CHAPTER 1

Paying for Health Care

1.1 MEDICARE

Older Americans pay for health care in a variety of ways, including private insurance or insurance provided by their present or former employers. But the primary payer of health care for the elderly is Medicare, enacted in 1965 as part of the Social Security program. Medicare, a federally subsidized health care insurance program for older citizens, is operated by the Centers for Medicare and Medicaid, a part of the Department of Health and Human Services. Medicare does not provide health care; rather it reimburses private care providers.

Medicare consists of four parts: Part A, which pays for hospitalization and other institutionalized care; Part B, which pays for physicians’ charges; Medicare Advantage (formerly Medicare Part C or Medicare + Choice), which pays for health care delivered through managed care entities; and Part D, a prescription drug payment program. Participants in Medicare are referred to as “beneficiaries.”

Medicare beneficiaries must be entitled to Social Security, either as workers who qualify for Social Security or as spouses or former spouses of eligible workers. Workers are citizens and resident aliens, not aliens who stay outside the United States for more than six consecutive months, those who are deported, or those convicted for subversive activity.

3. Id. §§ 406.11, 406.50.
1.2 MEDICARE PART A ELIGIBILITY AND ENROLLMENT

Medicare Part A, which reimburses the costs of hospitalization, limited coverage of post-hospitalization, skilled nursing home care, limited amounts of home health care, and hospice care, is financed by a 2.9 percent payroll tax (1.45 percent each paid by the employer and employee) on all wages and 2.9 percent on self-employment income. Unlike the Social Security payroll tax, there is no limit on the amount of wages or self-employment income subject to the tax. The Affordable Care Act imposed, effective January 1, 2013, the Additional Medicare Tax of .9 percent that is paid only by employees or by self-employed individuals whose wage or compensation income exceeds the threshold amount of $200,000 for a single taxpayer and $240,000 for a married couple filing a joint return.4

[1] Individuals Age 65 or Older

Individuals are eligible for Medicare Part A if they are:

- 65 or older and entitled to monthly Social Security or Railroad Retirement benefits;
- 65 or older and are the spouse or surviving spouse of an individual who is or was entitled to Social Security or Railroad Retirement benefits;
- 65 or older and a divorced spouse, whose marriage lasted at least ten years and who never remarried, of an individual who is or, if deceased, was entitled to monthly Social Security or Railroad Retirement benefits;5 or
- 65 or older and federal, state, or local government employees who were hired after March 31, 1986, who pay the Medicare wage tax even though as public employees they do not participate in Social Security.6

Individuals who are eligible for Medicare Part A because they are age 65 or older and are eligible for Social Security or for Railroad Retirement benefits need not receive such benefits. They must only be eligible.7 For example, Arlene, age 65, was eligible for reduced Social Security benefits

5. 42 C.F.R. § 406.5.
6. Id. § 406.10(a).
7. 42 U.S.C. § 1395c; id. § 406.10.
at age 62, but she is waiting to claim those benefits when she reaches age 66, her full retirement age. At age 65, Arlene is eligible for Medicare. In contrast, Ben, age 62, is receiving Social Security benefits. He will not be eligible for Medicare until he reaches age 65.

An individual who turns age 65 and is receiving Social Security or Railroad Retirement benefits is automatically enrolled in Medicare Part A and Part B. An individual’s Medicare eligibility card is mailed out about three months before he or she turns age 65 with instructions on how to decline Part B (for which there is a monthly premium). Individuals who turn age 65 and are not receiving Social Security or Railroad Retirement benefits must apply for Medicare.

At age 65, dependents and surviving spouses of insured workers are eligible for Medicare. For example, Edith, age 65, is married to Earl, age 67, whose work record makes him eligible for Social Security but who has not yet filed for his Social Security benefits. Edith does not qualify for Social Security on her own work record. Edith is eligible at age 65 for Medicare because her husband, Earl, is entitled to receive Social Security. That he has not yet filed for his Social Security benefits does not affect Edith’s eligibility for Medicare.

A divorced, unmarried spouse or a surviving divorced spouse, who has not remarried, is eligible for Medicare based on the eligibility of the former spouse if the marriage lasted for 10 years or more. For example, Florence, age 65 and single, was married for 20 years to Frank. They divorced when Florence was age 52. She never remarried. Frank is age 67 and eligible for Social Security. Florence is eligible at age 65 for Medicare based on her marriage to Frank. If Frank had died or had remarried before Florence turned age 65, she would still be eligible for Medicare when she turned 65.

Federal, state, and local government employees hired after March 31, 1986, who pay the Medicare wage tax are eligible for Medicare even though as public employees they do not participate in Social Security. To qualify for Medicare they must have the same number of qualifying quarters of employment as those employees covered by Social Security. Their spouses are eligible in the same manner as those of Social Security workers.

8. 42 C.F.R. § 406.6(a).
9. Id. § 406.6(c).
10. Id. § 406.10(a).
11. Id. §§ 406.11, 406.15.
[2] **Individuals under Age 65**  
Although the great majority of Medicare beneficiaries are age 65 or older, some younger persons do participate:

- Individuals under age 65 are eligible for Medicare if they have received Social Security or Railroad Retirement disability benefits for at least 25 months (meaning that they are considered “under a disability”). This includes disabled workers, disabled Railroad Retirement annuitants, and disabled surviving spouses. Individuals receiving Social Security parental benefits who are disabled are deemed to be eligible as disabled surviving spouses. Beneficiaries are automatically enrolled in both Part A and Part B of Medicare beginning in their 25th month of disability. Usually they receive their Medicare card about three months before they are entitled to Medicare.

- Individuals whose disability is caused by amyotrophic lateral sclerosis (ALS, or Lou Gehrig’s disease) need not wait for 25 months to qualify. The application for disability benefits is treated as an application for Medicare.

- Individuals with end-stage renal disease, regardless of their age, are eligible for Medicare. To be eligible the individual must have a permanent and irreversible kidney impairment and require regular kidney dialysis or a kidney transplant. The individual must apply for Medicare and satisfy a waiting period of three months after the first month that dialysis was begun. There is no waiting period if the individual received a kidney transplant or has begun self-dialysis.

[3] **Enrollment**  
As indicated, enrollment for Part A beneficiaries is automatic upon reaching age 65 if they are receiving Social Security or Railroad Retirement benefits. If they are not receiving Social Security or Railroad Retirement benefits, they can apply during their initial enrollment period, which

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12. *Id.* § 406.12.  
13. *Id.* § 406.12(a).  
14. *Id.* § 406.12 (a)(2).  
15. *Id.* § 406.12(a)(1).  
16. *Id.* § 406.12(c).  
17. 42 U.S.C. § 426(h).  
extends for seven months, from the third month before they turn 65 and for the next four months after they turn 65. Application for Medicare benefits can be made online or at a Social Security Administration office, or, for railroad workers, through the Railroad Retirement Board.

Enrolling in Medicare prior to the month of eligibility is preferable because participation in Medicare begins on the first month of eligibility if the beneficiary enrolls during the three months before the date of eligibility. If the individual enrolls in the first month after turning 65, participation begins on the first day of the following month. Enrollment in the second month of eligibility causes participation to begin in the second month after the month of enrollment. If the individual enrolls during the last two months of eligibility, participation does not begin until three months after the month of enrollment.\textsuperscript{19}

Individuals who do not enroll during their initial enrollment period may do so in a later year, but only during the general enrollment period, which takes place each year from January 1 to March 31.\textsuperscript{20}

Eligibility begins on the first day of the month that the individual meets all the eligibility requirements and continues until through the day of death, even though Social Security eligibility terminates on the last day of the month before the month of death.\textsuperscript{21} For example, Garth, age 67, receives Medicare and Social Security. He enters the hospital on June 7 and dies on June 12. Although his Social Security benefits terminate as of May 31, his Medicare eligibility continues through June 12, his date of death. Greta, who is receiving Social Security, turns age 65 on March 22. She automatically is entitled to Medicare beginning on March 1.\textsuperscript{22} If Greta had entered a hospital on March 5, before she turned age 65, her Medicare coverage would have applied because her eligibility commenced on March 1.

[4] Voluntary Enrollment

Some individuals age 65 or older have health insurance through a group health plan offered by their employer or the employer of their spouse. If they enroll in Medicare, their employer-provided insurance may be the primary payer. Medicare does not pay for services that are paid by a group health plan of an employer with 20 or more employees, but it is the secondary payer for noncovered costs that are otherwise covered by

\textsuperscript{19} Id. § 406.22.
\textsuperscript{20} Id. § 406.21.
\textsuperscript{21} Id. § 406.10.
\textsuperscript{22} Id.
Medicare.\textsuperscript{23} It the employer has fewer than 20 employees, Medicare is the primary payer and the employer insurance is the secondary payer. Individuals who have employer-provided group health insurance have the right to defer entry into Medicare, but because there is no premium charged by Part A, there is no reason not to enroll at age 65.\textsuperscript{24} If, however, they failed to enroll, when that employer-based health insurance ends, the individual may enroll in Part A without waiting for a general enrollment period because they are eligible to enroll during a special enrollment period (SEP).\textsuperscript{25} The SEP begins for an individual age 65 or older on the first day of the month in which the individual is no longer covered by the employer group health insurance and terminates at the end of the eighth month after he or she is no longer enrolled in a group health plan. Medicare coverage begins on the first day of the month following the month of their enrollment.\textsuperscript{26}

Individuals who are not eligible for Medicare Part A may voluntarily enroll. They must be at least age 65 and be a resident citizen or a permanent resident alien who has lived in the United States continuously for the immediate five previous years.\textsuperscript{27} Individuals who voluntarily enroll in Part A must also enroll in Part B.

To enroll, individuals must file an application for Medicare during an initial enrollment period that begins on the first day of the third month before eligibility begins (that is, before the individual turns 65 and meets the other eligibility requirements) and continues for seven months thereafter.\textsuperscript{28} For example, although about to turn 65 on April 1, Greta is not eligible for Social Security benefits. She can voluntarily enroll in Medicare Part A during her initial enrollment period, which begins on January 1 and lasts until July 31.

Those who are not eligible for Social Security or Railroad Retirement benefits but who enroll in Medicare Part A must pay a monthly premium set each year according to a statutory formula.\textsuperscript{29} The cost is determined by the number of quarters that they paid Medicare taxes. In 2017, if they paid for less than 30 quarters, the standard Part A premium is $413 per month. If they paid Medicare taxes for 30 to 39 quarters, the standard

\begin{thebibliography}{9}
\bibitem{23} Id. § 411.100(a)(1).
\bibitem{24} Id. § 406.21.
\bibitem{25} Id. § 406.24.
\bibitem{26} Id. § 406.24.
\bibitem{27} 42 U.S.C. § 1395i-2(a); 42 C.F.R. § 406.20(b).
\bibitem{28} 42 C.F.R. § 406.20.
\bibitem{29} Id. § 406.32.
\end{thebibliography}
1.2 Medicare Part A Eligibility and Enrollment

Part A premium is $227 per month. Each month the beneficiary is sent a bill, which must be paid even for the month in which the beneficiary dies. A beneficiary can end participation by giving written notice to the Social Security administration. Participation ends on the last day of the month following the month in which the notification was given.

If an individual’s Medicare eligibility depends upon being eligible for Social Security, if for any reason an individual becomes ineligible for Social Security benefits, he or she is also ineligible for Medicare. Social Security benefits can be lost, for example, if an individual is deported or if a resident alien remains outside the United States for more than six months.


[a] Hospital Insurance Benefits

Medicare Part A provides hospital inpatient insurance benefits that include reimbursement for the usual daily hospital charges including bed and board; nursing services; intern or residents in training services; medical social services such as counseling, drugs, equipment, and supplies; and certain diagnostic and therapeutic services. Part A also pays for the cost of an ambulance providing transportation to and from the hospital. Medicare Part A pays for a semiprivate room or ward room if a bed is available. If the beneficiary insists upon a private room, the hospital can charge the beneficiary the prevailing rate for the extra charge for a private room. Part A does not pay for physicians (who are covered by Part B); nurse practitioners; private duty nurses or attendants (unless required by the beneficiary’s condition); phones; televisions; or post-hospitalization drugs, supplies, and equipment.

Medicare Part A only pays for “inpatient” status. Those treated in a hospital but who are considered to be an “outpatient” are covered under the less generous provisions of Medicare Part B, which imposes co-pays for many services. Even an individual who stays in a hospital overnight may still be considered an outpatient. An individual is an inpatient starting when he or she has been formally admitted to a hospital with a doctor’s

30. Id. § 406.32(e).
31. Id. § 406.28(a)(2).
32. Id. § 409.10–409.18.
33. Id. § 409.27(c).
34. Id. § 409.11.
35. Id. § 409.10(b).
36. Id.
order. The day before the individual is discharged is his or her last inpatient day. Individuals are outpatients if they receive emergency department services, observation services, outpatient surgery, lab tests, X-rays, or any other hospital services, and their doctor has not written an order to admit them to a hospital as an inpatient. Unless formally admitted by a doctor, even if they spend a night in the hospital, they are outpatients.

[b] Spell of Illness and 90-Day-Coverage Period
Medicare reimbursement for hospital benefits is subject to a limited number of days. Part A pays for medically necessary care for up to 90 hospital days per benefit period, but after the first 60 days, the patient is responsible for a daily co-pay. Known as a “spell of illness,” the benefit period begins with initial date of hospitalization and ends 60 days after the day of discharge from a hospital, a Critical Access Hospital (CAH), or from a skilled nursing facility (SNF). Readmission to the hospital during those 60 days, regardless of the health care reason, continues the day count. There are no limits on the number of spells of illness covered by Part A, but for each spell of illness, the beneficiary must pay an initial deductible of $1,316 (in 2017, adjusted annually for inflation) for the initial hospitalization period. After the first 60 days of care, the beneficiary must pay a daily coinsurance of $329 (in 2017) for days 61 through 90. What Medicare refers to as “coinsurance” is more commonly known as a “co-pay.”

For example, Hailey breaks her hip and enters the hospital on May 1, 2017. She is discharged on May 30, for a total of 30 days. Her stay is covered by Part A, though she must pay a deductible of $1,316. On June 10, she suffers a heart attack and returns to the hospital, where she remains for 20 days, leaving on June 30. Part A pays for these 20 days, and there is no deductible, because Hailey is still within the same spell of illness that was in effect for up to 60 days after her discharge on May 30. The fact that she was readmitted for a different ailment is irrelevant in the determination of a spell of illness. As of June 30, she has used 50 days of hospital care. On July 10, she is again admitted to the hospital. She still is within the spell of illness that began on May 1 and did not end until 60 days after her discharge on May 30. Having used up 50 days of coverage, however, if she now remains more than 10 days she will have to pay coinsurance of $329 per day for days 61 through 90.

Another example. Hugh enters the hospital on June 1, 2006. On July 25, he is discharged to an assisted-living facility. Hugh will be credited with

37. Id. § 409.60.
55 days of hospitalization that ended the day he moved into the assisted-living facility. Unlike a nursing home, an assisted-living facility does not qualify as “hospital” care for purposes of Medicare reimbursement because it is not licensed to provide skilled nursing care.

Part A reimbursement for care during a spell of illness ends after 90 days. A beneficiary is entitled to coverage for an unlimited number of 90-day periods, however, as long as they arise from a separate spell of illness even though the medical reason for the hospitalization is the same. For example, in 2017, Jack is diagnosed with cancer. On March 1, he enters the hospital for treatment and is discharged after 10 days. He pays the deductible of $1,316. On July 10, more than 120 days after his discharge, he returns to the hospital for more cancer treatment. Because 60 days have passed since his discharge from the hospital, Jack is in a new spell of illness. He must again pay the $1,316 deductible. Jack remains in the hospital until August 20, for a period of 41 days. He is discharged, but returns to the hospital on September 5. Because he was readmitted within 60 days of his discharge, he is considered to be within the same spell of illness and so when readmitted on September 5, he is on the 42nd day of hospitalization. He does not have to pay the deductible, but if he remains in the hospital for more than 19 days (for a total of 60 days), he will be responsible for the daily coinsurance of $329 a day for up to 30 additional days of hospitalization.

[c] Lifetime Reserve 60-Day Coverage
In addition to the 60 days of Part A full coverage (less the deductible) and the 30 days of coinsurance coverage, beneficiaries have 60 days of “lifetime” reserve days with a daily coinsurance rate of $658 (in 2017). The 60 days is a once-in-a-lifetime benefit. Once used, they are not renewed. After the first 90 days of continuous hospitalization, if all of the lifetime reserve days have been used, the individual is responsible for 100 percent of the cost of their hospitalization.

The beneficiary has the choice of whether to elect to use his or her lifetime reserve days. For example, if the beneficiary had supplemental health insurance that would pay the cost of care past day 90, the beneficiary might prefer not to invoke the lifetime reserve days. If the beneficiary elects to use lifetime reserve days, the election can be revoked by a writing submitted during the stay in the facility or within 90 days after discharge, unless the beneficiary has died or the facility has already filed a claim for Part B Medicare reimbursement.38

38. Id. § 409.66.
For example, Joy entered a hospital on March 1, 2017, and remained there until her discharge on July 1 for a total of 122 days. She was obliged to pay the initial deductible of $1,316 and $329 coinsurance per day for days 60 through 90. After day 90 she elected to use her 60 days of lifetime reserve days and pay the coinsurance of $658 a day for days 90 to 122, or 32 days. She has 28 more lifetime reserve days remaining. On February 1, 2018, she entered a hospital and remained there until her death on March 5, 2018. Because she was discharged from the hospital more than 60 days earlier, she was considered to be in a new spell of illness. Although she must pay the initial deductible of $1,316, Part A will again reimburse her for up to 60 days of hospitalization.

Medicare Part A reimburses in-patient mental health care in the same manner. In 2017, coverage included unlimited benefit periods, an initial deductible of $1,316, no coinsurance for days 1 through 60, coinsurance of $329 for days 60 through 90, and 60 lifetime reserve days with coinsurance of $658. However, inpatient reimbursement is limited to 190 days over a lifetime for inpatient psychiatric hospital care. Additionally, the patient must pay 20 percent of the Medicare-approved amount for mental health services that were provided by doctors or other providers while the patient was in the hospital.

**[d] Skilled Nursing Facility (SNF) Care**

Contrary to popular belief, Medicare Part A does not pay for long-term care. Part A reimburses skilled nursing home care for 100 days of care for each spell of illness, but only if:

- It was medically necessary,
- Entry into the nursing home occurred after three consecutive days of necessary hospitalization, and
- Only if the nursing home care began within 30 days after the date of discharge from the hospital.  

Note that the three consecutive days of hospitalization must have been as an inpatient. Individuals who spent overnights in the hospital under “observational status” do not qualify as having met the requirement of three consecutive days. A class action suit that challenged this interpretation of the Medicare Act was rejected. In response, Congress enacted the Notice of Observation Treatment and Implication for Care Eligibility Act,

40. 42 C.F.R. § 409.30(a).
41. Landers v. Levitt, 545 F.3d 98 (2d Cir. 2009).