

Medicare Advantage Enrollment by Immigration and English Proficiency Status

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Overall, Medicare Advantage (MA) offers lower premiums, more benefits, and limits on out-of-pocket spending compared with traditional Medicare. MA enrollment has grown rapidly over the past decade, with much of this growth driven by socially marginalized populations.^{1,2} Medicare beneficiaries had access to a mean of 39 MA plans in 2022, and plans have substantial variations in costs, coverage, and quality.¹ Thus, choosing among MA plans could be challenging for some Medicare beneficiaries, especially for those facing decision-making constraints.³

Immigrants are a marginalized population that regularly underuses health care due to limited eligibility and exclusion from public health insurance, lack of familiarity with the US health care system, and linguistic barriers.^{4,5} Limited English proficiency (LEP) is of interest because more than half of first-generation immigrants report LEP.⁶ LEP is a barrier to accessing high-quality care, communicating with clinicians and providers, and understanding and making informed health care choices. Previous research has examined enrollment patterns from a race and ethnicity perspective.^{1,2} Very few studies have examined Medicare enrollment patterns among immigrants, especially those who have LEP.

Understanding the overall trends and patterns of MA enrollment among immigrants is of high policy relevance, as the immigrant population is aging faster than the US-born population. The number of older adult immigrants was 7 million in 2018, but this population is projected to reach 22 million by 2060, equivalent to 14% of the total older adult population.⁶ LEP could lead to suboptimal coverage choices if LEP immigrants are unable to make fully informed decisions due to language limitations. In this study, we examined the trends and patterns of MA enrollment by immigration and English proficiency status.

METHODS

We used data from the 2008-2019 Medicare Expenditure Panel Survey (MEPS), a nationally representative survey of the US civilian noninstitutionalized population. The survey collects information on respondents' demographic and socioeconomic characteristics,

ABSTRACT

OBJECTIVES: Complex Medicare Advantage (MA) health plan choices may overwhelm immigrants, especially for those facing decision-making constraints due to limited English proficiency (LEP). We examined the trends and patterns of MA enrollment by immigration and English proficiency status.

STUDY DESIGN: We employed a cross-sectional design using data from the 2008-2019 Medical Expenditure Panel Survey.

METHODS: Our outcome was enrollment in an MA plan. Our primary independent variables were immigration and English proficiency status. We categorized the sample into 3 groups: LEP immigrants, non-LEP immigrants, and US-born residents. After adjusting for individual-level characteristics, we estimated the adjusted rates of MA enrollment for each group.

RESULTS: Our adjusted analysis showed that MA enrollment was higher among immigrants than US-born residents, but the highest enrollment was found among LEP immigrants (LEP immigrants: 45.5%; 95% CI, 42.7%-48.2%; non-LEP immigrants: 42.1%; 95% CI, 39.4%-44.8%; US-born residents: 35.1%; 95% CI, 34.5%-35.6%). MA enrollment was higher among LEP immigrants with better health status (good self-reported health: 45.4%; 95% CI, 41.9%-48.8%; poor self-reported health: 41.4%; 95% CI, 37.7%-45.1%). However, we found small to no differences in the adjusted rates of MA enrollment between those with good vs poor self-reported health in both the non-LEP immigrants and US-born residents groups. We found no consistent enrollment patterns by socioeconomic status such as race/ethnicity, education, and income.

CONCLUSIONS: Our findings suggest higher MA enrollment among immigrants, especially for LEP immigrants. Future research should study the care experience of immigrants in MA.

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health status, and health care use and spending. We included all Medicare beneficiaries enrolled in MA or traditional Medicare.

Our primary outcome was enrollment in an MA plan. Our primary independent variables were immigration and English proficiency status. We categorized the sample into 3 groups: LEP immigrants, non-LEP immigrants, and US-born residents. Immigrants in this study are foreign-born residents regardless of time of US residence, citizenship, or immigration status who are eligible for Medicare. LEP respondents were those who self-identified as speaking English “not at all” or “not well.” To adjust for sample characteristics, we included age, sex, race/ethnicity, Medicare-Medicaid dual eligibility, marital status, education, family income, Census region of residence, self-reported health, and number of chronic conditions. Chronic conditions included arthritis, asthma, autism spectrum disorder, cancer, cardiac arrhythmias, chronic kidney disease, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, dementia, depression, diabetes, hepatitis, HIV infection, hyperlipidemia, hypertension, osteoporosis, schizophrenia, stroke, and substance abuse disorders.

We first examined trends in MA enrollment among LEP immigrants, non-LEP immigrants, and US-born residents. To produce stable estimates, we calculated the mean rate of MA enrollment for each group in 2008-2010, 2011-2013, 2014-2016, and 2017-2019. Next, we examined the adjusted rates of MA enrollment among LEP immigrants, non-LEP immigrants, and US-born residents by health and socioeconomic statuses. We used a single model to analyze all samples, which included LEP immigrants, non-LEP immigrants, and US-born residents. Specifically, we ran a linear probability model after adjusting for all control variables described above, immigration and English proficiency statuses, and interaction terms associated with the variable of interest. Using the marginal effects from the linear probability model, we estimated the mean adjusted values of the outcomes for each group while holding all other variables constant except the variable of interest. For all analyses, we used survey weights to generate representative estimates.

RESULTS

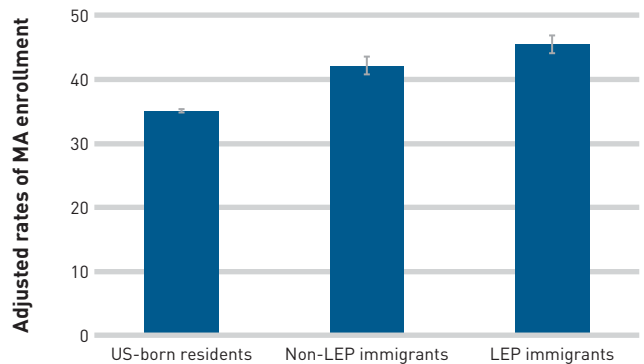
Our sample included a total of 45,633 Medicare beneficiaries (3089 LEP immigrants, 2453 non-LEP immigrants, and 40,091 US-born residents) (eAppendix Table [eAppendix available at ajmc.com]). Our descriptive analysis showed differences in sample characteristics between immigrants and US-born residents, but the sample characteristics also differed between LEP immigrants and non-LEP immigrants. LEP immigrants were more likely to be Latino, to be dually eligible for Medicare and Medicaid, to have a high school degree or lower, and to have family income below 200% of the

TAKEAWAY POINTS

This study showed differences in Medicare Advantage (MA) enrollment by immigration and English proficiency status.

- ▶ MA enrollment was higher among immigrants than US-born residents, but the highest enrollment was found among immigrants with limited English proficiency (LEP).
- ▶ MA enrollment was even higher among immigrants with LEP who had better reported health status.
- ▶ We found no consistent enrollment patterns by socioeconomic status.
- ▶ Understanding the overall trends and patterns of MA enrollment among immigrants is of high policy relevance, as the immigrant population is aging faster than the US-born population.

FIGURE. Adjusted Rates of MA Enrollment by Immigration Status and English Proficiency*



LEP, limited English proficiency; MA, Medicare Advantage.
*Immigrants include all foreign-born Medicare beneficiaries.

federal poverty level (FPL), and they were less likely to report good health status than non-LEP immigrants and US-born residents.

Our adjusted analysis showed that the mean adjusted rates of MA enrollment during 2008-2019 were 45.5% (95% CI, 42.7%-48.2%), 42.1% (95% CI, 39.4%-44.8%), and 35.1% (95% CI, 34.5%-35.6%) for LEP immigrants, non-LEP immigrants, and US-born residents, respectively (Figure). The growth in MA enrollment was higher among immigrants than US-born residents, but the highest was found among LEP immigrants (43.5% to 55.7%, 44.5% to 48.0%, and 33.8% to 36.6% for LEP immigrants, non-LEP immigrants, and US-born residents, respectively, from 2008-2010 to 2017-2019) (eAppendix Figure).

Our adjusted analysis also found that MA enrollment was higher among immigrants with better self-reported health status. The adjusted rates of MA enrollment were higher among LEP immigrants with good health (45.4%; 95% CI, 42.0%-48.8%) than those with poor health (41.4%; 95% CI, 37.7%-45.1%) (Table). However, we found small to no differences in the adjusted rates of MA enrollment between those with good vs poor self-reported health in both groups of non-LEP immigrants and US-born residents (non-LEP

TRENDS FROM THE FIELD

TABLE. Adjusted Rates of MA Enrollment by Immigration Status and English Proficiency^a

	Adjusted rates (%) of MA enrollment (95% CI)		
	US-born residents	Non-LEP immigrants	LEP immigrants
Self-reported health			
Poor	34.7 (33.6-35.8)	40.3 (35.2-45.5)	41.4 (37.7-45.1)
Good	35.4 (34.8-36.1)	40.9 (37.8-44.0)	45.4 (42.0-48.8)
Number of chronic conditions			
0	33.6 (32.6-34.7)	43.8 (39.1-48.4)	45.7 (41.3-50.1)
1-3	35.8 (35.1-36.5)	41.7 (38.6-44.9)	47.0 (43.8-50.3)
≥4	35.1 (33.5-36.6)	39.6 (30.8-48.5)	36.3 (29.5-43.1)
Race/ethnicity			
White	34.1 (33.5-34.8)	37.7 (32.8-42.7)	28.0 (16.8-39.2)
Black	37.4 (36.2-38.6)	53.2 (44.4-62.0)	29.8 (13.3-46.3)
Latino	38.3 (32.9-43.7)	44.0 (39.8-48.3)	48.1 (43.6-52.5)
Other	45.4 (42.9-47.8)	52.4 (48.7-56.1)	56.8 (54.3-59.2)
Education			
High school or lower	36.2 (34.8-37.5)	43.1 (38.0-48.1)	43.3 (40.3-46.3)
College graduate	35.6 (34.8-36.4)	37.3 (33.0-41.7)	47.5 (42.5-52.6)
Advanced degree	34.4 (33.4-35.3)	42.0 (38.0-45.9)	43.4 (36.6-50.2)
Income			
< 200% of FPL	34.5 (33.3-35.7)	40.6 (35.4-45.7)	38.6 (35.0-42.3)
200%-399% of FPL	38.1 (37.3-38.9)	47.5 (43.7-51.3)	49.5 (45.8-53.1)
> 399% of FPL	32.2 (31.3-33.1)	33.0 (28.6-37.4)	43.2 (36.0-50.5)

FPL, federal poverty level; LEP, limited English proficiency; MA, Medicare Advantage.

^aImmigrants include all foreign-born Medicare beneficiaries.

immigrants, poor vs good: 40.3%; 95% CI, 35.2%-45.5% vs 40.9%; 95% CI, 37.8%-44.0%; US-born residents, poor vs good: 34.7%; 95% CI, 33.6%-35.8% vs 35.4%; 95% CI, 34.8%-36.1%). Likewise, the adjusted rates of MA enrollment were higher among immigrants with no or 1 to 3 chronic conditions than those with more than 4 chronic conditions. However, the adjusted rates of MA enrollment among US-born residents did not vary by number of chronic conditions.

Further, our adjusted analysis showed differential patterns of MA enrollment by race and ethnicity (Table). For White and Black beneficiaries, the adjusted rates of MA enrollment were the highest among non-LEP immigrants (White: 37.7%; 95% CI, 32.8%-42.7%; Black: 53.2%; 95% CI, 44.4%-62.0%) and the lowest among LEP immigrants (White: 28.0%; 95% CI, 16.8%-39.2%; Black: 29.8%; 95% CI, 13.3%-46.3%). For Latino and other beneficiaries, however, the adjusted rates of MA enrollment were the highest among LEP immigrants (Latino: 48.1%; 95% CI, 43.6%-52.5%; other: 56.8%; 95% CI, 54.3%-59.2%) and the lowest among US-born residents (Latino: 38.3%; 95% CI, 32.9%-43.7%; other: 45.4%; 95% CI, 42.9%-47.8%).

For education and income, we did not find consistent patterns of MA enrollment (Table). For education, the adjusted rates of MA enrollment were higher among LEP immigrants with a college degree than those with an advanced degree and those with a high school

degree or lower (college: 47.5%; 95% CI, 42.5%-52.6%; advanced degree: 43.4%; 95% CI, 36.6%-50.2%; high school or lower: 43.3%; 95% CI, 40.3%-46.3%). However, we found the opposite pattern among non-LEP immigrants (college: 37.3%; 95% CI, 33.0%-41.7%; high school or lower: 43.1%; 95% CI, 38.0%-48.1%; advanced degree: 42.0%; 95% CI, 38.0%-45.9%). For income, the adjusted rates of MA enrollment were higher among those with family income of 200% to 399% of FPL, especially for LEP immigrants (47.5%; 95% CI, 43.7%-51.3%) and non-LEP immigrants (49.5%; 95% CI, 45.8%-53.1%). However, we found small or no differences in the adjusted rates of MA enrollment between those with family income below 200% of FPL and those with family income above 400% of FPL.

DISCUSSION

Our study shows that MA enrollment was higher among immigrants than US-born residents, but the highest enrollment was found among LEP immigrants. Notably, MA enrollment was higher among LEP immigrants with better self-reported health status.

Our finding aligns with prior findings showing high MA enrollment among racial and ethnic minorities, which included immigrant populations across racial and ethnic group categories.^{1,2} There may be several potential reasons for this trend. First, insurance decision-making is a complicated task, so immigrants may rely on friends, family members, and/or navigators to guide their enrollment process, especially if those providing advice are bilingual.^{7,8} Second, the benefit design of MA plans could be attractive to immigrants. Immigrants may feel more comfortable enrolling in an MA plan that offers culturally and linguistically tailored care, bridging the gap between their health care needs and available resources. Additionally, some immigrants may prefer the comprehensive benefits and lower out-of-pocket costs offered by MA plans. However, it was unexpected that enrollment of LEP immigrants in MA plans would be substantially higher. This finding could signal the challenges that LEP immigrants face when selecting health plans, such as language barriers, cultural differences, and a lack of familiarity with the US health care system. Thus, health care navigators and health insurance brokers could play a vital role in assisting immigrants in navigating the complexities of the health care landscape in the United States, providing support with plan selection and enrollment.

High MA enrollment among immigrants, especially for LEP immigrants, could contribute to improvements in well-being if their coverage choice is informed. First, MA beneficiaries have flexibility in choosing among different health plans that could offer care coordination or translation services that may enhance enrollees' health. In previous studies about choice among Medicare beneficiaries, extended benefits were the most common reason for choosing an MA plan.⁹ Relatedly, immigrants could choose MA plans as a continuation of their employer-provided or Medicaid health maintenance organization coverage. This has the potential to improve continuity of care and prevent avoidable adverse events.

Also, MA plans include out-of-pocket maximums that may offer additional financial security for immigrants with lower incomes.¹ Because MA plans are financed through capitated payments and receive additional bonus payments based on quality performance, there may be an increased incentive to maintain or improve their enrollees' health.¹

On the other hand, our findings for high MA enrollment among LEP immigrants could also indicate suboptimal coverage choices. Choosing health insurance is among the most important financial and health-related decisions an individual can make, but this can be challenging because of the complexity and difficulty of terms and concepts. If immigrants are unable to make fully informed decisions due to language limitations, this could lead to suboptimal choices that do not meet their preference or care needs. Evidence suggests that beneficiaries with low cognitive functioning are less responsive to the generosity of MA benefits in their decisions.¹⁰ Also, beneficiaries with higher health insurance literacy were more likely to enroll in low-cost or high-rated MA plans.³ Linguistic limitations among immigrants could affect health plan choices and put immigrants at risk of enrolling in high-cost or low-rated MA plans because of an uninformed choice. Narrow networks of providers or prior authorization restrictions from some MA plans could also make it challenging for LEP immigrants to navigate or to make informed choices.

Limitations

Our study has 5 key limitations. First, our measure of immigration, English proficiency status, and MA enrollment was self-reported and may be subject to reporting bias. Second, all immigrants included in this study are lawfully present and longer-stayed due to eligibility for Medicare. Thus, implications from our findings may not be generalizable to other immigrant populations. Third, coverage choices may differ by immigration and citizenship statuses or country of origin. However, we treated immigrants as a homogeneous population. Fourth, we accounted for differences in sample characteristics, but unobserved differences in individual-level characteristics may have remained. Finally, our analysis was cross-sectional, and thus we could not evaluate what might be driving the observed trends and patterns of MA enrollment.

CONCLUSIONS

Our findings have important implications for enrollment decisions among immigrants, especially for LEP immigrants. Medicare beneficiaries frequently rely on the one-on-one help provided by brokers and agents in choosing Medicare coverage.⁹ Recommendations from brokers and agents who work on commission from insurers could lead to substandard health plan selections, which could be worsened by linguistic limitations of LEP immigrants. However, relatively few

Medicare beneficiaries used the federal Medicare.gov website and hotline or other insurance assistance programs in 2022.⁹ Thus, it is essential that Medicare coverage choice is fully informed and that LEP immigrants have access to useful resources to make informed decisions. CMS requiring enrollment material to be made available in multiple languages is an important first step, but it must also ensure the availability of independent and multilingual health care navigation services to support the Medicare health plan decisions of LEP immigrants. ■

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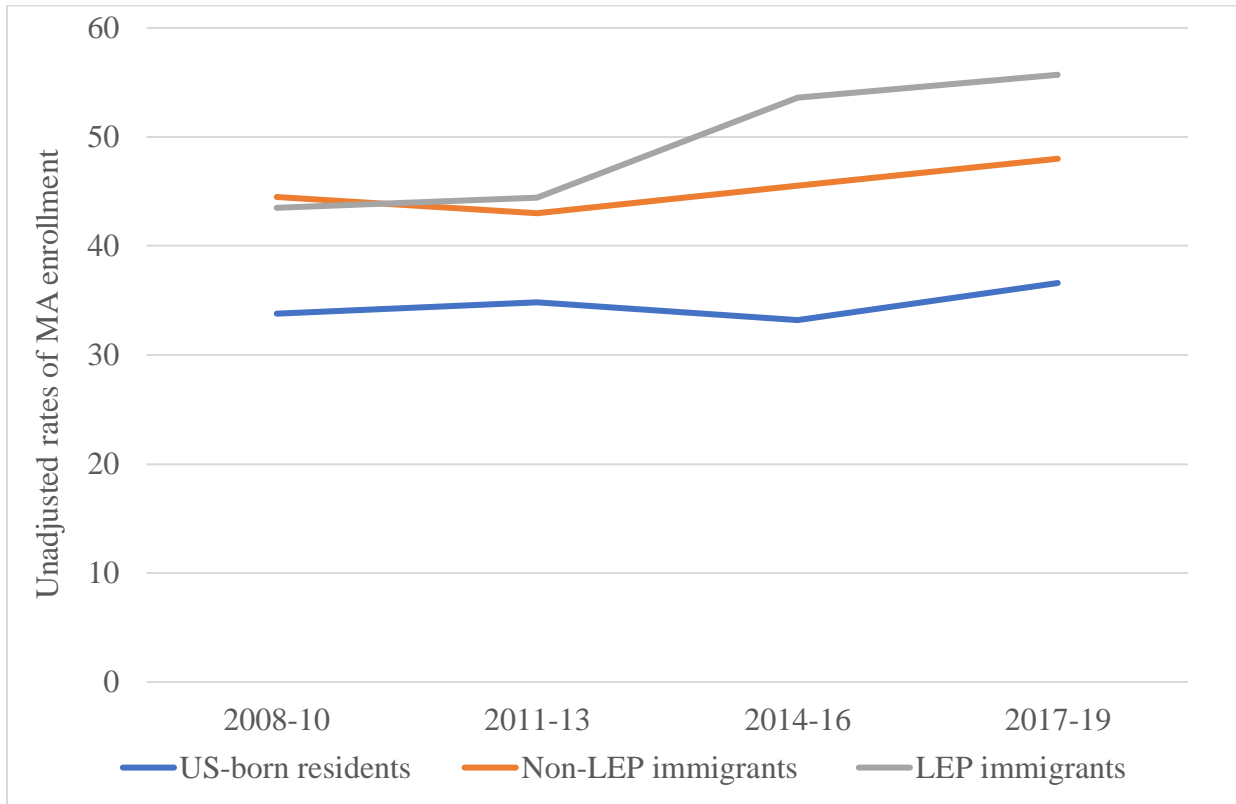
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eAppendix Figure. Trends in MA enrollment by immigration status and English proficiency from 2008 to 2019



NOTE Immigrants include all foreign-born Medicare beneficiaries. LEP; limited English proficiency.

eAppendix Table. Sample characteristics of Medicare beneficiaries by immigration status and English proficiency.

Characteristic	US-born residents (n=40091)	Non-LEP immigrants (n=2453)	LEP immigrants (n=3089)
Age, mean (SD)	71.1 (10.2)	71.2 (9.4)	72.9 (8.5)
Female, %	56.2	50.9	59.2
Race/ethnicity, %			
Non-Latino White	70.7	19.9	3.0
Latino	5.9	40.3	71.9
Non-Latino Black	19.8	8.1	1.4
Non-Latino other or multiple	3.7	31.8	23.8
Medicare-Medicaid dual, %	14.1	19.3	56.4
Married, %	48.9	60.9	52.8
Education, %			
High school or lower	18.4	25.3	68.6
College graduate	49.1	32.8	19.9
Advanced degree	32.4	41.9	11.5
Family income, %			
<200% of FPL	23.4	23.4	44.7
200-399% of FPL	45.5	44.8	46.1
>399% of FPL	31.1	31.7	9.2
US census regions, %			
Northeast	23.4	23.4	44.7
Midwest	45.5	44.8	46.1
South	31.1	31.7	9.2
West	23.4	23.4	44.7
Good self-reported health, %	73.8	77.6	53.9
Number of chronic conditions, %			
0	27.1	29.6	27.7
1-3	60.4	63.3	61.9
4+	12.5	7.0	10.4

NOTE: Immigrants include all foreign-born Medicare beneficiaries. LEP; limited English proficiency, FPL; federal poverty level.