In 2014, the Affordable Care Act (ACA) extended more affordable health insurance coverage options to millions of American families. Building on earlier efforts under the Children's Health Insurance Program Reauthorization Act of 2009, which expanded children's eligibility for public coverage and simplified enrollment processes, several ACA provisions had the potential to further increase coverage rates for children. In this brief, we explore changes in coverage among children in recent years using data from the National Health Interview Survey. We focus on changes by state Medicaid expansion status, age group, and race and ethnicity. We find the following:

- The uninsurance rate for all children fell from 8.3 percent in 2010 to 5.3 percent in 2017.
- Children in expansion states experienced a decline in the uninsurance rate from 6.1 percent in 2013 to 4.0 percent in 2015 and sustained these gains through 2017. The uninsurance rate for children in nonexpansion states dropped from 8.6 percent in 2013 to 6.0 percent in 2015 but then increased to 7.8 percent in 2017.
- Children in all age groups experienced declines in uninsurance from 2013 to 2015 in both expansion and nonexpansion states, but the uptick in uninsurance in nonexpansion states left only teens with a net coverage gain in those states by 2017.
- Hispanic children experienced strong coverage gains in expansion states that largely eliminated the gap in uninsurance between white and Hispanic children in those states by 2017.
- In 2017, uninsured children were more likely than insured children to be teens, to be Hispanic, and to live in the South.
- In 2017, about 43.6 percent of uninsured children had been uninsured for one year or less, while 13.8 percent had been uninsured for one to three years, and 42.7 percent had been uninsured for more than three years.
Children uninsured for one year or less were more likely to have an adult in their household report job loss or Medicaid loss as a reason the child was uninsured, while children uninsured for more than three years were more likely to have high costs or no perceived need for coverage reported as a reason they were uninsured.

**Background**

Following decades of efforts to expand health insurance coverage through Medicaid and the Children’s Health Insurance Program (CHIP), the uninsurance rate for children stood at approximately 8 percent when the ACA was passed in 2010. By comparison, the uninsurance rate among all nonelderly adults that year was 22.4 percent and, despite more generous eligibility for public insurance than their childless counterparts, the uninsurance rate for parents was 21.0 percent.\(^1\)

The ACA contained several provisions aimed at reducing uninsurance, including an expansion of Medicaid eligibility to adults with incomes up to 138 percent of the federal poverty level (FPL), federal subsidies for families with moderate incomes to purchase private insurance in the newly created health insurance Marketplaces, and a requirement that all Americans obtain health insurance coverage or pay a penalty. Ultimately, the Medicaid expansion was only implemented in 31 states and the District of Columbia by January 2017. Overall, recent estimates suggest that approximately 19 million people have gained insurance coverage since 2010 (Cohen, Zammitti, and Martinez 2018).

Several sources have documented a decline in the uninsurance rate for children since 2010 (Gates et al. 2016; Alker and Pham 2017). Following the CHIP reauthorization in 2009, new Medicaid and CHIP outreach and enrollment efforts and eligibility expansions were implemented that targeted children. In addition, the availability of subsidized Marketplace coverage and the individual mandate to obtain coverage included as part of the ACA likely enabled or encouraged some families to insure their children. Furthermore, the ACA Medicaid expansion likely had important implications for children’s coverage. Parents experienced significant reductions in uninsurance under the ACA (Karpman, Gates McMorrow, et al. 2016; Karpman and Kenney 2017; McMorrow et al. 2017), and evidence suggests that children are more likely to be covered when their parents have insurance (Aizer and Grogger 2003; Dubay and Kenney 2003; Kenney, Long and Luque 2010). Indeed, early findings have demonstrated that the ACA Medicaid expansion to parents had a positive coverage effect for already eligible children (Hudson and Moriya 2017).

Children under age 6 have historically had lower uninsurance rates than their older counterparts, and teenagers have had the highest uninsurance rates (Gates et al. 2016). Under the ACA, coverage gains have been documented through 2015 for children under age 6, ages 6 to 12, and ages 13 to 18 (Karpman, Gates, Kenney, et al. 2016; Gates et al. 2016) as well as through 2016 for children age 3 and younger (Haley, Wang, et al. 2018) and ages 6 to 18 (Wagnerman and Burak 2018).

While Medicaid and CHIP had largely eliminated differences in uninsurance rates between black and white children before implementation of the major ACA coverage expansions, Hispanic children had a much higher uninsurance rate than white or black children in 2013 (Gates et al. 2016). The
uninsurance rate among children in all racial and ethnic groups declined between 2013 and 2015, with particularly large coverage gains for Hispanic children (Schwartz et al. 2016).

Here, we update estimates of children’s coverage through 2017 and consider patterns by age group, race and ethnicity, and state Medicaid expansion status.

Data and Methods

We used data from the National Health Interview Survey (NHIS) to examine changes in insurance coverage for children (ages 0 to 18) from 2010 to 2017. We used public use data from the Integrated Public Use Microdata Series NHIS database, which provides harmonized versions of NHIS variables across all data years (Blewett et al. 2018), and we supplemented this with data from the 2017 early release file available at the National Center for Health Statistics research data center.²

We examined uninsurance at the time of the survey among children and considered changes over time in states that did and did not expand Medicaid under the ACA. We classified states that had expanded Medicaid by January 2017 as Medicaid expansion states and all others as nonexpansion states.³ We also examined coverage changes separately for children under age 6, those ages 6 to 12, and those ages 13 to 18 as well as for non-Hispanic white, non-Hispanic black, and Hispanic children.

We described the demographic and socioeconomic characteristics of the remaining uninsured children in 2017 and compared them to the characteristics of insured children. We included information on the education and citizenship of adults in a child's health insurance unit, which is a subset of the family definition used on the NHIS that better approximates the unit used to determine eligibility for various health insurance programs. We also examined the duration of uninsurance for uninsured children and classified those who had been uninsured for one year or less as short-term uninsured and those who had been uninsured for more than three years as long-term uninsured. Finally, we described the reasons a child was uninsured, as reported by an adult in the child's household, for all uninsured children and separately for short- and long-term uninsured children.

This analysis had several limitations. First, we relied on the early release file for our estimates of 2017 uninsurance rates. The early release file contains information on state Medicaid expansion status that is not available publicly, but it does not include final data edits and weights, so there may be small discrepancies between the early release estimates reported here and estimates using the final 2017 file with state identifiers.⁴ Second, the NHIS implemented a new sample design in 2016, and some differences between estimates from 2016 onward and estimates from earlier years may be attributable to the new sample design. Finally, the NHIS has a smaller sample size than other federal surveys, such as the American Community Survey or the Current Population Survey, and therefore estimates based on its data are less precise than estimates based on those sources. However, the NHIS has a longer consistent approach to measuring insurance coverage than the Current Population Survey and has more recent data available than the American Community Survey, so it continues to play an important role in tracking insurance coverage over time.
Results

From 2010 to 2017, the uninsurance rate among all children dropped from 8.3 percent to 5.3 percent (figure 1). In Medicaid expansion states, the uninsurance rate fell from 7.0 percent in 2010 to 3.6 percent in 2017, while children in nonexpansion states saw a decline from 10.3 percent in 2010 to 7.8 percent in 2017. However, although the NHIS data show that both expansion and nonexpansion states saw steady coverage gains from 2013 to 2015, they indicate that children in nonexpansion states experienced an uptick in uninsurance between 2015 and 2017.

**FIGURE 1**
Uninsurance Rate among Children Age 18 and under, by State Medicaid Expansion Status, 2010–17

![Graph showing uninsurance rate among children 2010-2017 by state Medicaid expansion status](image)

- **Source:** Urban Institute analysis of National Health Interview Survey data. Data for 2017 are from early release files.
- **Notes:** Coverage status is at the time of the survey. Medicaid expansion states are those that expanded as of January 2017. * Estimate differs significantly from 2017 estimate at p < 0.05.

When we consider coverage changes by age, we find significant reductions in uninsurance among all age groups in Medicaid expansion states from 2013 to 2017 (figure 2). The uninsurance rate fell from 4.5 percent to 2.9 percent among children under age 6, from 5.4 percent to 3.2 percent among those ages 6 to 12, and from 8.3 percent to 4.8 percent among teenagers. Despite their significant coverage
gain, the uninsurance rate for teens in expansion states remained higher than those in the younger age groups in 2017.

FIGURE 2
Uninsurance Rate among Children Age 18 and under, by Age and State Medicaid Expansion Status, 2013 and 2017

Source: Urban Institute analysis of National Health Interview Survey data. Data for 2017 are from early release files.
Notes: Coverage status is at the time of the survey. Medicaid expansion states are those that expanded as of January 2017.
* Estimate for 2017 differs significantly from 2013 estimate at p < 0.05.

In nonexpansion states, children in all age groups experienced gains in coverage between 2013 and 2015 but saw those gains recede between 2015 and 2017. As a result, there were no net changes in the uninsurance rate from 2013 to 2017 for children under age 6 or those ages 6 to 12. Teens experienced a net gain in coverage from 2013 to 2017 but still had a higher uninsurance rate (10.0 percent) in 2017 compared to children under age 6 (5.6 percent) and those ages 6 to 12 (7.6 percent). Moreover, children in nonexpansion states in each age group were more likely to be uninsured than their counterparts in expansion states in all years.
FIGURE 3
Uninsurance Rate among Children Age 18 and Under, by Race and Ethnicity and State Medicaid Expansion Status, 2013–17

Source: Urban Institute analysis of National Health Interview Survey data. Data for 2017 are from early release files. Notes: Coverage status is at the time of the survey. Expansion states are those that had expanded Medicaid as of January 2017.
* Estimate for 2017 differs significantly from 2013 estimate at p < 0.05.

Using the NHIS to examine coverage changes by race and ethnicity (figure 3), we find that black and Hispanic children in Medicaid expansion states experienced significant declines in uninsurance from 2013 to 2017, with most of the gains coming between 2013 and 2015. The uninsurance rate for black children fell from 4.4 percent in 2013 to 2.6 percent in 2017, and the uninsurance rate for Hispanic children fell from 10.8 percent in 2013 to 4.6 percent in 2017. Although the uninsurance rate for black children was similar to that for white children in expansion states in each year, the decline in uninsurance for Hispanic children from 2013 to 2017 largely eliminated a significant 2013 coverage gap between white and Hispanic children in expansion states. By 2017, the uninsurance rate for white children was not statistically different from that for black or Hispanic children in expansion states.

In nonexpansion states, children in all racial and ethnic groups experienced significant coverage gains between 2013 and 2015, but this pattern reversed between 2015 and 2017. The net coverage changes between 2013 and 2017 were therefore insignificant for all groups in nonexpansion states, and
each group had a higher uninsured rate in 2017 than their counterparts in expansion states. There were no significant differences in the uninsured rate between black and white children in nonexpansion states in 2017 or earlier years, but with an uninsured rate of 14.1 percent in 2017, Hispanic children in nonexpansion states were much more likely to be uninsured than any other group in expansion or nonexpansion states.

Remaining Uninsured Children in 2017

In 2017, estimates from the NHIS suggest that about 4.1 million children under age 19 remained uninsured. Compared to insured children, uninsured children were more likely to be in their teens and less likely to be under age 6 (table 1). Uninsured children were more likely to be male than insured children, and this relationship was particularly pronounced among teens: 57 percent of uninsured teens were male compared with 50 percent of insured teens (data not shown). Uninsured children were also less likely to be white and more likely to be Hispanic than insured children. Although the vast majority of uninsured children were citizens (88.5 percent), about 30 percent of uninsured children had a noncitizen member of their health insurance unit compared to about 15 percent of insured children. Among Hispanic uninsured children, just over 60 percent had a noncitizen in their health insurance unit (data not shown).

We find that about one-quarter of uninsured children lived in a health insurance unit in which no adult had graduated from high school compared with only 10 percent of insured children. Further, about a quarter of uninsured children lived with an adult who had a college degree compared with 43 percent of insured children. We also find that uninsured children were more likely to live in the South and less likely to live in the Northeast than insured children. In 2017, 52 percent of uninsured children were living in the South compared with 36 percent of insured children. The greater concentration of uninsured children in the South may relate in part to the lack of Medicaid expansion for many states in that region. Almost 58 percent of the remaining uninsured children in 2017 lived in states that had not expanded Medicaid under the ACA (data not shown).
<table>
<thead>
<tr>
<th>Characteristics of Uninsured and Insured Children Age 18 and Under, 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
</tr>
<tr>
<td>Age 0–5</td>
</tr>
<tr>
<td>Ages 6–12</td>
</tr>
<tr>
<td>Ages 13–18</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td><strong>Race and ethnicity</strong></td>
</tr>
<tr>
<td>White, non-Hispanic</td>
</tr>
<tr>
<td>Black, non-Hispanic</td>
</tr>
<tr>
<td>Hispanic</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td><strong>Individual citizenship</strong></td>
</tr>
<tr>
<td>Citizen</td>
</tr>
<tr>
<td>Noncitizen</td>
</tr>
<tr>
<td><strong>Citizenship in HIU</strong></td>
</tr>
<tr>
<td>Any noncitizen in HIU</td>
</tr>
<tr>
<td>No noncitizen in HIU</td>
</tr>
<tr>
<td><strong>Highest education in HIU</strong></td>
</tr>
<tr>
<td>Less than high school</td>
</tr>
<tr>
<td>High school graduate</td>
</tr>
<tr>
<td>Some college</td>
</tr>
<tr>
<td>College graduate</td>
</tr>
<tr>
<td><strong>Census region</strong></td>
</tr>
<tr>
<td>Northeast</td>
</tr>
<tr>
<td>Midwest</td>
</tr>
<tr>
<td>South</td>
</tr>
<tr>
<td>West</td>
</tr>
<tr>
<td><strong>Sample size</strong></td>
</tr>
<tr>
<td>1,036</td>
</tr>
</tbody>
</table>

Source: Urban Institute analysis of National Health Interview Survey data.

Notes: HIU = health insurance unit. Coverage status is at the time of the survey.

* Estimate differs significantly from estimate for uninsured group at p < 0.05.

There is considerable variation among uninsured children in the length of time since they last had coverage. About 43.6 percent of uninsured children in 2017 had been uninsured for one year or less, 13.8 percent had been uninsured for one to three years, and about 42.7 percent had been uninsured for more than three years or had never had insurance (figure 4).
When we examine reasons that children were uninsured (as reported by their adult family members), we find that cost was the most commonly reported reason (35.5 percent) followed by a family member’s job loss or change (19.6 percent). About 9.2 percent were reportedly uninsured because they lost Medicaid because of a family member’s new job or income increase, and 11.9 percent were reported as losing Medicaid for other reasons (figure 5). Adult family members reported that 7.4 percent of uninsured children did not have coverage because it was not wanted or needed. A variety of other reasons, including divorce or death of a parent, no employer offer of coverage, and moving from another state or country, rounded out the reported reasons for a child being uninsured.
FIGURE 5
Reported Reasons for Being Uninsured among Children Age 18 and Under, 2017

- Cost is too high: 35.5%
- Job change or loss: 19.6%
- Lost Medicaid because of new job or income increase: 9.2%
- Lost Medicaid because of other reasons: 11.9%
- No need for coverage: 7.4%
- Left school or aged out of eligibility for coverage: 3.0%
- Employer does not offer: 2.6%
- Moved from another state or country: 2.6%
- Parents’ divorce or death: 1.4%
- Insurer refused coverage: 0.9%
- Other reasons: 11.1%

Source: Urban Institute analysis of National Health Interview Survey data.
Notes: Sample includes 845 children who were uninsured at the time of the survey. Respondents are adults in the child’s household. More than one reason can be reported.

Comparing children who were uninsured for one year or less (short-term uninsured) to those who had been uninsured for more than three years (long-term uninsured) suggests that the short-term uninsured were far more likely than the long-term uninsured to be uninsured because of a family member’s job loss or change (28.1 percent versus 12.2 percent), aging out of coverage (5.9 percent versus 0.4 percent), or losing Medicaid for an unspecified reason (20.9 percent versus 1.9 percent) (figure 6). Long-term uninsurance was more likely to be related to cost, with 46.8 percent of long-term uninsured children having cost as a reported reason for lacking coverage compared with 23.2 percent of short-term uninsured children. Almost no short-term uninsurance was related to a lack of perceived need for coverage, whereas not wanting or needing coverage was reported for 15.9 percent of long-term uninsured children.
FIGURE 6
Reported Reason for Being Uninsured Among Children Age 18 and Under, by Duration of Uninsurance, 2017

<table>
<thead>
<tr>
<th>Reason</th>
<th>Long-term</th>
<th>Short-term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost is too high</td>
<td>12.2%</td>
<td>23.2%*</td>
</tr>
<tr>
<td>Job change or loss</td>
<td>6.8%</td>
<td>11.8%</td>
</tr>
<tr>
<td>Lost Medicaid because of new job or income increase</td>
<td>1.9%</td>
<td>20.9%*</td>
</tr>
<tr>
<td>Lost Medicaid because of other reasons</td>
<td>0.4%*</td>
<td>15.9%</td>
</tr>
<tr>
<td>No need for coverage</td>
<td>0.4%</td>
<td>5.9%*</td>
</tr>
<tr>
<td>Left school or aged out of eligibility for coverage</td>
<td>11.8%</td>
<td>8.0%</td>
</tr>
</tbody>
</table>

Source: Urban Institute analysis of National Health Interview Survey data.
Notes: Sample excludes children who were uninsured for one to three years. Short-term uninsured are those uninsured one year or less (n=376), and long-term uninsured are those uninsured for more than three years (n=360). Respondents are adults in the child’s household. More than one reason can be reported.
* Estimate differs significantly from estimate for long-term uninsured at p < 0.05.

Discussion

Data from the NHIS suggest that the uninsurance rate fell from 8.3 percent in 2010 to 5.3 percent in 2017 among children age 18 and under. Although children in states that did and did not expand Medicaid under the ACA experienced coverage gains over this period, a significant drop in uninsurance among children in nonexpansion states from 2013 to 2015 was followed by an increase in their uninsurance rate between 2015 and 2017. Related analyses of coverage patterns for children using American Community Survey data through 2016 (Haley, Kenney, et al., forthcoming) and Health Reform Monitoring Survey data through March 2018 (Karpman, Kenney, and Gonzalez 2018) have not detected any significant increases in uninsurance among children, however, so additional analysis will be necessary to confirm the patterns found in the NHIS.
Continued monitoring of uninsurance among children will be important as various state and federal policy and regulatory developments may affect future trends in coverage. Reductions in federal funding for outreach and enrollment assistance, shortened open enrollment periods, repeal of the federal individual mandate penalty, and general uncertainty surrounding the future of the ACA since 2017 have raised concerns that a reversal of recent coverage gains could be on the horizon. For example, the repeal of the federal individual mandate penalty and increased availability of plans with more limited benefits are expected to further increase the cost of comprehensive coverage for unsubsidized consumers in the individual market. Moreover, several states are considering using work or “community engagement” requirements to restrict Medicaid eligibility and implementing premiums, lock-out periods, and related policies that could have negative spillover effects on children’s coverage. Other policies, such as the expected implementation of the ACA Medicaid expansion in additional states (including Maine and Virginia), could have positive effects on children’s coverage.

Reported reasons for being uninsured reveal the need for strategies to reduce churn and improve coverage transitions around job loss and Medicaid eligibility changes, which could in turn reduce short-term uninsurance among children. The dominance of cost as a driver of long-term uninsurance suggests the importance of increasing awareness of low-cost Medicaid and CHIP options for eligible uninsured children, but it also raises concerns about the uninsurance rate going forward as private health insurance premiums continue to rise. Furthermore, almost 16 percent of long-term uninsured children were reported as not needing or wanting insurance, so additional efforts to educate parents about the health and financial risks of forgoing coverage for seemingly healthy children may be warranted (Blumberg, O’Connor, and Kenney 2005).

Uninsurance declined among children in all age groups in expansion states between 2013 and 2017, but only teens saw a statistically significant decline in nonexpansion states over this period. Despite these gains, however, teens still had higher uninsurance rates than younger children in 2017, at 6.8 percent nationally and 4.8 and 10.0 percent in expansion and nonexpansion states, respectively. This suggests the need for additional outreach strategies targeted at teens and their parents to ensure that children maintain coverage during these critical adolescent years. Outreach and enrollment assistance through public schools may be one promising avenue to reach both teens and younger school-age children who are eligible for assistance but uninsured (Blumberg et al. 2018).

Hispanic children in expansion states saw strong gains in coverage that largely eliminated the coverage gap between Hispanic and white children in those states by 2017. At the same time, 14.1 percent of Hispanic children in nonexpansion states were uninsured in 2017, a rate far higher than any other group we examined. Moreover, although most uninsured children were citizens, nearly one-third were living in families with adults who were not citizens, and about one-quarter were living with adults who lacked a high school degree. Many of these children were likely eligible for Medicaid or CHIP, but barriers to their enrollment may include a lack of awareness of eligibility, limited health insurance literacy, language barriers, or concerns about revealing the documentation status of family members. A potential expansion of the definition of a “public charge,” currently under consideration by the administration, could worsen existing barriers to enrollment among Medicaid and CHIP eligible children.
living in legal immigrant families (Batalova, Fix and Greenberg 2018; Perreira, Yoshikawa, and Oberlander 2018).

Finally, although this analysis cannot explicitly attribute the stronger gains in coverage for children in expansion states to the Medicaid expansion itself, of the 4.1 million remaining uninsured children in 2017, about 58 percent were living in a nonexpansion state and 52 percent were living in the South. In conjunction with recent and historic research on the effects of Medicaid expansions to parents on children’s coverage (Aizer and Grogger 2003; Dubay and Kenney 2003; Hudson and Moriya 2017), this suggests that additional expansions could further reduce uninsurance among children.

Notes

1 Authors’ estimates using the National Health Interview Survey.
4 We compared the uninsurance rate for children by age group from the early release file to estimates from the final 2017 public use data and found no meaningful differences, but we do not have access to state identifiers on the final 2017 data, so estimates by Medicaid expansion status using the final data edits and weights are not yet available.
5 Gains in coverage for each age group between 2013 and 2015 were significant at p < 0.05, but only the increase in uninsurance for children ages 6 to 12 from 2015 to 2017 was significant at p < 0.05.
6 Gains in coverage for each racial and ethnic group between 2013 and 2015 were significant at p < 0.05, but only the increase in uninsurance for white children from 2015 to 2017 was significant at p < 0.05.

References


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**Stacey McMorrow** is a senior research associate in the Health Policy Center at the Urban Institute. She has extensive experience using quantitative methods to study the factors that affect individual health insurance coverage and access to care as well as the impacts of state and national health reforms on employers and individuals.

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