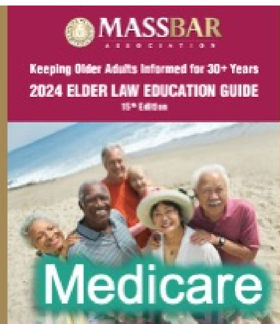

CHAPTER 7

MEDICARE
What You Need to Know

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INTRODUCTION

Medicare is a health insurance plan administered by the federal government through the Centers for Medicare and Medicaid Services (CMS). Established in 1966 under Title XVIII of the Social Security Act, Medicare serves more than 65 million people (as of 2023). This vast program insures U.S. citizens and legal residents who are age 65 or older and people under age 65 with certain disabilities. The "Medicare & You" 2024 guide, available from CMS, is the national handbook as well as an excellent reference, published annually for Medicare beneficiaries.

The Social Security Administration (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. FOUR DIFFERENT PARTS OF MEDICARE

1. Part A

i. **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" when the person's doctor AND the hospital both agree to the admission.

ii. **Emergency room:** If the hospital does not agree, the person's stay will not be covered by Part A. Going to the emergency department is NOT a Part A hospital admission. Part A does not cover all inpatient costs; certain costs will be covered by Part B. A common misconception is that Part A covers custodial nursing home care (custodial care includes feeding, bathing and toileting); Part A ONLY covers SNF stays under certain conditions, as discussed below.

iii. **Admissions:** When a person is first admitted as an inpatient to a hospital, the Part A benefit begins and beneficiaries are responsible for the Part A deductible. 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 benefit period 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.

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

2. Part B

i. **Outpatient:** Helps cover services from doctors, nurse practitioners, therapists and other health providers, some preventative care, emergency department visits, urgent care visits, 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."

ii. **Observation:** A person who is in the hospital for observation or in the emergency room does not qualify for Part A benefits. 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. Medicare Part C (Medicare Advantage)

i. **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. If you do not use the network providers, you generally will not have coverage, even under original Medicare.

ii. **Yearly limits:** Medicare Advantage plans have a yearly limit on out-of-pocket costs for Medicare Part A- and B-covered services. Once the yearly limit is reached, no additional payments from the beneficiary are necessary for the remainder of the year.

iii. **Payments due:** The Part B monthly premium (and any Part A monthly premium if you owe it) may be due, and the Medicare Advantage plan itself may be due a premium for Part C. Depending on your plan, you may have deductibles and co-pays until you reach your yearly limit. Additional cost information is found below.

iv. **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. 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.

4. Medicare Part D

i. **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.

ii. **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." The planners do not include information on premium adjustments.

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

5. **Medicare Parts Work Together**
   i. 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.
   ii. 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"	Inpatient admit until stabilized; discharge to home.	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.

6. **Understanding the Basic Parts of Medicare**
   i. **Original Medicare:** Part A and Part B are called "Original Medicare." Under Original Medicare, you can choose any available provider anywhere in the country that accepts Medicare. Payment is fee-for-service. Parts A and B do not cover drugs.
   ii. **Limits:** Medicare does not cover all medical expenses. Part A limits the number of days you are covered for hospital and skilled nursing home stays. Part B charges co-insurance for almost all services. If you enroll in Original Medicare, you should strongly consider purchasing a Medicare Supplement for Parts A and B. The supplement has an additional premium but covers the co-insurance you would otherwise have to pay. If you have preexisting conditions that require regular physician visits, you may find that a supplement will save you money. There are decision charts in this chapter to help you decide.
   iii. **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.

iv. **Medicare Advantage Plans:** Medicare Advantage plans (Part C) cover Part A, hospital, and Part B, medical benefits, and are sold and managed by private insurers. These plans manage your Medicare A and B benefits. They have a range of premiums, costs and rules, and may or may not offer prescription drug coverage. Some also offer limited dental, vision, fitness, transportation, and hearing device insurance. You pay your Part B premium and usually another separate premium to the Medicare Advantage plan.

v. **Two types of Medicare Advantage Plans — (PPO) and (HMO):** 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. 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.

vi. **Medicare Advantage Plans:** Medicare Advantage plans are also sold as PPOs. PPOs establish a network of physicians for whom you pay less than if you go outside the network. A PPO plan isn't the same as Original Medicare with a Medigap Supplement; usually, you pay extra for the additional benefits.

vii. **Private Fee-for-Service plans (PFFS):** Another form of Medicare Advantage option is the Private Fee-for-Service plans. Under a PFFS plan, you can go to any Medicare-approved doctor; there is no network or restriction. However, a doctor does not have to agree to treat you under a PFFS plan, even if the doctor has treated you before. The PFFS plan works differently than Original Medicare. The PFFS plan determines how much it will pay doctors, other health care providers and hospitals, and how much you must pay when you get care.

viii. **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).

ix. **Need to compare — online calculator:** Before you decide on a Medicare Advantage plan, you should compare the benefits and costs. There is an online cost calculator and plan comparison tool run by CMS, at www.medicare.gov/find-a-plan/questions/home.aspx.

x. **Precludes Medigap Plan:** When you have a Medicare Advantage plan, you cannot buy Medigap insurance to cover your deductibles, co-pays and co-insurance. 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.

xi. **MSA:** 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.

xii. **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.

xiii. **MSA 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.

xiv. **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.

B. MEDICARE LIMITATIONS

1. Payroll and Federal Income Taxes

All Medicare beneficiaries pay 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..

i. **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.

ii. **Inpatient hospitalization:** Part A benefits cover inpatient hospitalization, SNF care, hospice and home care. Part A benefits do not automatically start when you go to the hospital. In order to get Part A benefits, you must be admitted as an inpatient by both your doctor and the hospital.

iii. **Emergency room coverage:** If your doctor tells you to go to the emergency department, you are NOT covered by Part A, only Part B. When you are admitted as an inpatient, you will pay a deductible of $1,632 for 2024. 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.

iv. **60-day rule:** 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.

v. **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. To qualify, 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:

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

   b. You must need these services on a daily basis;

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

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

vi. **Custodial care:** If you do not meet all four of these 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.

vii. **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 care must meet certain requirements. These services must be of such complexity and sophistication that the skills of a qualified therapist 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 nurse, the service CANNOT be regarded as a skilled nursing service although 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 skilled nursing facility, or most Medicaid nursing facilities. These services are only provided in the “home.”

viii. **Part B deductible:** Part B has a yearly $240 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.

ix. **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, which fills the gaps in Medicare.

x. **Medicare Costs: Part A:** About 99% of all Medicare enrollees get Part A without a monthly premium. For those who have not worked at least 40 quarters in Medicare-covered employment, there are fees that are discussed below in the enrollment section. Part A has a deductible for each period of $1,632; the deductible is not prorated but due on the first day of admission. Part A also charges co-insurance for SNF stays, home health care and hospice care, all detailed in the chart below.

   a. **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.

   b. **2024 deductible.** The deductible for 2024 is $240. Part B also requires a monthly premium and pays for 80% of the approved costs of covered services. 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 2024 Part B premium, the income tax filing for 2022).

   c. **Calculating Part B deductible.** Specific amounts can be calculated using the table titled “Medicare 2024 Costs at-a-Glance.” Note that Part B premiums for certain transplant patients are different.

   d. **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.

e. **Part D costs.** Medicare Part D plans have monthly premiums and deductibles. Under law, no plan can charge more than $545 for a deductible in 2024. 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. Once you and your plan spend $5,030 in 2024 for covered drugs, you will pay no more than 25% of the cost of prescription drugs until your out-of-pocket spending reaches $8,000 in 2024. Once this amount is reached, "catastrophic coverage" is triggered. This results in no co-payment or co-insurance for covered Part D drugs for the rest of the calendar year. More detailed information on Part D and choosing a Part D plan is presented in the chart at the end of this chapted titled "Calculate Your Medicare Part D Premium for 2024."

f. **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.

g. **Medicare 2024 Costs at-a-Glance Chart.**

MEDICARE 2024 COSTS AT-A-GLANCE	
Part A premium	Most people don't pay a monthly premium for Part A. (If you buy Part A, you'll pay up to $505 each month for the entire time you have Part A.)
Part A hospital inpatient deductible and co-insurance	You pay: • $1,632 deductible for each benefit period | **$1,676 in 2025** • Days 1–60: $0 co-insurance for each benefit period • Days 61–90: $408 co-insurance per day of each benefit period | **$419/day in 2025** • Days 91 and beyond: $816 co-insurance per each "lifetime reserve day" after 90 for each benefit period (up to 60 days over your lifetime) • Beyond lifetime reserve days: all costs
Skilled nursing facility stay when Medicare Part A-eligible	First 20 days: $0 for each benefit period • Days 21–100: $204 co-insurance per day of each benefit period | **$209.50/day 2025** • Days 101 and beyond: all costs
Part B premium	For those enrolling in Part B for the first time, the standard Part B premium is $174.70 (or higher depending on your income); those in the highest bracket pay $594 per month. Medicare uses your income from two years ago (2022) to calculate your premium. | **$185 / month in 2025** (For immunosuppressive drug premiums, see Chart: Medicare Part B Immunosuppressive Premiums 2024.)
Part B deductible and co-insurance	$240 per year. After your deductible is met, you typically pay 20% of the Medicare-approved amount for most doctor services (including most doctor services while you're a hospital inpatient), outpatient therapy and durable medical equipment.
Part C premium	The Part C monthly premium varies by plan. Compare costs for specific Part C plans. You usually also have to pay the Part B premium.

Part D premium	There are now two types of Part D monthly premiums. One must be paid to the insurance plan to obtain the insurance. This amount varies by plan. There is also an income-adjusted premium where higher-income consumers pay more. This premium, called the Medicare Part D IRMAA, is paid directly to Medicare and NOT to the insurance company. Social Security determines if you owe this extra premium, which can range from $12.90 per month to $81 per month. If your yearly income in 2022 was $206,000 or less filing jointly, or $103,000 filing singly, you pay only your plan premium. Compare costs for specific Part D plans.
Home Health Care	Whether under Part A or Part B: $0 for approved home health care services; 20% of the Medicare-approved amount for durable medical equipment.
Hospice Care	$0 for hospice care and limited costs for outpatient care; does not include custodial care. There is a small co-payment of $5 to $10 for each prescription drug and similar products for pain relief and symptom control. You can also use your Part D plan to cover this cost. Medicare does not cover room and board when you get hospital or hospice care in your home or another facility.
	(Source: www.medicare.gov)

2. Medicare Advantage Limitations

i. **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. 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.

ii. **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.

iii. **Two complaints:**

a. The plans do not always follow the same rules for providing care as Original Medicare. For example, 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 at the Medicare number, but at something less than the Medicare number. CMS has made clear that this is illegal. As a practical matter, this is difficult for one 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.

b. The use of prior authorizations (PAs). Original Medicare generally does not require any approval for a physician's order for services. 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.

iv. **Prior authorization (PA) concerns:** 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. One study compared access to care by Original Medicare beneficiaries 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.

v. **Recent legislation on prior authorizations (PAs):** The law does not prohibit Advantage Plans from using PA, but Massachusetts does require the plans to follow specific procedures. In essence, the law requires the insurer to accept electronic uniform PA forms and make a decision within two business days. If the insurer does not accept the form or fails to respond, the PA request is automatically approved.

vi. **Appeal of prior authorization (PA) denials:** If your PA request is denied, there is a procedure you can follow to appeal the decision. See https://www.mass.gov/guides/frequently-asked-questions-about-internal-appeals for further information. In addition to the PA, drug plans frequently use "step therapy."

vii. **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. The CMS guidance is at https://www.cms.gov/medicare/health-drug-plans/managed-care-marketing/medicare-guidelines.

3. Enrolling in Original Medicare or Medicare Advantage

i. **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.

ii. **Preferred physician:** Before enrolling, 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 plans.

iii. **NCOA questions:**

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

Each year, Part C (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 increase slightly each year.

b. How can I measure quality for all of the various plans?

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)

1) A significant advantage is that it provides a better fit for individuals with ongoing medical issues. 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. 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.

2) "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.

3) 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, which makes comparing costs relatively simple.

C. ELIGIBILITY FOR MEDICARE AND ENROLLMENT

1. Citizenship

To be eligible for Medicare, you must be a U.S. citizen or a legal resident (green card holder).

2. Social Security

i. 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.

3. 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, SSA recommends you enroll online.

4. 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. If you have not paid Medicare taxes for 40 quarters for that period of time (not how much in taxes you paid), then you will pay a monthly premium. If you worked more than 30 quarters, but fewer than 40, it costs $278/month; if you worked fewer than 30 quarters, then $505 each month for the entire time you have Part A. If you work additional quarters, you can add these to your SSA account and reduce your lifetime premiums. Request an update from Social Security so you get the credits earlier.

5. Under 65 with Disabilities

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

i. **End-stage Renal Disease (ESRD):** If you have end-stage renal disease (ESRD) or amyotrophic lateral sclerosis (ALS), you are eligible for Medicare at any age. Individuals under age 65 with disabilities other than ESRD or ALS must have received Social Security Disability benefits 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 Social Security Disability benefits.

Individuals with ESRD and ALS, however, do not have to collect Social Security Disability 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. Individuals suffering from ALS are eligible for Medicare coverage immediately upon approval for Social Security Disability benefits (but after the five-month waiting period).

ii. **36-month post-transplant rule:** Medicare enrollees who are 36 months post-kidney transplant and no longer eligible for full Medicare coverage can elect to continue Part B coverage of immunosuppressive drugs by paying a premium based on earnings.

6. Cautionary Points

i. **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 year you delayed as a late enrollment penalty for as long as you have Medicare.

ii. **Late payments:** This late enrollment penalty is paid as an increase in 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 is a coverage gap.

iii. **Sign-up dates:** You can sign up between Jan. 1 and March 31 of the following year, but coverage does not begin until July 1. If you have incurred such a sanction, 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.

iv. **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, you will pay a penalty for late enrollment each month for as long as you have Medicare Drug coverage. Medicare calculates this penalty by multiplying 1% of the "national base beneficiary premium" ($34.70 in 2024) times the number of full, uncovered months you didn't have credible drug coverage. The monthly premium is rounded to the nearest $.10 and added to your Part D premium. This is in addition to any extra premium you owe due to income levels.

v. **Appeals:** You can appeal this by asking for a "reconsideration" from your drug plan, but you must pay the extra amounts during your appeal.

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

D. 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 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 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 or protect you from penalties. Be sure to sign up for Medicare Parts A and B (and also Medigap) 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.

E. 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 Payment

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 www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Reimbursing-Medicare/Reimbursing-Medicare-. 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 www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Beneficiary-Services/Medicares-Recovery-Process/Medicares-Recovery-Process 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.	Group Health Plan 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	
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*	Usually doesn't apply
Are covered under TRICARE	Entitled to Medicare and TRICARE	Medicare pays for Medicare-covered services 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

F. 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 $400 per day for days 21 through 100. A Medigap plan will pay the co-insurance of $400 per day for all of the days when you qualify for Medicare coverage but will not pay for any costs beyond the 100 days. This is because Medicare itself does not cover more than 100 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.

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

i. **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.

ii. **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.

iii. **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.

iv. **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

i. **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.

ii. **Premiums for Medicare Supplements:** May exceed $200 a month, paid to the insurance company.

iii. **Prescription medicines:** Also, the supplements do not cover most prescription medicines. In many cases, retirees incur the additional cost of a Part D plan.

iv. **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	Yes	Yes	Yes
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

i. **Original Medicare:** Parts A and B, even with a Medigap Supplement, do not offer prescription drug coverage. Some Medicare Advantage plans *(Medicare Part C, see Section 3)* do not offer drug coverage. If you elect Medicare Parts A and B, or a C plan without prescription drug coverage, you should always consider prescription drug costs and which Part D plan is right for you.

ii. **Private insurance:** Medicare Part D is an option that provides prescription drug coverage to Medicare beneficiaries through a private insurance company. This program provides coverage for many common medicines that can be obtained at participating local pharmacies or mail-order programs. Coverage levels and monthly premiums vary by insurance company, but the basic structure and minimum coverage levels are specified by Medicare. Part D plans have four basic components:

a. **Deductible:** Some plans (especially lower-premium options) have a deductible. A deductible is a dollar amount a policyholder must pay out of pocket before the insurance company pays benefits. The deductible may apply to all medicines the plan covers or only certain drugs (e.g., brand-name medicines). Insurance companies may choose not to include a deductible; in such cases, coverage begins immediately.

b. **Initial Coverage Stage:** This stage provides benefits with a co-pay (fixed dollar amount) or co-insurance (percentage of cost) for covered drugs. Insurance providers classify medicines

in tiers. Tiers are often divided in categories like preferred generics, non-preferred generics, preferred name brand, non-preferred name brand and specialty drugs. Generally, the higher the tier, the higher the amount the policyholder pays out of pocket. These co-pays change if the policyholder reaches the coverage gap.

c. **Coverage Gap:** Although Medicare has officially removed the coverage gap from Medicare Part D plans, most private insurers still use a coverage gap in their policies. The coverage gap (also called the "donut hole") goes into effect when the total cost of drugs covered under the plan reaches $5,030 (2024 numbers) in one calendar year and extends until $8,000. In the gap, policyholders generally pay 25% of the cost of both their generic and brand-name medicines, usually more than the co-pay.

d. **Catastrophic Coverage:** If a policyholder's out-of-pocket cost reaches $8,000 during 2024, the coverage gap is closed and the policyholder moves into the catastrophic coverage stage. As of publication, there were no prices on the CMS website, but they are expected to be low. Please note, on Jan. 1, the plan resets for the new year, returning to the initial coverage stage (or deductible stage).

iii. **Medicare Part D websites:** Medicare has two websites that will help you with Part D coverage. One site 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); this site is at www.medicare.gov/drug-coverage-part-d/how-to-get-prescription-drug-coverage/6-tips-for-choosing-medicare-drug-coverage. One site also 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

i. **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.

ii. **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.

iii. **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. If your request is denied, you can appeal this decision. Follow all the steps listed at https://medicare.gov/medicare-prescription-drug-coverage-appeals.

iv. **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, and have been successfully taking a drug for your condition, and Medicare requires that you utilize step therapy.

v. **<u>SimpleCare or GoodRx:</u>** 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.

vi. **<u>Role of pharmacist:</u>** 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.

vii. **<u>Part D insulin new costs:</u>** 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. https://medicareadvocacy.org/ira-part-d-improvements-start-january-2023/. This benefit is NOT reflected in the plan information posted on the Medicare Planner for Part D website. See the end of the chapter for specific information on how to determine drug costs, including insulin, for Part D.

viii. **<u>Difficulties paying for insulin:</u>** 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.

ix. **<u>Opioid medication new rule:</u>** 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

i. **<u>Late enrollment defined:</u>** If you do not enroll in a Part D plan when initially eligible, have creditable coverage from another source or have 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.

ii. **<u>Sanctions:</u>** 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). There are some Part D plans that do not require premiums, which may benefit those who need little or no prescription medication.

iii. **<u>Penalties:</u>** These penalties can be significant. Medicare calculates the penalty by multiplying 1% of the "national base beneficiary premium" ($34.70 in 2024) 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. In Medicare's example, a person who delayed Part D coverage for 24 months pays an additional $7.90 per month in 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.

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

ORIGINAL MEDICARE & MEDICARE ADVANTAGE PLANS AT-A-GLANCE				
	Original Medicare (Parts A & B)		**HMO Part C (Medicare Advantage)**	**PPO Part C (Medicare Advantage)**
What do I pay?	Part B premiums, deductibles and co-insurances	Medigap premiums, Part B premiums, 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	You can go to any doctor, regardless of 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 local geographic area	For most plans, in your local geographic area
Where can I get emergency care?	Anywhere in the country	Anywhere in the country	Anywhere in the country	Anywhere in the country
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

i. **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.

ii. **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.

iii. **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.

iv. **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.

v. **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.

vi. **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.

vii. **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.

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

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

i. **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.

ii. **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:

a. Out-of-pocket maximums;

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

c. Coordination of care;

d. Prescription drug benefits;

e. Elimination of deductibles; and

f. Low (or zero) monthly premiums.

iii. **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.

iv. **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.

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

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

b. Obtaining/losing employer coverage;

c. Qualifying for MassHealth;

d. Obtaining a low-income subsidy;

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

f. Enrolling in Part B.

G. 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

i. **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:

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

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

c. **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?

3. Medicare Denials

i. **Notice:** Medicare can deny coverage for a service before you receive it, or may deny a service or full payment after it is received. Medicare should notify you in writing that a future service will not be covered. Medicare does this by sending an "Advance Beneficiary Notice of Non-Coverage." In this case, if you get the service before you appeal, 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.

ii. **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. You will 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 a deadline.

iii. **Website for appeals:** General information on appeals is found at www.medicare.gov/claims-appeals/how-do-i-file-an-appeal.

iv. **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.

H. 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

i. https://Medicare.gov/medicare-and-you.

ii. https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options.

iii. https://www.medicare.gov/manage-your-health/coordinating-your-care/accountable-care-organizations.

iv. https://www.medicare.gov/sign-up-change-plans/joining-a-health-or-drug-plan.

v. https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/PPO.

vi. https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/PFFS.

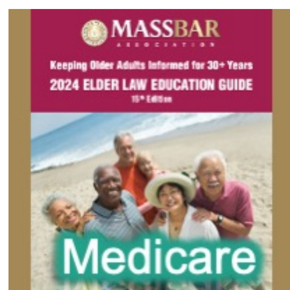
vii. https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/SNP.

viii. 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.

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

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

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



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