Association of Covered California and Healthcare Access and Utilization among Latino Population

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Abstract

Background and Purpose: The Patient Protection and Affordable Care Act resulted in establishment of Covered California (Covered CA), a marketplace providing federally subsidized health insurance in California. This study explored whether obtaining Covered CA coverage improves healthcare access and utilization among Latinos, and whether acculturation plays a role in utilization of healthcare. **Methods:** 270 Latino adults in San Diego community completed a self-report survey. **Results:** Those with Covered CA were significantly more likely to have a main provider ($p<.0005$), to select doctor's office as location for services ($p<.05$), and significantly less likely ($p<.0005$) to report cost as an obstacle to care compared to uninsured participants. The more acculturated group was more likely to report receiving care at a doctor's office ($p<.05$). Those who were less acculturated were more likely to report cost as an obstacle to care ($p<.05$). However, no significant associations were found between acculturation or insurance type and utilization of healthcare. **Conclusion:** Although health insurance and higher levels of acculturation do improve access, the study did not find their significant association with utilization of provider visits. Our results suggest that healthcare providers might want to consider additional factors to improve utilization of services instead of mainly emphasizing insurance.

Keywords: Covered California, Affordable Care Act, Hispanics, Latino, access to care, health insurance, acculturation, utilization

Introduction

When the insurance mandate of the Affordable Care Act (ACA) took effect, health insurance became a requirement for most Americans due to the high number of uninsured individuals in the U.S. and the rising costs of health care. States received the opportunity to create health insurance exchanges to help with enrollment assistance (Kaiser Family Foundation, 2014). California is one of the states that chose to participate and established Covered California (Covered CA), the state's health insurance exchange. By increasing health insurance coverage and providing more opportunities for health care provider visits, Covered California's goal aims to increase access to care. However, there is no conclusive evidence on whether this increase in access through Covered CA actually results in increased utilization of health care services.

The enactment of Covered CA may have an important impact on Latino population because of the high rate of uninsured individuals in this group. Prior to the first enrollment of the healthcare exchange 36% of Latinos were uninsured; that rate dropped to 23% after the first enrollment, which lasted from January 2014 to March 2014 (Doty, Blumenthal, & Collins, 2014). Studies in recent years show that ACA has led to improvements in healthcare access and affordability among low-income populations (Sommers, McMurtry, Blendon, Benson & Sayde, 2017; Chen, Vargas-Bustamante, Mortensen, Ortega, 2016). In an Oregon-based study, Spanish-preferring Latinos had the largest increase in insurance coverage rate as a result of ACA (Heinzman, Bailey, DeVoe, Cowburn, Tapka, Duong, Marino, 2017). Limited studies have examined the effect of the ACA insurance

mandate on the actual utilization of healthcare services suggesting some reductions in disparities (Alcala, Chen, Langellier, Roby, Ortega, 2017; Wherry, Miller, 2016). This study evaluated the relationship of Covered CA or other insurance with healthcare access and utilization specifically among the Latino population. Additionally, previous research has suggested that those who are more acculturated tend to have higher rates of insurance and utilize medical services more than those who are less acculturated (Askim-Lovseth & Aldana, 2010; Frank, Liebman, Ryder, Weir, & Arcury, 2013), and we would like to explore this association in the Latino population for Covered CA and whether it is different from other categories of insurance.

Purpose

The objective of this study was to answer two questions:
1. Do San Diego community Latinos, who are enrolled in Covered CA, report different healthcare access and utilization compared to those who do not have any insurance or use a different type of insurance?
2. What is the relationship of acculturation with healthcare access and utilization among the Latino population using Covered CA plans and how it compares to that under other insurance categories?

Methods

Study Design

The study followed a cross-sectional design and used a self-report survey in English or Spanish to collect the participants' data. The survey was translated in Spanish by an individual bilingual in English and Spanish and piloted with individuals whose native language is Spanish. The dependent variables for this study included three separate questions for access and two separate questions for utilization of healthcare. The independent variable was the type of insurance and level of acculturation.

Participants

Latino adults (N = 270) from San Diego, California were recruited at a local health fair and two community Spanish churches. The convenience sample included 270 adults between the age of 18 and 78.

Measures

A self-report survey was constructed to evaluate the main variables of interest for this study. The questionnaire was piloted and adjusted based on the feedback received. The final survey was translated into Spanish and then approved by Loma Linda University's institutional review board. The participants completed an anonymous self-report survey in their choice of English or Spanish language providing information concerning their perceived access and utilization of health care services as well as their current insurance plan, if any.

Access to Care. Access was measured by three different variables: (a) main provider, (b) location of health services, and (c) obstacles to healthcare. Provider variable was a dichotomous 'yes' or 'no' variable. Location of health services was a categorical variable with the answer options of 'community clinic', 'doctor's office', or 'other'. The obstacles preventing participants from seeing a doctor were measured using three categories: 'no obstacles', 'too expensive or no insurance', 'all other'.

Utilization of Healthcare Services. Utilization was measured by two different variables: (a) time since last doctor visit and (b) delaying seeing a doctor. Three categories of responses for 'time since last doctor visit' included 'less than or equal to one year ago', 'greater than one year up to two years ago', or 'greater than two years ago'. Three categories of responses for delaying seeing a doctor were 'never', 'sometimes', or 'frequently'.

Type of Insurance. The main predictor variable was the type of insurance individuals used, which included three categories of responses: 'no insurance', 'Covered CA, or 'other insurance'. 'Other insurance' included Medi-Cal not obtained through Covered CA, employer-based insurance, Medicare, military health insurance and private insurance (not Covered CA). This was done to determine specifically the effect of Covered CA. Participants were thus classified into three groups according to their self-reported insurance status.

Level of Acculturation. This additional predictor variable was measured using five questions developed specifically for this survey and modeled after the California Health Interview Survey (CHIS). The responses to each of the five questions were dichotomized into 'more acculturated' or 'less acculturated' categories. Responses of 'very well', 'moderately well', or 'fairly well' to the question of how well the participant understands English in general were assigned a 'more acculturated' category. A response of 'English' as the primary language spoken at home was assigned to a 'more acculturated' category. A negative response to the question, whether a participant has a strong sense of being a member of the native culture of their ancestors, was assigned a 'more acculturated' category. A positive response to whether the participants consider themselves as U.S. American was assigned a more acculturated category. If a participant stated 'yes' to the question whether they feel that they are part of U.S. American culture, such response was also considered a 'more acculturated' response.

The variable was then calculated by the number of 'more acculturated' responses to the five questions. The overall score value of acculturation was then categorized into 'less acculturated', 'average acculturated' or 'more acculturated' levels. Scores of zero to one were designated as 'less acculturated'; two to three were designated as average level of acculturation; and four to five as 'more acculturated'.

Covariates. The covariates included in the survey were gender, BMI, age, primary language, Latino, ancestry of origin, country of birth, race and level of education. These covariates were obtained from demographic questions in the survey.

Analyses
Statistical analysis was conducted using SPSS version 22. Comparisons across the three different insurance groups were explored using a Kruskal-Wallis test for ordinal variables and a chi-square test for nominal variables to determine if there are significant associations at the bivariate level between the insurance group and each of the health care access and utilization outcome variables. To correct for the covariates, multinomial logistic regression was used for nominal or ordinal dependent variables with three or more groups, and binary logistic regression was employed for dichotomous dependent variables. These tests enabled us to determine whether the three types of insurance groups are significantly associated with any of the outcome variables.

Results

Sample Characteristics
Table 1 displays the demographic and clinical characteristics of the 270 Latino participants. There were more participants having no insurance (37%) and other insurance types (42%) compared to those having Covered CA (21%). There were 73% female participants and 27% male participants, and their ages ranged from 18 to 78 years. More than half of the participants were born in Mexico (54%) and had Spanish as their primary language (77%). Forty-eight percent of participants were in the average acculturated group. Seventy percent of participants who had health insurance had it for more than 12 months. Forty-five percent of the participants reported a community clinic or a doctor's office as their primary source of care.

Table 2 presents the demographic characteristics of the participants, grouped by their health insurance status. Those who were uninsured were more likely to be born in Mexico ($p<.01$) and have Spanish as their primary language ($p<.01$). Those who had other insurance were more likely to be born in the U.S. ($p<.001$) and not use Spanish as their primary language ($p<.001$). Those who had no insurance were less likely to understand English very well ($p<.001$), while those who had other insurance were more likely to understand English very well ($p<.01$). Uninsured participants were more likely to have only completed grade school ($p<.001$) and less likely to have completed a four-year college ($p<.05$) or higher ($p<.01$). Those who had other insurance were more likely to have completed a four-year college ($p<.05$) or higher ($p<.01$).

Table 1.

Demographic and Clinical Characteristics of the Participants

		n	%
Age		37[a]	60[b]
Gender	Male	72	27
	Female	198	73
Race	White	141	52
	Mixed	34	13
	Other	95	35
Country of birth	United States	97	36
	Mexico	147	54
	Other	26	10
Highest grade of education completed	did not complete grade school	19	7
	grade school	46	17
	high school	72	27
	two-year community college	41	15
	four-year college	59	22
	graduate or professional school	33	12
Insurance group	no insurance	100	37
	Covered CA	57	21
	other insurance	113	42
Level of acculturation	less acculturated	64	24
	average acculturated	129	48
	more acculturated	77	29
Presence of main provider	Yes	152	56
	No	118	44
Location of health services	community clinic	122	45
	doctor's office	122	45
	other (Pharmacy, ER)	26	10
Preventing from seeing a doctor	no obstacles	138	51
	expensive/no insurance	102	37
	all other	30	11
Delaying seeing a doctor	Never	85	31
	Sometimes	137	51
	frequently or more	48	18
Time since last doctor visit	one year ago or less	194	72
	greater than one up to two	40	15
	greater than two years ago	36	13
Length of time having insurance	less than or equal to 12 months	49	30
	greater than 12 months	116	70

[a] Median   [b] Range

Table 2.

Demographic Characteristics of the Different Health Insurance Groups

		No insurance		CC		Other insurance	
		n	(%)	n	(%)	n	(%)
Gender	male	29	(29)	13	(23)	30	(27)
	female	71	(71)	44	(77)	83	(73)
Race	white	62	(62)	30	(53)	49	(43)
	mixed	11	(11)	5	(9)	18	(16)
	other	27	(27)	22	(39)	46	(41)
Country of birth***	United States	10	(10)***	25	(44)	62	(55)***
	Mexico	77	(77)**	29	(51)	41	(36)***
	other	13	(13)	3	(5)	10	(9)
Spanish primary language***	no	10	(10)**	8	(14)	44	(39)***
	yes	90	(90)	49	(86)	69	(61)
Understanding of English***	very well	27	(27)***	28	(49)	81	(72)**
	moderately well	31	(31)	20	(35)	24	(21)
	not well	42	(42)***	9	(16)	8	(7)***
Highest grade of education completed***	not complete grade school	11	(11)	6	(11)	2	(2)*
	grade school	31	(31)***	8	(14)	7	(6)**
	high school	31	(31)	22	(39)	19	(17)*
	two-year community college	12	(12)	9	(16)	20	(18)
	four-year college	12	(12)*	9	(16)	38	(34)*
	graduate/professional school	3	(3)**	3	(5)	27	(24)**
Ancestry of origin	Mexican	96	(96)	50	(94)	105	(93)
	other Latino	4	(4)	3	(6)	8	(7)
Length of having insurance***	less or equal 12 months	0	(0)	29	(54)**	20	(18)*
	more than 12 months	0	(0)	25	(46)*	91	(82)
Level of acculturation***	less acculturated	44	(44)***	11	(19)	9	(8)***
	average acculturated	38	(38)	37	(65)	54	(48)
	more acculturated	18	(18)*	9	(16)	50	(44)**
BMI		28	(25)[a]	29	(27)[a]	27	(34)[a]
Age		40	(52)[a]	33	(57)[a]	35	(56)[a]

*$p<.05$, **$p<.01$, ***$p<.001$ [a] Median (Range)

Those who had Covered CA were more likely to have insurance for less than a year ($p<.01$). Those who had other insurance were less likely to have it for less than a year ($p<.05$). Those who had no insurance were more likely to be less acculturated ($p<.001$), while those who had other insurance were more likely to be more acculturated ($p<.01$). There were no significant differences among insurance groups for gender, race, BMI and age.

Healthcare Access Factors
Table 3 shows the results of the bivariate analysis between the different insurance groups and the dependent variables. Those who had no insurance were less likely to have a main provider ($p<.001$) and more likely to have a community clinic as a usual source of care ($p<.001$) compared to those who had other insurance. Participants with no insurance were less likely to have no obstacles to care compared to those with other insurance ($p<.001$) and more likely to have health care services out of reach due to expense than those with either Covered CA ($p<.01$) or other insurance ($p<.001$).

To determine if the significant relationships found between the different insurance groups and the various access factors was due to the insurance groups or due to any covariate, a multivariate analysis was performed (Table 4). Even when correcting for the covariates, those who have either Covered CA or other insurance are significantly more likely ($p<.001$ in both cases) to have a main provider compared to those with no insurance.

Table 3.

Bivariate Analysis of the Access Factors of Different Insurance Groups

		No insurance		Covered CA		Other insurance	
		n	(%)	n	(%)	n	(%)
Main provider***	yes	12	(12)***	41	(72)	99	(88)***
	no	88	(88)***	16	(28)	14	(12)***
Location of health services***	community clinic	72	(72)***	34	(60)	16	(14)***
	doctor's office	13	(13)***	18	(31)	91	(81)***
	other	15	(15)	5	(9)	6	(5)
Preventing from seeing a doctor***	no obstacles	12	(12)***	33	(58)	93	(82)***
	expensive/no ins	82	(82)***	10	(17)**	10	(9)***
	all other	6	(6)	14	(25)***	10	(9)
Delaying seeing a doctor	never	29	(29)	15	(26)	41	(36)
	sometimes	47	(47)	33	(58)	57	(51)
	frequently	24	(24)	9	(16)	15	(13)
Time since last doctor visit***	≤1 year ago	58	(58)***	45	(79)*	91	(81)***
	1-2 years	18	(18)	5	(9)	17	(15)
	> 2 years ago	24	(24)***	7	(12)*	5	(5)***

*$p<.05$, **$p<.01$, ***$p<.001$

Those who had Covered CA were more likely ($OR=2.95$, $p<.05$) and those who had other insurance were more likely ($OR=24.7$, $p<.001$) to have a doctor's office as their source of care versus a community clinic than those who had no insurance. Those who had Covered CA or those with other insurance were less likely ($p<.001$ in both cases) to report cost as an obstacle compared to those who had no insurance. Thus, even after correcting for the covariates, there remains a significant association between having Covered CA or other insurance and the three health care access factors of having a main provider, location of health care services and obstacles to obtaining health care.

Healthcare Utilization Factors
There were no significant relationships identified between the three insurance groups and delaying in seeing a doctor. However, those individuals with no insurance were less likely to have seen a doctor within the last year compared to those with Covered CA ($p<.05$) or those with other insurance ($p<.001$) (Table 3).

A multinomial logistic regression was performed to determine if the identified relationships were due to the different insurance groups or if they were due to one of the covariates (Table 4). In this analysis, those who had other health insurance compared to no insurance were 89% less likely to report visiting a health care provider greater than two years ago versus less than a year ago ($p<.01$). No significant relationship, however, was found between Covered CA and no insurance with respect to time since last health care visit. Therefore, the significance found in the bivariate analysis was due to other covariates rather than the Covered CA insurance.

The Influence of Acculturation on Access and Utilization
Table 5 shows the results of the bivariate analysis between acculturation categories and the healthcare access factors. We found several significant relationships. The more acculturated group more frequently reported having a main provider ($p<.05$), were less likely to report going to a community clinic as their source of care ($p<.05$) and were more likely to report receiving care at a doctor's office ($p<.05$) compared to those who were less acculturated. Those who were less acculturated were less likely to report no obstacles to care ($p<.05$) and more likely to report cost as the obstacle to care ($p<.05$), compared to those who were either in the average or more acculturated group.

Table 4.
Multivariate Analysis of Access Factors of Different Insurance Groups

		Covered CA vs None		Other insurance vs None	
		OR	(95% CI)	OR	(95% CI)
Main provider	Yes vs No	60.2***	(16.8, 215)	99.3***	(26.8, 368)
Location of	Dr's Office vs Clinic	2.95*	(1.04, 8.38)	24.7***	(8.47, 72.1)
health services	Other vs Community Clinic	1.04	(0.28, 3.88)	1.66	(0.41, 6.73)
Preventing from	Too Expensive vs No Obstacles	0.04***	(0.01, 0.13)	0.01***	(0.00, 0.03)
seeing a doctor	Other Reasons vs No Obstacles	1.13	(0.27, 4.82)	0.30	(0.06, 1.51)
Time since last	> 2 yrs vs ≤ 1 yr	0.37	(0.10, 1.33)	0.11**	(0.25, 0.48)
doctor visit	1-2 yrs vs ≤ 1 yr	0.32	(0.09, 1.18)	0.83	(0.29, 2.36)
General health	Excellent vs Poor Health	4.11	(0.61, 27.6)	13.3*	(1.26, 140)
	Very Good vs Poor Health	0.73	(0.15, 3.55)	6.88	(0.91, 51.1)
	Good vs Poor Health	1.15	(0.26, 5.07)	3.28	(0.49, 24.0)
	Fair vs Poor Health	0.86	(0.19, 3.91)	2.23	(0.29, 17.2)

*p<.05, **p<.01, ***p<.001

Table 5.

Bivariate Analysis of the Access Factors of Different Acculturation Levels

		Less acculturated		Average acculturated		More acculturated	
		n	(%)	n	(%)	n	(%)
Insurance	no insurance	44	(69)***	38	(29)	18	(23)*
groups***	Covered CA	11	(17)	37	(29)	9	(12)
	other insurance	9	(14)***	54	(42)	50	(65)***
Main	yes	21	(33)*	74	(57)	57	(74)*
provider***	no	43	(67)**	55	(43)	20	(26)**
Location of	community clinic	39	(61)	62	(48)	21	(27)*
health	doctor's office	14	(22)**	59	(46)	49	(64)*
services***	other	11	(17)	8	(6)	7	(9)
Preventing from	no obstacles	20	(31)*	71	(55)	47	(61)
seeing a	expensive/no ins	36	(56)*	44	(34)	22	(29)
doctor**	all other	8	(13)	14	(11)	8	(10)
Delay	never	20	(31)	43	(33)	22	(28)
seeing a doctor	sometimes	34	(53)	64	(50)	39	(51)
	frequently	10	(16)	22	(17)	16	(21)
Time since last	≤ year ago	41	(64)	94	(73)	59	(77)
doctor visit	1-2 years	12	(19)	15	(12)	13	(17)
	>2 years ago	11	(17)	20	(15)	5	(6)

*p<.05, **p<.01, ***p<.001

There was a significant relationship between acculturation and insurance type. The more acculturated group had fewer cases of no insurance (*p*<.05) and more cases of other insurance (*p*<.001), compared to the less acculturated group. No significant association was found between acculturation and Covered CA. There was also no association between acculturation and any of the utilization factors: time since last visit and delay in visiting a health care provider. Thus, acculturation was associated with an improvement in access to care but not with utilization.

Discussion

Our study suggests that Latinos in one community of San Diego who are enrolled in a

Covered CA health insurance plan report that cost is less of an obstacle to care, compared to those who did not enroll in health insurance. This corroborates the findings of Burge and Schade (2014) that the federal government Covered CA subsidies decrease the costs of health care services to individuals.

The study also showed that individuals enrolled in other health insurance plans not under Covered CA also report better access factors compared to those with no insurance. These factors include the presence of a main provider, using a doctor's office and having no obstacles to care. Our findings corroborate those of De Jesus and Xiao (2013) who report that individuals without health insurance are less likely to have a primary source of care compared to those who are insured. Approximately 25% of Latino adults report not having a main provider to treat their medical needs (De Jesus & Xiao, 2013). Similarly, our findings demonstrate that those without insurance have a difficult time obtaining a main provider even though they report going to a community clinic as their source of care. These findings are also in agreement with Frank et al. (2013), as individuals without insurance delay seeking health care services until their health becomes dire. At this point, however, community clinics may not able to provide them the care they need, as many secondary and tertiary health care services cannot be performed by primary care doctors (Frank et al., 2013).

Ortega, Rodriguez, and Vargas Bustamante (2015) found that individuals with insurance who receive care at community clinics report that the quality is comparable to that received in other settings. Although our study did not look at the quality difference, our study is in agreement with Ortega et al. (2015) in that major deficits in quality have been reported for uninsured individuals who receive care at community clinics as they are less integrated into a usual source of care.

While our results show that Covered CA provides more opportunities for individuals to obtain health insurance, this does not eliminate all barriers to health care access due to factors such as financial, language and cultural barriers

(Nahin, Dahlhamer, & Stussman, 2010; Balcazar et al., 2015; Castañeda & Melo, 2014; Becerra, Androff, Messing, Castillo, & Cimino, 2015). Our findings show that those with Covered CA report having cost as an obstacle to care more than those with other insurance. This may be because, as demonstrated in other studies, those with other insurance have their employers either pay for their health insurance or have lower deductibles and copayments than those with Covered CA (Ortega et al., 2015; Ziemer et al., 2014). Karpman, Weiss, and Long (2015) found that low-income adults continue to have the most difficulty with provider access and these individuals were also 6% more likely to be Latino. Also, in our study, those with other insurance had fewer obstacles to care than those with Covered CA. This may be because they have been enrolled in their health insurance plan for a longer period of time, which afforded them more opportunities to become familiar with the health care system.

The findings that there were no significant relationships found among the three insurance groups and the delay in seeing a doctor is important because although health insurance is available, individuals may not be utilizing their health insurance to seek health care services when they need it. There are many factors involved, such as not having a usual place of care, not having a regular provider, mistrust of providers, the type and proximity of the health care facility to their place of residence, and not understanding the U.S. health care system (Ai, Noël, Appel, Huang, & Hefley, 2013; De Jesus & Xiao, 2014). In a study using the 2007 Pew Hispanic Healthcare Survey of over 4,000 Hispanic adults, De Jesus & Xiao (2014) found that those who had continuous health insurance during the past year saw a doctor sooner compared to those without insurance ($p<.05$). This finding was not supported in our study.

Many Latinos do not have the financial ability to afford the out-of-pocket costs of care even with insurance (Escarce & Kapur, 2006). Although Latinos often forgo medical care due to cost, they also do so because they prefer services that reflect their culture (Titus, 2014). Titus (2014) found that approximately 6% of Latinos seek a healer - a *curandero* for their health care needs mainly for

affordability purposes but also for language needs, fear of deportation, and for culturally appropriate heath care. These factors may contribute to the decision of Latinos to delay utilizing health care services when there is a perceived need and might serve as an explanation of our findings that Covered CA does not increase utilization of health care services.

Thus, when corrected for the covariates, the time between health care provider visits did not differ significantly between individuals with health insurance obtained through Covered CA and those uninsured. More research is needed to determine what methods are effective to educate and encourage people to utilize their health insurance.

Less acculturated Latinos in our study were less likely to have a main provider, since they lack health insurance, which is in agreement with Askim-Lovseth and Aldana (2010). More acculturated Latinos reported having other type of health insurance besides Covered CA likely due to having jobs that offer health benefits. These results are corroborated by De Jesus and Xiao (2013) who state that about 30% of all Latino adults work for an employer who does not offer health insurance compared to 13% of Whites. In addition, second or later immigrant generations, with deeper familial roots in the U.S., are more likely to have health insurance and a usual source of care than first immigrant generations due to more cultural and social capital as well as more English language proficiency (Balcazar, Grineski, & Collins, 2015; Teruya & Bazargan-Hejazi, 2013; Padilla et al., 2011).

In our study, those who are less acculturated have reported more obstacles to care than those who are average or more acculturated due to cost of health insurance and health care services, which include monthly premiums, copayments and deductibles. This is in agreement with Balcazar et al. (2015), who found in a survey of over 1,900 Latino adults in Texas that second and higher generations were significantly more likely not to have problems with cost when seeking health care services. They also found that this group was significantly more likely to have a regular doctor

and more likely to be continuously insured during the last 12 months compared to first generation noncitizens.

Our findings demonstrate that health insurance contributes to better access specifically in the ability to have a main provider, to have a doctor's office as the main source of care and for preventing obstacles to care. Higher rates of healthcare access among those with insurance may be a result of the lower costs of healthcare services, greater availability of resources, and a more structured pathway to services. In addition, lower acculturated Latinos are more likely to be less educated and have lower incomes than more acculturated individuals and this may play a role in explaining our results of the inability to access health care services (Padilla et al., 2011). Thus, although acculturation promotes better access, it has no influence on any of the utilization factors of time since last visit or delay in seeing a healthcare provider. These associations or rather the lack of them certainly warrant further investigation. One factor that can be further explored is the lack of utilization due to a lack of need of healthcare services in the Latino population.

Although we demonstrated that health insurance and higher levels of acculturation do improve access, having Covered CA insurance does not improve utilization, as there are neither increased provider visits nor differences in delay of care compared to not having insurance. Those specifically with Covered CA insurance healthcare plans did not report higher rates of utilization possibly because despite the insurance they still cannot afford the costs of healthcare services and may have a difficult time establishing care, since not all providers accept all Covered CA plans.

Limitations
One of the study limitations is that since this study relied only on an observational design, any associations between insurance group and outcome could be due to other factors such as religious beliefs, personality traits, mental health status, and location of residence. Mono-method bias is a threat to internal validity of the study, as

we collected the data mainly by one written survey. Selection bias may exist because the people who agreed to complete the survey might have been more interested in their health than those who declined to participate (Shadish, Cook, & Campbell, 2002). As this was a short survey, the questions were limited and could not measure the intricacies of key constructs such as acculturation. Finally, as the study was conducted in one geographical location, these results may not be generalizable to a larger Latino population in the U.S.

Conclusion

The study aimed to determine whether a type of insurance or a level of acculturation were associated with improved healthcare utilization and access among Latinos in San Diego community. Based on the results, there is an evidence of association between having a healthcare insurance plan and access to healthcare services, as well as higher acculturation and access to healthcare services. The findings did not, however, support that either insurance type or acculturation level corresponded with the improved utilization of healthcare services in this group. The improved access appears to fail to translate into an improvement in utilization.

As a result, health care providers might want to consider factors involved in improving utilization of services for individuals with Covered CA insurance instead of only emphasizing insurance enrollment. By evaluating these conclusions, health educators might be alerted to the possibility that access through Covered CA does not automatically equate to improved utilization. Further studies are warranted to determine what other factors could contribute to improving utilization of healthcare services.

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