

Medicare Cost-Sharing Requirements for 2009

Important Changes for 2009

- ✓ Beneficiaries now have 1 year from initial eligibility to have the Welcome to Medicare physical exam. In addition, the Part B deductible does NOT apply to the exam.
- ✓ The Part A deductible is \$1,068 per benefit period, up from \$1,024 in 2008.

Medicare Cost-Sharing Requirements for 2009			
Services	What Medicare Covers	What Beneficiary Pays in 2009	
Part A		Deductible	Coinsurance
Hospital care	Inpatient Care for up to 90 days per benefit period ¹ , plus 60 lifetime reserve days ²	Yes, Part A Deductible is \$1,068 per benefit period	None for first 60 days \$267/day for days 61-90 \$534/day for days 91-150
Post-acute care	Skilled Nursing Facility care, up to 100 days per illness, following a hospitalization of at least 3 consecutive days	Yes	None for first 20 days \$133.50/day for days 21-100
	Home Health care visits, if beneficiary meets eligibility rules	No	None
	Hospice care, if beneficiary meets eligibility rules	No	5%/day co-pay for respite care
Part B			
		Part B Deductible is \$135 per year	Premium - \$96.40 per month ³
Physician services	Physician office visits, outpatient hospital visits, surgical services	Yes	20% of approved amount ⁴
Emergency room services	Visits to Emergency Room	Yes	20% of approved amount
Laboratory tests (e.g. blood, urinalysis)	Medically necessary diagnostic laboratory tests ordered by a doctor or other approved clinician	No	None
Imaging and scans	Medically necessary imaging or scan, such as x-rays or MRIs, ordered by a doctor or other approved clinician	Yes	20% of approved amount

continued next page

Medicare Cost-Sharing Requirements for 2009

Medicare Cost-Sharing Requirements for 2009			
Services	What Medicare Covers	What Beneficiary Pays in 2009	
Part B (continued)			
<i>Mental health</i>	Professional mental health treatment such as individual or group psychotherapy; partial hospitalizations as a part of outpatient psychiatric treatment	Yes	50%
<i>Medical equipment and supplies</i>	Durable medical equipment such as wheelchairs, oxygen, or walkers	Yes (unless provided as part of an inpatient benefit period)	20% of approved amount
	Orthotics and prosthetic devices such as artificial limbs	Yes (unless provided as part of an inpatient benefit period)	20% of approved amount
	Medical supplies such as surgical dressings	Yes (unless provided as part of an inpatient benefit period)	20% of approved amount
<i>Physician-administered drugs</i>	Certain drugs typically administered by a clinician in a hospital outpatient department or clinician's office	Yes	20% of approved amount
Part C			
<i>Regular Medicare Part A and B services</i>	All Medicare Advantage and private fee-for-service plans must cover all regular Medicare services shown above	Varies by plan	Varies by plan
<i>Additional benefits</i>	Plans may offer additional benefits, including vision, dental, etc.	Varies by plan	Varies by plan
Part D			
<i>Prescription drugs</i>	Prescription drugs not covered under Part B, except excluded drugs	Standard deductible is \$296 per year (individual plan may waive deductible)	Premiums – vary by plan
			Coverage Gap: Begins when total spending by beneficiary and plan reaches \$2,700
			Some plans may offer coverage for some drugs in the gap
			Coverage gap ends when beneficiary out-of-pocket spending reaches \$4,350

Preventive Services Covered in 2009	
Preventive Service	Does Part B Deductible Apply? ⁵
Abdominal Aortic Aneurysm Screening	Yes
Bone Mass Measurement	Yes
Cardiovascular Screening	No
Colorectal Cancer Screening	No
Diabetes Screening	No
Diabetes Self-Management Training	Yes
Flu Shots	No
Glaucoma Tests	Yes
Hepatitis B Shots	Yes
Mammogram	No
Medical Nutrition Therapy Services	Yes
Pap Test and Pelvic Exam (including breast exam)	No
Welcome to Medicare Physical Exam (within first year of Part B eligibility)	No
Pneumococcal Shot	No
Prostate Cancer Screening	No
Smoking Cessation Counseling	Yes

¹ A **benefit period** is the way that Original Medicare measures use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day a beneficiary goes to a hospital or skilled nursing facility. The benefit period ends when the beneficiary has not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If the beneficiary goes into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins.

² In Original Medicare, **lifetime reserve days** are additional days that Medicare will pay for when a beneficiary is in a hospital for more than 90 days. Each beneficiary has a total of 60 reserve days that can be used during one's lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

³ \$96.40 is for individuals with annual income of less than \$85,000 or couples with annual income of less than \$170,000. For those with annual income greater than \$85,000 (individuals) or \$170,000 (couples), Part B premiums for 2009 range from \$134.90 to \$308.30.

⁴ The **Medicare approved amount** is the amount a doctor or supplier that accepts assignment can be paid. It includes what Medicare pays and any deductible, coinsurance, or copayment that the beneficiary pays. It may be less than the actual amount a doctor or supplier charges.

⁵ Medicare exempts specific tests and diagnostic screenings from the deductible, but not all diagnostic tests may be exempt. Beneficiaries should ask their clinicians whether recommended screenings are covered by Medicare and are exempt from the Part B deductible.

Fact Sheet 151, January, 2009

Written by K. Lynn Nonnemaker, Ph.D.
 AARP Public Policy Institute,
 601 E Street, NW, Washington, DC 20049
www.aarp.org/ppi
 202-434-3890, ppi@aarp.org
 © 2009, AARP.
 Reprinting with permission only.