

Counseling Tips — January 2024

What's New in 2024?

1. Have costs for Medicare Part A (hospital insurance) changed in 2024?

Yes, the costs associated with Part A are different this year. Remember, Medicare Part A covers inpatient hospital services, skilled nursing facility services, home health care (in certain circumstances after you are in a hospital or skilled nursing facility), and hospice. Look through your 2024 *Medicare & You* handbook (see question 6) to understand Part A-covered services. The following chart shows costs last year compared to this year.

Original Medicare Part A Costs: 2023 vs. 2024		
	2023	2024
Part A premium	\$0/month if you've worked more than 10 years	\$0/month if you've worked more than 10 years
	\$278/month if you've worked between 7.5 and 10 years	\$278/month if you've worked between 7.5 and 10 years
	\$506/month if you've worked fewer than 30 quarters (7.5 years)	\$505/month if you've worked fewer than 30 quarters (7.5 years)
Hospital deductible	\$1,600 each benefit period	\$1,632 each benefit period
Hospital coinsurance	\$0/day for days 1 – 60 once you've met your deductible	\$0/day for days 1 – 60 once you've met your deductible
	\$400/day for days 61 – 90 of each benefit period	\$408/day for days 61 – 90 of each benefit period
	\$800/day for days 91 – 150 (non-renewable lifetime reserve days)	\$816/day for days 91 – 150 (non-renewable lifetime reserve days)
Skilled nursing facility coinsurance	\$0/day for days 1 – 20 each benefit period (after a minimum 3-day inpatient hospital stay)	\$0/day for days 1 – 20 each benefit period (after a minimum 3-day inpatient hospital stay)
	\$200/day for days 21 – 100 each benefit period	\$204/day for days 21 – 100 each benefit period

If you have a Medicare Advantage Plan, your plan provides your Part A coverage. If you have the same Medicare Advantage Plan in 2024 as you did in 2023, your plan should have sent you an Annual Notice of Change (ANOC) or Evidence of Coverage (EOC) notice explaining any changes for the coming year. Review this notice to understand your plan's costs, covered services, and rules. Contact your plan if you did not receive these documents in the fall or if you want another copy. If you chose a new Medicare Advantage Plan, review the costs associated with the plan for 2024.

2. Have costs for Medicare Part B (medical insurance) changed in 2024?

Yes, the costs associated with Part B are different this year. Remember that Medicare Part B covers outpatient medical services, such as services from a licensed health professional, preventive services, outpatient therapy, and home health services (if you are homebound and need skilled care).

Original Medicare Part B Costs: 2023 vs. 2024		
	2023	2024
Part B premium*	\$164.90/month	\$174.70
Part B deductible	\$226/year	\$240
Part B coinsurance	20% for most services	20% for most services
* If your annual income is higher than \$103,000 for an individual (\$206,000 for a couple), you will pay a higher Part B premium. Visit www.medicare.gov for Part B costs by annual income.		

Medicare Advantage costs: If you have a Medicare Advantage Plan, your plan administers your Part A and Part B coverage. Remember that most people with Medicare, whether they have Original Medicare or a Medicare Advantage Plan, pay the Part B monthly premium. Some people with a Medicare Advantage Plan may also pay an additional monthly premium for being enrolled in that plan. The amount you pay for Medicare Advantage Plan deductibles, copayments, and/or coinsurances varies by plan.

If you have the same Medicare Advantage Plan in 2024 as you did in 2023, your plan should have sent you an Annual Notice of Change (ANOC) or Evidence of Coverage (EOC) notice explaining any changes for the coming year. Review this notice to understand your plan's costs, covered services, and rules. Contact your plan if you did not receive these documents in the fall or want another copy. If you chose a new Medicare Advantage Plan, you should get an EOC for the new plan. Review that document to understand the costs associated with the plan for 2024.

3. Have costs for Medicare Part D (prescription drug coverage) changed in 2024?

If you have Medicare prescription drug coverage, often referred to as Part D, your plan should have notified you about any changes in costs for 2024. Part D plans can change the drugs they cover, their pharmacy networks, and their costs (such as copayments, coinsurance charges, and deductibles) from year to year. Remember, there are two main ways that you can get your Medicare prescription drug coverage:

- A Medicare Advantage Plan that covers both health and drug coverage, or
- A stand-alone Part D plan that works with Original Medicare.

Your Part D plan should have sent you an ANOC or EOC notice informing you of your plan's benefits, costs, and covered drugs for 2024. If you have a Medicare Advantage Plan with prescription drug coverage, you should have received one EOC that describes both your health and prescription drug coverage for 2024.

Part D plans must include the minimum coverage that is set by law, but each plan may offer varying types of coverage. For example, in 2024 Part D plans can set a maximum deductible (amount you pay out-of-pocket before your insurance begins to pay) of \$545. However, some plans may not require you to pay any deductible. The following chart shows costs last year compared to this year. Be sure to review your plan materials for specific cost changes.

Medicare Part D Costs: 2023 vs. 2024		
	2023	2024
Part D maximum deductible	Up to \$505/year	Up to \$545/year
Part D coverage gap threshold You reach the coverage gap, or donut hole, when you and your plan together have spent this much on covered drugs since the start of the year.	\$4,660	\$5,030
Part D catastrophic coverage limit You get out of the donut hole and reach catastrophic coverage when you have spent this much out of pocket* since the start of the year.	\$7,400	\$8,000

*Note the out-of-pocket costs that help you get out of the donut hole include what you've spent on covered drugs since the start of the year (deductible, copays); most of the discount for brand-name drugs while you're in the donut hole; and any drug costs paid by family members, most charities, State Pharmaceutical Assistance Programs (SPAPs), AIDS Drug Assistance Programs (ADAPs), and/or the Indian Health Service.

4. How are the Part D coverage phases changing in 2024?

The coverage phases will remain the same next year. However, your costs during the catastrophic coverage phase will change. In the past, you would owe 5% of the cost of your covered drugs once in the catastrophic coverage phase. In 2024, you will not owe anything for your Part D covered drugs once in the catastrophic coverage phase. See more information on the four coverage phases below:

Deductible period: Until you meet your Part D deductible, you will pay the full negotiated price for your covered prescription drugs. Once you have met the deductible, the plan will begin to cover the cost of your drugs. While deductibles can vary from plan to plan, no plan's deductible can be higher than \$545 in 2024, and some plans have no deductible.

Initial coverage period: After you meet your deductible, your plan will help pay for your covered prescription drugs. Your plan will pay some of the cost, and you will pay a copayment or coinsurance. How long you stay in the initial coverage period depends on your drug costs and your plan's benefit structure. For most plans in 2024, the initial coverage period ends after you have accumulated \$5,030 in total drug costs. Note that the total drug costs include the amount you and your plan have paid for your covered drugs.

Coverage gap: After your total drug costs reach a certain amount (\$5,030 for most plans), you enter the coverage gap, also known as the donut hole. When you enter the coverage gap you will be responsible for 25% of the cost of your drugs. For example, if a drug's total cost is \$100 and you pay your plan's \$20 copay during the initial coverage period, you will be responsible for paying \$25 (25% of \$100) during the coverage gap.

Catastrophic coverage: In all Part D plans, you enter catastrophic coverage after you reach \$8,000 in out-of-pocket costs for covered drugs. This amount is made up of what you pay for covered drugs and some costs that others pay. In the past, you would owe 5% of the cost of your covered drugs for the remainder of the year once in this coverage phase. In 2024, this 5% coinsurance requirement is eliminated, meaning you will not be responsible for any of the cost of your Part D covered drugs once reaching the catastrophic coverage phase. This effectively means that your Part D out-of-pocket spending will be capped at \$8,000.* The out-of-pocket costs that help you reach the \$8,000 catastrophic coverage limit include:

- Your deductible
- What you paid during the initial coverage period
- Almost the full cost of brand-name drugs (including the manufacturer's discount) purchased during the coverage gap
- Amounts paid by others, including family members, most charities, and other persons on your behalf
- Amounts paid by State Pharmaceutical Assistance Programs (SPAPs), AIDS Drug Assistance Programs, and the Indian Health Service

Costs that do not help you reach catastrophic coverage include monthly premiums, what your plan pays toward drug costs, the cost of non-covered drugs, the cost of covered drugs from pharmacies outside your plan's network, and the 75% generic discount.

Your Part D plan should keep track of how much money you have spent out of pocket for covered drugs and your progression through coverage periods—and this information should appear in your monthly statements.

Note: If you have Extra Help (see question 5), you do not have a coverage gap. You will pay different drug costs during the year. Your drug costs may also be different if you are enrolled in an SPAP.

*In 2025, your out-of-pocket drug costs will be capped at \$2,000.

5. How is the Extra Help program changing in 2024?

Extra Help is a federal program that helps pay for most of the out-of-pocket costs of Medicare prescription drug coverage. It is also sometimes called the Part D Low-Income Subsidy (LIS). You are eligible for the program if your income and assets are below federally set limits. You could also be automatically enrolled in the program if you have Medicaid, a Medicare Savings Program (MSP), or Supplemental Security Income (SSI).

Up until 2024, you would qualify for either full or partial Extra Help, depending on your income and assets. In 2024, the Extra Help program is expanding so that all beneficiaries earning less than 150% of the federal poverty level (FPL) will be eligible for full Extra Help. Partial Extra Help will be effectively eliminated. The 2024 income limits have not been released yet. Until they are released, you may qualify based on your 2023

income if you also have limited assets. The 2023 monthly income limit was \$1,843 for individuals and \$2,485 for couples.

To actively apply or learn more about eligibility, contact your Social Security Administration branch. [Find your local branch](#) or call the national line at 800-772-1213.

6. What is the *Medicare & You* handbook? How can I get one?

Medicare & You is a handbook published by Medicare each year. It explains Medicare-covered services and the costs associated with Original Medicare for the coming year. Each Medicare beneficiary is mailed a copy of *Medicare & You* in the early fall, regardless of whether they have Original Medicare or a Medicare Advantage Plan. If you did not receive one last year, call 1-800-MEDICARE to request a copy. You can also download a general version of the handbook at www.medicare.gov.

7. What is a transition refill?

A transition refill, also known as a transition fill, is typically a one-time, 30-day supply of a drug that you were taking:

- Before switching to a different Part D plan (either stand-alone or through a Medicare Advantage Plan)
- Or, before your current plan changed its coverage at the start of a new calendar year

Transition refills let you get temporary coverage for drugs that are not on your plan's formulary or that have certain coverage restrictions (such as prior authorization or step therapy).

Transition refills are not for new prescriptions. You can only get transition fills for drugs you were already taking before switching plans or before your existing plan changed its coverage.

The following situations describe when you can get a transition refill if you do not live in a nursing home (there are different rules for transition refills for those living in nursing homes):

1. Your current plan is changing how it covers a Medicare-covered drug you have been taking.
 - If your plan is taking your drug off its formulary or adding a coverage restriction for the next calendar year for reasons other than safety, the plan must either:
 - Help you switch to a similar drug that is on your plan's formulary before January 1
 - Or, help you file an exception request before January 1
 - Or, give you a 30-day transition fill within the first 90 days of the new calendar year along with a notice about the new coverage policy.
2. Your new plan does not cover a Medicare-covered drug you have been taking.
 - If a drug you have been taking is not on your new plan's formulary, this plan must give you a 30-day transition refill within the first 90 days of your enrollment. It must also give you a notice explaining that your transition refill is temporary and informing you of your [appeal rights](#).
 - If a drug you have been taking is on your new plan's formulary but with a coverage restriction, this plan must give you a 30-day transition refill free from any restriction within the first 90 days of your

enrollment. It must also give you a notice explaining that your transition refill is temporary and informing you of your appeal rights.

- In both of the above cases, if a drug you have been taking is not on your new plan's formulary, be sure to see whether there is a similar drug that is covered by your plan (check with your doctor about possible alternatives) and, if not, to file an exception request. (If your request is denied, you have the right to appeal.)

Note: If you file an exception request and your plan does not process it by the end of your 90-day transition refill period, your plan must provide additional temporary refills until the exception is completed.

Remember: All stand-alone Part D plans and Medicare Advantage Plans that offer drug coverage must provide transition fills in the above cases. When you use your transition fill, your plan must send you a written notice within three business days. The notice will tell you that the supply was temporary and that you should either change to a covered drug or file an exception request with the plan.

8. What is the Medicare Advantage Open Enrollment Period?

During the Medicare Advantage Open Enrollment Period (MA OEP), you can switch from your Medicare Advantage Plan (excluding Medical Savings Accounts, cost plans, and PACE) to another Medicare Advantage Plan or to Original Medicare with or without a stand-alone prescription drug plan. The MA OEP occurs each year from January 1 through March 31. Remember, you can only use this enrollment period if you have a Medicare Advantage Plan. Changes made during this period take effect the first of the following month. For example, if you switch to a new Medicare Advantage Plan in February, your new coverage begins March 1. Unlike Medicare's Open Enrollment Period, you can only make a single change during the MA OEP.

9. Will I have other opportunities to change my coverage in 2024?

Many people have to wait until Medicare's Open Enrollment Period to change their coverage if they aren't happy with it. You may have the opportunity to change your coverage earlier in 2024, though, depending on your circumstances.

If you have Extra Help: If you have Extra Help in 2024, you have a Special Enrollment Period (SEP) to enroll in a Part D plan or switch between plans. This SEP is available once per calendar quarter for the first three quarters of the year (January-March, April-June, and July-September). If you use the Extra Help SEP to change your coverage, the change will become effective the first of the month following the month that you make the change. For example, if you use the Extra Help SEP to choose a new Part D prescription drug plan in March, that plan will become effective April 1. If you use your Extra Help SEP in one quarter, you will have to wait until the next quarter to make another change, unless you have a different SEP.

If you enrolled in a plan by mistake or because of misleading information: If you enrolled in a Medicare Advantage Plan or Part D plan by mistake or after receiving misleading information, you may be able to disenroll and change plans. Typically, you have the right to change plans if you:

- Joined unintentionally: You may have enrolled believing you were joining a Medigap plan to supplement Original Medicare, or you meant to sign up for a stand-alone Part D plan and accidentally joined a Medicare Advantage Plan.

- Joined based on incorrect or misleading information: You may have been misled for example if a plan representative told you that your doctors are in the plan's network but they are not, or you were promised benefits that the plan does not really cover.
- Through no fault of your own, ended up or were kept in a plan you do not want: You can make a change if you tried to switch plans during an enrollment period but were kept in your old plan or if you were enrolled in a plan because of an administrative or computer error.

The steps you should take to disenroll depend on whether you have used services and whether the plan paid for those services.

- If you used any service since joining the plan (for example, saw a doctor or filled a prescription) and received a denial of coverage, you should request retroactive disenrollment, meaning disenrollment back to the date you enrolled in the plan. Depending on your situation, you may then wish to select Original Medicare (with or without a Part D plan) or a different Medicare Advantage Plan. If you are granted retroactive disenrollment, be sure to ask your providers to re-file claims with your new plan.
- If you have not used any services since joining the plan, you may want to request a Special Enrollment Period (SEP) to disenroll from your plan. This option may be processed faster than retroactive disenrollment. If your request is granted, you will be disenrolled from your plan at the end of the month in which you made the request. To prevent gaps in coverage, sign up for new coverage immediately after you are disenrolled from the plan you did not want.

To request retroactive disenrollment or an SEP, call 1-800-MEDICARE and explain to the customer service representative exactly how you joined the plan by mistake.

If you qualify for another Special Enrollment Period (SEP): There are several circumstances in which you may be able to make changes to your Medicare health/drug coverage. For example, you have a SEP if you move outside of your plan's service area, if your Medicare Advantage Plan terminated a significant amount of its network providers, or if you enroll in certain State Pharmaceutical Assistance Programs (SPAPs).

If you need to make changes to your coverage but you are not sure whether you qualify for an SEP, call your State Health Insurance Assistance Program (SHIP) to learn more. Contact information for your SHIP is on the final page of this document.

9. What are Postal Service Health Benefits?

The Postal Service Health Benefits (PSHB) program is a new program offering health insurance to eligible Postal Service employees, Postal Service annuitants (retirees), and their eligible family members. PSHB will replace Federal Employee Health Benefits (FEHB) coverage for these eligible groups, starting in 2025. Some Postal annuitants eligible for PSHB may wish to enroll in Medicare Part B as they transition from FEHB to PSHB. They can do so using a Special Enrollment Period that will last from April 1, 2024, through September 30, 2024.

Eligibility letters will be sent to annuitants and eligible family members in early 2024. The United States Postal Service (USPS) has created two fact sheets on this new program—one for [current Postal employees](#) and one for [Postal annuitants](#). You can read more about these upcoming changes in these fact sheets. These fact sheets and

more are in the benefits section of www.liteblue.usps.gov. We will also provide more information on PSHB and what it means for some Medicare beneficiaries in the April Medicare Minute on FEHB coverage.

10. Will I be getting a new Medicare card?

No, you will not be getting a new Medicare card. Starting in April 2018, CMS sent new Medicare cards to all Medicare beneficiaries. By the end of January 2019, all beneficiaries had their new Medicare cards, which were designed to better protect against identity theft by removing their Social Security number. Although the rollout of these updated cards is complete, scams around these new cards continue.

For example, scammers may falsely tell you that Medicare is issuing an updated or new card—perhaps a plastic one, metal one, or one with a chip. The scammers may tell you that you need to verify your identity for them to send your new Medicare card. This is the scammer’s attempt to gain your personal or financial information.

Here are some red flags to be aware of:

- Unsolicited calls from someone claiming to be from Medicare.
- Anyone needing your information so that they can send you an updated Medicare card.
- Anyone claiming that your card is expiring and that you will be charged a fine if you do not get a new one.
- Anyone stating that Medicare is issuing new cards and you need to verify your number.

If you believe you have experienced potential fraud, contact your Senior Medicare Patrol (SMP). Contact information for your local SMP is on the final page of this document.

11. Who should I contact if I have questions about my 2024 Medicare coverage?

1-800-MEDICARE (800-633-4227): Call 1-800-MEDICARE to request another copy of your *Medicare & You* handbook or to learn more information about your 2024 coverage.

State Health Insurance Assistance Program (SHIP): Contact your SHIP if you have questions about changes in costs and coverage of your Medicare in 2024, for help understanding SEPs, or to learn about programs that can help you with Medicare costs. SHIP counselors provide unbiased Medicare counseling and assistance. Contact information for your SHIP is on the final page of this document.

Medicare Advantage Plan or Part D plan: If you have a Medicare Advantage Plan or Part D plan, contact your plan to ask about changes in your costs or coverage for 2024.

Senior Medicare Patrol (SMP): Contact your SMP if you believe you have experienced potential fraud, errors, or abuse. Contact information for your local SMP is on the final page of this document.

SHIP case study

Leo has Original Medicare and a stand-alone Part D plan. In January 2024 he is diagnosed with a condition that requires him to take a new prescription drug. He calls his Part D plan and learns this drug is not on the plan's formulary.

What should Leo do?

- Leo can call his State Health Insurance Assistance Program (SHIP) for help.
 - If he doesn't know how to reach his SHIP, he can call 877-839-2675 or visit www.shiphelp.org.
- The SHIP counselor can tell Leo about formulary exceptions.
 - The SHIP counselor can help Leo request a formulary exception and can instruct him on how to ask his doctor to write a letter that supports his medical need for the drug.
- The SHIP counselor can also let Leo know about his opportunities to change coverage in the coming year.
 - If Leo has Extra Help, he may be eligible for a Special Enrollment Period to change drug plans once per calendar quarter in the first three quarters of the year.
 - He might also qualify for a Special Enrollment Period if, for example, he enrolls in a State Pharmaceutical Assistance Program (SPAP) or moves outside of his current plan's service area. The SHIP counselor can talk to Leo about all possible special enrollment periods to check if he qualifies.

SMP case study

Marie is 66 years old and has Original Medicare. She was surprised to get a call from Medicare, saying that she would be getting a new card this year. The caller just needed her to provide her Social Security number and address to verify her Medicare number. Marie was about to enter her doctor's office so said she would call back later that day, using the callback number the caller provided. Marie sensed something was off, but her husband did say that he was sent a new card a few years ago, so this may be something that happens periodically.

What should Marie do?

- Marie should call her local SMP.
 - If she is unsure how to reach her local SMP, she can go to www.smpresource.org or call 877-808-2468.
- The SMP team member can tell Marie that Medicare beneficiaries are not receiving new cards, and the call was likely a scam. Medicare will not call you unannounced and ask for your personal information over the phone. If a new Medicare card was being issued, they would notify you by mail. Marie should not call that person back.
- The SMP team member will recommend that in the future Marie immediately hang up on people claiming to be from Medicare unless there has been a recent request for a callback from Medicare's customer service line.
- The SMP team member can encourage Marie to continue to protect her personal information from callers she doesn't know.

Local SHIP Contact Information	Local SMP Contact Information
SHIP toll-free: SHIP email: SHIP website: To find a SHIP in another state: Call 877-839-2675 and say “Medicare” when prompted or visit www.shiphelp.org .	SMP toll-free: SMP email: SMP website: To find an SMP in another state: Call 877-808-2468 or visit www.smpresource.org .
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