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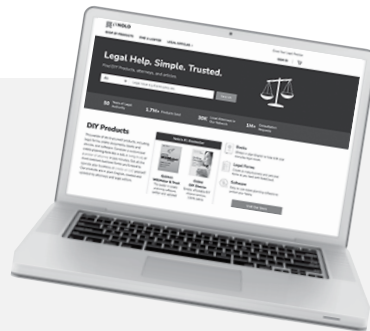
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# **Social Security, Medicare & Government Pensions**

**Get the Most Out of Your  
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**Attorney Joseph L. Matthews**



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## About the Author

**Joseph L. Matthews** has been an attorney since 1971. In the early years of his career, he taught at the law school of the University of California at Berkeley. Mr. Matthews is the author of *Long-Term Care: How to Plan & Pay for It*, *How to Win Your Personal Injury Claim*, and *The Lawsuit Survival Guide: A Client's Companion to Litigation*, all published by Nolo.

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**A**re you approaching retirement, or are you disabled? Do you help support someone who is?

If so, you'll want to get the most retirement and pension income you're entitled to and obtain the broadest medical coverage you can afford. People in their retirement years have access to a wide variety of programs to help with financial support and medical care. But many people are unaware of exactly what those programs are or how they work, and so do not receive all the benefits they could.

This book is intended to help you get all the benefits to which you are entitled: Social Security (both retirement- and disability-based, including for dependents and survivors), Supplemental Security Income, veterans benefits, and civil service benefits.

With regard to medical care, almost everyone is aware that Medicare is available to many people, but few people understand exactly how it works and what it does and does not cover. This book carefully, in plain language, explains Medicare rules and regulations. It also explains how the holes in Medicare can be filled by medigap private insurance, Medicare Advantage health plans, Medicaid (for people with low income), and veterans benefits.

## **Locating Chapters That Fit Your Needs**

Each chapter in this book explains a different benefit program designed to help older Americans. Each chapter explains how the program works and how it may relate to other programs discussed in the book. Not all of these programs will apply to you. But, even if you don't think you're eligible for a particular benefit, take a look at the general requirements discussed in that chapter. You might be surprised to find that a program, or some part of it, applies to you in ways you hadn't realized. Pay special attention to explanations of how your income, or your participation in one benefit program, might affect your rights in another program.



## TIP

**You have earned these benefits.** A key word in this book is “entitled.” Almost all of the benefits discussed here are paid to you because you worked for them, paying contributions into the system throughout your working life. If you’re an older American facing retirement and a fixed income, these programs provide crucial support. And you are entitled to it.



## RESOURCE

**Private pensions and 401(k) deferred benefit plans** are far more complex than can be covered in this book. We recommend that you consult *IRAs, 401(k)s & Other Retirement Plans: Strategies for Taking Your Money Out*, by Twila Slesnick and John C. Suttle (Nolo).

Depending on your age and stage of life, there are a number of major issues you should consider as you first scan through the book.

## If You Are 60 to 62 and Not Yet Retired

- Find out how soon (at what age) you’ll become eligible for Social Security retirement, dependents, or survivors benefits. (See “Timing Your Retirement Benefits Claim” in Chapter 2.)
- Learn how much your Social Security retirement benefits will be reduced if you retire early or increased if you retire later. (See “Timing Your Retirement Benefits Claim” and “The Amount of Your Retirement Check” in Chapter 2.)
- Explore when would be the best time to claim your benefits and which benefits to claim. (See Chapter 6.)
- Find out how much income you can earn without affecting your Social Security benefits if you claim them before full retirement age. (See “Working After Claiming Early Retirement Benefits” in Chapter 2.)
- See whether you can claim civil service retirement benefits if you have ever worked for the federal, state, or local government or any public agency or institution—such as a school system, library, or public health facility. (See Chapter 10.)

- Check the rules of your private pension plan—if you worked for a company that had a pension plan or if you belonged to any union—including whether your pension will be affected by your Social Security benefits. (Private pension plans themselves are outside the scope of this book.)

### **This Book Provides Ongoing Help to Caregivers**

People in their 60s must make initial decisions about Social Security, Medicare, and other benefit programs. But over the years, people also have to make new decisions concerning how they receive their Medicare coverage, choose medigap insurance or prescription drug plans, qualify for long-term care insurance benefits, and determine eligibility for Medicaid and other programs for people with low incomes. This book serves as a guide for caregivers, such as adult children, who might not have been involved in original choices about these matters, but who now must help loved ones make ongoing decisions over time.

## **If You Are Within Six Months of Your 65th Birthday**

- If you haven't already claimed retirement benefits, obtain a current estimate of the benefits you could receive from Social Security, your civil service retirement system, the private pension plan of any company where you've worked for at least three years, and the Department of Veterans Affairs, if you're a veteran. (See Chapters 10 and 11.)
- Be ready to claim your Medicare coverage as soon as you become eligible, if you choose to claim benefits at that time. (See Chapter 12.)
- Look into ways to supplement your Medicare coverage, including medigap insurance, a Medicare Advantage plan, or a Medicare drug coverage plan. (See Chapters 12, 14, and 15.)
- If you have low income and few assets other than your home, check into your eligibility to receive assistance with medical bills from Medicaid. (See Chapter 16.)

## **If You Are 65 or Older**

- If you have a low income and few assets, see whether you can get financial assistance from the Supplemental Security Income (SSI) program. (See Chapter 7.)
- Sign up for Medicare, after reading about Medicare rules as well as those of a Medicare Advantage or a medigap insurance plan that fills in holes in Medicare coverage. (See Chapters 13, 14, 15, and 16.)
- If you have low income and few assets other than your home, see whether you're eligible for Medicaid or for expanded Medicare coverage for prescription drugs. (See "Part D Prescription Drug Coverage" in Chapter 12 and see Chapter 16.)
- If you were in the military, see whether you can claim financial or medical benefits from the Department of Veterans Affairs (VA). (See Chapter 11.)

## **If You Are Within Six Months of Your 66th Birthday**

If you haven't already claimed Social Security retirement benefits, obtain a current estimate of the benefits you could receive when you reach full retirement age, which is between 66 and 67 for those born in 1954 or after. (See Chapter 1.)

## **If You Can Work Very Little or Not at All Because of a Physical or Mental Condition**

- Look into whether you might qualify for Social Security disability benefits. (See Chapter 3.)
- If you have low income and few assets, see whether you might qualify for disability benefits through the Supplemental Security Income (SSI) program. (See Chapter 7.)
- If you were in the armed forces and your physical condition is in any way related to your time in the service, investigate the qualification rules for veterans disability compensation and medical care. (See Chapter 11.)

## **If You Are a Spouse, Minor Child, Surviving Spouse or Child, or Former Spouse of a Worker Who Is Retirement Age or Is Disabled**

- Learn whether you're eligible for Social Security or civil service survivors or dependents benefits. (See Chapters 4 and 5.)
- Obtain an estimate of your own retirement benefits, and compare them to estimates of survivors or dependents benefits (you might be eligible for both but can collect only one).
- Check the rules of the pension plan of any company or government entity for which your spouse worked for more than three years. (See Chapter 10 for government pensions.)
- If you, your spouse, or your parent was in the military, look into whether you are entitled to any veterans retirement or disability benefits. (See Chapter 11.)

## **If You Are Age 60 or Older and Are Considering Getting Married**

- Find out what effect marriage would have on your right and your intended spouse's right to collect Social Security retirement, survivors, and dependents or disability benefits, and on the amount of those benefits. (See "The Amount of Your Retirement Check" in Chapter 2, and see Chapters 4 and 5.)
- Determine what effect marriage would have on your and your intended's eligibility for Supplemental Security Income (SSI) and Medicaid. (See Chapters 7 and 16.)

### **A Note for Same-Sex Spouses**

The U.S. Supreme Court has decided same-sex spouses are entitled to federal benefits such as Social Security dependents and survivors payments, veterans spousal benefits, and Medicare, on exactly the same terms as for other spouses. For rules concerning particular benefits for spouses, refer to the chapters in the book that explain those benefits.

## Living Together: Unofficial Marriages and Benefit Programs

Your eligibility for certain benefits and the amount of those benefits may depend on your marital status. Social Security and other programs don't provide dependents or survivors benefits for people who live together without being married even if they are registered domestic partners or have entered into a civil union under their state's laws.

Many people who live together believe they have a common law marriage—a legally recognized marriage—even though they never went through a formal ceremony, took out a marriage license, or filed a marriage certificate.

In fact, common law marriages are recognized only in Colorado, the District of Columbia, Iowa, Kansas, Montana, Oklahoma, Rhode Island, Texas, and Utah. And in Alabama, Georgia, Idaho, Ohio, Pennsylvania, and South Carolina, common law marriages are recognized only if they were formed before a certain date. If you don't live in one of these states and meet your state's particular requirements, you don't have a common law marriage and so are not eligible for Social Security or veterans dependents or survivors benefits based on your partner's work record.

If you do live in one of these states and apply for Social Security or veterans benefits based on your partner's work record, you'll be considered to have a common law marriage only if you and another person intend to be considered as married. You can show this in a number of ways—including living together as husband and wife for several years, using the same last name, referring to yourselves as married, having children together and giving them the family name you share, owning property together, and filing a joint tax return. You can even write out an agreement that says you regard yourselves as being in a common law marriage. However, there is no one thing you can count on to absolutely prove the existence of your common law marriage. And nothing guarantees that Social Security or other programs will consider you married when making a decision about your benefits.

Finally, if either you or the person with whom you live is still lawfully married to someone else, there can be no common law marriage.

### **Online Help on Social Security, Medicare, and Other Government Programs**

The internet has greatly increased public access to information about government programs. But not all this information is created equal. Plenty of information on the internet is helpful, but there is also a lot of confusing or misleading material. The government's own websites—like Social Security's [www.ssa.gov](http://www.ssa.gov) and Medicare's [www.medicare.gov](http://www.medicare.gov)—contain a huge amount of material, but the sites themselves can be hard to navigate.

This book will point you to some of the most useful internet tools and information from government websites covering retirement, pension, and medical benefits programs. If you find information on your own from nongovernment internet sources, make sure to confirm its accuracy on an official site before you use it to make a decision.

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# Social Security: The Basics

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**S**ocial Security is the general term that describes a number of related programs—retirement, disability, dependents, and survivors benefits. These programs operate together to provide workers and their families with some monthly income when their normal flow of income shrinks because of the retirement, disability, or death of the person who earned that income.

The Social Security system was originally intended to provide financial security for older Americans. Unfortunately, this goal of providing financial security is today increasingly remote. Benefits have not come close to keeping up with rapidly rising living costs, especially for seniors, which means that the support offered by Social Security is less adequate with each passing year. This shrinking of the Social Security safety net makes it that much more important that you get the maximum benefits to which you're entitled.

This chapter explains how Social Security programs operate in general. It's helpful to know how the whole system works before determining whether you qualify for a particular benefit program and how much your benefits will be. Once you understand the basic premises of Social Security, you'll be better equipped to get the fullest benefits possible from all Social Security programs for which you might qualify, which are explained in detail in Chapters 2, 3, 4, 5, and 6.

## History of Social Security

Public images of our society generally make invisible many millions of economically hard-pressed older Americans. The older person with little income and assets is left out of the standard media pictures of two-car, two-kid suburbanites and of wealthy retired couples in gated luxury communities.

During periods of extreme economic crisis, the number of people cast off by the economy spills over the normal lines of invisibility. One such period of extreme economic dislocation was the Great Depression of the 1930s, during which many millions of people were displaced—not only from job, home, and family, but from any hope for a place in the economy. Faced with the crisis of the Depression and with the possibility of massive social upheaval, President Franklin Roosevelt and Congress pushed through a number of

programs of national financial assistance—one of which was a system of retirement benefits called “Social Security,” enacted into law in 1935. But these retirement benefits were set at levels that barely kept people above the poverty line.

In 1939, Social Security benefits were extended to a retired worker’s spouse and minor children, and in 1956, they were extended to severely disabled workers. While these additions covered more people in need, neither new program deviated from the basic premise of Social Security: Provide just enough to keep starvation from the door, but not enough to guarantee a decent standard of living.

## **Benefits Now Provide Diminished Security**

The economic position of many older Americans today is increasingly precarious. People are living longer, private pensions are disappearing, and Social Security benefits—despite cost-of-living increases in most years—aren’t keeping up with their true living expenses.

And now the Social Security system itself is under pressure. Due to longer life spans and an overall population increase, there is a steady increase in the number of people collecting Social Security benefits. If the system continues as is, the total benefits that retirees, dependents, and survivors collect will eventually surpass the amount of taxes paid into the Social Security Trust Fund by younger workers and the interest earned on the fund. So, if the system isn’t altered, at some point—although experts disagree about exactly when—the system will no longer be able to pay the full benefits currently promised.

## **“Saving” Social Security**

Clearly, the Social Security system requires adjustment to ensure its continued health. There are simple ways to fix the Social Security system, but they’re ignored by some politicians who want nothing less than to end all public pensions and other support systems and force all retirement savings into the stock market. There, people’s savings would be bled by the financial institutions and other corporate profiteers that run Wall Street—a happy prospect for the people who bankroll elected national officials, but a disaster for working Americans.

Instead, simple adjustments to the system—none raising the basic Social Security tax rate—could address its financial problems without introducing investment risk or siphoning off funds to Wall Street.

**Remove cap on earnings subject to Social Security (FICA) tax.**

At present, the Social Security system doesn't tax earned income (wages) over \$168,600 per year (the amount goes up each year). This makes the FICA (Social Security) tax what's called a regressive tax (a tax that takes a larger percentage of the income of low-income people than of high-income people). For example, someone earning \$30,000 per year pays about 6.2% of their income in FICA tax while someone earning \$300,000 pays only 3.3% of their total income. The Congressional Research Service has found that removing this cap on taxed income, by itself, would keep the Social Security retirement system solvent for the next 75 years. So far, however, national politicians and their high-income supporters have resisted this change.

**Reduction against early benefits for nonearned income.** Under current rules, people can claim Social Security retirement or dependents benefits as early as age 62 and survivors benefits as early as age 60. But if someone collects any of these Social Security benefits and continues working, the benefits are partly reduced by income the beneficiary earns over a certain amount. The rule does not apply, however, to income from sources other than current work—such as investments, real estate, trusts, and so on. This rule penalizes those who must continue to work in order to survive, at the same time permitting others to collect their full benefit amount despite any amount—no matter how enormous—of nonearned income. If the same rule were applied to nonearned as well as earned income, the system could save significantly without taking anything away from those who most need benefits.

**Delay full retirement age.** The original standard age for full Social Security retirement benefits was 65. Congress raised that age for people born in 1938 or later, saving a great deal of money for Social Security. The age at which most people stop working continues to rise, so there's no reason why the full retirement age for collecting Social Security benefits shouldn't also rise again to parallel this changing reality.

**Slight reduction in benefits for high-income recipients.** Congress could create a yearly reduction in retirement benefits to people who continue to have a high income from work or investments after they claim retirement benefits—in other words, reduced benefits for people who don’t need them.

Any one of the adjustments discussed above would make a significant contribution to the long-term stability of Social Security. Several of them together could put the system on sound financial footing for many decades to come.

## What You Can Do

In response to this deteriorating situation, anyone facing retirement should take two important steps.

First, understand the rules regarding Social Security benefits. (They’re described in Chapters 1 through 5.) That will enable you to plan wisely for your retirement years, including answering the basic questions of when to claim your benefits and how much you can work after claiming them.

And second, become aware and active concerning proposed moves by Congress regarding the Social Security and Medicare programs. Local senior centers and national senior organizations such as the Alliance for Retired Americans in Washington, D.C. ([www.retiredamericans.org](http://www.retiredamericans.org)) are good sources of current information.

If you’re even beginning to think about your retirement, it is not too early to begin trying to safeguard it.

## Social Security Defined

Social Security is a series of connected programs, each with its own set of rules and payment schedules. All of the programs have one thing in common: Benefits are paid—to a retired or disabled worker, or to the worker’s dependent or surviving family—based on the worker’s average wages, salary, or self-employment income from work covered by Social Security.

The amount of benefits to which you're entitled under any Social Security program isn't related to your need. Instead, it's based on the income you've earned through years of working. In most jobs, both you and your employer will have paid Social Security taxes on the amounts you earned. You also pay Social Security taxes on your reported self-employment income.

Social Security keeps a record of your earnings over your working lifetime and pays benefits based upon the average amount you earned. But the only income Social Security considers is earned income, from work, on which Social Security tax was paid. Income such as interest or dividends, or income from the sale of a business or stocks or other investments, isn't counted in calculating Social Security benefits.

Four basic categories of Social Security benefits are paid based on this record of your earnings: retirement, disability, dependents, and survivors benefits.

## **Retirement Benefits**

You can choose to begin receiving Social Security retirement benefits as early as age 62. But the amount of your benefits permanently increases for each year you wait after 62, until age 70. Benefits don't increase past age 70, so don't wait until after age 70 to claim benefits.

The amount of your retirement benefits, if taken at full retirement age (currently 66+ years), will be between about 20% of your average income (if your income is high) and about 50% (if your income is low). For a 66-year-old single person first claiming retirement benefits in 2024, the average monthly benefit is about \$1,900; \$3,000 for a couple.

The highest earners first claiming their benefits in 2024 (at full retirement age) would receive about \$3,800 per month; \$5,700 for a couple (receiving benefits on one spouse's earnings record). These benefits usually increase yearly with the cost of living. (See Chapter 2 for a full description of retirement benefits.)

## Disability Benefits

If you're younger than full retirement age but have met Social Security's work requirements and are considered disabled under the Social Security program's medical guidelines, you can receive disability benefits.

The amount of these benefits will be roughly equal to what your retirement benefits would be if you'd reached full retirement age before claiming benefits. (See Chapter 3 for a full discussion of disability benefits.)

## Dependents Benefits

If you're married to a retired or disabled worker who qualifies for Social Security retirement or disability benefits, you and your minor or disabled children might be entitled to benefits based on your spouse's earning record. This is true whether or not you actually depend on your spouse for your support.

A spouse can be awarded retirement or dependents benefits, but not both. When you file a claim for Social Security benefits, Social Security will determine which benefit you'll receive, depending on which benefit is higher. (See Chapter 4 for a full discussion of dependents benefits.)



### TIP

**Note for same-sex spouses.** Married same-sex spouses are entitled to Social Security dependents and survivors benefits on the same terms as other spouses.

## Survivors Benefits

If you're the surviving spouse of a worker who qualified for Social Security retirement or disability benefits, you and your minor or disabled children might be entitled to benefits based on your deceased spouse's earnings record. (See Chapter 5 for a full discussion of survivors benefits.)

**TIP**

**You can choose the program from which to claim benefits.**

You might meet the eligibility rules for more than one type of Social Security benefit. For example, you might be technically eligible for both retirement and disability, or you might be entitled to benefits based on your own retirement as well as on that of your retired spouse. You can collect whichever one of these benefits is higher, but not both.

## Eligibility for Benefits

The specific requirements vary for qualifying to receive retirement, disability, dependents, and survivors benefits. The requirements also vary depending on the age of the person filing the claim and, if you're claiming as a dependent or survivor, on the age of the worker.

However, there's one requirement that everyone must meet to receive one of these Social Security benefits: The worker on whose earnings record the benefit relies must have worked in "covered employment," thereby earning official "work credits," for a sufficient number of years by the time the worker claims retirement benefits, becomes disabled, or dies.

## Earning Work Credits

All work on which Social Security taxes are paid is considered covered employment. About 96% of all American workers—around 180 million people—work in covered employment, including self-employment. For each year you work in covered employment, you receive up to four Social Security work credits, depending on the amount of money you've earned. Once you have enough work credits, you and your dependents and survivors can qualify for Social Security benefits.

The amount of work credits you need in order to qualify for specific programs is discussed in Chapter 2 (retirement benefits), Chapter 3 (disability benefits), Chapter 4 (dependents benefits), and Chapter 5 (survivors benefits).

## The Importance of Names and Numbers

The Social Security system does everything—records your earnings, credits your taxes, determines and pays your benefits—according to your Social Security number. On every form you fill out or correspondence you have with the Social Security Administration, you must include your Social Security number. You should also use your name exactly as it appears on your Social Security card. This will make it easier for Social Security to track the correct records.

If you've used more than one name on work documents, indicate all names you have used on correspondence with the Social Security Administration. As long as you have used the same Social Security number, your records should reflect all of your earnings.

If you've changed your name and want to ensure that all your future earnings will be properly credited to your Social Security record, you can protect yourself by filling out an Application for Social Security Card. This form allows you to register your new name and match it with your existing Social Security number. You'll be sent a new Social Security card with your new name, but the same number.

To complete this form, you must bring to your local Social Security office the originals or certified copies of documents that reflect both your old and new names. If your name has changed because you married or remarried, bring your marriage certificate.

If your name change is due to divorce, bring the final order of divorce, which includes a reference to the return of your former name.

If you have any questions, particularly concerning the type of documents you can bring to show your old and new names, call Social Security at 800-772-1213.

The Social Security Administration (SSA) keeps track of your work record through the Social Security taxes paid by your employer through payroll taxes and by you through FICA taxes.

The self-employed—that is, people who receive pay from others without taxes being withheld (such as freelancers and consultants) or who take a draw from a self-owned or partnership business—earn

Social Security credits by reporting income and paying tax for the net profit from that income on IRS Schedule SE. Income that isn't reported won't be recorded on your earnings record. Although many people fail to report self-employment income to avoid paying taxes, a long-term consequence is that the unreported income won't count toward qualifying for Social Security retirement or other benefits, and will reduce the amount of benefits for those who do qualify.

## **Coverage for Specific Workers**

There are special Social Security rules for coverage of some workers in certain sorts of employment.

### **Federal Government Workers**

If you were hired as an employee of the federal government on or after January 1, 1984, all your work for the government since then has been covered by Social Security.

If you worked for the federal government before 1984, your work both before and after January 1, 1984 has been covered by the separate federal Civil Service Retirement System. (See Chapter 10 for a full description of civil service retirement benefits.)

### **State and Local Government Workers**

Many state and local government workers aren't covered by Social Security. State government employees are often covered by their own pension or retirement systems, and local government employees have their own public agency retirement system, or PARS.

However, some state and local government employees are covered by Social Security instead of—or in addition to—a state or PARS pension system. If so, these governments and their workers pay at least some Social Security taxes. And workers under these plans are entitled to Social Security benefits if they meet the other regular requirements.

If you're a government employee and aren't sure whether you're covered by Social Security, check with the personnel office at your workplace. And remember, even if your employment at a state or local agency doesn't entitle you to Social Security benefits, any other work you have done during your lifetime can qualify you, if you paid Social Security taxes.

### **Workers for Nonprofit Organizations**

Since 1984, all employment for charitable, educational, or other nonprofit organizations is covered by Social Security. (Some churches and religious organizations, however, are exempt from this rule.)

### **Members of the Military**

Whether your military service was considered by Social Security to be "covered employment" depends on when you served and whether you were on active or inactive duty. From 1957 on, all service personnel on active duty have paid Social Security taxes, and so all active service from that date is covered employment. Since 1988, periods of active service, such as reserve training, that happened while on inactive duty have also been covered.

### **Household Workers**

Household work—cleaning, cooking, gardening, child care, minor home repair work—should be covered by Social Security, like any other paid work. However, many employers don't report their household employees' earnings to the Internal Revenue Service (IRS) and don't pay Social Security taxes on those earnings. Of course, a lot of domestic workers don't want their earnings reported. They are paid so little that they prefer to receive the full amount, often in cash, without any taxes withheld.

A result of this nonreporting is that unreported earnings don't get credited to the worker's Social Security record. So when the worker or worker's family later seeks Social Security benefits, they might have trouble qualifying and, if qualified, will have lower benefit amounts than if the earnings had been reported.

If you want your earnings from household work reported to Social Security, you have several options. If you work for different employers and make less than \$1,000 per year from any one of them, you can report that income yourself as self-employment income and pay 15.3% self-employment tax on it in addition to income tax. Paying self-employment tax on federal income tax Form 1040, Schedule SE, credits the earnings to your Social Security earnings record.

If you work for any one employer who pays you a total of \$2,400 or more over the course of a year, you can ask that employer to withhold Social Security taxes from your pay, report your income to Social Security, and pay the employer's share of the Social Security tax on that income. The law requires the employer to do so. (See "Employer's Duty to Report Earnings of Household Workers," below.)

### **Farmworkers**

If you do farm or ranch work, your employer must report your earnings and pay Social Security taxes on them. The employer must also withhold your share of Social Security taxes from your paycheck if you earn \$150 or more from that employer in one year, or if the employer pays \$2,500 or more to all farm laborers, regardless of how much you earn individually. Any amounts you're paid in the form of housing or food don't have to be reported by the employer.

Farmworkers have long faced problems with employers who don't pay their share of the Social Security tax. To make sure your farmwork is counted toward your Social Security record, check your pay stub to see if Social Security taxes—labeled FICA—are being withheld. Also, ask the person who handles payroll to give you paperwork indicating that Social Security taxes are being paid on your earnings. If your employer isn't paying Social Security taxes on your earnings, or you get the runaround and you're unsure what the employer is doing, ask your local Social Security office to find out for you.

If you're worried about your employer finding out that you're checking on this, ask the Social Security field representative to make a confidential inquiry. Social Security can request all of the employer's wage records without letting the employer know which employee in particular has brought the matter to its attention.

### Employer's Duty to Report Earnings of Household Workers

If an employer hires a household worker—cleaner, cook, gardener, child sitter, home care aide—who isn't employed by and paid through an agency, and the employer pays that worker a total of \$2,400 or more during the year, the employer is required by law to report those payments and pay Social Security taxes on them. This rule exempts any worker who was younger than 18 during any part of the year.

Employers can report these taxes on their own Form 1040 federal income tax returns and pay the Social Security tax obligation along with their personal income taxes. To file and pay these taxes, the employer will need the names of the employees as they appear on their Social Security cards, the employees' Social Security numbers, and the amount of wages paid.

## Earning Work Credits

To receive any kind of Social Security benefit—retirement, disability, dependents, or survivors—the person on whose work record the benefit is based must have accumulated enough work credits. The number of work credits you need to reach the qualifying mark—what Social Security calls “insured status”—varies depending on the particular benefit you're claiming and the age at which you claim it.

You can earn up to four work credits each year, but no more than four, regardless of how much you earn. Before 1978, work credits were measured in quarter-year periods: January through March, April through June, July through September, and October through December. You had to earn a specific minimum amount of income to gain a work credit for that quarter, as follows:

- Before 1978, you received one credit for each quarter in which you were paid \$50 or more in wages in covered employment, or each quarter in which you earned and reported \$100 or more from self-employment.

- Beginning in 1978, the rules were changed to make it easier to earn credits. From 1978 on, you receive one credit, up to four credits per year, if you earn at least a certain amount of money in covered employment, regardless of the quarter in which you earn it. That means that if you earn all your money during one part of the year and nothing during other parts of the year, you can still accumulate the full four credits. The amount needed to earn one credit increases yearly. In 1978, when the new system was started, it was \$250; in 2024, it's \$1,730.

**EXAMPLE 1:** In 1975, Ulis was paid \$580 between January and March, nothing between April and July when he could not work because of a back injury, \$340 in August, and \$600 in cash from self-employment in October and November. For the year 1975, Ulis earned three credits: one credit for the first quarter, in which he was paid more than the \$50 minimum; nothing in the second quarter, so he got no credit; one credit in the third quarter, because he earned well over the \$50 minimum even though he worked only one month; and one credit for the last quarter, because in 1975 self-employment income was covered by Social Security.

**EXAMPLE 2:** Eve was paid \$800 in January 1978 but did not earn anything the rest of the year. Based on the earnings test in effect in 1978, she got three credits for the year—one for each \$250 in earnings—based on her earnings for January alone.

**EXAMPLE 3:** Rebecca was paid \$600 a month in 2024 at her part-time job, for total earnings for the year of \$7,200. Because her earnings of \$7,200 divided by \$1,730 (the amount needed to earn one credit in 2024) is more than four, she received the maximum four credits for 2024.

## Determining Your Benefit Amount

If you (or your dependents or survivors) are eligible for a Social Security benefit, the amount of that benefit is determined by a formula based on an average of your yearly reported earnings in covered employment since you began working. Social Security adjusts your earnings records every year that you have Social Security-taxed earnings (even after you begin collecting benefits, if you keep working).

### How Your Earnings Average Is Computed

Social Security computes the average of your yearly earnings, but places a yearly limit on the amount you can be credited with, no matter how much you actually earned that year. These yearly income credit limits are shown in the following table, “Yearly Dollar Limit on Earnings Credits.”



#### CAUTION

**Only employment-related income counts, and you must have paid Social Security taxes on that income.** Other income that you might have earned, such as interest, dividends, capital gains, rents, and royalties, won't be considered in calculating your Social Security benefits.

### Benefit Formula

Based on a worker's earnings record, the Social Security Administration computes what's called the worker's “Primary Insurance Amount,” or PIA. This is the amount a worker will receive in retirement benefits at full retirement age, which is 66 for everyone born in 1943 through 1954. The full retirement age is 67 for those born in 1960 or later. The exact formula applied to each worker's earnings record depends on the year the worker was born.

Yearly Dollar Limit on Earnings Credits			
1951–1954	\$ 3,600	1995	61,200
1955–1958	4,200	1996	62,700
1959–1965	4,800	1997	65,400
1966–1967	6,600	1998	68,400
1968–1971	7,800	1999	72,600
1972	9,000	2000	76,200
1973	10,800	2001	80,400
1974	13,200	2002	84,900
1975	14,100	2003	87,000
1976	15,300	2004	87,900
1977	16,500	2005	90,000
1978	17,700	2006	94,200
1979	22,900	2007	97,500
1980	25,900	2008	102,000
1981	29,700	2009–2011	106,800
1982	32,400	2012	110,100
1983	35,700	2013	113,700
1984	37,800	2014	117,000
1985	39,600	2015	118,500
1986	42,000	2016	118,500
1987	43,000	2017	127,200
1988	45,000	2018	128,400
1989	48,000	2019	132,900
1990	50,400	2020	137,700
1991	53,400	2021	142,800
1992	55,500	2022	147,000
1993	57,600	2023	160,200
1994	\$ 60,600	2024	168,600

**CAUTION**

**There is no “minimum” Social Security benefit amount.**

If your average earnings were quite low, your check will also be low.

Social Security benefits for a disabled worker (as described in Chapter 3), or for a worker’s dependents (as described in Chapter 4) or survivors (as described in Chapter 5), are based on a percentage of the worker’s PIA. Social Security can give you an estimate of your future retirement or disability benefits, or those of a worker on whose earnings record you’ll receive dependents or survivors benefits.

### **Veterans Can Receive Extra Earnings Credit**

If you’re a veteran of the U.S. Armed Forces, you might be eligible for extra earnings credit, including:

- an extra \$300 per quarter for active duty from 1957 through 1977, and
- \$100 of credit for each \$300 of active duty basic pay, up to a maximum credit of \$1,200 per year for active duty from 1978 through 2001. No extra credit is given if you enlisted after September 7, 1980 and didn’t complete at least 24 months’ active duty or your full tour.

Notice that no extra credit is given for active duty after 2001.

Don’t be alarmed if you don’t see your extra credits reflected on your Social Security statement. They will be added to your record when you actually apply for benefits, at which time you’ll have to provide proof of your military service. Active duty earnings from 1968 on should be included in the benefit estimates on your statement, although the extra credit amounts won’t show up in the statement’s year-to-year list of your earnings.

## Taxes on Your Benefits

A certain amount of Social Security benefits might be taxable, depending on your total income. In determining whether you owe any income tax on your benefits, the Internal Revenue Service looks at what it calls your “combined income.” This consists of your adjusted gross income, as reported in your tax return, plus any nontaxable interest income, plus one-half of your Social Security benefits. If your combined income as an individual is between \$25,000 and \$34,000 (or, for a couple filing jointly, between \$32,000 and \$44,000), you might have to pay income taxes on 50% of your Social Security benefits. If your combined income is more than \$34,000 (\$44,000 for a couple filing jointly), you might owe income taxes on up to 85% of your benefits. That 50% or 85% of your benefits will be taxed at your personal income tax rate.

### Unpaid Student Debt Can Reduce Benefits

More and more people still have student loan debt when they become eligible to collect Social Security benefits. You should be aware that if you’ve defaulted on federally guaranteed student debt when you begin receiving retirement, disability, dependents, or survivors benefits, the Social Security Administration can reduce the amount of your benefit until the debt is paid off. The size of the benefit reduction depends on the amount of your remaining debt and the amount you’re supposed to be paying off monthly. The maximum the government can take is 15% of benefits, and no one’s benefits can be reduced to less than \$750 per month.

**Note:** If you’re collecting Social Security disability benefits and your disability might be considered “total and permanent” by special Social Security rules, your entire remaining student debt might be discharged (wiped off the books). For a discussion of this discharge of debt, see Chapter 3.

The way to calculate any income taxes you might owe on your Social Security benefits is explained in the instruction booklet that accompanies the Form 1040 federal tax return. The IRS also publishes a free information booklet explaining numerous tax rules pertaining to older people. It's called *Tax Guide for Seniors*, Publication 554. To get the booklet, call the IRS at 800-829-3676 or download it from the website [www.irs.gov](http://www.irs.gov).

Taxes paid on Social Security benefits go back into the Social Security Trust Fund, not the general fund.

## Your Social Security Earnings Record

The Social Security Administration keeps a running account of your earnings record and the work credits it reflects. (It tracks these by using your Social Security number.) Based on those figures, Social Security can give you an estimate of what your retirement benefits would be if you took them at age 62, full retirement age, or age 70. It can also estimate benefits for your dependents or survivors, or your disability benefits, should you need them.

It makes good sense to find out what your Social Security retirement benefits will be several years before you actually consider claiming them. And you want to make sure that all your covered earnings are credited to you.

To check your earnings record and estimate of benefits, go to the Social Security Administration's website at [www.ssa.gov/myaccount](http://www.ssa.gov/myaccount).

A Social Security statement is supposed to be mailed yearly to everyone age 60 and older who isn't currently receiving Social Security benefits *and* who hasn't signed up to receive a benefit statement online through the Social Security Administration website. If you haven't received a Social Security Statement, or if you have a question about your earnings record, call Social Security at 800-772-1213.

## **U.S. Citizens' Rights to Receive Benefits While Living Abroad**

If you're a U.S. citizen living in another country, you're usually entitled to the same Social Security benefits—to the extent you earned them through work in the United States—as if you lived in the United States. However, your retirement benefits might be reduced if you also receive a pension in the other country. (See “Reductions for Government or Foreign Pensions” in Chapter 2.)

If you're married to someone who isn't a U.S. citizen, and you both live outside the United States, your spouse isn't entitled to Social Security dependents or survivors benefits based on your work record. (Your spouse might still be entitled to Social Security retirement benefits based on their own work performed while living in the United States; see the following section, “Receiving Benefits as a Noncitizen.”)

If you live in one of a few particular countries, there are restrictions on the sending of your Social Security benefits. If you live in Cuba or North Korea, a law passed during the Cold War forbids the Social Security system from sending your benefits there. Instead, you would have to have the benefits sent to a bank in the United States or in some third country, and then transfer the money on your own. If you live in Vietnam or Cambodia, or in one of the Central Asian former Soviet republics, you might be able to receive Social Security payments there, but only if you make special arrangements with Social Security and the U.S. embassy in that country.

## **Receiving Benefits as a Noncitizen**

It's increasingly common for people who aren't U.S. citizens to live and work here for long periods of time. This section explains your rights to collect Social Security benefits if you're not a U.S. citizen, whether you're living in the United States now or have since left to live in another country.

## Noncitizens Living in the United States

Noncitizens living in the United States are entitled to all the Social Security benefits that they or their spouse or parents have earned—under the same rules as U.S. citizens—if they’re lawfully in the United States. For example, you might be able to collect benefits if you:

- were not a U.S. citizen during some or all of the time you or your family member worked in the United States, but have since become a U.S. citizen, or
- are not a U.S. citizen, but are a lawful permanent U.S. resident or have another immigration status permitting you to be lawfully present in the United States.

## Non-U.S. Citizens Living Abroad

Many non-U.S. citizens live and work for a time in the United States, paying Social Security taxes and earning enough work credits to qualify for benefits for themselves and their families. However, many of these people ultimately leave the United States. Their ability to collect earned Social Security benefits after departing depends in large part on whether the United States has entered into agreements with their home countries. If you’ve formerly worked in the U.S., you need to look at three things to figure out your eligibility for benefits, including:

- your country of citizenship
- the country where you’re living when you request Social Security benefits, and
- the type of benefit you’re requesting.

To find out what your rights are to collect Social Security benefits based on your country of citizenship, your country of residence, and the type of Social Security benefit you’re entitled to receive, see the Social Security Administration’s publication *Your Payments While You Are Outside the United States*, available at [www.ssa.gov/pubs/EN-05-10137.pdf](http://www.ssa.gov/pubs/EN-05-10137.pdf). ●



## Social Security Retirement Benefits

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Many people look forward to retirement as a time of contentedness and quiet, a new time for old friendships, a period of calm sufficiency. They imagine they'll be able to do things they always wanted to do but never had time for. While this might prove true for some, others find a far different reality. Reduced financial resources make it tough to cope with a high-priced world, and retirement often becomes just a different round in the battle for survival. For this large group of people, "retirement" means continuing to work to make ends meet. And often they do so at lower-paying work than they had before reaching retirement age.

The Social Security retirement benefit program helps with some of the financial strain of retirement years. But Social Security retirement benefits alone are not sufficient for most people to live at anything near the standard of living they had during their working years.

This harsh reality brings into question both the age at which you retire and whether you'll continue to work after beginning to collect Social Security retirement benefits. Under Social Security rules, "retirement" can be within a range of years between 62 and 70, and it doesn't mean that you have to stop working altogether. It merely refers to the time you claim and start collecting Social Security retirement benefits. If you claim benefits before you reach your full retirement age but continue to work, the amount of your benefits will be reduced if you earn more than a specific amount of income. (See "Timing Your Retirement Benefits Claim," below.) After you reach your full retirement age, however, you'll collect the full amount of your retirement benefits no matter how much you continue to earn.

This chapter explains how Social Security figures your eligibility for retirement benefits, when you can (and when you should) claim the benefits, and what the rules are regarding earnings after you've started to claim your retirement benefits.

## Work Credits Required

To be eligible for Social Security retirement benefits, you must have earned at least 40 work credits over all your working years. Social Security refers to this as being “fully insured.” See Chapter 1 to review how work credits are earned.

## Checking Your Earnings Record

Even if you haven’t worked for many years and you didn’t make much money in the few years you did work, check your earnings record. You might be surprised to find that you have quite a few credits from years gone by, since it’s quite easy to get work credits, especially easy before 1978.

To check your earnings record, go to the Social Security Administration website at [www.ssa.gov/myaccount](http://www.ssa.gov/myaccount).

If you find that you don’t have enough work credits to be eligible for retirement benefits now, you might be able to work part time for a while and earn enough new credits to become eligible. You’ve got a high incentive for doing this, because once you qualify for retirement benefits, you’re eligible to receive them for the rest of your life. That could mean a lot of money over the years to come.

**EXAMPLE:** As a young woman in the 1970s, Millie had a good-paying job at an insurance company. After several years there, she married and stopped working outside the home. Her husband was quite a bit older and had earlier made money in business for himself, and he supported them both on his investments. After his death in 1980, Millie was able to live carefully on these investments. By the time she was in her 50s, however, Millie found that her assets were dwindling and the monthly income they produced no longer went very far.

When Millie turned 60, she found out from Social Security that she wasn’t eligible for survivors benefits based on her husband’s work record because he had made almost all his money from his investments rather than from work.

But Millie also checked her own Social Security work record and found that she had 36 work credits from her time at the insurance company many years before. With 36 credits, she needed only four more to be eligible for her own retirement benefits. She was able to get a part-time job at a local restaurant—the pay was low, but the work allowed her to earn her four additional work credits within a few months, qualifying her for Social Security retirement benefits. Even though these benefits weren’t that much, when added to her income from savings and investments, they made Millie’s life much more comfortable.

## Timing Your Retirement Benefits Claim

Two factors determine the amount of your retirement benefits. The first is your earnings record: how much you’ve earned over your working life. The higher your earnings, the higher your benefits.

The second is the age at which you claim your retirement benefits. You’re allowed to claim benefits as early as age 62, but the earlier you claim them, the lower the benefits will permanently be. You maximize your benefits if you wait until age 70 to claim them. This section explains how the timing of your claim affects the amount of your retirement benefits.

### If You Claim Benefits Before Full Retirement Age

You’re allowed to claim retirement benefits as soon as you turn 62, but if you claim benefits before your “full retirement age,” your monthly payment will forever be considerably less than if you wait until full retirement age. Nonetheless, out of financial need or other calculation, more than half of all people eligible for retirement benefits claim them before they reach full retirement age. Also, if you claim benefits before your full retirement age but continue to work, your benefits may be significantly reduced if your earnings are over certain yearly limits. (See “Working After Claiming Early Retirement Benefits,” below, for these limits.)

The amount by which your benefits would be permanently reduced if you claimed them early depends on the time between when you claim benefits and when you reach your full retirement age. The reduction is about 0.555% per month, or 6.7% per year, for the first three years of early retirement. Beyond the first 36 months of early retirement, that reduction is 0.415% per month. If you retire a full five years early, the total reduction can be up to 30%. And, remember, the reduction in monthly benefits is permanent. If you claim your benefits early, they don't increase to the full amount when you reach your full retirement age.

Full retirement age is going up gradually, from 65 to 67, for people born after 1937. For these people, early (reduced) retirement benefits will still be available at age 62. As you'll notice on the "Taking Early Retirement Benefits at Age 62" table below, those born in 1960 or later who retire at 62 will see their benefits shrink by as much as 30%.

## Your Break-Even Point

Of course, claiming retirement benefits at less than full retirement age means you'll collect benefits for a longer time. But the permanent reduction in the amount of your monthly benefits means that if you live past your early 80s, you'll wind up collecting less in total lifetime benefits than if you had waited until full retirement age. This point in life is referred to by Social Security as the "break-even age." See Chapter 6 to learn more about the break-even point.

The following table, "Taking Early Retirement Benefits at Age 62," illustrates the effect of claiming early benefits. The table assumes a monthly retirement benefit for the worker at full retirement age of \$1,000 and shows exactly how much claiming benefits at age 62 would reduce that amount, plus the overall percentage reduction in benefits.

Taking Early Retirement Benefits at Age 62 (based on a \$1,000 retirement benefit at full retirement age)			
Year of Birth*	Full Retirement Age	Retirement Benefit	
		Amount	Percent Reduction
1943–54	66	750	25.00%
1955	66 + 2 months	741	25.83%
1956	66 + 4 months	733	26.67%
1957	66 + 6 months	725	27.50%
1958	66 + 8 months	716	28.33%
1959	66 + 10 months	708	29.17%
1960 and later	67	700	30.00%
* If you're born on January 1, use the prior year of birth.			



TIP

**What if you must retire for health reasons?** Some people are forced to stop working before full retirement age because of ill health. If you're under full retirement age and in that position, consider applying for Social Security disability benefits rather than early retirement. The reason is that disability benefits are calculated by the same formula as full retirement benefits, but the amount doesn't depend on the age at which you qualify for them. And the "disability freeze," a benefit calculation rule by which Social Security ignores any low-earning years that were caused by your disabling condition, can actually increase your disability benefits and eventual retirement benefits. Be warned, however, that proving you're incapable of doing any sort of work can be a difficult process. (See Chapter 3.)

**TIP**

**Widows and widowers can switch from retirement to survivors benefits.** Financial straits force many widow(er)s to claim their retirement benefits at or before full retirement age, even though they would become eligible for a higher monthly retirement amount if they waited longer. Although claiming early retirement benefits permanently reduces their retirement benefits based on their own earnings record, Social Security rules permit widow(er)s who have previously claimed early retirement to switch to full survivors benefits at full retirement age. And, for many people, these full survivors benefits are higher than their own reduced retirement benefits. (See Chapter 5 for a full explanation of survivors benefits.)

The same rules apply to widows as to widowers, although the disparity in earnings between men and women means this ability to switch benefits is used mostly by women.

## Full Retirement Age

For a long time, Social Security considered 65 to be full retirement age. Benefit amounts were calculated on the assumption that most workers would stop working full time and would claim retirement benefits upon reaching age 65.

Now that people are generally living longer, the Social Security rules for what is considered full retirement age are changing. Age 65 is still considered full retirement age for anyone born before 1938. But full retirement age gradually increases from age 65 to 67 for people born in 1938 or later. For people born between 1943 and 1954, full retirement age is 66. For people born in 1960 or later, full retirement age is 67.

In addition, to give incentive for people to delay making their retirement claims, Social Security offers higher benefits for people who wait to make their claims until after reaching full retirement age. (See below.)

Full Retirement Age for Those Born After 1942	
Year Born	Full Retirement Age
1943–1954	66 years
1955	66 years + 2 months
1956	66 years + 4 months
1957	66 years + 6 months
1958	66 years + 8 months
1959	66 years + 10 months
1960 or later	67 years

## If You Claim Benefits After Full Retirement Age

If you wait until after your full retirement age to claim Social Security retirement benefits, your benefit amounts will be permanently higher. Your benefit amount is increased by 8% each year you wait up to age 70. Also, if you delay your benefits claim until after full retirement age, after you die, your spouse's survivors benefits (see Chapter 5) will also be correspondingly higher. This is a particularly good strategy if, financially, you don't need your retirement benefits at full retirement age and you're in good health, expecting to live well past age 70. This means you're likely to collect your higher benefits for many years.

After age 70, there's no longer any age-related increase and so no reason to delay claiming benefits.



### TIP

**Everyone can claim some or all Medicare coverage at age 65.**

Even if you don't claim Social Security retirement benefits when you turn 65, you can be eligible for Medicare benefits and may want to sign up for some or all of them. (Enrolling in Medicare doesn't affect your current or future retirement benefits.) (See Chapter 12 for more information.)

## Reversing a Suspension of Benefits

What happens if you delayed collecting retirement benefits when you reached full retirement age, but at some point before age 70, your financial or health circumstances change and you need those benefits right away? You can file papers with Social Security “undoing” your suspension of benefits and begin collecting them at any time. And once you begin collecting them, an eligible spouse (and/or ex-spouse) and child can begin collecting dependents benefits as well. However, benefits you might have collected during those suspended months can’t be collected retroactively. You (and your dependents, if any) are only entitled to benefits beginning with the month you file your request to undo the suspension.

## The Amount of Your Retirement Check

The amount of your Social Security retirement benefits depends on how much you earned in covered employment over all your working years. Social Security calculates your benefits based on the amounts in your highest-earning 35 years. Then it applies a set of formulas to these earnings; the exact figures depend on the year you were born. For most people, the amounts are less than bountiful. For example, the average retirement benefit for someone who reaches full retirement age in 2024 is about \$1,900 per month. The maximum retirement benefit for someone first claiming benefits in 2024 is about \$3,800 per month (at full retirement age). Once you claim your benefits, there’s a small cost-of-living increase most years.

Under Social Security’s benefit calculation system, the lower your average lifetime earnings, the higher a percentage of those earnings you’ll receive in benefits. If your earnings have averaged in the middle range—the equivalent of around \$30,000 to \$40,000 per year in today’s dollars—you can expect a retirement benefit of about 40% of your average earnings for the last few years before you reach full retirement age.

### **Dependents Benefits Don't Affect Amount of Retirement Benefits**

The amount of your retirement benefits isn't affected by the fact that your spouse (and/or ex-spouse) or child(ren) are receiving benefits. This is true whether your spouse collects retirement benefits based on their own work record or collects dependents benefits based on your work record. There's a limit on how much all of your dependents can collect based on your work record (see Chapter 4), but this limit doesn't affect the amount you personally receive in retirement benefits.

If your average earnings have been on the low side—less than \$30,000 a year in current dollars—then your benefits might be about 50% of your earnings in the years just before you claim retirement benefits.

If your earnings have always been at or near the maximum credited earnings for each year (see Chapter 1), then your retirement benefits might be about 25% of your earnings in the year in which you retire.

But these figures are just rough averages. To get a much more accurate estimate of what your personal retirement benefits will be, you can either phone Social Security at 800-772-1213 or log in to your Social Security account to see your statement. Go to [www.ssa.gov/myaccount](http://www.ssa.gov/myaccount) and sign up if you don't already have a login. Your statement will provide you with an estimate of what your monthly retirement benefits would be if you claim benefits at age 62, at full retirement age, or at age 70. The actual amount you'll receive in retirement benefits will depend on what your actual earnings are in the years between getting this estimate and claiming those benefits. So, the closer you are to actually claiming your retirement benefits, the more accurate this estimate will be.

## **Increases for Cost of Living**

Whatever the amount of your Social Security retirement benefit, you'll usually receive an automatic cost-of-living increase on January 1 of each year. This increase is tied to the rise in the Consumer Price Index: the cost of basic goods and services. In a very few years, when the cost of living has not risen, there's no increase at all. For 2024, the cost-of-living increase is 3.2%.

## **Increases If You Keep Working After Claiming Retirement Benefits**

As explained above, the amount of your Social Security retirement benefits depends on your average qualifying income over your highest 35 years of lifetime earnings. But can your benefit amount go up if you continue to earn and pay Social Security taxes after you claim retirement benefits? The answer is yes. If, after you claim benefits, your earnings in any year raise your earnings average over your highest 35 years, Social Security will raise your retirement benefit amount accordingly. This is true whether you claim benefits early, at full retirement age, or after full retirement age.

## **Reductions for Government or Foreign Pensions**

Many people have earned retirement benefits from work covered by Social Security and also public employee retirement system benefits from working in government jobs not covered by Social Security. Similarly, some people have earned Social Security retirement benefits from work in the United States and also a pension from work in another country.

Social Security artificially boosts the retirement benefits of people who have many years with very low or no Social Security earnings—to make sure people have at least a small amount. But because of a law called the “Windfall Elimination Provision,” this artificial benefits raise is eliminated for people who have either public employee system or foreign retirement benefits.

## Those Affected

If your age and work history fit certain categories, your Social Security check will be reduced by 10% to 35% because of this windfall. You might be affected by this reduction if you:

- first became eligible for a government pension in 1986 or later, and
- worked fewer than 30 years at jobs covered by Social Security.

## Those Not Affected

The windfall reduction doesn't affect you if you:

- only worked for an employer not covered by Social Security before 1957
- only earned a government pension based solely on work for the railroad, or
- were a federal government employee hired on January 1, 1984 or after.



### CAUTION

**Government pensioners seeking spouse's benefits may face limits.**

Another rule limits benefits to people who collect both Social Security spousal benefits (dependents benefits as the spouses of retired or deceased workers) and public employment pensions based on their own work records. (See "Government Pension Offset" in Chapters 4 and 5 for details.)

## Working After Claiming Early Retirement Benefits

Because Social Security retirement benefits plus savings and other investments are often not enough to live on comfortably, many people keep working for at least a few years after they claim Social Security retirement benefits. Other people keep their jobs or take new ones to stay active and involved in the world of work. And if you keep working with a high enough yearly income, this may also increase your lifetime earnings average, thereby slightly increasing your benefits for the years to come.

However, if you claim *early* retirement benefits—meaning, after reaching age 62 but before reaching full retirement age—and continue to work, be aware that the money you earn over a certain amount each year will reduce your Social Security retirement benefits (until you reach full retirement age). Such a reduction in benefits applies only to that year. It has no permanent effect on the amount of benefits you'll receive in future years.

## Limits on Earned Income If Claiming Early Benefits

Until you reach full retirement age, Social Security will subtract money from your retirement check if you exceed a certain amount of earned income for the year. For the year 2024, this limit on earned income is \$22,320 (\$1,860 per month). The amount goes up each year. If you're collecting Social Security retirement benefits before full retirement age, your benefits are reduced by \$1 for every \$2 in any month you earn over the limit. After you reach full retirement age, there's no limit on the amount of money you can earn and still receive your full Social Security retirement benefit.

**EXAMPLE:** Henry is considering claiming early retirement benefits this year, at age 64. Social Security calculates that if he does so, he'll receive \$866 a month (which is about 13% less than if he waited until his full retirement age of 66). But Henry also intends to continue working part time, with an income that would be about \$5,000 over the yearly limit on earned income. If he does claim the early benefits and makes that part-time income, Henry would lose one dollar out of two from the \$5,000 he earns over the limit, which means \$2,500 for the year. Therefore, his \$10,392 in yearly retirement benefits would be reduced to \$7,892. So, by claiming early retirement and continuing to earn over the limit, Henry incurs a double penalty: His retirement benefits are reduced by 13%, and he loses an additional amount every year, to the extent he earns over the income limit, until he reaches full retirement age.

The amounts of early retirement benefits you lose as a setoff against your earnings aren't necessarily all gone forever. When you reach full retirement age, Social Security will recalculate upward the amount of your benefits to take into account the amounts you lost because of the earned income rule. The lost amounts will be made up only partially, however, a little bit each year. It will take up to 15 years to completely recoup your lost benefits. And remember, none of this readjustment will change the permanent percentage reduction in your benefits that was calculated when you claimed early retirement benefits (look again at the chart "Taking Early Retirement Benefits at Age 62" earlier in this chapter).

### **Change in How You Report Earnings**

The Social Security Administration bases its benefit calculations on earnings reported on W-2 forms and self-employment tax payments. Most Social Security recipients aren't required to send in an estimate of earnings.

But the Social Security Administration does request earnings estimates from some beneficiaries: those with substantial self-employment income or whose reported earnings have varied widely from month to month, including people who work on commission. Toward the end of each year, Social Security sends those people a form asking for an earnings estimate for the following year. The agency uses the information to calculate benefits for the first months of the following year. It will then adjust the amounts, if necessary, after it receives actual W-2 or self-employment tax information in the current year.

When beneficiaries reach full retirement age, Social Security no longer checks their income. Because there's no Social Security limit on how much a person can earn after reaching full retirement age, there's nothing to report.



## TIP

**You can collect retirement benefits plus unemployment benefits.** As this chapter explains, you can continue to work even after you begin claiming your Social Security retirement benefits. If you're working and you lose your job, you can collect unemployment benefits (assuming you otherwise qualify for them), even though you're also collecting your Social Security retirement benefits.

### Only “Earned Income” Affects Your Benefits

The rule that reduces your early retirement benefits based on income over a certain yearly amount applies only to what Social Security considers “earned income.” Basically, earned income means money you receive during the year for work you currently do. This rule favors the well-to-do who withdraw significant income from sources other than current work.

Earned income does *not* include:

- interest on savings or investments
- capital gains (profits from the sale of stock, property, or other assets)
- IRA or 401(k) withdrawals
- insurance cash-ins
- rental income, or
- private pensions.

Also, money you receive from certain types of sources based on work you performed *before* you claimed retirement benefits—known as “special sources”—isn't counted as earned income. These exempted amounts include:

- bonuses
- accumulated vacation pay or sick leave compensation
- private retirement fund payments
- deferred compensation
- accumulated commissions, and
- payments to the self-employed for work performed before claiming retirement benefits, if they're received more than one year after claiming benefits.

## Special Rule as You Approach Full Retirement Age

If you're already receiving your retirement benefits, a special higher earnings limit applies in the calendar year you turn full retirement age. If you'll reach full retirement age in 2024, you can earn up to \$4,960 per month during 2024 without losing any of your benefits. For every \$3 you earn over that amount in any month, you'll lose \$1 in Social Security benefits. Beginning in the month you reach full retirement age, you become eligible to earn any amount without penalty.

If you're self-employed, you can receive full benefits for any month during this first year in which you didn't perform what Social Security considers "substantial services." The usual test for substantial services is whether you worked in your business more than 45 hours during the month (or between 15 and 45 hours in a highly skilled occupation). ●

# Social Security Disability Benefits

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About 10 million disabled workers and their families receive Social Security disability insurance (SSDI) benefits. These people developed severe injuries or illnesses when they weren't old enough to collect retirement benefits but Social Security disability benefits provided an answer.

If you find it very difficult to work because of a physical or mental condition that isn't likely to resolve itself within a year—and you're short of retirement age—read this chapter carefully. If you have enough work credits for your age, you might be eligible for monthly SSDI benefits. And if you're eligible to receive disability benefits, your spouse and minor or disabled children may also be eligible to collect benefits. (See Chapter 4 for more information about dependents benefits.)

## Who Is Eligible

Social Security disability benefits are paid to workers and their families only when workers have enough work credits to qualify. Work credits for SSDI benefits are calculated in the same way as for retirement benefits, although the number of credits required to qualify for the disability program depends on a person's age. A person can earn up to four work credits per year, and anyone who works part time, even at a very low-paying job, easily accumulates them. (See Chapter 1 for a discussion of how work credits are earned.)



### RESOURCE

**Learn more about Social Security disability benefits.** This chapter will introduce you to Social Security disability benefits, but to learn more, including how to convince the Social Security Administration that a particular disability makes you unable to work, read *Nolo's Guide to Social Security Disability: Getting & Keeping Your Benefits*, by David A. Morton III, M.D. (Nolo). It includes details on whether you might qualify for benefits, how to apply, how to keep existing benefits, and how much you can work and still receive benefits.

## Work Credits Required

The number of work credits you’ll need to qualify for SSDI disability benefits depends on your age when you become disabled.

The “Work Credits Required to Qualify for Disability Benefits” chart below provides a quick reference to see how many work credits you need to qualify for disability benefits.

There are also rules that make it easier for younger workers and people who become blind to qualify for disability benefits. (See “Young Workers” and “Blind Workers,” below.)

Work Credits Required to Qualify for Disability Benefits	
If you became disabled at age:	You need this many work credits:
21 to 24	6
24 to 31	6-18
31 to 42	20
44	22
46	24
48	26
50	28
52	30
54	32
56	34
58	36
60	38
62 or older	40

### Help From the Americans with Disabilities Act

A federal law, the Americans with Disabilities Act, or ADA, prohibits employment discrimination on the basis of a worker's disability. The ADA is intended to help people with disabilities who want to work but are frustrated by noncooperative employers.

In general, the ADA prohibits employers from discriminating against disabled people when hiring, promoting, and making other job decisions. It also requires employers to maintain a workplace that doesn't have substantial physical barriers to people with disabilities. Under the ADA, employers must make reasonable job accommodations for qualified workers with disabilities, unless that would cause the employers undue hardship.

Unfortunately, the ADA is full of vague language. Disability rights advocates, lawyers, employers, and courts are still wrangling over precisely what terms like "reasonable accommodations" and "undue hardship" mean. So, there's no simple set of guidelines about how the ADA works in actual practice.

For information about how the ADA is being enforced and where you can go for help in seeking its protection, contact the Office on the Americans with Disabilities Act in the Civil Rights Division of the U.S. Department of Justice at 800-514-0301 (voice) or 800-514-0383 (TDD). The Justice Department also has an ADA website at [www.ada.gov](http://www.ada.gov).

### Requirement of Recent Work

In order to qualify for SSDI disability benefits, you must have earned at least 20 of the required work credits within the 10 years just before you became disabled, unless you qualify under one of the special rules for young or blind disabled workers. In other words, you need to have worked at least 5 of the last 10 years.

**EXAMPLE:** Monica worked for 10 years before she had children, earning 40 work credits during that time. After her children were in high school, she went back to work. That was in 2019, and, at the end of 2023, she became disabled with a back injury.

Although she had more than the 40 total credits required for disability benefits, she couldn't collect them because she had only worked 4 years—earning 16 credits—within the 10 previous years (2014 through 2023). She would need to work long enough to earn four more credits before she could qualify for disability benefits. In 2024, that means she would need to earn \$6,920 during the year (four credits at \$1,730 per credit) before she could qualify.

## Young Workers

If you were disabled between the ages of 24 and 31, you need only half of the work credits (2 per year instead of 4 per year) that you could have earned between age 21 and the time you became disabled.

If you become disabled before age 24, you would need only 6 credits in the three-year period immediately before you became disabled. These special rules exist because workers who become disabled at a young age obviously don't have the opportunity to acquire many work credits.

**EXAMPLE:** Boris became disabled at age 29. There were 8 years between when he was age 21 and the time he became disabled. During those years he could have earned 32 work credits: 4 per year. But under the special rule for young workers, Boris needs only half, or 16 credits, to qualify for disability benefits.

## Blind Workers

If you're disabled by blindness, you must have the same number of work credits as anyone else your age. However, you don't need to have earned 20 of your work credits within the 10 years immediately

preceding your disability, as required for other workers. Your work credits can be from any time.

For the purposes of Social Security disability benefits, being blind generally means having no better than 20/200 vision in your better eye, with glasses or other corrective lenses, or having a visual field of 20 degrees or less (or a combination of the two). (See “What Is a Disability?” below, for more information on blindness as a disability.)

## Disabled Widows and Widowers

If you’re a widow or widower age 50 or older and disabled, you might be able to receive SSDI disability benefits even though you don’t have enough work credits to qualify. The amount of these benefits would depend entirely upon your deceased spouse’s average earnings and work record. Because they’re based on your spouse’s work record, you would lose eligibility for these benefits if you remarry before age 50.

You must meet a number of qualifications:

- You must be disabled as defined by Social Security rules. (See “What Is a Disability?” below, for more on these rules.)
- Your spouse, at death, must have been fully insured—meaning they had enough work credits to qualify for disability benefits based on their age.
- Your disability must have started no later than seven years after your spouse’s death.
- If you already receive Social Security benefits as a surviving widow or widower with children (called “mother’s or father’s benefits”), your disability must have begun no later than seven years after these benefits ended. (See Chapter 5.)
- If you divorced before your former spouse died, you’ll be eligible for these benefits only if the two of you were married for 10 years or more.

### **Marital Status Does *Not* Affect Disability Benefits Based on Your Own Work Record**

If you collect Social Security disability insurance (SSDI) benefits based on your own work history and earnings record, neither your right to collect those benefits nor the benefit amount would be affected if you get married or divorced. Your spouse's prior, current, or future earnings or assets are not considered by Social Security when you apply for or collect SSDI disability benefits based on your own work record.

**Note:** This is not the case, however, if you're a widow or widower collecting disability benefits based on your prior spouse's work record (see "Disabled Widows and Widowers," above) or disability benefits through the Supplemental Security Income (SSI) program, for which total household income and assets are considered (see Chapter 7).

If you're collecting SSDI benefits based on your own work record, marriage might actually have a positive effect. If you get married and become entitled to Social Security dependents benefits (see Chapter 4) or survivors benefits (see Chapter 5) based on your spouse's retirement or disability, and those benefits would be higher than your own disability benefits, then you can collect the higher amount (but not both). Also, your spouse might be entitled to Social Security dependents or survivors benefits based on your eligibility for Social Security disability benefits. Your spouse getting these benefits wouldn't cause any reduction in your own benefits.

## **What Is a Disability?**

To receive Social Security disability benefits, you must have a physical or mental disability that both:

- is expected to last (or has lasted) at least one year, or to result in death, and
- prevents you from doing any "substantial gainful work."

Of course, several of the terms within these definitions are subject to different interpretations. This section explains some guidelines developed by Social Security and the courts regarding qualifications for Social Security disability benefits.

## Conditions That May Qualify

Social Security keeps a list of common conditions it considers disabling. (See “Listed Impairments,” below.) But every person’s physical and mental state is different, and the human mind and body can be very complex. So you might well have a condition that prevents you from working but is not on the list of common conditions. Don’t let that discourage you from filing for disability benefits.

But to get past one of the first steps of the disability determination process, your impairment must be “medically determinable,” meaning that it can be discovered and verified by doctors. Your medical records must include evidence that proves you have a loss of function.

If you’re considering making a claim for disability benefits, examine the requirement that the disability must prevent you from performing substantial gainful work, as described below. Discuss the matter thoroughly with your doctor or doctors.

## Must Be Expected to Last One Year

No matter how seriously disabling a condition or an injury is, it won’t make you eligible for Social Security disability benefits unless it has lasted, or is expected to last, one year. The disability will also qualify if it is expected to cause death.



### TIP

**You can apply for benefits upon diagnosis or inability to work.**

Even though the disability must be expected to last at least a year, you don’t have to wait for a year to apply for benefits. As soon as the condition is disabling and a doctor can *predict* that it is expected to last a year, you can qualify. (The application process is described in Chapter 8.)

**EXAMPLE:** Ladonna fell down some stairs and badly dislocated her hip. She was placed in a body cast and was told by her doctor to stay in bed for three to four weeks. The cast would stay on for two months. After that, Ladonna would need a cane for another two or three months. In six to nine months, she would be walking normally again, although a little bit more cautiously. She would be off work for a total of six or seven months.

Despite the seriousness of her injury and her total inability to work while she recovered, Ladonna will probably not qualify for Social Security disability benefits. The reason is that her disability is not expected to last for a year. However, she might qualify for her employer's disability benefits, if the company provides them, or for unemployment or state disability compensation through her state's employment or disability office.

If, after you begin receiving benefits, it turns out that your disability doesn't actually last a year, Social Security can't ask for its money back. You're not penalized for recovering sooner than expected, as long as the original expectation that the disability would last a year (or result in death) was expressed in writing by your doctor and accepted by the Social Security review process (and there was no fraud involved). However, you do have the obligation to tell Social Security if you return to work so that they can review your situation.

**EXAMPLE:** Ravi had a stroke, leaving most of his left side paralyzed. He was unable to walk on his own, was unable to speak clearly, and needed help with most simple daily life tasks. He began physical and speech therapy, but his doctors predicted that he was unlikely to recover full use of his left arm and leg. He applied for Social Security disability benefits, and after waiting three months to see if Ravi's condition was likely to improve, Ravi was found eligible for disability benefits because his condition was totally disabling and he wasn't expected to be sufficiently recovered to return to work within a year. However, through hard work, Ravi recovered both his speech and enough of the use of his arm and leg to return to work in 10 months.

Although his disability didn't last the required year, Ravi was able to keep the disability payments he had already received because the doctors had expected that his condition would be totally disabling for at least a year and the Social Security disability review process had accepted that prognosis.

## Listed Impairments

To simplify the process of determining whether a disability makes a person eligible for benefits, Social Security has developed a list of common serious conditions that it considers disabling (if your specific condition meets the criteria in the listing). If you prove, through medical records and doctors' reports, that you have one of the listed conditions—paralysis of both an arm and a leg, for example—Social Security will likely consider you eligible for benefits without making you prove that you can't perform substantial gainful work (instead, simply assuming that you can't do substantial work).

Every person's disability claim is considered individually, however, and having a condition on this list doesn't automatically qualify you for SSDI disability benefits. You must have evidence that your condition meets the requirements of the particular "listing." If you do, your application for disability benefits is likely to be approved, unless you've been working since you became disabled. If you have been working, Social Security will determine whether this work disqualifies you from getting disability, or whether instead it can be considered an "unsuccessful work attempt."

A select few of the conditions Social Security lists as being disabilities include the following, simplified for our discussion:

- a disease of the heart, lung, or blood vessels resulting in a serious loss of heart or lung function as shown by X-ray, electrocardiogram, or other tests—and, in spite of medical treatment, causing severe breathlessness, pain, or fatigue
- severe arthritis causing recurrent inflammation, pain, stiffness, and deformity in major joints so that the ability to get about or use the hands is severely limited
- mental illness resulting in the severe limiting of activities and interests, deterioration in personal habits, and/or seriously impaired ability to get along with other people, such that it prevents substantial gainful employment
- damage to the brain resulting in severe loss of judgment, intellect, memory, or communication ability

- cancer that is progressive and has not been controlled or cured (though some serious cancers qualify at any stage)
- Acquired Immune Deficiency Syndrome (AIDS) or its related secondary diseases, with certain severe complications
- a disease of the digestive system that results in severe malnutrition or anemia
- loss of major function of both arms, both legs, or a leg and an arm
- serious loss of function of the kidneys, and
- total loss of the ability to speak in a way that can be heard or understood.

The full listings are found in the Code of Federal Regulations (CFR) Title 20, Part 404, Subpart P, Appendix 1. You can also find the listings on the Social Security website at [www.ssa.gov](http://www.ssa.gov).

## Unable to Do Substantial Gainful Activity

To be eligible for Social Security disability benefits, you must be unable, because of your disability, to perform any substantial gainful activity—generally considered to be any work from which you earn \$1,550 (in 2024) per month or more.

If your condition doesn't meet the requirements of a listing, Social Security will then consider whether it prevents you from doing the job you had when you became disabled, or the last job you had before becoming disabled.

To determine whether you can do your past job (or other jobs), Social Security will look at your documented symptoms to determine your “residual functional capacity” (RFC). Your RFC is what activities you can still do despite your medical condition. Your RFC will include things like:

- how long you're able to sit, stand, walk, and lift
- how much weight you can carry and how often, and
- whether you can operate heavy equipment or drive.

If your disability prevents you from performing your usual job, Social Security will next decide whether you're able to do any other kind of substantial gainful work.

In determining whether you can switch to a less demanding job, Social Security will assess whether you're able to perform any kind of work (even the simplest, least-demanding job) existing anywhere in the economy, whether or not there are actually any such jobs available close to where you live.

For older applicants, as part of this determination, Social Security considers your education, training, and work experience ("vocational factors").

Social Security realizes that it's more difficult for older workers to find new employment or to retrain for other kinds of work, so the agency approves the disability claims of those older than 50 more readily than those of younger workers. The agency also knows that it won't be committing to as great an outlay of money when it grants disability benefits to people nearing retirement age as it does when it grants them to younger workers (older workers were on the brink of collecting retirement benefits anyway). For older workers without job skills, this means that they might be able to qualify for benefits even if they could do a less demanding job.

## **Special Rules for Blindness**

If your vision in your better eye is no stronger than 20/200 with correction, or if your peripheral field of vision is limited to 20 degrees or less, you're considered blind under Social Security disability rules. (There are a few other ways to qualify for disability for blindness as well.) Assuming that your work credits add up to the required amount for your age, you (and your family) can receive Social Security disability benefits.

Some blind persons are able to continue working, at least part time, while simultaneously collecting disability benefits. If you're blind, you can earn up to \$2,590 per month—the amount increases from year to year—before your job is considered "substantial gainful work" that would disqualify you from those benefits.

### Applying Protects Your Retirement Benefits

If you're legally blind and earning too much money to qualify for Social Security disability benefits, but also earning significantly less than before your blindness, you might want to apply for disability benefits anyway. Even though you won't receive cash benefits, Social Security can put what is called a "disability freeze" on your earnings record to protect your overall average.

The amount of your retirement benefits, or of your disability benefits if you later qualify, is determined by your average income over the years. (See "Determining Your Benefit Amount" in Chapter 1 for further explanation.) If, because of your disability, you're now making considerably less than you were before, these lower earnings will pull your lifetime average income lower, resulting in a lower ultimate Social Security payment. This special disability freeze provision for blindness permits you to work without having your lower income figured into your lifetime average earnings.

**Over 55 rule.** If you're over 55 and blind and doing substantial gainful work, you can qualify for a special status with Social Security. In any month you make above the substantial gainful activity amount—that is, earn more than \$2,590—you won't receive a disability check, but you will receive benefits for any month that your earnings fall below the limit.

The key is to show that the work you're doing requires a lower level of skills and abilities than what you were doing before you turned 55.

### Examples of Disability Determinations

The following examples help illustrate Social Security's reasoning in applying its guidelines and making disability determinations.

## Unsuitability for Other Work

**EXAMPLE:** Arnold has been a longshoreman for most of his life. At age 58, his back has been getting progressively worse. His doctor told him that he could no longer do longshore work and said that sitting for any length of time will aggravate the condition. Arnold applies for disability.

Because there's no question that Arnold's condition will last more than a year, Social Security will next ask whether it prevents Arnold from performing substantial gainful activity. Arnold's back prevents him not only from doing his regular job or other physical labor, but also from sitting or standing for long periods of time. Unless Social Security can describe a job that requires neither physical labor nor sitting, Arnold will probably get disability payments. And because Arnold has done physical labor all his life, he doesn't have the training, work experience, or education to do many other jobs. Considering his age and the difficulty of finding any type of work for which he could be retrained, Social Security will find him eligible for disability benefits.

## Two Conditions Combined

**EXAMPLE:** Ernestine has been a music teacher for many years. She is now 60 years old and is losing her hearing. She has also developed phlebitis, which makes it difficult for her to walk very far or to stand for long periods of time. She has to elevate her legs for a while every few hours. When her hearing loss makes it impossible for her to continue teaching music, she applies for disability benefits.

The combination of her two conditions might make her unable to maintain substantial gainful employment. She would have to find a job that required neither good hearing nor standing, and permitted her to put her legs up for a half hour several times a day. Because such jobs are scarce, Social Security would find Ernestine eligible for disability, particularly in light of her age.

## Mild Disability

**EXAMPLE:** Rebecca is 52 and has an aortic aneurysm. Despite medication, she has intermittent fatigue and shortness of breath, especially at her job as a waitress. Her doctor says that her work is too physically demanding and stressful for her heart. Rebecca applies for Social Security disability benefits.

Although Rebecca's condition—aortic aneurysm—is on Social Security's listing of impairments, she isn't automatically eligible for disability benefits. Her condition has to meet the criteria in the cardiovascular listing; in this case, an aneurysm must be dissecting (that is, separating from the wall of the artery).

If Rebecca's aneurysm isn't dissecting, Social Security would assess her limitations to see if she could do some type of less demanding work. Even if Social Security found she could only do sedentary work, the agency would probably find that she has job skills, such as dealing with the public and taking orders, that could be used at a desk job (called "transferable skills"). She is less likely to qualify for benefits than Arnold and Ernestine in the two prior examples.

## Amount of Disability Benefit Payments

Like other Social Security benefits, the amount of your actual disability check is determined by your age and your personal earnings record: your average earnings for all the years you have been working, not just the salary you were making most recently.

Disability benefits are also available for disabled workers' families (spouses and minor or disabled children). The maximum amount for worker and family combined is either 85% of what the disabled worker was earning before becoming disabled, or 150% of what the worker's individual benefit is, whichever is lower.

**EXAMPLE:** Manu was making \$3,200 a month when he became disabled at age 56. At that time, Manu's Social Security earnings record gives him an individual disability benefit of \$900 a month. Manu's wife and teenage daughter are also eligible to collect dependents benefits. Theoretically,

they could each collect up to 50% of Manu’s benefit (\$450), but their amounts will be limited by the maximum family benefit. Together with Manu, the family’s total benefits could not exceed 150% of Manu’s individual disability benefit, or \$1,350.

Estimating Benefit Amounts

There’s no simple formula for what your actual disability payments will be. Although some books and magazines print tidy charts matching age and income with disability benefit amounts, more often than not these charts mislead people, causing them to overestimate their benefits. The charts base their figures on your current earnings and assume that you have had a consistent earning pattern during your entire working life. Most people, however, don’t have such a perfect curve of earnings, so the estimates the charts give you are bound to be wrong.

However, you can get a general idea of Social Security disability benefits amounts by considering average payment amounts for 2024:

- overall average monthly payment for a disabled individual: \$1,540, and
- overall average monthly payment for a disabled individual plus a spouse and children: \$2,720.

In addition, it can be helpful to look at averages based on income levels.

Estimated Disability Benefits for 2024	
Average Annual Lifetime Income in Current Dollars	Monthly Benefits
\$10,000 to \$20,000	\$600 to \$900 (individual)
	\$1,020 to \$1,260 (couple or parent and child)
\$20,000 to \$30,000	\$850 to \$1,210 (individual)
	\$1,330 to \$1,815 (couple or parent and child)
\$30,000 to \$40,000	\$1,210 to \$2,180 (individual)
	\$1,480 to \$1,780 (couple or parent and child)
\$40,000 and up	\$1,650 to \$2,860 (individual)
	\$1,980 to \$3,300 (couple or parent and child)

**TIP**

**Check your eligibility for supplemental benefits.** If you receive only a small disability benefit, and you have savings or other cash assets of less than \$2,000 (\$3,000 for couples), you might be eligible for Supplemental Security Income benefits (SSI) in addition to your Social Security disability benefits. (See Chapter 7 regarding SSI.)

Relying on general estimates of disability benefits makes little sense, however, because you can get a very accurate estimate, based on your exact earnings record, directly from Social Security. You can get this estimate when you apply for benefits or by going to <http://ssa.gov/myaccount>.

## Cost-of-Living Increases

As discussed above, monthly disability benefit amounts are based entirely on your personal earnings record, with no consideration given to the minimum amount you need to survive. Whatever your monthly amount, however, there's usually a yearly cost-of-living increase based on the rise in the Consumer Price Index. For a few years, the cost-of-living increase was 5% or more. In most years, however, the increase has been only 1% to 3%, and in some years, there is no cost-of-living increase at all.

**CAUTION**

**Don't expect to start receiving disability benefits right away.**

Applying for disability benefits and proving your disability can be a slow, sometimes difficult business. You need to organize your paperwork, have the cooperation of your doctors, and be patient and persistent. What to expect in the application process and how best to prepare for it are discussed in Chapter 8.

## Student Debt and Disability Benefits

Many people who qualify for Social Security disability benefits still owe money on their federally guaranteed student loans. If you're in

default on any federally guaranteed student loans, the Social Security Administration can deduct an amount from your monthly SSDI disability benefits payment to help pay off this debt. The maximum the government can take is 15% of benefits, and no one's benefits can be reduced to less than \$750 per month.

### **Discharge of Student Loan Debts for Permanent Disability**

If you have what is considered “total and permanent disability” (TPD), you can apply to have the entire remaining amount of your federal student debt wiped off the books (“discharged”). In general, a disability is considered total and permanent if it renders you unable to work and the condition is expected to last more than five years (as opposed to the one-year qualifying requirement for collecting Social Security disability benefits). Those who qualify for TPD status include:

- veterans with service-connected TPD, as determined by the U.S. Department of Veterans Affairs (VA) (veterans no longer need to apply; the VA will automatically notify them of the debt discharge)
- someone already receiving SSDI or SSI benefits based on disability (see Chapter 7), whose next scheduled disability review is five years or more from the date of the most recent Social Security disability determination (or from the date of the original approval), or
- someone who is unable to engage in any substantial gainful activity by reason of a physical or mental impairment that can be expected to result in death, has already lasted for a continuous period of at least five years, or is expected to last for a continuous period of at least five years, as certified by the treating physician.

The discharge applies only to the Federal Direct Loan Program, Perkins Loans, the Federal Family Education Loan (FFEL) Program, and TEACH grants. Other loan programs and private loans have their own discharge rules.

To learn more about qualifying for this TPD discharge of debt and about the process for applying, visit the special TPD webpage of the Office of Federal Student Aid, U.S. Department of Education, at [www.disabilitydischarge.com](http://www.disabilitydischarge.com).

## Collecting Additional Benefits

Because disability payments are often not enough to live on, it's important for you to collect all the other benefits to which you may be entitled. You might also want to try to supplement your income by working a little bit, to the extent you can.

### Disability and Earned Income

Your benefit check won't be reduced if you earn a small amount of income while collecting Social Security disability benefits. However, if you regularly earn enough income for your work to qualify as gainful employment, you might not be considered disabled any longer and your benefits could be cut off entirely.

Social Security usually permits you to earn up to \$1,550 a month—\$2,590 if you're blind—before you'll be considered to be performing substantial gainful work. Also, in deciding how much you're earning, Social Security is supposed to deduct from your income the amounts of any disability-related work expenses, including medical devices or equipment such as a wheelchair, attendant care, drugs, or services required for you to be able to work. It will be up to you to prove the necessity and cost of such expenses.

The \$1,550 per month amount isn't fixed. You can't simply keep your income just below this level and expect that your disability benefits will automatically continue. Both your physical condition and the amount of your work will be reviewed periodically. (See "Continuing Eligibility Review," below, regarding periodic reviews.) This review will take into account the amount and regularity of your income, your work duties, the number of hours you work, and, if you're self-employed, the extent to which you run or manage your own business.

If you're working long hours or have significant work responsibility, particularly if you're in business for yourself, Social Security will look hard, during its review of your disability status, at whether the

\$1,550 income limit is a true measure of your work. If, for example, family members are suddenly earning quite a bit more than they used to from the business, Social Security might suspect that you're doing the work and simply paying them instead. Or, if you're not getting paid much but you're working long hours for a business in which you have an ownership interest, they might look more closely at whether you're still disabled.

But you are allowed a “trial work period,” during which you can test out working without risking the loss of your SSDI benefits. (See below.)

## **Other Social Security Benefits**

You are not permitted to collect more than one Social Security benefit—retirement, dependents, survivors, or disability—at a time. If you're eligible for more than one monthly benefit based either on your own work record or on that of a spouse or parent, you'll receive the higher of the two benefit amounts to which you're entitled, but not both. Supplemental Security Income (SSI) is an exception; you're allowed to collect SSI in addition to any other Social Security benefit. (See Chapter 7 for more on SSI.)

## **Other Disability Benefits**

You're permitted to collect Social Security disability benefits and, at the same time, private disability payments from an insurance policy or coverage from your employer. However, your private disability policy might allow the insurance company to “offset” your Social Security disability payments; that is, to reduce your private disability payments by the amount of your Social Security benefits.

You can also receive veterans (VA) disability compensation at the same time as Social Security disability benefits, and those benefits will not be offset. (See Chapter 11 for a full discussion of VA benefits.)

## Workers' Compensation

You can collect workers' compensation benefits—payments for injuries suffered during the course of employment—at the same time as Social Security disability benefits, but those benefits will be offset.

While you're receiving monthly workers' compensation payments, the total of your disability and workers' compensation payments generally can't be greater than 80% of what your average wages were before you became disabled. If they are, your disability benefits or workers' comp benefits will be reduced so that the total of both benefits is 80% of your earnings before you became disabled. If you're still receiving Social Security disability benefits when your workers' compensation coverage runs out, you can again start receiving the full amount of your Social Security benefits.

**EXAMPLE:** Maxine became disabled with a back condition while working as a gardener and earning \$1,400 a month. Her Social Security disability benefits were \$560 a month, and, because her disability was related to her job, she also received workers' compensation benefits of \$625 a month. The total of the two benefits was more than 80% of her prior salary (the combined benefits of \$560 and \$625 total \$1,185, and 80% of \$1,400 is \$1,120), so her Social Security disability benefits were reduced by the extra \$65, down to \$495 a month.

If Maxine was still disabled when her workers' compensation benefits ended, her Social Security disability benefits would go back up to \$560 a month (plus whatever cost-of-living increases had been granted in the meantime).

## Medicare

After you've been entitled to disability benefits for 24 months, you become eligible for Medicare coverage. This is true even if you're not age 65, which is otherwise the standard age to qualify for Medicare. Medicare hospitalization coverage (Part A) is free. However, like other Medicare beneficiaries, you must pay a monthly premium if you want to be covered by Medicare Part B medical insurance or by Part D for prescription drug costs. (See Chapter 12 for a full discussion of Medicare.)

## Medicaid and SSI

If you have few or no assets other than your home—or your disability and the resulting medical costs deplete your assets and hamper your ability to earn income—you might qualify for Medicaid coverage. Medicaid is a program of government medical coverage available to people based on their low income and assets. You can be eligible for Medicaid coverage as soon as you qualify under its rules, without the 24-month wait Medicare requires. And even when you do qualify for Medicare, Medicaid can continue to pay medical bills that Medicare won't if you continue to be eligible for both programs. (See Chapter 16 for a full discussion of Medicaid.)

### Protecting Your Medicaid Eligibility

If your disability was caused by an accident that was someone else's fault, you might have a chunk of money coming to you as the result of an insurance claim or a lawsuit. Receiving that money, however, might disqualify you from Medicaid and eligibility for other benefits, which would mean you'd have to spend your settlement money on future medical bills, with nothing left for other living expenses.

Federal law and the laws of many states address this problem by allowing you to set up a "special needs trust." This permits you to accept accident compensation without losing your Medicaid and other benefit eligibility. With such a trust, instead of the accident compensation going to you in a lump sum, it's held for you by a bank or similar institution and is used to pay only certain types of bills—usually medical and basic living expenses. If your situation requires a special needs trust, consult an experienced estate planning lawyer for help.

In many states, a cheaper and easier alternative to special needs trusts is now available for people who became disabled before age 26. The Achieving a Better Life Experience (ABLE) Act allows for the creation of ABLE savings accounts, special bank accounts for individuals with disabilities. Funds in the accounts don't count as assets for the purpose of Medicaid (or SSI, up to \$100,000).

If you qualify for Medicaid assistance, you might also qualify for cash payments from the SSI program, on top of your Social Security disability benefits. Like Medicaid, SSI is intended to assist people with low income and assets. (See Chapter 7 for more on SSI.)

## Continuing Eligibility Review

Eligibility for disability benefits is not necessarily permanent. Depending on the nature and severity of your condition, and on whether doctors expect it to improve, Social Security will periodically review your condition to determine whether you still qualify for benefits.

## When Your Eligibility Will Be Reviewed

If, when you apply for disability benefits, your doctors and Social Security's medical experts expect that your condition will improve, your medical eligibility will be reviewed 6 to 18 months after you're approved for benefits. If improvement in your condition is theoretically possible but not predicted by the doctors, Social Security will review your eligibility approximately every three years. If your condition is not expected to improve after you apply, Social Security will review your case every five to seven years.

If at any point after you're receiving disability benefits, you earn a steady or frequent monthly income of close to \$1,550 (in 2024) per month, Social Security might also call you in for a work review. The agency will determine whether you're actually able to perform gainful employment that would bring you more than \$1,550 per month. Social Security will also check to see whether you're arranging to be paid less than \$1,550 per month by having someone close to you receive money for your work, or whether you're being paid in some way other than cash wages or salary.

If you're in what's called a "trial work period," however, your benefits won't be terminated if you're doing work that brings your income over the limit (see a "Returning to Work," below).

## The Review Process

The first step in a review of your eligibility for disability benefits is a letter from Social Security with a Disability Update Report form for you to fill out. This short form contains questions about how your health has changed, the medical treatment you've received recently, and any work you've done.

Depending on your answers, Social Security might then send you a longer form to fill out, called the Continuing Disability Review Report, which is similar to your original disability application.

The form will ask for the names and addresses of the doctors, hospitals, and other medical providers you have seen since your original eligibility was established, or since your last review. It will also ask you whether you've worked recently.

Social Security will then refer your file to Disability Determination Services (DDS), the state agency that reviews all disability claims.

The DDS will obtain your current medical and employment records and might ask that you undergo a medical consultation or examination. The DDS will make a determination about your continued eligibility based on the medical records and reports and on your earned income. Unless your disabling impairment has substantially improved so that you can now do substantial gainful work, or you've regularly been earning more than \$1,550 per month (or are found to be doing substantial gainful employment despite being paid less than \$1,550 a month), your benefits will continue.

If your eligibility is terminated, you have a right to appeal that decision. (See Chapter 9 for a full discussion of the appeal process.) And if you lose your eligibility, benefits can continue for an adjustment period of up to three months while you look for work and wait for a paycheck.

## Returning to Work

Most disabled people would rather work than not, and many try to find ways of working despite their disabling conditions. Social Security provides various forms of encouragement for people to return to work. For example, it ensures that people will continue to receive their disability benefits during time they spend testing the workday waters. And if, after returning to work, a person later finds that their disability makes the work too difficult, the person's disability benefits can be restarted quickly and easily.

### Trial Work Period

Within any five-year period, you can try out some kind of work—and keep any income you earn—for up to nine months while still receiving full SSDI disability benefits. (Your medical condition must still qualify you as disabled during this trial period.) You can try one job for a month or two and, if it doesn't work out, attempt the same or another job sometime later—up to a total of nine months within any five-year period. These nine months don't have to be consecutive.

Any month in which you make more than \$1,110 is considered one of the nine trial work months. If you're self-employed, any month in which you work 80 hours or more is considered a trial work month.

After you've worked for nine trial work months, your trial work period is over, and your extended period of eligibility will begin.

### Extended Eligibility for Benefits

After you've worked for 9 months—the trial work period—during a 5-year span, Social Security gives you another 36-month period of eligibility during which you can continue to work without necessarily losing your eligibility for benefits. During this time, you'll receive your full disability benefits for any month you don't have “substantial” earnings. Again, earnings of \$1,550 per month are considered “substantial”; the amount is \$2,590 if you're blind. You don't need to file a new application for benefits or go through an eligibility review.

The first time that you make substantial earnings during this “extended period of eligibility” (EPE), a grace period starts, during which you can receive your full benefits and keep the income you make from work. The grace period lasts three months, after which your benefits will stop.

## Quick Restart of Benefits

What if you’ve finished your trial work period and EPE, your benefits have been stopped because you’re working enough to bring in “substantial” earnings, but you again find yourself unable to work? In such a situation, Social Security makes it easy to restart your benefits. For five years after your disability benefits stop, called the “expedited reinstatement” period, you can get an immediate restart of benefits if you again are unable to work, so long as your inability to work is caused by the same disabling condition as before.

You need not file a new application for benefits, although you do need to file a simple form requesting the resumption of benefits.

Social Security will again review your condition to determine whether you’re disabled. However, your benefits should be restarted on the first of the month following your request, without waiting for the review to be completed.

**EXAMPLE:** Roberta qualified for Social Security disability benefits because of a congenital back condition that worsened so much in her 30s that she could no longer work. After several years, however, a new surgical technique was developed that greatly improved Roberta’s condition. Roberta returned to work part time and soon earned a “substantial” income. That meant she no longer qualified for disability benefits. Her back remained strong enough for her to work for two years, but then it began to deteriorate again. Within another six months, she found she could no longer work. Because Roberta’s original disability was the same disability that caused her to stop working again, and it was within 60 months after she had returned to work, she regained her disability benefits within a month, simply by applying for reinstatement.

## Continuing Medicare Coverage

If you became eligible for Medicare coverage because you qualified for SSDI disability benefits for 24 months, you don't immediately lose that Medicare coverage once you return to work. After you return to "substantial" work for more than 9 months and your disability benefits stop, your Medicare coverage continues for another 93 months.

This is the period between the end of your grace period and the end of your expedited reinstatement period. During that time, your Medicare Part A coverage is free, but you must pay the same premium for Medicare Part B and Medicare Part D (prescription drug coverage) as other Medicare beneficiaries, unless you qualify for a Medicare Savings Program, administered by Medicaid (see Chapter 16). ●

## Social Security Dependents Benefits

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A retired or disabled worker with a family obviously needs more money than someone living alone—especially given that Social Security retirement benefits currently average only about \$1,900 per month (\$1,500 per month for disability benefits). The situation is particularly acute when the retired or disabled worker was the family’s primary breadwinner. To help alleviate this problem, Social Security provides dependents benefits to the spouse and minor children of retired and disabled workers.

## Who Is Eligible

Certain family members of a retired or disabled worker are eligible for monthly Social Security dependents benefits if the worker has enough work credits to qualify for, and has claimed and actually begun collecting, their own retirement or disability benefits. If a worker delays claiming retirement benefits until after reaching full retirement age, their dependent(s) must also wait to collect dependents benefits until the worker begins collecting. However, a qualifying divorced spouse need not wait until the ex-spouse worker actually claims retirement benefits (see “Effect of Marriage and Divorce,” below).

The amount of benefits paid to dependents is determined by the worker’s earnings record and, for a spouse, the age at which the spouse claims the benefit.

Although they’re called dependents benefits, you don’t have to actually depend on the worker for support in order to claim them.

## Individuals Who Qualify

To be entitled to dependents benefits, you need to fit one of the following categories:

- a spouse age 62 or older
- a divorced spouse age 62 or older, with certain conditions (see “Effect of Marriage and Divorce,” below)
- a spouse (or partner) younger than 62 who is caring for the worker’s child who is under age 16 or who became disabled before age 22

- unmarried children younger than 18
- unmarried children up to age 19 if still in high school
- unmarried children of any age if they were severely disabled before they reached age 22, for as long as they remain disabled (see Chapter 3)
- unmarried stepchildren up to age 18 (19 if still in high school) if living with and under the care of the retired or disabled worker, or
- grandchildren of the worker, if they live with and are under the actual care of the worker and the parents are deceased or disabled, or if the grandparent has adopted them.

## **Effect of Marriage and Divorce**

Couples come in many forms: companions who are not married; couples who are divorced; people who were divorced and later married someone else. Each status has some ramifications regarding Social Security dependents benefits.

### **Married Couples**

You're eligible for dependents benefits (often called "spousal benefits") based on your spouse's work record once you reach age 62 and you've been married for at least one year. You must wait to claim these benefits until your spouse begins collecting their benefits.

### **Divorced Spouses**

You're eligible for dependents benefits if both you and your former spouse have reached age 62, your marriage lasted 10 years, and you have been divorced at least 2 years. This two-year waiting period does not apply if your former spouse was already entitled to retirement benefits before the divorce.

You can collect benefits as soon as your former spouse is eligible for retirement benefits at age 62. Your ex does not actually have to be collecting those benefits for you to collect your dependents benefits.

## Remarried

If you're collecting dependents benefits on your former spouse's work record and then marry someone else, you lose your right to continue those benefits. However, you might be eligible to collect dependents benefits based on your new spouse's work record.

If you divorce again, you can collect benefits again on your first former spouse's record, or on your second spouse's record if you were married for 10 years the second time as well.

### Try to Stretch the Marriage to 10 Years

If you are in the process of getting a divorce and you have been married almost 10 years, try to have your spouse agree—or stall the legal paperwork long enough—that the divorce won't become final until after 10 years. This is the amount of time you must have been married to get Social Security dependents benefits.

Under Social Security rules, the marriage is considered in effect until the divorce legally becomes final, even if you and your spouse have already been living apart, you have separated your property, and one of you has begun paying spousal or child support.

If you anticipate that your spouse might object to the delay, you might remind them that your dependents benefits have no effect on the amount they can collect in retirement benefits. Nor would your benefits affect the amount of dependents benefits your ex's new spouse could collect in addition to yours.

Whether your former spouse remarries does not affect your eligibility. Nor does your collecting dependents benefits through your former spouse affect their new spouse's right to collect benefits. And there is no reduction in either of your benefits when two spouses (current and former) are collecting them.

### Dependents Benefits for Same-Sex Spouses

Same-sex spouses are entitled to federal Social Security dependents benefits on the same terms as other spouses. This is true regardless of whether the couple lives in the state where the marriage was performed.

**Foreign marriages.** A spouse in a same-sex couple who was married outside the United States but now lawfully lives in the United States might be entitled to dependents benefits based on the other spouse's work record in the United States, depending on the status of that marriage in the country where it was performed. Even if you have doubts about your right to dependents benefits as a same-sex spouse, the Social Security Administration encourages you to apply for them so that the agency can determine whether you are eligible.

**Retroactivity.** Spousal benefits may be retroactive. The Department of Justice and the Social Security Administration have decided in several cases that the right to spousal benefits for a same-sex spouse can apply to someone who applied for such benefits before the Supreme Court's same-sex marriage decision on June 26, 2015. If you were married and applied for spousal benefits before that date but were denied those benefits (because you lived in a state that did not recognize your marriage), reapply to Social Security specifically requesting retroactive benefits back to the date you first applied.

### Unmarried Couples

For the most part, Social Security laws don't recognize the relationship between two adults who are not officially married. There are two exceptions.

First, if one person in an unmarried couple adopts the minor child of the other person, that child becomes eligible for dependents benefits based on the adoptive parent's work record. The other person in the couple does not, however, become eligible for Social Security benefits.

Second, if you live in a state that recognizes common law marriage and you qualify under that state's rules for such marriages, you might also qualify for dependents benefits. The states that recognize common law marriages are Colorado, the District of Columbia, Iowa, Kansas, Montana, Oklahoma, Rhode Island, Texas, and Utah. Alabama, Georgia, Idaho, Ohio, Pennsylvania, and South Carolina recognize common law marriages that were formed before certain dates.

The qualifying rules for a common law marriage vary somewhat from state to state, but all require that you have lived together and have represented yourselves as married by such things as using the same name and owning property together.

### **Mother's or Father's Benefits**

If you care for a disabled worker's child who is under 16 or disabled (and became disabled before age 22), you can get dependents benefits whether or not you're currently married to the worker. Social Security calls these benefits "mother's or father's benefits." But you don't need to be the legal mother or father of the child to get this benefit, unless you're divorced from the disabled worker. This benefit can be as much as 75% of the amount that the disabled parent receives in SSDI benefits, but it's subject to the maximum family benefit amount (see below).

## **Calculating Dependents Benefits**

The amount of benefits available to a retired or disabled worker and their dependents is calculated based on the total number of people in the immediate family. Social Security figures that the economies of scale permit two to live more cheaply than one, three to live more cheaply than two, and so on. Therefore, the amount by which benefits increase with each additional dependent is smaller and smaller for each person added.

## One Dependent

The basic Social Security benefit for one dependent, whether the dependent is a spouse, divorced spouse, or qualifying child, is 50% of the worker's retirement or disability benefit amount. If a divorced spouse and a new spouse both receive dependents benefits, each receives 50% (with no reduction to the primary worker's retirement or disability benefit amount).

The actual amount of your dependents benefit is based on the earnings record and timing of the retirement benefit claim of the worker on whom you are a dependent. Even if the worker has claimed retirement benefits before full retirement age, dependents benefits will be based upon what the worker would have received at full retirement age.

Some workers delay claiming retirement benefits until after full retirement age, up to age 70, in order to receive higher benefits. If so, the worker's retirement benefits will be higher, but the dependents benefits won't. Dependents benefits are based on what the worker would have received if they had claimed retirement benefits at full retirement age, not on the worker's higher delayed benefit amount.

However, if you are the worker's spouse, the amount of your spousal benefits depends on your age when you first claim the benefits. The amount of a spouse's dependents benefits is permanently lower if the spouse claims them between age 62 and their full retirement age. At each of the ages listed below, a dependent whose full retirement age is 66 receives a benefit as follows:

Dependent Spouse's Age	Percent of Worker's Benefit
62	35.0%
63	37.5%
64	41.7%
65	45.8%
Full Retirement Age	50.0%

The best way to find out the amount of retirement or disability benefits that you and your dependents are likely to receive is to review your official Social Security statement (discussed in Chapter 1).

**TIP**

**Dependent eligible for Medicare at age 65.** At age 65, a spouse might be eligible for Medicare coverage based on the worker's earnings record, even if the spouse doesn't have enough Medicare earnings to qualify on their own. In order for a spouse age 65 to qualify for Medicare on the worker's record, the worker must be at least age 62 and personally have sufficient work credits to qualify for Social Security benefits.

## Family Benefits

If your family includes more than one dependent—a spouse and one or more children, or no spouse but two or more children—the benefits paid to the worker and the dependents will be calculated according to the “maximum family benefit amount.” This amount is less than the total would be if the worker's benefits and individual dependents benefits were paid separately without a family limit.

The maximum family benefit is 150% to 180% of a retired worker's benefits—the precise amount depends on a complicated Social Security formula—or 150% of a disabled worker's benefits. The retired or disabled worker collects 100% of their benefits, and the remaining 50% to 80% is divided equally among the dependents.

**EXAMPLE:** Chiang-Fa is retired. Alone, he would be entitled to \$900 per month in retirement benefits. He and his wife Yoka have a 17-year-old daughter. With no daughter, Yoka would have been entitled to a \$450-per-month dependents benefit—50% of Chiang-Fa's \$900 retirement benefit.

However, because their daughter is also eligible, the three of them together are limited to a maximum family benefit of 180% of Chiang-Fa's benefit, or \$1,620. That amount would be divided as follows: Chiang-Fa, \$900; Yoka and the daughter, each \$360. Once the daughter reaches age 18, however, she is no longer eligible for dependents benefits, and Yoka would begin to get a full 50% dependents benefit of \$450 per month.

If Yoka is entitled to her own benefit (on her own work record), that could lower the portion of Yoka's benefit that counts toward the family maximum and raise the daughter's amount.

## Eligibility for More Than One Benefit

Many people are not only eligible for their own Social Security retirement or disability benefits but also for dependents benefits based on their spouses' work records. As with other Social Security benefits, you aren't permitted to collect both but only whichever one is higher.

If your own earnings record is low and your spouse's earnings record high, you might be entitled to higher monthly benefits as a dependent than you would be by collecting your own retirement or disability benefits. You have no choice about claiming one benefit or another. When you claim either your own retirement benefits or dependents benefits, Social Security will "deem" you to have applied for both. You will then collect whichever of the two benefits is higher, but you can't claim one while putting off the other to allow it to grow.

## Working While Receiving Benefits

Before full retirement age, a dependent's benefit will be reduced by \$1 for every \$2 of income earned over the yearly maximum. After a dependent reaches full retirement age, benefits are not reduced, regardless of how much the dependent is earning. (See Chapter 2 for a full explanation of benefit reductions.)

If several dependents are receiving a combined family benefit amount, one dependent's income doesn't affect the amount the other family members receive.

**EXAMPLE:** Grace and Omar and their teenage son receive combined family retirement and dependents benefits of \$1,650 a month. Grace's and the son's portions of the family benefit are \$350 each. Grace is offered a job for a year as a substitute teacher at a salary that is \$6,000 more than the yearly earnings limit for her age of 63 years old.

Since Grace's benefit amount is reduced \$1 for every \$2 she earns above the limit, her benefit would be reduced by half (\$1 out of \$2) of \$6,000. That means a reduction of \$3,000, or \$250 per month. Since her own part of the family benefit is \$350, that benefit would be reduced to \$100 per month. The rest of the family's benefits—Omar's \$950 per month and the son's \$350—would not be affected.

### Perils of Claiming Early: Reduced Benefits

If you claim retirement benefits before full retirement age, your retirement benefits will be reduced. (See Chapter 2 for details.) And if you later switch to dependents benefits, those benefits, too, will be reduced by the same amount that your retirement benefits were reduced.

**EXAMPLE:** Clare would have been eligible for retirement benefits of \$500 per month at age 66. She decided to claim early retirement benefits at age 62—and received her full retirement amount of \$500 less 25%, for a monthly sum of \$375. When Clare’s husband turned 66, he applied for retirement benefits and received \$1,200 per month. At that time, Clare switched from her own retirement claim to dependents benefits, which ordinarily would have been \$600, or 50% of her husband’s monthly amount. But because Clare had already taken 25% reduced retirement benefits at age 62, her dependents benefits were now reduced by 25%. She ended up getting \$450 per month, instead of the \$600 per month she would have received had she waited.

## Government Pension Offset

Most people who work for a federal, state, or local government or for a public agency are now fully covered by the Social Security system and are also eligible to receive benefits under their agency’s public retirement system. But millions of people of retirement age worked for a branch of government—federal, state, or local—or for a public agency, such as a school district, and earned a retirement pension under the Civil Service Retirement System (CSRS) or a similar pension system that paid no Social Security taxes. (See Chapter 10 for more information about the CSRS.) These people might be subject to a reduction in Social Security dependents benefits called the “government pension offset.”

The government pension offset applies if you receive Social Security dependents or survivors benefits and also receive a retirement pension (based on your own work record) from the CSRS or another civil service pension system that didn't contribute to Social Security. If you receive this type of pension, your Social Security dependents or survivors benefits are reduced dollar for dollar by two-thirds of the amount of your civil service pension.

The government pension offset does not apply, however, to people who are eligible to receive retirement benefits under the Federal Employees Retirement System (FERS), state or local Public Employees Retirement System (PERS), or any other public employment retirement system that does pay Social Security taxes.

In particular, the government pension offset does not apply to:

- federal employees who pay Social Security taxes on their earnings
- federal employees who switched from the CSRS to the FERS before July 1, 1988
- federal employees who switched from the CSRS to the FERS after June 30, 1988 and worked for at least five years under FERS
- federal Civil Service Offset employees (employees who had at least five years of federal employment under the CSRS, then left federal employment but were rehired after December 31, 1983 following a break of a year or more)
- people whose retirement benefit is based on work for a state or local government or public agency whose pension system paid Social Security taxes at the time they retired (and who retired before July 1, 2004), or
- people who retired on or after July 1, 2004, and whose retirement benefit is based on work for a state or local government or public agency whose pension system paid Social Security taxes during the last five years of employment.

If you're entitled to benefits under any CSRS pension, you should consider this government pension offset when calculating the amount of your combined CSRS retirement pension and Social Security dependents or survivors benefits. This rule might affect which pension benefit you choose to collect.

**EXAMPLE:** Gina and her husband both worked for the government under the Civil Service Retirement System (CSRS). Her husband also worked in the private sector, paying Social Security taxes on his earnings. Gina is entitled to \$500 per month in Social Security dependents benefits, based on her husband's private sector work record. She is also entitled to a CSRS pension of \$400 per month (her own retirement pension) and a \$250 per month CSRS dependents benefit based on her husband's work under the CSRS.

If Gina claims her own CSRS retirement pension, her Social Security dependents benefits would be reduced by two-thirds of her \$400 pension (meaning the amount deducted from her Social Security dependents benefit would be \$266). If, instead, she claims her CSRS pension dependents benefits but not her own CSRS retirement pension, her Social Security dependents benefits are not affected. So, she is better off collecting her smaller CSRS dependents benefits (\$250) plus her full Social Security dependents benefits (\$500), for a total of \$750 per month, than she would be collecting her own larger CSRS retirement benefit (\$400) with her reduced Social Security dependents benefit amount ( $\$500 - \$266 \text{ offset} = \$234$ ), for a total of only \$634 a month.

**TIP**

**Private employer pensions are not affected.** The pension offset rule does not apply to pensions paid by private, as opposed to government employers. As far as Social Security is concerned, you are entitled to your full Social Security dependents benefits as well as your private pension benefits. However, your private pension plan might require that your pension benefits be reduced by the amount you receive from Social Security. ●

## Social Security Survivors Benefits

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The Social Security laws recognize that a worker's family might need financial support after the worker dies. Even if the surviving spouse has always worked, the loss of the deceased spouse's income will almost surely be an economic blow to the family. And if the surviving spouse didn't work, or earned much less than the deceased spouse, the loss of the deceased worker's income can be financially devastating. Recognizing the family financial burden brought on by the loss of an earner, Social Security provides for what are called "survivors benefits" to be paid to the spouse and minor children of an eligible worker who has died.

## Work Credits Required for Eligibility

Surviving family members of a deceased worker are entitled to survivors benefits only if the worker earned enough work credits before dying. Work credits are accumulated based on earnings from employment covered by Social Security. The required number of work credits depends on the worker's age at death. (See Chapter 1 for more on earning work credits.)

The number of work credits on the worker's Social Security record needed for survivors to collect benefits is listed in the "Credits Required on Deceased's Work Record" chart, below.



### TIP

**Credits earned just before death might make up for a lack of work credits.** Even if the deceased worker didn't have enough work credits according to the chart below, benefits might still be paid to the surviving spouse and children if the worker had at least one and one-half years of work in covered employment in the three years immediately before dying.

Credits Required on Deceased's Work Record	
If the worker died or became disabled at age:	Work credits needed:
28 or younger	6
30	8
32	10
34	12
36	14
38	16
40	18
42	20
44	22
46	24
48	26
50	28
52	30
54	32
56	34
58	36
60	38
62	40

### Who Is Eligible

Provided the deceased worker had enough work credits, here's who can claim survivors benefits:

- a surviving spouse age 60 or older
- a divorced surviving spouse age 60 or older, if the marriage lasted at least 10 years

### Survivors Benefits for Same-Sex Spouses

A same-sex surviving spouse is entitled to federal Social Security survivors benefits on the same terms as any other surviving spouse. This is true regardless of the state in which the same-sex couple lived, if the marriage was lawful in the state where it was performed.

**Foreign marriages.** The surviving spouse of a same-sex couple who was married outside the United States but who now lawfully lives in the United States might be entitled to survivors benefits based on the deceased spouse's work record in the United States. The right to benefits in this situation depends on the status of that marriage in the country where it was performed. Even if you have doubts about your right to survivors benefits as a same-sex surviving spouse, the Social Security Administration encourages you to apply so that they can determine whether you're eligible.

**Retroactivity.** These benefits may be retroactive. The Department of Justice and Social Security Administration have decided in several cases that the right to spousal benefits for a same-sex spouse can apply to someone who applied for such benefits before the Supreme Court's same-sex marriage decision on June 26, 2015. If you were married, widowed, and applied for survivors benefits before that date but were denied those benefits (because you lived in a state that did not recognize your marriage), reapply to Social Security specifically requesting retroactive benefits back to the date you first applied.

- a surviving spouse younger than 60, if caring for the worker's child who is younger than 16 or disabled; this benefit, sometimes called the "mother's or father's benefit," can also be paid to a surviving divorced spouse who is taking care of the workers' child if the surviving ex-spouse is the legal mother or father of the child and is unmarried
- a surviving spouse age 50 or older who becomes disabled within seven years of the worker's death (or within seven years after their mother's or father's benefits end); if you were

divorced, you can collect these disabled survivors benefits only if your marriage lasted at least 10 years

- unmarried children younger than 18; benefits can continue to age 19 if the child is still a full-time high school student
- unmarried children of any age who were severely disabled before age 22 and are still disabled, or
- one or both parents of the worker who are at least age 62 and who were dependent on the worker for at least one-half of their financial support. If an unmarried dependent parent remarries after the worker's death, the parent loses the survivors benefits.

## Length of Marriage Rule

To collect benefits as a surviving spouse, you must have been married for at least nine months before the worker's death. However, there are some exceptions to this rule. If you're the biological parent of a child with the worker, or you adopted the worker's child or adopted a child with the worker before the child was 18, the nine-month rule doesn't apply.

The rule is also waived if you were previously married to the same person and your first marriage lasted more than nine months. And the nine-month rule doesn't apply if the worker's death was the result of an accident, as opposed to an illness, or occurred while they were on active military duty.

## Effect of Remarrying

One of the assumptions behind survivors benefits for spouses is that the majority of surviving spouses are women and that women are financially dependent on their husbands. Although things are changing, the fact that there are still fewer women than men in the workforce and that women still make less than 84 cents for every dollar men earn in wages, in comparable jobs, means this assumption isn't entirely out of date.

Another assumption is that if a surviving spouse—usually a woman—remarries, her need for survivors benefits will end, because there is a new spouse upon whom to depend financially. So a series of qualifying Social Security rules apply to collecting survivors benefits after remarriage:

- A widow or widower who remarries before age 60 loses the right to collect survivors benefits through the deceased spouse, even if they're still caring for the former spouse's children. The children, however, remain eligible for benefits. (However, at age 62, the remarried spouse might be eligible for dependents benefits based on the new spouse's record.)
- If the widow or widower is older than 50 and disabled, getting remarried won't affect the survivors benefits.
- A widow or widower who remarries after reaching age 60 doesn't lose survivors benefits from the deceased former spouse. However, it might make sense to apply—at age 62 or later—for dependents benefits based on the new spouse's earnings record if that benefit would be higher than the survivors benefits. In that case, Social Security would pay a combination of the survivors benefit and the dependents benefit based on the new spouse's record.
- If you were divorced from your now-deceased former spouse, and the two of you had been married for at least 10 years, you're eligible for survivors benefits even if you remarried before age 60 but are again widowed or divorced. After age 60, you can remarry without losing your survivors benefits.
- If you were divorced from your now-deceased spouse, you're older than 50, and you're disabled, getting remarried won't affect your benefits.

**EXAMPLE:** Akiko and Yosh were divorced 10 years ago, after being married for 25 years. Three years ago, Yosh died. Akiko has a new sweetheart, Ben. They have been together for the past year and are now considering marriage. But Akiko is concerned about the effect their marriage would have on her right to collect Social Security survivors

benefits. Akiko is 59, and next year she would be eligible for survivors benefits based on Yosh's work record because their marriage lasted more than the required 10 years.

If Akiko waits one more year, she and Ben can marry and she will still be able to collect survivors benefits based on Yosh's record. If she marries before reaching age 60, she will lose those benefits.

## Amount of Survivors Benefits

Like all other Social Security benefits, the dollar amounts of survivors benefits are determined by the deceased worker's earnings record. In addition, the amount of the survivors benefits depends on whether and when the worker had claimed retirement benefits. If the worker had claimed Social Security retirement benefits before death, the amount of survivors benefits is equivalent to what the deceased worker was receiving. That is, if the worker claimed reduced retirement benefits before full retirement age, the survivors benefits will be similarly reduced. On the other hand, if the worker waited until after full retirement age to claim benefits, and therefore got a higher benefit amount, the survivors benefits will be similarly higher. If the worker died before claiming retirement benefits, Social Security determines what the worker's full retirement benefit would have been and bases the survivors benefits on that amount.

## Percentage of Benefits Awarded

Exactly what percentage of the deceased worker's retirement benefit will be awarded to a survivor depends on whether you're the spouse or child of the deceased worker. Also, if you're a surviving spouse, the amount goes up or down depending on the age you first claim benefits.

The amount of the benefit changes between age 60 and "full benefits age." Full benefits age, or the retirement age for survivors, is set by Social Security based on the year of your birth; it's slightly different than the full retirement age set for workers (for those born before 1962).

As with retirement benefits, the full benefits age will be going up in the coming years. The changes are shown on the following chart. The age at which a person can collect full survivors benefits is currently 66—but this will change in the coming years. For people born in 1957 or after, the survivors full benefits age is gradually rising, finally reaching age 67 for those who were born in 1962 or after.

**Surviving Spouse at Full Benefits Age**

A surviving spouse who waits until the full benefits age to claim benefits will receive 100% of what the deceased worker’s full retirement benefit would have been if the deceased worker died before claiming those benefits or if the worker claimed the benefits at full retirement age. But if the deceased worker had claimed retirement benefits early or had deferred payments until after full retirement age, the amount of the survivors benefits will be based on the level of benefits the worker was actually receiving (reduced for an early claim, increased for a delayed claim).

Full Benefits Age for Widow(er)s	
Birth Date	Full Benefits Age
1/2/45–1/1/57	66 years
1/2/57–1/1/58	66 + 2 months
1/2/58–1/1/59	66 + 4 months
1/2/59–1/1/60	66 + 6 months
1/2/60–1/1/61	66 + 8 months
1/2/61–1/1/62	66 + 10 months
1/2/62 and later	67 years

**Surviving Spouse Under Full Benefits Age**

A surviving spouse who claims benefits at age 60 will receive 71.5% of what the worker would have been receiving (further reduced if the worker claimed early benefits, enhanced if the worker delayed the claim until after full retirement age). Each year a surviving spouse delays claiming benefits after age 60, those benefits will rise 4.1%

to 5.7% per year, depending on the year of birth, until the survivor reaches full benefits age. (A widow or widower who waits until full benefits age to collect survivors benefits will receive 100% of what the worker would have been receiving.)

Delaying benefits until later might be a good idea for survivors who are under full benefits age and who are still working. (See “Working While Receiving Benefits,” below, for more information.)

### **Surviving Spouse Caring for Child**

A surviving spouse who is caring for the worker’s child, if that child is younger than 16 or disabled, is eligible for benefits regardless of the surviving spouse’s age. The amount of benefits will be 75% of what the worker’s retirement benefits would have been.

### **Minor or Disabled Child**

A surviving minor (under 18) or disabled child receives 75% of what the worker’s retirement benefits would have been. This is over and above what the survivor parent receives. This amount is, however, subject to the per-family maximum discussed in “Surviving Spouse and Children Together,” below.

### **Dependent Parent**

A surviving parent who was dependent on a deceased son or daughter for at least half of their financial support might be eligible for 82.5% of what the deceased worker’s retirement benefit would have been. If there are two surviving dependent parents, they each get 75%.

### **Surviving Spouse and Children Together**

A surviving spouse and children together are not entitled to the full amount each would get alone. A maximum is placed on the total amount that one family can receive.

The family benefit limit is 150% to 180% of what the deceased worker’s retirement benefits would have been. The benefits are divided equally among the surviving spouse and children.

## Estimating Benefit Amounts

You can get a general idea of survivors benefit amounts by looking at these recent average figures:

- overall average monthly benefit for surviving spouse: \$1,775, and
- overall average monthly benefit for surviving spouse with two children: \$3,650.

In addition, it can be helpful to look at averages based on income levels.

### Low Income

The survivor of a worker who had low income most of their working life—less than \$30,000 per year in current dollars—might receive monthly benefits between \$600 and \$1,000. If both a surviving spouse and a minor child will be receiving benefits, the monthly total for the two might be between about \$1,000 and \$1,500.

### Moderate Income

The survivor of a worker who had a moderate annual income—around \$30,000 to \$40,000 in current terms—might receive between \$1,000 and \$1,500 per month. A surviving spouse and child might receive a total between about \$1,500 and \$2,000.

### High Income

The survivor of a worker who averaged relatively high earnings—\$40,000 per year or more in current dollars—can expect between \$1,400 and \$2,600 per month. The high earner's surviving spouse and child together might receive between \$1,600 and \$3,900.

### Getting an Official Estimate

You can get a very accurate personal estimate of what your family members' survivors benefits are likely to be directly from Social Security or by logging into your Social Security account.

## Eligibility for More Than One Benefit

Many surviving spouses are eligible for their own Social Security retirement or disability benefits and also for benefits based on their spouses' work records. However, you're permitted to collect only one type of benefit, whichever is higher. If your own earnings record is low and your deceased spouse's earnings record was high, you may be entitled to higher benefits as a surviving spouse than as a retired or disabled worker.

Even if you will ultimately be eligible for a higher retirement benefit after you turn age 62, you might be able to claim survivors benefits as soon as you're eligible at age 60, and then switch to your own retirement benefits whenever they become higher than your survivors benefits. Claiming survivors benefits before you reach full retirement age doesn't reduce your own retirement benefit.

It also works in reverse: You might be able to claim reduced early retirement benefits—between age 62 and full retirement age—on your own work record, and then switch to full survivors benefits at any later age if those benefits would then be higher. Options for claiming one benefit and later switching to another, and the best time to do so, are explained in Chapter 6.

**EXAMPLE:** Francesca would be eligible for full retirement benefits of \$600 per month at age 66, based on her own work record; at age 62, she is eligible for reduced retirement benefits of \$450 per month. At age 66, she would also be eligible for a full survivors benefit of \$800 per month based on her deceased husband's work record; at age 62, she is eligible for a reduced survivors benefit of \$600 per month.

Francesca has two choices at age 62: She can claim her early retirement amount of \$450 per month and then switch to full survivors benefits of \$800 per month at age 66. Or she can claim her reduced survivors benefits of \$600 per month at age 62 and collect that amount, plus cost-of-living increases, for the rest of her life.

Francesca has to decide whether she can get along well enough with the \$450-per-month retirement benefits she would receive for three years until she switched to her \$800 survivors benefits. If she can manage, then waiting would be better in the long run. Waiting for the higher survivor benefit makes particularly good sense if she will also be working during those three years, because her benefits might be reduced because of her earnings.

### **One-Time Payment for Funeral or Burial Expenses**

In addition to the monthly survivors benefits to which family members might be entitled, a family can also receive a one-time-only payment—currently \$255—intended to defray funeral or burial expenses. A surviving spouse can claim the money if the couple was not divorced or legally separated at the time of death.

If there is no qualifying spouse, the \$255 sum can be paid to the surviving minor children, divided equally among them. You must file a claim for the death benefit at your local Social Security office within two years of the worker's death.

## **Working While Receiving Benefits**

Many surviving spouses find that, despite their survivors benefits, they also have to work to make ends meet. How much a surviving spouse earns, however, can affect the amount of survivors benefits if the survivor is less than full retirement age.

The benefit for a surviving spouse who is less than full retirement age will be reduced by \$1 for every \$2 of income earned over the yearly maximum. (See Chapter 2 for details.) Once a surviving spouse reaches full retirement age, there is no reduction in benefits, regardless of how much is earned.

If a widow, or widower, and children are receiving a combined family benefit amount, the parent's earnings don't affect the amount the children receive.

**EXAMPLE:** Manjusha and her teenage son receive a combined family survivors benefit of \$1,500 a month, or \$750 each. Manjusha is taking a job at a salary that is \$6,000 more than the yearly earnings limit.

Since Manjusha is 62, her benefit amount is reduced \$1 for every \$2 she earns over the limit. Her benefits would be reduced by half of \$6,000, for a total reduction of \$3,000, or \$250 per month. Since Manjusha's part of the family benefit is \$750, that benefit would be reduced to \$500 per month. But her son's \$750 would not be affected.

## Government Pension Offset

If you worked enough years for a local, state, or federal government or public agency, you might be entitled to retirement benefits from that agency's pension system. You might also be entitled to Social Security survivors benefits based on your deceased spouse's work record. Most people don't have any problem collecting the full amount of both benefits. But people whose government agency work was more than 20 years ago might find themselves subject to a reduction in their survivors benefits. If your government agency work was under the Civil Service Retirement System (CSRS) or another pension system that did not pay into the Social Security system, collecting your own retirement pension might cause you to lose a substantial portion of your Social Security survivors benefits.

This government pension offset rule for Social Security survivors benefits is the same as for Social Security dependents benefits. (For more information, see "Government Pension Offset" in Chapter 4.)

This rule won't only affect how much your combined government pension and dependents benefits are, but it might also cause you to choose to collect your own Social Security retirement benefits, if you

are eligible for them, rather than Social Security survivors benefits. The combination of your CSRS pension and your own Social Security retirement benefits might be more than your CSRS pension and your survivors benefits reduced by two-thirds of the amount of your pension.

**EXAMPLE 1:** Marta worked for a state government for a number of years, earning a CSRS pension of \$690 per month. She is also entitled to a Social Security survivors benefit of \$1,400 per month based on her late husband's work in the private sector, for which he and his employers paid Social Security taxes. Because of the public pension offset rule, however, Marta can't collect the full amount of both benefits. Her Social Security survivors benefit will be reduced by two-thirds of the amount of her CSRS pension. So, she collects her \$690 per month pension plus a \$940 per month survivors benefit ( $\$1,400 - \$460$  offset [which is two-thirds of \$690] = \$940).

**EXAMPLE 2:** Alice is entitled to \$500 per month in Social Security survivors benefits based on her deceased husband's nongovernment work record, for which he and his employer paid Social Security taxes. She is also entitled to both a CSRS pension of \$400 per month and a \$250 per month benefit as a widow based on her husband's public employee retirement record. Ordinarily, she would choose to claim her own CSRS pension rather than the lower public employee widow's benefit.

But if she claims her own CSRS pension, her Social Security survivors benefits would be reduced by two-thirds of her CSRS pension (\$400). On the other hand, if she claims CSRS pension dependents benefits, her Social Security amounts won't be reduced at all. She is better off collecting both her smaller CSRS pension dependents benefits (\$250) and her full Social Security dependents benefits (\$500), rather than her larger CSRS pension retirement benefit (\$400) and the reduced Social Security amount, which would be \$233 ( $\$500 - \$267$  offset = \$233).

The pension offset rule doesn't apply to pensions paid by private, nongovernmental employers. However, the rules of a few private pension plans provide that your pension benefits will be reduced by what you receive from Social Security. ●

## When to Claim Social Security Benefits and Which One to Claim

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**A**s explained in Chapters 1 through 5, the age at which you claim Social Security retirement, dependents, or survivors benefits affects the monthly amount you receive—earlier claims (up to age 70) mean lower monthly benefits. In some situations, an early claim will also reduce how much you will receive if you later switch to a different benefit. Also, the age at which you claim your benefits can affect how much your survivors collect. Altogether, the difference between filing a claim before, at, or after full retirement age can be many thousands of dollars over your and your family’s lifetime.

So, how do you choose the best time to claim a Social Security benefit? And which benefit should it be? There is no simple answer, but several factors can help you make a decision that best fits your personal situation. This chapter discusses the factors that apply to everyone and then explains how specific situations—which depend on your family situation and work history—might present you with certain options.

## Considerations for All Beneficiaries

You can claim your Social Security retirement or dependents benefits as early as age 62, or your survivors benefits as early as age 60 (or sooner if you’re disabled or caring for the deceased worker’s child who is younger than 16 or disabled; see Chapter 5).

But the monthly amount you receive—for your lifetime—is reduced for every month before you reach full retirement age that you claim these benefits. (See Chapter 2 to learn about full retirement age.) On the other hand, you can increase your retirement benefit amount for every year past full retirement age (up to age 70) that you wait to claim benefits. Also, by delaying retirement benefits, you increase the amount your surviving spouse can collect.

## Your Lifetime Total: The Break-Even Point

Based on the way the Social Security system calculates benefits, if you claim benefits early but you live past a certain age—called your

“break-even point”—you will wind up collecting less in total lifetime benefits than if you had waited to claim them at full retirement age. Similarly, if you wait until full retirement age to claim benefits, or delay them further, but don’t live past your break-even point, you will have collected less in total lifetime benefits than if you had claimed benefits early.

Here’s how these break-even points work.

**Early claim break-even point.** For people who claim benefits at age 62, their break-even point is between 75 and 76 years old (the exact point depends on your earnings record and the year you were born). That means that if you claim early benefits but live past that age, your total lifetime benefits will be less than if you had waited until full retirement age to claim them. The longer you live past the break-even point, the more you lose by having claimed early benefits. (Remember, though, that you might want or need to claim early benefits despite this, for other reasons discussed in this chapter.) Because average life expectancy for people age 62 is about 21 years for men and 24 years for women, most people will lose money over their lifetime if they claim benefits at age 62.

**Delayed claim break-even point.** For most people who delay claiming retirement benefits until age 70, their break-even point is about age 79 or 80. For people who live past that age, after delaying benefits until age 70, total lifetime benefits will be more than if they had claimed them at full retirement age.

**Your personal break-even point.** Your personal break-even point may differ from the figures above. Your actual break-even point will depend on a combination of factors, including your earnings record and when you were born. However, the figures above will give you a close estimate. To get more specific information about your personal break-even point, you can call Social Security at 800-772-1213 and ask them to do the calculations for you, or go to the Social Security website’s page “When To Start Receiving Retirement Benefits” at [www.ssa.gov/pubs/EN-05-10147.pdf](http://www.ssa.gov/pubs/EN-05-10147.pdf).

## Factors to Consider

Many people jump at the chance to begin collecting benefits as early as possible, regardless of their break-even point. For some, claiming early benefits is a necessary, or at least sensible, financial choice. But for others, it might be a poor decision that can cost them many thousands of dollars over a lifetime. Before you decide whether to claim early benefits or to delay your claim, consider the following factors.

### Immediate Financial Need

You might be in a financial situation that leaves you no real choice—you need your Social Security benefits now, even though your monthly benefits will be lower than if you wait, and your total lifetime benefits will probably be lower. For many people in these difficult economic times, the extra income of even a substantially reduced Social Security benefit is what allows them to afford the bare essentials of daily life.

Even if you don't need your Social Security benefit to meet essential daily expenses, you might want to collect a reduced benefit early in order to have a little extra money to make yourself or your family more comfortable. Having the extra money to use now—to do things you might not otherwise be able to afford—might be worth the chance that you will collect less in benefits over your entire lifetime. For example, you might want to use the extra money to do some traveling that you could not otherwise afford or might not be physically able to do later. Or, you might want to use the money to offer financial help to your children or grandchildren at a time when they could really use it. If there's any reason why you feel that using the money now is important to you, you might want to claim benefits early even though, in a purely financial sense, it might not be the best decision.

### You Can Undo an Early Claim

Some people claim early benefits because they need the money immediately, but then their financial situation improves. If, after claiming early benefits, you find new work, switch jobs, get a pay raise, or otherwise come into money, your new income or assets might reduce your need for early benefits. Or your income could even wipe out those benefits entirely (if the new money is earned from work you do) because of the earned income offset rule. (For more about this rule, see “Continuing to Earn Before Full Retirement Age,” below.)

If you find yourself in this situation, you’re not stuck with the decision you made to claim early benefits. You have the following two options.

**Suspend benefits.** You can ask Social Security to suspend your benefits. This means your benefits will stop until you notify Social Security that you want your benefits to resume. While your benefits are suspended, your lifetime benefits won’t suffer the monthly percentage reductions that would have occurred if you had continued to collect early benefits. When you resume collecting your benefits, Social Security will recalculate them, with a reduction based only on those months you actually collected early benefits.

**Withdraw claim, repay benefits.** Another option is to withdraw your benefit claim. You can withdraw your application within 12 months after first becoming eligible for benefits, if you repay all the benefits you’ve received so far. Withdrawing your claim would remove all early claim reductions from Social Security’s calculation of your benefit amounts, meaning you would be able to claim your full benefit at full retirement age, or a greater amount if you delay your claim even further. To learn more about how to withdraw a claim and what you would have to repay, see Social Security’s online information “Cancel Your Benefits Application” at <https://www.ssa.gov/manage-benefits/cancel-your-benefits-application>.

## Continuing to Earn Before Full Retirement Age

Even if you could really use your retirement benefits before you reach full retirement age, it might not make sense to claim them now if you're going to keep working and earning more than a very small income. As explained in Chapters 2, 4, and 5, a Social Security penalty takes \$1 from your retirement, dependents, or survivors benefits for every \$2 in income you earn over a low, yearly limit (until you reach full retirement age). If you'll be earning only a slight amount over the yearly limit, it might still make sense to claim early benefits if you need the money. But if you'll be working and earning a substantial amount over the yearly limit, claiming your benefits early would be a double mistake: Your immediate benefits would be substantially reduced if not wiped out altogether by the \$1-out-of-\$2 earnings offset rule, and your lifetime benefits would be permanently lower because you claimed them early.

## Life Expectancy

If a health condition makes it likely you won't live past your mid-70s, then claiming early retirement benefits makes sense. You will get to use or save the money, even though it's a reduced amount, for however many years you live.

If, instead, you wait until full retirement age to claim benefits but die within a few years of receiving them, you will have received less in total lifetime benefits even though your monthly benefit amount will have been greater than if you had claimed early benefits.

If, on the other hand, you have no life-threatening medical conditions, your health is generally good, and you have a family history of relatively long life, you might want to delay claiming retirement benefits at least until, and perhaps even later than, full retirement age. With a long life expectancy (likely to live into your 80s), you are more likely to collect greater total lifetime benefits by delaying your benefits claim.

## Availability of Other Benefits

Your eligibility for Social Security survivors benefits (see Chapter 5) might allow you to delay claiming your own retirement benefits past full retirement age, making those retirement benefits higher than if you claim them earlier. Claiming early survivors benefits might be a good idea even if those benefit amounts are lower than your early retirement benefits. That's because in the long run, the yearly increase in your unclaimed retirement benefits can make up the difference between lower dependents or survivors benefits you claim now and what your present retirement benefits would be. If you were born before January 2, 1954, you can also claim Social Security dependents benefits (see Chapter 4) early while delaying claiming your own retirement benefits past full retirement age. The scenarios for claiming one benefit while delaying another are discussed in the following sections.

## Considerations When You're Entitled to More Than One Benefit

In addition to the factors that apply to everyone (discussed above), if you qualify for more than one type of Social Security benefit, you might want to delay claiming one benefit while you collect another type instead. Whether you're able to do this varies according to your prior and current marital status, the benefits available to you, and, with regard to dependents benefits, the year you were born.

### Unmarried, Divorced, or Widowed

If you've never been married, or if you were married but are now divorced or widowed, the best time to claim benefits depends on which benefits you're eligible for and whether you have dependents yourself.

### **Dependent Children Can Change the Equation**

Any decision about when to claim retirement benefits might be a bit different if you have a minor or disabled child who is eligible for dependents benefits (which would pay the child an additional 50% of your retirement benefits). Dependents benefits payable to a minor child last only until the child turns 18, so if your child is already close to that age, the extra benefits wouldn't last long and probably won't affect your decision one way or the other. If, on the other hand, you have a younger child, the total benefits your child could collect until age 18 might make it worth claiming your retirement benefits earlier than you otherwise would.

### **With No Benefits From Anyone Else's Work Record**

If you aren't eligible for dependents or survivors benefits based on the work record of a prior spouse, you probably need to consider only the factors discussed in the previous sections—your immediate financial need, continuing work, and life expectancy—in deciding when to claim your retirement benefits.

### **With Benefits From a Former Spouse's Work Record**

If you were married previously, you might be eligible for dependents or survivors benefits based on your former spouse's work record. (Remember, though, that if you're divorced, you must have been married for at least 10 years to be eligible for dependents or survivors benefits. And a divorced spouse might be able to claim dependents benefits as soon as the former spouse reaches full retirement age, whether or not the former spouse actually claims retirement benefits then; see Chapter 4.) If your survivors benefits are higher than your own retirement benefits, you might be able to claim those instead

of your own benefits. Whether and when to consider such a claim depends on the following rules.

**Survivors benefits.** A wrinkle in the Social Security laws allows you to claim early retirement or survivors benefits and then switch to the other of these two benefits without the early claim reducing the new benefit amount. It can work in either of two ways:

- You can claim survivors benefits as early as age 60 (or earlier if you're disabled or caring for the deceased worker's child who is younger than age 16 or disabled; see Chapter 5). If you claim survivors benefits before full retirement age, your early claim reduces those survivors benefits but does not affect your own retirement benefits. Your retirement benefit will continue to grow (until you reach age 70) while you're collecting survivors benefits. At any point, you can switch to your own retirement benefits. Given this rule, even if your survivors benefits are somewhat smaller than your retirement benefits, you might want to claim those smaller benefits for several years while your retirement amount grows.
- You can claim your own retirement benefits before you reach full retirement age even if your survivors benefits would be larger. Why? Because your early retirement benefits claim won't affect your later survivors benefits, which can grow if you delay claiming them. So, you can first take your reduced retirement benefits without affecting your survivors benefits. When you switch to the survivors benefits later, they will be higher for the rest of your life.

**Dependents benefits.** You can't choose between dependents benefits and your own retirement benefits. When you file for either, Social Security will pay you whichever one is higher. And filing for either dependents or retirement benefits early will cause your dependents or retirement benefits to be reduced by the same percentage.

## Married Couples

The rules for married couples allow for some manipulations that can mean higher lifetime benefits for one or both spouses.

### If Only One Spouse Is Eligible for Retirement Benefits

Although their numbers are shrinking rapidly, there are still many married women who did not do enough paid work outside the home during their lifetime to have earned Social Security retirement benefits. (This happens with men, too, of course, but the number of men in this situation is smaller, so the discussion here will assume the example of a no-retirement-benefits wife with a husband who has earned retirement benefits.)

A wife in this circumstance is eligible for dependents benefits (spousal benefits) only when her husband claims retirement benefits, and is eligible for survivors benefits when her husband dies. If the wife claims dependents or survivors benefits before her full retirement age, she will get a reduced benefit.

The husband, in this case, is eligible only for his own retirement benefits. He would have no dependents benefits based on his wife's work record, and no survivors benefits if she dies before him.

In addition to a reduction in benefits if the husband starts receiving benefits before reaching full retirement age, a married couple with only one retirement benefit is faced with two Social Security rules:

- If the husband delays his retirement benefits claim until after full retirement age (up to age 70), both his retirement benefits and the wife's survivors benefits (if she outlives him) will go up.
- The wife can't claim dependents benefits (spousal benefits) until the husband claims his retirement benefits.

### Early Retirement or Dependents Claim Reduces the Other Benefit for You as Well

You're eligible for a reduced retirement benefit at age 62. If you claim retirement benefits at any time before you reach full retirement age, that early claim permanently reduces those benefits by 0.52% per month (until you reach full retirement age). The same is true for dependents benefits: If you claim dependents benefits between age 62 and full retirement age, those benefits are permanently reduced by 0.52% per month.

Many people don't realize, though, that claiming either early retirement or early dependents benefits also permanently reduces that other benefit for you. You can't claim early retirement benefits and then switch to full dependents benefits, or claim early dependents benefits and then switch to full retirement benefits. As soon as you claim one of those benefits early, the other one is also reduced by the same percentage.

**Note:** You claiming early retirement benefits does not reduce the amount of your spouse's or child's dependents benefit amount. Nor does your early retirement benefits claim affect the amount of the survivors benefits you can claim based on your spouse's work record when your spouse dies.

### Both Spouses Eligible for Their Own Retirement Benefits

In most couples now reaching retirement age, both spouses have earned Social Security retirement benefits. That means that each spouse is also entitled to dependents (and, eventually, survivors) benefits based on the other spouse's work record. As soon as one spouse claims retirement benefits (at age 62 or later), the other (once reaching age 62) can claim dependents benefits (spousal benefits). And when one spouse dies, the other can claim survivors benefits as early as age 60 (or earlier if disabled, or if caring for the deceased spouse's minor or disabled child).

All this operates, though, under one basic principle: You can claim only one benefit (the higher), not both.

There is one exception that allows switching from one benefit to another, resulting in higher lifetime total benefits, and that involves survivors benefits. You can claim early retirement or dependents benefits, then switch to survivors benefits. Ordinarily, at age 62, a spouse might be reluctant to claim reduced retirement or dependents benefits because the reductions are permanent. Plus, an early claim of either of those benefits permanently reduces the other one, too. But the same is not true for survivors benefits; claiming your own early retirement or dependents benefits (while your spouse is living) doesn't affect the amount of survivors benefits you can collect (after your spouse has died). (Note, though, that if your spouse claims early retirement benefits, your eventual survivors benefit on your spouse's record will be reduced.)

So, if you have a considerably older spouse who has a higher earnings record, or your higher-earning spouse is in poor health, you might want to claim your retirement or dependents benefits early (whichever is higher), relying on the fact that you will be able to switch to full survivors benefits in the not-too-distant future.

## **Worker With Minor Child**

A worker approaching full retirement age might want to delay claiming their retirement benefits for a year or more, up to age 70, to get the benefit of a permanently higher retirement benefit amount, and also a higher amount for a surviving spouse. But if the worker has a minor child, the child would be eligible for dependents benefits as soon as the worker claims retirement benefits. This presents a conflict: Either wait to claim retirement benefits and therefore get a higher delayed retirement benefit but no dependents benefits for the child, or get dependents benefits now for the minor child but lose out on the higher delayed retirement benefits. ●

## Supplemental Security Income

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**A**lmost eight million people receive monthly benefit amounts from Supplemental Security Income (SSI), a program jointly operated by the federal and state governments and administered by the Social Security Administration. SSI is intended to guarantee a minimum level of income to financially hard-pressed older, blind, and disabled people.

SSI eligibility is based on your age or disability and on financial need, as determined by both your income and your assets. SSI benefits do not depend on how long you've worked or on how much you've paid into the Social Security system.

You must be quite financially needy to qualify for SSI payments; your income and assets must be so low that many people with no income other than their Social Security retirement benefits aren't eligible for SSI. However, others whose Social Security retirement benefit is low, or who aren't receiving any benefits, might receive a small SSI payment.

Despite these tight restrictions, if, after reviewing the rules explained in this chapter, you think you might be close to meeting the requirements for SSI eligibility, it could be worth your while to apply for it. If you qualify for SSI, you could also be eligible for Medicaid (discussed in Chapter 16) and food assistance from SNAP ("food stamps"), as well as free rehabilitation and home care programs, should you need them.

## Who Is Eligible

You must meet four basic requirements to be eligible for SSI cash benefits:

- You must be 65 or older, or blind or disabled.
- Your monthly income must be less than a certain minimum amount established by the state in which you live.
- Your assets must be worth less than \$2,000, or \$3,000 for a couple, although certain items are exempted from this amount—most importantly, your car and home.

- If you're a new applicant for SSI benefits, you must be a citizen of the United States or meet strict requirements for longtime residency, military service, or political asylum or refugee status. Some legal permanent residents of the United States might be eligible for SSI benefits if they're blind or disabled.

**TIP**

**The rules for each of these requirements are complicated,** but the complications almost always make it easier for you to qualify for SSI benefits than you might imagine. Generally speaking, you're permitted to have more income and assets than the initial figures indicate (more on this below).

## Blind or Disabled

If you're younger than 65, you might be able to qualify for SSI payments if you're blind or disabled.

You're considered blind if your vision is no better than 20/200 or your field of vision is limited to 20 degrees or less, even with corrective lenses. (There are a few other ways to qualify as legally blind as well.)

You're considered disabled if you have a physical or mental impairment that prevents you from doing any substantial gainful work and that's expected to last at least 12 months or to result in death.

This definition of disabled is the same as the test used for Social Security disability insurance benefits. (See Chapter 3.) But unlike the Social Security disability program, which looks at only the income you currently earn in order to determine whether you're doing substantial work, SSI looks at income from all sources and measures that income in a more complicated way.

## Citizens or Longtime Residents

SSI benefits are generally available only to U.S. citizens and longtime legal residents. Noncitizens must fall within one of the narrow categories described below.

The restrictions hit some of the country's neediest people the hardest. These are people, often elderly, who have lawfully immigrated to this country to join their children or siblings, only to be met here by joblessness and poverty.

As a noncitizen of the United States, you qualify for federal SSI benefits only if one of the following applies:

- You have a legal right to live in the United States and you were already receiving SSI benefits on August 22, 1996.
- You were legally living in the United States on August 22, 1996, and you're now blind or disabled.
- You're a lawful permanent resident of the United States (a "green card" holder) and you or your spouse have worked for at least 10 years in this country, having paid at least the minimum Social Security taxes to qualify for 40 quarters of work credits (see Chapter 1 for information about how work credits are earned).
- You're a veteran (honorably discharged) or an active duty member of the U.S. Armed Forces, or the spouse or child of one.
- You have been granted political asylum or refugee status; however, your benefits in this situation will last for only seven years after you've been admitted to the country.



### RESOURCE

**For a more detailed discussion of immigrants' eligibility for SSI:**

See the National Immigration Law Center website at [www.nilc.org](http://www.nilc.org) or contact their Los Angeles office at 213-639-3900.

### State Benefits Might Be Available

Nondisabled noncitizens who don't fall into one of the above categories are generally not eligible for federal SSI benefits. But when you reach age 65, your state might provide you with state supplement benefits as well as food stamps. If you don't fall into one of the above categories, you could still apply for both federal and state SSI assistance; you might be entitled to state benefits even if you're denied federal SSI.

### Income Limits

To figure out whether your income is low enough to qualify for SSI, you first need to understand that there might actually be two SSI payments:

- the basic federal SSI payment, and
- a state supplemental payment (SSP) in some states. Most states pay an additional amount over and above the federal benefit, and some of these states pay it alone if you qualify for it, even if you don't qualify for the federal payment.

Not all your income is counted when deciding whether you qualify for SSI. In fact, more than half of your earned income—wages and self-employment income—is not counted. And even though you might have income over the allowable maximum for federal SSI payments, you might still qualify for your state's supplemental payment. That's because a few states set a higher income limit than the federal SSI program does, making it easier to qualify for those states' supplemental payment than for the federal one. (See "Benefit Amounts," below.)

The federal SSI limit on counted income is \$943 per month for an individual (this means a total monthly earned income of about \$1,900), or \$2,500 per month for a couple. The exact figure varies

from state to state. In many states, you might qualify for the state's SSI supplemental payment—as well as Medicaid, SNAP food stamps, and other assistance—even if your counted income was too high to qualify for federal SSI.

### **Income That Is Counted**

In general, half of any income you earn in wages or self-employment, plus any money you receive from investments, pensions, annuities, royalties, gifts, rents, or interest on savings is counted toward the SSI limits. Social Security benefits are also considered counted income. In addition, if you receive free housing from friends or relatives, SSI will attribute some value to that housing and reduce your SSI benefit. (See “Reductions to Benefits,” below, regarding outside support.)

### **Income That Is Not Counted**

Some specific amounts of money and support are not counted in determining whether you qualify for SSI benefits.

SSI won't count:

- the first \$20 per month you receive from any source—except other public assistance based on need, such as General Assistance
- the first \$65 per month of your earned income—wages or self-employment
- one-half of all your earned income over \$65 a month
- irregular or infrequent earned income—such as from a one-time-only job—if such income isn't more than \$10 a month
- irregular or infrequent unearned income—such as a gift or dividend on an investment—up to \$20 per month
- food stamps, energy assistance, or housing assistance from a federal housing program run by a state or local government agency
- some work-related expenses for blind or disabled people that are paid for through public assistance
- some other types of one-time payments, such as tax refunds, reimbursement for financial losses such as insurance payments

for medical bills, or compensation for injury to you or your property, or

- up to \$100,000 in a special “Achieving a Better Life Experience” (ABLE) bank account, if you became disabled before age 26.

### Differences in Local Rules

Keeping in mind that different income limits apply in various states, one general suggestion applies to everyone: If you’re age 65, blind, or disabled, and you’re living on a small fixed income, and you have relatively few assets, apply for SSI benefits. The local Social Security or social welfare office might consider certain income differently than you do, and you might be pleasantly surprised to gain some help from SSI.

**EXAMPLE:** Carmela receives Social Security survivors benefits of \$310 a month and a \$40-per-month private pension payment, for a total of \$350 in regular unearned income. She also receives a quarterly dividend check; the most recent was \$15.

The dividend check would not be counted at all, because it’s infrequent income less than \$20 per month. The first \$20 of income from any source isn’t counted, so the \$350 total of unearned income would be reduced to \$330 of countable income.

Carmela also earns \$210 a month doing part-time work. Since the first \$65 a month of earned income isn’t counted, her earned income amount would be reduced to \$145; and since one-half of all earned income over \$65 a month isn’t counted, half of \$80 (\$145 – \$65) wouldn’t be considered for SSI purposes.

This leaves Carmela with \$105 countable, earned income to be added to the \$330 countable unearned income for the month, for a total of \$435 countable income. Since this amount is under the basic SSI qualifying limit of \$943 per month (in 2023), Carmela would be eligible for a federal SSI payment (though it would be reduced because of her income). Because Carmela lives in New York, where there is a small state supplemental benefit, she might be eligible for that amount as well. (See “States With Federally Administered Supplements,” below.)

## Asset Limits

In addition to the limits on your income, SSI rules limit the amount of assets and other resources you can have and still qualify. The general limit is \$2,000 in assets for an individual, \$3,000 for a married couple living together. But as with the rules regarding income, people are actually allowed more assets than these figures seem to indicate (most importantly, your home, household goods, and car—see below).

## Assets That Are Counted

The assets or resources that are counted by SSI include money in the bank, investments of any kind, real estate other than a primary residence, and personal property and household goods over certain limits.

SSI also counts any money or property in which you have an interest, even if you're not the sole owner. If you have a joint bank account with someone, SSI will consider that you own the entire account, because you have access to all of it (but if a co-owner of the account also receives benefits, SSI will count only half the account as belonging to you).

## Periodic Review of SSI Eligibility

Social Security periodically reviews your SSI eligibility and the amount of SSI you receive. These reviews take place every one to six years. When you receive a notice of review, you will have to produce the same kinds of information as you did for the original application: your income, assets, living arrangements, and, if claiming based on a disability, updated medical information. Often, most of this process can be handled by mail or telephone, although you might have to make a trip to the Social Security office for an interview. However, you do need to regularly report changes that might affect your eligibility, including changes in your income, address, living arrangements, and marital status.

If you hold any property in “joint tenancy” with someone else, SSI will consider that you own the entire property. If you have only a partial interest in some property—for example, an ownership interest in a family home along with other family members, and you don’t hold the property in joint tenancy—SSI will determine how much your individual ownership portion is worth and count that as an asset.

### **Assets That Are Not Counted**

You’re allowed to have more property than the \$2,000 and \$3,000 limits first seem to indicate. Several important categories of assets are not counted in determining your eligibility for SSI benefits. They include:

- your home and the land it sits on, regardless of value, as long as you live in it
- one automobile, regardless of market value
- your personal property and household goods—such as clothing, furniture, appliances, tools, sporting goods, hobby or craft material, and pets
- wedding and engagement rings, regardless of value
- property needed for medical reasons, such as wheelchairs, hospital beds, and prosthetics
- property essential to “self-support”—such as tools and machines used in your trade—up to a value of \$6,000
- life insurance policies with a total face value of \$1,500 or less per person, and term life insurance policies with no cash surrender value, and
- burial spaces for you and your spouse, plus a specially earmarked fund of up to \$1,500 for funeral and burial expenses.

**EXAMPLE:** Rose and Peter are living on Peter’s Social Security retirement benefits and on Rose’s pension. They qualify under SSI income limits and have the following assets: their home; a five-year-old car; \$1,500 in savings; stocks worth \$500; furniture and electronics worth about \$550; Peter’s tools, worth about \$600; and Rose’s jewelry, which, aside from her wedding band, is worth about \$200.

Despite the fact that Rose and Peter's house is now worth \$120,000, it isn't counted as an asset. The value of their car isn't counted at all. Their personal property and household goods add up to about \$1,350, but none of it will be counted.

Their total counted assets would be their savings and stocks worth about \$2,000. Since the SSI limit on resources is \$3,000 for a couple, Rose and Peter would qualify for SSI benefits.

### **Selling or Spending Assets**

Even if your countable assets appear to be over the limit, you might still qualify to receive some SSI benefits. The Social Security Administration has a special program where you can begin to receive SSI payments if you sell or spend enough property to come under the limits within a certain time period. That time period begins when you apply for benefits and runs nine months for real estate and three months for personal property and liquid assets.

**EXAMPLE:** Mariana applies for SSI benefits when she has more than \$5,000 in the bank. She's told that she won't be immediately eligible for benefits unless that amount is reduced to \$2,000 within the next three months. Mariana had always planned to be buried near her deceased husband, but never got around to making the arrangements. She now buys a burial space for \$2,000 in the same cemetery as her husband. Then she puts \$1,000 in a special account to cover her funeral expenses. Since funeral and burial amounts aren't counted as assets under SSI rules, and her assets are now down to \$2,000 (within three months of her application for SSI), she will begin receiving benefits as of the date she applied.

However, the sale or transfer must be a real one. Simply transferring title on the property to someone else while you keep control or use of it isn't enough; neither is selling something for a small token amount.

If Social Security does find out that you sold or transferred an asset for less than its market value, you could be ineligible for SSI for a certain number of months, depending on the value of the asset (up to a maximum of 36 months). The SSA can look at any asset transfer or sale that's less than three years before the date you apply for SSI.

## Benefit Amounts

Because supplement payments vary from state to state, the amount of your SSI check will vary depending on where you live, as well as on the amount of your countable income. The basic federal SSI payment for 2024 is \$943 a month for an individual and \$1,415 a month for a couple. These figures usually go up on January 1 each year; the amount of increase depends on the rise in the federal Consumer Price Index.

## States With Federally Administered Supplements

A number of states pay supplements to the basic federal SSI amount. In some of these states, the supplement is added on directly to the federal SSI payment. This means that a person needs to apply only once, to Social Security, to receive both the basic amount and the supplement. Both amounts are included in one payment, which is administered by Social Security.

The supplement amount might be different for blind and disabled recipients. Also, the amount might vary depending on whether the person receiving SSI lives alone, in the home of a family friend, in congregate living arrangements, or in a nursing facility.

States in which SSI recipients receive a federally administered supplement include:

California	Iowa	Pennsylvania
District of Columbia	Nevada	Rhode Island
Hawaii	New Jersey	Vermont

### SSI Might Get You Medicaid

If you're found eligible for SSI benefits, most states will also give you free health coverage through the Medicaid program (called "Medi-Cal" in California). You don't need to qualify for Medicare to get Medicaid. For an explanation of what Medicaid offers, see Chapter 16.

Your enrollment is automatic in many states, including Alabama, Arizona, Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Georgia, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Montana, New Jersey, New Mexico, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Washington, West Virginia, Wisconsin, and Wyoming.

In other states, you must separately apply for Medicaid after being granted SSI. This usually involves submitting an application to a state social services or welfare office. Some states will automatically enroll you based on your SSI grant. Others have slightly more restrictive eligibility standards and will separately evaluate your Medicaid application.

The states that automatically enroll you after you separately apply for Medicaid are Alaska, Idaho, Kansas, Nebraska, Nevada, Oregon, and Utah. The states that make an independent decision about whether you're eligible for Medicaid are Connecticut, Hawaii, Illinois, Minnesota, Missouri, New Hampshire, North Dakota, Oklahoma, and Virginia.

In addition, Delaware and Montana have federally administered supplements that are available only to people who live in protective care arrangements (Delaware administers the state supplement for all others). Social Security administers the supplement for some SSI recipients in Iowa and Michigan.

## States With Their Own Supplements

Most other states provide some kind of supplement to the basic federal SSI payment, but the kinds of supplements and rules for qualifying are administered entirely by the states. You must apply for these state supplements separately, at the social welfare agency in the county where you live.

Your supplement payments might range from a few dollars to a few hundred dollars above the basic federal SSI payment, or include noncash assistance with food, housing, transportation, and/or medical care. The amounts change frequently, based on the willingness of state legislatures to provide for SSI recipients in their state budgets.

## Reductions to Benefits

Your maximum SSI benefit amount will be reduced by income you make over allowable countable limits, as dictated by a number of specific rules.

### Limit on Earned Income

Your benefits are reduced by one dollar for every two dollars more than \$65 per month that you earn in wages or self-employment.

**EXAMPLE:** Ronda has a part-time job at which she earns \$280 a month. She is entitled to the basic federal SSI benefit of \$943 per month, but that amount is reduced by \$107.50 because of her earnings. (The total of \$107.50 is arrived at by taking the amount of her earned income that is more than \$65 (\$215) and dividing it in half—\$1 out of every \$2 over the limit.) Her monthly income would then be her earnings of \$280 plus her SSI benefit of \$835.50, for a total of \$1,115.50.

## Limit on Unearned Income

Your benefits are reduced dollar for dollar by the amount of any *unearned* income you receive that is more than \$20 a month. This unearned income includes Social Security benefits, pensions, annuities, interest on savings, dividends, or any money from investments or property you own.

**EXAMPLE:** Carl lives alone in a home he owns. His only income is his Social Security retirement check of \$330 per month. From Carl's \$330 Social Security check, \$20 is excluded, making his total countable unearned income \$310. Since he has no earned income, his total countable income would be the same: \$310. In the state in which Carl lives, the basic SSI payment is \$1,000 per month. From this, Carl's total countable income of \$310 is subtracted, leaving \$690 as Carl's monthly SSI payment.

## Limit on Outside Support

Your basic SSI payment will be reduced by up to one-third if you live in a relative's or friend's home without paying rent and/or you receive regular, substantial support in the form of food, clothing, and personal items.

**EXAMPLE:** Adam lives in his daughter's house without paying rent. His daughter also provides Adam all of his meals. Adam's only income is his \$370 per month Social Security check. The basic monthly SSI benefit of \$943 in Adam's state would be reduced by one-third (\$314) because Adam receives both regular food and free lodging from his daughter. This would leave an SSI amount of \$629. In determining Adam's countable income, SSI doesn't count \$20 of his \$370 Social Security check, leaving a total countable amount of \$350. This \$350 is subtracted from his reduced SSI benefit, leaving an actual monthly SSI payment to Adam of \$279, in addition to his Social Security benefit.

## Limit on Working Couples

A final example shows how SSI amounts are figured for a couple, and how SSI payments change when one person takes a job.

**EXAMPLE:** Beverly marries Carl and together they collect a monthly Social Security check of \$755. In figuring Carl and Beverly's SSI payment, \$20 would be exempted from the \$755 Social Security check, for a total countable income of \$735 a month. That \$735 would be subtracted from the basic SSI benefit for a couple, which in Carl and Beverly's state is \$1,500, leaving a monthly SSI payment of \$765.

When Beverly takes a part-time job paying \$100 a month, their SSI payment changes. Beverly and Carl's countable unearned income is still the same, \$735 a month—their Social Security check minus \$20. But now they have an earned income of \$100 a month. The first \$65 of this \$100 is not counted under SSI rules. Of the remaining \$35 of earned income, only one-half of it, or \$17.50, is considered counted income. Only \$17.50 is added to the \$735 of counted unearned income, making a total countable income of \$752.50 a month.

The basic SSI benefit for a couple in Carl and Beverly's state is \$1,500 a month. The \$752.50 countable income would be subtracted from this amount, leaving a monthly SSI payment to Carl and Beverly of \$747.50. Their monthly income would be their Social Security check of \$755, plus their part-time income of \$100, plus their SSI check of \$747.50. ●



## Applying for Benefits

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Once you get an accurate estimate of how much your Social Security benefits will be and decide when it's best to begin receiving them, applying for those benefits is usually fairly simple. For retirement, dependents, or survivors benefits, most people will already have on hand all the documents needed and can complete their application in a single trip to a local Social Security office; some of the work can also be done ahead of time online. Applying for disability benefits is more complex and usually takes longer, but it can also go smoothly if you're prepared with the proper documents. This chapter discusses the application process for each type of benefit and explains how to organize the required documents.

## **Retirement, Dependents, and Survivors Benefits**

The application processes for retirement benefits, dependents benefits, and survivors benefits all involve the same basic documents and procedures. The hardest part is figuring out the best time to claim benefits. For this, you must understand the relationship between your age and the amount you'll receive.

### **When to Claim Benefits**

You might be eligible for different types of benefits at different times in your life—for example, survivors benefits at age 60, based on your deceased spouse's work record, and retirement benefits at age 62, based on your own work record. And you are eligible for increased benefits for every month you wait to claim them up to age 70.

As a result, your decision about which benefits to claim and when to claim them should be based on how much each benefit would be (measured against the earnings limit for your age, if you intend to continue working) and other factors such as life expectancy and your current need for cash. (For reductions due to earnings, see Chapter 2; for reductions for working dependents,

see Chapter 4; for reductions for working survivors, see Chapter 5; and for options about choosing between different benefits and deciding when to claim them, see Chapter 6.)

To see how much each type of benefit would be at different ages, take a look at your Social Security statement, which you can view online (see Chapter 1). You should examine your statement about six months before you might claim any benefit. This will give you plenty of time to decide what's best for you, and to get the process started if you choose to file soon for benefits.

## **How and Where to File Your Claim**

All Social Security claims for benefits can be filed at local Social Security offices. In addition, an application for retirement, dependents, survivors, and disability benefits can be initiated by phone or through the internet (see “Begin your application process online,” below). Even online applications often require a visit to a local office to complete, however.

Most sizable cities have at least one local Social Security office, and in major urban areas there are usually several. To find the address and telephone number of the nearest office, go to [www.ssa.gov/locator](http://www.ssa.gov/locator) or call the SSA at 800-772-1213.

The following subsections describe how to get personal assistance with and local information about filing your claim.

## **Help on the Internet**

The Social Security Administration now offers a good deal of information and some of its application processes online at [www.ssa.gov](http://www.ssa.gov). Some of the information can be hard to locate, but Social Security is making good progress in helping people to apply for many Social Security benefits online.

You can also find a lot of information to help you with a disability claim at [www.disabilitysecrets.com](http://www.disabilitysecrets.com).



## ONLINE

**Begin your application process online.** Social Security allows people to use its website to file many types of claims for benefits, which might save you one or more trips to a Social Security office.

You can file an online application—or at least begin the process—for:

- retirement benefits
- disability benefits
- dependents benefits (spousal benefits only)
- Supplemental Security Income (SSI)
- Medicare Part A and Part B, and
- Extra Help for Medicare Part D.

To learn more about what Social Security allows you to do over the internet, see its webpage “Online Services” at [www.ssa.gov/onlineservices](http://www.ssa.gov/onlineservices).

## Help in Person

A Social Security worker in your local office is usually the best source of information and assistance for filing your claim. Face-to-face conversation is almost always more productive than discussions over the phone or via email. And when you’re ready to file your application, handing it to a real person is more secure than sending it by mail.

Most offices permit you to phone in advance and make an appointment to speak to someone personally—a good idea, because you might face long lines if you show up unannounced.

Whenever you consult with someone in a Social Security office, write down the person’s name and keep it with your other Social Security papers. That way, when you next contact the office, you can ask to speak with the same person, or you can refer to that person if a question arises about what occurred during your previous visit.

When filing papers, make sure the office gives you some proof that you filed—for example, bring along your personal copy of the application and ask them to stamp it “received” with the date.

## Help Over the Telephone

Social Security offers advice and help over its toll-free phone line at 800-772-1213. The phone lines are open between 7 a.m. and 7 p.m. local time Monday through Friday. It’s busiest at the beginning

of the month and early in each week, so choose your time to call accordingly. While the phone line has long wait times, you can accomplish a great deal over the phone. The Social Security workers can answer your general questions about benefits and rules and tell you how to fill out or submit a particular form. They might also be able to start your claim process for retirement and dependents benefits.

However, the application process can't be completed over the phone. Before your claim can actually be processed, you'll have to sign a written application and bring certain original documents to Social Security (see "Documents You'll Need," below).

### **For Early Retirement, Sign Up Three Months Before Your Birthday**

If you decide to receive a Social Security benefit payment as soon as you reach the youngest eligible age, file your claim three months before the birthday on which you'll become eligible. This will give Social Security time to process your claim so that you'll receive benefits as soon as you become eligible. If you file a claim for early retirement after you first become eligible, you can't get benefits retroactively for the months during which you were eligible but had not applied. (If you file after full retirement age, on the other hand, you can receive six months of retroactive benefits.)

What about Medicare? At age 65, anyone eligible for Social Security benefits is also eligible for Medicare coverage (explained in Chapter 13). Even if you aren't going to claim Social Security benefits by the time you reach age 65, you should sign up for Medicare coverage three months before your 65th birthday. There's no reason to delay signing up for Medicare, and waiting until after your 65th birthday will delay coverage. If you have current health care coverage through your employer when you turn 65, you might want to sign up for Part A only. (See Chapter 12 for more information.)

### **Getting the Best Results: Preparation, Patience, Perseverance**

Social Security offices are usually understaffed. Although individual Social Security workers are often helpful, polite, and well versed in the various regulations that govern Social Security programs, the maze of rules, when added to normal human fallibility, inevitably makes for occasional delays, misunderstandings, and mistakes.

It's up to you to help yourself. The most important thing is to keep your papers organized. During the benefit application process, you can mail papers and forms to your local Social Security office. However, it's best to deliver important papers—any original document or certified copy—in person. That way, the papers not only will be sure to get to the local office but also will go directly into your file. This will cut some time off the process and will help to avoid the misadventures that sometimes befall papers that go into Social Security's incoming mail stacks. Keep copies of any form or document you submit to Social Security.

If the local Social Security office asks to see the original or a certified copy, it will usually make a copy on the spot and return the original to you. It's also best to keep a copy in your files in case the original gets lost.

## **Documents You'll Need**

Whether you file for a Social Security benefit in person at a local Social Security office or do all or some of it online through the Social Security website, you'll need to have certain personal papers or information. What you need will depend upon the type of benefit you're applying for, as explained below.

Most documents required by Social Security must be originals or certified copies. However, if you want to apply for benefits right away but don't yet have all your documents together, file your claim

anyway—either by phone, on the internet, or by going to your local Social Security office. The Social Security workers will advise you about how to get the documents you need, and, in the meantime, the application process can begin.



#### CAUTION

**Make sure all your papers can be traced to you.** On any copy of a document you bring or send to Social Security, write your name as it appears on your benefit application and your Social Security number. If you're filing for survivors or dependents benefits, also include the name and Social Security number of the person on whose work record you're claiming benefits. If you bring or send an original document, clip a piece of paper to it with those names and numbers.

When you apply for any type of benefit, bring with you the number of your account at a bank, a credit union, or another financial institution. Social Security will arrange to have your monthly benefit payment directly deposited to your account. Direct deposit is now used for all Social Security and SSI beneficiaries. It saves money for the Social Security Administration and also avoids the problem of lost or stolen checks.

### Retirement Benefits

You may need some or all of the following documents or information to apply for retirement benefits:

- your Social Security number. You don't need your actual Social Security card.
- your birth certificate. If you don't have a birth certificate, bring any other evidence of the date of your birth: baptism record, military papers, immigration papers, driver's license, or passport.
- your military discharge papers, if you served in the military, and
- your most recent W-2 tax form or federal self-employment tax return.

## **Dependents Benefits**

You may need some or all of the following documents or information to apply for dependents benefits:

- marriage certificate, if you're applying for benefits based on your spouse's work record
- divorce papers, if you're applying as a divorced spouse, and
- birth certificate of any child claiming benefits. If you don't have a birth certificate, bring other evidence of the date of your child's birth: baptism record, immigration papers, or passport.

## **Survivors Benefits**

You may need some or all of the following documents or information to apply for survivors benefits:

- Social Security number of the deceased person on whose work record you're claiming benefits, and your own Social Security number
- divorce papers, if you're applying as a divorced spouse
- death certificate of your deceased spouse or ex-spouse
- your birth certificate and those of your children who are claiming benefits. If a birth certificate isn't available, bring other evidence of date of birth: baptism record, military papers, immigration papers, or passport.
- if your spouse died within the past two years, the most recent W-2 tax form or federal self-employment tax return of your deceased spouse, and
- if applying as a surviving dependent parent who was receiving support from your son or daughter who died, a recent tax return from your deceased child showing you as a dependent, or proof of expenditures by your deceased child showing how much support was given to you, as well as your own most recent tax returns.

## If You Retire From Your Own Business

If you're self-employed and are claiming retirement benefits before your full retirement age, Social Security might require some extra information from you. They'll want to see evidence that you are really giving up full-time work and not merely shifting your pay (in name only) to someone else.

The reason for this concern is the rule that retirement benefits will be reduced if you are under full retirement age and earn income over certain limits. (See Chapter 2 for these limits.) Some people with their own businesses try to get around this rule by continuing to work and paying a relative instead of themselves, or by continuing to run the business but being paid only for reduced work time.

Social Security is likely to ask for information regarding your continuing involvement with your own business if any of the following are true:

- You maintain ownership of the business.
- Other family members are involved in the business and a relative is assuming most of your previous duties.
- You continue to work for the business at lower pay.
- You control the amount you work and how much you're paid, such that you could manipulate either one.
- Your relatives now receive the salary you previously earned.

Social Security might ask for such documents as the business's pay and personnel records, personal and business tax returns, stock transfer agreements, and business expense records. Try to contact your local Social Security office several months in advance, so that you'll learn what documents Social Security wants and have time to gather the documents.

If Social Security determines that you provide services to the business that exceed the amount you're paid—based on the time you spend, the level of your responsibility, and the value of services you provide—the agency might attach a dollar value to those services. If this dollar value exceeds the amount of earned income permitted for early retirement, your benefits might be reduced.

## At the Social Security Office

When submitting your claim at your local Social Security office, you'll be interviewed by a case worker. If you haven't already submitted your application form online or over the telephone, the worker will help you fill out the form. The worker will open a file for you, which from then on will contain all of the documents pertaining to your application.

Write down the name of the worker who talks with you, and their direct telephone line if available, so that you can speak with the same person if you need to call in to provide or receive further information. The Social Security worker will make copies of the documents you've brought and will explain what other information is needed to process your application.

If additional documents are needed, ask whether you can mail in copies instead of bringing originals in person.

When you first apply, don't expect to be told precisely how much your benefits will be. Exact benefit amounts are based upon the computerized records kept at the Social Security Administration's national records center. Your precise benefit amount will be calculated there.

Applications take six to eight weeks to be processed, but when you receive your first payment, it will include benefits back to the date you first applied, or to the date on which you're first eligible, whichever is later (except in the case of disability benefits).

## Withdrawing a Benefits Application

After you turn in your application for retirement, dependents, or survivors benefits, your work situation might change, altering significantly the amount of benefits to which you're entitled. This might, for example, occur in one of the following situations:

- you're offered a new position, a new job, or an increased salary
- you're not laid off from a job you expected to lose
- you're called back to work after a temporary job loss, or
- you simply change your mind and decide to continue working full time.

In any of these situations, if the income you earn at your continued work significantly exceeds the earnings limit for early retirement, it might eat up your benefits. If so, your decision to claim early benefits might prove to be a poor one, because you'll receive little or no benefit payments while you continue to work, and your benefit amount will be permanently lower than if you had waited to file your claim at a later age.

You can withdraw your application within 12 months after first becoming eligible for benefits, if you repay all the benefits you've received so far, including any Medicare premiums that were automatically paid out of your monthly Social Security payments. You'll also need to get the consent of all dependents who are receiving benefits based on your work record (except for certain divorced spouses). To withdraw your claim, go to Social Security's webpage on canceling your benefits application at [www.ssa.gov/manage-benefits/cancel-your-benefits-application](http://www.ssa.gov/manage-benefits/cancel-your-benefits-application), which explains the procedure and also the amounts you will have to repay. You can also make an appointment at a local Social Security office to discuss with a Social Security worker the process and consequences of withdrawing your application.

## Disability Benefits

Eligibility for disability benefits depends upon your physical or mental condition, and your inability to work because of that condition. (See Chapter 3 for a more detailed account of the eligibility requirements.) Because the disability determination process involves these qualifying standards, the application requires much more time and effort than other Social Security benefit applications do. You must get and keep your papers organized, and be thorough and persistent in your contacts both with doctors and with Social Security personnel.



### RESOURCE

**Proving that your particular medical condition makes you unable to work may not be easy.** This book provides an introduction, but for more information and specialized advice concerning particular physical and mental conditions, see *Nolo's Guide to Social Security Disability: Getting & Keeping Your Benefits*, by David A. Morton III, M.D. (Nolo).

## When to File Your Claim

You won't be paid any disability benefits until you've been disabled for five full months. This waiting period begins with the first full month after the date your disability began. That date is usually the date you stopped working, or significantly reduced your work hours, because of your physical or mental condition.

However, disability claims take two to eight months for an initial decision. So, don't wait for the five months of disability to pass before filing your claim. You don't even need to wait to gather all the necessary information and doctors' reports. You can file the claim as soon as your medical condition forces you off work and the doctors expect that it will prevent you from working for a year or more. You can complete the gathering of necessary documents while the claim is being processed, with the help of your local Social Security office.

### Fast Claims for Severe Medical Conditions

The Social Security Administration has created a streamlined disability benefits claims process for people with certain severe medical conditions. For these people, the Social Security Administration will process benefit claims within a few days or weeks of completing the application. There are more than 200 conditions for which this fast application process, called "Compassionate Allowance," applies. To see the list of conditions and to get more information, go to the Social Security website: [www.ssa.gov/compassionateallowances](http://www.ssa.gov/compassionateallowances).

## Documents You'll Need

When you file an application for Social Security disability benefits, whether online or in person at a local Social Security office, you may need some or all of the following documents or information:

- your Social Security number and proof of age (such as a birth certificate) for yourself and any person eligible for dependents benefits

- names, addresses, and phone numbers of doctors, hospitals, clinics, and other health care institutions that might have diagnosed your medical condition and given estimates of the length of time it's expected to keep you disabled, plus the approximate dates of your treatment. Although you're not required to produce medical records of your disability—Social Security can request them directly from doctors and hospitals—you might speed up the process if you bring copies of key medical records you already have.
- a list of where you've worked in the past 15 years and a description of the kinds of work you did
- a copy of the past year's W-2 forms, or your last federal income tax return if you're self-employed
- the dates of any military service
- information concerning any other type of disability payment you're receiving
- if your spouse is applying for dependents benefits based on your work record, the date of your marriage and of any prior marriages. A certified copy of divorce papers will provide this information.
- if you're applying as a disabled widow or widower, your spouse's Social Security number and a copy of the death certificate, and
- if you're applying as a disabled surviving divorced husband or wife, proof that your marriage lasted 10 years. Marriage and divorce papers will serve this purpose.

If you're physically unable to get to a Social Security office in person, or you're unable to complete the forms or meet other filing requirements, your application can be completed by your spouse, a parent, another relative, a friend, or your legal guardian. And once the initial claim has been filed, a service worker in the local Social Security office can assist you by having the Social Security office directly request necessary documents.

## How Your Eligibility Is Determined

Applications for disability benefits go through several stages. Initially, you'll fill out an application at a local Social Security office or online and provide documents regarding your age and employment. After that, however, the process becomes more complicated, as Social Security determines whether your condition is actually disabling according to its standards.

### Disability Determination Services

When your application has been completed, the local Social Security office will check to see that you're not working a significant amount and you meet all the general requirements regarding work credits for your age (see Chapter 3 for the work credit requirements). Then, the office will forward your claim to a Disability Determination Services (DDS) office in your state. The DDS office will use your medical records and employment history to decide whether you're disabled under the rules of the Social Security law.

The decision at DDS is made by a disability claims examiner with the help of a doctor or psychologist. They examine all of the medical records you provided with your application and might request more information from you, your doctors, and your employers.

Based on these records, the claims examiner and doctor determine whether your disability is expected to last more than one year and whether it's severe enough to interfere with your ability to continue performing any of the work you have done over the past 15 years. If they agree that you can't do your past work, they'll then determine whether your condition is so severe that you can't perform any type of "substantial gainful work." (See "Unable to Do Substantial Gainful Activity" in Chapter 3 for more on how Social Security determines this.)

If your existing medical records show your condition limits you from performing even the easiest type of substantial gainful work, you will be found eligible for benefits. If not, your claims examiner might request further medical records and/or refer you for a consultative physical examination.

## Enlisting the Help of Your Doctor

Your medical records will be the biggest factor in the state DDS office's determination of your eligibility for disability benefits. Therefore, what your doctor puts in your records can be all-important.

If possible, discuss the matter with your doctor before you file your application for disability benefits. Inform your doctor that you intend to apply, and ask your doctor to make specific notations in your medical records of how your physical activities—particularly work-related activities, such as walking, sitting, lifting, carrying—are limited or how your mental or emotional condition affects your ability to regularly perform work. Ask also for your doctor to make a note of when your disability reached a point that it likely interfered with your ability to work.

Don't ask the doctor to give an opinion about whether you're disabled according to Social Security guidelines. Doctors will readily describe a specific medical condition, but many are unwilling to give an opinion about your ability to do any work at all. And, in any event, the DDS evaluation team wouldn't accept your doctor's opinion on this ultimate question of eligibility. Instead, the DDS team will base its determination on its own evaluation of your condition and limitations as they appear in your medical records.

In determining the nature and extent of your disability, the DDS will rely most heavily on the opinions of medical doctors, nurse practitioners, physician assistants, and psychologists, as opposed to physical therapists, chiropractors, and other healers. This reflects the fact that physicians, nurses, and PAs have diagnostic tools—such as laboratory tests, X-rays, MRIs, and other procedures—that are not usually available to nonphysician healers.

## Medical Examinations

In some cases, the DDS claims examiner may not feel that they can come to a conclusion about your disability based on your existing medical records. They might request further reports from doctors

who have examined or treated you. And they might request that you undergo a medical evaluation called a “consultative examination.”

Social Security pays the cost of the additional reports, examinations, or tests. If you must travel outside your immediate area to get to a physical examination, Social Security can pay for the cost of that travel, if you request it.

This extra examination or testing is often done by a physician who has already examined or treated you. This is particularly true if one of your doctors is a specialist in the area of medicine that deals directly with your disability. In other words, if you’ve seen an orthopedic surgeon for your back problem, Social Security is likely to have that same doctor perform the consultative examination.

However, if you haven’t been treated by a specialist in the field—for example, if only your internist or general practitioner has treated you for a particular medical problem—Social Security will probably send you to another doctor for this examination.

Consultative examinations are limited to specific issues the DDS needs to clarify regarding your ability to work. The exam often involves certain kinds of tests that your doctor hasn’t recently performed and that give DDS specific information on the extent of your disability. For example, Social Security might order a consultative exam for range of motion tests if your disability involves restricted movement.

The DDS will set up the examination and send the doctor a written request for the information needed and any specific tests it wants performed. The doctor won’t conduct a general examination and won’t prescribe any treatment for you. On rare occasions, a representative from DDS will attend the examination to record specific test results. The doctor will send a report to DDS describing the results of the examination, but they won’t take part in the final decision about whether you’re eligible for disability benefits.

Even though you might not like the idea of going through another medical examination, especially if it’s by a doctor you don’t know, you must cooperate with the DDS to successfully process your disability claim.

## Vocational Rehabilitative Services

When you apply for disability benefits, you might be referred to your state's vocational rehabilitation agency for a determination of whether any of its services might be of help to you. These free services can include job counseling, job retraining and placement, and specialized medical assistance. The services can also train you to use devices—such as a modified computer keyboard—that might enable you to work despite your disability.

## Supplemental Security Income (SSI)

You can file a claim for SSI benefits at your local Social Security office at the same time you file for disability benefits. (See Chapter 7 for a full discussion of the SSI program.) If you file for SSDI, the claims representative will ask you if you're interested in also filing for SSI.

If you believe you might be close to the qualifying income and asset limits for SSI benefits, go ahead and apply. If your state offers a separate state-administered supplementary payment in addition to the basic federal SSI payment, you might have to apply separately for that supplement at your local county social welfare office.

The process of applying for SSI benefits is very similar to applying for Social Security benefits. You will need to provide the same general documents. (See “Retirement, Dependents, and Survivors Benefits,” above, for instructions.) However, unlike Social Security benefit applications, SSI benefit applications also require that you show records of your income and assets.

## Proof of Income and Assets for SSI

Regardless of whether you're applying for SSI payments due to disability or blindness or because you're over age 65, you must bring information regarding your income and assets. This includes:

- information about where you live: for homeowners, a copy of your mortgage papers or tax bill; for renters, a copy of your rental agreement or lease and the name and address of the landlord

- documents indicating your current earned income, such as pay stubs and income tax returns
- papers showing all your financial assets, such as bank books, insurance policies, stock certificates, car registration, and
- information about your spouse's income and assets, if the two of you live together.

Even if you don't have all these papers available, you can go to your local Social Security office and file your application for SSI as soon as you think you might qualify for assistance. The Social Security workers can tell you how to get whatever other papers and records are necessary, and in some instances will get copies of the required records for you.

### **Proof of Age If 65 or Older**

If you're age 65 or older, bring your Social Security number and proof of your age, such as a birth certificate. If you don't have a birth certificate, bring other evidence of the date of your birth: baptism record, military papers, immigration papers, driver's license, or passport. If you're already receiving any kind of Social Security benefit, you don't have to bring proof of your age.

### **Proof of Blindness or Disability**

The process for proving that you're blind or disabled for purposes of SSI benefits is the same as the disability determination process when qualifying for Social Security disability benefits. (See Chapter 3 for the medical eligibility requirements.) The information you need to gather and the process of applying for disability benefits is discussed in "Disability Benefits," above.

### **Proof of Citizenship or Qualifying Legal Residence**

For a reminder of what immigration status you must hold in order to qualify for SSI, see Chapter 7.

If you're a U.S. citizen, you'll need to prove your citizenship by showing a copy of your birth certificate, baptismal record, U.S. passport, or naturalization papers.

If you're a noncitizen, bring proof of your qualifications under one of the categories listed in Chapter 7.

For proof of work for 10 years (one way of qualifying for SSI as a permanent resident), bring your legal resident alien card ("green card") and Social Security numbers for yourself and your spouse. The Social Security or local welfare office will use the numbers to check your reported Social Security taxes.

If you seek to qualify as a veteran of the U.S. Armed Forces, bring evidence of honorable discharge from the military. You will also need a copy of your marriage certificate if you're seeking SSI as the spouse of a veteran.

## **Finding Out What Happens to Your Claim**

You won't find out from your local Social Security office whether your claim for benefits has been approved; that word has to come from the Social Security Administration in Washington, D.C.

### **Notification of Eligibility**

Social Security will notify you in writing whether your claim has been approved, how much your benefits will be, and when you will get your first check.

From the time the application is filed, a retirement, dependents, or survivors claim usually takes from four to eight weeks. A disability claim can take up to eight months.

For all retirement, dependents, or survivors claims, you'll receive benefits dating back to the date you first applied, or first became eligible if you applied before you reached an age of eligibility. The timing of Social Security disability payments is discussed below.

SSI benefits based on age usually begin four to eight weeks after you complete the necessary paperwork. If your claim is based on a disability that hasn't already been established for Social Security disability payments, it might take three to eight months. When you do finally get your money, however, it will cover the period from the month after you filed your claim.

If you were unable to work for more than five months before applying for Social Security disability benefits, you could get benefits going back to your application date. You can actually get retroactive benefits going back to 12 months before your application date, if Social Security determines that your disability actually began 17 months before your application date.

If your claim for any Social Security or SSI benefit is denied, the written notice of denial will state the reasons why. You have a right to appeal a denial of your claim. Your appeal must be submitted within 60 days from the date you receive written notice of the denial or other decision. (See Chapter 9 for appeal procedures.)

### **When You Need Money in a Hurry**

It's possible to get some SSI payments even before your claim is finally approved. If you appear to be eligible for SSI and you need immediate cash to meet a financial emergency, the Social Security office can issue you an advance payment. The amount of this emergency payment will be deducted from your first regular SSI check.

Similarly, if you've already qualified for Social Security disability benefits and you appear financially eligible for SSI, you can be approved for and begin receiving SSI benefits immediately.

If you're financially eligible for SSI and appear to meet the disability requirements, but your disability application hasn't yet been approved by Social Security, you might be able to receive SSI payments while your claim is being reviewed by the disability office. These are called "presumptive disability payments," and they don't need to be repaid. You can get up to six months of presumptive payments.

## Methods of Receiving Payment

All new beneficiaries receive their Social Security and SSI benefits by direct deposit into their bank accounts or with a Direct Express debit card. It is also possible for a representative payee to receive payments on your behalf. You must indicate on the application which payment option you choose. You can change your method of payment after you begin to receive benefits.

### Direct Deposit

Direct deposit has a number of advantages: You don't have to wait for your check to arrive in the mail, nor do you have to travel to your bank to deposit the check. And you don't have to worry about a check being lost or stolen.

When you first sign up for benefits, you'll give Social Security the name and address of your bank branch and the number of the account where you want the funds deposited.

If you change banks—or want to close one account and open another—you can change your direct deposit information online in your Social Security account or by calling Social Security at 800-772-1213. But don't close your old account until you see that your benefit has appeared in your new one. If your benefit continues to be deposited in the old account, contact your local Social Security office.

### Debit Card

Some Social Security recipients don't want to receive their payments by direct deposit. For example, you might not want to pay the bank charge to maintain an account. Or, you might be moving and temporarily won't have a local bank account. If, for any reason, you don't want to receive your benefit payment by direct deposit, you can arrange with your local Social Security office to receive your payments via a Direct Express debit card.

## Substitute Payee

If you're unable to handle your own banking, you can have a family member, close friend, or legal representative receive your benefit payments on your behalf. That person must spend the money according to your wishes or directions. This can be done informally, by simply adding the other person as a joint account holder on the bank account where Social Security deposits your check. The bank can make this arrangement for you.

If you need some oversight on how that person spends your benefits, you can have this other person officially appointed by Social Security as a representative payee. That person would then personally receive the benefit payments on your behalf. Social Security can also appoint someone to be your representative payee against your wishes if the agency believes you're unable to manage your finances.

Anyone proposing to be your representative payee must bring to the local Social Security office medical proof—for example, a letter from your doctor—that you're unable to handle financial matters for yourself. The representative payee must sign a sworn affidavit at the Social Security office stating that they will use the Social Security check solely for your benefit. The Social Security office will then verify your medical condition and the identity of the representative payee.

If a person has already been appointed by a court to serve as legal guardian or conservator, proof of that court appointment is all that is required to be appointed representative payee. But people who are named to act in powers of attorney don't automatically qualify as representative payees; they must still apply for representative payee status at the local Social Security office.

The rules require that a representative payee deposit and keep the money belonging to the person entitled to Social Security in a separate bank account and periodically file an accounting with Social Security to show how the money has been spent to care for the beneficiary. The representative payee should keep all bills and receipts in a systematic and organized way so they can be produced easily. ●

## Appealing a Social Security Decision

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No matter how certain you feel that you deserve Social Security benefits, the agency might have other ideas and deny your claim. Sometimes this is a mere mistake that can be corrected. More often, the decision was a matter of judgment, especially with disability claims, where questions about medical conditions, ability to work, or income levels are subjective and susceptible to different interpretations.

But if your application for benefits is initially denied or is granted but you're awarded less than you believe you deserve, that need not be the end of the matter. Virtually all decisions of the Social Security Administration can be appealed, and many appeals, especially with regard to disability, are successful.

If Social Security has denied a new benefit or reduced an existing benefit, you can appeal the decision as long as you follow some fairly simple rules and are willing to think creatively about how to present your case in a convincing way. You'll need to put yourself into the shoes of the Social Security workers who first denied your claim, try to understand their reasoning, and then provide convincing evidence so that the next person who sees your file during the appeal process won't view your claim in exactly the same way.

This chapter explains the four possible levels of appeal following any Social Security decision. The first level is called "reconsideration"; it's an informal review that takes place in the local Social Security or Disability Determination Services (DDS) office where your claim was filed.

The second level is a hearing before an administrative law judge (an ALJ); this is an independent review of what the local Social Security office or Disability Determination Services office has decided.

The third level is an appeal to Social Security's national Appeals Council in Falls Church, Virginia. And the final level is filing a lawsuit in federal court.

**RESOURCE**

**Get extra advice regarding disability appeals.** More than 90% of all Social Security appeals involve claims for disability benefits (including SSI). Most of these appeals revolve around whether the applicant's physical or mental condition actually prevents gainful employment. Proving this requires careful presentation of medical information as well as completing certain special forms. This book will give you an introduction to this process, but for more information and specialized advice for various physical and mental conditions, see *Nolo's Guide to Social Security Disability: Getting & Keeping Your Benefits*, by David A. Morton III, M.D. (Nolo), and [www.disabilitysecrets.com](http://www.disabilitysecrets.com).

**CAUTION**

**Beware of the time limit for filing appeals.** The same time limit applies to each step of the appeals process. From the date on the written notice of Social Security's decision—whether denying or granting a benefit—you have 60 days to file a written notice that you're appealing that decision to the next stage in the process. If you receive the notice by mail, you have an additional five days to file your notice of appeal.

## Reconsideration of Decision

When a claim for any type of Social Security benefits—retirement, disability, dependents, survivors—or SSI is denied, or an existing benefit is ended, or you receive an amount that's less than what you believe you're entitled to, the first step to appeal that decision is to request reconsideration.

If the negative decision involved a denial of Social Security benefits, follow the procedures discussed below. Some additional procedures to follow when appealing denial of an SSI claim are discussed in "Requesting Reconsideration of SSI Decision," below.

### Is an Appeal Worth the Effort?

The first question that might occur to you when considering an appeal is whether it is worth the effort.

Let's start with some encouraging numbers: A substantial percentage of decisions are changed on appeal, particularly disability appeals, half of which are favorably changed in the appeal process.

Appealing a Social Security claim need not be terribly difficult. If you properly organized and prepared your original claim, most of your work for the appeal has already been done. In many situations, the appeal will require little more from you than explaining once more why the information you already presented should qualify you for a benefit. In other cases, it will involve presenting one or two additional pieces of information that better explain your situation to Social Security personnel. In all disability cases, you should submit information from your doctor about more recent visits or test results.

A negative Social Security decision can affect your rights for many years. Because it's so important, and because the appeal process is relatively simple, it's almost always worth the effort to appeal, especially for a disability claim.

### Requesting Reconsideration of Decision on Initial Benefits Claim

To start the appeal process, you file a written request for review of the decision, called a *Request for Reconsideration* (SSA-561-U2). The form is available online from Social Security's website at [www.ssa.gov/forms/ssa-561.pdf](http://www.ssa.gov/forms/ssa-561.pdf). You can also obtain a copy at your local Social Security office or by calling Social Security at 800-772-1213. See a sample of the form below. If you were denied Social Security disability or SSI benefits for medical reasons, you can file a request for reconsideration online.

The printed form comes in duplicate: a top copy for the Claims Folder (the Social Security office's copy) and a bottom Claimant's Copy (for you). You fill in only the top part of the form. The information requested is straightforward: name, address, Social Security number, and type of claim—retirement, disability, dependents, or survivors.

The appeals process is explained in the sections below. Social Security also provides information about the appeals process on its website at [www.ssa.gov/benefits/disability/appeal.html](http://www.ssa.gov/benefits/disability/appeal.html).

## Completing the Request for Reconsideration Form

The first few lines of the *Request for Reconsideration* form are fairly simple. On the top left, fill in your own name, exactly as it appears on your Social Security card.

On the top right is the box for the Social Security claim number. Copy that number from the written decision about your claim that you received from Social Security.

The most important part of the form follows the words: "I do not agree with the Social Security Administration's (SSA) determination and request reconsideration. My reasons are: ...." On those lines, state briefly and simply why you think you were unfairly denied your benefits.

You need not go into great detail, because your entire file will be examined—including any additional materials you want to submit. Your statement should simply identify the problem, such as: "The decision that I am not disabled was based on insufficient evidence about my condition. I am submitting an additional letter from my doctor about my condition." Or: "The DDS evaluation of my disability did not take into account my inability to sit for prolonged periods."

Along with your completed *Request for Reconsideration* form, you need to submit a form called a *Disability Report—Appeal* (SSA-3441-BK) to explain any changes in your condition since you filed your original claim for benefits and tell Social Security about

Form **SSA-561-U2** (10-2022) UF  
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Social Security Administration

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### REQUEST FOR RECONSIDERATION

NAME OF CLAIMANT:	CLAIMANT SSN:	CLAIM NUMBER: <i>(If different than SSN)</i>
ISSUE BEING APPEALED: <i>(Specify if retirement, disability, hospital or medical, SSI, SVB, overpayment, etc.)</i>		

I do not agree with the Social Security Administration's (SSA) determination and request reconsideration.  
My reasons are:

### SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFITS (SVB) RECONSIDERATION ONLY

#### THREE WAYS TO APPEAL

I want to appeal your determination about my claim for **SSI** or **SVB**. I have read about the three ways to appeal.  
I have checked the box below:

- ☐ **CASE REVIEW** - You can pick this kind of appeal in all cases. You can give us more facts to add to your file. Then we will decide your case again. You do not meet with the person who decides your case.
- ☐ **INFORMAL CONFERENCE** - You can pick this kind of appeal in all SSI cases except for medical issues. In SVB cases, you can pick this kind of appeal only if we are stopping or lowering your SVB payment. You will meet with a person who will decide your case. You can tell that person why you think you are right. You can give us more facts to help prove you are right. You can bring other people to help explain your case.
- ☐ **FORMAL CONFERENCE** - You can pick this kind of appeal only if we are stopping or lowering your SSI or SVB payment. This meeting is like an informal conference, but we can also get people to come in and help prove you are right. We can do this even if they do not want to help you. You can question these people at your meeting.

#### CONTACT INFORMATION

CLAIMANT SIGNATURE - <i>OPTIONAL</i> :		NAME OF CLAIMANT'S REPRESENTATIVE: <i>(If any)</i>	
MAILING ADDRESS:		MAILING ADDRESS:	
CITY:	STATE:	ZIP CODE:	CITY: STATE: ZIP CODE:
TELEPHONE NUMBER: <i>(Include area code)</i>	DATE:	TELEPHONE NUMBER: <i>(Include area code)</i>	DATE:

#### TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION

1. HAS INITIAL DETERMINATION BEEN MADE? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>FIELD OFFICE DEVELOPMENT (GN 03102.300)</b> <input type="checkbox"/> NO FURTHER DEVELOPMENT REQUIRED <input type="checkbox"/> REQUIRED DEVELOPMENT ATTACHED <input type="checkbox"/> REQUIRED DEVELOPMENT PENDING, WILL FORWARD OR ADVISE STATUS WITHIN 30 DAYS
2. IS THIS REQUEST FILED TIMELY? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If "NO", attach claimant's explanation for delay. Refer to GN 03101.020)</i>	
<b>SOCIAL SECURITY OFFICE ADDRESS AND DATE APPEAL RECEIVED:</b>	<b>SSI CASES ONLY - GOLDBERG KELLY (GK) (SI 02301.310)</b> RECIPIENT APPEALED AN ADVERSE ACTION: <input type="checkbox"/> WITHIN 10 DAYS AFTER RECEIVING THE ADVANCE NOTICE; <input type="checkbox"/> AFTER THE 10-DAY PERIOD AND GOOD CAUSE EXISTS FOR EXTENDING THE TIME LIMIT <input type="checkbox"/> PAYMENT CONTINUATION APPLIES AND INPUT MADE TO SYSTEM

**NOTE:** Take or mail the **completed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila, or any U.S. Foreign Service post and keep a copy for your records.

Claims Folder

recent medical visits you've had. (You can also submit this form online.) Instructions for completing this form can be found in *Nolo's Guide to Social Security Disability: Getting & Keeping Your Benefits*, by David A. Morton III, M.D. (Nolo). In addition, you can submit a statement describing in more detail why you think Social Security's decision was incorrect.

You should also submit any other relevant materials to the agency, such as recent medical records or a letter from a doctor or an employer about your ability to work. Such new material might be crucial to winning your reconsideration request—government workers have a tendency to believe that their agency was right the first time, unless you give them something new and different to change their minds.

### The Importance of Reviewing Your File

Sometimes a Social Security or SSI claim is denied because a document or another piece of information that should be in your file is not there. Or perhaps some information in the file is incorrect or unclear. This happens most often on medical issues, where medical records are missing or the report from the consultative examination includes a mistake based on a misunderstanding with the doctor who did the exam.

The only way for you to find out if such mistakes exist is to look at your file, which should contain all documents related to your claim. After you file your *Request for Reconsideration*, call your local Social Security office to set up an appointment to see your file or have it sent to you on a CD.

If you find a mistake in the file, write a letter to Social Security explaining the situation. Send the letter to your local Social Security office, asking that it be made part of your file for reconsideration. And, as always, keep a copy of the letter.

This additional information does not have to be submitted by the 65th day after the written decision (the date by which the request itself must be filed). But if you're planning to submit it after your *Request for Reconsideration*, indicate this on the form and submit the material as soon as possible. (Use the space where you explain your disagreement with the decisions.)

Be sure to include your Social Security number and your claim number, in addition to your full name (as it appears on your Social Security card) and the date, on all material you send in. And keep a copy for your records.

## The Reconsideration Process

Your claim will be reconsidered by someone in the Social Security or DDS office other than the person who made the decision on it the first time around. The claims examiner will consider everything that was in your file when the decision was made, plus anything you've submitted to the office since the original decision.

Generally, you don't appear in person for this review; you don't have the right to speak face to face with the person making the decision, although you can request a chance to do so. But the person doing the review may request more information—from you, your doctors, or your employer—and might ask you to come in for an informal interview.

You will receive a written notice of the decision made on your request for reconsideration—usually within 30 days (except for disability claims). If 30 days go by with no word, contact the local Social Security office and ask about the delay. Reconsideration of a disability claim often takes five to eight months, particularly if new medical information has been provided during the course of the appeal. If several months go by with no contact, you can call the DDS office and ask them about your disability reconsideration.

Once you receive your written decision, you can, if the decision is negative, file a request for an administrative hearing. (See the discussion of administrative hearings, below, for more information.) You must file your request within 65 days of the date of the written decision.

### Continuing Your Benefits During an Appeal

In some circumstances, if you've already been receiving Social Security or SSI disability benefits, you can continue to receive them while Social Security is deciding your appeal. You can request this in either of the following situations:

- You've been collecting Social Security disability benefits and you're now appealing Social Security's decision to end your benefits because the agency determined that your condition has improved.
- You've been collecting SSI benefits and Social Security has decided that you are no longer eligible or that you are eligible for lower benefits.

If you want your benefits to continue during the appeal process, you must make the request to your local Social Security office within 10 days of the date you receive a written notice ending or reducing your benefits.



#### CAUTION

**Continued benefits might not be for keeps.** If you continue to collect benefits while appealing Social Security's decision to end those benefits, and Social Security denies your appeal, you might have to pay back the benefits you received during the appeal process.

## Requesting Reconsideration of SSI Decision

If you request a reconsideration of a decision regarding a claim for SSI benefits, you'll be asked to choose among three possible procedures listed on the *Request for Reconsideration* form. Which one you choose depends upon how and why you were denied:

- **Case Review.** If Social Security denied your claim for SSI because the agency says that you aren't disabled, you're entitled only to what's called a "case review." This means that you won't be permitted to meet face to face with the Social Security examiner deciding your claim. But you can add more documentation to your file to be reviewed.
- **Informal Conference.** If your claim for SSI benefits was denied for nonmedical reasons—such as your income or assets or your immigration status—you can request a case review or an "informal conference." This option permits you to speak with the person reviewing your claim and to show additional documents. You can also bring along anyone you want to help support your argument.
- **Formal Conference.** If you've been receiving SSI benefits but Social Security decides to end or reduce them, you can request a "formal conference." Despite the name, this option is actually an informal meeting at which you can explain your situation in your own words, present written materials, and have people come to the meeting and give information. It is only "formal" in the sense that the Social Security office can issue a legal summons to require people to show up and answer questions if they refuse to come voluntarily. If you want Social Security to force someone to appear, you must notify your local office several weeks before the hearing date.

## Informal Meetings During Reconsideration

You might have an opportunity to meet with the claims examiner who is reviewing your file during the initial reconsideration of your retirement, disability, dependents, or survivors claim. Or, you might meet with the examiner during a conference regarding an SSI claim. These meetings are very informal. You will be given the chance to explain, in your own words and in person, why you believe the decision denying or ending your benefits was wrong.

There are several things to bear in mind during one of these meetings:

- Focus on addressing whatever reason Social Security gave (in the notice denying or ending your benefits) to justify its decision. Perhaps it was changes in your condition, your income, or your work hours. Be strong and direct in explaining why the agency's reasoning was wrong. Don't dilute your argument by telling your life story or explaining your whole medical history.
- If, along with your appeal, you submitted material that wasn't in your original file, ask whether the examiner has had a chance to read it. If so, explain how the new material shows that the original decision was incorrect. If not, give the examiner copies of these new materials and ask that they read them before you continue with the meeting.
- There's no need to go over all the documents in your file except to point out what you believe are errors, or to focus on something in a document that you believe is important but that seemed to have been ignored or misunderstood in making the original decision.
- The claims examiner will ask you questions so that they can focus in on what Social Security considers important. Don't dismiss or ignore any question. Try to answer all questions clearly and directly. If there's other information—from your doctor or employer, for example—that you believe might help answer the question, tell the examiner and either direct the examiner to an existing document in your file or ask that you be allowed to provide the information at a later point, but before the examiner makes a decision.

### Informal Meetings During Reconsideration (continued)

- Be calm and polite. Social Security employees understand that the denying or ending of benefits is an emotional matter for you, but they did not make the initial decision, and they are human, so you won't do yourself any good by taking out your frustration on them.

## Administrative Hearing

If Social Security denies your claim again after reconsidering it, you can request a formal administrative hearing. This hearing will be held in front of an administrative law judge. The people in the office that denied your claim won't take part in the judge's decision. That means you have a good chance of having the denial of your claim reversed at this hearing, even if you have no new information to present.

### Requesting a Hearing

As with other steps in the appeal process, you must file a request for this hearing with your local Social Security office within 65 days of the date on the written notice of the decision after reconsideration.

Your request must be filed on a form called *Request for Hearing by Administrative Law Judge* (HA-501-U5), reproduced below.

Along with your completed *Request for Hearing* form, you will need to submit a form called a *Disability Report—Appeal* (SSA-3441-BK) to update your disability information (if disability is the basis of your claim for benefits). This is the same form you used in filing for reconsideration of your original disability claim. Complete instructions for completing this form can be found in *Nolo's Guide to Social Security Disability: Getting & Keeping Your Benefits*, by David A. Morton III, M.D. (Nolo).



## SEE AN EXPERT

**Consider getting assistance with hearing preparation from an outside professional, such as a lawyer or an advocate specializing in Social Security matters.** If the issue is whether your physical or mental condition qualifies you as disabled, it's particularly important to get help, because you'll need to gather and present evidence that's convincing enough to sway a judge's decision. Your best chance of reversing Social Security's decision comes at the administrative hearing, so you'll want to be as well prepared as possible at this stage.

## Completing the Request for Hearing by Administrative Law Judge Form

The first three sections of the form are straightforward. Section 4 of the *Request for Hearing by Administrative Law Judge* form asks you to state the reasons you disagree with the determination made on your claim. State your reasons here simply and briefly; for example: “The decision that I am not disabled was based on incorrect statements about the number of hours I regularly work. I am submitting letters from my coworkers explaining that I actually work fewer hours than stated in the decision ending my benefits.”

Section 5 includes two boxes to indicate whether you have additional evidence to submit. You should always check the first box—the one that says you do have additional evidence, which will allow you to submit a new written statement to the judge, as well as any letters or documents that weren't already in your file. If it turns out that you don't have any additional letters or documents to submit, at the hearing you can inform the judge that you have no new written materials but would like an opportunity to speak.

After you (and your representative, if you have one) have organized your papers and spoken with your doctor, your employer, or another person who can provide additional or clarifying information about your claim, you (and your representative) should write a detailed statement summarizing and arguing your claim. Send that statement to your local Social Security office to be placed in your

file, and also send it directly to the administrative law judge at the hearing office who will hear your claim.

Do this at least two weeks before your hearing date so that the administrative law judge will have a chance to read the statement before the hearing. If you don't prepare it in advance, bring it with you to the hearing and present it there.

In Section 6 on the hearing request form, you must indicate whether you want to attend the hearing in person. If you don't, the judge will make a decision based solely on the papers in your file. It's almost always to your advantage to be present at the hearing. Your presence puts a human face on your claim and shows the judge that you're truly concerned about the outcome. It also allows the judge to ask you questions that might not get answered if you aren't there.

If you check "I wish to appear at a hearing" in Section 6 but later decide not to attend the hearing, you must notify the hearing judge's office beforehand. If, on the other hand, you checked the box saying that you don't want to attend the hearing but later decide you do, contact the hearing judge's office as soon as you can. The hearing will probably have to be rescheduled to a later date.

Section 8 of the request for hearing form asks for your representative's name and address. If you don't have a lawyer or other representative by the time limit for filing your request for hearing, file the request without naming anyone. If later you obtain a representative, you can supply that information then.



#### CAUTION

**Timing might be important.** To make sure that all your evidence gets in your file and to the administrative law judge in time for your hearing, you must submit all new evidence—letters, documents, records that were not previously given to Social Security—within 10 days of filing your request for a hearing. So, even if you are ready to file a request for an administrative hearing immediately after you receive written notice of the reconsideration decision, it is a good idea to wait until you have gathered whatever additional information you want the hearing judge to see. This might delay slightly the date of your hearing, but it will allow you to make sure all your evidence will be considered there.

## Preparing for the Hearing

During the time between filing your request for a hearing and the hearing date, you should take several steps. First, discuss your claim with the attorney or representative who will assist or represent you at the hearing. (See “Lawyers and Other Assistance,” below, for suggestions on obtaining legal representation.) It’s important to make sure that your representative understands what you believe to be the most important part of your claim and that your representative has thoroughly reviewed any documents that you believe support your position.

Second, examine your file, either at your local Social Security office or at the hearing office. This allows you to see that all the papers you have given to Social Security have found their way into your file. It also allows you to review all of the positive and negative information that Social Security has collected, such as a report on your disability from a consultative examination. Call your local Social Security office to see when and where you can examine your file, or if an electronic file can be sent to you or your Social Security account.

Finally, ask for new statements or records from your medical providers or employers that respond to the reasons expressed by the Social Security office or DDS examiners for rejecting your claim. Submit copies to your local Social Security office and directly to the administrative law judge at the hearing office, while keeping the original and at least one more copy.

## The Hearing

After you file the request for hearing, you will be notified by mail of the hearing date and place. You’ll receive this notice about 75 days before the hearing.

If you can’t attend on that date, contact the office of the administrative law judge (ALJ) and arrange for a new date. Act quickly: Most hearing offices are reasonable about rescheduling, but if you wait until the last week to request a change and you don’t have a

Form **HA-501** (06-2022)  
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### REQUEST FOR HEARING BY ADMINISTRATIVE LAW JUDGE

(Take or mail the **completed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila or any U.S. Foreign Service post and keep a copy for your records)

See Privacy  
Act Notice

1. Claimant Name	2. Claimant SSN	3. Claim Number, if different
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4. I REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE. I disagree with the determination because:

An Administrative Law Judge of the Social Security Administration's Office of Hearings Operations or the Department of Health and Human Services will be appointed to conduct the hearing or other proceedings in your case. You will receive notice of the time and place of a hearing at least 75 days before the date of hearing from the Social Security Administration, and 20 days before the date of hearing from the Department of Health and Human Services.

5. I have additional evidence to submit. <input type="checkbox"/> Yes <input type="checkbox"/> No Name and source of additional evidence, if not included.  Submit your evidence to the hearing office within 10 days. Your servicing Social Security office will provide the hearing office's address. Attach an additional sheet if you need more space.	6. Do not complete if the appeal is a Medicare issue. Otherwise, check one of the blocks  <input type="checkbox"/> I wish to appear at a hearing. <input type="checkbox"/> I do not wish to appear at a hearing and I request that a decision be made based on the evidence in my case. (Complete Waiver Form HA-4608)
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**Representation:** You have a right to be represented at the hearing. If you are not represented, your Social Security office will give you a list of legal referral and service organizations. If you are represented, complete and submit form SSA-1696 (Appointment of Representative) unless you are appealing a Medicare issue.

7. CLAIMANT SIGNATURE (OPTIONAL)	DATE	8. NAME OF REPRESENTATIVE (if any)	DATE
RESIDENCE ADDRESS		ADDRESS	
CITY	STATE	ZIP CODE	CITY
TELEPHONE NUMBER	FAX NUMBER	TELEPHONE NUMBER	FAX NUMBER

### TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION- ACKNOWLEDGMENT OF REQUEST FOR HEARING

9. Request received on \_\_\_\_\_ by: \_\_\_\_\_  
(Date) (Print Name) (Title)  
\_\_\_\_\_  
(Address) (Servicing FO Code) (PC Code)

10. Was the request for hearing received within 65 days of the reconsidered determination? ☐ Yes ☐ No  
If no, attach claimant's explanation for delay and supporting documents if any.

11. If claimant is not represented, was a list of legal referral service organizations provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	15. Check all claim types that apply:
12. Interpreter needed <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Retirement and Survivors Insurance Only (RSI)
Language (including sign language):	<input type="checkbox"/> Title II Disability - Worker or child only (DIWC)
13. Check one: <input type="checkbox"/> Initial Entitlement Case	<input type="checkbox"/> Title II Disability - Widow(er) only (DIWW)
<input type="checkbox"/> Disability Cessation Case or <input type="checkbox"/> Other Postentitlement Case	<input type="checkbox"/> Title XVI (SSI) Aged only (SSIA)
14. HO COPY SENT TO: _____ HO on	<input type="checkbox"/> Title XVI Blind only (SSIB)
<input type="checkbox"/> Claims Folder (CF) Attached: <input type="checkbox"/> Title (T) II; <input type="checkbox"/> T XVI;	<input type="checkbox"/> Title XVI Disability only (SSID)
<input type="checkbox"/> T VIII; <input type="checkbox"/> T XVIII; <input type="checkbox"/> T II CF held in FO <input type="checkbox"/> Electronic Folder	<input type="checkbox"/> Title XVI/Title II Concurrent Aged Claim (SSAC)
<input type="checkbox"/> CF requested <input type="checkbox"/> T II; <input type="checkbox"/> T XVI; <input type="checkbox"/> T VIII; <input type="checkbox"/> T XVIII	<input type="checkbox"/> Title XVI/Title II Concurrent Blind (SSBC)
(Copy of email or phone report attached)	<input type="checkbox"/> Title XVI/Title II Concurrent Disability (SSDC)
16. CF COPY SENT TO: _____ HO on	<input type="checkbox"/> Title XVIII Hospital/Supplementary Insurance (HI/SMI)
<input type="checkbox"/> CF Attached: <input type="checkbox"/> Title (T) II; <input type="checkbox"/> T XVI; <input type="checkbox"/> T XVIII	<input type="checkbox"/> Title VIII Only Special Veterans Benefits (SVB)
<input type="checkbox"/> Other Attached: _____	<input type="checkbox"/> Title VIII/Title XVI (SVB/SSI)
	<input type="checkbox"/> Other - Specify:

medical or another valid emergency, the judge could refuse to postpone your hearing. In that case, the judge could hold the hearing without you.

The hearing itself is conducted in a style less rigid than in a traditional courtroom. An ALJ presides, and everything said or done is recorded. You can be represented or assisted at the hearing by a friend or relative or by a lawyer or another advocate. (See “Lawyers and Other Assistance,” below, for more information about getting legal or other help.)

You need to submit any new evidence, or at least notify the hearing office that you will be bringing new evidence to the hearing, at least five days before the hearing. If you don’t, and you don’t have a valid reason such as illness or an unavoidable circumstance, the judge does not have to consider the evidence. It’s important to submit new, updated medical evidence, such as any recent test results or doctor’s notes from recent appointments—the judge will want to see medical evidence from the last 30–60 days, if possible.

You can present the testimony of any witnesses you would like to have help prove your claim. This testimony is informal. The person simply gives information regarding your employment or medical condition to the judge and answers any questions from the judge. The judge will give you an opportunity to explain your claim in your own words, and might also ask you some questions.

The ALJ who presides at your hearing is a lawyer who works for the Social Security Administration. The ALJ didn’t take part in the original claim decision or in reconsidering your claim. The judge will follow certain rules of procedure and might ask you questions about your claim that aren’t easy to answer. In general, however, the judges try to be as helpful as possible. If you aren’t sure how to present certain information to the judge, explain the problem and the judge should help you get the information into the official record of the case.

The judge will issue a written decision on your appeal, usually within four to six weeks of the hearing. You'll receive a copy of this decision in the mail. If your claim has been denied, you will have 65 days from the date on the written notice of the denial to file a further appeal.

If your claim has been approved, you might be entitled to receive benefits dating all the way back to the time you filed your original claim or even earlier.

## Appeal to the National Appeals Council

If your appeal has been denied after an administrative hearing, your next step is to file a written appeal with the Social Security Administration Appeals Council. You must file this within 65 days from the date on the written notice of the administrative law judge's decision.

### Completing the Form

The form you'll need at this stage of the appeals process is called *Request for Review of Hearing Decision/Order* (HA-520-U5). (Or you can submit this form online at <https://secure.ssa.gov/iApplNMD/oao>.)

The form is fairly straightforward, asking only that you give a brief explanation of why you think the administrative law judge's decision was wrong. If there's more to say than will fit onto this form, attach a separate piece of paper with the explanation. Also submit any documents that the judge didn't consider but that you believe are important to your claim.

On Question 10 of the form, you'll be asked to check either "Initial Entitlement" or "Termination or other." Initial Entitlement means you were denied after your first attempt to obtain a particular benefit. Termination or other means Social Security decided to end a benefit you were already receiving or to reduce the amount you receive.

Form **HA-520** (10-2023) UF  
Discontinue Prior Editions  
Social Security Administration

Page 1 of 2  
OMB No. 0960-0277

### REQUEST FOR REVIEW OF HEARING DECISION/ORDER

(Do not use this form for objecting to a recommended decision.)

(Either mail the signed original form to the Appeals Council at the address shown below, or take or mail the signed original to your local Social Security office, the Department of Veterans Affairs Regional Office in Manila, or any U.S. Foreign Service Post and keep a copy for your records.)

See  
Privacy Act  
Notice

1. Claimant Name	2. Claimant SSN	3. Claim Number (If different than SSN)
------------------	-----------------	---

4. I request that the Appeals Council review the Judge's action on the above claim because:

☐ Please grant me an extension of time to submit evidence or argument.

### ADDITIONAL EVIDENCE

You may submit any additional evidence or argument to the Appeals Council. If you have additional evidence that relates to the period on or before the date of the hearing decision, you must inform the Appeals Council about it or submit it, or any other evidence or argument, when you submit this form unless you request an extension of time by checking the box above. This will ensure that the Appeals Council has the opportunity to consider the additional evidence before taking its action. If you have a representative, then they must help you obtain the evidence. In limited circumstances, the Appeals Council may request the additional evidence related to the relevant period. If you submit neither evidence nor a legal argument now or within any extension of time the Appeals Council grants, the Appeals Council will take its action based on the evidence currently in your file.

**IMPORTANT: WRITE YOUR SOCIAL SECURITY NUMBER ON ANY LETTER OR MATERIAL YOU SEND US. IF YOU RECEIVED A BARCODE FROM US, THE BARCODE SHOULD ACCOMPANY THIS DOCUMENT AND ANY OTHER MATERIAL YOU SUBMIT TO US.**

**SIGNATURE BLOCKS:** You should complete No. 5 and your representative (if any) should complete No. 6. If you are represented and your representative is not available to complete this form, you should also print their name, address, etc. in section number 6.

**I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.**

5. Claimant's Signature	Date	6. Representative's Signature	Date
Print Name		Print Name <input type="checkbox"/> Attorney <input type="checkbox"/> Non-Attorney	
Address	City, State, ZIP	Address	City, State, ZIP
Telephone Number	Fax Number	Telephone Number	Fax Number

### THE SOCIAL SECURITY ADMINISTRATION STAFF WILL COMPLETE THIS PART

7. Request received for the Social Security Administration on \_\_\_\_\_ by: \_\_\_\_\_  
(Date) (Print Name)

\_\_\_\_\_  
(Title) (Address) (Servicing FO Code) (PC Code)

8. Is the request for review received within 65 days of the Judge's Decision/Dismissal? ☐ Yes ☐ No

9. If "No" ☐ (1) attach claimant's explanation for delay; and

checked: ☐ (2) attach copy of appointment notice, letter or other pertinent material or information in the Social Security Office.

10. Check one: ☐ Initial Entitlement  
☐ Termination or other

Social Security Administration  
Office of Appellate Operations  
6401 Security Blvd  
Baltimore, MD 21235-6401

**TAKE OR SEND ORIGINAL TO SSA AND  
RETAIN A COPY FOR YOUR RECORDS**

11. Check all claim types that apply:

<input type="checkbox"/> Retirement or Survivors (RSI)	<input type="checkbox"/> SSI Disability (SSID)
<input type="checkbox"/> Disability - Worker (DIWC)	<input type="checkbox"/> Title VIII Only (SVB)
<input type="checkbox"/> Disability - Widow(er) (DIWW)	<input type="checkbox"/> Title VIII/Title XVI (SVB/SSI)
<input type="checkbox"/> Disability - Child (DIWC)	<input type="checkbox"/> Other - Specify: _____
<input type="checkbox"/> SSI Aged (SSIA)	
<input type="checkbox"/> SSI Blind (SSIB)	

Also notice the section in the middle of the form under the heading “Additional Evidence.” Any documents you wish to submit to the Appeals Council that aren’t already in your file must be either attached to the form or sent directly to the Appeals Council within 15 days after filing your request for review.



#### SEE AN EXPERT

**If you aren’t yet represented by a lawyer who specializes in Social Security matters, hire one now.** The Appeals Council usually reverses an administrative law judge’s decision only when a technical argument can be made as to why the administrative law judge made a legal mistake. Simply arguing to the Appeals Council that the judge was wrong in deciding your case won’t be enough.

## Appeal Procedure

Unfortunately, your appeal to the Appeals Council is not likely to meet with much success. The Appeals Council reviews a case based on the written documents in your file only. If the Appeals Council believes there is merit to the appeal because of an error, it often sends the case back to the administrative law judge with the direction that the judge hold a new hearing and reconsider something the Appeals Council points out in its written decision.

Although the success rate of having claims denials overturned by the Appeals Council is very low, filing an appeal might be important. You’re required to file this appeal before you can move on to the next step, which is filing a lawsuit in federal court.

## Lawsuit in Federal Court

If your claim has been denied and you have unsuccessfully tried all levels of the Social Security Administration appeals process, you’re entitled to bring a lawsuit against the SSA in federal district court.

You must file the initial papers of this lawsuit within 60 days after the Appeals Council's decision is mailed.

A federal court lawsuit is a complicated, time-consuming, and expensive procedure. However, it might be worth it if you have a strong case. When you add up the total amount of benefits you might receive in your lifetime if your claim is approved, there could be a lot of money at stake. If the amount seems worth the time and effort to you, then you might investigate the possibility of filing a lawsuit. Consult with an attorney who specializes in Social Security appeals.

Whether or not you had legal assistance at some earlier stage of the appeal process, you certainly need expert legal assistance to file a lawsuit in federal court. Your odds of winning there depend almost entirely on convincing a court that the administrative law judge who heard your appeal made a mistake in interpreting the Social Security law. Simply asking a court to take another look at the facts of your case is almost never enough to win a federal lawsuit.

The main things you should weigh in deciding whether to file a lawsuit are your chances of winning (as explained to you by an attorney specializing in such cases), the money it will cost you to fight the legal battle, and the amount of money in benefits that you stand to gain. If you balance all these things and it still seems like a good idea to go ahead with the lawsuit, then consider hiring an attorney to help you proceed.

## **Lawyers and Other Assistance**

Under Social Security rules, you have a right to be represented at every stage of the appeal process by someone who understands the Social Security rules. This person can be a lawyer who specializes in Social Security matters, a nonlawyer from one of the many organizations that help people with Social Security claims, or a family member or friend who may be better than you are at organizing documents, writing letters, or speaking.

## Deciding Whether You Need Assistance

It's not always necessary to get assistance in preparing or presenting your appeal at the reconsideration stage. But, if your appeal involves medical issues or a hearing, it might be wise to seek help. This assistance can take several forms:

- talking over your appeal with a knowledgeable friend or relative
- having a person who specializes in Social Security problems go over your papers with you, make suggestions, and assist you at hearings, or
- having a lawyer or disability advocate prepare and present the appeal on your behalf.

Deciding whether to hire a lawyer or to seek an experienced nonlawyer representative depends on several things, such as:

- the complexities of your case. The more complicated the issues—particularly those involving a physical or mental condition as it relates to qualification for disability benefits—the more likely that you need expert help.
- how much money is at stake. For example, if your appeal is only about whether your disability began in March or April, it might not be worth hiring an attorney to represent you. On the other hand, if your benefits have been reduced significantly or denied entirely, it's much more likely to be worth it to hire an attorney.
- how comfortable you feel handling the matter yourself. Particularly at the reconsideration stage of the appeal process, many people feel confident obtaining their own records and documents and filing the forms or discussing their claim with a local Social Security office worker. However, many other people are uncomfortable about explaining things convincingly, and so would like assistance at this stage. And most people become uncomfortable at the prospect of an administrative hearing because they've never been through the process before. If so, it's a good idea at least to get some advice, and perhaps representation, before the hearing stage of the appeal process.

### What a Representative Can Do to Help

If you decide to have someone represent you during the course of your appeal—either a lawyer or a disability advocate—your representative can handle as much or as little of the process as you want. A representative can:

- look at and copy information from your Social Security file
- file a request for reconsideration, a hearing, or an Appeals Council review, and schedule or reschedule hearings
- provide Social Security with information on your behalf
- accompany you, or appear instead of you, and speak on your behalf at any interview, conference, or hearing, and
- receive copies of any written decisions or other notices sent by Social Security.

### Where to Find Assistance

Whether you should seek aid from a lawyer or an advocate depends on whether one or the other is easily available to you, and with whom you are most comfortable. If you reach the stage of considering going to federal court, however, you should consult with an attorney who has federal court experience in similar cases.



#### CAUTION

**Appointment of a representative must be in writing.** Once a person has agreed to become your representative for the appeal, you must provide their name to Social Security on a form entitled *Appointment of Representative* (SSA-1696). The representative will fill out part of the form and sign it, agreeing to serve as your representative. The form is available online ([www.ssa.gov](http://www.ssa.gov)) or at your local Social Security office, which is also where the completed form is to be filed.

## Hiring Specialists Other Than Lawyers

The first place to inquire about assistance with your Social Security appeal might be Social Security itself. Some denial letters from Disability Determination Services (DDS) are accompanied by a written list of local community groups and legal services organizations—such as disability rights groups, legal aid offices, and senior counseling services—that either assist with appeals or refer claimants to appeal representatives.

Finding someone through one of these groups or organizations doesn't guarantee that you'll want that person to represent you; that will depend on how well you and the person communicate and whether you feel confident in their advice. But finding someone to assist or represent you through one of these organizations at least assures you that the person has experience in Social Security appeals and has backing from a legitimate organization.

Senior centers are good resources, too. Many have regularly scheduled sessions during which trained advocates offer advice on Social Security problems. Whether or not a particular senior center has such a program, it can usually refer you to a Social Security advocacy group whose members are trained to assist in Social Security matters. You can usually make use of these referrals if you have a disability claim, even if you're not a senior citizen.

Also, each state has its own agency or department handling problems of older people, including Social Security disputes. These agencies are usually referred to as the Department of Aging or, variously, as the "office," "bureau," "division," "agency," "commission," "council," "administration," or "center" on aging. In most cases, this state agency will be able to refer you to somewhere near your home that offers assistance in preparing and presenting Social Security appeals. Call your state's agency and explain what you're looking for.

Other sources of assistance with Social Security matters are business and fraternal associations and unions. If you belong to such a group, it might have a referral service that can put you in touch with Social Security advocates.

Although some nonlawyer advocates provide free services, most charge a fee (although the amount is limited by Social Security rules—see below). The time to ask about fees is before you hire someone to assist or represent you. Get any fee agreement in writing.

### **Hiring Lawyers**

If your income is low, a lawyer might be available to assist or represent you through a “legal services” organization that has specialists in Social Security appeals. These are nonprofit organizations that seek funding from outside sources in order to serve low-income people. The first place to look for legal services offices is on the list of references provided by Social Security along with its notice denying your claim. You can also find legal services offices—sometimes listed as “Legal Aid”—online or in your telephone directory.

Be aware, however, that in the steady campaign by the federal government over past decades to slash public services for low-income people, many legal services offices have suffered staff cutbacks, and most of them now charge a fee for handling disability claims (if you win your case). So, it might not be easy to find a legal aid lawyer who can help you for free with your appeal.

You can also find an attorney in private practice. Most private lawyers know very little about Social Security, however; you need to find one who specializes in Social Security claims.

Asking for a referral to a disability lawyer (or Social Security attorney) from someone you trust can be a good way to find legal help. Also, two sites that are part of the Nolo family, [Lawyers.com](http://Lawyers.com) and [Avvo.com](http://Avvo.com), provide excellent and free lawyer directories. These directories allow you to search by location and area of law, and list detailed information about and reviews of lawyers. You can visit [www.lawyers.com/find-a-lawyer](http://www.lawyers.com/find-a-lawyer) and [www.avvo.com/find-a-lawyer](http://www.avvo.com/find-a-lawyer) to research attorneys.

Your local county bar association will also have a reference list of lawyers who specialize in Social Security appeals. Few lawyers specialize in Social Security appeals, and the few who are experts in the field usually list themselves with the bar association.

Normally, lawyers cost a lot of money. However, Social Security rules strictly limit the amount of money a lawyer or anyone else can charge for a Social Security appeal (which explains why so few lawyers specialize in the field).

## **Legal Limits on Lawyers' Fees**

Whether your representative is a lawyer or an advocate, Social Security rules limit the fees your representative can charge. And not only are fees limited, but they must be approved by Social Security in each individual case.

### **Fee Agreements**

Most lawyers and nonlawyers can charge a fee only if, with their help, you end up being approved for benefits. If you win your appeal at any stage of the process, you might be entitled to benefits from the date you first applied for them (or for Social Security disability insurance, even earlier)—referred to as “past-due benefits.” The lawyers take their fees as a percentage of your past-due benefits. Social Security rules say that a lawyer or another representative can take as a fee 25% of your past-due benefits, or \$7,200—whichever is less. However, if the lawyer pursues a lawsuit for you in federal court, different limits apply.

### **Fee Petitions**

In some situations, lawyers are allowed to ask Social Security if they can charge more than the \$7,200 cap. Social Security has the power to limit how much you are made to pay, however. If you agree to hire a lawyer under such a fee-for-service arrangement, the lawyer can't collect from you until after submitting a kind of bill called a “fee petition” to Social Security for approval.

The petition is filed when the appeal is finished and lists, in detail, each service the lawyer provided for your appeal and the amount of time the lawyer spent on each service. The lawyer must provide you with a copy of the petition. If you disagree with any of the information on the petition, you must notify your local Social Security office within 20 days of the date you receive it.

Social Security will examine the petition and determine a reasonable fee for the lawyer's services. Social Security will send you a written notice of the amount it has approved under the fee petition. The lawyer or other representative can't charge you any more than the fee Social Security decides on, except for out-of-pocket expenses incurred during your appeal (such as costs for photocopying, phone calls, postage, and transportation to and from your hearings).

### **Get It in Writing**

If you come to a fee arrangement with your lawyer or other representative, the representative must put it in writing, you both must sign it, and the representative must submit it to Social Security for approval. This can be done at any time before your claim is approved.





## Federal Civil Service Retirement Benefits

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**M**ore than two million people work as civilian employees of federal government agencies and departments; millions more have previously been employed there. And although the salaries of these government jobs aren't always as high as those in the private sector, a comprehensive retirement system is one of the benefits that makes federal government employment attractive.

This chapter discusses the two different federal retirement systems—the older Civil Service Retirement System, which still includes some current and many former employees, and the newer Federal Employees Retirement System—and explains the benefits available under each.

### **Employees of State and Local Governments**

Each state and many local governments have their own retirement systems for their employees. It isn't possible here to discuss the rules of all these plans, but most of them work very much like the federal government's Civil Service Retirement System (CSRS), described in this chapter.

In these systems, the amount of pension funds to which an employee may be entitled isn't based on total payroll contributions, as with the Social Security system, but on the highest average salary the employee reached and the number of years of employment. The age at which the employee can claim retirement benefits also depends on the number of years of employment.

As of July 1, 1991, employees of state or local governments who aren't covered at all by an employer pension plan became covered by Social Security. These employees are usually part-time, temporary, or probationary workers.

To find out what retirement plan covers your work, contact your personnel or retirement plan office, or the pension office of your public employees' union, if you belong to one.

On request, the pension office should provide you with an estimate of how much your pension benefits would be if you claimed those benefits at the various retirement ages permitted by the plan.



## RESOURCE

**For information about nongovernment, personal retirement plans.** See *IRAs, 401(k)s & Other Retirement Plans: Strategies for Taking Your Money Out*, by Twila Slesnick and John C. Suttle (Nolo).

## Federal Retirement Spousal Benefits for Same-Sex Spouses

Same-sex spouses are entitled to federal spousal benefits on the same terms as other spouses. This is true regardless of the state where the marriage was performed.

**Foreign same-sex marriages.** A spouse in a same-sex couple who was married outside the United States but now lawfully lives in the United States might be entitled to spousal benefits based on the other spouse's federal employment record, depending on the status of that marriage in the country where it was performed. Even if you have doubts about your right to federal spousal benefits as a same-sex spouse, the federal retirement system encourages you to apply for them so that it can determine whether you're eligible.

**Retroactivity.** The Department of Justice has decided that the right to spousal benefits for a same-sex spouse can apply to someone who applied for such benefits before the Supreme Court's same-sex marriage decision on June 26, 2015. If you were married and you applied for federal spousal benefits before that date but were denied those benefits (because you lived in a state that did not recognize your marriage), you can reapply to the federal retirement system now, specifically requesting retroactive benefits back to the date you first applied.

## Two Retirement Systems: CSRS and FERS

There are two entirely separate retirement systems for civilian federal workers, depending on the date the worker was first hired. Until 1984, all federal government workers were part of the

Civil Service Retirement System, or CSRS. Workers covered by CSRS don't receive Social Security benefits for their government employment; CSRS provides the only benefits those workers will receive for their years of federal government employment (though they might qualify for Social Security benefits through other work they have done).

All federal workers hired on or after January 1, 1984 were made part of a different plan called the Federal Employees Retirement System, or FERS. Workers hired by the federal government on or after January 1, 1984 are also covered by Social Security, which means that work for the government simultaneously builds toward both FERS and Social Security benefits.

Employees who were already working for the federal government on January 1, 1984 were given a choice. They could either remain in CSRS or switch over to FERS. For those who switched, their years of employment under CSRS were credited to FERS. Only a small percentage of employees who are still working for the federal government are enrolled in CSRS.

The rules for both systems are quite similar, and both are administered by the federal government's Office of Personnel Management (OPM). Both CSRS and FERS are funded by a combination of automatic payroll deductions from federal employees and contributions made by the employing agencies.

Under both systems, an employee can:

- receive benefits if disabled
- take early or full retirement
- provide for a survivor
- take a lump-sum retirement amount instead of monthly benefits, and
- participate in a special savings program called the Thrift Savings Plan.

Eligibility and benefit amounts for CSRS and FERS are determined in a very different way than under the Social Security system. In particular, benefits are based on the highest average salary for any three years of employment but don't depend on the total amount contributed in payroll deductions. And although benefits can be paid to retirees and to survivors (if the retiree so chooses), they aren't increased if the retiree has dependents.

### **CSRS Retirees May Face Pension Offset**

People who earned a retirement pension under the Civil Service Retirement System or a similar state pension system that didn't pay into the Social Security program, might be subject to a reduction in certain Social Security dependents or survivors benefits because of what's called the "government pension offset." This offset applies if you receive Social Security dependents or survivors benefits and also receive a retirement pension based on your own work record from CSRS. This government pension offset does not apply to people whose own retirement benefit is under the Federal Employees Retirement System (FERS). (For a full explanation of the government pension offset, see Chapter 4.)

## **Retirement Benefits**

Both CSRS and FERS retirement benefits are easy to qualify for and can be paid out in any one of several ways. Both programs also permit retirement benefits to be structured to provide for a survivor after the retired worker has died. And both offer a special savings plan that provides tax benefits and, in the case of FERS, includes contributions by the government.

### **If You've Left Federal Work, Then Returned**

Some people might be entitled to retirement benefits under both CSRS and FERS: those who worked for the federal government before 1984, when CSRS was their only option, and then left but rejoined federal employment after 1984.

If you worked for the federal government for at least five years but left that job before 1984, you can return to CSRS if you start a new job with the federal government. If you choose not to reenter CSRS, you will work under FERS, and you can qualify for retirement benefits under both CSRS and FERS once you have more than five years of employment under each system.

If you left federal employment for at least a year and you choose to reenter CSRS, you will also be covered by Social Security, as are all FERS employees. Once you collect both Social Security benefits and CSRS retirement, your CSRS payment will be reduced by the amount of your Social Security benefits attributable to your federal employment.

This prevents double payment, since most CSRS recipients don't receive Social Security benefits from their federal employment, and the amount of CSRS benefits is calculated as if there were no additional retirement money from Social Security.

## **Who Is Eligible**

If you've worked at least five years for the federal government as a civilian employee, you can qualify for a pension, referred to as a "retirement annuity." In addition, you can get retirement credit for any years of military service if you pay a premium based on the amount of your military pay. (However, you can't get credit for military service if you're also collecting a military retirement pension.) You can also get credit, after paying a small premium, for time you spent in the Peace Corps.

There are two types of retirement annuities under CSRS and FERS: an immediate annuity and a deferred annuity.

Minimum Retirement Age (MRA) by Year of Birth	
The following chart tells you when you reach your MRA for FERS, depending on the year you were born.	
Birth Year	MRA
1953–64	56
1965	56 + 2 months
1966	56 + 4 months
1967	56 + 6 months
1968	56 + 8 months
1969	56 + 10 months
1970 and after	57

### Immediate Annuity

You can retire at age 62 and immediately begin receiving an annuity if you worked for the federal government a total of five years. The years don't have to be consecutive, nor do they have to be for the same federal agency or department. Any combination of federal jobs totaling five years of work will qualify you.

**Special rule for 20 years of service.** If you have 20 years of service with the federal government, you can claim your immediate annuity earlier, at age 60.

**Special rules for 30 years of service.** With 30 years of service, a CSRS-covered worker can retire with a pension at age 55.

A worker covered by FERS with 30 years of service can retire with a pension at what is called the “minimum retirement age” (MRA). Your MRA depends on the year you were born (see the chart above).



## TIP

**Special rules apply to law enforcement personnel and firefighters.** Recognizing the high stress of these jobs, the FERS system has set earlier retirement years and lower requirements for years of service for these jobs. If you've been a federal law enforcement officer or firefighter under FERS, you can claim retirement benefits at age 50 with 20 years of service, or at any age once you have 25 years of service.

### If You Are Laid Off Before Becoming Eligible for Your Pension

CSRS and FERS rules allow some long-term workers to collect an immediate annuity if they're laid off from their jobs before reaching the normal eligibility age.

Under CSRS, a worker who has been employed for at least one year in the two years immediately before being laid off, and who is either age 50 with 20 years of service or any age with 25 years of service, may be eligible for an immediate annuity.

Under FERS, the eligibility for this immediate annuity is the same, except that you need not have been employed within the past two years.

The amount of the immediate annuity is reduced from its full amount by 2% per year for every year you're under age 55 when claiming this annuity.

There are two circumstances in which you might not be entitled to an immediate annuity after losing your job. The first is if you've been fired for cause: misconduct, delinquency, or poor job performance. The second is if you've been offered another job in the same agency, in the same geographic area, that isn't more than two grades or pay levels below the current job, but you refuse to take it.

## Deferred Annuity

If you end your federal employment before retirement age, you have a choice of leaving your payroll contributions in CSRS or FERS, or withdrawing them in a lump sum when you leave employment. If you leave the contributions in the system when you end your federal job, you can claim a retirement annuity at age 62. If you leave the money in the retirement system but later decide you want it without waiting for retirement, you can collect it in a lump sum at any time before you reach age 62.

You might need or want the lump sum immediately upon leaving your job. But if you've worked a long enough time to have reached a relatively high salary, you'll be eligible for a large pension when you reach age 62. Over your lifetime, that pension would probably amount to much more money than the lump sum you could withdraw when leaving your federal job.

Before deciding which course of action to take, find out from the Office of Personnel Management at the agency where you work exactly how much your lump-sum withdrawal would be, and get an estimate of what your annuity would be at age 62, so that you can make an informed choice.

## Calculating Benefits

Two factors are used to figure the amount of your federal CSRS or FERS retirement annuity.

The first factor is the number of years you were employed by the federal government and contributed to the retirement fund. This can include years of military service if you also have at least five years of civilian service (unless you're receiving a military retirement pension).

The second factor is your "high-three average salary"—meaning your average salary for the three consecutive years in which you had your highest earnings. For example, if in three successive years

you reached \$55,000, \$55,000, and \$58,000, you would add these together and divide the total by three. (The total would be \$168,000, which divided by three equals a high-three average of \$56,000.)

Both CSRS and FERS base the retirement annuity on the high-three average, but each computes the resulting benefit differently.



#### TIP

**You'll get a cost-of-living increase.** Both CSRS and FERS benefits are increased annually to keep pace with the rising cost of living. As with Social Security benefits, these cost-of-living increases are tied to the rise in the Consumer Price Index, a yearly indicator of the cost of goods and services.



#### ONLINE

**You can get benefit estimates online.** The Office of Personnel Management (OPM) operates the CSRS and FERS systems. OPM offers a website with a calculator that will estimate your federal civil service retirement benefits. Go to [www.opm.gov](http://www.opm.gov) and click "Calculators" (under "Retirement"). The calculator, called the Federal Ballpark Estimate, can estimate what your normal, early, or disability retirement benefits are likely to be. However, the accuracy of the estimate depends on how near you are to claiming your benefits—the nearer you are, the more accurate the estimate.

### CSRS Benefits

Once your high-three average pay is calculated, CSRS computes your pension benefits by adding:

- 1.5% of your high-three average pay, multiplied by your first 5 years of service, plus
- 1.75% of your high-three average pay, multiplied by the number of your years of employment over 5, up to 10, plus
- 2% of your high-three average pay, multiplied by the number of years of service over 10.

**EXAMPLE:** John put in 25 years working for a federal government agency. His highest three consecutive years of pay were \$57,000, \$61,000, and \$62,000. That makes his high-three average pay \$60,000. After 25 years, John's retirement pension would be figured like this:

- 1.5% of the \$60,000 average is \$900; that \$900 is multiplied by the first five years of service, for a total for the first five years of service of \$4,500; plus
- 1.75% of the \$60,000 average is \$1,050; that \$1,050 is multiplied by the second five years of service, for a total for the second five years of \$5,250; plus
- 2% of the \$60,000 is \$1,200; that \$1,200 is multiplied by the remaining 15 years of service, for a total for the last 15 years of service of \$18,000.

Together, the three parts of John's pension would add up to a yearly benefit of \$27,750.

### CSRS Benefits and Social Security

If your federal employment is covered by CSRS, it's not also covered by the Social Security system. However, most people who worked for the federal government under CSRS have also worked, or will work, at some other jobs during their lifetimes. If that other work is covered by Social Security and you earn enough work credits from that work to qualify for Social Security retirement benefits, you can collect both your retirement benefits and your CSRS annuity.

**Caution:** If you receive a CSRS pension and also Social Security dependents or survivors benefits based on your spouse's work record—rather than Social Security retirement benefits based on your own work record—the Social Security dependents or survivors benefits will be severely reduced. This is known as the “pension offset rule.” (See Chapters 4 and 5 for further discussion of the offset rule.) If you're receiving a CSRS annuity as the survivor of a CSRS worker, this rule doesn't apply.

**CAUTION****Some workers will receive separate CSRS and FERS benefits.**

If you had years of service under CSRS, left that job, and later returned to work for the federal government under FERS, you can receive two separate annuities, one using your high-three earnings under CSRS and the other using your high-three earnings under FERS.

**FERS Benefits**

FERS has several different types of retirement benefits: full benefits, reduced early retirement benefits, deferred benefits for people who left their federal jobs before retiring, and a supplement for longtime employees.

**Full retirement annuity.** Full FERS pension benefits are figured by taking 1% of the high-three average and multiplying it by the number of years of service.

**EXAMPLE:** Elvira worked 25 years for the federal government, switching to FERS in 1984. Her highest three consecutive years of pay were \$58,000, \$60,000, and \$62,000. That makes her high-three average pay \$60,000. Elvira's retirement pension would be figured like this: 1% of \$60,000 = \$600; \$600 x 25 (years of service) = \$15,000, which would be her yearly pension annuity. And under FERS, Elvira would also collect Social Security retirement benefits as soon as she reaches an eligible age.

**Reduced benefits for early retirement.** If you've accumulated enough years of service under FERS, you can take early retirement with lower benefits. With 10 years of service, you can take early retirement at the minimum retirement age (MRA). (See chart above.) Your benefits will be reduced from the full retirement amount by 5% for each year under age 62 at which you claim retirement.

**Deferred benefits if you leave.** If you leave your federal job after at least five years of service but before reaching retirement status, you

can claim retirement benefits when you reach a certain retirement age, which depends on your years of service. With five years of service, you can claim retirement benefits at age 62. With 10 years or more, you can claim retirement at the minimum retirement age but the benefit will be reduced by 5% per year for every year earlier than age 62 at which you claim benefits.

**TIP**

**Reduced benefits might make financial sense.** Although your deferred retirement benefits will be reduced 5% for every year under age 62 at which you claim them, it might still be to your advantage to claim as early as age 55. Since you aren't adding any more years of service and your high-three salary remains the same, the base amount of your benefit will be the same whenever you take it.

**Annuity supplement for long-term employees.** A special supplement to the retirement annuity is available at age 55 to people with 30 years' service and at age 60 with 20 years' service. The supplemental amount is based on total earnings and years of service and is figured using a complex set of calculations. To determine how much your annuity supplement would be, contact the OPM office at the agency where you work.

**CAUTION**

**Your supplement might be reduced by your earnings.**

Unlike the standard FERS annuity, if you're younger than 62, your annuity supplement is reduced by \$1 for every \$2 that you make over a certain yearly amount in earnings from other employment after you retire from federal government work. This earnings limit rule works the same as the earnings limit for Social Security benefits. (For more information, see "Working After Claiming Early Retirement Benefits" in Chapter 2.)

## Survivors Benefits

Unlike Social Security retirement benefits, the surviving spouse or another survivor of a federal CSRS or FERS retiree doesn't necessarily receive survivors benefits after the retiree dies. To plan ahead for this, the federal worker is given several choices at retirement.

The retiring worker can choose to:

- take a full retirement annuity—if so, no benefits will be paid to any survivors after the retiree dies
- elect a full survivor benefit for a current spouse, in which case the retiree's own annuity will be less
- elect to have survivor benefits paid to someone other than a current spouse (which would also reduce the retiree's own annuity), or
- choose to provide a reduced survivor benefit, which means their own annuity will be lower than a full retirement annuity but higher than if a full survivor annuity were provided.

## Annuity Without Survivor Benefits

At retirement, a CSRS or FERS employee can choose to take full retirement benefits without any provision for survivors. This makes particular sense if the retiree is unmarried and isn't supporting anyone else financially. It also makes good sense if the retiree, or retiree and spouse, have extremely limited income and immediately need the full retirement annuity to get by. Finally, it might be a wise choice if the retired worker is married but their spouse is not likely to outlive the worker.

A worker who is married at retirement must specifically choose this no-survivor-benefit option by filing a form with the Office of Personnel Management (OPM). The worker's spouse must sign and notarize this form, which acknowledges that the retiree has given up the right to a survivor annuity. If the spouse's whereabouts are unknown, or the spouse is unable to understand the waiver and knowingly sign the form, a petition can be filed with the OPM to waive the requirement of a written consent form.

## Annuity With Full Spousal Survivor Benefits

If you're married when you retire from federal employment, and you and your spouse don't waive your right to a survivor annuity, your retirement annuity will be reduced slightly to provide a lifetime annuity for your spouse if you die first.

This full survivor annuity can also be provided for a former spouse, although if the worker has remarried, the current spouse must consent. A survivor benefit ends when the surviving spouse dies or when the surviving spouse remarries before age 55. After age 55, the surviving spouse is free to remarry without losing the survivor annuity.

The amount of full survivor annuity is slightly different for CSRS and FERS employees.

**CSRS full survivor benefits.** A CSRS retirement annuity is reduced, to provide full survivor benefits, by 2.5% of the first \$3,600 per year, plus 10% of any amount greater than \$3,600. The surviving spouse's annuity will be 55% of the full retirement annuity—that is, 55% of the amount before the 2.5% and 10% reductions are taken. And the 55% will include any yearly cost-of-living raises the retiree has received since the pension began.

**EXAMPLE:** Ethel is eligible to receive a pension of \$9,250 a year. She provides a full survivor benefit for Dante, her husband, so her own retirement annuity is reduced.

The first \$3,600 is reduced by 2.5%, which means Ethel receives \$3,510 of that first \$3,600. The remaining \$5,650 is reduced by 10%, leaving \$5,085. Ethel's total pension is \$8,595 a year instead of \$9,250, a reduction of \$655 a year. For that reduction, Dante is entitled (if Ethel dies) to a surviving spouse's pension of 55% of the original \$9,250, which works out to \$5,087.50 a year.

**FERS full survivor benefits.** A FERS full retirement pension is reduced by 10% to provide an annuity for the surviving spouse. The surviving spouse's annuity will be 50% of the retiree's full pension amount—that is, 50% of the amount before the 10% reduction.

A retiring FERS worker can also choose a 5% reduction in their annuity to provide for a 25% annuity for a survivor. The survivor annuity will include any yearly cost-of-living raises the retiree receives after the pension begins.

**EXAMPLE:** Rigoberto is eligible to receive a pension of \$12,000 a year. He provides for a full survivor benefit for Doris, his wife, reducing his own retirement annuity by 10%, or \$1,200. So instead of \$12,000 per year, Rigoberto receives \$10,800—\$12,000 minus the \$1,200 reduction. In exchange for that reduction, Doris will be entitled, upon Rigoberto's death, to receive a surviving spouse's pension of 50% of the original \$12,000, which works out to \$6,000 a year.

### **Survivor Annuity to Someone Other Than Spouse**

Both CSRS and FERS provide for a 55% survivor annuity that can be paid to a person other than a current spouse, such as a fiancé, a child, or a sibling. The amount that your own retirement annuity is reduced to pay for this annuity depends on the difference in age between you and the named beneficiary.

If the beneficiary you name is older than you or no more than five years younger than you, your annuity will be reduced by 10%. Your annuity is reduced 5% for every additional five years the beneficiary is younger than you—reduced 15% if 5 to 10 years younger, 20% if 10 to 15 years younger, and so on.

If the person you name as beneficiary dies before you do, you can have your own annuity restored to the full amount for the rest of your life by simply notifying the OPM. Once you've chosen to name a beneficiary, however, you can't change your mind as long as that person lives and restore yourself to a full pension.

### **Reduced Survivor Benefits**

Both CSRS and FERS rules allow a retiring employee to divide up their annuity, taking the full amount of one part and using the rest to set up a survivor annuity. You can split up your annuity into survivor and non-survivor parts in any proportions you want.

For example, if you're entitled to a \$10,000-per-year annuity, you can choose to keep \$5,000 as fully your own and direct that the other \$5,000 be allotted to and reduced for a survivor benefit. That second \$5,000 would be reduced by the normal survivor percentages. For CSRS, the reduction would be 2.5% of the first \$3,600 and 10% of the remaining \$1,400—leaving you \$4,770 plus the untouched \$5,000. This arrangement would provide a survivor with 55% of the \$5,000 you assigned to the survivor annuity, which amounts to a yearly benefit of \$2,750 after your death.

### Deciding Whether to Reduce Your Annuity

No obvious answer exists regarding whether to take a reduced pension to provide for another person. Retirees and their spouses or other beneficiaries must decide for themselves. It will help to consider the following:

**Age.** If your spouse or other potential beneficiary is considerably younger than you are and likely to outlive you by many years, taking a reduced pension now probably makes good sense. The 55% pension could go for many years to your beneficiary. On the other hand, if your beneficiary is older than you are, there may be little advantage to reducing your own immediate pension.

**Health.** If you're in poor health and might not survive for many years, then it's probably important to provide a survivor annuity. Conversely, if your beneficiary is in poor health and not likely to survive you for long, it's probably better for you to take your full pension.

**Income.** If your spouse or other beneficiary has or will have a substantial retirement pension or other income of their own, there's less need to reduce your own pension to protect your beneficiary. On the other hand, if your beneficiary is working now and earning a salary that will enable you to afford taking a reduced pension, that will permit your beneficiary to count on a survivor annuity after you're gone.

## Thrift Savings Plan

In addition to the annuity pension plan to which both the employee and the employer contribute, federal employees have the opportunity to build up tax-deferred retirement savings through the Thrift Savings Plan (TSP). The TSP is similar to 401(k) savings plans made available to some employees in the private sector.

### Contributions to TSP Account

The TSP for a CSRS worker is funded solely by the worker; it's a savings account of the worker's own money, which defers tax liability until retirement. For FERS employees, the government also contributes to TSP accounts, so that the TSP is both a tax-deferring savings plan and an additional pension.

**CSRS contributions.** CSRS-covered workers can put up to 5% of their before-tax wages into a TSP savings account. They pay no income tax on the income, or on interest earned, if they leave the money in the account until retiring from federal service with a CSRS annuity.

**FERS contributions.** The government automatically contributes an amount equal to 1% of an employee's pay into a TSP account for the employee. A worker who is covered by FERS can also put up to 10% of their pretax wages into the TSP savings account. If the employee makes contributions, the government will match some of the amounts an employee puts in, in addition to its automatic 1% contribution.

The government matches dollar for dollar the first 3% of wages that an employee puts in the TSP account, and matches 50 cents per dollar for the next 2% of pay the employee puts in the TSP account. Employees who leave the money in the account until retiring from federal service won't owe any tax on the money put into the account or on the interest earned until the money is withdrawn at retirement.

## Withdrawals From a TSP Account

Employees who retire from federal service with either a deferred or an immediate annuity can take out their TSP money in a lump sum or in payments of equal amounts over time. Employees will owe income tax when the amounts are withdrawn. But a person who is no longer working full time is likely to be in a lower individual income tax bracket and so will owe less in taxes.

A retiring employee also has the option to transfer the money to an Individual Retirement Account (IRA), which continues the money's tax-deferred status. A retiring employee can also use the TSP account funds to purchase an annuity, which is a plan that pays a set amount for life to the retired worker. Some annuities also permit additional payments to the spouse of a retired worker after the worker dies.

An employee who leaves federal service and withdraws the TSP money before being eligible for a retirement annuity will owe a 10% penalty tax on the money in the account. However, the employee has the option of transferring, or rolling over, the money in the TSP account to a nongovernment Individual Retirement Account (IRA), which will maintain the same tax-exempt status and avoid the tax penalty. The normal limit on yearly contributions to an IRA account doesn't apply to this one-time transfer of TSP funds.



### CAUTION

**There is a time limit for withdrawing your funds from your TSP account.** If you leave your retirement money in your TSP account after you stop working for the federal government, you're required to start withdrawing your money by April 1 of the year following either:

- the year you turn age 70½, if you are at that time no longer employed by the federal government, or
- if you continue in federal employment after age 70½, whatever year you end that employment.

## Disability Benefits to Federal Workers

Both CSRS and FERS provide benefits for employees who become disabled while working for the government.

### Who Is Eligible

If you've worked for the federal government for five years or more under CSRS, you could be eligible for benefits if you become disabled before you reach retirement age. If you're covered by FERS, you need to have been employed for only 18 months.

### Definition of Disability

Under both CSRS and FERS rules, you're considered disabled if, because of disease or other medical condition, you're unable to perform your job. In deciding whether a worker is disabled, the OPM determines if all of the following are true:

- The employee can't perform useful and efficient service in the specific job.
- Every reasonable effort to preserve the person's employment, such as making physical modifications to the jobsite, has failed.
- There is no other vacant position that the employee could perform in the same government agency and geographic area, and at the same civil service grade or class as the current job.

It's somewhat easier to qualify for federal civil service disability than for Social Security disability benefits. Under federal civil service rules, you don't have to be so disabled that you're unable to do any sort of paid work. Instead, you can qualify for disability benefits merely because you're unable to work in the same government agency where you already work, doing a job there at the level you had attained when you became disabled. It doesn't matter that you might be able to work at some other job at a different level or outside the government agency.

Proof of disability depends on information from two separate but equally important sources. First, your physician must write a letter to the OPM fully describing your disability and the date it began and explaining why you're unable to perform your job effectively. You can assist your doctor by carefully explaining what your job entails and why your disability prevents you from performing it.

The second source of information is your supervisor at work. Your supervisor must give the OPM a written statement explaining your duties at work, how your disability impairs your job performance, and whether any other job of comparable rank and pay in the same agency is available to you. You can help yourself and your supervisor by pointing out the specific ways in which your disability interferes with your job and by noting when your disability began to make efficient work impossible.

## **Review of Disability Status**

Your disability doesn't have to be permanent for you to receive federal employees' disability benefits. But the government, at its expense, will periodically require that you be examined by a physician to determine whether or not you continue to be disabled.

As with your original claim for disability benefits, during a review it's helpful if your own physician can write a letter detailing the specific ways in which your condition continues to be disabling. The letter will assist the government's doctor—who will probably only see you once, for a brief examination—in understanding why you're still disabled. The best approach is to have your own doctor write to the government doctor directly, so that the explanation of your condition and its limitations will already be in your file when you undergo your examination.

If your disability is found to be permanent, or if you reach age 60 without recovering from the disability, you'll receive permanent disability retirement benefits. You won't be subject to any further government examinations, and you'll receive your disability benefits for life unless you're later considered to have recovered.

You would be officially considered recovered if:

- You voluntarily take any new job with the federal government.
- Your yearly earnings at jobs or self-employment outside the federal government reach 80% of the current pay for your previous government job.
- A medical examination determines you're physically able to perform your job.

If any of these types of recovery occur, your disability payments would end either:

- on the date you begin reemployment with the government
- six months from the end of the year in which you earn 80% of your prior salary, or
- one year from the date of the medical exam that determined you had physically recovered.

## Amount of Benefits

The amount of disability benefits is figured differently by CSRS and FERS.

### CSRS Disability Benefit Amounts

CSRS disability benefits are the *lower* of either:

- 40% of your high-three average pay (defined in “Calculating Benefits,” above), or
- a percentage of the regular pension you would have received if you had worked until age 60. This percentage varies depending on a certain number of years, which is calculated by adding together your years of service plus the number of years remaining until you reach age 60. Your high-three average salary is multiplied by the percentage, depending on the total number of years, to arrive at the disability benefits figure:
  - 10 years total: slightly more than 16%
  - 15 years total: slightly more than 26%
  - 20 years total: slightly more than 36%, and
  - 22 years or more: 40%.

**EXAMPLE 1:** Henry went on disability at age 55, after 10 years of employment during which he had reached a high-three average pay of \$34,000; 40% of his high-three pay would be \$14,400. Using the alternate method of computation, the number of years remaining until he reaches age 60 is 5, which would be added to his number of years of employment for a total of 15 years. At 15 years, the high-three average salary is multiplied by a bit more than 26%, for a total of \$8,925. Since Henry is entitled only to the lower of the two computations, he would receive \$8,925 per year in benefits.

**EXAMPLE 2:** Alice went on disability at age 50, with 15 years of service. Her high-three average salary was \$38,000. She had 10 years until she would reach age 60, which were added to her 15 years of service for a total of 25 years. Because this is more than 22 years, her yearly disability benefit would be 40% of her high-three average salary—which is the same figure as the alternate method of computing benefits—amounting to \$15,200.

### FERS Disability Benefit Amounts

Benefit amounts under FERS change over time. In the first year after disability, the disabled worker receives 60% of the high-three average pay, reduced by any Social Security disability benefits.

From the second year of FERS disability until age 62, the worker receives 40% of the high-three salary, minus 60% of any Social Security disability benefits. These benefits are increased yearly, based on a cost-of-living formula that is 1% lower than the rise in the Consumer Price Index.

At age 62, the calculation changes. If you have fewer than 20 years of service, your benefit figure is determined by taking 1% of your high-three average salary (plus all cost-of-living increases since going on disability) and multiplying that by the total number of years of employment. That figure will be the yearly disability benefits for the remainder of your lifetime.

If you have more than 20 years of service, your benefits will be equal to 1.1% of your high-three average salary (plus all cost-of-living increases), multiplied by the number of years of employment.

## **Payments to Surviving Family Members of Workers Who Die While Employed**

In addition to their retirement pension programs, CSRS and FERS provide some financial support for the family of a federal worker who dies while still employed by the government.

### **Who Is Eligible**

If a federal worker covered by either CSRS or FERS dies while still employed by the government, the surviving spouse and minor children can receive survivor benefits if the worker was employed by the government for at least 18 months.

### **Benefits for Spouse**

For the surviving spouse to collect benefits, either the couple must have been married at least a year when the worker died, or the surviving spouse must be the parent of the worker's child. The survivor benefit is paid to the surviving spouse regardless of the spouse's age.

Surviving spouses who also work for the federal government can collect both survivor benefits and their own retirement pension.

### **Benefits for Children**

The children of a deceased federal worker also receive benefits until each reaches 18 years of age or gets married. If the child is a full-time high school or college student, benefits can continue until age 22. If a child becomes disabled before reaching age 18, the survivor benefits can continue for as long as the child is incapable of full self-support.

A child of an unmarried deceased worker also qualifies for a survivor annuity. If the unmarried worker was the father, the worker

must have acknowledged the child or a court must have established paternity. Stepchildren can also qualify for benefits if they lived with the worker in a parent-child relationship.

## **Amount of Benefits**

The amount of survivor benefits depends on whether the deceased employee was covered by CSRS or FERS.

### **CSRS Benefits**

If a CSRS-covered worker dies while still employed by the government, the surviving spouse and qualifying children can each receive an annuity.

A surviving spouse's or child's CSRS annuity can be up to 55% of the retirement annuity that the worker earned before dying. The exact amount is determined by whether the worker chose to reduce their own retirement annuity, and by how much, in order to provide for survivors. For details, visit the OPM's website at [www.opm.gov/support/retirement/faq/survivor-benefits](http://www.opm.gov/support/retirement/faq/survivor-benefits).

### **FERS Benefits**

FERS benefits payable to a qualified surviving spouse or child are generally the same as for CSRS-covered employees, discussed just above, but the maximum benefit is 50% of the retirement annuity that the worker earned before dying, and the worker must have been employed for at least 10 years.

Also, children's survivor benefits under FERS are reduced by any Social Security survivors benefits the child receives. The spouse's survivor benefits aren't reduced by any Social Security survivors benefits. (See Chapter 5 regarding survivors benefits.)

A surviving spouse can also receive a death benefit of about \$30,000 (the figure goes up most years, adjusted for inflation), plus either 50% of the worker's yearly pay at the time of death or 50% of the worker's high-three average, whichever is higher.

## Applying for CSRS or FERS Benefits

Decisions about both CSRS and FERS benefit claims are made by the federal government's Office of Personnel Management (OPM). You must file a written application for specific benefits. You can apply at the personnel office within the agency at which you work. If you no longer work for the agency, you can file your application at any OPM office.

You can get general information about benefits, application forms, the application process, and appeals of decisions of the OPM by telephone from the OPM's Retirement Information Office. Recorded information is available 24 hours a day at 202-606-0400. For additional help, call 888-767-6738 (toll-free) or visit [www.servicesonline.opm.gov](http://www.servicesonline.opm.gov).

To obtain information about the benefits available to you based on your personal employment record, go in person to your agency's personnel office or put your request in writing and send it to:

U.S. Office of Personnel Management  
Employee Services and Records Center  
Boyers, PA 16017

This is the office where employee records are maintained, and most questions can be answered by the staff there. If there is some complicated question they can't answer, they will forward your inquiry to the Washington office of the OPM, which will respond. ●

## Veterans Benefits

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In addition to the pensions and benefits that arise from both public and private civilian employment, many older Americans may be eligible for certain benefits based on their military service.

The Veterans Benefits Administration of the Department of Veterans Affairs (VA) operates a number of programs providing financial, medical, and other assistance to veterans. Eligibility for some benefits depends on financial need or time of service. For older veterans, three major benefit programs are of particular value: disability compensation, veterans pensions, and, perhaps most significant, free or low-cost medical care through VA hospitals and medical facilities. This chapter explains some of these benefits.

## Types of Military Service Required

Veterans benefits are available only to people who performed active service in a uniformed branch of the military: Army, Navy, Marine Corps, Air Force, Coast Guard, Women's Army Auxiliary Corps (WAAC), or Women's Air Service Pilots (WASP).

Active service is defined as either active duty or active duty for training.

### Active Duty

Active duty means full-time service in one of the uniformed branches of the military forces mentioned above. It also includes full-time duty in the Commissioned Officer Corps of the Public Health Service or the National Oceanic and Atmospheric Administration (NOAA). And, under some circumstances, full-time members of the Merchant Marine who served during wartime and wartime members of the Flying Tigers can also qualify.

Any length of active duty can qualify a veteran for benefits, with the exception of pensions for financially needy veterans, which require at least 90 days of active duty service. (See "Pension Benefits for Financially Needy Disabled Veterans," below, for more on need-based pensions.)

## Active Duty for Training

Generally, membership in the National Guard or Reserve Corps doesn't qualify a person for veterans benefits. However, if a person in the Guard or Reserves is called up for full-time duty in the armed forces, this period of service is called "active duty for training." Additional duties might fall under "inactive duty for training." A person who is injured or becomes ill during a period of active or inactive duty for training is eligible for veterans disability compensation if the injury or illness leads to a disability.

## Compensation for Service-Connected Disability

The VA administers a system of benefits for veterans who have a disability that can be connected in any way to a period of service. More lenient than civil disability benefit programs, a veteran can receive assistance for partial disability, and almost regardless of the cause, as long as the injury or illness occurred during a time when the veteran was on active duty or training for active duty.

### Who Is Eligible

Compensation is available for veterans who have a "service-connected disability." "Service-connected" means that they were wounded, injured, or became ill—or aggravated an existing condition—while on active duty, or training for active duty, in the armed forces.

Your condition does not need to have arisen directly from military duties. Virtually all activities—including playing for the base softball team, eating in the mess, traveling to and from training, and going on authorized leave—are considered part of military duties. This standard rules out only injuries sustained while AWOL, engaging in willful misconduct, or committing some militarily punishable offense.

## Amount of Benefits

The amount of disability compensation to which you're entitled depends on the seriousness of the disability. When you apply for disability compensation, VA personnel will review your medical records and examine you to assess your disability.

Your disability is given a rating, based on the extent to which it interferes with the average person's ability to earn a living. This rating is expressed in percent of disability—0% to 100% disabled, in increments of 10%.

Unfortunately, this rating system doesn't normally take into account the real effect of your disability on the work you do. Rather, it applies arbitrary percentages—20% or 30% for the loss of a finger or toe, for example—to the theoretical average person's ability to earn a living. Obviously, the loss of a finger affects a piano player much more than it affects an opera singer. But the VA usually applies its fixed schedule of disabilities to common injuries and conditions.

However, if your disability doesn't match any of the simple descriptions in the VA's rating system, the VA will instead consider the effect of your condition on the work you're able to do.

Benefits range from about \$170 per month for a 10% disability to about \$3,740 per month for total or 100% disability. If you have at least a 30% disability rating, your dependents are also eligible for some minimal benefits.

Eligible dependents include your spouse and your children up to age 18, or age 22 if a full-time student, or any age if disabled. The total amount received depends on the number of dependents and on your disability rating—the higher the rating, the higher the benefits. The additional amounts for dependents range from about \$60 to \$210 per month for a spouse and \$40 to \$140 per month for one dependent child, with lower amounts for each additional child.

## Disabilities From Agent Orange, Radiation, and Gulf War Syndrome

Because of the military use of chemicals and radioactive materials, many veterans have fallen ill with serious, disabling diseases years after their service ended. These veterans used to have no way to prove their disease was caused by exposure during military service. After sustained pressure from veterans groups, the VA admitted that certain exposure does indeed cause specific diseases. As a result, if a veteran was exposed to Agent Orange or radiation and later is disabled by certain diseases, the disability is *presumed* to be service connected. To a limited extent, the same can be said of “Gulf War Syndrome.”

**Vietnam and Agent Orange.** If you served in Vietnam and have become disabled by certain diseases, you’re presumed to have contracted the disease through exposure to Agent Orange and will be eligible for service-connected disability benefits. Diseases include prostate cancer, Hodgkin’s disease, multiple myeloma, respiratory cancers (lung, bronchus, larynx, trachea), non-Hodgkin’s lymphoma, chloracne, soft-tissue sarcoma, acute/subacute peripheral neuropathy, and more.

**Radiation exposure.** If your work in the military exposed you extensively to ionizing radiation, you could be eligible for service-connected disability benefits if you’ve become disabled by most types of leukemia or lymphoma, most types of cancer, brain or central nervous system tumors, thyroid disease, or multiple myeloma.

**Gulf War Syndrome.** Almost immediately after serving in the Gulf War, many veterans complained about illnesses—joint pain, rash, fatigue, memory loss, intestinal problems—that they didn’t have before service in the Gulf. The cause(s) of some of these illnesses haven’t been definitively diagnosed, but if a veteran has a chronic qualifying medical condition, that illness can be presumed to be connected to Gulf service. And if the illness results in a persistent disability, the veteran can be eligible for service-connected disability compensation. For information about Gulf War–related illness and compensation, a veteran can call a special Gulf War Veterans Information Hotline at 800-PGW-VETS.

## Changes to Your Rating

Although most service-connected disabilities show up during or soon after military service, some conditions might not appear, or might not become disabling, until years after you get out of the service. Regardless of when a condition actually becomes disabling, if it can be traced to injury or illness that occurred while you were in the service, it can be compensated.

**EXAMPLE:** Claudio's knee was bashed while serving as a cook at a training camp during the Vietnam War. The knee healed well and Claudio had no serious trouble with it during the war or the years immediately following it. However, as he got older, his knee got steadily worse. His doctor diagnosed Claudio with a serious arthritic condition in the knee, a result of the wartime injury.

Because Claudio's knee condition resulted from his wartime service, he was entitled to claim disability benefits when the knee began to interfere with his normal activities, even though he made no such claim before he was discharged from the service.

Sometimes, a disability that was rated low when it first appeared grows progressively worse in later years. In such cases, veterans can claim disability benefits even if they were previously rated by the VA as not disabled. Or a veteran can apply for an upgrading of an already-existing disability rating if the condition has worsened over time.

**EXAMPLE:** Ernie was an M.P. in Kuwait during the Persian Gulf War. While on leave, Ernie picked up a lung infection. The scarring from it, over the years, occasionally gave him minor respiratory difficulty. A few years after his discharge, Ernie applied for a service-connected disability. Although he picked up his illness while on leave, he was eligible for benefits because he had been on active duty during wartime. He was given a 10% disability rating for his labored breathing.

As he got older, Ernie experienced more breathing difficulties, to the point that even mild exertion made his breathing painful and dangerously difficult. His doctor said that poorer circulation with age was making Ernie's lung condition worse. Since his doctor verified that his condition had worsened, Ernie could apply for an increase in his disability rating. The new disability rating was 40%, which meant not only that Ernie's own benefits would be higher, but that his wife was now also eligible for some benefits as a qualifying dependent. (See "Amount of Benefits," above, regarding dependents benefits.)

## Pension Benefits for Financially Needy Disabled Veterans

A small monthly cash benefit called VA pension is available to a financially needy wartime veteran who is 100% disabled from causes that aren't service-connected. Unfortunately, the amount is usually extremely low, only enough to bring the veteran's total income from all sources to just above the poverty line.

To qualify for this small cash benefit, the veteran must have had 90 days or more of active duty, with at least one day during a period of war. However, there is no requirement of service in or near actual combat.

These official periods of war include:

- **World War II.** December 7, 1941 through December 31, 1946
- **Korean War.** June 27, 1950 through January 31, 1955
- **Vietnam War.** August 5, 1964 through May 7, 1975, and
- **Persian Gulf War.** August 2, 1990 through a date yet to be set by Congress or Presidential Proclamation.

Note that the periods of time considered part of the Second World War and the Korean War are longer than the time spans normally attributed to those conflicts.

Totally disabled veterans who meet the service requirements are granted an amount that will bring their total annual income—including income from private pensions, Social Security, and SSI—up to a level established by Congress called the Maximum Annual Pension Rate (MAPR). Those levels, however, are extremely low: about \$1,400 per month from all sources for a veteran with no dependents, about \$1,800 per month for a veteran with one dependent—a spouse, or a child younger than 18, or a disabled child—and slightly higher for each additional dependent.

Some veterans are entitled to a larger benefit if they live in a nursing home, are unable to leave their house, or are in regular need of “aid and attendance.” Veterans with out-of-pocket medical expenses are also entitled to a larger benefit.

#### **Limits on Assets**

The pension described in this section is not for veterans with savings or other assets that could be used or cashed in for living expenses. (Fortunately, these potential living expense assets do not include the value of a home the veteran lives in.) Even disabled veterans with little or no income won’t qualify for the pension benefits if they have assets over about \$80,000, depending on the cost of living where the veteran lives and the amount of ongoing medical expenses that the veteran pays out of pocket.

## **Survivors Benefits**

Several VA programs provide benefits to a veteran’s surviving spouse, and in some instances to surviving children.

### The VA's Definition of Eligible Marriage

To collect benefits as the surviving spouse of a veteran, you must have been married to the veteran for at least one year and be married at the time of their death.

If you were divorced from the veteran, you can't claim survivors benefits. And if you were still married when the veteran died, you lose your survivors benefits if you later marry someone else.

However, if you remarried after the veteran's death but that later marriage has ended, you might again be eligible for survivors benefits through your first spouse's record.

### Dependency and Indemnity Compensation

A benefit known as "Dependency and Indemnity Compensation" (DIC) is paid to the surviving spouse of an armed forces member who died either while in service or from a service-connected disability after discharge. However, if the veteran was dishonorably discharged, no DIC benefits will be paid to the survivor.

The amount of the DIC benefit depends on whether the veteran had a service-connected disability at the time of death.

The basic monthly DIC benefit is about \$1,615; an additional amount of about \$340 per month is paid if the veteran had a 100% disability rating from a service-connected disability during the eight years immediately before their death (amounts go up slightly each year). Additional amounts are paid if the veteran has a minor child or the surviving spouse is in a care facility or housebound or in need of aid and attendance.

For a complete listing of DIC benefit amounts, see the Department of Veterans Affairs website at [www.benefits.va.gov/compensation](http://www.benefits.va.gov/compensation).

### VA Benefits for Same-Sex Spouses

Same-sex spouses are entitled to federal spousal benefits, including VA benefits, on the same terms as other spouses. This is true regardless of whether the couple lives in the state where the marriage was performed.

**Foreign marriages.** A spouse in a same-sex couple who was married outside the United States but now lawfully lives in the United States might be entitled to VA benefits based on the other spouse's military record, depending on the status of that marriage in the country where it was performed. Even if you have doubts about your right to VA spousal benefits as a same-sex spouse, the VA encourages you to apply for them so that they can determine whether you're eligible.

**Retroactivity.** The Department of Justice has decided that the right to spousal benefits for a same-sex spouse can belong to those who applied for such benefits before the Supreme Court's same-sex marriage decision on June 26, 2015. If you were married and applied for VA spousal benefits before that date but were denied those benefits (because you lived in a state that did not recognize your marriage), reapply to the VA specifically requesting retroactive benefits back to the date you first applied.

### Wartime Service Pension

The surviving spouse of a deceased veteran can claim a monthly pension, regardless of whether the death was connected to service, if that veteran would have been eligible for a wartime service pension and wasn't dishonorably discharged. This survivor pension, like the veteran's wartime pension, requires that the survivor be unmarried and have a low income, taking into account money from any other pensions or Social Security benefits the surviving spouse receives.

The amount of a survivor's pension depends on the survivor's income and whether or not the survivor also has dependent children,

is housebound, or requires “aid and attendance” (see below). Maximum pensions are between about \$925 and \$1,700 per month, but these amounts are usually reduced based on the survivor’s income.

A veteran’s surviving children can also collect a small survivors wartime pension after the veteran’s death if they’re under 18 (or 22 if in school full time, or any age if disabled before age 18). The child’s benefit is only about \$235.

## Aid and Attendance

The Aid and Attendance (A&A) benefit is a special additional program to assist veterans and survivors who are eligible for DIC benefits and who:

- are living in a nursing facility
- need help at home performing activities like bathing and eating
- are blind or have very low vision, or
- are largely confined to bed because of illness.

If a survivor is in a nursing facility, an A&A benefit can add between about \$500 per month onto the VA pension.

The DIC benefit for a housebound (but not in a care facility) survivor with a permanent disability is less, about \$200. The amount of the benefit depends on whether the survivor has additional sources of income and on the survivor’s medical expenses.

## Medical Treatment

One of the most important benefits available to many veterans is free or low-cost medical care. The VA operates more than 150 hospitals throughout the country. In addition, a great number of outpatient clinics provide health care for veterans. Also, specialized care might be available at no charge through a VA hospital, while the same care might be unavailable or beyond a veteran’s means in the world of private medicine.

If you had active duty in the military and were discharged under conditions other than dishonorable, you might be eligible for VA health care benefits. You must have served for 24 uninterrupted months to be eligible for health care. This minimum service time might not apply if you were discharged due to a service-connected disability or for hardship.

If you're a member of the National Guard or Reserves, you might qualify if you had active duty by federal order and served for the full period you were called for.

### **Medicare and VA Medical Treatment**

Many veterans who are eligible for VA medical treatment are also covered by Medicare. The general rule is that for any specific medical treatment, you can choose either of the benefits, but not both. This means that if you're charged copayments for treatment at a VA facility, Medicare can't pay for them. However, if you're treated by a private doctor or facility and the VA pays most but not all of the cost, Medicare might be able to pay some of the unpaid amount. However, if you're treated by a private doctor or facility and Medicare covers the bills, you can't submit any unpaid portion to the VA.

There's a significant exception to this rule, which kicks in where the VA covers services that Medicare doesn't, and vice versa. For example, if the VA authorizes you to receive treatment at a private facility but does not cover all the services you receive, Medicare can pay for any of those services that Medicare does cover.

In a few pilot programs at VA medical centers, dependents and survivors of a veteran can also receive some care if they're unable to afford care in the private sector. (But this kind of care for dependents and survivors is rare in a VA medical system heavily stressed by Vietnam, Iraq, and Afghanistan war veterans.) The VA might also

pay for long-term care in certain private facilities for some veterans with serious service-connected disabilities, if there is no space in a local VA facility.

Even if you qualify for treatment at a VA medical facility, however, limited VA medical resources mean that you might not always be able to get the care when you need it, or the treatment might be available only at a VA facility far from your home.

To meet the demand for medical care, and particularly for its limited number of hospital beds, the VA has established a priority system for deciding who gets treatment directly from VA hospitals, clinics, and doctors:

- **Priority Group 1.** Veterans with service-connected disabilities rated 50% or more disabling or as totally disabling based on individual unemployability
- **Priority Group 2.** Veterans with service-connected disabilities rated 30% or 40% disabling
- **Priority Group 3.** Veterans who are former POWs, received a Purple Heart, were discharged for a disability incurred or aggravated in the line of duty, have service-connected disabilities rated 10% or 20% disabling, or were disabled by medical treatment or vocational rehabilitation
- **Priority Group 4.** Veterans who are receiving aid and attendance or housebound benefits (see “Aid and Attendance,” above)
- **Priority Group 5.** Veterans with no disability rating but who have income and assets below certain dollar limits, are receiving VA pension, or are eligible for Medicaid
- **Priority Group 6.** Veterans who served at Camp LeJeune or in the Gulf War, veterans with compensable 0% service-connected disabilities
- **Priority Group 7.** Veterans whose income is below certain limits for their area and who agree to a copayment for services, and
- **Priority Group 8.** All other veterans who agree to pay copays.

### **TRICARE Medical Coverage for Military Retirees and Dependents**

A comprehensive and generous system of medical coverage, completely separate from veterans benefits, is available for retired military service members, their spouses, and their children younger than 21. This system is known as TRICARE and is administered by the Department of Defense. People with TRICARE coverage who become eligible for Medicare must be enrolled in both programs. For details on TRICARE eligibility, benefits, and the coordination of TRICARE and Medicare, visit the TRICARE website at [www.tricare.mil](http://www.tricare.mil).

### **Health Care Coverage for Dependents of Disabled Veterans**

The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is the VA's health care benefit for spouses and children of permanently disabled veterans. Children are eligible for CHAMPVA as long as they remain unmarried and, for stepchildren, living in the veteran's home and are:

- under age 18
- under age 23 if they're in school full-time, or
- disabled (and the disability happened before age 18).

### **Additional Veterans Programs Are Available**

This chapter explains the major programs for which older veterans are usually eligible. However, the VA administers many more programs that a veteran might find useful.

The VA provides financial support for education and vocational training, life insurance, home loans and other housing assistance, and a National Cemetery burial program.

Eligibility requirements vary for each of these programs, but either prior active duty or active duty for training are usual requirements. (See "Types of Military Service Required," above, for definitions.)

For information about other services the VA offers veterans and their families, visit the VA's website at [www.va.gov](http://www.va.gov).

## Getting Information and Applying for Benefits

The VA maintains a website ([www.va.gov](http://www.va.gov)) with much useful information about the programs discussed in this chapter. The website can be a little overwhelming, but if you're comfortable navigating the internet, you may find the site very useful. You might find it easiest to use the site's search engine by filling in just the specific subject you're interested in, such as disability compensation or Aid & Attendance.

The VA maintains large regional offices in major cities and many smaller offices known as "Vet Centers" in cities both large and small. Although applications are processed and decisions made at the regional offices, the Vet Centers provide information about benefits and claims. The Vet Centers can also provide you with application forms for various benefits, assist you in filling them out, and help you with an appeal if you're denied a benefit.

To find either the regional office or the Vet Center nearest you, look online or in the government pages in your telephone directory under United States Government, Veterans Affairs Department. Or, call the VA's national benefits information line at 800-827-1000, or their health benefits line at 877-222-8387. Also check the VA website at [www.va.gov](http://www.va.gov).

When appearing in person at a Vet Center, the veteran should bring discharge papers, medical records if applying for disability benefits, and wage or tax records indicating current income if considering an application for wartime service pension benefits.

A surviving spouse should bring the veteran's discharge or other military papers, marriage certificate, death certificate, recent wage or tax records, and birth certificates for any minor children or surviving children who are disabled or full-time students, plus evidence of their disability or student status.

Requests for medical treatment or admission to a VA medical facility, or VA coverage of medical treatment by a private facility, are usually handled at the admitting office of the VA medical facility or clinic itself. A veteran seeking medical attention at a VA hospital should (after calling to find out its appointment procedures) bring discharge papers and documents indicating that the veteran is receiving VA disability compensation or VA pension. ●



## Medicare

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The high cost of medical care and medical insurance, coupled with the lack of a comprehensive health plan available to all, is disappointing in a nation as wealthy as the United States. Yet whenever discussion of this issue makes its way into the political arena, proposals for creating a decent health care system run into dual roadblocks. The first is mounted by heavily bankrolled corporate interests—pharmaceutical, medical technology, and hospital companies; the insurance industry; and most doctors’ groups—who fight any limits on their profit making. The second is set up by politicians who refuse to take any steps that might be seen as opposing these corporate interests. Despite this opposition, since 1965, Medicare has been carving an inroad into the mountain of consumer health care costs.

Medicare pays for most of the cost of hospitalization and much other medical care for older and permanently disabled Americans (though for some, it still leaves almost half of all medical costs unpaid). Medicare now provides coverage for more than 65 million people, most of them age 65 and older.

Despite its broad reach, Medicare doesn’t pay for many types of medical services, and it pays only a portion of most services it does cover. Although Medicare expanded its coverage in 2006 to include some of the cost of prescription drugs, only recently has it begun to address the overall skyrocketing costs of those drugs.

And while the 2010 Affordable Care Act expanded Medicare coverage of certain preventive screenings and examinations, and slightly improved prescription drug coverage, it didn’t otherwise broaden Medicare.

This chapter discusses the Medicare system, what it covers, and how much it pays. Chapter 13 shows you how to apply for Medicare and take full advantage of its benefits.

The chapters that follow present detailed information about how to fill the gaps in Medicare coverage. Medigap supplemental insurance is discussed in Chapter 14, and the various Medicare Advantage plans are sorted out in Chapter 15. If you have low income and few assets, Chapter 16 explains the government Medicaid program, which provides free coverage in place of buying private insurance or a managed care plan.

### If You Will Turn 65 Soon

If you're turning 65 soon (and aren't already enrolled in Medicare through disability benefits eligibility), there are several things you need to do to prepare for Medicare.

Find out if your current health insurance will continue when you hit 65 and, if so, how it works in conjunction with Medicare.

See what Medicare supplement ("medigap") insurance policies (Chapter 14) and Medicare Advantage plans (Chapter 15) are available where you live.

Decide whether to enroll in traditional fee-for-service Medicare (this chapter), and whether to add a medigap policy (Chapter 14) to this, or instead to enroll in a Medicare Advantage plan (Chapter 15).

Look into whether you might be eligible for Medicaid (Medi-Cal in California) coverage, or for state assistance with your Medicare costs (Chapter 16).

Learn about Medicare prescription drug coverage and the insurance plans available in your state to deliver that coverage (this chapter).

Speak to your physician about scheduling an initial Medicare physical examination (within six months after first enrolling) and about preventive services covered by Medicare that are appropriate to your physical condition and health history.

## The Medicare Maze

There are two different ways that someone eligible for Medicare can receive the program's benefits. The first way is called "traditional Medicare" or "original Medicare," which includes Part A (hospital insurance) and Part B (medical insurance). With this type of Medicare coverage, a beneficiary can receive care from any doctor, hospital, clinic, or other provider who accepts Medicare patients. Medicare pays the provider a fee for each specific service. For services

for which Medicare doesn't fully pay, the patient has several choices. The patient can choose to:

- pay out of pocket
- buy a private supplemental insurance policy—commonly known as “medigap” insurance—that pays much of what Medicare doesn't (see Chapter 14)
- buy a separate Medicare Part D prescription drug coverage insurance plan, or
- apply for Medicaid coverage (Medi-Cal in California), which is a federal program for low-income people that pays almost all of the health care costs that Medicare doesn't pay. Even if you don't qualify for Medicaid, you can apply for subsidized coverage of prescription drugs (“Extra Help”) through Medicare Part D.

The second way that people can receive Medicare benefits is through a “Part C” Medicare Advantage plan, offered by private insurance companies. These plans cover everything that traditional Medicare does, plus some services Medicare doesn't cover at all.

Many Medicare Advantage plans also include outpatient prescription drug coverage. And, they eliminate some of the copayments and deductibles required by traditional Medicare.

Medicare Advantage plans are managed care plans similar to HMOs. They're generally less expensive than a combination of traditional Medicare with a medigap supplemental insurance policy. However, Medicare Advantage plans place greater limits on which specific doctors and other health care providers a patient can use, control referrals to specialists, and otherwise sometimes place restrictions on care.

Medicare Advantage plans also make annual changes: Sometimes they increase the copayment amounts they charge enrollees, sometimes they limit or eliminate specific coverage, and sometimes they eliminate coverage entirely in a particular geographic area. (For more information, see Chapter 15.)

Because of its lower cost, over half of Medicare beneficiaries are now enrolled in Medicare Advantage plans, though some of those are required to enroll because of their dual status as enrollees in both Medicare and Medicaid (see Chapter 16).

### **Medicare Prescription Drug Coverage**

Medicare Part D provides some coverage for outpatient prescription drug costs. Unfortunately, Medicare Part D prescription drug coverage leaves many drug costs uncovered. Part D handed its drug plans over to private insurance companies—whose inefficient overhead and enormous profits add to the cost of prescription drugs under Part D. And the program doesn't control the soaring overall costs of prescription drugs. In fact, historically, the law specifically barred the Medicare program from negotiating with drug companies for lower prices on behalf of Medicare patients.

This restriction helped drug prices increase at rates far above the cost of living, which, in turn, placed enormous economic pressure on seniors and the Medicare program alike. Beginning in 2024, the 2022 Inflation Reduction Act allows Medicare to negotiate prices on a limited number of brand-name drugs. How much of the savings will be passed on to beneficiaries remains to be seen.

(Medicare Part D's coverage is explained at the end of this chapter.)

## **Medicare and Medicaid: A Comparison**

People are sometimes confused about the differences between Medicare and Medicaid. Medicare was created to deal with the high medical costs that older citizens face relative to the rest of the population—especially troublesome given their reduced earning power. However, eligibility for Medicare isn't tied to individual financial need. Rather, it's an entitlement program; you're entitled to it because you or your spouse paid for it through Social Security and Medicare taxes.

Medicaid, on the other hand, is for low-income, financially needy people, set up by the federal government, and administered differently in each state.

Although you might qualify for and receive coverage from both Medicare and Medicaid, you must meet separate eligibility requirements for each program; being eligible for one program doesn't necessarily mean you're eligible for the other. If you qualify for both, Medicaid will pay for most Medicare Part A and B premiums, deductibles, and copayments or will offer you enrollment in a managed care plan that provides a combination of Medicare and Medicaid coverage.

Chapter 16 explains Medicaid, and the chart below describes the basic differences between the two programs.

A Comparison of Medicare and Medicaid	
Medicare	Medicaid
Who Is Eligible	
<p>Medicare is for almost everyone 65 or older, rich or poor; for people on Social Security disability; and for some people with permanent kidney failure.</p> <p>Medicare is an entitlement program; people are entitled to Medicare based on their own or their spouse's Social Security contributions, and on payment of premiums.</p>	<p>Medicaid is for low-income and financially needy people, including those older than 65 who are also on Medicare.</p> <p>Medicaid is an assistance program only for the needy.</p>
Who Administers the Program	
<p>Medicare is a federal program. Medicare rules are the same all over the country.</p> <p>Medicare information is available at your Social Security office or through the Centers for Medicare &amp; Medicaid Services.</p>	<p>Medicaid rules differ in each state.</p> <p>Medicaid information is available at your local county social services, welfare, or department of human services office.</p>

A Comparison of Medicare and Medicaid (continued)	
Medicare	Medicaid
Coverage Provided	
<p>Medicare hospital insurance (Part A) provides basic coverage for hospital stays, post-hospital nursing facilities and home health care.</p> <p>Medicare medical insurance (Part B) pays most of basic doctor and laboratory costs, and some other outpatient medical services, including medical equipment and supplies, home health care, and physical therapy. It covers some of the cost of prescription drugs for those who sign up for supplemental drug coverage (Part D).</p>	<p>Medicaid provides comprehensive inpatient and outpatient health care coverage, including many services and costs Medicare doesn't cover, most notably, prescription drugs, some diagnostic and preventive care, and eyeglasses. The amount of coverage, however, varies from state to state.</p> <p>Medicaid can pay Medicare deductibles and the 20% portion of charges not paid by Medicare. Medicaid can also pay the Medicare premium.</p>
Costs to Consumer	
<p>You must pay a yearly deductible for both Medicare Part A and Part B. You must also pay hefty copayments for extended hospital stays.</p> <p>Under Part B, you must pay the 20% of doctors' bills Medicare doesn't pay, and sometimes up to 15% more. Part B also charges a monthly premium. Under Part D, you must pay a monthly premium, a deductible, copayments, and all of your prescription drug costs over a certain yearly amount and up to a ceiling amount, unless you qualify for a low-income subsidy.</p>	<p>In some states, Medicaid charges consumers small amounts for certain services.</p>

## Medicare: The Basics

Medicare is a federal government program that assists older and some disabled people with paying their medical costs. Part A is called “hospital insurance” and covers most of the costs of a stay in the hospital, as well as some follow-up recovery costs afterward. Part B, “medical insurance,” pays some of the costs of doctors and outpatient medical care. And Part D pays some prescription drug costs.

Medicare Part C refers to separate Medicare Advantage plans, which can replace Parts A, B, and D (see Chapter 15).

Medicare is operated by the Centers for Medicare & Medicaid Services (CMS), part of the Department of Health and Human Services, in cooperation with the Social Security Administration. The Medicare program’s daily business, however, is run by private companies, called carriers or intermediaries, operating under contract with the federal government.

Most of a patient’s direct contact with Medicare happens with the company—Blue Cross, Blue Shield, or another large insurance company—that administers Medicare or that runs the patient’s Medicare Advantage or Part D prescription drug plan.

One of the outrages of the current Medicare system is that giving Medicare administrative monopolies to these private insurance companies drives up costs to the public.

### **Special Medicare Eligibility for End-Stage Renal Disease (ESRD)**

While Medicare coverage is generally reserved for people age 65 or older and people with long-term disabilities, a special Medicare provision provides full Medicare coverage to most people suffering from permanent kidney failure, known as “end-stage renal disease” (ESRD), regardless of their age. The rules regarding eligibility for this coverage and the extent of this coverage are discussed fully later in this chapter.

## Health Coverage If You Stop Working Before Age 65

Medicare and Medicare supplemental insurance and Medicare Advantage plans are available to most people age 65 and older. But what if you stop working before age 65—either because you choose to retire, are laid off, or lose your business? Chances are you'll lose your health insurance at the same time. Then the issue becomes finding affordable medical coverage, and a plan that will cover preexisting conditions, to fill the gap until you turn 65.

Here are some ways to try to stretch your medical coverage without turning to the open market for an individual health insurance policy:

- **Take advantage of continued health insurance from your employer.** If you're entitled to retirement benefits from your employer, these might include continued health care coverage. Be aware, however, that your employer is permitted to drop that retiree health coverage once you turn 65 and are eligible for Medicare. Many retiree health plans at least continue coverage for costs above what Medicare pays. If you aren't automatically eligible for retiree health coverage, you might be able to negotiate continued health coverage with your employer as part of your severance package, or with the purchaser of your business as part of its sale price.
- **Convert to individual coverage under an employer-sponsored plan.** Some employer-sponsored insurance plans permit employees to convert their group coverage to individual coverage upon leaving their employment. If your plan allows this, you'll probably have to pay all the premiums—and they might well be higher than when you were part of a group policy. Even if such individual coverage is available to you through your employer, you might want to compare its coverage and cost with individual insurance available through the new federal or state health insurance exchanges (see below).
- **Continue coverage under COBRA.** The federal Consolidated Budget Reconciliation Act (COBRA) mandates a period of continued health care coverage for people who lose or leave

their jobs (unless they're fired for gross misconduct) and their spouses and children. It also applies to employees whose hours are reduced below the number that qualifies them for health benefits. If you qualify for COBRA, you're entitled to buy 18 months of health insurance from the same company following the end of your employer-sponsored coverage. However, the extent of your coverage might be reduced, and you'll have to pay the full premiums—which will probably be higher than what your employer paid for you. (For more information, see *The Essential Guide to Federal Employment Laws*, by Lisa Guerin and Sachi Clements (Nolo), or search “COBRA” on the Department of Labor website at [www.dol.gov](http://www.dol.gov).) Also, check with the agency in your state dealing with labor and employment—most states have passed their own laws expanding on COBRA's coverage.

- **Find individual health insurance through your state's insurance exchange or the federal insurance marketplace.** Any individual can buy one of these health insurance policies, regardless of their prior medical history. These policies are sold through what is called a “health insurance exchange,” or “marketplace,” established by the Affordable Care Act. The cost of the health insurance policies depends on your age, the level of coverage you seek, and your income. About half of the states operate state health insurance exchanges on their own or in partnership with the federal government, while residents of the other states are eligible to use the federal marketplace. To find out what's available where you live, go online to the government site [www.healthcare.gov](http://www.healthcare.gov).
- **Claim early Medicare based on disability.** If you stop working because of a disability and you qualify for Social Security disability benefits, you'll qualify for full Medicare coverage once you've been entitled to disability benefits for 24 months. (See Chapter 3 for a full discussion of Social Security disability benefits.)

## Working After Age 65

If you have current health care coverage through your employer when you turn 65, you might want to continue with it and not sign up for Medicare Part B. (Medicare Part A is free for almost everyone, so there's no reason not to enroll in it after you turn 65, even if you keep your employer-based insurance. See Chapter 13 for more on enrolling for Part A.)

Many people who continue full-time employment after age 65 are enrolled in health insurance through their employer (often along with their spouse) or through their spouse's employer. If it's a large employer (with more than 20 employees), the employee with health coverage (and the Medicare-eligible spouse) can choose to either keep that health insurance or drop it (and its premium costs) and enroll instead in Medicare Part B.

This might also be true for some small employers—those with fewer than 20 employees—who make special arrangements with their health insurance carrier; check with your employer to see if this is the case for you.

As a rule, however, primary coverage by employer-based health insurance does not apply to most employer-based health insurance for current age-65 employees of small employers with fewer than 20 employees or to retiree health insurance. For smaller company employees and for retirees, employer-based coverage automatically becomes “secondary” to Medicare when they turn 65 and will only help pay for costs that Medicare doesn't pay (such as deductibles and copayments). So, these employees and retirees need to enroll in Medicare Part B—or a Part C Medicare Advantage plan (see Chapter 15)—as soon as they turn 65.

If you have the choice to remain enrolled in employer-based health insurance based on your or your spouse's current employment or to drop that insurance and enroll in Medicare Part B, how do you decide? As with most health insurance decisions, compare the costs. Look at the monthly premium, plus the deductibles and copayments, for your employer-sponsored coverage. Then compare that against the monthly cost for Medicare Part B (\$175 per month in 2024; more if

you have income over \$103,000, or \$206,000 as a couple), plus the cost of a medigap supplemental plan (average of \$150 to \$250 per month for the most common plan—see Chapter 14), and a Part D drug coverage plan (an average of \$35 per month). Alternatively, you could enroll in a Part C Medicare Advantage plan, which provides the full coverage of Medicare Part B, a medigap supplement, and Part D drug coverage, for the lower cost of just the Medicare Part B premium plus another \$25 per month (on average). Some Part C plans have no monthly premium.

Cost, however, isn't the only consideration. Be aware that not all doctors accept patients who are covered by Medicare as their primary insurance, especially those who have Medicare Advantage plans. So, even if Medicare Part B plus supplementary medigap insurance or a Medicare Advantage plan would be cheaper for you than keeping your employer-based coverage, before switching to Medicare, you need to check whether the doctors you regularly use accept Medicare patients, and a specific Medicare Advantage plan if you're considering one. If one or more of your regular doctors would no longer see you as a patient if you switch to Medicare as your primary coverage, or to a particular Medicare Advantage plan, you have to consider whether being forced to switch to another doctor is worth the money you would save by switching to Medicare Part B or a Medicare Advantage plan.

## **Employer-Based Health Coverage for Retirees**

Once you're Medicare eligible, your retirement health coverage might be cut off. About 12 million Medicare beneficiaries receive some kind of retirement health benefits from their former employers. These benefits often dovetail with Medicare coverage, paying its deductibles and copayments, and covering services Medicare doesn't, including prescription drugs. However, employers are free to reduce that health coverage or eliminate it entirely for retirees age 65 or older—even if they maintain the coverage for younger retirees.

If this happens to you, you'll have to fill in the gaps in Medicare coverage some other way, as described in Chapters 14 through 16.

## Part A: Hospital Insurance

Medicare is divided into several parts. Hospital insurance, referred to as “Part A,” covers most of the cost of hospital and skilled nursing facility care when you’re an inpatient. Doctors’ charges and other medical costs are covered, at least in part, by Medicare Part B. And Medicare Part D covers part of your prescription drug costs. If you’re enrolled in a Medicare Part C Medicare Advantage plan (see Chapter 15), your hospital insurance is provided by that plan rather than by Medicare Part A.

### Who Is Eligible

There are two types of eligibility for Medicare Part A hospital insurance: free and paid. Most people age 65 and older are eligible for free coverage, based on their work records or on their spouse’s work records. People older than 65 who aren’t eligible for free Medicare Part A coverage can nevertheless enroll in it and pay a monthly fee. (See Chapter 13 for enrollment procedures.)

### Free Coverage

The vast majority of people age 65 and older are automatically eligible for Medicare Part A hospital insurance. They don’t have to pay any monthly premium for it; the coverage is free.

The two largest categories of people automatically eligible are:

- people age 65 or older who are eligible for Social Security retirement benefits (or have civil service retirement work credits equal to an amount that would make them eligible for Social Security retirement). (See Chapters 2 and 10 regarding eligibility for these two programs.) You’re automatically eligible for Medicare coverage even if you don’t actually begin collecting your retirement benefits at 65, as long as you could have started collecting them. If you wait to claim retirement benefits until after 65, you can still begin Medicare coverage at 65.

- people age 65 or older who are eligible for Social Security dependents or survivors benefits. This includes same-sex spouses who are eligible for either of these Social Security benefits. Note that people who are age 65 or older and eligible for dependents benefits when a spouse turns 62 are entitled to Medicare coverage whether or not the spouse actually claims retirement benefits at that time.

Some additional categories of people who might also be eligible for free coverage include:

- people of any age who have been entitled to Social Security disability benefits for 24 months
- people with amyotrophic lateral sclerosis (ALS) who have been approved for Social Security disability benefits (no waiting period), and
- anyone who has permanent kidney failure (ESRD) requiring either a kidney transplant or maintenance dialysis, if the person or spouse has worked a certain amount at jobs covered by Social Security. (There's a full discussion of this special ESRD-based Medicare eligibility later in this chapter.)

### **Paid Coverage**

If you're age 65 or older but not automatically eligible for free Part A hospital insurance coverage, you can still enroll in the Medicare hospital insurance program by paying a monthly premium. The amount of your premium depends on how many Social Security work credits you or your spouse have earned, and on how long after your 65th birthday you apply for coverage.

If you aren't eligible for free Part A coverage based on your or your spouse's work record, you can purchase the coverage by paying a monthly premium of \$505 (in 2024); if you or your spouse has 30 to 39 work credits, your monthly premium will be \$278. Also, if you enroll in Part A coverage more than a year after you turn 65, your premium will be 10% higher than these monthly figures (unless you fit under an exception, such as having had health coverage, up to the point you apply for Part A, through an employer).

**CAUTION**

**Make sure to compare costs.** If you're considering enrolling in and paying for Medicare Part A hospital insurance, it might be cheaper for you to do so through an HMO or a health plan. The cost of such coverage will be part of the broader coverage and cost for full participation in the HMO or health plan, which will vary among different plans. Before purchasing Medicare Part A coverage as an individual, compare premiums and benefits of various group plans.

If you enroll in paid Part A hospital insurance, you must also enroll in Part B medical insurance, for which you pay an additional monthly premium. However, you can enroll in Part B without Part A.

## Types of Care Covered

Part A hospital insurance pays much of the costs you incur directly from a hospital as part of inpatient care. Under some circumstances, it also covers some of the cost of inpatient treatment in a skilled nursing facility and by a home health care agency. Doctors' bills aren't included in Part A coverage; they're covered under Medicare Part B.

A few basic rules apply to all claims under Part A hospital insurance coverage, whether for inpatient care at a hospital or nursing facility or for home health care.

### Doctor-Prescribed Care

The care and treatment you receive must be prescribed by a licensed physician.

### Reasonable and Necessary Care

The inpatient care you receive must be medically reasonable and necessary—that is, the type of care that can be provided only at a hospital or nursing facility. If you could receive the particular treatment just as well and safely as a hospital outpatient, at the doctor's office, or at your home, Part A won't cover you if you receive that treatment as an inpatient. Also, Part A won't normally cover the cost of hospitalization for elective or cosmetic surgery—except

for reconstructive surgery after an accident or a disfiguring illness—because these aren’t considered medically necessary.



#### CAUTION

**“Held for observation” is not the same as “admitted.”**

Medicare Part A hospital insurance kicks in only if someone is actually admitted to the hospital as an inpatient. Many times a patient is held and treated at the hospital—in a bed, in a room for more than 24 hours—but not formally admitted to the hospital. This is known as being “held for observation” and doesn’t trigger coverage by Medicare Part A. Instead, Medicare Part B medical insurance (see later in this chapter) would be available to cover the care provided by the hospital and the doctors, and Medicare Part D prescription drug coverage could cover any medications provided.

The problem is that the copayments and deductibles a patient has to pay under Medicare Part B and Part D are generally much higher than under Part A. Also, being held for observation—rather than being actually admitted to the hospital—doesn’t trigger eligibility for Part A coverage of follow-up skilled nursing facility or rehabilitation care (see the following section), which is quite common after hospital treatment. This can mean the entire very expensive cost of the nursing or rehab facility care must be paid out of the patient’s pocket.

If you or a loved one are taken to the hospital and treated there for more than 24 hours, ask your doctor to have you or the loved one formally admitted to the hospital, rather than merely being held for observation, so that Medicare Part A coverage will be available to cover the stay and any following skilled nursing or rehabilitation facility inpatient care. Be aware that doctors and hospitals usually use Medicare’s “Two Midnight” guideline in determining whether a patient is formally admitted as an inpatient. This refers to an expectation by the treating physician that the patient will need to remain in the hospital for at least two consecutive overnights (“two midnights”). However, this is only a guideline, not a hard-and-fast rule, and a doctor can admit a patient as an inpatient even if the doctor isn’t certain the patient will need to remain past two midnights, if in the doctor’s reasonable opinion an inpatient admission is medically required. Medicare, however, reserves the right to challenge the reasonableness of that decision.

**CAUTION**

**Custodial care isn't covered.** Part A hospital insurance covers only skilled medical treatment of an illness or injury. It doesn't pay for a stay in any facility, or for care from a home health agency, when the services are "custodial"—meaning primarily to make life more comfortable—to help with dressing, eating, bathing, or moving around. In reality, distinctions between medical treatment and custodial care sometimes blur, which can result in disputes between Medicare and patients.

## Medicare-Approved Facility or Agency

Medicare issues licenses to hospitals, nursing facilities, and health care agencies certifying that they meet its standards for quality of care and staffing. Medicare will cover only care that is provided by facilities it approves.

Find out in advance if the facility to which you plan to be admitted, or the home health care agency you intend to hire, is approved by Medicare and accepts Medicare payment. Check with the facility's admissions services or administrator's office, or with the administrator of the home health care agency.

Nowadays it's rare to find a hospital or skilled nursing facility that isn't Medicare approved. Some home health care agencies, however, aren't Medicare approved. That doesn't necessarily mean that the agency isn't reputable. Under most circumstances, Medicare Part A pays for very little home care, anyway. So if Medicare isn't going to cover much of your costs, you might want to switch to an agency that is good and less expensive, but not Medicare approved, as soon as your Medicare coverage ends.

## Facility Review Panel Approval

Each hospital and nursing facility has a panel of doctors and administrators that reviews your doctor's decision to treat you as an inpatient. The panel usually agrees with your doctor's initial decision. And the panel and your doctor usually agree on how long you should remain in the facility. Sometimes, though, the

panel decides you don't need to be an inpatient to receive certain treatment. Or it decides that you could be discharged from the facility earlier than your doctor recommends. The panel and your doctor will then consult with one another. Usually, they reach an agreement.

If, however, your doctor and the review panel don't agree that you require inpatient care, or they differ as to your discharge date, the question of whether Medicare Part A will pay for your inpatient care will be referred to a Peer Review Organization (PRO). (See Chapter 13 for more on the review process.)



#### CAUTION

**Psychiatric stays are limited.** Medicare Part A covers inpatient psychiatric hospital care, but the total number of days covered is limited. (See the "Psychiatric Hospitals" section, below, for details.)

## Foreign Hospital Stays

In almost all situations, Medicare doesn't cover hospital stays outside the United States, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands, even in an emergency.

There are, however, three exceptions to this rule:

- If you're in the United States when an emergency occurs and a Canadian or Mexican hospital is closer than any U.S. hospital with emergency services, Medicare will help pay for your emergency care at that foreign hospital.
- If you live in the United States and a Mexican or Canadian hospital is closer to your home than the nearest U.S. hospital, Medicare can cover your care there even if there's no emergency.
- If you're in Canada while traveling directly to Alaska from one of the other states, or from Alaska to one of the other states, and an emergency arises, you might be covered for your care at a Canadian hospital. However, Medicare won't cover you if you're vacationing in Canada.

Some medigap supplemental insurance policies (see Chapter 14) and Medicare Advantage plans (see Chapter 15) offer coverage for foreign travel emergencies, though not for nonemergency care.



#### CAUTION

**Consider buying travel insurance.** Because there is no Medicare protection for you while you're traveling outside the United States, and if you have no other medical insurance that would cover you while traveling, it might be wise to look into traveler's insurance. These short-term policies are available for a one-time-only premium. A travel agent should be able to give you details. If you have a medigap or Medicare Advantage plan, you might not need extra travel insurance.

## Skilled Nursing Facilities

A growing number of patients recovering from surgery or a major illness are referred by their doctors to skilled nursing facilities (sometimes also called “rehabilitative care centers”). These provide an important, less expensive alternative to hospitalization. Medicare may cover some of your costs of staying in a skilled nursing facility, but strictly limits how much it will pay. (See “How Much Medicare Part A Pays,” below, for details.)

You'll need to make sure your stay will be covered at all. You must meet two requirements before Medicare will pay for any nursing facility care. You must have recently stayed in a hospital, and your doctor must verify that you require daily skilled nursing care.

### Prior Hospital Stay

For your stay in a skilled nursing facility to be covered by Medicare Part A, it must begin after you've spent at least three consecutive days, not counting the day of discharge, in the hospital as a formally admitted inpatient—and within 30 days of being discharged. If you leave the nursing facility after coverage begins but are readmitted within 30 days, that second period in the nursing facility will also

be covered by Medicare. (For details, see “Benefit Period or Spell of Illness,” below.) Note: If you’re enrolled in a Medicare Advantage (Medicare Part C) plan, the rules for skilled nursing facility coverage might be slightly less strict; see Chapter 15.

Hospitals are supposed to provide a written notice to patients who are at the hospital “under observation” for at least 24 hours, explaining whether the patient’s stay at the hospital is officially an inpatient stay or an outpatient stay. If the stay was at least partly as an inpatient, the notice should indicate whether the inpatient status was for the three days (not counting the day of discharge) required for Medicare Part A to cover a following stay in a skilled nursing facility. If the stay was strictly an outpatient stay, the notice must also explain why the patient was not admitted as an inpatient.

When a patient seeks admission to a skilled nursing facility following a hospital stay that included a period of “under observation” outpatient status, the skilled nursing facility must give the patient a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) warning that care might not be covered by Medicare Part A.

### **Requiring Daily Skilled Nursing Care**

Your doctor must certify that you require daily inpatient skilled nursing care or skilled rehabilitative services. This care includes rehabilitative services by professional therapists and skilled nursing treatment—such as giving injections, changing dressings, monitoring vital signs, or administering medicines or treatments—that can’t be performed by untrained personnel. This daily care must be related to the condition for which you were hospitalized.

If you’re in a nursing facility only because you’re unable to feed, clothe, bathe, or move yourself, even though these restrictions are the result of your medical condition, your stay won’t be covered by Part A.

This is because you don’t require skilled nursing care as defined by Medicare rules. However, if you require occasional part-time nursing care, you might be eligible for home health care coverage (described above) through Part A.

## Aspects of Inpatient Care Generally Covered by Part A

The following list gives you an idea of what Medicare Part A does—and doesn't—pay for during your stay in a participating hospital. Remember, though, even when Part A covers a cost, there are significant financial limitations on its coverage. (See “How Much Medicare Part A Pays,” below, for the dollar figures.)

Medicare Part A hospital insurance covers:

- a semiprivate room (two to four beds per room); a private room if medically necessary
- all meals, including special, medically required diets
- regular nursing services
- special care units, such as intensive care and coronary care
- drugs, medical supplies, and appliances furnished by the facility, such as casts, splints, and wheelchairs; also, outpatient drugs and medical supplies if they permit you to leave the hospital or nursing facility sooner
- hospital lab tests, X-rays, other diagnostic testing, and radiation treatment billed by the hospital
- operating and recovery room costs
- blood transfusions; you pay for the first three pints of blood, unless you arrange to have them replaced by an outside donation of blood to the hospital, and
- rehabilitation services, such as physical therapy, occupational therapy, and speech language pathology services (speech therapy) provided while you're in the hospital or nursing facility.

Medicare Part A hospital insurance does not cover:

- personal convenience items, such as television, radio, or telephone
- private duty nurses, or
- a private room, unless medically necessary.

## Levels of Nursing Facility Care

Most nursing facilities provide what is called “custodial care”—primarily personal, nonmedical care for people who are no longer able to fully care for themselves. Custodial care often lasts months or years and isn’t covered at all by Medicare. For the most part, custodial care amounts to assistance with the tasks of daily life: eating, dressing, bathing, moving around, and some recreation. It usually involves some health-related matters: monitoring and assisting with medication and providing some exercise or physical therapy. But it’s ordinarily provided mostly by personnel who aren’t highly trained health professionals, and doesn’t involve any significant treatment for illness or physical condition.

A different, short-term kind of care known as “skilled nursing facility care” is covered by Medicare, although there are severe limits. (See “How Much Medicare Part A Pays,” below, regarding these limits.) Skilled nursing facility care, which takes place in a hospital’s extended care wing or in a separate nursing facility, provides high levels of medical and nursing care, 24-hour monitoring, and intensive rehabilitation. It’s intended to follow acute hospital care due to serious illness, injury, or surgery—and usually lasts only a matter of days or weeks.

The nursing facility care and services covered by Medicare are similar to what is covered for hospital care. They include:

- a semiprivate room (two to four beds per room); a private room if medically necessary
- all meals, including special, medically required diets
- regular nursing services
- special care units, such as coronary care
- drugs, medical supplies, treatments, and appliances provided by the facility, such as casts, splints, and wheelchairs, and
- rehabilitation services, such as physical therapy, occupational therapy, and speech therapy, provided while you’re in the nursing facility.

Medicare coverage for a skilled nursing facility does not include:

- personal convenience items, such as television, radio, or telephone
- private duty nurses, or
- a private room when not medically necessary.

## Home Health Care

The use of paid professional home health care (including part-time nursing care and physical and other therapies), and home health care agencies to provide the care, has increased enormously over the past two decades. The following sections explain Medicare's substantial coverage of home health care. You can also read Medicare's online publication *Medicare and Home Health Care* at [www.medicare.gov/pubs/pdf/10969-medicare-and-home-health-care.pdf](http://www.medicare.gov/pubs/pdf/10969-medicare-and-home-health-care.pdf).



### RESOURCE

**Learn more about home health care.** For a complete discussion of long-term care, particularly for older people, and how to finance it, see *Long-Term Care: How to Plan & Pay for It*, by Joseph L. Matthews (Nolo). For ordering information, visit [www.nolo.com](http://www.nolo.com).

## Coverage Provided

Part A home health care coverage requires a prior three-day hospital stay. Home care without a prior hospital stay might be covered by Part B. If you qualify for Part A home care coverage, Medicare pays for the following services provided by a participating home health care agency:

- part-time skilled nursing care—usually two to three visits per week as part of a plan certified by a physician, and
- physical therapy, occupational therapy, and speech therapy.

If you're receiving part-time skilled nursing care, physical therapy, occupational therapy, or speech therapy, Medicare can also pay for:

- part-time home health aides
- medical social services, and

- medical supplies and equipment provided by the agency, such as a hospital bed, a walker, or respiratory equipment.

However, Medicare won't pay for a number of services sometimes provided as part of home health care, including:

- full-time nursing care
- drugs and biologicals administered at home
- meals delivered to your home, or
- housekeeping services.

### **Restrictions on Coverage**

Despite the obvious financial as well as recovery advantages of home health care, Medicare coverage for it is severely restricted to the following:

- The agency providing the care must participate in Medicare—meaning it must be approved by Medicare and must accept Medicare payment. Not all agencies participate in Medicare, so find out before making arrangements.
- You must be confined to your home by an injury, illness, or other medical condition. If you need nursing care or other medical services but you're physically able to leave home to receive them, you might not be eligible for Medicare home health care coverage.
- You must initially require part-time skilled nursing care or physical or speech therapy. After your home health care coverage begins, Medicare can continue to cover your home care even if you need only occupational therapy—which helps you regain physical skills needed for daily living that you might have lost because of the illness or injury. Occupational therapy alone, however, can't justify home health care coverage in the first place.
- Your doctor must determine that you need home health care and must help set up a care plan in cooperation with the home health care agency. If your doctor has not mentioned home care to you but you feel it would be a good idea, make your wishes known. Most doctors will prescribe home care, can give you a referral to a Medicare-approved agency, and will cooperate with the home health care agency.

### **Skilled Nursing Home and Home Health Care Even If No “Improvement”**

Medicare Part A coverage for inpatient skilled nursing facility care or for home health care is intended for a period of recovery following a hospital stay for an illness, an injury, or surgery. But there can sometimes be a gray area regarding coverage when a patient reaches a plateau of recovery and their condition is no longer improving. In most cases, this is the point at which coverage ends. However, if nursing facility care or home care is necessary to keep the patient’s condition from deteriorating, Medicare Part A should continue to cover that care even though the patient is no longer improving.

The question of whether a person’s condition continues to justify Medicare Part A–covered skilled nursing care, either in a nursing facility or at home, or instead only requires nonskilled custodial care or nonskilled home care, which Medicare Part A doesn’t cover, can sometimes be tricky. If you or a loved one is in a situation in which Medicare is threatening to cut off skilled nursing facility care or home care, your best allies in keeping coverage are your doctor and the facility or agency providing the care. They need to make it clear to Medicare that skilled nursing care is still needed in order to maintain you at a functioning level, even if your underlying condition isn’t likely to improve any further.

## **Hospice Care**

Hospice care is home health care provided to a terminally ill patient who is in the last six months (or so) of life, as judged by the patient’s treating doctor.

Hospice care focuses not on treating the illness or fostering recovery, but on making the patient as comfortable as possible. Good hospice care can combine the efforts of family, doctors, nurses, social workers, dietitians, and clergy, as well as physical therapists and other trained caregivers.

Medicare Part A doesn't provide 24-hour hospice care, but it does cover visits by health care workers to the patient's home on a regular basis—daily if necessary—including a hospice nurse on 24-hour call. Significantly, and unlike other nonhospital Medicare coverage, Medicare also pays for any medication prescribed by a physician for symptom management and hospice patient comfort.

Medicare might also cover up to five days of inpatient care in a hospital or skilled nursing facility to give the family or other primary caregivers a respite from their duties. If approved by the hospice, this five-day respite care period can be repeated during a patient's care.

The following sections explain how Medicare coverage of hospice works. Medicare's website also provides information about its hospice coverage in the booklet *Medicare Hospice Benefits*, which you can find at [www.medicare.gov/Pubs/pdf/02154-medicare-hospice-benefits.pdf](http://www.medicare.gov/Pubs/pdf/02154-medicare-hospice-benefits.pdf).

### **Hospice Coverage Provided**

Medicare Part A can cover nearly the full cost of hospice care.

Hospice care covered by Medicare includes:

- physician services provided by a physician connected with the hospice—Medicare Part B will continue to cover services provided by the patient's other doctors
- nursing care
- medical supplies and appliances
- drugs for management of pain and other symptoms
- health aide and homemaker services
- physical and speech therapy, and
- medical social services, counseling, and dietary assistance.

### **Restrictions on Hospice Coverage**

Care must be provided by a Medicare-approved hospice, under a plan developed by the hospice and the patient's attending physician. The patient's doctor and the hospice's medical director must certify that the patient is terminally ill, with a life expectancy of six months or less. And the patient must sign a statement choosing hospice care instead of standard Medicare Part A benefits.

## **Right to Return to Regular Medicare Coverage**

Some people don't take advantage of hospice care, out of a misunderstanding about how it impacts their Medicare coverage. They might mistakenly fear that they'll permanently lose their regular Medicare coverage, won't be covered by Medicare for hospitalizations or other medical care, or will outlive their six-month diagnosis and be stuck without Medicare coverage. The fact is, however, that a Medicare patient can disenroll from hospice care and return to regular Medicare coverage at any time. Also, if the patient's doctor certifies that the six-month life expectancy no longer applies, the patient can "graduate" from hospice and return to regular Medicare.

This sometimes occurs with degenerative diseases, such as congestive heart failure or emphysema; the physician's best time estimate might be off by years. Most people who disenroll do so after the first or second 90-day evaluation period (discussed further in the next section).

## **How Much Medicare Part A Pays**

To understand any Medicare decision about how much of your hospital, nursing facility, or home care bill Medicare will pay, you have to know the basics of Part A payments. Those basics include benefit periods and deductible and coinsurance amounts.

### **Benefit Period or Spell of Illness**

How much Medicare Part A pays depends on how many days of inpatient care you have during what is called a "benefit period" or "spell of illness."

A benefit period or spell of illness refers to the time you're treated in a hospital or skilled nursing facility, or some combination of the two. The benefit period begins the day you enter the hospital or skilled nursing facility as an inpatient—and continues until you've been out for 60 consecutive days. If you're in and out of the hospital or nursing facility several times but haven't stayed out completely for 60 consecutive days, all your inpatient bills for that time will be figured as part of the same benefit period (even if you're readmitted for a different illness or injury).

There's no limit to the number of benefit periods you can have over your lifetime, except for stays in psychiatric hospitals (see below).

## **Hospital Bills**

Medicare Part A pays only certain amounts of a hospital bill for any one benefit period.

### **The Deductible Amount**

For each benefit period, you must pay an initial amount before Medicare will pay anything. This is called the hospital insurance deductible. The deductible is increased every January 1. In 2024, the amount is \$1,632.

### **First 60 Days Hospitalized**

For the first 60 days you're an inpatient in a hospital during any one benefit period, Part A hospital insurance pays all of the cost of covered services. You pay only your hospital insurance deductible. If you're in more than one hospital, you still pay only one deductible per benefit period—and Part A covers 100% of all your covered costs for each.

### **61 Through 90 Days**

After your 60th day in the hospital during one spell of illness, and through your 90th day, each day you must pay what is called a "coinsurance amount" toward your covered hospital costs.

Part A of Medicare pays the rest of covered costs. In 2024, this daily coinsurance amount is \$408; it goes up every year.

### **Reserve Days**

Reserve days are a last-resort coverage. They can help pay for your hospital bills if you're in the hospital more than 90 days in one benefit period. But the payment is quite limited. If you're in the hospital for more than 90 days in any one spell of illness, you can use up to 60 additional reserve days of coverage. During those days, you're responsible for a daily coinsurance payment. For 2024, the reserve days coinsurance amount is \$816 per day. Medicare pays the rest of covered costs.

### Two Benefit Spells Might Be Better Than One

You can get more total days of full Medicare coverage during two spells of illness than in just one. As a result, it can be in your financial interest to stretch your hospital or nursing facility stays into two benefit periods, if possible. For example, using home health care might help you stay out of the hospital or nursing facility for 60 days before you must return as an inpatient for further treatment. If the timing of your inpatient treatment could be somewhat flexible, discuss that timing and its effect on Medicare coverage with your doctor.

**EXAMPLE:** Oscar is in the hospital with circulatory problems, being treated with medication. His doctor recommends surgery, operating on one leg at a time, monitoring the first leg before attending to the second. Oscar and his doctor plan the dates of surgery so that he will be released from the hospital and will convalesce at home, with the help of home health care services, for more than 60 days before he returns to have the second operation.

This way, Medicare will consider the time Oscar spends in the hospital after the second surgery to be part of a new spell of illness, even though it results from the same condition that made the first operation necessary. If there had not been a 60-day break between hospitalizations, Oscar would have been in the hospital a total of more than 60 days and would have had to pay a hefty coinsurance amount for every day after his 60th day in the hospital—up to his 90th day.

You don't have to use your reserve days in one spell of illness; you can split them up and use them over several benefit periods. But you have a total of only 60 reserve days in your lifetime. Whatever reserve days you use during one spell of illness are gone for good. In the next benefit period, you would have available only the number of reserve days you didn't use in previous spells of illness.



## TIP

**Try to save up your reserve days.** Even if you are in the hospital for more than 90 days, you might want to save your reserve days for an even rainier day. For example, you might not want to use your reserve days if you currently have some private insurance, such as from an employer, that can help cover the costs of those extra days of hospitalization, but you might not have that insurance later in life.

**EXAMPLE:** Bert had a serious stroke, followed by several complications involving kidney failure and pneumonia. For six months, he was in and out of both a hospital and a skilled nursing facility (SNF), for a total of 130 days. Because Bert never spent 60 consecutive days out of the hospital or SNF, all his inpatient treatment was considered part of the same “benefit period.” So when his time in the hospital reached 91 days, he had no choice but to begin using up his “reserve days” coverage. He used 20 reserve days during this benefit period, leaving him with only 40 reserve days for the remainder of his lifetime.

If Bert had remained out of the hospital and SNF for 60 consecutive days during any part of this stretch of treatment, he would not have had to use up any reserve days. Or, if his condition had permitted it, he might have been able to receive some care in an intermediate-level or custodial care nursing facility instead of in an SNF. However, this would have been a practical alternative only if he had some supplemental health coverage that would have paid for some or all of this level of care (Medicare doesn’t cover it at all).

Or, if Bert’s condition had permitted, he might have received some care at home from a Medicare-approved home health care agency. Medicare would have paid the full amount of this care. And it would not have affected his right to receive coverage when he needed to return to the hospital or SNF.

If you want to use your reserve days, you don't have to make a formal request or fill out any form. Medicare will automatically apply them to cover your hospital bills—minus the hefty daily coinsurance you have to pay.

But if you don't want to use those reserve days, or want to use some but not all of them, you must notify the hospital administrator or billing office. Plan ahead: You must submit your notification before the reserve days come up.

## Psychiatric Hospitals

Medicare Part A hospital insurance covers a total of 190 days in a lifetime for inpatient care in a specialty psychiatric hospital (meaning one that accepts patients only for mental health care, not just a general hospital).

If you're already an inpatient in a specialty psychiatric hospital when your Medicare coverage goes into effect, Medicare can retroactively cover you for up to 150 days of hospitalization before your coverage began. In all other ways, inpatient psychiatric care is governed by the same rules regarding coverage and copayments as regular hospital care.

There's no lifetime limit on coverage for inpatient mental health care in a general hospital. Medicare will pay for mental health care in a general hospital to the same extent as it will pay for other inpatient care.

**EXAMPLE:** During the five months before his 65th birthday, Horace spent 60 days in a psychiatric hospital. Those 60 days are subtracted from Horace's lifetime total of 190 days of Medicare coverage in a psychiatric hospital. It leaves him with only 130 days more coverage under Part A for psychiatric hospitalization.

## Skilled Nursing Facilities

Despite the common misconception that nursing homes are covered by Medicare, the truth is that Part A covers only a limited amount of inpatient skilled nursing facility care.

For each benefit period, Medicare will cover only a total of 100 days of inpatient care in a skilled nursing facility. For the first 20 of these 100 days, Medicare will pay for all covered costs, which include all basic services (but not television, telephone, or private room charges). For the next 80 days, the patient is personally responsible for a daily copayment; Medicare pays the rest of covered costs. In 2024, the copayment amount is \$204; the amount goes up each year.

Reserve days, available for hospital coverage, don't apply to a stay in a nursing facility. After 100 days in any benefit period, you're on your own as far as Part A hospital insurance is concerned. However, if you later begin a new benefit period, your first 100 days in a skilled nursing facility will again be covered.

**EXAMPLE:** Bettina was hospitalized for several weeks with a broken hip. Upon leaving the hospital, she was moved to a Medicare-approved SNF for rehabilitation and recovery. She remained in the SNF for 18 days, then went home. However, some setbacks in Bettina's healing forced her to return to the SNF a week later, where she stayed for another 12 days.

Because Bettina's stays in the SNF were not separated by 60 days, they were considered to be within the same "benefit period." Therefore, of her total 30 days in the SNF, Medicare will pay the entire amount of her bills (minus Bettina's phone calls to her brother in New Zealand) for only the first 20 days. For the remaining 10 days, Bettina will be responsible for a copayment of \$204 per day, for a total of \$2,040.

If Bettina had had a medigap supplemental insurance policy (see Chapter 14) or a Medicare managed care plan (see Chapter 15) that covered Medicare nursing facility copayments, or had she been eligible for Medicaid (see Chapter 16), that insurance, care plan, or government program would have paid all or part of the \$2,040. Having no such extra coverage, Bettina will have to pay out of her own pocket.

### How Part A Payments Are Figured

To get a picture of how the overall Part A payment scheme works, an example of one person’s hospital stay might be useful.

Annika was hospitalized for a week for an intestinal disorder, went home for a week, came back to the hospital for another five days, and then was taken into surgery. Annika spent two days in intensive care and another week in the hospital recovering from the operation. Annika’s hospital bill for all her treatment included:

Semiprivate room, 19 days at \$1,600 per day	\$30,400
Surgery surcharge	3,200
Intensive care unit, 2 days at \$3,000 per day	6,000
Laboratory	1,250
Medications	465
Whole blood (6 units at \$175 per unit)	1,050
Telephone calls	94
Television (19 days at \$12 per day)	228
TOTAL DUE	<u>\$42,687</u>

Medicare doesn’t cover, and won’t pay anything for, the telephone or television (\$322) or the first three units of blood (\$525), which Annika must pay out of pocket. But Medicare Part A will cover all the other costs, less the \$1,632 deductible for Part A, paying a total of more than \$40,000.

Remember, though, that Annika will still have to face all her doctor bills, coverage for which she will depend on Medicare Part B and any medigap supplemental insurance she has.

### Home Health Care

Medicare Part A pays 100% of the cost of your covered home health care when provided by a Medicare-approved agency—and there’s no limit on the number of visits to your home for which Medicare will pay.

Medicare will also pay for the initial evaluation by a home care agency, if prescribed by your physician, to determine whether you’re a good candidate for home care.

However, if you require durable medical equipment, such as a special bed or wheelchair, as part of your home care, Medicare will pay only 80%.

## Hospice Care

Medicare pays 100% of the charges for hospice care, with two exceptions. First, the hospice can charge the patient up to \$5 for each prescription of outpatient drugs the hospice supplies for pain and other symptomatic relief. Second, the hospice can charge the patient 5% of the amount Medicare pays for inpatient care in a hospice, nursing facility, or the like every time a patient receives such respite care.

There's no limit on the amount of hospice care you can receive. At the end of the first 90-day period of hospice care, your doctor will evaluate you to determine whether you still qualify for hospice—meaning your illness is still considered fatal and you're still estimated to have less than six months to live. A similar evaluation is made after the next 90-day period, and again every 60 days thereafter. If your doctor certifies that you're eligible for hospice care, Medicare will continue to pay for it even if it exceeds the original six-month diagnosis. And if your condition improves and you switch from hospice care back to regular Medicare coverage, you can return to hospice care whenever your condition warrants it.

**EXAMPLE:** Ted is suffering from cancer. His doctors say it will be fatal within six months. Ted chooses to stop his chemotherapy treatment, stay at home, and receive hospice care there. After 90 days, however, Ted has not gotten any worse. His doctors determine that Ted's cancer has not progressed much and that Ted might live for another year or two. So Ted returns to traditional Medicare coverage.

After another nine months, however, Ted's cancer becomes much more aggressive. After Ted undergoes a short course of chemotherapy, his doctor estimates that Ted now has less than six months to live. Ted can now return to hospice care and stay on it for as long as his doctor still believes the cancer will be fatal within six months.

## Part B: Medical Insurance

The second part of Medicare coverage, Part B, is medical insurance. It's intended to help pay doctor bills for treatment either in or out of the hospital, as well as many of the other medical expenses you incur when you aren't in the hospital.

### Eligibility and Premiums

You're eligible for Medicare Part B medical insurance if you're age 65 or older and either a U.S. citizen or a legal resident of the United States who has been in the country lawfully for five consecutive years. This is true whether or not you're eligible for Medicare Part A. Anyone who wants Part B medical insurance must enroll in the program. (See Chapter 13 for details about enrollment.)

Everyone enrolled in Medicare Part B must pay a monthly premium; if you also are enrolled in a state Medicare Savings Program, administered by Medicaid (see Chapter 16), Medicaid pays your Part B premium.

The Medicare Part B premium is raised almost every year. The amount of your premium depends on which of the following categories you fall into:

- **Basic premium.** If you were not collecting Social Security benefits as of November 2023, or you first enroll in Medicare Part B in 2024, you'll pay a monthly Part B premium of \$174.70.
- **Higher income-based premium.** If your adjusted gross income (based on your 2022 tax return) is more than \$103,000 (or \$206,000 for a couple filing jointly), your monthly Medicare Part B premium for 2024 will be higher than the basic premium, as shown on the chart below. (If, however, in the year since your 2022 tax return, you've become widowed or divorced or had a significant drop in income, you can contact Medicare and request an adjustment of this income-based premium.)

Yearly Income in 2022	Total Monthly Premium
Single \$103,001–\$129,000	\$244.60
Married \$206,001–\$258,000	
Single \$129,001–\$161,000	\$349.40
Married \$258,001–\$322,000	
Single \$161,001–\$193,000	\$454.20
Married \$322,001–\$386,000	
Single \$193,001–\$499,999	\$559.00
Married \$386,001–\$749,999	
Single \$500,000 or more	\$594.00
Married \$750,000 or more	

## Types of Services Covered

Part B medical insurance is intended to cover basic medical services provided by doctors, clinics, and laboratories. However, the lists of services specifically covered and not covered are long, and don't always make a lot of common sense.

Making the effort to learn what is and isn't covered can be important, because you might get the most benefits by fitting your medical treatments into the covered categories whenever possible.



### TIP

**Medicare's website has an extended list of Part B covered services.**

On the following pages you'll find an explanation of many of the most common medical services covered by Part B. For a more extensive list of covered services, see Section 2, Part B, of Medicare's handbook *Medicare & You* at [www.medicare.gov/media/10991](http://www.medicare.gov/media/10991).

## Doctor Bills

Part B medical insurance covers medically necessary doctors' services, including surgery, whether the services are provided at the hospital, at a doctor's office, or—if you can find such a doctor—at home. Part B also covers outpatient medical services provided by hospital and doctors' office staff who assist in providing care, such as nurses, nurse practitioners, surgical assistants, and laboratory or X-ray technicians.



### TIP

**Medicare pays for a second opinion before surgery.** Before undergoing surgery, it's usually medically wise to get a second opinion from another doctor. Second opinions often lead to the decision not to have surgery. Recognizing this and the savings involved, Medicare will cover your obtaining a second doctor's opinion before undergoing any kind of surgery. And if the second doctor's opinion conflicts with the original doctor's recommendation for surgery, Medicare will pay for an opinion by yet a third doctor.

## Outpatient Care and Laboratory Testing

Medicare medical insurance covers outpatient hospital treatment, such as emergency room or clinic charges, X-rays, injections that are not self-administered, and laboratory work and diagnostic tests. Lab work and tests can be done at the hospital lab or at an independent laboratory facility, so long as that lab is approved by Medicare.



### CAUTION

**Beware of outpatient hospital charges.** Medicare pays only a limited amount of outpatient hospital and clinic bills. And unlike most other kinds of outpatient services, Medicare places no limits on how much the hospital or clinic can charge over and above what Medicare pays. (See "Different Payment Structure for Hospital Outpatient Charges," below, for details.)

## COVID-19 Vaccines, Testing, and Antibody Treatment

If you become ill with COVID-19 or see a medical provider because you think you might have COVID-19, Medicare Part A and B (or Part C, Medicare Advantage—see Chapter 15) will cover your treatment under the same terms as for any other illness. In addition, Medicare Part B or Part C will cover the administration of approved COVID-19 vaccines, testing, and special antibody treatments under the following conditions.

- **Vaccines.** Medicare covers the entire cost of vaccination with any of the FDA-approved COVID-19 vaccines, regardless of where you obtain the vaccination.
- **Testing.** Medicare covers the cost of tests to determine whether you're currently infected with the COVID-19 virus (diagnostic test) or have developed antibodies to the virus because of being previously exposed (antibody test), if you receive the test at a testing site approved by your local health department, but you might have to pay a copay now that the COVID-19 public health emergency has ended.
- **Treatment.** Special monoclonal antibody treatments were developed for people infected with the COVID-19 virus, but many of them are no longer used because they aren't as effective against more recent strains of the virus. Medicare will cover the cost of monoclonal antibody treatments when provided by a Medicare-participating provider if they are still approved for use by the FDA. Medicare Part D may cover newer oral antiviral treatments, subject to your Part D plan's deductible and copayment rules.

## Ambulances

Part B medical insurance will cover the cost of transporting a patient by ambulance, if transport by any other means would not have been medically advisable. This can include not only emergencies, but also nonemergency trips following discharge from a hospital—for example, to the patient's home or to a nursing facility. Transporting

residents of nursing facilities to see their doctors may also be covered. However, Medicare doesn't cover ambulance transport for regular visits from a person's home to a doctor's office, if the trip was arranged simply because the person needed some assistance.

If your doctor prescribes an ambulance for you for a trip from home to the doctor's office, Medicare might cover it but isn't required to. Medicare will cover the ambulance trip only if the doctor's communication with Medicare convinces Medicare that the ambulance was medically necessary.

If Medicare covers an ambulance trip, the ambulance company must accept the Medicare-approved amount as full payment for its services. Medicare will pay 80% of the Medicare-approved amount. You, or your medigap insurer or managed care plan (see Chapters 14 and 15 for descriptions of these plans), are responsible for paying the remaining 20%. The ambulance company can't bill you for any amount over that 20%.

If you need help getting to and from doctor visits, but an ambulance isn't considered medically necessary, look into free transportation for seniors in your community. Call your local senior center or the senior information line or elder care locator listed in your telephone directory or look online for these kinds of resources.

## **Administered Drugs**

Drugs or other medicines administered to you at the hospital or a doctor's office are covered by Medicare medical insurance. However, Medicare Part B doesn't cover most drugs you take by yourself at home, including self-administered injections, even if they're prescribed by your doctor. Exceptions to this rule include self-administered cancer medication, antigens, immunosuppressive drugs, and insulin delivered by insulin pump (and the pump itself). Also, a yearly flu shot and vaccines for COVID, pneumonia, and hepatitis B are covered by Medicare. (Note: Most Medicare Part D prescription drug plans also cover other vaccines; see below.)

## Medical Equipment and Supplies

Splints, casts, prosthetic devices, body braces, heart pacemakers, corrective lenses after a cataract operation, therapeutic shoes for diabetics, and medical equipment such as ventilators, wheelchairs, and hospital beds—if prescribed by a doctor—are all covered by Part B medical insurance. This includes glucose monitoring equipment for people who have diabetes.

To learn more about the many types of medical equipment and supplies Medicare Part B covers, and how different equipment can be rented or purchased, see Medicare’s online publication *Medicare Coverage of Durable Medical Equipment & Other Devices* at [www.medicare.gov/media/publication/11045-medicare-coverage-of-dme-and-other-devices.pdf](http://www.medicare.gov/media/publication/11045-medicare-coverage-of-dme-and-other-devices.pdf).

To find a Medicare-certified supplier of medical equipment near you, go to the Medicare website home page at [www.medicare.gov](http://www.medicare.gov), and under the “Providers & Services” tab, click “Find medical equipment & suppliers.”

## Oral Surgery

Some types of surgery on the jaw or facial bones, or on the related nerves or blood vessels, can be covered by Part B medical insurance. However, surgery on teeth or gums, even when related to an injury or a disease that didn’t originate with the teeth, is usually considered to be dental work, and so isn’t covered by Medicare.

However, even if the work in question is done by an oral surgeon who isn’t an M.D., Medicare might cover it if it’s the kind of treatment that M.D.s also provide and if Medicare would have covered it if an M.D. physician had performed it. This is particularly true if the treatment involves not only teeth and gums but also the bones, nerves, blood vessels, or tongue. If Medicare is to cover work performed by a nonphysician oral surgeon, that surgeon must participate in—that is, be certified by—Medicare. You should have your oral surgeon’s office check with Medicare about coverage before undergoing any procedure.

## **Outpatient Physical Therapy and Speech Therapy**

Part B of Medicare will cover some of the cost of outpatient physical and speech therapy—if it's prescribed and regularly reviewed by a doctor and provided by a Medicare-approved facility or therapist.

However, there are limits on how much Medicare will pay for these therapies.

Medicare covers only therapy that improves a patient's condition or that is needed to maintain—by preventing or slowing a decline in—a patient's condition. Successfully getting Medicare coverage for therapy under this second standard—maintaining an existing condition—can be difficult, with Medicare and the insurance companies that offer Medicare Advantage policies (see Chapter 15) frequently denying such claims. In order to meet this standard, you might need a good written explanation of medical necessity from the therapist and support from your treating doctor.

There are also yearly dollar limits on the amounts Medicare Part B will pay for outpatient therapy. And the amount Medicare pays will be partially determined by who provides you with the therapy services. These limits are explained in “Payments for Outpatient Therapies,” below.

## **Supervised Exercise Therapy for PAD Patients**

Peripheral artery disease (PAD) is a condition in which arteries or other blood vessels in the legs become clogged. PAD isn't only painful but also increases the risk of heart attack and stroke.

Researchers have determined that exercise therapy, such as treadmill walking, can significantly reduce PAD without surgery. This exercise therapy is particularly useful if conducted under the supervision of a certified exercise therapist. Medicare Part B will partially pay for a limited amount of such supervised therapy (usually up to only 12 weeks) if it's prescribed by a physician. The patient must pay out of pocket, or through other medical insurance, for any charges that Medicare doesn't pay for.

## Home Health Care

The same home health care coverage is available under Part B medical insurance as is provided by Part A hospital insurance. (See “How Much Medicare Part A Pays,” above, for information about home health care coverage under Part A.)

If you have both Part A and Part B, Part A will cover your home health care following a hospital stay of at least three days; otherwise, Part B will cover it. There’s no limit on the number of home health care visits that are covered, and you aren’t responsible for paying your Part B deductible for home health care. Only skilled nursing care or therapy while you’re confined to your home is covered, however, and such care must be ordered by your doctor and provided by a Medicare-approved home health care agency.

Part B medical insurance, like Part A coverage, will pay 100% of the approved charges of a participating home health care agency.

## Chiropractors

Part B might cover some care by a Medicare-certified chiropractor. Generally, Medicare will cover a limited number of visits to a chiropractor for manipulation of neck or back vertebrae that are out of place.

Medicare won’t, however, cover general health maintenance visits to a chiropractor, nor will it usually cover therapeutic manipulation other than that of the vertebrae. And Medicare generally won’t cover X-rays or other diagnostic tests ordered or performed by the chiropractor. Instead, your physician normally must order these tests.

If you go to a chiropractor and hope to have Medicare pay its share of the bill, have the chiropractor’s office check with Medicare ahead of time about the treatment being proposed. And even if Medicare initially covers the treatment, it might not do so indefinitely. So, if you continue with the treatments, have the chiropractor’s office regularly check with Medicare to find out how long it will keep paying.

## Preventive Screening Exams

Medicare covers the following examinations to screen for a number of serious illnesses:

- a one-time routine physical exam (sometimes called an “initial wellness exam”) within six months of the date a person first enrolls in Part B coverage
- an annual physical exam that includes a comprehensive risk assessment, which might lead to further Medicare-covered testing
- a Pap smear and pelvic exam for women every three years; every year for women at high risk of cervical or pelvic disease; Medicare covers this exam even if you have not yet met your annual Part B deductible
- bone density tests for women at high risk of developing osteoporosis or for anyone who is receiving long-term steroid therapy, who has primary hyperparathyroidism, or who has certain vertebral abnormalities
- blood glucose testing supplies—if prescribed by a physician—for patients with diabetes
- annual prostate cancer screenings for men older than 55
- a positron emission tomography (PET) scan, which is a diagnostic test for certain cancers
- annual eye screening for glaucoma
- blood screening for early detection of cardiovascular disease, if your doctor says you have risk factors
- screening test for diabetes, if your doctor says you’re at risk for the disease, and
- PET brain scans for patients with unusual Alzheimer’s-like symptoms, if your doctor believes the source might be a different type of brain disease known as “frontotemporal dementia.”

## Colorectal Cancer Screenings

Different types and levels of colon cancer screenings are covered by Medicare Part B. Your physician, under Medicare guidelines, determines which specific test you should receive. Medicare Part B pays 100% of the costs, except where noted below:

- fecal occult blood test: a lab test, once per year for people 50 and older
- blood-based biomarker test: a lab test, once every three years for people age 50 to 85
- flexible sigmoidoscopy: an outpatient examination performed in a doctor's office, clinic, or hospital outpatient department, once every 4 years if age 50 or older, or 10 years following a colonoscopy, or more often if patient deemed at high risk
- colonoscopy: an outpatient examination (more comprehensive than sigmoidoscopy) performed in a doctor's office, clinic, or hospital, once every 10 years, or 4 years after a sigmoidoscopy (or more frequently if at high risk). Medicare will cover colonoscopy for patients of any age if a doctor orders it. If the doctor removes tissue during the procedure, the patient must pay 20% of the Medicare-approved amount for the doctor's charges as well as a copayment if the procedure is performed in a hospital outpatient setting. (The Part B yearly deductible doesn't apply.)
- barium enema: an alternative to a sigmoidoscopy or colonoscopy; every four years if age 50 or over (or every two years if patient is high risk). The patient must pay 20% of the doctor's Medicare-approved charges and a hospital outpatient copayment if the procedure is performed at a hospital outpatient clinic. (The Part B yearly deductible doesn't apply).

## Mammography

Part B covers a yearly mammogram, even if you have not yet met your annual deductible. The mammogram must be performed by a doctor or facility certified by Medicare to perform mammograms.

**Podiatrists**

Medicare covers podiatrist services only when they consist of treatment for injuries or diseases of the foot. This doesn't include routine foot care or treatment of corns or calluses.

**Eye Care and Eyeglasses**

Medicare does not cover routine eye examinations, glasses, or contact lenses provided by an optometrist or optician. The only exception is for people who have undergone cataract or other eye surgery. For them, Medicare covers not only the surgery itself but also glasses, contact lenses, or intraocular lenses, as well as the cost of a post-surgical examination by a Medicare-certified ophthalmologist or optometrist. Medicare Part B does cover medical care from an ophthalmologist (an eye doctor with an M.D., not an optometrist) or other medical doctor for illness or injury to your eyes.

**Clinical Psychologists or Social Workers**

When a doctor or hospital prescribes it in conjunction with medical treatment, Medicare Part B can cover limited counseling by a clinical psychologist or clinical social worker. The practitioner must be Medicare approved. If your doctor suggests a clinical psychologist or social worker to help in your recovery from surgery, injury, or illness, contact the practitioner in advance to find out whether the services will be approved by Medicare.

**Day Care Mental Health Treatment**

Medicare Part B can, in some cases, cover mental health care, in the form of day treatment—also called “partial hospitalization”—at a hospital outpatient department or community mental health center, if prescribed by a physician. The facility must be Medicare approved and the particular day program certified for Part B coverage by Medicare.

### **Alzheimer's-Related Treatments**

Until recently, Medicare didn't cover various kinds of physical, speech, and occupational therapy, or psychotherapy and other mental health services, for people who had been diagnosed with Alzheimer's disease. Medicare's reasoning was that patients with Alzheimer's were incapable of medically improving, and that the treatment was therefore not "medically necessary."

Medicare has now reversed its backward stance. A patient can no longer be denied Medicare coverage for physician-prescribed therapies or treatments solely because the patient has been diagnosed with Alzheimer's. So, if you or a loved one has Alzheimer's and a physician prescribes a form of therapy or other treatment to counter the effects of the disease, make sure the treatment provider participates in Medicare and will submit its bills to Medicare for payment.

### **Obesity**

Medicare covers various medically approved weight-loss therapies and treatments for obesity, if prescribed by a physician. These range from stomach surgeries to diet programs to psychological and behavior modification counseling.

Not all treatments are covered, however, and not all patients will be eligible for all covered treatments. But if you're undergoing care from a physician for obesity, the physician can recommend specific treatments for you that are covered by Medicare and can submit it to Medicare for coverage approval.

### **Chronic Pain Treatment**

Medicare Part B covers services specifically to treat chronic pain if your doctor verifies that you've been suffering from such pain for more than three months. Treatment for chronic pain is sometimes offered on an outpatient basis at special pain management clinics, often attached to a hospital.

## **Outpatient Mental Health Services**

Medicare Part B will cover outpatient psychotherapy and counseling, individually or in groups, for diagnosed mental health issues such as clinical depression, anxiety, and substance use disorders. These mental health care services can be provided by provided by psychiatrists, clinical psychologists, nurse practitioners, physicians' assistants (PAs), clinical social workers, marriage-and-family therapists, and mental health counselors. Only practitioners who officially participate in Medicare, however, will be reimbursed.

Medicare can cover intensive outpatient program services provided by hospitals, community mental health centers, federally qualified health centers, and Rural Health Clinics. The care can include outpatient "partial hospitalization" services provided by a community mental health center or by a hospital. Partial hospitalization provides rigorous outpatient psychiatric services as an alternative to inpatient psychiatric care.

## **Services *Not* Covered by Medicare Part B**

When you look at the list of what Medicare medical insurance doesn't cover, plus the Medicare deductibles and copayments, it's easy to understand why people with traditional Medicare still wind up personally responsible for half of their medical bills. It also underlines the need for you to consider additional medical insurance, either through private supplemental plans, an HMO or other Medicare Advantage plan, or Medicaid or Qualified Medicare Beneficiary coverage. (See Chapters 14, 15, and 16 for more on these alternatives.)

The categories of medical treatment and services listed below aren't covered by Medicare.

However, not all the noncovered services listed below apply to HMO or other Medicare Advantage plan coverage. Many Medicare Advantage plans include some coverage for a few of these medical services even though Medicare itself doesn't cover them.

### **Treatment That Is Not Medically Necessary**

Medicare won't pay for medical care that it doesn't consider medically necessary. This includes some elective and most cosmetic surgery, plus virtually all alternative forms of medical care such as acupuncture, acupressure, and homeopathy—with the one exception of limited use of chiropractors. This is despite the fact that many people find these therapies more beneficial than traditional forms of medical care.

### **Vaccinations and Immunizations**

Medicare Part B covers a yearly flu shot and pneumonia, hepatitis B, and COVID vaccines (see “Types of Services Covered,” above). It doesn't cover other vaccinations and immunizations, such as shingles, RSV, and vaccines taken for travel abroad. An exception is for emergencies in which a vaccination is required because of risk of infection or exposure to communicable disease. However, most Medicare Advantage plans (see Chapter 15) and Part D prescription drug plans (see “Part D: Prescription Drug Coverage,” later in this chapter) do cover other vaccinations.

### **Prescription Drugs You Take at Home**

Medicare Part A covers drugs administered while you're in the hospital or in a skilled nursing facility. Part B medical insurance covers drugs that can't be self-administered and that you receive as an outpatient at a hospital, a clinic, or at the doctor's office. (There are a few exceptions for self-administered drugs; see “Types of Services Covered,” above.) Potential coverage for all other prescription drugs falls under Medicare Part D (see “Part D: Prescription Drug Coverage,” below), which you must enroll in and pay for separately from Parts A and B, or through a Medicare Advantage plan (see Chapter 15).

### **Medicare Medical Insurance Is Never Enough**

Part B Medicare medical insurance is intended to pay for a portion of doctor bills, outpatient hospital and clinic charges, laboratory work, some home health care, physical and speech therapy, and a very few drugs and medical supplies. But as described above, there are heavy restrictions on what is covered, and as the following section explains, there are limits on how much is paid.

Private Medicare supplement insurance—referred to as “medigap” insurance—might help you make up the difference. Instead, some people fill in the gaps in Medicare by joining a Medicare Part C Medicare Advantage health plan that combines basic Medicare-level coverage with supplemental benefits. (See Chapter 14 for a discussion of medigap insurance and Chapter 15 to learn about Medicare Advantage plans.) If you have low income and few assets other than your home, you might be eligible for Medicaid (called MediCal in California), which covers most of the costs Medicare leaves unpaid. (See Chapter 16 regarding the Medicaid program.)

### **Nonprescription Drugs**

Medicare Part B doesn’t cover any of the cost of nonprescription (“over-the-counter”) medicines, vitamins, or supplements, regardless of whether they provide help with a medical condition, even if they have been recommended by a doctor.

### **Hearing Exams and Hearing Aids**

Medicare Part B doesn’t cover routine hearing examinations or hearing aids. However, if your ears or hearing are affected by a specific illness or injury, examination and treatment by a physician might be covered.

### **General Dental Work**

Medicare doesn’t cover work performed by a dentist or an oral surgeon, unless the same work is also performed by physicians.

In other words, if the treatment is considered medical rather than dental, Medicare might cover it. Generally, Medicare won't cover treatment unless the problem is unrelated to normal tooth decay or gum disease, and involves either the blood vessels, nerves, or bones of the mouth or jaw.

### Long-Term Care

Medicare Part B covers some home health care, as described in the previous section. But that care is always relatively short-term, limited to a period of recovery from an acute illness, injury, or condition, and includes only skilled nursing care and therapy.

Medicare doesn't provide the kind of long-term care, either at home or in a facility, that many older people need because of frailty or other inability to perform, without help, the activities of daily life. Medicaid and long-term care insurance does cover certain nursing home costs. For a complete discussion of coverage for nursing home costs, see *Long-Term Care: How to Plan & Pay for It*, by Joseph L. Matthews (Nolo).

## How Much Medicare Part B Pays

When all your medical bills are added up, you'll see that Medicare Part B generally pays for only about half the total.

First, you pay a monthly enrollment fee. Then, Medicare doesn't cover all major medical expenses—for example, it doesn't cover routine physical examinations, over-the-counter medication, glasses, hearing aids, dentures, and some other costly medical services.

And for services it does cover, you must pay a yearly deductible, then Medicare pays only a portion of what it decides is the proper amount—called the “approved charges”—for medical services. In addition, when Medicare decides that a particular service is covered and determines the approved charges for it, Part B medical insurance usually pays only 80% of those approved charges; you're responsible for the remaining 20%.

Also, the approved amount might seem reasonable to Medicare, but it's often considerably less than what the doctor actually charges. If your doctor or other medical provider doesn't accept "assignment" of the Medicare charges (agreement that these charges will be the total that you owe), you're personally responsible for the difference.

Now that you know the worst, you can deal with the details of how much Medicare Part B pays. The rules aren't hard to understand—just hard to swallow.

## **Deductible Amounts**

Before Medicare pays anything under Part B medical insurance, you must pay a deductible, currently \$240 per year.

Medicare keeps track of how much of the deductible you've paid in a given year. It generally does a good job of keeping track, but it's always a good idea to keep your own records and double-check the accounting.

## **80% of Approved Charges**

For most services, Part B medical insurance pays only 80% of what Medicare decides is the approved charge. You're responsible for paying the other 20% of the approved charge, called your "coinsurance amount." And unless your doctor or other medical provider accepts assignment (see "Assignment of Medicare-Approved Amount," below), you're also responsible for the difference between the Medicare-approved charge and the amount the doctor or another provider actually charges.

Many Medicare enrollees cover this 20% through a private supplemental "medigap" insurance policy (see Chapter 14), while a large percentage of people avoid the charges by joining a Medicare Advantage managed care plan (see Chapter 15). Lower-income people might have the 20% paid by a state Medicaid or other program (see Chapter 16).

**TIP**

**Low-income seniors can receive state help.** Under programs known as “Qualified Medicare Beneficiary” (QMB), “Specified Low-Income Medicare Beneficiary” (SLMB), and Qualifying Individual (QI), Medicare recipients who have low incomes and few assets can receive considerable help with their basic Medicare expenses.

If you qualify as a QMB, your state will pay all Medicare premiums, deductibles, and coinsurance amounts. If you qualify as an SLMB, your state will pay the monthly Medicare Part B premiums, though not deductibles or coinsurance amounts. If you meet the standards as a QI, your state will pay all or part of your monthly Medicare Part B premium, but not any deductible or coinsurance. (See Chapter 16 for a full discussion of options for low-income persons.)

## Limit on Charges for Insulin and Pumps

If you take insulin through an insulin pump, both the pump and the insulin are covered by Part B. You pay no more than \$35 per month for the insulin, and the normal Part B deductible doesn’t apply.

## 100% of Approved Charges for Some Services

There are several types of treatments and medical providers for which Medicare Part B pays 100% of the approved charges rather than the usual 80%, and to which the yearly deductible doesn’t apply. In these categories, you aren’t required to pay the regular 20% coinsurance amount. In most of them, the provider accepts assignment of the approved charges as the full amount, so you actually pay nothing at all.

## Home Health Care

Whether you receive home health care under Part A or Part B, Medicare pays 100% of the charges, and you aren’t responsible for your yearly deductible. However, if you receive medical equipment—such as a wheelchair, chair lift, or special bed—from the home health care agency, you must pay the 20% coinsurance amount for that equipment.

### **Clinical Laboratory Services**

Medicare pays 100% of its approved amount for such laboratory services as blood tests, urinalyses, and biopsies. And the laboratory must accept assignment (except in Maryland, where a hospital lab can bill you, as an outpatient, for a 20% coinsurance amount).

### **Preventive Care Screenings**

Medicare Part B will pay 100% of the Medicare-approved amount for any covered preventive screening examination appropriately prescribed by a physician (see “Types of Services Covered,” above).

### **Flu, Pneumonia, Hepatitis B, and COVID Vaccines**

Medicare pays the full 100% of its approved charges for these vaccinations, and the yearly deductible doesn’t apply. However, the provider isn’t required to fully accept assignment; there might be up to an additional 15% charge on top of the amount Medicare approves.

### **Payments for Outpatient Therapies**

How much Medicare pays for outpatient physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) depends on where you receive the therapy.

**Therapy received in a doctor’s or therapist’s office, a rehabilitation facility, or a skilled nursing facility while you’re an inpatient.** Medicare will pay 80% of the Medicare-approved amount. You or your supplemental insurance or managed care plan remain responsible for the other 20%. There’s no cap on the amount Medicare will pay for therapy in these settings. However, once the costs to Medicare reach \$2,330 (in 2024), for you to receive more therapy, your therapist will have to provide written documentation to Medicare showing that your care continues to be medically necessary; your physician might have to provide supporting evidence.

**Therapy received at home.** If you receive therapy at home from a Medicare-certified home health care agency as part of a comprehensive Medicare-covered home health care program, Medicare will pay 100% of the cost. If you receive therapy at home that isn't part of a Medicare-covered comprehensive home health care plan, Medicare will pay 80% of approved charges.

**Therapy received at a hospital outpatient department.** There are financial advantages and disadvantages to receiving Medicare-covered therapy at a hospital outpatient department instead of in a doctor's or therapist's office, or at home. One advantage is that Medicare Part B pays the full Medicare-approved amount for the therapy, except for a patient copayment for each visit. This copayment is usually less than the 20% of the Medicare-approved amount a patient would be responsible for if therapy were provided in a doctor's or therapist's office, or at home.

The disadvantage is that a hospital outpatient department can charge an unlimited amount above the Medicare-approved amount for the therapy—an amount you would be personally responsible for. Before you begin therapy at a hospital outpatient department, find out whether they will accept “assignment” of the Medicare-approved amount as the total amount of the bill. (For a full explanation, see “Legal Limit on Amounts Charged” and “Assignment of Medicare-Approved Amount,” below.) If not, find out in advance how much more than the Medicare-approved amount they will charge. If it's more than you can comfortably afford, you might want to consider getting your therapy somewhere else.

**Outpatient mental health treatment.** For mental health services provided on an outpatient basis, Part B pays only 80% of approved charges. This is true whether the services are provided by a physician, clinical psychologist, or clinical social worker at a hospital, nursing facility, mental health center, or rehabilitation facility. The patient is responsible for the yearly deductible, for the unpaid 20% of the Medicare-approved amount, and, if the provider doesn't accept assignment, for the rest of the bill above the regular Medicare-approved amount, up to an additional 15%.

## Legal Limit on Amounts Charged

By law, a doctor or another medical provider can bill you no more than what is called the “limiting charge,” even if they don’t accept assignment from Medicare. The limiting charge is set at 15% more than the amount Medicare decides is the approved charge for a treatment or service. That means you might be personally responsible—either out of pocket or through supplemental insurance—for the 20% of the approved charges Medicare doesn’t pay, plus any amount the doctor charges up to the 15% limiting charge. Regardless of how much the doctor or other medical provider charges non-Medicare patients for the same service, you can be charged no more than 15% over the amount Medicare approves.

## Assignment of Medicare-Approved Amount

In most instances, Medicare pays 80% of the approved amount of doctor bills; you or your private medigap supplemental insurance pay the remaining 20%. However, you can avoid having to pay anything above the Medicare-approved amount if your doctor accepts assignment of that amount as the full amount of your bill.

More than 99% of all doctors who treat Medicare patients accept assignment of the Medicare-approved amount. That is because almost all doctors have signed up with Medicare in advance, agreeing to accept assignment, and so have become what are called “participating doctors.” They do this because they get paid by Medicare at a slightly higher rate.

There are still a few doctors, however, mostly specialists, who don’t accept assignment. When deciding whether to see a new doctor you’ve been referred to, check to see whether the doctor accepts Medicare assignment.



## TIP

**Treating doctors must accept assignment for Medicaid and QMB patients.** If you receive Medicaid assistance (called “Medi-Cal” in California) as well as Medicare, or are a Qualified Medicare Beneficiary (QMB), federal law requires that a doctor who agrees to treat you must also accept assignment. (See Chapter 16 for more on the Medicaid and QMB programs.)

## Different Payment Structure for Hospital Outpatient Charges

Medicare pays hospital outpatient departments differently from how it pays doctors and other providers. Sometimes, the difference can mean savings for you, but other times it can leave you with a large unpaid bill. Unlike charges for doctors or other providers, Medicare Part B pays 100% of the Medicare-approved amount for services provided by a hospital outpatient department, except that for each service the patient might be responsible for a copayment that varies with the type of service provided. These copayments are usually smaller than the 20% coinsurance amount you would pay if you received the same service at a doctor’s office or clinic.

(Note, however, that if a doctor who isn’t employed by the hospital outpatient department provides services to you at the hospital, that doctor will bill you separately and Medicare will pay only 80% of the Medicare-approved amount for that bill.)

But there’s also some payment risk if you receive care from a hospital outpatient department. As with individual doctors, the hospital doesn’t have to accept “assignment” of the Medicare-approved amount as the full charge for a particular service. Unlike doctors who don’t accept Medicare assignment, however, a hospital outpatient department isn’t restricted in how much more they can charge above the Medicare approved amount. Their charges can go as high as they want, and you would be personally responsible for everything above the Medicare-approved amount.

**ONLINE**

**The Medicare website at [www.medicare.gov](http://www.medicare.gov) has two helpful links for information on keeping down your medical costs.** The first, a provider search tool, will tell you which doctors and other health care providers in your area will accept assignment on Medicare-covered services. You'll find this directory at [www.medicare.gov/physiciancompare/search.html](http://www.medicare.gov/physiciancompare/search.html).

The Medicare website also offers a list, sorted by geography, of Medicare-certified suppliers of medical equipment and supplies. These suppliers accept Medicare's approved amount as the limit of what they can charge. To use this directory, go to the Medicare website home page at [www.medicare.gov](http://www.medicare.gov), and under the "Providers & Services" tab, click "Find medical equipment & suppliers." This will take you to Medicare's supplier directory.

There are several ways to respond to the high prices charged by hospital outpatient departments. First, before you receive any care at a hospital outpatient department, ask their financial office whether they accept assignment of the Medicare-approved amount as payment in full (except for your copayment). If so, find out what the copayment is. You'll then know the total amount—that is, the per-service copayment—that you'll have to pay each time you receive the service.

**Beware of Huge Outpatient Hospital Bills**

There's no limit to the amount a hospital outpatient department can charge a Medicare enrollee above the Medicare-approved amount for a particular service. Because of this loophole in Medicare rules, Medicare patients wind up paying on average almost 40% of the total charges for hospital outpatient department charges. For outpatient surgery, and for outpatient radiology and other diagnostic services, patients end up paying about 50% of total hospital charges. Because of these high costs, you should be wary of receiving medical care at a hospital outpatient department. Be sure to find out the charges *before* beginning treatment.

If the hospital outpatient department doesn't accept assignment of the Medicare-approved amount, find out how much more than that amount they will charge. If it's just a little bit higher, you might want to receive your treatment there anyway, if the care is recommended by your doctor and the facility is convenient for you.

If the hospital's charges will be considerably higher than the Medicare-approved amount, explain the situation to your doctor and ask whether the service could be performed just as well in a doctor's office or at an independent clinic or laboratory. If not, ask whether there's another hospital outpatient department where the service could be performed. If so, find out what that hospital's charges would be.

### **Private Fee-for-Service Plans Outside Medicare**

Some businesses, unions, and other organizations offer general employee health insurance plans—either during employment or after retirement—that accept people eligible for Medicare. A private health insurance plan that accepts Medicare enrollees must offer at least as much coverage as basic Medicare would provide, and most of these plans provide more than that.

If you choose to join or remain with such a health plan once you become eligible for Medicare, the plan—and not Medicare—will make all decisions about coverage for specific services and the amount of payment.

You might be responsible for plan premiums and copayments, as well as the difference between what the plan pays the provider and what the provider actually charges. Unlike regular Medicare, there's no legal limit on the amount a provider can charge you above what the insurance pays.

## Part D: Prescription Drug Coverage

Medicare can cover some of the costs of prescription medications you take at home. This Medicare Part D benefit is administered through private insurance companies that offer Medicare-approved prescription drug plans (PDPs), and through Medicare Advantage managed care plans that include a Part D-type drug benefit (MA-PDs).

### The Politics of Part D Administration

While Part D undoubtedly saves many people money, drug costs are higher than they need to be because of the program's little-discussed giveaway to two of the country's biggest industries: insurance and pharmaceuticals.

The enormous Medicare hospital and medical programs (Parts A and B) are operated by Medicare's own low-overhead bureaucracy, with only certain administrative tasks run by insurers. Nonetheless, in enacting Part D, Congress handed over almost the entire prescription drug program to private insurance companies. That means the program has to support their notoriously inefficient overhead, plus their profits.

Also, a provision in the original Part D law actually prohibited Medicare from negotiating with pharmaceutical companies for lower drug prices for Medicare beneficiaries. As a huge market, Medicare could have utilized its buying power to get price reductions; the VA, for example, has done this for many years, and its drug prices are half as much as those through most Part D plans. This Part D prohibition on such negotiations amounted to a massive pork barrel for the pharmaceutical industry. The Inflation Reduction Act of 2022 finally begins to make some inroads, mandating rebates from drug companies that raise prices faster than inflation and, beginning in 2024, allowing Medicare to negotiate prices on a limited number of high-cost drugs. How much of the savings from these provisions will actually be passed along to Part D beneficiaries remains to be seen.

Employer-sponsored health plans also frequently offer prescription drug coverage for Medicare beneficiaries; if so, Part D enrollment unnecessary for covered employees if the employer-sponsored coverage is at least equal to the coverage offered by a basic Medicare Part D plan.

For many people, Medicare Part D significantly reduces their out-of-pocket costs for prescription drugs, particularly for people with very high annual drug expenses.

## The Basics of Part D Drug Coverage

Medicare Part D provides substantial coverage for the cost of prescription drugs for people enrolled in Medicare. Before you plunge into the details offered in this section, you might want to familiarize yourself with the overall operation of the program by reading through this summary.

**Who is eligible?** If you're entitled to Medicare Part A or are enrolled in Medicare Part B, you can join a Medicare Part D prescription drug plan. Participation is voluntary for most people. But, if you receive benefits through Medicaid (Medi-Cal in California) you're automatically enrolled in a Part D plan in order to continue receiving drug coverage.

**Who runs the program?** Medicare operates the overall program, but you must choose one of the specific Part D prescription drug plans offered by private insurance companies in your state. You enroll directly with that insurance company.

**What does it cost to participate?** Most people pay a monthly premium to the insurance company. The premium can range from \$0 to \$50 per month—the cost varies depending on the plans available in your town, the particular plan you choose, and your income.

**What does it cover?** All plans cover some, but not all, prescription drugs in every category of medication. Each plan has a list, known as a “formulary,” of the specific drugs it covers. The plan will pay its share only for drugs listed on its formulary and purchased from a pharmacy or another distributor that participates in that plan.

**How much does the plan pay?** For basic Part D coverage, there are four payment stages (these figures are for 2024):

- **Deductible.** In many plans, you pay for the first \$545 per year of the total cost of your drugs. However, some plans reduce this deductible or even waive it entirely.
- **Partial coverage.** Once your total yearly drug expense reaches your plan's deductible (up to \$545), and before it reaches \$5,030, the plan pays roughly 75% and you pay up to 25% of your drug costs. Your portion comes in the form of a copayment for each prescription (many plans' copays are less than 25%). Your copayment might be higher for brand-name drugs and less for generics, depending on your plan.
- **Coverage gap ("donut hole").** Once your total yearly drug expense reaches \$5,030 (and until your total out-of-pocket costs reach \$8,000), you must personally pay 25% of your drug costs for both brand-name and generic drugs. This gap in coverage is commonly known as the "donut hole."
- **Catastrophic coverage.** If your total out-of-pocket costs for drugs in one year reach \$8,000, after that you'll have no copayment or coinsurance amount for covered drugs.



#### TIP

**Out-of-pocket costs?** To determine when you've reached the "catastrophic coverage" threshold, Medicare counts only what it considers your "true" out-of-pocket costs (TrOOP). For generic drugs that you purchase while in the donut hole coverage gap, your TrOOP is only the 25% that you personally pay out of the total actual cost; for brand-name drugs, the TrOOP is 95% of the total actual cost.

**How do I choose the right plan?** Not all plans are alike, and choosing the best plan for you involves several steps. You must get the widest possible coverage of the drugs you take, with the fewest restrictions on the drugs' availability to you. And you must do so with the lowest overall out-of-pocket cost to you. That doesn't necessarily mean the lowest premium, but instead takes into

account premium, deductible, copayments, availability of generic drugs, and any differences in coverage in the “donut hole” coverage gap. (See “Deciding on a Part D Plan,” below, for a step-by-step discussion of choosing the right plan.)

**Can I switch plans if I’m not happy with my plan?** Anyone can switch Part D plans. People who receive both Medicaid and Medicare benefits, and people who live in long-term care facilities, can switch at any time. Most people, however, can switch only during an open enrollment period from October 15 to December 7 of each year. The rules and procedures for switching plans are explained in Chapter 13.

### **People With VA, TRICARE, or FEHB Medical Coverage Need Not Join a Part D Drug Plan**

If you receive medical coverage through the Department of Veterans Affairs (VA), the Defense Department’s TRICARE program, or the Federal Employee Health Benefits Program (FEHB), you do *not* need to join a Medicare Part D plan when you become eligible for it at age 65. You’ll continue to receive prescription drugs through your existing program (which provides essentially the same coverage as Part D, but at less cost to you). If for any reason you lose coverage under any of these programs, you have 63 days to join a Medicare Part D plan without a penalty for late enrollment.

## **Eligibility**

Anyone who is entitled to Medicare Part A coverage (whether actually enrolled in it or not) or who is currently enrolled in Medicare Part B can join a Medicare Part D plan. This is true regardless of whether a person’s Medicare eligibility is based on age or disability. Except for people who also receive benefits from the Medicaid program (Medi-Cal in California), enrollment in Part D is voluntary. (The enrollment process is explained in Chapter 13.)

If you qualify for Medicaid (see Chapter 16) as well as Medicare, you must enroll in a Medicare Part D plan in order to receive any prescription drug coverage. Medicaid no longer covers any drugs for people who are also eligible for Medicare if those drugs are covered by an available Part D plan. In some states, however, Medicaid continues to cover a few drugs that aren't available under Part D. If you receive Medicaid benefits as well as Medicare, you can enroll in certain, but not all, Medicare Part D plans—but if you don't enroll yourself, Medicare will automatically enroll you in a plan.

### **Part D Might Not Be Right for Everyone**

If you have prescription drug coverage through a Medicare Advantage plan (see Chapter 15) or through employer-based coverage from your or your spouse's current work, you do not also need a Medicare Part D plan. Even if you're not otherwise covered for prescription drugs, enrollment in a Part D plan is voluntary. But program rules (for instance, a penalty on the premium you eventually pay if you later enroll in a plan after not enrolling when you turn 65) put some pressure on you to enroll even if you don't yet need the coverage. To decide whether enrolling is a good idea for you, and when, see "Deciding on a Part D Plan," below.

### **Premiums, Deductibles, Copayments, and Coverage Gaps**

The cost structure of Medicare Part D is complicated. Except for those who qualify for a low-income subsidy, most beneficiaries pay monthly premiums, a yearly deductible, and a copayment for each prescription filled. And there's a coverage gap that affects most beneficiaries, making them personally responsible for a large portion of their drug costs that are above a certain amount but below a "catastrophic" level.

## Premiums

Premiums are the monthly amounts you pay directly to your prescription drug plan or managed care plan to enroll you in Part D coverage. These amounts cover only your membership in the plan and don't pay the cost of any drugs, nor do they count toward your deductible or other cost-sharing amounts.

**Standard enrollment.** Most people must pay a monthly premium for Part D coverage, either for a stand-alone prescription drug plan or as part of the larger premium they pay if they're enrolled in a managed care plan. Monthly premium amounts for basic benefits vary from plan to plan and by geographic region.

**High income surcharge.** If you have a higher income, you pay a monthly Part D surcharge in addition to your plan's premium.

Officially known as the "income-related monthly adjustment amount" (IRMAA), the surcharge is based on your IRS tax return from two years previously. If you're enrolled in a Part D plan or Medicare Advantage plan with drug coverage, the IRMAA is automatically deducted each month from your Social Security benefits; if you don't collect Social Security benefits, you'll receive a monthly IRMAA bill from Medicare.

Yearly Income in 2022	Part D Surcharge
Single \$103,001–\$129,000	\$12.90
Married \$206,001–\$258,000	
Single \$129,001–\$161,000	\$33.30
Married \$258,001–\$322,000	
Single \$161,001–\$193,000	\$53.80
Married \$322,001–\$386,000	
Single \$193,001–\$499,999	\$74.20
Married \$386,001–\$749,999	
Single \$500,000 or more	\$81.00
Married \$750,000 or more	

**CAUTION**

**Lowest premiums are not always the best.** Finding a plan with a low monthly premium is important, but it isn't the only factor to consider in choosing a plan. A low premium does you little good if the plan doesn't cover some of your medications, or if it covers them but requires much higher copayments than other plans. Also, you might want to pay a higher premium for a plan that offers you first-dollar coverage (no deductible) or lower copayments within the "donut hole" coverage gap. (See "Deciding on a Part D Plan," below, for more information.)

**Medicare's "Extra Help" Low-Income Subsidy (LIS).** Extra Help is a program that helps people with low income and assets pay their Part D premiums, deductibles, and copays. You'll qualify for Extra Help if you get Medicaid or SSI, are enrolled in the QLB, SLMB, or QI program (see above), or don't quite qualify for these programs but have income and assets below certain levels.

In 2024, you might be eligible for Extra Help if you have yearly income of less than about \$22,000 as a single person, or about \$30,000 as a married couple (these figures are a bit higher in Alaska and Hawaii). You might qualify if your income is somewhat higher than this if you're still working or you have dependents living with you. And you must have assets (not including your home or household goods) of less than about \$17,000 (about \$34,000 for married couples living together).

### **Apply for Medicare Part D's Extra Help Program Before, and Separately From, Enrolling in a Part D Plan**

If you think you're anywhere close to qualifying for a Part D Extra Help low-income subsidy, you should apply for it. You apply for an Extra Help low-income subsidy separately from applying for Part D coverage, and applying for an Extra Help low-income subsidy doesn't commit you to join any Medicare Part D plan. If you're accepted for an Extra Help low-income subsidy, your Part D plan premium will be much less expensive regardless of which plan you choose. To learn about applying for an Extra Help low-income subsidy, see Chapter 13.

If you qualify for Extra Help, you'll pay no premium or deductible. And in 2024, you'll pay a copayment of no more than \$4.50 for each generic drug and no more than \$11.20 for each brand-name drug. But if you also get Medicaid and are in the QMB program, you won't pay more than \$4.60 for any covered drug.

### **Deductibles**

The deductible is the amount you must pay out of pocket for covered medications before your Part D plan begins paying any of your covered prescription drug costs.

**Standard enrollment.** With most plans, a Part D enrollee must pay out of pocket for the first \$545 (in 2024) of costs each year for prescription drugs that are covered by the enrollee's particular plan.

But some plans offer a reduced deductible, and others "first dollar" (no-deductible) coverage, meaning the plan begins paying their share of covered drugs for an enrollee's first prescription of the year (see below).

**With low-income subsidy.** Part D beneficiaries who get Extra Help don't pay any deductible amount.

**Waiver of deductible.** Some plans offer what is called "first dollar" coverage, which means you don't pay any deductible and the plan begins paying its share of drug costs with your first prescription. These no-deductible plans tend to have higher premiums. The amount you save, if any, will depend on the plan's premium and other cost features. (See "Deciding on a Part D Plan," below, for more information.)

### **Initial Copayments**

After you've reached your deductible amount in out-of-pocket costs for covered prescription drugs, your plan pays most of the cost of a covered drug and you're personally responsible for the remainder, known as a "copayment." This arrangement continues until you and your Part D plan combined reach a specific yearly total of expenditures—the beginning of the "coverage gap"—on drugs covered by your Part D plan.

**Standard enrollment.** After you pay your deductible for covered drugs, Medicare and your Part D plan pay 75% of the cost for covered drugs (and you pay the remaining 25% out of pocket) until your total covered expenditures have reached the beginning of the year's coverage gap. (Some plans charge you lower copays for certain drugs.) For 2024, the coverage gap begins at \$5,030 in total costs for covered drugs.

### What Counts as an Out-of-Pocket Cost?

Many of the rules concerning deductibles, copayments, and catastrophic limits revolve around the amount you pay out of pocket for your medications. In calculating these amounts, Medicare considers only what it determines to be a "true out-of-pocket" cost, or "TrOOP."

In order for a prescription drug payment to qualify as a TrOOP, the prescription drug must be:

- a drug prescribed by a physician and covered by the specific plan's formulary, or covered for a particular enrollee through an exception to the formulary, and
- paid for by the beneficiary, a relative, a charity, a church, or a service organization, or the like, but not by another insurance plan.

Also, for generic drugs you buy while in the donut hole coverage gap, your TrOOP is only 25% of the total actual cost; for brand-name drugs in the donut hole, the TrOOP is 95% of the total actual cost. It's important to remember that what you pay for your premium is *not* considered an out-of-pocket cost.

**Actual copayments can vary.** Your actual copayments for each prescription can vary:

- The total cost of a drug can vary from plan to plan. This is because each plan individually negotiates prices with pharmaceutical companies. So, if your copayment is a percentage of

the drug's total cost, what you pay will also vary. For example, if 30 doses of a medicine cost a total of \$80 with Plan 1 and \$100 with Plan 2, a 25% copayment would be \$20 per prescription with Plan 1, but \$25 with Plan 2.

- A plan is permitted to set up a different copayment system—such as tiered copayments for generic drugs and brand-name drugs, or higher copayments for certain drugs but none at all for other drugs—from the standard copayments described above. Plans can change their copayment structure as long as the average copayments for all covered drugs work out to be the same as with the standard copayment schedule. For this reason, before choosing a plan you must find out in advance what the actual copayment is for your specific drugs.

### You Pay the Full Cost of Any Drugs That Your Particular Plan Doesn't Cover

It's important to understand that your plan will pay its portion of the costs only for those drugs specifically included on its formulary (a list of the drugs your plan covers), unless you obtain an exception from the plan. Similarly, amounts you personally pay for drugs count toward your deductible and the coverage gap limits only if the drugs are specifically covered by your plan's formulary, or are covered by your plan after you obtain an exception for that drug from your plan. (See "Restrictions on Coverage," below, for a discussion of plan formularies and other plan payment restrictions.)



#### TIP

**Insulin costs are limited.** If you participate in a Part D plan that covers your use of insulin, your out-of-pocket copayments for that specific medicine are limited to \$35 per month.

## Coverage Gap (the “Donut Hole”)

Once your out-of-pocket prescription drug costs for the year (in 2024) reach \$5,030, and until they reach \$8,000, you’re in what’s known as the “coverage gap” (also known as the “donut hole”). While you’re in the gap, you’re personally responsible for paying 25% of the cost of both brand-name and generic drugs.

### Finding a Plan That Offers Better Coverage in the Gap

If you have high drug costs, look for a plan with extra coverage in the donut hole coverage gap. A few plans pay more of a patient’s drug costs within the gap, either reducing the patient’s 25% share or shortening the extent of the gap. The premiums for these plans, however, tend to be higher than for standard plans. But the higher premium might be worth it if you expect that your yearly drug costs will extend well into the coverage gap.

**Note: No gap with low-income subsidy.** There’s no difference in copays during the “donut hole” coverage gap for those qualifying for any category of low-income subsidy.

**Reducing costs within the donut hole.** You might reach the coverage gap but still have months to go before getting to either the catastrophic coverage limit or the end of the year. If so, you might want to consider using one or more of the following strategies for lowering the total cost of your medications, and thus the amount you pay out of pocket, within the gap. For more on finding the programs that might work for you, see “Finding discount programs,” below.

The strategies are:

- **State and community assistance programs.** Some states have programs to help older patients pay for prescription medicines that aren’t otherwise covered by Medicare or Medicaid. Some of these programs offer across-the-board discounts on all drugs while others provide only limited discounts on certain drugs. Some programs offer special tax credits for prescription drug costs and others limit their prescription drug assistance to

lower-income seniors. Local community-based programs also sometimes provide free or discounted drugs to seniors. To find out about state and community-based prescription drug assistance programs near you, call the Eldercare Locator at 800-677-1116 or go to the official Medicare website listing of state pharmaceutical assistance programs at [www.medicare.gov/pharmaceutical-assistance-program/state-programs.aspx](http://www.medicare.gov/pharmaceutical-assistance-program/state-programs.aspx). You can also contact the local office of your State Health Insurance Assistance Program (SHIP), discussed at the end of Chapter 13.

- **Veterans benefits.** If you're a veteran, you may be eligible for free or low-cost medical treatment by Veterans Affairs health providers. If so, this can include free (for disabled or low-income veterans) or low-cost prescription drugs, if prescribed by a VA doctor. Even if you normally see a civilian doctor and use Medicare to cover your care, you might want to see a VA doctor to get a prescription for long-term medication that would be expensive if you had to pay for it under Medicare Part D. (For a discussion of medical benefits for veterans, see Chapter 11.)
- **Physician samples.** In an effort to push their particular brands of drugs, pharmaceutical companies give free samples to doctors. The doctors, in turn, distribute those drugs free to patients. Doctors don't normally have enough samples to fill a long-term need for a medication. But your doctor might have enough free samples of your drugs to help lower your out-of-pocket costs while you're within the Part D coverage gap.
- **Switching to generic.** If you've been taking a brand-name medication, you might find that you can obtain the same results at a lower price with its generic equivalent, if one is available, or with a lower-cost drug that treats the same condition. Check with your doctor to see if a generic or another drug is available and whether the doctor believes that it would provide you with the same results. If so, you might want to try it. If you're satisfied with the less-expensive drug, you might save considerable money by continuing to use it because generic drugs are usually quite a bit less expensive than brand names.

- **Pharmaceutical company discount programs.** Under pressure from consumer groups, some pharmaceutical companies have created programs to provide certain specific medicines at reduced prices for Medicare patients. Most of these programs are available only for seniors with limited incomes. The programs don't necessarily include every drug manufactured by the company. And the discounts aren't usually very generous. Nonetheless, even a small discount on an expensive drug can amount to significant savings over time. In order to participate in one of these programs, you have to register with the pharmaceutical company. The doctor who prescribes the medication for you might have to fill out enrollment papers for you, too. Some of these programs provide free or discounted drugs only to doctors, who then distribute them to patients. To learn about specific pharmaceutical company programs that might help with the costs of drugs you take, see the official Medicare website's Pharmaceutical Assistance Programs page at [www.medicare.gov/pharmaceutical-assistance-program](http://www.medicare.gov/pharmaceutical-assistance-program).
- **Nonprofit and retail discount programs.** Several nonprofit and retail organizations, including large chain pharmacies, have set up programs—some through the use of discount “cards”—to provide discounted prescription drug medications, particularly for seniors. These organizations use their large membership's purchasing power to leverage drug companies into offering discounts on certain drugs, passing those savings on to their members. There's usually a membership fee and a copayment or processing fee for each medicine you order. Savings from these programs average less than 10%. For an expensive drug, however, that can still amount to a substantial amount.
- **Medications from Canada.** The exact same prescription drugs for which we pay exorbitant prices in the United States are available for far less—often 50% to 80% less—in Canada. That's because the Canadian public health system limits what pharmaceutical companies can charge for drugs there. (Even at these much-reduced prices, the drug companies profitably continue to sell their wares in Canada.) Because of the huge price differences,

many people in this country have been taking the trouble to buy their prescription medications from Canadian pharmacies, using mail-order and online prescription drug outlets, while others who live near the Canadian border physically travel across to obtain their drugs at Canadian health clinics.

If you choose to explore this option, you might be able to find services providing medicines from Canadian pharmacies by searching on the internet under “prescription drugs Canada.” But before using any mail-order or online Canadian drug outlet, ask people you know—or your local senior center—or a SHIP counselor (see Chapter 13) if they know anything about the particular program and the reliability of its services.

**Finding discount programs.** There are several ways to find out about government, pharmaceutical company, and nonprofit organization discount drug programs available where you live—starting with the four options below. Once you locate a program for which you might be eligible, you or your doctor must contact the program directly in order to enroll.

### Some Discount Drug Purchases Might Not Count as Out-of-Pocket Costs

If your out-of-pocket cost for prescription drugs reaches more than \$8,000 for the year (in 2024), you’ll pass the coverage gap and reach Part D’s catastrophic coverage. Once you reach that coverage, your Part D plan will pay all of your drug costs until the end of the year.

But not all of the money you spend out of your own pocket for prescription drugs during the coverage gap will necessarily “count” toward reaching the catastrophic coverage threshold. If you buy discounted prescription drugs through a state or local government-assisted drug program, the amounts you spend out-of-pocket for those drugs might not count. That’s because government funding is already supporting the purchase of these low-cost drugs. If you use one of these programs, check with the program staff about whether your out-of-pocket costs for drugs they supply will count toward reaching catastrophic coverage under Plan D.

- **Information from Medicare.** Medicare itself can direct you both to your state assistance program and to pharmaceutical company programs for a particular drug. It can also alert you to local programs in your area and can refer you to nonprofit and retail organizations that offer drug discount cards and other plans.

Medicare's information is on its website at [www.medicare.gov](http://www.medicare.gov). Under the "Health & Drug Plans" tab, look under "Find & Compare," then click "Find health & drug plans." This page asks you for some personal information—which is strictly confidential—in order to determine which programs you might be eligible for. It then directs you to your state's prescription drug assistance program and to any community-based programs in your area. And it directs you to some pharmaceutical company discounts that might be available for that drug. Finally, the Medicare website lists contact information for some of the nonprofit and retail organizations that offer drug discount cards and similar plans, and explains their basic benefits and eligibility rules.

You can also get this same information by calling Medicare's toll-free telephone line at 800-MEDICARE and asking about prescription drug assistance programs.

- **State Health Insurance Assistance Program (SHIP) and Health Insurance Counseling and Advocacy Program (HICAP).** Every state has a program to provide free counseling and assistance regarding Medicare, Medicaid, health insurance, and related problems. This program is called the "State Health Insurance Assistance Program" (SHIP) or the "Health Insurance Counseling and Advocacy Program" (HICAP). The program maintains local offices with trained counselors who can help you learn about your state's prescription drug assistance program and other drug discount programs that might be available to you. They can also help you with the enrollment process. Their assistance is free. For more about SHIP and HICAP, see Chapter 13.

- **Area Agency on Aging.** The Area Agency on Aging is a federal government clearinghouse for information about issues relating to seniors. Your agency can provide you with information about your state's assistance program and about community-based drug assistance programs. To find the Area Agency on Aging office nearest you, call their toll-free line at 800-677-1116 or visit <https://eldercare.acl.gov>.

### Waiver or Reduction of Copayments

Under certain circumstances, you might not have to pay the normal copayment for a covered drug. For example:

- If you reside for more than 90 days in a long-term care facility and are enrolled in both Medicare Part D and Medicaid, you don't have to make any copayments for covered drugs.
- Some plans waive or reduce copayments for certain drugs, particularly generic versions, mostly to coax people to join their particular plans. Waiving or reducing the copayment for a particular drug during a period of time, however, doesn't obligate the plan to continue doing so, nor must it continue to waive or reduce copayments on any comparable drug. The plan can change its copayment rules at any time.
- Pharmacies can waive copayments for any enrollee with a low-income subsidy, for any drug. There are no Medicare rules about when pharmacies can do this, except that they aren't supposed to advertise a policy of waivers. So, you might not know in advance whether your pharmacy will waive a copayment for you. If you're a Part D enrollee who receives a low-income subsidy, you should always ask the pharmacy to waive your copayment. You might be pleased to find out that the pharmacy is willing to do so.

- **Drug discount information clearinghouses.** Through several clearinghouses, most of which provide their information on the internet, you can find out about numerous drug assistance and drug discount card and similar programs. One helpful clearinghouse is RxAssist Patient Assistance Program Center ([www.rxassist.org](http://www.rxassist.org)). The RxAssist website provides both a direct link to pharmaceutical company drug assistance programs and information about other sites and organizations that can help you apply for assistance, as well as links to nonprofit and retail drug discount cards and similar programs.

### **Catastrophic Coverage**

Once your total expenditures for medications covered by your plan reach \$8,000 in a year, the plan will provide “catastrophic coverage” that pays the entire cost of covered drugs for the rest of the year. Your total expenditures are amounts paid by you and your plan combined during any year.

### **Restrictions on Coverage**

Medicare gives the private insurance and Medicare Advantage companies that operate Part D plans a lot of leeway in imposing limits on the coverage they offer. There are a number of different ways the plans can limit coverage, including restricting the specific drugs covered, providing different levels of payment for different drugs, requiring drug regimens such as “step therapy,” or requiring prior approval before covering certain drugs.

### **Formularies**

Every Part D plan, and every Medicare Advantage plan with drug coverage, issues a list, called a formulary, of the specific drugs it covers. Medicare requires each plan to include in its formulary at least two drugs in each “therapeutic class”—meaning a group of

drugs used to treat a specific illness or condition. Some plans offer more than two drugs in certain categories. But the availability of coverage for these “extra” drugs might depend on the plan member paying a higher premium or copayment, or having to get prior authorization or another exception from the plan before using the drug.

### Certain Drugs Excluded by Law

The Medicare program specifically prohibits Medicare drug plans from covering most medications within certain categories of drugs, even if these medications were lawfully prescribed by your physician.

These categories include:

- barbiturates (certain sedatives and sleeping pills)
- benzodiazepines (certain tranquilizers)
- drugs used for weight loss or weight gain, and
- over-the-counter medications.

Many of these drugs, which the drug plans are required to exclude, are covered by Medicaid (Medi-Cal in California) for people who qualify for that program. But “dual eligible” beneficiaries—those who are eligible for both Medicare and Medicaid (including many nursing facility residents)—are required to get their drug coverage through a Medicare plan. Dual eligible beneficiaries in some states, however, might still get coverage for some of these drugs if the Medicaid programs in their states will allow it. (See Chapter 16 for more information on Medicaid.)

Under Part D rules, if a drug isn’t on your plan’s formulary the plan won’t pay any portion of the cost of that drug, even if a physician has lawfully prescribed it for you (unless you ask for and receive an exception, discussed below). Also, any money you spend out of pocket on that nonformulary drug won’t count toward your Part D deductible or the coverage gap and catastrophic coverage limits.

## Formulary Changes Might Force You to Change Plans

A Part D plan can also change its formulary whenever it wants, by providing 60 days' notice to Medicare and to plan members. Such changes might include dropping a drug entirely from its formulary, dropping the coverage of a brand-name drug and substituting its generic equivalent, or increasing a patient's copayment for a drug.

- If the plan entirely drops a drug it has been covering for you, it must continue to cover it for you until the end of the calendar year.
- If the plan raises the copayment it charges for a drug, the plan must continue providing it to you at the former copayment level until the end of the calendar year.

However, if the plan switches from covering a brand-name drug to a generic equivalent, it can immediately require you to use the generic or else lose all coverage for that drug.

If you don't want to continue with a plan after it changes its coverage, you can explore switching to a different plan. If you're eligible for both Medicare and Medicaid, or are a resident of a long-term care facility, you can switch plans at any time. If not, you can switch plans only during the annual open enrollment period (starting October each year).

If you don't want to change plans, or you can't find a plan with better coverage, consider asking your physician to switch you from your previous drug to a different, equivalent drug that is on your plan's formulary.

## Tiered Copayments

Medicare allows the insurance companies that operate Part D plans to charge different copayment amounts for different drugs within the same class, even if the drugs are “therapeutically equivalent” (meaning they’re used in a similar way to treat the same illness or condition). Part D plans can structure their copayments in a number of ways: They might have lower copayments for generic drugs than for brand-name equivalents; there might be no copayments at all for certain generic drugs; or there might be different copayments for different brands within the same class.

### Exceptions to Drug Restrictions

Plan formularies and other cost containment restrictions aren’t necessarily the last word on coverage for a drug you use or want to use. Every plan is required to have two systems in place to allow you to challenge that plan’s listing or decision regarding coverage of your drug.

The first system allows you to file a request for an “exception” to the plan’s listing or decision. This means that you ask the plan to provide coverage that differs from its standard formulary. This type of exception usually requires that you and your doctor show some kind of “medical necessity,” meaning that the particular drug you want works better for you or has fewer or milder side effects than other drugs in the class.

The second system permits you to appeal a plan’s decision. Each plan has its own appeal process, but every plan allows you to ask for an internal review by the plan itself. If an internal review is unsuccessful, you can seek independent review and ultimately take the plan to court, if necessary.

Plans’ exceptions and appeals processes are discussed in Chapter 13.

## **Drug Substitution**

The Medicare Part D program allows plans to substitute a generic or another therapeutically equivalent drug instead of the drug you request. That means that although your doctor prescribes a specific drug for you, the plan can have the pharmacy dispense to you a different but equivalent drug. Of course, “equivalence” doesn’t mean “exactly the same.” You might have better results or fewer side effects with the drug your physician prescribes you. But under these drug substitution rules, a plan can overrule you and your physician and pay only for the substituted drug. In order to overcome such a drug substitution, you must request an exception to the plan’s substitution policy. (See Chapter 13 for more information about exceptions and appeals.)

## **Prior Authorization**

A Part D plan can place certain drugs on a restricted list that requires the plan’s prior authorization before it will cover the drug. This means that if you and your physician decide you should take any drugs on this restricted list, you must obtain the plan’s approval or else the plan won’t cover it. The plan might offer less expensive drugs that it considers to be “equivalent,” in which case your doctor might need to give a medical reason why you need this particular drug. Or, perhaps the drug you want to use is prescribed only in special situations, in which case your doctor might need to show the plan that yours is such a special case.

## **Step Therapy**

“Step therapy” refers to a treatment structure in which a patient must try a certain drug—one that is less expensive for the insurance company—before the plan will cover a different drug in the same class. If a Medicare Part D plan offers more than two drugs within a drug class, the plan can impose a step therapy requirement for certain drugs in that class. If that happens to you, your doctor must certify that you’ve tried the lower-tier drug and that it didn’t work well for you. Then, the plan will allow you to “step” up your therapy to the next-higher-tier drug.

## Supply Limits

You'll pay a copayment for each prescription you fill. So, one way to keep copayment costs down might be to have the doctor prescribe a large supply of a certain medicine so that it will take fewer prescriptions to get the same number of doses. Plans can block this tactic by imposing a supply limit that restricts the number of doses of a drug that can be filled per prescription.

### Broader Coverage, But Difficult Access, for Certain Drugs

Medicare requires each Part D plan to cover at least two drugs for each therapeutic category. And for the following six specific categories of drugs, Medicare plans must provide coverage for “all or substantially all” available drugs:

- antidepressants
- antipsychotics
- anticonvulsants (treatment of seizures)
- antiretrovirals (treatment of certain viruses, including HIV)
- immunosuppressants (cancer treatment), and
- antineoplastics (chemotherapy).

Although Part D plans must extend coverage to all drugs in these categories, the plans can restrict access to these drugs (except antiretrovirals) in other ways. Plans are permitted to make obtaining these drugs more difficult or expensive through “management” devices, such as tiered copayments, prior authorization, and step therapy requirements.

## Pharmacy Restrictions

Each Part D plan contracts with certain pharmacies to deliver prescription medications. To receive full coverage from your plan, you must get your drugs from a participating pharmacy, which includes large chains, independent drugstores, HMO pharmacies, or mail-order pharmacies. If you fill your prescription at a pharmacy

that doesn't contract with your plan (an "out-of-network" pharmacy), you might have a larger copayment, or you might not receive any coverage at all (depending on the drug and on your plan's rules).

## **Deciding on a Part D Plan**

If you're eligible for Medicare and are also enrolled in the Medicaid program (Medi-Cal in California), Medicare will automatically sign you up for a Part D drug plan. If you aren't enrolled in Medicaid, your participation in Medicare Part D is voluntary. Deciding whether to join a Part D plan, and if so what plan to choose, depends on several factors:

- whether you have other health insurance coverage (through your or your spouse's employer or union) that includes drug coverage
- whether you enroll in a Medicare Advantage (Medicare Part C) managed care plan that includes prescription drug coverage (see Chapter 15)
- whether you're eligible for a low-income subsidy
- your age and health
- the total cost of the drugs you use
- whether your drugs are covered by a particular plan
- how much the plan charges in premiums and copayments, and
- the plan's restrictions on access to drugs.

## **Should You Participate in Part D?**

Medicare Part D is mandatory for people who are also enrolled in Medicaid. For those who qualify for a low-income subsidy, Part D is an attractive low-cost option. And for most other people, Part D is still better than no coverage at all. But for a few people, deciding whether to join a Part D plan is a bit more complicated.

**Penalty for Delayed Enrollment.** In an effort to encourage everyone to join a Part D plan as soon as they're eligible, Medicare has created a financial penalty for those who delay enrolling (unless enrolled in Medicaid, a Medicare Advantage plan with drug coverage, or employer-sponsored insurance with drug coverage). The penalty takes the form of a rise in premiums of 1% per month—if and when you do eventually enroll in a plan—for every month you delay enrolling after you first become eligible. And that rise is permanent. So, for example, if you wait to join a Part D plan for two years after you're first eligible for Part D coverage, you'll always pay 24% (1% per month for 24 months) more in premiums for any plan you join.

This penalty for late enrollment offers a strong incentive for most people to join a Part D plan as soon as they're eligible. This is true even if you don't presently have many out-of-pocket prescription drug costs and:

- don't regularly take any prescription drugs, or
- take only one relatively low-cost drug.

If you aren't enrolled in an employer-sponsored insurance plan with drug coverage or a Medicare Advantage plan with drug coverage, and you have no or very low regular prescription drug costs, you have the following two options.

**Option 1: Not enrolling.** You can choose not to enroll in any drug plan for as long as you don't have any significant out-of-pocket drug costs. This means you'll incur the 1% per month penalty on the premium cost of any plan in which you eventually enroll. But that penalty will be partially or fully offset by the fact that you won't be paying any monthly premium for the years you aren't enrolled.

The risk with this approach is that after a few years your drug needs may change and you might then want to enroll in a particular plan that has a high monthly premium. If so, the 1% per month of delay penalty might add up to more than you've saved by not enrolling early. For example, if you delay 36 months before enrolling, then enroll in a plan that has an initial premium of \$50 per month, you'll pay an extra \$18 per month (36% of \$50) in premiums. And these monthly premium amounts go up each year.

### **No Penalty for Delayed Enrollment If Covered by Equivalent Employer-Sponsored Health Insurance**

As explained above, Medicare imposes a financial penalty on people who delay enrolling in Part D coverage. But this penalty does *not* apply if you're covered by an employer- or union-sponsored health plan (for either current employees or retirees) that provides what is called "creditable prescription drug coverage," meaning coverage that is as extensive as a basic Part D plan. When you first become eligible for Medicare, your employer- or union-sponsored plan will notify you whether that plan qualifies as creditable coverage. If your employer-sponsored plan does offer creditable coverage, you can remain in that plan as long as you can and want to, and incur no penalty if you later join a Medicare Part D plan.

If you subsequently lose coverage by a creditable plan, or the plan's drug coverage falls below what qualifies as creditable, then you can enroll without penalty in a Part D plan. You'll pay no higher premium than a person who is first eligible for Medicare as long as you enroll in a Part D plan within 63 days from the date you lose creditable coverage.

If your health plan doesn't qualify as providing creditable coverage, you must join a Part D plan when you first become eligible or else pay the 1% per month premium penalty when you do finally enroll. Even if you join a separate Part D plan, you may want to keep your employer-sponsored coverage instead of relying entirely on Medicare coverage. If your employer-sponsored coverage provides less expensive and/or more complete general health coverage than Medicare Parts A and B do, you might want to retain that coverage even though you also join a Part D plan.

### Stand-Alone Drug Plan or Managed Care Plan

Part D drug coverage is available either through a separate, stand-alone prescription drug plan (PDP) or as the prescription drug component (MA-PD) of full health coverage under a Medicare Advantage plan (see Chapter 15). Each type of plan offers a generally equivalent range of available coverage, though each specific plan is slightly different and costs vary.

If you belong to a Medicare Advantage plan that doesn't offer MA-PD drug coverage and you want drug coverage, you must leave your plan and enroll in a stand-alone PDP, which also means returning to regular Medicare coverage (also referred to as "Medicare fee-for-service") as described in earlier sections of this chapter. Or, you can join a different Medicare Advantage plan that does offer MA-PD drug coverage (most do). (Making this choice is discussed in Chapter 15.)

**Option 2: Enrolling in a low-premium plan.** For many people in the categories above, a better option than not enrolling at all in a plan is to enroll as soon as eligible in a low-premium plan. Several insurance companies offer plans with no monthly premium or a premium under \$10. These plans tend to have poorer coverage than plans with higher premiums. But if such a plan is available where you live, it might allow you to enroll in Part D for little or no money as soon as you're eligible, thus avoiding the late enrollment penalty. If and when your drug costs go up and you need better coverage, you can then switch to a more comprehensive plan with a higher premium. (For an explanation of switching plans, see Chapter 13.)

## Finding Out About Available Part D Plans

You can enroll only in a plan that operates in the state where you live. There are several ways to find out about the specific Part D plans available to you.

**Medicare.** The Centers for Medicare & Medicaid Services (CMS) is the federal agency that administers the Medicare program, including Part D prescription drug coverage. It provides personalized help in locating Part D plans. CMS can not only tell you what plans are available where you live, but can also narrow your choice for you according to the medications you regularly take. You can contact CMS by phone at 800-MEDICARE (800-633-4227). Or, you can visit its website at [www.medicare.gov](http://www.medicare.gov) and find information tailored to your specific geographic location and medication regimen.

**SHIP or HICAP.** Every state has a certified program that provides free advice to consumers about Medicare, Medicaid, and other health insurance matters. It's called the "State Health Insurance Assistance Program" (SHIP), or sometimes the "Health Insurance Counseling and Advocacy Program" (HICAP). These programs maintain local offices in most urban areas as well as some central rural locations. Trained counselors in these offices can tell you about all the Part D plans available in your state and can identify the plans that cover the drugs you regularly use. Once you've investigated several plans, the counselors can meet with you in person to help you make a final decision. To find your SHIP or HICAP office, see the contact information at the end of Chapter 13.

**State department of insurance.** Every state has a government agency that oversees insurance matters. You can contact your state department of insurance for the names, addresses, and phone numbers of every company offering a Part D plan in your state. See the end of Chapter 14 for a website that lists all of the state departments of insurance.

### Have Your Information Handy When You Contact Part D Assistance

In figuring out which Part D plan is best for you, you'll want to consider the medications you regularly use and the pharmacy where you prefer to get your drugs. Before you contact any agency or counselor for assistance in choosing a plan, have the following information handy:

- a list of the specific drugs you regularly use, including the brand (or generic) name, the dose size and frequency, and the current monthly cost
- the name and address of your pharmacy
- whether you currently receive Medicaid benefits, and
- whether you are, or think you might be, eligible for a Part D low-income subsidy.



#### CAUTION

**Get complete information from the plan itself.** You can get very helpful information about Part D plans from several sources. But the most thorough information about a specific plan comes from the plan itself. So, before you make a final choice, contact any plan that interests you and ask them to send you a complete description of the plan, including all the matters discussed in this section. You can get the phone number and address of any plan from Medicare itself, or from the other sources discussed above. Make sure to get any important information from the plan in writing. That's because while insurance companies usually have telephone information centers, their phone information tends to be somewhat unreliable. Also, you have no way of forcing the insurance company to abide by what someone tells you on the phone.

## Choosing a Part D Drug Plan

Once you decide to enroll in Part D and you find out what plans are available where you live, you must consider several factors in deciding which plan to choose. (When you're ready to join a particular plan, you enroll directly with that plan. The mechanics of enrollment are discussed in Chapter 13.) Here is a step-by-step guide to choosing the plan that's right for you (you can also use the Medicare Plan Finder at [www.medicare.gov](http://www.medicare.gov)).

**Step 1: List your regular medications and their costs.** The first step in deciding on a specific plan is to list the medicines you regularly take, including:

- the brand name and generic name (if there is one) of each drug (if you take the generic version and don't know the brand name, ask your doctor what it's called)
- the dosage you take
- how many doses are in each prescription you fill, and
- how often you fill the prescription.

**Step 2: See which plans include your medications in their formularies.** The single most important thing to consider in choosing a plan is whether all the drugs you regularly take are included in the plan's formulary. Eliminate from consideration any plan that doesn't include either the brand-name or the generic version of your drugs. Some plans might cover only the generic version of a drug you take, while others might cover both the brand-name and the generic versions. Under any plan that covers a brand-name drug, copayments for the brand-name will be higher than for the generic version.

**Step 3: Check with the different plans to see what the total monthly cost of your drugs would be, as well as your initial copayments.** For each plan that includes all your drugs on its formulary, ask the insurance company to provide you with an estimate (in writing) of the total monthly cost of each of your prescriptions—taking into account your normal dosage and number of doses. (Total costs differ among insurance companies because each one negotiates different drug prices with the pharmaceutical companies.) Also

ask the plans to tell you what your copayments would be for each prescription during the initial coverage period (prior to the “donut hole” coverage gap).

**Step 4: See whether the plan provides “first dollar” coverage.** The standard Part D benefit requires each person to pay out of pocket a \$545 (in 2024) per year deductible before the plan begins providing any coverage. Some plans, however, provide what is called “first dollar” coverage, meaning that they waive this deductible and begin paying their share from the first dollar you spend on covered medicines. These plans are generally more expensive but might be worth it if your prescription costs are high.

**Step 5: Ask whether the plan offers any coverage within the “donut hole” coverage gap.** A few plans offer extra coverage within each year’s “donut hole” coverage gap, during which most people must pay 25% of the cost of their drugs. If the total cost of your drugs will put you into the coverage gap, this added coverage might be very important. You can determine whether the cost of your drugs will enter into the coverage gap by calculating the total monthly cost of each of your drugs under each plan, multiplying each by 12 (months), then adding them all together.

**Step 6: Total the various costs, including the monthly premium.** Eliminate those plans that don’t cover your particular medications on their formulary. For the remaining plans, use the information you’ve gathered to determine how much money you would spend each year under each plan you’re considering. For each plan, add up:

- the plan’s yearly premiums
- your yearly deductible amount (if the plan doesn’t provide “first dollar” coverage)
- your copayments for all your drugs during the initial coverage period, and
- how much you would pay out of pocket during the coverage gap (this requires you to figure out how quickly—meaning, with how many monthly prescriptions—you would reach the coverage gap; you do this by adding up the total monthly cost of your drugs under each plan).

Once you've added up all of these items for each plan, you'll be able to compare the annual cost of each plan side by side. Before you make your final decision, though, there's one more step.

**Step 7: Look into access restrictions.** Though the cost of drugs is important, you should also consider ease of access to your drugs when choosing among plans. This is particularly true if your costs would be nearly the same for two or more plans. Plans restrict access in two different ways. They can place restrictions on coverage—for example, they might require or have drug substitution, prior authorization, step therapy, and supply limits—and they can require you to purchase your drugs from selected pharmacies and other sources. If a plan places a difficult or cumbersome restriction on your access to the drugs you need, you might want to consider a different plan with fewer restrictions at a somewhat higher cost.

### Free One-on-One Help in Choosing a Part D Plan

If you have any doubts or questions about choosing a Part D plan, it might be a very good idea to get free personal advice from an expert counselor with SHIP or HICAP near you. These trained counselors are familiar with all the plans offered in your geographic area. They will sit down with you and help you match your needs, preferences, and finances with the available plans. To find your local SHIP or HICAP office, see the contact information at the end of Chapter 13.



#### TIP

**Switching from one plan to another.** Enrolling in a particular Part D plan isn't necessarily forever. If you pick a plan that winds up not suiting your needs and you can find a better one, you can switch plans. When and how often you can switch plans depends upon whether you're also eligible for Medicaid, you receive a Part D low-income subsidy, or you reside in a long-term care facility. The options for switching plans are explained in Chapter 13.

## Medicare Coverage for People With End-Stage Renal Disease (ESRD)

Most people qualify for Medicare only when they reach age 65 or after they have received Social Security disability benefits for two years. But you might be eligible for a special category of Medicare coverage, regardless of your age or ability to work, if you suffer from long-term kidney failure, known as “end-stage renal disease” (ESRD).

### Eligibility for ESRD Medicare Coverage

To be eligible for ESRD-based Medicare coverage, you have to meet two conditions. One is medical—you must be diagnosed with ESRD, as defined by Medicare. The other has to do with the amount of Social Security work credits that have been earned by you, your spouse, or (if you’re a minor) your parent.

### Qualifying Medical Condition

To qualify for Medicare’s special coverage for people with serious kidney disease, your treating physician (usually a nephrologist or other kidney specialist) must diagnose you as having ESRD. Under Medicare’s definition, ESRD means that your kidneys have permanently stopped functioning, so that in order to stay alive, you require either long-term dialysis or a kidney transplant. The required dialysis can be either at a medical facility or at home.

### Earned Work Credits

Depending on your age, you or your spouse (or one of your parents, if you’re a minor) must have earned a certain number of Social Security work credits, also referred to as “quarters of coverage” (QCs), in order to be eligible for ESRD-based Medicare coverage. Workers can accumulate up to four QCs each year, based on their salary or wages and other earned income; the way Social Security calculates these work credits is explained in Chapter 1.

**Overall work record.** To qualify for ESRD-based Medicare coverage, you must have earned at least one QC for each year after the year you turned age 21, up to the year you were diagnosed with ESRD. Or, you can qualify instead based on your spouse's work record, if your spouse earned at least one QC for each year after turning 21, up to the year you were diagnosed with ESRD (or, up to the year your spouse reached age 62 or died). If you or your spouse were collecting Social Security disability benefits during any year, that year doesn't count in calculating the QCs needed. Regardless of your age, a minimum of six QCs by you or your spouse is required for you to be eligible for ESRD-based Medicare coverage.

Your child who is younger than age 22 can qualify for ESRD-based coverage if you or your spouse:

- have earned at least six credits within the last three years by working and paying Social Security taxes, or
- are getting, or are eligible for, Social Security or Railroad Retirement Board benefits.

**Recent work record.** Even if the overall number of QCs earned by you or your spouse doesn't meet the standard described above, you can still qualify for ESRD-based Medicare coverage if you or your spouse earned at least 6 QCs over the 13 calendar quarters immediately prior to the onset of your ESRD condition (or prior to the death of your spouse).



#### TIP

**Go to Social Security's website.** You can find out how many quarters of work credit you or your spouse have earned by going to the Social Security website at [www.ssa.gov/myaccount](http://www.ssa.gov/myaccount) and creating a personal account.

## Medical Care Covered by ESRD Medicare

If you qualify for this special Medicare eligibility for ESRD, Medicare will cover not only costs related to your treatment for ESRD but also costs for *all other medical care normally covered by Medicare*. That means you'll be fully eligible, on the same terms as anyone else, to:

- enroll in coverage for inpatient care under Medicare Part A, outpatient care under Medicare Part B, and outpatient prescription drugs under a Medicare Part D insurance plan (Parts A, B and D are explained in this chapter)
- purchase a “medigap” supplemental private insurance policy to pay some of the costs Medicare doesn’t pay (see Chapter 14), or
- enroll in a Part C Medicare Advantage plan, which puts all these coverages into one package (see Chapter 15).

Like anyone else eligible for Medicare, you’ll need to choose which parts of the program to enroll in, and will have to pay each part’s premiums, deductibles, and copayments, as well as the 20% of most charges that Medicare Part B doesn’t pay. The deductibles, copayments, and unpaid Medicare Part B 20% underline the importance of purchasing a medigap supplemental insurance policy, joining a Medicare Advantage plan, maintaining employer-sponsored health coverage, or (if you have low income and few assets other than your home) determining whether you’re eligible to enroll in your state’s Medicaid program (see Chapter 16).

To receive maximum Medicare coverage for costs specifically related to your ESRD care, you must enroll in both Medicare Part A and Medicare Part B (which charges a monthly premium), or enroll in a Part C Medicare Advantage plan (these plans combine Part A and Part B coverage). Once you’re enrolled in Part A and Part B, or in Part C, Medicare will cover:

- dialysis and related services, including the daily room cost if you receive your dialysis while an inpatient in a Medicare-participating hospital
- dialysis and related services if you receive dialysis as an outpatient at a Medicare-approved dialysis facility
- training for self-dialysis, for both you and a person you designate to help you at home with your self-dialysis, if you request self-dialysis and your treating physician approves
- self-dialysis equipment and supplies for use at home, including certain drugs that your doctor might prescribe, or
- services from your physician(s), as well as laboratory and other tests.

**CAUTION**

**Medicare doesn't pay for dialysis assistants at home.** While Medicare will pay for the training of a person to assist you with self-dialysis at home, Medicare won't pay for the person's actual services, nor for a professional dialysis aide to help you at home.

## **Coordination of Medicare With Group Health Insurance Coverage**

At the time you become eligible for ESRD-based Medicare, you might already have health care coverage through an employer group health plan, based on your or your spouse's current employment or through a retirement plan. If so, and if you enroll in ESRD-based Medicare, the private insurance will be the primary payer for your health care costs during a "coordination of benefits" (COB) period of 30 months, with Medicare as the secondary payer. This means that for this initial period, Medicare will contribute to payment of costs that your health plan doesn't pay (which can include deductibles, copayments, and sometimes a yearly cap on payments for renal services). The COB begins the first month that you become eligible for ESRD-based Medicare, whether or not you actually enroll at that time. At the end of the 30-month period, the roles are reversed, with Medicare becoming the primary payer and your employer group health plan becoming the secondary payer.

## **When ESRD Medicare Coverage Begins**

ESRD-based Medicare coverage becomes effective at different times, depending on the nature of your treatment.

**Hemodialysis provided at a facility.** If you receive hemodialysis at a dialysis center or clinic, your Medicare coverage becomes effective on the first day of your fourth month of treatment. If, however, you're resuming dialysis after your ESRD-based Medicare coverage

ended (due to recovery of kidney function following a transplant or dialysis—more on this below), your Medicare coverage can begin again without the three-month waiting period described above.

**Home (self) dialysis.** If you and your physician decide that you want and are able to perform self-dialysis at home, Medicare coverage becomes effective as soon as you begin treatment—even if you begin treatment at a facility before switching to home—if you complete a self-dialysis training program at a Medicare-certified facility and then perform self-dialysis at home.

**Kidney transplant.** If you're to receive a kidney transplant, your Medicare coverage begins the month you're admitted to the hospital for the transplant or for medical care preparing you for the transplant. The coverage can extend back to two months prior to the transplant if you're in the hospital that long prior to the surgery.

## When ESRD Medicare Coverage Ends

ESRD-based Medicare coverage ends 12 months after you stop dialysis. If you've had a transplant, ESRD-based Medicare coverage stops 36 months after the date of the surgery (unless you're then still on dialysis). However, special rules might permit continued Medicare coverage of immunosuppressive drugs even after other Medicare coverage ends. (See below.)

## Applying for ESRD Medicare Coverage

You apply for ESRD-based Medicare coverage through the Social Security system. You can begin this process online at Social Security's website [www.ssa.gov](http://www.ssa.gov) or by phoning Social Security at 800-772-1213. (If you phone, there's usually quite a long wait, but the Social Security phone system allows you to leave your name and number and get a return call instead of waiting on the line; this call-back service works well.)

### Special Length-of-Coverage Rules for Immunosuppressive Drugs

Very expensive drugs used to stop the body from rejecting a transplanted kidney are often used by transplant patients for months or years following the surgery. Medicare will pay 80% of the cost of those drugs for three years or indefinitely, depending on how you qualify for Medicare:

- If your Medicare coverage is based on ESRD-based eligibility alone, Medicare will cover the drugs for 36 months. After 36 months, you can enroll in special Medicare Part B coverage for these drugs for as long as you need them (until you become eligible for Medicare Part B under standard, non-ESRD eligibility rules). For this special Part B drug coverage, you'll pay \$103 per month (in 2024); the premium is higher for those with incomes above \$103,000 (individual) or \$206,000 (couple). There's also a yearly deductible (\$240 in 2024). The coverage is for these drugs only.
- If, before you got ESRD, you were eligible for Medicare because you were age 65 or older or had received Social Security disability benefits for at least 24 months, Medicare will cover the drugs indefinitely.
- If, after you had a transplant that was covered by Medicare, you qualify for Medicare because you're age 65 or older or have been receiving Social Security disability benefits for at least 24 months, Medicare will cover the drugs indefinitely.

Your specialist physician's office can provide initial help and ongoing support for the medical information you'll need to supply with your Medicare application. If you have problems with eligibility, you can also get help from the National Kidney Foundation at 800-622-9010 or online at [www.kidney.org](http://www.kidney.org). ●

## Medicare Procedures: Enrollment, Claims, and Appeals

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Chapter 12 described the eligibility rules for Medicare. As you'll remember, most people are eligible for Part A hospital insurance free of charge; if you aren't, you can enroll by paying a monthly premium. Part B medical insurance coverage is available to most people age 65 and older, and everyone covered pays a monthly premium for it. And Part D—which covers some of the cost of prescription drugs you take at home—is available to anyone who is eligible for Part A or B. Everyone who enrolls in Part D pays a monthly premium for prescription drug coverage, except those who are also eligible for Medicaid or who receive a special Part D low-income subsidy.

This chapter explains:

- how to enroll in Medicare Part A and Part B
- how to get Medicare to pay its share of your medical bills once you're enrolled
- what portion of the bill you must pay yourself
- how to read the notice Medicare sends you
- how to appeal a Medicare decision regarding your claim, and
- the separate procedures for enrolling in a Part D plan, switching Part D plans, requesting an exception to a Part D plan's formulary or another access restriction, and appealing a Part D plan's decision.

## Enrolling in Part A: Hospital Insurance

Medicare Part A, also called “hospital insurance,” covers most of the cost of inpatient care in a hospital. Part A also sometimes covers the cost of inpatient care at skilled nursing facilities and home health care. Most people age 65 or older are eligible for Part A coverage. Some will receive it automatically and free of charge, along with their Social Security benefits. Others will need to enroll and possibly pay a monthly fee.

## Those Who Receive Social Security Benefits

If you're under age 65 and already receive Social Security retirement, dependents, or survivors benefits or Railroad Retirement benefits, you don't need to do any paperwork to enroll in Medicare Part A hospital insurance. Social Security will automatically enroll you, and coverage will take effect on your 65th birthday. About three months before your 65th birthday, Medicare will mail you a Medicare card and information sheet.

Since Medicare Part A is free for people age 65 or over who receive Social Security benefits, automatic enrollment provides excellent supplemental coverage even if you have other health care coverage.



### CAUTION

**No new contributions to health savings accounts.** Once you are enrolled in Medicare (Parts A and B, or Part A alone), which you receive automatically once you claim Social Security benefits at age 65 or older, you're no longer allowed to make new pretax contributions to your health savings account (HSA). You can continue to use the funds already in your HSA account, however. This is true even for employees with HSA health plans who continue to work.

If you receive Social Security disability benefits for two years, regardless of your age, you'll be automatically enrolled in Medicare Part A, effective 24 months from the date Social Security declared that your disability benefits should begin. The Medicare card you receive in the mail will indicate that you're enrolled in both Part A and Part B. If you don't want to be enrolled in, and pay the monthly premium for, Part B, there's a form for you to sign indicating your rejection of Part B, which you send to Medicare. If you do want to be enrolled in both Parts A and B, you don't have to do anything. Just sign your Medicare card and keep it handy.

### **Managed Care Plans Handle Medicare Paperwork**

Many people who are about to qualify for Medicare have an HMO or another managed care insurance plan that they intend to keep when they become eligible for Medicare. Other people decide to join a Medicare Advantage HMO or other managed care plan when they first become eligible for Medicare.

If you intend to remain with your current insurance plan when you become eligible, your plan can sign you up for Medicare and switch you to the plan's Medicare coverage. Begin this process two to three months before you become eligible for Medicare.

Similarly, if you decide to join a Medicare Advantage managed care plan for the first time when you become eligible for Medicare, you can sign up for Medicare at the same time you sign up for the plan. Try to get the paperwork started at least two months before your Medicare eligibility begins.

Medicare Advantage managed care plans are discussed in Chapter 15.

If you're receiving Social Security benefits but don't receive your Medicare card in the mail within a month of your 65th birthday, or within a month of your 24th month of disability benefits, contact your local Social Security office or call the national Social Security office at 800-772-1213.

### **Those Who Don't Receive Social Security Benefits**

If you're soon to turn 65 but you're not receiving Social Security retirement, dependents, or survivors benefits, Railroad Retirement benefits, or federal civil service retirement benefits, you must apply for Medicare Part A either online on the official Social Security Administration website at [www.ssa.gov/benefits/medicare](http://www.ssa.gov/benefits/medicare) or at your local Social Security office. If you're going to apply for retirement or other Social Security benefits to begin on your 65th birthday, you can apply for Medicare at the same time, at your local Social Security office.

## Your Medicare Card

When you're enrolled in Medicare, you'll be sent a Medicare card that states:

- your name
- whether you have both Part A and Part B coverage or just Part A
- the effective date of your Medicare coverage, and
- your health insurance claim number—also called your “Medicare number.”

Always carry your Medicare card with you. You'll be asked to present it when you seek medical treatment at a hospital, a doctor's office, or another health care provider.

Also, you must include your Medicare number on all payments of Medicare premiums or correspondence about Medicare.

If you lose your Medicare card, you can have it replaced by applying in person at your local Social Security office or by calling the toll-free information line at 800-MEDICARE or Social Security's main office at 800-772-1213. Alternatively, you can apply for a new card online at [www.medicare.gov](http://www.medicare.gov).

## Who Is Eligible

If you're eligible for Social Security benefits, you can receive free Medicare Part A coverage at age 65 whether or not you actually claim your Social Security benefits.

For example, many people who continue working after reaching age 65 don't claim retirement benefits until later. Still, they can receive free Part A Medicare coverage by applying for it at their local Social Security office.

Also, if you aren't automatically eligible for free Part A coverage, you can purchase it for a monthly premium. The amount of the premium depends on how many work credits you or your spouse have earned. (See “Part A: Hospital Insurance” in Chapter 12 for details.)

## When to Apply

Whether you wish to claim Social Security benefits and Medicare, or just Medicare, apply well before you turn 65. You can apply as early as three months before your 65th birthday.

Signing up early is important for two reasons: First, it will ensure that your coverage begins as soon as you're eligible, on your 65th birthday. Second, if you wait more than three months after your 65th birthday to enroll, you won't be allowed to enroll in Part B until the following January 1, and your eligibility won't begin until July 1 of that year. (See "Enrolling in Part B: Medical Insurance," below, regarding delayed enrollment.)



### CAUTION

**Avoid delays in Part B coverage.** If you don't enroll in both Parts A and B during your initial enrollment period, not only will your enrollment in Part B be delayed, but you'll also have to pay a higher monthly premium for it. (See "Enrolling in Part B: Medical Insurance," below, for details.)

## When Benefits Begin

If you apply for Part A of Medicare within six months after you turn 65, your coverage will date back to your 65th birthday. But if you apply after that, your coverage will date back only up to six months before the month in which you applied. If your Medicare eligibility is based on disability, however, your coverage will date back up to one year before the date on which you apply.

## Appealing Denial of Coverage

Eligibility for coverage by Part A of Medicare depends solely on your age and on the number of Social Security work credits you or your spouse have acquired. (See "Part A: Hospital Insurance" in

Chapter 12 for a review of the eligibility requirements.) You can be denied coverage by Medicare Part A only if there's a dispute about whether you've reached 65, about the number of your or your spouse's work credits, or about the validity of your marriage.

Decisions about these matters are handled not by Medicare but by Social Security. And, like any other decision of the Social Security Administration, a decision denying eligibility for Medicare Part A hospital insurance coverage can be appealed. The appeal process is discussed later in this chapter.

## **Enrolling in Part B: Medical Insurance**

Medicare Part B, referred to as “medical insurance,” covers doctors' services plus laboratory, clinic, home therapy, and other medical services you receive—other than when you're an inpatient in a hospital or skilled nursing facility. Most people age 65 are eligible for Part B.

Everyone must pay a monthly premium to enroll, although some people might pay for Part B in the premiums they pay to HMOs or other Medicare Advantage plans (see Chapter 15).

This section explains who is automatically enrolled in Part B, who must take steps to enroll, and when to do so.

### **Those Who Receive Social Security Benefits**

If you're younger than 65 and already receiving Social Security retirement, Railroad Retirement, dependents, or survivors benefits, you'll be automatically enrolled in both Medicare Part A and Part B within three months of turning 65. Your coverage will become effective on your 65th birthday. Near that time, you'll be sent your Medicare card through the mail, along with an information packet. The monthly premium for Part B coverage will be deducted automatically from your Social Security check, beginning with the first month after your 65th birthday.

If you don't want Medicare Part B coverage—perhaps because you or your spouse are still working and you're covered by an employment-related health plan—notify Social Security of that fact on the form that comes with your Medicare card. If you reject Part B coverage when you're first eligible for it, you can enroll in Part B later on, although only during the first three months of any year. And if you enroll later, your premiums might be higher, though not if you've been covered by a comparable employer-sponsored health plan (see “Delayed Enrollment,” below).

## **Those Who Don't Receive Social Security Benefits**

If you're turning 65 but aren't eligible for Social Security benefits—or aren't yet going to claim benefits to which you're entitled—you can still enroll in Part B medical insurance either online on the official Social Security website at [www.ssa.gov/benefits/medicare](http://www.ssa.gov/benefits/medicare) or at your local Social Security office.

You can enroll during an initial period of seven months, which begins three months before the month you turn 65 and ends three months after the end of the month you turn 65. For example, if you turn 65 in July, your initial enrollment period starts April 1 and ends October 31. However, the earlier you enroll during this initial period, the better. If you enroll during the three months before you turn 65, your coverage will begin on your 65th birthday. If you enroll during the remaining four months of your initial enrollment period, your coverage might be delayed from one to three months after you sign up, depending on how long it takes to process your application.

## **Delayed Enrollment**

If you don't enroll in Part B medical insurance during the seven-month period just before and after you turn 65, but later decide you want the coverage, you can sign up during any general enrollment period. These are held January 1 through March 31 every year. If you sign up any time during one of these general enrollment periods, your coverage will begin on July 1 of the year you enroll.

Your monthly premium will be higher if you wait to enroll during one of the general enrollment periods instead of when you turn 65. For each year you were eligible for Part B coverage but did not enroll, your premium will be 10% higher than the basic premium.

### **Free Late Enrollment If Covered by Current Employment Health Plan**

If you're covered by a group health plan based on your own or your spouse's current employment, you can enroll in Part B coverage after your 65th birthday without having to wait for the open enrollment period and without any penalty. This exception refers only to a group health plan based on current employment, not to one based on retirement benefits from employment.

If you've delayed signing up for Medicare Part B because you've been covered by a health plan based on current employment, you can sign up for Part B coverage at any time while you're still covered, or within seven months of the date you or your spouse end that employment, or of the date the health coverage ends, whichever comes first.

If you sign up while you're still covered by a group health plan based on current employment, or during the first full month that you no longer have this coverage, your Part B coverage will begin the first day of the month you sign up. You can also choose, instead, to have your coverage (and the monthly premium you must pay) begin with any of the following three months. If you sign up during any of the remaining seven months of your special enrollment period, your Part B coverage will begin the month after you sign up.

To enroll in Part B after age 65 (when you already have Part A), you can fill out an *Application for Enrollment in Medicare Part B* (Form CMS40B) and bring it or mail it to a Social Security office. If for any reason you're not already enrolled in Medicare Part A, you can sign up for both Part A and Part B online at <https://secure.ssa.gov/iClaim/rib> (you can't sign up online for Part B only).

## Medicare's Payment of Your Medical Bills

Medicare doesn't handle day-to-day paperwork and payments with patients and doctors or other health care providers. It contracts out this work to what are called Medicare carriers or intermediaries. These are huge private corporations, such as Blue Cross or other large insurance companies, each of which handles claims for an entire state, and sometimes for more than one state.

The Medicare intermediary in your state receives, reviews, and pays claims. It sends notices that tell you and the medical provider of the amount of benefits paid, the amount of your medical bill that has not been paid, and the amount the health care provider is legally permitted to charge. (See “Your *Medicare Summary Notice*,” below, for more on these notices.) And it's with the intermediary that you'll initially correspond if you want to appeal a decision about Medicare coverage of health care charges. (See “Appealing the Denial of a Claim,” below, for appeal procedures.)

Medicare intermediaries handle billing for inpatient charges covered under Part A differently from outpatient charges covered under Part B. This section explains the differences in the billing process.



### TIP

**HMOs and Medicare Advantage plans do their own paperwork.**

If you belong to an HMO or other Medicare Advantage plan, the billing office there handles all your Medicare-related paperwork. All you have to do is pay your plan's own monthly premiums and copayments and deal with the plan's paperwork. You don't have to directly handle any Medicare forms and you won't receive any *Medicare Summary Notices*.

## Inpatient and Home Care Bills

Medicare Part A covers inpatient care in a hospital or skilled nursing facility, as well as some home health care. (See “How Much Medicare Part A Pays” in Chapter 12 for a review of Medicare Part A coverage.)

### **Medicare Billed Directly by Facility**

When you first check into a hospital or skilled nursing facility, you present your Medicare card to the admissions office and it takes care of the rest. Similarly, when you and your doctor make arrangements for a Medicare-approved home care agency to provide your care, you give the agency your Medicare number and it takes care of all the paperwork. The provider—the hospital, skilled nursing facility, or home health care agency—sends its bills directly to Medicare and to your medigap supplemental insurance carrier, if you have one. You shouldn't have to do a thing to get Medicare (and your medigap insurer) to pay its part of the bill.

The hospital, nursing facility, or home care agency accepts as payment in full the amount the Medicare intermediary decides is the approved charge for those of your inpatient services that are covered by Medicare (but see Chapter 12 for a reminder of what costs are covered). Unlike doctors' bills—for which you might be personally responsible for the difference between Medicare's approved charges and the actual amount of a bill—a hospital, nursing facility, or home care agency is not permitted to bill you for any covered inpatient charges over the amounts paid by Medicare.

The Medicare carrier will also send you a copy of the bills so that you'll know how much has been paid and how much you must cover on your own.

### **Patient Billed for Some Charges**

The hospital, nursing facility, or home care agency will bill you, and your private Medicare supplement insurance company (if you have such insurance), for:

- any unpaid portion of your deductible
- any coinsurance payments—for example, for hospital inpatient stays of more than 60 days, and
- charges not covered at all by Medicare, such as for a private room you requested that was not medically necessary, or for television and telephone charges.

The Medicare carrier will send you a form called a *Medicare Summary Notice* (MSN) that will show what hospital services were paid for and the portion of your deductible for which you're responsible. The hospital or other facility will bill you directly for the unpaid portion of your deductible and for those amounts not covered by Medicare or by Medicare supplemental insurance. (See Chapter 14 regarding supplemental insurance.)

## **Outpatient and Doctor Bills**

How much of your covered doctor and outpatient medical bills Medicare Part B will pay depends on whether your doctor or other medical provider accepts assignment of the Medicare-approved amount as the full amount of the bill. (For more information, see “How Much Medicare Part B Pays” in Chapter 12.)

If the doctor accepts assignment, you—perhaps assisted by private medigap insurance or Medicaid—are responsible only for your yearly Part B deductible, plus the 20% of the approved charges Medicare does not pay.

If the doctor or other provider doesn't accept assignment, then you and your additional insurance might also be responsible for all amounts of the bill up to 15% more than the Medicare-approved amount.

## **Assignment Method of Payment**

If your doctor or other health care provider accepts assignment of your Medicare claim, you're personally responsible for your yearly medical insurance deductible, and then only the 20% of the Medicare-approved amount of the bill that Medicare does not pay. By accepting assignment, the doctor or other provider agrees not to charge you a higher amount than what Medicare approves for the treatment or other covered service you've received.

### Catching Overbilling

Medicare does a decent job of catching billing errors and fraud by health care providers. But they're not perfect, so you should still check your bill carefully to determine whether the facility or other provider has billed you for services you did not receive or services that Medicare has paid, or has charged more than once for the same service.

The Medicare intermediary might look closely at the portion of the bill Medicare is supposed to pay, and if you have medigap supplemental insurance, the insurance company will also check the bill. But neither one will carefully examine the amounts for which you're personally responsible.

Check all medical bills to make sure there are no charges for services you did not receive. Then, place the bill from the facility or other provider next to the statement from the Medicare carrier and from your medigap insurance company. Compare them to see whether any amount the facility or other provider has billed you directly has been paid by Medicare or by your medigap insurer.

If so, you must contact the billing office at the facility or other provider, sending a copy of your statement from the Medicare carrier or medigap insurer that shows that the charges have been paid. If the problem is billing for a service you don't believe you received, ask the facility's or provider's billing office to send you a copy of your medical record where the service was recorded.

For more information about how to deal with what you believe are billing errors, go to the Medicare website at [www.medicare.gov](http://www.medicare.gov) and look under the tab "Providers & Services," then "Claims & appeals," then click "File a complaint (grievance)."

After you and the health care provider are informed by a *Medicare Summary Notice* form from Medicare how much the Medicare-approved charges are, the provider's office will either bill you directly for the remaining 20% of approved charges or bill your medigap supplemental insurance carrier if you have one.

**EXAMPLE:** Franco was examined for a painful knee by his regular doctor, who then decided to refer him to an orthopedist. Franco asked his doctor to refer him to someone who accepted Medicare assignment. The orthopedist examined Franco, took X-rays, and prescribed exercises and some medication. Franco’s own doctor charged \$200 for Franco’s original examination. The orthopedist charged \$300. Both doctors accepted assignment.

Medicare’s approved amount for Franco’s regular doctor was \$150 and, for the orthopedist, \$240. Because Franco had already paid his yearly deductible for Part B, Medicare paid 80% of the approved amount of each doctor’s bill: \$120 to Franco’s regular doctor (80% of \$150 = \$120) and \$192 to the orthopedist (80% of \$240 = \$192). Medicare sent these amounts directly to the doctors. Franco had to pay only the remaining 20% of the approved amounts.

The following chart shows who paid what amount of Franco’s bills in this example.

Payment of Doctor Bills—Assignment Accepted			
	Initial exam	Orthopedic exam	Total
Doctors’ normal charges	\$200	\$300	\$500
Amount approved by Medicare	\$150	\$240	\$390
Amount paid by Medicare (80%)	\$120	\$192	\$312
Amount patient paid (20%)	\$30	\$48	\$78

**Payment When No Assignment**

If your doctor or other health care provider doesn’t accept assignment of the Medicare-approved charges as the full amount of the bill, you—or you and your medigap supplemental insurance—will owe the difference between what Medicare pays and the full amount of the doctor’s bill, up to 15% more than the Medicare-approved amount. You end up having to pay one-third (33.25%) of the Medicare-approved amount, rather than one-fifth (20%) of the approved amount.

Medicare has a complicated way of calculating this. For nonparticipating doctors, Medicare lowers the approved fee to 95% of what it would be for participating doctors. But it allows nonparticipating doctors to charge 15% of this lowered fee to patients, in addition to their 20% copayment.

**EXAMPLE:** In the example above, Franco’s own doctor normally charged \$200 for an examination and the orthopedist charged \$300. If neither doctor accepted assignment but stuck to their normal fees, the payment amounts would be as follows.

Medicare’s approved amount for Franco’s regular doctor was \$150 and, for the orthopedist, \$240. But Medicare will allow only 95% of this fee as the approved fee since the doctor doesn’t accept assignment. The doctor can charge 115% of this lowered fee (which works out to an additional 9.25% of the regular approved fee). Medicare will pay 80% of the lowered fee.

The following chart summarizes who paid what amount of Franco’s bills in this example. You’ll see that his payment is one-third of the regular approved amount.

Payment of Doctor Bills—Assignment Accepted			
	Initial exam	Orthopedic exam	Total
Doctors’ normal charges	\$200.00	\$300.00	\$500.00
Amount approved for nonparticipating doctors (95% of approved fee)	\$142.50	\$228.00	\$370.50
Total amount doctor allowed to charge (115% of lowered fee)	\$163.88	\$262.20	\$426.08
Amount paid by Medicare (80% of lowered fee)	\$114.00	\$182.40	\$296.40
Amount paid by patient (20% of lowered fee)	\$28.50	\$45.60	\$74.10
Additional amount doctor can charge (15% of lowered fee)	\$21.38	\$34.20	\$55.58
Total amount paid by patient (20% of lowered fee + additional amount)	\$49.88	\$79.80	\$129.68



## TIP

**Handling Medicare billing paperwork is free.** Even a doctor or another health care provider who does not accept assignment must fill in the Medicare paperwork and send it to Medicare for payment—and you can't be charged for processing this Medicare paperwork.

## Paying Your Share of the Bill

Doctors and other health care providers must wait to find out how much the Medicare-approved charges are before asking you to pay your share. Until they know what the Medicare-approved amount is, they can't know the legal limit—15% over those approved charges—on how much they can require you to pay.

Following your treatment or other service, the doctor's or other provider's office will submit their bills for payment to Medicare. You don't have to submit the paperwork yourself.

If you have private medigap supplemental insurance that pays your deductible and the 20% coinsurance amount that Medicare does not pay, the doctor's office will send its paperwork to the insurance company as well as to Medicare. The doctor will receive payment directly from both Medicare and the supplemental insurance, after Medicare has determined the approved amount for the care you received.

Every three months you'll receive a form called a *Medicare Summary Notice* that includes the following information about every Medicare-billed service you received during the previous three-month period:

- how much of each bill is Medicare-approved
- how much Medicare will pay the provider
- how much of your deductible has been met, and
- how much must be paid by you or your private medigap insurance.

## Your Medicare Summary Notice

A form called a *Medicare Summary Notice* (MSN) is sent to you to explain what Medicare Part B is covering of your recent medical services and how much Medicare is paying for those services. You receive such a notice every three months; if you did not have any medical services during those three months, you won't receive an MSN for that period.

### Don't Let a Doctor Take More Than the Law Allows

Medicare rules are clear—and every doctor and other health care provider knows them. You can be charged only an extra 9.25% above what Medicare decides is the approved amount for a specific medical service (which is actually an extra 15% of the approved amount for unassigned claims). And the *Medicare Summary Notice* form does the arithmetic for you, stating the amount of the maximum charge.

If a doctor or another provider does not accept assignment and bills you more than the allowable amount, send the doctor's office a copy of your *Medicare Summary Notice* form, underlining the spot where the maximum bill is stated—and keep a copy for yourself. If you already paid the bill, and the amount you paid was more than the allowable Medicare-approved amount plus 15%, you're entitled to a refund.

Again, contact the doctor's or other provider's billing office and request your refund, letting them know the date you paid the bill, the amount you paid, and the Medicare-approved amount. If they won't refund the overpayment, contact the Medicare carrier, which will then contact the doctor or other health care provider directly.

The MSN is not a bill. It simply allows you to check the information Medicare has received from your medical providers and to see how much Medicare will pay and how much is left over to be paid by your supplemental insurance carrier or by you out of pocket. Every time you get an MSN form, you should check it carefully

to see that the information is correct and that you agree with Medicare's decisions. For an example of an MSN, information about what you need to look at closely on the form, and how to challenge any errors you find, go to the special Medicare webpage explaining the latest version of the MSN form: [www.medicare.gov/pubs/pdf/SummaryNoticeB.pdf](http://www.medicare.gov/pubs/pdf/SummaryNoticeB.pdf).

You can also receive your MSNs electronically on your computer rather than on paper through the mail. If you sign up for electronic MSNs, you'll get a monthly MSN rather than one every three months. You can sign up for that service by going to [www.medicare.gov/forms-help-and-resources/e-delivery.html](http://www.medicare.gov/forms-help-and-resources/e-delivery.html).

## **Appealing the Denial of a Claim**

Unfortunately, not every request for Medicare payment runs a smooth course. Occasionally, a Medicare hospital or nursing facility review committee might decide your inpatient stay need not last as long as you and your doctor think, and will recommend ending Medicare Part A coverage. Or, more commonly, the Medicare carrier will deny Part B coverage for what you believe is a covered medical service. Or sometimes it will cover only some but not all of a treatment that you believe should be covered.

You can appeal any of these decisions. This section explains the procedures you must follow.

### **Decisions About Inpatient Care (Medicare Part A)**

Occasionally, disputes arise about whether treatment as an inpatient in a hospital or skilled nursing facility continues to be medically necessary. These disputes often pit the patient and doctor on one side and the facility's Medicare review committee on the other. The review committee might believe that the patient can be moved from the hospital to home or to a nursing facility sooner than the doctor advises, or moved from the skilled nursing facility to a nonskilled

facility or to home care. If this happens to you, there are several steps you can take to convince Medicare to pay for your continued inpatient care.

### **Help From the State Health Insurance Assistance Program (SHIP) and Medicare Rights Center**

Every state has a program to provide free assistance to any person with questions or problems regarding Medicare, medigap supplemental insurance, Medicare managed care, Medicaid, and long-term care. For example, people often have questions about enrollment, paying bills, and filing appeals. The overall program is called the “State Health Insurance Assistance Program” (SHIP), though in your state the program might go by one of several different names—“Health Insurance Counseling and Advocacy Program” (HICAP), “Senior Health Insurance Benefits Advisors” (SHIBA), or something similar. Whatever the name, the program provides free counseling by professional staff plus trained volunteers. The offices are often connected to legal service agencies that can provide free or low-cost legal advice if the matter involves an interpretation of a law or rule, or a legal battle.

SHIP offices are staffed by dedicated people who aren’t only knowledgeable and trained to give helpful advice but are also willing to fight for your rights. They sit down with you in person, review your story and papers until they understand your situation, and help you handle the paperwork and telephoning sometimes necessary to make your enrollment or appeal work.

To find the SHIP office nearest you, see the contact information at the end of this chapter.

Help with all sorts of Medicare questions and problems is also available from the nonprofit Medicare Rights Center. Its website, [www.medicarerights.org](http://www.medicarerights.org), provides the answers to many common questions about Medicare. And you can call the center toll free at 800-333-4114 to speak, at no cost to you, with a knowledgeable counselor.

## Coverage Decisions

Initial Medicare approval of whether your treatment should be as an inpatient is made by the hospital's or nursing facility's Utilization Review Committee (URC), a group of doctors and administrators. The committee makes this determination before you're admitted or within one day of your emergency admission. The URC also periodically reviews your condition and progress in the facility and can decide—after checking your medical records and consulting with your doctor—that you no longer require inpatient care at that facility.

Such a decision does not mean that you'll be kicked out of the facility, but it might mean that the URC will recommend to Medicare that your inpatient stay at the facility no longer be covered by Part A insurance. If you and your doctor believe you should remain in the hospital, there are procedures to follow that might reverse the URC's decision. And even if the decision is not reversed, the process of appealing can give you a bit more time in the facility without being personally responsible for the huge inpatient bills.

**Notice of Noncoverage.** If the URC decides that your condition no longer requires inpatient care, it will consult with your doctor. If your doctor agrees, the URC will give you a written Notice of Noncoverage stating that your Medicare hospitalization coverage will end on a certain day. If you don't feel that you should be discharged from the hospital at that point, first express your wishes to your doctor. Ask that the doctor request from the URC that a longer period of inpatient care be approved.

If the doctor or ombudsman can't change or delay the URC's decision, or your doctor won't oppose the decision, but you still feel that you should not be discharged, you'll have to file an appeal to protect your right to have Medicare Part A cover your inpatient care.

If your doctor disagrees with the URC opinion that you should be discharged, the URC will either back off its decision and not contest your Medicare coverage—in which case you'll hear nothing about it—or will ask for an opinion from the state's Peer Review Organization (PRO). The PRO is a group of doctors who are paid

by Medicare to review the medical necessity and appropriateness of inpatient care. This is a bit like the foxes guarding the chickens, but the PROs are also medical professionals who respect the opinions of treating physicians. The PRO will review your medical records, the URC's recommendation, and your doctor's position.

If the PRO agrees that your continued stay at the hospital is medically necessary, you'll hear nothing more about the matter and Medicare will continue to cover your inpatient care. However, if the PRO decides that your inpatient care is no longer medically necessary, you'll receive a Notice of Noncoverage stating that your coverage for hospitalization will end as of a certain day.

### **Immediate Review**

If you receive a Notice of Noncoverage, it will contain important information, including when the URC intends to end your Medicare coverage and whether your doctor or the state PRO has agreed with the decision. How you'll obtain immediate review—the first step in appealing the decision—differs slightly depending on whether your doctor agreed with the URC or the decision was made by the PRO over your doctor's objection.

**Immediate review of joint URC and doctor decision.** If the Notice of Noncoverage states that your doctor agreed with the URC that coverage for your inpatient care should end, you must take some action to get the process moving.

If you're in the hospital, chances are you might have physical difficulty making phone calls and having conversations to get your immediate review started. You can have a friend or relative act on your behalf by making the necessary call requesting review of your case. You can also ask your doctor to initiate the review, even though the doctor initially agreed with the URC's recommendation that Medicare inpatient coverage should end on the specified date. You can also ask to speak with the hospital ombudsman, who can then make your request for immediate review.

Once the PRO has been notified that you're requesting immediate review, it will contact you in order to discuss the matter.

Request an immediate review by the PRO by noon of the first workday after you receive the Notice of Noncoverage. Contact may be made by phone or in writing at the number and address of the PRO given on the notice.

A representative of the PRO will speak with you directly about why you believe you still require inpatient care—and with the doctor who had you admitted to the hospital or with the physician overseeing your care.

### **Your Doctor Can Be Your Best Ally**

The most important element in winning an appeal, particularly for coverage of inpatient care, is gaining your doctor's cooperation. The decision on a Medicare appeal often depends on what the doctor notes in your medical records about your condition and the treatment involved—and on how much assistance you can get from the doctor in providing clarification to the people doing your Medicare review.

The problem is that many doctors view their responsibility to the patient as including only the technical treatment of a medical condition: your body and how it works. Many doctors aren't particularly concerned with how you pay the bill, as long as you pay it. And if it's someone else's bill—the hospital's, for example—the doctor might be even less interested.

If you're fortunate, your doctor will give some attention to your Medicare needs, calling the Medicare appeal personnel and writing a letter, if necessary. If so, you'll find the Medicare appeal process fairly simple. But if your doctor won't take the time to listen to your Medicare problem and help you with the appeal, you might have a frustrating time, which can't help your recovery process. It might also prompt you to consider changing doctors.

**TIP**

**Try again with your doctor.** Help from your doctor is the best hope you have of convincing the PRO to approve your continued coverage. Speak with the doctor again about why you think you should have continued coverage. Sometimes a doctor agrees with the URC decision on care without consulting the patient, or based on an expectation of the patient's improvement that has not occurred. Also, there might be more than one doctor treating you. If so, try to enlist the help of your other doctors. Ask them to speak with your admitting physician about your needing more inpatient care.

The PRO will review your case and, within a matter of days, inform you directly of its decision—either by phone or in writing. If the PRO agrees with the facility that your coverage should end, coverage will continue only until noon of the day after you receive notice of the PRO's decision. After that, the facility will bill you for all inpatient costs.

**TIP**

**Your coverage will continue during the review.** If you have requested an immediate review of a joint URC and doctor decision, Medicare will continue to cover your inpatient care until the PRO makes a decision.

**Immediate review of a URC decision your doctor opposes.** If your doctor believes that you need to remain in the hospital but the URC disagrees, the URC will have taken your case to the PRO before you receive a Notice of Noncoverage. And the notice will tell you that the PRO has already agreed with the URC.

You must still ask the PRO for immediate review. But unless you and your doctor can present some strong reasons why the decision should be changed, it will likely remain in effect.

The review process should then proceed as follows:

- Contact the PRO at once by phone or in writing to explain why you believe your continued inpatient care is necessary.
- Ask your doctor—or several doctors if more than one is treating you—to immediately call the PRO to give reasons why your inpatient care continues to be medically necessary. If doctors who are treating you haven't previously been in contact with the PRO regarding your case, they can help immensely now by backing up what your admitting physician has said about your continuing need for inpatient care.
- Within three working days of your request for review, the PRO will notify you in writing of its decision.
- Medicare Part A coverage will end the third day after you receive the Notice of Noncoverage, even if the PRO has not yet decided. If the PRO takes the full three days to decide on your coverage and then agrees with the Notice of Noncoverage, you'll be personally responsible for the full cost of one full day of hospital costs—the day after coverage stops but on which the PRO has not yet decided.

If the PRO upholds the decision that your inpatient coverage should end, that is not the last word on your Medicare coverage. Similarly, if you did not request immediate review, you can still appeal the decision of noncoverage. Several stages of appeal are open to you, as described below.

### **Have Your Bill Submitted to Medicare**

Whether or not you asked for immediate review, you must ask that the hospital or other facility billing office submit the bill to the Medicare intermediary for payment. If you can get strong backing from your doctors, the intermediary might reverse the decision of the URC. Without such support, however, the intermediary will probably uphold the decision of the URC. Either way, if you want to pursue an appeal of the decision, you must have the hospital submit the bill to Medicare. Only by getting a Medicare carrier's decision can you move your appeal to the next stage.

Unfortunately, while the intermediary is deciding on your claim, the hospital or nursing facility might bill you for the uncovered part of your inpatient stay. If you pay the bill and later win your appeal, Medicare will reimburse you.

### **Reconsideration of Carrier's Decision**

If the Medicare intermediary denies the claim for payment of part of your inpatient bill, you have 60 days from the date you receive the denial notice to submit a request for reconsideration. You'll find the address for sending this request on the notice denying your claim.

This reconsideration will be made by what Medicare calls a Qualified Independent Contractor (QIC). The QIC was not involved in the original determination of your appeal.

This request for reconsideration can be made by filing a special *Medicare Reconsideration Request* form. You can find this form online on Medicare's official website at [www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms20033.pdf](http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms20033.pdf). Or, this request can be made in the form of a simple letter explaining why your stay in the facility continues to be necessary. Once again, however, it's not so much what you say in your letter as whether you have the support of one or more of your doctors. Ask all of the doctors who support your position to send a letter to the intermediary stating their medical opinion, and also to give you a copy. Attach a copy of each doctor's letter to your request for reconsideration, and always keep an extra copy for yourself.

It's sometimes difficult to get a doctor to write a letter on your behalf, even if the doctor supports your position. Sometimes it's simply a matter of the doctor being too busy, or not concerned enough with your financial problem, to speak with you in person before you must send in your request for reconsideration. Other doctors charge a fee for writing any letter that does not involve consultation about treatment—as opposed to payment of bills—and the fee might be too high for you. If you haven't obtained a letter from a doctor who supports your position, at least list your doctor's name and phone number in your request to the QIC. Ask that the QIC contact the doctor before completing its reconsideration.

The QIC will give you a written decision on its reconsideration. If it again denies coverage, you have 60 days to begin the next step in the appeal process.



#### TIP

**Put everything in writing and keep copies.** Keep copies of all correspondence and other papers concerning Medicare claims and appeals. Also, keep notes on all conversations you have with your doctor, representatives from the hospital, the PRO, and the intermediary. Write down the date of the conversation, the name of the person with whom you talked, and what information was given or taken.

### Request an Administrative Hearing

If, upon reconsideration, your appeal is denied by the QIC, you have 60 days from the date on the QIC's written decision to request a hearing by an administrative law judge (ALJ). The hearing is held before an ALJ who is attached to a local office of the Office of Medicare Hearings and Appeals (OMHA). You can ask that an actual hearing be held, which the ALJ will conduct either in person or by telephone. Or you can ask that the ALJ decide your appeal without a hearing, just by reviewing written materials. You can request a decision by an ALJ only if the amount you're contesting is \$140 or more.

The form for requesting this administrative hearing is provided online at [www.hhs.gov/sites/default/files/omha-100.pdf](http://www.hhs.gov/sites/default/files/omha-100.pdf). For more information about how the hearing process works, you can go directly to the website of the Office of Medicare Hearings and Appeals at [www.hhs.gov/omha](http://www.hhs.gov/omha).

As with every other stage of a Medicare appeal, your doctor's (or doctors') cooperation is the single most important element. Your doctor could appear personally at the hearing and testify on your behalf in front of the judge, but most doctors would charge an arm and a leg to do this. Instead, ask your doctor—or several of your doctors, if possible—to write an explanation of why your medical condition required inpatient treatment. You can then present the written explanation to the judge. Be aware that many doctors charge for writing such a letter, and Medicare laws permit them to do so.

### Appeals Council and Federal Lawsuit

If the decision of the administrative law judge goes against you, you can file an appeal to the Social Security Appeals Council. And if that appeal goes against you, you can file an action in federal court challenging the Medicare decision. (See Chapter 9 for more information.)

You can file such a lawsuit only if the amount you're contesting is \$1,400 or more. Because of the time and expense involved, it's likely you would file such a lawsuit only if the amount is quite a bit higher than that anyway. If you're considering such a lawsuit at this stage, consult with an experienced attorney. You might be able to get a referral to such an attorney from a SHIP office (see contact information at the end of this chapter).

### Payment of Doctor and Other Medical Bills (Part B)

During the course of one or more of your Medicare Part B medical insurance claims, you might disagree with the carrier's decision about whether a particular treatment or service is covered by Medicare. If you find that the Medicare carrier has denied coverage for a certain bill, you have a right to appeal. However, the Medicare Part B appeal process is quite limited, and most people have more success informally contacting the carrier than they do with formal appeals.

### Read the *Medicare Summary Notice*

The place to start with a question or complaint about your Medicare Part B coverage of a particular treatment or service is the *Medicare Summary Notice* (MSN) you receive from the carrier. (See “*Your Medicare Summary Notice*,” above, for a discussion of the MSN.)

It not only shows whether a health care service is covered but also gives a description of the service, a Medicare code number—called a “procedure code”—for the service, and a limited explanation of why a particular service was not covered.

Certain services might be covered if they're described one way by your doctor's office in the Medicare forms they submit, but not covered if described differently. These problems are sometimes caused simply by a wrongly placed checkmark—for example, indicating

a routine physical exam (not covered) instead of indicating physical examination for a particular patient complaint (covered). Such a mistake could be made by any number of people involved in handling your claim: your doctor, someone in your doctor's office, or someone in the Medicare carrier's vast paperwork machinery.

The MSN might also indicate that you were denied coverage for a particular service because you had the service performed too frequently during a given time. For example, you might have had two mammograms in one year when Medicare normally covers only one per year. However, if the treatment was determined to be medically necessary by your doctor—because, for example, you have a family history of breast cancer, or prior exams have disclosed potential problems—Medicare can and should cover the second mammogram.

In either situation, the next step is to contact your doctor's office to get a letter supporting the medical necessity for the treatment provided.

### **Check With Your Doctor's Office**

If you believe that the MSN incorrectly describes the service or treatment you had, call your doctor's office and ask whether the claim form sent to Medicare had the same information as shown on your MSN. If either the claim form or the MSN had incorrect information, ask that the doctor's office contact the carrier with the correct information.

If coverage was denied because Medicare claims the treatment was not medically necessary or that you received the treatment too often, ask the doctor to write a letter explaining why the treatment was medically necessary. Also, ask that doctor to make a copy of any of your medical records that support this conclusion—and to send the letter and records to you so that you can then deal with the Medicare carrier.

### **Contact the Medicare Carrier**

Most mistakes in billing and coverage are corrected informally, by phone and letter. The Medicare carriers know that mistakes are often made, and they would rather correct them quickly and inexpensively than go through a lengthy and more costly appeal process.

The number to call to reach your carrier is printed in the “Customer Service Information” box in the upper right-hand corner of the first page of your MSN. When you reach your Medicare carrier, give your name, your Medicare number, and the date of the MSN, explaining that you want to discuss coverage of a particular item. Then explain why you believe a mistake was made and describe your doctor’s response to the problem. If you have a letter or any medical records from the doctor that explain matters, tell the Medicare carrier what you have. The carrier will either contact your doctor’s office or ask you to send in a copy of your doctor’s letter, or both.

If this informal contact results in a change in decision by the Medicare carrier, it will send you a revised MSN explaining what the new Medicare payments are and how much you owe. If it does not change the coverage decision based on this informal contact, your next step would be to push on to a more formal written appeal.

### **Write a Request for Redetermination**

If you haven’t been able to resolve the coverage question informally, you have 120 days from the date you receive the MSN within which to file a written request for redetermination of the carrier’s decision—also called a “request for review.” The bottom of the second page of your MSN provides information and a short form to help you appeal the decision.

Make a copy of the MSN, circle the items you want to challenge, sign the back of the copy, and send it to the carrier listed on the front of the form. Although the MSN says you can write your appeal on the form itself, it’s better to send along a separate, signed letter with the MSN, stating your reasons for appealing. There’s very little space allowed for your statement on the appeal form, usually not enough to explain your reasoning adequately. Or, you can file your request for redetermination on a form provided by Medicare online at [www.cms.gov/cmsforms/downloads/CMS20027.pdf](http://www.cms.gov/cmsforms/downloads/CMS20027.pdf), but this form, too, has only limited space to explain your reasons for requesting a change in Medicare’s decision.

The letter should include your full name as it appears on the MSN, your Medicare number, the date of the MSN, the date of the disputed medical service, and a brief explanation of why you believe the treatment or other service should be covered. Include any letter or other records from your doctor that support your position.

**TIP**

**Hold on to the documents.** Keep copies of all letters and documents you send to or receive from the Medicare carrier and from your doctor. Also, keep notes of every conversation you have with anyone at the Medicare carrier, including the date of conversation, the name of the person with whom you spoke, and any action decided upon in the phone call—such as, you'll send them a letter, they will contact your doctor, or they will call you back within a week.

### Time to Seek Assistance

If you're considering a request for a review of your medical bills, or you've completed the written review and are considering a request for a hearing, it might be time for you to get some assistance from a local State Health Insurance Assistance Program (SHIP) office (see contact information at the end of this chapter). This is particularly true if the amount you're contesting would put a sizable hole in your budget.

If you're considering an appeal to an administrative law judge for a hearing, you might want to consider not only help from SHIP but also the assistance of an experienced Medicare lawyer. (See Chapter 9 for tips on finding legal help.) SHIP can also help refer you to such lawyers.

On the following pages are samples of request for redetermination letters to a Medicare carrier. There are no magic words you must include in such a letter, but these examples demonstrate the kind

of simple information required. A letter should include several key points, each of which should be described as briefly and clearly as possible. Keep in mind that the letter is meant merely to point out how and where the error was made and where proof of the error can be found, not to serve as proof itself. Only your medical records and the opinion of your doctors can actually prove anything.

First, you should briefly describe the treatment you received.

Second, you should point out the specific reasons why the intermediary's decision not to cover the treatment was incorrect—for example, you did not have merely a routine physical exam but an exam to determine the cause of a specific problem, or you did not have a dental exam but an examination by an oral surgeon of the nerves in your jaw.

Third, refer to the doctor's letter or other medical records that support your claim.

Notice that at the bottom left of each letter is the notation "cc:" and next to it the name of the doctor. This indicates to the Medicare carrier that you have sent a copy of this letter to your doctor—an action you should take so that the letter goes into your medical file. Sending a copy of the letter to the doctor will help prepare the doctor for a call from the Medicare carrier, and it might remind the doctor to do a better job of explaining the medical necessity of your care the next time you have treatment.

When the carrier reconsiders your claim, it will review your file, check the documents on which the original decision was made, and investigate any new information you've presented or the carrier has obtained by contacting your doctor. You don't have an opportunity at this stage to appear in person and explain things.

If a mistake was made because incorrect or incomplete information had originally been provided to the carrier or someone made a simple clerical error, the carrier is likely to reverse its decision and provide you with coverage. You'll then receive a written notice of its review determination and a new MSN.

**Request for Redetermination Letter: Sample #1**

Betty Patient  
222 Public Street  
Consumer, USA 12345  
Telephone: 123-123-1234

March 1, 20xx

Transprofit Insurance Company  
P.O. Box 123  
Moneyville, USA 12345

Re: Request for Review and Redetermination  
Medicare Part B  
Medicare Number xx-xxx-xxxxA  
MSN Notice dated January 2, 20xx

To Whom It Concerns:

This letter is a request for review and redetermination of a decision made by Transprofit denying coverage of medical treatment I received on November 1, 20xx. A copy of the MSN notice of January 2, 20xx, denying coverage, is enclosed.

I believe that Transprofit denied coverage of the mammogram I received on November 1, 20xx, from Dr. Alice Well because I had previously had a mammogram in January 20xx, which Medicare covered, and Medicare does not normally cover more than one mammogram per year. However, this second mammogram was medically necessary because I have a family history of breast cancer and because my previous mammogram in January showed some spots of potentially cancerous tissue.

Apparently the original Medicare claim from my doctor's office did not include this background information. However, I am enclosing a copy of a letter from Dr. Well and a copy of the medical records from my January mammogram to indicate why the second mammogram was medically necessary.

Based on this information, please reconsider the original decision denying Medicare coverage of the November 1, 20xx treatment.

Yours truly,

Betty Patient

cc: Dr. Alice Well

**Request for Redetermination Letter: Sample #2**

Andy Q. Everyone  
18B Main Street  
Anytown, USA 12345  
Telephone: 222-222-2222

June 1, 20xx

Ourworld Insurance Inc.  
P.O. Box 567  
Big Money, USA 12345

Re: Request for Review and Redetermination  
Medicare Part B  
Medicare Number xx-xxx-xxxxB  
MSN Notice dated March 1, 20xx

To Whom It Concerns:

This letter is a request for review and redetermination of a decision made by Ourworld Insurance denying coverage of medical treatment I received on January 10, 20xx. A copy of the MSN notice of March 1, 20xx, denying coverage, is enclosed.

I believe that Ourworld Insurance denied coverage of the eye exam I received on January 10, 20xx, from Dr. Barry Eyesore, because Dr. Eyesore's office mistakenly noted on the Medicare claim form that I underwent a routine eye examination refraction on that date, marking on the form Procedure Code 92015.

This was a mistake. In fact, I had a specific examination and treatment for blurred vision and eye pain that I had been suffering. Dr. Eyesore's records indicate that this was a medically necessary examination for a medical condition, for which he prescribed medication, rather than a routine eye examination. Enclosed is a copy of my medical record from Dr. Eyesore indicating the nature of the exam on that date.

Based on this additional information, please reconsider the original decision denying Medicare coverage of the January 10, 20xx examination and treatment of my eyes.

Yours truly,

Andy Q. Everyone

cc: Dr. Barry Eyesore

If there's a dispute about whether a certain treatment truly was medically necessary, the carrier might well reverse itself at this stage, but it does so less often than in cases of simple clerical errors or missing documentation from the doctor.

Once the Medicare carrier has received your request for redetermination and your supporting documents, someone within the company who was not involved in making the original decision will decide on your request. You'll receive a written response from the carrier, called a *Medicare Redetermination Notice*, about 60 days after you file your request and supporting papers. It will contain information about a further appeal if you're not satisfied with the decision.

### **Request for Reconsideration by Qualified Independent Contractor (QIC)**

If the carrier reviews your file and still refuses to cover your treatment, you can continue your appeal by requesting a reconsideration.

You have 180 days from the date you receive the written notice of determination to request a reconsideration by what's called a "Qualified Independent Contractor" (QIC). A QIC is a company separate from the Medicare carrier itself. The address to which to send your request is printed on the carrier's written notice of determination.

You can file your Request for Reconsideration on a form provided by Medicare online at [www.cms.gov/cmsforms/downloads/CMS20033.pdf](http://www.cms.gov/cmsforms/downloads/CMS20033.pdf). However, space on the form is limited, and you might prefer to write a letter request instead, an example of which is shown below (see "Letter Requesting Reconsideration by QIC"). The letter requesting a reconsideration is similar to the letter requesting redetermination, except that you should refer to the date of the carrier's written notice of determination following your request for redetermination in addition to the original MSN.

In separate paragraphs, make the following points:

- Describe the treatment you received and the dates on which you received it. This description should be brief, since the carrier will get its full explanation from your medical records.

- State the specific reasons why the intermediary's initial decision not to cover the treatment was incorrect.
- Refer, by name and date, to your doctor's letter and to the specific medical records that support your claim.

Attach to your request for a reconsideration copies of letters from your doctors and of your medical records, if you have them. Also, call your doctors' offices to request that they send copies of your records to the address you've been given on the notice.

You'll get a written decision, called a *Medicare Reconsideration Notice*, from the QIC within about 60 days after you file your request for reconsideration. If you're not satisfied with this decision, you have 60 days from the date you receive the notice to request a hearing before an administrative law judge.

### **Hearing Before Administrative Law Judge**

If your claim for doctor bill coverage is once again denied after the reconsideration by the QIC, you can request a hearing before an administrative law judge if the amount you're contesting is \$180 or more. If the amount in dispute is less than \$180, the hearing before the carrier's hearing officer is the end of the line.

You must request a hearing before an administrative law judge within 60 days of the date you receive written notice of the decision by the carrier's hearing officer. (See Chapter 9 for a full discussion of the administrative hearing process.) Medicare provides an online form to request this hearing at [www.hhs.gov/sites/default/files/omha-100.pdf](http://www.hhs.gov/sites/default/files/omha-100.pdf).

### **Medicare Appeals Council Review**

If you don't receive a favorable ruling from the administrative law judge, you can appeal the decision to the Medicare Appeals Council. In Medicare Part B claims, the written appeal must be filed within 60 days of the date of the administrative law judge's written decision.

## Letter Requesting Reconsideration by QIC

Rosa Albarte  
3456 Broadway  
Anytown, USA 45678  
Telephone: 333-333-3333

June 1, 20xx

Your Money Insurance Co.  
P.O. Box 1234  
Greentown, USA 12345

Re: Request for Reconsideration by QIC, Medicare Part B  
Medicare Number xx-xxx-xxxxC  
Notice of Determination After Review Dated May 1, 20xx

To Whom It Concerns:

This letter is a request for a reconsideration by QIC following a determination made on May 1, 20xx. That determination upheld a decision made by Your Money denying coverage of a medical service I received on February 1, 20xx, and laboratory work performed on February 5, 20xx. A copy of the MSN notice of March 15, 20xx, denying coverage, is enclosed. Also enclosed is a copy of the written determination after review, dated May 1, 20xx.

I believe that Your Money denied coverage of the physical examination I received from Dr. Walter Thorough and of laboratory work ordered by Dr. Thorough because Dr. Thorough failed to give certain information to the carrier. The physical and the laboratory tests were not routine examinations but were a response to severe muscle fasciculation and cramping that I had been suffering over the previous several weeks. Dr. Thorough's records indicate that the examination and laboratory tests were medically necessary to diagnose and treat my condition.

I have enclosed a copy of my medical records from Dr. Thorough, as well as a letter from Dr. Thorough, both of which make clear that the examination and laboratory tests were medically necessary and should be covered by Medicare.

Yours truly,

Rosa Albarte

cc: Dr. Walter Thorough

### **Federal Court Case**

It's highly unlikely that a Medicare Part B decision will involve enough money that it would be economically sensible for you—and a lawyer representing you—to file a lawsuit in federal court to challenge a negative decision by the Medicare Appeals Council. However, if your claim is for \$1,850 or more, you do have such a right. You must file the lawsuit within 60 days of the written decision by the Appeals Council.

## **Medicare Part D: Enrollment, Exceptions, and Appeals**

How you enroll in a Part D plan will depend on several factors, including whether you:

- receive Medicaid benefits
- live in a long-term care facility
- have had employer-sponsored health coverage that included drug coverage
- qualify for a Part D low-income subsidy, or
- are in none of those categories.

Note that, if you believe you might be eligible for the Part D low-income subsidy, you must file two separate applications—one for Part D coverage, and one for the low-income subsidy (see below).

Once you're enrolled in a Part D plan, your plan's decisions about coverage and costs aren't necessarily final. The plan might exclude one of your drugs from coverage, might require you to jump through hoops to get coverage for a particular drug, or might charge you a higher copayment for your drug than for a generic equivalent. In any of these situations, you have the right to request an exception. And you have the right to appeal the plan's decision.

## Enrollment

How and when you enroll in a Part D plan depends on whether you're a Medicaid beneficiary or have been accepted for a Part D low-income subsidy. Regardless of the plan you enroll in or how you're enrolled, your coverage won't begin until the first of the month following the completion of your enrollment.

### Applying for Extra Help Paying for Medicare Part D

Medicare's Extra Help program offers assistance (also called a "low-income subsidy") to help pay for the cost of prescription drugs above and beyond what a standard Part D plan pays. (See Chapter 12.) You apply for Extra Help by submitting an application to the Social Security Administration (SSA) rather than to Medicare or to a Part D plan. Contact the SSA to get an Extra Help application and instructions, or to set up an appointment to get help applying. You can reach the SSA toll free at 800-772-1213. Or you can visit the special Social Security webpage called "Extra Help with Medicare Prescription Drug Plan Costs," at [www.ssa.gov/medicare/part-d-extra-help](http://www.ssa.gov/medicare/part-d-extra-help), to file an application online. Or, you can also apply for Extra Help at a local county Social Services office or another local government office in your state that processes Medicaid applications.

Free one-on-one help is available at your local SHIP or HICAP office. These programs have trained counselors on staff to help you with your application. To find the office nearest you, contact the SHIP or HICAP program in your state (for details, see the end of this chapter).

If your application for Extra Help is approved, the benefits will be retroactive to the date you first applied. Once approved, your participation in Extra Help will remain in effect for one year. Within the first year of your Extra Help, the Social Security Administration will review your finances to see if you remain eligible. If so, your participation in Extra Help will be automatically renewed. After the first year, SSA will periodically review your Extra Help eligibility.

## Enrolling in a Part D Plan

Most people will follow the standard enrollment procedures described below. If you're a Medicaid beneficiary or are qualified for a Part D low-income subsidy, your enrollment procedures will differ slightly (see below).

**Standard enrollment.** If you're not a Medicaid beneficiary and you haven't qualified for a Part D low-income subsidy, you enroll in Part D by signing up directly with the plan you want to join. Private insurance companies administer each Part D plan using their own enrollment forms and procedures. Some plans might permit you to enroll online, while others might require written forms. You must contact the plan directly to find out the details of their coverage and costs, and to enroll in the plan.

Your Part D plan will cover the cost of your medications only after you've completed enrollment in the plan and your Medicare Part A or B coverage has begun. This means that any drugs you buy while your application is pending won't be covered. It's therefore a good idea to decide on a plan and submit an application in the months before you become eligible for Medicare, so that coverage will begin as soon as you're eligible.

If you don't enroll in a Part D plan when you're first eligible for it, your premiums will be higher when you do finally enroll. Medicare allows the plans to charge an additional 1% for each month you delay enrolling (unless you've been enrolled in a Medicare Advantage or an employer-sponsored plan that covered prescription drugs). So, if you intend to enroll in a Part D plan as soon as you're eligible for Medicare, you should do the paperwork ahead of time. This will ensure not only that your coverage begins immediately, but also that you won't have to pay a higher premium because of a simple paperwork delay.

**Medicaid beneficiary.** If you're a Medicare beneficiary who is also eligible for Medicaid assistance (Medi-Cal in California), you can enroll in any Part D plan. But in order to get the full benefit of your low-income subsidy, you must enroll in a plan whose premium is at

or below your state's average. If you enroll in a plan with a premium higher than the state average, you'll be responsible for the extra premium cost out of your own pocket.

If you don't enroll in a Part D plan on your own, Medicaid will automatically enroll you in a plan with a premium below the state's average. And if that plan doesn't fit your needs for drug coverage, you can switch plans at any time (see "Switching Part D Plans," below).

**Low-income subsidized enrollment.** If you're eligible for one of the Part D low-income subsidies but aren't a Medicaid beneficiary, you can enroll in a Part D plan at any time, directly with the plan of your choice. If at any later time, your plan no longer offers you the best coverage, you can switch to another plan (see "Switching Part D Plans," below).

## Exceptions

Part D plans use a variety of methods to restrict or control the use of medications by their enrollees. (See "Part D: Prescription Drug Coverage" in Chapter 12.) These restrictions include excluding drugs from coverage, setting higher costs for certain drugs within the same class, substituting one drug for another, imposing a drug supply limit, and requiring you to try a series of other drugs before the plan will cover the one you want.

Medicare gives plans very broad discretion to create and change these coverage restrictions. This means that you might begin coverage with a plan whose restrictions don't seriously affect you, only to find the plan changes its rules later on. You might then find yourself with a restriction on one of your drugs that is financially burdensome, physically discomfiting, or even medically inadvisable. For example, your plan might drop one of your drugs from its formulary and replace it with a drug that the plan considers "equivalent," but this drug might not provide you with the same quality of relief or might have more side effects. Or, your plan might increase the copayment for your drug, costing you more money per prescription.

Eventually, you might be able to switch to a plan with fewer restrictions on your drugs. But until you're able to do so, or if there's no other plan available at the same cost with fewer restrictions, you have a chance to get your plan to lift its restriction in your individual case. You do this by requesting an "exception" from your plan's rules, based on "medical necessity." You make this request to the plan itself, not to Medicare. Each plan has its own rules for handling exception requests, and Medicare requires only that a plan have a formal procedure and make a decision, called a "Coverage Determination," within 72 hours after you file an exception request.

**Medical necessity.** Your doctor's support is the key to success with any exception request. To convince your plan that you need easier access to your drug, you must show that you have a medical necessity to take that particular drug rather than another drug that the plan considers equivalent. Medical necessity does not necessarily mean that you'll have very serious or dangerous medical consequences if you take the equivalent drug. But it does mean that there will be some change in your physical condition—for example, less effective treatment or more severe side effects—if you take the so-called equivalent drug instead of the one you usually take.

Your chance of convincing the plan of your medical need for a particular drug almost certainly requires an explanation from your doctor. The plan might request a letter from your doctor, or a copy of your medical records demonstrating your complaints to the doctor about the substituted medicine, or simply a phone conversation with your doctor. Whatever form the contact will take, it's important that you prepare your doctor to explain your problem. Meet with or talk to your doctor by phone about the problem and about your exception request. This will allow you to make certain that the doctor understands the full extent of your difficulty with the substituted drug and will give the doctor advance warning that the plan will be requesting information.

## Help With Exceptions and Appeals

As discussed in these sections about exceptions and appeals, it's crucial to have your doctor's help in explaining the medical necessity of a particular drug. But your doctor can only do so much—your doctor won't help you fill out request and appeal forms, or write your letters to the insurance company explaining your situation. To get help with the exception or appeal process itself, you might want to contact the counselors at your local SHIP or HICAP office, whose expert advice is free. You can find the local office of these counseling organizations by calling the central office for your state; for contact information, see the end of this chapter.

You can also get free expert counseling from the Medicare Rights Center; contact them through [www.medicarerights.org](http://www.medicarerights.org).

If your appeal reaches the later stages, and particularly if you intend to take it to federal court, you'll likely need the assistance of a lawyer experienced in Medicare appeals. (For a discussion of when a lawyer might be needed and how to find one, see Chapter 9.)

If the plan denies your request for an exception, you can file an appeal. Appeals are discussed below. And if your appeal is denied, or if you simply don't want to bother going through the appeal process, you can switch to another plan that offers better coverage of your drug (if you can find one) as soon as you're permitted to switch by Part D enrollment rules (see "Switching Part D Plans," below).

## Appeals

Part D plans regularly make decisions and change rules about their drug coverage. But these decisions and rules aren't necessarily the final word about coverage. You can appeal a plan's rule or decision if you find that it forces you to give up, or pay a higher copay for, a drug you and your doctor believe is medically necessary. Appeals initially go to the plan itself. At later stages, an appeal can be considered by independent reviewers outside the plan.

If at any stage of the process an enrollee wins a change in the plan's decision, its effect will be retroactive back to the time the enrollee first challenged the plan's coverage decision. This retroactivity works well when the issue is the amount of money an enrollee has to pay out of pocket. Retroactivity is only cold comfort, however, if the enrollee has been forced to make do with a substitute drug during the time spent on the appeal.

In almost every case, success with an appeal depends on your doctor's presenting a convincing argument that the drug in question is "medically necessary" to you (see "Exceptions," above).

### Types of Decisions That Can Be Appealed

Part D enrollees can appeal several types of plan decisions, including a plan's:

- denial of an exception request
- decision not to cover a drug—or to cover it only at a higher copay—because it's not on the plan's formulary or because of some other access restriction (such as step therapy or therapeutic substitution)
- decision not to cover a drug for a particular enrollee because it's not "medically necessary"
- decision not to cover a drug because it's excluded from the Medicare Part D program, and
- decision not to cover a drug—or to cover it at a higher copay—because it was provided by a pharmacy that didn't have a contract with the plan (called an "out-of-network pharmacy").

### Appeal Procedure

Each plan determines the details of its appeal procedure. But all plans must follow certain basic rules.

**Coverage determination.** When a plan makes a decision about coverage or an exception request, it issues a written letter called a "coverage determination." The plan must issue the coverage determination within 72 hours of the enrollee's filing of a prescription, denial of a prescription, or request for an exception.

**Redetermination.** Once an enrollee receives an unfavorable written coverage determination from the plan, the enrollee has 60 days to request what is called a “redetermination.” This second-round decision will also be made by the plan itself, though it might be made by someone within the plan bureaucracy other than the person who made the original coverage determination. From the date the plan receives a written request for redetermination, it has seven days within which to issue its redetermination decision.

**Reconsideration.** If an enrollee’s request for redetermination still does not result in a favorable decision, the enrollee can file a written request for reconsideration by an Independent Review Entity (IRE). This is where an independent arbitrator reviews and considers both the enrollee’s request and the plan’s reasons for denying the request. An enrollee must file a request for reconsideration by an IRE within 60 days following receipt of the redetermination decision. Your plan will provide contact information for the IRE that will hear your request. Once the IRE receives your written request for reconsideration, it has seven days to make a decision.

**Administrative hearing.** If the IRE turns down the enrollee’s request, the enrollee has 60 days within which to file a request for a hearing before an administrative law judge (ALJ). To have an administrative hearing with an ALJ, the amount in controversy must be at least \$180. But unless the drug coverage question for an enrollee involves only a one-time prescription, the ongoing cost of the drug to the enrollee will almost always exceed \$180. The ALJ must issue a decision within 90 days from the date of receiving the request.

**Medicare Appeals Council.** If the enrollee gets a negative decision from the ALJ, the enrollee has 60 days to file an appeal to the next highest level, called the “Medicare Appeals Council” (MAC). The MAC has 90 days to issue its decision.

**Federal court.** If the MAC denies an enrollee’s appeal, and the amount in controversy concerning the drug is at least \$1,850, the enrollee can file a claim in federal court. The enrollee has 60 days from the MAC’s decision to file the claim in federal court. If your coverage issue involves continuing expensive medication and you believe that appealing your decision to federal court might be worth

the time and expense, you almost certainly will want to consult with an attorney who specializes in Medicare appeals. For more information on hiring an attorney, see Chapter 9.

## Switching Part D Plans

The fact that you're in a particular Part D prescription drug plan doesn't mean that you're forever stuck with that plan or with the insurance company that issued the plan. There are several good reasons why you might want to switch from one plan to another. You might want to switch plans in the following cases:

- You begin taking a new medication, and your old plan does not cover that drug or covers it at a higher copayment than offered by another plan.
- Your current plan drops one of your drugs from its list of covered medications.
- Your current plan raises its premiums or changes its terms of coverage, making a different plan a better fit for you.
- A new plan is offered—or you learn about another plan—that would give you better coverage or lower costs than your current plan.

Whatever your reason, you can switch plans—to a different plan offered by the same insurance company or to a plan with a different company—at least once every year. And some people can switch as often as every month.

## When You Can Switch Plans

**Monthly switch.** People in two different categories can switch from one Part D plan to another as often as every month, with the new plan's coverage beginning on the first of the month following enrollment. "Dual eligibles"—people enrolled in both Medicare and Medicaid (Medi-Cal in California)—can switch plans as often as monthly. And a person who lives in a long-term care facility (if the facility is certified by Medicare or Medicaid) can also switch plans monthly.

**Once-yearly switch.** Low-income subsidy beneficiaries and standard enrollees (people who don't receive Medicaid coverage and who don't reside in a long-term care facility) can switch plans once a year, but the switch must happen during an open enrollment period (from October 15 to December 7 each year). **Note:** If you are currently enrolled in a Medicare Advantage plan that covers your prescription drugs (see Chapter 15) but you want to drop that plan, switch to original Medicare, and join a stand-alone Medicare Part D drug plan, you can do so between January 1 and March 31, with coverage to begin on the first of the month following enrollment.

## Plans You Can Switch To

If you want to switch from one Part D drug plan to another, you can switch to any Medicare-approved plan currently offered in your state by any company. If you're switching during the open enrollment period from October 15 to December 7 of each year, you can enroll in any plan being offered for the following calendar year, to begin coverage on January 1.

**Dual eligibles.** If you're a dual-eligible beneficiary (Medicare plus Medicaid), the full cost of your Part D premium is paid by Medicare, as long as your plan's premium is less than your state's average for all Part D plans. If you want to continue receiving that full premium payment, you can only switch to a new plan with a premium lower than your state's average premium. If you switch to a plan with a premium above your state average, you must pay the difference between the new premium and the state average.

## How to Switch From One Plan to Another

Switching from one plan to another is not difficult, but it does involve several steps.

**Step 1: Find a plan in your area.** Find out what plans are offered in your geographic area and select a plan that's right for you, using the selection methods explained in "Part D: Prescription Drug Coverage" in Chapter 12.

**Step 2: Enroll in the new plan.** Once you've found a plan you like, contact the insurance company directly to make sure you're eligible for the plan. If you're eligible, follow the insurance company's directions to enroll in the plan.

**Step 3: Cancel your old plan.** Once you receive written confirmation from your new insurance company that you're enrolled in your new plan, it's time to cancel your old plan. Notify your old plan—in writing—that you're canceling your policy. Do this even if the new insurance company has told you that it will notify the old company. Make sure that your cancellation becomes effective only after your new plan is in effect.



#### CAUTION

**Don't cancel your old plan too soon.** You might be signing up for a new plan to begin the following month or changing plans during the yearly open enrollment period to begin coverage on January 1. In either case, don't cancel enrollment in your current plan until you have written notification of enrollment in your new plan. And make sure you check the date the new coverage begins, so that you don't cancel your old plan before the new one goes into effect. As with any bureaucratic institution, delays and mistakes do occur. You want to avoid having any gaps in your insurance coverage.

**Step 4: Don't double-pay.** Make sure your old and new insurance policies don't overlap. If you pay for your Part D plan by sending the insurance company a check, this is easy—you simply don't send in any payment to the old company once your new coverage begins. But many people have their Part D premium amount automatically paid (for example, withheld from their Social Security benefit or transferred directly from their bank). If you pay your old Part D plan automatically, you must stop the automatic payment as of whatever date you begin your new plan.

**Step 5: Notify your pharmacist.** After you receive confirmation of enrollment in the new plan, notify the pharmacists you use about your new plan. This will make things go more smoothly when you fill your prescriptions.

## State Health Insurance Assistance Programs (SHIPs)

Every state has a nonprofit organization for consumer counseling about Medicare, medigap, Medicare Advantage plans, and related matters. The organization operates under the general name State Health Insurance Assistance Program (SHIP) or Health Insurance Counseling and Advocacy Program (HICAP), though in some states it has a similar but slightly different name. These central offices can direct you to a local counseling office near you. You can find the phone number and website for your state's SHIP/HICAP office on the SHIP organization website at [www.shiphelp.org](http://www.shiphelp.org). You can also find the website for your state's SHIP/HICAP office by going to Medicare's website at [www.medicare.gov/talk-to-someone](http://www.medicare.gov/talk-to-someone). ●

## Medigap Insurance

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Even for people who have coverage from both Medicare Part A and Part B, a serious illness or injury can cause financial havoc because of the bills Medicare leaves unpaid. About a third of all Medicare recipients age 65 and older respond to this risk by buying a private supplemental health insurance policy known as “medigap” insurance.

The term medigap comes from the fact that these insurance policies are designed to cover the gaps in Medicare payments. Unfortunately, even medigap coverage leaves some medical costs unpaid.

As an alternative, a Medicare Advantage plan typically provides broader coverage at slightly lower cost than the combination of traditional Medicare Part A and B plus a medigap policy (see Chapter 15). However, Medicare Advantage plans restrict the doctors and other providers available to you. And in recent years, some Medicare Advantage plans have been raising enrollee costs, reducing coverage, and dropping coverage entirely in many areas, adding an element of risk to the Medicare Advantage option.

Before choosing one type of coverage or another, compare benefits and approaches and measure your preferences against the price you would have to pay for each.

This chapter gives you guidance about the gaps in Medicare that need to be filled, and the types of medigap insurance policies that exist to partially fill them. Chapter 15 covers the various types of Medicare Advantage plans available as alternatives to medigap supplements. Before selecting either a medigap policy or a Medicare Advantage plan, review the advantages and disadvantages discussed in Chapter 15, and use the charts at the end of that chapter to compare the costs of and coverage provided by individual policies and plans.

As with other decisions about Medicare and related insurance coverage, you can get excellent, free counseling regarding medigap insurance from your local office of the State Health Insurance Assistance Program (SHIP), also known in some states as the “Health Insurance Counseling and Advocacy Program” (HICAP).

## Insurance From Continuing or Former Employment

Many people who become eligible for Medicare at age 65 continue to work and have health insurance through their employers. Many others have health insurance through a spouse's employer.

And many other people keep their job-related health insurance after they retire, as part of their retirement benefits packages, although they usually have to pay much more than current employees pay.

Most employment-based health plans require you to sign up for Medicare Part A when you turn 65, but cover your hospitalization in conjunction with Medicare. Most plans based on current employment don't, however, require you to sign up (and pay for) Medicare Part B, but many retiree plans do require you to enroll in Medicare Part B. The health benefits or human resources office at your work or union can explain the details of coordinating coverage between the employer's plan and Medicare.

The fact that you're eligible for a work-related health plan, however, doesn't mean that you have to continue with it. Work-related health insurance has become more expensive and less comprehensive for employees—particularly retired employees. You might find that Medicare plus a medigap policy, or Medicare through a Medicare Advantage managed care plan, provides you with as good or better coverage at a better price than your employer-based medical insurance does.

Even if you decide not to participate in the regular health plan offered in your workplace, your employer's insurance company might offer you a different policy with limited coverage for some services Medicare doesn't cover at all, such as prescription drugs, dental care, or hearing aids. Compare such a policy with the medigap policies and managed care plans discussed in this chapter to see which one offers you the best coverage for your money.

## Gaps in Medicare

When considering the kinds of supplemental coverage available, keep in mind the specific gaps in Medicare payments that you're trying to fill. Medicare coverage is explained in detail in Chapter 12, but some of the most significant things it doesn't cover, or covers but only partially pays for, are listed below.

### Gaps in Part A: Hospital Insurance

Medicare Part A covers almost all the cost of most hospital stays. Its most common gap is the deductible, which everyone must pay before Medicare pays any part of a hospital bill. A much less frequent but much more frightening gap is the daily coinsurance amount for hospital stays of longer than 60 days. All of the gaps are listed below.

#### Hospital Bills

Medicare Part A hospital insurance doesn't pay the following costs during a hospital stay:

- a deductible for each benefit period—\$1,632 in 2024
- a daily coinsurance amount (\$408 in 2024) for each day you're hospitalized more than 60 days and up to 90 days for any one benefit period
- a daily coinsurance amount (\$816 in 2024) for each day you're hospitalized more than 90 days and up to 150 days for any one benefit period
- anything past a hospitalization of 150 days
- first three pints of blood, unless replaced, or
- anything for medical costs during foreign travel

#### Skilled Nursing Facility Bills

Medicare Part A doesn't pay the following costs during a stay in a skilled nursing facility:

- a coinsurance amount of \$204 per day for each day you're in the facility more than 20 days and up to 100 days for any one benefit period, and
- anything for a stay of more than 100 days.

## Home Health Care

Medicare Part A doesn't pay the following costs for home health care:

- 20% of the approved cost of durable medical equipment or approved nonskilled care, and
- anything for nonmedical personal care services.

## Gaps in Part B: Medical Insurance

Medicare Part B leaves some very large gaps in the amounts it pays doctors and other outpatient providers, depending on whether the doctors or others accept assignment. Everyone with Part B faces the 20% of the Medicare-approved amount that Medicare doesn't pay. And if your doctor or other provider doesn't accept assignment, you're also responsible for up to 15% more than the amount Medicare approves. (See "How Much Medicare Part B Pays" in Chapter 12 for more on Part B payments.)

Medicare Part B doesn't pay the following costs for doctors, clinics, laboratories, therapies, medical supplies, or equipment:

- a yearly deductible (\$240 in 2024)
- 20% of the Medicare-approved amount
- 15% above the Medicare-approved amount if the provider does not accept assignment, or
- 20% of the total charges for some outpatient hospital services.

## Standard Medigap Benefit Plans

The federal government regulates Medicare supplement (medigap) insurance policies—and insurance companies can't offer medigap policies that duplicate Medicare's own coverage.

You can choose among the nine currently available standard medigap plans. The standard policies are specifically tailored to Medicare coverage, each one filling a certain number of Medicare's gaps.

### Important Changing Landscape for Medigap Policies

As of 2010, new medigap policies in original plans E, H, I, and J are no longer sold, but people with existing policies under those plans can continue them. People who continue with these policies should be aware, though, that their premiums are likely to rise more steeply over the coming years because there will be increasingly fewer people enrolled in these plans.

Also in 2010, policies began to be issued under two new plans, M and N, and a hospice copayment benefit was added to new policies under all plans.

In addition, some of the plans are subject to small changes from year to year. For more information on these changes and the coverage provided under each plan type, see “Descriptions of the Standard Medigap Plans,” below.



#### CAUTION

**Delay may limit your choices.** Insurance companies would be happiest if they could sell coverage only to healthy people. When you’re shopping for a medigap policy, you might find it hard to buy a policy if you’re already ill and didn’t buy a policy when you first became eligible. (The Affordable Care Act eliminated preexisting condition limitations for regular private insurance, but not for medigap.)

The federal government has, however, established some protections for people buying medigap policies, depending on when and under what circumstances you apply. You’ll receive the most coverage options if you apply within the first six months after you begin your Medicare Part B coverage. In a few other circumstances, you might also have options to purchase some, though not all, medigap policies without fear of being turned down because of your preexisting condition. If you wait too long to apply for a policy, however, the insurance companies are allowed to review your medical records and reject you if they consider you a bad “profit risk.” (To understand the rules regarding your right to purchase a medigap policy, see “Terms and Conditions of Medigap Policies,” below.)

### Medigap Does Not Cover Long-Term Care

Many older people fear the possibility of living out the final years of life in a nursing home. The prospect of nursing home life itself provokes distress for many, as does the financial ruin that can be brought about by the cost of long-term care. Unfortunately, neither Medicare nor medigap supplemental insurance nor managed care health plans protect against this potentially enormous cost. Medicare covers only a limited period of skilled nursing facility care and covers nothing of long-term custodial, nonmedical care in a nursing home. Medigap policies and Medicare Advantage plans similarly fail to cover long-term nursing home care.

Long-term care at home is increasingly an option for people who in years past would have been forced to enter a nursing home. More services are available at home, and more agencies and providers offer home care. However, while Medicare and medigap policies cover some short-term home health care, neither covers long-term nonmedical home care.

There's a type of private insurance that can cover some of the cost of long-term nursing home or at-home care. Referred to as "long-term care insurance," it's available in a variety of benefit packages but comes with numerous restrictions and exclusions. The cost of these policies varies greatly, depending on the extent of coverage and the age of the person purchasing the plan. Medicaid also covers long-term care costs.

For a complete discussion of these policies, the kinds of care they cover, and Medicaid coverage for nursing homes, see *Long-Term Care: How to Plan & Pay for It*, by Joseph L. Matthews (Nolo). (Visit Nolo's website at [www.nolo.com](http://www.nolo.com) for ordering information.)

Not every insurance company offers every medigap plan. And only the benefits included in each standard category of plans are standardized. Other important aspects—premium increases and preexisting illness exclusions, for example—vary from policy to policy and require careful comparison shopping.

When you consider medigap policies, your task is to see how many of the gaps in Medicare payments you can fill within the constraints of your budget. The broader the coverage in a medigap policy, the higher the cost.

And the cost of a standard policy can vary widely from company to company. So you must determine not only which standardized benefit plan best suits your needs, but which company offers which plan at the best price. Then examine the other elements of each policy, such as premium increases and preexisting illness exclusions, before making your choice.

## **Basic Benefits Included in All Medigap Plans**

The benefits included in the standard medigap plans and a chart comparing their coverage follow.

All standard medigap policies begin by offering the same basic benefits, including coverage of:

- hospital coinsurance amounts under Medicare Part A (but not necessarily the deductible)
- 365 days of hospital coverage after Medicare coverage ends
- some or all of the cost of covered blood transfusions
- some or all of the Medicare Part B coinsurance amount (the 20% of Medicare-approved amounts that Medicare Part B doesn't pay), and
- some or all of the out-of-pocket cost for hospice care (for all policies issued on or after June 1, 2010).

Notice that these basic benefits are meant to close gaps in Medicare coverage, not to provide separate medical insurance. If a hospitalization or medical treatment isn't covered at all by Medicare, a medigap policy won't cover any of it, either. The exception to this is those medigap policies that cover foreign travel.

## **Inpatient Hospital Costs**

For every benefit period, every medigap plan pays all your Medicare Part A coinsurance amounts through your first 90 days as an inpatient, plus your coinsurance amount for any reserve days. After your

reserve days are used up, every plan pays for the entire Medicare-approved amount of hospital charges for an additional 365 days. All plans pay some amount for the first three pints of blood you receive (Plans A through J pay the full amount; K pays 50%; L pays 75%). All plans except Plan A pay the yearly Part A hospital inpatient deductible (but Plans K and M pay only 50%, Plan L pays only 75%).

### **Medigap: It Pays to Shop Around**

The federal government decides what benefits must be included in standard medigap policies. But it doesn't control prices, which vary widely. Prices vary for different ages and change from state to state, reflecting regional health care costs and level of competition for customers.

But the price for the same policy can vary tremendously even within the same state. Even the most basic Plan A policy can vary in cost by hundreds or even thousands of dollars per year in some states. And the more extensive the plan, the greater the cost disparity among policies from different insurance companies.

Most of the time, there's no basis for the price disparities other than "name" recognition. Don't fall for the first policy that comes along. Even when you've decided what standard policy you want, comparison shop for the best price from several different insurance companies.

### **Medical Expenses**

Every plan pays some of the 20% coinsurance amount that Medicare Part B doesn't pay (except for preventive care copayments, which are covered separately). Plans A through J and Plan M pay the full Part B coinsurance amounts; Plan K pays 50% and Plan L pays 75% of the Plan B coinsurance amounts (up to those plans' yearly caps, after which they pay 100%). And Plan N pays the full Part B coinsurance amount except for a \$20 copayment for office visits and a \$50 copayment for emergency room visits (which the patient must pay out of pocket).

Only Plans C, F, and J pay the yearly Medicare Part B deductible. And only Plans F, G, I, and J pay the 15% “excess charges” above the Medicare-approved amount that a doctor is allowed to charge a patient if the doctor doesn’t accept assignment.



#### CAUTION

**Make sure there are limits on premium raises.** It’s always important to check the terms under which a medigap insurance company can raise the amount of your premium. And it’s particularly important when the initial premium already stretches your budget. (See “Terms and Conditions of Medigap Policies,” below.)

## Descriptions of the Standard Medigap Plans

Medigap policies are standardized. That means every policy in each lettered plan category must offer the same minimum coverage regardless of which insurance company offers it (though extra coverage can be added, and premiums vary).

As of June 1, 2010, no new policies have been sold in Plans E, H, I, and J. However, people already enrolled in one of those plans’ policies as of that date are allowed to continue with it.

### Special Rules for Massachusetts, Minnesota, and Wisconsin

If you live in Massachusetts, Minnesota, or Wisconsin, the standard medigap policies are somewhat different from the standard policies offered elsewhere. Each of these three states has a basic plan, plus options. You pay extra for any of the options you choose. The basic benefits in Massachusetts and Wisconsin include some things that the nine standard medigap policies don’t. For information on the details of medigap policies in any of these states, call your state’s department of insurance. You’ll find its phone number and contact information for its website at the end of this chapter.

## Standard Medigap Insurance Policies

All plans include these basic benefits:

- Hospitalization: Medicare Part A coinsurance plus 365 days of coverage after Medicare ends.
- Medical costs for outpatients: Some or all of the Medicare Part B coinsurance (the 20% of Medicare approved costs that Medicare Part B doesn't pay).
- Blood transfusions: All plans cover some or all of the first three pints of blood each year.
- Hospice: All plans issued June 1, 2010 or later cover hospice copayments (Plan K 50%, Plan L 75%); for policies issued before June 1, 2010, only Plans K and L provide this coverage.

A bullet below means that the plan covers the item 100%.

	Plan													
	A	B	C <sup>2</sup>	D	E <sup>1</sup>	F <sup>2,7</sup>	G <sup>7</sup>	H <sup>1</sup>	I <sup>1</sup>	J <sup>1</sup>	K	L	M <sup>5</sup>	N <sup>5</sup>
<b>Medicare Part A Deductible</b>		•	•	•	•	•	•	•	•	•	50%	75%	50%	•
<b>Medicare Part B Deductible</b>			•			•				•				
<b>Part B Coinsurance</b>	•	•	•	•	•	•	•	•	•	•	50%	75%	•	\$20
<b>Skilled Nursing Coinsurance</b>			•	•	•	•	•	•	•	•	50%	75%	•	•
<b>At-Home Recovery</b> <sup>3</sup>				•			•		•	•				
<b>Blood Transfusion Coinsurance (first three pints of blood)</b>	•	•	•	•	•	•	•	•	•	•	50% of first 3 pints	75% of first 3 pints	•	•
<b>Foreign Travel</b>			•	•	•	•	•	•	•	•			•	•
<b>Preventive Care Coinsurance</b> <sup>3</sup>	•	•	•	•	•	•	•	•	•	•	•	•	•	•
<b>Medicare Part B Excess Charges</b>						•	• <sup>6</sup>		•	•				
<b>Prescription Medicine</b>	No plan offers prescription drug coverage—you'll need to sign up for Medicare Part D to cover your medications (see "Part D: Prescription Drug Coverage" in Chapter 12).													
<b>Cap on out-of-pocket expenses</b> <sup>4</sup>											\$7,060 per year (in 2024)	\$3,530 per year (in 2024)		

<sup>1</sup> As of June 1, 2010, no new Plan E, H, I, or J policies will be sold. Existing policies can be continued.

<sup>2</sup> As of January 1, 2020, no new policies under Plan C or F will be sold to people newly enrolled in Medicare. Anyone with an existing Plan C or Plan F policy as of January 1, 2020 can keep it, and anyone who was eligible for Medicare before 2020 can buy Plan C or F.

<sup>3</sup> Coverage for preventive care (that isn't covered by Medicare Part B) continues for Plans E and J issued before June 1, 2010.

<sup>4</sup> After the cap on out-of-pocket expenses is reached, the policy will pay 100% of all covered Part A and Part B costs.

<sup>5</sup> Available as of June 1, 2010.

<sup>6</sup> 80% for policies issued before June 1, 2010; 100% for all Plan G policies issued June 1, 2010 or later.

<sup>7</sup> In some states, there are also high-deductible Plan F and Plan G policies in which the insured pays the first \$2,800 (2024) out of pocket before the policy pays anything.

The standard plans are summarized in the “Standard Medigap Insurance Policies” chart, above, and are discussed more fully in the subsections that follow, with separate sections on rules for policies issued before and after June 1, 2010.

## **Medigap Plan A**

### **Policies Issued Before June 1, 2010**

Plan A medigap policies include only the basic benefits discussed earlier. (See “Basic Benefits Included in All Medigap Plans,” above.) Because of their limited benefits, Plan A policies are the least expensive.

Plan A policies are most useful if the doctors who regularly treat you accept assignment of Medicare-approved amounts, and you can afford to pay for the uncovered costs of doctors who don’t accept assignment but by whom you might have to be treated. (See “How Much Medicare Part B Pays” in Chapter 12 regarding assignment practices.) Also, you must be able to afford the Part A hospital insurance deductible, bearing in mind that because there is a separate deductible for each separate hospital stay, you might have to pay it more than once in a year. (See “How Much Medicare Part A Pays” in Chapter 12 regarding Part A coverage.)

If these potential expenses plus the cost of a Plan A policy would put a severe strain on your finances, consider the alternative of a Medicare Advantage plan, which may provide broader coverage for less money. (See Chapter 15 for a full discussion of the Medicare Advantage option.)

### **Policies Issued June 1, 2010 or Later**

Plan A policies issued June 1, 2010 or later also include coverage for hospice copayments.

## **Medigap Plan B**

### **Policies Issued Pre-June 1, 2010**

In addition to the basic benefits, a Plan B policy also pays your Medicare Part A deductible.

If your doctors all accept assignment but your budget would be severely strained by paying more than one hospital deductible in a year, Plan B might be marginally better for you than Plan A. However, if you have to pay more than a few dollars a month more for Plan B than for Plan A, it might be a bad bargain.

Measure the yearly cost of a Plan B against the cost of a Plan A policy. If you're reasonably healthy—meaning you don't expect frequent hospitalizations—and the difference in premiums is more than 25% of the Part A Medicare deductible (\$1,632 in 2024), it's probably not worth the extra premium, and you should stick to a Plan A policy.

#### **Policies Issued June 1, 2010 or Later**

Plan B policies issued June 1, 2010 or later also include coverage for hospice copayments.

### **Medigap Plan C**



#### **CAUTION**

**Plan C has limited enrollment.** No new Plan C policies are sold to people newly enrolled in Medicare after January 1, 2020. If you already had a Plan C policy as of that date, you can continue it. And if you were eligible for (but did not enroll in) Medicare before 2020, you can still buy Plan C.

#### **Policies Issued Pre-June 1, 2010**

Plan C adds three benefits beyond the basic and other benefits offered in Plan B. First, it pays your yearly Medicare Part B deductible of \$240. (But because this policy will probably cost you more than \$240 per year over Plan A or B, that alone isn't a good reason to purchase it.)

Second, Plan C policies cover the Medicare coinsurance amount for skilled nursing care. Remember that, under Medicare skilled nursing coverage, you're personally responsible for a coinsurance amount (\$204 per day in 2024) for stays of 21 to 100 days in a skilled nursing facility. This can add up to a considerable amount of money, but it applies only if you're covered by Medicare for short-term skilled

nursing care in a nursing facility following a hospital stay. (See “Part A: Hospital Insurance” in Chapter 12 regarding Medicare skilled nursing coverage.) If you have a medical condition that puts you in and out of the hospital, this can be a valuable addition to your policy. But the odds are low that most people will be in a skilled nursing facility for more than 20 days more than once or twice in a lifetime.

Finally, Plan C offers some coverage for medical care while traveling outside the United States. For people who travel abroad frequently, this can be a valuable benefit. After you pay a \$250 deductible, Plan C pays for 80% of emergency medical costs you incur abroad. For purposes of these policies, “emergency” means any unplanned medical costs; it’s not restricted to “emergency room” treatment (as it’s called in the United States).

However, there are some restrictions on the coverage. Your emergency medical care must begin within the first 60 days of each trip abroad; if you take long trips, this policy won’t protect you after the first two months. And there is a \$50,000 lifetime maximum on these foreign travel medical benefits. If you spend a good portion of each year abroad, you might need a separate—that is, non-medigap—travel health insurance policy to cover you fully for treatment received outside the United States.

Remember that your overseas medical care must be emergency care; if you regularly spend time abroad and simply want to be able to see a doctor for ongoing medical problems, this policy won’t cover such visits.

The cost for Plan C policies is considerably higher than for Plan A or B but runs about the same as for Plans D and E.

#### **Policies Issued June 1, 2010 or Later**

Plan C policies issued June 1, 2010 or later also include coverage for hospice copayments.

### **Medigap Plan D**

#### **Policies Issued Pre-June 1, 2010**

Plan D is the same as Plan C, except it doesn’t pay the yearly Medicare Part B deductible, but it does cover at-home recovery (home health aide services).

### Policies Issued June 1, 2010 or Later

Plan D policies issued June 1, 2010 or later also include coverage for hospice copayments, but don't include at-home recovery.

### Medicare SELECT Medigap Policies

In addition to regular fee-for-service medigap policies, there is a category of supplemental insurance that is partly fee for service and partly managed care. It's called "Medicare SELECT." A SELECT policy must provide the same benefits as any of the standard medigap policies, but it has a two-tiered payment system.

If you use hospitals—and under some policies, doctors—who are members of the policy's network, the policy pays full benefits. If you use a provider outside the network, the policy pays reduced benefits. In this way, a Medicare SELECT medigap policy works like a preferred provider organization or an HMO with a point-of-service option, except that those managed care plans usually cover more services than most medigap policies. Because of the provider restrictions, Medicare SELECT policies are somewhat less expensive than regular medigap policies.

### Medigap Plan E



#### CAUTION

**Plan E has been discontinued.** No new Plan E policies have been sold since May 31, 2010. If you already had a Plan E policy as of that date, you can continue it.

Plan E adds minimal coverage of some preventive care but eliminates Plan D's coverage of at-home recovery. Plan E pays for only \$120 per year of such preventive health care and screening, so it's not much of a benefit.

## Medigap Plan F



### CAUTION

**Plan F has limited enrollment.** No new Plan F policies are sold to people newly enrolled in Medicare after January 1, 2020. If you already had a Plan F policy as of that date, you can continue it. And if you were eligible for Medicare before 2020, you can still buy Plan F.

### Policies Issued Pre-June 1, 2010

Plan F offers the most significant added benefit beyond Plans B, C, D, and E: payment of 100% of what a doctor actually charges you above the Medicare-approved amount. (Remember, doctors who don't accept assignment are permitted to charge a patient up to 15% more than the Medicare-approved amount for any covered service, as discussed in "How Much Medicare Part B Pays" in Chapter 12.) If you receive extensive medical care from doctors who don't accept assignment, that extra 15% mounts up quickly.

Because the extra 15% of medical bills can amount to a lot of money, insurance companies charge higher premiums for Plan F than for the plans discussed previously. If you're in generally good health and the few doctors you see all accept assignment, this higher premium might not be worth the extra coverage. If, on the other hand, you require frequent or extensive medical care and you receive it from doctors who don't all accept assignment, Plan F might be worth the higher premiums.

If you like the coverage offered by Plan F but find the higher premiums too much for your budget, many companies that offer Plan F also offer a high-deductible version of this plan for a much lower premium. These high-deductible plans provide coverage only when your out-of-pocket costs for covered services exceed a certain amount for the year.

### Policies Issued June 1, 2010 or Later

Plan F policies issued June 1, 2010 or later also include coverage for hospice copayments.

## Medigap Plan G

### Policies Issued Pre-June 1, 2010

Plan G is similar to Plan F. However, unlike Plan F, Plan G doesn't cover the Medicare medical insurance deductible. Plan G policies issued before June 1, 2010 cover only 80% of the excess charges some doctors and other providers charge under Medicare Part B.

### Policies Issued June 1, 2010 or Later

Plan G policies issued June 1, 2010 or later provide 100% coverage for doctors' excess charges under Medicare Part B and also include coverage for hospice copayments.

## Medigap Plan H



### CAUTION

**Plan H has been discontinued.** No new Plan H policies have been sold since May 31, 2010. If you already had a Plan H policy as of that date, you can continue it (though without drug coverage that the policy might have provided you before 2006).

Plan H policies (without the drug coverage provided before January 1, 2006) cover the Part A deductible, Part A skilled nursing facility coinsurance amounts, and some coverage for emergency care while traveling outside the United States. Plan H policies provide the same coverage as a Plan C policy except for the yearly Part B deductible that a Plan C policy covers. If you're considering keeping a Plan H policy, comparison shop with available Plan C policies.

## Medigap Plan I



### CAUTION

**Plan I has been discontinued.** No new Plan I policies have been sold since May 31, 2010. If you already had a Plan I policy as of that date, you can continue it.

Plan I policies (without the drug coverage provided before January 1, 2006) cover 100% of doctors' excess charges under Part B, which can be a significant amount if you regularly see a number of doctors or have major treatment in any particular year. It also includes coverage of at-home recovery, in addition to the more commonly covered Part A deductible, skilled nursing facility coinsurance amounts, and emergency care during foreign travel. It's comparable to a Plan F policy, except that Plan F pays the Part B deductible instead of covering at-home recovery. If you can find a Plan F policy for a considerably lower premium than your Plan I policy, it might be worth it to switch.

### Medigap Plan J



#### CAUTION

**Plan J has been discontinued.** No new Plan J policies have been sold since May 31, 2010. If you already had a Plan J policy as of that date, you can continue it.

Plan J policies (without the drug coverage provided before January 1, 2006) are the luxury model of medigap policies, and also the most expensive. They cover 100% of doctors' excess charges and the Part B deductible, as well as all the other costs covered by any other plan policy.

### Medigap Plan K

#### Policies Issued Pre-June 1, 2010

Plan K policies cover many Medicare gaps but pay only 50% of certain covered costs. Plan K compensates for this partial coverage by providing a cap on an insured person's out-of-pocket expenses. In addition to the standard Part A hospital coinsurance and extra lifetime hospital inpatient coverage offered under all medigap plans, Plan K policies cover 100% of the coinsurance amounts for Part B

preventive care and 50% of the Part A inpatient deductible, Part A coinsurance amounts for blood transfusions, skilled nursing facility stays and hospice care, and Part B coinsurance amounts.

Plan K policies also place a \$7,060 per year limit (in 2024) on a policyholder's out-of-pocket costs for covered medical expenses. After the policyholder reaches that amount, the policy pays 100% of all covered Part A and B costs.

**Policies Issued June 1, 2010 or Later**

There are no changes to Plan K policies issued June 1, 2010 or later.

**Medigap Plan L****Policies Issued Pre-June 1, 2010**

Plan L policies provide the same coverage as Plan K policies and have the same kind of yearly cap on a policyholder's out-of-pocket expenses. But Plan L policies cover 75% of the Part A inpatient deductible, Part A coinsurance amounts for blood transfusions, skilled nursing facility stays and hospice care, and Part B coinsurance amounts. And Plan L's yearly cap on out-of-pocket expenses is \$3,530 (in 2024). Because of this better coverage, Plan L policies are more expensive than Plan K policies.

**Policies Issued June 1, 2010 or Later**

There are no changes to Plan L policies issued June 1, 2010 or later.

**Medigap Plan M**

Plan M policies offer the same coverage as Plan D but pay only 50% of the Medicare Part A deductible.

**Medigap Plan N**

Plan N policies offer the same coverage as Plan D, but you must pay a \$20 copayment for each health care provider visit under Medicare Part B and a \$50 copayment for an emergency room visit.

## Terms and Conditions of Medigap Policies

In addition to comparing the services covered, the amount of benefits, and the monthly cost of different medigap insurance policies, there are several other things to consider before making a final decision.

Look first at how high the company says it can raise its premiums in the years to come—and therefore whether you will still be able to afford the policy when you might need it most. Also important are policy terms that determine whether you're covered for a particular illness during a certain time period after you purchase the policy.

### Premium Increases

It's one thing to find insurance coverage you can afford today. It might be quite another to find a policy that you can continue to pay for in the future when your income and assets have decreased and the policy premium has increased. In choosing a medigap policy, consider what the contract says about how much the policy premiums will rise over time. If the current premium will already be a significant strain on your financial resources, consider a less expensive policy, because any policy is sure to get more expensive in the future.

There are several ways insurance companies set up premium increases in medigap policies. Choosing the best premium increase terms—what the insurance companies call “rating” methods—is something for you to consider along with other terms of the policy.

### Level Premiums

The best method for the consumer is one called “level premiums.” This means that premiums don't go up on your policy as you reach a certain age, but only when the insurance company raises premiums on all medigap policies of the type you have. Of course, the premiums will go up regularly, but the amount they go up will be at least partially controlled by market forces and by your state's insurance commission.

## Attained Age

“Attained age” policies base your premium entirely upon your age. The company charges the same premium to everyone of the same age who has the same policy. As you get older, the premiums rise in lockstep, by a set amount. Some policies mandate that your premiums go up yearly; others hike the premiums when you reach a certain age plateau, such as 70, 75, or 80. Attained age policies tend to be cheaper at age 65 than comparable policies. However, once you reach 70 or 75, attained age policies tend to become, and stay, more expensive than other types.

When considering a policy with attained age premium increases, ask to see not only how much it would cost you at your present age, but also the current premium costs at each of the next age levels. That will give you a sense of how high the rates jump for that policy. Figure that your premiums will rise by at least the same percentages, and calculate how much your policy is likely to cost at your next two age levels. Only then will you have a realistic picture of how much this policy will cost.



### ONLINE

**Medigap information from Medicare’s website.** Medicare’s official website at [www.medicare.gov](http://www.medicare.gov) offers a link that can provide you with the names and contact information of insurance companies that offer specific medigap policies available where you live. On the [www.medicare.gov](http://www.medicare.gov) home page, click the “Health & Drug Plans” tab, then click “Find a Medicare Supplement Insurance (Medigap) policy.” Enter the requested information about your location. It will then provide you with information about specific medigap policies being sold where you live, including what the policies cover and which companies offer each type of policy, with contact information for those companies.

## Issue Age

The initial premium for an “issue age” policy is determined by your age when you first purchase it. From then on, as long as you keep the same policy, you pay the same premium as anyone else who buys the policy at the same age at which you bought it.

For example, if you buy an issue age medigap policy at age 65, in five years you will pay the same as a person who first buys the policy at that time at age 65. Your premium will steadily rise, but the increases might be controlled by the insurance company's need to keep the premium competitive to continue signing up new policyholders.

### **No Age Rating**

A few insurance companies sell policies that charge the same amount regardless of age. They base their premiums entirely on the cost of medical care in the geographic area in which you live. (For this reason, these are sometimes referred to as “community-rated policies.”) These policies tend to be a bit more expensive than others for people ages 65 to 75 and a bit less expensive for people age 75 and older.

### **Eligibility and Enrollment**

Your ability to purchase the medigap policy of your choice depends on when and under what circumstances you apply for it. The following sections discuss applying:

- during open enrollment periods
- during limited guaranteed enrollment periods, and
- outside these enrollment periods.

### **Applying During Open Enrollment**

You're guaranteed the right to buy any medigap policy sold in your state, without any medical screening or limits on coverage, if you:

- are within your first six months of enrollment in Medicare Part B, or
- leave a Medicare Advantage plan within a year of age 65.

### **Your First Six Months With Medicare Part B**

During the six months after you first enroll in Medicare Part B (see “Enrolling in Part B: Medical Insurance” in Chapter 13 for enrollment procedures), you can buy any medigap insurance policy sold in the state where you live. During this initial enrollment

period, federal law prohibits an insurance company from requiring medical underwriting—that is, prior screening of your health condition—before issuing a policy. Nor can the insurance company delay coverage because of preexisting health conditions. Companies are also prohibited from charging higher premiums based solely on your age or area of residence.

Most people enroll in Medicare Part B as soon as they turn 65. Your six-month open enrollment period for medigap begins on the first of the month during which you reach age 65 and are enrolled in Part B.

If you did not enroll for Medicare Part B on your 65th birthday but enroll during a yearly Medicare general enrollment period (January through March), your six-month open enrollment period for any medigap policy begins on July 1 of the same year. If you did not enroll in Medicare Part B on your 65th birthday because you were still covered by an employer-sponsored health plan, you have a six-month open enrollment period for any medigap policy beginning whenever you enroll in Medicare Part B.

### **You Leave a Medicare Advantage Plan Within a Year of Age 65**

If you joined a Medicare Advantage plan (see Chapter 15) at age 65 when you first became eligible for Medicare, but you leave the plan within a year, you have a guaranteed right to buy any medigap plan sold in your state. This is true whether your Medicare Advantage plan dropped you—perhaps because it stopped doing business in your county of residence or because you moved out of its business area—or you left the plan voluntarily.

However, to protect this guaranteed right, you must apply for a medigap policy within 63 days of the date your Medicare Advantage plan coverage ends. If you're still in the six-month period immediately following your enrollment in Medicare Part B, you have whatever is left of that six-month period within which to apply for a medigap policy, or 63 days from the end of your Medicare Advantage coverage, whichever is greater.

### **Medigap Coverage If You Move**

What happens if you buy a medigap policy while living in one place, then move elsewhere? Because all medigap policies are “guaranteed renewable,” your insurance company can’t cancel your policy. This is true even if you move to an area where the company doesn’t normally sell similar policies. However, the insurance company has a right to increase your premium if you’ve moved to an area where the costs of medical care are higher. The rates must be approved by the department of insurance in the state to which you have moved.

### **Applying With Limited Guaranteed Enrollment**

You have the guaranteed right to buy a medigap policy if, under certain circumstances, you:

- lose your Medicare coverage, or
- drop medigap, join a Medicare Advantage plan, then leave the Medicare Advantage plan.

You can use this right for any of several standard medigap plans, though not for all plans (see below). For those plans to which you have no guaranteed right, however, you can still purchase a policy if the issuing insurance company approves your application.

### **You Lose Coverage by a Medicare Advantage Plan or an Employer-Sponsored Policy**

Insurance companies are free to drop their Medicare Advantage plans, and they often do so in counties and even entire states in which the companies are unhappy with their profit margins. (See Chapter 15 for details.)

If you’ve been dropped from a Medicare Advantage plan because the company is no longer operating the plan where you live, you have a guaranteed right to purchase any standard medigap Plan A, B, C, or F policy sold in your state. (In Massachusetts, Minnesota, and Wisconsin, you have a right to purchase a medigap policy with provisions similar to these four standard medigap plans.)

You have the same guarantee if you're losing your Medicare Advantage coverage because you're moving out of your plan's service area.

These rules also apply if you lose employer-sponsored insurance that had operated like a medigap policy, meaning that it paid for some costs your Medicare coverage did not.

If you had a medigap Plan D, E, or G before dropping it to join a Medicare Advantage plan that has now dropped you, you also have a guaranteed right to again purchase that same plan from the same insurance company, if the company still sells the plan in your state.

To take advantage of any of these guaranteed rights, you must apply for a medigap plan within 63 days from the end of your Medicare Advantage or employer-sponsored coverage.

### **Some States Offer Extra Protection**

Some states' laws offer even more protection around your right to purchase a medigap policy than the federal guarantee described in this chapter. These state laws typically give you more medigap plans from which to choose. To find out what extra protection your state might offer, call your state's department of insurance (see contact information at the end of this chapter) or your local SHIP office (see contact information at the end of Chapter 13).

### **You Dropped a Medigap Policy to Join a Medicare Advantage Plan or a Medicare SELECT Policy, Then Left the New Plan Within a Year**

If you once had a medigap policy but dropped it to join a Medicare Advantage plan or to purchase a Medicare SELECT policy (see "Medicare SELECT Medigap Policies," above), you might have a guaranteed right to drop the Medicare Advantage plan and repurchase a medigap plan. However, you must meet two conditions:

- The Medicare Advantage plan or Medicare SELECT policy you drop must be the only one in which you've been enrolled.

- You must leave the Medicare Advantage plan or drop the Medicare SELECT policy within a year of when you joined.

If you meet these two conditions, you can either buy your original medigap policy from the same company (if it's still sold in your state), or buy any medigap Plan A, B, C, or F sold in your state. There's a time limit on applying for the new medigap policy, however. Your guaranteed right to purchase lasts only 63 days from the end of your previous coverage.

### **Applying Without Guaranteed Enrollment**

If you want to buy a medigap policy but have none of the guaranteed rights described above, an insurance company can freely choose whether or not to sell you a policy. Even if the company does offer you coverage, it can attach whatever terms, conditions, and premiums it chooses, as long as the coverage matches one of the standard plans.

In such circumstances, the insurance company is likely to demand that you undergo medical underwriting (screening)—particularly before they'll sell you one of their more desirable policies. The screening will involve a detailed examination of your medical history.

If your history shows a likelihood of extensive or expensive medical treatment in the foreseeable future, the company might refuse to sell you the policy. Or, they might offer to sell it to you at a high premium, perhaps also with limitations on when coverage begins.

### **Preexisting Illness Exclusion**

Most medigap policies contain a provision excluding coverage, for a set time immediately after you purchase the policy, of any illness or medical conditions for which you received treatment within a given period before your coverage began. Six months is a typical exclusion period: These policies provide no coverage, for six months after you buy the policy, for illnesses you were treated for within six months before the policy started. Usually, the shorter the exclusion period, the higher the premium.

If you have a serious medical condition that might require costly medical treatment at any time, and you've been treated for that condition within the recent past, consider a policy with a short exclusion period or none at all.

### **Discounts for the “Healthy”**

Some insurance companies offer extra discounts on medigap policies for people they consider to be better risks than others. For example, women might be offered lower premiums than men because women tend to remain healthier longer, meaning the insurance company collects more premiums before having to pay out on claims. For the same reason, nonsmokers are also frequently offered discounts.

You might also be able to reduce your premiums if you've been free of any serious illness or condition and are willing to prove it by undergoing what is called “medical underwriting”—a screening process during which the insurance company examines your medical history to see whether you're likely to cost them a lot of money in the near future. If the screening shows that you have had no serious illnesses or medical conditions over the previous 10 years, you might be able to purchase the policy at a significantly lower premium than if you had bought it without first being medically screened. Ask the insurance company whether they offer this sort of discount.

## **Finding the Best Medicare Supplement**

Shopping for a medigap policy can be difficult, not only because of the differences in policy terms among the 10 standard policies, but because of the wide spectrum of prices among insurance companies. Near the end of Chapter 15 is a chart to help you do a side-by-side comparison among different medigap and Medicare Advantage plans.

Fortunately, your first step—namely, finding out what medigap insurance policies are available in your state—is fairly simple. Your state department of insurance can give you a complete list of available

policies (see the contact information at the end of this chapter). Be warned, however, that their lists are often a bit stale, so you'll need to follow up with the insurance companies or insurance agents for the latest facts and figures. Many people also use insurance agents to find policies, although you should first read the cautions in "Using an Insurance Agent," below. In addition, some seniors' organizations offer discounts on certain medigap policies.

The Medicare.gov website also has a useful medigap policy finder that lists and compares policies in your area.

## **Using an Insurance Agent**

If you use an insurance agent to present you with a choice of medigap policies, make sure the agent is experienced with the provisions of several different policies from different insurance companies. Insurance agents tend to work with policies from certain companies and might not know of less expensive or less restrictive policies from other companies. So you might want to consult more than one agent.

Even if you arrange to get your insurance through an agent, keep your own ears and eyes open for policies that might fit your needs. Friends, relatives, and organizations to which you belong can all be resources to find out about available plans. And senior organizations can be a good source of information. A good insurance agent should be willing to find out the details of a policy you've located yourself. If the agent can't or won't check on such a policy, it's probably time to find a new agent. Likewise, if an insurance agent is unwilling to sit down with you and compare the coverage and costs of different policies, then you ought to comparison shop for a new insurance agent.

## **Senior Associations**

A number of organizations of seniors or retired people advertise medigap policies. These organizations don't actually act as insurers. Instead, they negotiate deals with insurance companies to offer medigap policies to their members, sometimes at reduced rates.

But some senior organizations act almost as fronts for insurance companies. These organizations might appear to exist for the benefit of older people, offering a number of programs or services for seniors. But many of these alleged benefits are nearly worthless. In truth, these organizations exist to sell themselves through membership dues and products (including overpriced insurance) behind a facade of supposedly protecting senior citizens.

### **Help With Decisions About Medigap and Medicare Advantage Plans**

Each state has a program to assist people with Medicare, medigap supplemental insurance, and Medicare Advantage plans. It's called the "State Health Insurance Assistance Program" (SHIP), although in some states it might have another, similar name, such as "Health Insurance Counseling and Advocacy Program" (HICAP).

SHIP has professional staff and volunteers who are knowledgeable not only about the rules pertaining to Medicare and medigap insurance but also about what policies are available in your state and what Medicare Advantage plans are available in your local area. SHIP staff can look over particular insurance policies and Medicare Advantage plans and help you see the strengths and weaknesses of each.

In larger states there are many SHIP offices, and you can reach the office nearest you by calling the state's general toll-free number. In smaller states there might be fewer offices, and you will be referred to a SHIP program at a local senior center or another nonprofit organization. (See the end of Chapter 13 for contact information.)

The best way to tell whether the policies a particular organization offers are good or bad is to compare their specific terms and prices with those of other policies offered by different insurance companies or health plans. In the final analysis, it's the terms of the policy, not an organization's good intentions or friendly advertising, that determine the quality of your coverage. The insurance company, not the senior organization, determines your coverage and pays your claims.

### **Beware of Mail-Order and Limited-Offer Policies**

Beware of medigap policy offers you receive unsolicited in the mail. Their flashy promises often far outstrip their coverage. If you do become aware of a policy through the mail, and its provisions seem good to you after comparing it with other policies, check the reputation of the company offering the policy. You can get information on the company from your state's insurance department or commission, or from your state or local consumer protection agency.

Also be wary of policies that are offered with short-time enrollment periods. You have likely heard or seen advertisements for insurance that holler: "Limited offer! One month only! Buy now, the greatest offer in years! Once the offer is over, you'll never get another chance at an opportunity like this again! Once-in-a-lifetime offer!"

This is nonsense.

If it's a reputable company with a legitimate policy to offer you, the same or similar terms will be available any time—although you must keep in mind your own six-month open enrollment period after you sign up for Medicare Part B. These advertising slogans are just another way insurance companies have of pressuring you into buying a policy without first carefully considering and comparing its terms.

Most companies permit you to look over your policy and carefully examine its terms for 10 days before you're obligated to keep it. If you decide you don't want the policy—for any reason—you can return it within 10 days to the company or to the insurance agent you bought it from. You'll be owed a refund of all the money you've paid up to that point. And if you're buying a new medigap policy to replace one you already have, you're legally entitled to 30 days to review the new policy to decide whether you want to keep it. You can cancel it without penalty at any time during those 30 days.

### **Only One Medigap Policy Required**

You need only one policy to supplement your Medicare coverage—and it's illegal for an insurance company to sell you any other health

insurance policy that duplicates coverage you already have with a medigap policy.

When you apply for a medigap policy, you will be asked to provide information concerning any health insurance policies you have. This gives written notice to the seller of your policy—insurance agent, broker, or company representative—about your existing insurance so that you won't be held responsible for paying for duplicate coverage if the insurer mistakenly sells it to you.

If you already have medigap insurance but want to replace it with a new policy, some rules help protect you while you make the change.

## Replacement Policies

If you're considering replacing your existing policy with a new one, there are a number of things to keep in mind.

First, even if your new policy would ultimately provide better coverage, it might have a preexisting condition exclusion that would deny you coverage for up to six months after you switch policies. If you've been treated in the previous six months for any serious medical condition that might require further treatment in the near future, don't cancel a basically good policy for one that's only slightly better if the new policy has such an exclusion.

Second, unless you're signing up within the first six months following your enrollment in Medicare Part B, the new insurance company from which you applied for coverage might reject you if you have had serious medical problems in the recent past. So, don't cancel your old policy until you've been given written notice from the new insurance company—not just from the agent or broker who sold you the policy—that your new policy is in effect.

When you apply for a replacement policy, you must sign a statement agreeing that you will drop your old policy when the new one takes effect. The law gives you a review period within which to decide between the old and new policies. Once you've received written notice of your acceptance in the new insurance plan, and you've been given a written copy of the new policy, you have 30 days to cancel either the new policy or the old one.

### **Dread Disease Policies: A Dreadful Idea**

A few insurance companies offer policies that don't provide medigap supplemental coverage but provide particularized health coverage that might overlap some with medigap policies and even Medicare coverage itself. Most of these policies cover treatment for a specific disease and are known as "indemnity" or "dread disease" policies. They are often solicited over the phone or by direct mail and are offered at low monthly premiums.

One of these policies might initially sound promising if it covers a particular disease—for example, a specific type of cancer—for which you have a high risk. However, close examination of these policies usually shows them to be a waste of money. They pay only a small, set amount of money for each day you're hospitalized or for each medical treatment for the specific disease, usually far less than the Medicare deductible or coinsurance that a medigap policy would pay.

And because they pay only when you're treated for the specific disease, you wind up needing to carry a medigap policy anyway to cover all medical bills not related to this particular disease. Or if you don't carry a medigap policy, you will be responsible for paying out of pocket for all medical bills not covered by this specific-disease policy. Either way, these policies are a bad investment.

### **Department of Insurance**

You can contact your state's department of insurance to ask for information about medigap insurance policies being sold in your state. To find contact information for your state, see the list of state departments of insurance maintained by the National Association of Insurance Commissioners (NAIC) at <https://content.naic.org/state-insurance-departments>.



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**M**edicare Part C health plans, referred to as “Medicare Advantage plans,” fill gaps in basic Medicare, as do medigap policies. But the two systems operate differently. As explained in Chapter 14, medigap policies work alongside Medicare: Medical bills are sent both to Medicare and to a medigap insurer, and each pays a portion of the approved charges. With a Medicare Advantage plan, on the other hand, enrollees no longer deal with Medicare directly, although enrollees still have to pay their monthly premium for Medicare Part B (see Chapter 12).

A Medicare Advantage plan takes the place of Part A and Part B, and often Part D as well, providing all basic Medicare coverage and often offering extended coverage in addition to basic Medicare. The extent of coverage beyond basic Medicare, the size of premiums and copayments, and decisions about whether a patient’s particular treatment should be covered are all controlled by the Medicare Advantage plan, not by Medicare. (See “Comparing Medigap and Medicare Advantage Plans,” toward the end of this chapter, to help compare specific policies.)

Medicare Advantage plans come in two basic forms: managed care plans and fee-for-service plans:

- **Managed care plans.** In return for coverage beyond basic Medicare, Medicare Advantage managed care plans charge a low monthly premium—or none at all—and small copayments. But they limit the doctors and other providers from which you can receive care; they cover only services provided by doctors and others who participate in that particular plan. They restrict services as well—placing limits on treatments and the length of hospital stays for managed care patients.
- **Fee-for-service plans.** With these plans, you can receive care from any doctor or other provider who participates in Medicare. But for each service or treatment, the doctor or other provider must accept the Medicare Advantage plan’s restrictions and amount of payment. If a doctor or another provider won’t accept the plan’s restrictions or payment level for a particular medical service, the plan won’t cover the patient’s care by that provider. In that case, the patient must

either personally pay the provider or seek care from a different provider who will accept the plan's terms.

Most fee-for-service plans also have provider networks. If you receive services from a provider within the network, your out-of-pocket costs will be lower than if you receive services from a provider who isn't in the plan's network.

### **Medicare Advantage Plan and/or Medicare Part D?**

Many Medicare Advantage plans include coverage for prescription drugs, but others offer no such coverage. So, deciding whether to join (or remain in) a Medicare Advantage plan involves comparing the prescription drug coverage offered by that plan with the coverage and cost of drugs under various Part D plans. You can compare the cost of your medications in each plan using Medicare's website at [www.medicare.gov/plan-compare](http://www.medicare.gov/plan-compare).

If a Medicare Advantage plan includes drug coverage, enrolling in that plan means that you don't also enroll in a Part D plan. But enrolling in a plan with drug coverage is a good idea only if that plan covers the drugs you regularly take and offers them at a reasonable copayment without serious access restrictions. (Coverage restrictions are discussed in more detail in Chapter 12. See "Part D: Prescription Drug Coverage.")

If a Medicare Advantage plan doesn't offer drug coverage, you might still want to keep or join that plan if you like its other coverage features and costs. But if you also want prescription drug coverage, you will have to enroll in a separate, stand-alone Part D prescription drug plan.

If your current Medicare Advantage plan offers drug coverage but doesn't cover your specific drugs, or does so with high copayments or access restrictions, consider joining a different Medicare Advantage plan that better meets your needs. Or, leave the managed care system altogether and return to original Medicare coverage under Parts A and B, and separately enroll in a stand-alone Part D prescription drug plan that does a good job of covering your drugs. (See Chapter 12.) If you leave Medicare Advantage altogether, you might also want to take out a medigap supplemental insurance policy to fill some of the gaps in Medicare coverage that your Medicare Advantage plan used to cover. (See Chapter 14.)

If you're considering a Medicare Advantage plan, you must decide whether any of the plans available in your area offer adequate care at an affordable cost. You should evaluate not only the cost of premiums and copayments but also how the plan limits the particular doctors and other providers you can get care from. Despite the lower monthly cost for Medicare Advantage plans, their limitations have resulted in only about half of Medicare beneficiaries choosing to enroll in these plans (others are automatically enrolled in a Medicare Advantage plan as part of their enrollment in Medicaid).

When considering a Medicare Advantage plan, you'll also need to assess the risks of yearly changes—including the chance that a particular plan might drop out of an entire geographic region—associated with these types of plans. In the past several years, many seniors have been dropped from Medicare Advantage plans that stopped serving the areas where they lived and have been forced to find another plan or return to original Medicare coverage. And millions of people have found their premiums shooting up, copayments rising, and coverage shrinking for those services not legally required by Medicare.

Not only do you risk your plan's disappearing or becoming far more expensive (at renewal time), but if you choose to leave a Medicare Advantage plan and return to regular Medicare, your chance to buy a medigap insurance policy (as discussed in Chapter 14) might be much more limited.

To learn what Medicare Advantage plans are available in the area where you live, you can visit the Medicare website at [www.medicare.gov](http://www.medicare.gov). To find out the recent history of a particular Medicare Advantage plan—whether it has dropped patients or hiked costs, for example—call your local SHIP or HICAP counseling office (see the end of Chapter 13 for contact information) or your state department of insurance (see Chapter 14 for contact information). If you're dropped from a Medicare Advantage plan, your alternatives and when you must exercise them are explained in “Your Rights When Joining, Leaving, or Losing a Medicare Advantage Plan,” below.

### **Joining a Medicare Advantage Plan Means Leaving Direct Medicare Protection**

If you join a Medicare Advantage plan, in effect you leave the Medicare program. The insurance company that runs the Medicare Advantage plan gets a monthly payment from Medicare on your behalf, but the plan itself then decides what health care providers you can use and approves or denies medical coverage for all of your specific medical care. (When the plan denies coverage, the plan itself handles the your request for reconsideration—the first level of appeal. But if your request for reconsideration is denied, then you're entitled to an independent review, just as in an appeal under original Medicare (covered in Chapter 13). For more information, see Nolo's website article on "How to Appeal a Denial of Medicare.")

If you leave a Medicare Advantage plan, you're permitted to rejoin traditional Medicare. But if you return to Medicare after the first year following your initial Medicare eligibility, you might find that not all medigap supplemental insurance policies will accept you. And you might be able to join another Medicare Advantage plan only during open enrollment. (See "Your Rights When Joining, Leaving, or Losing a Medicare Advantage Plan," below.)

## **Medicare Advantage Managed Care Plans**

Most Medicare Advantage plans are structured as managed care plans. In these plans, a patient's care is managed by the insurance company that issues the plan. The basic premise of managed care is that the member-patient agrees to receive care only from specific doctors, hospitals, and other providers—called a "network"—in exchange for reduced overall health care costs. The patient also agrees that the plan, rather than Medicare itself, will decide whether a particular medical service is covered.

There are several varieties of Medicare Advantage managed care plans. Some have severe restrictions on consulting with specialists or seeing providers from outside the network. Others give members more freedom to choose which doctors they can consult for treatment. Generally, more choice translates into higher cost.

## **Health Maintenance Organization (HMO)**

The HMO is the least expensive and most restrictive Medicare Advantage managed care plan. It's also the most common type of Medicare managed care plan. There are four main restrictions.

### **Care Within the Network Only**

Each HMO maintains a list—called a “network”—of doctors and other health care providers who participate with that HMO. The HMO member must receive care only from a provider in the network, except in emergencies.

If the plan member uses a provider from outside the network, the plan pays nothing toward the bill. And because a Medicare Advantage plan member has withdrawn from traditional Medicare coverage, Medicare itself picks up none of the tab, either. The plan member must pay the entire bill out of pocket.

Because of this restriction, it's very important to find out whether the doctors and other providers you regularly use, particularly your primary care physician, are included in the HMO's network. It's also important to make sure that the hospital in your vicinity, or a hospital you and your doctor prefer to use, is in the network. If all of your doctors and your preferred hospital are in the HMO's network, this restriction might not be as important to you.

However, most HMOs and other managed care plans (except for integrated HMOs like Kaiser Permanente) do sometimes drop doctors and hospitals. And doctors' groups and hospitals leave HMOs that become too stingy in reimbursing for medical care or authorizing services for their patients. If the plan or one of your

providers decides to cut ties, you won't be able to continue seeing that provider. So, even if you begin a managed care plan with all the right doctors and hospital, you might later find yourself searching for new doctors or a new hospital, or leaving your HMO and searching for a new managed care plan or medigap policy.

This instability of many managed care plans makes it important for you to discuss with your doctors any particular HMO you're considering. Ask first whether your doctor participates in that HMO, then whether your doctor has experienced problems with the plan, particularly with approval of treatments, referrals to specialists, or early release from inpatient hospital care.

Some doctors are uncomfortable speaking with patients about insurance companies. But responsible physicians will at least tell you if their offices have had regular, serious problems getting a plan's coverage for their patients, and certainly should tell you if they're considering dropping their contract with a particular plan.

### **Emergency and Urgent Care Anywhere**

Federal law requires that all Medicare Advantage plans cover emergency services nationwide, regardless of restrictions they place on the use of doctors and hospitals for routine care. The law also requires that these plans pay for covered services you receive from a nonplan provider if the treatment was urgently needed while you were temporarily outside the plan's geographic service area. Urgently needed care means care for an unforeseen illness or injury for which a reasonable person wouldn't wait until they could return home to seek medical help.

This required emergency or urgent care coverage doesn't apply to most foreign travel. However, some plans offer such travel coverage on their own. If you travel or live any part of the year outside the United States but aren't covered by your Medicare Advantage plan while abroad, it might be a good idea to buy a temporary travel medical policy covering you for the time you're out of the country.

### **All Care Through Primary Care Physician**

Within an HMO, a member must see their primary care physician before obtaining any other medical services. The member can't see other doctors or providers—even from within the plan's network—or obtain other medical services without a referral by the primary care physician.

This system encourages the primary care physician—who is paid less than a specialist by the plan—to take care of medical problems that don't absolutely require a specialist. Because of the hassle of the extra step, it also discourages the plan member from seeking specialist care.

This restriction is a significant reason why managed care is cheaper for insurance companies—and for the member/patient—than traditional fee-for-service policies are. However, since many seniors regularly require specialist care, this restriction is also a reason why many reject HMO coverage in favor of medigap insurance or less restrictive types of managed care.

### **Prior HMO Approval of Some Services**

HMOs require that your primary care physician or other network physician obtain prior approval from the plan for certain medical services the doctor might want to prescribe. If plan administrators don't believe a service is medically necessary—or believe service from a non-specialist or other less expensive treatment would do just as well—they might deny coverage for that prescribed service.

### **HMO With Point-of-Service (POS) Option**

A few Medicare Advantage HMOs have a significant wrinkle that makes them more attractive—and more expensive—than standard HMO plans. These plans offer what is called a “point-of-service” option. This option allows a member to see physicians and other providers who aren't in the HMO's network and to receive services from specialists without first going through a primary care physician.

## Special Needs Plans for Certain Chronic Conditions

In some states, a particular kind of Medicare Advantage plan, called a “Special Needs Plan,” might be offered to people with a specific serious chronic or disabling medical condition. Like all other Medicare Advantage plans, these C-SNPs (meaning “Chronic-Special Needs Plans”) offer both inpatient and outpatient care at least as broad as Medicare Part A and Part B, plus prescription drugs. Unlike other Medicare Advantage plans, though, a C-SNP is tailored to a specific condition, providing a network of doctors and other providers who specialize in the treatment of that condition, a broad selection of the drugs used to treat that condition, and usually a “care coordinator” who monitors a patient’s health status and helps ensure that the patient follows proper care procedures at home.

C-SNPs are offered in only about half of all states, with a total enrollment of only about 0.5% of all Medicare beneficiaries. And almost all C-SNPs (more than 95% of all C-SNPs offered) cover one or more of only three sets of conditions. If your doctor certifies that you have one of these three sets of conditions, you might qualify for a C-SNP that specifically covers your condition and actually find such a policy offered where you live:

- cardiovascular disorders,  
including chronic or congestive  
heart failure
- diabetes mellitus, or  
• chronic lung failure.

If you have one of the following conditions, technically you might also qualify for a C-SNP, but insurance companies have offered such C-SNPs in only a very few places in the country:

- cancer
- stroke
- alcohol/drug dependence
- Alzheimer’s or dementia
- disabling mental health disease
- neurological disorders
- HIV/AIDS
- autoimmune disorders
- end-stage liver or kidney disease, or
- severe hematological disorders.

### Special Needs Plans for Certain Chronic Conditions (continued)

In addition to the difficulty of finding a C-SNP for your condition where you live, there's the issue of whether the plan would actually be better for you than other Medicare Advantage plans. In theory, concentrating providers around a single condition and coordinating care should improve care. How a C-SNP plan performs, however, varies from plan to plan.

If you're interested in exploring whether a C-SNP might be right for you, you can find out what plans are available in your area by going online to the government's Medicare Plan Finder, [www.medicare.gov/find-a-plan/questions/home.aspx](http://www.medicare.gov/find-a-plan/questions/home.aspx). If you find a plan that interests you, be sure to compare it to what's offered by other Medicare Advantage plans in your area, including asking the insurance company what the plan's "quality measures" ratings are. For help in choosing a plan, you can get free counseling from a local office of the State Health Insurance Assistance Program (SHIP). (See information about SHIP at the end of Chapter 13.) More information is also available from Medicare's webpage on SNPs at [www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/SNP](http://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/SNP).

If you decide that you want to try a C-SNP offered where you live, you can enroll (with your doctor's certification that you have a qualifying condition) or disenroll under the same terms as you could with any Medicare Advantage plan (see "Your Rights When Joining, Leaving, or Losing a Medicare Advantage Plan," below). In addition, you can enroll in a C-SNP anytime you're newly diagnosed with the condition that qualifies you for the plan.

However, if a member does go outside the network or sees a specialist directly, the plan pays a smaller part of the bill than if the member had followed regular HMO procedures. The member pays a higher premium for this option than for a standard HMO plan and a higher copayment each time the option is used.

## Preferred Provider Organization (PPO)

Although it has a different name, the PPO works the same as an HMO with a point-of-service (POS) option (discussed above). If a member receives a service from the PPO's network of providers, the cost to the member is lower than if the member sees a provider outside the network.

PPOs tend to be more expensive than standard HMOs, charging both a monthly premium and a higher copayment for nonnetwork services. However, many people find that the extra flexibility in choosing doctors is an important comfort to them, and therefore worth the extra money.

## Provider Sponsored Organization (PSO)

The PSO is a group of medical providers—doctors, clinics, and a hospital—that skips the insurance company middleman and contracts directly with patients. As with an HMO, the member pays a premium, as well as a copayment each time a service is used.

PSOs are rare, and you're unlikely to find one where you live. However, if a PSO operates in your area, you might want to consider it as an alternative to other types of Medicare Advantage Plans.

## Medicare Advantage Fee-for-Service Plans

Some insurance companies offer what are called “fee-for-service” Medicare Advantage plans that they tout as offering greater enrollee “freedom” in choice of doctors and other providers. Unfortunately, for reasons described below, many people discover that this freedom is mostly illusory. Nonetheless, in some places—particularly in rural areas—these fee-for-service plans are a viable alternative if there are few or no other Medicare Advantage plans available.

## How Most Medicare Advantage Fee-for-Service Plans Work

Unlike managed care plans, most Medicare Advantage fee-for-service plans cover care provided by any health care provider that accepts Medicare patients. Also, many of these plans have a cap on the total out-of-pocket payments an enrollee will pay each year for care that is covered by the plan.

### Fee-for-Service Plans With Tiered Payment

Most fee-for-service plans maintain provider networks, just like a managed care plan. With these plans, you can receive medical services from any doctor or other provider who accepts the terms of the plan. But if you receive medical services from a provider within the plan's network, your out-of-pocket costs are lower than if you receive services from a provider who isn't in the plan's network.

## Disadvantages of Medicare Advantage Fee-for-Service Plans

Fee-for-service plans impose several significant restrictions that might severely limit a patient's choice of doctors and other providers, making such a plan a poor option if other types of Medicare Advantage plans are available. These restrictions are

- **Strict rules for providers.** For any specific medical treatment or service, a doctor or another provider must accept the terms offered by the fee-for-service plan. These terms include the nature and extent of care the insurance company will approve and what the provider will be paid. If the doctor or other provider isn't willing to accept the plan's terms, the plan won't cover the particular care with that provider. In that case, the patient must either personally pay for the care or seek treatment from a different provider.

- **Lack of predictable care.** The fact that a doctor or another provider previously accepted a plan's terms doesn't mean the provider will accept the terms the next time the patient wants care, either for the same or for a different medical service. In other words, if you enroll in one of these plans, you won't know whether care from a particular doctor or other provider will be covered by the plan until the time comes when you need it.
- **Few additional services.** Unlike other types of Medicare Advantage plans, fee-for-service plans usually don't cover many extra services (services not covered by original Medicare Part A and Part B).
- **Extra costs.** In some plans, you might have to pay the doctor or other provider out of your pocket—up to 15% more than the amount the plan pays the provider.

If you're considering a private fee-for-service plan, be sure to carefully evaluate your choices by following the suggestions offered in the rest of this chapter.

## Choosing a Medicare Advantage Plan

To evaluate a Medicare Advantage plan of any type, it's important to get a complete written explanation of its coverage, costs, and procedures. These are usually contained in a printed brochure called a "summary of benefits," available from each plan. Also, ask each plan for a chart showing premiums and copayments. Compare that written information with each important category discussed in this chapter.

If you don't understand exactly what the coverage, costs, and procedures are, ask a plan representative to tell you where they're explained in the written information. If you can't get an important piece of information in writing, don't join the plan.

## Choice of Doctors and Other Providers

For many people, the most important factor in choosing a Medicare Advantage plan is whether the doctors, hospitals, and other providers they already use and trust are in the plan's network of providers or, in the case of fee-for-service plans, whether those providers regularly accept the plan's terms.

### Tracking Membership Satisfaction

Your state department of insurance or department of corporations is charged with monitoring Medicare Advantage plans. And it pays to see whether many members complain about crucial services. Most complaints are based on a plan's having:

- rejected referrals to specialists
- ordered early discharge for hospital inpatients
- dropped coverage in certain geographic areas
- dropped doctors and hospitals from its network
- raised copayments
- switched drugs on the plan's formulary, or
- dropped extra coverage.

An excellent and free source of information about Medicare Advantage plans is the State Health Insurance Assistance Program (SHIP)—in some places called the “Health Insurance Counseling and Advocacy Program” (HICAP). To find your local office, contact the SHIP or HICAP office in your state (for contact information, see the end of Chapter 13).

**Managed care plans.** If the people and places you prefer for care are in a managed care plan's network, the tight restrictions of HMOs might not have much effect on you, at least for the foreseeable future. But if they're not, you'll have to find new doctors, which is rarely an easy or comfortable process. And you might have to use a hospital that's more distant from your home, leaving you a little less secure.

The problem isn't quite as great with PPOs or HMOs with a point-of-service option. These plans permit you to use providers who aren't in a plan's network. So, if you want to continue with a particular doctor or provider who isn't in the network, you can do so, but with a higher copayment each time you use the nonnetwork provider. If you're frequently treated by nonnetwork doctors, the extra payments might cancel out the cost advantage of managed care.

**Fee-for-service plans.** Some Medicare Advantage fee-for-service plans don't have a provider network, so there's no simple way to know that the doctors and other providers you use will accept the plan for any particular treatment or service. Before joining one of these plans, it's important to talk directly with your primary care doctor and any other doctor or other provider you regularly receive care from. Ask them whether they have experience with the plan you're considering and, if so, whether they often refuse to accept the plan's terms. If your regular providers have little experience with the plan or regularly refuse the plan's offered terms, joining that plan is probably not a good idea if you want to continue being treated by those same providers.

### Help With Medicare Advantage Choices

People finding their way through the Medicare Advantage maze can get help from the State Health Insurance Assistance Program (SHIP), also frequently called the Health Insurance Counseling and Advocacy Program (HICAP). SHIP is funded by a combination of government grants and private donations and has no connection to the health care or insurance industries. SHIP provides free counseling about Medicare Advantage plans and medigap policies. Local staff can help you compare plans and policies. They can also tell you about other people's recent experiences with specific plans and policies.

To find the SHIP or HICAP office nearest you, contact your state's central SHIP or HICAP office (see the end of Chapter 13 for contact information).



## ONLINE

**Compare plans on Medicare’s website.** Medicare’s official website at [www.medicare.gov](http://www.medicare.gov) offers a link that can give you the names and contact information for insurance companies offering Medicare Advantage plans available where you live. On the [www.medicare.gov](http://www.medicare.gov) home page, click “Health & Drug Plans.” Then look under “Find & Compare” and click “Find health & drug plans.” This takes you to a page that asks for your zip code and the type of plan you’re looking for. This page can then take you to information about specific Medicare Advantage plans being sold where you live, including basic information about what the policies cover and how to contact the insurance companies offering those plans.

In addition, it offers patient satisfaction ratings and statistics on how many people have left each plan. Be aware, though, that the information on this page is only intended to give you basic information about these health plans. To get the detailed information you need—about costs, networks, and coverage—to make a decision, you must contact the plans themselves. Also, you should always double-check such information with your local SHIP or HICAP office, because some of it might be out of date, and it might not include how many people have been dropped by the plan.

## Access to Specialists and Preventive Care

The requirement that you must visit your primary care physician to obtain most referrals to other providers is one of the main customer objections to managed care plans.

### Referrals

Your primary care physician refers you for testing, laboratory work, and treatment by most specialists. Speak with your primary care doctor and other providers you see regularly about their experiences with a particular plan. Does the plan often overrule the doctor’s recommendation? Has the plan set guidelines for the doctors that might affect their ability to send you for treatment?

### Direct Access to Specialists Through Treatment Plans

Medicare rules require managed care plans to develop a specific treatment plan for patients with a complex or serious condition, such as heart disease, cancer, or kidney failure. The treatment plan must outline what specialists you require, and it must allow you to see them without continuing to get referrals from your primary care doctor. If you have a condition that requires regular care by specialists, find out from the plan whether your condition is considered sufficiently serious or complex to permit direct access to those specialists.

### Preventive Care Options

Under Medicare rules, a managed care plan must permit members to obtain routine preventive women's health care screening from a gynecologist without first seeing a primary care physician. It must also permit a member to obtain Medicare-covered mammograms without a referral. Find out from a managed care plan how often other preventive care services—such as physical exams, prostate screening for men, cholesterol testing, or hearing exams—are covered by the plan.

### Now You Get Coverage, Now You Don't

The government doesn't regulate Medicare Advantage plan coverage except to insist that the plans offer at least basic Medicare benefits. Nor is there any regulation of premiums and copayments. What this means is that Medicare Advantage plans are free to change coverage and charges at renewal time.

Plans might cut back on coverage. In some plans, benefits are shifted from no-premium plans to deluxe plans with a premium. Raising copayments for specific services—particularly prescription drugs—is also common, as is restricting access to certain medications.

But to compete with other insurance plans, your plan might expand coverage. In recent years, for example, short-term custodial care and overseas travel coverage have been added to many plans, although most charge an added premium for these "extras."

## Prescription Drug Coverage

Many people get prescription drug coverage through their Medicare Advantage plan, rather than through a separate Medicare Part D drug plan.

If you're thinking about joining a Medicare Advantage plan with prescription drug coverage, it's very important that you examine that coverage closely. Review that coverage just as you would when considering a stand-alone prescription drug plan. (See "Part D: Prescription Drug Coverage" in Chapter 12.) In particular, you must determine whether the plan:

- includes on its formulary (its list of covered drugs) the drugs you regularly take
- charges reasonably low copayments for those drugs, and
- imposes no significant access restrictions to those drugs.

Once you've determined how well various Medicare Advantage plans cover the particular prescription drugs you take, you must weigh that information along with the other aspects of the plans discussed in this chapter. If you use many costly prescription drugs, how well a particular plan covers your drugs should be a major part of your decision. If you use few prescription drugs, then the other aspects of a plan might influence your decision more strongly.

Before you choose any Medicare Advantage plan, be sure to investigate the stand-alone Part D prescription drug plans that are available to you. Then, add the costs of the Part D stand-alone drug plan that best covers your drugs to the costs of a Medicare Advantage plan without drug coverage. It's this combination of costs and stand-alone Part D drug coverage benefits that you should consider when comparing these plans to other Medicare Advantage plans that include drug coverage.

### Consider Total Costs, Not Just Premiums

Many Medicare Advantage plans, particularly managed care plans, charge relatively small premiums, often much lower than the combined premiums of a medigap policy plus a Part D drug plan. But premiums don't tell the whole story of what your supplemental Medicare coverage will actually cost you. This is because a Medicare Advantage plan's medical coverage and its prescription drug coverage will both require you to make copayments.

Most Medicare Advantage managed care plans charge a copayment for doctor visits (usually \$5 to \$20), and many older people frequently consult several doctors. Drug coverage is offered only for drugs on a plan's formulary (see "Part D: Prescription Drug Coverage" in Chapter 12), and copayments vary depending on the type of medication and whether it's a brand-name or generic drug. Within these parameters, Medicare Advantage drug copayments can run up to 25% of the drug's actual retail cost.

By law, there's a limit on out-of-pocket expenses for members of Medicare Advantage plans. For 2024, the maximum out-of-pocket limit is \$8,850, not including out-of-pocket costs for prescription drugs. Each plan sets its own limit up to this maximum, with many plans setting a limit well below the maximum.

Only by comparing the copayments and premiums of various plans can you fully understand how much each plan is likely to cost you.

### Extent of Service Area

Consider the extent of a plan's service area, particularly if you live in a rural or spread-out suburban area. If the service area isn't broad enough to include a good selection of specialists, you might find your future care choices limited.

Also, find out whether the plan has what are called “extended service areas.” Some plans permit you to arrange medical care far from your home if you travel frequently or spend a regular part of the year away from its primary service area. This allows you to take care of nonurgent medical needs even if you’re not at your primary residence.

### **Appealing a Plan’s Decision About Your Care**

Up to 10% of prior authorization requests for services are denied by Medicare Advantage plans as being medically unnecessary or otherwise not covered. This phenomenon of having an insurance company overruling your doctor can be upsetting, and if it involves a serious condition, the plan’s rejection can be devastating, either to your health or to your wallet.

There’s a standard process for you to appeal such a denial of coverage. Unfortunately, the first step in the review process is handled by the plan’s insurance company itself. The plan will provide you with a written decision denying the coverage, which will also include instructions for filing the initial step in your appeal. This first step is a written request for reconsideration of their decision; you must do so within 60 days of receiving the notice from the plan denying coverage. The plan must then make a reconsideration decision within a set time limit: 30 days for a decision regarding coverage of a service you want to have performed, 60 days regarding payment for a service you’ve already had.

If the plan doesn’t provide the coverage you want after this initial reconsideration, your next step is to appeal to an independent review entity (IRE) that doesn’t work for the plan insurance company. At this point, your appeal will follow the same procedures as if you were in traditional Medicare, as explained in Chapter 13.

## Other Plan Features

Many Medicare Advantage plans offer a variety of features beyond basic Medicare coverage. The following benefits are either extra services some plans cover or major medical expenses for which some plans pay a portion of the total costs. If you're likely to use any of these benefits, a plan that offers them might be more attractive to you.

### Short-Term Custodial Care

Following an injury, a surgery, or a serious illness, you might not be strong enough to take care of yourself, but you might not require skilled nursing care. Instead, you might need what's called custodial care—help with dressing, bathing, eating, and other regular activities of daily living.

Custodial care isn't covered at all by Medicare, unless you're already receiving skilled nursing care or therapy. But some Medicare Advantage plans offer coverage for short-term custodial care, either at home from a certified home health care agency or in a certified care facility.

Such plans usually limit the number of home care visits or days you can spend in a care facility, and charge copayments as well as a separate premium for the coverage. Despite these limitations, this can be valuable added coverage, because many seniors can use this kind of care at some point.

### Medical Equipment

By way of reminder, traditional Medicare Part B pays 80% of the amount it approves for most doctor-prescribed medical equipment, such as wheelchairs, hospital beds, ventilators, and prosthetic devices. But the recipient is responsible for 20% of the approved amount, plus anything above that amount if the equipment company doesn't accept Medicare assignment. Some Medicare Advantage plans, on the other hand, pay the full cost of prescribed medical equipment, although it must be purchased or rented from a provider in the plan's network or, if you choose a fee-for-service plan, from a provider that accepts the plan's terms and payment levels.

### **Chiropractic Care, Acupuncture, and Acupressure**

Medicare pays for a very limited amount of chiropractic care and pays nothing at all for acupuncture or acupressure treatment. Some Medicare Advantage plans cover a greater amount of chiropractic care. And a few recognize the value of acupuncture and acupressure and pay for some of the cost.

Treatments must be received from providers in the plan's network or those who accept the plan's terms, and a copayment is almost always charged for each visit. However, if you regularly use one of these treatments and your practitioner happens to be in the plan's network or regularly accepts your fee-for-service plan's terms, this coverage can be a good money saver.

### **Foreign Travel Coverage**

Many people travel abroad to visit family; others hope to do some foreign traveling during retirement. Medicare provides no coverage for medical costs incurred outside the United States, nor do most Medicare Advantage plans. But a few Medicare Advantage plans offer coverage for emergency care while abroad. And some also offer free or low-cost immunizations for foreign travel. If you plan on traveling abroad frequently or for long stays, this coverage can be valuable.

### **Eye Examinations and Glasses**

Medicare covers only eye examinations and optometry services that are necessary because of an eye disease or other medical condition. It doesn't pay for regular vision testing or for eyeglasses or contact lenses, except after cataract surgery. A number of Medicare Advantage plans, however, offer some kind of bonus vision coverage, although none of them pays the full cost of glasses.

Some plans cover an eye examination every two years and offer a set annual amount toward prescription lenses. Instead of a set amount, other plans offer discount examinations, lenses, frames, and contacts from optometrists who participate in the plan's network.

### **Hearing Tests and Hearing Aids**

Some Medicare Advantage plans offer a free regular hearing exam, plus discounts on hearing aids. As with other Medicare Advantage coverage, the care must be obtained from a hearing center that is connected to the plan's network or that accepts the plan's terms and payment amounts.

### **Dental Work**

A few Medicare Advantage plans offer discounts on dental work. The discounts usually include a low copayment for cleaning and examination and up to a 35% reduction in the cost of other services. The networks of dentists are usually quite limited, however. Finding a dentist who participates in the plan—and with whom you're comfortable—is the key to making this extra coverage worthwhile.

### **After-Hours Advice and Treatment**

People don't always become ill during regular office hours. But visiting an emergency room can be a miserable—and often unnecessary—experience. Some Medicare Advantage managed care plans maintain 24-hour phone lines staffed by experienced nurses who can help you stay out of the ER. Other plans—usually provider-sponsored organizations or individual groups of doctors within larger HMOs—maintain evening and weekend clinics. There, you can consult a doctor for a lower copayment and less stress than a visit to an emergency room.

### **Chronic Disease Management and Wellness Programs**

The managed care industry does better than original Medicare in recognizing how much money it saves by monitoring and managing chronic conditions and offering programs to improve general health. As a result, many managed care plans offer free or low-cost educational and monitoring programs to help people with chronic illness keep their conditions under control. Some programs include blood pressure and cholesterol education for heart patients, diabetes

classes to control blood sugar levels, and classes for Parkinson's patients to reduce their risk of falls. Some plans offer programs to help people lead healthier lives, such as nutrition and exercise programs to improve flexibility and cardiac health, to help lose weight, and to help you quit smoking.

### Added Services in Some Plans

Some Medicare Advantage plans offer additional services not required by Medicare law. These might include:

- adult day care programs
- in-home aides for nonmedical assistance with the activities of daily living (such as dressing, bathing, toileting)
- palliative care at home for seriously ill patients
- help paying for home safety devices such as grab bars and wheelchair ramps
- transportation to and from medical appointments, and
- special services for chronically ill patients, tailored to their specific needs.

Not all plans will offer all of these new services, and the amount paid will vary from plan to plan. But if any of these are services that are likely to be of use to you, you might want to consider them when choosing a Medicare Advantage plan.

## Comparing Medigap and Medicare Advantage Plans

After you've found several medigap (see Chapter 14) and Medicare Advantage plans that seem to fit your needs and budget, the best way to compare them is to view their costs and coverage side by side. Refer to the "Comparing Medigap to Managed Care" chart below for a comparison of the major benefits of medigap and Medicare Advantage plans. Then, use the next chart to help you compare the actual plans you're considering.

Comparing Medigap to Managed Care		
	Medigap Plans	Managed Care Plans
<b>Choice of Doctor and Providers</b>	As long as doctor or other provider accepts Medicare, a medigap policy will cover whatever Medicare does.	Choice restricted to doctors and providers in the network. PPO and some HMO options allow nonnetwork providers at higher cost. Fee-for-service plans cover care only from providers who accept a plan's terms.
<b>Access to Specialists</b>	As long as specialist accepts Medicare, a medigap policy will cover whatever Medicare does.	Must get referral from primary care doctor to specialist also in plan's network. Limited direct access available for some serious conditions. In fee-for-service plans, specialist must accept plan's terms.
<b>Premiums</b>	Vary widely, with higher cost for plans with more services. Plan A: \$50–\$400/month. Plans B–G: \$100–\$400/month. Plans H–J: \$75–\$500/month (\$150–\$500/month for continuing plans with drug coverage). Plan K: \$50–\$150/month. Plan L: \$75–\$200/month.	Usually no or low premium for basic HMO that provides coverage equal to traditional Medicare Part A and Part B. Member must pay Medicare Part B premium. Broader coverage or more provider choices might cost between \$25–\$200/month.
<b>Copayments</b>	No copayments for services except under Plan N policies, which charge a \$20 copayment for each doctor's office visit and \$50 for each emergency room visit.	Require copayment for most services, generally \$5–\$25 per visit. In fee-for-service plans, might be responsible for up to 15% more than what plan pays.
<b>Treatment Approval</b>	Automatic if service is covered by Medicare.	Coverage denied if plan decides that treatment is medically unnecessary (perhaps if a different, cheaper treatment is available) or experimental.
<b>Geographic Mobility</b>	Most plans can be used wherever you obtain Medicare-covered services in the United States.	With managed care plans, nonemergency coverage limited to specific geographical area. Some plans offer care away from home. All plans must cover emergency care anywhere in the United States.

Comparing Medigap to Managed Care (continued)		
	Medigap Plans	Managed Care Plans
<b>Emergency Care Overseas</b>	Covered by Plans C–J, M, and N.	Some plans cover, but might charge a higher premium.
<b>At-Home Recovery</b>	Covered by Plans D, G, I, and J, but only if also receiving skilled nursing care at home (only if issued before June 1, 2010).	Some plans cover, but for a higher premium and copayment.
<b>Eye Exams and Glasses</b>	No, unless connected to illness or injury.	Most offer limited discounts on exams and lenses.
<b>Hearing Exams and Aids</b>	No, unless connected to illness or injury.	Most offer discounts on exams and hearing aids.
<b>Dental Discounts</b>	No.	Some offer discounts.
<b>Wellness Programs</b>	No.	Many offer a variety of low-cost or free wellness programs, including heart-healthy education, weight loss, quitting smoking, and cholesterol management.
<b>Chiropractic Care</b>	Only if covered by Medicare.	Some offer broader coverage than Medicare.
<b>Prescription Drugs</b>	No coverage (except for some people who had a Plan H, I, or J prior to January 1, 2006 and who keep that plan). Requires purchase of a separate stand-alone Medicare prescription drug plan. Must add the premium cost of the Medicare drug plan to the cost of the medigap policy when comparing costs with a managed care plan. Must also compare the drug copayments of the drug plan against the copayments of the managed care plan.	Some plans offer coverage, with copayments of \$0–\$25 per prescription. Amount of copay depends on whether you use generic or brand-name medication and your specific plan's formulary list (which might have separate copayment levels for different medications).

### Comparing Medigap Policies and Managed Care Plans

		Plan Name	Plan Name	Plan Name	Plan Name	Plan Name
Cost (monthly premium)						
Copayments (amount I must pay per visit)						
Other Medicare gaps left unfilled						
Is there coverage outside the plan?	Yes					
	No					
Cost of care outside the plan						
Dental care covered	Yes					
	No					
Choice of dentists	Yes					
	No					
Short-term custodial care	Yes					
	No					
Eyeglasses	Copayments					
	Visits per year					
Other services:						
Hearing exam	Yes					
	No					
Chiropractic	Yes					
	No					
Foreign travel	Yes					
	No					
Exercise program	Yes					
	No					
Other	Yes					
	No					
Prescription drug coverage (compare Part D drug plans and managed care plans)	Copayments					
	Annual limit					

## **Your Rights When Joining, Leaving, or Losing a Medicare Advantage Plan**

Insurance companies offering Medicare Advantage plans are free to charge whatever they want in premiums and copayments. They alone decide what types of medical care to cover, although they must provide at least the same basic services that Medicare does. Moreover, they might offer a Medicare Advantage plan one year and withdraw it the next—leaving its beneficiaries without coverage. Some Medicare Advantage plans do this region by region around the nation, deciding which spots are profitable enough for them and dropping plans—and the people in them—in places that don't measure up.

Despite this general corporate freedom for Medicare Advantage insurance companies, they must follow a few rules concerning people's rights to join or to leave their plans.

### **Joining When First Eligible for Medicare at Age 65**

When you approach age 65, you have an initial seven-month window in which to sign up for a Medicare Advantage plan (if you're otherwise eligible for Medicare and you sign up for Parts A and B). This seven-month period begins three months before the month you turn 65 and ends three months after the month in which you turn 65. During this period, you can join any Medicare Advantage plan that operates in the county of your primary residence. The plan must accept you, on the same terms and conditions as anyone else of your age, without any medical screening and regardless of your medical history or physical condition (unless you have ESRD and aren't already getting health benefits through the same organization that

offers the Medicare Advantage plan you want to join). If you don't sign up during this initial period, you can join later during a plan's open enrollment period (see below).

## Joining During a Plan's Open Enrollment Period

Every Medicare Advantage plan must have at least one month every year of what's called "open enrollment"—meaning that during that time, anyone eligible for Medicare can join the plan regardless of their medical history or condition. Open enrollment is October 15 to December 7 each year, with coverage to begin the following January 1. But some plans also have more open enrollment during other months of the year.

## Joining During Extended Open Enrollment Period

There's an extra open enrollment period for Medicare Advantage plans. Anyone already enrolled in a Medicare Advantage plan can enroll in another Medicare Advantage plan or drop an existing Medicare Advantage plan and return to original Medicare, between January 1 and March 31. If you enroll in a plan during this extended enrollment period, your coverage will begin on the first day of the following month. This enrollment period is called the "Medicare Advantage Open Enrollment Period."



### TIP

**You can switch to a highly rated plan any time.** If a Medicare Advantage plan is rated five stars by Medicare, you don't have to wait for an Open Enrollment Period to switch to it. You can switch to a five-star plan any time of the year, except for the first week of December (but you can only use this exception once per year).

## Leaving a Medicare Advantage Plan

When you can leave a Medicare Advantage plan depends on how long ago you joined. If you first enrolled in a plan during your initial Medicare eligibility period, you can drop the plan anytime during the first 12 months and revert to original Medicare coverage. If you want to switch to a new Medicare Advantage plan, you can do so during the open enrollment period from October 15 to December 7 each year (for coverage to start the following January 1) or during the extended enrollment period from January 1 through March 31 each year (for coverage to start the first of the following month).

After your first year of membership in a plan, you can leave the plan and join another plan, or return to original Medicare coverage, either during the open enrollment period from October 15 to December 7 each year (for coverage to start the following January 1) or during the extended enrollment period from January 1 through March 31 each year (with coverage starting the first of the following month).

## Joining When Dropped From Another Medicare Advantage Plan

If you have been enrolled in a Medicare Advantage plan and that plan notifies you—by October 1—that, at the end of the year, it’s dropping the plan in the county where you live, you have several options. You can return to original Medicare Part A and Part B coverage, and you’re guaranteed the right to supplement that coverage by purchasing one of several medigap insurance policies. (See “Finding the Best Medicare Supplement” in Chapter 14 for a discussion of choosing a medigap policy.)

Or, you can enroll in any other Medicare Advantage plan being sold in your county, if the plan hasn’t reached its membership limit for the year. You have this right to join a new Medicare Advantage plan during a special enrollment period from December 8 through the last day of February.

## Joining When Moving to a New Geographic Area

Each Medicare Advantage plan serves only a specific geographic area, often a single county. If you move from the plan's service area, you lose the right to continued coverage with that Medicare Advantage plan.

If you move out of a plan's service area and want a Medicare Advantage plan, you must apply to a plan that serves your new community. If you notify your current plan before you actually move, you have the right to enroll in a new plan (that operates in your new area) beginning the month before the month during which you move, and continuing for two full months after you move. If you don't notify your existing plan until after you move, you have a right to switch plans beginning the month you notify your plan, plus two more full months thereafter. You also have the right to join a new Medicare Advantage plan (one that operates in your new area) during that plan's open enrollment period, which runs from October 15 through December 7, and sometimes longer, each year. ●



## Medicaid and State Supplements to Medicare

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**W**hen all types of medical expenses for older Americans are added up, Medicare pays for only about half of them. If you have a low income and few assets other than your home, however, you might qualify for assistance from your state's Medicaid program (called Medi-Cal in California). Medicaid can not only pay Medicare premiums, deductibles, and copayments, it also covers some services Medicare does not.

If you have low income and assets, but either is too high to be eligible for Medicaid, you could still qualify for one of several Medicaid-administered programs to help you meet medical costs: Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualifying Individual (QI). (For a discussion of these programs, see “Other State Assistance With Medical Costs,” below.)

## Medicaid Defined

Medicaid's purpose is to help pay medical costs for financially needy people. The program was established by the federal government and is administered by the individual states. Medicaid operates in addition to Medicare to pay for many of the medical costs Medicare doesn't cover.

The basic difference between Medicare and Medicaid is simple: Medicare is available to almost everyone age 65 or older, regardless of income or assets, while Medicaid is available only to people over 65 or disabled, to families with minor children, and to foster youth and former foster youth until age 26—and in some states, to individuals of any age—who are financially needy. Just how “needy” you must be in order to get Medicaid is up to the state in which you live. (Note: Children with certain disabilities and foster youth and former foster youth until age 26 may be eligible for Medicaid without regard to financial need.)

There are currently almost 50 million adults who receive some form of Medicaid assistance; about 10 million of them are also on Medicare. (For a fuller comparison of the programs, see “Medicare: The Basics” in Chapter 12.)

There are federal guidelines for Medicaid, but within them, each state is permitted to make its own rules regarding eligibility, coverage, and benefits. This chapter explains the basic eligibility and coverage rules of Medicaid and indicates where eligibility standards might be higher or lower than the basic levels.

## Who Is Eligible

Generally, states use one of two ways to determine who is eligible for Medicaid. One way is to base eligibility on income and assets alone (“categorically needy”). The other is to base eligibility on income and assets plus medical costs (“medically needy”).

### **Medicaid Eligibility Expanded to People Under 65 in Some States**

Under Medicaid rules that have been in effect since the program’s beginnings, eligibility has generally been limited to people who are age 65 or older, disabled, or have minor children, if they also met the financial standards discussed in the following sections. However, under the health care reform law passed in 2010, individual states were allowed to expand Medicaid eligibility to financially needy people of any age. Over three-quarters of the states have decided to expand Medicaid under the Affordable Care Act.

## Categorically Needy

To qualify for Medicaid as categorically needy, your income and assets must be at or below certain dollar amounts. Some states use the same income and asset limits set by the federal Supplemental Security Income, or SSI, program. Other states establish their own Medicaid limits.

## SSI-Based Standards

In most states, you can automatically receive Medicaid if you're eligible for SSI assistance. To be eligible for SSI, you can't earn more than about \$1,400 to \$2,000 per month, or about \$2,000 to \$2,900 for a couple with both spouses eligible for SSI, though these amounts can vary depending on your state. Also, you can't possess cash and other assets of more than \$2,000 for an individual and \$3,000 for a couple.

Fortunately, a number of important assets aren't counted in the SSI eligibility calculation. You can own:

- your own home of any value
- a car (though in some states, only up to a certain market value)
- engagement and wedding rings
- household goods
- life insurance, and
- a burial fund.

(For details of SSI eligibility rules, see Chapter 7.)

## State Standards

States have gone in all directions when establishing their own Medicaid standards. In a few states, the standards are slightly less difficult to meet than SSI standards. In some others, the standards are stricter, including a dollar limit on the value of your home and lower limits on the values of your automobile and other property.

To find out your state's standards, contact your local county department of social services or department of welfare. You can also find the basic Medicaid eligibility requirements in your state by visiting the website of your state's Medicaid program. To find that website, go to [www.medicaid.gov](http://www.medicaid.gov), to the "Medicaid" tab, and then under "Program Information," click "Medicaid & CHIP Eligibility Levels."

Not all income is counted when Medicaid considers your eligibility, so if you're anywhere close to the eligibility limits in your state, consider applying for Medicaid or a state Medicare supplement (described in "Other State Assistance With Medical Costs," below) as well.

## Medically Needy

What if your income and assets are higher than your state's Medicaid limit under the categorically needy standard, but your medical expenses cancel much of this out? You might be what's called "medically needy" and eligible for Medicaid coverage in some states. Medically needy means your income and assets are over the Medicaid eligibility levels for your state but your current or expected medical expenses will reduce your income or assets to eligible levels.

This process of subtracting actual medical bills from income and assets is called "spending down," in Medicaid slang—because medical bills would force you to spend your extra money down to the point that you would meet eligibility levels.

The following states offer Medicaid coverage to medically needy people (but note that income limits vary from state to state, and some states limit benefits to children, people 65 or older, persons with disabilities, and pregnant women):

Arkansas	Louisiana	North Carolina
California	Maine	North Dakota
Connecticut	Maryland	Pennsylvania
District of Columbia	Massachusetts	Rhode Island
Florida	Michigan	Tennessee
Georgia	Minnesota	Utah
Hawaii	Montana	Vermont
Illinois	Nebraska	Virginia
Iowa	New Hampshire	Washington
Kansas	New Jersey	West Virginia
Kentucky	New York	Wisconsin

**EXAMPLE:** Roberta's income is low, but her savings are \$2,000 more than what is allowed to qualify for Medicaid as categorically needy by the rules in her state. However, surgery, home nursing care, physical therapy, and medication have left Roberta with medical bills of almost \$3,000 (not paid for by Medicare). Roberta's state offers Medicaid coverage to the medically needy. If she paid her \$3,000 medical bills, she would be spending her savings down to a level that would meet the Medicaid standards. Instead of forcing her to spend that money and be reduced to Medicaid savings levels, Roberta qualifies immediately for Medicaid, which will pay the bills.

### Medicaid When One Spouse Is in a Nursing Home

The Medicaid rules get a bit tricky when one spouse is in a nursing home paid for by Medicaid while the other spouse remains at home. Some states look only at income in the nursing home resident's name, but other states consider the joint income of both. A monthly income allowance is permitted for the at-home spouse, and some of the nursing home resident's income can be used to support the at-home spouse. At-home spouses are also allowed to keep their homes and to retain between about \$30,000 and \$150,000 in other assets, depending on the state. These figures go up periodically, usually on January 1 or July 1 of each year.

However, Medicaid can also place a lien on the home or on other assets in an amount equal to the entire amount Medicaid spends on nursing home care for the spouse. When the at-home spouse dies or sells the house, Medicaid will enforce the lien, taking money that the at-home spouse would otherwise be able to spend or leave to survivors.

To take best advantage of Medicaid coverage for long-term care, it is important to understand these rules and also the alternatives to nursing homes that can serve your needs while preserving as much of your savings as possible.

Long-term care and how it's paid for, including a comprehensive discussion of Medicaid nursing home rules, is covered fully in *Long-Term Care: How to Plan & Pay for It*, by Joseph L. Matthews (Nolo).



## TIP

**If your income and assets are a little too high for Medicaid, the government might help through other programs.** If your income and assets are low but slightly too high for you to be eligible for Medicaid in your state, you might still be eligible for state Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualifying Individual (QI) benefits. These programs help meet medical costs not paid for by Medicare. You might also qualify for a low-income subsidy to help pay the costs that come with Medicare Part D prescription drug coverage. (See “Other State Assistance With Medical Costs,” below, for details.)

## Determining Couples’ Income and Assets

In determining your eligibility, Medicaid generally considers your income and assets plus those of your spouse, if you live together. If you’re divorced or separated and living apart, your spouse’s income and assets aren’t counted, except to the extent that your spouse is actually contributing to your support.

This rule of considering a spouse’s income in determining Medicaid eligibility has had the unfortunate effect of keeping many older couples from marrying. They fear that if they marry, a serious illness could bankrupt both of them before they would become eligible for Medicaid assistance.

If both spouses become eligible for Medicare, however, this loss of Medicaid might not be as serious, and marriage might make financial sense in other ways. For example, when spouses marry, each becomes eligible at age 62 for Social Security dependents benefits based on the other’s work record. If one person has earned considerably higher Social Security or civil service benefits than the other, this ability to get dependents benefits might make a considerable difference. (See Chapter 4 regarding dependents and Chapter 10 regarding civil service benefits.) The same is true of Social Security or civil service survivors benefits. Marriage would allow one spouse to claim these benefits when the other dies and to collect them for life (see Chapters 5 and 10 for details).

## Financial Help From Friends or Family

The income or assets of your children, other relatives, or friends, even if you live with them, aren't considered in deciding your Medicaid eligibility. However, if you receive regular financial support from a relative or friend—cash or help with rent—Medicaid can consider that assistance as part of your income.

Also, if you're living rent free with children or other relatives and they give you all of your food and clothing, Medicaid could put a dollar amount on that support and count it as part of your income. This doesn't happen frequently. But it is possible that, during the application process, the person reviewing your eligibility could visit your home and determine whether you're receiving substantial, regular income in the form of noncash support.

## Medical Costs Covered by Medicaid

Medicaid covers the same kinds of services as Medicare and, in most states, also covers a number of medical services Medicare does not.

One of its best features is that it covers most long-term care, both at home and in nursing facilities. This includes not only long-term skilled nursing care, but also nonmedical personal care—such as adult day care and at-home assistance with the activities of daily living (ADLs).

Medicaid also pays many of the amounts Medicare does not pay in hospital and doctor bills. Specifically, this means Medicaid pays:

- the inpatient hospital insurance deductible and coinsurance amounts that Medicare doesn't pay
- the Medicare Part B medical insurance deductible
- the 20% of the Medicare-approved doctors' fees that Medicare medical insurance doesn't pay (for traditional Medicare), and
- the monthly premium charged for Medicare Part B medical insurance.

## Services Covered in Every State

In every state, Medicaid completely covers certain medical services, paying whatever Medicare does not.

These services include:

- inpatient hospital or skilled nursing facility care
- nursing home care in approved facilities
- outpatient hospital or clinic treatment
- laboratory and X-ray services
- physicians' services
- home health care, and
- transportation—by ambulance, if necessary—to and from the place you receive medical services.

### **Most Prescription Drug Coverage Comes From a Medicare Part D Drug Plan or a Medicaid Managed Care Plan**

For people who are eligible for both Medicare and Medicaid (known as “dual eligibles”), Medicaid doesn't provide much prescription drug coverage. Instead, a dual-eligible person must receive most drug coverage through a Medicare Part D prescription drug plan or through a Medicaid/Medicare managed care plan.

People who become dually eligible will be automatically signed up for either a special Medicaid/Medicare managed care plan with drug coverage or a Part D prescription drug plan. A dual eligible who doesn't like the coverage or access to drugs offered by the automatic-enrollment Part D plan can switch plans at any time. Automatic enrollment for dual eligibles and their right to switch plans is explained in the sections that discuss Part D prescription drug coverage in Chapters 12 and 13. If someone is enrolled in a Medicaid managed care plan, you can switch to another plan during certain periods each year.

Medicare Part D provides coverage for most categories of drugs but not all. To fill these gaps, many state Medicaid programs cover some of the drugs, both prescription and over the counter, that Medicare Part D plans don't.

## Optional Services

In all states, Medicaid also covers many other types of medical services that Medicare doesn't. However, state Medicaid programs aren't required to cover these optional services, and in some states they might charge a nominal fee for them. (See "Cost of Medicaid Coverage," below.)

Most states provide the following optional medical services commonly used by older people:

- **Prescription drugs.** All states provide Medicaid coverage for prescription drugs, though there might be a small copayment for each prescription filled. For people eligible for Medicare as well as Medicaid (dual eligibles), however, Medicaid no longer covers most drugs. Instead, dual eligibles receive their drug coverage through a separate Medicare Part D plan or a Medicaid managed care plan. In some states, though, Medicaid covers the cost of some prescription and over-the-counter drugs for dual eligibles that Medicare Part D plans don't cover.
- **Eye care.** Standard eyesight exams (every one to two years), plus the cost of eyeglasses.
- **Dental care.** Routine dental care, though the list of dentists whom you're allowed to see might be quite limited; most states also cover the cost of dentures.
- **Transportation.** Nonemergency transport to and from medical care, usually with some sort of van service under contract to the county.
- **Physical therapy.** Some amount of physical therapy beyond the very limited amount covered by Medicare.
- **Prosthetic devices.** All states cover the costs of medically necessary prosthetics beyond what is paid for by Medicare.

The types and amount of coverage for other optional services vary widely from state to state. However, these other optional services often include chiropractic care, podiatry, speech and occupational therapy, private-duty nursing, personal care services, personal care and case management services as part of home care, adult day care, hospice care, various preventive, screening, and rehabilitative services, and inpatient psychiatric care for those 65 and older.

## Medicaid Through Managed Care

People who qualify for both Medicaid and Medicare are known as “dual eligibles.” Increasingly, Medicaid and Medicare coverage is offered to dual eligibles through managed care (an HMO or similar plan). In some cases, these managed care plans are optional—a dual eligible can choose to receive traditional Medicare Part A and Part B and enroll in a Medicare Part D prescription drug plan, with Medicaid paying for the Medicare premiums and also providing some additional coverage (which varies from state to state). In many geographic regions, though, dual eligibles who want Medicaid coverage are required to enroll in a Medicaid managed care plan.

These Medicaid managed care plans operate like Medicare Advantage plans, explained in Chapter 15. Their advantage for the patient is that all medical care—inpatient and outpatient, and usually prescription drugs—is handled by a single program, instead of the patient having to negotiate both Medicare and Medicaid, and perhaps a private insurance company for drug coverage. However, these plans require that medical care be received only from certain doctors, hospitals, clinics, and other providers, and they control a patient’s ability to see specialists.

Some of these managed care plans for dual eligibles are called “Special Needs Plans” (SNPs). These plans are specially designed for people with specific chronic conditions. The major difference between an SNP for dual eligibles and other Medicaid managed care plans is that an SNP has what’s called a “care coordinator” or an “interdisciplinary care team” that helps the patient deal with the different medical providers that people with such conditions often see, and tries to help the patient follow all medical instructions and properly take medications. If you’re interested in an available SNP for dual eligibles, you can enroll in it at any time of the year.

### Medicaid Through Managed Care (continued)

Each participating Medicaid/Medicare managed care plan for dual eligibles operates differently. Your county department of social services (or other department that administers Medicaid in your state) can explain what Medicaid managed care options are available to you. To help compare such a managed care plan with standard Medicare and Medicaid coverage—if your Medicaid program gives you the choice—contact the SHIP office nearest you for free counseling (see contact information at the end of Chapter 13).



#### CAUTION

**Coverage changes frequently.** Medicaid coverage for optional services changes frequently, with states adding some services and dropping others. Check with your local social services or social welfare office for the latest. You must also find out the terms on which such optional services are offered. Sometimes you can obtain such services only if the care is provided by county or other local health clinics, rather than from a private doctor or clinic of your choice.

## Requirements for Medicaid Coverage

Even if a particular medical service or treatment is generally covered by Medicaid, you must make sure that the care was prescribed by a doctor, administered by a provider who participates in Medicaid, and determined to be medically necessary.

### Care Must Be Prescribed by Doctor

The medical service you receive must be prescribed by a doctor. For example, Medicaid won't pay for chiropractic services or physical therapy you seek on your own. And if it pays for certain prescription medications, it might not pay for an equivalent medicine you could buy over the counter.

For services in which a medical doctor is generally not involved—such as regular eye exams or dental care—Medicaid might place restrictions on how often you can obtain the service and who can authorize it. And Medicaid will cover some services for those who qualify as medically needy only if the care is provided by certain public health hospitals, clinics, or agencies.

### **Provider Must Participate in Medicaid**

You must receive your treatment or other care from a doctor, a facility, or other medical provider that participates in Medicaid. The provider must accept Medicaid payment—or Medicare plus Medicaid—as full payment. And if you see a nonphysician, such as a physical therapist or chiropractor, or are visited by a home care agency, that provider must be approved by Medicaid.

Not all doctors and clinics accept Medicaid patients. So, before you sign up with any doctor or other provider, ask whether they accept Medicaid payment.

### **Treatment Must Be Medically Necessary**

All care must be approved by Medicaid as medically necessary. For inpatient care, the approval process is similar to the one used for Medicare coverage. By requesting your admission to a hospital or another facility, your doctor sets the approval process in motion. You won't need to be involved. In fact, you won't even hear about it unless the facility decides you should be discharged before your doctor thinks you should. (See “What to Do If You're Denied Coverage,” below.)

Prior approval from a Medicaid consultant is required before you obtain certain medical services. The rules vary from state to state, requiring prior approval for such services as elective surgery, some major dental care, leasing of medical equipment, and nonemergency inpatient hospital or nursing facility care.

If a particular medical service requires prior Medicaid approval, your doctor or the facility will contact Medicaid directly. You might be asked to get an examination by another doctor before Medicaid will approve the care, but this doesn't happen often.

If you have questions about the approval process, discuss it with both your doctor and a Medicaid worker at your local social service or welfare office. Ask what Medicaid considers most important in making the decision about the medical care you're seeking. Relay that information to your doctor, so that the doctor can provide the necessary information to Medicaid.

## **Cost of Medicaid Coverage**

Almost all Medicaid-covered care is free. And Medicaid also pays your Medicare premium, deductibles, and copayments if you're a dual eligible. However, there are a few circumstances in which you might have to pay small amounts for Medicaid-covered care.

### **No Payments to Medical Providers**

Hospitals, doctors, and other medical care providers who accept dual-eligible Medicaid patients must accept Medicare's approved charges—or the amount approved directly by Medicaid if it's not covered by Medicare—as the total allowable charges. They must accept, as payment in full, the combination of payments from Medicare and Medicaid or from Medicaid alone; they can't bill you for the 15% more than the Medicare-approved amount (which they could do if you weren't on Medicaid).

### **Fees to State Medicaid Agency for Services**

Federal law permits states to charge some small fees to people who qualify for Medicaid as medically needy. (See "Who Is Eligible," above, for the definition.) If you qualify as categorically needy, however, states can charge you a fee only for optional covered services. (See "Optional Services," above, for a description of these services.) State Medicaid charges will take one of three forms: an enrollment fee, a monthly premium, or copayments.

### Enrollment Fee

Some states charge a small, one-time-only fee when medically needy people first enroll in Medicaid. This fee can't be charged to people who are considered categorically needy.

### Monthly Premium

States are permitted to charge a small monthly fee to people who qualify for Medicaid as medically needy. This premium can be charged whether or not Medicaid services are actually used that month. The amounts vary with income and assets, but usually come to no more than a few dollars.

### Copayments

State Medicaid programs are permitted to charge a small copayment for each Medicaid-covered service you receive. A copayment can be charged to the medically needy for any service and to the categorically needy for optional services only. (See “Optional Services,” above, for a description of these services.)

## Medicaid and Private Health Insurance

Insurance companies aren't permitted to sell you a medigap insurance policy if you're on Medicaid. However, you're permitted to have other private health insurance—such as that provided by a retirement program or a policy you purchase to protect against a specific illness—and still qualify for Medicaid.

Medicaid will deduct the amount of your private health insurance premiums from the calculation of your income when determining whether you're under the allowable income levels to qualify.

However, if you do have private health insurance, and a medical service is covered by both your insurance and by Medicaid, Medicaid will pay only the amount your insurance doesn't. If you receive a payment directly from your insurance company after Medicaid has paid that bill, you must return that insurance money to Medicaid.

## Other State Assistance With Medical Costs

Many people with low income and assets have trouble paying the portion of medical bills left unpaid by Medicare and can't afford private medigap insurance, but don't qualify for Medicaid. If this is your situation, you might still get help paying Medicare premiums and portions of Medicare-covered costs that Medicare does not pay.

Three cost-reduction programs—called Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualifying Individual (QI)—are administered by each state's Medicaid program. They don't offer the extensive coverage beyond Medicare that Medicaid does, but the savings to you in Medicare-related medical costs can be substantial.

### **You Could Qualify for the Part D Prescription Drug Program's Extra Help**

If you qualify for any of the state assistance programs described in this section, you also qualify for a low-income subsidy called Extra Help to help pay the personal out-of-pocket costs that come with Medicare's Part D prescription drug coverage. The Medicare Part D program and Extra Help are explained in Chapter 12. You can apply for the Part D low-income subsidy when you apply for other state assistance programs (discussed below).

## Qualified Medicare Beneficiary (QMB)

If you're eligible for Medicare and meet the income and asset eligibility requirements for the QMB program, your state will pay all of your Medicare Part A and Part B premiums, deductibles, and coinsurance. Depending on how much you use Medicare-covered services in a year, this could mean a savings of up to several thousand dollars.

## **Income Limits**

To be eligible as a QMB, your income must be no more than slightly above the Federal Poverty Guidelines (FPG). This figure is established each year by the federal government; in 2024, the income level is about \$15,000 per year for an individual and about \$20,000 per year for a married couple. These figures are slightly higher in Alaska and Hawaii. Some states, however, allow residents to have higher incomes and still qualify as QMBs, especially for those with income from current work.

It's important to know that certain amounts of income aren't counted in determining QMB eligibility. Particularly if you're still working and most of your income comes from your earnings, you might be able to qualify as a QMB even if your total income is almost twice the FPG. QMB follows the SSI guidelines for countable income, described in Chapter 7. If, after applying these rules, the figure you arrive at is anywhere close to the QMB qualifying limits, it's worth applying for it.

## **Asset Limits**

There is a limit on the value of the assets you can own and still qualify as a QMB—generally, no more than about \$9,000 for an individual and about \$14,000 for a married couple. However, many assets, such as your house, your car, and certain personal and household goods, aren't part of the resources that are counted. (See “Who Is Eligible” in Chapter 7 for how SSI counts assets.)

## **Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual (QI)**

If your income is slightly too high for you to qualify for QMB benefits, you might still be eligible for one of two other state medical assistance programs: Specified Low-Income Medicare Beneficiary (SLMB) or Qualifying Individual (QI). The resource limits for eligibility are the same as for a QMB, but the income limits are 20% to 80% higher, depending on the program.

If your counted monthly income—after the same adjustments made in calculating income for SSI purposes (see Chapter 7 for these calculations)—is less than \$1,500 for an individual, or \$2,000 for a couple, you're likely to qualify for SLMB or QI support.

Because the SLMB and QI programs are for people with slightly higher incomes, they have fewer benefits than the QMB program. The SLMB and QI programs pay all or part of the Medicare Part B monthly premium, but don't pay any Medicare deductibles or coinsurance amounts. Nonetheless, this means potential savings of more than \$500 per year.

## **Applying for Medicaid, QMB, SLMB, or QI**

Before you can get coverage by the Medicaid, QMB, SLMB, or QI programs, you must file a written application separate from your Medicare application. An application for Medicaid also serves as an application for QMB, SLMB, or QI. If you're found ineligible for one program, you might still be found eligible for one of the others.

This section explains some of the things you'll need to do and documents you will need to gather to file an application for Medicaid, QMB, SLMB, or QI.

### **Where to File**

To qualify for Medicaid or the QMB, SLMB, or QI programs, you must file a written application with the agency that handles Medicaid in your state—usually your county's department of social services or social welfare department.

In many states, if you're applying for SSI benefits at your local Social Security office, that application will also serve as a Medicaid application. You'll be notified of Medicaid eligibility at the same time as you receive notice regarding SSI. (See Chapter 7 for a full discussion of the SSI program.)

If you or your spouse is hospitalized when you apply for Medicaid, ask to see a medical social worker in the hospital who can help you fill out the application.

## Required Documents and Other Information

Because eligibility for Medicaid and the QMB, SLMB, or QI programs depends on your financial situation, many of the documents you must bring to the Medicaid office are those that will verify your income and assets.

Although a Medicaid eligibility worker might require additional specific information from you, you will at least be able to get the application process started if you bring:

- pay stubs, income tax returns, Social Security benefits information, and other evidence of your current income
- papers showing all your savings and other financial assets, such as bank books, insurance policies, and stock certificates
- automobile registration papers if you own a car
- your Social Security number
- information about your spouse's income and any separate assets, if the two of you live together, and
- medical bills from the previous three months, as well as medical records or reports to confirm any medical condition that will require treatment in the near future. If you don't have copies of these bills, records, or reports, bring the names and addresses of the doctors, hospitals, or other medical providers who are treating you.

Even if you don't have all these papers, go to your local social services or social welfare department office and file your application for Medicaid as soon as you think you might qualify. The Medicaid eligibility workers will tell you what other documents you need—and sometimes can explain how to get necessary papers you don't have or can help get them for you.

## Application Procedure

A Medicaid eligibility worker—or an SSI eligibility worker if you apply for SSI at a local Social Security office—will interview you and assist you in filling out your application. There might be lots of forms to fill out, and you might have to return to the office for several different interviews.



### TIP

**Don't get discouraged.** Delays, repeated forms, and interviews don't mean you won't be approved. The state has created procedures that make it difficult for people to get through the qualification process, driving some people to give up on benefits to which they are entitled. Patience is not only a virtue; it's an absolute necessity.

Normally, you will receive a decision on your Medicaid application within a few weeks after you complete the forms and provide the necessary information. The law requires that a decision be made within 45 days. If you don't hear from Medicaid within a month after you apply, call the eligibility worker who interviewed you. Sometimes it takes a little polite pushing to get a decision out of an overworked social services agency.

## Retroactive Benefits

If you're found to be eligible and have already incurred medical bills, Medicaid might cover some of them. This retroactive eligibility can go back to the beginning of the third month before the date you filed your application. Make sure to show your Medicaid eligibility worker any medical bills you have from this period.

If you're denied eligibility for Medicaid, QMB, SLMB, or QI, you have a right to appeal (see below).

## Review of Eligibility

How long your Medicaid coverage will last depends on your finances and your medical costs. Medicaid eligibility is reviewed periodically, usually every six months and at least once a year.

If, upon review, the Medicaid agency finds that your financial situation has changed to put you over the eligibility limits for your state's Medicaid program, your coverage might be discontinued. Until then, your Medicaid or QMB, SLMB, or QI coverage will continue, even if your income or assets put you over the limits some months before.

Likewise, if you became eligible for Medicaid as medically needy because of high medical costs, but those medical costs have ended, you might be dropped from Medicaid when your review is completed. Until the review, however, you will remain on Medicaid regardless.

If new medical costs arise after your coverage has been ended, you can apply again for Medicaid coverage.

## What to Do If You're Denied Coverage

If you're denied Medicaid, QMB, SLMB, or QI coverage for which you believe you're eligible, go immediately to the office where you applied. Ask about the procedure in your state for getting a hearing to appeal that decision.

In some states, if you request a hearing in writing within 10 days after receiving the notice saying that your coverage is going to end, your coverage can stay in effect until after the hearing officer makes a decision.

At an appeal hearing, you'll be able to present any documents or other papers—proof of income, assets, medical bills—that you think support your claim. You'll also be allowed to explain why the Medicaid decision was wrong. If expected medical bills, which you claim will qualify you as medically needy, are the main question concerning your eligibility, then a letter from your doctor explaining your condition and the expected cost of treatment could be important.

The hearing itself is usually held at or near the welfare or social service office. You're permitted to have a friend, relative, social worker, lawyer, or another representative appear with you to help at the hearing.

### **Getting Assistance With Your Appeal**

If you're denied Medicaid, QMB, SLMB, or QI, you might want to consult with someone experienced in the subject to help you prepare your appeal. The best place to find quality free assistance with these matters is the nearest office of the State Health Insurance Assistance Program (SHIP) (see the end of Chapter 13 for contact information).

If there is no SHIP office near you, you might be able to find other assistance through your local senior center or by calling the senior information line listed in your telephone directory.

You can also hire a Medicaid lawyer or health care lawyer to help.

Although the exact procedure for obtaining this hearing, and the hearing itself, might be somewhat different from state to state, they all resemble the hearings given to applicants for Social Security benefits (covered in Chapter 9).

You should be notified of the decision on your appeal within 90 days after the hearing.

For more information, see Nolo's series of articles on Medicaid appeals at [www.nolo.com/legal-encyclopedia/medicaid-law](http://www.nolo.com/legal-encyclopedia/medicaid-law). ●

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