Uninsurance among Young Children, 1997–2015

Long-Term Trends and Recent Patterns

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Between 1997 and the first three quarters of 2015, the share of children age 18 and under without health insurance declined from 14.9 percent to 4.8 percent, a drop of more than 66 percent (Gates et al. 2016). This trend coincided with major expansions of children's eligibility for public coverage through the Children's Health Insurance Program (CHIP) beginning in 1997, rising participation rates among children eligible for Medicaid and CHIP,[1] and further efforts to reduce uninsurance for both children and parents under the Affordable Care Act (ACA).

Previous studies have demonstrated that children's health insurance coverage is associated with improved access to health care (Clemans-Cope et al. 2015; Gifford, Weech-Maldonado, and Farley Short 2005; Howell and Kenney 2012; Medicaid and CHIP Payment and Access Commission 2012; Smith 2015). The link between coverage and access to health care is especially important in early childhood, when well-child visits present critical opportunities to receive immunizations, screenings, and other preventive care that promotes long-term health and development (Gifford, Weech-Maldonado, and Farley Short 2005).

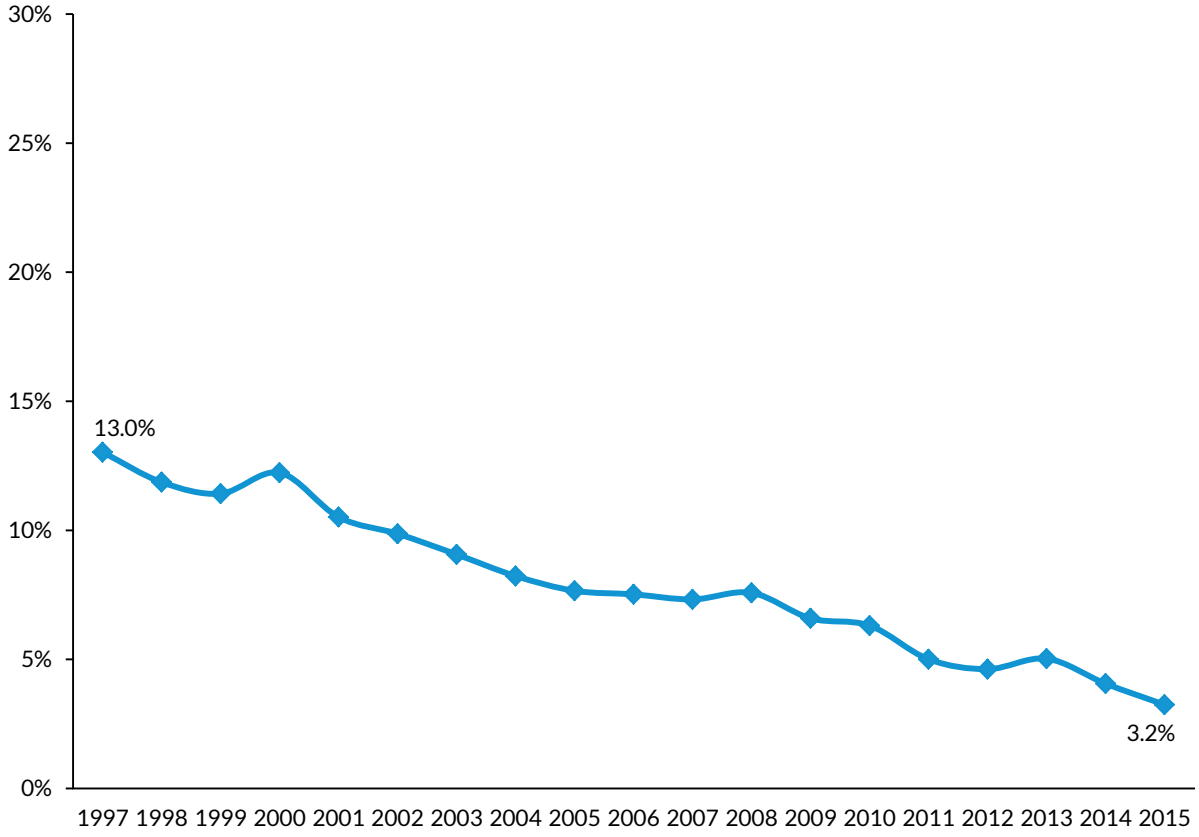
For this analysis, we used data from the National Health Interview Survey to focus on long-term trends in uninsurance for children age 5 and under (hereafter referred to as "young children"); assess differences by coverage status in young children's access to health care, service use, and health care affordability in 2014;[2] and examine changes in the composition of the uninsured and uninsurance rates for subgroups of young children between 2013 and 2014. The analysis supplements findings from and uses the same methods as Gates and colleagues (2016), which focuses on all children age 18 and under.

We found that the share of young children without health insurance fell from 13.0 percent in 1997 to 3.2 percent in January through September 2015, a 75 percent decrease (figure 1). Uninsurance for young children declined in the years leading up to the reauthorization of CHIP in 2009 and the passage of the ACA in 2010 and has fallen by nearly half in the ensuing 5 years (from 6.3 percent in 2010 to 3.2

percent in 2015). As of 2014, 1 million young children were uninsured, down from nearly 3 million in 1997 (Gates et al. 2016).

FIGURE 1

Uninsurance among Children Age 5 and Under, 1997–2015

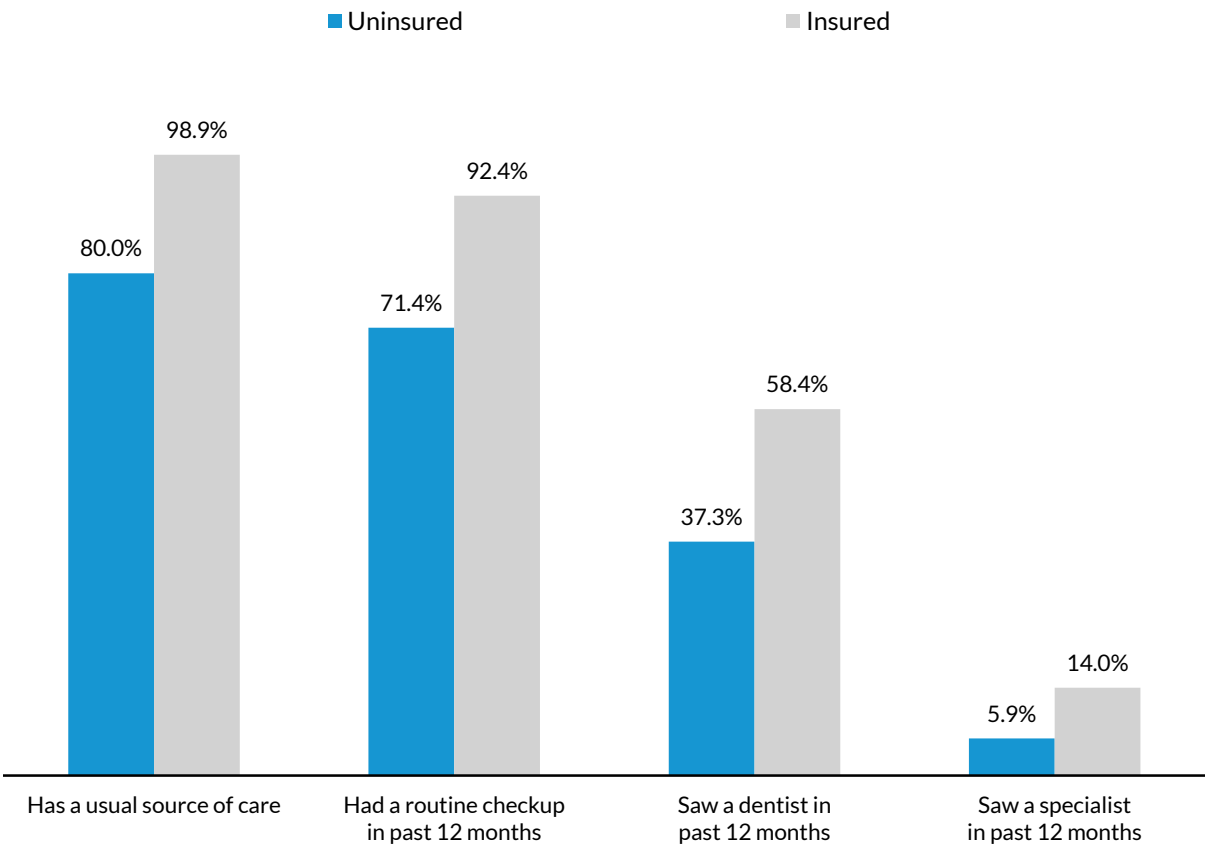


Source: Urban Institute tabulations of 1997–2014 and January-September 2015 National Health Interview Survey data.
Note: Uninsured is at time of survey.

Figure 2 shows that young children with insurance were substantially more likely to have regular access to care in 2014 than their uninsured peers. Nearly all insured young children (98.9 percent) had a usual source of care, and 92.4 percent had had a routine checkup in the previous year. In contrast, 80.0 percent of uninsured young children had a usual source of care and 71.4 percent had had a routine checkup. Those with insurance were also more likely than those who were uninsured to have seen a dentist (58.4 percent versus 37.3 percent) or a specialist (14.0 percent versus 5.9 percent) in the previous year.

FIGURE 2

Health Care Access and Service Use among Uninsured and Insured Children Age 5 and Under, 2014

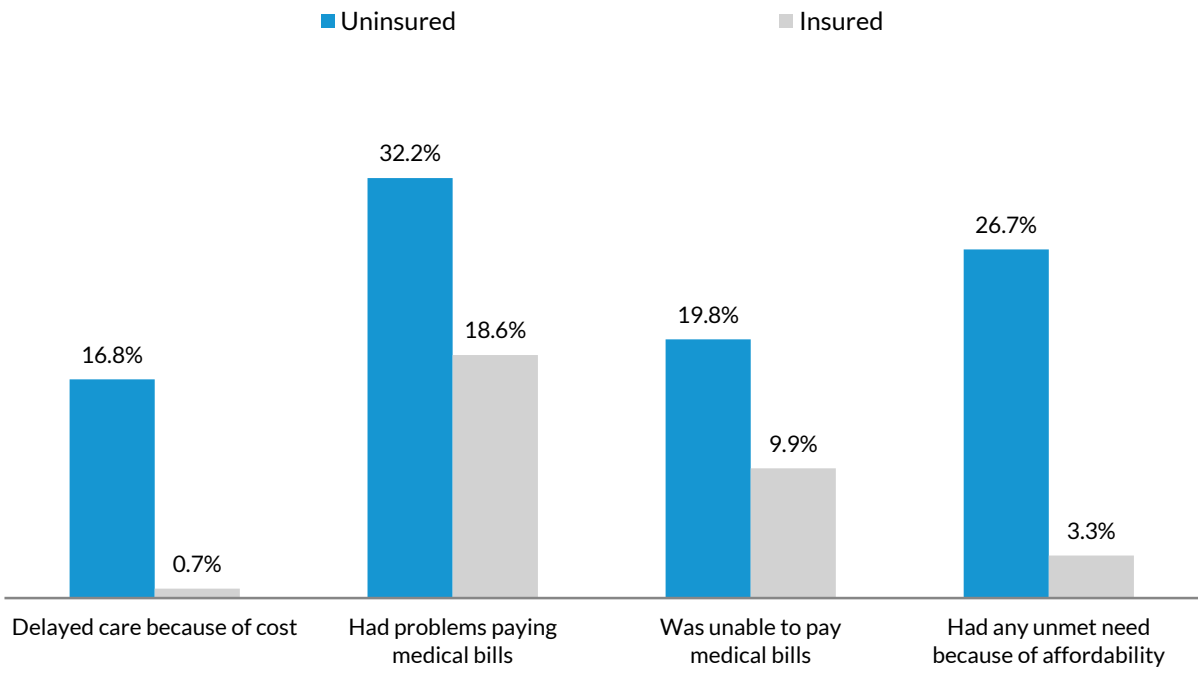


Source: Urban Institute tabulations of 2014 National Health Interview Survey data.
Notes: Uninsured is defined as those who lacked health insurance for all of the previous 12 months. Insured is defined as those with health insurance for all of the previous 12 months. Usual source of care is at time of survey. All estimates for the uninsured differ significantly from estimates for the insured ($p < 0.05$).

Insured young children were also significantly less likely than uninsured young children to have delayed care because of its cost (0.7 percent versus 16.8 percent), gone without care because it was not affordable (3.3 percent versus 26.7 percent), or lived in families that had problems paying medical bills (18.6 percent versus 32.2 percent) in the previous year (figure 3). Most of these estimated differences in access, service use, and affordability narrowed slightly but remained consistent after controlling for demographic and socioeconomic characteristics, region, health status, and activity limitations (data not shown).

FIGURE 3

Health Care Affordability among Uninsured and Insured Children Age 5 and Under, 2014



Source: Urban Institute tabulations of 2014 National Health Interview Survey data.
Notes: Uninsured is defined as those who lacked health insurance for all of the previous 12 months. Insured is defined as those with health insurance for all of the previous 12 months. All measures are for experience in 12 months before survey. "Any unmet need" includes unmet need for medical care, dental care, prescription drugs, eyeglasses, mental health care, specialist care and follow-up care. All estimates for the uninsured differ significantly from estimates for the insured ($p < 0.05$).

We found only one statistically significant change between 2013 and 2014 in the composition of the young children who are uninsured (and that was only significant at $p < 0.10$; table 1). As of 2014, 40.9 percent of uninsured young children were Hispanic, 41.5 percent were non-Hispanic white, and 11.4 percent were non-Hispanic black. Nearly 98 percent were in good health or better, and 95.2 percent were not limited in their activities. Uninsurance was concentrated in the South (41.3 percent) and West (30.0 percent). Although nearly 80 percent of uninsured young children were in families in which at least one adult worked, 91.6 percent were in families with incomes below 400 percent of the federal poverty level (FPL), making them potentially eligible for Medicaid, CHIP, or subsidized Marketplace coverage.

TABLE 1

Characteristics of Uninsured Children Age 5 and Under in 2013 and 2014

	2013	2014	
Sex			
Female	46.0%	48.0%	
Male	54.0%	52.0%	
Race/ethnicity			
White, non-Hispanic	39.9%	41.5%	
Black, non-Hispanic	11.3%	11.4%	
Hispanic	38.3%	40.9%	
Other race, non-Hispanic	10.6%	6.2%	
Citizenship status			
Citizen	94.9%	97.2%	
Noncitizen	5.1%	2.8%	
Self-reported health status			
Excellent or very good	85.2%	85.0%	
Good	13.7%	12.8%	
Fair or poor	1.1%	2.2%	
Limitations			
Has any activity limitation	3.5%	4.8%	
Has no activity limitation	96.5%	95.2%	
Region			
Northeast	10.6%	13.2%	
South	40.8%	41.3%	
Midwest	20.8%	15.5%	
West	27.8%	30.0%	
Highest education by HIU			
Less than high school	22.5%	21.2%	
High school	24.5%	31.9%	*
Some college	34.4%	28.1%	
College	18.5%	18.8%	
Work status by HIU			
Two full-time workers	15.1%	16.9%	
One full-time worker	54.7%	52.5%	
Only part-time workers	10.3%	9.0%	
No workers	18.4%	21.2%	
No adults	1.5%	0.4%	
HIU citizenship status			
Any noncitizen in HIU	27.4%	29.3%	
No noncitizens in HIU	72.6%	70.7%	
Income by HIU			
< 138% FPL	46.6%	50.5%	
138–400% FPL	45.2%	41.1%	
> 400% FPL	8.3%	8.4%	

Source: Urban Institute tabulations of 2013 and 2014 National Health Interview Survey data.

Notes: FPL = the federal poverty level; HIU = health insurance unit. All measures are at time of survey.

*/**/*** Estimate for 2014 differs significantly from the 2013 estimate at p < 0.10/0.05/0.01, respectively.

Table 2 shows that uninsurance fell for young children overall between 2013 and 2014, following the implementation of the ACA's key coverage provisions (from 5.0 percent to 4.1 percent). We also found statistically significant declines for boys, Hispanic children, and children with family incomes between 138 and 400 percent of FPL, among other groups. However, Hispanic young children remained disproportionately likely to be uninsured (6.5 percent) relative to non-Hispanic white children (3.3 percent), non-Hispanic black children (3.4 percent), and non-Hispanic children of other races (2.5 percent).

In addition, young noncitizen children were more than three times as likely to be uninsured as citizen children (13.0 percent versus 4.0 percent), and children with at least one noncitizen in the family were nearly twice as likely to be uninsured as children with only citizens in the family (6.4 percent versus 3.5 percent). Despite expansions of public and subsidized coverage to children in low- and moderate-income families, uninsurance rates continued to vary by educational attainment, work status, and family income. Approximately 5 percent of young children with family incomes below 138 percent of FPL or between 138 and 400 percent of FPL were uninsured, compared with 1.4 percent of young children in families with incomes above 400 percent of FPL.

These results show that the uninsurance rate for young children declined steadily between 1997 and the first nine months of 2015, which is after implementation of the major ACA coverage provisions targeted primarily at adults. We will continue to track coverage patterns for young children as we approach a CHIP funding decision in 2017, which will determine the coverage options available for children in the coming years and in turn have implications for their uninsurance rates and access to care. In addition, young children with coverage have greater access to care and service use, and their families struggle with fewer affordability problems than those of young children who are uninsured, even after controlling for observable characteristics. Some subgroups of young children continue to have disproportionately high uninsurance rates, however, including Hispanic children, children who are noncitizens or have at least one noncitizen in their family, and children in low- and moderate-income families.

These findings suggest that further reductions in the uninsurance rate for young children may require more targeted outreach toward families with uninsured children, most of whom are currently eligible for Medicaid/CHIP or subsidized Marketplace coverage, as well as continued emphasis on connecting parents with coverage, which has been shown to be positively associated with children's coverage (Dubay and Kenney 2003). Additional efforts will be necessary, however, for children who lack eligibility for affordable coverage because of their immigration status or other complexities. For example, several states are using options provided through the Children's Health Insurance Program Reauthorization Act of 2009 or state-funded programs to cover immigrant children.[3]

TABLE 2

Rates of Uninsurance among Children Age 5 and Under in 2013 and 2014

	2013	2014		
All young children	**5.0%**	**4.1%**	**	
Sex				
Female[a]	4.7%	4.0%		
Male	5.3%	4.1%	**	
Race/ethnicity				
White, non-Hispanic	4.0%	3.3%		+++
Black, non-Hispanic	4.1%	3.4%		+++
Hispanic[a]	7.5%	6.5%		
Other race, non-Hispanic	5.4%	2.5%	**	+++
Citizenship status				
Citizen[a]	4.8%	4.0%	*	
Noncitizen	21.7%	13.0%		++
Self-reported health status				
Excellent or very good[a]	5.0%	3.9%	**	
Good	5.6%	4.6%		
Fair or poor	3.4%	6.9%		
Limitations				
Has any activity limitation[a]	3.1%	3.7%		
Has no activity limitation	5.2%	4.1%	**	
Region				
Northeast[a]	3.5%	3.8%		
South	5.2%	4.4%		
Midwest	4.8%	2.8%	**	
West	5.9%	4.9%		
Highest education by HIU				
Less than high school[a]	8.4%	6.3%		
High school	6.3%	6.4%		
Some college	5.7%	4.1%	*	++
College	2.5%	2.0%		+++
Work status by HIU				
Two full-time workers[a]	3.2%	2.9%		
One full-time worker	5.4%	4.2%	*	++
Only part-time workers	6.3%	4.5%		
No workers	5.7%	5.1%		++
No adults	8.1%	1.7%		
HIU citizenship status				
Any noncitizen in HIU[a]	7.5%	6.4%		
No noncitizens in HIU	4.5%	3.5%	**	+++
Income by HIU				
< 138% FPL	5.8%	5.2%		+++
138–400% FPL	6.5%	4.6%	**	+++
> 400% FPL[a]	1.7%	1.4%		

Source: Urban Institute tabulations of 2013 and 2014 National Health Interview Survey data.

Notes: FPL = the federal poverty level. HIU = health insurance unit. All measures are at time of survey.

*/**/*** Estimate for 2014 differs significantly from the 2013 estimate at p < 0.10/0.05/0.01, respectively.

+/++/+++ Estimate differs significantly from that for the reference category (marked with [a]) at p < 0.10/0.05/0.01, respectively.

Notes

1. Urban Institute tabulations from the Health Policy Center's American Community Survey Medicaid and CHIP Simulation Model based on 2012 data from the Integrated Public Use Microdata Series.

2. For the analysis of differences in access, service use, and affordability, we focus on young children's insurance coverage status in the year before the survey. We analyze differences in these measures between young children who were insured for the entire previous year and those who were uninsured for the entire previous year.

3. Sinsi Hernandez-Cancio, Yasmin Peled, and Erika Ramirez, "California's Historic Decision to Extend Health Coverage to Every Low-Income Kids," *Families USA* blog, July 23, 2015, http://familiesusa.org/blog/2015/07/californias-historic-decision-extend-health-coverage-every-low-income-kid.

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Michael Karpman is a research associate in the Health Policy Center at the Urban Institute. His work focuses on the implications of the Affordable Care Act, including quantitative analysis related to health insurance coverage, access to and affordability of health care, use of health care services, and health status. This work includes efforts to help coordinate and analyze data from the Urban Institute's Health Reform Monitoring Survey. Before joining Urban in 2013, Karpman was a senior associate at the National League of Cities Institute for Youth, Education, and Families. He received his MPP from Georgetown University.

Jason A. Gates is a research assistant in the Health Policy Center at the Urban Institute. His current work focuses on the effects of expanding coverage on low income populations, children and families. His expertise is with the National Health Interview Survey, and he has experience analyzing the American Community Survey and Behavioral Risk Factor Surveillance System. He received his BA from Dickinson College.

Genevieve M. Kenney is a senior fellow and codirector of the Health Policy Center at the Urban Institute. She has been conducting policy research for over 25 years and is a nationally renowned expert on Medicaid, the Children's Health Insurance Program (CHIP), and broader health insurance coverage and health issues facing low-income children and families. Kenney has led a number of Medicaid and CHIP evaluations, and published over 100 peer-reviewed journal articles and scores of briefs on insurance coverage, access to care, and related outcomes for low-income children, pregnant women, and other adults. In her current research, she is examining implications of the Affordable Care Act, how access to primary care varies across states and insurance groups, and emerging policy questions related to Medicaid and CHIP. She received a master's degree in statistics and a PhD in economics from the University of Michigan.

Stacey McMorrow is a health economist with extensive experience using quantitative methods to study the factors that affect individual health insurance coverage and access to care as well as the impacts of state and national health reforms on employers and individuals. Her current work uses the Affordable Care Act and past Medicaid expansions to explore the effects of expanding insurance coverage on access to care, service use and health outcomes for various populations. Through this and other work, McMorrow has developed substantial expertise in analyzing data from several federal surveys, including the National Health Interview Survey and the Medical Expenditure Panel Survey. Other research interests include the role of community health centers and safety net providers under health reform, receipt of preventive and reproductive health services among women, barriers to care for low-income children, and the market-level effects of insurance expansions. McMorrow received her PhD in health economics from the University of Pennsylvania in 2009.

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