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7 Ways to Maximize Medicare Benefits

Medicare is vital to the health of nearly 68 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 45% of Medicare beneficiaries took advantage of a wellness visit in 2020, nearly double the percentage from 2017, more than half of beneficiaries were not using this benefit.

That's not the only Medicare benefit left lying on the examining table. Many healthy retirees 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.

Things can get even more confusing if you buy additional private insurance to help cover traditional Medicare's out-of-pocket costs, depending on what type you use. With a Medigap plan, you stay on Medicare and the private insurance simply helps pay the out-of-pocket fees in exchange for your premium. Medicare Advantage is private insurance you have instead of a government traditional Medicare plan. While MA insurers are required to provide coverage similar to Medicare, Medicare Advantage plans can have different rules for the benefits, provider networks and approval processes for health care services.

In some cases, Medicare beneficiaries and their families simply don't know about their benefits until it's too late. To get the most out of Medicare, retirees 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 need incentives to maximize the bang for your Medicare buck, consider this. The average 65-year-old couple will spend $12,800 on health care in their first year of retirement, according to Fidelity, and those costs can increase over time as people age and develop more health issues. That number looks even larger when you consider that half of Medicare beneficiaries had annual income below $36,000 per person in 2023. Even if you've dutifully read all 128 pages of the Medicare & You handbook (*https://www.medicare.gov/publications/10050-medicare-and-you.pdf*), 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 "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 nearly complete list of Medicare's preventive services at *www.medicare.gov/coverage/preventive-screening-services*.) Also, Medicare Part D now covers all adult vaccines recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices at no cost to beneficiaries. There are no copayments or deductibles for vaccines, including those for shingles, whooping cough, tetanus and more.

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 unless you have a Medigap plan that picks up some or all of this cost.

If you have a Medicare Advantage plan, you may also have additional benefits. It's common for plans to include some dental coverage, vision (eye exams and/or eyeglasses), hearing exams and aids, and gym memberships. These wellness benefits are not part of traditional Medicare. A 2024 Commonwealth Fund survey found only seven out of ten Medicare Advantage enrollees report using any of their supplemental benefits, which means nearly a third are leaving perks on the table.

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, executive director of the program on Medicare policy at KFF, formerly the Kaiser Family Foundation.

To find doctors in your area who accept assignment, go to *www.medicare.gov* and under "Providers & Services," click "Find care providers." 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.

3. Save On Drugs

If you have Part D prescription-drug coverage, your out-of-pocket costs will be no more than $2,000 a year as of 2025.

In some cases, you can rein in drug costs even more 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 or out-of-pocket limit. 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 *https://www.shiphelp.org/*).

4. Understand Home Health Benefits

Medicare can cover home health benefits in certain situations, such as paying for a nurse or physical therapist to come by your home weekly to administer treatment. However, eligibility rules can be complex and 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. Medicare will not pay for custodial or supportive care for help with daily living tasks like getting dressed, bathing and preparing food. 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, which means they're not getting covered by Medicare. To find and compare Medicare-certified home health agencies, go to *www.medicare.gov/care-compare*.

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, says Kayrish from the National Council on Aging.

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, co-founder

of Medicare consulting firm 65 Incorporated.

Fighting for your rights is even more important if you're on a Medicare Advantage plan. These plans require you to obtain prior authorization from your insurer for higher-cost services like inpatient hospital stays, skilled nursing facilities and chemotherapy. You must get insurer approval before the services are covered, whereas you usually don't with traditional Medicare.

Insurers fully or partially denied 3.4 million prior authorization requests in 2022, representing 7.4% of total requests, according to KFF. Don't assume you cannot receive the care because an insurer says no. You have the right to appeal through your insurer and provide more information to justify why the care is medically necessary. Speaking up is highly effective. 83.2% of appeals led to overturning the original rejection, yet fewer than one out of ten denied requests were ever appealed.

6. Explore Money-Saving Programs

Retirees 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.

All states restrict these programs to people with relatively modest incomes, with most states using a maximum gross monthly income of $1,715 for individuals and $2,320 for couples in 2024. However, a number of states—including Alabama, Arizona, Connecticut, Delaware, the District of Columbia, Louisiana, Maine, Mississippi, New Mexico, New York, Oregon and Vermont—have no limit on assets, so retirees who have built up a nest egg may qualify. Note that Alaska, Connecticut, the District of Columbia, Hawaii and Maine have higher income limits. 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 prescription drug costs. In some cases, the income limits are "higher than you would think," Schwarz says. New York's program, for example, accepts people 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 *https://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," says Stein from the Center for Medicare Advocacy. In fact, she says, "with good hospice care, people sometimes live longer, because so many of their needs are met."