Comparing Traditional Medicare & Medicare Advantage

Definitions

Traditional Medicare (also called original Medicare) is a government-administered program that consists of Medicare Part A (hospital inpatient, skilled nursing facilities, hospice) and Medicare Part B (physician services, hospital outpatient, ambulatory surgery centers, Part B drugs, durable medical equipment, mental health services). Patients enrolled in traditional Medicare can also obtain Medicare Part D prescription drug coverage from a health plan for an additional premium.

Medigap (also called Medicare supplement insurance) plans are Medicare-approved supplemental private insurance plans used to help cover a patient's share of out-of-pocket costs in traditional Medicare.

Medicare Advantage (also called Medicare Part C) is a program of Medicare-approved plans offered by private insurance companies as an alternative to traditional Medicare (Parts A and B). These plans include the same benefits as traditional Medicare plus extra benefits (e.g., dental, vision, hearing, transportation assistance, etc.) and often prescription drug coverage (Medicare Part D).

Provider Networks are physicians, other health care providers, and hospitals that a health plan contracts with to provide health care to its members. They are known as "network providers" or "in-network providers." A provider that is not contracted with the health plan is called an "out-of-network provider."

Prior Authorization is a health plan cost-control process that requires providers to qualify for payment by obtaining approval before performing a service or filling a prescription.

Cost-Sharing refers to a patient's out-of-pocket costs for health care services covered by their health insurance plan, typically in the form of deductibles, copayments, or coinsurance.

Deductible is the amount that a patient must pay before the health plan will pay for covered services.

Copayment is a predetermined, fixed amount that a patient must pay for a particular service or medication under their health insurance plan.

Coinsurance is the percentage of covered health costs that a patient must pay toward a covered claim after the deductible is met.

Premium is the amount, typically billed monthly, that patients pay for health coverage, regardless of health care use.

Key Differences Between Traditional Medicare & Medicare Advantage

There are two areas where fundamental differences between traditional Medicare and Medicare Advantage can affect a patient's Medicare experience:

(1) Provider networks and
(2) Cost-sharing.

Provider Networks

Traditional Medicare: Patients in traditional Medicare can see any physician and go to any facility that accepts Medicare.

Medicare Advantage plans have networks: Some Medicare Advantage plans only cover services from physicians and facilities that are in-network, while others provide out-of-network coverage with higher cost-sharing, making it important to know a physician's network status as well as the adequacy of the network in case referrals to specialists are needed. Plans use provider directories to inform enrollees about in-network physicians.

Cost-Sharing

Traditional Medicare typically requires 20 percent coinsurance for Part B services after the deductible is met and there is no annual limit on out-of-pocket costs, but patients can obtain a Medigap supplemental plan for an additional premium, which can help cover the out-of-pocket costs.

Medicare Advantage plans have annual limits on what a patient will pay for covered Part A and Part B services, albeit with different limits for in-network and out-of-network services. Once a patient reaches the plan's limit, the patient will pay nothing for covered services for the remainder of the year. For 2026, the maximum cost-sharing for Part A and Part B services is $9,250. Medigap plans cannot be used to help cover a patient's out-of-pocket costs with Medicare Advantage.

	Traditional Medicare	Medicare Advantage
Provider Networks	No	Yes
Cost-Sharing	No Annual Limit; 20 Percent Coinsurance After Deductible Met, Which Can Be Covered With Supplemental Medigap	Annual Limits That Vary Between In-Network and Out-of-Network Services; Cannot Be Covered With Supplemental Medigap

A Note About Prior Authorization

Medicare Advantage plans often require prior authorization for services,[1] even when a physician deems a service or procedure medically necessary.

Generally, prior authorization does not apply in Traditional Medicare; however, a new demonstration program in 6 states starting in 2026 will involve review of about 30 types of services, procedures, or devices. For more information, please see the Wasteful and Inappropriate Service Reduction (WISeR) model.

Resources

AMA: FixPriorAuth
AARP: The Big Choice: Original Medicare vs. Medicare Advantage
Centers for Medicare & Medicaid Services (CMS): Compare Original Medicare & Medicare Advantage
CMS Medicare Plan Finder: Review different Medicare Advantage (MA) plans to change from one MA plan to another, switch from Traditional Medicare to an MA plan, or switch from an MA plan to Traditional Medicare.
CMS: 2026 Medicare Parts A & B Premiums and Deductibles
Medicare Rights Center: Differences between Original Medicare and Medicare Advantage
State Health Insurance Assistance Program: Choosing Between Original Medicare and Medicare Advantage
The Commonwealth Fund: Traditional Medicare or Medicare Advantage: How Older Americans Choose and Why
AMA Policy H-330.867

[1] KFF, *Medicare Advantage in 2024: Premiums, Out-of-Pocket Limits, Supplemental Benefits, and Prior Authorization*, August 8, 2024. Available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-premiums-out-of-pocket-limits-supplemental-benefits-and-prior-authorization/