Mini-Medicare Manual & Resource Folder
(Developed by The MetroWest SHINE Program)

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An Introduction to Medicare

Medicare is a federal health insurance program for people age 65 or older, and people under age 65 with certain disabilities. Medicare is divided into different parts:

**Part A (Hospital Insurance)**
- Helps pay for inpatient hospital care, skilled nursing facility, home health care, and other services.
- *Free* for individuals (and their spouses*) who worked and paid into Social Security for at least 40 quarters (10 years).

**Part B (Medical Insurance)**
- Helps pay for outpatient medical services like doctors’ visits and outpatient tests.
- Standard premium; higher if income over $85,000 pp or $170,000 married filing jointly.

**Part D (Prescription Drug Coverage)**
- Outpatient prescription drug coverage.
- Premium varies by plan; higher if income over $85,000 pp or $170,000 married filing jointly.

*Initial Enrollment Period:* The Initial Enrollment Period for Medicare is a 7-month period that starts 3 months before the month of the 65th birthday (or 4 months before birth month, if birthday is on first of the month).
- **People who are already receiving Social Security (SS) or Railroad Retirement benefits when they turn 65,** should receive a Medicare card in the mail about three months before their 65th birthday and are **automatically enrolled** in Medicare Parts A & B (but not Part D). **Beneficiaries who do not want Part B coverage must notify Social Security as instructed by the letter that comes with the card.**
- **People under 65 with a disability** will get a Medicare card in the mail after they have received disability benefits from SS (or the Railroad Retirement Board) for 24 months. Medicare coverage may begin sooner for individuals who have permanent kidney failure or ALS (Lou Gehrig’s Disease).
- **People who are NOT receiving SS benefits when they turn 65** will NOT be automatically enrolled and **must contact the Social Security Office to enroll.** It is wise for beneficiaries to apply within the 3 months before they turn 65 in order to avoid a possible delay in the start of their Medicare coverage. *(Some people are eligible to enroll in Medicare online. Visit www.socialsecurity.gov/medicareonly for more information.)*

*Delayed Part B Enrollment for those who are still working:* People eligible for Medicare who are covered by an Employer Group Health Plan (EGHP) through their own (or their spouse’s*) current **active employment** (not a retiree plan or COBRA) may **delay Part B enrollment without penalty****, regardless of the number of employees. However, if there are fewer than 20 employees (or fewer than 100 if someone is eligible for Medicare based on disability), then Medicare is generally primary and it is very important for the client to check with the EGHP to see if Part B needs to be taken. *(If Medicare should be primary, but the insured does not enroll in Medicare, the EGHP may DENY claims and may even request reimbursement at a later date for claims paid inappropriately.)*

**Important Note!** When these individuals (or their spouses) stop working, if their IEP has ended, they have an **8-month Special Enrollment Period** in which to sign up for Part B. If they do not enroll in Part B during this period, they will have to wait for the General Enrollment Period and may have to pay a late enrollment penalty.**

**General Enrollment Period (GEP):** People who miss their initial enrollment and/or special enrollment period may sign up for Medicare during January, February, and March each year. Coverage begins July 1 of that year. A late enrollment penalty may apply.**

* **Same-Sex Spouses:** The federal government does NOT recognize same-sex marriages. Therefore, an individual may NOT qualify for Medicare or seek protection from the Part B penalty based on employment of same-sex spouse.

** **Part B Late Enrollment Penalty:** People who sign up for Part B during the GEP will have to pay a permanent monthly surcharge of 10% of the current Part B premium for each 12-month period they delayed enrollment in Part B.
Supplementing Medicare – Two Options

Original Medicare does not cover all medical expenses. (See “Medicare Gaps & Benefits Chart”.) Many Medicare beneficiaries choose to supplement their Medicare coverage in one of two ways:

<table>
<thead>
<tr>
<th>OPTION #1</th>
<th>OPTION #2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original Medicare (Parts A &amp; B)</td>
<td>Medicare Advantage Plan (Part C)</td>
</tr>
<tr>
<td>Medigap Plan (Covers Medicare gaps)</td>
<td>(Replaces Original Medicare but must still be enrolled in Parts A &amp; B)</td>
</tr>
<tr>
<td>Stand-alone Part D Plan</td>
<td>Includes Part D Coverage</td>
</tr>
</tbody>
</table>

**Medigap Plans**: Cover gaps in Original Medicare.

**Medigap Plans sold in Massachusetts**:

“Supplement 1” Covers MOST gaps.
“Core” Covers SOME of the gaps.

Sold by several different companies at different monthly premiums, but **coverage for Medicare services is identical**.

**Eligibility**: Must have Parts A & B and be a Massachusetts resident. Those under age 65 who are enrolled in Medicare due to a disability may also enroll in a Medigap plan unless they have ESRD.*

**Enrollment Period**: Currently, Medicare beneficiaries in Massachusetts may enroll in a Medigap policy at **any time** throughout the year. (This is called “continuous open enrollment”.)

**Medicare Advantage Plans**: Private health plans that contract with Medicare to deliver all medical services.

- Most charge a **monthly premium**
- Co-pays are charged for most services
- May also have **deductibles**
- Most plans offer extra benefits that are not covered by Medicare (e.g. limited dental, vision, and hearing services).

**MA Plans available (varies by County)**

- **HMOs (Health Maintenance Organizations)**: Members restricted to “network” of providers.
- **PPOs (Preferred Provider Organizations)**: Similar to HMOs, but members may use out-of-network providers for an additional cost.
- **PFFS (Private Fee For Service)**: Must use providers that accept terms of payment.
- **SNPs (Special Needs Plans)**: HMOs for institutionalized individuals or dual eligibles.

**Eligibility**: Must have Parts A & B and live in plan’s service area.*

**Enrollment Periods**: (SEPs also available)

- Initial Enrollment Period for Part B
- 8-month SEP for Part B
- Annual Enrollment Period (Oct 15 – Dec 7, coverage effective Jan 1 of the following year)

**Disenrollment Period: From Jan 1 – Feb 14**, MA plan members may disenroll and return to Original Medicare. Will have SEP to enroll in a stand-alone PDP during the same period, even if the plan they are leaving did not include drug coverage.

*Special note for people with kidney disease (or ESRD)*: Eligibility rules for Medicare beneficiaries with ESRD are different for Medigap plans versus MA plans. Please see SHINE Resource Manual for further details.
How to decide between “Original Medicare” plus Medigap or a Medicare Advantage Plan:

Many people who visit a SHINE counselor want to know, “which is the best plan?” Unfortunately, there is no simple answer to this question. There are advantages and disadvantages to every option. Some of these are listed below. The best thing to do is learn as much as you can about the various options and make the decision you feel best suits your individual needs.

Weighing the pros and cons…

<table>
<thead>
<tr>
<th>Original Medicare + a Medigap (Suppl 1) Plan</th>
<th>Medicare Advantage Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher monthly premium but NO co-pays</td>
<td>Lower monthly premiums (average) but has co-pays</td>
</tr>
<tr>
<td>Freedom to choose doctors and hospitals</td>
<td>Generally restricted to network</td>
</tr>
<tr>
<td>No referrals necessary</td>
<td>May need referrals for specialists</td>
</tr>
<tr>
<td>Some ‘routine’ services not covered (e.g. vision, hearing, dental)</td>
<td>May include extra benefits (vision, hearing, dental)</td>
</tr>
<tr>
<td>Covered anywhere in US</td>
<td>Only urgent and emergency services covered outside designated area</td>
</tr>
</tbody>
</table>

If you are considering a Medicare Advantage plan, here are some questions to consider:

- **Do your preferred doctors and hospitals accept the plan?** If it is important for you to continue seeing your current doctors, you should find out which Medicare Advantage plans they accept (if any).

- **How much are the co-pays for out-patient AND in-patient services? What is the “out-of-pocket maximum” for the year?** If you use a lot of services, your co-pays may add up quickly. Try to estimate how much your co-pays will be for the year and compare that to the annual cost of a Medigap plan.

- **If you are in a PPO, how much will you pay for out-of-network services?** Out-of-network costs are often considerably higher than the in-network co-pays for a given plan.

- **Are the medications you take on the formulary?** If you join a Medicare Advantage plan, you MUST take the Part D coverage offered by that plan. So it’s important to find out if they cover your medications and at what cost.

Employer and Union Retiree (Group) Health Coverage & Medicare

Retiree health plans can act as a supplement to Medicare or, in the case of a managed care plan, provide retirees with their Medicare coverage. Each retiree plan is unique and offers different coverage. Retirees must carefully review the ‘Outline of Coverage’ for the plan(s) offered.

In recent years, there has been a trend towards increasing costs and decreasing coverage of retiree plans. Therefore, retirees must have a clear understanding of their benefits in order to compare their coverage with the non-group options described above.

**Important Note:** Retirees should be extremely cautious about the decision to give up their retiree plan as most retiree plans will not allow people back into their plan once they disenroll.
Non-Group Coverage & Medicare

People eligible for Medicare who are already enrolled in private non-group coverage (an individual or a family plan) may be allowed to stay in that plan, but it will become secondary to Medicare. Since Medicare will be primary, individuals should enroll in both Parts A and B.

In most cases, keeping the private plan would be more costly, but under certain circumstances, it can be less costly. For example, for some people with very high drug costs, it is less costly to continue the drug coverage through their private plan than with Medicare Part D. HOWEVER, the individual MUST check with the plan to see if the plan will continue to provide drug coverage after the individual becomes eligible for Medicare.

COBRA & Medicare

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) may allow terminated employees or their families who lose coverage due to termination of employment, death, divorce or other life events to continue their coverage under their employer’s group health plan for themselves and their families for limited periods of time. This period is generally 18-36 months, depending on the qualifying event.

The interaction between COBRA coverage and Medicare is complicated. People who become eligible for Medicare while on COBRA will (in most cases) automatically lose their COBRA coverage. People who are already eligible for Medicare when they become eligible for COBRA, are allowed to take COBRA, but it only makes sense to do so in limited cases.

IMPORTANT: Anyone on COBRA who is Medicare eligible should check with the COBRA plan to see if Medicare should be taken. COBRA is secondary to Medicare (unless someone qualifies for Medicare due to ESRD). If the insured does not enroll in Medicare, the COBRA plan may DENY claims and may even request reimbursement at a later date for claims paid inappropriately.

COBRA & The Medicare Part B Penalty:

It is very important for ANYONE eligible for Medicare to understand that coverage through COBRA does NOT give them protection from the Part B late enrollment penalty.

In order to avoid the penalty, they must sign up for Part B during their 8-month Special Enrollment Period following the end of their active employment.

They will NOT get a Special Enrollment Period to sign up for Part B when their COBRA coverage ends (a common misconception). They will have to wait for the General Enrollment Period to enroll (Jan-March for coverage effective July 1) and they will be subject to the Part B late enrollment penalty.

COBRA & Medicare Part D:

The late enrollment penalty for Medicare prescription drug coverage works differently. Most (but not all) COBRA plans include drug coverage that is considered “creditable” or as good as Part D coverage. As long as a person has “creditable” drug coverage in place, he/she does not have to worry about incurring a late enrollment penalty for Part D. Once this “creditable” drug coverage ends, he/she will have 2 months to sign up for a Part D plan without incurring a penalty.
Medicare’s Outpatient Prescription Drug Coverage (Part D)

Who is eligible to enroll in Medicare Part D? No matter what your age or income, if you have Medicare Part A or Part B, you are eligible to enroll in a Part D Plan.


If your income is greater than $85,000 pp or $170,000 married filing jointly, you will pay a higher premium for your Part D Plan. (See SHINE Info sheet “Medicare Premiums & IRMAA”.)

The Standard Levels of Coverage for Part D Plans in 2013 are as follows:

<table>
<thead>
<tr>
<th>Deductible</th>
<th>$0 - $325</th>
<th>You pay full cost of drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Coverage</td>
<td>Up to $2,970</td>
<td>Plan pays 75%, you pay 25% (approx)</td>
</tr>
<tr>
<td>Coverage Gap</td>
<td>Over $2,970</td>
<td>You pay 47.5% for brand-name drugs and 79% for generic drugs</td>
</tr>
<tr>
<td>(“donut hole”)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catastrophic Coverage</td>
<td>When retail cost of drugs &gt; $6,734</td>
<td>Plan pays 95%, you pay 5%</td>
</tr>
</tbody>
</table>

What is the Part D Gap? After you and your plan have spent up to the initial coverage level for covered drugs, you are in the “donut hole.” The Affordable Care Act (ACA) is gradually closing this coverage gap.

Catastrophic Coverage: Medicare drug plans provide special coverage if you have extremely high drug costs. If the total retail cost of your drugs exceeds the catastrophic coverage level (this figure may vary somewhat from plan to plan), your drug plan will pay 95% of your drug costs and you will pay the remaining 5%.

Can I choose any Part D plan that I want? If you join a Medicare Advantage HMO, PPO, or SNP and want to have drug coverage, you must choose one of the Part D plans that Medicare Advantage plan offers. If you have Original Medicare or a Medicare Advantage PFFS without drugs, you may choose one of several “stand-alone” Part D plans offered in your area.

How do I compare plans? Medicare requires all Part D plans to cover AT LEAST TWO drugs within each therapeutic drug class, but every plan will have its own unique list of covered drugs (formulary) with different costs. The best way to compare Part D plans is to use the Medicare Plan Finder found on www.medicare.gov. This website can help you choose a plan that covers ALL your drugs with the fewest restrictions possible. You will have to pay the full cost of non-covered drugs.

When can you enroll in a Medicare Part D plan or change from one to another?
- You can enroll in a Part D plan OR change your plan during the Annual Enrollment Period which is October 15 through December 7 for coverage that will be effective January 1 of the following year.
- For those who are newly eligible for Medicare, the Initial Enrollment Period will be the same as for Part B: a seven-month period that includes the three months before the month you become eligible, the month you are eligible and three months after the month you become eligible.
- There are also Special Enrollment Periods (SEPs) for certain qualifying events which allow some individuals to join or change their plans at other times during the year.

What is the “Late Enrollment Penalty”? If you do not join a Part D plan when you are first eligible AND you do NOT have other drug coverage that is comparable to Part D (“creditable coverage”), you may have to pay a late enrollment penalty when you do join a Part D plan. To estimate your penalty, multiply 1% of the average Part D premium (for the current year) by the number of full months you were eligible for but did not join a Part D plan. This penalty is added each month to your Part D drug plan’s premium for as long as you have a Part D plan. Your current (or prior) employer or insurance company should notify you if the coverage you have is “creditable.”
Medicare Coverage for Vaccines

Medicare covers some vaccines and immunizations. The way Medicare covers them depends on which vaccine you need.

**Medicare Part B currently covers:**
- Pneumococcal (pneumonia) vaccine
- Influenza virus vaccine (includes both the seasonal flu shot and H1N1 vaccine)
- Hepatitis B vaccine for individuals at medium to high risk

**Medicare Part D:** All Part D plans must cover all other commercially available vaccines, including the vaccine for **shingles** (herpes zoster).

Your Part D plan will pay for the vaccination itself and for your doctor to give you the shot (administration). However, you will need to make sure you follow your particular plan’s rules in order for the vaccine to be covered. *Before you get a vaccination, you should check coverage rules with your Part D plan and see where you should get your shot so that it will be covered for you at the lowest cost.*

Ask your doctor’s office to call your Part D plan first to find out if there is a way that the doctor can bill your plan for the vaccination. There may be a way for him/her to submit the bill so that you will not have to pay the whole cost up front.

**You may need to pay more for your vaccination** if your doctor cannot submit the bill to your Part D plan through a partnering pharmacy; and/or does not directly bill your plan for the drug using the electronic billing system.

In these circumstances, the doctor will bill you for the entire cost of the vaccination and you will have to pay the entire bill up front. You will then have to follow your Part D plan’s rules to be reimbursed. The doctor is not limited in how much he/she can charge you for the vaccine but your Part D plan will only pay its approved amount for the vaccine costs. When you are reimbursed by the plan, you will only be reimbursed for your Part D plan’s approved payment. You will be responsible for the difference between the doctor’s charge and the plan’s approved payment.
“Extra Help” (LIS) for Medicare Part D

“Extra Help” (also known as the Limited Income Subsidy or LIS) is a federal program that helps Medicare beneficiaries with limited income and assets pay the costs associated with a Medicare Part D plan – the premium, deductible, and co-pays.

Beneficiaries may qualify for either full or partial “Extra Help” depending on their income & assets:

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>&quot;Full&quot;</td>
<td></td>
<td>$0 monthly premium</td>
</tr>
<tr>
<td>135% FPL plus $20 disregard</td>
<td>Changes annually</td>
<td>$0 deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low drug co-pays**</td>
</tr>
<tr>
<td>&quot;Partial&quot;</td>
<td></td>
<td>Sliding scale for plan premium</td>
</tr>
<tr>
<td>150% FPL plus $20 disregard</td>
<td>Changes annually</td>
<td>Reduced deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15% co-insurance for all drugs</td>
</tr>
</tbody>
</table>

* Countable assets include bank accounts, IRAs, stocks, bonds, second home, second car, boat. (Unlike MassHealth, LIS does not count the cash surrender value of life insurance policies.)

** People in nursing homes on LTC MassHealth AND people in the Frail Elder Waiver program have $0 drug co-pays.

- Beneficiaries apply for “Extra Help” through the Social Security Administration (SSA) using the agency’s printed or online application (www.ssa.gov or call 800-772-1213).

- If approved for “Extra Help”, beneficiaries must enroll in a Medicare Part D plan to get coverage.

- Beneficiaries who do NOT enroll themselves in a Part D Plan will eventually be automatically enrolled into a basic Part D Plan that is selected randomly.
  
  Note: This plan may NOT be the best plan for the beneficiary if it does not cover all the drugs he/she is taking OR if it has restrictions on his/her drugs.

- Beneficiaries with LIS should try to choose a basic (not enhanced) Part D plan that covers ALL their medications (without restrictions) AND whose premium is under the regional average.

  Note: Sometimes it is necessary to choose a plan with a premium over the benchmark in order to obtain a plan that covers all the drugs beneficiary is taking. In that case, the beneficiary will have to pay a portion of the premium.

- Beneficiaries who have “Extra Help” are allowed to switch their Part D Plans on a monthly basis.

- Medicare beneficiaries who have MassHealth, CommonHealth, or one of the Medicare Savings Programs (QMB, SLMB, or QI-1), are automatically deemed eligible for “Extra Help” and will not have to apply. If a person loses one of these programs:

  ➔ prior to July, he/she will remain eligible for LIS through the end of that calendar year.

  ➔ during July or later, he/she will remain eligible for LIS through the end of the following calendar year.

- Eligibility for LIS is reviewed periodically by Social Security. Beneficiaries who are chosen for review will receive a “Redetermination Form” (in August/September) which must be completed and returned within 30 days or the “extra help” subsidy will be lost at the end of December of that same year.
Limited Income Newly Eligible Transition (LI NET) Program
Administered by Humana, 1-800-783-1307 (Dedicated SHIP line: 866-934-2019)

LI NET provides immediate, but temporary, prescription drug coverage (with no formulary restrictions) to people who are eligible for LIS but are not yet enrolled in a Part D plan.

- Medicare auto-enrolls all full dual eligibles (Medicare and MassHealth) into LI NET for two months, beginning the first month they are eligible for both programs.
- Other LIS beneficiaries will not be auto-enrolled in LI NET, but will be enrolled in LI NET at the pharmacy (aka POS or ‘point of sale’ enrollment) if they have not yet enrolled in a Part D plan.

**These beneficiaries must provide proof of eligibility in order to use the LI NET program – either a MassHealth card or LIS award letter from Social Security.**

**Instructions for Pharmacy:** If an E1 query reveals member is not yet enrolled in a plan, submit claim to LI NET (instructions found at www.humana.com/pharmacists/resources/li_net.asp), using this data:

<table>
<thead>
<tr>
<th>BIN#</th>
<th>Patient ID = Social Security # or Medicaid ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>015599</td>
<td></td>
</tr>
<tr>
<td>Group ID</td>
<td>Cardholder ID = Medicare Number</td>
</tr>
<tr>
<td>(may be left blank)</td>
<td></td>
</tr>
<tr>
<td>PCN#</td>
<td></td>
</tr>
<tr>
<td>05440000</td>
<td></td>
</tr>
</tbody>
</table>

- After two months, beneficiaries who have NOT enrolled in a plan on their own will be auto-enrolled into a randomly selected plan below the benchmark. (They may switch to a plan of their choice if they wish.)

- The LI NET program can also be used by LIS beneficiaries to be reimbursed for prescriptions paid for out-of-pocket while they were eligible. (It is best to call LI NET to determine the window for this retroactive coverage.)

  *Beneficiaries must send pharmacy receipt along with a completed “Prescription Drug Claim Form” to Humana. (To obtain form, go to apps.humana.com/marketing/documents.asp?file=1339468 or call 1-800-783-1307.)*
Prescription Advantage (1-800-AGE-INFO)

What is Prescription Advantage (PA)? It is a state-sponsored prescription drug insurance plan for Massachusetts seniors (age 65 and over) and low-income people with disabilities. For people on Medicare, PA helps pay Part D (or other “creditable”) plan costs. For people not on Medicare, the program provides primary prescription drug coverage. (Note: Massachusetts DOES recognize same-sex marriages.)

How does Prescription Advantage help? If your income is less than 300% FPL:

- The biggest benefit PA will provide you is it will help pay for your prescription drugs if you reach the “donut hole” or “gap” in your drug plan.
- PA also sets a limit on your out-of-pocket co-pays for the year. If you exceed that limit, PA will cover all your prescription drug costs fully.
- You will also be allowed to enroll in or switch drug plans one extra time during the year outside the normal open enrollment. This SEP applies to both PDPs and MA-PDs.

Who is eligible to join Prescription Advantage?

- Seniors with Medicare with incomes up to 500% FPL.
- People with disabilities under age 65 with incomes up to 188% FPL (working no more than 40 hours per month).
- Seniors who are not Medicare eligible have no income limit.

You cannot join this program if you are a MassHealth or CommonHealth member. Your immigration status does not affect your eligibility.

How much will it cost to join Prescription Advantage? For many seniors, Prescription Advantage is FREE to join (seniors with Medicare with incomes less than 300% FPL). For Medicare beneficiaries with higher incomes, the cost is $200 per year. It is also free for seniors who are NOT eligible for Medicare.

How do I apply? To apply for Prescription Advantage, call 1-800-AGE-INFO for an application. Applications may be submitted at any time throughout the year.

Important note for new members: Co-pay assistance during the coverage gap can begin immediately for new members. However, any costs incurred prior to joining Prescription Advantage cannot be applied towards the Prescription Advantage out-of-pocket spending limit.

Once I have Prescription Advantage, how do I access my benefits? People with a Medicare Part D or other creditable plan should bring that card and their new Prescription Advantage card when they buy prescription drugs. People not on Medicare use just their Prescription Advantage benefit card.

What if I’m not eligible for Medicare? For people not eligible for Medicare, PA provides primary prescription drug coverage. This coverage has no monthly premium. Depending on income, members will pay a co-payment for prescription drugs and will have an annual out-of-pocket spending limit and quarterly deductible.
MassHealth Programs

MassHealth Programs

There are several different types of MassHealth coverage, each with its own set of eligibility rules and benefits. For more info, call MassHealth Customer Service at 1-800-841-2900, or visit their website at www.mass.gov/masshealth. (Massachusetts DOES recognize same-sex marriages.)

When applying for MassHealth, use one of three MassHealth applications:

- "Senior MBR" Application (Orange)
- "MBR" Application (Purple)
- "MassHealth Buy-In" Application

MassHealth Standard (Use the “MBR” for anyone under 65 AND for clients over 65 who are caretakers of a child under 19. Use the “Senior MBR” application for anyone else 65 or older.)

- The most comprehensive MassHealth program, providing a wide range of health care benefits. Services include (but are not limited to) inpatient hospital service, doctors, chiropractors, vision care, nursing facility care, home health care, adult day health, mental health and substance abuse services.
- For members with Medicare, MassHealth provides secondary coverage and will pay Medicare premiums, co-pays, and deductibles as long as MassHealth providers are used.
- The income limit for people 65 and older is 100% FPL (asset limit is $2000/individual and $3,000/married couple). The income limit for people under 65 (and those who are caretakers of a child under 19) is 133% FPL (no asset limit).
- Must be a US citizen or ‘qualified’ non-citizen.

CommonHealth (Use the “MBR” application regardless of age. Write “CommonHealth” at top.) Health care benefits for adults and children with disabilities whose incomes are too high to be eligible for MassHealth Standard. Benefits offered are similar to those offered under MassHealth Standard. There are no income or asset limits regardless of age, but those with incomes above 150% FPL will pay a monthly premium based on their income:

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Primary Coverage Premium</th>
<th>Secondary Coverage Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>151% - 200%</td>
<td>$15 - $35</td>
<td>$9 - $21</td>
</tr>
<tr>
<td>201% - 300%</td>
<td>$40 - $128</td>
<td>$26 - $83</td>
</tr>
<tr>
<td>301% - 400%</td>
<td>$136 - $192</td>
<td>$88 - $124</td>
</tr>
<tr>
<td>401% - 600%</td>
<td>$202 - $392</td>
<td>$141 - $274</td>
</tr>
<tr>
<td>Over 600%</td>
<td>Contact MassHealth</td>
<td>Contact MassHealth</td>
</tr>
</tbody>
</table>

Are individuals required to work?

- Individuals 65 and older are eligible for CommonHealth only if they work* at least 40 hours per month AND can document their disability (by MassHealth or SSA).
- Individuals under 65 do not have to work to be eligible. Those who do not work at least 40 hours/month may have to pay a one-time deductible (spend-down) which is based on their income and must be met before the individual turns 65.
- Individuals under 65 who do meet the work requirement have no spend-down.

CommonHealth & Medicare:

- Individuals who are eligible for Medicare, must be enrolled in Parts A & B and are responsible for paying the Part B premium unless they meet income and asset guidelines for SLMB or QI-1.
- Individuals with CommonHealth & Medicare are considered “dual eligible” and will be deemed eligible for LIS regardless of income or assets.

*MassHealth is liberal in its definition of “work.” Being paid $1 per hour is a widely accepted criterion for “work.” (Examples of acceptable “work” include babysitting, dog walking, personal assistant, etc.)
Tips for Counseling Clients going on Medicare under age 65 (Disabled)

Clients currently on MassHealth Standard or CommonHealth

- These individuals will remain eligible for program but MassHealth will become secondary to Medicare (they MUST enroll in Medicare).

- MassHealth will no longer cover their drugs -- they will be deemed eligible for LIS (with temporary drug coverage through LINET) and automatically enrolled in a Part D Plan (if they do not enroll themselves first).

Clients NOT on MassHealth Standard or CommonHealth

- Most importantly, they MUST be told about the CommonHealth program since all of these clients are disabled. Even if the client currently has coverage through another source, he/she should be made aware of this important program for possible future needs (see details on previous page of this manual).

- If they have been covered by Commonwealth Care, they are no longer eligible for this coverage because they have become eligible for Medicare. But they are candidates for CommonHealth and should be encouraged to apply.

- If they have EGHP coverage, they will probably not need to sign up for Part B (EGHP will be primary if there are 100 or more employees) and/or Part D (if their drug coverage is creditable). But it is a good idea to have them verify this with the Benefits Administrator at the company.

- **Drug Coverage:** If they do not have creditable drug coverage, you should advise them about their Medicare Part D options.

- They are eligible for any Medigap or Medicare Advantage Plan, unless they have ESRD, in which case special restrictions apply.

...AND, as you do for all your clients,

- You should screen them for all other benefit programs, including LIS, MSPs, Prescription Advantage, and HSN.
**MassHealth Personal Care Attendant (PCA) Program:** *(Use the “Senior MBR” application and complete “PCA Supplement”)*

- A program to help people with long-term disabilities live independently at home.
- Provides members full MassHealth benefits plus funds to hire their own “personal care attendant” or PCA to assist with ADLs. (MassHealth determines the number of hours/week that a PCA is needed.)
- Individuals must require assistance with two or more ‘activities of daily living’ or ADLs (such as bathing, dressing, eating, toileting, taking medications, and moving about inside the home) in order to be eligible.
- For those 65 and older, the income limit is 133% FPL (asset limit is $2000/individual and $3,000/married couple). The PCA program is also available to those under 65 who are on MassHealth Standard or CommonHealth.
- Members are allowed to hire and train their own PCAs. PCAs can be a friend, or even a family member. Spouses, however, are NOT allowed to be paid as PCAs.
- Members may also appoint a “surrogate” (a friend or family member) to help with the management of the PCA program.
- Once PCA services are approved, members must obtain those PCA services within 90 days.

*For additional information, see the “PCA Consumer Handbook” at http://www.mass.gov/eohhs/docs/masshealth/memlibrary/pca-consumer-handbook.pdf*

**MassHealth Senior Care Options (SCO):** *(Contact plan to enroll)*

- A managed care program for seniors aged 65 or older who have full MassHealth Standard (members are NOT required to have Medicare to be eligible).
- Program combines Medicare/MassHealth services as well as social and psychological services to help seniors maintain their health and live in the community as long as possible.
- Includes dental services.
- Must use SCO network providers.
- Only available in certain geographic regions.

**Long-Term Care (LTC) MassHealth:** *(Complete Senior MBR & LTC Supplement)*

- MassHealth covers LTC costs for individuals living in nursing homes or other LTC facilities if they meet certain criteria.
- There is no income limit to qualify for MassHealth LTC. Single (unmarried) individuals must private pay for their care until their assets are below $2000. Once their assets are below $2000, the individual is allowed to keep a “personal needs allowance” (amount changes annually) and amounts paid for health insurance premiums. MassHealth will then cover the cost of the facility.
- If the institutionalized individual is married, the community spouse is allowed to keep a limited amount of assets (changes annually) as well as ALL of his/her own income. He/she may also be allowed to keep some or all of the institutionalized spouse’s income. MassHealth annually determines a Minimum Monthly Maintenance Needs Allowance (MMNMA) and a maximum allowance. If the community spouse’s income is lower than the MMNMA, the institutionalized spouse’s income can be used to meet this amount. The community spouse may appeal to retain more assets or income.

*For information on additional MassHealth Programs for non-Medicare beneficiaries (MH Essential, MH Limited, and MH Basic) see SHINE Resource Manual, Chapter 8.*
MassHealth Programs for Frail Elders

Home & Community-based Services Waiver for Frail Elders (aka “Frail Elder Waiver”)

The “Frail Elder Waiver” is for low/moderate-income Massachusetts residents who qualify for nursing facility or other institutional care but want to live at home. The Waiver allows MassHealth members to get needed health care and support services at home rather than in an institution. The goal of the program is to help frail elders live safely in their communities for as long as possible.

Qualified elders will receive full MassHealth benefits as well as in-home services that may include: Homemaker, Personal Care, Respite Care, Home Health Aide, Chore, Grocery Shopping Services, Home Delivered Meals, Laundry Services, Skilled Nursing, Day Care Programs, and Transportation.

Eligibility:
- Must be 60 years and older.
- Must be evaluated and deemed “nursing home eligible”* by a designated ASAP (Aging Services Access Point) or SCO.
- Income level at or below 300% SSI.
- Asset limit: $2,000.
- If married, special provision allows elders to “waive” their spouse’s income and assets to become eligible (must transfer assets over $2000 limit to spouse).

How to Apply: Applying for the “Frail Elder Waiver” is a two-step process:

1st Step: The elder must contact the local ASAP (______________________________) and request an evaluation by their nursing staff.

2nd Step: Once the assessment is complete, the elder must send a completed MassHealth application (“Senior MBR” and a portion of the “LTC Supplement”) to MassHealth with a note on it that indicates it is a “Frail Elder Waiver” application (or the ASAP may be able to send in the completed MassHealth application with their nursing assessment).

PACE (Program of All-Inclusive Care for Elders) or Elder Service Plan

PACE is a program for frail elders 55 and over who need extra services so they can stay at home. It combines medical care and social services that can be provided at an adult day health center, home, and/or a facility. Services are delivered through PACE-authorized health centers in designated communities. To apply, contact program directly. (To find out if there is a PACE plan near you, visit http://www.massresources.org/elder-service-plans.html)

- Must be evaluated and deemed “nursing home eligible”* by ASAP.*
- Must live in PACE program service area and must receive all services through PACE health center.
- No fee for program if MassHealth eligible (via Frail Elder Waiver rules).
- If not MassHealth eligible, members may have to pay a monthly premium.

* In order to be considered “nursing home eligible,” a person must require the services of a trained professional on a daily basis which could not be provided in a lower-level setting (such as an Assisted Living Facility). Trained professionals include licensed nurses, nurses’ aides and therapists.
Adult Foster Care or Adult Family Care (AFC) *(To apply, contact local ASAP)*

- AFC is a MassHealth program for frail elders and adults (age 16 and over) with disabilities who cannot live alone safely but prefer to live in a home setting rather than an institution. Individuals must be eligible for MassHealth and require assistance with at least one activity of daily living like bathing or dressing. *(People on ‘Frail Elder Waiver’ ARE eligible for AFC.)*

- AFC adults may live in the homes of trained care providers or a care provider may move into the home of the AFC adult. *(Room and board is not included. AFC adults living in a caregiver’s home may be required to pay a monthly fee for room and board.)*

- Caregivers provide meals, companionship, personal care assistance, and 24-hour supervision and receive up to $18,000/year (tax-free) from MassHealth to provide care. Caregivers can be family members or non-family members BUT caregivers CANNOT be spouses, parents of minor children, or legally responsible relatives.

- An AFC agency screens and trains caregivers, provides ongoing case management and periodic visits by social workers and registered nurses.

Group Adult Foster Care (GAFC) *(To apply, contact MassHealth at 800-841-2900)*

- GAFC is a MassHealth program that pays for personal care services for frail elders and adults with disabilities who live in GAFC-approved housing (including some assisted living facilities). *GAFC does NOT pay housing costs.*

- To qualify, residents must be eligible for MassHealth, be at least 22 years old, and require assistance with at least one activity of daily living.

- For a list of assisted living residences that accept GAFC, call local ASAP or the Elder Affairs’ Information unit at 1-800-243-4636.
Medicare Savings Programs (MassHealth Buy-In Programs)

MassHealth Buy-In Programs (also referred to as Medicare Savings Programs or MSPs) are federal programs that help pay for Medicare premiums and (in some cases) Medicare deductibles and co-payments for Medicare beneficiaries who meet the income/asset guidelines. These programs include:

**Qualified Medicare Beneficiary (QMB)** is for Medicare beneficiaries whose assets are too high to qualify for MassHealth Standard, but whose income is less than or equal to 100% FPL. Countable assets are limited to the same levels as full LIS. The program pays for Medicare premiums, as well as deductibles and coinsurance for both Medicare Part A and Part B. *(Use the “Senior MBR” application.)*

**Specified Low-Income Medicare Beneficiaries (SLMB)** is for Medicare beneficiaries whose income is between 100% and 120% FPL. Countable assets are limited to the same levels as full LIS. This program pays the monthly Part B Medicare premium only. *(Use the “Buy-In” application.)*

**Qualifying Individuals (QI-1)** is for certain Medicare beneficiaries whose income is between 120% and 135% FPL. Countable assets are limited to the same levels as full LIS. This program pays the monthly Part B Medicare premium only. *(Use the “Buy-In” application.)*

*Another way to apply:* MIPPA (Medicare Improvements for Patients & Providers Act of 2008) adjusted the income and asset limits for MSPs to equal those for the **Full** LIS. There is a reciprocal arrangement between MassHealth and Social Security so individuals found eligible for one program will have their application forwarded and be found eligible for the other program.

**Note:** While the stated asset levels for the MSPs are the same as for full LIS, there are differences in what is counted toward this limit. The LIS application (through SS) allows for a $1500 disregard of assets simply by stating that it will be used for burial expenses. Also, the LIS application does not count the cash value of life insurance policies (which is counted by MassHealth).
Health Safety Net (HSN)

HSN is a program that helps low-income Massachusetts residents of all ages pay for medically necessary health services at designated Massachusetts Community Health Centers (CHCs) and hospitals. People with Medicare may also be eligible to use HSN as secondary coverage for Medicare co-pays and deductibles.

HSN Eligibility: To be eligible, you must:
- be a Massachusetts resident (you do NOT need to be a US Citizen)
- have income no higher than 400% of the Federal Poverty Level (FPL)
- be ineligible for MassHealth Standard

HSN Covered Services: Most medically necessary services are covered as long as they are provided by a Massachusetts CHC or acute care hospital. HSN will also pay for eligible services you received up to 6 months before your application date. Covered services include:
- Hospital stays
- Emergency services
- Out-patient doctor visits & tests
- Mental health services
- Vision & hearing services
- Dental services (only at certain CHCs)
- Prescription drugs

HSN-Primary & HSN-Secondary: If you qualify for HSN and do not have any other insurance, you will have HSN-Primary. If you have other insurance (e.g. Medicare or a Medicare Advantage plan), you will get HSN-Secondary. If you have HSN-Secondary, your other insurance will need to be first billed for health services you get before the HSN is billed.

HSN Co-Pays & Deductibles: Co-pays and deductibles for HSN depend on your family income:

- Full HSN (For those with incomes below 200% of FPL): No deductible. Co-pays only for drugs.
- Partial HSN (For those with incomes between 201% and 400% of FPL): You will have an annual deductible, based on your family income. For hospital fees, you must pay your entire deductible amount before HSN coverage begins. For CHC fees, you will pay co-pays (based on your income) for each visit until your family deductible is met. Once you have paid your family deductible, the HSN pays for all covered medical services for the rest of the year for all family members.

  Estimating your deductible*: Deductible equals 40% of the difference between your family income and 201% of the current FPL or “federal poverty level” (depends on family size).

  Example: Family of 2 has income of $45,000: Deductible = \[45,000 – 201\% \text{ FPL}\] x 40%

* Only MassHealth can determine your exact deductible! You will be notified of the amount of your family deductible in your eligibility letter. (It will be your responsibility to keep track of your co-pays and be able to show proof once you have met your family deductible.)
If you have Medicare, what will HSN cover? In order to save money, many people with Medicare have no supplement, or choose a supplement that has high deductibles and/or co-pays. HSN can help pay for some of these costs as well as cover some services that are not covered by Medicare.

For hospital in-patient care:
- HSN covers hospital deductibles and co-pays (including the Part A deductible as well as Medicare Advantage hospital co-pays) only after you have met your family deductible (if you have one).
- HSN does not cover fees from private doctors or specialists and independent labs. If you are admitted to the hospital, and you receive bills from private doctors or labs, you will be responsible for them.
- Also, HSN does not cover any co-pays that may be charged to you in a Rehab Hospital or Skilled Nursing Facility.

For out-patient services:
- You can receive outpatient services at CHCs including prescription drugs and limited dental services (only available at certain facilities).
- You can go to any CHC (not just the one that is nearest to you).
- You can also contact the nearest hospital that accepts HSN and ask a “financial counselor” if you can receive any out-patient services at the hospital and what those services will cost. You are still responsible for any fees that may be charged for private doctors or labs. (Sometimes these fees are waived by private doctors, but you need to ask.)
- If you have a deductible, you will have co-pays for your office visits and services until you meet your family deductible. After that, you will have no co-pays for the remainder of the year (except for drugs).

Out-patient prescription drugs:
- HSN has a limited number of CHC or hospital outpatient pharmacies in its network and each requires that your prescription be written by a clinician who works at that affiliated facility. In most cases, you will need to see a doctor at the hospital or CHC where the pharmacy is located in order to have your prescription filled there.
- Low co-pays for most medications (those with Partial HSN do NOT have to meet their deductible first to be eligible for these co-pays). The HSN will not pay for prescriptions you get filled at a local retail pharmacy (for example, CVS, Walgreens, etc.) unless they have a special agreement with a neighboring CHC.
- You are not required to have a Medicare Drug Plan in order for your prescriptions to be covered at these designated HSN locations. However, HSN has a very restricted list of medications they will cover, so it is highly recommended that you stay enrolled in your Part D Plan.

How to apply: If you are 65 or older, use the MassHealth “Senior MBR” application. If you are under 65, use the MBR application. You must complete the entire application in order to obtain benefits. For applications, call MassHealth at 1-800-841-2900. You may also obtain applications and assistance at your local hospital or CHC.

How long are you eligible for the HSN? HSN eligibility lasts for one year from the start date as determined by MassHealth. However, you may receive review forms before the year is over. If you get review forms or any other forms asking for information, you should complete and return them as soon as possible.

Will you have MassHealth or HSN Card? No. You should carefully save your eligibility letter and bring a copy with you to the hospital or CHC for proof of your HSN eligibility. You may also be able to use your Social Security number.
Medical Hardship

**What is Medical Hardship?** Medical Hardship provides assistance for individuals or families whose medical expenses exceed a certain percentage of their gross income. It is a one-time determination and takes into account past medical expenses; it is not an on-going eligibility category.

**Is there an income or asset limit to qualify for Medical Hardship?** No. A Massachusetts resident at any income level may qualify for medical hardship. Assets are not counted.

**What benefits do Medical Hardship patients get?** For Medical Hardship patients, the HSN pays for all HSN-eligible medical expenses after applicants pay the percentage for which they are responsible. Families with higher incomes pay a higher percentage than families with lower incomes (see below table):

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Applicant responsible for this amount (Percentage of Gross Income)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-200% FPL</td>
<td>10%</td>
</tr>
<tr>
<td>201-300% FPL</td>
<td>15%</td>
</tr>
<tr>
<td>301 – 400% FPL</td>
<td>20%</td>
</tr>
<tr>
<td>401 – 600% FPL</td>
<td>30%</td>
</tr>
<tr>
<td>601 % and above</td>
<td>40%</td>
</tr>
</tbody>
</table>

If the family's allowed medical bills are higher than their percentage contribution, HSN pays the rest of the HSN-eligible expenses.

For example, if your family income is less than or equal to 200% of the FPL, you can qualify for Medical Hardship if your family's medical bills are greater than 10% of your income. In this case, the HSN will pay HSN-eligible medical bills greater than 10% of your income.

**What medical expenses can I count?**
- Unpaid bills from medical providers that would qualify as tax-deductible medical expenses.
- Unpaid medical bills incurred up to 12 months prior to the date of application can be included.
- May include services from private physicians and lab tests.
- Bills not eligible for reimbursement by HSN may be used to determine whether an individual has met the threshold for Medical Hardship eligibility.
- HSN co-pays.

Even though HSN counts allowed medical bills from any health provider when determining eligibility for Medical Hardship, it will **only pay for services covered by HSN** (medically necessary services provided at Massachusetts CHCs or hospitals, and on the list of MassHealth Standard covered services).

**How do I apply for Medical Hardship?** Medical Hardship applications (also called a “Special Services Application”) can be obtained at hospitals and CHCs or by calling the Division of Health Care Finance and Policy (DHCFP) at 800-609-7232. Applications are processed by DHCFP.
Commonwealth Care

Commonwealth Care is a premium assistance program to help uninsured adults purchase health insurance. Non-working individuals, the self-employed, and employees from companies of any size are potentially eligible. Employees must either have no access to insurance or work for employers who contribute less than 33% (or less than 20% for family coverage) towards their insurance costs.

**Eligibility:** *(Those eligible for Medicare are NOT eligible, except those who need to pay for Part A)*
- Have a gross household income at or below 300% FPL.
- Be a US citizen/national or legal immigrant.
- Be aged 19 or older.
- Be uninsured or paying full premium for COBRA or a private non-group insurance plan.

**Coverage:** Coverage will be provided under designated health plans and includes inpatient services, outpatient services, prescription drugs, mental health services, and limited dental and vision care.

**Cost:**
- Costs for premiums and co-pays are determined by income and plan selection.
- Enrollees whose gross household income is under 100% FPL will pay no monthly premium.
- Enrollees whose gross household income is greater than 100% but less than 300% FPL may have the premium waived or pay a sliding scale premium based on plan selection.

For more information and application go to [www.macommnwealthcare.com](http://www.macommnwealthcare.com) or call 1-877-MA-ENROLL. *(Use the “MBR” or “Senior MBR” application.)*

Commonwealth Choice

This is a program for people without insurance *who do not qualify for Commonwealth Care.*

Enrollees choose one of many private insurance plans with lower than market-rate premiums that cover preventive and primary care, emergency services, hospitalization, and mental health services (some plans also include prescription drug coverage).

- Open to all adults and families unless they have access to employer-sponsored coverage that meets the state’s *minimum creditable coverage standards.*
- Different levels of coverage are available.
- Premiums are based on insurer and plan chosen, age, location, and occupation.
- Most plans have deductibles.
- Plans with lower premiums have higher co-pays.
- Some plans restrict coverage to certain doctors and hospitals.

**Enrollment Period:** *July 1st through August 15th* of each year. *(Applies to Commonwealth Choice plans, as well as all other non-group plans sold in Massachusetts).*

**Note:** *In certain situations (like losing employee health coverage), people may qualify for a 63-day special enrollment period.*

For more information and application go to [www.mahealthconnector.org](http://www.mahealthconnector.org) or call 1-877-MA-ENROLL.
Veterans and Military Health Benefits

The Veterans Administration (VA) provides inpatient and outpatient medical services and prescription drugs. A veteran can enroll at any VA health care facility or Veterans Agent office at any time of year. Application forms may also be obtained by calling 1-877-222-VETS (1-877-222-8387). In addition, Veterans Agents are available in most towns in Massachusetts and will have information about other programs for veterans.

Information for veterans eligible for Medicare – Some key points to remember:

- The VA medical benefits program is separate from Medicare. Veterans may be enrolled in both programs but the enrollment process (and the eligibility criteria) is distinct for each.

- The Medicare program is divided by types of care or service: inpatient ("Medicare Part A"), outpatient ("Medicare Part B"), and prescription drug ("Medicare Part D"); seniors can decide in which "parts" of Medicare they wish to participate. VA offers a comprehensive medical benefits program that does not distinguish among the types of care or services received; generally veterans who are enrolled in VA health care are eligible for the entire medical benefits package (including prescription drugs), however, some veterans may be subject to a copayment for some care or medications received.

- VA does not recommend that veterans cancel or decline coverage in Medicare (or other health care or insurance programs) solely because they are enrolled in VA health care. Unlike Medicare, which offers the same benefits for all enrollees, VA assigns enrollees to priority levels based on a variety of eligibility factors, such as service-connection and income. There is no guarantee that in subsequent years Congress will appropriate sufficient medical care funds for VA to provide care for all enrollment Priority Groups. This could leave veterans, especially those enrolled in one of the lower Priority Groups, with no access to VA health care coverage. For this reason, having a secondary source of coverage may be in a veteran’s best interest.

- In addition, a veteran may want to consider the flexibility afforded by enrolling in both VA and Medicare. For example, veterans enrolled in both programs would have access to non-VA physicians (under Medicare Part A or Part B) or may obtain prescription drugs that are not on the VA formulary if prescribed by non-VA physicians and filled at their local retail pharmacies (under Medicare Part D).

- Veterans could be subject to a penalty for enrolling "late" for Medicare Part B, even if they are enrolled in VA health care. This is different than Medicare Part D (prescription drugs) where veterans can delay enrollment without penalty if they are enrolled in a prescription drug plan that provides a benefit at least as good as that offered by Medicare. The prescription drug benefit in the VA medical benefits program is at least as good as that offered by Medicare. In addition, "late" enrollment in Medicare is only allowed at a certain time of the year (see "General Enrollment Period" info) and individuals who choose not to enroll when they are first eligible may be left without access to health care until they can enroll in Medicare.

- Veterans should take time to understand their options under the Medicare program. They should read carefully all information received from Medicare or the Social Security Administration—action may be required. For example, seniors are required to sign and return a card if they choose NOT to enroll in Medicare Part B. Failure to return the card could result in automatic enrollment and deduction of the Medicare Part B premium from the beneficiary’s Social Security check. Conversely, without some action, a senior would not be automatically enrolled in the prescription drug coverage under Medicare Part D.
**Military Retiree Benefits - TRICARE for Life (TFL):**

TRICARE For Life (TFL) is TRICARE's Medicare wrap-around coverage available to all TRICARE beneficiaries who are eligible for and enrolled in Medicare Parts A & B. TFL provides secondary coverage to Medicare and covers most of Medicare’s coinsurance and deductibles for no monthly premium. In addition, the TRICARE Pharmacy program provides “creditable” drug coverage to all members.

Those eligible for TFL include:
- uniformed service retirees (including retired National Guard members and reservists)
- family members, widows and widowers
- certain former spouses if they were eligible for TRICARE before age 65

For more information about TFL, call 1-866-773-0404 or visit www.TRICARE.mil. Call 1-800-538-9552 for other military retiree eligibility and benefit questions.

**Civilian Health and Medical Program of the Dept of Veterans Affairs (CHAMPVA):** CHAMPVA provides coverage for most medical care including inpatient and outpatient services, mental health services, prescription drugs, skilled nursing care and durable medical equipment to the spouse or child of qualified veterans. For more information about CHAMPVA call 1-800-733-8387 or contact the VA Health Administration Center, PO Box 65023, Denver, CO 8026 or visit www.va.gov/hac.

**Benefits for Veterans & Widows with Limited Incomes**

**Massachusetts State Benefits (Chapter 115):** Veterans and widows may be entitled to reimbursement of their medical expenses if income is below $1,800/month and assets are less than $3,200 ($2,430/month and assets less than $7,000 for a married couple). This is an entitlement based on military service. Contact the city or town Veterans' Services Officer to apply or call the Massachusetts Department of Veterans Services at 617-210-5480. These benefits are not countable income for MassHealth programs.

**Federal Aid & Attendance Pension:** The Aid and Attendance Pension provides benefits for veterans and surviving spouses who require the regular attendance of a caregiver to assist with one or more activities of daily living (eating, dressing, bathing, etc.) due to physical or mental impairment. Applicants do not have to reside in a facility to be eligible for this program. The care can be provided in the home by either outside agencies or family members. The best way to apply is to contact the local Veterans’ Services Officer.

**Note:** Veterans who are independent but have sick spouses may be eligible for this benefit as well.
An Introduction to Long-Term Care

What is Long-Term Care (LTC)?
- LTC includes a wide range of services designed to help people with chronic illnesses or disabilities that leave them unable to care for themselves for an extended period of time. People with dementia or cognitive impairment (from diseases like Alzheimer’s) may also need LTC.
- Most LTC is non-skilled personal care assistance, such as help performing everyday activities like bathing, dressing, eating, cooking, and shopping.
- LTC may also include skilled care, which is provided by licensed nurses or therapists.

Why do I need to think about this? Won’t Medicare cover me once I’m 65?
- Contrary to popular belief, Medicare provides little or no coverage for LTC.
- Medicare pays only for short-term medical care at home or for a limited stay in a nursing home after a hospitalization.

Bottom line: You should not rely on Medicare or your Medicare Supplement to pay for LTC

But I’m perfectly healthy and I don’t EVER plan to be in a nursing home!
- About 70 percent of individuals over age 65 will require at least some type of LTC services during their lifetime. Over 40 percent will need care in a nursing home for some period of time.
- A person can need LTC services at any age. Forty percent of people currently receiving LTC are adults 18 to 64 years old.
- One of the most important advantages of planning ahead is to ensure greater independence should you need care. Your choices for receiving care outside of a facility and being able to stay at home or receive services in the community for as long as possible are greater if you plan ahead.

How much does LTC cost?
The cost depends on where and how long you receive services. According to the “Cost of Care Survey” by Genworth Financial in March of 2008:
- The average cost of a nursing home in Massachusetts in 2008 was over $100,000 per year.
- The average cost for home care (15 hours/week for a home health aide) in Massachusetts was over $20,000 per year.

When does Medicaid pay for LTC?
- MassHealth (the Massachusetts Medicaid program) will pay for LTC services in a nursing home only after the individual has spent most of their assets (excluding their home if a family member lives there).
- MassHealth will also pay for some LTC services at home if a person’s income and assets meet certain limits (“Frail Elder Waiver”).

If I am a Veteran, what LTC services can I get through the VA?
- The VA may provide LTC for certain eligible veterans. Benefits are determined by the nature of the disability, veteran status, and personal finances.
- Middle-class veterans who need LTC for non-service-related conditions may find it difficult to access VA benefits for LTC.
- For more information, contact your local VA office or visit the VA website (www.va.gov) to view available programs and services or download a Veterans Benefits fact sheet. You can also call the VA at 1-800-827-1000 to obtain information about available services in your area.
Will My Disability Insurance Pay for LTC?
- Disability insurance is intended to replace some of the income of a working person who becomes disabled and can no longer work.
- Disability benefits do not cover either medical care or LTC; they provide a partial salary replacement while you are unable to work.
- Most disability insurance policies do not provide any benefits once you are over age 65 – exactly when you are more likely to need LTC.

What are some of the different ways people privately pay for LTC? Paying for LTC out of your personal income and resources can be challenging. There are an increasing number of private payment options available for this purpose.
- Savings, Pensions, & Retirement Accounts
- Reverse Mortgages or Home Equity Loans
- Life Insurance (certain policies can be used to help pay for LTC while you are still alive)
- Charitable Remainder Trusts
- LTC Annuities
- LTC Insurance Plans

What is Long-Term Care (LTC) Insurance?
- As mentioned above, most LTC services will NOT be covered by traditional health insurance or Medicare.
- Purchasing a LTC Insurance Policy is one way people pay for LTC services should the need arise.

How are LTC Policies structured?
- You select a "Daily Benefit Amount", which is the maximum daily amount of expenses for care the policy will pay. Some policies may specify a monthly amount (instead of a daily amount) so you have the flexibility to receive more care on some days and less care on others.
- You choose a "Maximum Lifetime Benefit" or total lifetime amount you want the policy to provide (policies offer choices of different amounts like $100,000 or $300,000).
- You choose the "Elimination Period" or waiting period (period of time before benefits will begin).
- You choose the type of coverage you prefer – "Comprehensive" or "Facility Care Only." Comprehensive policies cover services provided in nursing homes, assisted living centers, as well as care at home. Be sure to check that the policy you are considering doesn't place too many restrictions on which facilities they will cover.
- Look for a policy that pays for "skilled, intermediate, and custodial" care rather than one that pays only for "skilled" home health care workers (like registered nurses). You want to be able to pay for home health care attendants and people you may need for cooking and cleaning.

When Are LTC Benefits Paid?
- Once you have a LTC policy in place, "Benefit Triggers" refer to the conditions under which you are eligible to claim benefits. Most policies use the inability to perform "Activities of Daily Living" (like walking, eating, or bathing) to determine if you are eligible for benefits.
- Benefit Triggers vary between policies and can impact how easily you qualify for benefits. It is important to look closely at this section in any policy you are considering.

Some important options to consider adding to your policy:
- Inflation protection: This maintains your level of coverage even as the cost of LTC rises. Without this protection, down the road your benefits may not cover your expenses and you'll have to make up the difference.
- Nonforfeiture Benefits: If you add this option and you drop your coverage for any reason, you will be able to recoup some or all of the premiums you have paid.
- Shared Care: This option allows the spouse receiving LTC benefits to use the other's benefit pool. Upon the death of one spouse, the other typically inherits the other's remaining pool free of charge.
Consider a front-loaded policy. With this, you pay the entire cost of the premiums before you retire. You’ll pay more upfront, but payments will end just as your income decreases.

Look into cash benefits policies. Once you are receiving benefit payments, these policies will send you a regular cash payment (for example $250 per week). Instead of filing claims for specific care, you are free to use the payout as you see fit, including paying family members for providing care or reimbursing travel expenses for a visiting relative. You’ll pay more for these policies, but the added flexibility is worth it for some families.

What Does LTC Insurance Cost?

Costs vary greatly. Premiums are based on your age and health at the time of purchase, the policy, and the coverage you select.

The chart below shows the average annual premium amounts paid for LTC insurance in 2007 for specific age groups. (Policies provided an average of 4.8 years worth of benefits, with an average daily benefit amount of $160 and included Inflation Protection.)

<table>
<thead>
<tr>
<th>Age</th>
<th>Annual Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under age 40</td>
<td>$881</td>
</tr>
<tr>
<td>40 to 49</td>
<td>$1,781</td>
</tr>
<tr>
<td>50 to 59</td>
<td>$1,982</td>
</tr>
<tr>
<td>60 to 64</td>
<td>$2,249</td>
</tr>
<tr>
<td>65 to 69</td>
<td>$2,539</td>
</tr>
<tr>
<td>Age 70 and older</td>
<td>$3,026</td>
</tr>
</tbody>
</table>

Can I get LTC Insurance if I have a pre-existing condition?

Having certain conditions means you may not qualify for LTC insurance. However, insurance companies have different standards, so while you may be denied coverage by one company, another might accept you.

You will probably not be approved to purchase a policy if you currently use or need LTC services, or have AIDS, Alzheimer’s Disease (or other dementia), Parkinson’s Disease, Multiple Sclerosis, a history of strokes, or metastatic cancer.

Once I have a policy, can it be cancelled by the company?

Once you are accepted for coverage, your coverage cannot be cancelled for any reason other than non-payment of premium as due, or if you have received the policy's maximum benefits. If you develop one of the health conditions listed above after obtaining coverage, you would be covered for the care you need for that condition.

Can my rate (or premium) go up?

Yes. Most policies have "level premiums." A level premium is what the insurer has projected it must charge its policyholders over the life of their policies to cover its costs. But it does not mean that your premiums will never go up.

An insurer with higher than anticipated losses may raise your premium if approved by the Division of Insurance and as long as it does so for all other policyholders.

Is LTC Insurance something you should consider?

If you can afford the premium and have significant assets you would like to protect, LTC Insurance can be an effective way to protect against the potentially devastating costs of LTC. It may also provide you with greater choices of providers of LTC services.

If you have very limited income and assets, and can’t afford the premiums, LTC Insurance is probably not for you.
What is a MassHealth (Medicaid) Qualified Policy?
- When a person has LTC services paid for by MassHealth, he/she will have a lien placed on their primary residence to recover the funds paid on their behalf after their death. This process is called “recovery.” You can avoid “recovery” by having a LTC policy in place as of the day you enter a nursing home that meets or exceeds the following specifications: a “Daily Benefit Amount” of at least $125 for nursing home care; an “Elimination Period” no longer than 365 days; a “Benefit Period” of at least 730 days
- Note: Although a policy may satisfy these requirements at the time it is purchased, if an insured uses the policy to pay for non-nursing home benefits (e.g. home health care), the amount of benefits remaining available to pay for nursing home care may be less than what is necessary to meet the MassHealth minimum coverage requirements on the day you enter a nursing home.

Where can I Buy LTC Insurance?
- Most people buy LTC insurance directly from an insurance agent, financial planner or broker.
- Many private and public employers offer group LTC insurance as an optional benefit. Employers do not typically contribute to the premium cost (as they do with health insurance), but they often negotiate a favorable group rate for employees. It’s important to note that these group policies are not subject to all the same state protections as individual policies.

Things to Consider Before Buying LTC Insurance
- Find a good agent! Contact several companies and agents before purchasing a policy.
- Ask questions and understand all written materials. Compare “Outlines of Coverage.”
- Check out the financial stability of the companies and their rate increase histories.
- Never pay with cash.
- Be sure to use the “free-look” period (during which time policy can be cancelled and premium fully refunded).

Where can I go for more information?
- Call the Massachusetts Division of Insurance 617-521-7777 to request a “Massachusetts Guide to Long-Term Care Insurance.”
- www.longtermcare.gov – Website created by the federal government that provides a wealth of information and planning tools.
Reverse Mortgage Information & State Website

The Executive Office of Elder Affairs (EOEA) and the Office of Consumer Affairs and Business Regulation (OCABR) launched a web site to educate seniors about an increasingly popular product, reverse mortgages. The web site, www.mass.gov/reversemortgage, is designed to provide information and guidance to potential borrowers about this complicated product.

Reverse mortgages are loans that enable seniors 62 years and older to convert the equity in their home into income. Seniors with limited or fixed incomes often find themselves struggling to pay for unexpected expenses so they may turn to these products to generate income. A reverse mortgage lender lends the owner borrower money based on the value of the property, the age of the borrower and the accumulated equity in the home.

Borrowers may receive the money as a lump sum at settlement, monthly installments or a line-of-credit that enables the borrower to draw money when the individual chooses until the line of credit is exhausted. Repayment on the loan is generally not required until the borrower is deceased or no longer permanently resides at the property.

Consumers who are considering a reverse mortgage are strongly advised to:

- Review all aspects of the loan (including lump sum, term loan, line of credit) to determine if any of these reverse mortgage options are well suited to their needs.
- Obtain independent legal and financial advice to understand the impact of the transaction including any factors that may trigger repayment of the loan.
- Explore all alternatives with a reverse mortgage counselor or independent financial representative. The availability of no-cost or low-cost programs and benefits for home repairs and energy assistance may reduce or eliminate the need for a reverse mortgage.
- Understand all obligations under the loan including the responsibility to pay homeowners’ insurance and property taxes.
- Be wary of high-pressure sales tactics to buy or use the proceeds of the reverse mortgage to buy other financial products.

Massachusetts Law provides seniors obtaining a reverse mortgage with some unique protections:

- **Mandatory Counseling:** All reverse mortgage borrowers must obtain counseling from a counselor approved by the Executive Office of Elder Affairs. Borrowers are strongly encouraged to participate in face-to-face counseling.
- **“Cooling off” Period:** Massachusetts law provides all reverse mortgage borrowers with a cooling off period which gives them the right not to proceed with a transaction for seven days after a loan commitment is issued by the mortgage lender.
- **Program Approval:** Massachusetts law requires all reverse mortgage programs to be approved by the Division of Banks. A list of approved reverse mortgage programs and additional resources are available at www.mass.gov/reversemortgage. The local elder services provider at 1-800-AGE-INFO (1-800-243-4636) and the Division of Banks at (617)956-1500 may also address any questions consumers have.