
Notes and Brief Reports

Summary of 1982 Legislation Affecting SSI, OASDI, and Medicare*

I. Background and Brief Legislative History

On September 3, 1982, President Reagan signed into law Public Law 97-248 (H.R. 4961), the Tax Equity and Fiscal Responsibility Act of 1982, and on September 8, 1982, he signed Public Law 97-253 (H.R. 6955), the Omnibus Budget Reconciliation Act of 1982. These bills contain Supplemental Security Income (SSI) and Medicare legislation recommended by the administration and other provisions affecting these programs and the Old-Age, Survivors, and Disability Insurance (OASDI) program. (The administration did not include any major OASDI proposals in its legislative program for 1982 (fiscal year 1983).) Although Medicaid, Aid to Families with Dependent Children, and other related legislation was included in Public Law 97-248, these amendments are not included in this note because they do not specifically affect the SSI or OASDI programs and do not affect the Social Security and Medicare trust funds.

A. President's Recommendations to the Congress

The administration submitted proposals for changes in the SSI program, along with legislation affecting the programs of Aid to Families with Dependent Children, Child Support Enforcement, and social services, in the proposed "Social Welfare Amendments of 1982," a draft bill submitted to the Congress on June 18, 1982. The administration's proposals with respect to the Medicare program were included in a draft bill "to make improvements in the Medicare and Medicaid programs, and for other purposes" and sent to the Congress on June 15, 1982.

As is indicated in the summary section that follows, a number of the SSI proposals adopted in Public Law 97-248 were essentially the same as the administration's

recommendations and several of the Medicare provisions were similar to, or based on, administration recommendations.

B. Congressional Budget and Legislative Process

As in past years, the Congress established in its First Concurrent Budget Resolution (S.Con.Res. 92, adopted June 23, 1982) revenue and expenditure targets for major programs for fiscal year 1983. Also, as in 1981, the budget resolution generally contemplated that the congressional committees with substantive jurisdiction would develop the specific legislation needed to meet the various budget targets and the resultant legislative proposals would be combined into an overall "Omnibus Budget Reconciliation Act" under the overall jurisdiction of the House and Senate Budget Committees. A major exception, however, was that legislation affecting revenues and expenditure matters within the jurisdiction of the Senate Committee on Finance would be handled, in the Senate, as a separate Finance Committee bill. As a result of this arrangement, SSI and Medicare legislation was included in the Finance Committee bill, the "Tax Equity and Fiscal Responsibility Act of 1982." And, in light of the constitutional requirement that revenue raising measures originate in the House of Representatives, and to facilitate a separate House-Senate conference on matters that were within the jurisdiction of the House Committee on Ways and Means, the Finance Committee selected a relatively minor House-passed bill, H.R. 4961, as the vehicle for its 1982 major revenue and expenditure proposals.¹

Meanwhile, legislation dealing primarily with programs such as the Food Stamp program or the Civil Service Retirement System, which are not within the jurisdiction of the Ways and Means and Finance Committees, was developed in the appropriate committees

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¹ H.R. 4961, as passed by the House on December 15, 1981, contained miscellaneous tax legislation and technical modifications in the 1981 Omnibus Budget Reconciliation Act. It included two SSI amendments: an unnegotiated check provision similar to the administration's proposal and an amendment substituting a monthly prospective accounting system for the monthly retrospective accounting system for SSI payments enacted under Public Law 97-35.

and formed into the "Omnibus Budget Reconciliation Act of 1982," H.R. 6955. Because of the interrelationships between Social Security and SSI and other public programs, this bill includes provisions that indirectly affect the OASDI and SSI programs, although they are of primary import to other programs.

II. Summary of Provisions of Public Law 97-248

A. Provisions Directly Affecting the SSI Program*

1. Effective date of application and proration of initial SSI benefit payment.* The new law provides that an application will be effective on the date of filing or, if later, the date on which the individual becomes eligible for SSI. Thus, individuals who file applications in the month of attainment of age 65, but prior to the actual date of attainment, will not be considered eligible for SSI until such date. If the application is filed after the individual reached age 65 and met all other eligibility requirements, the effective date of the application is the date on which it was filed.

The SSI payment for the first month of eligibility will be prorated by the number of days in the month for which there is an effective application. For example, persons who file and meet all the eligibility requirements on the 15th of the month will receive about half of the payment amount for the month of filing that they would receive had they filed and been eligible on the first day of the month. The SSI payment would also be prorated from the date eligibility conditions are met in the first month following a month of ineligibility. This provision is effective October 1, 1982.

Under prior law, an application for SSI payments was considered to be effective as of the first day of the month in which it was filed. This resulted in all new SSI recipients being paid a full month's benefit regardless of when in the month they filed.

2. Rounding of SSI eligibility and payment amounts.* The SSI monthly benefit and income eligibility amount, if not in whole dollars, will be rounded to the next lower whole dollar amount after the annual cost-of-living adjustment is calculated. Subsequent benefit and eligibility standard increases due to annual cost-of-living adjustments will be based on the SSI standard that resulted before the previous year's amount was rounded downward. The purpose of basing the annual cost-of-living increase on the unrounded SSI standard is to prevent the adverse, cumulative effect that would occur year to year from downward rounding.

* Those provisions that are similar to or identical with proposals submitted by the administration in its bill, the "Social Welfare Amendments of 1982," are marked with an asterisk.

Under prior law, the monthly SSI standards were rounded to the next higher dime when the annual cost-of-living adjustment was calculated. The impact on the monthly payment for any single recipient was minimal. Over time, however, this rounding procedure has had a compounding effect that results in benefit payments that are slightly higher than the cost-of-living increases otherwise would have caused. The provision is effective October 1, 1982.

In addition to rounding down of the benefit and eligibility amounts, the Secretary of Health and Human Services has indicated the Department's intention to use existing authority (under section 1631(a)(3) of the Social Security Act) to establish ranges of incomes within which fixed amounts of benefits will be payable; this is intended to assure that individual monthly benefit payments will be in whole-dollar amounts as though the calculated monthly benefit payments, if not in whole-dollar amounts, were rounded down to the next lower whole dollar.

3. Coordination of SSI and OASDI cost-of-living adjustments.* As an exception to retrospective accounting, the amendment provides that increases in OASDI benefits, including OASDI cost-of-living adjustments (COLA's), in the month that an SSI COLA becomes effective and in the following month will be taken into account as income in such months. Thus, OASDI COLA's paid in July and August will be counted as income in determining SSI benefits in July and August instead of waiting until September (under the 2-month retrospective accounting system) to count the OASDI increase as income.

The amendment also provides that other changes in income and relevant circumstances may, at the Secretary's option, be taken into account in the month that the change is expected if there is reliable information available concerning the change. The amendment is effective October 1, 1982.

This amendment corrects a defect in the SSI retrospective accounting provision enacted under the Omnibus Budget Reconciliation Act of 1981. The retrospective approach is designed to permit more accurate determinations of benefits than the prospective approach it replaced. That is, it bases determinations on past circumstances instead of anticipated circumstances. More accurate determinations, in turn, reduce program overpayments. However, since a fully retrospective method does not permit taking into account income increases anticipated in the coming month even when clearly reliable information on the increase is available, excessive payments may occur. The primary example is the situation in which the SSI and OASDI COLA's occur in July, but the SSI payment for July and August is based on the unadjusted OASDI benefit received in May and June. The result is that the recipient receives a "windfall" in July and August because the SSI payment

for those months is based on the increased SSI rate without taking into account the known increase in the OASDI benefit. The amendment corrects this defect without increasing the margin for error by providing for prospective accounting of expected changes when such expectation is based on dependable information.

The net general effect of the amendment is to require the coordination of the OASDI and SSI COLA's and, in addition, to authorize the Secretary, subject to determination that the facts may be relied upon, and subject to considerations of equity and administrative feasibility, to use the most current other dependable data in administering the SSI program. Anticipated changes under consideration for being taken into account under the Secretary's discretionary authority include cost-of-living adjustments in other Federal benefits such as Veterans Administration pension and compensation payments, Federal Civil Service retirement payments, Railroad Retirement Board benefits, and Black Lung benefits.

4. Phaseout of hold-harmless protection.* Federal contributions toward the cost of States' supplementary payments will be phased out by 1985. This continues a process begun last year by the 1982 Continuing Budget Resolution, which provided that such Federal contributions be reduced to 60 percent of what they otherwise would have been for fiscal year 1982. The new provision further reduces Federal payments to 40 percent of what they would otherwise be in fiscal year 1983, 20 percent in fiscal year 1984, and no Federal funding for fiscal year 1985 and future years.

The hold-harmless provision was included in the legislation establishing the SSI program as an inducement to States with payment levels in the pre-SSI assistance programs that were higher than the new Federal SSI benefit levels to supplement SSI benefits. Under hold-harmless, State liability for the cost of supplementing SSI benefits up to the levels that were in effect in the State in January 1972 is limited to the amount spent by the State for benefits on behalf of aged, blind, and disabled persons in calendar year 1972. Any additional costs for such supplementation is borne by the Federal Government. Since the Federal protection applied only to supplements needed to maintain January 1972 assistance levels, the added cost against which States were protected related to increased numbers of persons made eligible for SSI (and thus to State supplementary payments) by SSI eligibility provisions that were more liberal than those previously used by some States.

Hold-harmless was intended to be a transitional provision, with Federal funding to phase out as Federal SSI benefits increased. However, two of six States originally eligible for hold-harmless money continue to receive Federal contributions toward the costs of their supplementary payments. Hawaii and Wisconsin continue to benefit from the hold-harmless provision primarily be-

cause of a 1976 change in the law that provided that hold-harmless payments would no longer be reduced by the effect of increases in Federal SSI benefits. The new provision ensures that hold-harmless funding will phase out for Hawaii and Wisconsin also.

5. Exclusion from resources of burial plots and certain funds set aside for burial expenses. This change provides for the exclusion of burial spaces for the use of an individual and members of his or her immediate family. The Secretary is authorized to prescribe limits on the size and value of the burial spaces that are excluded. The amendment also provides for the exclusion of up to \$1,500 each for an individual and spouse held in separately identifiable burial funds. However, the amount excluded as a burial fund will be reduced by the face value (\$1,500 or less) of life insurance already excluded from resources and any amount held in an irrevocable burial arrangement (not considered a resource because it cannot be redeemed for cash). Thus, the exclusion of burial funds is not an exclusion of additional amounts of resources. Rather, it gives SSI recipients an alternative to life insurance and irrevocable burial plans for providing for their burial expenses without affecting their SSI eligibility. The provision also stipulates that future SSI benefits will be reduced by any amounts of the excluded burial funds used for purposes other than those for which they were set aside. The Secretary is authorized to exclude from income and resources increases in the value of burial funds which result from accrual of interest or from appreciation. This change is effective November 1982 (the second month following the month of enactment).

6. Mandatory passthrough under State supplementation provisions. This provision enables States to switch from the "maintaining of total expenditures" method of compliance with the mandatory passthrough provision to the "maintaining of payment levels" method without first having to pass through to all current recipients all the Federal cost-of-living increases that have occurred since December 1976.

Beginning with the increase in July 1977, States that supplement Federal SSI benefits have been required to pass through to recipients all Federal cost-of-living increases. States may meet this requirement by either (1) maintaining their supplementary payments at levels that are no lower than the levels in effect in December 1976, or (2) maintaining total expenditures for State supplementary payments in a 12-month period following a Federal cost-of-living increase that are no lower than the expenditures for such payments in the preceding 12-month period. Some States did not wish to maintain the December 1976 payment levels for every category of supplementary payments recipients and, thus, chose to meet the passthrough requirement by maintaining total expenditures. In order for these States to switch to maintaining payment levels, they would, without this

change, have to raise each recipient's State supplementary payment level to the level in effect in December 1976 for such recipient (or category of recipients). The new provision maintains the passthrough requirement but allows States to meet the requirement by maintaining the State supplementary payment levels that were in effect in December of the preceding 12-month period rather than those in effect in December 1976. This change is effective for months after June 1982.

7. Treatment of unnegotiated checks under the SSI program.* This provision makes a technical change pertaining to the treatment of unnegotiated SSI State supplement checks. It assures that States will be credited with their shares of any unnegotiated checks that contain State supplementary payment amounts even if the checks do not also include Federal SSI amounts.

Under the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35), the Department of the Treasury, beginning in October 1982, will notify SSA of such SSI State supplement checks that have not been presented for payment within 180 days of the date of issuance. SSA is then required to credit State accounts with the appropriate shares of the unnegotiated checks and investigate the eligibility of persons whose SSI checks have remained uncashed. However, because of an error in drafting the legislation, the language left doubt about the authority to credit States for amounts of uncashed checks that were entirely for State supplementary payments (that is, it did not include any amounts for Federal SSI benefits). This amendment remedies that situation. The provision is effective October 1, 1982.

B. Provisions Directly Affecting the Medicare Program**

1. Medicare reimbursement to hospitals. The provision substantially changes the method of Medicare reimbursement for a hospital's inpatient routine operating costs (that is, bed, board, and routine nursing) under which reimbursement generally could not exceed 108 percent of the average routine cost per day incurred by other hospitals of the same type (unless the hospital qualified for an exception or exemption).

• Reimbursement limits. This provision extends reimbursement limits (so-called section 223 limits) to include costs of ancillary services and special care units, applies the limits on a cost-per-case basis, and adjusts them for each hospital's case-mix. Limits are set at 120 percent of the mean in fiscal year 1983, and reduced to 115 percent in fiscal year 1984, and to 110 percent in fiscal year 1985. In no case would reimbursement on a cost-per-case basis be reduced below the allowable cost-per-case reimbursement for the hospital's cost-reporting period

that immediately precedes the first cost-reporting period to which the new limitation is applicable. Provision is made for appropriate exemptions, exceptions, and adjustments from the limits. Effective date: cost-reporting periods beginning on or after October 1, 1982.

- **Rate of increase limit.** The provision establishes a system for limiting the per case rate of increase in hospital revenue for 3 years beginning after September 30, 1982. The target rate is set using the previous year's allowable cost per case (or after the first year, the previous year's target amount) increased by the percentage increase in the hospital wage and price index, plus 1 percentage point. For the first 2 years, hospitals with operating costs above the target rates would be reimbursed up to 25 percent of those excess costs; none of the excess would be reimbursed in the third year. Hospitals with operating costs below the target rate of increase would be paid their costs plus a bonus of 50 percent of the savings (not to exceed 5 percent of the target rate). Provider payments could not exceed the amount payable under the new section 223 reimbursement limits. The law also provides for a reduction in payments to hospitals that withdraw their employees from the OASDHI program after August 15, 1982. The reduction would reflect the savings achieved through withdrawal, but could be offset by expenditures for comparable insurance benefits. Effective date: Limits apply to a hospital's first three cost-reporting periods beginning on or after October 1, 1982, but cease upon implementation of a prospective payment system.
- **Prospective reimbursement.** This provision requires the Secretary to develop, in consultation with the Senate Finance Committee and the House Ways and Means Committee, Medicare prospective reimbursement legislative proposals for hospitals, skilled-nursing facilities, and, to the extent feasible, other providers. Effective date: A report to the committees on the proposals is due by December 31, 1982.
- **Recognition of State hospital cost control system.** This provision authorizes Medicare hospital payments (at the request of a State) under a hospital reimbursement control system in the State if, and so long as, (1) the system applies to substantially all non-Federal hospitals to at least 75 percent of hospital inpatient revenues in the State, and to the State's Medicaid program, (2) the system treats payors, hospital employees, and patients equitably, and (3) the Secretary is satisfied that the system will not result in greater Medicare expenditures over a 3-year period. The provision insures that State hospital reimbursement demonstrations in continuous operation since July 1, 1977, will continue at least 6 months after the Secretary notifies a State of his decision to terminate the project.

2-3. Single reimbursement limit for skilled-nursing facilities and home health agencies. These provisions require the Secretary to issue regulations establishing a single reimbursement limit (rather than different rates for hospital-based and freestanding locations) for skilled-nursing facilities and for home health agencies,

** Provisions that are similar to or identical with proposals submitted by the administration in its Medicare/Medicaid bill are marked with a double asterisk. Also, many Medicare provisions in Public Law 97-248 (TEFRA) were further modified in Public Law 98-21, the Social Security Amendments of 1983. See pages 3-48 in this issue.

based on the cost experience of freestanding facilities. Exceptions could be made based on legitimate differences in hospital-based skilled-nursing facilities resulting from factors such as more complex case mix or the effects of Medicare cost allocation requirements. Effective date: The provision applies to home health agency reporting periods beginning on or after the date of enactment, and skilled-nursing facility cost-accounting periods beginning on or after October 1, 1982.

4. Elimination of nursing differential. This provision eliminates the routine nursing salary cost differential (now 5 percent) for both hospitals and skilled-nursing facilities. Since 1969, Medicare paid hospitals and skilled-nursing facilities an additional amount for in-patient routine nursing salary costs on the theory that older patients require more nursing care than younger patients. The Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) reduced, effective October 1, 1981, the hospital inpatient routine nursing salary cost differential from 8.5 percent to 5 percent. Effective date: The provision applies to cost-reporting periods ending after September 30, 1982, but only for the portion of that period occurring after that date.

5. Elimination of duplicate overhead payments for outpatient services. This provision requires the Secretary to issue regulations to limit the reasonable charge for the services of physicians who perform services in hospital outpatient departments to a percentage of the amount of the prevailing charge for similar services furnished in a physician's office, taking into account the extent to which the overhead costs of the department have been included in the hospital's costs or charges. Effective date: The provision applies to charges for services rendered on or after October 1, 1982.

6. Prohibiting payment for Hill-Burton free care. This provision requires the Secretary to provide, by regulation, that the costs incurred by a hospital or skilled-nursing facility in complying with its free care obligations under the Hill-Burton Act are not reasonable costs for purposes of Medicare reimbursement. Effective date: The provision applies to all such costs that have been, or will be incurred, except those recognized by the final judgment of a U.S. Court of Appeals entered into prior to September 3, 1982.

7. Prohibiting payment for anti-unionization activities. Medicare reimbursement for costs incurred for activities directly related to influencing employees with respect to unionization would be prohibited. Under prior law, the reasonable costs of consultants to hospitals on union organizing activities were recognized by Medicare if these activities did not violate the National Labor Relations Act. Effective date: The provision applies to costs incurred after September 3, 1982.

8. Reimbursement of provider-based physicians. This provision directs the Secretary to prescribe regulations, similar to those previously in effect, with respect

to provider-based specialists (for example, radiologists, anesthesiologists, and pathologists) that will distinguish between (1) professional medical services that are personally rendered to individual patients; that contribute to the patient's diagnosis and treatment; and that are reimbursable under Part B on a charge basis, and (2) professional medical services of practitioners that are of benefit to patients generally and that can be reimbursed only on a reasonable cost basis. Reasonable cost reimbursement for provider-based services cannot exceed a reasonable compensation equivalent established by the Secretary in regulations. Effective date: For reductions for cost-reporting periods ending after September 30, 1982, but only for the portion of the period occurring after that date.

9. Prohibiting recognition of payments under certain percentage arrangements. Prior law specifically excluded, in determining reasonable costs for home health agencies, any cost under a contract where the amount payable by the home health agency was determined as a percentage of the agency's reimbursement or claim for reimbursement. Under Public Law 97-248 payments made by *any provider* of services to contractors, employees of related organizations, consultants, or subcontractors would not be reimbursed where compensation is based on percentage arrangements, except where such arrangements are reasonable and are part of customary business practice or provide incentives for efficient and economical operations. The provision also does not apply where such costs are subject to limits on reimbursement of provider-based physicians. Effective date: Subject to a number of exceptions, the provision is generally effective September 3, 1982. Beginning October 1, 1982, the provision would apply only where the limitation on the services of provider-based services (item 8 above) has not been implemented.

10. Eliminating "lesser of costs or charges" provision. Under this provision the general requirement limiting payment for services furnished by providers to the lower of the provider's actual charge or the reasonable cost of the service will be eliminated for a class of providers, if and when the Secretary determines and certifies to the Congress that such action will not increase Medicare payments to that class of providers. The Conference Report expresses the intent that such determination will take into account both past experience and possible changes in cost accounting and charging practices of providers in the absence of the provision. The "lower of costs or charge" provisions are to be re-established if the Secretary determines that their elimination has increased program costs.

11. Elimination of private room subsidy. The provision requires the Secretary to publish regulations eliminating the current Medicare subsidy for private rooms that are not medically necessary. Medicare currently determines its payments to a hospital on the basis of the

average costs of all its accommodations, including the additional costs of private rooms even though Medicare generally does not pay for private rooms that are not medically necessary. Effective date: Regulations are to be issued by October 1, 1982; if they are published on an interim basis, final regulations must be issued by January 31, 1983.

12. Radiologist/pathologist.** The provision eliminates the 100 percent Part B reimbursement rate applicable to inpatient radiology and pathology services. Medicare will pay for such services on the same basis as for other physicians' services—that is, 80 percent of the reasonable charge after the Part B deductible has been met. (Under prior law, such services were not subject to the deductible and coinsurance features of the Part B program.) Effective date: The provision is effective for services furnished on or after October 1, 1982.

13. Reimbursement for assistants at surgery. Under prior law, Part B carriers generally followed local medical practice and/or private sector reimbursement policies in reimbursing assistants at surgery. The new provision prohibits reasonable charge reimbursement for assistants at surgery in hospitals where an approved training program exists in the specialty and a qualified staff physician is available to provide the service, except when (1) the surgery is performed by a team of physicians needed to perform complex medical procedures; (2) the patient has multiple conditions that require the presence of, and active care by, a physician of another specialty during surgery; and (3) in the case where exceptional medical circumstances exist. The Secretary may specify other appropriate exceptions by regulations. Effective date: The provision is effective with respect to services performed on or after October 1, 1982.

14. Prohibition of payment for ineffective drugs. This provision authorizes implementation of section 2103 of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35), which prohibited, effective October 1, 1981, the use of Federal funds under Medicare Part B and under Medicaid to pay for certain drugs. These are prescription drugs that the Food and Drug Administration has determined to be less than effective in use. Subsequent appropriations legislation had, in effect, barred implementation of this provision through September 30, 1982, and the Department had provided for continued reimbursement of the drugs. Effective date: September 30, 1982.

15. Medicare secondary for older workers.** This provision amends the Age Discrimination in Employment Act (ADEA) by requiring employers of 20 or more employees to offer their employees aged 65 through 69 and their dependents health benefits coverage under the same conditions as offered the employer's younger employees. These benefits must be offered as primary to Medicare for such employees (and their spouses aged 65 through 69), but acceptance of such a plan is voluntary

by the working aged beneficiary. (Under prior practice, the employer could "carve-out" from his health plan those benefits that are actually paid for by Medicare, or, under certain circumstances, an employer could offer employees eligible for Medicare a separate plan that supplements Medicare.)

Medicare's payments are made secondary to the employment-based insurance with respect to services provided to these older workers and spouses. Medicare's payment for any item or service furnished to an employee (or spouse) would be reduced where the combined payment under Medicare and the employer's health benefits plan would otherwise exceed an amount equal to (1) the reasonable cost of items or services reimbursed on a cost or cost-related basis; or (2) the higher of the reasonable charge (or other amount payable under Medicare, without regard to the program's deductibles or coinsurance) or the amount payable under the employer group plan (without regard to deductibles or coinsurance imposed under that plan) for items reimbursed on a charge basis. In no case would Medicare pay more than it would have paid in the absence of any employer plan. Effective date: The ADEA legislation was amended effective January 1, 1983. The amendment to the Social Security Act is effective with respect to items and services furnished on or after January 1, 1983.

16. Interest charges on overpayments and underpayments. This provision requires the payment of interest by or to a provider or supplier of services under Medicare on settlement of an account taking longer than 30 days after the final determination. The rate of interest would be in conformity with the Treasury Fiscal Requirements Manual. Effective date: The provision is effective for final determinations made on or after September 3, 1982.

17. Temporary delay in periodic interim payments. This provision delays the periodic interim payments (PIP) to hospitals electing this payment method that are due during the last weeks in September until the following October in both 1983 and 1984.

18. Medicare coverage of Federal employees.** Medicare coverage would be extended to Federal employees. Such employees, and the Federal Government as their employer, would be required to pay the Hospital Insurance portion of the FICA tax (now 1.3 percent of earnings up to a yearly maximum). Federal wages earned after December 31, 1982, would be covered for purposes of earning quarters of coverage for determining Medicare eligibility. Persons employed by the Federal Government during January 1983 and at any time prior to that date would, if necessary, have their wages prior to January 1983 treated as if those wages were covered for purposes of determining Medicare eligibility. Effective date: Applies to wages paid in calendar years after 1982.

19. Coverage of extended care services without regard to 3-day prior hospitalization requirement. Under prior law, Medicare provides coverage of up to 100 days of "post-hospital extended care services" in a qualified skilled-nursing facility (SNF) following a hospital stay by the beneficiary of at least 3 consecutive days. This provision of Public Law 97-248 directs the Secretary to eliminate the 3-day prior hospitalization requirement when the Secretary determines it will not lead to an increase in cost and will not change the acute care nature of the SNF benefit. The Secretary is authorized to impose limits for persons covered without a prior hospital stay on the scope or extent of services covered and on categories of individuals eligible. The 3-day requirement may be reestablished if the Secretary determines that its elimination has increased program costs.

20. Part B premium as a temporary constant percentage of costs. This provision establishes that from July 1983 through July 1985, the monthly premium for Part B will be set at one-half the actuarial rate (25 percent of the expected average cost with a margin for error) for aged enrollees. After June 1985, calculation of the premium rate would revert to the previous method with the premium amount for July 1984-June 1985 serving as the base from which the July 1986 premium would be calculated. In the past, the Part B premiums are the lesser of the actuarial rate (that amount required to pay for one-half the expected monthly average cost of the Part B program, with a margin for error) for aged enrollees, or the past year's rate, increased by the same percentage as the most recent general cost-of-living adjustment to monthly Social Security cash benefits. Effective date: July 1, 1983, through June 30, 1985.

21. Special enrollment provisions for merchant seamen.** This provision establishes a special enrollment period for merchant seamen beginning the first month that occurs at least 20 days after enactment and ending December 31, 1982. Seamen who can document their former Public Health Service eligibility may enroll in Part A and Part B without having to pay the late penalty, and can elect retroactive coverage to October 1, 1981, if they enroll before January 1, 1983. The Secretary will disseminate information to make seamen aware of this provision. Without this provision merchant seamen would have lost health benefits through the repeal of a provision under the Public Health Service Act, and those who were eligible but not enrolled in Part A or Part B would have had to wait for a general enrollment period and pay a late enrollment penalty under Part B. Effective date: October 1982.

22. Extending Medicare proficiency examination authority. This provision extends the authority of the Secretary of the Department of Health and Human Services to conduct a program to determine the proficiency of health care personnel, including clinical laboratory personnel who do not meet formal edu-

tional requirements. Previous authority expired December 31, 1981; the new authority expires September 30, 1983. Effective date: The provision is effective upon enactment (September 31, 1982).

23. Prohibiting retroactivity of regulations regarding access to books and records. This provision bars retroactive application of regulations implementing section 952 of the 1980 Omnibus Reconciliation Act unless the regulations are issued in final form prior to January 1, 1983, preceded by a comment period of at least 60 days. Section 952 of the 1980 Omnibus Reconciliation Act, not yet implemented, directs the Secretary to prescribe in regulations the procedures and criteria to be used in obtaining access to the books and records of subcontractors who supply providers with goods and services valued at \$10,000 or more over a 12-month period.

24. Audit and medical review. Medicare fiscal intermediaries and carriers perform provider cost audits and medical necessity review (to the extent it is not duplicative of review done by the Professional Standards Review Organization (PSRO)) of claims using funds appropriated for Medicare contractor budgets. The amount to be spent on audits and medical review is negotiated by each contractor. Public Law 97-248 provides that the Medicare contractor budget will be supplemented by an additional \$45 million for fiscal years 1983, 1984, and 1985 that must be used exclusively for provider audits and medical necessity review. Effective date: October 1, 1982.

25. Private sector review initiative. This provision provides that the Secretary will undertake an initiative to improve medical review performed by Medicare contractors by setting specific standards to measure their performance in identifying and reducing unnecessary utilization, and will encourage similar efforts by private insurers and other private entities. The new law also affirms current provisions that waive beneficiaries' liability for payment of services they did not know would not be covered.

26. Utilization and quality control peer review program. This provision establishes a Utilization and Quality Control Peer Review Organization (UQCPCRO) program in place of the Professional Standards Review Organization program. Under prior law, nonprofit PSRO's, composed of licensed physicians in designated local areas, were required to review the medical necessity, quality, and appropriateness of health care services provided to Medicare beneficiaries. PSRO's received a Federal grant to perform this review, as well as to analyze profiles of care to identify aberrant patterns. States could contract with PSRO's for Medicaid review at a Federal match of 75 percent of the costs. PSRO's could not disclose information unless necessary for program purposes, and could not be held liable on account of any action resulting from the performance of review duties. Physicians and providers failing to meet their

obligations under the law could be sanctioned by PSRO's.

The UQCPRo program is very similar to the PSRO program with several important differences:

- Eligible organizations may be proprietary or non-profit and may be either physician groups or have available sufficient physicians to perform review. Facilities and facility associations are excluded from participating; payor organizations may participate after 12 months.
- The Secretary will enter into performance contracts with UQCPRo's for 2 years, renewable biennially. Contracts could be terminated only after a panel had reviewed relevant data and information and provided a recommendation to the Secretary. Contract nonrenewals would not be subject to termination panel procedures, but the UQCPRo would be able to present data and information on its performance.
- Geographic areas would be consolidated generally into Statewide areas if annual Medicare and Medicaid admissions are fewer than 180,000. No local area could be established with fewer than 60,000 total (both public and private) annual admissions.
- UQCPRo's will be exempt from the Federal Freedom of Information Act but must disclose relevant information to Federal and State fraud and abuse, licensure, and public health agencies. Private review is facilitated by requiring participating Medicare hospitals to release data on patients of private payors who contract with UQCPRo's.
- Sanctions will automatically become effective within 120 days if the Secretary fails to act upon a UQCPRo recommendation. The dollar amount triggering hearings and appeals of review decisions has been doubled.
- The Secretary cannot terminate or fail to renew any PSRO grants until the Department has entered into a contract with a UQCPRo for the area served by the PSRO. The UQCPRo program has no provision for statewide or national councils.

Effective date: The provision is effective with contracts entered into or renewed on or after September 30, 1982 (subject to the provision requiring continuance of PSRO's pending contracting with UQCPRo's).

27. Hospice care. Under prior law, unique hospice services such as outpatient palliative drugs, respite care, bereavement counseling, and home health services provided to beneficiaries who are not homebound were not covered and could not be reimbursed. Hospices were not recognized as distinct providers, although some were certified under other provider categories.

Public Law 97-248 authorizes Medicare Part A coverage of hospice care for beneficiaries having a life expectancy of 6 months or less. Covered hospice care would be available for two periods of 90 days and one period of 30 days to beneficiaries who elect such coverage in lieu of other Medicare benefits, except those relating to the services of the attending physician and services not related to the terminal condition. Inpatient care can com-

prise no more than 20 percent of aggregate patient days, with inpatient respite care limited to no more than 5 consecutive days on an intermittent basis. A 5-percent coinsurance is imposed on inpatient respite care, and a copayment is placed on drugs at the lesser of \$5 or 5 percent per prescription charge.

Hospices must provide a core of services directly that include nursing care, medical social services, physician services, and counseling services. All other services, including physical and occupational therapy, speech-language pathology, home health aide/homemaker services, drugs and medical supplies, and short-term inpatient care can be provided under arrangements. Care must be available on a 24-hour basis and be provided in accordance with a written plan developed and implemented by an interdisciplinary team composed of one physician, one nurse, and one social worker employed by the hospice, as well as one counselor. Hospices are classified as separate providers that must file separate cost reports. Reimbursement will be made on the basis of reasonable cost, not to exceed a cap amount equal to 40 percent of the estimated average Medicare expenditures for cancer patients during the last 6 months of life.

The Secretary will report to Congress by January 1986 on the equity of the reimbursement method and benefit structure, including the feasibility of prospectively reimbursing hospices. The Secretary will also report, prior to September 30, 1983, on the effectiveness of the hospice demonstration program, which will be continued until implementation of this provision.

Effective date: November 1, 1983, with a sunset provision of October 1, 1986.

28. Payments to Health Maintenance Organizations and competitive medical plans. Under existing law Health Maintenance Organizations (HMO's) are reimbursed by Medicare for services covered under both Part A and Part B, pursuant to section 1876 of the Social Security Act. Under section 1876, HMO's receive interim monthly capitation payments based on either cost or risk contracts. Under risk contracts, reimbursement is based on a comparison of the HMO's costs with its adjusted average per capita cost (AAPCC), which is the average cost of providing services to Medicare beneficiaries in the same geographic area as the HMO but who are not enrolled, and having the same characteristics as the enrolled populations. If the risk-based HMO's costs are less than the AAPCC, it shares the "savings" with the Medicare program. The organization may receive savings of up to 10 percent of the AAPCC. HMO's are not required to provide additional services with their savings.

The new provision in Public Law 97-248 authorizes, in addition to cost contracts, prospective reimbursement under risk-sharing contracts with HMO's and other eligible organizations at a rate equal to 95 percent of the AAPCC.

Organizations eligible to enter into contracts are federally qualified HMO's or organizations that provide specified health services, receive fixed and periodic payments on behalf of enrollees, provide physician services through staff physicians or physicians under contract, assume financial risk on a prospective basis, and meet financial viability standards. The organization must have at least 50,000 members, although this limitation may be waived for plans in non-urban areas. The organization must provide all Medicare services, and the Secretary must approve any additional services. The organization must also have arrangements for an ongoing quality assurance program in accordance with regulations to be established by the Secretary.

An annual open enrollment period of at least 30 days is required. Plans must generally accept beneficiaries in order of application up to capacity. A beneficiary may disenroll on a monthly basis with 1 month's notice. A plan may not disenroll or refuse to reenroll a beneficiary because of health status or services required. Combined Medicare and Medicaid enrollment in the HMO cannot exceed 50 percent of the total enrollment, except under certain circumstances. Two new Medicare members will be required to enroll in a plan for each current Medicare enrollee who converts to risk reimbursement. The Secretary may establish standards for consumer information to be supplied to eligible beneficiaries.

To the extent that the Medicare payment exceeds the eligible organization's adjusted community rate under a risk-sharing contract, the organization must use the savings to provide its Medicare members with additional benefits (selected by the organization and approved by the Secretary) or reduced cost sharing.

The Secretary may enter into reasonable cost contracts with eligible organizations that are determined not to have the capacity to bear the risk of potential losses under a risk-sharing contract, or which so elect, or which do not meet the membership size limitation.

The Secretary is required to conduct two studies: one on the benefits, in addition to Medicare benefits, which are provided under the new risk reimbursement; and another study on the extent to which Medicare beneficiaries terminate membership in HMO's and the reasons for such terminations.

Effective date: The provision will become effective 1 month after the Secretary notifies Congress that she is reasonably certain that the methodology for determining the prospective rate based on 95 percent of the AAPCC is developed and can be implemented on October 1, 1983, if later.

29. Technical corrections from Omnibus Budget Reconciliation Acts of 1980 and 1981. Public Law 97-248 also included 15 technical and minor policy changes in the provisions of the Omnibus Budget Reconciliation Acts of 1980 and 1981. Most of these provisions are effective as if they had been originally in-

cluded in the Reconciliation Act or Social Security Act provisions to which they relate.

C. Provisions Indirectly Affecting the OASDI and SSI Programs

1. Integration of private pension plans with Social Security. The new law provides that the OASDI employer tax rate will be the maximum rate at which employer contributions can be reduced under a defined contribution plan that is integrated with Social Security. For example, assume that the new provisions were applicable for 1982, when the employer's tax rate was 5.4 percent and the earnings base was \$32,400. An employer who contributed 10 percent of wages in excess of \$32,400 to an integrated defined contribution plan would have been required to contribute at least 4.6 percent (10 percent minus 5.4 percent) on wages below \$32,400. The intent of the provision is to limit the amount employers can reduce their contributions to a defined contribution plan and continue to get tax benefits with regard to the contributions. This provision is effective for years beginning after December 31, 1983.

2. Treatment of real estate agents and direct sellers. Effective for services performed after 1982, licensed real estate agents and individuals who are direct sellers will be treated for Federal income and Social Security tax purposes as self-employed persons where certain conditions are met. Substantially all the remuneration paid for their services must be directly related to sales or other output and such services must be performed pursuant to a written contract that provides that they will not be treated as employees for Federal tax purposes. The definition of direct sellers includes those individuals who solicit the sale of consumer products as well as those who attempt to increase the sales activities of direct sellers and who realize remuneration dependent on the productivity of those direct sellers. The definition of real estate agents includes the appraisal activities of licensed real estate agents in connection with real estate sales activities if such individuals realize remuneration dependent on sales or other output.

3. Independent contractors. Public Law 97-248 provides for an indefinite extension of the interim provisions first enacted as part of the Revenue Act of 1978 under which an individual is not treated as an employee for employment tax purposes if a taxpayer did not treat him as an employee in the past and had a reasonable basis for not doing so. The interim provisions also prohibit the Treasury Department from issuing any regulation or revenue ruling concerning the employment status of an individual for employment tax purposes. The interim provisions are intended to apply until such time as the Congress enacts legislation as to the classification of the workers in question as independent contractors or employees.

4. Reduction of certain employment tax liabilities where workers are reclassified as employees. The new law provides tax relief for employers in certain cases where a worker is reclassified from an independent contractor to an employee and the employer failed to withhold income taxes or Social Security taxes from the worker's earnings. In cases where the employer filed the informational reports required by law consistent with its treatment of the worker as an independent contractor, the employer's liability for the employee Social Security tax will be reduced to 20 percent of the employee Social Security tax. If the employer failed to file such reports, the employer liability will be 40 percent of the employee Social Security tax. The employer will be liable for the full amount of the employer share of the Social Security tax, as under prior law.

Assume that a worker, who was paid \$10,000 in 1983, was hired as an independent contractor and subsequently reclassified as an employee. Also, assume that the employer failed to withhold Social Security and income taxes from the worker's earnings. Under the new law, if the employer filed the proper informational reports, the employer's liability for the employee's Social Security tax would be reduced from \$670 (6.7 percent of \$10,000) to \$134 (20 percent of \$670). If the employer failed to file such reports, the employer's liability would be \$268 (40 percent of \$670). In either case the employer will also be liable for the full amount of the employer share of the Social Security tax—\$670.

This provision will not apply in any case in which (1) the employer intentionally disregarded its obligation to withhold Social Security and income taxes; (2) the employer withheld income taxes but not the employee share of the Social Security tax; or (3) the Social Security tax liability of statutory employees under the Social Security Act is involved.

The provision is effective upon enactment (September 3, 1982), except that it does not apply to any assessment made before January 1, 1983.

5. Relief for the Jefferson County Mental Health Center, Lakewood, Colorado. Effective immediately, the Secretary of the Treasury is required to pay \$50,000 in full settlement for claims of the Center against the United States for repayment of Social Security employee taxes that the Center erroneously refunded to its employees pursuant to instructions from the Internal Revenue Service.

6. Reporting of tips. The provision does not change the law with regard to reporting of tips to employers by employees and the withholding of Social Security taxes on those tips by employers. The purpose of the change is to facilitate the examination of income tax returns filed by tipped employees. The new law requires each food and beverage establishment that normally has 10 or more employees to file annually with the Internal Revenue

Service an informational return showing (1) gross receipts from food and beverage sales, (2) aggregate amount of charge receipts, (3) aggregate amount of tips shown on charge receipts, and (4) tip income reported by employees to the employer and mandatory service charges of less than 10 percent. If the reported tip income is less than 8 percent of gross receipts, the employer must allocate to the employees an amount equal to the difference between 8 percent of gross receipts and the amounts reported to the employer as tip income by employees. This allocation is for reporting purposes only and has no effect on the employer's Social Security or income tax withholding liabilities or on the employee's receipt of tip income. However, the provision is expected to lead to more accurate reporting of tip income and, therefore, additional revenues to the OASDI trust funds.

The requirements of this provision are effective for calendar years beginning after December 31, 1982, except that allocation rules first apply to payroll periods ending after March 31, 1983.

This section also requires the Secretary of the Treasury to submit to the Congress before January 1, 1987, a report, together with a cost-benefit analysis of any recommendations he may have for changes, on the operation of the present tip reporting system under the Social Security program.

7. Medicaid coverage of home care for certain disabled children. Under the provision, for purposes of establishing Medicaid eligibility, States may consider a disabled person aged 18 or younger as though eligible for SSI if he or she would be eligible for SSI if he or she were in a medical institution and if the State determines that he or she requires the level of care provided in an institution, that it is appropriate to provide such care outside of the institution, and that the cost of care at home is no more expensive than the cost of institutional care.

SSI recipients are eligible for Medicaid in most States. However, in some cases persons may be eligible for SSI (and thus for Medicaid) while they are institutionalized but be ineligible when living at home, either because parents' or spouses' incomes and resources are deemed to them when they live with their parents or spouses or because they receive support and maintenance in kind from the households in which they live. To retain Medicaid eligibility, some patients remain institutionalized even though their medical needs could be met appropriately and at less cost to the Government if they were living at home. Under the provision, at States' options, individuals aged 18 or younger who otherwise would be ineligible for SSI and Medicaid if they live at home may retain Medicaid eligibility while receiving home care at less cost to the Government. The provision is effective on October 1, 1982.

III. Summary of Provisions of Public Law 97-253 That Indirectly Affect the OASDI or SSI Program

There are Civil Service-, veterans-, and Food Stamp-related provisions in Public Law 97-253 that indirectly affect Social Security because of the interrelationships of payments under these programs. These provisions are as follows:

- **Creditable service based on military service and recomputation at age 62 of credit for military service of current annuitants.** Under present law, post-1956 military service is creditable under the Civil Service Retirement System (CSRS) for retirement annuity purposes as long as an individual is not eligible for Social Security retirement benefits. When an individual reaches age 62 and becomes eligible for Social Security retirement benefits, the CSRS annuity is recomputed without post-1956 military service. (Military service first became covered under Social Security on a contributory basis in 1957.)

Public Law 97-253 provides a new method for crediting post-1956 military service for CSRS purposes for current civil service annuitants, current Federal employees, and new employees. The changes would not affect the treatment of post-1956 military service under the Social Security program. The new provisions would operate as follows:

- **New employees.** Employees hired under CSRS on or after October 1, 1982, would receive credit for post-1956 military service toward a Civil Service annuity only if they deposit into the CSRS fund an amount equal to the CSRS contributions on their military wages (7 percent of basic military pay). If an employee elects not to make the deposit, post-1956 military service would not be credited toward the CSRS annuity either before or after the employee becomes eligible for Social Security benefits.
- **Current employees.** Employees under CSRS prior to October 1, 1982, would be treated similarly to new employees except that if they choose not to make the deposit, they would continue to be subject to the provision of present law, that is, military service would be used in computing the CSRS annuity payable before age 62; when the employee becomes eligible for Social Security retirement benefits, the CSRS annuity would be recomputed to remove post-1956 military service credited under CSRS.
- **Current annuitants.** Employees who are retired under CSRS on or before October 1, 1982, would have their CSRS annuity recomputed to restore credit for their post-1956 military service; the annuity would then be reduced by an amount equal to the proportion of the Social Security benefit that is attributable to military earnings. The Social Security Administration would furnish the

Office of Personnel Management with the information necessary to reduce the annuity under the new provision.

- **Disclosure of Social Security information in connection with the Civil Service Disability Retirement system.** The Director of the Office of Personnel Management may receive, upon request, information in the Social Security Administration's records. The information will be used to ensure the accuracy of information used in administering the Civil Service Disability Retirement program. The provision applies to information relating to people retiring on or after October 1, 1982.

- **Coordination of Food Stamp cost-of-living increases.** This provision excludes from income, for Food Stamp program purposes, amounts paid in July through September of each year that are attributable to cost-of-living adjustments in OASDI, SSI, Railroad Retirement, and veterans' benefits. This exclusion applies only if the household was eligible for Food Stamps in the month before such adjustments. The provision will obviate the need for decreasing the Food Stamp allotment to reflect increased income because of cost-of-living adjustments in other benefits in July, then increasing the food stamp benefit because of the Food Stamp cost-of-living adjustment in October. The provision is effective on enactment (September 8, 1982).

- **Civil Service retirement cost-of-living adjustments.** The provision delays for 1 month in each year 1983-85 the payment of cost-of-living adjustments in CSRS benefits. Thus, the month of adjustment will shift from April to May in 1983, to June in 1984, and to July in 1985.

The timing and amount of cost-of-living adjustments under several other Government retirement systems (for example, the military retirement system and the Foreign Service retirement system) are linked by law to the Civil Service adjustment. Thus, the changes in the timing and amount of Civil Service adjustments also will apply to these other retirement systems.

- **Rounding down of Civil Service retirement annuities.** Effective October 1, 1982, Civil Service annuity benefits not in full dollar amounts will be rounded to the next lower—rather than nearer—dollar at the time of initial determinations of benefit amounts and at the time of annual cost-of-living adjustments.

- **Advancement of effective date for certain reductions in Veterans' Administration (VA) pensions and compensation.** Under this provision, reductions in VA pensions, compensation, and dependency and indemnity compensation on account of changes in the number of dependents will be made on the last day of the month—rather than year—in which the change occurs. This provision is effective with respect to any change in the number of dependents that occurs after September 30, 1982.

- **Rounding VA pensions to the next lower dollar.** Ef-

fective after May 31, 1983, monthly nonservice-connected pensions not in full dollar amounts will be rounded to the next lower—rather than nearer—dollar.

- **Rounding veterans' compensation and dependency and indemnity compensation (DIC) to next lower dol-**

lars. (The effective date was delayed until January 1, 1984, by Public Law 98-21.) Under this provision, compensation and DIC rates not in full dollar amounts will be rounded to the next lower—rather than nearer—dollar. These changes are effective January 1, 1983.