LEGAL STATUS, ACCULTURATION, AND THE HEALTH OF IMMIGRANTS IN THE UNITED STATES

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ABSTRACT
A large body of evidence points to the existence of an immigrant health paradox whereby net health outcomes among newly arrived immigrants to the United States are more favorable relative to U.S. natives but with increased exposure to U.S. society, immigrant health outcomes tend to converge to native levels. Using data from a nationally representative sample of adult U.S. immigrants, this paper examines whether the pace of "negative" health assimilation varies across an understudied, though increasingly salient dimension of contemporary immigration: legal and citizenship status. Using data from the 2004 Survey of Income and Program Participation, we find that immigrant health trajectories over time spent in the U.S. vary considerably depending on legal and citizenship status. For both men and women, health outcomes tend to decline more precipitously with increased duration of U.S. residence for unauthorized migrants, as compared to their legally resident and naturalized counterparts, even after adjusting for factors known to predict health. For women this pattern holds with respect to self-reported general health and the prevalence of functional limitations, while for men, the finding only obtains for functional limitations, the prevalence of which increase sharply as unauthorized men spend more time in the country. This extended abstract briefly introduces the research, describes our data and methodological approach, and presents an initial set of findings.

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INTRODUCTION

Large-scale immigration during the past four decades has drastically altered the ethno-racial and demographic landscape of the United States (Bean and Stevens 2003; Portes and Rumbaut 2006). Between 1970 and 2010, the foreign-born population grew from 9.6 to about 39 million, and over this period, the percentage of the country's residents born outside of the United States increased from 4.7 to 13 percent. The scale and nature of contemporary immigration to the United States carries important implications for research on health disparities within the population, and especially inequalities by race and ethnicity. On the one hand, immigrants tend to be younger, on average, than the U.S. native-born population and also tend to be positively selected from their countries of origin. On the other hand, contemporary immigrants tend to originate in developing countries in Latin America and Asia, and thus arrive with a host of characteristics that tend to pose a risk to health outcomes, including low-levels of educational attainment, employment in low-paying and often dangerous occupations, little or no proficiency in English, and minority racial and ethnic status.

Given the demographic and socio-economic impacts of immigration on the U.S. population, a voluminous body of research examining the dynamics of immigration, adaptation and health outcomes has emerged over the past twenty or more years. Much of this research agenda has been driven by several consistent findings with respect to the health of immigrants. The first is that a number of studies have documented that, somewhat surprisingly, overall immigrants tend to report more favorable health outcomes than their relatively low socio-economic position and minority status would predict. However, research has also shown that the health of the foreign-born population converges with the native-population with increasing time spend living in the United States.

The accumulation of empirical evidence of an immigrant health "paradox" has generated considerable interest in better understanding the mechanisms underlying the negative association

between the health of immigrants and their duration of residence in the United States (Antecol and Bedard 2006; Palloni and Arias 2004; Palloni and Morenoff 2001). This relationship implies that the health benefits associated with immigrants' structural incorporation are washed out by other mechanisms that develop with time spent in the U.S. Duration of residence is associated with occupation and earnings mobility (Chiswick 1978; Ellis 2001; Myers 2007; Waldinger 2001), which in turn is positively related to health (Elo 2009). Even in spite of these gains, however, the health of the immigrant population, relative to whites, worsens the longer they live in the U.S.

Though much interest has been placed on understanding the mechanisms underlying the negative health assimilation of immigrants, little research has addressed the question of whether immigrant health incorporation patterns vary along the increasingly salient dimension of legal status, due in large part to the dearth of publicly available survey data with both measures of legal status and health outcomes. This research employs data from the Survey of Income and Program Participation (SIPP), which includes topical modules with questions about both the legal and citizenship status of immigrants *and* general health indicators. We use these data to compare adult unauthorized immigrants with their legally resident and naturalized counterparts, with respect to self-reported health and the prevalence of functional limitations, two indicators of general health and well being. In addition to comparing the adjusted health profiles of these three immigrant sub-populations, we examine whether the nature and magnitude of the association between years of residence in the United States and general health outcomes is moderated by both legal status and gender.

BACKGROUND

Assimilation, Legal Status, and Immigrant Health

The characteristics of immigrants in the United States vary significantly depending on migrants class of admission and mode of entry in to the country (Bean and Stevens 2003; Portes and Rumbaut 2006). Many of these characteristics, such as demographic and life course factors and

human capital are readily measurable and known to be significantly related to health outcomes. Thus, observed differences between immigrants of vary legal and citizenship statuses may derive in part from differences in such characteristics. Compared to legal non-citizens and naturalized immigrants, unauthorized immigrants may report more favorable health outcomes due to their tendency to be younger (Passel and Cohn 2010). On the other hand, unauthorized immigrants tend to have lower levels of educational attainment and are concentrated in low-paying occupations that often lack benefits such as health insurance coverage, all of which are negatively associated with health indicators (Elo 2009). Any remaining legal status and citizenship differences in health outcomes are likely to do selection mechanisms. Because of the especially arduous nature of unauthorized migration and residence in the U.S., undocumented migrants may be positively selected from their origin societies (Massey et al. 1987), and have a more favorable health profile as a result. Similarly, negative selection in return migration may lead to lead to even better relative health among the unauthorized. As the "salmon-bias" hypothesis holds, migrants that are relatively more prone to poor health outcomes may also be more prone to return to their country of origin, leaving behind their healthier counterparts. If the physical and psychic costs of unauthorized migration are more likely exert pressures on migrants to return home, then we would expect the relative health of unauthorized immigrants to increase over time as this leads to an increasingly select population of unauthorized migrants remaining in the country.

In contrast to the notion that increasing health selection over time may lead to more favorable health outcomes among the unauthorized, other factors distinctive to unauthorized migration, such as stress, may lead to a pattern whereby the health outcomes of unauthorized migrants deteriorate with increasing time spent in the U.S. that at a pace that exceeds legally resident migrants, even after accounting for the relatively slower rate of economic mobility experienced by the unauthorized.

DATA & METHODS

Data

We use data from the 2004 Survey of Income and Program Participation (SIPP). The SIPP is a nationally representative panel survey of households in the United States. The survey includes a core set of questions that are asked during every wave of the panel study as well as questions from topical modules which vary each wave. As the only publicly available nationally representative survey that includes questions allowing the inference of immigrants' legal and citizenship status, the SIPP is ideally suited to addressing the questions posited above. The questions used to determine legal status (described in more detail below) are included in the Wave 2 topical module. In addition to questions about legal status, the SIPP also asks respondents about their general health status and experiences with functional limitations in the topical module for Wave 5. The analytical sample is limited to foreign-born adults over the age of 17, and the sample is weighted using the SIPP person weights provided by the Census Bureau.

Dependent Variables

We examine two widely used indicators of overall health status: self-reported health and functional limitations, both of which are included in the SIPP topical module during Wave 5. Self-reported health is based on a question asking respondents to describe their general health status using one of five response categories: (1) Excellent; (2) Very Good; (3) Good; (4) Fair; or (5) Poor. The health status dependent variable used here collapses these categories in order to create a binary indicator with "fair" or "poor" responses coded '1' and all others coded '0'. The functional limitations dependent variable is based on responses to ten items in the SIPP asking whether respondents experience difficulty performing a range of everyday activities such as climbing stairs, reaching over one's head, or running errands.[1] We operationalize functional limitations as a count

[1] The ten items include: (1) lifting and carrying something weighing 10 pounds; (2) pushing or pulling large objects such as a living room chair; (3) standing or being on one's feet for an hour; (4) sitting for an hour; (5) stooping, crouching or kneeling; (6) reaching over one's head; (7) using hands and fingers to pick up small objects; (8) walking up flight of 10 stairs; (9) walking a quarter of a mile; and (10) going outside the home, for example, to shop or visit the doctor.

variable by summing the number of reported limitations, and thus the measure ranges from 0 (no limitations) to 10 (reported limitations on all indicators).

Legal Status and Duration of U.S. Residence

As indicated above, the Wave 2 topical module includes a series of questions that allow one to infer the probable legal status of immigrants. First, all foreign-born respondents are asked whether they are U.S. citizens and if they were, how they became citizens (e.g., naturalization, their or their spouse's military service, etc.)[2] All immigrants are also asked whether they had "legal permanent resident" (LPR) status upon arriving in the United States or instead arrived with some "other" status. Finally, non-citizens who *did not* report arriving with LPR status (i.e., their status was "other") were asked whether they had since adjusted to LPR status, and if so, the year their status was adjusted.

The large majority of immigrants who are neither citizens nor LPRs are likely to be unauthorized immigrants (Passel and Cohn 2011).[3] However, a non-negligible share will also consist of legal temporary migrants such as foreign university students, temporary workers, and refugees who have not yet adjusted to LPR status. One shortcoming of the public-use version of the SIPP is that the data for the legal status indicators are coded in such a way that makes it impossible to distinguish between unauthorized and legal temporary migrants (i.e., both are classified as "others").[4] Following an approach used by Hall, Greenman, and Farkas (2010), we address this shortcoming by using other indicators of probable legal status available in the data, and reclassify

[2] Here, "foreign-born" refers only to non-citizens or those who became citizens through naturalization or military service. The overwhelming share of foreign-born citizens in the United States obtained citizenship via naturalization, while smaller percentages became citizens through military service, adoption by U.S. citizen parents, foreign-birth to U.S. citizen parents, or some other means. In these analyses, foreign-born persons who were adopted by U.S. citizens, born on foreign soil to U.S. citizen parents, or reported becoming citizens in "other" ways are treated as native-born citizens and thus excluded from the analytical sample.

[3] Passel and Cohn (2011) estimate that of the 12.7 million foreign-born U.S. residents who are neither U.S. citizens nor legal permanent residents, 11.2 million, or 87 percent, are unauthorized.

[4] The more detailed response categories provided in the restricted-use version of the SIPP allows one to distinguish between LPRs, legal temporary migrants, and the residual "other" category that is assumed to consist of unauthorized residents.

non-citizen, non-LPR immigrants as legal if they meet one of the following criteria: (1) currently enrolled as a college or graduate student; (2) is a probable refugee arrival based on country of birth and year of entry in the U.S.[5]; (3) received some form of public assistance for which only legally resident immigrants are eligible (e.g., Social Security, SSI, food stamps); (4) currently servers in the military or is a veteran; (5) employed by federal, state, or local government; (6) works in a "specialty" occupation in which one is very unlikely to be unauthorized (e.g., judge, lawyer, protective services, etc.).

A second source of concern with respect to the SIPP legal status indicators is that the rate of non-response is relatively high. The Census Bureau allocates the missing responses using a "hot deck" procedure using basic demographic characteristics such as age, sex, race and geography. Given that legal status is known to correlate strongly with other characteristics (especially country of birth and duration of residence), we edit the responses to these questions, taking only valid responses at face-value, and coding all of the allocated responses as "missing".

Immigrants in the SIPP are also asked the year in which they moved to the United States. In the public-use data, responses are grouped into 20 categories ranging from prior to 1955 to 2004. The interval of the categories varies from seven-year to single-year categories, with smaller intervals used for the most recent arrival responses. In order to measure duration of residence in years, we approximate the year of arrival by recoding the responses in the data. In the case of odd interval categories, the middle year is chosen as the year of arrival. For even intervals, the year after the median is chosen as the arrival year. For example, those arriving between 1975 and 1978

[5] Probable refugees were identified using data provided by the Department of Homeland Security on the number of persons admitted as refugees by country of birth and year of arrival. Using these data, we calculated the proportion of admissions for a given country-year by dividing the number of refugee admissions by the total number of admissions, and this proportion was assigned to each foreign-born SIPP respondent as his/her probability of being a refugee upon arrival. For example, 94 percent of all immigrants born in the former Yugoslavia and arriving in 1996 were admitted as refugees, and thus a Yugoslavian-born respondent arriving in 1996 is assigned a refugee probability of 0.94. Refugee status is assigned to each respondent if his or her refugee probability exceeds a value drawn at random from a uniform distribution.

are coded as arriving in 1977. The approximated single-year arrival response is then subtracted from the survey year (2004) to create the duration of U.S. residence variable used in the analysis, measured in years.[6] Similar to the legal status questions, item non-response to the year of arrival question is also quite high (roughly 25 percent). As we describe in greater below, we employ multiple imputation techniques to account for problems posed by missing data.

Control Variables

In estimating models of self-reported health and functional limitations among adult immigrants, we include a number of covariates that are known to be associated with these outcomes. To account for language and national origin differences that might affect health status and reporting we include dummies for country or region of birth and English-language proficiency. Whether birthplace is measured at the country or region level is determined by cell sizes and in total 12 country-regions are compared to Mexico, the reference category. Also, respondents are coded '1' as limited-English proficient (LEP) if they report speaking English "not well" or "not at all", while those speaking only English at home or who otherwise indicate that they speak "very well" or "well" are coded '0'. While expectations about the nature and magnitude of the relationship between national origin and language are unclear, they are correlated with both legal status and duration of residence, and we thus include them in order to partial out effects that are due to pre-migration contextual effects on health and language norms in health reporting.

We also include a number of demographic and human capital determinants of health outcomes. We include age measured in years and account for the expected non-linearity in the association by included age-squared. We also include a marital status indicator, coded '1' for persons who are married and living with their spouse, and '0' otherwise. In addition, we include an

[6] Respondents whose approximated year of arrival precedes their birth year are assumed to have arrived in the U.S. prior to their first birthday, and thus their duration of U.S. residence is set as equal to their age.

indicator coded '1' if the respondent reports minor children (under 18) in the household and '0' otherwise.

We include a number of human capital factors that are known determinants of health status. We include educational attainment, measured in years. We also include homeownership, coded '1' for owners and '0' for renters to account for differences in health outcomes that might be associated with housing stability and tenure. Finally, health status is strongly associated to access to the healthcare system, and thus, to having health insurance coverage. Unauthorized immigrants are especially disadvantaged in this respect due the combination of their concentration in low paying and often informal jobs that lack benefits (Yoshikawa 2011) and simultaneous lack of access to public health care benefits (Prentice, Pebley, and Sastry 2005). We thus include a health insurance coverage dummy, coded '1' for persons with coverage, and a poverty indicator.

Methodological Approach

Sample sizes along with weighted means and percentages for the variables included in the analysis are shown in Table 1. Concerns with respect to the scale of missing data are reflected for the key variables in the analysis: self-reported health, functional limitations, legal status and duration of U.S. residence. For all four of these variables, data are missing at a rate that exceeds the threshold at which complete-case analysis through listwise deletion is typically recommended (Allison 2003). In the case of legal status and duration of residence, missing data problems derive from item non-response among immigrant respondents to the Wave 2 topical module. By contrast, the missing data observed for the two health outcomes derives from unit non-response, or attrition from the panel between waves 2 and 5.

We first perform complete-case analyses by estimating logit (for self-reported fair/poor health) and poisson (for number of functional limitations) models, separately for men and women, only among those immigrants with complete data on every variable included in the analysis. The results of the complete-case analysis are presented and briefly discussed below. In order to

increase statistical power and strengthen certainty in the interpretations drawn here, in the full paper we will handle the missing data using multiple imputation techniques, and present model results based on analyses of multiply imputed data sets.

RESULTS

Table 1 reports the weighted percentages and means of variables used in the analysis, separately by legal/citizenship status, for cases with complete data. Zero-order health comparisons indicate that compared to naturalized immigrants, the unauthorized and legal non-citizens, respectively, are less likely to report fair or poor health and report fewer functional limitations. This health advantage persists even though legal non-citizens, and especially the unauthorized, are relatively disadvantaged on socioeconomic indicators such as educational attainment, homeownership and health insurance coverage, and undoubtedly derives from the fact that the unauthorized and legal non-citizens, respectively, are substantially younger, on average, than naturalized immigrants.

In Table 2 we present results from a set of models estimated among adult immigrant women. Models 1-3 are logit models predicting fair/poor health, while Models 4-6 present coefficients from poisson models of the number of reported functional limitations. Because age is so strongly (though not perfectly; r = 0.660) correlated with duration of U.S. residence, partial out age effects by including both age of immigration and number of years in the U.S, thus allowing us to test the association between duration of residence, net of age. In Model 1, we include only the legal status dummies (unauthorized is the reference group), duration of residence, and age at immigration. Net of age at arrival and length of residence, neither legal non-citizens nor naturalized immigrant differ from the unauthorized with respect to the probability of reporting fair/poor health. As expected, net of age and legal status, immigrant women are more likely to report negatively health outcomes the longer they reside in the U.S.

Model 2 interacts legal / citizenship status with duration of residence and lends some support to the hypothesis that the reported health among unauthorized women will decline more precipitously with increased length of residence in the U.S. than legally resident immigrant women. While the association between duration of residence and fair/poor health is weaker for both legal non-citizens and naturalized women, only the later interaction effect is statistically significant at $p < .05$. The main effects of the legal status dummies indicate that among newly arrived immigrant women, the unauthorized are *less* likely to report fair/poor health compared to legal non-citizens and naturalized citizens, though again, the difference is only statistically significant for the latter.

Finally, Model 3 tests whether these legal and citizenship status differences persist when adjusting for other key determinants of health. The inclusion of the covariates does not alter the conclusions drawn in Model 2. Net of other factors, newly arrived unauthorized women report somewhat better health than their legal and naturalized counterparts, but their tendency to report fair/poor health increases more rapidly with years in the U.S. Models 4-6 repeats this exercise for the rate at which immigrant women report functional limitations, and these models yield largely the same patterns that were observed for fair/poor health. We have graphed legal status specific trajectories of both health outcomes over a twenty-year span for immigrant women Figures 1A (Fair/Poor Health) and 1B (Functional Limitations) based on the results of Model 3 and Model 6, respectively.

Finally, in Table 3 we turn to results from models of fair/poor health and functional limitations estimated among immigrant men. Models 1-3 indicate that for men, as with immigrant women, the probability of reporting fair/poor health increases with increased duration of residence in the United States. However, unlike women, the association between length of U.S. residence and self-reported health does not vary by legal and citizenship status for immigrant men, a result which is graphed in Figure 2A. The same is not true with respect to functional limitations, the results of which are shown in Models 4-6. Model 5 indicates that among newly arrived immigrants,

naturalized men, but not legal non-citizens, report functional limitations at a significantly higher rate than the unauthorized. However, the rate at which unauthorized men report functional limitations increases substantially more sharply with time spent living in the U.S. than is true for naturalized men. This conclusion holds in Model 6 with the addition of covariates, but this model also indicates that once adjusting for differences in background factors, significant differences emerge between naturalized and legal non-citizen men as well, both in main and interaction effects. When the results of Model 6 are graphed in Figure 2B, we can see that the sharp rise in the rate of reporting functional limitations among men appears after about 10 years of U.S. residence.

SUMMARY

The initial set of findings presented in this extended abstract lend empirical support to the notion that the degree to which immigrants experience "negative" health assimilation into the United States (i.e., the tendency for health outcomes decline and converge to native levels with increasing length of time spent in the country) is not uniform across the foreign-born population but rather varies significantly across migrants' legal and citizenship statuses. Among new arrivals, unauthorized immigrant men and women tend to report better general health and fewer functional limitations when adjusting for differences in background characteristics that tend to predict these health outcomes. More significant than this, however, is the fact that even when holding these background characteristics constant, the unauthorized foreign-born population experiences negative health assimilation at a pace that is significantly more rapid than legally resident non-citizens and naturalized immigrants. This result appears to be consistent with the notion that mechanisms distinctive to migrants' unauthorized status, over and above risk factors such as poverty and a lack of health insurance coverage, exert an effect on unauthorized migrant health outcomes that is increasingly negative with increased time spent living in the United States.

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Table 1. Weighted Means and Percentages for Variables Used in Analyses of Health Outcomes among Immigrant Adults, by Legal and Citizenship Status: SIPP

	Unauthorized	Legal Non-Citizens	Naturalized
N	1,044	2,426	2,986
% Fair/Poor Health	8	9.8	14.7
% Any Functional Limitation	7	10	18.5
Mean Number of Limitations	0.22	0.33	0.69
% Male	51.3	50.4	47
Mean Yrs. In U.S.	8.2	13.5	25.9
Mean Age at Immigration	26	25.8	24.2
Mean Age	34	39.3	49.3
% Married, Spouse Present	59	63.6	68.3
% Own Minor Children in HH	65.8	65.6	57.6
% Limited English	56.9	37.3	17.7
Education (%)			
0-8 Years Education	33.7	25.9	14.3
9-11 Years Education	15.3	11.2	7.7
H.S. / Some College	33.9	41.1	48.8
B.A. Degree or Higher	17.2	21.7	29.2
% Home owners	28.5	50.6	72.9
% in Poverty	21.8	15.7	11.6
% with Health Ins. Coverage	33.7	54	79

Table 2. Coefficients from Models of Reported Health (Logit) and Number of Reported Functional Limitations (Poisson) among Immigrant Women

	Self-Reported Fair/Poor Health (Logit)						*Number of Reported Functional Limitations (Poisson)*					
	Model 1		Model 2		Model 3		Model 4		Model 5		Model 6	
	B	*S.E.*	B	*S.E.*	B	*S.E.*	B	*S.E.*	B	*S.E.*	B	*S.E.*
Legal, Non-Cit	-0.16	*0.19*	-0.05	*0.29*	0.22	*0.31*	0.07	*0.20*	0.31	*0.29*	0.47	*0.31*
Naturalized	-0.25	*0.21*	0.39	*0.29*	0.92 **	*0.32*	0.09	*0.21*	0.66 *	*0.29*	0.90 **	*0.32*
Yrs.in U.S.	0.06 ***	*0.00*	0.09 ***	*0.02*	0.10 ***	*0.02*	0.06 ***	*0.00*	0.10 ***	*0.02*	0.10 ***	*0.02*
Age at Immigration	0.06 ***	*0.00*	0.06 ***	*0.00*	0.05 ***	*0.00*	0.06 ***	*0.00*	0.06 ***	*0.00*	0.05 ***	*0.00*
Legal x Yrs. U.S.			-0.02	*0.02*	-0.02	*0.02*			-0.03	*0.02*	-0.03	*0.02*
Natz. X Yrs. U.S.			-0.05 *	*0.02*	-0.04 *	*0.02*			-0.04 *	*0.02*	-0.04 +	*0.02*
Spouse Present					-0.15	*0.13*					-0.17 +	*0.09*
Child Present					0.07	*0.14*					0.14	*0.11*
Limited English					0.36 *	*0.16*					0.37 **	*0.11*
0-8 Yrs Ed. [ref]												
9-11 Yrs.					-0.17	*0.21*					-0.16	*0.16*
H.S. / Some Colleg					-0.41 **	*0.15*					-0.19 +	*0.11*
BA+					-0.90 ***	*0.23*					-0.70 ***	*0.17*
Homeowner					-0.33 *	*0.14*					-0.20 *	*0.10*
In Poverty					0.85 ***	*0.15*					0.39 ***	*0.11*
Health Insurance					-0.45 **	*0.16*					-0.04	*0.12*
Constant	-4.39 ***	*0.22*	-4.77 ***	*0.28*	-4.59	*0.38*	-3.91 ***	*0.22*	-4.31	*0.28*	-4.11 ***	*0.33*

*** p < .001; ** p < .01; * p < .05; + p < .10

Table 2. Coefficients from Models of Reported Health (Logit) and Number of Reported Functional Limitations (Poisson) among Immigrant Men

	Self-Reported Fair/Poor Health (Logit)						*Number of Reported Functional Limitations (Poisson)*					
	Model 1		Model 2		Model 3		Model 4		Model 5		Model 6	
	B	*S.E.*	B	*S.E.*	B	*S.E.*	B	*S.E.*	B	*S.E.*	B	*S.E.*
Legal, Non-Cit	-0.19	0.22	-0.29	0.34	-0.01	0.36	-0.28	0.27	-0.01	0.39	0.17	0.38
Naturalized	-0.57 *	0.23	-0.34	0.34	0.20	0.37	-0.23	0.28	0.61 +	0.34	0.86 *	0.35
Yrs.in U.S.	0.07 ***	0.01	0.08 ***	0.02	0.08 ***	0.02	0.07 ***	0.01	0.11 ***	0.01	0.11 ***	0.01
Age at Immigration	0.07 ***	0.01	0.07 ***	0.01	0.07 ***	0.01	0.07 ***	0.00	0.07 ***	0.00	0.06 ***	0.01
Legal x Yrs. U.S.			0.00	0.02	0.00	0.02			-0.03	0.02	-0.03 +	0.02
Natz. X Yrs. U.S.			-0.01	0.02	-0.01	0.02			-0.05 ***	0.01	-0.04 **	0.01
Spouse Present					-0.21	0.17					-0.16	0.17
Child Present					-0.15	0.17					-0.27	0.18
Limited English					0.27	0.18					0.23	0.18
0-8 Yrs Ed. [ref]												
9-11 Yrs.					0.17	0.25					-0.03	0.27
H.S. / Some Colleg					-0.40 *	0.18					-0.16	0.17
BA+					-0.70	0.23					-0.34	0.22
Homeowner					-0.20	0.16					-0.15	0.15
In Poverty					0.71 ***	0.18					0.79 ***	0.16
Health Insurance					-0.50 **	0.18					-0.20	0.18
Constant	-5.25 ***	0.29	-5.32	0.35	-5.11 ***	0.39	-4.44 ***	0.29	-5.00 ***	0.37	-4.64 ***	0.40

*** p < .001; ** p < .01; * p < .05; + p < .10

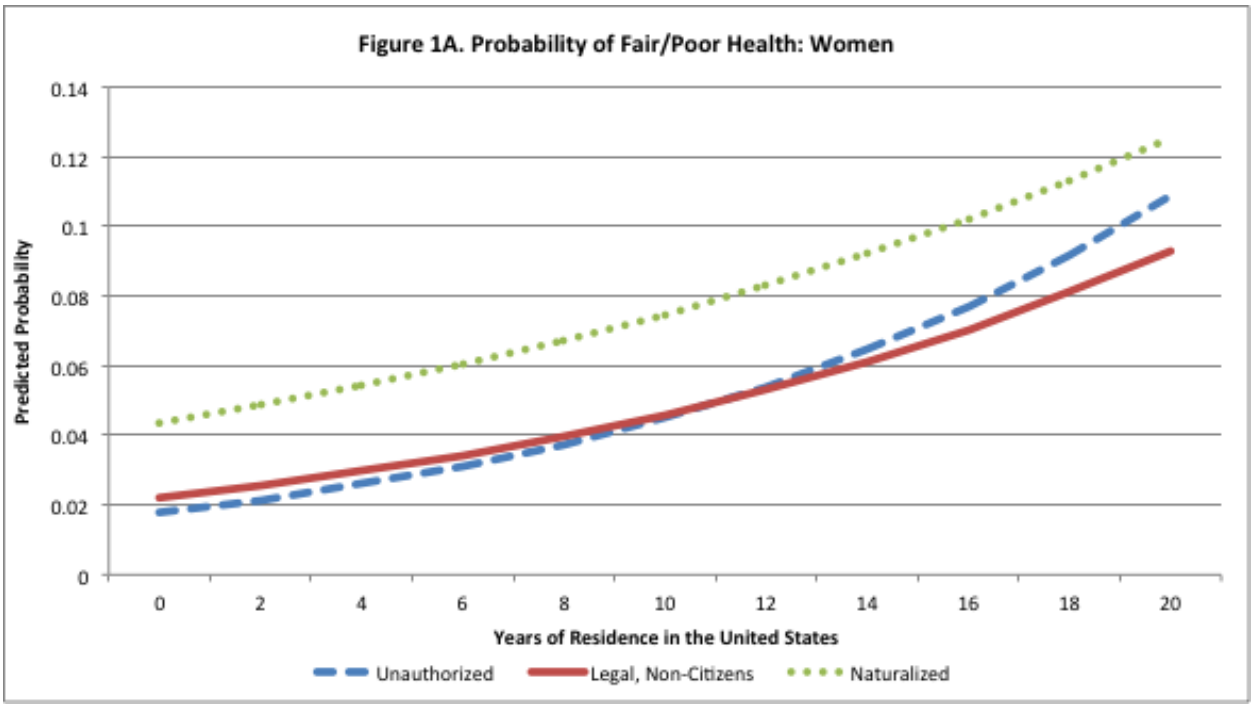
Figure 1A. Probability of Fair/Poor Health: Women
Predicted Probability
0.14
0.12
0.1
0.08
0.06
0.04
0.02
0
0
2
4
6
8
10
12
14
16
18
20
Years of Residence in the United States
Unauthorized
Legal, Non-Citizens
Naturalized

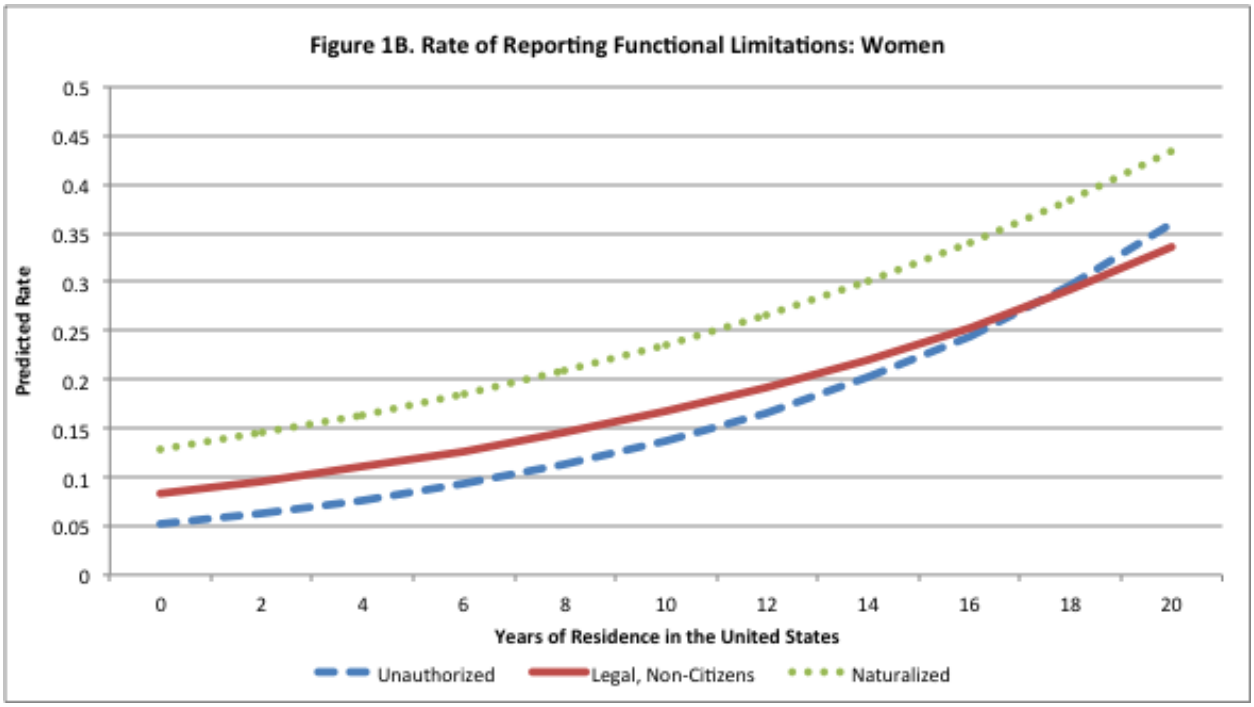
Figure 1B. Rate of Reporting Functional Limitations: Women
Predicted Rate
0.5
0.45
0.4
0.35
0.3
0.25
0.2
0.15
0.1
0.05
0
0
2
4
6
8
10
12
14
16
18
20
Years of Residence in the United States
Unauthorized
Legal, Non-Citizens
Naturalized

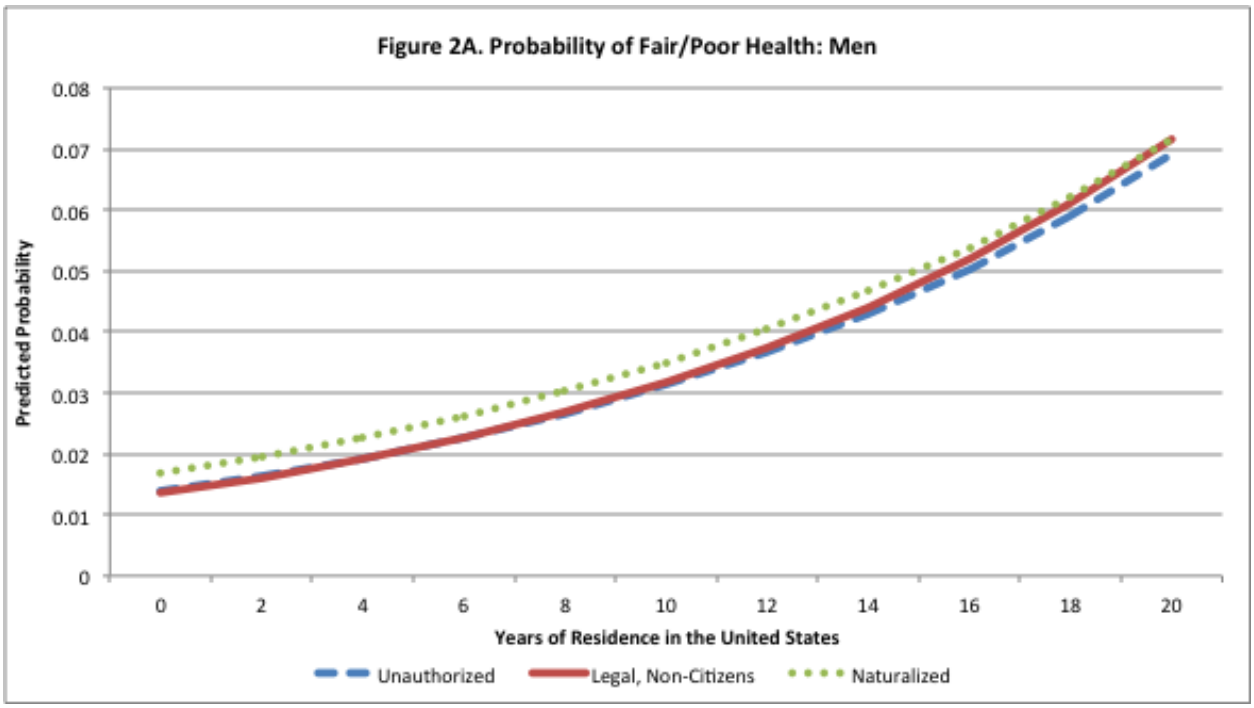
Figure 2A. Probability of Fair/Poor Health: Men
Predicted Probability
0.08
0.07
0.06
0.05
0.04
0.03
0.02
0.01
0
0
2
4
6
8
10
12
14
16
18
20
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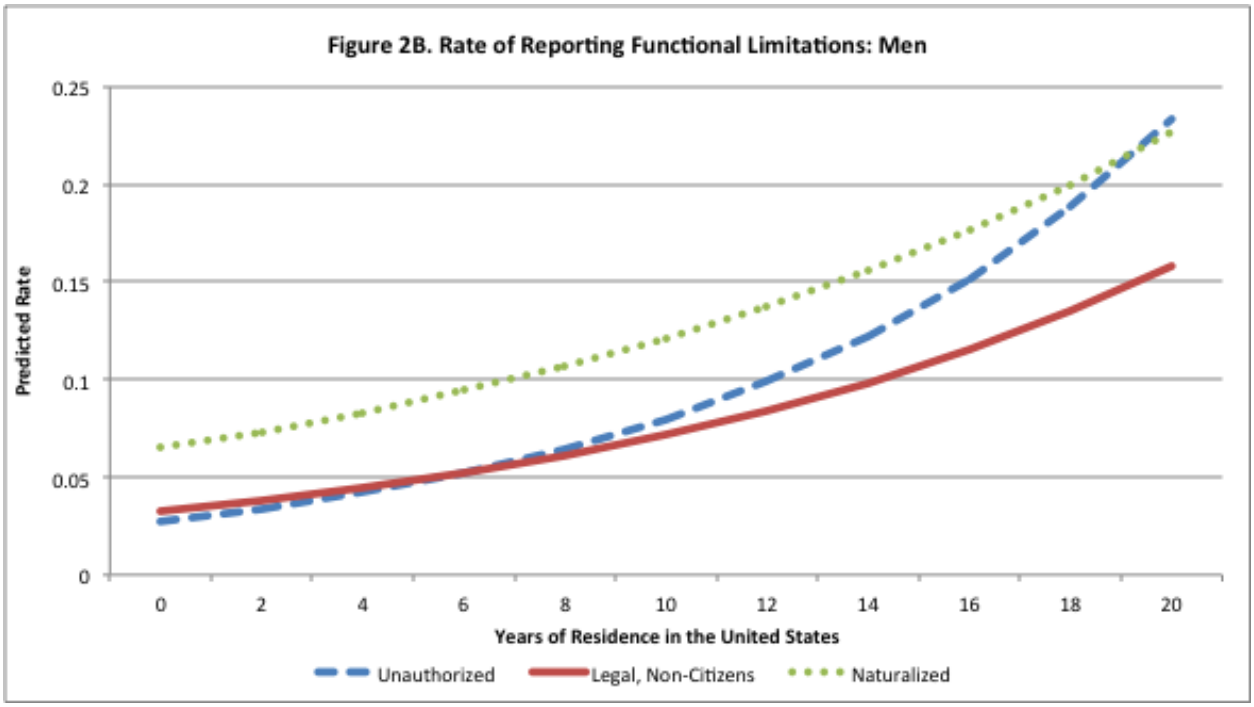
Figure 2B. Rate of Reporting Functional Limitations: Men
Predicted Rate
0.25
0.2
0.15
0.1
0.05
0
0
2
4
6
8
10
12
14
16
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