Welfare Reform and Older Immigrants' Health Insurance Coverage

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Objectives. I examined changes in older immigrants' health insurance coverage after welfare reform in the United States to determine whether the reform measures achieved their goal of saving money by reducing Medicaid participation without increasing the number of uninsured people.

Methods. Data were obtained from older adults who participated in the Current Population Survey's Annual Social and Economic Supplement from 1994 to 1996 and 2001 to 2005. I used logistic regression to estimate changes in the sample's Medicaid and health insurance coverage after welfare reform, paying special attention to noncitizens and recent immigrants.

Results. Older immigrants' health insurance status was associated with their citizenship status and length of stay in the United States. Medicaid participation significantly decreased among noncitizens and recent immigrants but increased among naturalized citizens. Private health insurance and employer-sponsored insurance coverage significantly increased among recent immigrants but decreased among established immigrants and naturalized citizens. The probability of being uninsured did not significantly change among any group of immigrants.

Conclusions. Given increases in postreform Medicaid participation among some immigrant groups, my findings suggest that the long-term cost-saving effectiveness of the current restrictive Medicaid eligibility policy is doubtful. (*Am J Public Health*. 2008;98:2029–2034. doi:10.2105/AJPH.2007.120675)

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 dramatically limited immigrants' access to Medicaid by imposing restrictive eligibility rules. The Personal Responsibility Act was intended to reduce the costs of public-assistance programs by shifting the responsibility for supporting poor immigrants away from the federal government and onto individual immigrant households.[1] This legislation prohibited states from providing federally funded Medicaid to postenactment immigrants (those who immigrated to the United States after the law was enacted) during their first 5 years in the country, and it granted states the right to determine the Medicaid eligibility of preenactment immigrants (those who entered the United States before the law was enacted) and of postenactment immigrants after their first 5 years in the country. During the study periods, most states provided Medicaid to noncitizens eligible for federally funded Medicaid, and several states (e.g., California) provided state-funded Medicaid to postenactment immigrants subject to the 5-year ban. The Personal Responsibility Act also imposed the "deeming" process, which requires benefit-granting agencies to include the income of immigration sponsors (those who invited immigrant applicants to the United States) when determining noncitizens' financial Medicaid eligibility. As a result, noncitizens—especially recent immigrants—have had very limited access to Medicaid since the law was enacted.[2,3]

There has been little research on whether or how these policy changes have affected older immigrants' health insurance coverage. Existing studies focus on younger immigrants, such as children or working-age adults. These studies show that after welfare reform, Medicaid participation rates declined more rapidly among immigrants than among natives.[4–6] A few studies have investigated welfare reform's effects on immigrants' health insurance coverage and Medicaid participation. Based on findings from a nonelderly sample, Borjas[4] argued that Medicaid eligibility restrictions did not affect health insurance coverage among noncitizens. Although strict eligibility rules discouraged noncitizens' Medicaid participation, the new rules also encouraged noncitizens' participation in employer-sponsored health insurance. As a result, the percentage of immigrants with health insurance coverage remained stable (at approximately 61%) after welfare reform.

However, another study, which focuses on a more vulnerable population, told a different story: among the children of foreign-born single mothers, the percentage uninsured increased by 9% after welfare reform, whereas the percentage uninsured among the children of native single mothers increased by only 2%.[7] Carrasquillo et al.[8] estimated that 100 000 to 140 000 uninsured immigrant children and 250 000 uninsured immigrant parents would become eligible for Medicaid if noncitizen restrictions were repealed.

Although these studies are valuable, they are limited by their focus on younger populations. Older immigrants warrant study as a separate group because they often face challenges that younger immigrants do not. For example, older immigrants are less able to learn English and memorize new information, which may make it harder for them to pass the US citizenship test.[9] In addition, their labor market participation rate is generally low,[10] which may make it harder for them to counter eligibility restrictions by working. Furthermore, older adults tend to have poorer health[11–13] and to need health insurance more urgently than do their younger counterparts do. Finally, the proportion of immigrants among older adults increased from 8.6% in 1990 to 10.8% in 2003.[14] These facts indicate that health care policymakers should study the needs of this vulnerable but growing population.

To the best of my knowledge, only 1 study has conducted separate analyses of older immigrants' Medicaid participation. Fix and Passel[5] showed that older noncitizens' Medicaid participation remained the same (28.2%) between 1994 and 1997, whereas older naturalized citizens' Medicaid participation increased from 11.1% to 14.9% during the same period. However, Fix and Passel's study was limited because it examined neither private insurance coverage nor the uninsurance rate, its study period ended just after welfare reform (1997),

and it did not provide information on recent immigrants who were ineligible for federally funded Medicaid. To fill the gaps in existing research, I examined the way Medicaid participation and health insurance coverage changed among older immigrants after welfare reform, to determine whether the reform measures achieved their goal of saving money by reducing Medicaid participation without increasing the number of uninsured people.

METHODS

Data Source and Sample

I used data from the Current Population Survey's (CPS's) Annual Social and Economic (ASEC) Supplement, collected during 1994 to 1996 and 2001 to 2005. The CPS collects extensive information on economic, social, and demographic characteristics from a nationally representative sample of the noninstitutionalized civilian population. My sample, therefore, does not include older adults living in institutions such as long-term-care facilities. Because the ASEC Supplement asked about health insurance coverage status in the year before the interview, the 1994 to 1996 CPS data covered a period before welfare reform (1993–1995), whereas the 2001 to 2005 data covered a period after welfare reform (2000–2004). I did not include the CPS data collected in 1997 to 2001, during which recent immigrants included both pre- and postenactment immigrants, each group of which were under different eligibility rules.

The sample consisted of adults who were 65 years or older at the time of the interview. The sample excluded American Indians because CPS health insurance coding schemes categorized the Indian Health Service program inconsistently across observation periods.[15] The final sample consisted of 148 807 older adults.

Measures

There were 4 dependent variables: Medicaid participation, private health insurance coverage, employer-sponsored insurance coverage, and no health insurance coverage. For the 3 health insurance variables, I assigned 1 to those who reported having the insurance in question and 0 to those who reported not having it. Because employer-sponsored insurance is 1 type of private health insurance, everyone identified as having employer-sponsored insurance also has private insurance. To avoid unnecessary complication, I did not develop multiple coverage variables; therefore, some individuals in the sample have 1 for all 3 health insurance variables.

Given the high rate of Medicare coverage among the older population, a substantial proportion of older adults covered by Medicaid and private insurance may also have Medicare coverage; however, I did not focus on Medicare because welfare reform does not seem to have directly affected it. The uninsured variable was coded 0 for an individual with Medicare, Medicaid, private insurance, or military health insurance, and it was coded 1 for an individual without insurance.

In creating these health insurance variables, I paid close attention to a change in the CPS health insurance questions and developed comparable measures between pre- and postreform periods. In 2000 the CPS added a health insurance verification question that decreased the estimated uninsurance rate by about 8%,[16] so I categorized as uninsured those whom this verification question identified as insured. As a result, I overestimated the percentage of uninsured, thereby ensuring that my statistics were commensurable across the observation periods.

I created 3 types of immigration variables. The first measure was based on immigration status and consisted of native-born citizens (people born in the United States, Puerto Rico, or US territories and outlying areas, or people born abroad to a US-citizen parent; i.e., people who are US citizens at birth) and immigrants. The second measure, based on citizenship status, categorized the sample into 3 groups: native-born citizens, naturalized citizens (foreign-born people who became citizens through naturalization), and noncitizens (foreign-born people who had not become citizens). The third variable, based on length of stay in the United States, consisted of native-born citizens, established immigrants (those who had lived in the United States for 5 or more years), and recent immigrants (those who had lived in the United States for less than 5 years).

Analysis

I used multivariate logistic regression to analyze the data. To evaluate the effect of welfare reform on older immigrants, I used a differences-in-differences approach that compared outcome measures (e.g., Medicaid participation) between the target population (e.g., noncitizen) and nontarget population (e.g., native-born citizen), and I examined the way these 2 groups differed pre- and postreform. This approach separated noncitizen eligibility restrictions from other factors that may have affected immigrants and native-born citizens alike (e.g., increases in private insurance premiums).

In addition to demographic and household variables (Table 1), the models included 3 major variables: immigration status (with native-born citizens as the reference group), welfare reform indicator (with a prereform sample as the reference group), and the interaction term between these 2 variables. The third variable, the interaction term, is the parameter of interest here. It showed how the difference in an outcome measure (e.g., Medicaid participation) between immigrants and native-born citizens changed after welfare reform when other related factors were controlled for. If the odds ratio of this interaction term is smaller than 1 and significant, immigrants' Medicaid and other health insurance coverage significantly decreased after welfare reform, compared with that of native-born citizens. I ran 3 different models based on types of immigration variables: immigration status, citizenship status, and length of stay.

Some sample households that included more than 1 older person had multiple observations, so I estimated statistical models with robust standard errors.[17] Following the US Census Bureau's instructions, I weighted the data with the ASEC Supplement person-weight variable for both descriptive and multivariate analyses. The CPS weight variables were created to address the issues of sampling design, nonresponses, and other nonsampling errors.[18]

In addition to the models reported here, I ran models with wealth indicators. Because the CPS does not provide sufficient data to determine total household wealth,[19] I used 2 other indicators that were available: having asset income and owning a house. Findings from models with these variables are consistent with the major findings reported here. (Full results from this alternative model are available from the author.)

TABLE 1—Characteristics of Immigrant and Native-Born Participants (N = 148 807) Before and After Welfare Reform: Current Population Survey's Annual Social and Economic Supplement, 1994–1996 and 2001–2005

					Immigrants, Citizenship Status				Immigrants, Length of Stay			
	Native-Born Citizens		Immigrants, Total		Naturalized Citizens		Noncitizens		Established[a]		Recent[b]	
Characteristics	Prereform	Postreform	Prereform	Postreform	Prereform	Postreform	Prereform	Postreform	Prereform	Postreform	Prereform	Postreform
Percentage of sample	91.32	89.59***	8.68	10.41***	5.34	7.37***	3.34	3.03***	8.21	9.90***	0.46	0.50
Race, %												
White	88.41	86.80**	56.47	45.27***	70.14	50.30***	34.62	33.03***	57.66	46.17***	35.22	27.55***
Black	8.48	8.68	2.77	4.75	2.13	4.44	3.79	5.50	2.42	4.62	8.94	7.18
Hispanic	2.51	3.28	26.30	28.84	17.51	24.90	40.36	38.43	26.76	28.34	18.12	38.73
Asian	0.56	0.78	14.15	21.11	9.99	20.33	20.81	23.00	12.92	20.83	36.09	26.53
Other	0.04	0.46	0.30	0.04	0.23	0.04	0.42	0.04	0.23	0.04	1.64	0.00
Age, %												
65–69 y	31.07	27.83***	29.48	32.67***	27.08	30.67***	33.32	37.55***	29.67	32.16***	26.16	42.79***
70–74 y	27.31	24.75	27.18	24.37	26.82	23.45	27.76	26.62	26.51	24.12	39.22	29.42
75–79 y	20.21	22.08	15.94	20.47	16.66	21.54	14.80	17.87	15.73	20.70	19.73	15.83
≥80 y	21.41	25.33	27.39	22.48	29.43	24.35	24.12	17.96	28.09	23.02	14.90	11.96
Gender, %												
Women	58.23	57.28***	60.09	57.91**	59.06	57.39	61.74	59.19	60.32	57.85**	56.11	59.07
Men	41.77	42.72	39.91	42.09	40.94	42.61	38.26	40.81	39.68	42.15	43.89	40.93
Education, %												
Less than high school	35.13	26.59***	47.32	42.62***	38.22	36.78***	61.87	56.82***	46.96	42.03***	53.68	54.07
High school diploma	34.67	36.94	27.25	26.36	30.57	28.55	21.94	21.04	27.46	26.68	23.43	20.09
College	30.19	36.46	25.43	31.02	31.21	34.67	16.20	22.14	25.58	31.28	22.88	25.83
Currently married, %												
Yes	56.15	56.07	51.82	55.60***	53.75	57.24***	48.75	51.61*	51.66	56.03***	54.73	47.14*
No	43.85	43.93	48.18	44.4	46.25	42.76	51.25	48.39	48.34	43.97	45.27	52.86
Household size	1.92	1.91	2.51	2.62***	2.12	2.36***	3.12	3.26**	2.42	2.56***	4.02	3.85
Mean per capita household income, $	20 627	23 078***	18 015	19 706***	20 173	21 197*	14 567	16 081***	18 205	19 982***	14 623	14 299
Unweighted sample size	47 361	86 014	4876	10 556	2 967	7 305	1 909	3 251	4 637	10 029	239	527

Note. To test the statistical significance of differences between pre- and postreform periods, I used the Pearson χ^2 statistic for categorical variables (e.g., race and education) and the Wald test for continuous variables (e.g., household size).
[a]Established immigrants were defined as those who had lived in the United States for 5 or more years.
[b]Recent immigrants were defined as those who had lived in the United States for less than 5 years.
*P < .10; **P < .05; ***P < .01, between pre- and postreform periods.

RESULTS

Descriptive Statistics

Table 1 summarizes sample characteristics by immigration status. The percentage of immigrants among older adults in the United States increased from 8.7% to 10.4% between the 2 periods. Older immigrants, especially noncitizens and recent immigrants, had less education and household income than did native-born older adults. With the exception of recent immigrants, the percentage of those without a high school diploma decreased in every group between the 2 periods, and the mean household income per person (adjusted for inflation) increased in every group between the 2 periods. Recent immigrants, by contrast, were less educated and lived in poorer households in the second period than in the first period.

Table 2 presents older adults' health insurance coverage by immigration status. Native-born citizens are better off than are immigrants in both periods. Almost all native-born citizens were insured; only a small percentage relied on Medicaid, a majority had private health insurance, and a relatively high proportion had employer-sponsored insurance. The native-born citizens' advantage was mainly because of their Medicare coverage: 97% of native-born citizens were covered by Medicare, compared with 89% of immigrants. In addition, only a small percentage of native-born citizens relied solely on non-Medicare health insurance; 3% of the insured, 1% of Medicaid recipients, and 4% of those with private health insurance did not have Medicare coverage, compared with 5%, 1%, and 11% of the same respective groups among immigrants lacking Medicare coverage. (Full results are available from the author.)

Native-born citizens' health insurance coverage changed little between the prereform

TABLE 2—Health Insurance Coverage Rates Among Immigrant and Native-Born Participants (N = 148 807) Before and After Welfare Reform: Current Population Survey's Annual Social and Economic Supplement, 1994–1996 and 2001–2005

					Immigrants, Citizen Status				Immigrants, Length of Stay			
	Native-Born Citizens		Immigrants, Total		Naturalized Citizens		Noncitizens		Established[a]		Recent[b]	
Health Insurance	Prereform	Postreform	Prereform	Postreform	Prereform	Postreform	Prereform	Postreform	Prereform	Postreform	Prereform	Postreform
Medicaid, %	7.82	8.01	20.30	21.99**	10.94	19.78**	35.26	27.38**	18.97	21.71**	43.93	27.59***
Private, %	69.49	63.49***	48.43	38.43***	59.55	43.02***	30.66	27.26**	50.28	39.39***	15.52	19.44
Employer-sponsored, %	27.13	27.73**	18.86	17.61*	22.78	20.03***	12.60	11.75	19.74	18.10**	3.26	8.15**
Uninsured, %	0.64	0.80***	4.95	6.05**	1.25	2.54***	10.88	14.58***	3.89	4.63*	23.83	33.97**
Unweighted sample size	47 361	86 014	4876	10 556	2 967	7 305	1 909	3 251	4 637	10 029	239	527

Note. To test the statistical significance of differences between pre- and postreform periods, I used the Pearson χ^2 statistic for categorical variables.
[a]Established immigrants were defined as those who had lived in the United States for 5 or more years.
[b]Recent immigrants were defined as those who had lived in the United States for less than 5 years.
*P < .10; **P < .05; ***P < .01, between pre- and postreform periods.

and postreform periods, except for private health insurance, which decreased. The same is true for immigrants as a whole, but not for immigrant subgroups. Medicaid participation increased among naturalized citizens and established immigrants, but Medicaid participation decreased among noncitizens and recent immigrants. Also, despite increases in rates for private and employer-sponsored insurance for recent immigrants, the percentage of uninsured among this group increased dramatically after welfare reform, from 24% to 34%.

Multivariate Analysis Results

Table 3 reports logistic regression results. The primary parameter of interest in this analysis was the interaction term between immigration variables and the welfare reform indicator that indicates how differences between native-born citizens and immigrants changed between pre- and postreform periods. Medicaid participation among immigrants as a whole did not change after welfare reform, as shown in model 1. However, naturalized citizens' Medicaid coverage significantly increased relative to that of native-born citizens, whereas noncitizens' Medicaid coverage significantly decreased relative to that of native-born citizens. Established immigrants' probability of participating in Medicaid did not change significantly, but recent immigrants' probability of participating in Medicaid decreased significantly.

Rates of coverage by private insurance and employer-sponsored insurance also differed by immigration status. Coverage by private insurance and employer-sponsored insurance declined more among naturalized citizens than among noncitizens. Established immigrants experienced significant declines in private and employer-sponsored insurance coverage, whereas recent immigrants experienced statistically significant increases. The probability of being uninsured did not change significantly among any group of immigrants.

DISCUSSION

I used CPS data to examine how older immigrants' health insurance coverage changed after welfare reform. My findings showed that changes in older immigrants' health insurance status after welfare reform were associated with their citizenship status and their length of stay in the United States. Multivariate logistic regression results showed that Medicaid participation significantly decreased among noncitizens and recent immigrants and that the rate of private health insurance and employer-sponsored insurance coverage increased among recent immigrants. These findings, along with nonsignificant changes in the probabilities of being uninsured, may lead some to conclude that the Personal Responsibility Act's noncitizen eligibility restrictions achieved their goal: reducing Medicaid participation among noncitizens without increasing the percentage of uninsured among this group.

However, other study findings cast doubt on the long-term effectiveness of Medicaid eligibility restrictions. The probability of participating in Medicaid significantly increased among naturalized citizens, and the chances of having private health insurance and employer-sponsored insurance significantly decreased among established immigrants and naturalized citizens. As a result of the mutually offsetting changes in coverage between naturalized citizens and noncitizens, and between established and recent immigrants, the probability of Medicaid participation among older immigrants as a whole did not significantly change.

These findings suggest that Medicaid eligibility restrictions may have affected the likelihood of older immigrants becoming naturalized and their position in the labor market without affecting their Medicaid participation per se. Differences in insurance coverage changes between naturalized citizens and noncitizens suggest that welfare reform may have promoted naturalization among older immigrants; older noncitizens who had received Medicaid before welfare reform may have become naturalized to secure their Medicaid benefits after welfare reform. This finding is consistent with those reported by Van Hook.[20]

Findings utilizing the length-of-stay variable suggest that established immigrants may have

TABLE 3—Adjusted Odds Ratios (AORs) for Health Insurance Coverage Status: Current Population Survey's Annual Social and Economic Supplement, 1994–1996 and 2001–2005

	Medicaid Coverage, AOR (95% CI)	Private Insurance Coverage, AOR (95% CI)	Employer-Sponsored Insurance, AOR (95% CI)	No Health Insurance Coverage, AOR (95% CI)
		Model 1[a]		
Native born (Ref)	1.00	1.00	1.00	1.00
Immigrant	1.90 (1.73, 2.08)	0.63 (0.58, 0.67)	0.77 (0.70, 0.84)	4.00 (3.17, 5.04)
Welfare reform	1.14 (1.09, 1.20)	0.68 (0.67, 0.71)	0.95 (0.92, 0.98)	1.30 (1.11, 1.52)
Immigrant × welfare reform	0.97 (0.87, 1.09)	0.89 (0.82, 0.98)	0.89 (0.80, 0.99)	0.91 (0.71, 1.16)
Wald χ^2 (*df*)	8008.29 (16)	12809.92 (16)	7642.02 (16)	3072.30 (16)
		Model 2[b]		
Native born (Ref)	1.00	1.00	1.00	1.00
Naturalized citizen	1.16 (1.01, 1.33)	0.78 (0.72, 0.86)	0.87 (0.78, 0.96)	1.49 (0.98, 2.27)
Noncitizen	3.12 (2.74, 3.56)	0.41 (0.36, 0.46)	0.58 (0.49, 0.68)	7.25 (5.56, 9.44)
Welfare reform	1.14 (1.09, 1.20)	0.69 (0.67, 0.71)	0.95 (0.92, 0.98)	1.28 (1.10, 1.50)
Naturalized citizen × welfare reform	1.62 (1.39, 1.90)	0.75 (0.68, 0.84)	0.86 (0.76, 0.97)	1.31 (0.83, 2.06)
Noncitizen × welfare reform	0.62 (0.53, 0.73)	1.11 (0.95, 1.30)	0.86 (0.71, 1.06)	1.07 (0.82, 1.41)
Wald χ^2 (*df*)	8155.32 (18)	12727.51 (18)	7635.82 (18)	3657.20 (18)
		Model 3[c]		
Native born (Ref)	1.00	1.00	1.00	1.00
Established immigrant	1.76 (1.60, 1.93)	0.67 (0.62, 0.72)	0.81 (0.74, 0.89)	3.27 (2.58, 4.15)
Recent immigrant	5.43 (3.70, 7.97)	0.15 (0.10, 0.23)	0.12 (0.06, 0.24)	15.97 (9.96, 25.58)
Welfare reform	1.14 (1.09, 1.20)	0.69 (0.67, 0.71)	0.95 (0.92, 0.98)	1.29 (1.10, 1.51)
Established immigrant × welfare reform	1.06 (0.95, 1.19)	0.85 (0.78, 0.93)	0.86(0.77, 0.96)	0.88 (0.68, 1.15)
Recent immigrant × welfare reform	0.33 (0.21, 0.52)	2.28 (1.37, 3.80)	2.87 (1.29, 6.40)	1.18 (0.70, 1.96)
Wald χ^2 (*df*)	7983.80 (18)	12763.06 (18)	7660.24 (18)	3418.12 (18)

Note. CI = confidence interval. Logistic regression analyses were controlled for demographic and economic variables (race and Hispanic origin, age, gender, education, marital status, household size, and per capita household income). The *P* value of the Wald test for model fit is significant at .01.
[a]Model 1 compared immigrants with native-born citizens.
[b]Model 2 compared naturalized citizens and noncitizens with native-born citizens.
[c]Model 3 compared established and recent immigrants with native-born citizens.

faced strong competition in the labor market from recent immigrants ineligible for Medicaid and other public benefits. As shown in Table 3, established immigrants' coverage by private health insurance—especially by employer-sponsored insurance—decreased after welfare reform, whereas the same types of insurance coverage increased among recent immigrants. Also, multivariate analysis of older adults' labor market participation showed that recent immigrants' labor market participation increased significantly after welfare reform, whereas established immigrants' labor market participation did not change significantly. (Full results are available from the author.) This evidence is, of course, only preliminary and warrants further investigation.

Of particular interest is a dramatic increase in the rate of being uninsured among recent immigrants. Table 2 shows that the percentage of uninsured among recent immigrants increased from 24% before reform to 34% after reform. Although the statistical significance shown in bivariate analysis disappeared after controlling for demographic and household characteristics in multivariate analysis, this finding demonstrates that this vulnerable population's position in the health care system has worsened after welfare reform.

Limitations

This study was limited by the fact that the CPS is not a longitudinal data set and thus did not allow me to follow the same individuals' health insurance coverage over time. Accordingly, the dynamic process by which older immigrants responded to eligibility restrictions could not be fully investigated. Also, this study's results may be biased because the CPS data were collected without any systematic guidelines for field interviewers to use when working with interpreters to interview non–English-speaking households, thus perhaps affecting data collection and subsequent analysis results.[21]

In addition, this study is focused on changes in federal policy; I did not explicitly take into account state variations in Medicaid policies because complete information on state policies was not available. Because a few states provide state-funded Medicaid coverage to ineligible noncitizens, Medicaid access in these states may differ from that in other states, which may have introduced a bias into the study results.

Another limitation is my overestimation of uninsurance rates and underestimation of health insurance coverage rates. I did this

because the CPS in 2000 added a health insurance verification question that decreased the estimated uninsurance rate by about 8%. To ensure that my statistics were commensurable across the observation periods, I categorized as uninsured those whom this verification question identified as insured, which resulted in an overestimation of uninsurance rates and underestimation of health insurance coverage rates. My health insurance variables are therefore comparable between the 2 periods, but the potential measurement errors I may have introduced should be kept in mind.

Policy Implications

My study's findings show that the long-term cost-saving effectiveness of restricting Medicaid eligibility is doubtful. These eligibility restrictions may have been effective in delaying ineligible older immigrants' participation in Medicaid, but they have been ineffective in helping this group find a permanent alternative.

Medicaid eligibility restrictions have also been shown to be a counterproductive way to address the high uninsurance rate that existed among older immigrants even before welfare reform.[22] Health insurance coverage expands access to medical care and improves health outcomes,[23,24] so to the extent that Medicaid eligibility restrictions reduce rates of insurance coverage, these restrictions increase the risk of poorer health care and health outcomes among groups affected by the restrictions. Restricted access to Medicaid may also incur higher long-term costs to society by limiting access to preventive health care and increasing the use of costly emergency department care.[25] A study in New York State shows that state spending on Medicaid coverage of emergency services (about $33 million) is almost equivalent to the amount needed to provide every uninsured older immigrant with health insurance coverage.[26]

Therefore, programs to provide affordable health insurance to older immigrants should be implemented. One possibility is to open the Medicare buy-in option to all immigrants, while providing Medicaid to older immigrants who cannot afford it. The buy-in option allows older adults who lack the 40 quarters of work experience required for premium-free Medicare to buy coverage by paying premiums. Currently, the buy-in option is only available to citizens and immigrants who have lived in the United States for more than 5 years. Allowing older immigrants to buy Medicare coverage, along with provision of Medicaid to poor immigrants, will likely reduce uninsurance rates and thus reduce government spending on health care for this vulnerable population. ■

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Human Participant Protection

No protocol approval was needed for this study.

References

1. *Federal Budgetary Implications of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.* Washington, DC: Congressional Budget Office; 1997.

2. *Guide to Immigrant Eligibility for Federal Programs.* 4th ed. Los Angeles, CA: National Immigration Law Center; 2002.

3. Zimmermann W, Tumlin KC. *Patchwork Policies: State Assistance for Immigrants Under Welfare Reform.* Washington, DC: Urban Institute; 1999.

4. Borjas GJ. Welfare reform, labor supply, and health insurance in the immigrant population. *J Health Econ.* 2003;22:933–958.

5. Fix ME, Passel JS. *Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform.* Washington, DC: Urban Institute; 1999.

6. Kandula NR, Grogan CM, Rathouz PJ, Lauderdale DS. The unintended impact of welfare reform on the Medicaid enrollment of eligible immigrants. *Health Serv Res.* 2004;39:1509–1526.

7. Kaushal N, Kaestner R. Welfare reform and health insurance of immigrants. *Health Serv Res.* 2005;40: 697–721.

8. Carrasquillo O, Ferry DH, Edwards J, Glied S. Eligibility for government insurance if immigrant provisions of welfare reform are repealed. *Am J Public Health.* 2003; 93:1680–1682.

9. Treas J, Mazumbdar S. Older people in America's immigrant families: dilemmas of dependence, integration, and isolation. *J Aging Stud.* 2002;16:243–258.

10. Quadagno J. *Aging and the Life Course: An Introduction to Social Gerontology.* 3rd ed. Boston, MA: McGraw-Hill College; 2005.

11. Gruber J, Madrian BC. Health insurance and early retirement: evidence from the availability of continuation coverage. In: Wise DA, ed. *Advances in the Economics of Aging.* Chicago, IL: University of Chicago Press; 1996: 115–143.

12. Centers for Disease Control and Prevention, The Merck Company Foundation. *The State of Aging and Health in America, 2007.* Whitehouse Station, NJ: The Merck Company Foundation; 2007.

13. *Health, United States, 2007 With Chartbook on Trends in the Health of Americans.* Hyattsville, MD: National Center for Health Statistics; 2007.

14. He W, Sengupta M, Velkoff VA, DeBarros KA. *65+ in the United States: 2005.* Washington, DC: US Census Bureau; 2005.

15. *Historical Changes in the CPS Health Insurance Coverage Items, 1989–2005 Survey Years.* Minneapolis: University of Minnesota School of Public Health State Health Access Data Assistance Center; 2006.

16. Nelson CT, Mills RJ. *The March CPS Health Insurance Verification and Its Effect on Estimates of the Uninsured.* Washington, DC: US Census Bureau; 2001.

17. Greene WH. *Econometric Analysis.* 5th ed. Upper Saddle River, NJ: Prentice Hall; 2003.

18. Hicks L. *CPS Annual Demographic Survey March Supplement: Weighting.* Washington, DC: US Census Bureau; 1998.

19. Ratcliffe C, Chen H, Shanks TRW, et al. *Assessing Asset Data on Low-Income Households: Current Availability and Options for Improvement.* Washington, DC: Urban Institute; 2007.

20. Van Hook J. Welfare reform's chilling effects on noncitizens: changes in noncitizen welfare recipiency or shifts in citizenship status? *Soc Sci Q.* 2003;84:613–631.

21. Pan Y. *Development of Guidelines on the Use of Interpreters in Survey Interviews.* Washington, DC: US Census Bureau; 2005.

22. Carrasquillo O, Carrasquillo AI, Shea S. Health insurance coverage of immigrants living in the United States: differences by citizenship status and country of origin. *Am J Public Health.* 2000;90:917–923.

23. Ayanian JZ, Weissman JS, Schneider EC, Ginsburg JA, Zaslavsky AM. Unmet health needs of uninsured adults in the United States. *JAMA.* 2000; 284:2061–2069.

24. Berk ML, Schur CL. Access to care: how much difference does Medicaid make? *Health Aff.* 1998;17: 169–180.

25. Scarpaci JL, Kearns RA. Locational attributes of health behavior. In: Gochman DS, ed. *Handbook of Health Behavior Research II: Provider Determinants.* New York, NY: Plenum Press; 1997:81–102.

26. Ghosh C. The uninsured elderly: immigrants forgotten in New York's healthcare reform. In: *Abstr Academy Health Meet.* Washington, DC: AcademyHealth; 2003. Abstract 3.