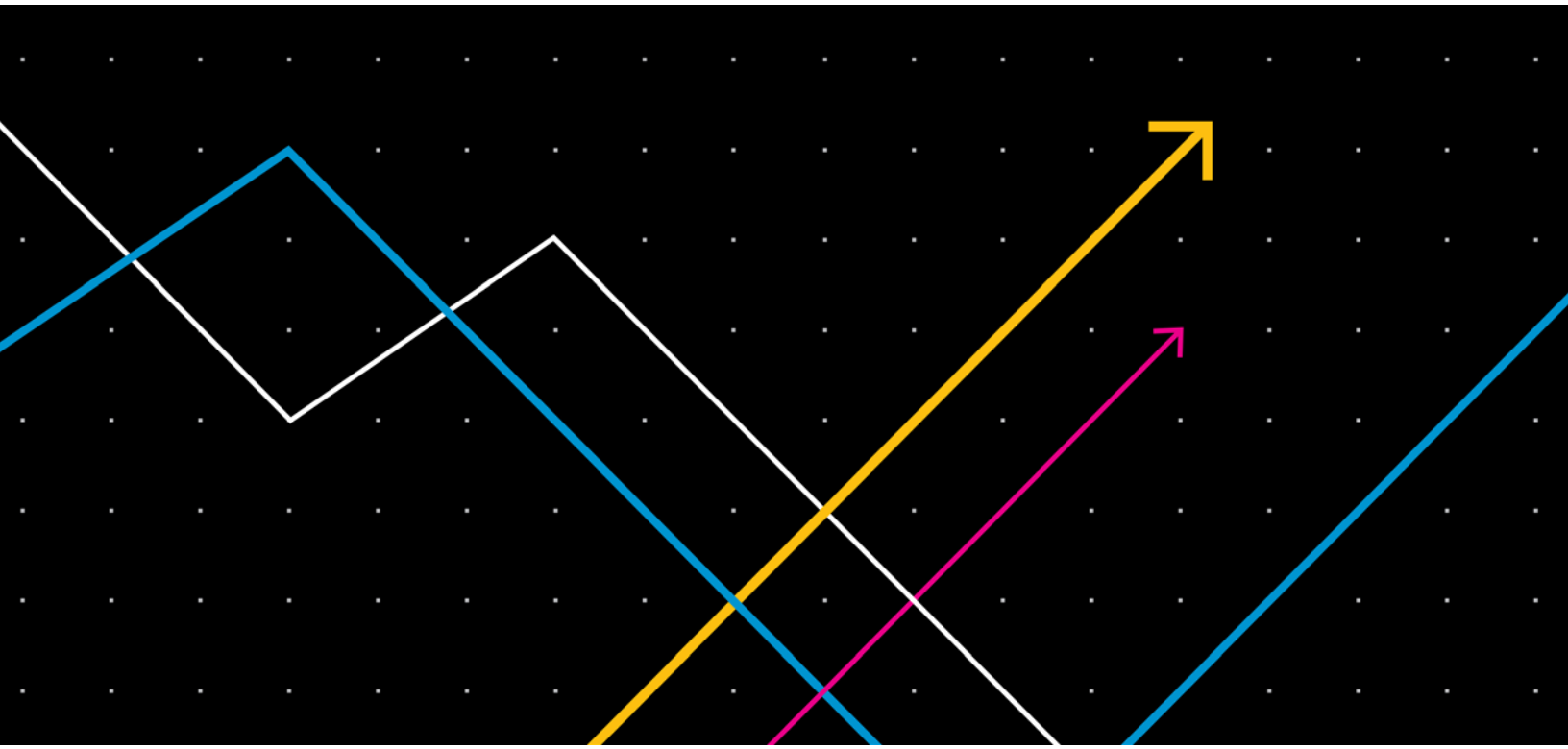

RESEARCH REPORT

Health Insurance Coverage among Children Ages 3 and Younger and Their Parents

National and State Estimates

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Executive Summary

Conditions during the earliest years of children's lives, including access to affordable health care for children and their parents, have both immediate and long-lasting impacts on children's health and well-being. In particular, health insurance coverage can improve health care access, health, and financial stability for the family (Howell and Kenney 2012; IOM 2009; Paradise and Garfield 2013; Wagnerman 2017). And reducing uninsurance among parents has been shown to have positive effects on coverage and receipt of care among children, ultimately contributing to children's healthy development (Burak 2016, 2017; Hudson and Moriya 2017; Venkataramani, Pollack, and Roberts 2017). This brief focuses on health insurance coverage among young children and their parents at the national and state levels, using data from the American Community Survey (ACS) and the Health Insurance Policy Simulation Model (HIPSM; see appendix A for details on the data and methods). We define young children as those ages 3 and younger. Our main findings are as follows:

- Medicaid and the Children's Health Insurance Program (CHIP) are important in insuring all children, but young children especially. Of the nation's 15.7 million young children in 2015, more relied on Medicaid/CHIP than on any other type of insurance coverage, with nearly half (48.8 percent, or 7.7 million) covered by Medicaid/CHIP.
- Just 3.5 percent of young children were uninsured in 2015, but 13.2 percent of parents of young children were uninsured, compared with 12.0 percent of parents of older children. Certain family characteristics, such as lower incomes, younger parents, and mixed immigration status, are more prevalent among families of young children, placing them at higher risk of lacking coverage.
- The Affordable Care Act (ACA) was associated with increased coverage among young children and their families. In the two years after implementation of the major coverage provisions of the ACA, the uninsurance rate for parents of young children fell from 19.7 percent to 13.2 percent—a drop of nearly a third, reflecting gains in coverage through Medicaid and the new Marketplaces. Though the ACA's coverage provisions were not targeted at children, uninsurance also fell for young children; this drop was associated with the ACA's coverage expansions to parents, subsidies for Marketplace coverage, and enrollment and outreach efforts.
- Nearly half (48.8 percent) of young children had Medicaid/CHIP coverage and over a fifth (20.2 percent) of their parents had Medicaid in 2015—a higher share than among older children (41.9

percent) and their parents (16.7 percent). This represents an opportunity for Medicaid and CHIP programs to reach low-income children at critical early ages.

- Because young children and their parents rely on Medicaid at higher rates than older children and their parents, contractions of Medicaid funding would have outsize effects on families with young children. Maintenance of eligibility (MOE) protections are particularly important for children ages 3 and younger: if, in the absence of federal MOE protections, all states reduced Medicaid/CHIP eligibility to 138 percent of the federal poverty level (FPL), uninsurance would be as much as six times higher among young children with family incomes between 138 and 200 percent of FPL and three times higher among those with family incomes between 200 and 300 percent of FPL nationally.
- The insurance status of young children and their parents depends on where they live. In 2015, uninsurance among young children ranged from less than 1 percent in Hawaii, Vermont, and Massachusetts to more than 10 percent in Alaska, and varied even more widely among their parents, ranging from below 3 percent in Massachusetts and Hawaii to over 20 percent in Texas, Georgia, and Mississippi. Likewise, rates of Medicaid/CHIP coverage varied across states for both young children and their parents.
- In 2015, parents of young children in nonexpansion states were nearly twice as likely to be uninsured as parents in expansion states. This suggests that additional states could achieve coverage gains for parents of young children through Medicaid expansion, with potential positive impacts for both parents and their children.

The low uninsured rates (below 5 percent in 42 states and the District of Columbia) among children ages 3 and younger in 2015 indicate that relatively few of these children experienced lack of insurance coverage as a barrier to getting the health care they need to thrive. Yet three in 10 young children are poor, and one in six has an uninsured parent, placing these families at risk for serious financial hardships and related problems. Because young children and their parents rely on Medicaid and CHIP more than older children and their parents, policy changes in Medicaid and CHIP that affect eligibility or enrollment would affect young children even more than older children. The ACA's premium tax credits and cost-sharing reductions for coverage in the Marketplaces contributed to recent increases in health coverage, particularly among parents, so the future of the Marketplaces is important as well. Because the earliest years of a child's life set the foundation for healthy development, it will be critical to assess the impact of future Medicaid, CHIP, and Marketplace policy changes on the health and well-being of young children and their families.

Health Insurance Coverage among Young Children and Their Parents

Conditions during the earliest years of children's lives, including access to affordable health care for children and their parents, have both immediate and long-lasting impacts on children's health and well-being. The rapid brain development that occurs during early childhood sets the stage for health later in life (Center on the Developing Child 2010; Halle et al. 2009; Robbins, Stagman, and Smith 2012). Disparities widen during childhood and accumulate over time, affecting later educational attainment, cognitive ability, and health and well-being (Center on the Developing Child 2010; Duncan, Morris, and Rodrigues 2011; Halle et al. 2009).[1]

Investments in childhood pay off in improvements in health and other outcomes in adulthood (Shonkoff, Boyce, and McEwen 2009). Expanded coverage of children under Medicaid and the Children's Health Insurance Program (CHIP) has been shown to lead to better long-term outcomes, including higher educational attainment and earnings, lower public spending on cash assistance, higher tax contributions, and better health (Brown, Kowalski, and Lurie 2015; Cohodes et al. 2014; Goodman-Bacon 2016; Lipton et al. 2016; Miller and Wherry 2016; Sommers, Gawande, and Baicker 2017). New literature assessing the long-term effects of coverage expansions builds on a substantial evidence base focused on shorter-term effects, which has found improvements in access to care and receipt of well-child and other preventive care for children, as well as lower financial burdens on families (Howell and Kenney 2012; Paradise and Garfield 2013; Wagnerman 2017). Expansions of health insurance coverage to parents also have improved receipt of health care among children, mental health and access to needed health care among parents, and financial well-being for the family, all of which can have positive impacts on children in the short and long run (McMorrow et al. 2017; McMorrow et al. 2016; Venkataramani, Pollack, and Roberts 2017).

One of the major public policy achievements over the last generation has been the substantial reduction in uninsurance among children (Gates et al. 2016; Karpman et al. 2016). Between 1997 and 2016, the uninsured rate for children ages 3 and younger fell by two-thirds, from 11.8 percent to 3.9 percent (Urban Institute tabulations of National Health Interview Survey data). Over this period, access to affordable health insurance coverage increased for children through the enactment of CHIP and the attendant expansion of eligibility for Medicaid and CHIP, outreach efforts, and the elimination of barriers to Medicaid and CHIP enrollment and retention (Stephens and Artiga 2013). Forty-nine states now offer Medicaid or CHIP coverage to children with family incomes at or above 200 percent of the

federal poverty level (FPL), and 19 states cover children with family incomes at or above 300 percent of FPL (Brooks et al. 2017).

The Affordable Care Act (ACA) was designed mainly to reduce uninsurance among adults, through tax credits and cost-sharing reductions for coverage on the new health insurance Marketplaces and the option for states to expand Medicaid eligibility to 138 percent of FPL for adults. So far, 31 states and the District of Columbia have implemented the Medicaid expansion under the ACA. But the law also included provisions expected to increase coverage among children (Kenney et al. 2011). In particular, declines in uninsurance were expected among children who were eligible but not already enrolled in Medicaid/CHIP as parents gained eligibility for Medicaid and subsidized Marketplace coverage; earlier research had shown that children gained coverage after coverage expansions to parents (Dubay and Kenney 2003; Kenney, Long, and Luque 2010; Kenney et al. 2012). Children's uninsurance rates did indeed fall after the implementation of the major coverage provisions of the ACA; evidence suggests a spillover effect whereby Medicaid and Marketplace coverage expansions to parents translated into gains in coverage and access to care for children (Alker and Pham 2017; Burak 2017; Hudson and Moriya 2017; Kenney et al. 2016b; Kenney et al. 2017; Lukanen, Schwehr, and Fried 2016; Venkataramani, Pollack, and Roberts 2017).

But the policy framework for children's coverage is now in doubt. CHIP has yet to be reauthorized, and several states anticipate funding gaps in the coming months that could lead to enrollment freezes or eligibility cutbacks for children (Kaiser Family Foundation 2017). The ACA's maintenance of eligibility (MOE) provisions require states to sustain eligibility for children's Medicaid/CHIP coverage at the levels in place when the ACA was enacted (Miskell and Alker 2015). If these provisions are not reauthorized, states could reduce children's Medicaid/CHIP eligibility to 138 percent of FPL—a large potential drop in every state. And though some states may further expand Medicaid to parents, major program changes now under consideration through legislation or waivers, such as work requirements and coverage time limits, could restrict enrollment for parents (Buderi 2017; Musumeci and Zur 2017). Finally, cuts to federal funding for Marketplace financial assistance and Medicaid (in the form of block grants or per capita caps) were part of every ACA repeal bill introduced in 2017 and may be revisited as part of future federal legislative efforts (Blumberg et al. 2017). The pressure to cut federal support for Medicaid, CHIP, and the Marketplaces may be especially strong under major tax reduction legislation that puts a large strain on the federal deficit.

This paper examines health insurance coverage among young children and their parents. Because the earliest years of a child's life are critical to healthy development, this analysis expands on previous research to focus on coverage among young children—those ages 3 and younger. We use data from the

American Community Survey (ACS) to describe national and state patterns of health insurance coverage among young children and their parents; compare these patterns with those for older children; study how these patterns have changed over time; identify the socioeconomic, family, and geographic characteristics of young children; and analyze variation in these characteristics by insurance status. Finally, using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) for the ACS, we assess the importance of the ACA's MOE protections for the coverage of young children by projecting how they would be affected if MOE provisions were eliminated and all states rolled back Medicaid/CHIP eligibility to 138 percent of FPL. We conclude with a discussion of the policy implications of our findings.

Results

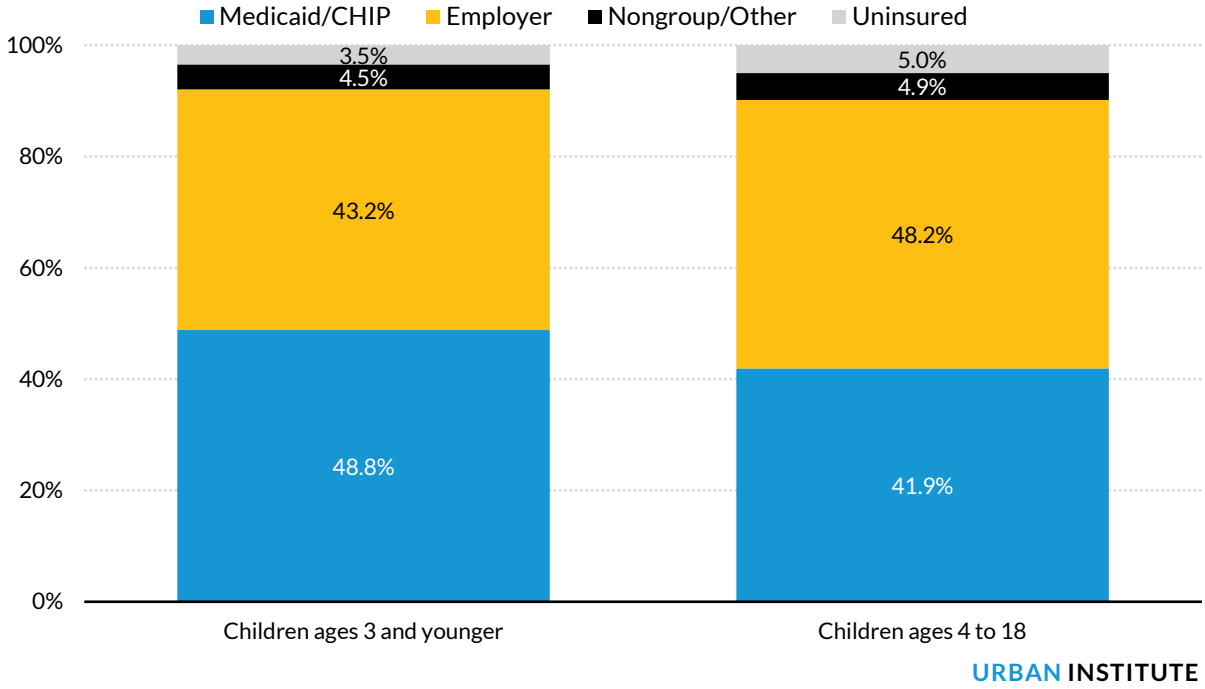
How does the health insurance coverage distribution of young children compare with that of older children?

In 2015, an estimated 15.7 million children were ages 3 or younger, constituting one in five of the nation's 77.9 million children (data not shown). Of these young children, nearly half (48.8 percent, or 7.7 million) had Medicaid/CHIP (figure 1). More children in this age group relied on Medicaid or CHIP for coverage than on any other type of insurance coverage. In 2015, 43.2 percent of young children had employer-sponsored coverage, and 4.5 percent had nongroup or other coverage (including coverage through health insurance Marketplaces). An estimated 3.5 percent of young children—543,000 children—were uninsured.

Older children were less likely than young children to have Medicaid/CHIP coverage (41.9 percent vs. 48.8 percent) and more likely to have employer coverage (48.2 percent vs. 43.2 percent). Older children had higher rates of uninsurance than young children—5.0 percent compared with 3.5 percent—nationally and in nearly every state.[2]

FIGURE 1

Health Insurance Coverage of Children Ages 18 and Younger, by Age, 2015



Source: Urban Institute analysis of 2015 American Community Survey data from the Integrated Public Use Microdata Series.
Notes: CHIP = Children's Health Insurance Program. Rates for children ages 3 and younger are significantly different from rates for children ages 4 to 18 at the 0.01 level.

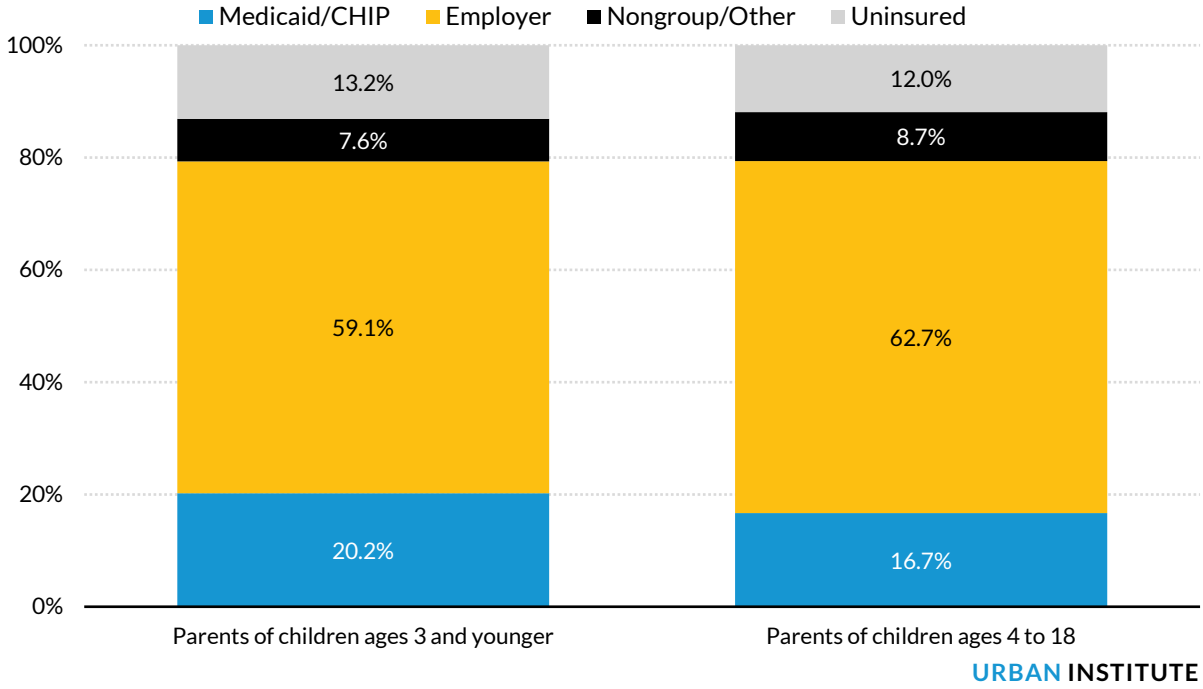
How does the health insurance coverage distribution among parents of young children compare with that among parents of older children?

In line with the patterns found among children, parents[3] of young children reported higher rates of Medicaid coverage (20.2 percent vs. 16.7 percent of parents of older children) and lower rates of employer-sponsored coverage (59.1 percent vs. 62.7 percent; figure 2). The parents of young children were more likely to be uninsured than the parents of older children (13.2 percent vs. 12.0 percent).

Though parents of young children were more likely to have employer and nongroup/other coverage than their children, they were much less likely to have Medicaid/CHIP coverage; consequently, a higher share of parents were uninsured. These parents were nearly four times more likely to be uninsured than their young children (13.2 percent vs. 3.5 percent).

FIGURE 2

Health Insurance Coverage of Parents of Children Ages 18 and Younger, by Child's Age, 2015



Source: Urban Institute analysis of 2015 American Community Survey data from the Integrated Public Use Microdata Series.
Notes: CHIP = Children's Health Insurance Program. "Parents of children ages 3 and younger" have at least one child age 3 or younger but may also have older children; "parents of children ages 4 to 18" have at least one child age 4 to 18 but may also have younger children. Rates for parents of children ages 3 and younger are significantly different from rates for parents of children ages 4 to 18 at the 0.01 level.

How have uninsurance rates changed over time for young children and their parents?

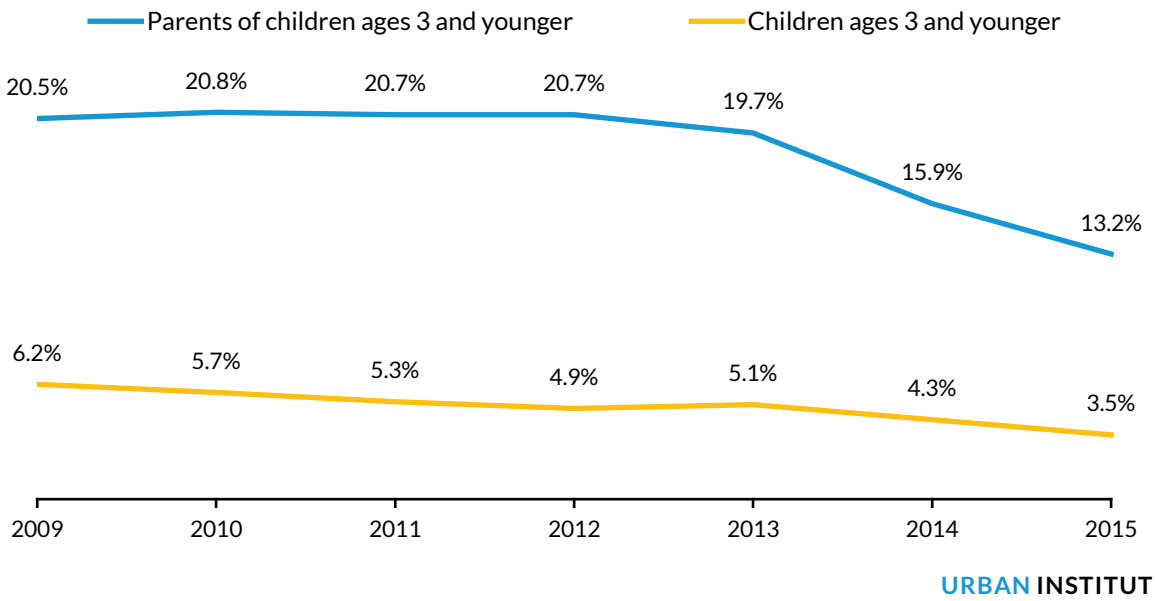
Figure 3 shows changes in uninsurance among young children and their parents between 2009 and 2015.[4] The uninsurance rate among young children fell by nearly half over this period, from 6.2 percent (1.0 million) in 2009 to 3.5 percent (543,000) in 2015, declining by 1.1 percentage points from 2009 to 2013 and by 1.6 percentage points between 2013 and 2015 under the ACA, mirroring trends among children overall (Gates et al. 2016).

In each year over this period, uninsurance was much higher among parents than among their young children, with these parents at least three times more likely to lack coverage than their children. Between 2009 and 2012, uninsurance among parents of young children was stable, ranging from 20.5 to 20.8 percent, and uninsurance fell by 1.0 percentage points to 19.7 percent in 2013. With the

implementation of the ACA's major coverage provisions in 2014—including Medicaid expansion in over half the states—uninsurance fell by 3.8 percentage points in 2014 (15.9 percent) and 2.7 percentage points in 2015 (13.2 percent), amounting to a decline of one-third during the first two years of the ACA.

FIGURE 3

Uninsurance among Children Ages 3 and Younger and Their Parents, 2009–15



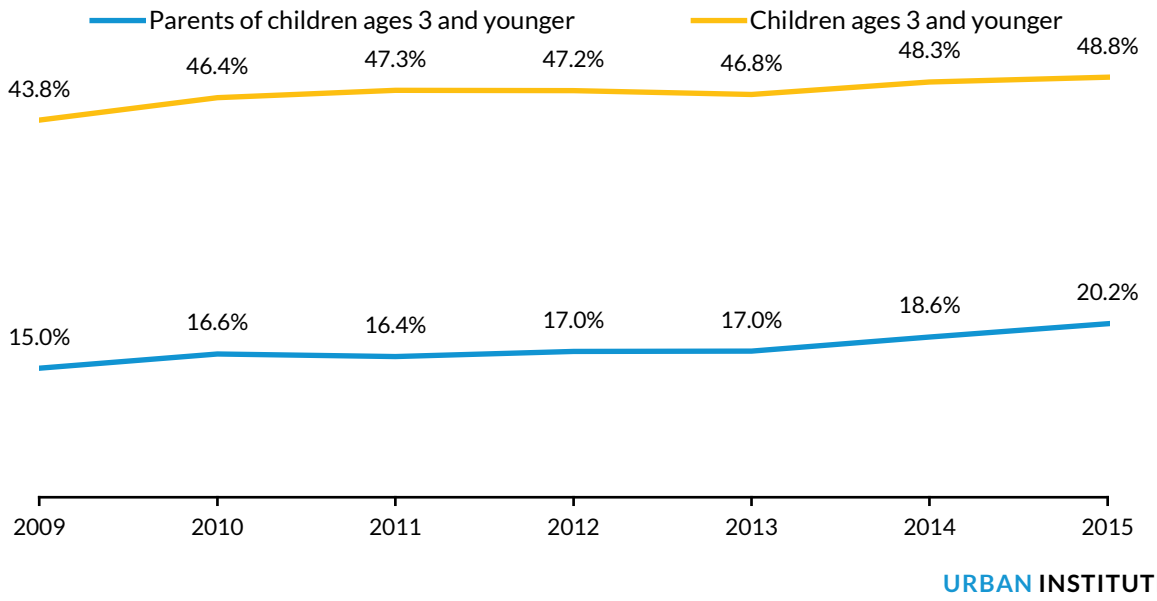
Source: Urban Institute analysis of 2009–15 American Community Survey data from the Integrated Public Use Microdata Series.
Note: Year-to-year changes for children and parents are statistically significant at the 0.01 level.

How have Medicaid/CHIP coverage rates changed over time for young children and their parents?

Concurrent with the reduction in uninsurance among young children, Medicaid/CHIP coverage rose over this period (figure 4). In 2009, 43.8 percent of young children had Medicaid/CHIP coverage, and by 2015, 48.8 percent did—an increase of 5.0 percentage points. Consistent with trends among children of all ages, this increase reflects declines in the number of children who were eligible for Medicaid/CHIP but not enrolled (Harrington et al. 2014; Johnston, Gates, and Kenney 2017; Kenney et al. 2016b; Kenney et al. 2017).

FIGURE 4

Medicaid/CHIP Coverage among Children Ages 3 and Younger and Their Parents, 2009–15



Source: Urban Institute analysis of 2009–15 American Community Survey data from the Integrated Public Use Microdata Series.
Note: Year-to-year changes for children and parents are statistically significant at the 0.01 level, except for the 2012–13 change for parents.

In each year, Medicaid coverage rates among parents of young children were much lower than Medicaid/CHIP coverage rates among their children. This is not surprising because eligibility levels were lower for parents than for children both before and after ACA implementation. Between 2009 and 2015, Medicaid coverage among parents of young children rose from 15.0 percent to 20.2 percent. While young children's Medicaid/CHIP coverage rose steadily over this period, most of the gains among their parents occurred after 2013, when the major coverage provisions of the ACA were implemented, reflecting trends for all parents (Kenney et al. 2016a, 2017).

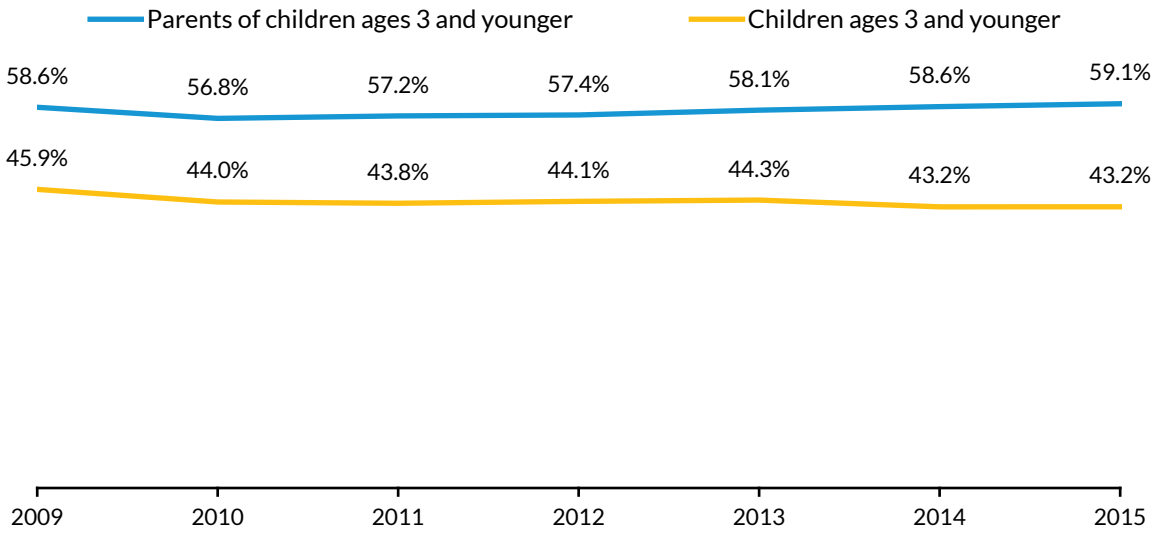
How have employer and nongroup/other coverage rates changed over time for young children and their parents?

Figures 5 and 6 show changes in employer-sponsored and nongroup/other coverage from 2009 to 2015. Rates of employer coverage were lower among young children than among their parents in each year. Rates of employer coverage among young children declined somewhat over this period, from 45.9 percent in 2009 to 43.2 percent in 2015, with almost all the decline occurring between 2009 and 2010

during the economic recession. Employer-sponsored coverage also fell among parents between 2009 and 2010, but rose slowly starting in 2011 to reach 59.1 percent in 2015, similar to the level in 2009.

FIGURE 5

Employer-Sponsored Coverage among Children Ages 3 and Younger and Their Parents, 2009–15



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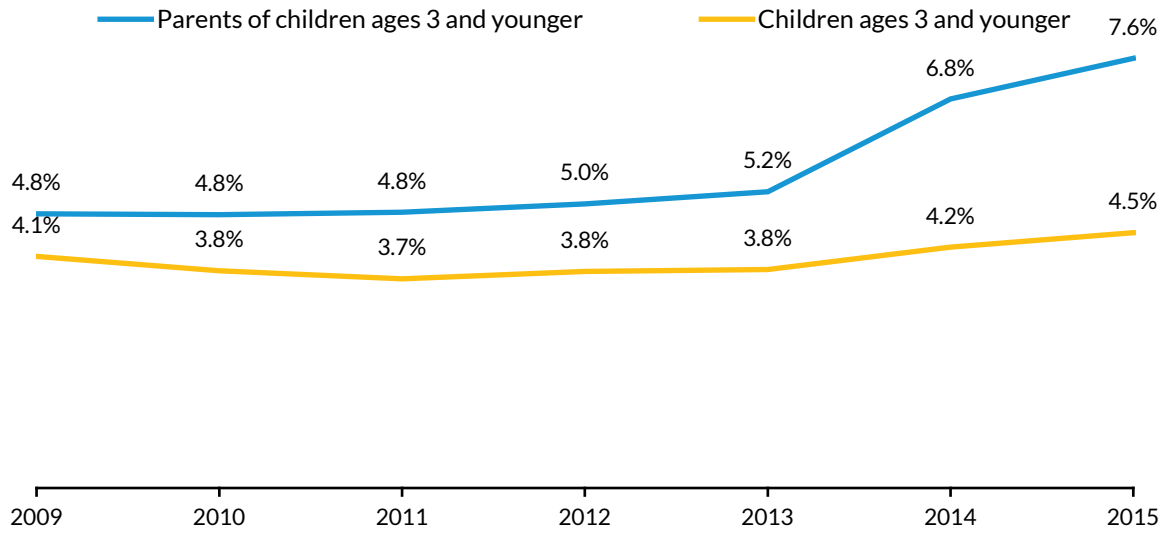
Source: Urban Institute analysis of 2009–15 American Community Survey data from the Integrated Public Use Microdata Series.
Note: Year-to-year changes for children and parents are statistically significant at the 0.01 level, except for the 2014–15 change for children.

Rates of nongroup/other coverage were relatively stable between 2009 and 2013. Until 2013, about 5 percent or less of children and of parents had nongroup/other coverage, and children were somewhat less likely to have such coverage than their parents. But after Marketplace coverage (subsidized and unsubsidized) became available under the ACA in 2014, nongroup/other coverage rose, particularly among parents. Parents' nongroup/other coverage rate increased by 1.6 percentage points (to 6.8 percent) from 2013 to 2014 and another 0.8 percentage points (to 7.6 percent) from 2014 to 2015.

FIGURE 6

Nongroup/Other Coverage among Children Ages 3 and Younger and Their Parents, 2009–15



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Source: Urban Institute analysis of 2009–15 American Community Survey data from the Integrated Public Use Microdata Series.
Note: Year-to-year changes for children and parents are statistically significant at the 0.01 level.

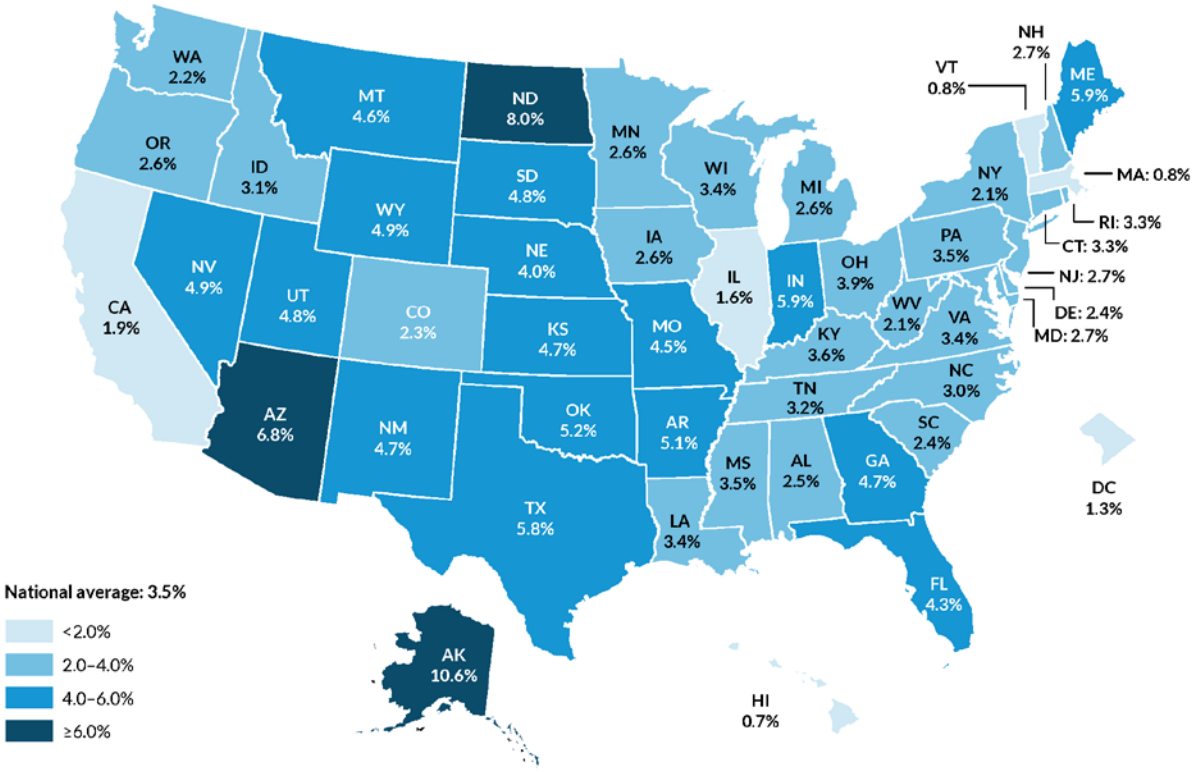
How does uninsurance among young children and their parents vary by state?

In 2015, uninsurance among young children ranged from less than 1 percent in Hawaii, Vermont, and Massachusetts to 8.0 percent in North Dakota and 10.6 percent in Alaska (figure 7). Forty-two states and the District of Columbia had uninsurance rates below 5 percent; Alaska, Arizona, Arkansas, Indiana, Maine, North Dakota, Oklahoma, and Texas had rates above 5 percent.

Seven states accounted for nearly half the nation's uninsured young children: Texas (91,000), Florida (37,000), California (37,000), Georgia (25,000), Arizona (23,000), Ohio (21,000), and Pennsylvania (20,000; appendix table B.1).

FIGURE 7

Uninsurance among Children Ages 3 and Younger, by State, 2015



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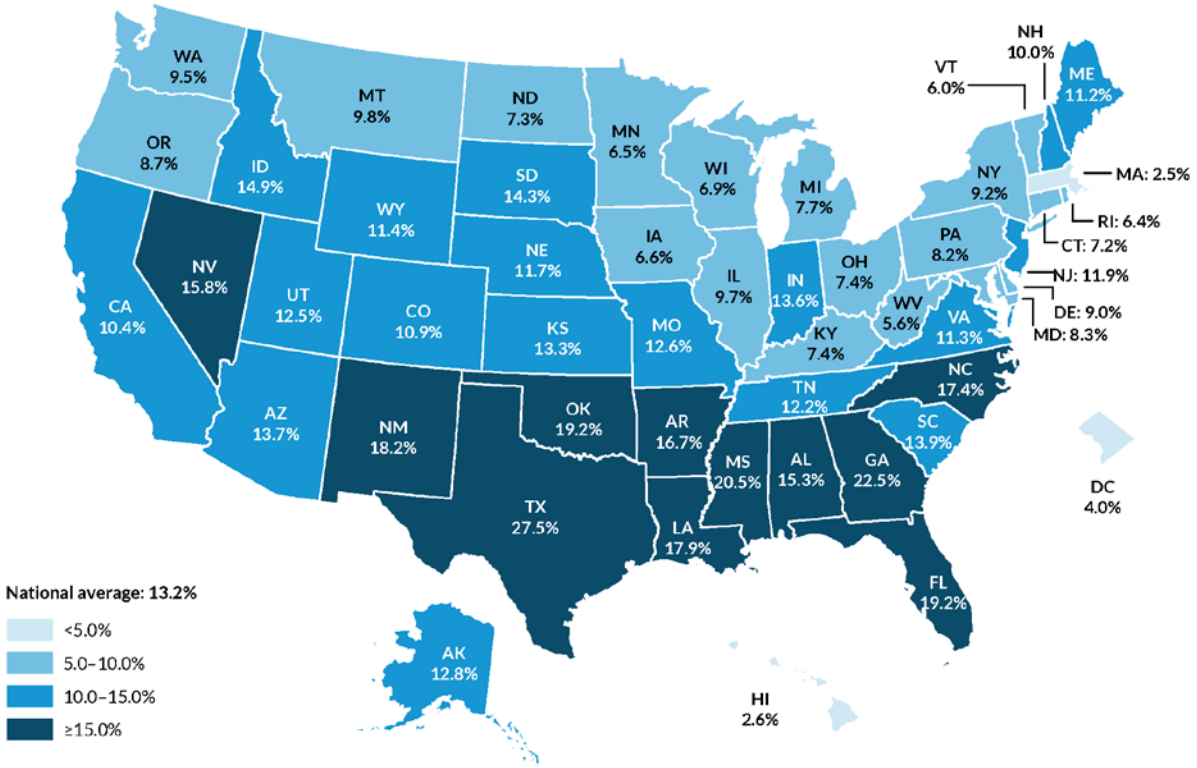
Source: Urban Institute analysis of 2015 American Community Survey data from the Integrated Public Use Microdata Series.
Note: State rates are significantly different from the national average at the 0.05 level except in Louisiana, Mississippi, and Virginia.

Uninsurance among parents of young children varied even more widely across states, ranging from below 3 percent in Massachusetts and Hawaii to over 20 percent in Texas, Georgia, and Mississippi (figure 8). Most (29) states had rates above 10 percent. The number of uninsured parents of young children was over 100,000 in Texas (525,000), California (252,000), Florida (193,000), Georgia (147,000), New York (104,000), and North Carolina (102,000; appendix table B.1).

FIGURE 8

Uninsurance among Parents of Children Ages 3 and Younger, by State, 2015



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Source: Urban Institute analysis of 2015 American Community Survey data from the Integrated Public Use Microdata Series.
Note: State rates are significantly different from the national average at the 0.05 level except in Kansas.

Uninsurance was lower among young children and among their parents in states that expanded Medicaid under the ACA. Consistent with patterns for all parents (Kenney et al. 2017), the uninsurance rate among parents of young children in nonexpansion states (18.5 percent) was nearly double that of parents in expansion states (9.5 percent). Nine of the 10 states with the lowest parent uninsurance rates were expansion states, and seven of the 10 states with the highest parent uninsurance rates were nonexpansion states (appendix table B.1).[5]

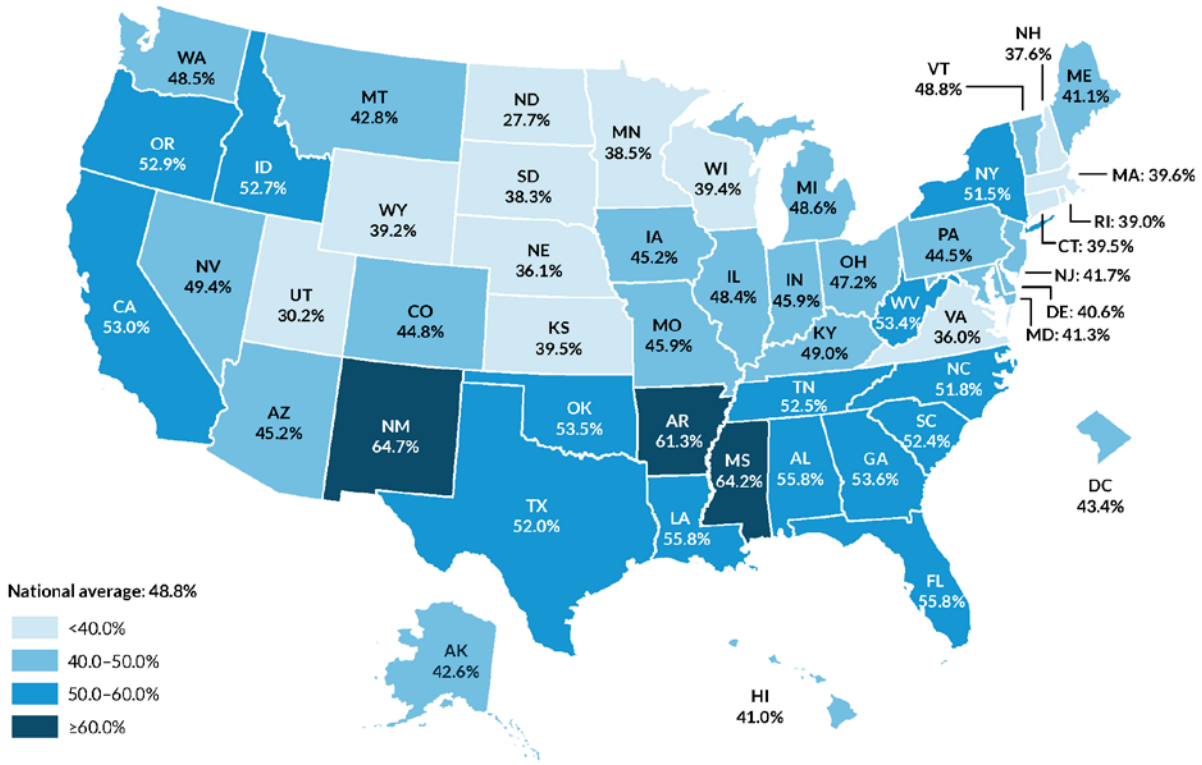
How does Medicaid/CHIP coverage among young children and their parents vary by state?

Though 48.8 percent of young children nationwide had Medicaid/CHIP, less than one in three in North Dakota (27.7 percent) and Utah (30.2 percent) were enrolled in Medicaid/CHIP, compared with over six

in 10 in Mississippi (64.2 percent) and New Mexico (64.7 percent; figure 9). More than 40 percent of young children were enrolled in Medicaid/CHIP in 37 states and the District of Columbia, and more than 50 percent were enrolled in 17 states. California and Texas had the highest numbers of young children with Medicaid/CHIP coverage—1.0 million and 808,000 respectively (appendix table B.2).

FIGURE 9

Medicaid/CHIP Coverage among Children Ages 3 and Younger, by State, 2015



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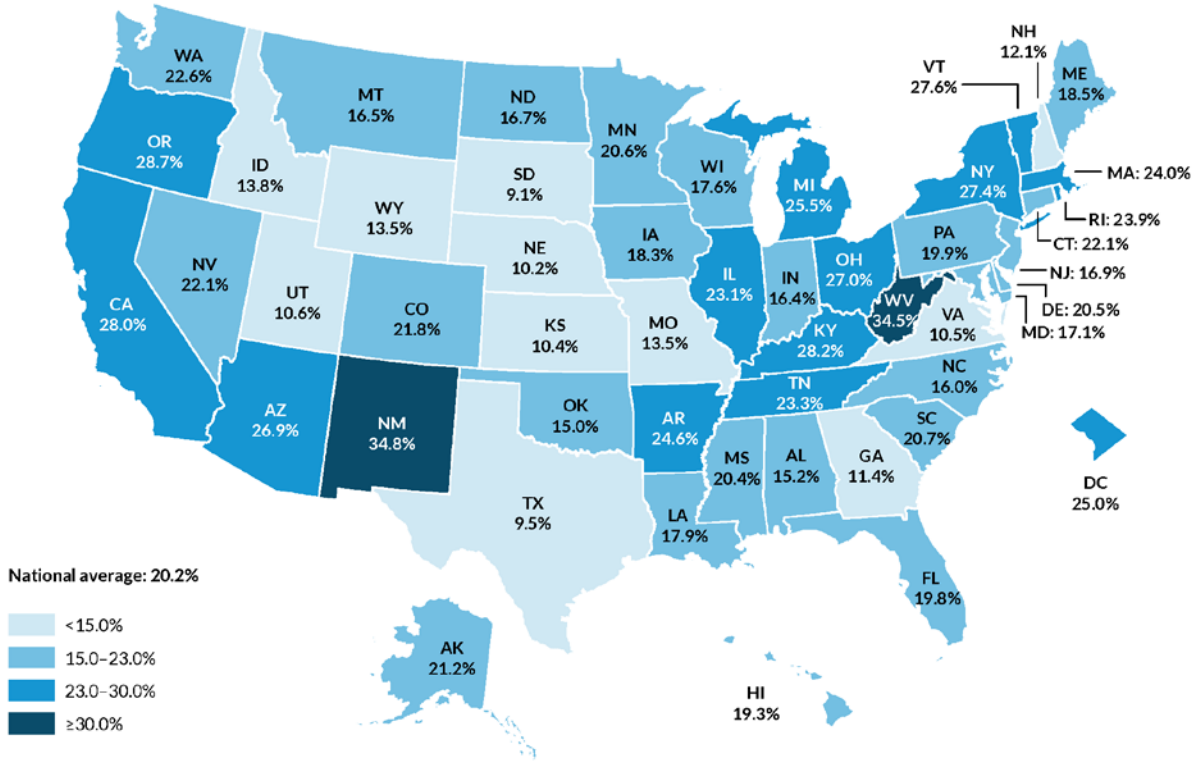
Source: Urban Institute analysis of 2015 American Community Survey data from the Integrated Public Use Microdata Series.
Note: State rates are significantly different from the national average at the 0.05 level except in Vermont.

Medicaid coverage among parents of young children varied even more widely, ranging from below 10 percent in South Dakota and Texas to above 34 percent in West Virginia and New Mexico (figure 10). This variation is not surprising, given the wide variation in Medicaid eligibility levels for parents across states. Medicaid coverage rates were much higher for parents of young children in expansion states (24.3 percent) than for those in nonexpansion states (14.3 percent), in line with the much higher availability of Medicaid coverage (appendix table B.2). The 10 states with the highest rates of Medicaid coverage among parents of young children had expanded Medicaid under the ACA by 2015, and nine of the 10 states with the lowest rates of Medicaid/CHIP coverage among parents of young children were

nonexpansion states (appendix table B.2).[6] In contrast, Medicaid/CHIP coverage rates for young children were similar in expansion and nonexpansion states, which is not surprising because the ACA's Medicaid expansion was targeted at adults.

FIGURE 10

Medicaid/CHIP Coverage among Parents of Children Ages 3 and Younger, by State, 2015



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Source: Urban Institute analysis of 2015 American Community Survey data from the Integrated Public Use Microdata Series.
Note: State rates are significantly different from the national average at the 0.05 level.

How do the characteristics of young children and their families compare with those of older children and their families?

Table 1 shows that certain characteristics of young children's families have important implications for their economic circumstances and access to health insurance coverage. Unsurprisingly, young children tended to have younger parents. Parental educational attainment was similar across children's age groups, but young children were less likely to have two full-time workers in the family and more likely to have parents not working or out of the labor force (possibly because of child care needs). Young

children were more likely to be poor and to receive Supplemental Nutrition Assistance Program benefits than older children.

TABLE 1

Characteristics of Children, by Age and Coverage Status, 2015

	All		Uninsured		Medicaid/CHIP		Employer/ Nongroup/Other	
	Age ≤3	Age 4–18	Age ≤3	Age 4–18	Age ≤3	Age 4–18	Age ≤3	Age 4–18
Family income								
<100% of FPL	29.3%***	25.6%	33.2%***	26.5%	53.2%***	49.8%	4.6%***	6.4%
100–138% of FPL	9.0%***	8.3%	11.4%***	10.1%	14.4%***	14.6%	3.3%***	3.2%
138–200% of FPL	12.8%***	12.3%	16.8%***	16.0%	15.8%***	16.4%	9.5%***	8.7%
200–400% of FPL	25.5%***	26.7%	24.8%***	25.4%	13.7%***	15.1%	37.6%***	35.9%
>400% of FPL	23.4%***	27.1%	13.7%***	22.0%	3.0%***	4.0%	45.1%***	45.8%
Race and ethnicity								
White, non-Hispanic	49.9%***	51.9%	46.6%***	38.5%	36.2%***	37.5%	64.2%***	64.6%
Hispanic	24.9%***	23.6%	30.7%***	39.4%	34.2%***	33.0%	15.1%***	14.7%
Black, non-Hispanic	13.3%***	13.6%	11.2%***	11.7%	19.3%***	19.5%	7.3%***	9.2%
Asian/Pacific Islander	4.8%***	4.9%	3.3%***	4.2%	3.2%***	3.7%	6.6%***	5.9%
American Indian/Alaska Native	2.1%***	2.1%	4.7%***	3.9%	2.6%***	2.7%	1.4%***	1.5%
Other/Multiple	4.9%***	3.7%	3.5%***	2.4%	4.5%***	3.6%	5.4%***	4.0%
Parents in household								
One parent	34.7%***	34.0%	34.7%***	33.5%	53.1%***	51.1%	16.0%***	20.6%
Multiple parents	62.6%***	60.6%	60.3%***	57.4%	42.9%***	42.5%	82.9%***	75.1%
Child only	2.7%***	5.4%	5.0%***	9.1%	4.0%***	6.4%	1.1%***	4.3%
Siblings (not mutually exclusive)								
Has siblings ages ≤3	31.2%***	17.8%	30.3%***	17.2%	32.2%***	23.1%	30.2%***	13.7%
Has siblings ages 4–18	53.1%***	69.8%	54.2%***	65.4%	58.9%***	72.3%	47.2%***	68.2%
No siblings	30.0%***	24.0%	31.9%***	29.7%	26.9%***	21.0%	33.1%***	25.9%
Parent's age (youngest)								
<19	19.7%***	3.1%	26.7%***	3.8%	29.9%***	5.4%	8.7%***	1.2%
19–25	56.0%***	28.8%	49.4%***	29.4%	48.7%***	37.6%	63.9%***	21.7%
26–30	19.9%***	43.4%	16.8%***	40.0%	15.1%***	36.4%	25.0%***	49.2%
31–35	1.8%***	19.4%	2.0%***	17.7%	2.3%***	14.2%	1.2%***	23.6%
No parents in family	2.7%***	5.4%	5.0%***	9.1%	4.0%***	6.4%	1.1%***	4.3%
Parents' health/coverage (not mutually exclusive)								
Has uninsured parent	16.0%***	14.3%	75.9%***	72.6%	25.3%***	22.9%	2.1%***	2.0%
Has parent with Medicaid	25.9%***	21.1%	0.8%	0.8%	52.2%***	49.5%	0.7%***	0.6%
All parents/Only parent uninsured	12.0%***	11.0%	65.7%***	62.5%	19.7%***	18.1%	0.2%***	0.5%
All parents have/Only parent has Medicaid	20.8%***	17.4%	0.4%***	0.5%	42.3%***	41.2%	0.3%***	0.2%
Parent has functional limitation	6.2%***	8.9%	5.0%***	7.2%	8.6%***	12.8%	3.8%***	6.0%
Highest educational attainment of parents								
Less than high school	8.6%***	8.9%	18.7%***	20.6%	15.2%***	16.6%	1.0%***	1.7%
High school	25.8%***	24.8%	31.9%***	31.7%	39.4%***	36.3%	11.4%***	15.0%
Some college	24.7%***	24.9%	23.8%***	21.8%	27.4%***	26.5%	22.1%***	23.9%
College graduate	38.3%***	36.1%	20.6%***	16.8%	14.0%***	14.2%	64.4%***	55.1%

	All		Uninsured		Medicaid/CHIP		Employer/ Nongroup/Other	
	Age ≤3	Age 4–18	Age ≤3	Age 4–18	Age ≤3	Age 4–18	Age ≤3	Age 4–18
Family work status								
More than one full-time worker	26.3%***	27.9%	15.7%***	19.2%	8.9%***	10.4%	45.0%***	42.6%
One full-time worker	52.6%***	51.7%	59.0%***	56.2%	55.9%***	54.2%	48.7%***	49.3%
Only part-time worker(s)	5.1%***	4.3%	5.5%***	4.7%	8.8%***	8.1%	1.3%***	1.4%
Not working or not in labor force	13.3%***	10.6%	14.8%***	10.8%	22.4%***	20.9%	3.8%***	2.5%
No parent in household	2.7%***	5.4%	5.0%***	9.1%	4.0%***	6.4%	1.1%***	4.3%
Family citizenship status								
Citizen child with noncitizen parent(s)	16.4%***	12.2%	20.1%***	17.3%	22.2%***	19.2%	10.2%***	6.3%
Citizen child with only citizen parents	80.0%***	79.6%	69.9%***	58.6%	73.2%***	71.9%	87.6%***	87.7%
Citizen child not living with parents	2.6%***	5.1%	4.7%***	7.5%	4.0%***	6.2%	1.1%***	4.1%
Noncitizen child	1.0%***	3.0%	5.3%***	16.6%	0.6%***	2.7%	1.1%***	1.9%
Parents' English proficiency								
Has parent who speaks English very well or better	88.1%***	83.8%	79.0%***	65.5%	80.7%***	75.6%	96.3%***	92.0%
No parent speaks English very well or better	11.9%***	16.2%	21.0%***	34.5%	19.3%***	24.4%	3.7%***	8.0%
Household SNAP recipiency								
Does not receive SNAP	71.3%***	76.6%	81.8%***	83.8%	46.3%***	50.8%	96.1%***	96.4%
Receives SNAP	28.7%***	23.4%	18.2%***	16.2%	53.7%***	49.2%	3.9%***	3.6%
Census region								
Northeast	16.2%***	16.2%	11.9%***	10.0%	15.1%***	15.4%	17.6%***	17.5%
Midwest	21.0%***	21.3%	20.8%***	17.4%	19.3%**	19.2%	22.7%***	23.2%
South	38.3%***	38.4%	46.6%***	50.3%	40.6%***	40.0%	35.3%***	36.0%
West	24.5%***	24.1%	20.6%***	22.3%	25.0%***	25.3%	24.4%***	23.3%
Metropolitan status								
Metropolitan area	79.7%***	78.7%	72.7%***	75.6%	77.8%***	77.2%	82.3%***	80.1%
Not in metropolitan area	7.7%***	8.0%	10.9%***	9.4%	8.8%***	9.1%	6.2%***	7.1%
Unclassifiable	12.6%***	13.3%	16.3%***	15.0%	13.4%***	13.8%	11.6%***	12.8%
State ACA Medicaid expansion status								
Expansion state	58.4%***	58.3%	47.3%***	44.3%	57.5%***	58.3%	60.2%***	59.5%
Nonexpansion state	41.6%***	41.7%	52.7%***	55.7%	42.5%***	41.7%	39.8%***	40.5%

Source: Urban Institute analysis of 2015 American Community Survey data from the Integrated Public Use Microdata Series.
Notes: ACA = Affordable Care Act; FPL = federal poverty level; SNAP = Supplemental Nutrition Assistance Program. Children are ages 18 and younger. State ACA Medicaid expansion status reflects decisions as of mid-2015.
/* Rate for children ages 3 and younger differs significantly from rate for older children at 0.05/0.01 level.

Though young children were more likely than older children to be citizens, they were more likely than older children to live in families with mixed immigration status: 16.4 percent of young children were citizens with at least one noncitizen parent, compared with 12.2 percent of older children. Lower rates of full-time work and lower income could reduce access to employer-sponsored insurance, and mixed immigration status could limit parents' eligibility for public coverage.

Thus, these family characteristics place young children at higher risk of having uninsured parents than older children. About 16 percent of young children had an uninsured parent, compared with 14.3 percent of older children—even though young children had a lower uninsurance rate (3.5 percent) than older children (5.0 percent). On the other hand, young children were more likely to have a parent enrolled in Medicaid—25.9 percent compared with 21.1 percent of older children—consistent with the higher rate of Medicaid coverage among these parents.

How do the characteristics of young children vary with insurance status?

Young children with Medicaid/CHIP coverage had lower family incomes on average than other young children (as expected, because Medicaid and CHIP are targeted at lower-income children). But almost a third (32.5 percent) of young children with Medicaid/CHIP coverage had incomes above 138 percent of FPL and are thus vulnerable to cutbacks of coverage above that level.[7] A third (33.2 percent) of uninsured children ages 3 and younger were poor, and nearly half (44.6 percent) had incomes below 138 percent of FPL. In contrast, the vast majority of young children with employer or nongroup/other coverage had incomes above 200 percent of FPL.

Though most young children who were uninsured or had Medicaid/CHIP were in families with at least one full-time worker, the worker did not necessarily have access to affordable employer-sponsored coverage. Just over three-quarters (75.9 percent) of uninsured children ages 3 and younger also had an uninsured parent. For most of these children (65.7 percent), the only parent in the household or both parents lacked coverage of any type. Though about half (52.2 percent) of young children with Medicaid/CHIP had at least one parent with Medicaid, 25.3 percent had at least one uninsured parent and 19.7 percent had no parent with insurance coverage. In contrast, the parents of almost all children with employer-sponsored or nongroup/other coverage were insured.

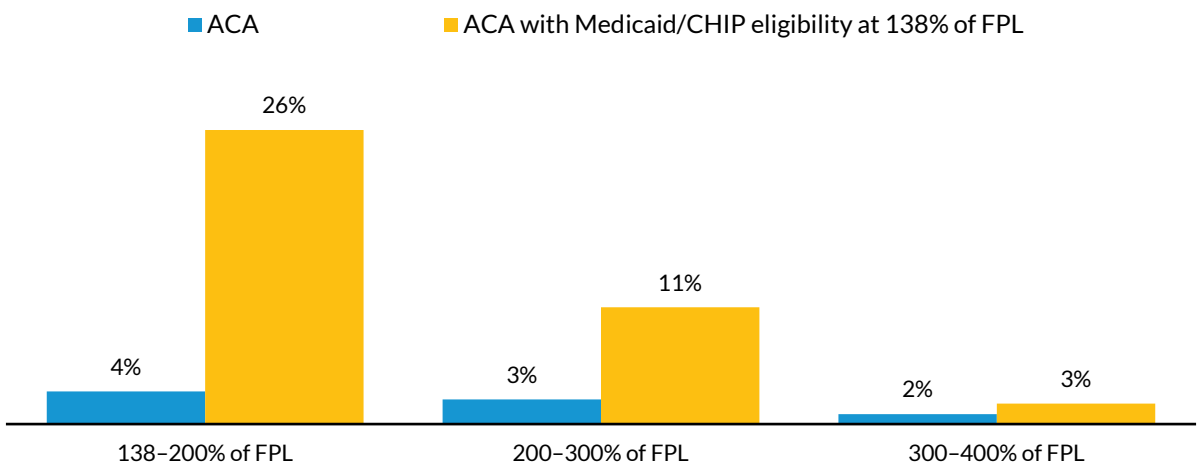
Most young children with employer-sponsored or nongroup/other coverage were citizens with citizen parents, but 20.1 percent of uninsured children ages 3 and younger were in mixed-citizenship families, and another 5.3 percent were noncitizens. In addition, 22.2 percent of young children with Medicaid/CHIP coverage were in mixed-citizenship families, and about one in five young children who were uninsured or enrolled in Medicaid/CHIP had no parent who spoke English very well or better.

How would uninsurance among young children change if states reduced Medicaid/CHIP eligibility to 138 percent of FPL?

Figure 11 uses the Urban Institute's HIPSM to project the effect on young children's coverage in 2018 if MOE provisions are lifted as part of CHIP reauthorization and all states reduce Medicaid/CHIP eligibility to the federal minimum of 138 percent of FPL.[8] Young children's reliance on Medicaid/CHIP coverage makes them especially vulnerable to cutbacks in Medicaid/CHIP funding and eligibility. Under current law, an estimated 2 to 4 percent of young children in the specified income bands are projected to be uninsured in 2018, consistent with trends shown above. Under reduced Medicaid/CHIP eligibility, roughly six times more children between 138 and 200 percent of FPL are projected to be uninsured in 2018, and more than three times more children between 200 and 300 percent of FPL. Uninsurance is also projected to be significantly higher in nearly every state (appendix table B.3).[9] Though these projections model Medicaid/CHIP eligibility as 138 percent of FPL or below under MOE elimination, they also assume that Marketplace subsidies and other ACA insurance provisions such as the individual mandate remain in place. Effects on uninsurance would be less severe if some states did not choose to cut back eligibility, but the uninsurance rates of young children would increase even further if ACA subsidies and enrollment efforts were reduced or eliminated.

FIGURE 11

Projected Uninsurance Rates among Children Ages 3 and Younger under Current Law and with Medicaid/CHIP Eligibility Reduced to 138 Percent of FPL, by Income, 2018



Source: HIPSM 2017.

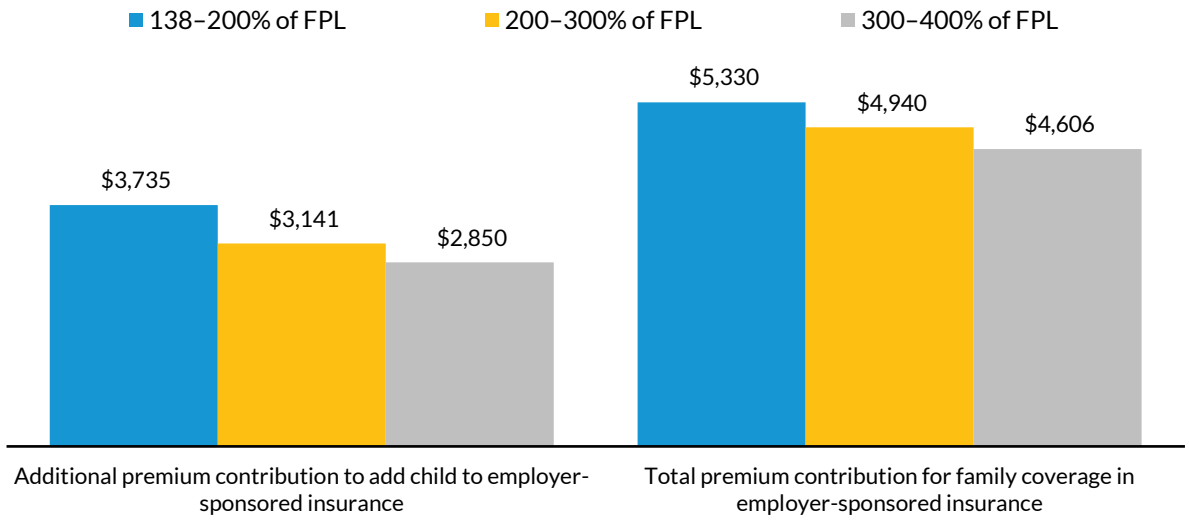
Notes: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; FPL = federal poverty level. If maintenance of eligibility provisions are eliminated, states could reduce Medicaid/CHIP eligibility to 138 percent of FPL for children. Rates under current law are significantly different from rates with eligibility at 138 percent of FPL at the 0.01 level.

How would out-of-pocket burdens among young children change if states reduced Medicaid/CHIP eligibility to 138 percent of FPL?

Building on these projected coverage changes, figure 12 shows the out-of-pocket premium contributions for employer coverage of families whose young children would lose Medicaid/CHIP coverage and become eligible for employer-sponsored coverage if Medicaid/CHIP eligibility were reduced to 138 percent of FPL. Families in the specified income groups would have to pay an additional $2,850 to $3,735 a year to add a child to employer coverage, with total premium contributions for family coverage averaging $4,606 to $5,330. Larger costs would fall on lower-income families. For instance, families between 138 and 200 percent of FPL would face an additional $3,735 in premium contributions, compared with $2,850 for those between 300 and 400 percent of FPL.

FIGURE 12

Projected Average Out-of-Pocket Premium Marginal Cost and Total Cost for Children Ages 3 and Younger Who Would Lose Medicaid/CHIP Coverage and Become Eligible for Employer-Sponsored Coverage, by Income, 2018



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Source: HIPSM 2017.
Note: FPL = federal poverty level.

Conclusion

This brief examined health insurance coverage among young children and their parents at the national and state levels. Children ages 3 and younger were less likely than older children to be uninsured. In 2015, less than 5 percent of these children lacked coverage, indicating that relatively few young children experienced lack of insurance coverage as a barrier to getting the health care they need to thrive.

After coverage expansions to adults and innovations and improvements in enrollment and renewal processes, Medicaid/CHIP coverage rose among young children between 2009 and 2015. In 2015, nearly half of young children had Medicaid/CHIP coverage—a higher share than among older children. This meant that many low-income children could be reached by Medicaid and CHIP at the critical early ages before they have access to other supports (such as those in school systems). For instance, young children with Medicaid/CHIP coverage can receive preventive health services under Medicaid's Early and Periodic Screening, Diagnosis, and Treatment benefit, which is designed to identify and treat health problems before they get worse.[10] Vision, dental, behavioral, and developmental screenings and appropriate follow-up care and treatment can set young children up for better health and functioning in childhood, making Medicaid/CHIP a critical link to children's readiness for school (Johnson and Rosenthal 2009; Kenney and Pelletier 2010).

Parents of young children were also more likely than other parents to have Medicaid coverage in 2015. Specifically, these parents experienced increases in Medicaid and nongroup/other coverage (including Marketplace coverage) under the ACA, while rates of employer-sponsored coverage were relatively stable; as a result, uninsurance among these parents fell sharply after ACA implementation. These coverage gains not only improved access to needed health care for parents (McMorrow et al. 2017), but also translated into gains in coverage and access for their children (Hudson and Moriya 2017; Venkataramani, Pollack, and Roberts 2017). Moreover, parents' Medicaid coverage rates were much higher, and uninsurance rates much lower, in expansion states than in nonexpansion states. This suggests that if more states choose to expand Medicaid, parents could see further coverage gains—which could, in turn, translate into improved coverage, health care access, and health outcomes for their children.

But parents of young children were also more likely to be uninsured than parents of older children. In particular, they were less likely to have employer-sponsored or nongroup/other health insurance, because of family characteristics including mixed immigration status, lower incomes, and lower rates of

full-time work. Parents of young children were nearly four times more likely than their children to lack insurance coverage, which could undermine the financial stability and well-being of the entire family.

Because young children and their families rely so heavily on Medicaid and CHIP, they are especially vulnerable to changes in the eligibility and enrollment policies of these programs—even more so than older children and their families (Chester and Burak 2016).[11] Congress appears to be moving forward on extending CHIP funding and continuing MOE provisions,[12] but it has not yet done so. If these protections are rescinded and states reduce eligibility, uninsurance among young children is projected to rise steeply. And Medicaid program changes under consideration for adults, such as coverage time limits and work requirements, could have outsize effects on the families of young children, given the high rates of Medicaid coverage among their parents. Finally, ACA repeal proposals containing substantial cuts to federal spending for Medicaid and other health coverage assistance are likely to come before Congress again next year (Blumberg et al. 2017).

Because three in 10 young children are poor and one in six has an uninsured parent, many families of children ages 3 and younger are already at risk for serious financial hardships and related problems (Hamel et al. 2016). Coverage losses among children or parents could imperil the financial stability of the entire family. Moreover, the impact of contractions in Medicaid and CHIP eligibility would likely vary across states, given the wide variation in uninsurance and Medicaid/CHIP coverage. In 2015, state uninsurance rates ranged from less than 1 percent to more than 10 percent for young children and from less than 3 percent to more than 20 percent for their parents; Medicaid/CHIP coverage rates ranged from less than 28 percent to more than 64 percent for young children and from less than 10 percent to more than 34 percent for their parents. Because the earliest years of a child's life set the foundation for healthy development, it will be critical to assess the impact of future Medicaid/CHIP policy changes on the health and well-being of young children and their families.

Appendix A. Data and Methods

American Community Survey

This brief uses the 2009–15 American Community Survey, an annual survey fielded by the US Census Bureau (Ruggles et al. 2015); this analysis is limited to noninstitutionalized civilians. Young children are defined as those ages 3 and younger, older children as those ages 4 to 18. A parent is defined as an adult living in a household with a biological child, adoptive child, or stepchild younger than 19. "Parents of young children" have at least one child age 3 or younger but may also have older children; "parents of older children" have at least one child age 4 to 18 but may also have young children.[13] The sample size in the 2015 ACS is 128,000 young children and 174,000 parents of young children. The ACS is fielded continuously over the course of the year, so the estimates reported here reflect averages for each year.

Health Insurance Policy Simulation Model (HIPSM)

Estimates of potential coverage impacts of the discontinuation of maintenance of eligibility protections and cutbacks of eligibility to 138 percent of FPL are based on the Urban Institute's Health Insurance Policy Simulation Model (Buettgens, Kenney, and Pan 2016; Buettgens et al. 2013). Coverage projections are modeled to simulate the state of coverage in 2018. To simulate MOE elimination, we model coverage with Medicaid/CHIP eligibility at 138 percent of FPL. If MOE provisions are discontinued, some states could choose to maintain eligibility, and others could choose to eliminate Medicaid and CHIP coverage for children younger than 6 with family incomes above 138 percent of FPL and for children ages 6 to 18 with family incomes above 100 percent of FPL. In this analysis, we do not predict which states would choose which option. Rather, we estimate the effects of all states eliminating Medicaid and CHIP coverage for children above federal minimum standards under MOE discontinuation. Projected changes would be smaller if some states choose to maintain eligibility using state funding.

Analysis

Health insurance coverage in the ACS is measured as status at the time of the survey, which differs from some other data sources that measure health insurance coverage status during the previous year. Insurance coverage is categorized as Medicaid/CHIP, employer-sponsored insurance, nongroup/other coverage (including Marketplace enrollees), and uninsured. Medicaid and CHIP coverage cannot be separately identified in this data source. To address potential misclassification of coverage on the ACS, we applied a set of coverage edits (Lynch et al. 2011).

We also examine estimates for each of the 50 states and the District of Columbia, according to state ACA Medicaid expansion status as of mid-2015 (29 states participated in the expansion by mid-2015) and according to socioeconomic, family, and geographic characteristics including family income as a percentage of FPL, race and ethnicity, number of parents, presence of siblings in young and older age groups (not mutually exclusive), parents' age (defined as the age of the youngest parent in the family), parents' insurance status (having a parent who is uninsured or having one's only parent in the household or both parents uninsured), parents' Medicaid coverage (having a parent who is enrolled in Medicaid or having one's only parent in the household or both parents enrolled in Medicaid), parents' functional limitation status (experiencing cognitive difficulties, trouble performing tasks outside the home, physical limitations, difficulty caring for oneself, or vision or hearing difficulties), highest educational attainment among parents in the family, family work status, family citizenship status (being a citizen child with at least one noncitizen parent [mixed immigration status], being a citizen child with only citizen parents, being a citizen child not living with parents, or being a noncitizen child), parents' English proficiency, household receipt of Supplemental Nutrition Assistance Program benefits over the past 12 months, region of residence, metropolitan/nonmetropolitan residency, and state ACA Medicaid expansion status as of mid-2015.

Limitations

Like all estimates that rely on survey data, coverage status and other characteristics may be measured with error. Coverage estimates from the ACS are consistent with other surveys, but there are potential sources of measurement error (Boudreaux et al. 2015). Changes to the data or methods for computing estimates could bias comparisons over time, and the misclassification of Medicaid/CHIP and other types of coverage in national surveys may have risen under the ACA; this may especially affect the ACS because it does not include ACA Marketplace coverage as a separate category or state-specific names

for Medicaid or CHIP. Additional details about methodology and assumptions underlying the projections under MOE discontinuation are available in Buettgens, Kenney, and Pan (2016).

Appendix B. Supplemental Tables

APPENDIX TABLE B.1

Uninsurance among Children Ages 3 and Younger and Their Parents, by State and State Medicaid Expansion Status, 2015

	Children Ages ≤3		Parents of Children Ages ≤3	
	Number (thousands)	Rate	Number (thousands)	Rate
Expansion states	**256**	**2.8%*** **	**1,087**	**9.5%*** **
Arizona	23	6.8%***	59	13.7%***
Arkansas	8	5.1%***	31	16.7%***
California	37	1.9%***	252	10.4%***
Colorado	6	2.3%***	39	10.9%***
Connecticut	<5	3.3%***	13	7.2%***
Delaware	<5	2.4%***	<5	9.0%***
District of Columbia	<5	1.3%***	<5	4.0%***
Hawaii	<5	0.7%***	<5	2.6%***
Illinois	10	1.6%***	76	9.7%***
Indiana	20	5.9%***	55	13.6%***
Iowa	<5	2.6%***	13	6.6%***
Kentucky	8	3.6%***	20	7.4%***
Maryland	8	2.7%***	30	8.3%***
Massachusetts	<5	0.8%***	9	2.5%***
Michigan	12	2.6%***	44	7.7%***
Minnesota	7	2.6%***	25	6.5%***
Nevada	7	4.9%***	27	15.8%***
New Hampshire	<5	2.7%***	6	10.0%***
New Jersey	11	2.7%***	64	11.9%***
New Mexico	5	4.7%***	21	18.2%***
New York	20	2.1%***	104	9.2%***
North Dakota	<5	8.0%***	<5	7.3%***
Ohio	21	3.9%***	52	7.4%***
Oregon	<5	2.6%***	20	8.7%***
Pennsylvania	20	3.5%***	59	8.2%***
Rhode Island	<5	3.3%**	<5	6.4%***
Vermont	<5	0.8%***	<5	6.0%***
Washington	8	2.2%***	46	9.5%***
West Virginia	<5	2.1%***	<5	5.6%***
Nonexpansion states	**286**	**4.4%*** **	**1,484**	**18.5%*** **
Alabama	6	2.5%***	42	15.3%***
Alaska	<5	10.6%***	7	12.8%**
Florida	37	4.3%***	193	19.2%***
Georgia	25	4.7%***	147	22.5%***
Idaho	<5	3.1%***	17	14.9%***
Kansas	7	4.7%***	27	13.3%
Louisiana	8	3.4%	52	17.9%***
Maine	<5	5.9%***	8	11.2%***
Mississippi	5	3.5%	35	20.5%***
Missouri	14	4.5%***	49	12.6%***
Montana	<5	4.6%***	6	9.8%***
Nebraska	<5	4.0%***	16	11.7%***

	Children Ages ≤3		Parents of Children Ages ≤3	
	Number (thousands)	Rate	Number (thousands)	Rate
North Carolina	14	3.0%***	102	17.4%***
Oklahoma	11	5.2%***	48	19.2%***
South Carolina	6	2.4%***	38	13.9%***
South Dakota	<5	4.8%***	8	14.3%***
Tennessee	10	3.2%***	46	12.2%***
Texas	91	5.8%***	525	27.5%***
Utah	10	4.8%***	33	12.5%***
Virginia	14	3.4%	57	11.3%***
Wisconsin	9	3.4%***	23	6.9%***
Wyoming	<5	4.9%***	<5	11.4%***
Total	***543***	***3.5%***	***2,571***	***13.2%***

Source: Urban Institute analysis of 2015 American Community Survey data from the Integrated Public Use Microdata Series.
Notes: State ACA Medicaid expansion status reflects decisions as of mid-2015. Estimates of fewer than 5,000 cases are suppressed.
*/**/*** State rate differs significantly from the national average at 0.10/0.05/0.01 level.

APPENDIX TABLE B.2

Medicaid/CHIP Coverage among Children Ages 3 and Younger and Their Parents, by State and State Medicaid Expansion Status, 2015

	Children Ages ≤3		Parents of Children Ages ≤3	
	Number (thousands)	Rate	Number (thousands)	Rate
Expansion states	**4,398**	**48.0%*** **	**2,780**	**24.3%*** **
Arizona	154	45.2%***	115	26.9%***
Arkansas	93	61.3%***	46	24.6%***
California	1,049	53.0%***	677	28.0%***
Colorado	117	44.8%***	77	21.8%***
Connecticut	59	39.5%***	40	22.1%***
Delaware	18	40.6%***	11	20.5%***
District of Columbia	16	43.4%***	9	25.0%***
Hawaii	31	41.0%***	16	19.3%***
Illinois	296	48.4%***	181	23.1%***
Indiana	153	45.9%***	66	16.4%***
Iowa	68	45.2%***	36	18.3%***
Kentucky	106	49.0%**	75	28.2%***
Maryland	117	41.3%***	62	17.1%***
Massachusetts	115	39.6%***	91	24.0%***
Michigan	223	48.6%**	145	25.5%***
Minnesota	108	38.5%***	80	20.6%***
Nevada	68	49.4%***	38	22.1%***
New Hampshire	19	37.6%***	8	12.1%***
New Jersey	174	41.7%***	92	16.9%***
New Mexico	69	64.7%***	39	34.8%***
New York	482	51.5%***	309	27.4%***
North Dakota	12	27.7%***	10	16.7%***
Ohio	257	47.2%***	190	27.0%***
Oregon	94	52.9%***	65	28.7%***

	Children Ages ≤3		Parents of Children Ages ≤3	
	Number (thousands)	Rate	Number (thousands)	Rate
Pennsylvania	254	44.5%***	142	19.9%***
Rhode Island	17	39.0%***	14	23.9%***
Vermont	12	48.8%	8	27.6%***
Washington	172	48.5%***	109	22.6%***
West Virginia	44	53.4%***	30	34.5%***
Nonexpansion states	**3,251**	**49.9%*** **	**1,148**	**14.3%*** **
Alabama	126	55.8%***	42	15.2%***
Alaska	20	42.6%***	11	21.2%***
Florida	483	55.8%***	199	19.8%***
Georgia	281	53.6%***	75	11.4%***
Idaho	46	52.7%***	16	13.8%***
Kansas	60	39.5%***	21	10.4%***
Louisiana	135	55.8%***	51	17.9%***
Maine	21	41.1%***	12	18.5%***
Mississippi	94	64.2%***	35	20.4%***
Missouri	136	45.9%***	52	13.5%***
Montana	21	42.8%***	10	16.5%***
Nebraska	38	36.1%***	14	10.2%***
North Carolina	248	51.8%***	94	16.0%***
Oklahoma	110	53.5%***	38	15.0%***
South Carolina	119	52.4%***	56	20.7%**
South Dakota	17	38.3%***	5	9.1%***
Tennessee	166	52.5%***	88	23.3%***
Texas	808	52.0%***	182	9.5%***
Utah	60	30.2%***	28	10.6%***
Virginia	146	36.0%***	53	10.5%***
Wisconsin	105	39.4%***	59	17.6%***
Wyoming	12	39.2%***	6	13.5%***
Total	***7,649***	***48.8%***	***3,928***	***20.2%***

Source: Urban Institute analysis of 2015 American Community Survey data from the Integrated Public Use Microdata Series.
Notes: State ACA Medicaid expansion status reflects decisions as of mid-2015.
*/**/*** State rate differs significantly from the national average at 0.10/0.05/0.01 level.

APPENDIX TABLE B.3

Employer-Sponsored Insurance Coverage among Children Ages 3 and Younger and Their Parents, by State and State Medicaid Expansion Status, 2015

	Children Ages ≤3		Parents of Children Ages ≤3	
	Number (thousands)	Rate	Number (thousands)	Rate
Expansion states	**4,172**	**45.6%*** **	**6,880**	**60.0%*** **
Arizona	144	42.2%***	224	52.5%***
Arkansas	45	29.9%***	94	50.4%***
California	812	41.0%***	1,320	54.6%***
Colorado	118	45.4%***	204	58.0%***
Connecticut	82	54.4%***	120	66.3%***
Delaware	23	53.8%***	36	66.3%***
District of Columbia	19	51.3%***	24	66.3%***

	Children Ages ≤3		Parents of Children Ages ≤3	
	Number (thousands)	Rate	Number (thousands)	Rate
Hawaii	33	43.6%*	51	63.1%***
Illinois	288	47.1%***	484	61.6%***
Indiana	155	46.6%***	252	63.0%***
Iowa	75	49.8%***	136	69.8%***
Kentucky	92	42.8%***	155	58.4%***
Maryland	143	50.6%***	245	67.4%***
Massachusetts	166	57.3%***	259	68.5%***
Michigan	212	46.2%***	352	62.1%***
Minnesota	155	55.4%***	257	65.9%***
Nevada	58	42.1%***	93	54.9%***
New Hampshire	28	56.2%***	46	73.0%***
New Jersey	221	53.0%***	359	66.4%***
New Mexico	28	26.5%***	49	43.0%***
New York	412	44.1%***	655	58.2%***
North Dakota	25	57.3%***	43	69.6%***
Ohio	252	46.4%***	433	61.4%***
Oregon	74	41.7%***	128	56.1%***
Pennsylvania	281	49.2%***	470	65.8%***
Rhode Island	23	53.0%***	39	63.8%***
Vermont	12	48.3%***	18	59.4%
Washington	157	44.0%***	286	59.4%***
West Virginia	35	43.0%	49	57.2%***
Nonexpansion states	**2,606**	**40.0%*** **	**4,631**	**57.7%*** **
Alabama	85	37.7%***	169	61.2%***
Alaska	17	36.0%***	29	54.6%***
Florida	293	33.9%***	500	49.6%***
Georgia	191	36.4%***	366	56.0%***
Idaho	34	39.1%***	66	56.7%***
Kansas	74	48.7%***	133	66.7%***
Louisiana	90	37.2%***	163	56.6%***
Maine	25	48.5%***	43	64.2%***
Mississippi	40	27.2%***	88	51.2%***
Missouri	135	45.3%***	251	65.0%***
Montana	21	44.2%***	37	61.2%***
Nebraska	54	51.0%***	90	67.2%***
North Carolina	170	35.6%***	316	53.9%***
Oklahoma	75	36.5%***	142	56.3%***
South Carolina	88	38.6%***	155	56.8%***
South Dakota	21	46.5%***	37	63.2%***
Tennessee	125	39.5%***	215	56.7%***
Texas	586	37.7%***	1,061	55.4%***
Utah	120	59.8%***	178	66.7%***
Virginia	203	50.0%***	333	66.0%***
Wisconsin	146	55.0%***	232	69.6%***
Wyoming	14	49.2%***	28	67.0%***
Total	***6,778***	***43.2%***	***11,512***	***59.1%***

Source: Urban Institute analysis of 2015 American Community Survey data from the Integrated Public Use Microdata Series.
Notes: State ACA Medicaid expansion status reflects decisions as of mid-2015.
*/**/*** State rate differs significantly from the national average at 0.10/0.05/0.01 level.

APPENDIX TABLE B.4

Nongroup/Other Coverage among Children Ages 3 and Younger and Their Parents, by State and State Medicaid Expansion Status, 2015

	Children Ages ≤3		Parents of Children Ages ≤3	
	Number (thousands)	Rate	Number (thousands)	Rate
Expansion states	**329**	**3.6%*** **	**712**	**6.2%*** **
Arizona	20	5.9%***	30	7.0%***
Arkansas	6	3.7%***	15	8.2%***
California	82	4.1%***	169	7.0%***
Colorado	19	7.5%***	33	9.3%***
Connecticut	<5	2.7%***	8	4.5%***
Delaware	<5	3.2%***	<5	4.2%***
District of Columbia	<5	4.1%***	<5	4.7%***
Hawaii	11	14.7%***	12	15.0%***
Illinois	17	2.8%***	45	5.7%***
Indiana	5	1.6%***	28	6.9%***
Iowa	<5	2.4%***	10	5.3%***
Kentucky	10	4.6%**	16	6.0%***
Maryland	15	5.4%***	26	7.2%***
Massachusetts	7	2.3%***	19	4.9%***
Michigan	12	2.5%***	27	4.8%***
Minnesota	10	3.6%***	27	6.9%***
Nevada	5	3.7%***	12	7.2%***
New Hampshire	<5	3.5%***	<5	5.0%***
New Jersey	11	2.6%***	26	4.7%***
New Mexico	<5	4.1%***	<5	4.0%***
New York	22	2.3%***	58	5.2%***
North Dakota	<5	7.0%***	<5	6.4%***
Ohio	14	2.6%***	29	4.2%***
Oregon	5	2.8%***	15	6.5%***
Pennsylvania	16	2.8%***	43	6.0%***
Rhode Island	<5	4.7%**	<5	5.8%***
Vermont	<5	2.1%***	<5	7.0%***
Washington	19	5.3%***	41	8.5%***
West Virginia	<5	1.4%***	<5	2.6%***
Nonexpansion states	**374**	**5.7%*** **	**759**	**9.5%*** **
Alabama	9	4.0%***	23	8.3%***
Alaska	<5	10.7%***	6	11.4%***
Florida	52	6.0%***	115	11.4%***
Georgia	28	5.3%***	66	10.1%***
Idaho	<5	5.2%***	17	14.6%***
Kansas	11	7.2%***	19	9.6%***
Louisiana	9	3.5%***	22	7.7%***
Maine	<5	4.4%	<5	6.1%***
Mississippi	7	5.1%***	14	7.9%***
Missouri	13	4.2%***	35	9.0%***
Montana	<5	8.3%***	7	12.5%***
Nebraska	9	8.9%***	15	10.9%***
North Carolina	46	9.7%***	74	12.7%***
Oklahoma	10	4.8%***	24	9.5%***
South Carolina	15	6.6%***	24	8.6%***
South Dakota	<5	10.3%***	8	13.4%***
Tennessee	15	4.7%***	29	7.8%***

	Children Ages ≤3		Parents of Children Ages ≤3	
	Number (thousands)	Rate	Number (thousands)	Rate
Texas	69	4.4%***	145	7.6%**
Utah	10	5.2%***	27	10.2%***
Virginia	43	10.5%***	61	12.2%***
Wisconsin	6	2.2%***	20	5.9%***
Wyoming	<5	6.8%***	<5	8.1%***
Total	***703***	***4.5%***	***1,471***	***7.6%***

Source: Urban Institute analysis of 2015 American Community Survey data from the Integrated Public Use Microdata Series.
Notes: State ACA Medicaid expansion status reflects decisions as of mid-2015. Estimates of fewer than 5,000 cases are suppressed.
*/**/*** State rate differs significantly from the national average at 0.10/0.05/0.01 level.

APPENDIX TABLE B.5

Projected Uninsurance Rates among Children Ages 3 and Younger under Current Law and with Medicaid/CHIP Eligibility Reduced to 138 Percent of FPL (without MOE), by Income, State, and State Medicaid Expansion Status, 2018

	138–200% of FPL		200–300% of FPL		300–400% of FPL	
	ACA	ACA w/o MOE	ACA	ACA w/o MOE	ACA	ACA w/o MOE
Expansion states	**3.2%**	**26.5%*** **	**2.3%**	**12.5%*** **	**1.4%**	**2.9%*** **
Arizona	13.4%	17.8%***	6.5%	6.0%***	1.2%	1.0%***
Arkansas	0.8%	19.9%***	2.6%	2.4%*	2.4%	2.4%
California	1.0%	22.4%***	1.4%	10.5%***	1.2%	1.2%
Colorado	1.2%	31.8%***	2.2%	18.0%***	3.2%	3.0%
Connecticut	0.7%	48.9%***	0.1%	24.3%***	2.1%	3.5%***
Delaware	4.4%	25.7%***	0.0%	0.7%***	0.6%	0.6%
District of Columbia	0.0%	35.4%***	0.0%	49.0%***	2.6%	16.4%***
Hawaii	0.3%	9.2%***	0.3%	5.9%***	0.1%	0.5%***
Illinois	4.2%	38.5%***	3.1%	18.7%***	1.5%	2.6%***
Indiana	7.6%	24.5%***	3.9%	7.3%***	3.8%	3.6%**
Iowa	2.8%	23.1%***	2.1%	14.2%***	1.0%	2.0%***
Kentucky	0.4%	19.0%***	0.9%	5.7%***	1.3%	1.2%
Maryland	0.6%	26.9%***	0.3%	17.5%***	1.6%	2.5%***
Massachusetts	0.0%	39.8%***	0.6%	22.1%***	1.0%	1.5%***
Michigan	5.3%	21.5%***	2.4%	5.1%***	0.4%	0.4%
Minnesota	7.3%	30.7%***	2.4%	12.0%***	0.9%	0.9%
Nevada	4.4%	22.6%***	6.9%	7.7%***	3.2%	3.2%
New Hampshire	2.1%	22.2%***	3.2%	17.6%***	0.4%	0.4%
New Jersey	1.3%	37.4%***	1.5%	19.0%***	2.5%	10.6%***
New Mexico	0.9%	30.7%***	0.4%	15.3%***	2.2%	5.1%***
New York	3.7%	34.6%***	2.2%	20.0%***	1.3%	10.2%***
North Dakota	11.6%	16.9%***	9.7%	9.7%	2.5%	2.5%
Ohio	3.0%	23.7%***	2.1%	3.7%***	1.1%	1.1%
Oregon	1.4%	23.7%***	1.3%	16.4%***	0.8%	1.4%***
Pennsylvania	5.3%	26.3%***	4.9%	13.7%***	0.9%	1.5%***
Rhode Island	0.0%	24.8%***	0.1%	12.9%***	1.5%	1.5%
Vermont	0.0%	54.4%***	1.6%	31.4%***	1.6%	2.4%***

	138–200% of FPL		200–300% of FPL		300–400% of FPL	
	ACA	ACA w/o MOE	ACA	ACA w/o MOE	ACA	ACA w/o MOE
Washington	0.5%	21.8%***	0.3%	12.8%***	1.2%	2.5%***
West Virginia	0.6%	17.8%***	0.8%	10.8%***	2.4%	2.7%
Nonexpansion states	**4.6%**	**25.4%*** **	**4.2%**	**8.8%*** **	**2.5%**	**2.5%**
Alabama	2.8%	22.0%***	3.1%	12.7%***	0.1%	2.0%***
Alaska	9.6%	26.4%***	8.8%	9.8%***	13.9%	13.9%
Florida	2.1%	30.2%***	2.6%	7.2%***	2.7%	2.2%***
Georgia	7.5%	23.5%***	5.3%	13.0%***	2.7%	2.7%
Idaho	2.4%	23.7%***	5.1%	5.1%	6.0%	6.0%
Kansas	6.6%	23.0%***	1.5%	6.1%***	0.5%	0.5%
Louisiana	1.0%	24.7%***	0.9%	12.9%***	1.5%	1.2%***
Maine	7.0%	54.6%***	3.3%	3.8%*	0.0%	0.0%
Mississippi	1.7%	25.9%***	3.9%	8.4%***	4.6%	4.6%
Missouri	3.1%	20.1%***	3.0%	15.9%***	2.2%	2.6%***
Montana	0.3%	21.8%***	3.5%	13.6%***	1.7%	1.7%
Nebraska	6.7%	12.1%***	3.0%	3.7%***	1.7%	1.7%
North Carolina	0.2%	16.8%***	2.3%	4.5%***	1.0%	0.9%
Oklahoma	5.0%	25.3%***	6.7%	9.1%***	3.0%	3.0%
South Carolina	3.8%	24.2%***	3.1%	6.8%***	3.2%	3.2%
South Dakota	5.8%	29.0%***	4.5%	4.9%	0.7%	0.7%
Tennessee	0.9%	26.9%***	1.1%	10.1%***	1.1%	1.1%
Texas	7.4%	29.5%***	7.6%	8.8%***	4.2%	4.3%
Utah	5.7%	14.8%***	3.6%	4.0%***	2.1%	2.1%
Virginia	4.9%	18.0%***	3.5%	4.7%***	1.6%	1.6%
Wisconsin	7.4%	43.8%***	2.4%	14.9%***	0.7%	0.7%
Wyoming	5.4%	13.1%***	7.4%	13.2%***	1.6%	1.6%
Total	***3.8%***	***26.1%**** **	***3.1%***	***10.9%**** **	***1.9%***	***2.7%**** **

Source: HIPSM 2017.

Notes: ACA = Affordable Care Act; FPL = federal poverty level; MOE = maintenance of eligibility. If MOE provisions are eliminated, states could reduce Medicaid/CHIP eligibility to 138 percent of FPL for children. State ACA Medicaid expansion status reflects decisions as of mid-2015.

*/**/*** Rate without MOE differs significantly from rate with MOE at the 0.10/0.05/0.01 level.

Notes

1 Gary W. Evans, Jeanne Brooks-Gunn, and Pamela Kato Klebanov, "Stressing Out the Poor: Chronic Physiological Stress and the Income-Achievement Gap," Pathways, Winter 2011, http://inequality.stanford.edu/sites/default/files/PathwaysWinter11_Evans.pdf.

2 Uninsurance rates were statistically significantly higher for older children than for young children in all states except the following: Louisiana, Maine, and Wisconsin, where the rates for the two age groups were not significantly different; Alaska, where the uninsurance rate for young children was 2.6 percentage points higher than that for older children, partially because of higher rates of Indian Health Service coverage among young children (which by convention is considered lack of coverage); and Arkansas, New Mexico, and Rhode Island, where the rates were lower for older children, but the two age groups differed by less than 1 percentage point. Medicaid/CHIP coverage rates were likewise higher for young children than for older children in nearly every state (data not shown).

3 Parents are classified by whether they had a young child (including parents with both young children and older children) or an older child (including parents with both young children and older children). Analysis and computation of standard errors took into account the overlapping samples. Results are sensitive to the treatment of parents who have both young children and older children; see appendix A.

4 The estimated number of children in this age group declined from 16.9 million in 2009 to 15.7 million in 2015 according to the ACS, consistent with declines in the number and share of children in the population over this period (Child Trends 2015).

5 Many other factors beyond Medicaid expansion also likely contribute to observed variation across states. For example, parents of young children in Arkansas and New Mexico, two expansion states, were uninsured at a higher rate than parents of young children in over half of nonexpansion states. This may be related to the characteristics of parents in those states; for example, parents of young children in Arkansas and New Mexico had lower incomes, were younger, and were more likely to live outside of metropolitan areas than parents of young children nationally, on average (data not shown).

6 Rates of employer-sponsored and nongroup/other coverage also varied across states (appendix tables B.3 and B.4). Nationally, 43.2 percent of young children and 59.1 percent of parents of young children had employer-sponsored coverage in 2015, with higher rates for parents than for children in every state. Rates of employer-sponsored coverage ranged from less than 30 percent in New Mexico, Mississippi, and Arkansas to 59.8 percent in Utah for young children, and from less than 50 percent in New Mexico and Florida to 73.0 percent in New Hampshire for parents of young children.

The share of young children with nongroup/other coverage was below 10 percent in 46 states and the District of Columbia. The share of parents of young children with nongroup/other coverage was below 10 percent in 39 states and the District of Columbia.

Rates of employer-sponsored coverage were somewhat higher in expansion states (45.6 percent for young children and 60.0 percent for parents of young children) than in nonexpansion states (40.0 percent and 57.7 percent). Rates of nongroup/other coverage were higher in nonexpansion states (5.7 percent and 9.5 percent) than in expansion states (3.6 percent and 6.2 percent). This was expected because parents in nonexpansion states could qualify for nongroup coverage through the Marketplaces if their income was between 100 and 138 percent of FPL, but parents in expansion states could not.

7 The share of Medicaid/CHIP-enrolled children ages 3 and younger with family incomes above 138 percent of FPL varied across states. For instance, less than one-quarter of these children in South Dakota (21.7 percent), West Virginia (22.2 percent), and Kentucky (24.3 percent) had incomes above this level, compared with over

half in New Hampshire (53.6 percent) and Vermont (50.4 percent). This likely reflects population and Medicaid/CHIP eligibility differences across states (data not shown).

8 Under MOE elimination, states could decide whether to reduce or maintain eligibility levels; this analysis assumes all states would reduce eligibility levels. See appendix A.

9 The projected impacts of rescinding MOE protections are also large for older children but somewhat lower than those for young children, with uninsurance projected to be nearly five times higher for older children between 138 and 200 percent of FPL and nearly three times higher for older children between 200 and 300 percent of FPL (data not shown).

10 "Early and Periodic Screening, Diagnostic, and Treatment," Centers for Medicare & Medicaid Services, accessed November 29, 2017, https://www.medicaid.gov/medicaid/benefits/epsdt/index.html.

11 Elisabeth Wright Burak and Stephanie Schmit, "Top Five Ways ACA Repeal and Medicaid Financing Changes Would Harm Our Youngest Children," *Say Ahhh!* (blog), Georgetown University Health Policy Institute, Center for Children and Families, February 27, 2017, https://ccf.georgetown.edu/2017/02/27/top-five-ways-aca-repeal-and-medicaid-financing-changes-would-harm-our-youngest-children/.

12 Joan Alker, "Positive Development for CHIP Emerges from Senate Finance Committee Leaders," *Say Ahhh!* (blog), Georgetown University Health Policy Institute, Center for Children and Families, September 13, 2017, https://ccf.georgetown.edu/2017/09/13/positive-development-for-chip-emerges-from-senate-finance-committee-leaders/.

13 In the 2015 ACS, 8.4 million parents had children ages 3 or younger only, 42.6 million had children ages 4 to 18 only, and 11.1 million had children in both age groups. The estimates for parents of young children include parents with young children only as well as those with both young children and older children. Some results are sensitive to the classification of parents with children in both age groups. For instance, if estimates for parents of young children excluded parents who also had older children, their health insurance coverage distribution in 2015 would be different: 16.8 percent would have Medicaid, 64.4 percent would have employer-sponsored coverage, 8.3 percent would have nongroup/other coverage, and 10.5 percent would be uninsured.

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Genevieve M. Kenney is a senior fellow and codirector of the Health Policy Center. She has been conducting policy research for over 25 years and is a nationally renowned expert on Medicaid, 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, variation in primary care 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.

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