Can't Buy Me Health-Care Access: Qualitative Experiences of U.S.-Born Latinx Adults' Health Insurance Coverage and Health-Care Use Post ACA

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Latinx persons have lower levels of health insurance coverage than other racial and ethnic groups even after passage of the Patient Protection and Affordable Care Act (ACA). Using 182 interviews from the American Voices Project, this study examines how U.S.-born Latinx adults experience health-care coverage and health-care use. Interview data demonstrate that health-care access is insufficient to ensure full health-care use. Health-care use costs are so high that they are insurmountable for Latinx Americans. Wealth and liquid assets constrain and are constrained by health-care use. Family members become a safety net. This study can inform policies and programs aiming to improve equity in Latinx individuals' health-care access by centering the importance of reducing economic costs of health-care use.

Keywords: health care, Latinx, adults, insurance, inequality

U.S.-born Latinx adults are twice as likely to be uninsured than their U.S. born non-Latinx White and Asian counterparts (Latino Data Hub 2024). Despite passage of the Patient Protection and Affordable Care Act (ACA), which expanded Medicaid eligibility and reduced income-based disparities in health insurance coverage, Latinx persons continue to be underinsured, less stably insured, and less likely to have seen the doctor in the past year than other racial and ethnic groups (Alcala et al. 2017; Mahajan et al. 2021; Sohn 2017). These disparities exist nationwide despite state variation in the implementation of the ACA. Latinx adults continue to experience systematic barriers that hinder their enrollment in health insurance

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programs and use of formal health-care institutions (Hernandez-Viver 2020). These disparities also exist in other domains. For instance, scholars have documented disparities in unmet dental health-care needs among Latinx persons (Scott and Simile 2005), but a majority of research in this area has focused on Latinx children (Assari and Hani 2018; Flores and Tomany-Korman 2008; Lewis, Robertson, and Phelps 2005; Flores and Lin 2013). Several explanations for the Latinx health insurance and use gaps have been proposed, such as immigration-related barriers (documentation status, linguistic barriers, and so on), employment, trust in medical systems, discrimination, administrative burdens, and high costs. However, although many studies have rightly focused on the health insurance and use experiences of Latinx immigrants, few have focused on a socioeconomically diverse sample of U.S.-born Latinx individuals.

Compared with Latinx immigrants, U.S.-born Latinx persons have different resources available to them to navigate the health-care landscape. U.S.-born Latinx individuals are birthright citizens, which grants them the ability to travel with more ease in the United States and internationally. They also have more education than first-generation immigrants and may access financial capital and credit cards with more ease than undocumented Latinx immigrants. Despite their privileges, U.S.-born Latinx adults remain underinsured relative to other racial and ethnic groups.

In this article, I examine how U.S.-born Latinx adults experience access to health insurance and health-care use by asking what their barriers to accessing health care are and how individuals tend to their health when they are underinsured or uninsured. Drawing on 182 interviews with U.S.-born Latinx individuals (ages eighteen through sixty-four), I find that access to "good health insurance" is not enough to ensure full use of health care.[1] This is because, even with good insurance, health-care use comes with costs so high that they are insurmountable for even middle-class and higher-income U.S.-born Latinx Americans, a population with low levels of wealth. The high costs of health care limit health-care use for U.S.-born Latinx adults across the socioeconomic spectrum, leading to devastating consequences for well-being among the most economically precarious. Family becomes a social safety net for unexpected medical costs, especially in families with mixed health insurance statuses,[2] which had negative implications for family assets. The story of U.S.-born Latinx Americans' health care shows that individuals get caught up in a vicious cycle of limited economic resources and limited health-care use and they reproduce one another: limited economic resources lead to underuse of health care; when catastrophic health events occur, Latinx economic resources are further threatened. The findings of this study shed further light on how, so long as health-care costs remain high and Latinx adults continue to be economically disadvantaged, U.S.-born Latinx persons will continue to be less able to access health care than more economically advantaged groups.

BACKGROUND

Research indicates that Latinx adults have lower rates of enrollment in health insurance and health-care use than most other racial and ethnic groups due to their reluctance to enroll in health insurance programs because of mistrust, racism, and discrimination; service unavailability and institutional constraints; and economic hardship and inability to afford formal health care.

1. All interviewee names are pseudonyms.

2. I use the term mixed-insurance families to describe the distinct constellations of insurance statuses in families. I borrow from the concept of mixed-status families in the immigration literature (Fix and Zimmerman 2001), which describes families in which family members have different citizenship or documentation statuses. In a parallel way, families have variations of insurance status constellations. Variation may stem from insurance status (whether a person has health insurance), type of insurance (public versus private), and insurance stability (whether a person is stably insured over time). Less insured family members rely on others in their family networks during health-care emergencies. Some of these health shocks threaten the economic and financial security of Latinx individuals in the United States.

Reluctance to Enrolling in Health Insurance Programs

Reluctance to enrolling in health insurance programs may drive lower health insurance coverage rates and lower levels of health-care use among Latinx persons. Within this population, lack of a lawful documentation status (being undocumented) may lead to a reluctance to seek formal health care due to deportation fears, which dissuade persons from seeking and using public services even when they are eligible for them (Perreira, Yoshikawa, and Oberlander 2018). Undocumented immigrants are five times more likely than naturalized citizens to be uninsured (Sanchez et al. 2017). Undocumented immigrants often fear disclosing their documentation status to medical providers, and this issue is more pronounced in states with restrictive immigration policies (Marrow and Joseph 2015; Van Natta 2023). Mixed-status families, in which some members are documented and others are not, also see rippling effects of fear of interacting with formal health-care institutions even if intended patients are Medicaid-eligible U.S. citizens (Castañeda and Melo 2014; Enriquez 2015). Mistrust in health-care institutions and misinformation about eligibility for health insurance programs also decrease enrollment in health insurance among the Latinx population (Vargas 2022). In addition, Helen Marrow and Tiffany Joseph (2015) document that financial constraints, language barriers, and bureaucratic requirements make it difficult for undocumented immigrants to enroll in health insurance.

After the rollout of Medicaid expansions via the Affordable Care Act, researchers focused on information gaps and barriers to enrollment among Latinx individuals. Veronica Terriquez and Joseph (2016) find that young Latinx adults are less likely to have health insurance via public programs, highlighting gaps in information. Franciso Pedraza, Vanessa Cruz Nichols, and Alana LeBrón (2017) used the 2015 Latino National Health and Immigration Survey to examine the extent to which the politics of immigration deter individuals from visiting health-care providers. They find that the Medicaid expansion did not eliminate health-care inequities within the Latinx population. Robert Vargas (2022) examines underenrollment in health insurance among low-income Latinx individuals in Chicago post-ACA using longitudinal ethnography and finds that some Latinx individuals were reluctant to enroll in health insurance programs due to previous interactions with other institutions, such as prisons. Some experienced negative interactions obtaining information about the ACA that led them to delay enrollment. Further, Vargas (2022) argues that disproportionate criminalization of people of color can hinder them from obtaining high quality employment with good health insurance coverage. Latinx individuals in Vargas's (2022) study also experienced discrimination and mistreatment in formal health-care settings.

Institutional and Context Constraints

Enrolling in health insurance programs and accessing health-care institutions are overlapping but distinct experiences. Having health insurance does not always lead to accessing health care. Even among those covered by health insurance, perceptions about the medical system (such as medical mistrust, fear of expensive copays) and structural constraints (economic insecurity, lack of accessible neighborhood medical centers) hinder individuals from visiting a doctor (Perreira, Allen, and Oberlander 2021). Neighborhoods in which Latinx communities and other people of color live may have fewer health-care providers. For instance, Jenny Guadamuz and her colleagues (2021) find that Black and Latinx neighborhoods in the most populated U.S. cities have fewer pharmacies. Variation in outreach services may also affect an individual's knowledge about programs for which they are eligible. State policy contexts determine eligibility for public health insurance programs. As of February 2024, forty-one states (including Washington, D.C.) have adopted the Medicaid expansion and ten have not (Kaiser Family Foundation 2024). The current study focuses on interviews with U.S.-born Latinx across the nation, spanning the spectrum state health-care policies.

Latinx Economic Resources and Inability to Afford Health Care

To understand barriers to health-care use in the United States, it is important to understand

the high costs of health care. Relative to other high-income countries, the United States spends about twice as much on health care, costs that are mainly driven by administrative costs and pharmaceuticals (Papanicolas, Worskie, and Jha 2018). The costs of health care have rapidly risen in recent decades. After the Affordable Care Act was passed, high deductible health plans became more common. These plans vary in nature but may include patient deductibles in the thousands of dollars (Wharam, Ross-Degnan, and Rosenthal 2013). Further, out-of-pocket costs are not always clearly disclosed to patients (Ubel, Abernethy, and Zafar 2013), offering greater reason for mistrust, particularly among low-income Latinx patients.

The economic costs of health care remain an important concern for many Americans (Wiltshire et al. 2020), but Latinx individuals have fewer economic resources to cope with those costs compared to several other racial and ethnic groups in the United States. The wealth disadvantages among Latinx adults persist across generations. Due to lower rates of intergenerational wealth transfers between parents and children, the starting points for wealth accumulation during adulthood disadvantage racialized Latinx groups such as Mexican Americans (Salgado and Ortiz 2020; Valdez et al. 2019). Discrimination is another factor influencing racial and ethnic differences in wealth building (Akresh 2011). For instance, racial and ethnic minorities' access to safe wealth-building mechanisms such as access to equitable sources of credit are not usually available in low-income neighborhoods that are majority people of color or ethnic enclaves (Oliver and Shapiro 2013; Pattillo 2010). U.S.-born Latinx individuals are part of a diverse ethnic group that generally have low health insurance rates and low levels of economic resources that could be impactful during a health emergency such as substantial assets, savings, and other forms of wealth (Keister, Vallejo, and Borellli 2015; Salgado and Ortiz 2020; Valdez et al. 2019; Vargas 2022). Even among educated and middle-class Latinx adults, economic resources may remain precarious (Vallejo 2012).

Latinx and Black individuals in the United States are more likely to forgo or delay care due to financial costs than White and Asian individuals (Mahajan et al. 2021). Lacking health insurance may lead to substantial out-of-pocket costs if one seeks care. Lack of health insurance contributes to economic precarity among Latinx communities (Vargas 2022). Further, persons with little to no discretionary income have difficulty meeting the costs of care (Rabin et al. 2020). Individuals with medical debt are more likely to delay care, avoid formal health-care institutions altogether (Hamel et al. 2016), and forgo dental care (Kalousova and Burgard 2013).

Health-Care Strategies Among Latinx Adults in the United States

When individuals experience numerous barriers to health care, they use alternate strategies to address their health. People "insure" themselves and use their social networks to do so. For instance, Andrea Cervantes Gómez and Cecilia Menjívar (2020) find that Latinx immigrants create economic networks of care that include selling medicine from abroad and charging undocumented immigrants for rides to the hospital. These authors also find that some community members took advantage of the systemic barriers that made it difficult for undocumented immigrants, especially undocumented indigenous immigrants in Kansas, to access health care. In addition, Cervantes Gómez and Menjívar (2020) document reliance on homemade medicine, foreign medical treatment, and other forms of self-healing. However, some of these options may be expensive if ethnic ties take advantage of the high need and low health-care access of Latinx persons. Some seek care in different countries. Danielle Raudenbush (2021) examines the binational health-care strategies of Mexican immigrants in San Diego, California, and finds that Mexican immigrants combined U.S.-based health care with health care they received in Mexico. The two sources of care complemented rather than replaced one another. Immigrants obtain specific types of care in Mexico: pharmaceuticals, specialist care, and health care for children (Raudenbush 2021; Vargas Bustamante 2020). These binational health-care possibilities require financial resources to travel, legal documentation to easily travel binationally,

and proximity to the southern border. It is possible that U.S.-born Latinx adults may have cultural norms and health-care repertoires that they learned from family and community ethnic ties.

Relative to Latinx immigrants, U.S.-born Latinx adults have different resources available to them to navigate the health-care landscape. They have U.S. citizenship, which grants them the ability to travel internationally, and they can access financial capital and credit cards with more ease than undocumented Latinx immigrants. Previous studies highlight barriers to enrollment among Latinx persons in Chicago during the rollout of the ACA (Vargas 2022) and informal health-care strategies used by Latinx immigrants in California (Raudenbush 2021) and Kansas (Cervantes Gómez and Menjívar 2020), but research is limited on how U.S.-born Latinx adults navigate being uninsured or underinsured and how they manage to take care of their health years after the ACA's implementation. This study leverages a unique source of national-level data to shed light on how a socioeconomically diverse sample of U.S.-born Latinx adults navigate health care.

THIS STUDY

This study relies on qualitative data from the American Voices Project, the first qualitative census of its kind. I analyzed 182 interview transcripts with Latinx U.S.-born adults between eighteen and sixty-four years old. My study builds on the important qualitative work of Vargas (2022), Cervantes Gómez and Menjívar (2020), and Raudenbush (2021). These scholars have examined Latinx adults' health-care strategies when individuals are uninsured or underinsured. The first study, by Vargas (2022), focuses on the rollout of the Affordable Care Act and barriers to and mechanisms facilitating enrollment among low-income Latinx adults in urban Chicago. The other two studies document how Latinx immigrants in Kansas and Southern California access formal and informal health care in circumstances of limited access or medical mistrust respectively. Although the strength of these studies lies in the detailed ethnographic accounts of discrimination, where people get information, and how they rely on and sometimes exploit ethnic ties, the studies are limited in the extent to which they can generalize results across contexts, and are limited by their focus on relatively disadvantaged Latinx populations. Middle-class and more educated U.S.-born Latinx adults are infrequently included in previous qualitative studies of health-care access. I build on the insights of previous research by using a large cross-context sample of interviews collected years after the ACA rollout and by focusing on U.S.-born Latinx adults across socioeconomic strata. I find two major patterns of health-care experiences. Group 1 includes individuals with stable health insurance coverage. Within group 1 are the few persons who have hit the health insurance lottery, so to speak. However, even good health insurance is not enough to ensure full use of health care. Group 2 includes individuals who have experienced unstable health insurance, who are uninsured, or who are in a mixed insurance status family.

METHODS

This study uses interview data from the American Voices Project (AVP), a national qualitative census. The specific interview questions I focus on are as follows: "Tell me what it's been like trying to get the health care you need. What about for your immediate family? A. Have you ever had to forgo getting the health care you need? What about anyone in your immediate family? B. Have you ever used alternative forms of medicine? (such as indigenous, non-Western, or informal forms of care)? What about anyone in your immediate family?"

Studies about Latinx health care informed my initial coding strategy. For example, based on studies by Raudenbush (2021) as well as Cervantes Gómez and Menjívar (2020), my initial coding book included a code related to using remedies outside the formal health-care system. In addition, the AVP pilot data informed my hypotheses regarding the health-care strategies of Latinx adults. The AVP's pilot study, for which I was a graduate fellow, provided rich information about the health-care strategies of Latinx persons in southern California. Themes from the pilot data included transnational care strategies, unstable health insurance, and mixed insurance status families. I included these themes in my initial codebook.

My analysis relied on 182 AVP interviews with U.S.-born Latinx adults and used an abductive analysis approach. This approach combines deductive and inductive coding by integrating themes found in research and in the AVP pilot data while remaining flexible to novel themes emerging from the data (Tavory and Timmermans 2014). After the first round of coding of interview transcripts, I updated the codebook with new, emerging themes: medical debt or cost concerns, economic insecurity due to medical issues or that affected care seeking, family support during health-care emergencies or health shocks, and unmet dental care needs.

RESULTS

Table 1 includes a summary of the population-weighted demographic characteristics of the U.S.-born Latinx adults included in this analysis. About 20 percent of the sample had a college degree. About 65 percent had worked in the last month. About 38 percent were married, and more than 50 percent were women. I organized my findings to showcase two main health-care experiences (groups 1 and 2) that emerged from the data. Group 1 includes people who have good, streamlined health insurance or who did not report lapses in health insurance coverage. One hundred and twenty-three interviewees are in this group (67 percent). Of those, fifty-two had the good insurance, usually via a private employer, a state job, or the military. Others had stable health insurance from public programs. Some insured respondents in group 1 reported experiencing bureaucratic barriers, long wait times for appointments, and economic burdens when accessing health care. However, group 1 distinctively had relatively stable access to health insurance. Group 2 respondents reported being uninsured, having unstable insurance or a lapse in health insurance coverage at some point, or had immediate family members who were uninsured. These are part of what I call mixed insurance status families, borrowing from the immigration literature's concept of mixed immigration status families (Fix and Zimmerman 2001). A total of fifty-four interviewees are in group 2 (30.22 percent). Within group 2, variation is significant. A handful of respondents reported having been disconnected from health insurance for most of their lives. Health insurance status for five respondents was unknown from the interview transcripts. In the next section, I describe each group in more detail, highlighting interviews that were emblematic of the themes in each group.

Group 1: Stable Health Insurance

Group 1 described their health insurance coverage and health-care use as streamlined, stable, and relatively good. Some reported a seamless health-care access experience. Others, however, reported that despite their insurance, health-care use remained costly despite being insured.

The Good Insurance

Miguel reported paying several hundreds of dollars a month for a health-care premium. During his interview, he lived in a state that had not expanded Medicaid and described his health-care plan as really good. Although he and his wife were separated, his wife remained on his health insurance plan. Miguel explained that his wife did not want to divorce because she had good insurance. This strategy of spousal insurance being a deterrent of divorce has been documented in quantitative research (Sohn 2015, 2020). Miguel described doctor bills as routine: "Big expense, big expense is the mortgage on the house, but other than that, no, I don't think I've had, just regular doctor bills that we pay, but that's not a great big expense." He also mentioned that his job provided comprehensive benefits, including dental insurance, health insurance, vision and eyewear coverage, and retirement benefits: "I have insurance through . . . which is a very good insurance, all the nurses compliment me [for] my insurance." A good job with benefits and stability were a prerequisite for the best type of health insurance. Miguel's case shows that secure financial resources facilitate access to health care, as indicated by being able to afford a mortgage and having stable employment with generous benefits. Miguel's story reflects a story of middle-class America. However, Miguel's experience was an outlier. His comment about the relative affordability of health care in relation to other expenses highlights the positive consequences of stable economic

Table 1. Descriptive Statistics of the Latinx and U.S.-Born Sample, American Voices Project

Variable	Variable Groups	Percent
Sociodemographic characteristics		
Age	18–24	13.57
	25–34	38.49
	35–44	22.81
	45–54	9.99
	55–64	15.14
Education	less than high school	13.56
	high school	18.59
	some college	47.16
	bachelor's degree	20.20
Worked in last month		64.74
Marital status	married	37.90
	cohabitating	13.98
	single	32.50
	other	15.62
Gender	woman	56.14
Region	Midwest	16.76
	West	40.04
	South	35.77
Health-Care group		
Group 1	good or stable insurance	67.03
Group 2	unstable or uninsured	30.22

Source: Author's tabulation.
Note: Descriptive statistics represent population-weighted percentages for the U.S.-born Latinx sample between the ages of eighteen and sixty-four in the AVP dataset.

resources. Similarly, Lucy lived in a Medicaid expansion state at the time of the interview, saying, "We're pretty lucky. I work for a big corporation. I have fairly good health-care coverage. I've also invested in a [health savings account (HSA)] for many years, so we have a pretty substantial sum of money just sitting in an HSA, so that if we were to have something catastrophic happen, we would be able to cover a lot of our out-of-pocket minimums and things like that." Lucy's husband is covered by her insurance, which covers vision and dental insurance. She described the health savings account as a cushion in the event of a larger health shock. If they were to have medical expenses, they would not have to solely rely on personal savings or family resources. Married couples in which one partner's health insurance coverage is solid via employment have an advantage and a pathway to comprehensive benefits. Like Miguel, Lucy reported secure employment that offered generous benefits. Sadly, their health-care experiences were outliers.

Costly Health Insurance and Strategies to Mitigate Cost

Unlike the few respondents who reported having a relatively streamlined health-care experience, others who had stable health insurance reported economic worries related to health-care use. Diana, a full-time worker and student, described co-pays as an economic burden. She

was covered by a state health insurance program and explained that her "health insurance sometimes [is] just so expensive and there's always co-payments. I'm always having to go to a new doctor. And so, in my blood, supposedly, I have a rheumatoid problem, but they don't know which one or they've done the tests, and nothing has popped up. . . . So, it makes me not wanna go to the doctor." Diana also had chronic health issues that led to more co-pays whenever she visited the doctor. She had received mental health services in the past, but due to the high cost per therapy session and her reality of living paycheck to paycheck, she stopped the therapy. Health insurance coverage, for some, is not equivalent to health-care use per se. As Diana's responses make clear, costs influence people's decisions to forgo preventive or urgent care even when they have access to stable health insurance.

Indeed, hospitalizations and unexpected medical needs may lead to economic insecurity due to job and income loss among those with health insurance. For example, Michael, a resident of a Medicaid nonexpansion state, shared his family's experience. They are stably insured and benefit from good insurance. He described access to medications as no big deal. When his father became ill, however, their family struggled to pay the mortgage. Michael explained that his mother took up more hours at work and that other extended family members supported them financially during that time. A health shock can negatively affect family and household socioeconomic status because it can mean the loss of someone's entire income contributions if that person is unable to work for some time. Health emergencies thus negatively affect family socioeconomic status both directly via health-care costs as well as indirectly via affecting individuals' source of income. If families are unprepared for such a shock to income, they may struggle financially. Although Michael's father was the one who had the medical issues and loss of income, the economic impact was felt by the family and thus garnered a familial response.

Some respondents were drawn to specific occupations because of their health-care benefits. For example, a respondent in a Medicaid expansion state mentioned he had recently obtained a job as a driver because of the good health insurance it provides. He described shifts in his coverage: "Well, when I first started out, I had HMO [health maintenance organization]. My company paid 100 percent, I didn't have to pay anything to them, and it covered 100 percent, I didn't have a co-pay." However, at the time of the interview he paid $100 a week for his insurance and reported substantial costs associated with health insurance for himself and his partner. His conversation with the interviewer is telling:

INTERVIEWER: Okay. What about medical costs, so that can include co-pays, prescriptions, health insurance premiums, those sorts of things?

INTERVIEWEE: That is actually more than our food budget.

INTERVIEWER: And how much on that do you spend per month?

INTERVIEWEE: We've probably spent, how much on medical with your insurance?

INTERVIEWEE 2 (interviewer's partner): $617 and that's pretty much it.

This respondent also reported they had to "dip into savings" to pay for hospital bills. Costs and economic burdens associated with health care were salient among persons who had a stable source of health insurance. Within group 1 respondents with stable health insurance, some had lucked out on good insurance, but many had trouble affording co-pays, health-care costs, or coping with health shocks in their families. Whereas respondents such as Miguel said that medical costs were a minor expense, others such as Diana considered avoiding health care because of the high costs. Despite having relatively stable access to health insurance coverage, health emergencies, health-care use, and regular costs of health care created economic barriers due to limited wealth, assets, and liquid cash to address health needs.

Economic barriers further delimited dental care use. For example, one respondent enrolled in a public health insurance program said,

> I mean, it would be great to see a dentist. I probably haven't seen a dentist in like ten years, maybe like seven years actually, but it's

> not something that is affordable to do. I could probably research and see if [provider] covers any or, like recommends any dentist offices but it's something that is not like an urgent issue, because I don't have any pain in my mouth. . . . So, I just think it would be great to get my teeth cleaned, but yeah, I don't really have $100 to spend on that.

Preventive dental needs were seen as an extra cost that, in limited economic circumstances, were beyond reach. However, some respondents mentioned they had urgent dental needs that affected their daily lives. In one woman's case, she mentioned that dental care is not included in her health insurance plan: "Well, I have a tooth that I need help with. So, I forgo it, but that's because the dentist is not covered in my health plan." The interviewer followed up to get more information.

INTERVIEWER: Is that like a really big problem for you or does it not bother you too much?
INTERVIEWEE: I just don't chew with that side of the mouth.
INTERVIEWER: How long has the tooth been bothering you?
INTERVIEWEE: Let's see, 2018.
INTERVIEWER: Okay, so it's been a couple years now?
INTERVIEWEE: Yeah.
INTERVIEWER: You're not willing to pay out of pocket to get it fixed?
INTERVIEWEE: Well, if we get some more Coronavirus aid, that's the first thing, I'm going to do. I already thought about it.

This woman related her suffering in detail and provided an example of a health need that she still ignores because she does not have the economic resources. Lacking dental insurance causes direct harm and suffering to low-income persons. These dental care experiences are similar to those captured in research on dental care disparities among Latinx children (Assari and Hani 2018; Flores and Tomany-Korman 2008; Lewis, Robertson, and Phelps 2005; Flores and Lin 2013), but most research on this area has overlooked the qualitative experiences and suffering caused by the lack of dental health insurance. Stable health insurance did not protect respondents from harms caused by unmet dental care needs.

Group 2: Uninsured, Unstably Insured, and Mixed Insurance Status Families

Individuals in group 2 described their health-care use as a costly, economically burdensome affair that was a source of financial stress. Some took on substantial debt, had overdue hospital bills, and had paid medical costs with credit cards they were still paying off. Members of this group had direct experience being uninsured themselves or reported a close family member's experience being uninsured or having long lapses of being uninsured in the past and having directly been affected by this lack of insurance. I call these families mixed health insurance families, borrowing the term from the literature on immigrant families (Fix and Zimmerman 2001).

Mixed Insurance Status Families

Martin, a veteran, had health insurance benefits because of his military service. He was directly affected by a family member's lack of health insurance. His parent, who had recently passed away, had not had health insurance and had had to sell their belongings and accept donations to afford $600 treatments. Martin was still paying some of these medical expenses as credit card debt. He explained, "We were paying out of pocket. . . . It was a little difficult. We sold a couple of things, and I stopped going out as much, of course. . . . So I stopped hanging out with friends . . . and eventually, it got too much for us to handle. People were reaching out to us and giving us money, donated money." Despite having good insurance, the reality of family support networks means that the burden of lacking health insurance may come from elsewhere. Families in which some members have health insurance and others do not can cause economic stress and threaten economic security in the short and long term. Experiences of being in mixed insurance families were common in group 2 members. Martin's economic situation was affected by his family members' lack of health insurance. This pattern of family being a medical safety net was common.

Although some respondents in mixed insur-

ance families struggled to meet health-care bills, others described medical debt as a contested, negotiable cost that takes work and navigation to resolve. The Ramirez couple were insured at the time of their interview. One of them had private and the other public health insurance. Their child has a disability. This family had experienced lapses in health insurance coverage in the past, which is a pattern disproportionately affecting Latinx and Black adults (Sohn 2017). The Ramirez couple have had to advocate for health-care benefits for their child: "Just getting [child's] [state health insurance program] back and to get them to do it retroactive, which that's the only way to get . . . would be to get his money back, took about six months of fighting and calling every week and getting an answering machine, going down there, waiting hours and getting no answers at all." They had an outstanding hospital bill in the thousands and hoped that their health insurance would cover that retroactively. In another case of a respondent enrolled in a public health insurance program, Joana asked her doctor to change her medication given the high cost: "There are two medications that the copay was like $60. I told the doctor, 'Please switch the medication. I can't afford the copay.'" Joana and the Ramirez family showcase how Latinx patients advocate for themselves to attempt to protect their economic positions or to avoid economic precarity. Navigating the high costs of health-care use was a theme for both groups of respondents, but respondents in group 2 were uninsured, had unstable health insurance, or supported uninsured family members, making their encounters with high health-care costs more catastrophic. Some respondents took action to attempt to mitigate the effects of the high cost of health-care use.

Gloria was uninsured, unemployed, and had chronic conditions. She mentioned that residents in the area where she lived who were uninsured went to a local tax-funded hospital, but this avenue of seeking medical care required more time and involved substantial waiting periods. Gloria was in a mixed insurance status family: some were covered by Medicaid, but others were uninsured. Her younger children were on Medicaid, and the older ones were uninsured. Gloria explained that if they needed medical attention, they would go to the hospital and get a bill. She said, "I don't pay it. I don't pay it. If I'm sick right now, I don't have Medicaid. I don't have none of that, so if I'm sick, I go to the hospital. Let them put it on my credit. I'm not going to pay it anyway. They ain't going to make you pay it, anyway." Although many respondents related avoiding the hospital and preventive health-care because of the high cost, Gloria's perspective reflects a challenge to the assumption that she needs to cover the high costs of health care.

Uninsured, Unstably Insured, or Underinsured

Whether an individual was uninsured, unstably insured, or underinsured was at times a result of oscillating eligibility for health-care programs and job or employment transitions. Economic worries and concerns about health-care use were common among uninsured, unstably insured, and underinsured respondents. As a result of these economic worries, people tended to avoid health-care institutions until necessary.

Ana, a photographer, and her family were uninsured at the time of their interview. They lived in a state that had not expanded Medicaid. She reported having money problems and avoided seeing the doctor. She mentioned traveling to Mexico was a more affordable potential strategy to see the doctor. The interviewer asked Ana, "Can you tell me about any needs you feel are not being addressed in [your] health care?" Ana responded, "Well, I mean, it's not like we don't wanna get checked when we're sick or anything, you know, there's no money. It's very costly." Economic insecurity and having little extra money and savings for health care led respondents like Ana to avoid it altogether. The last time she received regular preventive care was when she had health insurance during her pregnancy. Research documents the gendered ways in which women enter health care through their reproductive health-care access (Van Natta 2023), but this source of health care is temporary. Costs of health-care use among economically precarious U.S.-born Latinx adults block their access to regular as well as stable preventive visits to the doctor.

Many respondents avoided formal health-care institutions because of the perceived and actual high costs and instead looked for over-the-counter medication to address their health issues. Joseph, a young college student who took a break from his studies and began working, lived in a Medicaid expansion state. He described his experience during a health-care emergency:

> Well, actually, the thing was when I went to the hospital, I didn't have insurance at all. We didn't wanna take me to the hospital because I couldn't. . . . There's no way. We knew we would have a really big bill. It took me . . . I only took it for about a week, and after a week I just . . . there's just no way I could hold it no more. I was cramped on my bed, and I just couldn't move from there. And so, they just moved me.

Joseph did not apply for health insurance until after a major health event occurred. His family accrued medical bills and his parents dipped into their limited savings to cover them. Further, during a lapse in health insurance coverage, he skipped medication for a chronic condition for several months. Even among those eligible to enroll in public health insurance programs in expansion states, some people waited until the last minute or until matters worsened and pain or discomfort became unbearable before going to the doctor if they thought it would be costly. Others obtained cheaper medication to ease the pain. For example, Alex, a single mother with a disability living in a state that had not expanded Medicaid, spent some time uninsured and would purchase over-the counter medication to deal with back pain. The family received disability benefits at the time of the interview but had to fiercely advocate for themselves to get those benefits. In fact, they had to get a lawyer to get disability benefits and Medicaid. Before having Medicaid, they would "always take over the counter pills. . . . But it wouldn't help." Sometimes physical tasks like showering were difficult to do on their own. With benefits, they have a provider, but without them, Alex's mother would help. Relying on family for care and financial support was common, especially among respondents with multiple chronic conditions or health emergencies. Some in group 2 experienced extreme economic scarcity so much that at times the doctor was avoided until completely necessary. Over the counter medications seemed like a cost-effective solution to address at times serious health-care needs.

Being underinsured, that is, having health insurance coverage but underusing it because of high costs or gaps in some types of coverage, such as mental or dental health, can hinder access to needed treatment. One respondent living in a nonexpansion state worked in the service industry and were insured through their employer but had been uninsured. They reported that they had not been to a doctor in months because they worried about co-pays. This respondent was underinsured and the inability to afford co-pays also meant her partner's insurance covered her mental health medication. The respondent explained:

> But I was able to get by with [partner's] help because he would cover my part of the bill and I would just focus on getting money . . . to pay for anything, just pay for food, pay for medication. Because like I have depression [and] anxiety. I need medication or I will be a very unpleasant person to be around. Like me right now, me is good right now. Me without medication right now, not a good person. . . . So, I guess just health in general, is just a whole landmine of horrors, isn't it?

Mental health concerns were common among respondents in this study. This respondent's partner was able to cover the cost of her medications. Across interviews, those without health insurance and those who were underinsured had less access to affordable therapy and to continuous mental health medication. For example, Jocelyn did not finish college, worked at a small business, was uninsured, and lived in a state that had not expanded Medicaid. She reported getting a hospital bill. She had also considered transnational care to get health care. In her case, the lack of health insurance led to limited mental health support. Jocelyn described the following struggle: "I think definitely [I] would like to seek out some kind of mental health with the health services. But I

don't have insurance. I can't afford insurance. I can't even afford insurance when things are good." Jocelyn's experiences showcase the mental health consequences of being uninsured and unable to afford health insurance. The perception that health insurance was costly was common across interviews, but the experiences of Latinx adults in states that had not expanded Medicaid particularly emphasized the unaffordability of health insurance. Further, these cases also highlight how respondents with and without health insurance struggled to get mental health services given their high cost.

Like individuals in group 1, a few respondents in group 2 encountered issues accessing dental care. For instance, despite being a college graduate and employed, Nancy was uninsured at the time of her interview. She had been enrolled in her mother's health insurance plan and then in a public health insurance program. However, her income later disqualified her from that program, and she became uninsured. She said, "I hate going to the dentist because I'm just like, you're going to find something wrong, I'm going to end up paying you thousands of dollars." Some unmet needs were as basic as a dental cleaning. Economic worries about high health-care use related to general health care, mental health services, and dental care costs resonated across the experiences of U.S.-born Latinx adults with different education levels, employment statuses, and income brackets. Although a relative minority of respondents mentioned mental health and dental care services, it is important to note that interviews probed for health care broadly.

DISCUSSION

Latinx individuals are one of the least insured (Mahajan et al. 2021) and most economically disadvantaged ethnic groups in the United States (Kochhar, Fry, and Taylor 2011). Relative to their foreign-born counterparts, U.S.-born Latinx adults tend to have more resources at their disposal to engage with the formal U.S. health-care system. However, I argue that the high costs of health care combined with lower levels of wealth make health-care use unaffordable even for U.S.-born Latinx adults. Using 182 interviews, I demonstrate that health insurance coverage is not enough to ensure U.S.-born Latinx persons' full use of health care. Health-care use costs are so high, they are insurmountable for a population with limited wealth. The vicious cycle of limited economic resources constraining health-care use threatens family-level economic resources. U.S.-born Latinx persons, regardless of health insurance coverage, face barriers to full health-care participation and financial well-being. Health policies and programs need to take the socioeconomic calculus of U.S.-born Latinx patients seriously.

The study of U.S.-born Latinx adults' health insurance coverage and health-care use would benefit from attention by scholars of economic stratification, financial security, and family sociology. Although some respondents advocated for themselves when they encountered medical debt and hospital bills, many underinsured Latinx persons took on the neoliberal personal responsibility of paying for health care by relying on savings to pay medical bills for themselves or their families. Furthermore, family ties were a medical safety net. To better understand the long-term socioeconomic ramifications of being uninsured or underinsured in the Latinx community, researchers need to take seriously the expectations and realities of familial care in health emergencies.

This study showcases the pernicious nature of precarious health insurance coverage. Quantitative survey data and analyses focusing on binary measures of health insurance coverage (such as being insured or uninsured) overlook the fact that some insured Latinx adults remain underinsured and continue to budget their health-care use in ways that are unhealthy and risky. This finding has implications for how to better measure health insurance coverage in survey data. Precarious and unaffordable health care may lead to seeking health care elsewhere. As Raudenbush (2021) documents, binational health-care strategies are part of Latinx adults' repertoires that enable them to have agency over health-care decisions. One potential reason that U.S.-born Latinx persons use the formal health-care system less is that they rely on alternate forms of care and knowledge. For example, a minority of interviewees mentioned relying on home remedies and physicians abroad.

Many respondents reported feeling well and not engaging in preventive health care because they did not feel ill. Avoidance and minimization of preventive health-care needs may be relatively harmless in the short term but may lead to negative health outcomes in the long run. Future researchers may wish to dig deeper into narratives of well-being that may be a way to cope with limited resources or stem from a working-class upbringing. Some of these cognitive schemas may stem from growing up in families that were relatively disconnected from health-care systems. Indeed, Latinx children, whether U.S. or foreign born, remain less likely to have seen the doctor in the past year and less likely to be insured than non-Latinx White children (Ortega et al. 2017). Further, this cognitive process may be a way to cope with a medical system that is expensive and overwhelming (Eggerth et al. 2019).

Unmet dental needs were another theme in the interview data that showcased Latinx suffering. Research indicates that having health insurance increases the odds of having access to dental care (Akinkugbe et al. 2020). In this study, dental care needs were mentioned by persons with and without health insurance coverage. Research on Latinx dental unmet needs has largely focused on disparities among Latinx children (Assari and Hani 2018; Flores and Tomany-Korman 2008; Lewis, Robertson, and Phelps 2005; Flores and Lin 2013). Children of color with health insurance experience longer intervals between dental visits than insured White children (Pourat and Finocchio 2010). These disparities may be magnified among Latinx immigrant adults (Quandt et al. 2007). However, research is limited on U.S.-born Latinx adult experiences with dental care, with a few exceptions (Scott and Simile 2005; Akinkugbe et al. 2020). Aderonke Akinkugbe and her colleagues (2020) find no difference in the prevalence of having a dental visit in the past year between U.S-born and foreign-born Latinx adults. Barriers to dental care included cost, fear of needles, and access to dental providers (Akinkugbe et al. 2020). However, most studies on Latinx dental needs have been quantitative. What people do in response to unmet dental care needs and lack of dental insurance is an overlooked area of research in sociology and may provide a window into the long-term consequences of being chronically disconnected from comprehensive health insurance.

One theme in the interviews that emerged but was beyond the scope of this study was medical mistrust related to pain medication. Several respondents wanted to protect themselves from the consequences of the opioid crisis that they have seen in their communities and in the news. This is an important nexus for future research. Qualitative research on the perceptions of the opioid crisis among the Latinx community is limited, with the exception of Jennifer Unger, Gregory Molina, and Melvin Baron's (2020) study, which qualitatively examined perceptions of pain medication in a Latinx sample in southern California. Future researchers may wish to further use qualitative interviews to investigate medical mistrust and pain medications among the Latinx community.

This study focused on the experiences of U.S.-born Latinx adults. This is a diverse ethnic group that generally has low health insurance rates and few economic resources (Keister, Vallejo, and Borellli 2015; Salgado and Ortiz 2020; Valdez et al. 2019; Vargas 2022). Even among middle-class Latinx adults, economic resources may remain precarious (Vallejo 2012). The findings presented in this study shed further light on how, as long as health-care costs remain high and Latinx adults continue to be economically disadvantaged, U.S.-born Latinx individuals will continue to be less able to access health care than more economically advantaged populations. This process is akin to buying opportunity in education (Grusky, Hall, and Markus 2019), which shows that more privileged families are able to maneuver economic resources to better place their children in advantaged economic circumstances. They can buy access to better schools, higher-income neighborhoods, and mentoring services. The situation is similar in health care.

The findings in this study resonate with findings from other studies in this issue. For example, Theresa Rocha Beardall, Collin Mueller, and Tony Cheng (2024, this issue) focus on administrative burdens in communities of color. Some of these burdens were present among Latinx respondents in my study. My

findings show that individuals are not passive actors when they navigate health-care bureaucracies. At times, they exert their agency to contest medical debt. This issue also addresses gendered care work. Priya Fielding-Singh and her colleagues (2024, this issue) show how socioeconomic status shaped how mothers coped with the COVID-19 pandemic, which led to classed parenting approaches. Although my analysis does not focus on gender, many respondents in the analysis were mothers and experienced gendered expectations of care work. Some respondents mentioned how their husbands preferred they care for children and how some decided not to work since childcare became too expensive for them. Some of these fluctuating positions, from employed to unemployed, shifted family income and often program eligibility for Medicaid. In the study by Amy Casselman-Hontalas, Dominque Adams-Santos, and Celeste Watkins-Hayes (2024, this issue) on institutional distrust, the authors showcase how distrust of health care as an institution is aggravated when there is a public health crisis. In the interviews I analyzed, a minority U.S.-born Latinx respondents offered critiques of U.S. health care as an institution caring about profit over people. Further, some did not trust prescribed pain medication for fear of addiction and perceived that doctors overprescribed pain medications.

This study has limitations. First, the interview data lack detail about lapses in health insurance. Although some respondents reported how long they had been without health insurance, many did not. Future researchers may wish to further examine the experiences of U.S.-born Latinx adults and how much time they spend uninsured in young and middle adulthood. Second, health insurance status and health shocks unfold over time. Some families in group 1 may experience health shocks that eventually place them in group 2. Qualitative longitudinal studies are needed to better understand life course health-care experiences, especially as people age and develop chronic conditions and functional limitations. Third, relying on qualitative data from interviews without long-term relationships with respondents and without long-term ethnographic observation is problematic. By design, trust between respondents and interviewers may be limited. One interview per person may not be enough to ascertain deeper experiences related to discrimination, for example. Thus this analysis is not designed to disprove or contest existing accounts or theories about health-care inequities among Latinx persons. Instead, I aim to provide in-depth insights on the U.S.-born Latinx individuals' experiences with health insurance coverage and formal health-care use.

Despite its limitations, this study offers multifold contributions to the extant literature. First, my national analysis of Latinx health care is based on a sample that is more heterogeneous in terms of socioeconomic status, location, and age than participant samples covered by previous qualitative researchers focusing on Latinx' health care. Second, this study may propel novel avenues of future research. Future researchers may wish to explore within-group heterogeneity given previous work showing that Mexican and Central American persons experience steeper health-care barriers than other Latinx ethnic groups (Alcala et al. 2017). Future qualitative work may also focus on gender differences in health-care access and use. Some interviews in this study showed gendered burdens in who navigates children's health insurance bureaucracies. This is consistent with research on gendered health strategies in families suggesting that women with children often take the role of family health manager (Calarco and Anderson 2021). Third, my results can inform health policy.

POLICY IMPLICATIONS

The findings in this study are relevant for policymakers and health practitioners. First, Medicaid state expansions are a clear policy lever that can propel people into health insurance coverage. Second, policymakers might consider creating programs that help low-income adults with medical debt forgiveness. Policymakers and health organizations may create programs that help patients navigate bureaucracies and help patients advocate for their care and benefits. For example, efforts to have families enrolled in the same programs and providers would decrease the bureaucracies that families need to navigate when partners and children are covered by different health insur-

ance programs. In addition, although co-pays, premiums, or deductibles may seem like small amounts to pay to some, they are not negligible for individuals in economically precarious situations who do not have the extra disposable cash assumed by co-pays. Health programs that help cover co-pays among those who are in economically precarious situations would decrease some of the economic burdens that Latinx respondents in this study described. Some have advocated for more local approaches to health care. For instance, Vargas (2016) calls for on the ground interventions to increase trust among uninsured Latinx persons. This type of trust may be important for information dissemination. In conclusion, any policy response to health insurance and health-care use disparities among the Latinx community needs to meet U.S.-born Latinx individuals where they are.

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