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Another health insurance gap: Gaining and losing coverage among natives and immigrants at older ages

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ABSTRACT

As the immigrant population grows older and larger, limitations on access to health insurance may create a new subgroup of people who remain outside or on the margin of coverage. Using the Survey of Income and Program Participation (SIPP) data from the 2004 and 2008 panels, we address the health insurance gap between foreign-born and native-born adults among those aged 50–64 and the 65 and older, two sub-populations that have received relatively little attention in past research. We argue that current practices leave a significant minority of older foreign-born residents inconsistently covered or without any insurance. We find that health insurance coverage for older immigrants is both less likely and more episodic even when compositional differences in SES and assimilation are controlled.

1. Introduction

Lack of health insurance coverage represents a major challenge for U.S. immigrants, and as the immigrant population ages, eligibility rules for public assistance, employer plans, and Medicare may create a new class of people who remain outside the umbrella of coverage. Those aged 50–64 are particularly vulnerable. In recent decades, health insurance coverage for this age group has been declining, as fewer are covered by employer plans, and securing private individual insurance can be both difficult and costly (Smolka et al., 2012). Similar to other older minority status adults, those who are foreign-born are more likely to work in jobs that offer no coverage and more likely to be in or near poverty (Angel and Angel, 2006). However, older immigrants are at special risk. They may be ineligible for Medicaid because of legislative restrictions, have difficulty navigating the bureaucracy for public assistance, and are three times as likely as native-born adults to be uninsured (Buchmueller et al., 2007). While the eligibility of natives for Medicare at age 65 is near universal, insufficient employment histories in the US or lack of citizenship can exclude older immigrants from Medicare coverage.

In this paper, we address the health insurance gap between foreign-born and native-born adults among those aged 50–64 and the 65 and older, two sub-populations that have received relatively little attention in past research. We argue that current practices leave a significant minority of older foreign-born residents inconsistently covered or without any insurance. In the absence of policies that jointly addresses immigration reform and health insurance coverage, the changing age structure of the immigrant population will amplify this problem.

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2. Background and significance

2.1. Dynamics of HIC

Many studies look at health insurance coverage at a given point in time; however, health insurance coverage varies both across people with different characteristics and across time for the same person. Some people are able to maintain coverage through their employers until they retire and then shift to Medicare. Others, however, may have insurance on some occasions but not others, switching from employer plans to public assistance if they qualify, to private individual insurance if they can afford it, or to no coverage. For people in their 50s and early 60s, an age group that represents almost 20% of the total population, insurance coverage has been falling as out-of-pocket costs for health care have been rising, with minority elderly having much lower rates of coverage than whites (Smolka et al., 2012).

These estimates of the uninsured, however, do not include those who are intermittently uninsured. Health insurance status can change frequently within a given year and over a period of several years; thus, frequently cited figures may substantially underestimate the pool of individuals who are potentially vulnerable to the effects of non-coverage (Jensen, 1992; Sloan and Conover, 1998; Swartz et al., 1993a,b). Rather than defining only two groups at a specific time—those with or without health insurance—we incorporate the possibility of coverage transitions and identify three groups: those who are consistently covered; those who are consistently uncovered; and those who have intermittent coverage. In following people across time, this latter group can be further divided into those who move into the ranks of the insured—the 'gainers'—and those who move into the ranks of the uninsured— the 'losers.' Also important is which transitions—losing or gaining—are quickly reversed, since some people may gain coverage only to lose it again.

Non-coverage as well as intermittent coverage can have long term negative consequences for the health of older people. The incidence of chronic disease and non-acute diseases such as cancer increases with age. Early diagnoses and timely treatment can reduce cause-specific mortality as well as overall health care costs through early intervention (Maciosek et al., 2010; Miller et al., 2004; Wilper et al., 2009). Beginning at age 50, annual screenings for various cancers (e.g., colorectal, breast, prostate) and chronic diseases (e.g., cardiovascular disease, diabetes, osteoporosis) are recommended, especially for those with risk factors (CDC, 2013). Because utilization of preventive health services is largely determined by insurance coverage, those without health insurance are less likely to get these routine screenings, which can have long lasting effects on their health and well being.

Prior research also has documented that people with transitory coverage are much more likely than people with continuous coverage to forego preventive screenings. Even when individuals are without health insurance for relatively short spells, significant delays occur in their utilization of recommended follow-up care (Burstin et al., 1998), maintenance care for chronic conditions, and clinically indicated preventive services (Ayanian et al., 2000). For example, studies have demonstrated that gaining Medicare coverage increases the detection of cancers with recommended screening tests, particularly among those either intermittently or continuously uninsured before age 65 (Card et al., 2008; Strumf, 2012).

2.2. HIC and older immigrants

Examining the dynamics of health insurance coverage for immigrants compared to native born aged 50 and older will reveal the adequacy of our health and poverty programs for this growing segment of the population. At issue is whether older immigrants are able to acquire and keep their health insurance coverage. Although even undocumented immigrants are eligible for emergency Medicaid (Dinan, 2005), the question for older immigrants is whether they have routine access to health care and preventative screening.

A growing proportion of our older population is comprised of immigrants. In the past 20 years, the older foreign-born population increased by 70%, from 2.7 million to 4.6 million (U.S. Census Bureau, 2011). More than 12% of the foreign-born population is age 65 and older, with another 30% between the ages of 45 and 64 (Census, 2010). When Medicare and Medicaid were passed in 1965, the age structure of the foreign-born population was skewed toward those aged 60 and older, a reflection of the high rates of young European immigrants who came to the US in the early part of the 20th century and the much lower rates of entry during the middle decades of the 20th century. In that same year, the Hart-Cellar Act shifted immigration policy away from quotas and toward family reunification.

Since then, the number of naturalized citizens who sponsored their parents as new immigrants has increased. More than three-quarters of immigrants age 65 and older were admitted as immediate relatives of US citizens (U.S. Department of Homeland Security, 2006), and the number of aging parents whose immigration is sponsored by their adult children is likely to continue to grow (Treas and Batalova, 2009). By 1990, cohorts of older European immigrants were dying out, but through family sponsorship, the proportion of older immigrants being admitted to the US was increasing. Even if immigration remains concentrated among young adults, the number of older foreign born in the US will continue to expand as the larger cohorts currently in their 40s and 50s replace the smaller cohorts now older than 65 (Treas and Batalova, 2009; U.S. Census Bureau, 2010).

Despite family sponsorship, many older immigrants continue to live on the margins of US society. Gaining fluency in English, securing employment, and becoming a citizen are intertwined aspects of assimilation, and older immigrants face more difficulty than younger immigrants in making these adaptations to US culture (Angel and Angel, 2006). Not only are