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Beyond "chilling effects": Latinx and Asian immigrants' experiences with enforcement and barriers to health care

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Abstract

Objectives: Immigration enforcement policies are associated with immigrants' barriers to health care. Current evidence suggests that enforcement creates a "chilling effect" in which immigrants avoid care due to fear of encountering enforcement. Yet, there has been little examination of the impact of immigrants' direct encounters with enforcement on health care access. We examined some of the first population-level data on Asian and Latinx immigrants' encounters with law and immigration enforcement and assessed associations with health care access.

Methods: We analyzed the 2018 and 2019 Research on Immigrant Health and State Policy survey in which Asian and Latinx immigrants in California (n=1,681) reported on seven enforcement experiences (e.g., racial profiling, deportation). We examined the associations between measures of individual and cumulative enforcement experiences and usual source of care and delay in care.

Results: Latinx, compared to Asian, respondents reported the highest levels of enforcement experiences. Almost all individual enforcement experiences were associated with delaying care for both groups. Each additional cumulative experience was associated with a delay in care for both groups (OR=1.30, 95% CI 1.10-1.50). There were no associations with usual source of care.

Conclusion: Findings confirm that Latinx immigrants experience high levels of encounters with the enforcement system and highlight new data on Asian immigrants' enforcement encounters. Direct experiences with enforcement have a negative relationship with health care access. Findings have implications for health systems to address needs of immigrants affected by enforcement and for changes to health and immigration policy to ensure immigrants' access to care.

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Keywords

Enforcement; immigrant health; health care access; delay in care; usual source of care; Asian; Latinx; enforcement

1. Introduction

Foreign-born Asian and Latinx populations in the US face persistent barriers to health care.[1–3] The enactment and implementation of immigration enforcement policies in the US influence their ability to seek and receive needed health care.[4] Evidence suggests that enforcement policies create a "chilling effect" in which immigrants avoid health care over fear of the negative repercussions of enforcement actions. There has been limited population-level examination, however, of the extent to which either Latinx or Asian immigrants have experienced direct encounters with enforcement, and if those experiences may be related to their ability to access care. In this paper, we used some of the first population-based data on Asian and Latinx immigrants' direct encounters with surveillance, policing, and deportation to examine if enforcement experiences were associated with health care access.

Immigration enforcement policies are associated with reduced health care access and utilization among immigrant populations, particularly Latinx immigrants.[4,5] The relationship between enforcement policies and health care access has been largely explained as the result of anti-immigrant social climates that result from restrictive immigration policies.[6] For example, the Illegal Immigration Reform and Immigration Responsibility Act (IIRIRA) of 1996 expanded federal enforcement and authorized state and local law enforcement collaboration with immigration authorities. IIRIRA is among the growing patchwork of federal, state, and local immigration enforcement policies[7–9] which disproportionately target Latinx immigrant communities through racialized policing and surveillance.[10,11] Under President Obama, deportations expanded to historic levels.[12] President Trump employed openly racist and xenophobic rhetoric to expand federal enforcement and remove many immigrant protections.[13] By 2018-2019, the years of this study, the Trump administration had re-launched the Secure Communities Program and attempted to end the Deferred Action for Childhood Arrivals program, creating heightened vulnerability to enforcement for immigrants across the US.[14]

In these anti-immigrant climates, immigrants may feel unsafe and fear encountering immigration authorities or local law enforcement when seeking health care.[15] This is referred to as a "chilling effect" where the existence of a policy is sufficient to create environments in which immigrants avoid seeking care and distrust health care institutions.[6,16] Studies have linked enforcement policy enactment at federal, state, and local levels with changes in health care access across immigrant populations. President Trump's "Muslim ban" executive order was associated with an increase in missed primary care appointments among foreign-born individuals from the targeted countries.[17] At the state level, Asian and Latinx immigrants in US states with more, compared to fewer, enforcement policies, were less likely to have a usual source of care.[18] Qualitative studies have also

described enforcement policies as creating environments of "pathogenic policing" where Latinx immigrants' fear of encountering immigration authorities influences health care decision-making.[15,19] Related evidence indicates that Latinx immigrants who live in states with restrictive immigration policies are more likely to perceive discrimination.[20]

While the "chilling effect" hypothesis helps explain how enforcement policies shape anti-immigrant climates that, in turn, produce conditions with barriers to health care, there has been less examination of how enforcement policies have directly affected immigrants' daily lives. As restrictive enforcement policies have proliferated, so have the ways in which immigrants may encounter surveillance, policing, or deportation in their day-to-day lives. Federal, state, and local immigrant policies have linked criminal law enforcement activities to immigration enforcement. IIRIRA established section 287(g) of the Immigration and Nationality Act to authorize state and local law enforcement agencies' (e.g., police, sheriff) direct cooperation with federal immigration authorities.[21] As a result, local enforcement of criminal laws (e.g., stops, arrests), can be the precursor to federal enforcement activities (e.g., detention, deportation). These policies have blurred the lines between *criminal law* and *immigration law* enforcement and are described by legal and policy scholars as a system of "crimmigration."[22] This system has also been described as a "racial removal program" because it intends to control the migration of immigrants of color and enacts racialized local policing policies and practices.[23] Under this system, immigrants may be directly affected by immigration enforcement, such as home or work raids, apprehensions, and deportations, as well as criminal law enforcement, such as policing, arrests, and sentencing.[21] Beyond a "chilling effect," immigrants' direct experiences with these enforcement actions may influence their access to healthcare.

There is limited population data, however, about the extent to which immigrants encounter the surveillance, policing, or deportation of this "crimmigration" system.[5,15,24] Recent studies have found that Latinx immigrants who experience a home raid or knew someone deported experienced poor physical and mental health outcomes.[25,26] Evidence from the policing literature shows that people of color experience numerous law enforcement actions in their daily lives[27] and experiences of police brutality are associated with mistrust of health care institutions.[28] Yet there is little data regarding immigrants' exposure to deportation precursors, such as racial profiling or enforcement actions in neighborhoods. Examining immigrants' overall exposure to the enforcement system can advance understanding of how enforcement policies influence access to care.[15]

Latinx immigrants have been targeted and disproportionately affected by enforcement policies (over the last 10 years, Latinx immigrants have accounted for > 90% of annual deportations).[29] Therefore, much of our knowledge on the link between enforcement policy and health is based on research among Latinx immigrants.[17,30] By also examining the experiences of Asian immigrants, the fastest growing immigrant group in the US,[31] we aim to broaden understanding of the patterns of enforcement and assess if the relationships between enforcement experiences and health care access function distinctly for different groups. A recent study, for example, found that Asian noncitizens who were concerned about the deportation of a loved one had worse mental health, suggesting that the impact of a direct experience with deportation may be similar for Asian and Latinx immigrants.[30,32]

Research on undocumented Chinese immigrants showed that, despite having distinct migration routes than Latin American migrants, they also experienced encounters with enforcement at the border and when settling in communities. [33]

In this study, we examine Asian and Latinx immigrants' direct experiences with enforcement and their access to health care. We used data from a novel population-based, state-wide survey from California that was designed to capture immigrants' experiences with multiple enforcement policies and indicators of health care access. By focusing on a single state, we were able to focus on variations *within* an immigrant population living under the same policies, holding the state policy context constant. Data with Asian and Latinx immigrants allowed us to describe population patterns of both groups' experiences and assess if enforcement experiences had a distinct influence on either groups' health care access. We examined two aspects of health care access: having an existing connection with a provider and ability to access needed care in a timely manner. In our analysis, we tested the associations between individual and cumulative enforcement experiences and each outcome and whether or not the associations varied for Latinxs compared to Asians. We hypothesized that any and all enforcement experiences would be associated with being less likely to have a source of care and with delays in care, as such experiences fracture immigrants' trust in health care systems and raise concerns about visiting health care settings, respectively. We also hypothesized that there would be no differences in these associations for Asian or Latinx respondents.

Methods

Data

We used data from the 2018 and 2019 Research on Immigrant Health and State Policy Study (RIGHTS) (N= 1,681) survey that examined Asian and Latinx immigrants' experiences with local law and federal enforcement. The RIGHTS survey was a follow-up to the 2018 and 2019 California Health Interview Survey (CHIS). CHIS used an address-based sampling methodology, recruiting participants through mail and phone, and multimode data collection (e.g., web and phone) to produce a sample representative of California's non-institutionalized population.[34] CHIS participants were asked if they were willing to participate in future surveys. One to three months after completing CHIS, these participants ⩾ age 18 and born in any country in Latin America or Asia, excluding those in the Middle East, were recruited by phone to participate in the RIGHTS survey, for which they received $25 compensation. In 2018 42.5% and in 2019 31.4% of eligible CHIS participants completed the RIGHTS survey. Both surveys were conducted in English, Spanish, Chinese (Mandarin and Cantonese), Vietnamese, or Korean. Sample weights were calculated to adjust for study design and to produce population-representative estimates. Access to the CHIS and RIGHTS data was granted through [REDACTED] and IRB approval was obtained through [REDACTED].

Measures

The dependent measures of health care access and the covariates came from the CHIS survey. The independent measures of enforcement experiences came from the RIGHTS survey.

Usual source of care ––—Respondents were asked Yes or No "Is there a place that you usually go to when you are sick or need advice about your health?" This dependent variable reflected respondents' potential access to health care.[35]

Delay in care ––—Respondents were asked Yes or No "During the past 12 months, did you delay or not get any other medical care you felt you needed—such as seeing a doctor, a specialist, or other health professional?" This dependent variable reflected respondents' realized access.[35]

Individual and cumulative enforcement experiences.—Survey items were developed through a theoretically driven process. We reviewed the literature, obtained input from a community advisory board regarding community members' experiences, and conducted piloting and cognitive interviews in English, Spanish, and Mandarin. The final set of items had a Cronbach's alpha of 0.59 and ask respondents Yes or No if they had ever: (1) stayed inside or avoided certain areas to avoid police or immigration officials, (2) seen immigration officials in their neighborhood, (3) been watched by law enforcement on the street or in a public place, (4) been stopped by law enforcement for no reason, (5) been asked to show proof of citizenship or legal status by law enforcement, (6) been deported, or (7) known someone who had been deported. Each survey response was used as a dichotomous independent variable. We created a measure for cumulative enforcement experiences by summing the total number of individual experiences into a continuous variable (mean=0.9; range 0-7). The measure was used as an independent variable.

Covariates.—We controlled for socio-demographic characteristics associated with health care access. We classified respondents born in Asia as Asian and in Latin America as Latinx (Asian/Latinx). We included variables for citizenship status (naturalized vs. noncitizen green card holder, noncitizen non-green card holder), age (continuous), gender (female vs. male), education level (high school graduation vs. not), employment status (unemployed vs. employed or not in labor force), poverty (below 200% Federal Poverty Level (FPL) vs. at 200% FPL and above), and uninsured (Yes vs. No). We included usual source of care as a covariate of delay in care, as it can be a determinant of utilizing care.

Analysis

We conducted analyses in Stata 16 using weights to account for survey design. First, descriptive analyses described frequencies and distributions of all measures for the full, Asian, and Latinx samples. Second, logistic regression models tested associations between each dichotomous independent variable (seven enforcement experiences) and the dependent variables (usual source of care and delay in care), net covariates. Third, logistic regression models tested associations between the continuous independent variable (cumulative enforcement experiences) and the dependent variables, net covariates. We also

tested an interaction term for cumulative enforcement experiences by Asian/Latinx to assess differences between the groups.

We conducted two sensitivity tests (See supplemental tables). To account for potential increased exposure to enforcement over time, we included years in the US as a covariate in the models but it was not significant nor changed the findings. We tested an interaction term for enforcement experiences by citizenship status and it was not significant.

Results

Descriptive analyses

As shown in Table 1, about 58% of the sample was Latinx and 42% was Asian. About 49% were naturalized citizens, 27% noncitizen green card holders, and 23% noncitizen non-green card holders. Compared to Asians, higher proportions of Latinxs were noncitizens, had not graduated high school, and were below 200% FPL. Eighty-nine percent of Asians reported having a usual source of care, compared to 75% of Latinxs. In contrast, about 15% of both Asians and Latinxs reported delays in care.

Latinx respondents reported the highest levels of enforcement experiences (Table 1). Comparing Asian to Latinx respondents, 2% vs. 24% had stayed indoors to avoid law enforcement, respectively; 3% vs. 18% had seen immigration officials in their neighborhood; 6% vs. 12% had been watched by law enforcement; 11% vs. 15% had been stopped by law enforcement; 4% vs. 9% had been asked for proof of citizenship by law enforcement; 0.3% vs. 6% had been deported, and 12% vs. 43% knew someone deported.

Individual enforcement experiences and health care access

There was no association between any individual enforcement experience and having a usual source of care (Table 2), net covariates. In contrast, almost all enforcement experiences were associated with reporting a delay in care in the last 12 months, net covariates. There were increased odds in delaying care for those who reported ever having stayed indoors to avoid law enforcement (OR=1.88, 95% CI 1.20-2.90), been watched by law enforcement (OR=2.17, 95% CI 1.40-3.40), been stopped by law enforcement (OR=1.64, 95% CI 1.00-2.60), been asked to prove citizenship by law enforcement (OR=1.87, 95% CI 1.10-3.20), been deported (OR=2.53, 95% CI 1.10-6.00), or known someone deported (OR=1.66, 95% CI 1.20-2.30).

Cumulative enforcement experiences and health care access

There was no association between usual source of care and cumulative enforcement experiences (Table 3a, Model 1), nor its interaction with Asian/Latinx (Table 3a, Model 2), net covariates. In contrast, for each additional enforcement experience, respondents had 30% higher odds of reporting a delay in care in the last 12 months (OR=1.30, 95% CI 1.10-1.50), net covariates (Table 3b, Model 1). The interaction between cumulative enforcement experiences and Asian/Latinx was not significant (Table 3b, Model 2).

Discussion

We tested the associations between Asian and Latinx immigrants' experiences with enforcement and their access to healthcare. Our study is among the first to look at direct experiences with immigration enforcement and health care access among both Asian and Latinx immigrants. Consistent with data on immigration arrests and deportations,[36] we found that Latinx immigrants reported the greatest extent of enforcement experiences. One in seven Latinx respondents reported having been stopped by police, one in four had stayed indoors to avoid enforcement, and almost half knew someone deported. Notable proportions of Asian respondents also reported experiences such as having been stopped by police, the most common experience among this group. Despite differences in enforcement experiences between Asian and Latinx immigrants, all but one experience was associated with having delayed needed health care in the last year for both groups. These experiences also had a cumulative relationship with a delay in care for both groups. Contrary to what we expected, there was no association between enforcement experiences, individually or cumulatively, and having a usual source of care.

This study contributes to the growing literature on enforcement and health by examining the influence of both Asian and Latinx immigrants' *direct* contact with *multiple* enforcement policies on distinct aspects of health care access. Past studies have found that enforcement policies have a negative influence on various indicators of access to health care.[4] Some have used contextual measures of enforcement actions (e.g., arrest or deportation rate) or enactment of policies (e.g., state omnibus laws) in states and localities to capture how policy – a structural determinant of health – links to individual-level health care outcomes.[16,37,38] These contextual measures provide critical data on immigration climates that may produce "chilling effects." Yet, they tell us little about the enforcement actions that unfold under these policies. Our findings highlight the need to understand how direct contact with racialized surveillance, policing, and deportation may affect both Asian and Latinx immigrants' health care access.

We found that delaying care, but not having a usual source of care, may be related to Asian and Latinx immigrants' surveillance, policing, or deportation encounters. The direct experiences that we examined indicate that encounters with enforcement are highly prevalent among Latinx immigrants and not uncommon among Asian immigrants. Beyond avoidance due to perceived harms of enforcement, the direct consequences of immigrants' enforcement experiences may influence access to timely health care. For example, although federal guidance prevents ICE from approaching immigrants in certain public places or "sensitive locations," such as hospitals, [39,40] recent studies suggest that some immigrants perceive healthcare settings to be unsafe. [41] Avoidance of healthcare settings may not be exclusively the result of perceptions or concerns, but also immigrants' past experiences, such as seeing immigration officials in neighborhoods, that resulted in direct contact or risk of enforcement actions. Our findings also point to the need to go beyond the "chilling effect" to understand how the stress and economic impact of contact with the "crimmigration" system may influence health care seeking. Enforcement experiences may be linked to other structural health care barriers, beyond immigrants concerns about safety from enforcement. For example, immigrants who have had more contact with enforcement

may have experienced financial distress due to fines and fees associated with enforcement[42] or be concerned about employer retaliation if they take time off work to seek care.[43] Future research should include measures that capture these additional processes by which enforcement experiences shape health care decision-making and access to needed resources.

Surprisingly, we found that enforcement experiences were not associated with having a usual source of care. One explanation for this finding is that immigrants are able to establish and maintain trusting relationships with healthcare providers, such as with community health centers that provide care regardless of immigration status or the ability to pay.[44,45] Such trusted providers may also partner with trusted community entities, such as community health workers, faith-based organizations, or schools, to help patients connect with care within a trusted healthcare system.[46,47]

Limitations

There are some limitations to our study. The study is cross-sectional and the survey did not ask respondents to report the timing of experiences. This precludes assessment of causal relationships or of how the timing of experiences (e.g., in the last year; many years ago) may influence health care access. Experiences of delay may have been related to other external factors (e.g., cost, paid leave) in addition to experiences of enforcement. Our data is generalizable to California, a state with many inclusive immigrant policies. In states with more restrictive policies, the prevalence of enforcement experiences may be higher for both groups; further, the lack of policies, such as access to Medicaid, in such states may compound barriers to care, resulting in greater effects of enforcement experiences. Finally, there is extensive heterogeneity within Asian and Latinx immigrant populations that we did not capture and that may have influenced our estimates. We were also unable to distinguish noncitizens, non-green card holders by legal status (e.g., undocumented, Temporary Protected Status, Deferred Action for Childhood Arrivals). Future research should examine enforcement experiences within both populations, as well as among immigrant groups and legal statuses not captured in this study (e.g., African or Middle Eastern immigrants).

Implications

Our study highlights the importance of measuring and addressing immigrants' direct experiences with the institutions and individuals charged with implementing enforcement policies – encompassing both local policing and enforcement by immigration authorities. Future research can examine additional experiences, such as detention, but can also examine how inclusive, protective policies may improve health care access. In addition, our findings highlight that enforcement policies may have distinct influences on different aspects of health care access, such as having a usual place to receive care compared to the ability to seek timely care. Further research on the mechanisms by which immigrants maintain a usual source of care in restrictive policy environments may provide insights to inform health policies and interventions. Future studies should include multiple domains of health care access and utilization to understand distinct processes by which enforcement policies may influence the complex process of seeking health care.

Health care interventions should respond to the needs of individuals affected by the enforcement system. This could include trauma-informed health care delivery and use of community health workers to foster supportive environments for immigrants seeking care. Trust in healthcare systems could be facilitated by adopting strategies such as policies that establish protections from any law enforcement while in health care settings.[41] Developing interventions that address the potential harm of both *immigration* and *criminal* law enforcement may be particularly effective to address harms of the "crimmigration" system. Ultimately, state and local governments should support immigrants through inclusionary policies and practices that promote safe conditions to seek care.[48] There is evidence that enactment of inclusive state-level policies, such as those that limit cooperation of state and local law enforcement with federal enforcement efforts, are associated with improved health insurance coverage among Latinx noncitizens and may suppress some of the harmful effects of restrictive enforcement policies.[49,50]

Conclusion

Immigrants' access to care is critical for their well-being. As evidence mounts that immigration and law enforcement policies result in barriers to seeking and obtaining health care – and ultimately their physical and mental health [32,51]- understanding the multiple effects of immigrants' day-to-day encounters with the enforcement system can inform needed interventions and policies to protects their ability to obtain care in a timely manner. Ultimately, efforts to dismantle the policies that make up the enforcement system will likely improve immigrants' access to health care.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1.

Characteristics of a) full, b) Asian and c) Latinx samples

	a) Full sample (n=1681)	b) Asian sample (n=702)	c) Latinx sample (n=979)
	% or mean(sd)	% or mean(sd)	% or mean(sd)
Asian/Latinx			
Latinx	58%		
Asian	42%		
Citizenship			
Naturalized citizen	49%	63%	40%
Noncitizen green card holder	27%	26%	29%
Noncitizen non-green card holder	23%	12%	32%
Age	48.9 (0.62)	50.3 (19.0)	47.8 (14.1)
Sex			
Female	53%	55%	52%
Male	47%	45%	48%
Education Level			
High school graduation or higher	66%	86%	52%
No high school graduation	34%	14%	48%
Employment status			
Unemployed	4%	4%	4%
Out of labor force	36%	35%	37%
Employed	59%	60%	59%
Poverty			
At 200% Federal Poverty Level and above	47%	65%	34%
Below 200% Federal Poverty Level	53%	35%	66%
Uninsured			
Yes	81%	90%	75%
No	19%	10%	25%
Self-rated health			
Excellent	12%	12%	12%
Very good	20%	29%	13%
Good	34%	29%	37%
Fair/poor	35%	30%	38%
Usual source of care			
Yes	81%	89%	75%
No	19%	11%	25%
Delay in care in the last 12 months			
Yes	15%	15%	16%
No	85%	85%	84%
Enforcement experiences			
Stayed indoors to avoid enforcement	15%	2%	24%

	a) Full sample (n=1681)	b) Asian sample (n=702)	c) Latinx sample (n=979)
	% or mean(sd)	% or mean(sd)	% or mean(sd)
Seen immigration in neighborhood	12%	3%	18%
Watched by law enforcement	10%	6%	12%
Stopped by law enforcement	13%	11%	15%
Asked to prove citizenship by law enforcement	7%	4%	9%
Deported	4%	0%	6%
Know someone deported	30%	12%	43%
Mean number of enforcement experiences	0.91 (0.05)	0.37 (0.04)	1.28 (0.07)

Source: RIGHTS Study and CHIS, 2018 and 2019

sd = standard deviation

Analyses weighted

Table 2.

Associations between (a) usual source of care and (b) delay in care and each enforcement experience, net covariates

	(a) Usual source of care*			(b) Delay in care**		
	AOR	95% CI		AOR	95% CI	
Enforcement experiences						
Stayed indoors to avoid enforcement	0.88	0.6 -	1.4	1.88†	1.2 -	2.9
Seen immigration in neighborhood	0.68	0.5 -	1.0	0.99	0.6 -	1.5
Watched by law enforcement	0.96	0.6 -	1.6	2.17†	1.4	3.4
Stopped by law enforcement	0.70	0.4 -	1.1	1.64†	1.0	2.6
Asked to prove citizenship by law enforcement	1.05	0.6 -	1.9	1.87†	1.1 -	3.2
Deported	1.44	0.5 -	3.9	2.53†	1.1 -	6.0
Know someone deported	0.92	0.6 -	1.3	1.66†	1.2 -	2.3

*Covariates: Asian/Latinx, citizenship status, age, sex, education level, employment status, poverty level, uninsured, and self-rated health.

**Covariates: Asian/Latinx, citizenship status, age, sex, education level, employment status, poverty level, uninsured, self-rated health, and usual source of care.

†$p<0.05$

Source: RIGHTS Study and CHIS, 2018 and 2019 (n=1681)

Analyses weighted

Table 3.

Associations between (a) usual source of care and (b) delay in care and cumulative enforcement experiences (Models 1) and the interaction of cumulative enforcement experiences and race/ethnicity (Models 2)

	(a) Usual source of care*				(b) Delay in care*			
	Model 1		Model 2		Model 1		Model 2	
	AOR	95% CI	AOR	95% CI	AOR	95% CI	AOR	95% CI
Cumulative enforcement experiences	0.92	0.8 - 1.1	0.97	0.7 - 1.4	1.30*	1.1 - 1.5	1.19	0.9 - 1.6
Asian/Latinx								
Latinx	0.84	0.6 - 1.2	0.86	0.6 - 1.3	0.84	0.6 - 1.2	0.79	0.5 - 1.2
Asian	(ref)		(ref)		(ref)		(ref)	
Citizenship status								
Noncitizen non-green card holder	0.65*	0.4 - 1.0	0.65	0.4 - 1.0	0.69	0.4 - 1.1	0.69	0.4 - 1.1
Noncitizen green card holder	0.64	0.4 - 0.9	0.64*	0.4 - 0.9	0.77	0.5 - 1.2	0.76	0.5 - 1.2
Naturalized citizen	(ref)		(ref)		(ref)		(ref)	
Age	1.03*	1.0 - 1.0	1.03*	1.0 - 1.0	0.98*	1.0 - 1.0	0.98*	1 - 1
Sex								
Female	1.74*	1.3 - 2.4	1.74*	1.3 - 2.4	1.77*	1.3 - 2.5	1.76*	1.3 - 2.4
Male	(ref)		(ref)		(ref)		(ref)	
Education Level								
High school graduation or higher	1.74*	1.2 - 2.5	1.74*	1.2 - 2.5	1.4	1.0 - 2.2	1.44	1.0 - 2.2
No high school graduation	(ref)		(ref)		(ref)		(ref)	
Employment status								
Employed	1.02	0.5 - 2.1	1.02	0.5 - 2.1	0.8	0.4 - 1.6	0.84	0.4 - 1.6
Out of labor force	0.78	0.4 - 1.7	0.78	0.4 - 1.7	0.48*	0.2 - 1.0	0.48*	0.2 - 1.0
Unemployed	(ref)		(ref)		(ref)		(ref)	
Poverty level								
Below 200% Federal Poverty Level	0.88	0.6 - 1.3	0.88	0.6 - 1.2	1.2	0.8 - 1.6	1.2	0.8 - 1.7
At 200% Federal Poverty Level and above	(ref)		(ref)		(ref)		(ref)	
Uninsured								

	(a) Usual source of care*				(b) Delay in care*			
	Model 1		Model 2		Model 1		Model 2	
	AOR	95% CI	AOR	95% CI	AOR	95% CI	AOR	95% CI
Yes	0.24*	0.2 - 0.3	0.24*	0.2 - 0.3	1.2	0.8 - 1.9	1.2	0.8 - 1.9
No	(ref)		(ref)		(ref)		(ref)	
Self-rated health								
Excellent	0.66	0.4 - 1.1	0.66	0.4 - 1.1	0.31*	0.2 - 0.6	0.30*	0.2 - 0.6
Very good	0.89	0.5 - 1.4	0.89	0.5 - 1.4	0.34*	0.2 - 0.6	0.35*	0.2 - 0.6
Good	0.86	0.6 - 1.3	0.86	0.6 - 1.3	0.69*	0.5 - 1.0	0.69*	0.5 - 1.0
Fair/poor	(ref)		(ref)		(ref)		(ref)	
Usual source of care								
Yes					0.59*	0.4 - 0.9	0.60*	0.4 - 0.9
No					(ref)		(ref)	
Cumulative enforcement experiences X Race/ethnicity								
Latinx X Experiences of Enforcement			0.95	0.6 - 1.4			1.11	0.8 - 1.6
Asian X Experiences of Enforcement			(ref)		(ref)		(ref)	

Source: RIGHTS Study and CHIS, 2018 and 2019 (n=1681)

Analyses weighted

*p<0.05