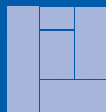




Immigrants in Connecticut: Labor Market Experiences and Health Care Access
Randy Capps, Karina Fortuny, Allison Cook, Everett Henderson, and Steve Zuckerman



The Urban Institute



Democracy Works
an advocacy center for democratic values

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SUMMARY

This profile of Connecticut's immigrants is intended to help policymakers, state planners, and service providers better understand the size, characteristics, and needs of the state's immigrant population. Beyond the basic demographics of the foreign-born population, the report focuses on immigrants in the labor force and health care access for different immigrant groups. Findings in the report are based on data from the 2000 Census, the 2004 American Community Survey (ACS), and the 2002–04 U.S. Current Population Survey (CPS), Annual Social and Economic Supplements. The data were supplemented by focus groups in Hartford, Danbury, and New Haven with health care providers and Spanish-speaking immigrants who are uninsured or covered by HUSKY. Following are highlights from the report.

- **The foreign-born share of Connecticut's population (12 percent) is about the national average, but Connecticut's immigrants have more diverse origins.** Nationally, Latin American and Caribbean immigrants account for over half of all immigrants, and Mexican immigrants alone for almost a third. But in 2004, only 22 percent of Connecticut's immigrants were Latin American—equal to the share of Asians. A much higher share of immigrants in Connecticut came from Europe or Canada (38 percent), and a higher share than the national average came from the Caribbean (14 percent). The two most common countries of birth for Connecticut immigrants were Poland (8 percent) and Jamaica (7 percent).
- **Half of Connecticut's immigrants are naturalized citizens, compared with a third nationally.** In 2004 the share of Connecticut immigrants who were undocumented (20 percent) was lower than the national average (29 percent). Connecticut's immigrants have been in the United States a relatively long time and are more likely to come from countries in Europe, Asia, and the Caribbean that have high naturalization rates.
- **Latin Americans are the most recent and fastest growing immigrant population; European immigrants are an older, shrinking population.** Between 1990 and 2000, the number of Mexican and Central American immigrants in Connecticut grew by 310 percent, and the number of South Americans grew by 125 percent. The number of Asian immigrants increased by more than 75 percent, and the number of Caribbean immigrants rose by 68 percent. The number of European and Canadian immigrants, however, fell by 9 percent, as many older immigrants from the last great wave of migration passed away. Over half of Latin American and Asian immigrants entered the country between 1990 and 2000, while 60 percent of European immigrants entered before 1980.
- **Connecticut's immigrants are concentrated in large cities and the suburban areas adjacent to New York City.** The pattern of immigrant concentration shows clustering primarily in three areas: Fairfield County (including Stamford, Danbury, Bridgeport, and towns in between), the Hartford metropolitan area, and the New Haven–Waterbury area. In 2000 the

half-dozen towns with the most immigrants were Stamford (35,000), Bridgeport (29,000), Hartford (23,000), Danbury (20,000), Norwalk (17,000), and New Haven (14,000).

- **Latin Americans are the poorest immigrants; median incomes for some Asian immigrants exceed the incomes of U.S.-born Connecticut residents.** Compared with the rest of the nation, Connecticut has a relatively low poverty rate. The state's immigrants, however, had a slightly higher poverty rate in 2000 than native-born residents (16 versus 12 percent). Nearly a third (31 percent) of immigrants from Mexico and Central America were poor, compared with only 11 percent of European immigrants. The median family income for Asian immigrants—excluding Southeast Asians—was slightly above the median for native-born residents (\$40,000) and over twice as high as that of Mexican and Central American immigrants (\$18,000).
- **Latin American, Caribbean, and Southeast Asian immigrants are the least educated and the most likely to be limited English proficient (LEP); other Asian immigrants are more likely to have college degrees than U.S.-born adults.** In 2000 over half (55 percent) of Mexican and Central American immigrants age 25 and over lacked high school degrees, compared with 40 percent of Southeast Asian immigrants, 34 percent of Caribbean immigrants, 30 percent of European immigrants, 29 percent of South American immigrants, and just 14 percent of native-born Connecticut residents. Two-thirds of Asian immigrants—excluding Southeast Asians—had four-year college degrees or more, compared with one-third of native-born residents and roughly one-tenth of Mexican/Central American and Caribbean immigrants. Two-thirds of Latin American immigrants and Southeast Asian immigrants were LEP, compared with about one-third of other Asian immigrants and one-quarter of Caribbean immigrants.
- **The best-educated workers earn the highest wages, regardless of whether they are immigrants.** In 1999 college-educated immigrants earned more than twice as much as high school dropouts (\$23 versus \$11 an hour), and natives earned about the same amount as immigrants at equivalent levels of education. Approximately 50 percent of foreign- and native-born workers with less than a high school degree earned below twice the minimum wage in 1999, compared with just 12 percent of native-born and 18 percent of foreign-born workers with a college degree or more.
- **As the share of immigrants in Connecticut's labor force is increasing, the number of native-born workers in the state is falling.** Between 1990 and 2000, the immigrant working-age population (18 to 64) in Connecticut increased by 40 percent for men, and 34 percent for women, at a time when the U.S.-born working-age population fell (by 4 percent for men and 3 percent for women). Without immigration, Connecticut's working-age population would have declined during the 1990s.
- **The population of well-educated immigrants is growing faster than less-educated immigrants in Connecticut; as a result, the state's foreign-born population is becoming much better educated over time.** Among men age 25 and over, the number of college-educated immigrants increased 53 percent between 1990 and 2000; the number of college-educated immigrant women almost doubled (88 percent). The number of U.S.-born men and women with college degrees grew much more modestly, by 8 and 25 percent, respectively. By contrast, the number of immigrants without high school degrees grew by less than 10 percent among men and actually fell among women.
- **Connecticut's immigrants are most heavily concentrated in low-skilled industries, but their numbers are growing rapidly in high-skilled industries.** In 2000, accommodation and food employed the highest share of immigrants (21 percent), followed by other services (18 percent), administrative/support (18 percent), manufacturing (17 percent), and construction

(16 percent). The share of immigrant workers without high school degrees was over 25 percent in all these industries. Yet, between 1990 and 2000, the number of immigrants grew rapidly in professional, scientific, and technical (92 percent) and information (81 percent)—sectors where the share of immigrants without high school degrees was under 10 percent.

- **Hispanic immigrant adults who are not U.S. citizens are the most likely to be uninsured.** In 2001–03, almost half of Connecticut’s Hispanic noncitizen adults age 19 to 64 were uninsured. Following national patterns, Hispanic noncitizens were about twice as likely as other noncitizens and native-born Hispanics to be uninsured; Hispanic noncitizens were four times as likely as non-Hispanic white natives to be uninsured. Uninsurance rates were about the same for naturalized citizens as for U.S.-born citizens.
- **Hispanic children with noncitizen parents are the most likely children to be uninsured.** In Connecticut, about a quarter of Hispanic children under age 19 with noncitizen parents were uninsured in 2001–03. Hispanic children with noncitizen parents are about three times more likely than Hispanic children with U.S.-born citizen parents to be uninsured. Among children from other ethnic groups, however, there are no major differences in insurance coverage between children with noncitizen parents and those with U.S.-born citizen parents.
- **Uninsured immigrants have limited health care access, especially in areas not served by community health centers.** In two of our study sites—Hartford and New Haven—uninsured adults and children can access primary care through community health centers (CHCs), hospitals, and other clinic settings. Primary care options are more limited in Danbury, which is not served by a CHC. The uninsured in smaller towns and rural areas have few options and often travel long distances to major urban areas for their health care. Uninsured immigrants in all three study sites have difficulty finding specialty, dental, and mental health care, as well as affording prescriptions. Up-front payment, billing, and HUSKY application requirements sometimes deter the uninsured from seeking care in emergency rooms (ERs) and other hospital facilities.
- **Recent changes in HUSKY eligibility rules for noncitizens have created confusion and deterred legal immigrants from applying for coverage.** There is considerable confusion about whether legal immigrants are eligible for HUSKY depending on how long they have lived in the United States. New requirements to verify their sponsors’ income are deterring legal immigrants from applying for HUSKY and stoking their fears that applying for insurance coverage may prevent them from becoming citizens or sponsoring their family members to immigrate. Additionally, some immigrant parents have younger, U.S.-citizen children who are eligible for HUSKY and older noncitizen children who are ineligible noncitizens; these parents find it frustrating to have health care coverage for some children and not others.
- **Long waiting times and difficulties setting appointments create significant barriers to health care access for immigrants, as well as other uninsured people.** Health care providers for the uninsured have limited capacity, especially in Danbury where there is no CHC; when health care staff are absent or retire, providers’ capacities are further reduced. The providers we interviewed have high no-show rates—above 30 percent in some cases—that make scheduling appointments and predicting patient load very difficult. Immigrants and other low-income patients often arrive at appointments too early or too late, and then have to wait a long time to see a health professional. They may also come to appointments with previously undiagnosed health conditions, which may lengthen visits and complicate scheduling. Immigrants may miss appointments because of transportation difficulties, illnesses or other family emergencies, and the reluctance of employers—especially in low-wage industries such as agriculture, construction, and housekeeping—to allow their employees to take sick leave.

INTRODUCTION

This profile of Connecticut’s immigrants is intended to help policymakers, state planners, and service providers better understand the size, characteristics, and needs of the state’s immigrant population. Beyond the basic demographics of the foreign-born population, the report focuses on immigrants in the labor force and health care access for different immigrant groups. The report provides conclusions and policy recommendations to help better serve the health care and other needs of immigrants, as well as to help Connecticut continue to benefit from its large, growing, and diverse population of newcomers.

Connecticut has a long history of welcoming newcomers. Like New York City and other New England states, Connecticut was a key destination for hundreds of thousands of U.S. immigrants at the turn of the 20th century. Most of these immigrants came from Canada and Europe. Starting in the 1990s and continuing through today, the United States is undergoing another wave of large-scale migration, and Connecticut is once again home to increasing numbers of newcomers. This time around, however, Connecticut’s immigrants are coming from across the globe.

The United States has entered a period of record-high immigration, at least in terms of absolute numbers. More than 14 million immigrants entered the country during the 1990s, up from 10 million in the 1980s, and 7 million in the 1970s. Between 1970 and 2000, the number of immigrants in the country tripled from 10 to 31 million. By 2004 the foreign-born population had risen to over 34 million, suggesting there could be as many as 40 million immigrants in the United States by 2010. The foreign-born share of the U.S. population has risen dramatically, from 5 percent in 1970 to 12 percent in 2004, and is projected to reach 13 percent by 2010. While high in absolute number, the 2010 immigrant population would still be below its maximum share of the U.S. population (near 15 percent) in the late 1800s.¹

Connecticut’s foreign-born population grew slowly during the 1970s and 1980s, but has increased rapidly since 1990. During the 1970s, the state’s immigrant population grew by 2 percent; it grew by 4 percent in the 1980s and by 14 percent in the 1990s. Deaths among older European immigrants—who were part of the earlier great wave of immigration—partially explain the slow growth of the state’s foreign-born population during the 1970s and 1980s. But by the 1990s, this trend was offset by large numbers of non-European immigrants. As of 2004, Connecticut had a foreign-born population of 395,000—the 18th largest in the country. In 2004 the foreign-born share of Connecticut’s population (12 percent) was about the same as the national average.²

Diversity of Connecticut’s Foreign-Born Population

Connecticut’s immigrant population is very diverse and has a number of distinguishing characteristics, which we will discuss in detail in this report. In contrast to the national pattern—where Latin

American and Caribbean immigrants represent over half of all immigrants—no single country or region of origin predominates among Connecticut’s foreign-born population. Connecticut is home to a substantial number of older European and Canadian immigrants, most of whom are naturalized citizens and are in their retirement or later working years. There are also substantial numbers of younger, more recent immigrants from countries across Asia, including some Southeast Asian immigrants. Like other states on the East Coast, Connecticut has a relatively high share of English-speaking Caribbean immigrants, and Jamaica is one of the state’s two largest source countries. Finally, there are rapidly growing numbers of immigrants from Latin American countries, many of whom are undocumented and limited English proficient (LEP). Compared with the national picture, Connecticut’s immigrants overall are less likely to be undocumented and more likely to be naturalized citizens. This means fewer Connecticut immigrants are ineligible for health care and other services, and more are eligible to vote and therefore participate more broadly in civic society.

Organization of This Report

The demographic diversity of Connecticut’s immigrants—described in detail in the second section of this report—is matched by diverse human capital endowments and experiences in the labor force. The third section of the report describes immigrants in Connecticut’s labor force, focusing on both higher-income workers (including Asian immigrants, who on average out-earn their U.S. born counterparts) and lower-income workers (including Latin American immigrants, who earn half as much as Asian immigrants). Wages and incomes are closely associated with educational attainment, which varies widely among different immigrant groups. Educational attainment and wages also vary across the industries in which immigrants work.

The fourth section of the report focuses on health care access for immigrants, with a particular focus on Latino immigrants, who are the most likely to be uninsured. This section describes recent figures for health insurance coverage of immigrants and their children by race and ethnicity, and compares these figures with U.S.-born Connecticut residents and national-level data. Fieldwork in three sites yielded additional information on health care access for immigrants and their children, again with a strong focus on Latino immigrants. This section of the report also discusses policy implications for the health care system in Connecticut.

The final section develops general conclusions and specific policy recommendations from the demographic, labor force, and health care access data described in the report. These recommendations are intended for state and local officials, policymakers, health and social service providers, advocates, and community leaders, as they meet the challenges posed by rapid recent immigration and chart the course toward a prosperous future for all Connecticut residents.

Methods and Data Sources

The bulk of the data analyzed in the report are taken from the 2000 U.S. Census of Population and Housing, 5 percent Public Use Microdata Sample (PUMS). The 2000 Census PUMS is the largest public-use data set with comparable information on populations across the country—down to the state and local level in most cases—and multiple measures of demographics, labor force characteristics, income, poverty, and housing. The census also offers sufficient detail and sample size to compare different groups of immigrants and different regions of the state in depth. Where possible, census figures are updated using 2004 data from the American Community Survey (ACS) and 2002–04 data from the U.S. Current Population Survey (CPS), Annual Social and Economic Supplements (conducted in March). The ACS and CPS identify immigrant groups in detail, but they lack the sample size of the census. Data from the March supplements to the CPS are used to analyze patterns of health insurance coverage.

The quantitative data are supplemented with information from fieldwork conducted in three Connecticut towns with large immigrant populations—Hartford, New Haven, and Danbury—in September 2005. In each site, researchers held a focused group discussion with adults who were

- foreign-born (regardless of citizenship or date of entry to the United States),
- working-age (18 to 64),
- working or living with a working spouse (or cohabiting partner),
- living with at least one biological child under 18 in the household,
- uninsured or covered by Medicaid or HUSKY, and
- Spanish speakers.

These immigrant community focus groups consisted of between 4 and 14 participants. The focus group participants were all Latinos, as Latino immigrants have the highest uninsurance rates and are therefore a central focus of the study.

Researchers also held a focus group of health care providers and additional semi-structured interviews with health advocates and community leaders in each of the three study sites. Between two and eight providers were included in these discussions in each site. These group and individual discussions focused on health care access issues—including insurance coverage, availability and location of services, and interpretation and translation services—that affect immigrants, particularly Latinos. All information gained from these discussions was strictly confidential, and findings are discussed in general in the fourth section of this report. The discussion guides for the provider and immigrant community focus groups are included in the appendix.

THE DIVERSE ORIGINS AND CHARACTERISTICS OF CONNECTICUT'S IMMIGRANTS

As of 2004, almost 12 percent of Connecticut residents were foreign-born, about the same as the national average. Yet, the state's foreign-born population is in no way average. Connecticut's immigrants include a diverse mix of people from around the world, and in contrast to the national picture, no single country of origin or ethnic group predominates. As a result of this diversity, Connecticut has relatively more immigrants who have been in the United States 20 years or longer, have become naturalized citizens, and are well educated, highly paid workers. But the statewide pattern masks important differences among the groups of immigrants living in Connecticut.

Immigrants Are a Large Component of Connecticut's Population Growth

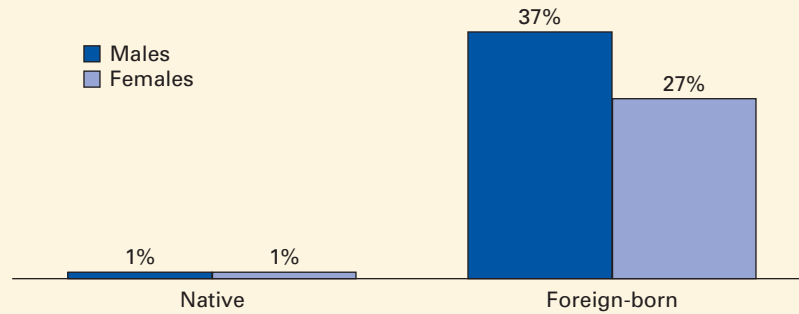
In Connecticut as in the nation, immigrants are key to future population and labor force growth as the native-born population ages. National studies have shown that half the growth of the U.S. labor force in the 1990s was the result of immigration (Sum, Fogg, and Harrington 2002). The immigrant population in Connecticut increased significantly from 1990 to 2000 (37 percent among males and 27 percent among females), while the native-born population increased only 1 percent (figure 1). The number of U.S.-born men who were working-age (18 to 64) actually fell by 40,000 (from 930,000 to 890,000) during the 1990s. Overall, Connecticut's population increased 4 percent during the decade.

Like the rest of the country, Connecticut is preparing for the retirement of the baby boomers, the largest birth cohort in U.S. history. As a result, more U.S.-born adults are in their later working years than their earlier working years. For instance, about 20,000 more U.S.-born Connecticut residents were in their fifties than in their twenties in 2000 (354,000 versus 334,000). This difference was even greater among U.S.-born non-Hispanic whites: 61,000 (314,000 versus 253,000). By contrast, Connecticut had about 11,000 more Hispanic immigrants in their twenties than in their fifties (18,000 versus 7,000). The age pyramid for Hispanic immigrants is much wider in the twenties, thirties, and forties than the pyramid for U.S.-born non-Hispanic whites, suggesting Hispanic immigrants will be a growing share of the labor force in the future (figure 2).³

Europeans Are Still the Largest Immigrant Group

Despite aging and declining in population, European immigrants are the largest single group in Connecticut. In 2004, 38 percent of the state's foreign-born population came from Europe, Canada, Australia, and New Zealand.⁴ The other two principal sources of Connecticut's immigrants were Asia—including the Middle East, South Asia, Southeast Asia, East Asia, and the Pacific

Figure 1. Population Growth in Connecticut, 1990–2000

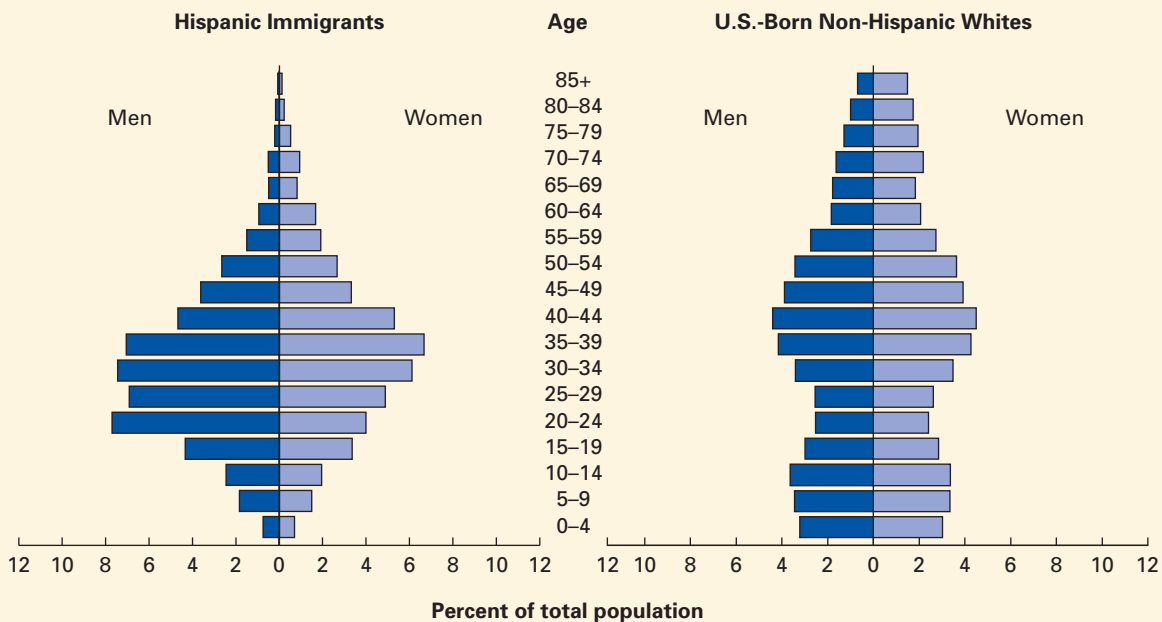


Sources: IPUMS, 1990 and 2000.

(22 percent)—and Latin America—including Mexico, Central America, and South America (also 22 percent). The Caribbean accounted for 14 percent and Africa for 5 percent of all immigrants (figure 3).

Nationally, Latin American and Caribbean immigrants account for over half of all immigrants (52 percent), and Mexico alone for almost a third. Unlike the national pattern, more of Connecticut foreign-born residents are from South America (12 percent) than from Mexico or Central America (10 percent). In addition, relatively more Connecticut immigrants are from Europe and the Caribbean—a pattern seen in other northeastern states such as New York and Massachusetts.

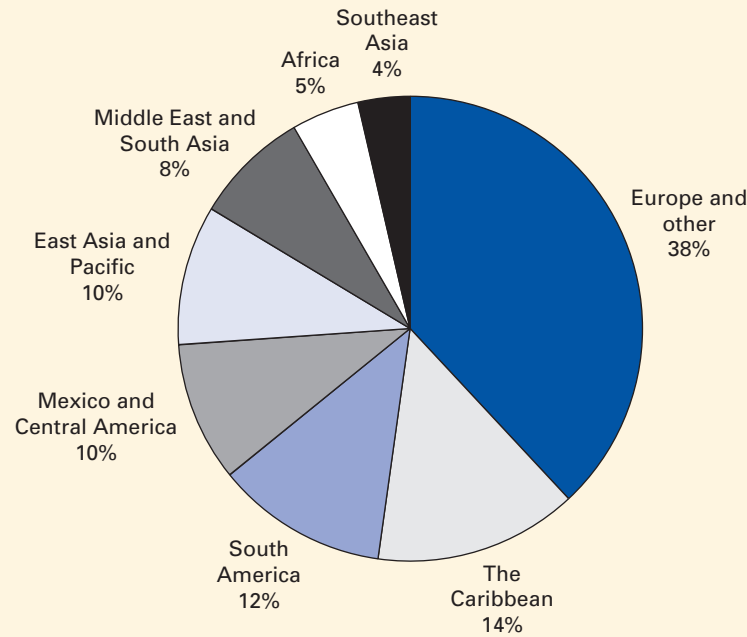
Figure 2. Age Structure of Hispanic Immigrants and Native-Born Whites, Connecticut, 2000



Source: 2000 Census, PUMS.

Note: The template for these population pyramids was borrowed from the Census Bureau.

Figure 3. Europe, the Caribbean, and South America Dominate Connecticut's Immigrants, 2004



Source: 2004 American Community Survey.

No Single Country Predominates among Connecticut's Immigrants

In contrast to the national pattern, where 30 percent of all immigrants are from Mexico, no single country accounts for even 10 percent of Connecticut immigrants (table 1). In 2000, the two most common countries of birth for Connecticut immigrants were Poland (8 percent) and Jamaica (7 percent). Canada, India, Italy, Mexico, and Brazil each accounted for 4 to 5 percent of the total. Portugal, China, and the United Kingdom rounded out the top 10 countries at just over 3 percent each. The great diversity of Connecticut immigrants means no single language or culture is dominant among them.

Table 1. Top 10 Countries of Birth for Connecticut Immigrants, 2004

	Number of immigrants	Percent of total
Poland	32,000	8
Jamaica	28,000	7
Canada	19,000	5
India	18,000	5
Italy	17,000	4
Mexico	15,000	4
Brazil	15,000	4
Portugal	13,000	3
China	13,000	3
United Kingdom	12,000	3
Total	395,000	100

Source: 2004 American Community Survey.

Latin Americans Are the Most Recent Immigrants

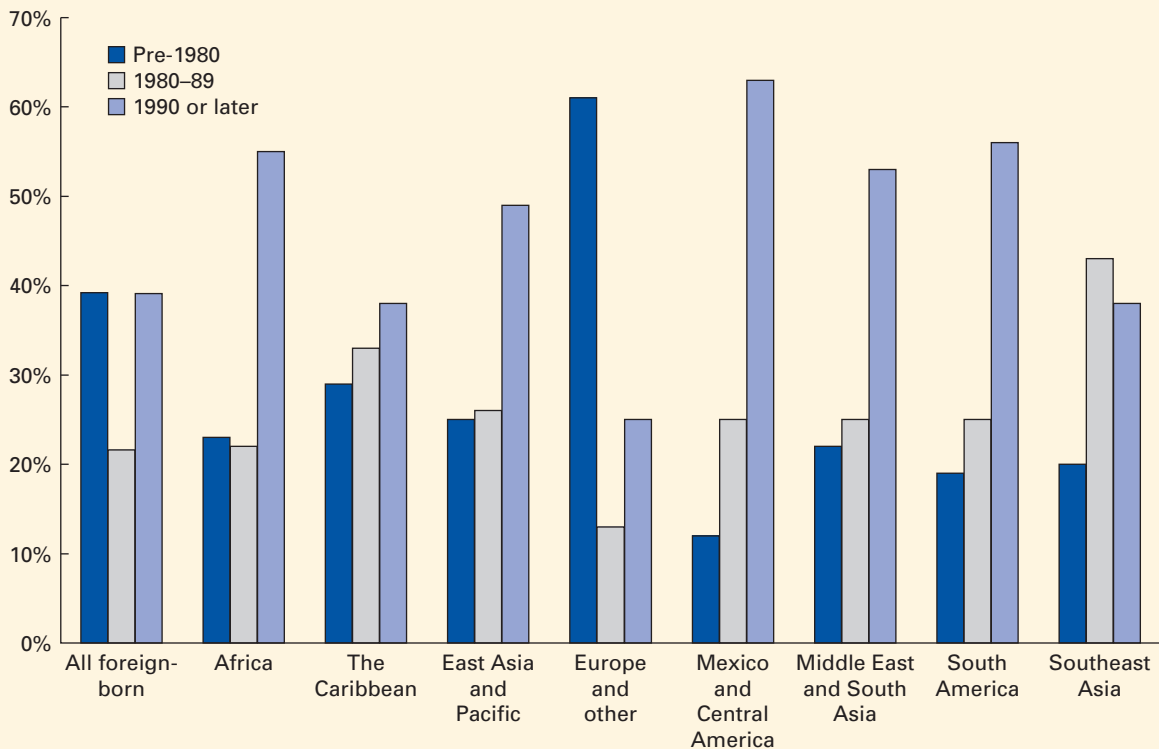
Connecticut has a substantial population of long-term immigrants. In 2000, as many Connecticut immigrants had arrived in the United States before 1980 (39 percent) as had arrived during the 1990s, and a smaller portion (22 percent) had arrived during the 1980s. Nationally, only 30 percent of immigrants arrived before 1980, while 42 percent came during the 1990s. Connecticut's immigrants have therefore been in the United States longer on average than immigrants across the rest of the country, meaning the state's immigrant populations are relatively well established.

The arrival patterns of Connecticut immigrants, however, differ by region of birth (figure 4). The most recent immigrant populations—those with the highest numbers arriving since 1990—are from Latin America, Africa, and Asia (except Southeast Asia). Immigrants from Europe, Canada, Australia, and New Zealand (“Europe and other” in the figure) have been in the United States the longest: 61 percent arrived before 1980. Almost half of immigrants from Southeast Asia arrived during the 1980s, which were peak years of refugee admissions from this region. Caribbean immigration to Connecticut has been relatively steady, with roughly equal shares arriving before 1980, during the 1980s, and during the 1990s.

Latin American Immigrants Are Increasing Most Rapidly

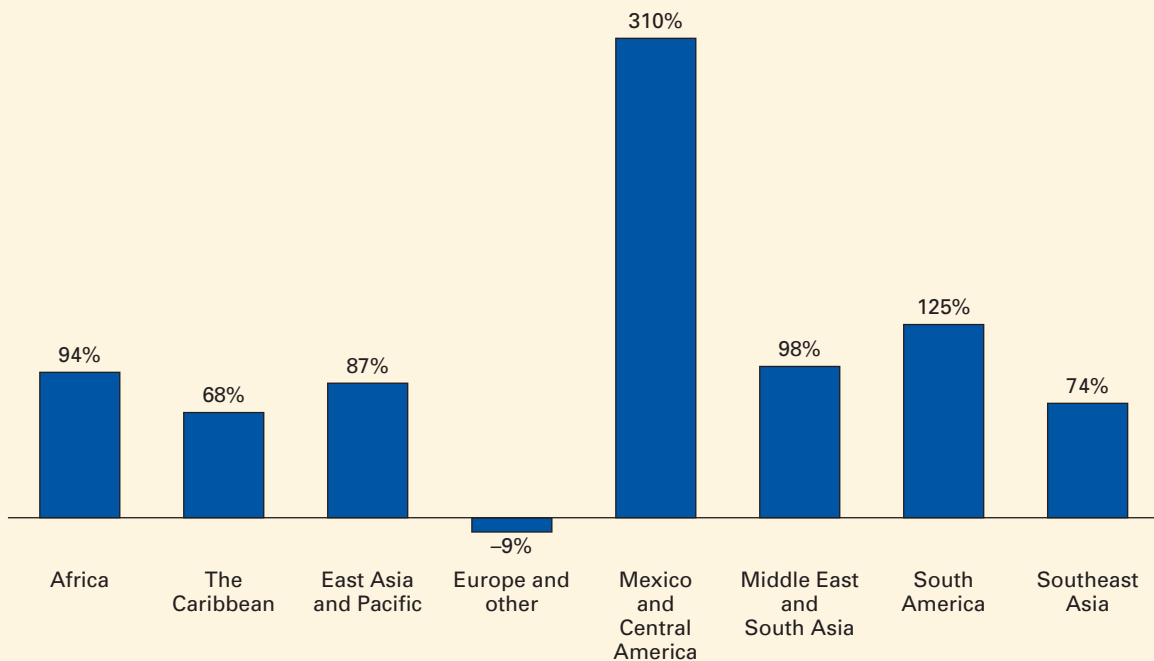
Latino immigrants are the youngest, most recent immigrants, as well as the group increasing most rapidly in Connecticut. Immigrants from Mexico and Central America had the highest population growth from 1990 to 2000 (310 percent), followed by South America (125 percent). By contrast, the

Figure 4. Immigrants in Connecticut by Origin and Date of Entry, 2000



Source: 2000 Census, PUMS.

Figure 5. Percent Change in Connecticut Immigrant Population by Origin, 1990–2000



Sources: IPUMS, 1990 and 2000.

number of European immigrants declined by 9 percent (figure 5). Very few European immigrants are coming to the United States now, and many older European immigrants from the last great wave of migration are passing away.

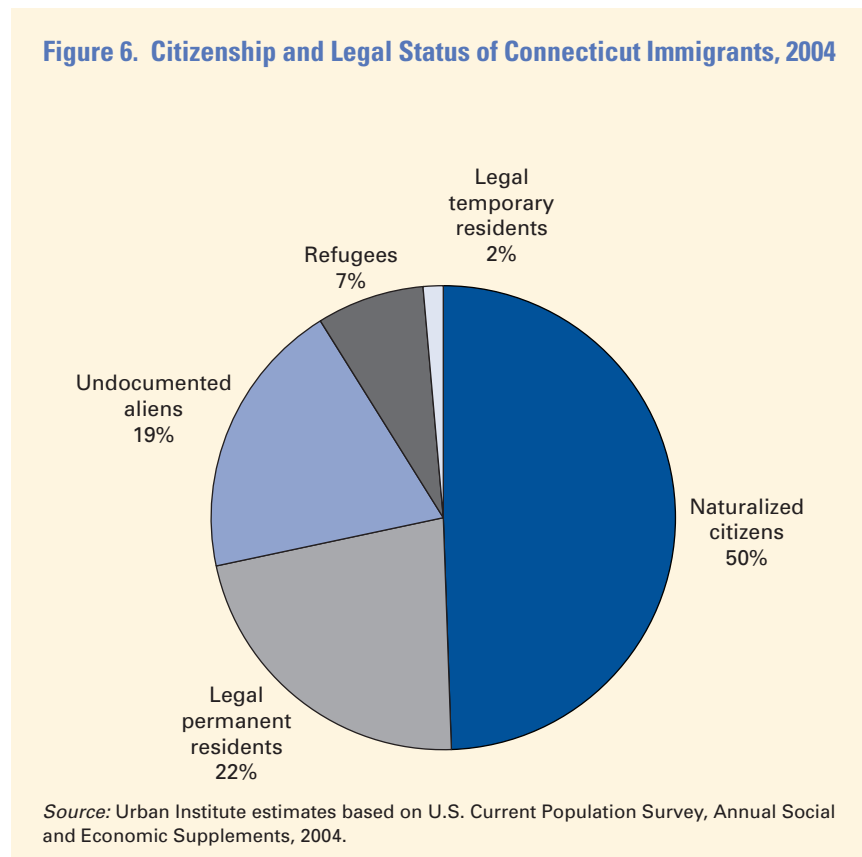
Half of Connecticut’s Immigrants Are Naturalized U.S. Citizens

Undocumented immigrants are growing faster than the overall immigrant population nationwide (Passel 2005),⁵ and are a topic of considerable public concern and policy discussion. Estimated at over 10 million in 2004, undocumented immigrants make up almost 30 percent of all immigrants nationally—roughly the same share as legally admitted noncitizens.⁶ Shares of undocumented immigrants are especially high in states near the southwestern border with Mexico and those with the fastest growing, most recent immigrant populations (Passel 2005). In Connecticut, which has a more diverse immigrant population and is far from the Mexican border, the share of undocumented immigrants is relatively low.

In Connecticut, only 19 percent of all immigrants were undocumented in 2004, compared with 29 percent nationally (figure 6). Twenty-two percent were legally admitted noncitizens—termed legal permanent residents (LPRs) in official government parlance;⁷ this number was also below the national average (29 percent).

Most important, half of all Connecticut foreign-born residents were naturalized U.S. citizens, compared with just 31 percent nationally. These high shares are associated with a relatively high share of European immigrants, who have high naturalization rates, and a lower share of Latino immigrants, who are the least likely to be naturalized (Fix, Passel, and Sucher 2003). The relatively high share of

Figure 6. Citizenship and Legal Status of Connecticut Immigrants, 2004



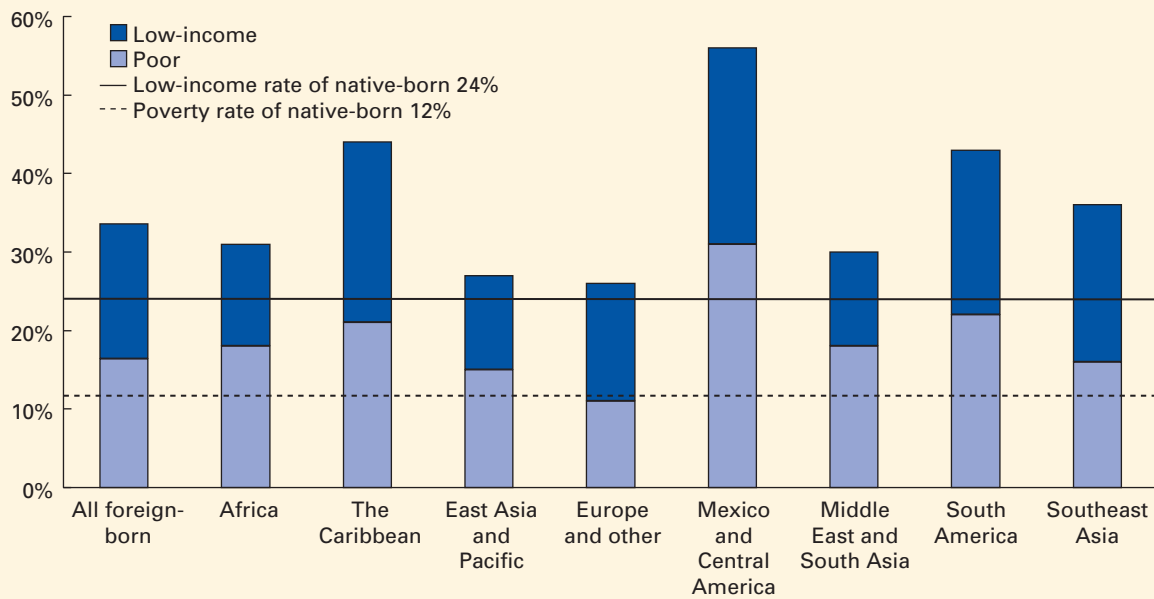
naturalized citizens means more immigrants can vote in Connecticut than is the case nationally. Connecticut's naturalized immigrants are fully eligible for all public benefits and services and may also be better integrated and more fully engaged in civil society than noncitizens. The mostly naturalized European immigrants are also substantially older than the noncitizens, who are predominantly from Latin American, Asian, and Caribbean countries.

Following the national trend, relatively small shares of Connecticut's immigrants were refugees and asylees or legal temporary residents, visitors such as students and temporary workers. Nonetheless, Connecticut has a substantial refugee population (almost 30,000)⁸ that includes Southeast Asians as well as more recent refugees from Africa, Eastern Europe, and the former Soviet Union.

Latin American and Caribbean Immigrants Have the Highest Poverty Rates

Connecticut residents have a relatively low poverty rate, but immigrants have a slightly higher poverty rate than U.S.-born Connecticut residents.⁹ In 1999, 16 percent of Connecticut foreign-born residents were poor, meaning their family income was below the federal poverty level. Thirty-three percent were low-income, meaning their family income was below 200 percent of the federal poverty level.¹⁰ This compares with a poverty rate of 12 percent and a low-income rate of 24 percent for native-born Connecticut residents. Nationally, about one-quarter (26 percent) of immigrants were poor and half (50 percent) were low-income in 1999. Compared with Connecticut, the rest of the country has substantially higher shares of Mexican and other Latin American immigrants, who tend to be poorer.

Figure 7. Poverty Rates for Immigrant Groups in Connecticut, 1999



Source: 2000 Census, PUMS.

Note: Low-income is family income below 200 percent of the federal poverty level. Poor is family income below the federal poverty level.

Connecticut immigrants from Mexico and Central America had the highest poverty and low-income rates: over half (56 percent) were low-income, and nearly a third (31 percent) were poor (figure 7). South American and Caribbean immigrants had the next highest poverty rates (22 and 21 percent, respectively). Immigrants from Asia and Africa had relatively low poverty rates, and immigrants from Europe had the lowest poverty rate—slightly lower than the rate for U.S.-born Connecticut residents. No group of immigrants, however, had a poverty or low-income rate significantly below the rate for the U.S.-born.

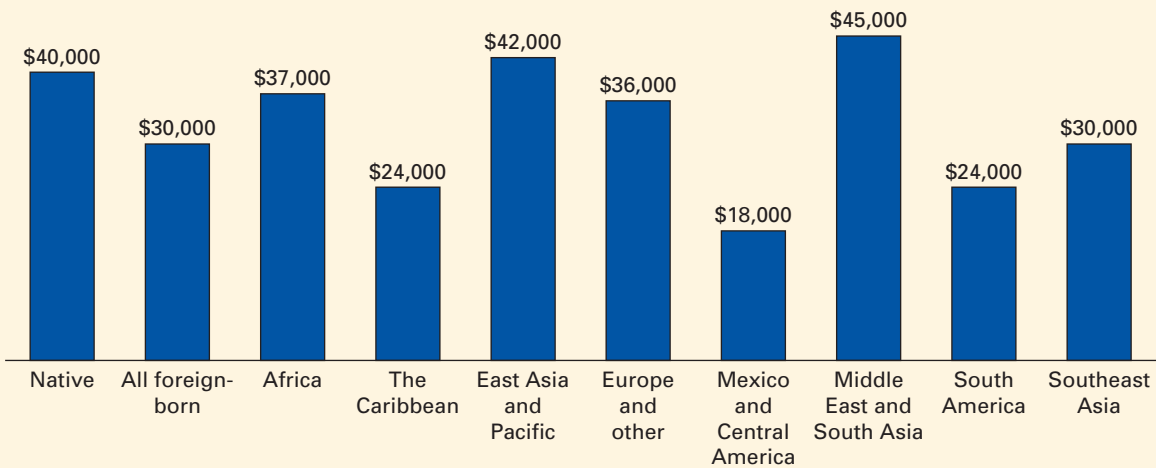
In general, the immigrant groups with the highest poverty rates (such as Latin Americans) have been in the United States for the shortest time, while the immigrants with the lowest poverty rates (such as Europeans) have been in the country the longest. This pattern suggests that, if the immigrants in the current wave are able to match the performance of those in earlier waves, their poverty rates will fall over time as they integrate economically.

Median Family Income for Some Asian Immigrants Exceeds Income for Natives

Connecticut's immigrants have median incomes almost 50 percent higher than those of immigrants nationally,¹¹ reflecting the generally higher income of all the state's residents. In 1999, the median family income of all Connecticut immigrants (\$30,000) was about three-quarters of the median family income of all native residents (\$40,000). These figures were substantially higher than the U.S. medians of \$22,000 for immigrants and \$32,000 for natives (figure 8).

As with poverty, however, family income varies greatly among immigrant groups. The median family incomes of immigrants from the Middle East and South Asia (\$45,000) and East Asia and the Pacific (\$42,000) actually exceeded those of native residents in 1999. Comparing the high and low

Figure 8. Median Family Income for Immigrant Groups in Connecticut, 1999

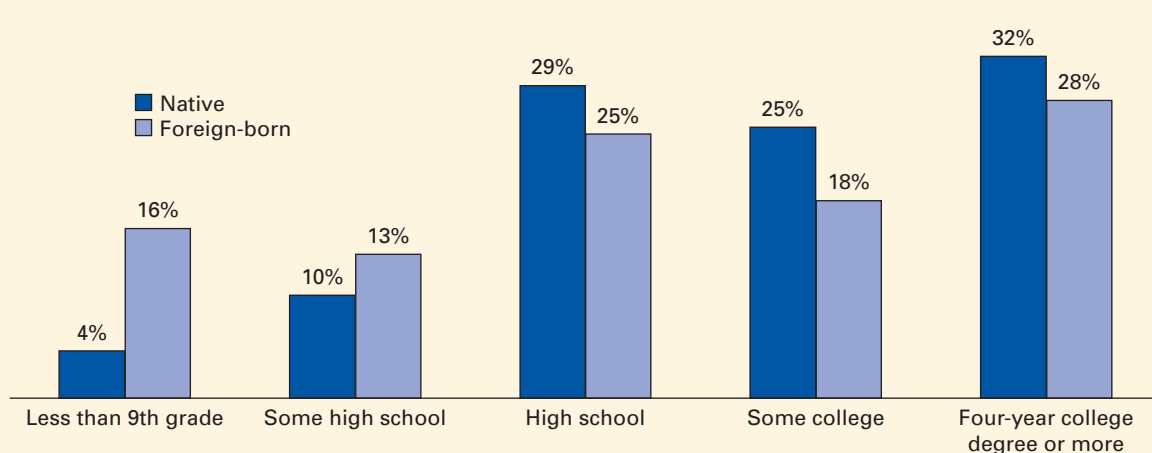


Source: 2000 Census, PUMS.

ends of the spectrum, the median family income for immigrants from the Middle East and South Asia was more than twice as high as that for immigrants from Mexico and Central America (\$18,000). The median family income of immigrants from South America and the Caribbean (\$24,000) was also substantially lower than the median for all immigrants.

Unlike the pattern for poverty rates, the groups with highest median incomes are not the groups who have been in the United States the longest. In fact, the median incomes of Asian and African immigrants exceed that of Europeans, despite the fact that Europeans on average have lived in the United States longer. At the other end of the spectrum, however, the group with the lowest median income (Central American immigrants) is also the group with the highest share of recent arrivals. Thus, while there is some evidence that long-term U.S. residence may increase immigrants' incomes, other factors are clearly at work. The most important factors here appear to be education and English proficiency.

Figure 9. Educational Attainment Rates of Connecticut Adults Age 25 and Over, 2000



Source: 2000 Census, PUMS.

Almost 30 Percent of Connecticut Immigrants Lack High School Degrees

In Connecticut, as nationally, a substantially higher share of immigrants than natives has less than a high school education; however, nearly the same shares have a college education (figure 9). In 2000, 29 percent of foreign-born adults age 25 and over had less than a high school education, twice the rate for native-born Connecticut adults (14 percent). Four times as many foreign-born as native-born adults had less than a ninth-grade education (16 versus 4 percent). At the other end of the spectrum, nearly as many immigrants as natives had a four-year college education or more (28 versus 32 percent). These figures for Connecticut compare favorably with national rates: 38 percent of immigrants and 17 percent of natives nationwide lack a high school education; 24 percent of both immigrants and natives have a four-year college education or more.

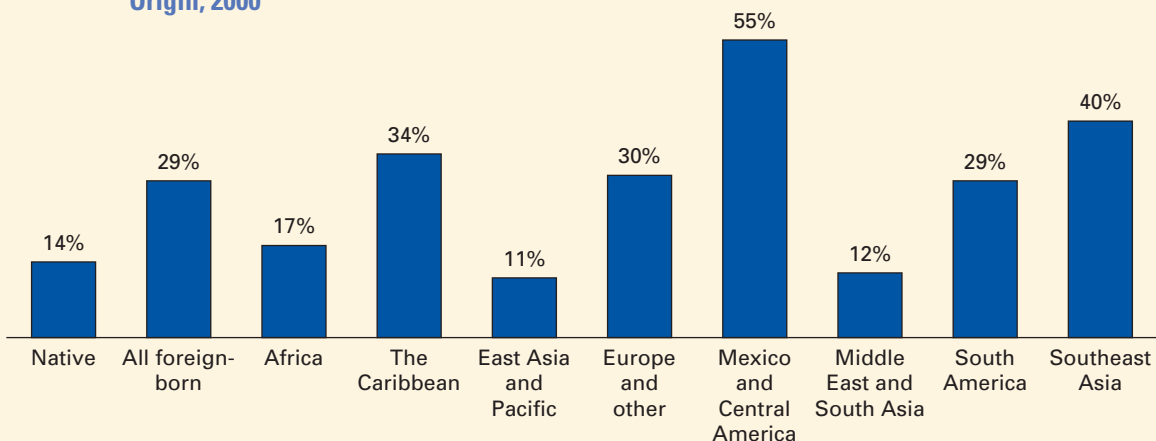
Over Half of Mexican and Central American Immigrants Lack High School Degrees

There is great variation across immigrant groups in educational attainment: some groups have far less formal education than native Connecticut residents, while others have more. Over half (55 percent) of immigrants age 25 and over from Mexico and Central America lacked high school degrees in 2000. Immigrants from Southeast Asia—many of them refugees—also had a relatively high share without a high school education (40 percent). Immigrants from other parts of Asia, however, were less likely to lack high school degrees than natives (figure 10).

Two-Thirds of Some Asian Immigrants Have College Degrees

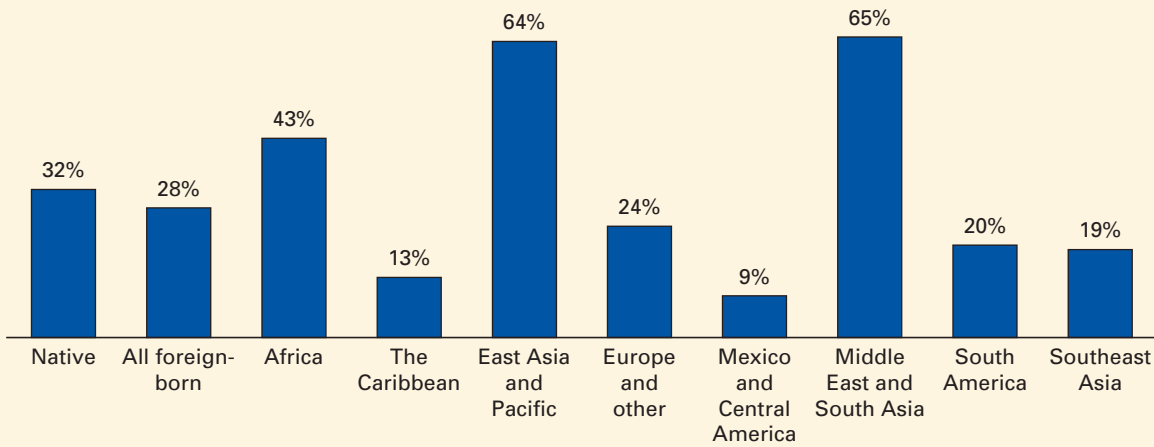
There is even more variation across Connecticut's immigrant groups in the share with a four-year college degree or more. In 2000, 64 percent of immigrants born in East Asia and the Pacific and 65 percent of immigrants born in the Middle East and South Asia had four-year college degrees, twice the share for native-born adults age 25 and over (figure 11). African immigrants were also more likely than natives to be college graduates, but European immigrants were *less* likely to be college graduates,

Figure 10. Share of Connecticut Adults Age 25 and Over with Less than a High School Degree by Origin, 2000



Source: 2000 Census, PUMS.

Figure 11. Share of Connecticut Adults Age 25 and Over with a Four-Year College Degree by Origin, 2000



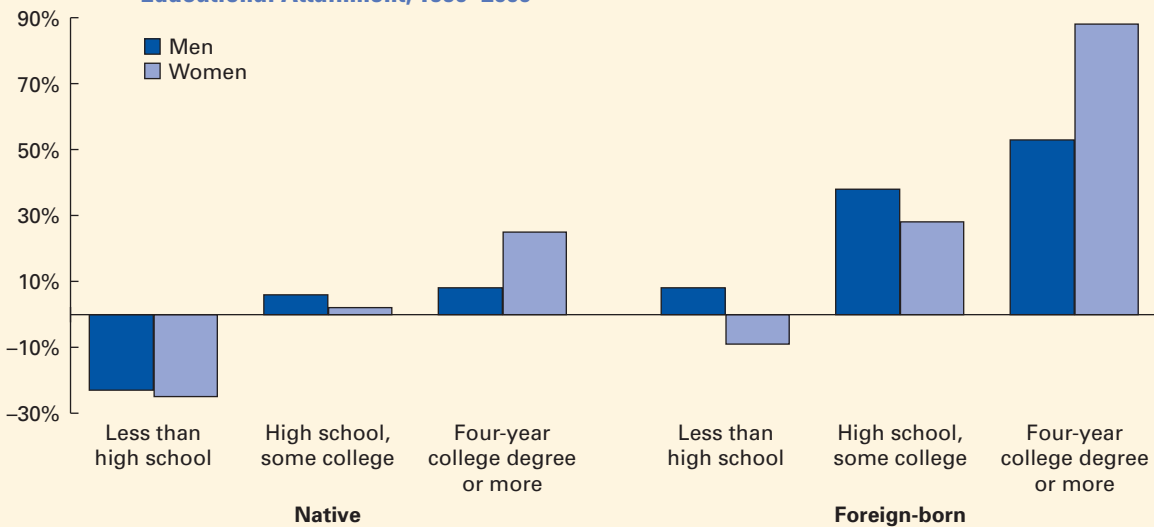
Source: 2000 Census, PUMS.

despite their relatively high incomes and low poverty rates. The groups with the lowest shares of college educations were immigrants born in the Caribbean (13 percent) as well as Mexico and Central America (9 percent); both groups also had relatively high poverty rates.

Well-Educated Immigrants Are Increasing Much More Rapidly than Less-Educated Immigrants

Because the population of well-educated immigrants is growing at a faster rate than less-educated immigrants in Connecticut, the state's foreign-born population is becoming much better educated over time. Among men age 25 and over, the number of college-educated immigrants increased 53

Figure 12. Percentage Change in Population of Connecticut Immigrants Age 25 and Over by Educational Attainment, 1990–2000



Source: 2000 Census, PUMS.

Note: Adults are age 25 and over.

percent between 1990 and 2000; the number of college-educated immigrant women increased 88 percent (figure 12). The number of U.S.-born men and women with college degrees grew more modestly, by 8 and 25 percent, respectively. By contrast, the number of immigrants without a high school education grew less than 10 percent among men and fell among women. Thus, immigrants contributed substantially to Connecticut’s 20 percent increase in college graduates during the 1990s. If these trends continue, immigrants will be a major component of growth in the state’s high-skilled labor force as older U.S.-born natives age and retire.

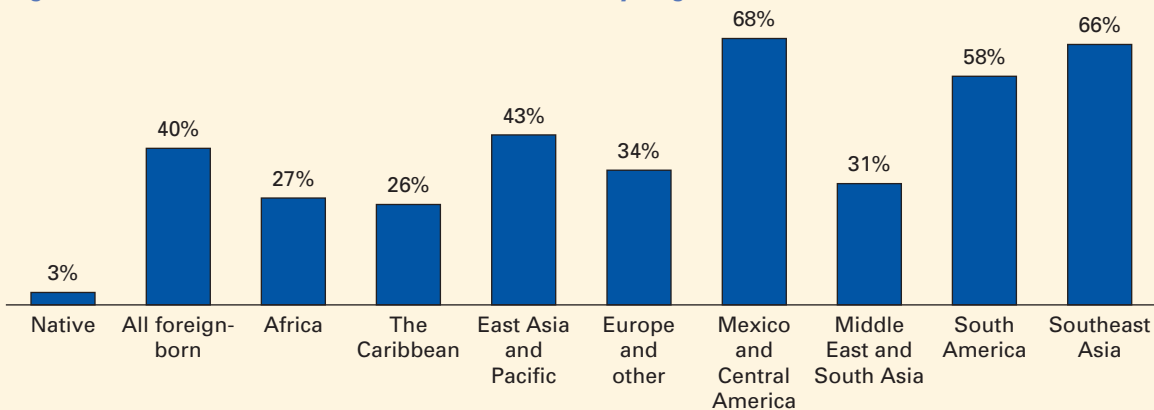
Two-Thirds of Central American and Southeast Asian Immigrants Are Limited English Proficient

Immigrants from Latin America and Southeast Asia are the most likely to lack English skills; the majority of immigrants from other regions of the world are proficient in English. The share of adults—here defined as age 18 and over—who were limited English proficient (LEP)¹² was five times as high among Connecticut’s immigrants as among the state’s overall population (40 versus 8 percent) in 2000 (figure 13). Immigrants from Mexico and Central America are the most likely to be LEP (68 percent), followed by immigrants from Southeast Asia (66 percent). Immigrants from the Caribbean and Africa are the least likely to be LEP (26 and 27 percent respectively), which is not surprising considering most African and Caribbean immigrants come from the English-speaking countries in those regions (such as Jamaica, Nigeria, and Trinidad and Tobago).

English Proficiency Is Correlated with Education

There is a strong correlation between English proficiency and educational attainment among immigrants. In 2000, the share of LEP immigrants over age 25 with less than a high school degree was 45 percent, more than twice the share for English proficient immigrants (19 percent, as shown in figure 14). The share of LEP immigrants with a four-year college degree or more was 17 percent, half the share for English-proficient immigrants (35 percent). Thus those groups of immigrants with the lowest educational attainment (Latin Americans and Southeast Asians) are also the most likely to be limited English proficient. Immigrants from the Caribbean, however, have relatively high English proficiency despite low education attainment, because they come from English-speaking countries.

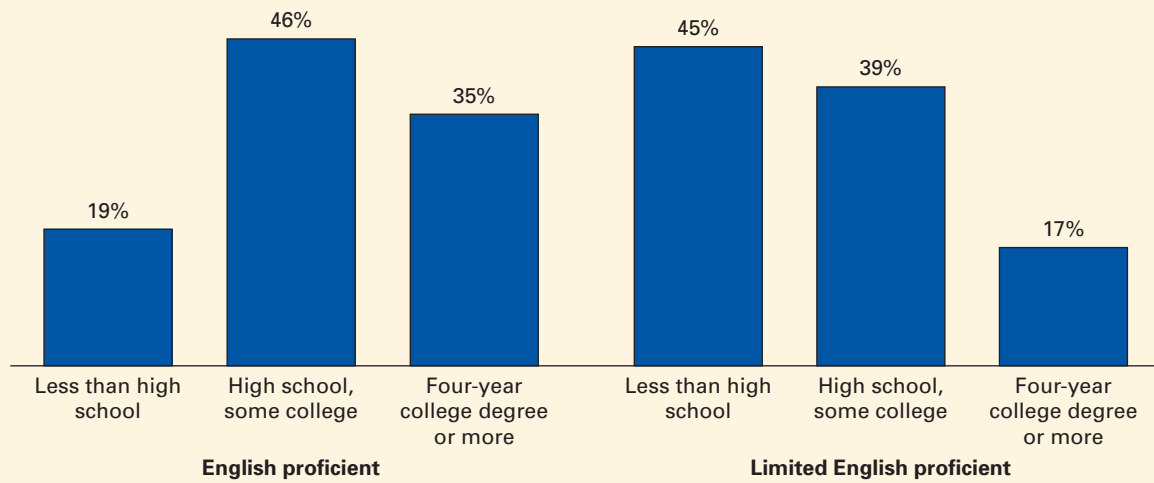
Figure 13. Share of Connecticut Adults Who Are LEP by Origin, 2000



Source: 2000 Census, PUMS.

Notes: Adults are age 18 and over. Limited English proficient (LEP) adults speak a language other than English at home and speak English less than “very well.”

Figure 14. Educational Attainment of Connecticut Adult Immigrants by English Proficiency, 2000



Source: 2000 Census, PUMS.

Note: Adults are age 25 and over. Limited English proficient adults speak a language other than English at home and speak English less than “very well.”

Spanish Language Predominates among Connecticut’s Immigrants

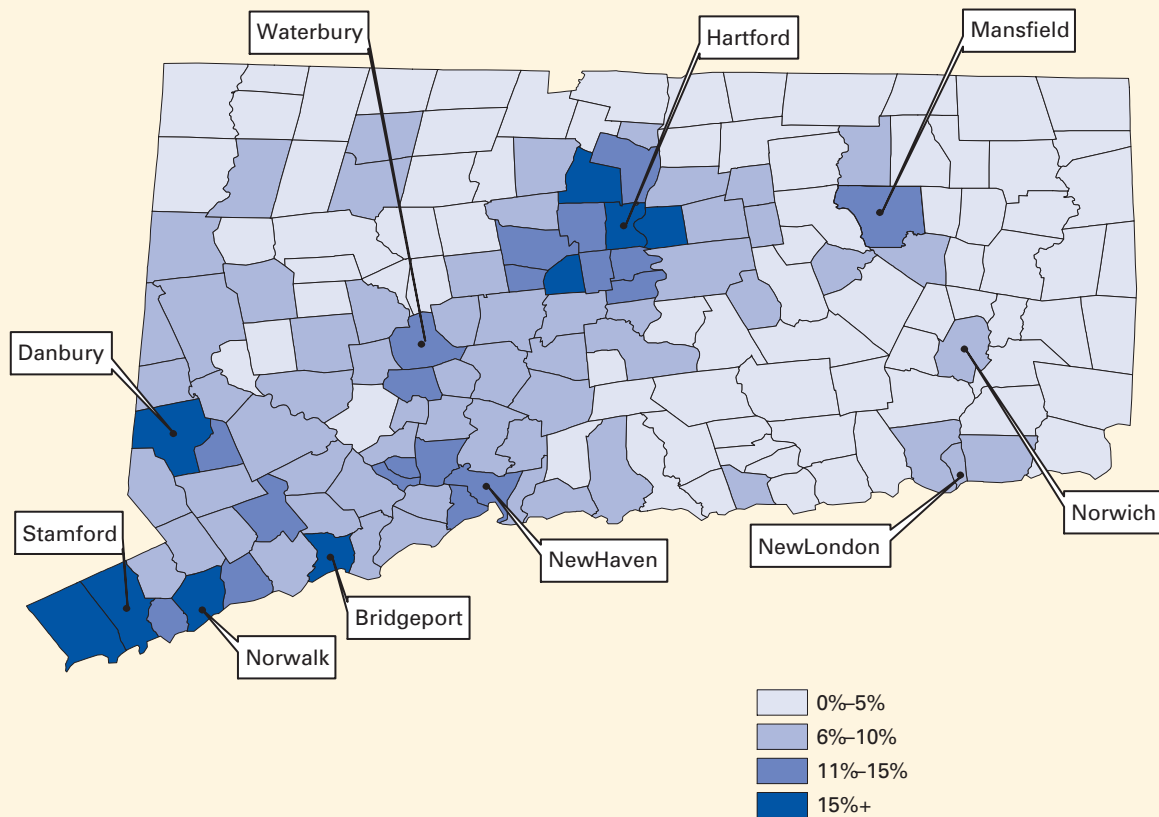
Despite the great diversity of Connecticut’s immigrants, many immigrants who do not speak English speak Spanish. In 2000, a third (35 percent) of LEP immigrants age 5 and above spoke Spanish; this was below the national level for Spanish among LEP immigrants (61 percent). Most of the other common languages spoken by the state’s LEP immigrants are also European languages (Polish, Portuguese, Italian, Russian, Albanian, and French), but each one accounts for less than 15 percent of all LEP immigrants. Three Asian languages—Korean, Chinese, and Vietnamese—together account for less than 9 percent of all LEP immigrants (table 2). The relatively low share of LEP immigrants that speaks languages other than Spanish makes providing interpretation and translation assistance for these immigrant groups more challenging.

Table 2. Top 10 Languages Spoken by LEP Connecticut Immigrants, 2004

	Number of speakers age 5 and older	Percent of total
Spanish	59,000	35
Polish	19,000	11
Portuguese	15,000	9
Italian	7,000	4
Korean	6,000	3
Chinese	6,000	3
Russian	4,000	3
Albanian	4,000	3
French	4,000	2
Vietnamese	4,000	2
Total	168,000	100

Source: 2004 American Community Survey.

Figure 15. The Foreign-Born as a Share of Total Connecticut Population, 2000



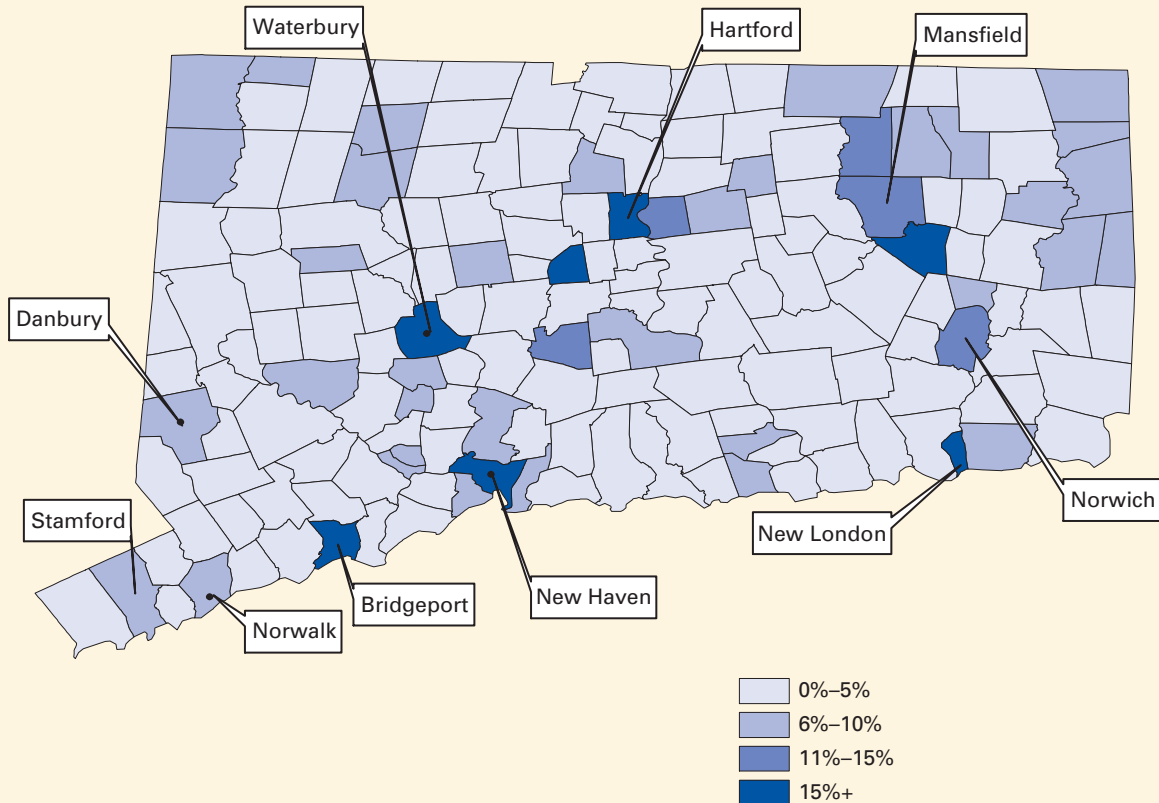
Source: 2000 Census, Summary File 3.

Immigrants Are Concentrated in Connecticut’s Major Cities, New York Suburbs

Connecticut’s immigrant communities are mostly concentrated in the largest cities and suburban areas adjacent to New York City. The pattern of immigrant concentration shows clustering primarily in three areas: Fairfield County (including Stamford, Danbury, Bridgeport, and towns in between), the Hartford metropolitan area, and the New Haven–Waterbury area (figure 15). In 2000 the half-dozen towns with the largest total number of immigrants were Stamford (35,000), Bridgeport (29,000), Hartford (23,000), Danbury (20,000), Norwalk (17,000), and New Haven (14,000) (Fishkin, Canny, and Hall 2005). The foreign-born share of the total population was highest in Stamford (30 percent), followed by Danbury (27 percent), Bridgeport (21 percent), Norwalk (20 percent), Greenwich (19 percent), and Hartford (19 percent). These areas appear in dark blue in figure 15. The areas of the state with the lowest shares of immigrants were the northwest and most of the eastern half of the state apart from Mansfield, New London, and Norwich.

Poverty—among both immigrants and U.S.-born Connecticut residents—is also most heavily concentrated in the state’s largest cities, where the most immigrants live. In 2000, Hartford, New Haven, Bridgeport, Waterbury, and New London all had poverty rates exceeding 15 percent for the native-born population (figure 16). But otherwise, the pattern of native-born poverty and immigrant concentrations did not match. The rural northeastern section of the state, which had few immigrants in 2000, also had relatively high native-born poverty. By contrast, the southwestern part of the state,

Figure 16. Share of Connecticut Native-Born Population Living Below the Poverty Level, 2000



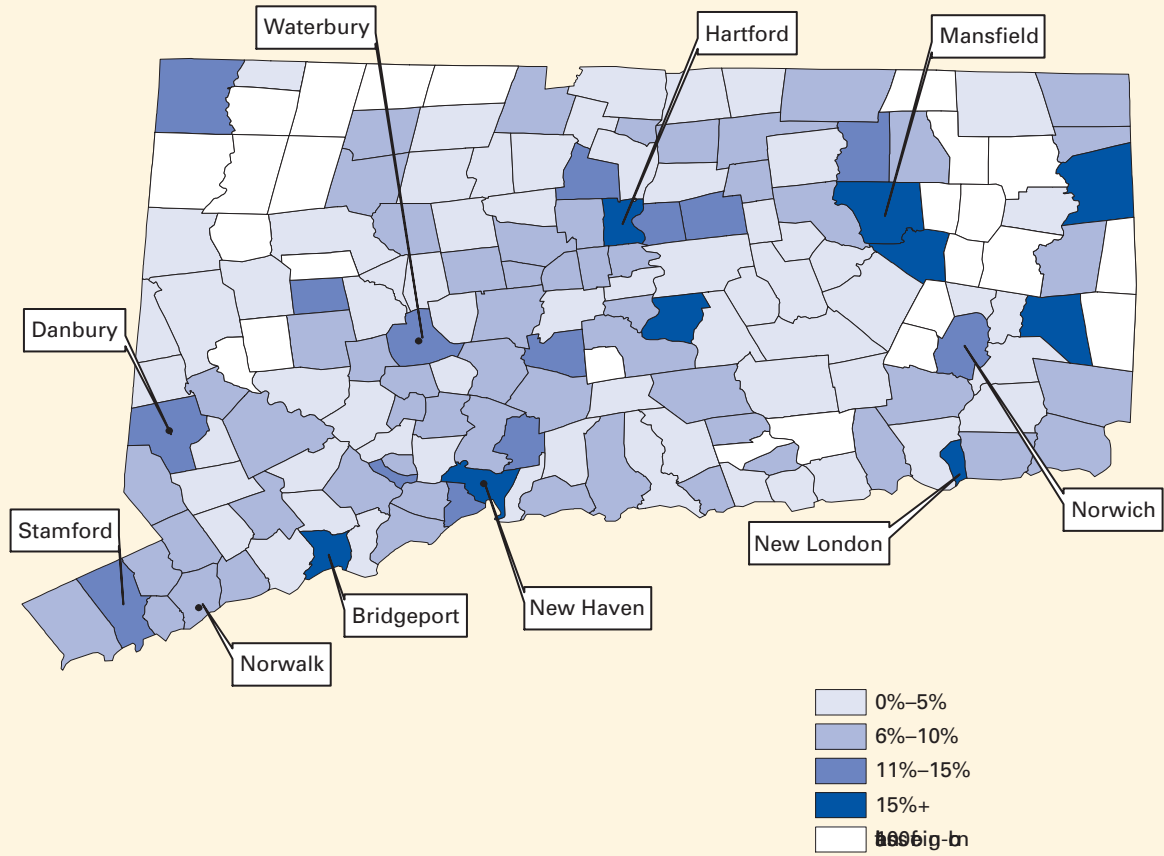
Source: 2000 Census, Summary File 3.

where far more immigrants live, had lower native-born poverty. Thus by 2000 immigrants had not yet moved in large numbers to the less prosperous rural parts of the state.

Poverty among Connecticut's immigrants is more widespread, because on average immigrants are poorer than natives. The 2000 foreign-born poverty rate was over 15 percent for Hartford, New Haven, Bridgeport, New London, Mansfield,¹³ and a few towns in the northeastern part of the state—again, areas with fewer immigrants. But even in Stamford and Danbury in more prosperous Fairfield County, the foreign-born poverty rate was over 10 percent (figure 17). Thus there are substantial numbers of poor immigrants across the state, even in the more prosperous suburbs of New York City.

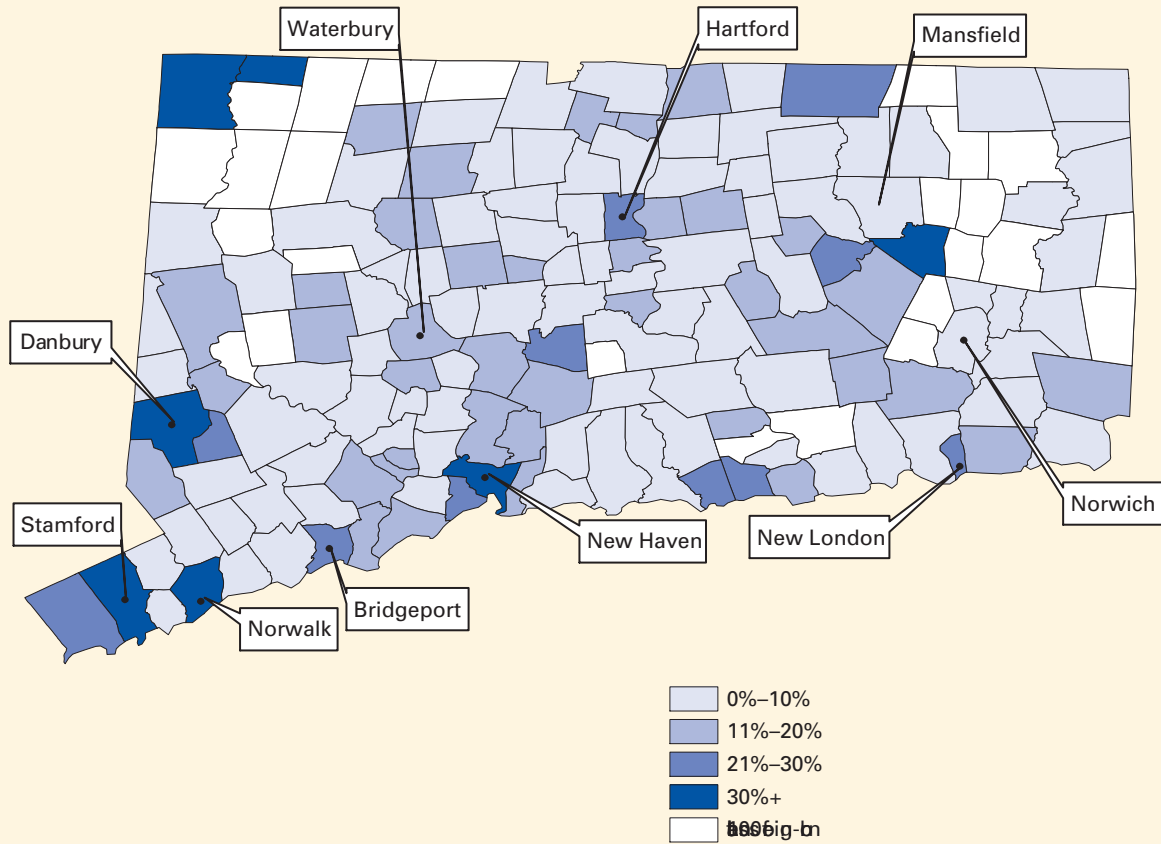
The poorest and most recent immigrants—those from Latin America—show a slightly different pattern of residential settlement than other immigrants. In 2000, Central and South Americans accounted for over 30 percent of immigrants in Stamford, Danbury, and New Haven (figure 18). Their share of all immigrants was lower in the Hartford area and most other areas farther east. Thus the highest concentrations of Latino immigrants are in the southwest, closer to New York City. The relative prosperity of these areas may be driving the migration of these most recent immigrants, who are seeking the strongest labor markets and best job opportunities.

Figure 17. Share of Connecticut Foreign-Born Population Living Below the Poverty Level, 2000



Source: 2000 Census, Summary File 3.

Figure 18. Latin American Share of Connecticut Foreign-Born Population, 2000



Source: 2000 Census, Summary File 3.

IMMIGRANTS IN CONNECTICUT'S LABOR FORCE

Immigrants are a large and growing share of workers at both the lower- and higher-skilled ends of Connecticut's labor force, and reliance on immigrant workers is increasing statewide. Connecticut has an unusually high share of highly skilled and highly paid workers, but also has a large and rapidly growing population of low-skilled immigrant workers who fill key jobs in various industries.

Immigrants Are a Relatively High Share of Connecticut's Low-Skilled Labor Force

The share of immigrants in the Connecticut labor force in 2000 (12 percent) was similar to their share of the U.S. labor force (12 percent), but immigrants composed a higher share of the low-wage labor force (16 percent).¹⁴ An even higher share of low-skilled workers—defined here as those with less than a high school degree—was immigrants: 28 percent in Connecticut and 32 percent nationally (figure 19). Thus Connecticut, like the United States generally, relies heavily on immigrants as lower-skilled workers (Capps, Fix, et al. 2003). But Connecticut also has substantial numbers of immigrants at the higher-skilled end of the labor force.

Immigrants Are an Important Component of Current and Future Workforce Growth

Nationally, immigrants accounted for half the growth in the labor force during the 1990s (Sum et al. 2002). This trend will accelerate, as the baby boomers—the largest native-born cohort of workers—retire over the next 10 to 20 years. Within this period, immigrants will begin to account for *all the labor force growth* in the United States. In other words, without immigration, the U.S. labor force would actually shrink over the next decade or two, while the elderly population would increase—leaving big shortfalls in services to the aging population and funding for programs to support them.

Connecticut is somewhat ahead of the national trend: the native-born labor force there actually shrank during the 1990s. The number of U.S.-born men of working age (18 to 64) fell by 4 percent, and the number of U.S.-born women fell by 3 percent. By contrast, the immigrant working age population in Connecticut increased significantly from 1990 to 2000: by 40 percent for men and 34 percent for women (figure 20). The overall growth in the working age population (foreign-and native-born together) was less than 0.5 percent. Thus without immigration during the 1990s, Connecticut's working-age population would have declined.

Figure 19. Immigrants as Shares of the Total Population and Workforce, Connecticut and the United States, 2000



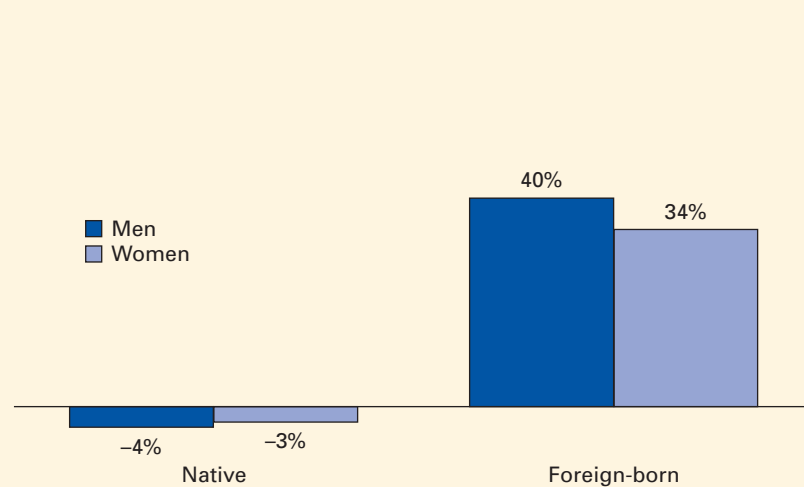
Source: 2000 Census, PUMS.

Note: Workers were able-bodied, age 18 to 64, employed at the time of the census, and earned nonzero wages in 1999. Low-wage workers earned less than twice the minimum wage in 1999. Low-skilled workers have less than a high school education.

Immigrant Men Are as Likely as U.S.-Born Men to Work, but Immigrant Women Have Lower Employment Rates

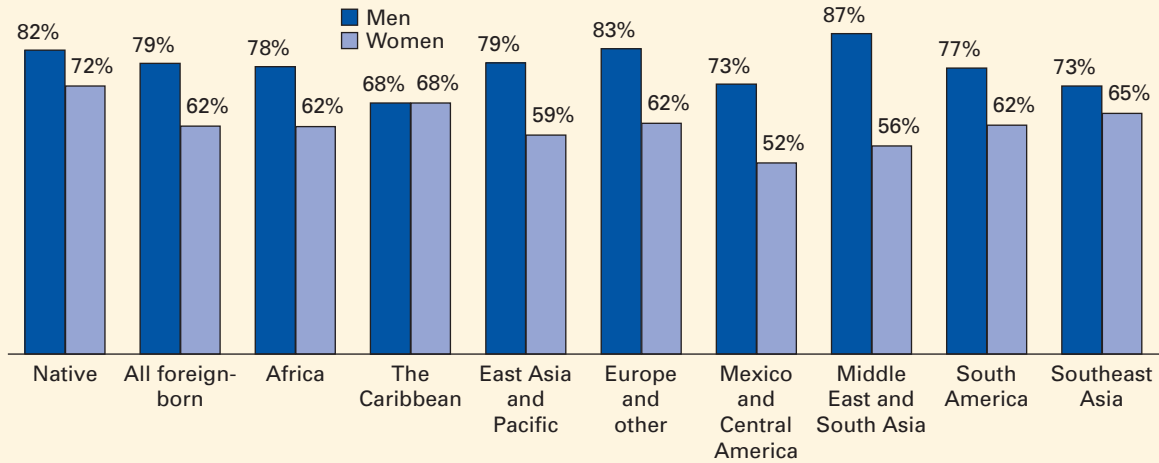
Most immigrants come to Connecticut for work, although immigrant men are substantially more likely than women to work. Fitting the national pattern documented elsewhere (Capps, Fix, et al. 2003), immigrant men in Connecticut are just as likely as U.S.-born men to work, while immigrant women have a substantially lower employment rate than native-born women (figure 21). In 2000 the employment rate for foreign-born men in Connecticut (79 percent) was comparable to that for

Figure 20. Change in Connecticut Working-Age Population by Nativity and Gender, 1990–2000



Sources: IPUMS, 1990 and 2000.
Note: Working-age is age 18 to 64.

Figure 21. Employment Rates of Connecticut Working-Age and Able-Bodied Adults by Gender and Origin, 2000



Source: 2000 Census, PUMS.
Note: Working-age is age 18 to 64.

U.S.-born men (82 percent). Employment rates for foreign-born men from the Middle East and South Asia (87 percent) and Europe, Canada, Australia, and New Zealand (83 percent) actually exceeded the rate for native-born men. Men born in Mexico, Central America, and Southeast Asia—the groups with the lowest educational attainment—also had somewhat lower employment rates (73 percent). Caribbean-born men had the lowest employment rate (68 percent).

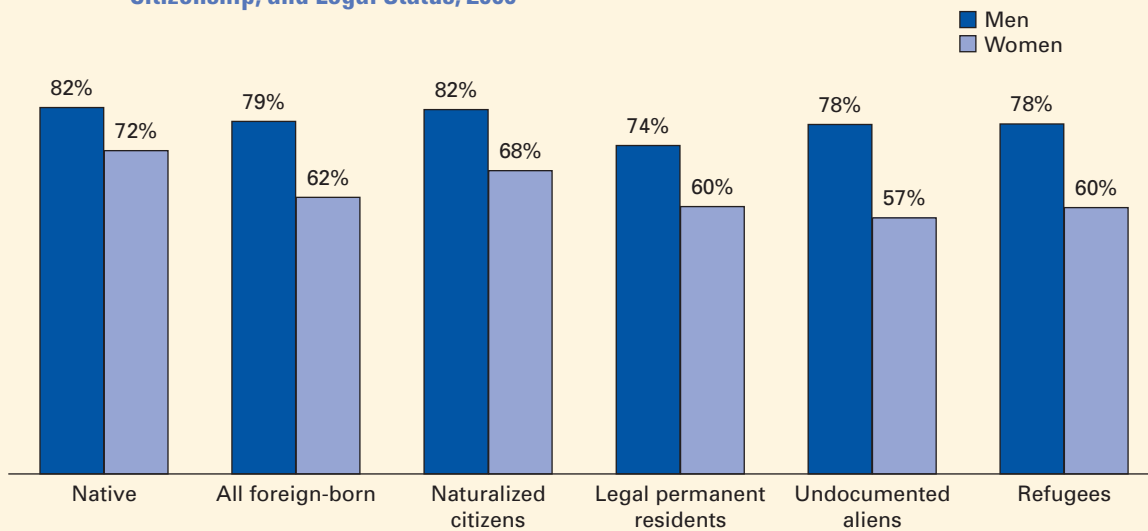
Employment patterns for Connecticut immigrant women differ from those for men. The overall rate for foreign-born women (62 percent) was lower than the rate for U.S.-born women (72 percent) in 2000. Foreign-born women from the Caribbean had the highest employment rate (68 percent), the same as the rate for foreign-born men from this region; no other group of immigrants had equal employment rates for men and women. By contrast, the largest gender gap in employment (over 30 percentage points) was for Middle Eastern and South Asian immigrants (87 percent for men versus 56 percent for women). The lowest employment rate was for women born in Mexico and Central America (52 percent).

The Employment Rate for Undocumented Men Is High, but the Rate for Undocumented Women Is Lower

The vast majority of undocumented immigrants—like other immigrants in Connecticut—are working. Immigrant men have employment rates similar to those of U.S.-born men regardless of citizenship and legal status, but employment rates among women vary more widely by citizenship and legal status. In 2000, the employment gap between undocumented and native men was only 4 percentage points, but the gap between undocumented and native women was 15 percentage points (figure 22).

Naturalized U.S. citizens were the most likely immigrants to be employed: 82 percent for men and 68 percent for women. These rates were comparable to those for U.S.-born men and women (82 and 72 percent, respectively). Compared with citizens, legal permanent residents had lower employment rates: 74 percent for men and 60 percent for women. Undocumented men had a higher

Figure 22. Employment Rates of Connecticut Working-Age and Able-Bodied Adults by Gender, Citizenship, and Legal Status, 2000



Source: 2000 Census, PUMS.
 Note: Working-age is age 18 to 64.

employment rate (78 percent) than that of LPR men, but the rate for undocumented women (57 percent) was lower than that of LPRs or citizens. Because most undocumented immigrants come from Latin America, the relatively low employment rate for undocumented women reflects the relatively low rate for women born in Mexico and Central America. The gender gap in employment was also relatively high for refugees (18 percent), most of whom come from Southeast Asia.

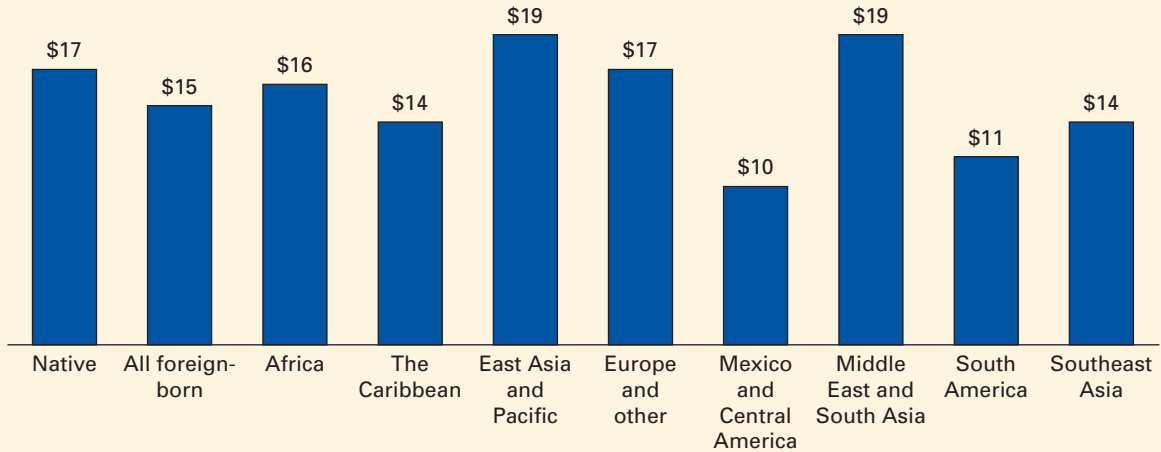
The Median Hourly Wage of Some Asian Immigrants Exceeds the Wage for Natives

Connecticut has a substantial number of highly paid immigrants; the highest paid were born in Asia. Overall, the median hourly wage of foreign-born workers in 1999 was not much lower than that of native workers: \$15 versus \$17 (figure 23). Immigrants from East Asia, the Pacific, the Middle East, and South Asia—the groups with the highest educational attainment—earned more than native workers (median wage of \$19). Immigrants from Europe, Canada, Australia, and New Zealand earned the same median wage as native workers (\$17), while immigrants from Africa earned slightly less (\$16). Immigrants from Southeast Asia and the Caribbean earned a lower median wage (\$14). Immigrants from Mexico, South America, and Central America earned the lowest median hourly wages (\$10–\$11). Thus immigrants from Asia—except Southeast Asia—earned almost twice the median hourly wage of Latin American immigrants. The immigrant groups with low educational attainment earned relatively low wages, while those with higher educational attainment earned higher wages.

Immigrants and Natives Receive Nearly the Same Returns to Education

The best-educated workers earn the highest wages, regardless of whether they are immigrants. Data from the census show a clear pattern of association between median wages and educational

Figure 23. Median Hourly Wage of Connecticut Workers by Origin, 1999

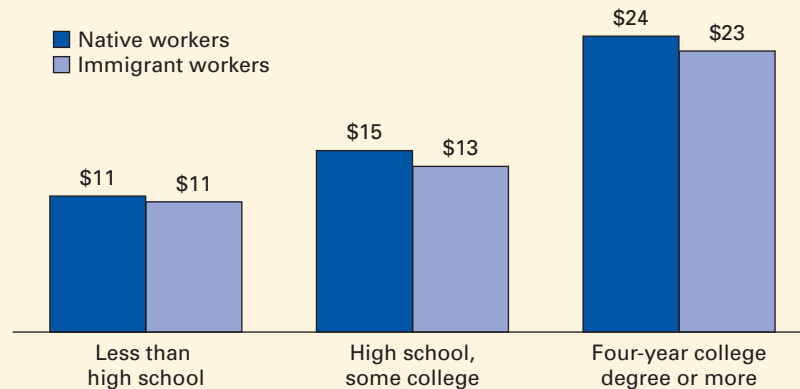


Source: 2000 Census, PUMS.

Note: Workers are able-bodied, age 18 to 64, and employed at the time of the census.

attainment; this pattern is nearly the same for immigrant and native-born workers. In 1999 college-educated immigrants earned more than twice as much as high school dropouts (\$23 versus \$11 an hour). At each stage of educational attainment displayed here, immigrants earned about the same median hourly wage as immigrants (figure 24).

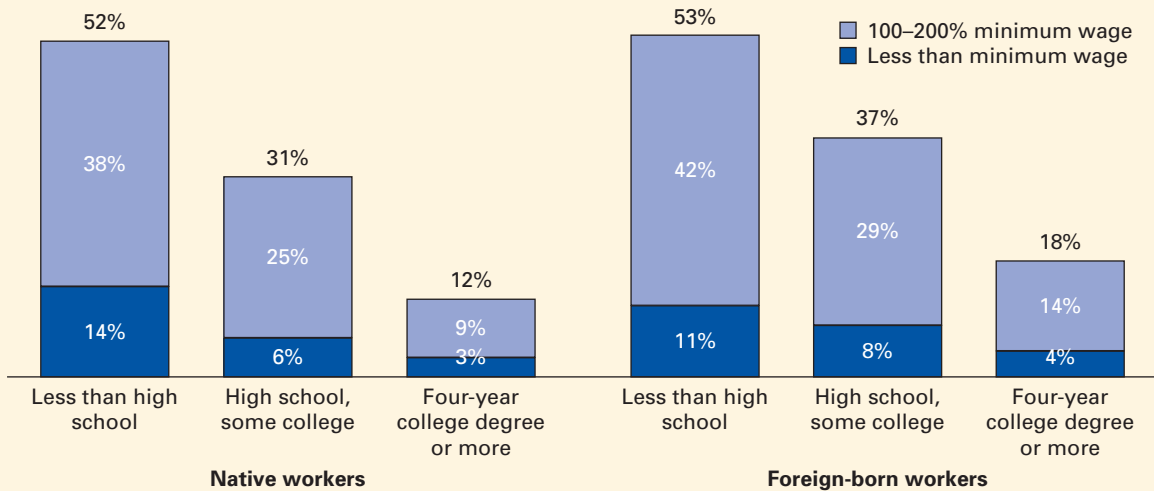
Figure 24. Median Hourly Wage of Connecticut Workers by Nativity and Education, 1999



Source: 2000 Census, PUMS.

Note: Workers are able-bodied, age 18 to 64, and employed at the time of the census.

Figure 25. Share of Connecticut Workers Earning Low Wages, by Nativity and Educational Attainment, 1999



Source: 2000 Census, PUMS.

Note: Workers are able-bodied, age 18 to 64, and employed at the time of the census.

Half of Immigrant and Native Workers without High School Degrees Earn Low Wages

Shares of workers earning below the minimum wage and below twice the minimum wage (“low wage”) are highest for the least educated workers,¹⁵ whether immigrants or natives. Over half of foreign- and native-born workers with less than a high school degree earned below twice the minimum wage in 1999, compared with just 12 percent of native-born and 18 percent of foreign-born workers with a college degree or more (figure 25). Fourteen percent of native-born workers without high school degrees earned below the minimum wage; this share was actually higher than for immigrant workers without high school degrees (11 percent).

Half of Limited English Proficient Immigrants Earn Low Wages

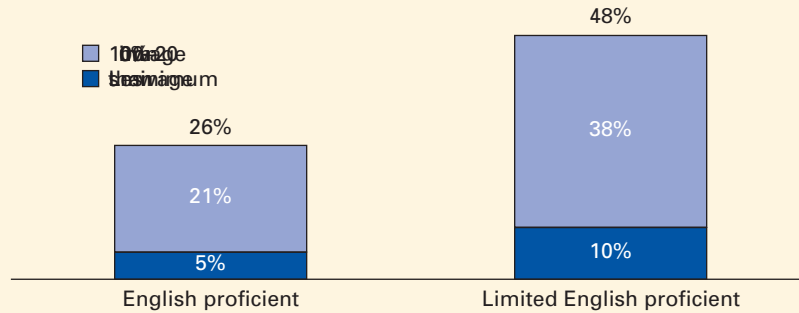
Immigrants’ wages are strongly affected by English proficiency. In 1999 English proficient foreign-born workers earned a median hourly wage of \$17, almost 50 percent higher than LEP foreign-born workers (\$12). LEP immigrants may earn relatively low wages because they have lower educational attainment than more proficient immigrants. Additionally, some better-educated immigrants may experience barriers to high-wage employment in the United States because of limited English skills.

LEP immigrants are about twice as likely as English proficient immigrants to earn low wages. In 1999, almost half of LEP immigrants earned below twice the minimum wage, compared with about a quarter of foreign-born, English-proficient workers. The share of LEP foreign-born workers earning below the minimum wage was also twice as high as the share of English proficient foreign-born workers: 5 versus 10 percent (figure 26).

Lower-Wage Immigrants Are Less Likely to Work Full-Time

Among all immigrant workers, Latin Americans are the least likely to work full-time.¹⁶ This means Latin American immigrants are doubly disadvantaged—with both lower wages and fewer hours of

Figure 26. Share of Connecticut Workers Earning Low Wages by English Proficiency, 1999



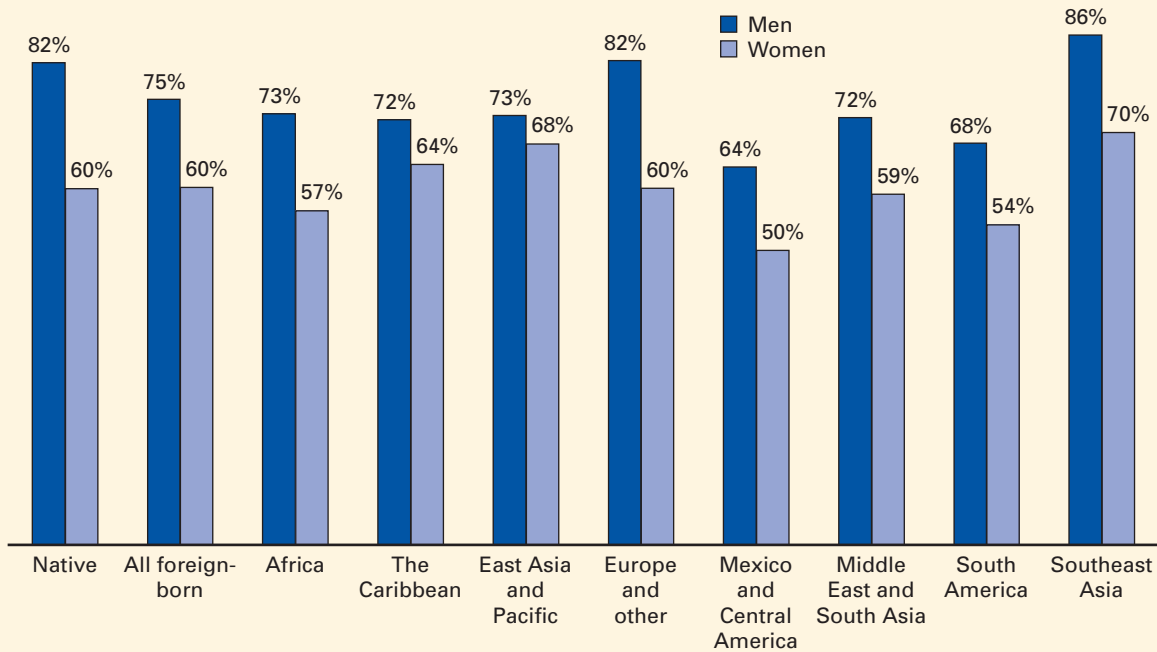
Source: 2000 Census, PUMS.

Note: Workers are able-bodied, age 18 to 64, and employed at the time of the census. Limited English proficient workers speak a language other than English at home and speak English less than "very well."

work. Additionally, among natives and most groups of immigrants, working women are significantly less likely to work full-time than men. Latin American women have the lowest rates of full-time work (figure 27).

In 1999, 64 percent of Mexican and Central American men who were employed worked full-time, compared with 75 percent of foreign-born men overall and 82 percent of native-born men. Only half (50 percent) of women from Mexico and Central America worked full-time. South

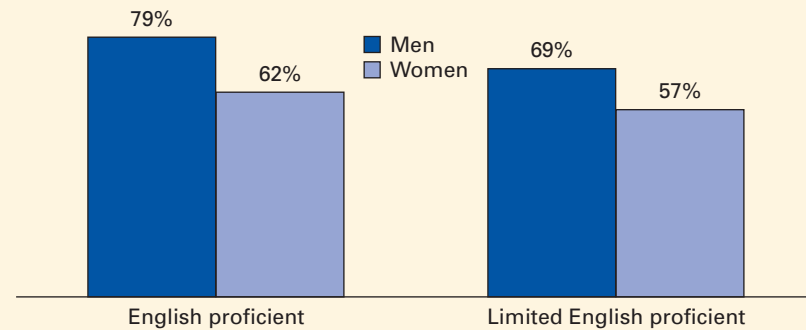
Figure 27. Share of Connecticut Workers Working Full-Time, by Gender and Origin, 1999



Source: 2000 Census, PUMS.

Notes: Workers are able-bodied, age 18 to 64, and employed at the time of the census. Full-time workers worked at least 48 weeks in 1999 and 35 hours a week during the average week.

Figure 28. Share of Connecticut Workers Working Full-Time, by Gender and English Proficiency, 1999



Source: 2000 Census, PUMS.

Notes: Workers are able-bodied, age 18 to 64, and employed at the time of the census. Full-time workers worked at least 48 weeks in 1999 and 35 hours a week during the average week. Limited English proficient workers speak a language other than English at home and speak English less than "very well."

American immigrants had the second lowest rates of full-time work (68 percent for men and 54 percent for women). Together with low wages, lower full-time work and lower labor force participation among women may explain why Latin American immigrants have such low family incomes and high poverty rates.

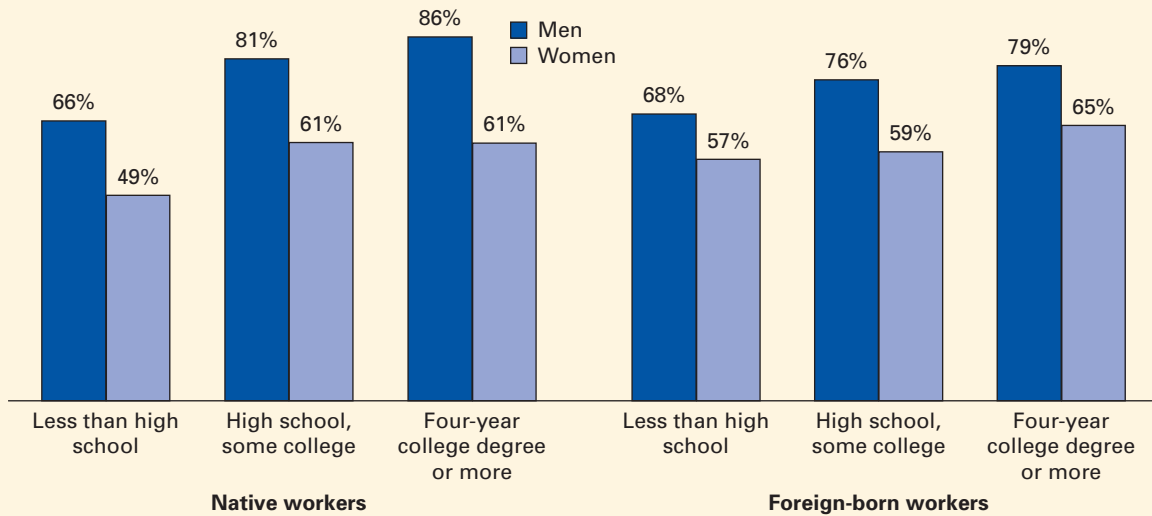
Some other immigrant groups have full-time employment rates as high or higher than those of U.S.-born Connecticut residents. In 1999, the full-time employment rate for European-born men (82 percent) was the same as that for U.S.-born men, while the rate for Southeast Asian men (86 percent) was higher. Overall, immigrant women were as likely to work full-time as native-born women (60 percent). However, full-time employment shares were higher for women born in Southeast Asia (70 percent), East Asia and the Pacific (68 percent), and the Caribbean (64 percent).

There are only minor differences in the amount of full-time work between LEP and English proficient workers. In 1999 the difference in the full-time employment rate between LEP and English proficient immigrants was 10 percentage points for men and 5 percentage points for women (figure 28). Thus, English proficiency affects immigrants' wages more than it affects the amount they work.

Like English proficiency, educational attainment has only a slight effect on full-time employment for immigrants, but the effect for native-born workers is more substantial. In 1999, the gap in full-time work between college-educated immigrants and those without a high school education was 11 percentage points for men and 8 percentage points for women. By contrast, the full-time employment gap for comparably educated natives was 20 percentage points for men and 12 percentage points for women (figure 29).

Thus, educational attainment appears to have more effect on full-time work for U.S.-born Connecticut residents than for immigrants. Less-educated immigrants may be able to find full-time jobs more often than less-educated natives. Other possible explanations are: native-born women without a high school education choose to work less and stay at home more, or immigrant women must work longer hours because their husbands' wages are lower. On the other hand, there may be significant underemployment—in terms of part-time and seasonal work—among higher-skilled immigrant men. The relatively low full-time employment rate for immigrant men with a four-year college degree (79 percent versus 86 percent for native-born men) suggests this may be the case.

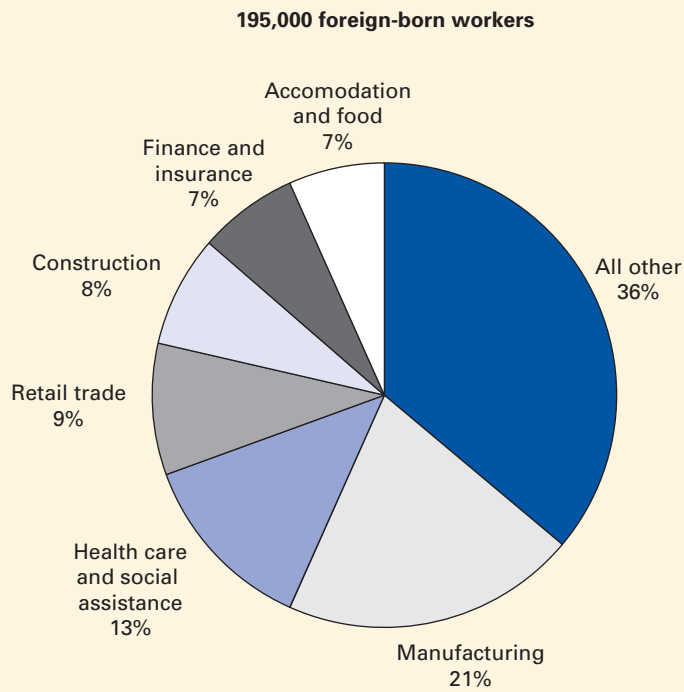
Figure 29. Share of Connecticut Workers Working Full-Time, by Nativity, Educational Attainment, and Gender, 1999



Source: 2000 Census, PUMS.

Note: Workers are able-bodied, age 18 to 64, and employed at the time of the census. Full-time workers worked at least 48 weeks in 1999 and 35 hours a week during the average week.

Figure 30. Major Industries for Connecticut Immigrant Workers, 2000



Source: 2000 Census, PUMS.

Note: Workers are able-bodied, age 18 to 64, and employed at the time of the census.

Manufacturing, Health Care, Retail Trade, and Construction Employ the Most Immigrants

Connecticut’s immigrants are employed in a mixture of higher- and lower-skilled industries. Manufacturing, health care and social assistance, retail trade, and construction together employed half of Connecticut immigrant workers in 2000 (figure 30).¹⁷ Manufacturing was the most common industry, employing 21 percent of all immigrant workers. Finance and insurance along with health care and social assistance are relatively high-skilled, high-paying immigrant industries. Manufacturing, retail trade, construction, and accommodation and food, on the other hand, are lower-skilled industries.

The Number of Immigrant Workers Is Growing Rapidly in Most Industries

Growing numbers of immigrant workers participated in the information-, technology-, and education-driven economic boom of the 1990s. The number of Connecticut immigrant workers grew rapidly from 1990 to 2000 in virtually all industries, while the number of native workers grew more slowly or declined in most industries (table 3). This growth in immigration occurred when Connecticut’s high-skilled job sectors—including information and professional, scientific, and technical services—were growing rapidly while some lower-skilled sectors—including manufacturing and wholesale trade—experienced overall declines in employment.

During the 1990s, there were increases in both immigrant and native workers in information; professional, scientific and technical; education and health; and public administration—all relatively high-skilled sectors of the economy. By contrast, the number of immigrant workers declined in manufacturing and wholesale trade, two relatively low-skilled industries that experienced much more substantial declines in the number of native-born workers. For most industries, though, the number of immigrant workers increased while the number of native-born workers declined.

Table 3. Growth Rate of Native and Foreign-Born Workers by Industry, 1990–2000

Industry	Percent change in foreign-born workers	Percent change in native workers
Professional, scientific, and technical	92	21
Other services	82	13
Information	81	34
Transportation	78	-5
Administrative, support, and waste management	53	-19
Public administration	52	5
Construction	43	-4
Education and health	39	10
Retail trade	28	-5
Accommodation and food	24	-1
Finance, insurance, real estate, and rental	15	-13
Manufacturing	-5	-31
Wholesale trade	-5	-26

Sources: IPUMS, 1990 and 2000.

Note: Workers are age 18 to 64 and employed at the time of the census.

Foreign-Born Shares of Workers Are Highest in Low-Skilled Industries

Despite their broad participation in the economy, Connecticut's immigrants remained most heavily concentrated in low-skilled sectors in 2000. Accommodation and food employed the highest share of immigrants (20 percent), followed by other services (18 percent) and administrative, support, and waste management (18 percent). In 2000, manufacturing (19 percent) and other services (20 percent) had the highest shares of foreign-born working women. Public administration and educational services (7 percent each) employed the lowest shares of immigrant working women. Among men, accommodation and food (26 percent) and administrative, support, and waste management (19 percent) employed the highest shares of immigrant workers. Public administration (5 percent) and information (8 percent) employed the lowest shares of immigrant men. Twelve percent of all Connecticut workers were foreign-born in 2000 (table 4).

Professional and Scientific Workers Are Paid the Most, Accommodation and Food Workers the Least

Immigrants in the highest-paid sectors of the economy earn as much or more than U.S.-born workers, although in most industries native workers earn slightly more than immigrants. In 1999, the industry with the highest median hourly wage for both immigrant and native workers was the professional and scientific sector, with foreign-born workers earning slightly more than native workers (\$24 versus \$22 an hour). Immigrants also earned as much as natives on average in finance and insurance (\$21 an hour) and information (\$20 an hour). The industries with the lowest median

Table 4. Share of Connecticut's Foreign-Born Workers in Major Industries by Gender, 2000

	Percent Foreign-Born		
	Overall	Men	Women
Accommodation and food	20	26	15
Other services	18	15	20
Administrative, support, and waste management	18	19	16
Manufacturing	17	16	19
Construction	16	16	8
Health care and social assistance	12	15	12
Transportation and warehousing	11	11	11
Retail trade	11	12	10
Professional, scientific, and technical	11	12	9
Real estate: rental and leasing	10	11	10
Finance and insurance	10	10	11
Wholesale trade	10	10	11
Arts and entertainment	9	10	9
Educational services	8	11	7
Information	8	8	8
Public administration	6	5	7

Source: 2000 Census, PUMS.

Note: Workers are age 18 to 64 and employed at the time of the census.

hourly wages for both foreign-born and native-born were accommodation and food and administrative, support, and waste management (\$10 for foreign-born workers in both industries). Thus, within-industry wage differentials between immigrants and natives are much smaller than differences across industries (table 5).

Professional and Scientific Workers Are the Best-Educated, Administrative and Support Workers the Least

Low-skilled immigrant workers are highly concentrated in lower-paid industries, and in all industries immigrants are more likely than U.S.-born workers to lack a high school education. In 1999, the industry with the highest share of foreign-born workers without high school degrees was administrative, support, and waste management (45 percent), followed by construction (38 percent), and accommodation and food (33 percent); all were relatively low paying industries. The industries with the lowest shares of both foreign- and native-born workers without high school degrees were professional, scientific, and technical; finance and insurance; educational services; public administration; and information—all relatively high-paying industries (table 5).

At the other end of the spectrum, some of Connecticut’s most highly skilled industries employ more highly educated immigrants than natives. Shares of workers with a college degree or more were actually higher for immigrants than natives in professional, scientific, and technical (71 versus 64 percent), educational services (68 versus 67 percent), and finance and insurance (55 versus 52 percent, as shown in table 5).

Very high shares of immigrants with college degrees in some of these industries may explain why immigrants in these industries earn as much or more than native workers. On the other hand, some industries—most notably construction, administrative and support, and other services—have very low shares of immigrants with college degrees, explaining why immigrants in those industries are paid lower wages.

Table 5. Median Hourly Wages and Educational Attainment Rates of Connecticut Workers, 1999

Industry	Median Hourly Wage		Less than a High School Education (%)		Four-Year College Degree or More (%)	
	Immigrants	Natives	Immigrants	Natives	Immigrants	Natives
Professional, scientific, and technical	\$24	\$22	3	1	71	64
Finance and insurance	\$21	\$21	3	2	55	52
Information	\$20	\$20	8	3	46	48
Public administration	\$19	\$22	6	4	43	38
Educational services	\$17	\$19	7	3	68	67
Construction	\$16	\$17	38	14	10	12
Health care and social assistance	\$15	\$16	16	6	36	37
Manufacturing	\$15	\$19	25	10	27	29
Real estate: rental and leasing	\$15	\$17	15	6	29	35
Transportation and warehousing	\$15	\$17	21	10	18	16
Wholesale trade	\$14	\$17	20	8	27	31
Arts and entertainment	\$12	\$13	19	9	25	30
Other services	\$11	\$13	29	12	16	24
Retail trade	\$11	\$13	21	12	25	19
Accommodation and food	\$10	\$10	33	19	13	12
Administrative, support, and waste management	\$10	\$13	45	14	13	22

Source: 2000 Census, PUMS.

Note: Workers are age 18 to 64 and employed at the time of the census.

HEALTH INSURANCE COVERAGE AND HEALTH CARE ACCESS FOR CONNECTICUT'S IMMIGRANTS

Health insurance coverage is more comprehensive in Connecticut than many other states, but there is wide variation in insurance coverage between immigrants and U.S.-born citizens, as well as among immigrants from different origins. The variations in the job skills and earnings of immigrants described earlier in the report have implications not only for income and poverty in immigrant families, but also for health insurance coverage, as the highest-skilled jobs are the most likely to carry employer coverage. The rate of citizenship also varies across racial and ethnic groups; this affects health insurance coverage because noncitizens may be ineligible for public coverage through Medicaid or other sources if their employers do not provide health insurance. In particular, this section focuses on Hispanic immigrants, who are most likely to be noncitizens and be uninsured.¹⁸ These patterns and variations affect the coverage of immigrant adults as well as their children—who in many cases are also uninsured.

Immigrants who lack health insurance coverage for themselves and their children have limited options in health care arrangements. The uninsured in Connecticut are served by community health centers (CHCs), hospital clinics, and free clinics in many locations. However, there are more providers for the uninsured in larger urban areas—including our study sites of Hartford and New Haven—than in smaller cities, towns, and rural areas. For instance, health care options for the uninsured are more limited in our third study site, Danbury, which does not have a CHC.

National research has shown that uninsured adults are less likely to have a stable place for health care—either a doctors' office, clinic, or hospital they visit regularly—and are more likely to use expensive emergency room care when they need it. According to a 2003 survey by the Kaiser Family Foundation, almost half (47 percent) of uninsured working-age adults (19 to 64) postponed seeking medical care within the past year because of cost, compared with just 15 percent of insured adults (Kaiser Commission on Medicaid and the Uninsured 2003). Over one-third of uninsured adults (35 percent) needed care but did not get it, compared with 9 percent of insured adults. The uninsured were almost three times as likely as insured adults to not fill a prescription because of cost (37 versus 13 percent).

Immigrants' access to care is complicated not only by their lack of health insurance but also by their relative poverty, low education attainment, cultural differences with U.S. providers, lack of familiarity with the U.S. health care system, and—in some cases—limited English proficiency. Immigrants may have more difficulty affording the co-payments and deductibles that come with health insurance coverage or the high medical bills that come with uninsurance. With lower educational attainment and cultural differences, some immigrants may have difficulty understanding how the U.S. health care system works. LEP immigrants also need adequate language interpretation at health facilities; this issue is especially important for immigrants who do not speak English or Spanish. For instance, LEP immigrants may find it difficult to schedule an appointment if interpretation

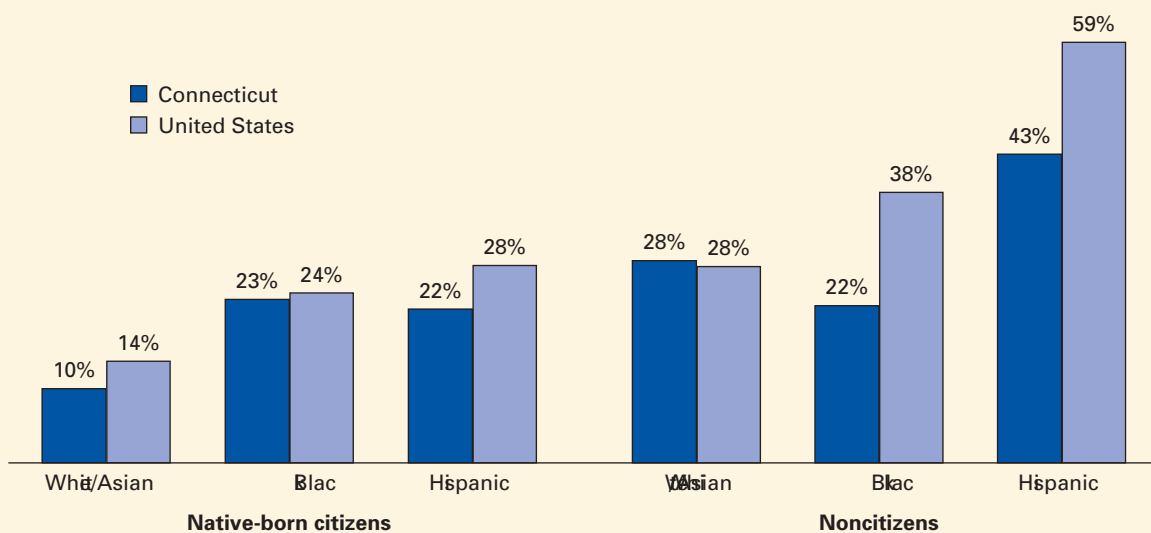
is unavailable when they call. They may also have bad experiences with health care providers or misunderstand instructions for follow-up care, reducing the likelihood they will return for further health care. Difficulties in any of these areas may create barriers to receiving adequate care and reduce immigrants' access to the health care system.

Hispanic Noncitizen Adults Are the Most Likely to Be Uninsured

Hispanic immigrants who are not U.S. citizens are much more likely than U.S.-born Hispanic citizens and noncitizens in other racial and ethnic groups to be uninsured.¹⁹ This pattern holds for both Connecticut and the United States as a whole, according to data from the March supplement to the CPS (figure 31). In Connecticut in 2001–2003, working-age noncitizens were almost three times as likely as working-age native citizens to be uninsured (31 versus 12 percent).²⁰ Among U.S.-born citizens, non-Hispanic blacks and Hispanics were about twice as likely as non-Hispanic whites and Asians to be uninsured.²¹ Among noncitizens, however, the uninsurance rate was about the same for non-Hispanic whites, blacks, and Asians. In fact, African Americans (i.e., native-born blacks) and native-born Hispanics (85 percent of whom were Puerto Rican) were just as likely to be uninsured as non-Hispanic noncitizens. Hispanic noncitizens, by contrast, were about twice as likely as other noncitizens, and four times as likely as native-born whites, to be uninsured. The pattern for Connecticut is similar to the national pattern, although the uninsurance rate for Hispanic noncitizen adults is higher nationally than in Connecticut.²²

National data from surveys other than the CPS show that immigrants and Hispanics are the two groups most likely to lack health insurance coverage. According to nationally representative data from the Medical Expenditure Panel Survey (MEPS), nonelderly immigrants (under age 65) were twice as likely as nonelderly natives to be uninsured in 1998 (24 versus 10 percent) (Mohanty et al. 2005). Lower employer and other private coverage was the main factor driving uninsurance among the nonelderly: only 58 percent of immigrants had employer-sponsored coverage, compared with

Figure 31. Uninsurance Rates of Connecticut Adults by Citizenship and Race/Ethnicity, 2001–03



Source: 2002–2004 March Supplements to the U.S. Current Population Survey.
 Note: Adults are age 19 to 64.

75 percent of natives. Rates of public coverage through Medicaid and other sources were very similar between nonelderly immigrants and natives in 1998. According to another national study using the 2004 MEPS, 36 percent of Hispanics were uninsured, compared with 15 percent of non-Hispanic whites, 22 percent of non-Hispanic blacks, and 19 percent of other/mixed race nonelderly people (Rhoades 2005).

According to the 1997 National Survey of America's Families (NSAF), low-income noncitizen adults age 19 to 64 were almost twice as likely to be uninsured as low-income U.S.-born citizen adults (58 versus 34 percent), but in the NSAF both private and public coverage were significantly lower for noncitizens. The same patterns held for higher-income noncitizens versus U.S.-born citizens (Ku and Matani 2000). Throughout all three years of the NSAF data—1997, 1999, and 2002—Hispanics had lower rates of employer-sponsored coverage and higher rates of uninsurance than non-Hispanic whites nationwide. Despite their greater need for public coverage, Hispanics were enrolled in public programs such as Medicaid and State Children's Health Insurance Program (SCHIP) to the same degree as non-Hispanic whites (Wherry and Finegold 2004).

Hispanic immigrants are more likely to lack health insurance coverage because they are the least-educated and lowest-paid workers in Connecticut. Nationally, adults with lower incomes and educational attainment are more likely to lack health insurance, in part because they are less likely to obtain coverage through their employers. According to national data from the March supplement to the CPS, in 2003 almost half (45 percent) of U.S. working-age adults with incomes below the federal poverty level (FPL) were uninsured, compared with 17 percent of those with incomes of 200–399 percent of FPL and 6 percent of those with incomes over 400 percent of FPL. Forty-two percent of U.S. working-age adults without a high school degree were uninsured, compared with 24 percent of high school graduates and just 10 percent of college graduates (Hoffman, Carbaugh, and Cook 2004). Employer coverage was the main factor driving lack of health insurance among poorer and less-educated adults. In fact, were it not for substantial public coverage through Medicaid, the uninsurance rates for these adults would be even higher.

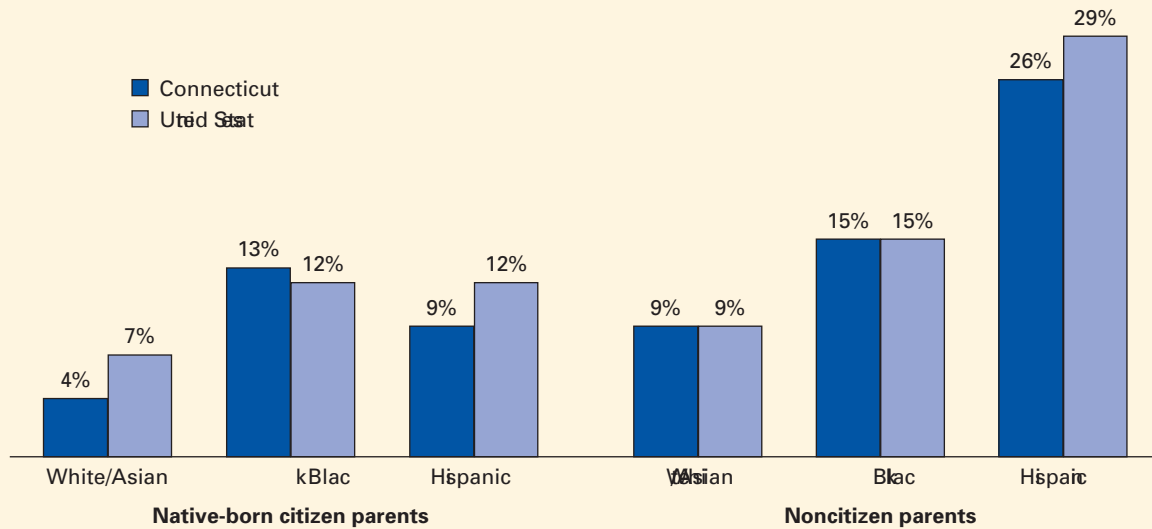
Hispanic Children with Noncitizen Parents Are the Most Likely Children to Be Uninsured

The lower health insurance coverage for noncitizen Hispanics extends to their children, in Connecticut and nationally.²³ In Connecticut, Hispanic children with noncitizen parents were about three times as likely as Hispanic children with U.S.-born citizen parents to be uninsured in 2001–2003 (26 versus 9 percent, as shown in figure 32). Among children from other ethnic groups, however, there were no major differences in insurance coverage between children with noncitizen parents and those with U.S.-born citizen parents. Moreover, the uninsurance rate for Hispanic children with noncitizen parents (26 percent) was substantially lower than that for working-age noncitizen adults (43 percent), due mostly to coverage of children through the Healthcare for Uninsured Kids and Youth (HUSKY) program.

HUSKY Increased Coverage of Immigrant Parents and Their Children but Eligibility and Application Barriers Remain

In addition to lower employer health coverage, many immigrants—especially Hispanics—face barriers to public health insurance coverage through Medicaid, SCHIP, and other programs. As shown earlier, Latin Americans are the most recent immigrants to Connecticut; they are also the most likely to be undocumented (Passel 2005). In Connecticut as in most other states, undocumented immigrants are generally ineligible for public health care coverage, although Medicaid is available for

Figure 32. Uninsurance Rates of Connecticut Children by Race/Ethnicity and Parents' Citizenship, 2001–03



Source: 2002–2004 March Supplements to the U.S. Current Population Survey.
 Note: Children are under age 19.

hospital deliveries and emergencies. The 1996 welfare reform law also restricted the eligibility of *legal* immigrants in the country less than five years for Medicaid and other federally funded health insurance programs (Fix and Passel 2003), although Connecticut restored eligibility to all legal immigrants regardless of length of U.S. residence, using state funding (Zimmermann and Tumlin 1999).²⁴

HUSKY is Connecticut's state- and federally funded health insurance program for low-income children and adults. HUSKY A, the state's Medicaid managed care program, provides free health coverage for children under the age of 19 and pregnant women with household incomes below 185 percent of FPL. Parents and relative caregivers are also eligible for free coverage through HUSKY A if their family incomes fall below 150 percent of FPL.²⁵ Children in higher-income families are eligible for coverage with co-pays and premiums under HUSKY B, Connecticut's SCHIP program.²⁶ In addition, HUSKY Plus is a supplemental program for children in HUSKY B with special physical and behavioral health needs. HUSKY is therefore a vital source of coverage for immigrant parents and their children, many of whom are U.S. citizens.

The number of children in the state with health insurance coverage has increased by 75,000 since HUSKY was implemented (Connecticut Voices for Children 2005a). Most of this increase occurred in the Medicaid program, which became HUSKY A in 1998. HUSKY A increased coverage of low-income children from 158,000 to 218,000 between July 1998 and May 2005. HUSKY B, also started in 1998, has enrolled 15,000 higher-income children by May 2005. Moreover, HUSKY coverage has been extended to a diverse group of immigrants and their children. In October 2004, HUSKY enrollees included 24,000 adults and children from Spanish-speaking households—including many U.S. citizens of Puerto Rican descent—as well as several thousand others from households where a dozen different languages were spoken.²⁷ After welfare reform, coverage of adults declined significantly, but then rebounded in 2001 when coverage was expanded to all parents of HUSKY children with incomes below 150 percent of FPL.

HUSKY and similar SCHIP programs across the country have reduced the share of low-income children without health insurance substantially, even among children with noncitizen parents. Nationally, from 1999 to 2002, the share without health insurance dropped from 19 to 12 percent for low-income children with citizen parents and from 29 to 22 percent for low-income citizen children with noncitizen parents (Capps, Kenney, and Fix 2003). Most of this improvement resulted from gains in public coverage through Medicaid and SCHIP programs. Nonetheless, low-income citizen children with noncitizen parents remained twice as likely to be uninsured as children with citizen parents in 2002. Thus children with noncitizen parents are more likely to be uninsured even when they themselves are U.S.-born citizens.

HUSKY currently covers legal immigrant parents, children, and pregnant women, regardless of how long they have lived in the United States, but there have been several changes in eligibility rules over the past decade. There is a federal match—through Medicaid and SCHIP—for legal immigrants who have lived in the United States for at least five years, but because of provisions in the 1996 federal welfare reform law, Connecticut must use state appropriations for the full cost for legal immigrants in the country less than five years. The Connecticut legislature funded coverage of legal immigrants with less than five years of U.S. residence from July 1, 1997, through June 30, 2003, using two-year appropriations. The appropriation was not renewed for July 1, 2003, and legal immigrants with less than five years of U.S. residence lost coverage, demonstrating the political and fiscal vulnerability of state-funded public coverage for legal immigrants. The legislature restored coverage of legal immigrants with less than five years' residence with a permanent appropriation effective July 1, 2004.²⁸ Undocumented immigrants—whether adults or children—remain ineligible for HUSKY.

One other important change in noncitizen eligibility for HUSKY involves recent federal rules, now being implemented in Connecticut, that require *some* legal immigrants to provide information about their sponsors during the eligibility process, and may also require sponsors to pay back the value of HUSKY insurance coverage. Starting in December 1997, U.S. immigration law has required sponsors of most legal immigrants—those who have relatives as sponsors—to document three years' worth of income as part of the immigration process. Following federal rules, the Connecticut Department of Social Services (DSS) now requires sponsored immigrants who entered the United States after December 1997 and have not yet become U.S. citizens to provide information about their sponsors' incomes. DSS also requires eligibility workers to consider the income of sponsors when determining HUSKY eligibility in some cases—mostly if the sponsors do not live in the same household as the sponsored immigrant (Connecticut Voices for Children 2005b). In some cases, DSS has also required immigrants' sponsors to repay the value of HUSKY coverage, in a process known as “recovery.” Inquiries about sponsors' income and recovery from sponsors could significantly deter noncitizen participation in HUSKY, and there are reports that the implementation of these new sponsor rules has varied from DSS office to office.

Beyond these changes in legal immigrants' eligibility, there have also been several recent changes in the income threshold for parents' eligibility for HUSKY A. The threshold for parents' eligibility was increased to 150 percent of FPL on January 1, 2001, decreased to 100 percent of FPL effective April 1, 2003, and then restored to 150 percent of FPL on July 1, 2005. As with the legal immigrant eligibility changes, the changes in the income threshold for HUSKY A parents were instituted to save appropriations during the state's 2003–04 budget crisis.

The HUSKY application process has also changed in recent years, first making it easier and then more difficult for applicants to prove how much income they earn. Income verification can be a hurdle in the benefits application for low-income people, especially immigrants, because many work at jobs that do not provide pay stubs or other written proof of wages (Holcomb et al. 2003). It may be especially difficult for immigrants who work in less formal sectors of the economy—such as migrant agriculture, construction, and domestic work—to obtain paperwork or oral verification of their

incomes from employers. In July 2001, Connecticut DSS began allowing HUSKY applicants to declare their own incomes. But in July 2005, the rules changed again, and DSS now requires applicants to submit documentation of income. This change may make it more difficult for those immigrants without formal employment, cooperative employers, or good English language skills to provide the required documentation in order to obtain HUSKY for themselves and their children.

Focus Group Participants Report Multiple Barriers to HUSKY Enrollment

Language, cultural barriers, immigration-related fears, and misunderstandings about HUSKY eligibility are among the factors that may explain why children in immigrant families are relatively more likely to be uninsured even when they are U.S.-born citizens or eligible legal immigrants. These issues were addressed during our field research in Hartford, New Haven, and Danbury during September 2005. In each of the three study sites, we spoke with primary health care providers and held a focus group of Spanish-speaking immigrants who were uninsured and/or had children insured by HUSKY. We focused on Spanish-speaking immigrants because Latino immigrants have the highest poverty rates and are the most likely to be uninsured.

Focus group participants mentioned that immigrants may not understand their U.S.-born children are eligible for HUSKY, even if the parents are undocumented. Nationally, about three-quarters of children of immigrants are U.S.-born citizens; among preschool-age children this share is above 90 percent (Capps et al. 2005). All these U.S.-born children are entitled to the same benefits as other U.S.-citizen children, including eligibility for Medicaid, SCHIP, and other public benefit programs.

However, two-thirds of U.S.-born children of immigrants have at least one undocumented parent (Capps et al. 2005). Research conducted in Texas, Los Angeles, and New York City suggests that many noncitizen parents avoided applying for Medicaid or SCHIP for their children after the 1996 welfare reform law, even when their children were eligible citizens (Capps et al. 2002; Rodriguez, Hagan, and Capps 2004; Zimmermann and Fix 1998). Noncitizen parents often misunderstand the noncitizen eligibility rules surrounding these programs, leading them to believe their children are ineligible. Undocumented parents sometimes fear deportation for themselves or other family members if they contact government agencies. In 1999, the federal government issued a clarification that receipt of Medicaid, SCHIP, and other non-cash benefits cannot be used as a basis for deportation or denial of citizenship or immigration applications (Connecticut Voices for Children 2005a). Yet, even with extensive outreach to immigrants about the eligibility rules, many remain concerned about the dangers of contacting the government for assistance (Holcomb et al. 2003).

Additionally, some families include younger children who are U.S.-born citizens and older children who are ineligible noncitizens. Immigrant parents often bring some children with them to the United States and then have more children after they arrive. In these families, the younger children are U.S.-born citizens and therefore eligible for HUSKY, while the older children are ineligible because they are undocumented immigrants. Focus group participants in one of our sites were frustrated that they could find medical care and prescription medicines for their younger but not their older children, because the older ones were ineligible for HUSKY. They also told us they sometimes use medicines prescribed for one child to treat another child, or swap children when they take them to doctor's appointments. Such coping strategies may help immigrant parents obtain medical care for their uninsured children but could also lead to improper diagnosis and treatment.

Changes in HUSKY's noncitizen eligibility rules over the past few years have further increased confusion among immigrants and health care providers as to which legal immigrants are eligible for the program. As a result, some health care providers refer immigrants to legal service providers for more in-depth eligibility information. For instance, some health providers told us that all legal

immigrants are eligible for HUSKY, while others told us that legal immigrants must reside in the United States for at least five years to be eligible, and still others told us the residency requirement is 10 years. Immigrants in our focus groups told us they are afraid to apply for HUSKY because they may be required to pay back the government for their health insurance or because participation may prevent them from becoming U.S. citizens. The recent confusion and changes surrounding noncitizens' eligibility for HUSKY—especially the sponsorship provisions—have heightened immigrants' anxiety about the program. Moreover, the changes in the adult HUSKY income threshold, along with the new income verification requirements in 2005, have confused all applicants—not only those who are immigrants.

Outreach to immigrant communities and staffing Medicaid/SCHIP offices with bilingual, culturally competent staff have helped reduce immigrants' fears and misconceptions about participation in several different states with large immigrant populations (Holcomb et al. 2003). In Connecticut, HUSKY outreach has been cut back, and several providers told us the reduced outreach has lowered immigrant participation in the program. Applicants can still receive help over the telephone from the HUSKY Infoline, which provides interpretation across a variety of languages. More extensive outreach, however, may be necessary to help immigrants understand complex eligibility rules, allay their fears about applying for benefits, translate and interpret application forms, and guide immigrants through the application process, which has become more difficult since income verification requirements were reinstated.

Outreach may be necessary not only for initial application, but also for renewals, and to help immigrants and other HUSKY enrollees sort through the maze of health plans and primary providers from which they must choose. Both providers and immigrants participating in our focus groups told us that the initial HUSKY application process is straightforward, and most eligible immigrants do not have difficulty obtaining the coverage they need. But after one year, HUSKY enrollees must re-apply for the program, and the renewal process is more daunting than the initial application. Immigrants and their children are sometimes dropped from HUSKY because they miss renewal deadlines, do not complete all the paperwork, or are not informed when their applications are held up for lack of proper verification.

Moreover, once they become eligible for HUSKY, immigrants and other enrollees have difficulty deciding which plan to choose, and within each plan, their primary care provider. In all three sites, providers reported that some plans offer better prescription drug coverage, while others offer greater access to private physicians, particularly specialists. Thus immigrants, like other HUSKY participants, must make informed decisions about which plans and primary care providers are best suited to the needs of parents and their children. Yet, language barriers, lower education levels, and lack of information about the U.S. health care system all make it much more difficult for immigrant parents to make informed health care choices.

Despite all the challenges surrounding HUSKY eligibility, renewal, and managed care, immigrants and their children who are insured by HUSKY have substantially more health care choices than those who are uninsured. In all three study sites, providers reported that HUSKY enrollees have access to a substantial number of doctors in private practice. The number of doctors who accept HUSKY is greater than the number who accepted Medicaid before the HUSKY program started, although the number of providers accepting new HUSKY patients has declined somewhat in recent years.

Lower Health Insurance Coverage Reduces Immigrants' Access to Care

Uninsured immigrants' health care options are much more limited, although primary care is available in Connecticut's major urban areas. For instance, the two larger cities we visited for this

project—Hartford and New Haven—have community health centers and large hospitals with satellite clinics that serve the uninsured, including clinics based in public schools. Connecticut has many CHCs, but their service areas do not extend to many smaller cities, towns, and rural areas. In Danbury, for instance, uninsured immigrants have very limited options: one free pediatric clinic, one free adult clinic, and the hospital clinic and emergency room. Danbury’s free pediatric clinic is funded almost entirely through private donations and has only one full-time and one part-time doctor. The adult clinic has a months-long waiting list for new patients. Many immigrants—adults and children—use the emergency room, mobile vans supported by Danbury’s health department, or school-based clinics for their primary care visits, because they lack other alternatives. But even in Danbury, which is currently not served by a CHC, uninsured immigrants can find preventative and primary care health services, according to both the providers and immigrants who participated in our field research.

Specialty Care

Study participants reported that uninsured immigrants have more difficulty obtaining specialty care. In Hartford and New Haven, the CHCs and hospital clinics are generally staffed with specialists. Hospitals and private doctors in both cities, however, often bill for consultations with specialists and for procedures; sometimes providers require payment up front, which prevents low-income uninsured immigrants from getting the care they need in a timely fashion. In Danbury, doctors at the free pediatric and adult clinics scramble to find specialists who are willing to take uninsured patients at reduced fees, and they often have to refer patients to specialists out of town. Because of the expense and difficulty associated with finding specialists, uninsured immigrants and their children may delay needed care and eventually present more acute symptoms in hospital emergency rooms. Providers are under the impression that in Connecticut, emergency rooms cannot turn away uninsured or non-paying patients, and so emergency rooms become many immigrants’ last option for specialty care.

Dental Care

In all three study sites, uninsured patients have very limited options for dental care—usually there is only one source of care in the city. In Hartford and Danbury, the uninsured must go to the dental clinics operated by the hospitals. In Hartford the waiting time for an appointment is six to eight months—according to providers. In Danbury, HUSKY patients also use the hospital’s clinic as their primary source of dental care, because private dentists in Danbury do not take HUSKY. One of the CHCs in New Haven provides dental care for uninsured children and takes walk-ins for dental emergencies.

Mental Health

According to providers in all three study sites, it is very difficult to find mental health services for the uninsured. Some primary care providers reported that they refer patients to *spiritualistas*—or folk healers—because they cannot find counselors or psychiatrists that will take uninsured or HUSKY patients. In New Haven one of the CHCs and another community clinic provide basic mental health services, but they have difficulty finding psychiatrists who will agree to see uninsured patients with more severe mental illnesses. In Danbury the free clinics refer patients to local psychiatrists who will take on patients for a fee. In all three study sites, however, primary care providers reported that they have referred uninsured patients with severe symptoms to psychiatric services out of town.

Prescription Medications

Uninsured immigrants find it particularly difficult to afford medications. Focus group participants in all three sites mentioned they have had difficulties obtaining prescription drugs, paying for them, and/or understanding the correct dosages and side effects of the medications. The CHCs, hospital clinics, and free clinics provide medications or refer clients to nearby pharmacies that serve the uninsured; they often write prescriptions or dispense several months' worth of medication at a time. Both providers and immigrants participating in the focus groups told us that prescription drugs are often too expensive even when obtained at a reduced cost or through HUSKY with a co-pay. Prescription costs add up quickly for low-income families, especially those with several children.

Cost of Care

Uninsured immigrants in Hartford, New Haven, and Danbury can generally find primary care for free or for a nominal fee that takes into account family income. Specialty, dental, and mental health care, however, can be very expensive, and the uninsured are often required to either pay a deposit up front, apply for HUSKY and be rejected, or agree to a payment plan—especially when they obtain care from hospitals and hospital clinics. The cost of care can be a deterrent to seeking care, even in an emergency. Immigrants and providers in our focus groups reported that sometimes immigrants with health emergencies avoid the emergency room because they fear they might be forced to pay, billed an excessive amount, or reported to immigration authorities. Many immigrants also find it difficult to understand why they must pay so much for health care, when basic health services are provided for free in their home countries. Immigrants' inability to understand just how expensive U.S. health care can be and to budget accordingly can leave them with few or no good options when health care emergencies arise.

Language, Culture, and Other Factors Also Affect Immigrants' Access to Care

The lower rate health insurance coverage of Connecticut's immigrants may affect their access to health care, but insurance is not the only factor driving access. In 1997, according to national data from the NSAF, low-income noncitizen adults age 18 to 64 were only half as likely as low-income U.S.-born citizen to go to a doctor on a regular basis (20 versus 44 percent), and twice as likely to lack a usual source of health care (37 versus 19 percent) (Ku and Matani 2000). Nationally, low-income children with noncitizen parents were also about twice as likely as low-income children with citizen parents to lack a usual source of health care. The pattern of lower use of doctor's offices and other regular sources of health care among noncitizens extended to higher-income adults and children as well. When controlling for insurance coverage, noncitizen adults were 6 percent less likely and Hispanics 12 percent less likely to visit a doctor or nurse. Thus, immigrants and Hispanics were less likely to seek regular health care than other uninsured adults.

National research on spending on health care also suggests that immigrants face access barriers beyond health insurance coverage. In 1998, according to the MEPS, immigrants spent 55 percent less than U.S.-born citizens on health care, when controlling for characteristics such as age, income, and educational attainment (Mohanty et al. 2005). Nationally, immigrants spent significantly less than natives on all categories measured by the MEPS, including emergency care, office-based visits, and prescription drugs. Moreover, following the pattern for health insurance, Hispanic immigrants spent the least on health care—half the amount spent by non-Hispanic white immigrants. Even

within the uninsured and publicly insured groups, immigrants spent significantly less than natives on health care, suggesting other barriers such as language and culture may reduce their access to care.

Our field research in Hartford, New Haven, and Danbury suggests several factors beyond health insurance coverage can affect immigrants' access to care. Beyond health insurance coverage, the major health access issues raised by focus group participants included communicating with doctors (i.e., language and cultural barriers), scheduling appointments, transportation to appointments, and immigrants' fears about approaching providers for health care and applying for HUSKY. Immigrants' fears about seeking health care and applying for HUSKY are discussed earlier, while the other three factors are discussed below.

Language and Cultural Barriers

The Spanish-speaking immigrants we included in our focus groups reported they are usually able to find providers who speak their language, even if they are uninsured. Hospitals, CHCs, and other facilities where uninsured immigrants go for care are well staffed by Spanish-speaking doctors and nurses in Hartford, New Haven, and Danbury. Sometimes, however, immigrants have difficulty making appointments because they cannot communicate with receptionists or staff that schedule appointments. In some hospitals and larger clinics, specialists use the telephone language line for translation. Both providers and immigrants participating in the focus groups reported that use of the telephone for interpretation reduces interaction between providers and patients. Community-based organizations (CBO) also provide interpretation in some health facilities. For instance, in Danbury, the director of a local CBO provides Spanish interpretation one day a week at the free pediatric clinic.

Providers reported it is more difficult to find bilingual staff and other interpretation services for languages other than Spanish. According to census data, Spanish accounts for about a third of all adults who speak English as a second language in Connecticut, but no other language except Polish accounts for even 10 percent. It is much more difficult to find bilingual health professionals or interpreters for the dozens of other languages spoken by very small numbers of immigrants across the state. By regulation, hospitals and clinics must provide interpretation, and many use telephone language lines when they cannot find staff or in-person interpreters who speak the patients' primary language. Even these telephone language lines, however, may not provide adequate interpretation in rare languages. For instance, some Mexican immigrants—particularly those from southern Mexico—speak Spanish poorly because their first language is an indigenous North American language. Similarly, some immigrants from the former Soviet Union—for instance those from Ukraine—speak Russian as a second language. It can be difficult to find interpreters—even on telephone language lines—for relatively rare languages such as Ukrainian and indigenous Mexican dialects.

While immigrants in our focus groups told us they are for the most part comfortable with their primary care providers, they occasionally experience miscommunication and cultural misunderstandings. At the free clinics and CHCs, Spanish-speaking health professionals and interpretation are available. But the hospitals and their clinics are staffed by a larger group of doctors, nurses, residents and medical students; in these settings Latino immigrants are more likely to encounter non-Latino health professionals who do not speak Spanish. At times these providers, most likely unwittingly, offend some Latino immigrant patients by not making eye contact, touching patients without forewarning them, and not explaining why they are doing certain things during examinations. Immigrant patients who do not feel at ease with their providers or who have difficulty communicating with them are less likely to follow provider instructions for therapy, taking medications, and making lifestyle changes to improve general health.

Difficulties in cross-cultural care between providers and recent immigrants may be a function of providers' inadequate training in this area. A 2003 national survey of resident physicians in their first

year of training found that virtually all (96 percent) felt it was important to address cultural issues when providing care (Weissman et al. 2005). A quarter (25 percent) of the residents surveyed, however, felt they were not prepared to provide culturally adequate care for new immigrants, and almost a quarter (24 percent) felt they were not adequately trained to identify cultural customs that might affect medical care. These findings led the authors to conclude that resident physicians' training to provide culturally competent care lags significantly behind their training in clinical and technical areas.

Transportation

The three study sites—Hartford, New Haven, and Danbury—all have community clinics, CHCs, hospitals, or other facilities that serve nearby immigrant communities. Hartford and New Haven, however, cover relatively large geographic areas, and immigrants often have to travel across town to hospitals, especially for emergency, specialty, dental, or mental health care. Focus group participants reported they rarely use public transportation, and the bus systems in Hartford and New Haven do not always link their neighborhoods with health facilities. Instead, immigrants are more likely to drive, get rides from family members and friends, and even walk long distances (even in bad weather or when sick).

Danbury is a smaller community and most immigrants there live near downtown, where the two free clinics and the hospital are located. These health facilities are within walking distance of most immigrants' neighborhoods. Additionally, many uninsured immigrants—as well as some HUSKY participants—receive primary care from the city health department's van service, which operates out of parking lots in immigrant neighborhoods across the city. Immigrants in Danbury therefore have less difficulty getting to and from health care facilities. Transportation within Connecticut's cities, however, may be more of a barrier for pregnant women, sick adults, or adults with sick children, especially in bad weather. Taking the bus or walking long distances in such cases may not be an option.

HUSKY enrollees are guaranteed transportation assistance for medical appointments through federal Medicaid regulations. Some providers reported they offer bus tokens or passes for their low-income patients, and some pay for taxis for pregnant women and parents with sick children. However, some providers in the focus groups reported they had recently had difficulty obtaining HUSKY funding for transportation. Immigrants who must take children with them or travel long distances for appointments may find it more difficult to secure the transportation assistance they are entitled to under HUSKY.

Transportation to health providers is most problematic for uninsured immigrants who live in Connecticut's small towns and rural areas. For instance, Danbury's van service and the free pediatric clinic receive a substantial number of immigrants who live in nearby towns without facilities for the uninsured. Providers reported they see patients from as far away as Waterbury, and many of the towns in between Danbury and Waterbury. Providers in Hartford visit agricultural areas and see migrant workers there. Additionally, one CHC in New Haven receives funding from the states of Connecticut and Massachusetts to serve farmworkers who live in New Haven and commute to the fields in both states. One provider encountered an insured immigrant who took a daylong bus ride across the state and stayed overnight in the cafeteria at the University of Connecticut Health Center in order to receive dental care there.

Appointments, Waiting Times, and Hours of Operation

In all three focus groups, immigrants reported frustration with the waiting time at their health care providers—regardless of whether they are uninsured. They said they sometimes come to appoint-

ments early and then have to wait for hours, while at other times they are a few minutes late and miss their appointments altogether. Sometimes they leave before they can see a doctor or nurse. Focus group participants also expressed frustration that they have to schedule appointments months in advance for many services, especially dental care. These frustrations most likely apply to all patients at these clinics, not only immigrants.

Providers echoed the patients' frustrations with appointment setting and waiting times, but said patients' inability to arrive on time for appointments exacerbates the problem. Some clinics in our study sites have appointment no-show rates of 30 percent or higher, so they generally overbook appointments. One day they may see 10 patients, while the next day they only see one patient in the same time slot. Patients often arrive early, expecting to be seen early, and then become frustrated and leave when the waiting time is too long. Others arrive a half hour or more late and expect to be fit into the schedule. Many patients—especially men—go to the doctor infrequently, and so when they come in for an appointment they present multiple health problems that have not been previously diagnosed. As a result, appointments are often longer than providers anticipate, thereby increasing the waiting time for other patients. For all these reasons, providers find it very difficult to schedule appointments efficiently.

The limited capacity of health care providers for the uninsured is another reason waiting times can be long and appointments difficult to set. The CHCs and other large clinics have very high case-loads and limited staff. As a result, staff absences can extend waiting times, even for patients with scheduled appointments. The dental clinics in all three study sites and the adult free clinic in Danbury have appointment backlogs several months' long, often making it very difficult for patients to schedule an appointment at all.

There are a number of reasons immigrants may have more difficulty scheduling health appointments and arriving on time than other patients. First of all, they are more likely to be uninsured and therefore have more limited options for health care; many of their health care options are understaffed and overused. Second, some immigrants are late for appointments because they do not understand the importance of arriving on time, or that arriving early will not mean they are seen earlier. Third, immigrants may use forms of transportation—for instance, rides from friends—that are unreliable and make it difficult to arrive on time. Fourth and most important, many immigrants have jobs—in agriculture, construction, and housecleaning, for instance—that do not carry vacation or sick leave. Some employers are reluctant to give employees any time off at all. A provider in Danbury reported that one employer came to a doctor's visit with an immigrant mother and her child to complain that the mother was missing too many days of work for unnecessary health appointments.

Both the providers and immigrants we met with suggested expanding health providers' office hours to accommodate working people. The pediatric clinic in Danbury has been very successful in scheduling appointments *before* work, and their first time slot in the morning is the most popular. One of the CHCs in New Haven is open until 9 p.m. four evenings each week, and receives many patients during evening hours. Providers in Hartford, however, told us that they were unable to operate evening hours efficiently because there was not enough demand, especially in the winter when it gets dark early. Providers characterized the Hartford neighborhoods where uninsured immigrants live as dangerous at night, and reported that residents there are reluctant to leave their homes after dark.

CONCLUSION AND RECOMMENDATIONS

The analysis in this report shows great variation among immigrants in their educational attainment, earnings, poverty, and other factors, with some groups of immigrants appearing to integrate more quickly and easily than others. Latin American immigrants, the group growing the fastest, generally have the lowest education levels and are the lowest-paid and most likely to lack health insurance. Southeast Asian and Caribbean immigrants are also among the poorest and least-educated immigrants. Other Asian immigrants, by contrast, are better educated and better paid than native-born Connecticut residents. The number of Asian immigrants is also growing quickly. The number of European immigrants, however, is likely to continue to decline for the foreseeable future.

Immigrants are a key element of Connecticut's future labor force growth as more native-born workers retire. There are substantial numbers of immigrant workers in low-skilled jobs in manufacturing, construction, retail trade, and services, but there is also a rapidly growing, highly educated immigrant workforce in the state's highly paid finance, information, technology, and health care industries.

The lower-skilled immigrants who take the lower paying jobs—in particular, Latino immigrants—are a major focus of this report and should be a major focus of public policy. As their numbers grow, the number of adults and children without employer-provided health insurance and with needs for other benefits and services is also likely to grow. This growth will place demands on the state of Connecticut to improve immigrants' labor market opportunities to help immigrants obtain employer coverage, expand public health care coverage, or otherwise improve immigrants' access to health care.

The analysis in the report leads to several broad policy recommendations. These recommendations are intended for Connecticut officials, policymakers, and health and service providers to help immigrants better integrate into the state's economy and social fabric, and to improve their access to health care.

- **Continue to welcome immigrants to Connecticut to support future labor force and population growth.** Connecticut has a long history of welcoming newcomers. Today's immigrants are more diverse than in the past, but they fill increasingly important roles in the state's economy, at both higher- and lower-skilled ends of the labor force. As the baby boomers retire, the demand for workers and for residents who pay into Social Security and other old-age benefits programs will continue to increase.
- **Continue to support immigration of highly educated workers for Connecticut's high-skilled industries.** Connecticut is attracting large numbers of highly educated immigrants; in fact, the number of college-educated immigrants is growing much more rapidly than the number of immigrants without a high school education. The state is home to a number of leading

universities, high-tech employers, and large financial, educational, and health service industries.

- **Support education, job training, and English language programs for recent immigrants.** A significant share of recent immigrants—those from Latin America in particular—lack English proficiency and English language training. Like native-born workers, immigrants without a high school degree face uncertain prospects in the labor market. As older and more-skilled workers retire in the coming years, the demand for better-educated and experienced workers will increase. Educating the immigrants already in Connecticut can help fill future high-skilled labor force shortages, and might help reduce uninsurance among immigrant workers as well.
- **Expand HUSKY coverage for noncitizens, to include all children regardless of legal status, length of U.S. residency, or sponsorship.** Employer coverage rates are relatively low among immigrants, especially Latin Americans, making HUSKY an increasingly important source of insurance for them and their children. Uninsured immigrants in Connecticut have far fewer sources for health care than those enrolled in HUSKY, especially for prescriptions and for specialty, dental, and mental health care. Recent noncitizen eligibility rule changes have created confusion about which groups of legal immigrants are eligible for HUSKY and which are not, leading to substantial enrollment reductions. Further restrictions on immigrants' HUSKY eligibility—while not on the table in Connecticut—would substantially reduce their access to care and increase the burden on CHCs, hospitals, and other providers for the uninsured. Conversely, expanding HUSKY eligibility to all children regardless of citizenship or immigration status—as implemented in New York and Massachusetts—would improve health care access, especially among Latin American immigrants and their children. Expansion of HUSKY eligibility could also improve the financial picture for hospitals and CHCs across the state by reducing the need for uncompensated care.
- **Restore funding for HUSKY outreach and community-based application assistance to immigrant communities.** Immigrants may be confused by recent eligibility changes and may not understand that U.S.-born citizen children are eligible for HUSKY even if the parents or other adults in the family are undocumented immigrants. Parents should understand that applying for HUSKY for their children will not prevent them from becoming U.S. citizens or sponsoring other family members for emigration, or lead to deportation of undocumented family members. Immigrants who do enroll are having difficulty with HUSKY's renewal process and with choosing health plans and primary care providers. Restoring HUSKY outreach and community-based application assistance would help immigrants better understand eligibility rules and complete all the necessary paperwork to ensure that they and their children are insured when eligible.
- **Increase the number of CHCs and other safety net providers across the state, and increase their capacity.** The largest concentrations of immigrants are in Connecticut's major urban areas. These immigrants can find primary care through CHCs, hospitals, school-based clinics, and other providers for the uninsured—as we found in our field research in Hartford and New Haven. In Danbury, by contrast, health care options for the uninsured are much more limited, in part because there is no CHC. Smaller towns and rural areas often have no services for the uninsured, who must travel long distances to major urban areas for their health care. Expansions of CHCs into underserved parts of the state along with programs to reach farmworkers and other needy populations in rural areas would help improve their health care access. However, increasing the number and capacity of CHCs and other providers should be done in tandem with extending coverage to uninsured immigrants, as research has shown that expanding care is not a substitute for increasing coverage as a means for improving health care access and utilization (Cunningham and Hadley 2004).

APPENDIX: FOCUS GROUP INSTRUMENTS

Questions for Health Care Providers

1. Please describe your role as a health care provider in the community. Where do you work? What kind of health services do you provide? Which populations do you serve on a regular basis?

PROBE: immigrants? Which specific immigrant groups? Which language groups?

2. In your experience, what do residents in this community do initially for health care or advice? Is this different for immigrants? If so, which immigrant groups and why?
3. Please describe the health care network for uninsured patients in the community. Where can they go for care? Where do they go most often? For which kinds of health problems?
4. Please describe the health care network for HUSKY patients in the community. Where can they go for care? Where do they go most often? For which kinds of health problems?
5. What, in your opinion, are some of the major barriers facing immigrants for health care in this community? Are these barriers different for different immigrant groups? If so, why?

PROBE: insurance coverage, income, language/interpretation, comfort level with health care providers, location, hours, waiting times, transportation

6. What services are you unable to provide to uninsured clients? Why or why not? Has this changed over time?
7. What services are you unable to provide to HUSKY clients? Why or why not? Has this changed over time?
8. What effect would *expanding* HUSKY coverage have on the health care system for immigrants in this community?
9. What effect would *reducing* HUSKY coverage have on the health care system for immigrants in this community?
10. What suggestions do you have for improving the delivery of health care for immigrants in your community? In Connecticut? Do you think this would involve new spending?

Questions for Immigrant Community Residents

1. What are some of the health problems that people in your neighborhood have? What do you see are the most common health problems among these?

PROBE: heart disease, cancer, diabetes, HIV/AIDS, accidents, injuries, colds, allergies, dental problems, vision, hearing ...

2. When you want general information on health or advice about your and your family's health, where do you go?

PROBE: media, magazines, TV, doctor's office, clinic (which one), public health office, family, friends, pharmacist, other

3. When you and your family have a specific health problem or become ill, where do you go? How did you choose this doctor or clinic (or other place for health care)?

PROBE: doctor's office, clinic (which one), public health office, family, friends, other

4. You were invited to this discussion because you either had coverage under HUSKY, or because you did not have any form of health insurance. For those of you with HUSKY, have you found that the coverage meets your needs? Are there any services that you are not able to obtain under HUSKY?

For those of you without insurance, have you been able to obtain the health care you needed? How does not having insurance affect your ability to get care, where and when you need it?

5. Have you ever tried to apply for HUSKY and been unable to apply or been rejected? If so why?

PROBE: ineligible because of immigration status, ineligible because of income, unable to do paperwork, didn't understand rules, eligibility workers unfriendly.

6. When you go to the doctor or clinic (or other place for health care), how do you get there? How long does it take you to get there? Is the location convenient?

7. What are the best times for you to go to the doctor's office or clinic (or other place for health care)? Can you find someplace that is open at these times?

PROBE: mornings, afternoons, evenings, weekends, any specific times?

8. Do you sometimes talk to a doctor, nurse, or other health care provider over the phone—to answer your questions or give you advice? Are you able to get the information you need over the phone in these cases?

9. When you go to a doctor's office, clinic hospital, or some other health facility, about how long do you have to wait to see a doctor or nurse? Does this wait time bother you? Do you sometimes leave because the wait is too long?

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10. Is language a problem for you when talking with a doctor/nurse? If it is a problem, is there usually a translator available?
 11. Do you feel comfortable when you go to the doctor or clinic (or other place for health care)? Does your doctor and his/her staff speak your language? Do they relate to you, culturally and ethnically? Do they understand your concerns?
 12. What else can you tell us about what you and your family need for health care? Are there any services that you and your family need but are unable to get? Which ones?
 13. What suggestions do you have to improve the health care you receive? Any suggestions you have for doctors, clinics, hospitals, health care providers, or state and local government would be appreciated.

NOTES

- ¹ These figures are based on Urban Institute projections and analysis of decennial census and 2004 American Community Survey data.
- ² Ibid.
- ³ Other groups of immigrants—Caribbean and Asian for instance—are also relatively young, but not as young as Hispanic immigrants. European immigrants are relatively old, with an age structure similar to that of native-born non-Hispanic whites (but with virtually no children among these immigrants).
- ⁴ Throughout this report we refer to this group of mostly non-Hispanic white immigrants as “European immigrants.”
- ⁵ According to our definition, undocumented immigrants are those who entered the United States illegally (often across the border with Mexico), overstayed a valid visa (such as a tourist or student visa), or otherwise violated the terms of their immigration status.
- ⁶ The Urban Institute has estimated the number of undocumented immigrants by subtracting the number of legal immigrants over the course of the past few decades—using U.S. Department of Homeland Security data—from the total number of noncitizens counted in the U.S. Census, Current Population Survey, and other official data sources (Passel 2005). The census and CPS collect data on nativity and citizenship of adults and children, but they do not collect information on the legal status of noncitizens.
- ⁷ Legal permanent residents (LPRs) are immigrants admitted permanently to the United States, usually for employment or because they have a close family member who is a U.S. citizen or LPR. After five years—three years if married to a U.S. citizen—LPRs are eligible to apply for citizenship. In most cases, they must pass a naturalization test to become citizens.
- ⁸ Refugees are admitted to the United States owing to fear of persecution, usually from countries on a list developed by the U.S. Department of State. After one year, refugees become LPRs. We include those refugees who have become LPRs or naturalized citizens in the refugee category.
- ⁹ The 2000 Census measured income for the year before the survey (1999). In our analysis of the census data, we define families as individuals or nuclear family groups (parents and minor children). Our family differs substantially from that used by the Census Bureau for their official data: their families include larger groups of relatives living together, and they *exclude* individuals from family income calculations. Additionally, we *exclude* public assistance income from all our income and poverty calculations.
- ¹⁰ In 1999, the federal poverty level was \$17,029 for a family of four, slightly higher for larger families and lower for smaller families.
- ¹¹ Because we define families as smaller units, including individuals, and exclude public assistance income, our median income figures are substantially lower than those reported by the Census Bureau for their larger family units.
- ¹² In all households where a language other than English is spoken, the census asks whether members of the household over age 5 speak English “very well,” “well,” “not well,” and “not at all”. The census categorizes all people speaking English less than “very well” as limited English proficient.
- ¹³ Foreign-born students attending the University of Connecticut compose a large portion of the foreign-born poverty population in Mansfield. Most of these students are single and are temporary U.S. residents, so they are not the central focus of our study. Our study focuses primarily on immigrant families with children, who are more heavily concentrated in other parts of the state.
- ¹⁴ Low-wage workers are defined as those earning less than twice the minimum wage, or \$11.30, in Connecticut in 1999. Throughout the report wages are defined based on total earnings divided by the total number of weeks worked and average hours worked per week. Total earnings include wage and salary and, in the case of self-employed workers, non-zero self-employment income. The census asked respondents about their incomes, weeks of work, and average hours worked per week in 1999, the year before the survey.

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- ¹⁵ In 1999, the minimum wage in Connecticut was \$5.65 per hour, and low-wage workers earned below twice that amount (\$11.30 per hour).
- ¹⁶ Throughout the report, “full time” workers worked at least 48 weeks and on average at least 35 hours a week in 1999.
- ¹⁷ For this analysis we use the broad industry categories in the 2000 Census to create a large enough sample for analysis within each industry. Note that industry codes have changed recently and so the industry labels we use—drawn from the 2000 Census—may not be comparable to those for other data sources.
- ¹⁸ In this section, “Hispanic immigrants” are those who chose the “Hispanic” ethnicity option when responding to the CPS. In most cases, they are the same as the “Latin American” immigrants described earlier and are mutually exclusive from other racial and ethnic groups discussed in this section (i.e., non-Hispanic whites, blacks, and Asians). This section focuses on race/ethnicity as opposed to country/region of origin in order to more easily compare immigrants to natives within the same ethnic groups. Puerto Ricans are included under the “U.S.-born citizens” category.
- ¹⁹ In the CPS, respondents are asked whether they and other household members received health insurance coverage through their employers, other private sources, Medicare, Medicaid, and other public sources at any time during the year before the survey was taken. The uninsured in this report are all those who reported that they did not receive coverage from any of these sources and verified that they did in fact lack coverage.
- ²⁰ Adults age 65 or over are excluded from this analysis because most of them receive coverage through Medicare. The figures in this chart and the following chart are comparisons between U.S.-born citizens and noncitizens. Noncitizens are disaggregated from immigrants who have become citizens because noncitizens face eligibility restrictions on public coverage (such as Medicaid) that citizens do not face. The insurance coverage rates for naturalized citizens—which are close to those of U.S.-born citizens—are not displayed here.
- ²¹ Asians are included with non-Hispanic whites in this analysis because of the small sample of Asians in Connecticut in the CPS data. The three most recent years of CPS data (2002–04) were combined for this analysis to increase the precision of the estimates. Health insurance coverage was reported for the year before the survey, so these figures are for 2001–03.
- ²² Due to small sample sizes, the figures shown here for Connecticut are not statistically significant. However, the data for Connecticut follow the same pattern as the national data, which show significant differences among the groups analyzed at $p < 0.05$.
- ²³ In this analysis, children are all individuals 0–18 years old residing with their parents. Here we disaggregate children by their parents’ citizenship rather than their own citizenship, since 80 percent of all children of immigrants are U.S. citizens. Children with “U.S.-born citizen” parents are those whose parents (both parents in the case of a two-parent family) are born in the United States. Children with “noncitizen parents” are those with at least one parent who is a noncitizen immigrant. There was a small sample (193) of children who were no longer living with their parents because they were either living independently or living with other family members or as part of a foster family. These children are excluded from our analysis because the citizenship status of their parents is unknown.
- ²⁴ Immigrants who become citizens are eligible for Medicaid and SCHIP, but in most cases legal immigrants are not eligible to become citizens until they have lived in the country for at least five years.
- ²⁵ In 2005, the annual income thresholds for a family of four were \$29,025 for 150 percent of FPL and \$35,798 for 185 percent of FPL.
- ²⁶ Children with household incomes between 185 and 235 percent of FPL—e.g., a family of four with an annual income from \$35,798 to \$45,473—pay capped co-payments. Children with household incomes between 235 and 300 percent of FPL pay capped co-payments and premiums, and those with household income above 300 percent of FPL can buy into the plan at negotiated group rates.
- ²⁷ October 2004 HUSKY A enrollment file, based on correspondence with Mary Alice Lee at Connecticut Voices for Children.
- ²⁸ Correspondence with Mary Alice Lee and Sharon Langer, Connecticut Voices for Children, October 7, 2005.

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