

Using Medicare Benefits and Changing Your Coverage

Once enrolled in Medicare, beneficiaries need to know how to actually use their benefits and what options exist when their needs change. This course covers how specific Medicare benefits work in practice and explains the rules and timing around switching plans or Medigap coverage. CPAs and advisors who work with retired clients will find this material especially relevant when clients face coverage changes, annual plan notices, or questions about whether their current plan still meets their needs.

CREDIT HOURS 2 | FIELD OF STUDY BUSINESS | EXAM QUESTIONS 10

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LEARNING ASSIGNMENTS AND OBJECTIVES

Assignment

- Study the full course materials included here.
- Complete the review questions after each chapter.
- Answer 10 final exam questions.
- Final exam is scored immediately, 70% or better passes.
- Certificate of completion is available in your account.
- Failed exams can be retaken free of charge.

Course Objectives

- Recognize how to make sense of the different parts of Medicare.
- Recognize the intricacies involved with changing coverage.

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Chapter 1: GETTING THE INSIDE SCOOP ON USING CERTAIN MEDICARE BENEFITS

Chapter Objective

After completing this chapter, you should be able to:

- Recognize how to make sense of the different parts of Medicare.

Over the years, out of thousands of people who've sent me questions about Medicare, the folks I remember best are the ones who stumped me. They not only asked tough questions but also drew my attention to situations I never knew existed. So then, of course, I scrambled to explore those situations and obtain the answers from legal experts in government agencies, mainly Medicare and Social Security. If that experience was like pulling teeth on occasion, it most often resulted in lighting up some obscure regulations and allowed me to pass along information on these issues to a wider audience. For me, it was a form of higher education, and I'm indebted to the readers who triggered it.

Some of those answers are elsewhere in this course. In this chapter, I examine some of the other finer points of Medicare coverage that aren't always properly explained in the official guides. You may never encounter any of these issues. But if you do, I hope the information in these pages empowers you to get the most out of your coverage and avoid the occasional traps that lurk in the undergrowth of Medicare regulations.

TAKING A CLOSER LOOK AT PART A

I explain aspects of Part A, which primarily helps pay for different types of short-term nursing care, in several other chapters — including what it covers (Chapter 1 of course 81451E of course 81451E, Chapter 2 of course 81451E of course 81451E), what it costs (Chapter 1 of course 81452E), who is eligible (Chapter 1 of course 81453E), and when and how to sign up (Chapter 2 of course 81451E of course 81453E, Chapter 1 of course 81451E of course 81454E). This section looks more closely at Part A services. It explains how **hospital benefit periods** work and considers certain practices in hospitals and skilled nursing facilities (SNFs) that you may never have heard of but need to know how to deal with if you happen to run into them.

Understanding hospital benefit periods

A *hospital benefit period* is one of those pieces in the Medicare jigsaw puzzle that people find especially difficult to understand. And that's not in the least surprising. Wouldn't you think that a

benefit period is simply a length of time during which Medicare will cover your care after you're admitted to the hospital? But no, it doesn't work like that.

Medicare officials explain that a benefit period begins on the day you're admitted and ends when you've been out of the hospital for 60 days in a row. If you leave the hospital on a certain date (for example, May 5) but are readmitted within 60 days of that date (say, June 23), you're still within the same benefit period. But if you go back into the hospital more than 60 days from the time you left (say, July 17), you're then in a new benefit period. The difference between the two has an impact on your costs — perhaps to the tune of hundreds of dollars.

This issue is made more complicated by the fact that any time you spend in a skilled nursing facility (where you may go for continuing care after being discharged from the hospital) also counts toward a benefit period but has different rules and out-of-pocket costs. And — wouldn't you just know — expenses in benefit periods are likely to be different depending on whether you're enrolled in original Medicare or a Medicare Advantage (MA) plan.

In the following sections, I tease apart these different strands to make more sense of benefit periods as they apply either in hospitals or in skilled nursing facilities, in the original program or an MA plan.

Hospital coverage in original Medicare

Here's what you pay and what Medicare pays for hospital care in each separate benefit period:

- **Days 1 through 60:** You're responsible for the first chunk of costs until you've met the Part A hospital deductible (a maximum \$1,736 in 2026). After that, you pay nothing further for hospital care (bed, meals, and nursing services) during the same benefit period. (However, you still need to pay Part B co-pays for doctors' services while you're in the hospital; I discuss Part B in more detail later in this chapter.)
- **Days 61 through 90:** You pay a daily co-pay (\$434 in 2026), regardless of whether you've stayed more than 60 consecutive days in the hospital or have been readmitted during the same benefit period.
- **Beyond 90 days:** You're responsible for 100 percent of the costs — but you can draw on up to 60 *lifetime reserve days* for a hefty daily co-pay (\$868 in 2026), as I explain in Chapter 1 of course 81452E. Medicare places no limit on how many benefit periods you can have. But after you've been out of the hospital for 60 days, you enter a new benefit period. So if you go back into the hospital then, you must meet a new Part A deductible (another \$1,736 in 2026) before coverage kicks in again.

Tip

All Medigap policies provide extra coverage for hospital stays beyond 60 days, and several cover the whole Part A deductible. (You can see which policies cover these benefits in Chapter 2 of course 81452E.)

Perhaps one source of confusion over benefit periods is that three of the rules involve a time frame of 60 days, yet each has a different meaning. So to be clear, here's a quick primer:

- **60 days** = the number of days you must have been out of the hospital or skilled nursing facility to qualify for a new benefit period
- **60 days** = the maximum length of time that Medicare will cover 100 percent of your care in a hospital after you've met the deductible for each benefit period
- **60 days** = the maximum number of lifetime reserve days that you can draw on to extend Medicare coverage for hospital care during one or more benefit periods

Skilled nursing care in original Medicare

The time spent in both the hospital and the SNF count toward a benefit period. And you must stay out of both for 60 days to qualify for a new benefit period.

But your share of the costs in an SNF is different from those listed in the preceding section for hospitals. In an SNF, in any one benefit period, you pay the following:

- **Days 1 through 20:** Nothing for bed, meals, and nursing care
- **Days 21 through 100:** A daily co-pay (\$217 a day in 2026)
- **Beyond 100 days:** All costs

Warning

You can't use any hospital lifetime reserve days to extend Medicare coverage in an SNF beyond 100 days in any one benefit period. However, you may get more coverage if you have a Medigap policy, long-term-care insurance, *Medicaid* coverage, or insurance from an employer or union. If you have one of these, check with your plan to see what SNF charges are covered.

Hospital and SNF coverage in Medicare Advantage plans

Medicare Advantage plans (such as HMOs and PPOs, which I explain in Chapter 1 of course 81451E of course 81455E, Chapter 1 of course 81451E of course 81456E) also use Medicare benefit periods. But their charges for hospital and skilled nursing care vary widely from plan to plan, and they may also be very different from those in original Medicare.

Remember

Typically, Medicare Advantage plans don't charge the Part A deductible for each benefit period. Most often, they charge a flat-dollar daily co-pay for the first several days (which can vary from \$100 to over \$500 a day) and nothing after that for the remainder of the benefit period. Also, Medicare Advantage plans may have different rules from those in the original program. If you're in one of these plans, check your coverage documents or call the plan to be sure of its rules and what a hospital or SNF stay would cost.

Taking note of the three-day rule

If you're in the original Medicare program, you must spend at least three days in the hospital as an officially admitted patient before Medicare will cover your stay in an approved SNF. This type of facility (most often a nursing home) is where you may go for further care needed after being discharged from the hospital, such as intravenous injections or physical therapy.

Remember

The three days must be consecutive. They include the day you're admitted but not the day you're discharged because one "day" counts only if you're in the hospital at midnight. Nor do they include any time you spend in the emergency room. Also — and this point is super-important — you must be an official inpatient during those three days instead of just being held in observation status, which I explain in the following section.

If you haven't met the three-day inpatient requirement, the SNF staff should tell you that Medicare won't cover your stay there. You'll be given an Advance Beneficiary Notice of Non-Coverage (ABN), which you must sign to say you understand you're responsible for all costs if you do stay. (I discuss ABNs in the later section "Receiving a notice saying that Medicare may not pay.")

However, if the SNF fails to give you this warning, and you stay for treatment in the SNF despite not having met the three-day rule, the facility can't bill Medicare — or you — for your stay.

Remember

Note two important exceptions to the three-day rule:

- It's not usually applied to people enrolled in Medicare Advantage plans.
- It affects only coverage in a skilled nursing facility. If you're discharged from the hospital to another kind of facility for specific ongoing care, such as a rehabilitation hospital, Medicare provides coverage under different rules.

Defining observation status

When you're in the hospital — lying in a hospital bed, wearing a hospital gown, with a hospital ID bracelet on your wrist, eating hospital food, and getting nursing care — you may be forgiven for assuming that you're a formally admitted inpatient! But in reality, you may not have been admitted at all. You may have been placed in *observation status* instead. This designation means that

- You're officially classified as an outpatient.
- Your doctor hasn't written an order for you to be admitted as an inpatient.
- Hospital doctors are still “observing” your condition in order to decide whether you should be admitted or discharged.

The following sections explain the effects of being in this status and what you can do to avoid big billing charges.

Understanding the consequences of being in observation status

Remember

For many patients in original Medicare, the distinction between inpatient status and observation (outpatient) status is critically important — maybe even to the extent of costing several thousand dollars — for three reasons:

- **The cost of your hospital stay as an outpatient will be paid under Part B, not Part A.** Therefore, you won't be responsible for the standard Part A hospital deductible (\$1,736 in 2026). But under Part B, each service you receive requires a 20 percent co-pay. And although the amount you pay for a single service can't exceed the amount of the Part A deductible, several different services may add up to more than that. Also, if you are not enrolled in Part B, you would be responsible for the whole hospital bill out of your own pocket.
- **Most hospitals don't allow patients to use their own prescription medicines but provide the drugs and charge full price for them on the hospital bill.** If you have Part D or other drug coverage, you must pay the hospital upfront and then see whether your drug plan will refund the cost.
- **Medicare rules require you to stay in the hospital for three whole days as a formally admitted inpatient before Medicare will cover any continuing care you need in a skilled nursing facility.** I explain this concept in the earlier section “Taking note of the three-day rule.” If you're in observation status for all or part of the three days, Medicare won't pay anything toward your stay in an SNF. (But if you're enrolled in a Medicare Advantage plan, it may not apply the three-day rule; check with the plan.)

Under Medicare regulations, hospitals are supposed to decide whether to admit or discharge patients within 24 hours and should keep them under observation for no more than 48 hours except in “rare and exceptional cases.” But in recent years, hospitals have kept many patients in observation limbo for far longer periods — 72 hours is common, and even 14 days isn't unheard of. Medicare now requires all hospitals to issue notices to people who are being kept in observation to tell them that they are not admitted inpatients. These Medicare Outpatient Observation Notices (known as MOONs) should be issued to patients after they've been in observation status for at least 24 hours and within 36 hours of entering the hospital.

Protecting yourself against big bills

Here's what you can do to try to avoid the charges that may come as a result of being placed in observation status if you (or someone you're looking out for) go into the hospital:

- **Inquire about your status each day you're in the hospital.** It can be changed (from inpatient to observation or vice versa) at any time. The MOON notice that the hospital is

required to give you within 36 hours of entering the hospital should confirm your status, as explained in the preceding section. It should also provide a clinical rationale for your being kept in observation, though the stated reason may be very general — for example, “Patient’s condition needs monitoring” — rather than specific to your own case. If you don’t receive this notice, ask for it.

- **Ask your own doctor whether observation status is justified.** If it isn’t, ask the doctor to call the hospital to explain the medical reasons why you should be admitted as an inpatient. (Many doctors aren’t aware of the financial implications of observation for Medicare patients.)
- **Request that the hospital doctor reconsider your case or refer it to the hospital committee that decides status.**
- **Examine other continuing care options.** If you need rehab or other kinds of continuing care after you’re discharged from the hospital but discover that Medicare won’t cover your stay in a skilled nursing facility because you were in observation status, ask your doctor whether you qualify for similar care at home through Medicare’s home health benefit or Medicare-covered care in a rehabilitation hospital.
- **If you go to a skilled nursing facility and have to pay for it yourself, you can try appealing Medicare’s decision.** When you receive your Medicare Summary Notice (see Chapter 3 of course 81456E), make a copy and highlight the SNF’s charge. Send this copy to the address provided on the notice with a letter saying you want to appeal Medicare’s decision of non-coverage, on the basis that you should’ve been classified as an inpatient during your hospital stay and not placed under observation. If this appeal is denied, you can go to a higher level of appeal, as I explain in Chapter 1 of course 81458E.

Being aware of the improvement standard

Until recently, patients receiving certain kinds of care — notably skilled nursing, home health, or physical therapy — could suddenly have their Medicare coverage terminated on the basis that their medical condition wasn’t “improving.” Never mind that those services were often keeping these patients stable and preventing any further deterioration of their health. The administrative contractors that Medicare relies on to pay claims have often used a rule of thumb known as the *improvement standard* to determine whether Medicare should continue to pay these patients’ bills. (“Administrative contractors?” you say. Don’t worry; I discuss them in a bit more detail later, in the section “Zooming In on Part B.”)

Jimmo v. Sebelius, a class action lawsuit brought by the Center for Medicare Advocacy and settled in 2013, made it clear that this practice — though never part of Medicare law or regulations — should no longer happen.