Older Immigrants and Health Insurance:
Differences by Region of Origin in Patterns and Sources of Coverage

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Much attention has been paid to the aging of the U.S. population. Because most people aged 65 and older rely on either Medicare (for health and hospital insurance) or Medicaid (for long term care), a major focus has been on the increased medical costs likely to accompany this demographic shift. Less attention has been paid to the growing diversity of that population, particularly to the growth in the older foreign-born population. For this group, health insurance coverage is less common. Special health insurance programs for foreign born children and pregnant women provide a safety net for these vulnerable subgroups, but programs for foreign born adults are less common and more restrictive.

In the past 20 years, the older foreign-born population grew from 2.7 million to 4.6 million (U.S. Census Bureau). This growth reflects the aging of immigrants who migrated earlier in the 20th century as children or young adults as well as the recent acceleration in immigrants arriving at older ages through family reunification (U.S. DHS 2006). More than one-third of these more recently arrived immigrants come from Latin America, and another 30 percent come from Asia (U.S. DHS 2004). Although the current population of the 65 and older foreign born reflects the European ancestry of the early 20th century wave of immigrants, those on the verge of old age reflect the Latin American and Asian ancestry of the late 20th century arrivals. By 2050, the proportion of foreign-born elderly who are Hispanic or non-Hispanic Asian is expected to increase to about 70 percent (U.S. Census Bureau, 2003).

Immigrants differ not only by region of origin, but also in their education, work skills, family structure, and language ability. These characteristics shape their employability, economic success, interaction with federal and state bureaucracies, and the likelihood that they will become citizens, all of which can have important implications for HI coverage. In addition, their length of residency and year of arrival places them in a particular policy context that may further restrict their eligibility for government subsidized HI programs.

In this paper, we provide a detailed examination of how foreign born from various regions of the world compare to the native born population in the stability of health insurance coverage in the years before retirement age, with specific attention to the sources of health insurance coverage. Using the two more recent SIPP panels and monthly reports of coverage, we view sequences of source-specific coverage as a latent pathway that impedes or facilitates health maintenance in pre-retirement (and for many, pre-Medicare coverage). Although coverage after age 65 is less common among foreign-born than native-born, changes in coverage and the substitution of one source for another are less frequent. We therefore concentrate on those aged 50-64 at first observation and follow them until the observation period ends or they reach age 65.

In drawing our comparisons, we will address the compositional difference among the foreign-born subgroups, since average age, employment status, level of education, household income, citizen status, facility with English, and years in the U.S can vary across subgroups. All

of these factors have been linked to HI coverage, and all differ between the foreign-born and the native born.

We expect that health insurance disadvantages of older immigrants will be visible in several ways. First, because of the connection between health insurance and certain types of employment, we expect older immigrants not only to have lower rates of coverage than native-born, but also to be less likely to have private coverage. Second, to the extent that immigrants from different regions experience different levels of disadvantage, we expect older European immigrants to look most like native born, with stable sequences of private coverage. We also expect those from Latin America to be overrepresented in groups of intermittent, public, or no HI coverage. Foreign-born adults are more likely to work in jobs that offer no coverage, may be ineligible for Medicaid because of legislative restrictions, and are three times as likely as native-born adults to be uninsured (Buchmueller, et al., 2007). We argue that current practices leave a significant minority of older foreign born residents inconsistently covered.

Data and Design

We study respondents aged 50 to 64 from the pooled 2004 and 2008 panels of the Survey of Income and Program Participation (SIPP), a longitudinal survey based on separate, independent samples of respondents who are interviewed every four months for up to four years. We set our age limit at 50 because clinical guidelines and public health recommendations suggest age 50 as a marker when screening for various forms of cancer and increasingly common chronic conditions should begin or occur more frequently (CDC, 2013). Pooling the 2004 and 2008 panels provides us with a longer overall time span and a larger number of foreign-born. Respondents were interviewed a total of 12 times over a span of 4 years.

SIPP has a number of strengths for studying changes in health insurance coverage. Respondents are followed over time regardless of whether they remain in the original households or leave to form new ones. They provide prospective longitudinal information on their health insurance coverage. Finally, because of the large size of the SIPP samples, the number of older immigrants is sufficient for subpopulation comparisons, including comparisons among immigrants by region of origin. SIPP has an attrition rate of about 35% over the four years of the survey; attrition rates between natives and immigrants are similar.

Variables. Our primary interest is in examining the sources and stability of HIC among subgroups of older foreign-born versus native-born persons as they transition from late midlife to old age. Because eligibility for Medicare at age 65 reconfigures HIC, in general, and the risk of being uninsured, in particular, we look only at those aged 50-64. We use a sequential series of trichotomous indicators coded '1' if respondents report having no health insurance, '2' if the primary payer is public insurance, and '3' if the primary payer is private insurance (including employer sponsored and self-financed policies). We then include region of origin as a covariate for HIC sequencing to test whether region of origin predicts membership in various latent classes. We specify the regions of Asia, Europe, Latin America, and a residual 'Other' category for those from remaining regions; we use the 'native born' as our reference group.

We use repeated measures latent class analysis, which unlike general growth mixture modeling does not require that a functional form be specified, allowing for more discrete

changes to model the HIC profiles for those aged 50 to 64 (Collins and Lanza, 2010). Missing data for type of health insurance coverage, including missing due to attrition is handled in the SAS procedure PROC LCA with full-information maximum likelihood.

Results

Table 1 reports the class membership probabilities and the point estimates for the region of origin groups with their Wald-based significance levels. The exponentiated coefficients can be interpreted as odds ratios. We identify 8 classes (based on the fit statistics of G-squared, AIC, and BIC) that combine profiles of stability with profiles of intermittency. Each HI source is associated with one stable profile. Classes 4, 7, and 8 are characterized by steady coverage from public programs, steady coverage from private policies, or no coverage, respectively. Classes 2 and 6 reflect the substitution of public coverage with private sources as well as the reverse. Classes 1, 3, and 5 are alternative sequencing between no coverage and private coverage or public coverage.

Figure 1 graphs the frequencies of class membership among those 50-64. Having stable private health insurance is the most common pattern (60%). The second largest class however is being consistently uninsured (11%), and another 15% are in latent classes characterized by no coverage during part of the time period. Having steady public coverage is the third most common class (10%), with the remaining classes alternating between private and public coverage. As we hypothesized, membership into these classes is associated with region of origin.

Figure 2 illustrates class membership probabilities by region of origin, making clear the HIC disadvantages of the foreign born, in general, but also the particular disadvantage of the foreign born from Latin America. The profile for 'steady private coverage' contains about 3 in four of the native born, but only 2.5% of those from Latin America.   The 'steady public coverage' class varies the least across region of origin, ranging from about 8 to 11 percent, with the native born and Latin American foreign born at the lower end of that range.

The profiles for intermittent or substituted coverage also demonstrate the fragility of coverage—particularly private coverage—for older Latin American immigrants. If we look at the 'none to Private' and 'public to private' profiles, we see that almost one-third of older Latin American immigrants are able to obtain private coverage during the observation period. Unfortunately, when we look at the 'private to none' and the 'private to public' profiles, it appears that about 13% are unable to retain their private coverage for even the relatively short period of 3-4 years.

Conclusion

Because of the association between health insurance coverage and access to health care, those without health insurance coverage are much more likely to forego treatment, screening, and follow-up for new and existing conditions. Among those in older age groups, for whom the risk of acute and chronic conditions increases, the failure to have routine medical care can accelerate the progression of disease and exacerbate the onset of disabling health conditions. For those who ultimately receive coverage—perhaps under Medicare at age 65—higher health care costs may be incurred.

In our longitudinal analysis of 50 to 64 year old respondents, we identified various classes of coverage, which differed in their stability in the source of insurance coverage. That many of these classes reflected periods without any coverage underscores the fragility of access for many of those nearing normal retirement age. These changes in coverage may reflect changes in eligibility for public health insurance programs or changes in employment and the availability of fringe benefits. Almost 20% of respondents have changes in the source of health insurance over the observation period. We find that immigrants are more likely to have no health insurance and be in volatile trajectories compared to the native born. Immigrants from Latin America are especially disadvantaged, indicating that the current health care system is not addressing the needs of this group adequately. Immigrants from Latin America are much more likely to be uninsured steadily or have a pattern of intermittent coverage. Immigrants from Asia do not fare much better in their patterns of health insurance coverage. As hypothesized, the immigrants that are most successful in maintaining health insurance, especially private health insurance, are the European immigrants. As the demographics of the older immigrant population changes, European immigrants will make up a much smaller share.

As our aging population becomes more diverse, reducing health disparities requires that we reduce disparities in insurance coverage. We find that having private coverage is more stable than having public health insurance, and that those with private coverage are more likely to stay insured compared to those in public programs. Expansion of public health insurance under the Affordable Care Act may help to extend coverage to groups on the margin and increase continuity in coverage. However, the Act does not address access for immigrants who have been in the U.S. fewer than five years, since the Affordable Care Act retains the restrictions adopted through welfare reform

Future research will explore differences in these patterns of health insurance coverage more thoroughly. We will examine how much of the differences by region of origin are because of compositional differences such as lower education, lower income, employment, and marital status. However, even if these factors mediate the relationship between region of origin and patterns of health insurance coverage, the problem of an underinsured migrant population remains. This paper extends our understanding of how health insurance is structured over time and across sub-populations and emphasizes the volatility in coverage experienced by those groups of foreign-born adults growing most rapidly. If our goal as a society is to expand health insurance coverage to all individuals, we cannot continue to ignore how immigrants' coverage differs from that of the native born.

Table 1: Class Membership and Odds of membership by Region of Origin						
Class	Membership Probability	Odds of class membership by Region of Origin	Europe	Asia	Latin America	Other
1 None->Private	0.047		0.5774*	2.2861*	7.0469*	2.6498*
2 Public->Private	0.030		0.6572	2.9341*	5.5432*	2.5731*
3 Private->None	0.047		0.3761*	1.0097	3.383*	2.469*
4 Steady Public	0.098		0.5272*	1.4633*	3.6536*	1.6705*
5 None->Public	0.031		0.4197*	1.8828*	7.7867*	2.6668*
6 Private->Public	0.032		0.5119*	1.0528	1.8813*	1.6666*
7 Steady Private	0.605		(Ref.)	(Ref.)	(Ref.)	(Ref.)
8 Steady Uninsured	0.110		0.5138*	2.0619*	10.3375*	2.3986*
*=p<.05						

Figure 1:
Class Membership Proabilities for Health Insurance Coverage

Legend:
- None-> Private
- Public->Private
- Private->None
- Steady Public
- None->Public
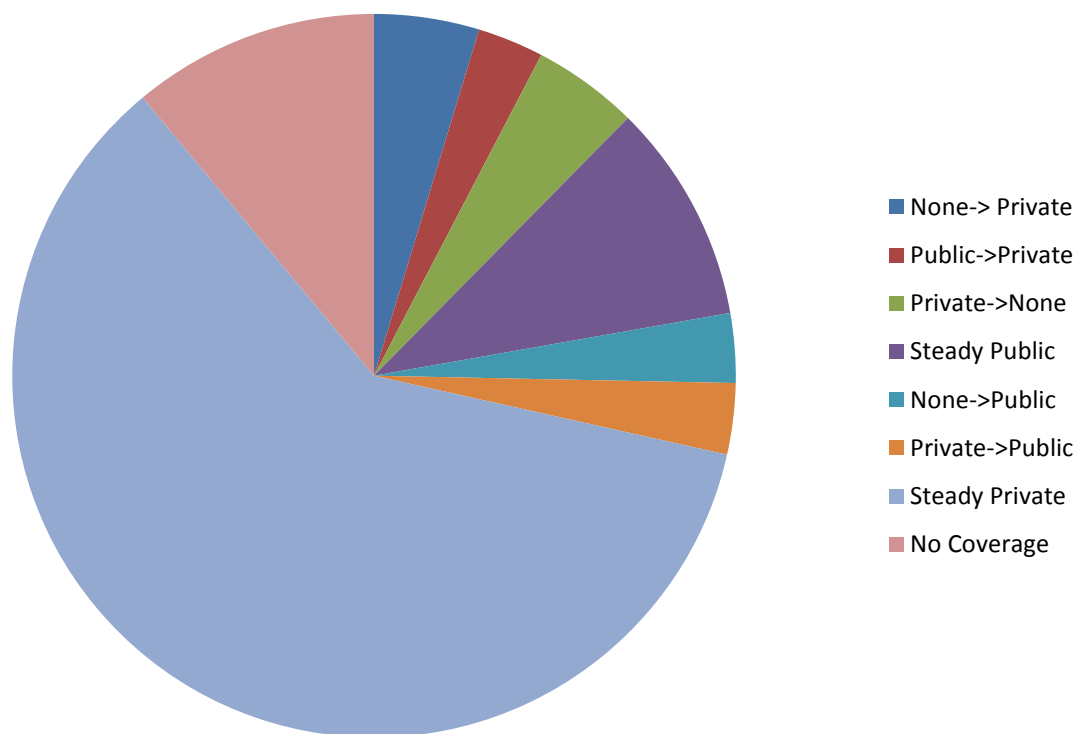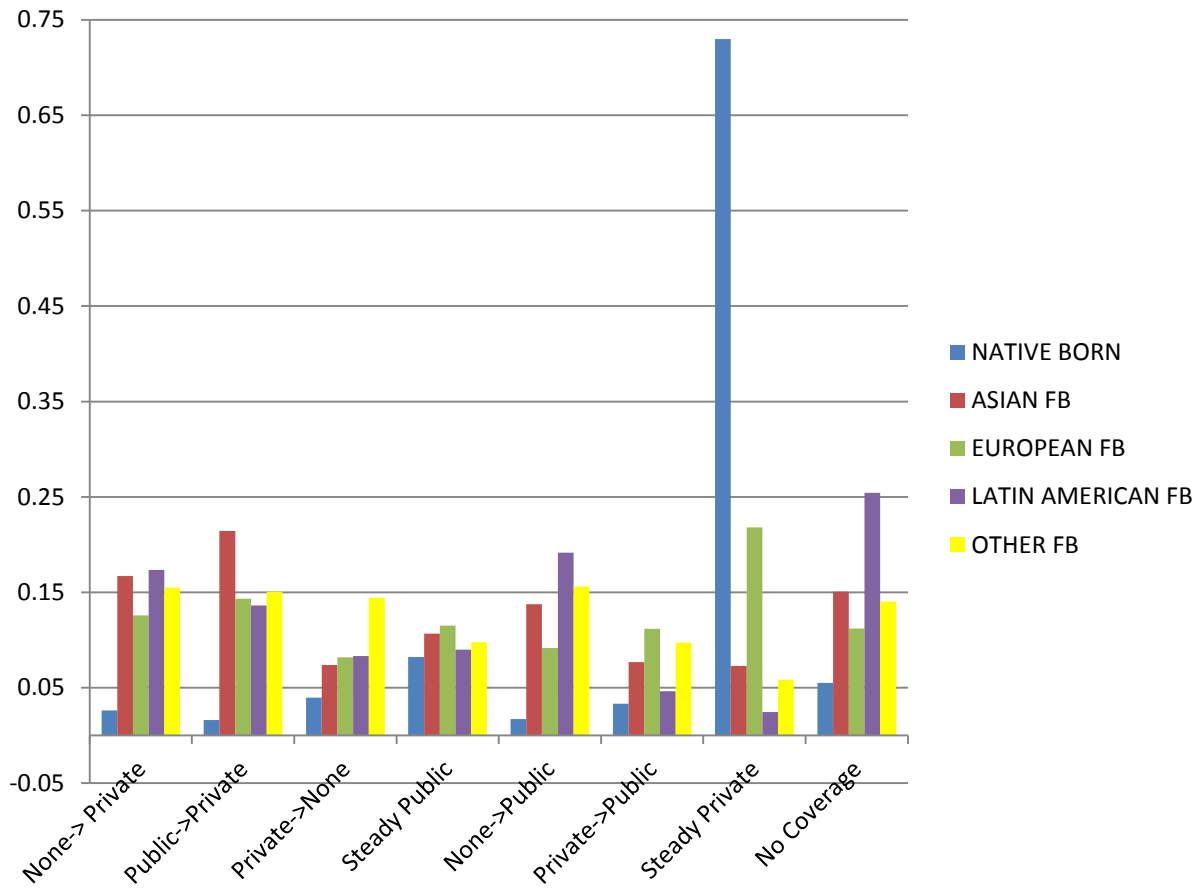- Private->Public
- Steady Private
- No Coverage

Figure 2. Probabilities of Latent Class Membership by Region of Origin

References

Collins, Linda M. and Stephanie T. Lanza. 2010. *Latent Class and Latent Transition Analysis*. Wiley: Hoboken, NJ

U.S. Census Bureau, 2003. National Population Projections

U.S. Census Bureau, Current Populatin Survey. Annual Social and Economic, 2011.

U.S. Department of Homeland Security, 2004. Table 8: Immigrants admitted by selected class of admission and region and country of birth: fiscal year 2004, Yearbook of Immigration Statistics.