Resources

⚠️ Important Resources: What You Need to Know About Medicare Advantage (MAPD) Problems

Below are reports and news stories from reliable sources showing the growing issues with MAPD plans — from denied care and disappearing networks to hospitals refusing coverage.

Medicare Advantage Plans Often Deny Needed Care, Federal Report Finds (New York Times) — A federal inspector general report found that MA plans frequently reject prior-authorization and payment requests that actually meet Medicare's coverage rules, delaying or denying medically necessary care.

Medicare Advantage Enrollees Have Access to About Half of the Physicians Available to Traditional Medicare Beneficiaries (KFF) — In 2022, MA enrollees had access to only 48% of the physicians available under traditional Medicare in their area, highlighting how restricted provider networks are a major tradeoff of Medicare Advantage coverage.

How Medicare Advantage Scams Seniors (Newsweek) — Insurers aggressively market "zero co-pay" MA plans to seniors, but many have limited networks and strict prior authorization rules, leaving retirees exposed to coverage denials and high out-of-pocket costs.

It's Time to End the Medicare Advantage Scam (The Nation) — The article argues that "Medicare Advantage" is misleading branding for private insurers who profit by denying care and restricting networks, and calls for Congress to stop allowing them to use the word "Medicare."

Prior Authorization Denials Up Big in Medicare Advantage -The share of prior authorizations denied (or partially denied) rose compared to earlier years. The increase is both in volume and in the types of services affected.

Hospitals and doctors are fed up with Medicare Advantage (Washington Post) — Talks about growing friction: claim denials, onerous prior authorization requirements, hospitals and physician practices refusing to accept some MA plans even from big insurers.

Medicare Advantage Increasingly Popular With Seniors — But Not Hospitals and Doctors (KFF Health News) — providers complaining about payment rates, denials, authorization burdens. Also notes that many hospitals / provider systems are refusing some MA plans even as Medicare Advantage enrollment rises.

Iowa Specialty Hospital to stop accepting certain Medicare Advantage plans — The hospital is stopping some MA plans because of frequent delays, denials, slow reimbursements.

Danbury Hospital sues health insurance giant for repeatedly failing to pay Medicare Advantage claims — Danbury Hospital (Connecticut) sues UnitedHealthcare for underpaying and breaching contract under their facility agreement.

Unacceptable: Nebraska Hospital Association speaks out about Medicare Advantage plans — Hospitals in Nebraska saying that MA plans cover more people but that enrollees may pay more; also many providers are not contracting with some MA plans, experiencing delays, denials.

Medicare Advantage coverage denials raise health care access concerns — A report by the HHS Office of Inspector General found that some denials by Medicare Advantage organizations met Medicare coverage rules (i.e. were improper denials), leading to delays, extra steps, burden.

Medicare Advantage is a disadvantage (VTDigger) — Argues that MA plans restrict access through narrow networks, create surprise billing risks, and prioritize insurer profits over patient needs.

She dumped Medicare Advantage; still healthy, she went to traditional Medicare & affordable Medi (Daily Kos) — A personal account of leaving MA for traditional Medicare due to better access and fewer barriers to care.

New Hampshire official warns Medicare Advantage market is 'collapsing' (Becker's Payer) — The state insurance commissioner warns that insurer exits are severely shrinking MA plan choices for seniors.

Medicare Advantage Plans Denied 2 Million Prior Authorization Requests in 2021(KFF) — A review finding that MA plans denied roughly 6% of prior-auth requests.

Thousands of Maryland seniors notified of the end of their Medicare Advantage plans (Maryland Matters) — More than 100,000 enrollees must switch plans after major insurers exit the state's MA market.

Medicare Advantage Plans Denied a Larger Share of Prior Authorization Requests in 2022 Than in Prior Years (KFF) — Denial rates rose to 7.4% in 2022, with most appealed denials reversed.

Why Johns Hopkins Refused to Let an Insurance Giant Decide Your Treatment (Johns Hopkins Medicine) — Explains why Johns Hopkins cut ties with UnitedHealthcare over excessive denials and burdensome authorization requirements.

Health Tracking Poll: Public Finds Prior Authorization Process Difficult to Manage (KFF) — Despite insurers' pledge to ease prior authorization burdens, the poll shows most people still experience delays and denials as a major problem, and very few are even aware that insurers made such a pledge.

1

Seniors with Medicare Advantage scrambling as market dramatically shrinks

Roughly 85% of all New Hampshire residents with Medicare Advantage plans will soon have six weeks to find different health care coverage as two major insurers are leaving the market and a third significantly reduces its reach.

State Insurance Commissioner D.J. Bettencourt had told lawmakers last month the Medicare Advantage market was "collapsing," but this shake-up is even more extensive than had been expected for the estimated 90,000 seniors who have this coverage.

"It's been quite a week," Bettencourt said during an interview. "This level of disruption is greater for these seniors since Medicare Advantage came onto the scene. Our message to them is there are still some great options in the marketplace for you, but begin doing your homework so you can make an informed choice that is the best fit."

https://www.yahoo.com/news/articles/seniors-medicare-advantage-scrambling-market-035900979.html?guccounter=1&guce_referrer=aHR0cHM6Ly93d3cuZ29vZ2xlLmNvbS8&guce_referrer_sig=AQAAAMQCJUZZK4fbIiInpztsYPgnRZz_5rxrPzPvwxquB4vJRzG3b23akTWuh9ZAC14XCw8zeSCkmQzegRROUabenl7y2bBhkc92u7DEemqkKvfpb7EKynNxJF-6uJlh0GFRFydwvQZXE3q3Lsijk3g4wS3A3n8CseviGe89D3YNGcEK

2

Thousands of Maryland seniors notified of the end of their Medicare Advantage plans

Danielle J. Brown, Maryland Matters

October 14, 2025, 2:00 PM

This article was republished with permission from WTOP's news partners at Maryland Matters. Sign up for Maryland Matters' free email subscription today.

Walkersville resident Marlene Eyler, 74, works as a host at a restaurant and cares for her 20-year-old grandson who lives with her. And now she has to add the chore of finding a new Medicare insurance plan to her challenges.

Eyler, who learned recently that she will lose her Medicare Advantage plan with Aetna, is one of thousands of Maryland seniors expected to receive notice this month that their supplemental Medicare plans will no longer be available next year, sparking frustration, fear and confusion.

"I'm very happy with Aetna, I haven't had any issues with them," Eyler said. "I'm just frustrated with the state of Maryland that they can't give the older people better insurance."

Insurance carriers say that Maryland's unique hospital system is costly for them to do business in, and several are reducing their coverage in the state or pulling out of counties entirely. But that leaves residents like Eyler forced to navigate finding a new health care plan for next year.

"I'm taking care of him," she said of her grandson, "plus having to worry about all this insurance stuff. And I have to work because I can't pay the bills without working."

Dean Slaughter, a 70-year-old Annapolis resident, is tired of having to change Medicare Advantage plans year after year. He recently got a letter from Aetna as well, telling him that his plan will no longer be available in 2026.

"Now we get to sit down and do the dog-and-pony show – see what's out there, which is not much to offer. The insurance companies are leaving the state of Maryland," Slaughter said.

Industry experts say as many as 100,000 Medicare recipients in Maryland, like Slaughter and Eyler, will have to scramble to find a new health care plan by the end of the year or risk losing coverage at an age where many require costly medical care.

About a quarter of Maryland Medicare recipients use a supplemental program called Medicare Advantage that helps retirees use a private insurer for additional health coverage such as vision, dental and transportation assistance that the standard Medicare plans may not offer.

But there’s been a long-running problem that’s coming to a head: State officials and people in the health care industry say the Medicare Advantage market in Maryland is more expensive than in most other states because of Maryland’s unique hospital payment system.

In recent years, the state has offered insurers a grant to help cover some of their costs and encourage them to keep offering the coverage in the state. That grant is going away, however, and some insurance companies have shrunk their presence in the state as a result.

A spokesperson for Humana said that the insurance company will no longer offer one of its Medicare Advantage plans in five major Maryland jurisdictions.

“Humana has exited one Medicare Advantage plan in Maryland for next year,” according to the statement. “Beginning Jan. 1, 2026 … Humana Gold Plus SNP (HMO DSNP), will no longer be available in the following counties: Anne Arundel, Baltimore, Harford, Howard and Baltimore City.”

Humana says that those affected by the termination will maintain their current coverage through Dec. 31, 2025, but they will need to find new coverage during the Medicare Annual Election Period, which runs from Oct. 15 through Dec. 7, if they want coverage next year.

Aetna shrunk its Medicare Advantage coverage to just three counties next year.

“Each year, we assess our ability to meet the health care needs of our members and adjust our plans to ensure they can deliver an excellent and sustainable member experience,” a spokesperson for Aetna said in a written statement. “In 2026, in Maryland, we will offer Medicare Advantage in the following counties: Frederick, Harford and Montgomery.”

Part of the issue comes from Maryland’s unique Total Cost of Care hospital payment model, in which a state board called the Health Services Cost Review Commission (HSCRC) sets hospital rates. Under the current system, insurance carriers pay higher hospital rates than in other states and get reimbursed by the federal government for Medicare Advantage services at lower rates than elsewhere. Meanwhile, insurance carriers are unable to negotiate hospital rates under their plans.

As a result, it’s more expensive to use Medicare Advantage in Maryland than in other states, and Maryland seniors aren’t getting the same quality of benefits, a spokesperson for CareFirst said in a recent statement.

Insurers reducing their footprint in the state leaves residents like Jie Shen, a 68-year-old living in Cockeysville, having to look for a new plan. That often means finding new doctors and hospitals for health care services.

“This is getting very frustrating,” Shen said. “I just want to stay on one plan at this point. I don’t know which one to choose.”

While there is time to search for a new plan, Medicare Advantage recipients note that the options available in Maryland are dwindling as carriers pull out of the state.

“It’s a hassle,” Slaughter said. “All of a sudden, you’re working with people who don’t even know you, and it’s not the way I want it … I feel like I am a number, and a cattle in line instead of a person, and it’s degrading.”

Even those who will still have their plans in 2026 are worried about what may come down the pipeline later.

Sharon Vickers, 78-year-old resident of Pasadena, was relieved to hear that her Medicare Advantage plan with CareFirst will continue into next year.

“I was concerned. Especially since my husband has passed, not having someone to sit and talk about it and discuss it,” she said.

As many Medicare recipients do, she works with an insurance broker to help find appropriate coverage for her needs. The broker informed her that she would be “comfortable this year,” but that he couldn’t “guarantee anything for next year.”

But she feels that the Advantage plans are already too expensive for what they offer and may skip out on coverage entirely.

“I may be looking at one day not being able to afford health care coverage,” Vickers said. “I’ll do what I have to do when the time comes, and that may mean going without health care.”

Meanwhile, the Maryland model is undergoing a major transition this year, as state health officials and federal officials finalize new terms of the States Advancing All-Payer Health Equity Approaches and Development, or AHEAD, model.

Current negotiations appear to prompt the state to offer solutions to the stabilize Medicare Advantage. There may also be significant changes to the state's Medicare rate-setting authority.

Shen, like other Medicare recipients, hopes something can be done so that insurers will stay in the state.

"I don't know if the state can help, but that's what I ask for," he said. "They should do something."

3

Hospitals and doctors are fed up with Medicare Advantage

Analysis by Julie Appleby

with research by McKenzie Beard

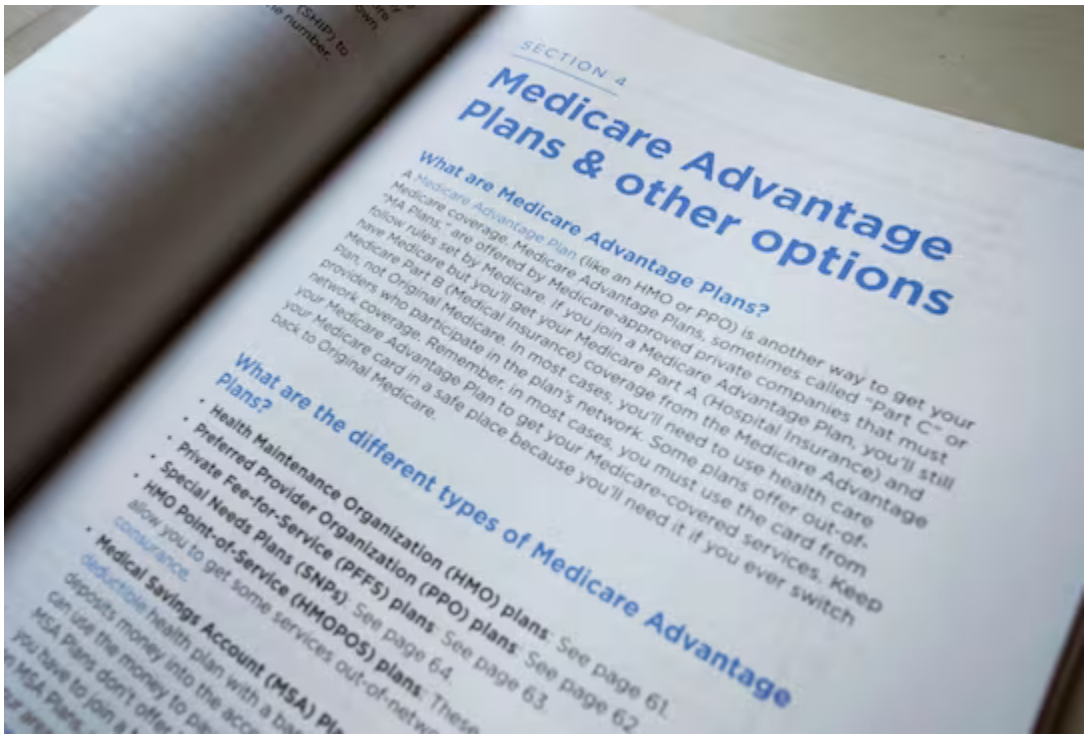
November 29, 2023 at 7:11 a.m. EST

Good morning. I'm Julie Appleby, a senior correspondent for KFF Health News who writes about health insurance, price transparency and big medical bills — like this one following a cat bite. Send your tips to juliea@kff.org

Not a subscriber? Sign up here.

Today's edition: New data on life expectancy shows that the country continues to grapple with the lasting ramifications of the coronavirus pandemic. The Texas Supreme Court appeared divided during oral arguments in a lawsuit challenging the state's abortion ban. **But first …**

Health providers are irked at the behavior of Medicare Advantage plans — and some are refusing to take them



There is increasing scrutiny around the business practices of privately-run Medicare plans. (Pablo Martinez Monsivais/AP)

Medicare Advantage plans are pretty popular with both lawmakers and ordinary Americans — they now enroll about 31 million people, representing just over half of everyone in Medicare, by KFF's count.

But among doctors and hospitals, it's a different story.

Across the country, provider grumbling about claim denials and onerous preapproval requirements by Advantage plans is crescendoing. Some hospitals and physician practices are so fed up they're refusing to accept the plans — even big ones like those offered by **United Healthcare** and **Humana**.

"The insurance companies running the Medicare Advantage plans are pushing physicians and hospitals to the edge," said **Chip Kahn**, president and CEO of the **Federation of American Hospitals**, which represents the for-profit hospital sector.

Last week, the industry's largest lobbying group, the **American Hospital Association**, fired off a letter to the **Centers for Medicare and Medicaid Services** warning that some insurers seem intent on circumventing new rules put in place by the Biden administration aimed at reining in some prior authorization and claim denials.

It isn't like we've never seen disputes between insurers and providers before, especially in negotiations with employer-sponsored plans.

But the focus now on Medicare Advantage "seems different," said **David Lipschutz**, associate director and senior policy attorney for the **Center for Medicare Advocacy**, who says hospitals and doctors are becoming "much more vocal" about their frustrations with some of the insurers' cost-control efforts.

Baptist Health in **Louisville,** for example, has threatened that all of its nine hospitals, along with its clinics and physician groups, will cut ties with Advantage plans offered by **UnitedHealthcare** and **WellCare Health Plans Inc.** beginning in January unless they can come to terms.

The plans "routinely deny or delay approval or payment for medical care recommended by your physician," the system wrote in a message to patients posted on its website.

The system's medical group, with nearly **1,500** physicians and other providers, left **Humana**'s network in September.

And in **San Diego**, more than **30,000** people are looking for new doctors after two large medical groups affiliated with **Scripps Health** said they would no longer contract with any Medicare Advantage insurers. Revenue "is not sufficient to cover the cost of patient care we provide," they said in a statement.

Lipschutz thinks providers are feeling emboldened following a study by the **Health and Human Services Department**'s inspector general published last year that found some Advantage plans have denied coverage for care that should have been provided under Medicare's rules.

The Biden administration's new rules, set to take effect in January, are in part a response to the OIG report. Enrollment for Medicare Advantage plans, supplemental plans for traditional Medicare coverage and stand-alone Medicare drug plans is open until Dec. 7.

While the insurance industry likes to boast that a huge majority of Congress supports the plans, there's increasing scrutiny at the Capitol, too.

Prior approval is a big point of friction. Virtually all Medicare Advantage enrollees are in plans that require the insurer to sign off in advance for at least some care, according to KFF. Insurers say that process ensures treatments are coordinated and appropriate.

In 2021, more than **35 million** requests for prior approval were submitted for Medicare Advantage enrollees, according to KFF, and over **2 million** of them were denied. For the small minority of patients who appeal (**11 percent**), a whopping **82 percent** won a full or partial overturning of the insurers' decision.

To be sure, commercial plans covering people with job-based insurance or those who buy their own through the Affordable Care Act also engage in prior approval, and there's lots of complaints about them, too.

The difference with Medicare, though, is that beneficiaries can choose the traditional, government-run program, where prior approval and claim denials are much more limited. Doctors and hospitals have plenty of gripes about how much traditional Medicare pays them, but

from their point of view, they spend less time fighting over medical decisions.

KFF Health News is a national newsroom that produces in-depth journalism about health issues and is one of the core operating programs at KFF — an independent source of health policy research, polling and journalism.

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Iowa Specialty Hospital to stop accepting certain Medicare Advantage plans

Local News

Sep 3, 2025

Amanda Rink

CLARION — Iowa Specialty Hospitals and Clinics will no longer accept certain Medicare Advantage plans. This is a move hospital leaders say is meant to protect patients and staff from a system that often delays or denies needed care.

Medicare is the federal health insurance program for people 65 and older. Medicare Advantage plans are run by private insurance companies. Funded with federal dollars, they must cover the same basic services as Medicare, but hospital leaders say they frequently add hurdles such as prior authorizations, narrow provider networks, and slow reimbursements.

The difference often becomes clear inside the hospital.

“When we have patients on Medicare Advantage plans, many of the plans require pre-authorization for services,” said Chief Nursing Officer Beth Carder.

She noted multiple cases where doctors and nurses recommended continued care, but insurers determined there was not medical necessity for the services.

“Families are confused and frustrated because their patient isn’t authorized for those services,” Carder said. “Some have ended up paying privately, which can get pricey as well.”

Chief Compliance Officer Reagan Swisher said many patients don’t realize how different Medicare Advantage is from traditional Medicare.

“Many families think that when they have Medicare Advantage … it’s Medicare, because of that Medicare Advantage name,” he said. “Health insurance is difficult to understand on a good day.”

Iowa Specialty Chief Executive Officer Steve Simonin said the hospital is preparing to notify patients about which plans will no longer be accepted. Some Advantage plans will still be accepted.

“We are planning on sending a letter via MyChart to all of our patients discussing which Medicare Advantage plans we don’t accept,” he said.

Hospitals nationwide are making similar moves. At least 27 health systems have stopped accepting certain Medicare Advantage plans, citing excessive prior authorization denials and slow insurer payments. On average, the federal government pays insurers about $1,000 a month for each enrollee, but hospitals say that hasn’t always translated into reliable coverage for patients.

To help patients sort through their options, leaders point to SHIIP, the Senior Health Insurance Information Program, a free, confidential service run by the Iowa Insurance Division.

SHIIP volunteers in Wright County are available in Belmond, Clarion, Hampton, and Garner to help seniors compare plans before they enroll. They also are available in Webster County.

Medicare's open enrollment period runs from September through December. Iowa Specialty leaders say they hope residents take time to review their choices carefully.

"This isn't about making life harder on patients," Simonin said. Ultimately, the hospital system wants patients to understand the coverage they are signing up for. "They're our neighbors," Simonin stated. "In Iowa, we take care of our neighbors."

Amanda Rink is editor of The Wright County Monitor. This story is published through a cooperative effort between The Monitor and The Messenger.

5

Danbury Hospital sues health insurance giant for repeatedly failing to pay Medicare Advantage claims

By **Rob Ryser**, *Staff Writer*

April 22, 2025

The Danbury Hospital main entrance at 24 Hospital Ave, Danbury, Conn., on Monday October 7, 2024. Danbury Hospital has filed a multimillion-dollar lawsuit against UnitedHealthcare, claiming the health insurance giant breached its contract and violated Connecticut's unfair trade practices law by underpaying the hospital for Medicare Advantage claims.

DANBURY – Danbury Hospital has filed a multimillion-dollar lawsuit against UnitedHealthcare, claiming the health insurance giant breached its contract and violated Connecticut's unfair trade practices law by underpaying the hospital for Medicare Advantage claims.

"Despite being on notice for the underpayment issue, United has failed to properly pay the outstanding balance due on Medicare Advantage claims," says a complaint filed by the

hospital in state Supreme Court in Danbury. “United (has) engaged in unfair claim payment practices by repeatedly breaching the facility agreement and underpaying claims in bad faith.”

The lawsuit, filed March 4, names two subsidiaries, UnitedHealthcare Insurance Co. and UnitedHealthcare of New England Inc., which are both owned by UnitedHealth Group, the largest health insurer in the country.

Officials at UnitedHealth did not immediately respond to requests for comment on Monday.

The hospital’s lawsuit, which seeks at least $1 million each on four counts of alleged violations, also seeks punitive damages, lawyers’ fees and interest.

“On January 1, 2023, United began to repeatedly underpay Danbury Hospital for Medicare Advantage claims provided in connection with the facility agreement and repeatedly failed to comply with the

terms of the facility agreement and on each occasion did so on bad faith," the lawsuit says.

Details about the facility agreement were not provided in the complaint, except that the hospital “became an in-network provider of medical services to United members and beneficiaries” in 2008.

The disagreement, which covers the 2023 calendar year, centers on “United’s failure to properly pay the Medicare Advantage claims,” according to the complaint.

Medicare Advantage is a privately run version of the government-funded Medicare program, mostly for people age 65 and older.

The lawsuit, which had not been answered in court by UnitedHealthcare on Monday, comes at a time when both the hospital and the health insurance giant have been in the headlines.

The parent company for Danbury Hospital as well as Norwalk and Sharon hospitals is now part of the much larger New York-based health care system Northwell. A state oversight agency approved the $20 billion deal earlier this month, in part because

Danbury-based parent company Nuvance was bleeding hundreds of millions of dollars annually in losses and in part because Northwell pledged to invest $1 billion in Nuvance over five years.

UnitedHealthcare parent company UnitedHealth Group made news last week when it announced lower-than-expected first-quarter results, and its stock took a dive, according to published reports.

https://www.newstimes.com/news/article/danbury-hospital-sues-unitedhealthcare-medicare-20286426.php?

6

‘Unacceptable’: Nebraska Hospital Association speaks out about Medicare Advantage plans

October 7, 2025 5:31 pm Karen Lucrece

LINCOLN, Neb. (KLKN) — A new struggle is being thrown at Nebraska hospitals, involving the future of Medicare.

The Nebraska Hospital Association said the Medicare Advantage Plan covers more people, but those that are enrolled may have to pay more.

A Medicare Advantage plan includes part A and part B benefits and often Part D coverage, offering a bundled alternative to original Medicare.

“It’s also important for Nebraska seniors to understand that not all Nebraska hospitals and clinics or healthcare providers do not contract with Medicare advantage plans,” said Jeremy Nordquist, the president of the Nebraska Hospital Association.

According to a survey of more than 90 hospitals, a majority said they’re struggling with payment delays, prior authorizations and denials from Medicare Advantage plans.

“These delays impact the patient care, it keeps them separate from their families and increases the overall healthcare cost in our system,” Nordquist said.

Officials said patient access and the financial stability of many rural hospitals in the state is on the line.

Many rural hospitals already face tight budgets and limited staff.

“These plans, Medicare advantage plans, also place substantial burdens on our doctors and nurses who must spend hours a week on the phone with insurers,” Nordquist said.

More than half of all Medicare-eligible Americans now have Advantage plans and that number is expected to grow to nearly two-thirds by 2034.

Hospital leaders said without change, the strain could jeopardize access to care for patients statewide.

“We are small but mighty 21 bed critical access hospital in a town of 1000 people,” said Laura Gamble, CEO of Pender Community Hospital. “And more than ever patients are wanting to get their care locally from people they know and trust.”

As the number of Medicare enrollees continue to rise, health leaders said the time for action is now.

“The bottom line is the way Medicare advantage plans restrict and deny patient care is unacceptable,” Nordquist said. “It puts our doctors, nurses and our hospitals on an unsustainable path.”

Categories: Health, Nebraska News, News, Top Stories

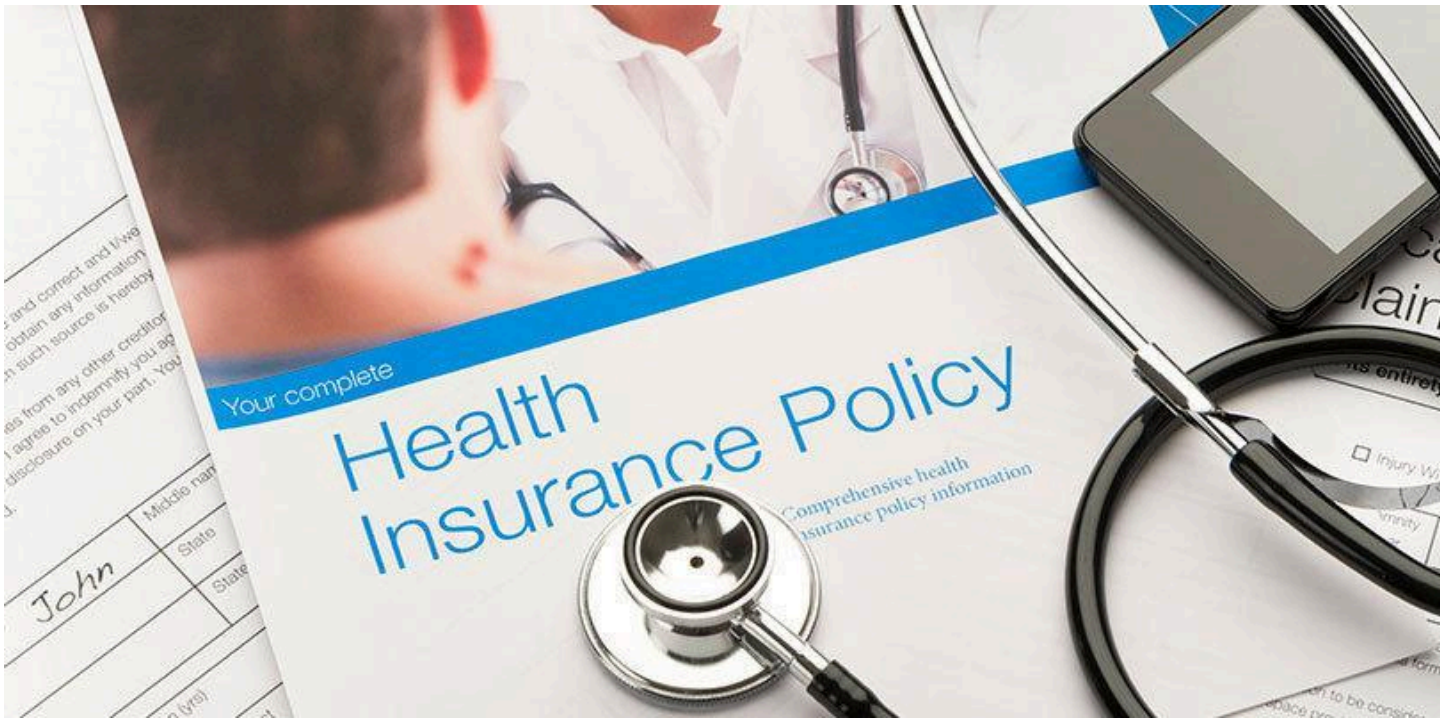
Tags: Americans, Coverage, Delays, denials, health, hospitals, Jeremy nordquist, Laura Gamble, Medicare, Medicare Advantage plans, medicare coverage, Nebraska Hospital Association, payment, rural hospitals, seniors

https://www.klkntv.com/unacceptable-nebraska-hospital-association-speaks-out-about-medicare-advantage-plans/

7

OIG: Medicare Advantage coverage denials raise health care access concerns

Apr 28, 2022 - 02:41 PM



The Centers for Medicare & Medicaid Services should take steps to prevent Medicare Advantage organizations from denying coverage and payment for medically necessary care, the Department of Health and Human Services' Office of Inspector General advised yesterday.

OIG reviewed a random sample of prior authorization and payment denials by 15 large MA organizations in 2019, and found 13% of coverage denials met Medicare coverage rules and 18% of payment denials met Medicare coverage and MA billing rules. The report describes the avoidable delays, extra steps, and administrative burden caused by

inappropriate health plan denials and illustrates the negative impact on patient care and access through a series of case examples.

“Denied requests that meet Medicare coverage rules may prevent or delay beneficiaries from receiving medically necessary care and can burden providers,” OIG said.

The report recommends CMS issue guidance on the appropriate use of MAO clinical criteria in medical necessity reviews; update its audit protocols to address the identified issues; and direct MAOs to take additional steps to address vulnerabilities that can lead to manual and systemic review errors.

AHA said the findings “confirm — and provide data and real-life examples — of the harm that certain commercial insurer policies have on patients and the providers that care for them. The AHA continues to push back forcefully against MA plan policies that restrict or delay patient access to care, and add cost and burden to the health care system, while also contributing to health care worker burnout. We’ll continue to make the case that these commercial health plan abuses must be addressed to protect patients’ health and ensure that medical professionals — not the insurance industry — are making the key clinical decisions in patient care.”

https://www.aha.org/news/headline/2022-04-28-oig-medicare-advantage-coverage-denials-raise-health-care-access-concerns?

8

Medicare Open Enrollment Brings Rise in Scams

News provided by
AgeSpan, Inc.
Oct 01, 2025, 09:04 ET

Massachusetts SMP Program Urges Vigilance

LAWRENCE, Mass., Oct. 1, 2025 /PRNewswire/ -- During Medicare's Open Enrollment period (October 15-December 7, 2025) beneficiaries have the chance to review and change their coverage. Unfortunately, it also brings a surge in scam calls, fraudulent mailings, and misleading marketing.

"Scammers know this is a confusing time, and they prey on that," said Lucilia Prates, MA SMP Program State Director. "Never confirm or provide your Medicare number with anyone who contacts you unexpectedly, and you do not know and trust."

Watch Out for Red Flags! Beware:

- Unsolicited mailings, calls, texts, or emails asking for your Medicare number.
- High-pressure or threatening tactics urging you to "act now."
- Too-good-to-be-true offers related to insurance plans, like free groceries, refunds, or other unrealistic benefits.
- Mailings that mimic government logos to look official.

Protect Yourself

- Treat your Medicare card like a credit card. Protect your Medicare number.
- Hang up on suspicious calls and ignore fake texts or emails.
- Don't click on links from unknown senders.
- Compare plans only through www.medicare.gov or 1-800-MEDICARE.
- Get free, unbiased, help from SHINE counselors in Massachusetts. To be connected to a local SHINE counselor and schedule an appointment call MassOptions at 1-800-243-4636 or email SHINE@mass.gov.

We can all do our part to fight Medicare fraud by staying alert, reviewing Medicare Summary Notices/Explanations of Benefits, keeping a Personal Healthcare Journal (My Health Care Tracker, now available in the app store!), and reporting any or all suspicious activity.

Together, we can make a difference and protect Medicare for ourselves and future generations.
For your free healthcare journal, or to report Medicare fraud or a suspicious communication, call the MA SMP Program at 800-892-0890.

About the Massachusetts SMP Program

The Massachusetts Senior Medicare Patrol Program, funded in part by the Administration for Community Living, and working under the leadership of AgeSpan, Inc., empowers beneficiaries, caregivers, and families to prevent, detect, and report healthcare errors, fraud, and abuse. To learn more or to become a volunteer, visit www.masmp.org.

Disclaimer: : This publication is supported by the Administration for Community Living (ACL), U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $602,337.00 with 100% funding by ACL/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by ACL/HHS, or the U.S. Government.

SOURCE AgeSpan, Inc.
https://www.prnewswire.com/news-releases/medicare-open-enrollment-brings-rise-in-scams-302568263.html?