

Record Number of Children Covered by Health Insurance in 2011

Increases in Public Insurance Offset Declines in Private Coverage

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Health insurance remains one of the most important factors in predicting access to health care.¹ Providing health insurance to ensure that children receive adequate care has been a priority among policy makers and children's advocacy groups for more than fifty years. The majority of American children (58.8 percent) are covered by private insurance, typically through their parents' employers. However, when parents become unemployed or otherwise lose employment benefits, public insurance may be the only option. The Great Recession caused many families to experience such hardship.²

Public insurance exists to cover children who live in low-income households or to cover gaps in insurance when private insurance is beyond parents' financial means. As private-sector employment benefits were cut and rates of unemployment and poverty increased during the Great Recession, so did rates of public insurance among children. Thus, expanding public coverage suggests that public insurance has been effective in meeting its intended goal.

Using 2008 through 2011 American Community Survey data, this brief describes rates of children's health insurance coverage nationally, by region, and by place of residence, or place type (that is, rural, suburban, and central city).³ The second half of this brief details the composition of coverage in the United States, specifically the proportion of children covered by private and public insurance.

Rates of Coverage Increased for the Fourth Year in a Row

Between 2008 and 2011, health insurance coverage among children aged 0 to 17 rose from 90 percent to 92.5 percent (see Table 1).⁴ In the most recent report, coverage increased slightly (by half of a percentage point) between 2010 and 2011. This increase likely stems from policies enacted to increase participation in government-sponsored health insurance programs. Insurance coverage among children has been on the rise since the 1960s as government-subsidized programs and Medicaid expanded.⁵ The modest increase in insured children between 2010 and 2011 may indicate

Key Findings

- Rates of insurance coverage for children under age 18 increased from 90 percent in 2008 to 92.5 percent in 2011.
- With the exception of the Midwest, all regions experienced a modest increase in children's health insurance coverage between 2010 and 2011.
- Rural places and central cities in the South and West experienced the greatest increases in rates of coverage since 2008.
- The proportion of children covered by public health insurance increased substantially for the fourth consecutive year in every kind of place—rural, suburban, and in central cities.
- Rates of private insurance coverage among children decreased for the fourth consecutive year.

that rates are stabilizing. Aside from the elderly population eligible for Medicare,⁶ children and teens are more likely than other age groups to have insurance. For example, in 2011, only 72.5 percent of young adults aged 26 to 34 had some type of health insurance.⁷

The West and South experienced the greatest overall increase in rates of coverage regionally since 2008, 3.2 and 3.1 percentage points, respectively. This increase likely occurred because there was greater opportunity for growth in coverage; these regions reported the lowest proportion of children covered in 2008. Children in the Northeast have the highest rates of coverage nationally (95.7 percent), followed closely by children in the Midwest (94.7 percent).

Coverage rates also vary by place type. Children who live in suburban areas have the highest rates of coverage (93.1 percent), followed by those in central cities (92 percent) and rural places (91.6 percent).⁸ Since 2008, however, gains in coverage among children in central cities and rural places have reduced the disparity between place types.

TABLE 1. PERCENTAGE POINT CHANGE IN HEALTH INSURANCE COVERAGE, FOR PERSONS UNDER AGE 18

	ALL PLACES			RURAL			SUBURBAN			CENTRAL CITY		
	% Insured in 2011	% Point Change from 2010	% Point Change from 2008	% Insured in 2011	% Point Change from 2010	% Point Change from 2008	% Insured in 2011	% Point Change from 2010	% Point Change from 2008	% Insured in 2011	% Point Change from 2010	% Point Change from 2008
United States	92.5	0.5	2.5	91.6	0.3	2.5	93.1	0.5	1.9	92.0	0.7	3.3
Northeast Region	95.7	0.3	1.3	93.4	-0.2	1.0	96.1	0.2	1.1	95.7	0.7	1.9
Midwest Region	94.7	0.4	1.3	92.7	0.4	1.1	95.6	0.5	0.9	94.5	0.2	2.2
South Region	90.8	0.6	3.2	91.3	0.2	3.1	91.0	0.5	2.6	90.1	0.8	4.4
West Region	91.1	0.7	3.1	88.9	0.5	4.2	91.6	0.7	2.5	91.0	0.8	3.6

Note: Bold indicates statistical significance ($p < 0.05$).

The largest increases occurred in places with historically low rates of coverage. Since 2008, for example, rural places in the West experienced a 4.2 percentage point increase in coverage (from 84.7 percent to 88.9 percent in 2011). Likewise, central cities in the South experienced a 4.4 percentage point increase in the same period of time (from 85.7 percent to 90.1 percent).

Amid increasing rates nationally, regionally, and by place type, only rural places in the West had a coverage rate below 90 percent in 2011. Indeed, inequality in rates of coverage between regions and place types appears to be diminishing as overall rates stabilize above 90 percent.

Shifts from Private to Public Insurance Continue

Significant declines in private insurance and increases in public insurance occurred in 2011. Thus, while *overall* rates of coverage increased only slightly between 2010 and 2011, the *type* of coverage shifted significantly, continuing a trend since 2008. Indeed, between 2008 and 2011, the rate of private coverage among children decreased by more than 5 percentage points across the United States, while public rates increased by more than 9 percentage points (see Table 2).

Regions with the lowest proportion of insured children in 2008 experienced the greatest increases in public coverage. The West led the increase with a 9.4 percentage point increase in public coverage.⁹ The smallest increase was 8.2 percentage points in the Northeast. Meanwhile, private coverage declined by between 4.8 and 6.1 percentage points in the West and South, respectively.

All place types—rural, suburban, and central city—experienced shifts from private insurance to public insurance between 2008 and 2011. In 2011, rates of public coverage were higher in rural places (43.3 percent) and central cities (45.8 percent) compared with suburban places

(30.3 percent). Correspondingly, the rate of private insurance in suburban places (66 percent) was higher than in rural places (52.8 percent) or central cities (49.9 percent). Of note, the shift from private to public coverage between 2010 and 2011 was less drastic than in previous years, which may suggest that the trend is slowing (see Figure 1).

Increases in Public Coverage Linked to Federal and State Policy and the Economy

Even amid economic recession, children's insurance rates rose 2.5 percentage points between 2008 and 2011, largely from gains in public insurance. While unemployment rates have declined since 2008,¹⁰ research shows that some individuals are taking jobs with no health benefits, with health benefits that are not available to dependents, or the premium—the upfront cost of insurance to the primary beneficiary—is unaffordable. Thus, many parents have turned to federal programs such as Medicaid or the State Children's Health Insurance Program (SCHIP) or state programs such as MaineCare or BadgerCare in Wisconsin.¹¹ This shift in type of insurance coverage, now a multi-year trend, reflects the economic and job market of 2011, four years after the beginning of the Great Recession.

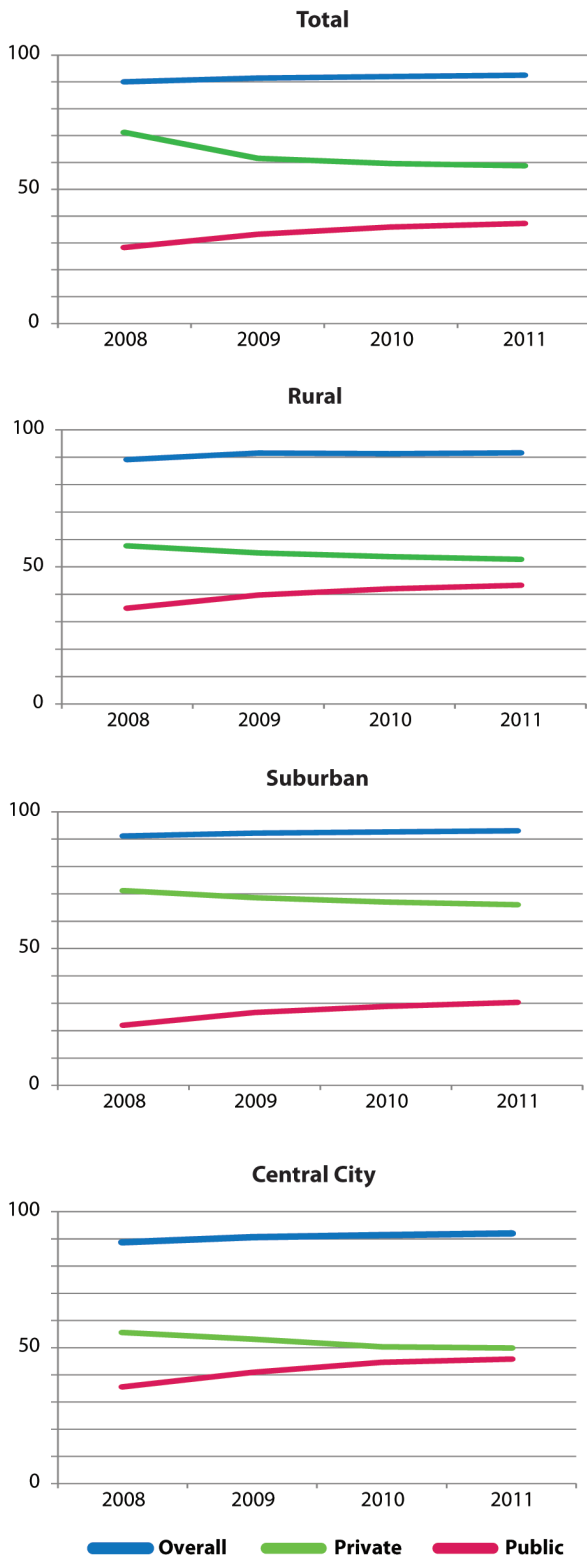
In addition, the federal government renewed the SCHIP,¹² expanded Medicaid, and embarked on a national effort to insure eligible children, all of which likely encouraged greater coverage. For example, the American Recovery and Reinvestment Act of 2009 directly appropriated funds to

TABLE 2. PERCENTAGE POINT CHANGE IN PRIVATE AND PUBLIC HEALTH INSURANCE COVERAGE, FOR PERSONS UNDER AGE 18

	ALL PLACES						RURAL						SUBURBAN						CENTRAL CITY					
	% Private in 2011	% Point Change from 2010	% Point Change from 2008	% Public in 2011	% Point Change from 2010	% Point Change from 2008	% Private in 2011	% Point Change from 2010	% Point Change from 2008	% Public in 2011	% Point Change from 2010	% Point Change from 2008	% Private in 2011	% Point Change from 2010	% Point Change from 2008	% Public in 2011	% Point Change from 2010	% Point Change from 2008	% Private in 2011	% Point Change from 2010	% Point Change from 2008	% Public in 2011	% Point Change from 2010	% Point Change from 2008
United States	58.8	-0.8	-5.3	37.3	1.3	9.0	52.8	-1.0	-4.9	43.3	1.3	8.4	66.0	-1.0	-5.2	30.3	1.5	8.4	49.9	-0.5	-5.8	45.8	1.2	10.2
Northeast Region	65.2	-1.2	-5.4	34.9	1.4	8.2	60.5	-1.0	-4.4	38.6	0.9	7.0	74.6	-1.4	-5.0	25.2	1.3	7.5	46.9	-0.7	-7.6	54.1	1.6	11.0
Midwest Region	63.4	-0.9	-6.1	35.5	1.4	8.8	60.6	-1.1	-5.4	37.6	1.4	7.8	72.1	-0.9	-5.8	27.3	1.5	8.2	49.8	-1.0	-7.2	48.6	1.2	10.5
South Region	54.1	-0.7	-5.0	39.6	1.2	9.1	46.0	-0.5	-4.8	49.0	0.8	8.6	60.6	-0.9	-5.1	33.1	1.4	8.7	47.9	-0.4	-5.0	45.2	1.1	10.1
West Region	57.6	-0.6	-4.8	36.9	1.4	9.4	52.2	-2.2	-4.5	40.9	2.4	9.6	62.0	-0.7	-4.8	33.0	1.6	8.8	53.6	-0.1	-4.9	40.8	1.0	10.0

Note: Bold indicates statistical significance ($p < 0.05$).

FIGURE 1. PERCENT OF OVERALL, PUBLIC, AND PRIVATE HEALTH INSURANCE AMONG CHILDREN BY PLACE TYPE



states to expand Medicaid, especially for children.¹³ Many states have also opted to sustain these levels of Medicaid funding. (Note that provisions in the Affordable Care Act that would significantly impact rates of children's health insurance did not take effect between 2008 and 2011.¹⁴)

Recent data on children's health insurance indicate that overall rates may be stabilizing, perhaps indicating saturation or a ceiling effect. However, the trend of rising public and declining private coverage may continue. Not all children who are eligible for public coverage are currently enrolled, creating a gap between participation rates and eligibility rates. This gap may remain for various reasons—parents may choose to abstain from federal insurance, or there may be a lack of information among the uninsured. These concerns may be particularly salient for undocumented workers, who may not be aware that their children are eligible for coverage, or they may choose not to participate because of the fear of deportation.¹⁵ Immigration reform and/or educational campaigns may succeed in increasing the participation rate among children of recently immigrated families, thus elevating the overall rate of coverage in the United States.

Revising federal health insurance programs will surely emerge in congressional discussions on the federal debt ceiling, in revisions to the 2011 Budget Control Act, and in upcoming federal budget proposals. Federal insurance programs make up 21 percent of the total budget each year.¹⁶ Thus, some lawmakers may look to reduce overall spending through cuts in funding for these programs. However, as more families turn to public insurance to provide coverage for their children, costs are likely to increase, despite cost-reducing measures required by the Affordable Care Act that go into effect in 2014. Some proposed policy changes would shift a greater proportion of the cost of care back to families, which could be particularly burdensome for low-income families.

If accessibility is to remain a goal of policy makers and children's health advocates, state and federal governments may need to find ways to control the cost of care rather than shifting increased financial responsibility to low-income families.¹⁷

Data

This analysis is based on U.S. Census Bureau estimates from the 2008, 2009, 2010, and 2011 American Community Survey. For more details or information, please refer to the American Community Survey. Tables were produced by aggregating information from detailed tables available on American Factfinder.¹⁸ Because estimates are based on survey data, caution must be used in comparing across years or places, as the margin of error may indicate that seemingly disparate numbers fall within sampling error.¹⁹ All differences highlighted in this brief are statistically significant ($p < 0.05$).

ENDNOTES

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), 1.

2. Although the Great Recession began in October of 2007, there is a lag effect of unemployment and loss of insurance coverage. That is, loss of insurance likely did not occur suddenly as the markets fell in autumn of 2007.

3. Data are available at <http://factfinder2.census.gov>.

4. It is possible that more children had health insurance coverage in 2011 than at any prior point. However, the American Community Survey only started asking about health insurance status in 2008.

5. D. Bae, “Introduction to the State Children’s Health Insurance Program,” Research Brief No 2 (Princeton, NJ: Robert Wood Johnson Foundation, 2007).

6. Those who are aged 65 or over are eligible for Medicare coverage. In 2011, the Census Bureau reported that more than 98 percent of individuals who are eligible for Medicare coverage were enrolled. See C. DeNavas-Walt, B. D. Proctor, and J.C. Smith, “Income, Poverty, and Health Insurance Coverage in the United States: 2011,” Current Population Reports, 60-243 (Washington, DC: U.S. Government Printing Office and U.S. Department of Commerce, 2011).

7. DeNavas-Walt, Proctor, and Smith, “Income, Poverty, and Health Insurance Coverage.”

8. Differences between suburban places and central cities, as well as rural places and central cities, are statistically significant ($p > 0.05$). However, there is no statistical difference between rates of coverage among children living in central cities and rural places.

9. A relatively small number of children have both private and public insurance, or, in states that allow it, have some form of public assistance to help them meet their private insurance premium.

10. The nation unemployment rate is now below 8 percent. Data available via the Bureau of Labor Statistics: <http://data.bls.gov/timeseries/LNS14000000>.

11. State estimates of coverage are available for 2008, 2009, and 2010. The Census Bureau discontinued state-level estimates in the 2011 data release.

12. SCHIP was renewed in 2009, but the full effect of the renewal will not be reflected in the rates for several years.

13. U.S. Department of Health and Human Services, “Two Year Anniversary of Children’s Health Insurance Law Sees Millions of Newly Insured Children, Families,” Press Release (Washington, DC: DHHS, 2011), available at www.hhs.gov/news/press/2011pres/02/20110203b.html.

14. First Focus, “What the Passage of Health Reform Means for Children” (Washington, D.C.: First Focus, March 25, 2010), available at: <http://firstfocus.net/sites/default/files/HealthReformPassage.pdf>.

15. For a complete discussion on public assistance and immigration, see Lisa Sun-Hee Park, *Entitled to Nothing: The Struggle for Immigrant Health Care in the Age of Welfare Reform* (New York: NYU Press, 2011).

16. Center on Budget and Policy Priorities, “Where do our federal dollars go?” August 13, 2012, available at: <http://www.cbpp.org/files/4-14-08tax.pdf>.

17. See Katherine Swartz, “Cost sharing: effects on spending and outcomes,” Research Synthesis Report No. 20 (Princeton, NJ: Robert Wood Johnson Foundation, 2010), 16. Swartz explains that when consumers, particularly low-income health care consumers, are required to pay a co-pay for preventive health services, they are much less likely to use such services. See also Kathryn Pitkin Derose, Carole Roan Gresenz, and Jeanne S. Ringel, “Understanding Disparities in Health Care Access—And Reducing Them—Through a Focus on Public Health,” *Health Affairs*, vol. 30, no. 10 (2011): 1844-1851.

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

19. Refer to the Census Bureau’s published tables for detailed margins of error.

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