Protective Citizenship: Functional Limitations, Welfare Participation and Naturalization among Later Life Immigrants to the U.S.

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Paper submitted for consideration for presentation at the annual meetings of the Population Association of America, Boston, MA, May 1-3, 2014.

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Abstract

Using the data from 2008-2010 American Community Survey, this paper investigates the links between health status, public welfare and healthcare program participation and naturalization among later life immigrants in the U.S. The results show that net of the many socio-demographic predictors, having a functional limitation increases the probability of naturalization, but this relationship is mediated by receiving Supplemental Security Income (SSI) and public health insurance. Findings also differ by country of origin. Public health insurance receipt predicts naturalization among older Mexicans, but receiving SSI does not. For older Chinese immigrants, both SSI and public health insurance receipt increase the odds of naturalization. None of these factors is related to naturalization of older Filipino immigrants. The results suggest that the combination of the current immigration, naturalization and welfare policies led to greater emphasize on instrumental functions of citizenship, especially among vulnerable subgroups such as recently arrived older foreign-born.

Introduction

Immigrants' participation in public welfare programs has always been a topic of heated discussions in the U.S., the country with the highest absolute number of international immigrants and one of the weakest welfare states among the developed countries. Fueled by anti-immigrant sentiments more than backed by strong evidence (Borjas and Hilton 1996; Tienda and Jensen 1986), the 1996 Personal Responsibility and Work Opportunity Act (PRWORA or welfare reform) explicitly targeted the foreign-born by introducing the restrictions on participation in the means-based programs for the recently arrived immigrants and non-citizens, and thus, creating an additional incentive for foreign-born to naturalize. Previous studies indeed found an increase in naturalization rates after 1996, but they also reported decline in the rates of welfare use among both native- and foreign-born, citizens and non-citizens alike (Borjas 2002; Fix and Passel 1999; Van Hook 2003; Van Hook, Brown and Bean 2006). Most of these studies looked at general foreign-born population and did not consider immigrants' health status as an important factor related to both welfare participation and naturalization. But given that most immigrants are young healthy adults who come to the U.S. to seek better economic opportunities, it is possible that the reform had little impact on their patterns of naturalization or welfare use. However, this paper follows some previous studies (Binstock and Jean-Baptiste 1999; Burr et al. 2008; Choi 2006; Nam and Jung 2008; Nam and Kim 2012) by arguing that the PRWORA had a sizable impact on a relatively small but growing and understudied subgroup of immigrants – older foreign-born who arrive to the U.S. in midlife and old age.

I use data from 2008-2010 American Community Survey to show that among those older foreign-born who arrived after age 50, poor health is associated with higher probability of naturalization. This relationship is mediated by participation in public healthcare and welfare

programs. There are, however, significant and intriguing differences by country of origin in the relative importance of these factors. For example, public health insurance receipt predicts naturalization of Mexican older foreign-born newcomers while receiving Supplemental Security Income (SSI) does not. For older Chinese immigrants, both receiving SSI and public health insurance predict naturalization but health status does not. None of these factors is related to naturalization of older Filipino immigrants. Overall, these findings suggest that the combination of current immigration, naturalization, healthcare and program participation policies fosters older foreign-born newcomers' reliance on the governmental welfare and healthcare programs for economic security and much needed access to health care. These policies also encourage older immigrants to naturalize to secure their rights to receive support from the state.

Even though these results could not and should not be extrapolated to all foreign-born, they are important amid the increasing numbers of older immigrant newcomers (Batalova 2012; Treas and Batalova 2009; U.S. Department of Homeland Security 2012) and mounting concerns about spending on public healthcare and welfare programs related to population aging (Keehan et al. 2011). Most importantly, these findings illuminate the problems that older immigrant newcomers face in the U.S. and point at some unintended consequences of the current policies.

Literature Review

The 1965 Immigration and Nationality Act (Hart-Celler Act) removed of the national-origin quotas and establishing the system of employment- and family-based preference categories (Immigration and Nationality Act (Hart-Cellar Act) 1965). According to the new family reunification provision, select categories of relatives of U.S. citizens are able to come to the U.S. as permanent residents. The country-of-origin quotas limit the number of siblings and

adult children of the U.S. citizens who can enter the country each year. However, the immigration of the immediate relatives of the U.S. citizens – spouses, minor children and parents – is not subject to the numerical limits.

Hardly anyone in 1965 anticipated that roughly 27 million of foreign-born would come to the U.S. in 1980-2000 (U.S. Department of Homeland Security 2012), creating a huge demand for the immigration of the relatives and sustaining considerable chain migration flows (Jasso and Rosenzweig 1986). Currently, the siblings and adult children of the U.S. citizens from some countries have to wait for more than 10 years to actually come to the U.S. (Anderson 2010; Bergeron 2013). From 1986 to 2012, the number of the admitted immediate relatives of the U.S. citizens who are not subject to quotas has increased more than two times from 223.5 to 478.8 thousands per year. But the number of the parents of the U.S. citizens increased even steeper: form 45.2 thousands in 1986 to 124.2 thousands in 2012, or from 7.5 to 12 percent of all immigrants admitted annually (U.S. Department of Homeland Security 2004; 2012). These figures are projected to increase as more adult immigrants naturalize and become eligible to bring their parents to the U.S. (Treas and Batalova 2009).

If most family immigrants "blend in" relatively well with the general foreign-born population, the parents of the U.S. citizens stand out in a number of important ways. First of all, unlike the majority of the foreign-born who are relatively young when they migrate, most parents of the U.S. citizens arrive in midlife and old age. Second, unlike younger immigrants, they are typically not seeking education or employment opportunities, but come to join their adult children and their families. To be sure, they play an important economic role within their families and households providing childcare and helping with the housework (Treas 2008; Treas and Mazumdar 2002). But because of their age and because they spend most of their time with

family members and close circle of co-ethnics, their opportunities for acculturation and economic incorporation in the U.S. are extremely limited. On top of that, low levels of education and limited English language proficiency coupled with the lack of economic resources and general unfamiliarity with life in the U.S. make the newly arrived older foreign-born highly dependent on their adult children (Angel et al. 1999; Treas and Mazumdar 2002). Finally, unlike younger immigrants, older foreign-born parents are more likely to experience health problems when they arrive (Choi 2011; Wakabayashi 2010). It is plausible that some of them may come precisely because they experience health decline and need their children's assistance. But despite reaching the age when health problems are quite frequent and the need for health care is high, older and middle immigrant newcomers often lack health insurance (Burr et al. 2008; Choi 2006; Nam 2008).

One of the concerns underlying the 1996 welfare reform was that the immigrants come to the U.S. because of the generous welfare benefits, and that undocumented immigrants receive welfare (Borjas 2002; Van Hook 2003; Weil and Finegold 2002). So the reform, among other things, restricted the welfare eligibility to the U.S. citizens and select categories of legal permanent residents and refugees. Now most foreign-born are not eligible for most welfare programs, such as Supplementary Security Income (SSI), Medicaid, Temporary Assistance to Needy Families (TANF), during their first five years in the U.S. as legal permanent residents even if they meet the other requirements for these programs (for example, for SSI, those are low income level, being age 65 or older or having a disability). Since 1996, the foreign-born also cannot receive SSI benefits for more than 7 years unless they naturalize. Because those who qualify for SSI are almost automatically covered by Medicaid, losing SSI benefits puts a person at risk of losing both supplemental income and health insurance. Thus, the 1996 welfare reform

might have encouraged naturalization among the foreign-born who are otherwise eligible for welfare based on their income, age and/or disability status, such as older immigrant who migrated in late life.

Indeed, the previous research found naturalization rates has been increasing since 1996, although it is not clear to what degree this increase is attributable to the reform (Balistreri and Van Hook 2004; Fix and Passel 1999; Gilbertson and Singer 2003; Nam and Kim 2012; Van Hook 2003; Van Hook, Brown and Bean 2006). Studies also found that naturalized citizens are more likely than non-citizens to have public health insurance and receive SSI (Borjas 2002; Burr et al. 2008; Fix and Passel 1999; Nam and Jung 2008; Van Hook 2000) , which is not surprising given the eligibility criteria described above. However, since most data sets lack information on the timing of naturalization, there is only indirect evidence that program participation is related to *decisions* to naturalize. Also, many previous studies do not take into consideration the age at arrival (Nam and Kim 2012), which is critical for understanding health, welfare use and economic wellbeing of older foreign-born in the U.S. (Angel et al. 1999; Wakabayashi 2010). For example, one recent study revealed that among those who migrated before age 35, naturalization was associated with better health in old age; but among those foreign-born who migrated after age 50, naturalized is associated with worse health compared to non-citizens (Chapter 1). The relationship was even strong for those who naturalized soon after arrival, suggesting that older immigrant newcomers who experience health problems are more likely to naturalize. This paper extends the previous research by investigating whether, controlling for many other socio-demographic factors, poor health indeed influence the decision to naturalize among older foreign-born who migrated in later life, and whether this relationship is mediated by participation in the governmental welfare and health care programs, such as SSI and Medicaid.

State variations in welfare benefits

The 1996 welfare reform established the minimum welfare payments and eligibility criteria, but it gave the states freedom to increase cash benefits or/and to expand the eligibility to other categories of residents, including the foreign-born. As the result, there are substantial differences between the states with respect to the generosity of their welfare programs for the immigrants (Zimmerman and Tumilin 1999). Several previous studies explored the effect of these variations on naturalization and program participation rates. For example, residence in generous states was associated with higher rates of naturalization, although state-level favorable attitudes toward immigrants were found to be a stronger predictor of naturalization than the level of welfare benefits or welfare accessibility for the immigrants (Van Hook, Brown and Bean 2006). Older immigrants residing in more generous states have higher rates of health insurance coverage (Nam 2011). Again, this study focused on the foreign-born of all ages, and the effects of the state level welfare accessibility for the foreign-born might be larger for the older foreign-born newcomers who tend to relay on these programs more heavily.

Mexican, Chinese and Filipino older foreign-born

Although there are many similarities among older foreign-born newcomers as most of them come as legal permanent residents through the family reunification provision, have few socio-economic resources and limited English language skills, the degree to which they rely on public welfare programs and the degree to which they tend to naturalize to retain welfare benefits might vary because of the differences in the socio-economic status, human and social capital of their children's families and ethnic communities. For example, older foreign-born newcomers from China might benefit from the higher socio-economic status of their children who are able to provide them not only with more financial support, but also with the information about the state

welfare and healthcare programs. Better educated adult immigrant children are also able to help their elderly parents navigate naturalization application processes and assist with paying fees. Mexican older foreign-born newcomers, on the other hand, are likely to lack this information about the services and have limited support with the application process. As the results, they might resort to the governmental programs only in case of the extreme need (e.g. severe disability). Mexican immigrants are generally less likely to naturalize because of the high fees, complex application process, and distrust in the government (Gonzalez-Barrera et al. 2013; Liang 1994). They are also less likely to participate in public welfare and healthcare programs even though they are more likely to experience health problems. The expectations for older immigrants from the Philippines are less clear, but given relatively high socio-economic status of the adult Filipino migrants and relatively good health of older Filipino migrants, it is likely that they will be less dependent on the public welfare and health care programs compared to Mexican or Chinese.

In sum, this paper improves on previous research on immigrants' welfare use and naturalization by exploring the relationship between health, program participation and naturalization among older foreign-born newcomers, and comparing this relationship across three largest groups of older foreign-born: Mexican, Chinese and Filipino.

Data and Method

I use data from the 2008, 2009 and 2010 American Community Survey (ACS) (Ruggles et al. 2010). Besides its large sample size and numerous socio-demographic measures, the ACS asks about the year of migration and, since 2008, about the year of naturalization, which is crucial for this research. The sample is limited to foreign-born age 50 and above who migrated

after age 50 and spent at least 5 years in the U.S., a rough approximation for eligibility to naturalize.

The conventional models estimate the probability of being a citizen at the time of the survey as a function of certain predictors. However, because some of the foreign-born citizens naturalized many years before the survey, the causal direction of the association between various time-varying predictors, such as income or welfare use, and naturalization often remains unclear in cross-sectional data. To overcome (albeit imperfectly) these limitations, I further restrict the main analytical sample to non-citizens and those citizens who naturalized in the year of the survey. I use a two-stage modeling approach, similar to the one proposed by Heckman (1979) and model naturalization in the year of the survey conditional on being a non-citizen prior to the year of survey.

In the first stage, I estimate probability of failing to naturalize prior to the year of the survey as a function of age, gender, race, Hispanic ethnicity, year of migration, duration of residence in the U.S., marital status, spouse's citizenship status, education, and generosity of the state of residence with regard to welfare benefits for the foreign-born. Age is measured in years. Gender is a binary variable with females coded as 1. Race variable distinguishes between white (reference), Blacks, Asian/Pacific Islanders and "other" race. Respondents who identified as Hispanic are coded as 1. Year of migration is measured in actual years. Duration of residence in the U.S. is a 4-category variable: 6-10 years (reference), 11-15 years, 16-20 years, and 20 + years. Marital status categories include "single or never married" (reference), "married", "divorced/separated" and "widowed". Respondents whose spouse is a U.S. citizen are coded as 1 and the others (those who are not married or whose spouse is not a citizen) constitute the reference group. Education is measured in categories ranging from 0 (no schooling) to 11

(college degree or more) and it is treated as a continuous variable. State generosity was defined based on the classification presented in Table 18 in Zimmerman and Tumilin (1999). I coded 12 states (Alabama, Arkansas, Idaho, Indiana, Louisiana, Mississippi, Ohio, Oklahoma, South Carolina, South Dakota, Texas, and West Virginia) classified as "least available" or most restrictive as 1, and all other states are coded as 0. After running the full model using maximum likelihood estimation with probit link function, I compute the predicted probabilities of being a non-citizen before the year of the survey. I include these probabilities as a variable (called "correction term") in the second-stage model that estimates probability of naturalization in the year of the survey. Inclusion of the correction term allows for less biased estimates of the predictors of naturalization, which is the ultimate goal of this paper.

The second stage model includes the same socio-demographic predictors as the first stage model except for the year of migration. In this model, age is a binary variable with those age 65 and older coded as 1 and those age 50-64 coded as 0. This model also includes measures of functional health, receipt of SSI, presence of public health insurance, employment status, English-language proficiency, and income. Functional health is measured as presence of functional limitations (coded as 1). Program participation variables are also binary, indicating whether a respondent receives SSI and has public health insurance. Employment status is a dummy variable with those who are employed either full- or part-time coded as 1. Respondents who reported not speaking English or speaking "but not well" were labeled as having limited English-language proficiency (LEP) and coded as 1.

Finally, I run separate two-stage models for the subsamples of the three largest subgroups of older foreign-born newcomers – those from Mexico, China and Philippines. Due to considerable reduction in the sample sizes, I used a dummy variable for marital status

(married=1, all others=0) and do not include employment status and income (which were not statistically significant for any of the groups in the preliminary analysis) in these models.

Results

The descriptive statistics for the main analytical sample – foreign-born age 50 who migrated after age 50, spent at least 5 years in the U.S. and haven't naturalized or naturalized in the year of survey – are presented in Table 1. About 4% of the sample naturalized in the year of the survey, but only 1.6% of Mexicans did compared to 3.8% of Chinese and 6.1% of Filipino older immigrant newcomers. About 22.8% of older foreign-born age 50 and older who migrated in midlife and old age report having a functional limitation, although this proportion is higher among Mexicans (25.1%) compared to Chinese (19.3%) and Filipino (19.2%). More than a half (55.9%) of the sample report having public health insurance and about 10.2% receives SSI, but again, there are significant differences between the groups. The program participation rates are the lowest among the older foreign-born from Mexico and the highest among the older foreign-born from China. Among the Filipino older foreign-born, the program participation rates are the closest to the average for the entire sample. Older Chinese foreign-born are more likely to be married and more likely to have a spouse who is a citizen. Older Mexican foreign-born have the lowest mean level of education and older Filipino foreign-born – the highest. Older foreign-born from the Philippines also have the lowest rates of limited English language proficiency. Only about 12% of the older immigrants live in the states that have restrictive welfare policies; however, Mexicans are much more likely to reside in such states compared to the other older immigrants, most likely because of the high concentration of Mexican immigrants in Texas. The mean value of the correction term can be interpreted as the average probability of being a non-

[Table 1 about here]

citizen by the time of the survey. These probabilities were derived from the models presented in the Appendix Table A. The predicted probability of being a non-citizen by the time of the survey is about 70.6% of the pooled sample, but it is much higher for the Mexican (88.2%) and considerably lower for the Chinese (61.7%) and Filipino (64.0%) older immigrants, reflecting the differences in naturalization rates among these groups.

Table 2 presents the partial models that show the independent and joint effects of functional health, receipt of public health insurance and SSI on probability of naturalization for the pooled sample and the subsamples of Mexican, Chinese, and Filipino older foreign-born, net of age, gender, race (pooled sample only) marital status, spouse's citizenship status, education, employment status and income (pooled sample only), English language proficiency, number of years in the U.S., state welfare generosity and correction term. The main finding for the pooled sample is that all three variables – having a functional limitation, receiving public insurance and receiving SSI – independently increase the odds of naturalization. However, only public insurance and SSI remain statistically significant once all three variables are included in the model (Model 4), and the SSI receipt seems to be a stronger mediator (Model 2) compared to public health insurance receipt (Model 3).

There are interesting differences between the subgroups of later life migrants. For older immigrants from Mexico, only receiving public health insurance is significantly increases odds of naturalization while receiving SSI is not. For older immigrants from China, on the other hand, both public health insurance and SSI receipt predict naturalization, and receiving SSI is the main

mediator of the relationship between having functional limitations and naturalization. For older foreign-born from Philippines neither functional health, nor public health insurance, nor SSI receipt is significantly associated with naturalization.

[Table 2 about here]

Table 3 presents the full models (Model 4 from Table 2) predicting naturalization in the year of the survey for the pooled sample and for the subsamples of the older foreign-born from Mexico, China and Philippines. Unlike Table 2, Table 3 shows the effects of all socio-demographic predictors and the differences in these effects between the subgroups.

Old age does not predict naturalization among later life immigrants, perhaps, because it has the opposite effects in at least two subgroups: Mexican foreign-born newcomers age 65 and older are less likely to become citizens but older Filipino immigrants are more likely to naturalize compared to their young counterparts (age 50-64). Even though gender is not statistically significant in the pooled sample, older female Mexican and Filipino immigrants are less likely to become citizens compared to males. Respondents of other race are less likely to naturalize. Somewhat surprisingly, married older foreign-born are less likely to naturalize than single (although it is statistically significant only for the pooled sample), but having a spouse who is a citizen significantly increases the odds of naturalization for all subgroups except Chinese. Widows and widowers are also more likely to naturalize compared to single/never married older foreign-born newcomers.

Consistent with the previous research, higher levels of education increase the probability of naturalization, although the coefficients are statistically significantly only for the pooled

sample and Mexican subsample, suggesting that socio-economic standing might not be equally strong predictor of naturalization for all subgroups of older immigrants. The effect of income is relatively weak and nonlinear: low income older foreign-born are more likely to naturalize than those who report either very low or high income. Limited English language proficiency is associated with lower probability of naturalization, although it is statistically significant only for the pooled sample and Mexican subsample. Interestingly, those who spend between 16 and 20

[Table 3 about here]

years in the U.S. are the most likely to naturalize, although the effect seems to be driven by Mexicans. Older foreign-born newcomers from China who spent 6-10 years in the U.S. have the highest probability of naturalization, and those who spent 16-20 years – the lowest. Duration of stay in the U.S. is not significantly linked to naturalization of older immigrants from the Philippines.

Residing in a state that has implemented restrictive welfare policies has negative but not statistically significant effect on naturalization of older foreign-born newcomers. The correction term is statistically significant in the models for the pooled sample, which justifies the adjustment, although it is not significant for the subsamples of older foreign-born from Mexico, China and the Philippines. The additional analyses (not presented but available upon request) also show that the main results are consistent in the models with or without the correction term.

Discussion and Conclusion

This paper tests the hypothesis that poor health may encourage foreign-born who immigrate in midlife and old age to naturalize in order to ensure access to public welfare and health care programs. Using data from 2008-2010 American Community Survey and taking advantage of the new question about the year of naturalization, I find that net of the many socio-demographic predictors, having a functional limitation, receiving SSI and public health insurance independently increase the probability of naturalization. But the effect of poor health seems to be mediated by participation in public welfare and health care programs, as only SSI and public health insurance receipt predict naturalization in the full model, net of other controls. However, I also find that there are important differences between the immigrant subgroups by country of origin in the way health and welfare program participation matter for naturalization. For example, public health insurance receipt increases the odds of naturalization for older Mexican foreign-born, but receiving SSI has no significant effect. For older Chinese immigrants, both SSI and public health insurance receipt increase the odds of naturalization. None of these factors are related to naturalization among older Filipino immigrants.

These results suggest that the combination of the current immigration, naturalization and welfare policies leads to greater emphasize of the instrumental function of citizenship among vulnerable in terms of health and socio-economic status population subgroups, such as immigrants coming in old age. Current immigration policy makes it easier for older immigrants to enter the country but the laissez-faire stance on immigrant incorporation makes them economically dependent on their children's families. While many older Americans, foreign-born and native-born alike, rely on social security and retirement savings for economic security and on Medicare and private health insurances to meet their health needs in old age, older immigrant newcomers have no access to these resources. Coming in their 50s and 60s and lacking

necessarily education, skills and, most importantly, English-language proficiency, they are unlikely to enter the formal labor market, least to work the required 10 year in SSI and Medicare eligible employment. Moreover, the fragmented health care system makes it difficult even for middle income families to afford a private health insurance for an elderly person. Finally, the 1996 welfare reform institutionalized the link between citizenship status and welfare participation, creating an incentive to naturalize for otherwise eligible for public programs foreign-born. Thus, current policies foster older foreign-born newcomers' dependency on the governmental welfare and healthcare programs for economic security and much needed access to health care. These policies also encourage older immigrants to naturalize to secure their rights to receive support from the state.

The differences found between older foreign-born are also interesting as they are likely to reflect inequalities in access to welfare programs that are not related to the formal eligibility criteria or objective needs. Older Chinese immigrants have relatively low rates of functional limitations but relatively high rates of naturalization and welfare program participation. The opposite is true for older Mexican foreign-born. Although the differences in attitudes toward receiving welfare might play a role, it is also likely that older Chinese immigrants benefit from higher socio-economic status of their children and larger community, which are able to provide them with knowledge about the available programs, assist with the application process, appeal denied claims, and prepare for naturalization tests. But older Mexican foreign-born, lacking these family and community resources, may seek to apply for public welfare and healthcare programs only if they experience disability or other considerable health problems. Older Filipino immigrants have average rates of naturalization, functional limitations and welfare participation,

and they show no clear patterns of naturalization. This could be related to a considerable number of transnational immigrants among this group, although more research is needed in this area.

This research is not free from the limitations. Panel data with the specific timing of naturalization, onset of program participation and health decline is needed to better estimate whether and by how much program participation and poor health increase the odds of naturalization. Although this research compares older Mexican, Chinese, and Filipino immigrants, the sample size was too small to look at other immigrant subgroups, which might reveal other important differences. Similarly, there might be important difference by gender, family structure and support given/received from adult children that future research should seek to investigate once better data become available.

As more adult foreign-born naturalize, more older immigrant parents become eligible to join them in the U.S., so I might expect the number of older immigrant newcomers to increase in the coming decades. Longer waiting periods for immigration of the siblings of the U.S. citizens may also contribute to the increased numbers of older immigrants, as potential immigrants age before they are allowed to enter the country. High naturalization rates and heavy reliance on public welfare and health care programs among this group reveal its disadvantaged position and call for development of a clear strategy for providing older immigrant newcomers an affordable healthcare options, perhaps, through some combination of state, private and family contribution.

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Table 1. Descriptive statistics (percentages and means) for the main analytical sample: Foreign-born age 50+ who migrated after age 50 and have not naturalized or naturalized in the year of survey, ACS 2008-2010

	All	Mexico	China	Philippines
Naturalized this year	3.8	1.6	3.8	6.1
Functional limitations	22.8	25.1	19.3	19.2
Public health insurance	55.9	49.7	68.6	53.9
SSI recipient	10.2	7.0	14.4	9.8
Age 65+	70.5	70.8	77.2	66.3
Female	61.1	60.4	57.8	64.6
Race				
White	47.8	-	-	-
Black	8.4	-	-	-
Asian/Pacific Islander	29.0	-	-	-
Other	14.8	-	-	-
Hispanic	43.4	-	-	-
Marital status				
Married	44.3	43.5	56.8	45.6
Divorced/Separated	20.2	-	-	-
Widowed	28.7	-	-	-
Never Married	6.8	-	-	-
Spouse is a citizen	9.9	7.6	16.1	12.9
Education (mean)	4.4	2.1	4.8	6.2
Employed	24.6	-	-	-
Income				
Very low income	55.3	-	-	-
Low income	25.1	-	-	-
Middle income	12.8	-	-	-
High income	6.1	-	-	-
Limited English	70.5	89.2	88.4	36.9
Number of years in the U.S.				
6-10 years	53.7	51.6	52.6	58.9
11-15 years	21.4	22.6	21.9	20.5
16-20 years	13.6	12.9	14.8	12.3
21+ years	11.3	12.9	10.7	8.3
Limited benefit state	12.2	27.8	5.6	4.5
Correction term	70.6	88.2	61.7	64.0
N	18,710	3,840	1,552	1,442

Table 2. Log odds coefficients from the logistic regression models predicting naturalization in the year of the survey: Foreign-born age 50+ who migrated after age 50, ACS 2008-2010

	(1)	(2)	(3)	(4)
All (N=18,710)				
Functional limitations	0.357**	0.229	0.286*	0.154
	(0.130)	(0.118)	(0.125)	(0.110)
Receives SSI	-	0.573***	-	0.446**
		(0.166)		(0.153)
Public health insurance	-	-	0.947***	0.847***
			(0.152)	(0.182)
Mexico (N=3,840)				
Functional limitations	0.771*	0.732*	0.595	0.599
	(0.345)	(0.341)	(0.333)	(0.329)
Receives SSI	-	0.259	-	-0.028
		(0.493)		(0.473)
Public health insurance	-	-	1.662***	1.665***
			(0.432)	(0.435)
China (N=1,552)				
Functional limitations	0.835*	0.312	0.736*	0.264
	(0.328)	(0.394)	(0.326)	(0.382)
Receives SSI	-	1.665***	-	1.556***
		(0.464)		(0.448)
Public health insurance	-	-	1.046**	0.937*
			(0.403)	(0.427)
Philippines (N=1,442)				
Functional limitations	0.187	0.122	0.205	0.143
	(0.386)	(0.373)	(0.409)	(0.395)
Receives SSI	-	0.361	-	0.386
		(0.465)		(0.478)
Public health insurance	-	-	-0.077	-0.113
			(0.357)	(0.368)

*** p<0.001, ** p<0.01, * p<0.05.
Standard errors in parentheses (adjusted for the country of birth for the pooled sample).
All models also include: age, gender, race (pooled sample only), marital status, spouses' citizenship status, education, employments status and income (pooled sample only), English language proficiency, number of years in the U.S., state welfare generosity and correction term.

Table 3. Log odds from the full logistic regression models predicting naturalization in the year of the survey: Foreign-born age 50+ who migrated after age 50, ACS 2008-2010

	All	Mexican	Chinese	Filipino
Functional limitations	0.154	0.599	0.264	0.143
	(0.110)	(0.329)	(0.382)	(0.395)
Public health insurance	0.847***	1.665***	0.937*	-0.113
	(0.182)	(0.435)	(0.427)	(0.368)
Receives SSI	0.446**	-0.028	1.556***	0.386
	(0.153)	(0.473)	(0.448)	(0.478)
(Age 50-64)				
Age 65+	0.089	-1.207*	-0.179	1.002*
	(0.171)	(0.541)	(0.373)	(0.418)
Female	-0.174	-0.759*	0.242	-0.606*
	(0.111)	(0.330)	(0.333)	(0.280)
(White)				
Black	-0.006	-	-	-
	(0.379)			
Asian	0.179	-	-	-
	(0.264)			
Other	-0.537***	-	-	-
	(0.130)			
Hispanic	-0.298	-	-	-
	(0.340)			
(Single/Never married)				
Married	-0.777**	-0.377	-0.294	-1.015
	(0.302)	(0.400)	(0.753)	(0.538)
Divorced/Separated	0.288	-	-	-
	(0.183)			
Widowed	0.531***	-	-	-
	(0.126)			
Spouse citizen	3.092***	1.960*	1.203	3.044***
	(0.490)	(0.870)	(1.423)	(0.914)
Education	0.145***	0.246***	0.056	0.082
	(0.025)	(0.066)	(0.060)	(0.059)
Employed	0.212	-	-	-
	(0.160)			
(Very low income)				
Low income	0.319**	-	-	-
	(0.110)			
Middle income	0.362	-	-	-
	(0.239)			
High income	-0.056	-	-	-
	(0.231)			

LEP	-0.265*	-0.961**	-0.520	0.261
	(0.121)	(0.308)	(0.406)	(0.350)
(6-10 years in the U.S.)				
11-15 years in the U.S.	-0.009	-0.203	-2.551*	0.208
	(0.242)	(0.402)	(1.006)	(0.669)
16-20 years in the U.S.	0.685*	1.453*	-1.263	0.382
	(0.330)	(0.584)	(1.280)	(0.923)
21+ years in the U.S.	0.194	1.622	-2.042	-0.527
	(0.425)	(0.941)	(1.552)	(1.451)
(Generous state)				
Ungenerous welfare state	-0.285	-0.601	0.597	0.336
	(0.205)	(0.433)	(0.493)	(0.641)
Correction term	3.061**	4.492	-1.101	3.395
	(0.972)	(2.640)	(3.408)	(2.189)
Constant	-6.976***	-8.215**	-3.083	-6.088**
	(0.734)	(2.665)	(2.756)	(2.077)
N	18,710	3,840	1,552	1,422
Log likelihood	-2765	-276.9	-203.1	-298.4
chi2	7705	72.23	69.62	63.73
DF	24	14	14	14
Pseudo R-squared	0.094	0.119	0.139	0.088

*** p<0.001, ** p<0.01, * p<0.05.
Standard errors (adjusted for clustering by country of birth for the pooled sample) in parentheses.

Appendix Table A. Probit models of failing to naturalize by the year of the survey: Foreign-born age 50+ who migrated after age 50 and spent 5+ years in the U.S., ACS 2008-2010

	All	Mexico	China	Philippines
Age	-0.009*	-0.012**	-0.002	-0.024***
	(0.004)	(0.004)	(0.004)	(0.005)
Female	0.063	0.117*	0.070	-0.024
	(0.051)	(0.059)	(0.057)	(0.066)
(White)				
Black	0.186	-	-	-
	(0.157)			
Asian/Pacific Islander	-0.023	-	-	-
	(0.158)			
Other	0.174	-	-	-
	(0.119)			
Hispanic	0.492*	-	-	-
	(0.207)			
(Single/Never married)				
Married	0.542***	0.273***	0.585***	0.603***
	(0.103)	(0.070)	(0.074)	(0.085)
Divorced/Separated	-0.172**	-	-	-
	(0.053)			
Widowed	-0.122	-	-	-
	(0.066)			
Spouse citizen	-1.401***	-1.013***	-1.174***	-1.226***
	(0.096)	(0.091)	(0.074)	(0.091)
Education	-0.061***	-0.062***	-0.043***	-0.064***
	(0.007)	(0.010)	(0.008)	(0.009)
Year of migration	0.047***	0.038***	0.062***	0.049***
	(0.005)	(0.009)	(0.012)	(0.014)
(6-10 years in the U.S.)				
11-15 years in the U.S.	-0.417***	-0.098	-0.316**	-0.437***
	(0.058)	(0.091)	(0.098)	(0.108)
16-20 years in the U.S.	-0.523***	-0.379**	-0.346*	-0.555***
	(0.065)	(0.121)	(0.146)	(0.161)
21+ years in the U.S.	-0.379***	-0.406*	-0.428	-0.614*
	(0.095)	(0.185)	(0.222)	(0.250)
Ungenerous welfare state	0.175*	0.122*	0.048	-0.263*
	(0.071)	(0.061)	(0.116)	(0.132)
Constant	-92.860***	-73.383***	-123.101***	-95.749***
	(10.917)	(18.686)	(24.491)	(27.580)
N	36,031	4,608	3,879	3,399
Log likelihood	-17717	-1543	-1964	-1620

DF	16	10	10	10
chi2	9876	495.9	847.3	864.5
Pseudo R-squared	0.285	0.187	0.261	0.302

*** p<0.001, ** p<0.01, * p<0.05.
Standard errors (adjusted for clustering by country of birth for the pooled sample) in parentheses.