91st Congress }
2d Session } CONFIDENTIAL COMMITTEE PRINT

STAFF DATA ON H.R. 17550, SOCIAL SECURITY AMENDMENTS OF 1970

(AS PASSED BY THE HOUSE OF REPRESENTATIVES)

PREPARED BY THE STAFF

OF THE

COMMITTEE ON FINANCE

(NOTE.—This document has not been reviewed by the committee.)

JUNE 17, 1970

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE
46-389 O WASHINGTON : 1970

COMMITTEE ON FINANCE

RUSSELL B. LONG, Louisiana, *Chairman*

CLINTON P. ANDERSON, New Mexico
ALBERT GORE, Tennessee
HERMAN E. TALMADGE, Georgia
EUGENE J. McCARTHY, Minnesota
VANCE HARTKE, Indiana
J. W. FULBRIGHT, Arkansas
ABRAHAM RIBICOFF, Connecticut
FRED R. HARRIS, Oklahoma
HARRY F. BYRD, JR., Virginia

JOHN J. WILLIAMS, Delaware
WALLACE F. BENNETT, Utah
CARL T. CURTIS, Nebraska
JACK MILLER, Iowa
LEN B. JORDAN, Idaho
PAUL J. FANNIN, Arizona
CLIFFORD P. HANSEN, Wyoming

TOM VAIL, *Chief Counsel*
EVELYN R. THOMPSON, *Assistant Chief Clerk*

CONTENTS

	Page
Cash benefit programs	1
5% increase in benefits	1
Automatic increase in benefits by Secretary of Health, Education, and Welfare	1
Increase in earnings limitation to $2,000; increases thereafter determined by Secretary of Health, Education, and Welfare	2
Increase in widows' benefits	2
Equalizing computation of average wages for men and women	3
Elimination of actuarial reduction for certain spouses	3
Additional gratuitous wage credits for members of the uniformed services	4
Eligibility of blind persons for disability insurance	4
Relationship between disability benefits and workmen's compensation	5
Childhood disability benefits for those disabled before age 22	5
Liberalization of eligibility requirements for divorced women	5
Medicare and medicaid amendments	7
Relationship between medicare and Federal employees' benefits	7
Hospital insurance for the uninsured	8
Limitation on Federal payment for disapproved expenditure	9
Experiments in prospective reimbursement	10
Limitation on coverage of costs	11
Limitation on prevailing charge levels	12
Establishment of incentives for States to emphasize outpatient care	13
Payment for physician's services in the teaching setting	14
Termination of payments to suppliers of services	15
Elimination of requirement that States move toward comprehensive medicaid program	17
Determination of reasonable hospital costs under medicaid	18
Amount of payment where customary charges are less then reasonable cost	19
Institutional planning under medicare program	20
Payments to States under medicaid for installation and operation of claims processing and information retrieval systems	21
Advance approval of extended care and home health coverage under medicare program	22
Prohibiton against reassignment	23

Medicare and medicaid amendments—*Continued* | Page
Utilization review requirements for hospitals and skilled nursing homes under medicaid and maternal and child health programs...... 24
Elimination of requirement that cost-sharing charges imposed on individuals, other than cash recipients, under medicaid be related to their income.......... 25
Notification of unnecessary admission.......... 26
Use of State health agency to perform certain functions under medicaid.......... 27
Health maintenance organization.......... 28
Coverage prior to application for medicaid.......... 29
Hospital admissions for dental services under the medicare program.......... 30
Exemption of Christian Science sanatoriums from certain nursing home requirements under medicaid.......... 31
Physical therapy services under medicare.......... 32
Extension of grace period for termination of part B coverage of failure to pay premium is due to good cause.......... 34
Extension of time for filing supplementary medical insurance claims... 35
Waiver of enrollment period requirements because of administrative error or inaction.......... 36
Elimination of 3-year limitation on initial enrollment in supplementary medical insurance plan.......... 37
Waiver of recovery of incorrect medicare payments from survivor who is without fault.......... 38
Requirement of minimum amount of part B claim to establish entitlement to hearing.......... 39
Collection of part B premiums from individuals entitled to both social security and railroad retirement benefits.......... 40
Payment for certain inpatient hospital services furnished outside the United States.......... 41
Study of chiropractic coverage.......... 42
Financing.......... 43
Increase in tax rates.......... 43
$9,000 wage base; increases in wage base by Secretary of Health, Education, and Welfare.......... 43
Table 1—Projected wage base and employer-employee combined tax rate.......... 44
Table 2—Projected maximum employer-employee combined taxes..... 45

SUMMARY OF PRINCIPAL PROVISIONS OF H. R. 17550 THE SOCIAL SECURITY AMENDMENTS OF 1970

CASH BENEFIT PROGRAMS

Five Percent Increase in Benefits. -- The House-passed bill provides for a five percent across-the-board benefit increase, effective January 1971. The minimum benefit would also increase by five percent, from the present $64 to $67.20. Special monthly payments to individuals 72 and over who are not insured under social security would be increased five percent, from $46 to $48.30 for an individual and from $69 to $72.50 for a couple.

Automatic Increase in Benefits by Secretary of Health, Education, and Welfare. -- A provision was added to the bill on the House floor under which the Secretary of Health, Education, and Welfare would increase social security benefits any January (beginning January 1973) if he determines that the cost of living has increased at least three percent between the last July-to-September calendar quarter preceding a Secretarially determined benefit increase and the most recent July-to-September quarter. (The point of comparison for the first of these increases would be the third calendar quarter of 1971). A similar increase would be provided by the Secretary for persons age 72 and over who receive special payments. These increases would be in addition to any increases approved by the Congress in the future. Thus, for example, if the Congress in 1978 raised the benefits of a particular individual 10 percent from $150 to $165, and the Secretary in January 1979 determined a benefit increase

of four percent, the individual's benefits would be increased to $171.60, and all future Secretarially determined benefit increases would be based on the new amount.

Under the House bill, benefits would not be reduced if the cost of living went down.

Increase in Earnings Limitation to $2,000; Increases Thereafter Determined by Secretary of Health, Education, and Welfare. -- Under present law, an individual may earn $1,680 (or up to $140 in any one month) with no reduction in social security benefits. For each $2 earned between $1,680 and $2,880, benefits are reduced $1; for earnings above $2,880, benefits are reduced one dollar for each dollar earned. The House-passed bill contains a provision increasing the earnings limitation from $1,680 to $2,000 (about $167 a month); every $2 earned above $2,000 would reduce social security benefits by one dollar. An estimated 900,000 beneficiaries would receive additional benefits under this provision in 1971, and another 100,000 persons who would receive no benefits under present law would receive some benefits in 1971 under this provision which would become effective in 1971.

Under another provision of the House-passed bill, the Secretary of Health, Education, and Welfare would increase the earnings limitation at the beginning of each odd-numbered year on the basis of his determination of the extent to which average taxable wages have risen since 1971.

Increase in Widows' Benefits. -- Under present law, a widow applying for benefits at age 62 or later is eligible for a monthly payment equal to 82-1/2 percent of the amount her deceased husband would have

received had he become entitled to benefits at age 65 (his Primary Insurance Amount). Under the House-passed bill, the benefit for a widow eligible for benefits for the first time at or after age 65 would be increased from 82-1/2 percent to 100 percent of her deceased husband's Primary Insurance Amount. The benefits for widows becoming entitled to benefits between ages 62 and 65 would be actuarially reduced similar to the way her husband's benefits would have been reduced had he applied for benefits before age 65. The same provision would apply to dependent widowers. An estimated 3.3 million widows and widowers would benefit from this provision beginning in January 1971.

Equalizing Computation of Average Wages for Men and Women. -- Social Security benefits are based on a formula related to average wages. Under present law, a woman may have three more years of low earnings disregarded than a man in calculating her average wages. The House bill would apply the same rules for calculating average wages to men as now apply to women. An estimated 10.2 million persons would receive larger benefits beginning next January under this provision; 60,000 persons would become eligible for benefits for the first time as a result of the reduced eligibility requirements for men.

Elimination of Actuarial Reduction for Certain Spouses. -- Under present law, when a woman applies before age 65 for a retirement benefit based on her own earnings they are actuarially reduced. If she subsequently applies for a wife's benefit after reaching age 65, her wife's benefit is

also actuarially reduced to reflect the fact that she began receiving benefits before age 65. The House bill would eliminate the actuarial reduction in such cases. About 100, 000 beneficiaries would be affected by this provision, effective six months after enactment of the bill.

Additional Gratuitous Wage Credits for Members of the Uniformed Services. -- Present law provides for a social security wage credit of up to $100 a month, in addition to earnings credits for basic pay, for military service performed after 1967. Under the bill, the additional gratuitous wage credits would also be provided for service during the period from 1957 (when social security coverage was extended to military service) through 1967. Approximately 130, 000 beneficiaries would be affected effective January 1971.

Eligibility of Blind Persons for Disability Insurance. --Under present law, a disabled person must meet a test of recent work under social security to be eligible for disability benefits--generally five years' worth of work in employment covered under social security during the ten years preceding disablement. The House bill would eliminate for blind persons this test of recent attachment to covered work. Under the bill, a blind person would be insured for disability benefits if he had one quarter of coverage for each year elapsed after he reached age 21 or after 1950, whichever requirement is lower. An estimated 30, 000 blind persons would become eligible for benefits under this provision after it becomes effective in January 1971.

Relationship Between Disability Benefits and Workmen's Compensation. -- Under present law, social security disability benefits must be reduced when workmen's compensation is also payable and the combined payments exceed 80 percent of average current earnings before disablement. Under the bill, social security disability benefits would be reduced by the amount by which the combined payments under both programs exceed 100 percent of average current earnings before disability. An estimated 60,000 disabled beneficiaries would be affected by this provision, effective January 1971.

Childhood Disability Benefits for Those Disabled Before Age 22. -- Under present law, a person who becomes disabled before age 18 may qualify for childhood disability benefits which are payable to a qualified disabled adult, son, or daughter of an insured retired, deceased or disabled worker. The bill would extend such childhood disability benefits to those cases where disability begins before age 22. About 13,000 disabled individuals would qualify for benefits under this provision, effective January 1971.

Liberalization of Eligibility Requirements for Divorced Women. -- Under present law, benefits are payable to a divorced wife age 62 or older and a divorced widow age 60 or older if her marriage lasted 20 years before the divorce, as well as to a surviving divorced mother. In order to qualify for any of these benefits, a divorced woman is required to show that: (1) she was receiving at least one-half of her support from her former husband, (2) she was receiving substantial contributions from her former husband pursuant to a written agreement, or (3) there was a court order in effect

46-389 O - 70 - 2

providing for substantial contributions to her support by her former husband. The House bill would eliminate these support requirements for divorced wives, divorced widows, and surviving divorced mothers. An estimated 10,000 persons would become eligible for benefits under this provision, effective January 1971.

RELATIONSHIP BETWEEN MEDICARE AND FEDERAL EMPLOYEES' BENEFITS

Problem

Federal retirees and older employees have been required to take full coverage and pay full premiums despite the fact that the Federal Employees Programs will not pay any benefits for services covered under Medicare. Thus the retiree, who also has earned entitlement to Medicare, is paying the F.E.P. for coverage for which no claims will be paid him. This is particularly true in the case of hospitalization. The F.E.P. does not presently offer such employees or retirees with dual eligibility the option of electing a lower-cost policy which supplements rather than duplicates Medicare benefits.

House Bill

Effective January 1, 1972, Medicare would not pay a beneficiary, who is also a Federal retiree or employee, for services covered under his Federal Employee's health insurance policy which are also covered under Medicare unless he has had an option of selecting a policy supplementing and not duplicating Medicare benefits. In effect, the F.E.P. would then have to pay such costs and not Medicare.

Further the government contribution toward the cost of the supplementing health policy must at least be equal to the amount it contributes for high-option coverage under the government-wide Federal Employees Health Benefit Program. Thus F.E.P. could not reduce the government contribution even though the supplemental coverage cost less.

HOSPITAL INSURANCE FOR THE UNINSURED

Problem

A substantial number of people reaching age 65 are ineligible for Part A (hospital insurance) coverage under Medicare and also encounter difficulty in securing private health insurance coverage with benefits as extensive as those of Medicare.

House Bill

Permits persons reaching age 65 who are ineligible for Part A of Medicare to voluntarily enroll for hospital insurance coverage by paying the full cost of coverage (initially estimated at $27 monthly and to be recalculated annually) and where such persons enroll in Part A also requiring that they enroll in Part B (Supplementary Medical Insurance Plan). Where the Secretary of H.E.W. finds that it is feasible, those States and other public employee groups which have, in the past, voluntarily elected <u>not</u> to participate in the Social Security program could opt for and pay the Part A premium costs for their retired or active employees age 65 or over.

LIMITATION ON FEDERAL PAYMENT FOR DISAPPROVED EXPENDITURE

Problem

A hospital or nursing home can, under present law, make large capital expenditures which may have been disapproved by the State or local planning board, and still be reimbursed by Medicare and Medicaid for capital costs (depreciation, interest on debt, return on net equity) associated with that expenditure.

House Bill

Prohibits reimbursement to providers under the Medicare and Medicaid programs for capital costs associated with expenditures of $100,000 or more which are determined to be inconsistent with State or local health facility plans.

EXPERIMENTS IN PROSPECTIVE REIMBURSEMENT

Problem

Reimbursement on the present reasonable cost basis contains little incentive to decrease costs or improve efficiency and the retrospective cost-finding and auditing have caused lengthy delays and great confusion. Payment determined on a prospective basis might provide an incentive to cut costs. However, providers might press for a rate less favorable to the government than the present rate, and they might cut back on the quality of their services to reduce costs.

House Bill

Instructs the Secretary to experiment with various methods of prospective reimbursement, and to report to the Congress with an evaluation of such experiments by July 1, 1972. The Secretary is to supply detailed plans of such experiments to the Ways and Means and Finance Committees for Congressional study prior to initiation of the experiments.

LIMITATION ON COVERAGE OF COSTS

Problem

Certain institutions may incur excessive costs, relative to comparable facilities in the same area, as a result of inefficiency or "the provision of amenities in plush surroundings." Such excessive costs are now reimbursed under Medicare.

House bill

Authorizes Secretary to establish limits on overall direct or indirect costs which will be recognized as reasonable in comparable facilities in an area. He may also establish maximum acceptable costs in such facilities with respect to items or groups of services (for example, food costs, or standby costs). The beneficiary is liable for any amounts determined as excessive (except that he may not be charged for excessive amounts in a facility in which his admitting physician has a direct or indirect ownership interest). The Secretary is required to give public notice as to those facilities where beneficiaries may be liable for payment of amounts determined as not "necessary" to efficient patient care.

Limitation on Prevailing Charge Levels

Problem. -- Under the present reasonable charge policy, Medicare pays in full any physicians' charge that falls within the 83rd percentile of customary charges in an area. However, there is no limit on how much physicians in general can increase their customary charges from year to year, (apart from the fact that many carriers have not developed comprehensive and effective charge screens). The Administration has proposed an interim limitation during fiscal 1971 of the 75th percentile of customary charges.

House Bill. -- Recognizes as reasonable only those charges which fall within the 75th percentile. Starting in 1972 increases in physicians' fees allowable for Medicare purposes would be limited to a factor which takes into account the costs of practice and the increase in earnings in an area.

Establishment of Incentives for States to Emphasize Outpatient Care

Problem. -- There has been substantial unnecessary and overutilization of costly institutional care in Medicaid accompanied by insufficient usage of less costly out-of-institution health care.

House Bill. -- Effective January 1, 1971, to discourage and prevent overutilization of institutional care, the bill provides for a one-third reduction in the Federal medical matching share for Medicaid for stays in a fiscal year which exceed: 60 days in a general or TB hospital; 90 days in a skilled nursing home; 90 days in a mental hospital (and no Federal matching after an additional 275 days of such care in a mental hospital during an individual's lifetime).

To encourage greater use of outpatient hospital services, clinic services, and home health services, Federal matching for such costs would be increased by 25 percent.

Additionally, the Secretary would assure that average reimbursement for intermediate care in a State was reasonably lower than payments for skilled nursing home care in that State. The bill also makes clear that an intermediate care facility does not include any public institution for mental diseases or mental defects.

46-389 O - 70 - 3

Payment for Physician's Services in the Teaching Setting

Problem. -- Physicians in private practice are generally reinbursed on a fee-for-service basis for care provided to their bona fide private patients. Difficulties have arisen -- including abuse and possible fraud -- in determining how and whether payments should be made in teaching hospitals where the actual care is often rendered by interns and residents under the direction (sometimes nominal) of an attending physician who is assigned to (but not selected by) the Medicare patient.

The issue relates to the compensation of the attending physician often termed the supervisory or teaching physician. The salaries of interns and residents are now covered in full as a Part A hospital cost. In general, patients were not billed for the services of teaching physicians prior to Medicare and since Medicare billings have been essentially limited to Medicare and Medicaid patients. The proceeds are most frequently used to finance and subsidize medical education rather than being paid directly to the teaching doctor. While charges have often been billed on a basis comparable to those charged by a private physician to his private patients the services provided are often less.

<u>House Bill.</u> -- No fee-for-service will be payable where: (a) non-Medicare patients who have insurance or who are able to pay are not required to pay a charge by a teaching physician; (b) Medicare patients are not required to pay any charges for physicians' services; or, where Medicare patients are required to pay such charges, deductible and coinsurance amounts attributable to those services are not generally obtained from them or on their behalf.

Where fees-for-service are not payable, reimbursement will be allowable only on an actual costs basis under Part A.

TERMINATION OF PAYMENTS TO SUPPLIERS OF SERVICES

Problem

Present law does not provide authority for the Secretary to withhold future payments for services rendered by an institution or physician who abuses the program, although payments for past claims may be withheld on an individual basis where the services are not reasonable or necessary.

House Bill

The Secretary would be authorized to suspend or terminate Medicare payments to a provider found guilty of program abuses. Further, there would be no federal participation in Medicaid payments which might be made subsequently to this provider. Program review teams would be established in each State to furnish the Secretary with professional advice in discharging this authority.

ELIMINATION OF REQUIREMENT THAT STATES MOVE TOWARD COMPREHENSIVE MEDICAID PROGRAM

Problem

The Medicaid program has been a significant burden on State finances. Section 1903e of Title 19 requires each State to show that it is making efforts in the direction of broadening the scope of services in its Medicaid program and liberalizing eligibility requirements for medical assistance. These required expansions of Medicaid programs have been forcing states to either cut back on other programs or to consider dropping Medicaid. The original date for attainment of those objectives was 1975. The Finance Committee, the Senate and the House approved an amendment in 1969 postponing the date to 1977.

House Bill

Repeals section 1903e.

Determination of Reasonable Hospital Costs Under Medicaid

Problem. -- Under present H.E.W. regulations States are required to reimburse hospitals under Medicaid on the basis of the Medicare reasonable cost formula. Many States maintain that use of the Medicare formula for Medicaid reimbursement can result in their paying more than the actual costs of providing inpatient care to Medicaid recipients and hamper their efforts at controlling the costs of hospital care.

House Bill. -- Allows States to develop their own methods of hospital reimbursement. The method developed must cover actual costs and avoid having hospitals or private patients subsidize inpatient care for Title 19 recipients. The reimbursement may not exceed the reasonable cost determined under Medicare.

Amount of Payment where Customary Charges are less than Reasonable Cost.

Problem. -- Under present law, Medicare reimbursement is based on reasonable costs. This results occasionally, in the program paying higher amounts for beneficiaries than the beneficiaries would be charged were they not covered by Medicare, as some institutions' customary charges are set at a level below costs, with the difference being met by revenues from endowments and investments.

House Bill. -- Provides that reimbursement for services under Medicaid and Medicare could not exceed the lesser of reasonable costs determined under Medicare, or the customary charges to the general public. The provisions would not apply to services furnished by public providers free of charge or at a nominal fee. In such cases reimbursement would be based on those items included in the reasonable cost determination which would result in fair compensation.

Institutional Planning Under Medicare Program

Problem. -- Under present law there is no requirement that providers of services develop fiscal plans, such as operating and capital budgets, which are regarded as sound business practices.

House Bill. -- To remedy those deficiencies in the management of some hospitals and extended care facilities, all providers would be required, as a condition of Medicare participation, to have a written overall plan and budget reflecting an operating budget and a capital expenditures plan which would be updated at regular intervals.

Payments to States Under Medicaid for Installation and Operation of Claims Processing and Information Retrieval Systems.

Problem. -- Many States do not have effective claims administration or well designed information storage and retrieval systems for their Medicaid programs and do not possess the financial and technical resources to develop them.

House Bill. -- Authorizes 90 percent Federal matching toward the cost of designing, developing and installing mechanized claims processing and information retrieval systems deemed necessary by the Secretary. The Federal government would assist States with technical advice and development of model systems. Federal matching at 75 percent would be provided toward the costs of operating such systems.

46-389 O - 70 - 4

Advance Approval of Extended Care and Home Health Coverage Under Medicare Program

Problem. -- Uncertainty about determinations of eligibility for care in an extended care facility or home health program following hospitalization have created major difficulties for intermediaries, institutions and beneficiaries. The essential problem is in determining whether the patient is in need of skilled nursing and medical services or in fact, needs a lesser level of care. Retroactive claims denials resulting from determinations that skilled care was not required, while often justified, have created substantial friction and ill-will.

House Bill. -- Authorizes Secretary to establish by diagnosis minimum periods during which the post-hospital patient would be presumed to be eligible for benefits.

Prohibition Against Reassignment

Problem. -- Medicare and Medicaid presently pay providers directly under assignment, but the law is silent with respect to reassignment of these payments. H.E.W. has allowed reassignments to other organizations including discount and collection agencies. These reassignments have led to added administrative costs and inflated claims.

House Bill. -- Prohibits payment to anyone other than the physician or other person who provided the service, unless such person is required as a condition of his employment to turn his fees over to his employer.

Utilization Review Requirements for Hospitals and Skilled Nursing Homes Under Medicaid and Maternal and Child Health Programs

Problems. -- Inadequate utilization review in Medicaid and Maternal and Child Health Programs.

House Bill. -- Requires hospitals and skilled nursing homes participating in Titles 5 and 19 to use the same utilization review committees and procedures now required under Title 18 for those programs. This requirement is in addition to any other requirements now imposed by the Federal or State governments.

Elimination of Requirement That Cost-Sharing Charges Imposed on Individuals, Other Than Cash Recipients, Under Medicaid Be Related to Their Income

Problem. -- Substantial administrative difficulties have been encountered in establishing cost-sharing charges related to income for the medically-indigent. For example, if a State required a medically-indigent person whose income was $2,000 to pay $1 of the cost of a prescription, under present law, the recipient with income of $2,200 would have to make a higher co-payment -- say $1.05 or $1.10 for his prescription.

House Bill. -- Authorizes use of flat deductible or co-payment amounts for medically-indigent regardless of income variations. It is expected that, in the main, these deductibles and co-payments would be employed with respect to items of health care or serviceswhich are often provided at the initiative of the patient.

Notification of Unnecessary Admission

Problem. -- Institutional Utilization Review Committees must review all long-stay cases and a sample of all admissions. If in the review of a long-stay case, further hospitalization is found unnecessary, the Committee must promptly notify the physician and patient, and Medicare payments stop 3 days after such notifications. Under present law notification and a payment cut-off is not required where unnecessary hospitalization is determined during a sample review of admissions.

House Bill. -- Would require notification and a payment cut-off after 3 days, in those cases where unnecessary utilization is discovered during a sample review of admission.

Use of State Health Agency to Perform Certain Functions under Medicaid

Problem. -- Under present law, one State agency may certify health facilities for participation in Medicare, and another for participation in Medicaid, resulting in a duplication of efforts.

Also, some State agencies lack the capability to perform Statewide utilization reviews of services provided under Medicaid.

House Bill. -- Requires that the State Health Agency certify facilities for participation under both Medicare and Medicaid.

Requires that Federal participation in Medicaid payments be contingent upon the State Health Agency establishing a plan for statewide review of appropriateness and quality of services rendered.

Health Maintenance Organization

Problem. -- Certain large medical care organizations (such as the Kaiser and San Joaquin Foundations) tend to deliver medical care more efficiently and economically than the medical care community at large, in good part because they operate on a prepayment basis which gives them incentives to keep costs low and control utilization.

Medicare does not currently pay these comprehensive programs on a prepayment basis, and consequently the financial incentives to economical operation in such programs have not been available to Medicare.

House Bill. -- Authorizes Medicare to make a single combined Part A and B payment, prospectively on a capitation basis, to a "Health Maintenance Organization," which agreed to provide care to a group not more than one-half of whom are Medicare beneficiaries who freely choose this arrangement. Such payments may not exceed 95 percent of present Part A and B per capita costs in a given geographic area.

The Secretary could make these arrangements with existing prepaid groups and foundations, and with any new organization which meets the broadly defined term "Health Maintenance Organization."

Coverage Prior to Application for Medicaid

Problem. -- A minority of States do not cover an otherwise eligible Medicaid recipient for care provided during the 3-month period prior to his application for Medicaid. Application is often delayed because of lack of information or the sudden nature of illness.

House Bill. -- Requires all States to afford retroactive protection for otherwise covered care during the 3-month period prior to application for Medicaid.

Hospital Admissions for Dental Services under the Medicare Program

Problem. -- Where hospitalization is for performance of noncovered dental procedures, payment for the hospitalization may be made if the beneficiary has other impairments so severe as to make hospitalization necessary. Some intermediaries require that a physician certify as to need for hospitalization in such cases.

House Bill. -- Eliminates any requirement of corroboration by physician of need for hospital care where the dentist has already certified as to such need.

Exemption of Christian Science Sanatoriums from Certain Nursing Home Requirements Under Medicaid.

Problem. -- Christian Science Sanatoria are permitted to participate as skilled nursing homes under Medicaid. As such, they are required to meet certain general requirements which are inappropriate to Christian Science facilities such as: having a skilled nursing home administrator licensed by the State; maintain an organized nursing service under the direction of an R. N.; maintenance of detailed medical records; etc.

House Bill. --Exempts Christian Science Sanitoria from such inappropriate requirements.

Physical Therapy Services under Medicare

Problem. -- Physical therapy is presently covered as an inpatient service, and as an outpatient service when furnished through a participating facility or home health agency. Services cannot be provided in a therapist's office, even though it may be more accessible to the beneficiary than the participating facility.

An additional problem relating to physical therapy is that a patient can exhaust his inpatient benefits and continue to receive payment for treatment only if the facility can arrange with another facility to furnish the therapy as an outpatient service.

A final problem is the rapidly increasing cost of physical therapy services and findings of abuse in institutions.

House Bill. -- Would include as covered services under Part B, physical therapy provided in the therapist's office under such licensing as the Secretary may require and pursuant to a physician's written plan of treatment.

Would authorize a hospital or extended care facility to provide outpatient physical therapy services to its inpatients, so that an inpatient could conveniently receive his Part B benefits after his inpatient benefits have expired.

Would control physical therapy costs by limiting total payments in one year for services by an independent practitioner in his office or the patient's home to $100, and by basing reimbursement for services provided in an institutional setting on a reasonable salary rather than fee-for-service basis.

Extension of Grace Period for Termination of Part B Coverage if Failure to Pay Premium is Due to Good Cause.

Problem. -- Under present law, an individual's coverage under Part B is terminated for non-payment of premiums, after a period of 90 days from due date. Cases have arisen in which the failure to pay premiums is clearly related to the enrollee's physical or mental incapacity.

House Bill. --Extends 90-day grace period for an additional 90 days where the Secretary finds there was good cause for the failure to make timely payment.

Extension of Time For Filing Supplementary Medical Insurance Claims

Problem. -- Under present law an absolute limit for the filing of Part B claims is December 31 of the year following the year in which the services were provided. In some cases, beneficiaries have been denied benefits because of late filing resulting from delayed determination of entitlement or other mistake on the part of the Government or its agents.

House Bill. -- Authorizes payment of such claims where delay beyond the normal limitation is due to error on the part of the Government or its agents.

Waiver of Enrollment Period Requirements Because of Administrative Error or Inaction

Problem. -- In some cases it has been discovered that due to an action, inaction or error on the part of the Government an individual has been enrolled or has not been enrolled in Part B without his knowledge or inadvertently.

House Bill. -- Authorizes Secretary to provide for equitable relief in such cases to avoid penalizing beneficiary.

Elimination of 3-Year Limitation on Initial Enrollment in Supplementary Medical Insurance Plan

Problem. -- At present, an individual reaching age 65 may not enroll in Part B if he has not done so within the 3-year period following the expiration of his initial 7-months period of eligibility (3-months prior to his birthday, the birthday month, and the 3-months following the birthday month). Some who have not enrolled in timely fashion are barred from Part B.

House Bill. -- Eliminates 3-year limitation but retains provision providing for a 10 percent increase in premium for each 12-months period elapsed from the time a beneficiary could have enrolled and when he actually enrolls.

Waiver of Recovery of Incorrect Medicare Payments from Survivor Who is Without Fault

Problem. -- Under present law, waiver of recovery of an overpayment of cash benefits is permitted if the individual from whom recovery is being considered is without fault -- for example, a widow whose late husband had been overpaid. No similar provision is provided for in Medicare.

House Bill. -- Allows waiver of Medicare overpayments on a basis comparable to those authorized for overpayments of cash benefits.

Requirement of Minimum Amount of Part B Claim to Establish Entitlement to Hearing

Problem.--No "de minimis" rule is applied with respect to entitlement to a hearing on a Part B claim. Some 45 percent of hearings involve amounts of less than $100. A costly administrative burden is created by such hearings on small claims.

House Bill.-- Provides for fair hearing only where amounts of $100 or more are at issue.

Collection of Part B Premiums from Individuals Entitled to Both Social Security and Railroad Retirement Benefits.

Problem. -- Railroad retirees who are also social security beneficiaries are sometimes enrolled twice because of divided administrative responsibility between social security and the Railroad Retirement Board.

House Bill. -- Gives Railroad Retirement Board responsibility for collection of Part B premiums from all eligible railroad retirees.

Payment for Certain Inpatient Hospital Services Furnished Outside the United States

Problem. -- At present, coverage in a foreign hospital near the U. S. border is available only where an emergency occurs within the U. S., and the foreign institution is the closest adequate facility. This limitation creates difficulty in securing necessary non-emergency care for border residents who ordinarily do and would use the nearest hospital suited to their medical needs.

House Bill. -- Authorizes use of a foreign hospital by a U. S. resident where such hospital was closer to his residence or more accessible than the nearest suitable U. S. hospital. Such hospitals must be approved under an appropriate hospital approval program.

Study of Chiropractic Coverage

Problem. -- Substantial discussion and debate have occurred over the appropriateness and cost of covering chiropractic services under Medicare. Many citizens have urged the Congress to include such coverage.

House Bill. -- Requires the Secretary to conduct a study of chiropractic services in those States in which the services are presently covered under Medicaid, in order to determine whether and under what conditions chiropractic services should be covered under Part B of Medicare. The Secretary would be required to report to Congress within two years on the results of the studies and his findings and recommendations.

FINANCING

Increase in Tax Rates. --Under present law, social security tax rates are scheduled to increase from a total of 9.6 percent (the rate for employers and employees combined) to 11.8 percent beginning in 1987. Within this total, the combined rate for the cash benefit programs is scheduled to rise from 8.4 percent in 1970 to 9.2 percent in 1971, and to 10 percent in 1973 and thereafter. The combined employer-employee Medicare tax rate is scheduled to rise gradually from 1.2 percent in 1970 to 1.8 percent by 1987.

Under the House bill, the tax rate would rise to an ultimate rate of 13 percent compared with 11.8 percent under present law. Because of the increase in revenues from the rise in the wage base, the House bill would reduce the scheduled tax rate increases for the cash benefit programs from 1971 through 1974. On the other hand, it would increase the Medicare tax rate in 1971 from the presently scheduled 1.2 percent to 2.0 percent; it would remain at 2.0 percent thereafter.

$9,000 Wage Base; Increases in Wage Base by Secretary of Health, Education, and Welfare. -- The House-passed bill would increase the wages taxed under social security from the present $7,800 to $9,000. Thereafter, the House bill would authorize the Secretary of Health, Education, and Welfare to increase the amount of wages taxed every two years based on his determination of the extent to which average taxable wages have risen since 1971.

Tables I and II show the projected wage base, tax rates, and maximum taxes under present law and under H. R. 17550.

TABLE I

PROJECTED WAGE BASE AND EMPLOYER-EMPLOYEE COMBINED TAX RATE

	Present Law				H. R. 17550			
Year	Wage base	Cash benefit tax rate	Medicare tax rate	Total tax rate	Wage base	Cash benefit tax rate	Medicare tax rate	Total tax rate
1970	$7,800	8.4%	1.2%	9.6%	$ 7,800	8.4%	1.2%	9.6%
1971-72	7,800	9.2%	1.2%	10.4%	9,000	8.4%	2.0%	10.4%
1973-74	7,800	10.0%	1.3%	11.3%	10,200	8.4%	2.0%	10.4%
1975	7,800	10.0%	1.3%	11.3%	10,800	10.0%	2.0%	12.0%
1976	7,800	10.0%	1.4%	11.4%	10,800	10.0%	2.0%	12.0%
1977-78	7,800	10.0%	1.4%	11.4%	12,000	10.0%	2.0%	12.0%
1979	7,800	10.0%	1.4%	11.4%	13,200	10.0%	2.0%	12.0%
1980	7,800	10.0%	1.6%	11.6%	13,200	11.0%	2.0%	13.0%
1981-82	7,800	10.0%	1.6%	11.6%	13,800	11.0%	2.0%	13.0%
1983-84	7,800	10.0%	1.6%	11.6%	15,000	11.0%	2.0%	13.0%
1985-86	7,800	10.0%	1.6%	11.6%	16,200	11.0%	2.0%	13.0%
1987-88	7,800	10.0%	1.8%	11.8%	18,000	11.0%	2.0%	13.0%
1989-90	7,800	10.0%	1.8%	11.8%	19,200	11.0%	2.0%	13.0%
1991-92	7,800	10.0%	1.8%	11.8%	21,000	11.0%	2.0%	13.0%
1993-94	7,800	10.0%	1.8%	11.8%	22,200	11.0%	2.0%	13.0%

TABLE II

PROJECTED MAXIMUM EMPLOYER-EMPLOYEE COMBINED TAXES

Year	Present Law			H. R. 17550		
	Cash Benefits	Medicare	Total	Cash Benefits	Medicare	Total
1970	$ 655.20	$ 93.60	$ 748.80	$ 655.20	$ 93.60	$ 748.80
1971-72	717.60	93.60	811.20	756.00	180.00	936.00
1973-74	780.00	101.40	881.40	856.80	204.00	1,060.80
1975	780.00	101.40	881.40	1,080.00	216.00	1,296.00
1976	780.00	109.20	889.20	1,080.00	216.00	1,296.00
1977-78	780.00	109.20	889.20	1,200.00	240.00	1,440.00
1979	780.00	109.20	889.20	1,320.00	264.00	1,584.00
1980	780.00	124.80	904.80	1,452.00	264.00	1,716.00
1981-82	780.00	124.80	904.80	1,518.00	276.00	1,794.00
1983-84	780.00	124.80	904.80	1,650.00	300.00	1,950.00
1985-86	780.00	124.80	904.80	1,782.00	324.00	2,106.00
1987-88	780.00	140.40	920.40	1,980.00	360.00	2,340.00
1989-90	780.00	140.40	920.40	2,112.00	384.00	2,496.00
1991-92	780.00	140.40	920.40	2,310.00	420.00	2,730.00
1993-94	780.00	140.40	920.40	2,442.00	444.00	2,886.00

O