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Hispanic Children Least Likely to Have Health Insurance

Citizenship, Ethnicity, and Language Barriers to Coverage

Michael J. Staley and Jessica A. Carson

This policy brief examines health insurance coverage of Hispanic children and its relationship to their citizenship status, their parents'[1] citizenship status, parents' insurance coverage, language spoken at home, and their state's Medicaid expansion policies.

Hispanic Children Are Least Likely to Have Health Insurance

In 2014, 94 percent of U.S. children had health insurance.[2] Although this is a record high for children's coverage, 4.3 million children still remain without health insurance, and Hispanic children make up a disproportionate share of this group.

Hispanic children have historically had the highest rates of uninsurance among children of any racial/ethnic group.[3] In 2014, the most recent year for which data are available, 95.4 percent of non-Hispanic white children, 95.3 percent of black children, and 94.4 percent of multiracial children had health insurance coverage. In comparison, only 90.3 percent of Hispanic children were covered, leaving more than 1.7 million Hispanic children uninsured. Hispanic children in rural areas are less likely to have health insurance than Hispanic children in urban areas (9.4 percent versus 12.2 percent, respectively).[4]

Nearly 40 percent of all uninsured children are Hispanic, although Hispanic children make up only 24.3 percent of children in the United States (see Figure 1). By contrast, though nearly 52 percent of U.S. children are non-Hispanic white, they comprise only 40 percent of uninsured children. Black, non-Hispanic children account for 13.6 percent of children in the United States but just 10.8 percent of uninsured children.

KEY FINDINGS

- Hispanic children are less likely to have health insurance than black or white children, a gap that is explained by differences in citizenship status between Hispanic and non-Hispanic children.
- **3X** Noncitizen Hispanic children are nearly three times more likely to be uninsured than Hispanic citizen children living with citizen parents.
- **7X** Hispanic children who do not have an insured parent are seven times more likely to be uninsured than Hispanic children with at least one insured parent.
- Children in states that expanded Medicaid are less likely to be uninsured than children in non-expansion states, although low and moderate income children are more likely to be uninsured regardless of state expansion status.

Children's Citizenship Status Is a Key Driver of Hispanic Children's Uninsurance

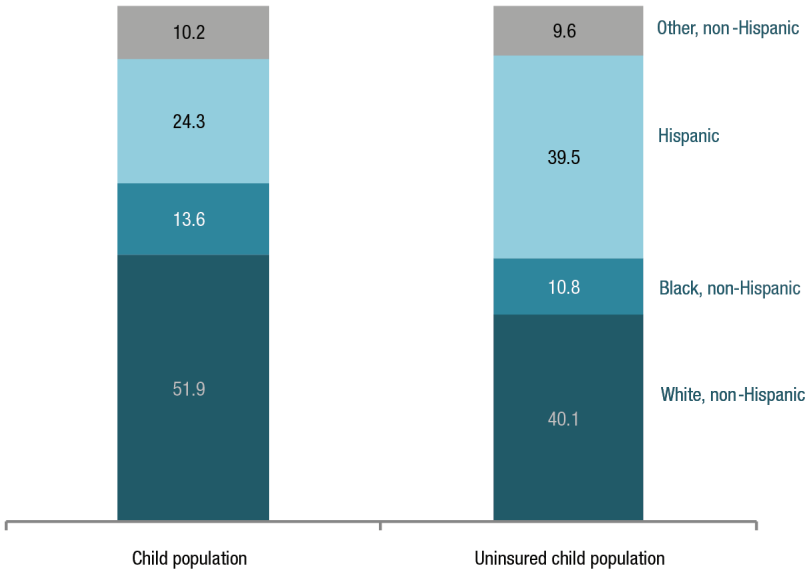
Ethnicity is related to several factors associated with lower rates of insurance coverage. Hispanic children are more likely to be noncitizens and to have parents who don't speak English at home, don't have health insurance, or aren't citizens themselves. Below, we examine these relationships to identify which of these factors matter most for Hispanic children's insurance coverage.[5]

The majority of all Hispanic children (56.1 percent) are citizens living with citizen parents (what we term "all-citizen families").[6] This kind of family makes up a much smaller share of *uninsured* Hispanic children (36.1 percent). On the other hand, noncitizen children make up just one in twenty Hispanic children (5.2 percent) but more than one in five uninsured Hispanic children (22.9 percent).[7]

Of course, citizenship is not the only barrier to coverage that noncitizen Hispanic children face. Nevertheless, when we statistically control for language, income, family, and residential characteristics (all potential barriers to coverage), noncitizen Hispanic children would still be nearly three times more likely to lack insurance than Hispanic children in all-citizen families (see Figure 2). In other words, family citizenship status is an especially strong predictor of uninsurance among Hispanic children.

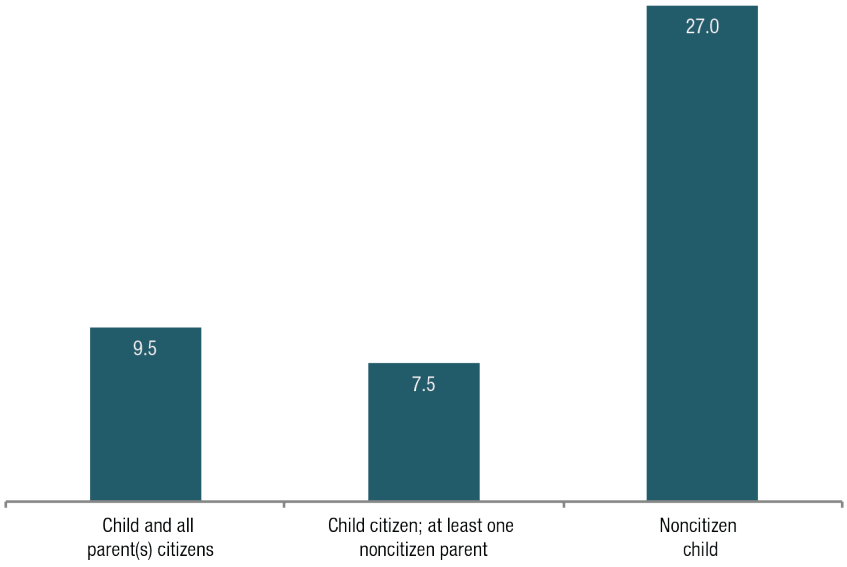
Figure 2 demonstrates that child citizenship status matters much more in predicting insurance status than does parental citizenship status. Indeed, citizen children in households with a noncitizen parent do not have an appreciably different probability of being insured—they're actually slightly less likely to be uninsured than children in all-citizen families. While this finding warrants deeper investigation than can be provided here, it is possible that these children are more often insured due to better community outreach efforts to mixed-citizenship families.

FIGURE 1. RACE/ETHNICITY OF CHILD POPULATION AND UNINSURED CHILD POPULATION



Source: 2014 American Community Survey

FIGURE 2. HISPANIC CHILDREN'S PROBABILITY OF BEING UNINSURED, BY FAMILY CITIZENSHIP STATUS



Note: All differences between citizenship statuses are statistically significant ($p<0.05$). Predicted probabilities are displayed in percentages.

Parent's Insurance Status Is the Strongest Predictor of Children's Uninsurance

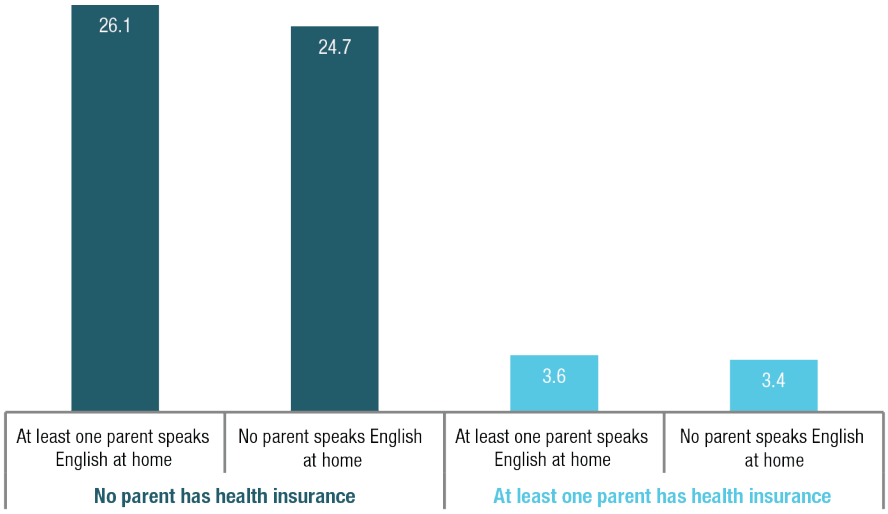
Given that insured parents may be more likely to enroll children in coverage, we also assessed the relationship between Hispanic children's insurance coverage and that of their parents. Even after accounting for children's personal characteristics (for example, age and sex) and family characteristics (such as income and household structure), parental insurance status emerged as the single strongest predictor of uninsurance of the factors considered here. Specifically, Hispanic children whose parents are uninsured face a risk of uninsurance 7.2 times that of Hispanic children who live with at least one insured parent (not shown).

After accounting for parents' insurance status, whether parents spoke English at home or not became inconsequential in predicting children's coverage (see Figure 3). In other words, parents' language spoken at home is only related to Hispanic children's insurance status because it is related to parents' insurance status.

Medicaid Expansion Matters Most for Moderate-Income Families

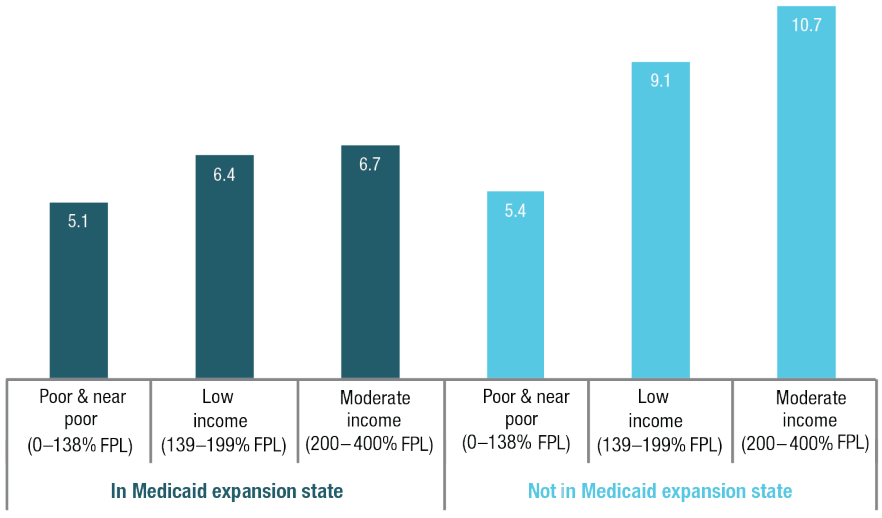
Figure 4 shows that regardless of income, Hispanic children are less likely to be uninsured in a state that expanded Medicaid than in a state that did not.[8] In both kinds of states, poor and near poor children are the least likely to be uninsured, due to their consistent eligibility for public insurance.

FIGURE 3. HISPANIC CHILDREN'S PROBABILITY OF BEING UNINSURED, BY PARENT CHARACTERISTICS



Note: Differences between parental insurance statuses are statistically significant; differences between language categories are not ($p<0.05$).
Predicted probabilities are displayed in percentages.
Source: 2014 American Community Survey

FIGURE 4. HISPANIC CHILDREN'S PROBABILITY OF BEING UNINSURED, BY FAMILY INCOME AND RESIDENCE IN A MEDICAID EXPANSION STATE



Note: FPL is federal poverty line. All differences within income categories and between Medicaid expansion statuses are statistically significant. All differences between income categories are statistically significant, except for between 139–199% and 200–400% of the FPL in states that expanded Medicaid ($p<0.05$).
Predicted probabilities are displayed in percentages.
Source: 2014 American Community Survey and the Henry J. Kaiser Family Foundation

Importantly, Figure 4 also shows the apparent benefit of Medicaid expansion for moderate-income children.

In non-expansion states, the probability of being uninsured is higher among moderate-income children than low-income children (10.7 percent, compared to 9.1 percent). In contrast, in states that expanded Medicaid, probabilities of uninsurance are similar for moderate and low-income children (6.7 versus 6.4 percent). This suggests that in non-expansion states, moderate-income children who are ineligible for CHIP (200–400 percent federal povery line [FPL]) may be excluded from public coverage and unable to afford private coverage. In short, living in a state that expanded Medicaid appears to have the most effect on Hispanic children in moderate-income families ($38,192 to $76,384 for a single parent with two children in 2015).[9]

Finally, after the Children's Health Insurance Program (CHIP) reauthorization in 2009, some states eliminated the five-year waiting period for newly immigrated, lawfully residing children to enroll in Medicaid and CHIP. Hispanic children in these states were 1.2 times more likely to be insured than Hispanic children living in states with a waiting period.[10]

Policy Considerations: Steps to Insuring All U.S. Children

Insuring children in the United States has been a longstanding priority among many lawmakers at the state and federal levels, and more evidence is emerging that supports extending public coverage to undocumented children.[11] Medicaid, CHIP, and most recently the Affordable Care Act (ACA) have bolstered the rates of coverage among children, and several states have expanded public coverage beyond the limits of federal programs.

Providing better access to coverage to Hispanic children is key to closing the uninsured gap among minors. Hispanic children account for 39.5 percent of all uninsured children, and they are disproportionately uninsured compared to other race and ethnic groups. Our findings reveal a complex landscape of uninsurance among Hispanic children that extends beyond citizenship status alone; in fact, the insurance status of parents seems to be the most salient factor in predicting whether or not a Hispanic child will be insured.

Yet no one-size-fits-all policy change will provide coverage to the 1.7 million uninsured Hispanic minors. These findings will help lawmakers, community outreach organizations, and child welfare advocates identify characteristics of children who are more likely to be uninsured and where these children reside. Based on our analysis, we suggest the following policy considerations that might incrementally reduce the number of uninsured children.

- **Policy makers may consider how to strengthen and sustain outreach to Hispanic populations. Policies around insuring noncitizen children might also be carefully considered**. When we considered whether ethnicity or citizenship status was a stronger predictor of uninsurance, citizenship status came to the fore. In other words, because child citizenship status matters more than parents' citizenship status, increased attention to noncitizen children may help increase the number of insured Hispanic children.
- **By expanding Medicaid, states may be able to reduce the number of uninsured parents, which, in turn, may cause these parents to enroll their children in coverage.** Hispanic children in states that expanded Medicaid were slightly less likely to be uninsured than children living in states that did not. Medicaid expansion would likely affect moderate-income families the most (200 to 400 percent of FPL). However, expansion could also indirectly increase children's rates of coverage in other income categories as well, due to the strong link between parents' and children's insurance status.[12]
- **While the insurance gains are likely to be modest, eliminating or reducing waiting periods for children who recently immigrated might improve the reach of public insurance programs.** Some policies hinder noncitizen children, both lawfully residing and unauthorized, from becoming enrolled in health insurance. Before 2009, the federal government required that all newly immigrated children and pregnant women wait five years before enrolling in public coverage. In 2009, CHIPRA made the five year waiting period optional for states; currently, twenty-three states still have such a waiting period. Arizona and Florida are among states that have kept the five-year waiting period, and significant populations of immigrant children reside in these two states.

- **Extending coverage to all low-income undocumented children could reduce the number of uninsured children.** Although reliable data on undocumented children's health insurance is scarce, we find that noncitizen children are overrepresented in the uninsured population, suggesting that undocumented children may be as well. In 2015, policy makers in California—a state with a significant undocumented population—opted to extend state-funded public insurance to an estimated 170,000 undocumented children. California is the fifth state to enact such a provision, in addition to Washington, DC.[13]

Data

In this brief, we use the most recent data from the U.S. Census Bureau's American Community Survey collected in 2014, made available through the University of Minnesota's Integrated Public Use Microdata Series.[14] All estimates are based on survey data, so caution must be exercised in comparing estimates; estimates are weighted and corrected for complex survey design. Unless noted otherwise, all differences highlighted in this brief are statistically significant ($p<0.05$).

Endnotes

1. Throughout this brief, we use the term "parent" to refer to individuals on whom the child is likely to be dependent; however, 4 percent of children in our sample lived with adults other than their parents. In order to include these children in our analysis, we assign "parent" status to adults in the household who we deemed likely to be a child's primary caregiver. In these cases, "parents" include grandparents, foster parents, and other adult relatives (when no actual parent is present in the household). We excluded children living with nonfamily members such as friends, and children who are heads of their own households.

2. Michael J. Staley, "After Years of Decline, Private Health Insurance Rates Among Children Grew in 2014" (Durham, NH: Carsey School of Public Policy, 2016), http://scholars.unh.edu/cgi/viewcontent.cgi?article=1264&context=carsey.

3. Sonya Schwartz et al., "Historic Gains in Health Coverage for Hispanic Children in the Affordable Care Act's First Year" (Washington, DC: Center for Children and Families at Georgetown University Health Policy Institute and the National Council of La Raza, 2016), http://ccf.georgetown.edu/wp-content/uploads/2016/01/CCF-NCLR-Uninsured-Hispanic-Kids-Report-Final-Jan-14-2016.pdf.

4. In this sample, 8 percent of Hispanic children did not have data identifying whether they lived in a metropolitan area ("urban") or a nonmetropolitan area ("rural"). Since this 8 percent cannot be meaningfully classified as urban or rural—and because other place-based indicators were more central to this analysis—we chose to omit analysis by place of residence in the body of this brief. As a result, this sentence refers to a slightly different sample (one that excludes those who are not classified on the metropolitan measure) than do the other analyses from this brief. Note that 11.9 percent of children in non-identified areas were uninsured.

5. In preparing these analyses, we use a step-wise strategy to fit multiple iterations of the model predicting uninsurance among all children (that is, not just Hispanic children). We found that once our family citizenship measure was entered into the model, the relationship between ethnicity and uninsurance was fully mediated by citizenship status. Further testing of this effect through use of the KHB method (a general decomposition method that avoids the issue of rescaling bias in comparing nested nonlinear probability models) shows that 38 percent of the effect of ethnicity is due to citizenship status. After confirming this relationship, we limit our remaining analyses to a subpopulation of Hispanic children. The results discussed in this section emerged from a logistic regression model controlling for child's age; child's sex; family income categories (0–138 percent of the federal poverty line [FPL], 139–199 percent FPL, 200–400 percent FPL, and 401 percent FPL or more, specified for their relevance to Medicaid eligibility); family structure; family citizenship status; whether any parent speaks English at home; whether any parent has health insurance; residence in a Medicaid expansion state; residence in a Legal Immigrant Children's Health Improvement Act state; residence in a Hispanic migration destination state (see Daniel T. Lichter, Scott R. Sanders, and Kenneth M. Johnson, "Hispanics at the Starting Line: Poverty Among Newborn Infants in Established Gateways and New Destinations," *Social Forces* 94, no. 1 [2015]: 209–35); and interaction effects between family citizenship and Medicaid expansion, family income and Medicaid expansion, and family citizenship and Hispanic migration destination classification. Full results are available upon request.

6. We term this arrangement "all-citizen families" for readability throughout this brief. However, it is important to note that the unit of analysis in this brief is the child, and this term applies only to the focus child and all of his/her parents present. It is possible that noncitizen family members, such as siblings, grandparents, and other relatives, may be present in the home. In a small number of cases, these families might also include a noncitizen child who would be grouped into the "noncitizen child" category instead.

7. We use citizenship status in this analysis rather than immigration or lawfully residing status for two reasons: first, legal residence status is not collected by the American Community Survey, and second, citizenship is a universal threshold to accessing

public benefits, whereas legal residence is not. For example, noncitizen children are subject to a five-year waiting period after immigration in some states, making "lawfully residing" not universal in its relationship to insurance eligibility.

8. We estimate this by calculating the average probability of being uninsured, given a variety of personal and family characteristics (see endnote 5). Indeed, after finding no substantial effect across all income categories, we assess whether living in an expansion state matters more for children in some income brackets than in others here. Note that we interact measures of family income with residence in a Medicaid expansion state here, as not all children are eligible for Medicaid—even under new Medicaid expansion rules. We use 138 percent FPL as a lower-level cutoff in this brief to reflect the most current Medicaid eligibility requirements as outlined in ACA. ACA uses modified adjusted gross income (MAGI), which is the equivalent of the unmodified 133 percent FPL AGI. For more information, see http://www.shadac.org/news/aca-note-when-133-equals-138-fpl-calculations-affordable-care-act.

9. Note that we examine, but do not include in the figure children in families above 400 percent FPL. Their probability of uninsurance is 4.1 in expansion states and 6.5 in non-expansion states. It is unclear why the highest-income children face a higher risk of being uninsured than children below 138 percent FPL in non-Medicaid expansion states, but a lower risk of being uninsured in expansion states. Neither group of states extends Medicaid eligibility to children at income levels this high, suggesting that other, unmeasured characteristics of these children or their states may account for this relationship.

10. The Children's Health Insurance Reauthorization Act (CHIPRA) of 2009 authorized the use of federal Medicaid and CHIP funds to insure newly immigrated children without a five-year waiting period. Called the Legal Immigrant Children's Health Improvement Act, or the ICHIA option, states were not required to remove the existing five-year ban on access to public insurance. See Tricia Brooks et al., "Modern Era Medicaid: Findings From a 50-State Survey of Eligibility, Enrollment, Renewal and Cost-Sharing Policies in Medicaid and CHIP as of January 2015" (Washington, DC: Georgetown University Center for Children and Families with the Kaiser Family Foundation, 2015), http://ccf.georgetown.edu/wp-content/uploads/2015/01/Modern-Era-Medicaid-January-2015.pdf.

11. Providing coverage to undocumented children may break generational patterns of uninsurance and poor overall well-being, reduce disparities in poverty rates, and improve school attendance and performance; see: Shawna Malia Kanaiaupuni, "Child Well-Being and The Intergenerational Effects of Undocumented Immigration Status" (Washington, DC: Rockefeller Foundation and the United States Department of Agriculture, 2000), https://ideas.repec.org/p/wop/wispod/1210-00.html.

12. ACA largely focused on covering adults while maintaining enrollment eligibility thresholds established for children in Medicaid and CHIP prior to ACA's implementation.

13. Note that this extension of coverage is relatively new. Coverage for undocumented children in California begins in May 2016, and the full effect of these new policies won't be realized until at least 2017. See Sinsi Hernandez-Cancio, Yasmin Peled, and Erika Ramirez, "California's Historic Decision to Extend Health Coverage to Every Low-Income Kid" (Washington, DC: FamiliesUSA, 2015). http://familiesusa.org/blog/2015/07/californias-historic-decision-extend-health-coverage-every-low-income-kid.

14. Steven Ruggles et al., Integrated Public Use Microdata Series: Version 6.0 [machine-readable database] (Minneapolis: University of Minnesota, 2015).

About the Authors

Michael J. Staley is a research assistant at the Carsey School of Public Policy and a doctoral candidate in the Department of Sociology at the University of New Hampshire (*michael.staley@unh.edu*).

Jessica A. Carson is a vulnerable families research scientist at the Carsey School of Public Policy at the University of New Hampshire (*jessica.carson@unh.edu*).

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Huddleston Hall • 73 Main Street • Durham, NH 03824
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