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Medicare Part A Coverage

Who Is Eligible For Medicare Part A Hospital Benefits?

You are entitled to enroll in Medicare Part A without a monthly premium, when:

a) you are 65 years old and eligible for Title II Social Security or Railroad Retirement benefits or have enough quarters of coverage; or
b) you have been eligible for Title II Social Security or Railroad Retirement disability benefits for at least 24 months following a five-month waiting period; or
c) you have end-stage renal disease.

If you are age 65, but do not meet any of the above qualifications, you can still enroll in the Part A program by paying a monthly premium.

How Much Of My Hospital Stay Will Medicare Part A Cover?

Medicare Part A hospital insurance benefits will cover 90 inpatient days of approved hospital care for each spell of illness. You must pay a Part A deductible of $1,676 (2025) for each spell of illness.

Your "spell of illness" begins the first day you are hospitalized. When the hospital discharges you and you receive no additional hospital or skilled nursing care for the next 60 days, then your first spell of illness ends and a second spell of illness begins if you become sick again. For your second spell of illness, your Part A hospital insurance benefits would again cover 90 inpatient days of hospital care after you paid the new deductible.

If you need more than 60 days of hospital care in the same spell of illness, you will have to pay a daily coinsurance of $419 for the 61st day to the 90th day of each hospital stay.

If you need more than 90 hospital days during a spell of illness, you will have to decide whether to use some of your "lifetime reserve days." Each Medicare beneficiary has 60 nonrenewable lifetime reserve days. You will also have to pay a co-payment of $838 for each lifetime reserve day used.

How Much Of My Hospital Stay Will a Medicare Advantage Plan (MAP) Pay?

Medicare Advantage Plans (MAPs) are offered by private insurance companies and must provide at least the same total level of coverage that Medicare Part A and Part B provide, but the details, including deductibles and co-pays, may differ from Medicare. MAPs often require prior authorization to see specialists, get out-of-network care, get non-emergency hospital care, and more.

Your hospitalization out-of-pocket cost will depend on your Medicare MAP's hospital deductible and co-payment policy for that year. For example, one MAP may charge $250 a day for each day of hospital care up to a maximum of $4,500 per benefit period, while another MAP may charge a flat $300 for each hospital stay without a cap on your potential out of pocket costs. It is therefore crucial that the hospital co-payment and maximum co-payment policies be closely reviewed when selecting a Medicare Advantage Plan.

What Role Does My Doctor Play In The Coverage Of My Hospital Stay?

Medicare will cover your hospital stay if your physician certifies that you need inpatient hospital services for a medically necessary treatment or diagnostic study.

What Is The Prospective Payment System?

The Prospective Payment System provides an averaged payment for each type of diagnosis, also called a "Diagnostic Related Group," or DRG. Hospitals must absorb the difference in cost when your care costs more than the Medicare DRG averaged payment.

What Role Does The Quality Improvement Organization Play In My Hospital Stay?

The Quality Improvement Organization, or QIO, contracts with Medicare to review appeals by patients of hospital discharge notices of noncoverage to prevent patients needing hospital care from being improperly discharged. The QIO makes sure that hospitals provide you with a written notice explaining your right to hospital and post hospital care under Medicare. The QIO also ensures that a hospital that believes you no longer need hospital care, gives you a written notice of noncoverage also known as a Discharge Notice.

What Can I Do if I Disagree With a Proposed Hospital Discharge?

All hospitals must provide you with an Important Message from Medicare which explains your hospital discharge appeal rights, as well as a Discharge Notice if the hospital decides to discharge you. When you are advised of your planned date of discharge, either orally or in writing, if you think you are being asked to leave the hospital too soon, you have the right to appeal to your QIO. The QIO is authorized by Medicare to provide a second opinion about your readiness to leave. You can appeal this proposed discharge by calling 1-800-633-4227 (1-800-MEDICARE) and asking for your local QIO's phone number or by using the contact information on the notice the hospital provides. After calling your local QIO and appealing, you should then confirm your telephone appeal by writing to the QIO's office address.

If you appeal to the QIO no later than the day of scheduled discharge you qualify for an expedited appeal, the QIO is then required to issue a decision within one calendar day of having received all pertinent information. By requesting an expedited appeal, you are not personally responsible for paying for the days you stay in the hospital during the QIO review, even if the QIO disagrees with your appeal. If you request an appeal after the expedited appeal deadline, you may be held responsible for charges incurred after the date of discharge or as otherwise stated by the QIO.

What If My MAP (Part C) Wants Me Discharged And Tells Me I Will Have To Pay For All Of The Additional Care Provided?

You also have the right to appeal a MAP's hospital discharge decision to the Quality Improvement Organization (QIO). The hospital must put your right to appeal in writing. If the MAP or hospital notifies you that you will be discharged, then you have the right to an expedited appeal to avoid financial responsibility for the additional stay in the hospital while your appeal is decided.

What Are My Discharge Planning Rights?

A hospital must advise you of your discharge rights. The law requires hospitals participating in Medicare to:

a) identify each patient at an early stage of hospitalization whose health is likely to suffer upon discharge without adequate planning;

b) evaluate the need for and availability of post hospital care for those patients, and for other patients who request it; and
c) when the doctor asks, arrange for the discharge plan to begin.

How Does Outpatient Status Affect Me?

Hospitals can classify as “Outpatients” patients who are admitted to the hospital under Observation Status. Once a patient has been classified as an Outpatient, the patient can be charged for services that Medicare would normally have covered under “Inpatient” status. The Outpatient status can have significant effects, not only on billing, but on Medicare eligibility for subsequent nursing home care. Hospitals are required to notify the patient, in writing, through a Medicare Outpatient Observation Notice (MOON), that the patient is being classified as an outpatient within 36 hours of being changed to outpatient status. In the MOON, the hospital is required to explain the reasoning for the status and the implications of the status to the patient. Currently a MOON cannot be appealed to Medicare.

Patients most affected by observation status are those who need follow-up care at a skilled nursing facility (SNF). Many Medicare beneficiaries have Medigap policies that cover deductibles for inpatient hospital care and copayments for Part B services. However, Medicare covers a SNF stay under Part A only if the patient was a hospital inpatient for at least three consecutive nights. Patients under observation are responsible for paying their entire SNF bill out-of-pocket.