

To B or not to B: Making sense of Medicare's alphabet soup

Many of us find the process of signing up for Medicare coverage confusing. However, we also know that the choices we make could make a big difference in both how much we spend on medical care during our lifetime and what options will be available to us along the way. Understanding your health care priorities and matching them to appropriate coverage types can strengthen both your financial and emotional well-being. Start with a look at what you value when it comes to health insurance coverage. After all, you need to have a strong sense of your personal preferences and health concerns before you can really identify the policy types whose features best meet your needs. It's also important to have a strong grasp of the logistics and timelines associated with Medicare enrollment. We believe that there are three key steps to choosing a Medicare coverage option:

Prioritize your needs.

When you reach Medicare eligibility, you will be faced with an alphabet soup of Medicare coverage options. Before trying to negotiate the array of choices, consider which elements of insurance coverage you think are the most important.

Evaluate plan options based on how well they fit your priorities.

No plan is perfect for everyone, so find the types of policies that most closely align with your priorities. Why pay extra for features you don't care about?

Once you know your best matches for plans, shop for specific policies.

You will likely be able to choose from among several coverage providers. Shop for the best deal that's available where you live.

Look at yourself, then look at the coverage

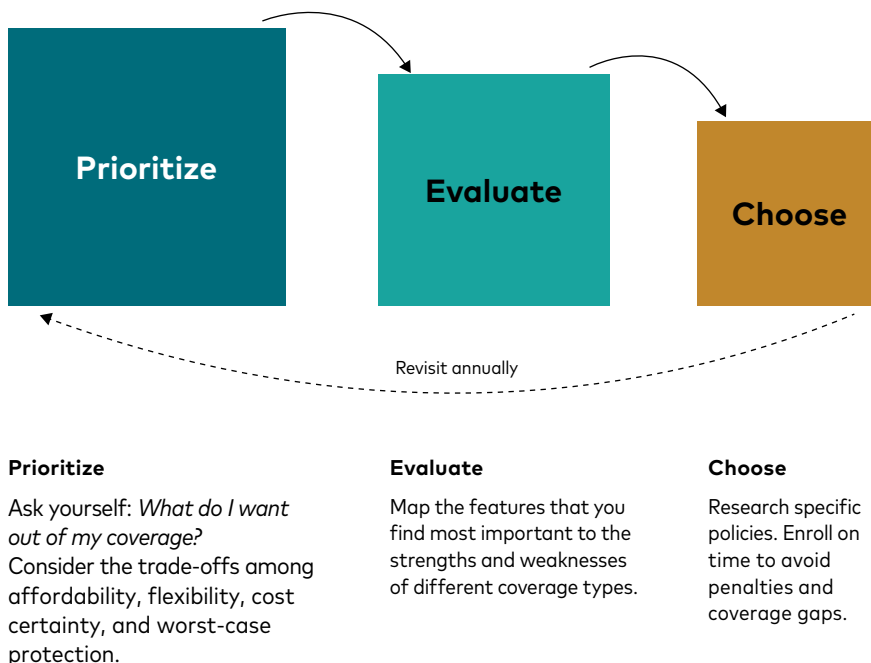
It's hard to choose health insurance—especially when it comes to Medicare. Most of us are not experts on the topic; often the sheer number of options, and our resulting confusion, leads to bad choices. Research backs this up. Abaluck and Gruber (2016), for example, found that retirees frequently made objectively poor choices when enrolling in Medicare prescription drug coverage. Bhargava, Loewenstein, and Sydnor (2017) found that a majority of employees at one large employer with a variety of health care options chose a plan that had a clearly superior alternative. These choices could not be explained by enrollee preference; they could only be attributed to a lack of understanding of how health insurance works. Your risk of choosing poorly can be greatly reduced, however, if you follow a process designed to help you choose wisely.

Choosing a health insurance plan is difficult if you don't understand what you need.

Most approaches to plan choice focus on comparing the features of different insurance options. We think a better approach is to first take time to consider what insurance features are really important for you—that is, to decide what you believe is worth paying for.

Figure 1 presents a schematic of our suggested process.

FIGURE 1.
A framework for choosing the right Medicare policy



Start by figuring out what's important to you

No one type of coverage is perfect for everyone, so you should think about which trade-offs among cost, convenience, and flexibility you're willing to make. Before diving into the details of Medicare, consider how you feel about each of the factors described below. Which ones are more important to you? Which are less important?

Overall affordability

You may just want the coverage that will most likely end up being the most affordable over your lifetime. Why pay more than you have to? Of course, what's most affordable over a lifetime might not be what's cheapest in any given year, and there could be dramatic spikes in costs during the years that you need more health care.

Think about what you're willing to pay for.

Plan flexibility

Some coverage options use provider networks, which can limit your treatment options. With health maintenance organization (HMO)-style plans, coverage is limited to in-network providers; with preferred provider organization (PPO)-style plans, out-of-network providers may be available at additional cost or in certain circumstances. Coverage options that don't use a network provide access to any provider that accepts Medicare.

Most networks are limited to one geographic area, which can be a problem if you travel frequently or split your time between summer and winter homes. A network-based plan may also restrict your ability to see a "best in class" specialist who is not a member of its provider network; it may also require referrals to see any type of specialist. Preapprovals for some treatments may be required, and payment can be denied for treatments deemed "not medically necessary." If that happens, you may have to pay all the costs of the service, although you can appeal the denial.

Worst-case-scenario protection

With some options, there is no limit to the amount you could owe in a particular year if you experience a worst-case health scenario. Others put a cap on the amount you would owe. The lower that maximum amount, the higher your premiums are likely to be.

Cost predictability

For some of us, knowing that "everything will be covered" makes pricier coverage worth the expense. Sudden spikes in medical costs can be especially troublesome for people on a strict monthly budget. If unexpected medical bills would produce real financial or psychological hardship, the predictability of costs may be more important to you than saving money. Even if you are not on a strict monthly budget, it may be comforting to know that you will have fewer hassles dealing with specific medical bills along the way.

How Medicare works

The Medicare system consists of five distinct parts:



Part **A**

Part A (hospital coverage)

Part A is the portion of Medicare that pays hospital costs. Part A also includes some benefits for skilled home care, hospice care, and the first 100 days of skilled nursing care. You probably won't have to pay any premiums for Part A, because you already paid for it with payroll taxes while you were working.

In 2022, you have to pay the first \$1,556 of the cost of each hospital stay. Part A covers the rest for the first 60 days, then you pay the first \$389 per day for days 61–90. After that, there are "lifetime reserve" days (you have a total of 60 days to use in your lifetime, and then they are done), for which you pay the first \$778 per day. You are responsible for the full cost of any additional days.



Part **B**

Part B (medical coverage)

Part B is the portion of Medicare that covers outpatient health care visits such as doctors, outpatient surgery, diagnostic testing, durable medical equipment, and ambulance services. Part B is not free. You'll pay premiums (\$170.10 per month in 2022)—and if your income is over a certain amount, your premiums are subject to surcharges.¹

Under Part B, you are responsible for the first \$233 of covered medical services. Once that deductible is met each year, you will typically owe 20% of the cost of such services, although you may also owe "excess charges" for some providers. Together, Part A and Part B are often referred to as Original Medicare, or traditional Medicare.²



Part **C**

Part C (Medicare Advantage)

Part C plans are private plans (usually HMO or PPO plans) that contract with Medicare to provide Medicare Part A and Part B benefits. Many of these bundled plans are available for only the cost of the standard Part B premium. Medicare pays a fixed amount to the private insurers that offer these plans, and they cover the same services as Parts A and B; many plans also include Part D coverage. These plans may also offer an array of additional services such as dental, hearing, and vision coverage, or even fitness memberships. A few plans offer rebates of some or all of your Part B premiums. In general, these plans require you to use the insurer's network of providers and hospitals to get full coverage.

¹ This surcharge is known as the income-related monthly adjustment amount (IRMAA) and in 2022 ranges from \$68 for an individual making over \$91,000 (\$182,000 for joint filers) to \$408.20 per month for individuals earning over \$500,000 (\$750,000 for joint filers).

² For a more complete description of what is and is not covered under Original Medicare, see Medicare & You, available at www.medicare.gov.



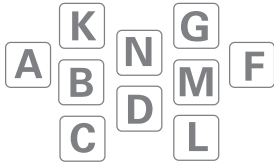
Part D

Part D (prescription drug coverage)

Part D plans are optional prescription drug plans available to everyone who has Medicare. These private plans contract with Medicare to provide at least a standard level of prescription coverage. They are available both as stand-alone plans and as part of Part C (Medicare Advantage) plans. Premiums vary, and there are surcharges for those with higher incomes, but as of 2022, the national average is about \$43 per month (Cubanski and Damico, 2021).

With Part D coverage, first you may have to pay a deductible (a maximum of \$480 in 2022). Then you will pay a portion of the cost, which can vary based on your coverage, the specific drug, and the pharmacy you use. Once you and your insurance have spent a combined \$4,430 (in 2022), you enter the coverage gap, which is also known as the "donut hole." In the coverage gap, you will generally pay 25% of the cost of your drugs.³ Once you've spent \$7,050 out of pocket, you get "catastrophic coverage," after which you pay only a small copayment or coinsurance amount for the rest of the year.

Medigap



Medicare supplemental insurance (Medigap)

Medigap policies are private policies designed to cover expenses not covered under Part A or Part B. They follow standardized forms, designated with letters A through N. (See **Appendix B** on page 21 for a rundown of the benefits offered by each policy.) Medigap policies add to the "alphabet soup" confusion—Medicare Part A and Medigap Plan A are not the same thing! Any Medigap policy designated with a particular letter provides a specific set of benefits, regardless of which company issues it.⁴ If you enroll in a Medicare Advantage plan, you will not need to purchase a Medigap policy.





³ Initially, the term "donut hole" referred to the fact that costs in the coverage gap were 100% the responsibility of the consumer. In 2022, the 25% coinsurance continues through the gap, with the remaining 75% of those costs being paid by the plan for generic drugs and 5% paid by the plan and 70% by the manufacturer for brand-name drugs. The portion paid by the manufacturer counts toward the coverage gap for the purposes of qualifying for catastrophic coverage. In 2024, coinsurance will no longer be required in the catastrophic plan. Beginning in 2025, maximum out-of-pocket costs for Part D will be capped at \$2,000 per year (although this amount can increase over time).

⁴ Massachusetts, Minnesota, and Wisconsin have their own standardized Medigap policy forms, distinct from the A–N standards.

Find plans that align with your priorities

The next step is to look for the types of coverage that dovetail as much as possible with your priorities. **Figure 2** presents some of the policy types you might choose or avoid, depending on what factors are most important to you.

FIGURE 2.
Matching your priorities to Medicare policy types

	 Overall affordability	 Plan flexibility	 Worst-case-scenario protection	 Cost predictability
If this factor is important to you... ...then consider these options...	<ul style="list-style-type: none"> • Medicare advantage (HMO* or PPO^) • Original Medicare with high-deductible Medigap Plan G (if you are in good health) • Original Medicare with Medigap Plan G (if you are in poor health) • Medicare MSA† (If you are in good health) 	<ul style="list-style-type: none"> • Original Medicare with any supplemental coverage 	<ul style="list-style-type: none"> • Original Medicare with Medigap Plan G • Original Medicare with high-deductible Medigap Plan G • Original Medicare with Medigap Plan L 	<ul style="list-style-type: none"> • Original Medicare with Medigap Plan G
...but avoid these options	<ul style="list-style-type: none"> • Original Medicare with Medigap Plan G (if you are in good health) 	<ul style="list-style-type: none"> • Medicare Advantage (HMO or PPO) 	<ul style="list-style-type: none"> • Original Medicare without Medigap 	<ul style="list-style-type: none"> • Original Medicare without Medigap • Original Medicare with high-deductible Medigap Plan G • Medicare MSA

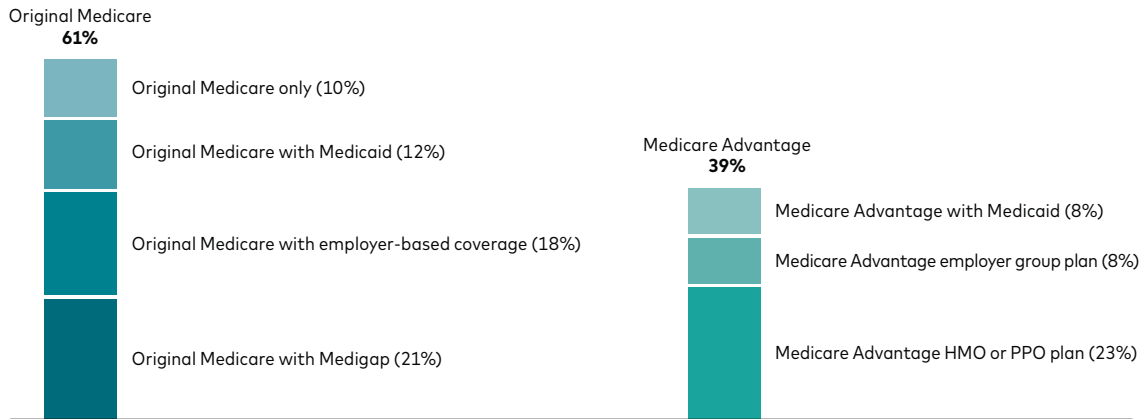
* Health maintenance organization.

^ Preferred provider organization.

† Medical savings account.

There is no out-of-pocket maximum with Original Medicare, so a lengthy hospital stay may be catastrophically expensive. A true worst-case scenario could result in out-of-pocket costs in excess of \$15,000 per year (Weber et al., 2021). For this reason, only 10% of Medicare enrollees choose Original Medicare without additional coverage (Figure 3).

FIGURE 3.
Distribution of Medicare insurance choices in 2018





Note: Since 2018, the share of Medicare beneficiaries choosing Medicare Advantage plans has continued to grow. In 2022, the share of beneficiaries in Medicare Advantage plans was 48%.

Sources: Vanguard, based on data from the Centers for Medicare & Medicaid Services and KFF (Kaiser Family Foundation).

For some of us, supplemental coverage may be available through an employer-based plan or Medicaid. If not, you will probably want coverage that provides more benefits and limits out-of-pocket costs. This can be accomplished with any of the following options:

HMO and PPO plans

Available as part of:	Strong in:	Weak in:
Medicare Advantage (Part C)	Overall affordability 	Plan flexibility 

HMO and PPO plans are available through Medicare Advantage (also called Part C). Medicare Advantage plans are offered by private companies that contract with Medicare to provide Medicare Part A and B benefits; most also include prescription drug coverage. HMO and PPO plans often provide additional benefits, including dental, vision, and hearing coverage or even gym membership. A variety of Medicare Advantage plans are available. If you are considering this type of coverage, you should evaluate each plan individually, as many features vary dramatically from plan to plan.

Medicare Advantage is an affordable option, but it may come with some care restrictions.




With an HMO or a PPO, you will likely be constrained to a specific provider network. This means that not all doctors who accept Medicare will be available to you. Although some large insurers have national networks, most networks are regional, so if you are a "snowbird" or travel frequently, it may be difficult to find covered services. Also, if you live in a more rural area or one with fewer hospitals, you are likely to have fewer Medicare Advantage plan options available—and the networks in those plans may include fewer first-rate hospitals you can use for specialized care. A study of physician networks showed that in 2015, the average plan included only 46% of the physicians in that plan's county, although those percentages varied widely among localities (Jacobson et al., 2017). The study also found that broader networks tended to be associated with PPO plans and plans with higher premiums but that only about one in five plans included 70% or more of the physicians in a county.

Medicare Advantage plans are required to cover everything Original Medicare covers, but they are not required to cover care that the insurer deems not "medically necessary." Some 99% of Medicare Advantage enrollees are in a plan that requires prior authorization for services such as durable medical equipment, skilled nursing facility stays, inpatient hospital stays, or ambulance services (Freed et al., 2022a). When that authorization is not granted, you may find you are not covered for a needed treatment—or facing a long and complicated appeals process before you can get paid for it. A 2022 report from the Office of the Inspector General found evidence of this risk: "... among the prior authorization requests that [Medicare Advantage Organizations] denied, 13 percent met Medicare coverage rules—in other words, these services likely would have been approved for these beneficiaries under original Medicare" (Grimm, 2022).

All Medicare Advantage plans have an out-of-pocket maximum for in-network services. The amount may vary, but for 2022, the highest maximum was \$7,550. Note that because the limit is only for services usually covered by Original Medicare, any expenses related to your covered extra benefits (prescription drugs or hearing aids, for example) won't count toward it.

Supplemental plans

"First-dollar" plans

Available as part of:	Strong in:	Weak in:
Standard Medigap Plan F or G	Cost predictability, worst-case-scenario protection  	Overall affordability 

The most popular Medicare supplements are standard Medigap Plans F and G, largely because they are the most comprehensive. These policies provide "first-dollar" coverage, and they cover all of the expense categories that supplemental policies are permitted to provide.⁵ This means that virtually everything is paid for by your premiums (although you will still need to pay for some things, including vision, dental, most long-term care, and Part D for prescription drugs). Plan F policies also include coverage for the Part B deductible (\$233 in 2022), but this plan is no longer available for new enrollees. However, many people will find that the lower premiums for Plan G relative to Plan F are more than enough to offset that cost.

These plans tend to have the highest premiums of the Medigap options—so if you are in good health, they are likely to prove to be the most expensive choice across your lifetime (Weber et al., 2021). However, they do provide a high degree of convenience and peace of mind.

⁵ With first-dollar coverage, you do not have to deal with copayments or deductibles. Instead, depending on the type of policy you have, your plan pays for expenses starting with either the first dollar charged for health care or the first dollar charged for hospitalization, except for the Medicare Part B deductible under Medigap Plan G.

High-deductible plans

Available as part of:	Strong in:	Weak in:
High-deductible Medigap Plan F or G, Medicare MSA plans	Worst-case-scenario protection, overall affordability  	Cost predictability 

High-deductible plans combine low monthly premiums with the requirement that you pay for some amount of care (up to the deductible). The Medigap plan that best fits this model is the high-deductible version of Plan G. These policies usually have the lowest premiums of any of the supplemental Medicare policies, mainly because typical retirees in good or average health wouldn't incur enough costs to collect benefits in most years. Once you meet the deductible (\$2,490 in 2022), the comprehensive coverage associated with Plan G kicks in. (The Medicare Part B deductible that is not covered under Plan G is counted toward the Plan G deductible.)

In short, this option combines low overall costs with a reasonable out-of-pocket maximum to protect against worst-case-scenario years. The drawbacks: a lower level of convenience than seen in the more expensive first-dollar standard forms of Plans F and G, and possible underwriting requirements if you want to switch to another option later. (You may have higher premiums or not get coverage at all.) These plans can be a particularly good choice for beneficiaries that are in relatively good health.

Accepting a higher deductible is often a good way to reduce your overall insurance costs.

Another high-deductible option is the Medicare MSA plan. Similar in structure to the high-deductible insurance plans with health savings accounts (HSAs) that are becoming more prevalent as employer benefit options, this is a special type of Medicare Advantage plan that combines a high-deductible insurance plan with a medical savings account (MSA). Each year, the insurance provider puts money into your MSA. Once you reach your deductible, all Medicare costs are covered—but you are usually responsible for all costs before that. Tax-free withdrawals from the MSA can be used to pay these costs; you can also use MSA funds for some things that are not covered by Medicare, such as dental and vision care. Because any unused funds stay in your MSA, your balance can accumulate over time. Lastly, unlike most other types of Medicare Advantage plans, an MSA plan allows you to see any doctor or hospital that accepts Medicare.

This plan can be a great choice for healthy seniors who are willing to deal with paying the bulk of their medical costs out of pocket and seeking reimbursement later. However, there are only a limited number of providers of MSA plans, and they are not available in all states. Also, because these plans are not common, there is no guarantee that all medical providers will accept MSA plans, even if they generally accept Medicare.

Other Medigap plans

The remaining standardized supplemental insurance plans fall along a spectrum between first-dollar and high-deductible coverage. Some of these coverages are close to first-dollar coverage but not quite as comprehensive as Plan F or G. For example, Plan N covers almost everything that Plan G covers, but you pay a copayment for some office and emergency room visits, and you are still on the hook if any providers bill you for excess charges. But lower premiums can make this a more economical alternative to a more expensive Plan G alternative for some consumers.

Other plans offer lower premiums with less coverage. Medigap Plan A, for example, offers more “bare bones” protection—but it does cover most Medicare Parts A and B coinsurance, which is where most of the big, unpredictable expenses are likely to lie.

Enroll on time and find your policies

Enroll in Medicare before you turn 65

Regardless of which Medicare option you choose, you will need to make that choice in a timely manner. Otherwise, you could encounter periods when you don't have coverage, and you may face premium penalties for the rest of your life. Medicare eligibility begins at age 65, but to begin receiving benefits then, you must enroll before you turn 65.

You have a seven-month initial enrollment period that extends from three months before your birth month to three months after it. As **Figure 4** shows, to begin Part A or Part B coverage in the month you turn 65, the best time to enroll is during the three months before your birth month. If you miss that window, there will be a delay before your coverage kicks in. If you then delay beyond the end of the third month after your birth month, you won't be able to enroll until the next general enrollment period for new enrollees (January 1 through March 31 each year), and your coverage will not take effect until July 1 of the year you enroll. Having a gap in coverage could prove very costly if something happens when you are not covered.

Not signing up during the initial enrollment period triggers lifetime premium penalties. For Part B coverage, a penalty of 10% of premiums is charged for each year of delay. For Part D coverage, you face a penalty of 1% of premiums for each month of delay. These penalties are assessed for the rest of your life, for as long as you remain enrolled.

You are allowed to defer enrollment past age 65, but only if you or your spouse are still working and you have employer-provided health coverage. With a deferment, you are assigned a special enrollment period that continues while you work and extends for eight months after your employment or coverage ends. If you want to make sure that you don't have a gap in coverage, you will want to enroll before you leave your employer plan. Note that some company plans may require you to sign up for Medicare as your primary insurance (typically if your employer has fewer than 20 employees). Consult with your employer to find out the best way to coordinate your job-related benefits with Medicare.

FIGURE 4.

To avoid gaps in coverage, enrollees should sign up before the month they turn 65

If you sign up for Part A and/or Part B...	...your coverage starts:
Before the month you turn 65	● The first day of your birth month
During the month you turn 65	● 1 month after your birth month
Up to 1 month after the month you turn 65	● 2 months after your birth month
Up to 2 months after the month you turn 65	● 3 months after your birth month
Up to 3 months after the month you turn 65	● 3 months after your birth month
During the general enrollment period (January 1 through March 31 of any subsequent year after you turn 65)	● July 1 of the year you enroll

Source: www.medicare.gov.

Unless you are actively contributing to an HSA, you may choose to sign up for Part A at age 65 even if you are still employed. (It’s free for most enrollees anyway.) If you participate in an HSA, you must stop contributing to it six months before your Medicare benefits become effective. You can still use your accumulated HSA balance to pay for qualifying expenses, including your Medicare premiums and expenses not covered by Medicare, such as long-term care or dental services. You cannot, however, use the balance to pay for Medigap policy premiums.

Medigap policies have a slightly different enrollment window. The initial enrollment period lasts for six months and begins once you are 65 and enrolled in Medicare Part B. As with Medicare, missing the enrollment window for buying Medigap policies can prove costly. That’s because during your initial enrollment period, the companies that provide Medigap insurance are not allowed to use medical underwriting to determine whether to cover you or how much to charge for your coverage—but after that period, they can, in most states, deny coverage or charge a higher rate based on your health status. It’s important to know the “guaranteed issue” policy in your state to know how this situation may or may not apply to you.

Shop for the right policy

Once you have an idea of the types of policies that you are interested in and you are approaching or are in your initial enrollment period, you will need to choose the insurers you want to use and policies you want to buy. As you begin this process, keeping a few important points in mind will help you organize your tasks:



You need to have a full list of your current medications

Getting the right prescription drug plan, whether that is a separate Medicare Part D plan or a Medicare Advantage plan that includes prescription drug coverage, is crucial. Different insurers cover different drugs at different levels, so have an up-to-date list of your medications on hand as you shop.



Coverage choices vary by area

Medicare has a very useful online tool for finding the best Part D and Medicare Advantage coverages where you live, based on your current prescriptions.⁶ Enter your zip code, the drugs you take, and your pharmacy, and the tool lays out the costs of different coverage options. The tool can also help you understand the Medigap options and premiums in your area.



Policies have different pricing models

When comparing prices of different policy options, understand how the various policies you are considering are rated. Is the policy priced using attained age, issue age, or community pricing? Attained age means that each year, the policy is priced based on the age you are today. At age 65, this would be the least expensive of the options, but the price could increase rapidly as you age. Issue age means that it is priced based on the first year you purchase the policy and will not increase because of age after that, although prices can still change for inflation. Community pricing means that everyone gets the same price, regardless of age, and any increases will also be the same across the board.



Free help is available

Every state has a State Health Insurance Assistance Program (SHIP), which offers free, personalized counseling about Medicare options and rules, and can help you navigate other state-specific benefits you may be eligible for.⁷ You may also be able to find information from your state insurance department or your local Area Agency on Aging.⁸

⁶ The tool can be found at www.medicare.gov/plan-compare/#/?year=2022/.

⁷ See www.shiptacenter.org/.

⁸ See www.n4a.org/.

Revisit your choices every year

Each year from October 15 through December 7, Medicare has an open enrollment period for current enrollees. Use this time to review your coverage and whether it still suits your needs. It's particularly important to look at your prescription drug coverage. Do you still have the best coverage based on the drugs you take? Insurance carriers can and do change their formularies, preferred provider pharmacies, and prices each year. A majority of Medicare beneficiaries fail to make sure their coverage will still meet their needs (Freed et al., 2020).

It's also a good time to consider if any of your priorities have changed, making you prefer a different type of coverage. Maybe you thought you'd be okay with the limitations of a Medicare Advantage plan, but you found those limitations to be a bigger hindrance than expected and now know that you need more flexibility. If so, you may want to choose a different carrier or switch back to Original Medicare coverage. Or you may decide that you want to enroll in a Medicare Advantage plan for the first time.

Note, however, that if you want to make a switch that involves new Medigap coverage, you may have to go through underwriting to purchase the Medigap policy. This means that insurance providers may be able to charge higher premiums or deny you coverage entirely.⁹ To avoid gaps, it's a good idea to apply for a Medigap policy before your current coverage has ended; that way, you can start using your Medigap coverage the day after your current coverage ends, and you won't have let one coverage lapse before knowing you had other coverage.

⁹ In some situations, you may have guaranteed issue rights, which allow you to purchase certain supplemental plans without medical underwriting. These situations usually occur because you lose your current coverage because of a situation that is beyond your control. There is also a special "trial period" provision for Medicare Advantage plans that provides guaranteed issue rights. Some states also provide additional circumstances when these rights apply.

Conclusion

Choosing your Medicare coverage is a daunting task. You can, however, quickly pare down the many options to a select few by deciding how much importance you place on affordability, flexibility, worst-case-scenario coverage, and cost predictability. No plan will be the best for everyone, and the best plan for you may not be the one you think of first.

Once you've narrowed your choices, shop carefully for the policies that make the most sense for you—and enroll on time. Revisit your choices annually to ensure that your priorities and your coverage are always in line with each other.

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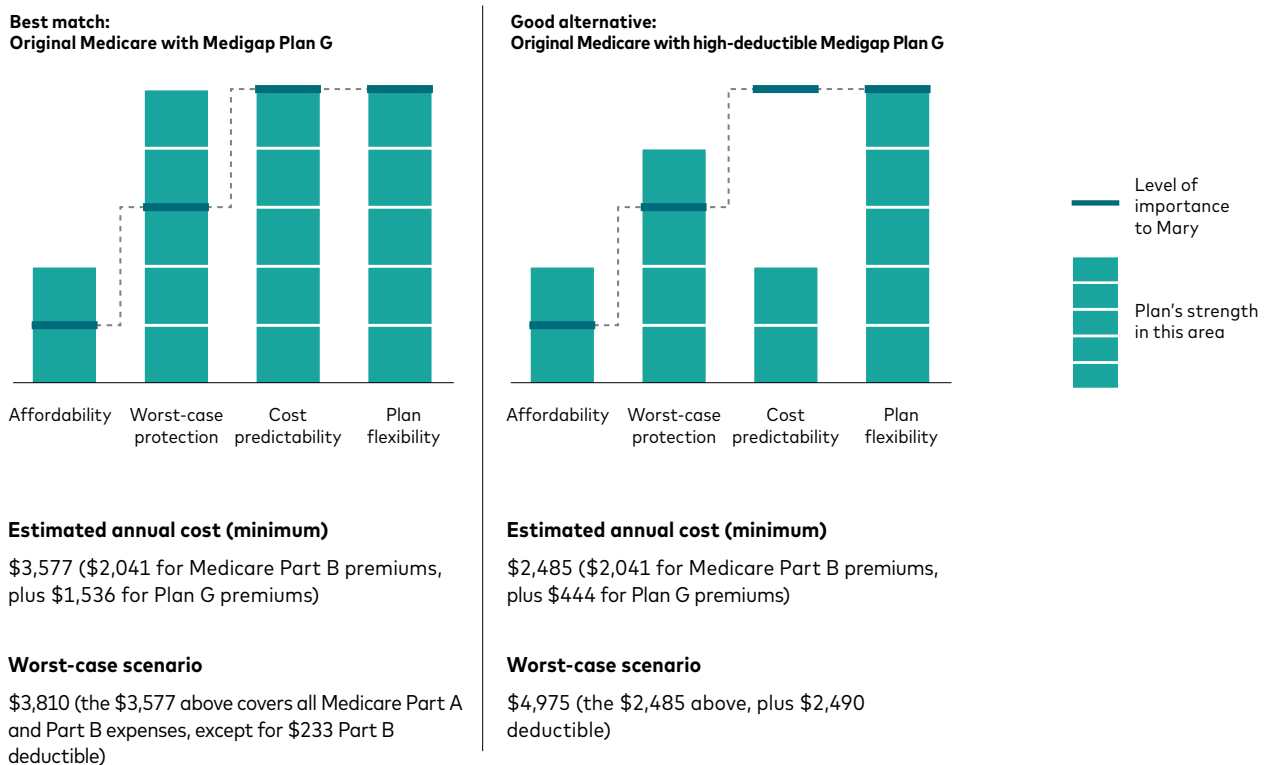
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Appendix A. Case studies¹⁰

Mary: Health concerns and a desire for convenience

Mary has a chronic medical condition. Although it's usually under control, there are stretches of time when she does not feel well and has to visit the doctor frequently. She and her doctor are watching for innovative treatments that may help her in the future. Mary is not very concerned about cost, as long as she knows there is some reasonable limit if things get worse. Rather, her biggest priority is to make sure that when she needs to, she can see whomever she needs to see, for whatever treatment she needs, with the least amount of hassle.

FIGURE A-1.
Mary chooses Medigap for maximum flexibility



Note: The case study is hypothetical and for illustrative purposes only.

Source: Vanguard.

For Mary, the best fit is a first-dollar coverage plan, such as that found with Original Medicare, paired with supplemental insurance Plan G. Supplemental Plan G is generally expensive, but it covers every issue that she prioritizes. She will also need to be careful to find a Part D prescription drug plan that adequately covers her medications.

¹⁰ Premiums are based on the least expensive quote for a 65-year-old nonsmoking woman from www.medicare.gov for someone living in Los Angeles, California. Typical costs are likely to fall somewhere between premium costs and out-of-pocket maximums, depending on health care services used each year. Premiums and out-of-pocket costs for prescription drugs and dental, vision, and hearing expenses are not included in these examples.

If Mary is willing to pay some costs out of pocket, she could choose Original Medicare with high-deductible Plan G instead, which would save her more than \$1,200 per year in premiums. But she might end up paying more in years where her costs are high.

Ben: Healthy and unworried

Ben is in great health, doesn't take any medications regularly, and generally sees a doctor only for his annual checkup or when something happens, like the time he injured his knee at the gym. He is aware that he is lucky in this respect and wants to be protected if something happens, but mostly he just wants to spend as little as possible on health insurance he doesn't use much. The idea of extra benefits, such as gym membership and dental, vision, and hearing coverage, appeals to him, because those are things he can use, and why pay extra for them if they can be included? He is willing to be part of a health care network; after all, he was part of one when he was working and never had a problem with it.¹¹

FIGURE A-2.
Ben chooses a low-cost Medicare Advantage policy



Note: The case study is hypothetical and for illustrative purposes only.
Source: Vanguard.

¹¹ Deductibles and deposits may vary by MSA plan.

Ben is likely to be well-served by a Medicare Advantage plan. His primary concern is cost, and there are many plans that can be had with no premiums (other than Part B premiums). For Ben, this is a particularly good option from a cost standpoint, because it also provides prescription drug coverage that he might not want to pay for separately—and not having that coverage would subject him to penalties that would make future benefits more expensive. The possibility of additional coverage for dental, vision, and hearing is also a bonus. Finally, Medicare Advantage plans also have an out-of-pocket maximum, so he knows that there is a limit to what he would owe if the worst ever happened.

Ben might also consider choosing an MSA plan if there is one available where he lives. As someone with a low risk of health care costs, he is a perfect candidate for this type of plan. Because he spends little on health care, he is likely to be able to build up his MSA against future years when his health care costs may go up.¹² He would, however, need to purchase a separate Part D policy for prescriptions if he goes this route.

¹² MSA contributions are not forfeited if they are not used in the year they are made; instead, they remain in the account. In addition, the unspent balance of an MSA can be invested in mutual funds.

Appendix B. Medigap coverages

Figure B-1 shows basic information about the benefits covered by Medigap policies.

FIGURE B-1.
Medigap plans and what they cover

Medigap benefits	Medigap plans									
	A	B	C*	D	F*,^	G*,^	K	L	M	N
Part A coinsurance; hospital costs up to an additional 365 days after Medicare benefits are used up	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Part B coinsurance or copayment	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes*
Blood (first three pints)	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Part A hospice care coinsurance or copayment	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Skilled nursing facility care coinsurance	No	No	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Part A deductible	No	Yes	Yes	Yes	Yes	Yes	50%	75%	50%	Yes
Part B deductible	No	No	Yes	No	Yes	No	No	No	No	No
Part B excess charge	No	No	No	No	Yes	Yes	No	No	No	No
Foreign travel exchange (up to plan limits)	No	No	80%	80%	80%	80%	No	No	80%	80%
Out-of-pocket limit	NA	NA	NA	NA	NA	NA	\$6,260*	\$3,310*	NA	NA

■ Yes = The plan covers 100% of this benefit
□ No = The plan doesn't cover this benefit
■ 80% ■ 75% ■ 50% = Percentage of benefit covered by plan
 NA = Not applicable

- * Plans C and F are no longer available for people who became eligible for Medicare after January 1, 2020.
- ^ Plans G and F also offer a high-deductible plan. If you choose this option, you must pay for Medicare-covered costs up to the deductible amount of \$2,490 before your Medigap plan pays anything. The Part B deductible counts toward that amount for Plan G.
- + Plan N pays 100% of the Part B coinsurance, aside from copayments of up to \$20 for some office visits and copayments of up to \$50 for emergency room visits that do not result in inpatient admission.
- * Each year, after you meet your out-of-pocket limit and your Part B deductible, the Medigap plan pays 100% of covered services for the rest of the calendar year.

Notes: Excess charge refers to the fact that some providers may charge up to 15% more than the amount Medicare pays for. Foreign travel exchange refers to payment for certain medically necessary emergency medical care in the first 60 days of travel, subject to a \$250 deductible and \$50,000 lifetime limit. If you live in Massachusetts, Minnesota, or Wisconsin, different Medigap policies apply, and the classification system is different.

Sources: Vanguard, based on a table available at www.medicare.gov.

Author



Stephen M. Weber,
CFP®

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