

KOREAN IMMIGRANTS AND HEALTH CARE ACCESS: IMPLICATIONS FOR THE UNINSURED AND UNDERINSURED

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ABSTRACT

As an ethnic group, Korean Americans have one of the highest uninsured rates in the U.S. (Brown et al., 2000). Through in-depth interviews (n=14) and surveys (n=268), this study found that one-third of the sample was uninsured. High premiums prevented the uninsured from purchasing health insurance. Although health insurance has been a strong predictor of health services utilization, this study also found that when examining the utilization of various health services by health insurance status, there were no major significant differences with the exception of Korean traditional health services. High deductibles prevented insured persons from utilizing health services.

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INTRODUCTION

In 2005, over 46.6 million people were uninsured in the U.S. (U.S. Census Bureau, 2006). The uninsured in the United States go without needed regular health check-ups and seek care in extreme emergencies, and are as a result extremely disadvantaged in terms of health. Low socio-economic status, adverse health behaviors, and lack of health insurance have all been identified as social factors that impact health (Huang, Yu, & Ledsky, 2006; Franzini & Fernandez Esquer, 2006; Kirby, Taliaferro, & Zuvekas, 2006; Lantz et al., 2006; Farmer & Ferraro, 2005; Lillie-Blanton & Hoffman, 2005; Shone, Dick, Klein, Zwanziger, & Szilagyi, 2005; Hargraves & Hadley, 2003; Guendelman, Wyn, & Tsai, 2000). Compared to those that have health insurance, individuals who lack health insurance coverage have been shown to have higher risk-adjusted rates of decline in their overall health and physical functioning (Baker, Sudano, Albert, Borawski, & Dor, 2001) and higher risk-adjusted mortality (McWilliams, Zaslavsky, Meara, & Ayanian, 2004). Likewise, reduced access to care can have serious consequences for health outcomes via lack of preventive services use, delayed diagnosis of disease, and poor monitoring and control of chronic diseases (Institute of Medicine, 2002).

Another important goal for the nation is to reduce the level of disparities in access to health care by race, ethnicity, and nativity in the United States. In 2003, immigrants were 26% of the nation's uninsured; immigrants were more likely to be twice as likely uninsured than U.S. citizens, while newer immigrants also were less likely to be insured than older immigrants (Employee Benefits Research Institute, 2005a). In fact, the two largest immigrant groups that lack health insurance coverage in the United States are Latino (58%) and Asian (30%) non-citizens (Brown et al., 2000; Ku & Blaney, 2000). The higher rates of uninsurance in these groups are attributed to lower rates of employment-based insurance (Brown et al., 2000). This delay in seeking health care due to uninsurance has major health implications for communities. Delayed diagnoses of conditions such as cancer, heart disease, and diabetes can reduce effective treatment and management. Access barriers reduce the use of preventative services.

In the last decade, Koreans have had one of the lowest rates of health insurance coverage among all racial and ethnic groups. The 1994 Current Population Survey found that 50% of Koreans ages 0–64 did not have health insurance. The 2001 California Health Interview Survey found that 21.7% of Korean children and 33.6% of non-elderly Korean adults ages 18–64 lacked health insurance among ethnic groups (Brown, Ponce,

Rice, & Lavarreda, 2002). The 2000 Korean American Health Survey of Koreans living in Los Angeles County found that 46% of the respondents did not have health insurance (Shin, Song, Kim, & Probst, 2005). The lack of health insurance coverage has had an impact on the health of the Korean American community as, in comparison, only 15.7% of the total U.S. population lacked insurance coverage in 2004 (U.S. Census, 2006).

Factors such as income, education, citizenship, and access to job-based insurance explain racial and ethnic disparities in health insurance coverage and access to health care; Brown, Lavarreda, Rice, Kincheloe, and Gatchee (2005) also found that Korean immigrants do not carry health insurance for themselves and attributed this to the high rates of self-employment and working in small businesses that do not provide employment-based insurance. Most Korean immigrant adults do not qualify for Medicaid, yet cannot afford private health insurance. Because many Korean immigrants do not have access to health insurance, this also means that these immigrants do not have a regular source of health care through which they can access cancer screenings and preventative services such as immunizations (Ryu, Young, & Park, 2001; Shin et al., 2005). Past research has shown that the lack of health insurance was the strongest predictor of health services utilization for Korean Americans (Ryu et al., 2001). At the same time, acculturation and income are factors in terms of health insurance coverage and health services utilization (Shin et al., 2005; Kim & Yoo, 2006). Research on Korean immigrants and their utilization of preventative health care such as breast and cervical screenings indicate that economic barriers (such as lack of health insurance), working long hours, language barriers, and length of residency in the U.S. affect utilization rates of preventative health practices (Juon, Choi, & Kim, 2000; Juon, Kim, Shankar, & Han, 2004; Lee, 2000; Kim et al., 1999; Maxwell, Bastani, & Warda, 2000).

KOREAN AMERICANS: DEMOGRAPHICS AND HISTORY

The 2000 census counted over 1.2 million Korean Americans in the U.S.; the Korean population grew by about one-third between 1990 and 2000, and is the fifth largest Asian ethnic population (U.S. Census Bureau, 2001). Although Korean Americans celebrated the centennial anniversary of immigration in 2003, the census also indicated that 78% of the population is foreign-born. The Korean American population reflects a historical legacy

of exclusionary immigration and citizenship laws aimed at Asians as well as the significance of contemporary immigration policies and social, economic, and political conditions in South Korea and the U.S.

Korean immigration to the United States can be divided into three different waves. Although few Koreans came to the U.S. before the turn of the 20th century, the first wave of Koreans, mostly men, migrated to the U.S. in 1903 as contract laborers who worked in the sugarcane fields in Hawaii and in agriculture along the West Coast. Over 7,000 Korean immigrants arrived before the Korean government ended emigration in 1905 in response to pressure from Japan. Although laborers were not allowed to emigrate, almost 1,000 Korean picture brides arrived between 1910 and 1924 to join – or in some cases, meet for the first time – their husbands under a provision of the Gentlemen's Agreement between Japan and the U.S. With the passage of the Immigration Act of 1924, Koreans were barred from migrating to the United States (Hurh & Kim, 1980; Park, 1997).

With the outbreak of the Korean War in 1950, the second wave of Korean immigrants, representing war brides, adoptees, and students, arrived. The largest wave of Korean immigrants arrived after the passage of the 1965 Immigration Act that abolished the racial quotas, which for decades had effectively excluded most Asians from immigrating to the U.S. The Immigration Act favored family reunification and the migration of specialized trained individuals in short supply for certain professional work such as health professionals, scientists, and engineers. Middle-class professionals from urban backgrounds, responding to economic, political, and cultural developments in South Korea and the U.S., largely comprised the third wave until the U.S.-amended immigration laws in the 1970s to restrict occupational preference admissions. Since then, Koreans have entered largely through family reunification preferences and represent a larger spectrum of education levels and occupational backgrounds more reflective of the general South Korean population (Park, 1997).

A large percentage of those immigrating after 1965 have experienced downward mobility and language barriers in accessing work regardless of education levels and pre-migration occupations. In response, many Korean immigrants have steered toward self-employment and demonstrate one of the highest propensities among all racial/ethnic groups to enter into business, concentrating in retail and service businesses (Yu & Chang, 2003). In 2000, approximately 20% of Koreans were self-employed, the highest rate among racial/ethnic groups and double the rate of the total U.S. population (Korean American Coalition – Census Information Center & Center for Korean American and Korean Studies, 2002). Many Korean immigrants have

opted for self-employment because they could not find a job commensurate with their education and work experience in the primary labor market; this high self-employment rate may contribute to the fact that many Korean Americans lack job-based health insurance and have the lowest rates of health insurance coverage among all racial and ethnic groups in the U.S. (Brown et al., 2005). Ethnic entrepreneurship comes at a cost to the health and well-being of Korean American entrepreneurs, families, employees, and communities.

METHODOLOGY

According to the 2000 Census, the Los Angeles-Riverside-Orange County and San Francisco-Oakland-San Jose metropolitan areas are respectively, home to the largest and the third largest Korean American populations in the U.S. (Yu & Chang, 2003). This study utilized a purposive sample of Korean immigrant small business owners age 18 and over residing in the greater Los Angeles and San Francisco Bay areas between 2005 and 2007, due to previous studies indicating the significance of ethnic entrepreneurship and access to health insurance. A total of 268 respondents completed survey questionnaires. Fourteen follow-up in-depth interviews, seven in the Los Angeles area and seven in the San Francisco Bay area, were conducted. Potential participants were recruited at their business locations in areas with a high concentration of Korean immigrant small businesses such as San Francisco's Japantown and the Oakland's Koreatown on Telegraph Avenue. They were also recruited through various Catholic and Presbyterian churches in the greater Los Angeles and San Francisco Bay areas.

Questions in the self-administered survey included demographics (such as age, gender, education level, and length of residence in the U.S.), access to health care for respondents and their family members, utilization of health care services, and barriers and challenges to health care access. The survey questionnaires, in-depth interview schedule, and consent forms were written in English and translated into Korean and rechecked for consistency by bilingual research assistants. The collected survey data were cleaned, coded, and entered into a statistical program (SPSS). Descriptive frequencies were conducted in terms of the demographics and utilization of health insurance. Comparisons of categorical characteristics between Korean immigrant with variables of health insurance coverage and health service were done for statistical significance using χ^2 tests.

In-depth interview participants were asked about barriers and challenges with utilizing health insurance and retirement planning. Bilingual researchers conducted all interviews in Korean, which were tape-recorded with consent, translated, and transcribed into English. The transcripts were reviewed for content analysis and an open coding process to develop emerging categories from the data (Strauss & Corbin, 1998). All interviewees are identified by pseudonyms.

RESULTS

Demographic Background

The respondents' ages ranged from 22 to 69 with a mean age of 49 years. While those who immigrated to the U.S. between 1991 and 2005 comprised 28.7% of the sample, 70.9% of the participants immigrated between 1965 and 1990 during the peak immigration decades of 1970s and 1980s that followed emigration and immigration reforms in South Korea and the U.S. The respondents were split evenly by gender and the majority (86.6%) were married while 13% were single (never-married, widowed, or divorced). About 90% had children. About 30% of the participants reported an annual family income below \$44,999, 40% reported incomes between 45,000 and 89,999, and about 30% reported an annual family income above \$90,000. The median household income of Korean Americans in the U.S. in 2003 was \$40,183 (Asian and Pacific Islander American Health Forum, 2005). Additionally, 70% reported that their spouses also were employed. The results show that 71% had health insurance for themselves but no one indicated that they had disability, long-term care, or dental insurance.

Health Insurance Too Expensive

Twenty-nine percent of our sample did not have health insurance. The uninsured participants most frequently cited affordability as the reason why they lacked health insurance for themselves and their spouses. Participants indicated that insurance payments were a "financial burden" and "too expensive" as an additional expenditure. Some respondents did not have health insurance for themselves and their spouses but their minor children were insured through programs such as Medicaid and Healthy Families, California's State Children's Health Insurance Program (SCHIP). Through

written responses or in-depth interviews, participants said that rather than paying expensive health insurance premiums every month, they opted to pay fee-for-services as needed, like Mr. Nam of San Francisco (personal communication, November 16, 2005):

I am healthy, and there is no one in family that is seriously sick. Plus it costs so much. I feel no need for health insurance. Since we don't have health insurance, if a major health issue came up, I would have to rely on my family for help.

Respondents cited their current good health and no perceived need for immediate or consistent medical care as a major reason for not having health insurance. Mrs. Choi, living in the Los Angeles area, saw paying for a doctor's services as needed as a better financial alternative to paying high monthly insurance premiums (Mrs. Choi, personal communication, November 18, 2005).

I have not had a major illness and that's why I don't have [health insurance]. Now that I'm older and I've been working so hard – I don't have major illnesses but get exhausted so I have reasons to [see a doctor]. But the reason why I can't get health insurance is because I would have to pay for it every month and rather ... since I only see a doctor several times a year due to stress or colds, I think that it saves money to pay when I go rather than to get insurance.

Ultimately, not having health insurance impacts the financial state of uninsured Korean immigrants, and sometimes in the most catastrophic way by depleting savings and racking credit card debt. Ms. Suh, who lives in the Los Angeles area, had such an incident (Ms. Suh, personal communication, January 21, 2007):

If it wasn't so expensive I would definitely have health care. I try to live as healthy as possible by taking supplements and having a good diet so that I don't have to visit the doctor as much. There was an incident 7 years ago when my youngest son got sick when he was a month old and was hospitalized for 4 days. Those 4 days cost \$43,000 ... The bill was put onto our credit card.

Ms. Suh eventually negotiated a lower repay amount with the hospital and paid off the medical bills, but her family continues to be uninsured. Mrs. Park of Los Angeles said that she could not afford health insurance premiums but their family's income makes them ineligible for Medi-Cal or Healthy Families. She shared what happened when her child had an accident (Mrs. Park, personal communication, December 1, 2005):

... last year, my youngest broke her arm. There was also a hairline fracture. That took about \$6000, \$7000 for same-day surgery, cast, etc. So when you have one incident like that, it's really difficult ... I think [the physician] saw her for about 20 minutes and put a

cloth sling on it – a bandage? And then we were charged \$670 ... I was so upset. This was on top of a \$200 deposit that they made us pay, just to see someone, even if they didn't have anyone who could take care of it.

Although upset by the cost and the process of her uninsured child's emergency treatment, Mrs. Park could not address these matters with the clinic staff, due to her limited English proficiency. Like Ms. Suh, she used a credit card to pay her child's medical bill. The uninsured respondents who cited affordability as a barrier shared that they tried to take care of their health through exercise, diet, and taking traditional Korean herbal medicine. Despite their efforts, Ms. Suh and Mrs. Park's examples illustrate the precarious financial situations of working, self-employed families in the U.S.

Health Insurance Used Only for Emergency Purposes

Respondents cited affordability most frequently as the reason why they chose their particular insurance plan (39.2%). Table 1 shows that for the respondents, the mean yearly deductible was \$7,173 but the minimum ranged from \$100 to \$16,800. The variation in the yearly deductible of health insurance demonstrates that respondents were purchasing a variety of health insurance packages, including preferred provider organizations (PPOs), health management organizations (HMOs), and other insurance plans. Those with higher yearly deductibles often had lower monthly costs, while those with higher monthly premiums had lower yearly deductibles. Higher deductibles also meant that respondents had large families, with each family member having a deductible to meet before their health insurance would cover health costs. Monthly costs for insurance plans ranged from \$16 to \$1,400 with the mean being \$381 per month. Co-payments for office visits ranged from \$5 to \$273. The limitations of these numbers do not account those with pre-existing conditions which may result in higher monthly payments and deductibles.

Table 1. Mean Out-of-Pocket Payments among the Insured.

Mean Costs	
Mean yearly deductible ($n=31$)	\$7,173.77
Mean co-payment for office visit ($n=43$)	\$40.42
Monthly payment for health insurance ($n=56$)	\$381

Because many of the respondents wanted to maintain a low monthly payment, often their yearly deductibles were quite high. This meant that when they utilized health care, it was often not covered by their insurance company. Several respondents discussed the difficulty of obtaining health insurance that provided 100% coverage and having expensive deductibles that prevented them from seeing health care providers on a regular basis. Rather, they treated their health care plans as coverage to be used for only emergency purposes. For example, Mrs. Lim explained (Mrs. Lim, personal communication, November 17, 2005):

Sometimes when I have a headache, I feel like I should get an X-ray and really check things out. But then I feel it's such a small thing and I know it will cost me hundreds of dollars. So I just ignore it and just go in when I think it's an emergency.

As a result of the high premiums and deductibles, even those who had insurance discussed their reluctance to seeking health care and incurring out-of-pocket expenses, accessing health services only for what they perceived as an emergency or a serious illness. Mrs. Choi had to pay \$3,000 out-of-pocket for a breast biopsy to test a suspicious lump and said, "It felt like I didn't have health insurance" (Mrs. Choi, personal communication, December 11, 2006). For respondents with high deductibles, health care visits and procedures were costs they incurred and paid rather than those covered by monthly premiums and co-payments. All the respondents noted that the key obstacle for health insurance and ultimately health care access was the cost. Mrs. Chung, who also noted that "finding and making the time to go is difficult" while running a business, discussed how cheaper health care coverage often meant higher deductibles and co-payments (Mrs. Chung, personal communication, January 19, 2007):

The problem is money. If the coverage is cheaper, then it would be easier. In our situation, because the deductible is high, any check-ups \$100 and below we pay with cash (out-of-pocket) ... But if I need to be hospitalized or have a serious illness, then I'll use the health insurance coverage because I need to.

Although this study found that Korean immigrant entrepreneurs continue to have a high rate of uninsurance, having health insurance did not translate into an increased use of health services. When examining the utilization of various health services by different health insurance status, there were no major significant differences with the exception of Korean traditional health services. There were significant differences in the utilization of Korean traditional health services between the insured and uninsured. The uninsured were more likely to have seen a Korean traditional medicine

practitioner (88%) in the last year compared to those who were insured (66%). This difference (66% compared to 88%) was statistically significant (p -value = 0.014). Moreover, when examining health care services, more Korean immigrants sought out Korean traditional health services than conventional health services.

Respondents also utilized traditional healing practices at a high rate, with 69% of participants reporting that they or someone in their family had visited a traditional doctor, most frequently for acupuncture treatments and herbal medicine. Mr. Moon, who is uninsured, stated his reasons for use of Korean traditional healers (Mr. Moon, personal communication, November 22, 2005):

I had pain in my shoulders so I went to a Korean acupuncturist. And I also took *han-yak* [Korean herbal medicine] because I believe that it works to heal the body more naturally and better than prescribed medicine.

Participants generally utilized traditional Korean practitioners for preventive care (check-ups and health supplements) and treatments for ongoing symptoms (e.g., allergies and backaches). They also commented that the costs to see a Korean traditional medicine practitioner were more affordable than seeing a medical provider and that costs ranged from \$10 for herbal remedies to \$50 for an acupuncture session.

When exploring use of emergency-related health services between the insured and uninsured, there were no significant differences (Table 2). Thirteen percent of the uninsured had utilized emergency-related services, while 16% of the insured had utilized such services. At the same time, 38% of those with health insurance utilized adult preventative health services compared to 29% of those without health insurance. This difference (38% compared to 29%) was not statistically significant (p -value = 0.436). When examining diagnostic type of health services, 35% of those with health insurance utilized diagnosis and treatment services for illness and injuries compared to 33% of those without health insurance. This difference (35% compared to 33%) was not statistically significant (p -value = 0.863). When examining child preventative health services, 6% of those with health insurance utilized such services as compared to 13% without health insurance. This difference (13% compared to 6%) was not statistically significant (p -value = 0.381). In terms of family planning and pregnancy-related services, 6% of those with health insurance utilized family planning and pregnancy-related services compared to 8% of those without health insurance. This difference (6% compared to 8%) was again not statistically significant (p -value = 0.634).

Table 2. Respondent’s Family Utilization of Health Services by Health Insurance Status.

Family’s Use of Health Services (<i>n</i> = 249)	Percentage of Utilization	<i>p</i> -Value
Herbalist/acupuncturist		
Without health insurance	88	0.014
With health insurance	70	
Emergency health services		
Without health insurance	13	0.768
With health insurance	16	
Adult preventative health services		
Without health insurance	29	0.436
With health insurance	38	
Diagnostic/treatment		
Without health insurance	33	0.863
With health insurance	35	
Child preventative health services		
Without health insurance	13	0.381
With health insurance	6	
Family planning/pregnancy-related services		
Without health insurance	6	0.634
With health insurance	8	

Even when respondents had health insurance, this did not mean they had access to other insurances that covered other health-related expenses. None of the participants indicated that they had other types of health-type insurances including dental, vision, disability, and long-term care insurance. For example, one respondent who has health insurance but no dental insurance incurred a \$10,000 bill for dental implants.

DISCUSSION

Making ends meet for immigrant families becomes a barrier to not only acquiring health insurance, but also in buying quality, accessible health insurance. Twenty-nine percent of immigrants in the sample were uninsured, while 71% of this sample had health insurance coverage. Even with obtaining a modest amount of health insurance, financial difficulties and

barriers still pose a challenge to accessing health care services. Past research has indicated that uninsured Korean immigrants were unable to access needed health services (Ryu et al., 2001). However, the high costs associated with accessing health insurance did not translate into the receipt of care among the insured in this study; there were no significant differences in different types of health care utilization between the insured and uninsured.

As a result, Korean immigrants with health insurance could be classified as underinsured – those with inadequate health insurance coverage and having medical bill problems (Pryor, Cohen, & Prottas, 2007). According to Schoen, Doty, Collins, and Holmgren (2005), 12 percent of those insured in the U.S. were underinsured and were significantly more likely to forgo needed health care due to costs compared to individuals with adequate insurance coverage. As a result, the underinsured, similar to the uninsured, are unable to seek proper care and adhere to follow-up care and prescribed medication as recommended by their physicians.

This study illustrates that even when Korean immigrants purchase private health insurance, costs to use such health services are a barrier to needed health services. Pryor et al. (2007) found that those who purchase private insurance often chose out of necessity to choose plans with lower monthly premiums; compared to those with employer-sponsored health plans, those with private health plans not only experienced higher premiums, but also higher deductibles, and levels of cost-sharing. Citing financial burdens, they opted for buying a cheaper health insurance plan that entailed lower monthly costs. However, the disadvantage to such a benefit has meant a higher yearly deductible and a higher co-payment per visit. For example, one respondent mentioned that her family would need to pay \$4,000 out of their own pocket before their health insurance would pay for any medical costs, and as a result she delayed seeking out different preventative cancer screenings. Research by Davis, Doty, and Ho (2005) found that high-deductible plans can increase financial barriers to obtaining necessary care without protection against financial hardships, as individuals with a high deductible have significantly greater difficulty accessing care due to cost compared to those with a lower or no deductible. Thirty-eight percent of adults with deductibles of \$1,000 or more reported problems with health care access, not filling prescriptions, not accessing specialist care, and forgoing recommended tests and needed care.

Owing to the financial costs of conventional health care and cultural reliance on traditional Korean medicine and practices, Korean immigrants in this study have sought out traditional medicine for preventive care and treatments. The results indicate that uninsured Korean immigrants were

more likely to seek out traditional health care providers than those that were insured, especially with the comparatively affordable costs of herbal medicine and acupuncture treatments. Previous research has shown that among Asian immigrants traditional health care is still widely practiced, but that those with insurance were more likely to utilize traditional Asian medicine (Ma, 1999; Pourat, Lubben, Wallace, & Moon, 1999; Jenkins, Le, McPhee, Stewart, & Ha, 1996). The respondents did not cite cost as a barrier to accessing traditional Asian medicine.

The costs of health care access are barriers for both the uninsured and insured, but immigration status can also act as a barrier in seeking affordable public health insurance programs. Several uninsured respondents in this study had minor children who were covered through Healthy Families, which provides health, dental, and vision coverage with no or low co-payments to children. However, according to the Asian Pacific Islander American Health Forum (2005), newer, uninsured respondents expressed concern that their immigration status also impacted their ability to access publicly funded health care programs. Most legally admitted immigrants who arrived after 1996 are not eligible for programs such as Medicaid and SCHIP until they have resided in the U.S. for five years, while some immigrants who would be eligible for these programs fear that these benefits may negatively impact their process of applying for U.S. citizenship. As a result, non-U.S. citizens, regardless of immigration status, are less likely to utilize such insurance programs.

CONCLUSION

Studies have shown that non-elderly people with low income, limited English proficiency, foreign birth, lack of citizenship, and high rates of self-employment are more likely to be uninsured (Brown et al., 2005; Employee Benefits Research Institute, 2005b). Moreover, previous research has consistently stated that Korean immigrants represent a high percentage of the uninsured and that lacking health insurance is a barrier to seeking and obtaining health services. Twenty-nine percent of our participants did not have health insurance – a figure much lower than previously reported for this population. As Korean immigrants have become more aware of the importance of the need for health insurance in the U.S., more people in the last decade have been purchasing private, non-group health insurance. Yet even when they purchase health insurance, Korean immigrants often find

themselves underinsured and still face difficulties in accessing needed health services.

Those who purchase private non-group health insurance have higher co-payments, deductibles, and premiums compared to those with employer-sponsored health plans (Pryor et al., 2007). Korean immigrants, who have high rates of self-employment and have no access to employer-sponsored health plans, obtain private, non-group health insurance plans. Research on the barriers and challenges of Korean immigrants obtaining and utilizing a quality, affordable, non-group health insurance plan has largely been unexplored. The findings of this study show that Korean immigrant entrepreneurs continue to exhibit high rates of uninsurance and even those with private health insurance were limited in their health care coverage. Their choices were often limited to a plan with lower monthly premiums but higher co-payments and higher deductibles. The results in this study show that the mean household deductibles were over \$7,000. This means that families must spend thousands of dollars out-of-pocket before their health insurance covers health expenses.

Our findings also indicate that as a result of these expenses, having health insurance did not automatically translate into utilizing health care services. Respondents did not utilize their coverage for more preventative health screenings and expected that they would use it in cases of emergencies and serious or catastrophic illnesses. According to Pryor et al. (2007), health insurance plans are not comprehensive, meaning that they fail to cover medically necessary and effective services and treatments (such as prescription drugs) as well as preventive care and disease management. Such plans must also be affordable and accessible even for persons with pre-existing conditions and health risk factors, through state and federally regulated standards that oversee and implement comprehensive and affordable coverage and benefits.

Affected by historical immigration and naturalization exclusion policies, the contemporary Korean American population is a largely foreign-born group. Scholars have noted that due to linguistic and cultural barriers that they face in the primary labor market, remarkable numbers of post-1965 Korean immigrants have turned to self-employment for livelihood. But this tendency to work as small business owners, has resulted in significant trends toward being uninsured or underinsured that threatens the health and financial security of Korean immigrant families. Newer, uninsured, and low-income Korean immigrants, who are unable to purchase health insurance, face hurdles in accessing health care but so do middle-income Korean Americans who are caught in the escalating costs and confusing policies of

existing health care coverage plans. Health insurance and immigrants' access to adequate, comprehensive coverage is a major policy issue. New immigrants face a five-year ban on access to health and other programs as a result of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). Although native-born Americans made up 73.9% of the uninsured population in 2003, immigrants accounted for an 86% growth in the uninsured population between 1998 and 2003 (Employee Benefits Research Institute, 2005a).

The involvement of immigrant voices in the policy debates around the escalating and potentially devastating costs, financial and otherwise, of contemporary health care access in the U.S. is essential. They are often not voiced due to language barriers but illustrate the lack of health insurance coverage options available to low- and middle-income individuals and families who opt for no or inadequate coverage in response to unaffordable premiums, co-payments, and/or deductibles. Mr. Song of Los Angeles (Mr. Song, personal communication, December 20, 2006) summarizes the difficulties and the health care crisis in today's society:

I work over 80 hours a week. I am considered middle-income. We, middle-income immigrants, who are working extremely hard for our families should have some benefits. We should have health insurance. We pay lots of taxes, but we do not see any benefits. We are stuck. We are not able to go to the doctor when we need to. When we get health insurance, we end up paying for everything. It's totally unfair.

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REFERENCES

Asian and Pacific Islander American Health Forum. (2005). *Diverse Communities, Diverse Experiences: The Status of Asian Americans & Pacific Islanders in the U.S.: A Review of*

- Six Socioeconomic Indicators and their Impact on Health*. San Francisco: Asian and Pacific Islander American Health Forum. Retrieved on February, 2007, from <http://www.apiahf.org/resources/pdf/Diverse%20Communities%20Diverse%20Experiences.pdf>
- Baker, D. W., Sudano, J. J., Albert, J. M., Borawski, E. A., & Dor, A. (2001). Lack of health insurance and decline in overall health in late middle age. *New England Journal of Medicine*, 345(15), 1106–1112.
- Brown, E. R., Lavarreda, S. A., Rice, T., Kincheloe, J. R., & Gatchee, M. S. (2005). The state of health insurance in California: Findings from the 2003 California health interview survey. Retrieved on June 20, 2006, from http://www.healthpolicy.ucla.edu/pubs/files/SHIC03_RT_0_81505.pdf
- Brown, E. R., Ojeda, V., Wyn, R., & Levan, R. (2000). Racial and ethnic disparities in access to health insurance and health care. Retrieved on October 10, 2005, from <http://healthpolicy.ucla.edu/pubs/files/RacialandEthnicDisparitiesReport.pdf>
- Brown, E. R., Ponce N., Rice T., & Lavarreda S. A. (2002). The state of health insurance in California: Findings from the 2001 California health interview survey. Retrieved on June 20, 2006, from <http://healthpolicy.ucla.edu/pubs/files/shic062002.pdf>
- Davis, K., Doty, M. E., & Ho, A. (2005). *How high is too high?: Implications of high-deductible health plans*. Boston: The Commonwealth Fun. Retrieved on January 8, 2007, from http://www.cmwf.org/usr_doc/816_Davis_how_high_is_too_high_impl_HDHPs.pdf
- Employee Benefits Research Institute. (2005a). Immigrants make up a growing share of U.S. population without health insurance, study finds. Retrieved on March 30, 2006, from http://www.ebri.org/publications/prel/index.cfm?fa=prelDisp&content_id=3527
- Employee Benefits Research Institute. (2005b). Sources of health insurance and characteristics of the uninsured: Analysis of the March 2005 Current Population Survey. EBRI Issue Brief #287. Retrieved on March 30, 2006, from http://www.ebri.org/pdf/briefspdf/EBRI_IB_11-20051.pdf
- Farmer, M. M., & Ferraro, K. F. (2005). Are racial disparities in health conditional on socioeconomic status? *Social Science Medicine*, 60(1), 191–204.
- Franzini, L., & Fernandez Esquer, M. E. (2006). The association of subjective social status and health in low-income Mexican-origin individuals in Texas. *Social Science Medicine*, 63(3), 788–804.
- Guendelman, S., Wyn, R., & Tsai, Y. W. (2000). Children of working low-income families in California: Does parental work benefit children's insurance status, access, and utilization of primary health care? *Health Services Research*, 35(2), 417–441.
- Hargraves, J. L., & Hadley, J. (2003). The contribution of insurance coverage and community resources to reducing racial/ethnic disparities in access to care. *Health Services Research*, 38(3), 809–829.
- Huang, Z. J., Yu, S. M., & Ledsky, R. (2006). Health status and health service access and use among children in U.S. immigrant families. *American Journal of Public Health*, 96(4), 634–640.
- Hurh, W. M., & Kim, K. C. (1980). *Korean immigrants in America: A structural analysis of ethnic confinement and adhesive adaptation*. Macomb: Department of Sociology and Anthropology, Western Illinois University.
- Institute of Medicine. (2002). *Care without Coverage: Too Little, Too Late*. Washington, DC: National Academy Press.
- Jenkins, C. N., Le, T., McPhee, S. J., Stewart, S., & Ha, N. T. (1996). Health care access and preventive care among Vietnamese immigrants: Do traditional beliefs and practices pose barriers? *Social Science and Medicine*, 43(7), 1049–1056.

- Juon, H. S., Choi, Y., & Kim, M. T. (2000). Cancer screening behaviors among Korean-American women. *Cancer Detection and Prevention, 24*(6), 589–601.
- Juon, H. S., Kim, M., Shankar, S., & Han, W. (2004). Predictors of adherence to screening mammography among Korean American women. *American Journal of Preventive Medicine, 39*(3), 474–481.
- Kim, B., & Yoo, G. (2006). Saving for health and the future: Korean immigrant entrepreneurs. Paper presentation at the National Association of Ethnic Studies, April, San Francisco, CA.
- Kim, K., Yu, E. S., Chen, E. H., Kim, J., Kaufman, M., & Purkiss, J. (1999). Cervical cancer screening knowledge and practices among Korean-American women. *Cancer Nursing, 22*(4), 297–302.
- Kirby, J. B., Taliaferro, G., & Zuvekas, S. H. (2006). Explaining racial and ethnic disparities in health care. *Medical Care, 44*(5 Suppl.), I64–I72.
- Korean American Coalition – Census Information Center & Center for Korean American and Korean Studies, California State University, Los Angeles. (2002). *Korean employment, poverty, and naturalization in the United States: Tables and highlights*. Los Angeles: KAC – CIC and CKKS, CSULA.
- Ku, L., & Blaney, S. (2000). *Health coverage for legal immigrant children: New census data highlight importance of restoring Medicaid and SCHIP coverage*. Washington, DC: Center on Budget and Policy Priorities. Retrieved on August 14, 2006, from <http://www.cbpp.org/10-4-00health.pdf>
- Lantz, P. M., Mujahid, M., Schwartz, K., Janz, N. K., Fagerlin, A., Salem, B., Liu, L., Deapen, D., & Katz, S. J. (2006). The influence of race, ethnicity, and individual socioeconomic factors on breast cancer stage at diagnosis. *American Journal of Public Health, 12*, 2173–2186.
- Lee, M. C. (2000). Knowledge, barriers, and motivators related to cervical cancer screening among Korean-American women: A focus group approach. *Cancer Nursing, 23*(3), 168–175.
- Lillie-Blanton, M., & Hoffman, C. (2005). The role of health insurance coverage in reducing racial/ethnic disparities in health care. *Health Affairs, 24*(2), 398–408.
- Ma, G. X. (1999). Between two worlds: The use of traditional and western health services by Chinese immigrants. *Journal of Community Health, 24*(6), 421–437.
- Maxwell, A. E., Bastani, R., & Warda, U. S. (2000). Demographic predictors of cancer screening among Filipino and Korean immigrants in the United States. *American Journal of Preventive Medicine, 18*(1), 62–68.
- McWilliams, J. M., Zaslavsky, A. M., Meara, E., & Ayanian, J. Z. (2004). Health insurance coverage and mortality among the near-elderly. *Health Affairs, 23*(4), 223–233.
- Park, K. (1997). *The Korean American dream: Immigrants and small businesses in New York City*. Ithaca, NY: Cornell University Press.
- Pourat, N., Lubben, J., Wallace, S. P., & Moon, A. (1999). Predictors of use of traditional Korean healers among elderly Koreans in Los Angeles. *The Gerontologist, 39*(6), 711–719.
- Pryor, C., Cohen, A., & Prottas, J. (2007). *The illusion of coverage: How health insurance fails people when they get sick*. Boston: The Access Project. Retrieved on April 8, 2007, from http://www.accessproject.org/adobe/the_illusion_of_coverage.pdf
- Ryu, H., Young, W. B., & Park, C. (2001). Korean American health insurance and health services utilization. *Research in Nursing & Health, 24*(6), 494–505.

- Schoen, C., Doty, M. M., Collins, S. R., & Holmgren, A. L. (2005). Insured but not protected: How many adults are underinsured? *Health Affairs, 115*, e697–e705.
- Shin, H., Song, H., Kim, J., & Probst, J. (2005). Insurance, acculturation, and health service utilization among Korean-Americans. *Journal of Immigrant Health, 7*(2), 65–74.
- Shone, L. P., Dick, A. W., Klein, J. D., Zwanziger, J., & Szilagyi, P. G. (2005). Reduction in racial and ethnic disparities after enrollment in the State Children's Health Insurance Program. *Pediatrics, 6*, e697–e705. Retrieved on October 8, 2006, from <http://pediatrics.aappublications.org/cgi/content/full/115/6/e697?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=Reduction+in+racial+and+ethnic+disparities+after+e&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sort-spec=relevance&resourcetype=HWCIT>
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.
- U.S. Census Bureau. (2001). Census 2000 demographic profile. Retrieved on October 1, 2005, from <http://www.census.gov/prod/cen2000/dp1/2kh00.pdf>
- U.S. Census Bureau. (2006). *Income, poverty, and health insurance coverage in the United States: 2005*. Washington, DC: U.S. Government Printing Office. Retrieved on November 10, 2006, from http://www.census.gov/prod/2006_pubs/p60-231.pdf
- Yu, E., & Chang, E. (2003). Entrepreneurs par excellence. In: E. Lai, & D. Arguelles (Eds), *The new face of Asian Pacific America: Numbers, diversity and change in the 21st century* (pp. 57–66). San Francisco: UCLA Asian American Studies Center and AsianWeek.