Delaware Medicare Assistance Bureau

Medicare Newsletter

Summer 2026

Trinidad Navarro, Insurance Commissioner

MEDICARE GLP-1 Bridge Program

Starting July 1, 2026, Medicare GLP-1 Bridge covers certain GLP-1 weight loss drugs.
It is available nationwide (including all states and U.S. territories) to certain people with Medicare drug coverage (Part D). If you qualify, your cost for these drugs is $50 per month, no matter your income level. This is a short-term program until December 31, 2027, that works outside of your Medicare Part D coverage, so your $50 payments don't count toward your Medicare drug plan deductible or yearly out-of-pocket limit. These drugs aren't eligible for the Medicare Prescription Payment Plan.

Medicare GLP-1 Bridge covers the following products when used to reduce excess body weight and maintain weight reduction:

1. Foundayo® (tablet)
2. Wegovy® (injection or tablet)
3. Zepbound® — KwikPen® only

Medicare GLP-1 Bridge doesn't cover the single-dose Zepbound® pen and Zepbound® vials, Mounjaro®, Ozempic®, or Rybelsus®.

You must meet ALL four of these requirements:

- You have Medicare Part D drug coverage (a standalone drug plan or a Medicare health plan that includes drug coverage). You're not eligible if your only Medicare coverage is through certain special plan types (like private fee-for-service plans, cost contract plans or a PACE organization).
- You aren't currently getting a GLP-1 drug paid for by your Medicare drug plan.
- You don't have Type 2 diabetes, moderate-to-severe sleep apnea, or fatty liver disease.
- You are at least 18 years old and are prescribed an eligible GLP-1 for weight loss as part of lifestyle changes, AND meet certain Body Mass Index (BMI) requirements (detailed on next slide)

BMI Requirements:

- **35 or higher**- No additional conditions required.
- **30 or higher**-Certain heart failure OR uncontrolled high blood pressure (also called hypertension) OR chronic kidney disease (stage 3a or above)
- **27 or higher**- Diagnosed pre-diabetes OR a history of heart attack or stroke OR blocked arteries in your legs or arms

Talk to your doctor to find out if a GLP-1 drug is right for you and if you qualify.

For more information and the approval process visit the website: **Medicare.gov/glp1bridge**

A Dexcom device is a small, wearable sensor that continuously measures glucose levels.

Transitioning from a Dexcom D6 to Dexcom D7

Dexcom G6 is being discontinued on July 1, 2026. Dexcom urges all Medicare users to transition to the G7.

Medicare Coverage for Dexcom G7
If you already have a G6, Medicare can cover the Dexcom G7 even if you already have a Dexcom G6, if you meet the same eligibility criteria for continuous glucose monitoring (CGM) coverage.

Medicare requirements to cover G7
Medicare Part B covers therapeutic CGMs like the Dexcom G6 and G7 if your doctor prescribes them for you and you meet specific medical requirements Dexcom+1. These include:

- Having type 1 or type 2 diabetes (or gestational diabetes in some cases).
- Being insulin-treated (any form), or
- Not using insulin but having a documented history of problematic hypoglycemia (e.g., recurrent level 2 lows or a level 3 event requiring assistance) Dexcom+1.
- Your treating provider must also confirm you have the training to use the device and that it's prescribed in accordance with FDA indications Dexcom.

Upgrading from G6 to G7
If you're currently on a G6:

- Contact your Medicare-approved distributor to request a prescription for the G7 Dexcom.
- Your doctor can write the prescription, and the distributor will handle the upgrade process, including pricing and compatibility checks (e.g., pump or pen integration) Dexcom.
- Medicare will cover the G7 if you meet the same criteria as for the G6.

Key Points
No automatic upgrade: Medicare won't automatically replace your G6 with a G7 unless you request it and meet coverage rules.

Same coverage rules apply: Whether you start with G6 or G7, you must meet the diabetes and hypoglycemia criteria.

Part B coverage: The G7 is considered durable medical equipment under Part B, so you need Part B active for coverage snuggymom.com+1.

Cost: Medicare typically covers 80% of the cost after your deductible, with a maximum of three sensors per year mafainsurance.com.

Bottom line: Yes, Medicare can cover the Dexcom G7 if you already have a G6 and meet the eligibility requirements. You'll need to coordinate with your doctor and Medicare-approved supplier to initiate the upgrade.

Filing a Pre-Service Medicare Advantage (MA) Standard Appeal

If you have a Medicare Advantage plan and you were denied coverage or authorization for a health service or item before you received the service or item, you can appeal to ask the plan to reconsider its decision. An appeal is a formal request you make if you disagree with a coverage or payment decision.

Before you start the appeal:

You will need to get an official written decision from your plan called a **Notice of Denial of Medical Coverage.** You should get the written denial within 14 days.

- Request a fast appeal if waiting for the standard decision could harm your health. If approved a decision will be made within 72 hours.

To start your appeal:

- Follow the appeal instructions on the "Notice of Denial of Medical Coverage".
- Your Plan has 30 days to make a decision, or 72 hours if you filed an expedited appeal.

If your appeal is denied:

- Your plan should send a written denial and automatically forward your appeal to the next level, the **Independent Review Entity (IRE).**
- The IRE should make a decision within 30 days of the date on your plan denial notice. If you file an expedited appeal, the IRE should make a decision within 72 hours.

If your IRE appeal is denied:

- If your service or item is worth more than $200 in 2026, you may make an appeal to the **Office of Medicare Hearings and Appeals (OMHA)** level. The instructions are on your IRE denial.
- You must file an OMHA appeal within 60 days of the date of the IRE denial letter.
- Your Plan has 30 days to make a decision, or 72 hours if you filed an expedited appeal.

If your OMHA appeal is denied:

- You may appeal to the **Council,** within 60 days of the date of your OMHA denial letter. Instructions are on the OMHA denial letter.
- There is no decision timeframe for the **Council** to make a decision about your appeal.

If your Council appeal is denied:

- If your health service or item is worth at least $1960 in 2026, you may appeal to the **Federal District Court** within 60 days of the date of the Council denial letter.
- There is no set timeframe for the court to make a decision.

Appeals in a Special Needs Plan:

If you have coverage through a Medicare Special Needs Plan (SNP), your plan must tell you in writing how to appeal. After you file an appeal, the plan will review its original decision. If your plan does not decide in your favor, the appeal is reviewed by an independent organization.

Welcome to Medicare Seminars

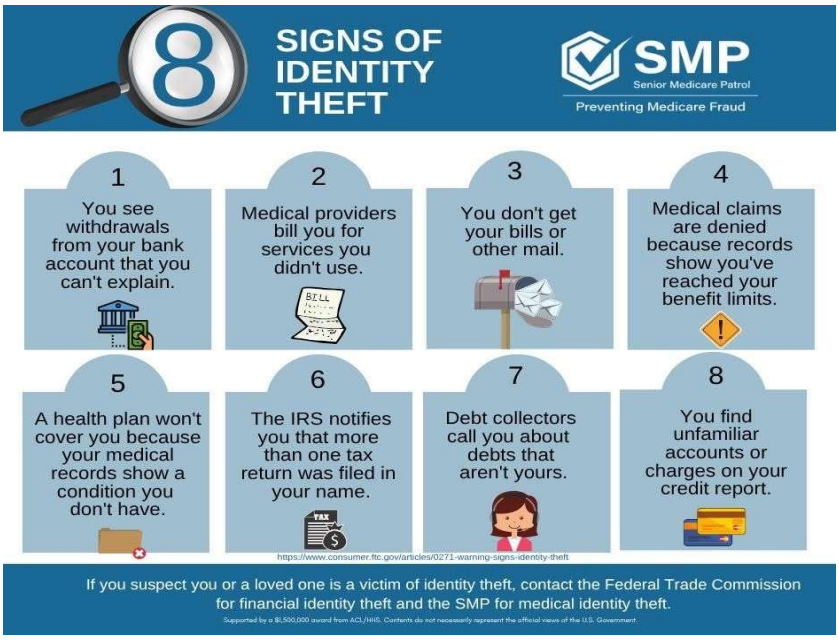
Sussex County
Thursday, August 20, 2026, 10 am-12 pm
Georgetown CHEER Community Center 20520 Sand Hill Road, Georgetown, DE

New Castle County
Wednesday, September 2, 2026, 12 pm-2 pm **Bear Library** 101 Governors Place, Bear DE

Thursday, September 3, 2026, 11:00 pm-1:00 pm **Hockessin Library** 1023 Valley Road, Hockessin, DE

Kent County
Thursday, September 10, 2026, 10 am-12 pm
Delaware Department of Insurance 1351 West North Street Suite 101, Dover DE

To register call 302-674-7364
Or online
http://de.gov/dmabcalendar



Are you concerned about identity theft?

Here are eight warning signs. If you have questions about medical identity theft, contact **Delaware Senior Medicare Patrol "SMP"** at:

1-800-223-9074

Are you interested in helping others within your community with questions regarding Medicare?

The Delaware Medicare Assistance Bureau, DMAB, is looking for volunteers.

Free Medicare training for volunteers!
No experience necessary.
302-674-7364