Chapter 2

MEDICARE

- Medicare Part A
    - Hospital Care
    - Skilled Nursing Facility Care
    - Home Health Care
    - Hospice
- Medicare Part B
- Qualified Medicare Beneficiary
- Specified Low Income Medicare Beneficiary
- Medigap Insurance Policy
- Medicare Advantage
- Medicare Part D

Congress approved Medicare in 1965 to pay some of the cost of health care services for the aged. In order to receive this assistance with the current cost of health care, a person must be 65 years of age or older and entitled to Social Security retirement insurance or Railroad Retirement cash benefits. A person who has received Social Security disability benefits or Railroad Retirement Disability Income for 24 months or longer is also entitled to receive Medicare assistance regardless of his or her age. However, an application to enroll in Medicare must be filed by this disabled person. An application for Medicare can be filed after receiving 21 months of disability benefits. Persons of any age who have end-stage renal disease or amyotrophic lateral sclerosis can also apply for this coverage.

There are three basic threshold criteria for Medicare coverage:

1. The care and supplies to be provided must be medically reasonable and necessary for diagnosis or treatment of illness or injury or to improve the functioning of a malformed body part.
2. The care and supplies must be prescribed by a doctor.
3. The services and the supplies must be obtained through a Medicare-certified provider.

Medicare seldom pays all the costs of health care. In many areas of coverage, the patient is required to pay a specified deductible amount each year or during each illness. In addition, the patient may have to pay for a portion of the cost. Medicare calls this a coinsurance payment or co-payment.

The present Medicare program provides two separate packages of benefits, Part A and Part B. A person who is 65 years of age and who is entitled to Social Security or Railroad Retirement benefits is automatically enrolled in Medicare Part A and will be deemed to have enrolled in Medicare Part B. A person who is not receiving Social Security or Railroad Retirement Benefits must enroll for Medicare Part A during the initial enrollment period. This period begins in the third month before the person attains age 65 and extends for the next seven months. A person who takes early Social Security retirement is automatically enrolled in Medicare when he or she attains age 65.

A person aged 65 and older (or a person under age 65 who is disabled) who has not received credit from Social Security for 40 quarters of coverage may enroll in Medicare Part A, but he or she may have to pay a $441 per month premium in 2013 if the individual has 29 or fewer quarters of Social Security credits. Eligible individuals with 30-39 quarters of Social Security credits must pay a $296 per month premium in 2013.

Medicare Part A

Medicare Part A covers acute hospital care, a limited number of skilled nursing facility days, home health care and hospice care.

Hospital Care

Hospital coverage is available when the care and treatment needed can only be rendered on an inpatient basis at a hospital or a critical access hospital. Hospital coverage can be extended if a patient who would otherwise be discharged requires a skilled nursing facility level of care and no appropriate placement in a Medicare-certified skilled nursing facility is available.

The spell of illness concept is central to coverage for hospital and skilled nursing facility care. A spell of illness begins on the day a patient first receives inpatient care. It ends when a Medicare beneficiary has not been in a hospital or skilled nursing facility as an inpatient for 60 consecutive days, or has not received a Medicare-covered level of care for 60 days. There can be more than one spell of illness in a given calendar year. This will give rise to a second deductible, new coinsurance amounts and a new set of hospital days.

Medicare Part A will pay for inpatient hospital care that is medically necessary for treatment or diagnosis after the patient meets the initial first day deductible, which is $1,184 in 2013. Benefits cover 90 days of inpatient hospital care for each spell of illness. There is a $296 per day deductible for the 61st through 90th day in the hospital during the same spell of illness in 2013. In addition, a patient is allowed a maximum of 60 lifetime reserve days with a $592 per day deductible in 2013. Each year, there is an adjustment to the initial deductible, coinsurance amount and lifetime reserve daily amount. This adjustment is normally published in October of the year preceding the new calendar year in which the new deductible will apply.

Maximum Coverage for Hospital Care (2013)

Days in Hospital	How Much You Pay	**How Much Medicare Pays**
First 60 days	$1,184 for first day	Balance
61-90 days	$296/day	Balance
91-150 days	$592/day	Balance
After 150 days	All Costs	Nothing

Medicare covers a lifetime maximum of 190 days of inpatient psychiatric hospital care. This is in addition to the coverage for hospital care described above. However, a person

can only use 150 of these days for this care in one benefit period. Also, this care is subject to the same deductibles and co-insurance, which is described above for other forms of hospitalization.

Coverage under Part A includes the hospital room on a semiprivate basis, nursing services, operating room costs, prescriptions and medical supplies, laboratory tests and x-rays provided by the hospital as part of its services. While in a hospital, physician services are not covered under Part A. The physician services provided while in a hospital will be billed under Medicare Part B. Certain luxury items (private rooms, private duty nurses, television, and telephone) are not covered by Medicare. Medicare does not pay for the first three units of blood that are received in a hospital in any calendar year. This blood deductible is in addition to the deductibles and coinsurance described above. However, the Part B blood deductible may apply.

LIFE SITUATION #4

Joseph, who is over 65, was hospitalized for 20 days, received 30 days of skilled care in a nursing facility, and went home for 62 days before being readmitted to a hospital. The first "spell of illness" ended 60 days after the expiration of Joseph's stay in the nursing facility. A new spell of illness will be triggered by the second hospitalization. New in-patient hospital deductibles must be paid.

Skilled Nursing Facility Care

There are many restrictions that apply to Medicare coverage for skilled nursing facility care. Skilled nursing care requires that the care must be provided by or requires the supervision of skilled nursing personnel or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing home facility on an inpatient basis. Medicare never extends coverage to a patient who needs custodial care only. For each spell of illness, Medicare Part A will pay all the costs for a covered skilled nursing home stay for the first 20 days and all but $148 per day in 2013 for up to an additional 80 days as long as all of the following conditions are met:

1. The individual was a patient in a hospital for three consecutive days not including the day of discharge. In addition, the patient must be admitted to the skilled nursing facility within 30 days of discharge from the hospital. (Note: there are a few limited exceptions to the requirement that the admission must occur within 30 days of discharge from the hospital).
2. A doctor must certify that the patient needs skilled nursing home care.
3. The services the patient needs must include either daily skilled nursing or skilled rehabilitation services (or a combination of these services).
4. The services are provided by or under the supervision of a trained individual.
5. The services are received on a daily basis, which means therapy services at least 5 days per week and/or nursing care 7 days per week.
6. The services are provided by a Medicare-certified skilled nursing facility.
7. The skilled services must be provided on an inpatient basis.

A Medicare beneficiary is entitled to receive coverage for skilled care in a nursing home (subject to the following co-payments in 2013):

Days in SNF	How much you pay	**How much Medicare Pays**
First 20 days	Nothing	100 percent of approved amount
Additional 80 days	$148/day	Balance
Beyond 100	All Costs	Nothing

Home Health Care

A Medicare home health benefit can be available under Medicare Part A or Medicare Part B. However, Medicare Part A home health care benefits are limited to 100 visits and must follow a prior hospital or skilled nursing facility stay. The threshold criteria for home health care is as follows:

1. The patient must be generally confined to the home. This means that this individual's condition must be such that the patient requires assistance to leave home (such as crutches, cane, walker, or assistance of another person, etc.) or that leaving the home without assistance is not advisable, and that leaving home requires a considerable effort. This is often known as the homebound requirement.
2. The home health care must be included in a plan of care by a doctor.
3. The patient must require skilled care. This means speech or physical therapy service or intermittent skilled nursing care. Occupational therapy will count toward the required skilled care, if it had been originally provided in conjunction with physical therapy, speech therapy, or skilled nursing.
4. The services rendered must be medically reasonable and necessary.
5. The services must be provided by, or under arrangements with, a Medicare certified home health agency.

Once these criteria have all been met, several medical services are fully paid for by Medicare, including the following:

1. Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse.
2. Physical, occupational, and speech therapy.
3. Medical social services under the direction of a physician.
4. Part-time home health aide services.

Hospice

To be entitled to Medicare hospice coverage, a person must be certified as terminally ill. This means that a physician must state that in his or her clinical judgment, the person's life expectancy is six months or less if the illness follows its expected course. In addition, the

patient must waive all rights to Medicare payments for the duration of the hospice care for any regular Medicare services related treatment of the terminal illness. Instead, the patient elects to receive palliative services provided under the arrangement of the hospice or provided by an attending physician, if the attending physician is not an employee of the hospice.

The primary advantage of hospice Medicare is that a terminal patient's broad needs can be met with a hidden array of services for a longer period of time. Hospice care provides the terminally ill patient with a holistic approach that concentrates on the patient's pain management, offers specialized care, and attempts to meet the spiritual and emotional needs of the patient and his or her family. The hospice patient is liable for coinsurance amounts only for respite care and drugs. However, the coinsurance cannot exceed $5 per prescription. It is important to remember that only medications for palliative purposes are covered under the hospice benefit.

Medicare hospice is often more economical to the patient and the patient's family than hospital, home health, and nursing home care. This is because the increased care allowed the hospice patient is provided regardless of the patient's ability to pay. For instance, the hospice provider pays for all of the cost of the hospice patient's prescriptions that are necessary for the patient's control of the pain at home and the related symptoms associated with the terminal illness. However, in some instances, the regular home health benefit may provide equal or better coverage.

Medicare hospice provides physician services, nursing services, social services, counseling services to the terminally ill and family members, short-term inpatient care provided in a hospice inpatient unit or in a hospital or skilled nursing facility, medical appliances and supplies, drugs, home health aid services, homemaker services and physical therapy provided for symptom control or to help the patient maintain activities of daily living.

The hospice benefit is divided into periods. The first two benefit periods are 90 days, followed by an unlimited number of 60-day periods. A person may designate another hospice one time in each election period.

In addition, a person may opt out of, and return to, Medicare hospice coverage at any time. Medicare Part A coverage that was waived when the Medicare hospice benefit was elected is automatically resumed with the effective cancellation date. To opt back into hospice, a new election form and physicians certificate is necessary.

It is important to remember that Medicare Advantage plans may provide, but are not required to provide, hospice care to their beneficiaries. A beneficiary may change the designation of the particular hospice from which the care will be received once each election period.

Medicare Part B

Medicare Part B is a voluntary program for persons who are 65 years of age or older who are citizens or who have been a lawful permanent resident for five years preceding the date of the application. The major benefit under Medicare Part B is payment of the physician's charges for surgery, consultations, office visits and the physician's visits to the patient's hospital or nursing home room. Durable medical equipment, outpatient physical

therapy, X-rays, and diagnostic tests are also covered. Medicare Part B also covers home health visits not covered under Part A.

Medicare Part B does not cover prescription drugs that do not require administration by a physician, routine physical checkups, eyeglasses, eye exams to prescribe eyeglasses, hearing aids or hearing exams for hearing aids, dental services and routine foot care. Ambulance transportation is only covered when other modes of transportation would be harmful to the patient. For a non-emergency trip to be covered, the patient must not be able to rise out of bed without assistance, be unable to walk and unable to sit in a chair or wheelchair. Ambulance service that is not an emergency must be certified in advance with a doctor's written order certifying that the patient meets these criteria.

Preventive care services, checkups and comfort items are for the most part not covered under Medicare. However, certain preventative care services are now covered under Medicare Part B due to laws being passed that specifically include these services. These services include, for Medicare eligible persons, an annual mammogram for women enrolled who are age 40 and older, Pap smears and pelvic exams for beneficiaries considered a high risk following an abnormal Pap smear. A woman not in this group is entitled to a Pap smear and a pelvic exam once every two years. The deductible does not apply to these procedures. Prostate screening for men over age 50 and colorectal cancer screening tests for beneficiaries age 50 or older are also included.

A person who is enrolled under Medicare Part A is assumed to want coverage under Medicare Part B. A person covered under Medicare Part A may decline to be covered under Medicare Part B before the coverage begins or within 2 months after being notified that Medicare Part B coverage has commenced.

Medicare Part B has an annual deductible requirement of at least $147 in 2013. Each year, before Medicare pays anything, the patient must incur medical expenses equal to the deductible, based on Medicare's approved reasonable charge, not on the provider's actual charge. In addition, there is a coinsurance amount which the patient must pay. This is equal to 20 percent of the Medicare approved amount.

Most Medicare beneficiaries will pay a $104.90 Part B premium amount each month in 2013. However, there is a Part B premium surcharge for high income individuals and married couples that is based on that person's or couple's 2011 adjusted gross income plus tax-exempt income. An individual who in 2011 had annual income greater than $85,000 and married couples who had income in 2011 greater than $170,000 will pay a Part B Medicare premium of $146.90 per month in 2013. An individual with income for 2011 greater than $107,000 and married couples with 2011 income greater than $214,000 will pay a monthly premium of $209.80 in 2013. An individual with annual income in 2011 greater than $160,000 and married couples with an annual income in 2011 greater than $320,000 will pay a monthly premium in 2013 of $272.20 each. Individuals with annual incomes greater than $214,000 and married couples with annual incomes greater than $428,000 in 2011 will pay a monthly premium of $335.70 per month in 2013.

A major problem with Medicare Part B is the difference between the cost of medical items or services, particularly physician's services, and the Medicare-approved reasonable charge. When an item or service is determined to be covered under Medicare, it is reimbursed at 80 percent of the reasonable charge for the item or service, and the patient is responsible for the remaining 20 percent. Unfortunately, the reasonable charge set by

Medicare may often be substantially less than the actual charge. The result of the reasonable-charge reimbursement system is that the Medicare payment, even for items and services covered by Part B, is often insufficient to pay the complete amount of the charge for the service. The patient is thus left with out-of-pocket expenses. However, when a physician accepts Medicare assignment, he or she agrees to accept the Medicare-approved amount as full payment. Medicare will pay 80 percent and the patient is responsible to pay the 20 percent co-payment. When a physician does not accept assignment, the patient is liable for the co-payment plus a balance above the Medicare fee schedule amount. However, under federal law, there is a set limit (limiting charge) that the physician may charge. A physician not accepting assignment for payment of a Medicare claim may submit a balanced bill that does not exceed 115 percent of the Medicare-approved amount. The patient's Medicare Summary Notice will state the Medicare approved charge for the doctor's services.

LIFE SITUATION #5

Mary is treated by a doctor who does not accept Medicare assignment. This physician's actual charge is $100, but the Medicare fee schedule states the allowable charge is only $70. This doctor may charge Mary only 115 percent of the scheduled amount, or $80.50, for this service, since the doctor has not agreed to accept assignment of the Medicare benefit. Mary would be responsible for paying the physician the entire $80.50 and then requesting Medicare to reimburse her $56 ($70 x 80 percent). If the doctor accepted assignment, the doctor would file Mary's claim and request her to pay $14 ($70 x 20%).

Qualified Medicare Beneficiary

A Qualified Medicare Beneficiary is a person at least 65 years of age or a disabled individual who has a countable income at or lower than the Federal poverty level that is $710 per month in 2013 and countable assets less than $4,000 ($6,000 for a couple). The Medicaid program in the state where the beneficiary resides will pay the Qualified Medicare Beneficiary's Medicare Part B premium, the Medicare Part A deductibles and the Medicare Part A coinsurance. The Federal statute is referred to as the Qualified Medicare Beneficiary Program.

Specified Low Income Medicare Beneficiary

A Specified Low Income Medicare Beneficiary is a person at least 65 years of age or a disabled individual who has a countable income between 100 and 120 percent of the Federal poverty level and countable assets less than $4,000 ($6,000 for a couple). The Medicaid program in the state where the beneficiary resides pays the Specified Low Income Medicare Beneficiary's Part B premium. However, the Medicare Part A deductible and the Medicare Part A coinsurance must be paid by the Medicare beneficiary.

Medigap Insurance Policy

"Medigap" is the term used to describe the supplemental insurance policy needed to cover the health care costs, deductibles and co-pay amounts not provided by Medicare. This

policy is important for Medicare recipients who rely on traditional Medicare coverage Medicare Part A.

The standardized Medigap policies that may be sold are as follows:

- Plan A contains the basic or "core" benefits. The following is a list of the benefits that are contained in the core policy and that must be contained in all Medigap policies:

1. Part A hospital coinsurance for days 61 to 90 ($296 per day in the year 2013;
2. Part A lifetime reserve coinsurance for days 91 to 150 ($592 in 2013);
3. 365 lifetime hospital days beyond Medicare coverage;
4. Parts A and B three pint blood deductible;
5. Part B 20 percent coinsurance.

The other Medigap policies contain the core benefits plus one or more additional benefits are as follows:

- Plan B policies contain the core coverage and 100% of the Part A deductible.
- Plan C policies contain the core coverage for 100% of the Part A deductible; the skilled nursing home facility coinsurance, 100% of the Part B deductibles, and foreign emergency care.
- Plan D policies contain the core coverage plus 100% of the Part A deductible, SNF coinsurance, and foreign emergency care.
- Plan E is no longer available since it included the same coverage as plan D.
- Plan F contains the core coverage plus 100% of the Part A deductible, SNF coinsurance, 100% of the Part B deductible, 100% of the Part B excess charges and foreign emergency care. There is also a high deductible option with the same benefits plus a $2,000 deductible that is adjusted for the CPI since 2011.
- Plan G contains the core coverage plus 100% of the Part A deductible, SNF coinsurance, 100% of the Part B excess charges, and foreign emergency care.
- Plan H has been discontinued since it provided the same coverage as plan D but with drug coverage that is no longer necessary due to Medicare Part D.
- Plan I has been discontinued since it provided the same coverage as plan G but with drug coverage that is no longer necessary due to Medicare Part D.
- Plan J has been discontinued since it provided the same coverage as plan F but with drug coverage that is no longer necessary due to Medicare Part D.
- Plan K contains the core coverage plus 100% of the Part A hospital coinsurance for the 61st through the 90th day and for days 91 through 150 and for 100% of Part A eligible expenses after these benefits are exhausted, including lifetime reserve days; 50% of coinsurance for 21st through 100th day, until out-of-pocket limit is met, 50% of Hospice care, 50% of reasonable cost for three pints of blood, 100% of cost-sharing for Part B preventive services after deductible paid and 100% of all cost-sharing under Part A and B for balance of year after out-of-pocket met .
- Plan L contains the core coverage and 100% of the Part A hospital coinsurance for 61st through 90th day and for days 91 through 150, 100% coinsurance amount for each Medicare lifetime inpatient reserve day used; 100% of Part A eligible expenses after benefit exhausted, including lifetime reserve days; and 75% of the skilled

nursing facility coinsurance for 21st through 100th day, until out-of-pocket limit is met; 75% of cost-sharing for all Part A eligible expenses until out-of-pocket limit met and 75% of reasonable cost for three pints of blood Part B.

- Plan M contains the core benefits plus 50% of the Part A deductible, the skilled nursing facility coinsurance, and foreign emergency care.
- Plan N contains the core benefits plus 100% of the Part A deductible, the skilled nursing facility coinsurance, and foreign emergency care and the lesser of $20 or the Part B coinsurance/co-payment for office visit (including specialists) and the lesser of $50 or Part B coinsurance/co-payment for emergency room visits. The co-payment waived if patient admitted to hospital and the emergency visit is subsequently covered under Part A.

Medicare Advantage

The ever increasing cost of the Medicare deductibles, the Medicare supplement and the additional cost of the Medicare Part D prescription drug plan will eventually drive most of the 35 million fee-for-service Medicare beneficiaries into joining the 11.7 million Medicare beneficiaries presently enrolled in a Medicare Advantage plan. These services are found in Part C of the Medicare Statutes. This is known as a Medicare Advantage plan. A Medicare Advantage plan is owned by a private company that provides all of a beneficiary's health care and prescriptions through the plan's health care providers for a capitated rate paid by the Centers for Medicare and Medicaid. The Medicare Advantage company must provide all the services currently available under Medicare Parts A and B. The primary physician who is assigned to the Medicare Advantage beneficiary serves as a gatekeeper to specialists. Thus, the beneficiary's health care cost is reduced while his or her health is maintained. However, a Medicare Advantage beneficiary loses the right to select any doctor and must select from a panel of physicians offered by the plan.

Every year in November, the Center for Medicare and Medicaid conducts an annual coordinated enrollment period during which time all Medicare beneficiaries are able to choose between the original Medicare program and a Medicare Advantage plan. A Medicare beneficiary has between October 15 and December 7 to join, switch or drop a Medicare Advantage Plan. The coverage begins on January 1 of the ensuing year, as long as the plan receives the request by December 7th. Between January 1 – 14, a person who is a member of a Medicare Advantage Plan can leave his or her plan and switch to the original Medicare. If a person switches to the original Medicare during this period, he or she will have until February 14 to also select a Medicare Prescription Drug Plan to add drug coverage. The coverage will begin the first day of the month after the enrollment form is received. Although Medicare Advantage may seem to save beneficiaries more money at first, they will only save money if the Medicare beneficiary uses the plan's doctors for all their care. In addition, because Medicare Advantage plans only have one-year contracts, the provider can decide to change its costs and even leave the Medicare program.

Medicare Part D

Medicare's prescription drug program began on January 1, 2006. This program known as Medicare Part D provides limited financial assistance with drug expenses to persons enrolled under Medicare Part A or Part B who pay the additional Part D premium to a private company. These prescription drug plans offered pursuant to Medicare Part D are provided by private companies. Thus, a person eligible for Medicare must affirmatively enroll in a voluntary prescription drug coverage program under Medicare Part D for one year at a time. Medicare Advantage Plans normally provide prescription coverage.

It is important to understand that the drugs offered by different plans vary. This new law does not authorize the establishment of specific lists of medications that must be offered by the Medicare Part D formularies. In general, once a person selects a prescription drug plan, he or she is locked in to the drug plan and cannot change until the next annual enrollment period. This is true even though the plan in which he or she enrolls changes the formulary or cost sharing arrangement, with enrollment in the new plan becoming effective January 1 of the following year. The annual enrollment period for Medicare Part D is between October 15th and December 7th of each year. During this period, a person who is eligible for Medicare can enroll in a plan or change his or her enrollment from one plan to another. An individual who is already in a plan can decide if he or she wants to remain in the same plan for the current year or if he or she wants to select another plan. There is a late penalty for failure to timely enroll when a person is first eligible. The penalty is 1% of the national average premium for every month that a person delays enrollment. Thus, a person who becomes eligible to enroll in Part D at age 65 and delays enrolling until age 66 can be assessed a 12% penalty on his or her premium for the remainder of his or her life. The amount of the penalty will vary each year as the national average premium changes. However, this penalty is waived if a person had creditable coverage with an employer or through the Veterans Administration or Tricare. Creditable coverage means that the employer's drug plan is equivalent to the Part D benefit.

The monthly premium that a Medicare beneficiary will have to pay on a monthly basis for Part D drug benefits varies from company to company and depends on the formulary being provided by that company. A Medicare beneficiary who elects to pay this premium will then pay an annual deductible for prescriptions. The annual deductible for 2013 is the first $325 of prescription drug expenses incurred during 2013 for drugs on the plan's list of covered drugs or formulary. The enrolled Medicare beneficiary then pays a coinsurance amount equal to 25% of his or her prescription costs, for formulary drugs, in excess of the annual deductible up to the initial coverage limit in 2013 of $2,970. The Medicare beneficiary's prescription drug plan sponsor pays the remaining 75% until total drug expenses paid for by the plan and the beneficiary reach $2,930. The Affordable Care Act then provides that the drug manufacturer will pay 50% of the cost of the brand-name drugs and the plan will pay another 2.5%, providing seniors with total coverage of 52.5% in what is called the donut hole. Coverage by the plan of generic drugs in this donut hole is 21%. Once the total formulary expense has exceeded $6,733.75 in 2013, the Medicare beneficiary enters the catastrophic portion of the Medicare Part D Program. The Part D plan then covers 95% of the excess drug expense incurred. The cost-sharing by the patient is set at

the greater of a 5% coinsurance amount or fixed copayments. The fixed copayments are $2.65 for a generic/preferred multi-source drug and $6.50 for any other drug.

The annual premium and the deductibles are expected to increase each year as the cost of this additional Medicare benefit increases. Prescription costs will be treated as incurred by the Medicare beneficiary only if they are paid by the eligible beneficiary or by another individual on behalf of the eligible beneficiary. If the eligible individual is reimbursed for such costs through insurance, a group health plan, or other third-party payment arrangement, the prescription cost may not count toward the eligible beneficiary's incurred share of cost.

In addition to the normal monthly premium, there is also a Part D premium surcharge for high income individuals and married couples that is based on that person's or married couple's 2011 adjusted gross income plus tax-exempt income. An individual who in 2011 had annual income greater than $85,000 and married couples who had income greater than $170,000 will pay a Part D Medicare additional premium of $11.60 per month in 2013. An individual with income for 2011 greater than $107,000 and married couples with 2011 income greater than $214,000 will pay an additional monthly premium of $29.90 in 2013. An individual with annual income in 2011 greater than $160,000 and married couples with an annual income in 2011 greater than $320,000 will pay an additional monthly premium in 2013 of $48.10 each. An individual with annual income greater than $214,000 and married couples with annual incomes greater than $428,000 in 2011 will pay an additional monthly premium in 2013 of $66.40.