



HEALTH CARE FOR CHILDREN OF IMMIGRANTS

Annotated Bibliography

Health Care and Children in Immigrant Families Project

NCSL

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INTRODUCTION

NCSL has compiled a bibliography of literature written over the past five years (2002-2006) on the policies and trends that affect the health of immigrant children and their families in the United States. Key issues covered are health status; access to health care; federal, state, county and city programs; cost estimates; U.S.-Mexico health insurance; and U.S.-Mexico border health.

The bibliography also includes research on the difficulties encountered by people whose primary language is one other than English. Language is a key component to accessing health care by immigrants who comprise a significant portion of the limited English proficiency (LEP) population. Similarly, articles pertaining to issues and initiatives in border health focus mostly on Mexican immigrant and migrant groups that populate this region of the country. While the rest of this bibliography omits literature pertaining to specific ethnic groups, this type of group-specific focus could not be avoided in this portion of the literature.

Within each category, the research is presented in reverse chronological order. With a few exceptions, literature descriptions are either abstracts or excerpts taken directly from the text with minor edits.

DEMOGRAPHICS, HEALTH STATUS AND ACCESS

Why Immigrants Lack Adequate Access to Health Care and Health Insurance

Migration Policy Institute

1 September 2006

Immigrants, both legal and unauthorized, often rely on a patchwork system of safety-net clinics and hospitals for free or reduced-price medical care, including state- and county-owned facilities, as well as charitable and religiously affiliated facilities. Their reliance on this system has led many states and communities to be concerned about uncompensated health care costs for uninsured immigrants and the state and local fiscal burdens that result.

This paper summarizes key issues and research concerning immigrants' access to private health insurance, public health insurance, and to health care in general. These include insufficient employer-based health coverage, language barriers, and residency eligibility requirements for public benefits.

<http://www.migrationinformation.org/Feature/display.cfm?id=417>

The Number of Uninsured Americans is at an All-Time High

Center on Budget and Policy Priorities

29 August 2006

Key findings from new data released by the Census Bureau show that the number of uninsured Americans rose to 46.6 million in 2005. While the percentage of native-born citizens who were uninsured rose in 2005, the percentage of non-citizen immigrants who lacked coverage was unchanged. Nonetheless, non-citizen immigrants were far more likely to be uninsured (43.6 percent uninsured) than native-born citizens (13.4 percent). The principal reason so many immigrants lack insurance is that they are less likely to be offered health insurance by their employers.

<http://www.cbpp.org/8-29-06health.pdf>

Unequal Access: Immigrants and U.S. Health Care

Immigration Policy in Focus, Vol. 5, Issue 5

July 2006

Immigration Policy Center

Despite the important role that immigrants play in the U.S. economy, they disproportionately lack health insurance and receive fewer health services than native-born Americans. Some policymakers have called for limits on immigrants' access to health insurance, particularly Medicaid, which are even more stringent than those already in place. However, policies that restrict immigrants' access to some health care services can lead to the inefficient and costly use of other services (such as emergency room care) and negatively impact public health. The future economic success of the United States depends on a healthy workforce. Therefore, the authors argue, policies must be devised that improve, rather than restrict, immigrants' access to quality health care.

http://www.aifl.org/ipc/infocus/unequal_access.pdf

The Role of Employer-Sponsored Health Coverage for Immigrants: A Primer

The Henry J. Kaiser Family Foundation and the National Council of

June 2006

LaRaza

This primer explores current trends in coverage of employer-sponsored health insurance for immigrant workers. Much like all Americans, U.S. immigrant families are experiencing a deterioration of health coverage offered in the workplace. However, this trend is complicated by the fact that many immigrants have limited access to other health safety-net programs such as Medicaid, thus severely limiting their ability to gain regular access to health care.

<http://www.kff.org/uninsured/upload/7524.pdf>

Undercounted. Underserved. Immigrant and Refugee Families in the Child Welfare System

The Annie E. Casey Foundation

May 2006

This report focuses on the needs of immigrant and refugee children in the child welfare system. It is a result of extensive research, including a literature review; interviews with child welfare workers, immigration attorneys, adoptive parents, foster youth, advocates, staff of community-based agencies, researchers, and policymakers; and the recommendations from a consultative session with national experts and child welfare practitioners. It outlines challenges facing immigrants in the child welfare system. It also outlines recommendations and promising practices in regarding research and data collection about immigrants in the child welfare system and setting policies that affect this population.

<http://www.aecf.org/initiatives/familytofamily/tools/immigration.pdf>

Fast Facts on Immigrant Work and Health Issues: National and California Figures

Grantmakers Concerned with Immigrants and Refugees

April 2006

These fast facts focus on the immigrant population in the United States, already a significant part of the U.S. workforce and projected to account for much of its growth in the coming years. While immigrants have high rates of labor participation, they are disproportionately concentrated in low-wage sectors plagued with high occupational safety and health risks. Immigrant workers are also less likely to have access to health insurance or regular medical care. Significantly, these trends hold for both authorized and unauthorized workers.

http://www.gcir.org/resources/gcir_publications/Immigrant_Work_Health.pdf

Are Immigrants Responsible for Most of the Growth of the Uninsured?

Kaiser Commission on Medicaid and the Uninsured

October 2005

Some in the health policy community have suggested that immigration is a major factor behind recent increases in the uninsured population. This analysis is intended to address the extent to which immigrants are the driving force behind the increasing uninsured population by examining changes in coverage over the 1994 to 2003 period. The report concludes that non-citizens have much higher uninsurance rates than native citizens. For example, in 2003 the uninsurance rate for non-citizens was 47.1 versus 14.9 percent for native citizens. The number of uninsured non-citizens has also been increasing, even in the midst of strong economic times. Immigrants experienced larger percentage point declines in Medicaid and larger increases in uninsurance rates than did native citizens. However, while the growth in the number of uninsured non-citizens increased consistently throughout the 1994-2003 period, there are simply too few non-citizens to dominate the overall trends.

<http://www.kff.org/uninsured/upload/Are-Immigrants-Responsible-for-Most-of-the-Growth-of-the-Uninsured-issue-brief.pdf>

Health Care Expenditures of Immigrants in the United States: A Nationally Representative Analysis

American Journal of Public Health, Vol. 95, No. 8

August 2005

Using the 1998 Medical Expenditure Panel Survey linked to the 1996–1997 National Health Interview Survey, the authors analyzed data on 18,398 U.S.-born persons and 2,843 immigrants (place of birth outside the United States on survey response). Using a 2-part regression model, the authors estimated total health care expenditures, as well as expenditures for emergency department visits, office-based visits, hospital-based outpatient visits, inpatient visits, and prescription drugs. Results show that immigrants accounted for \$39.5 billion in health care expenditures. After multivariate adjustment, per capita total health care expenditures of immigrants were 55% lower than those of U.S.-born persons (\$1,139 vs. \$2,546). Similarly, expenditures for uninsured and publicly insured immigrants were approximately half those of their U.S.-born counterparts. Immigrant children had 74% lower per capita health care expenditures than U.S.-born children. However, emergency department expenditures were more than 3 times higher for immigrant children than for U.S.-born children. This study counters the assumption that immigrants represent a disproportionate financial burden on the overall U.S. health care system.

<http://www.ajph.org/cgi/content/abstract/95/8/1431>

[Subscription required for access to full text.]

Immigrants and Employer-Provided Health Insurance

University of Michigan Economic Research on the Uninsured

August 2005

The objective of this study is to investigate the factors underlying the lower rate of employer-sponsored health insurance coverage for foreign-born workers. Among their findings, the authors conclude that:

- The large difference in coverage rates for immigrants and native-born Americans is driven by the very low rates of coverage for non-citizen immigrants. Differences between native-born and naturalized citizens are quite small and for some outcomes are statistically insignificant when controlled for observable characteristics.
- Results indicate that the gap between natives and non-citizens is explained mainly by differences in the probability of working for a firm that offers insurance. Conditional on working for such a firm, non-citizens are only slightly less likely to be eligible for coverage and, when eligible, are only slightly less likely to take up coverage.
- Roughly two-thirds of the native/non-citizen gap in coverage overall and in the probability of working for an insurance-providing employer is explained by characteristics of the individual and differences in the types of jobs they hold.

They conclude that the substantially higher rate of uninsurance among immigrants is driven by the lower rate of health insurance offers by the employers of immigrants.

<http://www.umich.edu/%7Eeriu/pdf/wp38.pdf>

Migrant and Seasonal Farmworkers: Health Insurance Coverage and Access to Care

Kaiser Commission on Medicaid and the Uninsured April 2005

Nearly three million workers earn their living through migrant or seasonal farm labor. Migrant and seasonal farmworkers and their families confront health challenges stemming from the nature of their work, their extreme poverty and mobility, and living and working arrangements that impede access to health coverage and care. This brief provides an overview of migrant and seasonal farmworkers and the health challenges they face and considers options for improving their health coverage and access to care.

<http://www.kff.org/uninsured/upload/Migrant-and-Seasonal-Farmworkers-Health-Insurance-Coverage-and-Access-to-Care-Report.pdf>

Illnesses Among Recently Immigrated Children

Seminars in Pediatric Infectious Disease, Vol. 16, No. 2 April 2005

The number of children immigrating to the United States has increased steadily during the last decade. American families are adopting a significant portion of these children, more than 20,000. Recently immigrated children face many different health risks when compared to children born in the United States. They are subject to many infectious diseases no longer seen commonly in the United States such as malaria, tuberculosis, and HIV. They are more likely to have inadequate immunity to vaccine-preventable illnesses. Recent immigrants have a higher likelihood of having malnutrition and developmental delay. Finally, many will have suffered psychological trauma in either institutions or refugee camps. These children require specialized testing, care, and treatment in the pediatric office.

<http://www.journals.elsevierhealth.com/periodicals/yspid/article/PIIS1045187004001256/abstract>

[Subscription required for access to full text.]

The Health and Well-Being of Young Children of Immigrants

The Urban Institute

February 2005

This report focuses on the health and well-being of young children under 6 in immigrant families, those with at least one parent born outside the United States. Eight key themes emerge from the research:

- children of immigrants are a large share of the young child population;
- most young children of immigrants are citizens living in mixed-status families;
- over one-quarter of young children of immigrants have unauthorized parents;
- more young children of immigrants than natives live in two-parent families;
- many young children of immigrants live in families with low incomes, have parents with low education levels and limited English proficiency, and interact less often with their parents;
- young children of immigrants have higher levels of economic hardship but lower use of benefits than children of natives;
- children of immigrants are more likely to have fair or poor health and to lack health insurance;
- children of immigrants are more often in parental care and less often in center-based child care.

http://www.urban.org/UploadedPDF/311139_ChildrenImmigrants.pdf

2005 National Healthcare Disparities Report

U.S. Department of Health and Human Services

2005

The NHDR tracks disparities in both quality of health care and access to health care. Measures of health care quality mirror those in the NHQR and encompass four dimensions of quality—effectiveness, patient safety, timeliness, and patient centeredness. Measures of health care access are unique to this report and encompass two dimensions of access—facilitators and barriers to care and health care utilization. This year’s NHDR and NHQR focus on findings from a set of core report measures which represent the most important and scientifically credible measures in the full measure sets. Core report measures were selected from the full measure sets by the HHS Interagency Work Groups that support the reports based on their clinical importance, policy relevance, and data reliability. The 2005 reports also introduce a number of new composite measures as well as improved methods for summarizing quality and disparities. It reports disparities among several population groups including immigrants and children.

<http://www.ahrq.gov/qual/nhdr05/nhdr05.pdf>

Health Coverage for Immigrants

Kaiser Commission on Medicaid and the Uninsured

November 2004

This is a two page fact sheet on health coverage for immigrants in the United States. Health coverage for immigrants remains a pressing policy challenge. Although most immigrants are in working families, many work in jobs that do not offer health insurance. Federal law has restricted Medicaid and SCHIP eligibility for many immigrants since 1996. As a result of limited private and public coverage, immigrants have high uninsured rates, and, as such, experience difficulties accessing care. In response to the federal restrictions on Medicaid and SCHIP, a number of states have stepped in with replacement programs. As of 2004, some 25 states offered state-funded coverage to immigrants and/or used an available SCHIP option to provide prenatal care without regard to immigration status.

<http://www.kff.org/uninsured/upload/Health-Coverage-for-Immigrants-Fact-Sheet.pdf>

Immigrants and Health Coverage: A Primer

National Council of La Raza and the Kaiser Commission on Medicaid and the Uninsured October 2004

A major challenge facing many immigrants is lack of health insurance coverage, and, in recent years, the gap in overall health insurance coverage rates between low-income citizens and immigrants has widened. Health insurance helps assure that people receive preventive care and regular check-ups, are able to see a specialist or go to the hospital if needed, and are protected from high medical costs. It is important to address the lack of health coverage among immigrants, as lack of health insurance has been shown to have a significant negative impact on individuals' health and financial well-being. This brief provides statistics on health coverage of immigrants in the United States as well as the role Medicaid plays in providing coverage.

<http://www.nclr.org/content/publications/download/27509>

Demographic Change and the Life Circumstances of Immigrant Families

The Future of Children: Children of Immigrant Families, Vol. 14, No. 2 Summer 2004
Foundation for Child Development

Several major demographic shifts over the past half-century have transformed who we are and how we live in this country in many ways. Most striking, however, is the fact that children today are much more likely to be a member of an ethnic or racial minority group. This article presents a wide range of statistics reflecting cultural, family, social, economic, and housing circumstances across various race/ethnic and country-of-origin groups. Key observations include:

- Children in immigrant families are much less likely than children in native-born families to have only one parent in the home, and they are nearly twice as likely as those in native-born families to be living with grandparents, other relatives, and non-relatives.
- Children in immigrant families were only slightly less likely than children in native-born families to have a father who worked during the past year, but many of their fathers worked less than full-time year-round.
- Official poverty rates for children in immigrant families are substantially higher than for children in native-born families (21% versus 14%).

The author concludes that these results point to a growing need for policies and programs to assure the health, educational success, and well-being of all children across the varied race/ethnic and immigrant-origin groups who now live in this country.

http://fcd-us.org/uploadDocs/DJHPackard06_11_04.pdf

Facts About Immigrants

National Immigration Law Center

July 2004

This brief outlines key statistics about immigrants in the United States. Areas covered include demographics, economic contributions, labor trends, use of public benefits, language proficiency, and how restrictions on support services to immigrants can negatively impact children.

http://www.nilc.org/immspbs/research/pbimifacts_0704.pdf

Health Insurance Coverage of the Foreign Born in the United States: Numbers and Trends

Immigration Facts No. 8

June 2004

Migration Policy Institute

Immigrants living in the United States are much less likely to be insured than natives. There are several reasons for this. Over one-fourth of immigrants age 16 and over who are in the labor force are part-time or seasonal workers or are unemployed, according to the 2002 Current Population Survey. Part-time and temporary workers usually are not provided with employment-based insurance. Unauthorized immigrants, who are estimated to be about 26 percent of all foreign-born, are barred from government insurance programs. Because of their status, the unauthorized are not likely to have employment-based insurance or the resources to purchase private insurance. Legal, permanent immigrants are allowed to work, but must be resident for five years before becoming eligible for government insurance programs, with some exceptions. Many temporary immigrants, such as students, do not qualify for government insurance programs and may be limited to temporary employment, if they are allowed to work at all. The Migration Policy Institute has compiled the following information on health insurance coverage of the foreign born from the 2001 to 2003 Current Population Surveys (Annual Social and Economic Supplements, formerly called the March Supplements).

http://www.migrationpolicy.org/pubs/eight_health.pdf

Health, Life Expectancy, and Mortality Patterns Among Immigrant Populations in the United States

Canadian Journal of Public Health, Vol. 95, No. 3

May/June 2004

The U.S. immigrant population has grown considerably in the last three decades, from 9.6 million in 1970 to 32.5 million in 2002. However, this unprecedented population rise has not been accompanied by increased immigrant health monitoring. In this study, the authors examined the extent to which U.S.- and foreign-born blacks, whites, Asians, and Hispanics differ in their health, life expectancy, and mortality patterns across the life course. The National Statistics System (1986-2000) and National Health Interview Survey (1992-1995) data were used to examine nativity differentials in health outcomes. Logistic regression and age-adapted death rates were used to examine differentials. Among their findings, the authors report that male and female immigrants had, respectively, 3.4 and 2.5 years longer life expectancy than the U.S.-born. Compared to their U.S.-born counterparts, black immigrant men and women had, respectively, 9.4 and 7.8 years longer life expectancy, but Chinese, Japanese, and Filipino immigrants had lower life expectancy. Most immigrant groups had lower risks of infant mortality and low birthweight than the U.S.-born. Consistent with the acculturation hypothesis, immigrants' risks of disability and chronic disease morbidity increased with increasing length of residence.

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=15191127&dopt=Abstract

[Subscription required for access to full text.]

Immigration and Health

Annual Review of Nursing Research, Vol. 22

May 2004

The purpose of this integrated review was to examine research on the relationships between immigration and health. The review was limited to studies of immigration into North America published since 1994. The results suggested that, although recent research has furthered the understanding of immigration and health, the multiple health effects of the various social and cultural processes immigrants undergo are still not clearly understood. In addition, research on acculturation has not clarified the positive or negative effects of acculturation on health. The incorporation of transnational perspectives and contemporary

concepts and frameworks such as biculturalism, undocumentedness, and transitions was noted as a significant contribution from recent research. The results of this integrative review indicate that interdisciplinary research on immigration and health is moving in new directions. The reviewers provide suggestions for future research on health disparities as well as on possible health protective factors among diverse immigrant populations.

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15368770&query_hl=15&itool=pubmed_DocSum

[Subscription required for access to full text.]

Assuring the Health of Immigrants: What the Leading Health Indicators Tell Us

Annual Review of Public Health, Vol. 25

April 2004

Over the past 20 years, the United States has experienced one of the largest waves of immigration in its history. Understanding the health status and needs of immigrants is important because of their growing numbers and their contribution to the health of the nation, but it is challenging because of gaps in national databases, the heterogeneity of immigrant populations, and uncertainty about how migration affects health. *Healthy People 2010* outlines the nation's public health objectives for the current decade. It includes ten leading health indicators (LHIs) chosen because of their importance as public health issues, their ability to motivate action, and the availability of data to measure their progress. In this paper, we discuss the health of immigrants from the perspective of these LHIs, as they provide a framework for anticipating some of the future health needs of immigrants and help define priority areas for research and action.

<http://arjournals.annualreviews.org/doi/abs/10.1146/annurev.publhealth.25.101802.123107?journalCode=publhealth>

[Subscription required for access to full text.]

Health Insurance Coverage of Children in Mixed-Status Immigrant Families

Snapshots of America's Families III, No. 12

October 2003

The Urban Institute

This Snapshot uses data from the 1999 and 2002 National Survey of America's Families (NSAF) to examine the health insurance coverage of low-income citizen children. (In 2002, 72 percent of all children with noncitizen parents were themselves citizens and thus qualified for benefits on the same terms as citizen children with citizen parents.) The Snapshot also looks at differences in health insurance coverage between children whose parents or other caregivers responded to the survey in English and those whose family responded in Spanish. Limited English skills—like lack of citizenship—may prevent parents from applying for public benefits for their children.

<http://www.urban.org/url.cfm?ID=310886>

How Race/Ethnicity, Immigration Status and Language Affect Health Insurance Coverage, Access to Care and Quality of Care Among the Low-Income Population

Kaiser Commission on Medicaid and the Uninsured

August 2003

This report seeks to disentangle the roles that race, language and citizenship status play in insurance coverage, access to health care and quality of health care, particularly for the low income Latino population. (Low-income is less than 200 percent of the poverty line or \$30,520 for a family of three in 2003.) Understanding the roles played by citizenship status and language is important for developing policies to help reduce disparities in health care coverage and access. A person's citizenship status (e.g., citizen, legal immigrant, or

unauthorized alien) affects eligibility for benefits like Medicaid or the State Children's Health Insurance Program (SCHIP) and the likelihood of having a job that offers benefits like insurance coverage. English proficiency affects a person's ability to discuss medical problems with a physician or nurse and to complete an insurance application or decipher a medical bill. Restoration of legal immigrants' eligibility for public benefits and increasing the availability of language assistance, such as translations and interpreters, could improve immigrants' access to health services and bring them closer to parity with citizens and those with better English skills.

This analysis is based on the 1999 National Survey of America's Families, a national survey conducted by the Urban Institute. It demonstrates that citizenship status and language proficiency have a significant impact on insurance coverage, access to care and the quality of care received among the low-income population. Latinos who are not citizens or who have limited English proficiency are much more likely to be uninsured, less likely to use health care services, and more likely to experience problems communicating with their health care providers than their citizen and English-speaking counterparts.

<http://www.kff.org/uninsured/upload/How-Race-Ethnicity-Immigration-Status-and-Language-Affect-Health-Insurance-Coverage-Access-to-and-Quality-of-Care-Among-the-Low-Income-Population.pdf>

Gaps in Coverage for Children in Immigrant Families

The Future of Children, Vol. 13, No. 1

2003

Children of immigrants represent a growing share of all American children, and their families are increasingly dispersed across the United States. Protecting and preserving the public health requires policymakers to confront the challenge of providing access to health care for these families. Adequate health insurance coverage is a critical first step to accessible, quality health care; yet obtaining this coverage is far more burdensome for children in immigrant families than for their native-born peers. Immigrant families face difficulties in securing job-based insurance, and their eligibility for public health coverage is limited. Immigration concerns and language barriers inhibit enrollment in programs for which families are eligible, and a lack of culturally and linguistically appropriate services further limits access to quality care. Major efforts are needed to increase the number of immigrant children with access to quality health care. Three elements are key: restoring and expanding federal eligibility rules for Medicaid and SCHIP; working with trusted community groups; and improving linguistic and cultural competence.

http://www.futureofchildren.org/usr_doc/tfoc13-1g.pdf

The Health and Well-Being of Children in Immigrant Families

New Federalism: A Survey of America's Families, No. B-52

November 2002

The Urban Institute

Children of immigrants are the fastest growing segment of the U.S. population under age 18. One in five children in the United States is the child of an immigrant, evidence of the demographic impact of recent rapid immigration. In addition, one in four low income children is an immigrant's child (Fix, Zimmermann, and Passel 2001). But despite their demographic and policy significance, children of immigrants and their well-being are rarely studied on a national scale. In this brief, the authors present a number of key indicators—both positive and negative—of child well-being. The measures fall within three areas: (1) family environment, (2) physical and emotional health, and (3) access to needed services.

<http://www.urban.org/url.cfm?ID=310584>

Vaccination Coverage of Foreign-Born Children 19 to 35 Months of Age: Findings From the National Immunization Survey, 1999-2000

Pediatrics: Official Journal of the American Academy of Pediatrics, Vol. August 2002
110, No.2

The object of this study is to compare coverage estimates of foreign-born children 19 to 35 months old with those of U.S.-born children of the same age group. The National Immunization Survey is a multistage, random-digit dialing survey designed to measure vaccination coverage estimates of U.S. children 19 to 35 months old. Data from 1999–2000 were combined to permit comparison of vaccination coverage among foreign- and U.S.-born children. Findings show that foreign-born and U.S.-born children 19 to 35 months of age had comparable 3:3:1 series coverage (3 or more doses of diphtheria and tetanus toxoids and pertussis vaccine [DTP/DTaP/DT], 3 or more doses of poliovirus vaccine, and 1 or more doses of measles-containing vaccine), the standard in most countries. However, coverage for a U.S. standard, 4:3:1:3 series (4 or more doses of DTP/DTaP/DT, 3 or more doses of poliovirus vaccine, 1 or more doses of measles-containing vaccine, and an adequate number of *Haemophilus influenzae* type b [Hib] doses based on age at first dose) was lower among foreign-born children because of markedly lower Hib cover and marginally lower DTP/DTaP/DT coverage. In addition, hepatitis B coverage was markedly lower in foreignborn children. The authors conclude that lower vaccination coverage among foreign-born children, especially against Hib and hepatitis B, is of concern because foreign-born children often live in households and communities characterized by more intense exposure to these diseases, and many originate from countries with much higher prevalence rates of these diseases than the United States. The differences in Hib and hepatitis B coverage suggest a need for increased culturally competent public health immunization interventions to increase coverage among foreign-born children.

<http://pediatrics.aappublications.org/cgi/reprint/110/2/e15>

Ethnic-Immigrant Differentials in Health Behaviors, Morbidity, and Cause Specific Mortality in the United States: An Analysis of Two National Data Bases

Human Biology, Vol. 74, No. 1 February 2002

This study examines the extent to which various ethnic-immigrant and U.S.-born groups differ in their risks of all-cause and cause-specific mortality, morbidity, and health behaviors. Using data from the National Longitudinal Mortality Study, 1979-1989, we estimated, for major U.S. racial and ethnic groups, mortality risks of immigrants relative to those of the U.S.-born. The Cox regression model was used to adjust mortality differentials by age, sex, marital status, rural/urban residence, education, and family income. Logistic regression was fitted to the National Health Interview Survey data to determine whether health status and behaviors vary among ethnic-immigrant groups and by length of U.S. residence. Compared with U.S.-born whites of equivalent socioeconomic and demographic background, foreign-born blacks, Hispanics, and Asians/Pacific Islanders (APIs), U.S.-born APIs, U.S.-born Hispanics, and foreign-born whites had, respectively, 48%, 45%, 43%, 32%, 26%, and 16% lower mortality risks. While American Indians did not differ significantly from U.S.-born whites, U.S.-born blacks had an 8% higher mortality risk. Black and Hispanic immigrants experienced, respectively, 52% and 26% lower mortality risks than their U.S.-born counterparts. Considerable differentials were also found in mortality for cancer, cardiovascular, respiratory, infectious disease, and injury, and in morbidity and health

behaviors, with API and Hispanic immigrants generally experiencing the lowest risks. Consistent with the acculturation hypothesis, immigrants' risks of smoking, obesity, hypertension, and chronic condition, although substantially lower than those for the U.S.-born, increased with increasing length of U.S. residence. Given the substantial nativity differences in health status and mortality, future waves of immigrants of diverse ethnic and cultural backgrounds will likely have a sizeable impact on the overall health, disease, and mortality patterns in the United States.

FEDERAL/FEDERAL-STATE PROGRAMS

Automatically Enrolling Eligible Children in Families into Medicaid and SCHIP: Opportunities, Obstacles, and Options for Federal Policymakers

The Commonwealth Fund

October 2006

Sixty-two percent of uninsured children and two-thirds of uninsured, poor parents qualify for publicly funded health coverage programs but are not enrolled. This study assesses the potential impact of automatically enrolling children and parents in Medicaid and the State Children's Health Insurance Program (SCHIP) based on determinations of other means-tested programs. Current law permits states to cover some uninsured parents based on information in their children's Medicaid case files. However, current federal law forbids states from providing Medicaid or SCHIP based on the final income determinations of non-health agencies—the type of auto-enrollment that could reach eligible children. For such auto-enrollment to succeed, federal policymakers need to provide states with additional flexibility in determining eligibility and new resources for investing in information technology.

http://www.cmf.org/usr_doc/Dorn_auto-enrollingchildren_931.pdf

Medicaid and SCHIP Eligibility for Immigrants

The Henry J. Kaiser Family Foundation

April 2006

This fact sheet provides an overview of the current federal eligibility rules for Medicaid and the State Children's Health Insurance Program for immigrants.

<http://www.kff.org/medicaid/upload/7492.pdf>

State Funded Medical Assistance Programs Excerpt from *Guide to Immigrant Eligibility to Federal Programs* Table 10

National Immigration Law Center

January 2006

This table lists the state-funded programs that provide medical care to immigrants who are not eligible for coverage under the federally funded Medicaid program. In many states or counties, limited medical assistance, such as prenatal or preventive care, are available to all persons regardless of immigration status.

http://www.nilc.org/pubs/guideupdates/tbl10_state-med-asst_2006-01.pdf

Stretching the Safety Net to Serve Undocumented Immigrants: Community Responses to Health Needs

Issue Brief, No. 104

February 2006

Center for Studying Health System Change

A small but increasing proportion of immigrants to the United States is unauthorized. Because most unauthorized immigrants lack health insurance, they primarily rely on safety net providers for care. Communities with more developed safety nets and historically large

numbers of immigrants appear more adept at caring for both legal and unauthorized immigrants, according to Center for Studying Health System Change's (HSC) 2005 site visits to 12 nationally representative communities. Communities with less experience caring for immigrant populations and less-developed safety nets face challenges caring for this population, but many are taking steps to improve their ability to meet immigrant needs. As the number of immigrants in the U.S. grows, the need to develop community health care capacity for immigrants will intensify.

<http://www.hschange.org/CONTENT/818/818.pdf>

Automatically Enrolling Eligible Children and Families into Medicaid and SCHIP: Opportunities, Obstacles, and Options for Federal Policymakers

The Commonwealth Fund

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Sixty-two percent of uninsured children and two-thirds of uninsured, poor parents qualify for publicly funded health coverage programs but are not enrolled. This study assesses the potential impact of automatically enrolling children and parents in Medicaid and the State Children's Health Insurance Program (SCHIP) based on determinations of other means-tested programs. Current law permits states to cover some uninsured parents based on information in their children's Medicaid case files. However, current federal law forbids states from providing Medicaid or SCHIP based on the final income determinations of non-health agencies—the type of auto-enrollment that could reach eligible children. For such auto-enrollment to succeed, federal policymakers need to provide states with additional flexibility in determining eligibility and new resources for investing in information technology. This report addresses the need for automatic enrollment-mechanisms to be sensitive to immigrant families who may fear negative consequences to enrolling in public assistance programs.

http://www.cmwf.org/usr_doc/Dorn_auto-enrollingchildren_931.pdf

Ebbing and Flowing: Some Gains, Some Losses as SCHIP Responds to Third Year of Budget Pressure

New Federalism: Issues and Options for States, No. A-68

May 2005

The Urban Institute

This paper examines the State Children's Health Insurance Program on its five-year anniversary. Over two-thirds of states expanded income eligibility to at least 200 percent of poverty, 35 states created separate programs, and states invested unprecedented resources in outreach and streamlined enrollment procedures. SCHIP and Medicaid could cover 84 percent of low-income uninsured children. Following SCHIP, uninsurance has been reduced from 23.3 percent to 17.5 percent for children with incomes between 100 and 200 percent of poverty. For poor children, the uninsurance rate stagnated at 27 percent. Some challenges lie ahead for the program. SCHIP funds have been plentiful to date, but may run short over the next several years. Closing the remaining coverage gaps for children will require a number of Medicaid and SCHIP policy changes, including increasing enrollment efforts and extending eligibility to immigrant children.

<http://www.urban.org/url.cfm?ID=311166>

Covering New Americans: A Review of Federal and State Policies Related to Immigrants' Eligibility and Access to Publicly Funded Health Insurance

Kaiser Commission on Medicaid and the Uninsured

November 2004

This brief provides an overview of health coverage challenges facing immigrants, the federal rules regarding immigrants' eligibility for Medicaid and SCHIP, and state efforts to provide replacement coverage for immigrants who are ineligible for Medicaid and SCHIP. It also reviews actions states can take to encourage enrollment of eligible immigrants in public health coverage and to improve immigrants' access to care.

<http://www.kff.org/medicaid/upload/Covering-New-Americans-A-Review-of-Federal-and-State-Policies-Related-to-Immigrants-Eligibility-and-Access-to-Publicly-Funded-Health-Insurance-Report.pdf>

Not Getting What They Paid For

Immigration Policy Brief

June 2003

Immigration Policy Center

As Congress prepares to take up reauthorization of public-benefit programs, policymakers once again will consider the extent to which legal immigrants in the United States utilize these programs. Since passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), most taxpaying, lawful permanent residents are ineligible to receive many of the benefits their tax dollars help to fund. As a result, PRWORA has increased food insecurity and reduced access to health insurance among both legal immigrants and their U.S.-citizen children. At the same time, benefit restrictions do not significantly reduce federal, state and local healthcare expenditures in the long run given the high costs of caring for the uninsured. Despite claims by some anti-immigrant groups that use of public benefits by legal immigrants has increased since the passage of PRWORA, benefit use has in fact declined substantially.

http://www.aif.org/ipc/policy_reports_2003_benefits.asp

Prenatal Coverage for Immigrants Through the State Children's Health Insurance Program (SCHIP)

National Health Law Center

June 2003

This issue brief provides outlines recent amendments to the Department of Health and Human Services' State Children's Health Insurance Program (SCHIP) regulations that enable states to use federal funds to provide prenatal health services to women who are not eligible to receive federal benefits. It also lists issues for states to consider in evaluating whether to implement the fetus option.

http://www.nilc.org/immspbs/health/Issue_Briefs/Prenatal%20coverage%20through%20SCHIP.pdf

Welfare Reform, Labor Supply and Health Insurance in the Immigrant Population

Working Paper No. 9781

June 2003

National Bureau of Economic Research

Although the 1996 welfare reform legislation limited the eligibility of immigrant households to receive assistance, many states chose to protect their immigrant populations by offering state-funded aid to these groups. The author looks at these changes in eligibility rules to examine the link between the welfare cutbacks and health insurance coverage in the immigrant population. The data reveal that the cutbacks in the Medicaid program did not reduce health insurance coverage rates among targeted immigrants. The immigrants responded by increasing their labor supply (i.e., working more hours), thereby raising the probability of being covered by employer-sponsored health insurance.

<http://papers.nber.org/papers/w9781>

[Subscription required for access to full text.]

Immigrants and Medicaid After Welfare Reform

The Guttmacher Report on Public Policy

May 2003

In this special analysis, the author outlines changes in eligibility requirements for legal immigrants as a result of the 1996 welfare reforms. It focuses on changes in coverage for women of reproductive age and issues of access to prenatal care, postpartum care, and treatment for breast and cervical cancer.

<http://www.guttmacher.org/pubs/tgr/06/2/gr060206.pdf>

Noncitizens' Use of Public Benefits Has Declined Since 1996: Recent Report Paints Misleading Picture of Impact of Eligibility Restrictions on Immigrant Families

Center on Budget and Policy Priorities

21 April 2003

The authors refute conclusions drawn in a Center for Immigration Studies (CIS) Report that participation in welfare programs by immigrants are back to where they were prior to the 1996 reforms. CIS' claims that welfare use has failed to decline since 1996 – despite overwhelming data and research showing that the opposite is true – turns out to rest on the fact that the establishment of the SCHIP program led to an expansion in publicly-funded health insurance for low-income citizen children, a portion of whom live in households that include immigrant members. Trends in participation by children and adults who are noncitizens (rather than citizens) provide a much more appropriate yardstick by which to measure the impact of the 1996 restrictions on noncitizens' eligibility for public benefits. A new analysis of Census Bureau data (using the same database as CIS used) shows that among both noncitizen adults and noncitizen children, Medicaid participation declined between 1996 and 2001, a fact CIS inexcusably fails to disclose in its report.

<http://www.cbpp.org/4-14-03wel.pdf>

The Application Process For TANF, Food Stamps, Medicaid and SCHIP: Issues For Agencies and Applicants, Including Immigrants and Limited English Speakers

The Urban Institute

January 2003

This report explores one key dimension of access to public benefits—the application and eligibility determination process. Of particular interest is how local-level administrative procedures and operations may generally affect eligible families' access to benefits. Special consideration is given to exploring these issues as they relate to immigrants and limited English speakers. The four major public benefits programs examined in this study are Temporary Assistance for Needy Families (TANF), food stamps, Medicaid, and the State Children's Health Insurance Program (SCHIP). The findings presented are primarily based on site visits conducted between June 2001 and December 2001 in six different localities: New York City (five counties/NY), Dallas (Dallas and Tarrant Counties/TX), Seattle (King County/WA), Raleigh (Wake County/NC), Arlington (Arlington County/VA), and Sedalia (Pettis County/MO). The sites vary in terms of the overall size of their client base and the diversity of the immigrant population, and the way in which application and eligibility determination processes are structured and implemented.

<http://www.urban.org/url.cfm?ID=410640>

Five Things Everyone Should Know about SCHIP

New Federalism: Issues and Options for States, No. A-55

October 2002

The Urban Institute

This paper examines the State Children's Health Insurance Program on its five-year anniversary. Over two-thirds of states expanded income eligibility to at least 200 percent of poverty, 35 states created separate programs, and states invested unprecedented resources in outreach and streamlined enrollment procedures. SCHIP and Medicaid could cover 84 percent of low-income uninsured children. Following SCHIP, uninsurance has been reduced from 23.3 percent to 17.5 percent for children with incomes between 100 and 200 percent of poverty. For poor children, the uninsurance rate stagnated at 27 percent. Some challenges lie ahead for the program. SCHIP funds have been plentiful to date, but may run short over the next several years. Closing the remaining coverage gaps for children will require a number of Medicaid and SCHIP policy changes, including increasing enrollment efforts and extending eligibility to immigrant children.

<http://www.urban.org/url.cfm?ID=310570>

Immigrant Access to Health Benefits: A Resource Manual

National Immigration Law Center

August 2002

The Access Project and the National Health Law Program (NHeLP) have released a revised publication, entitled *Immigrant Access to Health Benefits: A Resource Manual*. This manual, originally published in 2000, has been revised and expanded. It was written for use as a resource in conjunction with an intensive training program developed by The Access Project and the National Health Law Program.

Immigrant Access to Health Benefits: A Resource Manual is essentially a primer on health access for immigrants. It details and explains basic eligibility requirements for key federal and state programs and identifies issues that can be significant barriers to access to health care for immigrants and their families. Below are the topics covered in this manual:

Chapter 1: Medicaid and SCHIP for Immigrants

Chapter 2: Health Benefit Programs Available to All Noncitizens Regardless of Status

Chapter 3: State and Local Programs

Chapter 4: New Responsibilities for Sponsors

Chapter 5: Verification of Status, Confidentiality, and Reporting

Chapter 6: Public Charge Determinations

Chapter 7: Linguistic and Cultural Access in Health Care Settings

<http://www.healthlaw.org/search.cfm?fa=download&resourceID=67219&print&q=immigra nt%20health&expand=0&coq=&dr=0&ts=&ia=0&ct=4&po=0> [available for purchase]

The Decline in Medicaid Use by Noncitizens Since Welfare Reform

Health Policy Online No. 5

June 2002

The Urban Institute

This brief looks at whether the enrollment of noncitizens in Medicaid has decreased since the enactment of welfare reform. The common expectation has been that noncitizen enrollment would decrease, given that welfare reform significantly restricted Medicaid eligibility of noncitizens, barring most of them from receiving Medicaid during the first five years of living in the country unless states chose to cover them through state programs. The analysis detailed in this brief finds that Medicaid enrollment among noncitizens did in fact *decrease* after welfare reform as intended by law, and that noncitizens are much less likely than native citizens to receive Medicaid. However, a report released by the Center for Immigration Studies (CIS) in March 2003 suggested the opposite—that enrollment of noncitizens in Medicaid increased after welfare reform and remains much greater than that of native households.

http://www.urban.org/UploadedPDF/900621_HPOnline_5.pdf

Immigrant-Friendly Health Coverage Outreach Enrollment

Health Care Issue Brief

June 2002

National Immigration Law Center

More than one out of every three children who are eligible for Medicaid but not enrolled lives in an immigrant family. This issue brief outlines some of the concerns of immigrant families face about accessing public benefits that outreach workers, application assisters, and advocates should understand. Some of these concerns include: confusion about eligibility; issues of confidentiality of those waiting to adjust to lawful status; fears of being deemed a public charge; placing liability on the sponsor; and language barriers. The brief also highlights recommendations for facilitating the application process and expanding access.

[http://www.nilc.org/immspbs/health/Issue_Briefs/Immigrant-Friendly App Enrllmnt.PDF](http://www.nilc.org/immspbs/health/Issue_Briefs/Immigrant-Friendly_App_Enrllmnt.PDF)

The Impact of Welfare Reform on Immigrant Welfare Use

Center for Immigration Studies

March 2002

This paper examines the impact of the 1996 welfare reform legislation on welfare use in immigrant households. Although the data indicate that the welfare participation rate of immigrants declined relative to that of natives at the national level, this national trend is entirely attributable to the trends in welfare participation in California. Immigrants living in California experienced a precipitous drop in their welfare participation rate (relative to natives). Immigrants living outside California experienced roughly the same decline in participation rates as natives. The potential impact of welfare reform on immigrants residing outside California was neutralized because many state governments responded to the federal legislation by offering state funded programs to their immigrant populations and because the immigrants themselves responded by becoming naturalized citizens. The very steep decline of immigrant welfare participation in California is harder to explain, but could be a by-product of the changed political and social environment following the enactment of Proposition 187.

<http://www.cis.org/articles/2002/borjas.pdf>

The Scope and Impact of Welfare Reform's Immigrant Provisions

The Urban Institute

January 2002

In this paper, the authors discuss the background and character of the changes introduced by this comprehensive, far-reaching law and then sketch the post-enactment responses of the Congress, the states, and the courts. They further explore the impacts that the law has had on benefit use among immigrants, highlighting the changes in usage among different immigrant groups and factors related to these changes, such as naturalization and rising incomes. We conclude by discussing a number of issues that may be examined within the context of welfare reauthorization.

http://www.urban.org/Uploadedpdf/410412_discussion02-03.pdf

STATE, COUNTY, CITY SPECIFIC REPORTS

Health Insurance, Health Care Use, and Health Status in Los Angeles County

Public Policy Institute of California

December 2006

This report presents an overview of insurance coverage, use of care, and general health status of the population in Los Angeles County. As the key findings indicate, large racial and ethnic differences exist in health insurance coverage and the use of some forms of medical care.

Immigration status plays an important part in these differences as well. Controlling for other individual characteristics makes many of the significant race/ethnicity or immigrant status differences shrink. In addition, the authors found that racial, ethnic, and, in some cases, immigrant status differences in the authors' health status measures were smaller than those found in their other measures. Because government plays an important role in the public provision and subsidization of care in California, a clear need exists for specific information about the populations that may use these public services. The large cost of these services, and their importance to the public's overall health, makes this need more pressing. The findings offer some insight into how particular population groups were faring in 2000–2001 with regard to several health-related measures.

http://www.ppic.org/content/pubs/report/R_1206MBR.pdf

Important Update on New Medicaid Citizenship Documentation Requirements and Texas

Policy Page, No. 274

30 November 2006

Center for Public Policy Priorities

Some recent media reports have erroneously stated that the new federal Centers for Medicare and Medicaid Services (CMS) rules deny Medicaid coverage to newborns of “Emergency Medicaid” non-citizen mothers. In fact, the new federal law and rule did not change eligibility for Medicaid in any way. It is critical that Texas health care providers and social service agencies understand the correct policy so that (1) eligible U.S. citizens are not wrongfully denied Medicaid, and (2) health care providers do not incur avoidable uncompensated care. Providers and community-based organizations should also make certain that Texas Medicaid policies are being followed correctly in their facilities and communities, because these policies should minimize Medicaid denials and delays for U.S. citizens of all ages— not just newborns. This brief provides key facts on new Medicaid documentation requirements.

<http://www.cppp.org/files/3/POP%20274%20cit%20doc%2011%2029%2006.pdf>

Los Angeles Healthy Kids Program Gets a Healthy Start: Findings from the First Evaluation Study

Health Policy Briefs No. 19

November 2006

Urban Institute

The Los Angeles Healthy Kids program extends health coverage to uninsured children from birth through age 18 in families with income below 300 percent of the federal poverty level who are ineligible for Medicaid or SCHIP. Results from the first case study report on Healthy Kids implementation indicate that the program is off to a very positive start. Researchers found that the program's effective community-based outreach and simplified enrollment have fueled strong enrollment, its benefits package and managed care provider network were carefully designed to meet the needs of vulnerable children, and that Healthy Kids has been implemented smoothly.

http://www.urban.org/UploadedPDF/311398_Los_Angeles_Healthy_Start.pdf

Simplify, Automate, and Follow the Leader: Lessons on Expanding Health Coverage for Children

California Health Care Foundation

November 2006

California has learned a great deal in recent years about how to provide health insurance for children. The state has significantly expanded enrollment in Medi-Cal and Healthy Families,

and many counties have developed Children's Health Initiatives (CHIs) to cover children ineligible for state programs. As a result, the number of uninsured children in California has fallen by nearly one-fifth during the last five years.

While there is substantial popular support for continuing to expand coverage until all children in California have insurance, nearly one million remain uninsured. This issue brief synthesizes key lessons from successful initiatives, as well as from reforms that have been identified but not yet implemented.

<http://www.chcf.org/documents/policy/SimplifyAutomateAndFollowTheLeaderIB.pdf>

A Profile of Young Children in the Los Angeles Healthy Kids Program: Who are They and What are Their Experiences on the Program?

Urban Institute

October 2006

Mathematica Research, Inc.

The report provides an analysis of data from a survey—conducted by Mathematica Policy Research for the evaluation—of the parents of Healthy Kids children ages 1 to 5. The key findings from the analysis of the survey are as follows:

- Most Healthy Kids enrollees are age 3 to 5 and are in two-parent, Latino working families.
- While most Healthy Kids are in good health, a substantial proportion are not, according to several different measures. Special attention should be paid to health access for these vulnerable children, because of their fragile health status.
- Consistent with findings from the evaluation case study and focus groups, parents reported very positive experiences about the outreach, enrollment, and renewal processes for Healthy Kids.
- Healthy Kids is not substituting for employer-sponsored health insurance to any great degree, since few Healthy Kids enrollees have access to private insurance coverage. Emergency Medi-Cal plays an important role in providing financial access to health services for uninsured young children in Los Angeles County, and a large number of Healthy Kids enrollees retain Emergency Medi-Cal coverage after enrolling.
- Access to care for Healthy Kids enrollees is very good for many services, particularly preventive and primary care services, and the use of preventive care is high compared to national benchmarks. Almost all Healthy Kids enrollees have a usual source of care, and the location of the usual source of care was usually close to the child's home.

http://www.urban.org/UploadedPDF/411370_healthy_kids.pdf

What do Parents Say About the Los Angeles Healthy Kids Program?

Urban Institute

October 2006

Mathematica Research, Inc.

The Healthy Kids Program Evaluation was launched in May 2004 to carefully document and assess the implementation and impacts of the program. As part of this effort, a series of focus groups were conducted in the spring of 2005 to explore parents' feelings about and experiences with Healthy Kids and to learn how, and how well, the program is meeting families' needs. A total of 86 parents participated in 12 focus groups, convened in five of the county's largest Service Planning Areas. Half of the groups were conducted with parents of Healthy Kids enrollees, and three groups each were conducted with parents of children in

Medi-Cal and parents of uninsured children to provide a basis for comparison and to learn more about the extent to which public programs are integrated. Each group explored a broad range of critical issues, including parents' views of: outreach, enrollment, and renewal; access to various types of care; the affordability of cost sharing; and overall opinions of Healthy Kids and suggestions for improvement.

The focus groups revealed that parents overwhelmingly place a very high value on health insurance. Unanimously, parents said that Healthy Kids provides them with "peace of mind," "security," and "assurance" and that the coverage afforded their children easier access to care, made health services dramatically more affordable, and increased parents' options for where and when to obtain care.

http://www.urban.org/UploadedPDF/410308_parents_say.pdf

Illinois' All Kids: A Step in the Right Direction

Families USA Issue Brief

October 2006

On October 6, 2005, Illinois Governor Rod Blagojevich unveiled a plan to offer universal health coverage to the state's children. This proposal came in the form of legislation known as "All Kids," sponsored by State Senate President Emil Jones and House Speaker Michael J. Madigan. Just a few weeks later, on October 27, the Democrat-controlled House (by a vote of 79-28) and Senate (by a vote of 32-23) passed All Kids. The plan was implemented on July 1, 2006, making Illinois the first state in the nation to offer health coverage to all children. This issue brief highlights the main components of the program.

<http://www.familiesusa.org/assets/pdfs/illinois-all-kids-brief.pdf>

Determinants of Children's Participation in California's Medicaid and SCHIP Programs

Health Services Research Online Version

August 2006

With the goal of developing a comprehensive predictive model of eligible children's enrollment in California's Medicaid (Medi-Cal [MC]) and State Children's Health Insurance Program (SCHIP; Healthy Families [HF]) programs, the authors examined the effects of multiple family-level factors and contextual county-level factors on children's enrollment in Medicaid and SCHIP using data from the 2001 California Health Interview Survey data on outstationed eligibility workers (OEWs), and administrative data from state agencies and local health insurance expansion programs for fiscal year 2000–2001.

Principal Findings show that participation in MC and HF programs is determined by a combination of family-level predisposing, perceived need, and enabling/disabling factors, and county-level enabling/disabling factors. The strongest predictors of MC enrollment were family-level immigration status, ethnicity, and income, and the presence of a county-level expansion program"; and the county-level ratio of OEWs to eligible children. Important HF enrollment predictors included family-level ethnicity, age, number of hours a parent worked, and urban residence; and county-level population size and outreach and media expenditure.

<http://www.healthpolicy.ucla.edu/pubs/publication.asp?pubID=182>

[Subscription required for access to full text..]

Los Angeles Healthy Kids Improves Access to Care for Young Children

Health Policy Briefs No. 18

July 2006

Urban Institute

This brief presents preliminary results on differences in perceived and realized access to care from the initial survey of established and new enrollees that was conducted as part of the Los

Angeles Healthy Kids Initiative evaluation. The Healthy Kids evaluation was designed to both provide feedback to stakeholders on the initiative and to assess the impact of the program on insurance coverage, access to care, use of services, satisfaction with care, quality and content of care, and developmental and health status for children under age 6. The evaluation includes case studies of implementation, focus groups with parents, ongoing process monitoring, and a longitudinal survey of parents of children enrolled in Healthy Kids. First 5 LA contracts with the Urban Institute and its partners—the University of Southern California, the University of California at Los Angeles, Mathematica Policy Research, Inc., and Castillo & Associates—to conduct the evaluation.

http://www.urban.org/UploadedPDF/311407_healthy_kids.pdf

Santa Clara County Children’s Health Initiative Outreach and Enrollment Efforts Are Effective and Helpful to Parents

Evaluation of the Santa Clara County Children’s Health Initiative, Issue February 2006
Brief No.3

Mathematica Policy Research, Inc., The Urban Institute, University of California – San Francisco

A major component of the Santa Clara County Children’s Health Initiative (CHI) is expanded and coordinated outreach for the three health insurance programs available to children in families with incomes under 300 percent of the federal poverty level: Medi-Cal, Healthy Families, and Healthy Kids. CHI partners work together to conduct extensive, coordinated outreach to eligible families and assist parents with applying. The intensity and coordination of the outreach provided ensure that all children enroll in the programs for which they are eligible. Between the inauguration of the program in 2001 and December 2005, CHI had processed 105,000 applications, a clear testament to the efficacy of its outreach. This brief provides information about methods of outreach and enrollment, as well as parents’ perceptions of the application and enrollment process, with emphasis on the new, locally funded Healthy Kids program, which provides coverage for children in families with income up to 300 percent of the federal poverty level who are not eligible for Medi-Cal or Healthy Families. The information in this brief is derived from a survey of parents with children enrolled in Healthy Kids, focus groups, and site visits.

<http://www.mathematica-mpr.com/publications/pdfs/chiparents.pdf>

The Effect of New Insurance Coverage on the Health Status of Low-Income Children in Santa Clara County

Health Research Educational Trust

2006

This study examines whether providing health insurance coverage to unauthorized children affects the health of those children by analyzing data from a survey of 1235 parents of enrollees in the new insurance program (“Healthy Kids”) in Santa Clara County, California. The study group, who were children continuously insured by Healthy Kids for one year, were significantly less likely to be in fair/poor health and to have functional impairments than the comparison group of newly insured children (15.9 percent versus 28.5 percent and 4.5 percent versus 8.4 percent, respectively). Impacts were largest among children who enrolled for a specific medical reason (such as an illness or injury); indeed, the impact on functional limitations was evident only for this subgroup. The study group also had fewer missed school days than the comparison group, but the difference was significant only among children who did not enroll for a medical reason. Health insurance coverage of unauthorized children in Santa Clara County was associated with significant improvements

in children's health status. The size of this association could be overstated, since the comparison sample included some children who enrolled because of an illness or other temporary health problem that would have improved even without insurance coverage. However, even after limiting the study sample to children who did not enroll for a medical reason, a significant association remained between children's reported health and their health coverage. The authors thus cautiously conclude that Healthy Kids had a favorable impact on children's health.

<http://www.blackwell-synergy.com/doi/pdf/10.1111/j.1475-6773.2006.00625.x>

Out of the Many, One: Integrating Immigrants in New Jersey

National Immigration Forum

2006

This report examines the challenge of immigrant integration in a comprehensive manner. Issues that matter to immigrants, such as learning English, adapting to a new society, accessing health care and other services, finding jobs, and feeling secure and confident in the future are covered in some detail. The report contains a total of 53 recommendations. Although many focus on state government operations, the report also looks at important role that local government leaders can play in building a fair and inclusive community. The report also covers the crucial work of private and civic sector organizations in addressing immigrant need and in building "unity in diversity." Finally, the Report sets forth a plan of action, based on models from other states, for a structured partnership between state government and private sector organizations to promote the integration of immigrants.

<http://www.fundfornj.org/files/outofthemany.pdf>

Legal Status and Health Insurance Among Immigrants

Health Affairs, Vol. 24, No. 6

Nov/Dec 2005

The foreign-born represent a disproportionate share of non-elderly U.S. adults without health insurance. Using data from Los Angeles County, the authors find that most of the insurance disparities between the foreign-born and native-born can be explained by traditional socioeconomic factors. Unauthorized immigrants, however, have lower rates of coverage – both private and public – even after a wide array of factors are controlled for. Applying Los Angeles County rates to the U.S. population implies that unauthorized immigrants account for one-third of the total increase in the number of uninsured adults in the United States between 1980 and 2000.

<http://content.healthaffairs.org/cgi/reprint/24/6/1640>

[Subscription required for access to full text.]

Ensuring Health Coverage for California's Immigrant Children

California Working Paper #2

November 2005

New America Foundation Health Policy Program

The New America Foundation is committed to achieving universal health insurance coverage for all people in America. The most promising route to universal coverage is a system that relies on shared responsibility among individuals, employers, and the government. To that end, the New America Foundation has released a series of three papers outlining how to cover all children in California as a first step towards universal coverage. This paper is a component of that series.

This paper describes the current avenues and barriers to health insurance for California's immigrants and offers recommendations for improving access to care. It is intended to serve

as a complement to the New America Foundation's proposal for covering California's children as a first step toward universal health insurance for all in California. Because immigrant families sometimes have unclear or mixed citizenship status and a tenuous connection to the formal labor market and tax system, careful consideration of how to meet this population's health insurance needs without exposing them to undue financial and legal burdens must be a part of any plan to extend health insurance to all children and, eventually, all Californians.

http://www.newamerica.net/files/archive/Doc_File_2685_1.pdf

Who Signs Up? Family Participation in Medi-Cal and Healthy Families

UCLA Center for Health Policy Research

November 2005

This report provides estimates of program participation expressed as the ratio of children who are enrolled in either the MC or the HF programs to the total number who are eligible to participate in the programs and who do not have private or employer sponsored health insurance coverage. Program participation rates are provided by geographic region and by county (where sample size permits). Because parents are the decision makers regarding children's health insurance enrollment, this report also highlights the disparities in children's enrollment by parental characteristics including ethnicity, immigration status, English language proficiency and language spoken in the home. By learning about the parents of uninsured eligible children, we can better target them with outreach programs. The report also provides the most frequent reasons parents give for not enrolling their eligible children in the programs, by ethnicity.

http://www.healthpolicy.ucla.edu/pubs/files/WhoSignsUp_RT_111605.pdf

Analysis of the Funding and Provision of Health Care to Immigrants after Welfare Reform: Local Consequences and Variation in New Mexico Executive Summary

Report to the Office of Border Health, New Mexico Department of Health

November 2005

Using a qualitative research design, this study addressed one overarching question: What are the local consequences of the 1996 PRWORA (welfare reform) on the funding and provision of health services to immigrants? This local level investigation provides policy makers with an understanding of how the 1996 PRWORA has resulted in variation in local policies and in the responses (decision-making and practices) of safety net providers to these changes.

The three study aims analyzed are:

1. The responses of the state, counties and safety-net providers to the eligibility and benefits changes in the 1996 PRWORA (i.e. Medicaid, sponsor-deeming, five-year bar) pertinent to the funding and provision of health services to immigrants.
2. The impact of welfare reform on the willingness and ability of the safety-net providers (government and private) in New Mexico to serve immigrants.
3. New Mexico's policies regarding the funding and provision of health services to immigrants in comparison to those of other border states (Arizona, Texas, and California).

http://www.borderhealth.org/files/res_590.pdf

The Santa Clara County Healthy Kids Program: Impact on Children's Medical, Dental, and Vision Care Final Report

Mathematica Policy Research, Inc.

July 2005

The Santa Clara County Children's Health Initiative (CHI), launched in January 2001, is an ambitious effort to close gaps in health insurance coverage for children. The program consists of two parts. The first is a new insurance product, Healthy Kids, which eliminates significant gaps in existing public coverage by extending eligibility to all uninsured children in the county with household incomes below 300 percent of the federal poverty level (FPL). This analysis focuses primarily on the group of children whose household income is below 250 percent of the FPL. These children, who account for more than 85 percent of Healthy Kids enrollees, are distinct from children in the 250 to 300 percent of the FPL range because their program eligibility for Healthy Kids is based on their unauthorized immigration status, not solely on their income level. This status makes them ineligible for other public health insurance programs, leading to health care experiences that may be very different from other low-income children. Among the key results of this study are:

- Children enrolled in Healthy Kids are predominantly from two-parent working households that have lived in the county for at least two years. However, most lived below the FPL, and two-thirds did not have any health insurance coverage for six months or longer before enrolling.
- Participation in Healthy Kids leads to dramatic increases in the medical care that children receive. These improvements include large gains in access to, and use of, care; sizable reductions in unmet need; and improvements in parents' confidence in, and satisfaction with, care.
- Participation in Healthy Kids leads to dramatic improvements in dental and vision care, including a roughly threefold increase in whether children have a usual source of care for these services, receive a recent checkup, and receive a dental procedure such as a cavity filling or tooth extraction.

<http://www.mathematica-mpr.com/publications/PDFs/santaclara.pdf>

Santa Clara Healthy Kids Program Reduces Gaps in Children's Access to Medical and Dental Care

Evaluation of the Santa Clara County Children's Healthy Initiative, Issue August 2005
Brief, No.2

Mathematica Policy Research, Inc., The Urban Institute, University of California – San Francisco

This brief presents findings from a survey of families with children enrolled in the Healthy Kids program in Santa Clara County, California. Launched in January 2001 by the Santa Clara County Children's Health Initiative (CHI), Healthy Kids provides health insurance coverage to children in the county with household income below 300 percent of the federal poverty level (\$58,050 for a family of four) who are ineligible for the two major state insurance programs, Medi-Cal and Healthy Families. The vast majority of Healthy Kids enrollees are in households with income below 250 percent of the federal poverty level, low enough to qualify them for one of the state programs. However, they are ineligible for the state programs because of their immigration status. This brief provides a profile of these children and information on the impact of Healthy Kids on their medical and dental care.

<http://www.mathematica-mpr.com/publications/PDFs/chihealthykids.pdf>

Expanding Coverage for Children: The Santa Clara County Children's Health Initiative

Evaluation of the Santa Clara County Children's Healthy Initiative, Issue April 2005
Brief, No.1

Mathematica Policy Research, Inc., The Urban Institute, University of California – San Francisco

The Santa Clara County Children’s Health Initiative (CHI) was developed by a coalition of community organizations, county agencies, and the local Medicaid health plan to improve the health and well-being of low-income children in the county. CHI has two parts; the first is a new insurance product, Healthy Kids, which covers children ineligible for the two major state insurance programs, Medi-Cal and Healthy Families. Current enrollment in Healthy Kids is about 13,000. The second part of CHI—a comprehensive outreach campaign built on the message that all children under 300 percent of poverty are eligible for coverage—finds uninsured children and enrolls them in the public program for which they are eligible.

<http://www.mathematica-mpr.com/publications/pdfs/chiexpandcov.pdf>

Immigration Status and Health Insurance Coverage: Who Gains? Who Loses?

American Journal of Public Health, Vol. 95, No. 1

January 2005

The authors compared health insurance status transitions of nonimmigrants and immigrants by using multivariate survival analysis to examine gaining and losing insurance by citizenship and legal status among adults with the Los Angeles Family and Neighborhood Survey. They found significant differences by citizenship and legal status in health insurance transitions. Unauthorized immigrants were less likely to gain and more likely to lose insurance compared with native-born citizens. Legal residents were less likely to lose insurance compared with native-born citizens. Legal residents were less likely to gain and were slightly more likely to lose insurance compared with native-born citizens. Naturalized citizens did not differ from native-born citizens. Previous studies have not examined health insurance transitions by citizenship and legal status. Policies to increase coverage should consider the experiences of different immigrant groups.

http://www.rand.org/pubs/reprints/2005/RAND_RP1154.pdf

Uninsured Working Immigrants: A View from a California County

Journal of Immigrant Health, Vol. 7, No. 1

January 2005

This article informs a county’s efforts to provide health insurance to uninsured working immigrants—a group left out of national and state strategies that aim to expand coverage. The authors analyzed a population-based survey data administered in English, Spanish, Cantonese, Mandarin, Korean, Vietnamese, and Dari on 5,540 nonelderly adult workers in Alameda County, California. The study models the likelihood of employment-based coverage, estimates the eligibility for public programs, and evaluates the affordability of average employee share of premiums by citizenship status and years lived in the United States (tenure). Immigrant workers in Alameda County are disproportionately uninsured. They constitute 29% of the employee labor force but 54% of uninsured employees. Employment-based coverage increased with citizenship and length of stay (tenure) in the United States. Noncitizens with less than 5 years residency in the United States faced the greatest disadvantage in securing employment-based coverage, an effect that is greater than disadvantages associated with race/ethnicity. A citizenship-tenure divide existed in obtaining employment-based coverage, suggesting that policies focusing on noncitizen and new immigrant workers would greatly relieve the disparate uninsured rates among workers. The expansion of nonemployment based coverage programs would cover more than 30% of Alameda County’s uninsured immigrant workers; but subsidies will also be needed for the lowest-income workers who are not eligible for these programs.

<http://www.springerlink.com/content/p5u68x175v425883/>

[Subscription required for access to full text.]

The Impact of the Children's Health Initiative (CHI) of Santa Clara County on Medi-Cal and Healthy Families Enrollment

Mathematica Policy Research, Inc.

September 2004

This issue brief is based on an evaluation of the Santa Clara County Children's Health Initiative (CHI) conducted by Mathematica Policy Research, Inc. through support from The David and Lucile Packard Foundation. The CHI evaluation has three main components: (1) an enrollment analysis that measures the CHI's impact on children's enrollment in Medi-Cal and Healthy Families; (2) an impact analysis that measures the effects of Healthy Kids on participating children's access to care, their utilization of services, unmet health care needs, school-related outcomes, and parents' satisfaction with their children's health care and perceptions of care quality; and (3) a process analysis that documents key elements of CHI and Healthy Kids, including the goals and challenges of CHI and the qualitative experiences of Healthy Kids participants and their families.

http://ihps-ca.org/resources/pdfs/SC_MER_NB.pdf

California Report Card: Focus on Immigrant Children 2004

Children Now

23 August 2004

The *California Report Card 2004* focuses on children in immigrant families to help Californians better understand the lives of almost half of California's children and families, about whom stereotypes often prevail. The report's data—obtained from sources such as the 2000 Census, the 2001 California Health Interview Survey and the 1999 and 2002 National Survey of America's Families — show that:

- Most immigrant families in California have full-time workers: 84% of all children in immigrant families have at least one parent who works full-time.
- Among California children in low-income families, those in immigrant families are much more likely to have a parent working full-time (74%) than those in native families (44%).
- Children in immigrant families are more likely to be poor and live in crowded housing.
- Poor children in immigrant families are less likely to receive food stamps than poor children in native families.
- Children in immigrant families are less likely to have health insurance coverage from their parents' employers and, though public programs help, they are more likely to be uninsured than children of nonimmigrants.
- Children in immigrant families are less likely than children in native families to attend preschool and less likely to participate in after school enrichment activities once in school.

<http://caimmigrant.org/repository/wpcontent/uploads/2006/08/CHILDRENNOW%2004%20-%20CAReportCard%20Focus%20on%20Imm%20Families.pdf>

Update on Florida SCHIP Freeze

The Henry J. Kaiser Family Foundation

23 July 2004

In December 2003, the Kaiser Commission on Medicaid and the Uninsured released a report on six states that had stopped enrolling children in their SCHIP programs. The report, *Out in the Cold: Enrollment Freezes in Six State Children's Health Insurance Programs*

Withhold Coverage from Eligible Children, presented the findings of a survey by the Center on Budget and Policy Priorities. Since the report was issued, four of the states have lifted their SCHIP freezes and are once again enrolling children in their programs. Only Florida and Utah continue to impose freezes on SCHIP enrollment. This is an update describing how program rules and procedures have changed in Florida.

<http://www.kff.org/medicaid/upload/Update-on-the-Florida-SCHIP-Enrollment-Freeze.pdf>

Moving Immigrants from a Medicaid Look-Alike Program to Basic Health in Washington State: Early Observations

The Henry J. Kaiser Family Foundation

May 2004

In 2002, the Washington State legislature eliminated three state-funded programs for individuals whose immigration status prevented them from qualifying for Medicaid. Although fully state funded, and, thus, technically not part of the Medicaid program, the benefits provided were identical to those in Medicaid. Since these programs were separate from Medicaid, in this report, we refer to these immigrant benefits as Medical Assistance, an umbrella term used in Washington to refer both to Medicaid and similar state-funded programs. This program elimination affected over 28,000 individuals, over 90 percent of whom were children; the rest were parents or other relatives caring for children. About two-thirds were of Hispanic origin, and more than 80 percent spoke a primary language other than English. Rather than eliminating these individuals' eligibility for health coverage outright, the legislature instead set aside "slots" for them in the state's Basic Health program, a state-funded health insurance program with premiums, cost-sharing, and a more limited benefit package than Medicaid. To enroll, families had to complete the Basic Health application and pay the first month's premium (or have payment made on their behalf). Despite substantial efforts by public and private outreach workers and the involved state agencies, only about half of those terminated from the Medical Assistance programs for immigrants successfully enrolled in Basic Health during the first transitional months—October through December 2002. A large proportion of those who did enroll have not retained their coverage.

<http://www.kff.org/medicaid/upload/Moving-Immigrants-from-a-Medicaid-Look-Alike-Program-to-Basic-Health-in-Washington-State-Early-Observations.pdf>

New Country, New Perils: Immigrant Child and Family Health in NYC

New School University

April 2004

This newsletter covers several issues facing immigrant families in New York City: obstacles to accessing government-funded health care; increased risk of environmental illnesses; cultural attitudes toward food and childhood obesity; and mental health of immigrant students.

http://www.fcd-us.org/uploadDocs/5.14.04.immigrant_health_in_NYC.pdf

Building an On Ramp to Children's Health Coverage: A Report on California's Express Lane Eligibility Program

Issue Brief

2004

The Children's Partnership and The Henry J. Kaiser Family Foundation

A promising strategy called Express Lane Eligibility (ELE) has been pioneered in California to more efficiently enroll uninsured children into publicly funded health insurance programs. It is a story of successes and challenges, offering important lessons for other states

interested in a high-leverage way to increase children's health insurance enrollment. Almost 85 percent of America's uninsured children are eligible for coverage through Medicaid or the State Children's Health Insurance Program (SCHIP), but they are not receiving it. Express Lane Eligibility uses two common-sense strategies to find and enroll these nearly seven million "eligible but uninsured" children in health insurance coverage. First, it targets large numbers of eligible children where they can be found: in other public benefit programs like school lunch and food stamps. More than 70 percent of low income uninsured children are already receiving other public assistance benefits of some kind. Second, it expedites children's enrollment in health coverage by using information already submitted by parents when they enrolled their children in other benefit programs. [Note: Although this report does not directly focus on immigrant children, the program is directed towards facilitating access to public programs for citizen and legal immigrant children who meet income eligibility requirements.]

<http://www.kff.org/medicaid/upload/Building-an-On-Ramp-to-Children-s-Health-Coverage-A-Report-on-California-s-Express-Lane-Eligibility-Program-Report.pdf>

Out in the Cold: Enrollment Freezes in Six State Children's Health Insurance Programs Withhold Coverage from Eligible Children

The Henry J. Kaiser Family Foundation

December 2003

This report presents the findings of a survey of state SCHIP officials and child health advocates in six states that were implementing enrollment freezes in November 2003. It is part of a series of surveys conducted over the last three years by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured to track strategies that states are using to facilitate enrollment in health coverage for children and families. The survey found that the enrollment freezes in these states are causing tens of thousands of eligible children to go without health insurance and are creating inequities among children. The enrollment freezes also have amplified the need for effective outreach efforts aimed at helping families protect the eligibility of children currently enrolled in SCHIP in these states; these children stand to join uninsured, eligible children awaiting admittance into SCHIP if they do not comply promptly with renewal procedures and keep current on their premium payments.

<http://www.kff.org/medicaid/upload/Out-in-the-Cold-Enrollment-Freezes-in-Six-State-Children-s-Health-Insurance-Programs-Withhold-Coverage-from-Eligible-Children.pdf>

Funding Health Coverage for Low-Income Children in Washington

Center on Budget and Policy Priorities

10 November 2003

The state of Washington has been a trailblazer among the states in developing innovative approaches to expand health insurance coverage, particularly for low-income families and children. The recent economic downturn and resulting shortfalls in state tax revenues have, however, created a harsh fiscal environment in which the state has begun to adopt a variety of cutbacks in Medicaid, SCHIP and Basic Health. Some of these policies will increase the number of people without health insurance and create greater stress on safety net health care providers. Washington has already implemented changes in procedures for enrolling children in Medicaid that will reduce the number of covered children by about 28,000, as estimated by state officials. The state now plans to impose monthly premiums for low-income families whose children receive Medicaid benefits and to increase monthly premiums for those who receive SCHIP benefits, beginning February 2004, provided that the federal government approves a special waiver.

<http://www.cbpp.org/11-10-03health.pdf>

Neighborhood and Family Effects on Children's Health in Los Angeles

RAND Labor & Population Working Paper Series 03-25

April 2003

RAND Corporation

This paper examines the effects of family and neighborhood factors on child health in one of the largest urban areas in the United States, Los Angeles County. The authors use data from a new representative survey of neighborhoods and households in L.A.—the Los Angeles Family and Neighborhood Survey, or L.A.FANS—to examine the effects of family and neighborhood characteristics on child health status. A particular focus is on differences between Latinos and other race/ethnic groups as well as differences by duration of family residence in the U.S. and other key factors. The authors seek to answer two questions. First, how are family background factors such as immigrant status, ethnicity, and social class related to child health outcomes? Second, are there differences in health outcomes by neighborhood-level socioeconomic status, once individual and family differences are held constant? Among the child health outcomes examined are the mother's report of the child's overall health status, reports of physician diagnoses of key chronic diseases (such as anemia and asthma), and, among children aged 12-17 years, body mass index adjusted for age as well as indicators of being overweight or at risk of being overweight.

<http://www.rand.org/labor/DRU/DRU2400.11.pdf>

**Demographics, Health, and Access to Care of Immigrant Children in California:
Identifying Barriers to Staying Healthy**

Health Policy Fact Sheet

March 2003

Center for Health Policy Research

Almost half of children ages 0-17 in California — 4.4 million—are either immigrants themselves or live in families with at least one immigrant parent. Of these, one-third are U.S.-born children of documented immigrant parents, who are either naturalized, legal permanent residents, refugees, or other documented aliens. A significant percentage (7.1%) are U.S.-born children living in families with at least one unauthorized parent. Another 3.7% are immigrant children without legal documentation living mainly with unauthorized parents. Fewer than 4% are immigrant children of documented immigrant parents. U.S.-born children of unauthorized parents (U.S./Undoc.) and unauthorized children of unauthorized parents (Undoc./Undoc.) face many barriers to staying healthy in comparison with U.S.-born children of U.S.-born parents (U.S./U.S.).* These barriers are most burdensome to U.S./Undoc. and Undoc./Undoc. children who are the focus of this brief.

http://healthpolicy.ucla.edu/pubs/files/NILC_FS_032003.pdf

The Health Status of Newly Arrived Refugee Children in Miami-Dade County, Florida

American Journal of Public Health, Vol. 93, No. 2

February 2003

Compared with children born in the United States, refugee children from all countries have an increased risk of certain conditions that may involve significant morbidity and use of substantial health care resources, as well as of serious communicable diseases of public health concern. Studies of refugee children have found increased risks of hepatitis B, tuberculosis, and intestinal parasitic infection. Refugee children may also have an elevated risk of lead poisoning. Leaded gasoline is used in developing countries, as is leaded pottery and folk medicines containing lead. Industries such as recycling of lead-containing car batteries may contribute to air and soil lead concentrations. Screening for anemia is

recommended for children in these countries because this condition is associated with parasitic infection and other infectious diseases, as well as with elevated blood lead levels (BLLs). The primary goal of this study was to describe the health status of Cuban refugee children screened at the Miami–Dade County Health Department Refugee Health Assessment Center (RHAC), a health screening facility in Miami, Florida, administered by the Florida Department of Health. The RHAC provides comprehensive health evaluations at no charge to legally documented immigrants within 90 days of their arrival in the United States.

<http://www.ajph.org/cgi/reprint/93/2/286>

Health Status and Hospital Utilization of Recent Immigrants to New York City

Preventive Medicine, Vol. 35, No. 3

September 2002

Background. This paper examines hospital utilization, estimated hospital costs, and mortality rates for U.S.-born, foreign-born, and Puerto Rican-born persons residing in New York City.

Methods. The authors conducted a multivariate regression analysis using New York City neighborhoods as the unit of analysis. They utilized data from the Statewide Planning and Research Cooperative System data set and from the 1997 Housing and Vacancy Survey. They also examined mortality rates using 1990 death certificate data and decennial census data.

Results. The foreign-born are much less likely to be hospitalized for most major categories of illness and have lower mortality rates than either U.S.-born or Puerto Rican-born New Yorkers. The life expectancy at 1 year of age of the foreign-born is 4 years longer than for U.S.-born persons and 6 years longer than Puerto Rican-born persons. The authors estimate that the overall cost of providing hospital-based care to the foreign-born was \$611 million dollars less than the cost of providing hospital-based care to an equivalent number of U.S.-born persons in 1996.

Conclusion. The foreign-born in New York City appear to be healthier and consume fewer hospital resources than U.S.-born populations. It is possible that the cost of hospital utilization would be lower still if the foreign-born population had better access to ambulatory and preventive services.

http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6WPG-46K5DX8-5&_coverDate=09%2F30%2F2002&_alid=371299795&_rdoc=1&_fmt=&_orig=search&_qd=1&_cdi=6990&_sort=d&_view=c&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=83cc27c3f6d42245d60d3569ac82ecd6

[Subscription required for access to full text.]

Immigrant Well-Being in New York and Los Angeles

Immigrant Families and Workers: Facts and Perspectives, Brief No. 1

The Urban Institute

August 2002

Despite their strong attachment to the labor force, large numbers of immigrants and their families in New York and Los Angeles have low incomes, lack health insurance, and are food insecure. The most powerful predictor of poverty and hardship is their limited English skills. Legal immigrants arriving *after* welfare reform's enactment in 1996—who have the most restricted access to public benefits—are poorer than immigrants arriving before the law's enactment.

<http://www.urban.org/url.cfm?ID=310566>

The Miami Dade County Immigrant Health Access Task Force: Access to Public Health Trust Services: Success and Challenges

Brandeis University

May 2002

This report documents the efforts of the Immigrant Health Access Task Force in their collaboration to broaden access to services provided with Public Health Trust (PHT) Funds. The PHT receives money from a half-cent sales tax in Miami-Dade County and provides funding to the Jackson Memorial Hospital, the primary public hospital facility in the county. Immigrants and other low-income residents had a difficult time accessing care due to encounter fees and immigration documentation required to obtain free or subsidized care. The Immigrant Health Access Task Force was organized around the effort to address these problems. This report documents Task Force activities and highlights areas in need of continued attention. It is based on interviews with the advocacy group leaders, representatives of the PHT, and discussions with thirteen uninsured residents who accessed or attempted to access this care. The report concludes that efforts to date succeeded in changing certain PHT policies that limited access, yet barriers to care still exist for immigrant and low-income populations. The final section includes a list of wide ranging recommendations for continued Task Force activity.

<http://www.accessproject.org/downloads/Access%20to%20Public%20Health-Miami.pdf>

Health Coverage for Immigrants in New York: an Update on Policy Developments and Next Steps

The Commonwealth Fund

July 2002

The study examines the ways in which federal welfare reform limited legal immigrants' access to Medicaid and how a New York State Court of Appeals decision provides coverage for those previously denied. The report also examines how the state is implementing the court decision and addresses other issues, including states' need for federal financial assistance to help provide health coverage to legal immigrants on the same basis as citizens. The authors also consider the national implications of the federal government's retreat from supporting Medicaid coverage for immigrants.

http://www.cmfw.org/usr_doc/bachrach_healthcoverage.pdf

COST ESTIMATES

Undocumented Immigrants in Texas: A Financial Analysis of the Impact to the State Budget and Economy

Texas Comptroller

December 2006

Much has been written in recent months about the costs and economic benefits associated with the rising number of unauthorized immigrants in Texas and the U.S. as a whole. Most reports tie the costs of the unauthorized population to education, medical expenses, incarceration and the effects of low-paid workers on the salaries of legal residents. Revenue gains to governments resulting from unauthorized immigrants consist primarily of taxes that cannot be avoided, such as sales taxes, various fees and user taxes on items such as gasoline and motor vehicle inspections.

This financial report focuses on the costs to the state of Texas; that is, services paid for with state revenue, including education, healthcare and incarceration. What government-sponsored services are available to unauthorized immigrants is often determined by federal

restrictions on spending. The report also identifies areas of costs to local governments and hospitals. Finally, it analyzes the \$7.7 billion impact on the state's economy as well as state revenues generated by unauthorized immigrants.

The Comptroller's report estimates that unauthorized immigrants in Texas generate more taxes and other revenue than the state spends on them. This finding is contrary to two recent reports, FAIR's, "The Cost of Illegal Immigration to Texans" and the Bell Policy Center's "Costs of Federally Mandated Services to Unauthorized Immigrants in Colorado", both of which identified costs exceeding revenue.

<http://www.cpa.state.tx.us/specialrpt/undocumented/undocumented.pdf>

Immigrants and the Cost of Medical Care

Health Affairs, Vol. 25, No. 6

November 2006

Foreign-born adults in Los Angeles County, California, constituted 45% of the county's population ages 18–64 but accounted for 33 percent of health spending in 2000. Similarly, the unauthorized constituted 12 percent of the nonelderly adult population but accounted for only 6 percent of spending. Extrapolating to the nation, total spending by the unauthorized is \$6.4 billion, of which only 17 percent (\$1.1 billion) is paid for by public sources. The foreign-born (especially the unauthorized) use disproportionately fewer medical services and contribute less to health care costs in relation to their population share, likely because of their better relative health and lack of health insurance.

<http://content.healthaffairs.org/cgi/content/abstract/25/6/1700>

[Subscription required for access to full text.]

The Economic Impact of the Hispanic Population on the State of North Carolina

Frank Hawkins Institute of Private Enterprise at the University of North Carolina, Chapel Hill
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January 2006

Immigrants from Latin America, authorized and unauthorized, are dramatically changing North Carolina's demographic and economic landscape. Hispanics live in every one of the state's 100 counties and work in all sectors of the economy. North Carolina's rapidly growing Hispanic population contributes more than \$9 billion to the state's economy through its purchases and taxes, while the net cost to the state budget (after Hispanic tax contributions) is an estimated \$102 per Hispanic resident for health care, education, and corrections. If recent migration trends continue, the total economic impact of Hispanic spending in North Carolina could increase to \$18 billion by 2009. Clear opportunities exist for financial institutions and other businesses statewide to capitalize on this increasingly significant market. This study documents the nature and magnitude of North Carolina's Hispanic population change and estimates the economic impact of Hispanic residents on individual counties, metropolitan areas, and the state as a whole, along with their associated costs and benefits.

http://www.kenan-flagler.unc.edu/assets/documents/2006_KenanInstitute_HispanicStudy.pdf

Immigration. Effects on Colorado and the Nation: A Review of Research

The Bell Policy Center

29 December 2005

This report presents the results of the Bell Policy Center's review of existing research on the effects of immigration. Key findings from the research include:

- Immigration drives economic growth in the nation as a whole, adding about \$10 billion to the U.S. economy annually.
- Immigrants come to the U.S. to work. While 83 percent of native-born men work, the rate is 86 percent for documented immigrant men and 90 percent for undocumented immigrant men.
- Wages and employment of native-born U.S. workers are affected minimally by immigration.
- Immigrants pay their way. Under most scenarios, immigrants pay more in taxes to all levels of government than they consume in services.

<http://www.thebell.org/pdf/IMG-brief12-05.pdf>

The Impact of Illegal Immigration on Minnesota: Costs and Population Trends

The Office of Strategic Planning & Results Management

8 December 2005

Minnesota Department of Administration

Minnesota's illegal immigrant population is on the rise and so are the financial and social challenges associated with this increase. This report summarizes the information available on costs and population trends attributed to illegal immigrants, on a state and national basis. To properly address this issue, policy makers need information on the impact this population has on state resources. This is especially true when one considers the impact on the state's K-12 education, health care and corrections systems. For the first six months of 2005, state legislatures across the country considered almost 300 bills on immigrant and refugee policy issues and passed 47 new laws.⁶⁴ In contrast, the Minnesota legislature gave very little consideration to the issue during the 2005 session.

The facts contained in this report are the first step in understanding the impact of illegal immigration on Minnesota, the challenges we face and the actions that may be needed to address this growing concern.

http://www.state.mn.us/mn/externalDocs/Administration/Report_The_Impact_of_Illegal_Immigration_on_Minnesota_120805035315_Illegal%20Immigration%20Brief%2026.pdf

Immigrants in Connecticut: Labor Market Experiences and Health Care Access

Urban Institute

November 2005

This profile of Connecticut's immigrants is intended to help policymakers, state planners, and service providers better understand the size, characteristics, and needs of the state's immigrant population. Beyond the basic demographics of the foreign-born population, the report focuses on immigrants in the labor force and health care access for different immigrant groups. Findings in the report are based on data from the 2000 Census, the 2004 American Community Survey (ACS), and the 2002–04 U.S. Current Population Survey (CPS), Annual Social and Economic Supplements. The data were supplemented by focus groups in Hartford, Danbury, and New Haven with health care providers and Spanish-speaking immigrants who are uninsured or covered by HUSKY.

http://www.urban.org/UploadedPDF/311256_immigrants_in_connecticut.pdf

The Impact of Immigration on Health Insurance Coverage in the United States

EBRI Notes, Vol. 26, No. 6

June 2005

Employee Benefit Research Institute

This article examines the issue of immigration and health insurance coverage in the United States. It first examines the status of health insurance coverage among immigrants as

compared with nonimmigrants. It then examines the impact of immigration over the period 1994–2003, a much longer period than is covered by previous studies. More than 11 million immigrants in the United States were uninsured in 2003, accounting for 26.1 percent of the 44.7 million uninsured individuals in the country. Immigrants accounted for about one-third of the increase in the uninsured between 1994 and 1998, but between 1998 and 2003 they accounted for 86 percent of the growth in the uninsured, presumably because PRWORA restricted their benefits under public assistance programs for five years after they entered the United States. To the degree that immigration continues to increase, it is likely that the uninsured will also continue to increase as a proportion of the population.

http://www.ebri.org/pdf/notespdf/EBRI_Notes_06-2005.pdf

Undocumented Aliens – Questions Persist About Their Impact on Hospitals’

Uncompensated Care Cost

Government Accountability Office

May 2004

Hospitals generally do not collect information on their patients’ immigration status, and as a result, an accurate assessment of unauthorized aliens’ impact on hospitals’ uncompensated care costs—those not paid by patients or by insurance—remains elusive. GAO attempted to examine the relationship between uncompensated care and unauthorized aliens by surveying hospitals, but because of a low response rate to key survey questions and challenges in estimating the proportion of hospital care provided to unauthorized aliens, GAO could not determine the effect of unauthorized aliens on hospitals’ uncompensated care costs. Federal funding has been available from several sources to help hospitals cover the costs of care for unauthorized aliens. The sources include Medicaid coverage for emergency medical services for eligible unauthorized aliens, supplemental Medicaid payments to hospitals treating a disproportionate share of low-income patients, and funds provided to 12 states by the Balanced Budget Act of 1997. In addition, the recently enacted Medicare Prescription Drug, Improvement, and Modernization Act of 2003 appropriated \$1 billion over fiscal years 2005 through 2008 for payments to hospitals and other providers for emergency services provided to unauthorized and certain other aliens. By September 1, 2004, the Secretary of Health and Human Services must establish a process for hospitals and other providers to request payments under the statute.

<http://www.gao.gov/new.items/d04472.pdf>

Medical Emergency: Cost of Uncompensated Care in Southwest Border Counties

MGT of America, Inc.

September 2002

This study has two central purposes. The first is to estimate the costs to southwest border counties and county healthcare providers for delivering emergency medical services to undocumented immigrants. The second purpose of the study is to recommend changes to federal laws and policies contributing to the challenges local governments and hospitals face when providing such care to undocumented immigrants.

The study’s scope is narrow. First, the authors aim to only estimate the cost of providing emergency hospital and transportation services to undocumented immigrants. Costs incurred for preventive, acute, and extended or rehabilitative health care, and nonemergency medical transportation are beyond the scope of this study because these services fall outside the federal definition of an “emergency.” This is significant given that emergency medical costs represent only a small portion of the costs borne by counties and medical providers that serve undocumented immigrants. Second, the study is restricted to estimating costs and addressing

policy issues specific to the 24 southwest border counties in Texas, New Mexico, Arizona, and California. Third, the study only estimates costs incurred by hospitals and emergency medical transportation providers, not physicians. The majority of services delivered by a physician in a hospital's emergency department are not paid by or through the hospital, but are billed separately and cannot be captured by examining uncompensated hospital costs. Therefore, costs incurred by physicians attending an undocumented immigrant in a medical emergency are not included in our cost estimate.

<http://www.bordercounties.org/vertical/Sites/%7BB4A0F1FF-7823-4C95-8D7A-F5E400063C73%7D/uploads/%7BFAC57FA3-B310-4418-B2E7-B68A89976DC1%7D.PDF>

Language Access

Paying For Language Services in Medicare: Preliminary Options and Recommendations

Center on Budget and Policy Priorities

October 2006

This report discusses how the federal government could design payment systems for language services in Medicare. Medicare has a number of complex payment systems for inpatient hospital care, outpatient hospital services, physician visits, managed care and other services. A method of paying for language services that works in one Medicare payment system may not be feasible or appropriate for another. This paper reviews information about current approaches to pay for language services, current Medicare payment systems and principles that could be considered in designing payment systems for language services. It then reviews a number of options for inpatient and outpatient hospital systems, physician services and managed care plans.

http://www.kaisernetwork.org/health_cast/uploaded_files/Issue_Brief_on_Medicare_and_Language.pdf

Language Services Resource Guide

National Health Law Program

October 2006

In 2003, the National Health Law Program convened national organizations interested in working together on language access issues, recognizing that the ultimate goal in the health care setting is effective communication between provider and patient. This guide, developed with input from the coalition, gathers basic information about providing language services in one document. Information includes interpreter and translator associations and agencies, training programs, assessment tools, and other materials.

<http://www.calendow.org/reference/publications/pdf/cultural/ResourceGuideFinal.pdf>

Hospital Language Services for Patients with Limited English Proficiency: Results from a National Survey

Health Research and Education Trust & National Health Law Program

October 2006

In 2005-2006, the Health Research and Educational Trust (HRET) The American Hospital Association, and the National Health Law program collaborated to conduct a study on patient language services in Hospitals. The report describes current practices, common barriers, and the specific resources and tools needed to provide language services to patients with limited English proficiency (LEP). The following are some of the key findings:

- Sixty-three percent of hospitals encountered patients with LEP either daily or weekly and an additional 17 percent encountered them at least monthly.
- Eighty-two percent of hospitals indicated that staff interpreters were the most frequently used resources for providing language services.
- Ninety-two percent of hospitals indicated that telephonic services were the most available resource for providing language services during off-hours. Eighty-eight percent of hospitals reported providing language services during off-hours.
- Of the three percent of hospitals that received reimbursement, 78 percent reported receiving reimbursement from Medicaid.
- The most frequent barrier facing hospitals was not being able to identify LEP patients before they arrived at the hospital.
- Hospitals indicated that staff would find packaged in-service programs and model approaches and best practices from other health care institutions helpful for providing language services to LEP patients. Training that hospital staff would find most useful for providing language services included how to respond to LEP patients and family members and cultural competency training.
- Thirty-three percent of hospitals were engaged in initiatives to improve language services and 72 of those engaged indicated that they would be willing to share information about their initiatives.

http://www.calendow.org/reference/publications/pdf/cultural/HRET_Language_Services_Brief.pdf

Interpretation: Estimates of the Cost of Interpretation Services for Connecticut Medicaid Recipients

Mathematica Policy Research, Inc.

August 2006

This report summarizes analyses that calculate the size of the limited English proficient population within Connecticut's Medicaid program. It also estimates the cost of providing these enrollees with face-to-face interpreters in compliance with federal laws and guidelines. Using a range of federal, state and local resources as well as qualitative and quantitative research methods, this report estimated that:

- Connecticut's Medicaid program covers 22,353 people with LEP.
- Limited English proficient Medicaid recipients use 4.6 percent of Medicaid services.
- Assuming that the state arranges for matching federal funds, the total expense to the Connecticut, Medicaid program would be \$2.35 million.
- The annual cost for providing interpreter services through Connecticut's Medicaid program would be \$4.7 million (the total of \$3.2 million for Medicaid managed care enrollees and \$1.5 million for Medicaid fee-for-service enrollees).
- Of the three mechanisms available to secure federal matching funds, it appears that the most advantageous mechanism would be for the state to reimburse interpreter services as a "covered expense" that would pay for 50 percent of the cost.

Further, contacts with Connecticut providers revealed that they do not track the number of limited English proficient patients they serve and are not aware of medical interpretation resources for these patients. In order to raise awareness of the need for and availability of interpreters, and create an effective system for implementing an interpretation program across provider types, a work group comprised of key stakeholders should be formed to

identify the: (1) obstacles to the provision of services, (2) successful approaches to meeting the needs of the limited English proficient community and (3) possible educational and outreach activities that could increase the use of existing services.

<http://www.gcir.org/new/reports/pdfs/limitenglishproficiency.pdf>

Obtaining Data on Patient Race, Ethnicity, and Primary Language in Health Care

Organizations: Current Challenges and Proposed Solutions

Health Services Research, Vol. 41, Issue 4, Part 1

August 2006

The objective of this research is to provide an overview of why health care organizations (HCOs) should collect race, ethnicity, and language data, review current practices, discuss the rationale for collecting this information directly from patients, and describe barriers and solutions. Principal findings indicate that hospitals and HCOs with data from their own institutions may be more likely to look at disparities in care, design targeted programs to improve quality of care, and provide patient-centered care. Yet data collection is fragmented and incomplete within and across organizations. A major factor affecting the quality of data is the lack of understanding about how best to collect this information from patients. The researchers conclude that if HCOs make a commitment to systematically collect race/ethnicity and language data from patients, it would be a major step in enhancing the ability of HCOs to monitor health care processes and outcomes for different population groups, target quality initiatives more efficiently and effectively, and provide patient-centered care.

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&list_uids=16899021&cmd=Retrieve&indexed=google

[Subscription required for access to full text.]

Summary of State Law Requirements Addressing Language Needs in Health Care

National Health Law Program

January 2006

State laws provide a source of potential protection for limited English proficient (LEP) persons. In recent years, state legislatures and administrative agencies have increasingly recognized the need for linguistically-appropriate health care and have adopted measures that require or encourage health and social service providers to overcome language barriers. Currently, 43 states have one or more laws addressing language access in health care settings (up from 40 states in July 2003). Some states' laws provide detailed guidance, while others note the importance of language access but do not specify the nature of the services that will be provided. California continues to have more laws addressing language access in health settings than any other state.

<http://www.healthlaw.org/library.cfm?fa=download&resourceID=79666&appView=folder&print>

[available for purchase]

Improving Cultural Competency in Children's Health Care: Expanding Perspectives

What practical changes in processes can make healthcare providers and the systems in which they work more effective in responding to the needs of diverse children? And how can health care delivery organizations track their progress? This report describes initial efforts to answer these questions and provides recommendations and findings from early pilot test results.

<http://www.calendow.org/reference/publications/pdf/cultural/NICHO%20Improving%20Cultural%20Competency%20in%20Children%27s%20Health%20Care.pdf>

Pay Now or Pay Later: Providing Interpreter Services in Health Care

Health Affairs, Vol. 24, No. 2

July 2005

March/April 2005

Research amply documents that language barriers impede access to health care, compromising quality of care, and increase the risk of adverse health outcomes among patients with limited English proficiency. Federal civil rights policy obligates health care providers to supply language services, but wide gaps persist because insurers typically do not pay for interpreters, among other reasons. Health care financing policies should reinforce existing medical research and legal policies: Payers, including Medicaid, Medicare, and private insurers, should develop mechanisms to pay for interpretation services for patients who speak limited English.

<http://content.healthaffairs.org/cgi/content/abstract/24/2/435>

[Subscription required for access to full text.]

HIPAA and Language Services in Health Care

National Health Law Program

March 2005

In 1996, the Health Insurance Portability and Accountability Act (HIPAA) became law and began to reshape how patients and healthcare providers think about the privacy of patient information. For interpreters who work in health care settings, it is important to understand how the patient privacy requirements of HIPAA affect their work and conduct. It was not until April, 2003, that the regulations outlining health privacy protections became fully operational. The “privacy rule” provides a set of minimum national standards that limit the ways that health plans, pharmacies, hospitals, clinicians, and others (called “covered entities”) can use patients’ personal medical information. As stated by the Department of Health and Human Services, “A major goal of the Privacy Rule is to assure that individuals’ health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public’s health and well being.” The regulations protect medical records and other individually identifiable health information, whether it is on paper, in computers or communicated orally. The responsibility to abide by HIPAA binds the covered entity not only to ensure that its own staff protect patient privacy but also that anyone who it “controls” (such as volunteers) and with whom it contracts (called “business associates”) follows these regulations. Thus interpreters who work in health care settings – whether as an employee, independent contractor or volunteer – are generally required to uphold the HIPAA privacy regulations. The purpose of this memo is to explain HIPAA and its application to interpretation provided in health care settings.

<http://www.healthlaw.org/library.cfm?fa=detailItem&fromFa=summarize&id=72774&appView=Topic&r=folderid--23177,fa--summarize,appview--topic,rootfolder--23177,id--133>

3

Straight Talk: Model Hospital Policies and Procedures on Language Access

California Health Care Safety Net Institute

2005

This document is designed to offer American hospitals a set of tools to utilize in updating their own internal Policy and Procedure Manuals. Drawing on the expertise and generosity of “Best Practice” hospitals from around the nation, this document also incorporates some new and innovative operational procedures. For example, while many hospital systems have policies affirming access of LEP patients to interpreters, the ability of staff to actually access

those services is often impeded by outdated procedural mechanisms. These Model Policies and Procedures address this issue by ensuring that access to interpreter services is readily available to frontline practitioners. While the study, review and creation of these Model Policies and Procedures was based primarily on California public hospitals, this Model is applicable and adaptable to the entire U.S. hospital industry. The only significant distinguishing feature required in the adoption of these procedures in a state other than California is to ensure that state specific laws and regulations regarding language access in health care settings have been incorporated and referenced. In addition, local counties and cities may have additional ordinances which should be considered. Every hospital system will want to incorporate additional specifics in the procedural sections addressing the details of departments to contact and steps to follow in accessing language services.

<http://www.calendow.org/reference/publications/pdf/cultural/SNI%20CAPH%20Model%20Hospital%20Policies%20and%20Procedures.pdf>

Congressional Briefing: The Growing Need for Language Services

National Health Law Program

December 2004

In this briefing, key statistics about the limited English proficient (LEP) population were presented to demonstrate the growing number of people who need language services to navigate the complex health care system. It also presents key trends in the proportion of LEP populations in the states as well as the rate of growth in LEP populations in recent years.

<http://www.healthlaw.org/library.cfm?fa=detailItem&fromFa=summarize&id=72078&appView=Topic&r=appview--topic.id--1333,folderid--23177,rootfolder--23177,fa--summarize>

Enforcing Language Access Rights: Trends and Strategies

Clearinghouse Review: Journal of Poverty Law and Policy

Sept/Oct 2004

Equal access to governmental activities is necessary. In large part people with limited English proficiency do not have equal access. In this article the authors suggest some strategies and offer examples of programs working to achieve more access. They review the federal law on language access and describe some programs' advocacy to maximize such access. Jane Perkins discusses recent federal court trends on the enforceability of federal obligations to provide language access. Mary R. Mannix describes advocacy efforts to secure language access in public benefit programs and a new Welfare Law Center project which aims to ensure that welfare agencies and private contractors delivering welfare and related services provide language access. Jack Daniel and Wanda Hasadsri describe California Rural Legal Assistance's strategies based on state law.

<http://www.healthlaw.org/library.cfm?fa=detailItem&fromFa=summarize&id=76299&appView=Topic&r=folderid--23177,fa--summarize.appview--topic,rootfolder--23177,id--1333>

Overcoming Language Barriers in Health Care

American Journal of Public Health, Vol. 94, No. 5

May 2004

Objectives. The authors assessed the impact of interpreter services on the cost and the utilization of health care services among patients with limited English proficiency. Methods. They measured the change in delivery and cost of care provided to patients enrolled in a health maintenance organization before and after interpreter services were implemented.

Results. Compared with English-speaking patients, patients who used the interpreter services received significantly more recommended preventive services, made more office visits, and had more prescriptions written and filled. The estimated cost of providing interpreter services was \$279 per person per year.

Conclusions. Providing interpreter services is a financially viable method for enhancing delivery of health care to patients with limited English proficiency.

[http://www.ajph.org/cgi/reprint/94/5/866?maxtoshow=&HITS=10&hits=10&RESULTFO
RMAT=&fulltext=Overcoming+Language+Barriers+in+Health+Care&andorexactfulltext=an
d&searchid=1&FIRSTINDEX=0&sortspec=relevance&resourcetype=HWCIT](http://www.ajph.org/cgi/reprint/94/5/866?maxtoshow=&HITS=10&hits=10&RESULTFO
RMAT=&fulltext=Overcoming+Language+Barriers+in+Health+Care&andorexactfulltext=an
d&searchid=1&FIRSTINDEX=0&sortspec=relevance&resourcetype=HWCIT)

Immigrant Health: Selectivity and Acculturation

The Institute for Fiscal Studies

January 2004

There is renewed concern that in spite of overall improvements in health racial and ethnic disparities in health persist and in some cases may even have expanded. Identifying the determinants of the original health selection of migrants and the forces that shape health paths following immigration is critical to understanding ethnic health differences. This paper is divided into six sections. Section 1 provides a simple descriptive comparison of some salient health outcomes of foreign born and domestic born Americans. Relying on the existing scientific literature, the section that follows highlights some key findings and the hypotheses these findings generate about the health status of foreign-born population. Two of the more central questions that have emerged involve the mechanisms shaping health selectivity and the determinants of health trajectories following immigration. With this in mind, section 3 outlines some simple theoretical models of health selectivity of immigrants and their subsequent health trajectories following immigration. Section 4 uses data from the New Immigrant Survey to provide new information on the diversity of health outcomes of new legal immigrants to the United States. New empirical models that estimate the determinants of health selectivity and health trajectories following immigration are presented in section 5. The final section summarizes our views on the principal research and public policy questions about immigrant health that are high priority. It also contains our recommendations about how scientific funding agencies may best go about assisting the research community in answering these questions.

<http://www.ifs.org.uk/wps/wp0423.pdf>

In the Right Words: Addressing Language and Culture in Providing Health Care

Issue Brief No. 18

August 2003

Grantmakers in Health

This Issue Brief synthesizes key points from the day's discussion with a background paper previously prepared for Issue Dialogue participants. It focuses on the challenges and opportunities involved with ensuring language access for the growing number of people who require it. Sections include: recent immigration trends and demographic changes; the effect of language barriers on health outcomes and health care processes; laws and policies regarding the provision of language services to patients, including an overview of public financing mechanisms; strategies for improving language access, including enhancing access in delivery settings, promoting advocacy and policy change, improving interpreter training, and advancing research; and roles for foundations in supporting improved language access, including examples of current activities.

[http://www.calendow.org/reference/publications/pdf/cultural/TCE0811-
2002 In the Right W.pdf](http://www.calendow.org/reference/publications/pdf/cultural/TCE0811-
2002%20In%20the%20Right%20W.pdf)

Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities

National Health Law Program

August 2003

This comprehensive manual (a revision of the 1998 original) shows advocates and providers how to overcome language barriers to obtain appropriate medical care for their clients. It outlines language access responsibilities under federal and state law, as well as in the private sector, and offers recommendations for addressing identified problems. Over 46 million people (more than 17 percent of the United States population) speak a language other than English at home. It is critical that the growing numbers of limited English proficient (LEP) residents be able to communicate with their health care providers. Accurate communication ensures the correct exchange of information, allows patients to provide informed consent for treatment, and avoids breaches of patient-provider confidentiality. This manual is designed to assist advocates, policy makers, and providers in understanding the current status of language access and the legal protections that govern it. Baseline facts, checklists, and legal/policy recommendations are highlighted throughout.

<http://www.healthlaw.org/library.cfm?fa=download&resourceID=79554&appView=folder&print>

[Available for purchase]

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http://www.calendow.org/reference/publications/pdf/cultural/TCE0811-2002_In_the_Right_W.pdf

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<http://www.healthlaw.org/library.cfm?fa=download&resourceID=79554&appView=folder&print>

[Available for purchase]

Improving Access to Health Care For Limited English Proficient Health Care Consumers: Options For Federal Funding For Language Assistance Services

Health In Brief, Vol. 2 Issue 1

April 2003

The California Endowment

Health providers that receive federal funding may not discriminate against Limited English Proficient health care consumers. In California, there are other requirements for managed health care plans to provide culturally and linguistically appropriate services. While many providers believe that language assistance services are costly, they often overlook the costs of not providing such services as a result of decreased patient satisfaction, medical errors and avoidable complications (and increased health care costs) arising from miscommunication. There are several options to obtain federal funding for language assistance services. This brief identifies policy options for California that would allow the state, health plans and providers to maximize federal funding. This brief also provides an in-depth analysis of how eight states have used federal funding to help implement language assistance services for Limited English Proficient health care consumers

http://www.calendow.org/reference/publications/pdf/cultural/TCE0416-2003_Health_In_Brief.pdf

Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters

Pediatrics, Vol. 111, No. 1

January 2003

Background. About 19 million people in the United States are limited in English proficiency, but little is known about the frequency and potential clinical consequences of errors in medical interpretation.

Objectives. To determine the frequency, categories, and potential clinical consequences of errors in medical interpretation.

Methods. During a 7-month period, the authors audiotaped and transcribed pediatric encounters in a hospital outpatient clinic in which a Spanish interpreter was used. For each transcript, they categorized each error in medical interpretation and determined whether errors had a potential clinical consequence.

Results. Thirteen encounters yielded 474 pages of transcripts. Professional hospital interpreters were present for 6 encounters; ad hoc interpreters included nurses, social workers, and an 11-year-old sibling. Three hundred ninety-six interpreter errors were noted, with a mean of 31 per encounter. The most common error type was omission (52%), followed by false fluency (16%), substitution (13%), editorialization (10%), and addition (8%). Sixty-three percent of all errors had potential clinical consequences, with a mean of 19 per encounter. Errors committed by ad hoc interpreters were significantly more likely to be errors of potential clinical consequence than those committed by hospital interpreters (77% vs 53%). Errors of clinical consequence included: 1) omitting questions about drug allergies; 2) omitting instructions on the dose, frequency, and duration of antibiotics and rehydration fluids; 3) adding that hydrocortisone cream must be applied to the entire body, instead

of only to facial rash; 4) instructing a mother not to answer personal questions; 5) omitting that a child was already swabbed for a stool culture; and 6) instructing a mother to put amoxicillin in both ears for treatment of otitis media.

Conclusions. Errors in medical interpretation are common, averaging 31 per clinical encounter, and omissions are the most frequent type. Most errors have potential clinical consequences, and those committed by ad hoc interpreters are significantly more likely to have potential clinical consequences than those committed by hospital interpreters. Because errors by ad hoc interpreters are more likely to have potential clinical consequences, third-party reimbursement for trained interpreter services should be considered for patients with limited English proficiency.

<http://pediatrics.aappublications.org/cgi/reprint/111/1/6>

Providing Language Interpretation Services in Health Care Settings: Examples from the Field

National Health Law Program

May 2002

Health care providers have raised legitimate concerns about providing language services for patients with LEP. To address some of these concerns, the National Health Law Program, with funding from The Commonwealth Fund, undertook an assessment of programs under way to improve access to interpreter services in health care settings. It examined several different methods of providing oral interpretation, including using bilingual providers/staff, hiring staff interpreters, contracting with qualified interpreters, and creating interpreter pools. Because of time and cost limitations, this report does not address translation of written materials, interpretation in government offices, or other promising practices regarding, for example, cultural competency or ensuring language concordance between providers and patients. The National Health Law Program developed a short survey instrument and distributed it to interested organizations nationwide during the fall of 2001 and winter of 2002. From the completed surveys, 14 programs and projects were selected for more in-depth assessment. Programs were selected to reflect a range of interpreter services in different health care settings, funding sources, and costs of implementation. Programs profiled in this report include those sponsored by state and local governments, managed care organizations, hospitals, community-based organizations, and educators.

http://www.cmwf.org/usr_doc/youdelman_languageinterp_541.pdf

What a Difference an Interpreter Can Make: Health Care Experiences of Uninsured with Limited English Proficiency

The Access Project

April 2002

This report, based on a survey of 4,161 uninsured respondents who received health care between May and August of 2000 at 23 primarily safety net hospitals in 16 cities, compares the perceptions and experiences of adults who needed and easily got an interpreter with those who needed and did not get an interpreter (or had difficulty getting one), and with other uninsured who did not need an interpreter. Overall, the uninsured who got an interpreter had similar or more positive experiences at the hospital where they received care than the uninsured without language barriers. However, adults who needed and did not get an interpreter had more negative perceptions about their health care experiences than those who either got interpreter services or did not need them.

<http://www.healthlaw.org/library.cfm?fa=detailItem&fromFa=summarize&id=69328&appView=Topic&r=appview~~topic.folderid~~23177,fa~~summarize.id~~1342,rootfolder~~2317>

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Report to Congress. Assessment of the Total Benefits and Costs of Implementing Executive Order No. 13166: Improving Access to Services for Persons with Limited English Proficiency

Office of Management and Budget

14 March 2002

This report focuses on the benefits and costs of providing language-assistance services to LEP persons pursuant to Executive Order 13166 and the Title VI regulations. Under the Executive Order, “[e]ach Federal agency shall prepare a plan to improve access to its federally conducted programs and activities by eligible LEP persons.” In addition, “[e]ach agency providing Federal financial assistance [to hospitals, universities or a myriad of other state and other entities] shall draft Title VI guidance.” Based upon the limited data available and the range of assumptions set forth herein, the anticipated cost of LEP assistance, both to government and to the United States economy, could be substantial, particularly if the Executive Order is implemented in a way that does not provide uniform, consistent guidance to the entities that it covers. Of the economic sectors examined in the report, provision of language services could be most costly for the healthcare sector. This conclusion is tempered by the fact that many government agencies and private entities that serve a significant LEP population have already taken certain steps to provide language services. To the extent that such services are already being provided, the economic impact of implementing the Executive Order will depend upon the cost of any additional steps taken. Unfortunately, there was insufficient data to make a proper determination regarding current levels of language assistance provided by these entities, and the report does not take into account in the cost estimates current levels of language assistance. Accordingly, the estimates herein address the overall cost of LEP assistance, not the possible additional costs that may ultimately be required to implement the Executive Order and agency guidance.

<http://www.whitehouse.gov/OMB/inforeg/lepfinal3-14.pdf>

U.S.-Mexico Health Insurance

Proposed California Strategy for Binational Health Insurance

California-Mexico Health Initiative

Binational Health Insurance is a concept that arose due to the intense need for an insurance that would cover Mexican immigrants and their families. Over half of the 10 million Mexican immigrants in the U.S. lack health insurance. Among unauthorized immigrants the number is higher: 70% of them do not have health insurance. Binational Health Insurance would build on existing health insurance infrastructures in Mexico and California. This new product would result from a working partnership between private insurers in the U.S. and public providers in Mexico.

Component I: Preventive and ambulatory health care in the U.S. Private insurers will offer this coverage to Mexican immigrants living in the U.S. and to their dependents living in the U.S. Two public providers, Popular Insurance (PI) and the Social Security Institute (IMSS) will offer this coverage in Mexico.

Component II: Services that require hospitalization will not be covered in the U.S. In order to control costs and create an affordable product, hospitalization services in the U.S. would be excluded from the plan’s coverage. They will continue to be provided through the existing safety net system in California. They will be provided in Mexico for dependents.

Component III: Catastrophic coverage for tertiary care services (e.g. transplants, chemotherapy). These services will be provided in Mexico through Seguro Popular (Popular

Insurance) and/or the Mexican Social Security Institute (IMSS). This component will provide, with a deductible, transportation costs to Mexico for patients to receive these services.

<http://www.ucop.edu/cmhi/documents/binationalinsurpro.pdf>

Willingness to Pay for Cross-Border Health Insurance between the United States and Mexico

California Policy Research Center

August 2006

The Mexican-born population residing in the United States has the lowest health insurance coverage rate (55 percent) among the foreign-born. This lack of health insurance coverage may be associated with poor health outcomes and slower improvements in socioeconomic status. Since the 1990s, governmental, business and not-for-profit organizations from the U.S. and Mexico have been working together to develop alternatives for cross-border health insurance. Although California approved a related legislation in 1998, the number of enrollees into these plans remains low. To estimate the potential demand for cross-border insurance, this paper analyzes the results of a survey that used a closed-ended (yes/no) format to determine the Willingness-to-Pay (WTP) for health insurance between the U.S. and Mexico. The results show that 62 percent of the surveyed population was interested in a product that offered preventive and ambulatory care in the U.S. and comprehensive care in México, though only 57 percent was WTP \$75 to \$125 USD a month, if this health plan offered services in Mexico through public providers. Only 23 percent were willing to pay \$150 to \$250 USD a month for the same plan, if services in Mexico were offered through private providers. Consistent with previous findings in the literature, several variables showed to be related with the WTP, such as income or age. Using Logit and OLS specifications, the two strongest predictors of WTP for such a product were: i) Having insured dependents in Mexico increased WTP by 11-12 percent, and ii) Sending remittances for health purposes increased this probability in 12-14 percent. Since the Mexican born represent almost 60 percent (7 million) of the total number of unauthorized immigrants in the U.S., the eventual regularization of these workers is discussed here. It concludes that cross-border insurance can be an alternative for health coverage under a new guest-worker program or a possibility to extend health insurance coverage among first generation immigrants under an amnesty program.

http://www.ucop.edu/cmhi/documents/wtp_binatins.pdf

U.S.-Mexico Border Health Issues

U.S. – Mexico Border Health Commission 2005 Annual Report

The United States-Mexico Border Health Commission Act establishes a binational commission to conduct a comprehensive needs assessment in the U.S.-Mexico border area to identify, evaluate, prevent, and resolve health problems and potential health problems that affect the general population of the area and to implement the actions recommended by the needs assessment. The commission was established in 2000. Section seven of the act requires the commission to submit annual reports regarding all activities of the commission. The 2005 Annual Report outlines the activities of the ten regional offices, various programs of the commission such as the Binational Tuberculosis Card Project, and notable border and binational events.

http://www.borderhealth.org/files/res_589.pdf

Healthy Border 2010: An Agenda for Improving Health on the United States-Mexico Border

U.S. – Mexico Border Health Commission

The Healthy Border Program establishes 10-year objectives for binational health promotion and disease prevention in the border region. It is the first binational program that embraces common health elements from the United States and Mexico. From the United States it draws on the 1998 Healthy *Gente* Program, which provides health objectives for the United States region that borders Mexico and uses the framework of Healthy People. From Mexico it draws on the National Health Indicators (Indicadores de Resultado) Program, which tracks health measures at Mexico's national, state, and local levels. As an agenda for improving health on the border, the program has two overarching goals:

- Increase and improve the quality of life and years of healthy life
- Eliminate health disparities

The report outlines a 10-year bilateral agenda for the Healthy Border Program, providing year 2000 baseline data and year 2010 targets. Through this program, the Commission and its partners will identify and prioritize health issues, support and design public health programs that are unique for the border, and track progress toward the goals and objectives. The Healthy Border Program will also serve to promote cross-border collaboration.

http://www.borderhealth.org/files/res_63.pdf

Binational Health Week: Mobilizing Existing Networks and Resources to Focus on Migrant Health Care Issues

The California Health Initiative

12 August 2006

The California-Mexico Health Initiative, a program of the California Policy Research Center, University of California Office of the President, endorsed by the Mexican government and funded primarily by The California Endowment, has been the sponsor of a highly focused annual effort that seeks to reduce health disparities and improve access to care for the low income population of Mexican origin in the U.S. as well as in their places of origin. This innovative strategy, called Binational Health Week (BHW), seeks to mobilize existing networks and resources in a highly-organized, synergistic effort that result in significant and concrete improvements that do not require major infrastructural changes. The strength of BHW — as well as its weakness — is that it relies on volunteer contributions of more than 300 organizations that all come together once a year to provide services to this highly underserved population. During BHW this year, these organizations provided services to over 70,000 people throughout 22 counties of California and 8 states of Mexico with high migration rates.

<http://www.ucop.edu/cmhi/documents/bhwmobilizingnetworks.pdf>

Shared Destiny: Shaping a Binational Agenda for Health Priorities in the San Diego-Baja Region

International Community Foundation

May 2006

This Report highlights existing cross-border health deficits in the San Diego-Baja California border region, particularly in the areas of health care access and disease risks and identifies existing institutional barriers that are currently inhibiting expanded cross-border health coverage today. The report identifies that the need for expanded cross-border health services is now more urgent than ever before and this need now goes beyond existing border area residents to the growing number of fixed income Americans now retiring in Baja California

due to economic reasons. In an effort to offer practical solutions to overcome existing barriers this report offers a strategic agenda for improving the quality of cross-border health. Beyond the well acknowledged need to expand cross-border health research and to promote regulatory reform, the agenda includes the following specific recommendations: improve the leveraging of technology, particularly in the area of telemedicine; expand emergency cross-border health services; formalize cross-border anti-human trafficking protection teams; re design disease-specific programs in the border area; and move beyond crisis to prevention as a strategy to expand the level of financing of cross-border health services.

<http://www.calendow.org/reference/publications/pdf/cultural/ICF-shared-destiny-report-final.pdf>

Mexican and Central American Immigrants in the United States: Health Care Access

University of California, Mexican Secretariat of Health 2006

The Mexican Ministry of Health, the University of California (through the California-Mexico Health Initiative of the California Policy Research Center, Office of the President), the UCLA Center for Health Policy Research and The California Endowment have commissioned this document so as to present an objective, comprehensive overview of health-related matters faced by Mexican and Central American residents while in the United States. The document focuses on the population of Mexican ancestry in the United States and in California, with an emphasis on immigrants. Beginning with the numbers, trends, and sociodemographic characteristics of this population, it goes on to depict their geographic dispersion across the U.S., the economic and social importance of remittances sent back to Mexico, their social conditions, and their medical insurance coverage. It also includes a brief description of the Central American immigrant population and their situation regarding access to health services. It concludes with some final remarks about the main characteristics of Mexican and Central American immigrants, to be considered in any new strategies designed to increase their access to health insurance.

http://www.ucop.edu/cmhi/documents/hlthcareaccess2006_eng.pdf

Mexico-United States Migration: Health Issues

Consejo Nacional de Población October 2005

The fundamental purpose of “Mexico-United States Migration: Health issues” is to present a general overview of the conditions faced by Mexican residents in the United States concerning their health care. The document begins by describing the volume, trends, and characteristics of Mexican migration to the United States. It then addresses specific questions on migrant health, such as the availability of medical insurance coverage, the main ailments this population suffers, and access to and use of medical services. Finally, some consideration is given to the implications of the prevailing situation, conditions requiring special attention are identified, and the main political challenges are noted. This report is a binational effort.

http://www.ucop.edu/cmhi/documents/migrationreport_conapo.pdf

Theorizing Cross Border Interventions: The California-Mexico Health Initiative

The California-Mexico Health Initiative 9 April 2005

This paper discusses the four-year-old California-Mexico Health Initiative; located at the California Policy Research Center, part of the University of California’s Office of the President. The Initiative has organized three sets of activities. Binational Health Week, a political and educational “fiesta” that focuses on migrant health issues that entails the mobilization of community and government resources to improve migrants’ health in the

United States as well as that of their families in Mexico. Secondly, the Initiative sponsors scholarly forums that present state of the art research findings on migration and health issues by scholars from both countries and rotates the sites between Mexico and the United States. Third, the Initiative has formed institutional collaborations between the Mexican and Californian health administrations. Funding for these activities comes from a variety of private and university sources as well as the United States-Mexico Border Health Commission. Previous research suggests that costliness and lack of resources are key limitations to the establishment of state policies that integrate migrant subjects. The authors suggest that an additional challenge exists in the transnational travel of concepts regarding health care delivery between Mexico and the United States as well as the politics of collaboration between the two countries.

http://www.ucop.edu/cmhi/documents/theorizingcross_borderinterventions.pdf

HIV/AIDS Among Mexican Migrants and Recent Immigrants in California and Mexico

Journal of AIDS, Vol. 37, Supplement 4

1 November 2004

This special issue contains original review articles by researchers from the University of California and the Secretariat of Health of Mexico. The articles on epidemiology, prevention, and health care services review available published data and selected unpublished data on Mexican migrants in California specifically and across the United States. These articles identify research and intervention needs and, where available, document effective methods of outreach and interventions with the Mexican migrant population. An article addressing the issue within Mexico outlines the emerging data on the vulnerability of Mexicans migrating to the United States with regard to HIV, sexually transmitted diseases, and associated behaviors. Lastly, a concluding article presents an analysis of policies that serve as barriers or facilitators of prevention and care for Mexican migrants in California. All the articles offer compelling evidence for integrating tailored outreach, prevention, and health care services for the Mexican migrant population into the overall health care infrastructure of communities in California and Mexico.

<http://www.ucop.edu/cmhi/documents/jaidsnov2004.pdf>

The Health of the California Region Bordering Mexico

Journal of Immigrant Health, Vol. 6, No. 3

June 2004

Healthy Border (HB) 2010 is the health promotion and disease prevention agenda through the year 2010 of the United States–Mexico Border Health Commission (BHC). On the United States side, it draws from the Healthy People (HP) 2010 objectives, identifying those most important and relevant for the border. The BHC has harmonized the list of objectives from both countries into a set of 19 that will be monitored and addressed in a collaborative manner. HB provides a framework for describing the border region's health and comparing with others. For this report, available data were collected for the HB indicators for San Diego and Imperial counties, and for California. Data on Latino populations were considered a proxy for Mexican-Americans and people of Mexican origin in California, because more specific data are not available. Results are presented on the 14 indicators for which the data were most complete. Those of most concern include access to health care and tuberculosis in both counties, plus motor vehicle crash injury deaths and asthma hospitalizations in Imperial. These issues should be given priority attention. Conversely, the region's and Latinos' experience with breast cancer mortality and infant mortality is favorable. Recommendations include binational collaborations in assessing and improving the health of our border communities.

<http://www.dhs.ca.gov/ps/dcdc/COBBH/docs/PP1210-485160137-144.pdf>

[Unpublished version; Subscription required for access to full text.]

Foundation Approaches to U.S.-Mexico Border and Binational Health Funding

Health Affairs, Vol.21, No.4

July/August 2002

This special report highlights government and foundation initiatives responding to the health needs that exist along the U.S.-Mexico border. Some of these initiatives include regional preventive services, community outreach programs, and improved water quality in the poorest neighborhoods. Efforts include multisectoral collaboration including universities, foundations, and other non-profit organizations.

<http://content.healthaffairs.org/cgi/reprint/21/4/271>

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