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2026 ELDER LAW EDUCATION GUIDE

17th Edition

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May 2026

Dear Massachusetts Older Adults,

It is my pleasure to introduce the 17th edition of the Elder Law Guide for Older Adults (Guide), produced through the continued partnership between the Massachusetts Bar Association (MBA) and the Massachusetts Chapter of the National Academy of Elder Law Attorneys (MassNAELA).

Over the years, this Guide has become a trusted resource for individuals, families and professionals throughout the commonwealth. Our goal has always been to provide clear, practical information that helps people better understand the legal and financial issues that often accompany aging, and to make those topics accessible to everyone.

Each year, we review and update the Guide to ensure it reflects the most current laws, policies and resources available in Massachusetts. This edition represents the collective knowledge and experience of many dedicated professionals who work every day to support older adults and their families.

This year, the Advisory Committee (AC) engaged our group of reviewers to include more than 50 additional professionals who offered valuable insight and fresh perspectives. Their contributions helped strengthen the Guide and ensure the information remains accurate, relevant and easy to navigate.

Producing this Guide is truly a collaborative effort. I am deeply grateful to the attorneys, AC advisors, other volunteers, and MBA staff who generously contributed their time and expertise to make this publication possible.

A special recognition is extended to Elizabeth A. O'Neil, director of public and community services at the MBA, whose leadership and support continue to be invaluable to this project, and attorney Grace Mobley, who served for the first time as the project counsel and set a standard for excellence for others to follow in future years.

We hope this Guide serves as a helpful resource for you, your family, and those who support older adults across Massachusetts. Your feedback is always welcome, and we encourage you to share your thoughts on how we can continue improving future editions.

Sincerely,

Alex L. Moschella, Esq.
Chair, MBA Elder Law Advisory Committee

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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

INTRODUCTION

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) and your beneficiary designations, must also be consistent with your estate planning 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.

A. 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. A power of attorney usually will come into effect as soon as it is signed and will

authorize your agent to begin acting immediately on your behalf. Some powers of attorney are called springing powers of attorney and those only come into effect if you are deemed incapacitated or unable to manage your finances by one or two clinicians.

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 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 at-

torney. 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 trusts).

B. 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 owned by a trust upon a person's death pass according to the terms of the trust, outside of probate. 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. Assets owned by a trust do not require probate. Another type of non-probate property is 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.

C. 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.

D. 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.

E. 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

INTRODUCTION

This chapter will summarize the probate process and wealth transfer taxes that may occur during life (gift tax) or at death (estate tax).

Probate is the legal process by which the probate court oversees the transfer of the decedent's assets that were individually owned by the decedent at death without a designated beneficiary. Through probate, a petitioner can request that the probate court: validate a last will and testament ("will") or determine that the decedent died intestate (without a will), determine the decedent's heirs-at-law, and appoint a personal representative to administer the decedent's estate.

Many individuals share a common goal to avoid probate because the probate process creates delays transferring or transacting with a decedent's assets, comes with expense, and becomes a matter of public record.

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 "decedent") with property in the decedent's individual name in order to transfer the property to: the decedent's heirs-at-law when a decedent died intestate (without a will), or to the devisees designated in the decedent's will when a decedent died testate (with a will).

   The probate process is necessary when the asset itself does not establish the subsequent owner after the decedent'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 decedent's will, whether the decedent died intestate, and who the decedent'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 decedent's probate assets. A personal representative can be nominated in a decedent's will and will ultimately need to be appointed by the probate court. If no valid personal representative is nominated in a decedent's will, or the decedent 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 decedent 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 decedent's estate[3] 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 decedent died intestate, determine a decedent's heirs-at-law, and/or 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 decedent must have been either:

i. Domiciled at the time of the decedent's death in the county where the petition is filed;[4] or

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 property 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:

i. Admit the decedent's will to formal probate and determine both the heirs and devisees.

ii. Determine that the decedent died without a will and determine the heirs.

iii. 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. If it is necessary to pursue a late and limited probate, the petitioner should consider whether the appointment of a personal representative is required.

More information published by the commonwealth and forms can be found at the following website: https://www.mass.gov/lists/probate-and-family-court-forms-for-wills-estates-and-trusts.

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 (e.g., 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 (e.g., 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 be able to 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).

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 that 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 2026, the federal estate and gift tax exemption is $15,000,000.

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 the 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. Decedents may also reduce their gross estate by leaving certain assets to qualified charities using the unlimited charitable deduction.

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 2026 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 ($15,000,000 in 2026).

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.

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.

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1. Mass. Gen. Laws c. 190B, Sec. 3-203.
2. Mass. Gen. Laws c. 190B, Sec. 3-1201.
3. Mass. Gen. Laws c. 190B, Sec. 1-201(24).
4. Mass. Gen. Laws 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. Mass. Gen. Laws c. 167D, Sec. 12 and MGL c. 171, Sec. 42.

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 multifaceted 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, which are summarized below. These are the legal documents that should be executed with an elder law attorney. The non-legal documents presented below should also be discussed with your elder law attorney and your loved ones, but 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, understanding your rights and options in Massachusetts around end-of-life choices, and funeral planning.

A. LEGAL DOCUMENTS RELATED TO HEALTH CARE

1. **Health Care Proxy — (M.G.L. Chapter 201 D)**

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 are encouraged to name alternate agents, but co-agents are not allowed; only one agent at a time may 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 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 Vehicles (RMV) or the Massachusetts Donor Registry, accessible here: https://registerme.org/. If you are interested in donating only certain organs or tissues, or for only limited purposes (e.g., for transplantation only,

and not for research), then you should fill out a donor card and indicate those choices on the card instead of signing up with the RMV or the Donor Registry.

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. In addition, to address the costs and delays that occur when an adult without decisional capacity does not have a health care proxy and guardianship seems like the only option, the Massachusetts Medical Society supports pending legislation ("An Act Improving Medical Decision Making") that would create a less burdensome option and allow physicians to appoint short-term surrogate decision-makers (such as spouses, adult children or close friends) without waiting for court approval.

4. **Supported Decision-Making**

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), can be an alternative to guardianship. 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 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.

SDM agreements are legally recognized in 23 states. Currently, there is legislation pending in Massachusetts to establish a legal framework for SDM agreements, and to require courts to consider SDM as an alternative to guardianship.

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 the following:

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. Massachusetts is one of a few states that permits health care proxies but does not formally recognize living wills in its statutes.
   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. A living will is often referred to as an Advanced Directive or a Personal Directive.
   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 the POLST form, discussed below.
3. **Physician Orders for Life-Sustaining Treatment (POLST — ALSO KNOWN AS, MOLST — SEE ATTACHED FORM)**
   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. A patient can initiate this conversation with his or her provider at any time.
   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**

   a. 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.

   b. 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.

   c. 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 cellphone, 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 in the Helpful Resources section of this chapter.

D. CARE MANAGEMENT

1. **Aging Life Care Management**

Working with an aging life care manager (formerly known as a geriatric care manager), whether for proactive planning, general guidance or crisis situations, is an option available for families. Finding an aging life care manager who is a member of the Aging Life Care Association (ALCA) ensures a level of credentialing and expertise, professionalism, and adherence to the Code of Ethics, including a commitment to acting in the best interest of the client, and not accepting referral fees.

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, 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. Aging life 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. An aging life care manager can be an essential part of your care team, and work collaboratively with others involved in your care, support family members at a distance, and be an important advocate for those who may not have family or trusted individuals in their support circle.

Typically, these services are privately paid at an hourly rate (pricing varies across the country), but may also be reimbursed through a long-term care insurance plan.

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

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:
4. **Definitions**

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 nurse 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 covers long-term custodial care (i.e., room and board in a hospice house is not included in Part A or B of Medicare).
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.
4. A geriatric care manager can be helpful in hospice 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 (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**

   a. As of October 2025, medical assistance in dying (MAID) — also called medical aid in dying or death with dignity — is not yet legal in Massachusetts, but legislation is advancing through the state legislature, with the End of Life Options Act (H.2505/S.1486) reintroduced in January 2025. This proposed legislation would allow competent terminally ill adults with six months or less to live to obtain prescription medication to end their life peacefully, should they choose to do so.

   b. 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.

   c. 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. FUNERAL PLANNING

1. **Prepaid Funeral Contracts**

   In Massachusetts, prepaid funeral contracts are regulated under state law. 239 CMR 4.00. A preneed funeral contract is defined as:

   "Any written agreement between a Buyer and a Licensed Funeral Establishment in which:

   (a) the Licensed Funeral Establishment agrees, prior to the death of a named Beneficiary, to furnish Funeral Goods and/or Services for that named Beneficiary upon his or her death, and

   (b) the Buyer, pursuant to that agreement, tenders funds made payable to a banking institution or insurance company to the Licensed Funeral Establishment for the purpose of paying all or part of the cost of those Funeral Goods and/or Services at the time they are actually provided."

   Preneed funeral contracts require careful review of contract terms, funeral home or provider reputation, state laws and future flexibility. It is wise to fully understand what costs and services are covered and how changes or cancellations are handled before purchasing a prepaid funeral plan. It is important to consult with an attorney to review if such contracts are to be revocable or irrevocable for Medicaid spend-down purposes.

2. **More Information About Funeral Planning**

   Planning a funeral and the disposition of bodily remains are as much personal decisions as health care decision-making during life. While funeral homes and funeral directors provide valuable help, there are other alternatives that do not involve engaging a funeral home. The Funeral Consumers Alliance of Eastern Massachusetts (https://fcaemass.org/) and the Funeral Consumers Alliance of Western Massachusetts (https://funeralconsumerswmass.org/) offer a wealth of information about Massachusetts laws, practices and forms pertaining to death, burial, cremation, anatomical gifts and related subjects.

H. HELPFUL RESOURCES

1. Hospice Residences in Massachusetts: https://www.hospicefed.org/page/GIP
2. Five Wishes: https://www.fivewishes.org/
3. Conversation Project: https://theconversationproject.org/
4. Honoring Choices of Mass: https://www.honoringchoicesmass.com/
5. What If Workbook: https://whatifworkbook.com/

Honoring Choices® MASSACHUSETTS
Your Health Care. Your Choice!

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 appear to be 18 years old, of sound mind, and under no constraint or undue influence.
- Have Witness One sign, then print name and the date;
- Then have Witness Two sign and print 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 Agent(s) 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.

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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. If there are exceptions to your Agent's decision-making, list here.

_____

_____.

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		***Witness Two***	
Signed:	_____	Signed:	_____
Print Name:	_____	Print Name:	_____
Date:	_____	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 _____

HIPAA PERMITS DISCLOSURE OF POLST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Medical Record # (Optional)

Massachusetts POLST Form: A Portable Medical Order (adapted from the National POLST form)

Health care providers should complete this form only after a conversation with their patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients-pdf).

Patient Information. **Having a POLST form is always voluntary.**

This is a medical order, not an advance directive. For information about POLST and to understand this document, visit: www.polst.org/form

Patient First Name: _____

Middle Name/Initial: _____ Preferred name: _____

Last Name: _____ Suffix (Jr, Sr, etc): _____

DOB (mm/dd/yyyy): ____/____/____ State where form was completed: _____

Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-___ ___ ___ ___

A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.

Pick 1

☐ **YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion.** (Requires choosing Full Treatments in Section B)

☐ **NO CPR: Do Not Attempt Resuscitation.** (May choose any option in Section B)

B. Initial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing.

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.

Pick 1

☐ **Full Treatments (required if choose CPR in Section A).** Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.

☐ **Selective Treatments.** Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.

☐ **Comfort-focused Treatments.** Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital **only** if comfort cannot be achieved in current setting.

C. Additional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis).
[EMS protocols may limit emergency responder ability to act on orders in this section.]

D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe and tolerated)

Pick 1

☐ Provide feeding through new or existing surgically-placed tubes ☐ No artificial means of nutrition desired

☐ Trial period for artificial nutrition but no surgically-placed tubes ☐ Not discussed or no decision made (provide standard of care)

E. SIGNATURE: Patient or Patient Representative (eSigned documents are valid)

I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's representative, the treatments are consistent with the patient's known wishes and in their best interest.

✖ (required)

I/ (or my patient representative) provide(s) consent to submit this form to the Commonwealth of MA and its POLST Registry. Check here: ☐

The most recently completed valid POLST form supersedes all previously completed POLST forms.

If other than patient, print full name: | **Authority:**

F. SIGNATURE: Health Care Provider (eSigned documents are valid)

I have discussed this order with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge. [Note: Only licensed health care providers authorized by law to sign POLST form in state where completed may sign this order]

✖ (required) | **Date** (mm/dd/yyyy): Required ___/___/___ | **Phone # :**

Printed Full Name: | **License/Cert. #:**

Supervising physician signature: ☐ N/A | **License #:**

A copied, faxed or electronic version of this form is a legal and valid medical order. This form does not expire. 2023

Massachusetts POLST Form – Page 2 *******ATTACH TO PAGE 1********

Patient Full Name:

Contact Information (Optional but helpful)

Patient's Emergency Contact. (Note: Listing a person here does **not** grant them authority to be a legal representative. Only an advance directive or state law can grant that authority.)

Full Name:	☐ Legal Representative ☐ Other emergency contact	Phone #: Day: Night:
Primary Care Provider Name:		Phone:

☐ Patient is enrolled in hospice — Name of Agency:

Agency Phone:

Form Completion Information (Optional but helpful)

Reviewed patient's advance directive to confirm no conflict with POLST orders:
(A POLST form does not replace an advance directive or living will)

- ☐ Yes; date of the document reviewed (mm/dd/yyyy):_____/_____/_____
- ☐ Conflict exists, notified patient (if patient lacks capacity, noted in chart)
- ☐ Advance directive not available
- ☐ No advance directive exists

Check everyone who participated in discussion: ☐ Patient with decision-making capacity ☐ Court Appointed Guardian ☐ Parent of Minor ☐ Legal Surrogate / Health Care Agent ☐ Other: _____

Professional Assisting Health Care Provider w/ Form Completion (if applicable): Full Name:	Date (mm/dd/yyyy): / /	Phone #:

This individual is the patient's: ☐ Social Worker ☐ Nurse ☐ Clergy ☐ Other:

Form Information & Instructions

- **The Massachusetts POLST Form must be honored by all health care providers.**
- **Completing a POLST form:**
  - Provider should document basis for this form in the patient's medical record notes.
  - A patient's health care proxy may execute or void a POLST form only if the patient lacks decision-making capacity.
  - Only a MD, DO, NP or PA can sign this form.
  - All copies of the POLST are valid. The patient must receive a copy, and a copy must be included in the medical record.
  - Last 4 digits of SSN are optional but can help identify / match a patient to their form.
  - If a translated POLST form is used during the conversation, attach a completed translation to the signed English form.
- **Using a POLST form:**
  - Any incomplete section of POLST creates no presumption about patient's preferences for treatment. Provide standard of care.
  - No defibrillator (including automated external defibrillators) or chest compressions should be used if "No CPR" is chosen.
  - For all options, use medication by any appropriate route, positioning, wound care, and other measures to relieve pain and suffering.
- **Reviewing a POLST form:** This form does not expire but should be reviewed whenever the patient:
  (1) is transferred from one care setting or level to another;
  (2) has a substantial change in health status;
  (3) changes primary provider; or
  (4) changes his/her treatment preferences or goals of care.
- **Modifying a POLST form:** This form cannot be modified. If changes are needed, void form and complete a new POLST form.
- **Voiding a POLST form:**
  - If a patient or patient representative (for patients lacking capacity) wants to void the form: destroy paper form and contact patient's health care provider to void orders in patient's medical record (and POLST registry, if applicable).
  - For health care providers: destroy patient copy (if possible), note in patient record form is voided and notify registries (if applicable).
- **Additional Forms.** Can be obtained by going to www.mass.gov/POLST
- For additional information, contact the Massachusetts POLST Call Center at 844-771-1629 M-F 9:00AM-5:00PM EST or e-mail POLSTSupport@uhealthsolutions.org Also see the Massachusetts MOLST-to-POLST Transition website www.mass.gov/POLST

State Specific Info	For Barcodes / ID Sticker

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: _____

_____

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 par
minor child, a court appointed guardian or executor, a custodial parent, or a health care agent), plea

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

INTRODUCTION

Retirement is not a single event but a gradual transition that unfolds in stages — each with its own opportunities, challenges and decisions. Thoughtful planning helps ensure that this next chapter of life is both secure and fulfilling. This section explores key considerations in preparing for and living through retirement, including assembling a trusted team of professionals, understanding what to expect as work life gives way to new routines, organizing the practical and financial aspects of retirement, and anticipating the next phases that follow. By approaching retirement with clarity and structure, individuals can focus less on uncertainty and more on enjoying the years ahead with confidence and purpose.

A. ASSEMBLING YOUR RETIREMENT PLANNING TEAM

Successful retirement planning is not just about saving money — it's about having the right people in your corner to guide you through complex decisions. Assembling a trustworthy and experienced team can make all the difference in navigating taxes, legal documents, health care decisions and investment strategies. At a minimum, consider working with a Certified Public Accountant (CPA), an elder law attorney and a financial advisor. Each brings unique expertise to help safeguard your future.

Your CPA helps you plan for the tax implications of retirement, including strategies for minimizing taxes on your income, investments and estate. As retirement income often comes from multiple sources — Social Security, pensions, retirement accounts and investments — a CPA can ensure your tax strategy is both efficient and compliant.

An elder law attorney provides legal advice tailored to aging individuals, including estate planning, powers of attorney, long-term care planning and Medicaid eligibility. They help protect your assets while ensuring your wishes are clearly documented and legally enforceable.

A financial advisor helps manage your assets and investment strategy to ensure your savings last through retirement. They can also help you navigate decisions around insurance, annuities, risk tolerance and income generation.

1. **<u>Choosing the Right Professionals</u>**

   When selecting your retirement team, it is important to choose individuals who not only have the right credentials but who also communicate clearly, act in your best interest, and understand your goals. Begin with referrals from trusted sources, and then meet with candidates to assess compatibility.

   Here are some key considerations when evaluating potential advisors:

   a. **Credentials & Licensing**: Confirm professional licenses and designations (e.g., CPA, CFP®, JD, CELA, or membership in NAELA for elder law attorneys).

   b. **Experience:** Look for professionals with specific experience in retirement and aging-related planning.

   c. **Fiduciary Duty:** Ask whether the advisor is held to a fiduciary standard, meaning they are required to act in your best interest.

   d. **Communication Style:** Choose someone who explains complex topics in ways you understand and who respects your input.

   e. **Fee Structure:** Understand exactly how each professional is compensated (flat fee, hourly, commission-based or asset-based).

   f. **References or Reviews:** Don't hesitate to request testimonials or client references.

2. **Understanding Fees and Expenses**

   Before engaging any professional, request a clear explanation of their fees. This will help you avoid surprises and compare providers more effectively. Fees can vary widely depending on the service model, and it is important to understand what is included and what will cost extra.

   a. CPAs may charge hourly rates or flat fees for tax returns and planning sessions.

   b. Elder law attorneys often bill by the hour, although some estate planning work may be offered for a flat fee.

   c. Financial advisors might charge:

      i. A percentage of assets under management (typically 0.5%–1.5%);

      ii. Hourly or flat-rate fees for planning services; and/or

   d. Be sure to ask:

      i. "Are there any ongoing fees?"

      ii. "Will I be charged for phone calls, emails or quick check-ins?"

      iii. "Do you receive any compensation from third parties for recommending products?"

   e. Transparency is key. Professionals who are upfront about fees and willing to explain their value are likely to be better long-term partners.

B. WHAT TO EXPECT WHEN YOU RETIRE

Retirement "sticker shock" is often one of the biggest surprises for new retirees. Budgeting without a steady paycheck can make every expense feel sizable. This is true even for people with robust savings. The true cost of retirement is higher than most expect with the need to balance fixed (or less predictable) incomes with inflation, added health care costs and longer life expectancies.

1. **Budgeting**

   It is important to understand how much you may need to spend in retirement. Be sure to account for:

   a. Health insurance premiums, copays and prescriptions. Make sure to compute these costs using your health insurance in retirement, such as Medicare, with respect to deductibles and coverage. You should also factor in the potential need for future care, such as home health aides, needed home improvements, or an eventual transition to independent or assisted living.

   b. Having fun – travel, leisure and similar expenses.

   c. Home maintenance and potential modifications for aging in place.

   d. Inflation and rising costs over time.

   e. Taxes on retirement income (Social Security, IRA distributions, etc.).

   A good way to adjust to these numbers is to track your spending for up to six months prior to retirement to have a sense of your current spending habits.

2. **Income Projecting**

   Retirement income typically comes from multiple sources. The names and terms describing these areas often overlap and may seem confusing. The following is a list of general sources of retirement income and what they refer to:

   a. **Social Security** — Social Security is the federal pension program. You can collect this income early or at your full retirement age. Claiming sooner reduces your benefit, whereas delaying your claim increases your payout. You should review your standard benefit amount, as well as the early and delayed amounts, prior to claiming your benefit to decide which option works best in your situation.

b. **Pensions** — Private or state pensions also provide a potential source of monthly income. You should review the payout options, if offered, on such plans. Options may include lump sums, annuity, or contractual amounts, and the ability to provide survivorship benefits.

c. **Retirement accounts** — The most common retirement accounts are IRAs, 401(k)s, Roth IRAs, 403(b)s, and 457(b) plans. Most mandate required minimum distributions (RMDs). You should review which dates apply to your plans. You should also determine if you will need more or less than your RMD amount.

d. **Investment income** — This refers to dividends, interest, capital gains or rental income. These amounts typically fluctuate.

e. **Part-time work or consulting** — Some retirees find part-time work provides not only a financial boost but also a great way to stay socially and mentally engaged.

3. **Stay Flexible but Anticipate Common Surprises**

a. **Health care costs can escalate quickly.** Switching health insurance changes co-pays, deductibles and coverages. Also anticipate more frequent health care spending.

b. **Inflation.** While it sounds complicated, inflation simply means costs rise over time. In retirement, your income may not rise as quickly as those costs; therefore, what feels like "enough" at age 65 may not suffice at 85.

c. **Lifestyle.** Retirement can be a vacation, but you should not spend as though you are on a long vacation. It is easy to spend more than planned on dining out, hobbies or grandchildren.

d. **Emotional adjustment — Not all surprises are financial.** The transition from work life to retired life requires mental and emotional recalibration.

C. ORGANIZING YOUR RETIREMENT FOR MAXIMUM EFFECTIVENESS

Retirement is something most people look forward to — yet preparing for it can feel overwhelming. One of the most common concerns is whether the money saved will provide for a comfortable retirement as well as be sufficient for any potential health challenges. The key to peace of mind is creating a personalized retirement plan based on your priorities, resources and goals. Here's a step-by-step guide to help you organize your retirement effectively.

1. **Define Your Retirement Vision**

Start by identifying what you want your retirement to look like.

a. What activities bring you the most joy outside of work?

b. For what do you want more time — travel, volunteering, hobbies, or spending time with family?

Clarifying your ideal lifestyle will help guide your financial and logistical planning.

2. **Assess Your Financial Readiness**

Take a comprehensive look at your financial situation:

a. Review your income, expenses, savings, investments and debts.

b. Evaluate Social Security, pension benefits and other sources of income.

c. Consult with an accountant or financial planner for a realistic projection of future spending and savings needs. They may also provide a helpful spreadsheet or tool to track your spending and project long-term financial sustainability.

3. **Evaluate Your Insurance Coverage**

   Insurance is a critical part of retirement planning:

   a. Review your life insurance, health insurance and long-term care insurance.

   b. Consider consulting an independent financial advisor or insurance specialist for guidance, especially regarding long-term care options.

4. **Review Other Insurance Policies**

   Don't overlook essential property and liability insurance:

   a. **Auto Insurance:** Who is covered under your policy? (e.g., adult children, caregivers).

   b. **Homeowners Insurance:** Does your policy provide adequate replacement value for your home in the event of a disaster, such as fire or flood?

5. **Update Your Estate Plan**

   a. **Review existing documents regularly.** Ensure your will, trust, health care proxy and durable power of attorney reflect your current wishes, relationships and financial situation.

   b. **Consider changes in family circumstances.** Marriage, divorce, births, deaths or estrangement may require updates to beneficiaries or fiduciary appointments.

   c. **Align your plan with retirement accounts.** Confirm that beneficiary designations on IRAs, 401(k)s and annuities are consistent with your estate plan.

   d. **Address long-term care considerations.** Incorporate planning for incapacity, potential nursing home care, and Medicaid eligibility if appropriate.

   e. **Evaluate tax implications.** Review estate and income tax strategies in light of current federal and Massachusetts laws and exemptions.

   f. **Plan for digital assets.** Include instructions for online accounts, passwords and digital property.

   g. **Communicate with your advisors.** Coordinate with your attorney, financial planner and CPA to maintain a cohesive, up-to-date plan.

   Retirement is a natural time to review and update your estate plan.

   Key considerations include:

   i. **How often should you review your plan?** Every three years is a good rule of thumb — or whenever major life events occur (e.g., birth of a grandchild, family illness, divorce or death).

   ii. **What does your estate plan include?** Wills, trusts, health care proxies, powers of attorney.

   iii. **Is it accessible?** Ensure your loved ones know where to find key documents.

   iv. **Are your beneficiaries current?** Review designations on bank accounts, retirement plans and brokerage accounts.

6. **Reconsider Your Living Arrangements**

   Your home situation may need to change as your lifestyle evolves. Ask yourself:

   a. Do I want to stay in my current home?

   b. Would downsizing or moving to a condo be a better fit?

   c. Should I consider retirement communities, assisted living, or long-term care facilities in the future?

D. LOOKING AHEAD: PLANNING FOR THE PHASES OF RETIREMENT

1. **Go-Go Stage**

   • You are active, healthy and financially secure. This is the time to pursue your dreams — travel,

explore new hobbies, and enjoy freedom.

2. **Slow-Go Stage**
   - Energy levels may decline slightly, but you are still independent. You might reduce travel or opt for longer stays in fewer places.
3. **No-Go Stage**
   - You become more home-based and may need assistance with daily activities. At this point, you might benefit from family support, professional care managers, geriatric physicians, and in-home caregivers or agencies.

E. LOOKING TO THE FUTURE

Retirement isn't an end — it's a transition. Work has provided structure, routine and purpose for years. Planning a new structure and purpose ahead of time is essential to enjoying your retirement fully. Here are some final tips to ensure that your retirement is all you have hoped.

1. Time flies! Your first few years in retirement are likely to be the best ones. Presumably, you have health and wealth at this point, and if so, you should do the things that you want during this phase. Travel might be a top priority. If so, organize your travel experiences into two parts. The first part may be travel that is more extensive and more strenuous. (go stage); you might spend time going from place to place and easily adapt to an active travel schedule. As you slow down a bit, (slow stage) you can still travel, but it may be to one place for a long period of time as opposed to many venues for short sprints, or perhaps a long cruise will fit your needs better.
2. If you have changed your living arrangements, you might be challenged to find new friends. Depending upon where you move, this might mean that you actually engage in a whole new set of acquaintances and have a different kind of social life than before.
3. If you have a spouse or a partner, be certain to discuss your retirement with that person. You both need to consider each other's plans, which will hopefully align.
4. There is a psychological component to retirement. The most important aspect for well-being is to avoid isolation. Understand that it takes a village to help you in retirement. This includes joining groups with similar interests. There are nonprofit groups called "Villages" in the Commonwealth of Massachusetts that provide social interaction with peers, assistance with transport to medical appointments where necessary, trips, and other wonderful activities. Some of these are Newton at Home and "Villages" in Beacon Hill, Wellesley and Cambridge. Also, don't overlook professional care managers, geriatric physicians, and caregiver agencies if you require more support.

CHAPTER 5
PENSIONS

INTRODUCTION

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 as these plans are generally not subject to ERISA. 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 took effect, 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 as these plans were historically popular amongst employers. 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. A worker will only have access to a pension if their 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. Since every pension plan is different, 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. Once you have earned a vested benefit, that pension is yours when you reach retirement — even if you stopped working at the company after you vested. 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 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, therefore, 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 and surviving beneficiaries, as well as 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 those 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.

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 $96 for a Certified Itemized Statement of Earnings and $61 for a Non-Certified Itemized Statement of Earnings. 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. Another helpful document the Social Security Administration can provide 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 Sample Pension Benefit 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. Snail Mail: 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: https://www.ssa.gov/retirement/full-retirement-age.	

   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 2026 is a 2.8% 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 for each month between election of early retirement and their FRA. 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. One can also apply for both early retirement and Social Security Disability Insurance (SSDI) and receive early retirement benefits while the disability determination plays out. If an individual is determined to be disabled with an onset date prior to the election of early retirement benefits, the benefit changes to SSDI with no reduction for having elected early retirement. Note that working can affect early retirement benefits and SSDI benefits. See D,

How Working Affects Retirement Benefits, and E, How Working Affects Disability Benefits.

3. **Full Retirement Age:** Once an individual reaches FRA (see chart on previous 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 by 8% for each full year of delay. 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 work 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. FRA 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. Advisors may 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. These are decisions to be made on a case-by-case basis.

   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.
6. It is important to note that overpayments and underpayments in the SSA's programs can occur. For more information on why improper payments occur and what you must do to resolve the issue, please see the links below.
   https://www.ssa.gov/manage-benefits/resolve-overpayment
   https://www.ssa.gov/pubs/EN-05-10098.pdf
   https://www.aarp.org/social-security/faq/payment-wrong-amount/

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. https://www.irs.gov/pub/irs-pdf/p554.pdf.

   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.

   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.

2. If an individual has limited savings and other retirement benefits, then beginning Social Security payments early may be financially necessary.

3. 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. These individuals can also consider applying for SSDI, as noted in A.2. above.

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 2026, the annual earnings limit is $24,480 ($2,040 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 2026, that annual earnings limit is $65,160 ($5,430 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

The SSDI benefit, like the retirement benefit at FRA, is the full benefit the individual has earned. SSDI is payable to those with insured status who are under FRA and meet Social Security's disability standard. Once the SSDI beneficiary reaches FRA, the benefit automatically switches to a retirement benefit with no change in benefit amount.

1. SSDI beneficiaries (and certain of their disabled family members eligible for dependent or survivor 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 disability waiting period for Medicare are those diagnosed with ALS or End-Stage Renal Disease. Please refer to Chapter 7 for an excellent review of the Medicare program.

2. 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.

a. **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 2026, "services" is defined as $1,160 or more a month in gross wages or 80 hours or more a month in self-employment. See here for a table of prior years' trial work thresholds: https://secure.ssa.gov/poms.nsf/lnx/0413010060. 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.

b. **Extended Period of Eligibility (EPE).** The EPE is an additional period in which to test the ability to work without immediate termination of SSDI 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 payments 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 the beneficiary is overpaid if they receive payment in what should have been a suspended month. 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.

c. **Substantial Gainful Activity (SGA).** SSA generally defines SGA by a dollar amount of monthly wages that is pegged to the annual COLA. In 2026, SSA presumes SGA when a person eligible for benefits based on disability has gross monthly wages at $1,690 or more. For those eligible on the basis of statutory blindness, the presumed SGA level is $2,830 gross or more in monthly wages. See here for a table of prior years' SGA thresholds: https://secure.ssa.gov/apps10/poms.nsf/lnx/0410501015. Certain deductions may apply to rebut the presumption of SGA: impairment-related work expenses; subsidy or special conditions; unsuccessful work attempts; or unincurred business expenses (for self-employment). https://secure.ssa.gov/apps10/poms.nsf/lnx/0410505010, https://secure.ssa.gov/apps10/poms.nsf/lnx/0410501055.

d. **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.

e. **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.

f. **Check out Ticket to Work programs on the SSA website.** Visit 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 (Wife's and Husband's Benefits).** 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 married for at least one year, and being age 62 and older, or 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 Retirement 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 Retirement 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 marriage must have lasted nine months, or have been expected to last nine months at the time of the marriage. 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 (some exceptions apply), 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. Increasingly, Social Security expects consumers and third parties to use electronic resources on its website, SSA.gov. Social Security encourages people to use these resources. In-person appointments may still be made, but there may be increased wait times due to reduced staffing. Individuals may now apply for Social Security benefits, but not SSI benefits, through the Social Security website, if they have signed up for "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. Most appeals may also be filed online.
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 properlvy 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 information on the WEP and GPO reduction calculations, please see https://secure.ssa.gov/apps10/poms.nsf/lnx/0202610000 and https://secure.ssa.gov/apps10/poms.nsf/lnx/0202608000.
    d. A worker with 30 or more years of work where earnings were "substantial" (see Social Security Substantial Earnings Table at https://www.ssa.gov/pubs/EN-05-10045.pdf) 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. https://www.ssa.gov/benefits/retirement/social-security-fairness-act.html.

   a. Social Security states that it had increased benefits for benefit recipients affected by the WEP or GPO and had completed paying out WEP and GPO retroactive increases owed to recipients in July 2025.

   b. Those not in receipt of Social Security benefits due to the WEP or GPO should apply.

CHAPTER 7
MEDICARE
What You Need to Know

INTRODUCTION

Health insurance, including Medicare, does not cover all services and costs. This chapter provides a basic overview of Medicare to help you choose the coverage that best meets your needs.

Medicare Part C ("Medicare Advantage" or "MA") plans are administered by private insurers. Medicare Advantage plans receive a fixed amount for services, paid by the Medicare trust funds, and the remainder of the funding comes from participants, including additional premiums beyond the usual Part B. MA plans must cover Part A and B services, but they can also 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. MA plans usually require that the patient see health care providers only in the network, and the Health Maintenance Organization (HMO) model 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) has noted that MA plans frequently deny care using prior authorizations that Original Medicare would provide.

Medicare Part D ("Prescription Drug Plan") is generally funded by federal general revenues and participant premiums. In 2026, the federal government has capped the total out-of-pocket expenses and deductibles for participants. 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 have rules for if and how they cover certain drugs, including prior authorization, step therapy and quantity limits; they may also completely deny coverage for a drug.

All of these plans are discussed in detail below.

A. 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:** Your Medicare card shows Part A coverage as "Hospital."
    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's 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 proprietary commercial algorithms and 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 and 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.medicare.gov/providers-services/claims-appeals-complaints/appeals/original-medicare/appeal-part-a-hospital-status-change. (This does not apply to Medicare Advantage plans. Information for filing MA denials is 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, InterQual, that is regularly used to determine where to discharge patients, particularly for admission into rehabilitation facilities. It is typically used by the care management, usually 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 types of facilities (acute rehabilitation facility and the basic facility) as long as you meet specific requirements. Part A can 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, not counting the day of discharge. (Some Medicare Advantage plans may waive this requirement.); you must also enter the SNF within a short time (generally 30 days) from when you were discharged from the hospital. In addition to the "three-day rule," (counted from midnight to midnight), all of the following must be certified as medically necessary by a physician as true:

i. A physician certifies that you need skilled services that must be performed by professional personnel for a condition for which you were in the hospital or for a new condition that started while you were already receiving SNF care.

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, depending 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. Custodial care is not covered. 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 aide services. Most services are available when there is a reasonable likelihood that the patient will improve and do require the patient to participate.

i. **Exception for services needed to maintain your condition/slow deterioration**

Skilled nursing, home health, and outpatient therapy can be provided to maintain your condition. Your restoration potential is not the deciding factor in whether you need skilled services. Services that can maintain your condition or slow your deterioration can also be covered by Medicare. 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 will not be regarded as a skilled nursing service, even if a nurse actually provides or supervises the service. Moreover, 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 one week in advance that you are going 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.

2. **Medicare Part B: Your Medicare Card Shows Part B Coverage as "Medical"**

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.

3. **"Medicare Advantage" or "MA"**

a. **Network benefits:** Subject to prior authorizations and network restrictions, MA includes all the benefits and services under Parts A and B and may or may not offer outpatient prescription drug coverage. Medicare Advantage plans are run by private health insurance companies and approved by Medicare, and they 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. Information on how to appeal prior authorization denials and out-of-network decisions is provided below.

b. **Payments due:** You will continue to pay the Part B monthly premium (and any Part A monthly premium if you owe it). 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. **Medicare Advantage plans website:** Medicare Advantage 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. **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.

   i. **Special needs plans:** 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).

e. **Artificial Intelligence (AI) and the use of AI and algorithms in determining benefits:** CMS has authorized the use of artificial intelligence to review and support prior authorization requests and, starting in 2026, requires MA plans to report more data on prior authorization practices. MA plans cannot use AI if it overrides the standards for medical necessity or relies on a large dataset without considering the specific patient's medical condition and clinical notes. However, because these processes are proprietary, it can be difficult to access the information necessary to file an appeal.

4. **<u>Medicare Part D</u>**

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 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 will be covered. 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."

B. 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
Example: Heart surgery — stent	Room, nursing care, 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.

C. 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. ACOs are not Medicare Advantage plans, and they do 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 Medicare Advantage plan.
3. **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 Medicare Advantage. The Medicare 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.

a. **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.

b. **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 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.

c. **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.

D. MEDICARE LIMITATIONS AND COSTS

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.

1. **Not All Medical Bills Are 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.

   a. **Medicare costs:** Specific premium, deductible and co-insurance cost amounts for Parts A, B and D can be found at Medicare.gov. Costs for specific Medicare Advantage plans can be found at the Medicare Planfinder or by calling the insurer directly.

      i. **Part A premium, deductible and co-insurance:**

      (a) **Part A premium:** To be eligible for premium-free Part A, a person must have 40 work credits with Social Security based on their own earnings or those of a qualifying spouse, parent or child. Those who do not have the minimum 40 credits through their own record or their relative's record 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 Social Security Administration (SSA) to recalculate your work credits each year, which may reduce your Part A premium.

      (b) **Part A deductible:** When you are first admitted as an inpatient, you will pay a deductible. 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, with a new deductible, starts with your next inpatient hospital admission. 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) **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 MEDICARE PART A: 2026 chart in this chapter's Appendix.

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

(a) **Part B premium:** You will pay a monthly premium for Part B, based on your income. 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 2026 Part B premium, the income tax filing for 2024). See discussion on IRMAA below. 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. Part B generally starts in January, except the first year you are enrolled, when the plan starts depending on when you first enroll; the deductible in your first year is due when you start using services.

iii. **Part B co-payments and coinsurance:** These costs are calculated based on the service you receive; it is generally 20% of the Medicare-approved cost. There is no limit on co-payments or coinsurance that you may pay throughout the year.

b. **Medicare Advantage requires enrollment in Part A and Part B:** You will pay a Part A premium, if any, as well as your Part B premium, to Medicare. You will pay an additional monthly premium for Medicare Advantage coverage, as well as deductibles and co-insurance based on your plan. You will pay for any out-of-network services. Most Medicare Advantage 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.

c. **Part D costs:** Medicare Part D plans have monthly premiums and deductibles. Under law, no plan can charge more than $615 for a deductible in 2026. Premiums average $34.50/month, but this can vary with each plan. 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 $2,100 in deductible, co-payment and co-insurance, you pay nothing for your Medicare-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 for more information.

d. **IRMAA:** For both Medicare Parts B and D, Medicare beneficiaries with higher incomes are charged an Income-Related Monthly Adjustment Amount (IRMAA). An IRMAA is calculated on your income from two years prior, meaning that your 2026 IRMAA is determined by your 2024 income. Regardless of whether you are in Medicare Advantage or Original Medicare, the IRMAA for Parts B and D is collected by the SSA. 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.

e. **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.

2. <u>Medicare Advantage Limitations</u>

a. **Network requirement:** Medicare Advantage plans require that you get care from the plan networks. 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. **Physician participation:** 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 to see if your physician is a part of the network you want.

c. Criteria for providing care may differ between Original Medicare and some Medicare Advantage plans. **CMS has made clear that it is illegal for Medicare Advantage plans to apply more restrictive coverage rules than Original Medicare**, but as a practical matter, this is difficult for a patient to address without a health advocate.

   i. **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-pre-claim-review-initiatives/prior-authorization-certain-hospital-outpatient-department-opd-services.

   In contrast, Medicare Advantage plans generally do require PA: PAs are most likely necessary for the highest-cost services, such as chemotherapy drugs, SNF stays and acute inpatient stays. If a Medicare Advantage plan offers prescription drug coverage, PAs are generally required for high-cost drugs. One study compared access to care by Original Medicare beneficiaries and Medicare Advantage beneficiaries. Forty-one percent of Original Medicare beneficiaries received care without a PA that would have been required by a Medicare Advantage plan. Most PAs were required for Part B drugs, radiology and radiation oncologists.

   ii. **Recent PA legislation:** Federal law does not prohibit Medicare Advantage plans from using PAs, 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.

   iii. **Step therapy as a form of PA:** 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.

   iv. **Appeal of PA denials:** If your PA request is denied, you can appeal the decision.

d. **Medicare Givebacks and predatory marketing:** Many Medicare Advantage 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.

   Additionally, CMS allows insurance agents for Medicare Advantage plans to receive commissions on a sliding scale, allowing greater bonuses for plans with limited coverage.

E. CHOOSING BETWEEN ORIGINAL MEDICARE OR MEDICARE ADVANTAGE

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.

1. **Consider the Following to Help You Evaluate Your Options:**

   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. However, CMS has a "crosswalk" policy where you may be shifted to a different Medicare Advantage plan if your current plan is canceled or the carrier ceases to do business in your area. See 42 CFR Sec 422.530 – Plan Crosswalks.

   b. **How is the Medicare Advantage plan 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.

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

      i. **Original Medicare with a Medicap policy may provide 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.

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

      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, which is a requirement of some Medicare Advantage plans, is not a requirement for Original Medicare.** Individuals in rural and isolated areas may have difficulty finding Medicare Advantage plans that work with their local health care services.

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 at least two Medicare Advantage plans. You may want to consider calling SHINE back for a second opinion, since SHINE counselors can differ in their recommendations.

F. ELIGIBILITY FOR MEDICARE AND ENROLLMENT

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

2. **Citizenship/Lawful Presence**

   Prior to 2025, residents of the U.S., including citizens, permanent residents and lawfully present immigrants, could be eligible for Medicare. This included lawfully present immigrants age 65 or older without a 40-quarter work history, as those individuals could purchase Part A after residing in the U.S. for five continuous years.

   Starting in July 2025, refugees, asylees, and people with Temporary Protected Status will no longer be eligible for Medicare. Those who currently have Medicare who fall under these categories will be terminated no later than July 2027.

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.

4. **Eligibility at Age 65**
   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 should 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.

5. **Eligibility for People Under 65 with Disabilities**
   Medicare is also available to people younger than 65 who have certain disabilities:

   a. **Social Security Disability Insurance (SSDI) Recipients:** Individuals under age 65 who qualify for SSDI will be eligible for Medicare after 24-consecutive months. 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.

   b. **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 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.

c. **Amyotrophic Lateral Sclerosis (ALS):** Individuals suffering from ALS are eligible for Medicare coverage immediately upon approval for SSDI benefits.

6. **Medicare Enrollment Periods**

a. **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.

b. **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.

c. **Open enrollment period:** Between Oct. 15 and Dec. 7 of each year, you can:

i. Join, drop, or switch to another Medicare Advantage plan;

ii. Switch from Original Medicare to Medicare Advantage, and vice versa;

iii. Join, drop, or switch to another Part D plan.

Enrollment changes are effective Jan. 1 of the next year.

d. **Medicare Advantage open enrollment period:** Those already on a Medicare Advantage plan can switch to another Medicare Advantage plan or return to Original Medicare between Jan. 1 and March 31 of each year.

e. **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, such as:

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.

You can get more information about special enrollment periods at https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods.

f. **Failure to enroll:** If you do not sign up for Medicare during the initial enrollment period or when you are first eligible, your monthly premiums may increase as follows:

i. **Part A and Part B:** If you are covered by insurance based on your or your spouse's current work insurance, you will not face late enrollment premiums. However, if you do not have cur-

rent work-based health insurance, your Part A monthly premium can be increased by 10% for twice the number of years that you delay enrollment. Additionally, your Part B monthly premiums may increase 10% for each 12-month period that you delayed enrolling in Medicare. Part B late enrollment penalties last for as long as you have Medicare, or until you turn 65, whichever is earlier

If you have incurred such a late enrollment penalty, you should look into filing for "equitable relief." A successful claim for equitatble relief may waive the Part A and Part B late enrollment penalties and allow a "special enrollment date" if the federal government has misled you about enrollment rules.

ii. **Part D:** If you waited 63 or more days to enroll in Part D or a Part C plan with drug coverage after the 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 changes annually. For 2026, the penalty is $38.99 per month, multiplied by the number of months you were eligible for Part D but did not enroll, rounded to the nearest dime. This penalty is in effect for as long as you have Medicare Part D coverage, or until you turn 65, whichever is earlier.

"Creditable coverage" is prescription drug coverage that meets Medicare's minimum prescription drug coverage. Check with your insurance plan to confirm whether your coverage is considered "creditable."

You can appeal Medicare Part D late enrollment penalties 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.

G. 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.

H. 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.

   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. Note the 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

I. OPTIONS TO ENHANCE ORIGINAL MEDICARE COVERAGE

1. **Medigap**

Medigap plans, also known as "Medicare Supplement" plans, cover many of the expenses you owe under Original Medicare A and B, but they do not cover more services or give you more coverage than Original Medicare.

Example One: Medicare does not cover hearing aids, so Medigap does not cover hearing aids.

Example Two: 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 a daily co-insurance for days 21 through 100. A Medigap plan can pay for all of the days when you qualify for Medicare coverage but will not pay for any costs beyond that 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.

a. **Medigap enrollment**

Currently, in Massachusetts, you can enroll in a Medigap plan at any time of the year because the state has a continuous open enrollment policy. Additionally, you can purchase a Medigap plan at initial enrollment or during any annual renewal. This is not true in all states — 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. You cannot be charged more because of preexisting conditions.

b. **Massachusetts Medigap options and premium rates**

There are three types of Medigap plans in Massachusetts: Core, Supplement 1 and Supplement 1A. Their costs vary, as do their benefits. Medigap 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 Massachusetts site to compare Medicare supplement plans ("Medigap"): https://www.mass.gov/doc/2025-medicare-supplement-product-listing-20252026/download.

c. **The advantages and disadvantages of Medigap plans:**

i. **Out-of-pocket costs:** Massachusetts Medigap plans 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.

ii. **Medigap premiums:** Premiums for supplement plans can be expensive, and they are paid to the insurance company.

iii. **Prescription medicines:** Medigap plans do not cover most prescription medicines. In many cases, retirees incur the additional cost of a Part D plan.

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.

2. **Part D Prescription Drug Coverage: You Will Have a Separate RX Card or a Line on Your MA Card for Coverage**

a. **Refer to the description of Part D plans, above.**

b. **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=2026.

Be sure to use the "medicare.gov" websites for full comparisons. Private insurers' websites will not include information on competitors' products.

c. **Part D formularies, tiers and quantity limitations**

i. **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.

ii. **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.

iii. **Exceptions:** If a plan does not carry a drug you need, you and your physician may request an "exception." To do so, 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.

iv. **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 — and have been successfully taking a drug for your condition — and Medicare requires that you utilize step therapy.

v. **Third-Party RX coverage:** If Medicare does not cover your drugs, or you have not been successful with an appeal, check these third-party drug coverages. Be sure to check with your pharmacist where you pick up your prescriptions to see if you can get a better price using some third-party coupon plans, such as CostPlus Drugs, GoodRx or SimpleCare. These plans do NOT have a membership fee or a premium. 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.

d. **Role of pharmacist:** Your pharmacist can provide factual information on your prescriptions, 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.

i. **Part D insulin 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.

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.

ii. **Opioid medications:** 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.

iii. **Available options to reduce medication costs:** There are multiple options for beneficiaries who have difficulty paying for medicines:

(a) **Medicare Extra Help:** Medicare offers "Extra Help" (also known as the "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-payments. The application for this program can be made through the SSA.

(b) **Alternative medicines:** 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 your medication in consultation with a medical professional.

(d) **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.

(e) **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.

3. **<u>Change from Original Medicare to Medicare Advantage</u>**

a. **Medicare Advantage 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 Medicare Advantage plan must be separately researched. Moreover, not all Medicare Advantage plans cover prescription drugs.

b. **Medicare Advantage website:** The website, www.Medicare.gov, lists the Medicare Advantage plans available in your area; the website also identifies those plans with drug coverage. Medicare Advantage 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. Also, 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 Medicare Advantage 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.

J. CHANGING MEDICARE PLANS

1. **Comparing Insurance Providers**

   a. **Criteria:** When shopping for Medicare Advantage, Medicare Part 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?

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.

K. 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" (ABN) 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 — and deadlines — 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, Medicare Interactive, found at www.medicareinteractive.org/get-answers/medicare-denials-and-appeals.
5. **Appeal an Out-of-Network Decision by the MA:** You can appeal an out-of-network decision by going to your insurer's website, downloading the forms and following the directions. The No Surprises act protects you from surprise bills for emergency care from out-of-network providers and out-of-network providers at in-network facilities.

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.

L. KEY INFORMATION

The Medicare Advocacy Project (MAP) is devoted to assisting individuals, regardless of age, who may have been wrongfully denied Medicare or Medicare coverage. MAP will provide help by giving advice or free legal representation to Massachusetts Medicare beneficiaries whether they are enrolled in traditional Medicare or in a Medicare Advantage plan.

Each year, many elders and persons with disabilities are wrongfully denied Medicare coverage. Some are denied coverage for physicians' services, durable medical equipment, home health care or skilled nurs-

ing facility care. Others are forced to leave the hospital prematurely, are denied prior approvals by their managed care plans, or are made to wait for coverage to begin while facing potentially permanent monthly surcharges in addition to payment of their monthly health insurance premiums. Countless others hit roadblocks, such as medication denials, created by Medicare's complex systems. As a result of these denials, beneficiaries risk gaps in insurance coverage, interference with access to necessary medication or medical care, and/or severe financial duress.

If you have questions about your Medicare enrollment or claims, contact MAP through your closest legal aid office Those offices are:

1. **Community Legal Aid:** 855-252-5342 or www.communitylegal.org.
2. **Greater Boston Legal Services:** 617-371-1234 or www.gbls.org.
3. **Metrowest Legal Services:** 800-696-1501 or www.mwlegal.org.
4. **Northeast Legal Aid:** 978-458-1465 or www.northeastlegalaid.org.
5. **South Coastal Counties Legal Services:** 800-244-9023 or www.sccls.org.

The Massachusetts Legal Resource Finder, https://masslrf.org/en/home, can help clarify which legal aid agency serves your area.

M. APPENDIX

For additional information about Medicare appeals, see https://medicareadvocacy.org/wp-content/uploads/2025/04/Slides-Medicare-Appeals-101-4-2025.pdf.

To access forms and learn more about claims, appeals and complaints, go to https://www.medicare.gov/basics/forms-publications-mailings/forms/appeals.

- 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.
- https://medicareadvocacy.org/frequently-asked-questions-about-the-observation-status-court-decision/.

1. **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

   FAQs; CMS manual updates can be found at https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-policy-manual

   For detailed information on the need for skilled nursing care when there is no likelihood of improvement, see https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec409-32.pdf.

"When Can I Buy Medigap?" https://www.medicare.gov/supplements-other-insurance/when-can-i-buy-medigap.

i. https://www.ncoa.org/age-well-planner/medicare.

2. **Cost charts for Original Medicare A, B and D — 2026**

MEDICARE PART A: 2026			
SERVICES	**BENEFIT**	**MEDICARE PAYS**	**DEDUCTIBLE YOU PAY* You owe this full amount when you are admitted as an inpatient; it is not prorated.**
Hospitalization: • 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 $1,736	$1,736 (deductible)
	61st to 90th day	All but $434 per day	$434 (co-insurance) per day
	91st to 150th day (lifetime)**	All but $868 per day	$868 (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) • Semi-private room and board • Skilled nursing and rehabilitative services • Other service	First 20 days	100% of approved amount	Nothing
	Additional 80 days	All but $217 per day	$209.50/day (co-insurance)
	Beyond 100 days	Nothing	All costs
Home Health Care: • 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	• 100% of approved amount • 80% of approved amount for durable medical equipment	Nothing for services 20% of approved amount for durable medical equipment
Hospice Care: • 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)

Blood: Blood transfusions for inpatients, including SNF, hospice and some home health care.	Check with your provider for costs.	• Nothing • All	• Patient must have paid the Part A deductible.

Medicare "beneficiaries" receive "medically necessary and reasonable" (least expensive) treatment. Not all services/tests are provided under Medicare.

* 2026 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. This can be up to $565 each month. To calculate the coverage, and to find out how to avoid the penalty, see https://www.medicare.gov/basics/costs/medicare-costs.

**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.

3. Chart — Medicare Part B — 2026

Medicare Part B 2026			
SERVICES	**BENEFIT**	**MEDICARE PAYS**	**YOU PAY+**
Medical Expenses: • 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)	Unlimited if medically necessary	• 80% of the approved amount after $283 deductible, as well as 80% for most outpatient services, including mental health	• $283 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
Outpatient hospital care	• Unlimited if medically necessary	• 80% of the approved amount after the deductible.	• 20% of the approved amount for doctors' and other health care providers' services, after the deductible. • A co-payment to the hospital for each service you get in a hospital outpatient setting; not to exceed the Part A hospital stay deductible amount.
Outpatient Mental Health Services	• Yearly depression screening • Visits for mental health	• Everything • 80% of the approved amount after $283 deductible	• Nothing if your provider accepts assignment • 20% of the approved amount after $283 deductible

Clinical Laboratory Services: • Blood tests, urinalysis and more	Unlimited if medically necessary	100% of approved amount	Nothing for services
Home Health Care: **(if you don't have Part A)** • Intermittent skilled care • Home health aide services • Durable medical equipment • Other services and supplies • No custodial care — must be recovering	Unlimited as long as you meet Medicare conditions	• 100% of approved amount • 80% of approved amount for durable medical equipment	• 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 cost	Medicare payment to hospital based on hospital cost	20% of Medicare payment amount (after $240 deductible)

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.

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. These premiums are found at Medicare.gov.

4. 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 2027 and beyond: Leave insulin off your list of drugs when you are on the medicare.gov website. The $35 co-pay is a universal rule, so all insurers should charge you $35/month in 2026 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.

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 2026 income threshold of $2,982 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 $162,660 (2026). 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 $2,982, 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 $3,032 ($50 over the income limit), the Medicaid $522 standard (less a $20

income disregard) is applied and subtracted from $3,032. That figure, $2,490, is then multiplied by six, and as a result, a $14,940 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 per the federal Post-Eligibility Treatment of Income (PETI) regulations at 42 CFR 435.726.

3. Applicants seeking coverage under the PCA program may have lower recurring deductibles, since an additional $1,247 PCA disregard is subtracted from their gross income, resulting (using the prior example) in a monthly deductible of $1,263, which, when multiplied by six, imposes a $7,578 deductible (as opposed to a whopping $14,940 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 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 the couple needs services, the non-applicant spouse's income is disregarded, but the spouse's assets are limited to $162,660 (as of January 2026). In addition, the income threshold for an individual in 2026 is $2,982 (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. *However, if the income of an individual who was initially deemed eligible for PACE (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 per the federal Post-Eligibility Treatment of Income (PETI) regulations at 42 CFR 435.726.

CAVEAT: At present, there is no penalty imposed for transferring assets. However, as of March 2026, there will likely be a five-year lookback for any transfers made to non-qualifying individuals. As this has not been codified as of the writing of this update, the reader MUST confirm whether this policy is being implemented at the time of application.

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 waitlist 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 waitlist. 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. As of July 1, 2025, the PCA wage rate is $20 to $22.40 per hour based on experience. As of Jan. 1, 2026, an additional $3.35 per hour can be added for complex care. Based on the federal poverty levels, effective Jan. 13, 2026, the MassHealth PCA disregard amount is $1,247 for an individual and $1,748 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. 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.

Enrolling in SCO is open to MassHealth Standard members who are 65 or older and:

a. Reside in an area serviced by an SCO;

b. Live at home or in a long-term care facility;

c. Do not have to meet a recurring six-month deductible;

d. 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. 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 2026, 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. GAFC regulations 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:

1. Over the age of 60 or chronically disabled;
2. Have a medical, physical, cognitive or mental condition that limits their ability to care for themselves;
3. Need daily help with one or more ADLs (e.g., dressing, bathing, eating or toileting);
4. Have the ability to live independently, with support services;
5. Meet eligibility requirements for public housing, GAFC, ElderChoice subsidized rents and/or SSI-G;
6. Do not need full-time skilled nursing care;
7. Are medically approved for assisted living by their physician and 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 $1,330 (2026), or a couple's income is greater than $1,803 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

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 Aging and Independence, 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 Aging and Independence 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 ASAPs, 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. **Patient Paid Amount (PPA):** 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. The following Example 1 shows how the Patient Paid Amount (PPA) would be determined under the facts described to calculate how much of this unmarried applicant's income must be paid each month to the nursing home.

b. **Example 1: Patient Paid Amount (PPA):**

EXAMPLE 1 Patient Paid Amount (PPA)
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 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.

c. **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.

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 2026 is $2,643.75, 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 $793.13).

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 $1,593.13, which is $800 more than the federal minimum of $793.13. As a result, Mrs. Smith's MMMNA is $3,443.75, which is the total of the minimum monthly allowance of $2,643.75 plus the $800 excess shelter costs. Because Mrs. Smith requires additional funds above her own $1,800 income to satisfy her $3,443.75 monthly need, each month her spouse can transfer $1,643.75 ($3,443.75 - $1,800) of his income to her, to the extent available, rather than include it in his PPA 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 2026, 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 (including, but not limited to, the following):**

      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. **<u>Special Rules for the Principal Residence</u>**

a. **Equity in the home:** MassHealth will treat equity in an applicant's home, up to $1,097,000 (as of 2026), 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 ERU:**

i. The notice form is mailed by the 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 the 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 recommended to consult an elder law attorney 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. Waiver requests must be filed within a time-sensitive deadline.

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 regarding 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 2026, 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 ÷ $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 ÷ $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	2026 Maximum Monthly Payment for Pension with Aid and Attendance
Single veteran	$2,424
Veteran with a spouse	$2,874
Surviving spouse of a veteran	$1,558
Two veterans married	$3,845

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.

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.

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 2026, the net worth must be no more than $163,699. The VA's net worth limit increases every Dec. 1 to match the Consumer Price Index inflation percentage increase for Social Security.

- 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.
- 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.
- 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.

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 $163,699 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 2023 $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 2026 is $2,874. For example, a claimant seeking eligibility in January 2026 who transferred $2,874 in covered assets on Nov. 1, 2025, 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, 2024, the VA pays a veteran with no dependents rated at 10% disability $175.51 per month, while the VA pays the same veteran rated at 100% disability $3,831.30 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. Please note that in addition to federal benefits, veterans also are eligible for state benefits. Please contact your local VSO for further information. 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.

CHAPTER 11
RESIDENTS' LEGAL RIGHTS IN LONG-TERM CARE

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

24/7 care: Nursing homes provide around-the-clock skilled nursing care and assistance with activities of daily living (ADLs). Nursing homes 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).

3. Assisted Living

Definition: Assisted living is intended to encourage and maximize older adults' autonomy and privacy,[1] and some, but not all, residences have "memory care" units. Assisted living is a residential arrangement providing room and board for eligible older adults and disabled individuals who need some minimal aid, support, or supervision with ADLs. ADLs include meal preparation, medication management, housekeeping, laundry, dressing, bathing, grocery shopping and transportation[2] The omnibus long-term care legislation to improve the quality and oversight of long-term care (Chapter 197 of the Acts of 2024, effective Dec. 5, 2024) allows ALRs to provide certain additional health care services, as detailed below, which a resident may pay for in addition to the regular monthly charges.

4. Continuing Care Retirement Community

A continuing care retirement community (CCRC) is an option that offers older adults a continuum of housing: independent living, support services and skilled nursing care. CCRCs may allow elders to remain housed in the same community as their services are adjusted and altered depending on their needs.[3] Services may include skilled nursing and health care, housekeeping, transportation, specialized meals, recreational activities and emergency help.[4] Any skilled nursing care unit in a CCRC is subject to DPH and MassHealth regulations. However, care units in CCRCs are not subject to the rules regarding ALRs.

B. NURSING HOMES

1. Choosing a Nursing Home

a. **CMS website tool:**. CMS has a website tool that allows you to compare nursing homes and view data on nursing home inspections, staffing, quality measures and quality ratings. (See Medicare.gov.)

b. **State website:** Mass.gov also offers important survey information about nursing homes and tools to compare facilities. Survey performance tools allow consumers to compare facilities in the areas of facility administration, quality of nursing care, kitchen and food services, and activities.

c. **Ombudsman and others:** When choosing a nursing home, it is important to speak with others, such as the long-term care ombudsman. Ombudsmen are a resource and source of support for nursing home residents, tasked with enforcing residents' rights and advocating for positive change for residents. Other resources include care managers (often referred to as aging life advocates), and other residents and their family members. 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 also contain information on how to select a nursing home and what questions to ask. Residents and family members should not rely solely on the information on government websites, nor on the physical attributes of buildings.

d. **Medicaid-certified:** Most nursing homes in Massachusetts are Medicaid- and Medicare-certified. In the few facilities that are private-pay-only, or for people who are not eligible for Medicaid or Medicare coverage, the resident must pay for the cost of their care out of pocket, which can cost thousands of dollars per month. Once a resident has established eligibility for Medicaid (see Chapter 9), the resident will be required to turn over a portion of their income and Medicaid will cover the rest.

2. **Dementia Care Standard for Nursing Homes**

   a. **Safeguards:** Massachusetts law provides additional safeguards for dementia residents in nursing homes. All direct care workers are required to complete eight hours of initial dementia care training. Workers must also complete other additional hours of training annually and pass an exam.

   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 outside, prohibition against overhead paging systems except for use in emergencies and barriers to prevent elopement of dementia care residents.) Not every nursing home in Massachusetts has a DSU. DSCUs must be certified every year by DPH. Direct care workers are required to undergo additional and ongoing dementia care training. DSCUs must have at least one "therapeutic activities director" who is responsible for developing and implementing activities for residents. These regulations are intended to ensure that dementia units are staffed with appropriately trained workers.[5]

   c. **Antipsychotic medication:** 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. Residents have the following rights:

      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;
      ix. 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' advance notice of a roommate change, barring any emergency.[6]

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, including having visitors 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.[7]

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 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.[8] 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.[9]

However, a resident cannot be transferred or discharged for nonpayment pending an administrative appeal of a denial of eligibility.[10]

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 documented form and manner that the resident can understand.[11] 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.[12]

   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.[13]

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.[14]

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.[15] A physician must document the reason for an intra-facility transfer in the resident's clinical record.

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.[16] The state law does not contain any provisions regarding the content of the notice or the appeal process. 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.[17]

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.[18]

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.[19]

d. 20-day bed hold defined: The MassHealth bed hold period is currently 20 days for medical reasons and 20 days for personal leave but subject to change on a yearly basis.

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.[20] 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. **Monitoring and licensing:** DPH monitors and licenses Massachusetts nursing homes.[21] 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 history and experience in providing long-term care.[22]

   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.[23]

   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.[24] Such inspections are unannounced, and occur at least twice per year.[25] 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. At the expiration of such time period, the violation will be made public if no correction plan has been submitted.[26]

   d. **Complaints:** DPH fields complaints by or on behalf of nursing home residents through its website and telephone hotline.

   e. **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. The consent must be documented in the resident's medical record on a form approved by DPH, and must include 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. See DPH Circular Letter: DHCQ 17-2-699, dated 2/1/17.

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.[27] Among other things, these regulations include transfer and discharge provisions, bed hold rights and the right to request a fair hearing in certain circumstances.

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.[28] 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.[29]

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.[30]
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.[31]
3. **Prohibit Non-refundable Deposits:** Nursing home facilities cannot require residents to pay a non-refundable deposit.[32]
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.[33]

F. ASSISTED LIVING RESIDENCES (ALRS)

1. **Regulations**
   a. **AGE certifies all ALRs:** The Executive Office of Aging and Independence (AGE), formerly known as the Executive Office of Elder Affairs (EOEA) certifies all assisted living residences (ALRs) in Massachusetts.[34] 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. Massachusetts state law regulates ALRs. There is no federal regulatory authority. As a result, ALR residences and their regulations differ from one state to another.
   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.[35]
   c. **Individual service plans:** Prior to admission, an ALR evaluates a prospective ALR resident and assesses the appropriateness of ALR services for that individual. A prospective resident then receives an individualized service plan detailing the types of services to be provided, who renders such services, 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.[36]
   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.[37] All assisted living residency agreements must include a cover sheet summarizing important provisions of the agreement, and the resident or legal representative must sign the form, which must be retained in the resident's record.[38] See cover sheet attached in Appendix.
2. **Skilled Care in Assisted Living:** Effective Dec. 5, 2024, Chapter 197 of the Acts of 2024 (the omnibus long-term care legislation) allows qualified ALR employees or qualified third-party providers, subject to a written care order, to administer "basic health services." Basic health services are defined as: injections; application or replacement of simple non-sterile dressing; the management of oxygen; specimen collection and the completion of home diagnostic tests, including warfarin, prothrombin or international normalized ratio testing and glucose testing; and ointments or drops.[39]
   a. **Certification to provide basic health services:** AGE will conduct annual compliance reviews for those ALRs that provide basic health services. AGE, 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. The new law specifically states that the nurse need not be on the premises but must be available to staff for consultation. AGE has issued draft regulations that are expected to be finalized by the time this guide goes to print. An ALR resident may still opt to have a third-party provider, and not the ALR, administer basic health services.

b. **Additional fees permitted:** ALRs that choose to offer basic health services may charge additional fees to residents for such services. The amount and purpose of fees must be adequately disclosed to residents or prospective residents.

c. **All basic health services must be offered:** Any ALR that provides basic health services must provide all of the basic health services listed.

d. **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 AGE 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).[40]

It is important to note that because assisted living is a residential model, residents have rights as tenants required under landlord/tenant laws.[41]

5. **Complaints and Enforcement**

ALR residents should not give up their legal rights. See Section H below for information on arbitration and filing complaints.

a. **Definition:** The Assisted Living Ombudsman Program has been expanded and combined with the Long-Term Care Ombudsman Program, now housed under the Executive Office of Health and Human Services (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.[42] 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.[43]

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:**

i. **Assisted Living Ombudsman Program:** In the case of a complaint or violation, a resident, family member of a resident, or representative of a resident may contact a statewide ombudsman.

ii. **AGE complaint:** In addition to contacting the Ombudsman Program or an attorney, residents can file a complaint with AGE or the Attorney General's Office.

iii. **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. In addition, the Attorney General's recently formed Elder Justice Unit is expected to issue consumer protections regulations specific to the rights of ALR residents in 2026.

iv. **Penalties:** The new long-term care bill establishes penalties that AGE can impose upon an ALR that provides basic health services without the requisite certification. Fines are no more than $1,000 per day.

G. CONTINUING CARE RETIREMENT COMMUNITY (CCRC)

1. **Oversight**

AGE 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.

H. RESOLVING PROBLEMS/ENFORCING RIGHTS

If you are having problems with care or services, facing neglect or abuse, threatened with a discharge or eviction, or experiencing any other consumer issues in long-term care or assisted living, it is important to assert your rights and build a record with the public agencies charged with long-term care oversight.

1. **Arbitration**

a. **No good reason to give up important consumer rights:** Nursing homes, ALRs and CCRCs frequently include pre-dispute, binding arbitration requirements in their admission agreements. By agreeing to arbitration, consumers give up important rights, including the right to a jury trial, and the right to file a class-action lawsuit, in the event they suffer harm by the provider. Consumers also bind their heirs from pursuing lawsuits after death. There is generally no good reason for residents to voluntarily agree in advance to waive their rights. Alternative dispute resolution, be it arbitration or something else, is always an option once a dispute has arisen if the parties agree.

b. **Confidentiality:** The results of arbitrations are confidential, and there is no record of the outcomes. This has resulted in issues of abuse and neglect being kept 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.

c. **Prohibition on binding arbitration:** Federal regulations now 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.[44]

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

2. **Ombudsman Program**

The statewide Ombudsman Program is administered by the EOHHS. 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.

a. **Regular visitation:** Ombuds staff (often volunteers) visit facilities on a regular basis, can speak with residents confidentially, and can offer options for residents to voice their complaints and work toward resolution with staff. Each facility is required to post, in a conspicuous location, the name and contact information of the visiting ombudsman assigned to that facility.

b. **Mediation:** The assisted living ombudsman can act as a mediator and attempt to resolve problems or conflicts that arise between an ALR and one or more of its residents, or between residents.

c. **Contact information:** Phone: (617) 222-7495.

d. **Complaints:** File a complaint with the Ombudsman's Office for nursing home or assisted living issues.

State Long-Term Care Ombudsman (for Nursing Homes)

or

ALR Ombudsman Operations Manager (for ALRs)
One Ashburton Place, Fifth Floor
Boston, MA 02108

3. **Department of Public Health (DPH)**

a. **Complaints:** DPH fields complaints by or on behalf of nursing home residents through its website and telephone hotline. Information is available on the DPH website: www.mass.gov/nursing-home-consumer-information.

b. **DPH complaint form:** www.mass.gov/how-to/file-a-complaint-regarding-a-nursinghome-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; or
Fax: (617) 753-8165; or
Phone: (800) 462-5540 (24-hour complaint line for those unable to file a written complaint).

4. **Executive Office of Aging and Independence (AGE)**

a. **Complaints:** AGE handles complaints regarding assisted living residences:

b. **AGE Complaint Form:** https://www.mass.gov/how-to/file-a-massachusetts-assisted-living-residence-alr-complaint-form.

Send by:

Email: AGEhelp@mass.gov

Mail: Executive Office of Aging and Independence, Assisted Living Certification Unit, One Ashburton Place, 10th Floor, Boston, MA 02108

5. **Attorney General's Office (AG or AGO)/93A Consumer Protection Law**

a. **Complaints:** The AG's Office takes complaints regarding unfair and deceptive consumer practices and should be copied on 93A demand letters. The AG has promulgated consumer protection regulations for nursing homes and is in the process of drafting regulations for assisted living residences. Also note that regulations regarding fees, effective Sept. 2, 2025, apply to both nursing

homes and assisted living residences.

b. **Contact:**
Health Care and Fair Competition Bureau, Elder Justice Unit
Office of the Attorney General, Consumer Protection Division
Mail: One Ashburton Place, Boston, MA 02108
Consumer Protection Hotline: (617) 727-8400
Email: ago@state.ma.us
Fax: (855) 237-5130

c. **Demand Letter:** 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.

6. **Elder Abuse and Neglect Hotline**

a. **File an elder abuse and neglect report (includes financial abuse):** Elder Abuse Hotline: (800) 922-2275

b. **Reporting Guide:** https://www.mass.gov/doc/elder-abuse-online-reporting-user-guide.

c. **MA Adult Protective Services Online Report:** https://hssmaprod.wellsky.com/intake/.

7. **Other Consumer Resources**

a. **Dignity Alliance Massachusetts:** www.dignityalliancema.org.

b. **Massachusetts Advocates for Nursing Home Reform (MANHR):** www.manhr.org.

c. **National Consumer Voice for Quality Long-Term Care:** theconsumervoice.org/home.

d. **Justice In Aging:** https://justiceinaging.org/our-work/healthcare/long-term-services-and-supports/nursing-facilities

e. **Long Term Care Community Coalition (New York-based):** https://nursinghome411.org.

f. **Legal services:** To find a local legal services program: https://masslrf.org/en/home/.

g. **Elder law attorneys:** To find a local elder law attorney: https://massnaela.com/.

h. **Aging Life Care Advocates (care managers):** To find a care advocate: https://www.alcanewengland.org/.

1. MASS. G.L. ch. 19D § 1.
2. Id.
3. MASS. G.L. ch. 93 § 76.
4. Id.
5. 105 C.M.R. § 150.022 – 150.029 Dementia Special Care Units.
6. MASS. G.L. ch. 111, § 70E.
7. 940 C.M.R. §§ 4.06- 4.07.
8. Nursing Home Reform Law, 42 U.S.C. §§ 1395i-3(a)-(h) and 1396r(a)-(h).
9. 42 C.F.R. § 483.15(c)(1).
10. 940 C.M.R. § 4.09(2).
11. 42 C.F.R. § 483.15(c)(1).
12. 42 C.F.R. § 483.15(c)(3).
13. 42 C.F.R. § 483.15(c)(3).
14. 42 C.F.R. § 483.15(e)(1)(i).
15. Id.
16. Id.
17. 42 C.F.R. § 483.10(e)(6), 940 C.M.R. § 4.06(11).
18. 42 C.F.R. § 483.15(c)(1) and (2).
19. 42 C.F.R. § 483.15(e)(1)(i).

20. 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.).
21. MASS. G.L. ch. 111, § 71.
22. Id.
23. Id. § 72.
24. MASS. G.L. ch. 111, § 72.
25. Id.
26. Id.
27. 130 C.M.R. § 456.406.
28. Id.
29. 940 C.M.R. § 4.03.
30. 940 C.M.R. § 4.04.
31. Id.
32. Id.
33. 940 C.M.R. § 4.06.
34. 651 C.M.R. § 12.03.
35. 651 C.M.R. § 12.04.
36. Id.
37. 651 C.M.R. § 12.08.
38. 651 C.M.R. §12.08(4).
39. Chapter 197 of the Acts of 2024.
40. 651 C.M.R. § 12.08.
41. M.G.L. c. 186 and c. 239, 940 C.M.R. § 3.17.
42. 651 C.M.R. § 13.00.
43. Id. § 13.03
44. 42 C.F.R. § 483.70(n).

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.

MassNAELA
National Academy of Elder Law Attorneys
Massachusetts Chapter
Leading the Way in Special Needs and Elder Law in Massachusetts℠

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

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www.MassNAELA.com

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Elder Advocates Spread the Word:

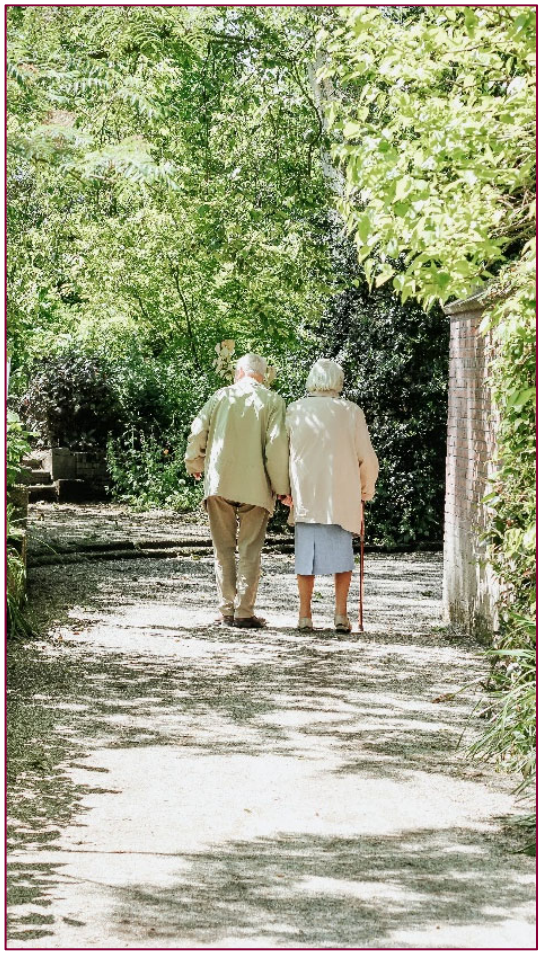
Just Say "NO" to Arbitration!

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.



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 condition 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 AGING & INDEPENDENCE (AGE)

1. **Statewide Agency**

   The Executive Office of Aging & Independence (AGE), 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 attorney 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. If a guardian is requesting authority to admit an incapacitated person to a nursing home, the legal test applied by the judge is not the wishes of the incapacitated person but rather their best interests.

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, by talking with the individual about ways to spot potential scams, and by 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, and file a consumer complaint with the Office of the Attorney General at 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 if they 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.

   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
   https://www.equifax.com/personal/credit-report-services/credit-freeze

   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://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, many 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.

Massachusetts ranks among the more cautious states regarding elder driving safety. Its combination of mandatory, in-person renewal at age 75, vision testing, and explicit medical self-reporting makes it more stringent than most states except Missouri and Georgia, which impose earlier or more frequent testing. The system emphasizes both personal responsibility and direct oversight by the Registry of Motor Vehicles (RMV) to balance driver independence and road safety.

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. The result is that older adults, families, physicians, police officers and lawmakers are 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), who will work 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.
2. 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.
3. 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 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 it is 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.

5. Medically impaired drivers who voluntarily surrender their license, or who fail the competency road test, are eligible for a Mass ID free of charge.

   Prior to a formal driving assessment, it may be appropriate to take a mature driver safety course online. Carfit is a program offered through the American Occupational Therapy Association and AARP. The RMV provides optional evaluation programs through hospitals and driver rehab centers to assess driving capacity and offers educational workshops like "Shifting Gears" to help families recognize warning signs of unsafe driving.

D. RMV FORMS

The authority for immediate threat suspensions in Massachusetts comes from Massachusetts General Laws, Chapter 90, Sections 22(a) and 22(b).

1. **Request for Immediate Threat License Suspension/Revocation (RMV-IT Form)**
   a. This is the official RMV form used by law enforcement officers, physicians or other qualified professionals to request that the RMV suspend or revoke a driver's license immediately.
   b. Available directly through Mass.gov (PDF-fillable form).

      The form requires:

      i. Driver's identifying information.
      ii. Detailed statement describing the observed conduct or medical condition posing an immediate threat.
      iii. Reporter identification and signature (must not be anonymous).

      Completed forms are submitted to MassDOT RMV's Driver Control Unit via email or fax for urgent review.

      Once received, an RMV hearing officer may issue an indefinite suspension on the same day if public safety risk is confirmed.

2. **Request for Medical Evaluation (RMV-MED Form)**
   a. Used by medical professionals to notify the RMV that a driver's health condition could impair safe operation.
   b. May accompany or serve as a precursor to an immediate threat form.
   c. Sent to the RMV Medical Affairs Division (P.O. Box 55889, Boston, MA 02205; Fax (857) 368-0018).
   d. This report can lead the RMV to require medical documentation, impose restrictions, or initiate suspension under M.G.L. c. 90 § 22(b) and 540 CMR 24.00.

3. **Complaint of Improper Operation Form**
   a. Used primarily by law enforcement following motor vehicle incidents (e.g., erratic or reckless driving, crash linked to medical impairment).
   b. Filed internally through police or crash reports but can prompt a parallel immediate threat suspension at the RMV's discretion.

4. **An Immediate Threat suspension is most frequently triggered by one of two RMV forms**:
   a. RMV-IT form (Immediate Threat Suspension/Revocation)
   b. RMV-MED form (Request for Medical Evaluation)

   Both forms provide the RMV with authority to impose an immediate, indefinite license suspension when credible evidence suggests a driver presents an urgent public safety risk under Massachusetts General Laws Chapter 90, Section 22(a)-(b).

E. 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. Since May 7, 2025, all U.S. citizens have needed 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 accommodation or provide guidance.

The RMV provides specialized contact lines and hours for older drivers who need to renew their licenses or complete identification services in person.

F. RMV CONTACT INFORMATION

1. **For Older Drivers**
   a. **Senior appointment line:** (857) 368-8005. Available Monday–Friday, 9 a.m.–5 p.m.

      This direct line is reserved for customers age 65 or older or individuals with disabilities who need assistance scheduling an appointment for license or ID renewal.

   b. **Email for senior assistance:** MassDOTRMVSeniors@dot.state.ma.us.

   c. **Website (for booking appointments):** www.mass.gov/rmv — Select "Make/Cancel a Reservation" and choose "Senior Transaction" for available appointments.

2. **Senior Appointment Hours**
   a. **Designated senior hours:** Wednesdays, typically 9 a.m.–5 p.m., at 17 RMV Service Centers, including Brockton, Danvers, Fall River, Greenfield, Lawrence, Leominster, Plymouth, Revere, South Yarmouth, Springfield, Watertown and Worcester.

   b. **Senior appointments:** Appointments during these hours are limited to license and ID renewals and registration or title transactions for seniors only.

   c. **AAA members:** Seniors who belong to AAA may renew at participating AAA branches by booking through https://aaa.com/appointments.

3. **General RMV Office Hours**

   Most RMV Service Centers operate Monday–Friday, 8 a.m.–6 p.m., with appointment-based services; a few (like Boston-Haymarket) offer limited Saturday hours, typically 9 a.m.–4 p.m.

   These senior-dedicated services are designed to minimize wait times and provide a safer, less crowded environment for older motorists needing in-person assistance.

   Alternatives to in-person renewal: For Massachusetts drivers age 65 and older, there are limited but convenient alternatives to in-person renewal, depending on age, license type, and membership in partner organizations.

G. ELIGIBILITY AND ALTERNATIVES

1. **Online Renewal (for drivers under age 75)**
   a. Drivers age 65–74 may renew online via the RMV's Online Service Center if there are no changes to name, address or medical status, and if a REAL ID upgrade is not required.

   Process:

   a. Visit Mass.gov/myRMV.
   b. Enter date of birth, license/ID number and Social Security number (last four digits).
   c. Pay the renewal fee and verify the address for mailing.
   d. The renewed license is mailed within 10–14 business days.

2. **AAA Branch Renewal (for AAA members)**
   a. Members of AAA Northeast can renew both driver's licenses and registrations at participating AAA offices without needing to visit an RMV location.
   b. This is available to drivers of any age, including those 75 and older, if their license status is active and they pass the required vision screening at AAA.
3. **By Mail (temporary option with vision certification)**
   a. During specific RMV programs or public health periods, the RMV has permitted mail-in renewals for older citizens who provide a vision-screening certificate completed by an optometrist or ophthalmologist.
   b. This option may reappear in certain hardship or accessibility situations — contact the RMV Senior Phone Line (857) 368-8005, Monday-Friday, 9 a.m.–5 p.m.) for current eligibility.
4. **Travel Assistance and Accessible Services**
   a. The RMV and MassDOT partner with local senior centers and the MBTA Travel Instruction Program to help older adults reach service centers or AAA branches.
   b. Some councils on aging provide volunteer ride programs for local RMV appointments.
5. **In Massachusetts**
   a. In-person renewal is mandatory at age 75 and over, but drivers 65-74 can renew online or at AAA branches if they meet basic criteria.
   b. Those requiring assistance can call (857) 368-8005 or email MassDOTRMVSeniors@dot.state.ma.us for help scheduling or exploring mail-in options.
   c. Eligibility for online or mail-in driver's license renewal for older adults depends on age, medical reporting status and license type.
6. **Drivers are Eligible to Renew Online Through the RMV Online Service Center if They Meet All of the Following:**
   a. Are younger than 75 years old at the time of renewal.
   b. Have no new medical conditions or vision changes requiring RMV evaluation.
   c. Hold a valid, active Class D (passenger) or Class M (motorcycle) license.
   d. Are renewing a standard or REAL ID license already on file with the RMV (name, signature and photo up to date).
   e. Have not legally declared or self-reported any cognitive or physical impairment that may affect driving.

f. Do not require any legal presence documentation update (e.g., immigration or citizenship verification).

If all these criteria are met, renewal can be completed at https://mass.gov/myrmv with the new license mailed within 10–14 business days.

7. **Mail-In Renewal Eligibility**

Mail-in renewal is currently limited but may apply if:

a. The RMV issues a temporary accommodation for individuals with mobility or health restrictions preventing in-person visits.

b. A vision-screening certificate completed by a licensed optometrist or ophthalmologist is provided (RMV form).

c. Seniors call the RMV Senior Line (857) 368-8005, Monday–Friday, 9 a.m.–5 p.m. to confirm availability or receive mailing instructions.

d. Eligibility for mail-in renewal is verified individually through RMV customer service, and some exceptions are made for those 75 and older with verified health limitations or pandemic-related safety concerns.

To file a complaint with the Massachusetts RMV Medical Affairs — typically with the intent to trigger a medical review or immediate threat suspension — the following types of evidence and documentation are required:

8. **Required Evidence for Medical Affairs Complaints**

a. **Detailed factual observations:** The complaint must describe specific behaviors, incidents or medical symptoms that raised concern about the driver's ability to operate safely. This includes episodes like loss of consciousness, confusion, erratic driving or observed physical/cognitive impairment.

b. **Medical records or completed evaluations:** Supporting medical documentation is strongly encouraged, such as a physician's letter, treatment notes, or the RMV's own "Request for Medical Evaluation" form completed by a licensed health care provider. Forms may include diagnosis, medication history, and the provider's professional assessment of driving safety.

c. **Completed RMV forms:** The "Request for Medical Evaluation" form (RMV-MED) must be completed and submitted by law enforcement or a medical provider, with their signature and contact details.

d. **Specific incident details:** Effective complaints include the exact dates, locations and descriptions of relevant incidents (such as when and where the concerning driving occurred) along with the identity of the complainant.

e. **Other supporting documentation:** Photos, police reports, witness statements or prior crash records may be attached to strengthen the complaint.

9. **Review Process and Additional Information**

a. The RMV Medical Affairs Division may request additional information or clarification from reporting parties or the driver's own medical team once the complaint is received.

b. Anonymous complaints are accepted but may be less effective due to limited ability to gather records or follow up.

c. The RMV will inform the driver of the complaint and may require a medical hearing or additional evaluation.

d. To initiate a medical complaint, the RMV expects specific, factual and documented evidence from the reporting party, ideally backed by medical evaluations or provider statements. This ensures that only credible, well-supported concerns trigger medical review or suspension actions for driver safety in Massachusetts.

H. 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:

1. The Massachusetts RMV has dedicated a part of its website to addressing the needs of, and providing resources concerning, older adult drivers.
2. Community senior centers are also typically a great source of information.
3. 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.
4. 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.
5. 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.
    a. 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.
6. 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.
7. For more information on this topic, please refer to the Massachusetts RMV brochure on "YourgHealth and Driving Safely in Massachusetts": https://www.mass.gov/doc/your-health-and-driving-safely-0/download.
    a. 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.

I. STATUTORY AUTHORITY

1. **Under M.G.L. c. 90 § 22(a):**
    a. The Registrar of Motor Vehicles may suspend or revoke immediately, without a prior hearing, any person's license or right to operate a motor vehicle if the Registrar determines that the person's continued operation "would constitute an immediate threat to public safety."
    b. This law grants the RMV discretionary power to act swiftly based on reports from police officers, physicians or other credible sources, who observe medical, cognitive or behavioral signs that suggest a driver is unsafe.
    c. M.G.L. Section 22(b) complements this by authorizing similar immediate action for medical conditions or impairments that render a person unfit to operate safely.
2. **Implementation and Regulation**
    a. The RMV enforces this authority under its Medical Affairs Division and 540 CMR 24.00, which outline the standards for medical fitness to drive and procedures for review and reinstatement following an immediate threat suspension.
    b. In short, M.G.L. Chapter 90, § 22(a) and (b) serve as the statutory foundation for all immediate threat license suspensions in Massachusetts, empowering the RMV to revoke or suspend a driver's license when evidence indicates an urgent risk to public safety.

c. The RMV uses specific forms that can trigger an immediate threat complaint — the formal process for suspending or revoking a driver's license when the person is deemed unsafe to operate due to behavior, impairment or medical condition.

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 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 the recipient will receive from SSI, 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 (SSA) 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 rule also extended 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. The 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 SSA, 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 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 TRUST

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 dependent adult child's government benefits. The assets held in a properly drafted special needs trust are for the sole benefit of the dependent adult child and are generally used to supplement the dependent adult child's needs that are not paid for with government benefits. Trustees use their discretion to manage and distribute assets on behalf of the adult disabled child.

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 do 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 life allows family members to make 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 not created until the

testator's death by a testator's will and, therefore, 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 child 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 without transfer penalty 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 limited 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 effective 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. 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 eligible designated beneficiaries and to benefit from the prolonged lifetime distribution periods, including allowing remainder beneficiaries of a special needs trust to be a charity. Presently, the age at which an individual is required to begin taking RMDs depends on the individual's date of birth as follows:

Date of Birth	**RMD Age**
Before 1951:	70.5
July 1, 1949 - Dec. 31, 1950:	72
1951 - 1959:	73
1960 or later:	75

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. To be eligible, the disabled person, before the age of 46, must either (1) have received a determination letter from the SSA awarding benefits based on blindness or disability or (2) have a "disability certificate" certifying that the individual would qualify for such benefits[1].

Contributions to the account from all sources per year cannot exceed $19,000 in 2026, 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.

[1] 26 U.S. Code § 529A(e)(1) and 2

CHAPTER 15
BANKRUPTCY AND DEBT

INTRODUCTION

A catastrophic injury 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 may have to 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; and 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:** Liquidation[1]

b. **Chapter 11:** Reorganization (or Rehabilitation bankruptcy[2])

c. **Chapter 12:** Adjustment of debts of a family farmer with regular annual income[3]

d. **Chapter 13:** Adjustment of debts of an individual with regular income[4]

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. Some people 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 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. 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 to satisfy requirements of a potential 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 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 specifics of Chapter 7 and Chapter 13 bankruptcy, 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. A Chapter 13 bankruptcy filing may often stop or delay a foreclosure and give you an opportunity to 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 your financial stability 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 a non-bankruptcy court payment order 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. **<u>Protected Assets</u>**

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. **<u>Secured Creditors</u>**

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 security for the money 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 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 are generally not liable to pay unsecured debts standing only in the name of a deceased spouse or other family member However, there may be limited circumstances in which you may be obligated to repay those debts.

   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] Court orders to pay for child support, alimony or other domestic support obligations, along with

most income taxes and student loans, are generally not discharged in a bankruptcy filing. However, there are times when income taxes[23] and student loans[24] 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 by 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 by 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 unsecured 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 motor 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 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 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, whose fees 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. 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. 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 three- to five-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 with which counsel may be able to assist you.

4. **Payment plans Under Chapter 13**

a. **The 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 provide 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 Explanation**

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 Negotiation**

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 Offers**

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 apart 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 most 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 forgiven amounts of debt in excess of $600 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 tax consequences for using the retirement funds to pay 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 lender controls the decision to grant or not grant a loan modification. 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 endeavored to resolve 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

1. **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 move 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.
2. **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.

3. **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.

4. **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, employers, 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.

5. **Your Privacy:** You should be very reluctant to disclose any of the following personal information, especially to a debt collector:

    a. Social Security number;

    b. Driver's license number or state-issued ID number;

    c. Bank or other financial account number;

    d. Bank or other financial institution routing number;

    e. Any credit card or other account number;

    f. The name of any minor child; and

    g. Birth date. (M.G.L. c. 93H)

    Debt collectors are prohibited from committing violations of federal and state law which prevent "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; and 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.

6. **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.

7. **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.

8. **Resource Directory Lists Consumer Credit Agencies:** The Resource Directory lists some agencies to contact for further information.

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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 in Section C that compares a reverse mortgage with a standard mortgage and a HELOC.

3. **Types of Reverse Mortgages**

   a. **HECM:** In 2026, 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 common 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:** If a homeowner chooses a fixed interest rate, they receive a one-time lump-sum disbursement after closing. No further draws can be made, and the lump sum is usually significantly less than what is available under the adjustable interest rate option.

      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 $720 per month, whereas a 75-year-old living in the same house might have a tenure payment of $1,059 per month (calculated 10/30/25 assuming $400,000 home value, 6.500% expected rate, 6.125% initial rate adjusting monthly, $17,649 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. Provided 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 $178,751. But if the individual leaves the line of credit alone and allows it to grow, it could grow to $359,231 in 10 years and $721,932 in 20 years, even if the home decreases in value (calculated 10/30/25 assuming $600,000 home value, 6.500% expected rate, 6.125% initial rate adjusting monthly, $21,648 financed closing costs, 6.625% 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 $53,371 in five years and $75,660 in 10 years (calculated 10/30/25 assuming $400,000 home value, 6.500% expected rate, 6.125% initial rate adjusting monthly, 0.5% MIP, $17,649 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 $171,383 in five years and $241,452 in 10 years because of the compounding effect of the loan charges (calculated 10/30/25 assuming $600,000 home value, 6.375% expected rate, 6.00% initial rate adjusting monthly, 0.5% MIP, $21,649 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. Pay off existing mortgage debt to eliminate monthly principal and interest payments;

ii. Eliminate 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. Defer the date that one begins drawing Social Security retirement benefits in order to receive a larger monthly benefit;

vii. Replace 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. Supplement income to help pay for everyday living expenses;

x. As a "safety net" for emergencies or large expenditures;

xi. In some divorce situations to effectuate an equitable division of assets;

xii. 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 2026, lenders may consider up to the first $1,249,125 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 $24,982.50, 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. **Default Counseling**

If a homeowner defaults on their HECM due to nonpayment of real estate taxes, homeowners insurance, condo fees, or certain other municipal charges, the lender can proceed with foreclosure. This could result in a foreclosure auction and ultimate eviction from the home. It is crucial that homeowners reach out to their loan servicer and a HUD-certified HECM counselor to discuss options to cure the default.

4. **Approved HUD Housing Counseling Agencies**

   a. List of HUD Housing Counseling agencies providing HECM counseling within the commonwealth as of January 2026:

      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. Credit.org

      1450 Iowa Ave., Suite 200

      Riverside, CA

      Tel: (951)779-7731

      vi. Housing Assistance Corp.
      460 West Main St.

      Hyannis, MA 02601
      Tel: (508) 771-5400

      vii. Neighborworks Housing Solutions
      68 Legion Pkwy.
      Brockton, MA 02301
      Tel: (617) 770-2227, ext. 344 and 343

      viii. 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)

INTRODUCTION

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 2025 Cost of Care Survey, in Massachusetts, the median cost for home care is $7,245 per month. Many will transition to an assisted living setting, with a median cost of $ 9,058 per month. Dementia units typically cost an additional $2,000–$4,000. Semi-private rooms in nursing homes have a median cost of $14,448, and private rooms, $15,543. 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 (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% 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 and 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 LTCI benefits, 50% of policyholders will use their LTCI 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:

- Includes coverage for nursing home care for at least 730 days;
- Pays at least $125/day for nursing home care; and
- 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 an 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, 2025). 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. LONG-TERM CARE INSURANCE PREMIUMS

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.

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.) Hybrid LTCI products (see below) 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 or the 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 best to reduce the inflation protection, as some insurance companies have identified that reducing the inflation protection will likely reduce the percentage of future rate increases. It is not recommended to extend the elimination period. Typically, the difference in premium does not justify the additional out-of-pocket expense. 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 the 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, a 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 now available.

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:**

   a. **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 x 365 x 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.

   b. **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 durations. They may be two, three, four, five, six, eight or unlimited benefit durations.

   c. **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 cri-

teria 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 were 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 fewer 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.

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 may not fulfill 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.

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 may be 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 even less underwriting than those with a life insurance platform. With the rise in interest rates over the last few years, the cost of hybrid products has become much more competitive with traditional LTCI. In fact, a limited-pay hybrid LTCI policy may be less expensive than a traditional LTCI. An advantage of the hybrid is that several of these products provide cash benefits, guaranteed premiums and a death benefit. It needs to be restated that hybrid policies do 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 and flexibility.
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 do NOT provide home protection under the Massachusetts MassHealth Exemption Law discussed above.
3. **Simplified Issue and Guaranteed LTCI Products:** There are now several products in Massachusetts that provide either simplified or guaranteed issue, meaning those with preexisting conditions that would typically result in a denial are still insurable. Three of these products are annuity hybrids and require a single premium payment, but there is one simplified issue traditional policy that can be paid for annually.

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 agent prior to purchasing a policy.

2. **IRS does not treat LTCI benefits as income:**

Benefits received from an LTCI policy for reimbursement for care are 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 $430 per diem for 2026, 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 2026, 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 $6,200 against federal income taxes. Deductions for qualified LTCI policies are age-based: ages 71 and older — $6,200, ages 61 to 70 —

$4,960, ages 51 to 60 — $1,860, ages 41 to 50 — $930 and ages 40 and under — $500. 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 says 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. This is 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, to 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, typically, 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 before 60, as premiums are more reasonable and health is less precarious.

While there are traditional policies that can be purchased as young as 18 years old, greater options be-

come 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 canceled 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 remainderperson 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 person, persons, or a trust (hereinafter referred to as the "remainderperson") 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 "remainderperson." 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 remainderperson 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 remainderperson. The life tenant may still be eligible for a reverse mortgage, provided that the remainderperson 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 remainderperson will receive the balance. See Example 1 on the next page as to how the life estate is calculated on the next page)

EXAMPLE 1

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 remainderperson 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 remainderperson 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 remainderperson'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 remainderperson'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 remainderperson predeceases the life tenant.

EXAMPLE 2

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 will 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.

Filing Fee $35

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 Incor 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 certi copy of a disability award letter issued to the person by the United States Social Security Administration, or 2) a letter signed physician registered with the board of registration in medicine certifying that each person meets the disability requirements st 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, s 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 nu
(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:_____

Filing Fee $35

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
(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 Incom 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 certi copy of a disability award letter issued to the person by the United States Social Security Administration, or 2) a letter signed physician registered with the board of registration in medicine certifying that each person meets the disability requirements st 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, s 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: _____ , Massach
(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:

a. $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;

b. $750 to veterans who suffered the loss of one foot, one hand or one eye; who received the Congressional Medal of Honor, Navy Cross or Air Force Cross; or who were a prisoner of war, and their spouses or surviving spouses;

c. $1,000 to veterans who suffered total disability in the line of duty and are incapable of working, and their spouses or surviving spouses;

d. $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;

e. $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;

f. 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;

g. 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

h. 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 it 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.

   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. With respect to real property, a taxpayer should own and occupy the property as their domicile, or own it jointly with a spouse or as a tenant in common with a person who is not a spouse, and must have lived in the commonwealth for the past 10 years.

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.

   A city or town can vote to allow an approved representative to provide the services to the city or town if

the taxpayer is physically unable, or allow a maximum reduction of the real property tax bill to be based on 125 volunteer service hours in a given tax year rather than $2,000.

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 $2,820 (for 2025) 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 2025, single older adults cannot earn more than $75,000. For heads of household, and married couples filing a joint return, the annual 2025 income limitations are $94,000 and $112,000, 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 $1,298,000 for 2025. 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 $650,000, and she earned $23,000 in 2025, 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 $2,820 income tax credit for 2025.

4. **Senior Bonus Deduction**

The One Big Beautiful Bill Act creates an additional deduction for senior citizens. Effective for 2025 through 2028, individuals who are age 65 and older by Dec. 31, 2025, may claim an additional deduction of $6,000 per individual, or $12,000 for a married couple if both spouses qualify. This deduction phases out for taxpayers with higher adjusted gross income. This deduction is in addition to the current additional standard deduction for senior citizens under existing law.

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 https://www.sec.state.ma.us/divisions/cis/citizen-information-service.htm, (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

INTRODUCTION

The landlord/tenant relationship has been described as the second most emotional human relationship (second to the marital relationship.) Virtually all tenancies are established by a written lease that describes the rights of the parties in terms of duration, amount of rent to be paid, how the lease or tenancy may be terminated, and a host of other items agreed upon. In addition to rights and responsibilities outlined in a lease, the landlord/tenant relationship is heavily impacted by statute, regulation and court decisions. As a tenant, is it important to understand your rights and responsibilities. This chapter explores key considerations for all tenants.

A. 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.

B. 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.

C. 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 mut 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).

D. 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, unless it is an emergency. 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 30 days, whichever is longer, 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).

E. 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 "First-Tier Court 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 that 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).

F. 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, except where such commendations would result in "undue hardship" to the landlord.

G. 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, color, national origin, religion, sex, familial status, disability, source of income, sexual orientation, gender identity, age, marital status, veteran or active military status, and/or genetic information.

H. 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, Sections 9-10.

A helpful website: www.masslegalhelp.org/housing.

The local Council on Aging can refer you 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

INTRODUCTION

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 subsidies under Project-Based Section 8, where the U.S. Department of Housing and Urban Development (HUD) pays a portion of the rent on behalf of eligible low-income tenants.

In order to qualify for these programs, the household has to pass, among other criteria, financial eligibility tests. Traditionally, financial 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, MFH owners are required to do so by Jan. 1, 2027. This deadline has already been postponed three times. PHAs were required to implement the new income exclusion rules by July 1, 2025, but there is no published deadline for implementation of the rest of the HOTMA eligibility criteria.

A. ELIGIBILITY UNDER THE "OLD" RULES

In order to qualify for a housing unit or subsidy under the "old" rules, the income of the household has to be less than the applicable income limit. The income limits for Section 8 housing are determined by HUD and are based on the area median income (AMI) of the specific region where the housing is located. In general, households must earn less than 50% of the AMI to be eligible, with priority given to those earning below 30% of AMI.

1. **Income**

Eligibility and rent are based on the anticipated gross annual income of all household members minus deductions, if any. Income includes unearned income; regular income from employment and public benefits, such as Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI); 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. Temporary, nonrecurring or sporadic payments (including gifts) are not counted as "income."

a. **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:

i. If a household's only asset is a $50,000 bank account earning 3% interest, the interest of $1,500 annually ($125/month) will be included in the calculation of income and, thus, the determination of rent.

ii. 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 the purpose of

determining eligibility and the calculation of 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.

b. **Trust distributions**

One question 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*, the U.S. Court of Appeals for the First Circuit ruled that distributions of principal from certain self-settled special needs trusts (cash, stocks, bonds, etc., owned by the trust) are not "income."

B. ELIGIBILITY RULES AS MODIFIED BY HOTMA

HOTMA became law in July 2016. Regulations issued in February of 2023 are complex and difficult for PHAs and MFH owners to implement without concrete guidance. Thus, HUD has issued a series of notices clarifying the HOTMA changes to the income rules and the implementation of new asset rules. Significant program, system and software changes are required to implement the changes 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 cover 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.

1. **Assets**

Once HOTMA is implemented, eligibility will depend not only on income but also on assets. The asset limit, initially $100,000, is adjusted each year for inflation and is, as of the date of this chapter, $103,200. Further, if a household owns real estate 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:

a. Retirement accounts;
b. Trusts that are not revocable by, or under the control of, a member of the family or household;
c. ABLE accounts;
d. 529 plans;
e. Necessary items of personal property;
f. Non-necessary items of personal property with a total value of less than $50,000;
g. Tax refunds; and
h. 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 included in the asset calculation.

The PHAs and MFH owners have a choice as to whether to impose these asset limits on existing tenants. They can:

a. Enforce these limits on existing tenants;
b. Not enforce these limits on existing tenants;
c. Not enforce these asset limits against certain types of tenants considering age, disability, etc.; or

d. Delay enforcement to give the household six months to reduce the assets.

They must impose the asset limits on new tenants.

2. **Income**

a. All earned income received by adult household members and unearned income of all family members count unless they are specifically excluded.

Income includes actual income generated by assets and income imputed on assets exceeding $50,000 (now $51,600, adjusted for inflation), including assets given away within the prior two years. Imputed income is based on the passbook savings rate, which is now published annually.

Among the categories of income that are excluded are:

i. Nonrecurring income (income received in one year that is not expected to be received in the next year);

ii. Distributions from retirement accounts that are not periodic;

iii. Lump-sum additions to net family assets, such as lottery winnings and inheritances;

iv. Veterans' Administration Aid and Attendance benefits;

v. Workers' compensation;

vi. Insurance payments and settlements for personal or property losses regardless of the frequency of payments; and

vii. Payments from claims based on negligence resulting in disability regardless of whether received periodically or as a lump sum.

b. HOTMA also addresses how distributions from trusts should be treated:

i. Distributions of principal from a trust that is an excluded asset are not income.

ii. Distributions of income from a trust, unless it is used for payment of a minor's health and medical care, are countable.

c. Though HOTMA describes, 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:

i. MassHealth;

ii. The Supplemental Nutrition Assistance Program (SNAP);

iii. SSI; and

iv. Temporary Assistance for Needy Families (TANF).

C. CONCLUSION

In conclusion, once HOTMA is fully implemented by each PHA and MFH, the key to understanding the eligibility rules will be not only to consult the HOTMA regulations and the notices, but also to investigate the specific eligibility rules adopted by the PHA and MFH where the tenant is living or to which the prospective tenant is applying. Tenants who need legal representation should contact an elder law attorney at https://massnaela.com/ or a legal services program at 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 (Newton),
(508) 799-2386 (Central & Western MA),
(603) 606-6590 (New Hampshire)
www.ALZ.org

Executive Office of Aging & Independence
(800) 243 4636
https://www.mass.gov/orgs/executive-office-of-aging-independence-age

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
https://www.nationalmssociety.org/resources/get-connected/in-your-area/mam

DEBT RELIEF LEGAL AID

Massachusetts Debt Relief Foundation
508-232-4633
https://www.madrf.org/

ELDER ABUSE PREVENTION AND REPORTING INFORMATION

Attorney General Elder Hotline
(888) AG-ELDER, (888) 243-5337
www.mass.gov/info-details/the-attorney-generals-elder-hotline

Executive Office of Aging & Independence/Elder Abuse and Protective Services
(800) 922-2275
https://www.mass.gov/info-details/report-abuse-of-adults-aged-60

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
gladlaw@gladlaw.org
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
1-800-MEDICARE (1-800-633-4227), available 24/7
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
https://www.mass.gov/info-details/serving-the-health-insurance-needs-of-everyone-shine-program

SOCIAL SECURITY INFORMATION

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