POLICY RESEARCH REPORT

April 2000

Racial and Ethnic Disparities in Access to Health Insurance and Health Care

A Publication of

UCLA Center for Health Policy Research

and

The Henry J. Kaiser Family Foundation

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by

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The research on which this report is based was funded by a grant from The Henry J. Kaiser Family Foundation.

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Acknowledgements

The authors are grateful to the Henry J. Kaiser Family Foundation for its financial support of the study and to Catherine Hoffman, Ph.D., our program officer, for her intellectual support.

Natasha Razak and Shannon Currieri assisted with developing tables, conducting literature searches, and writing parts of sections. Delight Satter, M.P.H., provided essential background on American Indians and Alaska Natives and reviewed that section. Ninez Ponce, Ph.D., and Marjorie Kagawa-Singer, R.N., Ph.D., reviewed the manuscript and provided helpful comments and suggestions.

Hongjian Yu, Ph.D., Jenny Kotlerman, and Lisa Lara, M.P.H., conducted the extensive data analysis and statistical support for this study.

Cynthia Oh and Timothy Lambert provided extensive and valuable support for the production process.

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Executive Summary

Racial and ethnic groups in the United States continue to experience major disparities in health status. Compared to the majority non-Latino white population, racial and ethnic minorities bear a disproportionate burden of mortality and morbidity across a wide range of health conditions.

These disparities in health status are compounded by reduced access to health care services. Although many factors affect health status, the lack of health insurance and other barriers to obtaining health services diminish racial and ethnic minorities' utilization of preventive services and medical treatments that could reduce disease and contribute to improved health status. This report examines disparities in health insurance coverage and access to physician services across major racial and ethnic groups and subgroups in the United States.

To examine the relationship of ethnicity and other factors on health insurance coverage and on access to health services, we analyzed two population-based surveys, the Current Population Survey and the National Health Interview Survey.

Insurance Coverage Differences Across Racial and Ethnic Groups

Ethnic minorities are much more likely than non-Latino whites to be uninsured. Over one-third of Latinos (37%) are uninsured, the highest rate among all ethnic groups and two and a half times the rate of 14% for non-Latino whites (whites). Nearly one-fourth of African Americans, and about one-fifth of Asian Americans and Pacific Islanders (AAPIs) and American Indians/Alaska Natives (AI/ANs) are uninsured.

The higher uninsured rates of ethnic minorities are attributable in large part to their lower rates of job-based insurance, which covers 73% of whites, but only 43% of Latinos, 51% of AI/ANs, 53% of African Americans, and 64% of AAPIs. Most ethnic minorities' employment-based coverage rose three to four percentage points between 1994 and 1997. However, these gains did not narrow the 9- to 30-point gap in job-based coverage between these groups and whites because they were offset by declines of up to five percentage points in Medicaid coverage for all minority groups.

Access to Care Differences Across Racial and Ethnic Groups

Racial and ethnic groups, including both children and adults, differ in their access to health services. Among preschool children (ages 0-5), who need at least annual physician visits just for preventive care, 8% of AAPI and Latino children did not see a doctor visit in the past year, compared to 5% of white and African-American children. For school-age children (6-17 years), Latinos, AI/ANs, and AAPIs one and a half to two times the rate for African-American or white children not to have visited a doctor during the previous two years.

One-third of Latino and AAPI men in fair or poor health have not visited a physician in the past year, a considerably higher rate than for whites and African Americans. Latino, African-American, and AAPI women in fair or poor health are similarly less likely than white women not to have visited a physician. Among adults in good to excellent health, Latino and AAPI men and women experience disparities compared to whites and African Americans.

Racial/ethnic groups also differ in the proportion who have a connection to the health care system, measured by whether the person has a place where they regularly go for care. Latino, AI/AN and AAPI children are two to three times as likely as whites and African Americans to lack a usual place for care. Similar disparities by ethnicity are found among adults, with Latinos and AAPIs more likely not to have a usual source of care. Having health insurance coverage increases the likelihood that an individual will have a usual source of care and receive physician services.

Latinos' Health Insurance Coverage and Access to Health Care

Latinos experience the highest uninsured rates of all ethnic groups. Nearly four out of ten (37%) nonelderly Latinos are uninsured. Among Latinos, Mexican-Americans and Central and South Americans have the highest rates of uninsurance (38% and 42%, respectively), but Latinos of every national origin, including Cubans and Puerto Ricans, have significantly higher uninsured rates than whites.

Latinos are uninsured at extraordinarily high rates because only 43% have employment-based health insurance, compared to 73% of whites. Latinos' job-based coverage increased between 1994 and 1997 (from 40% to 43%), but this increase was offset by a drop in Medicaid coverage (from 20% in 1994 to 16% in 1997), in part due to the effects of welfare reform.

While almost nine out of 10 (87%) uninsured Latinos are workers or their dependents, Latinos are far less likely than whites to have job-based coverage—regardless of how much they work or the size of the firm or the industry in which they work. Latino workers are about twice as likely as whites to report that they work for an employer that does not offer health insurance to any workers.

Latino noncitizens have very high uninsured rates (58%). Even among Latino U.S. citizens, however, a still-high 27% are uninsured. This high uninsured rate among Latino citizens suggests that other factors in addition to citizenship—such as educational attainment, employment characteristics, and income level—play an important role in providing access to job-based coverage.

Latinos are the most likely among all ethnic groups to have no usual source of care: 12% of Latino children (vs. 4% of white children) and 26% of Latino adults (vs. 15% of white adults). Having health insurance coverage increases the likelihood of Latinos, as well as other groups, having a regular connection to health care services.

Latino children are less likely than white children to make timely visits to the physician, a disparity that is exacerbated for uninsured Latinos. Latino adults, regardless of their health status, are less likely than whites to have had timely physician visits, a problem that is exacerbated by lack of insurance.

African Americans' Health Insurance Coverage and Access to Health Care

African Americans' job-based insurance remains lower than that of whites (53% and 73%, respectively), despite recent improvements in the economy. Nearly one-quarter (23%) of African Americans remain uninsured, an increase from 21% in 1994 and a rate that is one and a half times the uninsured rate for whites.

Medicaid provides an important safety net for African Americans, but Medicaid coverage dropped from 24% in 1994 to 19% in 1997. This change was driven both by gains in job-based coverage and by the implementation of welfare reform, which discouraged or excluded many low-income working families from enrolling.

African Americans and whites are about equally likely to have a usual source of care, but large proportions of uninsured African American children and adults remain without any ongoing connection to the health care system. Among uninsured African-American children through age 5, one in ten has not visited a physician in a 12-month period, twice the rate for those who are insured. And among school-age African-American children (ages 6-17), one in five uninsured children has not had a physician visit in a two-year period, a rate two to three times as high as their counterparts with coverage.

African-American women in fair to poor health, particularly the uninsured, are less likely than their white counterparts to have had a recent physician visit, with one in five not seeing a physician for more than one year. African-American men in fair or poor health are more likely than their female counterparts not to have visited a physician in the past year. Among African-American men who are in fair or poor health and uninsured, one in four has not visited a physician in the past year despite their compromised health status.

Asian Americans and Pacific Islanders' Health Insurance Coverage and Access to Health Care

Overall, 21% of Asian Americans and Pacific Islanders (AAPIs) are uninsured, compared to 14% of whites. AAPIs are a highly diverse population, however, whose health insurance coverage and access to health services differ widely across ethnic subgroups.

Uninsured rates vary widely among AAPI subgroups, from one in three Koreans; to one in four Southeast Asians; one in five South Asians, Chinese, and Filipinos; and one in 12 third-plus-generation AAPIs. Disparities in uninsurance result from wide differences in job-based coverage, ranging from just under one-half of Koreans and Southeast Asians to a high of more than three-fourths of Japanese and third-plus-generation AAPIs.

Medicaid coverage is generally low among the AAPI population, ranging from just 1% to 2% for Chinese, Japanese, Filipino, and Koreans to nearly one in five for Southeast Asians. The higher Medicaid coverage of Southeast Asians reflects both their high poverty rates and the high proportion of refugees among this group.

Both connection to the health care system and health care use are better for AAPI children and adults with health insurance, compared with those who are uninsured. AAPI children and adults without insurance are much less likely to have a usual source of care. This effect of coverage is also seen for each of the AAPI subgroups examined.

Eight percent of AAPI children ages 0-5 have not had a doctor visit in the past year and 12% of those ages 6-17 have not had a physician visit within two years. For uninsured children ages 6-17, the proportion without a physician visit rises to 19%.

AAPI men and women in excellent to good health are less likely to have been to a physician in a two-year period than their white counterparts. Those without coverage, especially men, have even less contact with the health care system: one-half (52%) of uninsured men and 27% of uninsured women have not had a visit in the past two years.

American Indians and Alaska Natives' Health Insurance Coverage and Access to Health Care

The United States government has a trust responsibility to provide health care to federally recognized American Indians and Alaska Natives (AI/ANs). Since 1955, the Indian Health Service (IHS), an agency within the U.S. Department of Health and Human Services, has provided and administered health services for much of the AI/AN population.

However, contrary to widespread assumptions that most AI/ANs have access to IHS services, only one in five persons who identify themselves as American Indian or Alaska Native report having IHS coverage. Among those who report having IHS coverage, one in three also receives job-based or other private health insurance, and one in five also has Medicaid coverage.

AI/ANs, like many other ethnic minorities, are seriously disadvantaged by low family incomes. Half (50%) of all nonelderly AI/ANs are poor or near poor, with family incomes below 200% of the federal poverty level, twice the rate for whites (23%).

Insurance coverage improves access to care for AI/ANs. About a third of uninsured AI/ANs (35%) report that they do not have a usual source of care, more than three times the proportion of those who have some form of health insurance coverage.

Uninsured AI/AN children and adults are less likely to meet the standards for regular care we applied for this analysis, but even those with IHS coverage do not fare as well as those with other types of coverage.

Introduction

Racial and ethnic groups in the United States continue to experience major disparities in health status. Compared to the majority non-Latino white (or "white," for brevity) population, racial and ethnic minorities bear a disproportionate burden of mortality and morbidity across a wide range of health conditions.[1]

These disparities in health status are compounded by disproportionately reduced access to health care services. Health care is only one of many factors that affect health status, but the lack of health insurance and other barriers to obtaining health services effectively diminish racial and ethnic minorities' utilization of preventive services and medical treatments that could reduce their burdens of disease and contribute to improved health. This report examines disparities in health insurance coverage and access to physician services across major racial and ethnic groups and subgroups in the United States.

Disparities in Health

Mortality is a crude indicator of health status, but it demonstrates how critical the disparities are for racial and ethnic minorities. For some groups, these disparities begin early in life and are sustained throughout the lifecourse. African-American infant mortality rates are more than double those of whites (14% vs. 6%), while Native American infant mortality rates (10%) are more than one and a half times those of whites. Among adults, death rates for African Americans are approximately 55% higher than for whites.[2] Diabetes kills African-Americans at more than three times the rate for whites, and it kills American Indian/Alaska Natives at more than twice the rate, and Hispanics at more than one and a half times the rate for whites.[3]

Although many factors account for differences in health status, good access to appropriate health services could reduce many of these disparities. In spite of their higher mortality and morbidity for cardiovascular disease, African Americans and Latinos are less likely to undergo treatment for their conditions, and are especially less likely to receive high-technology cardiac procedures, such as cardiac catheterization and coronary revascularization.[4] African-American

[1] Collins KS, Hall A, Neuhaus C, *U.S. Minority Health: A Chartbook*, New York: The Commonwealth Fund, May 1999.

[2] Nickens HW, "The Role of Race/Ethnicity and Social Class in Minority Health Status," *Health Services Research,* 1995; 30:151-62.

[3] *Health, United States, 1998*, Hyattsville, MD: National Center for Health Statistics, 1998, pp. 204-205, provides age-adjusted death rates for diabetes mellitus.

[4] Hall WD, Ferrario CM, Moore MA, et al., "Hypertension-Related Morbidity and Mortality in the Southeastern United States," *American Journal of the Medical Science*, 1997;313: 195-209; Mitchell JB, McCormack LA, "Time Trends in Late-Stage Diagnosis of Cervical Cancer. Differences by Race Ethnicity and Income," *Medical Care* 1997; 35:1220-4; and Mitchell JB, Khandker RK, "Black-White Treatment Differences in Acute Myocardial Infarction," *Health Care Financing Review* 1995;17:61-70.

women present more frequently than white women with late-stage breast cancer, probably related to barriers to life-saving diagnostic services and treatment.[5] Higher rates of late-stage diagnosis may account for the 14% difference in breast cancer survival rates between white and black women.[6] Asian-American and Pacific Islander women have the lowest screening rates for cervical cancer, despite having a high incidence of cervical cancer. Vietnamese women's cervical cancer rate, the highest among all groups, is nearly five times the rate for white women.[7] African-American men have the highest prostate cancer incidence and mortality, suggesting a greater need than other groups for screening and diagnosis.[8]

Thus, for ethnic minorities, any disparities in access to health services will only exacerbate chronic conditions, such as heart disease, diabetes, and cancer, by delaying diagnosis and reducing effective management and treatment. Access barriers typically reduce use of preventive services, such as screenings and health education and counseling, diminishing efforts to prevent disease and death.

Data Sources

To examine the relationship of ethnicity and other factors on health insurance coverage and on access to health services, we analyzed two population-based surveys, the Current Population Survey and the National Health Interview Survey.

Current Population Survey

The Current Population Survey (CPS) is a national cross-sectional survey, administered in person and by telephone, with a sample of approximately 50,000 households, including 136,000 persons. The CPS is conducted by the U.S. Bureau of the Census to obtain information on employment, unemployment and demographic status of the non-institutionalized, U.S. civilian population. The March CPS contains extensive information on health insurance coverage, employment, and sources of income during the previous calendar year, as well as ethnicity, immigrant and citizenship status, and nativity of each household member. For these analyses, we used the CPS for March 1998 (reflecting health

[5] Breen N, Wesley MN, Ray MM, Johnson K, "The Relationship of Socio-Economic Status and Access to Minimum Expected Therapy Among Female Breast Cancer Patients in the National Cancer Institute Black-White Cancer Survival Study," *Ethnicity & Disease* 1999;9:111-125.

[6] Green MacDonald PA, Thorne DD, Pearson JC, Adams-Campbell LL, "Perceptions and Knowledge of Breast Cancer Among African-American Women Residing in Public Housing," *Ethnicity & Disease.* 1999;9:81-93.

[7] Collins, Hall, and Neuhaus, *U.S. Minority Health: A Chartbook*, 1999.

[8] Collins, Hall, and Neuhaus, *U.S. Minority Health: A Chartbook*, 1999.

insurance coverage in 1997) with comparisons to the 1995 CPS (reflecting health insurance coverage in 1994).

For some analyses, we also used data from the February 1997 CPS, which asks employed adults questions about whether their employer offers health insurance to anyone who works in the firm, whether the employee is eligible, and whether the employee accepts the coverage.

National Health Interview Survey

The National Health Interview Survey (NHIS), which is administered by the National Center for Health Statistics, is a national in-person survey of the non-institutionalized population. It includes demographic, health status and utilization information in the core survey. Special supplements provide additional information on health insurance coverage, reported reasons for lack of coverage, and access to health care services. For most of the analyses, we merged the 1995 and 1996 surveys, which together include information on access to health care services for approximately 166,000 persons. Because the 1996 NHIS collapsed several Asian American and Pacific Islander (AAPI) ethnic subgroups into fewer groups, we merged the 1994 and 1995 NHIS for analyses of AAPI ethnic subgroups. We continued to use the 1995 and 1996 NHIS for analyses of the AAPI population overall in order to maintain comparability to other major ethnic groups. Due to differences in the way that American Indian/Alaska Natives were classified by the NHIS in 1996 compared to 1995 and 1994, we also used the 1994 and 1995 NHIS for analyses of this group.

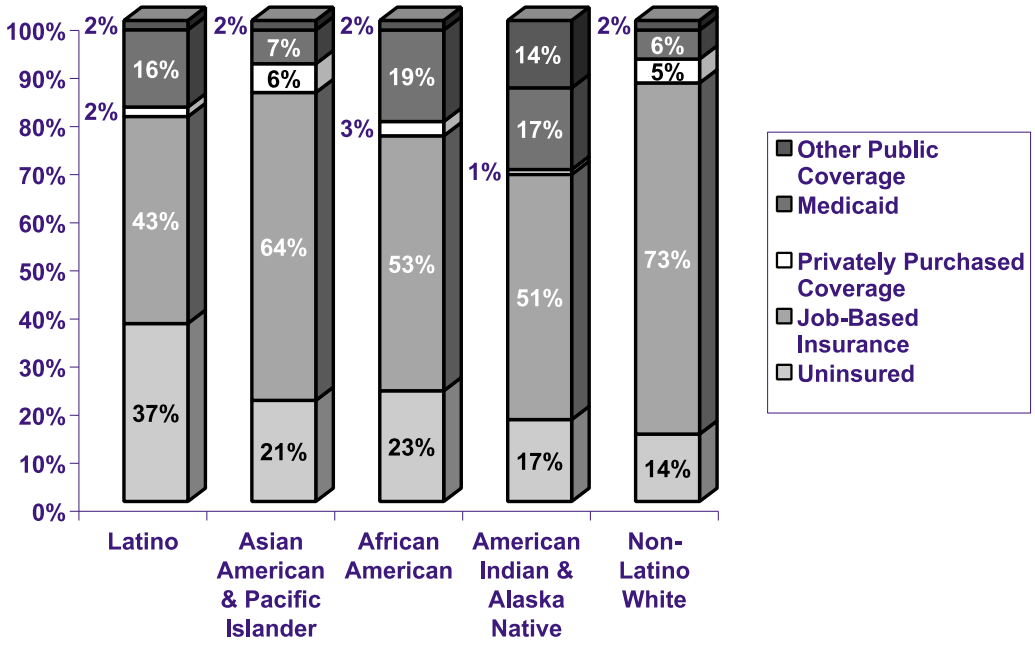
Appendix B provides information about major variables used in the report, including the classification of respondents into ethnic groups and subgroups.

An Overview[9]

Insurance Coverage

Ethnic minorities are much more likely than non-Latino whites ("whites," for brevity) to be uninsured (Exhibit 1-1). Over one-third of Latinos (37%) are uninsured, the highest rate among all ethnic groups and two and a half times the rate for whites (14%). Nearly one-fourth of African Americans, and about one-fifth of Asian Americans and Pacific Islanders (AAPIs) and American Indians/ Alaska Natives (AI/ANs) are uninsured. These rates may understate the problems with insurance coverage because those classified as insured may have been covered for less than the full year, or they may have coverage that is not comprehensive or that requires high deductibles and co-payments that diminish access to medical care for low- and moderate-income persons.

Exhibit 1-1. Health Insurance Coverage by Race/Ethnicity
Ages 0-64, United States, 1997



Source: March 1998 Current Population Survey

The great majority of nonelderly persons who have health insurance coverage obtain it through their own or a family member's employment. Employers who provide coverage typically pay for a share of the premium cost, which makes health insurance more affordable for workers. Given the high price of privately

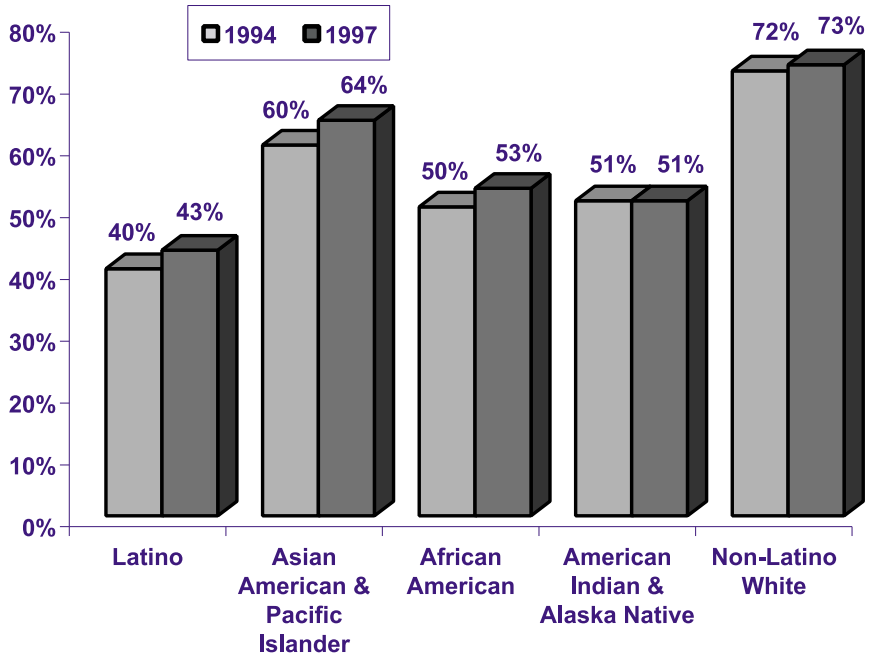
[9] All references in the text to differences in proportions between groups are statistically significant ($p < .05$) unless otherwise stated.

purchased health insurance, it is not surprising that employees who do not obtain job-based coverage are very likely to be uninsured. Ethnic minorities have much lower rates of job-based insurance than whites, which covers 73% of whites but only 43% of Latinos, 51% of AI/ANs, 53% of African Americans, and 64% of AAPIs. Thus, the primary driver in ethnic minorities' high uninsured rates relative to whites is their much lower rates of job-based coverage.

Despite some gains, most minorities are still less likely to have job-based insurance

Between 1994 and 1997, minorities' rates of job-based insurance rose three to four percentage points (Exhibit 1-2), a clear benefit of the continuing growth in the nation's economy. Despite the growth in job-based coverage, however, these gains did not narrow the 9- to 30-point gap in job-based coverage between minorities and whites because they were offset by declines in Medicaid coverage.

Exhibit 1-2. Changes in Job-based Health Insurance Coverage by Race/Ethnicity, Ages 0-64, United States, 1994-1997



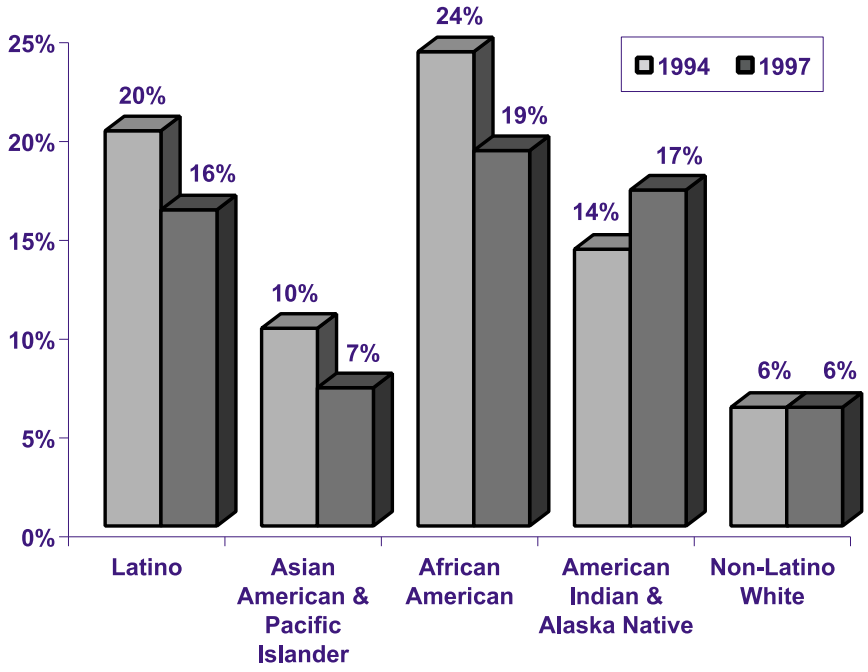
Source: March 1995 and 1998 Current Population Survey

Medicaid losses offset gains in job-based coverage

Medicaid is an important health insurance safety net for many low-income people, including many members of ethnic and racial minorities. Due to their lower incomes, African Americans, Latinos and American Indians/Alaska Natives are about three times as likely to participate in the Medicaid program as whites (19%, 16%, and 17%, respectively, vs. 6%). All minority groups,

except AI/ANs, experienced drops in Medicaid coverage of between three and five percentage points (Exhibit 1-3), fully offsetting their gains in job-based coverage.

Exhibit 1-3. Changes in Medicaid Coverage by Race/Ethnicity Ages 0-64, United States, 1994-1997



Source: March 1995 and 1998 Current Population Survey

Medicaid provides critical protection for minority children

The insurance patterns among minority children ages 0-17 track closely those of nonelderly minorities overall. Latino children fare the worst (with 29% uninsured), followed by African-American children (19%), and AAPI children (15%), all well above the rate for white children (11%; Exhibit 1-4). Although the data suggest that only 13% of AI/AN children are uninsured, much of this reported coverage is from the Indian Health Service (IHS) and may be misleading because IHS coverage is not comparable to job-based or other private health insurance or Medicaid coverage.

Less than half of African-American (46%), Latino (40%), and AI/AN (45%) children have job-based insurance, compared to two-thirds of AAPI children (66%) and three-fourths of white children (73%). With disproportionately low rates of job-based insurance, Medicaid provides an especially important safety net for low-income children, protecting three in ten African-American (31%), Latino (28%), and AI/AN (30%) children. The new Children's Health Insurance Program (CHIP), now being implemented by the states with generous federal matching funds, may increase access to coverage for children whose family incomes are low but above the more restrictive Medicaid levels set by states.

Exhibit 1-4. Health Insurance Coverage by Race/Ethnicity, Children, Ages 0-17, United States, 1997

Racial/Ethnic Group	Uninsured	Job-Based Insurance	Medicaid	Privately Purchased Insurance	Other Government Coverage
African American	19%	46%	31%	2%	2%
AAPI	15%	66%	13%	4%	2%
Latino	29%	40%	28%	2%	2%
AI/AN	13%	45%	30%	<1%	12%*
Non-Latino White	11%	73%	10%	4%	2%

Source: March 1998 Current Population Survey
* 24% of AI/AN children report having IHS coverage, and another 12% (shown in Exhibit 1-4) do not report having IHS coverage or any private health insurance or Medicaid but do report another source of public coverage.

Access to Care

Health insurance provides financial access to a broad range of covered health care services, depending on the benefits package, from preventive care to screening and diagnostic services to treatment and management of health conditions. The disparities in health insurance coverage that ethnic minorities experience therefore translate into disparities in access to health care services. Financial barriers to using health services are often compounded by other factors, such as too few providers in a community, long travel times to the nearest provider, and practitioners who do not speak the language or understand the culture of their patients.

To examine disparities in access we focus on the extent to which respondents have, or do not have, a regular person or place where they receive care, an important component in the receipt of ongoing, consistent care. We also examine whether respondents visited a physician at least once in a recent period of time, using different standards that we developed for children and for adults. In all these measures of access, we find substantial disparities by ethnicity, related in large part to the lack of health insurance coverage.

To examine the timeliness of physician visits for children, we use a modified version of the American Academy of Pediatrics guidelines and present minimum expectations for a physician visit: examination by a physician in the past year for children ages 0-5 and at least a biannual visit for children ages 6-17.[10] A

[10] The American Academy of Pediatrics (AAP) recommends annual visits for children and adolescents ages 24 months through age 17 (except for children ages 7 and 9), and more frequent visits for children under 24 months of age. Thus our criteria of at least one physician visit in the past year for children under the age of 5 and a visit at least every two years for children ages 6-17 is a reasonable, somewhat conservative, estimate of minimal requirements. See American Academy of Pediatrics, "Recommendations for Preventive Pediatric Health Care," *Pediatrics* 1995; 96:712.

child who receives this minimum number of visits might be assumed to have received at least preventive care—immunizations, monitoring of growth and development, and opportunities for the provider to counsel the parent.[11] Among children ages 0 to 5 (Exhibit 1-5), AAPI and Latino children are the most likely not to have had a doctor visit in the past year (8%)—well above the rates for white and African-American children (5%). The lack of even one physician visit in a year means that these children are not receiving the monitoring of growth and development or the preventive services recommended for healthy development. They also may not be receiving treatment for acute or chronic conditions, some of which, such as chronic middle-ear infections, may result in long-term problems that can also affect social and educational development.

Larger proportions of school-age children have not seen a provider in the previous *two* years, a conservative standard for children in this age range. Latino, AI/AN and AAPI children ages 6-17 all were one and a half to two times as likely as African-American or white children not to have visited a doctor during the previous two years (Exhibit 1-5).

Exhibit 1-5. Percent of Children Who Have Not Obtained Minimum Number of Doctor Visits, by Age and Race/Ethnicity, Ages 0-17, United States, 1995-1996

	African American	AAPI	Latino	AI/AN	Non-Latino White
Overal 0-5*	5%	8%	8%	**	5%
Overall 6-17*	8%	12%	16%	18%	7%

Source: 1995 and 1996 National Health Interview Surveys, except AI/AN for which the 1994 and 1995 National Health Interview Survey were used

*Examination by a physician in the past year for children ages 0-5 and at least a biannual visit for children ages 6-17.

**Sample size too small for reliable estimate.

For adults, we relate doctor visits to self-reported health status, and expect that adults in fair to poor health would need to see a physician within the last 12 months and that adults in good to excellent health should not go without a doctor visit for longer than two years.[12] Adults in good to excellent health may not require medical care for acute or chronic conditions, but women and men require preventive visits to obtain screening tests for cardiovascular disease and cancer.

[11] This measure does not distinguish between preventive visits and those for care of an acute or chronic condition. A child who has only one visit in a year may or may not have received preventive care.

[12] This standard assumes that adults who are in fair to poor health should have received medical attention although there is no professional consensus on this, as there is for preventive care.

Annual and biannual doctor visits were chosen as indicators of access to care based on recommendations of the American Cancer Society, U.S. Preventive Services Task Force, American Medical Association, American Academy of Family Physicians and others.[13]

Adults experience disparities in access to health services related to race and ethnicity. Among adults who report being in poor or fair health status, ethnic minorities are less likely to have visited a physician in the previous year. Within each ethnic group, almost twice as many men as women who are in poor or fair health status did not visit a physician in this time period. However, within each gender, there are significant disparities in access by race and ethnicity (Exhibit 1-6). Latino and AAPI men in fair to poor health are more likely than whites and African Americans not to have visited a physician in the past year. Latino, African-American, and AAPI women in fair to poor health are similarly less likely than white women not to have visited a physician.

Exhibit 1-6. Percent of Adults in Fair to Poor Health Who Have Not Had a Doctor Visit in Past Year by Gender and Race/Ethnicity, Ages 18-64, United States, 1995-1996

	African American	AAPI	Latino	AI/AN	Non-Latino White
Men	15%	17%	25%	*	14%
Women	9%	8%	13%	*	6%

Source: 1995 and 1996 National Health Interview Surveys, except AI/AN for which the 1994 and 1995 National Health Interview Survey were used

*Sample size too small for reliable estimate.

Among adults in excellent to good health, men in every ethnic group are less likely than women to visit a physician at least once every two years. There are also significant disparities by ethnic group. One in every five African-American and white males have not seen a physician in the past two years, compared to 30% of AAPI males and 34% Latino males (Exhibit 1-7). Although women are more likely to visit a physician, for reproductive services even if not for other preventive or medical care, Latina women are nearly two times as likely as Afri-

[13] Preventive measures, such as cancer and blood cholesterol screening, rely on regular visits to a health care provider. The American Cancer Society (ACS) recommends that men over the age of 40 get screened annually for prostate cancer, and that women who are or have been sexually active receive annual Pap tests. Other conditions affecting both men and women, such as colorectal cancer and high blood cholesterol, warrant regular screening. For colorectal cancer, the second most common cancer in the country, annual exams for people over the age of 40 are recommended. Blood cholesterol screening is recommended every five years after the age of 19 or 20, and more frequently for middle-aged men and women and anyone whose family has a history of high cholesterol. See the U.S. Preventive Services Task Force, *Guide to Clinical Preventive Services*, Second Edition, Columbia-Presbyterian Medical Center; website at: http://cpmcnet.columbia.edu/texts/gcps/.

can-American and white women not to have visited a physician in a two-year period.

Exhibit 1-7. Percent of Adults in Good to Excellent Health Who Have Not Had a Doctor Visit in Past Two Years, by Gender and Race/Ethnicity, Ages 18-64, United States, 1995-1996

	African American	AAPI	Latino	AI/AN	Non-Latino White
Men	21%	30%	34%	*	20%
Women	8%	15%	14%	*	8%

Source: 1995 and 1996 National Health Interview Surveys, except AI/AN for which the 1994 and 1995 National Health Interview Survey were used
*Sample size too small for reliable estimate.

For children and adults, knowing where to go for health care services and having a relationship with a provider of care facilitates obtaining care when it is needed. People who cannot identify a regular or usual source of care are much less likely to obtain preventive services, or diagnosis, treatment and management of acute and chronic health conditions.[14] In general, parents are likely to assure that their children have such a connection to the health system, yet Latino and AAPI children are two to three times as likely as whites and African Americans to lack a usual source of care (Exhibit 1-8). Similar disparities by ethnicity are found among adults, with Latinos and AAPIs more likely not to have a usual source of care.

Exhibit 1-8. Percent Without a Usual Source of Care by Age and Race/Ethnicity, Ages 0-64, United States, 1995-1996

	African American	AAPI	Latino	AI/AN	Non-Latino White
Children 0-17	5%	8%	12%	7%	4%
Adults 18-64	15%	20%	26%	16%	15%

Source: 1995 and 1996 National Health Interview Surveys, except AI/AN for which the 1994 and 1995 National Health Interview Survey were used

[14] Newacheck PW, Hughes DC, Stoddard JJ, "Children's Access to Primary Care: Differences by Race, Income, and Insurance Status," *Pediatrics* 1996; 7(1): 26-32; Stoddard J, St. Peter R, Newacheck P, "Health Insurance Status and Ambulatory Care in Children," *New England Journal of Medicine* 1994; 330:1421-1425; Wood DL, Hayward RA, Corey CR, Freeman HE, Shapiro MF, "Access to Medical Care for Children and Adolescents in the United States," *Pediatrics* 1990; 86(5): 666-673; Brown ER, "Access to Health Insurance in the United States," *Medical Care Review* 1989; 46(4): 349-385.

Among both adults and children, Latinos and AAPIs appear to be the least well connected to the health care system, as well as having the highest uninsured rates. Lack of health insurance coverage reduces the likelihood that an individual will have a usual source of care or see a physician, as we will see in subsequent sections of this report. Both uninsurance and lack of connection to the health care system are related to being an immigrant and especially a noncitizen.

Conclusion

Even from this overview, it is clear that having health insurance coverage is an essential factor in promoting access to timely health care services. It also is clear that ethnic minorities, on the whole, have poorer health insurance coverage and poorer access to health care.

Latinos

Overview

Latinos overall are the most disadvantaged of the five major ethnic groups that are the focus of this report. They have the lowest educational attainment and the largest proportion who are poor or near poor. However, Latinos are also a diverse group, comprised of many first-generation immigrants with low educational attainment, as well as third-plus generation Americans, many of whom have attended college. In this section of the report, we examine health insurance coverage and then focus on access to health care services, including information about the differences among Latino subgroups, as well as the disparities of Latinos compared with the majority white population.

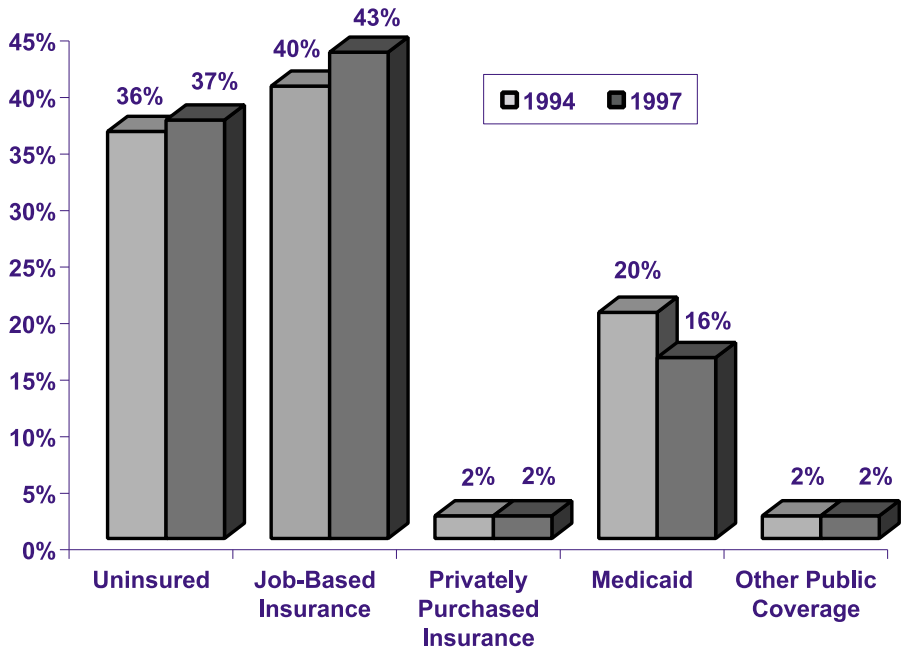
Health Insurance Coverage

Latinos' high rates of uninsurance vividly demonstrate the holes in the United States' patchwork health insurance system. Latinos experience the highest uninsured rates of all ethnic groups. Nearly four out of ten (37%) nonelderly Latinos are uninsured, compared to 14% of whites, and 17%-23% of other major ethnic groups (Exhibit 1-1). As a result of their high uninsured rate, Latinos account for a disproportionate share of the uninsured population, comprising 23% of the nonelderly uninsured although they account for just 12% of the nation's nonelderly population.

Latinos are at the greatest risk of being uninsured

Latinos' uninsured rate is extraordinarily high because only 43% have employment-based health insurance, compared to 73% of whites and 51%-64% for other ethnic groups. Although Latinos' job-based coverage increased between 1994 and 1997 (from 40% to 43%), this increase was offset by a concurrent drop in Medicaid coverage (from 20% in 1994 to 16% in 1997; Exhibit 2-1). This section examines health insurance coverage of Latinos, as well as several subgroups of Latinos, and the effects of coverage and the lack of insurance on access to health services.

Exhibit 2-1. Changes in Health Insurance Coverage Among Latinos, Ages 0-64, United States, 1994-1997

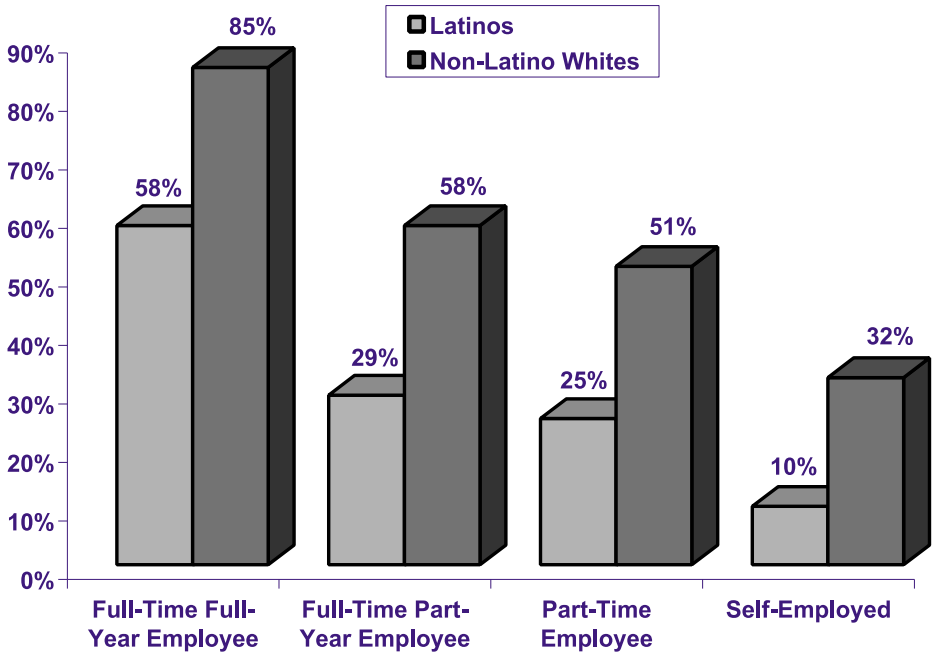


Source: March 1995 and 1998 Current Population Survey

Job-based coverage lower for Latinos regardless of the work they do

Almost nine out of 10 (87%) uninsured Latinos come from working families. Latinos are far less likely than whites to have job-based coverage no matter how much they work. Even among families in which the primary earner works as an employee full-time all year—the group most likely to have access to job-based coverage—Latinos are only about two-thirds as likely as whites to have job-based coverage (58% vs. 85%; Exhibit 2-2). If the primary earner is employed part-time or seasonally, Latinos are half as likely as whites to have job-based coverage. And among those in self-employed families, Latinos are only about one-third as likely to have job-based coverage. Latinos' disadvantage in job-based coverage in each family work status is compounded by their somewhat lower proportion in full-time full-year employee families (63% of Latinos vs. 71% of whites) and their higher proportion in nonworking families (14% vs. 7%).

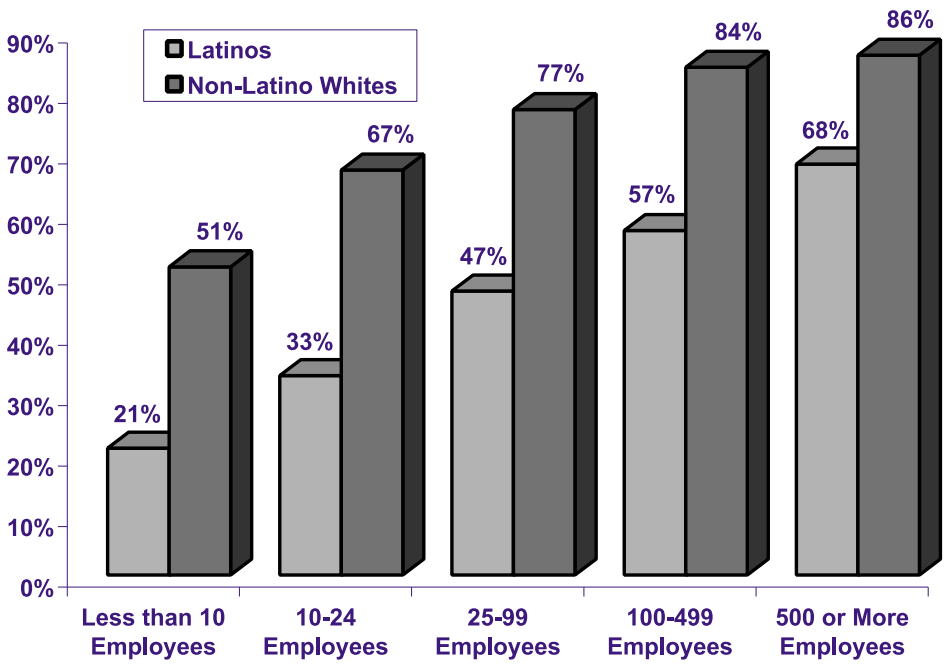
Exhibit 2-2. Job-Based Insurance by Work Status of the Primary Earner, Latinos and Non-Latino Whites, Ages 0-64, United States, 1997



Source: March 1998 Current Population Survey

Latinos are less likely than whites to receive job-based coverage regardless of the firm size in which they work (Exhibit 2-3). The coverage gap ranges from approximately 30 percentage points for firms with fewer than 100 employees to 18 percentage points in firms with 500 or more employees. Compounding this disadvantage, a higher proportion of Latinos live in families whose primary earner works in a firm with fewer than 100 employees (47% of Latinos vs. 37% of whites), data in Appendix A, Exhibit A2.

Exhibit 2-3. Job-Based Insurance by Firm Size of the Primary Earner, Latinos and Non-Latino Whites, Ages 0-64, United States, 1997



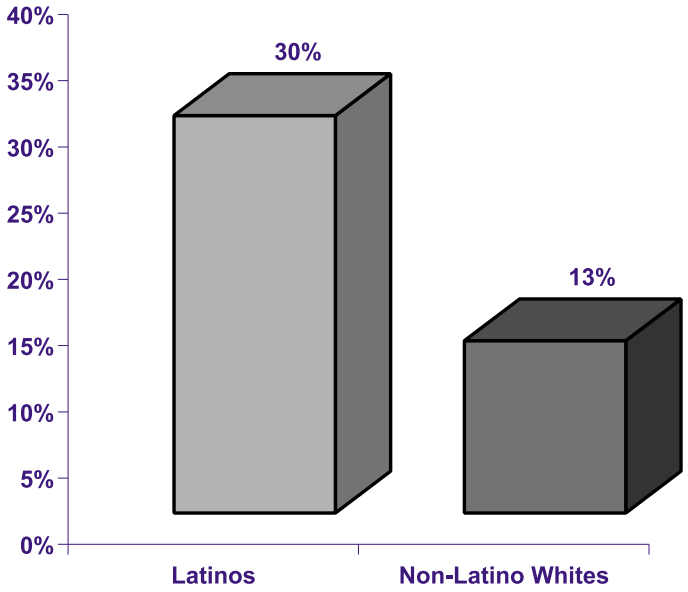
Source: March 1998 Current Population Survey

Similarly, in every industry, Latinos are less likely to have job-based insurance. Latinos are even disadvantaged in public administration, the economic sector with the highest job-based insurance rates. Among persons in families whose primary breadwinner works in public administration, 78% of Latinos have job-based coverage compared to 84% of whites. And Latinos are much more likely than whites to work in low-coverage occupations and industries. (See Appendix A, Exhibit A4, for coverage by industry.)

Latinos are less likely than all other groups to be offered job-based insurance

The pervasiveness of the Latino disadvantage in job-based insurance suggests that neither the amount nor the type of employment adequately explains this gap. An important contributor to the disparity is whether an employer offers coverage to any employees ("the offer rate"). Latino workers are about twice as likely as whites to report that they work for an employer that does not offer health insurance to any workers—30% vs. 13% (Exhibit 2-4). As a result, Latinos are much less likely to be insured through their employer—53% vs. 67%, a gap of 14 percentage points.

Exhibit 2-4. Employees Whose Employer Does Not Offer Coverage to Any Worker, Latinos and Non-Latino Whites, Employees Ages 19-64, United States, 1997



Source: February 1997 Current Population Survey

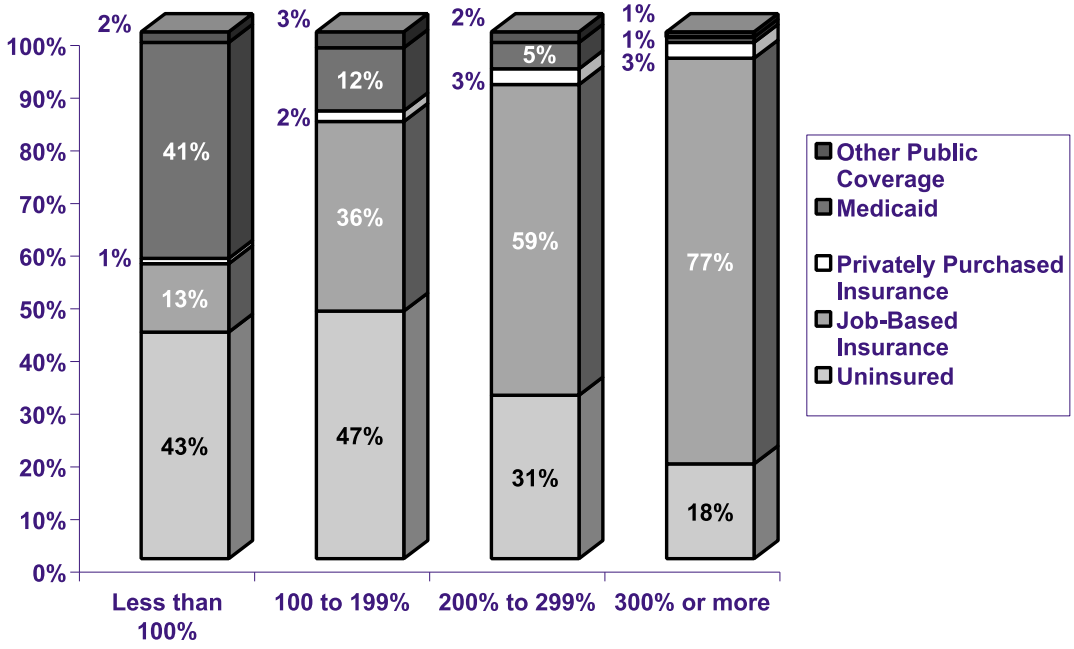
Poverty is an important determinant of coverage

A worker's income is highly correlated with both the likelihood that an employer will offer coverage and with the affordability of coverage to the employee. Employers can hire low-wage workers without offering health benefits more readily than they can hire high-wage workers without benefits. And Latinos are the poorest of all major ethnic groups, with family incomes so low that in 1997, six out of ten (59%) Latinos were poor or near-poor (that is, family incomes below 200% of poverty), compared to 23% of whites (data in Appendix A, Exhibit A1).[15] At that level of family income, essentials such as housing, transportation, food, and clothing are likely to be higher priorities for a family than the $1,700 average employee share of health insurance premiums for family coverage.[16] Privately purchasing health insurance is even more unaffordable at such family income levels. It is therefore not surprising that 43%-47% of Latinos with family incomes below 200% of poverty are uninsured (Exhibit 2-5).

[15] Poverty levels are standardized measures based on total family income and family size. In 1997, the federal poverty level for a family of three was $8,350 for one person, $10,805 for two persons, and $12,802 for three person-families (U.S. Department of Commerce, Bureau of the Census: http://www.census.gov/hhes/poverty/threshld/thresh97.html).

[16] Rice T, Pourat N, Levan R, Silbert L, Brown ER, Gabel J, et al., *Trends in Job-Based Health Insurance Coverage*, Los Angeles: UCLA Center for Health Policy Research, June 1998.

Exhibit 2-5. Health Insurance Coverage by Family Income Relative to Poverty, Latinos, Ages 0-64, United States, 1997



Source: Current Population Survey, 1998

Educational attainment is an important determinant of earnings and also of health insurance coverage. Among Latinos in families whose primary breadwinner has less than a high school education, only 26%-30% receive job-based insurance, leaving 43%-50% uninsured (see Appendix A, Exhibit A3). However, even among Latinos who are college graduates, 17% are uninsured, compared to only 7% of whites. As with most characteristics, Latinos have poorer health insurance coverage within each educational attainment group, and more Latinos have breadwinners who have not graduated from high school (46% of Latinos vs. 10% of whites) and fewer who have graduated from college (9% vs. 29%).

Medicaid is an important safety net for many Latino children

As with nonelderly Latinos overall, Latino children experience low rates of job-based coverage (40%), which drives up the proportion who have no health insurance of any kind (29%; see Appendix A, Exhibit A3), the highest uninsured rate for children among all ethnic groups. Medicaid provides a partial safety net for low-income children, protecting 28% of Latino children from being uninsured.

Young adult Latinos least likely to have coverage

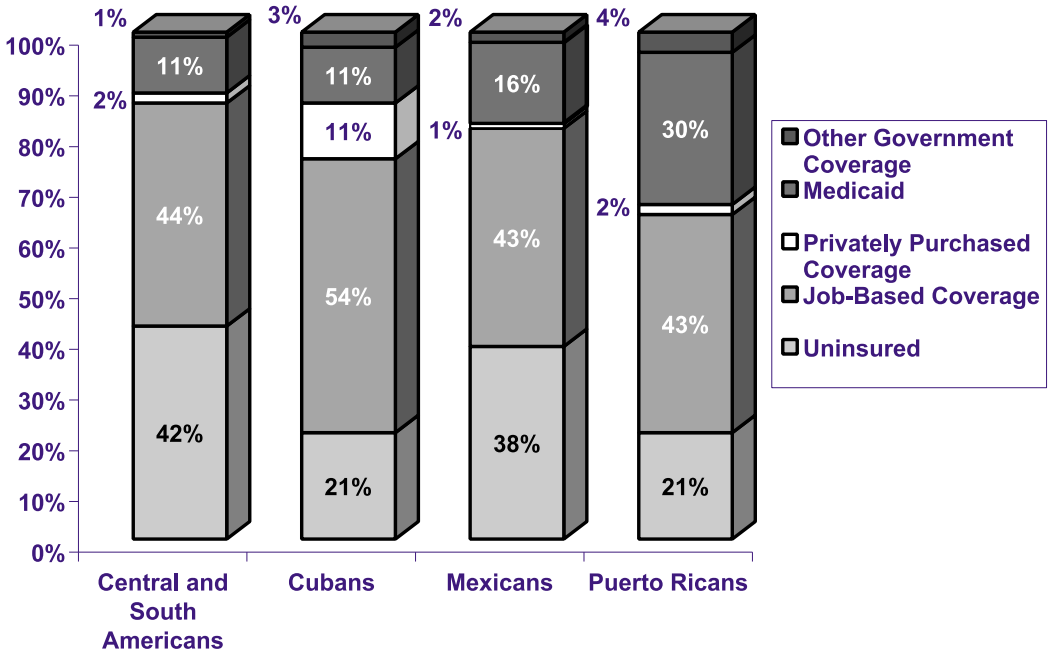
Half (50%) of young adult Latinos, ages 18-29, are uninsured (data not shown). Latino males in this age group are disproportionately uninsured. Their high uninsured rates are driven by low rates of job-based insurance; 56% of males are uninsured vs. 42% of females. Latinas would have

uninsured rates comparable to those of males if not for Medicaid, which covers 16% of Latinas compared to 5% of Latino men. This pattern reflects Medicaid's emphasis on covering pregnant women and poor single parents with children. Although uninsured rates among whites decline steadily with increasing age, reaching a low of 12% of whites ages 55 to 64, among Latinos uninsured rates remain higher, declining only to 32% among those ages 55 to 64 (data not shown).

Coverage varies among Latino subgroups

Mexican-Americans and Central and South Americans have the highest rates of uninsurance (38% and 42%, respectively), but Latinos of every national origin, including Cubans and Puerto Ricans, have significantly higher uninsured rates than whites (Exhibit 2-6).

Exhibit 2-6. Health Insurance Coverage among Latino Subgroups Ages 0-64, United States, 1997



Source: March 1998 Current Population Survey

Latinos as a whole have very low rates of employment-based health insurance, but the rates for Central and South Americans, Mexican-Americans, and Puerto Ricans (44%, 43%, and 43%, respectively) are the lowest among Latino subgroups. Low job-based coverage rates drive the high uninsured rates for these groups. Three in ten (30%) Puerto Ricans, however, are covered by Medicaid, due both to their poverty and to the fact that all are citizens by birth. This higher Medicaid coverage partially compensates for Puerto Ricans' low job-based coverage. Mexican-Americans are only about half as likely to receive Medicaid (16%), and

Central and South Americans only a third as likely (11%). Although Cubans are more than twice as likely as whites to purchase private coverage (11% vs. 5%), all other Latinos subgroups are less than half as likely as whites to do so.

Between 1994 and 1997, Mexican-Americans' job-based coverage rose from 40% to 43% but these gains were offset entirely by a drop in Medicaid coverage from 19% to 16%. Puerto Ricans, Central and South Americans, and Cubans also experienced increases in job-based coverage, most of which were offset by drops in Medicaid coverage. These declines in Medicaid coverage, largely the result of the early implementation of welfare reform, left these groups uninsured in 1997 at the same high rates they experienced in 1994.

Latinos are hurt by lack of citizenship

The high uninsured rate among Latinos overall reflects, in part, the extraordinarily high uninsured rate among Latino noncitizens (58%). Even among Latino U.S. citizens, however, a still high 27% are uninsured (Exhibit 2-7). This high uninsured rate among Latino citizens suggests that other factors in addition to citizenship—such as educational attainment, employment characteristics, and income level—play an important role in providing access to job-based coverage under our system in which employers voluntarily decide whether to provide coverage.

Lack of citizenship can reduce access to both job-based coverage and Medicaid, and lack of legal residency greatly intensifies this disadvantage. We have focused the analysis of citizenship and immigration status on Mexican-origin Latinos for two reasons. First, Mexican-Americans and Mexicans comprise 70% of nonelderly Latinos in the United States. Second, although the Current Population Survey and other surveys of the general population do not directly ask noncitizens whether they are legal or undocumented residents, we were able to estimate undocumented status among Mexican noncitizens based on information from a household survey of Mexican immigrants in Los Angeles.[17] We estimate 15% of all Mexican-origin residents in the U.S. are undocumented.

Comparable proportions of U.S.-born and naturalized Mexican-American citizens have job-based insurance (47% and 46%, respectively; Exhibit 2-7). However, U.S.-born Mexican-Americans are twice as likely to receive Medicaid coverage (20% vs. 10%), resulting in a higher uninsured rate among naturalized citizens.

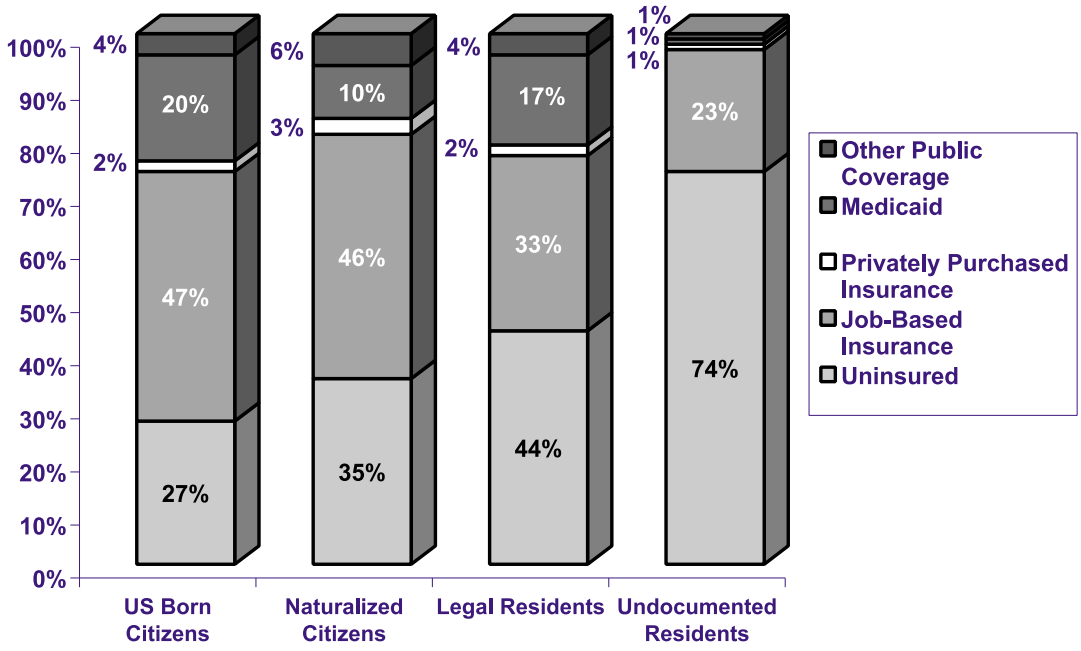
Only about one-third (33%) of Mexican noncitizens who are legal U.S. residents receive employment-based insurance. But despite their low job-based coverage and their high rates of poverty (32% have incomes below poverty), just 18% of these legal residents receive Medicaid coverage, leaving nearly half (44%) uninsured.

Finally, only one in four (23%) undocumented Mexican residents has job-based insurance. And because almost none receives Medicaid coverage, three-

[17] Marcelli EA, Heer DM, "The Unauthorized Mexican Immigrant Population and Welfare in Los Angeles County: A Comparative Statistics Analysis," *Sociological Perspectives* 1998; 41: 279-303.

fourths (74%) are completely uninsured. This high uninsured rate means that an estimated 2.1 million undocumented Mexican residents are uninsured, out of a total of 2.9 million estimated to be residing in the United States in 1997.

Exhibit 2-7. Insurance Coverage by Citizenship and Immigration Status, Latinos of Mexican Origin, Ages 0-64, United States, 1997



Source: March 1998 Current Population Survey

Like most immigrants, Mexican immigrants to the United States are attracted by employment opportunities.[18] Mexican immigrants participate in the labor force at very high rates; 84% of those who are legal U.S. residents and 91% of those who are undocumented residents are workers and their family members. But few of these workers or their dependents are able to obtain health benefits through employment. Many Mexican immigrants—whether they are legal residents or undocumented—come to the United States with low educational attainment, placing them at a disadvantage in the labor market and in their access to job-based insurance. Noncitizens are much less likely to work for an employer who offers health benefits to any employees,[19] and their low incomes

[18] Portes A, Rumbaut RG, *Immigrant America: A Portrait.* Berkeley: University of California Press, 1996; Simcox DE. (ed.), *U.S. Immigration in the 1980s: Reappraisal and Reform,* Boulder, CO: Westview Press, 1988.

[19] Brown ER, Rice T, "Employees' Access to Job-Based Insurance," in HH Schauffler, ER Brown, et al., *The State of Health Insurance in California, 1998*, Berkeley and Los Angeles: Health Insurance Policy Program, January 1999.

[20] Hernandez DJ, Charney E (eds.), *From Generation to Generation: Health and Well Being of Children in Immigrant Families*, Washington, DC: National Academy Press, 1998; and Brown ER, Wyn R, Ojeda VD, *Access to Health Insurance and Health Care for Children in Immigrant Families*, Los Angeles: UCLA Center for Health Policy Research, June 1999.

make the private purchase of health insurance unaffordable for many.

Medicaid does not provide the same level of safety-net protection for noncitizens as for citizens.[20] In addition, many legal residents are reluctant to apply for Medicaid even when they are eligible for it. The 1996 welfare reform legislation terminated Medicaid entitlement for legal residents who entered the United States after August 22, 1996, with some exceptions.[21] Although nearly all states have extended Medicaid eligibility to legal residents who entered the country prior to that date, many legal immigrants have been deterred from obtaining coverage because they fear that they will jeopardize future citizenship prospects or be forced to repay Medicaid covered expenses at a later date.[22] Undocumented residents, whose status in the United States is especially uncertain, are generally not eligible for Medicaid except on an emergency basis.

Access to Care

The high uninsured rates of Latinos have serious consequences for their access to health care services. In this section of the report, we examine Latinos' connection to the health care system and their use of health care services. We report on the proportion of Latinos with a regular person or place where they receive care, an important component in the receipt of ongoing, consistent care. We also examine use of health care services, using a conservative criterion for children: examination by a physician in the past year for children ages 0-5 and at least a biannual visit for children ages 6-17.[23] For adults, we connect visits to reported health status, and expect that adults in fair to poor health should not go longer than one year without seeing a physician and that adults in good to excellent health should not go for longer than two years without a doctor visit.

Lack of insurance limits Latinos' connection to the health care system

Having a regular connection to the health care system is important to ensure access to ongoing preventive services and for medical care when sick. Latinos are the most likely among all ethnic groups to have no usual source of care. One in nine Latino children (12%) and one in four Latino adults (26%) report that they do not have a usual source of care, compared to 4% of white children and 15% of white adults (Exhibit 2-8).

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[21] Refugees are eligible for Medicaid for their first seven years in the United States. Immigrant children who arrived in the United States after July 22, 1996 are eligible in California for Medicaid coverage, paid for entirely by state tax dollars without the standard federal matching funds.

[22] Perry MJ, Stark E, Valdez RB, *Barriers to Medi-Cal Enrollment and Ideas for Improving Enrollment: Findings from Eight Focus Groups in California with Parents of Potentially Eligible Children*. Menlo Park, CA: Henry J. Kaiser Family Foundation, 1998.

[23] The American Academy of Pediatrics (AAP) recommends annual visits for children and adolescents ages 24 months through age 17 (except for children ages 7 and 9), and more frequent visits for children under 24 months of age. Thus our criteria of at least one physician visit in the past year for children under the age of 5 and a visit at least every two years for children ages 6-17 is a reasonable, somewhat conservative, estimate of minimal requirements. See American Academy of Pediatrics, "Recommendations for Preventive Pediatric Health Care," *Pediatrics* 1995; 96:712.

Exhibit 2-8. Percent With No Usual Source of Care by Age Group and Health Insurance Status, Latinos and Non-Latino Whites, Ages 0-64, United States, 1995-1996

	Latino	Non-Latino White
Children 0-17	**12%**	**4%**
Uninsured	32%	16%
Medicaid	6%	4%
Job-based/Private Insurance	4%	3%
Adults 18-64	**26%**	**15%**
Uninsured	49%	36%
Medicaid	11%	10%
Job-Based/Private Insurance	12%	11%

Source: 1995 and 1996 National Health Interview Surveys

Having health insurance coverage increases the likelihood of having a regular connection to health care services. Latinos with Medicaid, job-based, or private coverage are about as likely as whites with similar coverage to have a usual source of care. However, uninsured Latinos are much more likely than uninsured whites to lack a usual source of care. One-third (32%) of uninsured Latino children and one-half (49%) of uninsured Latino adults have no usual source of care, compared to 16% of white children and 36% of white adults without coverage.

Across Latino subgroups, having insurance increases connection to the health care system

Puerto Ricans are less likely to lack a usual source of care compared to Mexican-Americans and those whose national origins are from other Latin American countries (12% vs. 22%; Exhibit 2-9). For each ethnic subgroup, having insurance greatly improves the connection to the health care system, reducing the proportion without a usual source of care.

Exhibit 2-9. Percent with No Usual Source of Care by Health Insurance Status, Latino Subgroups, Ages 0-64, United States, 1995-1996

	Mexican-American	Puerto Rican	Other Latin American*
Subgroup Overall	22%	12%	22%
Uninsured	43%	37%	51%
Insured	10%	6%	8%

Source: 1995 and 1996 National Health Interview Surveys
*Other Latin American" includes all Latinos except those who are not Mexican-American or Puerto Rican

Insurance coverage improves access to care for young and school-age Latino children

Latino children are less likely to have timely physician visits than their white counterparts. And for uninsured Latinos, health care access is even more compromised relative to their counterparts with coverage.

For children ages 0-5, past-year physician visit rates are lower for Latinos than for whites, with 8% and 5%, respectively, missing a physician visit during the past year (Exhibit 2-10). Among young Latinos, coverage makes an important difference. Those who are uninsured are 2.5 times as likely as those with coverage not to have had a doctor visit in a 12-month period (16% vs. 6%). Thus, one in six uninsured Latino preschool children did not have the advantage of a physician examination in a one-year period, missing out on immunizations and physical, social and developmental monitoring that are an important component of these visits.

Exhibit 2-10. Percent of Children Who Have Not Obtained Minimum Number of Doctor Visits by Age Group and Health Insurance Status, Latinos and Non-Latino Whites, Ages 0-17, United States, 1995-1996

	Latino	Non-Latino White
Ages 0-5*	**8%**	**5%**
Uninsured	16%	12%
Medicaid	6%	4%
Job-Based/Private Insurance	6%	4%
Ages 6-17*	**16%**	**7%**
Uninsured	29%	17%
Medicaid	9%	6%
Job-Based/Private Insurance	12%	6%

Source: 1995 and 1996 National Health Interview Surveys
* Examination by a physician in the past year for children ages 0-5 and at least a biannual visit for children ages 6-17.

For school-age Latino children, the disparities are greater. Among children ages 6-17, 16% of Latinos have not seen a physician in the past two years, compared to 7% of whites. Among school-age children who are uninsured, three out of ten (29%) Latino children have not had a physician visit in the past two years (vs. 17% of comparable white children). Insurance coverage significantly improves access to care for these school-age children, bringing their use rates closer to those of whites, but still not eliminating the gaps, suggesting that additional barriers reduce Latino children's access to care.

Among Latino adults in fair to poor health, gender and insurance status affect probability of a doctor visit

Latinas who are in fair to poor health, and thus experiencing health problems, are less likely than their white counterparts to have had a recent physician visit. Thirteen percent of Latinas who report being in fair or poor health did not have a doctor visit in the past year, a rate that is double that of their white counterparts (6%; Exhibit 2-11). Among uninsured Latinas in fair to poor health, one in four (24%) went for more than one year without seeing a physician, three times the rate of those with coverage and about twice the rate for uninsured white women (13%). Thus, one-quarter of uninsured Latinas in fair or poor health did not see a physician in a 12-month period, demonstrating the severe impact of not having insurance on access to health services.

Latino men in fair or poor health are twice as likely as their female counterparts not to have seen a physician in the past year (25% vs. 13%; Exhibit 2-11). For uninsured Latino men in fair or poor health, 40% have not had a doctor visit in the past year—despite their health problems—twice the rate for those with coverage (19%).

Exhibit 2-11. Percent of Adults in Fair to Poor Health Who Have Not Had a Doctor Visit in Past Year by Gender and Health Insurance Status, Latinos and Non-Latino Whites, Ages 18-64, United States, 1995-1996

	Latino	Non-Latino White
Women	**13%**	**6%**
Uninsured	24%	13%
Medicaid	7%	3%
Job-Based/Private Insurance	8%	5%
Men	**25%**	**14%**
Uninsured	40%	29%
Medicaid	*	*
Job-Based/Private Insurance	19%	12%

Source: 1995 and 1996 National Health Interview Surveys
*Sample size too small for reliable estimate.

Latinas in good to excellent health—the population whose main visits would likely be for preventive services and for acute health problems—are less likely than white women to have been to a physician in a two-year period (14% vs. 8%). Among uninsured women in good to excellent health, one in four (25%) Latinas did not visit a physician in a two-year period (Exhibit 2-12).

Uninsured Latinos in good to excellent health are the least likely to have had a physician visit

Latino men in good to excellent health are more than twice as likely as Latinas (34% vs. 14%) and more than one and a half times as likely as their white male counterparts (34% vs. 20%) not to have visited the doctor in the past two years. Even though coverage improves access for Latino men, their reduced access is evident regardless of health insurance status; nearly one-quarter (23%) of insured men and half (50%) of those without coverage have not had a doctor visit in the past two years.

Exhibit 2-12. Percent of Adults in Good to Excellent Health Who Have Not Had a Doctor Visit in Past Two Years by Gender and Health Insurance Status, Latinos and Non-Latino Whites, Ages 18-64, United States, 1995-1996

	Latino	Non-Latino White
Women	**14%**	**8%**
Uninsured	25%	18%
Medicaid	5%	5%
Job-Based/Private Insurance	9%	7%
Men	**34%**	**20%**
Uninsured	50%	35%
Medicaid	23%	17%
Job-Based/Private Insurance	23%	18%

Source: 1995 and 1996 National Health Interview Surveys

For both children and adults, Mexican-Americans are less likely to have met the physician visit criterion than Puerto Ricans or other Latin Americans (Exhibit 2-13). The importance of coverage, however, is very consistent across each Latino subgroup. Particularly striking is the effect on Mexican-American adults: among the uninsured, 42% have not met the physician visit criterion, compared to 18% of those with health insurance coverage.

Exhibit 2-13. Percent of Children and Adults Who Have Not Met Physician Visit Criterion, Latino Subgroups, Ages 0-64, United States, 1995-1996

	Mexican-American	Puerto Rican	Other Latin American
Children 0-17*	16%	3%	8%
Uninsured	28%	9%	15%
Insured	11%	3%	5%
Adults 18-64**	28%	13%	19%
Uninsured	42%	23%	33%
Insured	18%	10%	11%

Source: 1995 and 1996 National Health Interview Surveys
*Physician visit past year for children ages 0-5 and past two years for children ages 6-17
**Physician visit past year for adults in fair or poor health and past two years for adults in good to excellent health
***Other Latin American" includes all Latinos except those who are not Mexican-American or PuertoRican

Conclusions

Health Insurance Coverage

Latinos experience the highest uninsured rate of any group: 37%, compared to 14% for whites. Latinos' are uninsured at such high rates because only 43% have employment-based health insurance, compared to 73% of whites. Medicaid provides a partial safety net for low-income children, protecting about one in four Latino children from being uninsured. Medicaid covers a smaller proportion of women and a still smaller proportion of men.

Latinos' job-based insurance rose during the latter 1990s, a benefit of the nation's strong economy, but their Medicaid coverage fell faster, in part due to the provisions of the welfare reform legislation.

Despite low rates of job-based insurance, nearly nine in ten (87%) uninsured Latinos are workers or their dependent spouses or children. Latinos are far less likely than whites to have job-based coverage no matter how much they work. Even among families in which the primary breadwinner works as an employee full-time all year, Latinos are only about two-thirds as likely as whites to have job-based coverage.

Two factors reduce Latinos' access to employment-based coverage. First, they are more likely to work for an employer who does not offer health insurance to any employees. Second, they are more likely to have low incomes that make the required contribution for health benefits less affordable when it is offered.

Latinos as a whole have very low rates of employment-based health insurance, but the rates for Central and South Americans, Mexican-Americans, and Puerto Ricans are the lowest among Latino subgroups. One in nine Cubans privately purchase coverage, more than twice the rate for whites; all other Latino subgroups

are less than half as likely as whites to do so. Medicaid covers three in ten Puerto Ricans, due both to their poverty and to the fact that all are citizens by birth. Medicaid somewhat offsets Puerto Ricans' low job-based coverage, something it does less well for other groups that include noncitizens and naturalized citizens.

The high uninsured rate among Latinos overall reflects, in part, the extraordinarily high uninsured rate of Latino noncitizens. However, lack of health insurance is not restricted to noncitizens. One in four Latinos who are U.S. citizens are uninsured, a rate that far exceeds the rate for whites. Lack of citizenship can reduce access to both job-based coverage and public coverage programs such as Medicaid, and lack of legal residency greatly intensifies this disadvantage. Latino citizens' low job-based coverage and high uninsured rates suggest that other factors in addition to citizenship—such as educational attainment, employment characteristics, and income level—play an important role in providing access to health insurance.

Access to Care

Latinos are the most likely among all ethnic groups to have no usual source of care: 12% of Latino children (vs. 4% of white children) and 26% of Latino adults (vs. 15% of white adults). Having health insurance coverage increases the likelihood of Latinos, as well as other groups, having a regular connection to health care services.

Latino children are less likely than white children to have timely visits to the physician, a disparity that is exacerbated for uninsured Latinos. One in six uninsured preschool Latino children and three in ten school-age Latino children have not had even minimum periodic visits to the doctor.

Among Latino adults in fair to poor health, one in four women and 40% of men who are uninsured did not visit a physician in the past year, rates that are far higher than for insured Latinos and for both insured and uninsured whites. Among those in good to excellent health, one in four women and half of men who are uninsured had not visited a physician in more than two years.

Policy Implications

The very limited access to health services for many Latinos deprives them of the benefits these services provide for health, benefits that are more readily available to other groups. Both children and adults who are uninsured are less likely to receive preventive and screening services, or diagnosis, treatment, and management of both chronic and acute conditions. Although other factors in addition to insurance coverage appear to contribute to disparities between Latinos and whites in their use of physician services, Latinos' high uninsured rates are their fundamental barrier.

The high uninsured rates among Latinos of all ages and work status, regardless of whether they are citizens or noncitizens, are unlikely to be reduced dramatically in the absence of substantial subsidies. The low incomes prevalent among so many Latinos—more than half are poor or near poor—make health insurance

unattainable without either a substantial contribution from an employer or a substantial subsidy from government. If public policy is not going to mandate employers to offer and pay for health benefits, then public programs would seem to be the only alternative to bring health insurance coverage within financial reach of the large and growing Latino population.

But public policy in recent years has tended to discourage or bar noncitizens from enrolling in Medicaid and other public benefit programs. Although nearly all states have extended coverage to pre-welfare reform legal immigrants (those who resided in the United States when the legislation was enacted on August 22, 1996) and the Congress has reinstated Medicaid eligibility for some groups it had excluded, many noncitizen families have avoided the Medicaid program due to fears of being labeled a "public charge." They fear that enrolling themselves or even their U.S.-citizen children in means-tested programs, such as Medicaid or their state CHIP plan, will be used against them when they try to renew their visas, return to the United States from abroad, or apply for citizenship.[24] For immigrant parents who are undocumented, fear of the Immigration and Naturalization Service (INS) may deter them from applying for either program, even when their children are U.S. citizens and thus fully eligible for all benefits available to other citizens.

These effects of recent welfare and immigration reform laws may be moderated by recent policy changes concerning Medicaid enrollment and immigration status. The INS and the State Department ruled in May 1999 that noncitizens would not be classified as a "public charge" if they or their children enroll in Medicaid or CHIP (except those who receive long-term care under Medicaid). Nevertheless, persons who immigrate legally to the United States after August 22, 1996 will continue not to be eligible for Medicaid (except emergency services) unless their families are refugees or asylees—and then, only for seven years. The Clinton Administration has proposed, beginning in federal fiscal year 2000, to extend eligibility to these recently arrived legal immigrants.

[24] Perry, Stark, Valdez, Barriers to Medi-Cal Enrollment and Ideas for Improving Enrollment, 1998.

African Americans[25]

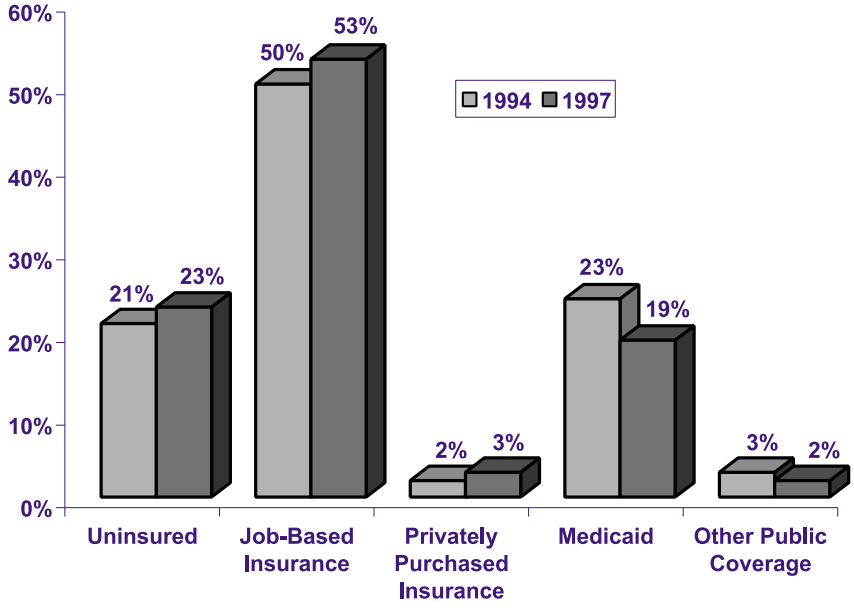
Overview

Employment-based health insurance is the major source of coverage across all racial/ethnic groups, and among African Americans, this type of coverage increased moderately during the latter 1990s. The strong economy has produced employment gains for African Americans that have increased their chances of access to job-based insurance, but their job-based coverage is still lower than that for non-Latino whites ("whites," for simplicity). Medicaid offsets some, but not all, of African Americans' lower employment-based coverage. Major gaps between African Americans and whites persist in both health insurance coverage and access to health services. This section examines these continuing disparities.

Health Insurance Coverage

Between 1994 and 1997, job-based coverage among African Americans increased from 50% to 53%. However, during the same period, African Americans' Medicaid coverage dropped from 23% to 19%, while privately purchased insurance and other coverage remained statistically unchanged, pushing up African Americans' uninsured rate from 21% to 23% (Exhibit 3-1).

Exhibit 3-1. Changes in Health Insurance Coverage Among African Americans, Ages 0-64, United States, 1994-1997



Source: March 1995 and 1998 Current Population Survey

[25] Shannon Currieri helped write this section.

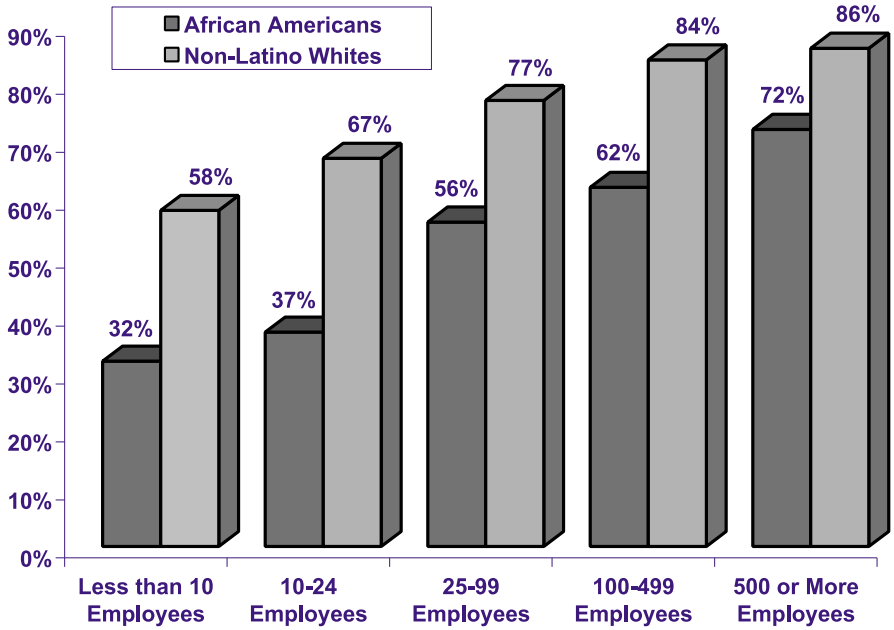
Gains in job-based insurance offset by loss of Medicaid coverage

As the nation's economy continued to grow through the late 1990s, African Americans' job-based coverage also improved. The proportion of African Americans in working families grew from 77% in 1994 to 82% in 1997. And the proportion in families headed by a full-time full-year employee—the group most likely to have access to job-based coverage—rose from 53% to 58%. Even this improvement, however, left the proportion of African Americans living in full-time full-year employee families still well below the figure for whites (71%), which also left African Americans' employment-based coverage well below that for whites (53% vs. 73%).

Despite employment in large firms, African Americans obtain less job-based insurance

African Americans are more likely to work in settings that generally provide access to employment-based health insurance, but they are less likely than whites in comparable settings to receive such coverage. African Americans are the least likely among all ethnic groups to come from families where the primary earner works for a firm with fewer than 25 employees and the most likely to work in firms with 500 or more workers (data in Appendix A, Exhibit A2). But regardless of what size firm African Americans work in, they are less likely than whites to receive job-based insurance (Exhibit 3-2). For example, among persons in families whose primary earner works in a firm with 500 or more employees, only 72% of African Americans have job-based coverage compared to 86% of whites. And the discrepancy is even greater—by 20 to 30 percentage points—among those whose primary breadwinner works in a firm with fewer than 500 employees.

Exhibit 3-2. Job-Based Insurance by Firm Size of Primary Earner, African Americans and Non-Latino Whites, Ages 0-64, United States, 1997



Source: March 1998 Current Population Survey

Similar disparities in job-based coverage are found for industry of employment. Whites are far more likely to have job-based insurance regardless of industry (data in Appendix A, Exhibit A12). Among those whose primary breadwinner works in a low-coverage industry (including agriculture, forestry, and fishing; mining; construction; retail; business, personal, and entertainment services), 66% of whites have job-based coverage compared to 45% of African Americans. Among those in high-coverage industries (including manufacturing; transportation, communication, and utilities; wholesale; financial and professional services; and public administration), 86% of the white population has job-based insurance compared to 72% of the African-American population.

African Americans are also disadvantaged by lower proportions of family breadwinners who have graduated from college (13% of African Americans vs. 29% of whites), as well as higher proportions who have not graduated from high school (20% vs. 9%). These disparities in educational attainment result in lower earnings and less access to health benefits.

Single adult households have fever opportunities to get job-based insurance

Higher proportions of African Americans live in single-parent families, reducing their access to health insurance. One-third (35%) of African Americans live in single-parent families, compared to 11% of whites (Appendix A, Exhibit A1). Married-couple families have two opportunities to be offered job-based

coverage (compared to just one opportunity for single-parent families), and they usually have higher incomes with which to pay the employee contribution for job-based coverage. Even among single-parent families, African Americans are less likely to receive job-based coverage compared to whites (36% vs. 53%). For both ethnic groups, married couples with children experience higher rates of employer-based coverage, though a gap still persists between the coverage rates of African Americans (73%) and whites (81%; Exhibit 3-3).

Medicaid offers considerable protection to poor children and their families who do not receive job-based insurance. Among African-American adults and children in single-parent families, 38% are covered by Medicaid compared to 23% of whites in single-parent families, a difference related to higher poverty rates among these African-American families. Despite the protection that Medicaid provides by partially offsetting African Americans' lower job-based coverage, uninsured rates among African-American single-parent families are higher than among persons from married couple families: 22% for single parents and their children vs. 15% for married couples and their children. Nevertheless, Medicaid protects single-parent families without job-based or other coverage from even higher uninsured rates.

Exhibit 3-3. Insurance Coverage by Family Type, African Americans, Ages 0-64, United States, 1997

	Uninsured	Job-Based Insurance	Medicaid	Privately Purchased Insurance	Other Government Coverage
Single without children	34%	47%	12%	4%	4%
Married without children	17%	73%	3%	3%	4%
Married with children	15%	73%	7%	2%	2%
Single with children	22%	36%	38%	2%	1%

Source: March 1998 Current Population Survey

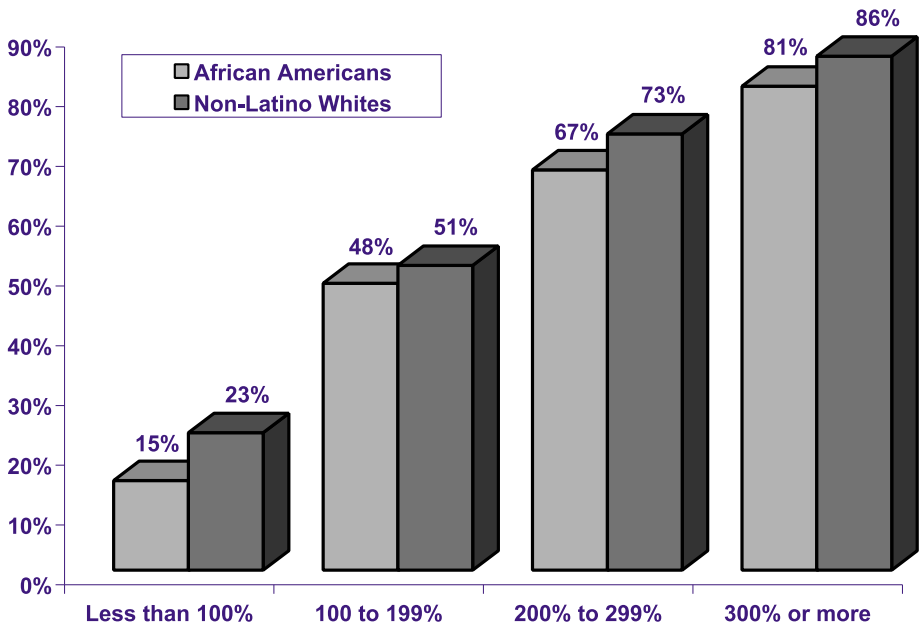
Poverty is a critical determinant of coverage

Less full-time employment, lower educational attainment, and lower proportions of two-earner families all contribute to lower rates of job-based coverage and to lower family incomes. African Americans are three times as likely as whites (27% vs. 9%) to have family incomes below poverty (about $13,000 for a family of three), and about half as likely (31% vs. 59%) to have incomes greater than 300% of the federal poverty level (about $38,500 for a family of three; data in Appendix A, Exhibit A1).[26]

[26] Poverty levels are standardized measures based on total family income and family size. In 1997, the federal poverty level was $8,350 for one person, $10,805 for two persons, and $12,802 for three person-families (U.S. Department of Commerce, Bureau of the Census: http://www.census.gov/hhes/ poverty/ threshld/thresh97.html).

Exhibit 3-4 suggests the central importance of income in obtaining job-based coverage. Although whites are slightly more likely than African Americans to receive employment-based insurance at each income level, these differences (ranging from three to eight percentage points) are much smaller than the disparities by family work status and by firm size, discussed above. However, given the wide variation in insurance coverage across income groups, much of the difference in job-based insurance coverage between African Americans and whites may be due to difference in family incomes.

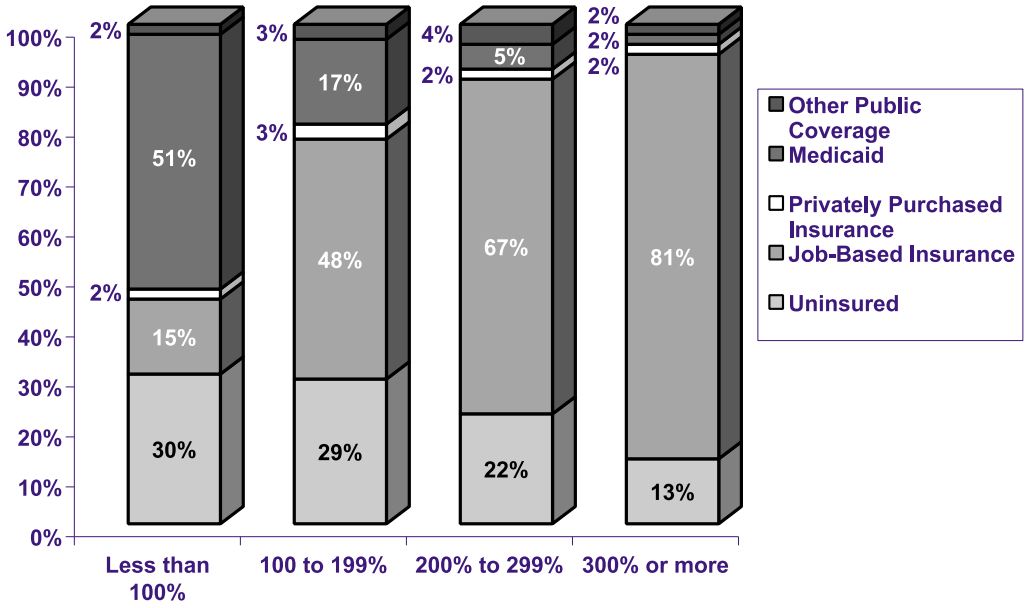
Exhibit 3-4. Job-Based Insurance by Family Income Relative to Poverty, African Americans and Non-Latino Whites, Ages 0-64, United States, 1997



Source: March 1998 Current Population Survey

The high proportion of African Americans with low incomes also helps explain why African Americans have higher rates of Medicaid coverage than whites (19% vs. 6%, Exhibit 1-1), and it underscores the important role that Medicaid plays for all low-income American families with children. Medicaid covers half (51%) of African Americans with family incomes below poverty and 17% of those between 100% and 199% of poverty (Exhibit 3-5). Medicaid largely equalizes uninsured rates among African Americans and whites for those with family incomes below 200% of the federal poverty level—but it is an incomplete safety net since three out of ten persons below 200% of the federal poverty level remain uninsured, regardless of race or ethnicity.

Exhibit 3-5. Health Insurance Coverage by Family Income Relative to Poverty, African Americans, Ages 0-64, United States, 1997



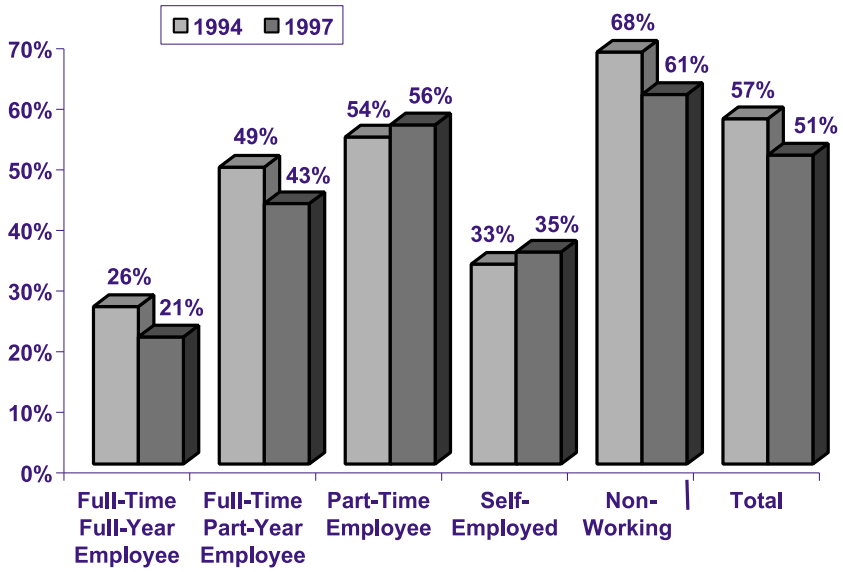
Source: March 1998 Current Population Survey

Medicaid's role as a safety net declined during the mid 1990s, as Medicaid coverage of African Americans dropped from 24% in 1994 to 19% in 1997. Some of this decline was related to increasing employment and rising rates of job-based coverage, but, as noted earlier, Medicaid coverage fell faster than job-based insurance rose, driven largely by welfare reform. Among African Americans with family incomes below poverty, Medicaid coverage fell between 1994 and 1997 for persons in families headed by a full-time full-year employee, those headed by a seasonally (full-time part-year) employed adult, and those in nonworking families (Exhibit 3-6). Declining Medicaid coverage caused the uninsured rate among poor African Americans to increase from 24% to 30%.

Medicaid coverage rates have dropped for African Americans

Among African Americans with family incomes below poverty, Medicaid coverage fell both for people in full-time full-year working families and for those in nonworking families. For nonworking families, Medicaid coverage declined from 60% to 54% between 1994 and 1997.

Exhibit 3-6. Changes in Medicaid Coverage Among African Americans with Family Incomes Below 100% of Poverty, by Family Work Status, Ages 0-64, United States, 1994-1997



Source: March 1998 Current Population Survey

Access to Care

Health insurance coverage clearly facilitates African Americans' connection to the health care system and their access to health care services, as it does for all ethnic groups. To examine the timeliness of physician visits for children, we use a modified version of the American Academy of Pediatrics guidelines and present minimum expectations for a physician visit: examination by a physician in the past year for children ages 0-5 and at least a biannual visit for children ages 6-17 (see Appendix B for fuller description). For adults, we relate doctor visits to self-reported health status, and expect that adults in fair to poor health would need to see a physician within the last year and that adults in good to excellent health should not go for longer than two years.

Lack of coverage reduces African Americans' connection to the health care

Large proportions of uninsured children and adults remain without any ongoing connection to the health care system. Having an identified place or person that one usually goes to for medical care provides a connection to the health system that has been shown to be an important component of access to health care. African-American children ages 0-17 are slightly more likely than white children not to have a usual source of care (Exhibit 3-7).

African-American children's access to care varies considerably by insurance status. Uninsured children are three to four times as likely to be without a usual source of care as their insured counterparts (children with Medicaid, employment-based or other private health insurance).

Exhibit 3-7. Percent Without a Usual Source of Care by Age Group and Health Insurance Status, African Americans and Non-Latino Whites, Ages 0-64, United States, 1995-1996

	African American	Non-Latino White
Children 0-17	**5%**	**4%**
Uninsured	18%	16%
Medicaid	4%	4%
Job-Based/Private Insurance	3%	3%
Adults 18-64	**15%**	**15%**
Uninsured	35%	36%
Medicaid	8%	10%
Job-Based/Private Insurance	10%	11%

Source: 1995 and 1996 National Health Interview Surveys

African-American adults are three times as likely as African-American children to be without a usual source of care, while African-American adults' rates are similar to those of white adults (Exhibit 3-7). However, African Americans' increased incidence of diabetes, diabetes-related complications, and hypertension makes a usual source of care crucial for early detection and consistent management of chronic diseases in adults. Yet, 15% of African-American adults overall have no usual place or person they go to, and among those without coverage, slightly over one-third (35%) do not have a regular connection to the health care system. Medicaid, employment-based coverage, and other forms of health insurance are critical in ensuring a regular connection, reducing the proportion without a usual source to 8%-10%.

African-American children ages 0-5 are as likely as white children to have seen a physician in the past year (5% of each; Exhibit 3-8). Among uninsured young African-American children, 10% have not visited a physician in a 12-month period, more than twice the rate for their counterparts with Medicaid. For younger children, regular monitoring by a physician provides important development assessment and preventive care.

Uninsured African-American young and school-age children less likely to have seen a physician than those with coverage

Uninsured school-age African-American children are similarly disadvantaged. Twenty percent of these children ages 6-17 have not had a physician visit in a two-year period, three to four times the rate for their counterparts with coverage. For school-age children, regular checkups are important for assessment of physical and social development, as well as a source of information for behavioral and nutritional counseling.

Exhibit 3-8. Percent of Children Who Have Not Obtained Minimum Number of Doctor Visits by Age Group and Health Insurance Status, African Americans and Non-Latino Whites, Ages 0-17, United States, 1995-1996

	African American	Non-Latino White
Ages 0-5*	**5%**	**5%**
Uninsured	10%	12%
Medicaid	4%	4%
Job-Based/Private Insurance	6%	4%
Ages 6-17*	**8%**	**7%**
Uninsured	20%	17%
Medicaid	5%	6%
Job-Based/Private Insurance	6%	6%

Source: 1995 and 1996 National Health Interview Surveys
* Examination by a physician in the past year for children ages 0-5 and at least a biannual visit
for children ages 6-17.

Uninsured African-American men and women in fair or poor health have poor access to care

African-American women in fair to poor health are less likely than their white counterparts to have had a physician visit in the past year: 9% of African-American women, compared to 6% of their white counterparts (Exhibit 3-9). Uninsured African-American women in fair or poor health are particularly disadvantaged; one in five (19%) went for more than one year without seeing a physician. Having any kind of insurance coverage—employment-based coverage, Medicaid, or other forms of coverage—improves access considerably for African-American women in fair or poor health.

African-American men in fair or poor health are more likely than their female counterparts not to have seen a physician in the past year (15% versus 9%; Exhibit 3-9). Among men without coverage, one-quarter (26%) have not seen a physician in the past year. Among those with private coverage, 16% of African-American men went more than a year without a visit, indicating additional access barriers.

Exhibit 3-9. Percent of Adults in Fair to Poor Health Who Have Not Had a Doctor Visit in Past Year by Gender, Health Insurance Status, African-Americans and Non-Latino Whites, Ages 18-64, United States, 1995-1996

	African American	Non-Latino White
Women	**9%**	**6%**
Uninsured	19%	13%
Medicaid	5%	3%
Job-Based/Private Insurance	7%	5%
Men	**15%**	**14%**
Uninsured	26%	29%
Medicaid	*	6%
Job-Based/Private Insurance	16%	12%

Source: 1995 and 1996 National Health Interview Surveys
*Sample size too small for reliable estimate.

Uninsured men and women in excellent-good health less likely to have physician visit

Differences by gender in physician visits are also seen among those in good to excellent health. African-American men in good to excellent health are more than twice as likely as their female counterparts not to have visited the doctor in the past two years (21% vs. 8%) (Exhibit 3-10).

The importance of insurance coverage in promoting access to preventive services and care for acute conditions is evident for these adults in good to excellent health, with more than a third (35%) of uninsured African-American men not having had a physician visit in the past two years. Although coverage improves access to care, still nearly one out of five (17%-18%) have not had a visit in a two-year period, limiting their opportunities for early detection of disease and for health promotion.

Exhibit 3-10. Percent of Adults in Good to Excellent Health Who Have Not Had a Doctor Visit in Past Two Years by Gender and Health Insurance, African Americans and Non-Latino Whites, Ages 18-64, United States, 1995-1996

	African American	Non-Latino White
Women	**8%**	**8%**
Uninsured	15%	18%
Medicaid	5%	5%
Job-Based/Private Insurance	6%	7%
Men	**21%**	**20%**
Uninsured	35%	35%
Medicaid	18%	17%
Job-Based/Private Insurance	17%	18%

Source: 1995 and 1996 National Health Interview Surveys

Conclusions

Health Insurance Coverage

African Americans benefited from the strong economy during the latter 1990s, as did most groups. Employment gains increased African Americans' job-based health insurance from 50% to 53% between 1994 and 1997, but major gaps between African Americans and whites persist in both health insurance coverage and access to health services.

Whether a family's primary breadwinner works in a low-coverage or high-coverage industry, African Americans are less likely than whites to have job-based coverage. The high proportion of African Americans with low incomes—half are poor or near poor—contributes to their low rates of job-based insurance by making employee premium contributions less affordable.

African Americans' low incomes and the large proportion who live in single-parent families combine to help explain their higher rates of Medicaid coverage (19% vs. 6% for whites) and underscores the important role that Medicaid plays for all low-income American families with children. However, between 1994 and 1997, African Americans' Medicaid coverage dropped from 23% to 19%, pushing up their uninsured rate from 21% to 23%. The drop in Medicaid was driven both by gains in job-based insurance and by the implementation of welfare reform, which discouraged or excluded many low-income working families from enrolling.

Access to Health Services

African Americans and whites are about equally likely to have a usual source of care, but large proportions of uninsured children and adults remain without any ongoing connection to the health care system. African-American children who are uninsured are four times as likely to lack a regular source of care as are children with Medicaid, employment-based coverage, or other coverage.

Among African-American children through age 5, one in ten of those who are uninsured has not visited a physician in a 12-month period, twice the rate for those with any type of coverage. And one in five school-age African-American children (ages 6-17) who are uninsured has not had a physician visit in a two-year period, a rate two to three times as high as their counterparts with coverage.

African-American women in fair to poor health are less likely than their white counterparts to have had a recent physician visit, and those who are uninsured are particularly disadvantaged with one in five not seeing a physician for more than one year. African-American men in fair or poor health are more likely than their female counterparts not to have visited a physician in the past year. Among African-American men who are in fair or poor health but do not have any coverage, one in four has not visited a physician in the past year despite their compromised health status.

Policy Implications

The poor access to health services among significant groups of African Americans is cause for considerable concern. Although many factors affect health, regular medical care offers opportunities for preventive services, including health counseling, and for screening tests, such as breast, cervical or prostate cancer screening. Early diagnosis of these life-threatening diseases could lead to earlier treatment, which could reduce African Americans' high cancer death rates. Physician visits typically include screening for hypertension, which is higher among African Americans and a major contributor to mortality from cerebrovascular diseases. In the absence of good access to physician services, it is unlikely that chronic illnesses such as these will be diagnosed and managed effectively.

African Americans' access to health services is compromised by an uninsured rate that is one and a half times the rate for whites. Low family incomes are the primary reason for lack of health insurance, often making even job-based insurance unaffordable to low-income African-American families. Although Medicaid covers nearly a third of African-American children, their low rates of job-based insurance leaves one in five uninsured. Medicaid protects much smaller proportions of African-American adults, even among those who have very low incomes and poor access to job-based coverage, leaving one in four uninsured.

Expanding public coverage programs to more adults in families with eligible children and offering coverage to childless adults would improve financial access of African-American adults to health services.

Asian Americans and Pacific Islanders[27]

Overview

Asian Americans and Pacific Islanders (AAPIs) are a very heterogeneous population. AAPI ethnic subgroups vary in language, cultural characteristics, citizenship status, and other socioeconomic characteristics, with variations related to their national origins, circumstances of immigration, and whether they are first-, second-, or third-plus-generation residents of the United States. Although all ethnic and racial groupings are comprised of diverse subgroups, it is particularly misleading to assume that average reasonably characterizes the AAPI population simply because distinctively different national subgroups have been aggregated into one larger AAPI classification. AAPIs include immigrants from South Asia (e.g., India, Pakistan, and Bangladesh); from China, Hong Kong, Taiwan, Japan, Singapore, and Malaysia; from Korea; from the Philippines; from Southeast Asia (e.g., Vietnam, Cambodia, Laos, Thailand, and Myanmar); from Indonesia; from other Asian countries and from the Pacific Islands (e.g., Fiji, Samoa, and Guam to name just a few). All of these nationalities have been represented in the United States long enough to include a substantial number of third-plus-generation Americans whose identification with their national origins may be quite marginal.

Access indicators for ethnic subgroups reflect this same variation among AAPIs. Aggregated AAPI data on health insurance coverage and access to health services suggest that AAPIs are the least disadvantaged minority group in the U.S. Yet, a number of AAPI ethnic subgroups experience serious barriers to obtaining health insurance coverage and using health services, resulting in significant disparities between these AAPI groups and non-Latino whites ("whites," for short). This section examines health insurance coverage and access to care for AAPIs overall and for a number of ethnic subgroups. (However, small sample sizes often preclude making specific estimates for subgroups, or result in differences that appear large but that do not reach accepted levels of statistical significance.)

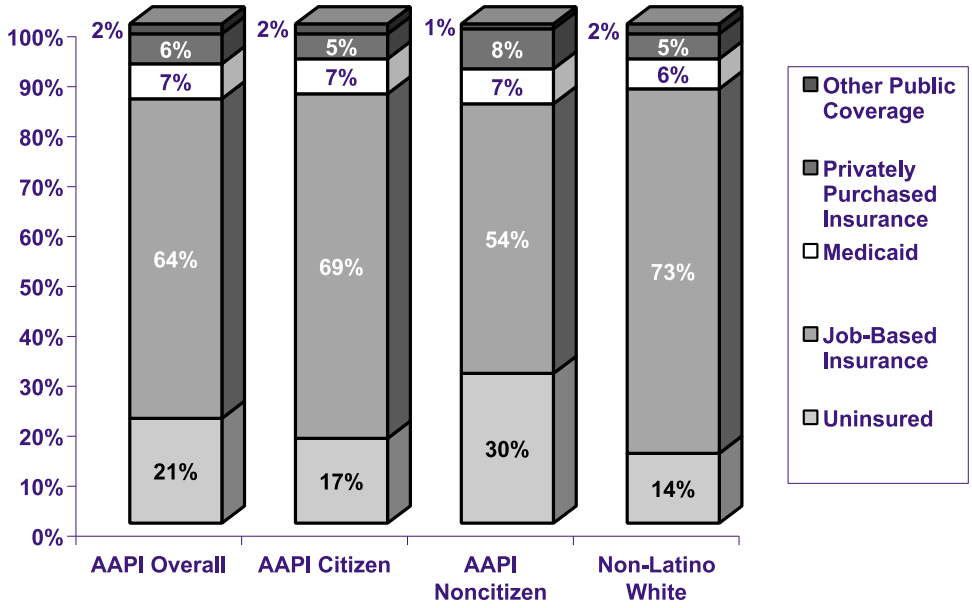
Health Insurance Coverage

Overall, AAPIs are moderately disadvantaged in their health insurance coverage compared to whites. AAPIs are less likely to receive job-based insurance (64% vs. 73%) and more likely to be uninsured (21% vs. 14%; Exhibit 4-1). Some of this difference is due to poorer coverage among noncitizens, who comprise a large proportion of AAPIs (33% of AAPIs were noncitizens in 1998, compared to just 2% of whites; Appendix A, Exhibit A1). Noncitizens have substantially poorer coverage, with only 54% receiving job-based insurance and 30% remaining uninsured (twice the uninsured rate for whites), despite their relatively high rate of privately purchased insurance (Exhibit 4-1). Even AAPIs who are citizens,

[27] Natasha Razack helped write this section.

however, have somewhat lower rates of job-based coverage and somewhat higher uninsured rates than whites.

Exhibit 4-1. Insurance Coverage by Citizenship Status, Asian Americans and Pacific Islanders and Non-Latino Whites, Ages 0-64, United States, 1997



Source: March 1998 Current Population Survey

In order to better understand within-group differences, we disaggregated AAPIs into ethnic subgroups based on their national origin or their parents' national origin.[28] (This approach permits us to identify health insurance coverage for first- and second-generation members of ethnic subgroups but not those in the third-plus-generation members of those same subgroups.) AAPI subgroups vary widely in their health insurance coverage (Exhibit 4-2). Uninsured rates range from 8% for third-plus-generation AAPIs to 13% for Japanese to 34% for Koreans. One in every five South Asians, Chinese, and Filipinos is uninsured, as is one in four Southeast Asians (27%) and other AAPIs (24%).

Most of the variation in uninsured rates among AAPI subgroups is driven by differences in employment-based insurance. Variations among AAPI subgroups

[28] In order to provide AAPI ethnic subgroup detail, we constructed a proxy subgroup measure based on the birthplace of the respondents or his/her parents because the CPS data tapes do not specify detailed ethnic backgrounds of AAPI respondents. We classified most people by their own birthplace. If the respondent was born in the U.S. but one of his or her parents was not, we assigned the birthplace of the parent to the respondent. If both parents were born outside of the U.S., we assigned the birthplace of the father to the respondent. If both parents were U.S.-born, we labeled these individuals as "Third-Plus Generation AAPIs." We then categorized individuals into eight ethnic subgroups: **South Asian** (India, Pakistan, Bangladesh), **Chinese** (China, Hong Kong, Taiwan, Singapore), **Filipino**, **Japanese**, **Korean**, **Southeast Asian** (Vietnam, Cambodia, Laos), **Third-Plus-Generation AAPI**, and "**All Other**." The "All Other" category includes individuals from Thailand, Myanmar, Indonesia, Fiji, Samoa, Guam, and Other Pacific Islands. These countries had too few respondents to report separately. We provide a more detailed discussion of this issue in Appendix B.

in job-based coverage reflect their diversity in citizenship/immigrant status and in economic and labor force characteristics within the population. Employment-based coverage rates range from not quite half of Koreans and Southeast Asians (48% and 49%, respectively) to a high of more than three-fourths of Japanese and third-plus-generation AAPIs (77% and 78%, respectively). Koreans' low rates of employment-based coverage are due to high rates of self-employment and employment in small firms, which are less likely to offer job-based coverage. Although larger than average proportions of Koreans privately purchase health insurance, their lack of access to job-based insurance is the main factor contributing to their high uninsured rates.

Medicaid coverage is generally low among the AAPI population. Just 1% to 2% of Chinese, Japanese, Filipino, and Koreans have Medicaid coverage—not more than one-third the rate for whites (6%). Third-plus-generation AAPIs and South Asians have Medicaid coverage rates that are comparable to those of whites. However, almost one in five (18%) Southeast Asians are covered by Medicaid, reflecting both their high poverty rates and the refugee status of many Southeast Asians in the U.S., which provides more generous Medicaid eligibility for refugees.

Exhibit 4-2. Health Insurance Coverage by Ethnic Subgroup, Asian Americans and Pacific Islanders and Non-Latino Whites, Ages 0-64, United States, 1997

Racial/Ethnic Group	Uninsured	Job-Based Insurance	Medicaid	Privately Purchased Insurance	Other Public Coverage
AAPI Overall	**21%**	**64%**	**7%**	**6%**	**2%**
South Asian	21%	69%	4%	5%	*
Chinese	20%	67%	2%	10%	1%
Filipino	20%	74%	2%	3%	2%
Japanese	13%	77%	2%	7%	1%
Korean	34%	48%	1%	14%	3%
Southeast Asian	27%	49%	18%	4%	2%
Third-Plus-Generation AAPI	8%	78%	8%	5%	2%
All other AAPI	24%	59%	11%	5%	2%
Non-Latino White	**14%**	**73%**	**6%**	**5%**	**2%**

Source: March 1998 Current Population Survey
*Sample size too small to make estimate

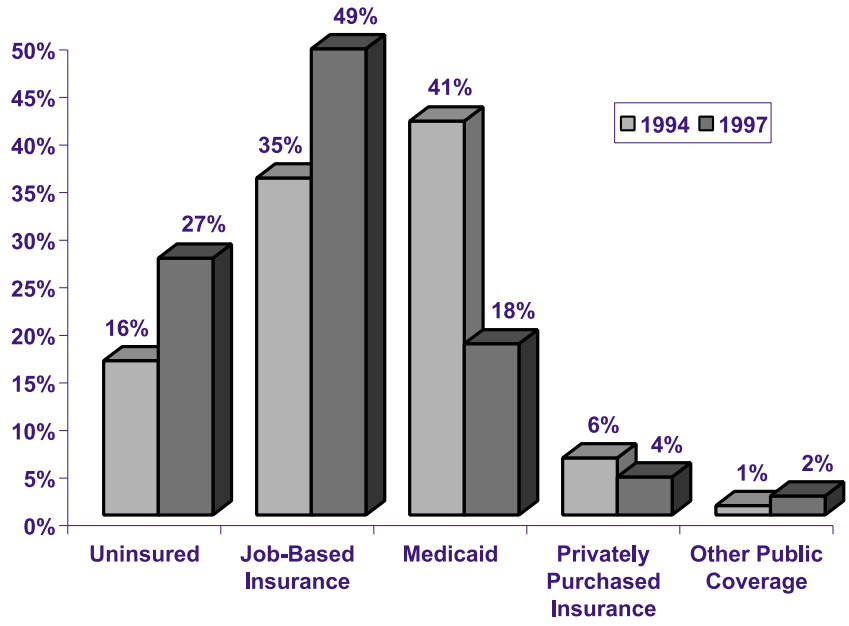
Southeast Asians' Medicaid rates drop substantially, while uninsured rate jumps from 16% to 27%

Between 1994 and 1997, as the economy continued to prosper, the proportion of Southeast Asians covered by job-based insurance increased from a very low 35% to a still-low 49% (Exhibit 4-3). Like other minorities, Southeast Asians increased their

participation in the labor force as the U.S. economy improved. In 1994, nearly half (46%) of Southeast Asians lived in families where no adult worked outside the home, while only 37% had primary wage earners who worked full time for the full year as employees, and the remaining 17% had primary earners who worked part time or seasonally as employees, or were self-employed. By 1997, only 16% of Southeast Asians were in nonworking families, 58% had full-time full-year breadwinners, and 26% had part-time, seasonal or self-employed primary earners.

However, Southeast Asians' Medicaid coverage plummeted during this same period (from 41% to 18%), resulting in an 11-percentage point increase in their uninsured rate (from 16% to 27%). The dramatic increase in employment among Southeast Asians improved family incomes for many, though 23% continued to live in poverty, and 22% were near poor, with family incomes between 100% and 199% of the federal poverty level.[29] The proportion of near-poor (100-199% of poverty) Southeast Asians who were covered by Medicaid dropped from 41% in 1994 to 11% in 1997 (Exhibit 4-4).

Exhibit 4-3. Changes in Health Insurance Coverage Among Southeast Asians, Ages 0-64, United States, 1994-1997



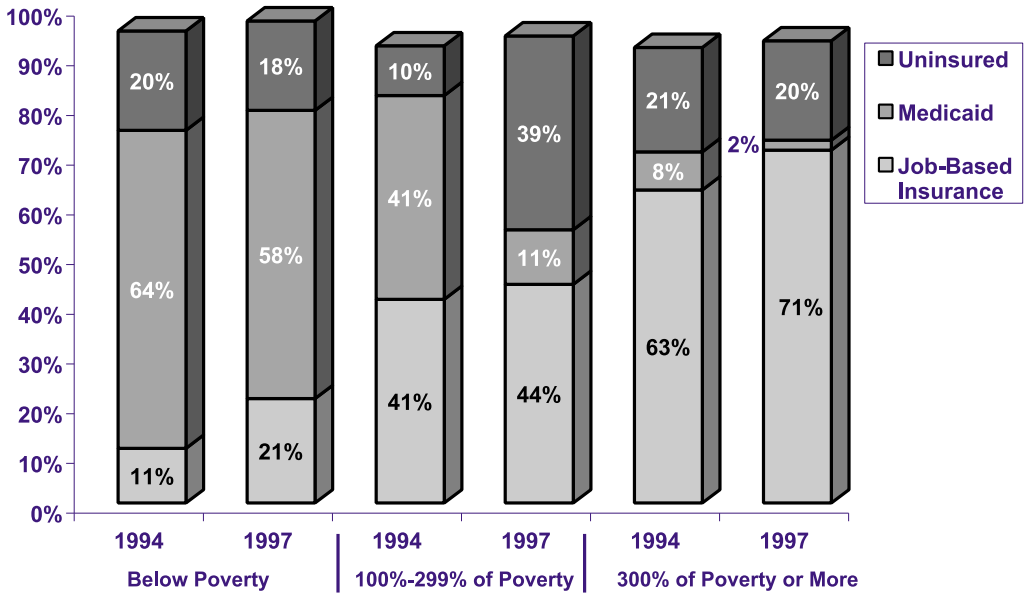
Source: March 1995 and 1998 Current Population Survey

In addition to increasing participation in the labor force and rising employment-based insurance rates reducing the need for Medicaid, Southeast Asians' Medicaid coverage fell for other reasons related to changes in public policy. It is likely that most Southeast Asian immigrants entered the country as

[29] Poverty levels are standardized measures based on total family income and family size. In 1997, the federal poverty level for a family of three was $8,350 for one person, $10,805 for two persons, and $12,802 for three person-families (U.S. Department of Commerce, Bureau of the Census: http://www.census.gov/hhes/poverty/threshld/thresh97.html).

refugees, entitling them to generous eligibility provisions for Medicaid. Welfare reform limited most refugees' eligibility for Medicaid to seven years. Many refugees were confused about the new eligibility policies. In addition, many noncitizens grew fearful that participation in Medicaid would jeopardize their prospects for citizenship.[30]

Exhibit 4-4. Changes in Health Insurance Coverage by Family Income Among Southeast Asians, Ages 0-64, United States, 1994-1997



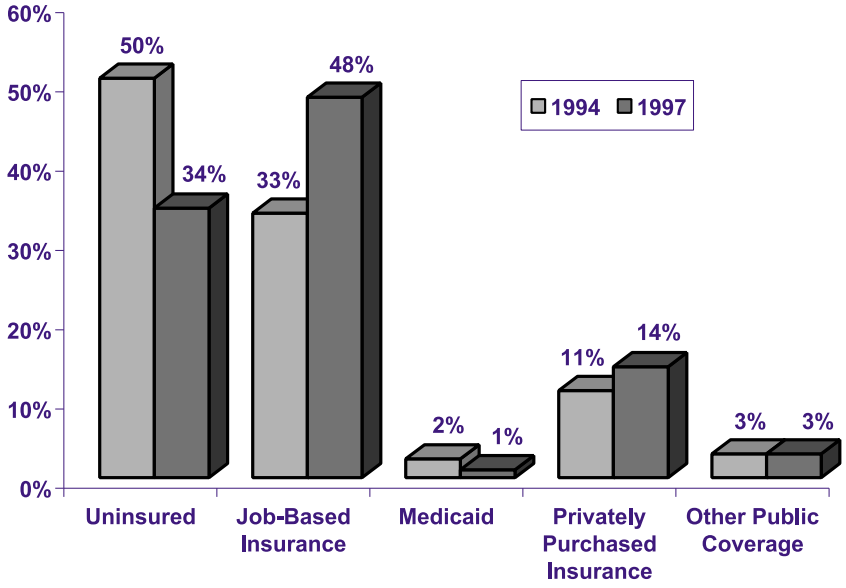
Source: March 1995 and 1998 Current Population Survey

One-third of Koreans are still uninsured

Koreans' very high uninsured rate (34%) in 1997 was, in fact, a considerable improvement over the 1994 rate of 50% (Exhibit 4-5). This improvement is related to a substantial increase in job-based coverage, which rose from 33% in 1994 to 48% in 1997, and a not-statistically-significant increase in the private purchase of health insurance (from 11% to 14%). These improvements in coverage are benefits of the strong economy, as the proportion of Koreans in nonworking families fell from 22% to 12%, while the proportion in families whose primary breadwinner was a full-time full-year employee increased (but not significantly) from 52% to 58%.

[30] *Immigrants and Welfare Resource Manual: 1998 Edition*, Los Angeles: National Immigration Law Center, 1998, p. 1; and Perry, Stark, and Valdez, *Barriers to Medi-Cal Enrollment and Ideas for Improving Enrollment*, 1998.

Exhibit 4-5. Changes in Health Insurance Coverage Among Koreans, Ages 0-64, United States, 1994-1997



Source: March 1995 and 1998 Current Population Survey

High rates of both self-employment and employment in small firms continue to limit Koreans' access to job-based health insurance, the source of coverage for most nonelderly Americans. Self-employed workers must privately purchase coverage, the most costly way to obtain health insurance. Small firms are the least likely to offer job-based insurance: Among all AAPIs, only 35% of those with primary earners in very small firms (less than 10 employees) have job-based coverage, compared to 82% of those with primary earners employed in firms with 500 or more workers (see Appendix A, Exhibit A8).

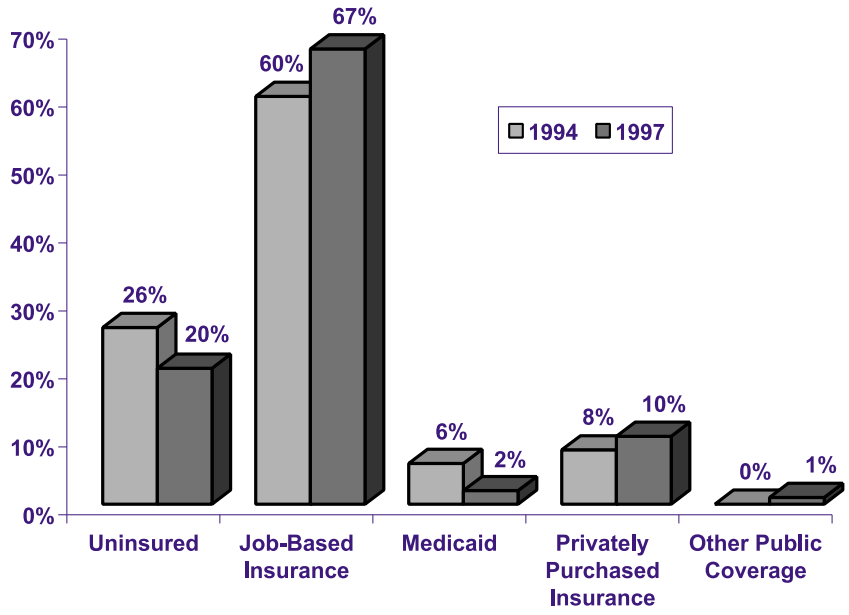
Chinese still disadvantaged in spite of recent gains

Between 1994 and 1997, the uninsured rate for Chinese declined from 26% to 20%, as job-based coverage rose (Exhibit 4-6), a result of growing employment and increasing incomes. (The increase in privately purchased insurance was not statistically significant.) Despite these improvements, however, Chinese continue to have lower job-based coverage than whites (67% vs. 73%) and lower participation rates in Medicaid (2% vs. 6%), resulting in a continuing disparity in uninsured rates (20% for Chinese vs. 14% for whites).

Lower rates of job-based insurance may be due, in part, to a higher proportion of Chinese in nonworking families (17% for Chinese vs. 7% for whites; data not shown). But lower Medicaid participation rates are likely due, in large part, to widespread concerns among immigrants that enrolling themselves or their children in Medicaid would jeopardize their applications for citizenship. For example, even among U.S. citizens who live in families with children and have family incomes below 200% of poverty (i.e., those who are most likely to be eligible

for Medicaid), only 13% of Chinese have Medicaid coverage compared to 24% of whites (data not shown).

Exhibit 4-6. Changes in Health Insurance Coverage Among Chinese, Ages 0-64, United States, 1994-1997

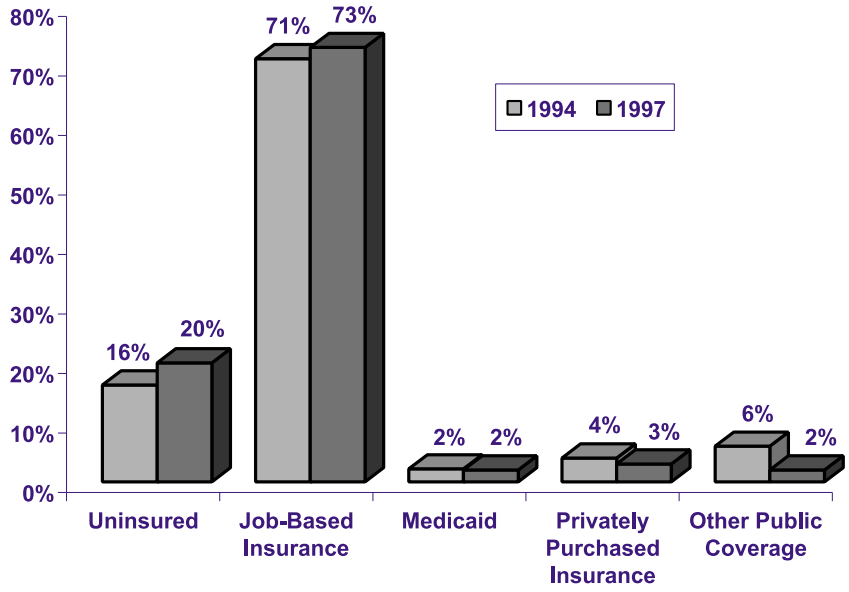


Source: March 1995 and 1998 Current Population Survey

Filipinos less likely to have Medicaid, more likely to be uninsured

Although Filipinos have essentially the same job-based coverage rate as whites (74% and 73%, respectively), they are less likely to have Medicaid coverage (2% vs. 6%) and thus have a higher uninsured rate than whites (20% vs. 14%). For Filipinos, job-based coverage rates rose slightly (but not significantly) from 71% in 1994 to 73% in 1997 (Exhibit 4-7). Although rates of Medicaid and privately purchased coverage remained the same during this period, other sources of public coverage declined by four percentage points, pushing up Filipinos' uninsured rate from 16% in 1994 to 20% in 1997, but this was not a statistically significant change. These trends may in part be explained by a demographic shift towards uninsurance among younger Filipinos as compared to an older generation who were more likely to be covered by military/Champus/VA.

Exhibit 4-7. Changes in Health Insurance Coverage Among Filipinos, Ages 0-64, United States, 1994-1997



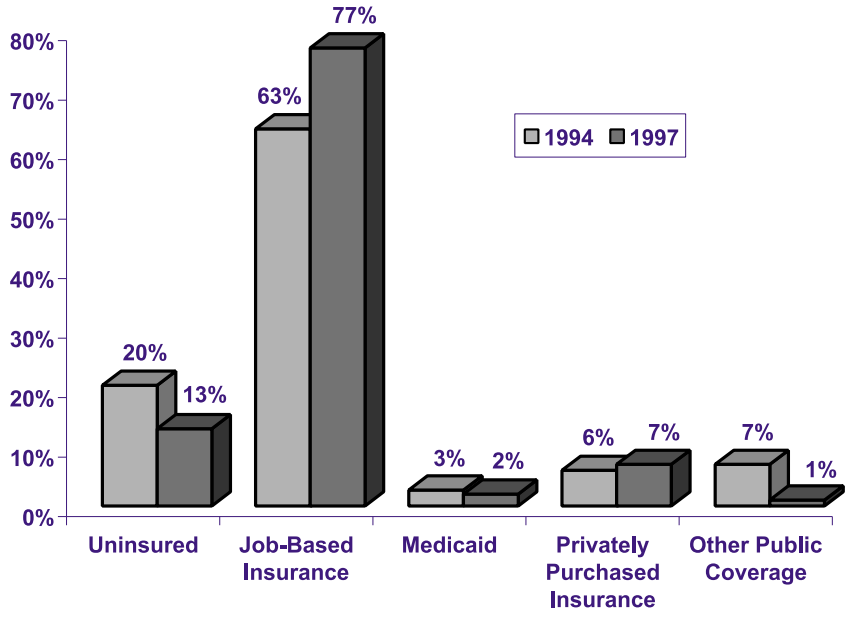
Source: March 1995 and 1998 Current Population Survey

Japanese and third-plus-generation AAPIs are protected by high employment, high income

Japanese have a high rate of employment-based insurance (but not significantly different from that of whites). This high rate of job-based coverage is offset by a lower rate of Medicaid coverage (2% of Japanese vs. 6% of whites), resulting in comparable uninsured rates (13% of Japanese vs. 14% of whites; Exhibit 4-2).

Japanese experienced an increase in job-based coverage between 1994 and 1997, from 63% to 77% (Exhibit 4-8). While Medicaid and privately purchased insurance rates remained the same during this time period, other forms of public coverage dropped from 7% to 1%. Similar to Filipinos, this drop in public coverage may be partially attributable to a generational shift away from military/Champus/VA coverage. Nevertheless, the increase in job-based coverage rates among Japanese was large enough to more than offset the drop in other public coverage, resulting in a not-statistically-significant drop in the uninsured rate from 20% to 13%.

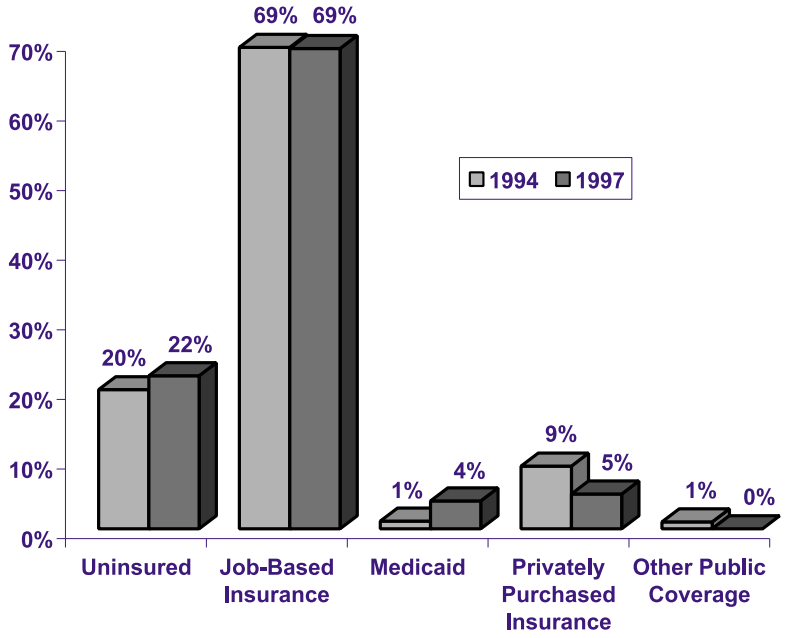
Exhibit 4-8. Changes in Health Insurance Coverage Among Japanese, Ages 0-64, United States, 1994-1997



Source: March 1995 and 1998 Current Population Survey

South Asians apparently did not experience the benefits of the strong economy to the same extent as most other groups. Their job-based insurance rate did not increase between 1994 and 1997, remaining steady at 69% (Exhibit 4-9), unlike the experience of other AAPI subgroups. At the same time, South Asians' privately purchased coverage apparently declined (but not significantly) from 9% to 5%. Although their Medicaid coverage increased from 1% to 4%, that did not fully offset declining privately purchased coverage, resulting in their uninsured rate inching up (not significantly) from 20% to 22%.

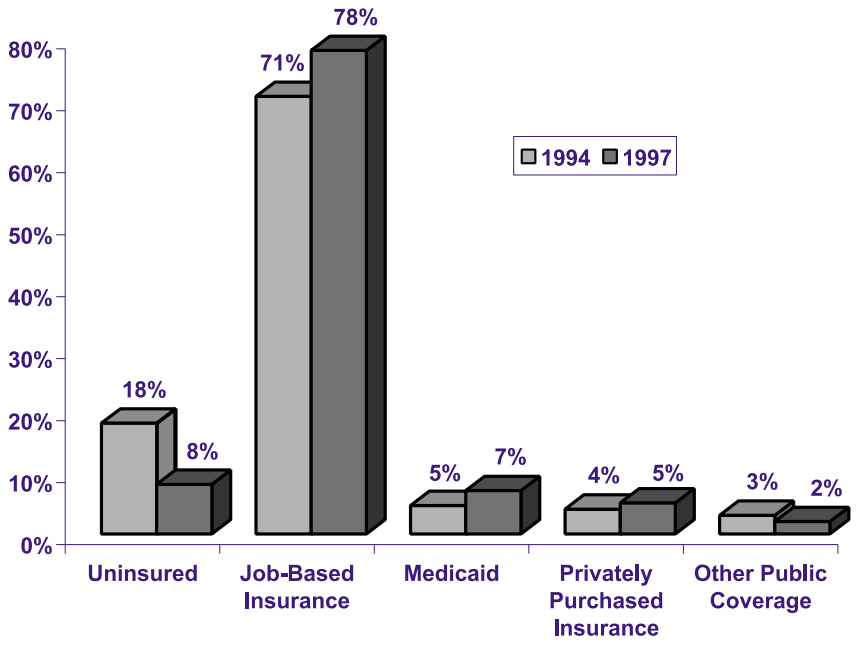
Exhibit 4-9. Changes in Health Insurance Coverage Among South Asians, Ages 0-64, United States, 1994-1997



Source: March 1995 and 1998 Current Population Survey

Third-plus-generation AAPIs have the most favorable health insurance coverage profile of all AAPI subgroups, and their coverage also is more favorable than that of whites. Third-plus-generation AAPIs have slightly higher job-based insurance rates than whites (78% vs. 73%; Exhibit 4-10), resulting in lower uninsured rates (8% vs. 14%). Among third-plus-generation AAPIs, job-based coverage rates increased from 71% in 1994 to 78% in 1997, while Medicaid coverage also increased (not significantly) from 5% to 7%, resulting in a decline in their uninsured rate from 18% to 8%—the lowest rate among all groups examined in this study.

Exhibit 4-10. Changes in Health Insurance Coverage Among Third-Plus-Generation Asian Americans and Pacific Islanders, Ages 0-64, United States, 1994-1997



Source: March 1995 and 1998 Current Population Survey

Access to Care

In this section of the report, we examine Asian Americans' and Pacific Islanders' connection to the health care system and their use of health care services, with a focus on the effects of health insurance coverage. We report on the proportion of AAPIs with a regular person or place where they receive care, an important component in the receipt of ongoing, consistent care and a factor that affects the probability of obtaining health services at all. We also examine the use of physician services. For children, we use a modified version of the American Academy of Pediatrics guidelines and present minimum expectations for a physician visit: examination by a physician in the past year for children ages 0-5 and at least a biannual visit for children ages 6-17 (see Appendix B for fuller description). For adults, we connect visits to reported health status, and expect that adults in fair to poor health will not go longer than one year without seeing a physician and that adults in good to excellent health will not go longer than two years without a physician visit.

Using the NHIS, we report both aggregated data and data for a number of AAPI ethnic subgroups (see discussion of AAPI subgroups used in the NHIS in Appendix B). Although AAPIs overall have lower death rates compared to whites,

there are several health risks for this group related to high rates of cervical cancer, diabetes, accidents and unintentional injuries, pneumonia, and influenza.[31] In the face of these significant risks, AAPIs experience important barriers in their access to health care compared to whites.

Lack of insurance severely affects AAPIs' connection to the health care system

AAPI children are more likely than white children to lack a regular connection to the health care system (8% vs. 4%; Exhibit 4-11). Among AAPI children, having health insurance coverage is critical to ensure a regular doctor or place where they receive care. One-third (33%) of uninsured AAPI children have no regular source of care, compared to only 4% of AAPI children with coverage. Uninsured AAPI children have less connection to the health care system than uninsured white children, suggesting that fewer safety net options are accessible to uninsured AAPIs.

AAPI adults also are less likely than white adults to have a regular source of care (Exhibit 4-11). One out of five AAPI adults (20%) reports no regular person or place they routinely use for health care, compared to 15% of white adults. As with AAPI children, AAPI adults benefit considerably from having insurance; half of uninsured AAPI adults are without a usual source of care, compared to 13% of those with insurance.

Exhibit 4-11. Percent With No Usual Source of Care by Age Group and Health Insurance Status, Asian American and Pacific Islander, Ages 0-64, United States, 1995-1996

	Asian American and Pacific Islander	Non-Latino White
Children 0-17	**8%**	**4%**
Uninsured	33%	16%
Medicaid	*	4%
Job-Based/Private Insurance	4%	3%
Adults 18-64	**20%**	**15%**
Uninsured	52%	36%
Medicaid	*	10%
Job-Based/Private Insurance	13%	11%

Source: 1995 and 1996 National Health Interview Surveys
*Sample size too small for reliable estimate.

[31] Collins KS, Hall A, Neuhaus C, *U.S. Minority Health: A Chartbook*, New York: The Commonwealth Funds, May 1999.

Insurance coverage significantly improves connection to health care system across AAPI subgroups

This benefit of insurance is seen across AAPI ethnic subgroups. The proportion of nonelderly without a usual source of care ranges from 9% of Filipinos to 26% of Koreans, with large disparities between those with insurance and those who are uninsured. This variation in usual source of care parallels the health insurance coverage findings, with Koreans the least likely to have coverage.

The importance of coverage for each ethnic subgroup is illustrated below (Exhibit 4-12). Consistently within each ethnic subgroup, those who are insured are much more likely to have a usual person or place where they receive care than those without coverage.

Exhibit 4-12. Percent With No Usual Source of Care by Health Insurance Status, Asian American and Pacific Islander Subgroups, Ages 0-64, United States, 1994-1995

	Chinese	Filipino	Korean	Vietnamese	Japanese	South Asian	All Other AAPIs
All ages 0-64	21%	9%	26%	18%	15%	21%	19%
Uninsured	53%	34%	48%	42%	52%	40%	46%
Insured	12%	4%	13%	10%	10%	15%	13%

Source: 1994 and 1995 National Health Interview Surveys

For both young and school-age Asian American and Pacific Islander children, insurance coverage improves health care use

For children ages 0-5, physician visit rates are similar between AAPIs and whites, with 8% and 5%, respectively, lacking a physician visit during the past year (Exhibit 4-13). Among young AAPI children, the 8% without a physician visit in a 12-month period will miss scheduled immunizations, and are less likely to have the advantage of ongoing physical, social and developmental monitoring that are an important component of these visits.

Among school-age AAPI children, 12% have not seen a physician in the past two years, compared to 7% of their white counterparts. One out of five uninsured AAPI children (19%) has not had a physician visit in the past two years, twice the rate seen for AAPI children with coverage.

Exhibit 4-13. Percent of Children Who Have Not Obtained Minimum Number of Doctor Visits by Age Group and Health Insurance Status, Asian Americans and Pacific Islanders and Non-Latino Whites, Ages 0-17, United States, 1995-1996

	Asian American and Pacific Islander	Non-Latino White
Ages 0-5*	**8%**	**5%**
Uninsured	**	12%
Medicaid	**	4%
Job-Based/Private Insurance	**	4%
Ages 6-17*	**12%**	**7%**
Uninsured	19%	17%
Medicaid	**	6%
Job-Based/Private Insurance	9%	6%

Source: 1995 and 1996 National Health Interview Surveys
* Examination by a physician in the past year for children ages 0-5 and at least a biannual visit
for children ages 6-17.
**Sample size too small for reliable estimate.

Among AAPI adults in fair to poor health, a considerable portion have not had a recent physician visit

Overall, AAPI women and men who are in fair to poor health, and thus experiencing health problems, are at least as likely as their white counterparts to have been without a doctor visit in a 12-month period (Exhibit 4-14). For these AAPI adults with health problems, 8% of women and 17% of men went for more than one year without seeing a physician.

Exhibit 4-14. Percent of Adults in Fair to Poor Health Who Have Not Had a Doctor Visit in Past Year by Gender and Health Insurance Status, Asian Americans and Pacific Islanders, Ages 18-64, United States, 1995-1996

	Asian American and Pacific Islander	Non-Latino White
Women	**8%**	**6%**
Uninsured	*	13%
Medicaid	*	3%
Job-Based/Private Insurance	*	5%
Men	**17%**	**14%**
Uninsured	*	29%
Medicaid	*	6%
Job-Based/Private Insurance	*	12%

Source: 1995 and 1996 National Health Interview Surveys
*Sample size too small for reliable estimate.

AAPI men in good to excellent health, especially those uninsured, are the least likely to have had a physician visit

AAPI women and men in good to excellent health—the population whose main visits would likely be for acute problems and for screening services and prevention—are less likely to have been to a physician in a two-year period than their white counterparts (Exhibit 4-15).

AAPI men in good to excellent health are twice as likely as their female counterparts to have not visited the doctor in the past two years (30% vs. 15%). And those men who are uninsured have even less contact with the health care system; half (52%) have not had a visit in the past two years. This difference by insurance is also seen for AAPI women; among those who are uninsured, 27% of women have not had a visit in the past two years, compared to 12% of those with coverage.

Exhibit 4-15. Percent of Adults in Good to Excellent Health Who Have Not Had a Doctor Visit in Past Two Years by Gender and Health Insurance Status, Asian Americans and Pacific Islanders, Ages 18-64, United States, 1995-1996

	Asian American and Pacific Islander	Non-Latino White
Women	**15%**	**8%**
Uninsured	27%	18%
Medicaid	12%	5%
Job-Based/Private Insurance	12%	7%
Men	**30%**	**20%**
Uninsured	52%	35%
Medicaid	24%	17%
Job-Based/Private Insurance	24%	18%

Source: 1995 and 1996 National Health Interview Surveys

Across Asian American and Pacific Islander subgroups, uninsured less likely to have physician visit

For each AAPI subgroup, children and adults who are insured are more likely to have met the physician visit criterion than those without coverage (Exhibit 4-16). For example, among uninsured Chinese children ages 0-17, 35% have not had met physician visit criterion (a visit in the past year if ages 0-5 or in the past two years if ages 6-17). Among insured Chinese, the proportion not meeting the criterion drops to 10%. Other AAPI ethnic subgroups exhibit these same disparities by insurance coverage.

Exhibit 4-16. Percent of Children and Adults Who Have Not Met Physician Visit Criterion, Asian American and Pacific Islander Subgroups, Ages 0-64, United States, 1994-1995

	Chinese	Filipino	Korean	Vietnamese	Japanese	South Asian	All Other AAPIs
Children 0-17*	14%	7%	12%	11%	7%	12%	18%
Uninsured	35%	12%	26%	26%	17%	29%	30%
Insured	10%	6%	5%	8%	6%	6%	16%
Adults 18-64**	27%	16%	29%	23%	19%	22%	26%
Uninsured	42%	22%	48%	38%	48%	31%	39%
Insured	22%	15%	19%	17%	15%	18%	23%

Source: 1994 and 1995 National Health Interview Surveys
*Physician visit past year for children ages 0-5 and past two years for children ages 6-17.
** Physician visit past year for adults in fair or poor health and past two years for adults in good to excellent health.

Conclusions

Health Insurance Coverage

Asian Americans and Pacific Islanders (AAPI) are a highly diverse population. AAPI ethnic subgroups vary in language, cultural characteristics, citizenship status, and other socioeconomic characteristics, with variations related to their national origins, circumstances of immigration, and whether they are first-, second-, or third-plus-generation residents of the United States.

Aggregated AAPI data on health insurance coverage and access to health services suggest that AAPIs are the least disadvantaged minority group in the U.S. Yet, a number of AAPI ethnic subgroups experience serious barriers to health insurance coverage and to obtaining health services, resulting in significant disparities between these AAPI groups and non-Latino whites.

AAPIs who are citizens have only slightly lower rates of job-based coverage and only slightly higher uninsured rates than whites. Noncitizens, on the other hand, have considerably poorer coverage, with only 54% having job-based insurance, offset by only slightly higher rates of privately purchased insurance, resulting in an uninsured rate that is about twice that of AAPIs who are citizens.

Uninsured rates range widely among AAPI ethnic subgroups. One in three Koreans is uninsured, a rate that is four times the uninsured for third-plus-generation AAPIs. One in four Southeast Asians is uninsured, as are one in every five South Asians, Chinese, and Filipinos. These disparities in uninsurance result from wide differences in job-based coverage, ranging from just under half of Koreans and Southeast Asians to a high of more than three-fourths of Japanese and third-plus-generation AAPIs. These disparities reflect differences across groups in citizenship/immigrant status, educational attainment, and economic and labor force characteristics. High rates of both self-employment and

employment in small firms continue to limit Koreans' access to job-based health insurance, the source of coverage for most nonelderly Americans.

Medicaid coverage is generally low among the AAPI population, ranging from just 1% to 2% of Chinese, Japanese, Filipino, and Koreans to nearly one in five Southeast Asians. The higher Medicaid coverage of Southeast Asians reflects both their high poverty rates and the high proportion of refugees among Southeast Asians in the U.S., providing them with access to more generous Medicaid eligibility.

Access to Health Services

AAPI children and adults are less likely than whites to have a regular source of care. These AAPI-white differences are greatly exacerbated for both children and adults who are uninsured.

Some disparities between AAPIs and whites in access to a regular source of care are replicated for physician visits. Compared to whites, AAPI children ages 6-17 are more likely not to obtain the recommended minimum number of doctor visits. These AAPI-white differences are also found for adults, including those in fair to poor health as well as those in better health. For those groups for whom sample size permits an examination by insurance status, we find that AAPI-white disparities are largest among the uninsured. Among adults in good to excellent health, AAPI men and women are less likely to have visited a physician in the past two years than their white counterparts. The uninsured have even worse access: one in four uninsured AAPI women and half of AAPI uninsured men have not visited a physician in the past two years, reducing their opportunities to obtain important screening tests and other preventive services.

Policy Implications

Although many AAPIs are insured and obtaining health services at recommended intervals, many remain uninsured and deprived of the access to services that they need. The result is inevitably poor diagnosis and management of chronic diseases. The one in four uninsured AAPI women in good to excellent health who have not had a physician visit in two years are likely among the many AAPI women with low rates of cancer screening.

For many AAPIs, high rates of self-employment and employment in small firms is at the root of their lack of health insurance. Coverage will be elusive for these workers and their families in the absence of employer mandates or alternatives that extend affordable health insurance to those who do not receive employer-sponsored and -subsidized health benefits.

Public policy alternatives could assist many of them, particularly those with lower incomes. Expanding Medicaid and the new Children's Health Insurance Program (CHIP) to fully include adults in the families of eligible children would offer affordable options for these families. Some states, such as Washington and Tennessee, have developed state programs to provide substantial health insurance subsidies for childless working adults, as well as for families with children. The recent curtailment of Medicaid eligibility for immigrants, enacted with welfare reform, will exacerbate, rather than ameliorate, these problems.

American Indians and Alaska Natives[32]

American Indians and Alaska Natives (AI/ANs) experience significant disparities for most health indicators. AI/AN infant mortality rates are nearly one and a half times those of whites, with high death rates due to sudden infant death syndrome, congenital anomalies, and pneumonia and influenza.[33] The health status of many AI/AN adults is further jeopardized by high rates of diabetes, obesity (especially among women), cigarette smoking, and alcohol abuse, including binge drinking, and chronic drinking.[34] Although many factors contribute to these health problems, comprehensive health care coverage could ameliorate and help prevent them through effective medical care, counseling, and health education programs.

The Special Situation of American Indians and Alaska Natives

The United States government has a trust responsibility[35] to provide health care to all federally recognized American Indians and Alaska Natives. While there are at least 2.4 million self-identified AI/ANs,[36] not all are affiliated with tribes recognized by the federal government. Since 1955, Indian Health Service (IHS), an agency within the U.S. Department of Health and Human Services, has provided and administered health services for much of the AI/AN population, specifically, those whose tribes are federally recognized.[37]

AI/ANs' access to coverage and services is complex and limited

[32] Delight Satter, manager of the American Indian and Alaska Native Program in the UCLA Center for Health Policy Research, provided substantial assistance with the policy context for this section.

[33] *Health, United States, 1998*, Hyattsville, MD: National Center for Health Statistics, 1998, p. 190.

[34] *Trends in Indian Health, 1997,* Indian Health Services, Department of Health and Human Services, Rockville, MD; Indian Health Service, *Regional Differences in Indian Health, 1997,* Rockville, MD: U.S. Department of Health and Human Services, 1997.

[35] The relationship between the federal government and American Indian and Alaska Native people is based on treaty obligations, case law, the Snyder Act of 1921 (PL 83-568), the Indian Health Care Improvement Act (PL 94-437), and other public policies. (Pevar SL, *The Rights of Indians and Tribes: The Basic ACLU Guide to Indian and Tribal Rights*, 2nd Ed. Carbondale, IL. Southern Illinois University Press, 1992).

[36] U.S. Census Bureau, "Resident Population Estimates of the United States by Sex, Race, and Hispanic Origin: April 1, 1990 to June 1, 1999," Population Estimates Program, Population Division, Washington D.C.: July 1999 (http://www.census.gov/population/estimates/nation/intfile3-1.txt).

[37] Many tribes have elected to manage their own health care systems, under compacts with the IHS.

[38] This percentage is widely recognized to be an undercount, due to a number of factors, such as misclassification and sampling issues. (Indian Health Service, *Adjusting for Miscoding of Indian Race on State Death Certificates*, Rockville, MD: U.S. Department of Health and Human Services, 1996.)

American Indians and Alaska Natives face many barriers to accessing Indian Health Services. It is estimated that AI/ANs comprise approximately 1% of the total U.S. population.[38] They are dispersed through much of the nation, but especially concentrated in California, Oklahoma, Arizona, New Mexico, Alaska, Washington, North Carolina, Texas, New York, Michigan, and South Dakota. The geographic dispersion of the relatively sparse AI/AN population throughout reservations and urban areas would challenge any agency. With a few exceptions, IHS clinics and hospitals are located on reservations, primarily in rural areas. Even these facilities are often under-funded, under-staffed and may offer a more narrow range of services than Medicaid or private insurance plans. In locations where the IHS does not have its own facilities, or is not equipped to provide a needed service, the IHS contracts with local hospitals, state and local health agencies, tribal health institutions, and individual health care providers.[39]

Moreover, because of their location on or near reservations, IHS services are not very accessible to urban Indians who make up 55%-70% of the AI/AN population. Indians who are eligible for IHS services, but who live in urban areas or do not reside on their tribal reservation, are ineligible for contract care, with rare exceptions. To obtain IHS care, the individual would have to travel to their home reservation. The Indian Health Care Improvement Act (PL 94-437), enacted in 1975, requires the U.S. Department of Health and Human Services to contract with urban Indian organizations to provide health programs for urban Indians. However, just $25 million was appropriated for urban Indian health services in 1997, 1.4% of the $1.8 billion IHS health services budget. The limited resources of this program are reflected in the absence of even one AI/AN health clinic in Los Angeles County, the urban area with the greatest number of AI/ANs.[40]

In addition to the barriers created by geographic dispersion of the population and insufficient resources for IHS services as well as tribal-specific eligibility policy, only members of federally recognized tribes are eligible for IHS services. While 554 tribes are currently recognized by the federal government, many other tribes are recognized solely by their home states and not the federal government, leaving their members ineligible for IHS services.[41]

It is important to note that population-based data on AI/ANs are very limited, a problem imposed by their relatively small numbers, their geographic dispersion, and misclassification in many surveys and databases, compounded by survey questions that do not adequately measure the complexity of AI/AN access problems.

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[39] Pevar,S.L., *The Rights of Indians and Tribes: The Basic ACLU Guide to Indian and Tribal Rights*.

[40] Personal Communication: Delight Satter, Program Manager, American Indian and Alaska Native Program, UCLA Center for Health Policy Research, August 27, 1999.

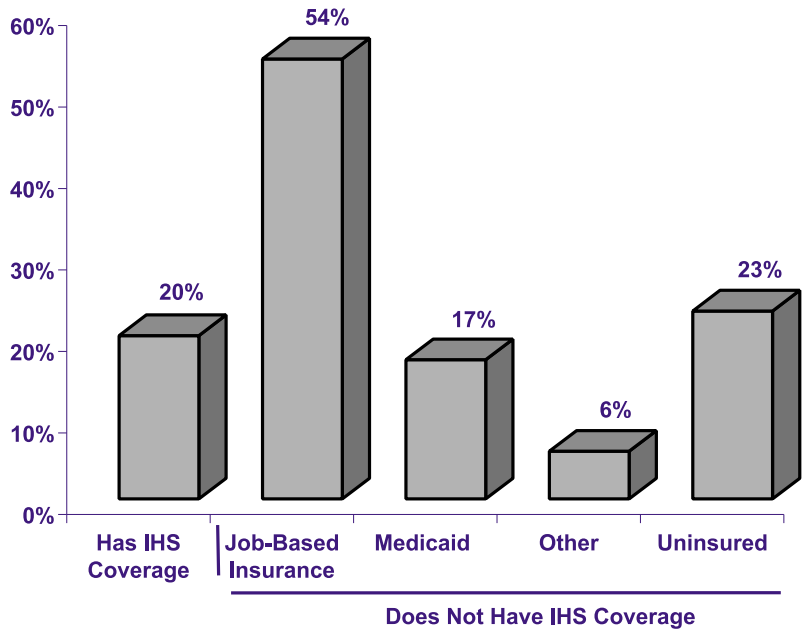
[41] Department of the Interior, Bureau of Indian Affairs.

Health Insurance Coverage

Contrary to widespread assumptions that most AI/ANs have access to IHS services, only one in five persons who identify themselves as American Indian or Alaska Native report having IHS coverage (Exhibit 5-1). (This low proportion may be due to several factors, including the ineligibility of tribes that are not federally recognized, perceived barriers to using IHS services, and the validity of questions about the IHS and the manner in which they are asked in the Current Population Survey.) Among those who do report having IHS coverage, one in three also receives employment-based or other private health insurance, and one in five also has Medicaid coverage (data not shown).

Among the 80% who report not having IHS coverage, 54% are covered by job-based insurance (Exhibit 5-1), compared to 73% of non-Latino whites (for brevity, "whites"). Another 17% are covered by Medicaid and 6% by other sources of public coverage or private health insurance. Almost one-fourth (23%) of AI/ANs who report not having IHS coverage remain without any health insurance at all, well above the uninsured rate for whites (14%).

Exhibit 5-1. Health Insurance Coverage for American Indians and Alaska Natives by Indian Health Service Coverage, Ages 0-64, United States, 1997



Source: March 1998 Current Population Survey

American Indians and Alaska Natives, like many other ethnic minorities, are seriously disadvantaged by low family incomes. Half (50%) of all nonelderly AI/ANs are poor or near poor (data not shown), with family incomes below 200% of the federal poverty level, twice the rate for whites (23%). Essentially the same proportion of AI/ANs who report not having IHS coverage are poor or near poor

(47%), a group that clearly would not have the financial resources to obtain health insurance or health care services without access to employment-based insurance (that does not require a substantial employee contribution), Medicaid, or other public coverage.

American Indians and Alaska Natives did not experience the gains from improvements in the economy and employment levels that many other groups did . The proportion who are full-time full-year employees remained unchanged between 1994 and 1997 (data not shown). Similarly, the proportion with employment-based health insurance also remained constant during this period, although uninsured rates declined moderately from 22% to 18% as Medicaid coverage rose from 14% to 17% (data not shown). Tribes may have intensified their efforts to enroll their eligible members in Medicaid, but lack of adequate data makes it difficult to confirm or reject any explanation for this trend.

Access to Care

While AI/ANs' uninsured rate is slightly lower than for other ethnic groups and similar to that of whites, AI/ANs face significant access barriers to receiving health care services. Some experience barriers due to a lack of coverage, while others have coverage but experience cultural barriers, long travel times, or other barriers to receiving care.

In this section of the report, we examine American Indian and Alaska Natives' connection to the health care system and their use of health care services. We report on the proportion of AI/ANs with a regular person or place where they receive care, an important component in the receipt of ongoing, consistent care. We also examine use of health care services, using a conservative criterion for children: examination by a physician in the past year for children ages 0-5 and at least a biannual visit for children ages 6-17.[42] For adults, we connect visits to reported health status, and expect that adults in fair to poor health should not go longer than one year without seeing a physician and that adults in good to excellent health should not go for longer than two years.

Insurance coverage improves access to care for American Indians and Alaska Natives

Having a regular connection to the health care system is important in ensuring access for ongoing prevention services and care when sick. Having health insurance coverage further increases the likelihood of having a regular connection to health care services. However, more than a third of uninsured American Indians and Alaska Natives (35%) report that they

[42] The American Academy of Pediatrics (AAP) recommends annual visits for children and adolescents ages 24 months through age 17 (except for children ages 7 and 9), and more frequent visits for children under 24 months of age. Thus our criteria of at least one physician visit in the past year for children under the age of 5 and a visit at least every two years for children ages 6-17 is a reasonable, somewhat conservative, estimate of minimal requirements. See American Academy of Pediatrics, "Recommendations for Preventive Pediatric Health Care," *Pediatrics* 1995; 96:712.

do not have a usual source of care, more than three times the proportion of those who have some form of health insurance coverage or participate in the Indian Health Service (Exhibit 5-2).

Exhibit 5-2. Percent With No Usual Source of Care by Health Insurance Status, American Indians and Alaska Natives, Ages 0-64, United States, 1994-1995

Health Insurance Status	No Usual Source of Care
IHS*	5%
Other Insurance**	11%
Uninsured	35%

Source: 1994 and 1995 National Health Interview Surveys
* IHS only and IHS and other insurance
** Includes private, employer-based insurance, Medicaid, and Medicare

Uninsured AI/AN children and adults less likely to meet physician criteria, but those with IHS coverage do not face as those with other coverage

Among AI/AN children and adults combined, the uninsured are less likely to have met the physician visit criterion than those who have any type of coverage (Exhibit 5-3). Ironically, AI/ANs who are covered by only the Indian Health Service, in comparison to those with other forms of coverage, were more likely to be able to identify a usual source of care but less likely to have obtained the minimum number of doctor visits for their age group and health status (Exhibit 5-3).

Exhibit 5-3. Percent of Children and Adults Who Have Not Met Physician Visit Criteria* by Health Insurance Status, American Indians and Alaska Natives, Ages 0-64, United States, 1994-1995

Health Insurance Status	Not Met Physician Visit Criteria
IHS Only	17%
IHS & Other Insurance**	12%
Other Insurance**	10%
Uninsured	29%

Source: 1994 and 1995 National Health Interview Surveys
* At least one physician visit in past year for children ages 0-5 and in past two years for children ages 6-17, and past year for adults in fair or poor health and past two years for adults in good to excellent health.
**"Other insurance" includes private, employer-based insurance, Medicaid, and Medicare

Conclusions

Health Insurance Coverage

The United States government has a trust responsibility to provide health care to federally recognized American Indians and Alaska Natives (AI/ANs)—a responsibility that Indian Health Service (IHS) has partially fulfilled since 1955. However, contrary to widespread assumptions that most AI/ANs have access to IHS services, only one in five persons who identify themselves as American Indian or Alaska Native report having IHS coverage. Among those who do report having IHS coverage, one in three also receives employment-based or other private health insurance, and one in five also has Medicaid coverage.

AI/ANs, like many other ethnic minorities, are seriously disadvantaged by low family incomes. Half (50%) of all nonelderly AI/ANs are poor or near poor, with family incomes below 200% of the federal poverty level, twice the rate for whites (23%). Lack of employment opportunities and low incomes limit AI/ANs' options for obtaining coverage other than that provided by the IHS.

Access to Care

Insurance coverage improves access to care for AI/ANs. However, more than a third of uninsured AI/ANs (35%) report that they do not have a usual source of care, more than three times the proportion of those who have any type of health insurance coverage or participate in the Indian Health Service.

Uninsured AI/AN children and adults less likely to meet the physician visit criterion, but those with IHS coverage do not fare as well as those with other coverage. This pattern may be due to the dearth of IHS services available to AI/ANs who are not members of federally recognized tribes, those who live in urban areas, and those who live some distance from their tribe's reservation.

Policy Implications

Data on health insurance coverage and access to care for AI/ANs is severely limited. The absence of adequate data limits policy makers' understanding of AI/ANs' health needs, advocates' ability to document these needs, and researchers' ability to enhance our understanding of these issues.

Nevertheless, available data suggest that IHS and tribal health care services are inadequate to compensate for low rates of other coverage and to provide minimally adequate access to health care.

Conclusion

Health insurance coverage is central to reducing financial barriers and promoting access to health care services. Lack of health insurance and poor access to timely health services deprive many ethnic and racial minorities of the benefits that regular medical care and preventive health services offer. Disparities in health insurance coverage and access to health care services thus contribute to and exacerbate disparities in health status. These disparities should be a concern to the entire nation because ethnic and racial minorities comprise a growing proportion of the U.S. labor force and of the total population—projected to rise from 28% of the population in 2000 to 38% in 2025 and 47% in 2050.[43]

During the latter 1990s, job-based insurance coverage increased for many groups, a result of the sustained strength of the economy that generated both improved employment opportunities and higher incomes. However, large numbers of persons—particularly those with lower levels of educational attainment—have not received equal benefits from the economy. In addition, the implementation of welfare reform and other policy changes has reduced Medicaid coverage, offsetting the increases in job-based coverage for many persons. The recent period of economic growth thus has been associated with only slight increases in job-based insurance and with greater declines in Medicaid coverage, which combined to drive up uninsured rates.[44]

Each ethnic group considered in this report experiences these trends somewhat differently. But, compared to non-Latino whites, all have lower rates of employment-based health insurance and higher uninsured rates. Latinos experience the highest uninsured rates. The many Latinos who have low educational attainment and low incomes are less likely to be offered job-based insurance or to find it affordable when it is offered. Latinos who are non-citizens find themselves excluded from Medicaid or fear that enrolling themselves or their children in Medicaid or other public health care coverage programs will adversely affect their immigration status or citizenship application. The enormous diversity among Asian Americans and Pacific Islanders translates to wide variations in their educational levels, incomes, immigration status, and health insurance. Their health insurance coverage ranges from relatively good for first- and second-generation Japanese and third-plus-generation AAPIs overall to very poor for first- and second-generation Koreans and Southeast Asians. Nearly one in four nonelderly African Americans is uninsured, reflecting low average incomes and low rates of job-based insurance, as well as recent declines in Medicaid coverage. Despite the inadequate data on American Indians and

[43] *Resident Population of the United States: Middle Series Projections, 1996–2000, 2015–2030, and 2035–2050, by Sex, Race, and Hispanic Origin, with Median Age, U.S. Bureau of the Census, March 1996* (U.S. Department of Commerce, Bureau of the Census: http://www.census.gov/population/ www/projections/ natproj.html).

[44] A new report on health insurance coverage from the U.S. Census Bureau demonstrates that this is a continuing problem. See Campbell JA, *Health Insurance Coverage: 1998* (P60-208), Washington, D.C.: U.S. Bureau of the Census, October 1999.

Alaska Natives, it is clear that the limited coverage provided by the Indian Health Service does not fully compensate for low rates of job-based insurance coverage. For most of these groups, federal and state policies and their implementation apparently have driven down Medicaid coverage faster than private job-based insurance has been rising.

Across all ethnic groups, lack of health insurance results in weak connections to the health care system and poor access to health services. Because uninsured persons in fair or poor health visit physicians less often than their insured counterparts, they are less likely to receive care needed to manage their chronic conditions, such as diabetes or high blood pressure. Uninsured children and adults, whether in good or poor health, are less likely to receive preventive health services or care for acute conditions.

Public policy could compensate for limitations in the United States' voluntary employment-based health insurance system. For the majority of uninsured persons, low incomes make insurance coverage unaffordable without substantial financial assistance. Overall, 57% of the uninsured are poor or near poor, with family incomes below 200% of the poverty level.[45] A national health care system that covered the entire population, or even one that mandated all employers to cover those who work for them and their dependents, would address the health insurance needs of this population.

In the absence of universal coverage, however, Medicaid or an alternative public program could provide more generous opportunities for working families and individuals to obtain subsidized health insurance coverage. Federal policy concerning eligibility for Medicaid and other public benefits affects Latinos and Asian Americans and Pacific Islanders more than other ethnic groups. Welfare reform policies that reduced eligibility for noncitizens have had an adverse effect both on noncitizens themselves and on citizen children in mixed-status families—families in which one or more parents is a noncitizen and one or more children is a citizen. Nearly 1 in 10 U.S. families with children is a mixed-status family, and among immigrant families (i.e., those with at least one noncitizen parent), 85 percent are mixed-status families. The children in these families are especially likely to be deprived of public benefits that have been available to other citizen children. As Michael Fix and Wendy Zimmerman of the Urban Institute note, welfare reform created two classes of citizen children: one class that lives in households with noncitizens and often loses benefits and overall household resources as a result; and a second class that lives in households with only citizens and suffers no comparable disadvantage.[46] Congress could modify these policies to restore legal immigrants' eligibility for public health care programs.

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[45] In 1997, poverty levels, which are standardized measures based on total family income and family size, were $8,350 for one person, $10,805 for two persons, and $12,802 for three person-families (U.S. Department of Commerce, Bureau of the Census: http://www.census.gov/hhes/poverty/threshld/thresh97.html).

[46] Fix M, Zimmerman W, *All Under One Roof: Mixed-Status Families in an Era of Reform*, Washington, D.C.: Urban Institute, June 1999.

States have many options to expand coverage for their uninsured populations. Federal law provides states the opportunity to cover working families with children to a greater extent than ever before, with generous matching federal financial support. The family coverage option of section 1931 of the Social Security Act allows states considerable flexibility in setting income eligibility for Medicaid to cover parents as well as children above the federal poverty level.[47] In addition, section 1115 allows states to obtain federal waivers in order to restructure their Medicaid programs and enable uninsured adults without children, as well as families above the current income eligibility limits, to buy into the program on a sliding scale.[48] These options, which could cover all low- and moderate-income workers and their families, would address the needs of many members of ethnic minority groups.

Local jurisdictions also could help expand coverage for ethnic minority and other workers. Some municipalities have adopted a "living wage" ordinance, both to raise living standards and to increase health insurance coverage. Some 14 cities and counties have adopted ordinances that require municipal contractors to pay a minimum wage above the federal (or state) minimum, and some of them require a higher minimum wage if the contractor does not provide and pay for health insurance benefits.[49] This policy directly affects a relatively small number of employees, but it sets a standard for employment compensation and health benefits that potentially could have broader effects.

It is not hyperbole to suggest that the future of the nation and its economy depend on the well being of all population groups. Effective public policies are needed and feasible to expand health insurance coverage and improve access to care.

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47 Guyer J, Mann C, *Taking the Next Step: States Can Now Take Advantage of Federal Medicaid Matching Funds to Expand Health Care Coverage to Low-Income Working Parents*, Washington: Center on Budget and Policy Priorities, August 1998. See also section 1931(b)(2)(c) of the Social Security Act.

48 Riley T, Pernice C, *How Are States Implementing Children's Health Insurance Plans?* Second edition. Portland, ME: National Academy for State Health Policy, September 1998. The waiver option is found in section 1115 of the Social Security Act.

49 Silverstein S, "Santa Monica Makes a Notably Aggressive 'Living Wage' Proposal," *Los Angeles Times*, September 28, 1999.

Appendix A. Detailed Tables

Exhibit A1. Population Distribution of Sociodemographic Characteristics by Race/Ethnicity, Ages 0-64, United States, 1997

	African American	Asian and Pacific Islander	Latino	American Indian and Alaska Native	Non-Latino White
Age					
Children Ages 0-17	36%	32%	38%	34%	28%
Adults Ages 18-64	64%	68%	62%	66%	72%
Women Ages 18-64	55%	53%	48%	49%	51%
Men Ages 18-64	45%	47%	52%	51%	49%
Citizenship					
Citizen	97%	67%	70%	NA	98%
Non-Citizen	3%	33%	30%	NA	2%
Family Income Relative to Federal Poverty Level					
Less than 100%	27%	14%	28%	26%	9%
100%-199%	24%	13%	31%	24%	14%
200%-299%	18%	18%	17%	18%	17%
300% or more	31%	54%	24%	32%	59%
Primary Breadwinner's Educational Attainment					
Less than 9 years	4%	7%	26%	7%	2%
9-12 years	16%	6%	20%	18%	7%
High school graduate	38%	21%	27%	36%	33%
Some college	29%	23%	19%	25%	29%
College graduate	13%	43%	9%	14%	29%
Family Type					
Single without children	28%	22%	22%	26%	23%
Married without children	8%	14%	9%	12%	19%
Married with children	29%	55%	50%	38%	47%
Single with children	35%	8%	19%	23%	11%
Region of Residence					
Northeast	17%	17%	14%	6%	20%
Midwest	18%	11%	8%	19%	27%
South	56%	18%	32%	28%	33%
West	9%	54%	46%	46%	20%

Source: March 1998 Current Population Survey

Exhibit A2. Population Distribution of Family Employment Characteristics by Race/Ethnicity, Ages 0-64, United States, 1997

	African American	Asian and Pacific Islander	Latino	American Indian and Alaska Native	Non-Latino White
Work Status*					
Full-Time Full-Year Employee	58%	69%	63%	53%	71%
Full-Time Part-Year Employee	12%	8%	13%	18%	9%
Part-Time Employee	10%	9%	8%	9%	8%
Self Employed	1%	5%	3%	3%	4%
Nonworking	18%	10%	14%	17%	7%
Industry*					
Agricultural/forestry/fish/mining	1%	1%	8%	2%	2%
Construction	4%	3%	8%	7%	8%
Durable Goods	9%	14%	11%	8%	12%
Nondurable Goods	8%	7%	10%	6%	7%
Trans/communication/utility	10%	7%	7%	6%	8%
Wholesale	2%	3%	4%	3%	4%
Retail	15%	17%	17%	12%	14%
Financial Service	6%	6%	4%	3%	7%
Business/personal/entertainment	12%	12%	13%	11%	9%
Professional Service	26%	24%	14%	18%	22%
Public Administration	7%	5%	4%	6%	6%
Firm Size*					
<10	8%	15%	18%	14%	14%
10-24	7%	7%	12%	8%	9%
25-99	11%	13%	17%	13%	14%
100-499	15%	13%	15%	19%	14%
500+	60%	51%	38%	46%	49%

Source: March 1998 Current Population Survey

* Employment characteristics are shown for primary wage earner in family.

Exhibit A3. Health Insurance Coverage by Demographic Characteristics, Latinos, Ages 0-64, United States, 1997

	Uninsured	Job-Based Insurance	Medicaid	Privately Purchased Insurance	Other Government Coverage
Latinos Overall	37%	43%	16%	2%	2%
Central and South Americans	42%	44%	11%	2%	1%
Cuban Americans	21%	54%	11%	11%	3%
Mexican Americans	39%	43%	16%	2%	2%
Puerto Ricans	21%	43%	30%	2%	4%
Age					
Children Ages 0-17	29%	40%	28%	2%	2%
Adults Ages 18-64	41%	46%	9%	2%	2%
Women Ages 18-64	36%	46%	13%	3%	2%
Men Ages 18-64	46%	45%	6%	2%	2%
Citizenship					
Citizen	27%	49%	20%	2%	2%
Non-Citizen	58%	31%	8%	2%	1%
Family Income Relative to Federal Poverty Level					
Less than 100%	43%	12%	41%	1%	2%
100%-199%	47%	36%	12%	2%	3%
200%-299%	32%	59%	5%	3%	2%
300% or more	18%	77%	1%	3%	1%
Primary Breadwinner's Educational Attainment					
Less than 9 years	50%	26%	20%	1%	2%
9-12 years	43%	30%	24%	1%	2%
High school graduate	34%	48%	14%	2%	2%
Some college	23%	61%	12%	3%	2%
College graduate	17%	74%	3%	5%	2%
Family Type					
Single without children	53%	35%	9%	2%	2%
Married without children	34%	56%	3%	4%	3%
Married with children	32%	52%	12%	2%	2%
Single with children	32%	25%	40%	1%	2%
Region of Residence					
Northeast	34%	39%	24%	1%	2%
Midwest	28%	55%	13%	1%	2%
South	38%	44%	12%	3%	2%
West	38%	42%	17%	2%	1%

Source: March 1998 Current Population Survey

Exhibit A4. Insurance Coverage by Family Employment Characteristics, Latinos, Ages 0-64, United States, 1997

	Uninsured	Job-Based Insurance	Medicaid	Privately Purchased Insurance	Other Government Coverage
Work Status*					
Full-Time Full-Year Employee	32%	58%	6%	2%	1%
Full-Time Part-Year Employee	47%	29%	21%	2%	1%
Part Time Employee	47%	25%	22%	3%	2%
Self Employed	63%	10%	15%	9%	3%
Nonworking	34%	6%	54%	1%	5%
Family Industry*					
Agricultural/forestry/fish/mining	54%	27%	18%	2%	<1%
Construction	47%	39%	12%	1%	1%
Durable Goods	29%	63%	7%	1%	<1%
Nondurable Goods	34%	56%	8%	1%	1%
Trans/communication/utility	26%	66%	5%	2%	1%
Wholesale	32%	52%	10%	5%	1%
Retail	46%	37%	12%	2%	2%
Financial Service	20%	66%	9%	4%	1%
Business/personal/entertainment	46%	39%	12%	3%	1%
Professional Service	22%	65%	8%	3%	2%
Public Administration	7%	78%	6%	1%	10%
Firm Size*					
<10	58%	23%	14%	5%	1%
10-24	51%	33%	12%	2%	2%
25-99	39%	47%	10%	2%	1%
100-499	32%	57%	9%	1%	<1%
500+	21%	68%	8%	1%	2%

Source: March 1998 Current Population Survey

Exhibit A5. Health Insurance Coverage by Sociodemographic Characteristics, African Americans, Ages 0-64, United States, 1997

	Uninsured	Job-Based Insurance	Medicaid	Privately Purchased Insurance	Other Government Coverage
African Americans Overall	23%	53%	19%	3%	3%
Age					
Children Ages 0-17	19%	46%	31%	2%	2%
All Adults Ages 18-64	25%	56%	12%	3%	3%
Women Ages 18-64	23%	56%	16%	3%	2%
Men Ages 18-64	28%	58%	8%	3%	4%
Family Income Relative to Federal Poverty Level					
Less than 100%	30%	15%	51%	2%	2%
100%-199%	29%	48%	17%	3%	3%
200%-299%	22%	67%	5%	3%	4%
300% or more	13%	81%	2%	2%	2%
Primary Breadwinner's Educational Attainment					
Less than 9 years	39%	17%	38%	1%	6%
9-12 years	26%	29%	41%	2%	2%
High school graduate	27%	50%	19%	3%	2%
Some college	20%	62%	13%	3%	3%
College graduate	11%	80%	3%	4%	3%
Family Type					
Single without children	34%	47%	12%	4%	4%
Married without children	17%	73%	3%	3%	4%
Married with children	15%	73%	7%	2%	2%
Single with children	22%	36%	38%	2%	1%
Region of Residence					
Northwest	23%	50%	24%	2%	1%
Midwest	19%	53%	23%	2%	3%
South	25%	53%	17%	3%	2%
West	19%	56%	17%	4%	4%

Source: March 1998 Current Population Survey

Exhibit A6. Health Insurance Coverage by Family Employment Characteristics, African Americans, Ages 0-64, United States, 1997

	Uninsured	Job-Based Insurance	Medicaid	Privately Purchased Insurance	Other Government Coverage
Work Status*	17%	74%	4%	2%	2%
Full-Time Full-Year Employee	31%	41%	25%	1%	2%
Full-Time Part-Year Employee	30%	30%	35%	3%	1%
Part Time Employee	59%	15%	11%	14%	1%
Nonworking	28%	9%	54%	3%	6%
Industry*					
Agricultural/forestry/fish/mining	36%	46%	11%	3%	4%
Construction	34%	56%	8%	1%	<1%
Durable Goods	21%	70%	7%	2%	<1%
Nondurable Goods	19%	74%	4%	2%	1%
Trans/communication/utility	16%	76%	6%	1%	1%
Wholesale	20%	66%	12%	1%	1%
Retail	28%	46%	23%	3%	1%
Financial Service	15%	72%	8%	2%	2%
Business/personal/entertainment	32%	41%	21%	%	2%
Professional Service	18%	67%	10%	3%	1%
Public Administration	9%	80%	3%	1%	7%
Firm Size*					
<10	41%	32%	19%	5%	3%
10-24	37%	37%	20%	5%	1%
25-99	28%	56%	12%	4%	1%
100-499	21%	62%	12%	2%	2%
500+	15%	72%	9%	1%	2%

Source: March 1998 Current Population Survey
* Employment characteristics are shown for primary wage earner in family.

Exhibit A7. Health Insurance Coverage by Sociodemographic Characteristics, Asian Americans and Pacific Islanders, Ages 0-64, United States, 1997

	Uninsured	Job-Based Insurance	Medicaid	Privately Purchased Insurance	Other Government Coverage
Asians Americans and Pacific Islanders Overall*	21%	64%	7%	6%	2%
South Asians	22%	69%	4%	5%	0%
Chinese	20%	67%	2%	10%	1%
Filipinos	20%	73%	2%	3%	2%
Japanese	13%	77%	2%	7%	1%
Koreans	34%	48%	1%	14%	3%
Southeast Asians	27%	49%	18%	4%	2%
Third-Plus-Generation AAPIs	8%	78%	7%	5%	2%
All Other AAPIs	23%	59%	11%	5%	2%
Age					
Children Ages 0-17	15%	66%	13%	4%	2%
Adults Ages 18-64	24%	63%	4%	7%	2%
Women Ages 18-64	23%	64%	5%	6%	2%
Men Ages 18-64	26%	62%	3%	8%	1%
Citizenship					
Citizen	17%	69%	7%	5%	2%
Non-Citizen	30%	54%	7%	8%	1%
Family Income Relative to Federal Poverty Level					
Less than 100%	33%	24%	36%	7%	1%
100%-199%	35%	48%	9%	5%	3%
200%-299%	23%	67%	2%	5%	3%
300% or more	15%	77%	1%	6%	1%
Primary Breadwinner's Educational Attainment					
Less than 9 years	25%	30%	40%	3%	2%
9-12 years	33%	40%	23%	2%	2%
High school graduate	30%	57%	7%	5%	2%
Some college	22%	65%	5%	6%	3%
College graduate	15%	76%	1%	8%	1%
Family Type					
Single without children	35%	52%	4%	9%	1%
Married without children	23%	67%	2%	7%	1%
Married with children	16%	71%	6%	5%	2%
Single with children	21%	46%	29%	4%	1%

Source: March 1998 Current Population Survey
* AAPI subgroups are constructed from a proxy subgroup measure created from CPS data. See Appendix B for description of the method used to construct the measure.

Exhibit A8. Health Insurance Coverage by Family Employment Characteristics, Asian Americans and Pacific Islanders, Ages 0-64, United States, 1997

	Uninsured	Job-Based Insurance	Medicaid	Privately Purchased Insurance	Other Government Coverage
Work Status*					
Full-Time Full-Year Employee	15%	79%	1%	3%	2%
Full-Time Part-Year Employee	38%	48%	5%	7%	2%
Part Time Employee	33%	35%	24%	7%	1%
Self Employed	41%	20%	12%	27%	<1%
Nonworking	34%	18%	32%	12%	3%
Industry*					
Agricultural/forestry/fish/mining	34%	63%	1%	1%	<1%
Construction	27%	68%	3%	3%	<1%
Durable Goods	13%	82%	<1%	4%	<1%
Nondurable Goods	28%	69%	<1%	3%	<1%
Trans/communication/utility	13%	81%	3%	3%	<1%
Wholesale	28%	69%	6%	3%	<1%
Retail	30%	50%	7%	10%	3%
Financial Service	13%	74%	5%	7%	<1%
Business/personal/entertainment	28%	55%	8%	6%	2%
Professional Service	14%	76%	4%	6%	<1%
Public Administration	3%	84%	1%	<1%	12%
Firm Size*					
<10	35%	35%	10%	17%	2%
10-24	34%	58%	2%	5%	1%
25-99	25%	68%	4%	2%	1%
100-499	16%	77%	4%	3%	1%
500+	12%	82%	2%	2%	2%

Source: March 1998 Current Population Survey

* Employment characteristics are shown for primary wage earner in family.

Exhibit A9. Health Insurance Coverage by Sociodemographic Characteristics, American Indians and Alaska Natives, Ages 0-64, United States, 1997

	Uninsured	Job-Based Insurance	Medicaid	Privately Purchased Insurance	Other Government Coverage
American Indians and Alaska Natives Overall	18%	50%	17%	1%	13%
Age					
Children Ages 0-17	13%	45%	30%	<1%	12%
Adults Ages 18-64	21%	53%	11%	2%	13%
Women Ages 18-64	20%	51%	16%	2%	12%
Men Ages 18-64	23%	55%	7%	2%	13%
Family Income Relative to Federal Poverty Level					
Less than 100%	25%	10%	49%	1%	15%
100%-199%	24%	42%	15%	1%	18%
200%-299%	19%	66%	4%	1%	11%
300% or more	9%	81%	<1%	3%	7%
Primary Breadwinner's Educational Attainment					
Less than 9 years	20%	33%	38%	2%	7%
9-12 years	21%	28%	35%	<1%	15%
High school graduate	20%	50%	15%	1%	14%
Some college	15%	58%	11%	3%	13%
College graduate	14%	76%	<1%	2%	8%
Family Type					
Single without children	28%	40%	15%	4%	14%
Married without children	19%	64%	7%	1%	9%
Married with children	12%	63%	11%	1%	13%
Single with children	17%	34%	37%	<1%	12%
Region of Residence					
Northeast	23%	60%	14%	<1%	3%
Midwest	12%	56%	18%	1%	13%
South	22%	49%	15%	2%	12%
West	18%	47%	19%	1%	14%

Source: March 1998 Current Population Survey

Exhibit A10. Insurance Coverage by Family Employment Characteristics, American Indians and Alaska Natives, Ages 0-64, United States, 1997

	Uninsured	Job-Based Insurance	Medicaid	Privately Purchased Insurance	Other Government Coverage
Work Status*					
Full-Time Full-Year Employee	14%	72%	3%	1%	10%
Full-Time Part-Year Employee	19%	39%	23%	1%	18%
Part Time Employee	31%	29%	25%	4%	12%
Self Employed	37%	13%	30%	5%	15%
Nonworking	22%	11%	49%	2%	16%
Industry*					
Agricultural/forestry/fish/mining	**	**	**	**	**
Construction	**	**	**	**	**
Durable Goods	**	**	**	**	**
Nondurable Goods	**	**	**	**	**
Trans/communication/utility	**	**	**	**	**
Wholesale	**	**	**	**	**
Retail	**	**	**	**	**
Financial Service	**	**	**	**	**
Business/personal/entertainment	**	**	**	**	**
Professional Service	**	**	**	**	**
Public Administration	**	**	**	**	**
Firm Size*					
<10	36%	24%	21%	5%	15%
10-24	26%	55%	11%	1%	7%
25-99	16%	59%	7%	3%	15%
100-499	18%	61%	12%	<1%	9%
500+	11%	68%	9%	<1%	12%

Source: March 1998 Current Population Survey
* Employment characteristics are shown for primary wage earner in family.

Exhibit A11. Health Insurance Coverage by Sociodemographic Characteristics, Non-Latino Whites, Ages 0-64, United States, 1997

	Uninsured	Job-Based Insurance	Medicaid	Privately Purchased Insurance	Other Government Coverage
Whites Overall	14%	73%	6%	5%	2%
Age					
Children Ages 0-17	11%	73%	10%	4%	2%
Adults Ages 18-64	15%	73%	4%	6%	2%
Women Ages 18-64	14%	73%	5%	6%	2%
Men Ages 18-64	17%	73%	2%	6%	2%
Citizenship					
Citizen	14%	73%	5%	5%	2%
Non-Citizen	28%	54%	10%	7%	2%
Family Income Relative to Federal Poverty Level					
Less than 100%	33%	23%	35%	6%	4%
100%-199%	27%	51%	11%	6%	4%
200%-299%	16%	73%	3%	6%	2%
300% or more	7%	86%	1%	5%	1%
Primary Breadwinner's Educational Attainment					
Less than 9 years	30%	33%	28%	5%	5%
9-12 years	28%	47%	18%	5%	3%
High school graduate	17%	69%	7%	5%	2%
Some college	13%	75%	4%	5%	3%
College graduate	7%	85%	1%	6%	1%
Family Type					
Single without children	25%	61%	5%	6%	3%
Married without children	11%	79%	1%	7%	3%
Married with children	9%	81%	3%	5%	2%
Single with children	19%	53%	23%	3%	2%
Region of Residence					
Northeast	13%	76%	6%	4%	1%
Midwest	11%	77%	5%	5%	1%
South	17%	69%	6%	5%	3%
West	15%	70%	6%	7%	3%

Source: March 1998 Current Population Survey

Exhibit A12. Insurance Coverage by Family Employment Characteristics, Non-Latino Whites, Ages 0-64, United States, 1997

	Uninsured	Job-Based Insurance	Medicaid	Privately Purchased Insurance	Other Government Coverage
Work Status*					
Full-Time Full-Year Employee	9%	85%	2%	3%	1%
Full-Time Part-Year Employee	25%	58%	9%	6%	2%
Part Time Employee	25%	51%	14%	8%	3%
Self Employed	32%	32%	4%	29%	3%
Nonworking	26%	25%	32%	9%	9%
Industry*					
Agricultural/forestry/fish/mining	19%	66%	5%	9%	1%
Construction	22%	67%	4%	6%	1%
Durable Goods	8%	88%	1%	2%	1%
Nondurable Goods	9%	87%	3%	2%	<1%
Trans/communication/utility	9%	86%	2%	2%	1%
Wholesale	8%	86%	2%	3%	1%
Retail	20%	64%	8%	6%	2%
Financial Service	7%	88%	1%	3%	<1%
Business/personal/entertainment	19%	69%	5%	5%	2%
Professional Service	9%	84%	3%	4%	1%
Public Administration	4%	84%	1%	2%	10%
Firm Size*					
<10	24%	58%	5%	11%	2%
10-24	20%	67%	5%	6%	2%
25-99	14%	77%	4%	4%	1%
100-499	9%	84%	3%	3%	1%
500	7%	86%	3%	2%	2%

Source: March 1998 Current Population Survey

* Employment characteristics are shown for primary wage earner in family.

Appendix B. Methods and Data Sources

Health Insurance Coverage

We used data from the March 1995 and 1998 Current Population Surveys to examine health insurance coverage, and we used the February 1997 Current Population Survey to examine, for some groups, the extent to which employers offer health insurance.

Health Insurance Status

The March CPS asks respondents about health insurance coverage for each family member during the previous calendar year. Children insured by any source at any time during 1997 were counted as insured. Because a person may have multiple sources of coverage reported for 1997, a single hierarchical variable was created to reflect rank ordering of reported health insurance coverage. We counted persons who reported having coverage through their own or a family member's employment at any time during 1997 as covered by job-based health insurance. Children who did not have any private coverage, but who had Medicaid coverage at any time during the year were counted as having coverage through that federal-state program. Persons who had other public coverage or privately purchased health insurance (i.e., not obtained through employment) were counted as "other coverage" or privately purchased insurance respectively. Those with no reported coverage of any kind during the year were categorized as "uninsured."

Ethnicity

We categorized respondents into five broad ethnic groups: Latinos are individuals of any race who identify themselves as Hispanics of either North American or Latin American origin; African Americans (i.e., non-Latino blacks); Asian Americans and Pacific Islanders (non-Latino Asians); American Indians/ Alaska Natives; and non-Latino whites (whom we usually refer to as "whites" for simplicity).

Latino Ethnic Subgroups. The CPS provides a breakout of Hispanic national subgroups, which we used to classify Latinos into the following ethnic subgroups: Mexican-American (which includes Mexican-American, Chicano, Mexican, and Mexicano), Puerto Rico, Cuban, and Central and South American.

Asian American and Pacific Islander Ethnic Subgroups. The CPS collects, but does not report, national subgroups for Asian Americans and Pacific Islanders. We therefore developed an alternative method to classify AAPIs into ethnic subgroups. We constructed a proxy subgroup measure based on the birthplace of AAPI respondents or his/her parents. We classified most people by their own birthplace. If the respondent was born in the U.S. but one of his or her parents was not, we assigned the birthplace of the parent to the respondent. If both parents were born outside of the U.S., we assigned the birthplace of the father to the

respondent. If both parents were U.S.-born, we labeled these individuals as "Third-Plus-Generation AAPIs." We then categorized individuals into eight ethnic subgroups: **South Asian** (India, Pakistan, Bangladesh), Chinese (China, Hong Kong, Taiwan, Singapore), **Filipino, Japanese, Korean, Southeast Asian** (Vietnam, Cambodia, Laos), **Third-Plus-Generation AAPI**, and **"All Other."** The "All Other" category includes individuals from Thailand, Myanmar, Indonesia, Fiji, Samoa, Guam, and Pacific Islands. These countries had too few respondents to report separately.

Because Asia itself has a tradition of migration, particularly among Chinese and South Asians, this approach may misclassify some groups. Misclassification is especially likely for Malays and Asian Indians born in Singapore who would be classified as Chinese; ethnic Chinese born in Malaysia, Vietnam, Indonesia, and other Southeast Asian countries; and Vietnamese, Cambodian, Lao children born in refugee camps in Malaysia, Thailand and the Philippines. It is difficult to estimate the percentage of misclassifications, but we believe it would be a small proportion of the NHIS AAPI sample. The misclassification would likely underestimate the number of Chinese, Cambodian, Lao, Malays, and Asian Indians, and overestimate the number of Filipinos, All Other AAPIs, and Vietnamese. The Current Population Survey also is limited for analyses of AAPIs because it is not translated into any Asian or Pacific Islander language; non-English speaking respondents are thus linguistically isolated from answering questions directly and require an interpreter to participate.

Immigration and Citizenship Status

For analyses of the Latino and AAPI populations, which include large proportions of noncitizen and citizen immigrants, we classified respondents into: (1) noncitizens; (2) naturalized citizens; or (3) US-born citizens. In addition, for residents of Mexican origin, we imputed legal status. Using data from an independent survey of Mexican immigrants in Los Angeles, we modeled legal status and classified noncitizen CPS respondents of Mexican origin as either "documented" or "undocumented."[50]

Family Work Status and Related Family Variables

A family was classified as a "full-time, full-year employee family" if at least one of the adults reported working for an employer at least 35 hours per week for 50-52 weeks in the specified calendar year; a "full-time, part-year employee family" if an adult worked for an employer full time for less than 50 weeks; a "part-time employee family" if no adult worked as a full-time employee but one worked for an employer less than 35 hours a week; "self-employed" if an adult was self-employed; or "non-working" if an adult worked during the year.

[50] Marcelli EA, Heer DM, "The Unauthorized Mexican Immigrant Population and Welfare in Los Angeles County: A Comparative Statistics Analysis," *Sociological Perspectives* 1998; 41: 279-303.

Using this hierarchical classification, we identified the person with the most advantageous employment tenure as the primary wage earner or primary breadwinner. We thus ranked employment classifications from full-time, full-year employees, at the top, to nonworking at the bottom.

We characterized the family's employment and some other factors based on the characteristic of the primary wage earner. We thus classified each person based on this family-level variable for education, industry, and firm size.

Health Care Access and Use of Health Services

We used data from the 1994, 1995 and 1996 National Health Interview Survey NHIS to examine whether a person has a regular (or usual) source of care and whether he/she visited a physician or other health professional provider within a specified period of time. Variables in the NHIS that are similar to those available in the CPS require no further definition, but we describe those that differ from the CPS variables discussed earlier.

Physician Visits and Regular Source of Care

Physician Visits. Information on physician visits was obtained using the NHIS question "During the past 12 months about how many times did (name) see or talk to a medical doctor or assistant."

Minimum Recommended Physician Visits for Children. The American Academy of Pediatrics (AAP) recommends annual visits for children and adolescents ages 24 months through age 17 (except for children ages 7 and 9), and more frequent visits for children under 24 months of age. We used a criterion of at least one physician visit in the past year for children under the age of 5 and a visit at least every two years for children ages 6-17, a reasonable, somewhat conservative, estimate of minimal requirements.[51]

Minimum Recommended Physician Visits for Adults. For adults, we connect visits to reported health status. Adults in fair to poor health who went longer than one year without visiting a physician and adults in good to excellent health who went longer than two years without visiting a physician were deemed not to have met a minimum standard of access to care.

Regular Source of Care. Information on whether or not a respondent has a person or place they regularly would go for medical care was based on the NHIS question, "Is there a particular person or place that (name) usually goes to when sick or needs advice about health?" This includes those with one or more regular sources of care, and a small number who use a hospital emergency room as a regular source of care. Having a regular source of care has been demonstrated to be a robust measure of access to health services.

[51] See American Academy of Pediatrics, "Recommendations for Preventive Pediatric Health Care," *Pediatrics* 1995; 96:712.

Ethnicity

With the NHIS we categorized respondents into the same five broad ethnic groups as with the CPS analyses: Latinos, African Americans, Asian Americans and Pacific Islanders, American Indians/Alaska Natives, and whites. Unlike the CPS, however, the NHIS includes adequate information to classify respondents into both Latino and AAPI ethnic subgroups. The NHIS provides detailed AAPI ethnic subgroups. It includes less detailed groupings of Hispanic (Latino) respondents: Mexican-American, Chicano, Mexican, and Mexicano (which we group into Mexican-American); Puerto Rico; Cuban; and "Other Latin American." We include in the Latino classification only persons with origins in the Western Hemisphere, excluding "Other Spanish."

We used the 1995 and 1996 National Health Interview Surveys for the majority of the analyses, with two exceptions. Coding changes in the 1996 survey did not permit specification of Asian American/Pacific Islander and Alaska Native subgroups, thus 1994 and 1995 National Health Interview Surveys were used for these subgroup analyses.

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