UF IFAS Extension UNIVERSITY of FLORIDA

FCS2338

Important Things to Know about Medicare Chapter Two: Medicare Part A--Hospital Insurance[1]

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Important Things to Know about Medicare is a series of 10 publications that will cover the most common Medicare concerns. The series will provide general information about Medicare, including the four major plans, supplemental policies, interactions with different types of insurance, and assistance programs. This section explains Medicare Part A. Medicare Part A is hospital insurance that helps cover in-patient care in hospitals, inpatient care in a skilled nursing facility, hospice care, home health care, and inpatient care in a religious non-medical health care institution (Centers for Medicare and Medicaid Services [CMS] 2013).

When Coverage Begins

If you are automatically enrolled in Medicare Part A and Part B, your coverage will begin when you become eligible. The earliest time you can sign up for Medicare Part A and Part B (excluding end-stage renal disease) is during your 7-month **initial enrollment period**, which begins 3 months before you turn 65 and ends 3 months after you turn 65. If you sign up before your 65th birthday, your coverage will usually start the first day of your birthday month. If you sign up in the 3 months after your birthday, your coverage start date may be delayed (CMS 2013).

The **general enrollment period** occurs between January 1 and March 31 each year. If you did not sign up for Medicare Part A or Part B when you first became eligible, you can sign up during the general enrollment period and your coverage will start the following July. If you chose not to sign up for Medicare Part A or Part B when you first became eligible, you may be charged a **late enrollment penalty**. The late enrollment penalty for Part A is 10% for twice the number of years you did not have Medicare Part A after you became eligible. For example, if you chose not to enroll in Part A for two years after you became eligible, you will pay a 10% higher premium for 4 years (CMS 2013).

You may be exempt from the late enrollment penalty if you didn't sign up for Medicare Part A or Part B when you originally became eligible because you were covered under your own health insurance, usually through your employer or that of a spouse or other family member. In this case, you can sign up for Part A or Part B during a **special enrollment period**, which can occur during the 8-month period following the month after employment ends or coverage ends. You can also sign up for Part A and Part B any time you are still covered by your original group health plan. Note that COBRA and retiree health plans do not qualify you for the special enrollment period; if you are covered under COBRA or a retiree health plan and do not enroll in Medicare when you become eligible, you will be charged the late enrollment penalty (CMS 2013).

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What It Covers

The Medicare **benefit period** begins when the beneficiary first enters the hospital and ends when there has been a break of at least 60 consecutive days since hospital or nursing care was provided. The services described below are per benefit period. There is no limit to the number of benefit periods covered throughout your lifetime, but there are limits to days of care within each benefit period. You are also allotted 60 **lifetime reserve days** of inpatient hospital care if you exceed the limit per benefit period (Klees, Wolfe, and Curtis 2011).

Medicare Part A Covers

- Inpatient hospital services (up to 90 days per **benefit period** + 60 **lifetime reserve days**)
- Skilled nursing facilities services (up to 100 days per **benefit period** after an inpatient hospital stay of at least 3 days)
- Home health care if you are homebound
- Hospice care
- Inpatient psychiatric care (up to 190 days throughout your lifetime)
- Blood (after you pay for the first 3 pints per year)
- Inpatient care in a religious non-medical healthcare institution

(American Association of Retired Persons [AARP] 2012)

To see a full list of Part A-covered services and costs, see the CMS handout, **Medicare Part A: Covered Services**, reproduced below (CMS 2013).

Medicare Does Not Cover

- Long-term care
- Some preventative health services
- Hearing aids
- Eyeglasses
- Most dental care
- Services obtained outside the United States

(AARP 2001)

What It Costs You

- You do *not* have to pay monthly premiums for Medicare Part A. Exclusions include otherwise ineligible disabled people who voluntarily pay a monthly premium for coverage (Klees, Wolfe, and Curtis 2011). To see how much you have to pay for certain services, see the above list of covered services.
- For a frame of reference for hospital care, in 2012 the one-time deductible at the beginning of each benefit period was $1,156, which includes the first 60 days of inpatient hospital care. For days 61–90, the 2012 coinsurance payment was $289 per day. The 2012 coinsurance payments for lifetime reserve days was $578 per day (Klees, Wolfe, and Curtis 2011).
- For a frame of reference for skilled nursing care, in 2012 the copayment for days 21–100 was $144.50 per day (Medicare fully covers the first 20 days). After 100 days, Medicare does not pay any more for skilled nursing care (Klees, Wolfe, and Curtis 2011).

References

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Klees, B. S., C. J. Wolfe, and C. A. Curtis. 2011. Brief Summaries of Medicare and Medicaid. *Office of the Actuary, Centers for Medicare and Medicaid Services.* Retrieved from: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/downloads/MedicareMedicaidSummaries2011.pdf.

Medicare Part A: Covered Services

Blood	If the hospital gets blood from a blood bank at no charge, you won't have to pay for it or replace it. If the hospital has to buy blood for you, you must either pay the hospital costs for the first 3 units of blood you get in a calendar year or have the blood donated by you or someone else.
Home Health Services	Medicare covers medically necessary part-time or intermittent skilled nursing care, physical therapy, speech-language pathology services, and services for people with a continuing need for occupational therapy. A doctor enrolled in Medicare, or certain health care providers who work with the doctor, must see you face-to-face before the doctor can certify that you need home health services. That doctor must order your care and a Medicare-certified home health agency must approve it. Home health services may also include medical social services, part-time or intermittent home health aide services, and medical supplies for use at home. You must be homebound, which means leaving home is a major effort. • You pay nothing for covered home health care services • You pay 20% of the Medicare-approved amount for durable medical equipment
Hospice Care	To qualify for hospice care, your doctor must certify that you're terminally ill and expected to live 6 months or less. If you're already getting hospice care, a hospice doctor or nurse practitioner will need to see you about 6 months after you enter hospice to certify that you're still terminally ill. Coverage includes drugs for pain relief and symptom management; medical, nursing, and social services; certain durable medical equipment; and other covered services, as well as services Medicare usually doesn't cover, like spiritual and grief counseling. A Medicare-approved hospice usually gives hospice care in your home or other facility where you live, like a nursing home. Hospice care doesn't pay for your stay in a facility (room and board) unless the hospice medical team determines that you need short-term inpatient stays for pain and symptom management that can't be addressed at home. These stays must be in a Medicare-approved facility, like a hospice facility, hospital, or skilled nursing facility that contracts with the hospice. Medicare also covers inpatient respite care, which is care you get in a Medicare-approved facility so that your usual caregiver can rest. You can stay up to 5 days each time you get respite care. Medicare will pay for covered services for health problems that aren't related to your terminal illness. You can continue to get hospice care as long as the hospice medical director or hospice doctor recertifies that you're terminally ill. • You pay nothing for hospice care • You pay a copayment of up to $5 per prescription for outpatient prescription drugs for pain and symptom management • You pay 5% of the Medicare-approved amount for inpatient respite care
Hospital Care (inpatient)	Medicare covers semi-private rooms, meals, general nursing, and drugs as part of your inpatient treatment, and other hospital services and supplies. This includes care you get in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, inpatient care as part of a qualifying clinical research study, and mental health care. This *doesn't* include private-duty nursing, a television or phone in your room (if there's a separate charge for these items), or personal care items, like razors or slipper socks. It also doesn't include a private room, unless a private room is medically necessary. If you have Medicare Part B, it covers the doctor's services you get while you're in a hospital. • You pay a deductible and no copayment for days 1–60 each benefit period. • You pay a copayment for days 61–90 each benefit period. • You pay a copayment for each "lifetime reserve day" you use. (After the 90 days you are allotted for each benefit period, you may use your "lifetime reserve days." You have 60 lifetime reserve days to use over your lifetime). • You pay all costs for each day after the lifetime reserve days. • Inpatient mental health care in a psychiatric hospital is limited to 190 days in a lifetime. **Note:** Staying overnight in a hospital doesn't always mean you're an inpatient. You're considered an inpatient the day a doctor formally admits you to a hospital with a doctor's order. Always ask if you're an inpatient or outpatient because *it affects what you pay and whether you'll qualify for Part A coverage in a skilled nursing facility*. For more information, visit www.medicare.gov/publications to view the fact sheet "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" You can also call 1-800-MEDICARE (1-800-633-4227).
Religious non-medical health care institution (inpatient care)	Medicare will only cover the non-medical, non-religious health care items and services (like room and board) in this type of facility if you qualify for hospital or skilled nursing facility care, but medical care isn't in agreement with your religious beliefs. Only non-medical items and services that don't require a doctor's order or prescription, like unmedicated wound dressings or use of a simple walker during your stay, are available. Medicare doesn't cover the religious portion of care.

Skilled nursing facility care	Medicare covers semi-private rooms, meals, skilled nursing and rehabilitative services, and other medically necessary services and supplies after a 3-day minimum medically necessary inpatient hospital stay for a related illness or injury. An inpatient hospital stay begins the day you're formally admitted with a doctor's order and doesn't include the day you're discharged. To qualify for care in a skilled nursing facility, your doctor must certify that you need daily skilled care like intravenous injections or physical therapy. Medicare *doesn't* cover long-term care or custodial care. • You pay nothing for the first 20 days each benefit period. • You pay a coinsurance per day for days 21–100 each benefit period. • You pay all costs for each day after day 100 in a benefit period.
Adapted from: Centers for Medicare and Medicaid Services. 2013. *Medicare and You: The Official U.S. Government Medicare Handbook* (CMS Product No. 10050-28). Washington, DC: Government Printing Office.	