kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

ISSUE PAPER

June 2009

How Does Health Coverage and Access to Care for Immigrants Vary by Length of Time in the U.S.?

By Peter Cunningham and Samantha Artiga

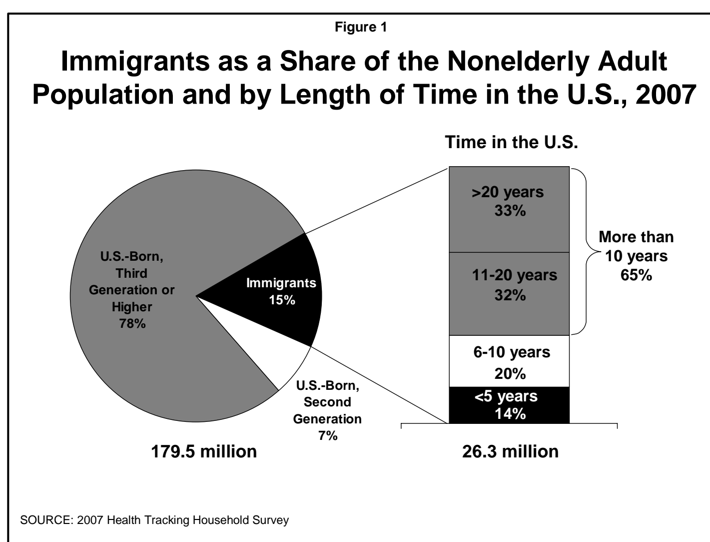
EXECUTIVE SUMMARY

A substantial amount of research has documented that, overall, immigrants are more likely to be uninsured than U.S.-born citizens and, as such, face increased barriers to accessing needed care. However, immigrants are a diverse group, ranging in country of origin, race/ethnicity, citizenship status, length of time in the country, and socioeconomic characteristics. Reflecting these differences, health coverage and access vary across immigrants. Further, the socioeconomic circumstances of immigrants change over the course of time they reside in the U.S. and often improve for adult children of immigrants (second generation Americans), which also has implications for their health coverage and ability to access care.

Based on data from the 2007 Health Tracking Household Survey, this analysis examines how health coverage and access to care for non-elderly adults vary based on immigrants' length of time in the U.S. and between immigrants, second generation Americans, and third generation and higher Americans. It also identifies the primary factors contributing to lower health coverage rates and greater access barriers among immigrants.

Key Findings

Almost two-thirds of immigrants have been residing in the U.S. for at least ten years, and about half of these longer-term immigrants are citizens. Overall, about 15% of non-elderly adults in the U.S. are immigrants. Most immigrants (65%) have been residing in the U.S. for at least ten years, with one-third in the U.S. for more than 20 years (Figure 1). Immigrants in the U.S. for more than ten years account for about 10% of the total non-elderly adult population. About 14% of immigrants are recent immigrants residing in the U.S. for less than five years, making up 2% of the total non-elderly adult population.

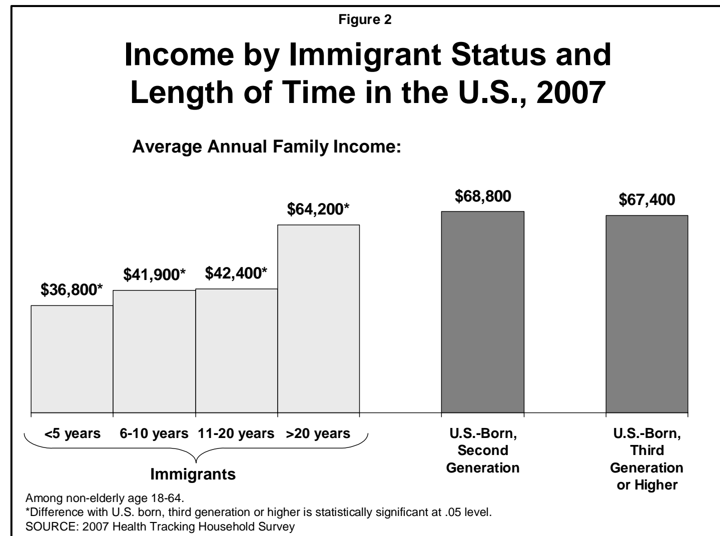


Overall, two-thirds of non-elderly immigrant adults are non-citizens (65%), but citizenship status varies significantly based on length of time in the U.S. About half (48%) of immigrants who have been in the U.S. for more than ten years are naturalized citizens, and the citizenship rate

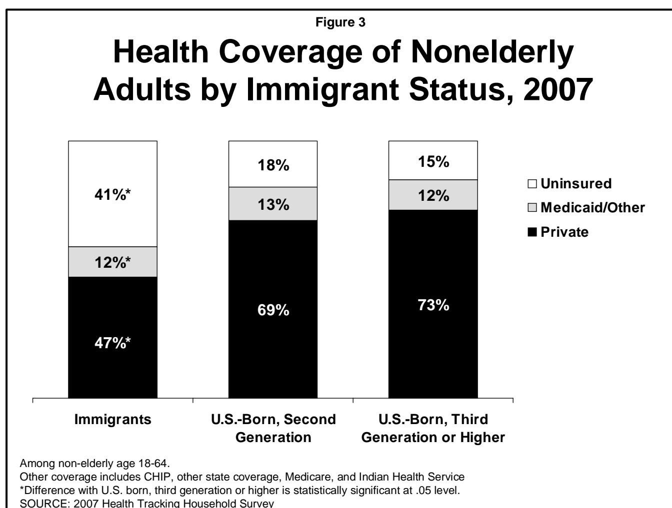
1330 G Street NW, Washington, DC 20005
Phone: 202-347-5270, Fax: 202-347-5274
Website: www.kff.org

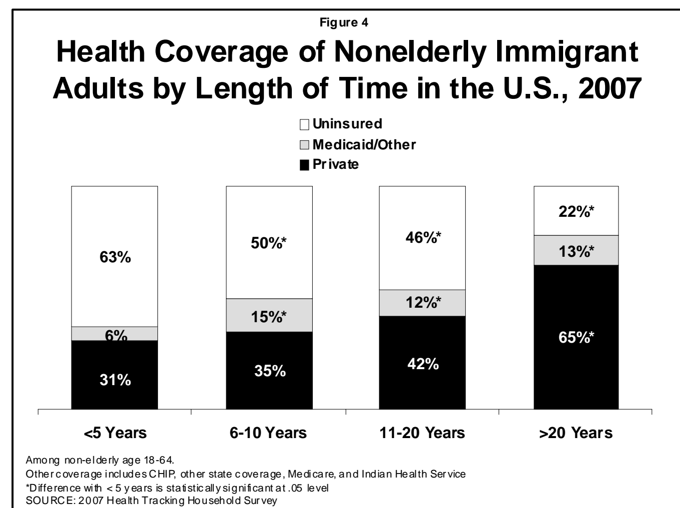
rises to nearly two-thirds (65%) for immigrants in the U.S. for more than 20 years. In contrast, very few recent immigrants are citizens.

There are substantial variations in socioeconomic characteristics of immigrants based on length of time in the U.S., with longer-term immigrants faring dramatically better than recent immigrants. Overall, average family income is lower among immigrants compared to U.S.-born residents (Figure 2). However, family income among recent immigrants is about $37,000 (57% of the U.S. average) compared to over $64,000 (95% of the U.S. average) for immigrants in the U.S. for more than twenty years. Similarly, immigrants who have been in the U.S. for longer periods of time have higher employment rates, and the employment rate for immigrants in the U.S. for more than twenty years is slightly higher than for U.S.-born residents.

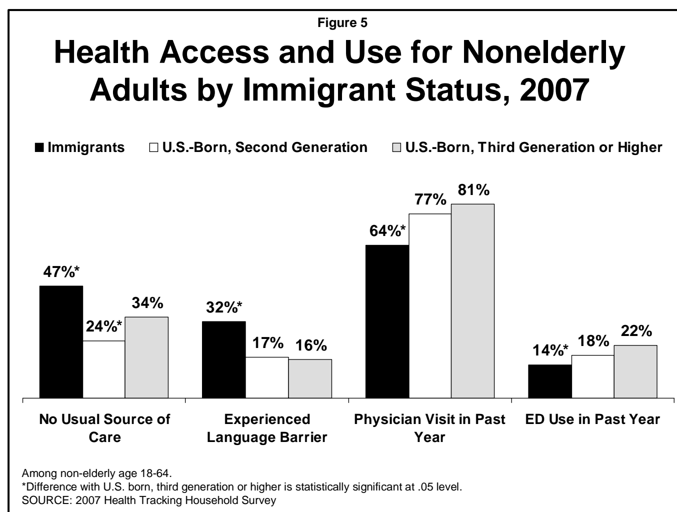


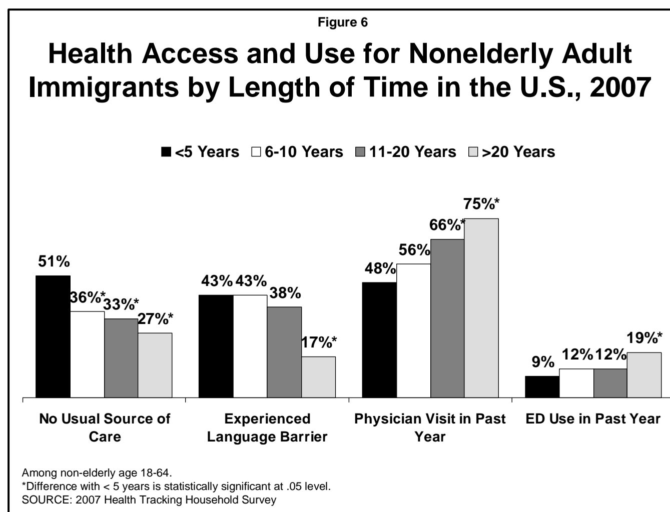
Immigrants have a higher uninsured rate than U.S.-born residents, but immigrants residing in the U.S. for longer periods of time are significantly less likely to be uninsured than recent immigrants. Uninsured rates among non-elderly adult immigrants are more than twice that of U.S.-born residents (Figure 3). However, the uninsured rate for recent immigrants is almost three times that of immigrants who have been in the U.S. for more than twenty years (63% vs. 22%) (Figure 4). Controlling for differences in socioeconomic characteristics, health status, and levels of assimilation (e.g., citizenship, language use) essentially eliminates the difference in the uninsured rate between U.S.-born residents and immigrants who have been residing in the U.S. for at least five years. The higher uninsured rate for recent immigrants persists after controlling for these differences, likely reflecting lower availability and take-up of employer-sponsored coverage among recent immigrants.





Reflecting their higher uninsured rate, immigrants have greater problems accessing care and obtain less physician care, but they are significantly less likely than U.S.-born residents to utilize the emergency room (Figure 5). Among immigrants, recent immigrants are the most likely to lack a usual source of care and experience language barriers with a physician, and they have lower levels of physician visits than longer-term immigrants (Figure 6). However, they also are the least likely to report using the emergency room. A significant portion of the differences in access to care between immigrants and U.S.-born residents is due to their higher uninsured rate. Controlling for differences in insurance as well as socioeconomic characteristics, health status, citizenship, and language largely eliminates differences in access among immigrants and between immigrants and U.S.-born residents.





Second-generation adults (i.e., adult children of immigrants) are similar to third generation and higher Americans in terms of socioeconomic status and health coverage, access, and use. Second-generation adults account for 7% of non-elderly adults. Overall, they are comparable with third generation and higher Americans in terms of their income and employment status, and are actually more likely to have obtained a college degree. The health coverage rates of second generation Americans also are comparable to third generation and higher Americans, and they are much less likely to be uninsured compared to immigrants. Reflecting these coverage rates, their health care access and use is similar to third generation and higher Americans, although they remain less likely to report having a usual source of care.

Conclusion

Often overlooked in debates and discussions related to immigrant issues is the great diversity among the immigrant population, and, in particular, the fact that their circumstances and situations change over time as they assimilate socially and economically within American society. While, overall, immigrants have a higher uninsured rate and face greater access barriers relative to U.S.-born residents, the findings in this report suggest that many immigrants eventually gain insurance and improved access to health care as they acquire language and job skills, improve their economic situation, and become more familiar with the U.S. health care system. Recent immigrants are most at risk for lacking coverage and facing access problems. As such, addressing the coverage and access barriers facing recent immigrants will be key to any effort to reduce overall disparities between immigrants and U.S.-born residents.

INTRODUCTION

A number of studies have documented the disproportionately high percentage of U.S. immigrants who are uninsured and lack access to medical care compared to the native born U.S. population (Schwartz and Artiga, 2007; Shah and Carrasquillo, 2006; Ku and Matani, 2001; Cunningham et al., 2007; Derose et al., 2007). Some of these studies have also noted differences in coverage and access based on citizenship and the racial/ethnic background of immigrants.

Nevertheless, the diversity of immigrant populations is usually downplayed in media coverage and policy discussions of immigrants, and differences that are noted are not well understood. Common depictions of immigrants often focus on poor immigrants from Mexico and other Latin American countries (frequently undocumented) who lack the educational background, English-language proficiency, and job skills necessary to obtain high wage jobs and access to employer-sponsored coverage. However, the reality is that there is great diversity in the immigrant population, not only in terms of their ethnicity and country of origin, but also in terms of their educational attainment, language skills, professional background, and socioeconomic status (Portes and Rumbaut, 2006; Livingston and Minushkin, 2008). Such diversity is also likely to be reflected in immigrants' health insurance coverage and access to medical care.

Immigrants also differ considerably in terms of their acculturation and assimilation into American society, which is often associated with the length of time they have been in the U.S. Some immigrants return to their country of origin after relatively short stays in the U.S., while many who stay already have or are able to acquire language and job skills that allow them to advance socioeconomically (Portes and Rumbaut, 2006). The assimilation of children of immigrants (i.e., second generation Americans) is even more advanced by the time they reach adulthood and access to educational opportunities in the U.S. provides them opportunities to maintain or improve upon their parents' economic status (Portes and Rumbaut, 2006; Suro and Passel, 2003).

Considering how health coverage and access varies by the length of time an immigrant has been in the country is important because it suggests that the high uninsured rates and access problems among immigrants are concentrated primarily among recent immigrants, and that these high levels are likely to decrease along with length of time in the U.S. Moreover, greater assimilation and economic advancement of second generation Americans is likely to further diminish access and coverage disparities experienced by their immigrant parents. From a policy perspective, this would suggest that the contribution of any given cohort of immigrants to the uninsured problem may be temporary, and is more acutely felt among those immigrants who are recent arrivals.

This report provides a broader picture of the relationship between immigration and health care coverage and access. In particular, the report shows that coverage and access to care among immigrants varies substantially depending on their length of time in the U.S., with immigrants who have been in the U.S. for a longer time having higher coverage rates and better access to care compared to more recent immigrants. For the adult children of immigrants (i.e., second generation Americans), there are virtually no differences in coverage and access with Americans who are third generation or higher. The report also examines the reasons for lower coverage rates and greater access problems among more recent immigrants, focusing on differences in socioeconomic status and measures that reflect greater assimilation.

ABOUT THE ESTIMATES

The estimates in this report are based on analyses of the 2007 Health Tracking Household Survey, a telephone survey of the civilian, noninstitutionalized population. The survey includes a sample of about 17,800 persons of all ages. The sample in this report is restricted to nonelderly adults between the ages of 18-64, or about 11,600 persons. The survey was conducted in Spanish for respondents who either did not speak English or preferred to conduct the interview in Spanish. A more detailed description of the survey and methodology for this report is provided in Appendix A.

The survey included questions about place of birth (i.e. in the U.S. or outside of the U.S.), citizenship, length of time in the country, and parents' place of birth. Using this information, most of the analysis in the report distinguishes between three groups:

- *U.S.-born, third generation or higher*. The sample person and both parents were born in the U.S.
- *U.S.-born, second generation*. The sample person was born in the U.S., but at least one parent was foreign-born.
- *Immigrants.* The sample person was born outside of the U.S.

The report examines variation of immigrants by length of time in the country, ascertained during the interview. The report distinguishes between immigrants who have been in the U.S.:

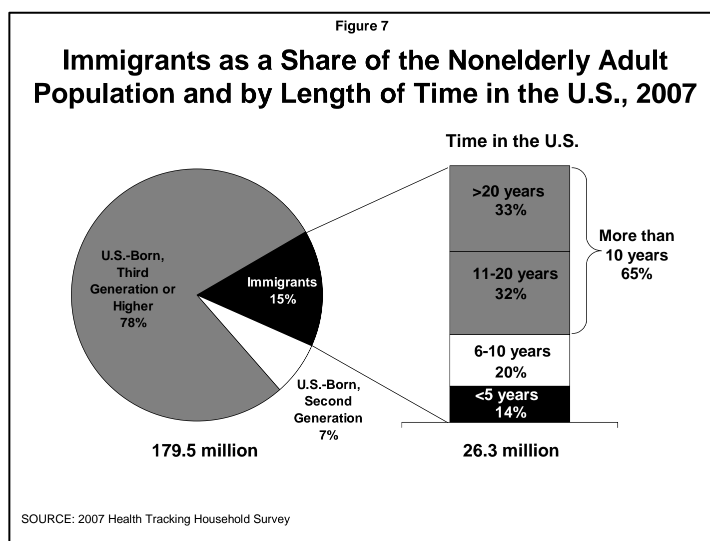
- Five years or less (i.e. entered 2002 or later);
- Between 6-10 years (i.e. entered between 1997-2001);
- Between 11-20 years (i.e. entered between 1987 and 1996); and
- Greater than 20 years (i.e., entered before 1987).

FINDINGS

Characteristics of Immigrants and Second Generation Americans

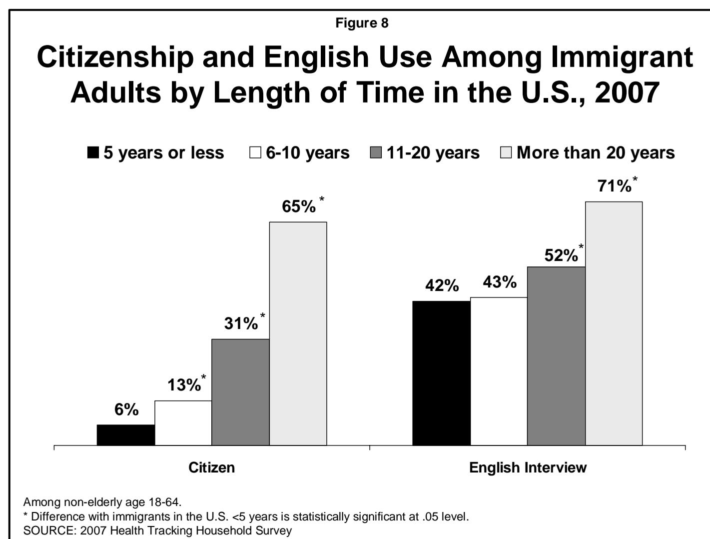
Length of Time in Country

About 15 percent of nonelderly adults are immigrants (Figure 7). Almost two-thirds of immigrants have been in the U.S. for over 10 years, and one-third have been in the U.S. for more than twenty years. Recent immigrants who have been in the U.S. 5 years or less make up 14 percent of the immigrant population and only 2 percent of the total nonelderly adult population. In addition, 7 percent of all nonelderly adults reported that they were second generation Americans (i.e. U.S-born citizens whose parents were born outside the U.S.).



Citizenship, Language, and Age

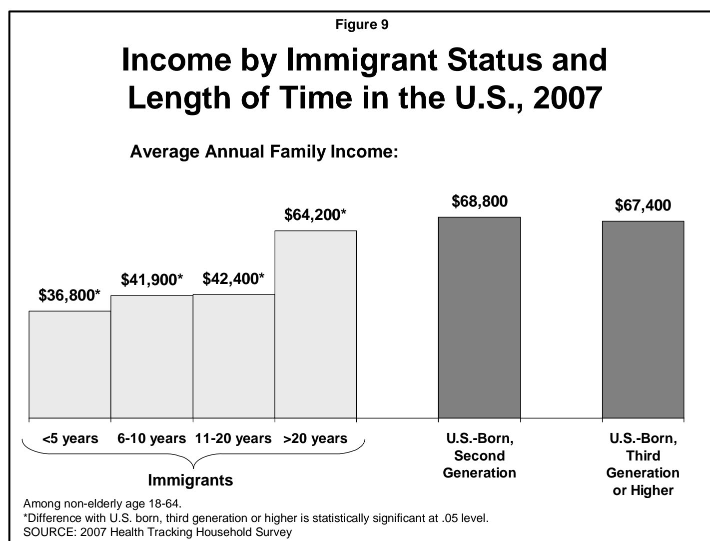
Length of time in the U.S. is associated with measures of assimilation for immigrants, including citizenship and English language skills (Figure 8). While two-thirds of immigrant adults are noncitizens, this varies dramatically by length of time in the country—few recent immigrants are citizens, compared to about two-thirds who have been in the U.S. for over 20 years. Similarly, the percent of immigrant respondents who conducted the survey interview in English was much higher for immigrants in the U.S. for more than 20 years compared to those in the country for shorter periods of time.



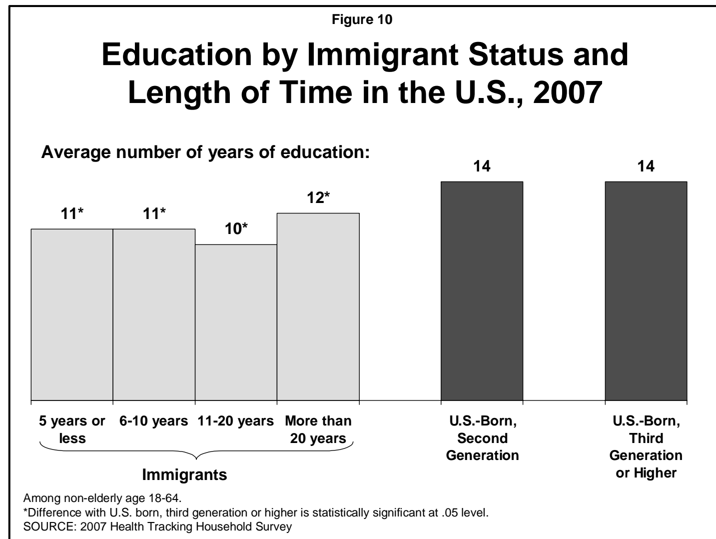
In general, there is little difference in age between immigrants and U.S.-born residents, although recent immigrants are considerably younger on average (33 years) compared to those who have been in the country for over 20 years (47 years).

Family Income and Education

Consistent with other data, immigrants have much lower incomes compared to U.S.-born residents (Schwartz and Artiga, 2006; Cunningham et al., 2006). However, family income among immigrants differs dramatically by length of time in the U.S (Figure 9). Average family income among recent immigrants is $36,800 (about 57 percent of the U.S. average) compared to over $64,000 for those in the U.S. for more than 20 years (or about 95 percent of the U.S. average).



Overall, immigrants also have lower levels of educational attainment compared to U.S.-born residents. On average, immigrants have about 11 years of education compared to 14 years for U.S.-born residents. Unlike income, educational attainment does not vary substantially among immigrants by length of time in the country (Figure 10).

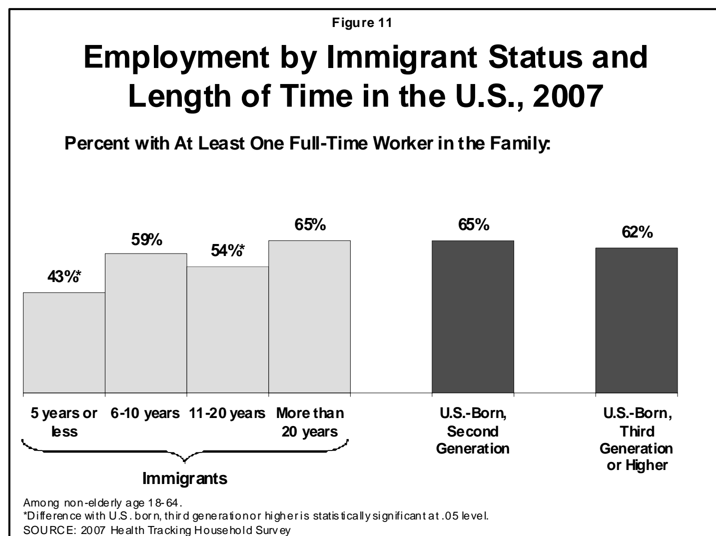


Second generation Americans are much more similar to other U.S.-born residents (third generation or higher) than they are to immigrants in terms of their income and educational attainment. This similarity in socioeconomic status between second generation and third generation or higher generation adults reflects, in part, the economic mobility of the adult children of immigrants. However, the wide gap between second generation Americans and the current immigrant population may also reflect differences in the background and socioeconomic characteristics between earlier cohorts of immigrants and more recent cohorts. For example, Hispanics comprise a much smaller share of second generation adults (about one-third) than they do among immigrants (about two-thirds), while whites comprise about half of second generation adults but only 15 percent of immigrants.

In contrast to immigrants from Europe, Canada, and Australia, who have higher educational attainment and are more culturally similar to the U.S., the socioeconomic status of Hispanic immigrants is generally lower because they have fewer job and language skills and tend to arrive in the U.S. at the bottom of the occupational ladder (Portes and Rumbaut, 2006). Living close to the border, Mexican immigrants also tend to be highly mobile and often return to their home country after relatively brief stays (Portes and Rumbaut, 2006). Thus, the improvement in socioeconomic status along with length of time in the country (and in subsequent generations) may reflect some self-selection of immigrants who choose to stay permanently and assimilate both economically and socially.

Employment

Immigrants are somewhat less likely to have at least one full-time worker in the family (57 percent) compared to U.S.-born adults (62 percent). As with socioeconomic status, among immigrants, those in the country for longer periods of time have higher employment rates, and the employment rate for those in the country more than 20 years is actually slightly higher than for U.S.-born residents (Figure 11).



Recent immigrants have lower levels of employment for a variety of reasons, including their younger age (i.e. reflecting less work experience in the U.S.), barriers associated with citizenship or visa requirements, lack of English language skills, and less education and job skills. Recent immigrants are also more likely to be employed in more tenuous job situations that increase the potential for job loss and unemployment, such as being in small firms and in industries where seasonal or contract work is more common, such as agriculture and construction (Table 1). Lower job security among recent immigrants is further compounded by lower levels of labor union membership.

Table 1:
Job Characteristics of Nonelderly Workers
by Immigrant Status and Length of Time in the Country, 2007

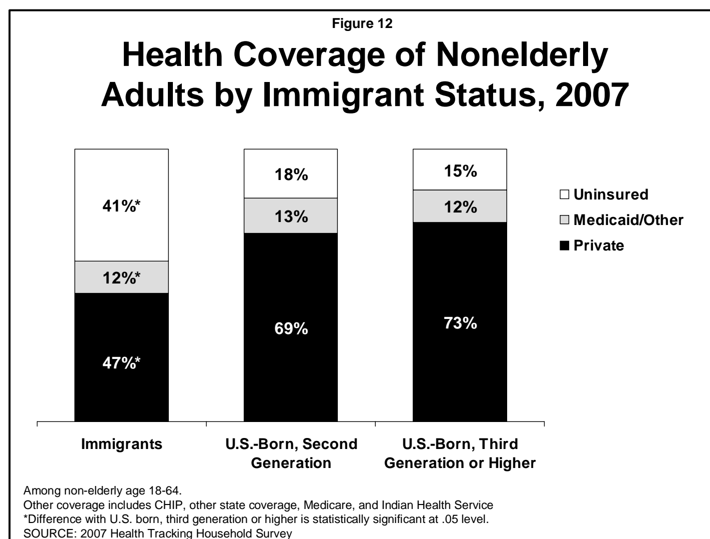
	Self-employed	Small firm (<25 workers)	Large firm (≥100 workers)	Agriculture, mining, construction industries	Labor union
All adults, 18-64	13.0%	27.5%	59.2%	12.4%	13.9%
Immigrants	15.5	38.9*	47.0*	19.5*	11.1*
0-10 years in U.S.	*19.4*	*49.7**	*36.3**	*22.3*	*6.0**
11+ years in U.S.	*14.0*	*34.2*+*	*51.6*+*	*18.3**	*13.5*+*
U.S.-born, second generation	12.9	24.8	61.5	11.6	15.8
U.S.-born, third generation or higher	12.6	25.9	61.0	11.3	14.2

Nonelderly includes adults age 18-64.
*Difference with U.S.-born, third generation or higher is statistically significant at .05 level.
+Difference with foreign-born, 0-10 years in U.S. is statistically significant at .05 level
Source: 2007 Health Tracking Household Survey.

Health Insurance Coverage

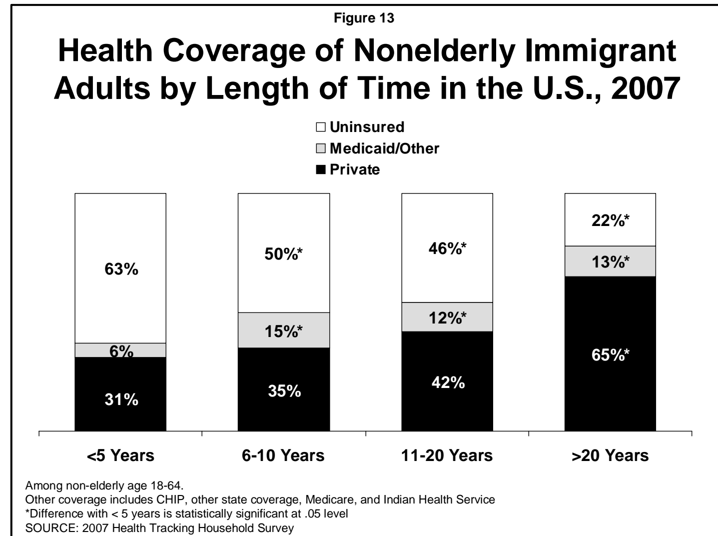
Distribution of Health Coverage

Differences in health insurance coverage between immigrants and U.S.-born residents closely follow differences in socioeconomic status and employment characteristics (Figure 12). Less than half of immigrant nonelderly adults (47 percent) have private insurance (compared to about 70 percent of all U.S.-born residents), while over 40 percent of immigrants are uninsured (compared to about 15 percent of U.S.-born residents). Even though immigrants have relatively low incomes, Medicaid and other public coverage (e.g. CHIP) provide limited



offsets to the large gaps in private coverage between U.S.-born residents and immigrants. Undocumented immigrants are ineligible for these programs, and, since 1996, most legal immigrants were also barred from this coverage during their first five years in the U.S. The recent Children's Health Insurance Program Reauthorization Act provides states the option to extend Medicaid or CHIP to legal immigrants who are pregnant women and children regardless of their date of entry, but other recent legal immigrants remain barred from the programs.

As with family income and education, health coverage among immigrants differs greatly by length of time in the U.S (Figure 13). Only 31 percent of recent immigrants in the U.S. for five years or less are privately insured, while almost two-thirds (63 percent) are uninsured. By contrast, among those in the U.S. for more than 20 years, almost two-thirds have private insurance (65 percent), while 22 percent are uninsured—about one-third of the uninsured rate for recent immigrants. Nevertheless, uninsured rates among longer-term immigrants are still higher than that of U.S.-born residents.



Given the cross-sectional nature of the data used in this analysis, it is possible that differences in coverage by length of time in the country may reflect (in part) coverage levels of different immigrant cohorts when they first arrived in the U.S. For example, if uninsured rates for the most recent cohort of immigrants (arrived between 2002 and 2007) were higher than for earlier cohorts when they first arrived in the U.S. (i.e., because of differences in educational levels and job skills), then differences in coverage rates among immigrants may not reflect the economic advancement of immigrants over time. While longitudinal data on immigrant cohorts is not available, data from the Current Population Survey indicate that uninsured rates for immigrants have been relatively stable over the past 15 years, and—consistent with general population trends—increased only slightly between 1994 and 2006 (from 34 to 37 percent) (Fronstin, 2008). Thus, it is unlikely that differences in coverage rates by length of time in the country in 2007 largely reflect differences in the characteristics of immigrant cohorts upon their arrival in the U.S. Instead, the data suggest immigrants experience improving socioeconomic status and corresponding increases in health coverage rates as their length of time in the U.S. increases.

Consistent with the similarities in socioeconomic status, second generation Americans have coverage levels that are very similar to other U.S.-born adults, and the small differences that exist are not statistically significant. Taken together, these findings suggest that the wide disparities in coverage between U.S.-born residents and immigrants narrow considerably the longer that immigrants are in the country and that further narrowing occurs by the time that U.S.-born children of immigrants reach adulthood.

Reasons for Lower Coverage Rates

To better understand why uninsured rates differ between U.S.-born residents and immigrants as well as among immigrants, adjusted estimates of the percent uninsured were computed that control for differences in other population characteristics that are known to be correlated with insurance status (Table 2). For example, the first set of adjusted estimates (column 2) control for differences in demographic characteristics (age, gender, family structure) and health status. Family income and educational attainment are added to the second set of adjustments (column 3), and the final adjustment (column 4) includes controls for assimilation (citizenship, English-language usage). Differences between the unadjusted and adjusted estimates reflect the extent to which the control variables in the adjustment account for differences in the uninsured rate between U.S.-born residents and immigrants as well as among immigrants.

Table 2:
Adjusted Uninsured Rates for Nonelderly Adults

		Adjusted uninsured rates[1]		
	(1) Unadjusted uninsured rates	(2) Adjusted for demographics and health status	(3) Adds education and income	(4) Adds citizenship and language of interview
Immigrants				
0-5 years in U.S.	63*%	57%*	49%*	34%*
6-10 years in U.S.	50*	45*	36*	21
11-20 years in U.S.	45*	42*	31*	21
>20 years in U.S.	22%*	22	18	13*
U.S.-born, second generation	18	18	21	22
U.S.-born, third generation or higher	15	16	17	19

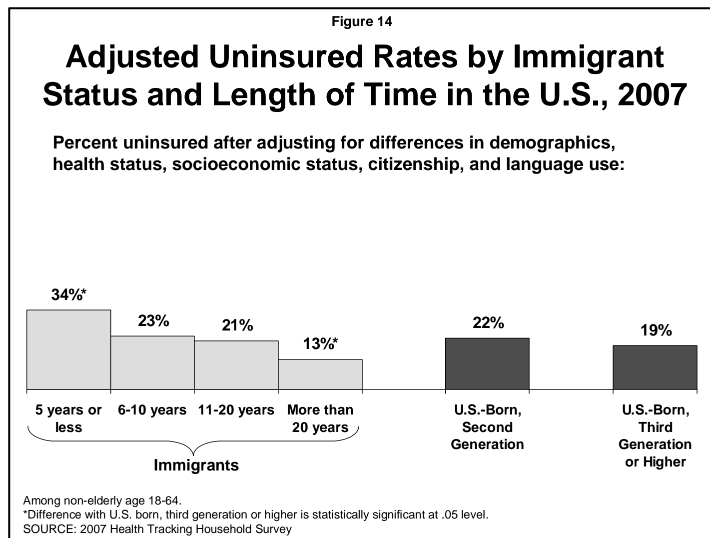
Nonelderly includes adults age 18-64.
[1]Computed from multivariate regressions. Demographic and health characteristics include age, gender, family composition, perceived health, and chronic conditions.
*Difference with U.S.-born, third generation or higher is statistically significant at .05 level.
Source: 2007 Health Tracking Household Survey.

The results show that differences in demographic and health characteristics account for few of the differences in uninsured rates between immigrants and U.S.-born residents. This is demonstrated by there being little difference between the unadjusted uninsured rates (column 1) and the estimates that adjust for health and demographic characteristics (column 2). Additional adjustments for family income and education (column 3) eliminate the difference in uninsured rates between U.S.-born residents and immigrants in the U.S. for more than 20 years, although there are still large differences among immigrants by length of time in the country.

Much of the remaining difference is accounted for by citizenship and the language of interview (column 4). Controlling for these final two factors essentially eliminates the remaining differences between U.S.-born residents and immigrants who have been in the U.S. for more than 5 years, and long-term immigrants (in the U.S. for more than 20 years) have lower uninsured rates compared to U.S.-born residents (Figure 14). Citizenship and English-language proficiency are likely to reflect greater assimilation into American society, which facilitates both the

awareness and ability to utilize key societal institutions, including the health insurance and health care systems (Pew Hispanic Center, 2004; Livingston and Minushkin, 2008). Citizenship may also facilitate enrollment in Medicaid and other public programs, and citizens may have a greater comfort level in applying for these programs.

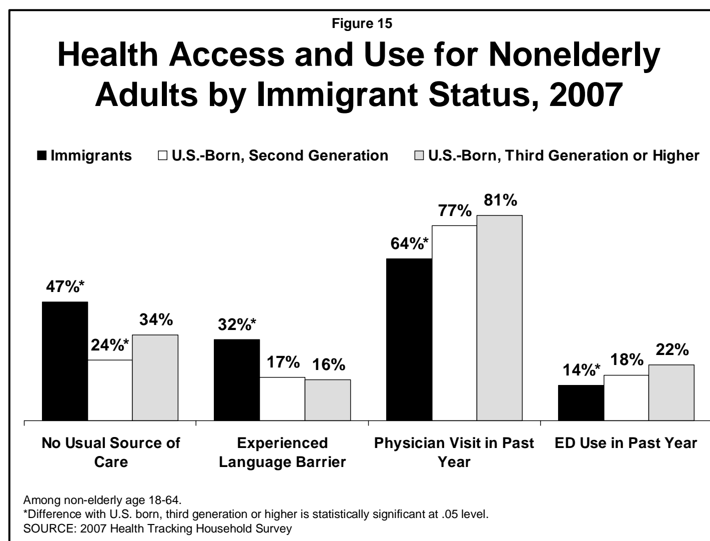
Recent immigrants continue to have higher uninsured rates even after controlling for their lower socioeconomic status, lower use of English, and low citizenship rates. Virtually all of the remaining difference reflects lower rates of private insurance coverage among recent immigrants compared to all other adults, which may reflect, in part, lower availability and take-up of employer-sponsored coverage. While sample sizes for recent immigrants are too small to examine this in detail, the survey data indicate that immigrant workers in the U.S. for more than 10 years are more likely to be offered and eligible for employer-based coverage (60 percent) compared to those in the U.S. for 10 years or less (46 percent). Similarly, take-up rates of employer-based coverage among immigrant workers offered and eligible for coverage are lower compared to U.S.-born workers (92 percent take-up for U.S.-born workers vs. 82 percent for immigrant workers), and take-up is even lower for recent immigrants (69 percent). In addition to a lower ability to afford the out-of-pocket premiums for employer-based coverage, recent immigrants may prefer to exchange health benefits for higher wages to support themselves and send remittances to family members in their country of origin (Reschovsky et al., 2007).



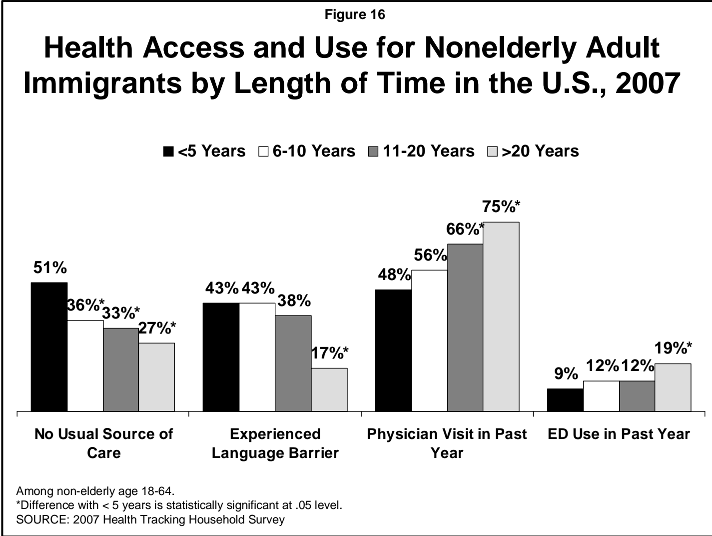
Access to and Utilization of Health Care

Access and Utilization Rates

Differences in medical care access and use between U.S.-born residents and immigrants are consistent with the differences in health coverage. Immigrants are more likely to lack a regular source of care compared to U.S.-born residents (Figure 15). Differences among immigrants are just as large, with more than half of recent immigrants going without a regular source of care compared to 27 percent of those in the U.S. for more than 20



years (Figure 16). Not surprisingly, a higher percentage of immigrants report having experienced a language barrier with their physician, and recent immigrants are more likely to report a language barrier.



Consistent with other research and in contrast to many popular perceptions, immigrants are less likely to visit the emergency department (ED) compared to U.S.-born residents (Cunningham, 2006). Recent immigrants have by far the lowest rates of ED use (9 percent used the ED in the previous year), and the rate of ED use increases for immigrants in the country for longer periods of time. These patterns reflect the fact that immigrants—in particular recent immigrants—are less likely to use health care of any type, as demonstrated by their much lower use of physician services.

Reasons for Greater Access Barriers

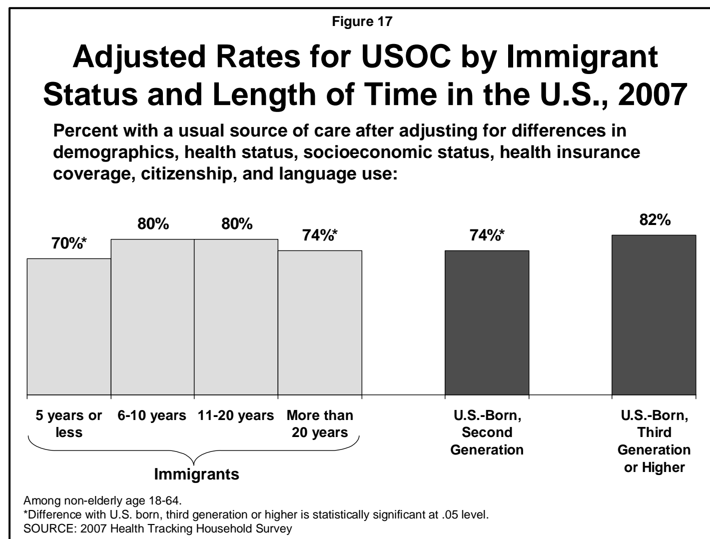
To better understand why immigrants experience greater access barriers than U.S.-born residents, Table 3 presents adjusted estimates of rates for usual source of care that control for differences that are known to be correlated with access, including demographics and health status (column 2); income, education, and health insurance (column 3); and citizenship and English-language usage (column 4).

Table 3:
Adjusted Rates for Usual Source of Care (USOC) for Nonelderly Adults

		Adjusted rates for USOC[1]		
	(1) Unadjusted Rate for USOC	(2) Adjusted for demographics and health status	(3) Adds education, income, and health insurance	(4) Adds citizenship and language of interview
Immigrants				
0-5 years in U.S.	49*%	54*%	66*%	70*%
6-10 years in U.S.	64*	68*	77	80
11-20 years in U.S.	67*	70*	78	80
>20 years in U.S.	73*	72*	73*	74*
U.S.-born, second generation	76*	76*	75	74
U.S.-born, third generation or higher	84	84	82	82

Nonelderly includes adults age 18-64.
[1]Computed from multivariate regressions. Demographic and health characteristics include age, gender, family composition, perceived health, and chronic conditions.
*Difference with U.S.-born, third generation or higher is statistically significant at .05 level.
Source: 2007 Health Tracking Household Survey.

The results show that demographic and health characteristics account for a relatively small portion of the difference in rates of usual source of care (as seen in the small differences between the estimates in column 1 and column 2). Adjusting for income, education, and health insurance significantly increases the rate of usual source of care for immigrants, narrowing differences among immigrants and eliminating the difference between U.S.-born residents and immigrants who have been in the U.S. for six to twenty years. Almost all of this change stems from the adjustment for health insurance, which is consistent with the large and longstanding body of research demonstrating the importance of health coverage for assuring access. Controlling for citizenship and language further increases rates of having a usual source of care for immigrants, although rates for recent immigrants and immigrants in the U.S. for more than twenty years remain lower than U.S.-born residents who are third-generation or higher (Figure 17). The persistence of these lower rates among recent and longer-term immigrants likely reflect differences in care-seeking patterns, preferences, and attitudes that are not accounted for by any of the measures in the adjustments.



CONCLUSION

Often overlooked in debates and discussions related to immigrant issues is the great diversity among the immigrant population, and, in particular, the fact that their circumstances and situations change over time as they assimilate socially and economically within American society. While, overall, immigrants have a higher uninsured rate and face greater access barriers relative to U.S.-born residents, the findings in this report suggest that many immigrants eventually gain insurance and improved access to health care as they acquire language and job skills, improve their economic situation, and become more familiar with the U.S. health care system. Some of this "improvement" also likely reflects some selecting out of immigrants who intend to stay in the country temporarily or are not successful in assimilating economically and socially into U.S. society. Additionally, given the cross-sectional nature of the analysis, some of the findings may reflect differences in characteristics of different cohorts of immigrants arriving in the U.S.

Overall, the findings suggest that the contribution of any given cohort of immigrants to the uninsured rate is likely to diminish over time. For example, immigrants who entered the U.S. between 1997 and 2007 accounted for about 14 percent of uninsured adults in 2007. If coverage follows the same pattern as shown in these results (and assuming no other changes), the contribution of this cohort to the uninsured rate in 2017 would decrease to about 8 percent. The contribution of immigrants to the uninsured rate in the future will depend on the number and

characteristics of new immigrants, general trends in insurance coverage, and the nature and extent of health reform.

The findings demonstrate that much of the higher uninsured rate among immigrants is driven by their more limited access to private coverage, which stems from them working in low-wage jobs and in firms and industries that often do not offer health coverage. As such, to the extent that potential health reform may address socioeconomic disparities in access to health coverage by increasing the availability and affordability of private insurance and/or increasing eligibility for Medicaid, the coverage differences between U.S.-born residents and immigrants will narrow. However, to further narrow the coverage gap, it also will be important to address coverage barriers related to language and citizenship status, especially for low-income recent immigrants with limited English language skills.

Increasing coverage rates among immigrants should go a long way in terms of eliminating disparities in access to care both among immigrants and between immigrants and U.S-born residents. The analysis illustrates that much of the difference in access among immigrants and between immigrants and U.S.-born residents is accounted for by the differences in their health coverage rates. However, as with coverage, it also will be important to address access barriers associated with citizenship status and language.

As long as immigrants, particularly recent immigrants, continue to experience higher uninsured rates, safety net providers—especially Community Health Centers—are likely to continue to play a key role in providing their care. Recent immigrants tend to rely on health centers to a much greater degree than other immigrants or U.S.-born residents. New or expanded health centers are often targeted in areas that have a large number of low-income immigrant communities, and they are particularly notable for addressing language and other cultural barriers to care.

Overall, the findings show that immigrants are a diverse group and that differences in their characteristics, including their length of time in the country, have a significant impact on their health coverage and ability to access care. Health coverage and access barriers for immigrants appear to diminish the longer they reside in the U.S. Among immigrants, recent immigrants are most at risk for lacking coverage and facing access problems. As such, addressing the coverage and access barriers facing recent immigrants will be important for reducing overall disparities between immigrants and U.S.-born residents.

This brief was prepared by Peter Cunningham of the Center for Studying Health System Change and Samantha Artiga of the Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation. The authors thank Paul Ginsburg for his helpful comments and Helena Bacellar at Social Scientific Systems, Inc. for her excellent programming assistance. The Health Tracking Household Survey used for this analysis was funded by the Robert Wood Johnson Foundation.

APPENDIX A: SURVEY AND METHODOLOGY

Description of data source

The estimates in this report are based on analysis of the 2007 Health Tracking Household Survey. The survey is a telephone-based survey conducted by the Center for Studying Health System Change and Mathematica Policy Research, Inc. The survey is representative of the civilian, noninstitutionalized population, and includes a sample of about 17,800 persons. The response rate for the survey was 43 percent. Survey weights used in the analysis were post-stratified to account for survey nonresponse based on age, sex, race/ethnicity, and education. Survey weights were also post-stratified to account for the increasing proportion of households without landline telephones, which are not included in random-digit dialing sampling frames. For more detail on sample design, survey questionnaires, and survey methods and procedures, see *2007 Health Tracking Household Report at (http://www.hschange.org/CONTENT/1060/).*

Definition of key measures

Immigrants. Immigrants are defined as all persons born outside of the U.S., including naturalized U.S. citizens.

Length of time in the U.S. Immigrants are asked the year in which they first came to the U.S. For those who don't recall the year, they are asked how many years they have been in the U.S.

Generation. U.S.-born respondents are asked whether one or both of their parents were born outside of the 50 U.S. states. *Second generation* Americans are defined as U.S.-born residents with one or both parents born outside of the U.S. Americans who are *third generation or higher* are defined as U.S.-born residents with both parents born in the U.S.

Health insurance coverage. All measures of health insurance coverage in this report (including employer-sponsored insurance coverage) reflect coverage on the day of the interview. Private insurance coverage reflects either coverage obtained through an employer (employer-sponsored insurance) or private insurance purchased directly (nongroup coverage). Medicaid and other state coverage includes Medicaid, the Children's Health Insurance Program (CHIP), other state-funded health insurance programs, Medicare, and the Indian Health Service.

Measures of access to care. No usual source of care reflects people who reported that they did not have a place or provider that they go to when a health problem arises. Language barriers with providers is based on respondents reporting that there was a time in the past 12 months when they had problems speaking with or understanding a health care provider because they spoke different languages.

Computing Adjusted Estimates of Uninsured Rates and Access to Care.

OLS regression analysis was used to calculate adjusted estimates of the percent uninsured by length of time in the U.S. for immigrants and generation. The dependent variable for the analysis was a binary indicator of whether or not the individual was insured. Independent

variables included indicators for length of time in the U.S. among immigrants and generation for U.S.-born residents, as well as other control variables. An initial adjustment included control variables for health status, prevalence of chronic conditions, gender, and age. A second adjustment added education and family income as indicators of socioeconomic status. A third adjustment added citizenship and language of interview (English vs. Spanish) as indicators of assimilation. Using the regression coefficients for length of time in the U.S. and generation, the adjusted estimates reflect marginal differences in the percent uninsured when controlling for other factors in the model.

A similar procedure is used when computing adjusted estimates of usual source of care by length of time in the U.S. and generation. Usual source of care is the dependent variable, while the binary indicator for insurance coverage is included as an additional control variable.

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1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, *Fax:* (202) 347-5274
Website: www.kff.org/KCMU

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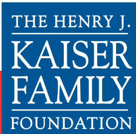

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.