# Access to Health Insurance and Health Care For Latinos in Washington State

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## INTRODUCTION

My research is looking at the access to health insurance and access to health care for Latinos in Washington State. Generally, my research aims to provide a general picture of the extent to which the health needs of the Latino community in Washington are being met. Specifically, I examine the rates of health insurance coverage within the Latino community and some possible causal factors that might help to explain those rates. In addition, I aim to present a general picture of the access to health care services within the Latino community in Washington. Much of the following information comes from studies and reports compiled in recent years by a number of scholars, medical professionals and health-oriented organizations. The Henry J. Kaiser Foundation, the U.S. Census Bureau, and the Washington State Department of Health have been particularly helpful in this regard. Another important source of information has come from a local partnership with two medical professionals Dr. Christopher Hall and Benita Aguilar who work at the Walla Walla Clinic. They have provided me with valuable information regarding the intricacies of issues relating to health insurance coverage and have been helpful in explaining local health issues facing the Latino community. They have also been instrumental in contacting local community members for participation in interviews, which also serve as a source of information for this project.

Latinos are more likely to be uninsured than any other racial/ethnic group in the U.S. A number of factors might explain these unusually high rates, including (but not limited to) employment status, income levels and legal status. This lack of insurance, in concert with cultural and/or language barriers, prevents many Latinos from receiving quality health care.

## METHODS

*Relevant Literature and Databases*

While most of the information I have gathered for this project has come from reports and surveys, I have also found academic studies useful. For the most part, these studies serve to confirm the information presented in the following Data section. Some aim to explain the lack of access to insurance and/or care by examining a specific causal factor (such as employer-based insurance), while others document Latino experiences in particular medical settings. Where they seem to be especially useful is in providing suggestions for policy changes that might address some of the specific health issues of the Latino community. Below is a brief discussion of some of the studies that have been particularly informative for this project.

One study shows that racial/ethnic and linguistic minorities face barriers to receiving care, despite efforts to relieve financial barriers through Medicaid services. Both Spanish-speaking and English-speaking Latinos were more likely to report negative experiences with a medical professional than whites.[1] These findings are echoed in the Data section, especially in *Figures 13-15*. A study by Patricia Docúmet and Ravi Sharma on access to health insurance and care among Latinos in Southwestern Pennsylvania notes the importance of recognizing *cultural barriers* to insurance and care. While documenting the more researched financial barriers to insurance and care they also point out that, "even if all had health insurance and no attention was given to cultural issues, there would still be large racial/ethnic disparities in access to health care."[2] Another study examines the extent to which *legal status* serves as a deterrent to seeking care. The study, which sampled undocumented residents in Houston, El Paso, Los Angeles and Fresno, found that 39% of undocumented Latino adults had been afraid of not receiving medical services because of their legal status.[3] When this fear is coupled with the overwhelming uninsured rate of undocumented Latinos (see Data section, *Figure 7*), it is reasonable to assume that many of the health needs of the undocumented community go unmet. Finally, a study by Richard Brown and Hongjian Yu illustrates the comparatively low rates of employer-based insurance coverage among Latinos. They cite a number of factors that might explain this gap, including age, educational attainment, *employment status* and *level of poverty*.[4]

While these studies help to articulate the conditions facing Latinos in the nation as a whole, it has become evident that there have been few (if any) studies conducted that directly address the lack of insurance and access to care among Latinos in Washington State. While there is a wealth of information of Latino experience in regions with more concentrated Latino populations (such as California or Texas), relatively little addresses the specific health issues of the Latino community in Washington.

The most useful source I have located for quantitative data has been the Henry J. Kaiser Family Foundation. Their online database is the most extensive I have found

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[1] Robert Weech-Maldonado, et al, "Race/ethnicity, Language and Patients' Assessments of Care in Medicaid and Managed Care," *Health Services Research* (June 2003) v38 i3, p789(20).

[2] Patricia Docúmet and Ravi Sharma, "Latinos' Health Care Access: Financial and Cultural Barriers," *Journal of Immigrant Health* (January 2004) v6 no1.

[3] Marc L. Beck and Claudia L. Schur, "The Effect of Fear on Access to Care Among Undocumented Latino Immigrants," *Journal of Immigrant Health* (July 2001) v3 no3.

[4] Richared Brown and Hongjian Yu, "Latino's Access to Employment-Based Health Insurance," p244.

regarding health related issues. In addition to having an entire department focused on Medicaid and the Uninsured, they have funded numerous in depth reports on racial/ethnic disparities in health care. In addition, they provide recent state and national statistics regarding insurance coverage and access to health care, including information on the many factors that affect access to insurance and care, such as employment status, income relative to the federal poverty level (FPL), and legal status.

The Washington State Department of Health has also been a valuable resource for information. Navigating their webpage and related links, I have found many informative statistics and reports, particularly regarding Latino's access to health care in the state. I have also found useful information from the U.S. Census Bureau, U.S. Department of Health and Human Services and Hispanic-oriented organizations like the National Council of La Raza (NCLR).

*Focus of Data Section*

The above mentioned resources have been instrumental in locating the specific areas of focus for this project. Based on the existing research, I have organized the Data section of my report into two parts. The first part examines the levels of health insurance coverage for Latinos. Due to previous findings, I have chosen three potential causal factors that are extremely important in determining whether Latinos have health insurance: *employment status*, *poverty* and *legal status*. *Employment status* refers to the amount of time one works (i.e. full time, part-time, etc.) as well as where one works (industry and firm size) and what position one occupies (high-skill, low-skill, etc.). All of these interrelated markers of employment status have an affect on whether one receives health insurance from their employer, which is the most common source of health insurance coverage for all Americans. The *poverty* section details the extent to which poverty within the Latino community affects rates of insurance. Poverty is measured by income in relation to the federal poverty level (FPL). Families who have annual incomes at or below 200% of the FPL are considered low-income. The *legal status* section examines the differences in health insurance coverage among Latinos who are U.S. born citizens, naturalized citizens, legal residents and undocumented residents.

The second part of the data section examines access to health care for Latinos. I focus on two factors that often limit or restrict Latino access to health care services: *lack of health insurance* and *language barriers*. The *lack of insurance* section will examine the extent to which being uninsured deters Latinos from receiving or seeking care. The section on *language barriers* examines the extent to which lack of English proficiency for Spanish-speaking Latinos limits the services available to them and/or negatively affects the quality of care they receive. It also briefly analyzes the various barriers to quality care that exist as a result of cultural differences.

*Interviews*

The two interviews I have conducted were set up through my contacts Dr. Christopher Hall and Benita Aguilar at the Walla Walla Clinic. The first interview, with Señora Lopez, was conducted on Friday, October 14, 2005 at the Walla Walla Clinic. Fellow student Lázaro Carrion accompanied me as a translator. Due to time limitations, the entire interview was conducted in Spanish, without translation back into English. As a result, I became little more than an observer during the course of the interview. Lázaro

used my prepared questions and added some of his own where he deemed appropriate. The interview lasted about a half hour and was recorded. A woman named Mary, who works as an interpreter (among other things) for the Walla Walla Clinic was also on hand for the interview.

The second interview was conducted on Tuesday, November 1, 2005 at the Walla Walla Clinic with Señora Jimenez. An interpreter from the Walla Walla Clinic named Carolina was on hand to assist with the interview. I asked questions in English, Carolina translated them into Spanish for Señora Jimenez and then translated her answers back to English. The interview lasted roughly a half hour and was recorded.

The central motivation for including interviews as a source of information for this project is to provide specific individual examples that bring the statistics and academic theory presented in my report to life. I was particularly interested in the interviewees' personal experiences with racism and discrimination because of their race/ethnicity or because of their lack of English proficiency. I also hoped to highlight the intricacies of the health insurance system and the tremendous variety that exists between different providers as well as how adequately these insurance plans cover the health needs of their customers. For more information about the interviews used in this report please refer to the Interview Discussion section and the interview transcripts added as appendices A and B.

## DISCUSSION OF INTERVIEWS

*Health Insurance Coverage*

The two interviews I conducted with Señora Lopez and Señora Jimenez help confirm some of the findings presented in the Data section. In addition, they shed light on other factors that might affect Latino experiences in health care, especially with regard to access to quality care.

Both women were married to men who worked full-time and had young children. Neither Señora Lopez (who had worked in fast food restaurants in the past) nor her husband (I don't know where he worked) receive health insurance from their employers. This confirms the findings in the Data section which shows that Latinos are far less likely to receive employer-based health insurance than their white and black counterparts. Señora Lopez' statements also reinforce the statistics that claim that low-skilled, low-paying jobs are less likely to come with health benefits. Señora Jimenez, her husband (who works at Tyson) and one of her four children are covered by the group insurance plan offered by Tyson. Her other three children, including her youngest son who needs special counseling services, are covered under MOLINA. The fact that Señora Jimenez' husband is offered an insurance plan by Tyson is perhaps a reflection of the fact that larger firms are more likely to offer their employees health benefits than small firms (see *Figure 3*).

Although both women seemed to come from poor or working class backgrounds, neither cited any specific instances in which they did not seek care because of the costs (although Señora Jimenez did seem anxious about whether the costs of her son's counseling would be covered in the future). In both cases, public health insurance (MOLINA and Basic Health) effectively filled the void that otherwise might have existed given that both women are from presumably low-income families. Because of the sensitivity surrounding issues of legal status for some Latinos in the U.S., I did not ask the participants of these interviews about their legal status.

Interestingly, within both Señora Lopez' and Señora Jimenez' immediate families, there are different sources of insurance for different family members. As mentioned above, Señora Jimenez, her husband and one of her children are covered by her husband's employer-based insurance while her three other children are covered by Medicaid. In Señora Lopez' immediate family, she is insured under Washington State's Basic Health Plan (which provides subsidized health insurance to low-income individuals not eligible for Medicaid or Medicare), her two daughters are insured by MOLINA and her husband is uninsured. The fact that both families have numerous insurance providers indicates the complexities of the health insurance system in America. Needless to say, all of these separate plans and providers are often accompanied by confusion and frustration about what services are available to which family members and who can receive care at what facilities.

The level of coverage provided by the different insurance plans also varies greatly. Señora Lopez' husband, who is uninsured, has very little access to health services. He is forced to go to the Family Medical Center (a local community clinic that serves many Latinos in Walla Walla) on open clinic days, which usually happen once a week for a few hours. Señora Lopez, who is covered by Washington's Basic Health Plan, is also limited to receiving care at the Family Medical Center, however, she has more access to the medical professionals and health services at the clinic than her husband.

Señora Lopez' children have the most options available to them. Because they have MOLINA, Señora Lopez can choose their health care provider (although some clinics and hospitals are reluctant to accept Medicaid). They receive care at the Pediatrics department of the Walla Walla Clinic (where my community partners Dr. Hall and Benita Aguilar work).

Señora Jimenez highlighted the shortcomings of the insurance plans covering her family. Much of the information presented in the data section focuses on the rates of insurance among Latinos and the factors causing these rates. But another interesting component of insurance related issues is the coverage that is actually provided. The extent of coverage varies significantly from provider to provider, and particular plan to plan. The interview with Señora Jimenez illustrates the shortcomings of the insurance coverage that low-income people often receive (whether it's from their employer or the government). When Señora Jimenez went to the emergency room because of an eye infection, they told her that her insurance [she is covered under her husband's job-based insurance plan] would not cover the visit. She recalls: "They said my plan would only cover me if my illness was life threatening. In this case, they told me, you are not in a very dangerous situation. That's what they told me. This insurance only covers for emergencies. The people who have this insurance work very hard and it's not fair because the benefits are very restricted." Thus, the inadequate coverage provided by some employers, coupled with the low rates of insurance coverage among Latinos in general, can have profoundly negative effects on the quality of care many poor Latinos receive.

Señora Jimenez also drew attention to the limitations of coverage provided through MOLINA. Her son has some kind of mental illness and needs to see a psychologist on a regular basis but MOLINA has failed to cover the necessary number of visits. This is perhaps a reflection of the limited services that state-run Medicaid programs (like MOLINA) often offer to their customers. While Señora Lopez didn't want to go into specifics, throughout the interview she labeled her son's mental health issues as severe and in need of much treatment. However, under MOLINA, he is only covered for 13 visits a year. She became very emotional on a number of occasions as she began to speak of how badly he needs care from a specialist, and how unfair it is that MOLINA doesn't offer sufficient treatment to those it covers. She said:

> He needs a specialist, a psychologist, but MOLINA would only cover 13 sessions for the whole year. My son needs more than 13 sessions. The doctor said she knows for sure that my son needs more than 13 sessions… And I think it's not fair. Because this is a big problem and he needs help, but they won't cover it. It's not fair.

*Access to Care*

Both Señora Jimenez and Señora Lopez are Mexican Americans with limited English proficiency. As noted in the Data section, lack of English ability can have negative affects for Latinos with regard to accessing quality care. When I asked Señora Jimenez if she felt as though some medical professionals did not value her as a patient because of her race/ethnicity or lack of English proficiency, she replied that these were not really issues for her. She said that she has never felt like the language barrier has ever prevented her from receiving medical care or affected the quality of care she has received and noted that interpreters have always been provided for her. In contrast, when

Lázaro asked Señora Lopez a similar question about discrimination based on her race/ethnicity and/or her lack of English proficiency, she provided personal experiences of discrimination with regard to both.

Interestingly, the instance of racism she described occurred in an interaction with another Latina woman (a receptionist at the Family Medical Center). She had this to say about her experience with the receptionist while trying to get her daughter in to see a doctor: "I would call them [Family Medical Center] and ask for care for my daughter and they would tell me to wait until there was an available doctor. So I kept calling for a doctor but the racist receptionist wouldn't put me through." What is interesting here, and indeed troubling, is that there seems to be a current of racism among some of the more established Latinos in the Walla Walla community towards those who have come to the area more recently. When asked why she thought this problem of second and third generation Latino discrimination towards comparatively recent Latino immigrants existed, she replied: "I don't know, that's one thing I want to understand… It's an example of discrimination within one's race that exists not only in the clinics but everywhere. Instead of being united as Latinos—I can't believe people are like this. It's incredible really, how some people treat others." This inter-Latino racism (and perhaps classism as well) presents a barrier to accessing health care that is not discussed in the Data section of this report. More research on this issue is needed.

Señora Lopez also articulated experiences in which she felt discriminated against because she spoke Spanish. Although her stories about incidents at work do not deal directly with health care, they are still informative in as much as they provide an example of the kinds of discrimination Latinos often face in any number of social situations/interactions. She had the following to say about an encounter with a customer while she was working at McDonalds:

> One time, I was working at McDonalds and here comes a man and I wasn't offending him—nothing, nothing—and I was talking and asking a question to a co-worker in Spanish and he called me out and pointed at me and said, 'Here in my country one has to speak English.' And I told him, 'Why? This is a free country.' He said, 'But you have to speak English in this country… and I'm going to tell your manager to fire you.'

The above incident reflects the ways in which Spanish-speaking Latinos are often made to feel that they don't belong in the U.S. because they don't speak English. With respect to health care, when medical services are not provided in Spanish, some Latinos are made to feel that they can't access necessary resources. When asked if she thought she would receive better treatment if she spoke English she replied immediately, "Oh yes, I would defend myself right away. The treatment would be better." It is somewhat unclear in the context of the interview whether she is referring to her experiences at the Family Medical Center or whether she is referencing her experiences at work. But regardless, her statement strongly asserts that speaking English would make it easier for her to take care of her needs while receiving the respect and treatment she deserves.

## DISCUSSION OF FINDINGS AND RECOMMENDATIONS

In sum, as documented in the Data section, Latinos are more likely than any racial/ethnic group in the U.S. to lack health insurance. These high uninsured rates can be explained (at least in part) by the inter-related factors of employment status, poverty, and legal status. Lack of insurance presents one of the major barriers to accessing medical care. Due to the high costs of medical services, those without insurance often forgo medical care. However, as important as having health insurance is to receiving quality care, it isn't the only determining factor. Cultural issues and the language barrier also play a role in determining one's access to health care.

The interviews I conducted with Señora Lopez and Señora Jimenez confirmed many of the findings presented in the Data section. In addition, the interview with Señora Jimenez illustrated the limitations of some insurance plans. Whether private (i.e., employer-based) or public (i.e., MOLINA), many plans fail to adequately meet the health needs of the people they serve. Furthermore, the interview with Señora Lopez demonstrated the existence of discrimination within the Latino community and the ways in which it hinders access to care for some Latinos (especially recent immigrants).

Addressing the health needs of the Latino community in Washington is complicated. Solutions must be found not only within medical institutions and legislative policies affecting health practice, but must also draw from resources and strategies outside of the health spectrum. Health issues are just one of many concerns facing the Latino population in Washington. Addressing issues of education, poverty and immigration (to name a few) within the Latino community will simultaneously move us in the right direction as we try to better meet the health needs of Latinos. Below are some recommendations that might help to improve health conditions for Latinos in Washington.

*Improving Access to Health Insurance*

There are many ways to address the high uninsured rates among Latinos. One approach would be to enforce an employer mandate in the state, requiring all employers to provide employees *and* their dependents with health insurance. Because an overwhelming majority of the uninsured Latinos in the U.S. come from working families, this could drastically increase insurance rates. However, currently employers are not obligated to provide health benefits of any kind to their employees, and due to the increasing costs of insurance, it might be unrealistic to expect employers (especially smaller firms) to shoulder that burden on their own. To solve this problem, the government could subsidize a substantial part of the cost or provide meaningful incentives to firms who covered their employees.

To further increase the insured rates among Latinos, public insurance offered through state run Medicaid programs like MOLINA could be offered to more people, regardless of legal status. Since 1996, with the passage of the Illegal Immigration Reform and Immigrant Responsibility Act, legal immigrants' access to social services (including Medicaid) has been severely limited and undocumented residents have become completely ineligible.[5] Poor people and undocumented residents alike deserve

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[5] Suárez, Zulema. "Hispanics and Health Care." *Hispanics in the United States.* Edited by Pastora San Juan Cafferty and David W. Engstrom. Transaction Publishers: New Brunswick, 2004, p208.

comprehensive health insurance, and the state should cover all persons who don't receive employer-based insurance or who can't afford to purchase an insurance plan on their own. As noted in the Data and Interview Discussion sections, having insurance does not always guarantee that one's health needs will be sufficiently met. In addition to expanding Medicaid coverage to more people, it is equally important that all plans adequately and efficiently meet the health needs of the people they serve (the same goes for employer-based insurance).

Another approach to solving the insurance problem in the U.S. would be to offer federally funded health insurance to all U.S. residents. This would alleviate the burden on employers to cover their employees, while allowing for standardized coverage for all people living in the U.S. Having one, uniform system would no doubt increase efficiency and more effectively meet the health needs of the entire U.S. population. While this approach seems perhaps too idealistic to be taken seriously, it is important to note that many western countries have similar systems in place. Why shouldn't everyone in the U.S. be given comprehensive health insurance coverage? It can be argued that it is in the state's best interest to provide all people with health insurance. Brown and Yu note that "diminished access to health insurance for any large group can have significant consequences for the nation, potentially increasing the amount of uncompensated care rendered by health care providers, decreasing the group's contributions to the economy, and boosting social tensions."[6]

*Improving Access to Care*

Aside from increasing access to health insurance, there are many ways to improve access to care for Latinos. Because many Latinos speak Spanish as their primary language, services need to be provided in medical facilities serving Latino populations. Spanish-speaking Latinos have a right to quality care and this cannot be achieved without extensive bilingual services. This includes providing medical information in Spanish as well as having trained medical interpreters on hand to meet the needs of Spanish-speaking Latinos.

In addition to offering medical services in Spanish, medical institutions must make an effort to employ a diverse workforce, especially Latino medical professionals. Due to shared culture and language, Latinos often feel more comfortable receiving care from fellow Latinos. Because Latinos are underrepresented in medical professions, health institutions must make a concerted effort to recruit Latino professionals.

Using community networks as a source of information about the health care options available to the Latino community is also essential. In many cases, Latinos don't know what programs they are eligible for or what services are available to them. Informal social networks and community-based outreach programs can be effective resources for passing along this kind of information. In whatever ways we can, we must facilitate these community networks and work towards educating members of the Latino community on their options for care. More research in this area is essential.

[6] Richard Brown and Hongjian Yu, "Latinos' Access to Employment-Based Health Insurance," p249.

## Appendix A: Interview Transcript #1

This interview was conducted Friday, October 14, 2005 at the Walla Walla Clinic with Señora Lopez. She is indicated below as SL. Señora Lopez is married and has two young daughters. She speaks some English but her first language is Spanish. The questions were asked by Lázaro Carrion in Spanish and her answers were translated into English by Lázaro at a later date. An employee of the clinic named Mary who works as an interpreter was also present during this interview and she is indicated below as M.

Q: Can you give us some background on your family?
SL: I have two daughters, they are both under the same insurance company. I live with my husband. One is two years old the other is five months old.

Q: So you have medical insurance?
SL: Yes, but my insurance is different than the insurance my daughters have. They have MOLINA (Medicaid). I have Basic Health. My husband doesn't have insurance.

Q: Who provides the insurance, the government or do you pay for it?
SL: The government.

Q: So you don't receive health insurance from your job?
SL: No.

Q: Do you feel like you have a good understanding of the insurance options available to you?
SL: Before I didn't but now I do.

Q: Do you feel like you have a choice regarding different health insurance providers available to you, or do you only have one option given to you?
SL: Right now, I have no option for myself, the plan is given to me, but I can chose for my daughters.
M: But don't you have to qualify for it?
SL: Yes. You do have to qualify for the insurance and it all depends on what one earns at work.

Q: And why is that?
SL: Because they charge me [according to level of income].

Q: Do you feel like you have a good understanding of the services that come with your insurance?
SL: Yes, the social worker over there [Family Medical Center] explained it to me very well.

Q: Is there a pamphlet or written info that helps explain the services available?

SL: Every six months or year, a paper comes home regarding the services. One also comes for my daughters insurance.

Q: Are there any services not covered by your insurance?
SL: As of right now, not yet, but I don't know what restrictions exist.

Q: So you don't know what restrictions exist?
SL: No, I don't know.

Q: Overall are you satisfied with your health plan?
SL: Right now, yes.

Q: If you could change anything about your plan, or your children's what would it be?
SL: I would like for it to cover more, because right now it doesn't cover enough. Because the appointment, I have to pay for it, so every time I go to the doctor I have to pay for it out of my pocket.

Q: And what about your daughters insurance?
SL: Nothing, everything is fine.

Q: Where does your family receive medical attention, here or at the other clinic [Family Medical Center]?
SL: My daughters get it here and I get it at the other clinic.

Q: So your husband doesn't go to the other clinic because he doesn't have insurance?
SL: Even though he doesn't have insurance, he does go.

Q: Can you compare the treatment or services that you received at Family Medical Center with the care provided to your daughters [at Walla Walla Clinic]?
SL: Ever since I have been coming here [Walla Walla Clinic], the service has been good. I've had a good experience with my daughters here. The treatment here has been better because… I had an experience with my daughter where she was throwing up, she was sick and would throw up the food and suero [evidently similar to penicillin] and I would call them [Family Medical Center] and ask for care for my daughter and they would tell me to wait until there was an available doctor. So I kept on calling for a doctor but the racist receptionist wouldn't put me through. I would have to go to the general [director of the clinic?] and then they would check my daughter, finally, and would say there's nothing wrong with her. That same day I went to Saint Mary's and they checked my daughter… and I had to come back home that same night and… so the next day I went back and a doctor came and treated my daughter and they finally told me what was wrong with her. At the other clinic they wouldn't check my daughter, they told me there were no doctors available. They made me wait when my daughter was dehydrated, sick. When they didn't treat her that's when I went to this clinic [Walla Walla Clinic].

Q: So now that you're coming to this clinic, what differences have you found?

SL: The treatment is completely different. The service is quicker, their not telling me when a doctor is going to be available, when I go they attend to me right away.

Q: So is the doctor prescribing the right medicine and giving the correct treatment?
SL: Yes. Over there they did too, but the receptionist would be the one saying the doctor was not available, or the doctor wasn't there, or to wait, that kind of thing.

Q: Do you or anyone if your family have a personal provider?
SL: I have my own personal doctor over there [Family Medical Center]. And my daughter's doctor is Dr. Hall.

Q: Has there ever been a time where did not seek care because you could not afford the cost?
SL: No, everything has been fine. The medical coupon and insurance has covered enough. I didn't struggle to get this kind of insurance.

Q: Are your families health needs adequately met?
SL: Yes, everything is fine.

Q: Have you ever experienced discrimination, poor treatment because of race?
SL: Up until now, the doctors have treated me well, and the doctor over there did as well. Only when I was pregnant, the receptionist did not want to get me through.

Q: Do you think if you spoke English well enough to defend yourself it would help you to get better service?
SL: Oh yes, I would defend myself right away. The treatment would be better. Because even at work they shut one up if one doesn't speak English.

Q: Has there ever been a case where the language barrier has kept you from getting any service whatsoever?
SL: As of right now, no. But the receptionist makes the process really slow.

Q: Do those receptionists speak Spanish?
SL: Yes, they speak it very well.

Q: So why do you think that problem exists, with them being Spanish speaking Latinos or Mexican receptionists.
SL: I don't know, that's one thing I want to understand, or know, I guess in this case. It's an example of discrimination within one's race. That exists not only in the clinics but everywhere. Instead of being united as Latinos—I can't believe people are like this. It's incredible really, how some people treat others.

Can I say something about my job? One time, I was working at McDonalds and here comes a man and I wasn't offending him—nothing, nothing—and I was talking and asking a question to a co-worker in Spanish and he called me out and pointed at me and said, 'Here in my country one has to speak English.' And I told him, 'Why? This is a free

country.' He said, 'But you have to speak English in this country… and I'm going to tell your manager to fire you.'

Q: Really, did he tell you this in Spanish or English?
SL: He told me in English. I don't see any document here at work that says I have to speak in English. But he continued on threatening me, telling me he was going to get me fired. And even as he was leaving, he would continue pointing at me in a threatening manner.

In my current job, at a restaurant, the manager, she never tells her people, the Americans, to shut up when they are talking.

Q: They are trying to force you into becoming "American"?
SL: Well, yes. This is my culture and my native tongue is Spanish. And you can't tell me I can't speak Spanish because this is a free country.

Q: So do you feel like the definition of American does not necessarily mean losing ones culture and language?
SL: No. It doesn't have to mean that. It doesn't mean that.

Q: If you could talk to a politician in relation to the needs of the Latino community, ask them a question, what would it be?
SL: Well, questions, I have too many. But whether they know the value of them ….

Q: But if you talk to a politician and they would listen to you, what would you tell them?
SL: I would share with him my experience at the restaurant and ask him why such things exist. Why do these things happen? Because of what I know of the history of the United States—more or less the American people are not from here. Why did that man treat me that way? Because he is not from here. Yes he was born here, but he is not from here. I don't know if I'm wrong, but I do know that the Indians are the rightful owners of this land. I really did feel bad, him pointing a finger at me like that.

Q: Do you think if you spoke English really well, these kind of things would continue to happen?
SL: Not as much, but they get offended when one doesn't speak English. But just like they are offended when we speak Spanish in front of them, it's the same when they speak English to someone who doesn't know it. How am I going to know when someone is speaking behind my back and I tell that to my manager, because when I walk by, those workers they laugh. So I know they are talking behind my back in English, it's the same thing. She (manager) only shuts us Hispanics up, and not them. They'd always do that to us at McDonalds. They always have done that. That what I would tell them. We ask them for a law that prohibits that. That way we have proof and they won't tell us anything (about speaking Spanish).

-- At this point we concluded the interview, asking Señora Lopez if she had any questions for us or about my project and then thanking them for their time.

## Appendix B: Interview Transcript #2

The following interview with Señora Jimenez took place on Tuesday November 1, 2005 at the Walla Walla Clinic. She is indicated below as SJ. An interpreter named Carolina (an employee of the Walla Walla Clinic) served as the interpreter.

Q: Tell me about your family, are you married, do you have any kids?
SJ: I am married and I have 4 kids.

Q: Do you work and does your husband work?
SJ: I don't work, I stay at home, my husband works and he has this insurance [Señora Jimenez passes me a Blue Shield Insurance card].

Q: Where does your husband work?
SJ: At Tyson

Q: And they provide insurance?
SJ: Yes, they provide insurance for him and for the family. The insurance that my husband has is just for him, me and one child. His insurance doesn't cover my other children, because they are older. Only my youngest child is covered.

Q: Do you have a good understanding of the services provided by your insurance plan?
SJ: Actually, I don't understand exactly what the benefits are. One time I had to go to the emergency room because I was very very sick, something in my eye, and they told me that my insurance doesn't cover this. I felt very frustrated about this, because I didn't know about this. And after that they prescribed the wrong medication to me, and I had to go to a specialist to fix all of this.

Q: So they wouldn't accept the insurance you had [Blue Shield, plan for Tyson workers]?
SJ: No. I'm so sure what this insurance covers. With this plan, we pay a little bit more, but have more benefits.

Q: You mentioned MOLINA (Medicaid) earlier, do you have MOLINA in addition to your husband's insurance?
SJ: I've had a bad experience with MOLINA, too. MOLINA is what I have for my kids, for my youngest, and I had a bad experience with it because I've had a lot of trouble with him [her son], I don't want to explain about that, but I've had lots of trouble with him. He needs a specialist, a psychologist, but MOLINA would only cover 13 sessions for the whole year. My son needs more than 13 sessions. The doctor said she knows for sure that my son needs more than 13 sessions. She said she would continue seeing my son without payment. And I think its not fair. Because this is a big problem and he needs help, but they won't cover it. Its not fair.
I'm really angry with this country because this is a country where they say that they care about the kids and all the people who live here. But sometimes I feel like they care about animals than people, because in my case, my kids need a lot of help… and I understand

in some cases, they might say, it isn't that serious, and they can say, just take this for this year. But in my case it is a very very serious problem, with my kid, and he needs a lot of therapy. I think it's unfair because I know this country has many resources to help people.

Q: What are some of the things you would change about your medical plan if you could?
SJ: Other than the issue with my son, my coverage has been OK. I really think it has a lot to do with the physician, because some physicians really want to help, but others just say, 'OK, you're fine, you're son is fine, he doesn't need anymore specialists.' But then there are those like Dr. Hall [physician at the Walla Walla Clinic, my community partner] who say, 'OK we can try it this way, and if that doesn't work we can try this.' I think it depends on the physician.

Q: Do you think some physicians or other medical professionals have not valued you as a patient because of your race/ethnicity or because you speak Spanish?
SJ: I don't think this a problem for me, because I've had good experiences with physicians. When I go to some appointment, they provide me with an interpreter.

Q: Where do you receive your care?
SJ: I go to the Women's clinic, and I also receive care here [Walla Walla Clinic]. I really haven't had any experiences with discrimination because I speak Spanish. My only complaint is that my insurance only gave my son 13 sessions of therapy.

Q: And this is because your plan doesn't cover anything more?
SJ: Yes, and I don't think this insurance has very good coverage. When I went to the emergency room because I had problems with my eyes, they told me my insurance wouldn't cover it. They said my plan would only cover me if my illness was life threatening. In this case, they told me, you are not in a very dangerous situation. That's what they told me. This insurance only covers for emergencies. The people who have this insurance work very hard and it's not fair because the benefits are very restricted.

Q: You mentioned earlier, that you didn't know exactly what your insurance plan covers. Does Tyson do anything to provide you with this sort of information, of the exact services available to you?
SJ: Yes. Tyson provides a document for us to read, they explain all the benefits. But we don't know exactly how much services will cost. When I had to go to the emergency room, I wasn't sure that it was not going to be covered. When I got the bill a few weeks later, my insurance company said that they wouldn't pay it.

Q: Going back to the psychologist, you mentioned that she was going to cover additional sessions with your son after the 13 sessions covered by your insurance. Has there ever been a time when you did not seek care because of the cost?
SJ: I'm not sure what's going to happen. I only have one session left under my insurance. She [psychologist] told me not to worry, that she would continue seeing my son and that next year, she would write a letter to the insurance company telling them that my son needed special attention.

Recently things have gotten worse for my son. I have court protection for me and my son from a man, a young man. My son is 14, but in my mind he's 11. The man is 19 years old. He can't come within 500 feet of my son or me, but this weekend he was only 5 feet from my son. I had to call the police, and my son was very scared, I was very scared. It has been a huge problem between this guy and my son, a very serious problem. And they said just 13 sessions. And in this case, it is not fair, because my son is sick and he needs to stay close to the specialist.

At this point I thanked Señora Jimenez for her time and asked her if she had any further questions. She did not, but said that she was glad to see students taking an interest in these issues and that she hoped to helpful in any way she could.

# Appendix C

## Health Insurance Coverage by Race and Hispanic Origin: 1987 to 2004—Con.

(Numbers in thousands. People as of March of the following year)

| Race and Hispanic origin and year | Total people | Covered by private or government health insurance | | | | | | | | Not covered |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Total | Private health insurance | | | Government health insurance | | | | |
| | | | Total | Employment based | Direct purchase | Total | Medicaid | Medicare | Military health care[1] | |
| **HISPANIC (ANY RACE)** | | | | | | | | | | |
| **Numbers** | | | | | | | | | | |
| 2004 | 41,839 | 28,160 | 18,714 | 17,208 | 1,698 | 11,462 | 9,123 | 2,618 | 694 | 13,678 |
| 2003 | 40,425 | 27,188 | 18,183 | 16,788 | 1,551 | 10,716 | 8,505 | 2,462 | 639 | 13,237 |
| 2002 | 39,384 | 26,627 | 18,108 | 16,714 | 1,469 | 10,280 | 7,946 | 2,535 | 724 | 12,756 |
| 2001 | 37,438 | 25,021 | 17,322 | 15,965 | 1,390 | 9,227 | 7,074 | 2,295 | 704 | 12,417 |
| 2000[2] | 36,093 | 24,210 | 17,114 | 15,893 | 1,337 | 8,566 | 6,552 | 2,141 | 682 | 11,883 |
| 1999[3] | 34,773 | 23,311 | 16,634 | 15,275 | 1,398 | 8,168 | 6,253 | 1,979 | 626 | 11,462 |
| 1999 | 32,804 | 21,853 | 15,424 | 14,214 | 1,264 | 7,875 | 5,946 | 2,047 | 589 | 10,951 |
| 1998 | 31,689 | 20,493 | 14,377 | 13,310 | 1,133 | 7,401 | 5,585 | 2,026 | 503 | 11,196 |
| 1997[4] | 30,773 | 20,239 | 13,751 | 12,790 | 1,028 | 7,718 | 5,970 | 1,974 | 526 | 10,534 |
| 1996 | 29,703 | 19,730 | 13,151 | 12,140 | 1,105 | 7,784 | 6,255 | 1,806 | 474 | 9,974 |
| 1995 | 28,438 | 18,964 | 12,187 | 11,309 | 1,011 | 8,027 | 6,478 | 1,732 | 516 | 9,474 |
| 1994[5] | 27,521 | 18,244 | 11,743 | 10,729 | 1,208 | 7,829 | 6,226 | 1,677 | 630 | 9,277 |
| 1993[6] | 26,646 | 18,235 | 12,021 | 9,981 | (NA) | 7,873 | 6,328 | 1,613 | 530 | 8,411 |
| 1992[7] | 25,682 | 17,242 | 11,330 | 9,786 | (NA) | 7,099 | 5,703 | 1,578 | 523 | 8,441 |
| 1991 | 22,096 | 15,128 | 10,336 | 8,972 | (NA) | 5,845 | 4,597 | 1,309 | 522 | 6,968 |
| 1990 | 21,437 | 14,479 | 10,281 | 8,948 | (NA) | 5,169 | 3,912 | 1,269 | 519 | 6,958 |
| 1989 | 20,779 | 13,846 | 10,348 | 8,914 | (NA) | 4,526 | 3,221 | 1,180 | 595 | 6,932 |
| 1988 | 20,076 | 13,684 | 10,188 | 8,831 | (NA) | 4,414 | 3,125 | 1,114 | 594 | 6,391 |
| 1987[8] | 19,428 | 13,456 | 9,845 | 8,490 | (NA) | 4,482 | 3,214 | 1,029 | 631 | 5,972 |
| **Percents** | | | | | | | | | | |
| 2004 | 100.0 | 67.3 | 44.7 | 41.1 | 4.1 | 27.4 | 21.8 | 6.3 | 1.7 | 32.7 |
| 2003 | 100.0 | 67.3 | 45.0 | 41.5 | 3.8 | 26.5 | 21.0 | 6.1 | 1.6 | 32.7 |
| 2002 | 100.0 | 67.6 | 46.0 | 42.4 | 3.7 | 26.1 | 20.2 | 6.4 | 1.8 | 32.4 |
| 2001 | 100.0 | 66.8 | 46.3 | 42.6 | 3.7 | 24.6 | 18.9 | 6.1 | 1.9 | 33.2 |
| 2000[2] | 100.0 | 67.1 | 47.4 | 44.0 | 3.7 | 23.7 | 18.2 | 5.9 | 1.9 | 32.9 |
| 1999[3] | 100.0 | 67.0 | 47.8 | 43.9 | 4.0 | 23.5 | 18.0 | 5.7 | 1.8 | 33.0 |
| 1999 | 100.0 | 66.6 | 47.0 | 43.3 | 3.9 | 24.0 | 18.1 | 6.2 | 1.8 | 33.4 |
| 1998 | 100.0 | 64.7 | 45.4 | 42.0 | 3.6 | 23.4 | 17.6 | 6.4 | 1.6 | 35.3 |
| 1997[4] | 100.0 | 65.8 | 44.7 | 41.6 | 3.3 | 25.1 | 19.4 | 6.4 | 1.7 | 34.2 |
| 1996 | 100.0 | 66.4 | 44.3 | 40.9 | 3.7 | 26.2 | 21.1 | 6.1 | 1.6 | 33.6 |
| 1995 | 100.0 | 66.7 | 42.9 | 39.8 | 3.6 | 28.2 | 22.8 | 6.1 | 1.8 | 33.3 |
| 1994[5] | 100.0 | 66.3 | 42.7 | 39.0 | 4.4 | 28.4 | 22.6 | 6.1 | 2.3 | 33.7 |
| 1993[6] | 100.0 | 68.4 | 45.1 | 37.5 | (NA) | 29.5 | 23.7 | 6.1 | 2.0 | 31.6 |
| 1992[7] | 100.0 | 67.1 | 44.1 | 38.1 | (NA) | 27.6 | 22.2 | 6.1 | 2.0 | 32.9 |
| 1991 | 100.0 | 68.5 | 46.8 | 40.6 | (NA) | 26.5 | 20.8 | 5.9 | 2.4 | 31.5 |
| 1990 | 100.0 | 67.5 | 48.0 | 41.7 | (NA) | 24.1 | 18.2 | 5.9 | 2.4 | 32.5 |
| 1989 | 100.0 | 66.6 | 49.8 | 42.9 | (NA) | 21.8 | 15.5 | 5.7 | 2.9 | 33.4 |
| 1988 | 100.0 | 68.2 | 50.7 | 44.0 | (NA) | 22.0 | 15.6 | 5.5 | 3.0 | 31.8 |
| 1987[8] | 100.0 | 69.3 | 50.7 | 43.7 | (NA) | 23.1 | 16.5 | 5.3 | 3.2 | 30.7 |

NA Not available. Respondents were not asked detailed health insurance questions about direct-purchase coverage before the 1995 Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC).

[1] Military health includes: CHAMPUS (Comprehensive Health and Medical Plan for Uniformed Services)/Tricare and CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs), as well as care provided by the Health and Medical Program of the Department of Veterans Affairs, as well as care provided by the Department of Veterans Affairs and the military.

[2] Implementation of a 28,000 household sample expansion.

[3] Estimates reflect the results of follow-up verification questions and implementation of Census 2000-based population controls.

[4] Beginning with the 1998 CPS ASEC, people with no coverage other than access to Indian Health Service are no longer considered covered by health insurance; instead, they are considered to be uninsured. The effect of this change on the overall estimates of health insurance coverage is negligible; however, the decrease in the number of people covered by Medicaid may be partially due to this change.

[5] Health insurance questions were redesigned. Increases in estimates of employment-based and military health care coverage may be partially due to questionnaire changes. Overall coverage estimates were not affected.

[6] Data collection method changed from paper and pencil to computer-assisted interviewing.

[7] Implementation of 1990 census population controls.

[8] Implementation of a new CPS ASEC processing system.

# Appendix D

## Health Insurance Coverage by Race and Hispanic Origin: 1987 to 2004

(Numbers in thousands. People as of March of the following year)

| Race and Hispanic origin and year | Total people | Covered by private or government health insurance | | | | | | | | Not covered |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Total | Private health insurance | | | Government health insurance | | | | |
| | | | Total | Employment based | Direct purchase | Total | Medicaid | Medicare | Military health care[1] | |
| **ALL RACES** | | | | | | | | | | |
| **Numbers** | | | | | | | | | | |
| 2004 | 291,155 | 245,335 | 198,262 | 174,174 | 26,961 | 79,086 | 37,514 | 39,745 | 10,680 | 45,820 |
| 2003 | 288,280 | 243,320 | 197,869 | 174,020 | 26,486 | 76,755 | 35,647 | 39,456 | 9,979 | 44,961 |
| 2002 | 285,933 | 242,360 | 198,973 | 175,296 | 26,639 | 73,624 | 33,246 | 38,448 | 10,063 | 43,574 |
| 2001 | 282,082 | 240,875 | 199,860 | 176,551 | 26,057 | 71,295 | 31,601 | 38,043 | 9,552 | 41,207 |
| 2000[2] | 279,517 | 239,714 | 201,060 | 177,848 | 26,524 | 69,037 | 29,533 | 37,740 | 9,099 | 39,804 |
| 1999[3] | 276,804 | 236,576 | 198,841 | 175,101 | 27,415 | 67,683 | 28,506 | 36,923 | 8,648 | 40,228 |
| 1999 | 274,087 | 231,533 | 194,599 | 172,023 | 26,179 | 66,176 | 27,890 | 36,066 | 8,530 | 42,554 |
| 1998 | 271,743 | 227,462 | 190,861 | 168,576 | 25,948 | 66,087 | 27,854 | 35,887 | 8,747 | 44,281 |
| 1997[4] | 269,094 | 225,646 | 188,532 | 165,091 | 27,158 | 66,685 | 28,956 | 35,590 | 8,527 | 43,448 |
| 1996 | 266,792 | 225,077 | 187,395 | 163,221 | 28,335 | 69,000 | 31,451 | 35,227 | 8,712 | 41,716 |
| 1995 | 264,314 | 223,733 | 185,881 | 161,453 | 30,188 | 69,776 | 31,877 | 34,655 | 9,375 | 40,582 |
| 1994[5] | 262,105 | 222,387 | 184,318 | 159,634 | 31,349 | 70,163 | 31,645 | 33,901 | 11,165 | 39,718 |
| 1993[6] | 259,753 | 220,040 | 182,351 | 148,318 | (NA) | 68,554 | 31,749 | 33,097 | 9,560 | 39,713 |
| 1992[7] | 256,830 | 218,189 | 181,466 | 148,796 | (NA) | 66,244 | 29,416 | 33,230 | 9,510 | 38,641 |
| 1991 | 251,447 | 216,003 | 181,375 | 150,077 | (NA) | 63,882 | 26,880 | 32,907 | 9,820 | 35,445 |
| 1990 | 248,886 | 214,167 | 182,135 | 150,215 | (NA) | 60,965 | 24,261 | 32,260 | 9,922 | 34,719 |
| 1989 | 246,191 | 212,807 | 183,610 | 151,644 | (NA) | 57,382 | 21,185 | 31,495 | 9,870 | 33,385 |
| 1988 | 243,685 | 211,005 | 182,019 | 150,940 | (NA) | 56,850 | 20,728 | 30,925 | 10,105 | 32,680 |
| 1987[8] | 241,187 | 210,161 | 182,160 | 149,739 | (NA) | 56,282 | 20,211 | 30,458 | 10,542 | 31,026 |
| **Percents** | | | | | | | | | | |
| 2004 | 100.0 | 84.3 | 68.1 | 59.8 | 9.3 | 27.2 | 12.9 | 13.7 | 3.7 | 15.7 |
| 2003 | 100.0 | 84.4 | 68.6 | 60.4 | 9.2 | 26.6 | 12.4 | 13.7 | 3.5 | 15.6 |
| 2002 | 100.0 | 84.8 | 69.6 | 61.3 | 9.3 | 25.7 | 11.6 | 13.4 | 3.5 | 15.2 |
| 2001 | 100.0 | 85.4 | 70.9 | 62.6 | 9.2 | 25.3 | 11.2 | 13.5 | 3.4 | 14.6 |
| 2000[2] | 100.0 | 85.8 | 71.9 | 63.6 | 9.5 | 24.7 | 10.6 | 13.5 | 3.3 | 14.2 |
| 1999[3] | 100.0 | 85.5 | 71.8 | 63.3 | 9.9 | 24.5 | 10.3 | 13.3 | 3.1 | 14.5 |
| 1999 | 100.0 | 84.5 | 71.0 | 62.8 | 9.6 | 24.1 | 10.2 | 13.2 | 3.1 | 15.5 |
| 1998 | 100.0 | 83.7 | 70.2 | 62.0 | 9.5 | 24.3 | 10.3 | 13.2 | 3.2 | 16.3 |
| 1997[4] | 100.0 | 83.9 | 70.1 | 61.4 | 10.1 | 24.8 | 10.8 | 13.2 | 3.2 | 16.1 |
| 1996 | 100.0 | 84.4 | 70.2 | 61.2 | 10.6 | 25.9 | 11.8 | 13.2 | 3.3 | 15.6 |
| 1995 | 100.0 | 84.6 | 70.3 | 61.1 | 11.4 | 26.4 | 12.1 | 13.1 | 3.5 | 15.4 |
| 1994[5] | 100.0 | 84.8 | 70.3 | 60.9 | 12.0 | 26.8 | 12.1 | 12.9 | 4.3 | 15.2 |
| 1993[6] | 100.0 | 84.7 | 70.2 | 57.1 | (NA) | 26.4 | 12.2 | 12.7 | 3.7 | 15.3 |
| 1992[7] | 100.0 | 85.0 | 70.7 | 57.9 | (NA) | 25.8 | 11.5 | 12.9 | 3.7 | 15.0 |
| 1991 | 100.0 | 85.9 | 72.1 | 59.7 | (NA) | 25.4 | 10.7 | 13.1 | 3.9 | 14.1 |
| 1990 | 100.0 | 86.1 | 73.2 | 60.4 | (NA) | 24.5 | 9.7 | 13.0 | 4.0 | 13.9 |
| 1989 | 100.0 | 86.4 | 74.6 | 61.6 | (NA) | 23.3 | 8.6 | 12.8 | 4.0 | 13.6 |
| 1988 | 100.0 | 86.6 | 74.7 | 61.9 | (NA) | 23.3 | 8.5 | 12.7 | 4.1 | 13.4 |
| 1987[8] | 100.0 | 87.1 | 75.5 | 62.1 | (NA) | 23.3 | 8.4 | 12.6 | 4.4 | 12.9 |
| **WHITE ALONE[9]** | | | | | | | | | | |
| **Numbers** | | | | | | | | | | |
| 2004 | 234,077 | 199,289 | 165,327 | 144,246 | 23,511 | 61,311 | 25,586 | 34,084 | 8,567 | 34,788 |
| 2003 | 232,254 | 198,270 | 165,852 | 144,780 | 23,253 | 59,495 | 23,959 | 33,765 | 8,105 | 33,983 |
| 2002 | 230,809 | 198,103 | 167,151 | 146,210 | 23,511 | 57,072 | 22,171 | 33,135 | 8,065 | 32,706 |