

## Public Insurance Drove Overall Coverage Growth Among Children in 2012

### Rates of Coverage Vary Across the Country

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Lawmakers, children's rights advocates, researchers, and health care professionals understand that health insurance coverage is the most important determinant of access to health care and is directly linked to better health outcomes among children.<sup>1</sup> Thus, lawmakers have promoted policy that seeks to enroll children in public health insurance programs when they are otherwise uninsured.

The major form of public health insurance available to children is provided by Medicaid and the State Children's Health Insurance Program (SCHIP), reauthorized in 2009. Before the Affordable Care Act (ACA), the federal government required that states provide Medicaid coverage to (1) younger children, ages 0 to 5, who lived in families with income at or below 133 percent of the federal poverty level; and (2) older children, ages 6 to 19, who lived in families with income at or below 100 percent of the federal poverty threshold.<sup>2</sup> Before SCHIP and ACA, many states expanded Medicaid beyond these levels. SCHIP incentivized states to expand their public insurance by expanding existing Medicaid or initiating their own state-level program. Although SCHIP decreased the disparities in coverage rates among states and increased the number of insured children overall, coverage remains uneven among the states. Eligibility for SCHIP currently varies by state; forty-six states and Washington, DC, extend insurance coverage via SCHIP to children who live in families with income equal to or below 200 percent of the federal poverty level.<sup>3</sup> Many states extend coverage to low-income families with income higher than 200 percent of the federal poverty level; the federal government provides matching funds to states extending

#### KEY FINDINGS

92.8%

Between 2011 and 2012, overall rates of health insurance coverage among children increased slightly (0.3 percentage point); 92.8 percent of the nation's children had health insurance in 2012.

+/-

Rates of public health insurance coverage for children grew from 28.3 percent in 2008 to 38.1 percent in 2012, whereas rates of private health insurance coverage for children decreased from 64.1 percent in 2008 to 58.3 percent in 2012.



Since 2008, rates of public health insurance among children have increased the most (more than 10 percentage points) in the South, the West, and central cities throughout the United States, which has resulted in narrowing the gap among regions and place types.



Rates of coverage are uneven among states: Whereas 97 percent or more of children are covered in Massachusetts, Vermont, and Washington, DC, fewer than 90 percent of children in Alaska, Arizona, Florida, Montana, Nevada, Oklahoma, Texas, and Utah are covered.



Private insurance remains the dominant form of health insurance for children in forty-six states and Washington, D.C., although four-year trends indicate that private coverage is highly dependent on the quality of jobs in state and regional economies.

coverage to children in families with income up to 300 percent of the federal poverty level.<sup>4</sup>

Most recently, ACA expanded Medicaid for older children: 6- to 19-year-olds from low-income families are eligible if their household earns income up to 133 percent<sup>5</sup> of the federal poverty level (expanded from 100 percent of the federal poverty level before ACA was passed).<sup>6</sup> A June 2012 Supreme Court decision allows states to opt out of this Medicaid expansion under ACA. Nevertheless, as of June 9, 2014, twenty-six states, which include 53 percent of U.S. children, have opted to expand coverage. Furthermore, five states, capturing 11.5 percent of U.S. children, have opened discussion on expansion, and nineteen states have opted out of expansion—thereby excluding 35.6 percent of U.S. children who live in the twenty-five states that have decided not to expand Medicaid coverage provided by the ACA.<sup>7</sup> Thus, children ages 0 to 19 of working and nonworking parents, whose combined household income is below approximately \$30,675 (for a family of four in 2012), or 133 percent of the poverty level, are eligible for coverage under ACA in Washington, DC, and the twenty-seven states that opted to expand public health insurance.<sup>8</sup>

Using data from the American Community Survey, this brief examines the rates of health insurance coverage among children under 18 in the United States by region and by rural, suburban, and central city residence between 2008 and 2012. Growth in rates of insured children slowed in 2012, but shifts from private insurance to public insurance continued. Understanding how coverage varies by region, state, and place type provides clearer insight on how existing policy affects children in the United States. Documenting where uninsured children live—by region, state, and place type—helps policy makers tailor future policy to insure the remaining 7 percent of American children.

## Change in Rates of Coverage Between 2008 and 2012

Although overall health insurance coverage increased only slightly between 2011 and 2012 (0.3 percentage point), this increase is part of a trend beginning in 2008. Rates of insurance among children have grown by 2.8 percentage points since 2008; 92.8 percent of children reported some form of coverage in 2012 (see Table 1). Between 2008 and 2012, rates grew the most in central cities (by 3.6 percentage points, to 92.4 percent), followed by rural places (by

2.8 percentage points, to 91.9 percent) and suburban places (by 2.3 percentage points, to 93.4 percent).

SCHIP, Medicaid, and other state insurance programs had the strongest effect in locations where coverage was traditionally the lowest, although these policies bore increased coverage for all children, regardless of place type. Despite these increases, rates of coverage in central cities and rural places still lag slightly behind those of suburban places. The higher rate of coverage in suburban places correlates with lower rates of child poverty there.<sup>9</sup> In addition, those who live in the suburbs are more likely than those in central cities or rural places to have jobs that provide health insurance coverage and other benefits (that is, “good jobs”).<sup>10</sup>

The South and West had the largest increases in coverage (more than 3 percentage points) between 2008 and 2012. Rates in the South and West have not reached rates in the Northeast or Midwest, although the disparity between these regions is narrowing. Similarly, policies aiming to increase rates of health insurance had the largest effect on regions in which coverage rates were traditionally the lowest (for example, the West and South). The spatial distribution of children and policy changes in states in which children are concentrated may help explain these disparate effects. Slightly fewer than 28 percent of American children live in only three states, all of which are in the West and South. Nearly 13 percent of American children live in California (West). And children who live in Florida and Texas combined (South) account for an additional 15 percent of the population under age 18. The California legislature’s decision to expand Medicaid under ACA affected a large proportion of children in the West; likewise, the number of children in Florida and Texas, where Medicaid expansion was rejected, also disproportionately affects coverage rates in the South.<sup>11</sup> Although the full effect of Medicaid expansion is not reflected in these data and will not be reflected in the American Community Survey for several years, the disparate growth in coverage rates between the West and the South will likely continue. Rates of coverage in the West will likely grow to rival rates in the Northeast and Midwest, whereas rates in the South are likely to continue to grow, but may continue to lag behind the other three regions. If state policy makers in the South continue to prevent the expansion of Medicaid, children in these states will have limited access to private or public forms of insurance.

**TABLE 1: PERCENTAGE POINT CHANGE IN HEALTH INSURANCE COVERAGE, FOR PERSONS UNDER AGE 18, 2008, 2011, AND 2012**

	ALL PLACES			RURAL			SUBURBAN			CENTRAL CITY		
	% Insured in 2012	% Point Change from 2011	% Point Change from 2008	% Insured in 2012	% Point Change from 2011	% Point Change from 2008	% Insured in 2012	% Point Change from 2011	% Point Change from 2008	% Insured in 2012	% Point Change from 2011	% Point Change from 2008
United States	92.8	<b>0.3</b>	<b>2.8</b>	91.9	<b>0.3</b>	<b>2.8</b>	93.4	<b>0.4</b>	<b>2.3</b>	92.4	<b>0.3</b>	<b>3.6</b>
Northeast Region	95.9	0.2	<b>1.5</b>	93.8	0.4	<b>1.4</b>	96.3	0.2	<b>1.3</b>	95.7	0.1	<b>2.0</b>
Midwest Region	94.8	<b>0.2</b>	<b>1.4</b>	92.7	0.0	<b>1.1</b>	95.9	<b>0.3</b>	<b>1.1</b>	94.6	0.1	<b>2.2</b>
South Region	91.4	<b>0.6</b>	<b>3.8</b>	91.6	<b>0.4</b>	<b>3.5</b>	91.6	<b>0.7</b>	<b>3.3</b>	90.8	<b>0.7</b>	<b>5.1</b>
West Region	91.3	0.2	<b>3.3</b>	89.6	<b>0.8</b>	<b>5.0</b>	91.8	0.2	<b>2.7</b>	91.1	0.1	<b>3.7</b>
Alabama	95.9	<b>1.2</b>	<b>4.0</b>	95.2	0.8	<b>4.0</b>	96.3	<b>1.5</b>	<b>3.2</b>	96.1	1.0	<b>5.4</b>
Alaska	86.1	-2.1	-1.0	82.2	-1.3	3.6	86.0	-3.3	-5.2	88.0	-3.2	-1.2
Arizona	86.8	-0.4	<b>3.0</b>	81.5	-2.6	2.4	88.3	-1.6	<b>1.9</b>	86.3	0.9	<b>4.1</b>
Arkansas	94.1	-0.3	<b>2.8</b>	94.1	-0.4	<b>3.1</b>	94.3	-0.8	<b>0.7</b>	93.7	0.4	<b>4.7</b>
California	92.1	0.1	<b>2.9</b>	90.5	-0.3	<b>5.2</b>	92.1	<b>0.5</b>	<b>2.5</b>	92.1	-0.2	<b>3.2</b>
Colorado	91.2	0.6	<b>5.5</b>	88.7	2.6	<b>11.4</b>	91.6	-0.8	<b>2.4</b>	91.4	<b>1.8</b>	<b>7.9</b>
Connecticut	96.2	<b>-0.9</b>	<b>1.1</b>	97.1	-0.4	1.8	97.2	-0.6	<b>1.0</b>	93.7	<b>-1.4</b>	<b>1.2</b>
Delaware	96.5	1.1	<b>4.3</b>	97.8	<b>4.2</b>	<b>9.3</b>	95.9	0.4	<b>2.7</b>	97.4	-0.3	<b>4.8</b>
District of Columbia	98.3	2.2	<b>2.6</b>	NA	NA	NA	NA	NA	NA	98.3	2.2	<b>2.6</b>
Florida	89.1	<b>1.0</b>	<b>6.6</b>	87.2	-0.3	<b>6.6</b>	89.1	<b>1.2</b>	<b>6.5</b>	89.5	0.7	<b>7.0</b>
Georgia	91.2	0.7	<b>2.6</b>	92.0	<b>2.7</b>	<b>3.4</b>	90.7	0.5	<b>2.1</b>	92.0	-0.6	<b>4.2</b>
Hawaii	96.5	0.2	0.2	95.2	0.6	2.6	97.3	0.4	-0.7	96.9	-1.1	-1.2
Idaho	91.5	0.6	<b>5.2</b>	90.0	<b>2.4</b>	<b>6.5</b>	92.5	-0.4	<b>5.5</b>	91.8	0.0	<b>3.1</b>
Illinois	96.7	<b>0.3</b>	<b>2.3</b>	95.9	-0.3	1.1	96.9	0.2	<b>1.8</b>	96.7	<b>0.9</b>	<b>3.7</b>
Indiana	91.6	-0.4	<b>1.7</b>	87.8	0.0	<b>2.2</b>	93.6	-0.1	<b>1.4</b>	91.0	-1.0	<b>1.8</b>
Iowa	96.0	0.4	<b>1.6</b>	95.2	-0.1	<b>1.5</b>	96.8	-0.2	0.4	96.4	<b>1.8</b>	<b>3.1</b>
Kansas	93.4	-0.2	<b>1.6</b>	92.3	0.0	<b>2.4</b>	95.2	0.0	0.5	92.2	-0.8	<b>1.6</b>
Kentucky	94.5	0.6	<b>1.4</b>	94.3	1.0	<b>2.4</b>	94.7	0.3	<b>1.3</b>	94.3	0.1	0.0
Louisiana	94.7	0.5	<b>2.5</b>	93.6	0.2	<b>3.9</b>	95.4	0.7	<b>2.6</b>	94.6	0.4	<b>0.9</b>
Maine	95.4	0.6	<b>2.8</b>	94.9	0.8	<b>3.3</b>	95.7	1.1	1.4	95.9	-1.2	<b>5.8</b>
Maryland	96.2	<b>0.7</b>	<b>1.4</b>	95.6	1.3	2.3	96.3	<b>0.9</b>	<b>1.2</b>	95.5	-0.1	<b>2.2</b>
Massachusetts	98.6	0.3	<b>0.6</b>	NA	NA	NA	98.7	<b>0.4</b>	<b>0.8</b>	98.0	-0.2	0.1
Michigan	96.0	0.1	<b>1.2</b>	94.2	0.0	-0.6	96.7	0.0	<b>1.4</b>	95.7	0.5	<b>2.0</b>
Minnesota	94.6	<b>0.9</b>	<b>0.9</b>	92.1	-0.2	0.4	95.9	<b>1.7</b>	<b>1.0</b>	94.4	0.1	<b>1.1</b>
Mississippi	92.7	0.8	<b>5.3</b>	93.2	1.2	<b>6.2</b>	91.7	-0.8	<b>2.4</b>	93.2	<b>3.5</b>	<b>10.0</b>
Missouri	93.0	-0.3	0.1	91.0	-1.1	-0.7	94.2	0.0	0.3	92.2	0.0	0.8
Montana	88.9	0.4	<b>3.3</b>	86.8	-0.2	<b>4.4</b>	93.0	1.3	-0.7	92.7	1.5	2.7
Nebraska	94.0	-0.2	<b>0.8</b>	92.8	-1.1	1.5	96.2	0.8	0.2	93.7	0.2	0.7
Nevada	83.4	-0.4	<b>3.6</b>	83.9	-1.9	2.5	83.9	-1.9	<b>2.6</b>	83.0	1.7	<b>4.8</b>
New Hampshire	96.0	-0.3	<b>1.1</b>	95.5	-0.9	<b>3.2</b>	96.2	0.1	0.9	96.5	-1.3	<b>-1.7</b>
New Jersey	94.9	0.1	<b>2.1</b>	NA	NA	NA	95.0	0.0	<b>1.8</b>	93.9	1.0	<b>4.5</b>
New Mexico	92.0	1.1	<b>5.6</b>	91.7	0.5	<b>6.2</b>	93.1	<b>5.6</b>	<b>7.6</b>	91.2	-2.1	<b>3.4</b>
New York	96.1	0.3	<b>1.9</b>	92.7	-0.8	<b>2.0</b>	96.7	0.3	<b>1.8</b>	96.0	0.4	<b>1.9</b>
North Carolina	92.4	0.1	<b>2.2</b>	91.9	<b>-1.1</b>	<b>1.9</b>	92.0	-0.6	<b>1.6</b>	93.3	<b>1.8</b>	<b>3.2</b>
North Dakota	93.1	-0.5	0.9	91.4	0.5	-0.6	95.9	-2.2	<b>2.0</b>	94.6	-1.4	<b>3.2</b>
Ohio	94.7	<b>0.6</b>	<b>1.9</b>	92.4	1.1	<b>1.6</b>	95.6	<b>0.6</b>	<b>1.4</b>	94.4	-0.2	<b>3.7</b>
Oklahoma	89.9	0.6	<b>2.8</b>	88.6	<b>1.5</b>	<b>3.4</b>	91.4	-0.4	<b>2.7</b>	89.7	0.6	<b>2.3</b>
Oregon	93.6	0.9	<b>6.4</b>	92.6	2.0	<b>8.5</b>	93.6	0.5	<b>6.1</b>	94.4	0.9	<b>5.5</b>
Pennsylvania	94.9	0.3	<b>1.0</b>	92.8	<b>1.9</b>	0.0	95.5	0.2	<b>0.6</b>	94.7	-0.4	<b>2.8</b>
Rhode Island	95.5	-0.6	<b>1.1</b>	NA	NA	NA	95.3	-0.6	<b>0.2</b>	95.9	-0.4	<b>3.3</b>
South Carolina	91.7	0.2	<b>4.3</b>	89.6	<b>-2.4</b>	2.0	92.0	0.6	<b>4.6</b>	93.8	2.0	<b>6.5</b>
South Dakota	94.2	0.2	<b>2.6</b>	92.8	0.0	<b>4.8</b>	97.7	0.3	<b>2.7</b>	94.3	0.3	<b>-1.7</b>
Tennessee	94.3	0.0	<b>1.5</b>	93.8	-0.6	0.8	95.3	0.3	<b>1.2</b>	93.5	0.2	<b>2.5</b>
Texas	87.6	<b>0.8</b>	<b>5.4</b>	85.6	0.0	<b>4.7</b>	88.4	<b>1.2</b>	<b>4.0</b>	87.3	0.6	<b>7.0</b>
Utah	89.9	0.9	<b>3.0</b>	88.2	2.8	1.1	90.7	0.5	<b>2.1</b>	87.5	0.9	<b>6.9</b>
Vermont	97.2	-0.4	<b>1.2</b>	96.4	-0.8	1.6	98.8	0.3	<b>1.0</b>	NA	NA	NA
Virginia	94.4	0.3	<b>2.0</b>	93.5	1.1	<b>2.8</b>	94.3	-0.1	<b>1.4</b>	95.2	0.7	<b>3.1</b>
Washington	94.2	0.4	<b>2.7</b>	94.3	1.6	2.4	94.6	0.3	<b>3.1</b>	93.7	0.2	<b>2.1</b>
West Virginia	96.1	0.5	<b>2.8</b>	96.4	1.2	<b>4.8</b>	95.5	0.1	0.3	97.2	-0.3	<b>4.4</b>
Wisconsin	95.3	-0.3	<b>0.5</b>	93.8	0.6	<b>1.9</b>	96.5	-0.3	0.0	94.8	<b>-1.1</b>	0.3
Wyoming	90.7	-0.7	-0.6	90.0	-0.3	-0.3	NA	NA	NA	91.6	<b>-5.1</b>	-2.5

Note: Bold typeface indicates a statistically significant change ( $p < 0.05$ ).

Source: American Community Survey, 1-year estimates, 2008–2012



## Change in Rates of Coverage Between 2011 and 2012

Rates of children's health insurance coverage grew slightly (0.3 percentage point) between 2011 and 2012 in the United States (see Table 1). Although this increase appears small, more than an estimated 249,000 additional children reported coverage in 2012 than in 2011. Compared with growth realized in previous years, increases in overall coverage rates have slowed.<sup>12</sup> The largest overall regional increase in coverage occurred in the South (0.6 percentage point); the Midwest also saw a significant increase (0.2 percentage point) between 2011 and 2012. The Northeast and West saw no significant change.

Places in the rural West grew by a modest 0.8 percentage point, and the rural South experienced a 0.4 percentage point increase from the previous year. Rates increased by 0.7 percentage point in both suburban places and central cities in the South.

## Public Coverage Continues to Rise Amid Declining Rates of Private Insurance

Rates of public insurance coverage among children increased between 2011 and 2012 by 0.8 percentage point among children in the United States—the smallest one-year increase since 2008 (see Table 2 on pages 6 and 7). Accordingly, rates of private insurance declined by 0.5 percentage point between 2011 and 2012, the smallest decrease since 2008. Thus, the shift from private insurance to public insurance appears to have slowed between 2011 and 2012.

Private to public coverage shifts were most marked in the South and West, where both public and private coverage has been historically low compared with other regions. However, coverage also shifted slightly in the Northeast from private to public. Rates of insurance were relatively stable in the Midwest (see Table 2).

While increases in public insurance and decreases in private insurance were modest in nearly all place types and place types within regions (that is, rural Midwest, central cities in the South, suburban West), rural places in the West witnessed a particularly large increase (1.7 percentage points) in public insurance coverage.

## Private and Public Shifts in Coverage Remain Dependent on State Economies

Although the trend of increasing public insurance amid decreasing private insurance is prevalent among children nationwide, this shift is not uniform in all states (see Table 2). For example, in California, rates of private insurance have decreased 5.4 percentage points since 2008, whereas public insurance has increased by 9.7 percentage points. At the same time, states such as Nevada and Oregon experienced increases in public insurance greater than 10 percentage points since 2008 but witnessed decreases in private coverage of less than 10 percentage points since 2008. Indeed, sixteen states experienced increases in public insurance exceeding 10 percentage points, whereas only one state—Montana—experienced decreases in rates of private coverage exceeding 10 percentage points.

Differences among states suggest that, despite federal reform, private health insurance remains dependent upon state and local policies and economies. Places that have high rates of private coverage generally have low rates of child poverty. In places where child poverty rates are high, rates of private insurance are typically low.<sup>13</sup> Health insurance coverage, particularly private coverage, is more common in economies that have “good jobs”—higher paying jobs that offer benefits for employees and dependents—compared with economies that are more likely be composed of jobs that are part-time, low wage, and do not offer benefits to employees and/or their dependents. For example, the Bakken oil boom in rural North Dakota reinvigorated the state's economy, creating many good jobs.<sup>14</sup> Correspondingly, North Dakota has one of the lowest child poverty rates in the nation. These trends correspond with changes illustrated in Table 2: the proportion of children covered by public insurance in 2012 decreased from 2011, whereas rates of private insurance in rural areas of North Dakota rose 3.4 percentage points.<sup>15</sup>

Despite large increases in the ranks of children covered by public insurance since the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, rates of private coverage still exceed those of public coverage in most states. Only four states—Arkansas, Louisiana, Mississippi, and New Mexico—have rates of public coverage that exceed private rates. These four states also had the highest rates of child poverty in 2012 (28 percent or more).<sup>16</sup> Thus, children in these states

may be more likely to rely on Medicaid and SCHIP. In contrast, Alabama has a high rate of child poverty—slightly less than 28 percent—but has more children covered by private insurance than by public insurance. This evidence suggests that other factors, such as employment status and employment quality, also contribute to rates of public and private insurance. However, the disparity between public and private coverage among children is narrowing in all states and places: rates of public coverage have continually increased during the past five years, whereas rates of private coverage have steadily decreased.

## Moving Forward: Providing Coverage for the 7 Percent of U.S. Children Who Are Uninsured

Rates of health insurance among children have slowed since 2010. Public insurance continues to gain child enrollees, although private insurance rates are decreasing. Initial increases in public insurance rates are attributable to CHIPRA, but future increases in coverage hinge on various factors including immigration reform, Medicaid expansion under ACA, and whether or not parents who qualify for fully or partially subsidized health care actually enroll their qualified children in these programs.

## Covering Children of Immigrant Families

In 2010, 16.4 percent of children living in households in which at least one parent was an immigrant lacked any form of health insurance<sup>17</sup>—a rate that far exceeds the 8.0 percent rate of all uninsured children nationally in 2010.<sup>18</sup> CHIPRA and ACA improve access to affordable health insurance for both non-native immigrant children and for children who are U.S. citizens but reside with undocumented/unauthorized parents and guardians. Because the proportion of immigrant children who lack insurance is so large, policies aiming to bolster coverage in this population have the potential to significantly reduce the number of uninsured children overall.

Immigration reform that allows parents and their dependents to fast-track citizenship and thereby become eligible for public assistance would allow many

low-income children to become insured through public means. Even under ACA, lawfully present immigrants must wait five or more years to become eligible for Medicaid and SCHIP and other forms of government assistance.<sup>19</sup> Revising and/or overturning the five-year waiting period for lawfully residing immigrant children may increase the number of insured children in the United States.<sup>20</sup> Immigration reform advocates also note that a hostile climate toward undocumented residents prevents many parents from enrolling their eligible children in public insurance programs for fear that adult family members would be deported or suffer other consequences.<sup>21</sup> Thus, even in families of “mixed status”—that is, families whose members’ immigration statuses are different from each other—may opt to *not* enroll their Medicaid and/or SCHIP eligible children for health insurance coverage, even though ACA clearly states that those who are enrolling others for insurance do not have to disclose their own immigration status.<sup>22</sup>

One in four children in the United States lives in an immigrant family<sup>23</sup>; considering that a significant proportion of immigrant children are uninsured, policies that focus on this population will likely reduce the number of children who have no health insurance. In New York, for example, nearly 10 percent of all children were foreign born in 2012, but fewer than 4 percent had no health insurance coverage. Thus, New York demonstrates that immigrant children can indeed be insured, despite the existing barriers.

Even after all expansions and policy changes are complete, not all children in immigrant families will have health insurance coverage: nonnative, undocumented children will remain ineligible for public coverage.<sup>24</sup>

## Effectively Expanding Medicaid and Other Government-Sponsored Insurance

Under the ACA, the federal government is responsible for 100 percent of costs associated with insuring all income-eligible children who were not eligible for public health insurance coverage before the law took effect until the end of 2016. Therefore, children who are covered because of revisions to SCHIP and the ACA do not place any fiscal burden on states for the first two years after full implementation of the ACA.

**TABLE 2: PERCENTAGE POINT CHANGE IN PRIVATE AND PUBLIC HEALTH INSURANCE COVERAGE FOR PERSONS UNDER AGE 18, 2008, 2011, AND 2012**

	ALL PLACES						RURAL					
	% Private in 2012	% Point Change from 2011	%Point Change from 2008	% Public in 2012	% Point Change from 2011	% Point Change from 2008	% Private in 2012	% Point Change from 2011	%Point Change from 2008	% Public in 2012	% Point Change from 2011	% Point Change from 2008
United States	58.3	<b>-0.5</b>	<b>-5.8</b>	38.1	<b>0.79</b>	<b>9.76</b>	52.31	<b>-0.44</b>	<b>-5.36</b>	44.20	<b>0.90</b>	<b>9.27</b>
Northeast Region	64.6	<b>-0.6</b>	<b>-6.0</b>	35.7	<b>0.81</b>	<b>8.99</b>	59.90	-0.58	<b>-5.01</b>	39.56	1.00	<b>7.91</b>
Midwest Region	63.3	-0.1	<b>-6.2</b>	35.6	0.18	<b>8.93</b>	60.68	0.12	<b>-5.22</b>	35.64	0.20	<b>8.00</b>
South Region	53.6	<b>-0.4</b>	<b>-5.5</b>	40.7	<b>1.07</b>	<b>10.16</b>	45.29	<b>-0.72</b>	<b>-5.53</b>	50.09	<b>1.10</b>	<b>9.78</b>
West Region	56.9	<b>-0.7</b>	<b>-5.5</b>	37.8	<b>0.86</b>	<b>10.28</b>	51.51	-0.66	<b>-5.18</b>	42.58	<b>1.70</b>	<b>11.27</b>
Alabama	55.3	-0.7	<b>-7.2</b>	44.5	<b>2.66</b>	<b>12.62</b>	49.42	-1.66	<b>-6.31</b>	50.90	<b>3.10</b>	<b>11.30</b>
Alaska	57.5	0.0	<b>-8.8</b>	33.4	-1.73	<b>7.75</b>	40.44	-3.60	<b>-8.62</b>	46.94	1.60	<b>12.84</b>
Arizona	51.9	-0.8	<b>-4.6</b>	37.7	0.07	<b>8.67</b>	39.53	4.32	<b>-7.83</b>	46.30	<b>-7.10</b>	<b>11.07</b>
Arkansas	46.7	-0.2	<b>-2.8</b>	50.2	-1.51	<b>5.06</b>	38.57	-0.40	<b>-5.55</b>	58.66	-0.90	<b>7.61</b>
California	54.5	<b>-0.6</b>	<b>-5.4</b>	40.7	<b>0.86</b>	<b>9.71</b>	49.13	0.44	-0.84	46.51	0.80	<b>9.14</b>
Colorado	62.4	<b>-2.0</b>	<b>-5.6</b>	31.5	<b>2.19</b>	<b>12.48</b>	53.91	-2.41	-2.45	38.58	<b>6.60</b>	<b>15.42</b>
Connecticut	67.7	<b>-2.2</b>	<b>-7.3</b>	32.1	<b>1.78</b>	<b>10.05</b>	66.99	-3.98	<b>-8.31</b>	33.52	3.50	<b>10.05</b>
Delaware	62.3	0.2	<b>-8.2</b>	39.0	0.95	<b>13.82</b>	53.42	5.17	-2.94	52.25	2.80	<b>15.69</b>
District of Columbia	54.4	0.0	-1.1	51.2	1.23	<b>7.42</b>	NA	NA	NA	NA	NA	NA
Florida	50.2	-0.9	<b>-8.2</b>	41.3	<b>1.92</b>	<b>15.87</b>	39.06	-0.99	<b>-6.88</b>	50.74	-0.10	<b>14.94</b>
Georgia	53.8	-1.0	<b>-4.8</b>	40.0	<b>1.81</b>	<b>8.04</b>	43.56	-2.02	<b>-4.81</b>	51.55	<b>5.00</b>	<b>8.76</b>
Hawaii	68.6	-1.5	<b>-9.3</b>	32.0	1.19	<b>11.10</b>	58.26	-2.45	<b>-10.84</b>	40.82	3.20	<b>14.94</b>
Idaho	61.0	-1.3	<b>-3.6</b>	35.2	1.93	<b>10.44</b>	55.12	-1.71	-3.24	37.82	2.60	<b>8.73</b>
Illinois	59.5	0.8	<b>-6.4</b>	40.6	-0.34	<b>9.85</b>	58.61	-0.80	<b>-4.14</b>	43.67	2.00	<b>7.03</b>
Indiana	61.0	0.6	<b>-5.4</b>	34.2	-0.72	<b>8.19</b>	58.26	<b>2.94</b>	<b>-4.05</b>	34.81	-2.20	<b>8.38</b>
Iowa	69.7	0.1	<b>-4.4</b>	32.5	-0.09	<b>8.04</b>	65.86	-1.86	<b>-6.08</b>	36.59	1.20	<b>9.45</b>
Kansas	65.0	<b>-2.3</b>	<b>-6.5</b>	31.6	<b>1.75</b>	<b>9.20</b>	60.20	-2.10	<b>-7.41</b>	36.54	1.60	<b>11.66</b>
Kentucky	57.8	<b>1.8</b>	<b>-4.0</b>	39.9	-1.38	<b>6.36</b>	47.30	1.01	<b>-3.77</b>	50.39	-0.10	<b>7.20</b>
Louisiana	48.5	-0.7	<b>-2.8</b>	50.5	1.25	<b>6.41</b>	45.45	1.15	0.89	53.51	-0.10	<b>4.85</b>
Maine	57.3	-2.5	<b>-7.0</b>	43.5	<b>3.25</b>	<b>10.91</b>	52.06	-0.31	-3.63	49.69	2.10	<b>8.71</b>
Maryland	67.1	-0.5	<b>-7.1</b>	31.7	1.13	<b>8.97</b>	60.02	0.57	<b>-10.29</b>	38.99	0.70	<b>12.40</b>
Massachusetts	71.1	0.0	<b>-6.0</b>	32.4	0.38	<b>8.35</b>	NA	NA	NA	NA	NA	NA
Michigan	60.7	-0.6	<b>-6.9</b>	40.3	0.34	<b>9.44</b>	57.85	1.25	<b>-6.94</b>	40.34	-0.60	<b>6.40</b>
Minnesota	72.8	1.0	<b>-5.1</b>	25.6	-0.19	<b>7.47</b>	66.88	0.61	<b>-5.48</b>	25.64	-1.20	<b>7.80</b>
Mississippi	44.6	-0.7	<b>-4.7</b>	51.6	<b>1.98</b>	<b>10.58</b>	38.75	-0.25	<b>-4.56</b>	51.62	1.60	<b>10.30</b>
Missouri	61.0	<b>-1.9</b>	<b>-5.6</b>	34.8	<b>1.52</b>	<b>6.24</b>	51.86	-0.22	<b>-4.43</b>	34.83	-0.50	<b>5.50</b>
Montana	53.8	<b>-5.4</b>	<b>-11.9</b>	38.2	<b>5.01</b>	<b>16.30</b>	50.75	<b>-5.44</b>	<b>-10.59</b>	38.17	<b>5.30</b>	<b>15.60</b>
Nebraska	67.4	0.2	<b>-6.8</b>	29.4	-0.63	<b>8.21</b>	65.62	0.22	<b>-4.40</b>	29.38	-0.30	<b>7.40</b>
Nevada	57.9	<b>-4.2</b>	<b>-9.5</b>	29.1	<b>3.70</b>	<b>14.71</b>	58.53	-4.74	<b>-7.96</b>	29.12	1.40	<b>12.60</b>
New Hampshire	69.4	-2.2	<b>-7.8</b>	29.8	1.98	<b>9.58</b>	60.79	<b>-7.23</b>	<b>-11.41</b>	29.79	5.10	<b>14.80</b>
New Jersey	68.0	-0.9	<b>-5.9</b>	29.5	<b>1.15</b>	<b>9.15</b>	NA	NA	NA	NA	NA	NA
New Mexico	44.5	<b>3.6</b>	<b>-2.9</b>	52.1	-1.36	<b>9.76</b>	39.49	1.80	1.60	57.27	-1.60	3.61
New York	60.9	0.1	<b>-5.5</b>	40.0	0.54	<b>9.35</b>	60.79	0.76	<b>-2.78</b>	38.48	0.30	<b>8.33</b>
North Carolina	53.7	<b>-1.3</b>	<b>-6.4</b>	41.6	<b>1.40</b>	<b>9.43</b>	45.57	<b>-2.15</b>	<b>-6.89</b>	50.29	1.50	<b>9.80</b>
North Dakota	76.7	1.7	1.0	19.9	<b>-3.38</b>	0.89	74.20	<b>3.45</b>	1.27	19.94	<b>-4.60</b>	-1.98
Ohio	62.4	-0.8	<b>-7.1</b>	37.2	<b>1.57</b>	<b>10.95</b>	59.57	-0.34	<b>-5.81</b>	39.86	<b>2.70</b>	<b>10.05</b>
Oklahoma	51.7	-0.2	<b>-3.5</b>	42.3	0.85	<b>7.47</b>	44.90	0.22	<b>-3.47</b>	48.06	1.00	<b>7.72</b>
Oregon	59.3	1.0	<b>-8.6</b>	38.9	0.57	<b>17.81</b>	53.22	1.48	<b>-6.49</b>	46.36	3.30	<b>19.64</b>
Pennsylvania	64.1	-0.8	<b>-6.4</b>	35.8	0.73	<b>8.29</b>	61.62	0.58	<b>-4.17</b>	36.54	-0.20	<b>4.65</b>
Rhode Island	66.3	-1.0	<b>-6.5</b>	34.0	-0.75	<b>8.11</b>	NA	NA	NA	NA	NA	NA
South Carolina	52.7	<b>-1.7</b>	<b>-7.7</b>	42.1	<b>1.84</b>	<b>12.79</b>	41.93	<b>-3.59</b>	<b>-12.86</b>	50.54	0.49	<b>15.74</b>
South Dakota	66.1	0.2	-1.6	32.6	0.12	<b>3.14</b>	59.71	-2.05	-2.44	37.07	1.49	<b>5.76</b>
Tennessee	58.7	<b>1.6</b>	<b>-5.0</b>	39.5	-1.33	<b>7.85</b>	52.45	1.58	<b>-4.67</b>	46.24	-1.39	<b>7.23</b>
Texas	48.8	-0.4	<b>-4.6</b>	41.2	<b>1.15</b>	<b>10.90</b>	42.05	<b>-2.13</b>	<b>-7.03</b>	46.53	<b>1.84</b>	<b>12.78</b>
Utah	72.4	0.5	<b>-2.3</b>	20.5	-0.13	<b>6.77</b>	70.63	<b>5.54</b>	2.13	21.26	-2.32	0.26
Vermont	57.3	-0.8	<b>-6.0</b>	46.1	-0.25	<b>8.26</b>	50.48	-1.83	<b>-8.78</b>	52.42	0.18	<b>10.86</b>
Virginia	70.8	-0.3	<b>-4.3</b>	26.3	0.49	<b>7.01</b>	56.12	1.36	<b>-7.99</b>	41.18	-0.42	<b>10.60</b>
Washington	62.2	0.1	<b>-5.7</b>	36.6	0.13	<b>10.07</b>	48.18	-1.14	<b>-11.10</b>	51.39	2.24	<b>13.34</b>
West Virginia	57.4	1.1	<b>-2.3</b>	42.6	-1.71	<b>4.77</b>	51.69	0.10	-1.29	49.24	0.37	<b>5.46</b>
Wisconsin	66.6	0.8	<b>-8.4</b>	33.5	<b>-1.44</b>	<b>10.56</b>	63.74	0.64	<b>-6.77</b>	35.78	-1.13	<b>10.48</b>
Wyoming	62.2	<b>-5.9</b>	<b>-8.5</b>	31.7	3.55	<b>6.62</b>	61.61	<b>-6.10</b>	<b>-8.76</b>	31.97	<b>4.63</b>	<b>8.41</b>

Note: Bold typeface indicates a statistically significant change ( $p < 0.05$ ).  
Source: American Community Survey, 1-year estimates, 2008–2012



**TABLE 2: PERCENTAGE POINT CHANGE IN PRIVATE AND PUBLIC HEALTH INSURANCE COVERAGE FOR PERSONS UNDER AGE 18, 2008, 2011, AND 2012, CONTINUED**

SUBURBAN						CENTRAL CITY					
% Private in 2012	% Point Change from 2011	%Point Change from 2008	% Public in 2012	% Point Change from 2011	% Point Change from 2008	% Private in 2012	% Point Change from 2011	%Point Change from 2008	% Public in 2012	% Point Change from 2011	% Point Change from 2008
65.49	-0.52	-5.70	31.16	0.83	9.21	49.50	-0.35	-6.11	46.44	0.64	10.85
74.33	-0.24	-5.26	25.81	0.59	8.06	45.88	-1.00	-8.58	54.99	0.87	11.86
71.99	-0.13	-5.98	27.52	0.19	8.38	49.71	-0.06	-7.28	48.63	0.04	10.55
59.99	-0.59	-5.68	34.31	1.26	9.92	47.78	-0.09	-5.05	45.97	0.74	10.83
61.19	-0.85	-5.60	33.80	0.81	9.64	53.08	-0.47	-5.35	41.51	0.75	10.78
62.20	-0.77	-7.59	37.95	3.63	13.08	49.59	0.91	-7.22	49.33	0.17	12.88
61.62	3.06	-12.27	27.49	-7.09	5.41	63.94	0.30	-7.92	29.21	-2.20	6.89
61.79	-0.82	-2.15	29.41	-0.82	5.50	45.54	-1.60	-5.80	43.38	2.01	10.70
57.09	2.25	-0.80	39.65	-5.33	0.68	45.24	-2.71	-1.58	51.25	2.10	6.89
56.56	-0.88	-6.23	38.61	1.31	9.94	52.52	-0.41	-4.60	42.83	0.39	9.48
69.64	-3.38	-7.38	24.27	1.71	11.02	55.57	-0.13	-3.76	38.59	1.35	13.09
76.62	-2.13	-5.39	23.97	2.10	8.29	48.46	-1.10	-10.32	49.42	0.01	13.09
68.77	-0.52	-7.51	31.16	0.40	11.38	41.13	-3.67	-18.58	60.05	0.69	22.18
NA	NA	NA	NA	NA	NA	54.45	-0.02	-1.10	51.16	1.23	7.42
52.18	-1.33	-7.98	39.48	2.77	15.77	47.41	0.33	-8.77	44.27	0.09	16.10
58.74	-0.24	-5.00	34.49	0.72	7.67	44.21	-3.02	-3.81	50.91	2.76	8.83
75.25	-0.24	-4.90	26.23	-0.20	6.56	67.68	-3.23	-17.10	32.66	1.76	16.00
67.72	-0.75	-3.18	30.43	1.44	11.03	58.59	-1.65	-5.27	38.63	1.71	12.24
66.84	-0.13	-7.10	33.26	-0.07	10.07	47.52	3.13	-6.26	51.96	-1.93	10.55
70.44	0.15	-5.83	26.21	-0.35	7.83	48.59	-0.66	-6.02	45.79	-0.01	8.81
80.07	-1.95	-5.84	20.73	1.38	7.17	64.63	4.24	-0.69	38.69	-2.69	6.99
76.59	-1.77	-5.52	21.22	1.67	7.13	56.27	-4.01	-8.22	38.74	2.70	10.38
69.59	2.27	-2.03	28.53	-1.73	4.24	57.61	1.97	-7.54	39.65	-2.84	8.40
53.96	-2.94	-4.54	45.57	3.27	8.80	42.49	0.88	-3.87	55.58	-0.56	4.39
65.37	-1.79	-8.35	35.44	3.48	11.42	47.81	-9.65	-10.24	50.32	5.02	13.58
71.35	-0.77	-7.28	27.33	1.52	9.01	49.18	0.07	-5.78	50.12	-0.41	8.39
76.48	0.09	-4.86	27.21	1.00	7.79	53.61	0.28	-8.81	49.13	-2.14	9.37
69.76	-0.38	-6.11	31.89	0.00	9.55	43.03	-2.07	-9.24	57.00	1.52	11.72
79.76	1.25	-3.59	19.42	0.23	5.91	62.59	0.65	-8.15	35.17	-0.02	10.56
56.79	-1.38	-6.38	39.22	1.33	10.55	34.60	-3.86	-3.15	62.30	8.51	14.26
69.33	-1.36	-6.06	27.21	1.11	6.86	50.49	-4.49	-5.92	44.31	4.42	5.59
62.50	-9.36	-14.98	33.12	8.91	14.36	57.73	-2.87	-13.49	39.49	1.72	19.34
81.56	-0.41	-3.99	16.64	0.68	4.70	59.70	0.81	-10.88	36.28	-2.15	11.25
58.74	-6.37	-10.60	28.37	3.72	13.70	57.03	-1.69	-8.42	30.22	4.24	16.07
79.76	3.13	-3.61	19.16	-2.44	4.63	54.80	-8.16	-12.53	45.11	6.95	13.15
71.68	-0.41	-5.35	25.87	0.60	8.32	29.99	-4.34	-19.82	66.58	4.79	24.61
45.63	6.08	-3.92	51.47	0.61	12.76	48.46	3.05	-6.53	47.73	-2.78	13.37
76.61	0.46	-4.91	23.87	0.02	8.80	47.00	-0.29	-7.00	54.61	0.90	10.60
58.64	-1.98	-6.77	36.05	1.03	9.30	54.78	0.07	-5.46	40.99	1.88	9.08
84.36	-2.22	2.38	14.06	-2.07	0.46	76.36	0.31	0.34	23.50	-1.51	5.93
72.25	-0.41	-6.84	27.65	1.27	9.87	40.73	-1.38	-8.48	58.27	0.70	14.11
62.53	0.34	-0.63	33.07	-0.13	4.81	46.07	-1.64	-7.06	47.07	2.13	10.56
61.73	-0.92	-8.45	35.65	0.75	16.92	59.98	3.23	-10.11	38.46	-1.42	17.86
73.21	-0.59	-5.51	27.01	0.77	7.28	39.36	-1.95	-10.66	60.62	0.77	13.79
72.01	-0.82	-6.93	28.06	-2.21	7.21	54.69	-1.86	-5.28	46.26	2.63	9.55
56.54	-1.86	-5.72	38.82	2.91	11.72	52.87	1.55	-8.66	43.24	-0.24	13.23
85.99	6.58	4.58	17.82	-4.51	-1.46	64.13	-0.20	-3.10	34.53	1.01	0.20
69.38	1.47	-3.96	29.01	-1.04	6.29	50.58	1.94	-6.71	46.89	-1.76	10.42
56.03	0.03	-5.55	34.41	1.14	10.21	43.43	-0.37	-3.28	46.57	1.05	11.21
76.50	-0.07	-2.58	16.91	0.23	5.88	57.08	-2.63	-5.32	34.81	1.89	15.11
70.73	-0.16	-1.41	35.01	2.02	5.46	NA	NA	NA	NA	NA	NA
75.69	-0.76	-3.92	20.66	0.35	6.11	65.16	0.20	-4.65	33.67	1.33	8.79
68.19	0.68	-4.15	30.59	-0.96	9.04	56.38	-0.30	-5.52	42.16	1.15	9.77
63.54	1.49	-4.54	35.42	-2.31	4.56	53.87	1.94	0.88	46.72	-5.77	4.65
78.98	1.15	-5.62	21.36	-1.99	6.43	49.87	0.44	-13.16	50.21	-0.84	16.11
NA	NA	NA	NA	NA	NA	59.94	-9.51	-12.68	33.62	2.39	6.63

After 2016, the federal government will cover 95 percent of these costs associated with the ACA Medicaid expansion.<sup>25</sup> As noted, states now have the option to reject federal dollars for Medicaid expansion. As of June 9, 2014, twenty-six states and Washington, DC, expanded Medicaid, five states were still discussing expansion, and nineteen states indicated that they would not be accepting federal expansion funding for public insurance.<sup>26</sup> Expansion under ACA only affects children ages 6 to 19 by expanding coverage for families living between 100 and 133 percent of the federal poverty level.<sup>27</sup> However, many of these children were already covered through SCHIP. Analyses by Georgetown University's Health Policy Institute Center for Children and Families suggest that, if all fifty states expanded Medicaid, approximately 95 percent of children would be covered.<sup>28</sup>

## Insurance Coverage for Parents

Expansion under ACA may also be important for enrolling low-income parents, which may in turn expand rosters of covered children. Public policy researchers note that, when parents *and* children are covered over time, children tend to have more consistent coverage, particularly in low-income families.<sup>29</sup>

SCHIP and state-only funded programs that extend coverage to low-income children have been successful, particularly during the recent economic recession. Still, approximately 2.9 million children living in the United States remain uninsured. Because health insurance is critical in a fee-for-service health care system, policy makers and children's advocates ought to continue to look for ways that ensure all children have access to affordable health insurance and enroll in coverage.

## Data

This analysis is based on U.S. Census Bureau estimates from the 2008, 2009, 2010, 2011, and 2012 American Community Survey. Tables were produced by aggregating information from detailed tables available on American FactFinder.<sup>30</sup> Because estimates are based on survey data, caution must be used when comparing data from different years or place types; the margin of error may indicate that seemingly disparate numbers fall within sampling error.<sup>31</sup> All differences highlighted in this brief are statistically significant ( $p < 0.05$ ).

### Box 1: Defining Place Types Using the American Community Survey

The American Community Survey designates each sampled household or address as being located within one of several possible geographic components. In this analysis, "central city" designates households in the principal city of a metropolitan statistical area. "Suburban" includes those in metropolitan areas, but not within the principal city of that area, and "rural" consists of those households that are not within a metropolitan area at all.

## End notes

1. Jill Bernstein, Deborah Collet, and Stephanie Peterson, "How Does Health Insurance Coverage Improve Health Outcomes?" Issue Brief No. 1 (Washington, DC: Mathematica Policy Research, 2010).
2. American Public Health Association, "Medicaid Expansion" (Washington, DC: APHA, 2013), available at [www.apha.org/advocacy/Health+Reform/ACAbasics/medicaid.htm](http://www.apha.org/advocacy/Health+Reform/ACAbasics/medicaid.htm).
3. Centers for Medicare and Medicaid Services, "CHIP Eligibility Standards" (Washington, DC: CMS, 2011), available at [www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/CHIP-Eligibility-Standards-.html](http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/CHIP-Eligibility-Standards-.html).
4. Ibid.
5. Some sources indicate that expansion of Medicaid under the ACA is 138 percent of the federal poverty level, not 133 percent. Because of a revised methodology in the calculation of modified gross adjusted income, these two poverty levels are effectively the same. See American Public Health Association, "Medicaid Expansion," for a detailed explanation.
6. Ibid.
7. Analysis derived from 2012 ACS population estimates and from the list of states found at The Henry J. Kaiser Family Foundation, "Status of State Action on the Medicaid Expansion Decision, 2014," State Health Facts (Washington, DC: Kaiser Family Foundation, March 26, 2014), available at <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicare-under-the-affordable-care-act/>.
8. States that are undecided or have opted out of Medicaid expansion may later opt in. In addition, some states that have opted into expansion have customized the Medicaid expansion. See the Advisory Board Company, "Where the



States Stand on Medicaid Expansion” (Washington DC: Advisory Board Company, March 28, 2014), available at [www.advisory.com/daily-briefing/resources/primers/medicaidmap](http://www.advisory.com/daily-briefing/resources/primers/medicaidmap). Furthermore, states may choose to expand Medicaid under the Affordable Care Act via a federal matching program. See [Washington, DC: CMS, 2014], available at [www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/Childrens-Health-Insurance-Program-CHIP.html](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/Childrens-Health-Insurance-Program-CHIP.html).

9. Marybeth J. Mattingly, Jessica A. Carson, and Andrew Schaefer, “2012 National Poverty Rate Stagnates at 22.6 Percent: New Hampshire Child Poverty Jumps 30 Percent Since 2011,” Issue Brief No. 65 (Durham, NH: Carsey Institute, 2013), available at [www.carseyinstitute.unh.edu/sites/carseyinstitute.unh.edu/files/publications/IB-Mattingly-Carson-Same-Day-Poverty-web.pdf](http://www.carseyinstitute.unh.edu/sites/carseyinstitute.unh.edu/files/publications/IB-Mattingly-Carson-Same-Day-Poverty-web.pdf).

10. “Good jobs” are those that are full time, provide retirement and health benefits to the employee and dependents, have a degree of job autonomy, and have paid leave. For a full discussion, see Arne L. Kalleberg, *Good Jobs, Bad Jobs: The Rise of Polarized and Precarious Employment Systems in the United States, 1970s to 2000s* (New York: Russell Sage Foundation, 2011). Americans with “good jobs” left cities in droves beginning in the 1970s to settle in suburbs. See Harry J. Holzer et al., *Where Are All the Good Jobs Going? What National and Local Job Quality and Dynamics Mean for U.S. Workers* (New York: Russell Sage Foundation, 2011). Those with low incomes did not experience this type of migration. Compounded with this exodus of middle- and high-income families (who formerly paid taxes in cities) is the fact that many low-skill jobs moved to the suburbs. Workers in cities were and are unable to obtain these jobs because of transportation issues. Thus, low-income families often find themselves stranded in central cities with bad jobs and no health insurance. For a detailed discussion, see Bruce Katz and Katherine Allen, “Help Wanted: Connecting Inner-City Job Seekers with Suburban Jobs,” in *America at Work* (Washington, DC: Brookings Institution, Center on Urban and Metropolitan Policy, 1999), pp. 31–35.

11. Approximately 28 percent of U.S. children live in only three states: California, Texas, and Florida. Thirteen percent live in California, and another 15 percent live in Florida and Texas, combined.

12. National rates of coverage grew 1.37 percentage points between 2008 and 2009 [see Jessica A. Bean and Michael J. Staley, “Total Children Covered by Health Insurance Increased in 2009,” Issue Brief No. 34 (Durham, NH: Carsey Institute, 2011), available at [www.carseyinstitute.unh.edu/publications/IB-Bean-Health-Insurance.pdf](http://www.carseyinstitute.unh.edu/publications/IB-Bean-Health-Insurance.pdf)] and 1.94 percentage points between 2009 and 2010 [see Michael J.

Staley, Jessica A. Bean, and Jessica D. Ulrich, “Rates of Public Health Insurance Coverage for Children Rise as Rates of Private Coverage Decline,” Issue Brief No. 41 (Durham, NH: Carsey Institute, 2011), available at [www.carseyinstitute.unh.edu/publications/IB-Bean-Health-Insurance-Dec-2011.pdf](http://www.carseyinstitute.unh.edu/publications/IB-Bean-Health-Insurance-Dec-2011.pdf)].

13. Pearson’s correlation coefficient between the proportion of children living in poverty and the percent of insured children is  $-0.859$ . As child poverty increases, rates of children with private insurance coverage decrease. Analysis is available upon request.

14. Chip Brown, “North Dakota Went Boom,” *New York Times Magazine* (February 3, 2013), p. MM22.

15. Rates of child poverty decreased in North Dakota after 2010 (analysis conducted by the Carsey Institute and is available upon request).

16. Mattingly, Carson, and Schaefer, “2012 National Poverty Rate Stagnates.”

17. Wendy Cervantes and Lisa Shapiro, *Children of Immigrants and Healthcare Coverage* (Washington, DC: First Focus, 2011), available at [www.firstfocus.net/sites/default/files/ChildrenOfImmigrantsandHealthcareCoverage.pdf](http://www.firstfocus.net/sites/default/files/ChildrenOfImmigrantsandHealthcareCoverage.pdf).

18. See [www.carseyinstitute.unh.edu/sites/carseyinstitute.unh.edu/files/publications/IB-Bean-Health-Insurance-Dec-2011.pdf](http://www.carseyinstitute.unh.edu/sites/carseyinstitute.unh.edu/files/publications/IB-Bean-Health-Insurance-Dec-2011.pdf).

19. Some states have opted to provide coverage to lawfully residing immigrants before the five-year waiting period using state-only funds. For a summary of how ACA affects immigrants and their children, see “Key Facts on Health Coverage for Low-Income Immigrants Today and Under the Affordable Care Act” (Washington DC: Kaiser Family Foundation, March 2013), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/03/8279-02.pdf>.

20. National Immigrant Law Center, “How Are Immigrants Included in Health Care Reform?” Issue Brief (Washington, DC: National Immigrant Law Center, January 2014) available at [www.nilc.org/immigrantsshr.html](http://www.nilc.org/immigrantsshr.html).

21. Cervantes and Shapiro, *Children of Immigrants and Healthcare Coverage*.

22. For details on how immigration status affects enrollment in Medicaid, SCHIP, or for the Healthcare Exchange, see “What Do Immigrant Families Need to Know About the Marketplace?” (Washington, DC: HealthCare.Gov), available at [www.healthcare.gov/what-do-immigrant-families-need-to-know/](http://www.healthcare.gov/what-do-immigrant-families-need-to-know/).

23. American Academy of Pediatrics, “AAP Advocates for Access to Health Care for Immigrant Children” (Washington, DC: AAP, May 6, 2013), available at [www.aap.org/en-us/about-the-aap/aap-press-room/pages/AAP-Advocates-for-Access-to-Health-Care-for-Immigrant-](http://www.aap.org/en-us/about-the-aap/aap-press-room/pages/AAP-Advocates-for-Access-to-Health-Care-for-Immigrant-)

Children.aspx; Devlin Hanson and Margaret Simms, “Children of Immigrants: 2011 State Trends Update,” Issue Brief (*Urban Institute*, May 2014), available at [www.urban.org/immigrants/trends.cfm](http://www.urban.org/immigrants/trends.cfm).

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25. January Angeles, “How Health Reform’s Medicaid Expansion Will Impact State Budgets” (Washington, DC: Center on Budget and Policy Priorities, 2012), available at [www.cbpp.org/files/7-12-12health.pdf](http://www.cbpp.org/files/7-12-12health.pdf).

26. The Kaiser Family Foundation, “Status of State Action.”

27. Children ages 0 to 5 who live at or below 133 percent of the federal poverty line qualified for Medicaid coverage before the enactment of ACA.

28. Jocelyn Guyer and Martha Heberlin, “ACA Should Bring Insured Rate Up to 95%,” *A Children’s Health Policy Blog* (Washington, DC: Georgetown University Health Policy Institute Center for Families and Children), available at [http://ccf.georgetown.edu/ccf-resources/health\\_reform\\_could\\_cut\\_the\\_uninsured\\_rate\\_for\\_children\\_by\\_another\\_40/](http://ccf.georgetown.edu/ccf-resources/health_reform_could_cut_the_uninsured_rate_for_children_by_another_40/).

29. Heather Angier et al., “Trends in Health Insurance Status of U.S. Children and their Parents, 1998–2008,” *Maternal Child Health Journal*, vol. 17 (2013): 1550–1558; Phillip B. Levine, Robin McKnight, and Samantha Heep, “How Effective Are Public Policies to Increase Health Insurance Coverage Among Young Adults?” *American Economic Journal*, vol. 3, no. 1 (2011): 129–156.

30. See <http://factfinder2.census.gov>.

31. Refer to the Census Bureau’s published tables for detailed margins of error, available at: [www.census.gov/acs/www/Downloads/handbooks/ACSResearch.pdf](http://www.census.gov/acs/www/Downloads/handbooks/ACSResearch.pdf).

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