

## Access to Health Care for Mixed-Status Families

Although the vast majority (90%) are U.S.-born citizens, Hispanic children are highly likely to hail from immigrant families. In 2008, more than three-fifths (62%) of the nation's 16 million Latino children had at least one immigrant parent.<sup>1</sup> About 8.2 million—or 52% of the Latino child population—were citizen children living in mixed immigration status (“mixed-status”) families.<sup>2</sup> These families will make up the backbone of America's future generations. Projections show that immigrants and their U.S.-born descendants will compose 82% of the growth in the U.S. population between 2005 and 2050.<sup>3</sup> The health and well-being of the nation is linked to the health outcomes of mixed-status families.

Research has shown that children in mixed-status families are much more likely to be uninsured than children born to citizen parents, largely due to barriers to employer-based and public coverage programs for which they are eligible. However, there has been limited research on the experiences of mixed-status families' experiences within the health care system. To touch upon the potential implications of the structure of the health care system for mixed-status families, NCLR worked with Greenberg Quinlan Rosner Research to conduct a series of focus groups in early October 2009. This research focused on the influence of parent uninsurance on insured children's health care access and quality, with substantial emphasis on the experience of mixed-status families. The six focus groups took place in three sites—Charlotte, North Carolina; Chicago, Illinois; and Portland, Oregon. Five panels included Latino parents who were uninsured but whose children had health insurance, with one panel made up of parents in fully-insured families. Three of the six panels were composed entirely of immigrant parents with citizen children. Subsequent to this effort, NCLR will also look at the children in mixed immigration status families who are uninsured.

### Preliminary Findings

- **State public coverage programs are critical to health care access for citizen children in mixed-status families.** The vast majority of children in mixed-status families are covered through their state's Medicaid and Children's Health Insurance Program (CHIP). In some instances, children have health insurance through a parent's employer-based plan. In fact, in several cases where the entire family has coverage, parents rely on public coverage programs for insurance for their children, whether or not their jobs covered dependents. A few purchased direct insurance in the private market. Parents universally recognize the value of their children's coverage and are generally satisfied with the quality of care that their children receive.
- **However, parents in these families have dramatically lower access to health coverage and care and report poorer health.** While parents take their insured children on doctor visits and have developed relationships with their pediatricians, uninsured parents are much

<sup>1</sup> Richard Fry and Jeffrey S. Passel, *Latino Children: A Majority Are U.S.-Born Offspring of Immigrants* (Washington, DC: Pew Hispanic Center, May 2009).

<sup>2</sup> Ibid.

<sup>3</sup> Jeffrey S. Passel and D'Vera Cohn, *U.S. Populations Projections, 2005-2050* (Washington, DC: Pew Hispanic Center, 2008).

less likely to have a regular health care provider. They are more likely to forgo routine care, “self-medicate,” or use home remedies until they develop a serious health condition and are forced to seek emergency care. While parents’ uninsurance is not a significant factor in their children’s access to health care services, there may be other implications for children’s well-being that should be explored in future research.

- **The experiences of children and their families in navigating the public coverage system were inconsistent.** Although these families generally were able to enroll their children in public coverage, some parents did report that there were barriers—such as delays or a lack of language access—that they had to overcome. The presence of a facilitator, such as a social worker, to guide families through the enrollment process was a significant positive factor, especially in ensuring that children were enrolled as early as possible. For instance, in Illinois—a state with a robust state coverage program and a long-established Latino community—many of the parents learned of these programs during mothers’ pregnancies, when they had temporary public coverage for their prenatal care. However, in Oregon—a state with a rapidly growing but newer Latino population—parents were more likely to find out about programs later in the child’s life. It is important to note that these qualitative data describe the experiences of families that successfully connected to the public coverage system. NCLR will be undertaking more analyses to gain a perspective on uninsured citizen children in mixed-status families to further explore these issues.
- **Affordability is a significant problem, even when children are insured.** Nearly all of the uninsured parents reported carrying medical debt. Although the minimal cost-sharing of their children’s coverage provides some peace of mind, parents pay out of pocket for their health care and are often left with hefty bills that are difficult to pay off. In addition, some families with access to employer-based insurance cannot afford to pay their share of premiums or add a family member to their plans. As noted above, some parents with employer-based insurance have enrolled their children in public coverage programs in order to lower the burden of cost-sharing through their private insurance.
- **Parents recognize the comprehensive nature of their children’s health insurance, but perceive unequal treatment in health care settings.** Parents are generally pleased with the type and range of services available to them; however, they reported some negative experiences with providers, usually based on perceived differential treatment of themselves and their children when using public health coverage programs. Parents reported that being limited English proficient or having public coverage (or having a low enough income to qualify for these programs) sometimes garners negative treatment from health care staff. Many parents prefer to speak to doctors in Spanish, but have had mixed experiences obtaining interpreters, often needing to resort to using their children or nonprofessional, nonclinical staff as ad hoc interpreters. At a minimum, all of these barriers indicate that for these families, serious communication barriers exist in health care settings.

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