Beneficiary Costs in Medicare

FACT SHEET January 2021



The Medicare program offers seniors two basic options,
Traditional Fee-For-Service
(FFS) Medicare or Medicare
Advantage for the coverage
of Part A and B benefits.
With each choice, coverage
options are selected by
beneficiaries based on
their health care needs,
finances, and preferences.
The total amount, co-pays,
and deductibles paid by
beneficiaries vary depending
on the selected coverage.

BMA Policy Recommendations

It is important for Medicare beneficiaries to understand the array of coverage offerings and associated cost sharing obligations in order to make the best choice. Specific plan offerings differ by state and region. To ensure new and returning beneficiaries have the information to make the best selection, the Centers for Medicare & Medicaid must continue to improve written and online materials to provide clear, unbiased, user-friendly language and graphics, and engage in public campaigns to inform and educate beneficiaries and their caregivers.

Coverage Options for Medicare Beneficiaries

The Medicare program consists of several key options for health care coverage which include FFS Medicare, Medigap, Part D, and Medicare Advantage. Medicare beneficiaries may choose to receive coverage through FFS Medicare for medical coverage. Beneficiaries who chose FFS Medicare may add a Medigap plan to supplement this coverage to help pay out-of-pocket costs. The same beneficiary may also elect a prescription drug plan (Part D) for medications. Other beneficiaries may choose Medicare Advantage, which provides all FFS Medicare benefits with out-of-pocket cost protections and often includes drug benefits. Beneficiaries pay different amounts based on the type of Medicare option they choose. Beneficiaries pay for coverage through Part B premiums, Medigap premiums, and out-of-pocket costs, including annual deductibles and cost sharing like copayments and coinsurance.

- FFS Medicare: FFS Medicare provides limited coverage for hospital and other inpatient care (Part A), such as a stay in a skilled nursing facility; and provider services (Part B), such as a primary care visit.
- Medigap: Medigap, which is offered by private insurance plans, provides
 FFS Medicare beneficiaries with coverage of out-of-pocket co-pays and
 deductibles. Medicare Advantage enrollees are provided with similar out-ofpocket cost coverage, and therefore do not need an additional Medigap plan.
- Part D: All beneficiaries may choose prescription drug coverage through Part
 D options for medications accessed at a pharmacy. A private plan or pharmacy
 benefit manager administers beneficiary treatment under Part D. The vast
 majority of Medicare Advantage plans also include Part D coverage.
- Medicare Advantage: Medicare Advantage (Part C) provides coverage for all Part A and Part B services, and may offer supplemental benefits like dental, hearing, and vision services. Unlike FFS Medicare, All Medicare Advantage plans provide out-of-pocket cost protections for beneficiaries.

Out-of-Pocket Costs Differ for Beneficiaries in FFS Medicare and Medicare Advantage

- Beneficiaries pay a monthly Part B premium whether they chose FFS Medicare or Medicare Advantage.
- Medicare Advantage has a limit on out-of-pocket costs to be paid by beneficiaries for Part A and B benefits annually. FFS Medicare does not have such a limit.
- Medicare Advantage plans may offer supplemental benefits above and beyond those covered by Part A and B. FFS Medicare is not allowed to pay for any additional benefits.
- Beneficiaries in FFS Medicare may purchase a Medigap plan to pay out-ofpocket expenses not covered by Medicare. Medicare Advantage enrollees do not need, and are not allowed, to buy Medigap plans.
- Depending on the plan selected by the beneficiary, there are differences in out-of-pocket costs between FFS Medicare and Medicare Advantage.
- FFS Medicare pays all providers who accept Medicare. Medicare Advantage plans contract with networks of providers. Beneficiaries in Medicare Advantage may pay higher out-of-pocket costs if care is "out of network" or out of the country, depending on the kind of plan.