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Context matters: Where would you be the least worse off in the US if you were uninsured?

Carolyn Garcia, PhD, MPH, MS[Assistant Professor],

University of Minnesota School of Nursing 5-140 Weaver Densford Hall 308 Harvard Street SE
Minneapolis, MN 55455 T 612/624-6179 F 612/625-7091 Garcia@umn.edu

José A. Pagán, PhD[Professor and Director], and

Institute for Population Health Policy College of Business Administration The University of Texas-
Pan American 1201 W University Dr, Edinburg, Texas 78539 T 956/318-5306 F 956/292-7310
jpagan@utpa.edu

Rachel Hardeman, MPH[Doctoral Student]

University of Minnesota School of Public Health 5-140 Weaver Densford Hall 308 Harvard Street
SE Minneapolis, MN 55455 Hard0222@umn.edu

In 2006 there were about 47 million persons in the US without health insurance coverage (18% of the nonelderly population) and improving access to health care services for this vulnerable population is one of the most elusive health policy challenges today [1]. Uninsured persons not only have poorer access to health care than insured persons, but they also have poorer health outcomes over time [2-5]. Recent related research has also argued that the health care access and quality available to the *insured* population in a local community is likely to be lower in communities with relatively large uninsured populations [6-8]. The provision of uncompensated care to the uninsured population imposes a financial burden in local communities which is absorbed by health care providers as well as insurance payers, insured patients and taxpayers. The quantity and quality of health care services demanded by the uninsured population is lower than the mix of services demanded by the insured population, which reduces the average quality of health care services available and provided in the local health care market [6]. Thus, the local population without health insurance coverage may impose pecuniary (financial) and non-pecuniary (quality) spillovers on everyone else [6-8].

Uninsurance spillovers have been shown to be substantial and unambiguous for the insured population for a wide variety of health care access, use and quality indicators [7,8]. However, it is not entirely obvious that the same result (after considering the individual effect of being uninsured) applies for the *uninsured* population. That is, does spillover negatively impact the receipt of health care for the uninsured as has been shown for the insured? On the one hand, the uninsured population may impose a very small financial burden in a low uninsurance community. This community would be more willing to fund the local safety net because the fiscal impact of doing so is likely to be relatively small. On the other hand, the existence of few uninsured people in the local community may imply that safety net providers may lack experience providing services to this population, or may not be able to take advantage of economies of scale in the provision of health care services for the uninsured population. In a community with a large uninsured population, mostly-insured taxpayers will be less willing to subsidize a larger volume of health care services for the uninsured population, which would lead to access difficulties. The fact that the uninsured population is large at the local level also means that there could be economies of scale in the provision of services to the uninsured population. Thus, although it is clear that pecuniary

(financial) and non-pecuniary (quality) spillovers will be larger for the insured population the larger the local uninsurance rate, this may not be the case for the uninsured population.

This study uses a qualitative approach to explore these ideas by conducting a series of focus groups on health care access and quality with uninsured Latino mothers in two communities that differ substantially by the proportion of the local population that lacks health insurance coverage [9]. Communities in Texas and Minnesota were selected because nationally, Texas has both the highest overall rate of uninsurance (24.2%) and the highest rate among Latinos (60%), while Minnesota has the lowest overall rate of uninsurance (8.4%), and only 18% of Minnesota Latinos are uninsured (see Table 1) [10,11]. Differences in the safety net characteristics between Texas and Minnesota are presented in Table 2 to provide the reader some context on health care availability, eligibility requirements, and coverage differences across these two states [10-15].

Latinos are the largest racial/ethnic minority group in the country (by 2050, Latinos will comprise 25% of the US population), and about one-third of them are uninsured [11,16]. Mothers were selected because they are often the regular seekers of care for children and family members [17,18].

Methods

We used a qualitative focus group approach to obtain perspectives on health care access, quality and cost from uninsured Latino mothers [19]. Latino mothers who indicated they were currently caring for at least one child in their household were recruited. Eligible mothers had not had health insurance coverage for the six months prior to the focus group session, and had been residing in the respective state for at least that long.

Recruitment

Mothers in both states were recruited by Latina community liaisons that relied primarily on personal contacts in the community and subsequent referrals of participants. The liaisons were Latina adults who were well connected within the local Latino communities in their respective states. There were seventeen Latina mothers recruited for two focus groups in Minnesota and seventeen recruited for two groups in Texas (N=34). Both group sessions took place in close vicinities within each state, in McAllen, Texas and in the Twin Cities, Minnesota. All study procedures, including recruitment, were approved by the Institutional Review Boards of the University of Minnesota and the University of Texas-Pan American. Select participant demographics and health care use characteristics are presented in Tables 3 and 4. It is notable that the Texas participants reported higher levels of education and income than the Minnesota participants. Also, some of the Texas participants were US-born compared with none of the Minnesota participants.

Focus Groups

An interview guide was developed to standardize the flow of the focus group discussions with thirteen questions addressing accessibility, quality, and affordability. Sample questions include: “When you need health care for an illness or injury for yourself or someone in your family, where do you go?”, “When you need healthcare, how do you pay?”, and “Can you tell me about a time when you or someone in your family sought care/treatment and had a positive (quality) experience?” The focus groups were conducted between December 2007 and February 2008 and group size ranged from five to twelve participants. Trained staff from a nonprofit, community-based research organization based in Minneapolis, Minnesota (Hispanic Advocacy and Community Empowerment through Research (HACER)) moderated the group discussions in Spanish. This is an important element of the research design

because it should reduce differences in assessments of health care access, quality, and cost across communities that could arise from using different focus group moderators. Each session lasted two hours, including time for refreshments, completion of a demographic questionnaire, and gift card distribution. Recorded focus group discussions ranged from 60 to 70 minutes. Refreshments and child care were provided and each person received a \$50.00 gift card from Target as tokens of gratitude for participation.

Data Analysis

All discussions were audio-recorded. These recordings were translated into English and transcribed by experienced HACER staff. All project team members reviewed the transcripts. To capture the essence of the main points that were shared in the focus groups, we followed the analytical approach recommended by Morgan [19]. Two team members independently analyzed the transcripts and assigned descriptive labels (codes) to sections of the text from an initial focus group. These team members subsequently created a codebook applied to the remaining transcripts. Qualitative software facilitated organization and synthesis of the coded transcripts. Codes were organized into broad descriptive categories consistent with the foci of this study. These overarching categories provided a logical framework from which to assess the similarities and differences between and among the participant subgroups in each community/state.

Results

Overview of Focus Group Findings by State

Uninsured Latinas in Minnesota reported satisfaction with the care they receive in Minnesota-based clinics and hospitals. Their concerns focused heavily on the costs of care and of health insurance coverage. Participants in both Minnesota-based focus groups described difficulties associated with seeking care at safety net clinics or hospitals such as lengthy wait times for treatment or for an interpreter to arrive and assist. One Minnesota group talked about decisions to delay seeking care because of cost or language barriers. Although none of the participants in Minnesota stated they sought care in Mexico, those who had lived in Mexico previously felt the care they received in Minnesota was of higher quality than that in Mexico. One difference between the Minnesota groups was the sentiment in one group that Spanish-speaking health care staff were biased or discriminated against Latinos; the other Minnesota group did not specifically identify this observation.

Uninsured Latinas in Texas assessed health care quality very differently than uninsured Latinas in Minnesota. Overwhelmingly, Texas participants had very poor rankings for the quality of the care they were receiving, mostly from safety net providers, clinics, and emergency rooms. Unlike those in Minnesota, participants in Texas described going to Mexico for care and more often, for medications, although those who did not have legal US residency documents readily expressed that this was not an option for them as they would not be able to return to the US. These broad differences and similarities are described more specifically below.

Reasons for Being Uninsured

Many participants in Minnesota and Texas stated that they were uninsured because they were ineligible for Medicaid and considered private health insurance coverage unaffordable. Health care delays were reported due to difficulty understanding the application process for public health insurance. Being an immigrant—whether undocumented or not—created a barrier to obtaining health insurance coverage due to restrictions in public health insurance programs.

Accessing Care

Safety net use was the most common way participants reported regularly obtaining health care. Participants from Minnesota generally presented positive views of safety net system services, whereas Texas participants articulated more problems and complaints with the US-based safety-net system of care. As one mother from Minnesota described: “I like that here [Minnesota] they first take care of health and later figure out how they can pay.” In Texas, however, participants more often and more strongly described perceived challenges and problems with their safety net system.

Frustrations with the safety net system in Texas were noted as participants described decisions to seek care in Mexico rather than in Texas. A Texas mother shared:

I always pay in dollars there [Mexico]. It is cheap. The doctor treats you well. The doctor takes time to explain to you things, and they give you a good check up—all of your body. I think they are better than doctors from here [Texas].

Some mothers in Texas were unable to go to Mexico because they were undocumented immigrants. For them, family members assisted in obtaining health care from Mexico, specifically medications.

Affordability

The existence of sliding scale fee schedules was frequently mentioned positively by Minnesota participants as a way to handle the costs of health care received. Despite being mostly a positive health care feature, there were some in Minnesota who found even the sliding scale fees to be unmanageable at times. One mother explained: “So I went to the appointment. And they told me how I could do the payments. I asked for a loan from the bank, because it’s very expensive. And so now I am paying the bank.” Without payment plans, Texas participants described paying with credit cards or out of pocket.

A distinction between the two communities was the sentiment among Minnesota mothers that you could receive care regardless of your ability to pay whereas in Texas the mothers simply felt they could not seek care unless they were sure they could find a way to pay. Participants in Texas also described being turned down for care because of inability to pay.

Delay of Care

Women in both states explained that sometimes they need to delay seeking health care due to their inability to pay for health care services. Although women were willing to delay care for them, many Minnesota participants described willingness to take the “risk” of a high bill or to work out a payment plan so that their child could receive health care. This was an important difference between the states, as some mothers in Texas described needing to delay care even for a child because it was unaffordable.

Quality of Care

Participants’ frustrations and satisfactions were evident as they discussed the quality of the health care services received in their respective states. When asked to rank this quality, Minnesota participants ranked them between eight and ten using a scale of one to ten with ten representing excellent quality. In contrast, participants in Texas ranked the quality of their care at or below one using the same scale. A mother from Texas commented that the quality is: “Very bad, and if you would talk to a dozen others, people like us. They would rate it the same.” Quality of provider interactions was noted by one mother from Texas: “They don’t let you talk and then they say ‘thanks for coming’...they don’t care enough about their patients...they need to care more.”

Specific examples of negative health care experiences for the Texas participants included lengthy emergency room wait times, denied services, short time with the provider seen, inadequate explanation of care received or needed, poor treatment and bad attitudes exuded by staff, and significant medical errors. One woman demonstrated poor quality in an example involving a preventable medical error: “The doctor left a tube inside me, and he sent me home....I had the tube between 45 to 50 days inside me and I was two days away from dying because I had an infection in all my organs.” The rare positive health care experiences in Texas were limited to interactions with pediatricians. Three Texas participants described positive health care experiences, not in Texas, but in Michigan, Wyoming, and Idaho. In both states, participants perceived bias and discrimination in interactions with health care staff such as nurses or front desk personnel but rarely with the health care providers. These experiences were attributed to speaking Spanish or being a new immigrant. In Minnesota, a mother shared: “I have also been discriminated against. I have my papers all good and everything, thank God, but they discriminate against Hispanics when they’re not from here...especially when you don’t speak English.”

Discussion

Although uninsured Latino mothers had difficulties accessing affordable health care services in both Minnesota and Texas, there were also substantial differences in the health care experiences of mothers across the two communities studied. Our qualitative study results are consistent with the idea that the insurance-related structure of the local health care system matters when it comes to accessing care for the uninsured population. Uninsured Latino mothers in Minnesota rated the quality of health care services in their community to be much higher than uninsured Latino mothers in Texas. This result is consistent with the idea that uninsured individuals in low uninsurance communities are likely to benefit from non-pecuniary quality spillovers resulting from a high proportion of residents with health insurance coverage [8]. This is likely to be the case because the insured population demands higher quality care than the uninsured population and, thus, health care providers for a wide variety of services cater their services to the insured population. High quality comes at a cost, however, which is reflected in the relatively high prices perceived by Minnesota mothers.

The existence of sliding fee scales and payment plans for Latino uninsured mothers in Minnesota is consistent with the idea that the uninsurance problem is not as large in Minnesota than in other parts of the country. Thus, health care providers are able to provide these types of arrangements because the level of uncompensated care is likely to be very low. In contrast, it was not uncommon for uninsured Latino mothers in Texas to report that they had to pay upfront to obtain health care services.

The results from this study are consistent with recent research arguing that the health care access and quality available to everyone in a local community is likely to be lower in communities with relatively large uninsured populations [6,8,20]. Uninsurance spillovers have been shown to be substantial for the insured population for a wide variety of health care access, utilization, and quality measures [7,8]. Our study suggests that for some types of services the uninsured population represents a small financial burden in a low uninsurance community (e.g., Minneapolis, Minnesota). However, few uninsured customers at the local level implies that health care providers might not be prepared to provide services to this population, such as interpreters, perhaps because they are unable to capitalize on the economies of scale that could be attained in the provision of these health care services. In contrast, in a community with high uninsurance (e.g., McAllen, Texas), the fewer insured taxpayers will be less willing or able to subsidize health care services for the uninsured population, which would result in more access difficulties.

Conclusions

Our study findings support existing theoretical propositions and quantitative data, with the realities and perceptions of uninsured Latino mothers residing in two different health care markets in Minnesota and Texas. Results based on qualitative data are not intended to be generalized, although findings can be carefully transferred to comparable contexts and—when combined with findings based on quantitative data—these synthesized experiences of groups can inform policy recommendations and development. Additional qualitative or mixed-method inquiries in other contexts (e.g., other health care markets) are recommended to expand our qualitative insights regarding the experiences of the uninsured in the US.

Our study demonstrates some of the problems associated with accessing health care services for Latino mothers in two specific local contexts characterized by relatively large and small uninsured populations: McAllen, Texas and Minneapolis, Minnesota. At the community and system levels, policies making provision for health care services to the uninsured are likely to be more effective when they take into account the context or composition of each specific local health care system as well as the financial and non-financial spillovers that these uninsurance-related contexts generate. For example, in Minneapolis, Minnesota, one might consider policies that improve access for the uninsured by providing resources to make it easier for health care providers to offer services that they would not typically offer due to low demand (e.g., translators and interpreters). In McAllen, Texas one might focus on reducing the number of individuals without coverage, which could have a substantial impact on spillover-induced health care quality given that most of the population is uninsured. Trans-national health insurance plans that lower the cost of buying health insurance coverage while increasing the choice of health care providers could be effective in increasing access to health care services in this border community. Health insurance coverage could also reduce the purchase—by currently uninsured individuals residing in the US side of the border—of medication without a prescription in Mexico.

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Human Participant Protection

The study received institutional review board approval at the University of Minnesota and the University of Texas, Pan-American. All study participants provided written consent prior to the focus groups. To preserve participants' anonymity, no identifying information was collected from the participants.

Table 1

Proportion Uninsured and Proportion of Latinos in the United States by State

	Overall Uninsured Proportion (%)^a	Latino Uninsured Proportion (%)^b	Proportion of Latinos (%)^b
U.S.	15.9	32	15
Texas	24.2	60	38
Florida	20.7	37	33
New Mexico	20.4	44	41
Arizona	20.2	55	31
California	19.4	59	37
Georgia	18.9	23	8
Louisiana	18.8	7	3
Oklahoma	18.4	11	6
West Virginia	17.9	NSD	0
Arkansas	17.9	10	5
Alaska	17.7	4	4
South Carolina	17.7	10	4
Mississippi	17.4	6	2
Montana	17.4	NSD	2
Nevada	17.4	44	24
Colorado	17.0	41	20
Utah	16.6	31	12
Wyoming	16.1	13	8
North Carolina	16.0	21	7
Oregon	16.0	25	10
Alabama	15.4	11	3
Idaho	15.4	22	10
New Jersey	15.2	40	17
Illinois	14.3	28	14
Tennessee	14.2	13	4
Maryland	14.2	24	7
Indiana	14.2	13	5
Washington	13.8	20	9
Virginia	13.6	22	7
DC	13.5	25	9
New York	13.5	28	17
Delaware	13.0	25	7
Kentucky	12.7	6	2
South Dakota	12.4	9	3
Ohio	12.3	9	3

	Overall Uninsured Proportion (%) ^a	Latino Uninsured Proportion (%) ^b	Proportion of Latinos (%) ^b
North Dakota	12.2	NSD	2
Missouri	12.1	6	3
Rhode Island	11.8	22	11
Nebraska	11.8	20	8
Vermont	11.7	NSD	1
Michigan	11.4	7	4
Connecticut	11.3	27	12
Maine	10.8	NSD	1
Kansas	10.8	19	8
Pennsylvania	10.5	7	4
New Hampshire	10.3	7	3
Massachusetts	9.8	12	7
Wisconsin	9.8	17	6
Hawaii	9.1	11	7
Iowa	8.6	12	5
Minnesota	8.4	18	5

^aSource: Peterson [10].

^bSource: The Henry J. Kaiser Family Foundation [11].

Table 2

Comparison of Select Health Care Coverage Indicators in Minnesota and Texas

	Minnesota	Texas
Medicaid		
Medicaid Eligibility Requirements ^{c, d}	Pregnant women and children and Families w/children under 21: up to \$38,508 annually (275% FPL) for family of 2 Adult without children: up to \$20,808 annually (200% FPL)	Pregnant women and newborn under age 1: up to \$28,508 (185% FPL) Children ages 1-5: up to \$14,400 (133 % FPL) Children ages 6-18: up to \$10,000 (100% FPL) Adults without children (TANF eligible): cash assistance up to \$188 per month
Medicaid Enrollment as % of population under 200% FPL	55.6%	32.2%
Medicaid Spending (in millions) ^e	\$502	\$289
Safety Net		
Number of Safety Net Providers	14	58
BPHC-supported clinics per 100,000 population under 200% FPL	6.6	3
Patients served by FQHCs as a % of population under 200% FPL ^e	14.1%	18.1%
Uncompensated Care		
Uncompensated Care Spending ^f	\$207,638,774	
The States at a Glance		
State Health Policy Priorities 2006-2008 ^{g, h}	Cost <ul style="list-style-type: none"> Increased transparency Payment incentives Quality <ul style="list-style-type: none"> Health Care Homes Increased transparency Health information Access <ul style="list-style-type: none"> Medicaid eligibility expansion 	Cost <ul style="list-style-type: none"> Improved pricing through performance-based purchasing and market-based competition Quality <ul style="list-style-type: none"> Care management Consumer choice Access <ul style="list-style-type: none"> Improved access to basic health care services

^cSource: Minnesota Department of Health [13].^dSource: Texas Health and Human Services Commission [21].^eSource: The Henry J. Kaiser Family Foundation [11].^fSource: Minnesota Department of Health [12].^gSource: Task Force for Access to Health Care in Texas [15].

^hSource: Minnesota Department of Health [14].

Table 3

Participant Demographics

	MN #1 (n=5) Percent/Mean (Range; SD)	MN #2 (n=12) Percent/Mean (Range; SD)	TX #1 (n=7) Percent/Mean (Range; SD)	TX #2 (n=10) Percent/Mean (Range; SD)
Spanish as primary language	100.00	75.00	85.71	20.00
Age	33.00 (20-43; 9.46)	33.25 (22-51; 10.11)	34.86 (23-44; 6.72)	41.90 (21-63; 12.45)
Married	80.00	66.67	57.14	90.00
Children in Household	1.60 (1-3; 0.89)	1.83 (1-3; 0.58)	2.29 (1-4; 1.11)	1.56 (1-3; 0.88)
Education Level				
No schooling or kindergarten	0.00	8.33	0.00	0.00
1-8 (Elementary)	40.00	33.33	57.14	11.11
9-11 (Some High School)	60.00	50.00	28.57	33.33
12 or GED (High School graduate)	0.00	0.00	0.00	22.22
College 1-3 (Some college)	0.00	0.00	14.29	22.22
College 4+ (College graduate)	0.00	8.33	0.00	11.11
Employment Status				
Employed	40.00	25.00	28.57	22.22
Self-employed	0.00	0.00	14.29	33.33
Unemployed	0.00	16.67	0.00	11.11
Homemaker	60.00	58.33	42.86	22.22
Student	0.00	0.00	0.00	11.11
Unable to work	0.00	0.00	14.29	0.00
Income				
Less than \$10,000	40.00	33.33	50.00	37.50
\$10,000 to less than \$30,000	60.00	58.33	33.33	25.00
\$30,000 to less than \$50,000	0.00	8.33	16.67	25.00
\$50,000 to less than \$70,000	0.00	0.00	0.00	12.50
Birth Country				
US	0.00	0.00	0.00	40.00
Mexico	80.00	91.67	100.00	60.00
Other	20.00	8.33	0.00	0.00

	MN #1 (n=5) Percent/Mean (Range; SD)	MN #2 (n=12) Percent/Mean (Range; SD)	TX #1 (n=7) Percent/Mean (Range; SD)	TX #2 (n=10) Percent/Mean (Range; SD)
Years in US	5.70 (1.5-9; 3.27)	11.58 (2-23; 6.60)	12.14 (1-22; 8.17)	22.50 (1-52; 15.09)

Table 4

Participant Health and Health Care Access/Utilization across Focus Groups

	MN #1 (n=5) Percent/Mean (Range; SD)	MN #2 (n=12) Percent/Mean (Range; SD)	TX #1 (n=7) Percent/Mean (Range; SD)	TX #2 (n=10) Percent/Mean (Range; SD)
Health Status				
Excellent	0.00	0.00	0.00	11.11
Very Good	0.00	18.18	14.29	11.11
Good	0.00	36.36	42.86	44.44
Fair	100.00	18.18	42.86	33.33
Poor	0.00	27.27	0.00	0.00
Personal Doctor or Provider				
Yes	80.00	41.67	20.00	55.56
No	20.00	58.33	80.00	44.44
Number of US doctor visits				
1-3	80.00	25.00	60.00	55.56
4-6	20.00	33.33	0.00	11.11
7-11	0.00	16.67	0.00	11.11
12 or more	0.00	25.00	40.00	11.11
Number of doctor visits in Mexico past year				
1-3	0.00	16.67	0.00	50.00
4-6	0.00	16.67	16.67	10.00
7-11	25.00	8.33	0.00	0.00
12 or more	0.00	0.00	33.33	0.00
Never been to a doctor in Mexico	75.00	58.33	50.00	40.00