Older Immigrants and Medicare

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INTRODUCTION

Enrolling in the Medicare program and accessing its benefits can be complex and is often confusing for older adults. The process can be even more challenging for older immigrants, some of whom do not have a significant work history in the United States, are not citizens, or have limited English proficiency. Almost 7 million U.S. residents age 65 and older are immigrants, and 4 million Medicare beneficiaries are limited English proficient.[1]

To assist advocates working with older immigrants who may qualify for Medicare, this issue brief discusses Medicare policies and practices most relevant to older immigrants. Specifically, it looks at:

- Eligibility and enrollment, with particular attention to rules affecting non-citizens
- Help paying for coverage
- Post-enrollment issues potentially affecting immigrant beneficiaries
- Language access rights and resources in Medicare.

The issue brief includes numerous hypothetical examples. The names and details are created to illustrate the rules and are not actual case reports.

PROGRAM ELIGIBILITY, ENROLLMENT AND COSTS

The Social Security Administration (SSA) determines eligibility and handles enrollment for the two core Medicare benefits: Part A, generally referred to as the hospital benefit, and Part B, which covers physicians and most other health services. Beneficiaries with either Part A or Part B coverage can enroll in Part D, the prescription drug benefit. The Centers for Medicare and Medicaid Services (CMS) handles enrollment in Part D, the prescription drug benefit. Beneficiaries with both Part A and Part B coverage have the option to receive their benefits through managed care, called Medicare Advantage. CMS is in charge of Medicare Advantage enrollment.[2]

Premium costs for Medicare

Many older immigrants who immigrated later in life have little or no work history in the United States, a fact that affects their Medicare costs, and, in some cases, their eligibility.

Part A premiums can be a particular challenge for some immigrants. Most Medicare beneficiaries qualify for Part A coverage without paying a premium. They qualify based on their work credits (generally 40 quarters, approximately ten years) or on the work credits of their spouse.[3] Those without the required credits must pay high premiums for Part A coverage, up to $437/mo. in 2019.[4] Note that work credit requirements are different for people qualifying for Medicare on the basis of disability and that there also are unique rules for people with ESRD.

In addition, Medicare Part B requires a premium payment, which for 2019 is $135.50/mo.[5] Both Part A and Part B have late enrollment penalties that may apply to individuals who do not enroll when first eligible.[6] Medicare Prescription Drug Plans (PDPs) also have premiums that vary depending on the plan, as well as late enrollment penalties for delays in enrollment.

To purchase Part A, an individual must also enroll in Part B. In contrast, it is possible to enroll only in Part B and forgo Part A coverage. Individuals can enroll in the Part D prescription drug benefit if they have either Part A or Part B coverage.

Immigration status and enrollment

To enroll in either Part A or Part B, an individual must either be a U.S. citizen or be lawfully present in the United States. In most cases, as discussed in detail below, a non-citizen who does not qualify for premium-free Part A must be a lawful permanent resident (LPR) with five years of continuous residence in the U.S. immediately prior to Medicare enrollment.

Individuals who are not lawfully present (undocumented) are ineligible to receive any Medicare coverage under any circumstances.[7]

A. Citizens have no length of residency requirements

U.S. citizens face no length of residency requirement to enroll in Medicare, whether or not they have the work credits to qualify for premium-free Part A.[8] Those who are living abroad and return to the U.S. after they reach the age of 65, however, can face additional costs and gaps in enrollment if they do not enroll during the Initial Enrollment Period (IEP) around their 65th birthday. In most cases, they do not have a Special Enrollment Period (SEP) when they return so must wait until the General Enrollment Period (GEP), which extends from January 1 to March 31 each year, with coverage starting July 1. They also face late enrollment penalties if they do not enroll during their IEP, even though, when they are living abroad, they have no access to any Medicare benefits.

Case Examples: Citizens living abroad

Mr. Santos, born in the Philippines, came to the United States twenty years ago. He worked and contributed to Social Security and Medicare since shortly after he arrived. He has been a U.S. citizen for ten years but has lived in the Philippines for the last four years caring for relatives, who are now deceased. He returned to the United States in the fall last year, shortly after he turned 68. Because he is a U.S. citizen, he was able to begin his Part A Medicare immediately. The fact that he reestablished U.S. residence only months ago was irrelevant to his eligibility for Part A or Part B. Though eligible for Part B, he did however face a delay in enrolling. The fact that he was living overseas and unable to use Medicare benefits did not delay his IEP and there is no Special Enrollment Period for returning citizens. He will only be able to enroll in Part B during the GEP with enrollment effective July 1. Mr. Santos will also owe a late enrollment penalty for his Part B premium because he did not enroll during his IEP.

Ms. Reyes, who will have her 65th birthday in a few months, came to the U.S. in the same year as Mr. Santos. She also is a citizen and also spent extended periods out of the country to care for family members. She, however, does not have the work history needed for premium-free Part A, but she wants to enroll and pay the premiums. Because Ms. Reyes is a citizen, she can enroll in premium Part A during her IEP and in Part B without any length of residency requirements. The Social Security Administration (SSA) will not look at her time abroad when processing her enrollment.

B. Lawfully present non-citizens who qualify for Part A without a premium have no length of residency requirement

Lawfully present individuals[9] with work credits that qualify them for premium-free Part A also do not face any length of residency requirement.[10] This includes both LPRs and individuals in Temporary Protected Status (TPS) who have sufficient work credits. Because they qualify for premium-free Part A, these individuals can enroll in both Part A and Part B without any length of residency requirement.[11]

Although advocates for older adults report that they usually see only LPRs and TPS holders with the required work history, it is possible that other categories of lawfully present individuals, such as Compact of Free Association (COFA) Migrants or asylees, could accrue enough work credits to qualify for Part A without a premium. In many cases, these would be younger individuals who qualify for disability-based Medicare with fewer years of work credits.

Case Examples: Lawfully present residents (LPR) with sufficient work credits for Part A

Ms. Morales, originally from El Salvador, has lived and worked in the United States for 13 years holding Temporary Protected Status. Her work history qualifies her for premium-free Part A. She can enroll in both Part A and Part B. The fact that she is not an LPR will not be considered. It is sufficient that she is lawfully present.

Ms. Lopez is an LPR who came to the U.S. three years ago. She married another LPR shortly after arriving. Her husband, a long-term U.S. resident, has enough credits for premium-free Part A. Ms. Lopez is turning 65. Because she can rely on her husband's work history, she can start her Part A and Part B coverage right away, even though she has not been a U.S. resident for five years.

Advocacy tip

Terminology can be confusing. For example SSA and CMS use the term "entitled to Part A benefits" to describe someone who qualifies for premium-free Part A. Another possible point of confusion it the fact that, although "Lawful Permanent Resident" (LPR) is the term used in most immigration contexts for green card holders (and also used in this issue brief), SSA refers to those individuals as Lawfully Admitted Permanent Residents (LAPR).

C. Non-citizens without the work credits to qualify for premium-free Part A face additional status and length of residency requirements

Many non-citizen immigrants do not have the work credits to qualify for premium-free Part A. To be eligible for any Medicare benefits, these individuals must 1) be lawful permanent residents (LPR, holding a green card) and 2) have five years of continuous residence in the United States immediately prior to Medicare enrollment.[12] The Social Security Administration determines whether an individual has met the five-year continuous residency requirements.

When does the five-year period start? The five-year period of U.S. residency begins the day the individual arrives in the U.S. with the intention of establishing a home. The period can start before the individual has LPR status. The five-year clock can start, for example, with arrival under refugee or aslyee status. It cannot start with visitor status since visitors are assumed to be retaining their foreign residence.[13]

What qualifies as "continuing residence"? SSA looks at records of entry into the United States compiled by the Department of Homeland Security.[14] Temporary absences do not affect "continuous" residence as long as the individual intends to maintain U.S. residence, but if absences are frequent or of long duration, the agency may inquire in order to determine whether continued U.S. residency was intended. Examples of evidence of intent could include continuing to pay U.S. income taxes, maintaining a house or apartment with the individual's furnishings and belongings, etc. If an absence is over six months, SSA requires a "strong showing" of intent to retain U.S. residence.[15]

If SSA determines that continuous residence has been broken, the new five-year period begins on the date that the individual has returned to the United States.

Case Examples: LPRs without work credits

Mr. Rao, an LPR, came to the United States at age 62 to join the family of his son, a U.S. citizen. He has taken on a little part-time work but mostly helps care for his grandchildren. Because he does not have enough work history in the U.S. to qualify for premium-free Part A, Mr. Rao must wait for five years from his date of entry to the U.S. to qualify for any Medicare coverage. When he qualifies he can enroll in premium Medicare Part A and Part B, or can decide to enroll only in Part B.

Mr. Lee just turned 65. He has been an LPR since his arrival in the United States eight years ago but does not have sufficient work history to qualify for Part A without a premium. Most years, he takes a trip back to Korea to visit family, usually for about six weeks. Mr. Lee applied for Part B Medicare coverage. The Social Security Administration accepted his application because he is an LPR and, despite several short absences, has met the continuous residency requirements.

If an LPR subject to the five-year continuous residency requirement marries someone with premium-free Part A entitlement, the LPR, after a year of marriage, will also have Part A entitlement based on the spouse's work history. The continuous residency requirement will no longer apply.[16]

Case Example: LPRs with work credits by marriage

Mr. Williams, a 65 year old LPR, came to the United States from Jamaica last year when he was 64. Because he is subject to the five-year continuous residency period, he cannot enroll in Medicare until he is 69. However, next month he plans to marry Ms. Allen, also an LPR. She has been in the U.S. over 15 years and, because of her work history, qualifies for Part A without premiums. Once they are married for a year, Mr. Williams will be entitled to Part A without premiums based on Ms. Allen's record. He won't have to wait for five years to pass.

What about Medicare Part D and Part C (Medicare Advantage)? Part D and Part C do not have separate citizenship or length of residency requirements. Plans are prohibited from requesting from a member any documentation of citizenship or alien status. CMS provides the official status to the plan. If CMS records show that a plan member is not lawfully present, the plan is required to disenroll the member.[17] Individuals with either Part A or Part B can join a Part D plan. To join a Medicare Advantage plan under Part C, a beneficiary must have both Medicare Part A and Part B.

Advocacy tip

Enrollment denials or disenrollments arising from errors in SSA and/or CMS records will need to be corrected with those agencies. These denials are not subject to Medicare plan appeal processes.

PAYING FOR COVERAGE

Even when an immigrant qualifies for Medicare coverage, affording that coverage can be a challenge. This is particularly true for immigrants who must pay premiums to enroll in the Part A benefit. The steep Part A premiums are simply out of reach for many. Premiums for Part B and Part D coverage also add to the financial burden for low-income immigrants.

State Medicaid programs can assist with Medicare premiums

There are several ways that state Medicaid programs can assist low-income immigrants with Medicare costs. Every state's standard Aged and Disabled (A&D) Medicaid benefit includes payment of the Part B premium for Medicare beneficiaries. The income and asset limits for A&D Medicaid, though they vary by state, are low.

Medicare Savings Programs (MSPs) operated by state Medicaid agencies also offer premium relief and generally have higher income and asset limits. MSPs do not provide full Medicaid coverage; instead they are specifically designed to assist with Medicare affordability. Federal law sets minimum countable income and asset limits for MSPs that are higher than for A&D Medicaid, and states have the option to be more generous than federal law requires. The National Council on Aging (NCOA) has created a chart showing each state's requirements.[18]

The MSP with the richest program benefits, the Qualified Medicare Beneficiary (QMB) program, can be particularly helpful to low-income immigrants who must pay a premium for Part A. Under the QMB program, the state Medicaid agency pays both Part A and Part B premiums. In most states, income must be at or below 100% of the federal poverty level (FPL) and countable resources may not exceed (for 2019) $7,730 for an individual and $11,600 for a couple. As the NCOA chart shows, some states have raised income and/or asset cut-offs significantly and a few have abolished the asset test altogether.[19]

In addition to paying Medicare premiums, QMB enrollment protects beneficiaries from paying Medicare deductibles and co-insurance. Note that many QMBs also qualify for A&D Medicaid and are referred to as QMB-plus.

Two other MSP programs, the Specified Low-income Medicare Beneficiary (SLMB) program and the Qualified Individual (QI) program, only pay Part B premiums. The federal minimum income requirements for these programs are 135% of FPL and 150%, respectively. Minimum asset requirements for both programs are the same as for the QMB benefit.

State Medicaid programs, including MSPs, have immigration status and length of residency requirements.[20] For A&D Medicaid and MSPs, individuals must be "qualified" (a status that includes LPR but not TPS). Most qualified immigrants, including LPRs, are subject to a five-year bar before qualifying for Medicaid benefits. These restrictions mean that a Medicare-eligible individual with TPS cannot get help from Medicaid with Part B premiums or co-insurance. The five-year bar can also affect Medicaid eligibility for some LPRs.

Advocacy tip

Advocates report that many immigrant families are reluctant to apply for any needed Medicaid benefit for older family members because of fears of estate recovery. It is important to inform beneficiaries and their families that the QMB benefit and other MSPs are exempt from estate recovery.

Case Examples: Medicare Savings Programs

Ms. Morales, a TPS holder, has Medicare Part A coverage because of her long work history in the U.S. Her income is below 100% of FPL but she cannot qualify for QMB assistance with her Part B premiums because she is not in "qualified" status.

Ms. Gonzales, an LPR, gets Part A without paying a premium based on her husband's work history. Her income and assets qualify her for the SLMB benefit but she only has three years of continuous residence in the U.S. She will have to wait another two years before she can enroll in SLMB to get help with her Part B premiums.

Enrolling in the QMB program can be challenging

As discussed above, the QMB benefit can be particularly helpful to low-income immigrants who must pay a premium for Part A. The mechanics and timing of enrolling in the QMB program, however, can be complex. Enrollment procedures depend on the state and on whether the individual already is enrolled in Part B. For those who are not enrolled in Part B and/or who are in "group payer states" as discussed below, enrollment may require visits to both the Social Security office to apply for "conditional" Part A enrollment, and to the state Medicaid agency to apply for QMB enrollment.

In the majority of states (identified as "Part A buy-in states"), individuals can apply for QMB coverage at any time of the year and coverage begins in the month immediately following approval. In 14 states (identified as "group payer states"), however, people without premium-free Part A may only apply at SSA for conditional Part A enrollment during the General Enrollment Period (January 1-March 31) each year, [21] with QMB enrollment beginning no earlier than July 1.

A Justice in Aging fact sheet[22] and recently-issued clarifying guidance from SSA detail the specific steps needed to apply in each set of states.[23]

Advocacy tip

Advocates should give their clients step-by-step guidance so that they follow through with all needed procedures. Particularly in group payer states, calendared reminders and follow-up may be needed to ensure that clients successfully navigate the enrollment process.

Case Example: Enrolling in QMB

Mrs. Chen is 66 and lives in Arizona, a group payer state. She came to the U.S. seven years ago and has met the status and residency requirements to qualify for Medicare. Since she has no work history, she has not enrolled in Medicare because she cannot pay the premiums, especially the Part A premium, which tops $440/mo. In June, she meets with an advocate who tells Mrs. Chen that, with her income and assets, she qualifies for the QMB program, which will pay both her Part A and Part B premiums. She tells Mrs. Chen, however, that she must wait until January to go to SSA and apply for conditional Part A enrollment and for Part B. With Mrs. Chen's consent, the advocate also tells her daughter and urges both of them to put the date on their calendars. In December, the advocate contacts both Mrs. Chen and her daughter to remind them to make an appointment with SSA in January and, after applying for conditional enrollment at SSA, to go directly to the state Medicaid office to apply for QMB. The advocate follows up in late January to make sure that Mrs. Chen took the required steps. She did, and finally on July 1, to her great relief, Mrs. Chen gets both Part A and Part B coverage without premiums. Mrs. Chen, because of her QMB status, is also protected from payment of co-insurance and deductibles.Her QMB enrollment also automatically qualifies her for the Part D Low-income Subsidy (discussed below) to help her with prescription drug co-insurance.

Marketplace enrollment offers an alternate coverage option

Immigrants who do not qualify for premium-free Part A can also consider enrolling in a Qualified Health Plan (QHP) in the Marketplace and applying for financial assistance in the form of premium tax credits and cost-sharing reductions.

QHPs are available to LPRs as well as individuals on non-immigrant visas and with other status, including many temporary status categories.[24] Immigrants who are eligible to enroll in QHPs and do not have other "minimum essential coverage" may also qualify for premium tax credits and cost-sharing reductions to help them afford coverage.[25] There are no length of residency requirements for QHPs or for premium tax credits and cost-sharing reductions. Further, lawfully present individuals, unlike citizens, can receive premium tax credits and cost sharing reductions, even if their income is below 100% of FPL if they are ineligible for Medicaid because of their immigration status.[26]

When sorting through beneficiary eligibility and enrollment options, it is important to remember that, though there are significant variations among the states, QMB income counting rules are grounded on SSI income counting rules. In contrast, Marketplace rules on premium tax credits and cost-sharing reductions apply Modified Adjusted Gross Income (MAGI) rules.[27]

Depending on an individual's income and circumstances, getting coverage through the Marketplace may be less expensive than paying for Part A. Those who choose Marketplace coverage rather than Medicare need to be aware that, if they later decide to switch to Medicare, they can face late enrollment penalties for both Part A and Part B.[28] They also may face gaps in coverage because they may only be able to enroll in Medicare during the annual General Enrollment Period.[29]

Because of the range of visa and status categories for which Marketplace enrollment is permitted and because there is no length of residency requirement, the Marketplace also is an option for older adults who do not currently qualify for Medicare at all, including LPRs who are still in their five-year waiting period.

Advocacy tip

Advocates should remind clients choosing Marketplace coverage that, even if their income is below tax filing requirements, they need to file income tax returns in order to get MAGI-based subsidies.

Case Examples: Marketplace and Medicare

Ms. Park is an LPR who is eligible for Medicare but does not qualify for premium-free Part A. Her income is at 200% FPL, which is too high to qualify for the QMB program in her state. Because her income is low enough to qualify her for premium tax credits and cost-sharing reductions in the Marketplace, she decides to enroll in a Qualified Health Plan. She will face both Part A and Part B enrollment penalties if she later decides to enroll in Medicare and will only be able to do so during certain times of year.

Mr. Jones is an LPR who arrived in the U. S. when he was 62. He is now 66 and enrolled in a Marketplace plan with premium tax credits and cost-sharing reductions. Next year he will have been in the U.S. for five years. At that time he will become eligible for Medicare and, because of his low income, he will also qualify for his state's Medicaid program. He will lose his eligibility for Marketplace subsidies so he will switch from the Marketplace to Medicare. His Medicaid coverage will assist with his Medicare costs.

Some people choose to enroll only in Part B

Enrolling only in Medicare Part B and not in Part A is an available option for people who face steep Part A premiums but don't qualify for either subsidies for Marketplace coverage or QMB assistance for Medicare premiums. Part B enrollment allows them to also enroll in Part D and, if they qualify, to get the Low-Income Subsidy (LIS) to help pay for Part D costs (see below). This course is far from ideal because it leaves an individual without coverage for hospital costs. However, it is an available option. If these individuals later decide to enroll in Part A, they can face late enrollment penalties and also may be limited to enrolling during the General Enrollment Period with coverage not starting until July. If they enroll in Part B and not in Part D, they could also face Part D late enrollment penalties.

Case Example: Declining Part A coverage

Mr. Singh came to the U.S. eight years ago. He is now 65, LPR and eligible for Medicare but not for premium-free Part A. From his career in India, he has a pension and a small nest egg, disqualifying him for Medicaid or Marketplace subsidies. Because has always been healthy, he decides to conserve resources and only enroll in Part B and not in Part A. By doing so, he will have coverage for doctor visits but risks wiping out his nest egg if he needs hospital care. Though he currently only takes one inexpensive generic drug, he enrolls in a low cost Part D plan so that he will not face late enrollment penalties if he later finds that his drug coverage needs increase.

The Part D Low Income Subsidy ("Extra Help") can reduce prescription drug costs

Beneficiaries who qualify for Part D, i.e., those who are enrolled in either Part A or Part B, also may be eligible for the Part D Low Income Subsidy (LIS or "Extra Help").[30] Because LIS asset and income limits are higher than those for QMB and other Medicare Savings Programs, some individuals with higher incomes may qualify for this benefit. The Social Security Administration determines LIS eligibility. Individuals may apply with SSA in-person, on-line or by phone.

There are no additional immigration status or length of U.S. residency requirements for LIS beyond what is needed for Part A and Part B eligibility.[31] LIS enrollment is automatic for Medicare beneficiaries receiving SSI and for those enrolled in any Medicaid program, including Medicare Savings Programs such as the QMB program. Others can apply by contacting the Social Security Administration and meeting income and asset eligibility requirements.[32] Instructions for applying are available in 18 languages.[33]

Case Example: Extra Help v. QMB

Ms. Morales, a low-income TPS holder with premium-free Part A, successfully applied for the Part D Low Income Subsidy. Although she had been unable to enroll in the QMB program because she was not a "qualified" immigrant, that was not a factor in evaluation her LIS application. Having LIS gives her with significant relief from prescription drug costs.

Policy Watch

In 2018, the Department of Homeland Security proposed new regulations that would treat receipt of the LIS benefit as a factor in determining whether an applicant for LPR status would likely be a public charge.[34] As proposed, the changes would be prospective and not affect current LIS enrollees. Advocates will want to monitor the progress of this proposal.[35]

SUMMARY OF ELIGIBILITY AND PREMIUM ASSISTANCE OPTIONS—LPR AND TPS

	MEDICARE ELIGIBILITY	AVAILABLE PROGRAMS TO HELP W/ COSTS		
	Does 5 yr. residence apply?	Medicaid and MSPs	Part D LIS	Are Marketplace subsidies available?
LPR—qualifying work record	No	Yes w/ 5 yr residence	Yes	No
LPR –w/out qualifying work record	Yes but w/ Part A premium	Yes w/ 5 yr. residence	Yes if enroll in either A or B	Yes*
TPS—qualifying work record	No	No	Yes	No
TPS-w/out qualifying work record	No	N/A	N/A	Yes

*For those with income below 100% FPL, subsidies are available only if they cannot qualify for Medicaid because of their immigration status.

POST ENROLLMENT ISSUES

Medicare does not pay for services outside the U.S.

Many immigrants, particularly those who are citizens, may spend significant time overseas during their retirement. Medicare does not cover health care provided outside the United States.[36]

Medicare premium payment liabilities continue even when a beneficiary is abroad.

The obligation to continue payment of Medicare premiums continues when a beneficiary spends time abroad. If a beneficiary stops paying Part A or Part B premiums, late enrollment penalties can arise and the beneficiary may have to wait until the next Medicare General Enrollment Period to reapply, resulting in many months without coverage. Beneficiaries who have Medicare coverage and spend time abroad should be careful about how they handle their Medicare premiums.

Case Example: Time abroad

Ms. Adebayo, originally from Nigeria, is a U.S. citizen with Medicare Part A and Part B coverage. She rushed back to Nigeria after a niece died suddenly, leaving several small children. She now realizes that she is needed for an indefinite time to make sure that the children are properly cared for. Though she has the option of stopping her Part B premiums, she decides that she will let SSA continue to deduct the premium from her monthly Social Security benefit. She does not want to face late enrollment penalties when she returns or have a gap in coverage while she waits for an enrollment period to re-enroll.

LANGUAGE ACCESS AND MEDICARE

Older immigrants with limited English proficiency need language assistance to understand their benefits, address their health care needs, and exercise their rights under Medicare.

Governing statutes

The statutory bases for language access rights in Medicare are found in Title VI of the Civil Rights Act of 1964[37] and the Health Care Rights Law, Section 1557 of the Affordable Care Act.[38] Section 1557 applies the provisions of Title VI to the Department of Health and Human Services (HHS) and to health programs and activities, any part of which receive Federal financial assistance from HHS. The HHS Office for Civil Rights has enforcement responsibility. In addition, Section 1557 provides for a private right of action.[39]

HHS takes the position that those physicians and other providers who participate in Medicare only as Part B providers and do not receive any other Federal financial assistance from HHS are not subject to Section 1557, but asserts that almost all physicians in fact are covered because they accept Federal financial assistance from sources other than Medicare Part B.[40]

Regulations and guidance

The HHS Office for Civil Rights and CMS have each adopted regulations implementing these statutes. CMS has also developed sub-regulatory guidance for Medicare Advantage plans and Prescription Drug Plans. CMS has noted, however, that plan and provider obligations under the statutes may be broader than the specific requirements in its guidance and advises plans to independently assess their obligations under these statutes.

HHS regulations require free, accurate, and timely language assistance when needed to provide meaningful access to individuals with limited English proficiency.[41] The HHS regulations do not identify specific instances where interpreter services are required or specific documents that must be translated, but, in commentary, the agency provides guidance on factors to be considered in enforcement.[42] Interpreter and translation services must be provided by "qualified" interpreters and translators.[43] Covered entities may not require that individuals provide their own interpreters and may not use a minor child except in cases of emergency.[44] Medicare plans also are required to include taglines with "significant" documents and communications. The tagline must provide information in the top 15 languages of the state announcing the availability of language services.[45]

Medicare regulations governing health and prescription drug plans include additional specific requirements. They require that Medicare Advantage and Medicare Prescription Drug Plans must translate "vital materials" into any non-English language that is the primary language of at least five percent of the individuals in a plan benefit package service area.[46] In the Medicare Communications and Marketing Guidance (MCMG), CMS identifies vital documents as including most basic marketing materials (application, evidence of coverage and summary of benefits, provider and drug lists, etc.); enrollment and disenrollment communications; and appeals and grievance notices. [47] Except for a few Medicare Advantage plan service areas, the five percent threshold means that Spanish is the only language required.

Advocacy Tip

If clients are in Medicare Advantage plans are having problems getting needed interpreter services, the most expeditious route to getting individual issues addressed is likely to be filing a grievance with the plan and/or a complaint with CMS at 1-800-Medicare.

MCMG also requires plan call centers to have interpreter services in all languages.[48] Wait times should not be excessive.

Agency resources

The Medicare consumer website, Medicare.gov, is available in Spanish.[49] The Medicare & You Handbook is also published in Spanish. An "Information in Other Languages" page[50] lists all non-English language forms and publications available from CMS. The 1-800-Medicare help line provides free interpretation services in all languages and, as noted above, all call centers for Medicare Part D plans and Medicare Advantage plans are required to do so as well.[51]

The Marketplace website, HealthCare.gov, also is available in Spanish. HealthCare.gov has non-English resources as well.[52] The Marketplace Call Center and QHPs are also required to provide interpretation services.[53]

Advocacy Tip

CMS data show that very few individuals who speak languages other than Spanish ask for interpreter services when calling 1-800-Medicare. Plan level data are not available, but it appears that uptake there as well is limited. This suggests that LEP individuals are either unaware of the free service or reluctant to ask for it. Advocates should explain the availability of these services to their clients and encourage their use when they have questions or if they receive a document from Medicare or from their MA plan in English that they do not understand.

CONCLUSION

Advocates can assist their older immigrant clients to navigate Medicare enrollment, costs, and language hurdles. Justice in Aging is available to work with advocates as they encounter Medicare issues for their immigrant clients. Contact info@justiceinaging.org.

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ENDNOTES

1 Migration Policy Institute, "State Immigration Data Profiles, United States," available at www.migrationpolicy.org/data/state-profiles/state/demographics/US; CMS Office of Minority Health, "Understanding Communication and Language Needs of Medicare Beneficiaries," 8, 10 (Apr 2017), available at www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Issue-Briefs-Understanding-Communication-and-Language-Needs-of-Medicare-Beneficiaries.pdf.

2 For a description of the parts of Medicare and services covered, see CMS "Medicare & You" (2019), available at www.medicare.gov/forms-help-resources/medicare-you-handbook/download-medicare-you-in-different-formats.

3 42 C.F.R. § 406.10. See also 42 C.F.R. § 406.12 which applies to individuals who qualify for premium-free Part A based on disability determination by the Social Security Administration, and 42 C.F.R. § 406.13, which applies to individuals with ESRD. See CMS, "Original Medicare (Part A and B) Eligibility and Enrollment," available at www.cms.gov/Medicare/Eligibility-and-Enrollment/OrigMedicarePartABEligEnrol/. The POMS provisions concerning Part A entitlement are found at subchapter HI 00801, available at https://secure.ssa.gov/apps10/poms.nsf/subchapterlist!openview&restricttocategory=06008.

4 SSA requires fewer work credits for individuals under 65 who qualify for Medicare on the basis of disability, using a formula based on the applicant's age when becoming disabled. For a chart of credits needed based on age, see SSA, "How You Earn Credits" (2019), p. 3, available at www.ssa.gov/pubs/EN-05-10072.pdf.

5 CMS, "Medicare costs at a glance," available at www.medicare.gov/your-medicare-costs/medicare-costs-at-a-glance.

6 For a summary of late enrollment penalties, see www.mymedicarematters.org/enrollment/penalties-and-risks/. To calculate late enrollment penalties see www.medicareinteractive.org/get-answers/medicare-health-coverage-options/original-medicare-enrollment/medicare-part-b-late-enrollment-penalties.

7 The SSA POMS GN 00303.800 has created some confusion about whether this prohibition applies to undocumented persons with ESRD. The POMS provision notes that there are no residency, citizenship or alien status requirements for Medicare entitlement based on ESRD. Entitlement, however, must be distinguished from actually access to the benefit. Pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), no Medicare payments can be made for an undocumented beneficiary. See SSA POMS RS 00204.010(B), available at https://secure.ssa.gov/apps10/poms.nsf/lnx/0300204010. Thus, as with other Medicare benefits, ESRD-based Medicare is only available to those non-citizens who are lawfully present.

8 42 C.F.R. § 406.20.

9 For the definition of lawfully present for purposes of SSA benefits as well as Medicare determinations, see 8 C.F.R. § 1.3 and SSA POMS RS 00204.00 available at https://secure.ssa.gov/apps10/poms.nsf/lnx/0300204010.

10 42 U.S.C § 1395o; 42 C.F.R. § 406.10 (a)(1).

11 42 U.S.C. § 1395o; 42 C.F.R §§406.10 and 407.10(a)(1).

12 For Part A, these restrictions are found at 42 U.S.C. § 1395i-2(a)(3) and 42 C.F.R. § 406.20. The restrictions for Part B are found at 42 U.S.C. § 1395o(2) and 42 C.F.R § 407.10(a)(2).

13 SSA POMS GN 00303.800(B)(4), available at https://secure.ssa.gov/apps10/poms.nsf/lnx/0200303800.

14 *Id.*

15 *Id.* See also SSA POMS GN 00303.740 describing SSA procedures to determine residence, available at https://secure.ssa.gov/apps10/poms.nsf/lnx/0200303800.

16 SSA POMS GN 00303.800(A)(2), available at https://secure.ssa.gov/apps10/poms.nsf/lnx/0200303800.

17 Medicare Managed Care Manual, Ch. 2, at 50.2.7, available at www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY_2019_MA_Enrollment_and_Disenrollment_Guidance.pdf.

18 See NCOA, Chart: Medicare Savings Programs: Eligibility and Coverage, available at www.ncoa.org/wp-content/uploads/medicare-savings-programs-coverage-and-eligibility.pdf.

19 *Id.*

20 See CMS, "Eligibility for Non-Citizens in Medicaid and CHIP" (Nov. 2014), available at www.medicaid.gov/medicaid/outreach-and-enrollment/downloads/overview-of-eligibility-for-non-citizens-in-medicaid-and-chip.pdf.

21 These states, called "Group Payer" states, are: AL, AZ, CA, CO, IL, KS, KY, MO, NE, NJ, NM, SC, UT, and VA.

22 Justice in Aging, "SSA Clarifies Handling of Medicare Part A Conditional Applications," available at www.justiceinaging.org/wp-content/uploads/2018/08/SSA-Clarifies-Handling-of-Medicare-Part-A-Conditional-Applications.pdf.

23 SSA POMS, HI 00801.140, available at https://secure.ssa.gov/poms.nsf/lnx/0600801140.

24 See "Immigration status and the Marketplace," available at www.healthcare.gov/immigrants/immigration-status/. For additional detail see NILC, "'Lawfully Present' Individuals Eligible under the Affordable Care Act," available at www.nilc.org/issues/health-care/lawfullypresent/.

25 Ctr. on Budget & Policy Priorities, "Key Facts: Immigrant Eligibility for Health Insurance Affordability Programs," (2015), available at www.healthreformbeyondthebasics.org/key-facts-immigrant-eligibility-for-coverage-programs/.

26 26 U.S.C. § 36B(c)(B). See also HealthCare.gov "Coverage for lawfully present immigrants," available at https://www.healthcare.gov/immigrants/lawfully-present-immigrants/.

27 For a primer of MAGI counting rules, see Nat'l Health Law Program, "Advocate's Guide to MAGI," available at https://healthlaw.org/resource/advocates-guide-to-magi-updated-guide-for-2018/.

28 If they don't enroll in either Part A or Part B, they would not face Part D late enrollment penalties. Late enrollment calculations are only triggered after the individual becomes eligible for Part D. Part D requires either Part A or Part B coverage. See 42 C.F.R. § 423.38 and 423.46.

29 CMS has created a Medicare-Medicaid Master FAQ that discusses the details of interaction between Medicare and Marketplace coverage, available at www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Overview1.html. See especially Questions A.6, A.8 and A.9.

30 See www.ssa.gov/benefits/medicare/prescriptionhelp/.

31 HHS has not determined the Low Income Subsidy to be a federal "public benefit."See ASPE, "Summary of Immigrant Eligibility Restrictions Under Current Law," available at https://aspe.hhs.gov/basic-report/summary-immigrant-eligibility-restrictions-under-current-law. Thus eligibility is not limited to "qualified" immigrants.

32 See SSA Extra Help webpage at www.ssa.gov/benefits/medicare/prescriptionhelp/ for information on the program and links to application forms. For details of eligibility and benefit levels, see also a helpful chart from the National Council on Aging, available at www.ncoa.org/wp-content/uploads/part-d-lis-eligibility-and-benefits-chart.pdf.

33 See SSA, "Extra Help Information in Other Languages," available at www.ssa.gov/benefits/medicare/prescriptionhelp/other-languages.html.

34 For an overview of the impact of the public charge proposal on older adults, see Justice in Aging, "Public Charge: A Threat to the Health & Well-being of Older Adults in Immigrant Families," (Oct. 2018), available at www.justiceinaging.org/wp-content/uploads/2018/09/Public-Charge_A-Threat-to-the-Health-Wellbeing-of-Older-Adults-in-Immigrant-Families.pdf.

35 Justice in Aging will alert its network to any significant developments. Another good source of information is the Protecting Immigrant Families website, available at https://protectingimmigrantfamilies.org/about-us-2/.

36 There are minor exceptions for people in transit between the continental U.S. and Alaska and for emergency use of a hospital across the border that is closer than the nearest U.S. facility.

37 42 U.S.C. § 2000d et seq.

38 42 U.S.C. § 18116.

39 45 C.F.R. § 92.301. See also discussion at 81 Fed. Reg. 31376, 31439-40 (May 18, 2016)(hereinafter "Final Rule"), available at www.govinfo.gov/content/pkg/FR-2016-05-18/pdf/2016-11458.pdf.

40 See discussion at 80 Fed. Reg. 54172, 54195 (Sept. 8, 2015), available at www.govinfo.gov/content/pkg/FR-2015-09-08/pdf/2015-22043.pdf and Final Rule at 31383, supra note 24.

41 45 C.F.R. § 92.201 (a) and (c).

42 See Final Rule at 31416, supra note 41.

43 The definition of qualified interpreter and qualified translator are found at 45 C.F.R. § 92.4.

44 45 C.F.R. § 92.201(e). See also commentary at Final Rule 31417-18, supra note 41.

45 45 C.F.R. § 92.8. Note however that a joint Report to the President by HHS, the Department of the Treasury and the Department of Labor recommended scaling back the regulation requiring inserts, asserting that the requirement is costly and wasteful. See "Reforming America's Healthcare System Through Choice and Competition," p. 75, available at www.hhs.gov/sites/default/files/Reforming-Americas-HealthCommunications and Marketing Guidelines-System-Through-Choice-and-Competition.pdf.

46 42 C.F.R. § 422.2268(a)(7) and 42 C.F.R. § 423.2268(a)(7).

47 The full list of communications subject to translation requirements is found at MCMG at 100.4, available at www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/CY2019_Medicare_Communications_and_Marketing_Guidelines.pdf. That list is effective as of January 1, 2019.

48 *Id.* at 30.3.

49 https://es.medicare.gov/.

50 www.medicare.gov/about-us/other-languages/information-in-other-languages.html.

51 MCMG, supra note 49 at 30.3, available at www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/CY2019_Medicare_Communications_and_Marketing_Guidelines.pdf.

52 www.healthcare.gov/language-resource/.

53 45 C.F.R. § 155.205(c).