# *Medicare Enrollment Guide: 2024 Edition*

*Open enrollment for Medicare plans began on Oct. 15 and ends on Dec. 7. Here's what older Americans need to know about shopping for health insurance.*

I Credit...Taimy Alvarez/South Florida Sun Sentinel, via Alamy Live News

**By Paula Span**
Paula Span writes the biweekly New Old Age column.

Published Nov. 20, 2022Updated Oct. 16, 2023

Open enrollment season is upon us again. From now through Dec. 7, more than 65 million Americans are deciding which Medicare options will give them the best health coverage. A flood of television and radio ads, emailed promotions, texts and mailers serve as reminders, though not necessarily clarifying ones.

"It's a very consequential decision, and the most important thing is to be informed," said Jeannie Fuglesten Biniek, an associate director at KFF, formerly the Kaiser Family Foundation, and a co-author of a recent literature review comparing Medicare Advantage, administered by private insurers, and traditional Medicare.

If you are navigating this decision for yourself or for a loved one, here are some important factors to consider. This guide, first published for last year's enrollment period, has been updated for 2024.

## Why the marketing barrage?

Medicare — the federally funded health care program — has been in place since 1965. Since then, an expanding array of Medicare Advantage plans have become available. Last year, the typical beneficiary could choose from 43 Advantage plans, KFF has reported.

Medicare Advantage plans, like traditional Medicare, are funded by the federal government, but they are offered though private insurance companies, which receive a set payment for each enrollee. The idea is to help control costs by allowing these insurers, who must cover the same services as traditional Medicare, to keep some of the federal payment as profit if they can provide care less expensively.

The biggest providers of Advantage plans are Humana and United Healthcare, and they and others market aggressively to persuade seniors to sign up or switch plans. A Senate report found that some of these Advantage plan practices were deceptive; for example, some marketing firms sent Medicare beneficiaries mailers made to look like government letters. Medicare has issued new marketing regulations to reduce the confusion.

But the marketing has paid off for insurers. The proportion of eligible Medicare beneficiaries enrolled in Medicare Advantage plans has hit 51 percent.

## Which is better: Medicare or Medicare Advantage?

Credit...Bill Clark/CQ Roll Call, via Associated Press

The two plans operate quite differently, and the health and financial consequences can be significant. Each has, well, advantages — and disadvantages.

Jeannie Fuglesten Biniek, associate director at KFF, is a co-author of a recent literature review comparing Medicare Advantage and traditional Medicare. One important finding, Dr. Biniek said: "Both Medicare Advantage and traditional Medicare beneficiaries reported that they were satisfied with their care — a large majority in both groups."

Advantage plans offer simplicity. "It's one-stop shopping," she added. "You get your drug plan included, and you don't need a separate supplemental policy," the kind that traditional Medicare beneficiaries often buy, frequently called Medigap policies.

Medicare Advantage may appear cheaper, because many plans charge low or no monthly premiums. Unlike traditional Medicare, Advantage plans also cap out-of-pocket expenses. Next year, you'll pay no more than $8,850 in in-network expenses, excluding drugs — or $13,300 with the kind of plan that permits you to also use out-of-network providers at higher costs (called P.P.O.s, or preferred provider organizations).

But a majority of Advantage plans don't allow that choice. "Most plans operate like an H.M.O. — you can only go to contracted providers," said David Lipschutz, the associate director of the Center for Medicare Advocacy.

Advantage enrollees may also be drawn to the plan by benefits that traditional Medicare can't offer. "Vision, dental and hearing are the most popular," Mr. Lipschutz said, but many plans also include gym memberships, transportation, or certain over-the-counter items.

"We caution people to look at what the scope of the benefits actually are," he added. "They can be limited, or not available to everyone in the plan. Dental care might cover one cleaning and that's it, or it may be broader." Most Advantage enrollees who use these benefits still wind up paying most dental, vision or hearing costs out of pocket.

The Commonwealth Fund recently reported that 21 percent of Medicare Advantage beneficiaries have problems paying medical bills and debts, as do 14 percent of those with traditional Medicare.

## What are the downsides to Medicare Advantage?

One big downside is that these insurers require “prior authorization,” or approval in advance, for many procedures, drugs or facilities.

“Your doctor or the facility says that you need more care” — in a hospital or nursing home, say — “but the plan says, ‘No, five days, or a week, two weeks, is fine,’” said David Lipschutz, the associate director of the Center for Medicare Advocacy. Then you must either forgo care or pay out of pocket.

Advantage participants who are denied care can appeal, and in 2021 those who did so had the denials reversed 82 percent of the time, according to a KFF analysis. But only about 11 percent of beneficiaries or providers filed appeals, “which means there’s a lot of necessary care that enrollees are going without,” Mr. Lipschutz said.

A report last year by the inspector general’s office determined that 13 percent of services denied by Advantage plans met Medicare coverage rules and would have been approved under traditional Medicare.

Advantage plans can also be problematic if you are traveling or spending part of each year away from home. If you live in Philadelphia but get sick on vacation in Florida, all local providers may be out of network. Check to see how the plan you’re using or considering treats such situations.

## So maybe I should just go with traditional Medicare?

Credit...Justin Sullivan/Getty Images

“The big pro is that there are no networks,” Jeannie Fuglesten Biniek, associate director at KFF, said of traditional Medicare. “You can see any

doctor that accepts Medicare," as most do, and use any hospital or clinic. Traditional Medicare beneficiaries also largely avoid the delays and frustrations of prior authorization.

But traditional Medicare sets no cap on out-of-pocket expenses, and its 20 percent co-pay can add up quickly for hospitalizations or expensive tests and procedures. So most beneficiaries rely on supplemental insurance to cover those costs; they either buy a Medigap policy or have supplementary coverage through an employer or Medicaid. Medigap policies are not inexpensive; KFF reported that in 2021 they averaged $150 to $200 a month.

The KFF literature review found that traditional Medicare beneficiaries experienced fewer cost problems than Advantage beneficiaries if they had supplementary Medigap policies — but if they didn't, they were more likely to report problems such as delaying care for cost reasons or having trouble paying medical bills.

Traditional Medicare also provides somewhat better access to high-quality hospitals and nursing homes. David Meyers, a health services researcher at Brown University, and his colleagues have been tracking differences between original Medicare and Medicare Advantage for years, using data from millions of people.

The team has found that Advantage beneficiaries are 10 percent less likely to use the highest quality hospitals, 4 percent to 8 percent less likely to be admitted to the highest quality nursing homes and half as likely to use the highest-rated cancer centers for complex cancer surgeries, compared with similar patients in the same counties or ZIP codes.

What's more, some Medicare Advantage plans have narrow provider networks compared with what would be available through traditional Medicare, Dr. Meyers and his colleagues have reported. Some Advantage plans have limited access to primary care doctors and to dialysis centers. Doctors who treat higher numbers of complex patients with greater social and medical risks are less available than through traditional Medicare.

Johns Hopkins researchers reported this summer that most Advantage plans offered narrow networks of psychiatrists, enrolling fewer than a quarter of those practicing in a service area.

“Providers are starting to push back more on Medicare Advantage plans, and that leads to fewer providers — hospitals, doctors’ groups — willing to contract with Advantage plans,” said David Lipschutz, associate director of the Center for Medicare Advocacy.

In general, patients with high needs — people who were frail, limited in activities of daily living or had chronic conditions — were more apt to switch to traditional Medicare than those who were not facing such intense medical demands.

“When you’re healthier, you may run into fewer of the limitations of networks and prior authorization,” Dr. Meyers said. “When you have more complex needs, you come up against those more frequently.”

Another downside to traditional Medicare, though, is that it does not include drug coverage. For that, you need to buy a separate Part D plan.

Unlike most Medicare Advantage plans, traditional Medicare does not include drug coverage. For that, you must buy a separate Part D plan.

Last year, beneficiaries could typically choose between 24 stand-alone Part D plans, at premiums that ranged from $6 to $111 a month and averaged $43 for policies available nationwide, said Juliette Cubanski, the deputy director of the program on Medicare policy at KFF.

“If you’re the person who doesn’t take many medications or only uses generics, the best strategy might be to sign up for the plan with the lowest premium,” Dr. Cubanski said.

“But if you take a lot of medications, the most important thing is whether the drugs you take, especially the most expensive ones, are covered by the plan.”

Different plans cover different drugs (which can change from year to year) and place them in different pricing tiers, so how much you pay for them varies. And, to make comparisons more dizzying, certain pharmacy chains are “preferred” by certain plans, so you could pay more at CVS than at Walmart for the same drug, or vice versa.

How does Part D work? First, most stand-alone plans have a deductible: $545 in 2024. You pay that amount out of pocket before coverage kicks in.

Then, a Part D plan, either stand-alone or as part of a Medicare Advantage plan, usually establishes five tiers for drugs. The cheapest two tiers, for generic drugs, could be free or run up to about $20 per prescription. Next comes a tier for preferred brand-name drugs, probably $40 to $50 per prescription in 2024.

Drugs on the next highest tier, for nonpreferred brand-name drugs, usually involve coinsurance — paying a percentage of the drug’s list price — rather than a flat co-pay. For national stand-alone plans, that ranges from 40 percent to 50 percent, Dr. Cubanski said.

Drugs that cost more than $950 a month are considered specialty drugs, the highest-priced tier. You pay only 25 percent of the price, but because these are so expensive, your costs rise.

Once your total drug costs reach $5,030 (for 2024), including out-of-pocket costs and what your plan paid, you have entered the so-called coverage gap phase and will pay 25 percent of the cost, regardless of tier.

Finally, when your costs reach $8,000 — including what you’ve paid, plus the value of manufacturer discounts — you have hit the threshold for catastrophic coverage. After that, thanks to the Inflation Reduction Act, you pay nothing more.

Part D beneficiaries with diabetes should already be receiving savings on insulin since Medicare capped prices at $35 a month, and they should receive savings from negotiated prices with drug makers starting in 2026. All adult vaccines are free for Medicare beneficiaries.