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Health Aff (Millwood). Author manuscript; available in PMC 2024 August 05.

Published in final edited form as:

Health Aff (Millwood). 2023 June ; 42(6): 753–758. doi:10.1377/hlthaff.2022.01465.

Continuous Eligibility And Coverage Policies Expanded Children's Medicaid Enrollment

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State Continuous Eligibility and Coverage Policies and Children's Medicaid Enrollment During the COVID-19 Pandemic

We examined children's Medicaid participation from 2019–2021. As of March 2021, states newly adopting continuous Medicaid coverage for children during the COVID-19 pandemic experienced a 4.62% relative increase in children's Medicaid participation compared to states with previous continuous eligibility policies. More than 655,000 additional children enrolled in Medicaid in continuous coverage states during the study period.

The Centers for Medicare and Medicaid Services (CMS) has historically allowed state Medicaid agencies to provide children with 12 months of continuous eligibility (CE) through a state plan amendment.[1] Continuous eligibility policies allow children to remain insured regardless of short-term fluctuations in their family income or household size and have been associated with improved access to preventive care.[2,3] As of January 2020, 24 states had adopted continuous eligibility policies for all Medicaid-insured children.[4]

The March 2020 Families First Coronavirus Response Act (FFCRA) incentivized continuous coverage (CC) for Medicaid recipients by providing an enhanced federal match for state Medicaid spending that was contingent on providing continuous Medicaid coverage, without eligibility redetermination, to all beneficiaries throughout the federal COVID-19 Public Health Emergency.[5] We assessed children's Medicaid participation before and after March 2020 in states that newly adopted continuous coverage pursuant to the FFCRA compared to states with prior CE policies for children. As of March 2021, new CC states had an increase of 1.86 percentage points in children's Medicaid participation (95% CI: 0.22 to 3.49) compared to prior CE states (Exhibit 1). This was a 4.62% relative increase

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Conflicts of Interest: The authors have no conflicts of interest to disclose.

Access to Data: Dr. Vasan and Dr. Venkataramani had full access to all the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

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in participation, corresponding to more than 655,000 additional Medicaid-enrolled children across 26 states. The Consolidated Appropriations Act, 2023 requires that all states have 12-month continuous eligibility policies for Medicaid- and CHIP-insured children by 2024.[6]

Study Data and Methods

We used CMS enrollment data to determine the monthly number of child Medicaid beneficiaries in each state from March 2019 to March 2021, 12 months before and after enactment of the FFCRA.[7] We estimated the proportion of children in each state who were enrolled in Medicaid, calculated as the number of child Medicaid beneficiaries divided by the total population of children in each state in the 2019 American Community Survey. CHIP beneficiaries were excluded from our primary analysis, as some states have differing CE policies for Medicaid and CHIP.

The primary exposure was state-level adoption of 12-month CE policies for children's Medicaid as of 2020. Data on state CE policies were obtained from a 2020 Kaiser Family Foundation report based on a 50-state survey of Medicaid and CHIP eligibility, enrollment, and cost sharing policies.[4] To compare characteristics of states newly adopting continuous coverage for all Medicaid enrollees in March 2020 ("new CC states") and states that had CE policies for children prior to the FFCRA ("prior CE states"), we examined state-level poverty rates from the American Community Survey, 2019 and 2020 unemployment rates from the Bureau of Labor Statistics, and 2020 Medicaid income eligibility thresholds for children from the 2020 Kaiser Family Foundation report.[4] We also compared race and ethnicity of residents in new CC and prior CE states.

We then examined unadjusted trends in children's Medicaid participation in new CC and prior CE states and used a difference-in-differences design to estimate the mean change in child Medicaid participation in new CC states relative to prior CE states, adjusting for state, month, year, Medicaid expansion status, state-level unemployment rate, and state Medicaid income eligibility threshold for children. We noted a slight downward trend in children's Medicaid participation in prior CE states relative to new CC states in the year prior to enactment of the FFCRA. To address this potential violation of the parallel trends assumption, we adjusted for pre-existing trends using the de Chaisemartin and D'Hautfoeuille difference-in-differences estimator, which accounted for pre-intervention trends without over-controlling for post-period dynamic treatment effects.[8]

We conducted two sensitivity analyses. First, we examined combined children's Medicaid and CHIP participation. Second, we examined children's Medicaid participation through December 2021. As a falsification test, we assessed adults' Medicaid participation in new CC versus prior CE states from March 2019 through March 2021, as most state CE policies did not extend to adult beneficiaries. Observations were weighted by 2019 state population. Analyses were conducted using STATA 17.0 with 2-tailed significance set at $p<0.05$. Per University of Pennsylvania policy, institutional review board review was not required given our use of aggregate, deidentified data.

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Limitations

This study had several limitations. First, our observational research design precluded assessment of whether differences in children's Medicaid participation were due to CE policies or other state-level characteristics correlated with CE policy implementation. Second, we did not adjust for state-level variation in COVID-19 incidence, which may have impacted Medicaid enrollment. Third, use of state-level administrative data precluded assessment of heterogenous associations between CE policies and Medicaid participation based on child and caregiver demographic characteristics. Future studies should use individual-level data to assess whether CE policies had differential impacts across demographic groups.

Results

Our final sample consisted of 49 states and the District of Columbia, including 24 states with prior CE policies for all Medicaid-insured children as of January 2020 and 26 states and territories that newly implemented CC following enactment of FFCRA. Arizona was excluded due to lack of available data on children's Medicaid enrollment. Exhibit 2 shows characteristics of new CC and prior CE states.

Our comparison of unadjusted trends in children's Medicaid participation found that new CC states had a lower mean participation rate than CE states prior to the COVID-19 pandemic but experienced a greater increase in participation following enactment of the FFCRA (Exhibit 3).

In unadjusted analyses, prior CE states collectively experienced a 9.03% increase in enrollment between March 2020 and March 2021, with an increase of 1,311,888 beneficiaries, while new CC states collectively experienced a 14.67% increase in enrollment during the same period, with an increase of 2,081,871 beneficiaries (Appendix Exhibit A1).[9] When we examined state-level trends in enrollment, we found that seven of the 11 states with the greatest percent increase in children's Medicaid enrollment between March 2020 and March 2021 were new CC States (Exhibit 4).

In difference-in-differences models, we found that after adjusting for state, month, year, and Medicaid expansion status, as of March 2021, new CC states had a 1.86 percentage point increase in children's Medicaid participation (95% CI: 0.22 to 3.49) compared to prior CE states (Exhibit 1 and Appendix Exhibit A1).[9] This is a 4.62% relative increase in participation and corresponds to more than 655,000 additional children enrolled in Medicaid across these 26 states.

In sensitivity analyses, we found results were similar when examining combined Medicaid and CHIP participation data through March 2021 (a 1.69 percentage-point increase in new CC states, 95% CI 0.43 to 2.94; Appendix Exhibit A2).[9] In addition, the association between new CC policies and increased Medicaid participation persisted through December 2021 (a 2.34 percentage-point increase in new CC states, 95% CI 0.03 to 4.64; Appendix Exhibit A3).[9] In our falsification test examining trends in adults' Medicaid participation, we found no significant relative change in Medicaid participation rate for adults across new CC and

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prior CE states (a 0.31 percentage-point decline, 95% CI: −2.08 to 1.46; Appendix Exhibit A4).[9]

Discussion

While both prior CE and new CC states experienced increases in children's Medicaid participation during the COVID-19 pandemic, the increase was significantly greater in new CC states compared to prior CE states. Our findings suggest that policies providing for continuity of coverage may help increase access to and ensure stability in children's health insurance, particularly when families are faced with challenging economic circumstances. These results are consistent with other recent work showing increased Medicaid participation as a result of policies providing for continuity.[10,11]

Expiration of the FFCRA's continuous coverage provision in April 2023 will generate a high volume of recertification paperwork for states to process rapidly, which may result in gaps in coverage for Medicaid-insured children.[12] However, our results suggest that the new requirement that all states adopt 12-month continuous eligibility for Medicaid-insured children by 2024 may lead to modest improvements in the stability of children's health insurance coverage in the future.[6]

Our findings also have implications for other continuity of coverage policies such as extended continuous eligibility for children through age 6, 12-month postpartum eligibility, and 12-month continuous eligibility for adults.[13] Several states have either submitted CE waivers or had waivers approved by CMS in the past year; California, Oregon, Massachusetts, and Washington have proposed providing multi-year continuous eligibility for children, and Illinois, New Jersey, and New York have proposed providing 12-month continuous eligibility for adults.[13] Additionally, pursuant to the Consolidated Appropriations Act, 2023, the state option of providing 12-month postpartum Medicaid continuous eligibility has now become permanent.[6] Our analysis suggests that by reducing recertification requirements, these policies may reduce churn and boost program retention. Although increases in coverage may increase short-term costs for state Medicaid agencies, these policies could decrease administrative costs and ultimately lead to improved access to care and better health outcomes for beneficiaries. Overall, this study adds to the growing body of evidence showing that policies that reduce administrative burdens associated with accessing government benefits may boost enrollment and retention.[14,15]

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Funding/Support:

This project was supported by Agency for Healthcare Research and Quality grant F32HS028555 to Dr. Vasan and National Institutes of Health grant K23HL136842 to Dr. Kenyon. Dr. Venkataramani acknowledges funding from the National Institutes of Health, Robert Wood Johnson Foundation, and Independence Blue Cross for work unrelated to the present manuscript.

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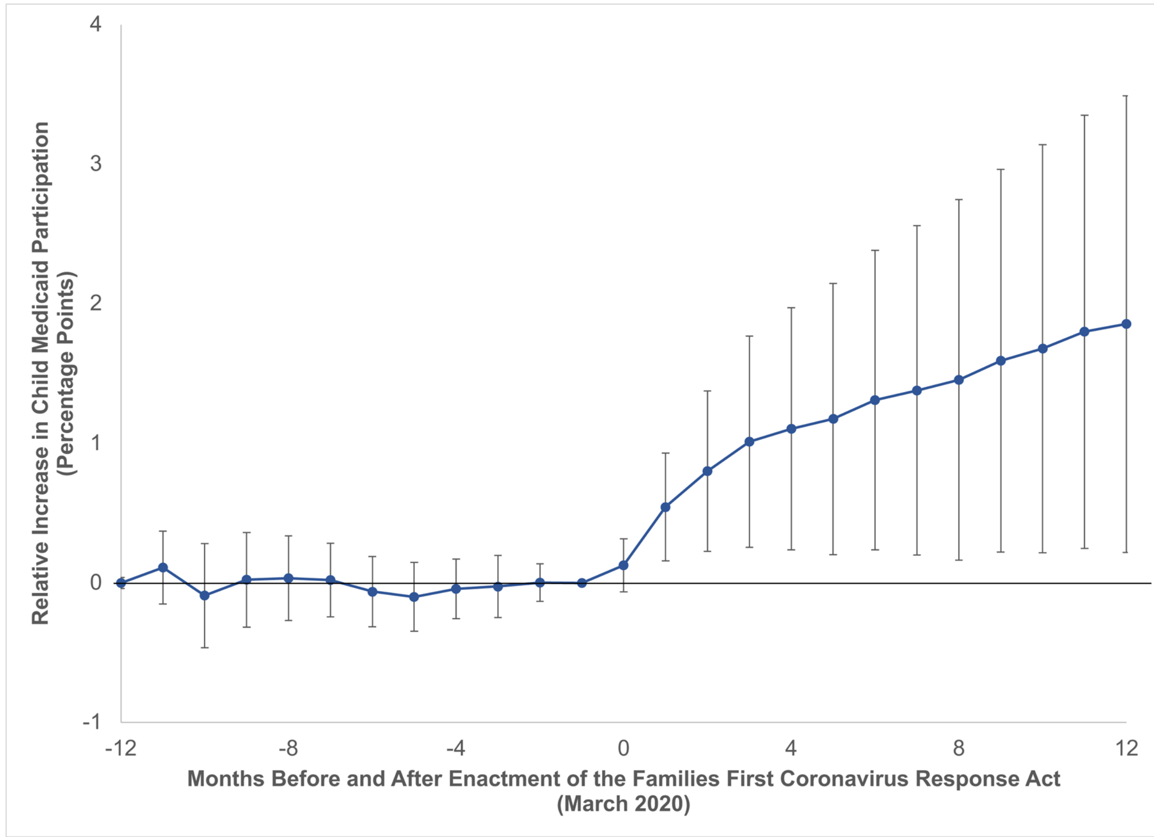

Exhibit 1: Adjusted Estimates of Increases in Child Medicaid Participation in New Continuous Coverage States Relative to Prior Continuous Eligibility States, March 2019-March 2021

Source: Medicaid participation data from March 2019-March 2021 were obtained from CMS Monthly Medicaid and CHIP Application, Eligibility Determination, and Enrollment Reports available at data.medicaid.gov. Prior continuous eligibility status was obtained from the Kaiser Family Foundation report, *Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey* (https://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility,-Enrollment-and-Cost-Sharing-Policies-as-of-January-2020.pdf). New continuous coverage status was ascertained based on authors' analysis of the Families First Coronavirus Response Act.

Notes: Prior continuous eligibility states are those that had adopted 12-month continuous eligibility policies for Medicaid-insured children ages 0 to 18 years through a state plan amendment as of January 2020. New continuous coverage states adopted continuous coverage for all beneficiaries, including children, pursuant to the March 2020 Families First Coronavirus Response Act. Arizona was excluded from this analysis due to lack of available monthly data on number of children enrolled in Medicaid.

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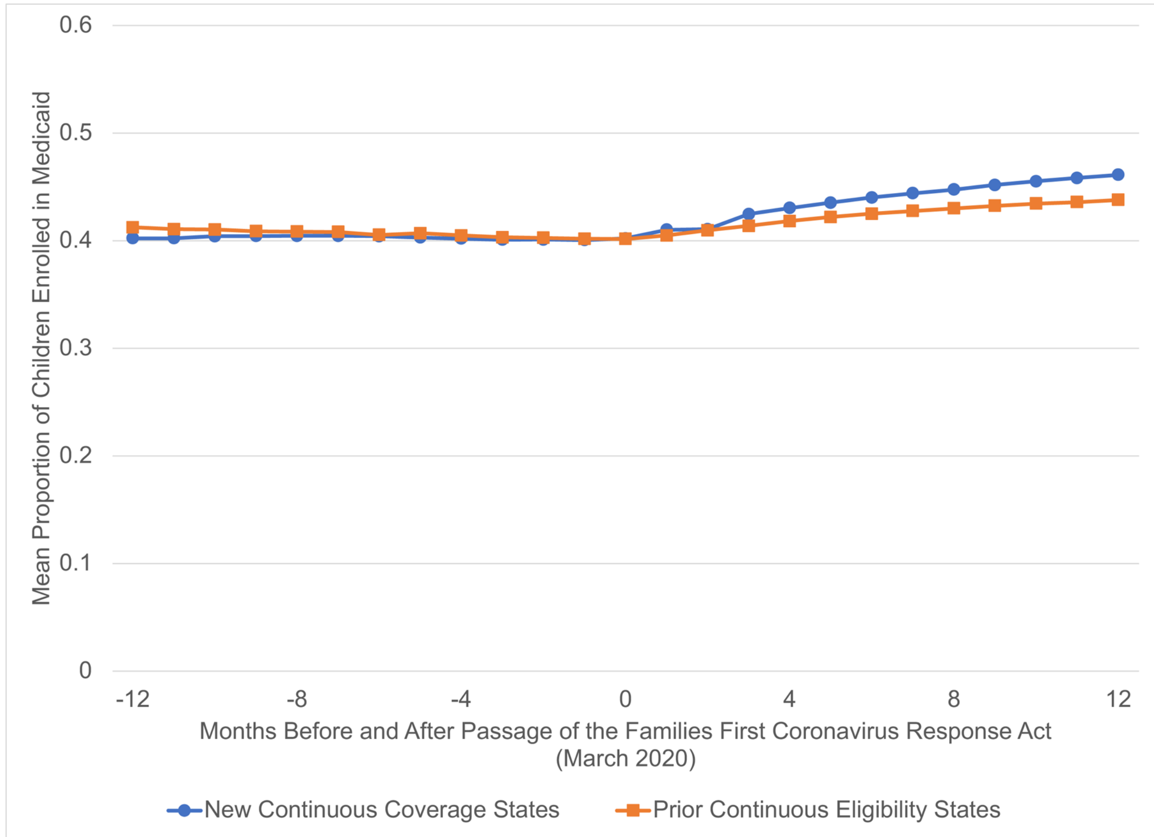

Exhibit 3: Unadjusted Trends in Children's Medicaid Participation in Prior Continuous Eligibility States and New Continuous Coverage States, March 2019-March 2021

Source: Medicaid participation data from March 2019-March 2021 were obtained from CMS Monthly Medicaid and CHIP Application, Eligibility Determination, and Enrollment Reports available at data.medicaid.gov. Prior continuous eligibility status was obtained from the Kaiser Family Foundation report, *Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey*(https://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility,-Enrollment-and-Cost-Sharing-Policies-as-of-January-2020.pdf). New continuous coverage status was ascertained based on authors' analysis of the Families First Coronavirus Response Act.

Notes: This analysis includes 26 new continuous coverage states and territories and 24 prior continuous eligibility states. New continuous coverage and prior continuous eligibility are defined in the Exhibit 1 notes. Arizona was excluded from the analysis due to lack of available monthly data on number of children enrolled in Medicaid.

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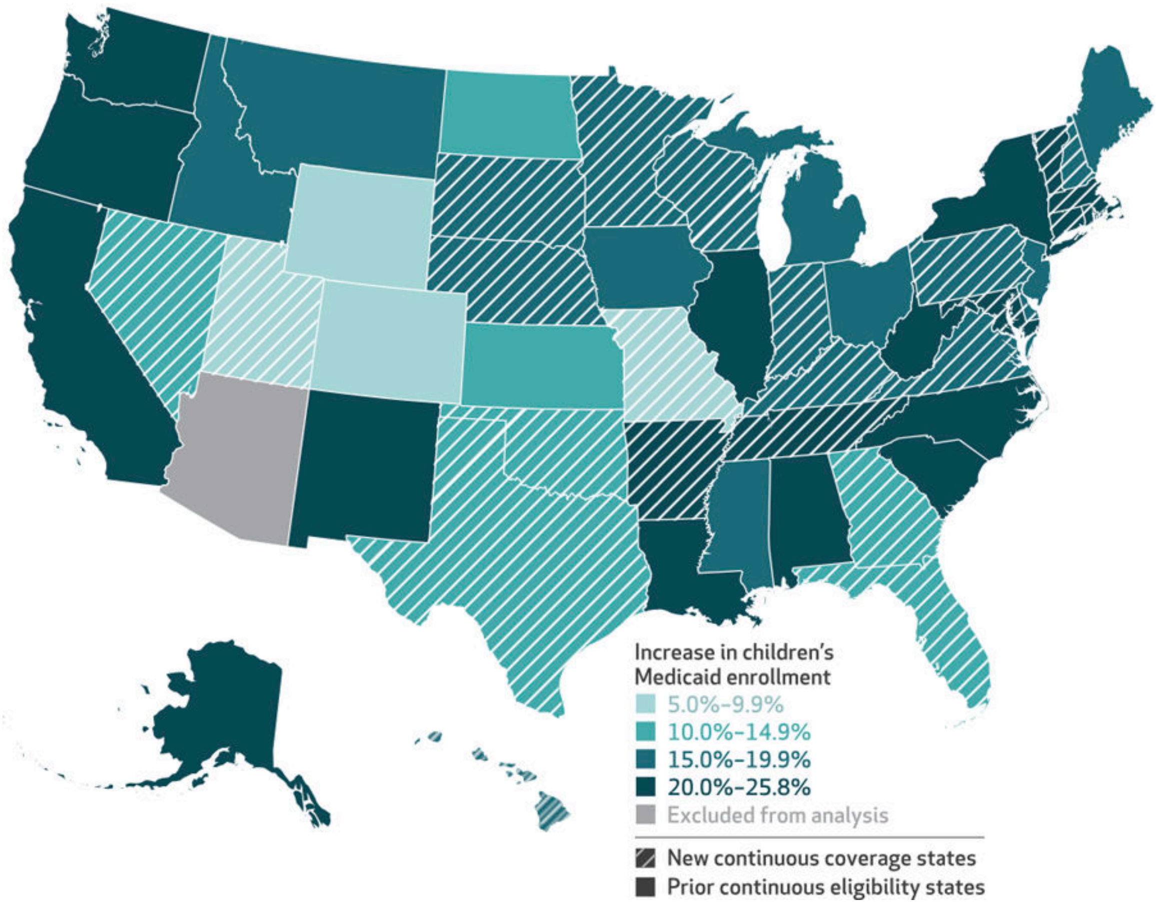

Exhibit 4: Increases in Children's Medicaid Enrollment, by State Prior Continuous Eligibility and New Continuous Coverage Status, March 2020-March 2021

Source: Prior continuous eligibility status was obtained from the Kaiser Family Foundation report, *Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey* (https://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility,-Enrollment-and-Cost-Sharing-Policies-as-of-January-2020.pdf). New continuous coverage status was ascertained based on authors' analysis of the Families First Coronavirus Response Act. Medicaid enrollment data from March 2020-March 2021 were obtained from CMS Monthly Medicaid and CHIP Application, Eligibility Determination, and Enrollment Reports available at data.medicaid.gov.

Notes: States shown without hatch marks are prior continuous eligibility states. See Exhibit 1 notes for definitions of prior continuous eligibility and new continuous coverage states. Arizona was excluded from this analysis due to lack of available monthly data on number of children enrolled in Medicaid.

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Exhibit 2:

State-Level Characteristics of Prior Continuous Eligibility and New Continuous Coverage States, 2019–2020

	Prior Continuous Eligibility States (n = 24)	New Continuous Coverage States (n = 26)
State-level characteristics		
Poverty rate (2019)	12.5%	12.2%
Child poverty rate (2019)	16.7	16.5
Unemployment rate (2019)	3.8	3.5
Unemployment rate (2020)	8.7	7.5
Median household income (2019)	$68,873	$65,365
Medicaid income eligibility threshold for children (% FPL)	218	212
Race/ethnicity		
White	69.7	74.2
Black	12.1	13.9
Hispanic	19.0	17.3
Asian	7.1	4.3
American Indian / Alaskan Native	0.9	0.7
Native Hawaiian / Pacific Islander	0.2	0.2
Multiple Races	3.6	3.3

Source: State-level poverty rate, child poverty rate, median household income, and race and ethnicity information for state residents were obtained from the 2019 American Community Survey. Unemployment rates for 2019 and 2020 were obtained from the Bureau of Labor Statistics' Local Area Unemployment Statistics, which include monthly, seasonally-adjusted unemployment rates in each state. State Medicaid family income eligibility thresholds for children for 2020 were obtained from the Kaiser Family Foundation report, *Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey* (https://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility,-Enrollment-and-Cost-Sharing-Policies-as-of-January-2020.pdf). For each state, the highest income eligibility threshold for children of any age was used.

Notes: Prior continuous eligibility states include AL, AK, CA, CO, ID, IL, IA, KS, LA, ME, MI, MS, MT, NJ, NM, NY, NC, ND, OH, OR, SC, WA, WV, and WY. New continuous coverage states and territories include AR, CT, DE, DC, FL, GA, HI, IN, KY, MD, MA, MN, MO, NE, NV, NH, OK, PA, RI, SD, TN, TX, UT, VT, VA, and WI. Values represent the average across all included states in each category, weighted by 2019 state population. We recognize that race and ethnicity are social constructs and include these data given that individuals in minoritized groups may face additional barriers to Medicaid participation. Race and ethnicity reflect the categories available in the American Community Survey, and all listed race categories are non-Hispanic. Arizona was excluded from this analysis due to lack of available monthly data on number of children enrolled in Medicaid. Prior continuous eligibility and new continuous coverage are defined in the Exhibit 1 notes. FPL=federal poverty level.