Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

Getting Back on Track: A Detailed Look at Health Coverage Trends for Latino Children

by Kelly Whitener and Alexandra Corcoran

Introduction

From 2008 to 2016, the Latino child uninsured rate fell steadily, eventually achieving a historic low of 7.7 percent in 2016.[1] Although this rate was still higher than that for non-Latino children, the decline signaled steady progress towards narrowing health coverage disparities between Latino children and their peers. However, as the overall child uninsured rate started going in the wrong direction between 2016 and 2019, Latino children were disproportionately affected.[2] Erasing years of progress, Latino children's uninsured rate reached 9.3 percent in 2019.[3] This 1.6 percentage point increase was more than twice as fast as the 0.7 percentage point increase for non-Latino youth (from 3.7 percent in 2016 to 4.4 percent in 2019).

At the national level, the Trump administration publicized and implemented the "public charge" rule, which penalized adults for using public programs prior to gaining citizenship. Even though 95 percent of Latino children are citizens and not subject to public charge, many Latino families avoided enrolling their children in Medicaid or CHIP out of fear of adverse immigration consequences, known as the "chilling effect."[4] Federal cuts to funding for outreach efforts and health insurance navigators who could help explain the nuances of the public charge rule and remind families of the affordable coverage options available to them only exacerbated the problem.[5] Moreover, repeated attempts to repeal the Affordable Care Act (ACA) and ongoing court battles have left many families uncertain about the availability of public coverage.[6]

At the state level, red tape barriers, such as frequent income reviews between renewal periods, closure of applications without screening eligibility for other assistance programs, and unreasonably quick turnaround deadlines for information requests made getting and keeping coverage harder for families.[7] As of 2019, there were approximately 1.83 million uninsured Latino children in the nation, an increase of 354,400 children compared to 2016. This report takes a closer look at who these children are.

Figure 1. Uninsured Rate for Latino and Non-Latino Children, 2016-2019

Source: Georgetown University Center for Children and Families analysis of U.S. Census Bureau 2016-2019 American Community Survey (ACS) data using Public Use Microdata Sample (PUMS).
* Change is significant at the 90 percent confidence level relative to the prior year indicated.

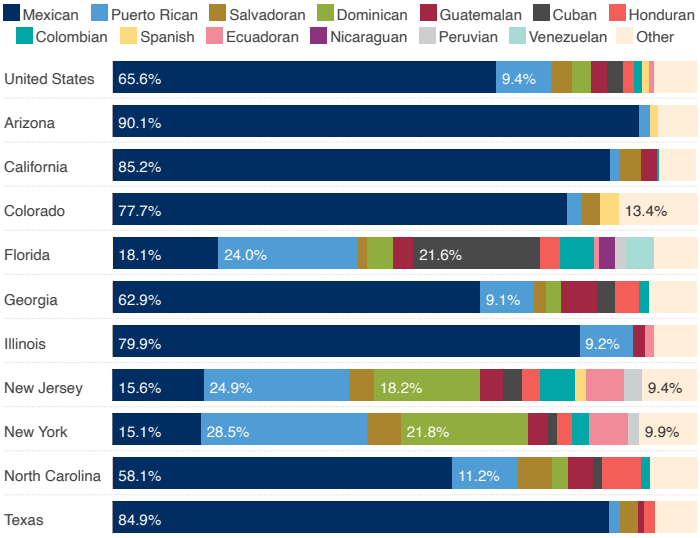
Understanding Diversity within the "Hispanic/Latino" Category

Within the broad label "Hispanic/Latino" there are many different stories shaped by socioeconomic status, documentation status, state of residence, immigration history (or lack thereof for those whose families have lived here since before the U.S. existed), and country of origin (see Appendix A for an explanation of how the U.S. Census Bureau collects and compiles Latino data).[8] Across the 50 states and the District of Columbia (D.C.), 65.6 percent of Latino children are of Mexican descent and 9.4 percent are of Puerto Rican descent.[9] Children whose families identify as Salvadoran, Dominican, Guatemalan, and Cuban each represent between two and four percent of the national Latino child population (see Figure 2).[10] However, there are significant differences at the state level—in Arizona, for example, 90 percent of Latino children are Mexican while in New York, Puerto Rican and Dominican children make up more than half of the Latino child population.

Which Latino Children are Losing Coverage?

Coverage losses were widespread across age groups and income levels between 2016 and 2019. School-age Latino children saw a slightly sharper increase than young children, jumping 1.8 percentage points from 8.7 percent in 2016 to 10.5 percent in 2019 (see Table 1). The lowest income Latino children, those with family incomes at or below 137 percent of poverty, lost the most ground with their uninsured rate rising more than two percentage points in the three-year period (see Figure 3).[11]

Figure 2. Diversity of Ethnicity within the Latino Child Population in 10 States with Largest Latino Child Population



Source: Georgetown University Center for Children and Families analysis of U.S. Census Bureau 2019 American Community Survey (ACS) data using Public Use Microdata Sample (PUMS).

Table 1. Uninsured Rate for Latino Children by Age, 2016-2019

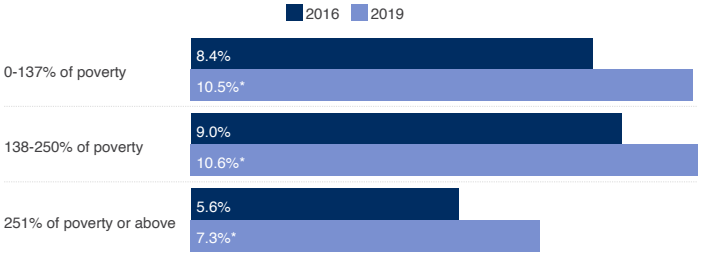
Age	2016	2019
Under 6	5.3%	6.6%*
6-18	8.7%	10.5%*

Source: Georgetown University Center for Children and Families analysis of U.S. Census Bureau 2016-2019 American Community Survey (ACS) data using Public Use Microdata Sample (PUMS).
* Change is significant at the 90 percent confidence level relative to the prior year indicated.

Latinos, Immigration, and Citizenship Status

Many Latinos have deep family roots in what is today the United States (U.S.), dating back to well before Europeans arrived on the East Coast and the U.S. expanded its territory to the west and south, annexing large parts of Mexico. Yet, assumptions that all Latinos are immigrants remain prevalent. In fact, the vast majority (80.3 percent) of Latinos in the U.S. are citizens, many of them with long histories that even predate the founding of the U.S.

Figure 3. Uninsured Rate for Latino Children by Income, 2016-2019

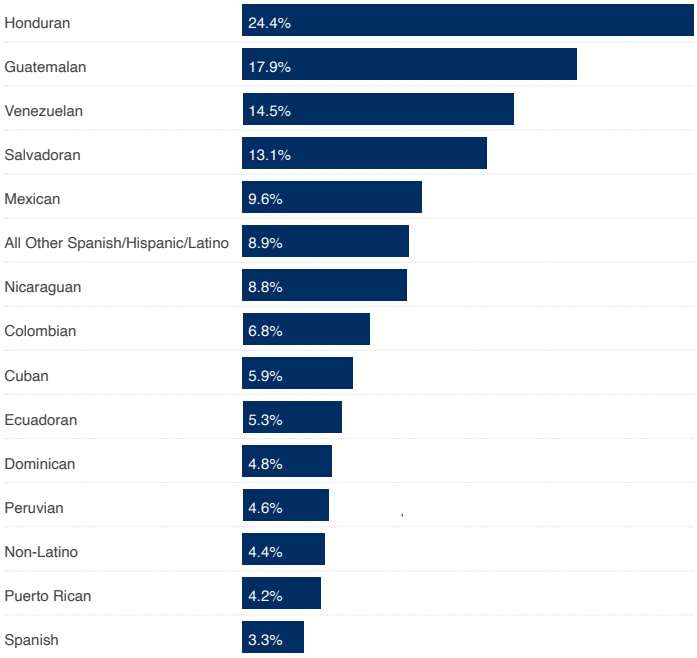


Source: Georgetown University Center for Children and Families analysis of U.S. Census Bureau 2016-2019 American Community Survey (ACS) data using Public Use Microdata Sample (PUMS).
* Change is significant at the 90 percent confidence level relative to the prior year indicated.

These trends illustrate how the systemic barriers to coverage that Latino children face have grown over the past three years. But they do not tell the full story. Looking at the data through the lens of detailed demographics and state residency helps illuminate the distinct challenges that families face in accessing health coverage. Disaggregating the data in this manner can also serve as the first step towards targeted outreach and enrollment efforts to make sure that all children get the care they need to grow and thrive.

When disaggregated, the national uninsured rate of 9.3 percent for Latino children reveals wide variation (see Figure 4). For example, while almost a quarter of children of Honduran descent are uninsured, approximately 8.8 percent of Nicaraguan children are uninsured, and only 3.3 percent of children of Spanish descent are uninsured. The uninsured rate for Puerto Rican children is on par with the uninsured rate for non-Latino children.

Figure 4. National Child Uninsured Rate by Detailed Ethnicity, 2019



Source: Georgetown University Center for Children and Families analysis of U.S. Census Bureau 2019 American Community Survey (ACS) data using Public Use Microdata Sample (PUMS). Note that the uninsured rate for Puerto Rican children reflects those who are living in one of the 50 states or the District of Columbia.

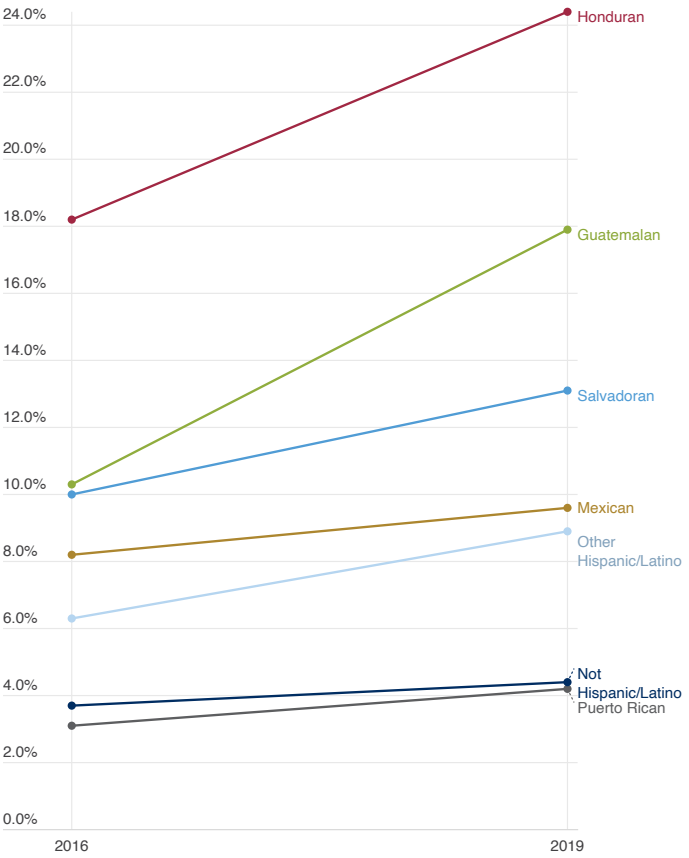
Further, the child uninsured rate has not accelerated at an even pace for different communities of Latino children (see Figure 5). While the uninsured rate for Guatemalan children shot up more than seven percentage points during the past three years, the uninsured rate for Puerto Rican children residing in the states or D.C. rose just over a percentage point. Some groups, such as Dominican children, saw no statistically significant change in their uninsured rate over the three years (see Appendix B).

Puerto Rico

The Commonwealth of Puerto Rico is a territory of the U.S., and Puerto Ricans are U.S. citizens. The child uninsured rate for Latino children living in the Commonwealth is 3.5 percent.[12] In this report, references to Puerto Rican children reflect those who are living in one of the 50 states or the District of Columbia.

Factors Associated with Higher Uninsured Rates

Figure 5. Changes in Child Uninsured Rate by Detailed Ethnicity, 2016-2019



Source: Georgetown University Center for Children and Families analysis of U.S. Census Bureau 2019 American Community Survey (ACS) data using Public Use Microdata Sample (PUMS). Graphic only shows those subgroups for whom there was a statistically significant change at a 90 percent confidence interval relative to the prior year indicated. See Appendix B for full results. Note that the uninsured rate for Puerto Rican children reflects those who are living in one of the 50 states or the District of Columbia.

State Residency. There is considerable variation in the Latino child uninsured rate by state (see Figure 6). State-level policies play a key role in enhancing or limiting access to health coverage for Latino children. The Latino child uninsured rate ranges from 1.8 percent in Massachusetts to 19.2 percent in Mississippi. The five states with the highest rates of uninsured Latino children are: Mississippi (19.2 percent), Texas (17.7 percent), Tennessee (17.7 percent), Georgia (16.3 percent), and Arkansas (15.5 percent).

Between 2016 and 2019, South Carolina saw the largest jump in the uninsured rate for Latino kids, rising 6.8 percentage points from 8.5 percent to 15.3 percent (see Appendix C). California and Texas are home to the largest numbers of Latino children (4.89 million and 3.87 million, respectively) but Latino children in Texas are almost four times more likely to be uninsured compared to their peers in California (see Appendices D and E).

Importantly, some subgroups of Latinos are more likely to live in certain states — while a quarter of Mexican children live in Texas, less than five percent of Puerto Rican children do. And, while Guatemalan children are most likely to live in California, roughly one in five live in Florida, Texas, or Georgia (19.6 percent) (see Figure 7). As a result of this geographic variation, state and local policies to make coverage more affordable and inclusive to Latino children and families play an important role in reducing the uninsured rate for specific subgroups.

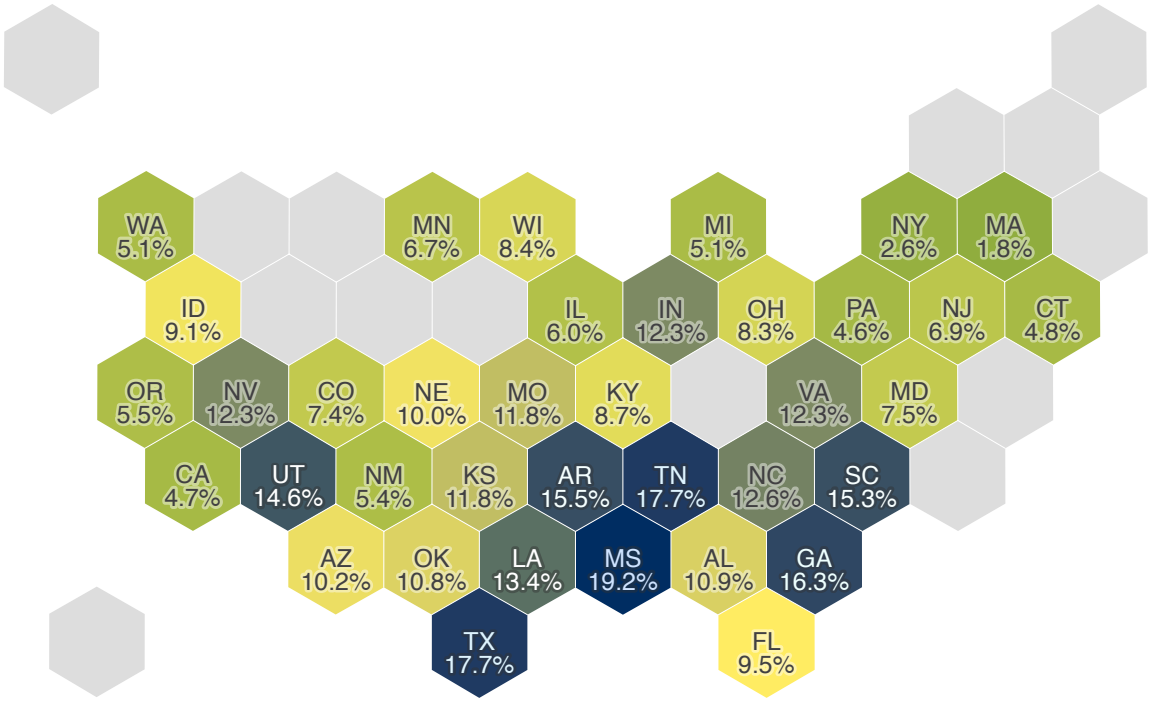
The uninsured rate for Latino children in states that had not implemented Medicaid expansion by 2019 is more than 2.5 times higher than expansion states (14.9 percent to 5.8 percent respectively). For non-Latino children, the uninsured rate in non-expansion states is only slightly more than 1.5 times the rate of expansion states (5.8 percent to 3.6 percent) (see Table 2).

Table 2. Uninsured Rate for Latino and Non-Latino Children by Expansion Status, 2019

	Latino	Non-Latino
Expansion States	5.8%	3.6%
Non-Expansion States	14.9%	5.8%

Source: Georgetown Center for Children and Families analysis of U.S. Census Bureau 2019 American Community Survey Public Use Microdata Sample (PUMS). Maine and Virginia, who expanded between 2016 and 2019, are excluded from this analysis.

Figure 6. Uninsured Rate for Latino Children, 2019



Source: Georgetown Center for Children and Families analysis of U.S. Census Bureau 2019 American Community Survey Public Use Microdata Sample (PUMS). To ensure accuracy and consistency, Georgetown CCF calculates the coefficient of variation (CV; also known as the relative standard error) for each estimate. Estimates with CVs greater than 25 percent are not presented in this analysis. See methodology section for full details.

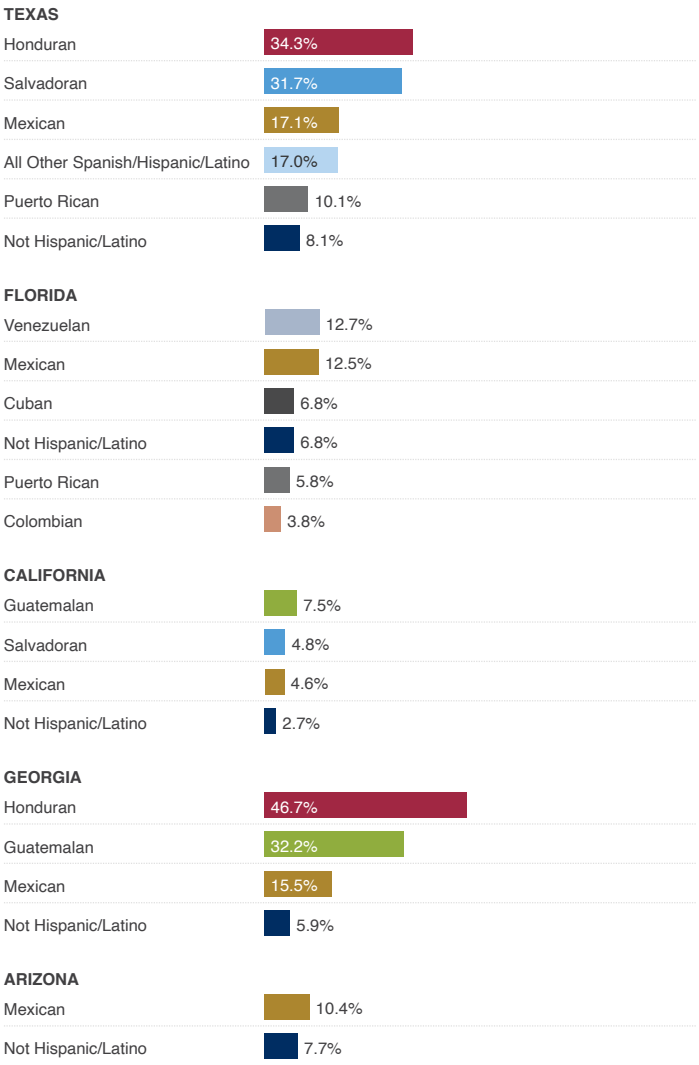
Figure 7. Top States of Residence for Latino Children from Different Backgrounds

Mexican Children		Puerto Rican Children		Salvadoran Children		Dominican Children		Guatemalan Children	
California	32.3%	Florida	18.7%	California	25.7%	New York	37.5%	California	23.5%
Texas	25.5%	New York	16.3%	Texas	16.0%	New Jersey	16.7%	Florida	8.7%
Arizona	5.4%	Pennsylvania	9.7%	Maryland	10.8%	Florida	10.6%	Texas	6.8%
Illinois	4.6%	New Jersey	7.6%	Virginia	8.6%	Pennsylvania	7.8%	New York	6.5%
Colorado	2.5%	Massachusetts	6.2%	New York	8.2%	Massachusetts	7.8%	Georgia	4.1%
Washington	2.4%	Connecticut	5.2%	Massachusetts	3.5%	Connecticut	2.9%	Massachusetts	4.0%
Florida	2.0%	Texas	4.3%	New Jersey	3.3%	Rhode Island	2.4%	New Jersey	3.7%

Source: Georgetown Center for Children and Families analysis of U.S. Census Bureau 2019 American Community Survey Data Public Use Microdata Sample (PUMS).

Due to sample size and reliability limitations, it is not possible to disaggregate the Latino child uninsured rate by subgroup for every state. However, a closer look at the five states with the highest number of uninsured Latino children illustrates how variable coverage rates are, both within and between states (see Figure 8). In Florida, Colombian and Puerto Rican children have the lowest uninsured rates (3.8 percent and 5.8 percent) overall and Cuban children have the same uninsured rate as non-Latino children (6.8 percent). Almost one out of every two Honduran children in Georgia is uninsured, compared to less than one in five Mexican children in the state, signaling that these communities face different barriers to coverage.

Figure 8. Latino Child Uninsured Rate by Detailed Ethnicity and State, 2019



Source: Georgetown Center for Children and Families analysis of U.S. Census Bureau 2019 American Community Survey Data Public Use Microdata Sample (PUMS).

While Arizona has one of the highest numbers of Latino children in the nation, over 90 percent are of Mexican descent. Consequently, it is only possible to estimate the uninsured rate for children of Mexican descent with accuracy in Arizona: 10.4 percent. Children of Mexican descent in Arizona's neighboring California are much less likely to be uninsured. While Guatemalan children in California have the highest uninsured rate of the state's reliable estimates for Latino subgroups at 7.5 percent, they are better off than their counterparts in Georgia where 32.2 percent of Guatemalan children are uninsured.

Language. Federal regulations direct Medicaid agencies to communicate available benefits and eligibility requirements "in plain language" and in "a manner that is accessible and timely" to English-language learners through the provision of oral interpretation and written translations at no cost to the individual. Federal regulations also require that the Medicaid application itself is accessible to English-language learners.[13]

However, recent research indicates that more oversight of these requirements is needed because language remains a major barrier for many Latino families: Latino adolescents in Spanish-speaking households are more likely to be uninsured than Latino adolescents overall and over half of uninsured school-age Latino children in Texas have at least one parent more comfortable with a language other than English (LOE). [14]

More than Spanish

Families from Latin America speak a wide variety of languages. For example, the Mexican government recognizes 68 national languages, 63 of which are indigenous.[15] In the U.S., there are approximately 32,000 Latino individuals who speak either an Uto-Aztecan language (such as Michoacán Nahuatl or El Nayar Cora) or another Central or South American language (such as Mixtec or Quechua) at home and roughly 26,000 Latinos speak Portuguese in the house.[16]

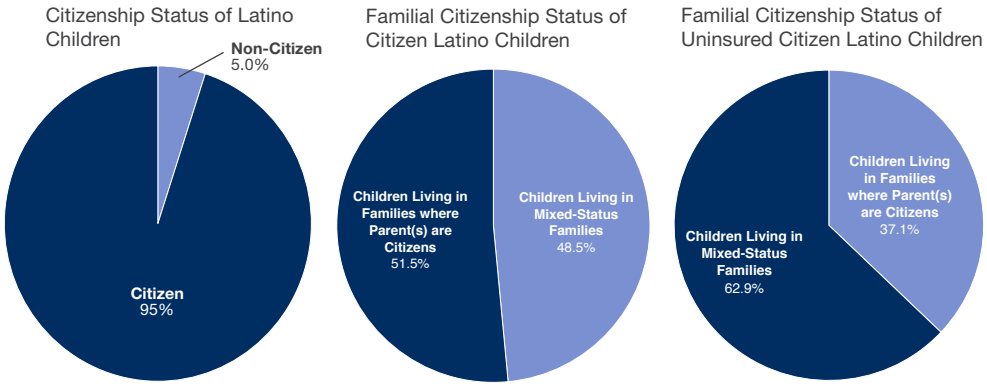
Disaggregated data shows the communities for whom language is a bigger barrier: less than four percent of Puerto Rican children living in the states or D.C. have parents who indicate that they do not speak English or have difficulty speaking English. In contrast, over one-third of Guatemalan and Honduran children, and over a quarter of Salvadoran children, have parents who are English-language learners. For uninsured Latino children specifically, over half of Guatemalan and Honduran children without health coverage (60.9 percent and 66.6 percent, respectively) live with LOE parents.

Citizenship Status of Child. Overall, 95 percent of Latino children are U.S. citizens (see Figure 9). However, for those Latino children who are not citizens, accessing coverage is more difficult. In 16 states, children without citizenship must be lawfully-residing for five years before they can enroll in Medicaid or CHIP and in 43 states undocumented children are not eligible for comprehensive coverage. Children and youth with Deferred Action for Childhood Arrivals (DACA) status are also ineligible for federally-funded, comprehensive coverage.[17] As a result of this patchwork of eligibility, some Latino children are more likely to be eligible for public coverage programs than others. For example, while nearly all Puerto Rican children are citizens and can enroll in Medicaid, CHIP, or Marketplace coverage without worrying about the immigration-based restrictions, Venezuelan and Honduran children are much less likely to be citizens, forcing a greater share of them to contend with these barriers.

Citizenship Status of Parents and Public Charge. Despite the fact that the overwhelming majority of Latino children are citizens, almost half of Latino children who are citizens live in a mixed-status family, meaning they have at least one non-citizen parent. A disproportionate share of uninsured Latino citizen children live in mixed-status families (see Figure 9). In 2018, the Trump Administration introduced the "public charge" rule which would have allowed an immigrant's participation in public benefit programs to count against them in their application for permanent residency. While the final rule stipulated that children's participation in programs like Medicaid and CHIP would not affect parents' green card applications, the long, hostile messaging campaign around the public charge rule left many immigrant families worried and confused. Almost four in five adults in immigrant families with children who indicated that they understood the Trump-era public charge rule did not understand that children's Medicaid enrollment would not affect their own public charge determination.[18] The Trump Administration also worked hard to change immigration policies in other ways, such as by limiting asylum, reducing refugee resettlement, trying to end DACA and Temporary Protected Status (TPS) designations, and conducting high-profile workplace raids.[19]

The "chilling effect" of the public charge rule and other immigration rule changes was likely widespread across Latino ethnicities. More than half of Honduran, Guatemalan, Salvadoran, Venezuelan, Ecuadoran, Dominican, and Mexican children living in the U.S. have at least one parent who is not a citizen. However, for a few subgroups, the

Figure 9. Latino Child Population by Citizenship Status



Data Note: Who is included in the non-citizen category?
The American Community Survey tracks citizenship status—not immigration status. The "non-citizen" category includes children and adults who are lawfully-residing permanent residents, lawfully-residing residents under another protected class (for example, temporary protected status, deferred enforcement departure, and special immigrant juveniles), and those without documentation.

Source: Georgetown University Center for Children and Families analysis of U.S. Census Bureau 2019 American Community Survey (ACS) data using Integrated Public Use Microdata Sample (IPUMS). For the purposes of this analysis, mixed-status families are defined as families where the child is a citizen and at least one parent is not a citizen. Children living in families where parent(s) are citizens include single-parent households with a citizen parent and two-parent households where both parents are citizens.

public charge rule was likely less of a concern. For example, roughly 35 percent of Cuban children have at least one non-citizen parent and only 7.1 percent of Puerto Rican children have at least one non-citizen parent (a share lower than non-Latino children overall). Note that although the Biden Administration withdrew the Trump-era public charge rule in March 2021, the data presented here are from 2016-2019 when the Trump-era rule was proposed, finalized, and implemented.

Recommendations

As communities of color have disproportionately borne the brunt of the COVID-19 crisis, the number of Latino children without coverage has likely worsened. Survey results from 2020 show that Latino households with school age children were three times more likely to report food insecurity than non-Latino white families, signaling widespread economic distress.[20] Further, the importance of accessing comprehensive and affordable health coverage is pressing. Latino adults participate in the workforce at a higher rate than the national average,[21] but they are less likely to have jobs with employer-sponsored health insurance.[22] Latino workers are also more likely than their white counterparts to be in frontline jobs where they are exposed to the virus, leading to higher rates of infection and stress for families.[23] And, 31 percent of children affected by the serious COVID-related multisystem inflammatory syndrome have been Latino.[24] It will take a concerted, and strategic, effort on the part of national and state policymakers to help Latino children get the health coverage they need both now and into the future.

Federal recommendations:

Conduct robust outreach and enrollment campaigns to reach eligible but uninsured Latino children: The majority of uninsured children are eligible for Medicaid or CHIP but unenrolled. The Medicaid/CHIP participation rate for Latino children is on par with children overall, but increases in Medicaid/CHIP enrollment are correlated with decreases in the uninsured rate.[25] Robust outreach programs would help inform Latino families about their coverage options and culturally and linguistically competent enrollment assistance would help eligible children access free or low-cost coverage. The Biden Administration recently announced increased funding for community groups to provide in-person enrollment assistance during the Marketplace special enrollment period created as a result of the COVID-19 pandemic.[26] Continuing these investments and ensuring funds are available to assist with enrollment in Medicaid, CHIP, and Marketplace plans could help regain lost ground on Latino child insurance rates.

Clear and consistent messaging around the reversal of the Trump-era Public Charge Rule: On March 9, 2021, the Biden Administration rescinded the public charge rule.[27] However, erasing the rule's "chilling effect" will take time. While trusted community messengers will be critical in communicating the policy changes (see state/local recommendations below), immigrant families identify U.S. Citizenship and Immigration Services, legal professionals, and state government agencies as among the most trusted sources of information.[28] The Administration must use the power of their office to ensure families that they can sign up for coverage without fear.

Remove all citizenship-based eligibility criteria from Medicaid and CHIP: As of 2021, 34 states and the District of Columbia already allow lawfully-residing immigrant children to enroll in Medicaid or CHIP without a five-year waiting period under section 1903(v)(4) of the Social Security Act.[29] A total of six states (California, Illinois, Massachusetts, New York, Oregon, and Washington) and the District of Columbia leverage state funds to cover undocumented children.[30] Though only five percent of Latino children are not citizens (and an even smaller share are undocumented), eliminating citizenship and immigration-based eligibility restrictions would help reach more children by creating an inclusive public coverage system. Making income eligibility the sole criteria for Medicaid and CHIP across all states would also simplify and strengthen outreach and enrollment messaging and streamline program administration and financing.[31]

State/local recommendations:

Expand Medicaid: Currently, there are 12 states still refusing to accept federal funds to expand Medicaid eligibility for adults up to 138 percent of the federal poverty level. Years of research show that expanding Medicaid coverage to

more adults lowers the child uninsured rate as newly-eligible parents enroll their whole family.[32]

Simplify and tailor enrollment and renewal processes: The data presented above show that children in the poorest households and in LOE households are more likely to be uninsured. Burdens such as 10-day turnaround times for state requests for information likely disproportionately affect these families. States should adopt streamlined enrollment and renewal processes that lessen the burden on families and tailor their instructions to meet the linguistic preferences of beneficiaries' families. Disaggregated data shows that that language is much more likely to be a barrier for Guatemalan and Honduran families, highlighting an opportunity for agencies to craft accessible materials for these communities.

Work with a range of community groups to target outreach and enrollment efforts: Given the diversity within the Latino community, state agencies must ensure that they are working with a variety of groups and community leaders. For example, community leaders reaching out to mixed-status Venezuelan families in Florida may need to use different messages than those working with the Cuban community.

Fund Promotora programs: Promotoras, or community health workers who share a background with those they are serving, can play an important role in connecting Latino communities to coverage.[33] Given the disparities highlighted by the disaggregated data, it will be important for state and local governments to partner with Promotoras who have connections in the appropriate community.

Conclusion

Overall, Latino children are more likely to be uninsured than their peers, even though nearly all Latino children are U.S. citizens. Research has shown that having health coverage as a child has life-long, positive impacts such as improved health, improved educational outcomes, and higher paying jobs in adulthood. Efforts to cover more Latino children will require developing a deeper understanding of the characteristics of subgroups of uninsured Latino children such as by age, income level, state residency, and country of origin. As a starting place, policymakers and stakeholders at the state and local level can turn to Census Bureau data to identify groups of Latino children that may benefit from more targeted outreach and enrollment efforts and build partnerships with community health workers to reach them in culturally and linguistically appropriate ways. Over the long term, the Biden Administration can work to improve Census Bureau data to address issues with the sample size and how the questions are phrased to better capture lived experiences. Leaders at the federal and state levels can also begin to rebuild trust among Latino communities by sharing clear and reliable information as they work toward more inclusive health coverage policies.

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Appendix A. How the Census Bureau Collects Questions about Race and Ethnicity on the American Community Survey and Compiles Hispanic/Latino Data

The American Community Survey (ACS), fielded by the U.S. Census Bureau, collects questionnaires from approximately 3.5 million households every year and extrapolates estimates from these responses.[35] The ACS provides the most reliable annual estimates of health insurance coverage for geographic areas of over 65,000 individuals. The data is used by various agencies at multiple levels of government to plan outreach and enrollment efforts.[36] However, post-survey quality checks and measures of accuracy conducted by the Census Bureau indicate that the Latino population is consistently under-sampled in the ACS.[37] Exacerbating this challenge, young children ages 0-4, especially young Latino children, have historically been undercounted in ACS and Census Bureau data.[38]

The Census Bureau follows guidelines set by the Office of Management and Budget (OMB) that define race and ethnicity as two separate facets of a person's identity.[39] The ACS definition of Hispanic/Latino is:

> *"Hispanics or Latinos who identify with the terms 'Hispanic,' 'Latino,' or 'Spanish' are those who classify themselves in one or more of the specific Hispanic, Latino, or Spanish categories listed on the questionnaire ('Mexican,' 'Puerto Rican,' or 'Cuban') as well as those who indicate that they are 'another Hispanic, Latino, or Spanish origin.' People who do not identify with any of the specific origins listed on the questionnaire but indicate that they are 'another Hispanic, Latino, or Spanish origin" are those who identify as Argentinian, Colombian, Dominican, Nicaraguan, Salvadoran, Spaniard, or other Spanish cultures or origins […] Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race."*

When tallying responses, the Census Bureau constructs the "Hispanic/Latino" category by adding together all those who indicate that they were of Mexican, Puerto Rican, Cuban, or another Hispanic/Latino origin, regardless of race (see Data Note). While the Census Bureau does not specifically list Brazilian as an option for Latino ethnicity, if a Brazilian individual self-identifies as Hispanic/Latino and indicates "another Hispanic, Latino, or Spanish origin" on their survey, they are counted as Latino. A very small share of individuals who indicate that they are of Brazilian descent also indicate that they are Hispanic/Latino on the Census.[40]

Data Note: Concerns about the ACS Definition of Hispanic/Latino

Separating ethnic and racial identity is not a universally accepted standard for collecting demographic data.[41] Asked to choose a race, but not identifying as white, a large share of Latino survey respondents select "Some other race" or skip the race question altogether.[42] The Census Bureau itself has conducted research showing that combining the questions on race and Hispanic/Latino question into a single "race/ethnicity" question would reduce item nonresponse rates and yield more accurate results.[43] In a 2017 report to OMB, the Census Bureau concluded that, "By combining the race and Hispanic origin questions into one question on race/ethnicity, the research has shown that Hispanics can better find themselves among the race and ethnicity categories."[44]

Appendix B. National Latino Child Uninsured Rate by Detailed Ethnicity, 2016-2019

Ethnicity	2016	2019
Colombian	6.1	6.8
Cuban	4.8	5.9
Dominican	5.1	4.8
Ecuadoran	6.2	5.3
Guatemalan	10.3	17.9*
Honduran	18.2	24.4*
Mexican	8.2	9.6*
Nicaraguan	7.6	8.8
Not Latino	3.7	4.4*
Other Hispanic/Latino	6.3	8.9*
Peruvian	5.7	4.6
Puerto Rican	3.1	4.2*
Salvadoran	10.0	13.1*
Spanish	3.5	3.3
Venezuelan	13.4	14.5

Source: Georgetown University Center for Children and Families analysis of U.S. Census Bureau 2016-2019 American Community Survey (ACS) data using Public Use Microdata Sample (PUMS).
* Change is significant at the 90 percent confidence level relative to the prior year indicated.

Appendix C. Latino Child Uninsured Rate by State, 2016-2019

State	Uninsured Rate 2016	Uninsured Rate 2019	Percentage Point Change in Uninsured Rate
United States	7.7	9.3	1.6*
Alabama	7.3	10.9	3.7
Arizona	11.1	10.2	-0.9
Arkansas	9.4	15.5	6.1*
California	4.1	4.7	0.5*
Colorado	7.4	7.4	0.0
Connecticut	3.6	4.8	1.2
Florida	8.6	9.5	0.9
Georgia	13.2	16.3	3.1*
Idaho	10.3	9.1	-1.1
Illinois	3.3	6.0	2.7*
Indiana	8.1	12.3	4.2*
Kansas	7.7	11.8	4.1*
Kentucky	9.7	8.7	-1.0
Louisiana	11.6	13.4	1.8
Maryland	7.2	7.5	0.3
Massachusetts	--	1.8	--
Michigan	4.9	5.1	0.3
Minnesota	9.0	6.7	-2.3
Mississippi	--	19.2	--
Missouri	9.0	11.8	2.8
Nebraska	12.1	10.0	-2.0
Nevada	9.8	12.3	2.5
New Jersey	6.5	6.9	0.4
New Mexico	4.7	5.4	0.7
New York	2.7	2.6	0.0
North Carolina	11.2	12.6	1.4
Ohio	5.9	8.3	2.4
Oklahoma	9.3	10.8	1.5
Oregon	5.6	5.5	-0.1
Pennsylvania	6.2	4.6	-1.6
South Carolina	8.5	15.3	6.8*
Tennessee	11.7	17.7	6.0*
Texas	13.5	17.7	4.3*
Utah	11.1	14.6	3.5
Virginia	13.3	12.3	-1.0
Washington	3.8	5.1	1.3
Wisconsin	6.4	8.4	2.0

Source: Georgetown University Center for Children and Families analysis of U.S. Census Bureau 2016-2019 American Community Survey (ACS) data using Public Use Microdata Sample (PUMS).
* Change is significant at the 90 percent confidence level relative to the prior year indicated.

To ensure accuracy and consistency, Georgetown CCF calculates the coefficient of variation (CV; also known as the relative standard error) for each estimate. Estimates with CVs greater than 25 percent are not presented in this analysis. As a consequence, some states are excluded entirely from the above table and others include only one estimate. For more information on suppression rules, see the methodology section.

Appendix D. Number of Uninsured Latino Children by State, 2016-2019

State	Uninsured Children 2016	Uninsured Children 2019	Change in Number of Uninsured Latino Children
United States	1,476,200	1,830,600	354,400*
Alabama	5,900	10,200	4,300*
Arizona	83,800	78,400	-5,400
Arkansas	8,400	14,300	5,900*
California	204,800	227,700	22,900*
Colorado	30,300	30,800	500
Connecticut	6,700	9,300	2,600
Florida	114,200	136,900	22,700*
Georgia	49,100	64,300	15,200*
Idaho	8,500	7,800	-700
Illinois	24,700	44,500	19,800*
Indiana	14,500	23,500	9,000*
Kansas	10,400	16,200	5,800*
Kentucky	6,100	--	--
Louisiana	8,500	11,300	2,800
Maryland	14,600	17,100	2,500
Massachusetts	--	4,900	--
Michigan	9,300	9,900	600
Minnesota	10,100	8,400	-1,700
Mississippi	--	6,500	--
Missouri	8,700	11,600	2,900
Nebraska	10,300	9,100	-1,200
Nevada	28,500	36,700	8,200*
New Jersey	36,000	38,900	2,900
New Mexico	14,700	16,400	1,700
New York	29,000	27,800	-1,200
North Carolina	42,600	51,000	8,400
Ohio	9,300	14,400	5,100*
Oklahoma	15,800	18,800	3,000
Oregon	11,300	11,200	-100
Pennsylvania	20,400	16,000	-4,400
South Carolina	8,900	16,800	7,900*
Tennessee	17,000	28,700	11,700*
Texas	510,400	686,800	176,400*
Utah	18,900	26,300	7,400*
Virginia	34,300	34,200	-100
Washington	13,700	19,200	5,500
Wisconsin	9,800	13,100	3,300

Source: Georgetown University Center for Children and Families analysis of U.S. Census Bureau 2016-2019 American Community Survey (ACS) data using Public Use Microdata (PUMS). Estimates rounded to the nearest hundred. These numbers are estimates, not direct counts, and should be interpreted as such.
* Change is significant at the 90 percent confidence level relative to the prior year indicated.

To ensure accuracy and consistency, Georgetown CCF calculates the coefficient of variation (CV; also known as the relative standard error) for each estimate. Estimates with CVs greater than 25 percent are not presented in this analysis. As a consequence, some states are excluded entirely from the above table and others have only one estimate present. For more information on suppression rules, see the methodology section.

Appendix E. Comparing the Rate of Uninsured Latino Children to Uninsured Non-Latino Children

	Uninsured Rate: Latino Children	Uninsured Rate: Non-Latino Children	Latino Children are X Times as Likely to be Uninsured as Non-Latino Children
United States	9.3	4.4	More than 2x
Alabama	10.9	2.8	Almost 4x
Arizona	10.2	7.7	Almost 1.5x
Arkansas	15.5	4.2	More than 3.5x
California	4.7	2.7	More than 1.5x
Colorado	7.4	4.2	Almost 2x
Connecticut	4.8	3.1	More than 1.5x
Florida	9.5	6.8	Almost 1.5x
Georgia	16.3	5.9	Almost 3x
Idaho	9.1	3.9	Almost 2.5x
Illinois	6.0	3.6	More than 1.5x
Indiana	12.3	6.5	Almost 2x
Kansas	11.8	4.6	More than 2.5x
Kentucky	8.7	4.0	More than 2x
Louisiana	13.4	3.8	More than 3.5x
Maryland	7.5	2.3	More than 3x
Massachusetts	1.8	1.4	Almost 1.5x
Michigan	5.1	3.1	More than 1.5x
Minnesota	6.7	3.0	More than 2x
Mississippi	19.2	5.4	More than 3.5x
Missouri	11.8	6.3	Almost 2x
Nebraska	10.0s	4.3	Almost 2.5x
Nevada	12.3	4.7	More than 2.5x
New Jersey	6.9	3.4	2x
North Carolina	12.6	4.4	Almost 3x
Ohio	8.3	4.6	Almost 2x
Oklahoma	10.8	7.8	Almost 1.5x
Oregon	5.5	3.8	Almost 1.5x
South Carolina	15.3	4.9	More than 3x
Tennessee	17.7	3.9	More than 4.5x
Texas	17.7	8.1	More than 2x
Utah	14.6	6.6	More than 2x
Virginia	12.3	3.7	Almost 3.5x
Washington	5.1	2.6	Almost 2x
Wisconsin	8.4	3.1	More than 2.5x

Source: Georgetown University Center for Children and Families analysis of U.S. Census Bureau 2016-2019 American Community Survey (ACS) data using Public Use Microdata Sample (PUMS).

There are many ways to measure barriers to comprehensive coverage and high-quality care. This table compares Latino children's uninsured rates to non-Latino children's uninsured rates based on ethnicity without regard to race. The purpose of the chart is to illustrate disparities and show that it is possible for states to achieve lower uninsured rates, not to distinguish non-Latino children as models or an ultimate baseline.

Multipliers are rounded to the nearest 0.5. For example, the US disparity of 2.11 (Non- Latino Child Uninsured Rate x 2.11 = Latino Child Uninsured Rate) is reported as "more than 2x." Disparities less than 1.25x (seen in New Mexico, New York, and Pennsylvania) are not presented.

To ensure accuracy and consistency, Georgetown CCF calculates the coefficient of variation (CV; also known as the relative standard error) for each estimate. Estimates with CVs greater than 25 percent are not presented in this analysis. As a consequence, some states are excluded from the above table. For more information on suppression rules, see the methodology section.

Methodology

Data Sources

Georgetown University Center for Children and Families (CCF) uses the U.S. Census Bureau American Community Survey (ACS), an annual survey of approximately 3.5 million individuals, to analyze national, state, and local trends in health insurance coverage. The data in this report come from three sources:

1. 2016-2019 Public Use Microdata Sample (PUMS), a two-thirds sample of the full ACS data file. This sample allows for disaggregation by detailed Latino ethnicity. Files are downloaded from census.gov FTP platform.
2. 2019 Integrated Public Use Microdata Sample (IPUMS), a recoded and enhanced version of PUMS which enables the analysis of parental characteristics (such as comfort level with English).
3. 2019 Puerto Rico Community Survey Public Use Microdata Sample (PUMS), a sample of the full PRCS data file.

Other analyses and reports from CCF, including kidshealthcarereport.ccf.georgetown.edu and "Children's Uninsured Rate Rises by Largest Annual Jump in More than a Decade" (October 2020) use the American Community Survey detailed tables, published on data.census.gov. The detailed tables are based on the full sample of ACS results, but do not allow for detailed disaggregation. Consequently, estimates may vary between CCF's analyses.

Margin of Error, Statistical Significance, and Data Suppression

Following the instructions given in the "Calculating Margins of Error the ACS Way Using Replicate Methodology to Calculate Uncertainty" webinar (February 2020), standard error and coefficients of variation are computed using successive differences replication (SDR) in STATA statistical software. Margin of error calculations are not published in this report but are available upon request.

Statistical significance is determined using the U.S. Census Bureau "Statistical Testing Tool" with a confidence interval of 90 percent. In other words, when the difference between two values is marked as significant, there is a 90 percent likelihood that the difference is not due to chance or sampling error. Margins of error are a critical part of determining statistical significance. Two estimates with high levels of uncertainty, or high margins of error, indicate that the difference could be due to chance or sampling error. Consequently, they are less likely to "pass" the significance test.

To ensure accuracy and consistency, CCF calculates the coefficient of variation (CV; also known as the relative standard error) for each estimate. CCF follows the instructions included in the Census Bureau's publication, "Understanding and Using American Community Survey Data: What All Data Users Need to Know" (September 2020). CVs produce a comparable indicator of how large the error is by dividing the standard error of an estimate by the estimate itself. The lower the CV, the more reliable the estimate. Estimates with CVs greater than 25 percent are not presented in this analysis. Applying this rule results in the suppression of several estimates for Latino subgroups (for example, the uninsured rate for Puerto Rican children in Arizona) and of several states in figure 7 and the appendix tables (Alaska, Delaware, District of Columbia, Hawaii, Iowa, Maine, Montana, New Hampshire, North Dakota, Rhode Island, South Dakota, West Virginia, and Wyoming).

Demographic Characteristics

Children refers to individuals under age 19 (0 to 18 years of age). In 2017, the Census Bureau changed the upper bound for children from 18 (0 to 17 years of age) to 19 (0 to 18 years of age) on the detailed health insurance tables published on data.census.gov, thus making comparisons between earlier years difficult. Because this report uses microdata from PUMS and IPUMS, it is possible to compare trends from 2016 to 2019.

As noted in Appendix A, the Census Bureau distinguishes between race and Hispanic origin/Latino ethnicity. For the purposes of this analysis, "Latino" refers to all those who indicated that they were of Hispanic or Latino origin on question five of the ACS. "Latinx" can also be used to respect various gender identities and expressions. "Non-Latino" refers to all those who indicated that they were not of Hispanic or Latino origin on question five of the ACS.

Latino and Non-Latino individuals may be of any race.

English Proficiency

Question 14c of the ACS asks respondents "How well does this person speak English?" and provides them with the following options: Very well, Well, Not well, Not at all. For the purposes of this paper, individuals who indicate "Not well" or "Not at all" are categorized as "Language Other than English (LOE)." CCF linked parental language proficiency to children using the Integrated Public Use Microdata Sample's (IPUMS') "attach characteristic" feature.

Health Coverage

ACS data is collected over the course of a year and represents a "point-in-time" estimate of a person's insurance status. That is, the survey collects information on whether the respondent is insured at the moment they complete the form, not if they have been insured/uninsured at any point during the year. The US Census Bureau does not consider Indian Health Service (IHS) access a comprehensive form of coverage. Consequently, those who indicate that IHS is their only source of coverage are designated as uninsured.

Citizenship Status of Child and Parent

Unlike the decennial Census, the ACS collects data on respondents' citizenship status. Citizenship status is not the same as immigration status; a respondent classified as non-citizen can be lawfully-residing or undocumented. For the purposes of this analysis, "citizen" includes any person born in the U.S., any person born abroad to American parents, and any naturalized citizen. Citizenship status of children's parents was computed using the Integrated Public Use Microdata Sample (IPUMs) "attach characteristic" feature. More information on how the University of Minnesota codes the survey responses to create these enhanced variables, please see "Frequently Asked Questions (FAQ) Extract Option: Attach Characteristics."

Poverty Status

The Census Bureau determines an individual's poverty status by comparing their estimated income to the Census Poverty Thresholds. Though the overall Census Poverty Thresholds are similar to the Department of Health and Human Services Federal Poverty Level Guidelines, there are significant differences for Alaska and Hawaii. Further, the Census does not adhere to the same MAGI formula for computing income that state Medicaid and CHIP programs use when determining income-based eligibility.

Medicaid Expansion Analysis

This report relies on ACS data collected in 2019. For this reason, expansion status is determined based on if a state had *implemented* expansion for the majority of 2019. The expansion states include: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Washington, West Virginia, and Vermont. The following states are categorized as non-expansion: Alabama, Florida, Georgia, Idaho (implemented in November 2019), Kansas, Mississippi, Missouri (plans to implement in 2021), Nebraska (implemented in 2020), North Carolina, Oklahoma (plans to implement in 2021), South Carolina, South Dakota, Tennessee, Texas, Utah (implemented in 2020), Wisconsin, and Wyoming. Maine and Virginia were excluded from this analysis given that these estimates were also used to calculate change over time.

Endnotes

[1] We report the U.S. Census Bureau's categorization of "Hispanic or Latino," as "Latino." "Latinx" may also be used to respect various gender identities and expressions. Whitener, K. et al., "Decade of Success for Latino Children's Health Now in Jeopardy," (Washington, D.C.: Georgetown Center for Children and Families and UnidosUS, March 2020), available at https://ccf.georgetown.edu/wp-content/uploads/2020/03/Latino-Childrens-Health-Care-Coverage.pdf.

[2] Alker, J. and Corcoran, A., "Children's Uninsured Rate rises by Largest Annual Jump in More than a Decade," (Washington D.C.: Georgetown Center for Children and Families, October 2020), available at https://ccf.georgetown.edu/2020/10/08/childrens-uninsured-rate-rises-by-largest-annual-jump-in-more-than-a-decade-2/.

[3] Unless otherwise noted, all data in this factsheet come from Georgetown University CCF's analysis of the U.S. Census Bureau American Community Survey's (ACS) Public Use Microdata Sample, or PUMS. Because PUMS is a slightly smaller sample of the data presented in the Census Bureau's ACS Detailed Tables, estimates may vary slightly from what is reported in other CCF reports or analyses.

[4] Haley, J. et al., "One in Five Adults in Immigrant Families with Children Reported Chilling Effects on Public Benefit," (Washington, D.C.: The Urban Institute, June 2020), available at https://www.urban.org/research/publication/one-five-adults-immigrant-families-children-reported-chilling-effects-public-benefit-receipt-2019; C. Anderson, "Public Charge and Private Dilemmas: Key Challenges and Best Practices for Fighting the Chilling Effect in Texas, 2017-2019," (Children's Defense Fund Texas, November 2020), available at: https://cdftexas.org/wp-content/uploads/sites/8/2021/01/Public-Charge-and-Private-Dilemmas_report_020.pdf.

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[6] Kirzinger, A., Muñana, C., and Brodie, M., "KFF Health Tracking Poll – January 2019: The Public on Next Steps for the ACA and Proposals to Expand Coverage," (Washington, D.C.: Kaiser Family Foundation, January 2019), available at https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-january-2019/.

[7] Brooks, T., Park, E., and Roygardner, L., "Medicaid and CHIP Enrollment Decline Suggests the Child Uninsured Rate May Rise Again," (Washington, D.C.: Georgetown University Center for Children and Families, May 2019), available at https://ccf.georgetown.edu/wp-content/uploads/2019/06/Enrollment-Decline.pdf.

[8] Indeed, there is considerable debate around the use of the pan-ethnic label "Hispanic/Latino." While the label is a social construct that masks the complexities of individuals' lives, some contend that the unification of various identities lends political clout to otherwise marginalized groups. See: González op. cit. and Rubin, V., "Counting a Diverse Nation: Disaggregating Data on Race and Ethnicity to Advance a Culture of Health" (Oakland, CA: Policy Link, 2018), available at: https://www.policylink.org/sites/default/files/Counting_a_Diverse_Nation_08_15_18.pdf.

[9] Note that the uninsured rate for Puerto Rican children reflects those who are living in one of the 50 states or the District of Columbia. In addition to the American Community Survey, the U.S. Census Bureau fields a Puerto Rico Community Survey annually.

[10] There is significant evidence that these socially-constructed groupings shape the way that people encounter the healthcare system and can have meaningful impacts on individuals' access and health outcomes. For example, recent research found that while foreign-born Cuban women ages 25-64 experienced lower mortality rates than non-Hispanic white women, Mexican and Puerto Rican women both had higher mortality rates. Fenelon, A., Chinn, J., and Anderson, R., "A Comprehensive Analysis of the Mortality Experience of Hispanic Subgroups in the United States: Variation by Age, Country of Origin, and Nativity," *SMM- Population Health* 3 (December 2017, pg. 245-254), available at https://www.sciencedirect.com/science/article/pii/S2352827316300763.

[11] CCF uses the Census Poverty Threshold as a proxy for the Federal Poverty Level (FPL) which is used to determine Medicaid eligibility. See methodology section for more detail.

[12] Georgetown University Center for Children and Families analysis of U.S. Census Bureau 2019 Puerto Rico Community Survey (PCRS) data using Public Use Microdata Sample (PUMS). The Puerto Rico Community Survey, while similar to the American Community Survey, differs slightly on several questions. For more information on the PCRS, see U.S. Census Bureau, "Understanding and Using Puerto Rico Community Survey Data: What All Data Users Need to Know," (Washington, D.C.: U.S. Census Bureau, April 2020), available at https://www.census.gov/content/dam/Census/library/publications/2020/acs/acs_prcs_handbook_2020.pdf.

[13] 42 C.F.R. 435.905 (2016) and 42 C.F.R. 435.907 (2013).

[14] LOE is used in place of limited English proficiency (LEP), to stress the assets and abilities, rather than the deficiencies, of individuals. Knipper, S., Rivers, W., and Goodman, J., "Effects of Citizenship Status, Latino Ethnicity, and Household Language on Health Insurance Coverage for U.S. Adolescents, 2007-2016," Health Services Research 54, no. 6 (2019): 1166-1173, available at https://pubmed.ncbi.nlm.nih.gov/31385302/; and Alvarez Caraveo et al., "Barriers to Medicaid and CHIP Coverage for Eligible but Uninsured Latinx Children: A Texas Case Study," (Washington D.C.: Urban Institute, February 2021), available at https://www.urban.org/sites/default/files/publication/103471/barriers-to-medicaid-and-chip-coverage-for-eligible-but-uninsured-latinx-children-a-texas-case-study_1.pdf.

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[16] Georgetown University Center for Children and Families analysis of U.S. Census Bureau 2019 American Community Survey (ACS) data using Public Use Microdata Sample (PUMS).

[17] Brooks, T. et al., "Medicaid and CHIP Eligibility and Enrollment Policies as of January 2021: Findings from a 50-State Survey," (Washington D.C.: Georgetown University Center for Children and Families and Kaiser Family Foundation, March 2021),

available at https://www.kff.org/report-section/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2021-findings-from-a-50-state-survey-report/.

[18] Haley, J., "One in Five Adults in Immigrant Families," op. cit.

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[23] Dubay, L., "How Risk of Exposure to the Coronavirus at Work Varies by Race and Ethnicity and How to Protect the Health and Well-Being of Workers and Their Families," (Washington D.C.: Urban Institute, December 2020), available at https://www.urban.org/research/publication/how-risk-exposure-coronavirus-work-varies-race-and-ethnicity-and-how-protect-health-and-well-being-workers-and-their-families.

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[29] Brooks, T. op. cit.

[30] Ibid.; H.B. 130, 2021 General Assembly (Vermont, 2021).

[31] Whitener, K. and Alker, J., "Covering All Children," (Washington D.C.: Georgetown University Center for Children and Families, February 2020), available at https://ccf.georgetown.edu/wp-content/uploads/2020/02/CoverAllKidsFinal.pdf.

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[36] United States Census Bureau, "Why We Ask Questions About… Health Insurance Coverage," available at https://www.census.gov/acs/www/about/why-we-ask-each-question/health/.

[37] United States Census Bureau, 2019 American Community Survey, Table B98013, "Total Population Coverage Rate by Weighting Race and Hispanic or Latino Groups," available at data.census.gov.

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