State CHIP Policies and Access to Health Care for Children of Mexican Immigrants: Reducing Disparities in Health Care Utilization among America's Children

Extended Abstract

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While most U.S. children of immigrants are born in the United States, and thus, are American citizens, about 4% of all U.S. children are born abroad (Borjas 2011), and in 2010, there were an estimated 1 million unauthorized immigrant children under age 18 in the U.S. (Pew Hispanic Center 2013). These children – both recent legal permanent residents and the undocumented – are generally barred from accessing public health care and welfare benefits (Guendelman, Schauffler, and Pearl 2001; Kaushal and Kaestner 2005), potentially widening immigrant-native health disparities. In response, some states have extended coverage to these groups of immigrant children with or without federal matching dollars through the Children's Health Insurance Program (CHIP), originally State Children's Health Insurance Program (SCHIP).

Whether these policies have reduced nativity-based disparities in health and health care remains largely untested at the national level. The present study investigates the contextual effect of U.S. state health insurance eligibility criteria, particularly with respect to immigrant children, on nativity- and immigrant-status-based disparities in routine health care for children. Recent redistribution of the immigrant, particularly Mexican, population from traditional destination states to new and emerging receiving areas (Lichter and Johnson 2009; McConnell 2008; Migration Policy Institute 2011) makes a national approach more important than in the past for informing ongoing debates about federal immigration and health policy and their intersection.

We integrate originally-collected data on U.S. state-specific Children's Health Insurance Program (CHIP) eligibility policies with pooled child-level longitudinal data from the nationally representative Survey of Income and Program Participation (SIPP) panels from 1996-2000, 2001-2004, 2004-2007, and 2008-2011. This study addresses a pressing overarching research and policy question: How do nativity- and immigration-status-based disparities in routine health care utilization among U.S. children vary across states that do and do not provide public health insurance for immigrant children, controlling for the child's health status and family socioeconomic status?

Background

The Children's Health Insurance Program (CHIP), originally State Children's Health Insurance Program (SCHIP), was created under Title XXI of the Balanced Budget Act of 1997 and implemented by all states and the District of Columbia before the turn of the century. It sought to expand health insurance coverage to low-income children who were ineligible for Medicaid. Although not specifically designed for immigrant children, CHIP became the primary vehicle for extending health care coverage to vulnerable foreign-born families, which have faced length-of-residency requirements for federally sponsored assistance since the enactment of welfare reform in 1996. Using state-sponsored funds or through the 2009 Children's Health Insurance Program Reauthorization Act (CHIPRA), some states have chosen to cover undocumented children and legal permanent residents irrespective of time in country.. In addition, CHIP-affiliated prenatal care programs have become more inclusive, with 14 states opting to cover unborn children regardless of the mother's immigration status (Fortuny and Chaudry 2012).

While past research has found that children covered by CHIP are more likely to have a preventive care visit, a usual source of care, and no unmet health care needs (Dick et al. 2004; Fox et al. 2003; Kenney 2007; Shone et al. 2005), few studies have examined the effect of CHIP on disparities in health care access and utilization. One exception is Shone and colleagues' 2005 study of racial and ethnic disparities among New York CHIP (Child Health Plus) enrollees. They found that found most race/ethnic disparities in access and utilization of health care were attenuated when CHIP coverage was available, although disparities, especially between Hispanic and white children, in preventive care and ratings of health care quality persisted. To our knowledge, however, no national study has assessed whether nativity- and immigration-status-based disparities in health care access and utilization have declined through CHIP policies.

CHIP has reduced then number of uninsured children in most U.S. states (Davis 2009) and is likely to have an effect on nativity-based health care disparities since children who typically lack access to health insurance coverage tend to be disproportionately race/ethnic minorities. Indeed, 16 percent of Hispanic children (0 to 18 years) compared with 11 percent of African American and 7 percent of non-Hispanic white children, were without health coverage in 2011 (Kaiser Commission on Medicaid and the Uninsured, 2013). Hispanics, like African Americans, are more likely than non-Hispanic whites to live in families in which no adult holds a full time job. They are also more likely to have family heads who work in low-wage blue collar jobs, which are less likely than higher skill employment to offer health insurance benefits For children whose parents have jobs that do not provide health benefits and that pay above-poverty but low wages that disqualify them from Medicaid, CHIP provides a policy solution to being without health coverage. Where states choose to provide funding to cover low-income immigrant as well as native children, the children of Mexican immigrants should benefit, although we expect disparities within this group to persist depending on the child's and parents' immigration status.

Data and Methods

We combine originally-collected longitudinal data on state-specific Children's Health Insurance Program (CHIP) eligibility criteria with child-level, nationally representative data from the 1996, 2001, 2004, and 2008 panels of the Survey of Income and Program Participation (SIPP). We restrict the sample to all children under age 19, with no bound on family income.

Although the CHIP program targets children in families with incomes up to (or exceeding) 200% of the federal poverty line, we are interested in its impact on health disparities generally.

Our dependent variables are 1) whether the child visited a medical provider in the past year and 2) whether the child had a dental checkup in the past year. Regardless of morbidity, pediatricians recommend at least one routine care visit per year for the all children (Bright Futures and American Academy of Pediatrics 2008). Thus, any child who does not have at least one visit with a physician indicates a true access problem (Currie, Decker, and Lin 2008).

The key independent variables include whether or not immigrant children are ever covered by CHIP and whether undocumented immigrant children can be covered by CHIP. In addition, we include a scale of generosity toward immigrant children using these two variables combined with the eligibility income limit and the length of residency required for CHIP eligibility.

Children are identified as native- or foreign-born and as documented versus undocumented based upon their date and place of birth and their parent's reported immigration status, status adjustment, and immigration history, including their date of last immigration. Within-group comparisons are based on these nativity and status indicators. Each nativity/immigration status group is also compared with non-Hispanic white children as well.

Full models control for family income as a percentage of the poverty line and parent's educational attainment. We also control for the parent-reported child's health status as an additional step to ensure our results are not driven by morbidity. Year of observation is included to control for period effects and to evaluate change over time between 1996, when CHIP was beginning, and 2011. State fixed effects control for unobserved heterogeneity within states

In order to account for the longitudinal and multilevel structure of our data, we use SAS® 9.3 to generate hierarchical logistic regression models using the four panels as pooled cross-sectional data. All analyses are weighted by the child's longitudinal person weight provided by SIPP.

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