DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 406

[CMS–4018–F]

RIN 0938–AK94

Medicare Program; Continuation of Medicare Entitlement When Disability Benefit Entitlement Ends Because of Substantial Gainful Activity

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule will conform the existing Medicare eligibility regulations to reflect a change made by the Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999. That statutory change that was implemented effective October 1, 2000, provides working disabled individuals with continued Medicare entitlement for an additional 54 months beyond the previous limit of 24 months, for a total of 78 months of Medicare coverage following the 15th month of the reentitlement period.

EFFECTIVE DATE: These regulations are effective on November 23, 2004.

FOR FURTHER INFORMATION CONTACT: Denise Cox, (410) 786–3195.

I. Background

Before October 1, 2000, section 226(b) of the Social Security Act (the Act) provided that disabled beneficiaries who continued to engage in substantial gainful activity after completing a trial work period would receive Medicare coverage for 24 months following the 15th month of the reentitlement period.

Effective October 1, 2000, section 202 of the Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999 (Pub. L. 106–170) amended section 226(b) of the Act to extend the period of Medicare coverage to 78 months after the 15th month of the reentitlement period. Because section 202 was implemented effective October 1, 2000, Medicare coverage has already been extended to 78 months for all disabled individuals who continue to engage in substantial gainful activity after completing a trial work period. This regulation is intended to codify these statutory provisions.

II. Provisions of the Proposed Regulations

On July 25, 2003, we published a proposed rule in the **Federal Register** (68 FR 43998) to revise § 406.12(e)(2)(i) to be consistent with the amended section 226(b) of the Act, which was implemented effective October 1, 2000. We proposed to change the 24 months of extended Medicare coverage to 78 months of Medicare coverage following the 15th month of the reentitlement period.

III. Analysis of and Responses to Public Comments and Provisions of the Final Rule

In response to the July 25, 2003 proposed rule, we received no public comments. We are incorporating the provisions of the proposed rule as final.

IV. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements.

V. Regulatory Impact

A. Overall Impact

We have examined the impact of this final rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980 (Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132. This final rule will essentially conform our regulations to the plain language of the statute.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year as required by 5 U.S.C. 804). We estimate a cost of $112 million to the Medicare trust fund in calendar year 2005. This cost estimate includes Medicare payments for disabled beneficiaries who are currently working and entitled to Medicare coverage, as well as payments for individuals who will become entitled to disability benefits in the future and subsequently return to work with extended Medicare coverage. As noted above, the plain language of the statute gives us no discretion in interpreting this provision, and these costs flow directly from the statute, with or without implementing this final rule. Since this is a major rule, we are providing the following analysis under the Anticipated Effects in section V.B.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 to $29 million in any 1 year. For purposes of the RFA, beneficiaries are not considered to be small entities. Individuals and States are not included in the definition of a small entity. This final rule codifies provisions of the TWWIIA that were implemented on October 1, 2000. Eligible working disabled individuals are already receiving this extended benefit. Based on the legislation, they can continue to receive Medicare benefits for an additional 4½ years. Thus, the only impact on those small entities or rural hospitals currently serving these individuals is that they will continue to receive payment from Medicare for services furnished to individuals. This final rule will not impose any additional administrative or regulatory burdens on small entities. Therefore, we have determined and we certify that this final rule will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. As described above, this final rule extends Medicare coverage to eligible disabled working individuals who are already receiving coverage. Thus, those rural hospitals that currently serve these individuals will continue to receive payment from Medicare for these services. This final rule will not impose any additional administrative or regulatory burden on small rural hospitals. Therefore, we have determined and we certify that this final rule will not significantly affect the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in

any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. State, local, or tribal governments will not be affected since this final rule simply extends the Medicare entitlement for working disabled beneficiaries for an additional 54 months beyond the previous limit of 24 months.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This final rule, which was implemented effective October 1, 2000, will not have a substantial effect on State or local governments because the extension of Medicare entitlement is for individuals already receiving the coverage.

B. Anticipated Effects

1. Effects on Beneficiaries

Before October 1, 2000, disabled beneficiaries who returned to work received 24 additional months of Medicare coverage following the 15th month of their reentitlement period. Effective October 1, 2000, these beneficiaries received 78 months of Medicare coverage following the 15th month of the reentitlement period.

The extension of Medicare coverage allows these beneficiaries to return to work without fear of being unable to qualify for health insurance because of pre-existing medical conditions and being faced with the prospect of either no health insurance or health insurance at a high premium, or significant medical expenses. In addition, the law ensures that individuals already entitled to Medicare can continue to receive health care services from the same providers without incurring a break in coverage. This extended coverage also gives individuals with disabilities the ability to continue working and therefore lead productive lives. Together with the other provisions of the TWWIIA (for example, rehabilitation and job training), the extension of Medicare coverage will improve the overall quality of life for these beneficiaries.

Without this extension of coverage, the beneficiaries would have been forced to find other health insurance coverage (presumably at a higher cost, or with his or her disability excluded from coverage) or forego coverage entirely, and thus incur significant medical expenses. Either result would likely have lowered the beneficiary's overall quality of life and discourage him or her from returning to work. Instead, the Congress chose to extend Medicare coverage and has requested that the General Account Office study the overall impact of this extension so that it may decide in the future whether to extend the coverage indefinitely for this population.

2. Effects on the Medicare Programs

Anticipated expenditures to the Medicare program have been projected over a 5-year period and are shown in the following chart:

Year	2004	2005	2006	2007	2008
Cost* ($ in millions)	98	112	127	141	156
Disabled individuals affected**	35,000	39,000	42,000	45,000	48,000

*Rounded to nearest million.
**Rounded to nearest thousand.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Sections in 42 CFR Part 406

Health facilities, Medicare.

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

PART 406—HOSPITAL INSURANCE ELIGIBILITY AND ENTITLEMENT

Subpart B—Hospital Insurance Without Monthly Premiums

■ 1. The authority citation for part 406 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 2. In § 406.12, revise the introductory text to paragraph (e)(2) and revise paragraph (e)(2)(i) to read as follows:

§ 406.12 Individual under age 65 who is entitled to social security or railroad retirement disability benefits.

* * * * *

(e) * * *

(2) *Duration of continued Medicare entitlement.* If an individual's entitlement to disability benefits or status as a qualified disabled railroad retirement beneficiary ends because he or she engaged in, or demonstrated the ability to engage in, substantial gainful activity after the 36 months following the end of the trial work period, Medicare entitlement continues until the earlier of the following:

(i) The last day of the 78th month following the first month of substantial gainful activity occurring after the 15th month of the individual's reentitlement period or, if later, the end of the month following the month the individual's disability benefit entitlement ends.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: January 12, 2004.

Dennis G. Smith,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: February 18, 2004.

Tommy G. Thompson,

Secretary.

Note: This document was received at the Office of the Federal Register on Thursday, September 16, 2004.

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