MASSBAR ASSOCIATION

2018 ELDER LAW EDUCATION PROGRAM
Taking Control of Your Future: A Legal Checkup

NINTH EDITION




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CHAPTER 5

MEDICARE

What You Need to Know

INTRODUCTION

Medicare is a health insurance plan administered by the federal government through the Centers for Medicare and Medicaid Services (CMS). It serves more than 55 million people (as of 2015) and was established in 1966 under Title XVIII of the Social Security Act. This vast program serves U.S. citizens and legal residents 65 years or older and people under 65 years with certain disabilities. The "Medicare and You" 2018 guide, available from CMS, is an excellent reference.[1]

Starting in April 2018 through April 2019, Medicare will automatically send new cards for Medicare Parts A and B to beneficiaries. The card will arrive in the mail automatically. The new card will not use your Social Security number, but instead a new special Medicare number that only you have. This change will not affect your Medicare account, but does help protect you from fraud. You will **NOT** receive a telephone call from Medicare concerning this new card.

A. What are the Different Parts of Medicare?

Medicare has four different parts: Medicare Part A, Medicare Part B, Medicare Part C and Medicare Part D. These Parts are separate from each other, cover different health care and have different rules.

1. **Part A:** Helps cover inpatient hospital services, including a semi-private room, meals, general nursing services, some home health care, some skilled nursing facility care and hospice (both with some limitations) and most inpatient drugs.
2. **Part B:** Helps cover services from doctors and other health providers, some preventative care, emergency department visits, medically necessary outpatient services, lab work, durable medical equipment and ambulance services.
3. **Medicare Part C (Medicare Advantage):** Includes all the benefits and services under Parts A and B; it may include Medicare prescription drug coverage; is run by private health insurance companies; may include extra benefits and services and for an extra cost, such as vision, hearing and dental coverage, which are not covered by original Medicare. Generally you are in a network and must use the providers in that network for your health care.
4. **Medicare Part D:** Helps cover the costs of prescription drugs. If you have Part A, Part B and some types of Part C, you must enroll in Part D to have prescription drug coverage.

Part A and Part B are called "Original Medicare." Under Original Medicare, you can choose any available provider who accepts Medicare. Your physicians can participate in an "Accountable Care Organization," also called an "ACO." In an ACO, your doctors coordinate your care and share your medical records, which means you don't have as many repeated tests. An ACO cannot tell you which providers you must see or change your Medicare benefits.[2] You can purchase a Medicare Supplement, also called Medigap, if you have Original Medicare, including an ACO.[3] You may automatically qualify for Part A (read below), but you must sign up and pay a monthly premium for Part B. You must also sign up for Part D if you want prescription drug coverage.

Medicare Advantage Plans cover Part A, hospital and Part B, medical benefits, and are available from private insurers. They can have a range of premiums, costs and rules, and typically offer prescription drug coverage. You usually pay your Part B premium in addition to the Medicare Advantage Premium.[4] For example, a Medicare Advantage plan can be purchased from a Health Maintenance Organization (HMO), which restricts you to the doctors, other health care providers and hospitals in its network. There are special rules for emergencies. Under an HMO, you must have a primary care physician, who must authorize referrals before you can see specialists.[5]

Medicare Advantage plans are also sold by Preferred Provider Organizations (PPOs). PPOs establish a network of physicians for whom you pay less than if you go outside the network. A PPO plan isn't the same as Original Medicare with a Medigap Supplement; usually you pay extra for the additional benefits.[6]

Private Fee for Service Plans (PFFS) are another form of Medicare Advantage option. Under a PFFS plan, you can go to any Medicare-approved doctor; there is no network or restrictions. However, a doctor does not have to agree to treat you under a PFFS plan, even if the doctor has treated you before. The PFFS plan works differently than Original Medicare. The PFFS plan determines how much it will pay doctors, other health care providers and hospitals, and how much you must pay when you get care.[7]

Finally, Part C, Medicare Advantage, includes Special Needs Plans (SNP), which are limited to people with specific conditions.[8] Before you decide on a Medicare Advantage Plan, you should compare the costs. There is an online cost calculator and plan comparison tool run by CMS, at www.medicare.gov/find-a-plan/questions/home.aspx.

When you have a Medicare Advantage Plan, you cannot get Medigap insurance to cover your deductibles, copays and co-insurance.[9] You can use a Medicare Medical Savings Account (MSA) if you have a high-deductible Medicare Advantage Plan. You contribute nothing to the MSA. Medicare deposits money in your MSA to apply against the high deductible costs of your Medicare Advantage Plan. The Advantage Plan that you choose describes how much Medicare pays into the MSA. Any money left in the account at year end can be used towards next year's deductible, in addition to whatever Medicare contributes to the account for the new year. To avoid income taxes on withdrawals from your MSA, you must file Form 8853 with your Form 1040 income tax return, listing your qualified medical expenses (generally, expenses eligible for coverage under Parts A and B of Medicare). If you use all of the money in your MSA account and you have additional health care costs in a year, you'll have to pay for your Medicare-covered services out-of-pocket until you reach your Advantage Plan's deductible. You may use your MSA to pay for prescription drugs, but that does not count toward your deductible. So you may want to add drug coverage through a Medicare Prescription Drug Plan if you choose a Medicare Advantage Plan.

B. Am I Eligible for Medicare and How Do I Sign Up/Enroll?

- To be eligible for Medicare, you must be a U.S. citizen or a legal resident.
- If you are already getting benefits from Social Security or the Railroad Retirement Board, you will automatically get Part A and Part B starting the first day of the month you turn 65. If you are not already receiving those benefits, you will need to contact Social Security three months before your 65th birthday during the initial enrollment period. The initial enrollment period is the seven-month period that begins three months before you turn 65, and ends three months after you turn 65.
- Most people need to enroll in Medicare. You must contact Social Security three months before your 65th birthday during the initial enrollment period.[10] As stated above, the initial enrollment period is the seven-month period that begins three months before you turn 65, and ends three months after you turn 65.
    - If you have End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS) you also need to enroll, but you do not need to be 65.[11] Individuals under age 65 with disabilities other than ESRD or ALS must have received Social Security Disability benefits for 24 months before becoming eligible for Medicare. A five-month waiting period is required after a beneficiary is determined to be disabled before a beneficiary begins to collect Social Security Disability benefits.

      Individuals with ESRD and ALS, however, do not have to collect Social Security Disability benefits for 24 months in order to be eligible for Medicare. Individuals with ESRD are eligible for Medicare generally three months after a course of regular dialysis begins or after a kidney transplant. Individuals suffering from ALS are eligible for Medicare coverage immediately upon approval for Social Security Disability benefits (but after the five-month waiting period).

CAUTION: If you do not sign up for Part A and/or Part B during the initial enrollment period,

or when you are first eligible, your monthly Part B premium may increase 10 percent for each year you delayed as a late enrollment penalty. This increased premium is permanent. In addition, there is a coverage gap. You can sign up between Jan. 1 and March 31 of the following year, however, coverage only begins on July 1. If you do not enroll in Part A and B when you are first eligible, or when you lose your employer health insurance, you may have to pay a late enrollment penalty for as long as you have Medicare.

C. What if I am Turning 65, Still Working and Have Health Insurance From My Employer?

Full retirement age for Social Security benefits is now based on the year you were born, and the age when full benefits starts increasing. For those born between 1943 and 1954, the full retirement age is 66, and more benefits are available at age 70 *(see Chapter 12)*. Consequently, many people work beyond 65. If you are turning 65, still working and have health insurance coverage through your employer, there are additional considerations.

"By law, people who continue to work beyond age 65 still must be offered the same health insurance benefits (for themselves and their dependents) as younger people working for the same employer."[12,13] Your employer cannot require you to enroll in Medicare when you turn 65 or offer you a different kind of insurance, unless your employer has less than 20 employees. Generally, working people who have paid enough in Medicare taxes enroll in Part A, because they will not pay premiums. If your employer has fewer than 20 employees, Medicare is primarily responsible for your health care costs. The group health plan pays secondarily, after Medicare, up to covered costs. So in this case, if you fail to enroll in Medicare when you are first eligible, you may have little or no health coverage.

You may have had a Health Savings Account (HSA) with your employer group health insurance. This is an account used with a high deductible employer insurance to pay for uninsured medical costs on a pre-tax basis. If you are covered under either Part A, Part B or Part C of Medicare, you may no longer contribute to an HSA, but you can withdraw funds from an established HSA. HSA withdrawals that are used for qualified medical expenses are not taxable. But HSA withdrawals for other purposes are subject to tax (and, if the HSA owner is under age 65, a 20 percent penalty). Note that if you do not enroll in Medicare when you first qualify, you must stop all contributions to your HSA up to six months before collecting Social Security.[14] If you contribute to an HSA during the period you are retroactively covered under Medicare, you can now avoid a penalty by distributing from the HSA the monthly amounts attributable to your period of retroactive Medicare coverage.

If you do enroll in Part A while working, and you still keep your group insurance plan, you can delay enrolling in Part B. Be sure to notify your providers of your eligibility for Part A when seeking care. When you leave work, you will have a special enrollment period to enroll in Part B. You can enroll any time when you are still covered by the group health plan and during the eight-month period that begins after the employment ends or the coverage ends, whichever happens first.[15]

Be sure to sign up for Medicare Parts A and B (and also Medigap, as discussed on page 28) when first eligible or upon losing employer group coverage. Those who go for extended periods of time without credible coverage may be assessed a late enrollment penalty upon electing Part B at a later date. Your monthly premium for Part B will go up 10 percent for each full 12-month period that you could have had Part B, but did not sign up for it. It is generally not advisable to go without coverage "until needed" to save the monthly premium costs.

You cannot have two different insurances pay the same amount on a bill. One insurance will pay some money first, and then the second insurance will pay some money. For more information when you have two insurances, see "Your Guide to Who Pays First," from www.Medicare.gov.

D. Medicare Cost Shares/Coverage Limitations

Medicare does not pay all medical bills; for many services, the consumer (often referred to as the Medicare beneficiary) is liable for a portion of the cost of services received.

You have contributed to the Medicare program throughout your working life through payroll taxes and through income taxes. Those taxes cover the bulk of the Medicare program costs, but as a beneficiary, you do have some premiums, deductibles, co-insurance and co-pays.

2018 Costs at-a-Glance	
Part A premium	Most people don't pay a monthly premium for Part A. If you buy Part A, you'll pay up to $422 each month.
Part A hospital inpatient deductible and co-insurance	You pay: • $1,340 for each benefit period • Days 1–60: $0 co-insurance for each benefit period • Days 61–90: $335 co-insurance per day of each benefit period • Days 91 and beyond: $658 co-insurance per each "lifetime reserve day" after 90 for each benefit period (up to 60 days over your lifetime) • Beyond lifetime reserve days: all costs
Skilled nursing facility stay when Medicare Part A eligible	• First 20 days: $0 for each benefit period • Days 21–100: $167.50 co-insurance per day of each benefit periodper day of each benefit period • Days 101 and beyond: all costs
Part B premium	The standard Part B premium is $134 (or higher depending on your income); those in the highest bracket pay $428.60 per month.
Part B deductible and co-insurance	$183 per year. After your deductible is met, you typically pay 20 percent of the Medicare-approved amount for most doctor services (including most doctor services while you're a hospital inpatient), outpatient therapy and durable medical equipment.
Part C premium	The Part C monthly premium varies by plan. Compare costs for specific Part C plans.
Part D premium	There are now two types of Part D monthly premiums. One must be paid to the insurance plan, to obtain the insurance. This amount varies by plan. There is also an income-adjusted premium where higher-income consumers pay more. This premium, called the Medicare Part D IRMAA, is paid directly to Medicare and NOT to the insurance company. Social Security determines if you owe this extra premium, which can range from $13.30 per month to $76.20 per month. Compare costs for specific Part D plans.
Home Health Care	Whether under Part A or Part B: $0 for home health care services; 20 percent of the Medicare-approved amount for durable medical equipment.
Hospice Care	$0 for hospice care.

(Source: www.medicare.gov)

There is a small co-payment of $5-$10 for each prescription drug and similar products for pain relief and symptom control. You can also use your Part D plan to cover this. Medicare does not cover room and board when you get hospital care in your home or another facility where you live (like a nursing home).

Part A has a deductible of $1,340 (for 2018) for inpatient services. Additionally, there is a fixed limit on inpatient hospital and skilled nursing facility days in each period. The Part A benefit period does not automatically renew each year. Medicare does not pay for custodial care, which is non-skilled personal care, like bathing, dressing, feeding, getting out of bed, or using the bathroom. Because these services are not Medicare-approved, Medigap will not pay either.[16] However, Medicare is required to provide skilled nursing services if the beneficiary needs the services, even if the beneficiary's condition does not improve with the services.[17]

Part B has a $183 deductible before providing coverage for covered services. Once the deductible is satisfied, Part B only pays 80 percent of the cost of the majority of covered services; limited office visits have co-pays. Furthermore, Original Medicare generally does not cover the prescription medicines you would normally pick up at a pharmacy.

Many Medicare beneficiaries express concern that the deductibles, the 20 percent Part B co-insurance (without a cap or out-of-pocket maximum), the costs of Part A hospital and skilled nursing facility days and the lack of prescription coverage may cause major financial difficulties in the case of a medical issue. To address these concerns, Medicare beneficiaries have opportunities to obtain some additional coverage.

E. Options to Enhance Original Medicare Coverage

1. Buy a Medigap Plan for Supplemental Insurance

Medigap plans cover the deductibles, co-pays and co-insurance you owe under Original Medicare A and B. Medigap does not give you more coverage than Original Medi-

care. For example, under Part A, you would have up to 100 days in a skilled nursing facility (rehabilitation center). You would pay nothing for the first 20 days, and co-insurance of $164.50 per day for days 21 through 100. A Medigap plan will pay the co-insurance of $164.50 per day for all of the days when you qualify for Medicare coverage, but will not pay for any Medicare coverage beyond the 100 days. Medigap will not pay if you do not qualify for the skilled nursing facility, even if you have not used all your days. You have to pay a premium for Medigap plans. If you do not enroll in a Medigap plan when you first enroll in Medicare, you may not be able to buy a Medigap plan after. You may have to take a physical, and it may cost considerably more.[18]

Massachusetts offers two options of Medigap plans: the Core plan and Supplement 1.[19]

1) **Core:** The Core plan is the less expensive of the two options and covers the Part B co-insurance amount, paying for the 20 percent of approved amounts that Part B would normally require the Medicare beneficiary to pay out of pocket. With this option, policyholders would still pay the Part A and Part B deductibles out of pocket.
2) **Supplement 1:** Like the Core plan, this option covers the Part B co-insurance amount. Additionally, the Supplement 1 covers the Part A and Part B deductibles, providing more robust coverage than the Core plan. Due to the enhanced coverage, the Supplement 1 premiums are higher than the Core plan offerings.

The Advantages and Disadvantages of Medicare Supplements

- With Medicare supplements in Massachusetts, policyholders generally have low out-of-pocket costs when receiving covered services and flexibility in choosing providers.
- To obtain these benefits, though, policyholders must pay a premium to the insurance company (which may exceed $200 per month).
- Also, the supplements do not cover most prescription medicines. In many cases, retirees incur the additional cost of a Part D plan.

2. Part D: Buy a Medicare Part D Plan for Prescription Drug Coverage

Medicare Parts A and B, even with a Medigap Supplement, do not offer prescription drug coverage. Some, but not all, Medicare Advantage plans (Medicare Part C, see section 3) do not offer drug coverage. If you elect Medicare Parts A and B, or a C plan without prescription drug coverage, you should always consider whether Part D is right for you.

Medicare Part D is an option which provides prescription drug coverage to Medicare beneficiaries through a private insurance company. This program provides coverage for many common medicines which can be obtained at participating local pharmacies or mail order programs.

Coverage levels and monthly premiums vary by insurance company, but the basic structure and minimum coverage levels are specified by Medicare. Part D plans have four basic components:

1) **Deductible:** Some plans (especially lower premium options) have a deductible. A deductible is a dollar amount a policyholder must pay out of pocket before the insurance company pays benefits. The deductible may apply to all medicines the plan covers or only certain drugs (e.g., brand name medicines). Insurance companies may choose not to include a deductible; in such cases, coverage begins immediately.
2) **Initial Coverage Stage:** This stage provides benefits with a co-pay (fixed dollar amount) or co-insurance (percentage of cost) for covered drugs. Insurance providers classify medicines in tiers. Tiers are often divided in categories like preferred generics, non-preferred generics, preferred name brand, non-preferred name brand and specialty drugs. Generally, the higher the tier, the higher the policyholder's cost share. These co-pays change if the policyholder reaches the coverage gap.
3) **Coverage Gap:** The coverage gap goes into effect when the total cost of drugs used under the plan reaches $3,750 (2018 numbers) in one calendar year. This cost is based upon the total cost of the medicine (insurance payment plus co-pay). In the gap, policyholders generally pay more for their medicines, with the policy-

holder's cost of about 51 percent of the generic medicine cost and 40 percent of the name brand medicine price. Remember that brand name drugs are typically more expensive than generic. The examples on the Medicare website show a patient would pay $21.70 for a brand-name drug and $9.68 for a generic drug during the coverage gap.

4) **Catastrophic Coverage:** If a policyholder's out-of-pocket cost reaches $5,000 during 2018, the coverage gap is closed and the policyholder moves into the catastrophic coverage stage. As of publication, there were no prices on the CMS website but they are expected to be low. Please note, on Jan. 1, the plan resets for the new year, returning to the initial coverage stage (or deductible stage).

Part D Tiers, Formularies and Quantity Limitations

Each plan is required by Medicare to include certain classes of drugs, but the plans vary widely in what specific medicines are covered. It is very important to obtain the plan's formulary. The formulary lists each medicine covered and its tier. For many common drugs, there are major differences in coverage levels between insurance companies, so it makes sense to check the tier and quantity limitations for each of your medications with prospective insurance providers before enrolling. Note that an insurer cannot remove a therapeutic category (e.g., high blood pressure medication) during a plan year, but can remove any single drug from its coverage with 60 days notice to the insured.[20]

Please note that plans sometimes provide for formulary exceptions if a medically necessary medicine is generally not covered. In such cases, please contact the plan's customer service department and request a "formulary exception" to request your medicine is covered.

TIP: Your pharmacist can discuss insurance plans you research on the CMS website, but cannot market any specific plan to you. Select your Medicare Part D plan using the Medicare Part D plan finder tool, from the CMS website, found at www.medicare.gov/find-a-plan/questions/home.aspx. Recent studies show that some plans can cost up to $100,000 for the same drugs. If you take any single prescription that costs more than $600 a month, you should take great care to evaluate these plans. Mail order is not automatically cheaper than retail.

Late Enrollment Penalty for Part D

It is important to enroll in a Part D plan when first eligible or make sure you have credible coverage (or a Part C plan which includes Part D benefits). Those who fail to obtain coverage may be subject to substantial late enrollment penalties if coverage is desired later in life.

If you already have been accessed a late enrollment penalty, waivers may be available for those with lower incomes.

3. What Options are Available if Your Medicines are Still Too Expensive?

There are multiple options for retirees who have difficulty paying for medicines. Some notable options include:

1) **Explore alternative medicines with your pharmacist and doctor: Ask your regular pharmacist for a Drug Utilization Review (DUR), which is free. This report identifies duplicate drugs and suggests, drugs which may be more appropriate for you; then show this report to your doctor(s). Be sure that the DUR lists all the drugs you take, even those that you do not fill at that pharmacy.** Ask your doctor if a safe and effective generic medicine or an alternative therapeutic may work better for you. Often co-pays for generics can be more than 75 percent less than the brand-name medicines. Also, it may be possible to switch to a preferred brand-name from a non-preferred brand-name drug listed in the formulary to reduce co-pays. Of course, only consider changing in consultation with a medical professional.
2) **Local discount programs:** Some grocery stores and pharmacy chains offer discount programs which work in conjunction with your insurance plan. Please be sure to ask your pharmacist if your pharmacy offers such programs
3) **State pharmacy assistance:** Massachusetts offers a state pharmacy assistance program, Prescription Advantage, for those with lower incomes who do not otherwise qualify for MassHeath. This program provides out-of-

pocket maximums on co-pays and extra help in the coverage gap. Unlike Medicare Extra Help and MassHealth, there is no asset test; qualification is based upon income. You can reach Prescription Advantage at 1-800-AGE-INFO, option 2.

4) **Medicare Extra Help:** Medicare offers extra help to beneficiaries with lower income and assets. This program can reduce or eliminate your Part D premium and reduce co-pays. Application for this program can be made directly with Medicare.
5) **Veterans' Benefits:** The Veterans' Administration (VA) offers prescription benefit programs. For our readers who are veterans, please inquire with the VA to see if you qualify for benefits which may enhance the Part D benefit from your plan.
6) **Primary Outreach Programs**: Refer to the Pharmacy Outreach Program information on page 42.

4. Change from Original Medicare to Medicare Part C (Medicare Advantage)

While the CMS website will clearly state premiums, deductibles, co-pays and co-insurance, each Part C plan must be separately researched. The information about coverage options is found above. One limitation to consider is that not all Part C plans cover prescription drugs.

The website, www.Medicare.gov, lists all the Part C plans available in your area; the website identifies those Part C plans with drug coverage. The plan options vary by county of residence and all plans are not available in all areas. These plans may provide some major benefits such as:

- Out-of-pocket maximums;
- Reduced co-insurance amounts and co-pays for certain services;
- Coordination of care;
- Prescription drug benefits;
- Elimination of deductibles; and
- Low (or zero) monthly premiums.
- Star Rating — Pay particular attention to the star rating for both Part C and Part D plans; the star rating is a measure of quality.

These plans work similarly to employer-sponsored health insurance plans, often combining doctor, hospital, drug and additional services in one comprehensive plan.

Medicare Advantage plans are generally one-year programs. During each annual election period (usually starting in early October and ending in the first week of December), Medicare beneficiaries may change plans or disenroll from Part C and select other options (like stand-alone Part D plans), or return to original Medicare). Such changes take effect on Jan. 1.

During the year, there are options to change coverage if you have certain special circumstances. Some of the more common situations include:

1) Moving your primary residence outside the plan service area;
2) Obtaining/losing employer coverage;
3) Qualifying for MassHealth;
4) Obtaining a low-income subsidy;
5) Qualifying for state pharmacy assistance (Prescription Advantage); and
6) Enrolling in Part B.

In such circumstances, you may change plans with an effective date of the first of the following month.

F. Changing Medicare Plans

As long as you are enrolled in Medicare, you can change plans during the open enrollment period. This generally becomes available in early October, and decisions must be made by early December. The new plans go into effect Jan. 1. In certain circumstances, you can switch between Medicare Part D plans during the year; consult "Medicare and You" for further information.

G. Comparing Insurance Providers

When shopping for Medicare Part C, Part D and Medigap supplements, it is important to compare premiums among insurance companies. As coverage is standardized, please consider the following criteria when evaluating options:

- **Consider customer service quality and reputation:** Are claims processed accurately and are you able to obtain prompt and professional service when questions arise?

- **Premium consistency:** By how much do rates tend to change annually? How will those changes impact your budget?
- **Discount programs and value-added services**: Does the insurance company you are considering offer any discounts (based upon age, paying by automatic bank draft) or savings programs for dental or vision?

CONCLUSION

Navigating the Medicare system is confusing, but there are resources available to help. Please be sure to consult www.Medicare.gov, particularly "Medicare and You," or call 1-800-MEDICARE for detailed information, consult your trusted advisers and request written information from insurance companies before enrolling in any plan. Below is a chart of Medicare benefits and costs for Part A and Part B.

MEDICARE PART A: 2018

SERVICES	BENEFIT	MEDICARE PAYS	YOU PAY[1]
Hospitalization: • Semiprivate room and board • General nursing • Other hospital services and supplies (Medicare payments based on benefit periods)	First 60 days	All but $1,340	$1,340 (deductible)
	61st to 90th day	All but $335/day	$335 (co-insurance)/day
	91st to 150th day[2] (lifetime)	All but $670/day	$670 (co-insurance)/day
	Beyond 90 days (or 150 days if lifetime is used)	Nothing	All costs
Skilled Nursing Facility Care: (Have to be in hospital for 3 days beforehand) • Semiprivate room and board • Skilled nursing and rehabilitative services • Other services	First 20 days	100 percent of approved amount	Nothing
	Additional 80 days	All but $167.50/day	$167.50/day (co-insurance)
	Beyond 100 days	Nothing	All costs
Home Health Care: • Intermittent skilled nursing care • Physical therapy, speech language, pathology services • Home health aide services • Durable medical equipment (e.g., wheelchairs, hospital beds, oxygen and walkers) • Other services and supplies • No custodial care (must be recovering)	Unlimited as long as you meet Medicare conditions	• 100 percent of approved amount • 80 percent of approved amount for durable medical equipment	• Nothing for services • 20 percent of approved amount for durable medical equipment
Hospice Care: • Pain and symptom relief • Support services for the management of mental illness • DNR	For as long as doctor certifies need (6 months to live or less)	All but limited costs for outpatient drugs and inpatient respite care	Limited costs for outpatient drugs ($5 co-pay) and inpatient respite care (5 percent of approved amount)
Blood: Blood paid for or replaced under Part A of Medicare during the calendar year does not have to be paid for or replaced under Part B and vice versa.	Pints 1 – 3	Nothing	Patient must pay for 1-3 or have them replaced (self or usually family member)
	Pints 4 and over	All	Patient deductible is satisfied at 3 pints.

2018 Part A Monthly premium: $422 if the beneficiary has worked less than 40 quarters in Medicare-covered employment. Most beneficiaries do not pay a premium for Part A. This premium is paid for the entire time the person is on Medicare Part A. The Part C monthly premium varies by plan. Compare costs for specific Part C plans.

1. You must pay the amounts listed in the "You Pay" column; Medigap insurance will only pay the deductibles and co-insurance, but does not cover services Medicare itself doesn't cover. For example, Medigap will NOT add additional days to the Skilled Nursing benefit; when Medicare stops at 100, so does Medigap. You must pay the amounts listed in the "You Pay" column; Medigap insurance will only pay the deductibles and co-insurance, but does not cover services Medicare itself doesn't cover. For example, Medigap will NOT add additional days to the Skilled Nursing benefit; when Medicare stops at 100, so does Medigap.
2. You must pay the amounts listed in the "You Pay" column; Medigap insurance will only pay the deductibles and co-insurance, but does not cover services Medicare itself doesn't cover.

Medicare "beneficiaries" receive "medically necessary and reasonable" (least expensive) treatment. Not all services/tests are provided under Medicare.

MEDICARE PART B: 2018			
SERVICES	**BENEFIT**	**MEDICARE PAYS**	**YOU PAY**
Medical Expenses: • Doctor services, inpatient and outpatient • Surgical services and supplies • Podiatrist services • Physical, occupational and speech therapy • Diagnostic tests (e.g., X-rays, hearing exams) • Durable medical equipment • Urgent and emergency services (including ambulances)	Unlimited if medically necessary	• 80 percent of approved amount after $183 deductible • 50 percent for most outpatient mental health	• $183 deductible (pay once per year) • 20% of approved amount after deductible (except outpatient) • 20–40 percent for outpatient mental health • 20 percent for all physical and occupational therapy
Clinical Laboratory Services: • Blood tests, urinalysis, and more	Unlimited if medically necessary	• 100 percent of approved amount	• Nothing for services
Home Health Care (if you don't have Part A): • Intermittent skilled care • Home health aide services • Durable medical equipment • Other services and supplies • No custodial care – must be recovering	Unlimited as long as you meet Medicare conditions	• 100 percent of approved amount • 80 percent of approved amount for durable medical equipment	• Nothing for services • 20 percent 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 cost	• 20 percent of Medicare payment amount (after $183 deductible)
PREMIUMS (2018)[3] — Premiums are "means adjusted." $109 annual premium for individuals who have modified adjusted incomes of $85,000 or less (or $170,000 or less for joint filers) and have the SSA withhold their Part B premium.			
All others:	Premium*	Income Level (Individual)	Income Level (Joint)
	$134	$85,000 or less	$170,000 or less
	$187.50	$85,001–$107,000	$170,001–$214,000
	$267.90	$107,001–$133,500	$214,001–$267,000
	$348.30	$133,501–$160,000	$267,001–$320,000
	$428.60	Above $160,000	Above $320,000
*PREMIUM MAY BE HIGHER IF YOU ENROLL LATE			
MEDICARE PART C: MEDICARE "ADVANTAGE" – MANAGED CARE PLAN MEDICARE PART D: PRESCRIPTION DRUG BENEFIT			
3. Part B premiums must pay for 25% of Part B costs, including reserves. Gov't pays 75% ; Premium increase cannot exceed Cost of Living Adjustment in SSI for elderly.			

from: https://www.massbar.org/docs/default-source/elder-law-education-guides/2018-elder-law-program-taking-control-of-your-future.pdf?sfvrsn=10