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2025 ELDER LAW EDUCATION GUIDE
16th Edition



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Massachusetts Chapter of the National Academy of Elder Law Attorneys**

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May 2025

Dear Massachusetts Older Adults:

We are proud to present this 16th annual edition of the Elder Law Guide for Older Adults (Guide), produced by the Massachusetts Bar Association (MBA) in partnership with the Massachusetts Chapter of the National Academy of Elder Law Attorneys (MassNAELA). We believe that the Guide is the gold standard as a comprehensive “one-stop” resource for both non-attorneys and attorneys alike. Special effort is made each year to update and improve the Guide to make sure the Guide is “user-friendly.”

The terms “elder,” “elderly” and “senior” are used sparingly since leaders in the aging community tell us “older adults” do not like age-related labels.

This edition reflects the best thinking and expertise of leading MassNAELA elder law and MBA attorneys, as well as other experienced professionals throughout the commonwealth. This year, the goal of the Advisory Committee was to expand the number of reviewers by adding over 50 professionals to review the content with a fresh perspective. The Advisory Committee members, as well as MBA staff, editors and designers, are focused on one thing: “how to make the Guide better.”

The MBA and MassNAELA continue to enjoy a unique and long partnership committed to empowering all older adults to face the opportunities and challenges of aging. The amount of time committed by volunteers and staff to produce this publication is remarkable by all those listed below. It is important to note that many of these volunteers are current or past members of the MassNAELA Board of Directors or officers or past presidents. All of those named below are highly experienced professionals from the public and private sectors. This year, we also added two new chapters on Affordable Housing and Tenants’ Rights.

The Advisory Committee once again recognizes the exceptional support of Elizabeth A. O’Neil, the director of public and community services at the MBA, who provides invaluable staff support and leadership. The amount of time devoted by all the volunteers requires Beth’s expertise to keep us organized, meet all the deadlines and make numerous revisions to produce this annual publication.

We hope you find this year’s Guide informative. Your feedback is important to us, and we hope that you will share your comments on how to make the Guide better by reaching out to the MBA’s Community Service Department at communityservices@massbar.org.

Cordially,

Alex L. Moschella, Esq., chair
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The mission of the National Academy of Elder Law Attorneys is to develop awareness of issues surrounding legal services for older adults and those with special needs. The more than 400 attorney members of NAELA's Massachusetts Chapter work for the older adult population in areas as diverse as: planning for catastrophic care costs; disability planning; age discrimination in employment and housing; benefits planning, including Medicaid and Medicare; and guardianships, probate and estate planning.

The objective of both the national and Massachusetts chapters is to promote the highest standards of technical expertise while maintaining ethical awareness among attorneys who represent the most frail and vulnerable members of society.

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CHAPTER 1

ESTATE PLANNING

A. OVERVIEW OF THE PLAN

There are certain documents that are essential building blocks to most older adults' estate plans. These documents include health care documents, powers of attorney and a last will and testament. Various types of trusts, both revocable and irrevocable, may also have a place, depending on your goals and circumstances. As described below, the way you hold title to your assets, such as by joint ownership, must also be consistent with your estate documents. Even if you have these documents in place, it is important to review them regularly to account for changes in your wishes and circumstances, as well as the law.

B. ESSENTIAL DOCUMENTS

1. Health Care Proxy

- a. **Naming a trusted person:** A health care proxy is the essential document to sign to ensure that you have appointed an individual of your choosing, and an alternate individual, to make medical decisions for you in the event of your incapacity (your "health care agent"). You can also set forth any limitations upon your health care agent's authority to act. Once you sign the health care proxy, it is important to convey your wishes to the individuals you have chosen to act as your agent.
- b. **Health care provider role absent direction:** Absent direction from an appointed health care agent, a health care provider has the right to confer with "responsible parties" related to you by blood or marriage to obtain informed consent for medical care.
- c. **Emergency:** However, this approach may not be sufficient, particularly if the circumstances require emergency action, use of antipsychotic medication or discharge to a nursing facility. It also may not be clear who is going to act as the responsible party, which may lead to fighting among family about who has authority to act on your behalf and what your wishes are.
- d. **Guardianship:** If there is no health care agent and no agreement among the responsible parties, the medical provider or family may need to resort to the court to appoint a guardian (a court-appointed fiduciary) for authority to make medical decisions for you if you are incapacitated. The guardianship process involves a court proceeding, which is not ideal in an emergency. Family members have the right to petition the court for guardianship, and the person the court deems the most appropriate may be the last person you would want to fill that role.
- e. **Advance directive and MOLST/POLST:** You may also wish to prepare or complete other documents expressing your health care wishes, such as an advance directive (sometimes called a "living will") or a medical order for life sustaining treatment/physician order for life sustaining treatment (MOLST/POLST), depending on your circumstances.
- f. **Sample forms for health care proxy and MOLST/POLST:** A more detailed discussion of health care decision-making, including sample forms, is included in Chapter 3, "Health Care Decisions, Medical Information and End-of-Life Choices."

2. Powers of Attorney

- a. **Definition:** A power of attorney is a written legal document created by you (the "principal") that authorizes an agent (the "attorney-in-fact") to legally act on your behalf in handling your property and affairs.
- b. **Effective only during life:** A power of attorney is only effective during your lifetime and will be void upon your death. The attorney-in-fact can be a spouse, or a trusted family member, friend or professional person.

- c. **Attorney-in-fact:** You, as the principal, specify in the document the powers you are granting to the attorney-in-fact. You can authorize the attorney-in-fact, for example, to sign checks, invest assets, enter contracts, make gifts, fund trusts and transfer property. This document is a very powerful planning tool, and you should only appoint someone you fully trust.
- d. **Lack of power of attorney:** If you do not have a power of attorney, no person automatically has control over or access to your individually owned assets, and if you are unable to manage your finances, a conservator (a court-appointed fiduciary to manage a person's property) would need to be appointed for you through the Probate and Family Court.
- e. **Consent of joint owners:** Even if assets are held jointly, the consent or involvement of both joint owners may be required (e.g., selling a jointly owned home). Without an authorized person to deal with your assets, a conservator must be appointed. This involves time-consuming court proceedings, often at times when immediate action is needed.

3. Last Will and Testament

- a. **Personal representative:** A will leaves directions regarding several key functions upon your death. It nominates a personal representative (formerly executor) to deal with your property, and a guardian and conservator to care for any minor or disabled adult children. It empowers those fiduciaries to act, and it gives direction regarding the disposition of assets owned in an individual's name alone without a beneficiary or other automatic transfer provision. Every person needs a will, regardless of whether a trust (see below) is also part of your estate plan.
- b. **Intestate death:** If you do not have a will, you are considered to have died intestate. If you do not otherwise dispose of your assets (e.g., joint ownership, trusts or beneficiary designations), those assets pass to your closest living relatives (known as your heirs-at-law) as defined by the Massachusetts probate code. This may not be in keeping with your wishes (e.g., an estranged sibling could inherit your assets if you have no spouse, descendants or living parents).

4. Trust Agreements

- a. **Purpose:** Trusts are used to hold assets for the benefit of an individual or individuals (beneficiaries). The money or property held in the trust is managed by a trustee according to the grantor's (your) instructions.
- b. **Types of trusts:** There are many different specialized types of trusts, but the broader categories are (i) revocable trusts, (ii) irrevocable trusts, and (iii) special needs/supplemental needs trusts (SNT).
 - i. **Revocable Trust:** A revocable trust is a trust over which you, the grantor, retain the ability to amend or revoke (terminate) the trust. A revocable trust is often used as a will substitute designed to avoid probate by transferring the title of assets into the name of the trust. You generally serve as trustee during your life and name those people you wish to be trustees after your passing to carry out your wishes. If you have a revocable trust, you should still also have a will to direct that all assets that remain in your name at the time of your death, or that later come into the name of your estate (e.g., an inheritance or abandoned property), will be distributed to the trust. This type of will is sometimes referred to as a "pour over" will.
 - ii. **Irrevocable Trust:** An irrevocable trust is a trust that, once established, except for rights retained at the outset, cannot be changed or revoked by the grantor. For older adults, irrevocable trusts are commonly used for asset protection planning for long-term care and require careful thought and consideration and, most importantly, the expertise of an experienced elder law attorney. The trust must comply with MassHealth rules and regulations, and the assets that are transferred to the trust may trigger the "five-year look-back period" for eligibility. This trust is also established by you as the grantor but typically must have an "independent trustee," who may be a family member. Your access to and control of the trust will likely be limited to the income generated by the trust assets. The trust assets themselves are beyond your control, and

you may not have the right to change the beneficiaries or other terms of the trust.

- iii. **Special Needs or Supplemental Needs Trust:** A supplemental or special needs trust (SNT) is a specialized trust that protects assets for a disabled individual and supplements the needs of that individual by funding things that are not otherwise covered by government benefits and/or other sources of support. For government benefit purposes, funds in a properly drafted SNT are not counted as the beneficiary's assets in determining eligibility. Some trusts are designed to receive a disabled individual's own assets (first-party trusts), while others are designed to receive assets from other individuals or sources (third-party).

C. EFFECTS OF ASSET OWNERSHIP AND BENEFICIARY DESIGNATIONS ON AN ESTATE PLAN

1. Probate vs. Non-Probate Assets

How an asset is owned, along with any beneficiary designation associated with an asset, will determine where it passes upon a person's death. If an asset is owned jointly with rights of survivorship or as tenants by the entirety, such assets pass to the surviving owner(s). Assets that have a named designated beneficiary pass according to the terms of the designation. Assets that have a life estate interest pass to a remainder beneficiary when the life estate holder dies. Assets that are owned individually, without any beneficiary named, pass under a person's last will and testament, if they have one, or otherwise by state statute (intestacy).

2. Risks of Joint Ownership

With respect to joint ownership of property, there are several circumstances and risks to consider, some of which are the following:

- a. **Using a joint account as a will substitute:** Many people name one child as a joint owner on an account with the intent that the child will distribute the asset to others (including other children) after death, but there is no legal obligation to do so. Even if the joint owner has the best intentions to effectuate your wishes, if the joint owner is going through a divorce or being sued, the joint owner may not be able to transfer the joint asset as intended.
- b. **Risking loss of your funds:** Any joint owner has the legal right to access 100% of joint assets at any time. Likewise, you risk exposure of your assets to the joint owner's creditors (lawsuit, divorce, bankruptcy).
- c. **Negative impact on your joint owner:** There could be unintended negative consequences to the joint owner (or their children); e.g., in the context of an application for financial aid, the joint asset must be disclosed and is countable as the joint owner's asset on a financial aid application.

3. Avoiding the Need for Probate

- a. **Probate avoidance by asset type:** Avoiding probate simply means that the probate court is not needed to determine who owns assets at death because the assets expressly indicate who will inherit them. For example, assets with a beneficiary designation, joint property (e.g., jointly held bank accounts, real estate, stock accounts, etc.) and property passing by contract (e.g., 401(k)s, IRAs, life insurance, annuities, etc.) are usually non-probate property. Another type of non-probate property would be a life estate interest in real estate; the life interest would expire at the life estate holder's death and the property would pass in full to the remainder beneficiary.

D. PLANNING CONSIDERATIONS FOR UNMARRIED COUPLES

1. Same Needs and Rights

Unmarried couples have the same needs and rights as anyone else, but it is particularly important for these couples to protect one another through an appropriate estate plan. A properly drafted estate plan can establish rights for your partner that the law does not otherwise provide to an unmarried couple.

2. Incapacity

As noted above, should you become incapacitated without a health care proxy and/or a durable power of attorney, your partner may have little or no right to participate in your medical care or to assist and protect your financial or other interests. In addition, absent proper estate planning, your partner may not receive any intended post-death gifts or inheritance from you.

- a. **Example of owning home in sole name at death:** For example, if you die owning a house in your sole name that you shared with your partner and did not complete the appropriate planning, your partner will have no rights to the home. Often, the only options available to a partner in this situation are to vacate or to engage in costly litigation to try to establish an equitable interest in the home.

E. KEEP YOUR DOCUMENTS UPDATED

1. Change of Circumstances

Your circumstances change over time, so it is important to periodically review your plan to ensure that your documents still reflect your wishes and will accomplish your goals. The laws change periodically (such as major changes to the probate laws in 2012, and tax law changes in 2017, 2020, 2022 and 2023), and such changes can have significant and unintended consequences for plans executed prior to the changes.

2. Goals Change

Your goals may change as you progress to different stages of life (for example, planning for minor children, planning for marriage or remarriage, planning to minimize estate taxes, planning to avoid probate or to avoid the cost of long-term care). Changes may occur in your family makeup, and the persons you named as beneficiaries in your will or trust may no longer be appropriate due to death, disability or bankruptcy. Therefore, the plan that made sense at an earlier time may need to be updated.

3. Choice of Agent Changes

It is important to reevaluate the people you chose as agents in your health care proxy, durable power of attorney, will and trust, to determine whether those individuals are still appropriate choices. Often, individuals have listed parents or other family members who may no longer be living or competent, or friends with whom the individual has not kept in contact.

F. PRACTICAL TIPS FOR MAINTENANCE OF YOUR ESTATE PLAN

1. Document Access

Determine a safe place to keep your original documents and come up with a plan to access them in an emergency. Keep copies of your documents together in a folder or binder and let your fiduciaries know where they are stored. They can be stored in a file cabinet or drawer or on a shelf in your home. You do not need to put these documents in a safe-deposit box, and in fact, that can slow down access to them when they are needed most. Some attorneys and financial institutions have secure portals where you can upload and save your documents so you and your fiduciaries can access them in an emergency.

2. Asset Summaries

Update your asset summary every year and keep it with your documents. Put an end-of-year statement of each of your accounts with your documents and update them annually.

3. Beneficiary Designations

Confirm your beneficiary designations and put that confirmation letter with your documents.

4. Online Access

Prepare a list of all of your usernames and passwords for all of your online accounts that your fiduciary may need to access. Update this list annually.

5. Memorandum of Tangible Personal Property Updates

Complete and/or update any memorandum regarding the preferred distribution of your tangible personal property. Update this list annually, or when you sell or acquire new items that you wish to give to certain beneficiaries.

6. Check Before Changing Asset Ownership/Beneficiary Designations

Before making changes of ownership or changes of beneficiary designations of your assets, check in with your lawyer to make sure the change is consistent with your estate plan.

7. Health Care Proxies to Doctors

Provide a copy of your health care proxy to your treating doctors so it can be uploaded into your medical records.

8. Power of Attorney to Financial Institutions

Provide a copy of your durable power of attorney to your financial institutions to make sure they will honor it. You don't want to wait until a crisis to find out the institution's policy. Certain institutions have refused to honor powers of attorney that were not on their particular forms.

9. Check in Regarding Your Estate Plan

Consider checking in with your attorney every three to five years or if your health or financial circumstances change.

CHAPTER 2

PROBATE AND ESTATE TAX CONSIDERATIONS

A. PROBATE

1. Probate Court Process

- a. **Property in individual's name:** Probate is the court process that may be necessary when someone dies (the “decendent”) with property in the decendent's individual name in order to transfer the property to the decendent's heirs-at-law when a decendent died intestate (without a will) or to the devisees designated in the decendent's will when a decendent died testate (with a will).

The probate process is necessary when the asset itself does not establish the subsequent owner after the decendent's death (i.e., assets owned by a person individually with no joint owner, designated beneficiary, or other payable on death designation).

- b. **Determine validity of will and heirs-at-law:** Through the probate process, a petitioner may request the court to determine the validity of a decendent's will, whether the decendent died intestate, and who the decendent's heirs-at-law are, and to appoint a personal representative.
- c. **Appoint Personal Representative:** A Personal Representative is a fiduciary appointed to settle and distribute the decendent's probate assets. A personal representative can be nominated in a decendent's will and will ultimately need to be appointed by the probate court. If no valid personal representative is nominated in a decendent's will, or the decendent dies intestate, then state law provides a list of who may serve and who has greater priority to serve than others.¹ This fiduciary role was previously referred to as an "executor" or "executrix" prior to 2012.

2. Types of Probate

- a. **Voluntary Administration — Estates that do not exceed \$25,000:** An estate may qualify for a simplified probate procedure called voluntary administration. To be eligible for this process, the decendent must have probate assets consisting entirely of personal property (no real estate) valued at \$25,000 or less (excluding the value of an automobile) with no dispute among the interested parties.² Any interested person in a decendent's estate³ can use this process by filing a voluntary administration statement with the probate court.
- b. **Estates greater than \$25,000:** For estates greater than \$25,000, there are two options for probating an estate:
- i. **Formal probate.** A court proceeding that can: determine the validity of a will or whether a decendent died intestate, determine a decendent's heirs-at-law, and appoint a personal representative. Most estates involving the disposition of real estate will be administered through a formal probate.
 - ii. **Informal probate.** An administrative proceeding that can be quicker than a formal probate, but does not determine heirs or establish the validity of wills.

Interested parties should consult with competent counsel to determine whether a formal or informal probate is more appropriate in a particular situation.

- c. **Venue:** Interested parties must determine where to file. To proceed in a particular court, the decendent must have been either:
- i. Domiciled at the time of the decendent's death in the county where the petition is filed.⁴
 - ii. The owner of property in the county where the petition is filed.

An "ancillary probate" could be required to separately address the administration of real prop-

erty owned outside of Massachusetts. People who own property in multiple states should consult with a qualified attorney to discuss how to avoid the need for an ancillary probate.

- d. **Late and Limited Probate:** For deaths occurring on or after March 31, 2012,⁵ probate proceedings must be initiated within three years of the decedent's death.⁶ If they are not initiated within this period of time and assets must be probated, a petition for late and limited formal testacy and/or appointment can be filed. This process has the following limited applications:
- Admit the decedent's will to formal probate and determine both the heirs and devisees
 - Determine that the decedent died without a will and determine the heirs
 - Appoint a personal representative to administer the estate

The personal representative's authority is limited to confirming title to estate assets and paying administration expenses.

B. PROBATE AVOIDANCE

1. Benefits

Given the time, cost, and risk of challenges associated with the probate process, it is often advantageous for people to prepare their estate plan to avoid probate.

2. How to Accomplish

Avoiding probate can be accomplished in the following ways:

- a. **Transferring assets to a trust during life:** A trust is a separate legal entity that can have instructions for the disposition of trust assets after a decedent's death.
- b. **Designating beneficiaries:** By making accounts (i.e., retirement accounts, investment accounts, cash accounts, life insurance policies, annuities, etc.) payable on death to another person or entity.
- c. **Adding joint owners with rights of survivorship to assets:** By adding joint owners on assets (i.e., bank accounts, real property, brokerage accounts, mutual funds, stocks, etc.), the asset can pass by operation of law to the surviving joint owner after the individual's death.
- d. **Simplified methods:** In addition, there are simplified methods for dealing with specific probate assets without utilizing the court:
 - i. A spouse (or heirs, if the spouse is deceased) may collect bank and/or credit union accounts that do not exceed \$10,000;⁷ and
 - ii. A spouse may sell or reregister title to the decedent's automobile(s).⁸
- e. **Careful consideration required:** While implementing these strategies may avoid the probate process, they should be executed after careful consideration, as they impact the legal rights individuals and potential beneficiaries may have over the assets during life or upon death.

Depending on the situation, it may be more appropriate to keep assets in an individual's own name regardless of whether they may then pass through probate upon the individual's death.

C. FEDERAL AND MASSACHUSETTS ESTATE AND GIFT TAXES AND LIFETIME GIFTING

1. Estate Tax

Both Massachusetts and the federal government impose an estate tax on certain high-net-worth estates. When determining an individual's gross estate, assets like retirement accounts and life insurance death benefits are included in an individual's gross estate.

- a. **Federal Estate Tax:** In 2025, the federal estate and gift tax exemption is \$13,990,000.
- b. **Massachusetts Estate Tax:** The Massachusetts estate tax exemption is \$2,000,000 (which was recently raised from \$1,000,000 by legislation in October 2023, effective for decedents dying on or after Jan. 1, 2023).

- c. **Estate Tax Exemption for Married Couples:** With proper estate planning, a married couple may maximize the use of their estate tax exemption amounts and possibly reduce or avoid state and federal estate taxes. Currently, the federal estate tax rate is 40% and Massachusetts estate tax rate can be as high as 16% depending on the size of the decedent's gross estate.
- d. **Spousal Exemption:** There is no estate tax on property that passes to a spouse, as long as the spouse is a U.S. citizen and the property otherwise qualifies for the unlimited marital deduction.⁹ Decedents may also reduce their gross estate by leaving certain assets to qualified charities using the unlimited charitable deduction.¹⁰
- e. **Non-U.S. Citizens:** If one or both members of a married couple are not U.S. citizens, couples should consult with a qualified estate planning attorney to plan for the limited estate tax exemption allowed to a surviving non-U.S.-citizen spouse.

D. GIFT TAX

1. Massachusetts and Federal Tax

- a. **No tax limit in Massachusetts:** Massachusetts does not impose a gift tax.
- b. **Annual federal gift tax exclusion amount of \$19,000:** There is a federal gift tax. Individuals may give up to \$19,000 (married couples up to \$38,000) per person per year (the 2025 gift tax annual exclusion amount) without the need to file a federal gift tax return or pay a gift tax.
- c. **Reportable gifts:** Gifts in excess of the annual exclusion amount must be reported on a gift tax return but will not cause a gift tax to be due unless a person's total lifetime gifts exceed the lifetime exemption amount (\$13,990,000 in 2025).
- d. **Gifts for medical care or education:** Gifts to pay for a person's medical care or tuition for education made directly to institutions, even if the amount is in excess of the annual gift tax exclusion amount, are not considered gifts.¹¹

E. CONSIDERATIONS BEFORE MAKING SIGNIFICANT LIFETIME GIFTS

1. Need to Consult With an Attorney

Individuals should consult with a qualified attorney and tax professional before making significant gifts. Large gifts may have unanticipated consequences, including income tax consequences, effects on eligibility for government benefits, and consequences to an individual's own future financial needs.

2. Appreciated Assets

Gifts of assets that have appreciated in value (e.g., stock or real estate) may reduce potential estate tax liability, but could create an adverse income tax impact for the donee on the sale of the gifted asset that has appreciated.

3. Eligibility for Medicaid (MassHealth) Benefits

Gifts (including gifts that are below the federal gift tax exemption amount) may adversely impact eligibility for Medicaid benefits. Although gifts are not reportable for gift tax purposes, they are relevant when determining whether an individual may qualify for long-term care benefits. For example, if a person makes a gift and needs to enter a long-term care facility within five years of making the gift, the person could be denied eligibility for Medicaid benefits for a period of time based on the total amount gifted.

1. MGL c. 190B, Sec. 3-203

2. MGL c. 190B, Sec. 3-1201

3. MGL c. 190B, Sec. 1-201(24)

4. MGL c. 190B, Sec. 3-201

5. The date on which the MUPC became effective

6. Note that there are some instances where this statute of limitations can be extended up to four years.

7. MGL c. 167D, Sec. 12 and MGL c. 171, Sec. 42

8. MGL c. 90D, § 15A

9. IRC Sec. 2056

10. IRC Sec. 2055

11. IRC Sec. 2503(e)

CHAPTER 3

HEALTH CARE DECISIONS, MEDICAL INFORMATION AND END-OF-LIFE CHOICES

INTRODUCTION

A major area of concern for older adults is addressing health care decisions and end-of-life considerations. This is a multi-faceted concern, and effective planning includes legal considerations, medical and non-medical options, and personal choice. In Massachusetts, there are a number of documents that adults should implement as part of their health care decision planning. Some are legal documents to be executed with an elder law attorney, and some are non-legal documents that should be discussed with your elder law attorney and your loved ones and completed with your physician. In addition to putting in place the necessary documents for health care decision-making, there are other important ways to engage in health care and end-of-life planning, including accessing your medical records and preparing yourself and your family for a hospital visit, learning about care management, and understanding your rights and options in Massachusetts around end-of-life choices.

TIP: For those who have just learned that they have cancer, there is a booklet from the American Bar Association called the Cancer Legal Advocacy Guide, which details steps in determining the right type of care for an individual, at: https://www.americanbar.org/groups/health_law/interest_groups/educational_outreach/hlcancer/.

A. LEGAL DOCUMENTS RELATED TO HEALTH CARE

1. Health Care Proxy

As mentioned in Chapter 1, a health care proxy is a key element of a basic estate plan. Executing a health care proxy allows you (the principal) to appoint a trusted individual (the health care agent) to make health care decisions for you if you become incapacitated or unable to communicate your health care wishes. Massachusetts recognizes the health care proxy by statute and provides a form, which must be signed by the principal and witnessed by two witnesses (who are not named in the document and are not your physician or other health care provider). A sample health care proxy is included as an exhibit to this chapter. It can be completed at no cost to you, does not require a notary, and does not need an attorney. Once completed, it is a good idea to give copies of your current health care proxy to your primary health care provider and your elder law attorney.

- a. The health care proxy is only activated if you lack capacity to make your own health care decisions. Your lack of capacity must be determined by an attending physician in consultation with others. Your agent makes decisions for you only when and for as long as you cannot do that for yourself. If and when you regain the capacity to make medical decisions, the authority over such decisions shifts from your agent back to you individually.
- b. The agent you select must be 18 years of age or older. You should also appoint an alternate agent in the event that the first person becomes unavailable to act. You may only select one agent at a time to serve as your health care agent.
- c. The agent will be permitted to make a wide range of medical decisions on your behalf, including whether to allow you to receive antipsychotic medications, how to instruct doctors regarding “do not resuscitate” (DNR) orders and life support measures, and/or whether to admit you to a skilled nursing facility. However, if you do not want to give your health care agent such broad authority, you are free to limit the decisions your agent is authorized to make by stating these limitations in the health care proxy.

- d. Whether you decide to limit the decisions your health care agent can make, you can also state your affirmative wishes as to end-of-life care and whether or not you wish to be an organ donor. If you wish to be an organ donor, you should also record this with the Massachusetts Registry of Motor Vehicles.
- e. You are not legally required to provide a health care proxy upon admission to medical facilities. However, most hospitals, nursing homes, assisted living memory units and hospice providers require a current health care proxy form on admission for services as a practical consideration — they want to know whom to call if needed. If you execute a second or subsequent health care proxy, you will likely revoke any previous health care proxies. For example, this can happen upon admission to a hospital for treatment. The new health care proxy may not have the provisions of your earlier document, including the nomination of a successor health care agent. In order to avoid inadvertently revoking your current health care proxy, you are advised to bring your current health care proxy with you on admission to a hospital.
- f. Your health care proxy can be revoked by you at any time while you have capacity. If you lose capacity, your health care proxy can be revoked (or affirmed) by a probate court if a dispute arises about, for example, the validity of the health care proxy; whether an agent is available, willing and competent to fulfill their obligations; or whether an agent's decision was made in bad faith or was not in accordance with the principal's wishes.

2. HIPAA Release

A Health Insurance Portability and Accountability Act (HIPAA) release form authorizes release of your medical information to anyone you choose. A sample release form is included as an exhibit to this chapter. Unlike a health care proxy, which is not in effect until a physician determines that you have lost capacity to make medical decisions, a HIPAA release is in effect when you sign it. The HIPAA release allows you to authorize your health care agent, and/or other trusted chosen individuals, to see your medical records and speak with your providers — even if you have capacity — and can be useful if you want to include the input of these individuals in your own decision-making about your care.

3. Guardianship

If you lose capacity to make your own health care decisions, and you do not have a health care proxy in place, a court process will be required to appoint a guardian (a person with legal authority to make medical decisions on your behalf). Because it is a court process, appointing a guardian can be costly and involve delays. In addition, it can lead to objections and conflict within a family. Also, the court may appoint a person you would not have chosen. For these reasons, executing a health care proxy is highly recommended for adults who have the capacity to do so.

Because guardianship constrains the autonomy of an individual to make their own medical decisions, it can be intrusive and unwelcome. Another option, known as supported decision-making (SDM), may soon be an alternative to guardianship in Massachusetts. SDM allows a disabled or elderly person to remain the decision-maker and acknowledges the role of trusted advisors chosen by the person to help the person make decisions about their own well-being.

SDM is a legally recognized arrangement in 16 states, and there is legislation pending in Massachusetts to make SDM available and enforceable in the commonwealth. In states where SDM is legally recognized, SDM agreements are legally enforceable agreements that address the kinds of decisions that the decision-maker controls, including, but not limited to, the services, supports, financial decisions and medical care the decision-maker wants to receive.

NOTE: Medicare now gives you the option on its website to identify a contact in the event of a medical emergency. This does not replace a health care proxy. (See <https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms10106.pdf>.)

B. OTHER DOCUMENTS RELATED TO HEALTH CARE

In addition to legally enforceable documents described in the preceding section, there are non-legal documents that allow you to state your preferences regarding medical decisions, such as whether you want life-sustaining measures, like feeding tubes, respirators and cardiac resuscitation. These personal choices can be expressed not only in your health care proxy, but also in an advance directive, also known as a living will. Your choices can also be documented in medical orders, such as a DNR order and a physician order for life sustaining treatment (POLST). A living will, DNR or POLST makes an individual's treatment preferences known to the health care agent and the health care provider in a set of limited and specific circumstances and provides written evidence of the principal's wishes, values, beliefs and specific instructions. Whether to include provisions regarding these matters in a health care proxy or in a separate living will or medical order is a matter to be discussed with an elder law attorney and your physician.

1. Living Will

- a. A living will is a non-legal writing that memorializes your values and wishes regarding your end-of-life care. Unlike a health care proxy, a Massachusetts living will does not have requirements for how it must be executed.
- b. A living will is not a self-activating or legally enforceable document. However, if you have a health care proxy, your health care agent is legally authorized to carry out your wishes as stated in your living will. Moreover, if you have a health care proxy, a living will is valuable guidance to your health care agent in carrying out the difficult duty of articulating your end-of-life wishes on your behalf if you cannot.
- c. You can include directions about whether you wish to receive life-sustaining measures like cardiopulmonary resuscitation (CPR), artificial ventilation/breathing and artificial nutrition. You can also state your values and itemize your other wishes about dying and death.
- d. A living will can be helpful if you anticipate a potential dispute among family members regarding your health care treatment.
- e. Most states, other than Massachusetts, recognize living wills in place of health care proxies. If you spend time in other states, such as New Hampshire or Florida, there are legal requirements for living wills you should follow.

2. DNR

- a. A DNR order is a medical order signed by a physician.
- b. It instructs all health care providers, including ambulance services, paramedics and EMTs, about the use, or limitation of use, of life-sustaining treatments, like CPR.
- c. A DNR is different from a health care proxy. Unlike a health care proxy, a DNR can be acted upon without a physician certifying that a person has lost capacity to make medical decisions. However, a DNR only applies in a limited circumstance, such as one involving paramedics.
- d. In Massachusetts, a DNR order may be included in POLST form, discussed below.

3. Physician Orders for Life-Sustaining Treatment (POLST — formerly, MOLST)

- a. POLST is the acronym used for physician orders for life-sustaining treatment. It is a portable medical order signed by a physician that provides for discussing, documenting and communicating end-of-life treatment options and preferences between a doctor and patient.
- b. In order for the POLST to be effective, it must be signed by both the patient and a licensed health care provider authorized to complete a POLST form in Massachusetts. A POLST should be signed only after an in-depth conversation between the patient and the provider.
- c. In addition to having a health care proxy, anyone with a serious medical condition should speak

to their physician about a POLST. Your physician may ask you to complete a POLST. If you are uncomfortable in doing so, you should decline but ensure that your physician is aware that you have a health care proxy and that a copy is in your file.

- d. A POLST can include a DNR order, along with other medical orders.
- e. If you become unable to make or communicate treatment decisions to health care providers, and you have not executed a valid health care proxy or POLST, then decisions must be made by a court-appointed guardian. Guardianship can be a costly and time-consuming process and can be avoided by having the proper health care documents in place.

A sample POLST is included here: <https://www.mass.gov/doc/polst-form-use-on-tablets/download>.

C. ACCESSING YOUR MEDICAL INFORMATION, AND PREPARING YOURSELF AND YOUR LOVED ONES FOR THE HOSPITAL

1. Medical Records

Every physician who treats you keeps a record of your visit; when this record is entered on a computer, it is called an electronic medical record (EMR). The record belongs to the medical professional who wrote it, but you can inspect the record and get a copy of it, usually upon a request in writing. Under HIPAA, the doctor has 30 days to provide you with a copy of the medical record; if the records are older and no longer in the office, the process can take up to 60 days. You are charged a reasonable fee to copy the records, but you do not pay for the time it takes to find them.

You may be asked for permission for your medical record to be shared with your other providers. Some hospitals and physicians use the Mass HIway (the Massachusetts Health Information Highway), where your personal electronic health record (EHR) is shared with other providers who treat you. This is especially useful if you have specialists who treat you at different hospitals, since all of your doctors will be able to share their reports.

Your medical records are not shared automatically; you have to agree or “opt in” to have your records shared among your providers. Your spouse, family members or other persons cannot get your medical records without your permission. You generally have the right to see your records made by a psychologist or psychiatrist unless the provider feels that the inspection would “lead you to serious harm.”

There are situations where your medical provider must report certain conditions, such as injuries due to guns, burns on more than 5% of a person’s body, rape, sexual assault or opioid overdose. Results of HIV/AIDS tests cannot be disclosed without first obtaining your written permission.

2. Documents and Other Items to Bring with You to the Hospital

- a. Your health care proxy, living will (if any) and/or other advance medical directives. A sample health care proxy is included at the end of this chapter.
- b. A document with your name, age, address and phone number, as well as the names of close relatives or friends and their phone numbers; your Medicare or MassHealth insurance numbers; and any other health insurance cards.
- c. The list of current medications you are on, including all ones for heart and blood-thinning, as well as for any chronic illnesses you have.
- d. Your cell phone, tablet and/or computer with applicable chargers, because visitors may not be allowed to see you in the hospital or recovery rooms.

3. Communicating with Your Health Care Providers, Health Care Agent, Family and Friends

- a. It is very important to communicate with your health care agent as to what decisions you want them to make on your behalf in the event that you cannot make or communicate the decision for yourself. They cannot respect your wishes if you have not made choices for them to follow and told them clearly. You should also consider sharing your medical wishes and directives with your family,

friends and caregivers so that they will be aware of and respect your wishes.

- b. There are several resources available to help you do this. One is the Conversation Project (<https://theconversationproject.org/>), which specifically records your wishes. A copy of that form is included at the end of this section.

D. CARE MANAGEMENT

Working with a care manager, whether for general guidance or in crisis situations, is an option available for families. Care managers are able to address a broad range of issues related to their clients and have extensive knowledge of the costs, quality and availability of resources. Aging Life Care Association (ALCA) is the credentialing organization for care managers. These professionals are health and human services specialists who act as guides and advocates for families who are caring for older relatives or disabled adults. They are educated and experienced in any of several fields related to aging life care management, including, but not limited to, counseling, gerontology, mental health, nursing, occupational therapy, physical therapy, psychology or social work, with a specialized focus on issues related to aging and elder care. Typically, these services are privately paid but can also be reimbursed through a long-term care insurance plan.

The website for ALCA is www.aginglifecare.org. To find more information on what care managers do and find one in your area, click on “Find an Aging Life Care Expert” and enter your zip code.

Understanding Your Options and Making Treatment Decisions: For those who have learned that they have cancer, assistance and detailed information are available at the American Cancer Society’s website: <https://www.cancer.org/cancer/managing-cancer/making-treatment-decisions/making-decisions.html>.

E. UNDERSTANDING YOUR OPTIONS IN MASSACHUSETTS FOR END-OF-LIFE CARE

1. Learning that you have a serious or terminal illness is life-changing. Some of us avoid talking about serious illness or death and dying, especially with our spouse, children and those closest to us. However, quality of life can be enhanced when one’s wishes and values are understood and honored, even when time is limited. Your family, caregivers, physicians and medical teams will be empowered to honor your wishes and instructions if you have been clear and open about your choices and values.
2. When making personal choices for yourself, be as informed and concrete as possible. For example, understand how you will be affected by the progression of a disease. Will you be able to read, walk or feed yourself? These questions seem harsh, but they are necessary to establish what you value as quality of life. Where will you receive your care? Can you return home? Is your family unit able to care for you, or will you need assistance beyond what they can provide?
3. It is important to be clear with your family and providers about your wishes. Following your wishes will be a comfort for those who love and care for you. Quality-of-life decisions require consideration of several alternatives, including:
 - a. **Heroic Care:** This is aggressive care, which often has side effects. Ask your providers about the side effects of this care and whether people taking it have survived for six months, a year or more. What were they able to do? If you were to do this, would you enjoy your quality of life after enduring the side effects? Ask if this aggressive care would disqualify you from a clinical trial. Also, be very clear about your understanding before you sign an informed consent form. Remember that you have the right to ask questions before agreeing to any procedure.
 - b. **Clinical Trials:** Ask if the care being discussed is an approved experimental treatment of the Food and Drug Administration (FDA). Will you be receiving the experimental treatment or a different treatment? What percentage of patients are alive six months/one year after receiving this treatment? What are the side effects? What happens if you discontinue the experimental treatment? You may not qualify for a clinical trial, or you may decide against it.
 - c. **Palliative Care:** Palliative care is primarily intended to reduce pain, while also continuing treatment for a serious illness. Palliative care can begin at any time and at any age that you and your physician

decide. Palliative care can continue indefinitely. Palliative care specializes in evaluating complex pain and symptom management, advance care planning, and discussing goals of care and quality-of-life issues.

- d. **Hospice Care** — Unlike palliative care, which can be provided in conjunction with other treatment for those living with a serious illness, hospice care is for patients with a life-limiting illness with a life expectancy of six months or less. People can continue to receive care beyond the six-month period as long as they continue to meet hospice eligibility criteria. Hospice care focuses on care, comfort and quality of life and does not continue treatment for the terminal illness, except for alleviation of pain. Hospice addresses the physical, emotional and spiritual needs of patients and families to help them live fully for whatever time they have remaining. Patients and families receive care from an interdisciplinary hospice team, which includes a physician, nurse, social worker, spiritual counselor, hospice aide, volunteers, etc. Other benefits of hospice include coverage for medication pertaining to the terminal illness, durable medical equipment, and grief and bereavement follow-up/support.

IMPORTANCE OF HOSPICE CARE

1. Hospice care is for individuals with an anticipated life expectancy of six months or less, when cure is no longer an option and the focus shifts to symptom management and enhancing quality of life. In order for a patient to qualify for hospice, a physician must certify that the patient has a life-limiting condition and is unlikely to live beyond six months. If the patient continues to live beyond six months, the patient is reevaluated.
2. Hospice does not end automatically at the end of six months, so long as the patient meets the criteria. Hospice is a Medicare Part A benefit to which all Medicare enrollees have a right for nursing and similar care. Neither Part A nor Part B cover custodial care.
3. Hospice care also is covered by most private health insurance and most MassHealth plans. If the patient is qualified, it is covered by MassHealth. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice>.
4. A geriatric care manager can be helpful in these crises situations as an additional resource and a coordinator of hospice care and Medicare/other health insurance benefits.
5. When a patient enters hospice, they should obtain an itemized list (also known as an addendum) of what the hospice benefit covers, what insurance benefits cover and what is not covered. Inquire about team visits, medications and durable medical equipment.
6. Hospice care can be provided any place the person calls home (person/families private residence, skilled nursing facility, assisted living facility, group home, hospice house etc.).
7. The patient must have a DNR order executed when entering hospice. The DNR can be changed anytime, especially as it applies to hospice and palliative care. However, revoking the DNR will remove the patient from hospice care.
8. Hospice does not require a health care proxy to be activated on admission or for services.
9. Hospice also does not require a POLST form to admit a patient.

F. RIGHT TO DIE AND MEDICAL ASSISTANCE IN DYING

1. Terminology

When discussing options for end-of-life care, it is important to understand the nuanced language involved. Generally speaking, there are two approaches an adult with a terminal illness can choose if the person wishes to end their life: (1) voluntary withdrawal of life support, and/or nutrition and hydration, with, or without, palliative sedation (commonly referred to as the right to die); and (2) requesting life-

ending medication from a physician (commonly referred to as death with dignity, medical assistance in dying (MAID) or physician-assisted suicide).

2. Massachusetts Law

As of 2022, MAID — requesting life-ending medication from a physician — is not a protected right under Massachusetts law, and physicians cannot prescribe such medication to a patient without risking criminal prosecution. *Kligler v. Attorney General*, 491 Mass. 38. However, the right to die (i.e., voluntary withdrawal of life support, and/or nutrition and hydration, with, or without, palliative sedation), is a protected legal right under Massachusetts law. In other words, current Massachusetts case law protects a terminally ill adult's right to die, which explicitly includes palliative sedation. However, Massachusetts law does not permit a physician to prescribe life-ending medication for a terminally ill competent adult, who may then choose whether to fill the prescription, and further, whether and when to take the medication — i.e., MAID. Nevertheless, MAID is a highly personal decision, much like the decision to engage in palliative sedation and the right to die. The *Kligler* court indicated that MAID is an individual liberty that should be protected from state intervention, but through legislative action rather than judicial case law. Thus, *Kligler* foreshadows the possibility that the Massachusetts legislature will pass the pending End of Life Options Act that would protect a terminally-ill competent adult's right to choose MAID in Massachusetts.

3. Laws in Other States

The option to pursue MAID is already protected by law in a number of other states, including California, Colorado, Hawaii, Maine, Montana, New Jersey, New Mexico, Oregon, Vermont, Washington and the District of Columbia. In these locations, a terminally ill competent adult may request and receive a prescription from a physician for life-ending medication without criminal consequences. MAID is a controversial topic, and the laws vary from state to state, and are currently evolving within states, like Massachusetts.

4. End-of-Life Care and Disability Rights

Because society routinely fails to provide disabled individuals with basic social, economic and human rights, including adequate health care, support for MAID is regarded by some as undermining the disability community's ongoing fight for equality, inclusion, autonomy and care. However, MAID for terminally ill competent adults who choose it can, and should, coexist with the right to palliative care for individuals living a full life with a serious illness. There is common ground in preserving the right to self-determination in uniquely personal health care decisions for those living with and without disabilities, and with or without terminal illness.

G. HELPFUL RESOURCES

How to start the conversation about end of life:

<https://hospicefoundation.org/Hospice-Care/Starting-the-Conversation>

<https://samaritannj.org/resources/end-of-life-conversation-starters/>

<https://lifecare.org/news-events/hospice-end-of-life-discussion-guide/>

Five Wishes: Asks you to answer questions — such as how you want people to treat you, what you want them to know, etc. (paid site)

Massachusetts Health Care Proxy Instructions and Document

Instructions: Every competent adult, 18 years old and older, has the right to appoint a Health Care Agent in a Health Care Proxy. To create your Health Care Proxy, print this two page form and place the instructions page and the blank document in front of you. Follow the step-by-step instructions and sign and date the Health Care Proxy in front of two witnesses, who sign and date the document after you.

1. Your Name and Address *(Required)*

Print your full name in the blank space. Print your address.

2. My Health Care Agent is: *(Required)*

Print the name, address and phone numbers of your Health Care Agent.

- Choose a person you trust to make health care decisions for you based on your choices, values and beliefs, if you cannot make or communicate decisions yourself;
- Your Health Care Agent and Alternate Agent cannot be a person who is an operator, administrator or employee in the facility where you are a patient or resident or have applied for admission, unless they are related to you by blood, marriage or adoption.

3. My Alternate Health Care Agent *(Not required, but helpful to have an Alternate Agent)*

If possible, appoint a person you trust as a back-up or Alternate Agent, who can step-in to make health care decisions if your Health Care Agent is not available, not willing or not competent to serve, or is not expected to make a timely decision. Print the name, address and phone numbers.

4. My Health Care Agent's Authority *(Required)*

Here's where you give your Agent either the broadest possible decision-making authority to make "any and all" decisions including life sustaining treatments, or limit his/her authority:

- If you want to give "any and all" decision-making authority, just leave this area blank.
- If you do not want to give "any and all" decision-making authority, describe the way in which you want to limit your Agent's authority and write it down in the space provided.

5. Signature and Date *(Required)*

Do NOT sign ahead. Sign your full name & date in front of two adult witnesses who sign after you.

- You can have someone sign your name at your direction in front of two witnesses.

6. Witness Statement and Signature *(Required)*

Any competent adult can be a witness except your Health Care Agent and Alternate Agent.

- Two adults must be present as witnesses when this document is signed. They watch as you sign the document, or as another person signs at your direction, and sign after you to state that you are at least 18 years old, of sound mind, and under no constraint or undue influence.
- Have Witness One sign, then print his or her name and the date;
- Then have Witness Two sign and print his or her name and the date.

7. Health Care Agent Statement *(Optional)*

This section is not required, but it can help your doctors and family know the Agents you appointed have accepted the position. Your Agent(s) signs and prints the date in the spaces provided.

Important: Keep your original Health Care Proxy. Make a copy and give it to your Health Care Agent. Give a copy to your doctors and care providers to scan in your medical record so they know how to contact your Agent if you are ill or injured and unable to speak for yourself.

Massachusetts Health Care Proxy

1. I, _____ Address: _____,

appoint the following person to be my Health Care Agent with the authority to make health care decisions on my behalf. This authority becomes effective if my attending physician determines in writing that I lack the capacity to make or communicate health care decisions myself, according to Chapter 201D of the General Laws of Massachusetts.

2. My Health Care Agent is:

Name: _____ Address: _____

Phone(s): _____; _____; _____

3. My Alternate Health Care Agent

If my Agent is not available, willing or competent, or not expected to make a timely decision, I appoint:

Name: _____ Address: _____

Phone(s): _____; _____; _____

4. My Health Care Agent's Authority

I give my Health Care Agent the same authority I have to make any and all health care decisions including life-sustaining treatment decisions, except (list limits to authority or give instructions, if any):

_____.

I authorize my Health Care Agent to make health care decisions based on his or her assessment of my choices, values and beliefs if known, and in my best interest if not known. I give my Health Care Agent the same rights I have to the use and disclosure of my health information and medical records as governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d. Photocopies of this Health Care Proxy have the same force and effect as the original.

5. **Signature and Date.** I sign my name and date this Health Care Proxy in the presence of two witnesses.

SIGNED _____ DATE _____

6. Witness Statement and Signature

We, the undersigned, have witnessed the signing of this document by or at the direction of the signatory above and state the signatory appears to be at least 18 years old, of sound mind and under no constraint or undue influence. Neither of us is the health care agent or alternate agent.

Witness One

Signed: _____

Print Name: _____

Date: _____

Witness Two

Signed: _____

Print Name: _____

Date: _____

7. Health Care Agent Statement (Optional):

We have read this document carefully and accept the appointment.

Health Care Agent _____ Date _____

Alternate Health Care Agent _____ Date _____

MASSACHUSETTS MEDICAL ORDERS
for LIFE-SUSTAINING TREATMENT



(MOLST) www.molst-ma.org

Patient's Name _____

Date of Birth _____

Medical Record Number if applicable: _____

INSTRUCTIONS: *Every patient should receive full attention to comfort.*

- This form should be signed based on goals of care discussions between the patient (or patient's representative signing below) and the signing clinician.
- Sections A–C are valid orders only if Sections D and E are complete. Section F is valid only if Sections G and H are complete.
- If any section is not completed, there is no limitation on the treatment indicated in that section.
- The form is effective immediately upon signature. Photocopy, fax or electronic copies of properly signed MOLST forms are valid.

A	CARDIOPULMONARY RESUSCITATION: for a patient in cardiac or respiratory arrest	
Mark one circle →	<input type="radio"/> Do Not Resuscitate	<input type="radio"/> Attempt Resuscitation
B	VENTILATION: for a patient in respiratory distress	
Mark one circle →	<input type="radio"/> Do Not Intubate and Ventilate	<input type="radio"/> Intubate and Ventilate
Mark one circle →	<input type="radio"/> Do Not Use Non-invasive Ventilation (e.g. CPAP)	<input type="radio"/> Use Non-invasive Ventilation (e.g. CPAP)
C	TRANSFER TO HOSPITAL	
Mark one circle →	<input type="radio"/> Do Not Transfer to Hospital (<i>unless needed for comfort</i>)	<input type="radio"/> Transfer to Hospital
PATIENT or patient's representative signature D <i>Required</i> Mark one circle and fill in every line for valid Page 1.	Mark one circle below to indicate who is signing Section D: <input type="radio"/> Patient <input type="radio"/> Health Care Agent <input type="radio"/> Guardian* <input type="radio"/> Parent/Guardian* of minor Signature of patient confirms this form was signed of patient's own free will and reflects his/her wishes and goals of care as expressed to the Section E signer. Signature by the patient's representative (indicated above) confirms that this form reflects his/her assessment of the patient's wishes and goals of care, or if those wishes are unknown, his/her assessment of the patient's best interests. <i>*A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.</i>	
	<input checked="" type="checkbox"/> _____ Signature of Patient (or Person Representing the Patient)	_____ Date of Signature
	_____ Legible Printed Name of Signer	_____ Telephone Number of Signer
CLINICIAN signature E <i>Required</i> Fill in every line for valid Page 1.	Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section D.	
	<input checked="" type="checkbox"/> _____ Signature of Physician, Nurse Practitioner, or Physician Assistant	_____ Date and Time of Signature
	_____ Legible Printed Name of Signer	_____ Telephone Number of Signer
Optional Expiration date (if any) and other information	This form does not expire unless expressly stated. <i>Expiration date (if any) of this form:</i> _____ Health Care Agent Printed Name _____ Telephone Number _____ Primary Care Provider Printed Name _____ Telephone Number _____	

SEND THIS FORM WITH THE PATIENT AT ALL TIMES.

HIPAA permits disclosure of MOLST to health care providers as necessary for treatment.

F	Statement of Patient Preferences for Other Medically-Indicated Treatments		
	INTUBATION AND VENTILATION		
Mark one circle →	<input type="radio"/> Refer to Section B on Page 1	<input type="radio"/> Use intubation and ventilation as marked in Section B, but short term only	<input type="radio"/> Undecided <input type="radio"/> Did not discuss
	NON-INVASIVE VENTILATION (e.g. Continuous Positive Airway Pressure - CPAP)		
Mark one circle →	<input type="radio"/> Refer to Section B on Page 1	<input type="radio"/> Use non-invasive ventilation as marked in Section B, but short term only	<input type="radio"/> Undecided <input type="radio"/> Did not discuss
	DIALYSIS		
Mark one circle →	<input type="radio"/> No dialysis	<input type="radio"/> Use dialysis <input type="radio"/> Use dialysis, but short term only	<input type="radio"/> Undecided <input type="radio"/> Did not discuss
	ARTIFICIAL NUTRITION		
Mark one circle →	<input type="radio"/> No artificial nutrition	<input type="radio"/> Use artificial nutrition <input type="radio"/> Use artificial nutrition, but short term only	<input type="radio"/> Undecided <input type="radio"/> Did not discuss
	ARTIFICIAL HYDRATION		
Mark one circle →	<input type="radio"/> No artificial hydration	<input type="radio"/> Use artificial hydration <input type="radio"/> Use artificial hydration, but short term only	<input type="radio"/> Undecided <input type="radio"/> Did not discuss
	Other treatment preferences specific to the patient's medical condition and care _____ _____ _____		

PATIENT or patient's representative signature G Required	Mark one circle below to indicate who is signing Section G: <input type="radio"/> Patient <input type="radio"/> Health Care Agent <input type="radio"/> Guardian* <input type="radio"/> Parent/Guardian* of minor		
	Signature of patient confirms this form was signed of patient's own free will and reflects his/her wishes and goals of care as expressed to the Section H signer. Signature by the patient's representative (indicated above) confirms that this form reflects his/her assessment of the patient's wishes and goals of care, or if those wishes are unknown, his/her assessment of the patient's best interests. *A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.		
Mark one circle and fill in every line for valid Page 2.	Signature of Patient (or Person Representing the Patient) _____		Date of Signature _____
	Legible Printed Name of Signer _____		Telephone Number of Signer _____

CLINICIAN signature H Required	Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section G.		
Fill in every line for valid Page 2.	Signature of Physician, Nurse Practitioner, or Physician Assistant _____		Date and Time of Signature _____
	Legible Printed Name of Signer _____		Telephone Number of Signer _____

Additional Instructions For Health Care Professionals

- Follow orders listed in A, B and C and honor preferences listed in F until there is an opportunity for a clinician to review as described below.
- Any change to this form requires the form to be voided and a new form to be signed. To void the form, write VOID in large letters across both sides of the form. *If no new form is completed, no limitations on treatment are documented and full treatment may be provided.*
- Re-discuss the patient's goals for care and treatment preferences as clinically appropriate to disease progression, at transfer to a new care setting or level of care, or if preferences change. Revise the form when needed to accurately reflect treatment preferences.
- The patient or health care agent (if the patient lacks capacity), guardian*, or parent/guardian* of a minor can revoke the MOLST form at any time and/or request and receive previously refused medically-indicated treatment. ***A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.**



IMPORTANT INFORMATION ABOUT MASSACHUSETTS MOLST

The Massachusetts MOLST form is a MA DPH-approved standardized medical order form for use by licensed Massachusetts physicians, nurse practitioners and physician assistants.

While MOLST use expands in Massachusetts, health care providers are encouraged to inform patients that EMTs honor MOLST statewide, but that systems to honor MOLST may still be in development in some Massachusetts health care institutions.

PRINTING THE MASSACHUSETTS MOLST FORM

- Do not alter the MOLST form. EMTs have been trained to recognize and honor the standardized MOLST form. The best way to assure that MOLST orders are followed by emergency medical personnel is to download and reproduce the standardized form found on the MOLST web site.
- Print original Massachusetts MOLST forms on bright or fluorescent pink paper for maximum visibility. Astrobrights® Pulsar Pink* is the color highly recommended for original MOLST forms. EMTs are trained to look for the bright pink MOLST form before initiating life-sustaining treatment with patients.
- Print the MOLST form (pages 1 and 2) as a double-sided form on a single sheet of paper.
- Provide an electronic version of the downloaded MOLST form to your institution's forms department or to personnel responsible for copying/providing forms in your institution.

FOR CLINICIANS: BEFORE USING MOLST

MOLST requires a physician, nurse practitioner, or physician assistant signature to be valid. This signature confirms that the MOLST accurately reflects *the signing clinician's discussion(s) with the patient*. The MOLST form should be filled out and signed only after in-depth conversation between the patient and the clinician signer.

Before using MOLST:

- Access the *Clinician Checklist for Using MOLST with Patients* at: <http://www.molst-ma.org/health-care-professionals/guidance-for-using-molst-forms-with-patients>.
- Listen to *MOLST Overview for Health Professionals* at: <http://www.molst-ma.org/molst-training-line>.
- Access the MOLST website at: <http://www.molst-ma.org> periodically for MOLST form updates.
- For more information about Massachusetts MOLST or the Massachusetts MOLST form, visit <http://www.molst-ma.org>.

* Astrobrights® Pulsar Pink paper can be purchased from office suppliers, including:

Staples - Item #491620 Wausau™ Astrobrights® Colored Paper, 8 1/2" x 11", 24 Lb, Pulsar Pink, in stores or at <http://www.staples.com>, and

Office Depot – Item #420919 Astrobrights® Bright Color Paper, 8 1/2 x 11, 24 Lb, FSC Certified Pulsar Pink, in stores or at <http://www.officedepot.com>.

**Massachusetts Department of Public Health
Authorization for Release of Information
Permission to Share Information**

If you want the _____ to share information about you with another person or
(Fill in name of person or organization)
organization, please make sure that you fill out all of the sections below (Sections I-VI). This will tell us what information you want us to share and who to share it with. If you leave any sections blank, with the exception of Section II (B), your permission will not be valid, and we will not be able to share your information with the person(s) or organization you listed on this form.

SECTION I

I, _____, give my permission for _____
(print your name) (Fill in name of person or organization)
to share the information about me that I list in Section II with the person(s) or organization that I list in Section V.

SECTION II

A. Health and Personal Information

Please describe the information you want the _____ to share about you.
(Fill in name of person or organization)

Please include any dates and details you want to share.

B. Permission about Specific Health Information. Only if you choose to share any of the following information, please write your initials on the line:

____ I specifically give permission, as required by M.G.L. c. 111, § 70F, to share information in my record about HIV antibody and antigen testing, and HIV/AIDS diagnosis or HIV/AIDS treatment.

____ I specifically give permission, as required by M.G.L. c. 111, § 70G, to share information in my record about my genetic information.

____ I specifically give permission to share information in my record about alcohol or drug treatment. If this information is shared, I understand that a specific notice required by 42 CFR, Part 2 shall be included prohibiting the redisclosure of this confidential information.

SECTION III – Reason for Sharing this Information

Please describe the reason(s) for sharing this information. If you do not want to list reasons, you may simply write: "at my request," if you are initiating the request.

SECTION IV – Who May Share This Information

I give permission to the person or organization listed below to share the information I listed in Section II:

Name

Organization

Address

**Massachusetts Department of Public Health
Authorization for Release of Information**

SECTION V – Who May Receive My Information

The person or organization listed in Section IV may share the information I listed in Section II with this person(s) or organization:

Name

Organization

Address

I understand that the person(s) or organization listed in this section may not be covered by federal or state privacy laws, and that they may be able to further share the information that is given to them.

SECTION VI – How Long This Permission Lasts

This permission to share my information is good until _____.
Indicate date or event

If I do not list a date or event, this permission will last for one year from the date it is signed.

- I understand that I can change my mind and cancel this permission at any time. To do this, I need to write a letter to _____, and send it or bring it to the place where I am now giving
(Fill in name of person or organization)
this permission (or fill in specific location) If the information has already been given out by, I understand that it is too late for me to change my mind and cancel the permission.
- I understand that I do not have to give permission to share my information with the person(s) or organization I listed in Section V.
- I understand that if I choose not to give this permission or if I cancel my permission, I will still be able to receive any treatment or benefits that I am entitled to, as long as this information is not needed to determine if I am eligible for services or to pay for the services that I receive.

SECTION V – Signature

Please sign and date this form, and print your name.

Your Signature

Date

Print Your Name

If this form is being filled out by someone who has the legal authority to act for you (such as the parent of a minor child, a court appointed guardian or executor, a custodial parent, or a health care agent), please:

Print the name of the person filling out this form: _____

Signature of the person filling out this form: _____

Describe how this person has legal authority for this individual: _____

CHAPTER 4

RETIREMENT PLANNING

Retirement is a major life transition. The topics below are meant as a starting point and are followed by both relevant information and helpful resources. While not a comprehensive list, the topics provide a guide to additional information on retirement planning.

A. AFFORDING RETIREMENT

1. First, estimate your future income, expenses, assets and liabilities, with particular attention to expenses that are necessary versus discretionary, and including potential inheritances. Your analysis is more than just an inventory of current income, assets and expenses. Rather, it is important to: (1) consider future health insurance availability and its cost; (2) analyze Social Security options and pension benefits (survivor or single life); and (3) consider tax implications (including required minimum distributions), all as part of a comprehensive plan seeking to assemble the pieces of the retirement puzzle into a clear picture.
2. Next, list your current income, expenses, assets and liabilities. Note which income is guaranteed and which is not. Then, consider the changes to income and expenses that may occur upon retirement. These expenses might include increased health insurance costs, additional travel and vacation expenditures, or perhaps a decrease in income taxes. Other costs may stay the same, such as your mortgage payment.
3. Expenses can be grouped into three categories: (1) fixed monthly expenses, such as your mortgage payment; (2) variable monthly expenses, such as your basic needs and wants; and (3) discretionary expenses, such as items or services that you want, but do not need.
4. For married couples, it is also critical to look at expected changes in expenses and income that will occur upon the death of the first spouse. This is especially important to consider when planning with respect to future Social Security retirement or pension income.
5. Use online retirement calculators as a helpful resource to understand your retirement picture. These are tools designed to enable you to develop a well-formulated budget and make reasonable financial projections. Still, you must be discerning, as these are only tools, and the projections may vary widely among providers. The variations arise because some calculators are based on your current lifestyle, rather than your retirement lifestyle. Also, there may be some motivation on the part of investment firms to market their services. Likewise, your own calculations may be considerably different than those obtained from web calculators, but it is important to understand and evaluate all the data. Also, keep in mind that the median amount of retirement savings for Americans in their 60s is \$172,000. See www.nasdaq.com/articles/average-retirement-savings-by-age. The Social Security Administration offers some retirement calculators as a starting point. See <https://www.ssa.gov/prepare/plan-retirement>.

B. CALCULATING RETIREMENT NEEDS

1. Three of the most common sources of income for retiring individuals are Social Security benefits, pension plans and retirement accounts, such as 401(k)s, IRAs, 403(b)s, etc. There may, of course, be other sources of income available to retirees, such as investment or rental income. Part of your planning for retirement should include considering when you will need to start relying on this income. If you have other assets upon which you can rely, you will need to consider whether it would be advantageous to delay taking funds from these particular sources.
2. If you will be eligible for Social Security benefits, you may claim benefits as early as age 62; however, it can be advantageous to wait until your full retirement age, which is described in further detail in Chapter 6. At full retirement age or later, you will receive a larger monthly benefit. Depending on your other income, including retirement benefits, pensions and investment income, up to 85% of your Social Security benefit may be considered taxable income.

3. Along with the timing for claiming Social Security benefits, when to begin withdrawing from your pensions or retirement accounts should also be considered. With respect to retirement accounts, Congress passed what is known as the SECURE 2.0 Act in December 2022. While its full implications are beyond the scope of this chapter, it is important to note that the mandatory date by which you must begin taking “required minimum distributions” from your retirement accounts has been raised to age 73 beginning in 2023 (and age 75 in 2033). This can be important, because it can allow for further savings without prematurely drawing down on your accounts. Keep in mind that for many retirement accounts, such as 401(k)s and traditional IRAs, the amounts of the entire distributions are taxable income. You may want to consider developing a tax-efficient plan for the timing of withdrawing from such assets versus withdrawing from assets with different tax implications, such as Roth IRAs and non-qualified assets. Some people may feel that this analysis is beyond them. In those cases, it would be productive to enlist the help of a professional.
4. One of the primary concerns for individuals contemplating retirement is whether they will be able to afford to maintain their home. For many, the home represents security and a lifetime investment that is difficult to give up. Special consideration should be given to the expenses required to maintain the home and whether it will be realistic to afford these expenses after retirement. There are potential resources to help you. You may consider refinancing your mortgage, obtaining an equity loan, or applying for a reverse mortgage if you need liquidity (see Chapter 16 for further discussion regarding reverse mortgages). Your city or town may have abatement programs for older persons relative to real estate taxes (see Chapter 19 for further discussion regarding tax abatements). If you are considering selling your property as part of retirement planning, you should be sure to consider any potential capital gains tax consequences that will arise upon sale. Also, it is important to consider where you will live next and whether or not your new home will be affordable in retirement.

C. USE OF A FINANCIAL PLANNER

1. A financial planner is a professional who works with clients to help them manage their money and reach their long-term financial goals. Financial planning includes help with budgeting, investing, saving for retirement, tax planning, insurance coverage and more. Some financial planners may hold a Certified Financial Planner (“CFP”) or other professional designation to establish their professional qualifications. Due to the large number of titles and designations of those who specialize in providing financial advice and guidance, space limitations prevent listing them here. However, the American Association of Retired Persons (AARP) has a comprehensive guide available online. See <https://www.aarp.org/money/investing/info-2021/complete-guide-to-financial-advisers.html>.
2. If you have been successfully managing your money, you may decide against working with a financial planner; however, this may change as you age as your ability or desire to continue managing your finances also changes. A financial planner can also be valuable to ensure the continuity of financial management over time and for your family members, as they may become involved in assisting with your financial affairs. If you would like a personalized or second opinion regarding your financial plan, you should consider a consultation with a financial planner. Many financial planners offer free/complimentary consultations and analyses/proposed plans.
3. When selecting a financial planner, you will find that there are numerous financial professionals competing for the attention of older persons to assist in their retirement planning. The fees charged are often confusing. Word-of-mouth recommendations from friends and relatives are one starting point. You may also receive sound recommendations from your attorney or tax professional.
4. Conflicts of interest can be hard to detect. In some instances, vulnerable and/or unaware older adults are financially exploited by financial planners. If you ever have any concerns about this, you should immediately contact the Massachusetts Securities Division at (800) 392-6090 or cis@sec.state.ma.us.

D. UNDERSTANDING FEES AND EXPENSES

1. If you choose to have a professional assist you with your financial planning, one of the most important discussions to have with prospective financial advisors is their fee structure and scope of services. You should feel comfortable understanding how an advisor charges for their services and how such fees will affect the total return of your investments. Expect full disclosure and complete transparency. Fees may be structured based on a fee for services, based on a percentage of assets managed, by the trade, or some combination thereof. If your advisor is investing your funds in individual stocks, ask what fee you would pay for each trade (purchase or sale) of a stock. Excessive trading of stocks can be costly and reduce your total return. The practice is known as “churning” the account to benefit the advisor.
2. Fees may not be directly stated as charges to you and instead may be built in to the financial products a planner is recommending, such as commissions for sales of annuities or so-called 12b-1 fees for mutual funds. Be certain to also inquire about such considerations in determining the overall cost of employing a financial planner, as such fees can substantially impact your savings over time. It is always helpful to get several opinions at the outset to understand the various potential investment options and their relative costs.
3. Ask an advisor for the “ADV” brochure and “Relationship Summary” that list the firm’s and advisor’s disciplinary events. Also, ask about potential conflicts of interest and compensation arrangements (regulatory requirements), as these should be readily available. If the advisor seems reluctant to discuss any of these matters to your satisfaction, that should raise a red flag. It is also a good idea to go to the Financial Industry Regulatory Authority (FINRA) BrokerCheck site to see the disciplinary history and licenses held for any potential advisor. The site can be found at <https://brokercheck.finra.org>.

E. USING BINDERS AND ORGANIZERS

It is important to make sure that all your essential documents and papers, whether they are stored electronically or organized on paper, are in one place. A large, three-ring binder with tabs listing legal, financial, home and personal may work best. Your original documents, including your health care proxy, power of attorney, will, and any trusts and deeds to your home, as well as all insurance policies and a list of your assets and important passwords, should be in the binder. The binder should also include important documents that your personal representative or named agent, fiduciary, or loved one will need to have or know about upon your death. You also should tell that person where this binder is located so that it can be found in an emergency or upon your death. As your binder contains sensitive financial information, the binder should be kept in a secure location. Buying a fireproof security file box would be a good idea.

F. ADDITIONAL RESOURCES

These Securities and Exchange Commission (SEC) websites are easy to understand and have many embedded links with additional, unbiased information (subscriptions required).

- Status of investment advisors and related professionals at www.sec.gov/investor/seniors/guideforseniors.pdf.
- See also for excellent information on this topic: www.investor.gov/additional-resources/information/seniors.
- “Brokers and Investors Face a Crazy Quilt of State Regulations,” by Barley McCann, *Wall Street Journal*, May 7, 2021.

NOTE: Four states — Massachusetts, New York, New Jersey and Nevada — now have their own state regulations that must be followed by financial advisors. The 2019 SEC rule on “best interests” of the client states that financial advisors’ actions “must align with client interest and clear disclosure of fees and conflicts.”

- “A Simple Framework for Financial Advice,” by Eugene Scalia and Jay Clayton, *Wall Street Journal*, Dec. 15, 2020 (note former secretary of labor and SEC director, respectively).
- “Seven Questions to Ask When Picking a Financial Advisor,” by Shelly Banjo, *Wall Street Journal*, April 13, 2009.
- “SEC focuses attention on conflicts of interest in financial advice for seniors, retirement savers,” See <https://www.cnbc.com/2021/03/03/sec-sets-focus-on-conflicts-of-interest-in-advice-for-seniors.html>.
Note that the focus is on sales practices, exchange funds, real estate trusts, annuities, digital assets, and municipal and other bonds, as well as accounts that carry commission vs. annual fees.
- Another site that sets out key questions, advisor background and disciplinary history is <https://adviserinfo.sec.gov/>.

CHAPTER 5

PENSIONS

This chapter focuses on pensions and retirement plans that are subject to the Employee Retirement Income Security Act of 1974 (ERISA). This includes most pensions and retirement plans that are sponsored by private employers or unions. Except as indicated, the material in this chapter does not pertain to plans that are sponsored by state or federal government employers, nor does it include so-called “church plans,” which are sponsored by religious entities. Please review the resources included in the “Seek Outside Help” portion of this chapter for advice regarding these non-ERISA plans.

A. DIFFERENT TYPES OF PENSIONS

1. Private pensions weren't always protected by federal law as they are today. Before ERISA took effect in 1976, pensions were largely subject to the employer's rules, with few federal legal requirements or protections. After ERISA, private pension plan participants received a number of significant protections under federal law.
2. Most workers today will earn some kind of retirement benefit during their working lives. The most common types of benefits are defined benefit plans and defined contribution plans. Defined benefit plans (often called “pensions”) provide a fixed, monthly benefit payment upon retirement, with the amount determined based on a formula that typically considers the retiree's earnings and years of service. Defined contribution plans provide individual accounts for each worker who chooses to participate that are funded by worker contributions and may also include employer contributions. At retirement, the worker has access to the full balance in the account. The most common defined contribution plans are 401(k) and 403(b) plans.
3. This chapter focuses primarily on defined benefit pension plans (“pensions”). Many people who are reaching retirement age now earned a pension during their working years. Current private sector workers are much less likely to have access to a defined benefit pension. Nowadays, private sector employers are more likely to offer a 401(k) or other defined contribution plan.

B. EARNING A PENSION

Not every worker has access to a pension. You will only have access to a pension if your employer has decided to include a pension in the benefits that it offers its employees. The number of private employers that offer a defined benefit pension has fallen dramatically since the 1970s. Most public employers, however, continue to offer pensions to their employees.

In order to earn a pension benefit, plan participants must “vest” in a pension. Generally, workers vest in a pension by working for their employer for a required number of years. The specific requirements to vest in a pension are determined by law, but some pension plans may be more generous than the law requires. It is important to review your Summary Plan Description or Plan Document to determine how much service you need to complete in order to vest. After you have earned a vested benefit, that pension becomes yours (when you reach retirement age) even if you leave the company and work somewhere else. The pension then becomes a deferred vested benefit that you will be able to collect when you reach retirement age, regardless of where you work for the rest of your career.

The age at which a worker can retire and collect their benefit differs between plans, but most plans set normal retirement age at 65. A few months before you plan to retire, you should contact your plan to start your benefit. It typically takes at least a few months from applying to receive your benefits to receiving your first check.

C. FORMS OF BENEFITS

1. Your pension will likely have different options for how you may receive your benefit. The most common

types of benefit payments are a single life annuity, a joint and survivor annuity, a year certain and life annuity, and a lump-sum payment.

2. If you are married, then the default form of benefit is a joint and survivor annuity ("J&S annuity"). A J&S annuity pays a fixed monthly benefit to the participant during the participant's lifetime. If the participant's spouse lives longer than the participant, then the spouse will continue to receive a monthly benefit — a "survivor benefit" — after the spouse dies. The survivor benefit must be at least 50% of the amount that the participant received while alive.
3. A single life annuity typically pays the participant a larger amount each month than the J&S annuity. However, if the participant is married, the single life annuity will not provide a survivor benefit for the spouse. In order for a married participant to elect a single life annuity, the participant's spouse must sign a waiver before a notary, consenting to the form of benefit.
4. Many plans offer other annuity options in addition to the J&S annuity and the single life annuity. It is very important to carefully read and understand the benefit options. For example, some benefit options may not provide a benefit that continues throughout the participant or beneficiary's lifetime, or the benefit may not continue at the same level. Once you have chosen a form of benefit, the choice usually cannot be changed.

D. TAKING A DEFINED BENEFIT PENSION AS A LUMP SUM

1. Some plans give their participants the option to receive all or part of their defined benefit pension as a single lump sum. Plans are not required to offer benefits in a lump sum, and a participant cannot force a plan to offer a lump sum. If a plan does offer a lump sum, the amount will be calculated according to a plan formula, and the calculated amount will often represent the present value of the amount that a participant would receive as a single life annuity during their life expectancy. Once a plan pays out a lump sum, there are no additional benefits due to a participant.
2. Sometimes, pension plans will offer deferred vested retirees a "lump-sum buyout" or "lump-sum window." For a limited period of time, deferred vested participants and/or retirees who wish to take advantage of the offer may receive a lump sum, generally instead of receiving a monthly annuity. Often, these lump-sum windows are limited-time offers. Participants may only take advantage of the offer by submitting their lump-sum paperwork within a limited window of time.

The decision of whether to take a lump sum should be considered carefully, ideally with assistance from a financial advisor or tax planner. Some factors that you may want to consider include:

- a. **Guaranteed income:** Choosing a life annuity means guaranteed income each month that will not vary as a result of market performance. Coupled with Social Security benefits, lifetime pension payments generally ensure that you will have a fixed amount of monthly income for the remainder of your life. Taking a one-time lump-sum cash payment leaves it up to you to ensure that the money lasts as long as you need it, and it requires that you budget accordingly.
- b. **Longevity:** Your health and expected longevity should play an important role in determining which form of payment is right for you. Monthly annuity payments may be a prudent choice if you are in good health and expect to have an above-average life span. You cannot outlive lifetime annuity payments; as long as you are alive, you will have the comfort of knowing you will receive a monthly pension. You can also elect a joint and survivor annuity with your spouse, which means your spouse will continue to receive monthly benefits after your death. Most experts would agree that, for most retirees, a guaranteed stream of income for life is a better option than a lump sum. However, a few factors that might weigh in favor of taking a lump sum option include: if you are in poor health or do not expect to have a long life span, and you will not have a surviving spouse who will need lifetime income; or if you already have a substantial nest egg or other secure source of adequate income, such as a spouse's pension.

- c. **Investment risk:** If you choose to invest your lump-sum payment, the value of your investments will be subject to market fluctuations. This means that while the value of your investments may increase, it also may decrease. If you elect annuity payments, the investment risk remains with your company and the pension plan. If the market struggles, your annuity payments will remain the same, and your company will likely be required to make greater contributions to the pension plan to compensate for lower-than-expected investment returns. If you take a lump sum, no one is responsible for taking care of your money other than you.
- d. **Taxation of benefits:** Taking a lump-sum payment will result in being taxed on the entire amount all at once unless the payment is rolled over into an IRA or another employer-sponsored retirement plan. Depending on the size of the lump sum, you may be pushed into a higher tax bracket. Also, if you take a lump-sum distribution before age 59½, you may be subject to a 10% early withdrawal penalty in addition to the taxes owed. In the case of annuity payments, you will also be taxed each year on the value of monthly payments you receive, though given their smaller size, they are less likely to impact your tax bracket.
- e. **Financial health of your company and your pension plan:** If your company is struggling financially and is no longer able to meet its required contributions to the pension plan, the plan may be turned over to the Pension Benefit Guaranty Corporation (PBGC). The PBGC has limits on the benefits that it can pay, so your monthly benefit might be reduced (see here for current limits: <https://www.pbgc.gov/wr/benefits/guaranteed-benefits/maximum-guarantee>). It is important to understand that the vast majority of retirees who get their benefits from the PBGC receive the same amount that they would have received if the plan had not terminated.

E. THIRD-PARTY INTERESTS

In addition to participants, there are other people who may have rights under a pension plan. This includes surviving spouses, surviving beneficiaries, and people who receive all or part of their former spouse's pension post-divorce (often called "alternate payees").

Spousal survivor benefits for married participants are protected by law, and the spouse of a participant is guaranteed to receive at least 50% of a J&S annuity. In order to receive this benefit, however, in most instances, the participant must have been married to the spouse for at least one year prior to retirement. Pension plans are not required to provide benefits for non-spousal beneficiaries (such as children or domestic partners). However, some pension plans do provide options to leave a survivor benefit to a non-spousal beneficiary.

Pensions and 401(k) plans must be handled very specifically during divorce proceedings in order for the non-participant spouse to receive benefits under the participant's plan. If you are getting divorced and there is a pension benefit at issue, it is important to speak with an attorney who has experience in this area of the law.

F. LOST PENSIONS

1. Sometimes, pension plans can be hard to track down when the participant reaches retirement age. Sometimes, it's because a company goes out of business, changes its name or merges into another company. Other times, the pension plan has mistakes in its employment records, and no longer has a record that a former employee is entitled to a pension. While ERISA protects participants and their vested status, a participant is sometimes required to prove their employment, years of service or entitlement to a benefit prior to receiving their benefits.
2. The protections under ERISA are very strong, and you will not lose your right to a pension simply because your company has gone out of business, merged with another company, or lost your employment or pension records. There are steps that you can take to protect your rights.
3. Sometimes, plans are terminated or frozen. Often, when a plan is frozen, benefits earned are locked in place, and workers no longer are able to earn additional benefits. When a plan is frozen, the freeze

is either a soft freeze (meaning the plan is discontinued for newer employees joining the company and employees who have not yet vested in the plan, but the plan continues for current vested employees) or a hard freeze (meaning the plan is frozen for all employees, and vested employees no longer accrue benefits). If your employer does elect to freeze its pension plan, it may only freeze benefits going forward. Under no circumstances may an employer retroactively freeze a pension plan or reduce pension benefits that have already been earned. In the event of a plan freeze, it is strongly recommended that you request and obtain a statement from your company that details your frozen accrued benefit calculation. Keep this statement in a safe place until you are ready to commence your retirement benefits.

4. Many defined benefit pension plans have been terminated by the employers that sponsor their plans. A terminated plan, often the next step after a plan is frozen, is the complete shutting down of a pension plan. Terminating a plan is a complicated process that requires the involvement of the PBGC, which is an agency of the U.S. government. Once a plan is properly terminated, either all benefits will be paid out to participants as a lump sum, or a group annuity contract at an insurance company will be purchased for the remaining participants, and annuity certificates will be mailed to them.
5. See Pension Request Letter at the end of this chapter.

G. COMPILE YOUR DOCUMENTS

There are many important documents that you receive during employment concerning your pension. One of the most important documents you may receive is called a vesting letter. This is usually a document or certificate that your employer sends to you to acknowledge your vested status. This document will usually show the date you are eligible to receive your pension, the amount you will receive, and confirmation that you have vested in the pension. It is very important to keep this document in a safe place. Other important documents include W-2 forms, which can be used to prove employment and years worked, and 1099-R forms from your tax returns. This part of your tax return will show what, if any, retirement distributions you received during the year.

Tax returns are incredibly important and helpful to hold onto. If you have a pension, you should try to maintain copies of all tax returns during your working years, and you should keep the documents in a safe place.

The Social Security Administration can be a helpful resource to get additional information to help prove your years of employment or to help determine if you may have a potential pension. You can request an Itemized Statement of Earnings to prove years of employment with the employer you worked for and the total earnings for each year of employment. As of the publication of this chapter, Social Security charges \$92 for this record. This document can be completed at any Social Security field office or can be printed and mailed online at www.ssa.gov/forms/ssa-7050.pdf. The other document is a Statement of Potential Private Retirement Benefit, which is a helpful first step in determining if you or a spouse has earned a pension. It is free to request, and you will receive a document in return that explains your potential benefit and the amount recorded. A form letter that you can use to ask for this statement is included in the appendix to this chapter (see Pension Request letter)

H. SHARE YOUR DOCUMENTS

Once you've collected your documentation, contact your pension plan or former employer to share the information and explain why you are entitled to a benefit. If your company has merged with another company, you may need to contact the successor company. Keep copies of any written communications in your files.

If your initial attempts to obtain your pension are not successful, you may want to file a formal claim pursuant to ERISA. A claim for benefits is an official argument to persuade the plan to pay benefits. The plan must answer the claim with either an award of benefits or a denial of benefits. After the claim is denied, there is a right to appeal the plan's denial, and the argument is reconsidered, often with input from the plan's Board of Trustees or legal advisors. The claims and appeals process is protected by ERISA and found in the Code of Federal Regulations (29 CFR § 2560.503-1). Every pension plan has a claims and appeals process,

which you can request and which the plan must give to you upon request.

I. SEEK OUTSIDE HELP

There are several government agencies and other organizations that may be able to help you locate your pension. Please review the agencies and organizations below for further information.

1. Pension Benefit Guaranty Corporation (PBGC)

- a. The PBGC is a government agency in Washington, D.C., that insures private defined benefit pensions. In some cases, it is responsible for paying benefits, usually when a plan sponsor has declared bankruptcy.
- b. If the PBGC is responsible for your pension benefit, or you are the beneficiary to a pension benefit administered by the PBGC, then call its Customer Contact Center. Its hours are between 8 a.m. and 7 p.m., Monday through Friday, and the number is (800) 400-7242. Please have your Social Security number and pension plan's name or number ready to share when you call.
- c. Email: CustomerService@pbgc.gov
- d. PBGC
P.O. Box 151750
Alexandria, VA 22315-1750

Include your full name, customer ID, or the last four digits of your Social Security number at the top of each document, along with your request. Please allow four to six weeks for the PBGC to respond to your request.

2. U.S. Department of Labor, Employee Benefits Security Administration (DOL-EBSA)

- a. DOL-EBSA is available to answer questions if you believe that you have been inappropriately denied a retirement, health, disability or other ERISA employee benefit.
- b. (866) 444-3272
Assistance is available in over 105 languages. If you are deaf or hard of hearing or have a speech disability, please dial 7-1-1.
- c. Ask a question online:
https://www.askebsa.dol.gov/WebIntake/?_ga=2.163257278.323340782.1670360177-1857761670.1669841835.

3. The Pension Action Center

- a. The Pension Action Center provides free legal counseling for workers and retirees who live or worked in Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont and Illinois.
- b. To request assistance, call (800) 425-6067, or submit an online request for assistance through its website: www.umb.edu/pensionaction.

4. Massachusetts State Retirement Board

- a. The Massachusetts State Retirement Board (MSRB) administers the Massachusetts State Employee Retirement System (MSERS) for all municipal and state employees, as well as employees of the state judiciary.
- b. (617) 367-7770 (8 a.m.–5 p.m.)
- c. Email: rb@tre.state.ma.us
- d. Members of the MSERS may visit the MSRB offices to drop off completed retirement applications, forms and other documents at: the MSRB's Boston office at One Winter St., Downtown Crossing; or the MSRB's Springfield office: 436 Dwight St., Room 109A. Drop-off hours at both offices are Monday through Friday from 10 a.m.–3 p.m., except on state holidays.

SAMPLE PENSION BENEFIT REQUEST LETTER

Name: _____

Street Address: _____

City, State and Zip: _____

Today's Date: _____

OCO

Office of Earnings Operation

ATTN: ERISA Correspondence Group

P.O. Box 33007

Baltimore, MD 21290-3007

Dear Sir or Madam:

Please provide me with a copy of the SSA Notice SSA-L99-C1 regarding my potential pension benefits from _____ in _____.

(name of employer) (city and state where employer was located)

In support of my request, I am submitting the following facts:

Name: _____

Social Security Number: _____

Date of Birth: _____

Parents' Names: _____

I certify that I am the person to whom the record pertains, or that person's legal guardian, or a person who is authorized to sign on behalf of that individual. I know that the knowing and willful request or acquisition of records under false pretenses is a criminal offense subject to a fine of up to \$5,000. Please send the information to me at the address noted above. I am enclosing a copy of my photo ID as proof of my identity. Thank you.

(government-issued photo ID, such as driver's license)

Sincerely,

Signature: _____

REMEMBER TO ATTACH A COPY OF YOUR PHOTO ID TO THIS FORM BEFORE MAILING.

CHAPTER 6

SOCIAL SECURITY

INTRODUCTION

It is important for workers and their families to understand how Social Security benefits fit into the overall plan for financing retirement years. Workers earn insured status for Social Security benefits by paying Federal Insurance Contributions Act (FICA) taxes on their earnings. The Social Security Administration (SSA) generally provides insured workers and their spouses certain basic retirement benefits, payable monthly for life. A worker's retirement benefit at full retirement age (FRA) is based on their average indexed wages over a work history of up to 35 years. Spousal benefits are calculated based on the worker's Social Security benefits. The following is an overview of the basic Social Security retirement benefit program.

A. TIMING RETIREMENT

1. Chart: When Workers Reach Full Retirement Age for Social Security.

YEAR OF BIRTH	FULL RETIREMENT AGE
1943–1954	66
1955	66 + 2 months
1956	66 + 4 months
1957	66 + 6 months
1958	66 + 8 months
1959	66 + 10 months
1960 and later	67

*If you were born on Jan. 1 of any year, you should refer to the previous year. If you were born on the first of the month, your full retirement age will be determined as of the immediate previous month. See "Plan for Retirement" here: <https://www.ssa.gov/prepare/plan-retirement>.

- a. Individuals do not have to wait until their FRA before they can begin taking retirement benefits. Instead, an individual may elect to begin taking Social Security retirement benefits as early as age 62, but that results in the monthly amount being permanently reduced to reflect the longer period over an individual's lifetime during which payments will be made.
 - b. Alternatively, an individual can delay receiving retirement benefits after reaching FRA, up to age 70. By delaying the start of payments, each monthly amount will be increased above the monthly amount otherwise payable at FRA to account for the shorter period of an individual's lifetime during which monthly payments will be made.
 - c. Delaying Social Security payments past age 70 will not further increase the monthly Social Security payment.
 - d. Social Security benefits are eligible for cost-of-living adjustments (COLA). The COLA for 2025 is a 2.5% increase from the previous year.
2. **Early Retirement:** An individual may begin collecting Social Security benefits before FRA, and as early as age 62, but the monthly payments are permanently reduced to account for the longer period of one's life that benefits will be paid. If an individual's health status is precarious, choosing early retirement benefits may be prudent if one is not expected to live to one's life expectancy. In addition, if an early retirement beneficiary continues working past age 62, the amount of Social Security early retirement benefit payments may be reduced further to account for that work (see D, How Working Affects Retirement Benefits).

3. **Full Retirement Age:** Once an individual reaches FRA (see chart on prior page), they may elect to begin receiving the primary insurance amount based on their highest average indexed earnings during a work history of up to 35 years. Working past FRA at lower wages will not result in a reduction of Social Security payments (see D, How Working Affects Benefits).
4. **Delayed Retirement:** Delaying benefit payments between FRA and age 70 increases monthly payment amounts to reflect the shorter period over which they will be paid. Benefit payments delayed to age 70 will not be reduced if the individual continues working past age 70 at lower pay.

Helpful Tip: Individuals are advised to contact the SSA for a personal calculation and not to rely on the general calculators. Merely requesting the information does not trigger the benefit.

B. FACTORS AFFECTING THE CALCULATIONS

1. Average earnings over a work history of up to 35 years based on Social Security records for FICA and Self-Employment Contributions Act (SECA) taxes paid by the individual are used to calculate the amount of the retirement benefit. That amount is called the primary insurance amount (PIA), and it is used as the basis for any retirement, dependents' or survivors' benefits paid on that person's record.
2. The calculation also pays a higher percentage benefit amount for replacement of pre-retirement earnings to individuals with lower lifetime earnings. Working past retirement age, whether or not an individual's Social Security payments have begun, can increase the 35-year average if those wages are significantly higher. Stopping working early may limit the 35-year average to a lower amount if one would have earned substantially higher wages after reaching the earliest retirement age at 62.
3. One-hundred percent of benefits earned are paid if retiring at FRA in 2025, which is age 66 and 10 months. This is the age at which benefits will not be reduced due to "early retirement." After the worker's primary insurance amount at FRA is determined, it is adjusted to reflect when an individual's payments actually begin. For example, if an individual born in 1963 elects to begin retirement benefits in 2025 at age 62, the monthly amount will be permanently reduced by 30% compared to what would have been paid if the individual had started receiving benefits at their FRA. If the individual waits until age 70 before starting benefits, the benefits will be increased by 8% for each full year of delay. For example, if an individual reaches FRA at 66 and 10 months in 2025, but waits until age 70 or later to begin payments, then the monthly amount will be about 25.33% higher than what the individual would have received had they applied at FRA.
4. An individual who begins receiving monthly Social Security payments at age 62 receives a higher lifetime benefit total than an individual who begins payments at age 66 only until a crossover point at about age 78. The person who delays payments to age 70 will reach the crossover point at approximately age 84. After the crossover point, the decision to delay will result in higher lifetime benefits than the person who begins Social Security payments at an earlier date. However, the crossover point also depends on an individual's particular situation, including working status, taxes and rate of inflation.
5. Many advisors suggest that the best guide is to wait until benefits are necessary to sustain the individual's, and their dependents' and survivors', lifetime needs rather than base the decision solely on expected total lifetime benefits by starting benefits at a particular age.

The calculation for early or late retirement benefits can be confusing, but the SSA has a nifty calculator on its website, https://www.ssa.gov/oact/ProgData/ar_drc.html.

C. TAXES AND OTHER FACTORS TO CONSIDER

1. A portion of Social Security benefits is taxable if a recipient's income is over certain thresholds. If an individual's combined income (adjusted gross income, nontaxable interest and half of their Social Security benefits) falls between \$25,000 and \$34,000 (or \$32,000 and \$44,000 if filing jointly), then half of the

Social Security benefits are subject to income tax. If an individual's combined income is above \$34,000 (or \$44,000 if filing jointly), then 85% of their Social Security benefits are subject to income tax.

2. Some financial planners recommend that individuals begin Social Security payments at age 62 if they believe that they can invest those payments and receive a higher rate of return than what would otherwise accrue by delaying payments. This strategy assumes that the individual does not need the Social Security payments, and that future investment returns, net of investment fees and income taxes, are greater than the increased monthly payments of delaying Social Security payments.
3. For each full year that Social Security is delayed after FRA up to age 70, there is an 8% increase in the amount of benefits paid. In 2025, FRA is age 66 and 10 months.
4. If an individual has limited savings and other retirement benefits, then beginning Social Security payments early may be financially necessary.
5. If an individual is in poor or precarious health, then beginning payments early will result in that individual's greater overall receipt of benefits if they do not live to an average life expectancy or until the crossover point.

D. HOW WORKING AFFECTS RETIREMENT BENEFITS

1. Social Security monthly retirement payments begun before FRA can be reduced if an individual is continuing to work. For every \$2 earned above the annual earnings limit, the individual's early Social Security payments will be reduced by \$1.
2. For 2025, the annual earnings limit is \$23,400 (\$1,950 per month). In the year in which an individual attains FRA, Social Security will deduct \$1 for every \$3 earned above a separate annual earnings limit until the month before the month in which FRA is reached. For 2025, that annual earnings limit is \$62,160 (\$5,180 per month).
3. For those who elect retirement benefits at or after FRA, working past FRA will not result in a reduction of the monthly retirement benefit amount otherwise payable. An individual working past FRA may be able to increase their Social Security benefit if the wages paid increase the individual's prior career average upon which benefits were otherwise calculated. See B, Factors Affecting the Calculations.

E. HOW WORKING AFFECTS DISABILITY BENEFITS

1. The Social Security Disability Insurance (SSDI) benefit, which arises due to a medical condition, is the same as the benefit at FRA. Once the disabled worker reaches FRA, the benefit switches to a retirement benefit instead of a disability benefit.
 - a. Disabled workers (and certain family members eligible for dependent benefits based on their disability SSDI on the wage record of a worker) who have been approved for SSDI benefits are eligible for Medicare benefits after 24 months of payments, even if they have not reached age 65. No separate application is required. The only exceptions to the 24-month waiting period for Medicare are those diagnosed with ALS or End-Stage Renal Disease.
 - b. Please refer to Chapter 7 for an excellent review of the Medicare program.

Social Security provides certain work incentives that allow Social Security disability beneficiaries to try work without immediate loss of their benefits due to work. These work incentives apply to SSDI widow/widower or benefits based on disability, and disabled adult child benefits.

- i. **Trial Work Period.** Every Social Security disability beneficiary is entitled to one set of nine months in which to test the ability to work with no effect on their benefits. A trial work month is used when the beneficiary works at a level defined as "services." In 2025, "services" is defined as \$1,160 or more a month in gross wages or 80 hours or more a month in self-employment. Use of the nine months does not have to be consecutive. Until the ninth trial work month has been used, the beneficiary is entitled to their disability benefit, no matter how much money

- they make, as long as they continue to meet Social Security's disability criteria.
- ii. **Extended Period of Eligibility (EPE).** The EPE is an additional period in which to test the ability to work without immediate termination of entitlement. The EPE starts the month after the ninth trial work month has been used. The EPE lasts at least 36-consecutive months. Eligibility for benefit payment during the EPE depends on whether the beneficiary works at the substantial gainful activity (SGA) level. The disability benefit payment is suspended for months when the beneficiary works at the SGA level and is overpaid if they receive payment in what should have been a suspended month. However, the beneficiary can return to benefit payment eligibility by verifying that they are no longer working at the SGA level. However, work at the SGA level after the 36th month of the EPE results in termination of entitlement to the disability benefit.
 - iii. **Substantial Gainful Activity (SGA).** SSA generally defines SGA by a dollar amount of monthly wages that is pegged to the annual COLA. In 2025, SSA presumes SGA when a person eligible for benefits based on disability has gross monthly wages at \$1,620 or more. For those eligible on the basis of statutory blindness, the presumed SGA level is \$2,700 gross or more in monthly wages. Certain deductions may apply to rebut the presumption of SGA: impairment-related work expenses; subsidy or special conditions; unsuccessful work attempt; or unincurred business expenses (for self-employment).
 - iv. **Expedited Reinstatement (EXR).** EXR can be a faster way back on disability benefits for those who lose entitlement to benefits solely due to performance of SGA after the 36th month of the EPE. Eligibility requires application within 60 months of entitlement termination and continuing to meet the disability criteria for the same or closely related conditions. SSA provides for up to six months of provisional benefits while it processes the EXR application.
 - v. **Continued Medicare.** Those who lose entitlement to disability benefits solely due to performance of SGA after the 36th month of the EPE are entitled to a potentially lengthy period of Continued Medicare.
 - vi. Check out Ticket to Work programs on the SSA website, www.ssa.gov/work, to learn more about the work incentives and supports the SSA provides for disability benefit recipients. See also SSA's Red Book on Work Incentives at <https://www.ssa.gov/pubs/EN-64-030.pdf>.

F. FAMILY BENEFITS: DEPENDENT AND SURVIVOR BENEFITS

Family benefits provide monthly payments to certain close family members of people who are eligible for Social Security retirement or disability benefits or who have died with insured status. See <https://www.ssa.gov/family/eligibility>.

1. **Spouse.** Social Security benefits provide some protection to a worker's family. For example, a spouse may be entitled to receive dependent's benefits on the wage record of their spouse who is entitled to Social Security retirement or disability benefits. Spousal benefit eligibility is based on being age 62 and older, caring for a child of the wage earner age 15 or younger, or caring for a child of any age who has a disability.
 - a. If the spouse begins receiving the spousal benefit at FRA, the maximum amount of that benefit is half the amount that the wage earner working spouse receives at FRA. If the spousal benefit begins when the wage earner spouse is between age 62 and FRA, however, it will be reduced to reflect the longer period of payment. If the spouse is working when receiving the spousal benefit, the spouse's dependent benefits may be reduced due to the annual earnings test. (See D, How Working Affects Benefits.)
 - b. The spousal benefit is not increased for delayed payment of Social Security benefits that the wage earner working spouse receives after FRA. If a spousal benefit applicant has worked and earned

insured status by paying FICA, they would generally receive an amount equal to the higher of their own Social Security benefit or the spousal benefit.

- c. A spousal benefit does not reduce the working spouse's Social Security payment. If the wage earner spouse's birthday is Jan. 2, 1954, or later, it is no longer possible to take only one spouse's benefit at FRA and delay the other. Rather, if the wage earner spouse files for a benefit, the application is automatically treated as filing for the spousal benefit at the same time.

2. **Divorced Spouse.**

- a. A divorced spouse of a marriage that lasted at least 10 years can collect a spousal benefit based on the other spouse's Social Security work history if that benefit is higher than what the divorced spouse could collect based on their own work history.
- b. To collect the spousal benefit, the divorced person must be at least age 62 or caring for a child of the wage earner age 15 or younger, and unmarried, and the wage earner working ex-spouse must be entitled to Social Security benefits. If the wage earner working spouse qualifies for, but has not applied for, Social Security benefits, the spouses must have been divorced at least two years before the other spouse qualifies for the divorced spouse benefit.
- c. The maximum spousal benefit for a divorced person is equal to half of the former spouse's Social Security retirement benefit at FRA and can be subject to reduction if the divorced spouse is working, due to the annual earnings test. (See D, How Working Affects Benefits.)

3. **Children.** The children or dependent grandchildren of a worker who qualifies for Social Security retirement benefits may also qualify for Social Security benefits based on the wage earner parent's record. To receive benefits, the child must be unmarried, unless married to a person receiving Social Security disability benefits, and:

- a. under age 18; or
- b. 18–19 years old and a full-time student (no higher than grade 12); or
- c. 18 or older and disabled since before age 22.
- d. Normally, benefits stop when a child reaches age 18 unless the child is disabled. However, if a child is still a full-time student at a secondary (or elementary) school at age 18, benefits will continue until the child graduates or until two months after the child becomes age 19, whichever happens first.

4. **Adult Disabled Child.**

- a. An adult disabled child may be eligible for Social Security dependent or survivor benefits based on the work history of a parent who has died with insured status, or who receives Social Security disability or retirement benefits.

For the effect of the disabled child's earnings on these benefits (see "E. How Working Affects Disability Benefits").

Note that work at the SGA level after age 22, and prior to qualifying for these benefits, prevents disabled children from qualifying for these benefits, unless the presumption of SGA can be rebutted.

5. **Widow or Widower.**

- a. The widow or widower of a worker may receive a survivor benefit based on the worker's Social Security earnings history. The survivor benefit can begin as early as age 60, at a reduced rate, or when the widow or widower reaches FRA or older, at a higher monthly amount.
- b. The reduction for taking benefits early is 19/40 of 1% for each month under FRA. For example, if a widow or widower begins receiving a survivor benefit at age 60, that benefit will equal 71.5% of the deceased spouse's primary insurance amount at FRA.
- c. If a widow or widower qualifies for higher retirement benefits on their own record, they can switch

to that benefit as early as age 62.

- d. If a widow or widower is disabled before the death of the worker, or within seven years thereafter, they can begin receiving survivor benefits as early as age 50. Remarriage of the surviving spouse does not reduce or eliminate the survivor benefit.

6. Dependent Parent.

- a. If a worker who was supporting a parent dies, the dependent parent, who is at least age 62, may be eligible to receive Social Security survivor benefits.
- b. To be eligible, the dependent parent must be unmarried, and must have been receiving at least half of their support from the working child. The dependent parent must not have a work history of their own that would yield a higher benefit.

7. Family Cap.

- a. Total family benefits payable under a worker's record are capped. The total cap varies but is equal to about 150% to 180% of what the worker would otherwise receive at FRA.

G. CONTACTING SOCIAL SECURITY AND REPRESENTATION BY A THIRD PARTY

1. It is uncertain whether in-person appointments, as in the past, will still be available. It is important to contact local offices, since in the past, an appointment could be made to speak with a representative at a local Social Security office, but many persons now apply for benefits through the Social Security website, www.SSA.gov. Known as "my Social Security," this online tool allows the participant to check their earnings record, apply for benefits, and estimate future earnings and benefits to help make decisions about when to retire. The individual is also able to add or change direct deposit instructions, obtain benefit verification letters, and notify Social Security of any changes.
2. Other than the eligible individual or the parent of a minor child making the contact, the SSA will not provide information to or take instructions from a third party. The SSA will not recognize the authority of a person under a power of attorney or a court-appointed guardian or conservator without the person being appointed as the individual's representative payee or being appointed a representative by completion of the proper SSA Form 1696, Claimant's Appointment of a Representative, signed by the individual. The SSA's appointment of an individual as a beneficiary's representative allows the representative to take any actions on behalf of the individual that the individual could take themselves.
3. A representative payee can be appointed by filing Form SSA-11, Request to Be Selected as a Payee, which allows a third party, typically a relative or care organization, to receive and manage an individual's Social Security payment, but which also allows the payee to take actions on behalf of the individual with the SSA.

H. COORDINATING SOCIAL SECURITY WITH PRIVATE RETIREMENT BENEFITS

1. In budgeting for retirement years and deciding when to begin taking Social Security payments, it is important to consider other retirement benefits besides Social Security. Many employees earn tax-qualified retirement benefits through their work — for example, under 401(k), profit sharing or defined benefit pension plans. An individual may also own an individual retirement account (IRA), with a balance sheltered from tax until distributed. The payment of retirement benefits from these sources should be considered in overall retirement planning.
2. Employees typically receive their retirement benefits from private plans when they leave employment or retire. By law, employers must generally begin paying an employee's qualified retirement benefits in the calendar year in which the employee reaches a certain age. Owners of IRAs who reach age 73 after Jan. 1, 2023, must begin taking a required minimum distribution (RMD) at age 73 whether or not they are still working (for individuals who reached age 72 before Jan. 1, 2023, such age was formerly 72, and prior to Jan. 1, 2020, such age was 70 ½). For employees reaching age 73 in 2025, the first RMD must be

taken by April 1, 2026. For all subsequent years, the RMD must be taken by Dec. 31 of that year. The minimum distribution age will increase to age 75 in 2033. Failure to take RMDs in a timely manner can subject an individual to a 25% penalty for the amount not withdrawn.

3. RMDs from private retirement plans are generally spread over the life expectancy of the individual (or the individual and a beneficiary) and are taxed to the individual recipient at ordinary rates. Failing to take RMDs in a timely manner can subject an individual to excise tax.
4. Individuals who got married or divorced before receiving retirement payments from an employer should be particularly careful to verify that all beneficiary designations for retirement benefits are properly updated. Employees who have been divorced should also take into account any applicable qualified domestic relations order (QDRO) requiring the private plan to pay some portion of a worker's retirement benefits to an ex-spouse. Anyone who was married to an individual who died before receiving retirement benefits from their employer should contact that employer for information regarding any death benefit that may be due to the surviving spouse.
5. Financial and/or tax advisors can often help an individual evaluate their retirement options, considering available Social Security benefits, private retirement benefits and an individual's needs to be able to "afford to retire."

I. SOCIAL SECURITY BENEFITS AND GOVERNMENT PENSIONS

The Social Security Fairness Act of 2023, H.R. 82, has eliminated Social Security benefit reductions due to receipt of pensions from work on which no FICA was paid. The effective date is as to Social Security benefits payable for months after December 2023.

1. Prior to Jan. 1, 2024, Social Security retirement, spousal, and widow's or widower's benefits could be reduced if a worker earned a pension from "noncovered" work that was not subject to Social Security withholding taxes (FICA).
 - a. The Windfall Elimination Provision (WEP) reduced the Social Security retirement benefits that a worker might otherwise receive because of noncovered work.
 - b. The Government Pension Offset (GPO) reduced the Social Security benefits of a spouse, widow or widower who worked for a federal, state or local government and earned a pension due to noncovered work.
 - c. For the WEP reduction calculations, please see the WEP Online Calculator or Detailed Calculator: <https://www.ssa.gov/benefits/retirement/planner/anyPiaWepjs04.html>.
 - d. A worker with 30 or more years of work where earnings were "substantial" (See Social Security Substantial Earnings Table at www.ssa.gov/planners/retire/wep-chart.html) and covered by FICA taxes was not subject to WEP reductions.

The WEP reduced Social Security retirement benefits of workers with fewer than 30 years of earnings at jobs subject to FICA. The reduction could not exceed 50% of the amount of the pension received from public sector employment. If the worker paid FICA at jobs for more than 20, but fewer than 30, years of work, the reduction was gradually eliminated.

- e. Social Security spousal and widow's or widower's benefits were reduced under the GPO by two-thirds of the amount of the individual's government pension. For example, if a government employee was entitled to a government pension of \$600 a month and a Social Security spouse's, widow's or widower's benefit of \$500 a month, the Social Security payment (\$500) was reduced by two-thirds of the governmental pension (\$400), and the spouse, widow or widower was entitled to \$100 of Social Security plus \$600 of the government pension.
- f. If two-thirds of the government pension was more than the individual's Social Security monthly amount, the Social Security benefit was reduced to zero.

- g. There were some very narrow exceptions to the offset. For example, if an individual's government pension was not based on earnings, the offset did not apply.
2. For Title II benefit payments for January 2024 and continuing, the WEP and GPO reductions no longer apply. As of this writing, Social Security had not issued implementing instructions.
- a. When SSA implements the WEP and GPO elimination provisions, those receiving Social Security benefits reduced by the WEP or GPO should receive increased ongoing benefits and retroactive benefits for any reduction back to January 2024.
 - b. Social Security advises those receiving benefits reduced by the WEP or GPO to make certain Social Security has their correct address to ensure they receive outreach information.
 - c. Those not in receipt of Social Security benefits due to the WEP or GPO should apply.
 - d. <https://www.ssa.gov/benefits/retirement/social-security-fairness-act.html>.

CHAPTER 7

MEDICARE What You Need to Know

A. SUMMARY

Health insurance, including Medicare, does not cover all services and costs. The purpose of this chapter is to help you choose the coverage that best meets your needs.

Medicare is a health care system that is run by both the government and private businesses. Understanding where the government coverage begins and ends, and what private business covers, are key in making your decisions. Medicare plans are purchased on an individual basis; there are no “spouse” or “family plans.”

Medicare Parts A and B (“Original Medicare”) are funded 80% by federal taxes and 20% by patient payments. The government establishes the services that Medicare covers. Original Medicare benefits are the same nationwide and provide a wide range of care. You can see any health care provider that accepts Medicare without a referral or being in a network. Medicare does not use prior authorization; if you meet the diagnostic criteria, you qualify for the service. You are responsible for premiums (usually Part B), deductibles and co-insurance. There are no limits on the amount of costs you pay on Original Medicare; ways to reduce costs are listed below.

Medicare Part C (“Medicare Advantage” or “MA”) plans are a hybrid of funding. Part C plans receive 85% Medicare reimbursement for Medicare-approved services. The remainder of the funding comes from the participants, including additional premiums beyond the usual Part B. MA plans can offer benefits that Original Medicare doesn’t offer, such as vision, dental and other coverage. MA plans are expected to follow Medicare guidelines for diagnostic criteria, but usually require that the patient see health care providers only in the network, requires referrals and prior authorization for services. There is usually a limit on the amount of money (co-pays and co-insurance) for services, but this limit only applies to in-network or permitted services. Money you pay for services you receive that have not been approved by the plan’s prior authorization or are outside the network does not count toward the limit. The Centers for Medicare and Medicaid Services (CMS) have noted that MA plans frequently deny care using prior authorizations that Original Medicare would provide.

Medicare Part D (“Prescription Drug Plan”) is funded 85% by the government and 15% from participants. Effective in 2025, the federal government has capped the total out-of-pocket expenses for participants at \$2,000 per year; deductibles are capped at \$590 for 2025. Monthly premiums are also limited, but do not count in the cap. The government rules require that plans offer specific categories of drugs but do not require that all FDA-approved drugs be covered by each plan. Plans generally require step therapy, prior authorization, and they may completely deny coverage for a drug.

All of these plans are discussed in detail below.

B. FOUR DIFFERENT PARTS OF MEDICARE AND HOW TO ADVOCATE FOR BENEFITS

Medicare is a health insurance plan administered by the federal government through the CMS. This vast program insures U.S. citizens and legal residents who are age 65 or older and people under age 65 with certain disabilities.

1. Medicare Part A

- a. **Inpatient:** Helps cover inpatient hospital services, including a semi-private room, meals and general nursing services; Part A also covers some home health care, limited skilled nursing facility (SNF) care, certain hospice services and most inpatient drugs. In order to receive Part A hospital benefits, a person must be admitted as an “inpatient.” This happens when the person’s doctor AND the hospital both agree to the admission. If the hospital does not agree, the person’s stay will not be

covered by Part A. Part A does not cover all inpatient costs; certain costs will be covered by Part B. Part A does NOT cover custodial nursing home care (custodial care includes feeding, bathing and toileting); Part A ONLY covers SNF stays under certain conditions, as discussed below.

Criteria for inpatient admission: The doctor orders inpatient care to treat the patient, and the hospital must formally admit the patient. The doctor must have a reasonable expectation at the time of admission that the patient would need medically necessary hospital care crossing at least two midnights. The doctor uses the patient medical history, medical needs, severity of signs and symptoms, medical predictability of an adverse event, and the need for and availability of diagnostic studies. The criteria do not include test results that become available after admission, unless the post-admission information supports the conclusion that the admission was medically necessary.

This two-midnight rule applies to both Original Part A and Medicare Advantage plans.

Medicare administrators cannot solely use algorithms or artificial intelligence to make medical decisions to deny admission.

- b. **Emergency Room Not Covered Under Part A:** Going to the emergency department is NOT a Part A hospital admission. The emergency department as well as urgent care are covered by Part B. If the hospital tells you that you are under “observation status,” that is an indicator that you have not been admitted as an inpatient under Part A.
- c. **Addressing Reclassification from Inpatient to Observation Status:** If you were admitted as an inpatient under Part A, and then reclassified as an "observation" admission under Part B, you will be denied Part A benefits for nursing homes. Effective Jan. 1, 2025, there is a Medicare rule that allows you to appeal this denial. Details on how to appeal are found here: <https://www.govinfo.gov/content/pkg/FR-2024-10-15/pdf/2024-23195.pdf>. (This does not apply to Medicare Advantage plans. Information for filing MA denials are below.) The final rule is found here: <https://www.govinfo.gov/content/pkg/FR-2024-10-15/pdf/2024-23195.pdf>.
- d. **Hospital Admission:** When you are first admitted as an inpatient to a hospital, the Part A benefit begins, and you are responsible for the Part A deductible. You pay the full deductible on the first day of admission; it is not prorated. The Part A benefit period ends when the person has not been an inpatient or receiving skilled nursing care for a period of 60-CONSECUTIVE days. Under Part A, benefits can expire before the need for hospitalization or skilled nursing care ends. There can be more than one benefit period in a year, as long as the 60-consecutive-day interval requirement has been met. The Part A deductible is due for each new benefit period. Going to the emergency room under Part B without a hospital admission will not affect the 60-day count and force a restart of the 60-consecutive days. Part A has a deductible and co-insurance; costs are discussed below.
- e. **Inpatient Hospital Discharge:** Patients must have 24-hour notice prior to discharge from a hospital. There are requirements for discharge: the patient must be medically stable, the patient must be discharged into a safe environment, and appropriate care can be provided upon discharge. There is no requirement that appropriate care be provided in a nursing home if other appropriate sources of care are available.

There is a software program used to determine where to discharge patients, particularly for admission into rehabilitation facilities. The name is “Interqual,” which is typically used by the care management team, who are frequently nurses who specialize in insurance utilization. The nurse provides clinical information to the insurer to obtain appropriate benefits and responds to insurance questions. This system does not control what the primary physician considers "medically necessary" for the patient but does determine insurance coverage.

Interqual criteria are used to evaluate the severity of a patient's illness, assess comorbidities and complications, determine the intensity of services being provided and help determine patient admission.

f. **Acute Inpatient Facility and Skilled Nursing Facility (SNF) Admission:** There are two types of skilled nursing facilities; one is an acute rehabilitation facility and the second is a basic rehabilitation facility. Part A covers care in both the acute rehabilitation facility and the basic facility as long as you meet specific requirements. Part A will provide some coverage for up to 100 days per benefit period. To qualify for any SNF, you must first be admitted as an inpatient in a hospital or acute care unit for a minimum of three Medicare days (counted from midnight to midnight). Additionally, all of the following must be certified as medically necessary by a physician:

- i. You must need skilled services that must be performed by professional personnel for a condition for which you were in the hospital.
- ii. You must need these services on a daily basis; however, skilled therapy services received five calendar days a week will be considered “daily” for the purposes of coverage.
- iii. As a practical matter, the daily skilled services can only be provided on an inpatient basis.
- iv. The services must be reasonable and necessary (consistent with the nature and severity of the illness or injury).
- v. Your doctor must expect that your condition will improve sufficiently so you can function independently after a rehab stay. For example, you would be able to eat, bathe, dress yourself and live in a home rather than a facility.

Admission to an acute inpatient facility provides a higher level of care than an SNF. Common conditions for admission into an acute rehab include severe stroke, major multiple trauma (severe car accidents/ski accidents) and brain/spinal injury. You may not qualify for care if you had a hip or knee replacement and no other major conditions. Even with an appropriate diagnosis, you must meet the requirements for medical necessity; this involves assessing your functional limitations and potential for improvement. The Case Management team (nurses, not social workers) work with Medicare and Medicare Advantage to arrange for your benefits.

NOTE: A person does not automatically qualify for all the benefit days in acute care or an SNF. Generally, you are admitted for seven to 10 days, pending your progress. You can expect to be evaluated upon admission and reevaluated near the end of your allowed days. If you are no longer benefiting from therapy, or have reached your goals, you will likely be discharged. If you have not reached your medically necessary and reasonable goals, you can appeal the discharge date. Inform the social worker and also the case nurse. It is the case nurse who has to negotiate with the insurers. This may involve escalating the matter to the medical director of the plan that is administering your insurance coverage. This is an informal interim step, before you are discharged.

- g. **Hospice Care:** Provides care for terminally ill patients. Your physician must certify that you have a life expectancy of six months or less. Does not cover custodial care. For complete information, please refer to Chapter 3.
- h. **Home Health Services:** Medicare will cover medically necessary home health services under either Part A or B. Medicare covers skilled nursing care; physical, occupational and speech therapies; and some home health aid services. Most services are available when there is a reasonable likelihood that the patient will improve and do require the patient to participate.
 - i. **Jimmo standard:** Medicare does provide skilled care (nursing, physical therapy, occupational therapy) for services that are required to maintain the patient’s current function or to prevent or slow further deterioration. This requirement for care is referred to as the “Jimmo” standard, named after the court case that changed Medicare practice. (*Jimmo v. Sebelius*, Case No. 5:11-cv-17 (D. Vt.)). Skilled Jimmo care must meet certain requirements. These services must be of such complexity and sophistication that the skills of a qualified medical professional are

required to perform the procedure safely and effectively. If a service can be safely and effectively performed (or self-administered) by an unskilled person, without the direct supervision of a medical professional, the service CANNOT be regarded as a skilled nursing service, even if a nurse actually provides the service. A service is not considered a skilled nursing service merely because it is performed by or under the supervision of a nurse. The unavailability of a competent person to provide a non-skilled service, regardless of the importance of the service to the patient, does NOT make it a skilled service when a nurse provides the service. In addition, these services to “maintain” the patient’s current condition or to prevent or slow further deterioration that do require skilled nursing cannot be provided in a hospital or SNF, or most Medicaid nursing facilities. These services are only provided in the “home.”

ii. **Discharge and Appeals**

You should be told about one week in advance that you are about to be discharged from any Medicare service or facility, except inpatient hospital discharge, when the time frame can be less than one day.

Fast appeals. If you think you are being discharged too soon, you may have the right to ask for a fast appeal. Your provider has to give you notice on how to appeal this discharge. This applies to hospitals, SNFs, home health agencies, comprehensive outpatient rehabilitation facilities and hospice care facilities. For information on how to make this appeal, see <https://www.medicare.gov/providers-services/claims-appeals-complaints/appeals/fast-appeals>.

Additional information about appeals is found below.

Your Medicare card shows Part A coverage as “Hospital.”

2. **Medicare Part B**

- a. **Outpatient:** Helps cover services from doctors, nurse practitioners, therapists and other health providers; some preventive care; emergency department visits; urgent care visits; hospital visits by certain providers, e.g., radiologists and pathologists; medically necessary outpatient services; lab work; durable medical equipment; and ambulance services. Part B also covers certain drugs and certain vaccines that must be administered by a physician/qualified health care provider. Part B covers outpatient surgery (sometimes called “day surgery”) and time spent in the hospital for “observation.” A person who is in the hospital for observation or in the emergency room does not qualify for Part A benefits. You will be billed for physician services under Part B even when you are an admitted inpatient under Part A.

Home health services are provided as in Part A, including services under the Jimmo standard.

- b. **Not Covered:** Part B does not cover most dental care, eye exams for prescription glasses, dentures, long-term care, cosmetic surgery, massage therapy, routine physical exams (except for the “Welcome to Medicare” preventive visit), hearing aids and exams for fitting them, or concierge care. Part B has a yearly deductible, monthly premium and co-insurance/co-pays; costs are discussed below.

Your Medicare card shows Part B coverage as “Medical.”

3. **Medicare Part C (“Medicare Advantage” or “MA”)**

- a. **Network benefits:** Includes all the benefits and services under Parts A and B and may or may not offer outpatient prescription drug coverage. Medicare C/Advantage plans are run by private health insurance companies and approved by Medicare, and may include extra benefits and services for an extra cost, such as vision, hearing and dental coverage, and rides to medical appointments that are not covered by Original Medicare. Generally, you are in a network and must use the providers in that network for your health care, with exceptions for emergency care and urgent out-of-area care. If you do not use the network providers, you generally will not have coverage, even under Original Medicare.

- b. **Payments due:** You will continue to pay the Part B monthly premium (and any Part A monthly premium if you owe it) while on Part C. In addition, you are likely to pay the Medicare Advantage plan itself a premium. Depending on your plan, you may have deductibles and co-pays until you reach your yearly limit. The yearly limit does NOT apply to services that the plan has not authorized or are outside of your network. Additional cost-sharing information is found below.
- c. **Part C plans website:** Part C plans may or may not include prescription drug costs. You can check each plan’s benefits on the Medicare website, www.medicare.gov/plan-compare/#/?lang=en, or there is an online cost calculator and plan comparison tool run by CMS, at www.medicare.gov/find-a-plan/questions/home.aspx. If you have a Medicare Advantage HMO or PPO plan that includes prescription drug coverage, you may not enroll in a separate Part D plan for prescription drug coverage or in a Medigap (supplemental) plan.
- d. **Use of artificial intelligence and algorithms in determining benefits:** CMS prohibits MA plans from using artificial intelligence and algorithms as the sole criteria for determining benefits under the plan.

4. Medicare Part D

- a. **Prescription drugs — outpatient:** Helps cover the costs of outpatient prescription drugs. To get prescription drug coverage, you must enroll in either a free-standing Part D plan or in a Medicare Advantage plan that includes drug coverage. Medicare mandates that all drug plans cover certain drug classes but not all prescription drugs. You should check the plans when enrolling and annually during open enrollment to see if your prescriptions are covered by the plans. You must be enrolled in Part A and/or Part B to enroll in Part D. Medicare D plans have deductibles and monthly premiums. Detailed information on formularies, drug tiers and coverage gaps is below. You have to use certain pharmacies to get the benefits from Part D plans.
- b. **Medicare Planfinder tool:** The Medicare Planfinder tool can help you estimate your annual medical costs; be sure to use the one at www.medicare.gov for full information. Ask your doctor or pharmacist for your current drug list to use in your search. Private insurers have similar information but usually only list the plans they offer, not the full range of choices you have. Private plans generally end with “.com.”
- c. **Insulin coverage:** Specific information regarding Part D insulin coverage and diabetic supplies is located in the appendix “Part D — Insulin Coverage.”

C. HOW MEDICARE PARTS WORK TOGETHER

1. **Insurance pays once:** No insurance will pay twice for the same service. However, different parts of Medicare pay for different services due to one medical event.
2. **Table illustration:** The following table illustrates how these parts of Medicare work together. You will be billed separately for these services.

Service	Part A	Part B	Part D
Inpatient hospitalization	Room, nursing care.	Physicians, lab tests, X-rays.	N/A
Heart surgery — stent	Food, drugs you are given during your hospital stay.	Surgeon, stent, lab tests if needed to monitor Warfarin/Coumadin therapy (if indicated).	Covers outpatient medications such as Warfarin/Coumadin and anti-platelet drugs such as Clopidogrel/Plavix. Will not cover OTC medications like aspirin.

Emergency room visit, with "observation stay"	N/A	Physicians, lab tests, X-rays and time spent in ER.	N/A
Day surgery in the hospital	Follow-up care in home.	Surgeon, recovery, all services including medications used during the procedure.	N/A for medications used during the procedure. Outpatient medications, such as pain medications and antibiotics, are covered.
Chemotherapy in doctor's office	N/A	Drugs and physician/nursing services.	N/A
Vaccines, administered by qualified health care personnel	N/A	Covers flu, pneumococcal and COVID shots.	Covers shingles, tetanus, diphtheria and whooping cough shots; will cover RSV if you meet the medical requirements. If you have been billed, you can be reimbursed in full by your plan.

D. USEFUL INFORMATION ON MEDICARE

1. **Accountable Care Organizations:** An “Accountable Care Organization,” or ACO, is a type of Original Medicare plan. When your physicians participate in an ACO, your doctors coordinate your care and share your medical records, which means you don’t have as many repeated tests. An ACO does not limit your choice of providers or change your Medicare benefits, which is different from an Advantage plan.
2. **Medigap Plan:** You can purchase a Medigap or Supplemental plan if you have Original Medicare Parts A and B. This plan pays the co-pays under Parts A and B, but not deductibles. The plans are state-regulated. You cannot purchase a Medigap plan if you have a Part C plan.
3. **Types of Medicare Advantage Plans:** (PPO), (HMO) and (HMOPOS): There are generally two types of Medicare Advantage plans — a Health Maintenance Organization (HMO) and a Preferred Provider Organization (PPO). If you purchase an HMO, you are restricted to the doctors, other health care providers and hospitals in the HMO network. This means that if you go to a provider not listed in your network, you will likely not have insurance coverage for the visit, even if the provider accepts Medicare. There are special rules for emergencies and out-of-area urgent care. Under an HMO, you must have a primary care physician, who then orders medical care and submits a prior authorization for the care or a specialist referral. An HMO Point of Service (HMOPOS) plan encourages you to stay in the HMO network but allows for certain services out of network for a higher co-payment or co-insurance. A PPO plan isn’t the same as Original Medicare with a Medigap Supplement; usually, you pay extra for the additional benefits.
 - a. **Special needs plans.** Part C, Medicare Advantage, includes Special Needs Plans (SNP), which are limited to people with specific conditions or living in institutions, or dual beneficiaries (qualified for Medicare and Medicaid/MassHealth).
 - b. **Medicare Savings Accounts.** You can use a Medicare Medical Savings Account (MSA) if you have a high-deductible Medicare Advantage plan. You contribute nothing to the MSA. Medicare deposits money in your MSA to apply against the high deductible costs of your Medicare Advantage plan; this money is usually less than the plan deductible. MSA plans are used in place of Medigap Plans for Part C. The Advantage plan that you choose describes how much Medicare pays into the MSA. Any money left in the account at year end can be used toward next year’s deductible, in addition to whatever Medicare contributes to the account for the new year.

- i. **Taxes:** To avoid income taxes on withdrawals from your MSA, you must file Form 8853 with your Form 1040 income tax return, listing your qualified medical expenses (generally, expenses eligible for coverage under Parts A and B of Medicare). If you use all of the money in your MSA and you have additional health care costs in a year, you'll have to pay for your Medicare-covered services out of pocket until you reach your Advantage plan's deductible.
- ii. **MSA for Prescription Drugs:** You may use your MSA to pay for prescription drugs, but that does not count toward your deductible. Consider adding drug coverage through a Medicare Prescription Drug Plan (a Part D plan) if you choose a Medicare Advantage plan that does not include drug coverage; without prescription drug coverage at the beginning, you will likely have to pay a penalty to purchase Part D in the future.
- iii. **Health Savings Account (HSA):** If you have an existing health savings account (HSA), you should stop contributing to your HSA at least six months before you apply for Medicare. If you make HSA payments after you start Medicare, you may have to pay a tax penalty. You can use your HSA money after you enroll in Medicare to pay for deductibles, premiums, co-payments and co-insurance, but you cannot make additional HSA contributions when you enroll in Medicare.

E. MEDICARE LIMITATIONS AND COSTS

1. Payroll and Federal Income Taxes

All Medicare beneficiaries pay taxes over their working life from their Social Security benefits and earned income. These are the funds used to cover about 75% of the Medicare program costs. The remaining 25% is paid by individual beneficiaries, or through help programs.

- a. **All medical bills not paid:** Medicare, including Medicare Advantage plans, does not pay all medical bills, even for covered services. The beneficiary pays premiums, deductibles, co-payments and co-insurance for many services.
- b. **Inpatient deductible and 60-day rule:** When you are admitted as an inpatient, you will pay a deductible of \$1,676 for 2025. This is not prorated; you pay this if you stay one day or for 60 days. You pay this deductible each time you start a new Part A period, not just once a year. A Part A period ends only when you have been out of the hospital or not using any skilled nursing care for 60-consecutive days. If your Part A period has ended, a new one starts with your next inpatient hospital admission and you would pay another deductible. Part A does not cover any doctor's services while you are hospitalized; doctor's services are billed under Part B and you pay for them separately.
- c. **Skilled nursing home coverage:** Part A covers care in an SNF as long as you meet certain conditions, for up to 100 days per benefit period. After 100 days, Medicare does not pay anything.
- d. **Custodial care:** If you do not meet all four of the SNF admission criteria, you cannot receive SNF benefits under Part A, even if you have been an inpatient, or have available or unused SNF days. Part A does NOT cover custodial care (non-medical care for bathing, eating and toileting), even in hospice.
- e. **Part B deductible:** Part B has a yearly \$257 deductible before providing coverage for covered services. Once the deductible is satisfied, Part B pays 80% of the approved cost of the majority of covered services; limited office visits have co-pays. Furthermore, Original Medicare generally does not cover the prescription medicines you would normally pick up at a pharmacy. There are some exceptions — COVID vaccines and boosters, flu shots, Hepatitis B shots, pneumococcal shots and some insulin devices are covered under Part B.
- f. **Supplemental Medicare:** Many Medicare beneficiaries express concern that the deductibles, the 20% Part B co-insurance (without a cap or out-of-pocket maximum), the costs of Part A hospital and SNF days, and the lack of prescription coverage may cause major financial difficulties in the

case of a medical issue. To address these concerns, Medicare beneficiaries have opportunities to purchase supplemental Medicare called “Medigap,” which fills the gaps in Medicare.

g. **Medicare Costs:**

Part A premium, deductible and co-insurance:

- i. **Part A premium:** Eligible persons who have 40 work credits with Social Security do not pay a monthly premium for Part A. Those who have not worked the minimum 40 credits will pay a monthly premium for life, unless these individuals continue to work and add work credits. If this situation applies to you, ask the SSA to recalculate your work credits each year, to reduce your Part A premium.
 - a. **Part A deductible:** Part A has a 2025 deductible for each period of \$1,676; the deductible is not prorated but due on the first day of admission as an inpatient into a hospital.
 - b. **Part A co-insurance.** Part A also charges co-insurance for SNF stays and home health care durable medical equipment and hospice care, all detailed in the chart below.

ii. **Part B premium, deductible and co-pays:**

a. **Part B premium.** The lowest Part B premium for 2025 is \$185 per month. The monthly premium increases above the standard premium as your income increases; the amount is based on tax returns from two years earlier (e.g., for 2025 Part B premium, the income tax filing for 2023). Part B premiums for certain transplant patients are different.

b. **Part B deductible.** Part B has an annual deductible, paid only once per year as you use services. The Part B plan deductible is due when you start using services at the plan beginning. Plan B generally starts in January, except the first year you are enrolled, when the plan starts with your date of enrollment and the deductible is due when you first start using services. The deductible for 2025 is \$257. Part B also requires a monthly premium and pays for 80% of the approved costs of covered services.

The Part B premium is based on income.

- iii. **Part B co-pays.** These costs are calculated based on the service you receive; it is generally 15% of the Medicare-approved cost. There is no limit on the number of co-pays you must pay.

h. **Part C requires enrollment in Part A and Part B.** You will pay a Part A premium, if any, and the Part B premium to Medicare. You will pay an additional monthly premium for Part C coverage, as well as deductibles and co-insurance based on your plan. You will pay for any out-of-network services. Most Part C plans limit the total yearly amount you pay for in-network approved services. Your plan may or may not include drug coverage and additional benefits, such as eye exams and hearing aids. Each plan is different and changes yearly.

i. **Part D costs:** Medicare Part D plans have monthly premiums and deductibles. Under law, no plan can charge more than \$590 for a deductible in 2025. Each drug covered by your plan will be on a “tier,” which lets you know how much co-pay you will have. Any co-pay can change during the year. Most plans require you to use a certain pharmacy chain to receive insurance coverage. After you pay your deductible, you pay 25% of covered Part D drugs. Once you have paid \$2,000 in deductible, co-payment and co-insurance, you pay nothing for the covered medications for the rest of the year. You can spread your drug costs across the year by using monthly payments; this is called the “Medicare Prescription Payment Plan”; see [Medicare.gov/prescription-payment-plan](https://www.medicare.gov/prescription-payment-plan) for more information. More detailed information on Part D and choosing a Part D plan is presented in the chart at the end of this chapter titled “Calculate Your Medicare Part D Premium for 2025.”

- i. **IRMAA definition.** In addition to the premium charged by the drug plan, Medicare beneficiaries with higher incomes are charged a Part D Income-Related Monthly Adjustment

Amount (IRMAA). IRMAA means that you pay premiums to two different places each month, one to your insurer and the other to Social Security. The Part D premium chart is located at the end of this chapter. Thus, if your 2022 income (the earliest Medicare can verify from tax returns) is above \$103,000 if you file individually, or \$206,000 if you are married and file jointly, you will pay an extra amount for the prescription drug coverage. Adjustments to the amount you pay in IRMAA can be made after a life-changing event, such as the death of a spouse, marriage, divorce, loss of income, and an employer settlement payment. <https://www.ssa.gov/medicare/lower-irmaa>.

- j. **Medicare Savings Program:** The Medicare Savings Program (MSP) is a program available to beneficiaries that covers cost-sharing associated with Medicare. Each state has its own financial guidelines in order to qualify for MSP. MSP is administered by each state's Medicaid program. In Massachusetts, MassHealth administers the MSP. For more information on the MSP, see <https://www.mass.gov/info-details/get-help-paying-medicare-costs>.
- k. **Medicare 2025 Costs at-a-Glance Chart are located at the end of this chapter.**

2. Medicare Advantage Limitations

- a. **Network requirement:** A Medicare Advantage plan requires that you get care from the plan network. The only exception is emergency department services, as long as you are experiencing a true emergency and are not physically within the network system, i.e., out-of-state and out-of-area urgent care. Some patients feel there is an advantage to a Medicare Advantage plan, because there are physician specialists identified for you. Some patients find the waiting times to be too long.
- b. **Healthcare.gov:** Be sure to check whether your physician is in any Medicare Advantage plan that you select. Often, the plan lists themselves are out of date. Use [Healthcare.Gov](https://www.healthcare.gov) to see if your physician is in the network you want.
- c. **Disadvantages:**
 - i. Criteria for providing care may differ between Original Medicare and some Medicare Advantage plans. Some Medicare Advantage plans do not always follow the same rules for providing care as Original Medicare. For example, Original Medicare will provide oxygen support once your blood oxygen level goes below a certain number. All that is needed is the doctor's order, along with the test results. Medicare Advantage plans sometimes use different measures before providing services. In our example, the Advantage plan would not provide oxygen based on the Medicare criteria, but at something less than the Medicare criteria. CMS has made clear that this is illegal. As a practical matter, this is difficult for a patient to address without a health advocate. Please be aware that this example of oxygen supplementation is only one kind of example; CMS is investigating a significant number of claims.
 - ii. **The use of prior authorizations (PAs).**
Original Medicare generally does not require any approval for a physician's order for services; the services are given based on the patient's diagnosis and documented in the Current Procedural Terminology (CPT) code. There are some small exceptions, such as some durable equipment and some outpatient procedures; the full list can be found here: <https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives/prior-authorization-certain-hospital-outpatient-department-opd-services>.
 - iii. **In contrast, Medicare Advantage plans generally do require PA.** PAs are mostly likely necessary for the highest-cost services, such as Part B chemotherapy drugs, Part A SNF stays and Part A acute inpatient stays. If the plan offers prescription drug coverage, PAs are generally required for high-cost drugs. One study compared access to care by Original Medicare benefi-

ciaries and Medicare Advantage beneficiaries. Forty-one percent of Original Medicare beneficiaries received care without a PA required by the Advantage plans. Most PAs were required for Part B drugs, radiology and radiation oncologists.

- iv. **Recent legislation on prior authorizations (PAs):** Federal law does not prohibit Advantage plans from using PA, but starting Jan. 1, 2026, CMS requires that the insurers respond within 72 hours for expedited requests and seven calendar days for standard requests. Insurers must provide a specific reason for denial, regardless of how the request was submitted.
- v. **Appeal of prior authorization (PA) denials:** If your PA request is denied, there is a procedure you can follow to appeal the decision. In addition to the PA, drug plans frequently use what's known as "step therapy" (meaning that you are prescribed the most commonly used generic drug for your condition, to see if it works for you; you must fail on that drug before you can move up a "step" to a more expensive drug) as a type of PA.
- vi. **Medicare Givebacks:** Many plans advertise "Medicare Givebacks." CMS examined the actual money paid to plan participants and determined that there was "bait and switch" activity. In 2022, promised full rebates were not actually paid in Massachusetts. CMS advises that you first make sure the plan meets your Medicare needs. Medicare has marketing rules in place for Medicare Advantage plans to prevent predatory marketing tactics. The CMS guidance is at <https://www.cms.gov/medicare/health-drug-plans/managed-care-marketing/medicare-guidelines>. Also see <https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/plan-marketing-rules>.

F. CHOOSING BETWEEN ORIGINAL MEDICARE OR MEDICARE ADVANTAGE

Please read below to familiarize yourself with the various options in each plan.

TIP: Preferred physician: Before enrolling in any Massachusetts plan, ask if your preferred physician is part of the plan you are thinking about choosing. The answer may determine what plan you ultimately take. While most physicians accept Medicare, not all physicians and hospitals are part of the various Advantage plan networks.

NCOA website chart: The chart taken from the National Council on Aging (NCOA) website, under My Medicare Matters (a nonprofit group), will help you evaluate your options and give you personalized advice.

1. NCOA questions:

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

Each year, Medicare Advantage plans choose if they want to stay in Medicare or not. They can also change costs, providers and benefits each calendar year. Original Medicare will always be there, but its premiums, deductibles and co-insurance amounts can increase slightly each year.

b. Are Medicare Advantage plans rated?

Medicare uses a 5-star rating system to assess the quality of Medicare Advantage and Part D plans, with 5 stars being "excellent," 4 being "above average" and 3 being "average." These ratings are based on a variety of factors, including how well the plans help members manage chronic diseases, member satisfaction and how often members get screening exams and vaccines, among others. The ratings are posted on the Medicare Planfinder website at [Medicare.gov](https://www.Medicare.gov).

Some key information from the NCOA site: <https://www.ncoa.org/>.

c. Advantages of choosing Original Medicare combined with a Medigap policy (versus Medicare Advantage)

- i. A significant advantage is that it provides a better fit for individuals with ongoing medical issues. In some states, if you purchase a Medigap policy within six months of starting Part B at age 65 or older, the insurance agency cannot reject the application for any reason. However,

in Massachusetts, individuals can purchase a Medigap policy year round. Massachusetts Medigap policies cannot increase costs based on medical history. Having a history of cancer or a recent diagnosis of heart disease, chronic obstructive pulmonary disease (COPD), diabetes, or another chronic condition that will require frequent doctor visits may indicate that a Medigap policy is a better fit. The monthly payment will be the same every month, no matter how many doctor visits occur — so a Medigap policy may reduce total costs. This can be especially helpful when you are trying to diagnose a new health condition and need to seek second opinions. Original Medicare offers more flexibility with treatment options, and you are not limited to the network imposed by Medicare Advantage plans.

- ii. **“Snowbirds” or others who spend time out of state:** If your physician is licensed in Massachusetts, they cannot treat you, even via telemedicine, if you are not physically in Massachusetts. The only exception is if you are in the emergency department — then the emergency department physicians can CONSULT with your physician. This limitation is set by the Massachusetts board of licensing, and not regulated by Medicare. An alternative is to have a “backup” physician in your second home, to continue routine care. Network plans will not commonly have practitioners out of state.
- iii. Choosing a primary care physician (a requirement of some Medicare Advantage plans) is not a requirement for Original Medicare. The plan allows the patient to see any physician who accepts Medicare. Conversely, Medicare Advantage plans are more restricted in terms of the provider networks they work with. Individuals in rural and isolated areas may have difficulty finding plans in Massachusetts that work with their local health care services.

Massachusetts Medigap has three types of policies that are described in detail later in this chapter, making it relatively simple to compare costs.

ADVICE:

After you have listed all your medical needs, prescription drugs and primary care physicians, you may want additional help. You can contact Serving the Health Information Needs of Everyone (SHINE). Ask that the SHINE counselor calculate your costs and benefits under both Original Parts A and B, and D, plus a supplement. Then, ask SHINE to suggest two Part C Advantage plans. Then, call SHINE again and get a second opinion as above. SHINE counselors can differ in their recommendations.

G. ELIGIBILITY FOR MEDICARE AND ENROLLMENT

1. Enrollment

The SSA determines whether or not a person is eligible for Medicare.

2. Citizenship/lawful presence

To be eligible for Medicare, you must be a U.S. citizen or a non-citizen who has been lawfully present for five continuous years.

3. Social Security Procedures

The SSA mails Medicare cards to all Medicare recipients (beneficiaries) upon enrollment. The cards do not use your Social Security number, but a special Medicare number that only you have. Medicare will NEVER call you to check on your Medicare account; Medicare only writes to you. Do not give your Medicare number over the telephone. If you need to discuss your account, you can sign in to Medicare at www.medicare.gov/account/login or call 1-800-MEDICARE (1-800-633-4227). Since the SSA handles Medicare enrollment, you may enroll in person or online at www.ssa.gov. You may contact an SSA office for enrollment issues.

- a. If you are already getting benefits from Social Security or the Railroad Retirement Board, you will automatically get Part A and Part B starting the first day of the month you turn 65. If you are not

already receiving those benefits, you will need to contact Social Security three months before your 65th birthday during the initial enrollment period. The initial enrollment period is the seven-month period that begins three months before you turn 65 and ends three months after you turn 65.

b. In-Person or Online Enrollment

Most people must actively enroll in Medicare. You must contact Social Security during the initial enrollment period. You can enroll in person at your local SSA office, enroll online at www.SSA.gov, or call the SSA at (800) 772-1213, Monday through Friday from 7 a.m. to 7 p.m. As of the date of printing, the SSA recommends you enroll online.

c. Enrollment Periods (for purposes of Premium Part A and Part B)

- i. **Initial Enrollment Period:** The initial enrollment period (IEP) is the seven-month period that begins three months before you turn 65 and ends three months after you turn 65. If you enroll three months before you turn 65, coverage begins on the first of your birthday month. If you enroll during the three months after you turn 65, coverage begins the first of the month following the month of enrollment.
- ii. **General Enrollment Period:** The general enrollment period (GEP) for Original Medicare takes place from Jan. 1 through March 31 of each year. Coverage becomes effective the first of the month following the month of enrollment.
- iii. **Special Enrollment Period:** There are also special enrollment periods (SEPs), which fall outside of the general and initial enrollment periods available to beneficiaries in certain circumstances. Some of these situations include life changes such as changes in household or residence, loss of health coverage, end of incarceration, or other qualifying life events based on special circumstances. <https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods>.

d. Spouse

If you or your spouse has paid Medicare taxes for at least 10 years (40 quarters), then you do not have to pay a premium for Part A Medicare.

4. Under 65 with Disabilities

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

- a. **End-Stage Renal Disease (ESRD):** If you have end-stage renal disease (ESRD), you are eligible for Medicare at any age. Individuals with ESRD do not have to collect Social Security Disability Insurance (SSDI) benefits for 24 months in order to be eligible for Medicare. Individuals with ESRD are eligible for Medicare generally three months after a course of regular dialysis begins or after a kidney transplant.
 - i. **Part B-ID:** Medicare offers a special benefit for beneficiaries with ESRD who are 36 months post-kidney transplant and no longer eligible for full Medicare. This is called the Part B-ID or immunosuppressive drug benefit. This is a stand-alone benefit, meaning the only items covered under this benefit are immunosuppressive drugs. You may qualify for this benefit so long as you do not have or expect to get other types of health coverage that also cover immunosuppressive drugs.
 - ii. **Amyotrophic Lateral Sclerosis (ALS):** Individuals suffering from ALS are eligible for Medicare coverage immediately upon approval for SSDI benefits (but after the five-month waiting period). Individuals with ALS do not have to collect SSDI benefits for 24 months in order to be eligible for Medicare.
 - c. **Other Disabilities:** Individuals under age 65 with disabilities other than ESRD or ALS must have received SSDI for 24 months before becoming eligible for Medicare. A five-month waiting

period is required after a beneficiary is determined to be disabled before a beneficiary begins to collect SSDI benefits. Medicare is also available under the same rules for individuals who receive railroad retirement benefits. Most state and local Massachusetts employees may also be eligible to enroll in Medicare even if they are not eligible for SSDI benefits as long as they have paid into Medicare. See COBRA below.

5. Cautionary Points

- a. **Loss of health insurance:** If you do not sign up for Part A and/or Part B during the initial enrollment period, or when you are first eligible, or when you lose your employer health insurance, your monthly Part B premium may increase 10% for each 12-month period you delayed as a late enrollment penalty for as long as you have Medicare. See COBRA below.
- b. **Late enrollment penalty:** This late enrollment penalty is added to your monthly premium and is permanent if you are 65 or older. If you are younger than 65, the penalty ends at 65. In addition, there may be a coverage gap.
- c. **Sign-up dates:** As previously discussed, you can sign up between Jan. 1 and March 31 of any year, with coverage beginning on the first of the following month. If you have incurred such a late enrollment penalty, you should look into filing for “equitable relief.” A successful claim for equitable relief may waive the Part B late enrollment penalties and win a “special enrollment date” if the federal government has misled you about enrollment rules.
- d. **Part D late enrollment:** Part D also has a late enrollment penalty. If you waited 63 or more days to enroll in Part D or a Part C plan with drug coverage after loss of creditable coverage, you will pay a penalty for late enrollment each month for as long as you have Medicare Drug coverage. The late enrollment penalty for 2025 is \$36.78 per month, multiplied by the number of months you were eligible for Part D but did not enroll. This penalty is in effect for as long as you have Medicare Part D coverage. The monthly penalty changes every year. This is in addition to any extra premium you owe due to income levels.
- e. **Appeals:** You can appeal this by asking for a “reconsideration” from your drug plan, but you must pay the monthly premium plus whatever penalty you are appealing during that appeal process.
- f. **Need Parts A and B numbers:** You need Medicare A and B numbers to enroll in Medicare Advantage plans.

H. TURNING 65 AND STILL WORKING

1. Retirement Age

Full retirement age for Social Security benefits is now based on the year you were born, and the age when full benefits start has been raised. This means that you may qualify for Medicare before you qualify for full Social Security benefits. Consequently, many people work beyond age 65. If you are turning 65, still working and have health insurance coverage through your employer, there are additional considerations.

2. Working Beyond 65

“By law, people who continue to work beyond age 65 still must be offered the same health insurance benefits (for themselves and their dependents) as younger people working for the same employer.” If your employer has more than 20 employees, the employer’s health insurance is primary. Your employer cannot require you to enroll in Medicare when you turn 65 or offer you a different kind of insurance, unless your employer has fewer than 20 employees. If your employer has fewer than 20 employees, Medicare is primarily responsible for your health care costs. The group health plan pays secondarily, after Medicare, up to covered costs. In this case, if you fail to enroll in Medicare when you are first eligible, you may have little or no health coverage.

3. Group Insurance

If you do enroll in Part A while working, and you keep your group insurance plan, you can delay

enrolling in Part B. When you leave work, you will have a special enrollment period to enroll in Part B. You can enroll anytime when you are still covered by the group health plan based on current, active employment, and during the eight-month period that begins after the employment ends or the coverage ends, whichever happens first.

4. **COBRA**

Neither COBRA nor retirement health insurance coverage can extend the enrollment period for Part B nor protect you from penalties. Employer-sponsored health insurance must be based on active employment. Be sure to sign up for Medicare Parts A and B when first eligible or upon losing employer group coverage. COBRA is not considered credible coverage. Those who go for extended periods of time without creditable coverage may be assessed a late enrollment penalty upon electing Part B at a later date. Your monthly premium for Part B will go up 10% for each full 12-month period that you could have had Part B but did not sign up for it. It is generally not advisable to go without coverage “until needed” to save on the monthly premium costs.

5. **Employer Insurance**

Your employer’s insurance may coordinate benefits with Medicare; in some instances, the employer’s insurance will act like a Medicare Supplement and pay deductibles and co-insurance. Check the details where you work.

I. **MEDICARE IMPACT ON OTHER HEALTH INSURANCE AND PERSONAL INJURY SETTLEMENTS**

1. **Medicare Guide to Who Pays First**

You cannot have two different insurances pay the same amount on a bill. One insurance will pay some money first, and then the second insurance will pay some money. For more information when you have two insurances or sources of payment for a health-related injury, see “Medicare Guide to Who Pays First,” from www.Medicare.gov.

2. **Bill Payment**

If you have Medicare and other health insurance or coverage, be sure to tell your doctor and other providers. They will be able to send your bills to the correct payers to avoid delays. If you have questions about who pays first, or if your insurance changes, call (800) MEDICARE and ask for the Medicare coordination of benefits contractor.

3. **End-Stage Renal Coverage**

For information on ESRD, refer to www.medicare.gov/basics/end-stage-renal-disease.

4. **Personal Injury Settlement**

Money paid from a personal injury settlement, workers’ compensation claim, car accident, medical settlement or other compensation for personal injury will likely affect your Medicare benefits. You may owe Medicare money for your care. You should notify Medicare and speak with the Medicare coordination of benefits contractor. Failure to follow these rules can result in loss of Medicare coverage for certain conditions and a fine, possibly as much as \$1,000 per day.

Medicare will first send a demand for reimbursement. The procedure is found at <https://www.cms.gov/medicare/coordination-benefits-recovery/overview/reimbursing>. The time to respond is 30 days, before interest begins to accrue. There is, however, a waiver of recovery process described there.

5. **Third-Party Payments**

Medicare has legal authority to recover money from these third-party payments. See <https://www.cms.gov/medicare/coordination-benefits-recovery/insurer-services> for a description of the various steps. Note that interest accrues on unrecovered payments. Medicare has an automatic lien on any funds you are paid.

6. Chart: Payment Order of Third-Party Payments

IF YOU	CONDITION	PAYS FIRST	PAYS SECOND
Are age 65 or older and covered by a group health plan because you are working or are covered by a group health plan of a working spouse of any age	Entitled to Medicare and: 1. The employer has 20 or more employees 2. The employer has fewer than 20 employees and has no Medicare exceptions	1. Group Health Plan 2. Medicare	Medicare Group Health Plan
Have an employer group health plan after you retire and are age 65 or older	Entitled to Medicare	Medicare	Retiree coverage
Are disabled and covered by a large group health plan from your work or a family member who is working	Entitled to Medicare and: 1. The employer has 100 or more employees, or 2. The employer has fewer than 100 employees and no Medicare exceptions	1. Large Group Health Plan 2. Medicare	1. Medicare 2. Group Health Plan
Have been in an accident where no-fault or liability insurance is involved	Entitled to Medicare	No-fault or liability insurance for services related to accident claim	Medicare
Are covered under workers' compensation because of job-related illness or injury	Entitled to Medicare	Workers' compensation for workers' compensation claim-related services	Medicare usually doesn't apply
Are a veteran and have veterans benefits	Entitled to Medicare and veterans benefits	1. Medicare pays for Medicare-covered services 2. Veterans Affairs pays for VA-authorized services NOTE: Generally, Medicare and VA can't pay for the same service	Medicare usually doesn't apply
Are covered under TRICARE	Entitled to Medicare and TRICARE	1. Medicare pays for Medicare-covered services 2. TRICARE pays for services from a military hospital or any other federal provider	TRICARE may pay second
Are age 65 or older OR disabled and covered by Medicare and COBRA coverage	Entitled to Medicare	Medicare	COBRA

J. OPTIONS TO ENHANCE ORIGINAL MEDICARE COVERAGE

1. Medigap Plan for Supplemental Insurance

Medigap plans cover many of the expenses you owe under Original Medicare A and B. Medigap does not cover more services or give you more coverage than Original Medicare. Here are two examples. First, Medicare does not cover hearing aids, so Medigap does not cover hearing aids. Second, under Part A, you would have up to 100 days in an SNF (rehabilitation center) provided you meet the requirements.

You would pay nothing for the first 20 days, and co-insurance of \$419 per day for days 21 through 90. A Medigap plan will pay the co-insurance of \$419 per day for all of the days when you qualify for Medicare coverage but will not pay for any costs beyond the 90 days. This is because Medicare itself does not cover more than 90 SNF days in any one period. Medigap will not pay if you are not receiving skilled care, even if you have not used all your days. A Medigap plan may cover international travel emergencies for an extra cost.

2. Medigap Enrollment

You have to pay a premium for Medigap plans. Currently, in Massachusetts, you can purchase a Medigap plan at initial enrollment or during any annual renewal. This is not true in all states, and may not be true in the future. In some states, if you do not enroll in a Medigap plan when you first enroll in Medicare, you may not be able to buy a Medigap plan after, or you may have to take a physical exam to get Medigap, and it may cost considerably more.

3. Massachusetts Medigap Options

- a. **Core plan:** The Core plan is the least expensive of the three options and covers the Part B co-insurance amount, paying for the 20% of approved amounts that Part B would normally require the Medicare beneficiary to pay out of pocket. With this option, policyholders would still pay the Part B deductibles out of pocket and the Part A deductibles and co-insurance.
- b. **Supplement 1:** Like the Core plan, this option covers the 20% Part B co-insurance amount. Additionally, Supplement 1 covers the Part A and Part B deductibles, providing more robust coverage than the Core plan. Due to the enhanced coverage, the Supplement 1 premium is higher than the Core plan offerings. This plan is only available to those who were eligible for Medicare in 2020 or earlier.
- c. **Supplement 1A:** This plan covers the Part A deductible, but not the Part B deductible. If you are purchasing a Medigap plan, check if the plan covers Massachusetts state-mandated benefits, including yearly Pap tests and mammograms.
- d. **Premium rates and Medicare Planfinder:** Medicare Supplement premium rates are required to be in effect for at least 12 months. Effective dates shown for each carrier are based on the most recent filing on record with the Division of Insurance. Use this Medicare Planfinder tool to compare Medicare Supplement plans and prices available: www.medicare.gov/medigap-supplemental-insurance-plans/#/m/?year=2023&lang=en.

4. The Advantages and Disadvantages of Medicare Supplements: Side-by-Side Comparative Chart

- a. **Out-of-pocket costs:** Medicare supplements in Massachusetts work with Original Medicare; policyholders generally have low out-of-pocket costs when receiving covered services and flexibility in choosing providers. There are no networks, and no referrals are necessary.
- b. **Premiums for Medicare Supplements:** May exceed \$200 a month, paid to the insurance company.
- c. **Prescription medicines:** Also, the supplements do not cover most prescription medicines. In many cases, retirees incur the additional cost of a Part D plan.
- d. **Medigap in Massachusetts — Comparison Chart**

TIP: If your Medicare costs are too expensive, there are four types of Medicare Savings programs that may help. To find out if you are eligible, and how much help you qualify for, go to <https://www.medicare.gov/basics/costs/help/medicare-savings-programs>.

MEDIGAP IN MASSACHUSETTS: Compare These Plans Side-by-Side			
If a “yes” appears, the plan covers the described benefit. If “no” appears, the policy doesn’t cover that benefit.			
MEDIGAP BENEFITS	MEDIGAP PLANS		
	Core Plan	Supplement 1	Supplement 1A
BASIC BENEFITS			
Part A: inpatient hospital deductible	No	Yes	Yes
Part A: skilled nursing facility co-insurance	No	Yes	Yes
Part B: deductible*	No	Yes*	No
Foreign travel emergency	No	Yes	Yes
Inpatient days in mental health hospitals	60 days per calendar year	120 days per benefit year	120 days per benefit year
State-mandated benefits (Yearly Pap tests and mammograms. Check your plan for other state-mandated benefits.)	No	Yes	Yes

*Supplement 1 Plan (which includes coverage of the Part B deductible) will no longer be available to people who are new to Medicare on or after Jan. 1, 2020. These people can buy Supplement 1A Plan. However, if you were eligible for Medicare before Jan. 1, 2020, but not yet enrolled, you may be able to buy Supplement Plan 1.

5. Part D Prescription Drug Coverage

- Refer to the description of Part D plans, above.
- Medicare Part D websites:** Medicare has websites that will help you with Part D coverage. Medicare helps you determine which type of plan is right for you (e.g., which type of plan works for people who take a lot of expensive prescription medications, or those who don’t take any). Medicare helps you select between plans in your coverage area, which is <https://www.medicare.gov/plan-compare/#/?lang=end&year=2024>.
Be sure to use the “[medicare.gov](https://www.medicare.gov)” websites for full comparisons. Private insurers’ websites will not include information on competitors’ products.

6. Part D Formularies, Tiers and Quantity Limitations

- Classes of drugs:** Medicare requires each plan to cover certain classes of drugs, but the plans vary widely in what specific medicines are covered. It is very important to obtain the plan’s formulary, which lists each medicine covered and its tier. In addition, many drug companies impose “utilization management,” requiring prior authorization and step therapy (meaning that you are prescribed the most commonly used generic drug for your condition, to see if it works for you; you must fail on that drug before you can move up a “step” to a more expensive drug) before covering the drug, as well as quantity limits.
- Common drugs:** For many common drugs, there are major differences in coverage levels between insurance companies, so it makes sense to check the tier and quantity limitations for each of your medications with prospective insurance providers before enrolling. An insurer cannot remove a therapeutic category (e.g., high blood pressure medication) during a plan year, but can remove any single drug from its coverage with 60 days’ notice to the insured.

- c. **Exceptions:** If a plan does not carry a drug you need, you and your physician may request an “exception.” Not all plans provide for formulary exceptions if a medically necessary medicine is generally not covered. If your plan allows exceptions, you contact the plan’s customer service department and request a “formulary exception” for the medicine. To obtain an exception, your prescriber must state that all drugs in the plan’s formulary will not work as well or will have side effects. Exceptions can also be requested for quantity limits, step therapy and tiering. If your request is denied, you can appeal this decision. Follow all the steps listed at <https://medicare.gov/medicare-prescription-drug-coverage-appeals>.
- d. **Denial of coverage:** If a prescription drug you need is listed on the formulary, but you are denied coverage under Medicare, you can also appeal this denial of coverage. This is useful to know if you have just enrolled in Medicare, have been successfully taking a drug for your condition, and Medicare requires that you utilize step therapy.
- e. **SimpleCare or GoodRx:** If Medicare does not cover your drugs, or you have not been successful with an appeal, you can see if that drug is covered under a different program, such as SimpleCare or GoodRx. If you use these plans, you cannot use Medicare for the same prescription, and the costs will not be included in your Medicare coverage limits.
- f. **Role of pharmacist:** Your pharmacist can discuss insurance plans you research on the CMS website, but cannot market any specific plan to you. Select your Medicare Part D plan using the Medicare Part D Planfinder tool, from the CMS website, found at www.medicare.gov/find-a-plan/questions/home.aspx. Recent studies show that some plans can cost up to \$100,000 more for the same drugs. If you take any single prescription that costs more than \$600 a month, you should take great care to evaluate these plans. Mail order is not automatically cheaper than retail.
- g. **Part D insulin new costs:** Plans cannot charge you more than \$35 for a one-month supply of each Medicare Part D-covered insulin you take, and cannot charge you a deductible for insulin. This means that the \$35/month fee does not reduce your deductible. See the end of the chapter for specific information on how to determine drug costs, including insulin, for Part D.
- h. **Difficulties paying for insulin:** If you have difficulty paying for insulin, see if you qualify for Extra Help, and your co-payment for insulin would be lower. You apply for Extra Help through Social Security; for the Massachusetts-specific Medicare Savings Plan, call SHINE for Massachusetts — Serving the Health Insurance Needs of Everyone — at (800) 243-4636.
- i. **Opioid medication new rule:** New this year. Opioid and other narcotic pain medications are limited, except if you are a cancer patient, in palliative care or in hospice care. In those situations, ask your case manager, your nurse or your physician to notify the pharmacy you will use so that the necessary prescriptions can be filled. Without this notice, you may not be able to obtain your medication.

7. Late Enrollment Penalty for Part D

- a. **Late enrollment defined:** If you do not enroll in a Part D plan when initially eligible, unless you have creditable coverage through another insurer or drug coverage through a Medicare Advantage plan, you will be subject to a Part D late enrollment penalty even if you do not currently require medication.
- b. **Sanctions:** If you go without coverage for more than 63-consecutive days, you will face a 1% monthly sanction if you ever need Part D coverage in the future. It is important to enroll in a Part D plan when first eligible or make sure you have creditable coverage (or a Part C plan that includes Part D benefits).
- c. **Penalties:** These penalties can be significant. Medicare calculates the penalty by multiplying 1% of the “national base beneficiary premium” (\$36.78 in 2025) times the number of full, uncovered

months you didn't have Part D or creditable coverage. The monthly premium is rounded to the nearest \$.10 and added to your monthly Part D premium. The national base beneficiary premium can change each year, so your penalty amount can also change each year. If you already have incurred a late enrollment penalty, you may seek a waiver based on specified reasons. Waivers may be available for those with lower incomes who qualify for the Low Income Subsidy (LIS) Program (ExtraHelp).

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

ORIGINAL MEDICARE & MEDICARE ADVANTAGE PLANS AT-A-GLANCE				
	Original Medicare (Parts A & B)	Supplement (“Medigap”)	HMO Part C (Medicare Advantage)	PPO Part C (Medicare Advantage)
What do I pay?	Part B premiums, deductibles and co-insurances. Part A deductibles and co-insurances	Medigap premiums, Part B premiums, Part A and B deductibles, generally no co-payment	Medicare premiums and plan premium; your plan sets its own deductibles and co-pays.	Medicare premiums and plan premium; your plan sets its own deductibles and co-pays.
Can I go to any doctor?	Yes, if they accept Medicare.	Yes, if they accept Medicare.	No, you must go to in-network providers.	Yes, though PPOs have provider networks, you may go out of network for a higher co-pay.
Where can I get routine, non-emergency care?	Anywhere in the country.	Anywhere in the country.	For most plans in your network.	For most plans in your network.
Where can I get emergency care?	Anywhere in the country.	Anywhere in the country.	In network, unless out of geographic area.	In network, unless out of geographic area.
How do I get prescription drug coverage?	Part D	Part D	You must join a plan that includes drug coverage, also called MA-PD.	You must join a plan that includes drug coverage, also called MA-PD.
Will I need a referral to see a specialist?	No	No, unless you have a Medicare SELECT plan.	Usually	No, but you may pay more out of pocket if you go to a provider who is out of network.
Is there a limit to my out-of-pocket spending?	No	No	Yes, all Medicare Advantage plans must have limits on out-of-pocket spending.	Yes, all Medicare Advantage plans must have limits on out-of-pocket spending.

8. Options Available if Medicines Are Expensive

- a. **Multiple options:** There are multiple options for beneficiaries who have difficulty paying for medicines. In addition to “Extra Help” or the “Low-Income Subsidy” provided to low-income beneficiaries, the following options, some notable, may apply.

- b. **Alternative medicines:** Explore alternative medicines with your pharmacist and doctor. Ask your regular pharmacist for a Drug Utilization Review (DUR), which is free. This report identifies duplicate drugs and suggests drugs that may be more appropriate for you; then, show this report to your doctor(s). Be sure that the DUR lists all the drugs you take, even those that you do not fill at that pharmacy. Ask your doctor if a safe and effective generic medicine or an alternative therapeutic may work better for you. Often, co-pays for generics can be more than 75% less than the brand-name medicines.
 - c. **Use of brand names:** It may be possible to switch to a preferred brand-name from a non-preferred brand-name drug listed in the formulary to reduce co-pays. Of course, only consider changing in consultation with a medical professional.
 - d. **Local discount programs:** Some grocery stores and pharmacy chains offer discount programs that work in conjunction with your insurance plan. Please be sure to ask your pharmacist if your pharmacy offers such programs. You can compare the price on a national discount plan, like GoodRx, SimpleCare or Costplusdrugs, with your insurance price. You can buy the drug with a national discount plan, but you CANNOT combine the Medicare Part D benefit with the national discount plan.
 - e. **State pharmacy assistance:** Massachusetts offers a state pharmacy assistance program, Prescription Advantage, for those with lower incomes who do not qualify for MassHealth. This program provides out-of-pocket maximums on co-pays and extra help in the coverage gap. Unlike Medicare Extra Help and MassHealth, there is no asset test; qualification is based upon income. You can reach Prescription Advantage at (800) AGE-INFO, option 2.
 - f. **Medicare Extra Help:** Medicare offers “Extra Help” (also known as a low-income subsidy) to beneficiaries with lower income and assets. This program can reduce or eliminate your Part D premium and reduce deductibles and co-pays. Application for this program can be made through the SSA directly after you have enrolled in a Part D plan.
 - g. **Veterans benefits:** The Veterans Administration (VA) offers prescription benefit programs. For our readers who are veterans, please inquire with the VA to see if you qualify for benefits that may enhance the Part D benefit from your plan.
 - h. **Primary outreach programs:** Refer to Pharmacy Outreach Program in Chapter 8.
9. **Change from Original Medicare to Medicare Part C (Medicare Advantage)**
- a. **Part C does not cover all drugs:** While the CMS website will clearly state premiums, deductibles, co-pays and co-insurance for Parts A and B, each Part C plan must be separately researched. The information about coverage options is found above. One limitation to consider is that not all Part C plans cover prescription drugs.
 - b. **Part C website:** The website, www.Medicare.gov, lists all the Part C plans available in your area; the website identifies those Part C plans with drug coverage. These plans work similarly to employer-sponsored health insurance plans, often combining doctor, hospital and additional services in one comprehensive plan. The plan options vary by county of residence, and all plans are not available in all areas. Not all plans continue from one year to the next and some do not take new patients. Check if the plans you want provide these benefits:
 - i. Out-of-pocket maximums;
 - ii. Reduced co-insurance amounts and co-pays for certain services;
 - iii. Coordination of care;
 - iv. Prescription drug benefits;
 - v. Elimination of deductibles; and

- vi. Low (or zero) monthly premiums.
- c. **Star rating:** Pay particular attention to the star rating for both Part C and Part D plans; the star rating is a measure of quality.
- d. **One-year plans:** Medicare Advantage plans are generally one-year programs. During each annual election period (usually starting in early October and ending in the first week of December), Medicare beneficiaries may change plans or disenroll from Part C and select other options (like stand-alone Part D plans), or return to Original Medicare. Such changes take effect on Jan. 1.
- e. **Special circumstances:** During the year, there are options to change coverage if you have certain special circumstances. Some of the more common situations include:
 - i. Moving your primary residence outside the plan service area;
 - ii. Obtaining/losing employer coverage;
 - iii. Qualifying for MassHealth;
 - iv. Obtaining a low-income subsidy;
 - v. Qualifying for state pharmacy assistance (Prescription Advantage); and
 - vi. Enrolling in Part B.

K. CHANGING MEDICARE PLANS

1. Open Enrollment

As long as you are enrolled in Medicare, you can change plans during the open enrollment period. This generally becomes available in early October, and decisions must be made by early December. The new plans go into effect Jan. 1. In certain circumstances, you can switch between Medicare Part D plans during the year; consult “Medicare & You” for further information. <https://www.medicare.gov/medicare-and-you>. If you select an Advantage plan in the first enrollment period, you can make ONE change to a different Medicare Advantage plan or switch to Original Medicare and Part D between Jan. 1 and March 31 of the current year.

2. Comparing Insurance Providers

- a. **Criteria:** When shopping for Medicare Parts C and D and Medigap supplements, it is important to compare premiums among insurance companies. As coverage is standardized, please consider the following criteria when evaluating options:
 - i. **Consider customer service quality and reputation:** Are claims processed accurately, and are you able to obtain prompt and professional service when questions arise?
 - ii. **Premium consistency:** By how much do rates tend to change annually? How will those changes impact your budget?
 - iii. **Discount programs and value-added services:** Does the insurance company you are considering offer any discounts (based upon age, paying by automatic bank draft) or savings programs for dental or vision?

L. MEDICARE DENIALS AND APPEALS

- 1. **Notice:** Original Medicare can deny coverage for a service before you receive it, or may deny a service or full payment after the service is received. Your provider should notify you in writing if a future service will not be covered. Your provider should do this by asking you to sign an “Advance Beneficiary Notice of Non-Coverage” prior to rendering any services. In this case, you are agreeing that Medicare will not pay for it. You can still file an appeal, but you will have to pay for the service first. You can get this advance notice from an SNF when the facility believes that Medicare will not cover your stay or certain items or services.

2. **Appeals:** You can file an appeal if Medicare denies a service/coverage or payment. The process depends upon what type of Medicare coverage you have. Carefully read the notice for detailed instructions on how to appeal. You may be required to submit medical records and documentation and may need a qualified physician to work with you on the appeal. Be careful not to miss any appeal deadlines.
3. **Website for appeals:** General information on appeals is found at www.medicare.gov/claims-appeals/how-do-i-file-an-appeal.
4. **Additional benefit information and website:** You can find additional information on Medicare benefits at www.medicareinteractive.org/resources/toolkits/medicare-advocacy-toolkits. There is a nonprofit organization that can help you with appeals. This is Medicare Interactive, found at www.medicareinteractive.org/get-answers/medicare-denials-and-appeals.

TIP: For a complete reference on Medicare appeals, including Original Medicare, A Medicare Advantage plan, and Medicare drug coverage, as well forms and advice, see <https://www.medicare.gov/providers-services/claims-appeals-complaints/appeals>. The forms themselves can also be found at <https://www.medicare.gov/basics/forms-publications-mailings/forms/appeals>.

If someone will file an appeal for you, you need to fill out an Authorization to Disclose Personal Health Information form, found at <https://www.cms.gov/cms10106-authorization-disclose-personal-health-information>.

An excellent source is the Center for Medicare Advocacy, at www.medicareadvocacy.org.

M. NAVIGATING MEDICARE

1. Available Resources

Navigating the Medicare system is confusing, but there are resources available to help. Please be sure to consult www.Medicare.gov, particularly “Medicare & You,” or call (800) MEDICARE for detailed information. Consult your trusted advisors and request written information from insurance companies before enrolling in any plan.

2. Medicare Costs and Benefits

Below is a chart of Medicare benefits and costs for Part A and Part B. Medicare is an exceedingly complex program. For every rule cited in this chapter, many other rules and exceptions apply. “The devil,” practitioners in this field are quick to point out, “is in the details.”

3. Important Links

- a. <https://Medicare.gov/medicare-and-you>.
- b. <https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options>.
- c. <https://www.medicare.gov/manage-your-health/coordinating-your-care/accountable-care-organizations>.
- d. <https://www.medicare.gov/sign-up-change-plans/joining-a-health-or-drug-plan>.
- e. <https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/PPO>.
- f. <https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/PFFS>.
- g. <https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/SNP>.
- h. For resources on the Jimmo decision and settlement, see Jimmo decision FAQ: <https://www.cms.gov/Center/Special-Topic/Jimmo-Settlement/FAQs>; CMS manual updates can be found at <https://www.cms.gov/Outreach-and-Education/Outreach-and-Education?bucket-filter=MM8458.pdf>; for detailed information on the need for skilled nursing care when there is no likelihood of improvement, see <http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec409-32.pdf>.

- i. “Age Discrimination in Employment Act of 1967,” 29 USC § 621-34, at <https://www.eeoc.gov/statutes/age-discrimination-employment-act-1967>.
- j. “When Can I Buy Medigap?” <https://www.medicare.gov/supplements-other-insurance/when-can-i-buy-medigap>.
- k. <https://www.ncoa.org/age-well-planner/medicare>.

4. Cost charts for Original Medicare A, B and D — 2025

MEDICARE PART A: 2025			
SERVICES	BENEFIT	MEDICARE PAYS	DEDUCTIBLE YOU PAY* You owe this full amount when you are admitted as an inpatient; it is not prorated.
Hospitalization: <ul style="list-style-type: none"> • Semi-private room and board • General nursing • Other hospital services and supplies (Medicare payments based on benefit periods) Hospitalization does NOT include Medicare-approved doctors' services; you will pay an additional 20% of that amount while you are an inpatient. Hospitalization includes mental health inpatient stay, with the same benefits. Additionally, you will pay 20% of the Medicare-approved amount for mental health services you get from doctors and other providers while you're a hospital patient.	First 60 days	All but \$1,676	\$1,676 (deductible)
	61 st to 90 th day	All but \$419 per day	\$419 (co-insurance) per day
	91 st to 150 th day (lifetime)**	All but \$838 per day	\$838 (co-insurance) per day
	Beyond 90 (or 150 if lifetime is used) days	Nothing	All costs
Skilled Nursing Facility Care: (Have to be inpatient for 3 days beforehand) <ul style="list-style-type: none"> • Semi-private room and board • Skilled nursing and rehabilitative services • Other services 	First 20 days	100% of approved amount	Nothing
	Additional 80 days	All but \$209.50 per day	\$209.50/day (co-insurance)
	Beyond 100 days	Nothing	All costs
Home Health Care: <ul style="list-style-type: none"> • Intermittent skilled nursing care • Physical therapy, speech language, pathology services • Home health aide services • Durable medical equipment (e.g., wheelchairs, hospital beds, oxygen and walkers) • Other services and supplies • No custodial care — Must be recovering 	Unlimited as long as you meet Medicare conditions	<ul style="list-style-type: none"> • 100% of approved amount • 80% of approved amount for durable medical equipment 	<ul style="list-style-type: none"> • Nothing for services • 20% of approved amount for durable medical equipment
Hospice Care: <ul style="list-style-type: none"> • Pain and symptom relief • Support services for the management of mental illness • DNR 	For as long as doctor certifies need (6 months to live or less)	All but limited costs for outpatient drugs and inpatient respite care	Limited costs for outpatient drugs (\$5 co-pay) and inpatient respite care (5% of approved amount)

<p>Blood: Blood transfusions for inpatients, including SNF, hospice and some home health care.</p>	<p>Check with your provider for costs.</p>	<ul style="list-style-type: none"> • Nothing • All 	<ul style="list-style-type: none"> • Patient must have paid the Part A deductible.
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Medicare “beneficiaries” receive “medically necessary and reasonable” (least expensive) treatment. Not all services/tests are provided under Medicare.

* 2025 Part A Monthly premium: Most people don’t pay a monthly premium for Part A (sometimes called “premium-free Part A”). If you or your spouse do not have 40 quarters of credible coverage, you must buy Part A. If you have at least 30 quarters but not 40, you’ll pay up to \$285 each month in 2025, which increases in 2026 and each year thereafter. If you paid Medicare taxes for fewer than 30 quarters, or you are among certain individuals with disabilities who have exhausted other entitlements, you will pay the full the standard Part A premium of \$518 a month in 2025. This premium is paid for the entire time the person is on Medicare Part A. You can work the additional quarters to eliminate the penalty. Request the SSA to update your work record each year.

**You must pay the amounts listed in the “You Pay” column; Medigap insurance will only pay the deductibles and co-insurance, but does not cover services Medicare itself doesn’t cover. For example, Medigap will NOT add days to the skilled nursing benefit; when Medicare stops at 100, so does Medigap.

5. Chart — Medicare Part B — 2025

<p style="text-align: center;">MEDICARE PART B: 2025</p>			
<p style="text-align: center;">SERVICES</p>	<p style="text-align: center;">BENEFIT</p>	<p style="text-align: center;">MEDICARE PAYS</p>	<p style="text-align: center;">YOU PAY†</p>
<p>Medical Expenses:</p> <ul style="list-style-type: none"> • Doctors’ services, inpatient and outpatient • Surgical services and supplies • Podiatrist services • Physical, occupational and speech therapy • Diagnostic tests (e.g., X-rays, hearing exams) • Durable medical equipment • Urgent and emergency services (including ambulances) 	<p>Unlimited if medically necessary</p>	<ul style="list-style-type: none"> • 80% of the approved amount after \$257 deductible, as well as 80% for most outpatient services, including mental health 	<ul style="list-style-type: none"> • \$257 deductible (pay once per year) • 20% of approved amount after deductible • 20% for tests and durable medical equipment • 20% for all physical and occupational therapy
<p>Outpatient Mental Health Services</p>	<ul style="list-style-type: none"> • Yearly depression screening • Visits for mental health 	<ul style="list-style-type: none"> • Everything • 80% of the approved amount after \$257 deductible 	<ul style="list-style-type: none"> • Nothing if your provider accepts assignment • 20% of the approved amount after \$257 deductible
<p>Clinical Laboratory Services:</p> <ul style="list-style-type: none"> • Blood tests, urinalysis and more 	<p>Unlimited if medically necessary</p>	<p>100% of approved amount</p>	<p>Nothing for services</p>
<p>Home Health Care: (if you don’t have Part A)</p> <ul style="list-style-type: none"> • Intermittent skilled care • Home health aide services • Durable medical equipment • Other services and supplies • No custodial care — must be recovering 	<p>Unlimited as long as you meet Medicare conditions</p>	<ul style="list-style-type: none"> • 100% of approved amount • 80% of approved amount for durable medical equipment 	<ul style="list-style-type: none"> • Nothing for services • 20% of approved amount for durable medical equipment

Blood transfusions	Check with your provider for costs.	Check with your provider for costs.	
Outpatient Hospital Treatment: Services for the diagnosis or treatment of an illness or injury	Unlimited if medically necessary	Medicare payment to hospital based on hospital cost	20% of Medicare payment amount (after \$240 deductible)
Premiums chart is below.			

MEDICARE PART C: MEDICARE “ADVANTAGE” — MANAGED CARE PLAN

MEDICARE PART D: PRESCRIPTION DRUG BENEFIT

+ You must pay the amounts listed in the “You Pay” column; Medigap insurance will only pay the deductibles and co-insurance, but does not cover services Medicare itself doesn’t cover.

6. Chart — Medicare Part B Premiums 2025

Medicare Part B Premiums 2025			
Premiums are “means adjusted.” Part B premiums must pay for 25% of Part B costs, including reserves. The government pays 75%; the base premium increase cannot exceed the COLA (cost-of-living adjustment) in Supplemental Security Income (SSI) for older adults.			
Full Part B Coverage*			
Beneficiaries who file individual tax returns with modified adjusted gross income:***	Beneficiaries who file joint tax returns with modified adjusted gross income:**	Income-Related Monthly Adjustment Amount	Total Monthly Premium Amount
Less than or equal to \$106,000	Less than or equal to \$212,000	0	\$185
\$106,001 and less than or equal to \$133,000	\$212,001 and less than or equal to \$266,000	\$74	\$259
\$133,001 and less than or equal to \$167,000	\$266,001 and less than or equal to \$334,000	\$185	\$370
\$167,001 and less than or equal to \$200,000	\$334,001 and less than or equal to \$400,000	\$295.90	\$480.90
\$200,001 and less than \$500,000	\$400,001 and less than \$750,000	\$406.90	\$591.90
Greater than or equal to \$500,000	Greater than or equal to \$750,000	\$443.90	\$628.90
<p>*PREMIUM MAY BE HIGHER IF YOU ENROLL LATE. This late penalty applies for your lifetime.</p> <p>**For information for beneficiaries who are married and file separate income tax returns, see https://www.cms.gov/newsroom/fact-sheets/2024-medicare-parts-b-premiums-and-deductibles?mod=anlink%2F.</p> <p>*** Modified Adjusted Gross Income (MAGI)</p>			

MAGI is the figure used to determine eligibility for premium tax credits and other savings for marketplace health insurance plans and for Medicaid and the Children’s Health Insurance Program (CHIP). MAGI is adjusted gross income (AGI) plus these, if any: untaxed foreign income, non-taxable Social Security benefits, and tax-exempt interest.

- For many people, MAGI is identical or very close to AGI.
- MAGI doesn’t include SSI.
- MAGI does not appear as a line on your tax return: <https://www.healthcare.gov/glossary/modified-adjusted-gross-income-magi/#:~:text=MAGI%20is%20adjuste>.

Note that Part B premiums for certain transplant patients are different. Certain Medicare enrollees who are 36 months post-kidney transplant, and therefore no longer eligible for full Medicare coverage, can elect to continue Part B coverage of immunosuppressive drugs by paying a Part B premium.

7. Chart — Medicare Part B Immunosuppressive Premiums 2025

Medicare Part B Immunosuppressive Premiums 2025 Immunosuppressive Part B Coverage ONLY			
Beneficiaries who file individual tax returns with modified adjusted gross income:	Beneficiaries who file joint tax returns with modified adjusted gross income:	Income-Related Monthly Adjustment Amount	Total Monthly Premium Amount
Less than or equal to \$106,000	Less than or equal to \$212,000	0	\$110.40
\$106,001 and less than or equal to \$133,000	\$212,001 and less than or equal to \$266,000	\$73.60	\$184
\$133,001 and less than or equal to \$167,000	\$266,001 and less than or equal to \$334,000	\$184.10	\$294.50
\$167,001 and less than or equal to \$200,000	\$334,001 and less than or equal to \$400,000	\$294.50	\$404.90
\$200,001 and less than \$500,000	\$400,001 and less than \$750,000	\$404.90	\$515.30
Greater than or equal to \$500,000	Greater than or equal to \$750,000	\$441.70	\$552.10

Part D — Insulin Coverage

In 2022, a new rule went into effect that caps insulin at a \$35 co-payment for a one-month supply. All insurers should reflect the correct insulin co-pay of \$35 per month. Insulin pen needles to be used with insulin pens and insulin needles and syringes to be used with insulin vials are covered under Part D and Medicare Advantage plans (if the Medicare Advantage plan covers prescription drugs) and can be put into the Medicare.gov website. Other insulin supplies, such as alcohol pads and glucose testing equipment, glucometers, test strips, lancets and control solution, are covered under Medicare Part B. Some community pharmacies accept assignment and can provide these additional diabetes supplies, but if your pharmacy doesn't, you may want to try a specialty or mail-order pharmacy or durable medical equipment provider. Most Medicare Advantage plans will cover diabetes testing supplies at the pharmacy because they cover both Part B and Part D items.

TIP: Planning for 2025 and beyond: Leave insulin off your list of drugs when you are on the [medicare.gov](https://www.medicare.gov) website. The \$35 co-pay is a universal rule, so all insurers should charge you \$35/month in 2025 as a standard co-pay that is NOT subject to a deductible. Confirm your insulin brand is on the drug formulary of your Medicare Part D plan or Medicare Advantage plan (if your plan covers prescriptions drugs).

TIP: When starting or adjusting insulin, have your provider write the prescription for insulin with specific directions to increase the insulin dose up to a ceiling amount. This will allow the pharmacist to calculate an accurate amount of insulin you will need per month as you increase the dose. For example, if your provider starts you on 10 units daily and writes the prescription that way, you will get one 3mL pen for the month. If the provider tells you to increase the insulin dose by 2 units every 3-4 days and stop at 20 units daily, that one 3mL pen will only last you 25 days. This would mean you would have trouble refilling the prescription, and you would pay another \$35 co-pay for another prescription of one 3mL pen, which, at 20 units daily, will only last you 15 days. With the prescription reflecting the provider’s spoken directions to you, increasing the dose to 20 units daily, you would get two 3mL pens per month.

8. Chart — Calculate Your Medicare Part D Premium and IRMAA For 2025

CALCULATE YOUR MEDICARE PART D PREMIUM FOR 2025		
The tax filing status with modified adjusted gross income in 2022		
Filed individual tax return with modified adjusted gross income	Filed joint tax return with modified adjusted gross income	Income-related adjustment amount you pay each month
Note: These figures do not include any Part D late enrollment penalty, discussed above.		
Less than or equal to \$106,000	Less than or equal to \$212,000	Your plan premium
Greater than \$106,000 and less than or equal to \$133,000	Greater than \$212,000 and less than or equal to \$266,000	\$13.70 + your plan premium
Greater than \$133,000 and less than or equal to \$167,000	Greater than \$266,000 and less than or equal to \$334,000	\$35.30 + your plan premium
Greater than or equal to \$167,000 and less than or equal to \$200,000	Greater than \$334,000 and less than or equal to \$400,000	\$57 + your plan premium
Greater than \$200,000 and less than \$500,000	Greater than \$400,000 and less than \$750,000	\$78.60 + your plan premium
Greater than or equal to \$500,000	Greater than or equal to \$750,000	\$85.80 + your plan premium
The 2024 Part D national base beneficiary premium is \$34.70.		
Social Security calculates your Part D IRMAA; if your income goes down or you disagree with the calculations, file a dispute at: Medicare Income-Related Monthly Adjustment Amount — SSA: https://www.ssa.gov/forms/ssa-44.pdf .		

For those who are married but file separate tax returns, refer to [Medicare.gov](https://www.medicare.gov).

The Part A premium, Part B premium and IRMAA, and Part D IRMAA are deducted from your Social Security check. If you have an Advantage plan, these costs are not included in the premium you pay to the plan. If the amount isn’t taken from your check, you’ll get a bill from Medicare or the Railroad Retirement Board.

For a list of specific premiums, www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans.

Appendix

See “Medicare Appeals” for additional information about medicare appeals. To access this information, go to <https://www.medicare.gov/providers-services/claims-appeals-complaints/appeals>. This can also be found on the Massachusetts Bar Association’s website at <https://www.massbar.org/public/elder-law-education>.

- i. <https://www.aha.org/system/files/media/file/2024/02/faqs-related-to-coverage-criteria-and-utilization-management-requirements-in-cms-final-rule-cms-4201-f.pdf>
- ii. <https://medicareadvocacy.org/frequently-asked-questions-about-the-observation-status-court-decision/>
- iii. <https://www.aha.org/system/files/media/file/2024/02/faqs-related-to-coverage-criteria-and-utilization-management-requirements-in-cms-final-rule-cms-4201-f.pdf>

CHAPTER 8

COMMUNITY MEDICAID (MASSHEALTH) BENEFITS

Programs for Older Adults at Risk for Institutionalization

INTRODUCTION

In addition to providing long-term care coverage, Medicaid (known as MassHealth in Massachusetts) offers community benefits that enable older adults to stay at home while still receiving necessary care. Community MassHealth offers various programs and services to individuals age 65 and older who meet both financial and medical qualifications. Those under age 65 can also qualify if they are permanently disabled, although different rules apply. Individuals who are eligible for MassHealth insurance can also be covered by their own private insurance. For those older adults who wish to live at home, MassHealth offers various programs that allow an older adult to receive some care within their home. Adult and supportive day care, transportation and caretaker services are among a multitude of benefits that MassHealth provides to empower older adults to live at home. An experienced elder law attorney can help an individual determine which program might be most appropriate for each individual's particular circumstances.

Note that qualifying for MassHealth in a community setting does not translate into coverage in a nursing home setting. Planning for community MassHealth may have adverse consequences for achieving nursing home eligibility if not done properly, as the income and asset rules vary for all benefits. For example, the transfer rules differ in a community setting from the long-term care nursing home rules. In addition, be advised that there could be estate recovery claims. Therefore, one should consult with an elder law attorney who is well-versed in these matters. Regulations and agency practices also change regularly.

A. HOME- AND COMMUNITY-BASED SERVICES WAIVERS

For older adults who require nursing home-level care, but would like to live at home or in a residential community, Home- and Community-Based Services Waivers, also referred to as the Frail Elder Waiver (FEW), authorize MassHealth to pay for those services, regardless of the number of hours needed. The waiver program serves three important purposes: (1) saves the state money; (2) allows the older adult to remain at home with care; and (3) provides older adults with greater choices in their care. Under the FEW program, the responsibility of care for the older adult is shifted to family members, home care agencies or other designated caregivers. The goals of the program are to help older adults age outside of a nursing home, and to promote independent living. If an older adult qualifies for the FEW, they can participate in the Community Choices or Personal Care Attendant (PCA) programs, the Program of All-Inclusive Care for the Elderly (PACE), or senior care options (SCO), if eligible. Note that the extent of services authorized and the availability of providers may vary by geographic area.

1. The FEW allows those older adults who are eligible for nursing home care to receive services at home. To qualify for the waiver, an older adult must either be at least 65 years old or, if under 65, be permanently and totally disabled. Additionally, the individual must meet a clinical requirement and show that, if they did not receive waiver services, they would require institutionalization (nursing home care). In addition to the typical asset limitation of \$2,000 for MassHealth services, the waiver imposes a 2025 income threshold of \$2,901 per month. For couples, the income of the healthy spouse is not counted in determining eligibility. The non-applicant spouse's assets, however, are limited to \$157,920 (2025) (other than for the PACE program), but it is often beneficial to apply for only one spouse or to apply separately. Note that a recent MassHealth hearing decision found that long-term care insurance benefits are not considered income when determining eligibility for the FEW program. Although the administrative decision is not binding on MassHealth, it should be mentioned at the time of application, if appropriate.
2. If an individual's gross monthly income is greater than \$2,901, there will be a recurring six-month deductible that must be met before MassHealth coverage will begin. For example, if a single applicant's gross monthly income is \$2,951 (\$50 over the income limit), the Medicaid \$522 standard (less a \$20

income disregard) is applied and subtracted from \$2,901. That figure, \$2,409, is then multiplied by six, and as a result, a \$14,454 deductible must be met every six months before MassHealth benefits will begin/resume. This amount has to be paid out of pocket for medical or remedial expenses by the individual (remember, this individual can only have \$2,000 of assets) every six months, and then proof of payment has to be sent to MassHealth before becoming eligible for benefits. This approval is not retroactive, and then the individual has to meet this deductible every six months. *Note, if the income of an individual who was initially deemed eligible for the FEW (300% of the Federal Benefit Rate (FBR) or less) increases to a sum that exceeds this amount, the individual may still continue receiving benefits by paying the difference between their actual income and 300% of the FBR as a co-pay.

3. Applicants seeking coverage under the PCA program may have lower recurring deductibles, since an additional \$1,212.54 PCA disregard is subtracted from their gross income, resulting (using the prior example) in a monthly deductible of \$1,196, which, when multiplied by six, imposes a \$7,187 deductible (as opposed to a whopping \$14,454 deductible) that must be met every six months to maintain eligibility. An individual needing only 12-15 hours of care each week might benefit from applying for MassHealth benefits to cover care after the deductible is met.
4. Applicants must meet any deductible by paying qualifying medical expenses, including caregivers, Medicare and supplemental health (Medigap) premiums, and prescription and dental insurance premiums. Once the deductible is satisfied, MassHealth covers services for the balance of the six-month period, and the individual may retain all of their income. In many cases, however, individuals find that they can meet the recurring six-month deductible only if they have access to other resources (non-countable VA Aid and Attendance benefits, or family or spousal assets, for example, as assets are limited to \$2,000 for a single individual and \$3,000 for a married couple). Advocacy and legislative efforts are underway to reduce the deductible amounts, with the goal of ensuring that more individuals may remain at home, but it is unclear whether or when they will be successful.
5. Because MassHealth does not impose penalties for transferred assets in community cases, it is imperative that all applicants, but particularly those who anticipate having the recurring deductible, do not spend down their assets to \$2,000. Instead, they should consider moving excess assets out of their name to a trusted individual (who may have to return them, if long-term nursing home care is needed later) so that funds will be available for medical and non-medical expenses, including their recurring six-month deductible (if applicable), and so that they may stay in their home and receive care. However, this is not without some risk and should be done ONLY with the advice of an experienced elder law attorney.
6. Services and benefits of the FEW include MassHealth coverage of adult day health and supportive day programs. Supportive day is a social model day program, and adult day health is a medical model day program for older adults who need supervision and health services during the day, but will return home at the end of the day (the individual can leave home for services and be covered by the waiver). In addition, MassHealth covers home health services under the waiver. Additional benefits may include home-delivered meals, home modifications to improve accessibility, and transportation assistance for medical or other appointments.

B. COMMUNITY CHOICES UNDER FEW

Community Choices is a more care-intensive program for FEW participants who either face imminent nursing home placement or currently reside in a nursing home but wish to return home or to the community. To be eligible, the older adult must be already enrolled in or eligible for the FEW.

1. The program provides extensive home- and community-based services to older adults who require nursing home-level care and exhibit at least one of four indications of frailty:
 - a. Actively sought nursing home facility care within the last six months;
 - b. Recently experienced a serious medical event, regression in physical or cognitive functional ability, or a cumulative deterioration in functional ability;

- c. Was discharged from a nursing facility within the last 30 days; or
 - d. Is at risk of nursing facility admission due to the instability or lack of capacity of informal or formal supports.
2. Services are also provided to older adults who exhibit at least one of five clinical characteristics demonstrating risk:
 - a. Needs 24-hour supervision because of complex health conditions;
 - b. Experiences a significant cognitive impairment;
 - c. Is unable to manage/administer prescribed medications;
 - d. Experiences frequent episodes of incontinence; or
 - e. Requires daily supervision and assistance with two activities of daily living (ADLs).
ADLs are activities performed by a PCA to physically assist a member to transfer, take medications, bathe or groom, dress and undress, engage in passive range of motion exercises, eat and toilet.
 3. Services are provided by an agency hired through MassHealth and administered through the local Aging Service Access Point (ASAP). Community Choices offers more hours of service than any other similar program, and the care can often be put in place more quickly than other community care programs. Services offered include personal care, homemakers, nursing, companions, chore assistance, delivered meals, grocery delivery, laundry, transportation, home-based wander response systems, transitional assistance, and supportive day and adult day health.

C. PACE PROGRAM

The PACE program provides comprehensive medical and social services to frail older adults so as to allow them to live in their communities and to receive all of their health services under the same umbrella.

1. To be eligible, an individual must:
 - a. Be 55 years of age or older;
 - b. Live in a service area of a PACE organization (the PACE program is only available in certain parts of Massachusetts);
 - c. Be able to live safely in the community;
 - d. Be certified by the state as eligible for nursing home care; and
 - e. Agree to receive health services exclusively through the PACE organization.

All of the medical services are provided by MassHealth at no cost to the older adult. To be financially eligible, an individual's assets cannot exceed \$2,000, and a couple's assets cannot exceed \$3,000 if both are seeking coverage. Under current law, if only one member of a couple needs services, the non-applicant spouse's income and assets will be disregarded. In addition, the income threshold for an individual in 2025 is \$2,901 (with a deductible imposed if the applicant's income exceeds this figure). Note that the people who are not eligible for MassHealth can enroll in the PACE program and pay a monthly fee.

Through PACE, MassHealth will coordinate care for the older adult and provide the individual with medical professionals, including doctors, nurses, aides, therapists and social workers. Under this program, the older adult receives their primary care, emergency care, prescription drugs, in-home services, transportation and more. The services are available 24 hours a day, seven days a week. Although this coverage is comprehensive, it is important to note that a PACE recipient will have to change their doctor(s) and other medical providers to the PACE provider(s), and will be limited to which hospitals they can use for services.

The PACE program offers these services to recipients who are living at home in the PACE service area through the PACE Elder Service Plans. The recipients typically go to the PACE Elder Service Plan for a portion of the day to receive their care and receive some care in their homes. The PACE program also offers these services to recipients in assisted living residences and provides assistance with the cost of the assisted

living facility. The individual would contribute most of their income toward the cost of the assisted living facility, and the PACE program pays its contracted portion. That said, the assisted living facility must be in a PACE service area and must have a contract with the PACE program. Even if an assisted living facility is in a PACE service area and has a contract with PACE, the facility will only have a limited number of PACE beds. Individuals typically go in private-pay and get on a wait list for a PACE bed. For folks with limited funds, it is important to find out if the assisted living facility they are moving to has a contract with the PACE program and how they get on the wait list. If an individual with limited funds uses all of their assets to pay privately at a non-participating assisted living facility, they will have difficulty transitioning to a facility that accepts PACE because they will have no funds left to private-pay for the waiting period. It is important to note that the Veterans Aid and Attendance benefit could also be available to assist with the cost of private pay during the waiting period. See Chapter 10 for more information on this program.

D. PERSONAL CARE ATTENDANT (PCA) PROGRAM

The PCA program provides personal care services to older and disabled Massachusetts residents who wish to remain living at home. The PCA program is administered by MassHealth and seeks to enable independent living and prevent unnecessary or premature nursing home institutionalization. While MassHealth pays the caregivers, participants in this program or their surrogates are responsible for directing the care to assist with ADLs and instrumental activities of daily living (IADLs). A PCA participant or their surrogate acts as an employer and can hire friends, neighbors or certain family members (spouses and legal guardians are not eligible) to be their personal care attendant.

1. Eligibility Requirements.

- a. The PCA wage rate is \$19.50 per hour as of July 1, 2024, and \$20 per hour as of July 1, 2025. Based on the federal poverty levels, effective Jan. 21, 2025, the MassHealth PCA disregard amount is \$1,212.54 for an individual and \$2,344.12 for a couple.
- b. To be eligible for the program, an individual must have a permanent or chronic disability that requires them to receive hands-on assistance to perform at least two ADLs. ADLs are activities performed by a PCA to physically assist a member to transfer, take medications, bathe or groom, dress and undress, engage in passive range of motion exercises, eat and toilet. A doctor or nurse practitioner must prescribe the services for the older adult, and the services must be medically necessary.
- c. Additionally, the older adult must meet the \$2,000 asset limitation to qualify for MassHealth and a \$3,000 asset limitation for a couple. Each PCA applicant is assessed by a nurse and occupational therapist during enrollment in the program to determine the number of hours per week that assistance is required; MassHealth will then provide a budget for care services.
- d. Benefits include assistance with ADLs (e.g., bathing, grooming, eating, etc.), IADLs (e.g., homemaker services, laundry, meal preparation, etc.) and transportation. A personal care attendant may not be paid: (a) to help an older adult who is in a hospital or nursing facility, or in a community program funded by MassHealth; (b) to provide social services, such as babysitting, recreation or educational activities; or (c) to provide medical services that are available from other MassHealth providers.

E. SENIOR CARE OPTIONS

1. Eligibility.

Senior Care Options (SCO) is a no-cost health insurance and care program for individuals eligible for MassHealth and Medicare who are 65 or older, and it offers health services with social support services. SCO members receive all covered health services through the SCO plan, and they have a primary care physician (PCP) who is affiliated with the SCO, 24-hour access to care and active involvement in decisions about their care. All services are provided by the SCO and the PCP, and a team of nurses, specialists, and geriatric support services professionals develops an individualized plan of care.

- a. Enrollment is voluntary and open to MassHealth Standard members who are 65 or older;
- b. Reside in an area serviced by an SCO;
- c. Live at home or in a long-term care facility;
- d. Do not have to meet a recurring six-month deductible;
- e. Do not have end-stage renal disease.

The benefits for SCO members include all health services covered by MassHealth Standard, as well as coordination of care, including a centralized record of medical information, individualized assessment, primary and specialty medical care, preventive care, emergency care, X-rays and lab tests, medical supplies and equipment, prescription drugs, mental health and substance abuse treatment, rehabilitative therapy, nursing facility care (if needed), transportation for services, geriatric support services, adult day care, dental care and eye care, home care services and family caregiver support.

NOTE TO SCO AND PACE MEMBERS: If you enroll in MassHealth, and die with individually owned assets (this is referred to as a probate estate), MassHealth will have an automatic lien against your estate. MassHealth will seek reimbursement not for the costs of medical care and treatment, but for monthly premiums, which MassHealth pays to the SCO on your behalf. MassHealth starts making the premium payments in the month after you enroll, and the payments could be as much as \$3,000 per month.

If you are enrolled in SCO or PACE, you should discuss ways to avoid probate with an elder law attorney in order to avoid any estate recovery lien.

F. OTHER PROGRAMS FOR OLDER ADULTS

MassHealth also offers community programs to those older adults who are not at risk for institutionalization, but nonetheless require help within the home. These programs help prevent an older adult from entering a long-term care facility and aim to promote independent living among older adults.

1. SSI-G/Group Adult Foster Care

The SSI-G (the Supplemental Security Income assisted living benefit) and Group Adult Foster Care (GAFC) programs are designed for older adults who wish to transition to assisted living residences, but cannot afford the monthly rates. The GAFC program pays a daily rate to the assisted living facility directly for personal care and services, while the SSI-G component helps pay for the rent portion at an assisted living facility to the individual directly.

An individual can get GAFC benefits without SSI-G. For 2025, GAFC pays \$50 per day (\$1,525 per month) directly to the assisted living facility for services, such as daily personal care, homemaking, meals and transportation. The assisted living facility may combine the GAFC services with the room and board, which is paid by the resident, and the SSI-G program. The resident does not have to apply for or be eligible to receive SSI-G in order to qualify for GAFC. New regulations have been implemented for GAFC and can be found at 130 CMR 408.502 through 408.527.

Certain assisted living residences offer a limited number of beds for applicants who meet certain eligibility criteria:

- a. Over the age of 60 or chronically disabled;
- b. Have a medical, physical, cognitive or mental condition that limits their ability to care for themselves;
- c. Need daily help with one or more ADLs (e.g., dressing, bathing, eating or toileting);
- d. Have the ability to live independently, with support services;
- e. Meet eligibility requirements for public housing, GAFC, ElderChoice subsidized rents and/or SSI-G;
- f. Do not need full-time skilled nursing care;

- g. Are medically approved for assisted living by their physician and Aging Services Access Point (ASAP).

To qualify for GAFC, an individual may not have more than \$2,000 in countable assets, and a couple may not have more than \$3,000 in countable assets. Because MassHealth does not impose penalties for transferred assets in community cases, it is imperative that all applicants, but particularly those who anticipate having the recurring deductible, do not spend down their assets to \$2,000. Instead, they should move excess assets out of their name to a trusted individual (who may have to return them, if long-term nursing home care is needed later) so that funds will be available for medical and non-medical expenses. This should be done ONLY with the advice of an experienced elder law attorney.

In addition, if an individual's income is greater than \$1,324 (2025), or a couple's income is greater than \$1,783 if both spouses are applying (100% of federal poverty level), there will be a recurring six-month deductible.

Applicants must satisfy the deductible by paying qualifying medical expenses, including Medicare and supplemental health insurance premiums. Because only a portion of the monthly assisted living fee qualifies as a medical expense (the majority is considered room and board), individuals who are required to meet deductibles may have to pay as much as four times the amount of the deductible figure. Therefore, in cases where an applicant needs to meet a recurring six-month deductible, GAFC eligibility can be maintained only if the individual has access to other resources (non-countable VA Aid and Attendance benefits, or spousal or family assets, for example). Once GAFC benefits are in effect, the resident is required to contribute their income toward the monthly rent portion; GAFC pays the medical portion.

G. MASSACHUSETTS ADULT FAMILY CARE

1. Adult Family Care Program

The Adult Family Care program is a relatively new MassHealth program that provides care to older or disabled individuals by having the older adult move into a caregiver's home or having a caregiver move into the older adult's home.

- a. Similar to all MassHealth programs, the applicant must have less than \$2,000 in assets to qualify.
- b. Eligible caregivers include family members, friends or a professional service.
- c. Spouses and legal guardians are not eligible caregivers.
- d. Caregivers are paid for the 24-hour personal care they provide, and typically offer assistance with ADLs and IADLs. Although MassHealth will not pay for the room and board of the individual, depending on the level of care, caregivers receive an annual tax-free payment of between \$9,000 and \$18,000 from MassHealth, with the payment based on the level of care needed.
- e. Caregivers also can receive as many as 14 respite care days per year.
- f. To be eligible for Adult Family Care, the applicant must be 16+ or disabled and require either help with one ADL (level 1) or 24-hour assistance with ADLs (level 2). Care requirements, however, cannot be so severe as to necessitate residency in a nursing home.

H. OTHER IMPORTANT OLDER ADULT PROGRAMS

1. Statewide Nutrition Programs

The Elderly Nutrition Program, administered by the Executive Office of Elder Affairs, allows local agencies to provide nutritious meals to older adults. Meals are provided at congregate meal sites, such as senior centers, churches, schools and other locations. The congregate setting provides opportunities for socialization and companionship. It also offers programs related to nutrition education, exercise activities, health promotion and disease prevention. Some programs also offer meals on weekends. Transportation is often available for those who have trouble getting around on their own. The Elderly Nutrition Program also provides home-delivered meals to older adults (age 60 or older) and handicapped or disabled people

under age 60 who live in housing facilities occupied primarily by older adults where congregate meals are served.

Each meal contains at least one-third of the current daily Recommended Dietary Allowance of nutrients and considers the special dietary needs of older adults. In addition to providing meals, the Elderly Nutrition Program provides access to social and rehabilitative services.

To apply for one of the elderly nutrition programs, contact the Executive Office of Elder Affairs at (800) 882-2003 to find the elderly nutrition agency nearest to you.

2. Prescription Advantage

Prescription Advantage is a prescription drug insurance plan available to all Massachusetts residents age 65 and older, as well as younger individuals with disabilities who meet income and employment guidelines. An older adult is eligible for the program if they are not receiving prescription drug benefits under Medicaid. Individuals receiving Medicare benefits may be eligible for assistance with paying for prescription drug costs (also known as “Extra Help”) from Social Security. In order to receive this assistance, an application must be submitted to Social Security.

3. Pharmacy Outreach Program

The Massachusetts College of Pharmacy and Health Sciences (MCPHS) Pharmacy Outreach Program is a community service offered by the university. The purpose of the Pharmacy Outreach Program is to work closely with local and statewide health care resources, physicians and older adults to help relieve the burden of medication expenses. Any Massachusetts resident may utilize the MCPHS Pharmacy Outreach Program toll-free telephone number, (866) 633-1617, to inquire about prescription drug medication support programs that are available at low cost or free of charge. The website is www.MCPHS.edu/PharmacyOutreach. Consumers can ask any questions regarding their medications and general health.

4. Serving the Health Information Needs of Everyone Program

The Serving the Health Information Needs of Everyone (SHINE) program provides health insurance counseling services to older and disabled adults. SHINE counselors are trained to handle complex questions about Medicare, Medicare supplements, Medicare Health Maintenance Organizations, public benefits with health care components, Medicaid, free hospital care, prescription drug assistance programs, drug discount cards and long-term health insurance.

SHINE counselors help older adults and Medicare beneficiaries understand their rights and benefits under Medicare and other health insurance coverage. Counselors can identify and compare current options, and protect older adults from paying too much for their medical care. SHINE counselors also help older adults learn how to fill out insurance claims forms and public benefits applications.

SHINE counselors are available at most councils on aging, senior centers and Aging Services Access Points, hospitals and libraries. Counselors are also available for homebound clients. To locate a SHINE counselor in your community, contact your regional SHINE program at <https://www.mass.gov/info-details/find-a-shine-counselor>.

I. CONCLUSION

A long-term nursing facility is not the only choice for an older adult. There are a multitude of options for older adults who require medical care or assistance with everyday life, but do not wish to enter a nursing home. One of MassHealth’s community programs might be the solution for a qualified older adult to remain at home and independent. Applying for the above programs can be very complicated. Practices and policies often differ among MassHealth workers and offices. Individuals seeking eligibility should consult with an experienced elder law attorney knowledgeable about these programs.

CHAPTER 9

MASSHEALTH (MEDICAID) Nursing Home and Long-Term Care Benefits

INTRODUCTION

For most older adults, the prospect of long-term care in a nursing home is, to say the least, unpleasant. Older adults worry that the cost of long-term care will deplete their estates. The cost of nursing home care in Massachusetts, which typically ranges from \$140,000 to \$190,000 per year (the daily rate is often over \$400), only serves to compound these fears. The premiums to purchase long-term care insurance to pay for the cost of long-term care are frequently beyond the means of middle-income older adults, or long-term care insurance may not even be available to some older adults due to preexisting medical conditions.

Many older adults receive assistance from the federal Medicare program to help pay for medical expenses and the cost of prescription drugs. Generally, Medicare may pay for a portion of short-term rehabilitation in a skilled nursing facility but not for non-skilled (custodial) care. Medicaid (known as MassHealth in Massachusetts), on the other hand, is a joint federal-state program that pays for nursing home care for individuals who meet complex financial eligibility and clinical rules. The term “MassHealth” will be used throughout this chapter. A growing percentage of older adults are seeking alternatives to nursing homes, including remaining at home with caregivers or moving to independent living communities, continuing care retirement communities or assisted living facilities.

A. FINANCIAL ELIGIBILITY

1. Income and Assets Chart

INCOME All money an applicant receives, such as:	ASSETS Anything an applicant owns, such as:
Social Security	Cash
Dividends	Mutual Funds
Pensions	Automobile
Rental Income	Real Estate
	Retirement Accounts
	Whole Life Insurance

MassHealth is a complex area. Rules and regulations change frequently, and there are many exceptions to the rules. Unlike private health insurance, MassHealth has the right to recover its costs from your estate. It is important to consult with an experienced elder law attorney.

2. Income Limitations

- a. **Personal Needs Allowance (PNA):** There are no income thresholds for nursing home residents so long as the applicant’s income does not exceed the private pay rate at the nursing home. Instead, the resident contributes all of their income toward the monthly cost, minus certain allowed deductions for health insurance premiums and a Personal Needs Allowance (PNA), which is currently \$72.80, and MassHealth covers the difference.
- b. **Community Spouse:** If there is a non-applicant spouse, called a “community spouse,” they will be able to keep all of their own income. If that income is low and falls below a certain minimum, or if they have certain extraordinary expenses, the community spouse will then be allowed to keep a portion of the nursing home spouse’s income, as outlined in Section C of this chapter.

c. **Example 1: Community Spouse Deduction:**

EXAMPLE 1
Community Spouse Deduction

Charlotte is 70 years old and unmarried. She is admitted to a nursing home for long-term care and applies for MassHealth. She receives Social Security income of \$1,000 per month. She pays a Medicare supplement health insurance premium of \$220 per month. She must pay \$707.20 (\$1,000 - \$220 - \$72.80) of her Social Security to the nursing home each month as Patient Paid Amount (PPA), assuming she has less than \$2,000 of countable assets and is otherwise eligible. MassHealth will pay for the balance of her nursing home and medical care.

3. Minimum Monthly Maintenance Needs Allowance (MMMNA) and Shelter Expense

- a. **MMMNA:** MassHealth rules provide that a community spouse needs income equivalent to 150% of the federal poverty level for two persons, which through June 2025 is \$2,555, and is referred to as the Minimum Monthly Maintenance Needs Allowance (MMMNA). MassHealth will determine the community spouse’s actual income as well as their actual expenses.
- b. **Shelter expense:** In addition to the basic MMMNA, MassHealth makes an adjustment if the community spouse’s shelter expenses exceed 30% of the minimum (which is currently \$766.50).
- c. **MMMNA and PPA Calculations:** MassHealth calculates the MMMNA at the time it determines the nursing home spouse’s PPA, which is the amount of income the nursing home spouse must pay to the nursing home toward the costs of care each month. A MassHealth-eligible nursing home resident must pay all of their monthly income to the nursing home as PPA, minus certain allowed “deductions,” which include a PNA (\$72.80) to be used to meet the resident’s personal needs (e.g., haircuts, newspapers, etc.). Other deductions include the costs of any medical or health insurance premiums and, in Example 2 on this page, a Spousal Monthly Maintenance Income Allowance of \$400.

If the community spouse and nursing home resident’s combined income is insufficient to satisfy the MMMNA, a community spouse may file and present evidence at an administrative appeal to request an increased asset limit sufficient to generate additional income to satisfy the MMMNA. An experienced elder law attorney should be consulted to evaluate the merits of and prepare for such a hearing.

d. **Example 2: MMMNA and Shelter Expense:**

EXAMPLE 2
MMMNA and Shelter Expense

Mrs. Smith, a community spouse, has monthly income of \$1,800. Her shelter costs (mortgage payments or rent, condo fees, real estate taxes, homeowners insurance, utilities) total \$1,566.50, which is \$800 more than the federal minimum of \$766.50. As a result, Mrs. Smith’s MMMNA is \$3,355 which is the total of the minimum monthly allowance of \$2,555 plus the \$800 excess shelter costs. Because Mrs. Smith requires additional funds above her own \$1,800 income to satisfy her \$3,355 monthly need, each month her spouse can transfer \$1,555 (\$3,355 - \$1,800) of his income to her, to the extent available, rather than include it in his Patient Paid Amount that is paid to the nursing home.

4. Asset Limitation

- a. MassHealth imposes a \$2,000 asset limit for an individual applicant age 65 or older, or a single applicant of any age in a skilled nursing facility. Additionally, in 2025, the community spouse (if any) is generally allowed to keep up to \$157,920 of countable assets. This amount can be increased through an appeal by either spouse establishing that the amount of income generated by the community spouse’s asset allowance is inadequate to raise the community spouse’s income to the

MMMNA.

b. **MassHealth divides assets into three categories:**

- i. Non-countable assets;
- ii. Countable assets.

(Only countable assets are considered with respect to asset limitations. The assets of a married couple age 65 and older, when one member resides in a nursing home, are treated differently); and

- iii. Inaccessible assets.

c. **Non-Countable Assets:**

- i. A principal residence in Massachusetts (See special rules for the principal residence);
- ii. Household belongings and furnishings;
- iii. Personal belongings (e.g., clothing, jewelry, furniture, etc.);
- iv. Burial plots for the applicant and members of their family;
- v. Prepaid irrevocable burial contracts;
- vi. A \$1,500 burial bank account for miscellaneous funeral and burial expenses;
- vii. Term, group or other life insurance policies that have no cash surrender value;
- viii. Life insurance policies with face values totaling up to \$1,500, regardless of cash surrender value; and
- ix. One automobile for use by the applicant or their family. See Example 3.

d. **Countable Assets:**

All assets not considered non-countable or inaccessible are considered countable assets; that is, they are counted toward an applicant's \$2,000 asset limit, or the community spouse's \$157,920 limit. In some cases, both jointly held assets and assets in a trust will be viewed as countable assets.

e. **Example 3: Countable and Non-Countable Assets:**

EXAMPLE 3

Countable and Non-Countable Assets

Richard owns his home worth \$250,000, a car worth \$4,000 and mutual funds worth \$50,000. MassHealth does not consider the value of Richard's home or car when calculating Richard's countable assets. MassHealth does consider the \$50,000 Richard owns in mutual funds as a countable asset.

f. **Inaccessible Assets:**

- i. **No current legal ownership.** Like non-countable assets, inaccessible assets are also not included in the calculation of an applicant's assets for MassHealth purposes. Inaccessible assets are those to which the applicant has no current legal access, such as expected inheritances before probate is completed, or divorce assets prior to a final decree.
- ii. **Example 4: An Inaccessible Asset Can Become Countable**

EXAMPLE 4

An Inaccessible Asset Can Become Countable

Karen's sister Betty died six months before Karen applied for MassHealth. Under Betty's will, Karen is entitled to one-half of Betty's estate, which is worth \$200,000. Karen has not yet received any money from Betty's estate. The \$100,000 Karen expects to receive from Betty's estate is an inaccessible asset. Once Karen receives the \$100,000, it becomes a countable asset.

g. **Jointly Held Assets:**

MassHealth presumes that all funds held in joint bank accounts belong to the applicant. This presumption can be overcome if the non-applicant joint owner can demonstrate that they contributed part or all of the funds to the account.

i. **Example 5: Who Contributed to a Joint Account?**

EXAMPLE 5 Who Contributed to a Joint Account?
Andy owns a joint bank account with his daughter, which totals \$10,000. His daughter contributed \$8,000 of that amount when she was going through a divorce. When Andy applies for MassHealth, it is presumed that Andy owns all of the \$10,000 in the joint account. If, however, Andy can prove that \$8,000 of this account is attributable to his daughter, only \$2,000 will be counted as Andy's assets.

ii. **Example 6. A Joint Account Presumption**

Other assets held jointly, such as real estate, stocks, bonds and most mutual funds, are presumed to be owned proportionately by each owner. This presumption can also be overcome, and in some cases, the entire asset may be deemed inaccessible.

EXAMPLE 6 A Joint Account Presumption
Edna and Charley are joint owners of a stock and bond mutual fund with a value of \$20,000. If Edna applies for MassHealth, it may be presumed that she owns 50% of the mutual fund, or \$10,000. (See Section E regarding transfer penalties for additions to joint accounts made during the five-year look-back period.)

5. Special Rules for the Principal Residence

- a. **Equity in the home:** MassHealth will treat equity in an applicant's home, up to \$1,097,000 (as of 2025), as a non-countable asset if it is located in Massachusetts, and if the applicant, living in a nursing home, expresses in the MassHealth application an intent to return to that home.
- b. **Exemptions:** Any one of the following persons lives in the home:
 - i. The applicant;
 - ii. The applicant's spouse;
 - iii. A child under age 21;
 - iv. A disabled or blind child of any age;
 - v. A relative who is dependent on the applicant;
 - vi. A child who lived in the home for at least two years immediately before the applicant moved into a nursing home, and provided care that permitted the applicant to remain at home; or
 - vii. A sibling who has an equity interest in the home and has lived there for at least one year before the applicant moved into a nursing home.
- c. **Intent to return home:** If the applicant checks the box indicating that they do not intend to return home, the home becomes a countable asset and must be put on the market for sale.

6. Estate Recovery and MassHealth Liens

- a. **MassHealth Estate Recovery Unit (ERU):** ERU can recover for long-term care or nursing home benefits provided on behalf of a recipient of any age. Recovery, however, is limited under current law to collecting from the recipient's probate estate and, in the case of the recipient's home, can only be pursued if there is no surviving spouse, child under age 18, or disabled child of any age living in the home.

- b. **MassHealth’s current policy limit of \$25,000:** MassHealth will not pursue any estate recovery if the value of the member’s estate is \$25,000 or less.
- c. **LTCI exemption:** MassHealth cannot pursue estate recovery against the member’s primary residence if the member had a qualifying long-term care insurance policy, with available funds, at the time of their admission to a nursing home.
- d. **Pre-death lien over 55 on real property:** If the recipient owns real property, MassHealth may place a lien on such real property for the amount of funds expended on the recipient’s behalf after the recipient reaches age 55. This lien may be placed on the recipient’s real property (including, but not limited to, their primary residence) even before the recipient’s death, provided certain conditions are met.
- e. **Conditions:**
 - i. The recipient permanently resides in a nursing home;
 - ii. The recipient receives notice of the lien; and
 - iii. There is no spouse, child under age 18, or disabled child of any age residing in the house.
- f. **Notice liens definition:** These pre-death liens are simply notice liens. MassHealth has no claim against the real estate until the recipient dies and it files a claim against the estate. If the house is sold during the recipient’s life, however, MassHealth can seek recovery from the proceeds of the sale.
- g. **Notice forms and contact information for MassHealth Estate Recovery Unit (ERU):**
 - i. The notice form is mailed by the MassHealth Estate Recovery Unit (ERU) of the Executive Office of Health and Human Services (EOHHS) to authorized representatives or estate personal representatives.
 - ii. Petitions for probate filed in Massachusetts probate courts require the petitioner to state that ERU has first been notified of the death with a copy of the petition and the death certificate.
 - iii. The address and phone number of the ERU are: The Commonwealth of MA, Executive Office of Health and Human Services, MassHealth Estate Recovery Unit, PO Box 15205, (800) 754-1864/ (508) 856-7803 and fax (508) 856-7803.
- h. **Delayed or waived estate recovery:** MassHealth regulations also include circumstances in which estate recovery can be delayed or waived, so it is important to consult the latest regulations upon the death of a MassHealth member to determine whether and the extent to which MassHealth can recover against the estate. Estate recovery will not be required until after the death of a surviving spouse, if any, or while there is a surviving child who is younger than 21 years old or a child of any age who is blind or permanently disabled. This request is time-sensitive.
- i. **An Act to Improve Quality and Oversight of Long-Term Care — Chapter 197 of the Acts of 2024:** On Sept. 6, 2024, Gov. Maura Healey signed into law the above-titled Act. The Act amends GL 118E: 31 to explicitly limit MassHealth estate recovery to only federal mandated recovery for nursing home care and certain other long-term care costs for individuals who die on or after Aug. 1, 2024. It also ends estate recovery for people with disabilities receiving assistance under MassHealth’s CommonHealth program, subject to federal approval. Expect further guidance from MassHealth identifying what other long-term care costs are subject to mandatory recovery, recovery for people enrolled in managed care plans that pay for nursing home and other long-term care costs, and the effective date of the exception for the CommonHealth program.

7. Protecting the Home:

- a. **Legal strategies:** Older adults often want to “protect their home.” There is, unfortunately, no uniformly agreed-upon strategy to accomplish this goal. There are various legal strategies that may be employed in an attempt to protect a home, including, but not limited to, irrevocable trusts, life

estate deeds, outright gifts, and other strategies for the home (and other assets), but each planning option presents complex pros and cons for an older adult to consider.

b. **Relevant issues are:**

- i. The options available if MassHealth coverage is required during the five-year look-back period require special consideration;
- ii. The degree to which a strategy does, in fact, successfully protect homes during current MassHealth applications, administrative fair hearings and/or court appeals;
- iii. The level of control retained by the older adult over their home;
- iv. The older adult's access to equity in their home in the future (e.g., through a reverse mortgage);
- v. The tax impacts on the older adult and their family; and
- vi. The risks to an older adult's ongoing right to reside at home.

- c. **Complexity and changes:** Due to the extraordinary complexity of these issues, we continue to see changes in the relevant statutes, case law, regulations and MassHealth practices.

B. TRUSTS

1. Definition

If a MassHealth applicant is the beneficiary and grantor of a trust, and if, under any circumstance, trust principal (as opposed to trust income) can be paid to the grantor, then any amount of principal that the trustee has the discretion to pay to the applicant is considered a countable asset. Even principal that can be paid by a trust not created by the applicant may be countable under certain circumstances. The assets are considered countable even if a trustee never pays principal to the applicant.

a. **Example 7: A Beneficiary of Trust Assets**

EXAMPLE 7 A Beneficiary of Trust Assets
Paul is the beneficiary of a trust, which he set up himself. The trust holds \$100,000 in assets, and the trustee has the authority to make any amount of distributions of interest and principal to Paul on a regular basis. Paul applies for MassHealth. MassHealth will consider the entire \$100,000 as a countable asset for Paul.

b. **Example 8. Revocable Trust Assets**

If the applicant or their spouse is the grantor of a revocable trust, all assets in the trust are considered countable assets. The result is the same even if the applicant or their spouse is not a beneficiary of the revocable trust. See Example 8.

EXAMPLE 8 Revocable Trust Assets
Sam funds a revocable trust where his brother is trustee and his nephew is beneficiary. The trust holds \$100,000. Sam applies for MassHealth. MassHealth will consider the entire \$100,000 as a countable asset for Sam because Sam can revoke the trust at any time or transfer trust assets back to himself.

c. **Irrevocable Trusts**

Not all trust assets are countable assets, though. For example, certain types of trusts, including carefully drafted irrevocable trusts funded before the look-back period, "pooled trusts" qualifying under 42 U.S.C. s. 1396(d)(4)(C) and qualifying testamentary supplemental needs trusts, may prevent assets in such trusts from being deemed countable assets by MassHealth.

d. **Trust Complexities**

Treatment of trusts is a very complex area of law due to requirements of federal law, state regulations

and court decisions. Questions regarding the creation of and transfers of assets to and from trusts should be carefully reviewed with an experienced elder law attorney.

C. COMMUNITY SPOUSE RESOURCE ALLOWANCE (CSRA)

1. CSRA Definition

When a nursing home spouse has a spouse at home (called a “community spouse”), the resource rules are more complex. A married couple’s assets are pooled for the purpose of determining the nursing home spouse’s eligibility. MassHealth will calculate the couple’s total countable assets (sometimes called the “snapshot date”) as of the first day of a nursing home stay lasting 30 days or more. The couple’s assets are pooled without regard to which spouse actually owns the asset. The community spouse is allowed to keep a portion of the assets, called the Community Spouse Resource Allowance (CSRA), based on the equivalent of 120% of the federal poverty level for two persons.

- a. **Amount of CSRA:** In 2025, the maximum CSRA is \$157,920. If the countable marital assets exceed that amount, the excess assets disqualify the nursing home spouse, and must be spent down or applied to the costs of their nursing home care.
- b. **Increased CSRA:** Under certain circumstances, the community spouse may request an increased CSRA to meet living expenses, but that is a rare occasion because MassHealth will not grant an increased CSRA unless the community spouse needs more than the combined monthly income from both spouses to meet their living expenses.
- c. **90-day rule to transfer assets to community spouse:** Where MassHealth approves the nursing home spouse for eligibility, any assets higher in value than the \$2,000 asset limit still held in their name must be placed in the community spouse’s name within 90 days. If the nursing home spouse has assets exceeding the \$2,000 after 90 days, it will trigger a disqualification.
- d. **Example 9: Asset Transfer Between Spouses**

EXAMPLE 9
Asset Transfer Between Spouses
Mr. Smith is entering long-term care in a nursing home and is entitled to retain a CSRA of \$157,920. Mrs. Smith has \$79,000 in her name alone. There remains, however, \$20,000 in assets in Mr. Smith’s name. The Smiths are allowed 90 days to transfer all but the permissible \$2,000 from Mr. Smith’s name into Mrs. Smith’s account.

- e. **Uncooperative spouse:** In situations where one spouse refuses to cooperate with MassHealth, such as by refusing to supply the necessary documents, or the spouse has been physically separated from the applicant for reasons other than the MassHealth application, MassHealth may disregard the uncooperative or physically separated spouse’s assets, though an appeal may be necessary. In such a situation, the uncooperative or physically separated spouse will not be entitled to any of the applicant spouse’s income.

D. PERMISSIBLE SPEND-DOWN OF EXCESS ASSETS

1. Married Couples

A married couple need not necessarily spend down any assets that exceed the CSRA on nursing home expenses. For example, the excess assets can be used to pay off existing debt, e.g., a mortgage balance, or to make repairs or necessary purchases, such as a pre-need funeral contract, but timing is very important.

2. MassHealth-Compliant Annuity

Another option to consider is for the community spouse to purchase a MassHealth-compliant annuity, which converts excess countable assets into an income stream to the community spouse. The annuity income can be retained by the community spouse because the community spouse is not subject to an

income limit.

- a. **Requirements:** The MassHealth-compliant annuity must satisfy very specific requirements, including that it must be immediate, cannot have a balloon payment, must be irrevocable, cannot exceed the purchaser’s life expectancy, cannot be assignable, and must satisfy MassHealth requirements concerning naming the Commonwealth of Massachusetts as beneficiary.
- b. **Short-term:** Typically, the community spouse prefers an annuity with the shortest term possible, so as to recover funds more quickly. Non-MassHealth-compliant annuities can result in MassHealth disqualifying transfer penalties. An elder law attorney may present yet further spend-down options for consideration.

3. The Spend-Down Process

- a. **Single Person:** When a single applicant has countable assets that exceed the amount allowed by MassHealth, they will want to reduce these assets below the \$2,000 limit. This process is called a “spend-down.” There are many ways to achieve a spend-down, including purchasing non-countable assets, paying debts, purchasing an annuity and even gifting assets, knowing that there will be a controlled period of disqualification.
- b. **Married Couples:** Regardless of the options used to achieve the spend-down, the applicant will usually want to qualify for MassHealth as quickly as possible. A married couple has a greater range of options to achieve eligibility (and to save more assets) than a single individual.
- c. **Example 10: How the Spend-Down Process Works**

EXAMPLE 10	
How the Spend-Down Process Works	
Jack is single, requires nursing home care and has countable assets totaling \$34,000. In order to become eligible for MassHealth, Jack will need to spend down \$32,000. Jack is allowed to keep \$2,000 in assets. Jack spends his money in the following manner:	
Balance to be spent down:	\$34,000
Purchase of a prepaid burial contract:	\$10,000
Purchase of a burial plot:	\$2,000
Pay off credit card debt:	\$10,000
Attorney and professional fees (for illustrative purposes only):	\$8,500
Burial account:	\$1,500
Total remaining (allowable):	\$2,000

E. TRANSFER RULES

- 1. **Intent:** Medicaid, as implemented by MassHealth, was designed to provide medical-related coverage to those individuals and families who do not have enough assets to meet these needs themselves. Through a number of regulations, the program discourages individuals from intentionally impoverishing themselves by gifting to qualify for MassHealth.
 - a. **Five-year look-back period:** MassHealth will review financial records and penalize the applicant and/or their spouse for gifts or transfers made for less than fair market value during the 60-month period prior to applying for MassHealth (known as the five-year look-back period).
- 2. **Disqualifying Transfer Definition:** MassHealth will deem a transfer to be disqualifying if the applicant and/or community spouse transfers any assets, whether countable or non-countable, for less than fair market value during the look-back period, unless an exemption applies.
 - a. **Divisor rule:** MassHealth determines the period of ineligibility by dividing the total amount of disqualifying transfers by the applicable MassHealth divisor rate, which is currently \$441 and is regularly adjusted by MassHealth.

b. **Exemptions:** MassHealth does have several exemptions to its transfer penalties. For example, no penalties are applied when an applicant or their spouse transfers any assets to a spouse or to a blind or qualifying disabled child or to a qualifying trust for a disabled individual.

c. **Example 11: How the Look-Back Period Works**

EXAMPLE 11 How the Look-Back Period Works
Florence owns a condo with a fair market value of \$220,500. On April 1, 2025, Florence transfers the condo to her non-caretaker, non-disabled daughter as a gift. On June 1, 2025, Florence enters a nursing home and applies for MassHealth. Because the gift occurred during the 60-month period prior to the MassHealth application, MassHealth imposes a disqualifying transfer penalty of 500 days ($\$220,5000 \div \441 per day). As a result, MassHealth will not approve benefits for the applicant during the 500-day period commencing on June 1, 2025, assuming she is otherwise eligible for MassHealth on that date.

d. **Penalty period:** There are no penalties when an applicant or their spouse transfers the principal residence to a child who is under age 21, to a sibling who has lived in the home during the year preceding the applicant's institutionalization and who already holds an equity interest in the home, or to a qualifying caretaker child. A caretaker child is a child of the applicant who lived in the house for at least two years immediately prior to the applicant's institutionalization and who, during that period, provided care that allowed the applicant to remain in the home.

e. **Penalty period date:** MassHealth applies the disqualifying transfer penalty period beginning on the date when an applicant is "otherwise eligible" for MassHealth benefits. If an applicant delays the MassHealth application for more than 60 months after making a disqualifying transfer, it is not necessary to report the transfer to MassHealth. In this manner, an applicant can essentially cap their ineligibility at a maximum of 60 months. Applying for MassHealth too soon after a large transfer for less than the fair market value of the asset transferred can cause a much longer than necessary disqualification period. In the unfortunate event that an applicant is deemed ineligible, or disqualified from receiving benefits, it is imperative that the applicant consult with an elder law attorney to discuss what options, if any, are available.

f. **Example 12: Timing Is Important When Looking at When to Apply for MassHealth**

EXAMPLE 12 Timing Is Important When Looking at When to Apply for MassHealth
Mike owned a house with a fair market value of \$661,500. On April 1, 2020, Mike transferred the house as a gift to his non-caretaker, non-disabled son. On Feb. 1, 2025, Mike applied for MassHealth. MassHealth looked back 60 months from the date of Mike's application and flagged the disqualifying transfer. MassHealth calculated a 1,500-day ineligibility period ($\$661,500 \div \441 per day). This ineligibility period will commence on Feb. 1, 2025, and last 1,500 days (4.1 years). If Mike had waited to apply until after April 1, 2025, the transfer would not have been included in the look-back period and he could have been eligible for benefits on April 2, 2025, assuming he made no further disqualifying gifts after April 1, 2020.

F. DEEMING TRANSFERS TO BE GIFTS

1. Purpose of Transfers

A long-standing regulation, found at 130 CMR 520.019(F), states that MassHealth will not penalize an individual for transfers made for less than fair market value if the applicant proves, to MassHealth's satisfaction, that the assets were transferred exclusively for a purpose other than to qualify for MassHealth.

- a. **Transfers less than fair market value:** Despite this regulation and the reason for the transfer, MassHealth routinely considers transfers made for less than fair market value to be disqualifying gifts, resulting in a penalty period.
- b. **Gifts:** Gifts made for the purpose of paying for a grandchild's tuition, wedding plans, a down payment on a child's home, etc., may be viewed by MassHealth as disqualifying transfers, regardless of the donor's actual intent. Gifts using an individual's "annual exclusion" amount are still considered disqualifying gifts for MassHealth purposes.

G. MASSHEALTH APPLICATION PROCESS

1. **Process:** The MassHealth application is often difficult and time-consuming to complete. Applications are submitted to a central office of the Division of Medical Assistance, which scans the application and assigns it to one of the long-term care units for processing. Final determinations on an applicant's eligibility may take several months or more.
2. **Documentation Required:** The supporting documentation required for a successful application is substantial and includes, among other things, copies of health insurance cards and premium information, 60 months of bank and investment account statements, copies of checks, verifications of all withdrawals and transfers, two years of income tax returns, life insurance policies, gross and net income, trust documents (if applicable) and, if the applicant is married, a copy of the certificate of marriage and household expense information.
3. **Bank Withdrawals and Transfers:** Withdrawals, transfers, and sales of assets occurring in the 60-month period preceding the application must be explained, or disqualification periods may result. Many practitioners compare the process to the complexity of a multi-year tax audit. Under these circumstances, the use of a qualified elder law attorney experienced in the preparation and submission of MassHealth applications is strongly recommended.

H. IMPORTANCE OF AN ELDER LAW ATTORNEY

1. **Massachusetts Chapter of NAELA (MassNAELA):** Careful long-term care planning with an attorney experienced with Medicaid issues, particularly an elder law attorney who is a member of MassNAELA, prior to a hospitalization or medical crisis ensures that families understand their rights. Such planning allows families to evaluate their options and, ideally, enables families to protect the family home and other substantial assets.
2. **Planning Prior to Medical Crisis:** The more a person or family plans before a medical crisis occurs, the more assets the family can save. Good planning involves protecting the independence, integrity and wishes of the older adult or couple, as well as protecting assets. MassHealth may implement current and/or future proposed regulations to modify the law, or change the way it interprets the law.
3. **Experienced Attorney:** An experienced attorney will be able to conduct a complete review of your personal and financial situation, make appropriate recommendations to address your health care needs, and provide you with a framework of recommendations to protect your assets according to your own personal wishes.
4. **Eligibility Questions:** If you or a loved one is a current MassHealth beneficiary, or you have questions about eligibility or an application, you may call the state's toll-free number at (888) 665-9993. This service is available 24 hours a day, seven days a week, and can provide information on case status, key eligibility dates, plan information, items needed to process your case, examples of acceptable verifications, address information and more.
5. **Resource Directory:** You may also find resources on how to access an elder law attorney in the Resource Directory in Chapter 22 of this guide.

CHAPTER 10

VETERANS BENEFITS

Pension and Compensation for Eligible Veterans and Their Surviving Spouses

INTRODUCTION

The U.S. Department of Veterans Affairs (VA) provides two distinct financial benefit programs to qualified veterans or to their surviving spouses: 1) non-service-connected pension and 2) service-connected compensation. The VA pension is a needs-based benefit for disabled and elderly claimants who meet a specific set of financial and non-financial criteria. VA compensation, on the other hand, is a benefit for veterans who suffered a disabling injury during active military service.

A. VA PENSION WITH AID AND ATTENDANCE

Non-service-connected pension is a benefit that provides monthly payments to wartime veterans, or their dependents, who are disabled or over the age of 65, whose income after taking into consideration medical expenses is below the low-income threshold. The age requirement does not apply to surviving spouses. Pension claimants who are housebound or require the aid and attendance of another person are eligible for a higher payment amount. This enhanced pension is commonly referred to as “Aid and Attendance.” Aid and Attendance can serve as a critical source of funds that can help veterans and their surviving spouses offset the costs of their home care, assisted living or nursing home care.

The maximum amount a claimant is eligible to receive for pension with Aid and Attendance is based on that claimant’s payment category. A veteran, a veteran with a spouse and a surviving spouse of a veteran fall into different payment categories.

Claimant’s Payment Categories	2025 Maximum Monthly Payment for Pension with Aid and Attendance
Single veteran	\$2,358
Veteran with a spouse	\$2,795
Surviving spouse of a veteran	\$1,515

All VA pension payments are tax-free, as it is a reimbursement for care costs.

B. FINANCIAL LIMITATIONS

The VA pension benefit is needs-based, and therefore, the claimant must meet income and asset limitations. If a claimant is married, then the VA includes income and medical expenses of both spouses to determine total net income. All earned and unearned income is added together, such as Social Security, pension income, interest, dividends and business income. The claimant must also report lump-sum income, including inheritances, lottery winnings, gifts and awards.

1. All recurring unreimbursed medical expenses (UMEs) are used to offset gross income. These expenses can include nursing home costs, assisted living costs, home health care and health insurance premiums. These expenses, however, must be “out of pocket” and not reimbursable by insurance or a third party. The difference between the claimant’s gross income and unreimbursed medical expenses is the “Income for Veterans Affairs Purposes” (IVAP). If the IVAP is less than zero (if medical expenses exceed gross income), then the claimant can be eligible for the maximum pension payment with Aid and Attendance. If the IVAP is greater than zero, but less than the monthly Aid and Attendance benefit, then the claimant can receive benefits equal to their monthly benefit minus the IVAP.
2. The claimant must also have limited assets to qualify for the non-service-connected pension programs, including Housebound and Aid and Attendance. The VA uses a net worth test. It calculates the applicant’s IVAP (if a married veteran, the IVAP of both spouses is considered) and adds that to the countable assets.

Please note that the IVAP is often zero, as the IVAP calculation is based on the initial application for pension with Aid and Attendance, and recurring care costs generally exceed the income. For 2025, the net worth must be no more than \$159,240. The VA's net worth limit increases every Dec. 1 to match the Consumer Price Index inflation percentage increase for Social Security.

3. In calculating the claimant's net worth, the claimant's primary residence and up to two acres of attached land, vehicles for personal use and personal belongings are excluded. The recent rule changes specify that the exclusion of the primary residence is limited to the dwelling and a lot area of two acres. Excess acreage is counted but only to the extent that the excess land is marketable. If it is not marketable, then it will have no value. If the claimant's primary residence is sold, the sale proceeds will be considered as part of the claimant's net worth, unless the claimant purchases a new primary residence in the same calendar year. For example, if the claimant sold the primary residence on Dec. 10, they would only have 21 days to purchase the replacement residence, or the sale proceeds would be part of the claimant's net worth.
4. All assets that can be liquidated (with the exception of the primary home as described above, personal effects suitable for a "reasonable mode of life" and a vehicle), whether owned by the veteran or the veteran's spouse, such as CDs, annuities, stocks, bonds, savings accounts, checking accounts and IRAs, are included in the claimant's net worth. Term or group life insurance and other financial investments that do not have a cash surrender value are not countable assets. Lastly, the VA includes the annual income of the claimant and the claimant's dependents in the net worth calculations. For example, if a claimant has \$100,000 in countable assets and an annual income of \$12,000, then the VA will determine the net worth of the claimant to be \$112,000. However, as stated above, the income is often zero, as the IVAP is generally a negative number.
5. On Oct. 18, 2018, the VA implemented a three-year look-back period and a penalty period for certain asset transfers for claimants seeking non-service-connected pension and Aid and Attendance.
6. The VA will penalize a claimant who has, within the look-back period, transferred a "covered" asset on or after Oct. 18, 2018 (all transfers prior to Oct. 18, 2018, are exempt). A covered asset is the amount by which a claimant's net worth would have exceeded the \$155,356 limit if the uncompensated value of the covered asset had been included in net worth. For example, if a single claimant has \$0 in IVAP and \$140,000 in assets but gave away \$20,000 in 2023, the claimant has a "covered asset" that was transferred in the amount of \$9,462. In contrast, if a single claimant has \$0 in IVAP and \$120,000 in assets and gave away \$20,000 in 2023, no transfer of a "covered asset" has occurred because when the transferred asset is added back in, the claimant is still under the \$155,356 net worth limit. In other words, if a claimant's transfer of assets qualifies a claimant for a VA pension, then the VA will implement a penalty. If, on the other hand, a claimant's transfer had no effect on eligibility because the claimant was already asset-eligible before the transfer, then the VA will not apply a penalty and there is no "covered asset."

The length of the penalty is calculated by determining the value of the covered assets transferred and dividing that amount by the monthly penalty rate. The monthly penalty rate is determined by the Maximum Annual Pension Rate (MAPR) in effect on the date of the pension claim at the Aid and Attendance level for a veteran with one dependent, divided by 12. The penalty period will begin the month following the date of the last transfer. The monthly penalty rate for a veteran with one dependent in 2024 is \$2,795. For example, a claimant seeking eligibility in January 2025 who transferred \$2,727 in covered assets on Nov. 1, 2024, will be penalized for one month. The VA will not issue a penalty that exceeds five years, and the VA allows a claimant to "cure" a disqualifying transfer within a certain amount of time.

C. MILITARY REQUIREMENTS

The veteran must also meet specific military requirements to qualify for the VA pension. The veteran must have served at least 90 days of active duty, one day of which was served during a period of war. For veterans of the Gulf War to present, the service requirement is 24 months or completion of the requirement for active-duty service, whichever comes first. Periods of war fall within the following time frames:

World War II Dec. 7, 1941–Dec. 31, 1946 Merchant Marines (Dec. 7, 1941–Aug. 15, 1945)
Korean War June 27, 1950–Jan. 31, 1955 (inclusive)
Vietnam War Nov. 1, 1955–May 7, 1975 These dates apply for veterans who served “in-country” in the Republic of Vietnam during this time period otherwise. Aug. 5, 1964–May 7, 1975, inclusive for all others.
Gulf War Aug. 2, 1990–currently undetermined. A date to be set by law or presidential proclamation (for VA benefits purposes, this time of war is still in effect).

Active duty does not include “reserve” duty (unless activated). Finally, the veteran must have been discharged under conditions other than dishonorable.

D. DISABILITY REQUIREMENT

The VA pension is “non-service-connected” because the veteran’s or veteran’s surviving spouse’s disability does not need to be connected to or resulting from the veteran’s military service. To medically qualify for base pension, veterans must be either age 65 or older, or totally and permanently disabled or a resident in a nursing home. To receive the enhanced pension with Aid and Attendance, the claimant must require the aid of another person or require supervision from harm in order to perform personal functions required in everyday living (two or more “activities of daily living” a/k/a ADLs).

E. MARRIAGE REQUIREMENT

The pension benefit paid to a surviving spouse is referred to as Survivor’s Pension or Death Pension. For a surviving spouse of a veteran to qualify, the spouse must also satisfy certain marital requirements. The surviving spouse must have been married to the veteran for at least one year or, in the alternative, had a child with the veteran. The surviving spouse must also have remained married to the veteran and cohabitated with the veteran continuously until the veteran’s death. A divorce or separation from the veteran terminates the former spouse’s entitlement to Survivor’s Pension. Likewise, a surviving spouse who remarries after the veteran’s death terminates survivor’s eligibility. Benefits are available to the same-sex spouse of a veteran on the same terms as an opposite-sex spouse. The VA has provided guidance on marriage benefits for same-sex couples, available here: www.va.gov/opa/marriage/.

F. SERVICE-CONNECTED COMPENSATION

The VA’s service-connected compensation is distinct from the VA’s non-service-connected pension in several ways. Unlike the VA pension, VA compensation is not based on financial need, and there is no income or asset test to qualify. The asset limits and transfer penalties described above do not apply to service-connected eligibility. The compensation is a monetary benefit paid to a disabled veteran whose disability was incurred or aggravated while serving in active military service. Incurred in the line of duty does not mean combat-related. Unlike the VA pension, wartime service is not required. For example, a veteran who suffered from post-traumatic stress disorder (PTSD) during the Vietnam conflict could qualify for compensation, as could a veteran who injured their back on a military base during peacetime.

The VA pays compensation on a scale from 10% to 100% in increments of 10%. Effective Dec. 1, 2023, the VA pays a veteran with no dependents rated at 10% disability \$171.23 per month, while the VA pays the same veteran rated at 100% disability \$3,737.85 per month. The veteran with a rating ranging from 30% to 100% will receive a higher amount if the veteran has a spouse and/or dependent children.

The key component with compensation is establishing the nexus between the veteran’s disability and the veteran’s military service. This connection must be established with sufficient medical evidence. There are

some disabilities, however, that are presumed to be caused by a veteran's military service. This presumption relieves the claimant from the burden of proving the connection between the disability and the veteran's military service. For example, the VA presumes that a veteran with respiratory cancer who was exposed to Agent Orange during the Vietnam conflict has a service-connected illness and may qualify for compensation. For a full list of presumptive conditions, see <https://benefits.va.gov/BENEFITS/factsheets/serviceconnected/presumption.pdf>.

Nursing home coverage is available for veterans who need nursing home care for a service-connected disability. A veteran with a minimum service-connected disability rating of 60% for one condition who has been deemed permanently and totally disabled or has a 70% combined disability rating is similarly eligible. The disability does not need to be the reason for requiring nursing home care. In the case of a private nursing home contracted with the VA, there may be a co-payment.

A surviving, dependent child or parent of a veteran who died in the line of duty, or who died from a service-related injury or illness, may also qualify for compensation under certain conditions. This survivor's benefit is called "Dependency and Indemnity Compensation" (DIC). To qualify for DIC, for surviving spouses, they must have been married to a veteran who died while in the service, or married to a veteran who was rated as 100% disabled for at least 10 years prior to the veteran's death (other conditions may apply as well). If the surviving spouse remarries, then potential eligibility for DIC is terminated.

G. APPEALS

The Appeals Modernization Act took effect in February 2019 and significantly changed the appeals process. Any claimant who receives an initial VA claim decision after February 2019 will follow the new Appeals Modernization process if they disagree with the decision. There are three ways to appeal: (1) higher-level review; (2) supplemental claim; or (3) appeal to the Board of Veterans' Appeals. The VA brochure that explains the process is located at: <https://benefits.va.gov/BENEFITS/factsheets/appeals/Appeals-Brochure.pdf>.

H. ADVOCACY

In Massachusetts, there are veterans' service officers (VSOs) in each city and town across the state. The VSO is a public official appointed by the mayor of each city or the board of selectmen of each town. The VSO's primary role is to serve as a one-stop shop for all needs of veterans and eligible dependents. Some of the services offered by VSOs include providing outreach services to veterans to educate them on benefits and services; offering referrals to programs and services for veterans and their dependents; taking applications for state veterans benefits, including Chapter 115 financial benefits and the annuity program; and helping veterans access employment assistance through career centers and related programs. A VSO is also responsible for assisting with the proper internment of deceased veterans and qualified dependents.

All veterans and surviving dependents are highly encouraged to reach out to their local VSO to request a free benefits checkup. This link will help you find the VSO for your city or town: <https://www.mass.gov/info-details/find-a-veterans-service-officer-near-you>.

RESIDENTS' LEGAL RIGHTS IN LONG-TERM CARE

An Act To Improve Quality And Oversight Of Long-Term Care

On Sept. 6, 2024, Gov. Maura Healey signed an omnibus law, Chapter 197 of the Acts of 2024, to improve the quality and oversight of long-term care, effective Dec. 5, 2024. The law contains major changes to the regulation of nursing homes and assisted living residences, provides greater resident protections and creates several task forces to examine the further regulation of the various entities that provide long-term care services. Doubtless, as the law is implemented, the coming years will see some changes in the provision of long-term care services.

A. CONTINUUM OF CARE

1. Definition

Long-term care services are provided along a spectrum of care. Service might be provided in a private home, a continuing care retirement community, an assisted living residence (ALR) or a nursing facility. It is important for consumers to understand the differences between the settings and the different rules that apply within each context.

2. Nursing Home Care

- a. **24/7 care:** Nursing homes provide around-the-clock nursing care and assistance with activities of daily living (ADLs). Nursing homes, technically “long-term care facilities,” are subject to state and federal law, as well as regulations issued by the Massachusetts Department of Public Health (DPH), the state Medicaid program (MassHealth), the Office of the Attorney General and the federal Center for Medicare and Medicaid Services (CMS). Many of the regulations will be discussed below.

3. Assisted Living

- a. **Definition:** Assisted living has traditionally been a residential arrangement providing room and board for eligible older adults and disabled individuals who need some minimal aid, support, or supervision with activities of daily living, such as meal preparation, medication regimen, housekeeping, clothes laundering, dressing or bathing, grocery shopping and transportation needs.¹
- b. **Level of Care:** Prior to the COVID pandemic, assisted living residents should not have required the level of care provided in a nursing home.² However, the recently enacted omnibus long-term care legislation now allows ALRs to provide certain health care services, as detailed below.
- c. **Menu of services:** Typically, ALRs offer a “menu” of services, for which a resident must pay extra. Assisted living is intended to encourage the maintenance of older adults’ autonomy and privacy.³ ALRs often have “memory care” units.

4. Continuing Care Retirement Community

- a. A continuing care retirement community (CCRC) is an option that offers single and married older adults a continuum of housing, independent living, support services and skilled nursing care that is intended to allow them to remain housed in the same community as their services are adjusted and altered depending upon their needs.⁴ It is a comprehensive and individualized plan offering such services as nursing and health care, housekeeping, transportation, meals and special diets, recreational activities and emergency help.⁵ Any skilled nursing care unit in a CCRC is subject to DPH and MassHealth regulations. However, CCRCs are not subject to the rules regarding ALRs.

ARBITRATION

Long-term care providers — nursing homes, ALRs and CCRCs — frequently include pre-dispute, binding arbitration requirements in their admission agreements.

Harm by provider

By agreeing to arbitration, consumers are giving up important rights, including the constitutional right to a jury trial, and right to file a class-action lawsuit, in case they are harmed by the provider. Although the long-term care industry has argued that arbitration helps reduce legal costs, there is no good reason for residents to voluntarily agree in advance to waive their rights; alternative dispute resolution is always an option once a dispute has arisen if the parties agree.

Forced arbitration

The practice of forced arbitration has had the effect of denying residents and their family members access to justice.

Confidentiality

Because arbitrations are confidential and there is no record of the outcomes, the use of forced arbitration has also operated to keep issues of abuse and neglect out of the public eye. Residents and their families should be aware of the prevalence and risks of arbitration, and should exercise their right to “just say no” to arbitration clauses in admission agreements.

See the brochure regarding this issue in the Appendix at the end of this chapter.

B. NURSING HOME CARE

1. Choosing a Nursing Home

- a. **CMS website tool:** Once a health care practitioner has determined the level of care you need, you are able to make choices on which nursing home to use. CMS has a website tool that allows you to compare nursing homes and select the most appropriate ones. (See www.medicare.gov/care-compare/?providerType=NursingHome&redirect=true).
- b. **Ratings:** This website provides a wealth of information, including data on health inspections, staffing, quality measures and quality ratings. The nursing home reports this information to CMS, so it is important to visit the nursing home in person before you make a final decision.
- c. **Medicaid-certified:** Although most nursing homes in Massachusetts are Medicaid-certified, not all are, so a resident may only be able to stay in a private facility as long as they are able to pay for the required care. In order to use a Medicaid benefit to pay for nursing home care, the nursing home must be Medicaid-certified.⁶ Although the Attorney General’s regulations and Massachusetts law prohibit discrimination based on eligibility for MassHealth benefits, these provisions are often difficult to enforce.⁷
- d. **Ombudsman and others:** When choosing a nursing home, it is important to speak with others, such as the long-term care ombudsman, care managers (often referred to as aging life advocates), residents, and family members of residents. It is fair to say that the nursing home system has not recovered from the COVID pandemic, in particular with respect to widespread staffing shortages. The Massachusetts Advocates for Nursing Home Reform, a program of Dignity Alliance of Massachusetts (www.manhr.org), and the National Consumer Voice for Quality Long-Term Care (www.theconsumervoice.org) websites contain information on how to select a nursing home and what questions to ask.
- e. **Quotes:** The following are quotes from the Massachusetts Advocates for Nursing Home Reform website:
 - i. Surveys measure whether the nursing home meets certain “minimum” standards. If a nursing home has no deficiencies, it means that it met the minimum standards at the time of the survey. It is important to realize that surveys and ratings do not identify nursing homes that give

outstanding care.

- ii. While reading the Massachusetts and federal reports, keep in mind that the quality of a nursing home may get much better or much worse in a short period of time. These changes can occur when a nursing home's administrator or ownership changes or when a nursing home's finances suddenly change.
- iii. Survey inspectors are only in the nursing home for a few days, which means surveys only provide a "snapshot" of what the facility is like — and the "snapshot" is usually taken when the facility administration and staff know they are being observed. In addition, inspectors do not look at the care of all residents; they only look at a sample of residents.
- iv. Remember — Government agency reports represent "one piece of the puzzle" in searching for a nursing home. Low ratings can tell more of a story than high ratings. Consider ratings with your personal perceptions and other research to help make an informed decision.

2. Dementia Care Standard for Nursing Homes

- a. **Safeguards:** Massachusetts law provides further safeguards for dementia residents in nursing homes in the form of regulations that require all direct care workers to have eight hours of initial dementia care training, pass an exam, and have an additional four hours of training annually.
- b. **Dementia Special Care Units (DSCUs):** DSCUs provide specialized care to nursing home residents with dementia through a combination of additional and ongoing dementia care training, expanded activities, and a safe and comfortable physical environment (e.g., special lighting and floor coverings to minimize confusion, safe/supervised access to the outdoors, etc.).
- c. **DPH certification:** Not every nursing home in Massachusetts has a DSCU, since compliance with DSCU law is not mandatory. DSCUs must be certified every year by DPH, and finding out if a nursing home has one is as simple as just asking. DSCUs must have at least one "therapeutic activities director" who is responsible for developing and implementing activities for residents. These regulations ensure that dementia units are staffed with appropriately trained workers.⁸
- d. **Changes to prevent injuries:** The regulations mandate that a fence or barrier surround the facility to prevent injury and elopement of dementia care residents. Another significant change to the laws that aims to protect those living in dementia units is the prohibition against overhead paging systems, which often scare residents. Facilities can now use such systems only for emergencies.⁹ DPH has promulgated guidance with respect to the administration of antipsychotic medications that requires the written consent of the resident, the resident's health care proxy agent or a duly authorized guardian.

3. Nursing Home Resident Rights

- a. **State and federal law:** Under state and federal law, nursing home residents are entitled to certain rights with regard to quality of care, treatment, safety and quality of life.
- b. **Lists of rights:** Nursing home residents have the right:
 - i. To obtain, upon admittance to the facility, written notice of their rights as residents;
 - ii. To freedom of choice of a physician, facility and health care mode;
 - iii. To obtain, upon request, an itemized bill for nursing home services;
 - iv. To have all medical records and communications kept confidential to the extent provided by law;
 - v. To have all reasonable requests responded to promptly within the capacity of the facility;
 - vi. To access all of their medical records upon request;
 - vii. To refuse to be examined, observed or treated without jeopardizing access to other medical care;

- viii. To have privacy during medical exams or treatment;
- xi. To have informed consent to the extent provided by law;
- x. To be permitted to share a room with one's spouse; and
- xi. To receive at least 48 hours' notice of a roommate change, barring any emergency.¹⁰

A nursing home resident is also entitled to certain rights relating directly to their personal freedoms, including the right:

- i. To communicate with persons of one's choice, privately and without restriction;
 - ii. To make a complaint or express a grievance free from reprisal, restraint, coercion or discrimination;
 - iii. To be free from any requirement to perform any service for the facility not in the resident's individual care plan, unless one volunteers or is paid for such service;
 - iv. To participate in social, religious and community groups;
 - v. To manage one's own financial affairs; and
 - vi. To keep and use personal possessions and clothing as space permits, and to have personal possessions reasonably safeguarded and secured.¹¹
- c. **Prohibition on binding arbitration:** Effective September 2019, federal regulations provide that nursing home residents cannot be required to agree to binding arbitration as a condition of admission to, or continued stay in, a nursing home.¹²

C. NURSING HOME TRANSFERS AND DISCHARGES IN MEDICAID- AND MEDICARE-CERTIFIED FACILITIES

1. Federal Law Protections

Nursing home residents should not be transferred or discharged from their rooms (their homes) without cause. A transfer is usually to a hospital where a resident is expected to return, whereas a discharge is to another facility or location and the resident is not expected to return. Under federal law, residents in Medicaid- and Medicare-certified facilities must be given adequate notice prior to a transfer or discharge, and be informed of their right to a hearing to contest the proposed transfer or discharge.¹³ Most nursing homes in Massachusetts are certified to participate in the Medicaid and Medicare programs.

- a. **Transfer conditions:** The federal transfer and discharge requirements apply to transfers or discharges to a hospital, other institutional setting or community setting (return home), as well as to transfers between differently certified parts of a nursing facility. Intra-facility transfers are not subject to these requirements; the different requirements applicable to them are discussed later in this section.
- b. **Permissible reasons for transfer or discharge:** Before a nursing home can transfer or discharge a resident, there must be a permissible reason for the action properly documented in the resident's record. A resident can be moved only:
 - i. If necessary for the resident's welfare and the resident's needs cannot be met in the facility.
 - ii. If the resident's health has improved sufficiently so that the resident no longer needs nursing home care.
 - iii. Due to the clinical or behavioral status of the resident.
 - iv. If the health or safety of individuals in the facility would otherwise be endangered.
 - v. For nonpayment or if the resident does not submit the necessary paperwork for third-party payment.
 - vi. If the nursing home closes.¹⁴

However, a resident cannot be transferred or discharged for nonpayment pending an administrative appeal of a denial of eligibility.¹⁵

2. Discharge Planning

- a. **Required discharge plan:** As part of the discharge process, a facility must provide sufficient preparation and orientation to ensure a safe and orderly transfer or discharge from the facility, in a form and manner that the resident can understand, and the plan must be documented.¹⁶ The resident may not be transferred if the resident files a timely appeal, whether the transfer is between different certified units, to another nursing home, to a hospital or to another setting.
- b. **Notice requirements:** Notice of a transfer to another facility or a discharge must be given to the resident, or the resident's designated representative and to the Office of the Ombudsman, at least 30 days in advance, except in an emergency. Notice may be given fewer than 30 days in advance but must be given as soon as possible when the health and safety of individuals in the facility would be endangered, a resident's health improves sufficiently to not require care in the facility, the resident has urgent medical needs (e.g., a need for hospitalization), or if the resident has resided in the facility for fewer than 30 days.¹⁷

The notice must specify the action to be taken, the specific reason(s) for the action, the effective date of the transfer or discharge, and the location to which the resident is to be discharged or transferred, and must inform the resident of appeal rights.¹⁸

- c. **Appeal:** Any resident wishing to appeal a transfer or discharge has the right to request a fair hearing through the Office of Medicaid Board of Hearings. A resident has the right to refuse hospitalization, and an appeal can be a useful mechanism to ensure that a resident's directives are followed. For a transfer to be approved, a hearing officer must find that the facility complied with all of the legal requirements. The assistance of an attorney or a care manager can be very useful in the appeal process.
- d. **Timely appeal (30 days):** If a timely appeal is filed (30 days from the date of the notice for non-emergency situations), the transfer or discharge may not occur until 30 days after a hearing decision is rendered. For emergency situations, the appeal period is 14 days. If the transfer or discharge has not taken place, the resident cannot be moved until five days after the decision. If the resident has been moved, the facility must readmit the resident to the next available bed in the event of a favorable decision.¹⁹

3. Intra-facility Transfers

- a. **Definition:** Massachusetts law governs transfers within the same certified facility. Transfers are permitted to different living quarters or to a different room based on a change in the resident's needs, e.g., the resident requires, or no longer requires, specialized accommodations, care, services, technologies or staffing not customarily provided in connection with the resident's living quarters.²⁰ The reason for an intra-facility transfer must be documented in the resident's clinical record by a physician.
- b. **Nonpayment or termination of coverage:** A resident should not be transferred based on a change in the payment status, such as termination of Medicare coverage or establishing eligibility for MassHealth. A nursing home may not discriminate against a resident based on source of payment. However, upon termination of Medicare coverage, a resident might wish to move to a different bed with a lower daily rate.
- c. **Notification to resident:** The resident must be notified of the proposed intra-facility transfer and the right to appeal to the facility's medical director.²¹ The state law does not contain any provisions regarding the content of the notice or the appeal process. However, prior to a change of room, the resident must be given advance notice in writing with a reason for the change, and 48 hours' advance notice must be given for a change of roommate, except in an emergency.²²

4. Bed Hold

- a. **Massachusetts law 20-day hold:** Under Massachusetts law, a nursing home resident has the right to return to their bed following a medical or non-medical leave of absence, and the nursing home must notify the resident of this right. The bed of a MassHealth recipient must be held during this bed hold period.²³
- b. **Private-pay residents may pay:** Private-pay residents may pay to hold their beds during such leaves.
- c. **Right to Return:** If a medical leave exceeds the bed hold period, the facility must admit the resident to the first available bed in a semi-private room.²⁴
- d. **20-day bed hold defined:** The MassHealth bed hold period is currently 20 days for medical reasons and 20 days for personal leaves but subject to change on a yearly basis, since these limits are set in the annual Massachusetts budget.

5. Readmission After Hospitalization

- a. **Right to readmission:** A nursing home resident has the right to be readmitted to the resident's nursing home following a hospitalization.
- b. **Appeal rights:** The failure of a nursing home to readmit a resident following a hospitalization is a discharge, which requires notice and appeal rights.²⁵ The resident has a right to file an appeal, even if a nursing home has failed to give the required notice.

6. Department of Public Health Regulations (DPH)

- a. **DPH monitors and licenses all Massachusetts nursing homes:** DPH monitors and licenses nursing home facilities throughout the commonwealth.²⁶ To determine whether an applicant for a nursing home license is responsible and suitable for licensing, DPH will look to the applicant's criminal history, if any; financial capacity to operate a long-term care facility; and the applicant's history and experience in providing long-term care.²⁷
- b. **Resident funds:** DPH sets out rules and regulations governing medical and nursing care, the maintenance of medical records, the handling of resident funds, the prevention of loss or damage to residents' personal possessions, and standards of facility sanitation.²⁸
- c. **Right to visit and inspection:** DPH surveyors have the right to visit and inspect any nursing home at any time to monitor compliance with regulations.²⁹ Such inspections are unannounced, and occur at least twice per year.³⁰ If violations are found, the nursing home facility may be subject to a monetary fine, and will be expected to submit a plan of correction to DPH within a certain time period.
- d. **Public notice:** At the expiration of such time period, the violation will be made public if no correction plan has been submitted.³¹
- e. **Complaints:** DPH also fields complaints by or on behalf of nursing home residents through its website and telephone hotline.
- f. **Informed consent to treat with antipsychotic medication:** DPH requires nursing homes to obtain written informed consent to be treated with any psychotropic medication. The consent must be signed by the resident, the resident's health care agent or a duly authorized guardian.
- g. **Consent must be documented:** The written informed consent must be documented on a form approved by DPH and kept in the resident's medical record, and must include, at a minimum, the purpose for administering the psychotropic drug, the prescribed dosage and any known side effect of the medication. Note that guardians of protected persons must obtain court approval to consent to the administration of antipsychotic medication.
- h. **Informed consent for psychotropic medication:**
 - i. Mass. G.L. ch. 111 § 72BB (effective 7/1/14) requires documentation of informed consent prior

to the administration of psychotropic medications in long-term care facilities.

- ii. See DPH Circular Letter: DHCQ 17-2-699, dated 2/1/17. which:
 - o Summarizes the law.
 - o Lists many, but not all, covered psychotropic and antipsychotic medications.
 - o Requires an informed consent form:
 - Prior to administration of medication
 - Anytime a dosage range has changed beyond what a resident or authorized person has consented
 - At least yearly
- iii. Provides a good summary of when an agent under a health care proxy can consent to administration of antipsychotics without court approval.

D. MEDICAID REGULATIONS (MASSHEALTH)

To be certified for participation in MassHealth and Medicare programs, a nursing home facility must also follow regulations promulgated by MassHealth.³² Among other things, these regulations include transfer and discharge provisions, bed hold rights and the right to request a fair hearing in certain circumstances. Otherwise, the nursing home will not be reimbursed for any services the nursing home provides to MassHealth- or Medicare-eligible residents.³³

E. ATTORNEY GENERAL'S REGULATIONS – UNFAIR AND DECEPTIVE PRACTICES

Nursing home facilities must also follow the Attorney General's Office regulations, which state that it will be considered an "unfair and deceptive" act, in violation of Mass. G.L. ch. 93A, for a nursing home to fail to comply with any federal or state statute or regulation protective of resident rights, or for a nursing home to fail to disclose the policies of the facility to a resident or prospective resident.³⁴ Further, a nursing home will be in violation of Chapter 93A if it discriminates against a Medicaid-eligible resident on the basis of that resident's source of payment for nursing home services.³⁵

1. **Prohibit waiving liability:** The Attorney General's regulations also prohibit nursing homes from requiring residents to have a third-party guarantor, or requiring residents to waive the facility's liability for personal injury or loss of personal property.³⁶
2. **Prohibit limiting choice of physician:** Nursing homes may not limit a resident's choice of physician or, for that matter, a resident's choice of pharmacy.³⁷
3. **Prohibit non-refundable deposits:** Nursing home facilities cannot require residents to pay a non-refundable deposit.³⁸
4. **Privacy rights:** Other Chapter 93A violations include a nursing home's refusal to permit a resident to have privacy during medical treatment or other activities of daily living, or refusal to allow a resident to live in the same unit with their spouse, if both consent.³⁹
5. **Demand letter:** The Attorney General's regulations include other provisions by which nursing homes must operate in order to prevent liability. The consumer protection statute enables an aggrieved consumer to seek a non-judicial remedy by writing a consumer demand letter describing the unfair or deceptive act(s) or practice(s) and the relief sought, and provides a mechanism for suing a facility and collecting damages and possibly attorneys' fees should that be necessary.

F. LONG-TERM CARE OMBUDSMAN PROGRAM

The Long-Term Care (LTC) Ombudsman Program, previously administered by the Executive Office of Elder Affairs (EOEA), is now administered by the Executive Office of Health and Human Services (EO-HHS). The State LTC Ombudsman oversees a network of staff and volunteer visiting ombudsmen whose job it is to help resolve problems related to the health, welfare and rights of individuals living in nursing homes, rest homes and assisted living residences.

1. **Visiting facilities:** Visiting facilities on a regular basis, ombudsmen offer confidentiality and a way for residents to voice their complaints and work toward resolution with staff.
2. **Facilities must post notice:** Each facility is required to post, in a conspicuous location, the name and contact information of the visiting ombudsman assigned to that facility. To contact an assisted living ombudsman, you may call (617) 222-7495.

G. ASSISTED LIVING RESIDENCES (ALRS)

1. Regulations

- a. **EOEA certifies all ALRs:** The EOEA certifies all assisted living residences (ALRs) in Massachusetts.⁴⁰ ALRs are not licensed facilities and are not subject to the same type of government oversight as nursing homes or other licensed health care facilities. Regulation of ALRs is based on state law, as there is no federal regulatory authority. As a result, residences and the regulation of ALRs differ from state to state.
 - b. **Type of units required:** In Massachusetts an ALR must provide only single or double living units with lockable doors and a kitchenette within the unit or access to cooking facilities.⁴¹ Any newly constructed ALR must provide a full bathroom for each unit, while existing ALRs must provide, at minimum, a private half-bathroom.⁴²
 - c. **Individual service plans:** After evaluation of eligibility and assessment of appropriateness of assisted living services for an older adult, the older adult should receive an individualized service plan that sets out the services provided, who will provide them, how often and for how long the services will be provided, the payment terms and reimbursement source for such services, the way the residence will provide for the presence of 24-hour on-site staff capability, and information regarding self-administered medication management.⁴³
 - d. **Rights and responsibilities:** In addition to a service plan, each resident and sponsor of the ALR must execute a written agreement setting out the responsibilities and rights of the resident and sponsor with regard to the charges for services, a grievance procedure and termination conditions.⁴⁴ Effective Jan. 1, 2019, all assisted living residency agreements must include a cover sheet summarizing the important provisions of the agreement, and the resident or legal representative must sign the form, which must be retained in the resident's record.⁴⁵ See cover sheet attached in Appendix.
2. **Skilled Care in Assisted Living:** During the COVID-19 emergency, and continuing until March 31, 2025, ALRs were allowed to provide skilled care in certain circumstances on a temporary basis.⁴⁶ Effective Dec. 5, 2024, the omnibus long-term care legislation allows ALRs to provide "basic health services" on a permanent basis.⁴⁷
 - a. **Certification to Provide Basic Health Services.** An ALR must receive specific certification from EOEA to provide such basic health services. EOEA, in consultation with DPH, will establish operating plan requirements for ALRs that opt to provide basic health services, including staff access to an LPN or RN for consultation at all times.
 - b. **New Legal Provisions.** The new law specifically states that the nurse need not be on the premises. The new law permits qualified ALR employees or qualified third-party providers, subject to a written care order, to administer the following services: injections, application or replacement of simple non-sterile dressings; the management of oxygen; specimen collection and the completion of a home diagnostic test, including warfarin, prothrombin or international normalized ratio testing and glucose testing; and ointments or drops.
 - c. **Additional Fees Permitted.** ALRs that choose to offer basic health services may charge additional fees to residents for such services.
 - d. **All Basic Health Services Must Be Offered.** Any ALR that provides basic health services must provide all of the basic health services listed.

e. **Limited MassHealth Coverage for Skilled Care in an ALR.** As a result of the new legislation, residents who require long-term care services may be able to obtain that level of care in an ALR. However, unlike nursing homes, MassHealth (Medicaid) does not currently cover ALR care except in limited circumstances.

3. **Required Disclosures:** The new long-term care legislation expands the disclosures required of ALR applicants for initial certification or renewal. ALRs shall disclose to EOEa the name and address of each officer, director, trustee and limited partner or shareholder with not less than 5% percent interest in the ALR, and any history of enforcement actions. In addition, ALRs shall annually provide a statement prepared by a CPA or comparable reviewer to show whether the residence is fiscally sound.

4. **Assisted Living Resident Rights**

Massachusetts law specifies that a resident of an assisted living residence has the right:

- a. To live in a decent, safe and habitable environment;
- b. To be treated with consideration and respect;
- c. To have one's personal dignity and privacy observed;
- d. To retain and use personal property in one's unit;
- e. To communicate privately and without restriction;
- f. To contract or engage with health care professionals in one's unit as needed;
- g. To engage in community services and activities as one chooses;
- h. To manage one's own financial affairs;
- i. To present grievances and recommendations without reprisal;
- j. To have all of one's records kept confidential;
- k. To have privacy during medical treatment or other services;
- l. To have reasonable requests responded to promptly and adequately; and
- m. To be free from involuntary "discharge" or eviction without judicial process (summary process eviction proceedings).⁴⁸

It is important to note that because assisted living is a residential model, residents have rights as tenants required under landlord/tenant laws.⁴⁹

ALR residents should not give up their legal rights. See "Arbitration" information in the earlier Continuum of Care section. The Attorney General's recently formed Elder Justice Unit is in the process of drafting consumer protections regulations specific to the rights of ALR residents an Elder Justice unit and has announced its intention to promulgate regulations specific to the rights of ALR residents.

5. **Assisted Living Ombudsman Program**

- a. **Definition:** The Assisted Living Ombudsman Program has been expanded and combined with the Long-Term Care Ombudsman Program, now housed under the EOHHS. In the case of a complaint or violation, a resident, the family member of a resident, or the representative of a resident may contact a statewide ombudsman.
- b. **Right to enter:** The ombudsman will enter the ALR to review and examine the situation.⁵⁰ In order to maintain certification, each assisted living facility must comply with the Ombudsman Program and facilitate the ombudsman's right to enter and investigate the residence.⁵¹
- c. **Mediation:** The assisted living ombudsman acts as a mediator and attempts to resolve problems or conflicts that arise between an ALR and one or more of its residents. To contact an assisted living ombudsman, you may call (617) 222-7495.

d. **Enforcement:**

- a. **EOEA complaint.** In addition to contacting the Ombudsman Program or an attorney, residents can file a complaint with the EOEA or the Attorney General's Office.
- b. **Unfair and deceptive acts.** The Attorney General's regulations provide a mechanism for consumers to pursue complaints based on unfair or deceptive practices, which include disputes regarding the provision of services. See 940 CMR 3.01, 3.03, 3.05, 3.16 and 3.17.
- c. The new long-term care bill establishes penalties that EOEA can impose upon an ALR that provides basic health services without the requisite certification. Fines are no more than \$1,000 per day.

H. CONTINUING CARE RETIREMENT COMMUNITY (CCRC)

1. Oversight

EOEA compiles information about CCRCs in Massachusetts pursuant to Mass. G.L. ch. 93, § 76. The statute sets out disclosure requirements regarding the contractual rights of the parties.

2. **No oversight unless part of CCRC licensed by DPH:** There are no regulations governing CCRCs.

I. CONSUMER RESOURCES

If you are facing neglect, abuse, an illegal discharge or eviction, or any other consumer issue in long-term care or assisted living, it is important to protect your rights and build a record with the public agencies charged with long-term care oversight.

Consumer Organizations

- Dignity Alliance Massachusetts: www.dignityalliancema.org
- Massachusetts Advocates for Nursing Home Reform (MANHR): www.manhr.org
- National Consumer Voice for Quality Long-Term Care: theconsumervoice.org/home
- Justice In Aging: <https://justiceinaging.org/our-work/healthcare/long-term-services-and-supports/nursing-facilities>
- Long Term Care Community Coalition (New York-based): <https://nursinghome411.org>
- Long-Term Care Ombudsman Program: Phone: (617) 222-7495
- The LTC Ombudsman Program assigns an ombudsman to every nursing home in the state, and every area has an assisted living ombudsman program. They can be helpful in resolving consumer complaints.
- Website: www.mass.gov/orgs/massachusetts-long-term-care-ombudsman-program
- List of local Nursing Home and Rest Home Ombudsman Programs: www.mass.gov/doc/nursing-rest-home-ombudsman-local-contact-information/download
- List of local Assisted Living Ombudsman Programs: www.mass.gov/doc/assisted-living-ombudsman-local-contact-information/download
- To find a local legal services program: <https://masslrf.org/en/home/>
- To find a local elder law attorney: <https://massnaela.com/>
- To find a care manager <https://www.alcanewengland.org/>

To File a Complaint

- Department of Public Health

File a complaint with the Department of Public Health (DPH) — for Nursing Homes/Health Care Facilities

DPH website: www.mass.gov/nursing-home-consumer-information

- DPH complaint form: www.mass.gov/how-to/file-a-complaint-regarding-a-nursing-home-or-other-health-care-facility

The complaint form is on the website, but it can't be filed online — it must be faxed or mailed in. Consumers or their authorized representatives should send the complaint form (with HIPAA release form, if applicable) by:

Mail: Division of Health Care Facility Licensure and Certification Complaint Intake Unit
67 Forest St., Marlborough, MA 01752

Fax: (617) 753-8165

Phone: (800) 462-5540

(24-hour complaint line for those unable to file a written complaint)

- Executive Office of Elder Affairs (EOEA)
File a complaint with EOEA for Assisted Living Residences:
EOEA form: <https://www.mass.gov/how-to/file-a-massachusetts-assisted-living-residence-alr-complaint-form>

- **Attorney General's Office**
One Ashburton Place, Boston, MA 02108
Deputy Chief

The Attorney General's regulations provide that any violation of nursing home residents' rights is a per se violation of the state consumer protection statute, known as Chapter 93A. ALR residents can also claim protection under Chapter 93A.

- Send the demand letter to the facility, with copies to:

Mary Freeley, Esq., Deputy Chief
Health Care & Fair Competition Bureau
Elder Justice Unit
Office of the Attorney General
Consumer Protection Division
One Ashburton Place, Boston, MA 02108

- Consumer Protection Hotline: (617) 727-8400
Email: ago@state.ma.us
Fax: (855) 237-5130

- Ombudsman's Office

File a complaint with the Ombudsman's Office for nursing home and assisted living issues.
Carolyn Fenn, State Long-Term Care Ombudsman
One Ashburton Place, Fifth Floor, Boston, MA 02108
Phone: (617) 222-7495

Steven Ellsweig, ALR Ombudsman Operations Manager (for Assisted Living Residences)
One Ashburton Place, Fifth Floor, Boston, MA 02108
Phone: (617) 222-7495

- **Licensure and Certification**

File a complaint with the Division of Licensure and Certification
Division of Health Care Facility Licensure and Certification
Complaint Intake Unit
67 Forest St., Marlborough, MA 01752

- **Elder Abuse and Neglect**
File an Elder Abuse and Neglect Report (includes financial abuse)
Elder Abuse Hotline: (800) 922-2275

1. MASS. G.L. ch. 19D § 1.
2. *Id.*
3. *Id.*
4. MASS. G.L. ch. 93 § 76.
5. *Id.*
6. <https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/nursing-facilities/index.html>.
7. See 940 C.M.R. § 4.03 and MASS G.L. 151B, § 4.
8. 105 C.M.R. § 150.022 – 150.029 Dementia Special Care Units.
9. *Id.*
10. MASS. G.L. ch. 111, § 70E.
11. 940 C.M.R. §§ 4.06- 4.07.
12. 42 C.F.R. § 483.70(n).
13. Nursing Home Reform Law, 42 U.S.C. §§ 1395i-3(a)-(h) and 1396r(a)-(h).
14. 42 C.F.R. § 483.15(c)(1).
15. 940 C.M.R. § 4.09(2).
16. 42 C.F.R. § 483.15(c)(1).
17. 42 C.F.R. § 483.15(c)(3).
18. 42 C.F.R. § 483.15(c)(3).
19. 42 C.F.R. § 483.15(e)(1)(i).
20. *Id.*
21. *Id.*
22. 42 C.F.R. § 483.10(e)(6), 940 C.M.R. § 4.06(11).
23. 42 C.F.R. § 483.15(c)(1) and (2).
24. 42 C.F.R. § 483.15(e)(1)(i).
25. 42 C.F.R. § 483.15(e)(1), See 130 C.M.R. § 456.429, 130 C.M.R. § 610.028(D); and *Brunelle v. DMA* (Mass. Superior Ct.).
26. MASS. G.L. ch. 111, § 71.
27. *Id.*
28. *Id.* § 72.
29. MASS. G.L. ch. 111, § 72.
30. *Id.*
31. *Id.*
32. 130 C.M.R. § 456.406.
33. *Id.*
34. *Id.*
35. 940 C.M.R. § 4.03.
36. 940 C.M.R. § 4.04.
37. *Id.*
38. *Id.*
39. 940 C.M.R. § 4.06.
40. 651 C.M.R. § 12.03.
41. 651 C.M.R. § 12.04.
42. *Id.*
43. *Id.*
44. 651 C.M.R. § 12.08.
45. 651 C.M.R. §12.08(4).
46. Section 13 of Chapter 88 of the Acts of 2024, Section 39 of Chapter 2 of the Acts of 2023, and Section 23 of Chapter 20 of the Acts of 2021.
47. Chapter 197 of the Acts of 2024.
48. 651 C.M.R. § 12.08.
49. M.G.L. c. 186 and c. 239, 940 C.M.R. § 3.17.
50. 651 C.M.R. § 13.00.
51. *Id.* § 13.03.



EXECUTIVE OFFICE OF ELDER AFFAIRS

Assisted Living Certification Unit
www.mass.gov/elder

Assisted Living Residence (ALR): _____

Residency Agreement Cover Sheet: (651 CMR 12.08(4))

Initialing the box next to each section header confirms that the Resident or legal representative has read each statement listed on this form and has been given the opportunity to ask questions.

CARE:

- ___ An Assisted Living Residence (ALR) is not a nursing home.
- ___ Nurses are not required to be on duty and in the building 24 hours per day/7 days per week. Inquire with the ALR how often and when nurses are in the building.
- ___ Residents cannot receive skilled nursing care from ALR employees.
- ___ You may be required to provide and pay for additional private care if the ALR determines that your care needs exceed the level of care available at the ALR.

RESIDENCY:

- ___ A signed residency agreement is a contract between you and the ALR; read it carefully before signing. **Note:** If additional services are subsequently required, your monthly costs may increase.
- ___ Eviction from an ALR must comply with the provisions of landlord/tenant law, M.G.L. c. 186 or c. 239, and include all notices required by law.
- ___ The ALR cannot prevent you from returning to the ALR after a hospital or rehab stay; however, if your care needs exceed the ALR's capacity for services, you may be required to hire private care staff to meet your care needs.
- ___ Your resident agreement may allow the ALR to terminate your residency if it determines that you are no longer suitable to live there; if this is the case, the Residence must provide a ___ day notice prior to requiring you to leave.
- ___ Signing a residency agreement that includes an arbitration clause or signing a separate arbitration agreement may prohibit use of the court system to resolve disputes and instead require you to present your case to an mediator.

COST:

- ___ You should assess your finances to determine how long you can afford to stay at the ALR before making a commitment.
- ___ If you deplete your assets (run out of money) and are unable to afford the cost of the ALR in the future, the ALR may require you to move.
- ___ The ALR can change your monthly fees with ___ days' notice.
- ___ Your service plan can change based on the ALR's reassessment of your needs. Changes to your service plan may change your monthly costs.
- ___ If you fail to provide notice of termination of Residency in accordance with the terms of the Residency Agreement, you may incur additional charges.

RESIDENT RIGHT

___ Residents may file a complaint at any time with the Assisted Living Residence Ombudsman or the Assisted Living Residence Certification Unit at Executive Office of Elder Affairs by calling (617) 727-7750 or 1-800-AGE-INFO (1-800-243-4636).

Required Signatures

_____ Date: _____
Resident or Legal Representative

_____ Date: _____
ALR Witness: Name and Position

**A copy of this form should be provided to both parties after signing.
The ALR's copy should be maintained in the resident record.**

The Massachusetts Chapter of the National Academy of Elder Law Attorneys (MassNAELA) is a non-profit organization that was incorporated in 1992, to serve the legal profession and the public with the following mission:

- To provide information, education, networking, and assistance to Massachusetts attorneys, bar organizations, and other individuals or groups advising elderly clients, clients with special needs and their families;
- To promote high standards of technical expertise and ethical awareness among attorneys, bar organizations and other individuals or groups engaged in the practice of advising elderly clients, clients with special needs and their families;
- To develop public awareness and advocate for the benefit of the elderly, those with special needs and their families, by promoting public policies that support our mission; and
- To encourage involvement and enhance membership in, and to promote networking among members of the National Academy of Elder Law Attorneys.

MassNAELA is a voluntary association whose members consist of a dedicated group of elder law and special needs attorneys across the Commonwealth of Massachusetts.

CONTACT
INFORMATION FOR
MASSNAELA

P.O. Box 600046

Newtonville, MA 02460

Phone: (617) 566-5640

Fax: (781) 207-9027

www.MassNAELA.com

**ELDER ADVOCATES
SPREAD THE WORD:**

*Just Say
“NO” to
Arbitration!*



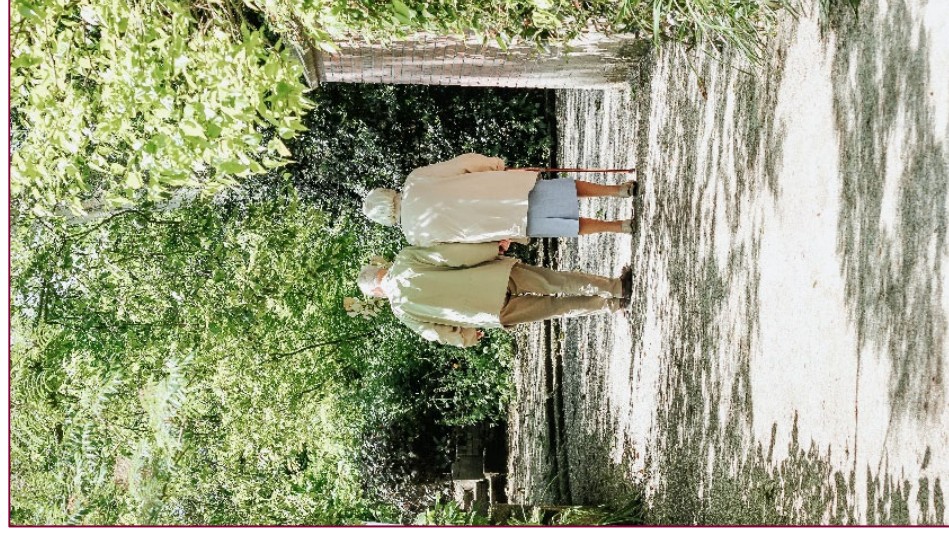


Frail nursing home residents and their frazzled family members are routinely asked to sign a stack of densely-printed documents at the time of admission, without adequate time to review them or to consult with counsel, and without realizing that the agreements may include forced arbitration provisions. Arbitration requires residents to waive their fundamental constitutional right to a jury trial, even if they later suffer serious injury, medical malpractice, or wrongful death. Because arbitration is secret and there is no public record of the outcome, it keeps cases of malpractice, abuse and neglect out of the public eye, effectively denying residents and their families access to justice.

A new federal rule from Centers for Medicare and Medicaid Services, effective September 16, 2019, provides that:

- *Residents may not be required to agree to arbitration as a condition of admission to a nursing home.*
- *Residents may not be required to agree to arbitration as a condition of continued stay in a nursing home.*
- *Residents and their representatives have a 30-day right to rescind the arbitration agreement.*
- *Nursing homes must explicitly inform residents or their representatives of the right not to sign an arbitration agreement as a condition of admission to, or right to remain in, the facility.*
- *The arbitration agreement itself must explicitly state that the agreement is not a condition of admission to, or right to remain in, the facility.*
- *Facilities must ensure that the agreement is explained to residents and their representatives in a “form and manner” that they understand, including in a language they understand.*

Although the new rule does not impose an outright ban on arbitration agreements in nursing homes, it does affirm the right of residents to “just say no” to arbitration clauses in admission agreements. Elder advocates should seize this opportunity to educate residents, their families and representatives, and the public about these critical rights.





THE COMMONWEALTH OF MASSACHUSETTS
OFFICE OF THE ATTORNEY GENERAL

ANDREA JOY CAMPBELL
ATTORNEY GENERAL

ONE ASHBURTON PLACE
BOSTON, MASSACHUSETTS 02108

(617) 727-2200
www.mass.gov/ago

FOR IMMEDIATE RELEASE:
October 15, 2024

MEDIA CONTACT:
Sydney Heiberger
617-727-2543

ATTORNEY GENERAL'S OFFICE SEEKS COMMUNITY FEEDBACK TO INFORM DRAFTING OF ASSISTED LIVING RESIDENCES REGULATIONS

BOSTON — The Massachusetts Attorney General's Office (AGO) is seeking public feedback to inform drafting consumer protection regulations for assisted living residences in Massachusetts. Members of the public can provide comments to the AGO through an online form, available [here](#).

Through regulation, the AGO seeks to protect residents of assisted living residences from unfair and deceptive acts and practices, including misrepresentation of available services, improper fees, and unlawful evictions. The aging population served by these facilities would benefit greatly from stronger consumer protections in all of these areas, and owners and operators will benefit from greater specificity regarding their legal obligations. At this time, Massachusetts does not have consumer protection regulations specific to assisted living residences.

"We know the best way to serve our constituents is by listening to them," said **Attorney General Andrea Joy Campbell**. "Every resident of an assisted living facility has the right to live in a safe and habitable environment, free from abuse, neglect, and exploitation. Our older adults deserve to age safely with dignity and respect, which is why creating consumer protection regulations for assisted living facilities is so important and responsive to their advocacy."

Assisted living residences are designed for older adults who can live independently in a home-like environment, but may need help with daily activities like housekeeping, bathing, or medication assistance. According to the Executive Office of Elder Affairs, more than 17,000 people currently live in these residences in Massachusetts and have various options available to them. It is critical that consumers know what to expect when choosing an assisted living residence as their home.

[Chapter 93A](#), the consumer protection statute, authorizes the Attorney General to promulgate regulations to protect consumers. These regulations can require that facilities make certain disclosures about their contractual terms, and they also can declare certain acts and practices to be unlawful.

Those who wish to provide feedback on the creation of regulations can do so through an online form, which can be found [here](#).

The AGO will use this feedback to inform draft regulations and will then proceed to promulgate regulations, a process which will include the publication of proposed regulations, a public hearing, and opportunities for the public to comment on the proposed regulations.

This project is being handled by Director Mary Freeley and Deputy Director Valerie Frias of the AGO's [Elder Justice Unit](#). AG Campbell created the Unit in August 2023 to protect and promote the safety and well-being of elders through enforcement actions, legislative advocacy, and community engagement and education.

###

Statements of Support:

Acting Secretary Robin Lipson, Executive Office of Elder Affairs: "We thank Attorney General Andrea Joy Campbell and her team for their dedication to protecting residents in assisted living. The demographics of these residents continues to evolve – they are now older, with more complex needs, and it is essential that we ensure these individuals are informed and protected as they navigate their living options. Elder Affairs looks forward to working with the Attorney General's Office as the team explores ways to address assisted living residence consumer issues."

Former Senator Richard Moore, Co-Founder of Dignity Alliance and Member of the Leadership Council of the National Consumer Voice for Quality Long-Term Care: "Protecting older adults in assisted living facilities from financial, or other forms of abuse, is an important goal for Dignity Alliance. Attorney General Campbell deserves high praise for taking action to expand consumer protections to this vulnerable population. And since October is designated as "Residents' Rights Month," it's a great time to launch the development of this vital effort."

John Ford, Northeast Justice Center and Dignity Alliance: "The Attorney General's concern for the residents of more than 250 Assisted Living Residences in Massachusetts echoes the concerns of many residents, their loved ones and their advocates. Their advocates in particular know the value and scope of the protections afforded by regulations issued pursuant to the Consumer Protection Act (chapter 93A), which give weight and specificity as to what would be an unfair act or practice. We applaud the Attorney General's commitment to the growing numbers of consumers who will be protected by the regulations."

Kathleen Lynch Moncata and Liane Zeitz, Mass. Chapter of the National Academy of Elder Law Attorneys: "Massachusetts has a long history of pioneering consumer protections for vulnerable populations such as nursing home residents and tenants and we welcome comparable protections for consumers of assisted living residences (ALRs). ALR residents currently have little legal recourse when they do not receive the quality of care they've contracted for or when their rights are violated. We support Attorney General Campbell's efforts to provide increased protections for this vulnerable population."

CHAPTER 12

ELDER ABUSE, NEGLECT, FINANCIAL EXPLOITATION AND SCAMS

INTRODUCTION

Elder abuse encompasses classic physical and emotional abuse, as well as neglect, self-neglect and financial exploitation. Numerous studies have found that elder abuse is far underreported, with roughly only one in five incidents being reported. This low figure is due partly to the common familial or close relationship between the victim and perpetrator. Some studies have shown that when abuse occurs, family members and caregivers may account for as much as 90% of the abuse. To stop the abuse and help victims, elder abuse, neglect, self-neglect, financial exploitation and the recent increase in scams must be on the forefront of educational efforts for those caring for older adults. In this chapter, the term “elder” will be used due to statutory references.

Otherwise, “older adult” is now the commonly accepted term.

A. DEFINITION OF ELDER ABUSE

Elder abuse has a broad definition because of the many ways in which older adults are vulnerable. In Massachusetts, elder abuse includes actions by almost anyone, including a caretaker, conservator or guardian.

1. Causes:

- a. Physical or emotional injury, including sexual abuse;
- b. Financial exploitation; or
- c. Denial of life necessities essential for physical and emotional well-being (neglect).
- d. Elder abuse also includes self-neglect, which is when older adults are unable to care for themselves. Some often-overlooked warning signs of neglect include bed sores, poor hygiene, malnutrition, mood changes and unaccounted-for changes to the older adult’s finances.

B. DEFINITION OF FINANCIAL EXPLOITATION

1. Definition

Financial exploitation is an act or omission that causes a substantial monetary or property loss to an older adult, or causes a substantial monetary or property gain to another person, which gain would otherwise benefit the older adult but for the act or omission of such other person. The consent of an older adult to the harmful act or omission is not valid if the older adult lacked capacity or if it was the consequence of misrepresentation, undue influence, coercion or threat of force.

2. Examples

- a. **Misuse of powers of attorney:** Misuse of durable powers of attorney and bank accounts, or misuse or neglect of the authority by a guardian or conservator.
- b. **Transfer of real estate:** Failure to provide reasonable consideration for the transfer of real estate.
- c. **Excessive charges for services or products:** Excessive charges for goods or services, or the use of fraud or undue influence to gain control of or obtain money or property.
- d. **Predatory practices, such as telemarketing and scams:** Predatory lending, telemarketing fraud, sweepstakes fraud and other scams that are targeted toward older adults also may be considered to be financial exploitation.
- e. **Family members:** For the more traditional forms of financial abuse by persons that the older adult trusts, it can be hard to identify the abuse because it happens over time, and in many cases, the

abuser is also a person who might ordinarily be expected to receive gifts from the older adult, such as a child or a sibling. Often, the older adult does not know it is happening because the older adult depends on and trusts the abuser.

- f. **Physical and emotional abuse:** Financial abuse is sometimes accompanied by physical or emotional abuse, which silences the older adult.

C. WARNING SIGNS

1. Unusual Bank Withdrawals

There are some warning signs that can help you identify whether financial abuse may be occurring, such as unusual bank withdrawals, failure to meet financial obligations, or withdrawals from investments in spite of penalties for early withdrawal.

2. Abrupt Changes in Legal Documents

Abrupt changes in wills, trusts, contracts, powers of attorney, property titles, deeds or mortgages.

3. Changes in Beneficiaries

Changes in beneficiaries on insurance policies, or financial activity that is inconsistent with the older adult's abilities (such as ATM withdrawals when the older adult has difficulty leaving the house) or previous spending patterns (such as online shopping).

4. New and Significantly Younger Friends

A new, and many times significantly younger, "friend" of the older adult, who has been receiving substantial "gifts" from the older adult. Sometimes, the "friendship" is couched in romantic terms, which perhaps fills a void in the older adult's life.

5. Shame in Admitting Victim of a Scam

Oftentimes, older adults refuse to believe that they have been a victim of the scam and, if they do believe it, are too ashamed to admit that they were victimized.

D. ROLE OF BANKS

1. Bank Tellers

Financial exploitation can be devastating to an older adult, and bank tellers are an evolving first line of defense. Often, financial exploitation can be hard to detect because the person exploiting the older adult has been trusted with the older adult's money, but a bank may be able to notice sudden changes in accounts and other suspicious activity.

2. Massachusetts Bank Reporting Project

Massachusetts has implemented a program, the Massachusetts Bank Reporting Project: An Edge Against Elder Financial Exploitation, that provides training to bank personnel in how to identify and report financial exploitation. The project has been successfully replicated in numerous communities. If you would like more information on the Bank Reporting Project, call (617) 523-7595 or visit <https://www.massbankers.org/>.

E. POWER OF ATTORNEY

1. Power of Attorney

A power of attorney gives another individual the power to make decisions about the older adult's property. In order for the power of attorney document to be valid, the older adult granting the power must be mentally competent at the time of execution and execute it knowingly and voluntarily, without fraud, coercion or undue influence. Such powerful instruments can easily be misused to exploit older adults. Therefore, the grant of power to an attorney-in-fact should be carefully and thoughtfully considered and drafted, and the actions of the attorney-in-fact should be monitored.

F. SELF-NEGLECT

1. Inability to Make Informed Decisions

Self-neglect is when older adults can no longer provide for their own essential life needs, cannot make informed decisions understanding the consequences of their actions, and/or their mental and physical condi-

tion declines without it being addressed. One of the reasons that the law includes this self-neglect is so that older adults can receive services from Protective Services.

2. Protective Services

Protective Services must always use the least restrictive measures to alleviate the neglect, and try to keep a self-neglecting older adult in the community safely.

3. Right to Refuse Treatment

Even in cases of self-neglect, an older adult who has capacity has the right to refuse services. If the older adult lacks decisional capacity, or there is reasonable cause to believe the older adult lacks decisional capacity, the court may be petitioned for a protective order under M.G.L. ch. 19A and/or for guardianship and/or conservatorship.

G. NURSING HOME ABUSE

1. Definition

Abuse in a long-term care facility is separately defined as, “ ... the willful infliction of injury, unreasonable confinement, intimidation, including verbal or mental abuse or punishment with resulting physical harm, pain or mental anguish or assault and battery ... ” Regulations require that reports of abuse in nursing homes be made to the Department of Public Health rather than Protective Services.

2. Attorney General’s Medicaid Fraud Division

The Office of the Attorney General’s Medicaid Fraud Division also has jurisdiction to address reports of abuse and neglect in nursing homes.

H. REPORTING ELDER ABUSE

1. Massachusetts Elder Abuse Hotline

Elder abuse should be reported when the reporter has reasonable cause to believe that abuse has occurred or is about to occur. The Massachusetts Elder Abuse Hotline can be reached at (800) 922-2275 or online at www.mass.gov/how-to/report-elder-abuse.

2. Mandated Reporters

Certain people, such as doctors, nurses, police and elder outreach workers, are considered to be mandated reporters, and are required by law to report suspected elder abuse.

3. Other Reporters

All other individuals, while not required to report elder abuse, may and should do so if the older adult is at risk of harm. Mandated reporters who have reasonable cause to believe abuse has occurred but fail to report may be subject to a \$1,000 fine.

4. Anonymous Reporting

The identity of the person who makes a report of elder abuse may not be disclosed to anyone, except to the district attorney or in compliance with a court order.

I. EXECUTIVE OFFICE OF ELDER AFFAIRS (EOEA)

1. Statewide Agency

The Executive Office of Elder Affairs, by law, maintains 22 Protective Services agencies throughout Massachusetts.

2. Role of Protective Service Agencies

The role of Protective Services is to investigate reports of abuse and, where appropriate, offer services, make referrals and connect older adults to community resources. All reports are received through a statewide centralized intake system.

J. RESPONSE TO REPORTS OF ELDER ABUSE

1. Privacy Rights

An allegation of abuse, once made, will result in a caseworker from Protective Services investigating the

allegation. Due care is taken to balance the rights of privacy and self-determination of the older adult and the need to protect the older adult from harm.

2. Protective Services Social Worker Investigation

If one or more types of abuse are found, then the Protective Services social worker will intervene to protect the older adult's safety. This intervention means that a care plan will be drafted with the older adult, if they have capacity.

3. Care Plan

The care plan may include counseling, legal aid, home health care, transportation, housing aid or safety planning.

4. Criminal Charges

Serious abuse is reported to Protective Services, who will report it to the prosecuting authority, which may elect to bring criminal charges against the alleged abuser. In addition to criminal charges, in some cases, there may be referrals to attorneys to take legal actions, including civil lawsuits to address the wrongdoing and restore the wrongfully removed property to the older adult.

5. Refusal of Care Plans

Elder abuse victims who have capacity can choose whether or not to take advantage of any of the services offered by Protective Services. If the older adult lacks capacity, and Protective Services believes the older adult is in need of protection, Protective Services can petition the court for the appointment of a guardian and/or conservator, or for a protective order pursuant to M.G.L. ch. 19A, Section 20.

6. Petitions to Court by Protective Services

In such petitions, Protective Services must prove by a preponderance of the evidence that the older adult is being abused, is in need of services and lacks the capacity to consent. Protective Services may only seek a protective order, or the appointment of a guardian or conservator, if that is the least restrictive and least intrusive means available for protecting the older adult.

K. PROTECTIVE SERVICES' RESPONSIBILITIES

1. Rights of Older Adults

An older adult should not lose rights once Protective Services has been contacted since services can only be provided if the older adult consents, or through a protective order issued by the court, or if a guardian or conservator consents on their behalf.

2. Doctrine of Self-Determination

Due to the doctrine of self-determination, an older adult who has capacity has the right to refuse services. In addition, the Department of Protective Services for an elder services agency may not serve in a fiduciary capacity for an abused older adult.

3. Conservator Appointments

Protective Services may not act as a conservator by making financial or property decisions for an abused older adult, or as a guardian by making personal or medical decisions for older adults.

4. Right to Counsel

In the event that Protective Services seeks a protective order, or appointment of a guardian and/or a conservator, the older adult has numerous rights with regard to those proceedings, including possibly the right to counsel.

5. Guardian Ad Litem (GAL)

The court may appoint a guardian ad litem (GAL) for the older adult, either for the purpose of conducting a neutral investigation and informing the court of their recommendations, or, in the case of an older adult who lacks capacity, for the purpose of representing the best interests of the older adult.

6. Differences Between Attorney for Older Adult and GAL

The difference between the GAL and an attorney appointed to represent the older adult is that the at-

torney would be required to advocate for whatever it is that the older adult wants, while the GAL would be required to advocate for what they believe is in the best interest of the incapacitated older adult.

L. PROTECTIONS AVAILABLE TO LGBTQ OLDER ADULTS

1. Right to Age with Dignity

Everyone has the absolute right to age with dignity. In Massachusetts, discrimination based on sexual orientation and gender identity is illegal. Laws are in place to protect against discrimination in medical care, housing and other services.

2. Special Training

Many people who provide elder services are required by law to have special training to care for LGBTQ older adults.

3. Long-Term Care Provider Responsibilities

Long-term residential care providers must intervene to stop discrimination and harassment by staff or other residents.

4. Reporting of Discrimination

You should report discrimination and harassment immediately.

5. GLBTQ Legal Advocates & Defenders Hotline

Contact an attorney, call the GLAD Answers legal hotline at (800) 455-GLAD or visit www.glad.org/know-your-rights/resources-from-glad-answers.

M. SCAMS

1. Definitions

Financial exploitation of older adults by strangers is often accomplished through scams. Unfortunately, scam artists target older adults in new and ever-changing ways that can result in significant financial loss, identity theft and emotional harm. Imposters pretend to be someone they are not in order to gain trust and obtain money or other valuable personal information from the target.

2. Imposters

Telephone scammers commonly impersonate someone from a government agency, such as the IRS, a bank or credit card company, or tech support firm, often using technology to disguise their caller identification and to appear to be calling from a legitimate business.

3. Use of Publicly Available Information

Scammers use publicly available information derived from a social media account, for example, to identify a potential target of a romance or grandparent scam.

4. Persistent and Repeated, Patient Contact

Scammers can be patient, repeatedly contacting a target over a period of days, and refine their tactics to achieve their goal. They may sound friendly and legitimate, offering a prize or reward, or they may demand payment and threaten a serious consequence, such as a loss of government benefits or even jail.

5. Pervasive Fraudulent Activity

Fraudulent activity by criminals seeking to steal money and personal information from unsuspecting older adults is pervasive. Many older adults feel embarrassed or ashamed if they believe they have been the victim of a scam. Others may not realize that they have been targeted.

6. Trusted Advisors and Family Members

Trusted advisors and family members can help to prevent this form of elder abuse by offering emotional support to the older person, by helping to monitor bank and credit card accounts, and by talking with the individual about ways to spot potential scams and advising them against sharing personal or financial information on the phone, by email or on social media.

7. Empowering Older Adults

By learning about and recognizing the warning signs of a scam, an older adult may feel empowered to hang up the phone, ignore an email solicitation, and avoid being taken in by these convincing but fraudulent schemes.

N. RED FLAG WARNING SIGNS OF SCAMS

1. Requests to buy a prepaid gift or debit card as a form of payment.
2. Unsolicited calls from an official-sounding government agency that asks for a Social Security or tax identification number.
3. Requests to wire money immediately because a grandchild or family member is in jeopardy.
4. Offers of prizes or gifts that promise a large payout if the prize-winner sends money to cover taxes or fees.
5. High-pressure tactics that convey a false sense of urgency — limited-time offers.
6. Requests for personal financial information to enroll in a free subscription or service.
7. Business schemes or investment opportunities in cryptocurrency, stocks and foreign currency that promise a high return within a short period of time.
8. Requests to visit websites or download software.
9. Requests for usernames, passwords, account numbers or texted security codes.
10. Threats of criminal prosecution if an alleged debt is not paid.

O. REPORTING SCAMS

1. Local Police, Federal Trade Commission and Massachusetts Attorney General's Office

If you suspect that an older adult has been the target of a scam, report the scam or fraud to the local police department, and to the Federal Trade Commission at [ReportFraud.ftc.gov](https://www.ftc.gov/ReportFraud), and file a consumer complaint with the Office of the Attorney General at [mass.gov/how-to/file-a-consumer-complaint](https://www.mass.gov/how-to/file-a-consumer-complaint) or call (617) 727-8400.

2. Need to Identify Source

Reporting fraud helps law enforcement and community partners to identify new scams and respond to emerging threats.

3. Resources and Online Sites

Resources are available to aid older adults who have been the victim of a scam.

- a. **The Federal Trade Commission:** The FTC's website offers helpful guidance about steps a consumer can take if they have paid someone they think may be a scammer, or gave a scammer their personal information or access to their computer or phone. That resource is available at: <https://consumer.ftc.gov/articles/what-do-if-you-were-scammed#Report>.
- b. **AARP Fraud Watch Network:** Provides free resources to assist individuals in spotting scams and offers guidance from fraud specialists if they have been the target of a scam. This resource is available at: <https://www.aarp.org/money/scams-fraud/about-fraud-watch-network/>.

4. How to Place a Fraud Alert or a Freeze on One's Credit Report

Equifax

(888) 298-0045

www.freeze.equifax.com

Experian

(888) 397-3742

www.experian.com/freeze

Trans Union

(888) 909-8872

www.transunion.com/creditfreeze

5. How to Check When There Has Been a Document Recorded for Your Property

Recently, there have been several scams affecting citizens in Massachusetts where property has been illegally taken or changed without the person's knowledge. If you would like to receive an email notification when there has been any change to your property, go to the following website to set up an account through the Massachusetts Secretary of State's Office. <https://cns.masslandrecords.com/>.

CHAPTER 13

OLDER ADULT DRIVING

INTRODUCTION

As the older adult population of the United States continues to grow, and the average life expectancy increases, an increasing number of individuals are continuing to drive later in life. Older drivers, their family members, practitioners, and society as a whole have an interest in both assessing an older adult's ability to continue to safely drive and in the transportation alternatives that may be utilized when a driver must eventually retire from driving.

There is no set age at which one loses the ability to drive safely. Rather, physical, visual and cognitive impairments, which often accompany the aging process, will gradually begin to diminish an older adult's ability to drive. Therefore, older adults, families, physicians, police officers and lawmakers are growing increasingly aware of the indications that it may no longer be safe for an older adult to drive, in an effort to minimize the risks to the older driver, other drivers, passengers and pedestrians.

A. THE AGING PROCESS

1. The aging process is generally accompanied by physical, visual and cognitive impairments, all of which may require medication. Drowsiness, dizziness, fatigue and blurred vision may result from taking medications, and such symptoms may make safe driving increasingly difficult. Drivers who take medications should be aware of the side effects of each medication and how exactly those side effects may impact driving abilities. Among the various physical limitations that challenge safe driving are diminished vision, slower reflexes and arthritis. Cognitive impairment, such as memory loss or dementia, may also greatly challenge an older adult's ability to safely drive. While those with mild symptoms of dementia may be able to safely drive with limitations, eventually, as dementia-related symptoms progress, the older adult will no longer be able to adequately evaluate their own driving.
2. Safe driving habits should be implemented by older adults who are able to, and who choose to, continue driving as they age. They may take proactive measures to ensure their own safety and that of others by maintaining good health, enrolling in driver safety classes tailored to older adults, and adjusting driving patterns to avoid driving when traffic is heavy or when visibility is limited. However, some older drivers may have difficulty recognizing when they have reached the point that they are no longer able to drive safely.
3. For others, they may realize the time has come to cease driving, but may resist, as their ability to drive provides continued independence.
4. It is crucial that family members and physicians support older drivers in driving cessation when it becomes necessary by engaging in candid conversations. Family members may struggle to determine when it becomes necessary to have this conversation. A pattern of clear and open dialogue must be established with the older driver in order to reinforce driving safety issues. While this conversation should be ongoing, family members should also be observing the older adult's ability to drive regularly by riding in the car with the older adult and observing the older adult's vehicle. Close calls while driving, getting lost and damage to the older adult's car are strong indicators that the older adult's driving abilities are diminishing.

B. DRIVING EVALUATIONS

1. Family members do have the option to have the older adult's driving clinically evaluated at several area hospitals or by an occupational therapist or a certified driving rehabilitation specialist (CDRS).
2. Prior to a formal driving assessment, it may be appropriate to take a mature driver safety course online. Carfit, a program offered through the American Occupational Therapy Association and AARP (Older Driver Initiative program), offers free safety education on in-vehicle safety features, explaining how they

work and how to find the safest adjustment for the tallest to the smallest individual driver. The program supports drivers by focusing on the driver’s comfort, safety and fit within their vehicle.

3. This conversation must be structured so that the older adult feels listened to and respected, and is aware of the transportation alternatives that are available. Careful attention should be given to determine who should initiate the conversation. It may be best to have one person conduct a private conversation so that the older adult does not feel ganged-up on. Other interested parties should then form a united front about the decisions reached during the conversation and help the older adult to make safe decisions. It is important to determine who might be the best person to communicate with the individual about driving concerns. The conversation may be best received from a trusted medical professional rather than a spouse, family member or friend. In planning such conversations with older adults, family members should take into consideration the driver’s personality, level of cognitive impairment, driving record, family relationships, available resources and the geographic proximity of those resources.
4. Unfortunately, in some cases, the older adult’s diminished insight, judgment and mood, as well as personality changes, may render the older adult unable to meaningfully participate in a conversation about driving. In these circumstances, with evidence of serious risk to self or others by continued driving, family members may need to take steps to remove the older adult’s access to keys and the vehicle, or have a doctor send a letter to the Registry of Motor Vehicles stating the individual is no longer able to drive. See www.alz.org/help-support/caregiving/safety/dementia-driving.

Even if an older adult does readily agree that it is no longer safe for them to drive, family members must still be sensitive to the notion that relinquishing one’s driving privileges may be both overwhelming and depressing for the older adult. Nearly one in four older drivers reported experiencing depression as a result of this conversation. This is to be expected, as surrendering driving privileges often results in fewer trips outside of the home, increased isolation, often-permanent dependency on others for transportation and other basic needs, and fewer social opportunities.

C. MASSACHUSETTS REGISTRY OF MOTOR VEHICLES

1. Although the Massachusetts Registry of Motor Vehicles (RMV) does not require drivers to renew their licenses more frequently when they attain a certain age, the RMV does require that drivers age 75 and older renew their driver’s licenses in person.
2. At the time of renewal, the licensee must either pass a vision screening or present a completed vision-screening certificate from an ophthalmologist.
3. The Medical Affairs Branch of the RMV has developed policies and procedures that set minimum physical qualifications for all motor vehicle operators in Massachusetts, regardless of age. As such, drivers must meet the minimum standards for vision, loss of consciousness and seizure conditions, as well as cardiovascular and respiratory conditions.
4. It is important to note that Massachusetts is a self-reporting state, and thus, “... [a] person is legally responsible for their actions behind the wheel. There are no mandatory reporting laws for physicians to report persons who may be unsafe to the RMV That means it is [the driver’s] responsibility to report any medical condition that may affect [their] ability to drive.”
 - a. However, though not required to report a potentially unfit driver, physicians may choose to report. Law enforcement officers may also report a potentially unfit driver.
 - b. When a report is received, the RMV will conduct an individualized assessment, which may include a road test, to determine whether the driver is, in fact, qualified to safely operate a motor vehicle.
 - c. Medically impaired drivers who voluntarily surrender their license, or who fail the competency road test, are eligible for a Mass ID free of charge.

D. IMPORTANCE OF PHOTO IDENTIFICATION FOR OLDER ADULTS

An older resident whose driver's license has expired or has been revoked, suspended or surrendered voluntarily should replace the license with another form of government-issued photo identification. An unexpired photo ID is necessary for banking and financial transactions or getting one's signature notarized. After May 7, 2025, all U.S. citizens will need Real IDs or passports to board domestic flights or enter federal buildings like a Social Security Administration field office. Acceptable forms of photo identification for banking and financial transactions may include a passport, a Massachusetts ID card or a handicap parking placard.

An older adult in Massachusetts without a valid license can apply for a state ID (Mass ID) by visiting an RMV Service Center. They must bring:

1. Proof of U.S. citizenship or lawful presence (e.g., naturalization certificate).
2. Proof of Social Security number or an affidavit if unavailable.
3. Proof of Massachusetts residency (e.g., utility bill).
4. Proof of date of birth and signature.

NOTE: If mobility is an issue, contacting the RMV disability line or AAA may help arrange accommodations or provide guidance.

E. RESOURCES

Resources are available to aid older adults and interested parties in dealing with the issues and challenges pertaining to older adult driving. Below is a list of several resources:

- The Massachusetts RMV has dedicated a part of its website to addressing the needs of, and providing resources concerning, older adult drivers.
- Community senior centers are also typically a great source of information.
- The U.S. Administration on Aging has developed “Eldercare Locator,” a search tool that connects older adults and their families with various services, including transportation.
- The American Automobile Association, AARP and the Alzheimer's Association, on both the state and national levels, are also helpful resources, as they have published brochures and feature websites that offer tips, guides and worksheets for addressing older adult driving issues and challenges.
- The Alzheimer's Association's website includes several helpful videos about different approaches to engaging in a conversation about driving and dementia, available at www.alz.org/help-support/caregiving/safety/dementia-driving.

Its 24/7 Helpline also has experienced counselors who can provide expert advice on how to address the unique challenges each family may face. To speak to a 24/7 Helpline counselor about your individual situation, call (800) 272-3900.

- AARP helps drivers stay safe, educated and confident behind the wheel with the AARP Smart Driver™ Course. These courses are designed to help drivers age 50-plus familiarize themselves with the current rules of the road, defensive driving techniques, and how to operate vehicles more safely in today's increasingly challenging driving environment. For more information or to register for classes, visit www.aarpdriversafety.org or call (888) AARP-NOW / (888) 227-7669.
- For more information on this topic, please refer to the Massachusetts RMV brochure on “Your Health and Driving Safely in Massachusetts”: <https://www.mass.gov/doc/your-health-and-driving-safely-0/download>.

All of these organizations have excellent resources that may be of help in addressing the sensitive issue of when an older adult should no longer be driving.

CHAPTER 14

SPECIAL NEEDS TRUSTS AND ABLE ACT

INTRODUCTION

Families with disabled dependents face special considerations. The disability community is the only minority group that anyone can unexpectedly join at any time. In recent years, The Arc of the United States identified the issue of aging family caregivers as an important concern for disabled dependents. They have created The Arc's Center for Future Planning, which has resources to help disabled people and their families create future plans. Families need to plan carefully for the eventual transition to the next generation of caregivers. This topic is a complex web of long-term services and supports to navigate, further compounded in its difficulty by the impact of dealing with the caregiver's own health care and long-term care needs. Early planning is essential for success, and it involves more factors than can be addressed in this brief chapter, such as: housing, public benefits, caregiver choices, guardianship and legal authority, advocacy, trustees and more.

A. SSI, SSDI AND MASSHEALTH DEFINITIONS

1. Supplemental Security Income (SSI)

Supplemental Security Income (SSI) is a means-tested benefits program that pays monthly benefits to low-income older adults (ages 65 or older), disabled adults, and disabled or blind children. Disability for adults is defined as the inability to work ("to engage in substantial gainful activity" in Social Security terms) due to a medically determinable physical and/or mental condition(s) that has lasted or is expected at least 12 continuous months or result in death. There is a separate disability definition for children. The program bases financial eligibility on income and assets. In order to be eligible for the benefit, an individual cannot have more than \$2,000 in countable resources.

SSI benefits are funded by the federal government and provide monthly cash assistance. Some states, including Massachusetts, supplement the amount of the SSI stipend with additional funds.

Although the living situation of the SSI recipient initially determines the amount of SSI the recipient will receive, other factors, principally what other income, earned or unearned, the recipient receives, can reduce the monthly payment. Generally, the more income an individual has, the lower the SSI monthly payment. It is important to note that the SSI rules greatly favor income from work ("earned income"), and the reduction to the SSI benefit from earned income is lower than from other income.

In April of 2024, the Social Security Administration published a final rule, "Expansion of the Rental Subsidy Policy for Supplemental Security Income (SSI) Applicants and Recipients." As of Sept. 30, 2024, food is no longer considered "In-Kind Support and Maintenance" (ISM) for SSI purposes. This new rule also extends the same advantageous policy to all SSI applicants and recipients nationwide that was previously only available in seven states due to judicial decisions. This change may increase the benefit amount some people are eligible to receive and will allow more people to qualify for critical SSI payments. SSA also implemented several other rules in 2024 to simplify applying for and accessing SSI benefits.

An individual eligible for SSI in most states, including Massachusetts, will be automatically eligible for Medicaid benefits (MassHealth in Massachusetts) not including nursing home Medicaid and certain MassHealth Home- and Community-Based Waiver Services.

If an individual receiving SSI or Medicaid benefits inherits a large sum of money directly rather than in a properly drafted trust, then that person may be disqualified from the program.

2. Social Security Disability Insurance (SSDI)

Social Security Disability Insurance (SSDI) is an earned benefit available to individuals over the age of 18 who are unable to work because of a medical condition that is expected to last at least one year or result in death. This definition is the same disability standard as in the SSI program. The benefit is

based on the person's work record and how much they have contributed to Social Security rather than on assets or income. SSDI benefits are administered by the Social Security Administration, and the program is largely funded by a participant's payments into Social Security during their working years. Since SSDI benefits are based on an individual's work record and not on their assets, an inheritance will not disqualify a recipient from receiving benefits.

SSDI also provides cash benefits for eligible family members. For example, a disabled adult child may also be eligible for SSDI on a parent's record if the disability began before the age of 22 and has been continuous, and if the parent is drawing their own Social Security benefits, or is deceased, and paid into the Social Security system. These benefits are sometimes referred to as Disabled Adult Child (DAC) benefits. A child may also start receiving a monthly private pension or other income upon a parent's death.

One of the consequences of SSDI or other non-working income, however, may be the loss of MassHealth benefits or the need to pay a premium for those benefits.

Note that income for public benefits programs differs from taxable income, and what is considered income varies from program to program. Additionally, income limits for MassHealth Standard are lower than the income limits for all MassHealth Home- and Community-Based Waiver Services.

If a disabled adult child receives a higher SSDI payment than the monthly SSI payment, then the adult child will be ineligible for SSI payments and may lose their automatic eligibility for MassHealth.

3. MassHealth

This loss of SSI may require a separate MassHealth application and special planning for continued MassHealth eligibility. Many times, this problem can be fixed by seeking a court order to assign pension payments or other income to a d4A trust (discussed below); however, some pensions and Social Security payments are non-assignable. Fortunately, there is a MassHealth regulation in place that protects individuals whose DAC benefits cause them to be over the income limits for MassHealth Standard. An older adult with a dependent adult child who receives SSI benefits must be mindful of the eligibility requirements and should seek qualified counsel to review their situation.

B. DIFFERENCES BETWEEN SSI AND SSDI

There are many significant differences between the SSI and SSDI programs. Among them are: a) how work income is treated, b) how distributions from trusts are treated, and c) the impact of supported housing. These differences go beyond the scope of this chapter. Suffice it to say that one needs to have a thorough knowledge of these programs and their differences.

C. SPECIAL NEEDS TRUSTS

A special needs trust (or supplemental needs trust) is a planning technique an attorney can utilize as part of an estate plan to offer a family flexibility and control over assets as well as protection for the disabled adult's government benefits. The assets held in a properly drafted special needs trust are for the disabled adult and are generally used to supplement the disabled adult's needs that are not paid for with government benefits. Trustees use their discretion to manage and distribute assets on behalf of the disabled adult.

D. TYPES OF SPECIAL NEEDS TRUSTS

1. **Third-party settled trusts are created and funded by a third party.** For example, a parent or other individual can establish a special needs trust and direct assets to that trust for the beneficiary. The assets did not originate from the beneficiary. These types of trusts can be established by a third party during life by creating a trust or at death by a third party's will (testamentary trusts). Creating a trust during your lifetime allows family members to give gifts during their lives to the trust and designate the trust as a beneficiary of accounts or receive a portion of inheritances. Conversely, a testamentary trust is created by your will and does not exist until the testator's death. Therefore, it is not a viable beneficiary until that time. The terms of the special needs trusts can include the ultimate disposition of the assets once the

beneficiary passes away (e.g., the remaining assets can go to other family members).

2. **First-party or self-settled trusts hold the assets of the beneficiary.** If properly established, the assets in a self-settled trust do not disqualify the beneficiary from SSI or Medicaid benefits. For example, if the beneficiary is injured and receives a settlement or award, those proceeds can be deposited into the special needs trust and are not considered a countable resource. In order to be properly established, this special needs trust must: 1) be established by the disabled individual, a parent, a grandparent, a legal guardian or the court; 2) be funded prior to the disabled beneficiary attaining age 65; and 3) provide a payback provision noting that the Commonwealth of Massachusetts and other states that have provided benefits will receive payment to the extent the beneficiary received Medicaid benefits during the beneficiary's entire lifetime (not just since the funding of the trust) upon the beneficiary's death. These types of trusts are usually referred to as "d4A trusts" in reference to their statutory title.
 - a. **d4C trusts are another type of self-settled trust.** These trusts are pooled trusts that have all the same requirements as d4A trusts, but differ in that they are administered by a nonprofit organization and not an individual trustee.
 - b. **Having a nonprofit administer the d4C trust makes it possible for the pooled trust to take smaller trust deposits while being economical with fees.** It also allows for individuals who cannot identify an appropriate trustee to manage their funds.
 - c. **Currently, pooled trusts are available to persons of any age.** MassHealth attempted to limit this planning option for individuals over age 64 as of March 1, 2024. However, through legislative advocacy, that limitation was reversed. Individuals over age 64 are able to use this planning option again as of Dec. 6, 2024. Individuals should consult with knowledgeable disability and elder law attorneys before considering this option.

These trusts must be reported to both Social Security and MassHealth when created or upon application for certain benefits by the disabled individual. (Note that Social Security recently stopped requiring reporting of unfunded third-party trusts.) Both agencies will review how the trusts were established, the trusts' terms, and how the trusts are administered to determine whether the trust assets are countable or whether a transfer penalty period will apply.

E. SPECIAL NEEDS TRUSTS AND LONG-TERM CARE PLANNING

Special needs trusts can also be used during the legal spend-down process for an individual to qualify for long-term MassHealth benefits. The transfer of assets to a special needs trust established for the sole benefit of a totally and permanently disabled person under the age of 65 is not a disqualifying transfer for an older adult seeking MassHealth long-term care benefits. Under the terms of the trust, the trustee must use the funds in a manner that is actuarially sound based upon the beneficiary's life expectancy, or the trust must contain the same payback provision as a self-settled trust (as discussed in Section D).

F. THIRD-PARTY SPECIAL NEEDS TRUSTS AS BENEFICIARIES OF RETIREMENT PLANS

When individuals attain a certain age, they must withdraw mandatory required minimum distributions (RMDs) from their retirement accounts. Individuals may designate certain beneficiaries to inherit the balance of their accounts after their death. The SECURE Act, signed into law on Dec. 20, 2019, created a number of changes for retirees (e.g., delaying the age to begin to take RMDs from 70.5 years to 72) and beneficiaries (e.g., limiting the amount of time over which a beneficiary may withdraw from the inherited account).

The SECURE Act, however, provides an exception for certain beneficiaries, including disabled or chronically ill beneficiaries. In these situations, a disabled or chronically ill beneficiary (or special needs trust for their benefit) may qualify as an eligible designated beneficiary and benefit from a prolonged distribution over the life expectancy of the beneficiary.

Special needs trust and account beneficiary designations should be carefully drafted by qualified estate and tax planning professionals to ensure that the special needs trust is an eligible designated beneficiary ("EDB"). Moreover, the special needs trust should only permit the beneficiary who is disabled or chronically

ill during their lifetime to receive distributions so that the trust will qualify to use the life expectancy of that individual for RMDs.

The Secure 2.0 Act was enacted on Dec. 29, 2022, and provided greater clarity for special needs trusts to be EDBs and to benefit from the prolonged lifetime distribution periods, including allowing remainder beneficiaries of a special needs trust to be a charity.

G. ABLE ACCOUNTS

ABLE Accounts can be a useful addition to special needs planning. These accounts are owned by the disabled person and can be managed by the disabled person or someone else on their behalf. Contributions to the account from all sources per year cannot exceed \$19,000 in 2025, except that some working disabled persons may be able to contribute more. Additionally, ABLE Account balances over \$100,000 count toward the \$2,000 asset limit for SSI. Similar to a d4A trust, there is a Medicaid payback at the death of the account owner. The uses and restrictions of ABLE Accounts and d4A trusts, and the differences between them, are complex and beyond the scope of this brief chapter.

For more information, you should consult with an elder law attorney.

CHAPTER 15

BANKRUPTCY AND DEBT

INTRODUCTION

A catastrophic medical event, ongoing medical expenses, unemployment, price increases in food, a rent raise, death of a spouse, or some other event could result in the creation of debt that is beyond an individual's ability to repay. While the prospect of bankruptcy is unthinkable to most, it may be an appropriate solution in some circumstances. If you are experiencing the stress of your own overwhelming debt, or confusion as to which bills you are legally obligated to pay for whatever reason, it is important to seek professional guidance to assess your individual situation and to compare the pros and cons of bankruptcy and non-bankruptcy options to determine what the best solution is for you. Also, you must consider whether you are legally responsible to pay the debts of a deceased spouse or family member, due to their inability or failure to make payment during their lifetime; or whether bankruptcy provides a viable alternative to avoid payment.

A. BANKRUPTCY

1. Definition

Bankrupt is a term that describes the legal status of a person or other entity (such as a business) that cannot repay some or all of their debts to creditors. Bankruptcy is imposed by a bankruptcy court order, and is most frequently initiated by the debtor. The Merriam-Webster Dictionary defines bankruptcy, in part, as the administration of an insolvent debtor's property by the court for the benefit of creditors.

2. Types of Bankruptcy

Depending on the type, or "chapter," of bankruptcy, debts are treated differently. There are five types of bankruptcy filings, but only four of them are available to individuals:

- a. Chapter 7: Liquidation¹
- b. Chapter 11: Reorganization (or Rehabilitation bankruptcy)²
- c. Chapter 12: Adjustment of debts of a family farmer with regular annual income³
- d. Chapter 13: Adjustment of debts of an individual with regular income⁴
- e. Chapter 9: For municipalities (including cities, towns, townships and school districts) [not available to individuals]⁵

3. Chapters 7 and 13 Appropriate for Older Adults

- a. **Chapter 7:** Referred to as a "straight" or "liquidation" bankruptcy. Chapter 7 is typically considered when a debtor has no hope of repaying debts. Under a Chapter 7 bankruptcy filing, some or all of the debtor's non-exempt assets are sold (liquidated) to pay the lenders (creditors).⁶ It is a quick way for a debtor to get a fresh financial start. Additionally, in many Chapter 7 cases, all of a debtor's assets are retained by the debtor.⁷
- b. **Chapter 13:** Is a reorganization bankruptcy designed for debtors with regular income who can pay back at least a portion of debts through a three- to five-year repayment plan.⁸ Chapter 13 allows debtors to keep their property while they are completing the repayment plan.⁹ Once the payment plan is complete, unsecured creditors cannot force the debtor to pay additional monies, and the balance of any dischargeable obligations owed to creditors as of the filing date will be discharged and uncollectable.¹⁰
- c. **Stigma of bankruptcy:** Most people would prefer to voluntarily settle their debts instead of filing bankruptcy. There is a perceived stigma attached to filing a petition in the bankruptcy court, so many people avoid it for as long as they can and avoid seeking relief from their debts out of unwarranted fear or embarrassment. Persons considering bankruptcy incorrectly believe that everyone will find out, but the reality is that usually the only people who may learn that you filed for bankruptcy are

your creditors and the people you tell.

- d. **Credit report:** If you file bankruptcy, although that fact stays on your credit report for seven to 10 years,¹¹ you can generally begin to improve your credit score immediately after your bankruptcy petition is filed. There is a big difference between a bankruptcy notation on your credit report and your credit score. If you begin to pay your bills on time after your bankruptcy is filed, your credit score will begin to improve immediately.
- e. **Credit score:** Your credit score is the number lenders and credit extenders, including banks, often refer to when deciding whether or not to loan you money. The point is, although you may have a bankruptcy notation on your credit report after a certain period of time, your credit score should improve to within an acceptable range for a lender by the time you seek credit, and you may be able to qualify for extensions of credit, including car loans, and even mortgages. Also, some lenders may consider the cause or the reason why it was necessary for you to file for bankruptcy protection and may be more willing to extend credit to you, despite your bankruptcy. In some cases, you may be a better credit risk following the entry of a Chapter 7 discharge than before you filed, because all or most of your debt was discharged and you cannot obtain a second Chapter 7 discharge until eight years after the filing of your Chapter 7 case.
- f. **Some debt may not be discharged:** In addition to obtaining the benefit of the automatic stay, the main objective and benefit of any bankruptcy filing for most debtors is usually the discharge of all debt that led to the bankruptcy in the first place. As noted below, notwithstanding the entry of a general discharge in either a Chapter 7 or Chapter 13 bankruptcy case, some types of debts may not be discharged, either because the bankruptcy code expressly says so or because a creditor or bankruptcy trustee challenges your right to discharge a particular debt.

Common examples of these types of potentially “non-dischargeable” debts include recently incurred income taxes, alimony and child support obligations, debts resulting from injuries or death caused by a debtor operating under the influence of alcohol, and debts incurred by fraud or intentional misconduct. Also, debts you do not list in your bankruptcy filing may not be discharged. If any debt is determined to be “non-dischargeable,” the debt will survive the bankruptcy and the creditor will be entitled to attempt to continue to collect it from you after your bankruptcy case is over.

You may be ineligible to obtain a second discharge for a period of time after you have received a discharge in a prior case; the time frame depends on which chapter bankruptcy was filed in the initial case and which type of bankruptcy is being filed in the second case. Also, in cases where creditors or trustees allege fraud or dishonesty before or during the bankruptcy case, a creditor or trustee may challenge the debtor’s right to obtain a discharge of all debts (not just a particular type of debt). These situations are fairly rare, and typically should not dissuade the honest debtor overwhelmed by debt from seeking the beneficial relief that may be available under either Chapter 7 or Chapter 13.

B. GENERAL CONSIDERATIONS

1. Pros of Bankruptcy

Before we discuss the specifics of Chapter 7 and Chapter 13 bankruptcy, the following are some general considerations to keep in mind as you weigh your options.

- a. **Stress minimization:** When creditors call you nonstop, it can be very stressful and demeaning. Overwhelming debt can have severe impacts on your mental and physical health. Bankruptcy stops all contact by creditors, including phone calls, visits, bills and threatening letters. Importantly, a Chapter 13 bankruptcy filing can often stop or delay a foreclosure and give you an opportunity to reorganize our mortgage debt, seek a loan modification or sell your property. Bankruptcy will, in most cases, also prevent the filing of lawsuits against you or the continuation of pending lawsuits.

In considering whether bankruptcy is right for you, it is often helpful to try to project yourself 18 months into the future in order to consider what your situation may look like if you do file and discharge all or most of your debt, as opposed to whether your stress levels and financial situation will continue to deteriorate if you do nothing.

- b. **Elimination of medical bills:** Bankruptcy can eliminate medical bills. Keep in mind, if you are continuing to incur medical debt, the bankruptcy will only discharge the bills you have incurred as of the day your case is filed. (You will be responsible for all bills incurred after filing. So, if you need ongoing medical care, you may want to plan ahead to determine the best time to file for bankruptcy.) If your only debt is nominal medical bills, keep in mind that effective April 2023, the three main credit reporting agencies have removed medical debt with an initial reported balance of under \$500. If you have medical debt that you cannot pay all at once, most health care providers will allow you to establish a periodic payment plan to pay the debt over time, and in some instances, depending on your source of income and amount of medical debt, they may be required by law to offer you a repayment plan.
- c. **Social Security income is protected:**¹² Social Security income is not considered in the “means test,” which determines whether or not you are eligible to file in Chapter 7 without having to make future periodic payments to the court. It is also excluded from consideration in determining the amount that you can afford to pay a creditor, such as credit card debt, if you decide not to file bankruptcy. There are many other exemptions that may be claimed in order to protect assets, which are immune from the reach of creditors, whether or not bankruptcy is filed.
- d. **The credit card cycle is stopped:** A bankruptcy discharge can free up funds in your monthly budget so you can better provide for yourself and your dependents. If you find yourself spending most of your monthly income on credit card minimum payments, and then relying on those same credit cards to afford food and other necessities, bankruptcy may be appropriate. Bankruptcy can stop the credit card cycle and give you a fresh financial start.

2. Protected Assets

- a. **Many assets protected:** In bankruptcy proceedings, many assets can be protected, which means that you will be able to keep those protected assets and avoid having them sold by court order to pay all or some of your creditors.¹³ This is often a critical factor in your decision to file bankruptcy, and you should review the extent to which your assets are likely protected (or “exempt”) with your attorney before making any decision about filing bankruptcy. As noted below, the most important of these protections include the homestead exemption for your principal residence, automobile exemption, and exemptions for your IRAs, pensions, 401(k) plans and most other retirement assets.
- b. **Insurance policy protection:** If your life insurance policy has accrued cash value, there may be a limit to the amount that can be fully protected from your creditors.¹⁴ Term life insurance policies with no cash value present are fully protected and generally may be retained by you. In most cases, the value of your pension, 401(k) or other retirement plan can be fully protected in a bankruptcy case.¹⁵

3. Secured Creditors

- a. **House and vehicles:** If you have a loan on your house or car and your loan balance is greater than the value of your house or car, you can keep those assets as long as you continue to pay for them. If that is the case, then your house and car are “upside-down,” which means that if you sold them, there would be no money left for you or your creditors because there is no equity in excess of the debt owed. If there is no equity, then there is nothing of value to be protected. However, if you file bankruptcy and fail to make payments on an “upside-down asset,” the secured creditor may seek relief from the stay and ask the court for an order allowing foreclosure and sale of the “upside-down asset.”¹⁶

Note that in a Chapter 7 bankruptcy, you may be able to “redeem” your vehicle.¹⁷ The bankruptcy court can reduce your car loan to the actual value of your car. So, if you owed \$15,000 on a car worth \$10,000, you would only owe \$10,000 on your car after the redemption procedure is completed. A similar opportunity may be available in Chapter 13, whereby you may be able to pay off the value of your car over the life of your Chapter 13 plan, and eliminate all or a portion of the debt that exceeds the retail value of your car.

- b. **Repossession:** If you fail to pay secured creditors, they are allowed to take back or repossess the property that you purchased and was used as security for the money they loaned to you.¹⁸ Secured creditors always have at least two avenues to collect the amount owed from you, namely collecting based on the promissory note or contract you signed, or seizing and selling the asset for which they loaned you the purchase money. Secured creditors that have properly filed their documents in the right place and in correct form have a lien upon your asset, whether it be a house, car, or even home furniture and furnishings.

Bankruptcy only gets rid of your legal obligation to pay your secured creditor money under the contract you signed; it does not get rid of the lien or right your secured creditor has to take back the property. So, in order to keep your house, car or other secured property, you need to keep paying as promised. On the other hand, you can “surrender” it or give it back to the creditor, and you will not owe them any additional amount based on your bankruptcy discharge.

- c. **Exemptions:** In bankruptcy, certain assets are exempt and cannot be used to satisfy your debts in the bankruptcy proceeding, although a secured lien can survive bankruptcy. Some states allow you to choose between your state law exemptions and federal bankruptcy exemptions. For example, in Massachusetts, the state’s homestead law can protect the equity in your primary residence up to \$1,000,000, or up to \$2,000,000 for a couple who are both elderly and/or disabled.¹⁹

4. Debts Related to Deaths of Spouses and Estates of Decedents

- a. **Limited circumstances not responsible for payment:** You may not be responsible to pay unsecured debts standing only in the name of a deceased spouse or other family member, except in limited circumstances.
- b. **Unsecured creditors:** Generally, for an unsecured creditor to be able to collect a debt of a decedent, such unsecured creditor must, within one year of an individual’s date of death, file a formal claim against the estate of the decedent with the probate court where the decedent’s estate is subject to probate (except Medicaid, which generally has three years).²⁰ Such unsecured creditors must also take certain additional steps to “perfect” their claims against an estate in order for the decedent’s estate to be legally bound to pay the debt. Accordingly, it is important to consult with an attorney prior to paying any debts of a decedent.

C. HOW CHAPTER 7 LIQUIDATION WORKS

1. Federal Court

Prior to filing a bankruptcy case where your debts are “primarily consumer debts,” you must obtain a certificate of credit counseling from an agency approved by the U.S. Trustee. This counseling is primarily online (with a short, live phone component). After filing, you must also take a second “financial management” course and file a financial management course certificate as a condition to obtaining a discharge.

- a. **Immediate effect upon filing:** When you file a Chapter 7 bankruptcy case, a federal court order goes into effect immediately, making it illegal for your creditors to contact you in any way, or commence or continue any action to collect from you or repossess your property.²¹ This provides breathing room and alleviates pressure. Some types of creditors can still collect from you.²² If you are under court orders to pay for child support, alimony or other domestic support obligations, these obligations, along with most income taxes and student loans, are generally not discharged in a

bankruptcy filing. However, there are times when income taxes²³ and student loans²⁴ may be eligible for discharge.

- b. **Period open:** A Chapter 7 case with no distributable assets stays open for about four months, at the conclusion of which the judge will issue an order discharging all of the dischargeable debts that you have listed in your petition. Generally, any debts that you have failed to list will not be discharged and you will still be obligated to pay them. To confirm that you are aware of all of your creditors, you should obtain copies of your credit reports from the three major credit reporting agencies: TransUnion, Experian and Equifax. These reports can be obtained online, and in some states, including Massachusetts, you are entitled to one free report per year from these reporting agencies. Certain websites and lenders provide unlimited free credit reports.

2. Documentation Needed

a. **Required list:**

- i. Two years of tax returns.
- ii. Bank statements.
- iii. Your driver's license or other government-issued photo identification card.
- iv. Proof of your Social Security number.
- v. A host of other documents that may apply to your case, such as deeds and evidence of the value of your house, vehicles, personal belongings, retirement plans and life insurance.
- vi. Frequently, you may be required to provide a copy of recent paychecks or other proof of your wages or earned income, if any.
- vii. Records of domestic support obligations you owe, such as alimony or child support.

3. Time Frame

About a month after your case is filed, you will have to attend a typically telephonic “meeting of creditors” where you will answer questions about your case from a court-appointed trustee.²⁵ Most people filing bankruptcy never see the inside of a courtroom. And these days, the meetings of creditors are held telephonically, by Zoom or other videoconferencing platforms so that debtors do not even have to leave their homes.

4. Exemptions You Can Use

- a. **Long and generous list:** Most people in a Chapter 7 case get the best of both worlds because they are allowed to keep most, if not all, of what they own, but they get rid of their debts forever. The bankruptcy laws have a long and generous list of exemptions that let people keep much of their real and personal property, so long as they fit within the allowed exemptions.
- b. **Mortgage and car loans:** If you have a mortgage on your house or a loan on your vehicle, you will generally be allowed to keep these assets, provided that you continue to pay the lender. If you miss payments on your house or car, the lender can foreclose on your house and repossess your vehicle, but they usually need to obtain the prior permission of the bankruptcy court. Bankruptcy rarely terminates the secured status of a lender, so it is important to understand that you can still lose your house or car (or other secured property) after your bankruptcy case is resolved if you fail to make payments to a secured lender as agreed.

D. CHAPTER 13 REORGANIZATION

1. Regular Monthly Income

- a. **Regular monthly payments:** For most people, Chapter 13 bankruptcy will only work for you if you have regular monthly income. However, “regular income” is not limited to earnings from employment and can generally include Social Security and other retirement income, as well as disability payments, transitional assistance and regular verifiable contributions by family members (including a spouse's income). Upon filing your case, you will be required to begin making regular

payments to your lender, plus an extra payment to catch up on the past-due amounts.²⁶

- b. **Court-appointed trustee:** This extra monthly payment will be paid to the court-appointed Chapter 13 trustee, who will keep track of your payments and pay off your creditors over a three- to five-year timetable.
- c. **Save home from foreclosure:** Filing a Chapter 13 bankruptcy can be an effective way to save your home from foreclosure and get three to five years to catch up on the past-due mortgage payments. Chapter 13 also works if you are behind on car payments, or any other secured item that you want to keep. The bankruptcy court generally has no authority to lower your monthly mortgage payment or to change the terms of your loan or mortgage.²⁷
- d. **Example 1: Chapter 13 Plan:**

EXAMPLE 1: Chapter 13 Plan

Let's assume that your regular mortgage payment is \$1,000 per month and that you are six months behind. Also, by this time, your bank has usually hired attorneys, whom you will have to pay because you agreed to do so when you signed your mortgage and promissory note. Let's estimate \$3,000 as a minimum legal fee, depending on how much work the bank's lawyers have done. If an auction of your home has been scheduled, you will also likely have to pay additional auctioneer fees and advertising fees. So now you owe the bank \$6,000 for past-due mortgage payments plus \$3,000 in legal fees, for a total past-due amount of \$9,000. The plan payment would also include a 10% fee to the trustee, whom you pay each month, bringing the total payment to about \$10,000. In most cases, the repayment plan would require you to repay that \$10,000 by dividing the payments over three to five years. So, for a three-year plan, that means that each month you will pay your \$1,000 mortgage payment to the Chapter 13 trustee, plus you will have to make an additional payment of \$278 each month for the next three years in order to catch up on your mortgage arrears. If you miss more than two or three payments, the court may dismiss your case, which means you are no longer protected by the bankruptcy court and the bank may seek to reschedule the foreclosure auction of your home.

2. Reverse Mortgages in Bankruptcy

- a. **Payment of all property expenses:** An older adult who has taken out a reverse mortgage may be uncertain about the circumstances under which a lender can foreclose. It is important for the homeowner to understand that, while there is no monthly mortgage payment due on a reverse mortgage, payment must still be made for real estate taxes, homeowners insurance, water and sewer charges, and basic maintenance on the property.
- b. **Municipal payments:** If the homeowner fails to pay real estate taxes or water and sewer charges, the reverse mortgage company or the municipality can foreclose on the property. In such a situation, Chapter 13 bankruptcy can provide the means for the homeowner with a reverse mortgage to keep their home, provided that the past-due municipal obligations are paid through the Chapter 13 plan. The homeowner will need to have sufficient income to pay all municipal obligations, which typically carry high interest rates, over three to five years, plus pay the real estate taxes on time in the future. It is important to note that the homeowner cannot draw additional funds from the reverse mortgage while the bankruptcy or payment plan is pending.

3. Other Debts

- a. **Credit cards:** If you have other debts, such as credit card bills or other unsecured debts, you may also have to pay a portion of those back. After you complete the three- to five-year repayment plan, any remaining balances on your credit card debts or other unsecured debts are discharged.

b. **Example 2: Credit Card Debt****EXAMPLE 2: Credit Card Debt**

If you are behind \$2,000 on your car payment, and also have \$20,000 of credit card bills, your Chapter 13 plan will require you to pay the full \$2,000 to fully catch up on your car loan, and you will typically have to pay back a percentage of the \$20,000 on your credit cards. The amount depends on how much of your monthly income is left over after all your necessary expenses are paid. The formula is based on your income, and each case must be independently analyzed to determine the additional amount that must be paid to the Chapter 13 trustee. The amount paid also must provide at least as much as the creditors could have received in a Chapter 7 case. The Chapter 13 trustee earns a 10% commission on the total amount to be paid to your creditors through the 3- to 5-year plan, and the trustee's fee is paid by you and added to your plan payment.

- c. **Unpaid rent:** If you do not pay your rent, the landlord may have a right to evict you and remove you, your family and your belongings from wherever you live. You must receive written notice prior to the landlord filing a court action to evict you (G.L. c. 239). If the condition of the premises is not safe, clean and compliant with certain health and safety codes, or for other good causes, you may have defenses and perhaps counterclaims against the landlord, which may either prevent or delay the eviction process. You may qualify for a free attorney to assist you if you are elderly or meet certain poverty levels. It is important that, very quickly after you receive an eviction notice, you contact an attorney. The attorney may be able to not only negotiate if and when you must vacate, but also force the landlord to pay for your moving, storage and other expenses. It is also important that you take notes and photos so that you can present documentary evidence to support any defenses you wish to present in court. Obtaining prompt return of any security deposit or unused last month's rent is another important activity that counsel may be able to assist you with.

4. Payment Plans Under Chapter 13

- a. **Plan document includes all debts secured and unsecured:** The monthly payment you make will be determined according to your Chapter 13 plan. The plan is a document that includes disclosure of all of your debts, both secured and unsecured, as well as the amount of your regular monthly income.²⁸ A calculation of how much your monthly payment will be is then required.
- b. **Payments to trustee:** As soon as your plan is agreed upon by the Chapter 13 trustee and the bankruptcy judge, your plan will be confirmed.²⁹ You will be ordered to make the monthly payment to the Chapter 13 trustee, who will pay each of your creditors. The plan payment may be in addition to your regular payments to secured lenders.

5. Benefits of Chapter 13

- a. **Strip off:** One of the most helpful benefits is that, in some cases, a Chapter 13 determination order can discharge a second mortgage on your home.³⁰ This is called a “strip off.” Whether you can take advantage of it or not depends on several factors, including the fair market value of your house and how much you owe the first mortgage holder.
- b. **Student loans:** If you have student loans or income taxes owed, a Chapter 13 can stop collection enforcement and in most cases, the accumulation of interest on past-due amounts for tax liabilities, as well as give you protection from your creditors because any payments made to them will be subject to court oversight.
- c. **Protects co-signer of loan:** Another benefit of a Chapter 13 is that it protects co-signers from creditor contacts on your accounts because co-signers receive the same bankruptcy court protection that you do, even though they are not filing bankruptcy.³¹ This is true when only one spouse files bankruptcy and the other spouse, who is a co-signer, is also granted bankruptcy court protection, even though the non-filing spouse did not file bankruptcy.

E. ALTERNATIVES TO BANKRUPTCY

1. Hardships

Explaining and documenting your financial hardship to your creditor may assist them in evaluating your settlement offer.

- a. **Medical and others:** Hardships that are ongoing, such as chronic medical conditions, loss of income from a business closure, the death of a bread-winning partner, or situations that have had a permanent impact on your finances, are among the most persuasive. It may be more helpful to demonstrate to your creditor that your financial situation is unlikely to improve, and that your offer to settle is often the proverbial “bird in hand” for your creditor.

2. Multiple creditors

- a. **Settlement opportunities:** If you have multiple creditors, you can explain to them that your settlement offers are on a first-come, first-served basis, and that once the money is gone, then no further offers will be forthcoming. This may motivate a creditor to take your offer, because they are usually able to obtain your credit report to confirm how many other creditors you have and how much you owe them.

3. Debt Settlement

- a. **Payment plan:** For example, if you have a \$10,000 balance on a credit card and you want to set up a payment plan to pay it off, the credit card company will usually let you make smaller monthly payments over time, so long as you agree to pay off the full \$10,000. Some creditors may allow periodic payments on a lesser amount than the full balance owed, but that must be negotiated and reduced to writing for your protection. Whether the creditor will agree to waive interest and late fees that are still accumulating depends on how well you negotiate an agreement with your credit card company. This type of settlement can be paid over time, and may not save you very much money in the long run.

Also, the longer a settlement agreement is in place, generally the worse it is for you because the credit card companies often have a clause that says if you miss an agreed payment, the deal is canceled and they can pursue you immediately for the full past-due balance. These payment plans sometimes fall by the wayside for one reason or another, often after people have made many monthly payments that they would not have had to make if they filed for bankruptcy earlier.

- b. **Lump-sum settlements:** The more beneficial type of settlement is a “lump-sum” settlement. With that same \$10,000 balance in the previous example, if you offer the credit card company an immediate payment of \$8,000 to settle this account in full and final settlement, the chances are that they will take it. If you are current with your payments, the credit card company is unlikely to agree to this, and that is because they are getting your payment every month and they have no incentive to offer you a deal. The longer you are unable to make your monthly payment, and the further behind you fall month after month, tells the credit card company that you are having financial difficulty. Typically, the more you fall behind, the better your chances are for a lump-sum settlement for a lower amount.

Before you agree to any type of settlement, it is best to get the terms of the agreement in writing. Also, you should insist that, upon receipt of your final payment, the credit card company will report to the credit bureaus that your account is “paid off” or “settled in full.”

There are other important consequences to consider before attempting to settle your credit card or other debts without the assistance of an experienced attorney. As you fall further behind on your monthly payments, your credit score will be negatively affected. You may be called up to twice weekly by your creditors. Creditor calls to your place of employment are permitted, unless you inform the creditor in writing not to do so. Oral requests to creditors asking them not to communicate with you at your place of employment are valid for 10 days. Written requests are valid until you remove

the restriction. You also run the risk that they will sue you in court if you do not make satisfactory payments. However, if you have an attorney, they cannot contact you by law. Further, typically your creditors will not file suit against you while you are represented by an attorney and are trying in good faith to negotiate a settlement.

- c. **Income taxes due if credit card company accepts and issues IRS Form 1099-C:** Note that settlements can cost you income taxes. If the credit card company agrees to accept \$2,000 to settle your \$10,000 balance, that may sound wonderful — a savings of \$8,000. But the IRS requires that any amounts of debt in excess of \$600 that are forgiven by your creditors be included in your gross income in the year that the debt was forgiven, and that income may be taxable. The credit card company will issue an IRS 1099-C form to you for the amount of forgiven debt.³² You should check with your tax preparer to see how much tax, if any, you will have to pay as a result of the debt forgiveness. In the event the debt is discharged in a bankruptcy case (rather than settled), this “phantom income” is generally not taxable.
- d. **Retirement account withdrawals:** Withdrawals from your retirement accounts to pay off credit card or other debts can have adverse consequences. Making such a withdrawal is generally a poor decision because you are using funds that were set aside for your future and will usually create income tax liability when withdrawn. Furthermore, depending on your age, you could suffer penalties and the tax consequences for using the retirement funds to pay the debts. Consult an experienced financial advisor to assess your situation.

4. Mortgage and Loan Modification

- a. **Definition:** A loan modification is typically a request by a borrower for a lender to change the terms of the borrower’s loan. This may involve changing all or some of the following: interest rate, principal balance, past-due amounts, collection costs, late fees, payment due dates, legal fees and/or auctioneer fees. A loan modification can also change your loan from an adjustable rate to a fixed rate in some instances.
- b. **Lender decision:** The decision to grant or not grant a loan modification is entirely the lender’s. In the case of real estate, the mortgage and promissory note that you originally signed when you bought your real estate or refinanced are the legally binding documents that control your relationship with your lender. The lender may simply refuse any change you request.
- c. **Modification application:** Your lender may have a website where you can fill out their specific loan modification application. Your lender may use a formula to determine your ability to participate in a loan modification, and if, for example, you are currently past due on your home mortgage, being in arrears can actually be a benefit when asking your lender to modify your loan. The reality is that most people who request a loan modification are behind on their mortgage and need the lender to make some changes to their loan in order to make the house more affordable. You will need to gather your financial documents, such as tax returns, paystubs and other evidence of assets, liabilities, income and expenses, to show your lender that you have money left over at the end of each month.

Also, it may be helpful for you to write a “hardship letter” to explain to the lender what caused you to fall behind with your mortgage payments, how you have resolved those problems, and why you anticipate being able to make your monthly payments in the future if the lender gives you a loan modification.

- d. **Dealing with the lender:** While the process of submitting a loan modification request is relatively straightforward, one difficulty usually lies in the constant follow-up that will be required from you to make sure that the bank has your completed package. Lenders often lose paperwork, and requests from them for you to resubmit your loan modification package are quite common, frequently due to the lender’s processing delays, so be sure to make legible copies of everything that you send to

your lender in case you need to refer to or send the paperwork again. It may take between three months to well over a year to get an answer from your lender on whether your modification has been granted.

Even though your lender is reviewing your loan modification application, the lender can still pursue its legal right to foreclose on your real estate. That is why some people are confused when they receive notice of a foreclosure proceeding from their lender's attorneys at the same time a loan modification is being processed. Remember that the lender is going to take the necessary steps to protect what is best for the lender, and you should take the necessary steps to protect what is best for you. You should consult with an experienced attorney to fully explain your rights and legal options.

e. **Dealing with debt collection correspondence — Sample letter**

(Name and address of Debt Collector)

RE: Your Name; Creditor's Name,

Account #: 1234567

Dear Sir or Madam,

I am writing to your company regarding its collection efforts on the above-referenced account and my ability to pay this debt.

I am unable to make any further payment because (state reasons for inability to pay, such as no ownership of or interest in any real estate or other assets that would not be exempt from process under Massachusetts law; or monthly income consisting of Social Security, public assistance, unemployment compensation, workers' compensation, veterans benefits, railroad retirement benefits, a pension or wages that are exempt from garnishment).

I clearly cannot afford to make even a minimum monthly payment on the balance. Further, my monthly income is entirely exempt from this process, and it is extremely unlikely that any judgment obtained against me would ever be collectible.

In light of the above, I will not make any further payments on your accounts and will not use the accounts anymore. My credit cards have been destroyed and the accounts are closed.

This letter is to request that you cease all contact with me regarding the collection of the above-referenced account, pursuant to the Fair Debt Collections Practices Act (15 U.S.C. section 1692). This letter is also to request that the creditor write off the balance owed by me as uncollectible and notify me in writing of this disposition.

Thank you for your attention to this matter.

Very truly yours,

(name of debtor)

F. DO NOTHING

a. **Wait for summons or complaint:** Another option for someone in debt is simply to do nothing. Waiting for a summons and complaint to arrive may be the best alternative. It may never arrive, and the creditor may close the case as uncollectible. But you could wait and see what the creditor does to collect. If all of your assets are either exempt or without value, disclosing that to the creditor may lead the creditor to close the case against you. You may draw from the above letter and send such a letter, certified mail, to the creditor or the creditor's representative. If a lawsuit is filed and the debt is admitted, and if you are insolvent, handling the matter yourself may be a reasonable choice.

b. **Attachable assets:** On the other hand, if you have attachable assets, such as a bank account or a motor vehicle, or if you earn enough wages so that it is worthwhile for a creditor to attach your pay, then you would be wise to seek advice of an attorney who can explain the wage or bank account attachment process to you and teach you how to avoid a wage attachment or defend the lawsuit.

- c. **Financial education courses:** In the meantime, attending financial education courses and learning about money management, financial affairs, budgeting skills and payment plans may be extremely helpful in dealing with communications by creditors and their aggressive representatives.
- d. **Consequences of ignoring creditors:** Of course, if a debt is denied either as to liability or as to the amount of the claim, then doing nothing would not be the best course of action. An attorney is needed to defend you in court if none of the alternatives suggested above apply. However, keep in mind that if you ignore a creditor, it is possible that your creditor will contact your family members, friends, neighbors, people you live with, and others who they believe can assist them in locating you. They are allowed to do this, but they are not allowed to inform others about your debt.
- e. **Your privacy:** You should be very reluctant to disclose any of the following personal information, especially to a debt collector:
 - i. Social Security number;
 - ii. Driver's license number or state-issued ID number;
 - iii. Bank or other financial account number;
 - iv. Bank or other financial institution routing number;
 - v. Any credit card or other account number;
 - vi. The name of any minor child; and
 - vii. Birth date. (IM.G.L. c. 93H)

Debt collectors are prohibited from committing violations of federal and state law preventing "Unfair and Deceptive Collection Practices."³³ Generally, these laws prohibit a debt collector from harassing, oppressing or abusing a debtor, using false, deceptive or misleading representations or means, requesting postdated checks, making too many communications in a seven-day period, making contacts at a place of employment and using deceptive forms. Violations of these laws may result in substantial damages to the debtor. An attorney can advise you if you have a case.

- f. **Need for bankruptcy or collection attorney:** All options are complex to consider at such a vulnerable time in your life, and the best decision for you depends on your personal situation. Each option has positive and negative consequences, and each has highly technical requirements. It is always recommended that you consult with an experienced bankruptcy or collection attorney to help you assess your specific situation and determine your best strategy.
- g. **Death of a spouse:** The death of a spouse or a family member may cause creditors to communicate with you to pay a debt that you believe is not your responsibility. An attorney can advise you as to your rights, insofar as your legal obligation to pay these bills. If you have a spouse or other relative in a Chapter 13 bankruptcy case who passes away during the term of the case, the personal representative of the estate of such deceased debtor may, if advisable, elect to continue that case (and potentially continue to obtain the benefit of bankruptcy protection for any co-debtor of the deceased debtor); otherwise, the bankruptcy case would be dismissed and a creditor could then file a claim in the decedent's probate estate.
- h. **Resource Directory lists consumer credit agencies:** The Resource Directory lists some agencies to contact for further information.

1. 11 U.S.C. §§ 701-784.
 2. 11 U.S.C. §§ 1101-1195.
 3. 11 U.S.C. §§ 1201-1232.
 4. 11 U.S.C. §§ 1301-1330.
 5. 11 U.S.C. §§ 901-946.
 6. 11 U.S.C. § 726 (2010).
 7. 11 U.S.C. § 522 (2010) (provides for exemptions of debtor's assets).
 8. 11 U.S.C. §1322 (2010).

9. 11 U.S.C. § 1306(b) (1986).
10. 11 U.S.C. § 1328(c) (2020).
11. 15 U.S.C. § 1681c(a)(1) (2018).
12. 42 U.S.C. § 407 (1998).
13. 11 U.S.C. § 522 (2010).
14. 11 U.S.C. § 522(d)(8) (2010).
15. 11 U.S.C. § 522(b)(3)(c) (2010); 11 U.S.C. § 522(d)(12)(2010); M.G.L. c. 235 § 34.
16. 11 U.S.C. § 362(d) (2020).
17. 11 U.S.C. § 722 (2005).
18. M.G.L. c. 255 § 13J & M.G.L. c. 255B § 22 (consumer credit); M.G.L. c. 255B § 20B (motor vehicles); M.G.L. c. 244 (real estate).
19. M.G.L. c. 188.
20. M.G.L. c. 190B § 3-803.
21. 11 U.S.C. § 362 (2020).
22. 11 U.S.C. § 362(b) (2020).
23. 11 U.S.C. § 523(a)(1) (2020).
24. 11 U.S.C. § 523(a)(8) (2023).
25. 11 U.S.C. § 341 (2005).
26. 11 U.S.C. § 1326 (2005).
27. 11 U.S.C. § 1322(b)(2) (2010).
28. 11 U.S.C. § 1322 (2010).
29. 11 U.S.C. § 1325 (2017).
30. 11 U.S.C. § 506 (2005).
31. 11 U.S.C. § 1301 (1984).
32. 26 CFR § 1.6050P-1 (2016).
33. See Federal Fair Debt Collection Practices Act and Regulations of the Massachusetts Attorney General.

CHAPTER 16

REVERSE MORTGAGES

Basic Information About a Potentially Helpful Retirement Tool

INTRODUCTION

Reverse mortgages are one of the most misunderstood financial products on the market today. For many older homeowners, their homes are their most valuable, if not their only, asset. Some may need funds to help pay for health care bills, property-related expenses or even subsistence needs. On the other side of the financial spectrum, many affluent baby boomers and their financial advisors are searching for creative ways to incorporate home equity into their comprehensive retirement plans. One tool available to homeowners who reach a certain age is a reverse mortgage.

Reverse mortgages allow older homeowners to borrow against their home equity and convert it into spendable cash in order to accomplish their personal financial goals. There are many myths and misconceptions about reverse mortgages, and they are not the answer for everyone. Homeowners should do their research, weigh their options, connect with U.S. Department of Housing and Urban Development (HUD) counselors, and speak to an elder law attorney or other trusted professional advisor before entering into one of these transactions.

A. REVERSE MORTGAGE

1. Definition

A reverse mortgage is a type of loan that enables an age-qualified homeowner to release or “cash out” some of the equity in their home without incurring a new monthly mortgage payment. The purpose of a reverse mortgage is to increase a homeowner’s access to spendable cash in their later years. The tradeoff is that the reverse mortgage is eating into the borrower’s home equity as the loan repayment balance increases steadily over time.

2. Reverse Mortgages Compared to Other Mortgages

- a. **Standard mortgage and HELOC:** In a “standard” mortgage, you pay principal to build equity in your home. In a home equity line of credit (HELOC), you can take out “loans” secured by the value of your home, but you must make interest payments on the outstanding loan balance. For all mortgages, there are eligibility rules and costs. See the Loan Comparison Chart (on page 140) that compares a reverse mortgage with a standard mortgage and a HELOC.

3. Types of Reverse Mortgages

- a. **HECM:** In 2025, Massachusetts homeowners can choose among a few types of reverse mortgages. By far the most common is the Federal Housing Administration (FHA)-insured Home Equity Conversion Mortgage (HECM). HECMs are offered through mortgage lenders, mortgage brokers, banks and credit unions. FHA made several program changes between 2014 and 2018 in an effort to improve consumer protections and stabilize the FHA Mutual Mortgage Insurance Fund.
- b. **Additional proprietary mortgages:** Additional proprietary reverse mortgage products are available for high-value properties. While many of these loans are set up to run similarly to a HECM, they often have different closing costs and interest rates and other unique features. An individual contemplating one of these loans should consult with an elder law attorney or a real estate attorney to have the loan terms reviewed and explained. As with a HECM, homeowners obtaining these loans are required to have reverse mortgage counseling with a HUD-certified reverse mortgage counselor prior to obtaining the loan.

The HECM program is the most prolific reverse mortgage program in Massachusetts.

B. HECM REVERSE MORTGAGES

1. Terms

- a. **No monthly payments:** Unlike a conventional “forward” mortgage, a HECM has no required monthly repayment obligation. It is a deferred payment loan. The repayment of the loan is deferred until the home is sold or the last borrower (or qualified non-borrowing spouse) has passed away, left the home permanently or defaulted on the terms of the mortgage. As with any mortgage, the borrower must keep current with property taxes, homeowners insurance, maintenance, and municipal utility charges.
- b. **Based on value of home and age:** The loan amount available under a reverse mortgage varies based upon a number of factors, but primarily upon the borrower’s age, the value of the home and the expected interest rate. Therefore, older borrowers with more valuable homes (up to the current limit) can access greater loan amounts.
- c. **Access to loan proceeds:** Borrowers can access loan proceeds in one of the following ways or any combination of them.
 - i. **Immediate Lump Sum.**
 - ii. **Tenure Payment.** A monthly amount sent to the homeowner that is guaranteed to continue as long as the homeowner occupies the home as their primary residence, even if for life. The older the homeowner at the start of the loan, the larger the tenure payment. For instance, a 62-year-old living in a \$400,000 house might have a tenure payment of \$710 per month, whereas a 75-year-old living in the same house might have a tenure payment of \$1,049 per month (calculated 10/25/24 assuming \$400,000 home value, 6.875% expected rate, 7% initial rate adjusting monthly, \$17,592 financed closing costs).
 - iii. **Term Payment.** A monthly payment that lasts for a finite number of months and then ends. These payments are usually for a larger amount than is available under the tenure payment option and may deplete the available loan balance quickly.
 - iv. **Line of Credit.** The homeowner can pull out loan funds at times and in amounts of their choosing. In that way, it is similar to a HELOC. However, that is where the similarities end. As long as the borrower meets their loan obligations, a HECM line of credit cannot be “called” or arbitrarily terminated by the lender the way a HELOC can. Also, the unused portion of a HECM line of credit grows larger at a guaranteed, compounding growth rate (the same interest rate at which the loan balance grows). So, a 62-year-old living in a home worth \$600,000 may start out today with a line of credit of \$168,078. But if the individual leaves the line of credit alone and allows it to grow, it will grow to \$350,609 in 10 years and \$731,367 in 20 years, even if the home decreases in value (calculated 10/25/24 assuming \$600,000 home value, 6.875% expected rate, 7% initial rate adjusting monthly, \$22,122 financed closing costs, 7.5% credit line growth rate).
- d. **Compounding interest:** The importance of understanding how compounding interest impacts any reverse mortgage is significant. The impact on the balance due at the time of payoff may cause some confusion among homeowners and their families.

2. Repaying a HECM Reverse Mortgage

- a. Six circumstances will trigger repayment of a HECM:
 - i. Most common — the last borrower (or eligible non-borrowing spouse) passes away.
 - ii. The borrower sells the property or otherwise conveys title without retaining a life estate interest or beneficial interest in a trust.
 - iii. The borrower ceases to occupy the real estate as their principal residence.

- iv. Failure to maintain the property such that the home falls into disrepair.
 - v. Failure to maintain the homeowners insurance on the property.
 - vi. Failure to pay the property taxes and, in some cases, municipal utility charges, which, if unpaid, become liens, such as water and sewer bills.
- b. **Outstanding repayment balance:** The outstanding repayment balance will be made up of any loan funds disbursed to the homeowner over the life of the loan plus interest, FHA mortgage insurance and servicing fees that have accumulated over time. Unless the homeowner makes voluntary prepayments, the charges will compound over time, so it is important to draw down only the loan funds that one needs to pay one's bills and live comfortably. For instance, a homeowner who withdraws \$20,000 initially for a home repair and to eliminate credit card debt may owe \$54,294 in five years and \$78,416 in 10 years (calculated 10/25/24 assuming \$400,000 home value, 6.875% expected rate, 7% initial rate adjusting monthly, 0.5% MIP, \$17,592 financed closing costs). Compare that to a homeowner who withdraws \$100,000 initially and deposits most of it in the bank. The homeowner could owe \$174,202 in five years and \$248,492 in 10 years because of the compounding effect of the loan charges (calculated 10/25/24 assuming \$600,000 home value, 6.625% expected rate, 6.75% initial rate adjusting monthly, 0.5% MIP, \$22,122 financed closing costs).
- c. **No prepayment penalty:** A HECM can be repaid, in part or in whole, without any prepayment penalty. Prepaying an adjustable-rate HECM down to a zero balance will close out the loan, whereas leaving a small outstanding balance will leave the loan open and accessible in the future. Usually, a HECM is repaid by selling the home, refinancing into a regular mortgage, or utilizing the cash or life insurance death benefit of a deceased borrower. Typically, the home is sold for a price that exceeds the HECM outstanding balance. In that case, the excess sale proceeds revert to the borrower or their estate.
- d. **Non-recourse loan definition:** A HECM is a “non-recourse” loan, meaning that, if the outstanding loan balance exceeds the home's fair market value at the time of repayment, the borrower or their estate is only responsible for repaying 95% of the home's value. FHA's mortgage insurance fund covers the repayment of any shortfall between the outstanding loan balance and the home's value. Neither the borrower nor the borrower's estate is personally responsible for repaying the shortfall. Lenders will allow the estate up to one year from the last borrower's date of death to repay the reverse mortgage. This one-year period includes an initial six-month repayment period plus additional, allowable extensions. Interest and FHA mortgage insurance will continue to accrue during this time, which can reduce the amount of any remaining equity in the home.
- e. **Reasons to use a HECM reverse mortgage:**
- i. Paying off existing mortgage debt to eliminate monthly principal and interest payments;
 - ii. Eliminating credit card debt and other unsecured debts;
 - iii. In-home care services;
 - iv. Home renovations and repairs, including accessibility modifications;
 - v. Dental work, hearing aids and other medical expenses not covered by Medicare or health insurance;
 - vi. Deferring the date that one begins drawing Social Security retirement benefits in order to receive a larger monthly benefit;
 - vii. Replacing lost income sources like a deceased spouse's Social Security or pension, or a depleted 401K, IRA or annuity;
 - viii. As a funding source for older adults caring for grandchildren or adult disabled children;
 - ix. Supplementing income to help pay for everyday living expenses;

- x. As a “safety net” for emergencies or large expenditures;
- xi. Extending the longevity of one’s other retirement savings and investments.

Note: A HECM should never be used as a means to purchase any other type of financial product, investment or annuity.

C. ELIGIBILITY FOR A HECM REVERSE MORTGAGE

1. Age

The minimum qualifying age for the FHA-insured HECM program is 62. New rules extend eligibility to a married applicant who has a spouse under age 62 as long as certain procedures are followed. These new rules create new protections, responsibilities and consequences for the “non-borrowing spouse,” which the couple should review with their attorney, a HUD-certified reverse mortgage counselor and their lender.

2. Property Value

There is no minimum property value requirement, though a homeowner must have enough equity in their home to pay off any existing mortgages or liens, and the home must meet FHA guidelines. In 2025, lenders may consider up to the first \$1,209,750 when determining an applicant’s eligibility and loan amount.

3. Residency

The property securing the loan must be the borrower’s primary residence.

4. Ownership

While home ownership is ordinarily a prerequisite, life tenants and beneficiaries of certain types of trusts may obtain a HECM, subject to some restrictions. Applicants should make sure that they or their attorney communicates with the lender early in the process to make sure their ownership interest meets HUD and lender guidelines.

5. Home Type and Condition

Single-family residences are eligible, but lenders will also extend credit on owner-occupied, multi-family homes (up to four units) and FHA-approved condominiums (individual condominiums can now be approved rather than entire condominium complexes/buildings). The form that a condominium association seeking FHA approval submits to HUD can be downloaded at https://www.hud.gov/sites/dfiles/OCHCO/documents/9992.pdf?utm_medium=email&utm_source=govdelivery.

6. Income and Credit

“Financial Assessment” is a term describing credit and income underwriting rules that assess the suitability of a HECM for each applicant’s financial situation and reduce the number of technical mortgage defaults caused by nonpayment of property taxes and homeowners insurance. Lenders must now analyze each applicant’s credit history, property charge payment history and income to determine the homeowner’s ability (income) and willingness (credit) to meet their ongoing property expenses. Those who don’t meet certain HUD thresholds will encounter “Life Expectancy Set Asides” that require setting aside what can be a substantial percentage of their available HECM funds for future property tax and insurance payments, or in some cases (where the borrower is 62 or a few years older and the property charges are large), their HECM application may be denied.

7. Compound Interest Example

Compound Interest Example

First, understand compound interest. Compound interest is the addition of interest to the principal sum of a loan or deposit, or in other words, interest on interest. For example, borrowing \$50,000, at a 2% interest rate, compounded monthly. In January, the interest is \$83.33 ($\$50,000 \times .02$, then divided by 12). In February, the interest is calculated on \$50,083.33, so the February interest is \$83.47.

Let's assume a 70-year-old couple in a \$500,000 home sets up a HECM line of credit with \$283,000 in it. First, their \$19,543 in closing costs are automatically subtracted, and then the couple withdraws \$125,000 immediately. Their beginning loan balance is \$144,543. Lender interest and FHA mortgage insurance begin accruing on that amount and compound over time. If the couple sells their home or dies 15 years later when they are 85, their outstanding loan balance could be \$255,627. Over that 15-year period, \$111,084 in lender interest and FHA mortgage insurance has built up and is added into their outstanding loan balance.

The difference between the home's value and the \$255,627 loan balance is their remaining home equity that they (or their estate in the event of their deaths) will receive as cash from the sale. The same \$500,000 home could either appreciate or depreciate over time, and that will impact how much equity, if any, the homeowners or their estate will receive upon sale. For instance, if the home appreciates at 4% per year over that 15-year period, it will be worth \$900,472. If it appreciates at 2% per year, then the home will be worth \$672,934. The difference between those figures and the \$255,627 loan payoff is the equity returning to the homeowners or their estate. Finally, if the home depreciates over the 15 years down to \$240,000, then the non-recourse protections built into the HECM program will protect the homeowners and their estate.

At the same time this couple's loan balance is growing due to the compounding interest and FHA mortgage insurance, their available line of credit is also growing larger. After our couple withdrew their initial \$125,000, their remaining available line of credit was \$138,457. Over the next 15 years, the available line of credit grows, and that growth, like their interest, compounds over time. By year 15, their available unused line of credit grows from \$138,457 to \$244,866. That's \$106,409 in additional line of credit growth that the couple had the opportunity to access if they wanted to.

8. Loan Comparison Chart

LOAN COMPARISON CHART						
Loan Type	Due Date	Interest Rate	Non-Recourse	Expenses	Income/Credit/Asset in Underwriting	Mortgage Payment and Balance
(Reverse mortgage) HECM (federally insured Home Equity Conversion Mortgage)	Death of borrower(s); Sale of home; Borrower(s)'s absence from property for six or more months in a year; Borrower(s) in hospital and/or nursing home care for 12-consecutive months; Foreclosure for nonpayment of property charges.	Adjustable or Fixed Rate (smaller sum available under fixed rate "lump-sum" option).	Yes	Mortgage insurance premium = 2% of home value; negotiable loan origination fee of \$2,500 to \$6,000 based on home value; Standard loan closing costs; annual MIP.	Only for purposes of confirming borrower's ability to pay property charges (potential proceeds from HECM loan are included in the calculation).	No mortgage payments are required. Loan balance increases at compounding interest. In these loans, the interest is added to the loan amount and becomes interest on interest.
Standard Mortgage	End of term of loan; Sale of home; Refinance of loan; Foreclosure for nonpayment.	Adjustable or Fixed Rate	No	Standard loan closing costs; Origination fee(s)/ points (if applicable).	Yes	Principal and interest payments are required, reducing loan balance over life of loan.
HELOC (Home Equity Line of Credit)	End of term of loan; Sale of home; Refinance of loan; Foreclosure for nonpayment.	Adjustable or Fixed Rate	No	Standard loan closing costs; Origination fee(s)/ points (if applicable).	Yes	Interest payments are required; Principal payments will reduce loan balance over the life of loan.

D. FEES ASSOCIATED WITH REVERSE MORTGAGE**1. Fees Vary Based on Lender**

Fees vary based upon the lender offering the program. Initial loan costs include those for FHA mortgage insurance, usual and customary third-party closing costs, and loan origination fees. Homeowners should shop around to see what different lenders offer for closing costs and lender credits.

2. FHA Mortgage Insurance

The FHA Initial Mortgage Insurance Premium is equal to either 2% of the home's value or \$22,996.50, whichever is less. More often than not, this insurance premium makes up the largest percentage of the total financed closing costs.

3. Origination Fee

An origination fee is another closing cost, and depending on the home's value, it can be as high as \$6,000 for a home valued at \$400,000 or more. In some cases, lenders will agree to reduce their origination fee or offer "lender credits" to offset some of the closing costs. However, this may cause the lenders to increase the interest rate margin, allowing them to recapture these fees over time.

- a. **Most closing costs built into the loan:** Although borrowers need not pay most closing costs out of pocket, they should be aware that if they finance the loan costs by adding them to their loan balance, they (or their estate on their death) will still pay them back (plus interest) when the loan becomes due and payable.

4. Ongoing Costs

- a. **FHA annual mortgage insurance premium:** FHA charges an annual mortgage insurance premium of .5% per year assessed against the outstanding loan balance. The annual mortgage insurance premium is in addition to the FHA initial mortgage insurance premium that is part of the financed closing costs.
- b. **Fixed and adjustable interest:** Most reverse mortgage lenders offer both fixed and adjustable interest rates. Keep in mind that borrowers who select a fixed interest rate must take all of their loan funds in one single disbursement lump sum at closing in a much lower amount than is available with an adjustable rate. A line of credit, tenure payment and term payment are available only with loans that have adjustable interest rates, not loans with fixed interest rates.
- c. **Monthly servicing fee:** HUD permits loan servicers to add a monthly servicing fee to the outstanding loan balance. Servicing fees are capped at \$35 per month for adjustable-rate loans and \$30 per month for fixed-rate loans. At the time of publication, most servicers do not charge these fees.
- d. **Compounding factor:** Interest, the FHA annual insurance premium, and the monthly servicing fee compound over time, thereby causing the outstanding loan balance to grow faster over time.

E. REVERSE MORTGAGE COUNSELING

1. Calculation Tip

TIP: Calculate the amount you will need immediately, and then calculate what you will need going forward. Ask for the calculations over different periods of time — the first year, the fifth year, etc. If you expect to live in the home indefinitely, what are the calculations 15 or 20 years out? Is the interest rate variable or fixed? How do these calculations fit into your overall plan? Know that both the lender and the reverse mortgage counselor are required to show each borrower an amortization schedule forecasting the loan's outstanding balance each year until the youngest borrower's 100th birthday.

2. Protection from Undue Influence

In an effort to protect older homeowners from undue influence and to ensure that they make the most educated decision possible, HECM applicants must complete a reverse mortgage counseling session with an independent, HUD-certified reverse mortgage counselor. All reverse mortgage counseling sessions within Massachusetts must take place with a HUD-approved, Massachusetts-based housing counselor. The required counseling can be completed in person, by telephone, or virtually via Zoom or similar platform.

3. Approved HUD Housing Counseling Agencies

- a. List of HUD Housing Counseling agencies providing HECM counseling within the commonwealth as of January 2025:
 - i. American Consumer Credit Counseling
130 Rumford Ave., Ste. 202
Auburndale, MA 02466

Tel: (617) 559-5700 • Toll-free (866) 826-7180

- ii. Cambridge Credit Counseling Corp.
67 Hunt St.
Agawam, MA 01001-1920
Tel: (800) 757-1788
- iii. Community Service Network Inc.
52 Broadway
Stoneham, MA 02180
Tel: (781) 438-9254
- iv. Credit Card Management Services — Debt Helper
400 West Cummings Dr., Ste. 4250
Woburn, MA 01801
Tel: (800) 920-2262
- v. Housing Assistance Corp.
460 West Main St.
Hyannis, MA 02601
Tel: (508) 771-5400
- vi. Neighborworks Housing Solutions
68 Legion Pkwy.
Brockton, MA 02301
Tel: (617) 770-2227, ext. 344 and 343
- vii. QuickCert
437 Turnpike St., Ste. 304
Canton, MA 02021
Tel: (888)383-8885

F. SOURCES OF LAW

1. HUD Handbook 4000.1 (replaces all previously published HUD Handbooks and mortgagee letters).
2. 12 U.S.C. § 1715z-20.
3. 24 CFR § 206.
4. M.G.L. c. 167E § 7.
5. M.G.L. c. 167E § 7A.
6. M.G.L. c. 19A § 36.
7. 209 CMR § 55.

CHAPTER 17

LONG-TERM CARE INSURANCE (LTCI)

Although most adults expect to remain healthy and independent throughout their lives, many will develop chronic illnesses or conditions that require care over a prolonged period of time. Such care can range from in-home care assistance, including social and adult day health programs, to care in assisted living or continuing care facilities, nursing homes or hospice. Care in all of these settings is very expensive.

According to the Genworth's 2024 Cost of Care Survey, in Massachusetts, the median cost for home care is \$7,607 per month. Many will transition to an assisted living setting, with a median cost of \$7,476 per month. Dementia units typically cost an additional \$2,000–\$4,000. Semi-private rooms in nursing homes have a median cost of \$14,372, and private rooms, \$15,330. In addition to the costs of facility care, those who can afford to supplement their care with private caregivers will often choose to add this expense to have care personalized, unrushed and scheduled.

While the average duration of long-term care is 2.2 years for men and 3.7 years for women ([longtermcare.gov](https://www.longtermcare.gov)), it is important to know that long-term care is not a “bell-shaped” curve, where the middle represents the highest utilization of care. It is a “U-shaped” curve, where those who are less healthy use less than a year of benefits and those who filed a claim and are in the claim process for more than a year are more likely to require four or more years of care. Nearly 16 percent of claims last more than five years. (Long Term Care Claim Experience Data for Genworth Life Insurance Company and Affiliates, Dec. 1974–Dec. 31, 2023.)

A. DEFINING LONG-TERM CARE INSURANCE

Long-term care insurance (LTCI) is insurance that protects against the possibly devastating costs of long-term care. LTCI helps pay for the cost of care in both private home settings and private facilities, preserving retirement assets, income streams, promoting greater choices in care, and minimizing the burden on family and friends. LTCI is defined and regulated by law by the Massachusetts Division of Insurance (DOI). 211 CMR 65.00.

B. QUALIFYING FOR BENEFITS

To qualify for benefits under an LTCI policy to help pay for care, the policyholder needs stand-by or hands-on assistance for at least two daily living skills, including bathing, dressing, toileting, continence, transferring and feeding oneself (from table to mouth). Older policies may only have five daily living skills identified, with bathing being excluded. Benefits can also be triggered when one requires substantial supervision due to a severe cognitive impairment. Many people may require some form of home care support prior to being eligible for benefits under their long-term care policy. While the bar appears high to qualify for long-term care insurance benefits, 50% of policyholders will use their LTCI insurance benefits with a 0-day elimination period, and 35% of insureds will qualify for their benefits with a 90-day elimination period. (American Association for Long-Term Care Insurance, November, 2024)

C. TRADITIONAL HEALTH INSURANCE DOES NOT COVER LONG-TERM CARE

Original Medicare, Medicare supplements, Medicare Advantage plans and ordinary health insurance generally do not cover long-term care expenses. As a result of this gap in coverage, the cost of long-term care is most often borne by the individual, who is forced to privately pay until they qualify for MassHealth (Massachusetts Medicaid) long-term care coverage in the community or in a nursing home. If an individual is receiving MassHealth benefits, under certain circumstances, a lien can be placed upon their home during life, and the home may be subject to an estate recovery claim at death. Due to the potentially devastating costs associated with long-term care and the strict asset requirements of MassHealth eligibility, many people seek LTCI to help pay for these costs and for home care to keep them home longer. Massachusetts provides an incentive to homeowners seeking LTCI with a law that provides an exemption for the home from estate recovery for certain traditional LTCI policies.

D. MASSACHUSETTS MASSHEALTH EXEMPTION

A significant benefit to a traditional LTCI policy (in contrast to a hybrid policy) is that Massachusetts law and MassHealth regulations allow for an exemption against a post-death claim by MassHealth for recovery of MassHealth benefits paid during the life of the policyholder, typically for nursing home care, but also other long-term care costs. (M.G.L. c. 118E, section 33.) This exception does not prevent a lien from being placed on the property, so if it is sold during the insured's lifetime, MassHealth will be entitled to recover any benefits paid from the proceeds of the sale. However, upon the death of the insured, the exemption will prevent MassHealth from recovering the benefits it paid when the home is inherited by the applicant's beneficiaries through the probate process. (Note: The LTCI exemption exempts collection of long-term care costs, but not everything. For instance, the exemption does not include ordinary medical bills, like hospitalizations, that may have been incurred by a person on MassHealth medical insurance.)

E. PROTECTION OF THE HOME

This exemption protects the primary residence (the "home"), provided that the LTCI policy meets certain minimum requirements at the time a claim is made for benefits under the policy:

1. Includes coverage for nursing home care for at least 730 days;
2. Pays at least \$125/day for nursing home care; and
3. Has an elimination period (deductible) of 365 days or less.

Note that the exemption will apply to a later nursing home stay even if the policyholder does not go into a nursing home when a claim is made and utilizes home care benefits under the policy beforehand. In order for the exemption to apply for nursing home care, there must be some small amount of benefits still on the policy prior to the date of admission to the nursing home.

The LTCI policy only protects the person insured and not their partner or spouse. However, a couple can obtain shared protection if a shared policy is obtained offering at least four years of benefits between the partners.

The cost of a LTCI policy that would meet this minimum is very small. For a 50-year-old couple of standard health, the cost would be less than \$100/month in total, regardless of gender. A 60-year-old couple's cost would be \$141/month. A 50-year-old male's cost would be \$37 a month, and a 60-year-old male's cost would be \$55 per month. A 50-year-old female's cost would be \$61 a month, and a 60-year-old female's cost would be \$91 per month. (National Guardian Life Insurance Co., October, 2024). Under regulations of the DOI, a notice must be attached to the first page of all LTCI policies in Massachusetts that says whether the policy is or is not intended to satisfy the Massachusetts LTCI exemption. 211 CMR 65.09.(1)(e).

F. HISTORY OF LONG-TERM CARE INSURANCE

Long-term care was first offered in the late 1970s, and the actuarial assumptions were, in part, based on life and disability statistics. Unfortunately, almost all the actuarial assumptions were incorrect and LTCI was grossly underpriced. This is not an uncommon phenomenon with new insurance products. Most people don't know that disability insurance went through the same growing pains as LTCI, with massive rate increases and most insurers leaving the market in the late 1980s. Today, the disability market has been stable for more than 20 years. LTCI is going through the same growing pains. Because the earlier policies were grossly underpriced, rate increases have been necessary to keep the insurance companies stable to be in a position where they can keep their promises and pay out claims. The longer companies held off in requesting rate increases and correcting for the premium deficiencies, the greater the deficits became, and the greater future rate increases required to maintain the ability for the company to pay future claims. Many of these old products will have to endure many phases of rate increases.

LTCI companies have corrected their actuarial assumptions and the industry has stabilized. Pricing has been stable for the traditional LTCI products issued in the last 12 years. (LIMRA 2024.) Some companies have had rate stability for even longer than that, and one has never had a rate increase on existing policyholders and guarantees their 10-pay premium. Hybrid LTCI products have guaranteed limited-pay premiums,

and a few products offer guaranteed lifetime premium payment options.

1. **Massachusetts Division of Insurance Actions:** The DOI, which regulates Massachusetts LTCI policies, has no legal basis to regulate out-of-state policies. However, the division has greatly limited rate increases on many older, underpriced products compared to most other states.
2. **Managing Older Policies with Rate Increases:** The older policies that were grossly underpriced are still of great value even with large rate increases. However, this may be of little comfort when the new premiums become unaffordable or the unknown of future rate increases impairs future estate planning. It is important for consumers to discuss rate increases or settlement options with a trusted advisor, LTCI specialist or attorney before making the decision to reduce benefits to avoid a premium increase. To reduce the premium cost, there may be options to reduce the daily/monthly benefit, inflation protection benefit duration, or increase the elimination period. Most often, it is best to keep the policy benefits originally purchased and pay the additional increases. However, if there is a need to reduce the benefits, it is not recommended to extend the elimination period. Typically, the difference in premium does not justify the additional out-of-pocket expense. Depending on age and health, it is recommended to reduce the daily/monthly benefit or the inflation protection. (Note: Some insurance companies have identified that reducing the inflation protection will likely reduce the percentage of future rate increases.) Decreasing from an unlimited policy to a limited benefit policy may also help reduce the extent of future rate increases. It is important to remember that long-term care is a U-shaped curve, and those policyholders who live past a year are more likely to require four or more years of care, so deciding to reduce duration of benefits based on long term care averages may not be prudent. Long-term care is expensive, and every tax-free dollar received from an LTCI policy provides consumers with more flexibility and care options as they age.
3. **Policy Lapse Notification:** It is important to make sure a policyholder has a person identified with the insurance company in case a payment is missed, or the policy becomes in danger of lapsing. Lapsing of policies may occur because of a changed address, changed bank account or a cognitive impairment. It is important to make sure not only that a third party has been identified, but also that the information for that third party stays up to date. A policyholder can identify more than one person with the company for this type of notification.
4. **Today's Long-Term Care Insurance Policies:** Newer policies are comprehensive, covering home care, adult day care programs, assisted living, nursing home and hospice. Almost all policies in Massachusetts include an alternative plan of care that allows the company to approve other services not identified in the contract that would be helpful and are cost-effective. Older policies may be limited to either home care only or nursing home only. Cash policies do not require invoices for claims to be paid. Cash benefits are deposited monthly into the insured account to be used by the insured without review.

Note that LTCI is underwritten, which means those applicants with chronic illnesses will have more limited options or be denied coverage from most LTCI companies. However, new products are coming on the market, including a traditional LTCI policy that offers simplified underwriting; and a guaranteed single-premium hybrid annuity product.

G. IMPORTANT FEATURES TO CONSIDER WITH LONG-TERM CARE INSURANCE

1. **Types of Care Covered:** While most of today's policies are comprehensive, older policies may be defined as "nursing home only" and will not cover care received at home or in an assisted living facility. There may be unique situations that allow for a "nursing home only" policy to pay for a secure memory unit in an assisted living setting. Others that are defined as "home care only policies" will not cover any facility settings or pay for home care to be provided in an assisted living or nursing home setting. The older policies that include both home care and nursing home coverage will typically include an assisted living setting based on the definition of the "nursing home" in the contract.

Home Care (HC): Care covered by LTCI may be identified as a Skilled Home Care Agency, Home Care Services, or home care services (the capitalization does make a difference). The distinction is critical prior to using services. Independent care providers need to be identified specifically in the policy to be a covered service. In Massachusetts, home care agencies are defined as employment agencies, and consequently, it is easy for an independent provider to become an agency and fulfil the agency definition. This gives additional flexibility to LTCI policies in Massachusetts that require agency caregivers.

2. **Benefit duration:**

Today's policies have pooled benefits: If less than the daily benefit is used, and benefits are pooled, then those unused, remaining benefits will extend the policy duration. As an example, if a policy has a \$200-a-day benefit and a three-year duration, the total value of benefits is \$219,000 ($\$200 \times 365 \times 3$). If less than \$200 a day is used, then benefits will last longer than three years (until the 219,000 is exhausted). If exactly \$200/day is used, then benefits will end at the three-year mark.

Older policies may have a fixed duration benefit: These policies identify a specific number of years of benefits regardless of the percentage of benefits utilized.

The minimum benefit duration to purchase in Massachusetts is two years, which is consistent with the Massachusetts MassHealth Exemption Law (see section D). Different companies offer different benefit duration. They may be two, three, four, five, six, eight or unlimited benefit durations.

Shared Benefits: Many policies offer shared benefits between partners. The way in which companies allow partners to share benefits is not the same. Some policies allow a couple to share the entire pool of benefits; either partner may use the full pool, leaving nothing to the other partner. This type of benefit-sharing provides the maximum protection to the healthy spouse, protecting the assets for their lifestyle with the intent that if the benefits are all used up, the estate can be spent down for the second spouse. Another option allows sharing but requires that one or two years of the pool be held for the healthy spouse. And still another option provides a pool for each partner and an additional pool of benefits that can be used by either spouse.

3. **Benefit Duration Factors to Consider:** Most people will need to “co-fund” their long-term care expenses. This means that if the cost of care is more than the daily/monthly LTCI benefit, the insured needs to supplement the difference out of their own pocket. This is an important concept, as longer benefit periods may be a waste of money if there are not adequate reserves to co-fund the cost of care for the full policy duration. In this case, it may be better to get a higher daily/monthly payout for fewer years. For those who have the financial resources to help pay for their own care, paying for benefits for six years or longer may be better, as longer care periods are more likely to help preserve assets, and these policies provide the greatest leveraging of premium, meaning more benefit for the cost.
4. **Inflation Protection:** Inflation benefits are purchased when the policy is issued. Inflation protection may be purchased as part of the level premium or purchased over time for an additional premium. Inflation benefits may be based on the CPI (consumer price index), or purchased with a fixed 3% or 5% simple inflation or anywhere from 1% to 5% compound inflation that may annually increase for a lifetime or for a limited period, for example, 10, 15 or 20 years. There are also inflation options that can be modified in future years priced at the newly attained age. For annually purchased benefits, it is recommended to identify if the future inflation option is impacted by age. For policies that increase by age, it is important to keep track of increasing premium, because as age increases, premiums can get out of control, and the cost vs. benefit needs to be watched.
5. **Elimination Period:** The elimination period (sometimes referred to as a “waiting period”) is the deductible period before claims are paid. It is the time that must elapse after a benefit-triggering event has happened and before coverage starts. The elimination period can be an expensive and frustrating period, although it typically will only need to be satisfied once. By law, the elimination period cannot be greater

than 365 days, and each day the insured receives any service would be applied against the elimination period. Individual policies cannot require that elimination periods be satisfied within a specified period of time or that days be consecutive.

Calendar-day elimination periods are a countdown of days from the day the policyholder meets the criteria for a claim. If it is a “reimbursement policy,” then the covered services must be received on day one to trigger the start of the elimination period countdown. In other words, the trigger to start the calendar-day countdown is the start date of covered services (as defined in the policy), whether that be at home, in adult day care, in an assisted living facility or in a nursing home.

On the other hand, if it is a “cash” policy, the elimination period qualification may start as soon as the definition of long-term care in the policy is met.

Service-day elimination periods are fulfilled by each day that a billed service is received and meets the definition of benefits paid by the policy. If the elimination period is 90 days, it would require 90 days of paid qualified services to fulfill the elimination period. If only three days a week of care was used, this would more than double the time before the policyholder would be eligible to receive benefits.

Some policies allow one qualified day of paid service during a week to satisfy one full week. In this instance, the elimination period could be satisfied sooner, with potentially less out-of-pocket expenses, than if a covered service was required to be received each day to satisfy the elimination period.

For most policies, rehabilitation days funded by Medicare will help satisfy the fulfillment of the elimination period IF these days are in a skilled nursing facility.

- 6. Elimination Period:** The elimination period or “EP” is one of the most misunderstood provisions in LTCI policies. Even if there is a 90-day EP, the claim process should be started immediately. A policyholder must be approved for benefits for any days to be counted toward the EP, and providers must also be covered under the policy. With some policies, caregiver training, respite care and equipment benefits may also be funded prior to the completion of the elimination period.

Waiver of the home care elimination period is a policy benefit that allows for services to start typically on day one or day 20 of receipt of qualifying care, when provided in the home. Some policies allow that this paid home care period counts against satisfaction of the facility elimination period as well.

For some LTCI policies, the waiver of the home care elimination period was built into the policy (rather than being an additional feature carrying additional cost), but the home care elimination period waiver may not fulfil the overall LTCI elimination period for facility services.

Hospice: Most policies require that the elimination period be fulfilled prior to receiving benefits for hospice services. However, a few carriers will fund hospice on day one of the claimant’s qualifying for benefits. (Note: If it is a life insurance based LTCI policy, in most states, the death benefit can be accelerated during this period.)

- 7. Medical Equipment:** Medical equipment is often covered by Medicare and may also be included in the benefits of an LTCI policy. Before any medical equipment is purchased, it is recommended to check to see if Medicare will cover it. If not, a claim should be filed under an LTCI policy. If the claim is approved, eligible expenses will qualify if purchased and approved after the initiation of the claim. Depending on the LTCI policy, payments under this benefit may be subtracted from the back end of policy benefits.

8. Options for Benefit Payments:

This provision defines how the daily or monthly benefit will be paid when the policyholder qualifies for benefits. Policies pay benefits in one of three ways:

- Reimbursement
- Indemnity
- Cash

Reimbursement policies are the most common and pay based on eligible expenses, up to a daily or monthly maximum. The key word here is “eligible,” and it requires the policyholder to fully understand the types of services the carrier will reimburse. For example, one carrier may pay for an independent aide while another will require that services be provided through a professional home care agency.

An indemnity policy pays the full daily benefit if one hour of service is required. Monthly indemnity policies typically pay based on the number of days in which services are utilized each month regardless of the actual expenses incurred.

Cash indemnity policies pay a monthly benefit regardless of services utilized or actual expenses.

H. NEW OPTIONS FOR LONG-TERM CARE

- 1. Hybrid LTCI Policies:** Traditional LTCI products are “use or it lose it,” meaning if the policy benefits are never used, the premiums paid are lost. Hybrid LTCI policies are LTCI products that leverage the benefits for long-term care, but are built on a life insurance or annuity platform so that a death benefit is also available. Hybrid LTCI products with a life insurance platform typically require less underwriting than traditional insurance, and hybrid LTCI products with an annuity platform require less than those with a life insurance platform. Originally, Hybrid LTCI products were more expensive than traditional LTCI policies, but with the rise in interest rates over the last few years, the cost of hybrid products has dropped and costs are much more competitive with traditional LTCI. In fact, for individuals, limited-pay hybrid LTCI may be more cost-beneficial than traditional LTCI. Hybrid policies are most competitive when paying over a reduced premium period of 20 years or less. Some hybrid policies only accept single premiums. An advantage of the hybrid is that several of these products provide cash benefits, guaranteed premiums and a death benefit. If a person can afford and wants to fund a product during their working years and be done paying prior to retirement, the hybrid is worth comparing since it may be about the same premium with all the added benefits of cash flexibility, and a death benefit. It needs to be restated, though-hybrid policies may NOT provide home protection under the Massachusetts MassHealth Exemption Law discussed above. However, buying a traditional LTCI product for home protection, together with a hybrid LTCI product for long-term care protection generally, may give the best overall protection.
- 2. Life Insurance with LTC Riders:** New LTCI policy options have become available in Massachusetts that provide a competitive LTCI option as an employee benefit, especially for younger employees and those with uninsurable conditions. Life insurance with an LTCI rider is a life insurance product that allows for acceleration of the death benefit for LTC expenses with an additional extension of benefits for LTC. There is no inflation benefit on this product. It is important to compare traditional and hybrid LTCI products when these benefits are offered at the employer site to make sure the most appropriate benefit is being obtained based on the individual situation. Again, these life insurance riders may NOT provide home protection under the Massachusetts MassHealth Exemption Law discussed above.
- 3. Other Alternative Products:** Because LTCI is an underwritten product, many will not be eligible for qualified LTCI products. However, there are alternatives that may be helpful in long-term care planning. A home care contract is available that is designed to help keep people in their own homes, and benefits become available as soon as any home care is required. (This can be used in conjunction with qualified LTCI policies to fund care before one may qualify for LTCI benefits.) Long-term care hours are purchased in bulk at a discounted rate. If one is still independent in all aspects of their personal and community care and still driving, regardless of diagnosis, they can be eligible to apply for this home care product. Annuities with long term care riders are another approach to funding long-term care without underwriting, as long as no care is required when purchased. (Note: LTC riders on annuities do not always cover home care, and most do not identify cognitive impairment as a trigger.) Depending on the state, if a policyholder has a second home, there may be a qualified LTCI annuity that is a guaranteed-issue, single-premium product, and is worth investigating.

I. MISCELLANEOUS LTCI ISSUES

1. International Benefits:

There is limited access to international benefits on most traditional LTCI policies. However, there are several hybrids that offer international benefits, and they all differ on how they are implemented and have access to the total pool of money. If considering living outside the United States, you should discuss this with an LTCI your agent prior to purchasing a policy.

For individuals who do not itemize deductions, no income tax deduction is available for LTCI.

2. IRS does not treat LTCI benefits as income:

Benefits received from an LTCI policy for reimbursement for care is not included in income [IRC Section 104(a)(3), 7702B (a)(2)], but if the contract provides for a per-diem reimbursement, the exclusion is limited to \$410 per diem for 2024, unless the policyholder can prove eligible long-term care expenses greater than that amount. Insureds will receive a 1099-LTC from the insurance company that appears to be income. The companion form 8853 offsets the income and should be filed with their tax return.

3. LTCI payments are not deemed income when applying for community MassHealth benefits:

In a MassHealth Fair Hearing decision from 2020, a hearing officer concluded that MassHealth's position that LTCI benefits constituted countable income in determining eligibility for community benefits under the FEW (Frail Elder Waiver) was incorrect. The decision was not appealed by MassHealth and stands for the proposition that benefits paid from an LTCI policy that constitute repayment for incurred medical expenses are not countable income for FEW eligibility purposes. However, it is important to note that past rulings may be a model for future cases, but do not guarantee the same decision.

Under IRC Section 7702B (a)(I), LTCI is treated as an accident and health insurance benefit. For those who itemize deductions, premiums may be deductible.

4. LTCI Deductions.

For individuals who do not itemize deductions, no income tax deduction is available for LTCI. For individuals who do itemize, there are deductions available.

For 2025, individuals who are self-employed, those who receive a 1099, or employees using a Health Savings Account (HSA) may deduct LTCI premiums paid up to \$5,880 against federal income taxes. Deductions for qualified LTCI policies are age-based, ages 71 and older — \$5,880, ages 61 to 70 — \$4,770, ages 51 to 60 — \$1,790, ages 41 to 50 — \$890 and ages 40 and under — \$480. For individuals who do not have 1099 income or an HSA account, the LTCI premium can be added to their other deductible medical expenses and count as a medical expense deduction if the total exceeds 7.5% of their adjusted gross income. Benefits are tax-free even if the premium is taken as a tax deduction. (American Association for Long-Term Care Insurance, November, 2024.)

Under regulations of the DOI, a notice must be attached to the first page of all LTCI policies in Massachusetts that say whether the policy is or is not intended to be a federally qualified long-term care insurance contract under the IRS regulations. 211 CMR 65.09.(1)(e).

Business owners may take 100% of the premium as a tax deduction for policies purchased for their employees and spouses and benefits remain tax-free, which is the same treatment for health insurance. Employers may also pay the premium on specific classes of employees vs. all employees. Known as executive carve-out, and classes may be defined as a specific salary range, tenure or job title. A class cannot be defined by age or sex. Plans purchased at work are fully portable. Self-employed business owners (sole proprietors, partnerships, LLCs, S-Corps) are allowed an age-based, first-dollar tax deduction for themselves, spouses and dependents, whereas so-called C-Corporation owners may deduct 100% of premium, including limited pay plans, for themselves, spouses and dependents. Consult with a tax advisor for more information.

J. WHEN TO PURCHASE LONG-TERM CARE INSURANCE

Purchasing LTCI has less to do with age and more to do with a person's financial situation and should be discussed with a financial advisor. Most people will benefit from some form of LTCI either to leverage their assets, create a pool of care funds outside of managed assets, or to take advantage of additional state protections. When a person can determine that their present financial path of income, expenses and savings will make them self-sufficient in retirement, it is time to consider LTCI. Purchasing LTCI while one is healthier provides more options at lower cost. The biggest risk of waiting is becoming uninsurable; the second biggest risk is the increasing cost with older ages.

If finances are tight, unless home protection under the Massachusetts MassHealth Exemption Law (see above) alone is important, then LTCI is not recommended. For very wealthy individuals, who do not care about leveraging assets or leaving anything behind to family or charity, it may make sense to self-insure. For those who must consider LTCI in the context of many competing expenses (saving for retirement, college expenses etc.), it may make sense to purchase policies with future purchase options so that health is protected and, when finances are more liquid, additional benefits can be purchased without additional underwriting. However, the additional benefits will be priced at attained age and can eventually render the policy more expensive than including inflation at purchase. That said, it often makes sense to purchase LTCI at least by the 50s as premiums are more reasonable and health is less likely to change.

While there are traditional policies that can be purchased as young as 18 years old, greater options become available at age 30.

Providing an LTCI plan for an adult child is a way of protecting an adult child's ability to have quality options and care as they age. Using gift exclusions, limited-premium LTCI policies can be purchased and paid up in full as part of the estate plan. For example, a 30-year-old male paying \$10,000 annually for 10 years into a hybrid policy would have over \$2.2 million in a cash LTCI benefit by age 80 years old and, if never used, a tax-free death benefit to his heirs. (Nationwide quote software 10-24.)

Noncancelable: LTCI policies cannot be cancelled unless premiums are not paid, however, most traditional policies do have the flexibility to raise rates on existing policyholders as approved by the state in which the policy was purchased. There are now many options for guaranteed-premium products.

K. MAKING A CLAIM UNDER LONG-TERM CARE INSURANCE

When an insured is ready to submit a claim to their insurer, the individual or their power of attorney must call the insurance company to initiate the claim. A family member or representative can only handle a claim if they have a valid power of attorney in place. The insurance company will then send claim forms for the policyholder and caregivers to complete. They will also request medical records from a primary care physician, and if additional information is required, they may request documents from any other specialty medical providers. An on-site assessment may also be required in the home or facility. When a call is made to initiate a claim, the claims specialist should provide a summary of benefits. It is always good to confirm benefits at the time of the claim and get clarification on any questions.

The claims forms should be totally and accurately completed. It is also a good idea to get a copy of medical records to make sure that medical and care needs are well documented. Medical records are often inaccurate or lacking critical information, complicating the claims department's decision-making process. Claims can be denied due to inaccurate or incomplete medical records. Processing times for claims typically take 30 days from the receipt of the last piece of information. This means the overall process can take up to several months if information is not received in a timely manner. An appeal can add another 60 days or more. It is important to make sure claims documentation is accurate with the first claim form.

If the LTCI agent is still accessible, it may be appropriate to reach out to that agent for assistance with filing the claim. There are specialists who can be hired to help individuals through the claims process. A policyholder or representative should be proactive in following up on the claim during the decision process to verify that all documentation has been received and there is no outstanding documentation that can hold up claims. Most companies have websites in which documentation can be uploaded directly to their site.

This is the most effective way to work with a claims department. If there is a choice of email or fax, email is typically best. If fax is necessary, a call should be made 24 to 48 hours after the fax has been submitted to ensure that it has been received. While claims typically take about 30 days, they can be approved in as fast as two weeks when documentation received is clear, consistent and complete. Some companies have limited paper documentation and rely on home assessments. If the insured has better and worse times of day, it is best to schedule these assessments during the “worst” performing part of the day. It may also be wise to have a care manager present during home assessments, to help the evaluating nurse from the LTCI company document the most accurate information regarding the insured’s functional abilities.

L. CLAIM DENIALS

If a claim is denied by the LTCI company, the policyholder or their legal representative should immediately reach out to an attorney or a long-term care expert specializing in insurance claims.

CHAPTER 18

HOMESTEADS AND LIFE ESTATES

INTRODUCTION

For most Americans, their home is their largest single asset. As we age, we become increasingly concerned about how its value can be protected and passed on to future generations. Homeowners need to educate themselves about how to protect their homes from creditors (by placing a homestead declaration on the home), how to reduce property taxes, how to borrow prudently on equity that has built up during their lifetimes, and how to efficiently transfer property to family and loved ones. Consulting with a knowledgeable elder law attorney is critical to determine appropriate planning steps.

A. HOMESTEAD DECLARATION DEFINITION

1. A homestead declaration is a document recorded with the Registry of Deeds that protects equity in one's principal residence against attachment, seizure, execution on judgment, levy or sale for the payment of debts from certain creditors and their claims that arise after the filing of the homestead. Protections automatically extend from the homeowner to any non-title spouse.
2. Massachusetts revised its homestead laws in 2011, 2022 and again in 2024 to provide homeowners with added protection against creditors. The 2022 amendment to the homestead laws clarified the 2011 law, expanded the class of individuals who could benefit from a homestead declaration, and expanded the ways in which a homestead could be terminated. The law provides homeowners with an automatic \$125,000 homestead exemption. Homeowners may record a declared homestead exemption to extend the exemption amount to \$1,000,000 per residence, per family under the 2024 revisions to the law. This protection extends to the homeowner's spouse and family. Further, multi-family homes and homes in trust are eligible for homestead protection so long as they are maintained as a primary residence for the filer.
3. Homesteads filed prior to March 2011 are grandfathered into the law and, therefore, homeowners do not have to refile. Caveat: A homestead filed prior to March 2011 may not be grandfathered if a mortgage (or equity line of credit) was subsequently filed before March 2011. If that is the case, it would be wise to file a new homestead now.
4. Homeowners do not have to refile homesteads when a home is refinanced (after March 2011), which had long been an issue with Massachusetts residents.
5. In 2024, Massachusetts passed Chapter 150 of the Acts of 2024, updating the homestead protection law. The law provides protection for real property or manufactured homes used as a primary residence from seizure or sale to pay debts. For individuals 62 or older or disabled, it offers protection of up to \$1,000,000 per person. If two owners qualify, the protection can increase to \$2,000,000. Attached to this chapter is the form used for natural persons.
6. In the homestead declaration for trust property, the trustee must specify each trust beneficiary who occupies or plans to occupy the property as their principal residence. The spouses of those beneficiaries must also be identified, with each indicating whether they currently occupy or intend to occupy the premises as their primary residence. Attached to this chapter is the form used for homes owned by trustee(s).

B. CLAIMS NOT PROTECTED

1. Federal, state and local taxes, assessments, claims and liens;
2. Liens on the home recorded prior to the filing of the declaration of homestead;
3. First and second mortgages;
4. A court order that the homeowner pay support to a former spouse or minor children; or

5. A Medicaid (MassHealth) lien if the owner requires nursing home care.

C. OTHER CONSIDERATIONS

1. If an individual recorded a homestead declaration before attaining age 62, the individual must file a new declaration to gain added protections for older homeowners.
2. Individuals who gift the remainder interest in the property to one or more individuals and reserve a life estate may lose the homestead protection over the entire property. To be safe, the life estate holder should record a new homestead with respect to the life estate.
3. A remainderman may record a declaration of homestead if they use the property as their primary residence.
4. When transferring a home to or from a trust, a new homestead declaration does not have to be recorded. See M.G.L. c. 188 § 10 (a)(1) — which states: a deed to a trustee or a trust for the benefit of a grantor shall not terminate the grantor's existing homestead.

D. DEED WITH A LIFE ESTATE

1. An individual may give a future interest in a home to another person by deed, while at the same time reserving the exclusive right to live in the home for life. This transfer is accomplished by executing and recording a deed transferring the remainder interest in the property to another while reserving a life estate. The individual retaining the right to live in the property is the “life tenant,” and the person receiving the future interest in the property is the “remainderman.” In some situations, individuals will give their children or other relatives the remainder interest in their homes.
2. The life tenant has the sole right to live in and operate the property. If the life tenant rents the property, the life tenant has the right to any income generated from the property. The life tenant has the duty to maintain the property.
3. Upon the death of the life tenant, the life estate terminates and the remainderman will then own the property in its entirety, avoiding probate.
4. If a property is owned in this format, then the property cannot be sold or mortgaged without the consent of both the life tenant and the remainderman. The life tenant may still be eligible for a reverse mortgage, provided that the remainderman consents.
5. If the property is sold during the life tenant's life, the life tenant will not receive the full sales proceeds since they do not entirely own the property. The life tenant will receive a portion of the sales proceeds (the actuarial value of the life estate), and the remainderman will receive the balance. See Example 1 below as to how the life estate is calculated:

EXAMPLE 1
HOW TO CALCULATE THE LIFE ESTATE & REMAINDER INTEREST

Under the current IRS interest rates (MassHealth now accepts this method of calculating value) https://www.law.cornell.edu/uscode/text/26/7520	
Mother's age:	97
Date of Birth:	May 18, 1926
Amount of sale:	\$470,000
Purchased in 2003 for:	\$300,000
Approximate work on condo:	\$10,000
Capital gains:	\$170,000
Mom's life estate value:	0.11280
Mom's share of capital gains:	\$19,176
Three children (percentage):	0.88720
Children's capital gains:	\$150,824

Each child will have roughly \$50,000 in capital gains, which breaks down as \$7,500 in federal tax and \$2,500 in Massachusetts tax.

6. The remainderman may be subject to and have to pay capital gains taxes when the property is sold if they do not qualify for the IRC Sec. 121 capital gains tax exclusion by not using the property as their primary residence. If the property is sold after the life tenant's death, the value of the entire property is included in the life tenant's gross estate, and the remainderman would benefit from a stepped up in cost basis in the property for capital gains tax purposes.
7. Under current MassHealth (the term used for Medicaid in Massachusetts) law, certain individuals who receive MassHealth benefits will have a lien placed on any property in which they have an ownership interest, including a life estate. If a MassHealth recipient owns a life estate in a property that has a lien and the property is sold during the life tenant's life, then MassHealth can collect on the lien from the proceeds of the sale that are attributable to the life estate's actuarial value, but not the remainderman's actuarial value. If the property is sold after the life tenant's death, MassHealth cannot enforce the lien because, under current law, that life estate is extinguished upon the death of the life tenant.
8. A transfer of a remainder interest is a disqualifying transfer under MassHealth regulations and creates a "five-year look-back period" on that transfer. If the transferor applies for MassHealth benefits within five years after making the transfer, then the transferor would be subject to a disqualification period for MassHealth benefits. The disqualification period is a period of time for which an applicant for MassHealth benefits would be ineligible for those benefits as determined by a formula that MassHealth utilizes. (See the section on Transfer Rules in Chapter 9.)
9. A transfer of a remainder interest is a taxable gift that needs to be reported on a federal gift tax return.
10. The remainderman's interest in the property is subject to their creditors, including a divorce judgment, and the future sale of the property may be further complicated if the remainderman predeceases the life tenant.

EXAMPLE 2

Larry retains a life estate and gifts the remainder interest in his home to his son, Robert. Larry needs to file a gift tax return reporting the gift of the remainder interest. Later, Larry decides he wants to sell his home to a third party. Not only does Larry need Robert to agree to sell the home, since Larry does not have full ownership of the property (he only has a life estate), Larry will only receive the actuarial value of his life estate and Robert would receive the balance of the sales proceeds. Larry can use his Section 121 capital gains tax exemption on his portion of the sales proceeds presuming he used the property as his primary residence two out of the last five years, but Robert, presuming he did not use the property as his primary residence two out of the last five years, would have to pay capital gains taxes on his portion of the amount realized less his portion of the property's cost basis.

The Commonwealth of Massachusetts

William Francis Galvin, Secretary of the Commonwealth

Declaration of Homestead for Homes Owned

by Natural Persons *(General Laws Chapter 188)*

In situations where the home is owned by multiple owners, each owner may be best served to complete a separate declaration of homestead.

1. I, _____,
(insert name of owner)

We, _____,
(insert name of owners)

_____ ,
_____ ,
hereby declare homestead pursuant to M.G.L. c.188 and state that I/we own the home described below and occupy or intend to occupy the home as my/our principal residence.

Owner Information

2. Check all that apply:

I/we, _____ am elderly (62 years of age or
(insert name (s))

I/we, _____
(insert name (s))

am/are disabled (have a physical or mental impairment that meets the disability requirements for Supplemental Security Income under 42 U.S.C. 1382c(a)(3)(A) and 42 U.S.C. 1382c(a)(3)(C). One of the following must be attached: 1) an original or certified copy of a disability award letter issued to the person by the United States Social Security Administration, or 2) a letter signed by a physician registered with the board of registration in medicine certifying that each person meets the disability requirements set forth in 42 U.S.C. 1382c(a)(3)(A) and 42 U.S.C. 1382c(a)(3)(C).

I am married to _____ who is not a co-owner of the home but who occupies or intends to occupy the home as his/her principal residence.

I/we, _____
(insert name (s))

am/are servicemember(s) who may be subject to protection under the servicemember(s) Civil Relief Act, 50 U.S.C. App 533, and I/we be called to active duty.

Home Information

3. Address: _____, Massach
(street number and name, city/town)

4. Select **ONE** of the following:

Deed is recorded in _____ Registry of Deeds in _____ and _____
(district/county) (book) (page)

Certificate of Title _____ registered in the Land Registration Office _____
(number) (document #)

Inheritance from _____, Docket number _____
(name of previous owner)
_____ in _____
(number) (county)

For manufactured homes, license number _____
(number)

5. I/we, whose names are signed on this document, acknowledge that I/we sign it voluntarily for its stated purpose.

To be signed by Applicant(s) in front of Notary Public.

Signed under pains and penalties of perjury this

_____ day of _____, 20_____.

For Use by Notary Public Only:

COMMONWEALTH OF MASSACHUSETTS

_____, ss.

_____, 20 _____, before me, the undersigned notary public, personally appeared

_____,
(name(s) of the document signer(s))

proved to me through satisfactory evidence of identification, which were _____,
(drivers license, passport, etc.)

to be the person(s) who signed the preceding or attached document in my presence, and who swore or affirmed to me that the contents of the document are truthful and accurate to the best of (his) (her) (their) knowledge and belief.

Notary Public: _____

My commission expires: _____

The Commonwealth of Massachusetts

William Francis Galvin, Secretary of the Commonwealth

Declaration of Homestead for Homes Owned by Trustee(s) (General Laws Chapter 188)

1. I, _____, Trustee
(insert name of owner)

We, _____,
(insert name of owners)

_____, Trustees
of certain trust _____
(trust name)

dated _____ and recorded _____ and _____
(date) (book) (page)

hereby declare homestead pursuant to M.G.L. c.188 and state that I/we own the home described below and which the beneficiaries listed herein occupy or intend to occupy as his/her/their principal residence:

Beneficiary Information

2. Enter beneficiary name(s): _____
(insert beneficiary name(s))

3. Check all that apply and enter beneficiary name(s):

_____ is/are elderly (62 years of age or over)
(insert beneficiary name(s))

(insert beneficiary name(s))

is/are disabled (have a physical or mental impairment that meets the disability requirements for Supplemental Security Income under 42 U.S.C. 1382c(a)(3)(A) and 42 U.S.C. 1382c(a)(3)(C). One of the following must be attached: 1) an original or certified copy of a disability award letter issued to the person by the United States Social Security Administration, or 2) a letter signed by a physician registered with the board of registration in medicine certifying that each person meets the disability requirements set forth in 42 U.S.C. 1382c(a)(3)(A) and 42 U.S.C. 1382c(a)(3)(C).

I/we, _____
(insert name (s))

am/are servicemember(s) who may be subject to protection under the servicemember(s) Civil Relief Act, 50 U.S.C. App 533, should I/we be called to active duty.

4. For each applicable beneficiary, complete one statement. Attach additional page(s) as necessary.

_____ is married to _____
who is not a co-owner of the home but who occupies or intends to occupy the home as his/her principal residence.

_____ is married to _____
who is not a co-owner of the home but who occupies or intends to occupy the home as his/her principal residence.

Home Information

5. Address: _____, Massachusetts
(street number and name, city/town)

6. Select **ONE** of the following:

- Deed is recorded in _____ Registry of Deeds in _____ and _____
(district/county) *(book)* *(page)*
- Certificate of Title _____ registered in the Land Registration Office _____
(number) *(document #)*
- Inheritance from _____, Docket number _____
(name of previous owner)
_____ in _____
(number) *(county)*
- For manufactured homes, license number _____
(number)

7. I/we, the trustee(s) whose name(s) are signed on this document, acknowledge that I/we sign it voluntarily for its stated purpose.

To be signed by Applicant(s) in front of Notary Public.

Signed under pains and penalties of perjury this

_____ day of _____, 20_____.

For Use by Notary Public Only:

COMMONWEALTH OF MASSACHUSETTS

_____, ss.

_____, 20 _____, before me, the undersigned notary public, personally appeared

_____,
(name(s) of the document signer(s))

proved to me through satisfactory evidence of identification, which were _____,
(drivers license, passport, etc.)

to be the person(s) who signed the preceding or attached document in my presence, and who swore or affirmed to me that the contents of the document are truthful and accurate to the best of (his) (her) (their) knowledge and belief.

Notary Public: _____

My commission expires: _____

CHAPTER 19

TAX ABATEMENTS

A. OVERVIEW OF EXEMPTIONS AND DEFERRALS

1. Each property tax exemption, deferral and credit has eligibility requirements that may include age, asset or income limitations. The applicant must be a resident of Massachusetts. Most exemptions require that the resident occupy their home for a minimum number of years (usually five or 10 years). An applicant may either own their home individually, or co-own the home with another person. Even a trust beneficiary can obtain the exemption if the beneficiary has a sufficient beneficial interest in the house held in trust, and the beneficiary is a trustee. Each exemption should be read carefully to determine its specific eligibility requirements.
2. Homeowners must file an application for an exemption or deferral at their local Board of Assessors' Office on or before April 1 of the year to which the tax relates, or three months after the tax bill is mailed, whichever is later. Applicants must pay their property taxes while their application is pending.
3. Approved applications will result in a reduced real estate tax bill to the taxpayer/applicant. Since an individual typically can qualify for only one exemption each year, it is important to review all exemptions annually in order to select the exemption that will result in the greatest tax reduction. If one is still having trouble paying their property taxes, they may receive additional relief through a hardship exemption, the Elderly and Disabled Taxation Fund, the Senior Work-Off Program or the Senior Circuit Breaker Tax Credit.

EXAMPLE 1

Mary lives in a two-family home. Mary occupies the first floor, and her son occupies the second floor. If she otherwise qualifies for a tax exemption of \$1,000, her tax reduction would be \$500 because Mary occupies 50% of the property.

B. EXEMPTIONS

Exemption discharges a taxpayer from the legal obligation to pay all or part of the tax, and examples can be found in the various clauses of Mass. G.L. ch. 59, § 5. Since an individual can only apply for one exemption, and the exemptions vary from town to town, applicants should contact their local tax authorities for particular details on programs.

1. Elderly Persons

The standard Elderly Persons exemption provides \$500 (or \$1,000 in some communities) for homeowners who are at least 70 years of age or 65 years of age in some communities. The applicant must have owned and occupied the property or other real property in the commonwealth as their primary residence for at least five years (or be a surviving spouse who inherits such real property and has occupied such real property in the commonwealth for five years and who otherwise qualified under this clause), the applicant's ownership interest must be at least \$4,000, and the applicant must have lived in Massachusetts for 10 years preceding the application. The Elderly Persons exemption is only granted to one person for the same parcel of property. If two older individuals own the property jointly, the exemption amount will only benefit one owner.

An applicant must also meet income and asset limitations to be eligible for this exemption. The standard exemption is available to single applicants who earn less than \$13,000 per year and have assets less than \$28,000. A married applicant cannot earn more than \$15,000 per year and cannot own assets that exceed \$30,000. The income limitations do not include Social Security benefits, and the asset limitations do not include the value of the home. As with other exemptions, the value of the applicant's cemetery plots,

registered vehicles, clothing and household furniture is also excluded when calculating the applicant's assets.

Cities and towns may adopt more liberal restrictions, and therefore, older adults should contact their local assessor to see if they qualify under the town's Elderly Persons exemption. For example, a city or town could increase the income limitations in the preceding paragraph from \$13,000 to not more than \$20,000 and from \$15,000 to not more than \$30,000; and could similarly increase the asset limitation from \$28,000 to not more than \$40,000 and from \$30,000 to not more than \$55,000 in accordance with Clause 41C of the General Laws of Massachusetts.

Applicants who do not qualify for this exemption because they exceed the income restriction should apply for the Older Citizens exemption, as there is no income restriction for that particular exemption.

2. Veterans

The Veterans exemption is available to certain veterans, as well as their spouses, surviving spouses and/or surviving parents. Although the residency requirement may vary from town to town, applicants seeking this exemption must have been a Massachusetts resident for at least six months prior to entering the service, or the veteran must have lived in Massachusetts for at least two years prior to filing for this exemption.

Disabled veterans, honored veterans, and their spouses or parents are eligible for one of several real estate tax exemptions. Exemption amounts vary depending on the severity of the veteran's disability or their medal awarded. A list of available veteran exemptions relating to real estate includes:

- \$400 to veterans who received at least a 10% disability rating from wartime service, veterans who have been awarded the Purple Heart, and mothers and fathers of veterans who have been awarded the Gold Star;
- \$750 to veterans who suffered the loss of one foot, one hand or one eye; veterans who received the Congressional Medal of Honor, Navy Cross or Air Force Cross; or who was a prisoner of war and their spouses or surviving spouses;
- \$1,000 to veterans who suffered total disability in the line of duty and are incapable of working, and their spouses or surviving spouses;
- \$1,250 to veterans who suffered in the line of duty the loss of use of both feet, both hands or both eyes, and their spouses or surviving spouses;
- \$1,500 to veterans who suffered total disability in the line of duty and to veterans who received assistance in acquiring "specially adapted housing," as well as their spouses or surviving spouses;
- A full exemption is available to surviving spouses of soldiers, sailors and guardsmen whose proximate cause of death was an injury or illness suffered during active duty or who are missing in action and presumed dead;
- A full exemption is available to surviving parents or guardians of soldiers, sailors and guardsmen whose proximate cause of death was an injury or illness suffered during active duty or who are missing in action and presumed dead, subject to approval by the legislative body of the municipality; and
- A full exemption is available to paraplegic veterans and veterans who are 100% disabled due to service-connected blindness and their surviving spouses.

There are no income or asset restrictions for the qualified Veterans exemption, but the applicant must occupy the property as their primary residence. Applicants who co-own the property must have an ownership interest in the property valued at \$2,000 to \$10,000, depending on the exemption. If the property is greater than a single-family home, the exemption amount is calculated and is prorated based on the value of the property that is occupied by the applicant.

A motor vehicle of a disabled veteran operated for personal use is exempt from automobile excise taxes. In addition, a motor vehicle of a veteran or their surviving spouse is exempt from automobile excise taxes if the veteran was a prisoner of war and the city or town allows this exemption provision.

The HERO Act recently expanded property tax exemptions for veterans in Massachusetts by allowing municipalities to double property tax exemptions with local options, and ties the annual property tax abatement amount to inflation, allowing exempted property tax amounts to increase with inflation.

3. Blind

The property tax exemption for the blind is either \$437.50 or \$500, depending on the city or town's discretion. An individual applying for this exemption will need to provide proof that they are legally blind. Most assessors will accept a certificate showing that the applicant is registered as legally blind with the Massachusetts Commission for the Blind or a letter from the applicant's physician stating that the applicant is legally blind.

While there are no income or asset restrictions, the blind applicant must own and occupy the property as their primary residence. Applicants who co-own the property must have an ownership interest worth at least \$5,000 in order to satisfy the requirement of this exemption. There is no apportionment of this exemption if the blind person co-owns the property (owns as a joint tenant or tenant in common, for example). A co-owning blind person will receive the entire exemption.

EXAMPLE 2

Sally and her sister are both legally blind, registered with the Massachusetts Commission for the Blind, and are joint owners of the property. Even though both women qualify for the exemption, the first person to apply for the exemption will receive the abatement because only one exemption is granted on the same parcel of land.

4. Older Citizens, Surviving Spouses and Minors

This exemption provides relief to three categories of persons: 1) widows and widowers; 2) minor children with one parent deceased; and 3) persons 70 years of age and older. The state statute compels cities and towns to provide a \$175 property tax exemption to applicants meeting the eligibility requirements. Some cities and towns, however, have voluntarily adopted a higher exemption amount.

There are no income limitations for these exemptions. As a result, this exemption is a good alternative for older adults who do not qualify under the Elderly Persons exemption. A surviving spouse or a minor with a deceased parent does not have to own and occupy the property for any period of time to receive this exemption. On the other hand, an older adult applying for this exemption must have owned and occupied the property as their primary residence for at least five or 10 years, depending on the town's discretion.

The dollar amounts in the original eligibility requirements under this exemption established by the commonwealth have become somewhat outdated with increasing property values. The commonwealth, therefore, now gives cities and towns the option of electing from several alternatives that vary in asset limitations and residency requirements. For example, under the original standard exemption, an individual cannot exceed \$20,000 in total assets, excluding any unpaid mortgage on the property.

Conversely, under the most flexible alternative within this exemption, cities and towns can vote to increase the asset limitation up to \$40,000, excluding the total value of the subject property.

EXAMPLE 3

Ethel is 70 years old and has lived in her home for the past seven years. Ethel has \$30,000 in the bank and a home valued at \$200,000 with an outstanding mortgage of \$170,000. Ethel would not qualify for this exemption if she lives in a town that adopted the standard exemption because she exceeds the asset limitation (\$30,000 cash + \$30,000 in equity) and she does not meet the residency requirement of 10 years. Ethel does, however, qualify for the exemption if she lives in a town that adopted the least restrictive alternative because she does not exceed the asset limitation and she does meet the residency requirement of five years.

Practice note: Check with the local assessor to determine which clause the city or town has adopted. Also check if the exemption amount is \$175 or if the city or town adopted a higher exemption amount. An applicant's personal belongings, household furniture, car and prepaid funeral expenses are not counted in determining the applicant's maximum total asset value amount.

EXAMPLE 4

George is 70 years old and has lived in his home for the past 10 years. In addition to \$13,000 in the bank, George owns a car worth \$15,000 and has household furniture valued at \$20,000. George also prepaid his funeral expenses. George would qualify for all clause 17 exemptions and would receive a reduction of taxes on his home of \$175.

5. Hardship

Individuals who do not qualify for any of the above exemptions may apply for a hardship exemption. A hardship exemption can be obtained by individuals who also received one of the above exemptions. This exemption grants relief to a homeowner in their tax bill due to medical hardship, financial hardship, or extenuating circumstances and expenses.

There are no express restrictions, and eligibility is determined on a case-by-case basis. This exemption is typically available to individuals who are unable to fulfill their tax obligation because of age, infirmity, poverty or financial hardship resulting from a change to active military status.

C. DEFERRING TAXES

1. The Elderly Tax Deferral, available under Mass. G.L. ch. 59, § 5,(41)(A), allows an older homeowner to defer payment on their property taxes. In contrast to tax exemptions, deferred taxes must eventually be paid. Under the deferral, all or part of the property taxes due on the property are deferred until the deferred tax amount reaches 50% of the then-assessed property value. A single older homeowner must be at least 65 years old to be eligible for the deferral. An older adult may own the property jointly or as a tenant in common. For older adults owning property jointly with a spouse, at least one spouse must be 65 years or older.
 - a. A qualified applicant must enter into a written tax deferral and recovery agreement with the city or town. This agreement is recorded at the Registry of Deeds. During the deferral period, the deferred tax amount incurs a maximum 8% interest annually, although the statute permits cities and towns to elect a lower interest rate. Some towns have elected an interest rate of zero. Deferred taxes must be repaid within six months after the death of the older homeowner or sale of the property. If the property is sold or the older homeowner is deceased and the taxes are not repaid, the tax deferral becomes a lien on the property.
 - b. The applicant must have owned and occupied any real property in Massachusetts (including the current property) for five years and must have been a resident of Massachusetts for the previous 10 years. While there are no asset limitations, the older adult's income may not exceed \$20,000 per year. Cities and towns may adopt higher income limitations. The deferral can be used in conjunction with one of the available real estate tax exemptions, as long as the applicants meet eligibility requirements for both.

EXAMPLE 5

Frankie has a yearly real estate tax bill of \$1,200 on his home. He is 73 years old and receives a \$500 reduction in his real estate tax under the Elderly Persons exemption. Frankie's remaining tax amount due of \$700 can be deferred.

D. OTHER TAX EXEMPTIONS AND CREDITS FOR OLDER ADULTS

1. Elderly and Disabled Tax Fund (Mass. G.L. ch. 60, §3D)

Pursuant to Mass. G.L. ch. 60, § 3D, the commonwealth authorized cities and towns to create an Elderly and Disabled Taxation Fund “... for the purpose of defraying the real estate taxes of elderly and disabled persons of low income.”

Each city or town may adopt the program. If adopted, the community will establish a five-person Taxation Aid Committee, which identifies the recipients of the aid and determines how much of their tax bills will be defrayed. The community’s taxpayers may donate any amount to the fund through their tax bills. Donated funds are deposited into a special account until administered by the committee.

An individual meeting the eligibility criteria must submit an application to the Taxation Aid Committee. The applicant must be elderly or disabled in accordance with their community’s eligibility guidelines. Since the statute does not provide specific standards to define elderly or disabled, the committee has some flexibility in administering the funds.

Whether elderly or disabled, the applicant must have some degree of financial hardship, and must disclose their financial information on the application. Certain communities consider other factors, such as marital status, employment status, work qualifications, public assistance received by the applicant or the value of the applicant’s home. Each community may establish its own unique standards to better meet its local needs.

Communities will frequently award aid to all qualified applicants because few residents apply for aid. This high acceptance rate is ordinarily due to a lack of knowledge of the program. Because an individual’s entire property tax burden can be covered by the tax fund, it is essential for potential applicants who meet the minimum qualifications to be made aware of the program and submit an application.

2. Senior Work-Off Abatement (Mass. G.L. ch. 59, § 5K)

The Senior Work-Off Abatement program enables tax-paying older adults to volunteer their services to the community in exchange for a reduction in their property tax bill.

An eligible older adult may save up to \$2,000 on their taxes, depending on the community’s election. The older adult will work at an hourly rate that may not exceed the state minimum wage; in exchange for such work, the city or town will issue a voucher to the older adult that will be applied against their property tax bill. By applying these vouchers, the older adults are not earning income, and therefore, the voucher is tax-free.

The state statute provides that the taxpayer must be more than 60 years of age and own property within the community. The applicant may be a trustee if the property is owned by a trust. More than one qualifying owner may earn the abatement on the same property, unless local provisions express otherwise. Older adults may earn the work-off abatement on top of any other exemptions and credits that may be available under any other statutes. Older adults may work in schools, libraries, senior centers, or other public departments and offices in the community.

Not every applicant is guaranteed work through the program. Generally, older adults must demonstrate a financial hardship in order to receive jobs with the community, and the hours an older adult may work are limited since they can only earn up to \$2,000 per year. In most towns, there is no automatic reenrollment, and as a result, interested workers need to apply each year.

The program has been well received in the communities that have adopted the senior work-off, because it: (a) decreases property taxes for the working older adult; (b) increases the involvement of older adults in local government; and (c) gives communities a skilled pool of potential older employees.

3. Senior Circuit Breaker Tax Credit (Mass. G.L. ch. 62, § 6(k))

The Senior Circuit Breaker Tax Credit differs from the other exemptions and deferrals discussed earlier because this program credits the older adult’s state income tax as opposed to their property tax. The

circuit breaker credit allows property owners or renters 65 years of age or older to claim a credit of up to \$2,730 (for 2024) for rent or real estate taxes paid on their principal residence to the extent the taxes exceed 10% of their total income. The state pays the credit as opposed to the local cities and towns.

Older homeowners who paid more than 10% of their income for real estate taxes and water and sewer charges are eligible for the credit. Older renters can count 25% of their rent as real estate taxes, so long as the rent exceeds 10% of the renter's total income for the tax year. In order to receive the credit, an older adult must file a state income tax return, even if they are not otherwise required to do so. The taxpayer will receive a refund if the credit due exceeds the amount of the income tax paid that year.

To be eligible for the credit for 2024, single older adults cannot earn more than \$72,000. For heads of household, and married couples filing a joint return, the annual 2024 income limitations are \$91,000 and \$109,000, respectively. However, the income limitations for the Senior Circuit Breaker Tax Credit include income that is not included in your Massachusetts income. For example, all of your Social Security income is included as part of the Senior Circuit Breaker Tax Credit income even though none of it is taxable as part of your Massachusetts taxable income. Additionally, most government pensions and Massachusetts non-taxable interest income, while not taxable as part of your Massachusetts taxable income, are included as parts of the Senior Circuit Breaker Tax Credit income limitation.

In all cases, the value of the home after abatements cannot exceed \$1,172,000 for 2024. In order for a renter to receive the credit, they cannot be receiving a rent subsidy, and they cannot pay rent to a landlord who is not required to pay real estate taxes. A taxpayer may add 50% of their water and sewer bill to their property tax assessment when calculating the credit, so long as the water and sewer bill is not already included in the municipal property tax bill. For example, delinquent water and sewer bills are generally added to the property tax, whereas the provisions of the circuit breaker credit only apply to current water and sewer bills.

Any property tax reductions or exemptions, such as the ones described in this guide, earned or received by the taxpayer must be taken into account before determining the total real estate tax paid.

EXAMPLE 6

Nancy is 81 years old and lives alone. Nancy's home is valued at \$350,000, and she earned \$23,000 in 2024, of which \$11,000 was for Social Security income. She had an unadjusted real estate tax bill of \$5,000 and a \$500 water and sewer bill. She can therefore add \$250 (50% of \$500) to her tax bill in calculating the circuit breaker credit, bringing it up to \$5,250. Nancy also received the Elderly Persons exemption of \$175 and earned \$500 through the Senior Work-Off Abatement. Nancy's adjusted property tax is \$4,575 (\$5,250 - \$175 - \$500). Nancy's qualifying income is \$22,300 (\$23,000 less \$700 for the over 65 income tax exemption). Therefore, 10% of Nancy's qualifying income is \$2,230. Because Nancy's adjusted real estate tax exceeds 10% of her total qualifying income by \$2,345, Nancy is eligible for \$2,345 instead of the full \$2,730 income tax credit for 2024.

E. ADDITIONAL RESOURCES AND CONCLUSION

Additional information and applications for exemptions can be obtained at the assessors' office in each city or town. Several assessors' offices have websites that provide local exemption information, downloadable applications and links to other websites. The following are additional resources that may be useful:

- Commonwealth of Massachusetts Citizen Information Service
www.sec.state.ma.us/cis, (617) 727-7030
- Department of Revenue, Division of Local Services, Property Tax Bureau
51 Sleeper St., Boston, MA 02210, (617) 626-2300

This chapter should provide you with information needed to determine whether you may be eligible for a real estate tax exemption or deferral. Because several cities and towns have adopted alternatives for many exemptions, you should contact your local assessors' office for specific eligibility requirements and exemption amounts.

CHAPTER 20

HOUSING: TENANTS' RIGHTS AND RESPONSIBILITIES

A. THE LANDLORD/TENANT RELATIONSHIP

It has been described as the second most emotional human relationship (second to the marital relationship), and the landlord/tenant relationship is heavily impacted by statute, regulation and court decisions. Virtually all tenancies are established by a written lease that describes the rights of the parties, in terms of duration, the amount of rent to be paid, how the lease or tenancy may be terminated and a host of other items agreed upon.

B. TENANTS' RIGHTS AND RESPONSIBILITIES

Generally speaking, a tenant has an obligation to pay the agreed-upon rent in a timely manner, to maintain the leased premises under their control and report any conditions that the landlord is responsible for maintaining or correcting, and to otherwise abide by the terms of the lease. The lease, however, is not the only controlling document since there are numerous statutes, rules and regulations that impact the parties' relationship.

C. THE STATE SANITARY CODE

The State Sanitary Code (SSC 105 CMR 410), issued by the Massachusetts Department of Public Health, establishes minimum standards for residential housing to protect the health, safety and well-being of occupants and the general public. The SSC is monitored and enforced by local Boards of Health, who respond to complaints or concerns and may issue orders to correct violations and file actions in court to enforce an order where there is non-compliance.

D. RELEVANT STATUTES AND CONSUMER PROTECTION REGULATIONS: SECURITY DEPOSITS

In most cases, a landlord will require a security deposit of one month's rent that must be deposited into an interest-bearing account in a Massachusetts bank and be identified as related to the named tenant. Interest must be paid or credited to the tenant annually. The law requires strict compliance by the landlord. When a tenant pays a security deposit, there should be a written document describing the condition of the premises in detail and signed by both parties. M.G.L. c. 186 § 15B, 940 CMR 3.17(4).

E. NOTICES TO QUIT

A landlord must provide "habitable" premises, referred to as the "implied warranty of habitability," and may not interfere with the tenant's "quiet enjoyment" of the leased premises. For example, a landlord may not enter the leased premises without the tenant's permission. If a dispute arises, and the landlord intends to evict the tenant, there are strict rules regarding due process. A lease agreement should prescribe the conditions under which the landlord may take steps to evict a tenant. In the absence of a lease, the landlord must serve a notice to quit on the tenant. If the tenant has not paid rent, a 14-day notice is sufficient if it informs the tenant of the amount of rent in arrears. Otherwise, the notice to quit must specify a date by which the tenant is to vacate the premises and must afford the tenant at least one rental period, or a minimum of one month, to vacate. If the tenant has not vacated by the date set in the notice to quit, the landlord is required to bring the matter to court in an action called summary process. M.G.L. c. 186 §§ 11 and 12; 940 CMR 3.17(5).

F. SUMMARY PROCESS

The landlord must file an action in the District Court or the Housing Court and follow the correct procedure for filing and serving a summary process complaint and summons. The tenant has the right to a trial and even a jury trial, but typically the judicial process begins with a status conference (in the

District Court) or a mediation session, called a “Tier One Event” (in the Housing Court). If the parties are unable to reach an agreement, there is a trial either by the judge or a jury. If possession is granted to the tenant, the issue of who remains in the premises is resolved, although there may be other issues related to a tenant’s claims for damages, which may be included in consumer protection claims under M.G.L. c. 93A. The landlord will have 10 days to file an appeal. If possession is awarded to the landlord, there is a 10-day period during which the tenant may file an appeal. If no appeal is filed, the landlord will request an execution, a document which provides legal authority to dispossess the tenant. If the tenant does not vacate voluntarily, the landlord retains a constable or police officer and a moving company to remove the possession of the tenant. The constable must give a 48-hour notice of intent to levy on the execution. If the execution is levied on, the tenant’s possessions are removed and placed in the moving van after which the tenant is a trespasser and can be removed from the premises. The tenant has the right to designate the place where the possessions are to be delivered, but failing that designation, the possessions are placed in storage and the tenant must arrange to retrieve them at their own expense. The constable or police officer is present to avoid or deal with any breach of peace. M.G.L. c. 239; 940 CMR 3.17(5).

G. REASONABLE ACCOMMODATION

Any tenant with a disability may not be discriminated against by virtue of that disability, and, in most cases (not in an owner-occupied, two-family dwelling), may request a reasonable accommodation in the context of any dispute. If the dispute bears on the disability, the landlord, in most cases, must accommodate any reasonable request.

H. UNLAWFUL DISCRIMINATION

Except for the owner-occupied two-family dwelling, no landlord may discriminate against a tenant or prospective tenant on the basis of race, religion, national origin, age, ancestry, military background or service, sex, sexual preference, marital status, disability or the need for a guide dog, or because the tenant is eligible for a rental subsidy.

I. STAYS OF EXECUTION

When an elderly or disabled tenant in a summary process action is not at fault, the tenant may request a stay (delay) of execution, and the judge has discretion to grant a stay of up to 12 months, on condition that the tenant pay “use and occupancy charges,” no longer called “rent,” and is engaged in a good faith search for new housing. A non-elderly, non-disabled tenant may request a stay, but the judge’s discretion is limited to a six-month stay. M.G.L. c. 239 Section 9.

A helpful website: www.masslegalhelp.org/housing

The local Council on Aging can refer an elder tenant to the Older Americans Act-funded civil legal services agency in your area if you need an attorney to help with an eviction or any serious landlord/tenant dispute.

CHAPTER 21

ELIGIBILITY FOR FEDERALLY FUNDED AND SUBSIDIZED HOUSING

Public Housing and Section 8 Tenant Vouchers and Project-Based Rental Assistance

Both the federal and state governments provide housing and rental subsidies to enhance the ability of low-income individuals and families to access affordable housing. This chapter addresses only the federal programs. Federally funded and subsidized housing is administered by two entities: Public Housing Authorities (“PHAs”) and Multi-Family Housing (“MFH”) owners. The former administer public housing developments and Section 8 tenant-based vouchers for use in the private market. The latter are private housing developers who receive Section 8 project-based rental subsidies on behalf of low-income families.

In order to qualify for these programs the household has to pass, among other criteria, financial eligibility tests. Traditionally, eligibility has been based only on the income of the members of the household. However, as a result of the passage of the Housing Opportunity Through Modernization Act (“HOTMA”), additional eligibility criteria will be imposed once the PHAs and MFHs implement HOTMA. As of now, they are required to do so by July 1, 2025. This deadline has already been postponed twice. These changes will be discussed later on in this chapter.

A. ELIGIBILITY UNDER THE “OLD” RULES

In order to qualify for a housing unit or subsidy, the income of the household has to be less than the applicable income limit. The U.S. Department of Housing and Urban Development (“HUD”) sets income limits at 80% of the Area Median Income (“AMI”) for lower-income households and 50% for very low-income households.

Eligibility and rent are based on the household’s anticipated gross annual income minus deductions, if any. HUD regulations allow exclusions for each dependent; for an elderly family; for a person with a disability; and for some medical expenses for families headed by an elderly person or a person with disabilities. Annual income is the anticipated total income from all sources received by the family head and spouse, and each additional household member 18 years of age or older. In general, rent is 30% of the household’s monthly adjusted income, i.e., income less deductions allowed by the regulations.

B. INCOME

Income, for the purpose of qualifying for housing or a subsidy and the determination of rent, includes unearned income, regular income from employment and public benefits, such as Social Security Income and Social Security Disability Insurance, and income derived from “net family assets” in excess of \$5,000. Net family assets include the value of assets after deducting reasonable liquidation costs but excluding necessary items of personal property, such as furniture and automobiles. Federal regulations exclude temporary, non-recurring or sporadic payments (including gifts) from the definition of income.

C. IMPUTED INCOME

To determine the income derived from net family assets, the rules require the PHA and MFH owner to consider the greater of (1) actual income derived from all net family assets or (2) a percentage of the value in excess of \$5,000 based on the current passbook savings rate.

For example, if a household’s only asset is a \$50,000 bank account earning 3% interest, the interest of \$1,500 annually (\$125/mo.) will be included in the calculation of income and, thus, the determination of rent.

- If the household’s only asset is vacant land with a value of \$50,000, though that asset generates no actual monthly income, interest will be imputed.
- If the passbook savings rate is 2%, then \$900 annually (\$75 month) will be imputed as income to the tenant for purpose of calculating the rent.

Net family assets include the value of assets disposed of for less than fair market value during the preceding two years. Thus, reducing the value of assets by making gifts does not reduce income or rent for at least two years after the date of the gift.

D. TRUST DISTRIBUTIONS

One question relative to the income of trust beneficiaries that was unsettled for many years was whether all distributions from the trusts were income — thus affecting the calculation of eligibility and the calculation of rent. In the case of *DeCambre v. Brookline Housing Authority*, Case 15-1458 (June 14, 2016), the United States Court of Appeals for the First Circuit ruled that distributions of principal (cash, stocks, bonds, etc., held by the trust) from certain self-settled special needs trusts is not income for eligibility purposes.

E. ELIGIBILITY RULES AS MODIFIED BY HOTMA

The Housing Opportunity Through Modernization Act (“HOTMA”) became law on July 29, 2016. It took until February of 2023 for HUD to issue regulations. The regulations are complex and difficult for the PHAs and MFH owners to implement without concrete guidance. Thus, much like Social Security issues instructions in its Program Operations Manual to clarify the minutiae of the Social Security regulations, HUD issued Notice H 2023-10, and Notice PIH 2023-27 on Sept. 29, 2023, clarifying the HOTMA changes to income rules and the implementation of asset rules. The notice has been revised since it was originally issued. Significant program, system and software changes are required to implement the changes to the rules at the local level, which has caused delays in the implementation of HOTMA.

It is challenging to describe the breadth of the changes to the eligibility rules, so the balance of this chapter will describe only the highlights. Moreover, the PHAs and MFHs are given wide discretion to adopt or reject some of the changes. Their choices are required to be in writing and available to the public. The MFH owners’ choices are to be incorporated in their Tenant Selection Plans and the PHAs in their Admissions and Continued Occupancy Plans (“ACOPs”) and/or their Administrative Plans.

F. ASSETS

Under HOTMA, eligibility depends not only on income but also on assets. The asset limit is initially \$100,000, adjusted for inflation. Further, if a household owns property suitable for occupancy, the household will be denied eligibility based on the ownership of that property regardless of its value.

All assets count unless they are specifically excluded. Among the excluded assets are:

- Retirement accounts
- Trusts that are not revocable by, or under the control of, a member of the family or household
- Tax refunds
- ABLE accounts
- 529 plans
- Non-necessary items of personal property with a total value of less than \$50,000; or
- Amounts recovered in any civil action based on malpractice or negligence resulting in disability.

Assets that were disposed of for less than fair market value during the prior two years are still counted.

The PHAs and MFH owners have discretion as to whether to impose these asset limits on existing tenants. They can:

- Enforce these limits on existing tenants;
- Not enforce these limits on existing tenants;
- Not enforce these asset limits against certain types of tenants considering age, disability, etc.; or
- Limit enforcement to give the household six months to reduce the assets.

G. INCOME

All amounts of income received by adult household members and unearned income of younger family members count unless it is specifically excluded.

Income includes actual income generated by assets and income imputed on assets exceeding \$50,000, including assets given away within the prior two years. Imputed income is based on the passbook savings rate, which is now published annually.

The types of income that are excluded include:

- Non-recurring income (income received in one year that is not expected to be received in the next year);
- Distributions from retirement accounts that are not periodic;
- Lump-sum additions to net family assets, such as lottery winnings and inheritances;
- Veteran's Administration Aid and Attendance benefits;
- Workers' compensation;
- Insurance payments and settlements for personal or property losses regardless of the frequency of payments; and
- Payments from claims based on negligence resulting in disability regardless of whether received periodically or as a lump sum.

HOTMA also addressed how distributions from trusts would be treated:

- Distributions of principal from a trust that is an excluded asset are not income. This adopts the *DeCambre* decision and expands upon it.
- Distributions of income from a trust, unless they are used for payment of a minor's health and medical care, are countable.

Though HOTMA described, in exquisite detail, how income should be calculated, HOTMA also gives PHAs and MFH owners the option, called Safe Harbor, to disregard those methods of determining income and instead to use income determinations from other programs, including:

- MassHealth;
- SNAP;
- SSI; and
- TANF.

CONCLUSION

Once HOTMA is implemented by each PHA and MFH, the key to understanding the eligibility rules will be not only to consult the HOTMA regulations and the notice, but also to investigate the specific eligibility rules adopted by that PHA and MFH as are supposed to be described in the Tenant Selection Plans of MFH owners and the ACOPs and/or Administrative Plans of PHAs. Tenants who need legal representation should contact an elder law attorney at <https://massnaela.com/> or a legal services program.

See <https://www.mass.gov/info-details/finding-legal-help>. HUD-approved counseling agencies may also be helpful.

See https://apps.hud.gov/offices/hsg/sfh/hcc/hcs_print.cfm?webListAction=search&searchstate=ma.

CHAPTER 22

RESOURCE DIRECTORY

GENERAL INFORMATION

Alzheimer's Association

(800) 272-3900, (617) 868-6718 (Waltham),
(508) 799-2386 (Central & Western MA),
(603) 606-6590 (New Hampshire)
www.ALZ.org

Executive Office of Aging and Independence

(617) 727-7750, (800) 243-4636
www.mass.gov/orgs/executive-office-of-elder-affairs

MassOptions: For Mass. Older Adults and Their Families

(800) 243-4636
www.MassOptions.org

National Council on Aging

(571) 527-3900
www.NCOA.org

National Multiple Sclerosis Society

(800) 344-4867
www.NationalMSSociety.org
www.NationalMSSociety.org/Chapters/MAM

ELDER ABUSE PREVENTION AND REPORTING INFORMATION

Attorney General Elder Hotline

(888) 243-5337
www.mass.gov/info-details/the-attorney-generals-elder-hotline

Executive Office of Elder Affairs/Elder Abuse and Protective Services

(800) 922-2275
www.Mass.gov/Reporting-elder-abuse-neglect

Long-Term Care Ombudsman

(617) 222-7495
www.mass.gov/orgs/massachusetts-long-term-care-ombudsman-program

Massachusetts Bank Reporting Project
www.mass.gov/info-details/the-massachusetts-bank-reporting-project

LEGAL INFORMATION

Justice in Aging

www.JusticeInAging.org

LGBTQ RESOURCES

GLBTQ Legal Advocates & Defenders

GLAD Answers
(800) 455-GLAD
(617) 426-1350
www.glad.org

Legal Assistance: Massachusetts Bar Association

Lawyer Referral Service

(617) 654-0400
Toll-free: (866) 627-7577
www.MassLawHelp.com

Massachusetts Bar Association Dial-A-Lawyer

(held on the first Wednesday of each month)
5:30–7:30 p.m.
(617) 338-0610
Toll-free: (877) 686-0711
www.MassLawHelp.com

Mass. Chapter of the National Academy of Elder Law Attorneys (MassNAELA)

(617) 566-5640
www.MassNAELA.com

National Academy of Elder Law Attorneys

www.NAELA.org

MEDICAL INSURANCE INFORMATION

MassHealth: Customer Service Center

(800) 841-2900

Massachusetts Health Care for All Health Care Resources

(800) 272-4232
(617) 350-7279
www.HCFAMA.org

MEDICARE AND MEDICAID SERVICES
Centers for Medicare and Medicaid Services

www.cms.gov

Prescription Drug Coverage: General Information

www.cms.gov/medicare/coverage/prescription-drug-coverage

Medicare HelpLine: Official U.S. Government Site for People with Medicare

(800) 633-4227

www.Medicare.gov

MCPHS Pharmacy Outreach Program

(866) 633-1617

www.mcphs.edu/patient-centers-and-clinics/pharmacy-outreach-program

Medicare Rights Center: Prescription Drug Plan

National Helpline: (800) 333-4114

www.MedicareRights.org

SHINE (Serving Health Insurance Needs of Everyone)

(800) 243-4636

www.Mass.gov/Health-insurance-counseling

SOCIAL SECURITY INFORMATION

Martin on Social Security

www.Law.Cornell.edu/socsec_treatise

Social Security Prescription Help

<https://www.ssa.gov/medicare/part-d-extra-help>

U.S. Social Security Administration

(800) 772-1213

www.SSA.gov

VETERANS INFORMATION

City of Boston Veterans Services

(617) 635-3026

www.Boston.gov/Departments/Veterans-services

Mass. Executive Office of Veterans Services

(617) 210-5480

www.mass.gov/orgs/executive-office-of-veterans-services

In each of the chapters, you may find additional resources that are not listed on these pages.