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Comment: Health Insurance Coverage of Foreign-Born US Residents—The Implications of the New Welfare Reform Law

In its closing days, the 104th Congress cut public services for immigrants. In this issue of the Journal, Thamer and colleagues report that rates of health insurance coverage are significantly lower for foreign-born populations than for those born in the United States.[1] While diminishing with time, differences in coverage persist until at least 15 years after immigration. Under the terms of Public Law 104-93, most new residents will be ineligible for public assistance to assure access to care during the first 5 to 10 years of their residency, when they are most likely to need it.

The article by Thamer et al. provides important information, but more work needs to be done to understand how immigrants acquire coverage. The authors ascribe the observed differences to maturation effects—adaptation to the host country over time—but at least some of the differences may be due to cohort effects: differences among successive waves of immigrants. To the extent that cohorts differ, lower levels of coverage may persist even without the exacerbation of the new law. This comment explores that interpretation and discusses the possible consequences of the new law in light of the distribution of vulnerability among immigrants.

Health insurance coverage is lowest among young and low-income workers, those in service, retail or construction trades, and for small businesses' employees. Thamer et al. find that duration of residence also is related to coverage, with the likelihood of coverage increasing with length of residence. Immigrants approach parity with nonimmigrants only after about 15 years. Differences in coverage among ethnic and racial immigrant groups mirror those in the same groups within the native-born.

Because of limitations in the National Health Interview Survey (NHIS), it is not clear to what extent changes in coverage are maturation effects, as the authors of the study suggest, and to what extent they are cohort effects. The initial

Editor's Note. See related article by Thamer et al. (p 96) in this issue.

dislocation of immigration and the subsequent gradual adjustment to new homes—the maturation effect—might well account for some of the increased coverage observed among immigrant cohorts with duration of residence. Recent immigrants may have trouble finding employment, or they may tend to be employed in lower-wage industries or ones that do not offer benefits. As time passes, immigrants become more integrated into US society, learn to speak English, and achieve longer tenure in their jobs, all conditions likely to lead to increased coverage.

Cohort differences between the current wave of immigrants and those of 5, 10, and 15 years ago also might contribute to these observed differences. Foreign-born residents are heterogeneous to an extent not captured by the data available in the study by Thamer et al. The racial and ethnic categories bundle together immigrant cohorts that are dramatically different. Hispanic immigrants range from highly educated political asylees to illegal or recently amnestied agricultural workers.[2] "Asian and Pacific Islanders" encompass everything from professionals from India or Japan to Hmong refugees. Although the authors controlled for broad categories of education and income, the full compass of differences among various cohorts of immigrants eludes analysis.

Overall, immigrants are better off than is popularly believed. Most immigrants are legal, and legal immigrants are on average better educated than their US-born counterparts. However, the immigrants in the present wave, legal and illegal, tend to have fewer skills than those of previous waves.[3] Incomes are relatively low among recent immigrants and among those from countries that contribute many illegal immigrants. More than 75% of undocumented immigrants have less than a high school education.[4] Because educational difference is a potent predictor of future employment, duration of residence cannot be expected to erase the difference in coverage among the less skilled immigrants and their predecessors.

Unfortunately, the study by Thamer et al. has no data on legal status (such as immigration status, eligibility for citizenship, or refugee status), a critical factor for understanding how duration of residence affects coverage. Legal status can influence coverage through maturation, as eligibility for citizenship develops over time. Illegal immigration status results in persistent cohort differences in coverage.

Other cohort differences in insurance arise from the variable generosity of states at different ports of entry. Recent Hispanic immigrants have tended to congregate in states such as Texas and Florida, which have low Medicaid coverage.[2] Since Public Law 104-193 allows states to deny services to legal immigrants, interstate discrepancies are likely to grow.

Thamer et al. remark that legislative initiatives may exacerbate the problems of the foreign-born population in gaining access to health care. Title IV of the Personal Responsibility and Work Opportunity Act of 1996 (Public Law 104-193) does just that. The law excludes all "unqualified aliens"—including many long-term legal residents—from all federal means-tested public benefits (including health services other than emergency medical care and care related to communicable disease control.)

The new law may free the federal government of responsibility for the care of legal immigrants, but state and county governments warn that such changes simply shift the burden of caring for these populations onto them.[5,6] Even before the new welfare law, the National Conference of State Legislatures claimed that "demand for newcomer health services continues to surpass the budgetary and program resources of state and local governments."[5]

Setting aside appeals to justice and common humanity, public health provides compelling reasons for maintaining outreach to all populations. Yet special efforts are needed to reach immigrants. In addition to economic and legal or institutional barriers, health care may be inaccessible to immigrants because of problems with language or cultural barriers.[5] Welfare reform is an exercise in federal handwashing that abrogates federal constitutional responsibility for the consequences of immigration policy for lower levels of government.

Traditional public health providers—caregivers of last resort who are likely to have to compensate for the federal withdrawal—need to understand the nature of the problem. Why are recent immigrants less likely to be insured? What are the implications of such lack of coverage for their health and for public health in the communities in which they reside? Two groups of immigrants, refugees and the elderly, are high users of welfare and will be especially vulnerable to the effects of the new law. These two groups constitute 21% of the immigrant population and 40% of immigrant users of welfare.[7]

Refugees and asylees are exempted from the ban on eligibility for the 5 years following their date of entry to the United States. Older immigrants on welfare get no leeway. These are largely older family members of primary immigrants for whom the Supplemental Security Income program often has been a bridge to coverage under Medicaid, given the difficulty and expense of obtaining stand-alone health insurance for persons over 65. Immigrants constitute 9% of the elderly population and 28% of the Supplemental Security Income population aged 65 and over.

Elderly noncitizen immigrants with little or no work history in the United States have few options. Family coverage for juvenile dependents is available, but not for elderly parents. Although the law requires that their sponsors or families be responsible for them, no commercial instruments may be available for acting on that charge. Medicare was developed in the first place in response to insurers' unwillingness to cover the elderly, a problem that still exists. States may be challenged to develop "buy-in" programs that allow elderly immigrants to obtain coverage through the public program at an average cost. Other state options include extensions to Medicaid through the medically needy program or a new eligibility category related to former eligibility for Supplemental Security Income.

For other immigrants—particularly the recent large cohort of less educated immigrants from Central America—the loss of access to public programs will translate into a challenge to community caregivers. This immigrant group already uses health services at relatively low rates. Further declines in access may mean worsened health and greater need for emergency care for preventable crises in persons with untreated diabetes, high blood pressure, and asthma.[8] Although the law provides exceptions for communicable diseases and emergencies, newer immigrants who are unlikely to understand this distinction will pose problems for public health outreach.

By hampering access to adult educational and language programs, the new law also will slow the integration of current immigrants into the workforce and thus limit their ability to obtain coverage. The 15 years that Thamer et al. indicate as the time needed for immigrants to achieve parity with native-born workers may seem

long, but the new law can only exacerbate the gap. □

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Aging in Today's World: A Call for Papers for the October 1997 Journal

The Journal has joined with some 80 others in a coordinated global effort to publish papers on the topic of *Aging* in *October 1997*. The final deadline for *acceptance* for this Journal will be in mid *June 1997*. Hence, first submissions should not be delayed. The peer-review process and subsequent revisions can seldom be completed in less than 16 weeks. As always, a first criterion for proceeding to peer review will be relevance to public health.

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