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Chapter **1**

The Nuts and Bolts of Medicare: What It Is and How It Works

Medicare is a federal government insurance system that helps 66 million seniors and people with disabilities pay for their healthcare. It's the only truly national healthcare program in the United States — meaning that it's available regardless of your income, the state of your health, or where you live nationwide — and it has been enduringly popular since it began in 1966.

Yet Medicare works like no other insurance you may have known in the past. To avoid total confusion, you're wise to gain at least a broad understanding of how the program is put together and how its rules may affect you personally.

This chapter provides an overview of the program: addressing common concerns about how Medicare is different from other types of health insurance; describing the four parts of Medicare coverage (A, B, C, and D); and providing a checklist for the decisions that you have to make in choosing among the coverage options that Medicare offers.



This stuff is basic information aimed primarily at people who are new to the program. (You can find more details of benefits and costs in later chapters.) But if you're an old hand looking for specifics in navigating Medicare more easily, feel free to skip these pages and plunge into Part 3 or 4.

Addressing Some Upfront Questions

When the prospect of becoming a Medicare beneficiary looms on the horizon, you suddenly become aware — if you're like most people — of how little you know about the program. And even if you think you know, can you be sure that the information you have is accurate? Based on questions I've received, I can tell you that a lot of perceptions about Medicare are way off base; quite often, they're gleaned from the internet or even mass emails that are deliberately designed to spread misleading information and scare seniors.

If you've had health insurance in the past, especially from an employer, you may be nervous about how Medicare coverage compares with it. So before I examine how Medicare actually works later in this chapter, I want to tackle some of the concerns people frequently raise about the program:

» **As a government-run system, will Medicare give me inferior care?** No (or at least, not inherently). The federal government runs and regulates Medicare and also largely pays for the medical services you use. Even so, those actual services are almost wholly private. The doctors you go to are *not* government employees; the hospitals and laboratories that provide services to you are *not* government-owned. Instead, they're free to enter or not enter into contracts with Medicare as they choose. Those who accept you as a Medicare patient are the same kind of independent, private practitioners that you would've seen for diagnosis and treatment before coming into Medicare.

» **Will Medicare allow me fewer choices than I have now?** No. In fact, the reverse may be true. If you've had health insurance from a private employer, for example, you probably had only two or three plans to choose from each year. In contrast, Medicare offers a choice between the original program (in which you can go to any doctor or other provider in the United States that accepts Medicare patients) and a variety of private Medicare Advantage health plans, which are likely similar to health plans you may have known in the past. Depending on where you live, you may be overwhelmed by the number of options; in some areas, the average beneficiary may be able to choose from as many as 43 Medicare Advantage plans. Also, there are an average of 21 Part D plans available in each state that offer Medicare prescription drug coverage. (I explain Medicare Advantage and Part D plans, and how they differ from the original program, in the next section.)

» **Will my health issues and pre-existing medical conditions work against me?**

Current and past health problems don't bar anybody from Medicare coverage or cause anybody to pay higher premiums or co-pays than somebody who is in perfect health. That kind of discrimination, which has been common in the past in private health insurance, has never existed in Medicare. (For the record: A history of smoking, alcohol use, or obesity doesn't increase rates either.)

» **Will Medicare be less expensive than the insurance I have now?** Medicare isn't free. Just like other insurance, it requires monthly premiums, deductibles, and co-pays that you're responsible for paying unless you qualify for a low-income program or have extra insurance that covers these costs (see Chapter 4 for details). However, you need to consider the alternatives. Without Medicare, most older and disabled people wouldn't be able to find affordable insurance on the open market.

Compared to most employer insurance (which as a whole covers younger and healthier people), Medicare is reasonably priced. In 2024, Medicare Part B premiums cost \$174.70 per month per person, whereas, according to the Kaiser Family Foundation's 2023 survey of employer health benefits, workers' monthly contributions to employer insurance averaged \$117 for a single person and \$548 for a family of two or more. Still, this isn't an apples-to-apples comparison; many employees pay more than these averages for health benefits, and Medicare beneficiaries usually pay extra for drug coverage, while those with higher incomes pay higher Part B premiums than the standard premiums. Medicare Part A, which covers hospital and nursing care, is free for most people who paid (or have spouses who paid) Medicare taxes long enough while they were working — generally at least 10 years. If you don't qualify for premium-free Part A, you might be able to purchase it.

» **Will I pay a large deductible before getting Medicare coverage?** Medicare does have some deductibles, but they're relatively small compared with the ones many people pay in high-deductible health plans that are sponsored by employers or bought through the 2010 Patient Protection and Affordable Care Act (commonly known as the Affordable Care Act or Obamacare) or on the open insurance market. (I examine deductibles, along with co-pays and other Medicare costs, in detail in Chapter 3.)

» **Will my out-of-pocket expenses be capped in Medicare?** Not necessarily. Original Medicare sets no limit on the costs you pay out-of-pocket during a year, although you may buy Medigap insurance to cover those costs (see Chapter 4). But all Medicare Advantage plans are required by law to set caps on these expenses (up to \$8,850 per year in 2024). In the Part D program, after you've spent a certain amount out-of-pocket on your prescription drugs in a year, you qualify for catastrophic coverage that greatly lowers your costs for the remainder of the calendar year. Beginning in 2025, people with Part D will have annual out-of-pocket drug costs capped at \$2,000.

- » **Do I have to sign up for Medicare again every year?** No; your coverage just rolls over from year to year unless you decide to change it. But you do have the opportunity to change your coverage if you want to during the open enrollment period that runs from October 15 to December 7 each year. During this time, you can switch from original Medicare to a Medicare Advantage plan (or vice versa), from one Medicare Advantage plan to another, or from one Part D prescription drug plan to another, as explained in Chapter 15.
- » **Will Medicare cover my younger spouse or other dependents?** No. Family coverage doesn't exist in Medicare — not for spouses, dependent children, or other family members. Each person must wait until age 65 to join the program unless they qualify through disability at a younger age, as explained in Chapter 5. Also, if you and your spouse are both in Medicare, each of you must pay premiums separately and in full unless you receive government assistance to help pay for them. Medicare doesn't give price breaks for married couples, even in its private Medicare Advantage health plans and Part D drug plans.
- » **Will Medicare coverage be cut off when I grow old?** No! Medicare coverage is based on medical necessity, not age. So if you need a hip replacement when you're in your 90s or even over 100, Medicare picks up most of the cost in the usual way.



REMEMBER

The idea of Medicare rationing care and denying coverage for people over a certain age has been spread through mass emails designed to discredit the Affordable Care Act. In fact, the act doesn't cut Medicare benefits or allow rationing, and no Medicare regulation limits care for people based on their age.

Coming to Terms with the ABCs (and D) of Medicare

Do you really need to know the details of what Parts A, B, C, and D stand for? Doesn't Medicare just pay its share of your bills and that's it? Well, not entirely. Medicare's architecture is more than a tad weird, but each of its building blocks determines the coverage you get and what you pay.

Besides that, however, is the simple fact that making sense of the information in the rest of this book is difficult unless you understand what Parts A, B, C, and D actually mean. The following sections break down the basics.

Part A

Medicare Part A is usually described as *hospital insurance* — a term originally coined to distinguish it from medical insurance (Part B). But the phrase is misleading. “Hospital insurance” sounds as though Part A covers your entire bill if you’re admitted to a hospital, but it doesn’t work that way. The services you receive from doctors, surgeons, or anesthesiologists while you’re in the hospital are billed separately and are covered under Part B. And you don’t even have to be hospitalized to get services under Part A, because some are provided in settings outside the hospital or even in your own home.



REMEMBER

A more accurate way to think of Part A is as coverage primarily for *nursing care*. It helps pay for the following:

- » The services of professional nurses when you’re admitted to a hospital or a skilled nursing facility (such as a nursing home or rehab center) for short-term stays or when you qualify for home health services or hospice care in your own home
- » A semiprivate room in the hospital or nursing facility
- » All meals provided directly by the hospital or nursing facility
- » Other services provided directly by the hospital or nursing facility, including lab tests, prescription drugs, medical appliances and supplies, and rehabilitation therapy
- » All services provided by a home health agency if you qualify for continuing care at home, as explained in Chapter 2
- » All services provided by a hospice program if you choose to stop treatment for a terminal illness, as explained in Chapter 2

The vast majority of people in Medicare are eligible for Part A services without paying any premiums for it. That’s because Part A is essentially paid for in advance by the Medicare payroll taxes that you or your spouse contributed from every paycheck while working. I explain the details of how that setup works — and your options if you don’t qualify for premium-free Part A — in Chapter 5.

But of course Part A services themselves aren’t free. You still pay deductibles and co-payments for specific services. I itemize these costs in Chapter 3 and explain how you may be able to lower them in Chapter 4. I also provide more detailed information on certain Part A coverage issues in Chapters 2 and 14.

Part B



REMEMBER

Many people in Medicare never need to go into the hospital, but almost everybody sees a doctor or needs diagnostic screenings and lab tests sooner or later. That's where Part B — known as *medical insurance* — comes in. The wide range of services it covers includes the following:

- » Approved medical and surgical services from any doctor who accepts Medicare patients, whether those services are provided in a doctor's office, in a hospital, in a long-term-care facility, or at home
- » Diagnostic and lab tests done outside hospitals and nursing facilities
- » Preventive services such as flu shots, mammograms, screenings for depression and diabetes, and so on, many of which are free
- » Some medical equipment and supplies (for example, wheelchairs, walkers, oxygen, diabetic supplies, and units of blood)
- » Some outpatient hospital treatment received in an emergency room, clinic, or ambulatory surgical unit
- » Some inpatient care in cases where patients are placed under observation in the hospital instead of being formally admitted
- » Inpatient prescription drugs given in a hospital or doctor's office, usually by injection (such as chemotherapy drugs for cancer)
- » Some coverage for physical, occupational, and speech therapies
- » Outpatient mental health care
- » Second opinions for non-emergency surgery in some circumstances
- » Approved home health services not covered by Part A
- » Ambulance or air rescue service in circumstances where any other kind of transportation would endanger the patient's health
- » Free counseling to help curb obesity, smoking, or alcohol abuse

You must pay a monthly premium to receive Part B services unless your income is low enough to qualify you for assistance from your state. Most people pay the standard Part B premium, which is determined each year by a formula set by law (\$174.70 in 2024). If your income is over a certain level, however, you're required to pay more.

You also pay a share of the cost of most Part B services. In original Medicare, this amount is almost always 20 percent of the Medicare-approved cost. Medicare Advantage health plans charge different amounts — usually flat dollar co-pays

for each service. I go into detail about the out-of-pocket costs for Part B in Chapter 3, and I explain ways to lower them in Chapter 4.

Part C

In the previous two sections, I describe coverage provided by Part A and Part B, which together form what is known as *traditional* or *original Medicare* — so named because that was the extent of the program’s coverage when it began back in 1966. It’s also called *fee-for-service Medicare* because each provider — whether it’s a doctor, hospital, laboratory, medical equipment supplier, or whatever — is paid a fee for each service.

But these days Medicare also offers an alternative to the original program: a range of health plans that mainly provide managed care through health maintenance organizations (HMOs) or preferred provider organizations (PPOs). These plans are run by private insurance companies, which decide each year whether to stay in the program. Medicare pays each plan a fixed fee for everyone who joins that plan, regardless of how much or little healthcare a person actually uses. This health plan program is called *Medicare Advantage* or Medicare Part C.



REMEMBER

Medicare Advantage plans must, by law, cover exactly the same services under Part A and Part B as original Medicare does. (So if you need a knee replacement, for example, the procedure is covered — regardless of whether you’re enrolled in a Medicare Advantage plan or in the original program.) But the plans may also offer extra benefits that original Medicare doesn’t cover — such as routine vision, hearing, and dental care. Most plans include Part D prescription drug coverage as part of their benefits package.

Still, being enrolled in one of these plans is a very different experience from using the original Medicare program. Your out-of-pocket costs are different, and so are your choices of doctors and other providers. I discuss the differences between original Medicare and Medicare Advantage plans in Chapter 9. I describe the different types of plans, and how to compare them properly to find the one that best meets your needs, in Chapter 11.

Part D

Part D is insurance for outpatient prescription drugs — meaning medications you take yourself instead of having them administered in a hospital or doctor’s office. Medicare’s drug benefit was only added to the program in 2006, a full 40 years after Medicare began. Since then, it has saved huge amounts of money for millions of people and allowed many to get the meds they need for the first time.



REMEMBER

Still, I can't gloss over the fact that Part D is a complicated benefit that takes a lot of getting used to. Here are just some of the peculiar ways it differs from other drug coverage you may have used in the past:

- » Coverage goes through four distinct phases during a calendar year, and in each phase the same drug can cost a different amount.
- » To get coverage, you must select just one private plan that provides Part D drugs out of many plans that are available to you.
- » Different plans cover different sets of drugs, and no plan covers all drugs.
- » Plans set their own co-pays for each drug, and these amounts can vary enormously, even for the same drug.
- » Plans may require you or your doctor to ask permission before they cover certain drugs or to try a less-expensive version before they cover the one you were prescribed.
- » Plans are allowed to change their costs and benefits or to withdraw from Medicare entirely each calendar year.

If this all sounds mystifying, you're probably wondering how on earth anyone can possibly navigate Part D to find good drug coverage. But yes, it's possible! In Chapter 10, I describe a strategy for effectively comparing plans and finding the one that best meets your needs, and Chapter 12 lets you know who can help you do it. I also discuss what Part D covers (Chapter 2), the costs you can expect (Chapters 3 and 4), and how to troubleshoot any problems that show up (Chapters 13 and 14).

Recognizing That You Have Choices and Must Make Timely Decisions



REMEMBER

Despite assertions to the contrary, Medicare is *not* a one-size-fits-all system. It comes with many options, which require you to make decisions within certain time frames. Here's a quick checklist for getting it right:

- » **Enroll at the right time, according to your circumstances.** If you misunderstand or ignore the rules, you face permanent financial penalties and may go without coverage for several months. I explain those potential traps and how to avoid them in Chapter 6.

- » **Research your options.** You need to understand the differences between being in the original Medicare program and enrolling in a private Medicare Advantage health plan. See Chapter 9 for details.
- » **Determine how to make smart choices if you opt for original Medicare.** That means deciding whether you need to add Part D prescription drug coverage and, if so, how to choose the drug plan that works best for you. It also means deciding whether you want to purchase Medigap supplemental insurance and, if so, understanding when you should buy it to ensure you receive all-important federal guarantees and protections. I discuss these choices in Chapter 10.
- » **Figure out how to make smart choices if you opt for a Medicare Advantage plan.** That means comparing plans according to your needs and preferences and understanding your options if you change your mind and want to return to original Medicare. See Chapter 11 for more info.
- » **Get help making your choices if you need to.** I explain how to get personal help from legitimate, informed sources (and avoid scamsters and frauds) in Chapter 12.
- » **Understand your right to change your coverage every year and at other times in certain circumstances.** I describe the purpose of various enrollment periods, their deadlines, and the process of switching to another plan or type of coverage in Chapter 15.

