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Nativity and citizenship status affect Latinos’ health insurance coverage under the ACA

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ABSTRACT
The 2010 Patient Protection and Affordable Care Act (ACA) aimed to increase health insurance access for the over 47 million uninsured people in the U.S.A., among whom ethnoracial minorities had the highest uninsured rates before the ACA. Studies have shown that Latinos have had the greatest improvements in health coverage under the ACA, but many may be at a significant disadvantage, specifically due to their nativity and immigration status, as the ACA explicitly excludes unauthorised immigrants from most of its provisions. Using the 2015 Latino National Health and Immigration Survey, a nationally representative sample of Latinos (n = 1493), we find that variation in health insurance access among Latinos can be traced to immigration status. This study finds no differences among U.S.-born versus foreign-born Latinos in the likelihood of being uninsured in 2015. However, among foreign-born Latinos, unauthorised immigrants are five times more likely than naturalised citizens to be uninsured and less likely to visit a primary care provider or clinic, even after controlling for other factors including language, income and education.

KEYWORDS
Patient protection and affordable care act; health insurance; health outcome; Latinos; immigrant

Introduction
A question of any public policy that proposes benefits is who will be eligible. The matter of who would be included as Affordable Care Act (ACA) beneficiaries was clearly framed to target younger, healthier persons, as well as low-income individuals, all demographic indicators of the over 47 million people who were likely to be uninsured but whose enrolment could reduce average premiums for consumers (Garfield, Licata, and Young 2014). Coincidentally, in the early years of ACA implementation (2011–2012), the Latino population represented 1 in 3 of the uninsured in the U.S.A. (Artiga 2013), and is currently the youngest ethnoracial group in the country with a median age of 28 years relative to 33 for Blacks, 36 for Asians, and 42 for Whites (Pew Research Center 2015). In contrast to the youthfulness that favours Latinos as ACA beneficiaries, the fact that nearly half of all immigrants are Latino and that 1 in 3 Latinos are foreign born (U.S. Census Bureau 2013) connects
them demographically to both sides of the debate, defining lines of inclusion and exclusion under the ACA.

Unauthorised immigrants are explicitly excluded from purchasing health insurance coverage through health exchanges and also excluded from Medicaid, Medicare, and the Child Health Insurance Programme (Stephens and Artiga 2013; Joseph and Marrow 2017; Wallace et al. 2013). As the articles by Casteñeda, López-Sanders and Joseph in this special issue explain, the consequences of de jure exclusion under the ACA extend beyond non-citizens to reach individuals who may be eligible to enrol in qualified health insurance plans and receive healthcare services. In this study, we complement this claim with an assessment of differences in healthcare coverage and healthcare use among Latinos from a nationwide study. Specifically, we explore who among Latinos lacks health insurance and reports less use of healthcare resources in the post-ACA period.

We argue that patterns in health insurance and utilization of health services among Latinos can be traced to nativity and citizenship status. Differences between U.S.-born and foreign-born Latinos, and between citizens and non-citizens, suggest that health disparities can be traced to policy design (Joseph 2016). Importantly, such differences also represent potential points of intervention to address disparities within the Latino community in the future.

In this investigation, we leverage data from a national survey of Latinos to describe and explain levels of healthcare coverage and use of healthcare services. Our analysis shows that foreign-born Latinos are more likely than their U.S.-born counterparts to report lacking coverage and more likely to report gaps in coverage in the last year. We find a parallel difference in the lower levels of doctor visits among immigrants as well. We sort these findings further to uncover that these differences hinge primarily on citizenship status.

**Theory and literature review**

Many studies have examined the impact of the ACA on Latinos’ access to health coverage, with many finding that Latinos have benefited tremendously from the passage of the law (USDHH 2016; Doty et al. 2016; Chen et al. 2016). Multiple studies have shown that Latinos have experienced greater increases in health coverage pre-/post-ACA implementation than any other ethnoracial group compared to white Americans (Sommers et al. 2015, 2016; Buchmueller et al. 2016). Moreover, a majority of Latinos continue to approve of the law, although to a lesser degree than in 2013 (Krogstad and Motel 2014; Kaiser Family Foundation 2016).

The positive impact of the ACA on Latino health insurance rates is remarkable given evidence from multiple public opinion surveys and studies that show a large percentage of Latino adults were uninformed about the nuances of the law (Sanchez and Morales 2013; Sanchez 2015; Mosqueira, Hua, and Sommers 2015) and did not know about the marketplaces (Doty et al. 2016). Major glitches in the Spanish language tools available were also found; these tools were meant to aid individuals in purchasing insurance and accessing subsidies. Given that many Latinos said they would utilise the web tools for their insurance needs, these glitches were especially important for Latino coverage (Dembosky 2014).
While we know a lot about how the ACA has affected the general Latino population, some studies are also exploring the internal variation among Latinos regarding insurance coverage. Heintzman et al. (2016) find that Spanish-preferring Latinos had the largest increase in coverage rates compared to English-preferring Latinos. Terriquez and Joseph (2016) find that 1.5 generation young Latinos who speak English with their families have similar insurance rates as their peers of other ethnoracial groups. However, young Latinos of the same generation who speak their native language with family are significantly less likely to have health insurance (Terriquez and Joseph 2016).

Among the general Latino population, the U.S. Department of Health and Human Services (2016) reports uninsured rates of 30.5% in 2016, down from 41.8%. However, once disaggregated by nativity status, the numbers look quite different. Doty et al. (2016) find that in 2013, foreign-born Latinos had an uninsured rate of 47% compared to 24% for U.S.-born Latinos. By 2016, the uninsured rate for the foreign born only decreased by 3%, whereas the decrease for the U.S. born was 10% (Doty et al. 2016).

Lasswell (1950) famously defined politics as answers to the questions: who gets what, when and how? These questions cover the material goods and the beneficiaries of any public policy, including the ACA, but settling these questions in politics always requires an explanation for why some are included and not others. The argument we advance below to explain the relationship between nativity and healthcare access among Latinos in the ACA era draws on a theory that connects the ‘who’, ‘what’, ‘when’, ‘how’ and ‘why’ questions to a broader relationship between public policy and individual engagement with government.

For classic studies of public policy, answering the who, what, when and how questions are important because policy shapes how material resources are redistributed for present and future politics (Schattschneider 1935; Lowi 1964; Wilson 1974). The idea of policy feedback – that material gains from policies alter the ability of actors to influence what happens in future rounds of policy-making – complements decades of political behaviour research that says people with more resources (i.e. time, money) are more likely to vote, contact elected officials, contribute to a campaign and encourage others to do the same. Besides resource effects, Pierson (1993) adds that public policy also has ‘interpretive’ effects that shift the interests of people who are impacted. For Schneider and Ingram (1993, 340), the interpretive effects of public policy mean that ‘[p]olicy teaches lessons about the type of groups that people belong to, what they deserve from government, and what is expected of them’.

The ‘interpretive’ effects of public policy are important for our study because they suggest who is more likely to engage with the government. Soss (1999) concludes that some public programmes, like welfare, teach clients that they are undeserving and dependent, which then informs their view of government and discourages their participation in politics. Similarly, Weaver and Lerman (2010) report that African-Americans with greater levels of contact with the ‘carceral state’ (i.e. law enforcement, court officials) are less trusting of government and less likely to vote. Rocha, Knoll, and Wrinkle (2015) find an analogous negative relationship between levels of local immigrant policing and Latino trust in government.

By contrast, programmes like the GI Bill characterise veterans as heroes who merit public support. This public acknowledgement of their sacrifice reinforces veterans’ ideas about civic duty, yielding greater levels of political participation among veterans who
use Veteran benefits (Mettler 2005). This line of research suggests that when it comes to evaluating Latinos’ use of healthcare resources under the ACA, we should consider carefully the kinds of lessons the ACA (and other salient policy domains) teach Latinos about using healthcare resources.

The exclusion of unauthorised immigrants from the ACA is our starting point for exploring how nativity structures how Latinos interact with healthcare resources. First, the public discourse and Congressional deliberation of the ACA were infused with anti-immigrant rhetoric that characterised the foreign born as undeserving and deviant (Lubin 2014). Perhaps the most infamous expression of nativism surrounding the ACA occurred when Joe Wilson, U.S. House of Representative from South Carolina, interrupted President Barack Obama’s speech to the joint session of Congress by yelling, ‘You lie!’ following President Obama’s statement that the ACA would not apply to those who are present unlawfully. Second, the ACA debates are reminiscent of earlier policies that produced exclusionary public benefits on the basis of nativity and citizenship status, from relief programmes of the 1930s Great Depression (Fox 2012) to the 1996 Welfare Reform Act (Lubin 2014; Fording, Soss, and Schram 2011). Although undocumented immigrants were not the affirmative target population of the ACA, the policy feedback literature noted above suggests that their historical exclusion from various public benefits communicates immigrants’ assumed ineligibility and until confirmed otherwise, an unfavourable place in society (Ortega, Rodriguez, and Vargas Bustamante 2015; Zucker-man, Waidmann, and Lawton. 2011).

The characterisation of unlawful immigrants as undeserving and deviant is consequential for Latinos for several reasons. First, although nativity, immigration status and ethnicity are all distinct demographic categories, the political arguments invoked to justify exclusion by nativity and immigration status conflate these categories. Such was the case in California’s Proposition 187, a 1994 ballot initiative to restrict unauthorised immigrants from public services and to mandate public officials report to authorities any person they suspected of being undocumented. Jacobson (2008, 47) explains that the proponents of Proposition 187 justified their position by interpreting a ‘discrete act of violating immigration law’ as ‘a criminal tendency in Mexicans’. Although a court struck down Proposition 187 on the claim that immigration policy is reserved to the federal government, critics also opposed the initiative because inviting people to report persons suspected of being undocumented is a call to action that likely shifts into profiling based on stereotypes about the physical appearance of an undocumented person, which would codify Latino ethnicity as subject to legal scrutiny.

Second, a similar conflation between ethnicity, nativity and citizenship status continues to find expression in immigrant policing debates. Critics raise concerns about racial profiling in response to policies like Arizona’s SB 1070, also known as the ‘show me papers’ law (Santa Ana and de Bustamante 2012), similar laws in Alabama, North Carolina and Georgia, as well as federal enforcement efforts like the Priority Enforcement Programme (formerly Secure Communities Programme) that harness the personnel power of local law enforcement officers to identify and detain people who are unlawfully present in the U.S.A. (Koulish 2010). The gravity of such policing programmes is increased in the context of developments in national immigration policy, including the passage of the 1996 Illegal Immigration Reform and Immigration Responsibility Act (IIRIRA), and the Anti-Terrorism and Effective Death Penalty Act (ATEDPA), which expand U.S.
immigration enforcement powers by removing due process for non-citizens, increasing
the set of deportable crimes, and allowing retro-active application of deportation proceed-
ings for crimes previously adjudicated (Welch 2002).

Third, the U.S.A. is described as a nation of immigrants, but some people are closer to
the experience of new arrivals than others. Since the 1900s, 12% of the U.S. population has
consisted of immigrants, with the exception being a dip to less than 5% shortly following
the Second World War (Gibson and Lennon 1999). Since 1980, the share of immigrants
among Latinos has never been less than 40%, and as of 2014, more than 50% of the immi-
grants in the country are Latinos (Brown and Stepler 2016).

Approximately one in three immigrants in the country is Latino (Pew Hispanic Center
2015). This demographic reality combines with the issues of racial profiling in immigra-
tion enforcement and the exclusionary design of public policy programmes to leave
Latinos more vulnerable to widening gaps in rights and privileges between non-citizens
and citizens created by enforcement laws like IIRIRA and ATEDPA.

The demographic profile of Latinos is further complicated by the prevalence of ‘mixed-
status’ households, where some individuals are lawfully present as legal permanent resi-
dents (LPR) or U.S.-born citizens, while others are undocumented (Vargas and Ybarra
2016; Vargas 2015; Xu, Pirog, and Vargas 2016; Vargas and Pirog 2016; Fix and Zimmer-
man 2001). Under the ACA, Castañeda and Melo (2014) find that mixed-status families
with citizen children often avoid enrolling their children in medical or nutritional pro-
grammes. For ‘mixed-status’ families, policy designed to exclude on the basis of nativity
and immigration status can discourage eligible household members from using the
resource out of concern that this may jeopardise the chances for either themselves or
another family member to adjust immigration status in the future. Corroborating that
documentation status matters for insurance coverage, Xu (2015) utilises the Immigration
Reform and Control Act of 1986 as a natural experiment to analyse how a change in docu-
mentation status affects insurance coverage among Latinos. She finds that gaining legal
status led to a 72.6 percentage increase in the probability of being insured, and a 44.5 per-
centage increase in gaining access to check-ups as a measure of preventive care.

Studies have shown that immigration status predicts health insurance coverage and
access to health services (Chavez 2012; Vargas Bustamante et al. 2012; Reyes and Hardy
2014; Pourat et al. 2014). Immigration status often interacts with other immigrant-specific
factors to affect health insurance and medical care for this population. Vargas Bustamante
et al. (2012) find both documentation status and length of stay in the U.S.A. to be predic-
tors of health insurance coverage. Pourat et al. (2014) find that unauthorised immigrants,
especially those who are uninsured, are less likely to access health and preventive services
than their documented and naturalised counterparts, as well as U.S.-born citizens.

In a recent complement to the above studies, Raymond-Flesch et al. (2014) analyse the
effects of changing documentation status on access to care. Their qualitative study of
‘DACAmented’ youth, a term used to describe individuals who are granted temporary re-
rieve from deportation under the authority of the Deferred Action for Childhood Arrivals
programme (DACA), found that despite the removal of undocumented status as a barrier
to care, these youth continued to avoid the healthcare system. Part of the reason is that
DACA is not a legal status, and it does not extend any social or welfare benefits to recipi-
ents. Although DACAmented youth can gain access to employer-sponsored health
insurance if offered and purchase health insurance at full cost outside Marketplaces,
evidence from focus groups and individual interviews revealed that costs of care and mistrust of providers were important factors influencing lack of health insurance and seeking medical care (Flynn, Eggerth, and Jacobson 2015). These minimal benefits, however, may be terminated soon given that President Trump promised to rescind DACA, an executive order that has not been signed into law, during his presidential campaign in 2016 (Hipsman, Gómez-Agüiñaga, and Capps 2016).

Among other factors that have been found to influence health insurance among immigrants are age and length of stay. Reyes and Hardy (2014) find that older immigrants are less likely to have health insurance coverage than their similarly situated native-born elders. Bustamante et al. (2014) find that among the foreign-born population, those who have been in the U.S.A. for at least 10 years and who have a legal status have higher insurance rates than those without legal status and shorter stays. It is important to highlight that the vast majority of unauthorised immigrants residing in the country have lived in the country for long periods of time. The Migration Policy Institute (n.d.) reports that 58% of all unauthorised immigrants have lived in the U.S.A. for more than 10 years, and 82% for more than 5 years.

The message that the immigration laws cited above convey is that non-citizenship is a liability, and this lesson is further reinforced by the exclusion of non-citizens from laws governing social policy programmes such as the ACA (Joseph 2016, 2017). These points explain why a health insurance programme that would appear to be a perfect fit for Latinos – a group with high rates of non-coverage and ideal demographic profiles in terms of health and age – may actually be falling short of its full potential for this group. The confluence of punitive immigration policy and exclusionary ACA policy, we believe, leads Latinos to exercise caution or avoid approaching service-providing organisations that are associated with the government. Why? Because utilisation of health insurance and care may provide a needed benefit, but one that does not warrant the risk of exposing oneself or loved ones to a punitive arm of the state.

Data and methods

We use the 2015 Latino National Health and Immigration Survey (LNHIS) from the Robert Wood Johnson Foundation (RWJF) Center for Health Policy at the University of New Mexico, which is a unique survey designed for the specific purpose of assessing to what degree the ACA has been effective in addressing the most salient health and healthcare concerns of the Latino community. The survey company Latino Decisions implemented the survey and worked in conjunction with the scholars at the RWJF Center for Health Policy to design the survey instrument. This is therefore an ideal data set for our research question. The LNHIS (total \(N = 1493\)) relies on a sample provided by a mix of cell phone and landline households along with web surveys. This mixed-mode approach improves our ability to capture a wide segment of the Latino population in the sample by providing a mechanism to poll the growing segment of the population that lacks a landline telephone and those who prefer to complete surveys online. This approach is sensitive to some of the major shifts in survey methodology driven by changes in the communication behaviour of the population. More specifically, the increasing number of Americans who use a cell phone for primary telephone communication (instead of landline telephones) motivates our expansion of a sample beyond landline households.
A total of 989 Latinos were interviewed over the phone and an additional 504 Latinos were sampled through the Internet to create a dataset of 1493 respondents. The web-focused respondents were randomly drawn from the Latino Decision’s national panel of Latino adults. Respondents for the online survey are from a double-opt-in national Internet panel, and then randomly selected to participate in the study and weighted to be representative of the Latino population. The web mode allows respondents to complete the survey in either English or Spanish, and contained the exact same questions as the phone mode.

All phone calls were administered by Pacific Market Research in Renton, Washington. The survey has an overall margin of error of ±2.5% with an American Association for Public Opinion Research response rate of 18% for the telephone sample. Latino Decisions selected the 44 states and Puerto Rico with the highest number of Latino residents for the sampling design, states that collectively account for 91% of the overall Latino adult population. Respondents across all modes of data collection could choose to be interviewed in either English or Spanish. All interviewers were fully bilingual. A mix of cell phone (35%) only and landline (65%) households were included in the sample, and the full dataset, including both phone and web interviews, are weighted to match the 2013 Current Population Survey universe estimate of Latino adults with respect to age, place of birth, gender and state. The survey was approximately 28 minutes long and was fielded from 29 January 2015 to 12 March 2015.

The primary outcome variables of interest are access to health insurance coverage and access to healthcare within the LNHIS dataset. We examined two health insurance coverage questions included in the LNHIS. The first insurance coverage survey item asks respondents about their health coverage over the last 12 months. The specific survey question we utilise is ‘At any time over the last 12 months, did you ever go without health insurance, even for a few weeks or months, or did you have health insurance throughout the entire time?’. We collapsed the response categories and coded this variable, 1 = went without health insurance at some point in last year and went without insurance the whole time, 0 = had insurance entire year. This measure allows us to make inferences about changes in access to coverage over the year prior to interview. While not as strong as true longitudinal data, this unique approach makes the most of the cross-sectional data we have to work with to assess the impact of the ACA on Latino health coverage. We predict prior year’s insurance coverage using logistic regression. Our next insurance coverage indicator asks respondents about their current coverage. The specific survey question we utilise is ‘Do you currently have health insurance coverage – Yes or No?’ Since this health insurance variable is also binary (1 = currently uninsured, 0 = currently insured), we use logistic regression to estimate this model.

To examine health access, we included an open-ended item that asks respondents approximately how many times they visited their primary care doctors or clinic in the past year. The specific survey question we utilise is ‘Thinking about all of the members of your household, including adults and dependent children, approximately how many visits to primary care doctors or clinics have been made in the past year?’ Given the question wording and variability of household composition, we standardise this variable with the total number of individuals in the household with the following survey item, ‘What is the total number of persons living in your household?’ In sum, our health access variable captures the total number of primary care doctor or clinic visits per year divided by
household composition. Moreover, given the distribution of this variable, we model this variable with ordinary least squares regression.

Our main explanatory variables include nativity and citizenship status. We utilise the following question to measure nativity, ‘Were you born in the United States, on the island of Puerto Rico, or in another country?’ The categories of the variable are foreign born and U.S. born, which we coded (0 = U.S. born, 1 = foreign born). We include Puerto Ricans as foreign born but do run a robustness check and find no differences when including them as U.S. born, in all models.

For our citizenship status models, unlike traditional nationally representative surveys that do not ask about citizenship status, we explicitly ask foreign-born respondents about their status and then create three distinct categories. Among foreign-born respondents we ask (U.S.-born respondents are U.S. citizens by birthright), ‘Are you currently a U.S. citizen, a LPR, or a non-citizen?’ The three categories include foreign-born respondents who have become naturalised U.S. citizens, foreign-born respondents who are LPR, and non-citizens, who we assume to be undocumented. We do acknowledge that this category can include immigrants who are in the U.S.A. legally (i.e. students on J visas, workers on temporary visas, refugees). This approach is aligned with current demography research that relies on a residual methodology that takes the difference between the total foreign-born population minus LPRs (Passel et al. 2014). Summary statistics for all variables used in this analysis are listed in Table 1. Our analytic approach is focused on the exploration of various categorical and ordinary least squares regression techniques.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Observations</th>
<th>Mean</th>
<th>SD</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured last year</td>
<td>1487</td>
<td>0.32</td>
<td>0.47</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Uninsured currently</td>
<td>1486</td>
<td>0.15</td>
<td>0.36</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Clinic/primary care provider visits</td>
<td>1337</td>
<td>3.14</td>
<td>5.61</td>
<td>0</td>
<td>87</td>
</tr>
<tr>
<td>Foreign born</td>
<td>1453</td>
<td>0.56</td>
<td>0.50</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Naturalised citizen</td>
<td>629</td>
<td>0.48</td>
<td>0.50</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Permanent resident</td>
<td>629</td>
<td>0.32</td>
<td>0.47</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Undocumented</td>
<td>629</td>
<td>0.20</td>
<td>0.40</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Self-rated physical health(a)</td>
<td>1488</td>
<td>3.30</td>
<td>1.08</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Self-rated mental health(b)</td>
<td>1488</td>
<td>3.75</td>
<td>1.06</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Female</td>
<td>1490</td>
<td>0.62</td>
<td>0.49</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Education(c)</td>
<td>1442</td>
<td>5.52</td>
<td>2.36</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Age</td>
<td>1425</td>
<td>45.87</td>
<td>17.00</td>
<td>18</td>
<td>98</td>
</tr>
<tr>
<td>Income missing</td>
<td>1493</td>
<td>0.21</td>
<td>0.41</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Income: less than 20k</td>
<td>1493</td>
<td>0.20</td>
<td>0.40</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Income: 20k–39k</td>
<td>1493</td>
<td>0.21</td>
<td>0.40</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Income: 40k–60k</td>
<td>1493</td>
<td>0.13</td>
<td>0.33</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Income: 60k–80k</td>
<td>1493</td>
<td>0.09</td>
<td>0.28</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Income: 80k–100k</td>
<td>1493</td>
<td>0.06</td>
<td>0.24</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Income: 100k–150k</td>
<td>1493</td>
<td>0.07</td>
<td>0.25</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Income: 150k+</td>
<td>1493</td>
<td>0.04</td>
<td>0.19</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Marital status(d)</td>
<td>1450</td>
<td>0.53</td>
<td>0.50</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>English language(e)</td>
<td>1493</td>
<td>0.58</td>
<td>0.49</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Mexican origin</td>
<td>1471</td>
<td>0.55</td>
<td>0.50</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

\(a\)Self-rated physical health (1 = poor, 2 = fair, 3 = good, 4 = very good, 5 = excellent).
\(b\)Self-rated mental health (1 = poor, 2 = fair, 3 = good, 4 = very good, 5 = excellent).
\(c\)Highest education levels completed (1 = no formal schooling, 2 = grade 1–8, 3 = some HS, 4 = GED, 5 = HS graduate, 6 = some college, 7 = associates, 8 = bachelors, 9 = MA, 10 = Ph.D./MD).
\(d\)Married (0 = unmarried, 1 = married).
\(e\)Language of interview (0 = Spanish, 1 = English).
intended to determine if our measures of nativity and citizenship status are associated with healthcare coverage and health access among the Latino population.

Finally, we control for a handful of measures that have been found to be correlated with healthcare coverage and access in previous research. Among the demographic variables, we include standard measures of income, educational attainment, age, marital status, language of interview and gender. To assess income, we have included several dummy variables representing different income categories: $20,000–$39,999, $40,000–$59,999, $60,000–$79,999, $80,000–$99,999, $100,000–$149,999, $150,000 and above, with less than $19,999 serving as the reference category. We also include a variable of ‘unknown’ income in the model, which includes respondents who did not report their income as a means of saving cases. One of the more important controls in our model is physical and mental health status. As shown in previous literature, respondents who have worse health status are also more likely to need health coverage and more likely to visit their primary care provider (Weinick et al. 2004; Ortega et al. 2007; Artiga 2013; Wallace et al. 2013). Therefore, we include both self-rated physical and mental health. The specific survey questions we utilise is ‘How would you rate your overall [physical|mental] health – excellent, very good, good, fair, or poor?’ We reverse code this variable in our analysis and so it ranges from 1 = poor to 5 = excellent. It is important to note that among Spanish-speaking respondents, self-rated health includes ‘más o menos’ instead of ‘regular’ as the translation for the ‘fair’ health response option. Recent evidence has shown that using ‘regular’ as the Spanish translation for ‘fair’ health overinflates poor health among Latinos (Viruell-Fuentes et al. 2011; Sanchez and Vargas 2016).

Finally, the U.S. Latino population is immensely diverse, with members originating from 21 countries all while coming from countries with various relationships with the U.S.A. Latinos also tend to reside in different areas of the U.S.A., have different cultural practices, and different immigration experiences given trade and political ties with the U.S.A. The dataset we utilise for this analysis allows us to explore the influence of this diversity on health coverage. The Mexican-origin population (which comprises 65% of the total Latino population) has been found to have unique healthcare outcomes relative to Latinos from other backgrounds (Weinick et al. 2004; Ortega et al. 2007). This variation motivates us to account for Mexican origin in our study, so we include a binary variable for Mexican origin to account for Latino heterogeneity by national origin. We also ran sensitivity analysis by stratifying all models by Mexican origin. The results remain constant, and we highlight the key differences in the results section. Given the high correlation between Mexican origin and citizenship status, we should be cautious of these stratified results and so we only provide the findings from our full models. All statistical analysis was conducted using Stata 12 software (StataCorp 2011) and survey weights were used to account for the complex survey design.

Our analytical approach is intended to first determine the relationship between nativity on insurance coverage and healthcare access within a nationally representative sample of Latino adults. We then delve deeper and focus on foreign-born respondents to examine the role of citizenship status on insurance coverage and healthcare access, controlling for multiple explanatory variables. Our primary focus is to assess to what degree the ACA has been effective in addressing the most salient health and healthcare concerns of the Latino community.
Results

We begin with a discussion of the distributions from our sample, which are provided in Table 1. After dropping missing data and the respondents who do not fit the interests of our study, we have a total sample of 1323–1378 respondents in our full nativity models and 595–599 respondents for our models that focus on foreign-born Latinos. The summary statistics suggest that 32% of respondents went without health coverage last year, 15% are currently uninsured and on average had three visits to the clinic or primary care provider in the past year. Figure 1 provides the distributions of our two dependent variables health coverage in 2014 (based on our question regarding coverage over past year) and current coverage in 2015 by citizenship status among the foreign-born Latinos. These distributions show that the uninsured rate among undocumented immigrants increased by 16 percentage points (from 33% to 49%) over the course of the years respondents were queried about, while uninsured rates among LPRs and naturalised citizens decreased from last year to the current year. Descriptive statistics reveal that our third dependent variable, primary care provider and clinic visits per household, also varied by citizenship among foreign-born Latinos. On average, naturalised citizen households had the most visits (mean = 4) last year compared to permanent residents (mean = 2 visits) and undocumented immigrants (mean = 2). This distribution highlights the variation among foreign-born Latinos and that undocumented immigrants were least likely to be covered and to visit a clinic in the past year. This is preliminary evidence that suggests the disparity in access to health insurance based on citizenship has become more apparent under the ACA.

On average, 56% of Latinos were foreign born in our sample, and among this population, 48% are naturalised citizens, 32% are permanent residents and the remaining 20% are undocumented. In general, respondents reported ‘good’ physical and mental health. The mean age in our sample is 46, and the majority of our sample has at least a high school education, and half reported being married at the time of the survey. Moreover, over half of our respondents completed the survey in English, and over half of the sample indicated that they are of Mexican ancestry, both consistent with national data on Latinos from the U.S. Census. In sum, our sample is representative of U.S. Latinos, as the U.S. Census estimates that about 65% of the Latino population is of Mexican

![Figure 1. Un-weighted summary statistics of insurance coverage (last year-2014 and currently-2015) and citizenship status among foreign-born Latinos (n = 627).](image-url)
origin, 63% of Latinos over age 25 have a high school education and about 74% of Latinos over 5 years of age speak Spanish at home.

Our first set of models estimates two logistic regressions and an ordinary least squares regression to test the differences across nativity on health coverage and healthcare visits, controlling for physical and mental health, age, education, income, marital status, Mexican origin and language of interview. We then estimate models that isolate the effects of citizenship among the foreign-born population, to better understand the association between citizenship status and health coverage and healthcare access.

The results of our first models are depicted in Table 2. Our first set of results in model 1 estimates the probability of being uninsured in the last year controlling for a variety of variables. We do not find strong support that there are significant differences between being foreign born versus U.S. born in the probability of being insured last year. Furthermore, we also find no nativity differences in the likelihood of currently being insured (model 2) and in the number of hospital visits. From these findings, we conclude that in our fully specified models, there are no differences among U.S. born versus foreign born in the likelihood of being uninsured last year, currently, and in the number of hospital visits, after controlling for a host of other factors, including language and national origin. We stratified these models by Mexican origin and also find no differences based on nativity in the likelihood of being uninsured and the number of hospital visits.

**Table 2.** Logistic coefficients and ordinary least squares regressions of nativity on health coverage and access using a 2015 Robert W. Johnson foundation/Latino decisions LNHI.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Logit model: uninsured last year</th>
<th>Logit model: currently uninsured</th>
<th>OLS model: clinic visits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>β</td>
<td>Odds ratio</td>
<td>β</td>
</tr>
<tr>
<td>Foreign born(^a)</td>
<td>−0.036</td>
<td>0.965</td>
<td>−0.242</td>
</tr>
<tr>
<td>Self-rated physical health(^b)</td>
<td>−0.110*</td>
<td>0.896*</td>
<td>−0.217***</td>
</tr>
<tr>
<td>Self-rated mental health(^c)</td>
<td>0.005</td>
<td>1.005</td>
<td>−0.050</td>
</tr>
<tr>
<td>Female</td>
<td>−0.274**</td>
<td>0.761**</td>
<td>−0.410***</td>
</tr>
<tr>
<td>Education(^d)</td>
<td>−0.044</td>
<td>0.957</td>
<td>−0.115***</td>
</tr>
<tr>
<td>Age</td>
<td>−0.029***</td>
<td>0.972***</td>
<td>−0.032***</td>
</tr>
</tbody>
</table>

Reference category income: less than 20

| Income missing              | −0.415**| 0.660**    | −0.488***| 0.614**  | −0.690*  |
| Income: 20k–39k             | −0.245  | 0.782      | −0.070   | 0.932     | −1.008***|
| Income: 40k–60k             | −0.504***| 0.604***   | −0.371   | 0.690     | −1.259***|
| Income: 60k–80k             | −0.668***| 0.513***   | −0.656*  | 0.519*    | −1.543***|
| Income: 80k–100k            | −2.098***| 0.123***   | −2.294***| 0.101***  | −1.136**  |
| Income: 100k–150k           | −1.350***| 0.259***   | −1.648***| 0.192***  | −1.078**  |
| Income: 150k+               | −1.302***| 0.272***   | −0.889   | 0.411     | −1.601**  |
| Marital status\(^e\)        | 0.317** | 1.373**    | 0.513***| 1.671***  | −0.317   |
| English language\(^f\)      | −0.094  | 0.911      | −0.641***| 0.527***  | 0.377    |
| Mexican origin              | 0.164  | 1.178      | 0.228   | 1.256     | 0.197    |
| Observations                | 1359   | 1358       | 1301    | 1301      |
| Adjusted R\(^2\)            | 0.0764 | 0.120      | 0.07    |

***p < .01, **p < .05, *p < .1, using complex survey weights.

\(^a\)Foreign born (0 = born in U.S.A. or Puerto Rico, 1 = foreign born).

\(^b\)Self-rated physical health (1 = poor, 2 = fair, 3 = good, 4 = very good, 5 = excellent).

\(^c\)Self-rated mental health (1 = poor, 2 = fair, 3 = good, 4 = vry good, 5 = excellent).

\(^d\)Highest education levels completed (1 = no formal schooling, 2 = Grade 1–8, 3 = Some HS, 4 = GED, 5 = HS graduate, 6 = some college, 7 = associates, 8 = bachelors, 9 = MA, 10 = Ph.D./MD).

\(^e\)Married (0 = unmarried, 1 = married).

\(^f\)Language of interview (0 = Spanish, 1 = English).
In addition to our measures of nativity, we briefly discuss the performance of the control variables. The socio-demographic factors are very meaningful, as essentially all of these controls have an impact on Latino health coverage and access. Respondents who report optimal physical health are less likely to be uninsured and less likely to visit their primary care provider or a health clinic. When stratified by nationality, we find Mexican-origin respondents’ self-rated health to be statistically associated with being uninsured last year (2014), a finding that was only marginally significant in the original model. Regarding gender, we find females, as opposed to males and Latinos with more education are less likely to be uninsured. This is especially true for Mexican-origin females relative to Mexican-origin men. Given the strong relationship between education and healthcare access, we find that Latinos with more education are more likely to visit their primary care provider or visit a clinic. We also find income differences, in that Latinos with higher incomes relative to income under $20,000 are less likely to be covered and have access to a healthcare clinic.

In our next set of models in Table 3, we delve deeper and examine coverage and health access among foreign-born Latinos, with particular focus on the role of citizenship status. In these models, we compare foreign-born respondents who have become naturalised U.S. citizens (reference category), foreign-born non-citizen respondents who are LPR, and non-citizens on health insurance coverage and healthcare access. In these models, we also control for physical and mental health, age, education, income, marital status, and language of interview.

### Table 3. Logistic coefficients and ordinary least squares regressions of citizenship status on health coverage and access using a 2015 Robert W. Johnson foundation/Latino decisions LNHIS.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Logit model: uninsured last year</th>
<th>Logit model: currently uninsured</th>
<th>OLS model: clinic visits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>β</td>
<td>Odds ratio</td>
<td>β</td>
</tr>
<tr>
<td>Reference category citizenship: naturalised citizen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Citizenship: permanent resident</td>
<td>0.356*</td>
<td>1.428*</td>
<td>0.342</td>
</tr>
<tr>
<td>Citizenship: undocumented</td>
<td>1.094***</td>
<td>2.985***</td>
<td>1.644***</td>
</tr>
<tr>
<td>Self-rated physical healtha</td>
<td>−0.183*</td>
<td>0.833*</td>
<td>−0.503***</td>
</tr>
<tr>
<td>Self-rated mental healthb</td>
<td>0.078</td>
<td>1.081</td>
<td>0.171</td>
</tr>
<tr>
<td>Female</td>
<td>−0.484***</td>
<td>0.616***</td>
<td>−0.541**</td>
</tr>
<tr>
<td>Educationc</td>
<td>−0.029</td>
<td>0.971</td>
<td>−0.112*</td>
</tr>
<tr>
<td>Age</td>
<td>−0.036***</td>
<td>0.965***</td>
<td>−0.037***</td>
</tr>
<tr>
<td>Reference category income: less than 20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income missing</td>
<td>−0.379</td>
<td>0.685</td>
<td>−0.045</td>
</tr>
<tr>
<td>Income: 20k–39k</td>
<td>−0.026</td>
<td>0.975</td>
<td>0.222</td>
</tr>
<tr>
<td>Income: 40k–60k</td>
<td>−0.651*</td>
<td>0.521*</td>
<td>−0.941***</td>
</tr>
<tr>
<td>Income: 60k–80k</td>
<td>−0.514</td>
<td>0.598</td>
<td>−0.074</td>
</tr>
<tr>
<td>Income: 80k–100k</td>
<td>−1.597***</td>
<td>0.202***</td>
<td>−1.418</td>
</tr>
<tr>
<td>Income: 100k–150k</td>
<td>−0.574</td>
<td>0.563</td>
<td>0.262</td>
</tr>
<tr>
<td>Income: 150k+</td>
<td>−1.964*</td>
<td>0.140*</td>
<td>−0.518</td>
</tr>
<tr>
<td>Marital statusd</td>
<td>0.184</td>
<td>1.202</td>
<td>0.350</td>
</tr>
<tr>
<td>English languagee</td>
<td>−0.266</td>
<td>0.766</td>
<td>−0.825**</td>
</tr>
<tr>
<td>Mexican origin</td>
<td>−0.146</td>
<td>0.864</td>
<td>0.124</td>
</tr>
<tr>
<td>Observations</td>
<td>596</td>
<td>597</td>
<td>592</td>
</tr>
<tr>
<td>Adjusted R²</td>
<td>0.121</td>
<td>0.208</td>
<td>0.102</td>
</tr>
</tbody>
</table>

**p < .01, *p < .05, *p < .1, using complex survey weights.**

aSelf-rated physical health (1 = poor, 2 = fair, 3 = good, 4 = very good, 5 = excellent).
bSelf-rated mental health (1 = poor, 2 = fair, 3 = good, 4 = very good, 5 = excellent).
cHighest education levels completed (1 = no formal schooling, 2 = Grade 1–8, 3 = Some HS, 4 = GED, 5 = HS graduate, 6 = some college, 7 = associates, 8 = bachelors, 9 = MA, 10 = Ph.D./MD).
dMarried (0 = unmarried, 1 = married).
eLanguage of interview (0 = Spanish, 1 = English).
Mexican origin and language of interview. The findings from our model 4 suggest that relative to naturalised citizens, LPRs are 42% more likely to be uninsured last year, which is marginally significant at the .01 level, holding all else equal. In model 5, we find no differences between naturalised citizens and LPRs in current health coverage, and we find that LPRs are 74% less likely (marginally significant) to visit the doctor or clinic relative to naturalised citizens, holding all else equal. As expected, the real significant and substantive differences are between undocumented citizens and naturalised citizens. For example, undocumented immigrants are almost three times more likely than naturalised citizens to be uninsured last year and five times more likely to be currently uninsured relative to naturalised citizens, holding all else equal (both significant at the .01 level). Moreover, we also find that undocumented immigrants are also less likely to visit a primary care provider or clinic relative to naturalised citizens, suggesting that citizenship status is a large barrier to both health coverage and access. When stratifying the models by citizenship status and Mexican origin, we find a larger disparity in coverage between naturalised and undocumented citizens. The main findings suggest that Mexican-origin respondents are the most vulnerable population that is both less likely to be insured and less likely to visit a primary care provider or clinic.

We also discuss the performance of the control variables in models that isolate the analysis to the foreign born. Similar to our first full models that compare health status, we also find that respondents who have optimal health are less likely to be uninsured and less likely to visit the clinic or doctor. We also find that women relative to men are less likely to be insured and as respondent get older they are also less likely to be uninsured and more likely to visit a doctor or clinic. When stratifying by Mexican origin, we find that among the foreign born, female non-Mexican Latinas were least insured in 2014 relative to their male non-Mexican co-ethnics. We also find that English-speaking Latinos are less likely to be insured in 2014, relative to Spanish-speaking Latinos. Lastly, unlike our full models, we find less income variation in the likelihood of health coverage and access among foreign-born respondents.

**Discussion and conclusion**

As has been documented in this volume, the ACA expanded access to health insurance to a much wider segment of the U.S. population, including significantly reducing the percentage of uninsured Latinos. However, the limitations of the health reform law, including its explicit exclusion of undocumented immigrants, have not decreased inequalities in health care among Latinos based on immigration status. We utilise data from the 2015 LNHIIS from the University of New Mexico to assess to what degree the ACA has been effective in addressing the most salient health and healthcare concerns of the Latino community. Our manuscript examines the intersection between immigration and health policy, specifically exploring potential differences in access to health insurance and care based on nativity among Latinos and citizenship status when foreign-born Latinos are isolated in a separate model.

The data reveal that foreign-born and particularly non-citizen Latinos continue to face issues in access to health insurance coverage and access to healthcare compared to U.S.-born Latinos. Our fully specified model reveals that nativity does not have a statistically significant impact on health coverage or partial coverage, as well as the number of
doctor visits a respondent reports over the year prior to the survey implementation. While this preliminary model suggests that there are no meaningful differences between foreign-born Latinos and those born in the U.S.A. after multiple enrolment periods, we take advantage of the large and diverse sample of this unique survey of Latino adults to investigate whether important variation exists across our dependent variables for Latino immigrants of varying immigration status. We find that the more fine-tuned approach to measurement of immigration status in the U.S.A. reveals important gradations in access to insurance and care, with permanent residents having lower levels of access than naturalised citizens, and both groups faring significantly better than non-citizens.

These results suggest that while the ACA has been highly effective in expanding access to care through insurance coverage to a much wider segment of the Latino population, not all Latinos have experienced the positive benefits of the reform policy (Doty et al. 2016). Our findings suggest that the ACA has heightened and made more evident the inequality in access to health insurance based on citizenship status. Thus, the policy design of the ACA to delineate coverage by status has been effective (Joseph 2016, 2017). In the current socio-political climate that many perceive to be punitive towards immigrants, the limitation of the law is important to follow closely. Our work not only has implications for scholars interested in understanding inequalities in healthcare access, but policymakers as well who may be looking for paths to identify gaps in care not fully closed by the ACA. Our results make clear that these stakeholders need to take a more refined look at the population to consider how gradation in immigration status influences immigrants’ access to both health insurance and medical care more broadly.

Finally, it is important to note that the future of the ACA is in serious doubt due to the recent presidential election outcome, as President Trump has suggested that he plans to tweak, and possibly repeal the law all together. While at the time of publication there remain more questions than answers, we believe that if the ACA were to be repealed there would be serious implications for Latinos in the U.S.A. For example, we are finding in our most recent work that a large percentage of Latino adults express worry and anxiety about the prospect of losing health insurance access if the ACA were to be repealed. More directly connected to the findings from our article, it is highly likely that the inequalities in health insurance coverage between Latino citizens and non-citizens will only increase given not only significant revisions to the ACA, but also major changes in immigration policy being proposed by the new Trump administration.

Notes

1. We want to note that we use the pan-ethnic terms Latino and Hispanic interchangeably throughout our paper, and that both terms are used to reference the roughly 50 million residents of the U.S.A. who trace their ancestry to Latin American countries of origin.

2. Some of this avoidance is rooted in the interpretation of anti-pauper provisions in immigration law. Specifically, immigrants in the U.S.A. enter under the condition that they will not become a ‘public charge’, a category that immigrants may perceive they will make if they accept any form of public assistance prior to their official status adjustment.

3. Passed in 2012 by the Obama Administration, the Deferred Action for Childhood Arrivals (DACA) is an executive order that grants eligible undocumented youth a temporary reprieve from deportation and a two-year work permit. However, DACA is not a legal status, and it does not extend any social or welfare benefits to recipients.
Disclosure statement

No potential conflict of interest was reported by the authors.

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References


