



Room to Grow: Inequities in Children's Health Insurance Coverage

AUTHORS

Colin Planalp, MPA
Senior Research Fellow

Andrea Stewart, MA
Research Fellow

50-STATE FACTSHEETS

As a companion piece to this brief, we have developed a set of 50-state profiles on children's uninsurance rates by race and ethnicity, income as measured by poverty level, citizenship status, age group, and metropolitan or non-metropolitan residence.

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Introduction

Health insurance is a linchpin in the United States' health care system. It can insulate families from deep financial strain and medical debt, as costs for health care services have grown increasingly unaffordable in recent decades. It also provides an entry point to the health care system for needed care that is much more difficult to access for people without insurance. And for children, the doorway to health care offered by insurance is uniquely important—ensuring their opportunity to develop into healthy adults by providing access to regular health screenings, routine services, vaccinations, and vital treatments when health issues are identified.

Children's health insurance coverage rates in the United States have improved since the 1990s, largely due to policy initiatives designed to provide kids with affordable health insurance options, such as the long-running Children's Health Insurance Program (CHIP) established twenty-five years ago.¹ Despite some upticks in uninsured rates beginning in 2017, children tend to have substantially lower uninsured rates overall than adults.² However, while overall rates remain low, disparities among select groups of children have persisted, with wide gaps in coverage found across the states and certain demographic categories.

In this issue brief and companion pieces that examine rates of children's health insurance across the nation and for all 50 states and the District of Columbia (D.C.), we examine U.S. and state-level trends in coverage with an eye toward health equity, aiming to quantify disparities across individual states and by race and ethnicity, income as measured by poverty level, citizenship status, age, and metropolitan status (i.e., urban versus rural geography).³

Unfortunately, various data limitations often cause challenges for quantifying issues related to health equity, especially at the state level and for smaller segments of the population. Small sample sizes can hamper researchers' abilities to produce reliable estimates even on measures such as health insurance rates. In order to improve our ability to investigate equity in children's coverage for important, smaller population segments at the state level, we used a data set that combined multiple years (2016-2020) of survey responses from the U.S. Census Bureau's American Community Survey (ACS).⁴ This approach offers a trade-off, such that we aren't specifically focused on the COVID-19 pandemic-era and the associated recent changes in health insurance trends, but we are much better able to document and understand how inequities have left some children underserved by the U.S. health care system.

3.6 million children lack health insurance in the U.S.

Considering the U.S. as a whole, our analysis found that 5.0 percent (or 5 in every 100 kids) of children age 17 and younger lacked health insurance during the time period from 2016-2020. However, when looking at a state-by-state picture, uninsurance amongst children ranged widely around that national average. For instance:

- At 1.3 percent (slightly more than 1 in 100 children), Massachusetts and Vermont had the lowest rates of children's uninsurance (Figure 1). Altogether, most states (29) had children's uninsurance rates that were significantly lower than the U.S. rate of 5.0 percent (Figure 2).
- At 10.6 percent, Texas had the highest uninsurance rate, more than twice the national average. At almost 11 in 100 children without health insurance, that represents roughly 785,500 kids without coverage. Including Texas, 15 states had children's uninsurance rates that were significantly higher than the U.S. rate of 5.0 percent.
- The remaining seven states had children's uninsurance rates that were not significantly different from the U.S. rate.

Figure 1. Five Highest and Lowest State Uninsured Rates for Children, 2016-2020

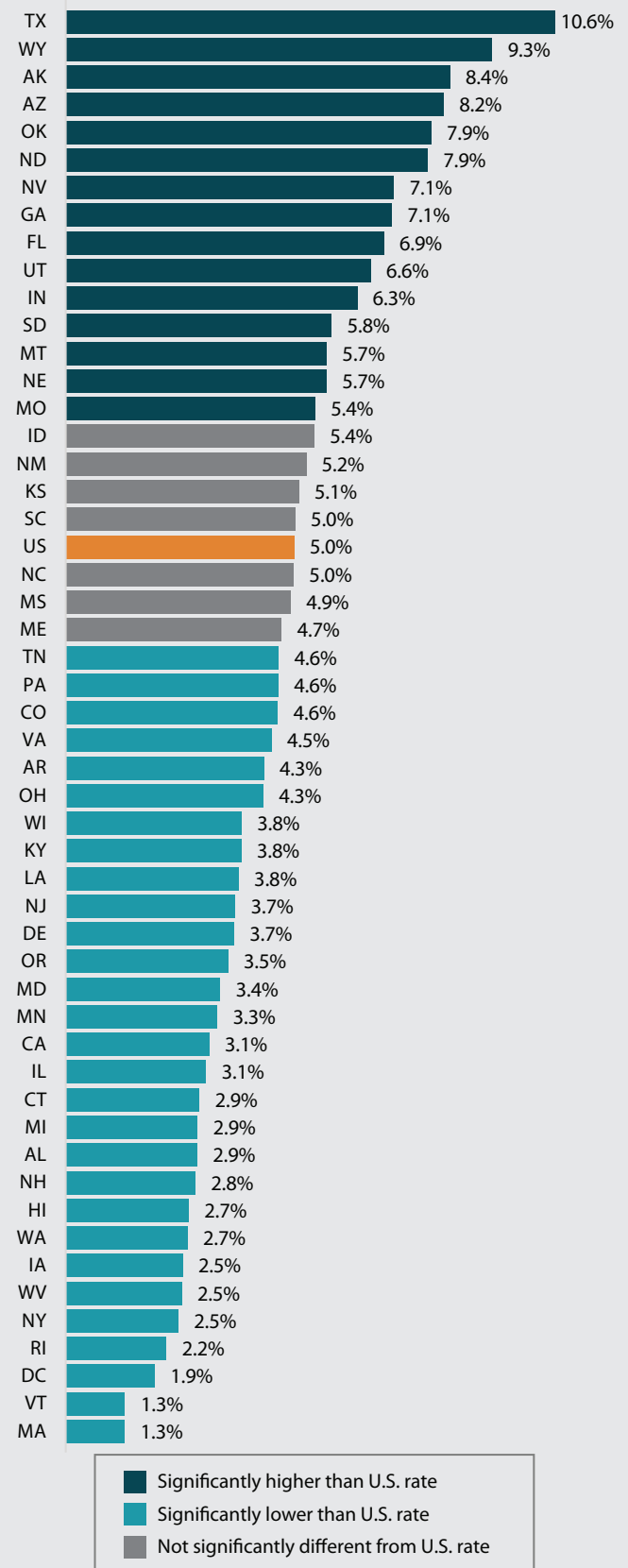
| States with Five Lowest Rates | Uninsured Rate | Number of Uninsured Children |
|-------------------------------|----------------|------------------------------|
| Massachusetts | 1.3% | 17,500 |
| Vermont | 1.3% | 1,500 |
| District of Columbia | 1.9% | 2,500 |
| Rhode Island | 2.2% | 4,500 |
| New York | 2.5% | 100,000 |
| West Virginia | 2.5% | 9,000 |
| Iowa | 2.5% | 18,500 |
| Washington | 2.7% | 44,000 |
| Hawaii | 2.7% | 8,000 |

| States with Five Highest Rates | Uninsured Rate | Number of Uninsured Children |
|--------------------------------|----------------|------------------------------|
| Texas | 10.6% | 785,500 |
| Wyoming | 9.3% | 12,500 |
| Alaska | 8.4% | 15,500 |
| Arizona | 8.2% | 135,000 |
| Oklahoma | 7.9% | 76,000 |
| North Dakota | 7.9% | 14,000 |

Continuing to examine state-level patterns, one factor in understanding children's health insurance rates is state decisions of whether to expand their Medicaid programs as authorized by the Affordable Care Act (ACA). Although the ACA's Medicaid expansion did not directly apply to children (children in all states were already eligible for Medicaid up to the expansion eligibility level of 0-138 percent of Federal Poverty Guidelines [FPG]), it did include expansion for parents of covered children. There is evidence that states that chose Medicaid expansion saw greater improvements in their children's health insurance rates after the law went into effect in 2014. That is likely due to a phenomenon termed the "welcome mat effect," in which people who were already eligible for coverage enrolled in it due to improved awareness—or when parents enrolled their children in health insurance coverage at the same time they enrolled themselves.⁵

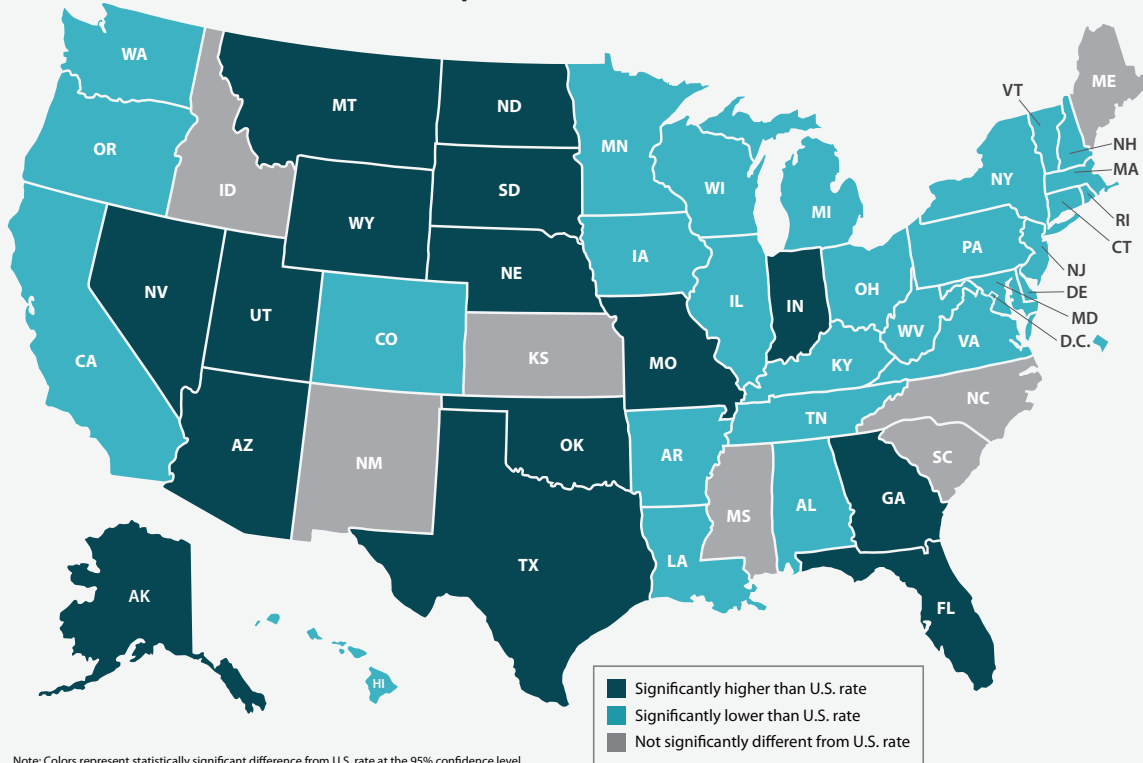
To that point, states' Medicaid expansion status in 2016—when our measurement period began—correlated with our findings regarding uninsured rates for children. For example, six of the ten states with the highest rates of uninsurance for children had not yet expanded Medicaid as of 2016, while all ten of the states or localities (including D.C.) with the lowest children's uninsurance had expanded their Medicaid programs.

Figure 2. State Children's Uninsurance Rates, 2016-2020



Note: Colors represent statistically significant difference from U.S. rate at the 95% confidence level.

Figure 3. State Children's Uninsurance Rates Compared to U.S. Rate, 2016-2020



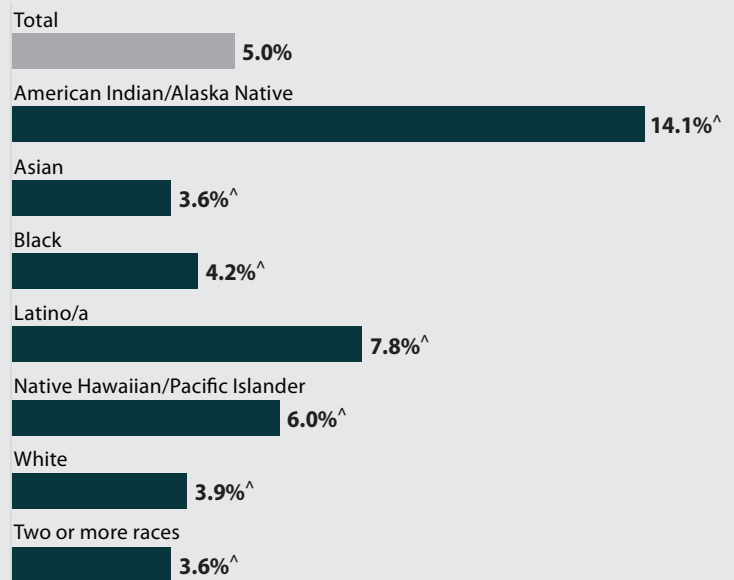
American Indian and Alaska Native, Latino/a children had highest uninsurance rates

At the national level, children's health insurance rates ranged widely by race and ethnicity categories, with Asian children and multi-racial children experiencing the lowest uninsurance rates and American Indian and Alaska Native children experiencing the highest uninsurance rates.

At 14.1 percent, American Indian and Alaska Native kids had the highest rate of uninsurance across all racial and ethnic groups. Their rate was nearly three times the 5.0 percent rate for children in the U.S. overall, a difference that was statistically significant.⁶ Latino/a children had the second-highest rate of uninsurance, at 7.8 percent. Their rate was more than one and a half times the 5.0 percent overall rate for U.S. children, a difference that was also statistically significant. At 6.0 percent, Native Hawaiian and other Pacific Islander children also had an uninsured rate that was significantly higher than the total child population rate of 5.0 percent.

The rates of uninsurance among American Indian and Alaska Native children and among Native Hawaiian and other Pacific Islander children are notable, as their higher rates often go unrecognized. Data disaggregation limitations, especially when looking at single-year estimates, often mean that the data for American Indian and Alaska Native and Native Hawaiian and other Pacific Islander children are typically combined with other racial and ethnic groups—masking the inequities

Figure 4. U.S. Children's Uninsurance Rates by Race/Ethnicity, 2016-2020



[^] Significantly different than the total children's population rate at the 95% level.

experienced by these children. However, we took a different approach for this analysis, combining multiple years of data, which allowed us to increase the sample size and produce reliable estimates for smaller population groups at a national level and for multiple states.

Black or African American children had an uninsurance rate of 4.2 percent, which was significantly lower than the total child population rate of 5.0 percent. White children had similar uninsurance rate at 3.9 percent, which again was significantly lower than the total child population rate. At 3.6 percent, both Asian children and children of multiple races had the lowest uninsurance rate, which was also significantly lower than the total child population rate of 5.0 percent.

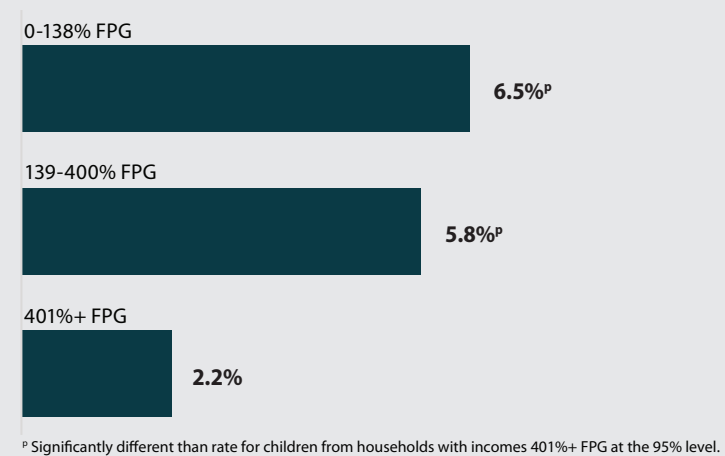
Uninsurance was highest among lower-income children

Using federal poverty guidelines (FPG), which are calculated by the Department of Health and Human Services (HHS) using a combination of household income and number of people in the household, we also analyzed children’s health insurance rates by family income. At the U.S. level, inequities were substantial, with children from households with lower incomes having an uninsurance rate roughly three times the rate for children of households with higher incomes.

With a rate of 6.5 percent, children from households with lower incomes (0-138 percent of FPG, or up to \$29,974 for a family of three in 2020) had the highest measure of uninsurance, making them significantly more likely to lack coverage than kids from households with higher incomes. Children from households with higher incomes (401 percent of FPG or higher, or above \$86,880 for a family of three in 2020) had the lowest rate of uninsurance, at just 2.2 percent.

At 5.8 percent, children from households with moderate incomes (139-400 percent of FPG, or up to \$86,880 for a family of three in 2020) had an uninsurance rate that fell between that of children from higher- and lower-income households. This rate also was significantly higher than the uninsurance rate for children of higher-income families.

Figure 5. U.S. Children’s Uninsurance Rates by Income, 2016-2020

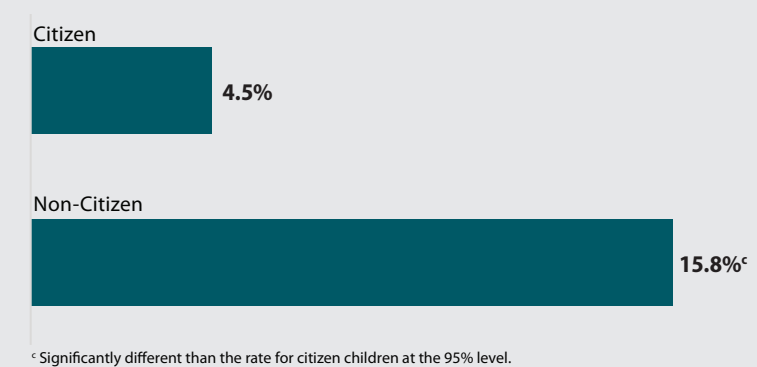


Non-citizen children uninsurance rates were more than triple the rate for citizens

Immigration status is an important factor in determining eligibility for health insurance programs in the U.S., both for children and adults. Private health insurance—such as employer-based insurance and individual-market coverage purchased directly from insurance companies—is available to citizens and may be available to some non-citizens. However, without financial assistance, private health insurance is often unaffordable for families.

Additionally, federally funded public health coverage programs (such as Medicaid and CHIP) are limited by federal law to American citizens and certain lawfully present residents, though with some restrictions. For instance, legal permanent residents typically have a five-year waiting period before they can enroll in Medicaid. And undocumented immigrants typically aren’t eligible for federally sponsored coverage programs, such as Medicaid or CHIP, at all. As a result, non-citizen children experience stark inequities in health coverage. While we weren’t able to directly identify undocumented immigrants in this analysis, they are included in our estimates of uninsurance among non-citizen children.

Figure 6. U.S. Children’s Uninsurance Rates by Citizenship, 2016-2020



At the U.S. level, 4.5 percent of children who are American citizens were uninsured. However, 15.8 percent of non-citizen children were uninsured (almost 520,000 children), roughly three and a half times the uninsurance rate for children with citizenship status. The difference in uninsurance rates between children who are citizens and those who are non-citizens was statistically significant.

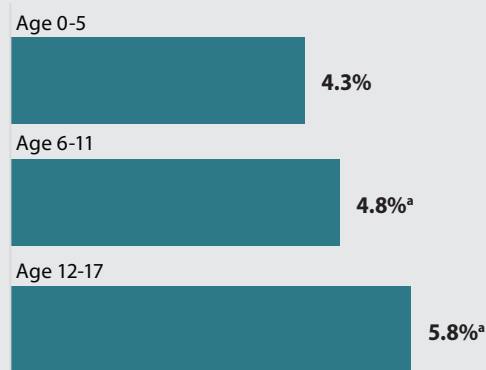
While individuals, including children, who are undocumented are not authorized to participate in federally funded public health insurance programs, some states have nevertheless established “cover all kids” programs to fund comprehensive or limited health insurance coverage for children who are undocumented as well as other children ineligible for federal programs using state-only dollars.

Older children were more likely to be uninsured

Across age groups, there is a clear pattern of higher uninsurance rates among older children. Slightly over four out of every 100 children age 5 and younger (4.3 percent) were uninsured when looking at the U.S. level, while almost six out of every 100 children (5.8 percent) age 12-17 lacked health insurance coverage.

At 4.3 percent, children age 5 and younger had the lowest uninsurance rate by age group. The rate increased to 4.8 percent among children ages 6-11, which was significantly higher than the youngest children. Adolescents age 12-17 had the highest rate of uninsurance, at 5.8 percent, which also was significantly higher than the rate for kids 5 and younger.

Figure 7. U.S. Children's Uninsurance Rates by Age, 2016-2020

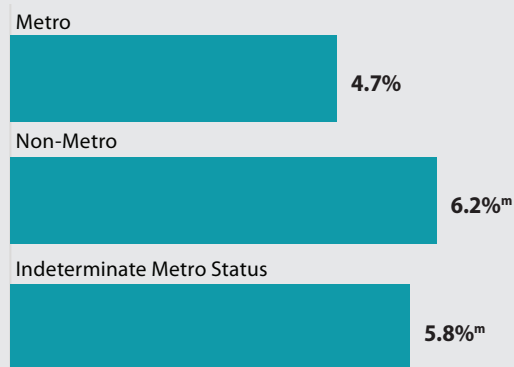


* Significantly different than the rate for children age 0-5 at the 95% level.

Children residing in non-metropolitan areas had significantly higher rates of uninsurance

Our analysis also found significant differences in health insurance coverage rates between children living in metropolitan areas and children living outside of these areas. Although this section could be interpreted by some as a comparison of “urban-rural” differences, it is important that we pause to acknowledge some clear distinctions from a more traditionally recognized “urban” and “rural” terminology. For our analysis, “metropolitan” residents include children living in principle cities, as well as surrounding suburban areas; and “non-metropolitan” residents includes children living in smaller cities that aren’t large enough to be considered metropolitan by U.S. Census Bureau definitions (e.g., “micropolitan”), ranging to children living in smaller towns and those residing entirely outside of even the smallest urbanized areas.⁷

Figure 8. U.S. Children's Uninsurance Rates by Metropolitan or Non-Metro Residence, 2016-2020



* Significantly different than the rate for children residing in metro areas at the 95% level.

Among children residing in U.S. metropolitan areas, 4.7 percent were without health insurance. By comparison, children residing in non-metropolitan areas had a significantly higher rate, at 6.2 percent. For these children of indeterminate metro status (for whom we could not determine whether they resided in metro or non-metro areas), 5.8 percent were uninsured.⁸

Conclusions on persistent inequities in children's health insurance

Overall, U.S. children have enviably low rates of uninsurance—5 percent compared to roughly 10 percent for non-elderly adults. That achievement is a result of policy choices at both federal and state levels that are aimed at increasing the number of children eligible for affordable coverage, as well as continuous efforts to enroll children in health insurance for which they are eligible. However, as this issue brief demonstrates, ongoing disparities in coverage rates for different populations of children remain.

Clear patterns emerged as we examined demographic categories at the U.S. level. By race and ethnicity, some children were significantly more likely to be uninsured than others: Latino/a children, for instance, had an uninsured rate that was roughly one and a half times the rate for the total population for U.S. children. And the uninsured rate for American Indian and Alaska Native children was even higher, at nearly three times the total population rate.

Our analysis also demonstrated that uninsurance was strongly correlated with income level, as children from families with the lowest incomes had the highest uninsurance rates, followed by children from families with moderate incomes, while children from families with higher incomes had the lowest uninsurance rates. The higher rates of uninsurance among children from lower-income families is notable because many of these kids are likely eligible for Medicaid or CHIP public coverage but are simply not enrolled, so those uninsurance rates could likely be reduced with enhanced outreach and enrollment efforts.⁹

Citizenship status had a strong association with health insurance coverage as well, with children who are not U.S. citizens having an uninsurance rate about three and a half times the rate for children who are citizens. Additionally, we found that uninsurance rates increased with age, such that the youngest age group of kids (5 or younger) had the lowest uninsurance rate, while older adolescents (age 12-17) had the highest uninsurance rate. And, as a proxy for urban and rural differences, we found that children residing in non-metropolitan areas of the U.S. had a higher rate of uninsurance than kids in metropolitan areas.

At the state level, children's health insurance rates also varied widely, meaning that the states where children live can have a dramatic influence how likely they are to have health insurance. For instance, children in Texas—which has the highest state uninsurance rate for kids—are approximately eight times as likely to be uninsured compared to children in Massachusetts and Vermont, the states with the lowest kids' uninsurance rates. In terms of the number of children, that represents about 785,500 kids without coverage in Texas—roughly the same number of uninsured kids as found in the 17 states with the lowest children's uninsurance rates

These inequities are surely influenced by state demographics as well as federal policies. For instance, Texas has one of the largest populations of undocumented immigrants in the U.S., which translates into a large share of children who are ineligible based on federal policy for health insurance programs such as Medicaid and CHIP.¹⁰ However, demographics and federal policy are not the only factors determining whether or not kids have health insurance coverage. Some states have taken the initiative to develop their own programs to cover kids who are ineligible for federally sponsored coverage. For instance, in 2006, Illinois launched a universal coverage program for open to all kids—including those who are undocumented—using state-only funding.¹¹

As a [companion piece to this brief](#), we have developed 50-state data profiles on children's uninsurance rates by race and ethnicity, income as measured by poverty level, citizenship status, age, and metropolitan status. These resources are designed to be used as a tool for people in all 50 states and D.C. to help identify children's health insurance coverage disparities within each state's unique context so that policymakers can develop and implement directed solutions to improve health equity through better access to coverage and ensure that all kids have an equal opportunity to develop into healthy adults.

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- ² Alker, J. & Corcoran, A. (2020). *Children's uninsured rate rises by largest annual jump in more than a decade*. Georgetown Center for Children & Families. https://ccf.georgetown.edu/wp-content/uploads/2020/10/ACS-Uninsured-Kids-2020_10-06-edit-3.pdf
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- ³ When testing for significant differences in uninsured rates we used a benchmark, or a standard or reference against which other data can be compared, of the total population when examining by race and ethnicity, and by "best performing," or the group with the best performance—in this case the lowest uninsured rate, for all other demographic categories.
- ⁴ While the U.S. Census Bureau has provided extensive documentation on the impacts that the COVID-19 pandemic has had on the single-year 2020 ACS estimates resulting in their release only in an "experimental" format (and cautioned strongly against their use), the Census Bureau has determined the combined five-year estimates for 2016-2020 fit for regular use.
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- ⁵ Arjun, L. & Guyer, J. (2008). *Putting Out the Welcome Mat: Implications of Coverage Expansions for Already-Eligible Children*. Georgetown Center for Children and Families. https://ccf.georgetown.edu/wp-content/uploads/2012/03/Strategy%20center_putting%20out%20the%20welcome%20mat.pdf
- ⁶ For American Indian and Alaska Native children, it is important to note that we did not classify access to the Indian Health Service (IHS) as coverage. While IHS provides important health care services to members of federally recognized American Indian and Alaska Native tribes, it is a limited system of hospitals and clinics rather than a comprehensive program to provide financial protection and access to a broader network of health care providers, such as Medicaid or private health insurance can provide.
- ⁷ U.S. Census Bureau. (2021, November 22). *Metropolitan and Micropolitan: About*. <https://www.census.gov/programs-surveys/metro-micro/about.html>
- ⁸ In understanding the significance of these data, it is important to note that our analysis was not able to determine the metropolitan status for roughly 12 percent of U.S. children, due to the fact that this subset of children resided in areas that straddled both metropolitan and non-metropolitan geographies. However, these areas do not make up a distinct "middle" category, but rather this category is one uniquely made up of children—some of whom live in metro areas and some of whom live in non-metro areas, two unique geographic areas—that we could not definitively determine whether they lived in metro or non-metro areas.
- ⁹ Kaiser Family Foundation (KFF). (2022). *Medicaid/CHIP child participation rates: 2013-2019* [Data set]. <https://www.kff.org/medicaid/state-indicator/medicaidchip-child-participation-rates/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>
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