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HISPANIC ACCESS TO HEALTH SERVICES: IDENTIFYING BEST PRACTICES FOR ELIGIBILITY AND ACCESS TO MEDICAID AND SCHIP PROGRAMS

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IUPLR works to expand the pool of Latino scholars and leaders and increase the availability of policy-relevant Latino-focused research.

Latinos and Health Programs: Challenges in Access and Use of Medicaid and State Children's Health Insurance Programs

I. Introduction

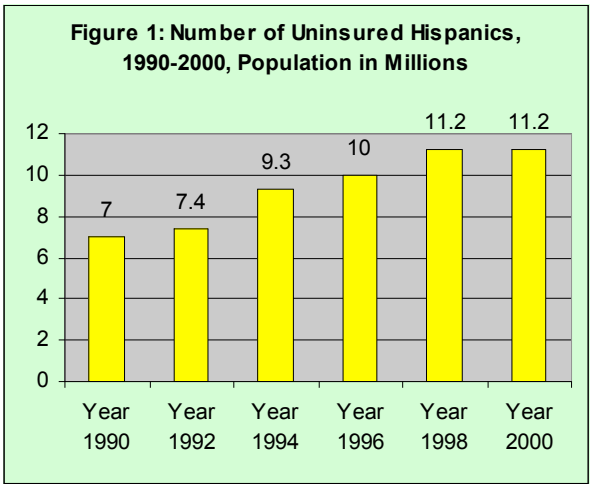
In a study examining the differential impact of Medicaid expansions on the health status of children by race and ethnicity, Lykens and Jargowsky (2002) have pointed out that access to public health insurance programs depends on three distinct realms of action. To benefit from public health insurance programs, such as Medicaid and the State Children's Health Insurance Program (SCHIP), an individual must first qualify for, then enroll in, and ultimately take advantage of the care plan available (Lykens and Jargowsky 2002). Although this is a seemingly simple statement of fact, each of these three realms presents a unique set of difficulties for Latinos, especially in terms of their ability to benefit from Medicaid and SCHIP programs. This literature review follows the three-part approach to health care access as outlined by Lykens and Jargowsky, examining existing literature in the areas of eligibility, enrollment, and actual care as it relates to Latinos. Also under review is the limited body of literature on culturally innovative interventions, particularly those that have been shown to be effective in reducing rates of under-enrollment among Latinos eligible for public health insurance programs. The goal of this literature review is to use existing knowledge as one basis for identifying practices that will best improve Latinos' access to public health insurance programs in an attempt to improve their well being and quality of life.

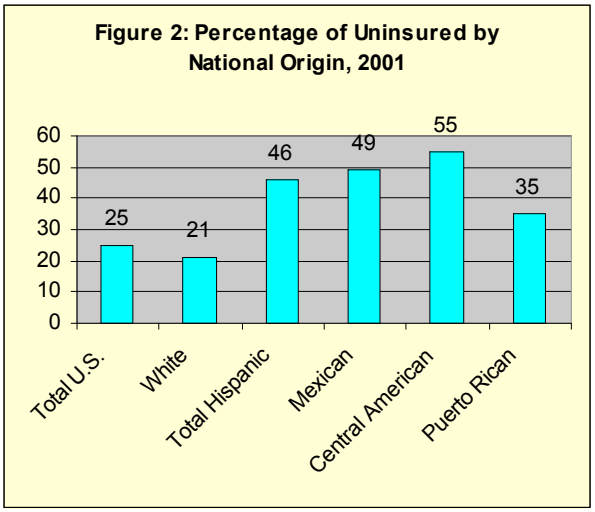
II. Background Information

Insurance Status of US Latinos

According to United States Census 2000 data, Latinos are now the largest minority group in the United States, comprising 12.5 percent of the total population. However, increases in health care access and coverage have not accompanied this demographic growth. Numerous studies have documented the various obstacles that both Latino adults and children encounter in obtaining and utilizing health care. Chief among these obstacles is access to health insurance, which is key to an individual receiving medical services (Maida 2001; Angel and Angel 1996; Schur and Feldman 2001). Barriers to acquiring health insurance can significantly lessen the amount and quality of

health care received. For example, when compared to children with Medicaid coverage, children without it are 30% less likely to receive ambulatory care and have 50% fewer visits to health care providers (Marquis and Long 1996; Lykens and Jargowsky 2002). Figures 1 and 2, shown below, demonstrate the scope of the problem.





Source: Doty (2003), "Latino Patients' Double Burden: Lack of Health Insurance and Limited English," page 2 and 3.

As shown above in Figure 1, the number of uninsured Latinos increased 60% from 1990 to 2000, rising from 7 million to 11.2 million. According to Doty (2003), this increase has been proportional to growth in the US Latino population during this period, so that "throughout the past decade, one-third or more of all non-elderly Hispanics have been uninsured each year—a rate two to three times that of non-Hispanic Whites" (Doty 2003). Figure 2 only gives us a snapshot for 2001 of the percentage of uninsured Latinos according to national origin. As is evident here, the most astonishing rates of the uninsured occur within the Mexican- and Central American-origin populations, who at 49% and 55%, respectively, have approximately twice the rates of uninsured of the total US population. These disparities in coverage are immense and speak to an institutionalized health care system that requires change if we are to see parity in health care access across racial and ethnic lines.

History of Latinos' Relation to Health Insurance

Before the establishment of Medicaid in 1965, the likelihood of having health care insurance was dependent on family income level and access to an employer who offered health benefits. The creation of Medicaid, therefore, effectively created a partnership between state and federal levels of government in order to assure a third source of possible health coverage to the "poorest poor" (Maida 2001). While this created a safety net for the most

indigent citizens, Medicaid did not address the needs of the working poor, many of whom continued to be uninsured. To fill this gap, the State Child Health Insurance Program (SCHIP), a federal government-subsidized health insurance program for children with much broader eligibility criteria than those used for Medicaid, was established in 1997 (Ross and Hill 2003). Nonetheless, access to public health programs continues to be a function of race and ethnicity (Shone et al. 2003).

For Latinos in particular, one of the factors most directly responsible for race- and ethnicity-based disparities is access to employment-based coverage. If coverage is not provided through an employee's benefits package, his or her remaining options are to purchase private insurance, to rely on a government-funded health program, or to remain uninsured. This first option obviously has its own set of obstacles. According to the March 2002 Current Population Survey (CPS), only about 43% of US Latinos received employment-based insurance in 2001, compared to about 63% of the total US population. This difference is largely due to the types of industries in which many Latinos work (Levan et al. 1999; Vitullo and Taylor 2002). In California, for example, many Latinos—particularly immigrants—are employed in sectors such as textiles, food processing, and electronics, low-wage industries that do not offer health insurance (Maida 2001). Schur and Feldman (2001) point out further that Latinos nationwide are disproportionately represented in the service industry, construction, and agricultural jobs, which are also associated with lower levels of job-based health care benefits.

Figure 3, shown below, gives an idea of the extent to which Latinos lag behind non-Latino Whites in terms of employment-based health insurance.

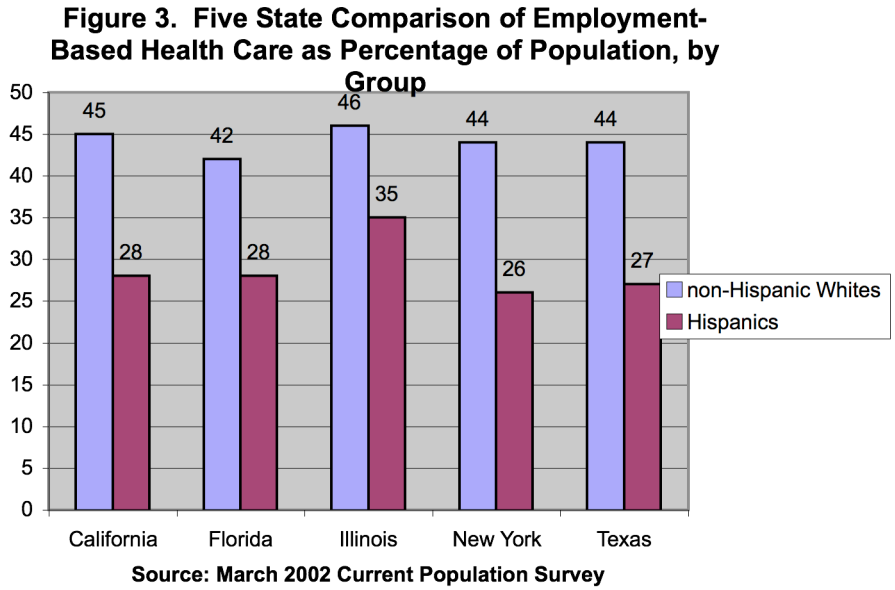
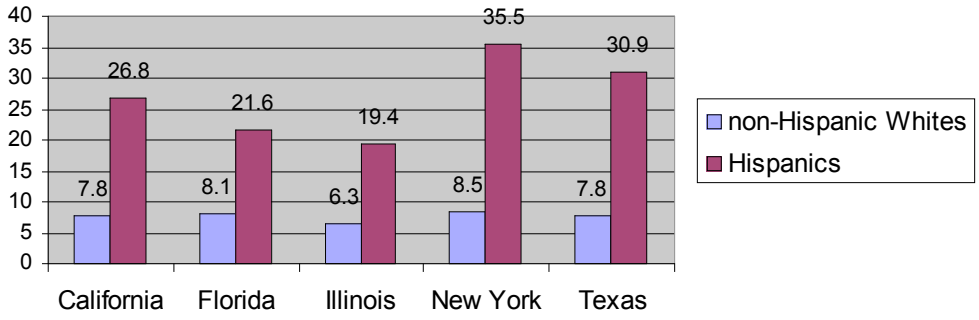


Figure 3 clearly shows that as of March 2002, in five states with significant numbers of Latinos, employment-based health care is consistently higher for non-Latino Whites than it is for Latinos. The difference in job-based coverage is especially apparent in New York, which has an 18% difference in coverage between Latinos and non-Latino Whites.

Low levels of coverage among Latinos are also a result of broader structural changes in the US economy within the past few decades, including a shift from a manufacturing-based economy to a service-based economy and trends toward higher insurance premiums among employers in the 1990s (Berman 1995). Besides these structural changes, the years 1979-1995 saw a marked expansion in the cost of health care relative to personal income, creating an increase in the number of low-wage workers who can no longer afford insurance (Kronick and Gilmer 1999). Moreover, when this trend is viewed in light of Latinos' already higher rates of poverty as compared to non-Latino Whites (see Figure 4 below), we can see that adequate health care is financially out of reach for many Latinos, a high percentage of whom earn less than the cutoff established by the federal poverty guidelines.[1]

[1] According to data from the US Department of Health and Human Services, the federal poverty level in 2006 was set at $16,660 for a family of three living in the continental US See http://aspe.hhs.gov/poverty/06poverty.shtml for more detailed information on federal poverty guidelines according to family size.

Figure 4. Five State Comparison of Percentage Living in Poverty, by Group



Source: U.S. Census 2000

Comparing the percentage of Hispanics living in poverty to the percentage of non-Hispanic Whites living in poverty in each of the five states, Figure 4 indicates the staggering percentage of Latinos who would struggle to afford private health care in comparison to non-Latino Whites. Given the economic demographics of Latinos in the US, the remaining two options for health care are, therefore, to either remain uninsured or to enroll in a government-funded public insurance program. However, a number of barriers prevent Latinos from successfully enrolling in and benefiting from public insurance programs. Starting with barriers to eligibility, the following sections survey the literature that has attempted to account for those factors primarily responsible for Latinos' persistent under-enrollment.

III. Barriers to Eligibility

For Latinos, as well as for others, the complexity and frequently changing nature of Medicaid and SCHIP eligibility requirements can itself be one of the greatest barriers in accessing either program. Before August 22, 1996, for instance, eligibility for Medicaid benefits was closely linked to the receipt of benefits from the federal and state welfare program Aid to Families with Dependent Children (AFDC). The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 severed that link, creating two independent programs, Medicaid and Temporary Assistance to Needy Families (TANF), the latter of which is a cash assistance program

with strict requirements for eligibility. Although TANF technically replaced AFDC, states nevertheless retained the July 1996 AFDC qualification criteria as their basis for determining Medicaid eligibility (Ku and Coughlin 1997).

In 1997 the Balanced Budget Act established SCHIP, a matching funds program that would provide states with federal dollars to ensure adequate health care coverage to uninsured low-income children who were not otherwise eligible for Medicaid. Depending on the state, this newly created children's health insurance program would function as an adjunct to Medicaid, as its own program, or as a composite of these two options (Newacheck et al. 1998; Maida 2001; Lykens and Jargowsky 2002; Byck 2000). States would have flexibility in determining eligibility criteria for SCHIP, a decision that has yielded differences in program implementation across state lines, but which has also allowed states a greater hand in administering to the unique health care needs of its uninsured youth population (Maida 2001; Lykens and Jargowsky 2002).[2]

While the signing of PRWORA accompanied an expansion in publicly funded health insurance programs, it also directly placed limits on immigrants' access to both Medicaid and SCHIP, going so far as to allow states the option of barring illegal immigrants from all but emergency and prenatal health care. The most important change effected by PRWORA pertained to legal immigrants entering the United States after August 22, 1996. As stipulated by the legislation, those entering the United States after this cutoff date would be ineligible for government-subsidized health care benefits—including Medicaid and SCHIP—for the first five years of their residency in the US (Benjamin et al. 2000; Ku and Blaney 2000; Maida 2001). The provision of services to legal immigrant groups was then left to the discretion of the states. This change inadvertently jeopardized the eligibility status for many low-income children (Ellwood and Ku 1998). As a result of these policy changes, health insurance coverage between 1995 and 1999 became more uncertain for low-income immigrant children and parents and, not surprisingly, declined for these groups (Ku and Blaney 2000). However, some states, such as California, have opted to spend their own funds to secure medical coverage for all eligible legal immigrants, irrespective of their entry date (Benjamin et al. 2000).

Despite the leeway of individual states, PRWORA's denial of immigrant access to Medicaid and SCHIP, when combined with the confusion surrounding the separation of Medicaid eligibility from AFDC, has had the overall effect of lowering Medicaid enrollment, particularly among non-citizen adults (Ellwood and Ku 1998). This problem has continued despite a recent report from the US General Accounting Office (GAO) that shows that, in the

wake of welfare reform, states are attempting to mitigate confusion through the use of a single application and set of qualifying criteria (US General Accounting Office 1998). States have also made efforts to boost enrollment of eligible families via expansions to Medicaid and SCHIP. However, these efforts have met with debatable success, given the significant number of state residents and immigrants who continue to lack insurance (Asch and Frayne 1995; Halfon et al. 1997; Maida 2001).

Nonetheless, the overall trend with Medicaid and SCHIP, until recently, has been a relaxation of eligibility criteria.[3] With the increased popular debates on the status of illegal immigrants in the United States and utilization of public services, there has been a growing move to make it mandatory for states to require documentation of legal status for Medicaid beneficiaries. For example under the auspices of the Deficit Reduction Act passed in 2005, which was enacted July 1, 2006, Medicaid eligibility for clients requires that the states "obtain proof of citizenship from most new Medicaid applicants, and from current enrollees who renew their eligibility" (p. 1). In addition, on June 9, 2006, CMS sent even stricter guidelines to states regarding documentation requirements.[4]

Since improved health is ultimately the goal of such moves toward greater flexibility, it is logical to assume that eligibility expansions would lead to an improvement in health care access and outcomes. Currie and Gruber (1996a) tested this assumption by examining the impact of Medicaid expansions on low-income children between 1984 and 1992, when the percentage of eligible children doubled. Their first observation was that the take-up[5] resulting from these expansions was far from its potential, which they attributed to the possibility that some of the newly eligible children already had private insurance.

Nonetheless, they also found that expansion of Medicaid eligibility had significant positive effects on the utilization of medical care. Using quantitative data from the National Health Interview Survey (NHIS) and the March Current Population Survey (CPS) from 1985 to 1993, Currie and Gruber created models showing the estimated effect of Medicaid eligibility expansions on the utilization of care. They discovered from these models that it was more efficient to expand eligibility for Medicaid than to raise income. They also found that Medicaid expansions significantly increased utilization of care received in physicians' offices, a significant finding given that

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[2] Income eligibility cut-offs and general SCHIP facts for California, Florida, Illinois, New York, and Texas can be found in Appendices 1 and 2, respectively).
[3] Prior to 2003 many states had increased income cut-off levels and done away with other requirements, such as in-person interviews and quarterly status reports (Ross and Hill 2003).
[4] Based on a report by Medicaid Alert, The Deficit Reduction Act fundamentally alters many aspects of the Medicaid program. These provisions make it significantly more difficult for people to qualify or enroll.

physician care is a more preventative form of health care and leads to a more efficient use of resources (Currie and Gruber 1996a).

Short and Lefkowitz (1993) also discuss the effects of increased eligibility, although they focus on well-child visits[6] among poor and near-poor preschool children. Using data culled from the 1987 National Medical Expenditure Survey, they found that among low-income children who would be uninsured without Medicaid, a continuous year of coverage improved the prospect of receiving preventative services by 17%. However, their study also points out that eligibility expansions alone cannot ensure that lower-income children will benefit from increased access to preventive visits. Because of factors outside income level and access to insurance (e.g. maternal education level), even universal eligibility for children below 200% of the federal poverty level (FPL) would not close the gap between lower- and higher-income groups of children. Short and Lefkowitz's study thus illustrates that a simple increase in eligibility for preventive services is not enough to address disparities in health care access and utilization (Short and Lefkowitz 1993).

Another study by Lykens and Jargowsky (2002) examines the impact of Medicaid expansions on different groups of children since the Omnibus Budget Reconciliation Act (OBRA) of 1986. During the four years following OBRA, states were required to increase the income eligibility threshold to 133% of FPL for children under six, with the option of increasing it to 185%. The authors ultimately found that these eligibility expansions had less of an impact on Latino children than they did on non-Latino Whites, although they state that this result can possibly be attributed to the small sample size of Latinos used in the study. Nevertheless, Lykens and Jargowsky conclude from the disparities in health outcomes between Latinos and non-Latino Whites that once providers and communities can reduce the non-financial (i.e. linguistic and cultural) barriers that Latinos face, eligibility expansions have the potential to benefit all children equally (Lykens and Jargowsky 2002).

As many of these studies indicate, then, eligibility expansions do not easily equate to improvements in health outcomes for Latinos (since expansions to public health insurance programs cannot guarantee that beneficiaries will enroll in the programs), nor do they reduce disparities that arise due to cultural, linguistic, or educational factors. Moreover, the disjuncture between eligibility expansions and health outcomes has been found to be more widespread among groups who are unfamiliar with the US health care system or who do not have a history

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[5] The take-up rate is calculated as the percentage of those who enroll in a program divided by the number of eligible persons. "Take-up" is used in reference to full capacity, or a 100% take-up rate.
[6] Well-child visits are regular preventative check-ups at a physician's office.

of public assistance—as is the case with many working poor families (Currie and Gruber 1996a; Currie and Gruber 1996b). To the degree that both of these characteristics apply to Latino families, it thus becomes necessary to consider more extensively the issue of enrollment.

IV. Barriers to Enrollment

Between 1989 and 1995, seven million additional poor and working-poor children received Medicaid due to eligibility expansions (Racine et al. 2001). This study breaks down the impact of these expansions according to race and ethnicity and examines their effect on rates of the uninsured, utilization of services, and health outcomes among non-Hispanic White, African American, and Latino children. In order to view the changing impact of expansions over time, the authors use a stratified before-and-after statistical model to compare rates of the uninsured among poor[7] and non-poor groups in 1989 and 1995. Table 1 summarizes the results of their study.

Table 1: Children's Uninsured Rates and Medicaid Rates by Income Group and Race/Ethnicity, 1989 to 1995

Parameter		1989	1995	Change
Uninsured Rates				
Poor	White	0.23	0.19	-0.04
	Af. American	0.25	0.14	-0.11
	Latino	0.46	0.28	-0.19
Non-Poor	White	0.04	0.03	-0.01
	Af. American	0.04	0.03	-0.01
	Latino	0.05	0.09	0.04
Medicaid Rates				
Poor	White	0.17	0.33	0.16
	Af. American	0.40	0.62	0.22
	Latino	0.25	0.48	0.23
Non-Poor	White	0.00	0.01	0.01
	Af. American	0.03	0.07	0.04
	Latino	0.01	0.03	0.02

Source: Racine et al. (2001), "Differential Impact of Recent Medicaid Expansions by Race and Ethnicity," p. 1137.

[7] "Poor" indicates family income less than 200% of the Federal Poverty Level (FPL). "Non-poor" refers to income levels from 300% to 400% of the FPL.

From this table, we can see the rates of health insurance coverage of poor and non-poor White, African American, and Latino children. From 1989 to 1995, there was a 19% decline in the rate of uninsured poor Latino children—the largest such decline among the populations examined. Furthermore, Medicaid rates for Latinos increased by 23 percentage points, which again represents the greatest change among the three groups. The study thus concludes that the Medicaid expansions in question caused significant decreases in the rates of the uninsured among poor Latino and African American children; and between these two groups, Latino children benefited to the greatest degree (Racine et al. 2001).

A study by UCLA and the Rand Corporation (1992) has found, however, that although eligibility expansions may benefit Latino children, few Medicaid-eligible Latino children are able to obtain full coverage (Shinkman 1997). This 1992 study of 812 Latino families in Los Angeles found that despite the fact that 84% of the children included in the survey were Medicaid-eligible, 19% had never enrolled in the program and an additional 21% had irregular coverage. The study pointed to parental non-citizen status as one of the major obstacles preventing a full take-up of benefits among eligible children. As stated by Robert Valdez, one of the authors of the study and a professor of public health at UCLA, "[t]he problem…is not isolated [to Los Angeles]. This is going to be an issue anywhere in any metropolitan area with a large concentration of immigrants, particularly among the undocumented" (Shinkman 1997).

It should be noted that this UCLA study was conducted before passage of PRWORA in 1996; subsequent studies that have examined the correlation between non-citizen status and enrollment have yielded conflicting results. Shortly after the enactment of SCHIP, Ellwood and Ku (1998) predicted that when combined with the immigrant provisions of PRWORA, the focus on expanding coverage for children would result in a disproportionate decrease in coverage for adults. In a more recent study, Carrasquillo et al. (2003) assessed the effects of the immigrant provisions on both uninsured children and parents. Using Current Population Survey (CPS) data, they determined that the primary effect of PRWORA has not been to bar large numbers of immigrants from public insurance programs, but rather to shift the costs of covering immigrants to states (Carrasquillo et al. 2003).

Similarly, Borjas (2003) has analyzed the impact of welfare restrictions on immigrant access to health insurance; using CPS data from 1995-2001, he has found that, contrary to expectations, immigrant uninsured rates during this period either remained the same or decreased. Borjas attributes this finding to the fact that, between 1995 and 2001, those immigrants who were potentially most impacted by welfare restrictions increased their labor supply,

and thus their probability of having employer-based coverage (Borjas 2003). One possible limitation of these findings, however, is that they do not account for potential effects of PRWORA on immigrant attitudes toward enrolling in public health insurance programs—an issue addressed in the following section. In other words, just because the negative effects of immigrant restrictions were offset by increased rates of employer-based coverage does not mean that immigrant populations eligible for public health insurance programs were more likely to enroll.

Factors Contributing to Latino Under-enrollment in Medicaid and SCHIP

A 1998 report from the US General Accounting Office (GAO) has attempted to determine the reasons why families do not take up the Medicaid benefits for which their children are eligible (GAO 1998). One possibility is a lack of information about available health insurance coverage. Households may not be aware of their eligibility status; since many working immigrant families are not welfare recipients, they may not believe they meet the criteria for public health care programs. Parents might also believe that insurance coverage is necessary only if their children require immediate medical attention. In addition, the confusing nature of welfare reform itself, not to mention the lengthy enrollment process, may further discourage families from enrolling in Medicaid (GAO 1998). Access to information itself may be a factor, either because the program is not well marketed to targeted groups or because potential consumers have difficulty understanding marketing strategies and are thus uninterested in learning more. Finally, because of immigrant restrictions or cost considerations, some families may be accustomed to past care obtained from clinics or emergency rooms and opt for these services over public health care programs. Other families may eschew health services altogether, relying more on alternative, home-based, or culturally specific forms of health care (GAO 1998).

In addition to information barriers, language continues to be one of the biggest obstacles to maintaining enrollment for Latino families. A study at the University of Pittsburgh examined over 12,000 families and determined that in 1992 difficulties with the English language may have cost 5 million eligible children their access to Medicaid benefits. Given that seventy-five percent of uninsured and Medicaid-eligible Latinos opted to conduct interviews in Spanish, researchers have concluded that language difficulties are key to understanding the significantly higher rates of uninsured among Medicaid-eligible Latino children when compared to other racial and ethnic groups (Language Barrier May Keep Children Uninsured 2000).

Related to language is the issue of education. Research has shown that educational level greatly affects Latinos' access to and utilization of health care services, since education affects occupational status and thus the

probability of acquiring employment-based insurance. In terms of accessing health care, higher levels of education are also associated with greater reception to learning about relevant health issues, as well as with increased ability to manage the complexities of any health care system. Research also suggests that higher levels of (specifically) maternal education lead to greater rates of health care utilization among children (Byck 2000). For the sake of efficient policy implementation, policymakers must take into account these differences in educational backgrounds even within the Medicaid and SCHIP eligible populations. When advertising the program, for example, program coordinators must clearly identify target groups so as to address the specific condition of each population.

Accordingly, one issue touched upon in the research is the difference between Medicaid-eligible and SCHIP-eligible populations. Byck (2000) attempts to identify characteristics of each group in order to see how uninsured, SCHIP-eligible children compare to children with different sources of insurance coverage (Medicaid, private, and private but financially SCHIP-eligible). Her research determined that both the health status and socio-economic characteristics of uninsured SCHIP-eligible children varies from those of children with other sources of coverage. When compared to those children enrolled in Medicaid, for example, SCHIP-eligible children were older, healthier, more likely to be White, and to come from a better-educated, employed, and two-parent family. Furthermore, because the higher educational levels among parents of SCHIP-eligible children often translates to increased job opportunities, it may be necessary to employ SCHIP outreach strategies that are different from those used for Medicaid-eligible populations (i.e. disseminating information at the work place). Program coordinators should also take into consideration the differences in employment patterns among groups with divergent sources of coverage, selecting particular industries for worksite outreach depending on the population targeted.

Perhaps the biggest factor contributing to low levels of enrollment in public health insurance programs among Latinos is immigrant status. In addition to the linguistic and cultural barriers that many Latinos encounter, legal immigrants in particular fear that receiving public assistance will threaten their immigrant status (GAO 1998; Maida 2001). This fear has its roots in the United States Immigration and Naturalization Service's (INS) policy for "public charge," which has had harsh repercussions for both legal and illegal immigrants in large part due to its ambiguous definition prior to 1999. "Public charge" policy prior to 1999 essentially gave the INS grounds to deport or to deny entry to any immigrant who relied upon (or who was believed to potentially rely upon) public assistance as his or her main means of support (Department of Justice 1999). With this policy in mind, immigrants feared that using public health care services would jeopardize their living situation in the US. As has been demonstrated by

Swingle (2000), one effect of "public charge" policy has been to deter immigrant women from seeking prenatal care and families from using immunization or nutrition programs for their children (Swingle 2000).

Recognizing the probability of negative health effects such as these, not only for immigrants, but for the larger population as well, the INS sought in 1999 to clearly define "public charge" as a description applicable only to those immigrants "who ha[ve] become (for deportation purposes) or who [are] likely to become (for admission or adjustment purposes) 'primarily dependent on the government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance or institutionalization for long-term care at government expense'"(Department of Justice 1999). The Department of Justice created this definition to dispel any confusion regarding the effects of public program participation on immigrant status. The emphasis in the new definition on cash assistance was clearly an attempt to separate public aid programs such as health care from the more long-term and intensive forms of support constitutive of "public charge" status. But despite these clarifications, the specter of "public charge" policy as it existed before 1999 may continue unnecessarily to discourage immigrants from using available services. Moreover, it should be stated that many eligible low-income families, immigrant or not, are also disinclined to participate in public programs for fear of being labeled welfare recipients (GAO 1998). This fear is substantiated given the fact that need-based public programs tend not to remedy racial and economic stratification, often highlighting and maintaining it instead (Meyer 1994). For such reasons, policymakers and administrators should take these fears into consideration when implementing particular programs rather than downplaying or dismissing them.

A study funded by the Texas Department of Health supports this contention. In examining the marketing strategies used during the starting phases of the state's SCHIP program, the study found that families were much more responsive if SCHIP was portrayed as a non-welfare or Medicaid type of program (Orchard Communications Inc. 1999). Some parents who participated in the study, for example, questioned the quality of care and the respect they would receive if the care were free. Barriers such as these stem from a prior history of economic and political disenfranchisement among the target population, which contributes to skepticism about government programs.

Additional barriers to enrollment include logistical deterrents, such as location of enrollment sites, enrollment hours, transportation, and communication problems. With the help of private and grassroots organizations, state agencies generally have been successful at overcoming logistical barriers to enrollment such as these (Managed Risk Medical Insurance Board 2002b), a point to which we will return in more detail in the section on culturally innovative interventions. Despite state efforts to enroll eligible Latinos, a few barriers to accessing

proper health care still remain, primary among which are the issues of actual care. For eligibility and enrollment to translate to increased health outcomes, enrollees must use their health benefits efficiently, and providers must offer culturally competent and quality services.

V. Barriers to Effective Utilization of Care

In their study of the impact of Medicaid expansions on low income children, Currie and Gruber (1996a) found that enrollment in public programs does not necessarily result in health improvements, since it can ensure neither the proper utilization of health care nor the competency and efficacy of care providers. In the case of Latinos, unfamiliarity with both the health care system and the importance of preventative care practices can preclude the positive health outcomes associated with eligibility and enrollment in public health insurance programs. In addition, there has been difficulty in several states to meet the demand for office based primary care physicians for Medicaid patients even though there are Federal compliance requirements that mandate equal access for Medicaid patients—particularly children (Berman et. al 2006). Reasons for the disparities in access to private practice physicians for Medicaid patients has been attributed in the literature to low Medicaid reimbursement rates, excessive bureaucratic procedures, and the preference of office based physicians in urban areas to locate in more affluent areas. (Perloff et. al. 1995). A study by Cunningham and Nichols (2005) suggested that beyond reimbursement rates, practice type, and location, minority physicians are more likely to accept Medicaid patients than are White physicians. Thus, there are observed differences in the characteristics of physicians who are more likely to serve these types of patients, impacting their willingness to provide the same type of access for Medicaid patients as for private pay patients. Logistical and cultural issues can also detract from many providers' abilities to provide necessary or appropriate services, although it is important to point out that such issues may vary widely not only from state to state, but from county to county and community to community. Especially relevant among these issues are the differences that may exist in access to public health programs and health care services between rural and urban Latino communities.

Although immigrant populations are often aware of services available to them in the event of a medical emergency, they may be unacquainted with the preventative health services available in their community, such as routine medical examinations and childhood vaccinations (Maida 2001). This is problematic as research has found

that when children lack access to preventive services they tend to rely upon improper and often costly sources of treatment. Lacking early detection of and treatment for medical conditions, these children are then more susceptible to serious illness (Byck 2000).

Factors Behind Barriers to Utilization of Care

Many factors account for this lack of access to primary care and prevention services. Cotler (2001) points to underlying social conditions such as poverty; in their study of racial and ethnic differences among pregnant substance abusers eligible for Medicaid, Argeriou and Daley (1997) also found that Latinos place greater emphasis on the family than do other racial/ethnic groups—another factor that can negatively impact utilization of preventative services. As Maida (2001) explains, familial networks serve as the primary care-giving unit for many Latinos, in particular for Latino immigrants coming from rural areas. This may shape attitudes toward methods of caring for the ill in ways that may not be amenable to regular use of the health care system (Maida 2001). Rural Latinos may also have problems finding health care providers in their area who will treat publicly insured patients, an issue that perhaps stems from the lower reimbursement rates that accompany public health insurance as compared to private insurance (Currie and Gruber 1996a).

The location of primary care providers can also predict access and utilization (Halfon et al. 1997). Many studies have documented a direct relationship between distance to providers and the rate and quality of treatment, particularly among low-income, minority, and Medicaid-eligible populations (Currie and Reagan 2001; Lykens and Jargowsky 2002). Due to disjunctions in location between practitioners and eligible children, some beneficiaries cannot find a provider. This has been the case in California, which has problems attracting providers who will accept Medicaid and SCHIP patients in rural areas. To address this issue, SCHIP policymakers in California created the Rural Health Demonstration Project (RHDP), which provides federal and state funds to programs that increase providers' incentives to set up facilities for disadvantaged groups (Managed Risk Medical Insurance Board 2002b). Some of the tactics the RHDP has used include increases in provider reimbursement rates, the provision of funding for additional office hours, and a greater reliance on telemedicine.[8] Although no formal study has been conducted on the effectiveness of the RHDP, a preliminary review of the program by the Managed Risk Medical Insurance Board

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[8] Telemedicine is a conferencing system that allows local physicians to consult with specialists via telecommunications systems with the patient present.

shows that many of the RHDP-sponsored projects have increased access to services and ultimately become self-sustaining since their inception (Managed Risk Medical Insurance Board 2002b).

Underutilization of Health Services

While programs like the RHDP attempt to increase rural Latino enrollment in public health insurance programs, studies have shown that disparities in treatment exist even within the Medicaid-enrolled population (Vitullo and Taylor 2002; Lieu et al. 2002). A study by Lieu et al. (2002) investigated health status and use of asthma management techniques among children of different racial and ethnic backgrounds. The authors examined the medical records of asthmatic children enrolled in Medicaid through five different Managed Care Organizations (MCOs) and interviewed parents by telephone concerning the asthma status of their children. Though researchers did find that asthma status scores[9] of Latino children were comparable to those of White children, the study also provided evidence that, relative to White children, Latino children had more absences from school due to asthma and tended to under-use inhaled anti-inflammatory medication. Lieu et al. concluded from these findings that when compared to White children, Latino children with asthma had poorer health and higher rates of under-use for preventative asthma treatments.

Finkelstein et al. (2002) demonstrated similar findings, further substantiating the relationship between minority status and under-use of preventative medications. In their study of inhaler usage among children with asthma, the authors concluded that Latinos and African-Americans were significantly more likely than non-Latino Whites to under-use controller medication for the prevention of asthma symptoms (79% and 75% vs. 69%, respectively). The authors found that these higher rates of under-use could be linked to the lack of a primary care physician—88% of all asthmatic patients without a regular source of primary care reported under-use, as compared to only 71% among those under the care of a primary practitioner. The study also found that the administration of written care plans lowered the likelihood of under-use from 79% to 60%. Follow-up appointments produced similar effects, reducing under-use of controller medications from 85% to 68% provided that the appointment had taken place within the previous six months (Finkelstein et al. 2002).

A related area of concern is the under-use of prenatal care by immigrant Latinas. Norton et al. (1996) examines utilization of maternity services among undocumented immigrant women in California, focusing on the

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[9] The American Academy of Pediatrics has created a system of scoring to rate physical and emotional wellness.

timeliness of Medicaid enrollment as it affects the likelihood of receiving adequate prenatal care. The study found that most eligible women took up their Medicaid benefits, although over 50% completed their first trimester without it. On average, resident Latinas stayed in the program for 7 months compared to undocumented immigrant women, who averaged 5 or 6-months in the program. Based on these findings, the authors concluded that pregnant undocumented women do not take full advantage of the Medicaid benefits for which they are eligible and for that reason may lack those services that are essential to the reduction of infant mortality rates and low birth weight (Norton, Kenney, and Ellwood 1996).

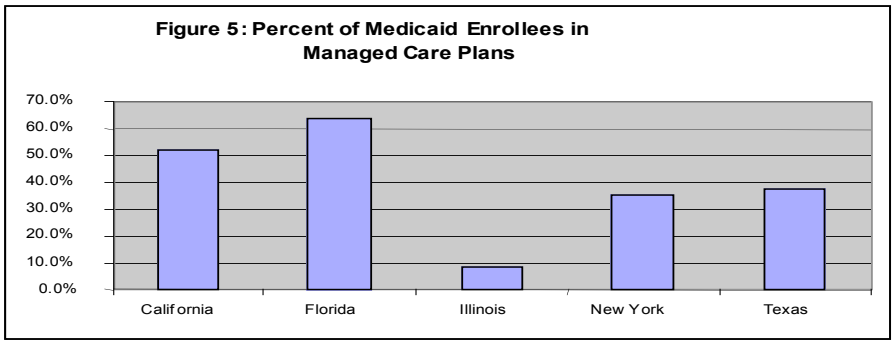
A study on Mexican American women by Moore and Hepworth (1994) found that despite similar sources of coverage and rates of enrollment, Mexican American women appear less likely to use maternal health services compared to non-Latino White women. For their analysis, the authors compared a sample of 308 Mexican American women and their children to a sample of 312 White women and their children; both populations were enrolled in the Arizona Health Care Cost Containment System, one of the state's Medicaid programs. The study used a time window spanning from before the sixth month of pregnancy to 60 days after delivery, and found that the average number of prenatal care visits for Mexican American and White women was 8.6 and 10.2, respectively. Furthermore, in the first trimester, 51.2% of Mexican Americans and 60.2% of Whites obtained prenatal care, but only 41.1% of Mexican Americans and 52.8% of Whites obtained adequate overall care. During the first year following birth, White infants averaged 9.8 physician visits compared to 8.2 visits for Mexican American infants. Based on these observations, the authors concluded that Mexican American women have more restrictive barriers to adequate care than do White women, such as the responsibility for a larger number of children and lack of access to transportation (Moore and Hepworth 1994).

Thus, even when Latinos are eligible for and utilize Medicaid benefits, there is a repeating history of under-use (Halfon et al. 1997; Shinkman 1997; Barents Group of KPMG Consulting Inc. 2001; Vitullo and Taylor 2002; Maida 2001; Finkelstein et al. 2002; Doty 2003). A study conducted jointly by the Centers for Medicare and Medicaid Services (CMS) with Barents Group of KPMG Consulting, Inc. (2001) has attributed these patterns of under-use to the shortage of basic information about public programs within both Latino communities and the Community Based Organizations (CBOs) that work with them (Barents Group of KPMG Consulting Inc. 2001). It may very well be that this unfamiliarity with available options results in Latino beneficiaries' relative lack of concern with the quality of care received. Because much of this informational gap arises from a community-level lack of infrastructure for communicating health-related information, the study recommends that CBOs forge

stronger links with federal-level programs such as Medicaid and SCHIP. Such partnerships would provide the requisite resources and tools for the successful transmission of program information to Latino enrollees.

Medicaid and Managed Care

A general trend in certain states' public health care has been the move from private providers to Managed Care Organizations (MCOs). In 2002 over half of Medicaid beneficiaries in California and Florida were enrolled in a managed care plan, as shown in the table below:

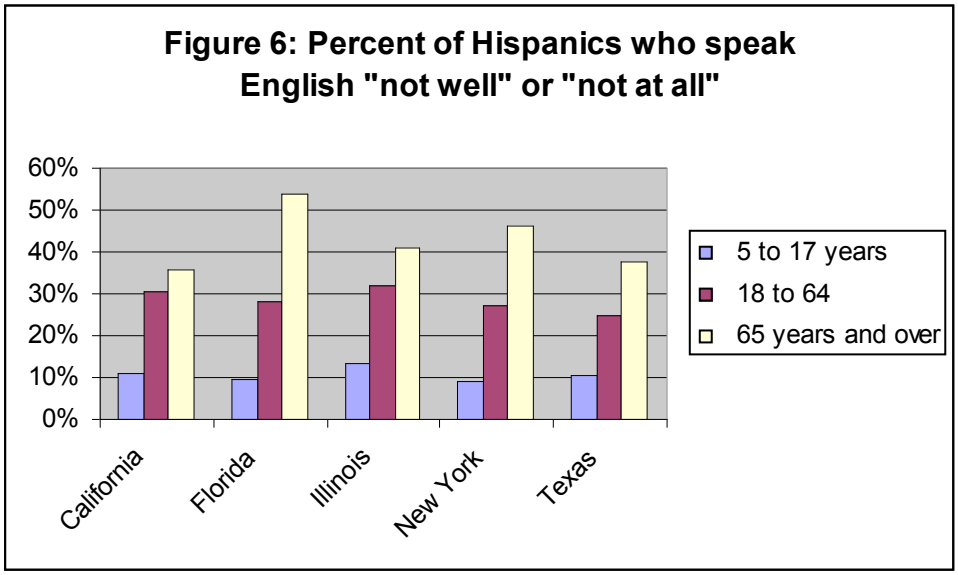


Source: Center for Medicaid and Medicare Services *2002 Managed Care Enrollment Report*

From Figure 5, we can see that, excluding Illinois, those states with a significant number of Latinos also contain a large percentage of Medicaid enrollees who participate in managed care plans. When discussing Latinos' utilization of health care services, it is necessary to make this distinction between managed care and traditional providers, because different sets of barriers accompany different forms of health care. While patients typically pay traditional providers according to a fee for service (FFS) schedule, managed care plans receive capitated (or flat) rates per enrollee, appropriating funds to meet the needs of beneficiaries. This can cause problems for Latinos, as well as for other disadvantaged groups, given that "[i]n a managed care or capitated rate environment, delivery of a service to an individual becomes a cost," potentially leading MCOs to "limit costs by limiting services" (Center for Mental Health Services 2001). One drawback to MCOs is that they may have a financial incentive to eschew services that are necessary for delivering culturally specific or culturally competent care (Center for Mental Health Services 2001).

The issue of educational literature is one of the most problematic areas for MCOs with respect to their provision of services. Most MCOs publish instructional literature to inform beneficiaries about available services,

program policies, and enrollee rights. However, it has been found that managed care plans have had difficulties producing and supplying linguistically appropriate educational materials to beneficiaries (Kominiski et al. 2003). This stems in part from enrollees' lower levels of education; in California, for instance, a study conducted by the UCLA Center for Health Policy Research has found that 35% of adult HMO enrollees ages 18-64, and 45% of enrollees ages 65 and older have a high school education or less. The same study has found that linguistic barriers may also significantly impede access to and utilization of the services provided by HMOs. The study reports that immigrants constitute more than a quarter of all HMO members in California, that 34% of HMO enrollees report that English is not their at-home language, and that in some counties this percentage increases to nearly 50%. In addition, 4% of all HMO enrollees do not speak English well or at all (Kominski et al. 2003). As suggested below in Figure 6, this percentage is much higher for Latinos in each of the five states shown, pointing to the need for MCOs in those states to provide linguistically appropriate health care services to their beneficiaries.



Source: US Census Bureau, Census 2000

Ideally, linguistically and educationally sensitive services would be a part of broader efforts by MCOs to provide all their beneficiaries with equal access to care. It is an implicit reference to the need for such equitable standards that the idea of cultural competency has gained currency within the literature. The section that follows, therefore, examines at length some of the culturally innovative interventions that have proved effective in

overcoming those barriers to eligibility, enrollment, and utilization described above, thereby increasing access to public health insurance programs for Latinos.

VI. Culturally Innovative Interventions

In their study of the ways in which managed care plans in California have adapted their services to the state's diverse populations, Coye and Alvarez (1999) introduce the idea of cultural competency by distinguishing it from cultural sensitivity. According to the definitions they provide, cultural sensitivity refers to an awareness on the part of health care providers of the impact that racial, ethnic, and linguistic variations can have on patient health. Coye and Alvarez distinguish this from cultural competency, which they define according to its functionality: cultural competency is "the ability to provide services [to diverse groups] that yield the desired clinical outcomes combined with a high degree of patient satisfaction." Given this emphasis on functionality, cultural competency is less a capacity for relating to others and more a set of practices or interventions that have concrete and measurable implications for health outcomes, cost-effectiveness, and level of patient satisfaction.

Although the ideal measure of cultural competency with respect to Latinos would be an improvement in health outcomes, very little of the existing literature attempts to investigate the effects of culturally competent interventions or practices on Latino health status. Most of the literature available on cultural competency is descriptive and focuses not on the effects of particular practices or interventions, but on the call for for providers to adapt services to the particular needs of the populations they serve. In the case of Latinos, this most often amounts to studies that demonstrate the need for linguistic adaptations such as the provision of interpreter services (Doty 2003), availability of bilingual and bicultural health workers (Center for Mental Health Services 2001), and Spanish translations of program information (Coye and Alvarez 1999). Other adaptations described in the literature include the establishment of community advisory committees that providers can consult to assess the changing needs of enrollees (Bureau of Primary Health Care 1999) and the inclusion of Latino cultural issues as part of the curriculum of US medical schools (Flores et al. 2002).

However, given that the focus of this literature review is Latino health status as reflective of access to public insurance programs, it might be more useful to define cultural competency here as interventions or practices

that are best able to reduce the gap between the number of Latinos eligible for public insurance and the number actually enrolled and utilizing available services. This makes sense when we recall that the impetus for this study is to determine why Latinos remain under-enrolled in Medicaid and SCHIP despite high levels of eligibility and despite measures such as eligibility expansions and established methods of outreach. Thus, culturally competent practices are those that are able to address and remedy the specifically *cultural* or non-financial reasons for Latino under-enrollment and under-utilization. This section will therefore focus on what we term "culturally innovative interventions"—methods shown to effectively reduce the gap between Latinos eligibility and their enrollment in and utilization of services—by examining recent literature that documents the effects of outreach practices on Latinos specifically or whose results can be applied to Latinos. However, in order to examine the culturally innovative interventions that have been most successful with Latino populations, it will be useful to first briefly review the general literature on outreach strategies in order to provide some basis for comparison.

General Literature on Outreach

When lawmakers signed SCHIP into existence in August 1997, federal legislation recognized outreach to be a central part of the newly created program. As defined by SCHIP legislation, outreach entails "activities to inform families of available coverage and to assist them in enrolling" (Westpfahl 1999). Title XXI mandated that states not only include such activities as a central component of their SCHIP program[10] but that they also submit a description of outreach plans to the federal government for review (Moore 1999). Further recognizing the centrality of outreach to the successful operation of SCHIP, the Health Resources and Services Administration (HRSA) of the United States Department of Health and Human Services (DHHS) created a standard for outreach in identifying four criteria of "model outreach programs":

1) program is tailored to serve specific populations;
2) program collaborates with existing networks and community organizations in order to efficiently use financial and social capital;
3) program relies on funding from both public and private sources; and
4) program implements and utilizes systematic collection of data in order to track program's effectiveness over time (Westpfahl 1999).

[10] Under 42 CFR 457.90

Most of the literature that describes general outreach practices reflects both these four criteria and the federal definition of outreach as consisting primarily of education and enrollment assistance. To that extent, we can divide general outreach strategies into two broad categories. The first is what might be termed a "call to action" strategy, the purpose of which is to familiarize the general population with the availability of public health care programs and services and to elicit inquiries from potential beneficiaries (Orchard Communications, Inc. 1999). Mass media campaigns, websites, telephone hotlines, local health fairs, and coordination with other government programs (such as school lunch programs) are all forms of a call to action approach. These broad, information-centered campaigns may be carried out through partnerships with county or community based organizations or through person-to-person contact, and may take place in innovative settings (e.g., malls, day care centers, fast food restaurants) or using innovative methods of information dissemination such as wash-off tattoos and refrigerator magnets (Westpfahl 1999).

The second type of outreach approach uses a strategy of assistance, whereby state- or community-level outreach workers help eligible families to navigate the enrollment process. Different states have tried various types of enrollment assistance, but the two main strategies are fee-based assistance and assistance via Community Based Organizations (CBOs). In fee-based programs, state certified assistants receive a stipend for each successful application submitted. In the case of assistance via CBOs, states or private organizations endow community groups with grants to fund state-certified assistants who then provide application outreach to target groups. It has generally been found that applications submitted with the aid of a certified assistant have a significantly higher application approval rating. For example, between July 1, 1998 and January 31, 2002, California's SCHIP program had a 79% approval rating for assisted applications compared to a 63% approval rating for non-assisted applications (Managed Risk Medical Insurance Board 2002a).

Most of the general outreach literature stresses the importance of simplifying enrollment and renewal processes as a way of maximizing the effectiveness of application assistance and removing unnecessary "procedural barriers" to the utilization of programs (Ross and Hill 2003). Also, in line with the "model outreach program" criteria defined by the HRSA, much of the literature suggests that alongside efforts to simplify enrollment and renewal processes, data collection must be a central component of outreach programs. In their survey of state outreach practices, for example, Ross and Hill (2003) mention the problems associated with a lack of quantitative data on outreach, stating that their research methods were limited to telephone interviews with program representatives and an examination of case studies because "rigorous studies evaluating specific outreach strategies

are largely unavailable." As we will see below, while the number of studies examining the effectiveness and cultural appropriateness of specific outreach interventions is increasing, these studies are largely qualitative measures conducted in localized areas and often admit to limitations in that regard.

The final issue in relation to the literature on federal and state outreach strategies as it pertains to Latinos is the role of private sponsors in enrolling beneficiaries in public programs. Several of the articles reviewed mention in particular the Robert Wood Johnson Foundation's "Covering Kids" initiative, a three-year, $47 million outreach effort implemented in 1997 that operated through state grants to all 50 states plus the District of Columbia (About Covering Kids 2003). The primary goals of Covering Kids overlap considerably with those specified in the general outreach literature. As stated by Judith Moore (1999), Covering Kids was established to "design and conduct outreach programs to assure children's health coverage, simplify enrollment processes, and coordinate existing coverage programs for low-income children."

What makes the Covering Kids initiative worth mentioning here is that part of this broad focus on outreach included a specific focus on Latino families. One of the projects funded by the Covering Kids initiatives, for example, convened public health workers and policy analysts specializing in Latino health in order to formulate a set of practices useful to enrolling Latino families in public health insurance programs. Through a partnership with the communications firm GMMB, the result of this collaboration was a communications kit entitled "Covering Kids: Reaching Latino Families." Printed in both English and Spanish the contents of the binder included specific information for conducting both community and media outreach, fact sheets on Latino health, template documents, and sample images for posters and fliers. Included among the outreach strategies discussed were the recruitment of *promotoras*, or lay community outreach workers; the use of holidays, cultural festivals, and other "fun" events as occasions for outreach; and relationship-building with existing networks of community organizations, businesses, schools, public programs, and health care facilities (*Covering Kids:* a National Program of The Robert Wood Johnson Foundation). In many ways, this initiative particularizes many of the main features summarized above from the general literature on outreach by stressing the dual importance of providing information and enrollment assistance.

In enumerating culturally specific methods of carrying out these two broad functions of outreach, the "Covering Kids: Reaching Latino Families" communications kit is thus a good way to segue from a discussion of general outreach literature to literature that documents culturally innovative interventions. Having first focused on some of the general strategies described by the literature, we are in a better position to see how specific interventions

are not only culturally specific and sensitive, but effective in terms of enrolling Latinos in public health insurance programs.

Literature on Outreach

When the general literature on outreach makes mention of issues related to Latinos and enrollment it is usually in the context of community-specific outreach procedures that target vulnerable populations (i.e. minorities, immigrants, children with special health care needs). Westphal (1999), for example, mentions that the ability to target specific populations is an important aspect of county- or community-based initiatives; Felland and Staiti (2001) elaborate more fully on this idea in their review of a report on local outreach efforts conducted by the Center for Studying Health System Change (HSC). In light of research suggesting that outreach is more effective at increasing enrollment than eligibility expansions, the HSC visited 12 communities around the nation and conducted interviews with outreach workers, county and state officials, providers, and SCHIP and Medicaid representatives. The goal was to survey the sorts of effective outreach activities at the local level so as to recommend state- and federal-level public health policies, particularly in a time of budget crisis. According to the study, states partner with a variety of different organizations; the most significant of these in terms of their ability to maximize enrollment of eligible populations are:

1. health care organizations such as hospitals, community clinics, and commercial health plans;
2. schools and school-related programs;
3. community and religious groups such as daycare centers, food banks, churches, homeless shelters, and AmeriCorps programs; and
4. employers, including businesses with large numbers of low-wage workers and small businesses that do not offer employment-based insurance (Felland and Staiti 2001).

A study by Howard L. Taras et al. (2002) expands upon the general findings of the HSC by looking specifically at the effectiveness of school-based assistance programs in one predominantly Latino community. In this study the authors examine the effectiveness of using schools as sites to conduct Medicaid and SCHIP outreach by focusing on the HATS (Health-Insurance Access Through Schools) program. HATS was an outreach effort implemented in California's San Diego County in 1999 following the initiation of the state's SCHIP program; the intent of the program was to use local schools to enroll eligible children that initial program advertisements had failed to reach. In addition to providing information and education about SCHIP and Medicaid, HATS provided

application assistance to eligible parents. The schools targeted by the program had large numbers of low-income families (below 250% FPL), of which more than 85% were Latino.

In their evaluation of the HATS program, the authors found that schools were particularly effective outreach sites given the access to large numbers of eligible children and information that would otherwise be difficult, if not impossible, to obtain (e.g. telephone numbers from school databases). Though the cost per enrolled child was significantly higher than the typical rate that the state pays application assistants ($75 as compared to $50), the authors concluded that this extra expense was cost-effective since HATS enabled outreach workers to reach those parents of eligible children who had not responded to broader methods of outreach (such as mailed flyers, notes sent home with students, or enrolling children on the basis of their participation in free or reduced-price lunch programs). As measured by the study, some of the effects of the HATS program included a greater utilization of well-child visits among those enrolled through HATS, including increased timeliness of required vaccinations. After one year of enrollment parents were also more likely to recognize the necessity of seeing a health care provider for issues such as obesity, gang involvement, and learning difficulties. From this study it is evident that while traditional, mass marketing-based campaigns may fail to reach many parents of eligible children, the strategic use of location and community-based resources can maximize contact between outreach workers and parents and, hence, increase enrollment of Latinos.

Community-based interventions have also proven effective in the realm of data collection on health insurance status among Latinos. In a study by Manos et al. (2001), researchers partnered with community members in order to gather information on the insurance and health status of Latinos in a predominantly immigrant community. Researchers trained women in Marin County, California to conduct interviews with Spanish-speaking mothers in their neighborhood concerning their children's health insurance status and access to care. The goals of the study were to develop collaborative relationships between communities and researchers, to utilize these collaborations to assess Latinos' eligibility for and enrollment in public insurance programs, and to use the results of community-based health investigations as the basis for interventions and policy recommendations. Community members interviewed a random sample of 252 mothers who provided information on 464 children between the ages of 0 and 18. Interviewers collected information on family demographics, medical insurance history, experiences in accessing health care, and mothers' opinions about health insurance.

From these interviews academic and community researchers found that 83% of neighborhood children were eligible for either Medicaid or Healthy Families (48.4% for Medicaid, 35% for Healthy Families). Of these, 28%

were not enrolled in either public health insurance program. Researchers found that un-enrolled children were older (median age 7 as compared to median age 4 for enrolled children), more likely to be non-citizens (22.2% compared to 4.8% for enrolled children), and less likely to have seen a doctor within the past year (58% compared to 78.7%). Researchers also determined that mothers of un-enrolled children had lower levels of education, were more likely to have paid out of pocket for medical expenses, and were more likely to cite difficulties with the enrollment process (such as providing documentation and understanding the required forms) (Manos et al. 2001).

Manos et al. suggest, however, that much of the difficulty in understanding enrollment paperwork resulted not from language barriers but from literacy levels, given that most families received care at a community health care center where bilingual forms and services were available. For example, despite the fact that "language barriers were not commonly cited as barriers to obtaining children's medical care," "nineteen percent [of mothers with non-enrolled children] said that the Spanish forms were hard to understand." This difficulty points to the difference between cultural sensitivity and the sorts of culturally innovative interventions necessary to reducing the gap between eligibility and enrollment. Linguistic services such as the translation of forms are often cited in the literature as being essential to providing culturally competent care (Doty 2003; Coye and Alvarez 1999; Bureau of Primary Health Care 1999). However, Manos et al. suggest that these services are not enough to boost enrollment of eligible Latino children; the authors point to the need for extensive community-based outreach and application assistance coupled with the streamlining and simplification of enrollment procedures.

This conclusion was also among the findings of Castaneda et al. (2003), who investigated best practices for enrolling eligible low-income children in California's First Things First (FTF) program. FTF was a health care initiative launched in 1998 by the California Health Care Foundation, which funded coalitions of public and private groups in nine California communities to determine the factors preventing eligible children from enrolling in Medicaid and SCHIP. These results were then to serve as the basis for formulating and implementing practices to get around these barriers.

Because community outreach workers were understood to be essential to the efforts of FTF, and because "[a] review of other studies reveals that although many broad generalizations are made about the importance of outreach, little specific guidance is provided for defining and conducting 'outreach' in the context of enrolling children in health insurance programs," the authors of the FTF study therefore attempted to identify specific characteristics of successful outreach workers and strategies (Castaneda et al. 2003). To collect data on these characteristics, Castaneda et al. conducted site-visit interviews with outreach workers and program administrators,

arranged monthly conference calls, and engaged in discussion with each of the 9 California FTF coalitions at a statewide conference. Using content analysis of the resultant data, the authors determined that successful outreach resulted from a combination of competent outreach workers and effective practices. Outreach worker competency was found to be a composite of personal/relational skills and training in seven key areas. These personal/relational skills include cultural sensitivity and linguistic competency; respect for confidentiality of information given by enrollees; ability to build community standing of the organization; commitment to community; capacity for effective communication on both one-on-one and group levels; ability to work independently; and flexibility and the ability to multitask. From interviews and discussions with program workers and representatives, researchers then determined that to be successful, outreach workers possessing these skills needed training in six different knowledge areas: overall outreach strategy, insurance rules and criteria for eligibility, immigration law pertaining to Medicaid and SCHIP, local organizations and networking strategies, client-centered outreach, and how to keep information confidential (Castaneda et al. 2003).

Yet the appropriate selection and training of outreach workers was found to be only part of successful outreach practices. Castaneda et al. found that effective outreach needed to combine competent outreach workers with three basic strategies for action:

1. Personal contact with clients. In the communities studied, this took the form of home visits and potlucks in rural areas, "street outreach" in urban areas, information sessions at places of employment, and aggressive personal follow-up for both enrollment and renewal processes.
2. Coordination between existing networks and programs. As has been documented in much of the literature on outreach, elementary and middle schools, community health centers, hospitals, churches, union meetings, neighborhood alliances, day cares, and other community organizations were strategically useful locations for conducting outreach.
3. Utilization of public communication strategies. Complementing personal contact, outreach workers would use community-wide events such as fairs and public celebrations to distribute information and advice about insurance programs. Radio programs were also found to be useful vehicles for spreading information, particularly in immigrant communities.

Thus, the best way to enroll all eligible children is to combine informed outreach worker selection and training with the use of specific types of action. However, the authors conclude that though this kind of outreach is essential, it must take place alongside an attempt to reduce structural barriers to enrollment at state and federal levels (Castaneda et al. 2003).

These structural limits to effective outreach have also been the subject of recent discussion among public health researchers, particularly as they pertain to racial and ethnic minorities. In December of 2003, the journal *Pediatrics* devoted an entire issue to the current state of SCHIP in regard to giving low-income children access to health care. Among the articles featured in this issue, two in particular have important implications for the issue of increasing Latinos' enrollment in SCHIP and Medicaid. In one of these studies Dick et al. (2003) examine demographic shifts in New York SCHIP enrollees between 1994 and 2001.[11] The objectives of the study were threefold: first, to describe the nature of these shifts; second, to ascertain whether changes in the populations eligible for SCHIP were responsible for demographic shifts; and third, to describe programmatic changes with respect to demographic changes in enrollees. The authors found that over the course of 7 years, enrollees in SCHIP are more likely to be older, poorer, and more racially diverse; they are less likely to have access to health care, as measured by longer periods of being uninsured before enrollment and by a decreased likelihood of having a usual source of care. Based on their findings, Dick et al. see these demographic shifts as less the product of changes in the populations eligible for SCHIP than in greater widespread knowledge of SCHIP as the program has matured. Changes in the program structure itself—a result of increased federal funding for outreach/advertising and enrollment simplification efforts—have also altered the demographics of SCHIP enrollees over time. Enrollment of Latino children in particular has increased significantly relative to enrollment of White children; in 2001 48.1% of SCHIP enrollees were Latino, as compared to 16.4% in 1994. In contrast, White enrollment fell from 74.3% in 1994 to 23.2% in 2001. By 2001 Latino children were thus the largest racial/ethnic group of enrollees in New York's SCHIP program.

A significant corollary to this dramatic increase in Latino enrollment is a shift in the ways enrollees first hear about SCHIP. In both 1994 and 2001 more enrollees surveyed originally encountered SCHIP via word of mouth than from other sources, with 38.8% of survey respondents replying that they learned about the program from a friend, neighbor, or relative. However, by 2001 this figure dropped to 28.3%, with more enrollees reporting that their first contact with SCHIP was through television advertisements (10.6% in 2001 versus 2% in 1994), outreach workers (13.1% in 2001 versus 2% in 1994) and doctor's offices or clinics (28.1% in 2001 versus 23.9% in 1994). When viewed alongside the fact that in 2001 nearly half of all New York SCHIP enrollees were Latino, this five-fold increase in the importance of outreach workers is significant. While these trends may simply reflect greater

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[11] Although SCHIP was not initiated at the federal level until 1997, NY has offered a children's health insurance

program maturity and funding of outreach, the authors also suggest that the growth and success of the program itself may indicate that current enrollment demographics more accurately reflect eligible populations. As the article states, "with 590,000 children enrolled in 2001, there was considerably less opportunity for differential selection than in 1994, when only 70,000 children were enrolled" (Dick et al. 2003). In this context, the increase in significance of outreach workers as a source of program information perhaps indicates the degree to which outreach has helped enroll those who were previously eligible but un-enrolled.

In another *Pediatrics* article from the same issue, Shone et al. (2003) examine the role of race and ethnicity among recent enrollees to SCHIP. The authors use data from the Child Health Insurance Research Initiative (CHIRI) to investigate differences in health insurance status and health care access between White, Black and Latino enrollees living in four states (Alabama, Florida, Kansas, and New York). According to the authors, the study is "the first multi-state investigation of racial and ethnic disparities among new SCHIP enrollees," and they are interested in determining whether, after controlling for other factors, race/ethnicity affects health insurance status and access to care prior to enrollment in SCHIP. Utilizing telephone and mail-in surveys with parents of newly enrolled SCHIP children, the study found that among new enrollees, Black and Latino children generally had poorer health status and access to care prior to enrollment, as determined by access and utilization measures such as prior enrollment in Medicaid, prior incidence of a usual source of care (USC), and prior continuity of care. Among socioeconomic measures surveyed, researchers also found that Black and Latino children were also more likely to live in a single-parent household, to have lower socioeconomic status, and to live in households with higher levels of unemployment or part-time employment. After controlling for other possible sources of disparity, researchers found that race and ethnicity at least partially affected health status and access to care among children newly enrolled in SCHIP; other factors possibly contributing to disparities included the type and extent of outreach efforts as well as the level of program maturity in different states of residence (Shone et al. 2003).

As discussed by the authors of the study, these results have important policy implications. Though SCHIP was found to have some involvement in reducing racial/ethnic disparities in health care access and health status, the fact that race/ethnicity has some independent impact on health status indicates that the provision of insurance to historically vulnerable groups may not be enough. Reducing these disparities will depend in part on "identifying and reducing non-financial barriers to care" (Shone et al. 2003)—that is, cultural barriers. The culturally innovative

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program, Child Health Plus (CHPlus), since 1991.

interventions that other recent studies have elaborated, however difficult it may be to generalize their results, may therefore be necessary to increase enrollment of minority children. In line with much of the other literature on outreach, Shone et al. also strongly recommend the systematic collection of data on race/ethnicity among SCHIP enrollees so as to monitor the effect of program efforts on disparities of access and outcome. Furthermore, because one of the findings of the study is that geography has a large bearing on the degree of racial/ethnic disparity among SCHIP enrollees, the authors state that interventions (including data collection) must be state-specific, a suggestion that resonates with the collaborative, community-based methods of data collection detailed above. Shone et al. conclude by referencing the potential effects of budget cuts on racial/ethnic disparities. They write, the "data presented here suggest that Black and Hispanic children could be hit the hardest by the most frequently discussed program cutbacks: benefit-package reductions, increased cost sharing, and capped enrollment. … [Thus] policy makers should think carefully about the effects of policy decisions on equity in access, use, and health outcomes among all racial and ethnic groups." We will return to this point in more detail in a later section of this report dealing with the policy implications of the current state budget crisis with respect to Latino enrollment in public programs.

VII. Conclusion: Best Practices in a Time of Budget Crisis

For the most part the literature does not address the effects of the budget crisis on state outreach practices, noting that this crisis is largely ongoing. However, since the beginning of the state budget crisis in 2001 (Ross and Hill 2003) a few researchers and policy analysts have made attempts to account for these effects. According to Jennifer Ryan, senior policy analyst for the National Health Policy Forum, the number of uninsured individuals grew from 41.2 million in 2001 to 43.6 million in 2002. At the same time, employer-based coverage decreased and unemployment grew, increasing the need for public health insurance programs at a time when states were experiencing a major shortage of funds (states were short $70 billion in 2003). The most common cost-containment strategies among states so far have been to decrease provider payments and access to prescription drugs, but states have also narrowed eligibility standards, eliminated outreach programs and enrollment simplification efforts, and increased cost sharing among beneficiaries (Ryan 2003).

However, in an inventory of SCHIP's sixth year, Ryan finds that SCHIP has been largely successful in providing low-income children access to health insurance. Between 1997 and 2003, the number of all uninsured children nationwide dropped from 13.9% to 9.1%, while the number of low-income uninsured children shrank by a third. This trend was largely due to states' attempts to simplify enrollment procedures and to target outreach campaigns to vulnerable populations. SCHIP also reduced rates of the uninsured among minority children; between 1999 and 2002, uninsured Black children dropped from 14.3% to 9.5%, and Latino children fell from 25.4% to 21.2% (Ryan 2003).

For these reasons, Ross and Hill (2003) stress that in times of limited funding, it is important for states to maintain both outreach efforts and efforts to simplify enrollment procedures. In particular, they recommend that states offer a seamless transfer between Medicaid and SCHIP, provide presumptive eligibility to eliminate waiting periods, link enrollment in Medicaid and SCHIP to enrollment in other public programs, and simplify renewal. Table 2 below summarizes the information and documentation requirements for Medicaid and SCHIP in 5 states. As the literature has shown, these efforts, among others, are of particular importance in enrolling Latinos. And while the literature does not yet quantify the effects of cuts to outreach on enrollment, in light of the foregoing discussion, it seems reasonable to suggest that if strategies that have proved successful in the past in enrolling Latinos are eliminated because of budget cuts, Latino enrollment in Medicaid and SCHIP will drop correspondingly:

Table 2: Information and Documentation Requirements for Medicaid and SCHIP Applications in 5 States

	California		**Florida**		**New York**		**Texas**		**Illinois**	
Info.	**Medicaid**	**SCHIP**	**Medicaid**	**SCHIP**	**Medicaid**	**SCHIP**	**Medicaid**	**SCHIP**	**Medicaid**	**SCHIP**
Income	✔	✔	•	•	✔	✔	✔	✔	•	•
Income deduc. [a]	✔	✔	•	•	✔	-	✔	✔	•	•
Assets	-	-	-	-	-	-	-	-	-	-
Interview	-	-	-	-	-	-	-	-	-	-

Legend

✔ = Information and documentation required.

• = Information required, documentation not required.

- = Information not asked for or required.

a= Income deductions allow families to deduct from the family's monthly income a portion of work-related expenses, out-of-pocket child care costs, and child support received.

Source: GAO analyses of states' joint applications and eligibility practices as of March 2001.

A review of the literature on barriers to health insurance among Latinos and of the literature on practices useful in overcoming such barriers yields a number of themes that point toward best practices. Among these are the following:

1. Because many of the barriers to enrollment that Latinos face are non-financial, eligibility expansions are a necessary but not sufficient condition of increasing Latino enrollment in Medicaid and SCHIP;
2. Strictly information-based outreach campaigns are not enough; personal contact with community insiders is necessary;
3. This personal contact must be intensive;
4. States must continue to combine community-based outreach with efforts to simplify and streamline enrollment and renewal procedures; and
5. Immigration laws, as they affect access to public services and public health insurance differentially, create barriers to enrollment and eligibility of Medicaid and SCHIP programs for segments of the Latino population.

It is significant that many of the above themes overlap with recurrent themes mentioned both in the focus group interviews we conducted and with current outreach strategies found to be effective in the five states studied in this report, as revealed via a telephone survey with agents for state Medicaid/SCHIP programs. Table 2 below summarizes state reported responses to questions regarding best outreach practices, particularly those that have been effective in reaching Latinos. This summary table was based on the state annual reports (Center for Medicare and Medicaid Services, State Children's Health Insurance Program 2001 State Annual Reports). As suggested in the literature, community based outreach strategies that rely on trusted community organizations such as schools and social service organizations and those that employ outreach workers who are culturally and linguistically sensitive are most likely to be effective in developing outreach strategies for the Latino community. More universal outreach strategies based on media—such as television or radio that are targeted to the Hispanic market—are important in effective media campaigns for the Latino community. However, little is mentioned in these reports of the broader institutional barriers, such as citizenship status, that may limit access to these programs

Table 3: State-Reported Best Outreach Practices

State	Best Outreach Practices	Outreach Practices Specific to Hispanic Population
California	• Advertising • Collateral and public relations • Community and school-based outreach • Certified application assistance • Health Faires • Public Service Announcements	• The advertising campaign includes Spanish
Florida	• School system • Family and friends • Television • Social Service Agencies • Newspapers • Radio Advertisements • Health Faires	• School system • Family and friends • Television • Social Service Agencies
Illinois	• Targeted outreach grants • Television ads • Print ads • Radio ads • Send applications home with students. • County fair outreach	• Television ads targeted to Hispanics • Print ads targeted to Hispanics • Radio ads targeted to Hispanics
New York	• Establishing relationships with organizations that represent migrant workers • County Fair outreach • Employing facilitated enrollers who represent and are fluent in language and cultures of target populations • Visiting major work places of target populations • Television ads (PSA) • Newspaper advertisements	• Establishing relationships with organizations that represent migrant workers • Employing facilitated enrollers who represent and are fluent in language and cultures of target populations
Texas	• Hundreds of community-based organizations • Free and paid media • Media relations • Corporate involvement • School based activities • Telethons	• Involvement of trusted individuals at the community level

Source: 2001 State Annual Reports

Focus Group Literature Review, Methodology and Findings

I. Literature Review

History of Focus Group Research in the Social Sciences

Though much of the literature reviewed suggests that the use of focus groups in academic research is a recent adaptation of traditional marketing research, other scholars have pointed out that this form of group interviewing technique is, in fact, indigenous to the social sciences, if underused until recent decades. In "Focus Groups – An Overview," Kristie Saumure (2001) states that the focus group emerged as an outgrowth of the turn to qualitative research in the 1930s, itself a result of the dissatisfaction researchers felt with established interviewing methods that privileged the agenda of the interviewer over the perspective of the interviewee. In 1941 American sociologist Robert K. Merton experimented with what Saumure calls "non-directive group interview techniques" (Saumure 2001), in which he asked audience members of a particular radio show not simply whether they liked the program or not, but also why their response was positive or negative. This was the first focus group, a term Merton would later invent in 1956 to refer to a type of informal interview in which the researcher asks a small group of individuals a series of open-ended but specific and guided questions about their attitudes toward and perceptions of a topic, medium, or product (Lewis 1995).

Throughout the 1950s, 60s, and 70s, focus groups were used mainly in marketing research as a means for assessing the effects of products, programs, services, and advertisements on consumers (Lewis 1995). A related use has been in the political arena, where focus groups serve as a "policy setting instrument" (Barnett 2003) that expand upon poll results by further probing voter impressions of particular candidates (Cohen and Engleberg 1989). It has only been recently that academic researchers, particularly social scientists, have begun to employ focus groups to their own ends—at first as a complement to other methodologies, and, by the late 1980s and early 90s, as "important data sources in themselves" (Barnett 2003). Fields as diverse as communications, education, and public health have used focus groups for their ability to reveal in-depth, individualized information inaccessible by way of either quantitative or traditional qualitative methods.

Focus Group Research in the Social Sciences: An Overview

Despite its disciplinary breadth and diversity the literature on focus groups presents a fairly consistent account of the structural and procedural features of this type of qualitative research. The typical focus group consists of one or two trained moderators who lead 6-12 interviewees through a structured set of questions on a specific topic. Interviews run 90-120 minutes and are highly informal, the goal being to promote free-flowing yet focused discussion of participants' responses to and attitudes toward the topic at hand (Bers 1989). Discussion sessions are recorded and transcribed, whereupon researchers analyze their content for recurrent themes.

The data generated through content analysis can be used for a number of purposes and in a variety of relations to other forms of research. For example focus group data can help to clarify or expand upon existing quantitative studies; it can also be used "pre-quantitatively" (Byers and Wilcox 1988), giving researchers insight into the constructs that everyday people use in conceptualizing particular topics, and thus into the type of language to use on surveys and in interviews. Focus groups can be used diagnostically, as a method that both pinpoints problems with a program or product and generates solutions. Focus groups can also be used as a "methodology of exploration" (Byers and Wilcox 1988), their data helping to generate hypotheses or ideas about a previously uncharted area of interest to the researcher (Bers 1989). But no matter what the use, the literature is almost unanimous in stressing that while focus group results can certainly complement and enrich quantitative data, they cannot serve as its substitute. Due to its highly subjective and contextual nature the data generated by focus groups cannot be generalized to larger populations (Barnett 2003).

Strengths and Limitations of Focus Group Research in the Social Sciences

As can be seen from this brief overview, there are a number of advantages and disadvantages that attend the use of focus group research. Some of the major advantages include the following:

- **Focus groups are exploratory.** As previously mentioned focus groups are a good source of information when there is a relative absence of prior research on a subject. According to Emerson and Maddox (1997), focus groups enable a researcher to enter a situation without knowing in advance what he or she will find—to "be surprised by the obvious and covert workings of that context."
- **The interactive nature of focus groups produces a type of information not accessible to other forms of research.** Focus groups prompt discussion that would not otherwise occur during either structured interviews or casual group conversation, as they allow participants to "bounce ideas off of each other" without being "limited to answering in a way that has been constructed by the researcher" (Saumure 2001).

- **Focus groups allow researchers to investigate a subject in greater depth and with greater accuracy.** The informal, relaxed atmosphere central to focus group discussion loosens participants' inhibitions, encouraging them to speak more openly and spontaneously (Byers and Wilcox 1988). Furthermore, the analysis of transcripts enables the researcher to examine "the exact words of front line participants" and thus to understand a situation much more deeply than through quantitative data or simple observation (Emerson and Maddox 1997).
- **Focus groups can be cost-effective for researchers and practical and empowering for participants.** The group interview can benefit research budgets by yielding more information in fewer sessions than individual interviews and with fewer demands on moderator time and energy (Saumure 2001). From the perspective of participants, focus groups act as institutional troubleshooting devices, assisting both "internal" and "external" audiences by enabling researchers and participants to collaboratively "integrate theoretical principles and best practice" (Emerson and Maddox 1997). This process can be empowering for focus group participants, whose collective input plays an active part in reshaping institutional or programmatic practices.

Like any research tool, however, a number of drawbacks accompany the use of focus groups. The disadvantages—many of which overlap with the advantages recounted above—include the following:

- **The interactive nature of focus groups can hinder the goal of evaluating people's attitudes and beliefs.** Though the dynamics of group interaction can often encourage conversation, they can also stifle individual expression. Certain personalities may attempt to dominate the conversation, and the desire for social approval can prevent people from saying what they think for fear of public embarrassment (Byers and Wilcox 1988). For this reason it can be difficult for the focus group researcher to distinguish individual from contextual responses (Gibbs 1997).
- **If the moderator and/or researcher are not aware of the problems associated with group dynamics, biased results can ensue.** If extroverts do all the talking or are the only ones who volunteer for focus group interviews, the resultant data will be weighted toward their opinions (Byers and Wilcox 1988). And even though the moderator's questions do not frame the discussion to the same extent that they do in a one-on-one interview, the questions nonetheless control the discussion setting; comments may thus be skewed in the direction of the researcher's agenda (Saumure 2001).
- **There can often be logistical difficulties in conducting focus groups.** While some researchers cite the cost-effectiveness of focus groups in relation to other methods of data collection, other scholars state that focus groups can be very expensive if conducted properly—using trained moderators, for example, and providing incentives and refreshments to participants (Byers and Wilcox 1988). Recruitment and screening of participants can present another difficulty, especially if researchers are probing for sensitive information or exploring the perceptions of a disenfranchised group (Saumure 2001; Keim et al. 1999).
- **The apparent ease with which focus groups can be assembled and moderated may be deceptive.** The informality of focus group discussions can suggest to researchers that their methodology need not be rigorous or systematic. In reality researchers and moderators have to follow specific guidelines so as to

ensure that data is not misapplied (Cohen and Engleberg 1989). As Trudy H. Bers (1989) writes in "The Popularity and Pitfalls of Focus Group Research," "the real danger is not that the research will lack utility, but that the results will be given more credibility than they warrant."

- **Lastly, the results from focus groups cannot be easily generalized.** As aforementioned, due to its highly subjective and contextual nature, the data generated by focus groups cannot be generalized to larger populations (Barnett 2003).

Despite the advantages and disadvantages associated with focus group research, the literature is adamant in stressing two points: one, that focus group research is undeniably useful when properly conducted with full knowledge of its limitations; and two, that its proper use depends on the objective of the project.

The Utility of Focus Groups in the Context of the Present Project

Given that the utility of focus group research is largely contingent upon the nature of the project involved, in this section we seek to clarify our decision to use focus groups in the context of the project's goals. Two questions are of particular significance here:

1. What is the overall goal of the project, and how do focus groups help us to realize this goal?
2. How have we attempted to control for the limitations of focus group research?

As stated in our project proposal, the goal of the current research is two-fold. First, we intend to survey the current status of US Latinos in regard to health care and health insurance. To that end, project staff synthesized literature in the area of access to health care programs that affect Latino subpopulations, focusing on federal and state programs such as Medicaid and SCHIP. The second part of the project is investigative, attempting to identify those programs and practices that have successfully increased access to health care among Latinos. We were interested not only in those programs that have increased Latino enrollment rates in public health insurance programs, but also in those that have ensured effective and culturally competent use of health care services, resulting in high levels of patient and provider satisfaction.

It is largely this emphasis on best practices that shaped both our decision to use focus groups and to adapt the standard model described in the literature to suit the specific needs of the project. Because focus groups allow us to converse directly with frontline participants in the day-to-day functioning of successful outreach programs, they are uniquely suited to the task of providing in-depth information on a subject that has not yet been explicitly or systematically explored. In this respect our decision to use focus groups was based mostly on their exploratory, pre-quantitative potential.

This focus on best practices has also governed some of our methodological choices described below, in particular the way we conducted focus groups in relation to our understanding of their limitations. Because we were mostly investigating site-specific examples of exemplary practices, the ability to replicate our findings was less of a concern than it might have been if we were interested in the representative experience of a target group. Our strategy was thus to conduct one group interview per different locale as opposed to the more standard practice of repeating several interviews with the same group of people until the information begins to repeat (Barnett 2003; Byers and Wilcox 1988; Keim et al. 1999). The size of the groups with which we met during the site visits also tended to be smaller than the figures described in the literature; according to Lewis (1995), however, smaller numbers may be advantageous when conducting focus group interviews with experts or when the researcher is looking for more specific information than just the open-ended expression of general feelings and perceptions. These structural modifications, then, were made not out of ignorance of the need for systematization when conducting focus group research, but rather out of consideration for the requirements of the project. Further, they were made in the explicit understanding that the results garnered by the interview process would be preliminary only, with limited application outside of their ability to suggest future quantitative studies and directions for policy.

II. Focus Group Methodology

Site Selection

In undertaking the focus group process, the project staff selected program sites to visit. Because the federal government requires that states provide outreach services for their health care programs—particularly for the State Children's Health Insurance Program (SCHIP)—the search for "best practices" began by first reviewing state-produced documents on outreach services and then contacting outreach coordinators for the SCHIP program. We discovered that neither California, Florida, Illinois, New York, nor Texas performs a thorough identification of best practices. Since outreach strategies and application assistance vary from state to state, we determined that insider knowledge of the programs on the part of outreach coordinators would be necessary in order to identify successful practices.

The initial criteria consisted of outreach practices that:

1. Focused on Hispanic communities;

2. Provided bilingual assistance;
3. Helped to enroll a large number of beneficiaries;
4. Sought to educate enrollees about the importance of preventative care; and
5. Worked towards creating partnerships with other community organizations.

What we found was that states often identified best practices by relying on criterion number three, which could be due to the relative ease with which locations that provide enrollment assistance can collect this kind of data. Focusing on the volume of applications is misleading, however, because it may speak more to population size rather than the effectiveness of a program's outreach services. Our next step was thus to contact state outreach coordinators who were able to refer us to community-based organizations (CBOs) whose successful practices would make them potentially useful for on-site visits. In this manner, we located three such organizations in Florida, Illinois, and California.

Florida

Florida is one of two states that do not coordinate outreach at a statewide level. Instead, it uses 17 regional outreach coordinators. We decided to concentrate on the outreach efforts in Dade County given that Latinos make up 57% of its population (Census 2000). Christine Irwin is the outreach representative for the Human Services Coalition (HSC) of Dade County, which is the regional arm of KidCare, Florida's SCHIP program.[12] In a telephone conversation, she identified four CBOs with outreach groups that worked with the county:

Organization	Contact	Phone number
GALATA Inc.	Joseph Luis	(305) 242-7060
Hispanic Coalition	Maria Lima	(305) 262-0060
Regis House	Jose Aquino	(305) 642-7600 ex. 208
STEPS in the Right Direction	Michael Salem	(305) 231-9936

After looking into these different CBOs, we chose Regis House because it most closely met our listed criteria. In addition to being highly respected by the HSC, Regis House has created the Healthy Outreach Program, which attempts to increase enrollment in Medicaid and SCHIP by holding community events and creating partnerships with local organizations including schools, health organizations, churches, and small businesses. They

provide bilingual services, assist with applications to the KidCare program, and work with health providers in the area to bring those unfamiliar with the health care system into a welcoming and culturally competent health care environment.[13]

Illinois

Initially, Illinois employed both fee-based enrollment entities and CBOs. Due to budget restrictions, the state discontinued their use of fee-based enrollment entities during FY 2002-2003. In order to compensate for this loss, they continue to work closely with privately funded CBOs, particularly the Covering Kids and Families Illinois (CKF-IL) statewide coalition. Gretchen Pence is the Outreach Coordinator for KidCare in Illinois. After speaking with her, she suggested contacting Laura Leon of the Illinois Maternal and Child Health Coalition (IMCHC).[14]

Illinois Maternal is the lead organization for the CKF-IL coalition. The main goals of the coalition are to reduce the number of uninsured children and adults eligible for but un-enrolled in Medicaid or SCHIP and to push for national and regional policies that will provide an enduring commitment to the use of health care services and the retention of beneficiaries. IMCHC works with schools, faith-based organizations, health care providers, and small businesses. Laura Leon is the outreach coordinator for IMCHC and was specifically chosen because of her extensive knowledge of both the state's outreach practices and the work of CBOs within the CKF-IL coalition.[15]

California

California uses both CBOs and fee-based enrollment entities in its outreach efforts. In our search for best practices, we were, therefore, interested in both types of programs and contacted several organizations that we felt could direct our search. These organizations included the Managed Risk Medical Insurance Board (MRMIB), the Healthy Families Program, and the MediCal Policy Institute. But unlike the processes described above for Florida and Illinois, we were unable to locate an outreach coordinator in California who would disclose the name of a specific group identified as exemplifying outstanding outreach practices. Instead, all three organizations that we contacted referred us to a document that rank-ordered the most successful fee-based enrollment entities on the basis

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[12] We contacted Christine Irwin on February 19, 2003. Email: chrissiei@hscdade.org, Phone: (305) 576-5001 x 16.
[13] More information on Regis House can be obtained from the Regis House website (http://www.regishouse.org).
[14] We contacted Gretchen Pence on February 13, 2003. Pence can be contacted by email at aidd2053@mail.idpa.sate.il.us, and by telephone at (217) 524-7156. Laura Leon can be contacted by email at lleon@ilmaternal.org, and by telephone at (312) 491-8161.

of the number of applicants enrolled. Though this alternative was less than ideal, we attempted to contact five of these organizations, an effort that proved generally unfruitful.

Because of financial and time constraints, our next strategy was to focus on potential sites in our immediate vicinity, since, by this time, we already had conducted the first two focus group interviews in Miami and Chicago. For this reason, the list of organizations from which we ultimately chose was limited to a few key programs, all of them medical clinics, operating out of the Central Valley region of California. They are listed in the table below.

Organization	Contact	Phone Number
Alliance Medical Center	Max Dunn	(707) 431-8234 ext. 208
Southwest Community Health Center	Naomi Fuchs, ED	(707) 547-2252 ext. 111
Sonoma Valley Community Health Center	Patricia Talbot	(707) 939-6070

But though the decision to narrow the list as such was primarily logistical, our choice proved an expedient one as well, for the Central Valley is home to a large number of both documented and undocumented Latino farm workers for whom the issue of access to public health insurance and quality medical care is crucial. Alliance Medical Clinic was our first choice out of the three sites because of its local and statewide reputation for providing such services to the underinsured and predominantly Latino farm worker population of California's Central Valley (Rose 2003). However, Alliance was in the process of moving its facilities to a new building and was not able at that time to participate. We next tried Southwest Community Health Center in Santa Rosa, California, speaking with its director, Naomi Fuchs. She indicated that she and her staff would be interested in participating and Southwest became our third focus group site.

Interviewing Methods

In tandem with the site visit selection process, another crucial part of our methodology was to draft what Lewis (1995) has called "questioning routes" for those whom we would be interviewing. In creating a list of queries, we kept in mind the set of five criteria by which we had selected sites (focus on Latino communities, linguistic and

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[15] More information on Illinois Maternal and Child Health Coalition can be obtained from the Illinois Maternal website (http://www.ilmaternal.org).

cultural competency, enrollment outreach, education on preventative care, and policy implications). Our list consisted of the following questions:

1. What are the main outreach strategies you employ to enroll individuals in Medicaid and the State Child Health Insurance Program (SCHIP)?
2. Have you collected any descriptive or empirical evidence before and after you employed your outreach strategies? If so, are they available for public dissemination?
3. How would you define cultural competency as related to the Hispanic population and enrollment in Medicaid and SCHIP?
4. What specific steps have you taken to integrate these ideas of cultural competency into your enrollment strategies for Hispanics? Could you list them?
5. What has been your response to a demand for Spanish speaking outreach? Do you feel your response has been adequate?
6. Do you have any available satisfaction surveys, or indicators of recipient satisfaction with outreach, education, and enrollment in Medicaid and SCHIP? If not, what is your perception of satisfaction?
7. Do you have any documented information on reasonable use of health care services (i.e. regular and continuous use of primary care for your Medicaid and SCHIP patients)?
8. Do you have any policy recommendations based on your observations that will enhance enrollment and utilization of Medicaid and SCHIP?
9. Budget restrictions in your state may cause some health care programs to be cut; how do you feel this will affect enrollment and utilization of Medicaid and SCHIP services? What have you experienced that leads you to draw such conclusions?
10. Do you have any policy recommendations or planned changes in strategy to continue successful enrollment of Hispanics in Medicaid and SCHIP in light of state budget restraints?

Along with a description of project goals, methodology, and use of data, this list of questions was submitted to the Human Subjects Review Board (IRB) at the University of California, Davis for review and approval of exemption status. The IRB had originally granted this exemption back in November of 2001, and reauthorized it for one year beginning February of 2003. Following the IRB's re-approval project staff made arrangements for the site interviews in Miami and Chicago (we would make these same arrangements for the California site several months later when we had finalized site selection).

Interviews in Miami and Chicago were ultimately conducted July 22 and 24, 2003, respectively, while the interview in Santa Rosa took place on December 17, 2003. In the first two interviews the Principal Investigator (PI) and the Co-PI served as moderators, while the final interview was conducted by the PI with the assistance of one of

the graduate student members of the project staff. In the meeting with Regis House in Florida, two informants were present, while the moderators met with five informants from Illinois Maternal and six from Southwest Community Health Center. As is standard procedure for focus groups, all interviews lasted approximately 120 minutes and were recorded for later transcription and content analysis, the results of which will be discussed in the following section of this report.

III. Key Findings of Focus Group Interviews

Common Themes and Trends

In responding to the ten interview questions, focus group participants at the three sites articulated a number of common themes and concerns regarding Latinos' access to public health insurance programs. These themes resonated with those documented in the aforementioned literature on outreach. Content analysis of the interviews conducted in Miami, Chicago, and Santa Rosa reveal that these common themes can be organized into five broad topic areas: barriers, outreach strategies, data collection, cultural competency, and policy suggestions. What follows is a summary of themes shared by all groups in these five general areas, as well as a more elaborate enumeration of the themes that, while not necessarily consistent across groups, nonetheless surfaced in important ways for some of the groups.

Barriers Mentioned by All Three Focus Groups

- People need help filling out the applications.
- Application forms are confusing.
- Some applicants have low literacy.
- There is a fear that enrolling in the program will jeopardize their immigration status (the issue of "public charge").
- Budget cuts have reduced or threatened to reduce outreach, training, and/or job security.
- The process of enrollment is complicated by Medicaid.
- State caseworkers and their agencies are difficult to deal with and tend to be less sensitive to community members than outreach workers and enrollment agents. They are also less likely to be bilingual.
- People often lose their enrollment status during the renewal process.

- Outreach workers have difficulty acting on behalf of their clients with respect to state caseworkers due to issues of confidentiality.
- People need face-to-face contact, which is time consuming.
- Generally, members of the Hispanic community are not comfortable using "hotlines" even if they offer a Spanish option.

Barriers Mentioned by Some of the Focus Groups

Barriers	**Chicago**	**Miami**	**Santa Rosa**
Community members are unaware of the structure of health care delivery.	√		
The Hispanic community is not eager to accept "handouts."	√		
The renewal process is complicated by the addition of a state caseworker.	√		
Once enrolled, people sometimes do not understand how to use the benefits.	√		
Some providers do not accept the health insurance of those enrolled.	√		
Patients do not understand the need for preventative care.	√		
Income declaration can be difficult, especially when people are paid in cash.	√	√	
There is a lack of data about the community.	√	√	
Some clinics are not flexible with their schedules, making it difficult for some to seek care.	√		
There is a lack of trust in government agencies.		√	
People use the emergency room if they do not have insurance or they do not know how to use their insurance.		√	
There is a frequent staff turnover and a lack of trained persons who understand the program.			√
Providers are not very familiar with the programs.			√
Spanish translations are confusing.			√
There is a lack of communication between state agencies and outreach.			√
Executive directors who hire outreach workers may not be looking for the most important qualities.			√
People are sometimes charged for things that should be covered by their insurance.			√
People indicate that they understand explanations when they really do not.			√

Current Outreach Strategies Mentioned by All Three Focus Groups

- Focus on educating the community.
- Have information available that is culturally and linguistically sensitive in Spanish and English.
- Partner and work with other local organizations.
- Help people to fill out forms.
- Perform outreach at community events.
- Make phone hotlines available.
- Employ culturally competent staff members.
- Provide brochures and flyers.
- Perform enrollment more generally.
- Utilize radio advertising.

Outreach Strategies Mentioned by Some of the Focus Groups

Strategies	**Chicago**	**Miami**	**Santa Rosa**
State offers monetary incentive ($50) for each accepted application.	√		
State covers legal immigrants during the time of their 5-year ban from public services.	√		
Make efforts to establish trustworthiness and credibility in the community.	√	√	
Use newspaper advertising.	√	√	
Count on word of mouth.	√	√	
Try to "bombard" the community with messages.	√		
Work in local schools.	√	√	
Design a "faith-based tool kit."	√		
Create contact lists at large events.	√		
Simplify the application process.	√		
Are sensitive to asking for social security numbers.	√		
Provide enrollment agents and counselors in the clinic.	√		√
Work to educate community leaders.	√		
Emphasize personal contact.	√	√	
Use trusted locations as intake sites.	√		
Belong to a statewide coalition.	√		

Strategies	Chicago	Miami	Santa Rosa
Explain the importance of health insurance.	√		
De-emphasize the fact that it is a state program.	√		
Presume eligibility in some clinics for patients who need treatment before they are enrolled.	√		
Share costs with other community groups.	√		
Inform people through media of the paperwork required to enroll.	√		
Establish a presence by traveling into the community.		√	
Obtain training by a state agency.		√	
Use poverty guidelines to make preliminary judgments of eligibility.		√	
Outreach workers also perform clinic referrals.		√	
Work with a nurse practitioner who is very familiar with the programs.		√	√
Establish links with other clinics.		√	
Work outside of standard working hours.		√	
Obtain grant money to fund certain outreach.			√
Work with local businesses.			√
Use the phone directory to make initial contact with potential clients.			√
Write letters to church priests.			√
Use the clinic database to find clients by targeting those who are self-paying.			√
Send information to lawyers to clarify the “public charge” issue.			√
Get in touch with people by using state agency lists of Medicaid recipients.			√
Advocate for changes at the state level.	√		

Data Collection

None of the groups have done research or keep data that specifically relates to outreach. Generally, they rely on observation to determine which strategies work best.

Aspects of Cultural Competence Mentioned by All Three Focus Groups

- Cultural competence requires having staff who are both bilingual and bicultural.
- Culturally competent individuals have compassion for the community they serve.

Aspects of Cultural Competence Mentioned by Some Groups

Cultural Competence	Chicago	Miami	Santa Rosa
Cultural competence requires understanding variations within the Hispanic community.		√	√
A culturally competent person comes from that community.	√	√	
Cultural competence requires communication skills and customer service.		√	⎫
Cultural competence requires an open mind.		√	
A culturally competent person has good translation and explanation skills.		√	
Cultural competence requires one-on-one interaction and personal relationships.			√
Cultural competence requires consistency in the people who interact with the community.			√
Cultural competence requires patience and listening skills.			√

Policy and Funding Issues and Suggestions Mentioned by all Three Focus Groups

- Funding cuts threaten their work and reduce job security.
- There should be coverage for undocumented people.
- Cultural insensitivity and lack of compassion from state agencies is a problem.

Policy and Funding Suggestions Mentioned by Some Groups

Policy and Funding Suggestion	Chicago	Miami	Santa Rosa
The state should create informational materials that address the "public charge" question.	√		
Clinics should use "presumptive eligibility" to provide services to people who are not yet enrolled.	√		
The application should be further simplified, particularly concerning income declaration.	√		
There should be funding to support helping people to use the benefits once they are enrolled.	√		
Time allowed to submit documents should be increased.	√		
Program representatives should be in every clinic.	√		
The benefits card should last 12 months rather than one month.	√		
The process of enrollment, or retroactive coverage should be faster.	√		
Enrollment agents and caseworkers need to be available outside of regular working hours.	√		
A more efficient system for reaching free-lunch eligible school children should be created.	√		
Outreach workers should be able to talk with caseworkers about their clients.	√		
More data would help outreach workers to target those likely to be eligible for enrollment.	√		
Outreach should be coordinated at the community, county, and state levels.		√	
The potential for a web-based eligibility and enrollment system should be explored.		√	
More funding should be made available for education.		√	
Outreach workers should continue to be funded because they mediate between clients and state agencies.			√
Providers need better training and manuals.			√
The hiring process should take into consideration cultural competence and compassion for the community.			√
There is a need for more education in preventative and prenatal care.			√

Particular Themes and Trends at Each Site

Having presented a summary of those themes and concerns found to be recurrent across sites to varying degrees, the following tables more extensively detail the themes and trends particular to each site with respect to barriers, outreach strategies, data collection, cultural competency, and policy and funding suggestions.

Barriers		
Chicago	**Miami**	**Santa Rosa**
• The applications can be confusing and many of the eligible candidates have low literacy levels. • Many Hispanics are especially concerned over the "public charge" issue when considering assistance for themselves or their children. This fear exists despite the fact that children of undocumented persons may be US citizens. • Budget cuts have caused the IMCHC to reduce staff. Some phones are now answered by recordings. • The level of illiteracy creates a challenge for education and enrollment, especially when missing one question on the application can drastically delay the process. Questions can be perceived as detailed or ambiguous and even those who are literate need assistance filling them out. • In the Hispanic community, people are generally unaware of the health care structure and the potential cost burden of health care in the US. They may not understand that they need to see a doctor to get a prescription for common medications. This may account for the lack of enthusiasm in the Hispanic community to find and use insurance. • The renewal process is difficult,	• People do not fill out applications unless they have help. • Immigrant communities are skeptical of government programs. • Immigrants are concerned that by enrolling in government programs they might become a "public charge" thereby jeopardizing their immigration status. • There is a lack of trust in US agencies and fear that personal information will be used for reasons other than those stated (e.g. by the INS or child protection services). • Income declaration can be a tedious process. • Medicaid eligibility confuses the application and renewal process by adding a caseworker at the county level along with more appointments and evaluations. • There is a paucity of bilingual/bicultural staff at the county level to deal with Medicaid applications. • For Medicaid applications, people have to go through an extensive and inconvenient evaluation process. For renewals, they also have to see a caseworker. • There is a general lack of information about the communities that outreach workers serve. • Funding cuts have eliminated mass outreach campaigns and have resulted in	• Some outreach workers are not well informed on MediCal. • They have a problem in that lawyers will advise people not to enroll in the programs because they believe it is a "public charge." • Community members are unwilling to do paperwork by themselves. • There is a lack of trained persons who understand the programs. • Frequent staff turnover due to poor salaries creates a situation where staff members are not well trained. • There is a lack of money for proper training at the local and state levels. • There is a marked lack of cultural sensitivity with the telephone information lines. • Hotline phone systems are confusing and difficult to deal with, especially for less educated people. • There is a lack of consistency with caseworkers at the state level. People have to deal with several different administrators. • Outreach agents do not have access to client's confidential

particularly if the patient is also enrolled in Medicaid. They then must see a state caseworker. State caseworkers are less likely to be bilingual/bicultural and are less sensitive than the outreach workers. Clients are unlikely to have a face-to-face interview, help with the renewal forms, or the option of using Spanish-language forms. • The Hispanic community generally has a high work ethic and is not enthusiastic about "handouts." • Getting government assistance has a stigma attached to it. This stigma is more of a problem with the renewal process than with the initial enrollment. • Some community members have expressed a preference for paying out-of-pocket over dealing with state offices. • State agents tend to be less sensitive to work hours and more suspicious of legal status. • Once they receive their benefits, some people have difficulty finding primary care physicians or understanding how to use the benefits. • Some providers, especially in remote areas, do not accept the program, forcing patients to travel to obtain care. • Some patients do not understand the value of preventative care. • State agencies that distribute the enrollment cards can be difficult to deal with. • Some people are paid salaries in cash, which makes income documentation difficult. • Budget cuts limit outreach.	cuts in outreach to schools, health service centers, community-based organizations and day care centers. • They have very little job security. • People are unwilling to fill out the forms or call caseworkers without the help of an outreach worker they trust. • Outreach workers do not ask for verification of income. Therefore, much time might be wasted as they go through the process with someone who is ultimately rejected. • State agencies will not share enrollment information about a client unless the client has signed a waiver. This makes it harder for outreach workers to track a client's success. • Following up on applications is expensive and time-consuming. • People use the emergency room if they do not know how to access or use insurance. • There is a 5-year bar from public services for immigrants. • Undocumented people are only able to access health care through federally qualified health clinics. Transportation to these clinics can be an issue. • The enrollment process is lengthy.	information and are unable to advocate at the state level. • Providers are not well educated in the programs. • Application forms are confusing. • Spanish interpretations of forms are often confusing to the clients. • California Kids is beginning to charge premiums of $25 per child. • There is a lack of communication between the state agencies, providers and outreach agents, which often results in the dissemination of misinformation. • There is a fear of policy changes. From the news media, they hear that policies might be changed to require schools, hospitals and health care centers to ask for documentation of legal status before offering services. • Executive directors of clinics who hire staff are not always aware of the skill set needed. • Although providers have information about the programs, it is often confusing. • People are sometimes charged for things that should be covered by the insurance, and rather than fill out the paperwork, people tend to pay the charges. • People often indicate that they understand when they do not. The outreach agent must reinforce ideas and quiz people during the enrollment process.

• Budget cuts are resulting in layoffs. • There is concern that new policies will result in a reduction in services. • Employers can be reluctant to work with KidCare because of the stigma attached. • There is a lack of data and information about the communities (number of undocumented, etc). • The Department of Health Services (DHS) does not have many bilingual/bicultural staff members. • People fear the cost of health care even if they have insurance. They don't understand the cost structure. • Some clinics are not flexible with their schedules. • Informed consent is required in order for an agent to advocate on behalf of a client. • People do not respond to applications and information left in various locations such as the library. • People are unlikely to call a toll-free number probably for fear of a language barrier.		

Types of Successful Strategies		
Chicago	***Miami***	***Santa Rosa***
• IMCHC employs mostly outreach workers who are also application agents. An outreach worker who is also an application agent is much more productive in the enrollment process than someone who only educates communities. • Outreach agents focus on educating the community, making enrollment much	• Regis House goes into the communities they serve to meet and enroll people. • They emphasize education in the enrollment process. • They try to establish credibility and trustworthiness. • They link with other community organizations. • They put an emphasis on personal contact	• The Community Health Center helps people to fill out forms. • They have obtained a grant to fund some enrollment outreach. • They have a nurse practitioner who knows the programs very well and encourages people to enroll. • They host community events where they have booths and signs.

easier. • The state of Illinois actively encourages program enrollment by awarding $50 for each accepted application. • The state covers legal immigrants during the 5 years they are barred from the use of public services. • They make an effort to be friendly, trustworthy, and available. • They employ Spanish and English media, grassroots campaigns, and other events to educate the community. • Some enrollment results from networks and word-of-mouth. • They attempt to "bombard" the community with messages. • In distributing applications through outreach and awareness campaigns at local schools, they maximize their use of time by targeting "free-lunch" eligible students. • They work with local organizations such as faith-based groups and have established links with community partners. • They have designed a "faith-based tool kit." • At large events, they screen people for eligibility and create contact lists that they use to call people. • They simplified the application itself and successfully made that change at the state level. • They have learned not to ask for social security numbers of parents whose children might be eligible. • They have someone on-site in clinics to counsel people with KidCare and help	with clients. • They use radio to advertise health events. • Their program has become known through word-of-mouth. • They have received training in outreach strategies from the Human Services Coalition. • They use federal poverty guidelines to make preliminary judgments of eligibility before starting the application process. • Outreach workers are also enrollment agents. • Their staff members are culturally competent. • They have information materials available in different languages. • Outreach workers also do clinic referrals. • They perform outreach in schools through school-based health centers. • They have an on-staff nurse practitioner. • They have links to contacts at health clinics. • Because CHIP enrollment will be "capped" the outreach workers are shifting their resources toward helping people use the insurance effectively. • Much of the outreach is done outside of normal working hours (i.e. evenings and weekends).	• They use radio and newspapers to advertise. • They work with local businesses. • They use the local directory to make phone calls. • They take care to explain INS issues. • They write letters to churches to be read to the congregation (in Spanish). • They create flyers in English because they believe flyers are more effective with the English-speaking population than with Spanish-speaking people. • They target all self-pay clients in their health system database. • They send information to lawyers to clarify the relationship between enrolling in these programs and adjusting status with the INS. • The Healthy Families program allows people to indicate that a third person may have access to their information. This allows the outreach workers to call and advocate on behalf of the patient. • They have an enrollment agent in the lobby of the provider's office. • They have been given a list of clients from MediCal whom they call when it is time to renew enrollment. • They prioritize empowering clients by teaching them how to do things on their own.

them through the application process. • They help clients to fill out applications. • They meet with community leaders and have created a fact sheet to explain the issue of "public charge." • They emphasize education and personal contact in their campaigns and try to put a "face" on the program. • With radio advertisements, they have agents talk directly to the public about programs. People recognize these enrollment agents. • Community members are greeted with smiles and positive attitudes by bilingual staff, which signals a helping and caring environment. • They have a sign in the clinic window to increase visibility. • They use trusted locations as intake sites. • They belong to a statewide coalition that enables them to strategize, resolve issues and smooth gaps between organizations and establish a better understanding of community needs. • The state has created English and Spanish brochures and applications. • They advocate for institutionalizing changes by having them implemented at the state, rather than local level. • They have a "hotline" with bilingual staff. • They have created a fact sheet in English and Spanish that explains the importance of health insurance. • The KidCare brochures do not have the state logo so they look more "friendly" and less like a government program. • Some clinics will use "presumptive		

eligibility" allowing people to receive care before their application is approved. • They try to share costs at outreach events (for booths, etc.) with other community groups. • They increase efficiency of outreach events by informing the public through flyers and newspapers of the documentation they should bring to events for eligibility assessment.		

Data Collection		
Chicago	***Miami***	***Santa Rosa***
• They have a tracking system for people they contact at various events. • They feel that documentation and data collection can be a burden on already busy outreach workers and enrollment agents. • From the basic data, they have observed that state enrollment numbers consistently went up until budget cuts forced them to curb outreach. • They have only general information that allows them to link enrollment with outreach strategies.	• They have information about access to health insurance from a University of Florida Survey. • They use anecdotal evidence to determine which strategies are most effective.	• They do not perform any surveys or data collection. • They make judgments on the effectiveness of various strategies based on observation.

Cultural Competence		
Chicago	***Miami***	***Santa Rosa***
• They believe that cultural competence requires both bicultural and bilingual competence. • They prefer to hire Hispanics to work in Hispanic communities. • They believe that cultural competence means having compassion for the community and understanding its struggles.	• In Florida it is especially important to understand the variations in cultures between Hispanics from different regions. • They believe a culturally competent person comes from the community and understands local problems, issues, and institutions. • A culturally competent person speaks the language of that community and has compassion and concern for its members. • Communication and "customer service" as well as an open mind are important to cultural competence. • Good translation and explanation skills are also helpful when working with different cultures.	• They believe that cultural competence in the Hispanic community requires one-on-one interaction and the development of a personal relationship. • Spanish-language fluency is important when working with the Hispanic community. Caseworkers and agents should be bilingual and bicultural. • The respondents feel that having consistency with their caseworker is important in the Hispanic culture. • Part of cultural competence is having patience and listening skills. • It is important to understand that literacy is an issue in the Hispanic community. For those who can read, literature must be written at a level people can understand, especially when considering those for whom English is a second language. • It is important to have training on the variations within the Hispanic community and to not make assumptions that all Hispanics are the same. • Customer service and the ability to educate are important characteristics of a culturally competent individual.

Policy and Funding		
Chicago	***Miami***	***Santa Rosa***
• The state should create informational materials addressing questions of "public charge" and the importance of health insurance. • The practice of using "presumptive eligibility" allowing people to receive care before their application is approved should be more widespread. • The application process needs to be further simplified, particularly in terms of income declaration. • Funding should be made available to help people access health care (e.g. help finding providers) once they are enrolled in the program. • The application should allow for self-declaration of income. • More time should be allowed for submitting documents. • There should be a "KidCare" representative in every DHS office. • 12-month rather than 1-month cards should be issue. • There should be a faster process to enroll people in SCHIP and/or retroactive coverage. • There needs to be access to agents, caseworkers and health care outside of normal working hours. This may require a phone or web-based system. • Coverage for undocumented people should be made available. • A more efficient system for reaching free-lunch eligible school children should	• Outreach should be coordinated at the community, county, and state levels and between public and private agencies to eliminate redundancy and increase efficiency. • All children should be eligible for the program, not only those who are documented and have been in the US for more than 5 years or those who have special medical needs. • Create a web-based eligibility and enrollment system for Medicaid similar to the one available for food stamps. This process would be done at the local level and eliminate the need for a state caseworker. • Spend more time educating people about the program and how to use the benefits.	• Funding reductions threaten jobs and reduce the level of consistency when caseworkers and agents leave their posts. • Funding reductions will put stress on clinics that will then be inundated with Medicaid clients. • Outreach workers are also mediators with state agencies. If their funding is cut, linkages will be lost. • Security in funding must be established for outreach agents. With funding cuts, jobs will be lost. The linkage with clients could be lost and clinics could lose money as people choose to go the emergency room rather than the clinic. • If funding restrictions limit the number of enrollment agents, people will be required to travel long distances to enroll in the programs. • Providers need training and manuals. If providers do not have training, people are charged for things that could be covered by the insurance. • People need to be hired who care about the clients and care about the job. • More education in preventive and prenatal care should be provided. • Universal coverage for all people (documented and undocumented) should be provided.

be developed. • The issue of informed consent should be modified so that agents could more easily advocate for clients. • More data on eligible clients and their locations should be gathered so they can better target potential clients. • Government agencies working in Hispanic communities need training in cultural sensitivity.		

Summary Thoughts

The choice of including focus groups in this study reflects several unique dimensions of this research project. First and foremost, there is no literature or specific national or local data set that collects or assesses information on best practices for outreach and enrollment activities for Latinos and publicly subsidized health insurance programs. Thus, it certainly meets a need by filling the gap in health literature by providing information in formerly "uncharted" areas of inquiry. Secondly, as a research tool it provides valuable insights and plausible hypotheses about barriers to enrollment and eligibility for Latino families with respect to enrolling in the federally subsidized SCHIP and Medicaid Programs, thereby expanding our understanding of the broader empirical observations from the US Census, Current Population Survey (CPS), and NHANES data sets. Finally, as an exploratory and interactive tool of inquiry that targets those practitioners in the field these focus groups provide us with a "snapshot" of cultural and linguistic best practices that have yielded successful results for Latino populations. Even with the dearth of literature on this topic, an interesting observation is the consistency of overlap in the published literature on cultural competency reviewed for this report and those highlighted by the participants in the focus groups.

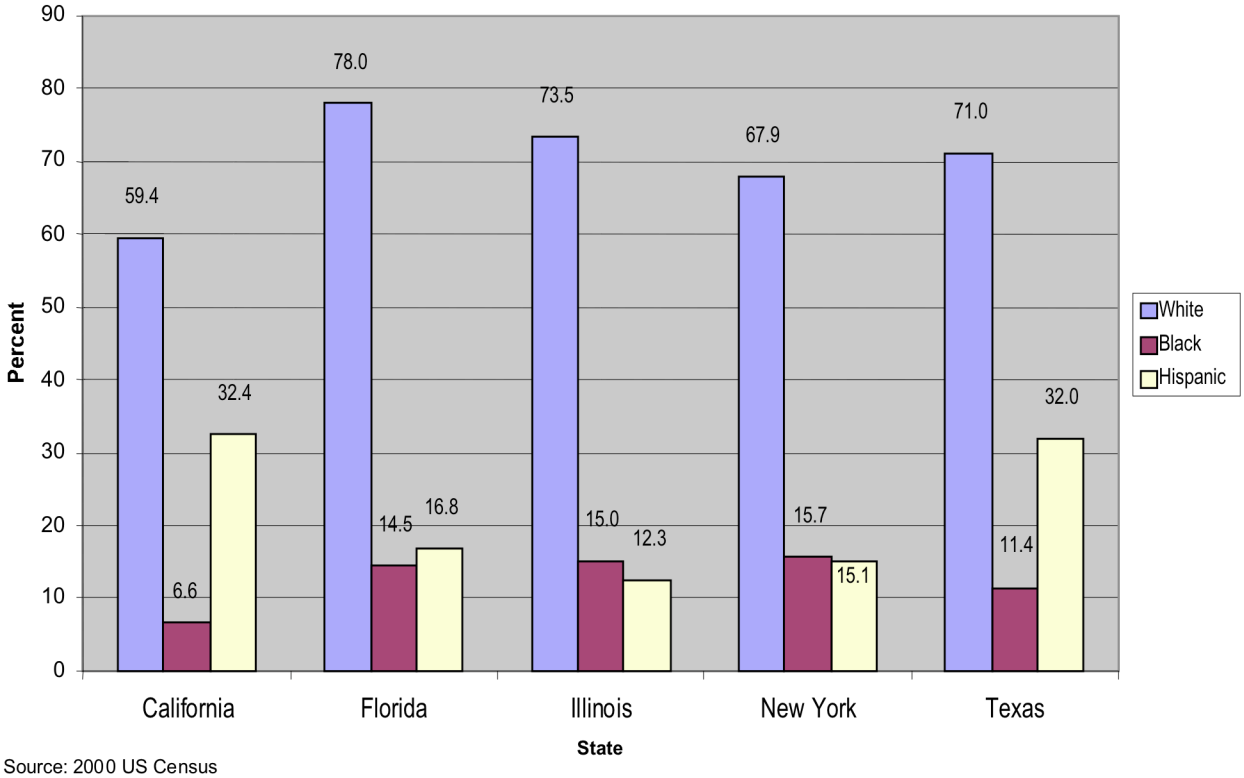
Although it is not the recommendation of this study to determine public policy objectives based on summary statements of focus groups, with proper application, administration, and interpretation of these results these data provide important insights into a complex and diverse Latino population with regard to health care access issues. Moreover, what is noteworthy is the broad scope of policy recommendations by the focus group participants. The recommendations ranged from site-specific administrative support issues, such as bilingual/bicultural enrollment and eligibility workers and simplified enrollment forms, to broader national policy recommendations linked to Federal welfare and immigration policies, such as the impact differential legal status within Latino families has on enrollment and the perceived adverse impact or stigma associated with the designation of "public charge." The breadth of these responses suggests that, at the field level, the problems associated with enrollment and eligibility of Latino subpopulations are beyond local administrative fixes or cultural/linguistic competency issues. Indeed, the spontaneous discussion in all three focus groups of "public charge" as well as the stigma and access barriers associated with undocumented family members were issues that clearly deserve attention in future studies on barriers to enrollment and eligibility of Latino families in publicly subsidized programs.

Current Demographic Trends

A number of demographic factors influence the relative impact of Latino-specific outreach strategies for public assistance and health care access programs. One key factor in diverting state funds to a specific ethnic group for outreach and enrollment programs is the overall size and distribution of that ethnic population in the state. Fortunately, US Census data highlights the distribution of Latino subpopulations, which is not equally distributed across states by size or by subpopulation. While Figures 2.1–2.19 throughout this chapter highlight the key summary findings, *please refer to the Data Appendix for the frequencies and rates that were used in preparation of these figures*.

Figures 2.1–2.2 illustrate the relative distribution of Latino subpopulations within five selected states as well as the absolute concentration of these populations across states. Figures 2.3–2.4 illustrate the relative distribution of Latinas and their subpopulations within the five selected states.

Figure 2.1
Race/Ethnicity as a Percent of State Total Population

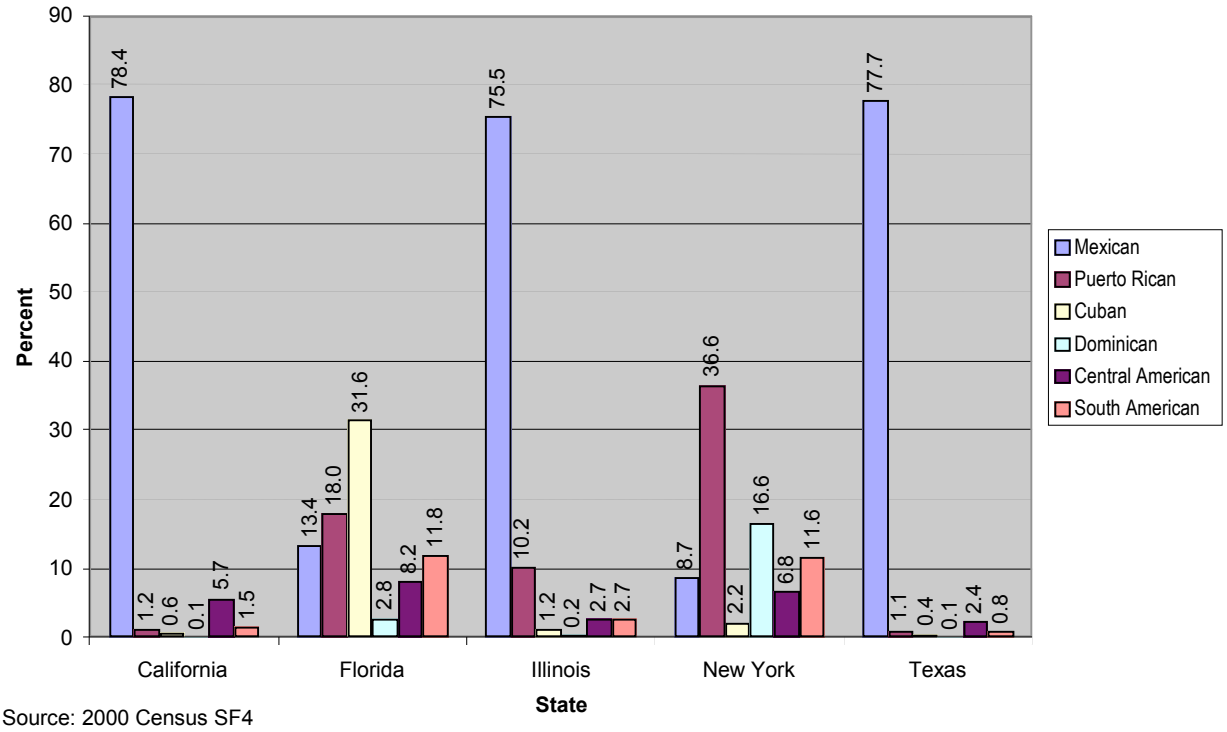


Source: 2000 US Census

Figure 2.1

- Almost 1/3 of the total populations of California and Texas are Latino. About 1 in 6 Floridians is Latino; about 1 in 8 Illinois residents is Latino; and about 1 in 6 New Yorkers is Latino.
- In absolute numbers, both California and Texas have the largest Latino populations of the five states, with 10,969,132 and 6,670,122 Latinos respectively. However, Florida and New York have just under 3 million, and Illinois has about 1.5 million Latino residents (See Data Appendix).
- Florida's Latino population exceeds the state's Black population; and in Texas and California, the Latino population is 3 and 4 times larger than the Black population, respectively. New York's Latino and African American populations are close to matching in size.

Figure 2.2
Subpopulations as a Percent of the State Hispanic Population



Source: 2000 Census SF4

Figure 2.2

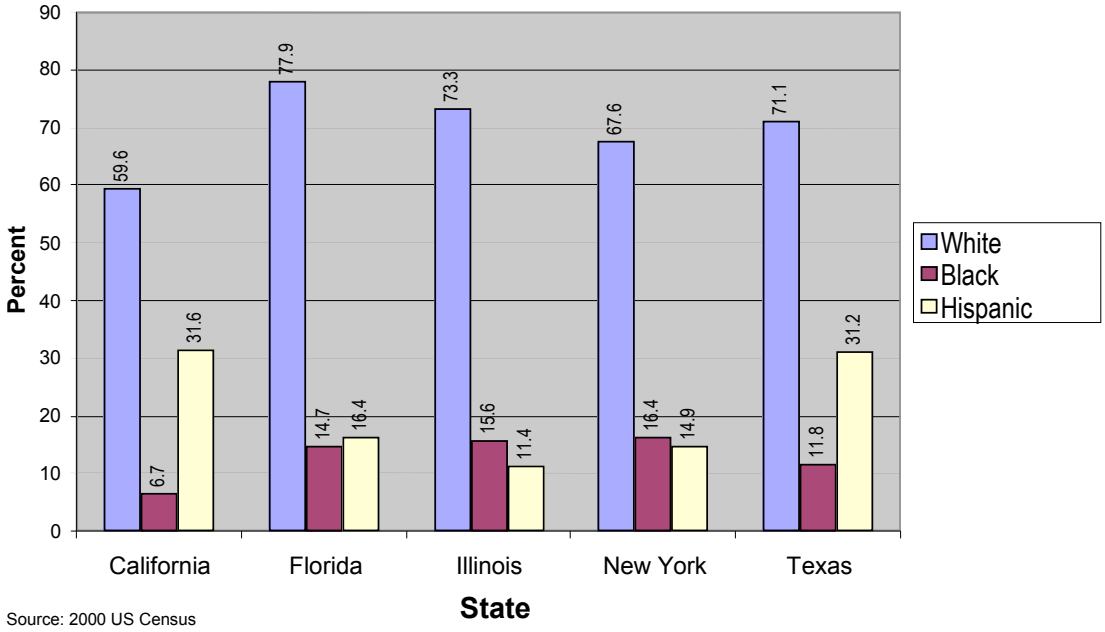
- About 78% of Latinos in California, Illinois, and Texas identified as Mexican-origin.
- Latino subpopulations vary across state by size and concentration:

  - In California the three major Latino subpopulations, in rank order of significance, are: Mexican (78.4% of Latino population), Central American (5.7% of Latino population), and South American (1.5% of Latino population).
  - In Florida the four top Latino subpopulations are: Cuban (31.6% of overall Latino population), Puerto Rican (18% of overall Latino population), South American (11.8% of

Latino population), closely followed by the growing Mexican population (13.4% of Latino population).

- In Illinois the two major Latino groups in the state are: Mexican (75.5% of overall Latino population) and Puerto Rican (10.2% of Latino population), with smaller subpopulations of Central Americans and South Americans, which are about equal in size and reflect 2.7% of the Latino population.
- In Texas Mexicans are more than 75% of the Latino population, followed by a much smaller Central American population (2.4% of Latino population).
- New York's two largest subpopulations include Puerto Ricans and Dominicans. Puerto Ricans are 36.6% and Dominicans are about 17 % of the Latino population followed by South Americans (11.6%).

Figure 2.3
Race/Ethnicity as a Percent of the State Total Female Population



Source: 2000 US Census

Figure 2.4

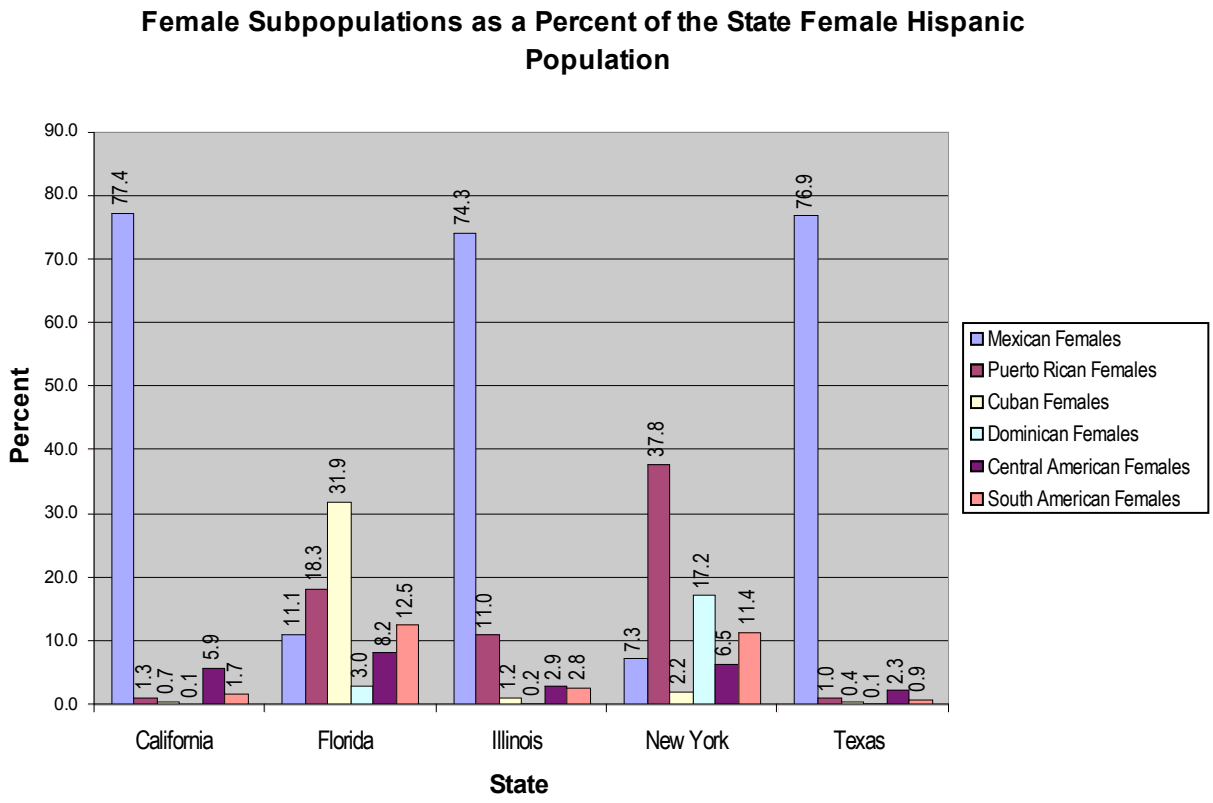


Figure 2.4

- Three quarters of all Latina women in California, Illinois, and Texas are Mexican-origin women.
- Cuban and Puerto Rican women represent over half of Latinas in Florida.
- In New York more than 50% of Latina women are Puerto Rican and Dominican.

Labor Force Participation Rates

A key factor in access to health insurance is employment location and participation in the labor market. Across all five states Mexicans, Dominicans, Central Americans and South Americans exhibit relatively high labor force participation rates vis-à-vis White labor force participation rates. Labor force participation rate data also indicates increased labor force participation of Latina women since the last census. Nevertheless, the Latina rate is still below White and Black female labor force participation rates in all five states. These female labor force participation rates suggest that many Latinas may be dependent on their spouse or public health insurance for coverage for themselves and their dependents.

Figure 2.5

Labor Force Participation Percentages					
Ethnicity	**California**	**Florida**	**Illinois**	**New York**	**Texas**
State Labor Force	**62.4**	**58.6**	**65.4**	**61.1**	**63.6**
State Female Labor Force	**55.5**	**52.8**	**59**	**55.1**	**56.2**
White labor force	63.1	57.8	66.7	62.3	64
White Females in labor force	55.7	51.1	59.4	55.5	55.7
Blacks In labor force	59.5	60.6	58.7	57.7	61.8
Black Females in labor force	59.2	60.2	58.9	56.9	62.2
Mexicans In labor force	60.9	68.2	64.2	62.3	59.7
Mexican Females in labor force	51.7	53.4	53.8	46.9	49.6
Puerto Ricans In labor force	65.4	61.9	59.9	51.9	70.9
Puerto Rican Females in labor force	59	56.6	55.2	47.1	63.5
Cubans In labor force	58.7	54.4	61	53.4	62.3
Cuban Females in labor force	52.3	47.5	56	47.4	55.1
Dominicans In labor force	69.8	64.4	67.9	54.7	65.2
Dominican Females in labor force	60.6	58.9	58.8	48.9	59.6
Central Americans In labor force	64.6	66	67.4	65.3	66.8
Central American Females in labor force	56.2	57	59.5	55.7	56.3
South Americans In labor force	67.9	64.4	68.8	64.7	66.4
South American Females in labor force	60.7	56.3	62.8	56.3	57.7

Source: Census 2000 Summary File 4

Figure 2.5

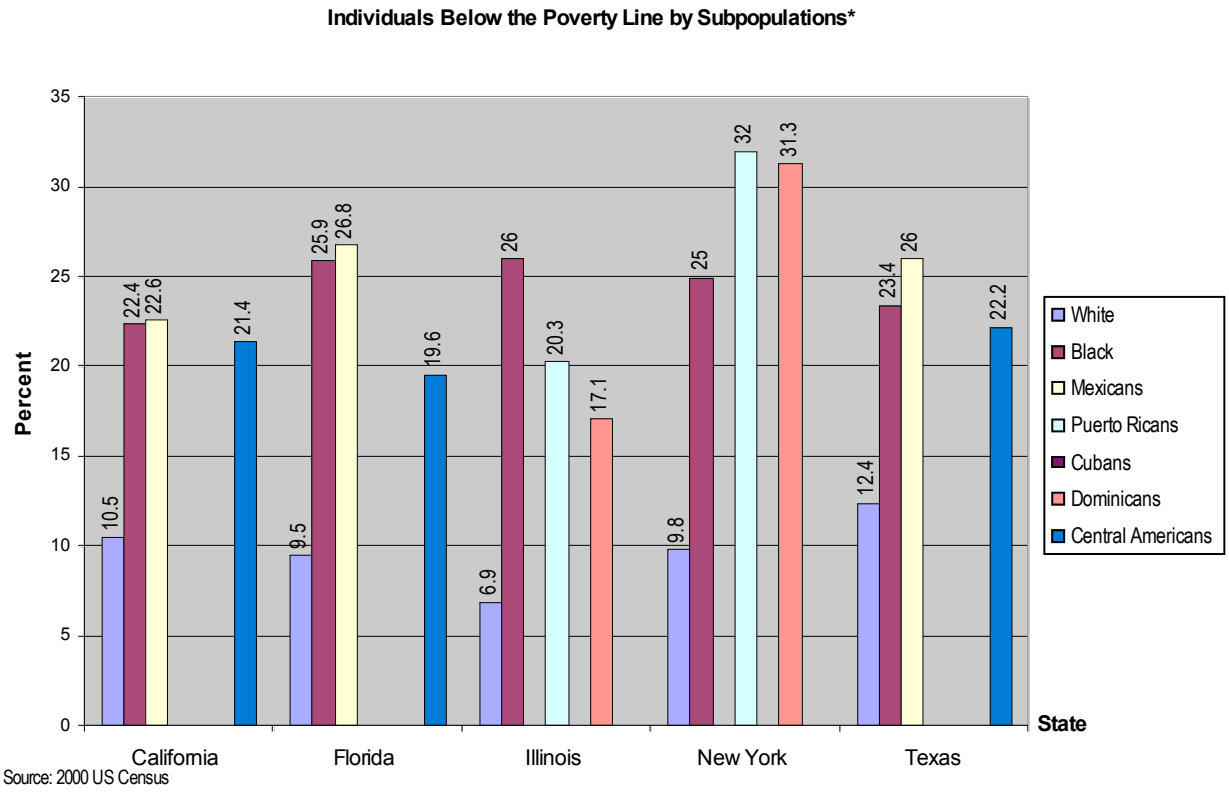
- In Florida all Latino subpopulations (with the exception of Cubans) have higher labor force participation rates than Whites.
- In both California and Texas four of the six Latino subpopulations have higher labor force participation rates than Whites.
- In California Mexican and Cuban women are below the labor force participation rates of White and Black women.
- In Florida Cuban women trail White and Black women in labor force participation.
- In Illinois Mexican and Puerto Rican women trail White and Black women in labor force participation.
- In New York Cuban, Mexican, Puerto Rican, and Dominican women have lower labor force participations rates than White and Black women.

- In Texas Mexican and Cuban women have lower labor force participation rates than White and Black women.

Poverty Status

In all five states poverty levels are a key criterion used in qualifying Latino families for publicly subsidized health insurance. Given the high rates of poverty in all Latino subpopulations, there is a growing concern that those who are most in need of government-sponsored health insurance have the least amount of access to these programs. Across four of the observed states (California, Texas, Florida, and New York), there was at least one Latino subpopulation below the poverty line with a higher percentage rate than Black individuals in these states. In addition, every Latino subpopulation in these states below poverty level had higher percentage rates as compared to White individuals who fell below the poverty line.

Figure 2.6



Source: 2000 US Census

*only includes two highest rates among the Hispanic subpopulations

Figure 2.6

The following are key observations specific to states with individuals below the poverty line:

- In California both Mexican-origin (22.6%) and Black (22.4%) individuals have the highest percentages below the poverty line, as compared to non-Latino Whites (10.5%).
- In Florida Mexicans have the highest percentage of individuals below the poverty line (26.8%), followed by Blacks (25.9%) and Central Americans (19.6%). Cubans (14.8%) have the lowest percentage of individuals within the Latino subpopulations below the poverty line; however, this group is still higher than the state average (12.5%).
- In Illinois Blacks (25.9%) have the highest percentage below the poverty line; however, Puerto Ricans (20.3%), Dominicans (17.1%), and Mexicans (16.5%) have percentages considerably higher than all those in the state(10.7%).
- New York has the highest percentage of Latinos below the poverty line, where 30% of Mexicans, 32% of Puerto Ricans, and 31.3% of Dominicans are below the poverty line. These percentages are higher percentages than Blacks (25%) and Whites (9.8%) who fall below the poverty line.
- In Texas more than twice as many Mexicans are below the poverty line as compared to Whites. Mexicans have the highest rate of poverty (26%), followed by Blacks (23.4%) and Central Americans (22.2%).

Immigrant Status

A key factor that influences enrollment and eligibility of Latinos for publicly subsidized programs, such as Medicaid and SCHIP, is immigrant status. This issue does not affect all groups equally, however. Puerto Ricans, for example, are US citizens; therefore, the issue of immigrant status does not influence their access to these programs. Yet for other Latino subpopulations immigrant status is an important factor both in eligibility for Medicaid and SCHIP programs.

These issues of immigrant status were further altered when the Clinton Administration provided greater latitude for states to deny immigrants, both legal and undocumented, access to publicly subsidized social services under the Administration's welfare reform policy, i.e., the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. This Act further limited access to social services for immigrants in order to address perceived abuses of welfare programs by these groups. This welfare reform measure combined with additional federal immigration reforms that strengthened the provisions for "public charge" (i.e., penalties placed on

immigrants relying on the public dole for income and service support) created further access barriers to social services for both legal and undocumented immigrants.[16]

In both the literature review and in the focus group summaries, concern was expressed that Medicaid/ SCHIP applications that require verification of legal status for certain Latino groups may act as a barrier to applying for and enrolling in Medicaid and SCHIP programs. Although specific data on the impact of such policies on these programs is not available, the potential magnitude of this problem for immigrant Latino subpopulations can be inferred from the size of the non-US-born population, relative to the overall size of these Latino subpopulations.

Figure 2.7

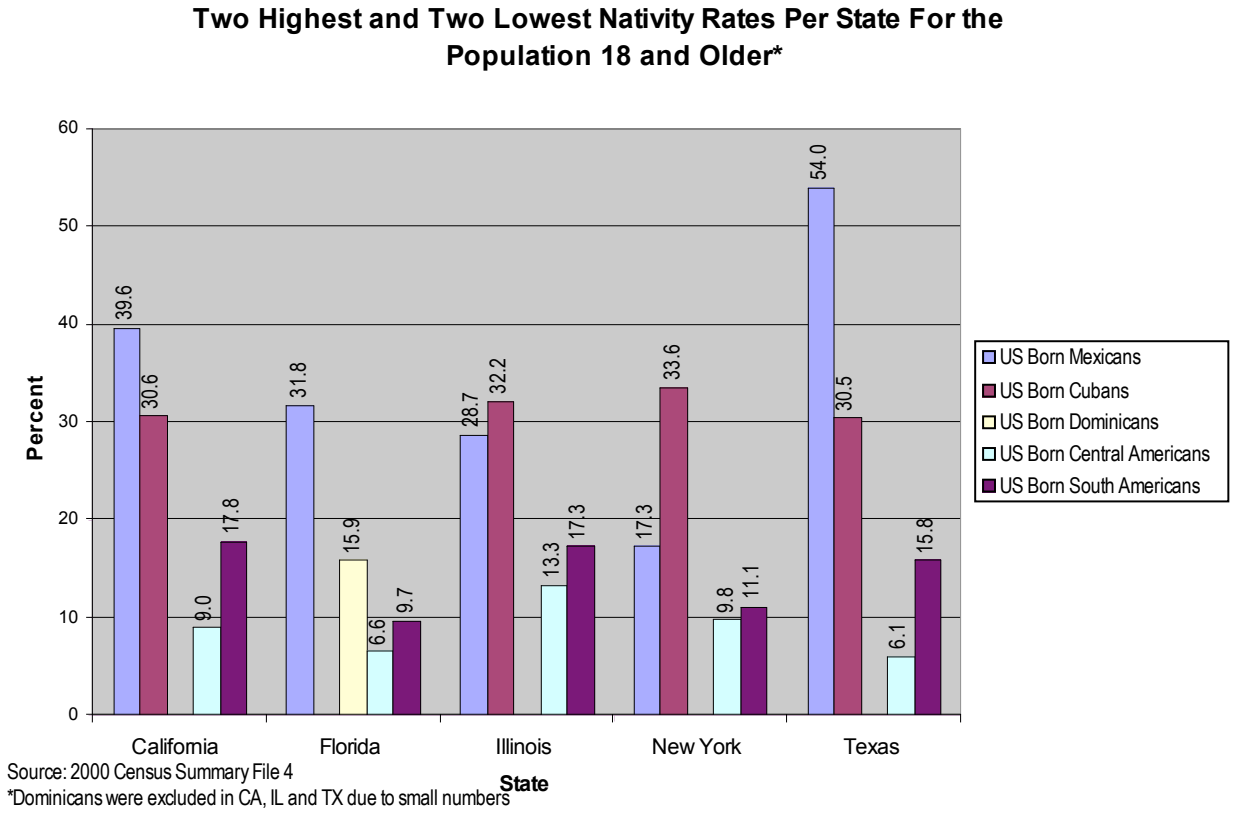


Figure 2.7

The US Census provides a snapshot of these nativity differences across the different Latino subpopulations by state:

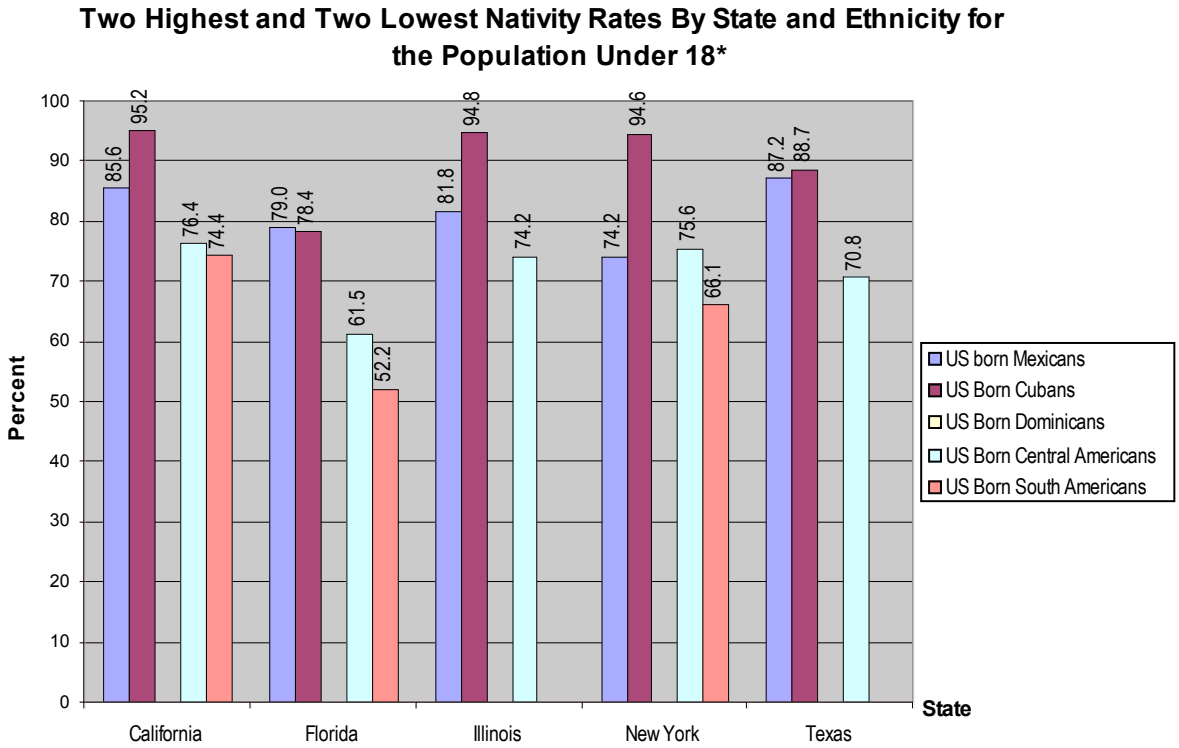
[16] Johnson, Kevin. R. 2004. *The Huddled Masses*, Temple University Press: Philadelphia, p. 91-103.

- Across all five states, Central Americans over the age of 18 have the lowest percentage of US-born individuals within their subgroup. Texas has the lowest percentage of US-born Central Americans (6.1%) and Illinois has the highest (13.3%).
- Texas has the highest percentage of US-born Mexicans over the age of 18 (54%), followed by California (39.6%), Florida (31.8%), Illinois (28.7%), and New York (17.3%).
- Florida has the lowest percentage of US-born Cubans over the age of 18 (14%) compared to the other four states where almost 30% of Cubans are born in the US.
- A small percentage of Dominicans over the age of 18 in New York (13%) and in Florida (15.9%) are born in the US. Given their relatively high concentration in these two states, the issue of immigrant status may be an important factor for this rapidly growing Latino subpopulation.

Nativity Status of Younger Latinos

Although Latinos over 18 are more likely not to be born in the US, many of their children are US-born. It is clear that the dilemma for many of these Latino families may be rooted in the fact that they have an array of legal and immigrant issues, further complicating the process for eligibility and enrollment in publicly subsidized health programs.

Figure 2.8



Source: 2000 Census Summary File 4

*excluded Dominicans in CA, IL and TX and South Americans from IL and TX due to small numbers

Figure 2.8

Some important observations about nativity for Latinos who are below the age of 18:

- Across all Latino subpopulations the number of US-born Latinos below the age of 18 is more than 50% of the total Latino population.
- Mexicans are the Latino subpopulation with the largest number of individuals under 18 years of age, with their children being born in the US at variable percentages, ranging from 74.2% in New York to 87.2% in Texas (See Data Appendix).
- In both New York and Florida, more than 70% of Dominicans below the age of 18 are US-born.
- The percentage of Cubans under the age of 18 who are born in the US is variable, ranging from 78.4% in Florida to 95.2% in California.
- Central and South Americans have the lowest percentages of US-born children.

Latinos and Language

A significant body of health care outreach literature suggests that linguistic competency is an important factor in achieving cultural competency with Latino subpopulations (Coye and Alvarez 1999). Degrees of English-language assimilation and bilingualism vary, however, with age and nativity being the prime factors. Therefore, linguistic and cultural preferences are important variables to consider in developing best practices for Latino

outreach (in order to increase enrollment in Medicaid/SCHIP programs). Spanish language adherence may be an important marker for cultural maintenance within an ethnic enclave and could also provide insights to potential strengths and barriers for developing outreach and enrollment strategies.

Figure 2.9

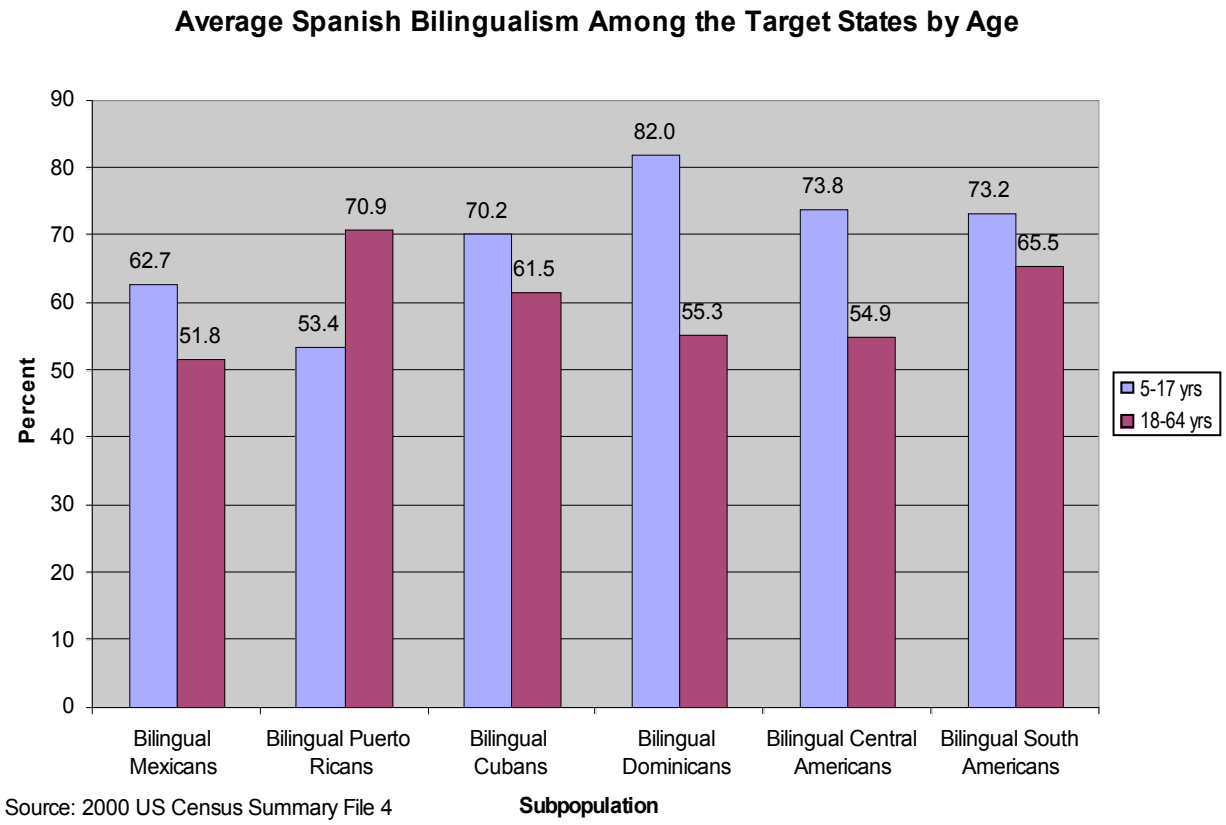


Figure 2.9

- In general (with the exception of Puerto Ricans), the older Latino groups are less bilingual than their younger counterparts, with most relying more on Spanish as a primary method of communication.
- Mexican Americans have the lowest percentage of bilingual skills as compared to all other Latino subpopulations.

Figure 2.10

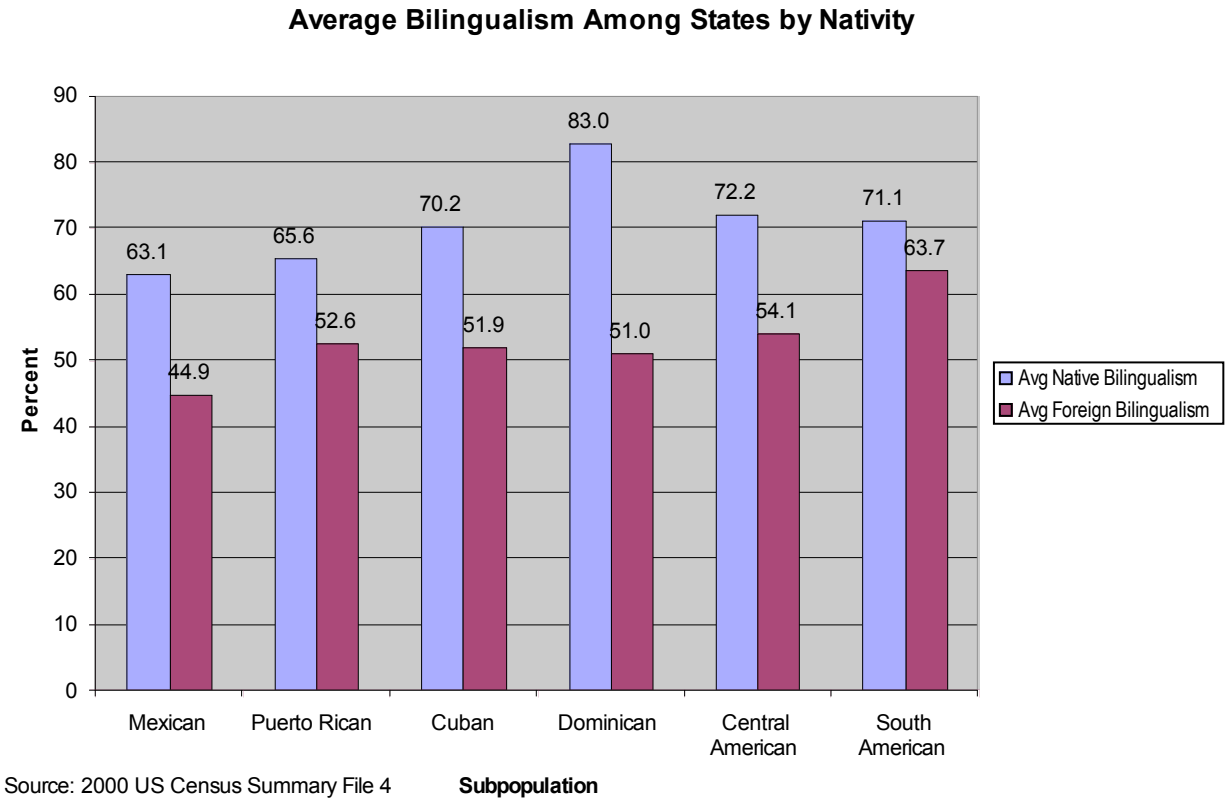


Figure 2.10

- Dominicans, Central Americans, and South Americans have the lowest percentages of US-born individuals who report English-only language skills.
- With the exception of the Mexican population, Florida has the highest percentage of US-born individuals who are competent in both English and Spanish.
- New York had the highest percentages of foreign-born populations (with the exception of Central Americans) who do not speak English.

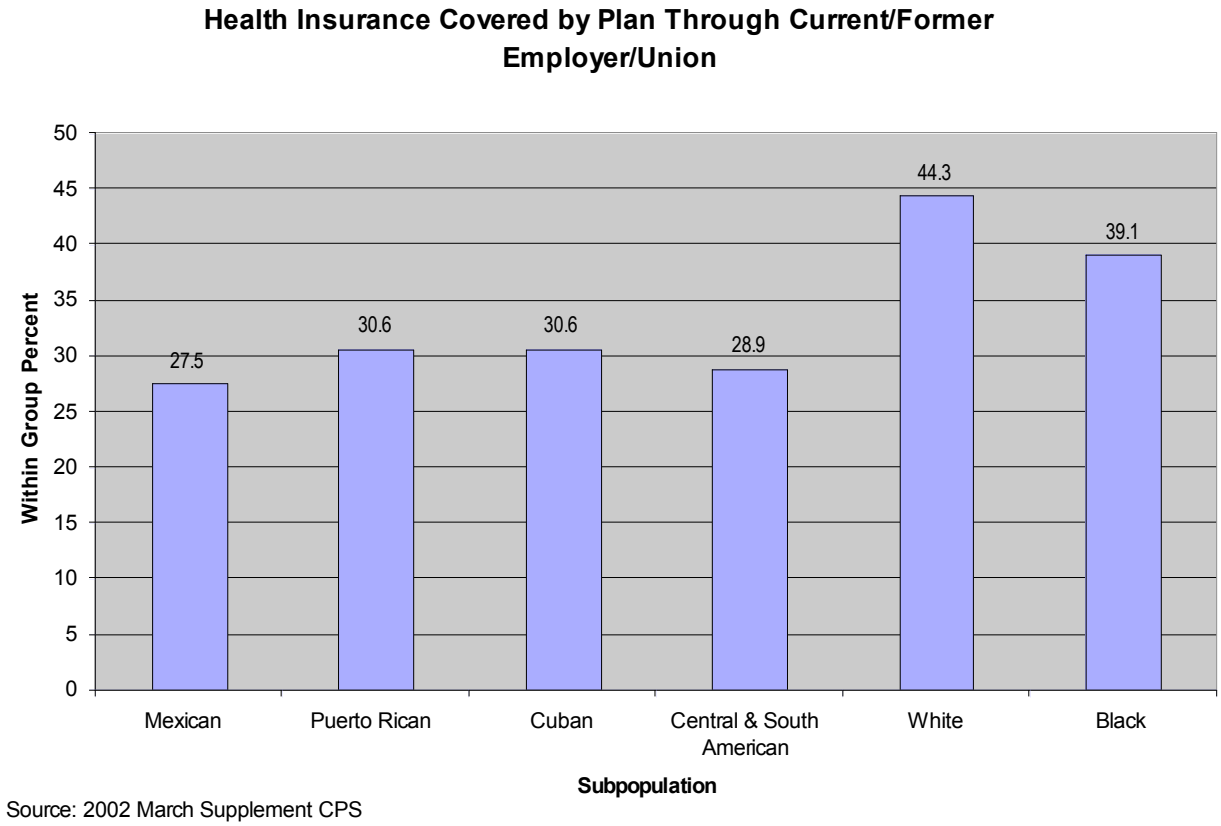
Latino Health Insurance Coverage and Utilizations: Findings from the Current Population Survey (CPS) March 2002 Supplement

Employer-/Union-Based Health Insurance

Latinos are the least likely to have employer- or union-based health insurance. This is more often determined by their job location than their employment situation (Vitullo and Taylor 2002). Since many Latinos work in service, manufacturing, and lower tier jobs, fringe benefits such as health insurance are limited (Maida 2001). While more than 40% of White non-Latinos have employer-based health insurance, within all Latino subpopulations less than one in three have employer-based health insurance.

Unfortunately, unlike the US Census, the Current Population Survey (CPS) March 2002 Supplement does not include Dominicans as a separate category. Nevertheless, similar trends of limited access are shared by all Latino subpopulations, as highlighted by Figure 2.11.

Figure 2.11



Source: 2002 March Supplement CPS

Figure 2.11

- Mexicans have the lowest within group coverage of employer-based health insurance (27.5%) followed by Central and South Americans (28.9%) and Cubans (30.6%).

- Blacks (39.1%) and Whites (44.3%) have higher levels of employer-based health insurance coverage than any of the four identified Latino groups.
- Less than half of all Americans surveyed have access to health insurance through their employer or union.

Private Health Insurance Family Coverage for Children

Of those Latinos with health insurance, a considerable number do not have health care coverage for their children. White non-Latino families are more than three times likely to have health insurance for their children as compared to Latino and Black families. Thus, although many minority group members do have employer-based health insurance, few of these families have access to private health insurance for their children.

Figure 2.12

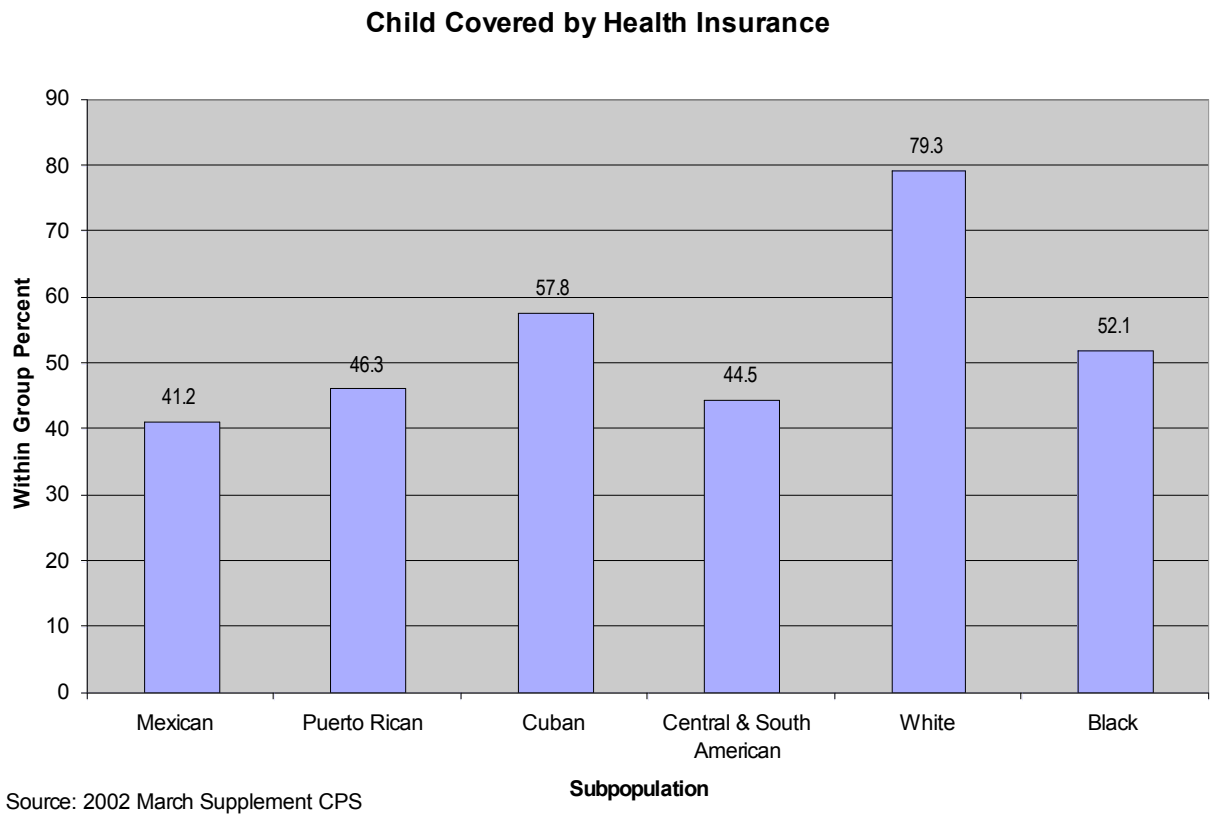


Figure 2.12

Key family coverage highlights from the Current Population Survey (CPS) March 2002 Supplement:

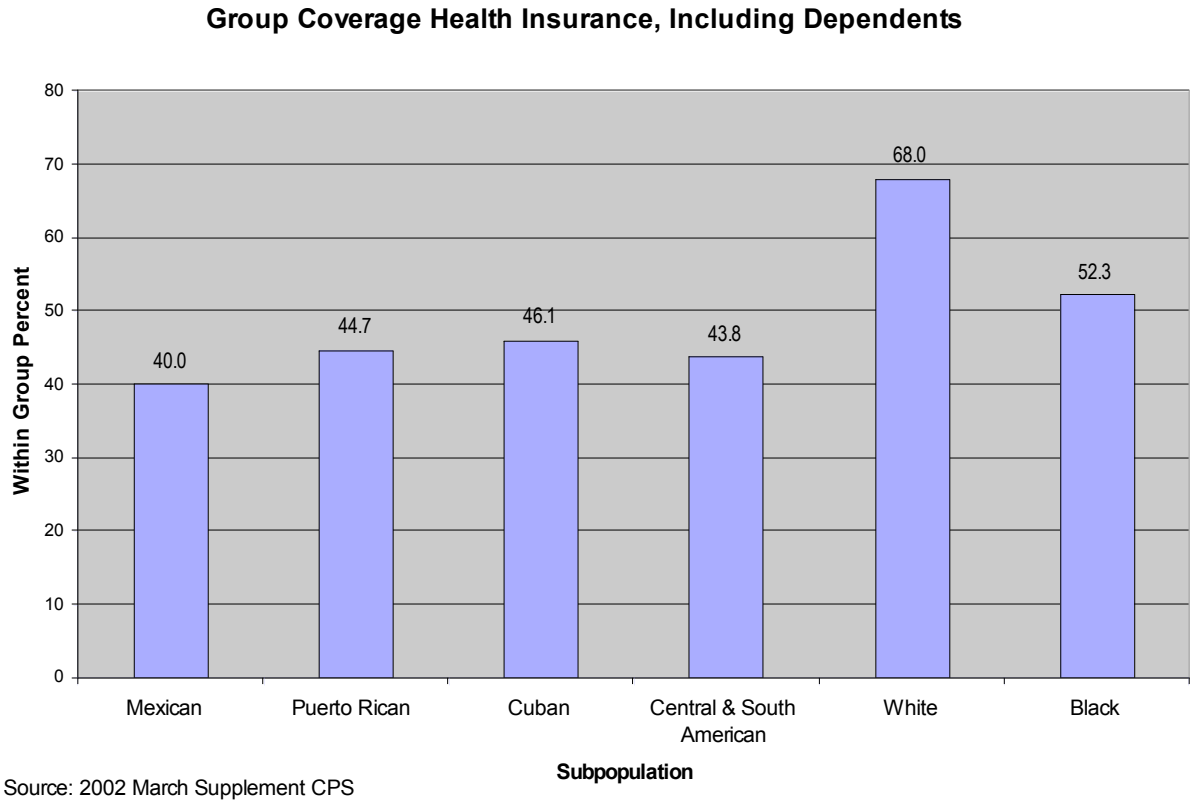
- Within Mexican households with employer- or union-based health insurance, only 41.2% have employer-based health insurance for their children.

- Within the Latino subpopulations, Central and South Americans (44.5%), Puerto Ricans (46.3%), and Cubans (57.8%) have the highest employer-based coverage for their children.
- Blacks (52.1%) have slightly higher rates of child coverage through their employer-based health insurance compared with Mexicans, Puerto Ricans, and Central and South Americans.
- White non-Latinos have the highest percentage of employer- or union-based health insurance child coverage compared to other racial and ethnic populations.

Available Dependent Coverage with Employer-/Union-Based Health Insurance

Similar to the distribution of the child health insurance coverage with private employer- or union-based health insurance, White non-Latinos represent the vast majority of Americans who have access to employer-based health insurance with dependent coverage. Almost two-thirds of all White non-Latinos with private health insurance have dependent coverage as compared to only 40% of Mexicans, 43.8% of Central and South Americans, 44.7% of Puerto Ricans, and 46.1% of Cubans.

Figure 2.13



Source: 2002 March Supplement CPS

Medicaid Coverage

The largest numbers of children covered by Medicaid in the United States are White non-Latino children, followed by Black and Mexican-origin children. However, within each racial and ethnic population there is considerable variation (Figure 2.14).

Figure 2.14

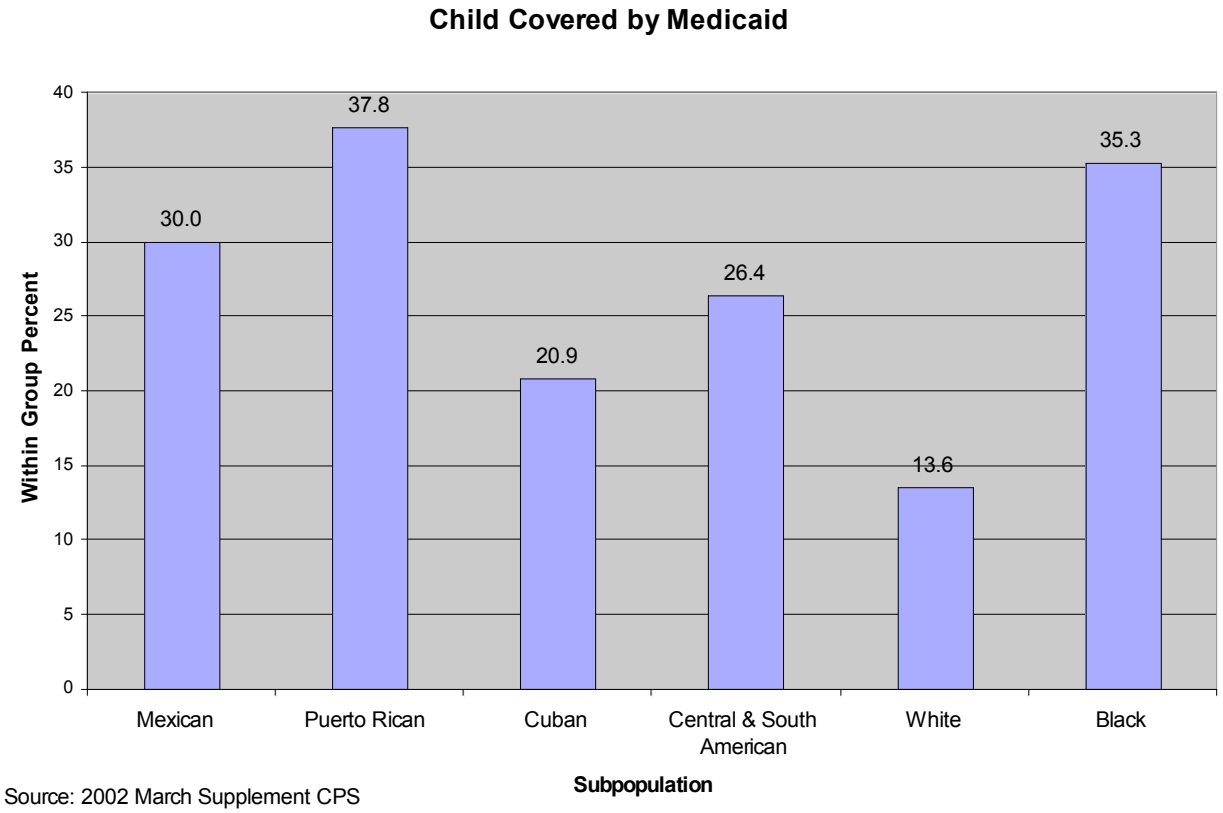


Figure 2.14

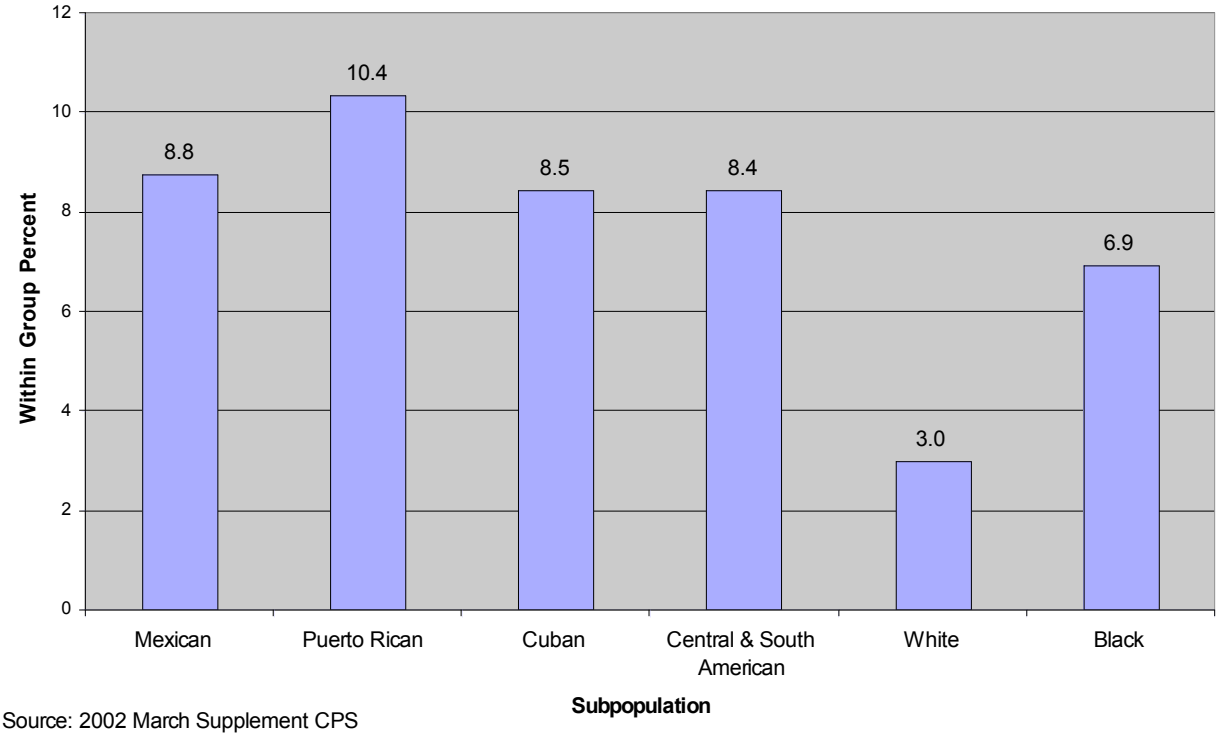
- Puerto Rican children (37.8%) have the highest percentage within group percent enrolled in Medicaid, followed by Black children (35.3%).
- Mexican children (30%) have the third highest percentage within group participation in Medicaid, followed by Central and South Americans (26.4%) and Cubans (20.9%).
- White children have the lowest percentage within group percent (13.6%) of any group, even though they have the largest absolute number of participants in Medicaid.

Participation in State Child Health Insurance Program

Participation in the State Children's Health Insurance Program (SCHIP) is lower than the state Medicaid program for all groups. Overall White children have the largest absolute number of children covered under this

program. While both African American and Mexican-origin children have similar numbers participating in this program, there is considerable variation within these groups (Figure 2.15).

Figure 2.15



Source: 2002 March Supplement CPS

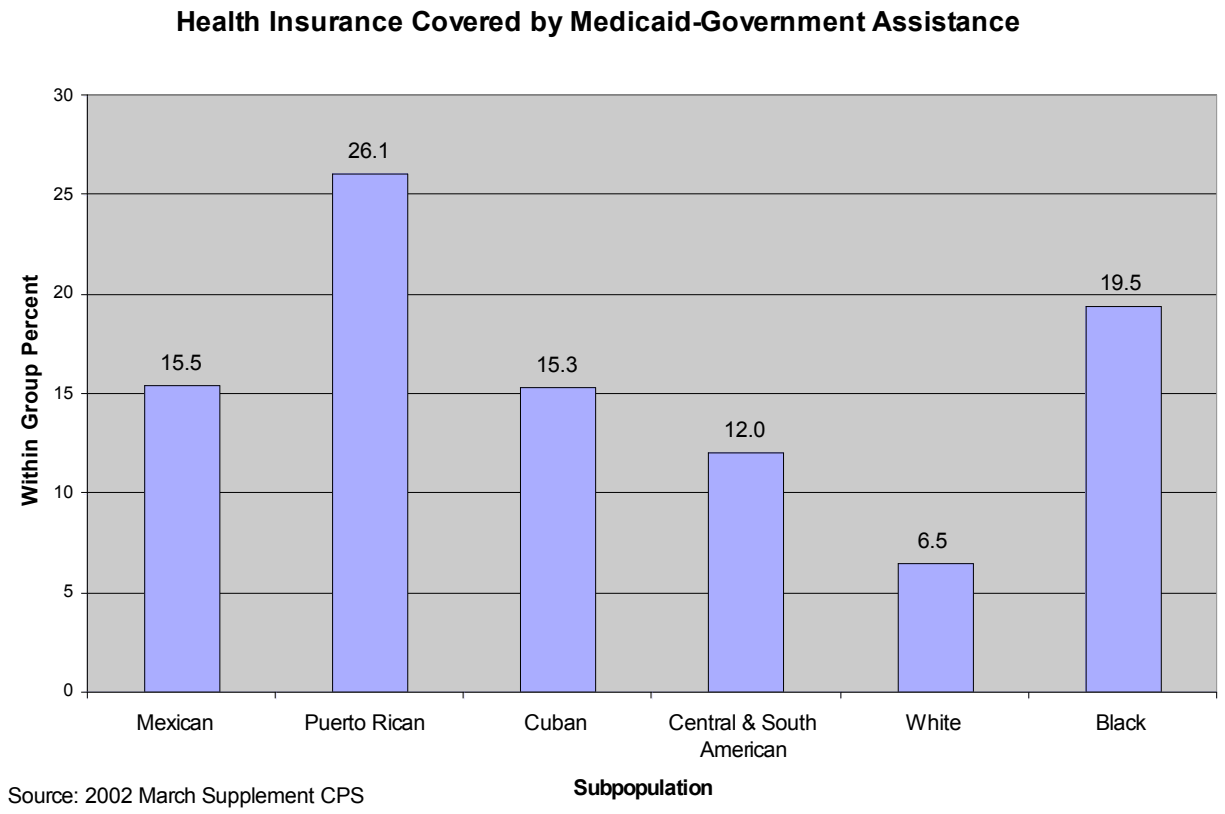
Figure 2.15

- A much smaller percentage of children are covered by SCHIP than Medicaid.
- Within Mexican households, 8.8% have children covered by SCHIP, which is lower than Puerto Rican (10.4%) household coverage for children.
- Both Cuban (8.5%) and Central/South American (8.4%) households have percentages similar to those of Mexican households.
- Blacks (6.9%) have a lower percentage of participation in SCHIP than do Latinos.
- White non-Latinos have the lowest percentage within group percent (3%), even though they have the highest absolute number of children in the program.
- The percentage of Whites and Blacks in the population whose children are covered (3.08%) is more than double the percentage of the other groups combined (1.44%).

General Medicaid Participation

Child participation in Medicaid and SCHIP is clearly higher than overall general adult population participation percentages in Medicaid. Given the statutory limitations of these programs in terms of targeting primarily vulnerable populations and income and time constraints, it is not surprising to see less representation of Latinos, as well as other groups, in the general Medicaid program. What is evident in Figure 2.16 is the wide gap between Puerto Ricans and other Latino subpopulations. This could be attributed to both legal status issues as well as state policies; i.e., access to Medicaid is more limited in certain states (e.g. Texas and Florida) and less restrictive in others (e.g. New York).

Figure 2.16



National Health and Nutrition Examination Survey (NHANES) 1999-2000: Utilization of Health Care Services

An important indicator of access to health care is utilization of health care services. The National Health and Nutrition Examination Survey (NHANES) 1999-2000 provides a wealth of information on health care status and

utilization of services. Unfortunately, the NHANES 1999-2000 does not break down this information at the level of specific Hispanic subpopulations—with the exception of the Mexican-origin population. Unlike the US Census 2000 or CPS March 2002 Supplement, we are limited to generalizing these data only to the specified groups sampled.

The NHANES 1999-2000 provides an important complement to our demographic US Census 2000 data and to our CPS March 2002 Supplement health insurance coverage data, by providing information on actual utilization of health services and professionals as well as types of health care delivery sites that are used by diverse groups. As we know from the CPS March 2002 Supplement data, financial access to health insurance is limited for Latinos; thus, we may expect that utilization of health care services might also be limited. The following figures (2.17 - 2.19) illustrate patterns of actual use of care and general health care sites where Latinos seek care. Continuity of health care is critical for effectively using preventive health care measures, such as health care screening for cancer and heart disease, and for cost-effective treatment and management of chronic health conditions. Nevertheless, when patients do not have regular access to a primary health care provider or health clinic on a regular basis, cost-effective health screening and early intervention are often improbable.

Figure 2.17

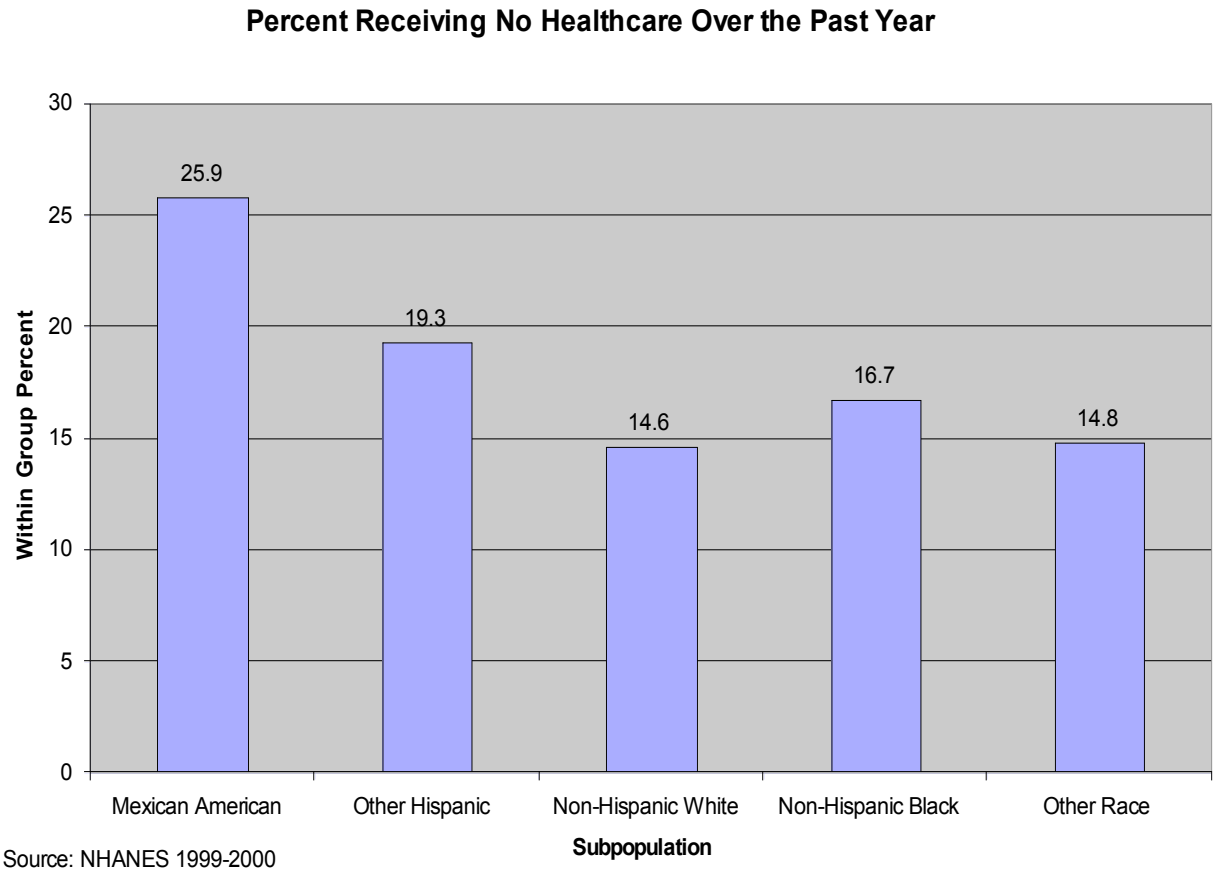


Figure 2.17

- About 1 in 4 Mexican Americans have received no health care over the past year, which is the highest percentage of any of the surveyed groups.
- About 1 in 5 other Hispanics have received no health care over the past year, compared to 1 in 6 non-Hispanic Blacks and about 1 in 7 non-Hispanic Whites.

Moreover, without a routine location for health care, individuals are not able be monitored for compliance with their treatment regimen or effectively addressing concerns with their provider that may arise during the course of a disease or an illness. Unfortunately, consistent with other indicators of health care access, Latinos are the group that are at greatest risk of not accessing care due to limited access to routine sites of health care services.

Figure 2.18

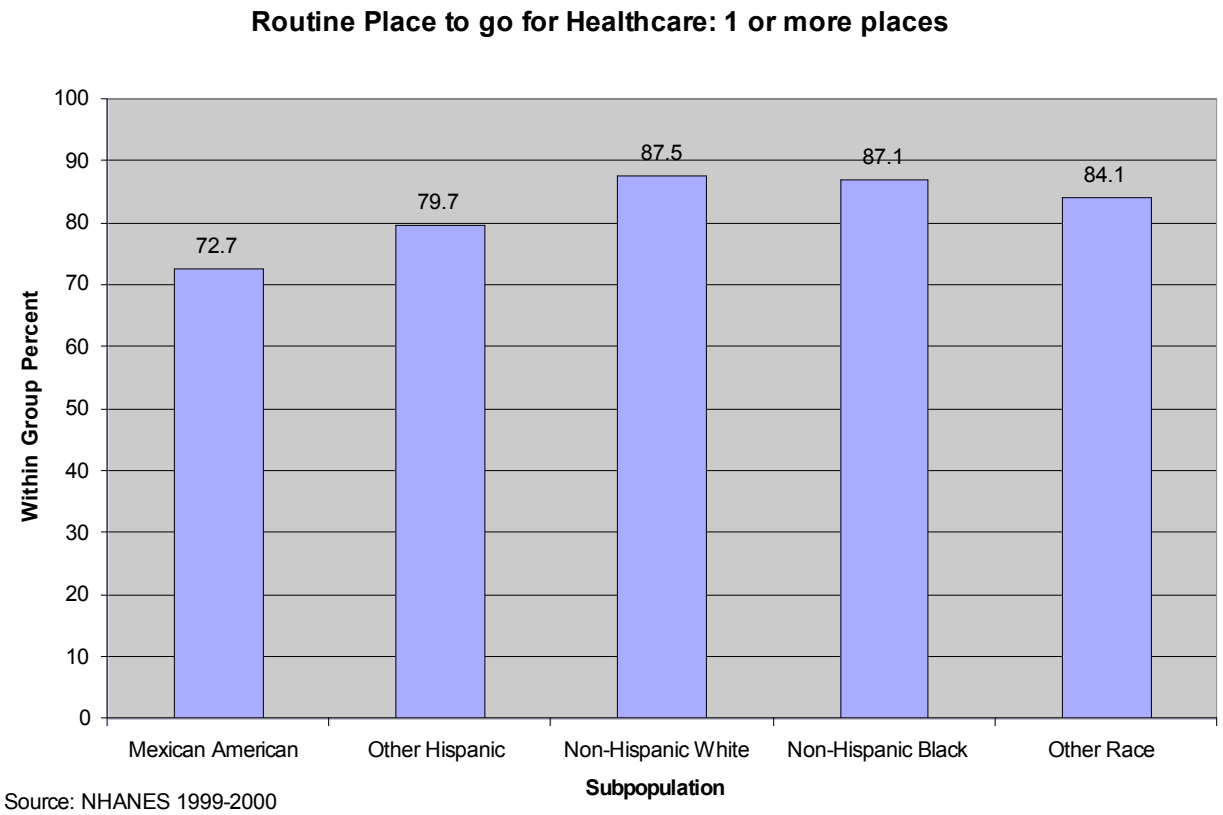
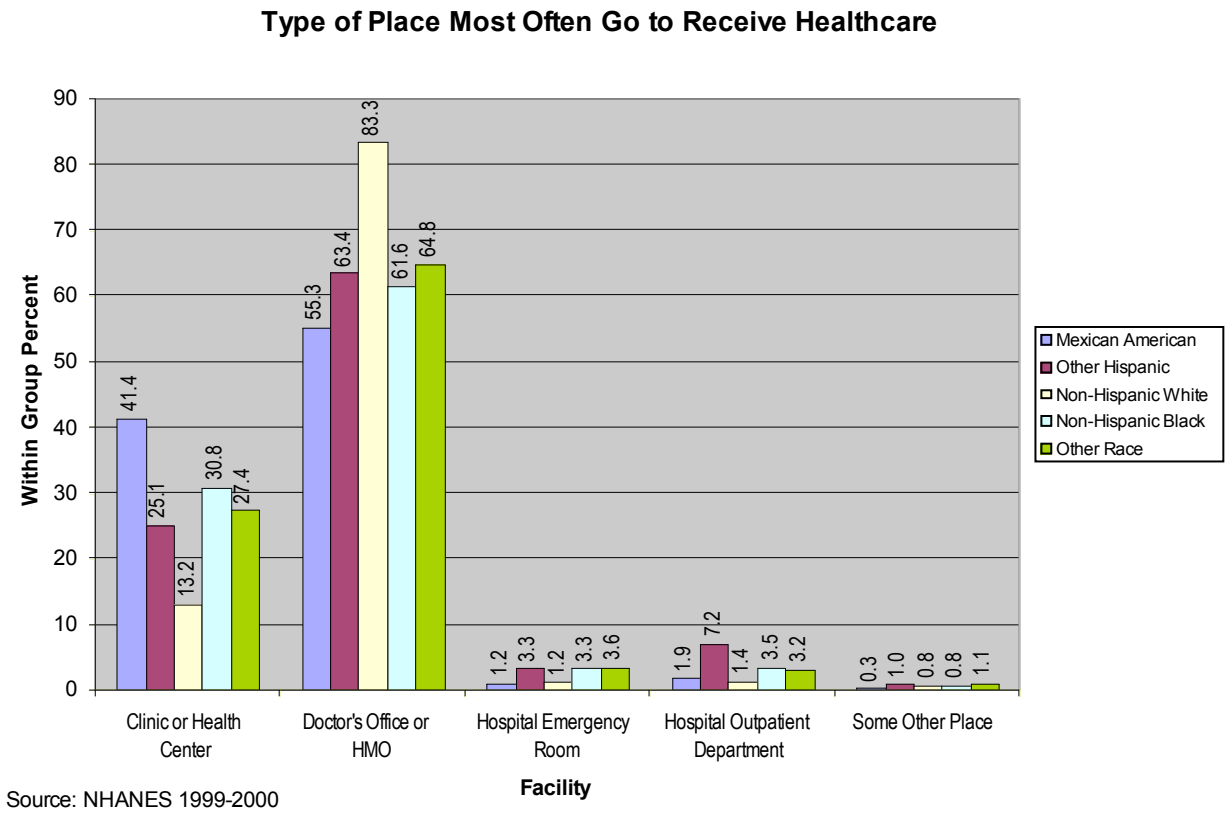


Figure 2.18

- More than 25% of Mexican Americans do not have one or more places to go for health care.
- Close to 90% of Non-Hispanic Whites and Non-Hispanic Blacks have at least 1 or more routine places to go for health care.
- About 1 in 5 other Hispanics do not have one or more places to go for health care.

Accessing health care for many Latinos requires not only access to health care providers, but health care providers in settings that are culturally and linguistically sensitive to their health care needs (Bureau of Primary Health Care 1999). Federally qualified health centers and local clinics have played central roles in the delivery of services in the communities of many low-income groups. Despite claims that Latinos increasingly seek care in hospital emergency rooms, the NHANES data suggests that about 97% of the Mexican-origin population seeks care at clinics, health centers, doctor's offices, or HMOs. About 90% of other Hispanics seek care in these types of settings as well.

Figure 2.19



Source: NHANES 1999-2000

Figure 2.19

The following patterns of delivery site preferences are observed:

- For those Latinos who do access health care, over 40% of Mexican Americans access their care in a health care clinic or health care center.
- Non-Hispanic Whites (83.3%) have the highest percentage of individuals who seek care in a doctor's office or Health Maintenance Organization (HMO); over 50% of all groups surveyed seek care in a doctor's office or HMO.
- Other Hispanics (7.2%) have the highest percentage of individuals who seek care in hospital outpatient department settings. Other Hispanics (3.3%) and non-Hispanic Blacks (3.3%) are at the same level of utilization of hospital emergency rooms.
- Mexican Americans (1.2%) and non-Hispanic Whites (1.2%) utilize hospital emergency rooms as sites of care at the same percentage.

Policy Recommendations

The findings of the three components of this project provide a method to prioritize best strategies for a set of practices that may result in expanded health care program access and utilization for Latinos. The feasibility and practicality of the widespread adoption of these exemplary practices, however, will be determined by various state-by-state factors, which will prioritize health policies that induce savings and cost efficiencies. Therefore, the following recommendations, while brief, are presented with assumed fiscal constraints as a guide.

Use for and Focus on Existing State Resources During Budget Crises

- To the greatest degree possible, states should maintain existing funding for outreach, specifically that which functions as enrollment assistance. Thus, if cuts are necessary, focus resources on retaining experienced outreach workers and training replacements so that current numbers of enrollment and eligibility outreach workers are maintained.
- States' resources should be concentrated as much as possible at the local level. Shift funding priorities away from mass media and information-based campaigns and more towards intensive, face-to-face community-based intervention efforts at enrollment assistance, health education, and data collection.
- Provide better training for state agency staff members in cultural competency. State hiring practices should be reviewed to assure that all efforts are made to recruit a diverse workforce (staff should be bilingual/bicultural).
- Maintain existing efforts to eliminate procedural barriers to enrollment (e.g., simplification of Medicaid/SCHIP applications, streamlining of enrollment process, yearly rather than quarterly renewal, presumptive eligibility, extended office hours, monetary incentives for successfully completed applications).
- Continue to promote SCHIP less as a Medicaid or welfare program and more as an insurance program for which working families are eligible; downplay association of program with the state or federal government to avoid stigma effect or fear of "public charge" issues.

Local-Level Interventions

- Research has shown that under-use of services partly stems from lack of basic information about them in Latino communities. This lack of information stems from lack of community-level infrastructure for disseminating

information. Thus, federal and state money is needed to build this infrastructure; federal and state agencies should take a more proactive role in forging stronger ties with community-based organizations.

- Increase initiatives to bridge outreach and enrollment assistance with community health education, particularly in immigrant communities.
- Institute mechanisms for data collection on outreach—research has shown that data collection efforts conducted jointly by community organizations and local universities have been successful. The federal government would be greatly served by funding local organizations to create staff positions specifically for data collection. Collection of data on race/ethnicity is particularly necessary in order to monitor the effect of public programs on racial/ethnic disparities in access and health outcomes. In addition, a cost effective link to archive and analyze community-based data should be established with strategic partnerships with local and state public colleges and universities.

State-Local Coordination

- Improve technical coordination between state agencies, local community-based outreach organizations, and health care providers. A specific example: provide enrollment and eligibility workers with laptop application forms that can be e-mailed directly to county/state SCHIP/Medicaid offices for review and approval. This would lower the overall processing cost and speed up the approval and tracking process for applicants.
- State programs should allow easier mechanisms for third-party access to client information, with client consent, so that local outreach workers can advocate on behalf of clients when so requested.
- Maintain state incentives/programs to encourage rural providers to accept Medicaid/SCHIP.
- Cultural competency requires that program material take factors of literacy and education level into consideration, as well as linguistic fluency. Federal and state agencies and HMOs need to coordinate efforts with local organizations to produce Spanish-language material that is not only linguistically appropriate, but that also matches the literacy levels of client populations as well.

Federal-Level Policy

- Policy makers should be aware that even with the best outreach efforts there are still limits on any effective community-based outreach program due to inherent federal restrictions and policies that bar the coverage of

immigrant populations. It has been demonstrated that these very restrictions do nothing to alleviate the burden of these uninsured groups on the health care system—it only shifts the burden of cost to state and local agencies. Implement some measure of universal coverage, either for all children, regardless of documentation, or, optimally, for all residents.

- One major factor behind Latino under-enrollment is not labor force participation, but rather the low-wage industries in which many Latinos work that do not offer employer-based insurance coverage. If the federal government is not willing to shift responsibility for insurance from private to public sectors so as to ensure some sort of minimum basic coverage for all citizens/children, it might consider instituting a federal mandate that all employers provide basic coverage to their employees.
- Abolish the five-year requirement for legal immigrants, or provide more funds to those states that choose to waive this requirement.
- Effect better communication about the "public charge" issue to state agencies and local communities. Despite clarification at the federal level, many people at the local level remain unaware of the issue. This results in communication of misinformation to clients as well the additional social stigma effects within immigrant communities about these health programs.
- Federal agencies need to be aware that the primary barriers to health care access for Latinos are cultural not financial. Because federal eligibility expansions only target financial barriers to access, these efforts need to be coupled with simultaneous efforts to address non-financial (i.e. cultural and administrative) barriers to enrollment (education, literacy, language, stigma, and immigration issues). Research has shown that reducing racial disparities in access to health insurance and health care requires identification and reduction of these non-financial barriers.

Conclusion and Policy Implications

Identifying "best practices" for the expansion of Latino eligibility and enrollment in Medicaid and SCHIP programs is the primary objective of this report. It is clear from both the literature targeting best practices used for outreach to the Latino population, the focus group summaries, as well as the overall demographic profile of the population, that there is an intersection of cultural and administrative factors that determine whether Latino families are motivated to enroll in these programs, and that focusing on financial barriers alone will not address the barriers to enrollment. The policy recommendations attest to this finding.

The fact remains, however, that in the midst of major state budget deficits few policymakers are focusing on increasing enrollment for Medicaid and SCHIP, let alone expanding eligibility. Moreover, much of the policy debates today focus on meeting existing enrollee needs, with some states like Florida and Illinois discussing minor expansions in these programs. States like California and New York, both with significant state budget shortfalls, are focusing on more draconian measures to reduce health care costs such as caps on enrollment, reduction of provider payments, and reducing or eliminating outreach dollars for Medicaid and SCHIP enrollment and eligibility workers. In light of this more restrictive state budgetary climate, choices must be made to maintain necessary direct health services to current enrollees and any proposed future expansions in these programs. Given the demographic profile of the Latino population across the five states, it is clear that the need for crafting targeted strategies for both public and private health insurance enrollment is paramount if we are to reduce the disproportionate number of uninsured Latinos. However, protecting funding for culturally and linguistically sensitive outreach workers to enhance eligibility and enrollment of underserved populations may be viewed as foolish or insignificant at best in light of the more formidable impact of targeted cuts to delivery of health services.

It is the direct aim of this report to demonstrate that the uninsured Latinos in the United States who are eligible for these programs but not enrolled would have a better chance of participating if available resources were spent on outreach worker efforts. Community-based eligibility and enrollment workers who are ethnically, linguistically, and culturally linked to the population play the central role of enrolling low-income Latinos into these programs. Moreover, the focus group summaries reveal that these individuals are trusted—not only for their cultural and community authenticity, but also as knowledgeable brokers of information. They are technically trained and have the information needed by clients to effectively fill out the detailed forms required for establishing eligibility for Medicaid and SCHIP, and they know how to follow up with appropriate agencies to ensure that the processing of

this information meets local, county, and state requirements. Certainly Latino enrollment in these programs does not always result in direct use of their services—many barriers still exist, as detailed in this report. This makes the communication from outreach workers during the enrollment process even more critical. Additionally, it has been shown that as outreach programs mature, the personal contact in targeted community locations, like schools and churches, becomes more and more critical as eligible populations become harder and harder to reach with more traditional media outreach campaigns.

The United States is a changing and growing nation. Our changing demographics require a mindful approach to the health of our residents. The current US health care system is easily overwhelmed in many places due to the growing number of uninsured persons. The rising cost of health care and the shift towards a service-based economy make the issue of the uninsured an inevitable and continuing challenge as we strategize to meet future needs. Despite the current national fiscal crisis, we do have a roadmap for implementing mechanisms that will work to better insure the health of the Latino community in the United States, should we choose to use it.

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Latinos and Health Programs Data Appendix

US Census 2000 Data Set

State Population by Subpopulations

	California	Florida	Illinois	New York	Texas
Total	33,871,648	15,982,378	12,419,293	18,976,457	20,851,820
Hispanic or Latino	10,969,132	2,680,314	1,529,141	2,865,016	6,670,122
Mexican	8,600,581	358,123	1,154,552	250,217	5,179,899
Puerto Rican	137,111	481,337	155,328	1,047,866	70,393
Cuban	70,623	846,080	18,742	62,753	27,034
Central American	622,246	218,696	41,494	193,972	159,227
South American	168,633	316,368	40,587	332,973	54,230

Source: 2000 US Census Summary File 4

Subpopulations as a Percent of the Hispanic Population

	California	Florida	Illinois	New York	Texas
Mexican	78.4	13.4	75.5	8.7	77.7
Puerto Rican	1.2	18.0	10.2	36.6	1.1
Cuban	0.6	31.6	1.2	2.2	0.4
Central American	5.7	8.2	2.7	6.8	2.4
South American	1.5	11.8	2.7	11.6	0.8

Source: 2000 US Census Summary File 4

Subpopulations as a Percent of the Total Population

	California	Florida	Illinois	New York	Texas
White	59.4	78.0	73.5	67.9	71.0
Black	6.6	14.5	15.0	15.7	11.4
Hispanic	32.4	16.8	12.3	15.1	32.0

Source: 2000 US Census Summary File 4

Population 16 Years and Older

Ethnicity	California	Florida	Illinois	New York	Texas
State Total	**25,596,144**	**12,744,825**	**9,530,946**	**14,805,912**	**15,617,373**
State Female Population	**12,998,409**	**6,615,066**	**4,934,988**	**7,810,436**	**7,960,900**
White Population	15,867,471	10,234,646	7,198,907	10,322,121	11,378,245
White Females	8,071,085	5,302,472	3,716,156	5,403,377	5,812,793
Black Population	1,617,340	1,629,041	1,324,414	2,190,706	1,725,126
Black Females	837,237	869,084	726,827	1,222,180	912,002
Mexican Population	5,636,693	244,920	767,615	175,007	3,511,357
Mexican Females	2,714,218	95,955	347,211	71,500	1,712,634
Puerto Rican Population	99,911	353,970	109,499	748,611	51,576
Puerto Rican Females	50,774	184,640	56,725	407,319	24,741
Cuban Population	58,195	720,924	14,591	53,113	21,759
Cuban Females	29,211	368,848	6,843	27,008	10,131
Dominican Population	4,110	59,684	2,649	350,900	3,686
Dominican Females	2,186	32,898	1,394	192,276	1,973
Central American Population	486,640	175,677	32,285	151,755	123,225
Central American Females	252,245	89,949	16,350	74,954	59,170
South American Population	139,351	257,350	32,559	272,666	43,515
South American Females	74,711	139,543	16,268	137,636	23,028

Source: Census 2000 Summary File 4

Labor Force Participation

Ethnicity	California		Florida		Illinois		New York		Texas	
	(Number)	(%)	(Number)	(%)	(Number)	(%)	(Number)	(%)	(Number)	(%)
State Labor Force	**15,977,879**	**62.4**	**7,471,977**	**58.6**	**6,230,617**	**65.4**	**9,046,805**	**61.1**	**9,937,150**	**63.6**
State Female Labor Force	**7,212,610**	**55.5**	**3,491,052**	**52.8**	**2,913,502**	**59**	**4,306,437**	**55.1**	**4,473,242**	**56.2**
White labor force	10,015,056	63.1	5,911,311	57.8	4,798,659	66.7	6,435,314	62.3	7,279,801	64
White Female labor force	4,498,115	55.7	2,711,762	51.1	2,206,406	59.4	2,999,271	55.5	3,240,493	55.7
Blacks labor force	962,583	59.5	987,065	60.6	777,940	58.7	1,264,387	57.7	1,066,727	61.8
Black Female labor force	496,056	59.2	522,998	60.2	427,934	58.9	695,632	56.9	567,423	62.2
Mexican labor force	3,430,100	60.9	167,115	68.2	492,626	64.2	108,962	62.3	2,094,888	59.7
Mexican Female labor force	1,403,465	51.7	51,229	53.4	186,756	53.8	33,555	46.9	849,169	49.6
Puerto Rican labor force	65,369	65.4	218,933	61.9	65,547	59.9	388,743	51.9	36,568	70.9
Puerto Rican Female labor force	29,963	59	104,498	56.6	31,339	55.2	191,972	47.1	15,716	63.5
Cuban labor force	34,159	58.7	392,003	54.4	8,902	61	28,347	53.4	13,556	62.3
Cuban Female labor force	15,286	52.3	175,246	47.5	3,830	56	12,797	47.4	5,581	55.1
Dominican labor force	2,868	69.8	38,442	64.4	1,798	67.9	191,767	54.7	2,402	65.2
Dominican Female labor force	1,324	60.6	19,386	58.9	820	58.8	94,023	48.9	1,175	59.6
Central American labor force	314,462	64.6	115,969	66	21,755	67.4	99,160	65.3	82,283	66.8
Central American Female labor force	141,804	56.2	51,262	57	9,734	59.5	41,718	55.7	33,311	56.3
South American labor force	94,586	67.9	165,678	64.4	22,402	68.8	176,321	64.7	28,896	66.4
South American Female labor force	45,360	60.7	78,549	56.3	10,214	62.8	77,546	56.3	13,279	57.7

Source: Census 2000 Summary File 4

Labor Force Participation Percentages

Ethnicity	California	Florida	Illinois	New York	Texas
State Labor Force	**62.4**	**58.6**	**65.4**	**61.1**	**63.6**
State Female Labor Force	**55.5**	**52.8**	**59**	**55.1**	**56.2**
Whites in labor force	63.1	57.8	66.7	62.3	64
White Females in labor force	55.7	51.1	59.4	55.5	55.7
Blacks in labor force	59.5	60.6	58.7	57.7	61.8
Black Females in labor force	59.2	60.2	58.9	56.9	62.2
Mexicans in labor force	60.9	68.2	64.2	62.3	59.7
Mexican Females in labor force	51.7	53.4	53.8	46.9	49.6
Puerto Ricans in labor force	65.4	61.9	59.9	51.9	70.9
Puerto Rican Females in labor force	59	56.6	55.2	47.1	63.5
Cubans in labor force	58.7	54.4	61	53.4	62.3
Cuban Females in labor force	52.3	47.5	56	47.4	55.1
Dominicans in labor force	69.8	64.4	67.9	54.7	65.2
Dominican Females in labor force	60.6	58.9	58.8	48.9	59.6
Central Americans in labor force	64.6	66	67.4	65.3	66.8
Central American Females in labor force	56.2	57	59.5	55.7	56.3
South Americans in labor force	67.9	64.4	68.8	64.7	66.4
South American Females in labor force	60.7	56.3	62.8	56.3	57.7

Source: Census 2000 Summary File 4

Individuals Below the Poverty Line

Ethnicity	California		Florida		Illinois		New York		Texas	
	(Number)	(%)	(Number)	(%)	(Number)	(%)	(Number)	(%)	(Number)	(%)
Total by State	**4,706,130**	**14.2**	**1,952,629**	**12.5**	**1,291,958**	**10.7**	**2,692,202**	**14.6**	**3,117,609**	**15.4**
Whites	2,059,640	10.5	1,159,903	9.5	618,955	6.9	1,230,589	9.8	1,797,015	12.4
Blacks	470,155	22.4	571,112	25.9	462,799	26	712,590	25	525,082	23.4
Mexicans	1,902,209	22.6	93,971	26.8	188,190	16.5	73,908	30.1	1,321,978	26
Puerto Ricans	21,602	16.1	82,067	17.4	30,983	20.3	325,020	32	8,048	11.8
Cubans	8,403	12.2	123,181	14.8	2,285	12.4	10,878	17.9	3,704	14.3
Dominicans	576	11.1	13,138	17.6	572	17.1	146,057	31.3	584	13.4
Central Americans	131,635	21.4	42,455	19.6	5,408	13.2	41,105	21.6	34,914	22.2
South Americans	19,659	11.8	54,744	17.5	4,372	10.9	57,501	17.5	7,206	13.6

Source: Census 2000 Summary File 4

- Non-Hispanic Whites have the lowest percentages of individuals below the poverty line.
- With the exception of Illinois, non-Hispanic Blacks and Mexicans have similar percentages of individuals below the poverty line. On average, about 1 in 4 are below the poverty line.
- California and Texas share similar distributions of poverty for Mexicans and Central Americans (their two largest Hispanic groups), where about 1 in 4 are below the poverty line.

Labor Force Participation

Ethnicity	California	Florida	Illinois	New York	Texas
State Labor Force	**15,977,879**	**7,471,977**	**6,230,617**	**9,046,805**	**9,937,150**
State Females Labor Force	**7,212,610**	**3,491,052**	**2,913,502**	**4,306,437**	**4,473,242**
Whites in labor force	10,015,056	5,911,311	4,798,659	6,435,314	7,279,801
White Females in labor force	4,498,115	2,711,762	2,206,406	2,999,271	3,240,493
Blacks in labor force	962,583	987,065	777,940	1,264,387	1,066,727
Black Females in labor force	496,056	522,998	427,934	695,632	567,423
Mexicans in labor force	3,430,100	167,115	492,626	108,962	2,094,888
Mexican Females in labor force	1,403,465	51,229	186,756	33,555	849,169
Puerto Ricans in labor force	65,369	218,933	65,547	388,743	36,568
Puerto Rican Females in labor force	29,963	104,498	31,339	191,972	15,716
Cubans in labor force	34,159	392,003	8,902	28,347	13,556
Cuban Females in labor force	15,286	175,246	3,830	12,797	5,581
Dominicans in labor force	2,868	38,442	1,798	191,767	2,402
Dominican Females in labor force	1,324	19,386	820	94,023	1,175
Central Americans in labor force	314,462	115,969	21,755	99,160	82,283
Central American Females in labor force	141,804	51,262	9,734	41,718	33,311
South Americans in labor force	94,586	165,678	22,402	176,321	28,896
South American Females in labor force	45,360	78,549	10,214	77,546	13,279

Source: Census 2000 Summary File 4

Employment

	California		Florida		Illinois		New York		Texas	
	(Number)	(%)	(Number)	(%)	(Number)	(%)	(Number)	(%)	(Number)	(%)
State Totals	**14,718,928**	**57.5**	**6,995,047**	**54.9**	**5,833,185**	**61.2**	**8,382,988**	**56.6**	**9,234,372**	**59.1**
Females Employed	**6,673,578**	**51.3**	**3,275,775**	**49.5**	**2,740,019**	**55.5**	**4,000,662**	**51.2**	**4,165,686**	**52.3**
Whites Employed	9,344,982	58.9	5,592,384	54.6	4,573,081	63.5	6,079,404	58.9	6,847,293	60.2
Female Whites Employed	4,225,660	52.4	2,573,534	48.5	2,114,686	56.9	2,849,230	52.7	3,058,485	52.6
Blacks Employed	828,497	51.2	876,286	53.8	655,926	49.5	1,092,796	49.9	934,234	54.2
Female Blacks Employed	438,073	52.3	467,995	53.8	368,796	50.7	608,835	49.8	504,527	55.3
Mexicans Employed	3,062,219	54.3	151,018	61.7	450,596	58.7	97,771	55.9	1,908,548	54.4
Female Mexicans Employed	1,232,859	45.4	45,372	47.3	168,919	48.7	28,745	40.2	765,586	44.7
Puerto Ricans Employed	58,147	58.2	200,035	56.5	59,082	54	335,239	44.8	30,998	60.1
Female Puerto Ricans Employed	27,305	53.8	95,206	51.6	28,318	49.9	165,907	40.7	14,167	57.3
Cubans Employed	31,448	54	363,376	50.4	8,266	56.7	25,807	48.6	12,504	57.5
Female Cubans Employed	14,359	49.2	160,163	43.4	3,592	52.5	11,713	43.4	5,193	51.3
Dominicans Employed	2,309	56.2	35,109	58.8	1,554	58.7	164,559	46.9	2,023	54.9
Female Dominicans Employed	1,156	52.9	17,464	53.1	709	50.9	78,788	41	1,051	53.3
Central Americans Employed	286,370	58.8	105,993	60.3	20,016	62	90,318	59.5	75,779	61.5
Female Central Americans Employed	127,433	50.5	45,768	50.9	8,768	53.6	37,137	49.5	30,010	50.7
South Americans Employed	88,170	63.3	152,696	59.3	20,927	64.3	160,543	58.9	26,629	61.2
Female South Americans Employed	42,247	56.5	71,288	51.1	9,583	58.9	68,642	49.9	12,181	52.9

Source: Census 2000 Summary File 4

- There is variation across states and ethnicities in the employment rate.
- The female employment rate is consistently lower than the overall employment rate by state and ethnicity, but still exhibits variation.

Employment

	California	Florida	Illinois	New York	Texas
State Totals	**14,718,928**	**6,995,047**	**5,833,185**	**8,382,988**	**9,234,372**
Females Employed	**6,673,578**	**3,275,775**	**2,740,019**	**4,000,662**	**4,165,686**
Whites Employed	9,344,982	5,592,384	4,573,081	6,079,404	6,847,293
Female Whites Employed	4,225,660	2,573,534	2,114,686	2,849,230	3,058,485
Blacks Employed	828,497	876,286	655,926	1,092,796	934,234
Female Blacks Employed	438,073	467,995	368,796	608,835	504,527
Mexicans Employed	3,062,219	151,018	450,596	97,771	1,908,548
Female Mexicans Employed	1,232,859	45,372	168,919	28,745	765,586
Puerto Ricans Employed	58,147	200,035	59,082	335,239	30,998
Female Puerto Ricans Employed	27,305	95,206	28,318	165,907	14,167
Cubans Employed	31,448	363,376	8,266	25,807	12,504
Female Cubans Employed	14,359	160,163	3,592	11,713	5,193
Dominicans Employed	2,309	35,109	1,554	164,559	2,023
Female Dominicans Employed	1,156	17,464	709	78,788	1,051
Central Americans Employed	286,370	105,993	20,016	90,318	75,779
Female Central Americans Employed	127,433	45,768	8,768	37,137	30,010
South Americans Employed	88,170	152,696	20,927	160,543	26,629
Female South Americans Employed	42,247	71,288	9,583	68,642	12,181

Source: Census 2000 Summary File 4

Percent Employed					
Ethnicity	**California**	**Florida**	**Illinois**	**New York**	**Texas**
State Totals	**57.5**	**54.9**	**61.2**	**56.6**	**59.1**
Females Employed	**51.3**	**49.5**	**55.5**	**51.2**	**52.3**
Whites Employed	58.9	54.6	63.5	58.9	60.2
Female Whites Employed	52.4	48.5	56.9	52.7	52.6
Blacks Employed	51.2	53.8	49.5	49.9	54.2
Female Blacks Employed	52.3	53.8	50.7	49.8	55.3
Mexicans Employed	54.3	61.7	58.7	55.9	54.4
Female Mexicans Employed	45.4	47.3	48.7	40.2	44.7
Puerto Ricans Employed	58.2	56.5	54	44.8	60.1
Female Puerto Ricans Employed	53.8	51.6	49.9	40.7	57.3
Cubans Employed	54	50.4	56.7	48.6	57.5
Female Cubans Employed	49.2	43.4	52.5	43.4	51.3
Dominicans Employed	56.2	58.8	58.7	46.9	54.9
Female Dominicans Employed	52.9	53.1	50.9	41	53.3
Central Americans Employed	58.8	60.3	62	59.5	61.5
Female Central Americans Employed	50.5	50.9	53.6	49.5	50.7
South Americans Employed	63.3	59.3	64.3	58.9	61.2
Female South Americans Employed	56.5	51.1	58.9	49.9	52.9

Source: Census 2000 Summary File 4

Unemployment

Ethnicity	California		Florida		Illinois		New York		Texas	
	(Number)	(%)	(Number)	(%)	(Number)	(%)	(Number)	(%)	(Number)	(%)
State Unemployment	**1,110,274**	**4.3**	**412,411**	**3.2**	**375,412**	**3.9**	**640,108**	**4.3**	**596,187**	**3.8**
Whites	570,127	3.6	270,783	2.6	209,787	2.9	338,601	3.3	362,616	3.2
Blacks	115,619	7.1	100,569	6.2	117,943	8.9	167,820	7.7	109,743	6.4
Mexicans	352,144	6.2	13,382	5.5	41,041	5.3	10,513	6	177,898	5.1
Puerto Ricans	5,251	5.3	16,900	4.8	6,173	5.6	52,433	7	2,558	5
Cubans	2,350	4	28,200	3.9	572	3.9	2,492	4.7	833	3.8
Dominicans	240	5.8	3,088	5.2	177	6.7	27,022	7.7	116	3.1
Central Americans	26,876	5.5	9,543	5.4	1,664	5.2	8,654	5.7	6,037	4.9
South Americans	5,735	4.1	12,555	4.9	1,395	4.3	15,612	5.7	1,908	4.4

Source: Census 2000 Summary File 4

- Non-Hispanic Whites have the lowest rates of unemployment across all states.
- Non-Hispanic Blacks have the highest rates of unemployment across all states.
- Within Hispanic subgroups, Cubans have the lowest unemployment rate across the five states.

Nativity (18 yrs and over)

	California		Florida		Illinois		New York		Texas	
	(Number)	(%)	(Number)	(%)	(Number)	(%)	(Number)	(%)	(Number)	(%)
18 years and over:	5,335,016	100.00	231,975	100.00	727,929	100.00	167,030	100.00	3,321,934	100.00
US-born Mexicans	2,114,068	39.63	73,782	31.81	208,940	28.70	28,902	17.30	1,794,354	54.02
Puerto Ricans	95,778	100.00	338,728	100.00	104,386	100.00	714,755	100.00	48,990	100.00
US-born Puerto Ricans	92,303	96.37	332,332	98.11	101,922	97.64	702,221	98.25	47,633	97.23
Cubans	56,525	100.00	703,851	100.00	14,175	100.00	51,813	100.00	21,223	100.00
US-born Cubans	17,307	30.62	100,295	14.25	4,561	32.18	17,420	33.62	6,467	30.47
Dominicans	4,026	100.00	57,101	100.00	2,555	100.00	334,974	100.00	3,565	100.00
US-born Dominicans	1,496	37.16	9,076	15.89	652	25.52	44,835	13.38	968	27.15
Central Americans	468,962	100.00	168,650	100.00	31,190	100.00	146,101	100.00	118,647	100.00
US-born Central Americans	42,152	8.99	11,118	6.59	4,160	13.34	14,362	9.83	7,185	6.06
South Americans	135,213	100.00	248,749	100.00	31,477	100.00	264,140	100.00	42,204	100.00
US-born South Americans	24,025	17.77	24,184	9.72	5,438	17.28	29,323	11.10	6,687	15.84

Source: Census 2000 Summary File 4

Nativity (under 18 yrs)

Under 18 yrs	California		Florida		Illinois		New York		Texas	
	(Number)	(%)	(Number)	(%)	(Number)	(%)	(Number)	(%)	(Number)	(%)
Mexicans	3,265,565	100.00	126,148	100.00	426,623	100.00	83,187	100.00	1,857,965	100.00
US born Mexicans	2,794,219	85.57	99,626	78.98	348,855	81.77	61,755	74.24	1,619,412	87.16
Puerto Ricans	41,333	100.00	142,609	100.00	50,942	100.00	333,111	100.00	21,403	100.00
US-born Puerto Ricans	40,993	99.18	141,839	99.46	50,524	99.18	331,746	99.59	21,179	98.95
Cubans	14,098	100.00	142,229	100.00	4,567	100.00	10,940	100.00	5,811	100.00
US-born Cubans	13,417	95.17	111,504	78.40	4,330	94.81	10,344	94.55	5,152	88.66
Dominicans	1,474	100.00	18,438	100.00	904	100.00	139,326	100.00	1,092	100.00
US-born Dominicans	1,369	92.88	13,309	72.18	759	83.96	105,003	75.36	963	88.19
Central Americans	153,284	100.00	50,046	100.00	10,304	100.00	47,871	100.00	40,580	100.00
US-born Central Americans	117,098	76.39	30,767	61.48	7,641	74.16	36,176	75.57	28,737	70.82
South Americans	33,420	100.00	67,619	100.00	9,110	100.00	68,833	100.00	12,026	100.00
US-born South Americans	24,876	74.43	35,293	52.19	6,165	67.67	45,501	66.10	8,007	66.58

Source: Census 2000 Summary File 4

Earnings										
Ethnicity	**California**		**Florida**		**Illinois**		**New York**		**Texas**	
	(Number)	(%)	(Number)	(%)	(Number)	(%)	(Number)	(%)	(Number)	(%)
State Total	9,502,776	82.5	4,739,369	74.7	3,754,061	81.7	5,516,841	78.1	6,202,954	83.9
State Mean Earnings	64,725	(X)	51,993	(X)	61,954	(X)	64,102	(X)	53,870	(X)
Whites with earnings	6,237,996	80.3	3,802,506	72.7	2,912,044	81.3	3,972,582	77.6	4,589,487	82.8
White Mean earnings	$70,031	(X)	$54,761	(X)	$65,415	(X)	$69,525	(X)	$57,868	(X)
Blacks with earnings	622,788	79	620,437	82.4	489,598	78.4	781,045	75.7	696,349	82.6
Black Mean earnings	$49,116	(X)	$38,030	(X)	$44,871	(X)	$47,579	(X)	$40,630	(X)
Mexicans with earnings	1,767,117	90.8	77,590	93.3	251,137	93.9	47,914	90.8	1,215,516	88.3
Mexican Mean earnings	$46,436	(X)	$41,828	(X)	$49,579	(X)	$48,090	(X)	$38,563	(X)
Puerto Ricans with earnings	39,378	85.3	134,776	84.7	40,299	83.3	248,680	70.2	22,373	92
Puerto Rican Mean earnings	$54,884	(X)	$42,256	(X)	$47,823	(X)	$44,871	(X)	$51,442	(X)
Cubans with earnings	21,857	78.7	254,663	78.7	5,940	83.1	18,878	70.3	8,983	86.8
Cuban Mean earnings	$63,281	(X)	$53,001	(X)	$69,534	(X)	$63,722	(X)	$62,334	(X)
Dominicans with earnings	1,595	87.6	22,466	91.1	1,060	89.7	115,111	82.1	1,313	93.7
Dominicans Mean earnings	$57,262	(X)	$41,564	(X)	$43,695	(X)	$39,303	(X)	$56,630	(X)
Central Americans with earnings	165,365	93.6	58,030	94.2	11,412	94.5	48,938	88.8	45,445	95.6
Central American Mean earnings	$44,162	(X)	$42,090	(X)	$50,899	(X)	$48,485	(X)	$39,422	(X)
South Americans with earnings	51,915	91.6	93,891	90.1	12,507	95	92,648	90.6	17,042	93.2
South American Mean earnings	$59,712	(X)	$49,346	(X)	$60,433	(X)	$52,464	(X)	$56,811h	(X)

Source: Census 2000 Summary File 4

Earnings

Ethnicity	California		Florida		Illinois		New York		Texas	
	(Number)	(%)	(Number)	(%)	(Number)	(%)	(Number)	(%)	(Number)	(%)
State Total	**9,502,776**	**82.5**	**4,739,369**	**74.7**	**3,754,061**	**81.7**	**5,516,841**	**78.1**	**6,202,954**	**83.9**
Whites with earnings	6,237,996	80.3	3,802,506	72.7	2,912,044	81.3	3,972,582	77.6	4,589,487	82.8
Blacks with earnings	622,788	79	620,437	82.4	489,598	78.4	781,045	75.7	696,349	82.6
Mexicans with earnings	1,767,117	90.8	77,590	93.3	251,137	93.9	47,914	90.8	1,215,516	88.3
Puerto Ricans with earnings	39,378	85.3	134,776	84.7	40,299	83.3	248,680	70.2	22,373	92
Cubans with earnings	21,857	78.7	254,663	78.7	5,940	83.1	18,878	70.3	8,983	86.8
Dominicans with earnings	1,595	87.6	22,466	91.1	1,060	89.7	115,111	82.1	1,313	93.7
Central Americans with earnings	165,365	93.6	58,030	94.2	11,412	94.5	48,938	88.8	45,445	95.6
South Americans with earnings	51,915	91.6	93,891	90.1	12,507	95	92,648	90.6	17,042	93.2

Source: Census 2000 Summary File 4

Mean Earnings

Ethnicity	California	Florida	Illinois	New York	Texas
State Mean	**$64,725**	**$51,993**	**$61,954**	**$64,102**	**$53,870**
White Mean earnings	$70,031	$54,761	$65,415	$69,525	$57,868
Black Mean earnings	$49,116	$38,030	$44,871	$47,579	$40,630
Mexican Mean earnings	$46,436	$41,828	$49,579	$48,090	$38,563
Puerto Rican Mean earnings	$54,884	$42,256	$47,823	$44,871	$51,442
Cuban Mean earnings	$63,281	$53,001	$69,534	$63,722	$62,334
Dominicans Mean earnings	$57,262	$41,564	$43,695	$39,303	$56,630
Central American Mean earnings	$44,162	$42,090	$50,899	$48,485	$39,422
South American Mean earnings	$59,712	$49,346	$60,433	$52,464	$56,811

Source: Census 2000 Summary File 4

Public Assistance Income

	California		Florida		Illinois		New York		Texas	
	(Number)	(%)	(Number)	(%)	(Number)	(%)	(Number)	(%)	(Number)	(%)
State Total receiving	**563,409**	**4.9**	**178,166**	**2.8**	**152,667**	**3.3**	**344,175**	**4.9**	**234,081**	**3.2**
State Mean Level	**4,819**	**(X)**	**2,449**	**(X)**	**2,532**	**(X)**	**3,699**	**(X)**	**2,285**	**(X)**
Whites receiving	247,317	3.2	111,009	2.1	64,867	1.8	137,523	2.7	137,293	2.5
White Mean level	$4,584	(X)	$2,477	(X)	$2,469	(X)	$3,586	(X)	$2,378	(X)
Blacks receiving	92,648	11.8	51,507	6.8	71,511	11.4	117,547	11.4	48,796	5.8
Black Mean level	$4,812	(X)	$2,431	(X)	$2,571	(X)	$3,634	(X)	$2,063	(X)
Mexicans receiving	158,244	8.1	3,739	4.5	10,283	3.8	5,058	9.6	83,131	6
Mexican Mean level	$4,820	(X)	$2,471	(X)	$2,613	(X)	$4,063	(X)	$2,321	(X)
Puerto Ricans receiving	3,229	7	9,390	5.9	4,553	9.4	59,089	16.7	644	2.6
Puerto Rican Mean level	$4,568	(X)	$2,252	(X)	$2,338	(X)	$3,848	(X)	$2,207	(X)
Cubans receiving	1,249	4.5	22,716	7	296	4.1	1,906	7.1	183	1.8
Cuban Mean level	$5,430	(X)	$2,449	(X)	$2,996	(X)	$3,179	(X)	$1,779	(X)
Dominicans receiving	66	3.6	1,529	6.2	72	6.1	24,617	17.6	41	2.9
Dominican Mean level	$5,406	(X)	$2,182	(X)	$2,328	(X)	$4,129	(X)	$2,044	(X)
Central Americans receiving	12,668	7.2	2,872	4.7	449	3.7	4,141	7.5	1,305	2.7
Central American level	$4,844	(X)	$2,412	(X)	$2,541	(X)	$4,470	(X)	$2,050	(X)
South Americans receiving	1,696	3	3,428	3.3	338	2.6	5,521	5.4	385	2.1
South American Mean level	$4,225	(X)	$1,966	(X)	$1,830	(X)	$4,212	(X)	$2,530	(X)

Source: Census 2000 Summary File 4

Public Assistance Income

	California		Florida		Illinois		New York		Texas	
	(Number)	(%)	(Number)	(%)	(Number)	(%)	(Number)	(%)	(Number)	(%)
State Total	**563,409**	**4.9**	**178,166**	**2.8**	**152,667**	**3.3**	**344,175**	**4.9**	**234,081**	**3.2**
Whites receiving PA	247,317	3.2	111,009	2.1	64,867	1.8	137,523	2.7	137,293	2.5
Blacks receiving PA	92,648	11.8	51,507	6.8	71,511	11.4	117,547	11.4	48,796	5.8
Mexicans receiving PA	158,244	8.1	3,739	4.5	10,283	3.8	5,058	9.6	83,131	6
Puerto Ricans receiving PA	3,229	7	9,390	5.9	4,553	9.4	59,089	16.7	644	2.6
Cubans receiving PA	1,249	4.5	22,716	7	296	4.1	1,906	7.1	183	1.8
Dominicans receiving PA	66	3.6	1,529	6.2	72	6.1	24,617	17.6	41	2.9
Central Americans receiving PA	12,668	7.2	2,872	4.7	449	3.7	4,141	7.5	1,305	2.7
South Americans receiving PA	1,696	3	3,428	3.3	338	2.6	5,521	5.4	385	2.1

Source: Census 2000 Summary File 4

Mean Public Assistance Income

	California	Florida	Illinois	New York	Texas
State Mean Level	**$4,819**	**$2,449**	**$2,532**	**$3,699**	**$2,285**
White Mean level of PA	$4,584	$2,477	$2,469	$3,586	$2,378
Black Mean level of PA	$4,812	$2,431	$2,571	$3,634	$2,063
Mexican Mean level of PA	$4,820	$2,471	$2,613	$4,063	$2,321
Puerto Rican Mean level	$4,568	$2,252	$2,338	$3,848	$2,207
Cuban Mean level of PA	$5,430	$2,449	$2,996	$3,179	$1,779
Dominican Mean level of PA	$5,406	$2,182	$2,328	$4,129	$2,044
Central American level of PA	$4,844	$2,412	$2,541	$4,470	$2,050
South American Mean level of PA	$4,225	$1,966	$1,830	$4,212	$2,530

Source: Census 2000 Summary File 4

Individuals Below the Poverty Line

Ethnicity	California		Florida		Illinois		New York		Texas	
	(Number)	(%)	(Number)	(%)	(Number)	(%)	(Number)	(%)	(Number)	(%)
Total by State	**4,706,130**	**14.2**	**1,952,629**	**12.5**	**1,291,958**	**10.7**	**2,692,202**	**14.6**	**3,117,609**	**15.4**
White	2,059,640	10.5	1,159,903	9.5	618,955	6.9	1,230,589	9.8	1,797,015	12.4
Black	470,155	22.4	571,112	25.9	462,799	26	712,590	25	525,082	23.4
Mexicans	1,902,209	22.6	93,971	26.8	188,190	16.5	73,908	30.1	1,321,978	26
Puerto Ricans	21,602	16.1	82,067	17.4	30,983	20.3	325,020	32	8,048	11.8
Cubans	8,403	12.2	123,181	14.8	2,285	12.4	10,878	17.9	3,704	14.3
Dominicans	576	11.1	13,138	17.6	572	17.1	146,057	31.3	584	13.4
Central Americans	131,635	21.4	42,455	19.6	5,408	13.2	41,105	21.6	34,914	22.2
South Americans	19,659	11.8	54,744	17.5	4,372	10.9	57,501	17.5	7,206	13.6

Source: Census 2000 Summary File 4

- Texas has the highest rate of individuals below the poverty line.
- There is significant variation across states.
- Whites are below the state average in each of the target states.
- Blacks and Mexicans are above the state average in each of the target states.
- Puerto Ricans are above the state average in each of the target states except Texas.
- Cubans, Dominicans, and South Americans are below the state average in California and Texas but above the state average in the other target states.

Spanish Bilingualism for those 18-64 Years of Age

	California	Florida	Illinois	New York	Texas
%Mexican	48.3	43.7	49.6	37.1	59.3
%Puerto Rican	51.8	76.3	73.2	70.6	70.3
%Cuban	63.5	61.4	64.6	59.9	60.9
%Dominican	73.4	67.0	65.6	52.9	74.0
%Central American	56.5	54.3	63.0	54.8	47.0
%South American	70.4	68.1	67.6	59.7	70.4

Source: 2000 US Census Summary File 4

Spanish Bilingualism for those 5-17 Years of Age

	California	Florida	Illinois	New York	Texas
%Mexican	62.6	62.8	65.9	62.4	62.2
%Puerto Rican	25.7	61.2	53.8	53.9	43.9
%Cuban	46.5	76.6	38.8	42.8	40.1
%Dominican	48.7	83.8	77.2	82.2	58.1
%Central American	75.1	73.5	70.5	71.5	72.7
%South American	66.1	77.7	65.7	74.8	63.7

Source: 2000 US Census Summary File 4

Spanish Bilingualism of Native Born

	California	Florida	Illinois	New York	Texas
%Mexican	59.0	60.9	64.1	54.0	69.2
%Puerto Rican	46.6	71.9	67.3	65.0	64.2
%Cuban	50.6	78.0	46.9	48.9	50.3
%Dominican	56.9	83.1	72.9	83.8	65.7
%Central American	73.2	73.4	69.4	68.9	71.5
%South American	60.2	77.4	64.7	76.1	60.5

Source: 2000 US Census Summary File 4

Spanish Bilingualism of Foreign Born					
	California	Florida	Illinois	New York	Texas
%Mexican	45.7	39.5	46.7	38.9	43.9
%Puerto Rican	37.4	58.7	55.4	53.5	49.3
%Cuban	60.4	50.7	64.7	56.6	60.7
%Dominican	78.5	62.6	63.9	48.7	72.1
%Central American	55.3	54.3	61.1	54.3	47.6
%South American	70.2	66.1	66.5	57.0	70.2

Source: 2000 US Census Summary File 4

Current Population Survey (CPS) March 2002 Supplement Data Set

Health Insurance, Covered by Plan Through Current/Former Employer/Union			
Ethnicity	**Frequency**	**Percent**	**Within Group Percent**
Mexican	4,663,303	2.29	27.47
Puerto Rican	732,449	0.36	30.63
Cuban	351,788	0.17	30.59
Central & South American	1,185,456	0.58	28.87
White	68,240,000	33.53	44.33
Black	9,762,441	4.8	39.06
Total	84,940,000	41.73	

Source: CPS March 2002 Supplement

- The percentage of Whites in the population covered by a plan through their current/former employer/union is four times more than the combined percentage of all the other groups (8.2%).
- The percentage of Blacks in the population is more than double that of Mexicans, which is about four times greater than the next nearest group (2.29% v. 0.58%).

Health insurance Paid by Former/Current Employer/Union (all, part, none)**							
Ethnicity	All		Part		None		Total
	(frequency)	(%*)	(frequency)	(%*)	(frequency)	(%*)	(frequency)
Mexican	1,074,889	23.05	3,324,352	71.29	264,062	5.66	4,663,303
Puerto Rican	183,464	25.05	495,029	67.59	53,955	7.37	732,449
Cuban	71,787	20.41	253,533	72.07	26,468	7.52	351,788
Central & South American	278,398	23.48	810,355	68.36	96,703	8.16	1,185,456
White	18,130,000	26.57	45,430,000	66.58	4,676,308	6.85	68,240,000
Black	2,225,603	22.8	6,860,437	70.27	676,401	6.93	9,762,441
Total	21,960,000		57,180,000		5,793,899		84,940,000

*Within group percent

**Those with health insurance

Source: CPS March 2002 Supplement

Health Insurance - Child Covered			
Ethnicity	Frequency	Percent	Within Group %
Mexican	3,332,090	5.99	41.16
Puerto Rican	384,005	0.69	46.25
Cuban	130,893	0.24	57.79
Central & South American	552,911	0.99	44.49
White	28,440,000	51.12	79.29
Black	4,877,597	8.77	52.06
Total	37,710,000	67.79	

Source: CPS March 2002 Supplement

- The percentage of Whites in the population whose children are covered is more than three times larger than the percentages of all other groups combined (16.68%).
- Two-thirds of the population (67.79%) has child coverage.

Health Insurance Group Coverage, Including Dependents			
Ethnicity	**Frequency**	**Percent**	**Within Group %**
Mexican	10,040,000	3.87	40.04
Puerto Rican	1,441,460	0.56	44.74
Cuban	634,288	0.24	46.08
Central & South American	2,341,794	0.9	43.78
White	129,000,000	49.76	67.96
Black	17,970,000	6.93	52.3
Total	161,400,000	62.28	

Source: CPS March 2002 Supplement

Health insurance Offered Through Employer Y/N – Person			
Ethnicity	**Frequency**	**Percent**	**Within Group %**
Mexican	4,797,563	4.75	92.84
Puerto Rican	763,192	0.76	91.21
Cuban	357,928	0.35	85.78
Central & South American	1,207,040	1.2	92.69
White	69,320,000	68.69	84.15
Black	10,060,000	9.97	93.05
Total	86,510,000	85.72	

Source: CPS March 2002 Supplement

- 85.72% of the population has health insurance offered through an employer.

Child Covered by Medicaid			
Ethnicity	**Frequency**	**Percent**	**Within Group %**
Mexican	2,427,265	4.36	29.98
Puerto Rican	313,476	0.56	37.75
Cuban	47,342	0.09	20.9
Central & South American	328,451	0.59	26.43
White	4,870,605	8.76	13.58
Black	3,303,575	5.94	35.26
Total	11,290,000	20.3	

Source: CPS March 2002 Supplement

- The percentage of Whites and Blacks in the population whose children are covered (14.7%) is almost three times larger than the percentages of the other groups combined (5.6%).
- The percentage of White children covered by Medicaid is lower than that of any other group.

Child Covered by States' CHIP			
Ethnicity	**Frequency**	**Percent**	**Within Group %**
Mexican	662,106	1.1	8.76
Puerto Rican	77,164	0.13	10.36
Cuban	20,358	0.03	8.46
Central & South American	109,013	0.18	8.43
White	1,245,368	2.07	2.99
Black	608,847	1.01	6.93
Total	2,722,857	4.52	

Source: CPS March 2002 Supplement

Health Insurance, Covered by Medicaid-Government Assistance			
Ethnicity	**Frequency**	**Percent**	**Within Group %**
Mexican	3,879,736	1.5	15.47
Puerto Rican	839,805	0.32	26.07
Cuban	211,084	0.08	15.33
Central & South American	642,351	0.25	12.01
White	12,390,000	4.78	6.53
Black	6,690,680	2.58	19.47
Total	24,650,000	9.51	

Source: CPS March 2002 Supplement

Health Insurance, Covered by Plan Not Related to Current/Past Employment

Ethnicity	Frequency	Percent	Within Group %
Mexican	428,969	0.21	2.53
Puerto Rican	92,800	0.05	3.88
Cuban	63,371	0.03	5.51
Central & South American	122,945	0.06	2.99
White	15,770,000	7.75	10.24
Black	1,042,031	0.51	4.17
Total	17,520,000	8.61	

Source: CPS March 2002 Supplement

- The percentage of Whites covered by a plan not related to current/past employment is at least double the percentage of any other group.
- 90% of those covered by a plan not related to current/past employment are White.

Health Insurance Champus, VA, or Military Person

Ethnicity	Frequency	Percent	Within Group %
Mexican	421,488	0.16	1.68
Puerto Rican	116,177	0.04	3.61
Cuban	19,019	0.01	1.38
Central & South American	55,975	0.02	1.05
White	6,969,245	2.69	3.67
Black	1,141,402	0.44	3.32
Total	8,723,306	3.37	

Source: CPS March 2002 Supplement

- 93% of those with Champus, VA or military coverage are either Black or White.
- Medicare covers a larger percentage of Cubans than any other group.

National Health and Nutrition Examination Survey (NHANES) 1999-2000 Data Set

Routine Place to go for Healthcare—One or More Places

	Percent	Within Group %
Mexican American	5.7	72.71
Other Hispanic	6.53	79.69
Non-Hispanic White	58.42	87.5
Non-Hispanic Black	10.25	87.06
Other Race	4.57	84.11
Total	85.46	

Source: National Health and Nutrition Examination Survey (NHANES) 1999-2000

Routine Place to Go for Healthcare

	Yes, 1 place or more (%)*	No (%)*	Don't Know (%)*
Mexican American	72.71	27.29	0
Other Hispanic	79.69	20.31	0
Non-Hispanic White	87.5	12.45	0.05
Non-Hispanic Black	87.06	12.94	0
Other Race	84.11	15.89	0

*Within Group Percentage

Source: National Health and Nutrition Examination Survey (NHANES) 1999-2000

Seen A Mental Health Profession in the Past Year		
	Percent	Within Group Percent
Mexican American	0.26	3.48
Other Hispanic	0.74	9.05
Non-Hispanic White	5.29	7.86
Non-Hispanic Black	0.78	6.62
Other Race	0.43	8.18
Total	7.5	

Source: National Health and Nutrition Examination Survey (NHANES) 1999-2000

Served in US Armed Forces		
	Percent	Percent Within Group
Mexican American	0.24	3.69
Other Hispanic	0.31	3.87
Non-Hispanic White	11.62	16.75
Non-Hispanic Black	1.3	11.9
Other Race	0.23	4.56
Total	13.7	

Source: National Health and Nutrition Examination Survey (NHANES) 1999-2000

Type of Place Most Often Go For Healthcare

	Clinic or Health Center (%)*	Doctor's Office or HMO (%)*	Hospital Emer. Room (%)*	Hospital Outpatient Dept. (%)*	Some Other Place (%)*	Don't Know (%)*
Mexican American	41.41	55.25	1.15	1.87	0.3	0.02
Other Hispanic	25.1	63.44	3.33	7.15	0.98	0
Non-Hispanic White	13.18	83.31	1.23	1.4	0.79	0.09
Non-Hispanic Black	30.78	61.6	3.3	3.49	0.83	0
Other Race	27.41	64.82	3.55	3.15	1.06	0

*Within Group Percentage

Source: National Health and Nutrition Examination Survey (NHANES) 1999-2000

Number of Times Received Healthcare Over The Past Year

	None (%)*	1 (%)*	2 to 3 (%)*	4 to 9 (%)*	10 or More (%)*	Don't Know (%)*
Mexican American	25.86	23	26.68	16.2	8.18	0.08
Other Hispanic	19.31	22.06	27.69	20.09	10.6	0.26
Non-Hispanic White	14.63	19.77	29.7	23.98	11.92	0.01
Non-Hispanic Black	16.68	22.65	28.78	20.11	11.65	0.12
Other Race	14.77	20.37	30.61	20.05	14.11	0.09

*Within Group

Percentage

Source: National Health and Nutrition Examination Survey (NHANES) 1999-2000

Time Since Last Healthcare Visit

	6 months or Less (%)*	More than 6 Months, But Not More Than 1 Year Ago (%)*	More than 1 Year, But Not More Than 3 Years Ago (%)*	More than 3 Years (%)*	Never (%)*	Don't Know (%)*
Mexican American	3.02	8.28	52.44	28.89	5.97	1.42
Other Hispanic	3.84	17.48	46.36	30.01	2.3	0
Non-Hispanic White	5.64	5.58	62.38	26.24	0.16	0
Non-Hispanic Black	10.87	15.16	54.01	19.44	0.52	0
Other Race	1.92	3.39	62.2	22.99	9.5	0

*Within Group Percentage

Source: National Health and Nutrition Examination Survey (NHANES) 1999-2000

Education

	Less than High School (%)*	High School Diploma (%)*	More than High School (%)*	Don't Know (%)*
Mexican American	69.65	14.24	15.95	0.15
Other Hispanic	54.96	12.86	31.75	0.42
Non-Hispanic White	31.46	23.5	44.87	0.18
Non-Hispanic Black	54.03	17.03	28.51	0.43
Other Race	44.79	19.12	35.3	0.8

*Within Group Percentage

Source: National Health and Nutrition Examination Survey (NHANES) 1999-2000

	Place of Birth		
	Born in US (%)*	Born in Mexico (%)*	Born elsewhere (%)*
Mexican American	60.24	39.62	0.14
Other Hispanic	41.45	0.35	58.21
Non-Hispanic White	95.3	0.04	4.66
Non-Hispanic Black	90.62	0	9.38
Other Race	64.71	0.21	35.08

*Within Group Percentage

Source: National Health and Nutrition Examination Survey (NHANES) 1999-2000

SCHIP Eligibility Requirements

Criterion	California		Florida		Illinois		New York		Texas	
	Medicaid Expansion SCHIP	SCHIP	Medicaid Expansion SCHIP	SCHIP	Medicaid Expansion SCHIP	SCHIP	Medicaid Expansion SCHIP	SCHIP	Medicaid Expansion SCHIP	SCHIP
Program Name	Medi-Cal for Children	Healthy Families Program	Medicaid	Healthy Kids	KidCare Assist, KidCare Moms & Babies	KidCare Share, KidCare Premium		Child Health Plus B	Medicaid	TexCare Partner-ship
Joint Application	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Face-to-Face Interview	No	No	No	No	No	No	Yes	No	Yes	No
Presumptive Eligibility	No	No	No	No	No	No	No	Yes[1]	Yes 3 mo.[2]	No
Crowd Out Policy	No	Yes 3 mo	No	No	No	Yes 3 mo.	No	No	No	Yes 90 days
Continuous Coverage[3]	Yes 12 mo.	Yes 12 mo.	Yes[4]	Yes 6 mo.	Yes 12 mo.	Yes 12 mo.	Yes 12 mo.	No	No	Yes 12 mo.
Pre-Printed re-Determination	No	Yes	No	Yes[5]	No	Yes	No	No	No	Yes
Income Disregards	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Required Asset Test	No	No	No	No	No	No	No	No	Yes[6]	No
Requires Social Security #	Yes	No[7]	No	Yes[8]	Yes	Yes	Yes	Yes	Yes	Yes[9]

[1] Presumptive eligibility is allowed once in the lifetime of a child.
[2] Infants through age 1.
[3] Continuous coverage is the duration of coverage despite changes in income.
[4] Children under 5 years of age get 12 months of continuous eligibility; those from 5 to 19 months receive 6 months.
[5] Pre-printed re-determination is not available for the Children's Medical Services (CMS) program.
[6] Planned on adding an asset test in 2000.
[7] Social Security number requested but not required.
[8] Social Security Number required as of the first quarter in 2003.
[9] Requires Social Security Number or proof of application.

	California	Florida	Illinois	New York	Texas
SCHIP Premium Amounts	$4-$9/child $27/mo capped	$5-$15/family/mo	$15/mo/1 child $25/mo/2 child. $30/mo/3 child. $360/yr capped	$9/mo for 166%-222% FPL $15/mo for 223%-250% FPL	$15-$18 depending on income
SCHIP Co-Pay or Co-insurance Amounts	Yes	Yes $5-$10	Yes Max $100/yr/family KidCare Share $2 KidCare Prem $5 $25 ER $3 generic script $5 brand script	No	Yes

Source: 2001 State SCHIP Annual Reports for each state available at the CMS webpage

California Eligibility Levels as a % of Federal Poverty Levels by Age

Program	Children 0-1 year	Children 1-6 years	Children 7-13 years	Children 14-18 years
Title XIX Child Poverty Related Groups or Section 1931	200%	133%	100%	
Medicaid SCHIP Expansion				100%
Separate SCHIP Program	250%	250%	250%	250%

Source: 2001 State SCHIP Annual Reports

Florida Eligibility Levels as a % of Federal Poverty Levels by Age

Program	Children 0-1 year	Children 1-6 years	Children 7-13 years	Children 14-18 years
Title XIX Child Poverty Related Groups or Section 1931	185%	133%	100%	100%
Medicaid SCHIP Expansion	200%			100%[1,2]
Separate SCHIP Program		200%	200%	200%[3]

[1]as of 9/30/01, the period the report covers, the only children left in the category are those 17-19, the rest aged-out into Title XIX as they were born prior to 10/1/1983
[2]These categories cover ages 14-19 years
[3]Children's Medical Services is SCHIP for children with special physical needs. Behavioral health coverage is for ages 5-18 only.
Source: 2001 State SCHIP Annual Reports

Illinois Eligibility Levels as a % of Federal Poverty Levels by Age

Program	Children 0-1 year	Children 1-6 years	Children 7-13 years	Children 14-18 years
Title XIX Child Poverty Related Groups or Section 1931	133%	133%	100%	34%[1]
Medicaid SCHIP Expansion	200%[2], 133%	133%	133%	133%
State Designed SCHIP	150% (share)	150% (share)	150% (share)	150% (share)
State Designed SCHIP	185% (premium)	185% (premium)	185% (premium)	185% (premium)
State Funded	185% (rebate)	185% (rebate)	185% (rebate)	185% (rebate)

[1]Born prior to 10/1/1984 based on a family of 4

[2]Born to a mother receiving coverage under Moms and Babies

Source: 2001 State SCHIP Annual Reports

New York

Eligibility Levels as a % of Federal Poverty Levels by Age

Program	Children 0-1 year	Children 1-6 years	Children 7-13 years	Children 14-18 years
Title XIX Child Poverty Related Groups or Section 1931	200%	133%	100%	100%[1]
Medicaid SCHIP Expansion	100%	100%	100%	100%[1]
Separate SCHIP Program	250%	250%	250%	250%[1]

[1]Category covers until age 19

Source: 2001 State SCHIP Annual Reports

Texas

Eligibility Levels as a % of Federal Poverty Levels by Age

Program	Children 0-1 year	Children 1-6 years	Children 7-13 years	Children 14-18 years
Title XIX Child Poverty Related Groups or Section 1931	185%	133%	100%	100%[1]
Medicaid SCHIP Expansion				100%[2]
Separate SCHIP Program	200%	200%	200%	200%

[1]Category covers through age 17

[2]Category is 15-18 years of age

Source: 2001 State SCHIP Annual Reports

2004 HHS Poverty Guidelines

Size of Family Unit	48 Contiguous States and D.C.	Alaska	Hawaii
1	$ 9,310	$11,630	$10,700
2	12,490	15,610	14,360
3	15,670	19,590	18,020
4	18,850	23,570	21,680
5	22,030	27,550	25,340
6	25,210	31,530	29,000
7	28,390	35,510	32,660
8	31,570	39,490	36,320
For each additional person, add	3,180	3,980	3,660

SOURCE: US Department of Health and Human Services
http://aspe.hhs.gov/poverty/04poverty.shtml, last accessed 3/14/04

Federal Poverty Line for a Family of Four				
% of FPL	1999	2000	2001	2002
100%	$16,700	$17,050	$17,650	$18,100
133%	$22,211	$22,677	$23,475	$24,073
185%	$30,895	$31,543	$32,653	$33,485
200%	$33,400	$34,100	$35,300	$36,200

Source: Source: 2001 State SCHIP Annual Reports

2002 Federal Poverty Levels

Size of family unit	February 2002 Poverty guidelines
1	$8,860
2	11,940
3	15,020
4	18,100
5	21,180
6	24,260
7	27,340
8	30,420

Source: US Department of Health Services

http://aspe.hhs.gov/poverty/02poverty.htm, last accessed 11/15/02