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ADDITIONAL MEDICAID AND MEDICARE AMENDMENTS

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RUSSELL B. LONG, *Chairman*

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ADDITIONAL MEDICAID AND MEDICARE AMENDMENTS

Waiver of Beneficiary Liability in Certain Situations Where Medicare Claims Are Disallowed

Problem

Under present law, whenever a Medicare claim is disallowed, the ultimate liability for the services rendered falls upon the beneficiary. This is true even when the program has paid the claim and subsequently it is determined that the claim should be reopened and disallowed. The result is that in many cases a beneficiary is liable for payment even though he acted in good faith and did not know that the services he received were not covered, and even though the hospital, physician or other provider of services was at fault.

Proposal

It is suggested that title XVIII be amended so that the beneficiary would be "held harmless" in certain situations where claims were disallowed but the beneficiary was without fault. In such situations the liability would shift either to the Government or to the provider—depending upon whether, for example, the provider utilized due care (i.e., acted reasonably) in applying Medicare policy in his dealings with the beneficiary and the Government. In the future, Professional Standards Review Organizations will be expected to give priority to determinations, either in advance or concurrent, designed to minimize the problem of retroactive denials.

Where the beneficiary was aware, or should have been aware, of the fact that the services were not covered, liability would remain with the beneficiary and the provider could either exercise his rights under State law to collect for the services furnished or appeal the determination through the Medicare appeals process.

Where neither the beneficiary nor the provider knew that noncovered services were involved, the Government would assume liability for payment as though a covered service had been furnished. (This situation would arise in many cases disallowed because the services were not medically necessary or did not meet the level of care requirements.) However, when Medicare made such a payment, it would make certain that the provider is put on notice that the type of service rendered was not covered with the result that in subsequent cases involving similar situations and further stays or treatments in the given type of case, he could not contend that he exercised due care. Thus, the Government's liability would be somewhat limited.

Where the provider did not exercise due care (that is, he knew or reasonably could be expected to know that such care was not covered), liability would shift to the provider, assuming that there was good faith on the beneficiary's part. The provider would be told that he could appeal the intermediary's decision, both as to coverage of the services and due care. If, on the other hand, he exercised his rights under State law and received reimbursement from the beneficiary, the

Medicare program would indemnify the beneficiary (subject to deductibles and coinsurance) and would be required to seek to recover amounts so paid from the provider.

It is suggested that the provision be effective with respect to claims submitted on or after July 1, 1971.

Estimated cost: $10 million.

Payment Under Medicare to Individuals Covered by Federal Employees Health Benefits Program

Problem

Under an amendment previously approved by the Committee, the Federal Employees Health Benefits Program would be required to make certain equitable changes with respect to coverage for persons covered simultaneously under that program as well as Medicare. The provision, however, omitted requiring similar adjustments with respect to the disabled who become covered under Medicare.

Proposal

Extend to annuitants, who have not attained age 65 but who are entitled to Part A and Part B or to Part B only, the same supplemental benefits under the FEHB program available to an annuitant who has attained age 65.

Waiver of Enrollment Period Requirements Where Individuals Rights Were Prejudiced by Administrative Error or Inaction

Problem

The Secretary of H.E.W., under an amendment previously approved, is authorized to waive the Part B enrollment period limitation where he finds that an attempt to enroll was delayed or not made as a result of fault on the part of H.E.W. The provision, however, does not encompass error on the part of other Federal agencies or employees; for example, where enrollment was delayed beyond the time specified because of a postal strike.

Proposal

The staff and the Department suggest that the provision be modified to encompass error on the part of the "Federal Government" rather than limiting it to the Secretary of H.E.W.

Outpatient Physical Therapy in Rural Communities

Problem

Outpatient physical therapy services are covered under Medicare only when furnished by participating hospitals, extended care facilities, home health agencies, clinics, rehabilitation agencies, and public health agencies. The participating provider may furnish outpatient physical therapy through employees or by making suitable arrangements for self-employed physical therapists to work under its supervision. Regulations permit payment for services in a self-employed therapist's private office only where the participating organization is a public health agency and neither it nor the other participating providers in the area are able to furnish a full range of physical therapy procedures on an outpatient basis. This regulation was adopted

because of the probability that participating organizations which provide none of the services themselves would not be able to adequately supervise the services independent practitioners perform in their private offices. An exception was made in the case of public health agencies because they represent the only possible agencies capable of arranging for this type of service in many rural areas and they often are not able to provide physical therapy on their premises. These agencies have no choice but to rely on a local independent practitioner and his facilities to provide physical therapy to patients.

While the above requirements appear reasonable, there are also some few rural or small communities where the only participant in the Medicare program is a hospital which does not provide physical therapy on its premises. This has created serious difficulties in arranging for and providing necessary physical therapy in those areas.

Proposal

Committee Report language would indicate that the Secretary was expected to afford hospitals in rural or small communities the same opportunity afforded to public health agencies in arranging for physical therapy in order to assure that covered outpatient physical therapy is available to beneficiaries in these rural areas. The Committee understands that some rural hospitals have already arranged for necessary physical therapy services to be provided to beneficiaries off their premises but in the immediate neighborhood of the hospital. If he has not already done so, it expects that the Secretary will validate such arrangements where they were reasonable under the circumstances.

Medicare Incentive Reimbursement Experiments

Background

Section 222 of H.R. 1 gives the Secretary authority to carry out prospective reimbursement experiments and demonstration projects in order to develop incentives for increased efficiency in the delivery of health services.

Problem

The only specific funding authority provided for these demonstrations under the House bill is the Social Security Trust Fund. This had led to a possible misinterpretation that demonstration projects for Medicaid and Maternal and Child Health program recipients are to be financed with Trust Fund dollars.

House Provision

The House bill provides specifically for funding of demonstrations under section 222 only through the Federal Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund.

Proposal

The staff and the Department suggest that section 222 be amended to provide specifically that demonstration projects for prospective reimbursement for services delivered to Medicaid and Title V recipients be financed with funds appropriated under Titles V and XIX of the Social Security Act. To the extent that joint projects are funded, involving Medicare beneficiaries as well as Medicaid or Title V

recipients, the cost would be appropriately divided between the Trust Fund and the other two titles.

Medicaid Utilization Review

Problem

Several States have developed and are applying utilization review procedures, different from the Medicare utilization review committees. These alternative approaches have met with some success. The ability of States to implement effective alternative methods would, however, be limited under section 237.

House Bill

Section 237 requires hospitals and skilled nursing homes participating in the Medicaid and Maternal and Child Health programs to have cases reviewed by the same utilization review committee already reviewing Medicare cases or, if one does not exist, by a committee which meets the Medicare standards.

Proposal

Until such time as professonal standards review organizations are operational in the States, it is suggested that the Secretary be allowed to waive the requirements of section 237 to permit States to substitute alternative utilization review systems where it can be demonstrated to the satisfaction of the Secretary that the alternate system will be superior in effectiveness to the Medicare requirement. To avoid duplication of review activity, in such cases, the Secretary might also require usage, where appropriate, of the more effective Medicaid review method for Medicare patients as well, in lieu of the regular Medicare procedure.

Maintenance of Effort Requirement for Care for Individuals 65 and Over in Mental Hospitals, Under Title XIX

Problem

Section 1903(b)(1) currently ties the maintenance of effort require ment for expenditures for care to individuals 65 years of age or older who are patients in institutions for mental diseases to expenditures for such services under State and local public health and public welfare programs for each quarter of the fiscal year ending June 30, 1965. This time period is no longer a reasonable base for current program requirements.

House Provision

None.

Proposal

It is suggested that section 1903(b)(1) be amended to provide for a more appropriate time period for the maintenance of effort requirement by indicating that States must make a satisfactory showing that:

> total expenditures from State and local sources for mental health services under State and local public health and public welfare programs for such quarter are not reduced

below the average of the total quarterly expenditures from such sources for such services under such programs for the preceding four quarters.

Training of Intermediate Care Facility Administrators

Problem

With the transfer of ICF services to title XIX the Department was provided the authority to set standards for intermediate care facilities. Although regulations for ICF's have not yet been issued, it is expected that standards for administrators of ICF's may be established which a substantial proportion of the administrators now operating ICF's may be unable to meet.

House Provision

None.

Proposal

Financing has been available under title XIX to provide supplemental qualifying training for skilled nursing home administrators who were unable to meet the requirements. This program terminates by statute June 30, 1972. The Department and the staff suggest that, to the extent of the amount of such funding utilized under the current provision, funds be continued, for not to exceed 2 years, to provide for supplemental training of ICF administrators who are unable to meet such standards as may be established in regulations by the Secretary.

Intermediate Care—Mental Hospitals

Problem

P.L. 92–223 transferred coverage of ICF services from the cash titles to Title XIX. Although the Committee intent was to make such services available to individuals age 65 or over in mental institutions this was not specified in the law.

Proposal

The staff suggests that to carry out the intent to include ICF services for individuals age 65 or over in mental institutions, section 1905(a)(14) be amended specifically to cover:

> (14) inpatient hospital services and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases.

No further change is required in Section 1905(a)(15) and (16) except to reverse the numbering to provide for the catch-all phrase to come last.

Leaving the rest of the present 1905(a)(16) unchanged while amending 1905(a)(14) will make clear that coverage of individuals 65 or over in ICF's which are part of institutions for mental diseases is optional with the States. It will also provide parallel treatment with inpatient hospital services and skilled nursing home services for such individuals.

Independent Review of Intermediate Care Patients

Problem

The recent transfer of care in intermediate care facilities from the cash assistance titles to the Medicaid program added section 1902(a)(31)(A) to the Social Security Act providing in part for independent professional review of patients in an ICF "which provides more than a minimum level of health care services as determined under regulations of the Secretary." The language can be interpreted as limiting the requirement for independent professional review *only* to patients in institutions which provide more than a minimum level of health care. In fact, the intent was that care in all ICF's should be subject to review.

House Provision

None.

Proposal

It is suggested that the "which" clause be deleted to clarify the Committee's intent that the independent professional review requirement applies to all ICF's.

Intermediate Care—Maintenance of Effort

Problem

P.L. 92–223, which transferred ICF services to title XIX, also provided coverage for services provided in public institutions for the mentally retarded. Federal matching for these services is available only if States maintain their fiscal effort. However, the law did not specify the base period for this maintenance of effort requirement.

Proposal

The staff suggests that the time period for the maintenance of effort be specified to provide that the State will not reduce the non-Federal expenditures with respect to patients in public institutions for the mentally retarded below the average amount expended for such services in such institutions in the four quarters immediately preceding the quarter in which the State elects to provide such services under title XIX.

Intermediate Care Facilities—Disclosure of Ownership

Problem

Present law requires disclosure of ownership of skilled nursing homes under Title XIX; however, comparable provision is not made with respect to intermediate care facilities.

Proposal

In view of the recent transfer of ICF's to Title XIX and in view of the fact that ICF's have problems comparable to skilled nursing homes which disclosure is intended to help solve, the staff and the Department suggest that the disclosure of ownership also be made applicable to Intermediate Care Facilities.

Coverage for Disabled Under Medicare—Disabled Mothers

Problem

Some women age 50 or older, entitled to mother's benefits for 24 months or more, may also have been eligible for, but did not claim disabled widow's benefits, solely because they were not encouraged to file for such benefits. Since they had a child in their care, they could more easily establish their right to mother's benefits; determinations of disability are too expensive to be made where no monetary benefit could, under existing law, accrue to them. Under the House provision to cover the disabled under Medicare such a woman would be eligible for Medicare if she had applied for disabled widow's benefits when she applied for mother's benefits. While she can now apply as a disabled widow, she would have to wait an additional 12 months before becoming eligible for Medicare, because her application would have only 12 months of retroactivity.

Proposal

Extend Medicare hospital insurance eligibility to persons entitled to mother's benefits who can meet all requirements for disability benefits except for actual filing of an application for disability benefits. The suggested change would provide a temporary transitional remedy to avoid hardship in such cases.

Coverage for Disabled Under Medicare—Termination When Disability Ceases

Problem

The House provision extending coverage to the disabled, in its present form, provides that where disability eligibility terminates, Medicare protection terminates at the same time. In a substantial percentage of these cases, disability termination is retroactive; thus, Medicare coverage would also terminate retroactively. This would result in expensive administrative adjustments of individual records and create overpayments for which in most cases, after costly development, SSA would have to waive recovery.

Proposal

Extend Medicare protection through the month following the month notice of termination of disability benefits is mailed. This change would add about $3½ million to the first year cost.

Qualification of Home Health Agency

Problem

Medicare law provides that as one of its conditions of participation of a "home health agency" the agency must be "primarily engaged in providing skilled nursing services *and* other therapeutic services". The intention behind this provision was that participating agencies should do more than provide skilled nursing services and should take responsibility for other needs of the patient. This provision has been interpreted to mean that an agency may participate only if it has both nurses and another type of personnel on staff. The staff understands

that in some cases an agency may be barred from participating because it has only nurses on staff even though the nurses may perform medical social services or other services in addition to nursing. If the agency employed home health aides, as well as nurses, it would, under the rules, be eligible to participate even though the aides add no significant skill to the services able to be performed by the agency if it had nurses alone.

Suggestion

The staff suggests that the Committee report indicate that a home health agency which renders skilled nursing and other therapeutic services should not be disqualified from participating solely on the ground that it employed only skilled nurses in the provision of skilled nursing and other therapeutic services. Of course, where the service is less than a skilled nursing service (such as that ordinarily provided by a home health aide), appropriate downward cost adjustment should be made commensurate with what would ordinarily be reimbursable for the lesser service.

Family Planning

Present Law

With the enactment of the 1967 Social Security Amendments, Congress significantly increased the commitment of the Federal Government to the provision of family planning services to welfare recipients and other persons with low incomes.

First, the 1967 Amendments required that family planning services be offered all appropriate recipients of Aid to Families with Dependent Children. The law provided that acceptance of the services be voluntary. Regulations issued by the Department of Health, Education, and Welfare state:

> Family planning services must be offered and provided to those individuals wishing such services, specifically including medical contraceptive services (diagnosis, treatment, supplies, and followup), social services and educational services. Such services must be available without regard to marital status, age, or parenthood. Individuals must be assured choice of method and there must be arrangements with varied medical resources so that individuals can be assured choice of source of service. Acceptance of any services must be voluntary on the part of the individual and may not be a prerequisite or impediment to eligibility for the receipt of any other service or aid under the plan. Medical services must be provided in accordance with the standards of other State programs providing medical services for family planning (e.g., maternal and child health services). (45 CFR 220.21).

The Department reports that in most States, family planning services may be offered without regard to marital status, parenthood or age.

Problem

Though Federal law and policy permit and encourage States to extend services to low income families likely to become welfare recipients as well as families already on welfare, most States have not taken advantage of this opportunity.

The progress which has been made under the 1967 Amendments, however, has not met the committee's expectations. The annual report by the Department of Health, Education, and Welfare covering family planning services includes information which makes clear that the mandate of the Congress that *all* appropriate AFDC recipients be provided family planning services has not been fulfilled. The report states:

> Many problems, of course, remain. Medical services [family planning] still are too limited, especially in rural areas but frequently in large urban areas as well. Replying to the question whether medical family planning programs currently available are adequate to meet the needs of eligible clients, 36 State welfare agencies answered in the negative in March, 1970. Thirty-one cited geographic inaccessibility as a major problem. Many reported a shortage of health professional and paraprofessionals and some reported that existing facilities are overcrowded. Even in the Nation's principal counties and cities where clinics are more likely to be found than in less populous sections, 50 out of 106 local welfare agencies reported that currently available medical planning programs are inadequate.
>
> Looking at their own capability of providing family planning services, many State and local welfare agencies report a shortage of staff to provide services and to arrange for adequate follow-up. Training programs for staff have not been mounted on the scale required. Although Federal funds may be used to match $3 for every $1 spent from State funds for services, time and again agencies emphasize the difficulty of raising the 25 percent share at State and local levels. Generally, no special funds have been made available to develop family planning services, as indicated, for example, by the general absence of full-time staff leadership for this program. Expectations among some groups that title IV funds would be available to reach substantial numbers of low-income families not currently receiving welfare have not been realized. . . .

Prior Committee Action and House Bill

H.R. 1.—The House bill provides for 100 percent Federal payments of the cost of family planning services if they are provided to recipients of welfare benefits for families and are necessary in order to permit the individual to work or participate in training programs, otherwise family planning services may be provided to welfare recipients as part of a State social service program, with 75 percent Federal matching as under present law.

1970 Senate action.—In 1970 the Committee and the Senate approved an amendment to provide 100 percent Federal funding for family planning services. A similar provision has been introduced in the 92nd Congress by Senator Long as part of S. 3019.

Proposal

Increase in Matching

It is suggested that the Committee again approve an increase in Federal matching for family planning services to 100 percent and

require States to make available on a voluntary basis such counseling services, and supplies directly and/or on a contract basis (utilizing organizations such as Planned Parenthood Clinics) throughout each State, to all present, former or potential recipients who are of child-bearing age desiring such services. Maximum confidentiality would be required. The Secretary would also be required to work with States to assure maximum utilization of persons participating in the Work Incentive Program as family planning aides and to perform related jobs.

Penalty for Failure To Provide Family Planning Services

Even with 100 percent Federal matching for the cost of services themselves it is likely that many welfare recipients or prospective recipients will not be informed of the availability of family planning services, and that many of those who express a desire to receive family planning services will not receive them. The availability of family planning services, apart from prevention of unwanted pregnancies, has a beneficial impact in terms of reducing maternal and child mortality and morbidity. The Committee may wish to consider imposing a financial penalty on States for failure to inform recipients of the availability of family planning services and to assure that recipents so desiring receive family planning services.

It is also recommended that the Federal share of Aid to Families with Dependent Children be reduced 2 percent, beginning in fiscal year 1975 if the State in the prior year has failed to inform at least 95 percent of the adults in AFDC families and on workfare of the availability of family planning and child health screening services; and/or if the State failed to actually provide or arrange for family planning services to persons desiring to receive them. It is envisioned that individuals of child-bearing age applying for or receiving AFDC would be required to sign a form acknowledging that they have been informed that they are eligible to receive family planning services on a voluntary and confidential basis. If they desire family planning services, an appointment would be set up at that time and a copy of the form would be sent to the clinic or physician providing necessary services and supplies. Similarly mothers with young children would be formally advised of child health screening services. When the AFDC recipient actually receives the family planning service, she or he would sign the form again. This would not preclude "walk-in" requests for family planning assistance by present and former recipients or those likely to become recipients in the absence of such services.

Liability and Consent

Further, to encourage timely seeking and provision of family planning services, it is suggested that the following language, drawn from the California Statutes, be incorporated into the Federal statute:

"No person providing such family planning services shall be legally liable civilly or criminally on account of provision of such services, except for negligence."

Notwithstanding any other provision of law the furnishing of these family planning services shall not require the consent of any one other than the person who is to receive them." [1]

[1] Sec. 10053.2 Welfare and Institutions Code, California Division 9, Part 1 Chapter 2.

Target Groups

In addition to the provision of counseling, services and supplies designed to aid those who voluntarily choose not to risk an initial pregnancy, emphasis should also be placed upon assisting those families with children who desire to control family size in order to enhance their capacity and ability to seek employment and better meet family needs.

The Secretary would be required to work with the States to assure that particular effort is made in the provision of family planning services to minors (and non-minors) who have never had children but who can be considered to be sexually active; for example, persons who have contracted venereal diseases, etc.

It is also recommended that the operation of the proposed amendment, if approved, be subject to review by the Inspector-General for Health Care Administration to determine compliance with the intent of the provision.

Penalty for Failure To Provide Required Health Care Screening

Present Law

In addition to family planning services, States are presently required to undertake the provision of another service which bears directly on the health of children—that is, health screening examination of children under age 21.

Problem

Many States have failed to implement the statutory requirement—or have implemented it only partially—because of their contention that the screening of all children under age 21 is not possible given available financial and health care resources. Those States have requested an amendment intended to permit orderly and progressive implementation of the health care screening requirement, beginning with the provision of such service to children undre age 6.

Prior Committee Action

Responding to the request of the States, the Committee previously approved an amendment which would permit orderly phasing-in of the health care screening requirement beginning with children under age 6 and covering all children by July 1, 1975.

Proposal

In review of the Committee response to the needs of the States but also recognizing the significance of early detection and treatment of illness in children—both in human and economic terms—the Committee may wish to consider imposing a financial penalty upon States which: (a) fail to adequately and generally inform recipients of the availability of child health screening services and to assure that recipients receive such services, and (b) fail to refer to or arrange for appropriate corrective treatment of illness or impairment disclosed by such screening.

It is suggested that the Federal share of Aid to Families with Dependent Children be reduced two percent, beginning in fiscal year 1975, if the State in the prior year has (a) failed to inform at least 95 percent of the adults in AFDC families and in the Employment

Corporation of the availability of child health screening services to children of ages eligible for such services; or, (b) failed to actually provide or arrange for such services; or, (c) failed to arrange for or refer to appropriate corrective treatment, children disclosed by such screen as suffering illness or impairment.

Outpatient Rehabilitation Coverage

Problem

Medicare presently provides a home health benefit under both Part A and Part B. Under Part A, a beneficiary may receive up to 100 home health visits in the year following discharge from a hospital or ECF. Part B covers up to 100 home health visits in a calendar year without a prior hospitalization requirement. To receive home health benefits under Part A or Part B, a patient must be homebound and require skilled nursing care on an intermittent basis or physical or speech therapy. Home health services must ordinarily be provided in the home; however, if use of equipment which cannot be taken to the home is involved, the services may be provided at an outpatient facility. Medicare also provides, under Part B, coverage of outpatient hospital services, and of outpatient physical therapy services provided by certain organized rehabilitation agencies.

There is a relatively small but effective group of free-standing rehabilitation facilities which provide a range of rehabilitation services on an outpatient basis, including some services which would be covered under Medicare if they were provided by participating home health agencies or by hospital outpatient departments. Under present law, Medicare payment cannot be made when such services are provided by free-standing rehabilitation facilities as such.

Proposal

It is proposed that the Medicare law be amended to provide a benefit under Part B which would consolidate the present Part B home health and outpatient physical therapy benefits. Coverage under the new benefit would be on two levels: homebound beneficiaries would be entitled to the full range of benefits, while beneficiaries who were not homebound would be entitled to rehabilitation benefits only. In order to qualify for rehabilitation services under the combined benefit, a beneficiary would have to have a need for physical or speech therapy. (That is, an individual who was not homebound could receive in the rehabilitation center covered clinical psychologists' services, medical social services or occupational therapy only if he also required physical or speech therapy.)

The new consolidated benefit would be subject to a coverage limit of 100 visits in a calendar year, as is the present Part B home health benefit. (Under the proposal, there would be no change in the provisions of present law relating to Part A home health benefits or Part B outpatient hospital services.)

Under the proposal, home health agencies could provide the full range of benefits provided under the combined benefit. Qualified organizations (including providers of outpatient physical therapy services under present law and free-standing rehabilitation facilities) would be able to provide such rehabilitation services included in the combined benefit as the Secretary found they were qualified to provide.

A rehabilitation center would not necessarily have to provide services to homebound patients in order to qualify.

Home Health Services

Problem

Home health services are covered under Medicare only if they are provided by a qualified home health agency under an overall plan of treatment prescribed by a physician to a beneficiary who has a need for such services. However, in some rural areas and small towns there are no home health agencies and only a few physicians to provide services over broad geographical areas. Some physicians in such areas use nurses to provide certain services to home-bound patients; such services would be covered as "home health services" if provided under the conditions described above, or as services "incident to a physician's service" where the physician actually accompanied the nurse. The services are, of course, services which the nurse is licensed to perform. Under present regulations, in the absence of a home health agency, the only way such services can be paid for under Medicare is if the physician performs such services himself or if he accompanies his nurse to the patient's home. Both alternatives represent a highly uneconomical use of scarce physician manpower.

Proposal

It is suggested that the Committee report include language which would authorize the Secretary to waive the normal requirements with respect to coverage of health services performed in the patient's home, so as to cover certain added services. The waiver would be permissible where: (1) the service was individual or intermittent; (2) the service was provided by a nurse or trained technician and the service of such a professional was required for the care; (3) the services cannot be provided appropriately by a home health agency, because there was no participating home health agency servicing the area which could provide the service in timely fashion; (4) the person performing such services was employed by a visiting nurse association or similar organization or a physician (or had entered into arrangements with such an organization or a physician which were acceptable to the Secretary); (5) the cost to the program was probably less than would have occurred if performed as an incident to physician's services; and (6) the services are ordinarily provided in a manner which the Secretary finds appropriate.

The services covered by the waiver would be limited to services which would be covered if performed as a regular home health service or as an incident to a physician's service. Payment would be made at no more than the reasonable charge or reasonable cost, as appropriate, for such services.

Medicare Coverage for Social Security Beneficiaries Under Age 65

Present Law

Under present law, persons aged 65 and over who are insured or are deemed to be insured for cash benefits under the social security or railroad retirement programs are entitled to hospital insurance (part A). Essentially all persons aged 65 and over are eligible to

enroll for medical insurance (part B) without regard to insured status. H.R. 1 includes a provision that would permit persons aged 65 and over who are not insured or deemed insured for cash benefits to enroll in part A, at a premium rate equal to the full cost of their hospital insurance protection ($31 a month through June 1973).

Problem

The Committee has tentatively adopted Amendment No. 989, sponsored by Senator Gurney, which would make Medicare protection (both part A and part B) available at cost on a voluntary enrollment basis to spouses aged 60–64 of Medicare beneficiaries. Spouses electing to enroll would pay $31 a month (through June 1973) for hospital insurance, and their monthly premium for medical insurance would be twice the premium paid by an individual who has attained age 65.

Many additional social security cash beneficiaries find it difficult to obtain adequate private health insurance at a rate which they can afford. This is particularly true if they are of an advanced age, say, age 60–64. Frequently, these older beneficiaries—retired workers, widows, mothers, dependents, parents for example—have been dependent upon their own group coverage or that of a related worker who is now deceased for health insurance protection. It is a difficult task for such older persons to find comparable protection when they no longer are connected to the labor force.

Proposal

Amendment No. 1138, sponsored by Senators Cranston and Gurney, would make Medicare part A and part B protection available to anyone who has not attained age 65 and is entitled to retirement, wife's, husband's, widow's, widower's, mother's, or parent's benefits under social security. The staff recommends that the Committee adopt Amendment No. 1138 in lieu of Amendment No. 989, with a modification to limit Medicare eligibility to persons entitled to the specified benefits who are aged 60–64. The staff believes that persons under age 60 who are not disabled generally, have relatively little difficulty in obtaining private health insurance and that no significant purpose would be served by making Medicare protection available to younger persons.

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