The “Gaps” in Medicare

Original Medicare, Medicare Supplement and Medicare Advantage Plans

What's NOT covered by Original Medicare (Part A & Part B)

Original Medicare consists of Part A (hospitalization) and Part B (medical). Unfortunately, Original Medicare has "holes" or "gaps" in the coverage they offer beneficiaries. Here are some routine services Original Medicare does not pay for:

- **Long-term or custodial care (assistance with eating, bathing & toileting)**
- **Routine eye exams, glasses or contact lenses**
- **Most dental services, procedures & supplies, including cleanings, fillings, extractions, dentures, dental plates**
- **Routine foot care**
- **Hearing aids and hearing exams**
- **Incontinence supplies, including adult diapers**
- **Acupuncture**
- **Many tests ordered by a chiropractor, including x-rays and massage therapy**

Original Medicare does NOT cover Prescription Medications

Many people are surprised to find out that not only is Medicare not free, but it also does not cover their PRESCRIPTION MEDICATIONS.

Exceptions would be drugs administered by injection or infusion in a doctor's office or other outpatient medical facility. These drugs would fall under Part B of Original Medicare.

Drugs that are typically injected at home, such as insulin*, are NOT covered by Original Medicare. Neither are syringes, needles, insulin pens, alcohol swabs, and gauze.

***If insulin is used with an insulin pump, Medicare will pay 80% of the Medicare-approved amount after the Part B deductible has been met**

Original Medicare does NOT cover Deductibles & Co-Pays

Original Medicare beneficiaries are responsible for deductibles and co-payments.

In 2023, they'll have to pay a Part A deductible of $1,600 before coverage kicks in, and they'll also have to pay a portion of the cost of long hospital stays -- $400 per day for days 61-90 in the hospital and $800 per day after that. Additionally, Medicare will only help pay for a total of 60 days beyond the 90-day limit, called "lifetime reserve days," and after that a beneficiary will pay the full hospital cost.

Part B typically covers 80% of doctors' services, lab tests and x-rays, but you'll have to pay 20% of the costs after a $226 deductible in 2022.

It's important to let your prospects know that there is no limit or cap on either the Part A or Part B costs for which they are responsible. These costs could quickly pile up and potentially lead to a catastrophic financial situation for them should they become seriously ill with cancer or certain chronic diseases.

Solutions to the Gaps in Original Medicare

There are two ways a Medicare beneficiary can address the gaps in Original Medicare to help limit their financial liability.

A **Medicare (Medigap)** policy or **Medicare Advantage** plan can fill in the gaps if you don't have the supplemental coverage from a retiree health insurance policy.

- **Option 1: Medicare Supplement or Medigap plan combined with a Part D prescription drug plan**
- **Option 2: An all-in-one Medicare Advantage plan, also known as Part C**

Let's take a look at both of these options now…

Option 1: Medicare Supplement aka Medigap

Those who wish to remain on Original Medicare but are concerned about its' out-of-pocket costs may want to consider a Medicare Supplement policy. These plans help fill the coverage gaps left by Part A and Part B. Supplement plans provide the SAME BENEFITS across all carriers but vary in cost.

There are 10 different lettered Medicare Supplement plans approved by Medicare, each with a different level of provided benefits. Plans F, G, and N are the most popular plans and account for the vast majority of Supplement policies.

As of 1/1/2020, Plan F can no longer be sold to anyone who qualified for Medicare after that date. Of these 3 popular plans, Plan F is the only one that covers the Part B deductible.

What do Medicare Supplements Cover?

The 3 MOST POPULAR Medicare Supplement plans (F, G, and N) offer:

2023 Medicare hospital insurance (Part A) covered ser

Services	Benefit	Medicare pays
Hospitalization Semi-private room and board, general nursing and other hospital services and supplies (Medicare payments based on benefit periods) *(See comments 1 & 2)*	First 60 days	All but $1,600
	61st to 90th day	All but $400/day
	91st to 150th day *(60 reserve days may be used only once)*	All but $800/day
	Beyond 150 days	Nothing
Skilled Nursing Facility Care Semi-private room and board, skilled nursing and rehabilitative services and other services and supplies (Medicare payments based on benefit periods) *(See comments 1 & 2)*	First 20 days	100% of approved amount
	Next 80 days	All but $200.00/day
	Beyond 100 days	Nothing
Home Health Care Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies and other services	Unlimited as long as you meet Medicare requirements for home health care benefits	100% of approved amount 80% of approved amount for durable medical equipment
Hospice Care Pain relief, symptom management and support services for the terminally ill	For as long as doctor certifies need	All but limited costs for outpatient drugs and inpatient respite care
Blood♦ When furnished by a hospital or skilled nursing facility during a covered stay	Unlimited during a benefit period if medically necessary	All but first 3 pints per calendar year

2023 Medicare medical insurance (Part B) covered

Services	Benefit	Medicare pays
Medical Expenses Doctor services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, most outpatient mental health services, and other services	Unlimited if medically necessary	80% of approved amount (after $226 deductible)
Clinical Laboratory Services Blood test, urinalysis, and more	Unlimited if medically necessary	Generally 100% of approved amount
Home Health Care Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies and other services	Unlimited as long as you meet Medicare requirements	100% of approved amount; 80% of approved amount for durable medical equipment
Outpatient Hospital Treatment Services for the diagnosis or treatment of an illness or injury	Unlimited if medically necessary	Medicare payment to hospital based on hospital costs
Blood♦	Unlimited during a benefit period if medically necessary	80% of approved amount (after $226 deductible and starting with 4th pint)

Medigap Benefit	Plan A	Plan B	Plan C	Plan D	Plan F*	Plan G*	Plan K	Plan L	Plan M	Plan N
Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B coinsurance or copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓***
Blood (first 3 pints)	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Skilled nursing facility care coinsurance	×	×	✓	✓	✓	✓	50%	75%	✓	✓
Part A deductible	×	✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B deductible	×	×	✓	×	✓	×	×	×	×	×
Part B excess charge	×	×	×	×	✓	✓	×	×	×	×
Foreign travel exchange (up to plan limits)	×	×	80%	80%	80%	80%	×	×	80%	80%
Out-of-pocket limit**	N/A	N/A	N/A	N/A	N/A	N/A	$6,940 in 2023	$3,470 in 2023	N/A	N/A

Note: Plan C & Plan F aren't available if you turned 65 on or after January 1, 2020, and to some people under age 65. You might be able to get these plans if you were eligible for Medicare before January 1, 2020, but not yet enrolled. Learn more about who can buy this plan.

*Plans F & G offer a high deductible plan in some states.

**Plans K & L show how much they'll pay for approved services before you meet your out-of-pocket yearly limit and Part B deductible. After you meet them, the plan will pay 100% for approved services.

***Plan N pays 100% of the costs of Part B services, except for copayments for some office visits and some emergency room visits.

What Doesn’t a Supplement plan cover?

Medicare Supplement plans do not typically cover:

- **Routine vision exams and eyeglasses**
- **Routine dental care and dentures**
- **Routine hearing exams and hearing aids**
- **Routine preventative physical exams**
- **Outpatient prescription drugs**
- **Long-term care**

If a beneficiary wants coverage for these things, then they would need to purchase extra policies.

How much does a Med Supp cost?

Monthly premium: In 2022, the average premium for all 10 Med Supp plans is $163 per month; for the most popular plans we've discussed here average monthly premiums are:

- **Plan F (not avail for anyone eligible for Medicare after 1/1/2020): $231**
- **Plan G: $190**
- **Plan N: $152**

Part B monthly premium: $164.90 (2023)

Part B annual deductible: $226 (2023) Only Plans C and F cover this cost

Additional Costs associated with Med Supp: Prescription Drug Plan (Part D)

Because Medicare Supplement plans do not cover outpatient prescription drugs, it's highly advisable that a beneficiary who chooses this option should also purchase a Part D prescription drug plan when they are first eligible to do so.

If a beneficiary chooses not to, they must be able to prove creditable coverage and that they have not had a gap in that coverage for more than 63 continuous days. Otherwise, they will be subject to a lifetime higher premium or penalty for Part D coverage.

Monthly premiums for a Part D prescription drug plan can be as low as $7-12 or hundreds of dollars on the higher end, with the average premium at $43 per month in 2022.

Additional Costs associated with Med Supp: Dental, Vision, & Hearing

Those who choose the Medicare Supplement option may also want to purchase a stand-alone dental, vision and hearing (dvh) policy since these services are not covered by either Original Medicare or any of the lettered Medicare Supplement plans currently available.

In 2022, average monthly premiums for these plans are around $30-45; there may also be additional co-pays or coinsurance.

Total Average Cost Per Month: Med Supp

Let's take a look at the average cost for a Medicare Supplement plan:

- **$190 monthly premium (Plan G)**
- **$170.10 monthly Part B premium**
- **$43 monthly Part D prescription drug premium**
- **$40 monthly Dental/Vision/Hearing plan premium**

This puts a person's premium costs alone at well over $400 per month, on average, if they go with the Medicare Supplement option. Many will be happy to do so considering that they have the flexibility of going to virtually any doctor or facility who accepts Medicare.

Option 2: Medicare Advantage Plan (Part C)

If the monthly costs of a Medicare Supp plan are too onerous, a beneficiary may want to look at Part C Medicare Advantage plans. Part C plans are typically "all in one" policies that cover Parts A, B and D.

Advantage plans are Medicare-approved and like Medicare Supplements and Prescription Drug Plans, they are sold by private companies.

Part C plans are a "managed care" approach to healthcare, and include provider networks, prior authorization requirements for certain medical services and prescriptions, referrals to specialists, copays and coinsurance.

Medicare Advantage Plans: Part C

These plans often provide extra benefits that Original Medicare and Medicare Supplements do not, such as:

- **dental/vision/hearing,**
- **free gym memberships,**
- **free transportation, and**
- **monthly or quarterly benefit cards for healthy food and over-the-counter items.**

Costs of Medicare Advantage Plans (Part C)

- Most carriers offer at least one if not multiple Advantage plans with $0 monthly premiums
- Some plans may also have $0 medical and/or prescription deductibles
- Plans have a yearly limit known as the “maximum out of pocket” (MOOP) for medical services; once this limit is reached, the plan picks up 100% of Part A and B services
- Typically pay between $0-$20 for primary care visits, around $40 for specialist visits and set copays or sometimes coinsurance for other services
- Prescriptions are usually included in the plan and costs range from $0 for generics to higher copays or coinsurance for non-preferred or specialty tiers
- Beneficiaries who select the Medicare Advantage option still MUST PAY their Part B premium of $164.90 per month, although some Advantage plans contribute

Total Costs for Medicare Advantage Plan

Advantage plans are “pay as you go” so it’s difficult to estimate an overall average cost.

Plans do have an annual maximum out of pocket amount for medical services, so a beneficiary’s financial responsibility is limited to that amount each year.

If a person is healthy and does not go to the doctor’s a lot, they would likely spend next to nothing on a Medicare Advantage plan that has a $0 monthly premium and low or no deductibles.

However, if a person has a serious medical issue, the copays and coinsurance could rack up fairly quickly. The upside is their yearly out of pocket is limited to a set amount of no more than $7,550 - some Advantage plans set limits lower than that though.

More on Medicare Advantage plans

One more thing to note about Part C is that most carriers offer “dual plans” - these are plans for low-income beneficiaries that zero out the costs typically associated with a Medicare Advantage plan.

Those who qualify pay $0 premium, copays and coinsurance. Their medications are also generally at no cost on dual plans. Additionally, they receive enhanced extra benefits such as more dental, vision, and hearing, as well as higher amounts for over-the-counter and healthy food.