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Generational Status, Health Insurance, and Public Benefit Participation Among Low-Income Latino Children

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Abstract

The objectives of this study were to (1) measure health insurance coverage and continuity across generational subgroups of Latino children, and (2) determine if participation in public benefit programs is associated with increased health insurance coverage and continuity. We analyzed data on 25,388 children income-eligible for public insurance from the 2003 to 2004 National Survey of Children's Health and stratified Latinos by generational status. First- and second-generation Latino children were more likely to be uninsured (58 and 19%, respectively) than third-generation children (9.5%). Second-generation Latino children were similarly likely to be currently insured by public insurance as third-generation children (61 and 62%, respectively), but less likely to have private insurance (19 and 29%, respectively). Second-generation Latino children were slightly more likely than third-generation children to have discontinuous insurance during the year (19 and 15%, respectively). Compared with children in families where English was the primary home language, children in families where English was not the primary home language had higher odds of being uninsured versus having continuous insurance coverage (OR: 2.19; 95% CI [1.33–3.62]). Among second-generation Latino children, participation in the Food Stamp (OR 0.26; 95% CI [0.14–0.48]) or Women, Infants, and Children (OR 0.40; 95% CI [0.25–0.66]) programs was associated with reduced odds of being uninsured. Insurance disparities are concentrated among first- and second-generation Latino children. For second-generation Latino children, connection to other public benefit programs may promote enrollment in public insurance.

Keywords

Health insurance; Latinos; Immigrant; Disparities; Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

Introduction

Latino children in the United States are less likely to have health insurance than non-Latinos [1–3]. This insurance disparity reduces access to and utilization of health care and may contribute to health disparities experienced by Latino children [1–7]. Increasing insurance coverage among Latino children has been designated as a priority in improving the health of this growing population [1–3, 7]. Public insurance programs, such as Medicaid and the State Children's Health Insurance Program (SCHIP), offer low or no-cost health insurance options for improving coverage [6]. However, eligible Latino children are less likely to be enrolled in public insurance programs than eligible non-Latinos [3, 8–11]. Lower enrollment rates of eligible Latino children in public insurance have been linked to deficits in knowledge about the programs, limited English proficiency, and distrust of government programs [1–3]. Latino families also experience barriers to the renewal of public health insurance [12, 13].

Studies of health insurance coverage have often focused on insurance status as a dichotomous classification (e.g. 'insured' vs. 'uninsured'). As a result less is known about insurance discontinuity among Latino children and how Latino children with gaps in coverage contribute to the population of children identified as eligible for, but not enrolled in, public health insurance.

Differences in eligibility across Latino children due to citizenship status further complicate research on enrollment in public health insurance. Studying the aggregate Latino population ignores these important eligibility differences and limits utility of research findings for policies and programs. First-generation, or immigrant Latino children, who are not yet citizens are often not eligible for public health insurance. Second-generation, or US-born Latino children with immigrant parents, have the same eligibility for public health insurance as children in nonimmigrant families, but are less likely to be insured than Latino children in non-immigrant families [14, 15]. Second-generation children, then, may represent an important target group to reduce the health insurance disparity among Latino children. However, more information is needed regarding factors associated with public health insurance coverage of second-generation Latino children.

We analyzed data from the 2003–2004 National Survey of Children's Health (NSCH) to explore the continuity of health insurance coverage among low-income Latino children by generational status. Our aims were to (1) measure health insurance coverage and health insurance continuity across generational subgroups of Latino children; and (2) determine if participation in public benefit programs was associated with increased health insurance coverage and continuity.

Methods

Data Source

The NSCH was conducted by the National Center for Health Statistics from January 2003 to July 2004. The NSCH comprised 102,353 interviews with a weighted response rate of 55.3%. Survey data were weighted to be representative of each state's population of non-institutionalized children less than 18 years of age and were adjusted for non-response.

Respondents completed the survey in either English (N = 96,318), or Spanish (N = 6,035). Further information on the design, methods, and operation of the NSCH is reported elsewhere [16].

Study Sample

We included only children income-eligible for Medicaid/SCHIP in their state of residence using annual income thresholds for Medicaid/SCHIP eligibility compiled by the Kaiser Family Foundation [17, 18]. We excluded non-Latinos whose race was not specified, non-Latino children who were neither black nor white, children whose Latino status was missing, and children whose generational status could not be determined (Fig. 1). Generational status of the child was determined using the country of birth for the child and parent(s) and is consistent with US Census definitions [19]. Generational status was assigned according the same process for non-Latino black and non-Latino white children, and only third-generation black and white children were included. Because the data did not allow for further specification, we use the term third-generation to mean third- and subsequent generations.

Study Variables

Sociodemographic Variables—The NSCH reported household income as a percentage of the federal poverty level (FPL) [16]. We categorized household income as <100% FPL, 100–200% FPL, or >200% FPL. Highest educational attainment in the household was categorized as less than high school, high school graduate, or more than high school. The number of children residing in the household was dichotomized as less than three, versus three or more. Family mobility was dichotomized as no more than one address change in the child's life, versus two or more. The NSCH dichotomized primary language spoken at home as English or other language. The child's age, family structure (i.e. head of household), and household employment were also included as sociodemographic variables.

Health and Healthcare Variables—Consistent with previous research, health status of the child was dichotomized to either poor/fair or good/very good/excellent [14, 20]. Presence of a chronic health condition was determined using a series of NSCH questions, which identified children who either needed or used a prescription medicine for a medical, behavioral, or other health condition that had lasted or was expected to last at least 12 months.

Health Insurance Coverage—Current health insurance status was categorized as uninsured, Medicaid/SCHIP-insured, or privately insured. Twelve month insurance status was categorized as continuous coverage, discontinuous coverage, or continuously uninsured. Children were classified as having continuous coverage if the respondent reported that the child currently had health insurance and denied a lapse in health insurance coverage in the previous 12 months. Children were classified as having discontinuous insurance for the past 12 months if (1) the respondent reported that the child currently had health insurance, but reported a lapse in coverage in the previous 12 months, or (2) if the child was currently uninsured, but the respondent reported insurance coverage at some time during the previous 12 months. Children were classified as continuously uninsured if the respondent reported no health insurance coverage at any time during the previous 12 months.

Household Public Benefit Participation—Households were coded as participating in Temporary Assistance for Needy Families (TANF), the Food Stamp Program, or the National School Lunch Program (NSLP) if the respondent indicated that at least one member of the household had participated in that public benefit program at any time during the 12 months prior to the survey. Households were coded as participating in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) if anyone who lived in the household was currently receiving WIC benefits. Of note, the Food Stamp Program was recently renamed the “Supplemental Nutrition Assistance Program,” or SNAP, but since the older term is more familiar, this paper employs it.

Statistical Analysis

Means or proportions were calculated for the five groups of children (first-, second-, and third-generation Latino, non-Latino black, and non-Latino white children) across sociodemographic variables, health and healthcare variables, health insurance status, and household public benefit participation. To test for independence between the racial/ethnic groups in bivariate analyses, we used the Pearson χ^2 test statistic with second-order correction according to the Rao-Scott method, which accounts for the complex survey design [21].

Multinomial logistic regression analyses were performed to explore the independent association between sociodemographic characteristics and insurance continuity. The model covariates were selected according to the conceptual model of Aday and Andersen for predicting access to health care [22]. We incorporated age, family structure, number of children in the household, household employment, and family mobility as predisposing variables. Household income, highest household education level, primary language spoken at home, and identification of a primary health care provider were labeled as enabling variables. Health status and the presence of a chronic health condition were considered need variables. To better understand within-group differences in the association between public benefit participation and insurance continuity, each racial/ethnic group was analyzed in a separate model utilizing the same covariates. We excluded first-generation children from the stratified modeling as many first-generation children, due to legislative restrictions, are not eligible for public health insurance or most public benefit programs. Children missing data for any of the regression model variables were excluded from regression analyses ($n = 386$), but were included in the reporting of the bivariate analyses.

The NSCH data were weighted to adjust for the complex sample design and non-coverage of households without telephones [16]. All analyses were performed with STATA, version 8.0 [23].

Results

The final study sample included a total of 25,388 children (1,200 first-generation Latino, 3,647 second-generation Latino, 2,062 third-generation Latino, 3,832 non-Latino black, and 14,647 non-Latino white) who resided in households income-eligible for Medicaid or SCHIP in their state of residence (Fig. 1).

Sociodemographics

Nearly all sample children lived in households earning less than 200% of the FPL, reflecting public health insurance income eligibility guidelines (Table 1). However, the distribution of children below 100% of the FPL differed by race/generational status. First- and second-generation Latino children were more likely to live in households with incomes less than 100% of the FPL compared to third-generation Latino, black, or white children.

Parental educational attainment was markedly lower among first- and second-generation Latino children. First- and second-generation Latino children generally lived in households where the primary language was not English; few other children did.

Health and Healthcare

Presence of a chronic health condition requiring medication and perceived health status were similar among first- and second-generation Latino children, while third-generation Latino children were more similar to black and white children. Parental identification of a primary health care provider for their child increased from first-generation Latino to third-generation Latino children. Household Public Benefit Participation The majority of study children lived in households participating in the NSLP; first-generation Latino children had the highest participation rates (80%). Latino children as a whole had higher family participation rates in WIC compared to black and white children. Food stamp participation was variable, but relatively common; participation in TANF was less common.

Health Insurance Coverage

The majority of first-generation children and one in five second-generation children were currently uninsured (Table 2). Current public coverage of second-generation children was similar to third-generation Latino and black children. Second-generation Latino children had lower rates of private coverage compared to third-generation Latino, black, and white children.

Almost half of first-generation children were uninsured the entire preceding 12-months and only one-third had continuous coverage. Seventy-two percent of second-generation children were continuously insured, compared with 81% of third-generation Latino, black, and white children.

Multivariate Analyses

In multinomial logistic regression models (Table 3), first-generation Latino children remained significantly more likely to lack coverage than other children (uninsured vs. continuously insured OR 6.16 95% CI [3.49–10.86]); discontinuously vs. continuously insured OR 2.29; 95% CI [1.43–3.67]). Compared with children living in households where the primary language was English, children living in households where the primary language was not English had more than twice the odds of uninsured status versus continuous coverage. Despite the narrow income range in this study, higher household income decreased the odds of uninsurance. The odds of uninsured status also decreased with household participation in the Food Stamp and WIC programs.

Stratified multinomial regression models examining the relationship between insurance status and public benefit participation by race/ethnicity for second-generation Latino, third-generation Latino, black, and white children are shown in Table 4. Food Stamp participation was associated with decreased odds of uninsurance for all racial/ethnic groups included these analyses. WIC participation was associated with decreased odds of uninsured status for second-generation Latino and white children.

Discussion

Insurance coverage for low-income Latino children varies by generational status. First- and second-generation Latino children had more discontinuous coverage and uninsurance, compared to third-generation Latino, black, or white children. First-generation children were the most disadvantaged; only one-third of first-generation children had continuous insurance and only first-generation children remained significantly less likely than white children to have continuous coverage in multivariate models. Reducing the insurance disparity among first-generation children remains challenging. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), which eliminated the five-year waiting period for public insurance for documented immigrants, offers an opportunity to reduce this insurance disparity. However, significant outreach is likely needed to inform families of this change, and undocumented first-generation children generally remain ineligible for public health insurance. A few states provide coverage for undocumented immigrants, but the stability of programs in states facing changes in political or economic circumstances is uncertain.

Second-generation Latino children were less likely to have private insurance coverage, more likely to be uninsured the entire year, and more likely to have discontinuous insurance than third-generation, black, or white children. In multivariate models second-generation children were not significantly more likely to lack insurance primarily due to the adjustment for home language, income, and educational status. Increasing enrollment of eligible second-generation children in public health insurance could reduce the disparity in health insurance coverage for Latino children. Unlike for first-generation children, legislative change to public health insurance eligibility would not be required. Our results indicate limited English proficiency may continue to affect second-generation families' ability to obtain coverage for their children; children living in households where the primary language was not English had twice the odds of uninsurance versus continuous coverage compared to children in primarily English speaking households. Parental limited English proficiency has been associated with decreased knowledge about public health insurance programs and associated eligibility rules, and limited availability of Spanish language forms and enrollment assistance in Spanish compound the language barriers to enrollment [10, 12, 24, 25]. Complicating the problem of limited English proficiency among parents of second-generation Latino children are concerns about the effect of enrolling their child in public health insurance on their own application for continued legal residence or citizenship, and undocumented parents of US-born children may worry their immigration status will be exposed through the enrollment process [3, 12, 25]. These fears can lead to decreased enrollment despite awareness about public health insurance programs [26]. However, fear and parental difficulty with the enrollment process may potentially be overcome by case

managers who provide information to families that addresses these fears and assist with public insurance applications [27].

Lower income and reduced access to employer-based insurance may also contribute to the insurance disparity among second-generation Latino children. We found children in the highest income households (>200% FPL) were significantly less likely to be uninsured than those in lower income households. The majority of second-generation child lived in households earning less than the FPL, the lowest income range. However, most second-generation Latino children were also members of households with at least one employed adult, but private coverage was nearly half that of third-generation Latino children. This is consistent with previous research demonstrating Latino children with non-citizen parents are less likely to have access to employer-based insurance [9, 11].

Due to the significant barriers second-generation Latino children face in enrolling in public health insurance, we expected they would experience much higher rates of discontinuous insurance compared to other citizen children. We found second-generation children were only somewhat more likely to experience discontinuous insurance than third-generation Latino, black, and white children. As with prior studies, we found many Latino, black, and white low-income children experience discontinuous insurance [20, 28, 29]. Discontinuous insurance leads to decreased access to health care and unmet health care needs, which is unfortunate considering that the majority of children who lose public insurance coverage remain eligible [20, 29–32]. The prevalence of insurance discontinuity among lowincome children and the adverse effects of discontinuous insurance highlight the need for policies and programs that promote continuity of health insurance among all lowincome children [29, 32, 33].

The complex barriers to public insurance coverage faced by second-generation children require continued development of outreach programs. We found that enrollment in WIC or the Food Stamp Program was associated with decreased odds of uninsurance for second-generation Latino children. Since the enrollment processes for WIC and Food Stamps are similar to those for public insurance, the association found in our study may indicate that families who are able to overcome barriers to enrollment to one program are similarly able to access other programs for which they are eligible. In contrast, there was no association between participation in the NSLP and health insurance coverage, even though participation in this program was much higher among all groups than for any other public benefit program. The relative ease of the enrollment process compared to other public benefit programs and its unrestricted access for immigrant children may allow families to overcome barriers to enrollment in the NSLP, but not for other public benefit programs for which they are eligible.

More than 70% of children who are uninsured participate in the NSLP, Food Stamps, or WIC [34]. Using these programs to perform outreach to uninsured children is the basis for Express Lane Eligibility (ELE) Programs. In ELE, states can provide presumptive eligibility for public insurance based on information provided by the family for other programs. ELE has been successful in some states in enrolling uninsured children and at reducing lapses in coverage during renewal [34]. However, a pilot program in California using information

from the NSLP application found that immigrant and limited English proficiency families still had difficulty completing the required steps for securing coverage after identification through the program [35]. As ELE programs continue to expand, careful attention should be paid to how they may or may not address the unique needs of immigrant and limited English proficiency families.

Our study has several limitations. First, actual Medicaid/SCHIP eligibility could not be determined from the NSCH data; FPL percentile of the household and state-by-state eligibility criteria were used as a proxy. Therefore, our sample may include children who are not eligible for public insurance and may have excluded eligible children residing in higher income households. However, it is unlikely this misclassification occurred differentially across racial/ethnic groups. In addition, NSCH data are based on caregiver report and no verification of findings was performed. While recall bias affects information provided by all caregivers, little is known about possible racial or ethnic recall differences. The cross-sectional design of NSCH also precludes drawing firm conclusions about causality in observed associations. Finally, length of lapses in insurance coverage for discontinuously insured children could not be determined from NSCH data. Longer lapses may exacerbate the negative effects of discontinuous insurance [29]. We did not find a sizable disparity in discontinuous insurance by generational status or racial group. However, a more precise measurement of discontinuity may have identified higher-risk groups.

Nevertheless, our findings are among the first to present year-long insurance status among subgroups of Latino children and to focus on health insurance coverage in the context of participation in public benefit programs. As with previous research, we found that disparities in health insurance coverage for low-income Latino children are concentrated among first- and second-generation children. Current federal legislation eliminating the 5-year waiting period for legal immigrants and individual state efforts to cover undocumented children may reduce the disparity for first-generation children. Reducing the disparity for second-generation children requires improving uptake and continuity of enrollment of public health insurance among eligible, but unenrolled, children. Future research should evaluate the effectiveness of outreach programs, including those using information from other public benefit program participation, on continuous enrollment in public health insurance among second-generation Latino children. Finally, this study underscores the heavy reliance of low-income children on public insurance for insurance coverage. Maintenance of these programs is essential to continue to offer low-income children access to comprehensive pediatric health care services.

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Fig. 1.

Determination of study sample. *Includes foreign-born children with at least one foreign-born parent. +Includes US-born children with at least one foreign-born parent. #Includes US-born children with only US-born parent(s) and includes 3rd and subsequent generation children. **Includes only children classified as third-generation

Table 1
 Characteristics of children income-eligible for Medicaid/SCHIP, by race, ethnicity, and generational status

Characteristic	First-generation Latino (n = 1,200)	Second-generation Latino (n = 3,647)	Third-generation Latino (n = 2,062)	Non-Latino black (n = 3,832)	Non-Latino white (n = 14,647)	P
<i>Demographics</i>						
Mean age of child, years	10.8	6.8	7.4	8.7	8.4	<.001 ^a
3 or more children in the household, %	61	58	51	53	49	<.001 ^b
Household income by federal poverty level (FPL)						
<100% FPL, %	71	56	48	50	30	<.001
100–199% FPL, %	29	43	51	47	64	
200%, %	0.4	0.6	1.5	2.6	5.7	
Highest education level attained in household						
Less than high school, %	46	41	13	10	6.4	<.001
High school graduate, %	33	40	43	48	43	
More than high school, %	21	19	43	41	51	
Head of household-single female, %	24	27	54	69	29	<.001
Employed member of household, %	83	84	81	78	83	<.001
2 or more address changes in child's life, %	53	47	55	60	52	<.001
Primary home language-not English, %	97	86	13	0.03	0.4	<.001
<i>Health and healthcare</i>						
Currently needs/uses prescription medication for chronic illness, %	3.0	4.2	15	15	17	<.001
Perceived health, fair to poor, %	13	11	4.7	5.5	2.9	<.001
Identify a primary health care provider, %	39	65	75	71	85	<.001
<i>Household public benefit participation</i>						
Temporary assistance for needy families (TANF), %	7.2	10.5	20	20	11	<.001
Food Stamp Program, %	21	31	40	51	27	<.001
National School Lunch Program, %	80	66	57	70	47	<.001
Women, Infants, & Children Program (WIC), %	33	41	33	26	21	<.001

^a Adjusted Wald test used to test for significance of differences in means

^b For this and all subsequent proportions Pearson χ^2 was used to test the significance of differences across proportions

Table 2

Health insurance coverage for children income-eligible for Medicaid/SCHIP, by race, ethnicity, and generational status

	First-generation Latino	Second-generation Latino	Third-generation Latino	Non-Latino black	Non-Latino white	<i>P</i>
<i>Current health insurance</i>						
Uninsured	58	19	9.5	7.7	9.7	<.001
Medicaid/SCHIP	31	61	62	68	48	
Private/other insurance	11	19	29	25	43	
<i>Health insurance, prior 12 months</i>						
No coverage	48	9.4	3.4	3.7	4.6	<.001
Discontinuous coverage	20	19	15	15	14	
Continuous coverage	32	72	81	81	81	

Table 3

Adjusted odds ratios from multinomial logistic regression models for insurance coverage among children income-eligible for Medicaid/SCHIP

	Uninsured versus continuous coverage OR (95% CI)	Discontinuous versus continuous coverage OR (95% CI)
<i>Demographics</i>		
Race/ethnicity		
First-generation Latino (n = 1,157)	6.16 (3.49–10.86) **	2.29 (1.43–3.67) *
Second-generation Latino (n = 3,531)	0.84 (0.50–1.42)	1.02 (0.72–1.46)
Third-generation Latino (n = 2,028)	0.67 (0.43–1.03)	1.00 (0.79–1.28)
Black (n = 3,774)	0.79 (0.57–1.09)	1.03 (0.86–1.22)
White (n = 14,512)	Reference	Reference
Age	1.03 (1.01–1.05) *	0.99 (0.97–1.00)
3 or more children in the household	0.87 (0.71–1.06)	0.80 (0.70–0.92)
Household income		
< 100% FPL	1.25 (0.99–1.58)	0.90 (0.76–1.05)
100%–199% FPL	Reference	Reference
200% FPL	0.39 (0.23–0.65) **	0.55 (0.43–0.71) **
Highest education level attained in household		
Less than high school	1.36 (1.02–1.83) *	0.95 (0.77–1.18)
High school graduate	1.25 (1.01–1.55) *	1.06 (0.92–1.21)
More than high school	Reference	Reference
Head of household-single female	0.86 (0.69–1.08)	0.98 (0.84–1.13)
Employed member of household	0.86 (0.65–1.14)	0.92 (0.77–1.11)
2 or more address changes in child's life	1.06 (0.86–1.30)	1.44 (1.27–1.64)
Primary home language-not English	2.19 (1.33–3.62) *	1.43 (1.00–2.07)
<i>Health and Healthcare</i>		
Currently needs/uses prescription medication for chronic illness	0.53 (0.34–0.83)	0.86 (0.71–1.05)
Perceived health, fair to poor	0.79 (0.51–1.22)	1.20 (0.90–1.61)
Identify a primary health care provider	0.24 (0.20–0.30) **	0.66 (0.56–0.77) **
<i>Household public benefit participation</i>		
TANF participation	0.86 (0.56–1.31)	0.93 (0.73–1.17)
Food stamp participation	0.30 (0.22–0.41) **	0.81 (0.67–0.96) *
School lunch participation	1.00 (0.81–1.22)	1.13 (0.98–1.30)
WIC Participation	0.50 (0.37–0.66) **	0.87 (0.74–1.03)

OR indicates odds ratio; CI indicates confidence interval

* $P < 0.05$;

** $P < 0.001$

Table 4

Adjusted odds ratios from multinomial logistic regression models for insurance coverage by Public Benefit Program participation among children income-eligible for Medicaid/SCHIP stratified by race/ethnicity

	Uninsured versus continuous coverage OR (95% CI)	Discontinuous versus continuous coverage OR (95% CI)
Second-generation Latino		
TANF	0.86 (0.31–2.37)	1.03 (0.54–1.96)
Food stamp	0.26 (0.14–0.48)**	0.68 (0.45–1.04)
School lunch	1.29 (0.84–2.00)	0.94 (0.66–1.36)
WIC	0.40 (0.25–0.66)**	0.91 (0.65–1.28)
Third-generation Latino		
TANF	0.42 (0.06–2.78)	0.96 (0.44–2.09)
Food stamp	0.11 (0.03–0.40)*	0.58 (0.28–1.19)
School lunch	0.94 (0.43–2.06)	1.19 (0.73–1.93)
WIC	0.87 (0.17–4.45)	0.71 (0.43–1.17)
Black		
TANF	1.00 (0.32–3.10)	0.90 (0.57–1.42)
Food stamp	0.16 (0.05–0.49)*	0.87 (0.61–1.25)
School lunch	1.76 (0.94–3.29)	1.50 (1.09–2.05)*
WIC	1.45 (0.65–3.20)	0.97 (0.65–1.43)
White		
TANF	0.64 (0.33–1.25)	1.01 (0.76–1.33)
Food stamp	0.22 (0.13–0.39)**	0.89 (0.69–1.13)
School lunch	0.84 (0.63–1.12)	1.19 (1.00–1.42)*
WIC	0.18 (0.11–0.31)**	0.77 (0.60–0.98)*

OR indicates odds ratio; CI indicates confidence interval Multinomial logistic regression analyses were adjusted for age of the child, number of children in the household, poverty level, caregiver's educational attainment and employment status, family structure and mobility, language spoken at home, child's health status, chronic health condition of the child, and identification of a primary health care provider

* $P < 0.05$;

** $P < 0.001$