

Medicare General Information, Eligibility, and Entitlement

Chapter 2 - Hospital Insurance and Supplementary Medical Insurance

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10 - Hospital Insurance Entitlement - (Rev. 1, 09-11-02)

Hospital insurance (HI), as well as supplementary medical insurance (SMI), is available to three basic groups of "insured individuals"- the aged, the disabled, and those with end stage renal disease. Following is an explanation of how an individual becomes "insured" as well as an explanation of the eligibility requirements for each group.

10.1 - Insured Status- (Rev. 1, 09-11-02)

To be eligible for premium-free HI, an individual must be "insured" based on his or her own earnings or those of a spouse, parent, or child. To be insured, the worker must have a specific number of quarters of coverage (QCs); the exact number required is dependent upon whether the person is filing for HI on the basis of age, disability, or end stage renal disease. QCs are earned through payment of payroll taxes under the Federal Insurance Contributions Act (FICA) during the person's working years. QCs earned by an individual who pays the full FICA tax are usable to insure the person for both monthly social security benefits and HI.

Federal employees were exempt from payment of FICA taxes prior to January 1983. However, beginning in January 1983, Federal employees became subject to the HI portion of the FICA tax (those actually employed in January 1983 were also deemed to have earned HI quarters of coverage for their Federal service prior to January 1983). Also, Government employees who pay only the HI portion of the FICA tax are only insured for HI; they are not insured for monthly social security benefits.

State and local Government employees hired after March 31, 1986, are eligible for Medicare coverage and must pay the HI portion of the FICA tax. A State may elect to cover employees hired prior to April 1986 for the Medicare portion of the FICA tax by requesting an agreement or modification of its existing agreement under section 218 of the Social Security Act.

10.2 - Hospital Insurance for the Aged - (Rev. 1, 09-11-02)

To be eligible for HI on the basis of age, a person must be age 65 or older and either eligible for monthly social security or railroad retirement cash benefits, or would be eligible for such benefits if the worker's Government QCs were regular social security QCs. An individual who is insured for monthly benefits need not actually file for benefits to receive HI benefits. If such a person continues to work beyond age 65, he or she may instead elect to file an application for HI only.

Premium-free HI for the aged begins with the month in which the individual attains age 65, provided he or she files an application for HI or for cash benefits and HI within 6 months of the month in which he or she attains age 65. If the application is filed later than that, HI entitlement can be retroactive for only 6 months. An individual attains age 65 on the day before his or her 65th birthday. For example, if an individual is born on August 1, the attainment date is July 31, and HI begins with July 1. Entitlement generally does not end until death.

10.3 - Hospital Insurance for Disability Beneficiaries - (Rev. 1, 09-11-02)

A disabled person who is entitled to social security or railroad retirement benefits on the basis of disability is automatically entitled to HI after 24 months of entitlement to such benefits. Since there is a 5-month disability benefits waiting period, the person actually becomes entitled to HI after being disabled for 29 months.

In addition, disabled persons who are not insured for monthly Social Security disability benefits but would be insured for such benefits if Government QCs were treated as social security QCs, are deemed to be entitled to disability benefits and automatically entitled to HI after being disabled for 29 months.

The months in the Medicare qualifying period need not be consecutive so that months from a previous period of disability benefit entitlement generally may be counted in determining when the qualifying period requirement is met. HI entitlement on the basis of disability is available not only to the worker, but to the widow, widower, or child of a deceased, disabled, or retired worker if any of them become disabled within the meaning of the Social Security or Railroad Retirement Acts.

If an individual recovers from a disability, HI entitlement ends with the month after the month he or she is notified of the disability termination. For example, if notification is November 15, entitlement ends December 31. However, if the individual's disability benefit entitlement ends only because he or she was working, HI entitlement may continue for up to 78 additional months.

10.4 - Hospital Insurance for Persons Needing Kidney Transplant or Dialysis - (Rev. 1, 09-11-02)

Individuals of any age with end stage renal disease (ESRD) who receive dialysis on a regular basis or a kidney transplant are eligible for HI (and are deemed enrolled for Supplementary Medical Insurance (SMI) unless such coverage is refused) if they file an

application. They must also meet certain work requirements for insured status under the social security or railroad retirement programs, or be entitled to monthly social security benefits or an annuity under the Railroad Retirement Act, or be the spouse or dependent child of an insured or entitled person.

10.4.1 - Effective Date of Entitlement for Persons on Dialysis - (Rev. 1, 09-11-02)

Entitlement usually begins after a 3-month waiting period has been served, i.e., with the first day of the third month after the month in which a course of regular dialysis begins. Entitlement begins before the waiting period has expired if the individual receives a transplant or participates in a self-dialysis training program during the waiting period..

10.4.2 - Entitlement Based on Transplant - (Rev. 1, 09-11-02)

Entitlement begins with the month the individual is admitted as an inpatient to a hospital for procedures in preparation for or in anticipation of a kidney transplant, provided the transplant surgery takes place within the following 2 months. If the transplant is delayed more than 2 months after the preparatory hospitalization, entitlement begins with the second month prior to the month of transplant. Under the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000, Congress extended immunosuppressive drug benefits to lifetime, as long as the beneficiary is entitled to Medicare and was entitled to Medicare when his/her transplant took place.

10.4.3 - Effect on Self-dialysis Training on Entitlement - (Rev. 1, 09-11-02)

Entitlement begins with the first month of the course of dialysis if the individual is expected to complete the self-dialysis training program and self-dialyze thereafter.

10.4.4 - End of Coverage Based on ESRD - (Rev. 1, 09-11-02)

HI coverage based on ESRD ends with the earliest of the following dates:

- The day an individual dies,
- The last day of the 12th month after the month the course of dialysis is discontinued, unless the individual receives a kidney transplant during that period or begins another course of dialysis, or
- The last day of the 36th month after the month the person receives a kidney transplant.

10.4.5 - Reentitlement for Beneficiaries with ESRD - (Rev. 1, 09-11-02)

If a person whose entitlement based on ESRD has ended begins a new course of regular dialysis or has a kidney transplant, reentitlement begins without a waiting period.

20 - Hospital Insurance Obtained by Premium Payment - (Rev. 1, 09-11-02)

20.1 - Eligibility Requirements - (Rev. 1, 09-11-02)

Individuals who want hospital insurance coverage but who are not otherwise eligible (i.e., do not qualify under either the regular or deemed insured provisions, in §§10.1, 10.2, 10.3 10.4 above) may obtain such coverage by enrolling timely, paying a monthly premium, and upon meeting the following three requirements:

- Attaining age 65,
- Enrolling or already having enrolled in the SMI program,
- Being a resident of the U.S., and either:
 - A citizen, or
 - An alien lawfully admitted for permanent residence who has resided continuously in the U.S. for the 5 years prior to the month of enrollment.

20.2 - Premiums for Hospital Insurance - (Rev. 1, 09-11-02)

Each year, the Secretary of the Department of Health and Human Services announces the amount of the hospital insurance premium payable for each month in the following calendar year. The applicable premium amount is 33/76 (about 43.4 percent) of the hospital insurance deductible for that calendar year. The premium is rounded to the nearest \$1. An individual who is not entitled to free Part A and wishes this type of coverage must enroll him/herself during the appropriate enrollment period. A premium is due for each month of entitlement under Premium HI.

20.3 - Beginning of Coverage - (Rev. 1, 09-11-02)

20.3.1 - Initial Enrollment Period (IEP) - (Rev. 1, 09-11-02)

Persons may enroll for premium hospital insurance by filing a request during the IEP which begins the third month before the month of first eligibility and lasts for 7 months. The individual's IEP for premium hospital insurance is in most cases the same 7-month period as the IEP for SMI.

The individual may enroll for hospital insurance when he or she enrolls for SMI, or later during his or her IEP. The beginning date of an individual's premium hospital insurance coverage period is determined by the rules applicable to SMI coverage based on an SMI enrollment during an IEP. (See chapter 2 §40 below.)

20.3.2 - General Enrollment Period (GEP)- (Rev. 1, 09-11-02)

Eligible persons who have not enrolled for premium hospital insurance during their IEP, or whose premium hospital insurance has been terminated, may enroll during a GEP (January 1 - March 31 of each year) if they are enrolling or have enrolled for SMI. As with SMI, an eligible person who enrolls for hospital insurance during a GEP will have hospital insurance coverage beginning the following July.

The same restrictions on enrollment and reenrollment apply as in the SMI program. Individuals who enroll late may pay a 10 percent premium penalty.

30 - End of Coverage for Hospital Insurance - (Rev. 1, 09-11-02)

A beneficiary's entitlement under the provision terminates:

- With the month of the individual's death,
- With the last day of the third month following the premium billing month (for nonpayment of premiums),
- With the end of the month following the month in which he or she files a voluntary request for termination,
- With the month SMI coverage is terminated, or
- With the month before the month in which he or she becomes entitled to hospital insurance under the regular or ESRD provisions. (See §2, §10.4 of this chapter.)

40 - Supplementary Medical Insurance (SMI)- (Rev. 1, 09-11-02)

Unlike the HI benefits program, which is largely financed by compulsory taxes on employers, employees, and the self-employed, the SMI benefits program is a voluntary program financed from premium payments by enrollees, together with contributions from funds appropriated by the Federal Government, and certain deductible and cost-sharing provisions.

40.1 - Eligibility for Enrollment - (Rev. 1, 09-11-02)

To obtain SMI coverage, eligible individuals must enroll in the plan during an enrollment period open to them and pay the required premiums. They are eligible to enroll if they are entitled to premium-free HI, or are age 65 and resident citizens or resident aliens. To qualify as a resident alien, an individual must have been lawfully admitted for permanent residence and have resided continuously in the United States during the 5 years immediately preceding the month of enrollment.

40.2 - Automatic Enrollment in SMI - (Rev. 1, 09-11-02)

Beneficiaries (except those residing in foreign countries or Puerto Rico) are deemed to have enrolled in SMI in the month before the month for which they are entitled to HI so

that HI and SMI coverage start in the same month. Thus, monthly beneficiaries other than disability beneficiaries are deemed to enroll in the month before attainment of age 65. Disability beneficiaries are deemed to enroll in the 24th consecutive month of entitlement to disability benefits.

Every potential "deemed" enrollee is given a reasonable opportunity (at least 2 months) to decline SMI enrollment by filing notice to this effect. He or she is deemed not to have enrolled and does not incur any premium liability. A refusal of SMI not timely filed is treated as a request for voluntary termination under existing disenrollment rules once it has been established that the individual does not wish to have SMI.

40.3 - Enrollment Periods - (Rev. 1, 09-11-02)

Enrollment is possible only during specified enrollment periods:

- An individual's initial enrollment period is of 7 months duration. It begins 3 full calendar months before and ends 3 full calendar months after the month in which the individual first meets all the requirements for enrollment.
- A general enrollment period occurs each year from January 1 through March 31. Coverage is effective the following July 1. These periods afford enrollment opportunities to those who failed to enroll during their initial enrollment periods and to those whose enrollment has terminated.
- A special enrollment period (SEP) is available, effective November 1984, for individuals age 65 or over who did not enroll in SMI when first eligible (or who terminated SMI enrollment because of coverage under a group health plan (GHP) based on their own or a spouse's current employment status). These individuals may enroll in SMI anytime while covered under the GHP or during the 8-month period immediately following the last month of GHP coverage based on current employment status.
- An SEP also became available, effective January 1987, for disabled beneficiaries under age 65 who did not enroll in SMI when first eligible (or who terminated SMI enrollment because of coverage under a GHP or a large group health plan (LGHP) based on their own or a family member's current employment status. These individuals may also enroll in SMI anytime while covered under the GHP/LGHP or during the 8-month period immediately following the last month of GHP/LGHP coverage based on current employment status.
- There is no SEP for individuals who have ESRD. This includes individuals who are dually entitled to Medicare based on ESRD and age or disability.

40.3.1 - Enrollment During the Individual's Initial Enrollment Period - (Rev. 1, 09-11-02)

Coverage begins on the first day of:

- The month in which the individual first becomes eligible for SMI if enrollment takes place during the first 3 months of the initial enrollment period,
- The month following the month of enrollment if enrollment occurs during the fourth month of the initial enrollment period,
- The second month following the month of enrollment if enrollment occurs during the fifth month of the initial enrollment period, or
- The third month following the month of enrollment if enrollment occurs during the sixth or seventh month of the initial enrollment period.

40.3.2 - Enrollment During General Enrollment Period - (Rev. 1, 09-11-02)

Coverage begins the following July 1.

40.3.3 - Enrollment During the Individual's Special Enrollment Period - (Rev. 1, 09-11-02)

If an individual enrolls in SMI or premium HI while still covered under a GHP or LGHP or during the first full month when not enrolled in a GHP/LGHP based on current employment status, coverage begins either with:

- The first day of the month of SMI or premium HI enrollment, or
- At the individual's option, with the first day of any of the following 3 months.

If the individual enrolls during any of the 7 remaining months of the special enrollment period, coverage begins with the first day of the month following the month of enrollment;

40.4 - Nature and Purpose of State Buy-in - (Rev. 1, 09-11-02)

Under the buy-in program, States may enroll certain groups of needy people in the supplementary medical insurance program and pay their premiums. The purpose of buy-in is to permit the State, as part of its total assistance plan, to provide medical insurance protection to designated categories of needy individuals who are eligible for Medicaid and also meet the eligibility requirements for SMI. It has the effect of transferring some medical costs for this population from the title XIX Medicaid program, which is partially State financed, to the title XVIII program, which is financed by the Federal Government. Federal matching money is available through the Medicaid program to assist the States with the premium payments for certain buy-in enrollees.

40.5 - End of Coverage - (Rev. 1, 09-11-02)

An individual may notify CMS in writing, at any time, that he or she no longer wishes to participate in the supplementary medical insurance plan. Termination of coverage takes

effect at the close of the calendar month following the calendar month in which the request for termination was filed.

Enrollment under medical insurance is terminated because of nonpayment of premiums. Termination is effective with the end of the grace period provided for payment of premiums. (See chapter 2, §40.7.4 of this manual.)

For individuals under age 65, enrollment is terminated because HI entitlement ended. SMI terminates at the same time as HI.

If not terminated sooner, coverage ends with the beneficiary's death.

40.6 - Termination and Reenrollment - (Rev. 1, 09-11-02)

An individual whose enrollment has terminated may reenroll only in a general enrollment period or a special enrollment period if the requirements are met.

40.7 - Premiums - (Rev. 1, 09-11-02)

A premium is due for each month of entitlement under SMI. The SMI premium covers about one-fourth of the cost of the Part B program.

40.7.1 - Amount of Premiums - (Rev. 1, 09-11-02)

In the third quarter of each calendar year, the Secretary of the Department of Health and Human Services announces the base premium for SMI coverage that is payable as of the following January 1. The SMI premium is the same for all enrollees even though the cost to the program is greater for ESRD enrollees and the disabled than it is for the aged. The SMI premium is refigured each year and is based on the lower of one-half of SMI program costs per aged enrollee or the general percentage by which social security benefits were increased during the calendar year in which the announcement occurs. (During the 5-year period, January 1984 through December 1988, the formula for computing the SMI premium has been modified to provide that the Part B premium reflects exactly one-fourth of the cost of the Part B program. Beginning with the premium announced for the period beginning January 1989, however, the method of computing the SMI premium reverts back to the pre-January 1984 rules.)

40.7.2 - Increase in Base Premium Amount - (Rev. 1, 09-11-02)

The base premium that is announced by the Secretary is paid by most enrollees. However, it is increased for those who enroll late or reenroll after a prior termination of entitlement. The amount of the increase is 10 percent of the base rate for each full 12-month period during which the individual could have been but was not enrolled in the program. However, months in which an individual has GHP coverage based on current employment status are not counted as months in which the individual "could have been,

but was not enrolled." This exception does not apply to individuals who are entitled to Medicare on the basis of ESRD.

40.7.3 - Collection of Premiums - (Rev. 1, 09-11-02)

SMI premiums are collected from benefits payable (in order of priority) by the Railroad Retirement Board, SSA, or Office of Personnel Management (Civil Service) unless the individual is covered under a State buy-in agreement. If the individual is entitled to such benefits but the payments are in suspense, e.g., due to work deductions, he or she is billed for the amounts due. Uninsured beneficiaries are also billed directly for the premiums due.

Premium bills are sent every 3 months unless the individual specifically requests a monthly bill or is also entitled to Premium -HI (in which case a monthly combined SMI-Premium-HI bill is sent).

40.7.4 - Grace Period for Payment - (Rev. 1, 09-11-02)

A grace period has been provided for payment of premiums by those who are billed directly. The period extends for 90 days after the month in which the bill is mailed. If the premiums are not received in that prescribed time, entitlement terminates at the end of the grace period. This 90-day grace period for paying overdue SMI premiums and continuing SMI coverage may be extended by CMS for good cause for up to an additional 90 days. Good cause, for example, is found if the enrollee was mentally or physically incapable of paying his or her premiums timely, or had some reasonable basis to believe that payment had been made, or the failure to pay was due to administrative error.

40.7.5 - Payment After Grace Period Applies - (Rev. 1, 09-11-02)

If an extension to the grace period (additional 90 days; a total not to exceed 180 days) has been granted, an enrollee may retain SMI entitlement by paying all past due premiums if there was a good cause for his/her failure to pay premiums within the initial grace period.

40.7.6 - Premiums Paid by Other Than the Enrollee - (Rev. 1, 09-11-02)

The following subsections describe premiums paid by other than the enrollee.

40.7.6.1 - Informal Arrangement

Enrollees who are being billed directly for Medicare premiums may turn over their premium bills to a friend, relative, employer lodge, union or other organization to pay premiums on their behalf. The third party payer forwards the proper amount of payment for each enrollee to CMS's Premium Collection Center. Enrollees participating in this type of informal arrangement continue to receive their premium notice (Form CMS-500),

and remain responsible for assuring that premiums paid on their behalf are paid timely in order to avoid termination of Medicare coverage.

40.7.6.2 - Premium Payer

Individuals may be designated as the premium payer for an enrollee and receive the enrollee's premium bills, if it is judged to be in the enrollee's best interest (e.g., the enrollee is competent, but too physically ill or infirm to be able to handle such matters). The individual receiving the premium bill must be a relative or friend showing personal interest in the welfare of the enrollee.

40.7.6.3 - Formal Group Arrangement

Employers, religious orders, lodges, unions or other organizations may enter into a formal agreement with CMS in order to receive a single bill and pay a lump sum for the premiums due from a group of individuals. Group payments under a formal group agreement may be made only on behalf of individuals who are already enrolled and are being billed for direct remittance. This type of arrangement is referred to as a "Formal Group Payer" arrangement. While included in a formal group payer arrangement, enrollees will no longer receive a premium notice (Form CMS-500). This arrangement is available only where the number of enrollees in the group is large enough to make it practicable to send one bill to the group payer and where the following conditions are also met:

- Enrollees included under the formal group arrangement are directly billed for their premium, and are not having his/her premiums deducted from a Social Security, Railroad Retirement, or Civil Service benefit, or, are not having premiums paid by a State Medicaid agency under a State buy-in agreement;
- The enrollee authorizes the formal group payer to pay premiums on his/her behalf;
- The formal group payer has a minimum of 20 enrollees; and
- The formal group payer agrees to submit premium payments via electronic funds transfer.

If the formal group payer agreement is terminated, or if the group payer alerts CMS to remove an individual from the group payer arrangement, CMS will resume collection of premiums from the individual through the direct billing process.

40.7.6.4 - Premium Surcharge Payment

States or local Governments may pay a lump sum for the total amount of the SMI late enrollment premium surcharge for a group of individuals. In order to pay the premium surcharge, States or local Governmental entities are required to enter into a formal agreement with CMS. An individual is not billed for the premium surcharge portion of

his/her SMI premium while under a premium surcharge agreement, however, he/she is billed for the base premium amount. If the enrollee is receiving a Social Security, Railroad Retirement, or Civil Service annuity, the agencies responsible for these programs will continue to withhold the base premium amount from the annuity. Enrollees who are billed directly for premiums will continue to receive a premium bill for the base premium amount.

The ultimate responsibility for paying premiums rests with the enrollees.

40.7.7 - Premiums Under Buy-In - (Rev. 1, 09-11-02)

Although a person who individually enrolls for SMI may be subject to an increase in the premium rate if he or she fails to enroll when first eligible, a State always pays premiums for its enrollees at the base rate. No premium surcharge for late enrollment is imposed.

40.8 - Waiver of Enrollment Period Requirements Due to Administrative Error - (Rev. 1, 09-11-02)

CMS and SSA are authorized to take necessary action to correct an erroneous SMI or premium hospital insurance enrollment or nonenrollment which was based upon the action, inaction, or error of a Government officer, employee, or agent. The action may include designating special individual enrollment periods and premium adjustments.

For the purpose of this provision, an individual's enrollment or nonenrollment in SMI is considered to have been prejudiced and due to the "action, inaction, or error" of an officer, employee, or agent of the Government, if there is an official record or other evidence showing that:

- The individual took reasonable appropriate and timely measures to assert his or her rights, and
- Due to administrative fault or other action, which may or may not have been erroneous at the time taken, his or her rights have been or are likely to be impaired unless relief is given.

This authority applies to all Part B cases which have arisen since the Medicare program began on July 1, 1966. It is applied to cases that come to CMS's or SSA's attention; however, intermediaries and carriers should not search their files.

50 - Identifying the Patient's Health Insurance Record Using the Health Insurance Card - (Rev. 1, 09-11-02)

As part of health insurance electronic data processing, health insurance cards are issued by CMS (or by the RRB where railroad retirement beneficiaries are involved) to individuals who have established entitlement to health insurance. An example of the Health Insurance card is found at the bottom of:

<http://www.medicare.gov/Basics/ymc.asp>

The HI card is used to identify the individual as being entitled and also serves as a source of information required to process Medicare claims or bills. It displays the beneficiary's name, sex, Health Insurance Claim Number (HICN), and effective date of entitlement to hospital insurance and/or medical insurance.

The Social Security Administration's Social Security Office assists in replacing a lost or destroyed HI card.

50.1 - Temporary Eligibility Notice - (Rev. 1, 09-11-02)

A Social Security field office may issue a temporary health insurance eligibility notice if medical services are needed immediately. Sample text for such notices follows:

TEMPORARY NOTICE OF MEDICARE ELIGIBILITY

(If the individual is only eligible for HI or SMI, delete the inapplicable words)

District Office Address:

Date:

Patients HICN

Dear

Based on the information given to the Social Security Administration, you are (Mr./Ms. is) eligible for hospital insurance beginning (mo.) (yr.) and for medical insurance beginning (mo.) (yr.) . This notice will serve as evidence of your (his,her) eligibility for these benefits for 60 days from the date shown at the top of this notice, unless you are notified otherwise during the 60-day period.

To obtain medical services (or payment for medical services) before you receive a health insurance card, show this letter to your hospital or doctor, but keep the letter with you. This temporary notice of eligibility is to be used only by the person to whom it is addressed. Misuse is unlawful and will make the offender liable to a penalty.

This letter should be destroyed as soon as you receive a health insurance card or other notice of eligibility.

Sincerely Yours,

Commissioner of Social Security

IMPORTANT: When services are provided on the basis of this notice, all bills or correspondence with a carrier, intermediary, or the Social Security Administration should show the patient's health insurance claim number.

50.2 - Health Insurance Claims Numbers (HICNs)- (Rev. 1, 09-11-02)

All HICNs issued by SSA are 9-digit numbers with at least one letter suffix (called a beneficiary identification code or BIC) in the tenth position. If there is an eleventh position, it may be either a letter or number e.g. 123-45-6789A or 987-65-4321D4. The HICN issued by the RRB, may contain either 6 or 9 digit numbers with up to a 3-position letter prefix e.g., A123456 or MA123-45-6789. If a beneficiary's entitlement changes, it is possible for the 9-digit number, the prefix, the suffix or all three to change. It is also possible to go from an SSA issued HICN to a RRB HICN or vice versa.

The numeric portion of a 9-digit HICN consists of a Social Security Number (SSN). If the BIC is A, T, TA, M, M1, J1, J2, J3, J4 or the RRB prefix is A or H the number is the beneficiary's own SSN. If the BIC or RRB prefix is other than one of the above, the SSN belongs to a number holder and the beneficiary is entitled as an auxiliary or survivor on that SSN.

Currently, the first three digits of the HICN range from 001-772. However this may change as SSA issues more numbers. All numbers except 00 are possible for the fourth and fifth digits and all numbers except 0000 are possible for the last four digits.

The patient's HICN is on his/her HI card, SSA award letter, SSA Benefit Verification letter, an SSA issued Temporary Notice of Eligibility, Explanation of Medicare Benefits (EOMB), Notice of Utilization (NOU), or Medicare Summary Notice (MSN). Where the patient cannot furnish a HICN, it may be an indication that he/she has not filed an application with SSA to establish entitlement to health insurance benefits, or that SSA action on a pending application has not been completed.

50.3 - HICNs Assigned by CMS - (Rev. 1, 09-11-02)

(See Section 50.2 for an explanation of the valid 9-digit numbers issued by SSA.)

A
B, B1, B2, B3, B4, B5, B6, B7, B8, B9, BA, BD, BG, BH, BJ, BK, BL, BN, BP, BQ, BR, BT, BW, BY
CI, C2, C3, C4, C5, C6, C7, C8, C9, CA, CB, CC, CD, CE, CF, CG, CH, CI, CJ, CK, CL, CM, CN, CO, CP, CQ, CR, CS, CT, CU, CV, CW, CX, CY, CZ
D, D1, D2, D3, D4, D5, D6, D7, D8, D9, DA, DC, DD, DG, DH, DJ, DK, DL, DM, DN, DP, DQ, DR, DS, DT, DV, DW, DX, DY, DZ
E, E1, E2, E3, E4, E5, E6, E7, E8, E9, EA, EB, EC, ED, EF, EG, EH, EJ, EK, EM

Fl, F2, F3, F4, F5, F6, F7, F8
Jl, J2, J3,J4
Kl, K2, K3, K4, K5, K6, K7, K8, K9, KA, KB, KC, KD, KE, KF, KG, KH, KJ, KL, KM
T, TA, TB, TC, TD, TE, TF, TG, TH, TJ, TK, TL, TM, TN, TP, TQ, TR, TS, TT, TU, TV, TW, TX, TY, TZ, and T2
W, Wl, W2, W3, W4, W5, W6, W7, W8, W9, WB, WC, WF, WG, WJ, WR, WT

50.4 - HICNs Assigned by the RRB - (Rev. 1, 09-11-02)

The RRB began using the social security number in their numbering system during calendar year 1964. The HICNs assigned prior to that time were 6-digit numbers assigned in numerical sequence and had no special characteristics. However, both the 6-digit numbers and the 9-digit social security numbers when used as claim numbers by the RRB always have letter prefixes. In rare cases, a qualified railroad retirement beneficiary may have a claim number with less than 6-digits. In this case, sufficient zeros are added between the prefix and other digits to make a 6-digit number, e.g., WD-001234. The current range of valid RRB claim numbers is 000001-994999.

50.4.1 - Six-Digit Numbers - (Rev. 1, 09-11-02)

The basic RRB claim numbers assigned to each type of prefix are shown in this section. Under the RRB system, it is permissible for two beneficiaries to have identical claim numbers. For example, when a widower remarries, the second wife is assigned the same claim number that was assigned to the first wife. Under the Medicare program, however, every individual has a distinctive claim number. Therefore, for Medicare purposes, pseudo numbers are assigned to railroad retirement beneficiaries who would otherwise have a claim number that was assigned to someone else.

The numbers in the series 995000 through 999999 were assigned to these beneficiaries. But, whenever possible, the Board will use the railroad retirement beneficiary's own 9-digit social security number with the appropriate prefix. They will only use the 6-digit number if the railroad retirement beneficiary does not have their own social security number and cannot obtain one because of Social Security Administration limitations on issuing numbers. An example of an individual who cannot get a number is a beneficiary who lives outside the United States and is not a citizen of the U.S.

50.4.2 - Valid RRB HICNs - (Rev. 1, 09-11-02)

A-000000	WD-000000	PD-000000
A-000-00-0000	WD-000-00-0000	PD-000-00-0000
MA-000000	WCD-000000	H-000000

MA-000-00-0000	WCD-000-00-0000	MH-000000
WA-000000	WCA-000000	PH-000000
WA-000-00-0000	WCA-000-00-0000	JA-000000
CA-000000	PA-000000	WH-000000
CA-000-00-0000	PA-000-00-0000	WH-000-00-0000
H-000-00-0000	MH-000-00-0000	WCH-000000
JA-000-00-0000	PH-000-00-0000	WCH-000-00-0000

60 - Medicare Part C, Medicare+Choice - (Rev. 1, 09-11-02)

Medicare Part C, which is also known as Medicare+Choice, is a Medicare program that gives beneficiaries more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have end stage renal disease, and were not in a Medicare+Choice plan at the onset of this condition.

Public Law 105-33, the Balanced Budget Act of 1997, establishes a new authority permitting contracts between CMS and a variety of different managed care and fee-for-service entities. The types of entities that may be granted contracts under this new authority include:

- Coordinated care plans, including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Provider-Sponsored Organizations (PSOs). A PSO is defined as a public or private entity established by health care providers, which provide a substantial proportion of health care items and services directly through affiliated providers who share, directly or indirectly, substantial financial risk.
- Religious fraternal benefit society plans which may restrict enrollment to members of the church, convention or group with which the society is affiliated. Payments to such plans may be adjusted, as appropriate to take into account the actuarial characteristics and experience of plan enrollees.
- Private fee-for-service plans which reimburse providers on a fee-for-service basis, and are authorized to charge enrolled beneficiaries up to 115 percent of the plan's payment schedule (which may be different from the Medicare fee schedule).

In addition to the Medicare+Choice contractors, beginning in January, 1999, up to 390,000 beneficiaries will have the choice (on a demonstration basis ending January 1, 2003) of enrolling in a Medical Savings Account (MSA) option. Under this option, beneficiaries would obtain high deductible health policies that pay for at least all Medicare-covered items and services after an enrollee meets the annual deductible of up to \$6,000. The difference between the premiums for such high deductible policies and the applicable Medicare+Choice premium amount would be placed into an account for the beneficiary to use in meeting his or her deductible expenses.

Past 1876 Contracts - HMO/CMP risk plans that remain in compliance with current contracting standards and comply with new requirements established under this statutory authority automatically transitioned into the Part C Medicare+Choice program. Section 1876 risk-based contractors were paid under a new Medicare+Choice payment methodology rather than the prior method in section 1876(a), and were subject to certain other Medicare+Choice provisions. The Secretary no longer accepts new 1876 risk applications. As of January 1, 1999, existing 1876 risk-based contracts were terminated, and plans in good standing transitioned to the Medicare+Choice program.

Repeal of Cost Option - As of August 5, 1997, the Secretary is prohibited from entering into any new 1876 cost-based contracts, unless the plan is a Health Care Prepayment Plan with an agreement under section 1833 of the Social Security Act. The 1876 cost-based payment authority is repealed and all cost contracts are terminated as of December 31, 2002.

Limited HCPP Option - Beginning January 1, 1999, the Secretary may only contract with those HCPPs that are sponsored by Union or Employer groups, or HCPPs that do not "provide, or arrange for the provision of, any inpatient hospital services" This amendment will result in the termination of section 1833 agreements with any organization that does not meet the new definition. CMS will establish transition rules for 1876 risk-based contractors that currently receive reimbursement on a cost basis for enrollees remaining under a previous HCPP agreement.

For more information, see the Managed Care Manual.