The Health Care Safety Net for Mexican Americans

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Support for this research was provided by the LBJ School Policy Research Institute- Urban Issues Program, the National Institute on Aging (RO1AG10939), and National Institute of Child Health and Human Development (RO1HD36093). We also gratefully acknowledge funding from several private foundations and government agencies that are listed at: http://www.jhu.edu/~welfare/welfare_fund.htm.

Abstract

Our reliance on an employment based health insurance system in the United States means that those individuals who are disadvantaged in the labor market are also disadvantaged in terms of health insurance coverage. Hispanics in the United States, and especially those of Mexican origin, have historically been disadvantaged in both domains. At all ages, Americans of Mexican origin have lower rates of health insurance coverage than other groups, including African Americans and other Hispanics. Although employment in jobs that do not offer benefits is the major barrier to health care coverage for this population, other factors, including immigration history, citizenship status, and language proficiency play a role. In what follows we compare health insurance coverage among Mexican American children, pre-retirement age adults, and the elderly to that of blacks and other Hispanic groups and review what is known of the causes of the low rates of health insurance coverage among Mexican Americans. We end with a discussion of policy options for overcoming some of the major barriers to adequate health care coverage for this group and other poor Americans.

The Health Care Safety Net for Mexican Americans

In the United States employer sponsored health insurance represents the largest source of health care coverage for the working age population. In 2001 approximately 71% of the insured population had private coverage, and of those approximately 63% were covered by employer sponsored plans.[1] For those without private coverage, the Federal government is the insurer of last resort. In 2001 slightly over 13% of insured Americans were covered by Medicare and an additional 11% received Medicaid. The military and other sources cover a relatively small fraction of the population, leaving over forty million Americans, or over 14% of the population, without health insurance.[2] This is a startling figure in and of itself, but it masks an even more serious problem that arises from the fact that although the proportion of uninsured Americans is high across the board, the proportion of uninsured is even higher among minority Americans, [3,4] among whom Mexican Americans face unique problems of seriously inadequate coverage, especially in the cases of children and working-age adults.[5,6,7,8,9,10,11,12,13]

In this discussion we present a general overview of the health care coverage of the Mexican American population of the United States and compare it to the situation of blacks and non-Hispanic whites, as well as to that of other Hispanic groups. Rather than focusing on one age group or one source of health care coverage we summarize rates of public and private coverage for children, pre-retirement age adults, and the elderly to point out the life-long vulnerability of the Mexican American population. An additional motivation for such a comparison arises from the fact that given a finite economic pie different age groups necessarily compete for resources.[14] Medicaid consumes a large fraction of our national health care budget but in addition, although nearly three quarters of Medicaid participants are children in poor families, over three quarters of Medicaid revenues go to pay for the long–term care of the elderly

and disabled.[15] The fact that Mexican Americans are at elevated risk of inadequate health care coverage at all ages adds an ethnic dimension to age differences in health care financing.

For this overview we draw upon three data sets, the first a recently completed study of the lives of families in poverty and their response to welfare reform, the second an ongoing longitudinal study of the older Mexican American population of the Southwest that is now in its tenth year, and the third the Health and Retirement Study (HRS) which includes an over sample of Hispanics. We employ each to identify major correlates of economic vulnerability and of inadequate health care coverage among these three age groups. We begin our examination, though, with data from the 2001 Current Population Survey (CPS) in order to identify the major sources of health care coverage for children and adults from the three major Hispanic groups, Mexican Americans, Cuban Americans, and Puerto Ricans and to compare their coverage to that of non-Hispanic blacks and whites.

In Exhibit 1 we examine patterns of health insurance coverage among Hispanics of three age groups: children and adolescents under eighteen, working-age adults, and elderly persons 65 and over. The data reveal that while 75% of non-Hispanic white children are covered by a parent's employer sponsored plan only about half of non-Hispanic black and Cuban American children are covered by such private insurance. Forty-five percent of Puerto Rican and only 39% of Mexican American children are covered by their parent's plans. In the absence of employer-based coverage Medicaid represents the most obvious alternative, and thus, the four minority groups display high rates of use of this program. Despite the relatively high rate of Medicaid coverage, though, the results show that substantial percentages of minority children do not participate. It also demonstrates the seriousness of the problem among Mexican American children and adolescents, over a quarter of whom have no insurance of any sort.

The middle panel of Exhibit 1 presents data on health insurance coverage among adults 18 to 64. Although a clear majority of non-Hispanic white adults report employer-sponsored health insurance, fewer than half of Mexican American or Puerto Rican adults report such coverage. The data clearly show that for adults publicly funded health care coverage does not make up for the lack of private coverage. Although a substantial fraction of non-Hispanic blacks (13%) and Puerto Ricans (22%) report receiving Medicaid, among all groups rather large percentages report no coverage, a situation which is particularly serious for the four minority groups. Approximately one quarter of black, Cuban American, and Puerto Rican adults report that they have no health insurance. The situation is even worse for Mexican Americans, though, 45% of whom report that they have no health insurance. This striking difference among Hispanics shows that Mexican Americans face rather unique and serious risks for inadequate coverage.[16,17,18]

These statistics underscore the complexity of the health care coverage system in the United States and the differential vulnerability of various groups. The situation of Mexican Americans reveals that even among minority populations other risk factors that are as yet poorly understood place certain groups at seriously elevated risk of inadequate health coverage. Such factors may relate to regional concentration and labor market differences, immigration status, language difficulties, and other barriers that increase the risk of inadequate coverage. Mexican Americans are far less likely than any other group to be employed in managerial or professional occupations.[19] Mexican origin adults, and especially immigrants, are over-represented in the service sector in which they are usually not offered employer-sponsored health insurance, or in which the premiums required for individual or family coverage place such coverage out of reach.[20]

The bottom panel of Exhibit 1 provides coverage data for adults 65 that clearly show the equalizing effects of universal health insurance, in this case Medicare, which covers over ninety percent of each group. Yet important group differences remain. While approximately 36% of non-Hispanic whites and 29% of non-Hispanic blacks report employer-based insurance, only about 15% of any of the three Hispanic groups report employer-based coverage. Such coverage can reflect continuing employment past age 65, but more importantly it usually reflects the ownership of supplemental Medigap or long-term care insurance that covers health care costs such as those for long-term care or prescription drugs and appliances that Medicare does not pay. Individuals without supplemental private coverage can face serious medical expenditures. Increasingly, private long-term care insurance is necessary to insure that even a substantial middle-class estate is not consumed by nursing home costs. For middle class retirees such supplemental coverage is often part of a generous retirement package. Even when it is not part of a retirement package, middle-class incomes make the purchase of supplemental Medigap plans possible.

For the destitute elderly, Medicaid pays the premiums and other expenditures not covered by Medicare. Such dual eligibility reflects economic marginality and the table shows that older blacks and Hispanics are at elevated risk of falling into this category. As among other age groups, the working poor, or in the case of the elderly those with low retirement incomes that are too high to allow them to qualify for Medicaid face particularly serious health care financing problems. Both working age and retirement aged minority group members often find themselves in this situation. In the CPS over 5% of older Mexican Americans report that they have no health insurance coverage. Whether this figure represents a misunderstanding of the survey question, a failure to qualify for Medicare, or simple non-participation is not clear. Nonetheless,

the fact that even a small fraction of older individuals do not participate in a universal program emphasizes the unique vulnerability of the entire group.[21,22]

Welfare, Children, and Families: A Three City Study

Given this clear Mexican American health care financing disadvantage that persists over the life course, it would be useful to examine the correlates of inadequate coverage. As before, let us begin with children. A recently completed study of the response to welfare reform of poor Hispanic, African-American, and non-Hispanic white families in Boston, Massachusetts, Chicago, Illinois, and San Antonio, Texas provides new information on the health care coverage of minority children. These three cities have diverse populations and very different welfare policies.[23] The study was begun in 1999 and includes an intensive survey of approximately 2,400 poor families with children, approximately 40 percent of which were receiving cash welfare payments when they were interviewed. Seventy-seven percent of the families had incomes below the poverty line and 73% were headed by single mothers.[24] Extensive baseline information was obtained on one child per household and his or her caregiver, usually the mother. For present purposes we focus upon the extent of health care coverage among poor families. Detailed ethnographic interviews were completed with at least 50 families in each of the three cities, and family accounts of health insurance problems emerged frequently. The ethnography provides useful insights into the system and community-level barriers that poor families face in acquiring health care.

Health Care Coverage for Poor Children

One of the major reasons for the large number of uninsured children in the United States is the fact that many children in poor families are not enrolled.[25] Differences in state eligibility criteria, as well as local administration of the program, are of major importance in determining who enrolls. Exhibit 2 shows the rather dramatic differences between cities in Medicaid coverage among families with children. In Boston, 82% of families with incomes below 100% of poverty include a child who receives Medicaid, a figure similar to that for Chicago. In San Antonio, on the other hand, only 64% of families with household incomes below 100% of poverty receive Medicaid. The figure for the U.S. as a whole from the March 2000 Current Population Survey is 60%. As family income increases, Medicaid participation decreases, although it remains much higher in Boston than in Chicago or San Antonio. In San Antonio, only 5% of children in families with incomes between 150% and 200% of poverty receive Medicaid.

Since Hispanics in San Antonio are primarily of Mexican origin, one might ask if the lower rates of coverage among Mexican American children generally reflect the fact that this group is heavily concentrated in Texas. Exhibit 3 presents the results of two logistic regressions of (1) any health insurance and (2) Medicaid participation on several factors that potentially influence coverage among the poor, including race and Hispanic ethnicity, citizenship status of both mother and child, mother's marital status, the child's age, and city. In each Three City Study household extensive information was collected on one randomly selected "focal" child. These analyses refer to that child. The results are rather dramatic and reveal that even when these other factors are controlled Mexican-origin children are only 29% as likely to be covered by any form of health insurance and 43% as likely to be covered by Medicaid as non-Mexican Hispanics, the reference group.

Exhibit 3 reveals some interesting associations that reflect national and state policy related to health care coverage. Although mother's citizenship status is not significant at conventional levels in predicting insurance of any sort, the children of mothers who are U.S. citizens are only 59% as likely as those whose mothers are not citizens to receive Medicaid. This probably reflects an immigrant parent's greater reliance on public health coverage. On the other hand, the child's citizenship status greatly influences the probability that he or she will be covered by some form of health insurance. Citizen children are far more likely to have health insurance, including Medicaid than non-citizens. Since most public programs base eligibility on U.S. citizenship this finding is to be expected.[26,27] On the other hand, the exhibit reveals that children in San Antonio are less than half as likely as children in Boston, the reference category, to be covered by any form of health insurance and only 63% as likely to be covered by Medicaid. Although the coefficient is slightly short of statistical significance, having a spouse present reduces the likelihood of having any form of health insurance. For Medicaid, on the other hand, the presence of a partner, whether he is living in the household or not, greatly reduces the probability of coverage. If a spouse is present in the household the child is only 45% as likely as a child whose mother has never been married to be covered, revealing the serious marriage penalty that is part of the Medicaid program.

Pre-Retirement age Hispanics: Asset Poor

The health insurance disadvantage among Mexican American children continues into adulthood and old age. Ethnographic, as well as survey data from the Three City Study reveal a serious lack of coverage for the parents of the children in households with incomes below 200% of poverty. Except during pregnancy or as a result of serious chronic illness or disability, the U.S. provides no health care safety net for adults. In the Three City Study, mothers went without

care or incomplete care for serious illnesses that interfered with their ability to work. If occupational disadvantage and the lack of health insurance were confined to early adulthood the situation of the group might not have serious long-term consequences. If, on the other hand, that disadvantage persists into mature adulthood the situation has much more serious implications for health. For most families the decade preceding retirement represents the pinnacle of economic achievement and security. This period of the life course also represents the launching pad for the retirement years. Economic uncertainty and inadequate health care coverage in the 50's and early 60's bode very ill for the retirement years.

In order to determine the extent and type of health insurance coverage among pre-retirement age Hispanics we employ the first wave of the Health and Retirement Study (HRS), a nationwide survey of employment, assets, health, health insurance, and retirement plans among a nationally representative sample of 12,654 individuals aged 51 to 61 including oversamples of 2,064 blacks and 1,174 Hispanics. In this survey health insurance included employer-based plans, privately purchased plans, Medicare, Medicaid, Veterans insurance, and Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) now called TRISTAR coverage.

Exhibit 4 presents data on the type of health insurance coverage among pre-retirement age adults by race and Hispanic ethnicity. In this exhibit private includes both privately purchased plans, which comprise a very small fraction of all insurance coverage, and employer sponsored group plans. The figure reveals a very high rate of private coverage among non-Hispanic white adults, but much lower levels of coverage among non-Hispanic blacks and Other Hispanics. Among Mexican American individuals employer based coverage is basically half of that of non-Hispanic whites. Forty percent report no health insurance of any form. The lack of health insurance at this age range places many of these individuals at serious risk of ill health

and its longer-term consequences. This is the point in the life course in which the consequences of chronic diseases, such as diabetes and hypertension, begin to take their toll.

The lack of health insurance is part of a package that includes low income and asset accumulation. By the time an individual or a couple reach the ages of 51 to 61 they have accumulated most of the wealth that they will ever have. Homes are close to being paid off and one's income is as high as it will probably get. Differences in wealth between groups during the pre-retirement years mean large differences in economic well-being and health during retirement. These differences have particularly profound implications for options in long-term care. Low income and a lack of retirement health benefits place minority Americans at serious risk of dependency on family or of incomplete and inadequate health care in old age.

Exhibit 5 presents data on the total value of the assets owned by families in different household types defined by race and Hispanic ethnicity, as well as by the marital status of the head. Female headship represents a major dimension of economic disadvantage given the traditionally lower lifetime earnings of women and the fact that many have not been continuously employed. This figure reveals stark differences in the total asset value of minority and non-minority households as well as between those headed by a couple or a male and those headed by a female. While the average pre-retirement age non-Hispanic white couple in the mid 1990's had over $300,000 in total assets, the average Mexican American couple had less than $100,000 in wealth. Female-headed households in all groups are seriously asset poor. Analyses of employment patterns among the elderly by Flippen and Tienda (1996) suggests that retirement for older Hispanics is not the voluntary termination of a career, but rather the end stage of a long period of unstable employment and joblessness. Such a career trajectory is one that results in inadequate asset accumulation and a high risk of late-life poverty.[28]

Elderly Hispanics: A Lack of Medigap Coverage

In order to assess health care coverage among older Mexican American individuals we employ data from a ten-year longitudinal study carried out in the southwestern United States.[29] The study, entitled the Hispanic Established Population for Epidemiologic Studies of the Elderly (H-EPESE), has followed a cohort of 3,050 Mexican American individuals who were 65 or older and who lived in Arizona, California, Colorado, New Mexico, and Texas at the time of the first interview in 1993 and 1994. Extensive information on household demographics, economics, health status and health care use was collected. The sample was recontacted and much of the same information collected again in 1995-96,1998-99, and 2000-01. At each wave, information on individuals who were too incapacitated to respond for themselves was collected from a knowledgeable proxy. Nearly half of the sample was foreign-born and over half had household incomes below the poverty level.

Exhibit 6 presents information on health insurance coverage in this relatively poor sample of older Mexican Americans. It shows that the Mexican American elderly are particularly dependent on Medicaid and that only 19 percent have private Medigap plans. Forty-one percent are dependent on Medicare alone. The lack of supplemental coverage places these individuals at serious risk of not receiving the care they need.[30] Medicare physician coverage requires the payment of a monthly premium and there is a substantial fair-share costs associated with hospital stays. In addition, Medicare does not cover the cost of prescription drugs, eyeglasses, hearing aids, or other specialized medical devices and appliances. The costs of a medical encounter for an older person without supplemental coverage can be quite high. As at other ages, the lack of a supplemental Medigap plan is part of a package that includes a lifetime of employment in jobs that do not provide retirement health plans and a retirement income that

can make the purchase of private coverage prohibitively expensive.

Medicaid represents the health care safety net for the poor elderly. For those with incomes below or slightly above poverty Medicaid covers the costs of premiums and other costs associated with Medicare. Such individuals have come to be referred to as "dual eligible" since they qualify for both Medicare and Medicaid. Dual eligibility, therefore, is itself an indicator of vulnerability. Unfortunately, for those individuals with incomes above 200% of poverty Medicaid is not available and if they do not have a private Medigap plan these older individuals must rely on their own resources to pay for what Medicare will not. It is for that reason that the accumulated assets are particularly important.

What is particularly striking about Exhibit 6 is that 7 percent of these elderly Mexican American respondents report no health insurance of any kind, a figure higher than that for the nation as a whole (cf. exhibit 1) that reflects the unique disadvantage of those older individuals living along the U.S/Mexico border. In order to make some sense of these findings we present type of health insurance by nativity in Exhibit 7. Among the foreign-born, 12% report no insurance and only 11% report that they have any private Medigap insurance. Thirty-eight percent are dual eligible. The data show, then, that nativity interacts with region and other factors to place Mexican-origin individuals in poorly paid service sector jobs in which they do not receive benefits. The disadvantage this group faces, therefore, arises from multiple sources and for a large fraction is life-long. This hardened disadvantage presents policy makers with a serious challenge in providing adequate health care coverage to the Mexican-origin population.

Discussion: Expanding Health Insurance Coverage to the Uninsured Mexican Origin Population

We are left with the question of how the specific health care financing needs of Mexican

Americans of all ages can be addressed. A comprehensive national health insurance system that would provide coverage to all residents on an equal basis would be the most direct solution, albeit one that has proved to be politically unattainable. Short of that we might suggest modifications to existing programs to help address the serious gaps in the health care safety net that poor Americans, including those of Mexican origin face. Among these suggestions are the following:

Increase outreach efforts to publicize State Children's Health Insurance Program. The state funded health insurance program for low-income children (SCHIP) is one obvious way to help address the health care needs of children who do not qualify for Medicaid. Unfortunately, not all eligible children are covered. In Texas, for example, although more than 3.3 million children were covered by the state's program in 2000, more than 2 million low-income children who were eligible were not enrolled.[31] As part of a general solution, the Federal Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) was enacted in December 2000 to improve outreach efforts. States were given permission to retain up to 10 percent of their 1998 SCHIP allotment for outreach activities. This gave states greater flexibility in identifying and enrolling children eligible for SCHIP.[32] It remains to be seen whether all states will take full advantage of this opportunity.

Despite ambitious state mass-media campaigns to encourage SCHIP enrollment, studies have shown that the lack of information, confusion about eligibility requirements, and administrative obstacles continue to pose significant barriers to participation.[33,34] Although health care organizations, including hospitals and health departments, traditionally have played important roles in identifying children who are eligible for public insurance, other organizations including schools, employers, community and religious groups are increasingly helping children

gain coverage.[35] In addition, most states have simplified complicated enrollment procedures for SCHIP and require re-certification only every 12 months.[36] Unfortunately, as with Medicaid coverage, states differ in the extent to which they have succeeded in enrolling eligible children.[37]

Less complicated procedures for moving among insurance plans would also make access easier. In particular, families report confusion over the process by which they change from Medicaid to SCHIP to other insurance plans as the eligibility and access of different family members to different insurance plans change. Both survey and interview data from the Three City Study indicate that households with medical insurance vary in both the source and amount of medical insurance coverage available to different family members.

Programs to reach rural children, including efforts in Texas, are potentially useful. In Texas, an experimental program along the U.S./Mexico border named the Border Vision Fronteriza (BVF) program which was carried out in 1999 employed trained volunteers or Promotores, the Spanish word for "promoter" which in this case refers to "health promoter," to educate Hispanic families about Medicaid and SCHIP. The project enrolled more than 10,325 children, greatly exceeding its initial goal of 4,500 children.[38] Unfortunately, such efforts are expensive and administratively complex and growing federal and state budget deficits will make them very difficult to carry out over the longer term.[39] The fact that many rural Mexican-origin children live in medically underserved counties limits the actual health impact of such outreach programs.

Low-income Adults

Targeted public subsidies. As we noted earlier, Mexican-origin workers, like minority Americans generally, have lower access to employer based health care coverage than more affluent groups.[40] Under our present system adults have limited access to public financing. Only

pregnant women are routinely covered. In October 2002 Health and Human Services Secretary Tommy G. Thompson issued a new regulation that allow states to use the State Children's Health Insurance Program (SCHIP) to provide health coverage for prenatal care and delivery to women who do not qualify for Medicaid. The new rules allow states to provide coverage regardless of the mother's immigration status. New Jersey, Rhode Island and Colorado have already obtained waivers to cover pregnant women using SCHIP funds. Since Hispanics have a high fertility rate and more than one-third of pregnant women in working families lack health insurance they could benefit greatly.[41] Once again, though, providing adult coverage under SCHIP creates serious budgetary problems for states that not all will accept.[42] Furthermore, family interviews in the Three City Study indicate that medical coverage that ceases soon after delivery leaves women who experience chronic conditions exacerbated by pregnancy and delivery without medical coverage, often while they are still in treatment.

Except in the case of pregnancy, publicly financed health coverage for adults is almost non-existent. For adults employment remains the primary source of care and this is likely to remain the case for the foreseeable future. Extending coverage to adults in the service sector has proved to be a major challenge. Short of subsidies for employers to provide coverage, along with requirements that they do so, it is hard to imagine that those who are not currently covered will soon be. Medical savings accounts, tax incentives for employers, and the other proposals that have been offered will probably not allow a working family to save enough for extensive care nor motivate service sector employers to shoulder large increases in employee compensation. Furthermore, such incentives for employee coverage have minimal effect on the large number of Mexican-American workers who are self-employed or working very small and family-operated businesses. Interviews with families in the Three City Study indicate that

workers who juggle several part-time or seasonal jobs remain either uncovered or have gaps in their medical insurance coverage. In our current political and economic environment, then, coverage for Mexican-origin working age adults remains elusive.

Older Adults

Information and outreach. Lower rates of ownership of supplemental Medigap coverage among Mexican American seniors means that many lack access to the full range of services they need. What seems like a moderate individual contribution for a middle class couple or individual may simply be more than a Mexican-origin Medicare beneficiary can afford. For this reason, it is important that all low-income families have the information they need about state assistance programs. Currently, several programs help pay Medicare premiums, deductibles, and coinsurance for eligible low-income Medicare beneficiaries. The most generous is the Qualified Medicare Beneficiaries (QMB) program, which pays Medicare Part and B premiums, deductibles, and co-insurance. As is the case for all programs with state contributions, states vary in qualification criteria and amount paid. To qualify for this program in Texas an individual must have a very modest income, less than $736 per month. As with programs for children outreach efforts can increase participation among those who are eligible. Recent efforts by the Texas Department on Aging to increase access to Medicaid services for "dual eligible" Hispanic retirees along the U.S./Mexico border suggest that state and local partnerships that include community and faith-based organizations and other non-governmental agencies, and that employ bilingual outreach specialists, can increase enrollment.[43] As has been demonstrated with programs for children administrative streamlining also helps. Making the application process easier for applicants, including a Spanish language version of a single application that combines eligibility requirements for both federal and state programs would make it easier for elderly

Mexican Americans to apply.[44] Three City Study family interviews indicate that the lack of medical coverage among older adults has potentially serious implications for poor families that include an older grandparent or that assume other responsibilities for aging adults. In these families working mothers of young children are often burdened with the additional responsibility of providing care to older relatives who often do not receive the medical treatment they need or do not receive financing for goods and services that would simplify the care giving task for the care provider.

Conclusion

The United States is unique among developed nations in having no universal health care financing program for all citizens and in linking health insurance coverage almost exclusively to employment. The very definition of a good job in the U.S. has evolved to include generous retirement and health benefits. In the best of circumstances those health benefits continue into old age as part of a generous retirement package. A large body of research reveals the shortcomings of this system, especially for the unemployed and those employed in the service sector. If health insurance is a job benefit toward which both the employer and employee must contribute it is unlikely to be part of the package offered to low productivity workers or to be something that they could afford if it were offered.

The findings of the Three City Study, The Health and Retirement Study, and the Hispanic-EPESE, and other data all show that from birth to death group-specific factors influence a family's ability to pay for health care. Mexican-American children face barriers to enrollment in Medicaid and other health insurance programs that we do not yet fully understand. For adults, factors related to nativity, citizenship status, and literacy play a role. Among the elderly, similar factors reduce access to Medigap coverage. What is clear from the Three City

Study is that the lives of the poor are highly unstable and that relatively minor adversities can disrupt routines and place a family at risk of inadequate coverage. When illness strikes a middle class family, employer-sponsored health insurance covers the cost and the family itself usually has other resources with which to adapt. Among the poor, health crises are often disastrous and given their low incomes and few assets such families have few material resources with which to cope. Many observers have noted what has been called "churning" in health care coverage among the poor as families move from private sources of coverage to public sources to no coverage at all. The only comprehensive solution for our nation's health care coverage crisis would be governmentally sponsored financing as in Canada. Barring such a comprehensive approach, the only solutions are partial and entail efforts to facilitate the enrollment of eligible individuals in existing programs. Unfortunately, for working age adults the options remain limited.

NOTES

[1]Mills, R.J. U.S. Census Bureau, "Health Insurance Coverage: 2001." *Current Population Reports*, P60-220. (September 2002). Accessed: http://www.census.gov/prod/2002pubs/p60-220.pdf (January 11, 2003).

[2]Based on 2002 Current Population Survey estimates, See Endnote 1.

[3]Angel, R. and J.L. Angel. "The Extent of Private and Public Health Insurance Coverage among Adult Hispanics," *The Gerontologist*, 36 (1996): 332-40.

[4]Mills, R.J. (2002). See Endnote 1.

[5] M. M. Doty and B.L. Ives. *Quality of Health Care for Hispanic Populations: Findings from The Commonwealth Fund 2001 Health Care Quality Survey*. Publication #526 (New York: The Commonwealth Fund, 2002).

[6]Halfon, N D., L. Wood, R.B. Valdez, M. Pereyra, N. Duan, "Medicaid enrollment and utilization of appropriate health services by Latino children in inner city Los Angeles." *Journal of the American Medical Association*. (1997), 277:636-41.

[7]Valdez, R. B., A. Giachello, H. Rodrigues-Trias, P. Gomez, C. de la Rocha, "Access to Health Care in Latino Communities." *Public Health Reports*, (1993), 108:534-539.

[8]M.D. Lillie-Blanton, W.A. Leigh, and I.A. Alfaro-Corre. *Achieving Equitable Access: Studies of Health Care Issues Affecting Hispanics and African Americans*. (Washington, DC:Joint Center for Political and Economic Studies, 1996).

[9]Santos, R., and Seitz, P. "Benefit Coverage for Latino and Latina Workders." In S.M. Perez (ed.) *Moving Up the Economic Ladder: Latino Workers and the Nation's Future Prosperity*. (Washington, DC: National Council of La Raza, 2000:162-185).

[10]A. De la Torre et al. "The Health Insurance Status of U.S. Latino Women: A profile from the 1982-84 HHANES." *American Journal of Public Health*, 86, (1996):533-537.

[11]A.L. Giachello. Hispanics and Health Care. In P.S. Cafferty and W.C. McCready (eds) In *Hispanics in the United States*. (New Brunswick, NJ: Transaction Publishers, 1992, 159-194).

[12]J.G. Iannotta (ed.) *Emerging Issues in Hispanic Health: Summary of a Workshop*. (Washington, DC: National Academies Press, 2002).

[13]M.L. Berk, L.A. Albers, and C.L. Schur. "The Growth in the US Uninsured Population: Trends in Hispanic Subgroups, 1977 to 1992." *American Journal of Public Health*, 86, (1996), 572-576.

[14]D.E. Hayes-Baustista et al. *The Burden of Support: Young Latinos in an Aging Society*. (Stanford, CA: Stanford University Press, 1988).

[15]D. Liska. Number A-8 in Series, *Assessing New Federalism: Issues and Options for States*. Urban Institute, Washington, DC. Accessed: http://newfederalism.urban.org/html/anf_a8.htm, (January 11, 2003).

[16]Valdez, R.B. et al. "Insuring Hispanics Against the Costs of Illness." *The Journal of the American Medical Association,* 269, (1993): 889-894.

[17]National Council of La Raza. "Hispanics and Health Insurance." (Washington, D.C.: Labor Council for Latin American Advancement, 1992).

[18]Angel, R. and J. Angel. "The Extent of Private and Public Health Insurance Coverage Among Adult Hispanics," *The Gerontologist*, 36, (1996):332-340.

[19]See National Council of La Raza. Accessed: http://www.nclr.org/about/nclrfaq.html (November 11, 2002).
[10]C. Schur and J. Feldman. *Running in Place: How Job Characteristics, Immigrant Status, and Family Structure Keep Hispanics Uninsured*. (New York, NY: Commonwealth Fund, 2001).
[21]M. Therrien and R. Ramirez. "The Hispanic Population in the United States." March 2000: *Current Population Reports*. P-20-535. Accessed: http://www.census.gov/population/socdemo/hispanic/p20-535/p20-535.pdf (November 20, 2002).
[22] U.S. Bureau of the Census, unpublished tabulations, Robert J. Mills (January 2, 2003).
[23]Winston, P., et al. *Welfare, Children & Families: A Three-City Study—Overview and Design.* (Baltimore, MD: Johns Hopkins University, 1999). Accessed: http://www.jhu.edu/~welfare/overviewanddesign.pdf. January 11, 2003.
[24]Families of different income levels and family structures were sampled at different rates, but we have survey weights which allow us to generalize our sample to the population of low-income single-mother and two-parent families living in low-income neighborhoods in the city as a whole. We employ these survey weights in all the tabulations reported here. See *Welfare, Children, and Families: A Three City Study, Overview and Design Report*, for details on weights and sampling.
[25] Selden, T. M., J. S. Banthin, and J. W. Cohen. "Medicaid's Problem Children: Eligible But Not Enrolled." *Health Affairs,* (1998), 17:192-200.
[26] L. Ku and S. Blaney. *Health Coverage for Legal Immigrant Children: New Census Data Highlight.* (Washington, DC: Center on Budget and Policy Priorities, October 10, 2000).
[25]The National Council of La Raza Statement of Raul Yzaguirre on the Hispanic Census Report: Hispanic Child Outcomes Continue to be Pressing Issues for the Nation. Families USA: (Accessed: http://www.familiesusa.org/media/statements/laraza2.htm (November 11, 2002).
[11]R. Zambrana, R.E. and L.A. Logie. Latino Child Health: Need for Inclusion in the U.S. National Discourse." *American Journal of Public Health*, (2000), 90:1827-1833.
[28] C. Flippen and M. Tienda. "Labor Force Behavior of Hispanic Elderly: Insights from the HRS*." HRS/AHEAD Working Paper Series 96-032*. (Ann Arbor: The University of Michigan, 1996).
[29]R.J. Angel, J. L. Angel, and K. S. Markides. "Stability and Change in Health Insurance Among Older Mexican Americans: Longitudinal Evidence from the Hispanic EPESE." *American Journal of Public Health,* 92(2002):1264-1271.
[30]R.J. Angel and J.L. Angel. *Who Will Care For Us? Aging and Long-Term Care in Multicultural America.* (New York: New York University Press, 1997).
[31] M. Perry, S. Kannel, R. Burciaga Valdez and C. Chang, *Medicaid and Children: Overcoming Barriers to Enrollment, (*The Kaiser Commission on Medicaid and the Uninsured, January 2000).
[32] Centers for Medicare and Medicaid Services. SMDL #01-021 Accessed: http://cms.hhs.gov/schip/sho7051a.asp (November 11, 2002).
[33]M. Brecht Carpenter and L. Kavanagh. *Outreach to children: Moving from enrollment to ensuring access.* 1998. National Education Center in Maternal and Child Health. (Georgetown University, Washington, DC. Accessed: http://www.mchlibrary.info/pubs/PDFs/Outreach.pdf on November 11, 2002).
[34]D.C. Ross and L. Cox, *Making it Simple: Medicaid for Children and CHIP Income Eligibility*

Guidelines and Enrollment Procedures, (Center on Budget and Policy Priorities/The Kaiser Commission on Medicaid and the Uninsured, October 2000).

[35]L E. Felland and A. Benoit. *Communities Play Key Role in Extending Public Health Insurance to Children*: Issue Brief No. 44. (Washington, DC: Center for Studying Health System Change, 2001).

[36]D.C. *Reducing The Number Of Uninsured Children: Outreach and Enrollment Efforts*. Testimony from Center on Budget and Policy Priorities before the Senate Finance Committee, March 15, 2001. Accessed: http://www.cbpp.org/3-15-01dcrtest.htm#N_2_(November 11, 2002).

[37]J.M. Wiener and N. Brennan. *Assessing The New Federalism. : Recent Changes In Health Policy For Low-Income People In Texas*, No. 23, p. 12, 2002.

[38]H. Ross Border Vision Fronteriza: Tapping into community workers and volunteers. U.S. Department of Health and Human Services *Closing the Gap Newsletter*, p. 9. Accessed: http://www.omhrc.gov/ctg/chip.pdf (November 11, 2002).

[39]Office of Management and Budget. *Analytic Perspectives: Budget of the U.S. Government, Fiscal Year 2003*, p. 297. (Washington, DC, 2002).

[40]Although Hispanics are less likely to be covered overall, they accept employer offers of health insurance at the same rate as whites and African Americans.

[41]J. Guyer, M. Broaddus, and A. Dude. 2001. *Millions of mothers lack health insurance coverage. (*Washington, DC: Center on Budget and Policy Priorities, 2001).

[42]National Governor's Association. HR-15. *The State Children's Health Insurance Program (S-CHIP) Policy. Accessed: http://www.nga.org/nga/legislativeUpdate/policyPositionDetailPrint/1,1390,531,00.html,* (November 11, 2002).

[43] J. Stockton, R. Bryant, and L. Santoyo. *Enrollment of Hispanc dual-eligibles on the U.S./Mexico border. Texas Department on Aging*, December 2001. Austin, TX: Texas Department on Aging.

[44] D. Carliner. "Getting the Elderly Their Due," *Health Affairs*, 21(2002):198-201.

Exhibit 1

Selected Type of Health Insurance Coverage for Persons Under 18 Years: 2001 By Race and Hispanic Ethnicity[1]

Type of Coverage	Non-Hispanic White	Non-Hispanic Black	Mexican American	Cuban American	Puerto Rican
Under 18 Years					
Employer	75%	51%	39%	52%	45%
Medicaid	15%	38%	35%	27%	42%
None	7%	14%	26%	18%	11%
Total (in thousands)	44,378	11,227	9,314	270	987
Aged 18 – 64 Years					
Employer	65%	58%	43%	57%	49%
Medicare	---	---	2%	4%	5%
Medicaid	5%	14%	8%	8%	22%
None	13%	24%	45%	25%	23%
Total (in thousands)	122,470	20,648	14,768	795	2,021
65 Years and Over					
Employer	36%	29%	17%	15%	17%
Medicare	97%	93%	91%	92%	97%
Medicaid	7%	20%	22%	31%	37%
None	.03%	2%	5%	3%	.04%
Total (in thousands)	27,973	2,801	992	311	213

[1]Respondents 15 and older were asked to indicate all forms of coverage a child living in the household had. We present only the most frequently reported. Categories may overlap.

Source: U.S. Census Bureau, *Annual Demographic Supplement*, 2002 and unpublished tabulations for Hispanic subgroups.

Exhibit 2

Children Covered by Medicaid

Family income relative to federal poverty	All 3 cities	Boston	Chicago	San Antonio	March 2000 CPS
< 100%	77%	82%	82%	64%	60%
100-124%	58%	86%	59%	30%	42%
125-149%	53%	63%	61%	35%	33%
150-199%	34%	64%	35%	5%	23%

Source: Three City Study

Exhibit 3

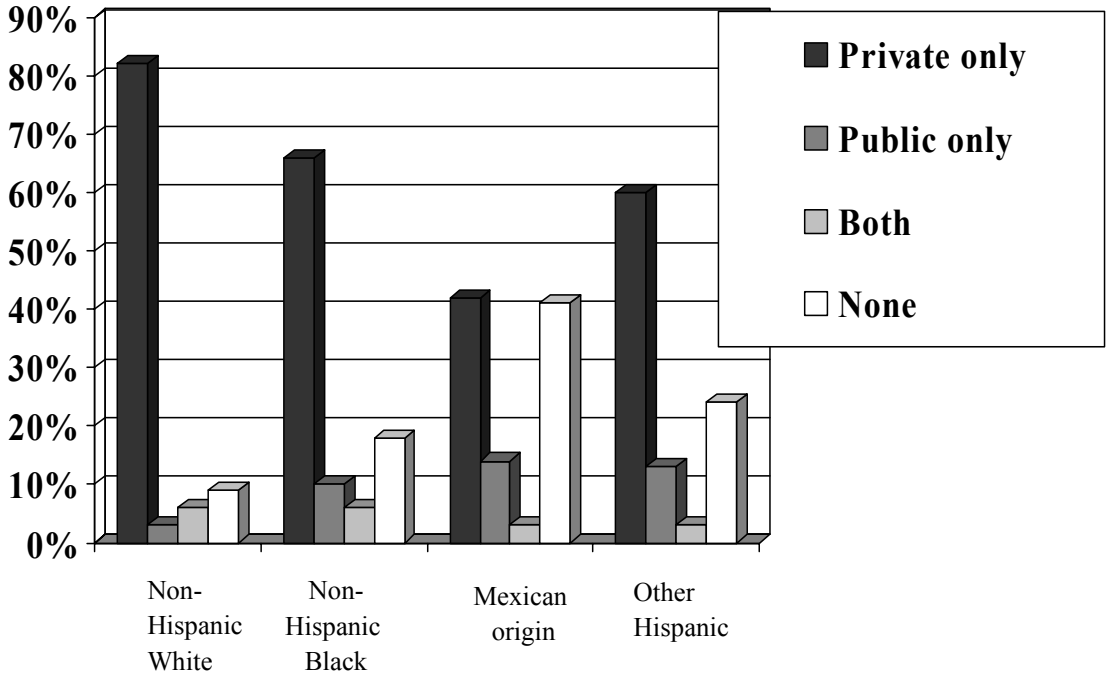
Determinants of Health Insurance Coverage for Children 18 and Younger Below 200% Poverty (Reference categories in parentheses)

	Any Health Insurance		Any Medicaid	
Independent Variable	Odds Ratio	Confidence Interval	Odds Ratio	Confidence Interval
Race/Hispanic Ethnicity				
Mexican-origin	.29	(.15 – .56)	.43	(.28 - .67)
Black	.97	(.54 – 1.75)	.89	(.63 – 1.28)
Non-Hispanic Whites (Non-Mexican Hispanic)	1.16	(.48 – 2.78)	.54	(.34 - .86)
Citizenship Status				
Child U.S. Citizenship	4.29	(2.41 – 7.63)	2.21	(1.34 – 3.66)
Mother U.S. Citizenship	.76	(.51 – 1.15)	.59	(.42 - .82)
City				
San Antonio	.49	(.27 - .90)	.60	(.40 - .89)
Chicago (Boston)	.85	(.51 – 1.42)	.97	(.71 – 1.31)
Mother's Marital Status				
Cohabitating	.72	(.40 – 1.28)	.63	(.41 - .97)
Spouse Present	.75	(.55 – 1.03)	.45	(.35 - .57)
Spouse Absent (Mother, Never Married)	.81	(.50 – 1.31)	.57	(.41 – 79)
Child's Age (in years)	.98	(.95 – 1.00)	.92	(.91 - .94)
Sample size = 2,140				

Source: Three City Study

Exhibit 4

Health Insurance Coverage among
Persons 51-61 Years Old



Source: Health and Retirement Study (HRS)

Exhibit 5

Racial and Ethnic Group Differences in
Wealth among Pre-retirement Age Individuals

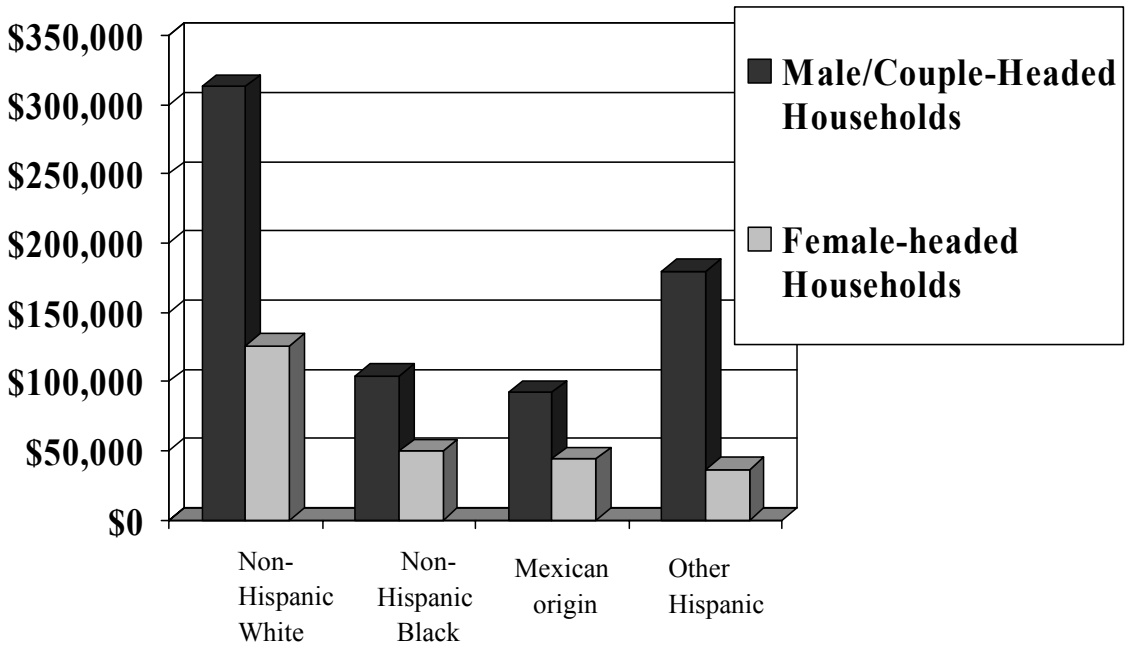


Exhibit 6

Health Insurance Coverage for Mexican-Origin and Non-Hispanic White Individuals 65 and Older

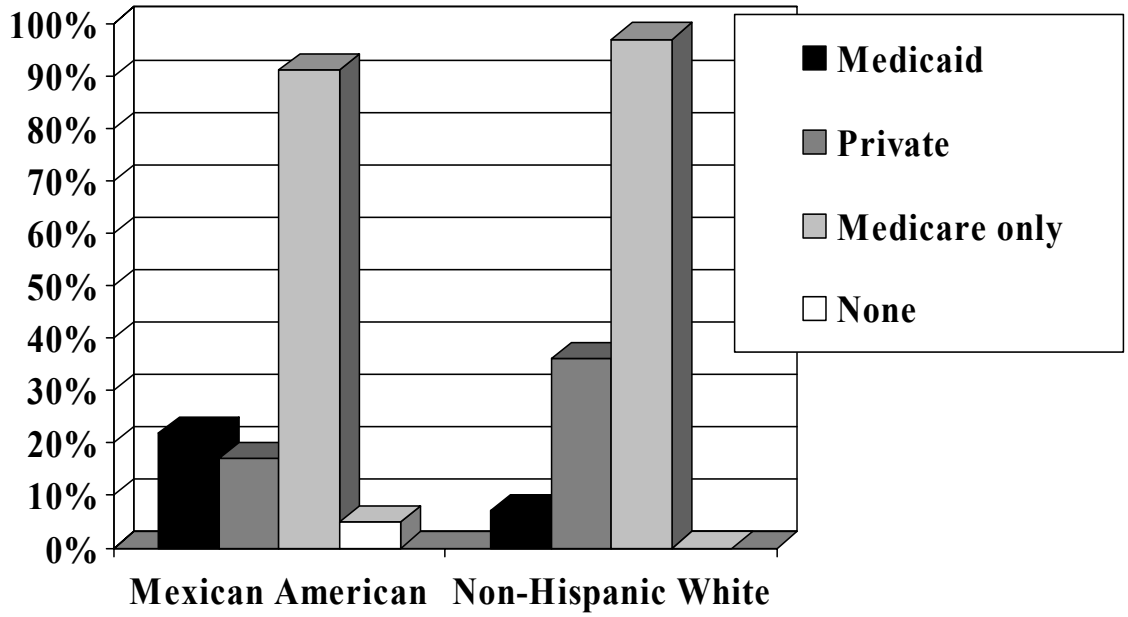
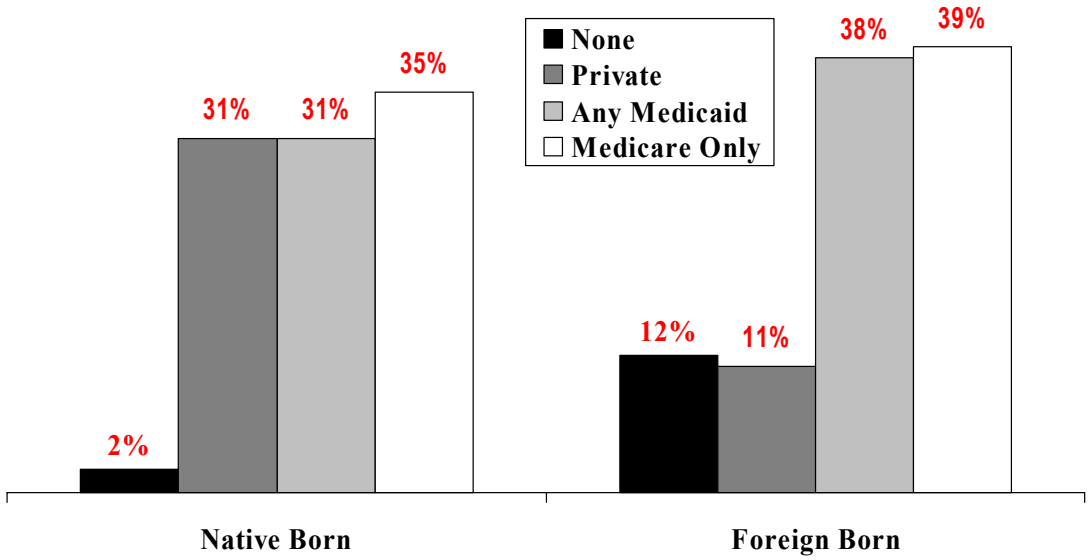


Exhibit 7

Health Insurance Coverage of Mexican–Origin Elderly Individuals by Nativity



Source: H-EPESE