reflect the past 12 months. Questions about trouble finding a doctor and doctor’s acceptance of insurance were first asked in 2011. See Data and Methods section for measure definitions. Estimates are weighted to account for NHIS sample design.

\*/\*\*/\*\*\* Estimate differs significantly from 2015 estimate at  $p < 0.10/0.05/0.01$ , using two-tailed  $t$ -tests.

## Conclusion

From 2008 to 2015, the rate and number of children covered by Medicaid/CHIP increased by approximately 32 percent, and uninsurance among children declined by 49.5 percent. Medicaid/CHIP coverage rates increased more for children in groups that have not had historically high Medicaid/CHIP coverage; these include non-Hispanic white children, older children, children in excellent or very good health, and children with higher socioeconomic status. Although the types of children covered by Medicaid/CHIP have become more heterogeneous over time, coverage rates remain higher among children in fair or poor health, non-Hispanic black and Hispanic children, and children in families with low socioeconomic status.

Children covered by Medicaid/CHIP in 2015 fared better than those in 2008 on measures of financial barriers, receipt of care, and access to providers. From 2008 to 2015, the share of children who experienced delayed or forgone care because of cost decreased, checkups and dental visits increased, and reported delays in care or trouble finding a provider decreased. We also find improvements in families' ability to pay medical bills and declines in trouble finding a provider from 2011 to 2015, when those outcomes were tracked. In 2015, the most recent year with available data, 95 percent of Medicaid/CHIP-covered children had a usual source of care, 85 percent had a checkup in the past year, and less than 2 percent reported having trouble finding a provider who would see them.

Some observers have suggested that children with Medicaid/CHIP coverage would experience more access problems as Medicaid enrollment expanded under the ACA (Turner 2017),<sup>13</sup> but instead we find that children with Medicaid/CHIP coverage were less likely to be told that a doctor did not accept their insurance type in 2015 relative to 2013 (data not shown). We also find no change in routine checkups for children. Although we find decreases in the share of children who had a usual source of care and in the share of children who saw a specialist in the past year between 2013 and 2015, we find no increase in the share of children reported to have unmet need for specialty care, and we find a decrease in the share of children told that a doctor did not accept their insurance type; both outcomes were rare in 2015, affecting 1.2 percent (data not shown) and 2.8 percent (figure 4) of children covered by Medicaid/CHIP, respectively.

These data indicate that financial access, provider access, and receipt of care among Medicaid/CHIP-covered children improved between 2008 and 2015, even though an estimated 16.6 million more nonelderly adults and children had Medicaid or CHIP at the time of the survey in 2015. We find similar patterns of improvements for children in fair, poor, or good health, for whom Medicaid/CHIP coverage is particularly important (data not shown). These children experienced large reductions in access barriers and in cost-related care delays: unmet need because of cost declined by 4.8 percentage points, and delayed care for any noncost reason declined by 4.3 percentage points.

Although these results show that children with Medicaid/CHIP coverage have high rates of primary care access and experience few barriers to obtaining needed care, these estimates may mask access challenges for subgroups of children. Access to specialty care and subspecialty care may be particularly problematic for children with special health care needs and for those in rural areas who rely on Medicaid and CHIP for coverage (Hoadley et al. 2017; MACPAC 2017; Silow-Carroll et al. 2016). This analysis is limited by its exclusive reliance on household survey data. When assessing access to care, it is important to monitor access across multiple domains (e.g., provider availability and accessibility, beneficiary use, and beneficiary perceptions and experiences), use a range of data sources and mechanisms (e.g., survey data, administrative data, and "secret shopper" audits), measure access for specific Medicaid/CHIP subgroups (e.g., disability status, rural residence, primary language, race/ethnicity), and measure access across states (Kenney, Gifford, et al. 2017). These findings should be supplemented by analyses of other data sources and key subgroups, as well as comparative analyses of children who are uninsured or have private coverage; these would provide a more comprehensive picture of access to care for children with Medicaid and CHIP coverage.

The structure of health insurance coverage for children may change dramatically in the coming years. The future of the ACA and the financing of Medicaid are currently being debated in Congress. Under the proposed replacement to the ACA, the American Health Care Act, per capita caps or block grants would replace the open-ended federal matching structure that has funded Medicaid since its inception in 1965 (Holahan et al. 2017; Rosenbaum et al. 2017). Federal dollars for CHIP are only authorized through fiscal year 2017, and the requirement that states maintain Medicaid and CHIP coverage at 2010 levels extends just through 2019 (MACPAC 2017). Altogether, these policy changes raise the risk that Medicaid/CHIP eligibility will decline among children, reversing the downward trend in uninsurance that has prevailed over the last several decades (Buettgens, Kenney, and Pan 2016). Even if policy changes do not directly target children, changes that reduce Medicaid coverage among parents could still cause a decline in Medicaid and CHIP coverage among children; earlier research has shown that children are more likely to enroll in Medicaid/CHIP when their parents also qualify for public coverage (Aizer and Grogger 2003; DeVoe et al. 2015; Dubay and Kenney 2003; Kenney, Long, and Luque 2010). With less federal funding for Medicaid and CHIP, states may reduce benefits and/or provider payments, which in turn could adversely affect access to care among children covered by these programs. Monitoring is critical to ensure that children, particularly those from low- and moderate-income families, continue to have adequate access to health care.

## Data and Methods

This analysis uses nationally representative data for the civilian, noninstitutionalized population from the National Health Interview Survey, which is conducted annually by the National Center for Health Statistics (NCHS). The NHIS consists of three main sections: the family core, sample adult core, and sample child core. Questions on the family core are answered for each member of the family by a knowledgeable adult and include basic demographic information, educational attainment, employment status, general health status, and detailed information on health insurance coverage. Questions on the sample child and sample adult core are asked of one child age 17 or younger (if present, excluding emancipated minors) and one adult older than age 17. The sample child and sample adult core include more extensive information on health status and details on health care access, receipt of care, and financial barriers. The NHIS included data on approximately 6,500 children and 2,600 sample children enrolled in Medicaid/CHIP in 2008, and approximately 11,000 children and 4,600 sample children enrolled in Medicaid/CHIP in 2015. The NHIS is fielded continuously throughout the year and can provide nationally representative annual or quarterly estimates. We used public data from IPUMS Health Surveys, which provides harmonized versions of NHIS variables across years (Blewett et al. 2016).

We classified NHIS families into health insurance units (HIUs), which more closely resemble the units used to estimate income eligibility for tax credits or Medicaid.<sup>14</sup> We used NHIS family income and personal earnings information, which include values imputed by NCHS for respondents with missing information on these characteristics, and redistribute family income and earnings across HIUs that make up a family. We then calculated HIU income relative to the federal poverty level. We adjusted all

income-based estimates and standard errors to reflect the multiple imputation technique used by NCHS.

We used data from 2008 to 2015 to track rates of Medicaid and CHIP coverage for children ages 18 and younger, measuring unadjusted differences in coverage rates over time. We tested whether the estimate for 2015 was different from those for earlier years using two-tailed *t*-tests that take account of the complex nature of the sample design. Unless otherwise noted, all differences discussed in the text are significant at the 0.10 level. Children's insurance coverage was measured at the time of the survey; children with multiple types of insurance were assigned a single type of coverage using an insurance hierarchy, which first assigns private insurance, followed by Medicaid/CHIP, other coverage, and (if no coverage is reported) uninsurance. We used a combined measure of Medicaid/CHIP coverage—instead of measuring coverage through these two programs separately—to reduce measurement error caused by respondents misreporting Medicaid as CHIP or CHIP as Medicaid coverage. We repeated this analysis for nonelderly adults ages 19 to 64. Finally, we measured the change in uninsurance among children, using data from 2008 to 2015 to track coverage rates for children ages 18 and younger and measuring unadjusted differences in coverage rates over time.

We examined changes between 2008 and 2015 in the characteristics of Medicaid/CHIP-enrolled children and the rates of Medicaid/CHIP coverage among children by age (birth to age 5, ages 6 to 12, or ages 13 to 18), race/ethnicity (non-Hispanic white, non-Hispanic black, other non-Hispanic race, or Hispanic), sex (male or female), health status (excellent or very good, good, or fair or poor), citizenship status, activity limitation, HIU income (at or below 138 percent of FPL, greater than 138 but less than 400 percent of FPL, or at or above 400 percent of FPL), HIU work status (two full-time workers, one full-time worker, only part-time workers, no workers, or no adults<sup>15</sup>), HIU highest education (less than high school, high school graduate, some college, or college graduate), HIU citizenship (any noncitizen or no noncitizen), and census region (Northeast, Midwest, South, or West).

We also compared financial barriers, receipt of care, and provider access experiences for children covered by Medicaid/CHIP over time (between 2008 and 2015 or between 2011 and 2015, depending on when measures were added to the NHIS). For this analysis, the sample of Medicaid/CHIP-covered children was limited to children with Medicaid/CHIP coverage at the time of the interview who also reported being insured (with any type of coverage) for the entire year. By limiting the sample to children with full-year insurance coverage, we ensured that outcomes measured for the past 12 months were not affected by periods of uninsurance.

We constructed four measures of financial barriers using information reported by a family respondent. Two of these measures were at the family level: family had trouble paying medical bills in the past 12 months (only available for 2011 through 2015) and family was unable to pay medical bills (only available for 2011 through 2015). The other two measures were at the child level: share of children with unmet need because of cost in the past 12 months (including unmet needs for medical care, dental care, prescription drugs, eyeglasses, mental health care, specialist care, and follow-up care) and share of children who delayed care because of cost in the past 12 months.

We generated four measures of receipt of care among children: having a usual source of care other than the emergency department, having had a routine checkup in the past 12 months (only asked for children ages 17 and younger), having seen a specialist in the past year, and having seen a dentist in the past year (only asked for children ages 1 and older). We also constructed nine measures of access to care among children: delayed care because couldn't get appointment soon enough, delayed care because of wait at doctor's office, delayed care because didn't have transportation, delayed care because office hours were not convenient, delayed care because couldn't reach doctor's office by phone, delayed care for any noncost reason (any of the previous five reasons), had trouble finding a doctor (only available for 2011 through 2015), was told a doctor was not accepting new patients (only available for 2011 through 2015), and was told a doctor did not accept their insurance type (only available for 2011 through 2015).

We estimated unadjusted differences and adjusted differences in these measures from 2008 to 2015. We expected that the characteristics of Medicaid/CHIP-covered children could change as the number of covered children increased. Changes in characteristics such as race/ethnicity, family income, or child health status may contribute to differences in provider access, financial barriers, and receipt of care that are not attributable to changes in Medicaid/CHIP coverage over time (Kenney and Coyer 2012). Thus, when comparing outcomes over time, we adjusted for individual and HIU characteristics including age, sex, race/ethnicity, citizenship, reported health status, activity limitations, highest educational attainment in the HIU, work status of HIU members, HIU citizenship, HIU income, and region.

We repeated this analysis of differences in financial barriers, provider access, and receipt of care over time for a subset of children in fair, poor, or good health. Good health status was combined with fair or poor to obtain adequate sample sizes; in 2015, 16 percent of children in the NHIS reported fair, poor, or good health, compared with 84 percent reporting excellent or very good health.

## Limitations

This analysis relies on self-reported data from the NHIS, a household survey. As in other analyses of NHIS, health insurance coverage and coverage type are likely measured with error. Therefore, we may not be accurately identifying children with Medicaid/CHIP coverage. Moreover, among children with full-year insurance coverage and Medicaid/CHIP coverage at the time of the survey, some may have had private coverage at some point during the year (Kenney and Coyer 2012). Additionally, NHIS is limited by its reliance on respondent recall, which may lead to measurement error. Recall error is a concern for questions that ask respondents to think about the past 12 months. Respondents may also feel pressure to provide a specific answer to survey questions. For example, parents may not want to disclose that they delayed care for their child because of cost. Responses to questions about unmet need because of cost are subjective; they rely on a parent's determination of needed care for their child. Also, NHIS only measures insurance coverage type at the time of the interview, so the data cannot be used to create samples of children who were covered by the same type of coverage for the entire year. Finally, the measures included in this analysis do not capture the quality of care received.

## Notes

1. Not all children who rely on Medicaid/CHIP for coverage are enrolled in the program for the full year. Based on 2015 NHIS data, we estimate that 1.3 million children were covered by Medicaid/CHIP at the time of the survey but not insured for the full year.
2. These questions were first added to the National Health Interview Survey in 2011.
3. These questions were first added to the National Health Interview Survey in 2011.
4. American Health Care Act of 2017, H.R. 1628, 115th Cong. (2017).
5. Monthly Medicaid and CHIP reports can be found on the Medicaid.gov website, <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/monthly-reports/index.html>.
6. The characteristics and rates of children both covered by Medicaid/CHIP at the time of the survey and insured for the full year are similar to those of all children who were covered by Medicaid/CHIP at the time of the survey (data not shown).
7. See note 6.
8. Other things equal, families of Medicaid/CHIP-covered children in 2015 were 7.4 percentage points less likely to have had problems paying medical bills and 5.2 percentage points less likely to have been unable to pay medical bills than families in 2008.
9. Other things equal, Medicaid/CHIP-covered children in 2015 were 3.6 percentage points more likely to have had a routine checkup and 6.6 percentage points more likely to have had a dental visit than those in 2008. The adjusted models also indicate that children covered by Medicaid/CHIP in 2015 were 1.0 percentage points less likely to report having a usual source of care than those in 2008, but the 0.9 percentage point unadjusted difference in having a usual source of care between 2015 and 2008 is not statistically significant at  $p < 0.10$ . Other things equal, Medicaid/CHIP-covered children in 2015 were 0.9 percentage points less likely to have had a usual source of care and 1.8 percentage points less likely to have seen a specialist in the past year than those in 2013. Usual source of care measures whether children have a place that they usually go to when they are sick or need advice about their health. Children who list a hospital emergency room as their usual place of care are not deemed to have a usual source of care, but children who report multiple places they go for care are deemed to have a usual source of care.
10. We find similar trends in reported delays of care for noncost reasons when lack of transportation is excluded from the measure.
11. Other things equal, Medicaid/CHIP-covered children in 2015 were 2.5 percentage points less likely to have delayed care for any noncost reason, 2.0 percentage points less likely to have delayed care because of a long wait at the doctor's office, and 1.0 percentage points less likely to have delayed care either because of inconvenient office hours or because they could not reach the doctor's office by phone than Medicaid/CHIP-covered children in 2008.
12. Other things equal, Medicaid/CHIP-covered children in 2015 were 0.7 percentage points less likely to report having trouble finding a doctor, 1.1 percentage points less likely to have been told a doctor was not accepting new patients, and 2.0 percentage points less likely to have been told that a doctor did not accept their insurance type than Medicaid/CHIP-covered children in 2008.
13. Charles Blahous, "What CBO Analysis of Partial Obamacare Repeal Really Means," *E21 Commentary*, January 17, 2017, <https://economics21.org/html/what-cbo-analysis-partial-obamacare-repeal-really-means-2191.html>.
14. We refer to these HIUs as "households" or "families," unless otherwise noted. For the two questions about paying family medical bills, the family definition used by NCHS is appropriate (not our constructed HIU measure).
15. Most of these are older teens either living alone or without their parents or grandparents.

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