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Medicare Part A Hospital Insurance

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What is it?

Medicare Part A is the portion of Medicare that is available premium free to all eligible individuals*. Medicare Part A provides services associated with hospital, hospice, skilled nursing care, and home health care.

*Although Part A is free for most individuals, those who need to buy coverage will pay up to $437 per month in 2019.

What does Medicare Part A cover?

Part A covers the costs associated with these types of health care:

- Inpatient hospital stays
- Stays at a skilled nursing facility (i.e., where medically necessary skilled nursing and rehabilitation care are provided), in contrast to a nursing home providing custodial care
- Home health care
- Psychiatric inpatient care
- Hospice care

Medicare Part A coverage is based on benefit periods

How are benefit periods determined?

Medicare Part A coverage is tied to a benefit period of 60 days for a spell of illness. A spell of illness benefit period commences on the first day of your stay in a hospital or in a skilled nursing facility and continues until 60 consecutive days have lapsed and you have received no skilled care. Medicare does not cover care that is or becomes primarily custodial, such as assistance with bathing and eating. A deductible applies for each benefit period.

Your benefit period with Medicare, the spell of illness, does not end until 60 days after discharge from the hospital or the skilled nursing facility. Therefore, if you are readmitted within those 60 days, you are considered to be in the same benefit period. On the other hand, Medicare considers it a new spell of illness if you are readmitted more than 60 days after discharge. The good news is that this means that if you are readmitted within 60 days, you are not charged another deductible; the bad news is that your previous admission is tacked on to the second one in calculating the percentage amount Medicare will cover, since Medicare full coverage is only for 60 days. There is no limit on the number of spells of illness Medicare will cover in your lifetime.

Example(s): *Uncle George goes into the hospital June 1 and is discharged July 31. On November 1, he is readmitted to the hospital. Once he pays his deductible again, Medicare will pay all his costs until December 30. If, however, George is readmitted to the hospital within 60 days of his July 31 discharge, there is no additional deductible.*

Coverage for inpatient care in a hospital

For inpatient hospital stays, Medicare will pay:

- 100 percent of costs for up to 60 days of inpatient care, after you pay the deductible. You pay $1,364 in 2019.
- After 60 days, beneficiaries are responsible for coinsurance costs. In 2019, beneficiaries must pay $341/day.
- Beneficiaries are also entitled to a lifetime reserve of 60 additional days. If those reserve days are also used, beneficiaries must pay $682/day in 2019 for days 91 to 150.
- If you choose not to use your lifetime reserve, all Medicare coverage stops after 90 days of inpatient care or after 60 days without any skilled care for this spell of illness.

Tip: *Part A coverage pays for all Medicare-approved inpatient hospital costs except for your physician bills, which are covered under Part B. Medicare approves costs considered reasonable and medically necessary.*

Specific services covered under Part A

Specific services covered under Part A include:

- A semiprivate room
- Meals
- General and skilled nursing services, including nursing in special care units such as intensive care
- Medications administered while in the hospital
- Clinical laboratory tests

- X-ray and radiotherapy
- Medical supplies, such as dressings and intravenous lines
- The use of equipment such as wheelchairs
- Operating room and recovery room charges
- Rehabilitation services, such as physical therapy and speech pathology, provided in the hospital.

Medicare will not pay for items considered luxuries, such as a television in your room or for a private room, unless your condition renders it medically necessary.

Coverage for skilled nursing facility care

What is a skilled nursing facility? The short answer is--not a nursing home. Medicare does not cover nursing home care but does cover care in a skilled nursing facility, which may be housed in a nursing home or in a hospital or may be freestanding. The significant attribute is the kind of care provided. A skilled nursing facility provides medically necessary nursing and/or rehabilitation services.

To receive Medicare coverage for care in a skilled nursing facility:

- A physician must certify that you require daily skilled care that can only be provided for an inpatient in a skilled nursing facility
- You must have been an inpatient in a hospital for at least three consecutive days for the same illness or condition before being admitted to the skilled nursing facility
- Your admission to the skilled nursing facility must be within 30 days of discharge from the hospital to receive Medicare
- The facility must be Medicare-approved to provide skilled nursing care

Coverage is limited to a maximum of 100 days per benefit period, with coinsurance requirements of $170.50/day in 2019 after day 20. Coverage includes:

- A semiprivate room
- Meals
- Rehabilitation services
- Prescription drugs administered while in the facility

Coverage for home health care

Home health care is care provided to you at home, typically by a visiting nurse or home health care aide. Medicare Part A covers medically necessary home health care offered by an agency certified by Medicare to provide home health care. The home health agency agrees to be paid by Medicare and to accept only the amount Medicare appoves for their services.

To receive home health services under Medicare, the following rules apply:

- You must be confined to your home
- Your physician must certify the care as medically necessary and approve the treatment plan

You should also be aware that:

- Medicare does not cover care that is primarily custodial, such as assistance in performing daily tasks
- Medicare will cover services such as nursing service, physical therapy, speech therapy, occupational therapy, and 20 percent of the cost of durable medical equipment, such as a wheelchair
- Currently there are no benefit periods, deductibles, co-payment, or coinsurance requirements for home health care

Coverage for psychiatric hospitalization

For inpatient psychiatric care, Medicare Part A will pay for the same kinds of services as if you were hospitalized in a general hospital:

- Semiprivate room
- Meals
- Nursing care
- Rehabilitation services, such as physical or occupational therapy
- Prescription drugs administered in the hospital
- Medical supplies

- Lab tests, X-rays, and radiotherapy

An important distinction from care in a general hospital is that you must use a facility that accepts Medicare assignments on all claims. Deductibles and coinsurance costs are the same as for a regular inpatient hospital stay. In the course of your life, Medicare will only pay for 190 days of inpatient psychiatric care (lifetime limit).

Coverage for hospice care

Hospice care is care for the terminally ill. Hospice care covered by Medicare Part A is comprehensive coverage, at home or in a facility where you live, for symptom management and pain control for the terminally ill. To receive coverage:

- The health-care provider must be certified by Medicare to provide hospice care
- The patient's doctor and the hospice care director must certify that the patient is terminally ill (i.e., has a life expectancy of six months or less)
- The patient must elect hospice coverage for the terminal illness instead of standard Medicare benefits, although Medicare will continue to cover care provided that it is not related to the terminal illness

Services include nursing care, medical appliances and supplies, prescriptions, home health aide and homemaker services, medical social services, and counseling.

There are two categories of costs for which a Medicare hospice patient may be responsible:

- A co-payment of up to $5 for each outpatient prescription for pain relief or symptom management.
- Respite care. The hospice may arrange for the hospice patient to be moved to an inpatient facility for up to five days at a time to provide respite to the hospice care personnel. The Medicare beneficiary may be charged a nominal daily fee for the inpatient care (5 percent of the Medicare-approved amount for in-patient respite care).

Note, too, that Medicare does not cover room and board when you get hospice care in your home or a facility where you live.

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