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Overview

Reducing health disparities in the nation is a goal for the U.S. Department of Health and Human Services (HHS), and the Affordable Care Act is making important strides toward meeting that goal. About 16.4 million uninsured people have gained health insurance coverage since the provisions of the Affordable Care Act took effect, including 4.2 million Hispanics/Latinos. And while the uninsured rate fell across all race and ethnicity categories, there was a greater decline among Hispanics/Latinos and Black/African Americans than whites. The uninsured rate among Hispanics/Latinos has dropped by 12.3 percentage points since the start of the first open enrollment period in October 2013. Additionally, 8.8 million Hispanics/Latinos with private health insurance now have access to preventive services, including tobacco cessation with no cost-sharing. With the expansion of Medicaid and the addition of \$11 billion to fund 1,300 community health centers throughout the country, the Affordable Care Act has substantially impacted communities of color.

This data brief focuses on a key provision of this landmark legislation that strengthens data collection standards that will help improve public health strategies and practices to address health disparities. New data collection standards issued in 2011 by HHS under Section 4302 of the Affordable Care Act, allow for additional levels of detail for race and Hispanic/Latino ethnicity, sex, primary language, and disability status collected in population health surveys conducted by the Department. This added granularity supports the monitoring of racial and ethnic health disparities in communities and enhances the ability of public health officials to identify and track the health and health care status of many population groups.

The HHS Office of Minority Health (OMH) has produced this data brief to highlight the importance of the HHS data standards by examining the health status of a diverse group of adult Hispanic/Latino males. Despite Hispanics/Latinos representing the largest minority group in the nation, their health needs remain poorly understood. Hispanics/Latinos are a heterogeneous population with historical, cultural, linguistic, generational, and socioeconomic differences. Health issues experienced by Hispanics/Latinos are often masked when data are aggregated into a single ethnic category. Deepening our understanding of diversity within minority populations provides even greater insights into strategies for addressing health care and health disparities. This data brief underscores the significance of the Affordable Care Act in helping to close the gap in health disparities.

Data included in this brief were collected prior to the establishment of the Health Insurance Marketplace and the brief describes issues that contribute to poor health outcomes among groups of non-elderly Hispanic/Latino males. This information will assist in developing tailored, culturally and linguistically appropriate interventions to reduce health disparities. From shaping those interventions to demonstrating the need for all Americans, including Hispanic/Latino males, to have access to quality affordable health care, the new data standards under Section 4302 are a vital component of the Affordable Care Act.

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Background

Previous studies have shown sex differences in cardiovascular risk factors, such as hypertension prevalence and smoking rates among Hispanics/Latinos [1]. However limited evidence exists on the varying health outcomes among diverse groups of adult Hispanic/Latino males. Hispanics/Latinos are a heterogeneous population; however analyses using national data sources are often limited by small sample sizes or only include few Hispanic/Latino groups. The growing proportion of the Hispanic/Latino population in the United States supports the importance of collecting and reporting detailed data for population groups.

With the implementation of Section 4302 of the Affordable Care Act, HHS adopted new data collection standards for race, ethnicity, sex, primary language and disability status that include additional granularity for race and Hispanic/Latino ethnicity [2]. More granular or detailed information on demographic data strengthen data collections by providing information on differential health needs and access to care that may exist within a particular population group.

We present estimates using data collected from the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), National Health Interview Survey (NHIS 2002-2012). For the purposes of this brief, adult Hispanic/Latino males are considered as non-elderly persons residing in the United States who self-identify as Hispanic/Latino/Spanish origin. This analysis of 21,483 non-elderly Hispanic/Latino males includes: Central/South Americans (17 percent), Cuban/Cuban Americans (5 percent), Dominicans (3 percent), Mexicans (41 percent), Mexican Americans (25 percent), and Puerto Ricans (10 percent). This data brief provides information on non-elderly Hispanic/Latino males prior to the establishment of the Health Insurance Marketplace and the expansion of Medicaid eligibility under the Affordable Care Act.

Keywords

disaggregated data, health disparities, Hispanic/Latino group, men's health, social determinants of health, Section 4302 of the Affordable Care Act

Highlights

Among non-elderly Hispanic/Latino males, 78% of Puerto Ricans, 72% of Mexican Americans, 71% of Dominicans, 69% of Cuban/Cuban Americans, and 53% of Central/South Americans were classified as insured.

Less than half of non-elderly Dominican (40%), Puerto Rican (40%), Mexican American (35%), Central/South American (30%), Cuban/Cuban American (30%), and Mexican (24%) males had a usual place for preventive care.

Nearly four out of five non-elderly Dominican males (highest among six groups of Hispanic/Latino males) were classified as never smokers.

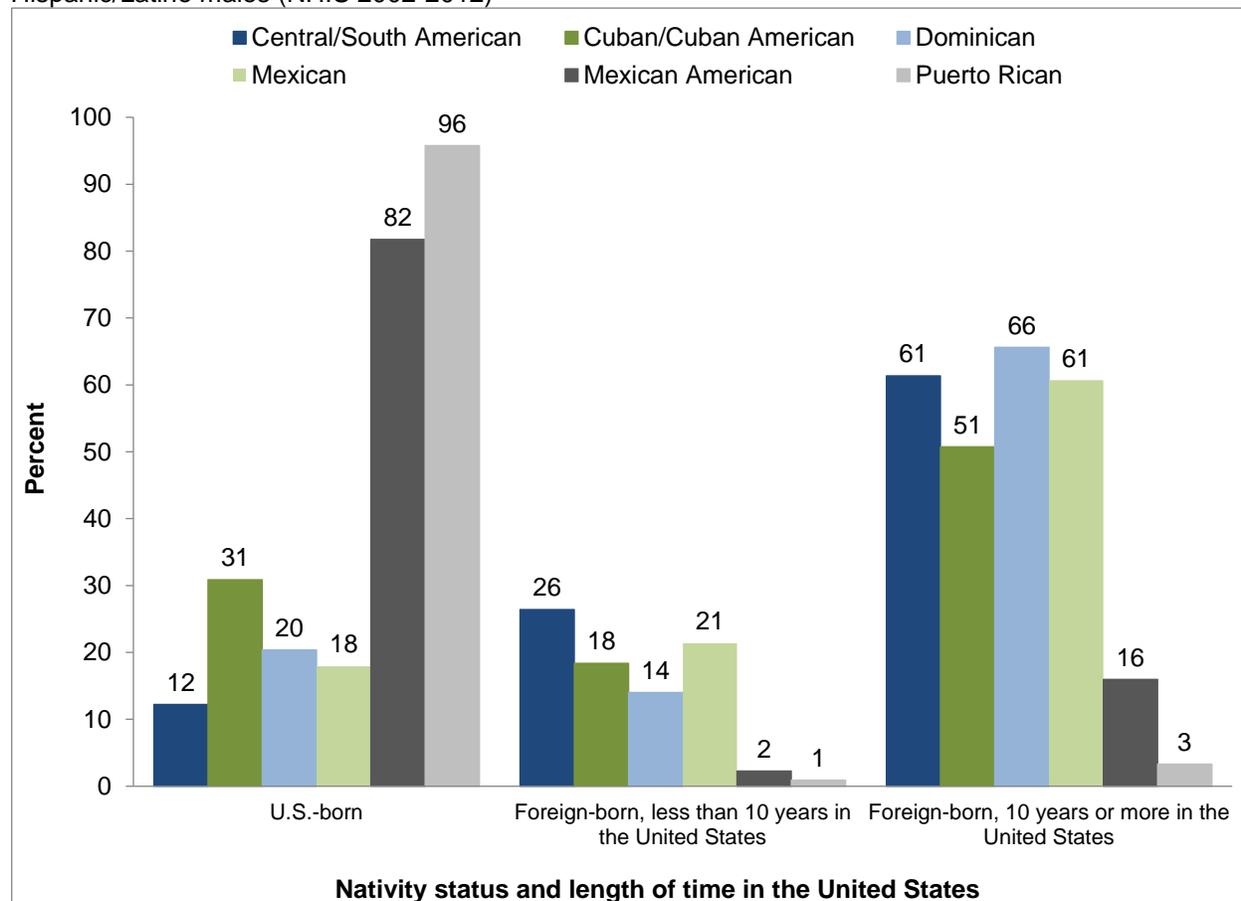
Among non-elderly Hispanic/Latino males, only 29% of non-elderly Central/South Americans, Cuban/Cuban Americans, and Dominicans (highest among six groups of Hispanic/Latino males) had a healthy weight.

Among non-elderly Hispanic/Latino males, 31% of Dominicans, 26% of Mexican Americans, 26% of Puerto Ricans, 24% of Cuban/Cuban Americans, 20% of Mexicans and 17% of Central/South Americans had been diagnosed with hypertension.

Data from the CDC/NCHS NHIS 2002-2012 based on household interviews of a sample of 21,483 civilian non-institutionalized adult Hispanic/Latino males (ages 18 to 64 years).

What is the nativity status among adult Hispanic/Latino males (ages 18 to 64 years) in the United States?

Figure 1. Nativity status and length of time in the United States among a diverse group of adult Hispanic/Latino males (NHIS 2002-2012)



NOTE: Data are based on household interviews of a sample of the civilian non-institutionalized population. U.S.-born includes anyone who was a born in one of the 50 United States, the District of Columbia, or U.S. territories. The foreign-born population includes anyone who was not born in the United States or a U.S. territory. Due to rounding, sum of bars for each Hispanic/Latino group may not equal 100 percent. All prevalence estimates were age-adjusted to the 2000 U.S. population standard.

Statistical significant difference in nativity and length of time in the United States among a diverse group of Hispanic/Latino males, $p < 0.001$

U.S.-born:

Among non-elderly Hispanic/Latino males, the highest proportion of U.S.-born males included Puerto Ricans (96 percent) and Mexican Americans (82 percent). A lower proportion of Cuban/Cuban American (31 percent), Dominican (20 percent), Mexican (18 percent), and Central/South American (12 percent) were classified as U.S.-born.

Foreign-born, less than 10 years in the United States:

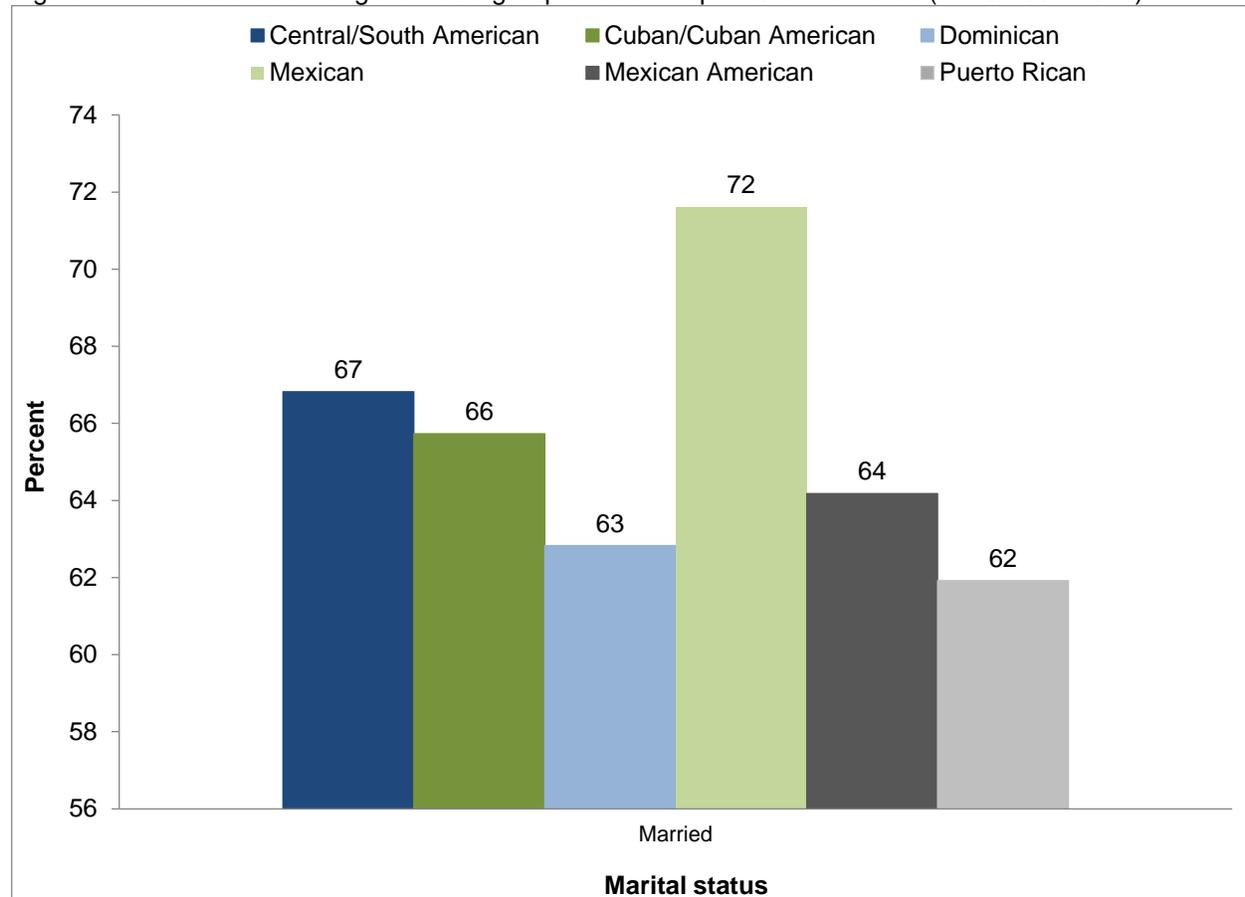
Among foreign-born non-elderly Hispanic/Latino males, 26 percent of Central/South Americans, 21 percent of Mexicans, 18 percent of Cuban/Cuban Americans lived in the United States for less than 10 years. A lower proportion of foreign-born non-elderly Dominican (14 percent), Mexican American (2 percent), and Puerto Rican (1 percent) males lived in the United States for less than 10 years.

Foreign-born, 10 years or more in the United States:

More than half of foreign-born non-elderly Dominican (66 percent), Central/South American (61 percent), Mexican (61 percent), and Cuban/Cuban American (51 percent) males lived in the United States for 10 years or more. A lower proportion of foreign-born non-elderly Mexican American (16 percent) and Puerto Rican (3 percent) males lived in the United States for 10 years or more.

What is the marital status among adult Hispanic/Latino males (ages 18 to 64 years) in the United States?

Figure 2. Marital status among a diverse group of adult Hispanic/Latino males (NHIS 2002-2012)



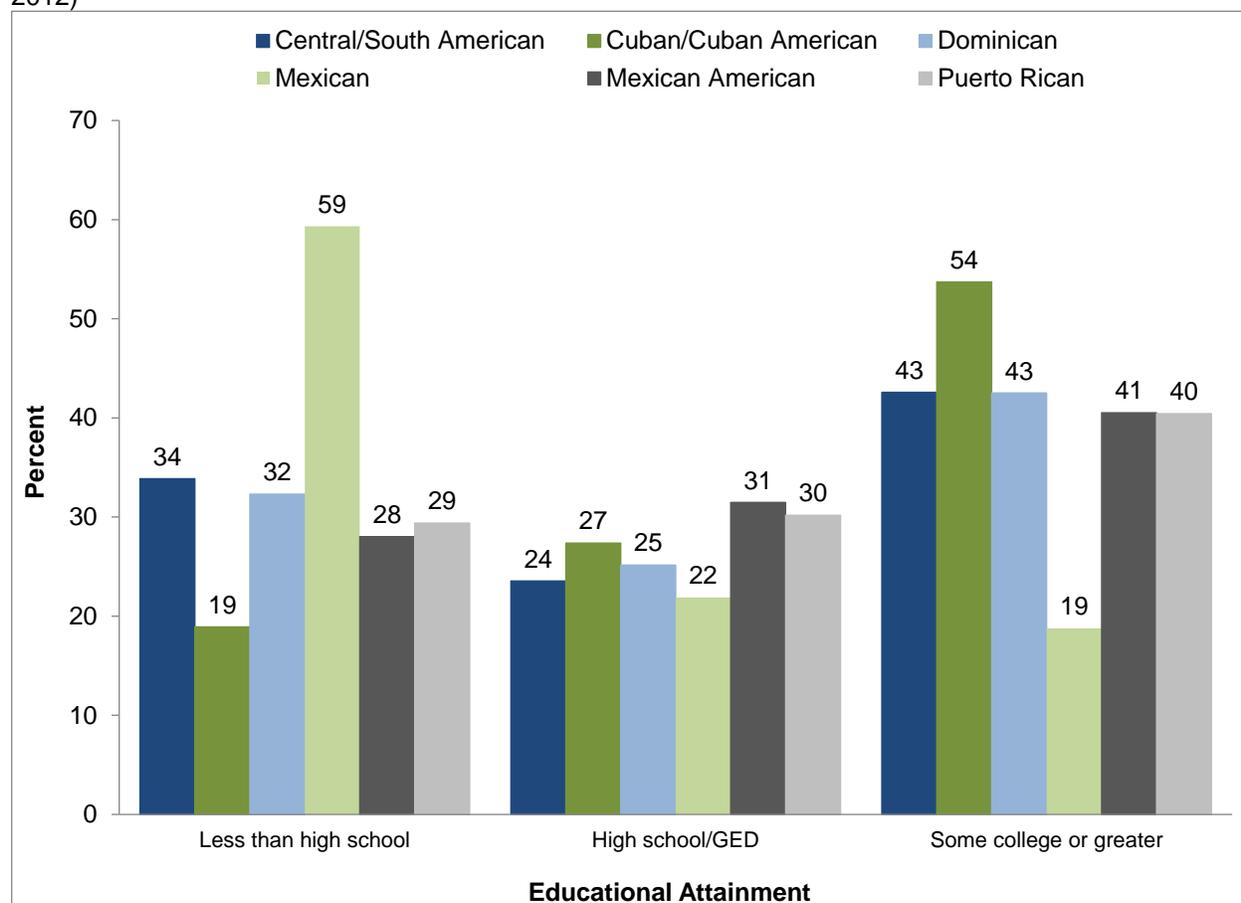
NOTE: Data are based on household interviews of a sample of the civilian non-institutionalized population. All prevalence estimates were age-adjusted to the 2000 U.S. population standard.

Statistical significant difference in marital status among a diverse group of Hispanic/Latino males, $p < 0.001$

Overall, a majority of non-elderly Hispanic/Latino males were married. Non-elderly Mexicans represented the highest proportion (72 percent) of Hispanic/Latino males who were married. Among non-elderly Hispanic/Latino males, 67 percent of Central/South Americans, 66 percent of Cuban/Cuban Americans, 64 percent Mexican Americans, 63 percent of Dominicans, and 62 percent of Puerto Ricans were married.

What is the educational attainment among adult Hispanic/Latino males (ages 18 to 64 years) in the United States?

Figure 3. Educational attainment among a diverse group of adult Hispanic/Latino males (NHIS 2002-2012)



NOTE: Data are based on household interviews of a sample of the civilian non-institutionalized population. GED is a certificate of general education development. Due to rounding, sum of bars for each Hispanic/Latino group may not equal 100 percent.. All prevalence estimates were age-adjusted to the 2000 U.S. population standard.

Statistical significant difference in educational attainment among a diverse group of Hispanic/Latino males, $p < 0.001$

Less than high school:

Non-elderly Mexican males (59 percent) represented the highest proportion of Hispanic/Latino males completing less than a high school level of education. A lower proportion of non-elderly Central/South American (34 percent), Dominican (32 percent), Puerto Rican (29 percent), Mexican American (28 percent), and Cuban/Cuban American (19 percent) males completed less than high school.

High school/ GED:

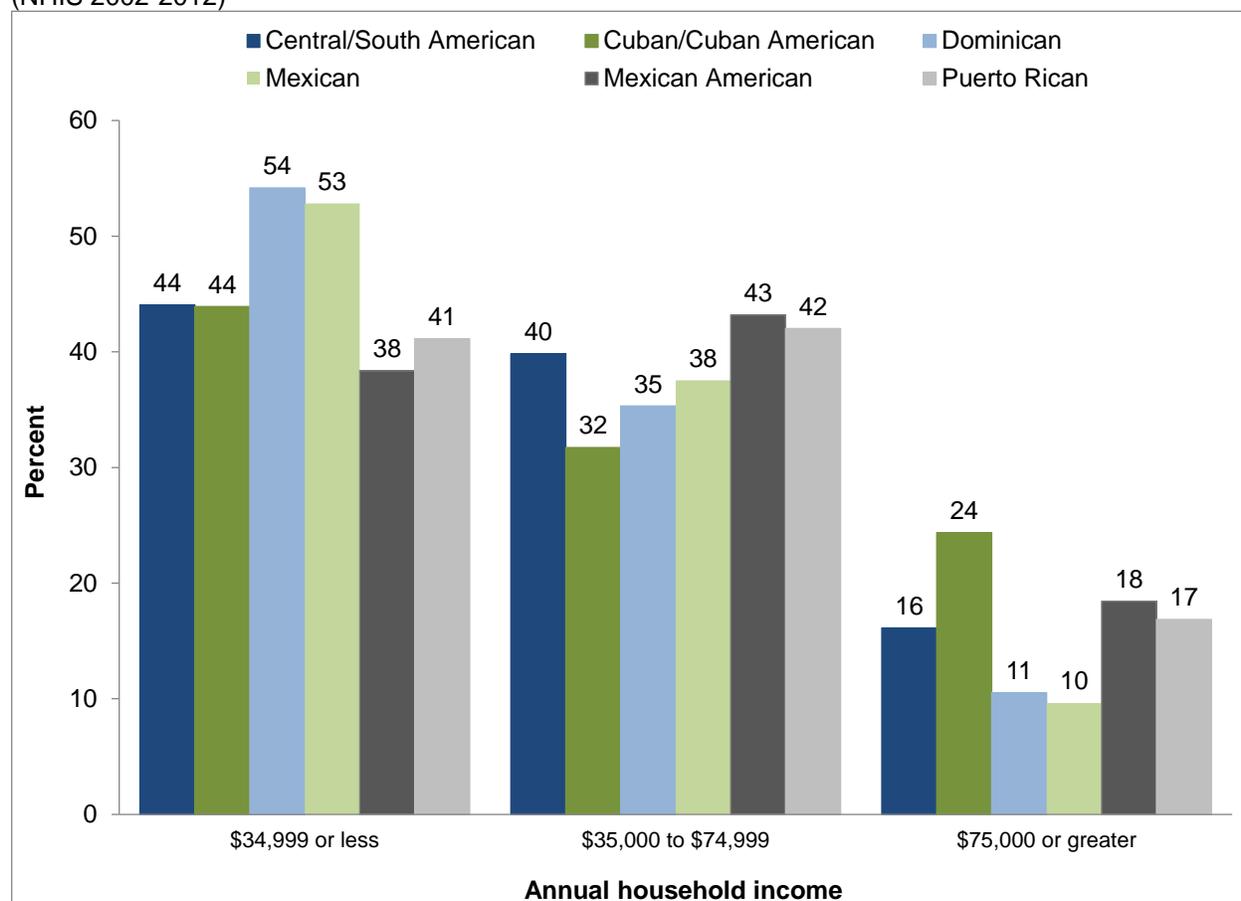
Non-elderly Mexican American males (31 percent) had the highest proportion of high school/GED completion. A lower proportion of non-elderly Puerto Rican (30 percent), Cuban/Cuban American (27 percent), Dominican (25 percent), Central/South American (24 percent), and Mexican (22 percent) males completed high school/GED.

Some college or greater:

Non-elderly Cuban/Cuban American males (54 percent) had the highest proportion of completing some college or greater. A lower proportion of non-elderly Central/South American (43 percent), Dominican (43 percent), Mexican American (41 percent), Puerto Rican (40 percent), and Mexican (19 percent) males completed some college or greater.

What is the reported annual household income among adult Hispanic/Latino males (ages 18 to 64 years) in the United States?

Figure 4. Reported annual household income among a diverse group of adult Hispanic/Latino males (NHIS 2002-2012)



NOTE: Data are based on household interviews of a sample of the civilian non-institutionalized population. Observations missing on income are not shown. Due to rounding, sum of bars for each Hispanic/Latino group may not equal 100 percent. All prevalence estimates were age-adjusted to the 2000 U.S. population standard.

Statistical significant difference in reported annual household income among a diverse group of Hispanic/Latino males, $p < 0.001$

Annual household income of \$34,999 or less:

Among non-elderly males, Dominicans (54 percent) and Mexicans (53 percent) reported the highest percentage of annual household income in this category. A lower proportion of non-elderly Central/South American (44 percent), Cuban/Cuban American (44 percent), Puerto Rican (41 percent), and Mexican American (38 percent) males reported an annual household income of \$34,999 or less.

Annual household income of \$35,000 to \$74,999:

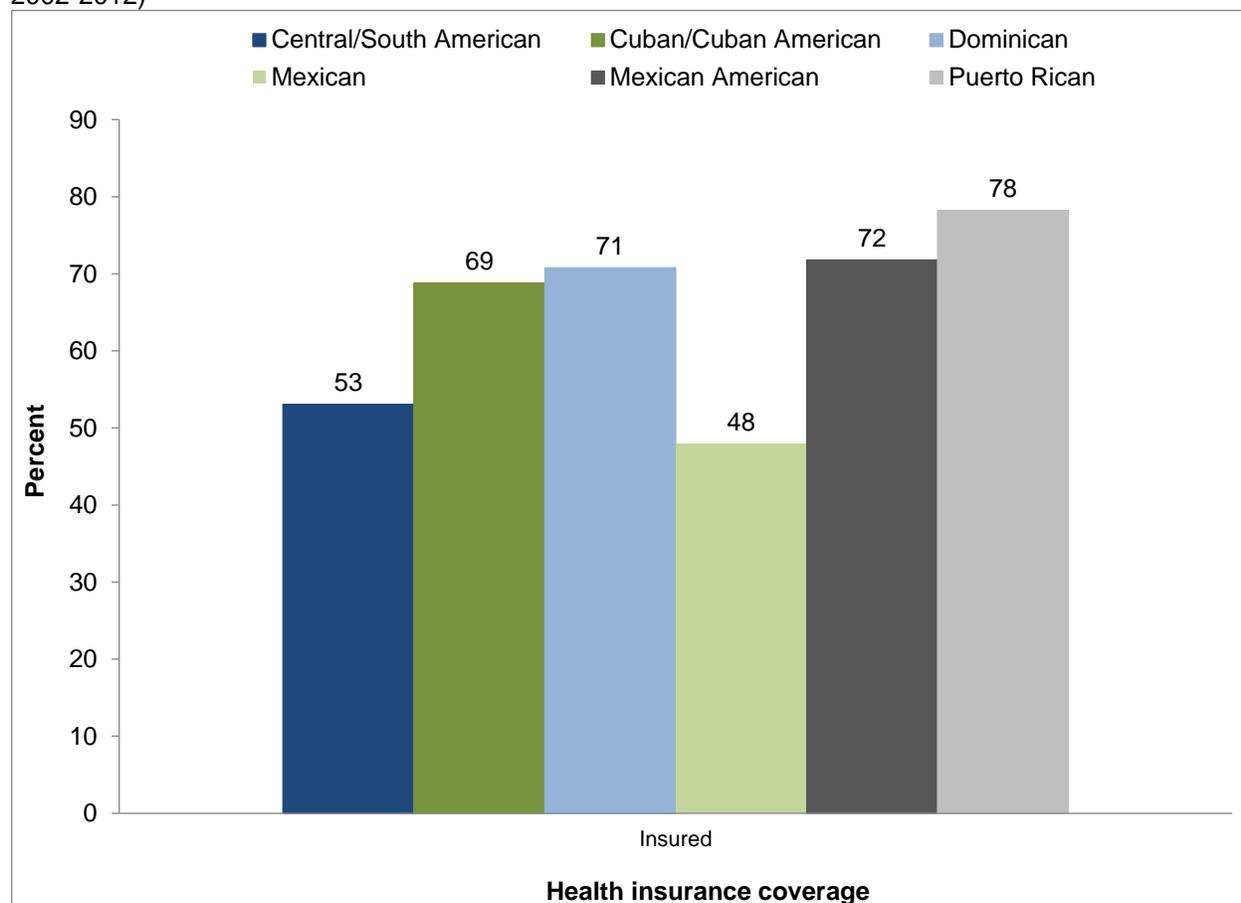
Among non-elderly males, Mexican Americans (43 percent), Puerto Ricans (42 percent) and Central/South Americans (40 percent) reported the highest percentage of annual household income in this category. A lower proportion of non-elderly Mexican (38 percent), Dominican (35 percent), and Cuban/Cuban American (32 percent) males reported an annual household income of \$35,000 to \$74,999.

Annual household income of \$75,000 or greater:

Non-elderly Cuban/Cuban American (24 percent) males reported the highest percentage of household income in this category. A lower proportion of non-elderly Mexican American (18 percent), Puerto Rican (17 percent), Central/South American (16 percent), Dominican (11 percent), and Mexican (10 percent) males reported an annual household income of \$75,000 or greater.

What is the health insurance coverage status among adult Hispanic/Latino males (ages 18 to 64 years) in the United States?

Figure 5. Health insurance coverage status among a diverse group of adult Hispanic/Latino males (NHIS 2002-2012)



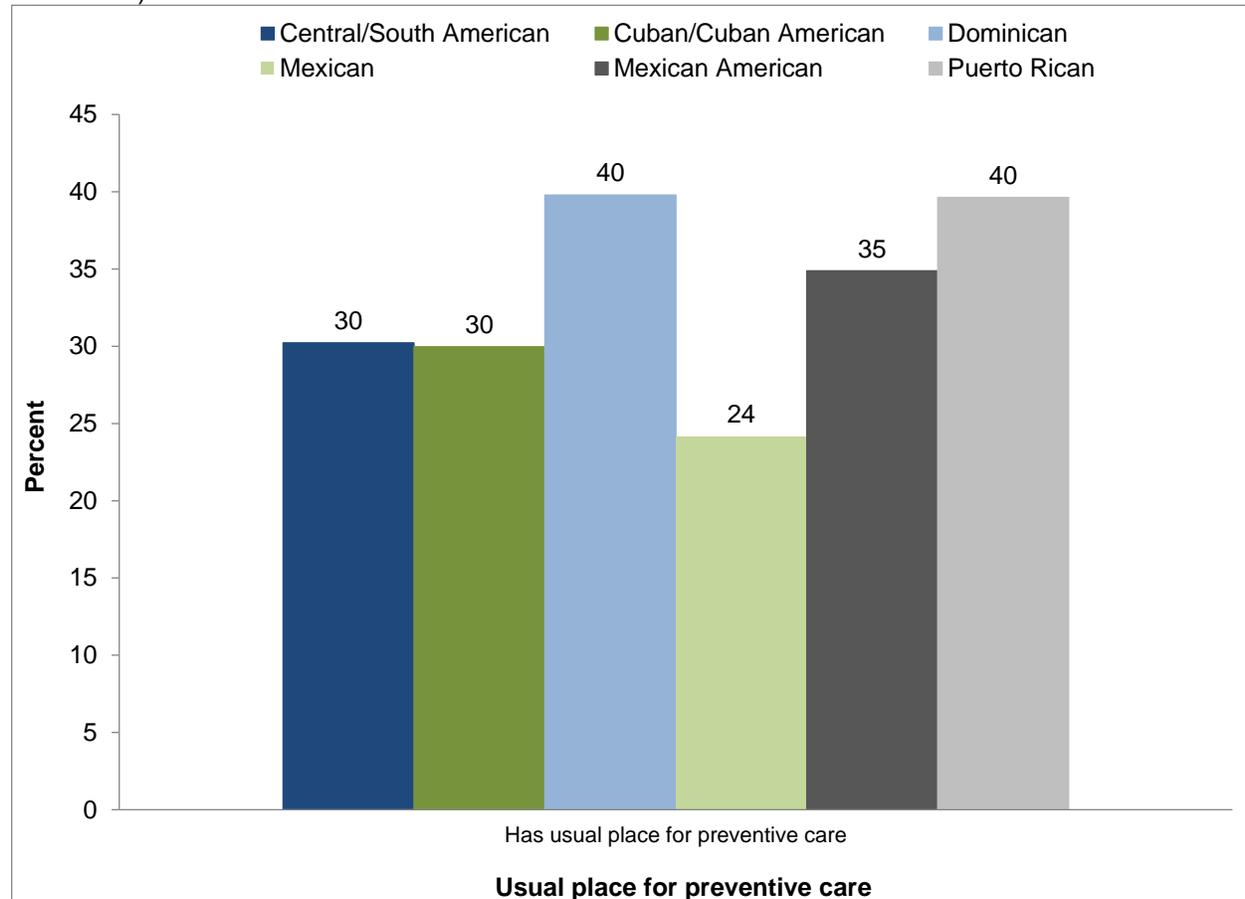
NOTE: Data are based on household interviews of a sample of the civilian non-institutionalized population. Non-elderly Hispanic/Latino males were considered insured if they had any private health insurance, government-, or state-sponsored health insurance plans. All prevalence estimates were age-adjusted to the 2000 U.S. population standard.

Statistical significant difference in health insurance coverage status among a diverse group of Hispanic/Latino males, $p < 0.001$

Non-elderly Puerto Rican males (78 percent) represented the highest proportion of Hispanic/Latino males with health insurance coverage. Additionally, a high proportion of non-elderly Mexican American (72 percent), Dominican (71 percent), Cuban/Cuban American (69 percent) and Central/South American (53 percent) males had health insurance coverage. Non-elderly Mexican males (48 percent) represented the lowest proportion of Hispanic/Latino males with health insurance coverage.

What proportion of adult Hispanic/Latino males (ages 18 to 64 years) in the U.S. report having a usual place for preventive care?

Figure 6. Proportion of adult Hispanic/Latino males who have a usual place for preventive care (NHIS 2002-2012)



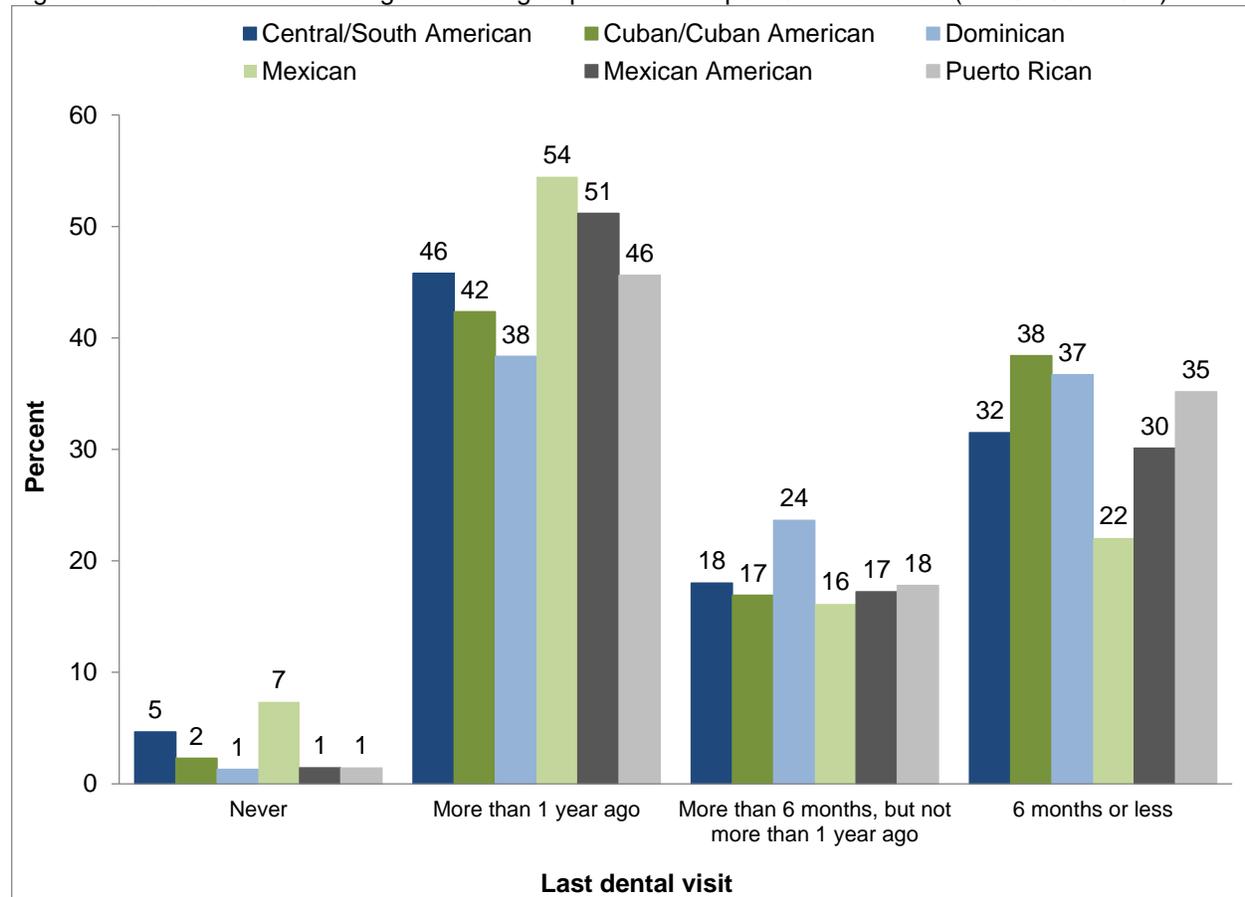
NOTE: Data are based on household interviews of a sample of the civilian non-institutionalized population. All prevalence estimates were age-adjusted to the 2000 U.S. population standard. Individuals who reported not obtaining preventive care anywhere or going to the emergency room for preventive care were classified as not having a usual place for preventive care.

Significant difference in having a usual place for preventive care among a diverse group of Hispanic/Latino males, $p < 0.001$

Dominicans (40 percent) and Puerto Ricans (40 percent) represented the highest proportion of non-elderly Hispanic males who had a usual place for preventive care. Thirty-five percent of non-elderly Mexican American, 30 percent of Central/South American, 30 percent of Cuban/Cuban American, and 24 percent of Mexican males had a usual place for preventive care.

When do adult Hispanic/Latino males (ages 18 to 64 years) in the U.S. report last seeing a dentist?

Figure 7. Last dental visit among a diverse group of adult Hispanic/Latino males (NHIS 2002-2012)



NOTE: Data are based on household interviews of a sample of the civilian non-institutionalized population. Due to rounding, sum of bars for each Hispanic/Latino group may not equal 100 percent.. All prevalence estimates were age-adjusted to the 2000 U.S. population standard.

Statistical significant difference in last dental visit among a diverse group of Hispanic/Latino males, $p < 0.001$

Never:

Among non-elderly Hispanic/Latino males, 7 percent of Mexicans, 5 percent of Central/South Americans, 2 percent of Cuban/Cuban Americans, and 1 percent of Dominicans, Mexican Americans, and Puerto Ricans never had a dental visit.

More than 1 year ago:

Among non-elderly Hispanic/Latino males, 54 percent of Mexicans, 51 percent of Mexican Americans, 46 percent of Central/South Americans, 46 percent of Puerto Ricans, 42 percent of Cuban/Cuban Americans, and 38 percent of Dominicans had a dental visit more than 1 year ago.

More than 6 months, but not more than 1 year ago:

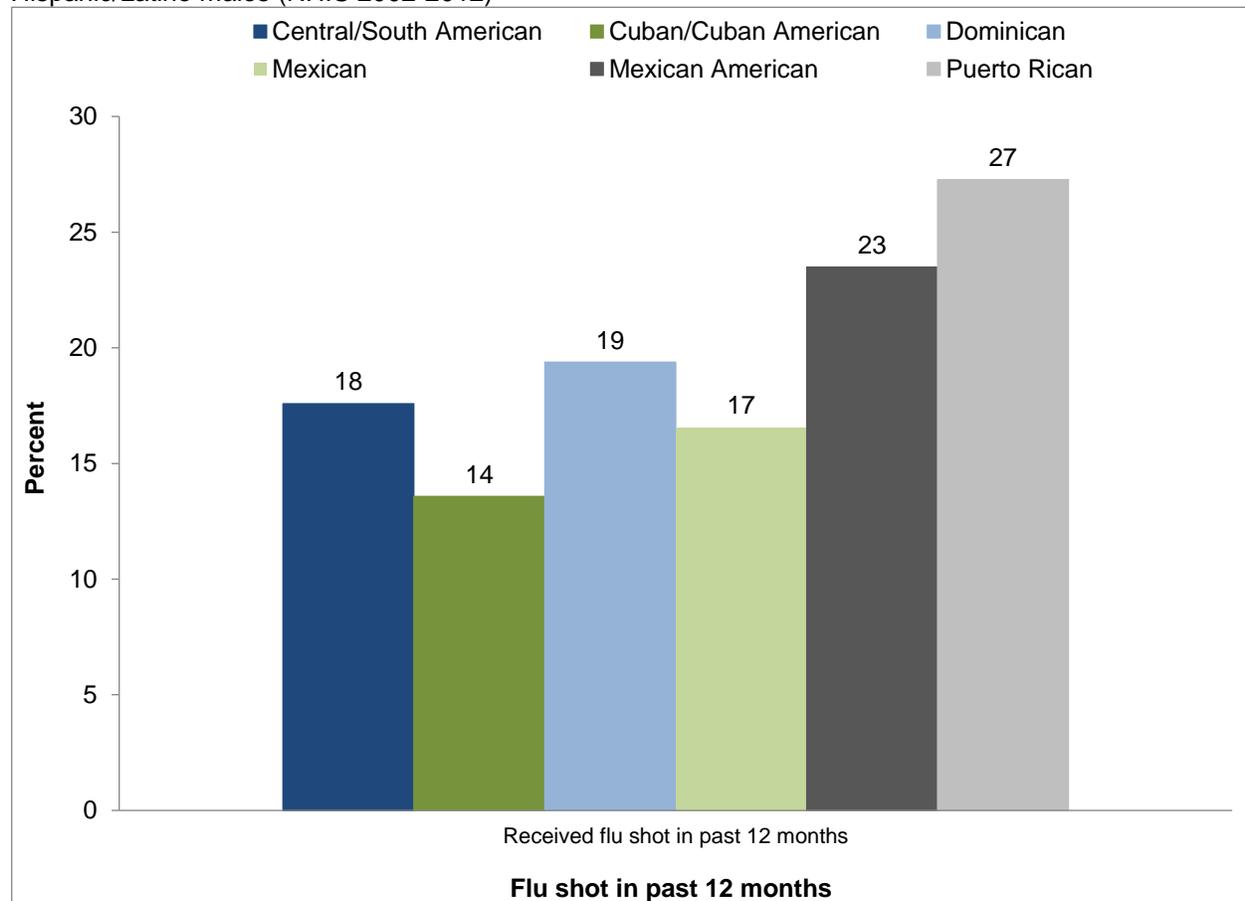
Among non-elderly Hispanic/Latino males, 24 percent of Dominicans, 18 percent of Central/South Americans, 18 percent of Puerto Ricans, 17 percent Cuban/Cuban Americans, 17 percent of Mexican Americans and 16 percent of Mexicans had a dental visit more than 6 months, but less than 1 year ago.

6 months or less:

Among non-elderly Hispanic/Latino males, 38 percent of Cuban/Cuban Americans, 37 percent of Dominicans, 35 percent of Puerto Ricans, 32 percent of Central/South Americans, 30 percent of Mexican Americans, and 22 percent of Mexicans had a dental visit in the past 6 months or less.

What is the prevalence of having a flu shot in the past 12 months among adult Hispanic/Latino males (ages 18 to 64 years) in the United States?

Figure 8. Prevalence of having a flu shot in the past 12 months among a diverse group of adult Hispanic/Latino males (NHIS 2002-2012)



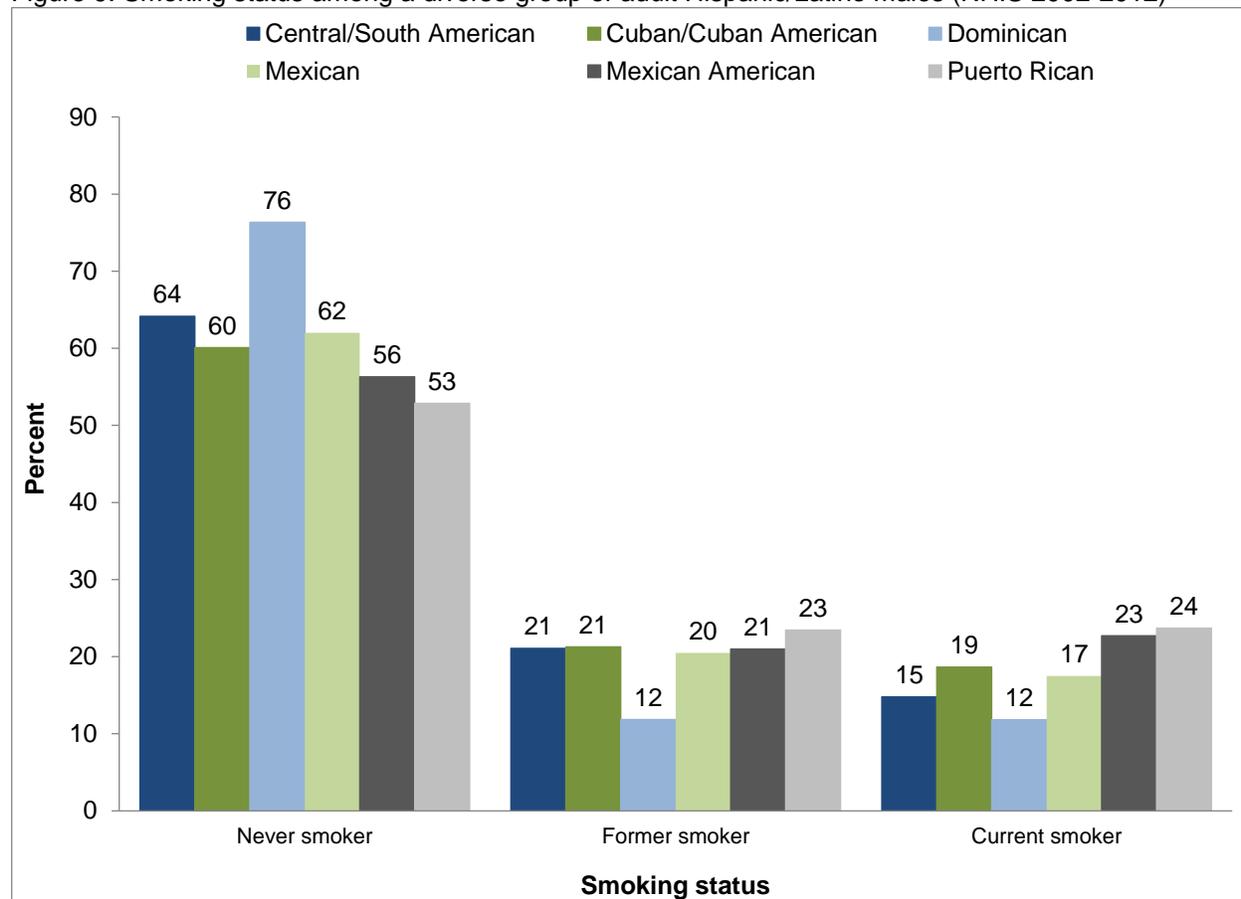
NOTE: Data are based on household interviews of a sample of the civilian non-institutionalized population. All prevalence estimates were age-adjusted to the 2000 U.S. population standard.

Statistical significant difference in having a flu shot in the past 12 months among a diverse group of Hispanic/Latino males, $p < 0.001$

A low proportion of non-elderly Hispanic/Latino males had obtained a flu shot in the past 12 months. Only 27 percent of Puerto Rican, 23 percent of Mexican American, 19 percent of Dominicans, 18 percent of Central/South American, 17 percent of Mexican, and 14 percent of Cuban/Cuban American males had obtained a flu shot in the past 12 months.

What is the smoking status among adult Hispanic/Latino males (ages 18 to 64 years) in the United States?

Figure 9. Smoking status among a diverse group of adult Hispanic/Latino males (NHIS 2002-2012)



NOTE: Data are based on household interviews of a sample of the civilian non-institutionalized population. Due to rounding, sum of bars for each Hispanic/Latino group may not equal 100 percent.. All prevalence estimates were age-adjusted to the 2000 U.S. population standard.

Statistical significant difference in smoking status among a diverse group of Hispanic/Latino males, $p < 0.001$

Never smoker:

A high proportion of non-elderly Hispanic/Latino males were never smokers. The highest proportion of never smokers was observed among non-elderly Dominican males (76 percent). A majority of non-elderly Central/South American (64 percent), Mexican (62 percent), Cuban/Cuban American (60 percent), Mexican American (56 percent), and Puerto Rican (53 percent) males were never smokers.

Former smoker:

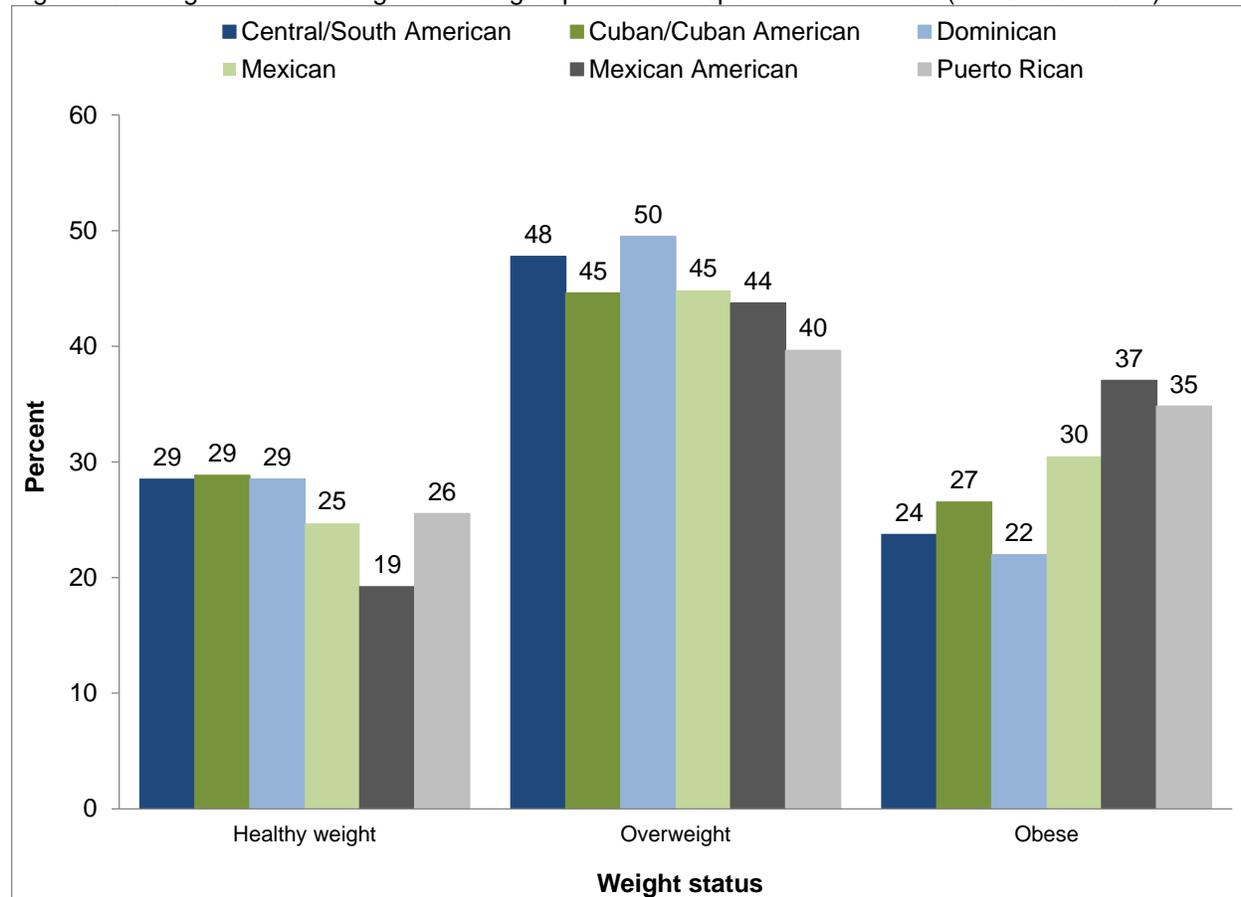
Less than one out of four non-elderly Hispanic/Latino males were former smokers. Among non-elderly Hispanic/Latino males, 23 percent of Puerto Ricans, 21 percent of Central/South Americans, 21 percent of Cuban/Cuban Americans, 21 percent of Mexican Americans, and 20 percent of Mexicans were former smokers. A lower proportion of non-elderly Dominican (12 percent) males were former smokers.

Current smoker:

A low proportion of non-elderly Hispanic/Latino males were current smokers. Non-elderly Puerto Rican (24 percent) and Mexican American (23 percent) males represented the highest percentage of current smokers. A lower proportion of non-elderly Cuban/Cuban American (19 percent), Mexican (17 percent), Central/South American (15 percent), and Dominican (12 percent) males were current smokers.

What is the weight status among adult Hispanic/Latino males (ages 18 to 64 years) in the United States?

Figure 10. Weight status among a diverse group of adult Hispanic/Latino males (NHIS 2002-2012)



NOTE: Data are based on household interviews of a sample of the civilian non-institutionalized population. Body mass index (BMI, kg/m²) was used as a health indicator of weight. Individuals classified as underweight, BMI less than 18.5 kg/m², are not shown. Individuals with a BMI between 18.5 kg/m² to 24.9 kg/m² were classified as healthy weight; 25.0 kg/m² to 29.9 kg/m² were classified as overweight; and those with a BMI of 30 kg/m² and above were classified as obese [3]. Due to rounding, sum of bars for each Hispanic/Latino group may not equal 100 percent. All prevalence estimates were age-adjusted to the 2000 U.S. population standard.

Statistical significant difference in weight status among a diverse group of Hispanic/Latino males, $p < 0.001$

Healthy weight:

Non-elderly Central/South American (29 percent), Cuban/Cuban American (29 percent), and Dominican (29 percent) males exhibited the highest proportion of healthy weight. Whereas, a lower proportion of non-elderly Puerto Rican (26 percent), Mexican (25 percent), and Mexican American males (19 percent) were classified as healthy weight.

Overweight:

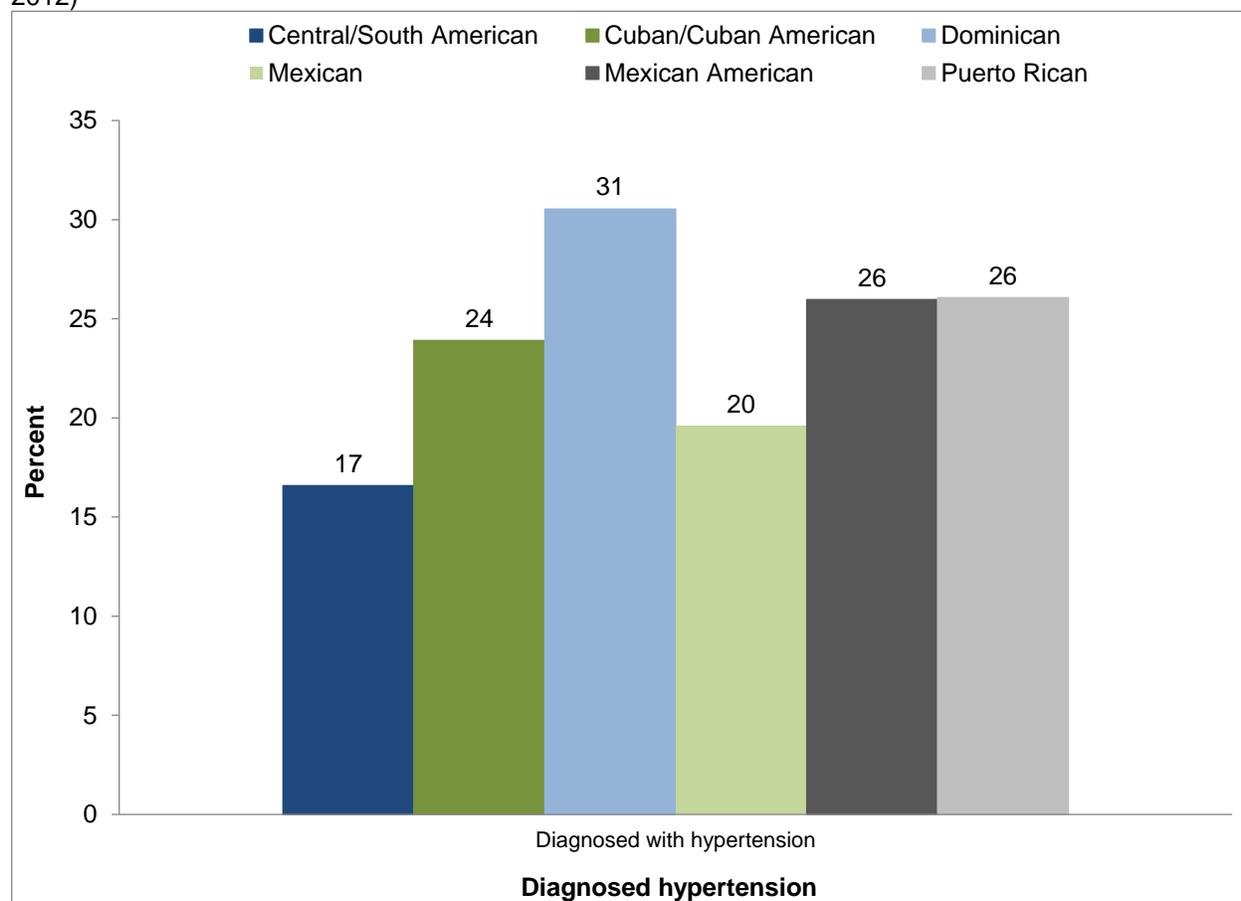
Non-elderly Dominican (50 percent), Central/South American (48 percent), Cuban/Cuban American (45 percent), Mexican (45 percent), Mexican American (44 percent), and Puerto Rican (40 percent) males were classified as overweight.

Obese:

Non-elderly Mexican American (37 percent) and Puerto Rican (35 percent) males exhibited the highest proportion of obesity. Whereas, a lower proportion of non-elderly Mexican (30 percent), Cuban/Cuban American (27 percent), Central/South American (24 percent), and Dominican (22 percent) males were classified as obese.

What is the prevalence of diagnosed hypertension among adult Hispanic/Latino males (ages 18 to 64 years) in the United States?

Figure 11. Diagnosed hypertension among a diverse group of adult Hispanic/Latino males (NHIS 2002-2012)



NOTE: Data are based on household interviews of a sample of the civilian non-institutionalized population. To be classified with diagnosed hypertension, non-elderly Hispanic/Latino males reported being told by a doctor or other health professional that they had hypertension on two or more different visits. All prevalence estimates were age-adjusted to the 2000 U.S. population standard.

Statistical significant difference in diagnosed hypertension among a diverse group of Hispanic/Latino males, $p < 0.001$

Overall, a low proportion of non-elderly Hispanic/Latino males had been diagnosed with hypertension by a doctor or other health professional. Among non-elderly Hispanic/Latino males, only 31 percent of Dominicans, 26 percent of Puerto Ricans and Mexican Americans, 24 percent of Cuban/Cuban Americans, 20 percent of Mexicans, and 17 percent of Central/South Americans had been diagnosed with hypertension by a doctor or other health professional.

The Office of Minority Health at the U.S. Department of Health and Human Services is dedicated to improving the health of racial and ethnic minority populations through the development of health policies and programs that help eliminate health disparities.

Summary

This data brief provides a profile of demographic, health, and well-being measures from a diverse sample of 21,483 non-elderly Hispanic/Latino males in the United States (NHIS 2002-2012). Non-elderly Cuban/Cuban American males (54 percent) represented the highest proportion of Hispanic/Latino males who completed some college or greater. Non-elderly Puerto Rican males represented the highest proportion of Hispanic/Latino males with health insurance coverage (78 percent). Two out of five non-elderly Dominican and Puerto Rican males had a usual place for preventive care. Non-elderly Dominican males (31 percent) represented the highest proportion of Hispanic/Latino males with a diagnosis of hypertension. These findings demonstrate the importance of examining health data by Hispanic/Latino group to illuminate ways to increase health awareness, bolster health care access, and further develop effective programs and policies to reduce health disparities among this diverse population in the United States.

Conclusion

This brief highlights the heterogeneity of demographic characteristics and health behaviors for non-elderly Hispanic/Latino males. Disaggregated data, such as those presented in this brief, can better illustrate the varying health status of the diverse U.S. Hispanic/Latino population and help to identify the nature and extent of potential intra- and inter-group disparities. New data collection standards implemented by the U.S. Department of Health and Human Services under Section 4302 of the Affordable Care Act include additional granularity for race and Hispanic/Latino ethnicity and support the monitoring of racial and ethnic health disparities in population data [2]. Using national data to report on measures of health and health care for population groups is an important tool to support health disparities elimination efforts through public health, policy, research, and programming.

To better address the health disparities presented in this brief, the Affordable Care Act makes health insurance coverage more affordable and accessible for millions of uninsured Americans, including non-elderly uninsured Hispanic/Latino males. The health care law also provides greater consumer protections, invests in prevention and wellness, and improves the quality of care. Key provisions in the Affordable Care Act offer coverage for recommended preventive services that may greatly reduce health disparities among non-elderly uninsured Hispanic/Latino males [4]. Preventive services such as blood pressure and diabetes screenings, obesity screening and counseling, immunizations, including flu vaccinations, and tobacco use screening and cessation interventions are provided with no cost-sharing [4]. Individuals with pre-existing conditions, many of which Hispanics/Latinos experience at higher rates than non-Hispanic Whites, can no longer be denied coverage [5]. Furthermore, the \$11 billion included in the Affordable Care Act to expand and establish new community health centers has increased access to culturally and linguistically appropriate care, as well as increased the number of patients served by *nearly 5 million*. The findings of this data brief will help inform targeted interventions, outreach, and enrollment efforts for non-elderly Hispanic/Latino males for enrollment in the Health Insurance Marketplace and access to high quality care.

Definitions [6]

Annual combined household income

Annual combined household income categorized as: \$34,999 or less, \$35,000 to \$74,999, and \$75,000 or greater. Observations missing on income were not shown.

Diagnosed hypertension

To be classified with diagnosed hypertension, non-elderly Hispanic/Latino males reported being told by a doctor or other health professional that they had hypertension on two or more different visits.

Educational attainment

Education was categorized as less than high school; high school graduate, including certificate of general education development (GED); or some college or greater.

Health insurance coverage

Non-elderly Hispanic/Latino males were considered insured if they had any private health insurance, government-, or state-sponsored health insurance plans.

Hispanic/Latino ethnicity [7]

Based on non-elderly males self-identifying as Cuban, Mexican, Puerto Rican, Dominican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic/Latino or Latino." The NHIS includes two questions on Hispanic ethnicity:

1. "Do you consider yourself Hispanic/Latino?", and
2. "Please give me the number of the group that represents your Hispanic origin or ancestry. You may choose up to five (5) if applicable."

Marital Status

Non-elderly Hispanic/Latino males who were not married included those reported to be widowed, divorced, separated, or never married.

Nativity and years in the United States

Nativity refers to place of birth and was based on a geographical place of birth recode provided by the NCHS/NHIS. For this study, two places of birth were analyzed: U.S.-born and foreign-born. The U.S.-born population includes anyone born in one of the 50 United States, the District of Columbia or a U.S. territory. The foreign-born population includes anyone who was not born in the United States or a U.S. territory. *Years in the United States* refers to the respondent's answer to "Years that {respondent} has been in the U.S." This question was asked of all respondents that were not born in the United States.

Smoking status

Those who reported smoking fewer than 100 cigarettes in their lifetime were classified as never smokers. Former smokers reported smoking 100 cigarettes or more in their lifetime and did not currently smoke every day or on occasion. Current smokers were classified as having smoked 100 cigarettes in their lifetime and currently smoking every day or on occasion.

Weight status

Weight status was based on body mass index (BMI, kg/m²). BMI classifications were based on cut-points established by the World Health Organization, using self-reported height and weight [3]. Individuals classified as underweight, BMI less than 18.5 kg/m², are not shown. Individuals with a BMI between 18.5 kg/m² to 24.9 kg/m² were classified as healthy weight; 25.0 kg/m² to 29.9 kg/m² were considered overweight; and individuals with BMI of 30 kg/m² and above were classified as obese.

Usual place for preventive care

Non-elderly Hispanic/Latino males were classified as having a usual place for preventive care if they reported going to a: 1) clinic or health center; 2) doctor's office or HMO; 3) hospital outpatient department; 4) some other place; or 5) doesn't go to one place most often were. Non-elderly Hispanic/Latino males who reported not obtaining preventive care anywhere or going to the emergency room for preventive care were classified as not have a usual place for preventive care.

Data Sources and Methods

Analyses in this data brief were based on National Health Interview Surveys collected from 2002-2012. Sampling weights were used to produce national estimates that were representative of the civilian non-institutionalized U.S. population. To identify a sample of non-elderly persons, our analysis was limited to adult Hispanic males (ages 18 to 64 years). In addition, women, males 65 and over, and persons who did not self-identify as being of Hispanic/Latino/Spanish origin were also excluded. These exclusions yielded a final sample of 21,483 non-elderly Hispanic/Latino males. All references in this data brief to Hispanic/Latino males included non-elderly persons residing in the United States who self-identify as Hispanic/Latino/Spanish origin.

Chi-square tests were used to assess the proportional differences for demographic and health measures by Hispanic/Latino group. P-values <0.050 were considered statistically significant. Statistical analyses were conducted using STATA 13 [8] to account for the complex sample design of the NHIS. Data were analyzed using sample weights to account for differential probabilities of sample selection, non-response, and sample non-coverage. All prevalence estimates were age-standardized to the 2000 U.S. population [9]. All estimates in this data brief have a relative standard error (RSE) less than 2.5 percent.

The authors intentionally did not use the terms "ethnic subgroups" or "subgroups" in reference to the categories within Hispanic/Latino groups. The use of Hispanic/Latino groups (and not the term subgroup) is consistent with the Hispanic Community Health Study/Study of Latinos (National Heart, Lung, and Blood Institute, National Institutes of Health) [1].

Limitations

Because we used a nationally representative sample of non-elderly Hispanic/Latino males from the CDC/NCHS/NHIS, all variables included in this analyses were self-reported and subject to recall bias. Also, the NHIS only collects data on non-institutionalized persons; thus, our findings are not generalizable to incarcerated populations, military personnel, or adults in nursing homes or other long-term care facilities.

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