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US HEALTH CARE SYSTEM AND SOCIAL INSURANCE AS IT APPLIES TO OLDER ASIAN INDIAN IMMIGRANTS IN USA

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ABSTRACT

Access to health care in old age also depends very much on what individuals are protected by various health insurances and other forms of social insurance that people may be entitled to especially after retirement. While inheritance, savings, income and other resources such as ability to navigate the system may play a advantageous role in the lives of many Americans who may have been in the United States for many generations, Asian Indians in the United States may have to rely greatly on their own saved income or employer sponsored health insurance or government sponsored insurance plans such Medicaid that is provided for low-income groups and Medicare. The following pages will give a brief description of various categories of social insurances that may play a role in meeting the health care needs of older Indians in USA.

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Social Insurance

While savings and good health go a long way in old age, it is never enough to stress the need to maintain staying in good health along with adequate means to support sustenance of daily living. The boomer philosophy of rugged individualism in the American context has driven settlers across frigid plains in the nineteenth century and astronauts into outer space in the twentieth century. Such philosophical views are not alien to older Indian immigrants, especially those born between 1946 and 1964. Chatzky and Roizen (2017) describe various steps with regard to taking care of health and financial goals to address the means in attaining both health and wealth in old age. This includes routine health checkup and maintaining healthy behaviors such as exercise, being active citizens, minimizing behaviors that induce stress, remaining motivated with embracing cherished values. Another aspect is frugal spending along with setting aside routine savings plans, investing in tax deferred financial schemes, and living within means. In addressing the above mentioned aspects of health and wealth, one of the widely discussed and most important subjects is health care spending in old age. Not undermining the interplay of health care and health care cost which the older people are strongly encouraged to take under control, it is frequently very hard to shop around and prioritize one's health needs. For the older Indian Americans that may mean shopping around and getting approval for quality health care procedures to be carried out beyond the borders of USA. These are preauthorized health care facilities outside USA approved by the accredited healthcare agency such as Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). This could mean saving thousands of dollars including out of pocket expenses such as copayments without compromising quality and safety (Lalli, 2016). This could also provide Indian nationals an opportunity to visit their home country reminiscing home coming feelings and renewing old relationships which may cater to their psychological need of being connected to their roots and having a sense of belonging in their old age.

According to The Fiscal Times, the total U.S. spending on health care topped three trillion in 2014 (Pianin, 2015). According to Lalli (2016), America stands the highest among the industrialized nation in the ever rising health care costs, a rate increase of 6.8 percent and 6.5 percent in 2015 and 2016 respectively. According to Rosenthal (2017), the United States spends almost 20 percent of its gross domestic product on healthcare, which is more than twice the

average of developed countries. In other words the United States spends nearly one-fifth of its gross domestic product on health care, over $3million a year. This is about the same amount as the entire economy of France, and frequently reported as delivering worse health outcome than any other developed countries (Rosenthal, 2017). The trend towards consumer-directed health plan comprising high deductibles was expected to reach one out of every five people by 2015. For major corporations incorporating high deductible health insurance seemed twenty percent cheaper than traditional plans (Lalli, 2016). The aspect of increasing life expectancy is among the most important factors in considering social security benefits for the older people (Mill, 2016).A big portion of these funds come from pay role deductions which are often taken out of your pay stub.

Private health insurance schemes take up the major chunk of the health care cost. The following list covers the major health insurance schemes other than the private health insurance plans in the United States.

Medicaid and Medicare

Medicaid also known in some places as medical, Medicare, and Veteran health insurance are government sponsored health insurance schemes. Medicaid or medical is often used for people who are disabled or low income groups; veteran health insurance is meant for people who have served in military service; Medicare is for people who have contributed into labor force or people who may have become disabled prior to their age 18. Some people have both Medicaid and Medicare. Medicare and social security are paid through payroll taxes and monthly premiums are deducted from social security checks (Mill, 2016). Medicare is primarily federally funded and Medicaid is state sponsored. A substantial number of older people especially the retired group are covered by Medicare. There are two categories under Medicare namely **Medicare Part A**(hospital, nursing facility stays, hospice care when terminally ill), **Part B, Part C, and Part D.** Medicare Part A covers inpatient hospital stay and long term rehab and Part B covers outpatient clinical visits, medical equipment, tests done outside hospitals, preventive measures, ambulance , air rescue service. In order to enroll in Medicare, recipient has to pay a premium as in private insurance. Premium is based on the annual income. Part C is often referred to as Medicare Advantage. Part C involves signing up with a private insurance company. The

limitation with enrolling in Part C, there may be limited number of providers in some rural areas or outside territories. Just as in the case of Part B, one become eligible for Part D starting three months before your sixty-fifth birthday and ending four months after it. If a person does not sign up for Part D as soon as that person becomes eligible, that person will incur a higher premium (mill, 2016).Someone with Medicare coverage can get treatment anywhere in the United States and there is no geographical boundaries. People purchase insurance plans such as Medigap to deal with gaps in coverage as may be seen in Medicare coverage which does not cover all medical procedures. People with Medicaid have restrictions getting medical care beyond their geographical jurisdiction such as beyond their county, city, or state of residence.

V.A benefit plan.

The veteran benefit comes out of the military budget of the federal government. This budget can vary depending on the sitting ruling party in office. VA hospitals are established regionally and veterans' health services are administered primarily through these settings.

SSI and SSD

In addition to health insurance coverage, social security administration provides retirement funds after an individual reaches retirement age**.** The earliest regular retirement age as of 2016 is 62 and full retirement age of 65 if born in 1937 and 67 if born in 1960 or after. An individual can opt to delay receiving social security benefits until he or she reaches the age of 70 in order to maximize his return. Up on reaching the age of 70, an individual is required to start withdrawing his or her social security benefits. People who become disabled are entitled to social security disability (SSD) benefits. Social security disability is offered to people who either became disabled prior to age 18 or people who have earned sufficient credits in the employment field. According to Mill (2016), as of 2016, Social Security gives a person one credit for every $1260 he or she earns. An individual can earn a maximum of four credits per year. When the individual has earned a minimum of forty credits, he or she is eligible to start receiving benefits. It should be noted that the above mentioned $1260 is adjusted every year to take into account the inflation and other factors. Another assistance program through social security administration is called supplementary security income (SSI) which is meant for low income group based on mean tested poverty level. People who are eligible for SSI are generally also eligible for Medicaid in their

respective states of residences. Visitors, undocumented aliens (people who are not legally in the United States), people on student visa or work permit are not eligible for such benefits unless they become permanent residents of the United States who are eligible to vote. Public assistance is another financial benefit offered through the local government which during the Clinton presidency put a cap for a maximum five years at which time the benefit will be terminated or converted to a different category depending on their legal and employment status. Many of the elderly immigrants were entitled to public assistance which is now under strict scrutiny due to their lack of US citizenship or overstay beyond a month outside the country. People who are SSI or public assistance recipient have to prove their eligibility requirement by proving that they have no other source of income or asset within or outside the country of US residency. Social Security administration has required immigrants to declare that they have no other source of income, investment or asset in their country of origin. They are also required to be citizens of the United States to be eligible for these benefits, a movement that was emphasized both in the congress and senate during the presidency of Bill Clinton.

The importance of social security benefits for minorities

Because many older Asian Indian immigrants may belong to the minority group, they may be also part of the lower-earning class of the population of the United States. In a 2012 survey conducted by Social Security of the "Income of the Population, 55 or Older", found that for beneficiaries aged sixty- five and older comprised at least 90 percent of the income received by 44 percent of Asian Americans, 46 percent of African Americans, and 53 percent of Hispanics, as compared with only 35 percent of the whites (Mill, 2016). Although older Indians as a minority classification may not be clearly defined in this study, some studies have found to include Indians as part of Asian population. Therefore some caution is required when talking about older Asian Indians in USA

While there may be some degree of mismanagement as in any large and complex systems, social security is also not exempt from such pitfalls. It is recommended that people who are not sure about their eligibility to apply for benefits to consult a financial planner or attorney who specializes in social security benefits to avoid serious mistakes. In simple terms, those who paid into the social security system get benefits and those who didn't don't get it. While access to

health care is the end goal, affordability to access the best health care cannot undermine the role of financial security which is a vital element not to be taken for granted. Sometimes the best and the latest available treatment options may not be the norm as approved by standard insurance plans and out of pocket expense for such treatment may not be within reach. The commercialization of American health care system which is directly related to rising health care costs tends to take a major toll on older Indians whose pockets are often just on the brink of bankruptcy when it comes to meeting their health care expenses when illness strikes them. Many of them travel to their native country where the American dollar currency exchange fetches attractive and comprehensive treatment options. The negative side to this approach means taking a higher risk in their native country where health care accountability is much less transparent when compared to treatment in their country of immigration like the United States and other developed nations. It is a difficult decision for the older retiring Indians to decide whether they should spend more time in US or in their country of origin taking various risk factors associated with their health. If old age is not a matter of concern due to their health status, they can choose to stay longer in any place they wish to reside.

Resources for financial health in older years

As we discussed earlier assuming that money is not everything for happiness, it is important to pay attention to financial planning to deal with unforeseen crises that is very likely to occur in old age. While the culture of religions may proclaim that "money is the root of all evil", money becomes a necessary evil to make negotiations much easier especially in old age when dependence on health system and other resources to take its course with less hassles. A little bit of planning goes a long way to minimize the burden on oneself, family members, and friends with time efficiency and avoid abomination from near ones. The need for a financial planner who specializes in old age planning becomes a necessity. Mr. Mill (2016) lists some of the items that will cater to such planning as early as possible.

Almost every financial planner will recommend investing while a person is young. This is important especially at a time when pension plans are vanishing from businesses and corporations. The following are some of the financial schemes described in Mill's book that when acted upon in a timely manner is likely to bring safe returns in old age.

1)401(k) plans that are offered by private companies

2) 403(k) plans, offered by nonprofit, tax-exempt employers, such as schools and colleges, hospitals, museums, and foundations

3) 457 plans, offered by federal, state, and local government agencies and 403(B) defined contribution plans used by nonprofit organizations

4) Other defined contribution plans include Employee Stock Ownership Plans (ESOP), money purchase plans, profit sharing plans, simplified employee pension (SEP) plans, savings incentive match plans for employees (SIMPLEs), and Thrift Savings Plans (TSPs). These schemes have one common factor that is there are no taxes on the earnings until he/she withdraws the money.

There are many employers who match a certain percentage of an employee contribution. The percentages of contributions vary but the match is between fifty cents and $1 for every dollar the individual contributes up to 6 percent of his/her salary. Not taking advantage of such a schemeis like refusing free bonus money. Actually, the return is greater than 100 percent when factoring in his/her tax savings.

5) Individual retirement accounts (IRAs) are Traditional IRAs and Roth IRAs. Traditional IRAs are tax deductible and Roth IRAs are not. Individuals are required to withdraw a minimum amount each year from their Traditional IRAs once they reach the age of seventy and a half. Roth IRAs do not have such requirements.

(SIMPLE) IRA is a match plan offered by business with no other retirement plans and with fewer than 100 employees. Like the 401(K) plans, employee contributions and earnings are tax-deferred. Each eligible employee can contribute a maximum of 12500 a year. The employer must either match 100 percent of employee contributions, up to 3 percent of his/her salary, or contribute 2 percent of compensation (up to $5,300) for each eligible employee, even those who don’t contribute to the plan. A simplified employee pension (SEP) IRA is similar to SIMPLE IRA, except that only your employer can contribute. The negative side to this scheme is that only your employer knows how much money is being contributed into your plan as you can’t contribute any of your own money unless you are self-employed and contribute your own money. The limit on employer contribution is 15 percent up to maximum of $40,000.00 a year. With both SIMPLE IRAs and SEP IRAs, one can still invest in a Traditional or Roth IRA.

Financial planning as a way to protect savings and improve eligibility for health insurance

Old age and retirement is frequently known to limit individual income as they are no longer employed. Unexpected health conditions can lead some people into bankruptcy and occasionally placing family members on financial burden. Asset planning and choosing trustees can minimize the chance of one's savings being used as fees for unnecessary legal and administrative expenses. If an individual's income exceeds the limits for a traditional IRA, his/her contributions won't be tax deductible since tax deductibility is the biggest advantage of a Traditional IRA. If one doesn't qualify for a tax deduction, then Roth IRA is probably the best choice.

Keogh Plans

The Keogh plans are tax deferred retirement plans for people who have self-employment income. Currently the Internal Revenue Services (IRS) no longer uses the term "Keogh Plan", but two types of defined –contribution plans are still referred to as Keoghs by most people: profit sharing and money purchase plans. Money purchase Keoghs requires the same contribution each year even if you don't make a profit. Contributions are limited to $5200 or 25 percent of an individual's self-employment income. Contributions to profit-sharing Keoghs can be zero to 25 percent of self-employment income up to $40,000 and can change each year. These complex plans are best handled by a specialist in accounting or a professional familiar with retirement savings.

Choosing the right investment

If an employee participates in a traditional pension plan, the employer makes all the investment decisions for you. For most retirement plans, you are basically your own scout. Other options are Stocks, Bonds, and Mutual Funds. It is not recommended to put all your funds in one investment as there is a risk of loss due to the fact that the investment doesn't perform well or becomes subject to mismanagement (fraud or negative market process).

Annuities

When buying annuity, you sign a contract with an insurance company that stipulates the amount of your investment, whether you choose a fixed or variable rate for interest, the method of

payment, and any fees. Fixed-rate annuities guarantee a specific interest rate for the life of the annuity. Interest rate in variable-rate annuities fluctuates with the ups and downs of the financial market. You can invest with one lump-sum payment or build it gradually over time.

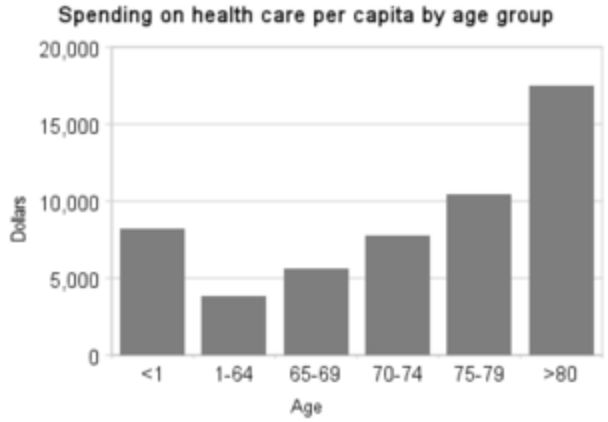
Each person's earnings grow tax-deferred, but the money you put in is not tax-deductible, so this is an investment best suited for someone who has taken full advantage of all the tax-deductible plans available and still has money left over to invest. It's unlikely that the average person in her or his twenties or thirties would choose this investment vehicle, but needs to be aware of it. Social Security Administration recommends that benefit holders open social security account (www.ssa.gov/myaccount) and regularly check your account. Planning ahead early on can mitigate financial insecurity and facilitate retirement with a sense of confidence.

A comparative approach to Canada's Health care services

In general US health care system is often compared to Canada's health care services. The Canadian province first introduced near universal health coverage in 1947. Canada's health program is largely a publically funded Medicare program where everyone who is enrolled in the medicare program gets same level of care. While the United States has a similar medicare program for seniors and disabled, they carry a large amount of copayments. The Canadian health care system is known as single payer system. All basic services are provided by private doctors whose entire fees are paid for by the government at the same rate. The pharmaceutical expenses in Canada are cheaper than pharmaceutical companies in USA largely due to the fact that in Canada, the government has price control strategies. Because of lower medication prices, many US residents seek pharmaceutical services from Canada. Hospital services are free through publically funded hospitals. According to the world health organization in 2007, the US ranks 37 as compared to Canada which ranks 30.

While the Canadian system may offer cheaper services, Canada has one of the longest waiting period for selective health care procedures. Overall the Canadians find their public health system more attractive than their American counterparts. The following charts provide information on health care spending in Canada.

Canadian Health care spending

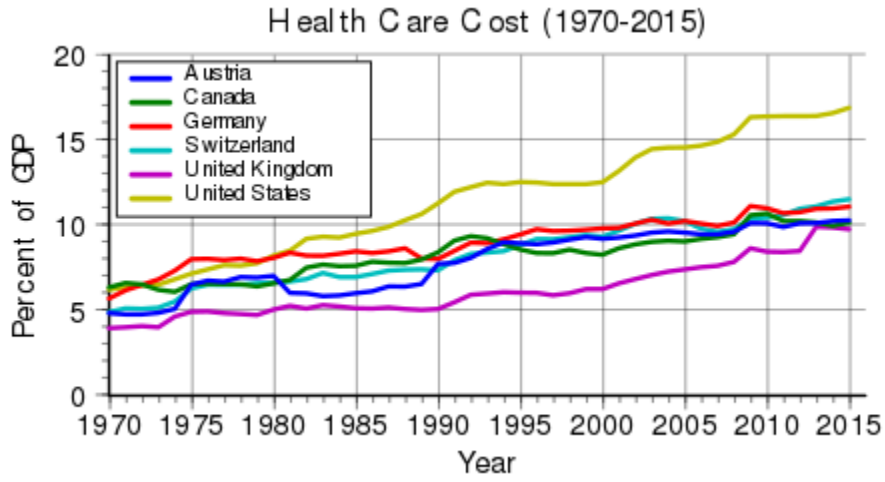


Canadian per capita health care spending by age group in 2007

https://en.wikipedia.org/wiki/Healthcare_in_Canada#cite_note-CIHI_p.xiv-26, p.xiv

Total Canadian health care expenditures in dollars in 1997 from 1975 to 2009.[27]

https://en.wikipedia.org/wiki/Healthcare_in_Canada#cite_note-CIHI_p.xiv-27, p.119



Canadian health care spending for 1970 to 2007 compared with other nations

https://en.wikipedia.org/wiki/Healthcare in Canada cite note-CIHI p.xiv-26

A comparative look at other countries

The following comparative chart gives an overall health spending statistics collected by the Organization for Economic Co-operation and Development (OECD) countries that include Canada and USA. The chart shows the highest per capita expenditure among the OECD countries is spent by USA.

Country	**Life expectancy. 2015.**[142]	**Under-five infant mortality rate per 1000 live births. 2015.**[143]	**Physicians per 1000 people. 2013.**[57][144]	**Nurses per 1000 people. 2013.**[58][145]	**Per capita expenditure on health (USD - PPP). 2015.**[146]	**Healthcare costs as a percent of GDP. 2015.**[146][147]	**% of government revenue spent on health. 2014.**[148]	**% of health costs paid by government. 2014.**[149]
Australia	82.8	3.8	3.4	11.5	4,420	9.3	17.3	67.0
Canada	**82.2**	**4.9**	**2.6**	**9.5**	**4,608**	**10.1**	**18.8**	**70.9**
France	82.4	4.3	3.3	9.4	4,407	11.0	15.7	78.2
Germany	81.0	3.7	4.0	13.0	5,267	11.1	19.7	77.0
Japan	83.7	2.7	3.3	11.5	4,149	11.2	20.3	83.6

Country	Life expectancy. 2015.[142]	Under-five infant mortality rate per 1000 live births. 2015.[143]	Physicians per 1000 people. 2013.[57][144]	Nurses per 1000 people. 2013.[58][145]	Per capita expenditure on health (USD - PPP). 2015.[146]	Healthcare costs as a percent of GDP. 2015.[146][147]	% of government revenue spent on health. 2014.[148]	% of health costs paid by government. 2014.[149]
Sweden	82.4	3.0	4.1	11.2	5,227	11.1	19.0	84.0
UK	81.2	4.2	2.8	8.2	4,003	9.8	16.5	83.1
US	79.3	6.5	2.6	11.1	9,451	16.9	21.3	48.3

https://en.wikipedia.org/wiki/Healthcare_in_Canada#cite_note-CIHI

Finding satisfaction as an element of quality of life in retirement

While health care cost may be directly related to major aspects of quality of life among older Indian immigrants in USA, their focus is also often on the various aspects of their family dynamics in the context of their immediate and extended social circle (Bean and Bell-Rose, 1999). Relationship between parents and children within the family and outer circle, their social status, the status of their children in relation to their education, employment, and marriage are some of the aspects older Asian Indian immigrants frequently grapple with when discussing sense of satisfaction with life in older years.

Suggestions

- There is so much discussion in the news media that social security account will deplete itself in the near future. This myth has no validity based on the strong history it has over the years
- The medical portion of the social security benefit, namely, Medicare need to look at more cost effective ways to be more comprehensive and minimize out of pocket medical expenses
- Retirement is a privilege and there should be ample opportunity for older people and retirees to travel and do activities as they please without social security placing restrictions on their private interest, especially for people who wish to travel to their native country to reminisce

their younger days. Such opportunities have therapeutic value for older people as well as their social circle.

- Promoting social net-work and support group of their choice can minimize isolation and loneliness in older years.
- Collaborative holistic model that will take into consideration care coordinators, designing each care plan, appropriate communication with agent, legal counsel, and family in an attempt to defining health and life goals.

Recommendations

- Adequate provisions in the retirement funds must be established early on in life to safeguard against people becoming at the mercy of public funds in older years.
- A team approach that include legal advisors, financial advisors, medical advisors, care givers, trustees, and other administrative and service providers can promote better coordination of services. Policies relevant to such provisions must be put in place like the health care proxy at early stage.
- A motion for universal health care plan covering all health care services need to put in place in older years.

References:

- Bean, D. F. & Bell-Rose, S. (Eds.). Immigration and opportunity: race, ethnicity, and employment in the United States.
- Chatzky, J., Roizen, M. F., and Spiker, T. (2017). Age proof. Hatchette Book Group, Inc., USA.
- Lalli, F. (2016). Your best health care now. Touchstone, New York.
- Mill, A. (2016). Social security 101. Adams Media, MA, USA.
- Pianin, E. (2015.) The Fiscal Times 2009-2017, Washington D.C: http://www.hhs.gov/afr.
- Rosentahl, E. (2017). An American Sickness. Penguin Press, New York.
- WHO (2000). Health Care in Canada.