Basics on Original Medicare vs. Medicare Advantage

Medicare beneficiaries can elect to have **Original Medicare** (sometimes called “traditional Medicare” or “fee-for-service Medicare”) or **Medicare Advantage** (MA).

Original Medicare includes Part A (hospital insurance) and Part B (medical insurance). Part A covers inpatient hospital stays, skilled nursing facility care, hospice care, and some home health care. Part B covers doctor visits, outpatient care, medical equipment, lab services, X-rays, and preventive services. People with Original Medicare also have the option to join a Part D (drug coverage) plan. **Medicare Advantage** (Part C) typically bundles Part A, Part B, and Part D coverage.

Contracting and reimbursement implications for federally qualified health centers (FQHCs) vary based on the patient’s Medicare coverage (and whether or not they are also enrolled in Medi-Cal); those scenarios are explored in *Considerations for Medicare Billing in Federally Qualified Health Centers*, available on the CHCF website.

California Health Care Foundation

December 2025

Author: Wipfli Advisory LLC

Doctor and Hospital Choice	
Original Medicare	**Medicare Advantage**
Patients can go to any doctor or hospital that takes Medicare, anywhere in the U.S.	In most cases, patients can only use doctors and other providers who are in the plan's network and service area (for non-emergency care). Use of out-of-network providers increases patient out-of-pocket costs.
In most cases, patients do not need a referral to see a specialist.	In most cases, patients need to get a referral to see a specialist.
Cost	
Original Medicare	**Medicare Advantage**
For full-benefit dually eligible enrollees (Medicare + Medi-Cal): Medi-Cal covers Medicare cost-sharing.	***For full-benefit dually eligible enrollees (Medicare + Medi-Cal):*** Medi-Cal covers Medicare cost-sharing for in-network providers.
For Medicare-only: • Patients pay the monthly **premium** for Part B (typically $185/month; higher income households pay more). If patients choose to join a Medicare drug plan, patients will pay a separate premium for Medicare drug coverage (Part D). • Patients pay a Part B **deductible** (currently $257/year). Note: Patients receiving care at an FQHC are not subject to the outpatient deductible. • Patients pay 20% **coinsurance** for Part B-covered outpatient services (i.e., Medicare pays 80% of the approved amount after a patient meets the outpatient deductible; providers are expected to collect the remaining 20% from patients). • Part A deductible and coinsurance are not addressed here; information is available on the CMS website.	***For Medicare-only:*** Patients pay the monthly Part B premium and may also have to pay the plan's premium. Some plans may have a $0 premium and may help pay all or part of patients' Part B premiums. Most plans include Medicare drug coverage (Part D). Out-of-pocket costs for health services vary by MA plan.
There is no yearly limit on what patients pay out of pocket unless patients have supplemental coverage, like Medicare Supplement Insurance (Medigap), Medi-Cal, employer, retiree, or union coverage.	Plans have a yearly limit on what patients pay for covered Part A, Part B, and Part D services (with different limits for in-network and out-of-network services). Once patients reach the plan's limit, patients pay nothing for covered services for the rest of the year. Patients can't buy Medigap to cover out-of-pocket costs.
Coverage	
Original Medicare	**Medicare Advantage**
Original Medicare covers most medically necessary services and supplies in hospitals, doctors' offices, and other health care facilities. Original Medicare doesn't cover some services, like routine physical exams, eye exams, and most dental care.	Plans must cover all medically necessary services that Original Medicare covers. For some services, plans may use their own coverage criteria to determine medical necessity. Plans may also offer some extra benefits that Original Medicare doesn't cover, such as dental and vision care.
In most cases, patients do not need approval (prior authorization) for Original Medicare to cover their services or supplies.	In many cases, patients may need to get approval (prior authorization) from their plan before it covers certain services or supplies.
Patients can join a separate Medicare drug plan to get Medicare drug coverage (Part D).	Medicare drug coverage (Part D) is included in most plans. In most types of Medicare Advantage plans, patients can't join a separate Medicare drug plan.

Source: Adapted from "Compare Original Medicare & Medicare Advantage," US Centers for Medicare and Medicaid Services, accessed July 2025.

Note: *MA* is Medicare Advantage; *FQHC* is Federally Qualified Health Center.

Disclaimer: The information contained in this document is provided solely for general illustration and guidance and does not create a business or professional services relationship. The application and impact of laws can vary widely based on the specific facts involved. Accordingly, the presentation is provided with the understanding that by providing it, the authors and publishers are not engaged in rendering legal, accounting, tax, or other professional advice and services. As such, it should not be used as a substitute for consultation with professional accounting, tax, legal, or other competent advisers. Before making any decision or taking any action, you should obtain appropriate professional guidance