Population Trends in Post-Recession Rural America
A Publication Series of the W3001 Research Project

Hispanic Health Insurance Rates Differ between Established and New Hispanic Destinations

Brief No. 02-16
August 2016
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In 2014, 66 percent of working-age Hispanic adults in the U.S. were insured, the lowest health insurance rate of any racial/ethnic group. Hispanic insurance rates are lowest in counties that had few, if any, Hispanics prior to 1990 but that experienced significant Hispanic population growth between 1990 and 2000 (1990s destinations). Hispanic insurance rates in these counties are low in large part because a larger percentage of Hispanic adults living in them are immigrants compared to Hispanics who are living in established destinations.

Hispanics' access to health insurance is important to overall U.S. population health and economic vitality due to the increasing size of the Hispanic population and their geographic dispersion across the U.S. Because the Hispanic population is younger, on average, than other racial/ethnic groups, a larger percentage of Hispanic women are in their prime child-bearing years relative to other racial/ethnic groups. Hispanic fertility is especially high among poor immigrants living in rural areas (Lichter et al. 2015). Large numbers of uninsured Hispanics in their prime child-bearing and working years has significant health care cost implications, especially for rural counties that are already challenged by health care funding shortages and hospital closures. Compared to individuals with health insurance, those without insurance have worse health outcomes, are at higher risk of premature mortality, and are less likely to utilize preventive care and more likely to utilize high-cost health care. High uninsured rates can contribute to overall poor community health, high and unsustainable collective unpaid health care costs, and reduced workplace productivity, all of which can place strains on local hospitals, governments, businesses, and communities.

This brief describes spatial variation in county-level Hispanic adult (ages 18-64) health insurance coverage rates, focusing on differences in Hispanic coverage rates between metropolitan, large nonmetropolitan, and rural established Hispanic destinations, new destinations that formed during the 1990s (1990s destinations), new destinations that formed during the 2000s (2000s destinations), and non-destinations.

Key Findings

Insurance rates among adult Hispanics are lowest in rural counties with historically small Hispanic populations but that experienced substantial Hispanic population growth between 1990 and 2010.

Lower insurance rates in counties with recent Hispanic population growth are due to comparatively larger shares of immigrant non-citizen Hispanics in those counties compared with older, more established Hispanic destinations.

Lower Hispanic insurance rates prevail in counties with state policies that limit recent immigrant access to health insurance or cash/food assistance programs.

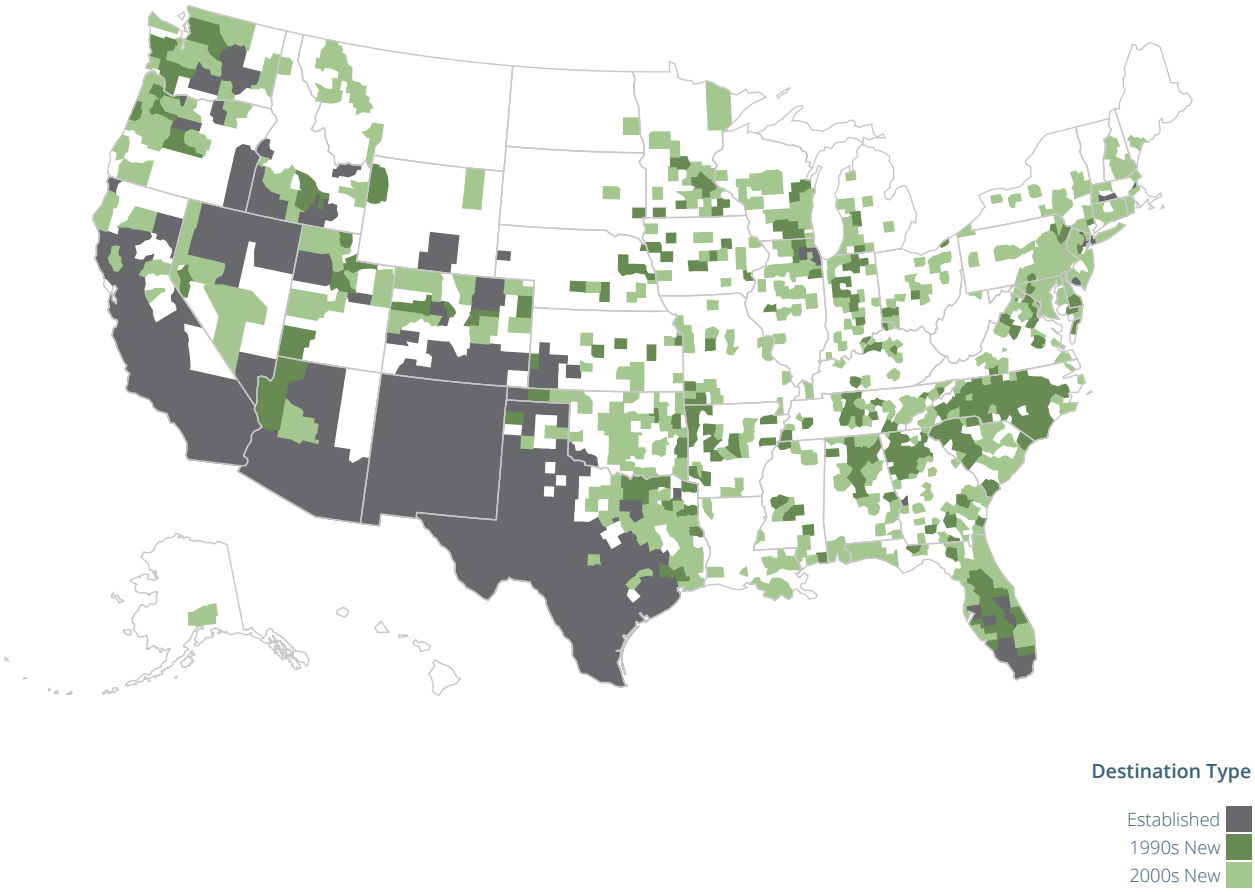
Hispanic Population Growth in New Destinations

Throughout the 1990s and 2000s, communities beyond the traditional Hispanic gateways experienced significant Hispanic population growth (Figure 1). Whereas established destinations are mostly concentrated in the southwest and southern Florida, new destinations are dispersed across the southeast, Midwest, northwest, and northeast.

Hispanic immigrants arriving in the U.S. in the 1990s, along with previous generations of Hispanic immigrants who initially settled in traditional gateways in the urban southwest, were drawn to small cities and rural towns

in the southeast and Midwest for jobs in construction, manufacturing, food processing, and the low-wage service sector. Following the economic boom of the 1990s, the first decade of the 2000s was characterized by economic recession and growing anti-immigrant sentiment, particularly against low-wage Mexican migrants perceived as "stealing" native jobs and pilfering taxpayer coffers. The 1990s boomtowns with low-wage industries that attracted large shares of Mexican immigrants have been especially vulnerable to the negative consequences of globalization and economic restructuring, including population out-migration, job loss, wage deflation and economic precarity. Hispanics in the rural southeast and Midwest especially, occupy low-wage periphery jobs in industries that fared poorly during the late 2000s recession, particularly manufacturing.

Figure 1: Established and New Destinations



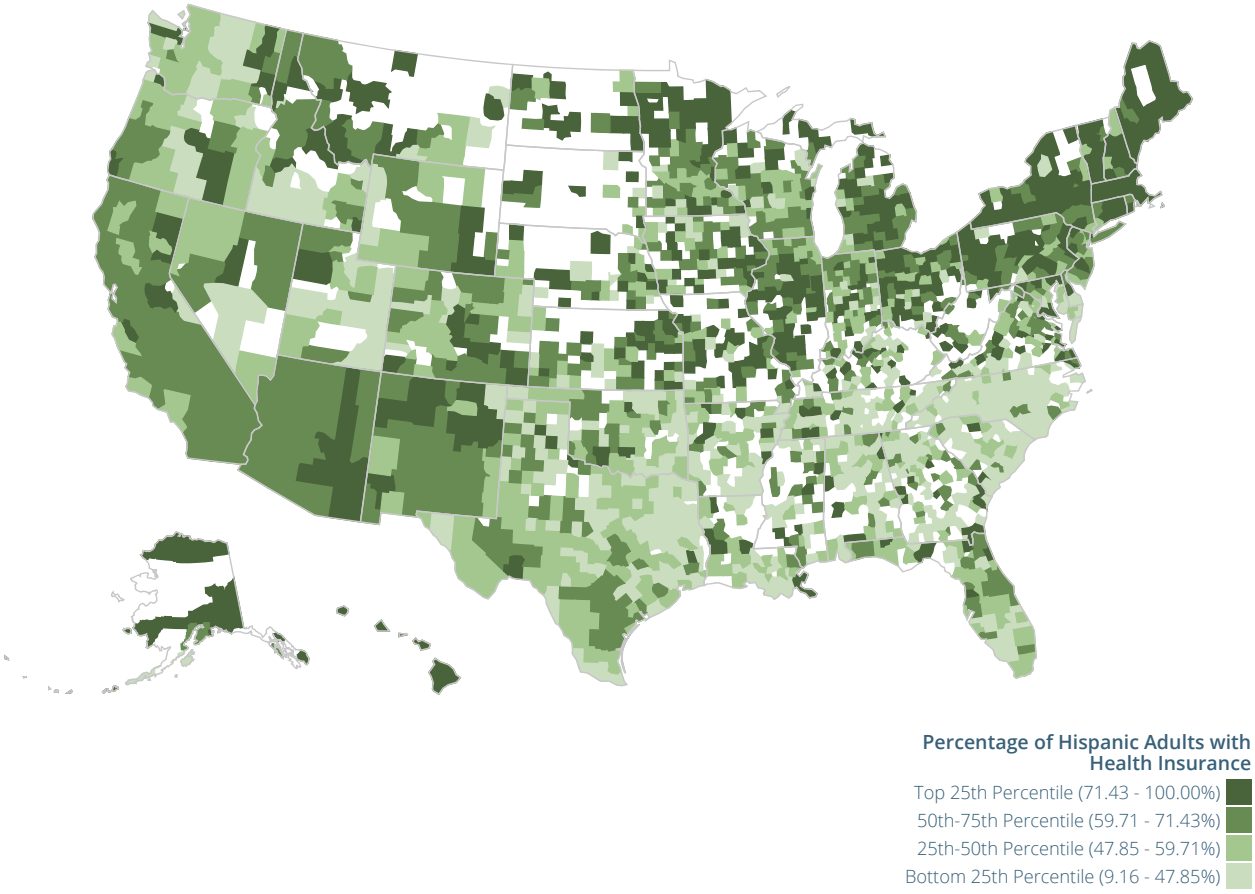
By the 2000s, many migrants to new destinations had considerable experience in the U.S., and flows of Hispanics to 2000s new destinations included both immigrants migrating directly from their origin countries (mostly Mexico) and domestic migrants moving from both established destinations and 1990s destinations. Given the declining economy and growing hostility toward racialized newcomers during the 2000s, Hispanics venturing into places without substantial Hispanic populations in the 2000s (compared to the 1990s and earlier) likely had to arrive with more education and/or job skills and experience to successfully compete for jobs that offer health insurance or wages sufficient to purchase insurance. The places that attracted and retained Hispanics during the 2000s likely also had better economic opportunities than the places hit hardest by the 2000s economic downturn. Otherwise, these places probably would not have experienced or maintained significant Hispanic population growth during the 2000s. Indeed, a significant share of counties (44 percent) that experienced more than 150 percent Hispanic population growth during the 1990s are concentrated in the south-Atlantic, whereas a greater percentage of counties with rapid Hispanic population growth during the 2000s are located in the northeast and Midwest (Figure 1). These places have drastically different labor markets, political and social contexts, and demographic composition, all of which influence Hispanics' opportunities to acquire health insurance. Therefore, in addition to distinguishing between

established and new destinations, it is also important to distinguish between counties that experienced most of their Hispanic population growth in the 1990s versus those wherein most growth occurred in the first decade of the 2000s.

Hispanic Insurance Rates are Lowest in 1990s Destinations and Rural 2000s Destinations

A comparison with Figure 1 shows considerable overlap between counties with the lowest Hispanic insurance rates and counties classified as new destinations. The majority of new destinations, especially 1990s new destinations, are located in the south. Hispanic health insurance coverage rates are lowest in the south, especially in North and South Carolina, Georgia, Alabama, Tennessee, and much of Texas, Hispanic coverage rates are also low in southwestern Idaho, most of Washington, and central Oregon (Figure 2).

Figure 2: Hispanic Adult (ages 18 – 64) Insurance Rates are Lowest in the Southeast and Northwest



Note: Rates for counties with fewer than 100 Hispanic adults and/or unreliable estimates not shown

Figure 3 shows that Hispanic health insurance rates are lowest in rural 2000s destinations and 1990s destinations across all three levels of metropolitan status (metropolitan, large nonmetropolitan, and rural). In the average 1990s destination and rural 2000s destination, fewer than half of Hispanic adults have health insurance. Gaps in insurance coverage rates between Hispanics and non-Hispanic Whites are also largest, on average, in 1990s destinations (Figure 4). The average Hispanic-White coverage gap exceeds 35 percentage points in 1990s destinations across all three categories of metropolitan status.

Figure 3: Percentage of Hispanic Adults with Health Insurance

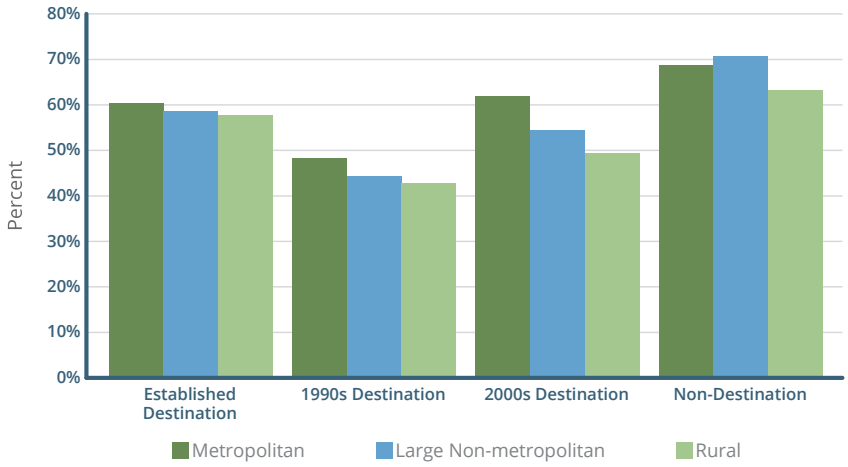
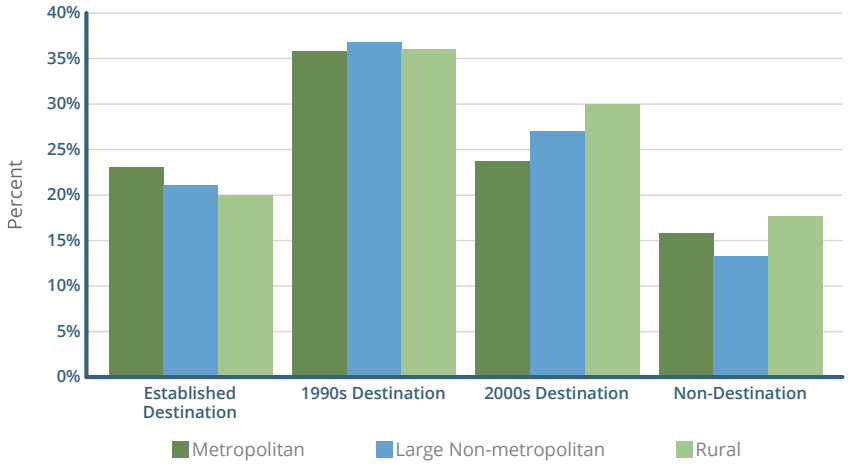


Figure 4: Hispanic-White Insurance Rate Gap



If these differences were simply a function of differences in county labor markets or socioeconomic environments, the patterns we see for non-Hispanic White and Black insurance rates should be similar to those observed for Hispanics. This is not the case. Non-Hispanic White and Black insurance rates vary little across the four types of destinations.[1] This suggests that the factors influencing Hispanic insurance coverage are different from the factors influencing insurance coverage for other racial/ethnic groups. The main factor contributing to lower Hispanic insurance rates in 1990s destinations and rural 2000s destinations is the much larger share of immigrants among the Hispanics living in these types of counties than in other counties.

[1] Average Non-Hispanic White and Black insurance rates by destination type and metropolitan status are available from the author upon request.

Differences in Immigrant Composition across Destinations

Results from regression models that accounted for Hispanic economic well-being, immigrant composition, labor market factors, and state policies on immigrant eligibility for health insurance and other safety net programs show that comparatively low Hispanic insurance rates in 1990s destinations (at all three levels of metropolitan status) and in rural 2000s destinations are attributable to larger relative shares of immigrants living in these counties (Figure 5). Hispanic insurance rates are significantly lower in these new destinations simply because the majority of Hispanics living in them are immigrants and are not U.S. citizens. For example, in the average rural 1990s destination, 72 percent of Hispanic adults (ages 18 – 64) are immigrants, and of

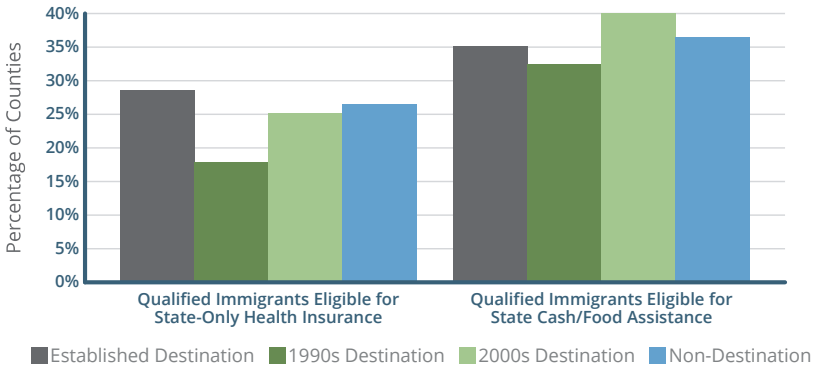
those, 82.5 percent are not U.S. citizens. In the typical metropolitan 2000s destination, only 44 percent of Hispanic adults are immigrants, and in the typical rural established destination, only 32 percent of Hispanic adults are immigrants.

Figure 5: Percentage of Hispanic Adults who are Foreign-Born, 2009-2013

Multiple forces interacted to drive Hispanic immigrants from established gateways in the U.S. southwest to new destinations in the 1990s, including the militarization of the Mexico/U.S. border; anti-immigrant legislation in traditional gateways (e.g., California's Proposition 187 in 1994); growing U.S. and international demand for pre-packaged foods that led to industry restructuring and relocation; and the resultant growing demand for low-wage and non-union labor in services, manufacturing and agriculture. Although these jobs often provide better wages than immigrants might secure in their home countries, they rarely come with health insurance. Even when they do, there are typically waiting periods before benefits take effect.

Across all destination types, average Hispanic insurance rates are lowest in farming-dependent counties, but they are especially low in 1990s destinations. In the average farming-dependent 1990s destination, only 35 percent of Hispanic adults have health insurance, compared to 53 percent in the average farming-dependent established destination. New destinations are also comparatively more reliant on manufacturing than established destinations, and Hispanic health insurance rates in manufacturing-dependent 1990s destinations are substantially lower than Hispanic insurance rates in manufacturing-dependent established destinations. It is possible that the farming and manufacturing jobs available to Hispanics in 1990s destinations are of lower quality (in terms of wages and access to employer-sponsored health insurance) than the farming and manufacturing jobs available to Hispanics in established destinations.

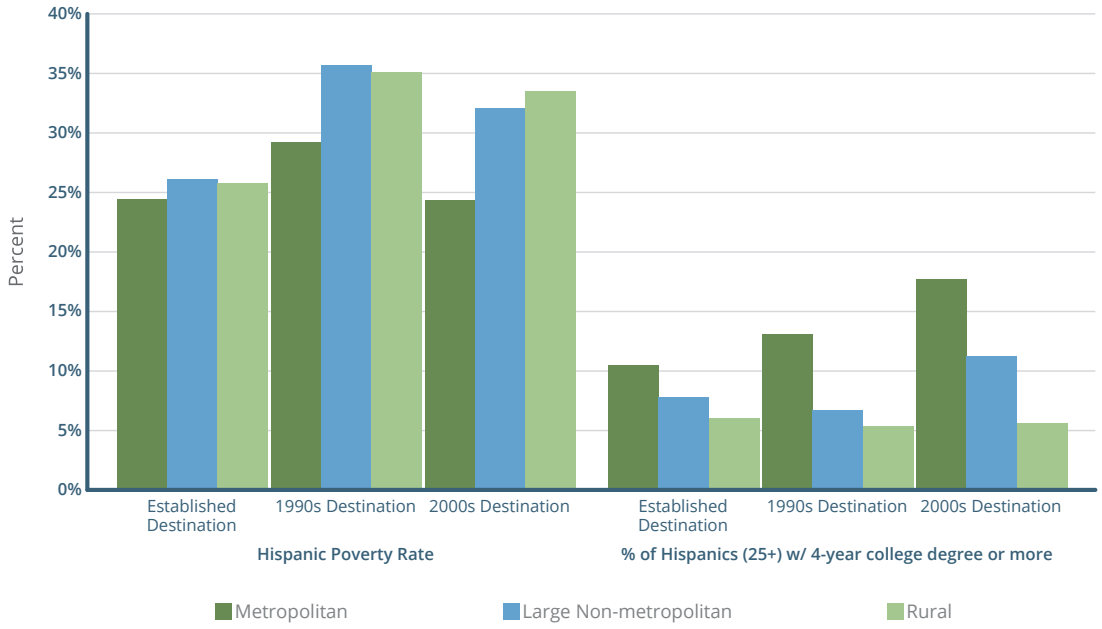
Figure 6: Authorized Immigrant Eligibility for State-Only Medicaid and/or Cash or Food Assistance during the Federal 5-Year Waiting Period



Differences in state Medicaid eligibility also influence Hispanic health insurance rates. Hispanics have disproportionately high reliance on Medicaid; in 2014, 33 percent of nonelderly Hispanics were covered by Medicaid, the highest rate of all major racial/ethnic groups. Unauthorized immigrants are ineligible for federally-funded Medicaid. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 further eliminated Medicaid access for immigrants with less than five years of qualified status in the U.S. States can choose to cover authorized immigrants during the five-year waiting period using state-only funding, but only 15 states currently do so. States that are home to the overwhelming share of 1990s destination counties (North and South Carolina, Alabama, Georgia, Tennessee, Arkansas, Oklahoma, Maryland and Oregon) do not cover immigrants with a state plan during this five-year waiting period. As shown in Figure 6, 1990s destinations are less likely than the other destination types to be located in states where immigrants are eligible for state-only insurance plans and cash/food assistance programs during the five-year ban. This means that 1990s destinations, where the Hispanic population is composed of comparatively larger shares of immigrants, especially poor recent immigrants, will have lower Hispanic insurance rates simply because most poor Hispanics in those places are not eligible for Medicaid.

The disadvantages associated with lower access to Medicaid and cash/food assistance programs in 1990s destinations are compounded by higher Hispanic poverty rates and lower Hispanic educational attainment in these same counties (Figure 7). Hispanic poverty rates are highest in 1990s destinations (across all three levels of metropolitan status) and nonmetropolitan 2000s destinations. Although Hispanic educational attainment is higher in metropolitan 1990s destinations compared to established destinations, this education advantage does not protect against higher Hispanic poverty rates and lower Hispanic insurance coverage rates in metropolitan 1990s destinations. Although not shown here, Hispanic employment rates are similar across all destination types.

Figure 7: Hispanic Poverty Rates and Educational Attainment by Destination Type and Metropolitan Status



Conclusions

Hispanic adult health insurance rates vary considerably between new and established destinations and by metropolitan status. 1990s destination counties have lower Hispanic adult health insurance rates than other counties, with the very lowest rates in rural 1990s destinations. Coverage rates are also comparatively low in rural 2000s destinations. Lower Hispanic insurance rates in these new destinations are due in large part to comparatively larger concentrations of immigrants among the Hispanics who live in them.

On the one hand, these findings suggest reasons to be cautiously optimistic about future trends in Hispanic health insurance coverage in new destinations. Despite higher Hispanic poverty rates and less access to Medicaid and cash/food assistance programs, Hispanics in metropolitan, large non-metropolitan, and rural 1990s destinations and rural 2000s destinations have insurance rates that are comparable to established destinations once differences in immigrant concentrations are held constant. As the current cohorts of Hispanic immigrants are succeeded by second and future generation U.S-born Hispanics in these places, insurance rates should climb. In addition, the most recent metropolitan new destinations (2000s destinations) have Hispanic insurance rates, poverty rates, and employment rates that are comparable to established destinations.

On the other hand, the findings presented here also support concerns that the migration of low-income Hispanic immigrants to small towns has driven the emergence of "rural immigrant ghettos" characterized by concentrated poverty, social isolation, and limited mobility (Lichter and Brown 2011; Lichter et al. 2015). This is worrisome given the young Hispanic age structure and the fact that Hispanic fertility is high in rural areas, especially among the poorest and most disadvantaged immigrants. Individuals without insurance are at risk of poor health, which may negatively affect their current and future children. Counties with low Hispanic insurance rates may also face economic burdens of unpaid health care costs, emergency departments may experience greater demand for services, and employers who rely on Hispanic immigrant labor may be faced with unhealthy workforces, potentially resulting in lower productivity. This is especially problematic for rural new destinations that already suffer from limited health care infrastructure, small tax bases, hospital closures, and competitive disadvantage due to prior decades of industrial restructuring and social safety net dismantling.

Placed-based (destination-specific) policy interventions may be more effective at increasing Hispanic insurance rates than broad sweeping policies. Universal Medicaid for immigrants would improve Hispanic insurance rates the most in 1990s destinations, but such a policy is unlikely to garner widespread public or political support. In counties with larger shares of U.S.-born Hispanics and eligible immigrants, the Affordable Care Act (ACA) should increase Hispanic insurance rates, especially in states that expanded Medicaid. Most undocumented immigrants are not eligible for Medicaid or marketplace subsidies under the ACA, and legal permanent residents are eligible only after a five-year wait. Therefore, the ACA is unlikely to immediately increase insurance rates among poor Hispanics in 1990s destinations and rural 2000s destinations, wherein the majority of Hispanics are immigrants, but it should improve coverage for future generations of Hispanics born in these places. Although improving access to Medicaid would increase insurance rates among poor Hispanics, the majority of insured Hispanic adults obtain their insurance through their employers. In established destinations and metropolitan 2000s destinations, improving Hispanic college completion rates could facilitate entry into occupations that provide health insurance. Finally, farming-dependent 1990s destinations may benefit from federal or state incentives to farm employers to provide employer-subsidized insurance.

Data and Methods

This research used the county as the unit of analysis because county governments provide political and economic structure, counties represents the context within which most social and health services are delivered, and county governments often administer state-level social programs. County boundaries also remain relatively consistent over time, allowing for straight-forward comparisons of Hispanic population size in 1990, 2000, and 2010.

Data are from the 2009/2013 American Community Survey (ACS) estimates[2]. Insurance refers to any type of coverage (i.e., public, private). Analyses focus on working-age adult (18-64) insurance rates. Most Hispanics aged 65+ (95 percent) have health insurance. Different federal and state policies apply to children's insurance, and a greater percentage of Hispanic children are U.S.-born compared to Hispanic adults, making them eligible for public insurance programs.

Metropolitan status categories are defined using the 2003 USDA Economic Research Service (ERS) Rural-Urban Continuum Codes (RUCC). The three metropolitan codes (RUCCs 1-3) are collapsed into *metropolitan*. *Large nonmetropolitan* counties are those with urban populations of 20,000 or more (RUCCs 4 and 5). *Rural* counties are those with urban populations of less than 20,000 (RUCCs 6-9). Hispanic destinations are defined based on Hispanic population size and growth. *Established destinations* are counties with a Hispanic population composition of at least 10 percent in 1990 (Lichter and Johnson 2009). *1990s new*

destinations are counties with <10 percent Hispanic population in 1990 but that experienced Hispanic population growth of ≥150 percent and ≥1,000 Hispanics from 1990 to 2000 (for counties ≥20,000 residents), or experienced Hispanic population growth of ≥150 percent and exceeded the national average percent Hispanic in 2000 (12.5 percent) (for counties with populations <20,000). *2000s new destinations* are counties that did not meet the requisite Hispanic population growth threshold in the 1990s but experienced Hispanic population growth of ≥150 percent and ≥1,000 Hispanics between 1990 and 2010 (for counties ≥20,000 residents) or experienced Hispanic population growth of ≥150 percent between 1990 and 2010 and exceeded the national average percent Hispanic in 2010 (16.3 percent). All other counties were classified as non-destinations. This resulted in 329 established destinations (representing 66.9 percent of Hispanic adults [ages 18-64], 310 1990s destinations (representing 11.3 percent of Hispanic adults), 571 2000s destinations (representing 14.7 percent of Hispanic adults), and 1,925 non-destinations (representing 7.0 percent of Hispanic adults). Results were robust to various destination definitions.

For more details on data and methods and more comprehensive analyses, see: Monnat, Shannon M. forthcoming. "The New Destination Disadvantage: Disparities in Hispanic Health Insurance Rates in Metropolitan and Nonmetropolitan New and Established Destinations." *Rural Sociology*.

[2] ACS data are estimates with sampling error. Some counties have larger margins of error, and thereby less reliable estimates, than others. Analyses are limited to counties with ≥100 Hispanics ages 18-64 and to counties with acceptable reliability values for Hispanic insurance rate, defined as having a coefficient of variation (CV) <40 percent (source). CVs were calculated in line with the U.S. Census's derived ratios formula (source). All analyses were weighted by the inverse of the CV to give less weight to less reliable estimates.

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Acknowledgments

Dr. Monnat acknowledges funding from the Robert Wood Johnson Foundation New Connections grant and support from the Population Research Institute at Penn State, which receives center core funding from NICHD (R24-HD041025). The W-3001 committee is funded by the Western Association of Agricultural Experiment Directors (WAAESD).