# ALL ABOUT MEDICARE

## First, here is what Medicare is:

Medicare is a federal government program that provides health insurance to people age 65 and over. Like most government programs, it is complicated. I speak with people every day who are confused, frustrated - who do not understand how Medicare really works. This is an effort to simplify the essentials. However, you should always check at www.Medicare.gov for any specific questions you may have.

Two groups of people are eligible for Medicare benefits: adults aged 65 and older, and people under age 65 with certain disabilities. The program was created in the 1960s to provide health insurance for senior citizens. If you are eligible for Medicare, your coverage may include:

- **Part A: Hospital Insurance**—Part A covers inpatient hospital care, skilled nursing facilities and some home health care. Most people do not have to pay a monthly premium for Part A coverage. Part A does have an annual deductible and additional co-payments. The annual deductible for 2024 is $1,632.
- **Part B: Medical Insurance**—Part B covers doctor visits, medically necessary supplies and equipment, physical and occupational therapy, outpatient mental health services and other outpatient hospital services. It also includes certain preventive benefits like mammograms and cardiovascular screenings. While Part B is optional, most people enroll when first eligible as there are higher premium costs for those enrolling later. The standard Part B premium amount for 2024 is **$174.90**. However, premiums for Part B may be higher based on your annual earnings. There is an annual deductible for Part B, which in 2024 is **$240**. Co-payments also apply to most Part B services.
    - There is one additional element that you must consider as it relates to both Part B and Part D, and that's IRMAA which is a surcharge added to your monthly Medicare Part B and Part D premiums, based on your yearly income. If your income 2 years ago exceeded $103,000 as an individual or $206,000 as a couple, you will be subject to an IRMAA surcharge – and **I have a separate document regarding this if needed.**
- **Part D: Prescription Drugs**—Part D is an optional program, but if you do not enroll in Part D when appropriate, you may be subject to an annual penalty. The average nationwide monthly premium for 2024 will be ~ $55.50 but most plans will be less than that. In fact, your plan can cost as little as $10/month.

Part A and Part B cover ~ 80% of your expected medical expenses. The remaining 20% can be covered either with a Medicare Advantage Plan or a Medicare Supplement.

## Medicare Supplements versus Medicare Advantage Programs

**1. Medicare Advantage – Neither Medicare nor an Advantage – and no, I do not favor these plans**

When you are turning 65, you may think that your great health will continue far into your senior years. Then, you discover that after 65 is when most medical claims are experienced, and quality coverage is essential.

Advantage Plans often cost little, sometimes, nothing. For a senior on fixed income, low or no costs coupled with all the "extra benefits" offered with these plans, are hard to turn down.

Once enrolled in a Medicare Advantage (MA) plan, you turn your Original Medicare benefits over to a private insurance company, which provides your health insurance, administers your plan, and pays your claims. You no longer have "Medicare" but rather a commercial policy, subject to the guidelines, claims management processes and limitations chosen by that particular insurance company.

Fewer doctors and hospitals accept Medicare Advantage patients, due to their experience of being unable to get timely or decent payments, and because of complicated paperwork and constraints.

Clients miss or minimize that in 2024 the Medicare Advantage out-of-pocket limit is set at $8,850 for in-network services. The 2024 average Max Out Of Pocket is around $5,478 for these low cost or free plans.

It is critical to understand that with a Medicare Advantage Plan, the insurance company decides whether to pay a claim or not. Plans from different insurance companies have dramatically different features, different claims management policies and completely different networks of providers.

With an Advantage Plan, besides a restrictive network of providers, there will usually be a copay to these providers. Typically, your primary care physician makes the decisions as to what tests and procedures will be approved for your treatment. Pre-certification is usually required for any services. When you travel, you are often only covered for emergency services. Specialty care facilities such as the MD Anderson Cancer Center and the Mayo Clinic will generally not be available to you.

Advantage Plans have begun to use Artificial Intelligence to manage patient care. Here's an example:

An algorithm, not a doctor, predicted a rapid recovery for an 85-year-old woman with a shattered left shoulder and an allergy to pain medicine. In 16.6 days, the algorithm estimated, she would be ready to leave her nursing home.

On the 17th day, her Medicare Advantage insurer followed the algorithm and cut off payment for her care, concluding she was ready to return to the apartment where she lived alone. Meanwhile, medical notes showed her pain was maxing out and that she could not dress herself, go to the bathroom, or even push a walker without help.

While she fought and won against the denial, she had to spend-down her life savings and use Medicaid services just to progress to the point of putting on her shoes, her arm was still in a sling.

You can read more details about Advantage Plan's use of Artificial Intelligence here: https://tinyurl.com/2nulsqq8

Medicare Advantage Plans are also not guaranteed renewable – can and often are canceled by the carrier at the end of any calendar year. The cancellation of your plan can leave you with difficulty ensuring that your preferred doctor(s) is(are) available in a new plan that you may choose during open enrollment.

Here's the real hooker in all of this: A serious illness is likely to make you ineligible for a Medicare Supplement, so you are stuck with the shortcomings of Advantage Plans for life.

Medicare Advantage Plans are a choice to examine **only** if monthly cost is the primary consideration.

2. **Medicare Supplements – MediGap –freedom of choice, no pre-certification, managed by Medicare.**

Often, the biggest proponents of Medigap plans are those who have had to use Medicare Advantage Plans with a serious illness and who have been subject to surprising limitations and out of pocket costs.

Also important, would you prefer to CHOOSE your hospital instead of only being able to go to the one that was the lowest bidder that joined the "Advantage" plan's restrictive network? A major benefit of Medigap plans is that you can go to any doctor, any hospital, that accepts Medicare, anywhere in the USA.

**MediGap Rules**

- You must have Medicare Part A and Part B.
- Except during an Open Enrollment or Guaranteed Issue Period, you must be medically eligible to obtain a MediGap plan and each carrier has different eligibility requirements.
- You pay the private insurance company a monthly premium for your Medigap policy in addition to the monthly Part B premium that you pay to Medicare (usually deducted from Social Security).
- You can buy a Medigap policy from any insurance company or appointed agent that's licensed in your state to sell one **AT ANY TIME.**
- Medigap policies are **guaranteed renewable**. The insurance company can't cancel your Medigap policy or increase your costs due to your health as long as you pay the premium.

**Medigap policies are standardized**

Every Medigap policy must follow federal and state laws designed to protect you, and they must be clearly identified as "Medicare Supplement Insurance." Insurance companies can sell you only a "standardized" policy as defined by Medicare and different levels of coverage are available with plans defined by the letters A through D, F through G, and K through N. All policies offer the same basic benefits, but additional benefits for additional costs are available based on the specific plan that you choose.

**Medicare approves the claims**

With a MediGap policy, Medicare Part A and Medicare Part B are your primary insurance. Your MediGap plan is supplemental. During claims administration, the provider submits the claim to **Medicare**, not your insurance company. **Medicare** reviews the claim to ensure that the procedure is a covered procedure. When the insurance company receives the Explanation Of Benefits (approval of claim), they are required to pay their share of the claim promptly or they are in violation of their agreement with Medicare.

What could be simpler? Supplements provide defined benefits, go to any provider in the USA that accepts Medicare, health care decisions are between you and your doctor, and your plan can never be cancelled.

**In short:**

- **All Medicare Supplement Plans of the same type are exactly the same regardless of carrier.**
- **The carrier is required to pay their share of all approved claims promptly.**
- **COST is the only difference between Medicare Supplements of the same plan type regardless of insurance company – and THAT key point is what the public often fails to understand.**