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UNITED STATES SENATE

RUSSELL B. LONG, *Chairman*

PART 9

MEDICARE-MEDICAID CASH BENEFITS EFFECTIVE DATES

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1. Reimbursement Limits on Payments for Paramedical Personnel

Previous decision—(Part 4–pp. 6–7)

The previous Committee decision was to limit Medicare cost reimbursement to a salary-related basis for various therapists. In addition to the therapists, other specialists such as social workers, medical records librarians, and dieticians also serve as employees and consultants to health care facilities. Social workers, for example, may arrange for a bed-patient to receive necessary home health care upon discharge from the institution. However, more and more of these supportive personnel, formerly employed on salary, are becoming independent consultants billing Medicare on a fee-for-service basis.

Proposal

The staff suggests that social workers, as well as any other paramedical personnel working in institutions, be subject to the same reimbursement limitation approved for therapists. The point is not to have Medicare pay on a fee-for-service or other nonsalaried basis in an amount unreasonably high in relation to what most qualified people in the same occupation working on a salaried basis are paid.

2. Statutory Specifications of Independent Professional Review in Intermediate Care Facilities

In previous actions, the Committee expressed its concern over the need for effective utilization review. In transferring the intermediate care benefit to Medicaid, thereby making it available to the medically-indigent, the Committee recommended that strong review requirements be a condition to the inclusion of such care in Medicaid.

The 1967 Finance Committee Report indicated an expectation that independent professional review would be required for ICF patients. The Department has issued regulations which have been only partially and ineffectively implemented.

Proposal

The staff suggests that statutory language—similar to that now in the statute with respect to independent review in skilled nursing homes—be provided so as to give more formal standing to the expectations of the Committee and the importance of the review process.

3. State Law Requiring Direct Laboratory Billing of Patients

Problem

Recently enacted New York State law requires that bills for laboratory services (arranged for by a physician and incidental to his services) be submitted by the laboratory to the patients receiving the services although they may assign their claim for Medicare payment of a portion of the cost to the laboratory. This change has

worsened a previously existing Medicare problem where a low cost service is provided and the cost of collection of an individual bill is large compared with the bill itself. The problem is especially serious with respect to collection of the coinsurance feature. A laboratory bill for $1.50 may be reasonable, but Medicare may pay only 80% of this amount, or $1.20. The patient is expected to pay the balance of 30 cents. The cost to the laboratory of billing the patient may far exceed the 30 cents. The result may be that the laboratory would raise its fee to, say $2.00, so that it could collect the $1.50 it requires directly from the Medicare program.

Proposal

The staff and the Department suggest that authority be provided for Medicare to negotiate a payment rate with a laboratory such that the total payment by Medicare for laboratory services will not be increased even though the negotiated payment covers the total charge to be made and no patient coinsurance is to be charged.

4. Eligibility of Community Mental Health Centers for Experimental and Demonstration Methods of Reimbursement by Medicare

Present law

Medicare payment for services furnished in a free-standing mental health center is provided to a physician-directed clinic where the paramedical services furnished are incident to a physician's professional services. (Services furnished by a center that is a unit of a hospital are reimbursable as hospital services.)

Problem

Although most services furnished in a free-standing center are presently reimbursable, payment may be made only on a fee-for-service basis, and then only upon submission of a physician's bill in each individual case. This is not only costly and cumbersome, but also presents problems for the centers since they generally charge non-Medicare patients a flat rate for the full range of services provided.

Proposal

The staff and the Department suggest that Section 222 of the House bill, which would provide authority for the Secretary to engage in experiments and demonstration projects with methods of payment, should be modified to include experimentation with methods of payment for the services of mental health centers.

5. Coverage of Supplies Related to Colostomys

Present law

Medicare covers the bags and straps which must be used in conjunction with some colostomys (an artificial opening of the bowel to the abdominal wall which is often made necessary by surgery for cancer of the bowel). This equipment is covered as it is considered a prosthetic device (a replacement for a body organ).

Problem

Some bowel cancer patients have surgery which results in a different type of colostomy necessitating daily irrigation and flushing rather than permanent attachment of a bag. Medicare does not cover this

irrigation and flushing equipment, since it is not permanently attached to the body and is therefore not considered a prosthetic device. This results in unequal treatment by the program of patients with colostomys.

Proposal

This distinction can be avoided by adding a phrase to the statute to include coverage for material directly related to the care of a colostomy."

6. Professional Standards Review Organization Modifications

The staff suggests the following minor modifications of the PSRO amendment which take into account suggestions from interested professional organizations and individuals and which might serve to improve and enhance the amendment:

(1) The Committee, in its earlier discussion of the PSRO provisions expressed its desire that the review organization cooperate with hospitals in performing required functions and fulfilling PSRO responsibilities.

It is suggested, therefore, that specific language be included in the amendment authorizing and directing the PSRO to acknowledge and accept in-hospital review of admissions and need for continued care, on a hospital-by-hospital basis where the PSRO has determined that the in-house review is effective. The PSRO might also limit its own review activities to given practitioners or given diagnoses where the balance of a hospital's "in-house" review is acceptable. Such evaluations and determinations would be made periodically by the PSRO which would also retain the final authority in determining the effectiveness of the review effort in a given hospital for purposes of Medicare and Medicaid.

(2) The draft amendment provides for exemption from civil liability where care is provided in accordance with the established norms and in the absence of negligence on the part of a practitioner or hospital. A problem arises in cases where, for example, the usual length of stay for a given illness might be six days but an individual practitioner might only hospitalize his patient for four days. In this case the doctor might be motivated to keep his patient in the hospital for an extra two days in order to assure himself of exemption from liability.

It is suggested that the provision concerning the exemption from civil liability be defined in terms of a range of patterns which fall within the scope of the norm which is considered acceptable by the PSRO in accordance with regulations of the Secretary.

(3) It is suggested that a specific exemption from the operation of the PSRO amendment be granted Christian Science sanatoria.

(4) The amendment presently calls for a State-wide Professional Standards Review Council. In each State where there are three or more PSROs the membership of this Council includes one representative from each PSRO, two physicians designated by the State Medical Society and four persons knowledgeable in health care from such State, two of whom are recommended by the Governor.

It is suggested that the amendment be modified so that the State-wide Professional Standards Review Council will also include two physicians nominated by the State Hospital Association.

7. Effective Date of Termination of Enrollment in Voluntary Hospital Insurance for the Uninsured

Problem

Under the House bill, voluntary termination of a person's hospital insurance would take effect at the end of the calendar quarter after the quarter in which the termination notice is filed. Premium liability would also continue during this period of 3 to 6 months but would not be easily collected because no Social Security monthly cash benefits are payable.

Proposal

The Committee's bill might provide that hospital insurance protection under this section would terminate as of the last day of the month immediately following the month in which the notice is filed.

8. Technical Change in House Bill—Voluntary Hospital Insurance for Civil Service Annuitants and Their Spouses

Problem

The House bill excludes from eligibility for hospital insurance coverage for the uninsured, certain civil service annuitants and their spouse who are now excluded from hospital insurance coverage under the special transitional provision (Section 103 of the Social Security Amendments of 1965).

Proposal

The Department and staff propose that civil service annuitants and their spouses, who are not excluded from hospital insurance protection under the special transitional provision, be eligible to enroll for hospital insurance protection for the uninsured. However, such eligibility will end one year after the year such person attains age 65 or one year after enactment of this section, whichever is latest.

9. Technical Change in House Bill—Termination of Voluntary Hospital Insurance When a Person Becomes Eligible as Insured Under Social Security

Problem

The House version of the bill overlooked the need to discontinue voluntary hospital insurance coverage where an individual becomes eligible for hospital insurance under the special transitional provision or as a result of becoming a cash beneficiary.

Proposal

It is suggested that the defect of the House bill be corrected to provide for automatic transfer from voluntary to regular hospital insurance.

10. Technical Change in House Bill—Limitation on Authority for Reassignment of Medicare Benefits

Problem

The House bill (Sec. 234) limited the persons who could receive Medicare payments to the patient, the person who provided the service, or the employee or facility involved in providing the service. By oversight, even the guardian of the patient could not receive the payment.

Proposal

It is suggested that the patient who is entitled to receive Medicare payments may allow them to be paid to persons whom present law allows to receive them.

11. Technical Change in Sec. 227 of House Bill—Authority of Secretary to Terminate Payments to Suppliers of Services

House Bill Provision

Program review teams established in each State would review cases of apparent program abuse and make recommendations to the Secretary regarding such cases. Concurrence of professional members of the team would be required in decisions involving professional matters. The bill inadvertently seems to require the professional members' concurrence in decisions involving claims by providers for payment in excess of costs, a nonprofessional matter.

Proposed Change

It is suggested that the professional team members' concurrence not be required in decisions involving provider claims for payment in excess of costs.

12. Technical Change—Refunding of Excess Premiums

Present law

Where Part B or the proposed Voluntary Hospital Insurance (for the uninsured) entitlement terminates due to the death of the enrollee, refund of any excess premiums is made to the legal representative of the enrollee's estate. If there is no legal representative and it is reasonably certain that none will be appointed, refund may be made, only to a relative of the deceased. Payments are made only where a claim is filed.

Problem

The Department believes that excess Part B premiums paid by a deceased enrollee could be best disposed of, in those cases where there is no legal representative of the deceased's estate, by adding them, as under present law for unpaid medical insurance benefits, to benefits subsequently payable on the same Medicare claims number. However, the Office of General Counsel has advised that this could not be done for overpaid premiums in the absence of necessary authority in the law. Consequently, a much more cumbersome claims procedure has had to be used. Where there is no claim for the excess premium payments, no refund is made.

If the provision, under which hospital insurance coverage is made available at a cost of $27 per month to the uninsured is enacted, excess premiums will also occur under that provision.

Proposal

It is suggested the bill include authority for the Secretary to dispose of excess supplementary medical insurance premiums and excess hospital insurance premiums, in the same manner as unpaid medical insurance benefits are disposed of.

1. Treatment of Earnings in Year of Attaining Age 72

Background

Under present law, the earnings limitation under the social security program does not affect a beneficiary's benefits for any month in which he is 72 years of age or older. However, in the year he attains age 72, earnings in and after the month in which he reaches age 72 are counted in determining whether benefits are reduced or withheld for the months before he reached age 72. Many beneficiaries are disappointed to find that earnings in the year of attaining age 72 may reduce their benefits for that year.

Under the House bill, only amounts earned before the month in which the beneficiary becomes 72 would be used in determining his earnings during the year for purposes of the earnings limitation. This provision would create an inequity based on the month in which an individual attains age 72. For example, under the $2,000 earnings limitation approved by the Committee, an individual earning $500 a month would receive full social security benefits in the year he became 72 if his birthday occurred before June 1, partial benefits if he was born during one of the summer months, and no benefits for the months of that year before he attained age 72 if his birthday fell in the last few months of the year.

Recommendation

The inequity in the House bill can be avoided by considering the portion of the year before the month in which an individual attains age 72 as a short year with a prorated earnings limitation. For example, if an individual attained age 72 in April, he would have an earnings limitation of $500 for the first three months of the year (3/12 times the earnings limitation of $2,000 for a full year). If the individual became 72 in July he would have an earnings limitation of $1,000 for the first six months of the year. Under such a provision, no premium would be placed on having a birthday earlier in the year.

2. Federal Home Loan Bank Board

Provision in the House Bill

The Federal Home Loan Bank Board requested that social security coverage be extended to the 500 employees of Federal Home Loan Banks. The House bill would extend coverage to all current and future employees of the Banks for years after 1970. Persons who are Bank employees on January 1, 1971 would also have their services after 1965 covered, but only if the social security contributions on account of such services were paid by July 1, 1971 or by "such later date as may be provided in an agreement entered into before such date with the Secretary of the Treasury or his delegate."

Recommendation

It is recommended that the House bill be modified to specify a date certain, such as January 1, 1972, by which time payment must be made under the agreement between the Banks and the Secretary of the Treasury. It is also recommended that the retroactive payments of contributions include the interest that would have been earned by the Trust Fund had the contribution been made in the time of employment.

3. Increased Widow's and Widower's Insurance Benefits

Under present law a wife's benefit is automatically converted to a widow's benefit if the woman is 62 or older at the time of her husband's death. Under section 104 of the bill, a wife's benefit would not be automatically converted to a widow's benefit until age 65 (under the new provision a widow's benefit would be reduced if it is taken before age 65). This will mean that a new application would have to be obtained from each new widow who has been getting wife's benefits and who wants to get a reduced widow's benefit rather than waiting until age 65 to get a full widow's benefit, with a resulting delay in the payment of the first survivor check for these widows.

Rather than requiring a new application for all widows between ages 62 and 65, it would be preferable to convert automatically to a reduced widow's benefit where the woman is not entitled to a benefit based on her own earnings. It is extremely unlikely that a woman who is not insured for benefits based on her own earnings and who has taken a reduced wife's benefit before age 65 would want her benefits terminated for a period of time after her husband's death.

Costs

The provision would have no long-range-cost effect.

Effective Dates

The House bill contains a series of different types of effective date provisions. Generally speaking, however, most of the provisions including the increase in social security benefits would become effective January 1, 1971.

The Committee may want to modify the effective date provisions in the House bill to reflect the passage of time since the House acted on the bill. In general, the increase in cash benefits and the provisions making persons eligible for new or higher benefits would become effective on January 1, 1971 (as under the House bill) even though the Social Security Administration has indicated that the increased benefits cannot be reflected in monthly checks until April 1971. This will necessitate a supplemental check making up for the increase in benefits for the earlier months. Other provisions which cannot become effective on the date of enactment of the bill (because of need for lead time) generally would be made effective July 1, 1970.

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