

Medicare

By Kim Glaun

Medicare is a federal health insurance program for persons 65 and over and younger persons with disabilities. Enacted in 1965 as Title XVIII of the Social Security Act, Medicare covers a portion of the cost of certain medical treatments.¹ The program was designed to provide a basic level of health care to older persons and younger persons with disabilities, a population that often lacked health insurance prior to Medicare's creation. Like social security, Medicare is a social insurance program, and eligibility does not depend on financial need.

Medicare comprises two main sections: Part A or Hospital Insurance, which covers inpatient hospital stays, skilled nursing facility care, and hospice and other services; and Part B or Supplemental Medical Insurance, which covers physician services, most home health care, laboratory tests, and other medical care. (See table 1 for authorities on Medicare.)

This article covers the following topics:

- Medicare administration and financing.
- Eligibility and enrollment.
- Covered services.

- Gaps in coverage and sources of supplemental coverage.

- Delivery of Medicare benefits (traditional Medicare versus Medicare health maintenance organizations (HMOs)).

- Key problems affecting clients and additional resources for advocates.

Administration and Financing

In contrast to Medicaid, which is a shared federal and state responsibility, Medicare's governance and financing are wholly federal. The Social Security Administration processes Medicare eligibility and enrollment. The Centers for Medicare and Medicaid Services (CMS), an agency within the U.S. Department of Health and Human Services, runs the Medicare program.² CMS contracts with insurance companies to process and review claims. For Part A, the contractors are called "fiscal intermediaries," and, for Part B, the contractors are called "carriers." Part A is financed by employee and employer federal payroll taxes, and Part B by general federal revenues and beneficiary premium payments.

Medicare Eligibility

In general, persons automatically qualify

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¹ Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 *et seq.* (2000).

² Health Care Financing Administration (HCFA) is the former name of the Centers for Medicare and Medicaid Services (CMS).

for Medicare on their 65th birthday if they are entitled to social security or railroad retirement benefits.³ Because such persons or their spouses paid Medicare taxes while working, they need not pay a premium for Part A.⁴ Persons who did not pay Medicare payroll taxes (i.e., many domestics and immigrants) can choose to “voluntarily enroll” in Medicare as long as they are U.S. citizens or are legal residents who lived continuously in the United States for five years directly preceding their Medicare application.⁵ Such persons need to pay all or part of the monthly Part A premium (\$319 in 2002). Regardless of their work history, all beneficiaries who choose to enroll in Medicare Part B must pay the monthly premium (\$54 in 2002).

Persons who are under 65 and receive social security disability payments automatically qualify for Medicare after a twenty-four-month waiting period.⁶ Individuals of all ages with end-stage renal disease qualify for Medicare if they or their spouses paid into the social security system.⁷

Medicare Enrollment

Persons should apply for Medicare through their local social security office. An application for social security retirement benefits is automatically regarded as an application for Medicare. Unless Medicare applicants choose otherwise, they will be enrolled in both Parts A and B. The Part B premium, and Part A if

Table 1.—Sources of Authority for Medicare

- Statute: Title XVIII, Social Security Act, 42 U.S.C. §§ 1395 *et seq.* (2000).
- Regulations: 42 C.F.R. Part 405 *et seq.* (2001).
- Federal court cases.
- Policy: Centers for Medicare and Medicaid Services program memorandum and manuals (available at www.cms.hhs.gov).

applicable, is then deducted from their monthly benefit checks.

In general, persons must enroll in Medicare when they first become eligible for the program. For most applicants, the initial enrollment period is the seven months surrounding their 65th birthday.⁸ Persons who delay Part B enrollment

- are permitted to apply for Medicare only during general enrollment periods, which are from January 1 to March 31 every year,⁹ and

- pay an increased monthly premium.¹⁰

Persons who have employer or union group health coverage based on their or their spouses' current employment can delay Part B coverage without penalty if they sign up during an eight-month enrollment period that begins the month the employment or the group health insurance ends.¹¹

Covered Services

Medicare Part A covers¹²

³ 42 U.S.C. § 1396c (2000); 42 C.F.R. § 406.10 (2001).

⁴ Persons currently qualify for full retirement benefits at 65 if they or their spouses have paid social security payroll taxes for at least forty quarters (about ten years). For more information, see Jenny Kaufmann, *An Introduction to Old-Age, Survivors, and Disability Insurance and Supplemental Security Income*, in this manual.

⁵ 42 C.F.R. §§ 406.20, 407.10 (2001).

⁶ *Id.* § 406.12.

⁷ *Id.* § 406.13

⁸ 42 U.S.C. § 1395p(d) (2000); 42 C.F.R. § 407.14 (2001).

⁹ See 42 C.F.R. §§ 407.15, 407.25 (2001). Enrollment is effective July 1.

¹⁰ The premium will increase by 10 percent for each twelve-month period during which the person was eligible but did not enroll. See 42 U.S.C. 1395(r) (2000); 42 C.F.R. § 408.22 (2001).

¹¹ 42 U.S.C. § 1395r(b) (2000). Also, if enrollees delay enrollment because of agency mistakes, erroneous statements, or delays, penalties may be waived. See 42 C.F.R. §§ 406.38 (Part B), 407.32 (Part A) (2001).

¹² See 42 U.S.C. § 1395x(b) (2000); 42 C.F.R. §§ 409.10 *et. seq.* (2001).

- inpatient hospital care up to 90 days per “spell of illness”;¹³
 - an additional 60-day lifetime allotment;
 - skilled nursing facility service up to 100 days following a 3-day hospital stay;
 - hospice care; and
 - home health care following a 3-day hospital stay up to 100 visits.
- Medicare Part B covers¹⁴
- physician services;
 - outpatient hospital procedures;
 - ambulance services;
 - medical equipment and laboratory and diagnostic services;
 - home health benefits not covered by Part A;
 - physical, speech, and occupational therapy;
 - certain preventive services including, flu, pneumonia, and hepatitis B vaccines, mammograms, pap smears, diabetes screening, self-management, and nutrition services, colorectal and prostate cancer screening, and bone mass measurements.

As an insurance program, Medicare imposes cost sharing on beneficiaries in the form of premiums, deductibles, copayments, and coinsurance. See table 2 for Medicare cost sharing in 2002.

Gaps in Medicare Coverage

Although Medicare has been a vital source of health coverage for millions of older and disabled persons, it has not kept pace with advances in modern medicine and does not cover many medical treatments

and items that are integral to health care today. Medicare pays only for services that are medically reasonable and necessary for the treatment or diagnosis of an illness or injury.¹⁵ Notable gaps in Medicare coverage include

- outpatient prescription drugs;
- most long-term care;
- routine physical examinations;
- most dental care;
- routine eye examinations or eyeglasses;
- hearing aids and related examinations; and
- routine foot care.

Private Supplemental Insurance

To help fill these coverage gaps and offset Medicare expenses, many beneficiaries have private supplemental insurance, including employer-sponsored retiree policies and Medigap plans. Federal law currently limits Medigap coverage to ten standard policies (A–J).¹⁶ All Medigap policies must cover a minimum set of benefits, including (1) inpatient hospital copayments and 365 additional days during a lifetime; (2) the Part B coinsurance or copayment amount; and (3) the first three pints of blood annually. Only three plans (H–J) include an outpatient prescription drug benefit.¹⁷

For older Medicare beneficiaries, federal law creates a six-month Medigap Open Enrollment Period, which starts on the first day of the month in which a person turns 65. Medigap insurers may not refuse to sell policies to persons during their open enrollment period. Federal law

¹³ A “spell of illness” begins the first day of inpatient hospital or skilled nursing facility (SNF) admission and ends when the beneficiary does not receive SNF or hospital inpatient care for sixty days. 42 U.S.C. § 1395x(a).

¹⁴ See generally 42 U.S.C. § 1395k, 1395x (2000).

¹⁵ See 42 U.S.C. § 1395y(a)(1)(A) (2000). Medicare’s acute care focus reflects medical treatment norms in 1965.

¹⁶ See 42 U.S.C. § 1395ss(a) (2001).

¹⁷ The H and I drug benefit includes a \$250 deductible and 50 percent coverage of costs up to \$2,500. The J benefit includes a \$250 deductible and 50 percent coverage of costs up to \$6,000.

does not afford such “guaranteed issue rights” to beneficiaries under 65 or to persons with end-stage renal disease.¹⁸

Low-Income Assistance for Medicare Beneficiaries

Medicare beneficiaries with limited means may qualify for Medicaid to cover some or all of their out-of-pocket medical expenses.¹⁹ The poorest beneficiaries qualify for full Medicaid coverage, which covers all Medicare expenses and fills in Medicare gaps, such as outpatient prescription drugs and extended long-term care. Beneficiaries with slightly more income and limited resources can receive limited assistance through the “Medicare Savings Programs.” The programs pay all or some of the Medicare cost sharing for persons with incomes slightly below and above the poverty line; most of them do not qualify for full Medicaid.²⁰ The primary benefits include the

- Qualified Medicare Beneficiary Program (QMB), which pays full Medicare cost sharing and premium payments for persons with incomes up to 100 percent of the federal poverty level (\$739 in 2002);
- Specified Low-Income Medicare Beneficiary (SLMB) program, which pays the monthly Part B premium for persons with incomes between 100 percent and 120 percent of the federal poverty level.
- Qualified Individual-1 program, which pays the Part B premium for persons with incomes between 120 percent and 135 percent of the federal poverty level.²¹

Persons must apply for Medicaid and the Medicare Savings Programs though

Table 2.—2002 Medicare Cost-Sharing Amounts

Part A

Inpatient Hospital (per benefit period)

Deductible: \$812

Copayments:

- \$0 for days 1–60
- \$203 per day for days 61–90
- \$406 per day for each lifetime reserve day (total of 60 non-renewable days)

Skilled Nursing Facility

Coinsurance:

- \$0 for days 1–20
- \$101.50 for days 21–100

Home Health

No home health coinsurance or deductible

Part A Premium (for persons who lack adequate work history):

- \$319 per month for persons with less than 30 quarters of Medicare work history
- \$175 for persons with 30–39 quarters of Medicare work history

Part B

Deductible: \$100 annually

Premium: \$54 per month

Coinsurance: 20 percent of the Medicare-allowed amount

their local Medicaid offices. Unfortunately about half of eligible beneficiaries are not enrolled in the Medicare Savings Programs due to burdensome enrollment procedures and lack of knowledge about the programs.²²

More than half of all states offer pharmacy assistance programs for low-income Medicare beneficiaries who do not qualify for full Medicaid. Program design, eligibility, and benefits differ widely among

¹⁸ Some state laws require insurers to offer at least one Medigap policy to persons under 65 during a special open enrollment period, i.e., California, Connecticut, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Mississippi, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, South Dakota, Texas, and Wisconsin. However, insurers may be permitted to charge higher premiums based on a person’s medical history.

¹⁹ Insurers are prohibited from knowingly selling Medigap policies to persons who are entitled to Medicaid. See 42 U.S.C. § 1395ss(d)(3) (2000).

²⁰ See *id.* § 1396a(a)(10)(E), 1396(p).

²¹ A five-year federal grant to states has been funding this program; the grant expires on December 31, 2002. See 42 U.S.C. § 1396u-3(d) (2000). At writing, Congress was expected to renew the benefit beyond 2002.

²² Patricia Nemore, *Variations in State Medicaid Buy-in Practices for Low-income Medicare Beneficiaries: A 1999 Update 1* (Henry J. Kaiser Family Found. 1999).

states. Also, certain pharmaceutical manufacturers offer discounts on their products to low-income older persons.²³

Delivery of Medicare Benefits

Persons can receive their Parts A and B Medicare benefits from the traditional, fee-for-service Medicare program or from a private health plan that participates in the Medicare+Choice (M+C) program.

Traditional Medicare

Most persons receive Parts A and B coverage through traditional fee-for-service Medicare. Under traditional Medicare, beneficiaries select their physicians and health care providers, who in turn bill Medicare a fee for each service or set of services rendered. Under Part B, Medicare pays the provider 80 percent of the Medicare approved amount, and beneficiaries are responsible for the 20 percent coinsurance, the \$100 deductible if unmet, and extra costs if the provider does not accept assignment.²⁴ Providers who “accept assignment” agree to accept as payment in full the Medicare-approved amount.²⁵

Physicians who do not accept assignment may charge, or “balance bill,” up to 15 percent above the amount Medicare pays the provider. This is called the limiting charge.²⁶ Unlike physicians, suppliers of medical equipment who do not accept assignment are not subject to the limiting charge.

The Medicare+Choice Program

Beneficiaries can also receive their Parts A and B coverage through a Medicare+Choice (M+C) health plan. In 1997 Con-

gress established Medicare+Choice as Medicare Part C.²⁷ Most M+C plans currently are HMOs, but the law permits other types of M+C products, including preferred provider organizations, provider-sponsored organizations, and private fee-for-service plans.²⁸

The federal government pays M+C plans a set monthly fee (capitated amount) for each Medicare enrollee regardless of the actual amount of health care used. Plans must

- provide enrollees all Medicare Part A and B services²⁹ and
- often offer additional benefits such as prescription drugs and preventive health care.

M+C plans have wide latitude to vary Part A and B cost-sharing requirements and can charge a separate monthly premium that is in addition to the Part B premium. Plans contract with Medicare on an annual basis and may withdraw from Medicare or change benefits from year to year.

Like non-Medicare HMO enrollees, Medicare HMO enrollees must select a primary care physician, from whom they can obtain referrals to specialists. Unless the plan network is available, or emergency or urgent services are needed, M+C enrollees are generally restricted to using doctors and providers in the HMO network.³⁰

Key Problems Affecting Medicare Beneficiaries

Three Medicare issues that commonly confront legal services attorneys are

²³ More information about state and manufacturer low-income drug assistance programs can be found at www.medicare.gov/Prescription/Home.asp.

²⁴ The Medicare-approved amount is often less than the actual amount that the provider charges.

²⁵ 42 U.S.C. § 1395u (2000); 42 C.F.R. § 424.44 (2001).

²⁶ Some state laws require providers serving Medicare patients to accept assignment. These laws exist in Connecticut, Florida, Massachusetts, Minnesota, New York, Ohio, Pennsylvania, Rhode Island, and Utah.

²⁷ See 42 U.S.C. § 1395w-21-28 (2000).

²⁸ See 42 C.F.R. § 422.4 (2000). At present only one Medicare+Choice (M+C) private fee-for-service plan is offered in over twenty states. For more information on these plans, see Kim Glaun et al., *Recent Developments in the Medicare Program*, 34 CLEARINGHOUSE REV. 355 (Sept.–Oct. 2000).

²⁹ 42 C.F.R. §§ 422.100-101 (2001).

³⁰ See *id.* § 422.113.

Medicare claim denials; hospital, skilled nursing facility (SNF), and home health discharges and care terminations; and M+C withdrawals.

Medicare Claim Denials. Providers are responsible for submitting claims to Medicare carriers and intermediaries.³¹ Because of pressures to limit costs and the complexity of the Medicare program, contractors often deny claims that should be granted. Claims that do not involve Medicare-excluded services or items may be ripe for appeal if the treatment came from a Medicare-authorized provider and its prescription from the patient's treating physician. There are different appeal procedures for Parts A, B, and C.³²

For each case, advocates should review the notice (Medicare summary notice in traditional Medicare) to identify the reason given for the denial.³³ Often claims are denied because of incomplete information or errors. Denials because the treatment "was not medically necessary" or "too many" or "too frequent" should be scrutinized for such mistakes, which can be rectified by having the provider submit a corrected claim.

Advocates should investigate whether such claims involve the use of a national coverage decision or local medical review policy. National coverage decisions are

CMS national policy statements about coverage of new technologies or services. Local medical review policies are adopted by contractors to restrict payments for treatment and are often at odds with current medical practice.³⁴ Advocates should enlist the support of the patient's treating physician; such support is often essential to a successful appeal.

Premature Discharges and Terminations of Care in Traditional Medicare.

Medicare beneficiaries in traditional Medicare often experience premature discharges from care or inappropriate treatment reductions and terminations from inpatient hospitals, SNFs, and home health agencies. Because Medicare pays such providers a fixed amount based on a patient's diagnosis or medical condition, they have an incentive to minimize care provided to maximize profits.³⁵ When services are terminated or denied, patients' rights vary with the care setting.³⁶

Hospital Discharges. If the hospital believes that the patient no longer needs inpatient hospital-level care and the attending physician concurs, the hospital must give the patient a written notice ("Notice of Discharge and Medicare Appeal Rights") at least three working days before releasing the patient.³⁷ The notice must explain

³¹ See 42 U.S.C. § 1395w-4(g)(4) (2000).

³² See, e.g., 42 C.F.R. §§ 405.701 *et seq.* (2001) (Part A appeals), 405.801 *et seq.* (Part B appeals), 522.560 *et seq.* (M+C appeals). In 2000 Congressional changes in the Medicare appeals process would unify Part A and B procedures. Pub. L. No. 106-554, § 521, 114 Stat. 2763 (2000), *amending* 42 U.S.C. §§ 1395ff. Although the law requires their implementation by October 1, 2002, CMS predicted, at writing, significant delays in their implementation.

³³ In the M+C program, health plans, rather than carriers or intermediaries, issue the initial formal determinations about Medicare coverage. These decisions, which are subject to appeal, are called "organization determinations." See 42 C.F.R. § 422.566 (2001).

³⁴ Medicare summary notices do not currently indicate whether local medical review policies or national coverage decisions are involved. National coverage decisions are listed in the CMS Coverage Issues Manual. Traditionally reluctant to release local policies, contractors are now posting them on www.lmrp.net.

³⁵ Payment systems are at 42 U.S.C. § 1395ww (2000) (hospital); *id.* § 1395yy (SNF); *id.* § 1395fff (home health).

³⁶ Notice and appeal rights governing discharges, terminations, and reductions in care are different for M+C enrollees. M+C protections are set forth at 42 C.F.R. §§ 422.560 *et seq.* (2001).

³⁷ See 42 U.S.C. § 1320c-3(e) (2000). Hospital discharge planning requirements can also be used as an advocacy tool. See Ctr. for Medicare Advocacy Staff, Medicare Handbook § 2.10[D] (Judith A. Stein & Alfred Chiplin Jr. eds., 2002). Medicare conditions of participation require hospitals to conduct discharge planning in cases where the patient's health would be impaired in the absence of such planning, and in others upon the request of the patient or the patient's representative or physician. See 42 U.S.C. § 1395x(ee) (2000); 42 C.F.R. § 482.43 (2001).

- the reason for the discharge;
- the patient's responsibility for hospital charges beginning the second day after the date of the notice; and
- the right to appeal the decision and to seek immediate Quality Improvement Organization (QIO) review while still in the hospital.³⁸

To obtain an expedited QIO review, the patient must remain in the hospital and file the request with the QIO by noon on the working day following the date of the notice.³⁹ The hospital must deliver the patient's medical records to the QIO by the close of business on the date of the expedited request, and the QIO must render a decision by the following working day. The hospital cannot bill the patient for care provided before noon on the day after the QIO notifies the patient or the patient's representative of its decision.⁴⁰ A patient who misses the deadline for an expedited QIO review of the hospital's discharge decision can still request a QIO review, but the QIO will have 30 days in which to issue a decision and the hospital is not prohibited from charging the patient pending the appeal.

If the QIO agrees with the hospital's discharge decision, the patient can file a

request for reconsideration with the QIO.⁴¹ If the patient is still in the hospital when the reconsideration is filed, the QIO must issue the decision within three working days of receiving the reconsideration request.⁴²

If the QIO reconsideration decision is unfavorable to the patient and the amount in controversy is at least \$200, the patient may request an administrative law judge hearing within sixty days of receiving the notice. The next steps in the appeal process are Department of Appeals Board and judicial reviews if the amount in controversy is at least \$2,000.⁴³

Skilled Nursing Facility and Home Health Terminations. Like hospitals, skilled nursing facilities and home health agencies often try to discharge beneficiaries for services based on the premise that Medicare will no longer pay for the care. Before providers can terminate services, they must give written notice indicating that

- the provider believes that care will no longer be covered and
- the beneficiary can request that the provider submit a "demand" or "no payment" bill to the intermediary to render an initial determination about coverage.⁴⁴

³⁸ The Quality Improvement Organization (QIO) is an entity that contracts with CMS to, among other purposes, monitor hospital claims to ensure that coverage is provided only for medically necessary care. See 42 U.S.C. § 1320c-3 (2000). Hospital patients' rights may vary slightly with their circumstances. For instance, if the treating physician disagrees with the hospital's initial discharge decision, the hospital may seek QIO review of its noncoverage determination. See 42 C.F.R. § 412.42(c)(2) (2001). If the QIO upholds the hospital's decision upon initial review, the patient may request from the QIO a reconsideration of its decision.

³⁹ In the M+C context the hospital must give a discharge notice the day before the discharge. As in traditional Medicare, expedited QIO review is available to M+C enrollees who file an appeal by noon following the first working day after they receive the notice. 42 C.F.R. § 422.620, 422.622 (2001).

⁴⁰ See 42 U.S.C. § 1320c-3(e) (2000).

⁴¹ See 42 C.F.R. § 478.16 (2001). The patient has sixty days to file a reconsideration request but may obtain an extension if good cause exists. See *id.* §§ 478.20-22 (2001).

⁴² See *id.* § 478.32(a).

⁴³ See *id.* §§ 478.40, 478.46.

⁴⁴ See *Sarrasat v. Sullivan*, CCH Medicare Medicaid Guide ¶ 38,504 (N.D. Cal. 1989) (establishing notice rights for SNF patients); *Healey v. Thompson*, *id.* ¶ 301,101 (D. Ct. 2001) (establishing the right to an advance beneficiary notice before a home health agency terminates or reduces home health services). In 2001 CMS proposed regulations as mandated by a settlement in *Grijalva v. Shalala*, 153 F.3d 1115 (9th Cir. 1998), *vacated and remanded*, 119 S. Ct. 1573 (1999) (Clearinghouse No. 49,567), which established a pretermination review mechanism for M+C enrollees receiving SNF, home health, and comprehensive outpatient rehabilitation facility care. If CMS fails to issue final regulations by December 31, 2002, plaintiffs can return to court to enforce the settlement.

In the SNF context the beneficiary may not be billed for continued care until the intermediary issues a formal decision regarding the claim.⁴⁵ By contrast, once the notice is delivered, home health agencies may charge patients to maintain care.⁴⁶

Medicare+Choice Plan Withdrawals. The M+C program has experienced significant difficulties since its inception. From January 1999 to 2002, scores of plans have exited the program or reduced service areas, affecting more than two million beneficiaries. Most of the remaining plans have significantly scaled back their additional benefits, such as prescription drugs; have instituted greater cost-sharing obligations; and have ended affiliations with prominent physicians and providers.

Beneficiaries affected by the instability in the M+C marketplace can switch to another M+C plan if one is available in their area or enroll in the traditional Medicare program. Until 2005, M+C enrollees may enroll in or depart from plans throughout the year without restrictions, as long as the new M+C plan is open for enrollment.⁴⁷ M+C enrollees who are affected by plan terminations and service

Table 3.—Resources for Advocates	
Internet	
■	CMS (Centers for Medicare and Medicaid Services) Web sites: www.medicare.gov (basic information for consumers) and www.cms.hhs.gov (technical information for providers and advocates).
■	Center for Medicare Advocacy, Inc.: www.medicareadvocacy.org (Medicare explanations, advocacy tips, and Medicare updates)
■	Medicare Rights Center: www.medicarerights.org (basic Medicare information and updates)
■	Center for Medicare Education: www.medicareed.org . (Medicare reports and issue briefs)
Medicare Guides	
■	CENTER FOR MEDICARE ADVOCACY STAFF, <i>MEDICARE HANDBOOK</i> (Judith A. Stein & Alfred Chiplin Jr. eds., 2002)
■	AARP Foundation/National Training Project, <i>Medicare Training Manual</i> (2002), at www.povertylaw.org/medicare/medicare.htm

area reductions have the right to purchase Medigap plan A, B, C, or F if such policies are sold in their state.⁴⁸ (See table 3 for resources for advocates.)

⁴⁵ CMS Medicare Intermediary Manual § 3630, at www.cms.hhs.gov.

⁴⁶ The right to maintain home health care pending review by a Medicare contractor is currently being litigated in *Healey*.

⁴⁷ 42 U.S.C. § 1395w-21(e)(2) (2000).

⁴⁸ Unfortunately these policies do not include prescription drug benefits—the most common reason beneficiaries join Medicare HMOs (health maintenance organizations). Additional Medigap protections are available to M+C participants who enrolled in an M+C plan upon first joining Medicare or who left the traditional Medicare program to join an M+C plan and were in the plan for less than one year before the plan left or reduced its service area. See *id.* § 1395ss(s).