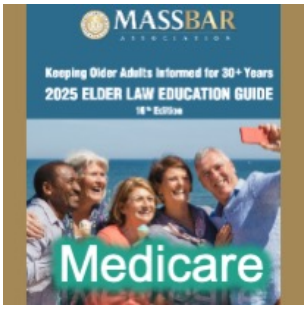

CHAPTER 7

MEDICARE

What You Need to Know

A. SUMMARY

Health insurance, including Medicare, does not cover all services and costs. The purpose of this chapter is to help you choose the coverage that best meets your needs.

Medicare is a health care system that is run by both the government and private businesses. Understanding where the government coverage begins and ends, and what private business covers, are key in making your decisions. Medicare plans are purchased on an individual basis; there are no "spouse" or "family plans."

Medicare Parts A and B ("Original Medicare") are funded 80% by federal taxes and 20% by patient payments. The government establishes the services that Medicare covers. Original Medicare benefits are the same nationwide and provide a wide range of care. You can see any health care provider that accepts Medicare without a referral or being in a network. Medicare does not use prior authorization; if you meet the diagnostic criteria, you qualify for the service. You are responsible for premiums (usually Part B), deductibles and co-insurance. There are no limits on the amount of costs you pay on Original Medicare; ways to reduce costs are listed below.

Medicare Part C ("Medicare Advantage" or "MA") plans are a hybrid of funding. Part C plans receive 85% Medicare reimbursement for Medicare-approved services. The remainder of the funding comes from the participants, including additional premiums beyond the usual Part B. MA plans can offer benefits that Original Medicare doesn't offer, such as vision, dental and other coverage. MA plans are expected to follow Medicare guidelines for diagnostic criteria, but usually require that the patient see health care providers only in the network, requires referrals and prior authorization for services. There is usually a limit on the amount of money (co-pays and co-insurance) for services, but this limit only applies to in-network or permitted services. Money you pay for services you receive that have not been approved by the plan's prior authorization or are outside the network does not count toward the limit. The Centers for Medicare and Medicaid Services (CMS) have noted that MA plans frequently deny care using prior authorizations that Original Medicare would provide.

Medicare Part D ("Prescription Drug Plan") is funded 85% by the government and 15% from participants. Effective in 2025, the federal government has capped the total out-of-pocket expenses for participants at $2,000 per year; deductibles are capped at $590 for 2025. Monthly premiums are also limited, but do not count in the cap. The government rules require that plans offer specific categories of drugs but do not require that all FDA-approved drugs be covered by each plan. Plans generally require step therapy, prior authorization, and they may completely deny coverage for a drug.

All of these plans are discussed in detail below.

B. FOUR DIFFERENT PARTS OF MEDICARE AND HOW TO ADVOCATE FOR BENEFITS

Medicare is a health insurance plan administered by the federal government through the CMS. This vast program insures U.S. citizens and legal residents who are age 65 or older and people under age 65 with certain disabilities.

1. Medicare Part A

a. **Inpatient:** Helps cover inpatient hospital services, including a semi-private room, meals and general nursing services; Part A also covers some home health care, limited skilled nursing facility (SNF) care, certain hospice services and most inpatient drugs. In order to receive Part A hospital benefits, a person must be admitted as an "inpatient." This happens when the person's doctor AND the hospital both agree to the admission. If the hospital does not agree, the person's stay will not be

covered by Part A. Part A does not cover all inpatient costs; certain costs will be covered by Part B. Part A does NOT cover custodial nursing home care (custodial care includes feeding, bathing and toileting); Part A ONLY covers SNF stays under certain conditions, as discussed below.

Criteria for inpatient admission: The doctor orders inpatient care to treat the patient, and the hospital must formally admit the patient. The doctor must have a reasonable expectation at the time of admission that the patient would need medically necessary hospital care crossing at least two midnights. The doctor uses the patient medical history, medical needs, severity of signs and symptoms, medical predictability of an adverse event, and the need for and availability of diagnostic studies. The criteria do not include test results that become available after admission, unless the post-admission information supports the conclusion that the admission was medically necessary.

This two-midnight rule applies to both Original Part A and Medicare Advantage plans.

Medicare administrators cannot solely use algorithms or artificial intelligence to make medical decisions to deny admission.

b. **Emergency Room Not Covered Under Part A:** Going to the emergency department is NOT a Part A hospital admission. The emergency department as well as urgent care are covered by Part B. If the hospital tells you that you are under "observation status," that is an indicator that you have not been admitted as an inpatient under Part A.

c. **Addressing Reclassification from Inpatient to Observation Status:** If you were admitted as an inpatient under Part A, and then reclassified as an "observation" admission under Part B, you will be denied Part A benefits for nursing homes. Effective Jan. 1, 2025, there is a Medicare rule that allows you to appeal this denial. Details on how to appeal are found here: https://www.govinfo.gov/content/pkg/FR-2024-10-15/pdf/2024-23195.pdf. (This does not apply to Medicare Advantage plans. Information for filing MA denials are below.) The final rule is found here: https://www.govinfo.gov/content/pkg/FR-2024-10-15/pdf/2024-23195.pdf.

d. **Hospital Admission:** When you are first admitted as an inpatient to a hospital, the Part A benefit begins, and you are responsible for the Part A deductible. You pay the full deductible on the first day of admission; it is not prorated. The Part A benefit period ends when the person has not been an inpatient or receiving skilled nursing care for a period of 60-CONSECUTIVE days. Under Part A, benefits can expire before the need for hospitalization or skilled nursing care ends. There can be more than one benefit period in a year, as long as the 60-consecutive-day interval requirement has been met. The Part A deductible is due for each new benefit period. Going to the emergency room under Part B without a hospital admission will not affect the 60-day count and force a restart of the 60-consecutive days. Part A has a deductible and co-insurance; costs are discussed below.

e. **Inpatient Hospital Discharge:** Patients must have 24-hour notice prior to discharge from a hospital. There are requirements for discharge: the patient must be medically stable, the patient must be discharged into a safe environment, and appropriate care can be provided upon discharge. There is no requirement that appropriate care be provided in a nursing home if other appropriate sources of care are available.

There is a software program used to determine where to discharge patients, particularly for admission into rehabilitation facilities. The name is "Interqual," which is typically used by the care management team, who are frequently nurses who specialize in insurance utilization. The nurse provides clinical information to the insurer to obtain appropriate benefits and responds to insurance questions. This system does not control what the primary physician considers "medically necessary" for the patient but does determine insurance coverage.

Interqual criteria are used to evaluate the severity of a patient's illness, assess comorbidities and complications, determine the intensity of services being provided and help determine patient admission.

f. **Acute Inpatient Facility and Skilled Nursing Facility (SNF) Admission:** There are two types of skilled nursing facilities; one is an acute rehabilitation facility and the second is a basic rehabilitation facility. Part A covers care in both the acute rehabilitation facility and the basic facility as long as you meet specific requirements. Part A will provide some coverage for up to 100 days per benefit period. To qualify for any SNF, you must first be admitted as an inpatient in a hospital or acute care unit for a minimum of three Medicare days (counted from midnight to midnight). Additionally, all of the following must be certified as medically necessary by a physician:

   i. You must need skilled services that must be performed by professional personnel for a condition for which you were in the hospital.

   ii. You must need these services on a daily basis; however, skilled therapy services received five calendar days a week will be considered "daily" for the purposes of coverage.

   iii. As a practical matter, the daily skilled services can only be provided on an inpatient basis.

   iv. The services must be reasonable and necessary (consistent with the nature and severity of the illness or injury).

   v. Your doctor must expect that your condition will improve sufficiently so you can function independently after a rehab stay. For example, you would be able to eat, bathe, dress yourself and live in a home rather than a facility.

   Admission to an acute inpatient facility provides a higher level of care than an SNF. Common conditions for admission into an acute rehab include severe stroke, major multiple trauma (severe car accidents/ski accidents) and brain/spinal injury. You may not qualify for care if you had a hip or knee replacement and no other major conditions. Even with an appropriate diagnosis, you must meet the requirements for medical necessity; this involves assessing your functional limitations and potential for improvement. The Case Management team (nurses, not social workers) work with Medicare and Medicare Advantage to arrange for your benefits.

   NOTE: A person does not automatically qualify for all the benefit days in acute care or an SNF. Generally, you are admitted for seven to 10 days, pending your progress. You can expect to be evaluated upon admission and reevaluated near the end of your allowed days. If you are no longer benefiting from therapy, or have reached your goals, you will likely be discharged. If you have not reached your medically necessary and reasonable goals, you can appeal the discharge date. Inform the social worker and also the case nurse. It is the case nurse who has to negotiate with the insurers. This may involve escalating the matter to the medical director of the plan that is administering your insurance coverage. This is an informal interim step, before you are discharged.

g. **Hospice Care:** Provides care for terminally ill patients. Your physician must certify that you have a life expectancy of six months or less. Does not cover custodial care. For complete information, please refer to Chapter 3.

h. **Home Health Services:** Medicare will cover medically necessary home health services under either Part A or B. Medicare covers skilled nursing care; physical, occupational and speech therapies; and some home health aid services. Most services are available when there is a reasonable likelihood that the patient will improve and do require the patient to participate.

   i. **Jimmo standard:** Medicare does provide skilled care (nursing, physical therapy, occupational therapy) for services that are required to maintain the patient's current function or to prevent or slow further deterioration. This requirement for care is referred to as the "Jimmo" standard, named after the court case that changed Medicare practice. (*Jimmo v. Sebelius*, Case No. 5:11-cv-17 (D. Vt.)). Skilled Jimmo care must meet certain requirements. These services must be of such complexity and sophistication that the skills of a qualified medical professional are

required to perform the procedure safely and effectively. If a service can be safely and effectively performed (or self-administered) by an unskilled person, without the direct supervision of a medical professional, the service CANNOT be regarded as a skilled nursing service, even if a nurse actually provides the service. A service is not considered a skilled nursing service merely because it is performed by or under the supervision of a nurse. The unavailability of a competent person to provide a non-skilled service, regardless of the importance of the service to the patient, does NOT make it a skilled service when a nurse provides the service. In addition, these services to "maintain" the patient's current condition or to prevent or slow further deterioration that do require skilled nursing cannot be provided in a hospital or SNF, or most Medicaid nursing facilities. These services are only provided in the "home."

ii. **Discharge and Appeals**

You should be told about one week in advance that you are about to be discharged from any Medicare service or facility, except inpatient hospital discharge, when the time frame can be less than one day.

Fast appeals. If you think you are being discharged too soon, you may have the right to ask for a fast appeal. Your provider has to give you notice on how to appeal this discharge. This applies to hospitals, SNFs, home health agencies, comprehensive outpatient rehabilitation facilities and hospice care facilities. For information on how to make this appeal, see https://www.medicare.gov/providers-services/claims-appeals-complaints/appeals/fast-appeals.

Additional information about appeals is found below.

Your Medicare card shows Part A coverage as "Hospital."

2. <u>Medicare Part B</u>

a. **<u>Outpatient:</u>** Helps cover services from doctors, nurse practitioners, therapists and other health providers; some preventive care; emergency department visits; urgent care visits; hospital visits by certain providers, e.g., radiologists and pathologists; medically necessary outpatient services; lab work; durable medical equipment; and ambulance services. Part B also covers certain drugs and certain vaccines that must be administered by a physician/qualified health care provider. Part B covers outpatient surgery (sometimes called "day surgery") and time spent in the hospital for "observation." A person who is in the hospital for observation or in the emergency room does not qualify for Part A benefits. You will be billed for physician services under Part B even when you are an admitted inpatient under Part A.

Home health services are provided as in Part A, including services under the Jimmo standard.

b. **<u>Not Covered:</u>** Part B does not cover most dental care, eye exams for prescription glasses, dentures, long-term care, cosmetic surgery, massage therapy, routine physical exams (except for the "Welcome to Medicare" preventive visit), hearing aids and exams for fitting them, or concierge care. Part B has a yearly deductible, monthly premium and co-insurance/co-pays; costs are discussed below.

Your Medicare card shows Part B coverage as "Medical."

3. <u>Medicare Part C ("Medicare Advantage" or "MA")</u>

a. **Network benefits**: Includes all the benefits and services under Parts A and B and may or may not offer outpatient prescription drug coverage. Medicare C/Advantage plans are run by private health insurance companies and approved by Medicare, and may include extra benefits and services for an extra cost, such as vision, hearing and dental coverage, and rides to medical appointments that are not covered by Original Medicare. Generally, you are in a network and must use the providers in that network for your health care, with exceptions for emergency care and urgent out-of-area care. If you do not use the network providers, you generally will not have coverage, even under Original Medicare.

b. **Payments due:** You will continue to pay the Part B monthly premium (and any Part A monthly premium if you owe it) while on Part C. In addition, you are likely to pay the Medicare Advantage plan itself a premium. Depending on your plan, you may have deductibles and co-pays until you reach your yearly limit. The yearly limit does NOT apply to services that the plan has not authorized or are outside of your network. Additional cost-sharing information is found below.

c. **Part C plans website:** Part C plans may or may not include prescription drug costs. You can check each plan's benefits on the Medicare website, www.medicare.gov/plan-compare/#/?lang=en, or there is an online cost calculator and plan comparison tool run by CMS, at www.medicare.gov/find-a-plan/questions/home.aspx. If you have a Medicare Advantage HMO or PPO plan that includes prescription drug coverage, you may not enroll in a separate Part D plan for prescription drug coverage or in a Medigap (supplemental) plan.

d. **Use of artificial intelligence and algorithms in determining benefits:** CMS prohibits MA plans from using artificial intelligence and algorithms as the sole criteria for determining benefits under the plan.

4. **Medicare Part D**

a. **Prescription drugs — outpatient:** Helps cover the costs of outpatient prescription drugs. To get prescription drug coverage, you must enroll in either a free-standing Part D plan or in a Medicare Advantage plan that includes drug coverage. Medicare mandates that all drug plans cover certain drug classes but not all prescription drugs. You should check the plans when enrolling and annually during open enrollment to see if your prescriptions are covered by the plans. You must be enrolled in Part A and/or Part B to enroll in Part D. Medicare D plans have deductibles and monthly premiums. Detailed information on formularies, drug tiers and coverage gaps is below. You have to use certain pharmacies to get the benefits from Part D plans.

b. **Medicare Planfinder tool:** The Medicare Planfinder tool can help you estimate your annual medical costs; be sure to use the one at www.medicare.gov for full information. Ask your doctor or pharmacist for your current drug list to use in your search. Private insurers have similar information but usually only list the plans they offer, not the full range of choices you have. Private plans generally end with ".com."

c. **Insulin coverage:** Specific information regarding Part D insulin coverage and diabetic supplies is located in the appendix "Part D — Insulin Coverage."

C. HOW MEDICARE PARTS WORK TOGETHER

1. **Insurance pays once:** No insurance will pay twice for the same service. However, different parts of Medicare pay for different services due to one medical event.

2. **Table illustration:** The following table illustrates how these parts of Medicare work together. You will be billed separately for these services.

Service	Part A	Part B	Part D
Inpatient hospitalization	Room, nursing care.	Physicians, lab tests, X-rays.	N/A
Heart surgery — stent	Food, drugs you are given during your hospital stay.	Surgeon, stent, lab tests if needed to monitor Warfarin/Coumadin therapy (if indicated).	Covers outpatient medications such as Warfarin/Coumadin and anti-platelet drugs such as Clopidogrel/Plavix. Will not cover OTC medications like aspirin.

Emergency room visit, with "observation stay"	N/A	Physicians, lab tests, X-rays and time spent in ER.	N/A
Day surgery in the hospital	Follow-up care in home.	Surgeon, recovery, all services including medications used during the procedure.	N/A for medications used during the procedure. Outpatient medications, such as pain medications and antibiotics, are covered.
Chemotherapy in doctor's office	N/A	Drugs and physician/ nursing services.	N/A
Vaccines, administered by qualified health care personnel	N/A	Covers flu, pneumococcal and COVID shots.	Covers shingles, tetanus, diphtheria and whooping cough shots; will cover RSV if you meet the medical requirements. If you have been billed, you can be reimbursed in full by your plan.

D. USEFUL INFORMATION ON MEDICARE

1. **Accountable Care Organizations**: An "Accountable Care Organization," or ACO, is a type of Original Medicare plan. When your physicians participate in an ACO, your doctors coordinate your care and share your medical records, which means you don't have as many repeated tests. An ACO does not limit your choice of providers or change your Medicare benefits, which is different from an Advantage plan.
2. **Medigap Plan:** You can purchase a Medigap or Supplemental plan if you have Original Medicare Parts A and B. This plan pays the co-pays under Parts A and B, but not deductibles. The plans are state-regulated. You cannot purchase a Medigap plan if you have a Part C plan.
3. **Types of Medicare Advantage Plans**: (PPO), (HMO) and (HMOPOS): There are generally two types of Medicare Advantage plans — a Health Maintenance Organization (HMO) and a Preferred Provider Organization (PPO). If you purchase an HMO, you are restricted to the doctors, other health care providers and hospitals in the HMO network. This means that if you go to a provider not listed in your network, you will likely not have insurance coverage for the visit, even if the provider accepts Medicare. There are special rules for emergencies and out-of-area urgent care. Under an HMO, you must have a primary care physician, who then orders medical care and submits a prior authorization for the care or a specialist referral. An HMO Point of Service (HMOPOS) plan encourages you to stay in the HMO network but allows for certain services out of network for a higher co-payment or co-insurance. A PPO plan isn't the same as Original Medicare with a Medigap Supplement; usually, you pay extra for the additional benefits.
    a. **Special needs plans.** Part C, Medicare Advantage, includes Special Needs Plans (SNP), which are limited to people with specific conditions or living in institutions, or dual beneficiaries (qualified for Medicare and Medicaid/MassHealth).
    b. **Medicare Savings Accounts.** You can use a Medicare Medical Savings Account (MSA) if you have a high-deductible Medicare Advantage plan. You contribute nothing to the MSA. Medicare deposits money in your MSA to apply against the high deductible costs of your Medicare Advantage plan; this money is usually less than the plan deductible. MSA plans are used in place of Medigap Plans for Part C. The Advantage plan that you choose describes how much Medicare pays into the MSA. Any money left in the account at year end can be used toward next year's deductible, in addition to whatever Medicare contributes to the account for the new year.

i. **Taxes:** To avoid income taxes on withdrawals from your MSA, you must file Form 8853 with your Form 1040 income tax return, listing your qualified medical expenses (generally, expenses eligible for coverage under Parts A and B of Medicare). If you use all of the money in your MSA and you have additional health care costs in a year, you'll have to pay for your Medicare-covered services out of pocket until you reach your Advantage plan's deductible.

ii. **MSA for Prescription Drugs:** You may use your MSA to pay for prescription drugs, but that does not count toward your deductible. Consider adding drug coverage through a Medicare Prescription Drug Plan (a Part D plan) if you choose a Medicare Advantage plan that does not include drug coverage; without prescription drug coverage at the beginning, you will likely have to pay a penalty to purchase Part D in the future.

iii. **Health Savings Account (HSA):** If you have an existing health savings account (HSA), you should stop contributing to your HSA at least six months before you apply for Medicare. If you make HSA payments after you start Medicare, you may have to pay a tax penalty. You can use your HSA money after you enroll in Medicare to pay for deductibles, premiums, co-payments and co-insurance, but you cannot make additional HSA contributions when you enroll in Medicare.

E. MEDICARE LIMITATIONS AND COSTS

1. Payroll and Federal Income Taxes

All Medicare beneficiaries pay taxes over their working life from their Social Security benefits and earned income. These are the funds used to cover about 75% of the Medicare program costs. The remaining 25% is paid by individual beneficiaries, or through help programs.

a. **All medical bills not paid:** Medicare, including Medicare Advantage plans, does not pay all medical bills, even for covered services. The beneficiary pays premiums, deductibles, co-payments and co-insurance for many services.

b. **Inpatient deductible and 60-day rule:** When you are admitted as an inpatient, you will pay a deductible of $1,676 for 2025. This is not prorated; you pay this if you stay one day or for 60 days. You pay this deductible each time you start a new Part A period, not just once a year. A Part A period ends only when you have been out of the hospital or not using any skilled nursing care for 60-consecutive days. If your Part A period has ended, a new one starts with your next inpatient hospital admission and you would pay another deductible. Part A does not cover any doctor's services while you are hospitalized; doctor's services are billed under Part B and you pay for them separately.

c. **Skilled nursing home coverage:** Part A covers care in an SNF as long as you meet certain conditions, for up to 100 days per benefit period. After 100 days, Medicare does not pay anything.

d. **Custodial care:** If you do not meet all four of the SNF admission criteria, you cannot receive SNF benefits under Part A, even if you have been an inpatient, or have available or unused SNF days. Part A does NOT cover custodial care (non-medical care for bathing, eating and toileting), even in hospice.

e. **Part B deductible:** Part B has a yearly $257 deductible before providing coverage for covered services. Once the deductible is satisfied, Part B pays 80% of the approved cost of the majority of covered services; limited office visits have co-pays. Furthermore, Original Medicare generally does not cover the prescription medicines you would normally pick up at a pharmacy. There are some exceptions — COVID vaccines and boosters, flu shots, Hepatitis B shots, pneumococcal shots and some insulin devices are covered under Part B.

f. **Supplemental Medicare:** Many Medicare beneficiaries express concern that the deductibles, the 20% Part B co-insurance (without a cap or out-of-pocket maximum), the costs of Part A hospital and SNF days, and the lack of prescription coverage may cause major financial difficulties in the

case of a medical issue. To address these concerns, Medicare beneficiaries have opportunities to purchase supplemental Medicare called "Medigap," which fills the gaps in Medicare.

g. **Medicare Costs:**

Part A premium, deductible and co-insurance:

i. **Part A premium:** Eligible persons who have 40 work credits with Social Security do not pay a monthly premium for Part A. Those who have not worked the minimum 40 credits will pay a monthly premium for life, unless these individuals continue to work and add work credits. If this situation applies to you, ask the SSA to recalculate your work credits each year, to reduce your Part A premium.

a. **Part A deductible:** Part A has a 2025 deductible for each period of $1,676; the deductible is not prorated but due on the first day of admission as an inpatient into a hospital.

b**. Part A co-insurance.** Part A also charges co-insurance for SNF stays and home health care durable medical equipment and hospice care, all detailed in the chart below.

ii. **Part B premium, deductible and co-pays:**

a. Part B premium. The lowest Part B premium for 2025 is $185 per month. The monthly premium increases above the standard premium as your income increases; the amount is based on tax returns from two years earlier (e.g., for 2025 Part B premium, the income tax filing for 2023). Part B premiums for certain transplant patients are different.

b. Part B deductible. Part B has an annual deductible, paid only once per year as you use services. The Part B plan deductible is due when you start using services at the plan beginning. Plan B generally starts in January, except the first year you are enrolled, when the plan starts with your date of enrollment and the deductible is due when you first start using services. The deductible for 2025 is $257. Part B also requires a monthly premium and pays for 80% of the approved costs of covered services.

The Part B premium is based on income.

iii. **Part B co-pays.** These costs are calculated based on the service you receive; it is generally 15% of the Medicare-approved cost. There is no limit on the number of co-pays you must pay.

h. **Part C requires enrollment in Part A and Part B.** You will pay a Part A premium, if any, and the Part B premium to Medicare. You will pay an additional monthly premium for Part C coverage, as well as deductibles and co-insurance based on your plan. You will pay for any out-of-network services. Most Part C plans limit the total yearly amount you pay for in-network approved services. Your plan may or may not include drug coverage and additional benefits, such as eye exams and hearing aids. Each plan is different and changes yearly.

i. **Part D costs:** Medicare Part D plans have monthly premiums and deductibles. Under law, no plan can charge more than $590 for a deductible in 2025. Each drug covered by your plan will be on a "tier," which lets you know how much co-pay you will have. Any co-pay can change during the year. Most plans require you to use a certain pharmacy chain to receive insurance coverage. After you pay your deductible, you pay 25% of covered Part D drugs. Once you have paid $2,000 in deductible, co-payment and co-insurance, you pay nothing for the covered medications for the rest of the year. You can spread your drug costs across the year by using monthly payments; this is called the "Medicare Prescription Payment Plan"; see Medicare.gov/prescription-payment-plan for more information. More detailed information on Part D and choosing a Part D plan is presented in the chart at the end of this chapter titled "Calculate Your Medicare Part D Premium for 2025."

i. **IRMAA definition**. In addition to the premium charged by the drug plan, Medicare beneficiaries with higher incomes are charged a Part D Income-Related Monthly Adjustment

Amount (IRMAA). IRMAA means that you pay premiums to two different places each month, one to your insurer and the other to Social Security. The Part D premium chart is located at the end of this chapter. Thus, if your 2022 income (the earliest Medicare can verify from tax returns) is above $103,000 if you file individually, or $206,000 if you are married and file jointly, you will pay an extra amount for the prescription drug coverage. Adjustments to the amount you pay in IRMAA can be made after a life-changing event, such as the death of a spouse, marriage, divorce, loss of income, and an employer settlement payment. https://www.ssa.gov/medicare/lower-irmaa.

j. **Medicare Savings Program:** The Medicare Savings Program (MSP) is a program available to beneficiaries that covers cost-sharing associated with Medicare. Each state has its own financial guidelines in order to qualify for MSP. MSP is administered by each state's Medicaid program. In Massachusetts, MassHealth administers the MSP. For more information on the MSP, see https://www.mass.gov/info-details/get-help-paying-medicare-costs.

k. **Medicare 2025 Costs at-a-Glance Chart are located at the end of this chapter.**

2. Medicare Advantage Limitations

a. **Network requirement:** A Medicare Advantage plan requires that you get care from the plan network. The only exception is emergency department services, as long as you are experiencing a true emergency and are not physically within the network system, i.e., out-of-state and out-of-area urgent care. Some patients feel there is an advantage to a Medicare Advantage plan, because there are physician specialists identified for you. Some patients find the waiting times to be too long.

b. Healthcare.gov**:** Be sure to check whether your physician is in any Medicare Advantage plan that you select. Often, the plan lists themselves are out of date. Use Healthcare.Gov to see if your physician is in the network you want.

c. **Disadvantages:**

i. Criteria for providing care may differ between Original Medicare and some Medicare Advantage plans. Some Medicare Advantage plans do not always follow the same rules for providing care as Original Medicare. For example, Original Medicare will provide oxygen support once your blood oxygen level goes below a certain number. All that is needed is the doctor's order, along with the test results. Medicare Advantage plans sometimes use different measures before providing services. In our example, the Advantage plan would not provide oxygen based on the Medicare criteria, but at something less than the Medicare criteria. CMS has made clear that this is illegal. As a practical matter, this is difficult for a patient to address without a health advocate. Please be aware that this example of oxygen supplementation is only one kind of example; CMS is investigating a significant number of claims.

ii. **The use of prior authorizations (PAs).**

Original Medicare generally does not require any approval for a physician's order for services; the services are given based on the patient's diagnosis and documented in the Current Procedural Terminology (CPT) code. There are some small exceptions, such as some durable equipment and some outpatient procedures; the full list can be found here: https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives/prior-authorization-certain-hospital-outpatient-department-opd-services.

iii. **In contrast, Medicare Advantage plans generally do require PA.** PAs are mostly likely necessary for the highest-cost services, such as Part B chemotherapy drugs, Part A SNF stays and Part A acute inpatient stays. If the plan offers prescription drug coverage, PAs are generally required for high-cost drugs. One study compared access to care by Original Medicare benefi-

ciaries and Medicare Advantage beneficiaries. Forty-one percent of Original Medicare beneficiaries received care without a PA required by the Advantage plans. Most PAs were required for Part B drugs, radiology and radiation oncologists.

iv. **Recent legislation on prior authorizations (PAs):** Federal law does not prohibit Advantage plans from using PA, but starting Jan. 1, 2026, CMS requires that the insurers respond within 72 hours for expedited requests and seven calendar days for standard requests. Insurers must provide a specific reason for denial, regardless of how the request was submitted.

v. **Appeal of prior authorization (PA) denials:** If your PA request is denied, there is a procedure you can follow to appeal the decision. In addition to the PA, drug plans frequently use what's known as "step therapy" (meaning that you are prescribed the most commonly used generic drug for your condition, to see if it works for you; you must fail on that drug before you can move up a "step" to a more expensive drug) as a type of PA.

vi. **Medicare Givebacks:** Many plans advertise "Medicare Givebacks." CMS examined the actual money paid to plan participants and determined that there was "bait and switch" activity. In 2022, promised full rebates were not actually paid in Massachusetts. CMS advises that you first make sure the plan meets your Medicare needs. Medicare has marketing rules in place for Medicare Advantage plans to prevent predatory marketing tactics. The CMS guidance is at https://www.cms.gov/medicare/health-drug-plans/managed-care-marketing/medicare-guidelines. Also see https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/plan-marketing-rules.

F. CHOOSING BETWEEN ORIGINAL MEDICARE OR MEDICARE ADVANTAGE

Please read below to familiarize yourself with the various options in each plan.

TIP: Preferred physician: Before enrolling in any Massachusetts plan, ask if your preferred physician is part of the plan you are thinking about choosing. The answer may determine what plan you ultimately take. While most physicians accept Medicare, not all physicians and hospitals are part of the various Advantage plan networks.

NCOA website chart: The chart taken from the National Council on Aging (NCOA) website, under My Medicare Matters (a nonprofit group), will help you evaluate your options and give you personalized advice.

1. NCOA questions:

a. **Which option is more stable from year to year?**

Each year, Medicare Advantage plans choose if they want to stay in Medicare or not. They can also change costs, providers and benefits each calendar year. Original Medicare will always be there, but its premiums, deductibles and co-insurance amounts can increase slightly each year.

b. **Are Medicare Advantage plans rated?**

Medicare uses a 5-star rating system to assess the quality of Medicare Advantage and Part D plans, with 5 stars being "excellent," 4 being "above average" and 3 being "average." These ratings are based on a variety of factors, including how well the plans help members manage chronic diseases, member satisfaction and how often members get screening exams and vaccines, among others. The ratings are posted on the Medicare Planfinder website at Medicare.gov.

Some key information from the NCOA site: https://www.ncoa.org/.

c. **Advantages of choosing Original Medicare combined with a Medigap policy (versus Medicare Advantage)**

i. A significant advantage is that it provides a better fit for individuals with ongoing medical issues. In some states, if you purchase a Medigap policy within six months of starting Part B at age 65 or older, the insurance agency cannot reject the application for any reason. However,

in Massachusetts, individuals can purchase a Medigap policy year round. Massachusetts Medigap policies cannot increase costs based on medical history. Having a history of cancer or a recent diagnosis of heart disease, chronic obstructive pulmonary disease (COPD), diabetes, or another chronic condition that will require frequent doctor visits may indicate that a Medigap policy is a better fit. The monthly payment will be the same every month, no matter how many doctor visits occur — so a Medigap policy may reduce total costs. This can be especially helpful when you are trying to diagnose a new health condition and need to seek second opinions. Original Medicare offers more flexibility with treatment options, and you are not limited to the network imposed by Medicare Advantage plans.

ii. "**Snowbirds" or others who spend time out of state:** If your physician is licensed in Massachusetts, they cannot treat you, even via telemedicine, if you are not physically in Massachusetts. The only exception is if you are in the emergency department — then the emergency department physicians can CONSULT with your physician. This limitation is set by the Massachusetts board of licensing, and not regulated by Medicare. An alternative is to have a "backup" physician in your second home, to continue routine care. Network plans will not commonly have practitioners out of state.

iii. Choosing a primary care physician (a requirement of some Medicare Advantage plans) is not a requirement for Original Medicare. The plan allows the patient to see any physician who accepts Medicare. Conversely, Medicare Advantage plans are more restricted in terms of the provider networks they work with. Individuals in rural and isolated areas may have difficulty finding plans in Massachusetts that work with their local health care services.

Massachusetts Medigap has three types of policies that are described in detail later in this chapter, making it relatively simple to compare costs.

ADVICE:

After you have listed all your medical needs, prescription drugs and primary care physicians, you may want additional help. You can contact contact Serving the Health Information Needs of Everyone (SHINE). Ask that the SHINE counselor calculate your costs and benefits under both Original Parts A and B, and D, plus a supplement. Then, ask SHINE to suggest two Part C Advantage plans. Then, call SHINE again and get a second opinion as above. SHINE counselors can differ in their recommendations.

G. ELIGIBILITY FOR MEDICARE AND ENROLLMENT

1. Enrollment

The SSA determines whether or not a person is eligible for Medicare.

2. Citizenship/lawful presence

To be eligible for Medicare, you must be a U.S. citizen or a non-citizen who has been lawfully present for five continuous years.

3. Social Security Procedures

The SSA mails Medicare cards to all Medicare recipients (beneficiaries) upon enrollment. The cards do not use your Social Security number, but a special Medicare number that only you have. Medicare will NEVER call you to check on your Medicare account; Medicare only writes to you. Do not give your Medicare number over the telephone. If you need to discuss your account, you can sign in to Medicare at www.medicare.gov/account/login or call 1-800-MEDICARE (1-800-633-4227). Since the SSA handles Medicare enrollment, you may enroll in person or online at www.ssa.gov. You may contact an SSA office for enrollment issues.

a. If you are already getting benefits from Social Security or the Railroad Retirement Board, you will automatically get Part A and Part B starting the first day of the month you turn 65. If you are not

already receiving those benefits, you will need to contact Social Security three months before your 65th birthday during the initial enrollment period. The initial enrollment period is the seven-month period that begins three months before you turn 65 and ends three months after you turn 65.

b. **In-Person or Online Enrollment**

Most people must actively enroll in Medicare. You must contact Social Security during the initial enrollment period. You can enroll in person at your local SSA office, enroll online at www.SSA.gov, or call the SSA at (800) 772-1213, Monday through Friday from 7 a.m. to 7 p.m. As of the date of printing, the SSA recommends you enroll online.

c. **Enrollment Periods (for purposes of Premium Part A and Part B)**

i. **Initial Enrollment Period:** The initial enrollment period (IEP) is the seven-month period that begins three months before you turn 65 and ends three months after you turn 65. If you enroll three months before you turn 65, coverage begins on the first of your birthday month. If you enroll during the three months after you turn 65, coverage begins the first of the month following the month of enrollment.

ii. **General Enrollment Period:** The general enrollment period (GEP) for Original Medicare takes place from Jan. 1 through March 31 of each year. Coverage becomes effective the first of the month following the month of enrollment.

iii. **Special Enrollment Period:** There are also special enrollment periods (SEPs), which fall outside of the general and initial enrollment periods available to beneficiaries in certain circumstances. Some of these situations include life changes such as changes in household or residence, loss of health coverage, end of incarceration, or other qualifying life events based on special circumstances. https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods.

d. **Spouse**

If you or your spouse has paid Medicare taxes for at least 10 years (40 quarters), then you do not have to pay a premium for Part A Medicare.

4. Under 65 with Disabilities

Medicare is also available to people younger than 65 who have certain disabilities:

a. **End-Stage Renal Disease (ESRD):** If you have end-stage renal disease (ESRD), you are eligible for Medicare at any age. Individuals with ESRD do not have to collect Social Security Disability Insurance (SSDI) benefits for 24 months in order to be eligible for Medicare. Individuals with ESRD are eligible for Medicare generally three months after a course of regular dialysis begins or after a kidney transplant.

i. **Part B-ID:** Medicare offers a special benefit for beneficiaries with ESRD who are 36 months post-kidney transplant and no longer eligible for full Medicare. This is called the Part B-ID or immunosuppressive drug benefit. This is a stand-alone benefit, meaning the only items covered under this benefit are immunosuppressive drugs. You may qualify for this benefit so long as you do not have or expect to get other types of health coverage that also cover immunosuppressive drugs.

ii. **Amyotrophic Lateral Scelerosis (ALS):** Individuals suffering from ALS are eligible for Medicare coverage immediately upon approval for SSDI benefits (but after the five-month waiting period). Individuals with ALS do not have to collect SSDI benefits for 24 months in order to be eligible for Medicare.

c. **Other Disabilities:** Individuals under age 65 with disabilities other than ESRD or ALS must have received SSDI for 24 months before becoming eligible for Medicare. A five-month waiting

period is required after a beneficiary is determined to be disabled before a beneficiary begins to collect SSDI benefits. Medicare is also available under the same rules for individuals who receive railroad retirement benefits. Most state and local Massachusetts employees may also be eligible to enroll in Medicare even if they are not eligible for SSDI benefits as long as they have paid into Medicare. See COBRA below.

5. Cautionary Points

a. **Loss of health insurance:** If you do not sign up for Part A and/or Part B during the initial enrollment period, or when you are first eligible, or when you lose your employer health insurance, your monthly Part B premium may increase 10% for each 12-month period you delayed as a late enrollment penalty for as long as you have Medicare. See COBRA below.

b. **Late enrollment penalty:** This late enrollment penalty is added to your monthly premium and is permanent if you are 65 or older. If you are younger than 65, the penalty ends at 65. In addition, there may be a coverage gap.

c. **Sign-up dates:** As previously discussed, you can sign up between Jan. 1 and March 31 of any year, with coverage beginning on the first of the following month. If you have incurred such a late enrollment penalty, you should look into filing for "equitable relief." A successful claim for equitable relief may waive the Part B late enrollment penalties and win a "special enrollment date" if the federal government has misled you about enrollment rules.

d. **Part D late enrollment:** Part D also has a late enrollment penalty. If you waited 63 or more days to enroll in Part D or a Part C plan with drug coverage after loss of creditable coverage, you will pay a penalty for late enrollment each month for as long as you have Medicare Drug coverage. The late enrollment penalty for 2025 is $36.78 per month, multiplied by the number of months you were eligible for Part D but did not enroll. This penalty is in effect for as long as you have Medicare Part D coverage. The monthly penalty changes every year. This is in addition to any extra premium you owe due to income levels.

e. **Appeals:** You can appeal this by asking for a "reconsideration" from your drug plan, but you must pay the monthly premium plus whatever penalty you are appealing during that appeal process.

f. **Need Parts A and B numbers:** You need Medicare A and B numbers to enroll in Medicare Advantage plans.

H. TURNING 65 AND STILL WORKING

1. Retirement Age

Full retirement age for Social Security benefits is now based on the year you were born, and the age when full benefits start has been raised. This means that you may qualify for Medicare before you qualify for full Social Security benefits. Consequently, many people work beyond age 65. If you are turning 65, still working and have health insurance coverage through your employer, there are additional considerations.

2. Working Beyond 65

"By law, people who continue to work beyond age 65 still must be offered the same health insurance benefits (for themselves and their dependents) as younger people working for the same employer." If your employer has more than 20 employees, the employer's health insurance is primary. Your employer cannot require you to enroll in Medicare when you turn 65 or offer you a different kind of insurance, unless your employer has fewer than 20 employees. If your employer has fewer than 20 employees, Medicare is primarily responsible for your health care costs. The group health plan pays secondarily, after Medicare, up to covered costs. In this case, if you fail to enroll in Medicare when you are first eligible, you may have little or no health coverage.

3. Group Insurance

If you do enroll in Part A while working, and you keep your group insurance plan, you can delay

enrolling in Part B. When you leave work, you will have a special enrollment period to enroll in Part B. You can enroll anytime when you are still covered by the group health plan based on current, active employment, and during the eight-month period that begins after the employment ends or the coverage ends, whichever happens first.

4. **COBRA**
   Neither COBRA nor retirement health insurance coverage can extend the enrollment period for Part B nor protect you from penalties. Employer-sponsored health insurance must be based on active employment. Be sure to sign up for Medicare Parts A and B when first eligible or upon losing employer group coverage. COBRA is not considered credible coverage. Those who go for extended periods of time without creditable coverage may be assessed a late enrollment penalty upon electing Part B at a later date. Your monthly premium for Part B will go up 10% for each full 12-month period that you could have had Part B but did not sign up for it. It is generally not advisable to go without coverage "until needed" to save on the monthly premium costs.

5. **Employer Insurance**
   Your employer's insurance may coordinate benefits with Medicare; in some instances, the employer's insurance will act like a Medicare Supplement and pay deductibles and co-insurance. Check the details where you work.

I. MEDICARE IMPACT ON OTHER HEALTH INSURANCE AND PERSONAL INJURY SETTLEMENTS

1. **Medicare Guide to Who Pays First**
   You cannot have two different insurances pay the same amount on a bill. One insurance will pay some money first, and then the second insurance will pay some money. For more information when you have two insurances or sources of payment for a health-related injury, see "Medicare Guide to Who Pays First," from www.Medicare.gov.

2. **Bill Payment**
   If you have Medicare and other health insurance or coverage, be sure to tell your doctor and other providers. They will be able to send your bills to the correct payers to avoid delays. If you have questions about who pays first, or if your insurance changes, call (800) MEDICARE and ask for the Medicare coordination of benefits contractor.

3. **End-Stage Renal Coverage**
   For information on ESRD, refer to www.medicare.gov/basics/end-stage-renal-disease.

4. **Personal Injury Settlement**
   Money paid from a personal injury settlement, workers' compensation claim, car accident, medical settlement or other compensation for personal injury will likely affect your Medicare benefits. You may owe Medicare money for your care. You should notify Medicare and speak with the Medicare coordination of benefits contractor. Failure to follow these rules can result in loss of Medicare coverage for certain conditions and a fine, possibly as much as $1,000 per day.

   Medicare will first send a demand for reimbursement. The procedure is found at https://www.cms.gov/medicare/coordination-benefits-recovery/overview/reimbursing. The time to respond is 30 days, before interest begins to accrue. There is, however, a waiver of recovery process described there.

5. **Third-Party Payments**

Medicare has legal authority to recover money from these third-party payments. See https://www.cms.gov/medicare/coordination-benefits-recovery/insurer-services for a description of the various steps. Note that interest accrues on unrecovered payments. Medicare has an automatic lien on any funds you are paid.

6. Chart: Payment Order of Third-Party Payments

IF YOU	CONDITION	PAYS FIRST	PAYS SECOND
Are age 65 or older and covered by a group health plan because you are working or are covered by a group health plan of a working spouse of any age	Entitled to Medicare and: 1. The employer has 20 or more employees 2. The employer has fewer than 20 employees and has no Medicare exceptions	1. Group Health Plan 2.Medicare	Medicare Group Health Plan
Have an employer group health plan after you retire and are age 65 or older	Entitled to Medicare	Medicare	Retiree coverage
Are disabled and covered by a large group health plan from your work or a family member who is working	Entitled to Medicare and: 1. The employer has 100 or more employees, or 2. The employer has fewer than 100 employees and no Medicare exceptions	1. Large Group Health Plan 2. Medicare	1. Medicare 2. Group Health Plan
Have been in an accident where no-fault or liability insurance is involved	Entitled to Medicare	No-fault or liability insurance for services related to accident claim	Medicare
Are covered under workers' compensation because of job-related illness or injury	Entitled to Medicare	Workers' compensation for workers' compensation claim-related services	Medicare usually doesn't apply
Are a veteran and have veterans benefits	Entitled to Medicare and veterans benefits	1. Medicare pays for Medicare-covered services 2. Veterans Affairs pays for VA-authorized services ***NOTE:*** *Generally, Medicare and VA can't pay for the same service*	Medicare usually doesn't apply
Are covered under TRICARE	Entitled to Medicare and TRICARE	1. Medicare pays for Medicare-covered services 2. TRICARE pays for services from a military hospital or any other federal provider	TRICARE may pay second
Are age 65 or older OR disabled and covered by Medicare and COBRA coverage	Entitled to Medicare	Medicare	COBRA

J. OPTIONS TO ENHANCE ORIGINAL MEDICARE COVERAGE

1. Medigap Plan for Supplemental Insurance

Medigap plans cover many of the expenses you owe under Original Medicare A and B. Medigap does not cover more services or give you more coverage than Original Medicare. Here are two examples. First, Medicare does not cover hearing aids, so Medigap does not cover hearing aids. Second, under Part A, you would have up to 100 days in an SNF (rehabilitation center) provided you meet the requirements.

You would pay nothing for the first 20 days, and co-insurance of $419 per day for days 21 through 90. A Medigap plan will pay the co-insurance of $419 per day for all of the days when you qualify for Medicare coverage but will not pay for any costs beyond the 90 days. This is because Medicare itself does not cover more than 90 SNF days in any one period. Medigap will not pay if you are not receiving skilled care, even if you have not used all your days. A Medigap plan may cover international travel emergencies for an extra cost.

2. **Medigap Enrollment**
   You have to pay a premium for Medigap plans. Currently, in Massachusetts, you can purchase a Medigap plan at initial enrollment or during any annual renewal. This is not true in all states, and may not be true in the future. In some states, if you do not enroll in a Medigap plan when you first enroll in Medicare, you may not be able to buy a Medigap plan after, or you may have to take a physical exam to get Medigap, and it may cost considerably more.
3. **Massachusetts Medigap Options**
   a. **Core plan:** The Core plan is the least expensive of the three options and covers the Part B co-insurance amount, paying for the 20% of approved amounts that Part B would normally require the Medicare beneficiary to pay out of pocket. With this option, policyholders would still pay the Part B deductibles out of pocket and the Part A deductibles and co-insurance.
   b. **Supplement 1:** Like the Core plan, this option covers the 20% Part B co-insurance amount. Additionally, Supplement 1 covers the Part A and Part B deductibles, providing more robust coverage than the Core plan. Due to the enhanced coverage, the Supplement 1 premium is higher than the Core plan offerings. This plan is only available to those who were eligible for Medicare in 2020 or earlier.
   c. **Supplement 1A:** This plan covers the Part A deductible, but not the Part B deductible.

      If you are purchasing a Medigap plan, check if the plan covers Massachusetts state-mandated benefits, including yearly Pap tests and mammograms.
   d. **Premium rates and Medicare Planfinder:** Medicare Supplement premium rates are required to be in effect for at least 12 months. Effective dates shown for each carrier are based on the most recent filing on record with the Division of Insurance. Use this Medicare Planfinder tool to compare Medicare Supplement plans and prices available: www.medicare.gov/medigap-supplemental-insurance-plans/#/m/?year=2023&lang=en.
4. **The Advantages and Disadvantages of Medicare Supplements: Side-by-Side Comparative Chart**
   a. **Out-of-pocket costs:** Medicare supplements in Massachusetts work with Original Medicare; policyholders generally have low out-of-pocket costs when receiving covered services and flexibility in choosing providers. There are no networks, and no referrals are necessary.
   b. **Premiums for Medicare Supplements:** May exceed $200 a month, paid to the insurance company.
   c. **Prescription medicines:** Also, the supplements do not cover most prescription medicines. In many cases, retirees incur the additional cost of a Part D plan.
   d. **Medigap in Massachusetts — Comparison Chart**

TIP: If your Medicare costs are too expensive, there are four types of Medicare Savings programs that may help. To find out if you are eligible, and how much help you qualify for, go to https://www.medicare.gov/basics/costs/help/medicare-savings-programs.

MEDIGAP IN MASSACHUSETTS: Compare These Plans Side-by-Side If a "yes" appears, the plan covers the described benefit. If "no" appears, the policy doesn't cover that benefit.			
MEDIGAP BENEFITS	**MEDIGAP PLANS**		
	Core Plan	**Supplement 1**	**Supplement 1A**
BASIC BENEFITS			
Part A: inpatient hospital deductible	No	Yes	Yes
Part A: skilled nursing facility co-insurance	No	Yes	Yes
Part B: deductible*	No	Yes*	No
Foreign travel emergency	No	Yes	Yes
Inpatient days in mental health hospitals	60 days per calendar year	120 days per benefit year	120 days per benefit year
State-mandated benefits (Yearly Pap tests and mammograms. Check your plan for other state-mandated benefits.)	No	Yes	Yes
*Supplement 1 Plan (which includes coverage of the Part B deductible) will no longer be available to people who are new to Medicare on or after Jan. 1, 2020. These people can buy Supplement 1A Plan. However, if you were eligible for Medicare before Jan. 1, 2020, but not yet enrolled, you may be able to buy Supplement Plan 1.			

5. Part D Prescription Drug Coverage

a. Refer to the description of Part D plans, above.

b. **Medicare Part D websites:** Medicare has websites that will help you with Part D coverage. Medicare helps you determine which type of plan is right for you (e.g., which type of plan works for people who take a lot of expensive prescription medications, or those who don't take any). Medicare helps you select between plans in your coverage area, which is https://www.medicare.gov/plan-compare/#/?lang=end&year=2024.

Be sure to use the "medicare.gov" websites for full comparisons. Private insurers' websites will not include information on competitors' products.

6. Part D Formularies, Tiers and Quantity Limitations

a. **Classes of drugs:** Medicare requires each plan to cover certain classes of drugs, but the plans vary widely in what specific medicines are covered. It is very important to obtain the plan's formulary, which lists each medicine covered and its tier. In addition, many drug companies impose "utilization management," requiring prior authorization and step therapy (meaning that you are prescribed the most commonly used generic drug for your condition, to see if it works for you; you must fail on that drug before you can move up a "step" to a more expensive drug) before covering the drug, as well as quantity limits.

b. **Common drugs:** For many common drugs, there are major differences in coverage levels between insurance companies, so it makes sense to check the tier and quantity limitations for each of your medications with prospective insurance providers before enrolling. An insurer cannot remove a therapeutic category (e.g., high blood pressure medication) during a plan year, but can remove any single drug from its coverage with 60 days' notice to the insured.

c. **Exceptions:** If a plan does not carry a drug you need, you and your physician may request an "exception." Not all plans provide for formulary exceptions if a medically necessary medicine is generally not covered. If your plan allows exceptions, you contact the plan's customer service department and request a "formulary exception" for the medicine. To obtain an exception, your prescriber must state that all drugs in the plan's formulary will not work as well or will have side effects. Exceptions can also be requested for quantity limits, step therapy and tiering. If your request is denied, you can appeal this decision. Follow all the steps listed at https://medicare.gov/medicare-prescription-drug-coverage-appeals.

d. **Denial of coverage:** If a prescription drug you need is listed on the formulary, but you are denied coverage under Medicare, you can also appeal this denial of coverage. This is useful to know if you have just enrolled in Medicare, have been successfully taking a drug for your condition, and Medicare requires that you utilize step therapy.

e. **SimpleCare or GoodRx:** If Medicare does not cover your drugs, or you have not been successful with an appeal, you can see if that drug is covered under a different program, such as SimpleCare or GoodRx. If you use these plans, you cannot use Medicare for the same prescription, and the costs will not be included in your Medicare coverage limits.

f. **Role of pharmacist:** Your pharmacist can discuss insurance plans you research on the CMS website, but cannot market any specific plan to you. Select your Medicare Part D plan using the Medicare Part D Planfinder tool, from the CMS website, found at www.medicare.gov/find-a-plan/questions/home.aspx. Recent studies show that some plans can cost up to $100,000 more for the same drugs. If you take any single prescription that costs more than $600 a month, you should take great care to evaluate these plans. Mail order is not automatically cheaper than retail.

g. **Part D insulin new costs:** Plans cannot charge you more than $35 for a one-month supply of each Medicare Part D-covered insulin you take, and cannot charge you a deductible for insulin. This means that the $35/month fee does not reduce your deductible. See the end of the chapter for specific information on how to determine drug costs, including insulin, for Part D.

h. **Difficulties paying for insulin:** If you have difficulty paying for insulin, see if you qualify for Extra Help, and your co-payment for insulin would be lower. You apply for Extra Help through Social Security; for the Massachusetts-specific Medicare Savings Plan, call SHINE for Massachusetts — Serving the Health Insurance Needs of Everyone — at (800) 243-4636.

i. **Opioid medication new rule:** New this year. Opioid and other narcotic pain medications are limited, except if you are a cancer patient, in palliative care or in hospice care. In those situations, ask your case manager, your nurse or your physician to notify the pharmacy you will use so that the necessary prescriptions can be filled. Without this notice, you may not be able to obtain your medication.

7. Late Enrollment Penalty for Part D

a. **Late enrollment defined:** If you do not enroll in a Part D plan when initially eligible, unless you have creditable coverage through another insurer or drug coverage through a Medicare Advantage plan, you will be subject to a Part D late enrollment penalty even if you do not currently require medication.

b. **Sanctions:** If you go without coverage for more than 63-consecutive days, you will face a 1% monthly sanction if you ever need Part D coverage in the future. It is important to enroll in a Part D plan when first eligible or make sure you have creditable coverage (or a Part C plan that includes Part D benefits).

c. **Penalties:** These penalties can be significant. Medicare calculates the penalty by multiplying 1% of the "national base beneficiary premium" ($36.78 in 2025) times the number of full, uncovered

months you didn't have Part D or creditable coverage. The monthly premium is rounded to the nearest $.10 and added to your monthly Part D premium. The national base beneficiary premium can change each year, so your penalty amount can also change each year. If you already have incurred a late enrollment penalty, you may seek a waiver based on specified reasons. Waivers may be available for those with lower incomes who qualify for the Low Income Subsidy (LIS) Program (ExtraHelp).

d. **Chart — Original Medicare and Medicare Advantage Plans At-a-Glance:**

ORIGINAL MEDICARE & MEDICARE ADVANTAGE PLANS AT-A-GLANCE				
	Original Medicare (Parts A & B)	**Supplement ("Medigap")**	**HMO Part C (Medicare Advantage)**	**PPO Part C (Medicare Advantage)**
What do I pay?	Part B premiums, deductibles and co-insurances. Part A deductibles and co-insurances	Medigap premiums, Part B premiums, Part A and B deductibles, generally no co-payment	Medicare premiums and plan premium; your plan sets its own deductibles and co-pays.	Medicare premiums and plan premium; your plan sets its own deductibles and co-pays.
Can I go to any doctor?	Yes, if they accept Medicare.	Yes, if they accept Medicare.	No, you must go to in-network providers.	Yes, though PPOs have provider networks, you may go out of network for a higher co-pay.
Where can I get routine, non-emergency care?	Anywhere in the country.	Anywhere in the country.	For most plans in your network.	For most plans in your network.
Where can I get emergency care?	Anywhere in the country.	Anywhere in the country.	In network, unless out of geographic area.	In network, unless out of geographic area.
How do I get prescription drug coverage?	Part D	Part D	You must join a plan that includes drug coverage, also called MA-PD.	You must join a plan that includes drug coverage, also called MA-PD.
Will I need a referral to see a specialist?	No	No, unless you have a Medicare SELECT plan.	Usually	No, but you may pay more out of pocket if you go to a provider who is out of network.
Is there a limit to my out-of-pocket spending?	No	No	Yes, all Medicare Advantage plans must have limits on out-of-pocket spending.	Yes, all Medicare Advantage plans must have limits on out-of-pocket spending.

8. Options Available if Medicines Are Expensive

a. **Multiple options:** There are multiple options for beneficiaries who have difficulty paying for medicines. In addition to "Extra Help" or the "Low-Income Subsidy" provided to low-income beneficiaries, the following options, some notable, may apply.

b. **Alternative medicines:** Explore alternative medicines with your pharmacist and doctor. Ask your regular pharmacist for a Drug Utilization Review (DUR), which is free. This report identifies duplicate drugs and suggests drugs that may be more appropriate for you; then, show this report to your doctor(s). Be sure that the DUR lists all the drugs you take, even those that you do not fill at that pharmacy. Ask your doctor if a safe and effective generic medicine or an alternative therapeutic may work better for you. Often, co-pays for generics can be more than 75% less than the brand-name medicines.

c. **Use of brand names:** It may be possible to switch to a preferred brand-name from a non-preferred brand-name drug listed in the formulary to reduce co-pays. Of course, only consider changing in consultation with a medical professional.

d. **Local discount programs:** Some grocery stores and pharmacy chains offer discount programs that work in conjunction with your insurance plan. Please be sure to ask your pharmacist if your pharmacy offers such programs. You can compare the price on a national discount plan, like GoodRx, SimpleCare or Costplusdrugs, with your insurance price. You can buy the drug with a national discount plan, but you CANNOT combine the Medicare Part D benefit with the national discount plan.

e. **State pharmacy assistance:** Massachusetts offers a state pharmacy assistance program, Prescription Advantage, for those with lower incomes who do not qualify for MassHealth. This program provides out-of-pocket maximums on co-pays and extra help in the coverage gap. Unlike Medicare Extra Help and MassHealth, there is no asset test; qualification is based upon income. You can reach Prescription Advantage at (800) AGE-INFO, option 2.

f. **Medicare Extra Help:** Medicare offers "Extra Help" (also known as a low-income subsidy) to beneficiaries with lower income and assets. This program can reduce or eliminate your Part D premium and reduce deductibles and co-pays. Application for this program can be made through the SSA directly after you have enrolled in a Part D plan.

g. **Veterans benefits:** The Veterans Administration (VA) offers prescription benefit programs. For our readers who are veterans, please inquire with the VA to see if you qualify for benefits that may enhance the Part D benefit from your plan.

h. **Primary outreach programs:** Refer to Pharmacy Outreach Program in Chapter 8.

9. Change from Original Medicare to Medicare Part C (Medicare Advantage)

a. **Part C does not cover all drugs:** While the CMS website will clearly state premiums, deductibles, co-pays and co-insurance for Parts A and B, each Part C plan must be separately researched. The information about coverage options is found above. One limitation to consider is that not all Part C plans cover prescription drugs.

b. **Part C website**: The website, www.Medicare.gov, lists all the Part C plans available in your area; the website identifies those Part C plans with drug coverage. These plans work similarly to employer-sponsored health insurance plans, often combining doctor, hospital and additional services in one comprehensive plan. The plan options vary by county of residence, and all plans are not available in all areas. Not all plans continue from one year to the next and some do not take new patients. Check if the plans you want provide these benefits:

   i. Out-of-pocket maximums;

   ii. Reduced co-insurance amounts and co-pays for certain services;

   iii. Coordination of care;

   iv. Prescription drug benefits;

   v. Elimination of deductibles; and

vi. Low (or zero) monthly premiums.

c. **Star rating:** Pay particular attention to the star rating for both Part C and Part D plans; the star rating is a measure of quality.

d. **One-year plans:** Medicare Advantage plans are generally one-year programs. During each annual election period (usually starting in early October and ending in the first week of December), Medicare beneficiaries may change plans or disenroll from Part C and select other options (like stand-alone Part D plans), or return to Original Medicare. Such changes take effect on Jan. 1.

e. **Special circumstances:** During the year, there are options to change coverage if you have certain special circumstances. Some of the more common situations include:

i. Moving your primary residence outside the plan service area;

ii. Obtaining/losing employer coverage;

iii. Qualifying for MassHealth;

iv. Obtaining a low-income subsidy;

v. Qualifying for state pharmacy assistance (Prescription Advantage); and

vi. Enrolling in Part B.

K. CHANGING MEDICARE PLANS

1. Open Enrollment

As long as you are enrolled in Medicare, you can change plans during the open enrollment period. This generally becomes available in early October, and decisions must be made by early December. The new plans go into effect Jan. 1. In certain circumstances, you can switch between Medicare Part D plans during the year; consult "Medicare & You" for further information. https://www.medicare.gov/medicare-and-you. If you select an Advantage plan in the first enrollment period, you can make ONE change to a different Medicare Advantage plan or switch to Original Medicare and Part D between Jan. 1 and March 31 of the current year.

2. Comparing Insurance Providers

a. **Criteria:** When shopping for Medicare Parts C and D and Medigap supplements, it is important to compare premiums among insurance companies. As coverage is standardized, please consider the following criteria when evaluating options:

i. **Consider customer service quality and reputation:** Are claims processed accurately, and are you able to obtain prompt and professional service when questions arise?

ii. **Premium consistency:** By how much do rates tend to change annually? How will those changes impact your budget?

iii. **Discount programs and value-added services:** Does the insurance company you are considering offer any discounts (based upon age, paying by automatic bank draft) or savings programs for dental or vision?

L. MEDICARE DENIALS AND APPEALS

1. Notice: Original Medicare can deny coverage for a service before you receive it, or may deny a service or full payment after the service is received. Your provider should notify you in writing if a future service will not be covered. Your provider should do this by asking you to sign an "Advance Beneficiary Notice of Non-Coverage" prior to rendering any services. In this case, you are agreeing that Medicare will not pay for it. You can still file an appeal, but you will have to pay for the service first. You can get this advance notice from an SNF when the facility believes that Medicare will not cover your stay or certain items or services.

2. **Appeals:** You can file an appeal if Medicare denies a service/coverage or payment. The process depends upon what type of Medicare coverage you have. Carefully read the notice for detailed instructions on how to appeal. You may be required to submit medical records and documentation and may need a qualified physician to work with you on the appeal. Be careful not to miss any appeal deadlines.
3. **Website for appeals:** General information on appeals is found at www.medicare.gov/claims-appeals/how-do-i-file-an-appeal.
4. **Additional benefit information and website:** You can find additional information on Medicare benefits at www.medicareinteractive.org/resources/toolkits/medicare-advocacy-toolkits. There is a nonprofit organization that can help you with appeals. This is Medicare Interactive, found at www.medicareinteractive.org/get-answers/medicare-denials-and-appeals.

TIP: For a complete reference on Medicare appeals, including Original Medicare, A Medicare Advantage plan, and Medicare drug coverage, as well forms and advice, see https://www.medicare.gov/providers-services/claims-appeals-complaints/appeals. The forms themselves can also be found at https://www.medicare.gov/basics/forms-publications-mailings/forms/appeals.

If someone will file an appeal for you, you need to fill out an Authorization to Disclose Personal Health Information form, found at https://www.cms.gov/cms10106-authorization-disclose-personal-health-information.

An excellent source is the Center for Medicare Advocacy, at www.medicareadvocacy.org.

M. NAVIGATING MEDICARE

1. Available Resources

Navigating the Medicare system is confusing, but there are resources available to help. Please be sure to consult www.Medicare.gov, particularly "Medicare & You," or call (800) MEDICARE for detailed information. Consult your trusted advisors and request written information from insurance companies before enrolling in any plan.

2. Medicare Costs and Benefits

Below is a chart of Medicare benefits and costs for Part A and Part B. Medicare is an exceedingly complex program. For every rule cited in this chapter, many other rules and exceptions apply. "The devil," practitioners in this field are quick to point out, "is in the details."

3. Important Links

a. https://Medicare.gov/medicare-and-you.
b. https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options.
c. https://www.medicare.gov/manage-your-health/coordinating-your-care/accountable-care-organizations.
d. https://www.medicare.gov/sign-up-change-plans/joining-a-health-or-drug-plan.
e. https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/PPO.
f. https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/PFFS.
g. https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/SNP.
h. For resources on the Jimmo decision and settlement, see Jimmo decision FAQ: https://www.cms.gov/Center/Special-Topic/Jimmo-Settlement/FAQs; CMS manual updates can be found at https://www.cms.gov/Outreach-and-Education/Outreach-and-Education?bucket-filter=MM8458.pdf; for detailed information on the need for skilled nursing care when there is no likelihood of improvement, see http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec409-32.pdf.

i. "Age Discrimination in Employment Act of 1967," 29 USC § 621-34, at https://www.eeoc.gov/statutes/age-discrimination-employment-act-1967.

j. "When Can I Buy Medigap?" https://www.medicare.gov/supplements-other-insurance/when-can-i-buy-medigap.

k. https://www.ncoa.org/age-well-planner/medicare.