

# The Rate of Children without Health Insurance Is Rising, Particularly among Latino Children of Immigrant Parents and White Children

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Health insurance is critical to children’s well-being. Children who have health insurance are more likely than those without coverage to use preventative health services,<sup>1,2,3</sup> experience fewer emergency room visits and hospitalizations,<sup>4</sup> have better overall health,<sup>5,6,7</sup> and have better educational and labor force outcomes.<sup>8,9</sup> Over the last decade, increased federal and state funding of the Child Health Insurance Program (CHIP)<sup>10</sup> and the implementation of the Affordable Care and Patient Protection Act (or ACA)<sup>11,12</sup> helped improve health insurance coverage among children.<sup>10</sup> Now, though, for the first time in close to a decade, the percentage of children under age 19 who did *not* have health insurance has increased, rising from 5.0 percent in 2017 to 5.5 percent in 2018, according to a recent Census report.<sup>13</sup> This amounts to roughly 425,000 more children who were uninsured in 2018 than in 2017.

Historically, rates of children without health insurance in the United States have varied across racial/ethnic groups, with Hispanic and non-Hispanic Black children more likely to be uninsured than their non-Hispanic White counterparts.<sup>13,14,15,16</sup> Children’s access to services—including health insurance and health care—is shaped by the immigrant experiences of their parents.<sup>a,17</sup> For example, prior research has found that having even just one U.S.-born parent is associated with a greater likelihood of having a regular health care provider<sup>18</sup> and better child health outcomes.<sup>19</sup>

In this brief, we examine whether the recent increase in the health uninsured rate has been experienced similarly by children across racial/ethnic groups. We used data from the 2011-2019 Current Population Survey (CPS), covering the time period from 2010 to 2018, to examine patterns of uninsured rates over time for children from the three largest racial/ethnic groups: Hispanic, non-Hispanic White, and non-Hispanic Black children.<sup>b</sup> We also compared the uninsured rates of Hispanic children with at least one U.S.-born parent with those of Hispanic children with only foreign-born parents (including foreign-born single parents). Methods of data collection and processing for the CPS have changed over time. Therefore, while we report overall trends in uninsured rates from 2010 to 2018, we



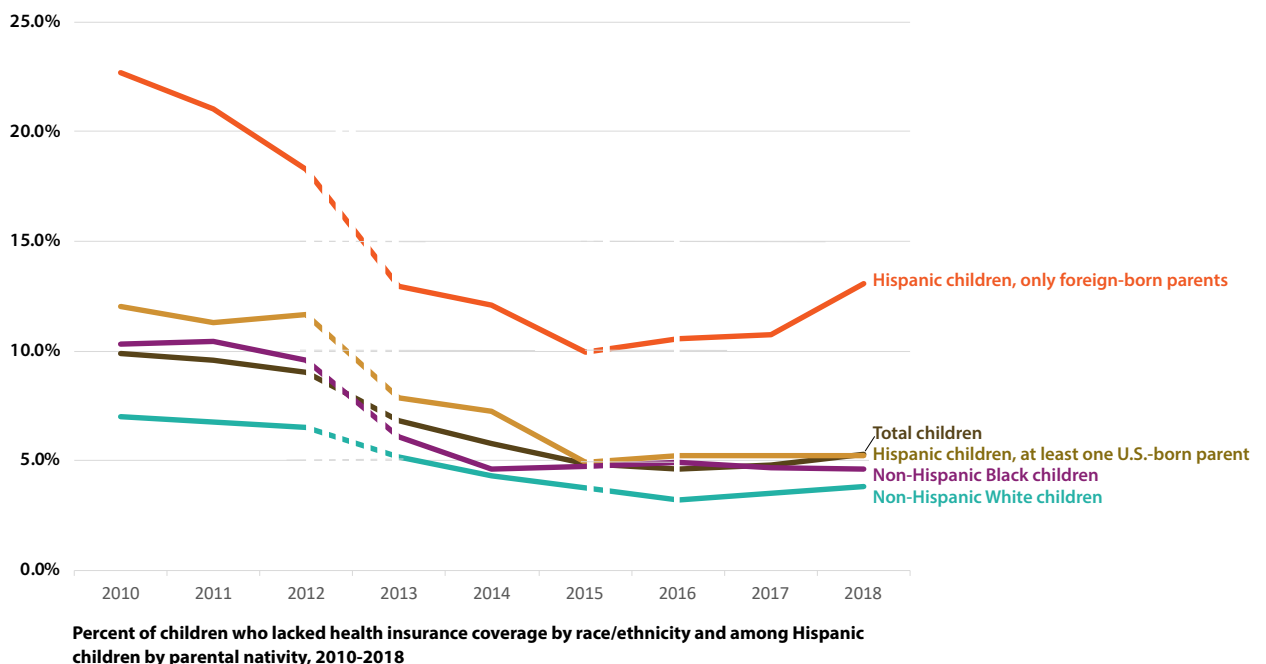
were only able to statistically compare changes in children’s uninsured rates within the three time periods for which direct comparisons can be made: 2010-2012, 2013-2015, and 2016-2018.<sup>c</sup> For clarity, we explicitly note in the text where direct comparisons can or cannot be made.

## Findings

- **Most of the 2010s witnessed substantial declines in the uninsured rate among children.**
  - In 2010, roughly 10 percent of children did not have health insurance coverage; in 2018, the comparable figure was just above 5 percent, as shown in figure 1.
  - Looking at the three time periods for which direct comparisons can be made, we find that the uninsured rate for children declined by around 0.9 of a percentage point from 2010 to 2012, and by roughly 2.0 percentage points from 2013 to 2015. However, the rate increased by almost 0.7 of a percentage point from 2016 to 2018. These changes are all statistically significant.<sup>d</sup>

- The overall declines across these three periods translate to a range of approximately 1.7 to 3.5 million fewer uninsured children in 2018 than in 2010, depending on estimation assumptions.<sup>e</sup>
- **Declines in the uninsured rate among children were seen across all groups.**
  - Hispanic children (including those with only foreign-born parents and those with at least one U.S.-born parent), non-Hispanic Black children, and non-Hispanic White children each benefited from these overall declines, which are concentrated in the mid-2010s.
  - From 2013 to 2015, for example, the uninsured rate declined by 1.4 percentage points for non-Hispanic White children and by 3.0 percentage points for both groups of Hispanic children (i.e., those with at least one U.S.-born parent and those with only foreign-born parents) (see Table 1), both of which were statistically significant decreases.<sup>f</sup>
- **Declines in uninsured rates among children were fairly steady until 2016, when a small but significant uptick began.**
  - Beginning in 2016, the uninsured rate among children rose by more than half a percentage point, resulting in roughly 515,000 more children who were uninsured in 2018 than in 2016.
- **This recent uptick was limited to Hispanic children with only foreign-born parents and non-Hispanic White children.**
  - Although Hispanic children with only foreign-born parents experienced a larger percentage increase in their uninsured rate than non-Hispanic White children, both groups contributed equally to the overall increase in the number of uninsured children, given their respective sizes and the racial/ethnic makeup of the child population.
  - Specifically, we find that:
    - **Hispanic children with only foreign-born parents experienced a 2.5 percentage-point increase in their uninsured rate**, from 10.6 percent in 2016 to 13.1 percent in 2018 (see Table 1). This translates to 206,745 fewer children with health insurance coverage.
    - **Non-Hispanic White children experienced an increase of slightly over half a percentage point in their uninsured rate**, from 3.2 percent in 2016 to 3.8 percent in 2018. This translates to 216,461 fewer children with health insurance coverage.
- **Despite declines in uninsured health rates among children during the early and middle portions of the last decade, racial disparities were still evidenced in 2018; Hispanic children with only foreign-born parents had the highest uninsured rate.**
  - In 2018, 3.8 percent of non-Hispanic White children were uninsured, compared to 4.6 percent of non-Hispanic Black children, 5.2 percent of Hispanic children with at least one U.S.-born

**Figure 1.** After a decade of decline, uninsured rates among children increased for Hispanic children from immigrant families and White children\*



Data sources: U.S. Census Bureau, 2011-2016 CPS ASEC, 2017 CPS ASEC Research File, 2018 CPS ASEC Bridge File, 2019 CPS ASEC.

\*Dashed lines represent changes in the data collection methods in the CPS, which preclude direct comparisons across time periods.



- parent, and 13.1 percent of Hispanic children with only foreign-born parents.
- o Put differently, in 2018, the uninsured rate for Hispanic children with only foreign-born parents was 3.4 times higher than the rate for non-Hispanic White children and 2.5 times higher than the rate among Hispanic children with at least one U.S.-born parent.

Currently, the United States and the rest of the world are facing an unprecedented pandemic and great economic uncertainty. The uptick in children's uninsured rates that we observed in 2018 is particularly troubling and may represent just a fraction of the full challenge, especially for Hispanic children whose families are being hit especially hard by the health and economic consequences of the pandemic.

## Discussion

Significant public investment in children's health insurance took place during the last decade, including the inception of the ACA and expansions in CHIP (each of which began in the previous decade).<sup>10</sup> During this period, which also saw economic growth in the United States, child health uninsured rates declined steeply, to roughly half their levels at the start of the last decade. In addition, the decade began with significant racial and ethnic disparities in uninsured rates and ended with smaller but persistent gaps.

Of particular note is the recent uptick from 2016 to 2018 in children's uninsured rates, which our analysis shows was driven by increases among both Hispanic children with only foreign-born parents and non-Hispanic White children. It is likely that different, albeit overlapping, sets of factors are at play. For both groups, the uptick in uninsured rates may not be driven by an economic contraction, since unemployment rates declined for both foreign-born and White workers during this period.<sup>20,21</sup> Instead, the uptick may reflect recent changes in some states to the processes for becoming and staying insured. For example, some states now include more frequent reviews of eligibility and increased, stricter documentation requirements for continuous enrollment. Many of these states face challenges in efficiently implementing the new requirements and in the use of electronic data to verify eligibility.<sup>22</sup> In 2017, the federal government shortened the open enrollment period to sign up for marketplace coverage and cut funding for enrollment assistance and outreach,<sup>23</sup> which may also have contributed to the uptick in uninsured rates in states that did not opt for longer open enrollment periods or supplement outreach efforts with state funds. Our supplementary analysis, which finds the recent uptick in uninsured rates driven primarily by declines in public health insurance coverage, provides some evidence for this change mechanism (analysis available upon request). To the extent that these factors matter, they may be having a disproportionate impact on Hispanic children with only foreign-born parents and White children.

## Data and Methods

We used data from the 2011–2019 Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC) to examine health insurance coverage for children. Data on health insurance coverage are collected for the previous year. For example, data collected in 2019 gather information about health insurance coverage in 2018. Therefore, our analytic sample was limited to children ages 1 to 18 in the survey year (e.g., 2019) because they were ages 0 to 17 in the reference year (e.g., 2018). We followed the Census Bureau's convention and defined health insurance coverage as having been enrolled in any public or private health insurance, including Medicaid, Medicare, CHAMPUS (health insurance through the Civilian Health and Medical Program of the Department of Veterans Affairs), or Veterans Affairs; or other military, employer-based, or privately purchased health care.<sup>9</sup> We defined White children as non-Hispanic White children, and Black children as non-Hispanic Black children. We applied ASEC weights to generate descriptive statistics and conduct statistical tests.

Changes in data collection methods and processing preclude direct comparisons across all the years included in this analysis. In 2014, health insurance questions included in the CPS ASEC were redesigned to address underreporting of coverage and, in 2016, the system of data processing was updated to take full advantage of the 2014 redesign. As a result, estimates of overall coverage and coverage types since 2016 are not comparable to estimates prior to 2016. Thus, we focused here on general patterns and reported on direct comparisons only within time periods that are directly comparable (2010–2012; 2013–2015; 2016–2018). Despite these limitations, the general patterns we observed across the 2010 to 2018 period are consistent with trends reported by Georgetown University's Center for Children and Families' analysis of American Community Survey data<sup>44</sup> and in the National Center for Health Statistics' analysis of National Health Interview Survey data.<sup>45</sup> Additionally, even our most conservative estimates—a decline of 1.7 million children from 2010 to 2018—indicate a real and substantial decline in the uninsured rate among children during this time period.

For Hispanic children with only foreign-born parents, the public charge rule that went into effect in February 2020,<sup>24</sup> and is currently under a temporary injunction, could also have a chilling effect—further suppressing enrollment of public services including healthcare.<sup>25</sup> The revised rule includes use of non-emergency Medicaid as the basis for denial of permanent residency (green cards), admission, and adjustment of immigration status. It may also reduce Medicaid/CHIP coverage beyond targeted groups of immigrants because of confusion and uncertainty about how the policy will be implemented for immigrant families, especially those that are of mixed status. Indeed, as many have detailed, the chilling effect will have an impact on both immigrant and nonimmigrant Hispanic communities.<sup>26</sup>

Immigration itself is unlikely to be driving these changes; recent immigrants tend to have higher uninsured rates,<sup>27</sup> but immigration from Mexico and other areas in Latin America has slowed<sup>28,29</sup> in recent years. However, internal migration—from traditional destination cities in places like California, New York, Texas, or Florida to more suburban and rural areas in the Southeast or Midwest—may be playing a role in the uptick to the extent that these new destination areas offer less generous access to health insurance.<sup>30</sup>

In addition, racial/ethnic disparities in health insurance coverage are likely to be confounded with differences in socioeconomic status. Racial/ethnic minorities are more likely to have low-wage jobs that do not offer employer-sponsored insurance coverage.<sup>31</sup> However, prior research suggests that differences in income, educational attainment, and employment are not sufficient to explain coverage disparities.<sup>32</sup>

The pandemic has both highlighted and exacerbated disparities and vulnerabilities faced by Latino communities. The U.S. unemployment rate soared to 1.5 times higher than at the peak of the Great Recession in the first two months since the pandemic outbreak.<sup>33</sup> Workers in the restaurant, service, and retail industries have been especially hard hit<sup>34</sup>—the very industries in which many low-income Hispanic parents work.<sup>35</sup> Indeed, recent polling by the Pew Research Center found that close to half of all Hispanics reported that they or someone in their household had lost a job or had their wages cut because of the COVID-19 pandemic.<sup>36</sup> Hispanic women are facing especially high levels of unemployment, exceeding those of other groups.<sup>37</sup> Employees in hard-hit sectors are at risk of losing not only their wages but also the health insurance that supports their families.

The Families First Coronavirus Response Act (FFCRA),<sup>38</sup> the Coronavirus Aid, Relief, and Economic Security (CARES) Act,<sup>39</sup> and other upcoming policies aimed at workers may mitigate losses in wages and benefits. However, since many of the COVID-19 policies aimed at providing economic support to workers and families will work through the tax system, some families will fall outside the reach of this and other policies—including mixed-status families.<sup>40</sup> In addition, although the public charge rule makes an exception for immigrants receiving emergency Medicaid, only a few states have expanded this program to cover COVID-19 treatment.<sup>41</sup> Faced with the uncertainty of how the public charge rule would be applied, many eligible immigrant families have already withdrawn from Medicaid or CHIP.<sup>42</sup>

Although the health community is still learning about the direct effects of COVID-19 on children, it is unlikely that children will be spared the social and emotional costs of the pandemic, and many will need the mental health services that health insurance can help provide.<sup>43</sup> More broadly, the recent uptick in uninsured rates is troubling, as it has left children vulnerable as the country entered the pandemic; it is especially concerning that the uptick was limited in part to Hispanic children with foreign-born parents, who have been one of the groups hardest hit by COVID-19.<sup>35</sup>

### Why research on low-income Hispanic children and families matters

Hispanic or Latino children currently make up roughly 1 in 4 of all children in the United States; this is projected to increase to almost 1 in 3 by 2050.<sup>i</sup> The families of the more than 18.5 million Latino children are incredibly diverse, including by country of heritage and immigration history.<sup>iii</sup> Some Hispanic families are recent immigrants, while others have been in the United States for centuries.<sup>iv</sup>

Latino families have many of the characteristics that have been linked to the economic success of children in the United States. Key among them is family stability. Most births to low-income Hispanic women occur in co-residential unions,<sup>v</sup> and the first five years of life among children born to Latina mothers is marked by few family transitions.<sup>vi</sup> Additionally, most Hispanic children live with an employed adult.<sup>vii</sup> Nonetheless, most Latino children live in families who struggle to make ends meet; an estimated 57 percent of Hispanic children live in or near poverty.<sup>viii</sup>

A wide range of federal, state, and local level programs and policies are in place to help low-income children thrive. High-quality, research-based information on the characteristics, experiences, and diversity of Hispanic children and families will help ensure these efforts align with the service needs of Hispanic communities.

<sup>i</sup> KIDS COUNT Data Center. (2019). Child population by race in the United States. Baltimore, MD: The Annie E. Casey Foundation.

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<sup>ii</sup> Federal Interagency Forum on Child and Family Statistics. (2017). America's children: Key national indicators of well-being, 2017, Table POP3. Washington, DC: Government Printing Office. Retrieved from <http://www.childstats.gov/americaschildren/tables.asp>.

<sup>iii</sup> ACF Hispanic Workgroup (2014). Survey data elements to unpack diversity of Hispanic populations. OPRE Report #2014-30. Washington, D.C.: Administration on Children, Youth and Families. Retrieved from <https://www.acf.hhs.gov/opre/resource/survey-data-elements-to-unpack-diversity-of-hispanic-populations>

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<sup>viii</sup> KIDS COUNT Data Center. (2019). Children below 200 percent poverty by race in the United States. Baltimore, MD: The Annie E. Casey Foundation. Retrieved from <https://datacenter.kidscount.org/data/tables/6726-children-below-200-percent-poverty-by-race#detailed/1/any/false/871,870,573,869,36,868,867,133,38,35/10,11,9,12,1,185,13/13819,13820>

**Table 1.** Percent of Children Uninsured by Race/Ethnicity and Among Hispanic Children Parental Nativity Status (Children ages 1-18 in the U.S. in March following the reference year)

	Total children		Hispanic children, only foreign-born parents		Hispanic children, at least one U.S. born parent		Non-Hispanic White children		Non-Hispanic Black children	
	Sample size	% uninsured	Sample size	% uninsured	Sample size	% uninsured	Sample size	% uninsured	Sample size	% uninsured
2010	53,486	<b>9.9%</b>	5,914	<b>22.7%</b>	6,998	<b>12.0%</b>	34,249	<b>7.0%</b>	6,325	<b>10.3%</b>
2011	51,875	<b>9.6%</b>	5,707	<b>21.0%</b>	6,847	<b>11.3%</b>	33,084	<b>6.8%</b>	6,237	<b>10.4%</b>
2012	51,953	<b>9.0%</b>	5,742	<b>18.3%</b>	7,090	<b>11.7%</b>	32,906	<b>6.5%</b>	6,215	<b>9.6%</b>
2013	14,939	<b>6.8%</b>	1,288	<b>12.9%</b>	1,618	<b>7.9%</b>	10,099	<b>5.2%</b>	1,934	<b>6.1%</b>
2014	49,643	<b>5.7%</b>	5,660	<b>12.1%</b>	7,292	<b>7.2%</b>	30,750	<b>4.3%</b>	5,941	<b>4.6%</b>
2015	46,402	<b>4.9%</b>	5,222	<b>10.0%</b>	7,060	<b>4.9%</b>	28,431	<b>3.8%</b>	5,689	<b>4.7%</b>
2016	45,676	<b>4.6%</b>	5,228	<b>10.6%</b>	6,965	<b>5.2%</b>	28,138	<b>3.2%</b>	5,345	<b>4.9%</b>
2017	43,492	<b>4.8%</b>	4,884	<b>10.7%</b>	6,748	<b>5.2%</b>	26,781	<b>3.5%</b>	5,079	<b>4.7%</b>
2018	42,937	<b>5.3%</b>	4,820	<b>13.1%</b>	6,591	<b>5.2%</b>	26,692	<b>3.8%</b>	4,834	<b>4.6%</b>
<b>Change in Uninsured Rates (*Statistically different at the 5 percent level)</b>										
Between 2010 and 2012	-0.87%*		-4.37%*		-0.33%		-0.51%		-0.74%	
Between 2013 and 2015	-1.95%*		-2.98%*		-2.97%*		-1.39%*		-1.36%	
Between 2016 and 2018	0.69%*		2.52%*		-0.02%		0.64%*		-0.36%	

Data sources: U.S. Census Bureau, 2011-2016 CPS ASEC, 2017 CPS ASEC Research File, 2018 CPS ASEC Bridge File, 2019 CPS ASEC.

## Endnotes

- a We used data from 2011–2019 to look at health insurance coverage for children ages 1 to 18 at the time of the survey. Data on health insurance coverage are collected for the previous year. For example, data collected in 2018 gather information about health insurance coverage in 2017. Likewise, for children who were either 1 or 18 years old at the time of the survey, data were collected on health insurance coverage for the previous year (when they were aged 0 and 17, respectively).
- b Another common data source of health insurance coverage in the United States is the American Community Survey (ACS). The Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC), however, has produced national estimates of health insurance coverage since 1987 and includes more detailed questions on health insurance coverage than ACS ([U.S. Census Bureau, 2019](#)); see also [Pascale J, Boudreaux M, King R. \(2016\)](#). For state-level estimates, ACS is the preferred data source ([U.S. Census Bureau, 2019](#)).
- c We drew on nationally representative data from the Annual Social and Economic Supplement (ASEC) to the Current Population Survey (CPS) from 2011 to 2019. To address underreporting of health insurance coverage, the Census Bureau administered, in 2014, a redesign of health insurance questions in the CPS ASEC. For ASEC 2011–2016 and ASEC 2019, we used [Public Use Microdata Files](#) from the Census Bureau FTP site; for ASEC 2017 and 2018, we used the 2017 ASEC Research File and 2018 Bridge File to draw upon health insurance data that can be directly compared with those of ASEC 2019. For information on changes in the methods of data collection and processing, see Appendix A of [Health Insurance Coverage in the United States: 2018](#). Several [studies](#) have also compared estimates of health coverage before and after the redesign.
- d The total percentage decline over the decade does not sum to the declines within each of the three time periods because the sum of the changes does not capture changes between periods (e.g., from 2012 to 2013). For example, the change in the uninsured rate from 2012 to 2013 cannot be statistically estimated due to changes in the health insurance questions.
- e We would arrive at an estimate of 3.5 million fewer uninsured children if we assumed that all of the observed decline was due entirely to changes in the uninsured rate and not to changes in data collection. On the other hand, if we were to assume that differences between periods are entirely due to changes in data collection—the most conservative assumption we can impose—we would arrive at an estimate of 1.7 million fewer uninsured children between 2010 and 2018.
- f Although the uninsured rate among non-Hispanic Black children fell from just under 10 percent to roughly 5 percent from 2010 to 2018, changes in data collection methods preclude us from directly comparing these two points in time. Changes within the three periods that can be compared were not statistically significant for non-Hispanic Black children.
- g For ASEC 2017–2019, we used a summary indicator for any health insurance coverage last year provided by the Census Bureau in the ASEC 2017 Research File, 2018 Bridge File, and the 2019 ASEC microdata file; for ASEC 2011–2016, we followed the Census Bureau’s methods to create a summary indicator for any coverage: <https://www.census.gov/topics/health/health-insurance/guidance/programming-code/cps-recoding.html>



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## About the Center

The National Research Center on Hispanic Children & Families (Center) is a hub of research to help programs and policy better serve low-income Hispanics across three priority areas: poverty reduction and economic self-sufficiency, healthy marriage and responsible fatherhood, and early care and education. The Center is led by Child Trends, in partnership with Duke University, University of North Carolina at Greensboro, and University of Maryland, College Park. The Center is supported by grant #90PH0028 from the Office of Planning, Research and Evaluation within the Administration for Children and Families in the U.S. Department of Health and Human Services.

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