Everything You Wanted to Know About Medicare

Medicare was created by the federal government as a way to make sure that elderly citizens of the U. S. would be able to afford healthcare. It was signed into law in 1965 by President Lyndon Johnson in 1965. At the time, 60% of U. S. citizens over 65 had no health insurance. Later, eligibility for Medicare was expanded to include people with certain disabilities and severe, chronic diseases. Medicare should not be confused with Medicaid, a separate government program set up in 1965 to provide healthcare coverage for low-income individuals (some of whom are also elderly).

How do you get Medicare?
Most people are eligible for Medicare when they reach the age of 65. If you have paid Medicare taxes on your income for at least 10 years you will be automatically enrolled in Medicare Part A (hospital insurance) and be asked to enroll in Part B (outpatient insurance) and Part D (drug insurance) or to choose a Medicare Advantage Plan (Part C) that covers all three. Some younger people are also eligible for Medicare if they are disabled, have end-stage kidney disease on dialysis, or have ALS (Lou Gehrig's Disease). They are enrolled differently, but have the same options of standard (Parts A, B and D) or Part C Medicare. Although you don't have to sign up for Part B and D (or Part C), if you don't do it when you are first eligible (unless you have equivalent insurance from an employer) you will pay a steep penalty if you sign up later.

What does it cost to get Medicare?
That depends. Most people pay nothing for Part A (that was paid for by their payroll taxes), pay a standard premium for Part B ($144.60 a month in 2020) and a choose a drug plan (Part D) that has a separate premium that varies depending on the plan and the state (the average cost in 2015 was about $40 a month). Families with higher incomes pay additional amounts for both Part B and D, that increases with higher income. Families with modest income and assets may qualify for extra help to subsidize their premium payments. Those on disability or who have low income and qualify for Medicaid usually pay no premiums. Those who choose an Advantage Plan (Part C) have to pay the same Part B premium they would otherwise pay and may also pay a premium to the Advantage Plan, depending on the particular plan.

What does Medicare cover?
Medicare covers most *medically necessary services*, but with some limitations. It covers hospital stays, outpatient services like doctors' visits and diagnostic tests, some preventive services, and short-term rehabilitation, nursing home and home care services after a hospital stay. It does not cover long-term nursing care in the home or an institution or assisted living facility. It does not cover routine vision care, eyeglasses, hearing tests, hearing aids, or routine dental care.

How much are the out-of-pocket costs on Medicare?
There are a lot of out-of-pocket costs on Medicare. You have to pay deductibles for hospital stays ($1,408) and outpatient care ($144.60) yourself before Medicare starts to pay anything for your care. If you are in the hospital for more than 60 days, you have to pay the first $352 per day of the cost of your care up to the 90th day and $704 a day after

that (up to a total of 60 days over your lifetime). For outpatient care, you pay 20% of the cost of most services after the deductible. Copayments for drugs varies by plan but is typically a percentage or flat amount per prescription (lower for generics). If you have an Advantage Plan, the costs vary by plan and may be different. For some people who are eligible for Medicaid, some or all deductibles and/or copayments may be paid by Medicaid. There is no limit to the out-of-pocket costs someone on Medicare may have to pay.

What are Medigap policies?
Medigap policies are issued by private insurers to help cover out-of-pocket costs on Medicare. There are strict regulations about what types of coverage can be offered. Medigap policies cannot cover out-of-pocket costs for drugs. There are many different policies and usually a number of different insurers offering each policy. The cost may vary, and you may have to shop around to find the best plan. There are agents who can do this for you. You have to sign up for a Medigap policy during the enrollment period at the end of the year (you can change each year if you want to). Many people choose to purchase a Medigap policy to limit their risk of high out-of-pocket expenses.

How is Medicare financed?
The financing of Medicare is complicated. Part A is financed almost entirely from payroll taxes—1.45% paid by workers and 1.45% by employers. However, unless the tax rate is changed, given the aging of the population and increasing cost of medical care, this will not be adequate for much longer. Part B costs are financed 25% by premiums paid by individuals and 75% from general revenues. Part D costs are covered 25.5% by premiums, 13% by payments from states, and the remainder from general revenues. Part C is not financed separately—payments are made directly to private plans to cover the costs of services for Parts A, B and D. (The payments to Part C have generally been higher than the cost Medicare would have paid under standard Medicare for the same services, partly due to higher administrative costs.)

How is Medicare administered?
Although Medicare pays for medical care for individuals like insurance companies do, it is not an insurance company. It just makes rules and then gives contracts to private insurance companies to administer all its claims and payments. It does this through *local carriers*, 12 for Part A & B services, 4 for durable medical equipment, and 4 for home healthcare and hospice. Medicare publishes a *handbook* that all local carriers are required to follow in administering its policies when handling claims, but they each interpret the regulations their own way. They may publish *local carrier determinations* to help providers understand whether or not a service will be covered. (Medicare may also publish *national determinations* that all carriers must follow.) This means that Medicare policy may differ from one region to another. It also means that the Medicare administration has no experience in claims handling—it is all done for them by private insurance companies. Like anything else in our government, there are checks and balances. Local carriers may be audited by Medicare to make sure they are following regulations appropriately. And anyone can *appeal* a decision by a local carrier. The carrier may review an appeal first, then Medicare may review it. But since Medicare is

part of the *administrative* arm of the government that only interprets the law Congress passed, there is always a further *judicial* appeal available.

Medicare—love it, improve it!
That's the motto of National Nurses United, for good reason. Medicare has worked well for over 50 years, but as costs have risen it has become overly complicated and too expensive for too many. It's time to give the benefits of Medicare to everyone but at the same time to make it better—simpler, more comprehensive and more affordable. Take a look at the brief outline of our plan, our executive summary or our comprehensive analysis to see what Medicare for All could look like.

For more information about Medicare go to www.medicare.gov or read the report by the Kaiser Family Foundation, A Primer on Medicare. You can also find additional resources on this Resource page under Background information.