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NEW AMENDMENTS ADDED BY HOUSE

PREPARED FOR THE USE

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UNITED STATES SENATE
RUSSELL B. LONG, *Chairman*

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CONTENTS

NEW AMENDMENTS ADDED BY HOUSE

Following are amendments included in H.R. 1 which were not part of either the House or Senate approved versions of H.R. 17550. They are amendments the Committee has not previously considered.

Medicare Coverage for Disabled Beneficiaries

(Section 201)

Problem

The disabled, as a group, are similar to the elderly in those characteristics—low incomes and high medical expenses—which led Congress to provide health insurance for older people. They use about seven times as much hospital care, and about three times as much physicians' services as does the nondisabled population. In addition, disabled persons are often unable to obtain private health insurance coverage. Cost estimates for coverage of the disabled under Medicare were estimated, in 1970, at about $2.8 billion for the first full year.

House Bill

Effective July 1, 1972, a social security disability beneficiary would be covered under Medicare after he had been entitled to disability benefits for not less than 24 consecutive months. Those covered would include disabled workers at any age; disabled windows and disabled dependent widowers between the ages of 50 and 65; beneficiaries age 18 or older who receive benefits because of disability prior to reaching age 22; and disabled qualified railroad retirement annuitants. An estimated 1.5 million disabled beneficiaries would be eligible initially. Estimated first full-year cost is $1.5 billion for hospital insurance and $350 million for supplementary medical coverage. Part A coverage for the disabled would be financed through the Medicare payroll tax. Part B coverage would be financed through premiums paid by the disabled and general revenues. The disabled would pay the same monthly premium as the aged ($5.80 beginning July 1st). Since the cost of physicians' services for the disabled is greater than for the aged, general revenues would be contributing over 50 percent of Part B costs for the disabled.

Proposal

At its executive session on February 22 the Committee approved the House amendment in the form in which it passed the House. The staff suggests a change in the effective date to provide opportunity for orderly implementation of the new coverage. Specifically, it is suggested that the effective date of July 1, 1972, be omitted and that a new effective date of January 1, 1973, or six months from the date of enactment of H.R. 1, whichever is later, be substituted.

Part B Premium Charges

(Section 203)

Problem

During the first 5 years of the program it has been necessary to increase the Part B premium almost 94 percent—from $3.00 monthly per person in July 1966 to a scheduled $5.80 rate in July 1972. The government pays an equal amount from general revenues. This increase and projected future increases represent an increasingly significant financial burden to the aged living on incomes which are not increasing at a similar rate. The President has proposed that the Federal Government assume the entire part B premium cost for beneficiaries through increased payroll taxes.

House Bill

Limits Part B premium increase to not more than the percentage by which the Social Security cash benefits had been generally increased since the last Part B premium adjustment. Costs above those met by such premium payments would be paid out of general revenues. Thus, in the future the general revenues would bear more than the traditional one-half share. No cost estimate available.

Proposal

The staff suggests acceptance of the House amendment.

Increase in Part B Deductible

Problem

The Medicare Part B program requires the beneficiary to pay the initial $50 of covered expenses during a year plus at least 20% of the balance. With the increase in medical care costs, the $50 deductible no longer bears the same relationship to total program costs or individual incomes as it did initially when Medicare became effective on July 1, 1966.

House Bill

Increases the Part B deductible to $60 effective January 1, 1972.

Proposal

The staff suggests deleting this provision. The House rationale does not take into account the fact that due to increased medical care costs, aged beneficiaries, according to H.E.W., are paying nearly as much out of pocket for medical care now as they were prior to Medicare. The 20 percent coinsurance which they must pay—apart from any amounts in excess of Medicare's "reasonable charge" determination—is being paid on substantially higher charges today than obtained in 1965. Finally, while it can be argued that deductibles and co-payments may deter unnecessary care it may also be argued that such requirements can also serve to deter the seeking of necessary care. The staff suggests that effective operation of the Professional Standards Review Organizations should serve to assure the medical necessity of services provided—an approach which appears preferable to imposing artificial economic barriers to necessary as well as unnecessary care.

Increase in Hospital Co-Payment and Lifetime Reserve Days

(Section 205)

Problem

It is contended that prolonged hospitalization is sometimes unnecessary and is encouraged in Medicare through lack of sufficient financial barriers and deterrents. Medicare covers 90 days of hospitalization during a spell of illness, with the beneficiary being responsible for the first $68 of a bill and, a co-payment amount of $17 for each day from the 61st through 90th. Present law also provides each beneficiary with a non-renewable lifetime reserve of 60 days of inpatient coverage, subject to a co-payment of $34 daily.

House Bill

Requires a daily co-payment by beneficiaries of $8.50 from the 31st through 60th days of hospitalization (retaining the $17 daily co-payment from the 61st through 90th days).

The number of lifetime reserve days would be increased from 60 to 120. The beneficiary would remain responsible for co-payment of $34 for each lifetime reserve day.

The estimated increased costs of these changes generally offset the savings. Those costs and savings are estimated to total $5,350 million respectively over the next 25 years.

Proposal

The staff suggests deletion of the House amendment and retention of present law.

The increased co-payment affects those seriously ill aged who can least afford increased costs (after having incurred heavy out-of-pocket costs during prolonged hospitalization) and is based on the somewhat tenuous theory that patients rather than physicians are responsible for continued hospitalization.

Automatic Enrollment for Part B

(Section 206)

Problem

Under present law, eligible individuals must initiate action to enroll in Part B of Medicare. Nearly 96 percent of eligible older people so enroll. Some eligibles, however, due to inattention or inability to manage their affairs, fail to enroll in timely fashion and lose several months or even years of necessary medical insurance coverage.

House Bill

Effective January 1, 1972, the House bill provides for automatic enrollment under Part B for the elderly and the disabled as they become eligible for Part A hospital insurance coverage. Persons eligible for automatic enrollment must also be fully informed as to the procedure and given an opportunity to decline the coverage.

Proposal

The staff suggests approval of the amendment.

Cost Sharing Under Medicaid

(Section 208)

Problem

Under present law, States may require payment by the medically indigent of premiums, deductibles and co-payment amounts with respect to Medicaid services provided them but such amounts must be "reasonably related to the recipient's income." However, States cannot require cash assistance recipients to pay any deductibles or co-payments.

House Bill

This section of the House bill contains 3 provisions.

1. It requires States which cover the medically indigent to impose monthly premium charges. The premium would be graduated by income in accordance with standards prescribed by the Secretary and details regarding the operation of the premium would be left to the Secretary's discretion. The House Committee report indicates that it would be expected that premiums would be fixed on a state-by-state basis at whatever level would be required to result in a savings under the medically indigent program of approximately 6 percent.
2. States could, at their option, require payment by the medically-indigent of deductibles and co-payment amounts which would not have to vary by level of income.
3. With respect to cash assistance recipients, nominal deductible and co-payment requirements, while prohibited for the six mandatory services required under Federal law (inpatient hospital services; outpatient hospital services; other x-ray and laboratory services; skilled nursing home services; physicians' services; and home health services) would be permitted with respect to optional Medicaid services such as prescribed drugs, hearing aids, etc.

Proposal

The staff suggests modifying the above amendment as follows:

1. The House bill permits States to impose co-payments and deductibles on the medically-indigent. The staff would recommend limiting such amounts to co-payments on patient initiated elective services only, such as office visits to physicians and dentists.
2. The House bill also allows States to impose co-payments and deductibles on the indigent for optional Medicaid services. The staff would recommend deleting this provision, as the savings ($5 million) would most probably be exceeded by the administrative costs.

Mandatory Medicaid Deductible for Families with Earnings

(Section 209)

Problem

Under present law, AFDC families with earnings can, at a certain earnings point lose eligibility for Medicaid. This has been called the "Medicaid Notch". This notch is believed to act as a potential work disincentive, since at a certain income level a family may precipitously lose Medicaid eligibility if it has additional earnings.

House Bill

Section 209 would remove this "notch" by requiring AFDC families with earnings to pay a Medicaid deductible. In States without a medically indigent program this deductible would be equal to one-third of all earnings over $720. The deductible amount is identical to the amount of earnings which AFDC families would be allowed to retain as an incentive to work. This approach eliminates any sudden loss of Medicaid eligibility. However, although eligible for Medicaid, every dollar of a recipient's retained earnings raises his Medicaid deductible by one dollar.

In those States with programs for the medically indigent, an AFDC recipient would not have to pay the deductible until his retained earnings exceeded the difference between a State's cash assistance level and its medically indigent level. At this point, however, his Medicaid deductible would increase dollar for dollar with his retained earnings.

Proposal

Although the House provision eliminates any sudden loss of eligibility for Medicaid, the provision acts as a substantial work disincentive, since the Medicaid deductible increases dollar for dollar, in many cases, with retained earnings.

The staff suggests that in order to avoid establishing a substantial work disincentive the Committee amend Section 209 and deal with the "Medicaid Notch" by allowing AFDC families currently eligible for cash assistance and Medicaid, who would ordinarily lose eligibility as a result of earnings from employment, to remain eligible for Medicaid for one year (or longer if desired by a State). States could charge a family premiums reasonably related to the family's earned income above the highest cash assistance level not to exceed 10 percent of such income.

Limits on Medicaid Payments for Skilled Nursing Home and Intermediate Care

(Section 225)

Problem

Payments for skilled nursing homes and ICF care have been increasing rapidly over the past years because of rising costs as well as increased and inappropriate utilization.

House Bill

Effective January 1, 1972, Federal financial participation in reimbursement for skilled nursing home and intermediate care per diem costs would not be available to the extent such costs exceed 105 percent of prior year levels of payment. In other words, a ceiling of 5 percent a year would be placed on nursing home and intermediate care payment increases in per diem costs for purposes of eligibility for Federal matching. The provision would except increased payment resulting from increases in the Federal minimum wage or other new Federal laws.

Proposal

The staff suggests deleting the above amendment as the 105 percent is an arbitrary and administratively difficult ceiling which does not

take into account many uncontrollable expenses. The Professional Standards Review provision, previously approved by the Committee should, over time, assure proper utilization. The booklet on "Long-Term Care" prepared by the staff contains additional suggestions for making nursing home and intermediate care payments more rational. The Committee may want to consider an amendment which would limit yearly increases in per-diem costs by factors reflecting wage and price changes generally affecting comparable facilities in a State or substantial area of a State.

Prohibition Against Requiring Professional Social Workers in ECFs Under Medicare

(Section 265)

Problem

Present regulations specify that an extended care facility must have a social worker or an effective arrangement with a public or private agency to provide social service consultation. Many facilities have had difficulty obtaining such consultation, and where obtainable, the consultants have often been quite expensive.

House Bill

Specifies that the provision of medical social services not be required as a condition of participation for an extended care facility under Medicare.

Proposal

The staff suggests deletion of the House change. Social services are potentially valuable in controlling utilization, since the social work personnel are primarily responsible for discharge planning.

Waiver of Requirement of Registered Professional Nurse in Rural Skilled Nursing Homes Under Medicaid

(Section 267)

Problem

Present law requires that skilled nursing homes under Medicaid have at least one full-time registered professional nurse on their staff. Some rural facilities have had difficulty in meeting this requirement.

This licensure provision originated in the Committee on Finance as part of the Social Security Amendments of 1967. It was the Committee's purpose to upgrade the quality of personnel administering nursing homes.

House Bill

Authorizes a waiver of the requirement for a full-time registered nurse in those cases where the nursing home is in a rural area and the facility is necessary to meet patient needs, and is making a goodfaith effort to comply with the requirement.

Proposal

The staff suggests that the permanent waiver feature of the House bill be deleted. This seems inconsistent with the objective of upgrading the quality of nursing home administration, and in our opinion would negate much of the improvements made since 1967.

Facilities incapable of meeting the nursing requirement could, of course, apply for certification as intermediate care facilities.

Licensure Requirement for Nursing Home Administrators

(Section 269)

Problem

Present law requires administrators of skilled nursing home under Medicaid to be licensed by the States. Such licensure involves satisfactory completion of a licensure examination.

House Bill

Permits States to establish a permanent waiver from licensure requirements for those persons who served as nursing home administrators for the three-year period prior to the establishment of the State's licensing program.

Proposal

The staff would suggest deleting the House "grandfathering" provision.

The Finance Committee approved the licensure provision in 1967 as a means of upgrading the quality of personnel administering nursing homes. The staff agrees with the American Nursing Home Association and State Health Departments that the House amendment would negate much of the progress made since 1967.

Coverage of Ptosis Bars

(Section 253)

Medicare covers such items as leg, arm, back and neck braces which are used to support weak body members. However, Medicare does not pay for ptosis bars which are used to support the drooping eyelids of patients suffering from paralysis of the muscles of the upper eyelids.

House Bill

Provides Medicare coverage for ptosis bars.

Proposal

The staff suggests deleting the House amendment. According to the American Association of Opthalmologists, ptosis bars are generally ineffective. The Association feels that ptosis bars are usually contraindicated, and rarely, if ever, indicated. Including these devices under Medicare might encourage inappropriate use.

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