

Chapter Five

Medicare A & B

1. **Sources of Law.** The Medicare Program, enacted in 1965, is Title XVIII of the Social Security Act. Title XVIII is codified at Sections 1395 through 1395ccc of Title 42 of the United States Code (42 U.S.C. §§ 1395 – 1395ccc). Medicare regulations are found at Title 42 of the Code of Federal Regulations, Parts 400 through 424 (42 C.F.R. Parts 400 – 424). In this chapter, when information has been taken from statutes or rules, the statutes or rules will usually be cited below the information toward the left margin.

2. **Administration of the Medicare Program.** The Medicare Program for decades was administered by the Health Care Financing Administration (“HCFA”). HCFA has been a part of the U.S. Department of Health and Human Services (“DHHS”). The main websites for HCFA are www.medicare.gov and www.hcfa.gov. On June 14, 2001, the current Secretary of Health and Human Services, Tommy Thompson, announced that the Health Care Financing Administration is to be renamed as “The Centers for Medicare & Medicaid Services.” This is abbreviated “CMS.”

3. Secretary Thompson stated that the Centers for Medicare & Medicaid Services will be organized into three (3) Centers, as follows:

- The Center for Beneficiary Choices will focus on the Medicare+Choice program and provide beneficiaries with information they need to make the best choice possible in choosing care.
- The Center for Medicare Management will focus on the traditional fee-for-service Medicare program.
- And the Center for Medicaid and State Operations will focus on programs administered by the states, including Medicaid, SCHIP (the State Children’s Health Insurance Program) and insurance regulation.

As of August 2001, however, www.medicare.gov and www.hcfa.gov were still the main websites for Medicare information.

4. Secretary Thompson further stated on June 14, 2001:

We also will make the 1-800-MEDICARE telephone line available 24 hours a day, seven days a week, beginning this fall, so callers can receive comprehensive information about health plan options available in their area.

We will improve the Medicare Web site to help Medicare beneficiaries compare benefits, costs, options and quality of providers. And we will propose grants to public libraries and train librarians to assist seniors in obtaining information about Medicare options and costs.

Finally, we will pursue Medicare contracting reform legislation ... to reduce the number of private health insurance companies that process claims and provide other administrative services from about 50 today to fewer than 20 by 2006.

These remarks can be downloaded from:

<http://www.hhs.gov/news/press/2001pres/20010614b.html>

5. **Medicare Program pamphlets and brochures.** An extensive array of pamphlets and brochures is available through www.medicare.gov. Many of these are revised annually. They include:

Medicare & You 2001

Medicare & You 2001 – Large Print

Medicare.gov Brochure

Medicare Hospice Benefits

Medicare Hospice Benefits – Large Print Edition

Women with Medicare – Visiting Your Doctor for a Pap Test, Pelvic Exam, and Clinical Breast Exam

Your Medicare Benefits

Medicare Coverage of Kidney Dialysis and Transplant Services

Medicare Coverage of Kidney Dialysis and Kidney Transplant Services – Large Print

Medicare Coverage of Skilled Nursing Facility Care

Medicare Coverage of Skilled Nursing Facility Care – Large Print Edition

Medicare and Your Mental Health Benefits

Medicare and Home Health Care

Your Guide to the Outpatient Prospective Payment System
Medicare and Other Health Benefits: Your Guide to Who Pays First
Clinical Trials
Private Contracts with Doctors and Other Practitioners Who Have Decided Not to
Provide Services Through the Medicare Program
Medicare Savings Programs
Does Your Doctor or Supplier Accept Assignment?
2001 Guide to Health Insurance For People With Medicare
Worksheet for Comparing Medicare Health Plans
Understanding Your Medicare Choices
Medicare Medical Savings Account Plan Brochure
Medicare Medical Savings Account Plan Offers You a New Option
Your Guide to Private Fee-for-Service Plans
Getting a Second Opinion Before Surgery
Guide to Choosing a Nursing Home
Nursing Home Brochure
Choosing a Doctor
Choosing a Hospital
Choosing Treatments
Pay it Right – Protecting Medicare From Fraud
Consumer Fraud Pamphlet: Medicare and Home Medical Equipment
Medicare’s Incentive Reward Program for Fraud and Abuse
Your Medicare Rights and Protections
Medicare Appeals and Grievances
Medigap Policies and Protections
Pap Tests: A Healthy Habit for Life
I Control My Diabetes Poster
Preparing for Emergencies: A Guide for People on Dialysis
Dialysis Keeps People with Kidney Failure Alive
Are You Getting Adequate Hemodialysis?
Medicare Preventive Services to Keep You Healthy.

To download any of these items, one simply goes to “Publications” at www.medicare.gov and then selects the desired item(s).

6. **Brief Overview of Medicare.** Medicare is a federally administered health insurance program for persons who are 65 or older, have been entitled to Social Security disability benefits for 24 months (are now in the 25th month), and most persons who have end-stage renal disease. Medicare has two parts – Part A (“hospital insurance”) and Part B (“voluntary supplemental medical insurance”). Enrollment is automatic for persons 65 or older who have established eligibility to Social Security or Railroad Retirement Benefits, or are in the 25th month of disability benefits. Because no premium is deducted for Medicare Part A for any of the foregoing beneficiaries, you will not encounter many of them wanting to “opt out” of Medicare Part A. A monthly premium is charged for Medicare Part B (2001: \$50.00). It is rarely wise to opt out of this, with the exception of person still covered by an employment-based Group Health Plan or Large Group Health Plan. The premium usually is deducted automatically from the monthly Social Security Benefit.

7. There are a few individuals who, though age 65, do not automatically qualify for Medicare Part A. These are people who do not have the 40 credits of Social Security coverage needed for automatic Medicare entitlement. They may enroll during specified enrollment periods. The first three calendar months of each year always constitute one of these enrollment periods; the other one is the “initial enrollment period” and begins the third month before the first month of eligibility and continues for seven months. Those who are enrolled (but who did not have automatic Part A entitlement) get what is called “Premium Medicare” – meaning they pay a premium. For Part A, the premium is 2001: \$300 per month if the person has fewer than 30 Social Security credits; \$165 per month if the person has at least 30 but fewer than 40 Social Security credits. If such persons enroll in Medicare Part B, they pay the usual premium for that (2001: \$50.00 per month). More detailed information about the topic of Social Security credits can be obtained through www.ssa.gov.

8. Anyone entitled to Part A Medicare can enroll in Part B. Enrollment in Part B is automatic for those enrolled in Part A by virtue of age and receipt of Social Security or Railroad Retirement disability benefits, end-stage renal disease, or Lou Gherig's Disease. By completing an SSA form, one can "opt out" of Part B coverage. Because the value of Medicare benefits invariably exceeds the \$50.00 per month premium, opting out rarely makes sense, except for persons who still have employment-based coverage under Group Health Plans or Large Group Health Plans.

9. There are certain deductibles and coinsurance amounts that beneficiaries must pay. One over-arching limit is that Medicare will only pay:

1. The Medicare "allowable amount" and then
2. Only if the service or care provided was "medically reasonable and necessary."

10. **Deductibles and coinsurance amounts (current for 2001).** These are encountered under both Parts A & B of traditional Medicare. When these amounts change, the change usually is effective on January 1. The discussion in paragraphs 11 through 14 concerns traditional Medicare. The coinsurance borne by Medicare beneficiaries who enroll in Medicare HMOs or Medicare "Fee-for-Service Plans" may vary from the amounts under traditional Medicare.

11. **Medicare Part A Cost-Sharing.** The deductible under Part A for hospital care is \$792 per spell of illness, and in addition there is a coinsurance amount imposed of \$198 per day for days 61 through 90. After hospitalization day 90 in a spell of illness, the Medicare beneficiary only receives Medicare coverage if he/she has elected to make use of his/her 60 days of "lifetime reserve." If the beneficiary so elects, there is still a coinsurance amount of \$396 for each reserve day used. There are also limits and coinsurance amounts applicable to skilled nursing care (which is the only category of nursing home care that Medicare covers). Medicare covers 100 days of reasonable and necessary skilled nursing care following a hospital stay. However, there is a coinsurance

amount of \$99 per day that the beneficiary must pay for days 21 through 100. These figures are current for 2001.

12. Under Part B, the 2001 deductible is \$100 per year. The coinsurance amount is 20% of what Medicare determines was the allowable amount for the services of the following: Doctors, physical therapists, rural health clinic services, and comprehensive outpatient rehabilitation facility services. For such services, Medicare will only pay 80% of what it determines was the allowable charge. The patient must pay the other 20% of the Medicare allowable amount. If a doctor or physical therapist has agreed with Medicare to “accept assignment” on all Medicare charges, the doctor or physical therapist receives the 80% payment directly from Medicare (CMS pays this via fiscal intermediaries – insurance companies). The co-insurance, the remaining 20% of the allowable charge – as allowed by Medicare – is the responsibility of the patient. 100% Medicare payment (of allowable charges) is made for the following services: The reasonable cost of home health services, and the reasonable cost of pneumococcal vaccine, and the Medicare fee schedule amount for clinical diagnostic laboratory tests.

13. An additional coinsurance under Part A is 20% of the Medicare-approved amount for durable medical equipment. Furthermore, under hospice care, there is a coinsurance of up to \$5 for outpatient prescription drugs, and 5% of the Medicare-approved amount for inpatient respite care. Under Part A, the beneficiary must also pay for the first 3 pints of blood (or replace the blood used by donation).

14. Additional coinsurance under Part B include 20% for outpatient physical, occupational, and speech therapy; 50% for outpatient mental health care; 20% for durable medical equipment, and the first 3 pints of blood received as an outpatient and 20% of the Medicare-approved amount for additional pints of blood. As under Part A, the deductible for blood can be met through donation by the Medicare beneficiary or others on the beneficiary’s behalf.

15. **Help for low-income Medicare eligibles regarding premiums, deductibles, and coinsurance amounts.** There are 5 programs that provide varying levels of help with Medicare coinsurance for persons of modest means. The most helpful of these “Medicare Savings Programs” is the “Qualified Medicare Beneficiary” program (“QMB”). QMB pays all Medicare premiums, deductibles, and coinsurance which the beneficiary would otherwise have to pay. To be eligible for QMB, countable income cannot exceed 100% of the Federal Poverty Income Limit (FPIL). The least generous Medicare Savings Program only pays a small portion of the Part B premium. This program is called Qualified Individual-2 (QI-2), and for it, countable income cannot exceed 175% of FPIL.

16. Medicare beneficiaries whose income is above the QMB level but below the QI-1 level can qualify for payment of the \$50 Part B premium under Medicare Savings Programs. The Medicare Savings Programs mentioned in these paragraphs 15 and 16 are discussed extensively in Chapter 7 (“QMB/SLMB/QI 1-2/QDWI ‘Medicare Savings Programs’.”)

17. **Appeals, hearings, and Medicare administrative law.** These topics are covered in Chapter 14.

18. **Provisions of law relating to Medicare.** As noted at the outset, Medicare is Title XVIII of the Social Security Act (“the Act”), codified at 42 U.S.C. §§ 1395 – 1395ccc.

19. **Freedom of choice.** A fundamental concept that has been part of Medicare since the beginning (since 1965) is “freedom of choice.” This freedom of choice is found at Section 1802 of the Act, which states:

BASIC FREEDOM OF CHOICE. – Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services.

42 U.S.C. § 1395a(a). It should be kept in mind that this freedom of choice of provider can be given up. Indeed, Medicare managed care (such as HMO Medicare) amounts to giving up some freedom of choice, usually in return for some added benefit and a more restricted range of choice of provider. Persons who enroll in Medicare managed care still receive Medicare benefits. They can also disenroll from managed care. Original (“traditional”) Medicare has the broadest range of choices.

20. The very first paragraph of Title XVIII of the Act, namely Section 1801 of the Act, has been a “prohibition against any federal interference” with the practice of medicine. This paragraph of the Act states:

Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

42 U.S.C. § 1395 (Section 1801 of the Act). Of course, since 1965, a complex set of Medicare regulations, at 42 C.F.R. Parts 400 – 424, has arisen. Thus, medical providers who choose to serve Medicare beneficiaries are, in fact, subject to regulations.

21. Section 1803 of the Act is a further “freedom of choice” section. It states:

Nothing contained in this title shall be construed to preclude any State from providing, or any individual from purchasing or otherwise securing, protection against the cost of any health services.

42 U.S.C. § 1395b. Thus, one has the right to arrange one’s own coverage (as long as one pays the cost).

22. Thus, early on, in the first three sections of Title XVIII, freedom of choice is emphasized as a characteristic of traditional Medicare.

23. **Part A in further detail.** Part A of Medicare is called “Hospital Insurance Benefits for the Aged and Disabled.” Thus, Part A is sometimes referred to as the “hospital part” of Medicare.

24. Part A is described at Section 1811 of the Act as follows:

The insurance program [Part A of Medicare] provides basic protection against the cost of hospital, related post-hospital, home health services, and hospice care...for (1) individuals who are age 65 or over and are eligible for retirement benefits under title II [Social Security benefits] of this Act (or would be eligible for such benefits if certain government employment were covered employment under such title) or under the railroad retirement system, (2) individuals under age 65 who have been entitled for not less than 24 months to benefits under title II of this Act (or would have been so entitled to such benefits if certain government employment were covered employment under such title) or under the railroad retirement system on the basis of disability, and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease, or Lou Gherig’s Disease.

42 U.S.C. § 1395c. Thus, Part A provides some coverage of hospital, skilled nursing facility, home health, and hospice care. This coverage is provided to people who are age 65, to people who are younger but who are entering their 25th month of Social Security or railroad retirement system disability benefits, to people who have end stage renal disease, or Lou Gherig’s Disease.

25. If an alien is outside the U.S. for six months or more, Social Security benefits to the alien will be suspended. Medicare Part A will also be suspended until the alien’s first full month back in the U.S. 42 C.F.R. § 406.50(a).

26. As noted at paragraph 7, persons who are age 65 or older and who do not have the Social Security credits to receive Part A on a premium-free basis, can pay a monthly premium for Medicare Part A.

27. **Scope of benefits (Part A).** The scope of Part A benefits is set forth at Section 1812 of the Act. Section 1812 uses the term “spell of illness” in setting forth the scope of

benefits. CMS has used the term “benefit period” as a synonym for “spell of illness.” To understand the “scope of benefits” under Part A, it is necessary to understand what is meant by “spell of illness” or “benefit period.” These terms mean the period of days that begins on the day a person goes to a hospital or skilled nursing facility for care. The period ends when a person has not received hospital or skilled nursing facility care for 60 days in a row. Thus, in order to start a new spell of illness or benefit period – in order to restart the number of days of coverage under Part A – it is necessary for there to be a 60-day break between discharge from the hospital or skilled nursing facility and entry again for a new course of treatment.

28. The scope of benefits under Part A, as established at Section 1812 of the Act, includes:

1. Up to 150 days of inpatient hospital services during any spell of illness (benefit period);
2. Up to 100 days of “post-hospital extended care services” (“Skilled Nursing Facility” services);
3. Home health services for persons not enrolled in Part B, and for Part B enrollees, up to 100 home health visits if needed upon leaving the hospital or skilled nursing facility; and
4. Hospice care. Hospice care must be “elected” and that means regular Medicare services meant to cure a disease will not be provided. “Palliative care” meant to alleviate pain will be provided. If hospice care is elected for one diagnosis and a different diagnosis requires care, the election for hospice care does not apply to that other diagnosis.

This basic scope of Part A benefits, set forth at Section 1812(a)(1), (2), (3), and (4) of the Act, is codified at 42 U.S.C. § 1395d(a).

29. Section 1812 also puts some limits on Part A benefits. In regard to the 150 days of hospital coverage, day 91 and after consumes, day-for-day, a one-time, 60 day “reserve” set of days. Thus, day 1-90 can be repeated for however many spells of illness a person has. But any day of hospitalization beyond day 90 in a benefit period consumes a day of the one-time 60 day reserve. Thus, if a Medicare beneficiary, over the course of a few years, had four spells of illness with hospitalizations lasting, respectively, 105 days,

110 days, 100 days, and 105 days, the Medicare beneficiary will have made use of all 60 reserve days (15 plus 20 plus 10 plus 15). 42 U.S.C. §§ 1395d(a)(1), 1395d(b)(1). Reserve days do not renew with a new benefit period.

30. Section 1812 of the Act also limits post hospital skilled nursing facility coverage to 100 days per benefit period. 42 U.S.C. §§ 1395d(a)(2)(A), 1395d(b)(2).

31. Section 1812 of the Act limits coverage of inpatient psychiatric care to 190 days total during lifetime. 42 U.S.C. § 1395d(b)(3).

32. Section 1812 of the Act also has limits on hospice care. However, the Medicare hospice benefit has actually been designed in a beneficiary-friendly manner. This is logical since hospice coverage requires that the person have a terminal illness.

33. The hospice benefit is in lieu of other Medicare benefits for the terminal illness, and is for up to two periods of 90 days each and unlimited number of subsequent periods of 60 days each. If a person elects hospice care, regular Medicare Part A benefits are not available for treatment (curing) of the terminal illness, but hospice services to alleviate pain are covered. The election for hospice coverage does not affect physician's services provided by the individual's attending physician. If a person elects to receive hospice care and changes his or her mind, the person can revoke the election and resume regular Medicare Part A coverage. If a person has revoked hospice coverage, the person can re-elect it. These conditions on the scope of hospice coverage are at paragraph (d)(1) of Section 1812 of the Act. 42 U.S.C. § 1395d(d)(1).

34. The Medicare Program, since its inception in 1965, has had deductible and coinsurance amounts under Part A and Part B. Section 1813 of the Act sets forth the basic arrangement of the Part A deductibles and coinsurance amounts. The basic amounts have been readjusted over the years (typically, each January 1). Paragraph 35 has the year 2001 Part A deductibles and coinsurance.

35. Based on Sections 1812 and 1813 of the Act, the scope of Medicare Part A coverage (with associated coinsurance and deductibles) is summed up in the publication “Medicare and You 2001” as follows:

- **Hospital Stays:** Semiprivate room, meals, general nursing, and other hospital services and supplies (this includes care in critical access hospitals). This does not include private duty nursing, or a television or telephone in the room. [If the hospital does not bill separately for a TV or telephone, they will not be pulled from the room.] It also does not include a private room, unless **medically necessary**. Inpatient mental health care coverage in an independent psychiatric facility is limited to 190 days in a lifetime.
 - **For each benefit period the beneficiary pays:**
 - ✓ A total of \$792 for a hospital stay of 1-60 days.
 - ✓ \$198 per day for days 61-90 of a hospital stay.
 - ✓ \$396 per day for days 91-150 of a hospital stay (lifetime reserve days).
 - ✓ All costs for each day beyond 150 days.

- **Skilled Nursing Facility (SNF) Care:** Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies (after a 3-day hospital stay).
 - **For each benefit period the beneficiary pays:**
 - ✓ Nothing for the first 20 days.
 - ✓ Up to \$99 per day for days 21-100.
 - ✓ All costs beyond the 100th day in the benefit period.

- **Home Health Care:** Part-time skilled nursing care, physical therapy, occupational therapy, speech-language therapy, home health aid services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) and supplies.
 - **The beneficiary pays:**
 - ✓ Nothing for home health care services.
 - ✓ 20% of the **Medicare-approved amount** for durable medical equipment.

- **Hospice Care:** Medical and support services from a Medicare-approved hospice, drugs for symptom control and pain relief, short-term respite care, care in a hospice facility, hospital, or nursing home when necessary, and other services not otherwise covered by Medicare. Home care is also covered, under hospice.

- **The beneficiary pays:**
 - ✓ A coinsurance of up to \$5 for outpatient prescription drugs and 5% of the Medicare-approved payment amount for inpatient respite care (short-term care given to a hospice patient by another care giver, so that the usual care giver can rest).
- **Blood:** Pints of blood at a hospital or skilled nursing facility during a covered stay.
 - **The beneficiary pays:** For the first 3 pints of blood, unless s/he or someone else donates blood to replace what is used.

Source: Medicare and You 2001, page 6. (As noted at paragraph 5, several even more detailed booklets exist, to be ordered.)

36. Under Section 1815 of the Act, Medicare Part A coverage occurs by payment to providers of services out of the Federal Hospital Insurance Trust Fund. 42 U.S.C. § 1395g. The Part A Trust Fund was created by Section 1817 of the Act. 42 U.S.C. § 1395i. Thus, except for the deductibles and coinsurance listed in paragraph 34, the Part A Medicare program is meant to be paid for by the Medicare Trust Fund.

37. **Part B in further detail.** Part B of Medicare was established (in 1965) by Section 1831 of the Act. Section 1831 states:

There is hereby established a voluntary insurance program to provide medical insurance benefits in accordance with the provisions of this part for aged and disabled individuals who elect to enroll under such program, to be financed from premium payments by enrollees together with contributions from funds appropriated by the Federal Government.

42 U.S.C. § 1395j.

38. **Eligibility for Medicare Part B.** Section 1836 of the Act defines who is eligible to enroll in Medicare Part B. Section 1836 states:

Every individual who –

- (1) is entitled to hospital insurance benefits under part A, or
- (2) has attained age 65 and is a resident of the United States, and is either (A) a citizen or (B) an alien lawfully admitted for permanent

residence who has resided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment under this part,

is eligible to enroll in the insurance program established by this part.

42 U.S.C. § 1395o.

39. An alien lawfully admitted who has resided continuously in the U.S. during the 5 years before the application for enrollment, is eligible for Medicare Part B (assuming other criteria are met). 42 C.F.R. § 407.10(a)(2)(iii).

40. **Enrollment periods.** Section 1837 of the Act establishes “enrollment periods” for Medicare Part B. Under Section 1837, the U.S. Secretary of Health and Human Services is given authority to promulgate regulations for enrollment. The Secretary has promulgated these regulations at 42 Code of Federal Regulations (C.F.R.) §§ 407.10 – 407.50.

41. The regulation at 42 C.F.R. § 407.17 provides for “automatic enrollment” in Part B. It states in relevant part:

§ 407.17 Automatic enrollment.

- (a) *Who is automatically enrolled.* An individual is automatically enrolled for SMI (“supplemental medical insurance,” which is Part B) if he or she:
 - (1) Resides in the United States;
 - (2) Becomes entitled to hospital insurance under any of the provisions set forth in §§ 406.10 through 406.15 of this chapter; and
 - (3) Does not decline SMI enrollment.
- (b) *Opportunity to decline automatic enrollment.* (1) SSA will notify an individual that he or she is automatically enrolled under paragraph (a) of this section and grant the individual a specified

period (at least 2 months after the month the notice is mailed) to decline enrollment.

42 C.F.R. § 407.17. Persons not receiving Social Security or Railroad Retirement Board benefits will have to proactively apply for Part B. The regulations referred to in paragraph (a)(2) of 42 C.F.R. § 407.17 – “§ 406.10 through 406.15” – are the regulations that implement Medicare Part A eligibility for persons who are 65 years of age, or who have received 24 months of Social Security Disability Benefits, who have end stage renal disease, or who have Lou Gherig’s Disease.

42. Thus, those persons who are entitled to Medicare Part A because they have enough Social Security credits to receive Medicare Part A when they reach age 65, or have received 24 months of Social Security disability benefits, have end stage renal disease, or Lou Gherig’s Disease are automatically enrolled in Medicare Part B. This automatic enrollment in Part B occurs at the time that entitlement to Part A occurs.

43. People who are age 65 but who are not “entitled” to Part A Medicare (due to a lack of 40 Social Security credits) can nonetheless voluntarily enroll in Part B. This is allowed for by Section 1837 of the Act (42 U.S.C. § 1395p) and the regulations for this are at 42 C.F.R. § 407.10. That C.F.R. section states:

§ 407.10 Eligibility to enroll.

- (a) *Basic rules:* [a]n individual is eligible to enroll for SMI if he or she -- . . .
 - (i) Has attained age 65. (An individual is considered to have attained age 65 on the day before the 65th anniversary of his or her birth.)
 - (ii) Is a resident of the United States.
 - (iii) Is a citizen of the United States, or an alien lawfully admitted for permanent residence who has resided continuously in the United States during the 5 years preceding the month in which he or she applies for enrollment.

42 C.F.R. § 407.10. For such person there is an “initial enrollment period” and a “general enrollment period.”

44. The “initial enrollment period” is set forth at 42 C.F.R. § 407.14, and is as follows:

§ 407.14 Initial enrollment period.

- (a) *Duration.* (1) The initial enrollment period is the 7-month period that begins 3 months before the month an individual first meets the eligibility requirements of § 407.10 [turns 65] and ends 3 months after that first month of eligibility...
- (b) *Deemed initial enrollment period.* (1) SSA or CMS will establish a deemed initial enrollment period for an individual who fails to enroll during the initial enrollment period because of a belief, based on erroneous documentary evidence, that he or she had not yet attained age 65. The period will be established as though the individual had attained age 65 on the date indicated by the incorrect information.
 - (2) A deemed initial enrollment period established under paragraph (b)(1) of this section is used to determine the individual’s premium and right to enroll in a general enrollment period if that is advantageous to the individual.

42 C.F.R. § 407.14.

45. In addition, Section 1837(e) of the Act, 42 U.S.C. § 1395p(e), establishes a “general enrollment period” which is from January 1 through March 31 of each year. Keep in mind: People are automatically enrolled in Part B if they are “entitled” to part A by virtue of having enough Social Security credits for premium-free Part A and are 65, or have received 24 months of Social Security disability benefits, have end stage renal disease, or Lou Gherig’s Disease. Most persons who are entitled to Part A will only need to concern themselves with the initial or general enrollment periods if they opt out of Part B and then change their mind. As set forth at paragraph 39 above, 42 C.F.R. § 407.17(a)(3) does allow persons to “decline SMI [Part B] enrollment.”

46. There is a group of persons for whom the Act, at Section 1837(i)(2), establishes a “special enrollment period related to coverage under group health plans.” This allows certain persons who declined Medicare Part B coverage because they were covered by a group health plan (GHP) or a large group health plan (LGHP) to enroll in Medicare Part B when coverage under the GHP or LGHP ends.

47. “Group health plans” mean health insurance paid for in whole or in part, or operated by, employers of less than 100 persons. “Large group health plans” are group health plans of employers (or paid for in whole or in part by employers) that average at least 100 employees during the year. 42 C.F.R. § 411.101.

48. In order to have a “special enrollment period,” a person 65 or older who has lost coverage under a GHP or an LGHP must have had that coverage by virtue of the person’s current employment or the current employment of the spouse. If the person is disabled and the person was covered by a large group health plan (LGHP), the person can have a special enrollment period if the LGHP coverage was through employment of the disabled person or the disabled person’s “family member.” Family members are defined at 42 C.F.R. § 411.201 as “spouse (including a divorced or common law spouse), a natural, adopted, foster, or stepchild, a parent, or a sibling.” The “special enrollment period” discussed here is not the special enrollment period for Medigap policies.

49. What the “special enrollment period” as described in paragraphs 44 – 46 above means, is this: If a person age 65 or older opted out of Medicare Part B because the person had health insurance under a group health plan or a large group health plan, due to employment of the person, or the person’s spouse, and if that coverage has ended, the person age 65 or older can enroll in Medicare Part B. If the person is disabled and if the health coverage was under a large group health plan, it is enough that the coverage was based on employment of the disabled person or an immediate family member. (If the coverage was through merely a “group health plan” – for fewer than 100 employees – then for disabled persons (just as for persons 65 or older) the coverage must have been based on the employment of the disabled person or the disabled person’s spouse.

50. Thus, for disabled persons who had large group health insurance because of the employment of a child, parent, or sibling, when that large group coverage ends, a special enrollment period occurs. For others – persons age 65 or older covered under a group health plan or a large group health plan, and disabled persons covered under a group

health plan – the coverage must have been due to employment of the individual or the individual’s spouse.

51. For the persons as described in paragraphs 44 – 48, the special enrollment period is established by Section 1837(i) of the Act. The special enrollment period starts in the month that the employment-related coverage ended. The special enrollment period ends on the last day of the eighth consecutive month during which the person did not have employment-related coverage under a GHP or LGHP. 42 C.F.R. § 406.24.

52. If a person is enrolling in Part B during a special enrollment period, the start of Part B coverage depends on when the person enrolls. If enrollment occurs during the month that GHP or LHGP coverage ended, the person can opt for Medicare Part B coverage to start right away (as of the 1st day of the month of enrollment) or as of the 1st day of any of the next three months. If the person enrolls in the first full month after there is no GHP or LGHP coverage, the person can opt to start Part B that month or in any of the three following months. 42 C.F.R. § 406.24(e). This creates an exception to the general rule that Medicare does not provide retroactive coverage. By virtue of 42 C.F.R. § 406.24(e), if GHP coverage ends on the 15th day of a month, and the person has open heart surgery by Dr. Famous on the 20th day of the month, and the person enrolls in Part B on the 31st day of the month, the Part B coverage is retroactive to the 1st of the month and covers the bill of Dr. Famous, heart surgeon.

53. If the person (eligible for a special enrollment period due to loss of GHP or LGHP coverage) does not enroll in Part B in the month of loss of GHP/LGHP coverage or in the following month, but waits until later in the special enrollment period, then Part B coverage does not start until the 1st day of the month following the month of enrollment. Thus, if a person eligible for a special enrollment period loses GHP/LGHP coverage effective January 30th, and enrolls in Medicare Part B on March 1st, and has open heart surgery performed by Dr. Famous on March 31st, Medicare Part B does not cover Dr. Famous’ bill, because under these facts “coverage begins on the 1st day of the month following enrollment.” Since enrollment did not occur in the month when GHP/LGHP

coverage ended (January 30th) nor in February, but rather occurred on March 1st, Part B coverage does not begin until April 1st, under these facts. If Dr. Famous does the open heart surgery on April 1st, it is covered; if Dr. Famous does the surgery on March 31st, it is not covered.

54. This concept of “coverage period” under Medicare Part B is further defined by Section 1838 of the Act and by 42 C.F.R. § 407.25. That regulation provides:

§ 407.25 Beginning of entitlement: Individual enrollment.

The following apply whether an individual is self-enrolled or automatically enrolled in SMI:

(a) *Enrollment during initial enrollment period.*

(1) If an individual enrolls during the first three months of the initial enrollment period, entitlement begins with the first month of eligibility.

(2) If an individual enrolls during the fourth month of the initial enrollment period, entitlement begins with the following month.

(3) If an individual enrolls during the fifth month of the initial enrollment period, entitlement begins with the second month after the month of enrollment.

(4) If an individual enrolls in either of the last two months of the initial enrollment period, entitlement begins with the third month after the month of enrollment.

(b) *Enrollment on reenrollment during general enrollment period.* (1) if an individual enrolls or reenrolls during a general enrollment period, entitlement begins on July 1 of that calendar year.

42 C.F.R. § 407.25. Thus, how early Medicare Part B coverage begins depends on when enrollment occurs.

55. The “coverage period” provisions of Section 1838 of the Act (42 U.S.C. 1395q) and 42 C.F.R. § 407.25 mean that persons who are automatically enrolled in Part B have coverage as of the 1st day of the month of enrollment. Persons who are not automatically enrolled are covered as of the 1st day of the month of eligibility only if they enroll during one of the 3 months before the month of eligibility. Persons who are not automatically enrolled in Part B and who are not entitled to a special enrollment period due to loss of

GHP/LGHP coverage, and who wait longer than the first 3 months before the month of eligibility, will have a gap between enrollment and coverage, as set forth in 42 C.F.R. § 407.25(2), (3), and (4) in paragraph 52, above.

56. **Determining the amount of the Medicare Part B premium.** This is governed by Section 1839 of the Act. Traditionally, the Medicare Part B premium and Part B deductibles and coinsurance have been meant to pay for 25% of Medicare Part B program costs, with the general federal Treasury paying the remaining 75% of program costs.

57. **Increased Part B premium due to late enrollment.** If a person delays enrolling in Medicare Part B beyond the initial enrollment period, the Part B premium is increased by 10% for each year of delay. This does not apply if the person delayed enrollment in Medicare Part B because the person was covered by a group health plan or a large group health plan, and the person enrolls in Part B during a special enrollment period (see paragraphs 44-49, above) on loss of GHP/LGHP coverage. This exception is provided for at 42 C.F.R. § 408.22-24. (Individuals who must pay a premium for Part A have a similar 10% penalty and exceptions for late enrollment. 42 C.F.R. § 406.32 (d).) (Because many self-employed persons do not have GHP or LGHP coverage based on employment, if they delay enrolling, they will pay a penalty.)

58. **Payment of the Medicare Part B premium.** Medicare beneficiaries who receive Social Security or federal civil service benefits or Railroad Retirement System benefits have their monthly Medicare Part B premium deducted from their benefit. Person who do not have their Medicare Part B premium deducted from their benefit pay the premium by “direct remittance.” The Medicare program sends such beneficiaries pre-addressed envelopes with a bill (either monthly or quarterly). (Medicare prefers quarterly billings, but will bill monthly if the beneficiary so requests.) Individuals who have to make direct payment of a Part A premium are billed monthly for that, under 42 C.F.R. § 406.32, and such individuals are also billed monthly for the Part B premium. 42 C.F.R. § 408.60(b).

59. **Premiums for persons in Texas who receive Medicaid.** It should be kept in mind that the Texas Medicaid program pays any applicable Medicare Part A and B premiums (and other deductibles and coinsurance) for Medicaid beneficiaries who also receive Medicaid due to being SSI beneficiaries.

60. Persons who are “Qualified Medicare Beneficiaries” have all their Medicare premiums, deductibles, and coinsurance (including the Part B premium and the Part A premium, if any) paid by the Medicaid program. This “QMB” and the other “Medicare Savings Programs” are discussed in Chapter 7 of this manual. QMB is a program of limited benefits (payment of the Medicare premiums and coinsurance and deductibles) for Medicare enrollees whose countable income is not more than 100% of the federal poverty income limit (FPIL). The other “Medicare Savings Programs” (SLMB and QI-1 (which pay the Part B premium), QI-2 (which pays a small part of the Part B premium), and QDWI (which pays the Part A premium for certain working persons with disabilities) are also discussed in Chapter 7). A person covered by “QMB” is unlikely to need a Medigap policy.

61. **The scope of Medicare Part B benefits.** Section 1832 of the Act defines the scope of Medicare Part B benefits. This is codified at 42 U.S.C. § 1395k. The regulations on Part B benefits are at 42 C.F.R. §§ 410.1 – 410.78.

62. The scope of Medicare Part B benefits under Section 1832 of the Act and under the regulation (42 C.F.R. §§ 410.1 – 410.78), with applicable deductibles and coinsurance amounts, is as follows:

- **Medical and Other Services:** Doctors’ services (except for routine physical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). Also covers second surgical opinions. Also covers outpatient physical and occupational therapy including speech-language therapy. Outpatient mental health care.

- **The beneficiary pays:**
 - ✓ \$100 **deductible** (paid once per calendar year).
 - ✓ 20% of **Medicare-approved amount** after the deductible, except in the outpatient setting.
 - ✓ 20% for all outpatient physical, occupational, and speech-language therapy services.
 - ✓ 50% for outpatient mental health care.

- **Clinical Laboratory Service:** Blood tests, urinalysis, and more.
 - **The beneficiary pays:**
 - ✓ Nothing for Medicare-approved services.

- **Home Health Care:** Part-time skilled care, home health aide services, durable medical equipment when supplied by a home health agency while getting Medicare-covered home health care, and other supplies and services.
 - **The beneficiary pays:**
 - ✓ Nothing for Medicare-approved services.
 - ✓ 20% of Medicare-approved amount for durable medical equipment.

- **Outpatient Hospital Services:** Services for the diagnosis or treatment of an illness or injury.
 - **The beneficiary pays:**
 - ✓ A coinsurance or fixed deductible and/or coinsurance amount which may vary according to the service.

- **Blood:** Pints of blood received as an outpatient, or as part of a Part B covered service.
 - **The beneficiary pays:**
 - ✓ For the first 3 pints of blood, then 20% of the Medicare-approved amount for additional pints of blood (after the deductible), unless the beneficiary or someone else donates blood to replace what is used.

- **Bone Mass Measurement:** Varies with the beneficiary's health status. (For: Certain people with Medicare who are at risk for losing bone mass.)
 - **The beneficiary pays:**
 - ✓ 20% of the Medicare-approved amount (or a set deductible and/or coinsurance amount) after the yearly Part B **deductible**.

- **Colorectal Cancer Screening:** Fecal Occult Blood Test – Once every 12 months. Flexible Sigmoidoscopy – Once every 48 months. Colonoscopy – Once every 24 months if the beneficiary is at high risk for cancer of the colon. Barium Enema – Doctor can substitute for sigmoidoscopy or colonoscopy. (For: All people with Medicare age 50 and older. However, there is no age limit for having a colonoscopy.)
 - **The beneficiary pays:**
 - ✓ Nothing for the fecal occult blood test. For all other tests, 20% of the Medicare-approved amount after the yearly Part B deductible. (25% if performed in an ambulatory surgical center or hospital outpatient department.)

- **Diabetes Services:** Coverage for glucose monitors, test strips, and lancets. Diabetes self-management training. (For: All people with Medicare who have diabetes (insulin users and non-users). If requested by the doctor or other provider.)
 - **The beneficiary pays:**
 - ✓ 20% of the Medicare-approved amount after the yearly Part B deductible.

- **Mammogram Screening:** Once every 12 months. (For: All women with Medicare age 40 and older.)
 - **The beneficiary pays:**
 - ✓ 20% of the Medicare-approved amount with no Part B deductible.

- **Pap Smear and Pelvic Examination:** (Includes a clinical breast exam) Once every 36 months. Once every 12 months if the beneficiary has a high risk for cervical or vaginal cancer, or if the beneficiary is of childbearing age and has had an abnormal Pap smear in the preceding 36 months. (For: All women with Medicare.)
 - **The beneficiary pays:**
 - ✓ Nothing for the Pap smear lab test. For Pap smear collection and pelvic and breast exams, 20% of the Medicare-approved amount (or a set deductible or coinsurance amount) with no Part B deductible.

- **Prostate Cancer Screening:** Digital Rectal Examination – Once every 12 months. Prostate Specific Antigen (PSA) Test – Once every 12 months. (For: All men with Medicare age 50 and older.)
 - **The beneficiary pays:**
 - ✓ Generally, 20% of the Medicare-approved amount for the digital rectal exam after the yearly Part B deductible.

deductible. No **coinsurance** and no Part B deductible for the PSA Test.

- **Shots (vaccinations):** Flu Shot – Once a year in the fall or winter. Pneumonia Shot – One shot may be all that is needed. The beneficiary should ask his or her doctor. Hepatitis B Shot – If the beneficiary is at medium to high risk for hepatitis. (For: All people with Medicare.)
 - **The Beneficiary pays:**
 - ✓ Nothing for flu and pneumonia shots if the health care provider accepts assignment. For Hepatitis B shots, 20% of the Medicare-approved amount (or set deductible and/or coinsurance amount) after the yearly Part B deductible.

Medicare Part B also provides coverage of:

- Ambulance services (when other transportation would endanger the beneficiary's health).
- Artificial limbs and eyes.
- Braces – arm, leg, back, and neck.
- Chiropractic services (limited).
- Emergency care.
- Eyeglasses – one pair after cataract surgery with intraocular lens.
- Immunosuppressive drug therapy (limited), extended coverage available for transplant patients including some ESRD patients.
- Kidney dialysis and kidney transplants.
- Medical supplies – items such as ostomy bags, surgical dressings, splints, casts, and some diabetic supplies.
- Outpatient prescription drugs (very limited). For example, some oral cancer drugs.
- Prosthetic devices, including breast prosthesis after mastectomy.
- Services of practitioners such as clinical psychologists, social workers, and nurse practitioners.
- Transplants – heart, lung, kidney, pancreas, and liver (under certain conditions).
- X-rays and some other diagnostic tests.

Source: Medicare and You 2001, pages 8-10.

63. **Payment of Medicare benefits.** Medicare pays Part A benefits only to the provider of the service. There are very narrow exceptions to this in the case of a “nonparticipating hospital” that provides emergency services, and in the case of Canadian or Mexican hospitals that are “closer or more accessible” than the nearest U.S. hospital

equipped to treat the Medicare beneficiary. Even with these exceptions, Medicare Part A will only pay the beneficiary if the hospital does not elect to receive the payment. In sum, Part A benefits are virtually always paid to the provider. 42 C.F.R. § 409.100.

64. Medicare pays Part B benefits either to the provider or the beneficiary, as follows: For physician's services and durable medical equipment, to the beneficiary or the physician or supplier, as directed by the beneficiary. For Part B services by other types of providers (home health agencies, outpatient clinics, ambulatory surgical centers, rural health clinics, skilled nursing facility services), to the provider. The regulation at 42 C.F.R. § 410.150 governs this.

65. Part A Medicare providers in general are required to accept the payment from the Medicare program plus any applicable beneficiary deductible or coinsurance as payment in full. Under Part B, physicians and suppliers of durable medical equipment can opt to be "participating providers." That means they (1) agree to accept assignment (accept payment by Medicare directly), and (2) agree to accept, as payment in full, the Medicare allowable amount. (The Medicare program pays 80% of the Medicare allowable amount. The beneficiary or another payer must pay the other 20%).

66. Physicians who treat Medicare beneficiaries who are also Medicaid beneficiaries are required to (1) accept assignment; and (2) accept as payment in full the Medicare and Medicaid payment for covered services. Section 1848 of the Act, 42 U.S.C. § 1395 w-4(g)(3).

67. Even if a physician is not a participating provider or is not serving a Medicaid beneficiary, the physician cannot charge the beneficiary more than 115% of the Medicare allowable amount. 42 U.S.C. § 1395w-4(g)(2)(c). Only if the physician has opted to sign an affidavit opting out of Medicare coverage for his or her services for 2 years (under 42 U.S.C. § 1395(b)(3)(B)(ii)) can a physician bill a Medicare beneficiary more than 115% of the Medicare allowable amount.

68. Since 1990, physicians have been required to submit the Medicare claim forms without charge to the beneficiary for the submittal. 42 U.S.C. § 1395w-4(g)(4). Only if the physician signs an affidavit opting out of Medicare coverage for his or her services for 2 years, can the physician avoid the requirement of submitting the claim forms.

69. **Use of private contracts by Medicare beneficiaries.** The “opt out” affidavits mentioned in paragraphs 65 and 66 are required by the statute that allows Medicare beneficiaries and physicians to agree that neither the beneficiary nor the physician will bill the Medicare program. Under such arrangements, the physician and the patient can agree on a bill without being bound by the Medicare allowable amount. Under these “Private Contracts” the Medicare beneficiary agrees not to submit a claim to Medicare. Such “Private Contracts” also require the physician to sign an affidavit agreeing not to accept Medicare payment (either directly or from patients) for 2 years from the date of the affidavit. 42 U.S.C. § 1395a.

70. **Medicare as secondary payer.** Section 1862 of the Act establishes Medicare as a “secondary payer” to group health plans, workmen’s compensation, auto or liability insurance, or no fault insurance. In regard to group health insurance plans, this means that the group plan cannot provide less coverage to Medicare beneficiaries than to other persons. This prevents the group health plan from passing off to Medicare the obligation to cover persons. This does not apply to group health plans with fewer than 20 employees covered. In regard to workmen’s compensation, auto or liability insurance, or no fault insurance, Medicare as secondary payer means this: (1) The Medicare program is “subrogated” to the Medicare beneficiary and can enforce the beneficiary’s right to payment from the workmen’s compensation, auto, liability, or no fault insurer; (2) The beneficiary must cooperate with Medicare to recover Medicare’s costs from the other source of coverage; and (3) If need be, Medicare can sue the other source of coverage to recover what Medicare has paid for the beneficiary. 42 U.S.C. § 1395y(b).

71. **Medicare Summary Notice.** Every time Medicare makes a payment, Medicare must send the beneficiary a statement which (1) lists the services or items for which

Medicare has made payment and the amount of such payment, and (2) informs the beneficiary of the beneficiary's right to request an itemized statement. 42 U.S.C. § 1395b-7(a). This will be sent once per month if Medicare services are received multiple times in a month.

72. In sum, Medicare A and B are a significant advance over the days before 1965 when many more elderly and disabled persons had no health insurance.

73. Medicare Part A and B do not cover all services at present, for instance, Medicare Part A and B do not cover:

- Acupuncture.
- Dental care and dentures (in most cases).
- Cosmetic surgery.
- Custodial care (help with bathing, dressing, toileting, and eating) at home or in a nursing home.
- Health care while traveling outside of the United States (except in limited cases).
- Hearing aids.
- Orthopedic shoes.
- Outpatient prescription drugs (with only a few exceptions).
- Routine foot care.
- Routine eye care.
- Routine or yearly physical exams.

Source: Medicare and You 2001, page 10.

74. To meet some of the gaps between what Medicare A and B cover and what is needed, careful consideration can be given to Medicare managed care (Medicare + Choice) and to Medicare Supplemental Insurance ("Medigap"). These are covered in Chapter 6.