

**Continuous Medicaid Eligibility for Children and Their Health**

**Working Paper**

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by Leighton Ku, PhD, MPH and

Erin Brantley, PhD, MPH

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# **Continuous Medicaid Eligibility for Children and Their Health**

## **Executive Summary**

Almost half the states offer 12-month continuous eligibility to children in their Medicaid programs to help children in low-income families retain insurance coverage and access to medical care throughout the year. This study analyzes the association of this policy for children in low-income families with a variety of health outcomes, including insurance gaps, access to preventive, general and specialty care, and health status. Using data pooled from the 2016 to 2018 National Surveys of Children's Health (n = 17,610), we examine outcomes for children under the age of 18 whose family incomes are below 138 percent of poverty. Virtually all of these children are eligible for Medicaid coverage across the nation. We compared outcomes for children living in 24 states with 12-month continuous eligibility policies to those living in 26 states (and the District of Columbia) without the policy.

Our multivariate analyses examined the effect of continuous eligibility on the outcomes after controlling for other relevant factors such as age, race/ethnicity, being foreign-born, having special health needs, and other Medicaid policies, such as income eligibility levels for parents and children. Continuous Medicaid eligibility is associated with:

- Raising the number of children who saw a specialist in the past year by 1.5 percentage points, which is equivalent to a one-eighth increase in access to specialists,
- Reducing unmet needs for specialty care by 6.0 percent, lowering the level of unmet needs by about one-third,
- Increasing the use of preventive care visits in the past year by 2.7 percentage points (marginally significant), equivalent to reducing the number without a preventive visit by about one-tenth,
- Reducing gaps in insurance coverage by 2.4 percentage points, equivalent to reducing the number with a gap by almost one-fifth, and
- Lowering gaps caused by application problems by 1 percentage point, almost halving the number with gaps due to application problems.

Further analyses were conducted for the subset of children with special health care needs, those whose parents reported they had chronic health problems. For these vulnerable children, continuous eligibility was associated with statistically significant increases in the number of children able to obtain general medical care, preventive care and specialty care.

We also found that broader Medicaid eligibility for parents and for children were often associated with positive outcomes for the children. Higher Medicaid eligibility levels for both parents and children may facilitate greater enrollment in Medicaid and reduce the risk of coverage loss. The analyses identified special challenges for immigrant (foreign-born) children, who had less insurance coverage and less medical care. This may be due to eligibility policies that bar many immigrant children from Medicaid coverage, such as recent public charge regulations by the Department of Homeland Security.

The Families First Coronavirus Response Act called on states to provide continuous coverage to Medicaid enrollees during the period of the public health emergency. But even after the public health emergency ends, the nation will experience higher unemployment, greater poverty and economic volatility. Policies like 12-month continuous Medicaid eligibility and expanded eligibility could lower insurance gaps and assure better access to care for a longer period.

## Introduction

The 2020 coronavirus (COVID-19) pandemic has heightened awareness of the instability of employment and income and the importance of health care coverage. As businesses across the nation shuttered during the spring, tens of millions of Americans filed for unemployment benefits.<sup>1</sup> There has been an unprecedented loss of jobs across the nation, particularly in the service sectors like the hotel and restaurant sectors, pushing the official unemployment rate to 14.7 percent in April<sup>2</sup> and could continue to rise. Loss of a job often leads to losing private health insurance coverage. A recent analysis estimated that, if the unemployment rate reaches 15 percent, the number of people with employer-sponsored coverage could fall by 30 million, the number on Medicaid could grow by 14 million and the number of uninsured could climb by 8.5 million. Higher unemployment rates would lead to even more drastic changes.<sup>3</sup>

To help states maintain their Medicaid programs, the Families First Coronavirus Response Act (P.L. 116-127) temporarily raises the federal Medicaid matching rate by 6.2 percentage points during the public health emergency, provided that states (a) do not restrict Medicaid eligibility or raise premiums, (b) provide continuous eligibility to participants (unless a participant voluntarily disenrolls or moves to another state), and (c) offer COVID-19 testing and treatment without cost-sharing.<sup>4</sup>

While these protections are temporary, concerns about the adequacy of Medicaid eligibility and continuity of coverage have existed for many years.<sup>5</sup> Medicaid enrollment tends to be less stable than private employer-sponsored coverage. In job-based coverage, the norm is that an insured employee (and his or her dependents) retains coverage until the employee leaves that job or voluntarily disenrolls, while Medicaid enrollees must periodically renew coverage and demonstrate income and categorical eligibility, e.g., that their age remains within permissible limits. Research has shown that people often lose Medicaid coverage due to paperwork burdens and that “churning,” that is, having gaps in Medicaid coverage, reduces the use of appropriate

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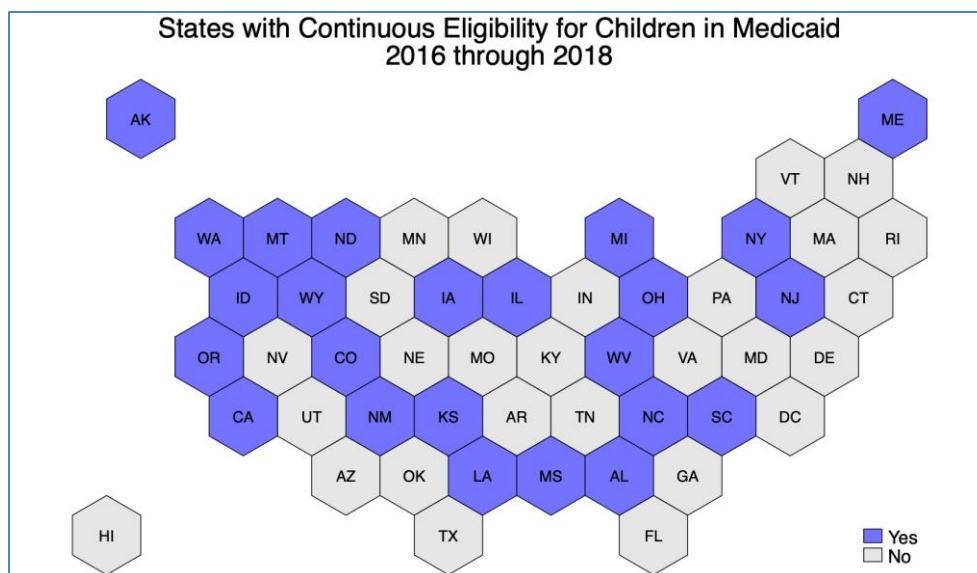
<sup>1</sup> Mutikani, L Millions more Americans file for jobless benefits; productivity tanks. Reuters. May 7, 2020. <https://www.reuters.com/article/us-usa-economy/millions-more-americans-file-for-jobless-benefits-productivity-tanks-idUSKBN22J0HT>

<sup>2</sup> U.S. Bureau of Labor Statistics. The Employment Situation: April 2020. May 8, 2020. <https://www.bls.gov/news.release/pdf/empst.pdf>

<sup>3</sup> Garrett B, Gangopadhyaya A. How the COVID-19 Recession Could Affect Health Insurance Coverage. Urban Institute. May 2020. <https://www.urban.org/research/publication/how-covid-19-recession-could-affect-health-insurance-coverage>

<sup>4</sup> Moss K, et al. The Families First Coronavirus Response Act: Summary of Key Provisions. Kaiser Family Foundation. Mar. 20, 2020. <https://www.kff.org/global-health-policy/issue-brief/the-families-first-coronavirus-response-act-summary-of-key-provisions/>

<sup>5</sup> A bibliography of relevant research can be found at <https://www.communityplans.net/research/continuous-eligibility-bibliography/>. For example, see Ku L, MacTaggart P, Pervez F, Rosenbaum S. Improving Medicaid's Continuity and Quality of Care, Association for Community Affiliated Plans, July 2009 or Sommers B. *From Medicaid to Uninsured: Drop-Out among Children in Public Insurance Programs*. *Health Serv Res*. 2005 Feb; 40(1): 59–78.



**Figure 1**

health care. This eligibility churn can lead to problems such as avoidable hospitalizations or emergency room care for diseases like asthma, diabetes or mental health problems, ultimately raising the average monthly cost of benefits.<sup>6</sup>

Because of the importance of health care during developmental years, states have the option to guarantee 12-month continuous eligibility for children in Medicaid or CHIP, so that children do not lose coverage because of paperwork burdens or modest fluctuations in income within a year. During the 2016-2018 period examined in this study, 24 states offered 12-month continuous eligibility for children in Medicaid (*Figure 1*) while 26 states (and the District of Columbia) did not. (States may offer also continuous eligibility for pregnant women up to 60 days postpartum. Two states, New York and Montana, offer continuous eligibility for adults using Medicaid waivers.<sup>7</sup>) Some states offer insurance coverage for higher-income children through separate state Children's Health Insurance Programs (CHIP) instead of through Medicaid. CHIP programs may also offer 12-month continuous eligibility, although in some states the Medicaid and CHIP continuous eligibility policies differ. When 12-month continuous eligibility is not in place, states may apply shorter certification periods (e.g., 6 months) or require periodic reporting of income changes, so that children may lose coverage in a shorter period.

States have other policy options to make it easier for children to enroll or stay enrolled in Medicaid, including presumptive eligibility, express lane eligibility and automated renewals.<sup>8</sup> In addition, broader parental Medicaid eligibility can improve enrollment of children by permitting

<sup>6</sup> *Ibid.*

<sup>7</sup> Artiga S, Rudowitz R, Musumeci M. How Can Medicaid Enhance State Capacity to Respond to COVID-19? Kaiser Family Foundation. Mar 17, 2020. <https://www.kff.org/medicaid/issue-brief/how-can-medicaid-enhance-state-capacity-to-respond-to-covid-19/>

<sup>8</sup> See ACAP's *Continuous Eligibility Bibliography*, *op cit.*

families to apply jointly. Broader child eligibility limits may also make it easier to remain enrolled because modest income fluctuations are less likely to lead to disqualification.

An earlier study analyzed the effects of 12-month continuous eligibility for children, examining the consequences for seven states that adopted the policy following the passage of the 2009 Children's Health Insurance Program Reauthorization Act. It found that adopting continuous eligibility significantly lengthened the average length of children's enrollment in a year, by about 2 percent.<sup>9</sup>

This study takes the opportunity to reassess the effects of Medicaid continuous eligibility for low-income children and consider a broader range of outcomes, based on pooled data from the 2016 to 2018 National Surveys of Children's Health (NSCH). We compare health measures for children under the age of 18 with family incomes below 138 percent of the poverty line who live in states with and without the policy. During this period, almost all children in the United States with family incomes below 138 percent of the poverty line were eligible for Medicaid in every state.<sup>10</sup> (Most children with incomes below 200 percent of poverty are eligible for either Medicaid or the Children's Health Insurance Program (CHIP), but analyzing Medicaid and CHIP together would be more complex because of state variation in the age limits and other program rules.)

From 2016 to 2018, 24 states used 12-month continuous eligibility consistently. This study is a cross-sectional comparison of outcomes in states with and without continuous eligibility, controlling for other factors.

## Methods

Data. We pooled data from the National Surveys of Children's Health (NSCH) from 2016 through 2018. The NSCH is an annual household survey about children's health conducted by the Census Bureau for the Maternal and Child Health Bureau (HRSA).<sup>11</sup> It is statistically representative of each state. Surveys were completed via the web or phone by an adult in the household. Overall weighted response rates were 40.7 percent, 37.4 percent, and 43.1 percent in

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<sup>9</sup> Ku L, Steinmetz E, Bruen, B. Continuous Eligibility Policies Stabilize Medicaid Coverage for Children and Could Be Extended to Adults with Similar Results, *Health Affairs*, 32(9): 1576-82, Sept. 2013.

<sup>10</sup> A small share of children may be ineligible because they were ineligible immigrant children, but most children in immigrant families are U.S.-born citizens and a majority of states have extended lawfully residing immigrant children. Undocumented children are not eligible for federally funded benefits. Center for Children and Families, Georgetown Univ. Health Coverage for Lawfully Residing Children. May 2018. [https://ccf.georgetown.edu/wp-content/uploads/2018/05/ichia\\_fact\\_sheet.pdf](https://ccf.georgetown.edu/wp-content/uploads/2018/05/ichia_fact_sheet.pdf). NSCH identifies whether children were US or foreign-born, but not more detailed immigration status.

<sup>11</sup> More description of NSCH can be found at <https://www.childhealthdata.org/learn-about-the-nsch/NSCH> or <https://mchb.hrsa.gov/data/national-surveys>.

2016, 2017, and 2018, respectively. To address the survey’s complex sampling design, all analyses were adjusted using weights and design parameters based on guidance from the Census Bureau.<sup>12</sup>

Our sample includes a total of 17,610 respondents 0 to 17 years old with family incomes at or below 138 percent of poverty, since this is the minimum federal Medicaid eligibility criterion for children. All children below that level (with exceptions for some immigrant children) are eligible for Medicaid in all states, even if they also have private health insurance. In addition, we focused on a subpopulation of children in low-income families who have “special health care needs,” meaning that they have one or more chronic health problem. The determination of special health care needs is based on a short questionnaire,<sup>13</sup> which asks whether the child has health problems (physical, mental or emotional) that require special assistance or that limit the child’s ability to do things that other children their age can do. The sample size for special health care needs children with incomes at or below 138 percent of poverty is 4,677. (We also conducted analyses for children with incomes between 138 and 200 percent of poverty. Results were equivocal due to the smaller sample sizes and difficulties in applying Medicaid or CHIP policies that vary across the states; results are not presented.)

Policy and other measures. We merged the NSCH data with information about each state’s Medicaid enrollment policies from 2016 to 2018, as reported by the Kaiser Family Foundation.<sup>14,15</sup> The primary policy variable is whether the state has a 12-month continuous eligibility policy for Medicaid children. From 2016 to 2018, 24 states had continuous eligibility for Medicaid children; there were no changes in this time period (Figure 1 on page 4).

We controlled for other Medicaid policy variables that might affect children’s eligibility and enrollment. These include parents’ Medicaid eligibility levels, children’s Medicaid eligibility levels (for school-age children), use of automated (*ex parte*) renewals, and presumptive Medicaid eligibility for children.<sup>16</sup> Medicaid eligibility levels are higher for very young children in many

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<sup>12</sup> Census Bureau. Technical documentation for NSCH. <https://www.census.gov/programs-surveys/nsch/technical-documentation.html>

<sup>13</sup> Bethell CD, Read D, Neff J, Blumberg SJ, Stein RE, Sharp V, Newacheck PW. 2002. “Comparison of the Children with Special Health Care Needs Screener to the Questionnaire for Identifying Children with Chronic Conditions— Revised.” *Ambulatory Pediatrics*, Jan-Feb 2(1): 49-57.

<sup>14</sup> Brooks T, Roygardner L, Artiga S. Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2019: Findings from a 50-State Survey. *The Henry J Kaiser Family Foundation*. March 2019. <https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2019-findings-from-a-50-state-survey/>.

<sup>15</sup> Kaiser Family Foundation. <https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-children-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Upper%20Income%20Limit%22,%22sort%22:%22asc%22%7D>

<sup>16</sup> As a sensitivity test, we included a variable adult Medicaid continuous eligibility, which is offered by Montana and New York. This did not meaningfully change the results for children’s continuous eligibility.

states; we used states' levels for school-age children. The majority of children our sample are in this age range.

In multivariate analyses, we also control for other demographic, health and social factors that may affect the health outcomes, including the child's age, gender, race/ethnicity, family structure, parental education and whether the family received food assistance (SNAP or WIC) in the past year. To account for variations in state economic conditions, we also controlled for the percent of state residents who were employed in each year, as reported by the Bureau of Labor Statistics.<sup>17</sup>

Following typical practice in policy research, we consider associations to be statistically significant when p-values are below 0.05, meaning that the relationship observed would occur by chance alone less than 5 percent of the time; sometimes this is also referred to as greater than 95 percent confidence. Smaller p-values, e.g., less than 0.01, indicate that the probability that the association occurred by chance alone is even smaller. We report whether significant associations have p-values below 0.05, 0.01, or 0.001. P-values of .05 to .1 are considered marginally significant, indicating that there is between a 5 percent and 10 percent probability that the finding is due to chance alone.

Health-related outcomes. First, we examine associations of continuous Medicaid eligibility with health coverage outcomes, including whether the child is currently uninsured (at the time of the interview), whether the child was uninsured for all or part of the prior 12 months (i.e., whether the child had a health insurance gap), and whether the child had a gap in insurance coverage that the respondent attributed to application problems. We also examined utilization of medical care in the past year including (a) any medical care,<sup>18</sup> (b) unmet need for medical care, (c) specialty care, (d) unmet need for specialty care,<sup>19</sup> (e) one or more emergency room visits, and (f) use of preventive care. Finally, we considered the parent's report of their child's overall health status on a five-point scale, (where 1 = excellent and 5 = poor) and whether the child was absent from school for 11 or more days due to illness or injury (school age children only).

## Results

We first examined bivariate relationships between whether or not a state had a continuous eligibility policy for child Medicaid in place and our outcomes. We then estimated multivariate regression models, controlling for the variables listed above. For dichotomous outcomes (most outcomes), we used linear probability models for ease of interpretation. In addition to the main

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<sup>17</sup> U.S. Bureau of Labor Statistics. Civilian Noninstitutional Population and Associated Rate and Ratio Measures for Model-Based Areas. <https://www.bls.gov/lau/rdscnp16.htm#data>. Published March 20, 2020. Accessed April 10, 2020.

<sup>18</sup> The sample sizes for any medical care and preventive care are reduced because we did not include 2018 data due to a major change in question wording.

<sup>19</sup> Unmet need for medical care has a small sample size since children who neither needed nor used specialty care are excluded.



**Table 1. Comparison of Health-Related Outcomes for Children Under 18 With Incomes at or Below 138 Percent of Poverty, 2016-18**

Outcome Variables	Child Lives in State:		Signif.	n
	with Continuous Eligibility	without Continuous Eligibility		
Currently uninsured, %	7.8%	11.7%	<.001	17,492
Uninsured all or part of past year, %	11.0%	15.9%	<.001	17,430
Gap due to application problems, %	1.5%	3.0%	0.001	17,409
Any medical care in past year, %	80.4%	78.6%	NS	11,900
Unmet need for any health care,%	4.2%	5.6%	0.052	17,487
Saw a specialist in past year, %	12.0%	10.9%	NS	17,402
Unmet need for specialty care, %	17.4%	22.0%	NS	2,914
One or more ER visits, %	26.9%	27.4%	NS	17,503
One or more preventive visit, %	95.2%	96.1%	NS	13,558
Missed 11 or more days of school, %	6.40%	5.10%	NS	12,166
Reported child health status, mean (1=excellent, 5=poor)	1.66	1.66	NS	17,446

Notes: GW analyses of 2016-18 National Survey of Children's Health. Weighted bivariate analyses.  
NS = not significant.

sample of children with incomes less than 138 percent of poverty, we also examined associations for the subgroup of children with a special health care need, due to the particular importance of health care for this population.

Weighted bivariate relationships are presented in *Table 1*. These are basic comparisons of rates in states with and without 12-month Medicaid continuous eligibility without adjustments for related policy, social or health factors. Children living in states with Medicaid continuous eligibility were much less likely to be uninsured than children in states without the policy (7.8% vs 11.7%,  $p < .001$ ) and were less likely to have had a gap in coverage in the previous 12 months (11.0% vs 15.9%,  $p < .001$ ). The chance of having a gap in coverage that the parent attributed to application problems was twice as high in states without continuous eligibility (3.0%) compared to states with the policy (1.5%,  $p = .001$ ). Children with access to continuous eligibility were less likely to have an unmet need for medical care (4.2% vs 5.6%), a difference that is marginally significant ( $p = .052$ ). There were no other significant differences between states with and without the policy.

Controlling for individual characteristics and state-level characteristics allows us to better isolate the effects of continuous eligibility. *Table 2* shows multivariate models for children with incomes at or below 138 percent of poverty. We used linear probability (regression) models adjusted for the survey's complex sample design.

**Table 2. Effects of Medicaid Continuous Eligibility and Other Policy Variables on Child Health Measures, Children Under 18 Below 138 Percent of Poverty, 2016-18 (see Notes)**

	Health Measures for the Child			
	Currently uninsured	Uninsured all or part of past year	Insurance gap, application problems	Any preventive care in past year
<b>State Medicaid Policy Variables</b>				
Continuous eligibility	-0.014	-0.024 **	-0.010 **	0.027 *
Parent eligibility level	-0.028 ***	-0.035 ***	-0.002	0.027
Autorenewal	0.012	0.006	0.001	-0.030 *
Child eligibility level	-0.022 **	-0.033 ***	-0.009 **	-0.018
Presumptive eligibility	-0.014	-0.006	0.002	-0.023
<b>Child Characteristics</b>				
Has special health care need	-0.046 ***	-0.026 **	0.000	0.137 ***
Foreign-born child	0.192 ***	0.213 ***	0.099 ***	-0.086 **
n	15,727	15,680	15,673	10,434

	Health Measures for the Child			
	Saw a specialist in past year	Had unmet need for specialty care	Health status (1 = excellent to 5 = poor)	Missed 11 or more school days
<b>State Medicaid Policy Variables</b>				
Continuous eligibility	0.015 *	-0.060 **	0.027	0.013
Parent eligibility level	0.021 **	-0.075 **	-0.014	0.019 **
Autorenewal	0.004	0.006	-0.031	-0.003
Child eligibility level	-0.023 **	0.013	-0.038	-0.010
Presumptive eligibility	-0.007	0.029	-0.029	-0.010
<b>Child Characteristics</b>				
Has special health care need	0.245 ***	0.030	0.758 ***	0.118 ***
Foreign-born child	-0.012	0.022	0.219 ***	0.006
n	15,647	2,632	15,726	10,965

Notes: GW analyses of 2016-18 National Survey of Children's Health. Multivariate analyses that also control for: age, gender, race/ethnicity, family structure, parents' education, whether the family receives food assistance, and the percent of state residents employed.

\* p < .1, \*\* p < .05, \*\*\* p < .01

Living in a state with Medicaid continuous eligibility is associated with a 2.4 percentage point reduced chance of having been uninsured for all or part of the past year, which is statistically significant (p < .05). Given that 13.4 percent of children had a gap in coverage in our sample, a 2.4 percentage point improvement indicates that the chance of having a gap decreased by almost one-fifth, a meaningful improvement. We also found that access to continuous eligibility is associated a 1.0 percentage point reduced chance of having a lapse of insurance due to application problems, which is statistically significant (p < .05). Given that only 2.3 percent of the sample had a lapse in

coverage for this reason, a 1.0 percentage point reduction signals that continuous eligibility reduced the risk of application problems by almost half. Parents' and children's Medicaid eligibility are also associated with improved coverage outcomes. Continuous eligibility is associated with a marginally significant 2.7 percentage point increase in having received at least one preventive visit ( $p < .1$ ). That is, continuous eligibility may lower the number of children without a preventive visit by about one-tenth. Continuous eligibility is also associated with a marginally significant ( $p < .1$ ) increase in having seen a specialist in the prior year. This suggests that the number of children who were able to see a specialist increased by about one-eighth. There was a 6.0 percentage point reduction in the chance of having an unmet need for specialty care, which is statistically significant ( $p < .05$ ). This is equivalent to reducing unmet needs for specialty care by almost one-third.

Continuous eligibility was not significantly associated with the other outcomes shown in Table 2. The policy was also not associated with other outcomes listed in Table 1, which we omit here for brevity. We report results for two notable child-level characteristics: special needs status and whether the child was born outside of the U.S. Having a special health care need is associated with a decreased chance of being uninsured ( $p < .01$ ) and greater utilization of any medical and specialty care ( $p < .01$ ). Foreign-born status is associated with an increased chance of uninsurance ( $p < .01$ ) and a reduced chance of utilization of any medical care ( $p < .05$ ). Both special health care needs and immigrant status are linked to poorer health status ( $p < .01$ ).

*Table 3* shows findings for the subpopulation of low-income children with special health care needs, as categorized by the survey. This group, which is 21.2 percent of the overall sample, has a higher average need for health care, but may have more stability of coverage regardless of continuous eligibility policy. We found no significant associations between Medicaid continuous eligibility policy and uninsurance or gaps in insurance for this group. A possible reason is that their parents have stronger motivation to keep their children enrolled due to their special needs. In some states, children with disabilities may have automatic Medicaid eligibility because of enrollment in the Supplemental Security Income program or may be covered by state programs for children with special needs, such as California's Child Health and Disability Program.

However, living in a state with continuous eligibility was associated with a 4.7 percentage point increase in reporting having received any medical care ( $p < .1$ ), a 6.2 percentage point increase in having one or more preventive visits ( $p < .05$ ), and a 5.3 percentage point increase in report of any specialty care ( $p < .05$ ). These are substantial increases in utilization. One possible explanation for the increased utilization, in the absence of changes in gaps in insurance, is that access to continuous eligibility helps children with special needs avoid churning between different types of insurance over the course of a year, making it easier to access care with their medical care providers. The policy is also marginally associated with an increase in chronic school absences ( $p < .1$ ).

**Table 3. Children with Special Health Care Needs: Effects of Medicaid Continuous Eligibility and Policy Variables on Child Health, Those Under 18 Below 138 Percent of Poverty, 2016-18 (see Notes)**

	Health Measures for the Child			
	Currently uninsured	Uninsured all or part of past year	Insurance gaps, application problems	Any medical care in past year
<b>State Medicaid Policy Variables</b>				
Continuous eligibility	0.009	0.005	-0.005	0.047 *
Parent eligibility level	-0.017	-0.028	0.007	0.068 ***
Autorenewal	0.017	0.014	0.004	-0.01
Child eligibility level	-0.011	-0.034 **	-0.014 *	-0.022
Presumptive eligibility	-0.014	-0.001	0.007	-0.048 *
<b>Child Characteristics</b>				
Foreign-born child	0.139 **	0.219 ***	0.101 *	0.004
n	4,225	4,222	4,208	2,806

	Health Measures for the Child			
	Saw a specialist in past year	Had unmet need for specialty care	Health status (1 = excellent to 5 = poor)	Missed 11 or more school days
<b>State Medicaid Policy Variables</b>				
Continuous eligibility	0.053 **	-0.045	0.021	0.043 *
Parent eligibility level	0.028	-0.056	-0.033	0.058 ***
Autorenewal	-0.002	0.006	-0.05	-0.006
Child eligibility level	-0.013	0.003	-0.045	-0.026
Presumptive eligibility	-0.005	0.04	-0.012	-0.008
<b>Child Characteristics</b>				
Foreign-born child	0.076	0.003	0.108	0.034
n	4,194	1,587	4,221	3,505

Notes: GW analyses of 2016-18 National Survey of Children's Health. Multivariate analyses that also control for: age, gender, race/ethnicity, family structure, parents' education, whether the family receives food assistance, and the percent of state residents employed.

\* p < .1, \*\* p < .05, \*\*\* p < .01

## Discussion and Conclusions

State Medicaid continuous eligibility policies are associated with a modest number of measures related to low-income children's health, including reductions in insurance gaps and improved access to care. Other factors, like broader Medicaid eligibility for parents or children, may also influence these health measures. The findings suggest that more generous state eligibility policies for children or their parents could also enhance low-income children's access to care.

These results should be interpreted as associations observed in a cross-sectional study of non-experimental survey data, not as causal findings that might be reached if this had been

conducted as a randomized experiment. Although we have statistically controlled for a variety of demographic and policy factors, it is possible that other unmeasured factors that differ between children living in states that adopted continuous eligibility and children living in other states might influence these findings. The data are primarily based on parents' (or caretakers') self-reports, so reporting error is possible. For example, parents may not have perfect recall of whether their children had gaps of insurance in the previous year.

Our analyses focused on children under 18 living in families with incomes at or below 138 percent of poverty because virtually all children in this group are eligible for Medicaid without monthly premiums in every state. Some may not enroll because they already have private coverage, such as from their parents' employment. Paperwork barriers are a leading reason why children in this range are uninsured or have gaps in coverage. These analyses indicate that the children living in states with 12-month continuous eligibility are less likely to have gaps in their insurance coverage, which has been associated with lower average monthly Medicaid costs and ongoing relationships with medical care providers.<sup>20</sup> We also find that more generous Medicaid eligibility criteria for parents and for children are associated with reduced insurance gaps. The analyses also show that continuous eligibility is associated with fewer gaps related to application problems, suggesting that the policy is effective in reducing paperwork barriers.

Our analyses also indicate that continuous eligibility is associated with better access to preventive services, increased use of specialists, and reduced unmet needs for specialty care, indicating that the reduction in gaps in coverage associated with continuous eligibility may translate into greater use of necessary care. The improvement in preventive service visits is consistent with findings that uninsured children have much lower vaccination rates than publicly-insured children.<sup>21</sup> Our findings about specialty care are also important. Although uninsured children or those with insurance gaps may be able to secure primary care through community health centers for free or with a reduced price, access to specialty care (e.g., care from gynecologists, psychiatrists, or other specialists) can be more challenging without insurance. Our findings are in line with prior research indicating that publicly-insured children have more access to specialty care than uninsured children.<sup>22</sup>

We did not detect significant associations with better health outcomes for children, such as better reported health status or fewer school days missed. This is in contrast to previous research finding, for example, that reducing gaps in children's Medicaid coverage was associated with

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<sup>20</sup> Ku L, Steinmetz, E, Bysshe T. Continuity of Medicaid Coverage in an Era of Transition, Washington, DC: Association of Community Affiliated Plans, Nov. 1, 2015  
[http://www.communityplans.net/Portals/0/Policy/Medicaid/GW\\_ContinuityInAnEraOfTransition\\_11-01-15.pdf](http://www.communityplans.net/Portals/0/Policy/Medicaid/GW_ContinuityInAnEraOfTransition_11-01-15.pdf)

<sup>21</sup> Hill H, Elam-Evans L, Yankey D, Singleton J, Kang Y. Vaccination Coverage Among Children Aged 19–35 Months — United States, 2017. *Morbidity and Mortality Weekly Report*. 2018;67(40).  
<https://www.cdc.gov/mmwr/volumes/67/wr/pdfs/mm6740a4-H.pdf>

<sup>22</sup> Skinner AC, Mayer ML. Effects of insurance status on children's access to specialty care: a systematic review of the literature. *BMC Health Services Research*. 2007;7(1):194. doi:10.1186/1472-6963-7-194

lowering rates of hospitalizations for preventable problems like asthma.<sup>23</sup> Regrettably, NSCH does not include measures of preventable health care utilization. For children with special health care needs, we detected a marginally significant increase in the number of days a child missed school due to illness. Potential reasons for this finding include that children's increased access to medical care might lead to more time spent out of school for medical appointments or to greater awareness of the need to stay home for health reasons, such as to avoid infections from other children.

The analyses in *Table 2* also show that having special health care needs decreases the probability of being uninsured, increases the use of preventive and specialty care and is associated with worse health and more school days missed. In subanalyses of children with special health care needs (*Table 3*), we no longer detect a significant reduction in the risk of an insurance gap; this is likely because these children's families have strong motivation to make sure their children have health insurance because of their chronic health needs. In addition, special eligibility or other health programs offer assistance for disabled children (e.g., California's Child Health and Disability Program). We find that continuous eligibility is associated with increased likelihood of receiving overall medical care, preventive care, and specialty care during the year. Perhaps the fact that continuous eligibility offers special needs children a better assurance of Medicaid coverage may provide parents or health care providers greater confidence that insurance coverage will be available, thereby increasing utilization. It is also possible that continuous eligibility reduces churn between types of insurance coverage, thereby reducing barriers to utilization.

Our analyses confirm the special risks that exist for immigrant children.<sup>24 25</sup> Children who are foreign-born are more likely to be uninsured and to receive less medical care during the year. They also have poorer health status. Under federal law, some immigrant children, such as those who are undocumented or who have had lawful residence for fewer than five years, may be denied Medicaid coverage, regardless of their incomes or health needs, although many states exercise options to extend Medicaid coverage to lawfully resident children without a five-year waiting period. The 2019 "public charge" regulation of the Department of Homeland Security would jeopardize immigration status for lawful immigrants who use Medicaid, causing many immigrant families to avoid Medicaid coverage, although this regulation is currently under legal challenge.<sup>26</sup>

These analyses indicate that gaps in health coverage for children in low-income families could be reduced through use of 12-month continuous eligibility policies and that this could also improve access to health care services for children, including those with special health care needs.

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<sup>23</sup> Bindman, A., et al. "Medicaid re-enrollment policies and children's risk of hospitalizations for ambulatory care sensitive conditions." *Med Care*. 2008;46(10):1049-54.

<sup>24</sup> Ku L, Matani S. Left Out: Immigrants' Access to Health Care and Insurance, *Health Affairs*, 2001 Jan/Feb; 20(1):247-56.

<sup>25</sup> Jarlenski M, Baller J, Borrero S, Bennett WL Trends in Disparities in Low-Income Children's Health Insurance Coverage and Access to Care by Family Immigration Status. *Acad Pediatr*. 2016 Mar;16(2):208-15.

<sup>26</sup> Ku L. New Evidence Demonstrating That the Public Charge Rule Will Harm Immigrant Families and Others. *Health Affairs Blog*. October 9, 2019. <https://www.healthaffairs.org/doi/10.1377/hblog20191008.70483/full/>

Other policies, such as broadening Medicaid income eligibility levels for parents or children, could also stabilize coverage. The analyses also indicate that immigrant children face higher health risks.

As of May 2020, the COVID-19 pandemic has triggered serious economic hardships and massive job loss.<sup>27, 28</sup> Some areas are loosening social distancing restrictions, which might improve employment.<sup>29</sup> However, it is unlikely that employment will recover to pre-COVID-19 levels in the near future, in part due to the reluctance of many Americans to engage in activities that may put them at risk of exposure to the virus, even if allowed.<sup>30</sup> The nation is experiencing an unprecedented period of economic volatility that is expected to last for a protracted period.<sup>31</sup>

Uninsurance for children began to rise in 2017 and 2018 after falling for many years,<sup>32</sup> and the economic disruption due to COVID-19 is likely to cause uninsurance to climb even further. Access to Medicaid will be crucial in determining the extent to which the economic downturn harms children's insurance and access to health care. The Families First Coronavirus Response Act takes steps to help stabilize Medicaid by requiring states to avoid eligibility cutbacks or terminating Medicaid coverage during the period of the COVID-19 public health emergency, in order to be eligible for an enhanced federal matching rate. These requirements are temporary and will lapse at the end of the COVID-19 public health emergency, but economic and budgetary pressures are likely to linger after the official public health emergency ends.

Broadening Medicaid eligibility policies, such as 12-month continuous eligibility or expanding Medicaid coverage in states that have not yet done so, and further extending measures to provide fiscal relief by continuing the elevated Medicaid matching rate, as included in the Families First law,<sup>33, 34</sup> could strengthen children's health insurance coverage during these difficult economic times.

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<sup>27</sup> Mutikani, L. Millions more Americans file for jobless benefits, productivity tanks. Reuters. May 7, 2020. <https://www.reuters.com/article/us-usa-economy/millions-more-americans-seek-jobless-benefits-productivity-dives-idUSKBN22J0HT>.

<sup>28</sup> U.S. Bureau of Labor Statistics. The Employment Situation. April 2020. May 8, 2020.

<sup>29</sup> Zapotosky M, Iati M, Wagner J. Country continues fitful moves toward normalcy--for now. Washington Post. May 8, 2020. [https://www.washingtonpost.com/health/virus-restrictions-reimposed-amid-patchwork-re-openings/2020/05/08/501f4194-915b-11ea-9322-a29e75effc93\\_story.html](https://www.washingtonpost.com/health/virus-restrictions-reimposed-amid-patchwork-re-openings/2020/05/08/501f4194-915b-11ea-9322-a29e75effc93_story.html)

<sup>30</sup> Saad L. Americans Remain Risk Averse About Getting Back to Normal. Gallup. April 14, 2020. <https://news.gallup.com/poll/308264/americans-remain-risk-averse-getting-back-normal.aspx>

<sup>31</sup> Carew S. Goldman Sachs slashes U.S. GDP estimate further. Reuters. March 30, 2020. <https://www.reuters.com/article/us-health-coronavirus-goldman-idUSKBN21I235>

<sup>32</sup> Alker J, Roygardner L. The Number of Uninsured Children is on the Rise. The Center for Children & Families. October 29, 2019. <https://ccf.georgetown.edu/2019/10/29/the-number-of-uninsured-children-in-on-the-rise-acs/>

<sup>33</sup> Fiedler M, Powell W. States will need more fiscal relief. Policymakers should make that happen automatically. Brookings Institution. Apr. 2, 2020. <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/04/02/states-will-need-more-fiscal-relief-policymakers-should-make-that-happen-automatically/>

<sup>34</sup> Gruber J, Sommers B. Paying for Medicaid — State Budgets and the Case for Expansion in the Time of Coronavirus. *NEJM*. Mar. 31, 2020. <https://www.nejm.org/doi/full/10.1056/NEJMp2007124>