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Source: *Public Administration Review*, NOVEMBER/DECEMBER 2014, Vol. 74, No. 6 (NOVEMBER/DECEMBER 2014), pp. 749-759

Published by: Wiley on behalf of the American Society for Public Administration

Stable URL: https://www.jstor.org/stable/24029499

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In spite of major coverage expansions under the Patient Protection and Affordable Care Act (ACA), a large proportion of immigrants will continue to remain outside the scope of coverage. Because various provisions of the ACA seek to enhance access, advancing knowledge about immigrant access to health care is necessary. The authors apply the well-known Andersen model on health care access to two measures—one focusing on perceptions of unmet health care needs and the other on physician visits during the last year. Using data from the New Jersey Family Health Survey, the authors find that prior to implementation of the ACA coverage expansions, immigrants in New Jersey reported lower levels of unmet health care needs despite poorer self-rated health compared with U.S.-born residents. The article concludes with a discussion of the use of Andersen model for studying immigrant health care access and the broader implications of the findings.

For more than 50 years, expanding health insurance coverage has been the central plank of reformers seeking to reshape the U.S. health care system. The case for broadly expanding coverage has been presented both as a social justice imperative and as a pragmatic cost-saving measure. Although President Lyndon B. Johnson greatly advanced this cause by signing the Medicaid and Medicare programs into law in 1965, universal coverage was not achieved even after their implementation. The Patient Protection and Affordable Care Act (ACA) of 2010, the signature domestic policy achievement of President Barack Obama's first term, advanced the reformers' historic quest for universal coverage (see Thompson 2013 for an overview).

Even though the ACA does not enact universal health care, it squarely addresses the problem of unequal access. Specifically, key provisions such as advance premium tax credits, cost-sharing subsidies, and the Medicaid eligibility expansion directly target affordability of health insurance. Additionally, guaranteed issue rules and other health insurance market regulations address access disparities.

Nevertheless, a significant proportion of adults remain outside the ACA coverage expansion because of their immigration status. Undocumented immigrants are summarily excluded from all coverage expansion provisions in the ACA. The foreign born who do not meet the five-year residency requirement are ineligible for Medicaid. Although they are eligible for health insurance exchange subsidies, exchange plans are not as comprehensive as Medicaid, and unfamiliarity with private health insurance may make it difficult to navigate the health care system. Together, the prevalence of these two immigrant groups (recent arrivals and the undocumented) imposes limits on the ACA's potential to advance health care access for immigrants.

Although the ACA contains measures to bolster facilities that provide services to vulnerable populations, it will take several years for the net impact of these measures to become apparent. Hospitals receiving the disproportionate share hospital (DSH) subsidy—an important part of the safety net—provide services to uninsured immigrants, among others. Because of the increased coverage and carefully crafted DSH reduction methodology, these hospitals are expected to be resilient in dealing with long-term DSH subsidy reductions, set to be phased in starting in 2014 (Hurt 2013; Riley, Berenson, and Dermody 2012). The ACA also provides additional capacity-building funds that are expected to strengthen community health clinics serving vulnerable populations, including immigrants.

Despite these measures, the sheer size of the immigrant population—both those who are completely outside the ACA and those who face barriers that U.S. citizens may not—stand in the way of the ACA's goal of solving the problem of unequal access.

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Public Administration Review, Vol. 74, Iss. 6, pp. 749–759. © 2014 by The American Society for Public Administration. DOI: 10.1111/puar.12280.

The undocumented immigrant population, although relatively stable since 2010, currently hovers around 11 million (Hoefer, Rytina, and Baker 2011; Passel and Cohn 2011). Further, there is great variation among states in the composition of immigrant populations and their representation among the uninsured (SHADAC 2013), making the situation in high-immigrant states particularly challenging. Our study on immigrant health care access focuses on one such state, New Jersey. We find that prior to implementation of ACA coverage expansions, immigrants in New Jersey reported lower levels of unmet health care needs despite poorer self-rated health compared with the U.S. born. We discuss the implications of this and other findings for the implementation of the ACA in New Jersey and nationwide.

Immigrant Health Care Access: New Jersey and the Nation

New Jersey offers a good case study to explore immigrant health care access, for two reasons. First, New Jersey is among the top five states in both the number of immigrants and the proportion of nonelderly adults who are undocumented or recent legal immigrants (Grieco et al. 2012; SHADAC 2013). Immigrants to New Jersey are heterogeneous with respect to national origin and therefore are likely to experience the broad spectrum of issues that immigrants experience nationwide. For example, New Jersey has a large Asian immigrant population, and Hispanic immigrants to New Jersey—compared with other high-immigrant states—show greater diversity in country of origin.

Second, New Jersey has a long history of enacting policies to enhance access to care, such as more inclusive eligibility conditions in Medicaid for immigrants. The state instituted a comprehensive all-payer hospital payment system that subsidized charity care in the 1980s, instituted inclusive community rating and preexisting condition rules in the 1990s (these were precursors to the ACA rules, which are quite similar), and enacted generous public coverage eligibility rules, particularly for children (Cantor and Monheit 2004). New Jersey Medicaid waives the five-year waiting period for legally present immigrant children and pregnant women at state expense (without federal matching funds) and also operates a medical emergency payment program for immigrants subject to the five-year exclusion period (New Jersey Department of Human Services 2013). In sum, the state's prior experience with ACA-like rules, combined with the size and heterogeneity of its immigrant population, makes it a good candidate to study immigrant health care access.

Whereas health care access has been studied intensively over the last four decades, access by immigrants has not received as much attention. Following large waves of immigration during the last two decades of the twentieth century, the number of foreign-born individuals in the United States reached 40 million in 2010 (Grieco et al. 2012). This rise in the immigrant population has corresponded with an increase in studies on immigrant health care access, albeit at a slower pace (for reviews, see Derose et al. 2009; Fortuny and Chaudry 2011; Kandula, Kersey, and Lurie 2004). A review by Derose et al. (2009) spanning nearly 20 years identifies 67 studies on immigrant health care, of which approximately 50 focus on access. All three reviews identify limitations in immigrant status measures, noting that this is partly because routine collection of immigration status information is a recent development.

Although there are gaps in knowledge about immigrant health care access, there is a high level of consensus on some points. Overall, immigrants use fewer health care resources, with one study estimating that immigrant use is 55 percent lower than that of U.S.-born individuals (Mohanty et al. 2005). Health care use by undocumented immigrants is even lower (Berk et al. 2000; Goldman, Smith, and Sood 2005). Some ascribe this to the so-called healthy immigrant paradox, which posits that the foreign born coming to the United States are healthier than the native born (e.g., Singh and Siahpush 2002). Others, such as Barcellos, Goldman, and Smith (2012), argue that lower use of health care by immigrants is attributable to undiagnosed conditions. The high incidence of undiagnosed conditions among immigrants is a result of both financial and nonfinancial access barriers. Lack of health insurance is the primary financial determinant of whether or not an individual sees a physician. Nonfinancial barriers are equally important in shaping immigrant attitudes and personal and family health care choices (Liebert and Ameringer 2013, 814–16).

Some of the nonfinancial barriers have roots in the 1996 welfare reform and the lasting impact it had on immigrant attitudes and behaviors in accessing public benefits. Noting the disproportionate effect of the 1996 welfare reform on immigrants, Ku and Matani draw attention to "a 'chilling effect' that affected immigrants who still were eligible" (2001, 248). This chilling effect persists and is reflected in a recent study of immigrants in which Liebert and Ameringer report that "many immigrants, rightly or wrongly, perceive that certain safety net providers . . . will not care for them" (2013, 818). Kaushal and Kaestner estimate that this "chilling effect" resulted in a 10-point increase in the percentage of uninsured "among low-educated, foreign-born, unmarried women" who were otherwise eligible (2005, 697). Therefore, it is not surprising that the most consistent finding on immigrant health care access is the negative effect of immigrant status on obtaining health insurance, resulting in significantly lower health care use by immigrants (Alegria et al. 2006; Carrasquillo, Carrasquillo, and Shea 2000; Ku and Matani 2001).

Applying the Andersen Model to New Jersey

Our goal in this article is to analyze immigrant health care access in New Jersey and to draw lessons from this analysis for New Jersey and other states. We go beyond health insurance and examine how a broader set of factors—as identified in the Andersen behavioral model—shape health care access. Using data from a statewide household survey, we examine two measures of health care access. One is individual perceptions of unmet health care needs, and the other is a utilization measure of whether or not the individual saw a physician in the last year. Unmet health care needs have been widely used as an indicator of access problems (e.g., Ayanian et al. 2000; Newachek et al. 2000). Berk, Schur, and Cantor (1995) recommend that measures of unmet health care needs cover a broad domain and include nonmedical services as well (e.g., mental health care, dental care, and prescription drugs). Further, given the vastly different experiences that the comparatively healthy and the ill have with the health care system, we carry out our analysis by segmenting the sample into two groups based on indicators of health status.

Andersen's original insight was that health care utilization is not completely determined by a simple combination of resource

availability and health care needs of families. Instead, Andersen (1968) proposed that the use of health care resources is a "fourth level" event, preceded by predisposing conditions, enabling conditions, and need factors. Predisposing conditions, as the term suggests, lead an individual to seek health care. Enabling conditions make it possible for an individual to get access to health care, and need factors make the use of health care an imperative. In subsequent work, Andersen (1995) describes modifications to his original approach. Notably, because of data limitations, he started advocating for individuals, rather than families, as the unit of analysis. Instead of presenting an etiological map in which the three conditions are sequentially arranged, he argues that these three sets of conditions might work independently of each other. Further extensions of the Andersen model have been proposed that take into account "contextual" variables such as the characteristics of the community and health care providers (Phillips et al. 1998). Our goal in this article is to adapt and apply the Andersen model at the individual level to better understand how immigration status is associated with access difficulties after accounting for a variety of predisposing, enabling, and need factors.

Given the centrality of immigrant status to this article, we set immigrant status apart from other predisposing factors. There are differing accounts as to how immigrant status influences health care access and utilization. On the one hand, the healthy immigrant paradox is advanced to explain the discordance between low socioeconomic status and better than expected health outcomes. There is a large and multifaceted literature on the healthy immigrant effect, and it offers two key supporting arguments (Markides and Coreil 1986; McDonald and Kennedy 2004). First, good health confers advantages, and immigrants are a self-selected group composed of healthier individuals. Second, the healthy are favored by the procedural medical requirements in legal immigration and in the trials and risks involved in nonlegal immigration. Palloni and Arias (2004) offer a related argument—labeled "salmon bias"—suggesting that immigrants in poor health return to their homelands in larger numbers, bringing down both morbidity and mortality of immigrant cohorts.

Other observers suggest that the vulnerability conferred by immigrant status is multifaceted and should be recognized in health care access models. Even those who find the case for the healthy immigrant effect compelling recognize that acculturation and assimilation can strip away the protective effects as immigrants adopt new habits and practices in a changed environment (e.g., Abraido-Lanza, Chao, and Florez 2005). Gelberg, Andersen, and Leake (2000) make a distinction between "predisposing traditional" and "predisposing vulnerable" domains and suggest that immigrant status falls in the latter domain.

Data and Methods

Data Collection

We used the 2009 New Jersey Family Health Survey (NJFHS) funded by the Robert Wood Johnson Foundation to examine immigrant access to health care prior to implementation of the ACA (see Brownlee et al. 2010 for complete methodological details). The 2009 NJFHS was a random-digit-dialed telephone survey designed to provide population-based estimates of health care coverage, access, use, and other salient health themes. The survey was designed and conducted by the Rutgers University Center for State Health Policy and fielded by Abt SRBI between November 2008 and November 2009. A total of 7,336 individuals responded (from 2,100 families with landlines and 400 families relying on cell phones in New Jersey), for an overall response rate of 45.4 percent. The adult in the household most knowledgeable about the health and health care needs of the family was interviewed; he or she answered questions concerning all members of the household related by blood, marriage, domestic partnership, adoption, guardianship, or foster care. Within the limitations common to population surveys, the NJFHS is well suited to analysis of immigrant health care access because it has rich data on a wide array of relevant variables.

Measurement

In this section, we describe the measurement of study variables. In addition to the dependent variables on unmet health care needs and physician visits, we describe the measurement of a key independent variable (immigration status) and variables in the three domains of the Andersen model.

Dependent Variables. The two dependent variables in the study were perceived unmet health care needs and whether or not the individual had seen a physician during the last year. Unmet health care needs in medical/surgical, dental, and mental health care domains were assessed by asking the respondent, "During the past 12 months, was there a time when you wanted (medical/dental/mental) care but could not get it at that time?" (separate questions were asked for each type of care). An unmet health care need for prescription drugs was considered present if the either of the following questions were answered affirmatively: (1) "During the past 12 months, was there a time when you didn't get or delayed getting a prescription because it cost too much? Please include refills of earlier prescriptions as well as new prescriptions"; (2) "During the past 12 months have you taken less of a prescribed medication to make that prescription last longer?" Whether or not the individual had seen a physician in the last year was directly assessed by asking, "During the past 12 months have you been to see either a doctor or a nurse practitioner? Do not count doctors seen while in the hospital overnight or the hospital emergency room."

Key Independent Variable. Our key independent variable was immigration status. The NJFHS defined "foreign born" as New Jersey residents born outside the United States, Puerto Rico, and other U.S. territories. In analyzing and modeling the effects of immigration, we classified immigrants into three categories based on duration of residence: foreign born who had lived in the United States for more than 10 years; foreign born who had lived in the United States between five and 10 years, and foreign born who had lived in the United States for less than five years. Our reference group was U.S.-born adults.

Predisposing Variables. For predisposing factors in the model, we used a set of variables that have been used in Andersen's behavioral model (Andersen 1995). These included age, gender, race/ethnicity, education, marital status, and health beliefs. Age was treated as a continuous variable because older individuals are more likely to seek care and therefore are more likely to experience access barriers. Women and educated individuals are similarly more likely to seek health care. For this analysis, education was categorized into four groups based on the individuals' highest level of educational

attainment: less than high school, high school or equivalent, some college, and possessing a college or advanced degree (the reference group). Marital status was also treated as a categorical variable, grouping adults as either married/living with a partner (the reference group), widowed/divorced/separated, or single and never married.

In the NJFHS, only the respondent was asked questions about attitudes toward health and health care. We chose two health beliefs as predisposing conditions and applied the respondent's answers to all members of the household. Using a four-point Likert scale with higher values corresponding to stronger disagreement, respondents were read the following statements: (1) "If you wait long enough, most health problems go away by themselves"; and (2) "Most things that affect my health happen to me by chance." We expected individuals who attribute health to chance or believe that healing is a matter of time to be less likely to report unmet health care needs and/or seek health care.

Enabling Variables. For enabling conditions, again we used classic variables to indicate an individual's ability to obtain care. In addition to income, we included measures of insurance status for dental coverage and medical coverage. Given the significant influence of public coverage, we classified medical coverage based on a hierarchy of any private insurance (the reference category), only public coverage, and uninsured. Organizational and delivery system characteristics also play an important role in shaping health care utilization. Because the NJFHS did not contain data on providers, we assigned a measure of physician supply using the respondent's county of residence. This measure was based on the work of Brownlee and Cantor (2007), who calculate the ratio of patient care physicians per 100,000 population in each county. We created categorical variables that classified each individual's county of residence as having a physician supply above the state average (the reference category), below the state average, or below both the state average and the most recent national benchmark (Weiner 2004).

Need Variables. For need-based measures, we used a range of measures including self-assessed measures of health, self-identified morbid or serious acute symptoms, and diagnosed instances of chronic conditions. Specifically, self-rated general, mental, and dental health were treated as continuous variables and ranged from 1 to 5, with 1 indicating excellent health and 5 indicating poor health. Acute symptoms are self-identifiable markers of potentially serious or morbid conditions requiring attention by a health professional (Baker et al. 1998).

Because the healthy have less interaction with the health care system, we separately analyzed two groups defined on the basis of health need variables. First, we constructed a broad indicator of any health problem, defined as having fair or poor general, mental, or dental health or reporting any symptom or any chronic health condition. We also made a narrower version of this variable using only our best indicators of a clinical health issue, thereby removing the complex and potentially culture-driven variation in perceptions of health needs that underlies questions of self-rated health (Bzostek, Goldman, and Pebley 2007). A health issue was defined as reporting any ever-diagnosed chronic condition or the experience of an acute symptom in the three months preceding the survey.

Analysis

Our analyses focus on nonelderly adults (ages 19–64), the population that historically has had the highest percentage of uninsured and some of the most persistent and pernicious access problems. Most of those expected to gain coverage under the ACA expansions are nonelderly adults. First, we compare the sociodemographic characteristics of all New Jersey nonelderly adult immigrants with those of U.S.-born New Jersey residents. We conduct this comparison by dividing immigrants into three groups based on the number of years spent in the United States (as described previously) because with time spent in the United States, immigrants

Table 1 Sociodemographic Characteristics of New Jersey Nonelderly Adults by Nativity and Time in the United States

			Foreign Born by Time in U.S.					
	U.S. Born (n = 3,972)		≥ 10 years (n = 457)		5 to <10 years (n = 103)		< 5 years (n = 55)	
Age (mean)	42		43		36		31	
	%	SE	%	SE	%	SE	%	SE
Male	47.25	(.97)	51.44	(2.68)	54.04	(5.16)	65.87	(6.15)
Race/ethnicity								
Non-Hispanic white	76.25	(1.46)	28.29	(3.51)	10.12	(3.92)	14.66	(8.64)
Non-Hispanic black	12.96	(1.22)	9.13	(2.28)	2.61	(2.58)	5.14	(4.80)
Hispanic	7.90	(.84)	29.88	(3.69)	48.59	(8.35)	53.17	(10.74)
Non-Hispanic other	2.89	(.53)	32.70	(4.02)	38.68	(8.49)	27.03	(9.41)
Marital status								
Married/living with partner	59.13	(1.55)	77.98	(2.84)	74.91	(5.59)	74.91	(7.61)
Widowed/divorced/separated	13.53	(1.08)	7.49	(1.79)	2.96	(2.48)	3.86	(3.26)
Single and never married	27.34	(1.28)	14.53	(2.29)	22.13	(5.14)	21.24	(7.06)
Education								
Less than high school	4.30	(.65)	10.95	(2.36)	19.80	(6.78)	19.77	(9.07)
High school or equivalent	36.89	(1.44)	28.43	(3.28)	27.31	(6.26)	24.91	(8.19)
Some college	25.82	(1.21)	13.43	(2.25)	13.48	(4.99)	1.85	(1.00)
Bachelor's or advanced degree	32.99	(1.35)	47.18	(3.83)	39.41	(8.01)	53.46	(10.50)
Family income (as percentage of FPL*)								
0%–100% FPL	4.56	(.73)	9.82	(2.73)	8.63	(3.39)	22.32	(9.41)
101%–200% FPL	8.35	(.96)	10.66	(2.19)	11.29	(5.03)	18.16	(6.80)
201%–350% FPL	20.98	(1.54)	15.42	(2.78)	38.98	(8.38)	23.39	(9.65)
Greater than 350% FPL	66.11	(1.73)	64.09	(3.88)	41.10	(8.27)	36.13	(10.27)

*FPL = Federal poverty level.
Source: 2009 New Jersey Family Health Survey.

likely become better assimilated. Second, we provide a comparison of health status and attitudes of nonelderly adult immigrants with the U.S. born. Third, we report a comparison of the U.S. born and immigrants on insurance status and perceived and realized access to health care.

For the final analysis, we divided immigrants into two groups based on the presence of a health issue. After restricting our data to the population that provided complete information on all variables, we carried out two multiple logistic regression models for each group that estimated the impact of immigration status on both perceived and realized access to care. Our first model used unmet health care needs (medical/surgical, mental, dental, or prescription drug) as the dependent variable, and the second model used whether or not the adult had had a doctor visit in the past year.

Immigrant status and the group of variables patterned after Andersen's behavioral model were independent variables in the models and were coded as described earlier and as shown in the tables. All analyses were done in STATA 12.0MP using survey weights, and standard errors were adjusted for the complex survey design including clustering at the household level.

Results

Table 1 confirms some well-known differences between immigrants and U.S.-born adults on demographic and socioeconomic characteristics. The foreign-born population included a much higher percentage of Hispanic and non-Hispanic individuals of races other than white or black. The starkest difference between the U.S.-born and the foreign-born populations was for those with less than five years' stay in the United States. Table 2 presents a comparison of

Table 2 Health Status and Attitudes of New Jersey Nonelderly Adults by Nativity and Time in the United States

	Foreign Born by Time in U.S.							
	U.S. Born (n = 3,972)		> 10 years (n = 457)		5 to <10 years (n = 103)		< 5 years (n = 55)	
	%	SE	%	SE	%	SE	%	SE
General health								
Excellent	30.73	(1.33)	26.29	(3.33)	32.86	(6.68)	14.63	(8.22)
Very good	32.54	(1.37)	28.84	(3.39)	21.97	(5.21)	23.81	(9.29)
Good	23.35	(1.30)	24.87	(3.12)	29.41	(6.23)	36.64	(9.45)
Fair	10.20	(.90)	18.39	(2.69)	14.36	(4.64)	20.46	(8.68)
Poor	3.18	(.55)	1.62	(.79)	1.40	(1.38)	4.47	(4.03)
Mental health								
Excellent	46.51	(1.61)	46.00	(3.81)	47.23	(7.74)	35.42	(10.09)
Very good	26.93	(1.34)	24.95	(3.18)	19.70	(6.10)	12.49	(5.79)
Good	19.61	(1.19)	22.72	(3.15)	31.09	(6.28)	41.12	(9.85)
Fair	4.58	(.64)	5.05	(1.43)	1.90	(1.33)	10.97	(5.58)
Poor	2.38	(.51)	1.28	(.74)	.07	(.07)	.00	(.00)
Dental health								
Excellent	29.10	(1.32)	21.18	(2.84)	18.33	(6.28)	19.68	(9.15)
Very good	27.64	(1.31)	25.36	(3.21)	22.39	(5.34)	9.69	(5.04)
Good	26.67	(1.27)	29.95	(3.24)	38.21	(6.04)	36.70	(8.94)
Fair	9.81	(.87)	18.04	(2.62)	20.55	(5.70)	21.86	(9.00)
Poor	6.79	(.84)	5.47	(1.46)	.52	(.39)	12.07	(6.43)
Chronic conditions								
Asthma	12.49	(.92)	8.25	(1.96)	1.43	(.84)	3.05	(2.36)
Diabetes	6.26	(.71)	7.44	(1.71)	.35	(.35)	4.74	(3.92)
Other chronic/long-lasting condition	16.24	(1.01)	11.18	(2.14)	3.41	(1.98)	5.62	(4.11)
Any chronic condition*	28.27	(1.24)	23.00	(2.98)	5.19	(2.29)	12.31	(5.62)
Acute symptoms†								
Morbid symptom	25.80	(1.30)	29.27	(3.13)	31.89	(7.05)	28.03	(6.95)
Serious symptom	18.38	(1.16)	22.52	(2.85)	24.66	(6.06)	24.31	(7.38)
Any symptom	31.26	(1.39)	38.58	(3.29)	36.09	(7.52)	35.88	(8.95)
Any health issue‡	44.58	(1.42)	49.79	(3.51)	37.59	(7.62)	39.97	(9.09)
Any health problem§	51.14	(1.42)	57.83	(3.57)	46.99	(7.83)	68.06	(7.75)
Attitudes‖								
If you wait, health problems go away								
Strongly agree	65.82	(1.70)	61.33	(3.98)	51.44	(8.39)	51.72	(10.67)
Somewhat agree	19.81	(1.39)	18.75	(3.02)	23.43	(6.82)	38.32	(10.41)
Somewhat disagree	10.58	(1.12)	14.52	(2.72)	14.75	(6.25)	9.49	(4.89)
Strongly disagree	3.79	(.81)	5.40	(2.45)	10.38	(5.73)	.47	(.38)
Health is due to chance								
Strongly agree	36.11	(1.71)	30.01	(3.70)	39.31	(8.25)	24.05	(9.14)
Somewhat agree	28.07	(1.55)	29.71	(3.79)	23.98	(6.92)	35.85	(10.90)
Somewhat disagree	21.39	(1.48)	19.78	(3.14)	23.16	(6.97)	35.18	(9.77)
Strongly disagree	14.42	(1.20)	20.50	(3.47)	13.55	(6.09)	4.92	(2.97)

*Asthma, diabetes, or any other long-lasting/serious condition.
†Presence in the past three months of one or more of 15 physical symptoms indicating a clinical need for care (Baker et al. 1998).
‡Defined as reporting any symptom or any chronic health condition.
§Defined as fair/poor general, mental, or dental health or reporting any symptom or any chronic condition.
‖Percentage of nonelderly adults living in a household where the survey respondent (strongly/somewhat) agreed/disagreed with the statement assessing an attitude toward health or health care.
Source: 2009 New Jersey Family Health Survey.

Table 3 Health Insurance Status and Access to Care of New Jersey Nonelderly Adults by Nativity and Time in the United States

	Foreign Born by Time in U.S.							
	U.S. Born (n = 3,972)		> 10 years (n = 457)		5 to <10 years (n = 103)		< 5 years (n = 55)	
	%	SE	%	SE	%	SE	%	SE
Health insurance status								
Private insurance	79.04	(1.31)	72.91	(3.48)	59.53	(8.04)	45.59	(10.76)
Public coverage	8.83	(.97)	6.09	(1.64)	6.44	(3.65)	4.55	(4.04)
Uninsured (medical)	12.13	(1.00)	21.00	(3.28)	34.03	(7.78)	49.86	(10.71)
Uninsured (dental)	34.36	(1.55)	41.38	(3.96)	48.86	(8.29)	73.63	(9.50)
Unmet health care need								
Didn't get medical/surgical care	6.64	(.72)	3.54	(1.14)	1.69	(1.66)	4.36	(4.10)
Didn't get mental health care	2.55	(.47)	1.10	(.43)	.00	(.00)	.00	(.00)
Didn't get dental care	9.44	(.89)	9.69	(2.24)	6.64	(3.30)	7.37	(4.56)
Didn't get/used less of prescription	12.75	(1.01)	13.37	(2.28)	10.89	(4.33)	6.37	(4.00)
Any of above	20.45	(1.21)	17.34	(2.62)	16.61	(4.91)	17.36	(6.39)
County physician supply*								
Above NJ average	53.15	(1.77)	60.78	(3.97)	62.71	(8.16)	62.27	(10.24)
Below NJ average	38.35	(1.73)	27.64	(3.52)	28.48	(7.74)	20.35	(7.65)
Below NJ average and national benchmark	8.50	(1.02)	11.58	(2.79)	8.81	(4.46)	17.37	(8.66)
No doctor visit in past year	28.77	(1.42)	31.57	(3.39)	47.54	(8.05)	55.73	(10.79)

*See Brownlee and Cantor (2007).
Source: 2009 New Jersey Family Health Survey.

health status and health-related attitudes showing that the U.S. born and immigrants with 10 or more years' stay were very similar to each other and differed in meaningful ways from immigrants with less than five years' stay. Immigrants with less than five years' stay differed from the U.S. born, with immigrants reporting self-rated health as excellent or very good being lower by 25 percent or more for general health, mental health, and dental health. More than two-thirds (68 percent) of immigrants with less than five years' stay reported a health problem—defined as having fair/poor self-rated health, acute symptoms, or a chronic condition—compared with 51 percent of the U.S. born. Table 3 presents results on health insurance status and measures of access to care. The percentage of uninsured among the U.S. born was 12 percent and rose to nearly 50 percent for immigrants with less than five years' stay in the United States. These differences were even starker for dental insurance. The comparisons on unmet health care needs revealed a surprise. In spite of poorer self-rated health, immigrants reported lower levels of unmet health care needs for all four categories.

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Our multivariate analysis of unmet health care needs and physician visits during the last year provided a more nuanced view. These results are presented in table 4. For ease of expression, we refer to the column "no reported health issue" in the table as the "well" and the column for "with reported health issue" as the "ill." Applying the Andersen behavioral model with a relatively full complement of variables for the three domains allows us to examine the relative importance of health insurance, the primary variable in enabling conditions domain, and also whether and how variables from other domains (predisposing and need) mattered.

We begin with a consideration of the findings on immigration status first. There was no statistically significant difference between immigrants with 10 or more years' stay and the U.S. born on perceptions of unmet health care needs. This nondifference stood in contrast with ill immigrants in the United States for less than 10 years, who had significantly lower odds than the U.S. born of having unmet health care needs. To our knowledge, the only study with a similar finding is that by Wu, Penning, and Schimmele (2005). They used a similar multivariate model and found that recent immigrants to Canada reported lower unmet health care needs. This finding on ill immigrants' lower perceived unmet health care needs was inconsistent with the facts that recent immigrants' self-reported health was worse than the U.S. born and that a slightly higher percentage of recent immigrants reported acute symptoms in the last three months. It is possible to dismiss these findings as mere perceptions, but perceptions about unmet health care needs matter because they drive care-seeking behaviors. This is because the ill who believe they do not have unmet needs are less likely to seek care, which can result in important health conditions going undiagnosed for longer (see Barcellos, Goldman, and Smith 2012 on undiagnosed conditions among recent immigrants). For the other dependent variable—no doctor visit in the past year—only the foreign born with 10 or more years in the United States had a statistically significant difference from the reference category of U.S. born. The well among immigrants with 10 or more years' stay had 44 percent lower odds of having no doctor visit in the past year compared with the U.S. born. Immigrants with less than 10 years' stay, on the other hand, had similar odds of not having had a physician visit in the last year compared with the U.S. born.

We found that a number of other variables in the predisposing domain had statistically significant associations with unmet health needs and physician visits. Most of these effects were consistent with what is commonly known. Men who fall into the well category had higher odds than women of not seeing a doctor during the last year. Among the predisposing variables, race/ethnicity had the strongest association with physician visits. Both the well and the ill among

Table 4 Multiple Logistic Regression Results for Any Unmet Health Care Need and No Doctor Visit in Past Year

	Any Unmet Health Care Need						No Doctor Visit in Past Year					
	No Reported Health issue (n = 2,711)			With Reported Health Issue (n = 1,876)			No Reported Health Issue (n = 2,711)			With Reported Health Issue (n = 1,876)		
	OR	SE	p	OR	SE	p	OR	SE	p	OR	SE	p
Foreign born, in U.S. less than five years	.80	(.57)		.14	(.16)	*	.87	(.66)		1.08	(.90)	
Foreign born, in U.S. five to 10 years	.86	(.82)		.31	(.18)	**	1.07	(.48)		.81	(.43)	
Foreign born, in U.S. 10 or more years	.54	(.21)		.68	(.21)		.56	(.15)	**	.99	(.29)	
Age	1.00	(.01)		.97	(.01)	**	.99	(.01)	*	.98	(.01)	**
Male	.76	(.17)		.70	(.14)	*	1.72	(.21)	**	1.28	(.26)	
Non-Hispanic black	.89	(.36)		.99	(.29)		.98	(.24)		1.21	(.40)	
Hispanic	.93	(.41)		.75	(.24)		2.19	(.69)	**	2.24	(.73)	**
Non-Hispanic other	.52	(.32)		.90	(.33)		1.88	(.61)	*	2.41	(.97)	**
Less than high school	.89	(.47)		.71	(.31)		.74	(.43)		.48	(.22)	
High school or equivalent	.99	(.31)		.64	(.15)	*	1.13	(.20)		1.02	(.29)	
Some college	1.63	(.51)		1.11	(.27)		1.16	(.22)		.94	(.29)	
Widowed/divorced/separated	1.04	(.41)		1.69	(.42)	**	1.19	(.38)		1.79	(.57)	*
Single and never married	.90	(.31)		.74	(.18)		1.11	(.25)		1.11	(.28)	
If you wait, health problems go away†	1.04	(.15)		.98	(.11)		1.17	(.12)		1.29	(.16)	**
Health is due to chance†	.99	(.11)		.94	(.08)		1.18	(.09)	**	1.02	(.10)	
Family income 0%–100% FPL	2.30	(1.30)		1.24	(.51)		.78	(.43)		1.15	(.54)	
Family income 101%–200% FPL	1.19	(.46)		1.12	(.35)		1.23	(.43)		1.16	(.44)	
Family income 201%–350% FPL	1.41	(.46)		1.15	(.31)		.77	(.17)		1.81	(.51)	**
Public coverage	.87	(.46)		.93	(.31)		2.36	(.99)	**	.93	(.43)	
Uninsured (medical)	1.97	(.61)	**	2.01	(.64)	**	4.35	(1.30)	**	2.94	(1.09)	**
Uninsured (dental)	2.21	(.63)	**	1.46	(.32)	*	.99	(.19)		2.18	(.56)	**
County physician supply below NJ average	1.25	(.30)		.85	(.17)		1.27	(.22)		.73	(.18)	
County physician supply below national benchmark	.62	(.25)		1.14	(.43)		1.46	(.52)		.89	(.32)	
Self-rated general health‡	1.05	(.17)		1.36	(.14)	**	.96	(.10)		.85	(.10)	
Self-rated dental health‡	1.56	(.20)	**	1.46	(.15)	**	1.16	(.10)	*	1.11	(.12)	
Self-rated mental health‡	.73	(.11)	**	1.02	(.10)		1.02	(.11)		.92	(.11)	
Asthma				1.40	(.30)					.58	(.14)	**
Diabetes				.84	(.25)					.98	(.34)	
Other chronic/long-lasting condition				1.19	(.28)					.46	(.13)	**
Morbid symptom				2.20	(.46)	**				.40	(.09)	**
Serious symptom				2.61	(.52)	**				.66	(.16)	*

Note: Reference groups, in order, are U.S. born, female, non-Hispanic white, college or advanced degree, married/living with partner, family income > 350% FPL, private coverage, having dental insurance, county physician supply above NJ average, and absence of condition/symptom (asthma, diabetes, etc.).
*p < .10; **p < .05.
† Included in the model as a continuous variable with a range of 1 to 4 and higher values indicating stronger disagreement.
‡ Included in the model as a continuous variable with a range of 1 to 5 and higher values indicating poorer health.
Source: 2009 New Jersey Family Health Survey.

the Hispanic and non-Hispanic other categories had higher odds of no doctor visit in the last year compared with non-Hispanic whites. The ill with a marital status of widowed/divorced/separated were more likely to report unmet health needs and more likely to have not seen a doctor in the last year. Health beliefs played a role as well, with the ill who believe that waiting makes health problems go away having lower odds of having seen a doctor in the last year. Similarly, the well who attributed health to chance had lower odds of having seen a doctor in the last year.

In the enabling conditions domain, a number of findings stand out. Among the ill, those in the income range of 201 percent to 350 percent of the federal poverty level had higher odds of not having had a doctor visit in the last year (OR = 1.81). This is consistent with health care access of moderate-income individuals who typically do not have access to public insurance coverage and yet find private coverage unaffordable (Pandey and Cantor 2004). It is not surprising that the well with public coverage had higher odds of having no doctor visit (OR = 2.36). While Medicaid coverage compared well with private coverage available to low-income individuals (Coughlin, Long, and Shen 2005), it did not compare well with all of private coverage. Thus, it is not surprising that the well on Medicaid coverage may choose to forgo physician visits. Consistent with much of the literature (Derose et al. 2009; Kandula, Kersey, and Lurie 2004), lack of health insurance exercises a powerful influence on diminished access. Especially dramatic is its effect on the well, who had much higher odds of not visiting a doctor in the last year (OR = 4.35).

The variables in the need domain had effects in the expected direction. The ill with morbid or serious symptoms had greater odds of unmet health needs (OR = 2.20 and 2.61, respectively). They also had lower odds of no doctor visit during the last year.

Discussion

The ACA is a complex piece of legislation that continues to face both successes and challenges in implementation across the United States (Thompson 2013). Given many pressing implementation challenges, the impact of the ACA on immigrant health care access is unlikely to receive top billing. Yet the sheer size and heterogeneity of immigrants nationwide requires a more thoughtful and deliberate approach to immigrant health care. Our study on immigrant health care access in New Jersey offers indications about the likely impact on immigrants nationwide. We discuss key findings, devoting

significant attention to the anomalous finding on lower unmet health care needs among immigrants, and note implications for New Jersey and other states. Before discussing these findings, we note some important caveats about our use of the Andersen model and data limitations.

The traditional Anderson model works well in explaining factors contributing to access to care, and we find that immigration status is associated with perceived and realized measures of access. Further research on immigrant health care access needs to carefully consider the causal pathways through which the effects of immigration status on health care access become manifest. One refinement of the Andersen model segments each of the three domains into traditional and vulnerable, designating immigration status as a predisposing vulnerable characteristic because of acculturation and literacy concerns (Gelberg, Andersen, and Leake 2000). Yet our study and other studies on immigrant health care access (e.g., Ku and Matani 2001; Liebert and Ameringer 2013) point to immigration status as playing a key role in the other two domains (enabling and need) as well. Immigration status confers systemic as well as person-level vulnerabilities in the enabling and need domains. Therefore, we call for a reformulation of the Andersen model for immigrant populations. This reformulation should be better and more fully informed by the causal mechanisms through which immigration status exercises an influence in each of the three domains.

Our analyses and results should be considered in light of data limitations. First, New Jersey differs from other high-immigration states in some salient ways. For example, New Jersey has actively sought to achieve access to care for all populations, and its residents are, on average, comparatively well off. The access problems we observe in New Jersey may be magnified in other states (see Ku et al. 2011 for a comparative analysis). Our analysis has other limitations common to survey data relying on household survey respondents. Second, implicit in our analysis is the assumption that there is no underlying difference in the way immigrants and the U.S. born evaluate perceptual objects. However, there is evidence for minor differences in Spanish-speaking respondents' perceptual evaluations (e.g., Finch et al. 2002; Hayes and Baker 1998), and future research should probe the influence of such differences using techniques such as anchoring vignettes (see Pandey and Marlowe 2014). Another limitation is the difficulty of incorporating provider/system characteristics and assessing their impact on immigrant health care access.

We want to highlight three key findings that are particularly relevant in shaping immigrant health care access. The first of these findings is the impact of immigration status on perceptions of unmet health needs, which is important for understanding health-care-seeking behavior. Understanding the reasons behind lower unmet health care needs among immigrants is important for health policy and practice. Our finding is particularly intriguing because it is the ill recent immigrants who report lower levels of unmet health care needs compared with the U.S. born (86 percent lower odds for those with less than five years' stay and 69 percent lower odds for those between five and 10 years' stay). Is this a result of a combination of the "healthy immigrant effect" and "salmon bias" discussed earlier? A comparison of self-rated health indicators (general, mental, and dental) shows that immigrants with less than five years stay rate their health as excellent or very good at much lower levels than the U.S. born (those between five and 10 years rate it slightly better but still much worse than the U.S. born), providing evidence against the healthy immigrant effect.

Another possible explanation for reports of lower unmet needs is that immigrants adjust their expectations for health care in response to broader social forces stigmatizing immigrant use of health care services. Ku and Matani (2001), among others, have characterized the post–welfare reform attitude as having a "chilling effect" on immigrants. Indeed, the fraught history of immigration reform is partly a product of sizable and well-mobilized political opinion against immigrant benefits and integration (Barreto et al. 2011). Some have argued that the ACA reforms may perpetuate this chilling effect by further restricting settings of care and isolating undocumented immigrants even more (Warner 2012).

A matter of even greater concern is the implication of these attitudes for care-seeking behavior. When the ill among the recent immigrants report lower levels of unmet health care needs, they are either looking elsewhere to meet these needs and/or mistakenly believe that their health care needs are being met. Portes, Fernández-Kelly, and Light identify some alternative sources of care as "folk healers and other informal providers; free clinics; transnational medicine (drugs and folk remedies sent from home; return in emergencies)" (2012, 18). These coping strategies carry risks ranging from being ineffective to doing real injury and development of full-blown diseases that may require more expensive acute care and/or chronic care treatments.

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Another possible explanation of this surprising difference could lie in how immigrants view the U.S. health care system. Immigrants, compared with the U.S. born, may have lower expectations of the health care system. Or their "rose tinted" view of the U.S. health care system may be based on a framing effect rooted in poorly performing health care systems in their countries of origin that burnishes experiences that the U.S. born may regard as a negative. Such a framing effect is plausible because the overwhelming majority of recent immigrants to New Jersey come from what are regarded as developing countries with even more dysfunctional health care systems. Perhaps this is also a reflection on New Jersey's modestly strong safety net institutions (Portes, Fernández-Kelly, and Light 2012, 18).

The second set of findings about the powerful influence of race/ethnicity and lack of health insurance deserves attention because Hispanic immigrants face additional burdens, and this has substantial bearing on immigrant health care access. Whereas a number of variables in all three domains—predisposing, enabling, and need—reach statistical significance, race/ethnicity in the predisposing domain and lack of health insurance in the enabling domain stand out. Both the ill and the well among Hispanic and non-Hispanic other categories have greater odds of not having visited a doctor in the last year as compared with white respondents. In the enabling

domain, insurance status—consistent with prior research—is a powerful antecedent of health care access (Derose et al. 2009; Fortuny and Chaudry 2011; Kandula, Kersey, and Lurie 2004). Lack of health insurance has an overwhelmingly powerful influence on all the dependent variables. Both the uninsured well and the ill are considerably less likely to have visited a doctor in the last year. Whereas the uninsured ill (compared with those with private coverage) have almost three times the odds of not having seen a doctor in the last year, the corresponding number for the uninsured well is more than four. The coverage expansions under the ACA should reduce the rate of uninsured and, as a result, have the potential to significantly influence both perceptions of unmet health care needs and physician visits. Our findings about the significant effect of race also call for a more concerted outreach to members of Hispanic and non-Hispanic other categories. Limited English proficiency may be an important contributor to the access gaps for these groups as compared with non-Hispanic whites.

The third finding of note pertains to public coverage. In our study, we find that public coverage is both ineffective and effective. The well on public coverage have more than twice the odds of not having seen a doctor in the past year. This is consistent with past research on Medicaid that has highlighted the challenges in designing extended provider networks and fostering client participation (Cunningham and Nichols 2005; Herd et al. 2013; Klein, Laugesen, and Liu 2013). The implication of inadequate ambulatory care access for the well is that states would need to come up with plans to cope with the large increase in the number of newly insured through Medicaid expansion and exchange health plans. As health care systems across the nation adjust to influx of newly insured patients, it would strain the capacity of provider networks and, as a result, further erode access for immigrant groups. For example, undocumented immigrants, with the scaling down of charity care funding (which pays for hospital-based services), may find it even harder to see a doctor (Liebert and Ameringer 2013). States may be able to address this by using funds available under the ACA for building community health centers and bolstering the safety net (see, e.g., Cunningham, Felland, and Stark 2012; Ku et al. 2012). In contrast, the ill on public coverage (compared with those on private coverage) are no different in terms of their odds of having seen a physician in the last year. This provides support for the perspective that public coverage, by and large, has been a force for leveling access gaps and is consistent with other research (Coughlin, Long, and Shen 2005).

In concluding, we want to highlight the national implications of our study. The anomaly in our data that new immigrants have lower perceived unmet health needs yet report poorer health suggests that their understanding of, or expectations about, using health care are different than those of the U.S. born or more acculturated immigrant populations. This implies that culturally tailored approaches are needed for new immigrant populations. While survey data do not directly measure these connections for undocumented immigrants, it is likely that they face many of the same, and likely more, challenges as their legally present counterparts in achieving effective access to care. ACA-imposed barriers to coverage for undocumented and new immigrants can further exacerbate the deleterious effects of a health care delivery system that often falls short of full cultural competence.

This lesson is unlikely to be limited to New Jersey's immigrant communities. The early failure of California's health insurance exchange to effectively reach and enroll large numbers of uninsured Latino residents eligible for coverage, for example, underscores the importance of reaching immigrants on their own terms (Dembosky 2014). The stumbles in California, a state committed to effective ACA implementation, in meeting enrollment goals in a large and comparatively homogeneous Latino population do not bode well for meeting more nuanced and varied needs of diverse immigrant groups across states less committed and well equipped to address access gaps in this population. Perhaps the greatest challenges will be faced by large immigrant populations in states that are not expanding their Medicaid populations—including the high-immigrant states of Texas and Florida—and have not made the historical commitment that New Jersey has to advancing access to care for all of their residents, regardless of immigration status.

Taken together, immigrant health care access presents a pressing challenge to policy makers at the national level. Whereas the political intractability of immigration politics stacks the deck in favor of a "do-nothing" option, exercising this option may turn out to be a pyrrhic exercise of policy myopia. There may be reasonable explanations for low utilization and anomalous perceptions of unmet health care needs such as acculturation deficit and fear of the health care system. That said, an inevitable result of not seeking appropriate care in a timely manner is that undiagnosed (and perhaps mistreated) conditions will worsen. And with the passage of time, many immigrants will satisfy the five-year stay requirement and become eligible for public benefits under the ACA when they are sicker. One can expect similar dynamics with undocumented immigrants unable to obtain primary care in a timely manner needing more expensive health care services in due time. The underlying promise of the ACA to enhance access and reduce costs can only be realized if redlining of immigrants (particularly undocumented immigrants) is overcome and mechanisms to address coverage gaps for low-income immigrants are instituted.

Acknowledgments

We are grateful to Frank Thompson, James Perry, and three anonymous reviewers for suggestions that have greatly improved the article. Needless to say, any remaining errors and weaknesses are our responsibility.

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Commentary

Will the Affordable Care Act Improve Access for the Medically Underserved? A New Jersey Comment

It has long been considered a New Jersey fact that the recent immigrant population, both legal and undocumented, suffers from inadequate quality of and access to comprehensive health care. While not addressing the quality of health care or any specific quality indicators of the care actually provided to these groups, Sanjay K. Pandey, Joel C. Cantor, and Kristen Lloyd in their article "Immigrant Health Care Access and the Affordable Care Act" make a valuable contribution to our understanding of the factors underlying access to health care by immigrants in New Jersey and, by extension, nationwide.

They make use of the "Anderson model" to better understand how two measures of health care access affect immigrant groups divided by time in the United States compared with the U.S.-born population. Data obtained from the New Jersey Family Health Survey prior to the implementation of the Patient Protection and Affordable Care Act (ACA) provided measures of perceptions of "unmet health care needs" as well as actual utilization ("whether or not the individual saw a physician in the last year"). This tool, well suited to the purposes of this evaluation, was designed and utilized by the Rutgers University Center for State Health Policy.

As the authors indicate, New Jersey has a long history of attempting to improve both the quality of and access to health care across the age continuum. Having spent more than three years as commissioner of health and senior services in New Jersey, I had a front seat to view many of those efforts. Early in my term, New Jersey enacted a law, sponsored by Senator Wayne Bryant, requiring every physician licensed in the state to take an approved course in "cultural competency." Each September, Minority and Multicultural Health Month, events are scheduled to

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Public Administration Review, Vol. 74, Iss. 6, pp. 759–760. © 2014 by The American Society for Public Administration. DOI: 10.1111/puar.12286.