April 2022

Four Things to Think About When Choosing Between Traditional Medicare and Medicare Advantage Plans

by Diane Archer, Senior Advisor on Medicare, Social Security Works

There are four important factors to consider when choosing between traditional Medicare, which is administered by the federal government, and Medicare Advantage plans, which are administered by corporate health insurers that contract with the government: 1. Coverage 2. Access 3. Incentives 4. Cost.

1. Coverage

Both traditional Medicare and Medicare Advantage plans cover the same benefit package. But, Medicare Advantage plans typically cover 25 percent fewer services than traditional Medicare because they take a narrow view of what care is medically necessary and profit more the less care they cover. Traditional Medicare covers care from most doctors and hospitals in the United States.

Medicare Advantage plans generally cover care only from doctors and hospitals in their network and, often, only in your area, except in emergencies or urgent care situations.

2. Access

With traditional Medicare, you are covered for all medically necessary care without a referral or prior authorization. You can get the care you need without delay. For more information on the **easy access you have with traditional Medicare, click here**.

With a Medicare Advantage plan, you often must have a referral from a primary care physician or prior authorization from your Medicare Advantage plan in order for your care to be covered. Delays and denials of care are common.

3. Incentives

With traditional Medicare, your doctors and hospitals have every incentive to provide you with all the care they think you need because traditional Medicare will pay for it.

Medicare Advantage plans receive a fixed amount from the government to cover your care regardless of how much they spend on your care. They might incentivize network doctors to withhold needed care. The less money a Medicare Advantage plan spends on your care, the more money the Medicare Advantage plan has for its shareholders. To learn more, read **this blog** post by Diane Archer and Theodore Marmor on the fundamental difference between traditional Medicare and private insurance.

4. Cost

Traditional Medicare has no out-of-pocket cap, so you need extra insurance to fill coverage gaps. Some people get this additional insurance from former employers, some buy an individual **"Medigap" or Medicare supplemental insurance policy** and **some qualify for Medicaid**, which fills gaps, because their income is low. With this extra insurance, you will have few if any out-of-pocket costs when you get medical or hospital care. You also need prescription drug coverage, if not through Medicaid or a former employer, through **a Medicare Part D drug plan**. Without this extra insurance, if you need a lot of costly care, your out-of-pocket costs could be astronomical.

With a Medicare Advantage plan, you cannot buy extra insurance to fill coverage gaps, and you can be liable for up to $7,550 in out-of-pocket costs–copays, coinsurance and deductibles–for your in-network care alone, so costs can be a barrier to care. If you are in an HMO, there is generally no limit to your out-of-pocket costs if you use doctors who are out of network. If you are in a PPO, your out-of-pocket cap out of network is as high as $11,300. Medicare Advantage plans usually include a Medicare Part D drug plan.