



7 Ways to Maximize Medicare Benefits

Medicare is vital to the health of about 60 million Americans. Yet many of its benefits are overlooked, underused or misunderstood.

Consider the annual “wellness” visit, during which a doctor will assess your health risks, take your blood pressure and other routine measurements, check for cognitive impairment, and offer personalized health advice. It’s free. While 23% of Medicare beneficiaries took advantage of a wellness visit in 2016, nearly triple the percentage from five years earlier, many people were still not using the benefit, according to research recently published in the journal *Medical Care*.

That’s not the only Medicare benefit left lying on the examining table. Many healthy seniors pass up a host of free preventive services, ranging from bone mass measurement to cancer screening—“the kinds of things that people don’t generally think of if they’re not sick,” says Bonnie Burns, a consultant at California Health Advocates. Other benefits, such as home health care, often go unused because they have complex eligibility requirements that are poorly understood by both providers and patients.

In other cases, Medicare beneficiaries and their families simply don’t know about their benefits until it’s too late. Jim Whitworth’s first wife, Anique, spent the final months of her life in a nursing home. “It wasn’t until a couple of days before she passed away that somebody mentioned to me that she ought to be on hospice,” says Whitworth, 83, a retired computer

engineer in Mesa, Ariz. “By that time, it was a weekend, and there was no way to contact them. So it didn’t happen.” Hospice care, which is available to terminally ill Medicare patients and generally given at home, “would have been really beneficial” for Anique, who did not want to be in the nursing home, he says. “It would have given her some comfort.”

To get the most out of Medicare, seniors must not only know what benefits are available but also who qualifies for them, how much they cost and the best way to access them. If you go for a routine doctor visit but choose a physician who’s not a “participating provider,” for example, you may get a bill that’s far higher than you expect.

If you need incentives to maximize the bang for your Medicare buck, here are about 6,000 of them: The average traditional Medicare beneficiary enrolled in both Part A and Part B spent \$5,460 out-of-pocket on Medicare and Medigap premiums, doctor visits, drugs and other health care needs in 2016, according to the Kaiser Family Foundation. That number looks even larger when you consider that half of Medicare beneficiaries have annual income below \$26,200.

Even if you’ve dutifully read all 120 pages of the *Medicare & You* handbook (www.medicare.gov/medicare-and-you), there is a good chance you have overlooked benefits, had claims inappropriately denied or are missing out on programs that could save you money. Here are seven ways to get better care—for less—from Medicare.



1. Take the Freebies

Many Medicare beneficiaries “don’t know there’s a whole list of things they can get that have no co-payments,” Burns says. These include screenings for cardiovascular disease and depression, counseling to help you quit smoking, and flu and pneumonia vaccines. (See a complete list of Medicare’s preventive services at www.medicare.gov/coverage/preventive-screening-services.)

You’re also eligible for a free “Welcome to Medicare” preventive visit within the first 12 months that you have Part B. And as part of your annual wellness visit, you can get free help planning for end-of-life care, and your doctor can help you complete an advance directive that spells out your wishes. (If you schedule a separate visit to discuss end-of-life care with your doctor, you’ll pay the standard 20% Part B co-insurance.)

If you have a Medicare Advantage plan, you may also have access to free wellness benefits. Some Advantage plans, for example, offer SilverSneakers membership at no additional cost. This program gives you a basic gym membership and access to group exercise classes designed for seniors.



2. Choose the Right Provider

So you’re on original Medicare, and you’ve found a good doctor who treats Medicare patients. Job done, right?

Wrong. You need to know whether the doctor accepts the Medicare-approved amount as full payment for services—known as “assignment”—

meaning you can’t be billed for more than your Medicare deductible and co-insurance.

Most doctors treating Medicare patients accept assignment. Those who don’t fall in two categories: nonparticipating providers, who can charge up to 15% more than a reduced Medicare-approved amount for Medicare-covered services—leaving you responsible for the extra charges; and “opt out” providers, who can charge whatever they want, as outlined in a private contract with the patient.

If you’re considering a doctor in a “concierge” practice, be sure you understand how much you’ll pay out of pocket. In these practices, which are growing fast in many parts of the U.S., patients are charged membership fees in exchange for perks such as same-day appointments and e-mail access to doctors. But Medicare does not cover concierge membership fees. And some concierge doctors have opted out of Medicare. The concierge fees “could be thousands of dollars, on top of other out-of-pocket expenses,” says Tricia Neuman, director of the program on Medicare policy at the Kaiser Family Foundation.

To find doctors in your area who accept assignment, go to www.medicare.gov and under “Forms, Help & Resources,” click “find care.” The search tool indicates which doctors accept Medicare payment amounts.

If you have a Medicare Advantage plan, check your plan’s provider directory or website to be sure you’re choosing doctors who are in the plan’s network—keeping in mind that doctors may be added to or removed from the network at any time. You’ll generally pay more to see out-of-network providers.



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3. Save On Drugs

Even if you have Part D prescription-drug coverage, your out-of-pocket costs can be eye-popping—in part because Part D doesn't put a cap on out-of-pocket spending. Once their spending has reached the "catastrophic" coverage threshold of \$6,550 in 2021, most people still must pay 5% of the cost of covered drugs.

In some cases, you can rein in drug costs by forgetting your Part D plan and simply paying cash. The reason: Big-box stores, such as Costco and Target, "have a host of generics they offer for a few dollars," whereas many Part D plans have higher standard co-pays—say, \$10 every time you fill a prescription, says Ann Kayrish, senior program manager for Medicare at the National Council on Aging. The downside of simply paying cash: The cost won't count toward your deductible. But for people with moderate drug costs who aren't going to meet their deductible anyway, this approach may make sense, Kayrish says.

When using your Part D plan, you'll generally pay less if you stick with your plan's list of "preferred" pharmacies. Also review your plan's formulary. Most Part D plans divide their formularies into five cost-sharing tiers—preferred generic, generic, preferred brands, nonpreferred and specialty drugs—with the lowest-tier preferred generics being the cheapest for enrollees. If you see a drug approved for your condition that's on a lower tier than one you're currently taking, ask your doctor if it's appropriate for you.

If that cheaper drug won't work for you, you can pursue a "tiering exception"—asking the plan to cover your current drug at the lower cost-sharing level, says Casey Schwarz, senior counsel for education and federal policy at the Medicare Rights Center. You'll need a letter from your doctor explaining why the lower-tier drug is not appropriate for you. Ask

your plan for instructions on sending in the request. For help, contact the Medicare Rights Center's help line at 800-333-4114 or your state health insurance assistance program (go to www.shiptacenter.org).



4. Understand Home Health Benefits

After Connie Henderson's husband, Eugene, was diagnosed with a rare genetic condition that causes lung problems, a doctor gave the rural Minnesota couple a bit of good news: Medicare's home health benefit would pay for a nurse to come to their home and administer the weekly plasma infusions that Eugene would need to treat the condition.

Unfortunately, the doctor was wrong. Because Eugene was not homebound, the home health agency said, he didn't qualify for the Medicare benefit, and the Hendersons would have to pay about \$200 a week for the service. That left Connie, 66, in a bind: She could let her husband go to an infusion center at a clinic, where she feared exposure to other ill patients could damage his health, or learn to give the intravenous infusions herself. She chose the latter. At first, it was "scary," she says. "I didn't think we could do it."

As the Hendersons discovered, even health providers have a hard time understanding Medicare's home health care benefit. To qualify, you must need skilled services such as nursing, physical therapy or speech therapy. And you must be "homebound," meaning you have difficulty leaving home without help or leaving home isn't recommended because of your condition.

Another stumbling block: "People choose an agency that's not Medicare-certified," says Denise Sikora, owner of DL Health Claim Solutions, in Lady Lake, Fla. In that case, she says, "they're not getting covered by Medicare." To find and compare Medicare-certified home health agencies, go to www.medicare.gov/homehealthcompare.

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Even when patients meet all the requirements, they're often inappropriately denied benefits, says Judith Stein, executive director of the Center for Medicare Advocacy. One issue: Many Medicare beneficiaries have been told their home health coverage is ending because their condition is not improving. But "improvement is absolutely not required in order to get home care," Stein says. Medicare will cover home health care "to maintain a person's condition or slow their decline," she says, "and that's very important for people with Alzheimer's, stroke or paralysis."



5. Fight for Your Rights

What should you do if you suspect you've been inappropriately denied Medicare benefits? Marshal some allies—which may include your doctors, state health insurance assistance program (SHIP) and patient advocacy groups—and fight back.

Review your quarterly Medicare summary notice, which shows services or supplies billed to Medicare. If any claims have been denied, first call the provider. Often, the problem is as simple as the provider having entered the wrong billing code, Stein says.

If the claim was submitted correctly, consider filing an appeal. Instructions are on the last page of the Medicare summary notice. Your SHIP may be able to provide sample letters of appeal and follow up with further assistance as your claim progresses, Kayrish says.

In some cases, Medicare beneficiaries must fight for their rights on the fly. If you are in the hospital and believe you're being discharged too soon, for example, you have the right to an expedited review of your case. Within two days of a hospital admission, you should receive a notice labeled "an important message from Medicare about your rights," which includes information on appealing a discharge decision. Until you get a decision on your appeal, "you stay in the hospital bed," says Diane Omdahl, president of Medicare consulting firm 65 Incorporated.



6. Explore Money-Saving Programs

Seniors living on a limited income may qualify for Medicare Savings Programs that will help cover Part B premiums and in some cases deductibles and co-payments, too. Although the programs help cover Medicare costs, they're administered by state Medicaid programs, and eligibility requirements vary from state to state. While all states restrict these programs to people with relatively modest incomes, a number of states—including Connecticut, Delaware and New York—have no limit on assets, so retirees who have built up a nest egg may qualify. If you're enrolled in a Medicare Savings Program, you automatically qualify for "Extra Help," which helps pay Medicare Part D drug costs.

Many states also offer State Pharmaceutical Assistance Programs (SPAPs), which can help cover Part D premiums, co-payments and other costs. In some cases, the income limits are "higher than you would think," Schwarz says. New York's program, for example, accepts seniors with income up to \$75,000 if single or \$100,000 if married.

To see if you qualify for a money-saving program, contact your SHIP or go to www.benefitscheckup.org.



7. Care for Those Who Need It Most

Many Medicare beneficiaries with the most severe health problems are missing out on some key benefits, Medicare experts say.

Among beneficiaries with a terminal illness, for example, hospice is "greatly underused," Omdahl says. If you're expected to live six months or less, the hospice benefit can provide care in your own home, drugs for controlling symptoms and relieving pain, respite care that allows family caregivers some time off, and other services. Under hospice, Medicare won't cover treatments that are meant to cure your terminal illness, but you can still receive treatment for other conditions. Hospice "doesn't mean you're giving up," Stein says. In fact, she says, "with good hospice care, people sometimes live longer, because so many of their needs are met." **K**

