Medicare Minute Teaching Materials — January 2025
What's New in 2025?

1. Have costs for Medicare Part A (hospital insurance) changed in 2025?
Yes, the costs associated with Part A are different this year. Remember, Medicare Part A covers inpatient hospital services, skilled nursing facility services, some home health care, and hospice. Look through your 2025 *Medicare & You* handbook (see question 9) to understand Part A-covered services. The following chart shows costs last year compared to this year.

Original Medicare Part A Costs: 2024 vs. 2025		
	2024	**2025**
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	**$285/month** if you've worked between 7.5 and 10 years
	$505/month if you've worked fewer than 30 quarters (7.5 years)	**$518/month** if you've worked fewer than 30 quarters (7.5 years)
Hospital deductible	**$1,632** each benefit period	**$1,676** 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
	$408/day for days 61 – 90 of each benefit period	**$419/day** for days 61 – 90 of each benefit period
	$816/day for days 91 – 150 (non-renewable lifetime reserve days)	**$838/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)
	$204/day for days 21 – 100 each benefit period	**$209.50/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 2025 as you did in 2024, 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 2025.

2. Have costs for Medicare Part B (medical insurance) changed in 2025?
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.

Original Medicare Part B Costs: 2024 vs. 2025		
	2024	**2025**
Part B premium*	**$174.70/month**	**$185/month**
Part B deductible	**$240/year**	**$257/year**
Part B coinsurance	20% for most services	20% for most services
* If your annual income is higher than $106,000 for an individual ($212,000 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 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 2025 as you did in 2024, 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 2025.

3. Have costs for Medicare Part D (prescription drug coverage) changed in 2025?
Yes. Each year, Part D plans can make changes to their premiums, deductibles, and copays. And throughout the year, you move through coverage phases. In each coverage phase, your costs will be different. In 2025, you can expect both the usual yearly changes to your plan's costs, and a major change to the way the coverage phases work (see question 4). Remember that there are two ways to get Part D coverage—through a stand-alone Part D plan, or as part of a Medicare Advantage Plan. The information here on Part D costs applies to both kinds of Part D coverage.

If you have Medicare prescription drug coverage, your plan should have notified you about any changes in costs for that plan in 2025. Part D plans can change the drugs they cover, their pharmacy networks, and their costs (such as premiums, copayments, and deductibles) from year to year. 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 2025. 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 2025.

If you have Part D, there is a good chance that there are significant changes for 2025, because changes to the law that sets up the rules for the Part D benefit made coverage more generous—there is now a $2,000 cap on out-of-pocket costs for covered drugs. Medicare is taking steps to stabilize Part D premiums during this transition to more generous coverage for out-of-pocket costs. Medicare is limiting the increase in the base premium to no more than 6% above the prior year's amount. The base premium is the average cost of basic benefits across all Part D plans. While individual Part D plan premiums may increase more than 6%, the average basic premium of all plans cannot. This results in an average premium increase of $2 per month for Part D enrollees. Individual plan premiums, particularly those for plans with enhanced benefits, may be changing more significantly.

The following chart shows costs last year compared to this year. Be sure to review your plan materials for specific changes for your plan.

Medicare Part D Costs: 2024 vs. 2025		
	2024	**2025**
Part D base premium	**$34.70**	**$36.78**
Part D maximum deductible	**Up to $545/year**	**Up to $590/year**
Part D coverage gap threshold	**$5,030**	**None**
Part D catastrophic coverage limit You pay $0 for covered drugs after your cost-sharing for covered drugs reaches this amount.	**$8,000**	**$2,000**

4. How are the Part D coverage phases changing in 2025?
Starting in 2025, your annual out-of-pocket Part D costs are capped at $2,000. After you reach this amount in out-of-pocket costs, you owe nothing for covered drugs for the rest of the year. This new cap changes the Part D coverage phases.

Previously, there were four Part D coverage phases: The deductible phase, the initial coverage period, the coverage gap (also called the donut hole), and catastrophic coverage. Beginning in 2025, there will just be three coverage phases:

> **Deductible period:** Until you meet your Part D deductible, you will pay the full negotiated price for most of 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 $590 in 2025, and some plans have no deductible. Some plans lower costs for specific drugs in the deductible, and some drugs, like insulin, which has costs capped at $35, and immunizations that are covered at 100%, are not subject to the deductible in any plan.

Initial coverage period: After you meet your deductible, costs for your covered prescriptions are split between you and your plan. Your plan will pay some of the cost, and you will pay a copayment or coinsurance.

Catastrophic coverage: After reaching the $2,000 cap, you owe $0 for covered prescription drugs.

The costs that count towards the deductible limit and the $2,000 cap are your True Out-of-Pocket (TrOOP) costs. These are costs you spend on covered Part D drugs, or that certain third parties spend on your behalf for covered drugs. They include payments from:

- Extra Help cost-sharing support
- Qualified State Pharmacy Assistance Programs (SPAPs)
- Indian Health Service and certain other Native American organizations
- AIDS Drug Assistance Program (ADAP)
- Friends or family members who pay for your prescriptions

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 is included in your monthly statements. Remember that only costs associated with covered drugs help you move through the coverage phases. If you spend money on non-covered drugs, those costs will **not** help you meet your deductible or reach the annual cap.

5. What is the Medicare Prescription Payment Plan (MPPP)?

Beginning in 2025, you have the option to sign up for a payment plan for Part D out-of-pocket costs. The MPPP allows you to spread your drug costs throughout the year, with the goal of helping you manage your monthly expenses. For example, if you anticipate reaching the annual Part D cap quickly due to expensive medications, you can spread those costs throughout the year—rather than paying a lot in the first months of the year and nothing in later months of the year. Note that the MPPP does not change or lower your drug costs.

Part D plans must include information about the MPPP in communications materials to you, such as plan notices or on their website. There is no cost to participate in the program. Although you can opt in to the program at any time, you will likely not see a significant benefit if you opt in during the last few months of the year. If you change Part D plans mid-year, your participation in the MPPP ends and you must opt in with your new plan.

When you sign up for the MPPP, your plan will communicate your choice to your pharmacy. You should pay $0 at the pharmacy for your covered Part D drugs. Your plan will pay the cost-sharing at the time of your purchase and send monthly bills to you for the cost-sharing amounts. You pay no fees or interest, even if your payment is late.

6. How is telehealth coverage changing in 2025?
Before the COVID-19 Public Health Emergency (PHE), Medicare telehealth coverage was very limited. For example, before the PHE, telehealth services were:

- Generally only covered in rural areas, and you would still have to go to a specific "originating site" (often a different medical office or clinic) to receive the telehealth.
- Generally only covered if provided via interactive, two-way audio and video technology
- Limited to certain providers, such as physicians and nurse practitioners

During the PHE, telehealth coverage was temporarily expanded to include more flexibilities and allow more people to receive care from their homes. These flexibilities were originally set to expire December 31, 2024, but they were extended through March 2025 as part of legislation passed to avoid a government shutdown and keep spending the same as it was in December 2024. For example, during the PHE and through March 31, 2025, telehealth services are:

- Covered for all beneficiaries in any geographic area, at home in addition to health care settings
- Sometimes delivered using audio only
- Provided by any health care professional that was eligible to bill Medicare

After March 31, 2025, most telehealth services will again be more limited. Only some of the PHE flexibilities have been made permanent. For example, after March 31, 2025, telehealth services will be:

- Still available regardless of geographic area for certain types of care
    - For example: Behavioral/mental health care, monthly End-Stage Renal Disease (ESRD) visits for home dialysis, diabetes self-management training, and Medicare nutrition therapy
- Still able to be delivered using audio-only communication platforms for behavioral/mental health care
- Subject to pre-PHE restrictions for other types of care

7. Are any Special Enrollment Periods (SEPs) changing in 2025?
Yes. There are two new SEPs that are available to dually eligible people and/or those eligible for Extra Help (also known as the low-income subsidy, or LIS).

- **Dual/LIS SEP:** You qualify for this SEP if in addition to Medicare, you have Medicaid, a Medicare Savings Program (MSP), or Extra Help. You can make a once-per-month change—either from a Medicare Advantage Plan to Original Medicare with a stand-alone Part D plan, or from one stand-alone Part D plan to another stand-alone Part D plan. You cannot use this SEP to enroll in a new Medicare Advantage Plan with prescription drug coverage.
    - **Note:** This SEP replaces the previous SEP for those with Medicaid, an MSP, or Extra Help to switch prescription drug coverage once-per-quarter for the first three quarters of the year.

- **Integrated care SEP:** You qualify for this SEP if you have both Medicare and Medicaid. You can make a once-per-month change into certain Special Needs Plans that meet federal requirements for integration and that offer a Medicaid plan in your state. This SEP can only be used to enroll in both the Medicare and Medicaid portions of a plan—in other words, to align enrollment with an integrated Dual Special Needs Plan (D-SNP) or Applicable Integrated Plan (AIP) and a Medicaid Managed Care Organization (MCO).

8. How has Medicare coverage for people in the custody of penal authorities changed?
Medicare will not cover a service if a beneficiary is not financially responsible for the care or if another government entity is obligated to provide or pay for the item or service. For example, Medicare will not cover medical care when someone is in prison, because federal and state law require the institution to provide and pay for necessary medical care. For years, Medicare used an extremely broad definition of custody as it applied to people in the custody of penal authorities. In addition to people physically detained in jails and prisons, the rules created a bar to payment for care for people on bail, parole, probation, home detention, and halfway houses. That meant that people living in the community who sought and received care from providers with no connection to the penal authority were denied Medicare coverage.

CMS has now updated this rule, bringing Medicare into line with the practical realities of modern criminal justice practices by removing the bar on payment for those who are on bail, parole, probation and home detention or who are required to reside in halfway houses.

As part of this change, CMS is also updating the definition of custody for the purposes of the existing Special Enrollment Period for people who were recently incarcerated. This will allow people who have been released from physical detention and are on bail, parole, probation, or home detention and individuals required to reside in halfway houses to enroll or re-enroll in Medicare Part B without having to wait until after that status is terminated to reestablish Medicare coverage. This change will increase access to care during a complicated transition. It will also increase administrative simplicity, because it more closely aligns with the Social Security Administration's criteria for determining incarceration status.

9. 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.

10. 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 rules 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 rules.

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.

11. 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 on 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 Fall Open Enrollment, you can only make a single change during the MA OEP.

12. Will I have other opportunities to change my coverage in 2025?
Many people have to wait until Fall Open Enrollment to change their coverage if they aren't happy with it. You may have the opportunity to change your coverage earlier in 2025, though, depending on your circumstances.

If you have Medicaid, an MSP, or Extra Help: If you have Medicaid, an MSP, or Extra Help, you have a Special Enrollment Period (SEP) to enroll in a stand-alone Part D plan or switch between stand-alone Part D plans. This SEP is available once per month, and cannot be used to enroll in a Medicare Advantage Plan (see question 7).

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 (633-4227) 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 local SHIP is on the last page of this document.

13. 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.

14. Who should I contact if I have questions about my 2025 Medicare coverage?

1-800-MEDICARE (800-633-4227): Call 1-800-MEDICARE (633-4227) to request another copy of your *Medicare & You* handbook or to learn more information about your 2025 coverage.

State Health Insurance Assistance Program (SHIP): Contact your SHIP if you have questions about changes in costs and coverage of your Medicare in 2025, 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 local SHIP is on the last page of this document.

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.

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 2025.

SHIP case study
Leo has Original Medicare and a stand-alone Part D plan. In January 2025 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.shiptacenter.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 Medicaid, an MSP, or Extra Help, he may be eligible for an SEP to change drug plans once per month.
    - He might also qualify for a Special Enrollment Period if, for example, if 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

Lola is 66 years old and has Original Medicare. Recently, she received a call from Medicare, and they stated that she would be getting a new card this year. The caller had her address but just needed her to confirm her Social Security number to verify her Medicare number for her new card. Lola was confused since she had a card and was about to enter her doctor's office, so she said she would call back later that day. Lola wanted to call the number back later because her husband did say that he was sent a new card a few years ago, so this may be something that happens periodically. She is also concerned that if she doesn't receive her new card, she will not have access to her Medicare benefits.

What should Lola do?

- Lola 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 Lola 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. Lola should not call that person back.
- The SMP team member will recommend that in the future Lola immediately hang up on people claiming to be from Medicare.
- The SMP team member can encourage Lola to continue to protect her personal information from callers she doesn't know.

Local SHIP Contact Information	Local SMP Contact Information
SHIP toll-free: 800-247-4422 **SHIP email:** idahoshiba@doi.idaho.gov **SHIP website:** shiba.idaho.gov **To find a SHIP in another state:** Call 877-839-2675 and say "Medicare" when prompted or visit www.shiphelp.org.	**SMP toll-free:** 800-247-4422 **SMP email:** idahoshiba@doi.idaho.gov **SMP website:** https://aging.idaho.gov/stay-safe/senior-medicare-patrol-fraud-prevention **To find an SMP in another state:** Call 877-808-2468 or visit www.smpresource.org.

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SHIP Technical Assistance Center: 877-839-2675 | www.shiphelp.org | info@shiptacenter.org
SMP Resource Center: 877-808-2468 | www.smpresource.org | info@smpresource.org