Understanding Medicare 2024

Part A Hospitalization
No Cost for most Americans
The deductible for Part A for 2024 is $1632.00 which covers the 1st 60 days in the hospital. Day 61-90 is $408 per day. Lifetime reserve is $816 per day

Buy in to Part A is $278 per month premium for people with 30 quarters of coverage and $506 per month premium for those with less than 30 quarters of coverage. Coverage refers to # of quarters of participation in social security.

Part B Outpatient
$174.70 Month for anyone new to Medicare in 2024; anyone on Medicare plus any income related surcharge on Parts B & D. The Part B deductible for 2024 is $240.

Part D Prescriptions
Price varies, based on the plan chosen.

Part C Offered from Private Insurance & Includes Parts A, B & D

Original Medicare is a fee for service program where the recipient pays 20% and Medicare pays 80%. There is no maximum out-of-pocket under Original Medicare. If you have a claim for $100,000, you owe $20,000. You can see any Doctor, in any hospital, if they take Medicare. With Original Medicare you also must contend with Medicare Assignment of Benefits which means the Doctor or facility bills Medicare directly. If they do not, they can bill you the excess charges that Medicare disallows. (Usually around 15%)

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Original Medicare requires Parts A & B and a separate drug plan

If you are working beyond age 65 and your employer has more than 20 employees, you can keep your group health plan and take Medicare Part A only. This is because your group health plan will pay first, and Medicare will pay second. If your employer has less than 20 employees, you must take Medicare Part A & B because then Medicare pays first. The group insurance must also include a creditable drug plan. If not, there are **lifetime fines** of 10% of the Part B premium calculated each year and 1% on the drug plans.
Part C is run by private insurance companies and is referred to as an MAPD (Medicare Advantage Prescription Drug plan)

3 Types of Plans in Nevada

HMO Must have a primary care physician. Referrals are required to see a specialist. If you go out of network, you pay the entire bill. These plans typically have no premium. For 2024 there are two HMOs that do not have a referral requirement.

PPO No referrals required, see any physician if they take the plan. In Nevada monthly premiums range from $0-150 per month depending upon the carrier.

If you go out of network, the cost sharing is greater than staying in network. Some plans have a deductible and additional maximum out of pocket for seeing non-network providers. These plans also have nationwide networks.

Medicare Advantage plans are run by insurance companies and the plans are based on the county where you live. If you move out of your home county, you must change your plan.

There are a combined over 60 different MAPD plans offered in Nevada. They include HMO's, PPO's, MSA's and SNP (Special Needs Plans). These SNP are offered for medical conditions such as Diabetes, Heart Conditions, COPD, or other breathing problems and for End Stage Renal Disease or Kidney Dialysis.

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Understanding Medicare Supplements

Medicare Supplements are plans that work with Original Medicare and pay part or all of what Original Medicare does not cover.

Medicare Supplement plans are designated by a letter; the plans range from plan A through plan N. The government decides what each plan's benefits are and the insurance carriers decide what rate to charge. Therefore, rates can vary as much as $100 per month for the same plan.

Plan F appears to be the most popular plan (Plan F, High Deductible F & C are being grandfathered in 2021 and will no longer be available. Anyone on those plans may keep them.) If you had any of these plans prior to 1/1/2020 you can keep them.

If you are Medicare eligible prior to 2020 you can buy a Plan F, High Deductible F or C after January 2020, otherwise you cannot buy any of these plans.

With Plan F, when you visit a provider, you need your Original Medicare card and your Medicare Supplement card. All Medicare approved services are covered without any payments from you. Also, all excess charges that Medicare disallows are covered in the Plan.

There is also a high deductible Plan F, & G. Their pricing varies by carrier. The deductible for 2023 is $2700. You pay the first $2700 and the plan pays everything else for the calendar year.

Some carriers offer a G Plan. The G Plan has a Part B deductible which for 2024 is $233 annually. Once that deductible is satisfied, there are no other charges. The difference in premium between Plan F & G is around $30-70 per month, depending upon the carrier. It is anticipated that since Plans C & F & High Deductible F are exiting the market that Plan G will become the plan of choice. Remember those that have Plan C, F or High Deductible F can keep it. Plan C, F and High Deductible F will ultimately end up costing more because the pool of participants will decrease over time, thus rates will increase. The impact on the high deductible plans will be less due to the high deductible.

Plan N has 3 charges. The 1st is the annual Part B deductible of $233; then Doctor Visits are $20. (Remember that the Doctor will have to take Medicare Assignment of benefits, or the Doctor can bill you what Medicare does not pay.) Lastly, emergency room services

are $50 and waived if you are admitted. All other services are covered at 100%. The cost difference between Plan F and Plan N are about $50-$70 per month. Some Plan N's in Nevada are guaranteed issued while others are not.

When you take Medicare Part B after retiring; you are in an open enrollment or guarantee issue period where there are no medical questions asked to obtain coverage. That is an 8-month window. (For those already 65)

If you are turning 65 and go onto Medicare there is a 7-month window which means 3 months before your birthday month, the month of your birthday and 3 months after your birthday month where you can apply for Medicare without lifetime penalties.

Choosing the right plan for you is critical to your financial future. Make sure you have the right information before deciding. Unlike Medicare Advantage, you are required to prove insurability if not in the guaranteed issue period.

Since Medicare Supplements do not cover prescription medications, you will need a separate drug plan.

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Understanding Medicare Part D

Part D:
Stand-alone prescription plans are provided so recipients can get price breaks on their medications. All plans follow the Medicare guidelines including the donut hole or gap phases. There are 3 phases in all Medicare drug plans. There are 3 different types of drug plans; the saver plan; the preferred plan and the enhanced plan. The saver plans usually have deductibles while the preferred and enhanced plans don't have deductibles.

Phase 1:
The maximum is $4660. Some plans have an annual deductible of up to $480. The $4660 is the total cost of the medication that you and your insurance company pays. After you spend the $4660, you then move to Phase 2 or the donut hole or gap.

Phase 2:
Maximum is $7400. The way you get to the $7400 is a bit complicated. When you buy generic medications, you pay 25% of the cost the insurance company pays for the medication. Example: During Phase 1 you pay $4 & your insurance pays $16 when you move to Phase 2 or the donut hole or gap you pay $5.00 or 25% of the $20.

Brands are treated similarly, during the donut hole or gap you pay 25% and the insurance company and drug company pay 75% but you count only 95% towards the $7400. If the drug costs $300 per month, you pay $75 and the insurance company and Drug Company pay the difference and you count 95% of the $300 towards the maximum out of pocket, or $285.

Phase 3:
Your costs are $4.15 for generic medications, and $10.35 for brand named medications or 5% of retail cost, whichever is higher.

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