

**A BURDEN NO CHILD SHOULD BEAR:**



**HOW THE HEALTH COVERAGE  
SYSTEM IS FAILING LATINO CHILDREN**

**NCLR**

The National Council of La Raza (NCLR)—the largest national Hispanic civil rights and advocacy organization in the United States—works to improve opportunities for Hispanic Americans. Through its network of nearly 300 affiliated community-based organizations (CBOs), NCLR reaches millions of Hispanics each year in 41 states, Puerto Rico, and the District of Columbia. To achieve its mission, NCLR conducts applied research, policy analysis, and advocacy, providing a Latino perspective in five key areas—assets/investments, civil rights/immigration, education, employment and economic status, and health. In addition, it provides capacity-building assistance to its Affiliates who work at the state and local level to advance opportunities for individuals and families.

Founded in 1968, NCLR is a private, nonprofit, nonpartisan, tax-exempt organization headquartered in Washington, DC. NCLR serves all Hispanic subgroups in all regions of the country and has operations in Atlanta, Chicago, Los Angeles, New York, Phoenix, Sacramento, San Antonio, and San Juan, Puerto Rico.

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# A BURDEN NO CHILD SHOULD BEAR:

## HOW THE HEALTH COVERAGE SYSTEM IS FAILING LATINO CHILDREN

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# Introduction

A nation's vitality depends on the health and well-being of its children. To give each generation the best chance of success, a country must ensure that its children are healthy. Regular, high-quality, comprehensive health care is essential for children's physical, cognitive, and emotional health,<sup>1</sup> because children with poor health outcomes have greater difficulty in many areas of their life. For example, poor health increases the likelihood that children will be left behind in the educational system, which in turn has serious repercussions for their economic and social prospects.

In the United States, the widespread lack of health coverage among Latino\* children is a serious problem for both the Hispanic community and the nation as a whole. Racial and ethnic minorities are much more likely than non-Hispanic White children to be uninsured, and Latinos in particular are overrepresented among uninsured children. In the U.S., one in five (20.5%) children under age 18 is Hispanic, but nearly two in five (38.8%) uninsured children are Hispanic.<sup>2</sup> Many uninsured are at risk for poor health consequences, as they are less likely than the insured to be able to access health care as soon as it is needed.

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\* The terms "Hispanic" and "Latino" are used interchangeably by the U.S. Census Bureau and throughout this document to refer to persons of Mexican, Puerto Rican, Cuban, Central and South American, Dominican, Spanish, and other Hispanic descent; they may be of any race.

The coverage gap puts Latino children at a disadvantage from a young age, and its effects can persist throughout their lifetimes. If not reduced, this gap will have severe repercussions for the U.S. as the Latino community continues to grow.

The U.S. Hispanic population has more than doubled in size since 1990 (22.4 million), reaching 45.5 million in 2007.<sup>3</sup> A recent report by the Pew Research Center projected changes in the demographic makeup of the U.S. based on birth, death, and immigration patterns. Based on current trends, the researchers predict that Hispanics will make up 29% of the U.S. population by 2050, reflecting the significant recent growth in the number of Hispanic children.<sup>4</sup> In fact, Hispanics will make up more than one-third (35%) of all children under age 17 by 2050.<sup>5</sup> Thus, improving Latino children's access to regular and comprehensive care will have a substantial, positive impact on outcomes for all children in the U.S. Reducing the children's health coverage gap now should be a chief priority for policymakers in Congress and in the White House.

## II. The Relationship Between Health Coverage and Healthy Outcomes

### Access to Care Is Critical to Children's Health

Increasing health coverage is a key component to reducing health disparities among children. Although health insurance alone is not sufficient to guarantee healthy outcomes, it improves families' access to health care, including preventive services and timely treatment of illness and disease. This in turn decreases the likelihood of poor health outcomes.

There is compelling evidence that Latino children suffer from preventable conditions more frequently and to a greater degree than their non-Hispanic White peers. For example, as one article from the *Journal of the American Medical Association* explains, studies consistently find that Latino children are "significantly more likely than White children to have suboptimal health status [and] spend more days in bed for illness."<sup>6</sup> Hispanic children are also more likely than White children to be hospitalized or die from injury.<sup>7</sup> Because these conditions—or their complications—are so often preventable, the disparities between Hispanic and White children are indicators that Hispanic children do not have equal access to health care.

One in four Hispanic adults is obese, and at every age level—including high school, elementary school, and preschool—Latino children are more likely than non-Hispanic White children to be overweight or obese or have a body mass index of 30 or more, a risk factor for multiple chronic diseases.<sup>8</sup> Access to health care can mitigate this problem through appropriate health education practices, health status tracking over time, and medical interventions when necessary. However, Latino children are less likely to receive such care, and uninsurance plays a role in this disparity. *The 2006 National Health Disparities Report* shows that overweight children who are uninsured are much less likely than their insured peers to receive counseling on healthy eating, an activity promoting behavior that helps to ensure normal weight maintenance.<sup>9</sup> Among Latino children, 52.3% with private coverage and 53.4% with public coverage received healthy eating advice while just 37.9% of uninsured children received such counseling.<sup>10</sup> Without access to the care that identifies and treats warning signs for illness and disease, Latino children continue to be more likely to develop diabetes and other chronic conditions that have long term effects on their quality of life.

Obesity is just one condition for which Latino children are at risk, and access to early and regular health care is key to preventing serious—and expensive—health conditions. Latino children are more likely than non-Hispanic White children to be hospitalized for asthma and gastroenteritis.<sup>11</sup> They are also 13 times more likely than non-Hispanic White children to have tuberculosis; a disease prevalent primarily among U.S.-Latino children.<sup>12</sup> Moreover, some disparities are worsening over time. Between 2001 and 2003, the rate of pediatric asthma hospitalizations increased for Hispanics but remained static for non-Hispanic Whites.<sup>13</sup> Taken together, the evidence shows a critical connection between Latino children's health status and their limited access to regular health care.

### Health Insurance Improves Access to Children's Health Care

Although Latino children face complex and inter-related barriers to high-quality health care, including poverty, cultural and linguistic barriers, and discrimination in health care settings, the most concrete obstacle to health care access is the cost. Health coverage mitigates a major barrier to care for many families by making medical services more affordable. For instance, low-income uninsured families might be forced to miss preventive pediatric exams or delay treatment for acute conditions. Caregivers might try over-the-counter or homeopathic remedies before bringing an uninsured child to a physician without breaking the household budget.<sup>14</sup> In the U.S.—particularly in light of rising health care costs that have outpaced the growth in income and inflation—health coverage is a critical mechanism that brings down the cost of health care services for patients and their families.\* When the out-of-pocket cost of care is lowered, families with health insurance are more likely to seek care for themselves and their children as soon as it is needed. Access to care is fundamental to children's health; pediatric care includes periodic, comprehensive exams designed to monitor children's physical, emotional, and cognitive development as well as screenings that detect and treat

\* Coverage allows families to access lower rates that insurers have negotiated with providers, and conventional insurance plans pay for all or part of the cost of services. Families with health insurance still might find health care unaffordable depending on the level of cost-sharing, or the policyholder's share of covered medical expenses. Often, conventional insurance plans require people to meet a deductible before covered benefits are paid, and plans might require families to make copayments at the time that medical care is provided.

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conditions before they become serious or chronic.<sup>15</sup> Children who do not receive these services regularly face the risk of developing avoidable health conditions. For instance, one measure of access is having a “usual source of care,” which is associated with better preventive care, fewer unmet health needs, and greater satisfaction with care received.<sup>16</sup>

Research confirms that lack of health coverage is correlated with children’s diminished access to care. One study estimates that uninsured children are 18 times more likely than children with continuous coverage to have unmet health needs; children without coverage are also 12 times more likely to experience delayed care and seven times more likely to have unfilled prescriptions than insured children.<sup>17</sup> Children with discontinuous coverage experienced problems with access similar to children who were uninsured during the whole year.<sup>18</sup> With such a high uninsurance rate, it is not surprising that Hispanic children are more likely than non-Hispanic children to have poor levels of access. According to the 2003 National Survey of Children’s Health, only 67.6% of Hispanic parents reported that their children had a personal doctor or nurse, compared to 89.4% of non-Hispanic White and 77.2% of non-Hispanic Black respondents.<sup>19</sup> Moreover, research has shown that uninsured Latino children are less likely than insured Latino children to have a usual source of care. One study found that 41% of uninsured Hispanic children had a usual source of care, compared to 51% of uninsured non-Hispanic Black and 74% of uninsured non-Hispanic White children.<sup>20</sup> In comparison, insured children of all races and ethnicities were significantly more likely to have a usual source of care; 75% of Hispanic, 79% of Black, and 90% of White children with health coverage had regular providers. While Hispanic children were still less likely than non-Hispanic children to have a regular source of care, health coverage was an important factor for the Latinos in the sample. Insured Latino children were nearly two times more likely (75%) to have a usual source of care than Latino children without coverage (41%).

While having health insurance could be correlated with other factors that are associated with access, there is evidence that obtaining children’s health coverage directly results in improved access to care. One study examined a sample of uninsured children before and after they were enrolled in the State Children’s Health Insurance Program (SCHIP). Before participating in SCHIP, 61% of non-Hispanic White children made all or most of their health care visits to a “usual source of care,” compared to 54% of

non-Hispanic Black children and 34% of Hispanic children. After enrolling in SCHIP, disparities by race and ethnicity were no longer observed, and all children experienced improved access to a regular provider; 87% of White, 86% of Black, and 92% of Hispanic children had a usual source of care.<sup>21</sup> Participation in SCHIP also equitably reduced unmet health needs. Before SCHIP enrollment, 27% of non-Hispanic White children, 38% of non-Hispanic Black children, and 29% of Hispanic children had unmet health needs. During their participation in the program, this measure fell to 19% for each group of children.<sup>22</sup> Health coverage opens the door to timely care.

## The Lifelong Benefits of Insuring All Children

Health insurance is a critical mechanism that makes it possible for many families to afford medical care, improving the odds that their children will receive this care as soon as it is needed. Decreasing the likelihood of developing ailments is important not only because of the effects on overall health, but also because sickness holds children back from making social and academic progress. Because health and economic outcomes are so intertwined, having poor health at a young age often generates ripple effects throughout other areas of life.

Providing coverage to uninsured Latino children could help to buffer the indirect effects of poor health on educational and economic achievement. For instance, increased absenteeism directly affects school performance, and children with frequent or chronic illnesses miss more days of school than children who are generally healthy.<sup>23</sup> An article published in *The Future of Children* recounts various ways in which chronic physical conditions affect school readiness and performance: children with chronic illnesses often face restricted activities; the stress, fatigue, and pain associated with illness can disrupt children’s cognitive abilities; and children who are medicated might experience side effects, including changes in cognitive function, from changes in body chemistry.<sup>24</sup> As a result, children with chronic conditions are often less ready to learn than their healthy peers. Moreover, formal education is highly valued by many employers, so children who fall behind in school face limited economic prospects later in life. In fact, The California Endowment recommends investing in Latino children’s health to increase school achievement, which in turn increases their contributions to society as adults in the form of higher income, homeownership, and civic participation.<sup>25</sup> Poor health outcomes change the opportunity structure for Latino children.

### III. Health Coverage Trends for Latino Children

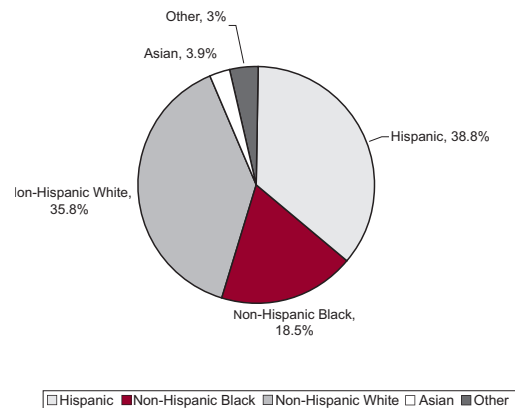
Hispanic families face complex barriers that prevent them from accessing both private and public health insurance for their children. Overrepresented among the uninsured for the past decade, Hispanics now make up the largest proportion of uninsured children, greater than any other racial or ethnic group. In 2006, 38.8% of uninsured children were Hispanic, 35.8% were non-Hispanic White, 18.5% were non-Hispanic Black, 3.9% were Asian, and 3% had another racial background (such as two or more races)<sup>26</sup> (see Figure 1). Hispanic children are more likely to be uninsured than non-Hispanic children regardless of nativity. In 2006, more than one in five (22.1%) Hispanic children lacked health coverage, compared to one in seven (14.1%) non-Hispanic Black children, one in ten (9.9%) non-Hispanic Asian children, and one in 13 (7.3%) non-Hispanic White children.<sup>27</sup> See Table I. Moreover, this coverage gap holds regardless of children’s citizenship status. Half (51.8%) of noncitizen Hispanic children went uninsured in 2006, compared to about one-third (29.8%) of noncitizen Black children, one-fifth (20.4%) of noncitizen Asian children, and less than one-tenth (8.4%) of noncitizen White children.<sup>28</sup>

These estimates are conservative because Census data reflect only children who were uninsured for a full calendar year; children with unstable coverage are not captured in these data. Yet, disruptions in coverage are another serious threat to health care access. One study found that between 1999 and 2001, 60% of children experienced lapsed coverage for four or more months, and Latino children were the ethnic group most likely to be uninsured or have insurance gaps.<sup>29</sup> Furthermore, children from poor and near-poor households—such as the four million

Latino children living below the federal poverty level (FPL)—were four to five times more likely to have lapsed coverage than children in affluent families.<sup>30</sup> It is reasonable to assume that families with frequently disrupted coverage are likely to have poorer access to health care than families with continuous coverage.

These data illustrate the magnitude of the uninsured problem for Hispanic children. Current coverage options for Latino children include private coverage, through either the workplace or individual market, and public health insurance programs. Latino children go uncovered when caregivers cannot afford to purchase private insurance and public safety-net programs are not available to them.

**Figure 1: Population of Uninsured Children, by Race and Ethnicity, 2006**



Source: NCLR calculation using data from the U.S. Census Bureau, 2006 *Annual Social and Economic Supplement*, “Current Population Reports, Series P-60, No. 233.” Conducted by the Bureau of the Census for the Bureau of Labor Statistics, Washington, DC, 2007.

	Non-Hispanic White (%)	Non-Hispanic Black (%)	Hispanic (%)	Asian (%)
U.S.-Born	7.3	13.7	19.0	9.9
Naturalized Citizen	11.5	8.4	28.2	5.5
Noncitizen	8.2	29.8	51.8	20.4
Overall	7.3	14.0	22.1	11.5

Source: NCLR calculation using data from the U.S. Census Bureau, 2006 *Annual Social and Economic Supplement*, “Current Population Reports, Series P-60, No. 233.” Conducted by the Bureau of the Census for the Bureau of Labor Statistics, Washington, DC, 2007.

## IV. Current Coverage Options for Latino Children

### Private Insurance: Employer-Sponsored Insurance and Nongroup Coverage

The most common way that Americans access health insurance is through private, employer-sponsored plans offered as part of employees' compensation packages. Workers can buy coverage for their entire families, and in 2006, 59.7% of U.S. children were covered by employer-sponsored insurance (ESI).<sup>31</sup> Latino children, however, are less likely than non-Hispanic children to have ESI coverage because their parents or other caregivers are less likely to be offered the opportunity to buy this coverage at work.\* Almost

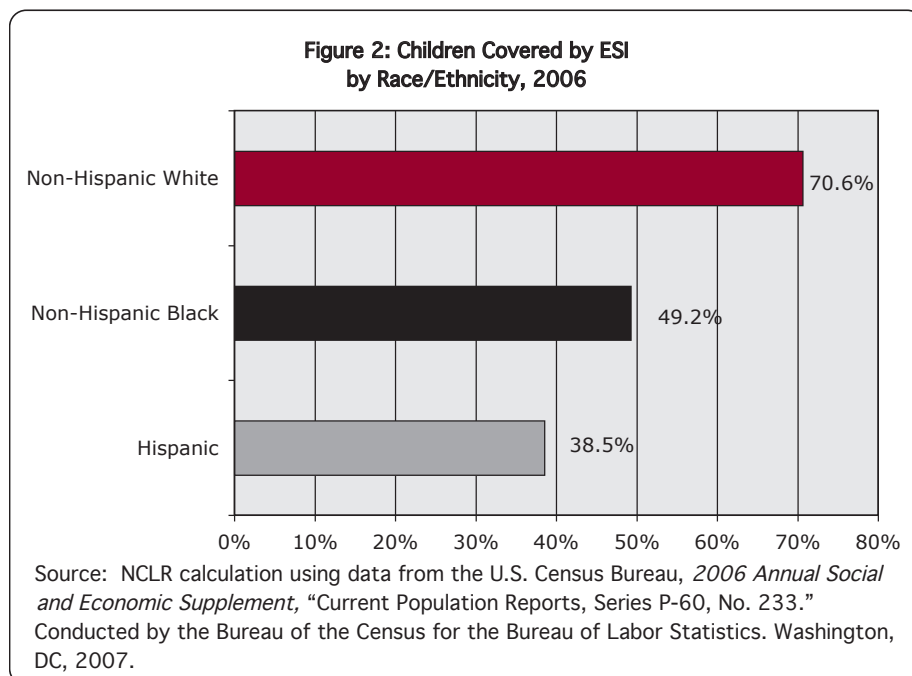
\*The disparity in ESI coverage seems to arise from Latinos' inadequate access to ESI rather than from issues of unemployment or affordability. Hispanics are more likely to be actively employed (65.2%) than non-Hispanic Blacks (58.4%) and non-Hispanic Whites (63.8%), but they are generally concentrated in small firms and industry sectors that are less likely to offer ESI to workers. As a result, Latino workers are offered ESI less often than their non-Hispanic peers. One analysis by the Kaiser Commission on Medicaid and the Uninsured found that, in 2005, 65.9% of Hispanics worked for an employer that offered ESI coverage to its employees, compared to 85.9% of non-Hispanic Black and 87.7% of non-Hispanic White workers. When ESI was offered, Hispanics and non-Hispanics were just as likely to be eligible for the benefit and took up the coverage at similar rates. As a result, in 2005, just more than half (54.0%) of Hispanic workers had ESI coverage in 2005, compared to 72.7% of Black workers and 82.8% of White workers.

two-fifths (38.5%) of Latino children were covered by an employer-sponsored health plan in 2006, compared to nearly half (49.2%) of non-Hispanic Black children and seven-tenths (70.6%) of non-Hispanic White children<sup>32</sup> (see Figure 2).

The employer-based coverage gap between Latino workers and other racial and ethnic groups holds across all income levels, but low-income Latinos are particularly vulnerable.<sup>33</sup> An Urban Institute study of low-income working families—defined as families living under 200% of the FPL with at least one family member in the workforce—found that Hispanic ethnicity was a significant negative predictor of children's access to ESI. Researchers found that 53.1% of low-income working families had access to ESI, but only 41.4% of low-income Hispanic families had access to health coverage through their employers.<sup>34</sup>

Obtaining coverage in the employer-based market is more common than directly purchasing insurance pol-

Source: Lisa Clemans-Cope and Bowen Garrett, *Changes in Employer-Sponsored Health Insurance Sponsorship Eligibility, and Participation: 2001 to 2005* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, December 2006). See Table 12: Decomposition of employee's change in health insurance coverage by race/ethnicity, 2001 and 2005.



icies in the individual “nongroup” market. Nongroup insurance is generally more expensive than employer-based coverage in the sense that families must pay 100% of the cost of premiums out-of-pocket, while many employers subsidize the cost of insurance for their workers. Moreover, insurers often limit coverage for preexisting conditions or deny coverage altogether for applicants with serious illnesses in their medical histories, so it is not always possible for families to obtain coverage in this market.<sup>35</sup> As a result of these factors, few Americans purchase this type of insurance. In 2006, just 6.6% of the nonelderly population—and 3.5% of all Hispanics—had direct-purchase coverage.<sup>36</sup> Even though relatively few children are covered by nongroup insurance, Hispanic children are even less likely than non-Hispanics to be covered by this type of plan. In 2006, just 2.2% of Hispanic children had nongroup health coverage, compared to 6% of non-Hispanic Whites and 3.1% of non-Hispanic Blacks.<sup>37</sup>

Latino children, therefore, are less likely than non-Hispanic children to be covered by any form of private coverage. Overall, 40.9% of Hispanic children had private coverage in 2006, compared to 50.6% of non-Hispanic Black children, 73.8% of non-Hispanic Asian children, and 76.9% of non-Hispanic White children (see Table 2). Hispanic noncitizen children have the lowest rate of private coverage; they are less likely than both Hispanic citizen children and non-Hispanic noncitizen children to be covered by a private plan. In fact, non-Hispanic White noncitizen children are three times more likely (66.2%) to have private coverage than Hispanic noncitizen children (22%). Hispanic children who are naturalized citizens are slightly

more likely (47.9%) than U.S.-born Hispanic children (42.8%) to have private coverage, but these rates are still markedly below the rates of their non-Hispanic peers.

If private coverage is not accessible, then Hispanic families must seek a different source of health insurance for their children. Low- and moderate-income Latino children often qualify for coverage through public safety-net programs that are designed to help families afford regular health care.

### Public Health Insurance Programs: Medicaid and SCHIP

Public safety-net programs are essential to Latino children because of their families’ difficulty in accessing private coverage through ESI or the individual market. Two publicly funded health insurance programs, Medicaid and SCHIP, play crucial roles in the health and welfare of American children by ensuring that low-income families have access to primary care. Both Medicaid and SCHIP are joint federal–state programs that are overseen by the Centers for Medicaid and Medicare Services under the U.S. Department of Health and Human Services (HHS). Together, these programs cover children living at or below 200% of FPL, and some states have applied for and received permission to set eligibility limits even higher. Medicaid and SCHIP are potential sources of meaningful coverage for Latino children when their families do not have health insurance through other mechanisms.

TABLE 2  
Percentage of Children (Under Age 18) Covered by Private Insurance  
by Race/Ethnicity and Nativity, 2006

	Non-Hispanic White (%)	Non-Hispanic Black (%)	Hispanic (%)	Asian (%)
U.S.-Born Citizen	77.0	49.3	42.8	76.1
Naturalized Citizen	72.7	54.1	47.9	79.4
Noncitizen	66.2	54.5	22.0	61.9
Overall	76.9	50.6	40.9	73.8

Source: NCLR calculation using data from the U.S. Census Bureau, *2006 Annual Social and Economic Supplement*, “Current Population Reports, Series P-60, No. 233.” Conducted by the Bureau of the Census for the Bureau of Labor Statistics. Washington, DC, 2007.

Though many Hispanic children are uninsured, those children with coverage are often enrolled in a public insurance program. In 2006, nearly two-thirds (63.6%) of Hispanics with coverage through Medicaid or SCHIP were children under age 18<sup>38</sup> (see Figure 3).

Hispanic children are also twice as likely (40.3%) as non-Hispanic White children (19.1%) to have public coverage<sup>39</sup> (see Table 3). Hispanic children who are naturalized citizens are less likely (26.6%) than U.S.-born Hispanics (41.6%) to have Medicaid or SCHIP coverage. Nearly one-third (29.7%) of Hispanic noncitizen children are covered by these programs,

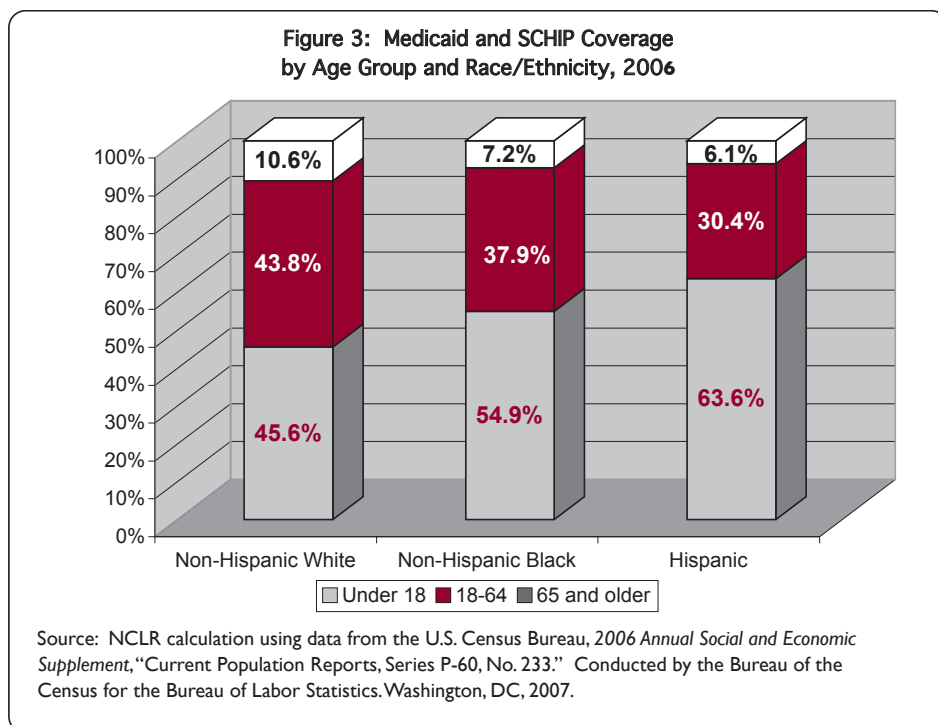
a rate that is comparable to or higher than the rates for non-Hispanic noncitizen children.

Evidence shows that past public coverage expansions have increased coverage rates among low-income Latino children. A 2001 study found that following Medicaid expansions in the 1990s, the uninsurance rate dropped dramatically among poor Hispanic children (from 46% in 1989 to 28% in 1995) as Medicaid enrollment for this group jumped sharply (from 25% to 48%).<sup>40</sup> Once they controlled for other factors, the researchers found that the reduction in uninsurance rates was substantially larger among poor Hispanic

**TABLE 3**  
Percentage of Children (Under Age 18) Covered by Medicaid/SCHIP by Race/Ethnicity and Nativity, 2006

	Non-Hispanic White (%)	Non-Hispanic Black (%)	Hispanic (%)	Asian (%)
Native-Born	19.0	41.1	41.6	17.1
Naturalized Citizen	16.7	43.0	26.6	16.8
Noncitizen	28.4	19.5	29.7	19.5
Overall	19.1	40.6	40.3	17.5

Source: NCLR calculation using data from the U.S. Census Bureau, 2006 Annual Social and Economic Supplement, "Current Population Reports, Series P-60, No. 233." Conducted by the Bureau of the Census for the Bureau of Labor Statistics. Washington, DC, 2007.



children (23%) than for non-Hispanic Black (11%) and White (3%) poor children.<sup>41</sup> Uninsurance among Latino children also declined since the inception of the SCHIP program in 1997. In addition to enrolling eligible children in SCHIP, states' outreach and education efforts identified additional children that were eligible for but not enrolled in Medicaid. Researchers have found that by 2003–2004, the overall decrease in Hispanic children's uninsurance rate was 7.6%, a percentage change of 26.7% since 1997–1998.<sup>42</sup> Together, Medicaid and SCHIP provide millions of Hispanic children and their families with access to care.

Although Medicaid and SCHIP have reached many Hispanic children, these programs could potentially serve even more who remain uninsured. Most of the 3.5 million uninsured Hispanic children are eligible for public coverage based on their families' income. The Kaiser Commission on Medicaid and the Uninsured has calculated that of all uninsured Hispanic children, 47.6% are living below FPL and 34.5% are between 100% and 200% of FPL.<sup>43</sup> In other words, about 82% of all uninsured Latino children fall within the target family income qualifications for SCHIP and Medicaid. Yet, structural, linguistic, and cultural barriers continue to prevent Latino families from enrolling children in these programs. For instance, many immigrant children—including undocumented children and some legal immigrant children—are categorically ineligible for public coverage, regardless

of family income levels.\* Therefore, there is reason to believe that these data fail to reflect the barriers to public coverage that foreign-born children—and particularly foreign-born Latino children—face. For instance, as Table 2 shows, Hispanic children who are naturalized citizens have a coverage rate (26.6%) that is even lower than the rate for Hispanic noncitizen children (29.7%) and that is significantly below the rate for U.S.-born Hispanic children (41.6%). Among other racial/ethnic groups, naturalized citizens have similar coverage rates to U.S.-born children. Moreover, while Hispanic noncitizen children have similar or higher rates of coverage than non-Hispanic noncitizen children, these data could reflect the formal and informal barriers that prevent many noncitizen children (of all races and ethnicities) from enrolling in these programs. Together with evidence of the high rate of uninsurance for foreign-born Latino children, the data suggest that there is an unmet need in the Latino community that safety-net programs are not fully addressing.

\*Although categorically ineligible immigrant children do not qualify for full-scale Medicaid, they may be eligible for emergency Medicaid—which covers treatment for the sudden onset of medical emergencies only—if they are otherwise qualified for the program.



## Alternatives to Health Coverage in the Latino Community

When Latino families cannot afford traditional clinical care for their sick children, they may seek care from alternative sources within their communities. NCLR explored these strategies in focus groups of Hispanic communities in the South, asking participants to describe what they did when they became ill. Respondents reported using home remedies or medicine purchased outside of the U.S. to treat sickness, and some foreign-born respondents described returning to their countries of origin to receive care. Other respondents sought treatment from fellow community members, such as traditional faith healers or people who were trained as medical workers in their home countries but who were not licensed to practice in the U.S.<sup>44</sup> While these strategies allow Latinos to seek health care for their children when they cannot afford to pay for services from a U.S. doctor or clinic, they may not provide venues for the most comprehensive and regular pediatric care. Fortunately, thousands of Latino families without access to private coverage and for whom public programs are unavailable have found alternatives for care for themselves and their children at Community Health Centers (CHCs).

Community-oriented health care systems have been meeting the demand for quality health care for uninsured Latinos when traditional mechanisms have proven inaccessible. CHCs are local, nonprofit, and community-owned centers that provide health care services to all who enter, regardless of insurance status or ability to pay. Nationwide, more than 60% of CHC patients are racial and ethnic minorities, with Latinos being both the largest and fastest-growing ethnic group of CHC clients. About one-third (36.1%) of patients served by CHCs in 2005 were Latino.<sup>45</sup> Furthermore, many CHCs serve the health care needs of children. More than one-third (36.7%) of CHC patients are children under the age of 19.<sup>46</sup> CHCs actively break down barriers that prevent Latino children and their families from accessing traditional health care. Low-income families, whether or not they have health coverage, often face physical barriers to care; the location of clinics and the hours they keep matter to families who might not own vehicles or who cannot take time off from work during the day. CHCs overcome these barriers by operating in neighborhoods where their client base lives and works, and many CHCs also offer transportation services or other mobile care. Many CHCs also provide services that are linguistically and culturally appropriate; nationally, CHCs provide medical care in languages other than English to 30% of their patients.<sup>47</sup>

The San Ysidro Health Center (SYHC), a Community Health Center located near the southern U.S. border in California, has been meeting the health care needs of Latino children and their families for nearly 40 years. As of March 2008, 20,530 patients ages zero to 18 were registered at SYHC. Of these, 90% identified as Hispanic. In 2007 alone, pediatric patients made 51,000 visits to SYHC. SYHC does not turn families away, even though thousands of families walk through their doors each year. Patients are either screened for eligibility for a public or grant-funded coverage program or served under a sliding-scale discount based on their ability to pay. One in four (25%) patients was treated under the sliding-scale payment system in 2007.<sup>48</sup> SYHC is a true safety net for thousands of Latino families who would otherwise find it difficult—even impossible—to access regular preventive care and treatment for their children.

Raúl is one child who has benefited from SYHC's care.\* At six months old, Raúl's head seemed to be growing too quickly. His family brought him to SYHC for routine pediatric exams, where doctors identified the problem and ordered further testing. SYHC's Pediatric Care Coordination program staff explained to Raúl's family the reasons that follow-up testing was ordered and arranged for transportation to and from the area children's hospital for medical appointments and radiological tests. When Raúl was eventually diagnosed with a congenital brain abnormality, SYHC staff explained his medical condition as well as what his family could expect to happen and the steps they would need to take to continue Raúl's medical care. By coordinating the logistics and explaining the condition, SYHC's family-centered program removed physical and informational barriers that would have hindered, or prevented entirely, Raúl's family from accessing vital medical care for their baby. Today, Raúl is one year old; he is covered by California's Medicaid program and is receiving ongoing treatment for his condition.

Laura is another child that SYHC has helped to connect with health coverage and care. According to SYHC, Laura's mother took her 15-year-old daughter to the SYHC dental clinic for a routine check-up and cleaning. During the visit, Laura's mother revealed to the staff a deep concern about Laura's health. Laura had been suffering from a breast disease for more than a year, and the family's attempts to seek treatment had been unsuccessful. Laura's mother had taken her to a local clinic, where the doctor ordered a mammogram, but because Laura and her family were uninsured, they were unable to afford the procedure and could not bring Laura for the tests. After describing Laura's condition to the SYHC staff, Laura and her mother were referred to SYHC's Pediatric Care Coordinator, who connected Laura with a state health coverage program that would cover the cost of her office visits and testing. Laura's family was then able to make appointments with the radiology and endocrinology departments at the area children's hospital for comprehensive treatment of her condition. Without access to health coverage, Laura would have had to wait even longer for treatment and care. Today, Laura is receiving the care she needs.

CHCs are indispensable sources of care for many Latino children, but it is unwise and unfair to rely on them to do all the work to eliminate disparities in health care access. While current CHCs have received increased funding in recent years, there are still many unmet health needs throughout the U.S. For example, poor and uninsured Latino families in rural areas might be hundreds of miles away from the nearest Community Health Center, leaving them with virtually no access to care. CHCs are also woefully understaffed and are particularly in need of primary care physicians. This makes meeting increasing demands for services very difficult and threatens their ability to serve their existing communities.

\* Last names of San Ysidro Health Center patients have been omitted and first names have been changed to protect patient confidentiality.

## A Burden No Child Should Bear

## V. Prevalent Barriers to Coverage for Latino Children

The trends described in this report show that Hispanic children are more likely than non-Hispanic children to go uninsured. This disparity can largely be traced to their low private coverage rates, particularly employer-sponsored coverage. Public programs fill much of the gap, but millions of Latino children are still uninsured. These disparities in children's health coverage are created and perpetuated by both structural and socioeconomic factors. Many of these factors, such as poverty, are common obstacles for families of uninsured children across all racial and ethnic groups. Yet, Latino children are more likely than non-Hispanic children to face certain additional barriers to health coverage.

### Children Living in Immigrant Families

As NCLR has shown, foreign-born Hispanic children are more likely than their U.S.-born peers to be uninsured, and noncitizen Hispanic children are the most vulnerable group. The citizenship status of caregivers can also be a powerful barrier to health coverage of any kind. Both citizen and noncitizen children of immigrant families—where at least one parent is an immigrant—are going uninsured. A 2003 analysis by the Kaiser Commission on Medicaid and the Uninsured examined low-income children's uninsurance rates by race and ethnicity and family citizenship status; the study found that, even among low-income immigrant families, Hispanic children were more likely to be uninsured than non-Hispanic children. For example, in mixed-status low-income families, 30% of Latino children were uninsured in 1999, compared to 23% of non-Hispanic Black children, 12% of non-Hispanic Asian children, and 11% of non-Hispanic White children.<sup>49</sup> Among children in low-income noncitizen families, 74% of Latino children were uninsured, compared to 36% of Black children, 22% of Asian children, and 17% of White children.<sup>50</sup>

Citizenship status is a factor for Latino children's low-coverage rates in both the private and public sector. For instance, working immigrant family members are less likely to have access to employer-based health insurance. One study found that in 1999, employers offered ESI to 80.9% of U.S.-born Hispanic workers, 75.3% of naturalized Hispanic workers, and 49.9% of noncitizen Hispanic workers.<sup>51</sup> When offered and eligible, noncitizen Hispanics took up coverage at

rates comparable to citizens of all races and ethnicities. While safety-net programs are meeting some of the need created by this gap, many immigrant families are hindered or prevented from enrolling their children in public coverage. One major barrier to these programs is imposed by federal law. Researchers estimate that in 2003–2004, approximately 403,000 children were legal immigrants who were ineligible for federal programs due either to the five-year bar or “sponsor deeming” requirements\* that can count resources outside the immigrants' family toward income eligibility.<sup>52</sup> In addition, although most children of immigrant families are citizens,\*\* there is a small but significant number of undocumented children in the U.S. who are ineligible for public health coverage.

In addition to legal impediments, fear and confusion surrounding eligibility requirements often deter immigrant families from participating in public programs. Most children with noncitizen parents are U.S. citizens and are thus eligible for Medicaid or SCHIP if they otherwise qualify; yet, given the complexity of the laws, parents may confuse their own ineligibility for programs with that of their (eligible) children. Moreover, some families might be reluctant to enroll their eligible children in a public health program for fear of unintended immigration consequences. Fear and confusion have a powerful chilling effect on mixed-status families' participation in public health coverage programs.

### Children Living in Limited-English-Proficient Families

Before Latino families can enroll their children in public or private health coverage programs, they must

\* As a result of laws passed in 1996, most legal immigrant children who are lawfully present in the U.S. are barred from federally funded Medicaid and SCHIP coverage for five years from the date that they entered the U.S. Prior to enactment of these restrictions, legal immigrant children were treated with the same eligibility standards as citizen children. After meeting the time bar, immigrant children are subject to further legal restrictions that may prevent them from gaining access to the program in times of need.

\*\*The Urban Institute estimates that four-fifths of all children of immigrant families—and two-thirds of children with undocumented parents—are U.S. citizens. *Children of Immigrants: Facts and Figures* (Washington, DC: The Urban Institute, May 2006), [http://www.urban.org/uploadedpdf/900955\\_children\\_of\\_immigrants.pdf](http://www.urban.org/uploadedpdf/900955_children_of_immigrants.pdf) (accessed May 2008).

understand what is required to sign up for and maintain coverage. Although most Latinos speak English fluently, some are limited-English-proficient (LEP). The Census Bureau estimates that in 2006, 78% of all Latinos older than five years spoke Spanish in the home, and 38.9% were LEP (spoke English “less than very well”).<sup>53</sup> In some families, all adult members of the household have limited English proficiency, which can be a significant barrier for these families who want to enroll their children in a health plan. For instance, in households where Spanish is spoken in the home and children under 18 are present, 32.1% meet the standard of linguistic isolation (meaning that all family members older than age 14 are LEP).<sup>54</sup>

Research demonstrates that primary language is a factor in uninsurance rates for Latino children. A 2003 study by the Kaiser Commission on Medicaid and the Uninsured examined uninsurance rates for low-income children by family citizenship status and primary language.<sup>55</sup> The researchers found that low-income Latino children in English-speaking families where all members were citizens had an uninsurance rate (16%) similar to the rate of low-income non-Hispanic White children in English-speaking citizen families (17%). Yet when they compared Latino low-income citizen families, children in primarily Spanish-speaking homes were more likely (26%) to be uninsured than the children in English-speaking homes (16%).<sup>56</sup> When language barriers *and* citizenship barriers were present, Latino children were even less likely to be covered by any type of health plan. Noncitizen Latino children living in Spanish-speaking noncitizen families had an uninsurance rate of 72%, four times the uninsurance rate for White children in English-speaking citizen families.<sup>57</sup>

If employers and insurance companies do not provide LEP families with information in their primary language, or if these families are not able to understand literature describing eligibility standards for public programs, then their ability to procure coverage for their children is constrained. In both the public and private systems, LEP families might be unable to understand fully the enrollment process, the scope of covered benefits, or the procedures required to maintain their children’s coverage from year to year. For example, in a study of parents who were applying for Medicaid for their eligible children, 46%

of Spanish-speaking parents did not complete the application process because materials were only available in English.<sup>58</sup> For LEP Latino families, language barriers are a serious obstacle that contributes to the children’s coverage gap.

## Children Living in Families Who Experience Discrimination

Discrimination against Latinos plays a role in the children’s health coverage gap. In 2005, NCLR documented evidence that Latinos experience bias based on primary language and/or national origin when it commissioned an independent study showing discriminatory treatment against Hispanics by the District of Columbia Department of Health and Human Services (DC DHHS).<sup>59</sup> To evaluate whether DC DHHS employees were treating LEP clients differently than English-proficient applicants, NCLR used matched pairs of testers, a commonly used method to measure compliance with civil rights laws. One group of testers was composed of non-Hispanic Whites whose primary language was English; they were matched with testers from a group of Spanish-speaking Latinos with similar socioeconomic profiles. In the NCLR study, the testers were seeking information about public health coverage for their U.S.-citizen children who would theoretically qualify for coverage services. Eighty percent of Spanish-speaking testers reported at least one discriminatory practice during their on-site and telephonic interchanges with the DC DHHS.<sup>60</sup> In some cases, employees asked Spanish-speaking Latinos inappropriate questions that were irrelevant to program eligibility. Two out of three times, no DC DHHS employee was available to provide testers with benefits information in Spanish despite federal laws requiring language assistance.<sup>61</sup> These findings show that discriminatory treatment is a very real barrier that hinders LEP Latinos and their children from accessing health coverage benefits to which they are entitled.

## VI. Conclusion

For millions of uninsured families, taking children to routine doctor visits is a serious hardship. By improving access to care, health coverage increases the probability that developmental problems are detected and treated before they become chronic problems that negatively affect children for the rest of their lives. Lack of employer-based coverage opportunities, impeded access to public programs, and the limited reach of robust alternatives play a role in Hispanic's growing rate of uninsurance. These barriers have a disproportionate impact on Latino children for a variety of reasons: parents are concentrated in jobs that do not offer health benefits; immigrants, including legal immigrants, are categorically ineligible for safety-net programs; and language and cultural barriers undercut enrollment in programs that are intended to serve low-income populations. Latino children deserve an equal chance to learn, grow, and succeed. Eliminating the coverage gap is a powerful step toward equity, which in turn will promote the health and well-being of the country as a whole.

- <sup>1</sup> *Children at Risk: Consequences for School Readiness and Beyond* (Washington, DC: RAND, 2005), [http://www.rand.org/pubs/research\\_briefs/2005/RAND\\_RB9144.pdf](http://www.rand.org/pubs/research_briefs/2005/RAND_RB9144.pdf) (accessed May 2008).
- <sup>2</sup> NCLR calculation using data from the U.S. Census Bureau, *2006 Annual Social and Economic Supplement*, "Current Population Reports, Series P-60, No. 233." Conducted by the Bureau of the Census for the Bureau of Labor Statistics. Washington, DC, 2007. See "Detailed Table HI-08: Uninsured Children by Poverty Status, Age, Race and Hispanic Origin: 2006," [http://pubdb3.census.gov/macro/032007/health/h08\\_000.htm](http://pubdb3.census.gov/macro/032007/health/h08_000.htm) (accessed May 2008).
- <sup>3</sup> U.S. Bureau of the Census, "Annual Estimates of the Population by Sex, Race, and Hispanic Origin for the United States: April 1, 2000 to July 1, 2007, NC-EST2007-03." Conducted by the Bureau of the Census, Population Division. Washington, DC, May 2008, <http://www.census.gov/popest/national/asrh/NC-EST2007-asrh.html> (accessed May 2008); Betsy Guzmán, *The Hispanic Population*, "Census 2000 Brief, C2KBR/01-3." Washington, DC: U.S. Bureau of the Census, May 2001, <http://www.census.gov/prod/2001pubs/c2kbr01-3.pdf> (accessed May 2008); and U.S. Bureau of the Census, *U.S. Interim Projections by Age, Sex, Race, and Hispanic Origin*. Conducted by the Bureau of the Census, Population Division. Washington, DC, May 2000. See "Table 1a. Projected Population of the United States, by Race and Hispanic Origin: 2000 to 2050" (March 2004), <http://www.census.gov/ipc/www/usinterimproj/> (accessed May 2008).
- <sup>4</sup> Jeffrey S. Passel and D'Vera Cohn, "U.S. Population Projections: 2005 to 2050" (Washington, DC: Pew Research Center, February 2008), <http://pewhispanic.org/files/reports/85.pdf> (accessed May 2008).
- <sup>5</sup> Ibid.
- <sup>6</sup> Glenn Flores et al., "The Health of Latino Children: Urgent Priorities, Unanswered Questions and a Research Agenda" *Journal of the American Medical Association* 288, No. 1 (June 2002): 82-90.
- <sup>7</sup> Ibid.
- <sup>8</sup> *Key Facts About Childhood Obesity in the Latino Community* (Washington, DC: National Council of La Raza, 2006), <http://www.nclr.org/content/publications/detail/41691> (accessed May 2008).
- <sup>9</sup> Agency for Healthcare Research and Quality, *2006 National Healthcare Disparities Report*, AHRQ Pub. No. 07-0012 (Rockville, MD: U.S. Department of Health and Human Services, December 2006) 153.
- <sup>10</sup> *2006 National Healthcare Disparities Report*. See Table 83b: Children age 2-17 with advice about healthy eating, by ethnicity, 2003, <http://www.ahrq.gov/qual/nhdr06/quality/effectiveness/maternalch/T83B.htm> (accessed May 2008).
- <sup>11</sup> *2006 National Healthcare Disparities Report*, 170-171.
- <sup>12</sup> "The Health of Latino Children."
- <sup>13</sup> *2006 National Healthcare Disparities Report*, 7.
- <sup>14</sup> *The Health of Latino Communities in the South: Challenges and Opportunities* (Washington, DC: National Council of La Raza, 2004) <http://www.nclr.org/content/publications/detail/26898/> (accessed May 2008).
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- <sup>26</sup> *2006 Annual Social and Economic Supplement*.
- <sup>27</sup> Ibid.
- <sup>28</sup> Ibid.
- <sup>29</sup> Marlon Satchell, MPH<sup>®</sup> and Susmita Pati, "Insurance Gaps Among Vulnerable Children in the United States, 1999-2001," *Pediatrics* 116, No. 5 (November 2005): 1155-1161, <http://pediatrics.aappublications.org/cgi/content/full/116/5/1155> (accessed May 2008).
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- <sup>32</sup> Ibid.
- <sup>33</sup> "Why Are Latinos the Most Uninsured Racial/Ethnic Group of US Children?"
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<sup>36</sup> 2006 Annual Social and Economic Supplement.

<sup>37</sup> NCLR calculation using data from 2006 Annual Social and Economic Supplement.

<sup>38</sup> Ibid.

<sup>39</sup> Ibid.

<sup>40</sup> Andrew D. Racine, Robert Kaestner, Theodore J. Joyce, and Gregory J. Colman, "Differential Impact of Recent Medicaid Expansions by Race and Ethnicity," *Pediatrics* 108, No. 5: 1135-1142.

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<sup>42</sup> *The State of Kids' Coverage* (Minneapolis, MN: State Health Access Data Assistance Center, University of Minnesota, August 2006), <http://coveringkidsandfamilies.org/press/docs/2006StateofKidsCoverage.pdf> (accessed May 2008).

<sup>43</sup> *Insurance Coverage of Children by Race/Ethnicity and Poverty Level in 2005: National and State Level Estimates* (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured., 2007), <http://www.kff.org/medicaid/upload/kcmu051706oth.pdf> (accessed May 2008).

<sup>44</sup> *The Health of Latino Communities in the South*.

<sup>45</sup> *Fact Sheet: Health Centers' Role in Reducing Racial and Ethnic Disparities* (Washington, DC: National Association of Community Health Centers, Inc., August 2006), <http://www.nachc.org/research/Files/General%20Disparities%20Fact%20Sheet%208.06.pdf> (accessed May 2008).

<sup>46</sup> *A Sketch of Community Health Centers: Chart Book 2006* (Washington, DC: National Association of Community Health Centers, Inc., 2006), [http://www.nachc.com/client/documents/Chart\\_Book\\_\\_2006.pdf](http://www.nachc.com/client/documents/Chart_Book__2006.pdf) (accessed May 2008).

<sup>47</sup> *Health Centers' Role in Reducing Racial and Ethnic Disparities*.

<sup>48</sup> Email communication from Dr. Roberto Cervantes to Jennifer Ng'andu and Kara Ryan, March 18, 2008.

<sup>49</sup> Leighton Ku and Timothy Waidmann, *How Race/Ethnicity, Immigration Status and Language Affect Health Insurance Coverage, Access to Care and Quality of Care Among the Low-Income Population* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, August 2003), <http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=22103> (accessed May 2008).

<sup>50</sup> Ibid.

<sup>51</sup> Claudia Shur and Jacob Feldman, *Running in Place: How Job Characteristics, Immigrant Status, and Family Structure Keep Hispanics Uninsured* (Washington, DC: The Commonwealth Fund, 2001), [http://www.cmf.org/usr\\_doc/schur\\_running\\_453.pdf](http://www.cmf.org/usr_doc/schur_running_453.pdf) (accessed May 2008).

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<sup>53</sup> NCLR calculation using data from U.S. Bureau of the Census, *2006 American Community Survey*. Conducted by the Bureau of the Census, American Community Survey Office. Washington, DC, 2007. See Detailed Table C16006. "Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over (Hispanic or Latino)."

<sup>54</sup> NCLR calculation using 2006 American Community Survey.

<sup>55</sup> *How Race/Ethnicity, Immigration Status and Language Affect Health Insurance Coverage*.

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<sup>57</sup> Ibid.

<sup>58</sup> *Medicaid and Children: Overcoming Barriers to Enrollment* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured 2000), <http://www.kff.org/medicaid/upload/Medicaid-and-Children-Overcoming-Barriers-to-Enrollment-Report.pdf> (accessed May 2008).

<sup>59</sup> *Department of Human Services Language Access Testing* (Washington, DC: Equal Rights Center study commissioned by the National Council of La Raza, January 2005).

<sup>60</sup> Ibid.

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